PROCEDURES FOR CONTINUITY OF CARE
between
COMMUNITY SERVICES BOARDS
and
STATE PSYCHIATRIC FACILITIES

(Revised Client Service Management Guidelines)

February 3, 1997

TABLE OF CONTENTS

Pag

INTRODUCTION ..... I-ii

1. EMERGENCY AND CRISIS RESPONSE SERVICES 1-3

2. PREADMISSION SCREENING AND ADMISSION TO INPATIENT PSYCHIATRIC HOSPITALS 4-10

3. COORDINATION OF TREATMENT PLANNING

4. COORDINATION OF DISCHARGE PLANNING .....

5. POST-HOSPITAL FOLLOW-UP CARE . . .

APPENDICES 20

A. Selected References: Statutes of Virginia Related to the Department of Mental Health, Mental Retardation and Substance Abuse Service (Non-Forensic) A-21

B. 42 CFR Part 2: Confidentiality of Alcohol and Drug Abuse Records: Final Rule (7/9/87) B-63

C. Procedures for the Transfer of Patients: Departmental Instruction No. 6 ..... C-84

D. Psychiatric Inpatient Treatment of Minors Act: Section by Section Analysis D-95

E. Table: Legal Status of Individuals Requiring Forensic Treatment Selected Statutes: Statutes of Virginia Related to the Department of Mental Health, Mental Retardation and Substance Abuse Services (Forensic) E-101

F. Case Management CSB and Related PRAIS Data Elements F-134

G. Philosophy/Values of System of Care: Principles of Service Delivery (Mental Health Plan 1996) G-144

H. Forms Related to Continuity of Care H-149

I. Patient Self-Determination Act: Departmental Instruction No. 120 ..... I-163

J. Medical Screening of Individuals Referred for Admission to DMHMRSAS Hospitals and Training Centers: Departmental Instruction No. 131 ..... J-171

K. Regional Crisis Stabilization Protocols K-180

L. Attorney General Opinion on Transportation Under ECO's and TDO's L-193

M. State Board Policy 1029, June 1990 - Definition of Serious Mental Illness M-200

INTRODUCTION

Purpose of the *Continuity of Care Procedures*

Consistent with the State Mental Health, Mental Retardation and Substance Abuse Services Board Policy on Client Management, the *Procedures for Continuity of Care* outline the basic operational roles, responsibilities, and expectations of community services boards (CSBs) and state psychiatric facilities in managing the care of individuals they serve. These procedures reflect important goals of our system of care: meeting the needs of individuals and families; establishing and supporting effective collaboration between community services boards and state facilities; involving individuals and families in treatment planning and service delivery; and working assertively with courts, sheriffs, and other agencies on behalf of individuals who need services. These procedures focus on a discrete subset of interactions between community-based service providers and state psychiatric facilities which share responsibilities for activities related to the pre-admission, hospital liaison, and discharge and follow-up processes.

These procedures conform to the Code of Virginia and, to the extent possible, are consistent with standards contained in the Department's Rules and Regulations for the Licensure of Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, Commission on Accreditation of Rehabilitation Facilities (CARF) standards, and Healthcare Finance Administration (HCFA) standards. The procedures are predicated upon and guided by the Department's mission, values, and principles of service development and delivery as described in Virginia's Mental Health Plan. These values and principles are listed in Appendix G of this document.

Lastly, it is recognized that managed care and other influences have caused and will continue to cause substantial changes in Virginia's mental health, mental retardation and substance abuse services system. The *Procedures for Continuity of Care* are offered to update the framework initially articulated in the 1988 Client Service Management Guidelines which offered a structure for the working relationship between community services boards and state psychiatric facilities relative to the management of client care. This document offers a revised framework reflecting concepts related to quality, continuity of care, and accountability, as well as Departmental policy and recent statutory changes. The *Procedures for Continuity of Care* will be re-evaluated in light of system change as it occurs.

Replacement of the Client Service Management Guidelines

These procedures replace the Client Services Management Guidelines, which have been in effect since July 1, 1988. CSBs and state psychiatric facilities should jointly develop mechanisms to operationalize the new *Procedures for Continuity of Care.*

Organization of the Continuity of Care Procedures

This document contains three types of information:

- ✓ Procedures that are related to hospital admissions, treatment planning, and discharge planning;
- ✓ Practitioner Guidance statements, which are contained in the procedures, that describe good practices in carrying out the procedures and recommend resource and reference materials;
- ✓ Appendix documents and Virginia Code Sections referenced in the text.

1 EMERGENCY AND CRISIS RESPONSE SERVICES

Introduction

Emergency and crisis response services are essential components of a community support system for adults with mental illness, mental retardation, or substance abuse and for children with serious emotional disturbance, mental retardation, or substance abuse. These services are short-term interventions aimed at resolving crises and supporting individuals in the least restrictive and most normalizing ways. These services must be in place in order to effectively manage the use of limited and costly inpatient hospital services.

Procedures

1.1 All community services boards shall provide emergency and crisis response services that are available 24 hours per day, seven days per week.

1.2 Emergency and crisis response services shall include, at a minimum: telephone interventions; face-to-face assessments and evaluations (including pre-admission screening); psychiatric consultation and other clinical consultation about medical conditions, substance abuse and special populations which include children, adolescents, older adults, people with mental retardation, and individuals involved in the forensic system.

1.3 When face-to-face crisis interventions are deemed appropriate, community services boards shall make every effort to insure such interventions are available and accessible throughout their respective catchment areas within one hour of initial contact for urban community services boards and within two hours of initial contact for rural community services boards.

Practitioner Guidance: It is recognized that there will be circumstances in which the above-noted response intervals will be increased due to factors involving distance and travel time, staffing levels, clinical acuity, and the amount of clinical activity in progress. These time frames are intended to serve as targets; failure to meet these targets should be the exception.

1.4 Crisis response services shall be available to any individual who is physically present within the community services board's catchment area regardless of where the individual legally resides.

1.5 When emergency and crisis response services are provided in collaboration with other agencies or organizations or through other arrangements with outside providers, these arrangements shall be described in formal written agreements, that is a contract, a letter of agreement, or joint procedures. When such other arrangements are adopted, the community services board shall retain responsibility for monitoring and ensuring the

providers' compliance with these procedures and all other Departmental policies and procedures relevant to facility admissions.

1.6 Emergency and crisis response services shall be provided by clinicians who have the knowledge, skills, abilities, and experience that qualify them to provide these services. This shall include knowledge of and experience with emergency access to community and hospital services and resources; mental status examinations and pre-admission screening of adults, minors, and individuals with other special needs and conditions (see 1.2, above); clinical approaches and treatment methods; and relevant statutes and procedures.

Practitioner Guidance: Community services boards should develop printed lists of emergency services and other programs, resources, and supports for individuals who could benefit from these services. Examples include mobile outreach services, warmlines, consumer drop-in centers, public and private human services agencies, and support groups. These lists should be given to emergency services clinicians for their use and for distribution to others.

.7 Prior to the disposition of an emergency situation, emergency and crisis response clinicians shall attempt to identify and contact any other current service providers and appropriate significant persons (such as a guardian or a minor's parent) to obtain additional information and their recommendations for intervention.

1.8 When the individual in need of crisis services has a dual diagnosis of mental retardation and mental illness, community services board mental retardation and mental health staff shall follow the procedures delineated in the appropriate Regional Crisis Stabilization Protocol. (See Appendix K).

1.9 In order to respond most effectively to crises, emergency and crisis response clinicians shall have timely access to relevant clinical, treatment, and demographic information about the individual maintained by the community services board.

The emergency response clinician shall not refer an individual who has received face-to-face emergency services to a state psychiatric facility without direct communication with a representative of the receiving facility. No individual shall be transported to a facility prior to confirmation and acceptance of the referral by the receiving facility. Such referrals shall include provisions for the individual's transportation.

If the individual receiving face-to-face emergency services is a consumer of a different community services board, or is a resident of a different CSB catchment area, then, whenever feasible and appropriate, clinicians from both CSBs shall discuss and concur with the proposed emergency intervention and agree upon responsibility for any follow-up of the individual.

Practitioner Guidance: A community services board may release and exchange any such information that is needed to formulate and effect emergency treatment when the individual who is the subject of face-to-face emergency services or his parent, guardian,

or committee refuses to authorize the release of information that may be necessary to formulate and implement a proposed emergency intervention. It is the intent of this procedure that any information exchanged about an individual be used only to facilitate a coordinated and well-formulated emergency response and intervention and that such information shall be protected from disclosure for any other purpose to any other person or organization.

2. PREADMISSION SCREENING AND ADMISSION TO INPATIENT PSYCHIATRIC HOSPITALS

Introduction

Preadmission screening ensures the ability of the community services boards to manage and coordinate admissions to:

- State psychiatric facilities;
- Private psychiatric hospitals under contract with the Department;
  Private psychiatric hospitals utilized by community services boards; and
  Private psychiatric hospitals for Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Medicaid recipients under age 21.

Preadmission screening by community services boards also assures that limited hospital resources are used appropriately and begins the process of community services board involvement in hospital treatment for the individual. The preadmission screening process serves to verify an individual's need for inpatient psychiatric hospital services and to divert individuals, for whom less restrictive alternatives are appropriate, from admission to an inpatient facility. Preadmission screening provides a uniform method of entry into all state psychiatric facilities and it is required by the Code of Virginia (§§ 37.1-65, 37.1-67.3, 37.1-197.1).

Procedures

2.1 All individuals being considered for voluntary admission to state psychiatric hospitals and contracted private hospitals shall be prescreened by community services boards prior to admission. All individuals who are admitted to any public or private hospital on an involuntary basis must also be prescreened. The prescreening shall be a face-to-face evaluation that is conducted by the community services board serving the catchment area in which the individual is physically located. The prescreening can take place at the community services board or any other agreed upon and appropriate location.

Practitioner Guidance: *CSB preadmission screening for inpatient psychiatric services under EPSDT is required for Medicaid recipients under age 21. Both state facility and private psychiatric hospital EPSDT admissions must be prescreened by the CSB.*

Practitioner Guidance: *A prescreening evaluation can be initiated by an Emergency Custody Order, a request for a Temporary Detention Order, a Petition for Involuntary Commitment, or by a request from a citizen, minor (older than 14 years), parent, police officer, or agency to evaluate an individual for psychiatric hospital admission.*

Practitioner Guidance: *Some forensic patients who are admitted to state psychiatric facilities pursuant to certain sections of the Virginia Code do not require preadmission screening by the community services board. Types of forensic legal status,*

corresponding code sections, and requirements for prescreening are reflected in the table entitled "Legal Status of Individuals Requiring Forensic Treatment." (See Appendix E).

***Practitioner Guidance**: Preadmission screening for persons who are mentally retarded and mentally ill should involve staff from both the mental retardation and the mental health programs of the community services board in accordance with the established Regional Crisis Stabilization Protocol.*

***Practitioner Guidance**: The clinician should inform the individual and his or her family that there is a cost for the prescreening evaluation and that the community services board will work with the individual and his or her family to determine their financial obligation.*

***Practitioner Guidance**: The clinician should inform the individual and his or her family that there is a cost for inpatient hospital treatment and that they will be billed by the hospital for inpatient treatment. The hospital will work with the individual and his or her family to determine their financial obligation as appropriate.*

Transfers from private psychiatric hospitals to state psychiatric hospitals shall be made in accordance with Departmental Instruction 6. (See Appendix C).

***Practitioner Guidance**: In accordance with private hospital transfer procedures outlined in Departmental Instruction No. 6, a preadmission screening by the community services board may not be required before the actual transfer to a state psychiatric facility. When a preadmission screening has been conducted by the community services board before the admission to the private facility from which transfer to a state facility is sought, the community services board in consultation with staff of the receiving state hospital should determine whether a second prescreening evaluation is warranted and may dispense with this second evaluation if it is deemed unnecessary.*

The community services board serving the catchment area in which the individual is physically located is responsible for performing the prescreening evaluation. When an individual is a resident of another community services board catchment area, the prescreening CSB may contact the "home" or "Case Management CSB" to solicit consultation from that CSB and to confirm the "Case Management CSB" designation. The "Case Management CSB" is defined as the CSB that serves the area in which the individual being admitted resides. The "Case Management CSB" is responsible for case management, CSB liaison during hospitalization, and the implementation of the discharge plan. (See Appendix F).

Consultation from other community services board staff shall be available to emergency services and crisis response staff to assist them with the prescreening process and the determination of need for hospitalization. Consultation shall be available in the following specialty areas: forensics, child and family services, substance abuse, mental retardation, geriatric services, and general medical clearance.

Practitioner Guidance: *The community services board should also make arrangements for translation services to be available for individuals who do not speak English or who are hearing impaired.*

2.5 When the prescreening involves a minor under the age of 14, community services board staff shall contact the minor's parents or guardian to obtain parental consent for the prescreening and admission. A minor 14 years or older is deemed an adult for purposes of consent for voluntary treatment. The minor's parents or guardian can petition for involuntary admission over the minor's objection and minor may also be involuntarily committed over their parent's or guardian's objection.

When the clinician's evaluation indicates that inpatient psychiatric hospitalization is required, such information shall be recorded on the DMHMRSAS Preadmission Screening Form (DMH 224 rev. 4/94).

Practitioner Guidance: *Timely and complete clinical information conveyed during the admission process helps to assure a smooth transition and the delivery of prompt, effective inpatient care and treatment. Any standardized functional assessment instruments being used by CSBs for adults and minors should be completed in full with all relevant information provided to the facility.*

The clinician shall ensure that all available information that can assist the hospital in admitting and treating the person accompanies the individual to the hospital. At a minimum, this information must include a fully completed Preadmission Screening Form (DMH 224), all court orders (e.g., detention orders, commitment orders, etc.), and other documents related to the admission.

Practitioner Guidance: *It is always helpful to hospital staff to have as much relevant information about the individual as possible upon admission so that treatment and discharge planning can be initiated promptly. Additional helpful information includes other clinical information and school and court records.*

Practitioner Guidance: *For child and adolescent admissions, it is helpful to note on the prescreening form the name, address, and telephone number of the child's parents or guardian.*

Practitioner Guidance: *When a private provider is involved with the individual, the clinician should write the name, address, and telephone number of the provider on the prescreening form or in the evaluation forwarded to the hospital.*

Practitioner Guidance: *For individuals involved in the forensic system, §19.2-174.1 of the Code of Virginia may apply. (See Appendix E).*

Practitioner Guidance: *For individuals with mental retardation and mental illness, it is important that the names, addresses, and telephone numbers of key community services*

board mental retardation and mental health program staff be included on the prescreening form.

2.8 All admissions shall be processed in accordance with the applicable statutory provisions.

<u>Practitioner Guidance:</u> Several types of hospital admissions can occur based upon the severity of the individual's presenting problems, the type of admission requested, the person's capacity to give informed consent, the presence of criminal charges, and the age of the individual. The different types of hospital admissions and their requirements are found in the Code of Virginia. They include:

- *Voluntary Admission of Adults, Age 18 and Older (§ 37.1-65);*
- *Voluntary Admission of a Minor, Age 0 through 17 (§ 16.1-338);*
- *Mental Examinations and Treatment of Minors (§ 16.1-275);*
- *Commitment of Mentally Ill or Mentally Retarded Children (§ 16.1-280);*
- *Voluntary Admission of an Objecting Minor Age 14 through 17 (§ 16.1-339);*
- *Involuntary Admission of an Adult (§ 37.1-67.3);*
- *Involuntary Admission of a Minor (§§ 16.1-341-345);*
- *Temporary Detention of an Adult or Minor (§ 37.1-67.1, § 16.1-340); and*
- *Forensic Admissions (§ 19.2-169.2, § 19.2-169.6, § 19.2-176, § 19.2-177.1, § 19.2-182.3, § 53.1-40.2, §§ 37.1-73 - 74, § 37.1-67.3 as identified in § 53.1-40.9).*

<u>Practitioner Guidance</u>: The legal status of individuals who are referred for forensic services is varied. Types of forensic legal status and corresponding relevant code sections are reflected in the table entitled "Legal Status of Individuals Requiring Forensic Services." (See Appendix E).

2.9 If the prescreening evaluation indicates that hospitalization is required, the clinician shall determine whether the individual is willing to be admitted voluntarily and whether the individual has the capacity to consent to voluntary hospitalization. If the individual is found to be incapable of consenting to voluntary admission, or is unwilling to be treated, and meets the Virginia criteria for involuntary admission or if the individual is fourteen years of age or older and refuses voluntary admission, then the individual may be hospitalized involuntarily, and this recommendation shall be recorded on the preadmission screening form.

When the prescreening evaluation indicates that the individual is in need of mental health care, but that hospitalization is not required, then the clinician shall begin emergency outpatient treatment or refer the individual for needed services from other community services board programs or other available providers.

The clinician shall notify the psychiatric facility where an individual will be admitted prior to the issuance of a Temporary Detention Order, an Involuntary Commitment Order or approval of a voluntary admission.

Practitioner Guidance: *Notification to the facility regarding a forthcoming admission is essential. When any state psychiatric hospital is at full occupancy, that facility will explore other arrangements with the community services board, such as a private hospital admission.*

Practitioner Guidance: *In accordance with §37.1-71 of the Code of Virginia, the judge will review transportation alternatives after commitment and may consult with treating staff and the community services board as to whether transportation alternatives may be utilized. Transportation alternatives, as specified in §37.1-72, may include placing the individual who has been certified for admission in the custody of a responsible person or persons, including a representative of the temporary detention facility in which the individual has been hospitalized.*

Practitioner Guidance: *The clinician should provide individual treatment recommendations and goals to be accomplished during the inpatient stay to the receiving hospital. This information will help the facility develop collaborative treatment planning that includes the individual, the CSB, and the hospital.*

Practitioner Guidance: *In accordance with the Attorney General Opinion relative to the transportation of persons under ECO's and TDO's, neither sheriffs' offices nor police departments have primary responsibility to transport persons subject to an emergency custody order or temporary detention order. Rather any law enforcement officer who is requested by the court to execute an ECO or TDO should do so without delay. A sheriff's office or a police department may not limit its execution of these orders to certain times of day. The Code of Virginia also provides that, should a sheriff be ordered to provide transportation of a person who has been committed to a hospital, transportation must commence within six hours of notification to the sheriff of the certification for admission. (See Appendix L).*

2.12 During the preadmission screening process, hospital personnel shall inquire about, and CSB staff are expected to provide, medical information when an individual is being considered for admission. The state psychiatric facility Medical Director or physician designee shall review with CSB prescreening staff the medical/surgical status of any individual being considered for admission when there is evidence of a medical problem. (See Appendix J).

The clinician shall attempt to contact the parents, family, or guardian of the individual who is being hospitalized and who has given consent for such contact to let them know how to participate in the individual's treatment. In cases involving minors, the clinician shall contact the parents/guardian to let them know how to participate in the individual's treatment.

Upon admission, the state psychiatric facility shall confirm and designate the "Case Management CSB" to initiate ongoing treatment coordination with that CSB.

Practitioner Guidance: *The designated "Case Management CSB" will be entered into the Patient Resident Automated Information System (PRAIS) upon the individual's admission to track and report inpatient treatment and utilization data. When confirming the "Case Management CSB" designation, the hospital may learn that the individual is a resident of a different community services board catchment area than the one in which the prescreening was done. In this circumstance, the hospital shall immediately contact both CSBs to ensure that the individual is assigned a case coordinator from the CSB serving the area where the individual resides, advise both CSBs of the "Case Management CSB" designation in the PRAIS system, and confirm the identity of the agreed upon "Case Management CSB." Specific definitions, procedures, and interpretive guidelines for the "Case Management CSB" designation can be found in "CASE MANAGEMENT CSB and Related PRAIS Data Elements," June 2, 1994. (See Appendix F).*

Practitioner Guidance: *The NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty By Reason of Insanity outlines basic expectations regarding the management of individuals who have been found NGRI. The NGRI coordinators in all CSBs and the Forensic Coordinators in all facilities have copies of the NGRI Manual.*

Upon admission, the state psychiatric facility shall determine whether an adult individual has executed an advance directive (formerly referred to as a living will) regarding medical treatment and health care decisions and adhere to conditions set forth in such directive, if one exists. (See Appendix I).

The state psychiatric facility shall appropriately evaluate any individual who presents at the facility for admission, whether or not they have been prescreened by a community services board. Should the hospital find that the individual does not require hospitalization, the hospital shall notify the appropriate community services board and the individual's parents if the individual is a minor child or adolescent to arrange for other services. It is the CSB's responsibility to put into place alternative services for the willing individual, if needed.

Practitioner Guidance: *In the rare instance when an individual who presents for admission has not been prescreened by a CSB, the absence of such prescreening should not delay or prevent the evaluation by the state psychiatric facility staff. State psychiatric facility staff should explore how the CSB was bypassed to avoid any such future circumstance.*

A community services board's staff member should attend all commitment hearings for residents of its catchment area, including recommitment hearings, or arrange for a surrogate or other representative to attend, regardless of the site of the commitment hearing. Surrogates can include qualified state facility or local community services board staff.

Practitioner Guidance: *Section 37.1-67.3 of the Code of Virginia makes no distinction between initial commitment and recommitment and requires a prescreening of every case*

by the CSB serving the catchment area in which the individual resides. Geographic considerations may make it impossible for a distant CSB to prescreen one of its residents in a state psychiatric facility. Under such circumstances, it is acceptable for a surrogate, such as a hospital staff or a local CSB, to conduct the evaluation on behalf of the "Case Management CSB". When such an alternative is used, the prescreening staff must review their findings and recommendations with the "Case Management CSB" prior to the commitment hearing, and any report that is presented at the hearing by an alternate prescreener must be approved by the "Case Management CSB".

When an individual requires a hearing for recommitment, staff at the state psychiatric facility shall notify the community services board at least 14 calendar days in advance of the hearing date. Community services board staff shall complete the prescreening evaluation for recommitment and attend the hearing unless other arrangements have been made with the hospital. (See 2.17).

Community services boards shall negotiate written agreements with all Juvenile and Domestic Relations and General District courts serving their catchment areas. The agreements shall specify the responsibilities of each party and the procedures to be followed in managing cases brought before the court that involve civil and forensic mental health evaluations and treatment. (See §37.1-197 in Appendix A)

Each community services board shall provide the courts and magistrates within its geographic catchment area lists of CSB employees and other designated clinicians who can perform the mental health examinations described above and in the cited statutes.

Practitioner Guidance: *A Directory of Mental Health Professionals With Training in Forensic Evaluation is available from the Department's Office of Forensic Services or the Institute of Law, Psychiatry, and Public Policy. For information, contact the Forensic Services Section in the Office of Mental Health and Substance Abuse Services, DMHMRSAS, P.O. Box 1797, Richmond, Virginia 23218 at telephone number (804) 786-4837 or Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, Virginia 22901 at telephone number (804) 924-5435.*

3. COORDINATION OF TREATMENT PLANNING

Introduction

Treatment planning assures that an individual is thoroughly and comprehensively assessed and provided with care that is appropriate to the individual's specific treatment and support needs.

Procedures

3.1 Community services boards shall ensure that each individual hospitalized in a state psychiatric facility who will require services and supports upon return to the community is assigned a CSB case manager who will be responsible for hospital liaison activity involving the individual's treatment and discharge planning. For individuals who were homeless or transient prior to admission, a case manager from the community services board that conducted the preadmission screening shall be the liaison. The CSB case manager shall be identified on the DMHMRSAS Preadmission Screening Form (DMH 224).

Practitioner Guidance: Individuals referred for hospitalization through the Virginia Department of Corrections or minors who are admitted from Department of Juvenile Justice (formerly the Department of Youth and Family Services) facilities and who will be returning to those facilities at discharge are not required to have a CSB case manager.

Practitioner Guidance: Individuals who are mentally retarded and mentally ill will be assigned a CSB case manager in accordance with established procedures reflected in the Regional Crisis Stabilization Protocol. (See Appendix K).

Practitioner Guidance: The NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty By Reason of Insanity outlines basic expectations regarding the management of individuals who have been found NGRI. The NGRI Coordinators in all CSBs and the Forensic Coordinators in all state psychiatric facilities have copies of the NGRI Manual.

3.2 The preliminary treatment plan shall be developed in accordance with the applicable Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Health Care Finance Administration (HCFA) standards and shall be based on the information obtained through the preadmission screening process, the initial hospital assessments, and other available records.

3.3 The treatment plan shall be developed collaboratively by the hospital treatment team; the individual; the individual's parents, family, or guardian, as appropriate; the assigned community services board case manager; and other collateral agencies as appropriate. Collateral agencies may include the Department of Social Services (DSS), the Department of Health, or the Department of Rehabilitation Services (DRS).

<u>Practitioner Guidance</u>: When a minor aged 14 years or older objects to further voluntary treatment, the hospital will take necessary safeguards to assure the release of the minor to the consenting parent or guardian or will initiate the commitment process.

<u>Practitioner Guidance</u>: Hospital staff, in cooperation with community services board staff, should provide active support to the individual by informing the individual's family, parents, or guardian of treatment and discharge planning meetings and by involving the family, parents, or guardian in treatment, as appropriate, while the individual is hospitalized

<u>Practitioner Guidance</u>: The state psychiatric facility should notify the CSB of a projected discharge date as early in the hospital stay as possible, preferably within three days of admission and no later than two weeks after admission.

3.4 The individual shall participate fully in the development and continued refinement of the treatment plan.

<u>Practitioner Guidance</u>: All individuals, including persons who are hospitalized, have the right to participate in decisions that affect them. Participation in the treatment planning process is perhaps the most significant way to involve hospitalized persons in these decisions. The treatment team should work closely with the individual who is hospitalized to explore, understand, and utilize the individual's own treatment goals, expectations, and preferences about the various options available for treatment and support. There should also be opportunities to learn about and utilize the person's past treatment experiences in designing the current treatment plan. Full participation means working collaboratively with the treatment team on all aspects of treatment and support and having the opportunity to make choices about one's own treatment. This type of participation and collaboration should be integrated into the treatment planning process for all individuals who are hospitalized.

3.5 The treatment plan shall be evaluated and revised when clinical or other significant changes occur.

3.6 State facility staff shall communicate with community services board staff, family, parents, or guardian, and collateral agencies throughout the course of an individual's treatment regarding treatment strategies and approaches that seem to be most effective, events or issues that will affect the individual's functioning or support in the community after discharge, and any prescribed psychotropic medications that the individual is or will be receiving and how to manage them.

3.7 Facility staff shall provide immediate notification of the transfer of an individual to another treatment facility for medical procedures (e.g., special hospitalization) to the "Case Management CSB" and appropriate family members, parents, or guardian.

3.8 The transfer of an individual from one state facility to another shall not change the case coordination responsibilities of the "Case Management CSB".

Overnight placement of an individual in the community on pass or revocation of any type of community pass shall require notification and consultation by facility staff with the "Case Management CSB". Family members, parents or guardian, and significant others, as appropriate, shall be notified of such placements and revocations.

3.10 State facility staff shall immediately notify the "Case Management CSB" and, as appropriate, the individual's family, parents or guardian, and other collateral agencies of an individual's unauthorized absence from a state psychiatric facility and of actions taken to locate the individual. Community services boards shall assist in attempts to locate these individuals to the extent possible. Facility staff shall follow Chapter 28 in the Administrative Practices Manual on Reporting Critical Incidents.

Case coordination for each individual and progress in treatment shall be documented at the facility or community services board when such individual is an open or active client of the CSB. These records must include documentation of the ongoing involvement of CSB staff, family members, parents or guardians, and other collateral agencies, as appropriate, in treatment planning and service delivery.

4. COORDINATION OF DISCHARGE PLANNING

Introduction

Like preadmission screening, discharge planning ensures that community services boards and state psychiatric facilities manage the individual's transition between hospital to community in an effective manner. Discharge planning must be coordinated among CSBs, state psychiatric facilities, families, parents, guardian, and other collateral agencies, as appropriate, to assure continuity of care.

Procedures

4.1 The discharge plan shall be based on the individual's biopsychosocial needs and shall identify the services necessary to meet these needs in a community setting.

Practitioner Guidance: The array of treatment, life support, and rehabilitation services which may be needed to assist an individual to transition at an optimal level to the community should be considered, located, or created. Essential components that may be needed to provide adequate services and supports include the following: case management services; crisis response services; mental health treatment; stable housing; health and dental care; income support and entitlements; peer support; family and community support; rehabilitation services, including vocational and prevocational services; client identification and outreach; and protection and advocacy.

4.2 Discharge planning is the joint responsibility of the "Case Management CSB" and the state psychiatric facility.

4.3 Discharge planning for out-of-state residents, including minors who will be discharged to an out-of-state placement, is also the joint responsibility of the state facility treatment team and the "Case Management CSB".

4.4 Discharge planning for individuals who have entered Virginia state psychiatric facilities through the Interstate Transfer process is the joint responsibility of the community services board that is designated as the "Case Management CSB" at the time of admission and the state psychiatric facility.

4.5 When an individual chooses not to return to his or her home community after hospitalization, or if returning to the home community is not appropriate or possible, the discharge plan shall be jointly developed by the "Case Management CSB", the state psychiatric facility treatment team, the family, parents or guardian, and other collateral agencies, as appropriate, and with the CSB serving the community in which the individual will reside following hospitalization.

Practitioner Guidance: When returning to the home community is not appropriate or possible and when there is a lack of consensus regarding placement between the involved

CSBs' discharge planning team members, the following dispute resolution process is recommended:

If team members are unable to agree on a plan, then they should appeal to their respective supervisors within three (3) days of the initial discharge planning meeting or the initial discharge plan contact.

(B) The supervisors or the mental health/mental retardation/substance abuse directors of the involved CSBs should attempt to resolve the disagreement. If they are unable to do so, the disagreement should be referred to the heads of the agencies that employ the disagreeing parties.

There should be resolution of the disagreement within ten (10) days of the initial appeal.

4.6 The individual who is hospitalized shall participate fully in the development of his or her discharge plan. In addition, participation shall be solicited from all persons and agencies who are involved with the individual. State psychiatric facility and community services board staff shall work together to ensure that family, parents or guardian, and other collateral agencies are appropriately involved in the discharge planning process.

Practitioner Guidance: *The development of a discharge plan requires ongoing communication and negotiation among the state psychiatric facility, the community services board, and the individual, and the individual's family, parents or guardian, and other collateral agencies, as appropriate.*

Practitioner Guidance: *Prior to discharge, the individual, the CSB case manager, state psychiatric facility staff and the individual's family, parents or guardian, and other collateral agencies as appropriate should develop an assertive outreach and back-up plan to further ensure successful community re-integration.*

Practitioner Guidance: *The NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty By Reason of Insanity outlines basic expectations regarding the discharge planning for individuals who have been found to be NGRI. The NGRI Coordinators in all CSBs and the Forensic Coordinators in all state psychiatric facilities have copies of The NGRI Manual.*

4.7 The discharge plan shall be recorded in its entirety on the Discharge Plan and Referral Summary form (DMH 226). Copies of the discharge plan will be provided to the individual, family, parents or guardian of a hospitalized minor, the "Case Management CSB", and the state psychiatric facility.

4.8 Prior to discharge, the individual, and, as appropriate, his or her family, parents, or guardian, shall meet with the CSB case manager and, as appropriate, visit the community treatment, rehabilitation, support, and residential programs that are included in the discharge plan.

Practitioner Guidance: *The individual, family, parents or guardian, and other members of the individual's support system should be given the name, address, and telephone number of CSB staff who can be contacted for assistance in the event of an emergency.*

Practitioner Guidance: *Consultation and communication between the state psychiatric facility physician and the community services board physician should occur before any discharge involving unusual medical issues, including monitoring the use of drugs such as Clozapine or Risperidone.*

Practitioner Guidance: *In accordance with § 37.1-98.2, community services boards and state facilities may exchange the information required to prepare and implement a comprehensive individualized treatment and discharge plan when the individual has refused consent.*

Practitioner Guidance: *Individuals who will continue to receive services from a community services board after discharge should receive a face-to-face appointment with the CSB case manager or other service providers within one week of the date of discharge from the state psychiatric facility. An appointment with the community services board physician should be scheduled no later than two weeks after discharge.*

4.9 Discharge to an emergency shelter or similar temporary setting shall not be part of the discharge plan unless the individual's continued hospital stay is clinically contraindicated, a continued hospital stay is detrimental to the individual's course of recovery, and both of these conditions are clearly documented on the discharge plan. Such discharges must be accompanied with comprehensive community supports including a plan to secure long-term, stable housing. CSB staff must provide face-to-face follow-up of individuals discharged to emergency shelters or similar temporary settings within seven calendar days of discharge from the state psychiatric facility.

Practitioner Guidance: *The US Department of Housing and Urban Development (HUD) has specific criteria which define various conditions of homelessness and eligibility for HUD funded homeless services. Providers of these services may request documentation about homeless persons being discharged from state facilities which outlines the following: (a) that the facility's policies allow discharge to an emergency shelter for the homeless, (b) that the facility does not serve as a support network to help the person obtain housing or, which describes what steps were taken to obtain housing and certifies that no subsequent residence could be located, and (c) that the person lacks the resources and support to obtain housing independently.*

4.10 When a hospitalized individual leaves the state psychiatric facility Against Medical Advice (AMA), facility staff shall immediately notify the "Case Management CSB" and, in the likelihood that the individual will remain in the area close to the state psychiatric facility, the CSB serving the catchment area in which the facility is located. When a minor is involved in such circumstances, the individual's parent or guardian must also be notified.

4.11 Community services boards and state psychiatric facilities shall jointly review the effectiveness of their discharge planning processes and outcomes on a regular basis and at least annually. These evaluations shall be used to refine CSB and state psychiatric facility procedures, agreements, and planning and problem-solving activities.

5. POST-HOSPITAL FOLLOW-UP CARE

Introduction

Post-hospital follow-up is essential for ensuring that individuals who are discharged from state psychiatric facilities receive the necessary community services and supports to live successfully in the community. There must be continuity of care among community services and supports as well.

Procedures

5.1 The community services board shall ensure that the individual is offered post-hospital services and supports and, if such services and supports are accepted, the CSB shall monitor implementation of the discharge plan.

5.2 For individuals for whom the CSB will be the post-hospital services provider, that community services board's staff shall conduct a face-to-face interview with the individual, and as appropriate, the individual's family, parents, or guardian no later than one week after the date of discharge. If the individual fails to keep the appointment and does not reschedule, then telephone contact and assertive outreach, which may include a home visit, shall be made to assess the individual's situation and implement a revised community support plan.

5.3 Post-hospital follow-up shall be provided by the community services board serving the community in which the individual lives or, in the case of a minor, the CSB serving the community in which the minor's parent or guardian resides. In those cases where a minor has been placed at a prohibitive distance from his or her guardian, the community services board serving the catchment in which the individual is placed shall provide the post hospital follow-up, as appropriate.

Practitioner Guidance: There are some situations in which CSBs would not be expected to continue to provide services to individuals after hospitalization. These situations arise when individuals no longer wish to receive services, when services have been successful and no further interventions are required, when an individual (or a minor's parents or guardian) cannot be engaged in services after documented efforts to re-engage them, or when all services are provided through other non-CSB affiliated agencies.

Practitioner Guidance: For individuals 65 years and older who are discharged from state psychiatric facilities, it may be appropriate to arrange for more intensive follow-up care. In such cases, the CSB should collaborate with state psychiatric facility staff to arrange:

- *Face-to-face contact in the placement setting after discharge until a satisfactory adjustment has been achieved, based upon the clinical judgment of the treating staff; or*

- *Telephone contact following discharge until a satisfactory adjustment has been achieved, based upon the clinical judgment of the treating staff.*

Practitioner Guidance: *The NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity outlines basic expectations regarding the management of individuals who have been found NGRI. The NGRI coordinators in all CSBs and the Forensic Coordinators in all state psychiatric facilities have copies of The NGRI Manual.*

Practitioner Guidance: *The continued involvement of and collaboration between the community services board's mental retardation and mental health program staff is essential to the successful community integration of persons who are mentally retarded and mentally ill.*

APPENDICES

Appendix A

Selected References
Statutes of Virginia Relating to the Department of Mental Health, Mental Retardation and Substance Abuse Services

Appendix B

42 CFR Confidentiality of Alcohol and Drug Abuse Records: Final Rule

Appendix C

Procedures for the Transfer of Patients to DMHMRSAS Psychiatric Facilities: Departmental Instruction No. 6

Appendix D

Psychiatric Inpatient Treatment of Minors Act: Section by Section Analysis

Appendix E

Table: Legal Status of Individuals Requiring Forensic Treatment
Selected References: Statutes of Virginia Related to the Department of Mental Health, Mental Retardation and Substance Abuse Services (Forensic)

Appendix F

"Case Management CSB" and Related PRAIS Data Elements

Appendix G

Philosophy/Values of System of Care: Principles of Service Delivery; (Mental Health Plan, 1996)

Appendix H

Forms Related to Continuity of Care

Appendix I

Patient Self Determination Act:
Departmental Instruction No. 120

Appendix J

Medical Screening:
Departmental Instruction No. 131

Appendix K

Regional Crisis Stabilization Protocol

Appendix L

Attorney General Opinion on Transportation Under ECO's and TDO's

Appendix M

State Board Policy 1029, June 1990 - Definition of Serious Mental Illness

APPENDIX A

Selected References: Statutes of Virginia Related to the Department of Mental Health, Mental Retardation and Substance Abuse Services (Non-Forensic)

§ 15.1-131

Police, etc., may be sent beyond territorial limits; reciprocal agreements between counties, cities or towns and certain private police forces for mutual aid

Whenever the necessity arises for the enforcement of laws designed to control or prohibit the use or sale of controlled drugs as defined in § 54.1-3401 or laws contained in Article 3 (§ 18.2-344 et seq.) of Chapter 8 of Title 18.2, or in response to any law-enforcement emergency involving any immediate threat to life or public safety, or during the execution of the provisions of § 37.1-67.01 or § 37.1-67.1 relating to orders for temporary detention or emergency custody for mental health evaluation or during any emergency resulting from the existence of a state of war, internal disorder, or fire, flood, epidemic or other public disaster, the policemen and other officers, agents and employees of any county, city or town and the police of any state-supported institution of higher learning appointed pursuant to § 23-233 may, together with all necessary equipment, lawfully go or be sent beyond the territorial limits of such county, city or town or such state-supported institution of higher learning to any point within or without the Commonwealth to assist in meeting such emergency or need, or while enroute to a part of the jurisdiction which is only accessible by roads outside the jurisdiction. However, the police of any state-supported institution of higher learning may be sent only to a county, city or town within the Commonwealth, or locality outside the Commonwealth, whose boundaries are contiguous with the county or city in which such institution is located. No member of a police force of any state-supported institution of higher learning shall be sent beyond the territorial limits of the county or city in which such institution is located unless such member has met the requirements established by the Department of Criminal Justice Services as provided in subdivision 2 (I) of § 9-170.

In such event the acts performed for such purpose by such policemen or other officers, agents or employees and the expenditures made for such purpose by such county, city or town or a state-supported institution of higher learning shall be deemed conclusively to be for a public and governmental purpose, and all of the immunities from liability enjoyed by a county, city or town or a state-supported institution of higher learning when acting through its policemen or other officers, agents or employees for a public or governmental purpose within its territorial limits shall be enjoyed by it to the same extent when such county, city or town or a state-supported institution of higher learning within the Commonwealth is so acting, under this section or under other lawful authority, beyond its territorial limits.

The policemen and other officers, agents and employees of any county, city or town or a state-supported institution of higher learning when acting hereunder or under other lawful authority beyond the territorial limits of such county, city or town or such state-supported

institution of higher learning shall have all of the immunities from liability and exemptions from laws, ordinances and regulations and shall have all of the pension, relief, disability, workers' compensation and other benefits enjoyed by them while performing their respective duties within the territorial limits of such county, city or town or such state-supported institution of higher learning.

Subject to the approval of the Congress of the United States, the governing body of any county, city or town or a state-supported institution of higher learning, may in its discretion, enter into reciprocal agreements for such periods as it deems advisable with any county, city or town, within or without the Commonwealth, including the District of Columbia, in order to establish and carry into effect a plan to provide mutual aid through the furnishing of its police and other employees and agents together with all necessary equipment in the event of such need or emergency as provided herein. No county, city or town or state-supported institution of higher learning, shall enter into such agreement unless the agreement provides that each of the parties to such agreement shall: (I) waive any and all claims against all the other parties thereto which may arise out of their activities outside their respective jurisdictions under such agreement and (ii) indemnify and save harmless the other parties to such agreement from all claims by third parties for property damage or personal injury which may arise out of the activities of the other parties to such agreement outside their respective jurisdictions under such agreement.

The principal law-enforcement officer, in any city, county or town or of a state-supported institution of higher learning having a reciprocal agreement with a jurisdiction outside the Commonwealth for police mutual aid under the provisions hereof, shall be responsible for directing the activities of all policemen and other officers and agents coming into his jurisdiction under the reciprocal agreement, and while operating under the terms of the reciprocal agreement, the principal law-enforcement officer is empowered to authorize all policemen and other officers and agents from outside the Commonwealth to enforce the laws of the Commonwealth of Virginia to the same extent as if they were duly authorized law-enforcement officers of any city, county or town or a state-supported institution of higher learning in Virginia.

The governing body of any city, county or town or a state-supported institution of higher learning in the Commonwealth is authorized to procure or extend the necessary public liability insurance to cover claims arising out of mutual aid agreements executed with other cities, counties or towns outside the Commonwealth.

The policemen, and other officers, agents and employees of a county, city or town or a state-supported institution of higher learning serving in a jurisdiction outside the Commonwealth under a reciprocal agreement entered into pursuant hereto are authorized to carry out the duties and functions provided for in the agreement under the command and supervision of the chief law-enforcement officer of the jurisdiction outside the Commonwealth.

§ 15.1-138

Powers and duties of police force; compensation; rewards

The officers and privates constituting the police force of counties, cities and towns of the Commonwealth are hereby invested with all the power and authority which formerly belonged to the office of constable at common law in taking cognizance of, and in enforcing the criminal laws of the Commonwealth and the ordinances and regulations of the county, city or town, respectively, for which they are appointed or elected. Each policeman shall endeavor to prevent the commission within the county, city or town of offenses against the law of the Commonwealth and against the ordinances and regulations of the county, city or town; shall observe and enforce all such laws, ordinances and regulations; shall detect and arrest offenders against the same; shall preserve the good order of the county, city or town; and shall secure the inhabitants thereof from violence and the property therein from injury.

Such policeman shall have no power or authority in civil matters, except that a policeman of a county, city or town may execute and serve an order of temporary detention and an emergency custody order and may exercise such other powers as may be specified for law-enforcement officers pursuant to § 37.1-67.01 or § 37.1-67.1 or may serve an order of protection pursuant to §§ 16.1-253.1, 16.1-253.4 and 16.1-279.1. However, a policeman of a city or town shall in all other cases execute such warrants or summons as may be placed in his hands by any magistrate for the county, city or town and shall make due return thereof.

Except as otherwise specifically provided in the charter of any city or town, such policeman shall not receive any fee or other compensation out of the state treasury or the treasury of the city or town for any service rendered under the provisions of this chapter other than the salary paid him by the city or town and a fee as a witness in cases arising under the criminal laws of the Commonwealth. And except as otherwise specifically provided in the charter of any city or town, such policeman shall not receive any fee as a witness in any case arising under the ordinances of his city or town; nor for attendance as a witness before any magistrate in his city or town. If, however, it shall become necessary or expedient for him to travel beyond the limits of the county, city or town in his capacity as a policeman, he shall be entitled to his actual expenses, to be allowed and paid as is now provided by law for other expenses in criminal cases.

Nothing in this section shall be construed as prohibiting a policeman of a county, city or town from claiming and receiving any reward which may be offered for the arrest and detention of any offender against the criminal laws of this or any other state or nation.

§ 16.1-275

(For effective date - See note) Physical and mental examinations and treatment; nursing and medical care

The juvenile court or the circuit court may cause any juvenile within its jurisdiction under the provisions of this law to be physically examined and treated by a physician or to be examined and treated at a local mental health center. If no such appropriate facility is available locally, the court may order the juvenile to be examined and treated by any physician or psychiatrist or examined by a clinical psychologist. The Commissioner of Mental Health, Mental Retardation and Substance Abuse Services shall provide for distribution a list of appropriate mental health centers available throughout the Commonwealth. Upon the written recommendation of the person examining the juvenile that an adequate evaluation of the juvenile's treatment needs can only be performed in an inpatient hospital setting, the court shall have the power to send any such juvenile to a state mental hospital for not more than ten days for the purpose of obtaining a recommendation for the treatment of the juvenile. No juvenile sent to a state mental hospital pursuant to this provision shall be held or cared for in any maximum security unit where adults determined to be criminally insane reside; the juvenile shall be kept separate and apart from such adults. However, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services may place a juvenile who has been certified to the circuit court for trial as an adult pursuant to § 16.1-269.6 or § 16.1-270 or who has been convicted as an adult of a felony in the circuit court in a unit appropriate for the care and treatment of persons under a criminal charge when, in his discretion, such placement is necessary to protect the security or safety of other patients, staff or the public.

Whenever the parent or other person responsible for the care and support of a juvenile is determined by the court to be financially unable to pay the costs of such examination as ordered by the juvenile court or the circuit court, such costs may be paid according to standards, procedures and rates adopted by the State Board, from funds appropriated in the general appropriation act for the Department.

The juvenile court or the circuit court may cause any juvenile within its jurisdiction who is alleged to be delinquent or in need of services to be placed in the temporary custody of the Department of Juvenile Justice for a period of time not to exceed thirty days for diagnostic assessment services after the adjudicatory hearing and prior to final disposition of his or her case. Prior to such a placement, the Department shall determine that the personnel, services and space are available in the appropriate correctional facility for the care, supervision and study of such juvenile and that the juvenile's case is appropriate for referral for diagnostic services.

Whenever a juvenile concerning whom a petition has been filed appears to be in need of nursing, medical or surgical care, the juvenile court or the circuit court may order the parent or other person responsible for the care and support of the juvenile to provide such care in a hospital or

otherwise and to pay the expenses thereof. If the parent or other person is unable or fails to provide such care, the juvenile court or the circuit court may refer the matter to the authority designated in accordance with law for the determination of eligibility for such services in the county or city in which such juvenile or his parents have residence or legal domicile.

In any such case, if a parent who is able to do so fails or refuses to comply with the order, the juvenile court or the circuit court may proceed against him as for contempt or may proceed against him for nonsupport.

§ 16.1-280

(For effective date - See note) Commitment of mentally ill or mentally retarded juveniles

When any juvenile court has found a juvenile to be in need of services or delinquent pursuant to the provisions of this law and reasonably believes such juvenile is mentally ill or mentally retarded, the court may commit him to an appropriate hospital in accordance with the provisions of §§ 16.1-338 through 16.1-345 or admit him to a training center in accordance with the provisions of § 37.1-65.1 for observation as to his mental condition. No juvenile shall be committed pursuant to this section or §§ 16.1-338 through 16.1-345 to a maximum security unit within any state hospital where adults determined to be criminally insane reside. However, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services may place a juvenile who has been certified to the circuit court for trial as an adult pursuant to § 16.1-269.6 or § 16.1-270 or who has been convicted as an adult of a felony in the circuit court in a unit appropriate for the care and treatment of persons under a criminal charge when, in his discretion, such placement is necessary to protect the security or safety of other patients, staff or public. The Commissioner shall notify the committing court of any placement in such unit. The committing court shall review the placement at thirty-day intervals.

§ 16.1-338

Parental admission of minors younger than fourteen and nonobjecting minors fourteen years of age or older

A. A minor younger than fourteen years of age may be admitted to a willing mental health facility for inpatient treatment upon application and with the consent of a parent. A minor fourteen years of age or older may be admitted to a willing mental health facility for inpatient treatment upon the joint application and consent of the minor and the minor's parent.

B. Admission of a minor under this section shall be approved by a qualified evaluator who has conducted a personal examination of the minor within forty-eight hours after admission and has made the following written findings:

1. The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; and

2. The minor has been provided with a clinically appropriate explanation of the nature and purpose of the treatment; and

3. If the minor is fourteen years of age or older, that he has been provided with an explanation of his rights under this Act as they would apply if he were to object to admission, and that he has consented to admission; and

4. All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor.

If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide the examination required by this section and shall ensure that the necessary written findings have been made before approving the admission. A copy of the written findings of the evaluation required by this section shall be provided to the consenting parent and the parent shall have the opportunity to discuss the findings with the evaluator.

C. Within ten days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the admission and to the minor. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured. A copy of the plan shall be provided to the minor and to his parents.

D. If the parent who consented to a minor's admission under this section revokes his consent at any time, or if a minor fourteen or older objects at any time to further treatment, the minor shall be discharged within forty-eight hours to the custody of such consenting parent unless the minor's continued hospitalization is authorized pursuant to §§ 16.1-339, 16.1-340, or § 16.1-345.

E. Inpatient treatment of a minor hospitalized under this section may not exceed ninety consecutive days unless it has been authorized by appropriate hospital medical personnel, based upon their written findings that the criteria set forth in subsection B of this section continue to be met, after such persons have examined the minor and interviewed the consenting parent and reviewed reports submitted by members of the facility staff familiar with the minor's condition.

F. Any minor admitted under this section while younger than fourteen and his consenting parent shall be informed orally and in writing by the director of the facility for inpatient treatment within ten days of his fourteenth birthday that continued voluntary treatment under the authority of this section requires his consent.

§ 16.1-339

(For effective date - See note) Parental admission of an objecting minor fourteen years of age or older

A. A minor fourteen years of age or older who objects to admission may be admitted to a willing facility for up to seventy-two hours, pending the review required by subsections B and C of this section, upon the application of a parent. If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide the examination required by subsection B of § 16.1-338 and shall ensure that the necessary written findings, except the minor's consent, have been made before approving the admission.

B. A minor admitted under this section shall be examined within twenty-four hours of his admission by a qualified evaluator designated by the community services board serving the area where the facility is located who is not and will not be treating the minor and who has no significant financial interest in the minor's hospitalization. The evaluator shall prepare a report which shall include written findings as to whether:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of inpatient treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. Inpatient treatment is the least restrictive alternative that meets the minor's needs. The qualified evaluator shall submit his report to the juvenile and domestic relations district court for the jurisdiction in which the facility is located.

C. Upon admission of a minor under this section, the facility shall immediately file a petition for judicial approval with the juvenile and domestic relations district court for the jurisdiction in which the facility is located. A copy of this petition shall be delivered to the minor's consenting parent. Upon receipt of the petition and of the evaluator's report submitted pursuant to subsection B, the juvenile and domestic relations district court judge or special justice appointed pursuant to § 37.1-88 shall appoint a guardian ad litem for the minor. The court and the guardian ad litem shall review the petition and evaluator's report, and shall ascertain the views of the minor, the minor's consenting parent, the evaluator, and the attending psychiatrist. The court shall conduct its review in such place and manner, including the facility, as it deems to be in the best interests of the minor. Based upon its review and the recommendations of the guardian ad litem, the court shall order one of the following dispositions:

1. If the court finds that the minor does not meet the criteria for admission specified in subsection B, the court shall issue an order directing the facility to release the minor into the custody of the parent who consented to the minor's admission. However, nothing herein shall be deemed to affect the terms and provisions of any valid court order of custody affecting the minor.

2. If the court finds that the minor meets the criteria for admission specified in subsection B, the court shall issue an order authorizing continued hospitalization of the minor for up to ninety days on the basis of the parent's consent.

Within ten days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the admission and to the minor. A copy of the plan shall also be provided to the guardian ad litem. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured.

3. If the court determines that the available information is insufficient to permit an informed determination regarding whether the minor meets the criteria specified in subsection B, the court shall schedule a commitment hearing which shall be conducted in accordance with the procedures specified in §§ 16.1-341 through 16.1-345. The minor may be detained in the hospital for up to seventy-two additional hours pending the holding of the commitment hearing.

D. A minor admitted under this section who rescinds his objection may be retained in the hospital pursuant to § 16.1-338.

E. If the parent who consented to a minor's admission under this section revokes his consent at any time, the minor shall be released within forty-eight hours to the parent's custody unless the minor's continued hospitalization is authorized pursuant to § 16.1-340 or § 16.1-345.

§ 16.1-341

(For effective date - See note) Involuntary commitment; petition; hearing scheduled; notice and appointment of counsel

A. A petition for the involuntary commitment of a minor may be filed with the juvenile and domestic relations district court by a parent or, if the parent is not available or is unable or unwilling to file a petition, by any responsible adult. The petition shall include the name and address of the petitioner and the minor and shall set forth in specific terms why the petitioner believes the minor meets the criteria for involuntary commitment specified in § 16.1-345. The petition shall be taken under oath.

If a commitment hearing has been scheduled by a juvenile and domestic relations district judge pursuant to subdivision 3 of subsection C of § 16.1-339, the petition for judicial approval filed by the facility under subsection C of § 16.1-339 shall serve as the petition for involuntary commitment as long as such petition complies in substance with the provisions of this subsection.

B. Upon the filing of a petition for involuntary commitment of a minor, the juvenile and domestic relations district court may schedule a hearing which shall occur no sooner than twenty-four hours and no later than seventy-two hours from the time the petition was filed. If the seventy-two-hour period expires on a Saturday, Sunday or other legal holiday, the seventy-two hours shall be extended to the next day that is not a Saturday, Sunday or legal holiday. In no case may the time period between the filing of the petition and the hearing under § 16.1-344 exceed ninety-six hours.

If the petition is not dismissed, copies of the petition, together with a notice of the hearing, shall be served immediately upon the minor and the minor's parents, if they are not petitioners. No later than twenty-four hours before the hearing, the court shall appoint counsel to represent the minor, unless it has determined that the minor has retained counsel. Upon the request of the minor's counsel, for good cause shown, and after notice to the petitioner and all other persons receiving notice of the hearing, the court may continue the hearing once for a period not to exceed seventy-two hours.

§ 16.1-342

(For effective date - See note) Involuntary commitment; clinical evaluation

Upon the filing of a petition for involuntary commitment, the juvenile and domestic relations district court shall direct the community services board serving the area in which the minor is located to arrange for an evaluation, if one has not already been performed pursuant to subsection B of § 16.1-339, by a qualified evaluator who is not and will not be treating the minor and who has no significant financial interest in the facility to which the minor would be committed. The petitioner, all public agencies, and all providers or programs which have treated or who are treating the minor, shall cooperate with the evaluator and shall promptly deliver, upon request and without charge, all records of treatment or education of the minor. At least twenty-four hours before the scheduled hearing, the evaluator shall submit to the court a written report which includes the evaluator's opinion regarding whether the minor meets the criteria for involuntary commitment specified in § 16.1-345. The evaluator shall attend the hearing as a witness.

§ 16.1-343

Involuntary commitment; duties of attorney for the minor

As far as possible in advance of a hearing conducted under § 16.1-344, or an appeal from such a hearing, the minor's attorney shall interview the minor; the minor's parent, if available; the petitioner; and the qualified evaluator. He shall interview all other material witnesses, and examine all relevant diagnostic and other reports. The obligation of the minor's attorney during the hearing or appeal is to interview witnesses, obtain independent experts when possible, cross-examine adverse witnesses, present witnesses on behalf of the minor, articulate the wishes of the minor, and otherwise fully represent the minor in the proceeding. Counsel appointed by the court shall be compensated in an amount not to exceed $100.

§ 16.1-344

(For effective date - See note) Involuntary commitment; hearing

The court shall summon to the hearing all material witnesses requested by either the minor or the petitioner. All testimony shall be under oath. The rules of evidence shall apply; however, the evaluator's report required by § 16.1-342 shall be admissible into evidence by stipulation of the parties. The petitioner, minor and, with leave of court for good cause shown, any other person shall be given the opportunity to present evidence and cross-examine witnesses. The hearing shall be closed to the public unless the minor and petitioner request that it be open.

Within thirty days of any final order committing the minor or dismissing the petition, the minor or petitioner shall have the right to appeal de novo to the circuit court having jurisdiction where the minor was committed or where the minor is hospitalized pursuant to the commitment order. The juvenile and domestic relations district court shall appoint an attorney to represent any minor desiring to appeal who does not appear to be already represented.

§ 16.1-345

Involuntary commitment; criteria

The court shall order the involuntary commitment of the minor to a mental health facility for treatment for a period not to exceed ninety days if it finds, by clear and convincing evidence, that:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. If inpatient treatment is ordered, such treatment is the least restrictive alternative that meets the minor's needs. If the court finds that inpatient treatment is not the least restrictive treatment, the court may order the minor to participate in outpatient or other clinically appropriate treatment.

If the parent or parents with whom the minor resides are not willing to approve the proposed commitment, the court shall order inpatient treatment only if it finds, in addition to the criteria specified in this section, that such treatment is necessary to protect the minor's life, health, or normal development, and that issuance of a removal order or protective order is authorized by § 16.1-252 or § 16.1-253.

Upon finding that the best interests of the minor so require, the court may enter an order directing either or both of the minor's parents to comply with reasonable conditions relating to the minor's treatment.

If the minor is committed to inpatient treatment, such placement shall be in a mental health facility for inpatient treatment designated by the community services board which serves the political subdivision in which the minor was evaluated pursuant to § 16.1-342. If the

community services board does not provide a placement recommendation at the hearing, the minor shall be placed in a mental health facility designated by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. The judge shall order the sheriff to transport the minor to the designated mental health facility as specified in § 37.1-71. The transportation of the committed minor by the minor's parent may be authorized at the discretion of the judge.

§ 19.2-169.6

Emergency treatment prior to trial

A. Any defendant who is not subject to the provisions of § 19.2-169.2 may be hospitalized for psychiatric treatment prior to trial if:

1. The court with jurisdiction over the defendant's case finds clear and convincing evidence that the defendant (I) is being properly detained in jail prior to trial; (ii) is mentally ill and imminently dangerous to self or others in the opinion of a qualified mental health professional; and (iii) requires treatment in a hospital rather than the jail in the opinion of a qualified mental health professional; or

2. The person having custody over a defendant who is awaiting trial has reasonable cause to believe that (I) the defendant is mentally ill and imminently dangerous to himself or others and (ii) requires treatment in a hospital rather than jail and the person having such custody arranges for an evaluation of the defendant by a person skilled in the diagnosis and treatment of mental illness provided a judge, as defined in § 37.1-1 or, if a judge is not available, a magistrate, upon the advice of a person skilled in the diagnosis and treatment of mental illness, subsequently issues a temporary order of detention for treatment in accordance with the procedures specified in § 37.1-67.1. In no event shall the defendant have the right to make application for voluntary admission and treatment as may be otherwise provided in § 37.1-65 or § 37.1-67.3.

If the defendant is committed pursuant to subdivision 1 of this subsection, the attorney for the defendant shall be notified that the court is considering hospitalizing the defendant for psychiatric treatment and shall have the opportunity to challenge the findings of the qualified mental health professional. If the defendant is detained pursuant to subdivision 2 of this subsection, the court having jurisdiction over the defendant's case and the attorney for the defendant shall be given notice prior to the detention pursuant to a temporary order of detention or as soon thereafter as is reasonable. Upon detention pursuant to subdivision 2 of this subsection, a hearing shall be held, upon notice to the attorney for the defendant, either (I) before the court having jurisdiction over the defendant's case or (ii) before a judge as defined in § 37.1-1, in accordance with the provisions of § 37.1-67.4, in which case the defendant shall be represented by counsel as specified in § 37.1-67.3; the hearing shall be held within forty-eight

hours of execution of the temporary order to allow the court which hears the case to make the findings, based upon clear and convincing evidence, which are specified in subdivision 1 of this subsection. If the forty-eight-hour period herein specified terminates on a Saturday, Sunday or legal holiday, such person may be detained for the same period allowed for detention pursuant to an order for temporary detention issued pursuant to § 37.1-67.1.

In any case in which the defendant is hospitalized pursuant to this section, the court having jurisdiction over the defendant's case may provide by order that the admitting hospital evaluate the defendant's competency to stand trial and his mental state at the time of the offense pursuant to §§ 19.2-169.1 and 19.2-169.5.

B. A defendant subject to this section shall be treated at a hospital designated by the Commissioner as appropriate for treatment and evaluation of persons under criminal charge. The director of the hospital shall, within thirty days of the defendant's admission, send a report to the court with jurisdiction over the defendant addressing the defendant's continued need for treatment as mentally ill and imminently dangerous to self or others and, if so ordered by the court, the defendant's competency to stand trial, pursuant to subsection D of § 19.2-169.1, and his mental state at the time of the offense, pursuant to subsection D of § 19.2-169.5. Based on this report, the court shall either (I) find the defendant incompetent to stand trial pursuant to subsection E of § 19.2-169.1 and proceed accordingly, (ii) order that the defendant be discharged from custody pending trial, (iii) order that the defendant be returned to jail pending trial, or (iv) make other appropriate disposition, including dismissal of charges and release of the defendant.

C. A defendant may not be hospitalized longer than thirty days under this section unless the court which has criminal jurisdiction over him or a judge as defined in § 37.1-1 holds a hearing at which the defendant shall be represented by an attorney and finds clear and convincing evidence that the defendant continues to be (I) mentally ill, (ii) imminently dangerous to self or others, and (iii) in need of psychiatric treatment in a hospital. Hospitalization may be extended in this manner for periods of sixty days, but in no event may such hospitalization be continued beyond trial, nor shall such hospitalization act to delay trial, so long as the defendant remains competent to stand trial.

§ 19.2-177.1

Determination of mental illness after sentencing; hearing

A person convicted of a crime who is in the custody of a local correctional facility after sentencing may be the subject of a mental commitment proceeding in accordance with the procedures provided in Chapter 2 (§ 37.1-63 et seq.) of Title 37.1. Such proceeding shall be commenced upon petition of the person having custody over the prisoner. If the person having custody over the prisoner has reasonable cause to believe that (I) the prisoner is mentally ill and

imminently dangerous to himself or others and (ii) requires treatment in a hospital rather than a local correctional facility and the person having such custody arranges for an evaluation of the prisoner by a person skilled in the diagnosis and treatment of mental illness, then a judge, as defined in § 37.1-1 or, if a judge is not available, a magistrate, upon the advice of a person skilled in the diagnosis and treatment of mental illness, may issue a temporary order of detention for treatment in accordance with the procedures specified in subdivision A 2 of § 19.2-169.6.

In all other respects, the involuntary civil detention and commitment procedures specified in Chapter 2 of Title 37.1 shall be applicable, except:

1. Any detention or commitment shall be only to a facility designated for this purpose by the Commissioner;
2. In no event shall the prisoner have the right to make application for voluntary admission and treatment as may be otherwise provided in § 37.1-65 or § 37.1-67.3;
3. The time that such prisoner is confined to a hospital shall be deducted from any term for which he may be sentenced, but in no event may such hospitalization be continued beyond the date upon which his sentence would have expired;
4. Any prisoner hospitalized pursuant to this section who has not completed service of his sentence upon discharge from the hospital shall serve the remainder of his sentence.

§ 37.1-48

Transfer of patients from one facility to another

The Commissioner may order the transfer of a resident or patient from one state hospital to another or from one training center for the mentally retarded to another. When so transferred, in accordance with appropriate admission, certification and commitment criteria as provided in this title, a patient or resident is hereby declared to be a lawfully admitted patient or resident of the facility to which he is transferred.

§ 37.1-64

(For effective date - See note) Admission procedures; forms

(a) Any person alleged to be mentally ill to a degree which warrants hospitalization in a hospital as defined in § 37.1-1 of this title may be admitted to and retained as a patient in a hospital by compliance with any one of the following admission procedures:
(1) Voluntary admission by the procedure described in § 37.1-65;
(2) Involuntary admission by the procedure described in §§ 37.1-67.1 through 37.1-67.4.

(b) The Board shall prescribe and the Department shall prepare the forms required in procedures for admission as approved by the Attorney General. These forms, which shall be the legal forms used in such admissions, shall be distributed by the Department to the clerks of the general district courts and juvenile and domestic relations district courts of the various counties and cities of the Commonwealth and to the directors of the respective state hospitals.

(c) Any person alleged to be mentally ill to a degree which warrants emergency hospitalization may be admitted to and retained as a patient in the state hospital closest to his domicile by compliance with the admission procedures provided in § 37.1-65 or §§ 37.1-67.1 through 37.1-67.4.

§ 37.1-65

Voluntary admission

Any state hospital shall admit as a patient any person requesting admission who, having been screened by the community services board or the community mental health clinic which serves the political subdivision of which the person is a resident and having been examined by a physician on the staff of such hospital, is deemed to be in need of hospitalization by such board or clinic and the physician for mental illness, mental retardation or substance abuse.

§ 37.1-67.01

Emergency custody; issuance and execution of order

Based upon probable cause to believe that the person is mentally ill and in need of hospitalization and that the person presents an imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self, any magistrate may, upon the sworn petition of any responsible person or upon his own motion, issue an emergency custody order requiring any person within his judicial district who is incapable of volunteering or unwilling to volunteer for treatment to be taken into custody and transported to a convenient location to be evaluated by a person designated by the community services board who is skilled in the diagnosis and treatment of mental illness in order to assess the need for hospitalization. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization without prior authorization. Such evaluation shall be conducted immediately. The person shall remain in custody until a temporary detention order is issued or until the person is released, but in no event shall the period of custody exceed four hours. A law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the county, city or town in which he serves to any point in the Commonwealth

for the purpose of executing an order for emergency custody pursuant to this section. Nothing herein shall preclude a law-enforcement officer from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

If an order of emergency custody is not executed within four hours of its issuance the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if such office is not open, to any judge or magistrate thereof.

§ 37.1-67.1

Involuntary temporary detention; issuance and execution of order

For the purposes of this section, a designee of a community services board is defined as an examiner able to provide an independent examination of the person who is not related by blood or marriage to the person, who has no financial interest in the admission or treatment of the person, who has no investment interest in the hospital detaining or admitting the person under this article and, except for employees of state hospitals and of the U.S. Department of Veterans Affairs, who is not employed by such hospital. For purposes of this section, investment interest means the ownership or holding of an equity or debt security, including, but not limited to, shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other equity or debt instruments.

A magistrate may, upon the advice of, and only after an in-person evaluation by, an employee of the local community services board or its designee who is skilled in the assessment and treatment of mental illness, issue an order of temporary detention if it appears from all evidence readily available that the person is mentally ill and in need of hospitalization and that the person presents an imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self, and the person is incapable of volunteering or unwilling to volunteer for treatment. Such order may include transportation of the person to such other medical facility as may be necessary to obtain emergency medical evaluation or treatment prior to placement.

A magistrate may issue such order of temporary detention without an emergency custody order proceeding. A magistrate may issue an order of temporary detention without a prior in-person evaluation if (I) the person has been personally examined within the previous seventy-two hours by an employee of the local community services board or its designee who is skilled in the assessment and treatment of mental illness or (ii) there is a significant physical, psychological or medical risk, to the person or to others, associated with conducting such evaluation.

An employee of the local community services board or its designee shall determine the facility of temporary detention for all individuals detained pursuant to this section. The facility shall be identified on the prescreening report and indicated on the temporary detention order. The Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention. The institution or other place of detention shall be approved pursuant to regulations of the Board of Mental Health, Mental Retardation and Substance Abuse Services. The employee of the community services board or its designee who is conducting the evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention order, the insurance status of the person. Except as provided herein for defendants requiring hospitalization in accordance with subdivision A 2 of § 19.2-169.6, such person shall not be detained in a jail or other place of confinement for persons charged with criminal offenses.

A law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing any order for temporary detention pursuant to this section. The duration of temporary detention shall not exceed forty-eight hours prior to a hearing. If the forty-eight-hour period herein specified terminates on a Saturday, Sunday or legal holiday, such person may be detained, as herein provided, until the next day which is not a Saturday, Sunday or legal holiday, but in no event may he be detained for longer than seventy-two hours or ninety-six hours when such legal holiday occurs on a Monday or Friday. For purposes of this section, a Saturday, Sunday, or legal holiday shall be deemed to include the time period up to 8:00 a.m. of the next day which is not a Saturday, Sunday, or legal holiday. Nothing herein shall preclude a law-enforcement officer from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

In any case in which temporary detention is ordered pursuant to this section upon petition of a person having custody of a defendant in accordance with subdivision A 2 of § 19.2-169.6, the magistrate executing the order of temporary detention shall place such person in a hospital designated by § 19.2-169.6 B, or if such facility is not available, the defendant shall be detained in a jail or other place of confinement for persons charged with criminal offenses and shall be transferred to such hospital as soon as possible thereafter. The hearing shall be held, upon notice to the attorney for the defendant, either (I) before the court having jurisdiction over the defendant's case, or (ii) before a judge as defined in § 37.1-1 in accordance with the provisions of § 37.1-67.4, in which case the defendant shall be represented by counsel as specified in § 37.1-67.3. In any case in which temporary detention is ordered pursuant to this section upon petition for involuntary commitment of a minor, the petition shall be filed and the hearing scheduled in accordance with the provisions of § 16.1-341.

On such petition and prior to a hearing as authorized in § 37.1-67.3 or § 16.1-341, the judge may release such person on his personal recognizance or bond set by the judge if it appears from all evidence readily available that such release will not pose an imminent danger to himself or others. In the case of a minor, the judge may release the minor to his parent. The director of

the hospital in which the person is detained may release such person prior to a hearing as authorized in § 37.1-67.3 or § 16.1-341 if it appears, based on an evaluation conducted by the psychiatrist or clinical psychologist treating the person, that the person would not present an imminent danger to self or others if released.

If an order of temporary detention is not executed within twenty-four hours of its issuance, or within such shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or if such office is not open, to any judge or magistrate thereof. Subsequent orders may be issued upon the original petition within ninety-six hours after the petition is filed. However, a magistrate must again obtain the advice of an employee of the local community services board or its designee who is skilled in the diagnosis or treatment of mental illness prior to issuing a subsequent order upon the original petition. Any petition for which no order of temporary detention or other process in connection therewith is served on the subject of the petition within ninety-six hours after the petition is filed shall be void and shall be returned to the office of the clerk of the issuing court.

The chief judge of each general district court shall establish and require that a magistrate, as provided by this section, be available seven days a week, twenty-four hours a day, for the purpose of performing the duties established by this section. Each community services board shall provide to each general district court and magistrate's office within its jurisdiction a list of its employees and designees who are available to perform the evaluations required herein.

§ 37.1-67.3

Same; involuntary admission and treatment

The commitment hearing shall be held within forty-eight hours of the execution of the temporary detention order as provided for in § 37.1-67.1; however, if the forty-eight-hour period herein specified terminates on a Saturday, Sunday, or legal holiday, such person may be detained, as herein provided, until the next day which is not a Saturday, Sunday, or legal holiday, but in no event may the person be detained for a period longer than seventy-two hours or ninety-six hours when such legal holiday occurs on a Monday or Friday. A Saturday, Sunday, or legal holiday shall be deemed to include the time period up to 8:00 a.m. of the next day which is not a Saturday, Sunday, or legal holiday.

The judge, in commencing the commitment hearing, shall inform the person whose involuntary admission is being sought of his right to apply for voluntary admission and treatment as provided for in § 37.1-65 and shall afford such person an opportunity for voluntary admission. The judge shall ascertain if such person is then willing and capable of seeking voluntary admission and treatment. If the person is capable and willingly accepts voluntary admission and treatment, the judge shall require him to accept voluntary admission for a minimum period of

treatment and after such minimum period, not to exceed seventy-two hours, to give the hospital forty-eight hours' notice prior to leaving the hospital, during which notice period he shall not be discharged, unless sooner discharged pursuant to § 37.1-98 or § 37.1-99. Such person shall be subject to the transportation provisions as provided in § 37.1-71 and the requirement for prescreening by a community services board or community mental health clinic as provided in § 37.1-65.

If a person is incapable of accepting or unwilling to accept voluntary admission and treatment, the judge shall inform such person of his right to a commitment hearing and right to counsel. The judge shall ascertain if a person whose admission is sought is represented by counsel, and if he is not represented by counsel, the judge shall appoint an attorney-at-law to represent him. However, if such person requests an opportunity to employ counsel, the court shall give him a reasonable opportunity to employ counsel at his own expense.

A written explanation of the involuntary commitment process and the statutory protections associated with the process shall be given to the person and its contents explained by an attorney prior to the commitment hearing. The written explanation shall include, at a minimum, an explanation of the person's right to retain private counsel or be represented by a court-appointed attorney, to present any defenses including independent evaluation and expert testimony or the testimony of other witnesses, to be present during the hearing and testify, to appeal any certification for involuntary admission to the circuit court, and to have a jury trial on appeal. The judge shall ascertain whether the person whose admission is sought has been given the written explanation required herein.

To the extent possible, during or before the commitment hearing, the attorney for the person whose admission is sought shall interview his client, the petitioner, the examiner described below, the community services board staff, and any other material witnesses. He shall also examine all relevant diagnostic and other reports, present evidence and witnesses, if any, on his client's behalf, and otherwise actively represent his client in the proceedings. The role of the attorney shall be to represent the wishes of his client, to the extent possible.

The petitioner shall be given adequate notice of the place, date, and time of the commitment hearing. The petitioner shall be entitled to retain counsel at his own expense, to be present during the hearing, and to testify and present evidence. The petitioner shall be encouraged but shall not be required to testify at the hearing and the person whose admission is sought shall not be released solely on the basis of the petitioner's failure to attend or testify during the hearing.

Notwithstanding the above, the judge shall require an examination of such person by a psychiatrist or a psychologist who is licensed in Virginia by either the Board of Medicine or the Board of Psychology who is qualified in the diagnosis of mental illness or, if such a psychiatrist or psychologist is not available, any mental health professional who is (I) licensed in Virginia through the Department of Health Professions and (ii) qualified in the diagnosis of mental illness.

The examiner chosen shall be able to provide an independent examination of the person. The examiner shall not be related by blood or marriage to the person, shall not be responsible for treating the person, shall have no financial interest in the admission or treatment of the person, shall have no investment interest in the hospital detaining or admitting the person under this article, and, except for employees of state hospitals and of the U.S. Department of Veterans Affairs, shall not be employed by such hospital. For purposes of this section, investment interest means the ownership or holding of an equity or debt security, including, but not limited to, shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other equity or debt instruments.

All such examinations shall be conducted in private. The judge shall summons the examiner who shall certify that he has personally examined the individual and has probable cause to believe that the individual (I) is or is not so seriously mentally ill as to be substantially unable to care for himself, or (ii) does or does not present an imminent danger to himself or others as a result of mental illness, and (iii) requires or does not require involuntary hospitalization or treatment. Alternatively, the judge, in his discretion, may accept written certification of the examiner's findings if the examination has been personally made within the preceding five days and if there is no objection sustained to the acceptance of such written certification by the person or his attorney. The judge shall not render any decision on the petition until such examiner has presented his report either orally or in writing.

Except as otherwise provided in this section, prior to making any adjudication that such person is mentally ill and shall be confined to an institution pursuant to this section, the judge shall require from the community services board which serves the political subdivision where the person resides a prescreening report, and the board or clinic shall provide such a report within forty-eight hours or within seventy-two hours if the forty-eight-hour period terminates on a Saturday, Sunday or legal holiday. The report shall state whether the person is deemed to be so seriously mentally ill that he is substantially unable to care for himself, an imminent danger to himself or others as a result of mental illness and in need of involuntary hospitalization or treatment, whether there is no less restrictive alternative to institutional confinement and what the recommendations are for that person's care and treatment. In the case of a person sentenced and committed to the Department of Corrections and who has been examined by a psychiatrist or clinical psychologist, the judge may proceed to adjudicate whether the person is mentally ill and should be confined pursuant to this section without requesting a prescreening report from the community services board.

After observing the person and obtaining the necessary positive certification and other relevant evidence, if the judge finds specifically that the person (I) presents an imminent danger to himself or others as a result of mental illness, or (ii) has been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (iii) that alternatives to involuntary confinement and treatment have been investigated and deemed unsuitable and there is no less restrictive alternative to institutional confinement and treatment, the judge shall by written order and specific findings so certify and order that the person be placed in a hospital or

other facility for a period of treatment not to exceed 180 days from the date of the court order. Such placement shall be in a hospital or other facility designated by the community services board which serves the political subdivision in which the person was examined as provided in this section. If the community services board does not provide a placement recommendation at the commitment hearing, the person shall be placed in a hospital or other facility designated by the Commissioner.

After observing the person and obtaining the necessary positive certification and other relevant evidence, if the judge finds specifically that the person (I) presents an imminent danger to himself or others as a result of mental illness, or (ii) has been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (iii) that less restrictive alternatives to institutional confinement and treatment have been investigated and are deemed suitable, and if, moreover, the judge finds specifically that (I) the patient has the degree of competency necessary to understand the stipulations of his treatment, (ii) the patient expresses an interest in living in the community and agrees to abide by his treatment plan, (iii) the patient is deemed to have the capacity to comply with the treatment plan, (iv) the ordered treatment can be delivered on an outpatient basis, and (v) the ordered treatment can be monitored by the community services board or designated providers, the judge shall order outpatient treatment, day treatment in a hospital, night treatment in a hospital, outpatient involuntary treatment with anti-psychotic medication pursuant to § 37.1-134.5, or such other appropriate course of treatment as may be necessary to meet the needs of the individual. Upon failure of the patient to adhere to the terms of the outpatient treatment, the judge may revoke the same and, upon notice to the patient and after a commitment hearing, order involuntary commitment for treatment at a hospital. The community services board which serves the political subdivision in which the person resides shall recommend a specific course of treatment and programs for provision of such treatment. The community services board shall monitor the person's compliance with such treatment as may be ordered by the court under this section, and the person's failure to comply with involuntary outpatient treatment as ordered by the court may be admitted into evidence in subsequent hearings held pursuant to the provisions of this section.

The judge shall make or cause to be made a tape or other audio recording of the hearing and shall submit such recording to the appropriate district court clerk to be retained in a confidential file. Such recordings shall only be used to document and to answer questions concerning the judge's conduct of the hearing. These recordings shall be retained for at least three years from the date of the relevant commitment hearing. The judge shall also order that copies of the relevant medical records of such person be released to the facility or program in which he is placed upon request of the treating physician or director of the facility or program. Except as provided in this section, the court shall keep its copies of relevant medical records, reports, and court documents pertaining to the hearings provided for in this section confidential if so requested by such person, or his counsel, with access provided only upon court order for good cause shown. Such records, reports, and documents shall not be subject to the Virginia Freedom of Information Act (§ 2.1-340 et seq.). Such person shall be released at the expiration of 180 days

unless involuntarily committed by further petition and order of a court as provided herein or such person makes application for treatment on a voluntary basis as provided for in § 37.1-65.

The procedures required by this section shall be followed at such commitment hearing. The judge shall render a decision on such petition after the appointed examiner has presented his report, either orally or in writing, and after the community services board which serves the political subdivision where the person resides has presented a prescreening report, either orally or in writing, with recommendations for that person's placement, care and treatment.

The clerk shall certify and forward forthwith to the Central Criminal Records Exchange, on a form provided by the Exchange, a copy of any order for involuntary commitment to a hospital. The copy of the form and the order shall be kept confidential in a separate file and used only for the purpose of conducting a firearms transaction record check authorized by §18.2-308.2:2.

§ 37.1-67.4

Same; where hearings may be held; services during temporary detention; costs

The hearing provided for pursuant to § 37.1-67.3 may be conducted by the judge at the convenient institution or other place provided for in § 37.1-67.1, if he deems it advisable, even though such institution or place is located in a county or city other than his own. In conducting such hearings in a county or city other than his own, the judge shall have all of the authority and power which he would have in his own county or city. A judge, substitute judge or special justice of the county or city in which such institution or place is located may conduct the hearing provided for in § 37.1-67.3.

Any such convenient institution caring for a person placed with it pursuant to a temporary order of detention is authorized to provide emergency medical and psychiatric services within its capabilities when the institution determines such services are in the best interests of the person within its care. The costs incurred as a result of such hearings and such costs incurred by the convenient institution in providing such services during such period of temporary detention shall be paid and recovered as provided in § 37.1-89. The maximum costs reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of Medical Assistance Services based on reasonable criteria.

Where coverage by a third-party payor exists, the institution seeking reimbursement under this section shall first seek reimbursement from the third-party payor. The Commonwealth shall reimburse the providers only for the balance of costs remaining after the allowances covered by the third-party payor have been received.

§ 37.1-67.5

Same; interpreters for deaf persons in commitment or certification proceedings

In any proceeding pursuant to § 37.1-65.1 or §§ 37.1-67.1 through 37.1-67.4 in which a deaf person is alleged to be mentally retarded or mentally ill, an interpreter for such deaf person shall be appointed by the justice of the court in which such proceeding is pending from a list of qualified interpreters provided by the Department for the Deaf and Hard-of-Hearing. Such interpreter shall be compensated as provided for in § 37.1-89.

§ 37.1-67.6

Appeal of commitment or certification order

Any person involuntarily committed pursuant to § 37.1-67.3 or certified as eligible for admission pursuant to § 37.1-65.1 shall have the right to appeal such order to the circuit court in the jurisdiction wherein he was committed or certified or wherein the hospital or mental retardation facility to which he was admitted is located. Choice of venue shall rest with the party noting the appeal. The court may transfer the case upon a finding that the other forum is more convenient. Such appeal must be filed within thirty days from the date of the order and shall be given priority over all other pending matters before the court and heard as soon as possible, notwithstanding § 19.2-241 providing time within which the court shall set criminal cases for trial. The clerk of the court from which an appeal is taken shall immediately transmit the record to the clerk of the appellate court. The clerk of the circuit court shall provide written notification of the appeal to the petitioner in the case in accordance with procedures set forth in § 16.1-112. No appeal bond or writ tax shall be required and the appeal shall proceed without the payment of costs or other fees. Costs may be recovered as provided for in § 37.1-89.

The appeal shall be heard de novo. An order continuing the commitment shall be entered only if the criteria in § 37.1-67.3 are met at the time the appeal is heard. The person so committed or certified shall be entitled to trial by jury. Seven persons from a panel of thirteen shall constitute a jury in such cases.

If such person is not represented by counsel, the judge shall appoint an attorney-at-law to represent him. Counsel so appointed shall be paid a fee of seventy-five dollars and his necessary expenses. The order of the court from which the appeal is taken shall be defended by the attorney for the Commonwealth.

§ 37.1-70

Examination of persons presented for admission

Any person presented for admission to a hospital shall forthwith, and not later than twenty-four hours after arrival, be examined by one or more of the physicians on the staff thereof. If such examination reveals that there is sufficient cause to believe that such person is mentally ill, he shall be retained at the hospital; but if the examination reveals insufficient cause, the person shall be returned to the locality in which the petition was initiated or in which such person resides.

The Board shall promulgate rules and regulations to institute preadmission screening to prevent inappropriate admissions to the facilities and programs operated by the Department.

§ 37.1-71

Transportation of person certified for admission

When a person has been certified for admission to a hospital under §§ 37.1-67.3, 37.1-67.4 or § 37.1-67.6, a determination shall be made by the judge regarding the transportation of that person to the proper hospital. The judge may consult with the person's treating mental health professional and any involved community services board staff regarding the person's dangerousness and whether the sheriff should transport or whether transportation alternatives as provided in § 37.1-72 may be utilized. If the judge determines that the person requires transportation by the sheriff, such person may be delivered to the care of the sheriff, as specified in this section, who shall transport such person to the proper hospital. In no event shall transport commence later than six hours after notification to the sheriff of such certification.

The sheriff of the jurisdiction where the person is a resident shall be responsible for transporting the person unless the sheriff's office of such jurisdiction is located more than 100 road miles from the nearest boundary of the jurisdiction in which the proceedings took place. In cases where the sheriff of the jurisdiction of which the person is a resident is more than 100 road miles from the nearest boundary of the jurisdiction in which the proceedings took place, it shall be the responsibility of the sheriff of the latter jurisdiction to transport the person. The cost of transportation of any person so applying or certified for admission pursuant to § 37.1-67.3 or § 37.1-67.4 shall be paid by the Commonwealth from the same funds as for care in jail.

If any state hospital has become too crowded to accommodate any such person certified for admission therein, the Commissioner shall give notice of the fact to all sheriffs and shall designate the hospital to which they shall transport such persons.

§ 37.1-72

Custody of certified person for purpose of transportation

Any judge who shall certify an admission under this chapter may order that such person be placed in the custody of any responsible person or persons, including a representative of the facility in which the individual is temporarily hospitalized during the temporary detention period, for the sole purpose of transporting such person to the proper hospital.

§ 37.1-73

Detention in jail after certification

It shall be unlawful for any sheriff, sergeant or other officer to use any jail or other place of confinement for criminals as a place of detention for any person in his custody for transportation to a hospital, unless the detention therein of such person not to exceed a period of twenty-four hours is specifically authorized by the committing judge, except that such authority shall not be given by any judge for the Counties of Augusta, Arlington and Fairfax and the Cities of Alexandria, Fairfax, Falls Church, Waynesboro and Staunton.

§ 37.1-74

Mentally ill persons not to be confined in cells with criminals

In no case shall any sheriff or jailer confine any mentally ill person in a cell or room with prisoners charged with or convicted of crime.

§ 37.1-75

Escape, sickness, death or discharge of certified person while in custody;
warrant for person escaping

If any person who has been certified for admission to a hospital, while in the custody of a sheriff or other person, shall escape, become too sick to travel, die, or be discharged by due process of law, the sheriff or other person shall immediately notify the Commissioner of that fact. If any person with whose custody a sheriff or other person has been charged under the provisions of this chapter shall escape, the sheriff or other person having such individual in custody shall immediately secure a warrant from any officer authorized to issue warrants

charging the individual with escape from lawful custody, directing his apprehension and stating what disposition shall be made of such person upon arrest.

§ 37.1-76

Arrest of certain persons involuntarily confined

If any person involuntarily confined in any hospital escape therefrom, the director may forthwith issue a warrant directed to any officer authorized to make arrests, who shall arrest such person and carry him back to the hospital or such other appropriate facility operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services which is in close proximity to the jurisdictions served by the arresting officer. The officer to whom the warrant is directed may execute the same in any part of the Commonwealth.

§ 37.1-77

Arrest without warrant

Any officer authorized to make arrests is authorized to make such an arrest under a warrant issued under the provisions of § 37.1-75 or § 37.1-76, without having such warrant in his possession, provided the same has been issued and the arresting officer has been advised of the issuance thereof by telegram, radio or teletype message containing the name of the person wanted, directing the disposition to be made of the person when apprehended, and stating the basis of the issuance of the warrant.

§ 37.1-78

Attendants to conduct persons admitted voluntarily to hospitals

When application is made to the director of a hospital for admission pursuant to § 37.1-65, he may send an attendant from the hospital to conduct such person to the hospital. If for any reason it is impracticable to employ an attendant for this purpose, then the director may appoint some suitable person for the purpose, or may request the sheriff of the county or city in which the person resides to convey him to the hospital. The sheriff or other person appointed for the purpose shall receive only his necessary expenses for conveying any person admitted to the hospital. Expenses authorized herein shall be paid by the Department.

§ 37.1-78.1

Transfer of patients

Whenever any patient is retained in or by a state hospital, the Commissioner upon recommendation by the community services board serving the patient's county or city of residence prior to his admission to such hospital may order the transfer of any such patient to any other hospital or Veterans Administration hospitals, centers, and other facilities and installations, and such other hospital or Veterans Administration hospitals, centers, and other facilities and installations may retain such patient under the authority of the admission or order applicable to the hospital from which such patient was transferred. No such transfer shall alter any right of a patient under the provisions of this chapter nor shall such transfer divest a judge or court, before which a hearing or request therefor is pending, of jurisdiction to conduct such hearing.

§ 37.1-88

Special justices to perform duties of judge under this title

The chief judge of each judicial circuit may appoint one or more special justices, for the purpose of performing the duties required of a judge by this title. At the time of appointment each such special justice shall be a person licensed to practice law in this Commonwealth, shall have all the powers and jurisdiction conferred upon a judge by this title and shall serve under the supervision and at the pleasure of the chief judge making the appointment. Within six months of appointment, each special justice appointed on or after January 1, 1996, shall complete a minimum training program as prescribed by the Executive Secretary of the Supreme Court. Special justices shall collect the fees prescribed in this title for such service and shall retain fees unless the governing body of the county or city in which such services are performed shall provide for the payment of an annual salary for such services, in which event such fees shall be collected and paid into the treasury of such county or city.

§ 37.1-89

Fees and expenses

Any special justice as defined in § 37.1-88 and any district court substitute judge who presides over hearings pursuant to the provisions of §§ 37.1-67.1 through 37.1-67.4 shall receive a fee of fifty-seven dollars and fifty cents for each commitment hearing and his necessary mileage. Any special justice and any district court substitute judge who presides over a hearing shall receive a fee of twenty-eight dollars and seventy-five cents for each certification hearing

and each order under § 37.1-134.5 ruling on competency or treatment and his necessary mileage. Every physician, psychologist, or other mental health professional, or interpreter for the deaf appointed pursuant to § 37.1-67.5 who is not regularly employed by the Commonwealth of Virginia who is required to serve as a witness or as an interpreter for the Commonwealth in any proceeding under this chapter shall receive a fee of fifty dollars and his necessary expenses for each commitment hearing in which he serves. Every physician, clinical psychologist or interpreter for the deaf appointed pursuant to § 37.1-67.5 who is not regularly employed by the Commonwealth and who is required to serve as a witness or as an interpreter for the Commonwealth in any proceeding under this chapter shall receive a fee of twenty-five dollars and necessary expenses for each certification hearing in which he serves. Other witnesses regularly summoned before a judge under the provisions of this chapter shall receive such compensation for their attendance and mileage as is allowed witnesses summoned to testify before grand juries. Every attorney appointed under § 37.1-65.1 or §§ 37.1-67.1 through 37.1-67.4 shall receive a fee of fifty dollars and his necessary expenses for each commitment hearing. Every attorney appointed shall receive a fee of twenty-five dollars and his necessary expenses for each certification hearing and each proceeding under § 37.1-134.5. Except as hereinafter provided, all expenses incurred, including the fees, attendance and mileage aforesaid, shall be paid by the Commonwealth. Any such fees, costs and expenses incurred in connection with an examination or hearing for an admission pursuant to § 37.1-65.1 or §§ 37.1-67.1 through 37.1-67.4 in carrying out the provisions of this chapter or in connection with a proceeding under § 37.1-134.5, when paid by the Commonwealth, shall be recoverable by the Commonwealth from the person who is the subject of the examination, hearing or proceeding, or from his estate. Such collection or recovery may be undertaken by the Department. All such fees, costs and expenses, if collected or recovered by the Department, shall be refunded to the Commonwealth. No such fees or costs shall be recovered, however, from the person who is the subject of the examination or his estate when no good cause for his admission exists or when the recovery would create an undue financial hardship.

§ 37.1-90

Place of hearing

Any hearing held by a judge pursuant to the provisions of this article may be held in any courtroom available within the county or city wherein the hospital is located or, unless objection thereto is made by the attorney for the person alleged to be mentally ill, in any appropriate place, open to the public, which may be made available by the Commissioner and approved by the judge. Nothing herein shall be construed as prohibiting the place of hearing being on the grounds of the hospital.

§ 37.1-91

Disposition of nonresidents

If it appears that the person examined is mentally ill and a nonresident of this Commonwealth, the same proceedings shall be had with regard to him as if he were a resident of the Commonwealth and if the nonresident be admitted to a state hospital under these proceedings, a statement of the fact of his nonresidence and of the place of his domicile or residence, or from whence he came, as far as known, shall accompany any petition respecting him. The Commissioner shall, as soon as practicable, cause him to be returned to his family or friends, if known, or the proper authorities of the state or country from which he came, if ascertained and such return is deemed expedient by the Commissioner.

§ 37.1-92

Admission of aliens

Whenever any person shall be admitted to a state hospital, or any other state institution which is supported wholly or in part by public funds, it shall be the duty of the Commissioner to inquire forthwith into the nationality of such person, and if it shall appear that such person is an alien, to notify immediately the United States immigration officer in charge of the district in which such institution is located.

Upon the official request of the United States immigration officer, in charge of the territory or district in which is located any court or justice certifying or ordering any alien for admission to such institution, it shall be the duty of the clerk of such court to furnish, without charge, a certified copy, in duplicate, of any record pertaining to the case of the admitted alien. Such information shall be deemed confidential.

§ 37.1-93

Admission of veteran to, or transfer to or from, a Veterans' Administration hospital or other facility

Whenever it appears that the person found to be mentally ill is a veteran eligible for treatment in a Veterans' Administration hospital, center, or other facility or installation, the justice may, upon receipt of a certificate of eligibility from the hospital, center, or other facility or installation concerned, certify or order the person to the hospital, center, or other facility or installation regardless of whether the person is a legal resident of this Commonwealth. Any veteran who heretofore has been, or hereafter is, a patient in a state hospital, and is eligible for treatment in a Veterans' Administration hospital, center, or other facility or installation may with the written consent of the manager of the Veterans' Administration hospital, center, or other

facility or installation, be transferred to the Veterans' Administration hospital, center, or other facility or installation. Any veteran heretofore or hereafter admitted to a Veterans' Administration hospital, center, or other facility or installation, if he be a legal resident of this Commonwealth, who is otherwise eligible for treatment in a state hospital, may with written authorization of the Commissioner, be transferred to the state hospital.

§ 37.1-98

Discharge, conditional release, and convalescent status of patients

A. The director of a state hospital may discharge any patient after the preparation of a predischarge plan formulated in cooperation with the community services board which serves the political subdivision where the patient resided prior to hospitalization or with the board located within the political subdivision the patient chooses to reside in immediately following the discharge, except one held upon an order of a court or judge for a criminal proceeding, as follows:

1. Any patient who, in his judgment, is recovered.
2. Any patient who, in his opinion, is not mentally ill.
3. Any patient who is impaired or not recovered and whose discharge, in the judgment of the director, will not be detrimental to the public welfare, or injurious to the patient.
4. Any patient who is not a proper case for treatment within the purview of this chapter.

The predischarge plan required by this paragraph shall, at a minimum, (i) specify the services required by the released patient in the community to meet the individual's needs for treatment, housing, nutrition, physical care and safety; (ii) specify any income subsidies for which the individual is eligible; (iii) identify all local and state agencies which will be involved in providing treatment and support to the individual; and (iv) specify services which would be appropriate for the individual's treatment and support in the community but which are currently unavailable. For all individuals discharged on or after January 1, 1987, the predischarge plan shall be contained in a uniform discharge document developed by the Department and used by all state hospitals. If the individual will be housed in an adult care residence, as defined in § 63.1-172, the plan shall so state.

B. The director may grant convalescent status to a patient in accordance with rules prescribed by the Board. The state hospital granting a convalescent status to a patient shall not be liable for his expenses during such period. Such liability shall devolve upon the relative, committee, person to whose care the patient is entrusted while on convalescent status, or the appropriate local public welfare agency of the county or city of which the patient was a resident

at the time of admission. The provision of social services to the patient shall be the responsibility of the appropriate local public welfare agency as determined by policy approved by the State Board of Social Services.

C. Any patient who is discharged pursuant to subdivision A 4 hereof shall, if necessary for his welfare, be received and cared for by the appropriate local public welfare agency. The provision of social services to the patient shall be the responsibility of the appropriate local public welfare agency as determined by policy approved by the State Board of Social Services. Expenses incurred by the provision of public assistance to the patient, who is receiving twenty-four-hour care while in an adult care residence licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1, shall be the responsibility of the appropriate local public welfare agency of the county or city of which the patient was a resident at the time of admission.

§ 37.1-98.2

Exchange of information between community services boards and state facilities

Community services boards and state facilities may, when the individual has refused consent, exchange the information required to prepare and implement a comprehensive individualized treatment plan including a discharge plan as specified in § 37.1-98 A. This section shall apply to all active clients of the community services boards and patients and residents in facilities.

When a patient who is deemed suitable for discharge pursuant to § 37.1-98 A or his guardian or committee refuses to authorize the release of that information which is required to formulate and implement a predischarge plan as specified in § 37.1-98 A, then the community services board may release without consent to those service providers and human service agencies identified in the predischarge plan only such information as is needed to secure those services specified in the plan. The release of any other client information to any agency or individual not affiliated directly or by contract with community services boards or facilities shall be subject to all rules and regulations promulgated by the Board or by agencies of the United States government which govern confidentiality of patient information.

It is the intent of this law that any information exchanged about a patient or resident be used only to facilitate treatment, training or community placement and that it shall be protected from disclosure for any other purpose.

§ 37.1-99

Discharge of involuntarily committed patients from a private hospital

The person in charge of a private hospital may discharge any patient involuntarily committed who is recovered, or, if not recovered, whose discharge will not be detrimental to the public welfare, or injurious to the patient, or meets such other criteria as specified in § 37.1-98. The person in charge of such institution may refuse to discharge any patient involuntarily committed, if, in his judgment, such discharge will be detrimental to the public welfare or injurious to the patient.

If the guardian, committee or relatives of such patient refuse to provide properly for his care and treatment, the person in charge of such institution may:

1. Apply to the Commissioner for the transfer of the patient to a state hospital; or
2. Apply to the Director of the United States Veterans' Administration Medical Center for the transfer of the patient to such center.

The state hospital or Veterans' Administration Medical Center may retain such patient under the authority of the admission or order applicable to the private hospital from which such patient was transferred. No such transfer shall alter any right of a patient under the provisions of Chapter 2 (§ 37.1-63 et seq.) of Title 37.1 nor shall such transfer divest a judge or court, before which a hearing or request therefor is pending, of jurisdiction to conduct such hearing. Prior to accepting the transfer of any patient from a private hospital, the Commissioner shall receive from such hospital a report which indicates that the patient is in need of further hospitalization. Upon admission to a state facility of a person pursuant to this section, the director of the facility shall notify the community services board or community mental health clinic which serves the area of which the committed person is a resident of the person's name and local address and of the location of the facility in which the person has been hospitalized, provided that such person or his guardian has authorized the release of such information.

The person in charge of a private hospital may grant a convalescent status to a patient in accordance with rules prescribed by the Board.

§ 37.1-100

Discharge of nonresident

The Commissioner may discharge a nonresident admitted under § 37.1-65 and shall do so whenever it is necessary to accommodate a resident patient.

§ 37.1-101

Providing drugs or medicines for certain persons released from state hospitals

When any patient is released from a state hospital, if such patient or the person legally liable for his care and treatment is financially unable to pay for drugs or medicines which are prescribed for him by a member of the medical staff of the state hospital in order to mitigate or prevent a recurrence of the condition for which he has received care and treatment in such institution, the Department or the community services board serving the patient's county or city of residence may, from funds appropriated to the Department for that purpose, provide such patient from time to time with such drugs and medicines. Such medication shall be dispensed only in accordance with law.

§ 37.1-107

Nonresidents

Nothing in this title shall be construed to forbid any hospital to charge for the removal, care and maintenance of any mentally ill, alcoholic or mentally retarded nonresident who has been admitted to such hospital, and whose committee or next friend has contracted with such hospital for the care and maintenance of such person, nor shall it be construed to permit the admission or retention of any nonresident to the exclusion of a resident of the Commonwealth.

§ 37.1-134.5

Judicial authorization of treatment and detention of certain persons

A. An appropriate circuit court, or judge as defined in § 37.1-1, may authorize on behalf of an adult person, in accordance with this section, a specific treatment or course of treatment for a mental or physical disorder, if it finds upon clear and convincing evidence that (i) the person is either incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, and (ii) the proposed treatment is in the best interest of the person.

B. For purposes of this section:

"Disorder" shall include any physical or mental disorder or impairment, whether caused by injury, disease, genetics, or other cause

"Incapable of making an informed decision" shall mean unable to understand the nature, extent or probable consequences of a proposed treatment, or unable to make a rational evaluation of the risks and benefits of the proposed treatment as compared with the risks and benefits of alternatives to that treatment. Persons with dysphasia or other communication disorders who are mentally competent and able to communicate shall not be considered incapable of giving informed consent.

C. Any person may request authorization of a specific treatment, or course of treatment, for an adult person by filing a petition in the circuit court, or with a judge as defined in § 37.1-1, of the county or city in which the allegedly incapable person resides or is located, or in the county or city in which the proposed place of treatment is located. Upon filing such a petition, the petitioner or the court shall deliver or send a certified copy of the petition to the person for whom treatment is sought and, if the identity and whereabouts of the person's next of kin are known, to the next of kin.

D. As soon as reasonably possible after the filing of the petition, the court shall appoint an attorney to represent the interests of the allegedly incapable person at the hearing. However, such appointment shall not be required in the event that the person, or another interested person on behalf of the person, elects to retain private counsel at his own expense to represent the interests of the person at the hearing. In the event that the allegedly incapable person is indigent, his counsel shall be paid by the Commonwealth as provided in § 37.1-89 from funds appropriated to reimburse expenses incurred in the involuntary mental commitment process. However, this provision shall not be construed to prohibit the direct payment of an attorney's fee either by the patient, or by an interested person on his behalf, which fee shall be subject to the review and approval of the court.

E. Following the appointment of an attorney pursuant to subsection D above, the court shall schedule an expedited hearing of the matter. The court shall notify the person who is the subject of the petition, his next of kin, if known, the petitioner, and their respective counsel of the date and time for the hearing. In scheduling such a hearing, the court shall take into account the type and severity of the alleged physical or mental disorder, as well as the need to provide the person's attorney with sufficient time to adequately prepare his client's case.

F. Notwithstanding the provisions of subsections C and E above regarding delivery or service of the petition and notice of the hearing to the next of kin of any person for whom consent to observation, testing or treatment is sought, if such person is a patient in any hospital at the time the petition is filed, the court, in its discretion, may dispense with the requirement of any notice to the next of kin.

G. Evidence presented at the hearing may be submitted by affidavit in the absence of objection by the person who is the subject of the petition, the petitioner, either of their respective counsel, or by any other interested party. Prior to the hearing, the attorney shall investigate the risks and benefits of the treatment decision for which authorization is sought and of alternatives to the proposed decision. The attorney shall make a reasonable effort to inform the person of this information and to ascertain the person's religious beliefs and basic values and the views and preferences of the person's next of kin.

H. Prior to authorizing treatment pursuant to this section, the court shall find:

That there is no legally authorized guardian or committee available to give consent;

2. That the person who is the subject of the petition is incapable either of making an informed decision regarding a specific treatment or course of treatment or is physically or mentally incapable of communicating such a decision;

3. That the person who is the subject of the petition is unlikely to become capable of making an informed decision or of communicating an informed decision within the time required for decision; and

4. That the proposed treatment or course of treatment is in the best interest of the patient. However, the court shall not authorize a proposed treatment or course of treatment which is proven by a preponderance of the evidence to be contrary to the person's religious beliefs or basic values unless such treatment is necessary to prevent death or a serious irreversible condition. The court shall take into consideration the right of the person to rely on nonmedical, remedial treatment in the practice of religion in lieu of medical treatment.

I. The court may not authorize the following under this section:

1. Nontherapeutic sterilization, abortion, or psychosurgery.

2. Admission to a mental retardation facility or a psychiatric hospital, as defined in § 37.1-1. However, the court may issue an order under this section authorizing a specific treatment or course of treatment of a person whose admission to such facility has been or is simultaneously being authorized under §§ 37.1-65, 37.1-65.1, 37.1-65.2, 37.1-65.3, or § 37.1-67.1, or of a person who is subject to an order of involuntary commitment previously or simultaneously issued under § 37.1-67.3.

3. Administration of antipsychotic medication for a period to exceed 180 days or electroconvulsive therapy for a period to exceed 60 days pursuant to any petition filed under this section. The court may authorize electroconvulsive therapy only if it is demonstrated by clear and convincing evidence, which shall include the testimony of a licensed psychiatrist, that all other reasonable forms of treatment have been considered, and that electroconvulsive therapy is the most effective treatment for the person. Even if the court has authorized administration of antipsychotic medication or electroconvulsive therapy hereunder, these treatments may be administered over the person's objection only if he is subject to an order of involuntary commitment, including outpatient involuntary commitment, previously or simultaneously issued under § 37.1-67.3 or the provisions of Chapter 11 (§ 19.2-167 et seq.) or Chapter 11.1 (§ 19.2-182.2 et seq.) of Title 19.2.

4. Restraint or transportation of the person, unless it finds upon clear and convincing evidence that restraint or transportation is necessary to the provision of an authorized treatment for a physical disorder.

J. Any order authorizing treatment pursuant to subsection A shall describe the treatment or course of treatment authorized and may authorize generally such related

examinations, tests, or services as the court may determine to be reasonably related to the treatment authorized. The order shall require the treating physician to review and document the appropriateness of the continued admission of antipsychotic medications not less frequently than every thirty days. Such order shall require the treating physician or other service provider to report to the court and the person's attorney any change in the person's condition resulting in probable restoration or development of the person's capacity to make and to communicate an informed decision prior to completion of the authorized treatment and related services. The order may further require the treating physician or other service provider to report to the court and the person's attorney any change in circumstances regarding the authorized treatment or related services which may indicate that such authorization is no longer in the person's best interests. Upon receipt of such report, or upon the petition of any interested party, the court may enter such order withdrawing or modifying its prior authorization as it deems appropriate. Any petition or order under this section may be orally presented or entered, provided a written order shall be subsequently executed.

K. Any order hereunder of a judge, or of a judge or magistrate under subsection M, may be appealed de novo within ten days to the circuit court for the jurisdiction where the order was entered, and any such order of a circuit court hereunder, either originally or on appeal, may be appealed within ten days to the Court of Appeals.

L. Any licensed health professional or licensed hospital providing treatment, testing or detention pursuant to the court's or magistrate's authorization as provided in this section shall have no liability arising out of a claim to the extent it is based on lack of consent to such treatment, testing or detention. Any such professional or hospital providing, withholding or withdrawing treatment with the consent of the person receiving or being offered treatment shall have no liability arising out of a claim to the extent it is based on lack of capacity to consent if a court or a magistrate has denied a petition hereunder to authorize such treatment, and such denial was based on an affirmative finding that the person was capable of making and communicating an informed decision regarding the proposed provision, withholding or withdrawal of treatment.

M. Upon the advice of a licensed physician who has attempted to obtain consent and upon a finding of probable cause to believe that an adult person within the court's or a magistrate's jurisdiction is incapable of making an informed decision regarding treatment of a physical or mental disorder, or is incapable of communicating such a decision due to a physical or mental disorder, and that the medical standard of care calls for testing, observation or treatment of the disorder within the next twenty-four hours to prevent death, disability or a serious irreversible condition, the court or, if the court is unavailable, a magistrate may issue an order authorizing temporary detention of the person by a hospital emergency room or other appropriate facility and authorizing such testing, observation or treatment. The detention may not be for a period exceeding twenty-four hours unless extended by the court as part of an order authorizing treatment under subsection A. If before completion of authorized testing, observation or treatment, the physician determines that a person subject to an order under this subsection has become capable of making and communicating an informed decision, the physician shall rely on

the person's decision on whether to consent to further observation, testing or treatment. If before issuance of an order under this subsection or during its period of effectiveness, the physician learns of objection by a member of the person's immediate family to the testing, observation or treatment, he shall so notify the court or magistrate, who shall consider the objection in determining whether to issue, modify or terminate the order.

N. The provisions of § 37.1-89 relating to payment by the Commonwealth shall not apply to the cost of detention, testing or treatment under this section.

O. Nothing in this section shall be deemed to affect the right to use, and the authority conferred by, any other applicable statutory or regulatory procedure relating to consent, or to diminish any common law authority of a physician or other treatment provider to provide, withhold or withdraw services to a person unable to give or to communicate informed consent to those actions, with or without the consent of the person's relative, including but not limited to common law or other authority to provide treatment in an emergency situation; nor shall anything in this section be construed to affect the law defining the conditions under which consent shall be obtained for medical treatment, or the nature of the consent required.

§ 37.1-197

Community services board; powers and duties

Every community services board shall:

1. Review and evaluate all existing and proposed public community mental health, mental retardation and substance abuse services and facilities available to serve the community and such private services and facilities as receive funds through the board and advise the appropriate local governments as to its findings.

2. Submit to the governing body or bodies of each political subdivision, of which it is an agency, a program of community mental health, mental retardation and substance abuse services and facilities for its approval.

3. Within amounts appropriated therefor, execute such programs and maintain such services as may be authorized under such appropriations.

4. In accordance with its approved program, enter into contracts for rendition or operation of services or facilities.

5. Make rules or regulations concerning the rendition or operation of services and facilities under its direction or supervision, subject to applicable standards or regulations promulgated by the State Board.

6. Appoint a coordinator or director of community mental health, mental retardation and substance abuse services, according to minimum qualifications as may be established by the Department, and prescribe his duties. The compensation of such coordinator or director shall be fixed by the board within the amounts made available by appropriation therefor.

7. Prescribe a reasonable schedule of fees for services provided by personnel or facilities under the jurisdiction or supervision of the board and collection of the same. All fees collected shall be included in the program submitted to the local governing body or bodies pursuant to subdivision 2 hereof and in the budget submitted to the local governing body or bodies pursuant to § 37.1-198 and shall be used only for community mental health, mental retardation and substance abuse purposes. Every board shall institute a reimbursement system to maximize the collection of fees from persons receiving services under the jurisdiction or supervision of the board consistent with the provisions of § 37.1-202.1 and from responsible third-party payors. Boards shall not attempt to bill or collect fees for time spent participating in involuntary commitment hearings pursuant to § 37.1-67.3.

8. Accept or refuse gifts, donations, bequests or grants of money or property from any source and utilize the same as authorized by the governing body or bodies of the political subdivision or subdivisions of which it is an agency.

9. Seek and accept funds through federal grants. In accepting such grants the board shall not bind the governing body or bodies of the political subdivision or subdivisions of which it is an agency to any expenditures or conditions of acceptance without the prior approval of such governing body or bodies.

10. Have authority, notwithstanding any provision of law to the contrary, to disburse funds appropriated to it in accordance with such regulations as may be established by the governing body of the political subdivision of which the board is an agency or, in the case of a joint board, as may be established by agreement.

11. Apply for and accept loans as authorized by the governing body or bodies of the political subdivision or subdivisions of which it is an agency. This provision is not intended to affect the validity of loans so authorized and accepted prior to July 1, 1984.

12. Develop joint annual written agreements, consistent with policies and procedures established by the State Board, with local school divisions; health departments; boards of social services; housing agencies, where they exist; courts; sheriffs; area agencies on aging and regional Department of Rehabilitative Services offices. The agreements shall specify what services will be

provided to clients. All participating agencies shall develop and implement the agreements and shall review the agreements annually.

§ 37.1-197.1

Prescription team

A. In order to provide comprehensive mental health, mental retardation and substance abuse services within a continuum of care, the community services board shall:

1. Establish and coordinate the operation of a prescription team which shall be composed of representatives from the community services board, social services or public welfare department, health department, Department of Rehabilitative Services serving in the community services board's area and, as appropriate, the social services staff of the state institution serving the community services board's catchment area and the local school division. Such other human resources agency personnel may serve on the team as the team deems necessary. The team, under the direction of the community services board, shall be responsible for integrating the community services necessary to accomplish effective prescreening and predischarge planning for clients referred to the community services board. When prescreening reports are required by the court on an emergency basis pursuant to § 37.1-67.3, the team may designate one team member to develop the report for the court and report thereafter to the team.

2. Provide prescreening services prior to the admission for treatment pursuant to § 37.1-65 or § 37.1-67.3 of any person who requires emergency mental health services while in a political subdivision served by the board.

3. Cooperate and participate in predischarge planning for any person, who prior to hospitalization resided in a political subdivision served by the board or who chooses to reside after hospitalization in a political subdivision served by the board, who is to be released from a state hospital pursuant to § 37.1-98.

B. The community services board may perform the functions set out in subsection A hereof in the case of children by referring clients who are minors to the locality's family assessment and planning team and cooperating with the community policy and management team in the coordination of services for troubled youths and their families.

§ 63.1-174.001

Admissions and discharge

A. The Board shall promulgate regulations:

Governing admissions to adult care residences.

2. Establishing a process to ensure that residents admitted or retained in an adult care residence receive the appropriate services and that, in order to determine whether a resident's needs can continue to be met by the residence and whether continued placement in the residence is in the best interests of the resident, each resident receives periodic independent reassessments and reassessments in the event of significant deterioration of the resident's condition.

3. Governing appropriate discharge planning for residents whose care needs can no longer be met by the residence.

4. Addressing the involuntary discharge of residents.

5. Requiring that residents are informed of their rights pursuant to § 63.1-182.1 at the time of admission.

6. Establishing a process to ensure that any resident temporarily detained in an inpatient facility pursuant to § 37.1-67.1 is accepted back in the adult care residence if the resident is not involuntarily committed pursuant to § 37.1-67.3.

B. Adult care residences shall not admit or retain individuals with any of the following conditions or care needs:

1. Ventilator dependency.

2. Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be healing.

3. Intravenous therapy or injections directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia or as permitted in subsection C.

4. Airborne infectious disease in a communicable state, that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.

5. Psychotropic medications without appropriate diagnosis and treatment plans.

6. Nasogastric tubes.

7. Gastric tubes except when the individual is capable of independently feeding himself and caring for the tube or as permitted in subsection C.

8 Individuals presenting an imminent physical threat or danger to self or others.

9. Individuals requiring continuous licensed nursing care (seven-days-a-week, twenty-four-hours-a-day).

10 Individuals whose physician certifies that placement is no longer appropriate.

11. Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the uniform assessment instrument and meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the uniform assessment instrument.

12. Individuals whose health care needs cannot be met in the specific adult care residence as determined by the residence.

13. Such other medical and functional care needs of residents which the Board determines cannot properly be met in an adult care residence.

C. Except for auxiliary grant recipients, at the request of the resident, and pursuant to regulations of the State Board, care for the conditions or care needs defined in subdivisions B 3 and B 7 may be provided to a resident in an adult care residence by a licensed physician, a licensed nurse under a physician's treatment plan or by a home care organization licensed in Virginia when the resident's independent physician determines that such care is appropriate for the resident. Regulations for this subsection shall be effective within 280 days of July 1, 1995.

D. In promulgating regulations pursuant to subsections A, B and C above, the Board shall consult with the Departments of Health and Mental Health, Mental Retardation and Substance Abuse Services.

APPENDIX B

42 CFR Part 2: Confidentiality of Alcohol and Drug Abuse Records: Final Rule (7/9/87)

federal register

Tuesday
June 9, 1987

Part II

Department of Health and Human Services

Public Health Service

42 CFR Part 2

Confidentiality of Alcohol and Drug Abuse Patient Records; Final Rule

PLEASE NOTE** JUDITH T. GALLOWAY
(301) 443-4640 CORRECT NUMBER
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any alcohol abuse or drug abuse prevention function which is federally assisted. Applicability is determined by the nature and purpose of the records, not the status or primary functional capacity of the recordkeeper. The definition of "alcohol abuse or drug abuse prevention function" includes specified activities "even when performed by an organization whose primary mission is in the field of law enforcement or is unrelated to alcohol or drugs."

The proposed regulations and the Final Rule at § 2.12 make the regulations applicable to any information about alcohol and drug abuse patients which is obtained by a federally assisted alcohol or drug abuse program. A program is defined to be those persons or legal entities which hold themselves out as providing and which actually provide diagnosis, treatment, or referral for treatment for alcohol and/or drug abuse. Thus, there is a fundamental shift toward determining applicability on the basis of the function of the recordkeeper and away from making that decision based solely on the nature and purpose of the records.

No alcohol and drug abuse patient records, whether identified by the nature and purpose of the records or the function of the recordkeeper, are covered by these regulations unless the diagnosis, treatment, or referral for treatment with which the records are connected is federally assisted.

Several commenters pointed out that while the regulatory language of the proposed rule on its face applies the rule to information about alcohol and drug abuse patients in federally assisted programs, the explanation of the applicability provision at § 2.12(e)(2) obscures the otherwise forthright statement by an additional standard based on the type of Federal assistance going to the program, i.e., some patient records in a federally assisted program would be covered and others would not. Those who commented on this section urged that coverage distinctions under the explanation in § 2.12(e)(2) be omitted because they result in disparate treatment of patient records within an alcohol and/or drug abuse program based on the type of Federal assistance going to the program. Other commenters asserted that basing coverage on the type of assistance is inconsistent with the clear meaning of the applicability provision in the proposed and Final Rule.

The Final Rule revises the proposed explanatory material at § 2.12(e)(2) to show that all alcohol and drug abuse patient records within a covered program are protected by the confidentiality provisions and that the record of an individual patient in an uncovered program, whose care is federally supported in some way which does not constitute Federal assistance to the program under § 2.12(b), is not afforded confidentiality protections. Thus, where a Federal payment is made to a program on behalf of an individual patient and that program is not otherwise federally assisted under § 2.12(b), the record of that individual will not be covered by the regulations. Although the Department expects them to be rare, it would be possible for such instances to occur. For example, if a Federal court places an individual in a for-profit program that is not certified under the Medicare program, that is not authorized to conduct methadone treatment, and is not otherwise federally assisted in any manner provided in § 2.12(b), the patient record of that individual would not be covered by the regulations even though the Federal court paid for the individual's treatment.

Comments to the proposed rule were persuasive that the type of assistance should not affect the scope of records covered within a covered program. When the determination of covered records was based on the purpose and nature of each record, it was consistent to view Federal assistance from the perspective of each individual record. However, when the determination of which records are covered is based on who is keeping the records, as in the proposed and Final Rule, it is consistent with the approach to view Federal assistance from the program level as applying to all alcohol and drug abuse patient records within the program.

Determining coverage based on Federal assistance to the program rather than to an individual represents a change in policy from the current regulations under which the Department views a Federal payment made on behalf of an individual as sufficient to cover that individual's record. However, any disadvantage in not covering individual records in those rare cases which may occur is outweighed by the advantages of consistency and efficiency in management of the program as a result of all alcohol and drug abuse patient records in the program being subject to the same confidentiality provisions.

The Final Rule includes new material at § 2.12(e)(3) which briefly explains the types of information to which the restrictions are applicable, depending on whether a restriction is on disclosure or on use. A restriction on disclosure applies to any information which would identify a patient as an alcohol or drug abuser. The restriction on use of information to bring criminal charges investigate a patient for a crime applies to any information obtained by the program for the purpose of diagnosis, treatment, or referral for treatment of alcohol or drug abuse.

Several commenters strongly urged the explicit inclusion of school-based education and prevention programs in the applicability of the regulations. School-based education and prevention activities may fall within the definition of a program if they provide alcohol or drug abuse diagnosis, treatment, or referral for treatment and if they hold themselves out as so doing. That is reflected in the Final Rule at § 2.12(e)(1) with the inclusion of "school-based programs" in the list of entities which may come under the regulations.

An example of how diagnosis affects coverage has been omitted at § 2.12(e)(3)(ii). It is omitted not because the example could never occur under the Final Rule, but because it is very unlikely that a "specialized" program, as program is defined under these regulations, would be treating a patient for a condition which is not related to alcohol or drug abuse such that the reference to a patient's alcohol or drug abuse history would not be related to the condition for which treatment is rendered. Inasmuch as the regulations only apply to programs, this example is more likely to confuse than provide guidance and for that reason has been taken out.

Notifying a Parent or Guardian of a Minor's Application for Treatment

The proposed rule at § 2.14 reorganized and revised but did not substantively amend the existing § 2.15 dealing with the subject of minor patients. Under both the existing and proposed rules, a minor patient's consent is generally required prior to notifying the minor's parent or guardian of his or her application for treatment. This is true even though without notification it is impossible to obtain parental consent in those cases where State law requires a parent, guardian, or other person to consent to alcohol or drug abuse treatment of a minor.

While this issue was not raised in the proposed rule, the Department has received several inquiries on it from the public since the proposed rule was published suggesting that in those States, where the parent's or guardian's consent is needed for the minor's treatment, the program should be free notify the parent or guardian of the minor's application for treatment without constraint. The Department has considered this issue and decided to

COMPARISON WITH PROPOSED RULE

Subpart A—Introduction

Reports of Violations

Both the existing and proposed rules provide for the reporting of any violations of the regulations to the United States Attorney for the judicial district in which the violations occur, for reporting of violations on the part of methadone programs to the Regional Offices of the Food and Drug Administration, and for reporting violations by a Federal grantee or contractor to the Federal agency monitoring the grant or contract. (See §§ 2.7 and 2.5, respectively.)

Inasmuch as it is the Department of Justice which has ultimate and sole responsibility for prosecuting violations of these regulations, the Final Rule continues to provide for the reference of reports of any violations to the United States Attorney for the judicial district in which the violations occur.

It also continues to provide for the reference to the Regional Offices of the Food and Drug Administration of any reports of violations by a methadone program. As a regulatory agency, the Food and Drug Administration has both the organization and authority to respond to alleged violations.

The Final Rule no longer directs reports of violations by a Federal grantee or contractor to the Federal agency monitoring the grant or contract or, as in the proposed revision of the rules, violations by a Federal agency to the Federal agency responsible for the program. This change is made in recognition of the lack of investigative tools available to granting and contracting agencies and of the ultimate referral which must be made to the Department of Justice. Of course, if alleged violations come to the attention of the Department of Health and Human Services, they will be forwarded to an appropriate representative of the Department of Justice.

Subpart B—General Provisions

Specialized Programs

Like the proposed rule at § 2.12, the Final Rule is applicable to any alcohol and drug abuse information obtained by a federally assisted alcohol or drug abuse program. "Program" is defined in § 2.11 as a person which says it provides and which actually provides alcohol or drug abuse diagnosis, treatment, or referral for treatment. A program may provide other services in addition to alcohol and drug abuse services, for example mental health or psychiatric services, and nevertheless be an alcohol or drug abuse program within the meaning of these regulations so long as the entity is specialized by holding itself out to the community as providing diagnosis, treatment, or referral for treatment for alcohol and/or drug abuse.

If a facility is a provider of general medical care, it will not be viewed in whole or in part as a program unless it has either (1) an identified unit, i.e., a location that is set aside for the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment, or (2) it has personnel who are identified as providers of diagnosis, treatment, or referral for treatment *and* whose primary function is the provision of those alcohol or drug abuse services.

Regardless of whether an entire legal entity is a program or if a part of the entity is a program, the confidentiality protections cover alcohol or drug abuse patient records within any federally assisted program, as "program" is defined in these regulations.

Those comments opposed to limiting applicability of the regulations to "specialized" programs focused on the desirability of full and uniform applicability of confidentiality standards to any alcohol or drug abuse patient record irrespective of the type of facility delivering the services.

The Department takes the position that limiting applicability to specialized programs, i.e., to those programs that hold themselves out as providing and which actually provide alcohol or drug abuse diagnosis, treatment, and referral for treatment, will simplify administration of the regulations without significantly affecting the incentive to seek treatment provided by the confidentiality protections. Applicability to specialized programs will lessen the adverse economic impact of the current regulations on a substantial number of facilities which provide alcohol and drug abuse care only as an incident to the provision of general medical care. We do not foresee that elimination of hospital emergency rooms and general medical or surgical wards from coverage will act as a significant deterrent to patients seeking assistance for alcohol and drug abuse.

While some commenters suggested that there will be an increased administrative burden for organizations operating both a specialized alcohol and/or drug abuse program and providing other health services, we view this as the same burden facing all general medical care facilities under the existing rule.

In many instances it is questionable whether applicability to general medical care facilities addresses the intent of Congress to enhance treatment incentives for alcohol and drug abuse inasmuch as many alcohol and/or drug abuse patients are treated in a general medical care facility not because they have made a decision to seek alcohol and drug abuse treatment but because they have suffered a trauma or have an acute condition with a primary diagnosis of other than alcohol or drug abuse.

In sum, we are not persuaded that the existing burden on general medical care facilities is warranted by the benefit to patients in that setting. Therefore, the Final Rule retains the language of the proposed rule at § 2.11 defining "program" and making the regulations applicable at § 2.12 to any information about alcohol and/or drug abuse patients which is obtained by a federally assisted alcohol or drug abuse program for the purpose of treating, making a diagnosis for treatment, or making a referral for treatment of alcohol or drug abuse.

Communications between a Program and an Entity Having Direct Administrative Control

The existing regulations at § 2.11(p)(1) and the proposed rule at § 2.12(c)(3) exempt from the restrictions on disclosure communications of information within a program between or among personnel in connection with their duties or in connection with provision of patient care, respectively. The Department has previously interpreted the existing provision to mean that communications within a program may include communications to an administrative entity having direct control over the program.

The Final Rule has incorporated that legal opinion into the text by amending § 2.12(C)(3) to exempt from restrictions on disclosure "communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis treatment, or referral for treatment of alcohol or drug abuse" if the communications are within a program or between a program and an entity that has direct administrative control over the program. Paragraph (d) of that same section is accordingly amended to restrict any further disclosure by an administrative entity which receives information under § 2.12(c)(3).

Explanation of Applicability

The existing regulations are applicable to patient records maintained in connection with the performance of

any alcohol abuse or drug abuse prevention function which is federally assisted. Applicability is determined by the nature and purpose of the records, not the status or primary functional capacity of the recordkeeper. The definition of "alcohol abuse or drug abuse prevention function" includes specified activities "even when performed by an organization whose primary mission is in the field of law enforcement or is unrelated to alcohol or drugs."

The proposed regulations and the Final Rule at § 2.12 make the regulations applicable to any information about alcohol and drug abuse patients which is obtained by a federally assisted alcohol or drug abuse program. A program is defined to be those persons or legal entities which hold themselves out as providing and which actually provide diagnosis, treatment, or referral for treatment for alcohol and/or drug abuse. Thus, there is a fundamental shift toward determining applicability on the basis of the function of the recordkeeper and away from making that decision based solely on the nature and purpose of the records.

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Several commenters strongly urged the explicit inclusion of school-based education and prevention programs in the applicability of the regulations. School-based education and prevention activities may fall within the definition of a program if they provide alcohol or drug abuse diagnosis, treatment, or referral for treatment and if they hold themselves out as so doing. That is reflected in the Final Rule at § 2.12(e)(1) with the inclusion of "school-based programs" in the list of entities which may come under the regulations.

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Notifying a Parent or Guardian of a Minor's Application for Treatment

The proposed rule at § 2.14 reorganized and revised but did not substantively amend the existing § 2.15 dealing with the subject of minor patients. Under both the existing and proposed rules, a minor patient's consent is generally required prior to notifying the minor's parent or guardian of his or her application for treatment. This is true even though without notification it is impossible to obtain parental consent in those cases where State law requires a parent, guardian, or other person to consent to alcohol or drug abuse treatment of a minor.

While this issue was not raised in the proposed rule, the Department has received several inquiries on it from the public since the proposed rule was published suggesting that in those States, where the parent's or guardian's consent is needed for the minor's treatment, the program should be free notify the parent or guardian of the minor's application for treatment without constraint. The Department has considered this issue and decided to

make no substantive changes in the existing section dealing with minor patients.

Although both the current rule and the proposed rule generally prohibit parental notification without the minor's consent, they also provide for an exception. Under this exception such notification would be permitted when, in the program director's judgment, the minor lacks the capacity to make a rational decision on the issue of notification, the situation poses a substantial threat to the physical well-being of the minor or any other person, and this threat may be alleviated by notifying the parent or guardian. Under this provision, the program director is vested with the authority to determine when the circumstances permitting parental notification arise. In discussing the Department's philosophy behind this provision, § 2.15–1(e) of the existing rule states: "It [this provision] is based upon the theory that where a person is actually as well as legally incapable of acting in his own interest, disclosures to a person who is legally responsible for him may be made to the extent that the best interests of the patient clearly so require."

While this exception would not permit parental notification without constraint whenever the program director feels it is appropriate, the Department believes it does provide the program director with significant discretion and does permit parental notification in the most egregious cases where the "best interests of the patient clearly so require." Accordingly, the Department has determined not to make any substantive changes in the manner in which the existing rule handles the issue of parental notification. However, proposed § 2.14 has been revised to clarify that no change in meaning is intended from the current rule.

Finally, it should be noted that this rule in no way compels a program to provide services to a minor without parental consent.

Separation of Clinical from Financial/Administrative Records

The current rules governing research, audit, or evaluation functions by a governmental agency at § 2.53 state that "programs should organize their records so that financial and administrative matters can be reviewed without disclosing clinical information and without disclosing patient identifying information except where necessary for audit verification." The proposed rule transformed this hortatory provision for maintenance of financial/administrative records apart from clinical records into a requirement in § 2.16 dealing with security for written records.

Several commenters predicted that such a requirement will pose an extremely cumbersome burden on programs, perhaps tantamount to requiring maintenance of two systems of files. The Final Rule has adopted the recommendation of those commenters to drop this requirement, primarily on the basis of the potential administrative and recordkeeping problems it poses in the varied treatment settings to which these regulations are applicable.

While it is desirable to withhold clinical information from any research, audit, or program evaluation function for which that clinical information is not absolutely essential, the Final Rule does not require recordkeeping practices designed to guarantee that outcome. The Final Rule does, of course, implement the statutory provisions which prohibits those who receive patient identifying information for the purpose of research, audits, or program evaluation from identifying, directly or indirectly, any individual patient in any report of such research, audit, or evaluation or otherwise disclosing patient identities in any manner (see §§ 2.52(b) and 2.53(d)).

Subpart C—Disclosures with Patient's Consent

Notice to Patients

Like the proposed rule, the Final Rule at § 2.22 requires that notice be given to patients that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records. The response to this provision in the proposed rule reflects strong support for notifying patients of confidentiality protections, although many stressed that the notice should be simplified in order to be useful rather than confusing to the patient. Some of those who recommended against adoption of a notice provision did so on grounds that the notice as proposed is too complex. Therefore, in response to many who supported the notice provision and those who opposed it on grounds that it is too complex, the Final Rule substantially revises the elements which must be included in the written notice to each patient and accordingly rewrites the sample notice which a program may adopt at its option in fulfillment of the notice requirement.

Form of Written Consent

The proposed rule retains the requirements in § 2.31 of the existing regulations for written consent to disclosure of information which would identify an individual as an alcohol or drug abuser. There was a great deal of support among those who commented on this provision for the retention of the existing elements of written consent on grounds that the present system is working well and that the elements which go to make up written consent are sufficiently detailed to assure an opportunity for a patient to make an informed consent to disclose patient identifying information. Others recommended a more generalized consent form.

The Final Rule retains all elements previously required for written consent, though in one instance it will permit a more general description of the required information. The first of the required elements of written consent in both the existing and proposed rule (§ 2.31 (a)(1)) asks for the name of the program which is to make the disclosure. The Final Rule will amend that element by calling for "(1) The specific name or general designation of the program or person permitted to make the disclosure." This change will permit a patient to consent to disclosure from a category of facilities or from a single specified program. For example, a patient who chooses to authorize disclosure of all his or her records without the necessity of completing multiple consent forms or individually designating each program on a single consent form would consent to disclosure from all programs in which the patient has been enrolled as an alcohol or drug abuse patient. Or, a patient might narrow the scope of his or her consent to disclosure by permitting disclosure from all programs located in a specified city, from all programs operated by a named organization, or as now, the patient might limit consent to disclosure from a single named facility. (In this connection, the Department interprets the existing written consent requirements to permit consent to disclosure of information from many programs in one consent form by listing specifically each of those programs on the form.)

This change generalizes the consent form with respect to only one element without diminishing the potential for a patient's making an informed consent to disclose patient identifying information. The patient is in position to be informed of any programs in which he or she was previously enrolled and from which he or she is willing to have information disclosed.

With regard to deficient written consents, the Final Rule at § 2.31(c) reverts to language from the existing regulations rather than using the language of the proposed rule to express the idea that a disclosure may not be made on the basis of a written consent

which does not contain all required elements in compliance with paragraph (a) of § 2.31. There was no intention in drafting the proposed rule to establish a different or more stringent standard than currently exists prohibiting disclosures without a conforming written consent. Because that was misunderstood by some, the Final Rule will not permit disclosures on the basis of a written consent which, "On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section . . ."

Express Consent to Redisclosure Permitted

Both the existing and proposed rules at § 2.32 prohibit redisclosure by a person who receives information from patient records pursuant to the written consent of the patient and who has been notified that the information is protected by Federal rules precluding redisclosure except as permitted by those Federal rules. However, the statement of the prohibition on redisclosure at § 2.32 does not make evident the Department's interpretation that it is possible for a patient, at the same time consent to disclosure is given, to consent to redisclosure in accordance with the Federal rules. The Final Rule rewords the statement of prohibition on redisclosure and adds the phrase shown in quotes below to the second sentence as follows:

> The Federal rules prohibit you from making any further disclosure of this information "unless further disclosure is expressly permitted by the" written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.

The purpose of the added phrase is to acknowledge that redisclosure of information may be expressly permitted in the patient's written consent to disclosure. For example, a patient may consent to disclose pertinent information to an employment agency and at the same time permit the employment agency to redisclose this information to potential employers, thus making unnecessary additional consent forms for redisclosures to individual employers. Similarly, a patient may consent to disclose pertient information to an insurance company for the purpose of claiming benefits, and at the same time consent to redisclosure by that insurance company to another organization or company for the purpose of administering the contract under which benefits are claimed by or on behalf of the patient.

Patient Consent to Unrestricted Communications for the Purpose of Criminal Justice System Referrals

Most of those who commented on the revision of § 2.35 generally supported the proposed changes. However, two State commenters encouraged retention of language in the existing regulations which explicitly permits a patient to consent to "unrestricted communications." Otherwise, those commenters say, the revision will act as a deterrent to criminal justice system referrals.

Both the proposed and Final Rule omit most limitations on disclosures to which a patient may consent. The criteria for permitting release of information with patient consent under the Final Rule are: (1) A valid consent under § 2.31 and (2) a determination that the information disclosed is necessary to carry out the purpose for which the consent was given (§ 2.13(a)). Although special rules for disclosures in connection with criminal justice system referrals were retained, they do not restrict "how much and what kind of information" a patient may consent to have disclosed under § 2.31. Section 2.31(a)(5) places no restrictions on how much or what kind of information a patient may consent to have disclosed. That section simply requires that each written consent describe how much and what kind of information the patient consents to have disclosed. A patient may consent to disclosure of any information concerning his or her participation in a program. In the case of a consent for the purpose of a criminal justice system referral, consent to disclose "any information concerning my participation in the program" pursuant to § 2.31(a)(5) would permit "unrestricted communications" from the program to appropriate persons within the criminal justice system to the same extent permitted by the existing rule. Therefore, the Final Rule does not substantively alter § 2.35 as proposed. (Paragraph (c) has been reworded for clarity.)

Subpart D—Disclosures Without Patient's Consent

Elimination of the Requirement to Verify Medical Personnel Status

The proposed regulations at § 2.51 implement the statutory provision which permits a disclosure "to medical personnel to the extent necessary to meet a bona fide medical emergency." The proposed rule added a requirement not contained in the existing § 2.51 that the program make a reasonable effort to verify that the recipient of the information is indeed medical personnel.

The Final Rule deletes the proposed verification requirement in response to comments from several sources that such a requirement is unnecessary, will cause delay, and could possibly impede emergency treatment. In view of those comments and our interest in easing the burden of compliance where possible, the Final Rule does not require verification of the "medical personnel" status of the recipient of information in the face of a medical emergency.

However, the statute permits disclosures only to medical personnel to meet a medical emergency and elimination of the verification requirement does not in any way expand upon the category of persons to whom a disclosure may be made to meet a medical emergency. Neither does elimination of the verification requirement affect the provision in the Final Rule at § 2.51(c) that a program document in the patient's records any disclosure which is made in the face of a medical emergency.

Assessment of Research Risks

The proposed regulations at § 2.52 modified and streamlined existing provisions in §§ 2.52 and 2.53 governing disclosures for scientific research. The proposal clarified that the determinatic of whether an individual is qualified to conduct scientific research would be le to the program director, and required that such qualified personnel have a research protocol which includes safeguards for storing patient identifying information and prohibits redisclosures except as allowed by these regulations.

The Final Rule adds an additional condition: The program director must ensure that a written statement is furnished by the researcher that the research protocol has been reviewed by an independent group of three or more individuals who found that the rights of patients would be adequately protected and that the potential benefits of the research outweigh any potential risks to patient confidentiality posed by the disclosure of records.

This revision was prompted by comment from both the public and private sectors that review of the research protocol for the purpose of ensuring the protection of human subjects participating in the research (in this case, the patients whose records are proposed for use in research) is imperative prior to permitting disclosure of patient identifying information for the conduct of scientific research. The requirement that researchers state in writing that the protocol has been reviewed for the protection of human subjects will provide an additional pc

of reference for the program director in determining whether to release patient identifying information for research purposes.

Researchers who receive support from the Department and many other Federal agencies are required under regulations for the protection of human subjects to obtain review of their protocol from an "institutional review board (IRB)." Such boards generally are set up by the institution employing the researcher. Regulations require that IRBs be composed of persons with professional competence to review research, as well as persons who can judge sensitivity to community attitudes and ethical concerns. Documentation of review and approval by an IRB or by another group of at least three individuals, appropriately constituted to make judgements on issues concerning the protection of human subjects, would meet the new requirement in § 2.52(a)(3).

Audit and Evaluation Activities by Nongovernmental Entities

The proposed regulations at § 2.53 simplify and shorten the provisions on audit and evaluation activities and divide them into two categories: (1) Those activities that do not require copying or removal of patient records, and (2) those that require copying or removal of patient records. The proposed rule permits governmental agencies to conduct audit and evaluation activities in both categories. In addition, if no copying or removal of the records is involved, the program director may determine that other persons are "qualified personnel" for the purpose of conducting audit and evaluation activities. There is no provision for nongovernmental entities to perform any audit or evaluation activity if copying or removal of records is involved.

In response to the proposed rule the Department received comment that third party payers should be permitted to copy or remove records containing patient identifying information as is permitted by governmental agencies that finance or regulate alcohol or drug abuse programs.

Recognizing that private organizations, like governmental agencies, have a stake in the financial and programmatic integrity of treatment programs arising out of their financing of alcohol and drug abuse programs directly, out of peer review responsibilities, and as third party payers, the Final Rule permits access to patient identifying information for audit and evaluation activities by private organizations in circumstances identical to the access afforded governmental agencies. Specifically, if a private organization provides financial assistance to a program, is a third party payer covering patients in the program, or is a peer review organization performing a utilization or quality control review, the Final Rule permits the private organization to have access to patient identifying information for the purpose of participating in audit and evaluation activities to the same extent and under the same conditions as a governmental agency.

Audit and Evaluation of Medicare or Medicaid Programs

In response to specific questions which have come to the Department's attention and in recognition of the continued importance of the integrity of the Medicare and Medicaid programs to the delivery of alcohol and drug abuse services, the Final Rule includes a new paragraph (c) in § 2.53 which clarifies the audit and evaluation provisions as they pertain to Medicare or Medicaid.

Specifically, the new paragraph clarifies that the audit and evaluation function includes investigation for the purpose of administrative enforcement of any remedy imposed by law by any Federal, State, or local agency which has responsibility for oversight of the Medicare or Medicaid programs. The new paragraph makes explicit that the term "program" includes employees of or providers of medical services under an alcohol or drug abuse program. Finally, it clarifies that a peer review organization may communicate patient identifying information for the purpose of a Medicare or Medicaid audit or evaluation to the agency responsible for oversight of the Medicare or Medicaid program being evaluated or audited.

Subpart E—Court Orders Authorizing Disclosure and Use

Court-Ordered Disclosure of Confidential Communications

The existing regulations at § 2.63 limit a court order to "objective" data and prohibit court-ordered disclosure of "communications by a patient to personnel of the program." The proposed regulations delete the provision restricting a court order to objective data and precluding an order from reaching "communications by a patient to personnel of the program." Deletion of that provision provoked considerable discussion and concern on the part of a large number of persons, 85% of whom opposed allowing court-ordered disclosure of nonobjective data.

The Final Rule at § 2.63 restores protection for many "communications by a patient to personnel of the program" and information which is of a nonobjective nature, but it does not protect that information from court order in the face of an existing threat to a third party or in connection with an investigation or prosecution of an extremely serious crime.

Because the existing regulations seem to be dealing uniformly with two related but not necessarily identical types of information, i.e., "objective" data and "communications by a patient to personnel of the program," the Final Rule drops those terms in favor of the term "confidential communications," a term in use since 1975 in existing § 2.63–1. "Confidential communications" are the essence of those matters to be afforded protection and are as readily identified as "objective" data. Furthermore, protection of "confidential communications" is more relevant to maintaining patient trust in a program than is protection of "communications by a patient to personnel of the program," a term which does not distinguish between the innocuous and the highly sensitive communication.

Most comments in opposition to relaxing the court order limitations on confidential communications said that the potential for court-ordered disclosure of confidential communications will compromise the therapeutic environment, may deter some alcohol and drug abusers from entering treatment, and will yield information which may be readily misinterpreted or abused.

While freedom to be absolutely candid in communicating with an alcohol or drug abuse program may have therapeutic benefits and may be an incentive to treatment, it is the position of the Department that those therapeutic benefits cannot take precedence over two circumstances which merit court-ordered disclosure of confidential communications.

The first of these is a circumstance in which the patient poses a threat to any third party. Existing rules do not permit a court to authorize disclosure of any communication by a patient to a program: for example, that the patient is abusing a child or has expressed an intention to kill or seriously harm another person. The balance between patient confidentiality and an existing threat posed by the patient to life or of serious bodily injury to another person must be weighted in favor of permitting a court to order disclosure of confidential communications which are necessary to protect against such an existing threat.

The second of these circumstance is one in which a patient's confidential

communications to a program are necessary in connection with investigation or prosecution of an extremely serious crime, such as a crime which directly threatens loss of life or serious bodily injury. The Department takes the position that it is consistent with the intent of Congress and in the best interest of the Nation to permit the exercise of discretion by a court, within the context of the confidentiality law and regulations, to determine whether to authorize disclosure or use of confidential communications from a patient's treatment record in connection with such an investigation or prosecution.

Our aim is to strike a balance between absolute confidentiality for "confidential communications" on one side and on the other, to protect against any existing threat to life or serious bodily harm to others and to bring to justice those being investigated or prosecuted for an extremely serious crime who may have inflicted such harm in the past. While many confidential communications will remain beyond the reach of a court order, revised § 2.63 of the Final Rule will permit a court to authorize disclosure of confidential communications if the disclosure is neccessary to protect against an existing threat to life or serious bodily injury, if disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, or, as in the existing rule, if disclosure is in connection with a legal proceeding in which the patient himself/herself offers testimony or evidence concerning the confidential communications.

Open Hearing on Patient Request in Connection with a Court Order

Courts authorizing disclosure for noncriminal purposes are required at § 2.64(c) of the Final Rule to conduct any oral argument, review of evidence, or hearing in the judge's chambers or in some manner that ensures patient identifying information is not disclosed to anyone who is not a party to the proceeding, to a party holding the record, or to the patient. The existing rules provide that a patient may request an open hearing. The proposed rule did not provide for the patient to request an open hearing.

The existing and proposed rule provides that a patient may consent to use of his or her name rather than a fictitious name in any application for an order authorizing disclosure for noncriminal purposes. The existing rule requires "voluntary and intelligent" consent. The proposed rule ensures the quality of the consent by requiring that it be in writing and in compliance with § 2.31.

Upon reconsideration, the Department has reinstated the provision permitting a patient to consent to an open hearing in a noncriminal proceeding but with the same formality as is required by the proposed rule for a consent by the patient to use his or her name in an application for an order. Therefore, the Final Rule at § 2.64(c) requires that any hearing be held in such a way as to maintain the patient's confidentiality "unless the patient requests an open hearing in a manner which meets the written consent requirements of these regulations."

Content of Court Order—Sealing of Record as an Example

The content of a court order authorizing disclosure for noncriminal purposes and any order for disclosure and use to investigate or prosecute a program or the person holding the records is limited at § 2.64(e) to essential information and limits disclosure to those persons who have a need for the information. In addition, the court is required to take such other measures as are necessary to limit disclosure to protect the patient, the physician-patient relationship, and the treatment services. We have included at § 2.64(e)(3) an example of one such measure which may be necessary: sealing the record of any proceeding for which disclosure of a patient's records has been ordered. It is the Department's experience that heightened awareness of this possibility by members of the treatment community and legal profession can limit dissemination of patient identifying information to those for whom the court determined "good cause" exists without turning all or a part of a patient's treatment record into public information. The Final Rule adds as an example of a measure which the court might take to protect the patient, the physician-patient relationship and the treatment service "sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered." A similar change has also been made in § 2.67(d)(4).

Extremely Serious Crime as a Criterion for a Court Order to Investigate or Prosecute a Patient

The proposed rule at § 2.64 purported to retain the existing standard with regard to court orders which may be issued for the purpose of investigating or prosecuting a patient; i.e., the standard that no court order may authorize disclosure and use of patient records for investigation or prosecution of nonserious crimes. In an effort to clarify the nature of those crimes for which a court may order disclosure and use of patient records to investigate or prosecute the patient, the proposed rule dropped the term "extremely serious" crime in favor of a more specific functional definition of a crime which "causes or directly threatens loss of life or serious bodily injury." While the proposed rule purported to retain the existing standard, comments received from law enforcement agencies have contested that outcome, asserting that the criterion as proposed would be significantly narrowed. Arguing in favor of a broader standard, law enforcement interests advocated a more flexible criterion which would permit courts to weigh relevant factors on a case-by-case basis.

Inasmuch as the change in the proposed rule was intended to clarify—not to further limit—those crimes for which a court may authorize use of a patient's record to investigate or prosecute the patient, the Final Rule reinstates the existing language, "extremely serious." This broader criterion will permit more flexibility and discretion by the courts in decidin whether a crime is of a caliber wh. merits use of a patient's treatment record to investigate or prosecute the patient.

The Final Rule names as examples of "extremely serious" crimes homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect. Deleted from the list of proposed examples is "sale of illicit drugs."

Based on the view that most patients in drug abuse treatment are vulnerable to a charge of sale of illicit drugs, many commenters asked that "sale of illicit drugs" not be categorically named as an extremely serious crime. To do so, they asserted, would make almost all patients in drug rehabilitation or treatment programs vulnerable to investigation or prosecution by means o court-ordered use of their own treatmen records.

While the Final Rule eliminates "sale of illicit drugs" as an example of an extremely serious crime, it does not alte the authority of a court to find that under appropriate circumstances sale o an illicit drug is, in fact, an extremely serious crime, and it reflects a decision to leave any such determination t court of competent jurisdiction w called upon to order the use of a patient's treatment records to prosecute the patient in view of any circumstance known to the court.

New Law To Permit Reporting of Child Abuse and Neglect

Section 106 of Pub. L. 99-401, the Children's Justice and Assistance Act of 1986, amends sections 523(e) and 527(e) of the Public Health Service Act (42 U.S.C. 290dd-3(e) and 42 U.S.C. 290ee-3(e)) to permit the reporting of suspected child abuse and neglect to appropriate State or local authorities in accordance with State law. The amended sections of the Public Health Service Act provide:

> The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

This newly enacted statutory exception to the restrictions on disclosure of information which would identify an alcohol or drug abuse patient provides a straightforward avenue for making reports of incidents of suspected child abuse and neglect in accordance with State law without resort to devices explained in the preamble to the proposed rule, i.e., obtaining a court order, reporting without identifying the patient as an alcohol or drug abuser, getting the patient's written consent, entering into a qualified service organization agreement, or reporting a medical emergency to medical personnel. While the potential still exists for using the devices described in the proposed rule, there is no foreseeable reason to use them to report suspected child abuse and neglect in view of the amendment.

Although the new law excepts reports of suspected child abuse and neglect from the statutory restrictions on disclosure and use, it does not affect the applicability of the restrictions to the original alcohol and drug abuse patient record maintained by the program. Accordingly, if, following a report of suspected child abuse or neglect, the appropriate State authorities wish to subpoena patient records (or program personnel to testify about patient records) for civil or criminal proceedings relating to the child abuse or neglect, appropriate authorization would be required under the statutes and regulations. While written patient consent would suffice for a civil proceeding, it would be necessary to obtain an authorizing court order under paragraph (b)(2)(C) of the confidentality statutes and § 2.65 of the regulations for use of the record to criminally investigate or prosecute a patient.

Editorial Changes

The Final Rule makes very few editorial or clarifying changes to the regulations as proposed.

Number, tense, punctuation, and sequential numbering are changed where appropriate. Definitions applicable only to prevention of multiple enrollments in detoxification and maintenance treatment programs are moved from the definitions section to § 2.34. Section 2.35(c) has been rewritten for clarity. A clarifying phrase or word is added to the definition of "patient identifying information" at § 2.11, to § 2.19 (a)(1) and (b)(1) and to § 2.31(a)(8). The phrase "or other" has been added to § 2.53(c) because a court order under § 2.66 may be issued to investigate a program for criminal or administrative purposes. At § 2.65(d)(3) alternative language is adopted consistent with language used elsewhere to express a similar thought. At § 2.65 (d)(4) the term "program" is used in lieu of "person holding the records" inasmuch as none but a program will be providing services to patients.

Regulatory Procedures

Executive Order 12291

This is not a major rule under Executive Order 12291. Overall costs to general medical care facilities will be reduced as a result of the decision to apply the regulations only to specialized alcohol and drug abuse treatment programs. Cost to covered programs will be reduced somewhat by simplification of the rules. The amendments do not have an annual effect on the economy of $100 million or more or otherwise meet the criteria for a major rule under the Executive Order. Thus, no regulatory analysis is required.

Regulatory Flexibility Act

As a result of the decision to apply the regulations only to specialized alcohol and drug abuse treatment programs, the Final Rule will not have a significant economic impact on a substantial number of small entities. The regulations will no longer apply to general medical care providers which render alcohol or drug abuse services incident to their general medical care functions; thus, the number of small entities affected will be less than substantial. The economic impact will be less than significant because much of that impact arises from the cost of determining that the records of a general medical care patient are subject to the regulations and thereafter treating those records differently than all others in the general medical care facility. It is anticipated that programs covered by these rules will realize a small savings as a result of the simplification of the rules.

Information Collection Requirements

Information collection requirements in this Final Rule are:

(1) Obtaining written patient consent (§ 2.31(a)),

(2) Notifying each patient of confidentiality provisions (§ 2.22), and

(3) Documenting any disclosure to meet a medical emergency (§ 2.51).

The information collection requirements contained in these final regulations have been approved by the Office of Management and Budget under section 3504(h) of the Paperwork Reduction Act of 1980 and have been assigned control number 0930-0099, approved for use through April 30, 1989.

List of Subjects in 42 CFR Part 2

Alcohol abuse, Alcoholism, Confidentiality, Drug abuse, Health records, Privacy.

Dated: July 3, 1986.

Robert E. Windom,

Assistant Secretary for Health.

Approved: April 9, 1987.

Otis R. Bowen,

Secretary.

The amendments to 42 CFR Part 2 are hereby adopted as revised and set forth below:

PART 2—CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Subpart A—Introduction

Sec.
2.1 Statutory authority for confidentiality of drug abuse patient records.
2.2 Statutory authority for confidentiality of alcohol abuse patient records.
2.3 Purpose and effect.
2.4 Criminal penalty for violation.
2.5 Reports of violations.

Subpart B—General Provisions

2.11 Definitions.
2.12 Applicability.
2.13 Confidentiality restrictions.
2.14 Minor patients.
2.15 Incompetent and deceased patients.
2.16 Security for written records.
2.17 Undercover agents and informants.
2.18 Restrictions on the use of identification cards.
2.19 Disposition of records by discontinued programs.
2.20 Relationship to State laws.
2.21 Relationship to Federal statutes protecting research subjects against compulsory disclosure of their identity.
2.22 Notice to patients of Federal confidentiality requirements.
2.23 Patient access and restriction on use.

Subpart C—Disclosures With Patient's Consent

Sec.
2.31 Form of written consent.
2.32 Prohibition on redisclosure.
2.33 Disclosures permitted with written consent.
2.34 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.
2.35 Disclosures to elements of the criminal justice system which have referred patients.

Subpart D—Disclosures Without Patient Consent

2.51 Medical emergencies.
2.52 Research activities.
2.53 Audit and evaluation activities.

Subpart E—Court Orders Authorizing Disclosures and Use

2.61 Legal effect of order.
2.62 Order not applicable to records disclosed without consent to researchers auditors and evaluators.
2.63 Confidential communications.
2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.
2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.
2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or the person holding the records.
2.67 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program.

Authority: Sec. 408 of Pub. L. 92-255, 86 Stat. 79, as amended by sec. 303 (a), (b) of Pub. L. 93-282, 83 Stat. 137, 138; sec. 4(c)(5)(A) of Pub. L. 94-237, 90 Stat. 244; sec. 111(c)(3) of Pub. L. 94-581, 90 Stat. 2852; sec. 509 of Pub. L. 96-88, 93 Stat. 695; sec. 973(d) of Pub. L. 97-35, 95 Stat. 598; and transferred to sec. 527 of the Public Health Service Act by sec. 2(b)(16)(B) of Pub. L. 98-24, 97 Stat. 182 and as amended by sec. 106 of Pub. L. 99-401, 100 Stat. 907 (42 U.S.C. 290ee-3) and sec. 333 of Pub. L. 91-616, 84 Stat. 1853, as amended by sec. 122(a) of Pub. L. 93-282, 88 Stat. 131; and sec. 111(c)(4) of Pub. L. 94-581, 90 Stat. 2852 and transferred to sec. 523 of the Public Health Service Act by sec. 2(b)(13) of Pub. L. 98-24, 97 Stat. 181 and as amended by sec. 106 of Pub. L. 99-401, 100 Stat. 907 (42 U.S.C. 290dd-3).

Subpart A—Introduction

§ 2.1 Statutory authority for confidentiality of drug abuse patient records.

The restrictions of these regulations upon the disclosure and use of drug abuse patient records were initially authorized by section 408 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act (21 U.S.C. 1175). That section as amended was transferred by Pub. L. 98-24 to section 527 of the Public Health Service Act which is codified at 42 U.S.C. 290ee-3. The amended statutory authority is set forth below:

Section 290ee-3. Confidentiality of patient records.

(a) Disclosure authorization

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Prohibition against use of record in making criminal charges or investigation of patient

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) Continuing prohibition against disclosure irrespective of status as patient

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) Armed Forces and Veterans' Administration; interchange of records; report of suspected child abuse and neglect to State or local authorities

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) Penalty for first and subsequent offenses

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) Regulations; interagency consultations; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders

Except as provided in subsection (h) of section, the Secretary, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(3) of Pub. L. 94-581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of drug abuse patient records under Title 38 was moved from 21 U.S.C. 1175 to 38 U.S.C. 4134.)

§ 2.2 Statutory authority for confidentiality of alcohol abuse patient records.

The restrictions of these regulations upon the disclosure and use of alcohol abuse patient records were initially authorized by section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582). The section as amended was transferred by Pub. L. 98-24 to section 523 of the Public Health Service Act

which is codified at 42 U.S.C. 290dd–3. The amended statutory authority is set forth below:

Section 290dd–3. Confidentiality of patient records

(a) Disclosure authorization

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Prohibition against use of record in making criminal charges or investigation of patient

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) Continuing prohibition against disclosure irrespective of status as patient

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) Armed Forces and Veterans' Administration; interchange of record of suspected child abuse and neglect to State or local authorities

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) Penalty for first and subsequent offenses

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) Regulations of Secretary; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders

Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(4) of Pub. L. 94–581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of alcohol abuse patient records under Title 38 was moved from 42 U.S.C. 4582 to 38 U.S.C. 4134.)

§ 2.3 Purpose and effect.

(a) *Purpose.* Under the statutory provisions quoted in §§ 2.1 and 2.2, these regulations impose restrictions upon the disclosure and use of alcohol and drug abuse patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program. The regulations specify:

(1) Definitions, applicability, and general restrictions in Subpart B (definitions applicable to § 2.34 only appear in that section);

(2) Disclosures which may be made with written patient consent and the form of the written consent in Subpart C;

(3) Disclosures which may be made without written patient consent or an authorizing court order in Subpart D; and

(4) Disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders in Subpart E.

(b) *Effect.* (1) These regulations prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstances exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.

(2) These regulations are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to insure that an alcohol or drug abuse patient in a federally assisted alcohol or drug abuse program is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.

(3) Because there is a criminal penalty (a fine—see 42 U.S.C. 290ee–3(f), 42 U.S.C. 290dd–3(f) and 42 CFR § 2.4) for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers* v. *United States*, 327 U.S. 614, 621–22, 66 S. Ct. 705, 707–08 (1946)).

§ 2.4 Criminal penalty for violation.

Under 42 U.S.C. 290ee–3(f) and 42 U.S.C. 290dd–3(f), any person who violates any provision of those statutes or these regulations shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

§ 2.5 Reports of violations.

(a) The report of any violation of these regulations may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of these regulations by a methadone program may be directed to the Regional Offices of the Food and Drug Administration.

Subpart B—General Provisions

§ 2.11 Definitions.

For purposes of these regulations:

Alcohol abuse means the use of an alcoholic beverage which impairs the

physical, mental, emotional, or social well-being of the user.

Drug abuse means the use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user.

Diagnosis means any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment.

Disclose or disclosure means a communication of patient indentifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the record of a patient who has been identified.

Informant means an individual:

(a) Who is a patient or employee of a program or who becomes a patient or employee of a program at the request of a law enforcement agency or official: and

(b) Who at the request of a law enforcement agency or official observes one or more patients or employees of the program for the purpose of reporting the information obtained to the law enforcement agency or official.

Patient means any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a program, if that number does not consist of, or contain numbers (such as a social security, or driver's license number) which could be used to identify a patient with reasonable accuracy and speed from sources external to the program.

Person means an individual, partnership, corporation, Federal, State or local government agency, or any other legal entity.

Program means a person which in whole or in part holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment. For a general medical care facility or any part thereof to be a program, it must have:

(a) An identified unit which provides alcohol or drug abuse diagnosis, treatment, or referral for treatment or

(b) Medical personnel or other staff whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers.

Program director means:

(a) In the case of a program which is an individual, that individual:

(b) In the case of a program which is an organization, the individual designated as director, managing director, or otherwise vested with authority to act as chief executive of the organization.

Qualified service organization means a person which:

(a) Provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(b) Has entered into a written agreement with a program under which that person:

(1) Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the progams, it is fully bound by these regulations: and

(2) If necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations.

Records means any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program.

Third party payer means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient's eligibility for Federal, State, or local governmental benefits.

Treatment means the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.

Undercover agent means an officer of any Federal, State, or local law enforcement agency who enrolls in or becomes an employee of a program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

§ 2.12 Applicability.

(a) *General*—(1) *Restrictions on disclosure.* The restrictions on disclosure in these regulations apply to any information, whether or not recorded, which:

(i) Would identify a patient as an alcohol or drug abuser either directly, by reference to other publicly available information, or through verification of such an identification by another person: and

(ii) Is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date) for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment.

(2) *Restriction on use.* The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290ee–3(c), 42 U.S.C. 290dd–3(c applies to any information, whether or not recorded which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date), for the purpose of treating alcohol or drug abuse, making a diagnosis for the treatment, or making a referral for the treatment.

(b) *Federal assistance.* An alcohol abuse or drug abuse program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (c)(2) of this section relating to the Veterans' Administration and the Armed Forces):

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:

(i) Certification of provider status under the Medicare program:

(ii) Authorization to conduct methadone maintenance treatment (see 21 CFR 291.505); or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of alcohol or drug abuse:

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of Federal financial assistance in any form, including financial assistance which does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities; or

(ii) Conducted by a State or local government until which, through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) *Exceptions*—(1) *Veterans' Administration.* These regulations do not apply to information on alcohol and drug abuse patients maintained in connection with the Veterans' Administraton provisions of hospital care, nursing home care, domiciliary care, and medical services under Title 38, United States Code. Those records are governed by 38 U.S.C. 4132 and regulations issued under that authority by the Administrator of Veterans' Affairs.

(2) *Armed Forces.* These regulations apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Veterans Administration furnishing health care to veterans.

(3) *Communication within a program or between a program and an entity having direct administrative control over that program.* The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are

(i) within a program or

(ii) between a program and an entity that has direct administrative control over the program.

(4) *Qualified Service Organizations.* The restrictions on disclosure in these regulations do not apply to communications between a program and a qualified service organization of information needed by the organization to provide services to the program.

(5) *Crimes on program premises or against program personnel.* The restrictions on disclosure and use in these regulations do not apply to communications from program personnel to law enforcement officers which—

(i) Are directly related to a patient's commission of a crime on the premises of the program or against program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) *Reports of suspected child abuse and neglect.* The restrictions on disclosure and use in these regulations do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities. However, the restrictions continue to apply to the original alcohol or drug abuse patient records maintained by the program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) *Applicability to recipients of information*—(1) *Restriction on use of information.* The restriction on the use of any information subject to these regulations to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a federally assisted alcohol or drug abuse program, regardless of the status of the person obtaining the information or of whether the information was obtained in accordance with these regulations. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see § 2.17) or through patient access (see § 2.23) is subject to the restriction on use.

(2) *Restrictions on disclosures—Third party payers, administrative entities, and others.* The restrictions on disclosure in these regulations apply to:

(i) Third party payers with regard to records disclosed to them by federally assisted alcohol or drug abuse programs;

(ii) Entities having direct administrative control over programs with regard to information communicated to them by the program under § 2.12(c)(3); and

(iii) Persons who receive patient records directly from a federally assisted alcohol or drug abuse program and who are notified of the restrictions on redisclosure of the records in accordance with § 2.32 of these regulations.

(e) *Explanation of applicability*—(1) *Coverage.* These regulations cover any information (including information on referral and intake) about alcohol and drug abuse patients obtained by a program (as the terms "patient" and "program" are defined in § 2.11) if the program is federally assisted in any manner described in § 2.12(b). Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-based programs, and private practitioners who hold themselves out as providing, and provide alcohol or drug abuse diagnosis, treatment, or referral for treatment.

(2) *Federal assistance to program required.* If a patient's alcohol or drug abuse diagnosis, treatment, or referral for treatment is not provided by a program which is federally conducted, regulated or supported in a manner which constitutes Federal assistance under § 2.12(b), that patient's record is not covered by these regulations. Thus, it is possible for an individual patient to benefit from Federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in § 2.12(b). For example, if a Federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by these regulations unless the program itself received Federal assistance as defined by § 2.12(b).

(3) *Information to which restrictions are applicable.* Whether a restriction is on use or disclosure affects the type of information which may be available. The restrictions on disclosure apply to any information which would identify a

patient as an alcohol or drug abuser. The restriction on use of information to bring criminal charges against a patient for a crime applies to any information obtained by the program for the purpose of diagnosis, treatment, or referral for treatment of alcohol or drug abuse. (Note that restrictions on use and disclosure apply to recipients of information under § 2.12(d).)

(4) *How type of diagnosis affects coverage.* These regulations cover any record of a diagnosis identifying a patient as an alcohol or drug abuser which is prepared in connection with the treatment or referral for treatment of alcohol or drug abuse. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by these regulations. The following are not covered by these regulations:

(i) diagnosis which is made solely for the purpose of providing evidence for use by law enforcement authorities; or

(ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved is not an alcohol or drug abuser (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

§ 2.13 Confidentiality restrictions.

(a) *General.* The patient records to which these regulations apply may be disclosed or used only as permitted by these regulations and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any Federal, State, or local authority. Any disclosure made under these regulations must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required.* The restrictions on disclosure and use in these regulations apply whether the holder of the information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement or other official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by these regulations.

(c) *Acknowledging the presence of patients: Responding to requests.* (1) The presence of an identified patient in a facility or component of a facility which is publicly identified as a place where only alcohol or drug abuse diagnosis, treatment, or referral is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of these regulations or if an authorizing court order is entered in accordance with Subpart E of these regulations. The regulations permit acknowledgement of the presence of an identified patient in a facility or part of a facility if the facility is not publicly identified as only an alcohol or drug abuse diagnosis, treatment or referral facility, and if the acknowledgement does not reveal that the patient is an alcohol or drug abuser.

(2) Any answer to a request for a disclosure of patient records which is not permissible under these regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse. An inquiring party may be given a copy of these regulations and advised that they restrict the disclosure of alcohol or drug abuse patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient. The regulations do not restrict a disclosure that an identified individual is not and never has been a patient.

§ 2.14 Minor patients.

(a) *Definition of minor.* As used in these regulations the term "minor" means a person who has not attained the age of majority specified in the applicable State law, or if no age of majority is specified in the applicable State law, the age of eighteen years.

(b) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under Subpart C of these regulations may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a State or local law requiring the program to furnish the service irrespective of ability to pay.

(c) *State law requiring parental consent to treatment.* (1) Where State law requires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under Subpart C of these regulations must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor's behalf.

(2) Where State law requires parental consent to treatment the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with Subpart C of these regulations or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director under paragraph (d) of this section.

(d) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under Subpart C of these regulations to his or her parent guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.

§ 2.15 Incompetent and deceased patients.

(a) *Incompetent patients other than minors*—(1) *Adjudication of incompetence.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs, any consent which is required under these regulations may be given by the guardian or other person authorized under State law to act in the patient's behalf.

(2) *No adjudication of incompetency.* For any period for which the program director determines that a patient, other than a minor or one who has been adjudicated incompetent, suffers from a medical condition that prevents knowing or effective action on his or her own behalf, the program director may exercise the right of the patient to consent to a disclosure under Subpart C of these regulations for the sole purpose

of obtaining payment for services from a third party payer.

(b) *Deceased patients*—(1) *Vital statistics.* These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative.* Any other disclosure of information identifying a deceased patient as an alcohol or drug abuser is subject to these regulations. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable State law. If there is no such appointment the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

§ 2.16 Security for written records.

(a) Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and

(b) Each program shall adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations.

§ 2.17 Undercover agents and informants.

(a) *Restrictions on placement.* Except as specifically authorized by a court order granted under § 2.6 of these regulations, no program may knowingly employ, or enroll as a patient, any undercover agent or informant.

(b) *Restriction on use of information.* No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is place in a program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

§ 2.18 Restrictions on the use of identification cards.

No person may require any patient to carry on his or her person while away from the program premises any card or other object which would identify the patient as an alcohol or drug abuser. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a program.

§ 2.19 Disposition of records by discontinued programs.

(a) *General.* If a program discontinues operations or is taken over or acquired by another program, it must purge patient identifying information from its records or destroy the records unless—

(1) The patient who is the subject of the records gives written consent (meeting the requirements of § 2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the program.

(b) *Procedure where retention period required by law.* If paragraph (a)(2) of this section applies, the records must be:

(1) Sealed in envelopes or other containers labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]"; and

(2) Held under the restrictions of these regulations by a responsible person who must, as soon as practicable after the end of the retention period specified on the label, destroy the records.

§ 2.20 Relationship to State laws.

The statutes authorizing these regulations (42 U.S.C. 290ee–3 and 42 U.S.C. 290dd–3) do not preempt the field of law which they cover to the exclusion of all State laws in that field. If a disclosure permitted under these regulations is prohibited under State law, neither these regulations nor the authorizing statutes may be construed to authorize any violation of that State law. However, no State law may either authorize or compel any disclosure prohibited by these regulations.

§ 2.21 Relationship to Federal statutes protecting research subjects against compulsory disclosure of their identity.

(a) *Research privilege description.* There may be concurrent coverage of patient identifying information by these regulations and by administrative action taken under: Section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a) and the implementing regulations at 42 CFR Part 2a); or section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR 1316.21). These "research privilege" statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage.* These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under Subpart E of these regulations of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes. However, the research privilage granted under 21 CFR 291.505(g) to treatment programs using methadone for maintenance treatment does not protect from compulsory disclosure any information which is permitted to be disclosed under those regulations. Thus, if a court order entered in accordance with Subpart E of these regulations authorizes a methadone maintenance treatment program to disclose certain information about its patients, that program may not invoke the research privilege under 21 CFR 291.505(g) as a defense to a subpoena for that information.

§ 2.22 Notice to patients of Federal confidentiality requirements.

(a) *Notice required.* At the time of admission or as soon threreafter as the patient is capable of rational communication, each program shall:

(1) Communicate to the patient that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records; and

(2) Give to the patient a summary in writing of the Federal law and regulations.

(b) *Required elements of written summary.* The written summary of the Federal law and regulations must include:

(1) A general description of the limited circumstances under which a program may acknowledge that an individual is present at a facility or disclose outside the program information identifying a patient as an alcohol or drug abuser.

(2) A statement that violation of the Federal law and regulations by a program is a crime and that suspected violations may be reported to appropriate authorities in accordance with these regulations.

(3) A statement that information related to a patient's commission of a crime on the premises of the program or

against personnel of the program is not protected.

(4) A statement that reports of suspected child abuse and neglect made under State law to appropriate State or local authorities are not protected.

(5) A citation to the Federal law and regulations.

(c) *Program options.* The program may devise its own notice or may use the sample notice in paragraph (d) to comply with the requirement to provide the patient with a summary in writing of the Federal law and regulations. In addition, the program may include in the written summary information concerning State law and any program policy not inconsistent with State and Federal law on the subject of confidentiality of alcohol and drug abuse patient records.

(d) *Sample notice.*

Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser *Unless:*

(1) The patient consents in writing;

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd–3 and 42 U.S.C. 290ee–3 for Federal laws and 42 CFR Part 2 for Federal regulations.)

(Approved by the Office of Management and Budget under Control No. 0930–0099.)

§ 2.23 Patient access and restrictions on use.

(a) *Patient access not prohibited.* These regulations do not prohibit a program from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the patient. The program is not required to obtain a patient's written consent or other authorization under these regulations in order to provide such access to the patient.

(b) *Restriction on use of information.* Information obtained by patient access to his or her patient record is subject to the restriction on use of his information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under § 2.12(d)(1).

Subpart C—Disclosures With Patient's Consent

§ 2.31 Form of written consent.

(a) *Required elements.* A written consent to a disclosure under these regulations must include:

(1) The specific name or general designation of the program or person permitted to make the disclosure.

(2) The name or title of the individual or the name of the organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose of the disclosure.

(5) How much and what kind of information is to be disclosed.

(6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.

(7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.

(9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

(b) *Sample consent form.* The following form complies with paragraph (a) of this section, but other elements may be added.

1. I (name of patient) ☐ Request ☐ Authorize:
2. (name or general designation of program which is to make the disclosure)

3. To disclose: (kind and amount of information to be disclosed)

4. To: (name or title of the person or organization to which disclosure is to be made)

5. For (purpose of the disclosure)

6. Date (on which this consent is signed)

7. Signature of patient

8. Signature of parent or guardian (where required)

9. Signature of person authorized to sign in lieu of the patient (where required)

10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (specific date, event, or condition)

(c) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

(Approved by the Office of Management and Budget under Control No. 0930–0099.)

§ 2.32 Prohibition on redisclosure.

(a) *Notice to accompany disclosure.* Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

§ 2.33 Disclosures permitted with written consent.

If a patient consents to a disclosure of his or her records under § 2.31, a program may disclose those records in accordance with that consent to any individual or organization named in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of § 2.34 and 2.35, respectively.

§ 2.34 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.

(a) *Definitions.* For purposes of this section:

Central registry means an organization which obtains from two or more member progams patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of avoiding an individual's concurrent enrollment in more than one program.

Detoxification treatment means the dispensing of a narcotic drug in decreasing doses to an individual in order to reduce or eliminate adverse physiological or psychological effects incident to withdrawal from the sustained use of a narcotic drug.

Maintenance treatment means the dispensing of a narcotic drug in the treatment of an individual for dependence upon heroin or other morphine-like drugs.

Member program means a detoxification treatment or maintenance treatment program which reports patient identifying information to a central registry and which is in the same State as that central registry or is not more than 125 miles from any border of the State in which the central registry is located.

(b) *Restrictions on disclosure.* A program may disclose patient records to a central registry or to any detoxification or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

(i) The patient is accepted for treatment:

(ii) The type or dosage of the drug is changed: or

(iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

(i) Patient identifying information:

(ii) Type and dosage of the drug: and

(iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of § 2.31, except that:

(i) The consent must list the name and address of each central registry and each known detoxification or maintenance treatment program to which a disclosure will be made: and

(ii) The consent may authorize a disclosure to any detoxification or maintenance treatment program established within 200 miles of the program after the consent is given without naming any such program.

(c) *Use of information limited to prevention of multiple enrollments.* A central registry and any detoxification or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not redisclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under Subpart E of these regulations.

(d) *Permitted disclosure by a central registry to prevent a multiple enrollment.* When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose—

(1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program: and

(2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollment.

(e) *Permitted disclosure by a detoxification or maintenance treatment program to prevent a multiple enrollment.* A detoxification or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollment.

§ 2.35 Disclosures to elements of the criminal justice system which have referred patients.

(a) A program may disclose information about a patient to those persons within the criminal justice system which have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or posttrial release, probation or parole officers responsible for supervision of the patient): and

(2) The patient has signed a written consent meeting the requirements of § 2.31 (except paragraph (a)(8) which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into accoun

(1) The anticipated length of the treatment:

(2) The type of criminal proceeding involved, the need for the information i connection with the final disposition of that proceeding, and when the final disposition will occur: and

(3) Such other factors as the program the patient, and the person(s) who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The writte consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified ascertainable event. The time or occurrence upon which consent becomes revocable may be no later tha the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on redisclosure and use.* A person who receives patient information under this section may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

Subpart D—Disclosures Without Patient Consent

§ 2.51 Medical emergencies.

(a) *General Rule.* Under the procedures required by paragraph (c) o this section, patient identifying information may be disclosed to medic personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the healt of any individual and which requires immediate medical intervention.

(b) *Special Rule.* Patient identifying information may be disclosed to medic personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdictio and that the information will be used f the exclusive purpose of notifying patients or their physicians of potentia dangers.

(c) *Procedures.* Immediately followir disclosure, the program shall documen the disclosure in the patient's records, setting forth in writing:

(1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;

(2) The name of the individual making the disclosure;

(3) The date and time of the disclosure; and

(4) The nature of the emergency (or error, if the report was to FDA).

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§ 2.52 Research activities.

(a) Patient identifying information may be disclosed for the purpose of conducting scientific research if the program director makes a determination that the recipient of the patient identifying information:

(1) Is qualified to conduct the research; and

(2) Has a research protocol under which the patient identifying information:

(i) Will be maintained in accordance with the security requirements of § 2.16 of these regulations (or more stringent requirements); and

(ii) Will not be redisclosed except as permitted under paragraph (b) of this section.

(b) A person conducting research may disclose patient identifying information obtained under paragraph (a) of this section only back to the program from which that information was obtained and may not identify any individual patient in any report of that research or otherwise disclose patient identities.

§ 2.53 Audit and evaluation activities.

(a) *Records not copied or removed.* If patient records are not copied or removed, patient identifying information may be disclosed in the course of a review of records on program premises to any person who agrees in writing to comply with the limitations on redisclosure and use in paragraph (d) of this section and who:

(1) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third party payer covering patients in the program, or which is a peer review organization performing a utilization or quality control review; or

(2) Is determined by the program director to be qualified to conduct the audit or evaluation activities.

(b) *Copying or removal of records.* Records containing patient identifying information may be copied or removed from program premises by any person who:

(1) Agrees in writing to:

(i) Maintain the patient identifying information in accordance with the security requirements provided in § 2.16 of these regulations (or more stringent requirements);

(ii) Destroy all the patient identifying information upon completion of the audit or evaluation; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section; and

(2) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third part payer covering patients in the program, or which is a peer review organization performing a utilization or quality control review.

(c) *Medicare or Medicaid audit or evaluation.* (1) For purposes of Medicare or Medicaid audit or evaluation under this section, audit or evaluation includes a civil or administrative investigation of the program by any Federal, State, or local agency responsible for oversight of the Medicare or Medicaid program and includes administrative enforcement, against the program by the agency, of any remedy authorized by law to be imposed as a result of the findings of the investigation.

(2) Consistent with the definition of program in § 2.11, program includes an employee of, or provider of medical services under, the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section.

(3) If a disclosure to a person is authorized under this section for a Medicare or Medicaid audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section, then a peer review organization which obtains the information under paragraph (a) or (b) may disclose the information to that person but only for purposes of Medicare or Medicaid audit or evaluation.

(4) The provisions of this paragraph do not authorize the agency, the program, or any other person to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the Medicare or Medicaid audit or evaluation activity as specified in this paragraph.

(d) *Limitations on disclosure and use.* Except as provided in paragraph (c) of this section, patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under § 2.66 of these regulations.

Subpart E—Court Orders Authorizing Disclosure And Use

§ 2.61 Legal effect of order.

(a) *Effect.* An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290ee-3, 42 U.S.C. 290dd-3 and these regulations. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under these regulations.

(b) *Examples.* (1) A person holding records subject to these regulations receives a subpoena for those records; a response to the subpoena is not permitted under the regulations unless an authorizing court order is entered. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under these regulations.

(2) An authorizing court order is entered under these regulations, but the person authorized does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person authorized to disclose must disclose, unless there is a valid legal defense to the process other than the confidentiality restricitons of these regulations.

§ 2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under these regulations may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information

or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under § 2.66 may authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

§ 2.63 Confidential communications.

(a) A court order under these regulations may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

§ 2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which it appears that the patient records are needed to provide evidence. An application mst use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given a written consent (meeting the requirements of these regulations) to disclosure or the court has ordered the record of the proceeding sealed from public scrunity.

(b) *Notice.* The patient and the person holding the records from whom disclosure is sought must be given:

(1) Adequate notice in a manner which will not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of these regulations. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order.

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

§ 2.66 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records to criminally investigate or prosecute a patient may be applied for by the person holding the records or by any person conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under § 2.66 is sought with an order under this section, the person holding the records must be given:

(1) Adequate notice (in a manner which will not disclose patient identifying information to third parties) of an application by a person performing a law enforcement function;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order; and

(3) An opportunity to be represented by counsel independent of counsel for an applicant who is a person performing a law enforcement function.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a person performing a law enforcement function that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within Federal, State, or local government has in fact been

represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment on only that public interest and need found by the court.

§ 2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or the person holding the records.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records to criminally or administratively investigate or prosecute a program or the person holding the records (or employees or agents of that program or person) may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a program or the person holding the records (or agents or employees of the program or person) in which it appears that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has given a written consent (meeting the requirements of § 2.31 of these regulations) to that disclosure.

(b) *Notice not required.* An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to the program, to the person holding the records, or to any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of § 2.64 of these regulations.

(d) *Limitations on disclosure and use of patient identifying information:* (1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under § 2.65 of these regulations.

§ 2.67 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the program are engaged in criminal misconduct.

(b) *Notice.* The program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order), unless the application asserts a belief that:

(1) The program director is involved in the criminal activities to be investigated by the undercover agent or informant; or

(2) The program director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find:

(1) There is reason to believe that an employee or agent of the program is engaged in criminal activity;

(2) Other ways of obtaining evidence of this criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the program outweigh the potential injury to patients of the program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to criminally investigate or prosecute employees or agents of the program; and

(4) Include any other measures which are appropriate to limit any potential disruption of the program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed under this section may be used to criminally investigate or prosecute any patient or as the basis for an application for an order under § 2.65 of these regulations.

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APPENDIX C

Procedures for the Transfer of Patients: Departmental Instruction No. 6

Departmental Instruction No. 6

Procedures for the Transfer of Patients

6 - 1 Background

Requests for transfers between DMHMRSAS facilities, between public facilities and private hospitals, and between State mental health authorities are frequently made in order to

insure patient welfare;

promote family and community support; and

secure the most appropriate type and locus of treatment.

6 - 2 Purpose

This instruction defines the requirements and procedures for the intrastate and interstate transfer of patients to and from the Department's hospitals and training centers, including the following types of transfers:

forensic transfers from other states and federal correctional institutions;
transfers between state facilities;
transfers from private hospitals to state facilities;
transfers from state facilities to private hospitals;
interstate transfers of civil patients/residents with mental health and/or with mental retardation.

6 - 3 Policy

The following policy principles apply in this Instruction.

Patient Desire

The desire and willingness of the patient or resident to be transferred and the expressed interests of family members are primary considerations in the transfer process.

Patient's Best Interest

The approval of any patient or resident transfer must rest on a clinical determination that the welfare and best interests of the patient or resident would be served.

Individualized Decision-Making

Intrastate and interstate transfer requests are decided on a case by case basis, taking into account:

expressed interests of the patient or resident and of the family;

the clinical picture and treatment needs; and

security and court of jurisdiction requirements needs of patients with forensic involvement.

Out-of-State Residents

Persons who are mentally ill, mentally retarded or substance dependent whose domicile is not Virginia shall be accorded the same protections related to their admission and hospitalization in a state facility as Virginia residents.

Individuals who are not residents of Virginia should not be denied admission to a state facility based solely on their non-resident status.

System - to - System Contact

The Commissioner is responsible for the interstate transfer of patients or residents entering or exiting Virginia state facilities.

The interstate transfer of patients or residents between public facilities shall occur on a system-to-system basis with all applications and supplemental information being coordinated by the Central Office rather than by individual facilities. The Office of Mental Health Services coordinates interstate transfer for patients with mental illness; the Office of Mental Retardation Services coordinates interstate transfer for residents with mental retardation.

Return of Non-Virginia Residents

The Code of Virginia authorizes the Commissioner to return patients or residents to their states or countries of origin. Further, the Commissioner may discharge a non-Virginia resident admitted voluntarily to accommodate a resident or patient from Virginia.

Private, Out-of-State Hospital Patients

Transfers of patients in private, out-of-state hospitals to Virginia State psychiatric facilities are determined on a case by case basis. Consistent with Code §§ 37.1-91; 37.1-100; and 37.1-107, non-residents may not gain admission to Virginia state psychiatric facilities by first being admitted to a Virginia private psychiatric hospital and then seeking transfer to a state facility. Such non-residents shall be handled consistent with the Code provisions which allow the Commissioner the discretion to discharge non-

resident patients when deemed expedient, or when their admission or retention would serve to exclude a Virginia resident.

6 - 4 Definitions

The following definitions apply in this Instruction.

Commissioner

The Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Forensic Patient

An individual who has been court ordered for admission in one of the following legal statuses: Not Guilty by Reason of Insanity, Jail Transfers, Forensic Evaluations, Incompetent to Stand Trial, Virginia Department of Corrections Transfers, Unrestorably Incompetent to Stand Trial with Pending Charges, Department of Youth and Family Services Transfers, or Ten Day Juvenile Treatment Evaluations.

State Treatment Facilities

All training centers and psychiatric hospitals operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

6 - 5 Transfer Procedures

The following transfer procedures shall be followed.

Forensic Transfers within the State

Transfers of patients adjudicated Not Guilty by Reason of Insanity (NGRI) from a forensic unit to a civil unit require written approval by the Forensic Review Panel. *See NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity for details of this process.*

Transfers of other non-NGRI forensic patients from a forensic unit to a civil unit require written approval from the court of jurisdiction.

Individuals in the Forensic Unit who were transferred from the Virginia Department of Corrections at the end of their sentences and after civil commitment shall be treated as civil patients with respect to transfer to a civil facility in their responsible CSB catchment area.

Forensic Transfers from outside Virginia

Periodically, requests are received from other states or from federal treatment facilities to transfer forensic patients into Department-operated facilities. Such individuals may be under pending charges, found Not Guilty by Reason of Insanity, found to be unrestorably incompetent to stand trial, or they are mentally ill individuals convicted of crimes and incarcerated in a state or federal prison system. If they are accepted for treatment within a Department facility, they can be admitted only as voluntary or involuntary patients under the provisions pertaining to Virginia civil commitment, regardless of legal status outside of Virginia.

Requests for transfers of non-Virginia forensic patients into state hospitals will be reviewed in accordance with the guidelines listed below:

- There must be no continuing court jurisdiction that would affect discharge from state hospitalization.
- Transferees must be manageable in the civil units of DMHMRSAS mental health facilities
  - i.e., they do not require secure placement as evidenced by documentation of the absence of violence and escape attempts while hospitalized. A description of the restrictiveness of their current placement should be provided.
- Transfer documents should include a clear, written description of the patient's current legal status, with copies of relevant state and/or federal statutes attached and the current forensic court order.
- There should be documentation of continuing family interest which demonstrates that the family is willing to visit while the patient is hospitalized, work with staff in discharge planning and stay involved with the patient after discharge.
- Any other information deemed relevant.
- All referrals must be approved by the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services.
- Referrals must be forwarded to:
  - Director of Forensic Services
    Department of Mental Health, Mental Retardation and Substance Abuse Services
    P.O. Box 1797
    Richmond, Virginia 23214

The Interstate Compact on Mental Health and Mental Retardation/ Developmental Disabilities does not apply to the following persons:

- those who are serving a sentence in a penal or correctional institution;
- those awaiting trial on a criminal charge and who are housed in a penal or correctional institution; or
- those who are institutionalized due to the commission of an offense for which, in the absence of mental illness or mental retardation, the person would be subject to incarceration in a penal or correctional institution.

Virginia does not accept admissions into its Forensic Unit from other states or federal jails and prisons.

Transfers Between Facilities within the State System

§ 37.1-48 authorizes the Commissioner to order the transfer of patients/residents from one state facility or training center to another. This Departmental Instruction provides for the delegation of this responsibility to the Directors of state facilities and training centers, consistent with the provisions of the Virginia Code § 2.1-20.01:2. Central Officce involvement to effect such transfers is not required. Transfers shall be arranged in accordance with the following procedures.

Step	Action
1	The sending facility ■ obtains agreement for the transfer from the receiving facility; ■ if the patient is on voluntary status, obtains consent from the patient, the parent (if a minor under age 14), or joint consent of the minor and parent (if minor is age 14 to 18); ■ notifies the CSB responsible for the patient;
2	The two facilities collaborate to arrange a date for transfer.
3	The sending hospital is responsible for arranging transportation of the patient to the receiving hospital and assuring that the medical record and a list of the patient's valuables accompanies the patient.

Please Note. Virginia Treatment Center for Children shall follow the above procedures for the purpose of transferring minors admitted through pre-screening by CSBs; i.e., for all public admissions.

Private Hospital Transfer of Involuntarily Committed Patients

§ 37.1-99 allows for the transfer of patients in private hospitals to state facilities by applying to the Commissioner for such transfer. Consistent with Virginia Code § 2.1-20.01:2, this Departmental Instruction authorizes the Directors of state facilities and training centers to receive such application. Central Office involvement to effect such transfers is not required. Transfers shall be arranged in accordance with the following procedures.

Step	Action
1	The sending private hospital ■ obtains consent of the patient to be transferred, if the patient is competent to give consent; ■ contacts the receiving state facility and the local Community Services Board to seek agreement for transfer.
2	At the time the patient is actually transferred from the private hospital to the State facility, the transferring hospital must send the original commitment order with staff accompanying the patient. The transferring hospital should retain a copy of the commitment order for its own records.
3	The sending hospital is responsible for arranging the patient's transportation to the state facility.
4	The receiving state facility should check all commitment papers at the time of admission.

Note: Preadmission screening prior to transfer may not be required when such screening has been completed by the community services board prior to admission to the private hospital for which transfer is being sought. In such cases, the community services board shall determine the clinical necessity for a second preadmission screening. Preadmission screening prior to transfer is required when such screening was not conducted prior to admission to the private hospital.

Private Hospital Transfer of Voluntarily Admitted Patients

When a private hospital in Virginia wishes to transfer a voluntary patient to a DMHMRSAS psychiatric facility, Central Office involvement is not required. Transfers shall be arranged in accordance with the following procedures.

Step	Action
1	The sending private hospital obtains consent of the patient to be transferred.
2	contacts the receiving state facility and the local Community Services Board to seek agreement for transfer.
3	arranges the patient's transportation to the state facility.

Note: Preadmission screening prior to transfer may not be required when such screening has been completed by the community services board prior to admission to the private hospital for which transfer is being sought. In such cases, the community services board shall determine the clinical necessity for a second preadmission screening. Preadmission screening prior to transfer is required when such screening was not conducted prior to admission to the private hospital.

State Hospital Transfers of Involuntarily Committed Patients

§ 37.1-78.1 authorizes the Commissioner to transfer patients in state facilities to any hospital and such hospital may retain the patient under the authority of the admission or order applicable to the hospital from which such patient was transferred. This Departmental Instruction provides for the delegation of this responsibility to the Directors of state psychiatric hospitals and training centers, consistent with Code § 2.1-20.01:2. Central Office involvement to effect such transfers is not required. Transfers shall be arranged in accordance with the following procedures.

Step	Action
1	The sending state hospital obtains consent of the patient to be transferred, if the patient is competent to give consent.
2	contacts the receiving private facility or Veterans Administration facility and the local Community Services Board to seek agreement for transfer.
3	arranges the patient's transportation to the willing receiving hospital.

If a competent patient refuses consent for the transfer, a hearing is required to determine the appropriateness of the transfer.

Interstate Transfer of Hospitalized Patients/Residents

When a DMHMRSAS hospital deems it appropriate to transfer a patient to hospital in another state:

Step	Action	
1	For transfer from DMHMRSAS to another state, the state facility ☐ obtains the consent of the patient and/or guardian, (if patient is a minor or incompetent) and a signed release of information; *DMHMRSAS Central Office staff will not process an interstate transfer request from a facility if the patient objects to the transfer;* ☐ completes DMH Form 223, "Request for Interstate Transfer"; ☐ collects and forwards patient information (typed clinical summary; and psychiatric, psychological, medical and psychosocial evaluations completed within the last six months) to the Interstate Transfer Coordinator Office of Mental Health/Office of Mental Retardation Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services P. O. Box 1797 Richmond, Virginia 23214	
2	For transfer to Virginia from another state, the Department's transfer coordinator reviews and coordinates the transfer process between the DMHMRSAS facility and the involved mental health or mental retardation authority in the receiving State.	
	If Approved	If Denied
	The written authorization is forwarded to the DMHMRSAS facility for inclusion in the patient's record. A copy of this authorization should also be included in the documents which accompany the patient at the time of actual transfer.	The state being denied has the right to appeal. In these circumstances the Department's transfer coordinator contacts the appropriate Compact Administrator to discuss the basis for the denial and to convey the reasons why Virginia disagrees, and follows up with additional supporting information.
3	Upon receipt of authorization to transfer, the receiving hospital will collaborate with the sending hospital to arrange a transfer date.	
4	The sending state pays all costs of transporting a patient under the Compact unless a specific agreement is made by two or more member states for a different allocation of costs.	

6 - 6 Private Bed Purchase

Admissions to private hospitals for adult patients involve direct admissions of patients prescreened by CSBs and referred to private hospitals. Should a patient later be transferred to a state facility, the procedures used are those delineated above for "Private Hospital Transfers for Involuntarily Committed Patients" and "Private Hospital Transfers for Voluntarily Admitted Patients".

Admissions to private hospitals for children and adolescents should follow the "Bed Purchase for State Hospitals and VTCC", the children and adolescents procedures dated 12/93. Such admissions are considered direct admissions from CSBs to state facilities. The state facility authorizes a private bed purchase for up to five days when the hospital is above census.

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6 - 7 Transportation Costs

The sending hospital or state shall pay for or provide for the cost of transporting a patient to another hospital or returning a patient to his resident state, unless other arrangements have been mutually approved.

During the transfer, staff shall accompany the patient and will insure that all appropriate physical care needs are met and that the patient's rights are preserved. The patient being transferred should carry personal identification and information on the patient's destination (receiving hospital) in the event the patient is separated from the escort.

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6 - 8 Authorities and References

- Virginia Code Sections 2.1-20.01:2; 37.1-1; 37.1-48; 37.1-65; 37.1-65.1; 37.1-67 ., et seq 37.1-78.1; 37.1-91; 37.1-99; and 37.1-107 of the Code of Virginia, as amended.
- *NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity.*
- Interim Departmental Instruction No. 127, *Implementing Privileges for Forensic Patients.*

6 - 9 Interpretation

For interpretation of the provisions of this Instruction, please contact the appropriate staff within the Division of Facility and Community Services or the Office of Quality Assurance in the Central Office.

Timothy A. Kelly, Ph.D.
Commissioner

This revised instruction replaces Departmental Instruction No. 6, TRANSFER OF PATIENTS OR RESIDENTS dated March 24, 1983.

Effective Date: June 5, 1995

APPENDIX D

Psychiatric Inpatient Treatment of Minors Act: Section by Section Analysis

PSYCHIATRIC INPATIENT TREATMENT OF MINORS ACT

Section By Section Analysis

I. Section 16.1-275

Section 16.1-275 is amended in two ways. A minor who is being considered by a judge for admission to a psychiatric hospital for an evaluation to provide a recommendation for the disposition of the child must first receive an examination by a mental health professional, as under current law. The new changes are:

- The evaluator must make written findings that the evaluation can only be done in an inpatient setting and not by a professional in the community; and

- The minor may be admitted to a state psychiatric hospital for up to ten days (no longer than thirty days) for the evaluation.

II. Section 16.1-336. Definitions

The most significant definitions are the following

- "Consent" means the voluntary, expressed and informed agreement to treatment. The admission evaluator must determine whether a minor age 14 or over is capable of giving informed consent.

- "Parent" means a biological or adoptive parent who has custody or with whom the minor regularly resides, a person with legal custody, a judicially appointed legal guardian, or the director or designee of a local department of social services, if the child is in social services custody.

- "Qualified Evaluator" sets a hierarchy of persons who can perform evaluations for hospitalization. Licensed mental health professionals or community services board persons who conduct the evaluations must be skilled in child mental health and familiar with this Code Section.

III. Section 16.1-338. Voluntary Admissions

This Section governs the voluntary admission of minors younger than fourteen and non-objecting minors fourteen and over to psychiatric hospitals.

- A minor under fourteen years old may be admitted by their parent's consent.

- A minor fourteen or over may be admitted by joint consent of the minor and their parent.

- An examination must be conducted by a qualified evaluator to determine whether hospitalization is required. The evaluator must make written findings that four conditions specified in this Section are met in order to approve the hospitalization.

  For admission to a state psychiatric hospital, the evaluation is done by the community services board prior to admission.

  For admission to a private sector hospital, the evaluation must take place within 48 hours after admission by a qualified evaluator.

- Within ten days of admission, a treatment plan must be developed. Both the minor and their parent must be involved in making the plan. Details of what should be in the plan are specified in Subsection C.

- If the parent who consented to admission changes their mind, or if a minor fourteen or over rescinds their consent, the minor must be discharged within 48 hours, unless admission is authorized by other procedures in this Act.

- A minor can be admitted voluntarily for up to ninety days without further authorization.

IV. Section 16.1-339. Voluntary Admissions of Objecting Minors

This Section governs the admission of a minor who is fourteen or older and who objects to voluntary admission, when their parent has consented to admission and a qualified evaluator has approved the admission based upon Voluntary Admission criteria. The minor may be admitted for up to 72 hours, over their objection, pending an independent evaluation and a court review.

- Within 24 hours of admission, an evaluation will take place by an independent evaluator designated by the community services board. The hospital petitions for a court review.

- The evaluator must determine whether the minor meets more stringent criteria for admission. These criteria are the three involuntary commitment criteria.

- A Juvenile and Domestic Relations Court Judge appoints a guardian ad litem. Together they review the evaluation information and ascertain the views of the minor and others.

- The Judge, within 72 hours of the minor's admission, must make one of three determinations.

  The minor should not be hospitalized.

  The minor should be hospitalized over their objection and under their parent's consent.

  The information is insufficient and an involuntary commitment hearing should take place to resolve the matter.

- The provisions for making a treatment plan and procedures when the minor's parent revokes consent for admission are the same as 16.1-338.

V. 16.1-340. Emergency Admissions

Emergency admissions procedures for minors are the same as for adults and are found in Section 37.1-67.1 of the Virginia Code.

- A Judge or Magistrate may issue an emergency custody order, based upon a petition that a minor is probably mentally ill and requires hospitalization. A law enforcement officer does not require a Judge's order to bring someone in to be evaluated who they think are mentally ill.

- The community services board or someone designated by the CSB must conduct an evaluation within 4 hours to determine whether emergency hospitalization is warranted.

- The Judge or Magistrate may then issue a Temporary Detention Order (TDO) and have the minor brought to a psychiatric hospital for emergency admission and treatment.

- Within 72 hours of the issuance of the TDO an involuntary commitment hearing must be held, unless the minor is admitted voluntarily.

VI. 16.1-341 through 16.1-345. Involuntary Commitment

The procedures are very similar to Virginia Code for adults. The significant differences are noted below.

- A parent or other reasonable adult may file a petition with the Juvenile and Domestic Relations District Court. A hearing must take place no sooner than 24 hours and no later

than 72 hours after the petition is filed, unless the court decides that the petition should be dismissed.

- The Judge shall appoint a lawyer for the child at least 24 hours before the hearing.

- The community services board will do an evaluation of the minor to determine whether the minor meets the three criteria for involuntary commitment. These criteria are more specific than in adult law. The evaluation report will be submitted to the court at least 24 hours before the hearing.

- The attorney for the minor will review all material and interview witnesses in order to represent the wishes of the minor during the hearing.

- If the Judge determines that the minor meets involuntary commitment criteria, then the Judge may order hospitalization for up to ninety days.

16.1-346. Treatment Plan and Discharges

This Section governs procedures that take place once a minor is involuntarily committed to a psychiatric hospital.

- Within ten days of admission, a treatment plan must be developed. Both the minor and their parent must be involved in making the plan. Details of what should be in the plan are specified in this Section.

- A minor must be discharged from the hospital when they no longer meet commitment criteria.

16.1-346.1. Predischarge Plans

This Section specifies the predischarge planning process and plan that must be developed before a minor leaves a hospital.

- The plan must involve the minor and the minor's parent(s).

- Details that must be included in the plan are specified in this Section.

XI. 16.1-347. Fees and Expenses

Qualified evaluators who are not employed by the Commonwealth and who do evaluations for involuntary commitment proceedings, shall be compensated as specified in 37 89. Other evaluations are considered a cost of treatment and cannot be billed to the Commonwealth.

X. 16.1-348. Availability of a Judge

The Chief Judge of every Juvenile and Domestic Relations District Court must ensure that a Judge is available at all times to do the hearings and reviews in this Article.

APPENDIX E

Table: Legal Status of Individuals Requiring Forensic Treatment

Selected References: Statutes of Virginia Related to the Department of Mental Health Mental Retardation and Substance Abuse Services (Forensic)

LEGAL STATUS OF INDIVIDUALS REQUIRING FORENSIC TREATMENT

LEGAL STATUS	RELEVANT VIRGINIA CODE SECTION	LOCATION
In Jail - Prior to Trial	§19.2-169/6	facility
In Jail - Convicted and Awaiting Sentencing*	§19.2-176	facility
In Jail - Convicted and Serving Local Time	§19.2-177.1	facility
In Jail - Convicted "State Responsible" Felons on way into DOC prison but Needing Emergency Psychiatric Admission	§19.2-177.1	Central State Hospital - Forensic
Incompetent to Stand Trial*	§19.2-169.2	facility
Not Guilty by Reason of Insanity - Commitment*	§19.2-182.3	facility
Dept. Of Corrections Female Transfers**	§53.1-40.2	CSH-Forensic
Dept. Of Corrections Transfers for Inmates Prior to Release in Need of Civil Commitment	§37.1-67.3 as identified in §53.1-40.9	CSH-Forensic

Title 16.1: "Courts Not of Record" (Juvenile and Domestic Relations Court)

Title 37.1: "Institutions for the Mentally Ill; Mental Health Generally"

Title 19.2: "Criminal Procedure" (Insanity, Incompetency to Stand Trail, and Transfers from Jails for Hospitalization)

Title 53.1: "Prisons and other Methods of Correction"

*** These types of forensic admissions do not require preadmission screening by the CSB.**
**** Male Department of Corrections Inmates who require psychiatric hospitalization are admitted to Marion Correctional Treatment Center, a Department of Corrections Facility. Facility = State Hospital.**

Title 19.2.
Criminal Procedure.

CHAPTER 11.
PROCEEDINGS ON QUESTION OF INSANITY.

Sec.
19.2-167. Accused not to be tried while insane or feebleminded.
19.2-168. Notice to Commonwealth of intention to present evidence of insanity; continuance if notice not given.
19.2-168.1. Evaluation on motion of the Commonwealth after notice.
19.2-169. [Repealed.]
19.2-169.1. Raising question of competency to stand trial or plead; evaluation and determination of competency.
19.2-169.2. Disposition when defendant found incompetent.
19.2-169.3. Disposition of the unrestorable incompetent defendant.
19.2-169.4. Litigating certain issues when the defendant is incompetent.
19.2-169.5. Evaluation of sanity at the time of the offense; disclosure of evaluation results.
19.2-169.6. Emergency treatment prior to trial.
19.2-169.7. Disclosure by defendant during evaluation or treatment; use at guilt phase of trial.
19.2-170 through 19.2-174. [Repealed.]
19.2-174.1. Information required prior to admission to a mental health facility.
19.2-175. Compensation of experts.
19.2-176. Determination of insanity after conviction but before sentence; hearing.
19.2-177. [Repealed.]
19.2-177.1. Determination of mental illness after sentencing; hearing.
19.2-178. Where prisoner kept when no vacancy in facility or hospital.
19.2-179. [Repealed.]
19.2-180. Sentence or trial of prisoner when restored to sanity.
19.2-181. [Repealed.]
19.2-182. Representation by counsel in proceeding for commitment.
19.2-182.1. [Repealed.]

§ 19.2-167. Accused not to be tried while insane or feebleminded. — No person shall, while he is insane or feebleminded, be tried for a criminal offense. (Code 1950, § 19.1-227; 1960, c. 366; 1964, c. 231; 1968, c. 789; 1975, c. 495.)

Law Review. — For note on partial responsibility as a mitigating factor, see 18 Wash. & Lee L. Rev. 118 (1961). For comment on the procedural methods for raising insanity in criminal actions in Virginia, see 18 Wash. & Lee L. Rev. 365 (1961).

Article sets forth procedure for commitment. — This article sets forth the procedure for the commitment to a state hospital for observation of a person charged with crime when there is reason to believe that his mental condition makes such confinement necessary. Barber v. Commonwealth, 206 Va. 241, 142 S.E.2d 484 (1965).

This section is merely declaratory of the common law. Delp v. Commonwealth, 172 Va. 564, 200 S.E. 594 (1939); Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

Insanity and feeblemindedness are placed on the same plane with respect to criminal liability. Graham v. Gathright, 345 F. Supp. 1148 (W.D. Va. 1972).

Commitment proceedings as to persons accused of crime are for their protection. Timmons v. Peyton, 240 F. Supp. 749 (E.D. Va. 1965), rev'd on other grounds, 360 F.2d 327 (4th Cir.), cert. denied, 385 U.S. 960, 87 S. Ct. 396, 17 L. Ed. 2d 305 (1966).

What emerges from this humane legislation is the assurance by the Commonwealth that one whose mental capacity to cope with the exigencies of a trial is in doubt shall not be put in jeopardy without a preliminary inquiry into his present mental condition. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963); Kibert v. Peyton, 383 F.2d 566 (4th Cir. 1967).

An accused is presumed to be sane at trial unless his mental condition is called into question by proof to the contrary. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963); Poteat v. Peyton, 270 F. Supp. 220 (W.D. Va. 1967); Jefferson v. Commonwealth, 214 Va. 747, 204 S.E.2d 258 (1974).

But he must have opportunity to raise

issue of insanity. — While efforts to overcome the presumption of sanity may be circumscribed by state prescriptions as to the quantum of proof and legal tests of insanity, procedural due process requires that a state shall afford an accused adequate opportunity to raise the issue. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

Or the protection is illusory. — The protection afforded the defendant by this section is illusory, however, if, when a reasonable doubt as to his sanity arises, neither court nor counsel seeks to utilize the procedures provided by the state for determining competency. Kibert v. Peyton, 383 F.2d 566 (4th Cir. 1967).

Separate hearing on issue of sanity was unjustified where the court, upon the concurrence of two qualified psychologists, considered defendant mentally competent to stand trial for murder, and the jury affirmed such a conclusion. Wilson v. Cox, 312 F. Supp. 209 (W.D. Va. 1970).

Availability of psychiatric testimony. — The right to a judicial determination of fitness to stand trial is not to be confused with the contention that a state is constitutionally obligated to provide at public expense the services of psychiatrists whose expert testimony may later prove useful in establishing the affirmative defense of lack of criminal responsibility. While the availability of such evidence at state expense may be invaluable to an indigent accused unable to employ his own psychiatrists, this would appear to be a merely incidental consequence of the primary statutory objective of preserving his right to a fair trial by first resolving his mental capacity to understand the charges and the nature of the proceedings against him. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

Ake v. Oklahoma to be applied prospectively. — The rule announced in Ake v. Oklahoma, 105 S. Ct. 1087 (1985) (that due process of law was denied where no psychiatrist was appointed to examine the defendant, to help him prepare his case, to serve as an expert witness for the defense, and to assist in the defense at trial) should be applied only to those cases tried subsequent to Feb. 26, 1985. Snurkowski v. Commonwealth, 2 Va. App. 532, 348 S.E.2d 1 (1986).

Refusal to appoint second psychiatrist not error. — The trial court did not err in refusing to appoint a second independent private psychiatrist, where soon after defendant was formally charged, his counsel moved for the appointment of a private psychiatrist to examine and evaluate the defendant and to aid in his defense and that motion was granted. Ake v. Oklahoma, 470 U.S. 68, 105 S. Ct. 1087, 84 L. Ed. 2d 53 (1985) does not require the appointment of a psychiatrist of the defendant's choice. The United States Supreme Court was careful not to prescribe the method for the selection of the independent psychiatrist. Beaver v. Commonwealth, 232 Va. 521, 352 S.E.2d 342, cert. denied, 483 U.S. 1033, 107 S. Ct. 3277, 97 L. Ed. 2d 781 (1987).

Plea of guilty by insane defendant. — A man whose mind is so crippled by psychosis that he cannot understand the proceedings or confer intelligently about the case is in no position to plead guilty or to consent to such a plea in his behalf. If a trial court accepts a plea of guilty from such a man, the resulting judgment is vulnerable to collateral attack. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

§ 19.2-168. Notice to Commonwealth of intention to present evidence of insanity; continuance if notice not given. — In any case in which a person charged with a crime intends (i) to put in issue his sanity at the time of the crime charged and (ii) to present testimony of an expert to support his claim on this issue at his trial, he, or his counsel, shall give notice in writing to the attorney for the Commonwealth, at least twenty-one days prior to his trial, of his intention to present such evidence. In the event that such notice is not given, and the person proffers such evidence at his trial as a defense, then the court may in its discretion, either allow the Commonwealth a continuance or, under appropriate circumstances, bar the defendant from presenting such evidence. The period of any such continuance shall not be counted for speedy trial purposes under § 19.2-243. (Code 1950, § 19.1-227.1; 1970, c. 336; 1975, c. 495; 1986, c. 535.)

Law Review. — For survey of Virginia law on criminal law and procedure for the year 1969-1970, see 56 Va. L. Rev. 1572 (1970). For comment on the insanity defense in Virginia, see 17 U. Rich. L. Rev. 129 (1982). For article, "Virginia's Capital Murder Sentencing Proceeding: A Defense Perspective," see 18 U. Rich. L. Rev. 341 (1984).

Commonwealth entitled to other sanity evaluations. — Subsection E of § 19.2-169.5 clearly provides that the Commonwealth is entitled not only to the report ordered under § 19.2-169.5, but also to the results of any other evaluation of the defendant's sanity when notice is given by the defense pursuant to this section; subsection E of § 19.2-169.5 cannot be

read as applying only to the report ordered. Blevins v. Commonwealth, 11 Va. App. 429, 399 S.E.2d 173 (1990).

Applied in Shifflett v. Commonwealth, 221 Va. 760, 274 S.E.2d 305 (1981).

§ 19.2-168.1. Evaluation on motion of the Commonwealth after notice. — A. If the attorney for the defendant gives notice pursuant to § 19.2-168, and the Commonwealth thereafter seeks an evaluation of the defendant's sanity at the time of the offense, the court shall appoint one or more qualified mental health experts to perform such an evaluation. The court shall order the defendant to submit to such an evaluation and advise the defendant on the record in court that a refusal to cooperate with the Commonwealth's expert could result in exclusion of the defendant's expert evidence. The qualification of the experts shall be governed by subsection A of § 19.2-169.5. The location of the evaluation shall be governed by subsection B of § 19.2-169.5. The attorney for the Commonwealth shall be responsible for providing the experts the information specified in subsection C of § 19.2-169.5. After performing their evaluation, the experts shall report their findings and opinions, and provide copies of psychiatric, psychological, medical or other records obtained during the course of the evaluation to the attorneys for the Commonwealth and the defense.

B. If the court finds, after hearing evidence presented by the parties, that the defendant has refused to cooperate with an evaluation requested by the Commonwealth, it may admit evidence of such refusal or, in the discretion of the court, bar the defendant from presenting expert psychiatric or psychological evidence at trial on the issue of his sanity at the time of the offense. (1982, c. 653; 1986, c. 535.)

Law Review. — For comment suggesting the need for reform of the insanity defense in Virginia, see 13 U. Rich. L. Rev. 397 (1979). For review of Fourth Circuit cases on criminal procedure, see 36 Wash. & Lee L. Rev. 485 (1979). For survey of Virginia law on criminal procedure for the year 1978-1979, see 66 Va. L. Rev. 261 (1980). For article, "The Role of Mental Health Professionals in the Criminal Process: The Case for Informed Speculation," see 66 Va. L. Rev. 427 (1980). For comment on the insanity defense in Virginia, see 17 U. Rich. L. Rev. 129 (1982).

There exists no constitutional right to the appointment of a private psychiatrist of the defendant's own choosing at public expense. Satterfield v. Zahradnick, 572 F.2d 443 (4th Cir.), cert. denied, 436 U.S. 920, 98 S. Ct. 2270, 56 L. Ed. 2d 762 (1978), decided under repealed § 19.2-169.

Liability for expenses where hospitalized under Title 37.1. — A person is liable for the expenses of his care, treatment, and maintenance when confined to a state hospital pursuant to Title 37.1, even though he previously had been confined to the facility pursuant to former § 19.2-169 as a person charged with crime. Commonwealth, Dep't of Mental Health & Mental Retardation v. Jenkins, 224 Va. 456, 297 S.E.2d 692 (1982).

§ 19.2-169: Repealed by Acts 1982, c. 653

Cross references. — For present provisions covering the subject matter of the repealed section, see §§ 19.2-168.1 and 19.2-169.1.

§ 19.2-169.1. Raising question of competency to stand trial or plead; evaluation and determination of competency. — A. *Raising competency issue; appointment of evaluators.* — If, at any time after the attorney for the defendant has been retained or appointed and before the end of trial, the court finds, upon hearing evidence or representations of counsel for the defendant or the attorney for the Commonwealth, that there is probable cause to believe that the defendant lacks substantial capacity to understand the proceedings against him or to assist his attorney in his own defense, the court shall order that a competency evaluation be performed by at least one psychiatrist, clinical

psychologist or master's level psychologist who is qualified by training and experience in forensic evaluation.

B. *Location of evaluation.* — The evaluation shall be performed on an outpatient basis at a mental health facility or in jail unless the court specifically finds that outpatient evaluation services are unavailable or unless the results of outpatient evaluation indicate that hospitalization of the defendant for evaluation on competency is necessary. If either finding is made, the court, under authority of this subsection, may order the defendant sent to a hospital designated by the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services as appropriate for evaluations of persons under criminal charge. The defendant shall be hospitalized for such time as the director of the hospital deems necessary to perform an adequate evaluation of the defendant's competency, but not to exceed thirty days from the date of admission to the hospital.

C. *Provision of information to evaluators.* — The court shall require the attorney for the Commonwealth to provide to the evaluators appointed under subsection A any information relevant to the evaluation, including, but not limited to (i) a copy of the warrant or indictment; (ii) the names and addresses of the attorney for the Commonwealth, the attorney for the defendant, and the judge ordering the evaluation; (iii) information about the alleged crime; and (iv) a summary of the reasons for the evaluation request. The court shall require the attorney for the defendant to provide any available psychiatric records and other information that is deemed relevant.

D. *The competency report.* — Upon completion of the evaluation, the evaluators shall promptly submit a report in writing to the court and the attorneys of record concerning (i) the defendant's capacity to understand the proceedings against him; (ii) his ability to assist his attorney; and (iii) his need for treatment in the event he is found incompetent. No statements of the defendant relating to the time period of the alleged offense shall be included in the report.

E. *The competency determination.* — After receiving the report described in subsection D, the court shall promptly determine whether the defendant is competent to stand trial. A hearing on the defendant's competency is not required unless one is requested by the attorney for the Commonwealth or the attorney for the defendant, or unless the court has reasonable cause to believe the defendant will be hospitalized under § 19.2-169.2. If a hearing is held, the party alleging that the defendant is incompetent shall bear the burden of proving by a preponderance of the evidence the defendant's incompetency. The defendant shall have the right to notice of the hearing, the right to counsel at the hearing and the right to personally participate in and introduce evidence at the hearing.

The fact that the defendant claims to be unable to remember the time period surrounding the alleged offense shall not, by itself, bar a finding of competency if the defendant otherwise understands the charges against him and can assist in his defense. Nor shall the fact that the defendant is under the influence of medication bar a finding of competency if the defendant is able to understand the charges against him and assist in his defense while medicated. (1982, c. 653; 1983, c. 373; 1985, c. 307.)

Cross references. — As to representation by counsel in proceeding for commitment, see § 19.2-182.

I. General Consideration.
II. Action by the Court.
III. Proof.
IV. Practice and Procedure.

I. GENERAL CONSIDERATION.

Editor's note. — Many of the cases cited in the following annotations were decided under repealed § 19.2-169.

As to constitutionality of procedure under former § 19.2-169, see Payne v. Slayton, 329 F. Supp. 886 (W.D. Va. 1971).

Former § 19.2-169 was enacted in clear recognition of the State's constitutional obligation to provide a hearing on the question of whether a person to be tried is in such a mental condition that his confinement in a hospital for the insane or colony for the feebleminded for proper care and observation is necessary to attain the ends of justice. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

Due process requires state to provide means to raise issue. — Due process requires that the State must provide an adequate means by which an accused can raise the issue of insanity at the time of trial and at the commission of the alleged offense. Hodnett v. Slayton, 343 F. Supp. 1142 (W.D. Va. 1972), appeal dismissed, 471 F.2d 648 (4th Cir. 1973).

Trial court's refusal to suspend proceedings as denial of due process. — Where insanity at the time of the trial was established by reliable and uncontroverted sworn medical testimony, on the strength of this prima facie showing, the trial court's refusal to suspend the proceedings and its decision to hold trial the very next morning was so arbitrary as to constitute a denial of due process. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

Procedures must be set in motion whenever bona fide doubt as to competency exists. — State hearing procedures must be set in motion whenever it appears in the course of the proceedings that a bona fide doubt as to a defendant's competency exists. McLaughlin v. Royster, 346 F. Supp. 297 (E.D. Va. 1972).

Commitment proceedings as to persons accused of crime are for their protection. Timmons v. Peyton, 240 F. Supp. 749 (E.D. Va. 1965), rev'd on other grounds, 360 F.2d 327 (4th Cir.), cert. denied, 385 U.S. 960, 87 S. Ct. 396, 17 L. Ed. 2d 305 (1966).

Failure to raise question. — The protection afforded the defendant is illusory if, when a reasonable doubt as to his sanity arises, neither court nor counsel seeks to utilize the procedures provided by the State for determining competency. Kibert v. Peyton, 383 F.2d 566 (4th Cir. 1967).

There exists no constitutional right to the appointment of a private psychiatrist of the defendant's own choosing at public expense. Satterfield v. Zahradnick, 572 F.2d 443 (4th Cir.), cert. denied, 436 U.S. 920, 98 S. Ct. 2270, 56 L. Ed. 2d 762 (1978).

No constitutional guarantee of examination. — There is no constitutional guarantee that every person indicted for a felony is entitled to a mental examination. Kerns v. Peyton, 292 F. Supp. 182 (W.D. Va. 1968); Newman v. Peyton, 303 F. Supp. 462 (W.D. Va. 1969).

A state prisoner who alleges mental incapacity to stand trial is not entitled as a matter of right to pretrial commitment and examination at state expense. Morris v. Peyton, 283 F. Supp. 63 (W.D. Va. 1968).

No obligation on court where defendant's mental health not in doubt. — Former § 19.2-169 placed no obligation upon the court or the attorney for the Commonwealth in cases where there was no reason to doubt petitioner's mental health. Newman v. Peyton, 303 F. Supp. 462 (W.D. Va. 1969). See also Kerns v. Peyton, 292 F. Supp. 182 (W.D. Va. 1968).

Former § 19.2-169 placed no obligation upon the court to appoint a committee except where the court or attorney for the Commonwealth had reason to believe that the person to be tried was in such mental condition that his confinement in a hospital for the insane or colony for the feebleminded for proper care and observation was necessary to attain the ends of justice. Wood v. Commonwealth, 146 Va. 296, 135 S.E. 895 (1926); Delp v. Commonwealth, 172 Va. 564, 200 S.E. 594 (1939); Tilton v. Commonwealth, 196 Va. 774, 85 S.E.2d 368 (1955).

State must assure indigent defendant access to competent psychiatrist who will conduct an appropriate examination and assist in evaluation, preparation, and presentation of the defense when the defendant demonstrates to the trial judge that his sanity at the time of the offense is to be a significant factor at trial. Tuggle v. Commonwealth, 230 Va. 99, 334 S.E.2d 838 (1985), cert. denied, 478 U.S. 1010, 106 S. Ct. 3309, 92 L. Ed. 2d 722 (1986).

Indigent entitled to psychiatrist in capital case on issue of future dangerousness. — When the prosecution in a capital sentencing proceeding presents psychiatric evidence of an indigent defendant's future dangerousness, due process requires that a state provide the defendant the assistance of a psychiatrist on the issue. Where the Commonwealth presented psychiatric evidence that defendant showed a high probability of future dangerousness, even though defendant's trial and direct appeal predated the decision of the United States Supreme Court in Ake v. Oklahoma, 470 U.S. 68, 105 S. Ct. 1087, 84 L. Ed. 2d 53 (1985), in light of that decision the trial court erred in denying his motion for an independent psychiatrist to rebut the Commonwealth's psychiatric evidence of future dangerousness. Tuggle v. Commonwealth, 230 Va. 99, 334 S.E.2d 838 (1985), cert. denied, 478 U.S. 1010, 106 S. Ct. 3309, 92 L. Ed. 2d 722 (1986).

Ake v. Oklahoma to be applied prospec-

tively. — The rule announced in Ake v. Oklahoma, 105 S. Ct. 1087 (1985) (that due process of law was denied where no psychiatrist was appointed to examine the defendant, to help him prepare his case, to serve as an expert witness for the defense, and to assist in the defense at trial) should be applied only to those cases tried subsequent to Feb. 26, 1985. Snurkowski v. Commonwealth, 2 Va. App. 532, 348 S.E.2d 1 (1986).

Commitment to a hospital or other means of inquisition is not granted ex mero motu; it is not a perfunctory order. Hawks v. Peyton, 370 F.2d 123 (4th Cir. 1966), cert. denied, 387 U.S. 925, 87 S. Ct. 2044, 18 L. Ed. 2d 982 (1967). See also Kerns v. Peyton, 292 F. Supp. 182 (W.D. Va. 1968).

Applied in Washington v. Commonwealth, 228 Va. 535, 323 S.E.2d 577 (1984).

II. ACTION BY THE COURT.

Action by court is discretionary. — Under former § 19.2-169 the lower court, after hearing the evidence, could in its discretion commit a person held for trial to the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services at the proper hospital, pending determination of his mental condition. Delp v. Commonwealth, 172 Va. 564, 200 S.E. 594 (1939).

The language of former § 19.2-169 imported the exercise of discretion by the trial court in deciding whether the circumstances warranted further inquiry into defendant's mental condition, rather than the imposition of a mandate requiring such action regardless of the circumstances. Elkins v. Commonwealth, 208 Va. 336, 157 S.E.2d 243 (1967).

And will not be disturbed absent abuse. — The trial court's choice is discretionary and its denial of defendant's motion for a mental examination before trial will not be disturbed unless it is clearly shown that the trial court abused its discretion. Poteat v. Peyton, 270 F. Supp. 220 (W.D. Va. 1967).

The use of former § 19.2-169 was entirely discretionary with the trial court. The failure of the trial court to exercise such discretion was reviewable only in the event of clear abuse of judicial discretion. Morris v. Peyton, 283 F. Supp. 63 (W.D. Va. 1968).

Denial of a motion for pretrial examination cannot be assailed except for abuse of discretion. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963); Poteat v. Peyton, 270 F. Supp. 220 (W.D. Va. 1967); Morris v. Peyton, 283 F. Supp. 63 (W.D. Va. 1968).

The denial of a motion for a pretrial examination or the denial of a motion for a continuance in order to effectuate a mental examination cannot be assailed except for a clear abuse of discretion. Ashby v. Cox, 344 F. Supp. 759 (W.D. Va. 1972).

While the Supreme Court has the power to review the action of the trial court in committing or refusing to commit persons to the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, it will not disturb the trial court's ruling unless it plainly appears that the discretion of the trial court has been abused. Delp v. Commonwealth, 172 Va. 564, 200 S.E. 594 (1939); Tilton v. Commonwealth, 196 Va. 774, 85 S.E.2d 368 (1955).

Denial of motion held not an abuse. — Where there was no prima facie showing of insanity that would cause the court to doubt the defendant's sanity, there was no abuse of discretion by the trial court in denying defendant's motion. Poteat v. Peyton, 270 F. Supp. 220 (W.D. Va. 1967).

A trial judge did not abuse his discretion in denying a pretrial examination under former § 19.2-169 where testimony indicated that petitioner understood the nature of the charges against him and that he was aware that he was subject to punishment for them if found guilty, where the reason for an expert witness's lack of faith in the petitioner's ability to stand trial was not his present mental condition or competence but was caused by petitioner's memory lapse occasioned by heavy drinking, where the petitioner appeared normal while in court, and the petitioner's own testimony revealed nothing which indicated any mental defect or disease at the time of trial, and where there was no evidence that the petitioner had any prior history of mental instability. South v. Slayton, 336 F. Supp. 879 (W.D. Va. 1972).

The trial court has the inherent power to require defendant to be examined by a psychiatric committee in order that his examiners might report their opinion as to his sanity at the time of his alleged crimes and testify to such opinion if called by the Commonwealth as rebuttal witnesses. Shifflett v. Commonwealth, 221 Va. 760, 274 S.E.2d 305 (1981).

Judge may invoke procedure sua sponte. — Since a defendant cannot always be expected to demand a sanity examination for himself, the judge may invoke the procedure sua sponte. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

And should do so when adequate showing has been made. — When an adequate showing has been made to raise the issue of the defendant's sanity, the trial court should order a hearing sua sponte. McLaughlin v. Royster, 346 F. Supp. 297 (E.D. Va. 1972).

III. PROOF.

An accused is presumed to be sane at the trial unless his mental condition is called into question by proof to the contrary. Payne v.

Slayton, 329 F. Supp. 886 (W.D. Va. 1971).

An accused is presumed to be sane at the trial and during the commission of the offense, and it is his burden to prove the contrary. Graham v. Gathright, 345 F. Supp. 1148 (W.D. Va. 1972).

A simple suggestion of mental deficiency is not enough to require deferment of trial. Hawks v. Peyton, 370 F.2d 123 (4th Cir. 1966), cert. denied, 387 U.S. 925, 87 S. Ct. 2044, 18 L. Ed. 2d 982 (1967).

Fact that defendant had been in a mental institution on different occasions did not make out a prima facie case of insanity where that fact was not established before the trial court. Poteat v. Peyton, 270 F. Supp. 220 (W.D. Va. 1967).

Burden on accused upon motion for pretrial commitment. — In proceeding on a motion for pretrial commitment for observation and report, an accused was not required to prove actual insanity, as is necessary where lack of criminal responsibility is asserted as an affirmative defense. His sole burden was to adduce facts sufficient to create in the court's mind reasonable grounds to doubt his sanity. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963); Ashby v. Cox, 344 F. Supp. 759 (W.D. Va. 1972).

In proceeding on a motion for pretrial commitment, an accused met his burden of creating a reasonable doubt as to his sanity where two specialists testified without contradiction or reservation that accused was presently in the grip of a serious psychosis, disabling him from assisting his counsel. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

In Virginia, unlike the federal practice, the burden rests upon the accused to prove his mental incompetency. Timmons v. Peyton, 240 F. Supp. 749 (E.D. Va. 1965), rev'd on other grounds, 360 F.2d 327 (4th Cir.), cert. denied, 385 U.S. 960, 87 S. Ct. 396, 17 L. Ed. 2d 305 (1966).

The duty of carrying the burden of proving a defendant's insanity at the time of trial falls upon the petitioner's attorney to present the issue to the court when he has reasonable belief that his client's mental condition is of a nature which may render him incompetent to stand trial and which may also raise a question of his client's sanity at the time of the crime. Payne v. Slayton, 329 F. Supp. 886 (W.D. Va. 1971).

The burden of proof on the issue of insanity rests with the accused. Hodnett v. Slayton, 343 F. Supp. 1142 (W.D. Va. 1972), appeal dismissed, 471 F.2d 648 (4th Cir. 1973).

Petitioner need not prove actual insanity. — In proceeding on a motion for pretrial commitment for observation and report, the petitioner is not required to prove actual insanity, but only to adduce facts sufficient to create in the court's mind reasonable grounds to doubt his sanity. Morris v. Peyton, 283 F. Supp. 63 (W.D. Va. 1968).

The question of whether or not the defendant knows right from wrong is not relevant to the question of whether he should have been afforded a pretrial mental examination. Ashby v. Cox, 344 F. Supp. 759 (W.D. Va. 1972).

Efforts to overcome presumption of sanity may be circumscribed by state. — The Supreme Court of the United States has stated that a defendant's efforts to overcome the presumption of sanity may be circumscribed by state prescriptions as to the quantum of proof and legal tests of sanity. Payne v. Slayton, 329 F. Supp. 886 (W.D. Va. 1971).

But due process requires opportunity to raise issue. — Although efforts to overcome the presumption of sanity may be circumscribed by state rules as to the quantum of proof and legal tests of insanity, due process requires that a state shall afford the accused adequate opportunity to raise the issue. Graham v. Gathright, 345 F. Supp. 1148 (W.D. Va. 1972).

Before indigent defendant is entitled to psychiatric assistance, he must make a threshold showing to the trial court that his sanity is likely to be a significant factor in his defense. Tuggle v. Commonwealth, 230 Va. 99, 334 S.E.2d 838 (1985), cert. denied, 478 U.S. 1010, 106 S. Ct. 3309, 92 L. Ed. 2d 722 (1986).

IV. PRACTICE AND PROCEDURE.

Proof of reasonable ground for questioning mental capacity entitles a person to a preliminary inquiry upon his mental capability to understand the nature of the charge against him and to assist in his defense. Owsley v. Peyton, 368 F.2d 1002 (4th Cir. 1966).

Hearing contemplated. — Former § 19.2-169 contemplated that the court would rule on the suggestion "after hearing evidence." Hawks v. Peyton, 370 F.2d 123 (4th Cir. 1966), cert. denied, 387 U.S. 925, 87 S. Ct. 2044, 18 L. Ed. 2d 982 (1967).

Presence of accused at hearing. — If the personal presence of the party sought to be committed is required at any hearing prescribed, it will present grave difficulties with respect to many suspected mentally ill persons accused of crime, and will, in effect, prejudice the rights of an accused, as many such persons are not in condition to appear in court. Timmons v. Peyton, 240 F. Supp. 749 (E.D. Va. 1965), rev'd on other grounds, 360 F.2d 327 (4th Cir.), cert. denied, 385 U.S. 960, 87 S. Ct. 396, 17 L. Ed. 2d 305 (1966).

Precommitment hearing does not decide issue of competency. — The precommitment hearing does not decide the issue of competency, but rather the existence of reason

to believe that the defendant may be incompetent. McLaughlin v. Royster, 346 F. Supp. 297 (E.D. Va. 1972).

Separate hearing on issue of sanity was unjustified where the court, upon the concurrence of two qualified psychologists, considered defendant mentally competent to stand trial for murder, and the jury affirmed such a conclusion. Wilson v. Cox, 312 F. Supp. 209 (W.D. Va. 1970).

The report from the hospital does not conclude the issue of competency. Counsel has a duty to explore the matter further and adduce evidence in court, when there is reason for doubt as to the mental condition of the accused. McLaughlin v. Royster, 346 F. Supp. 297 (E.D. Va. 1972).

Effective assistance of counsel. — If reasonable grounds exist for questioning the sanity or competency of a defendant and counsel fails to explore the matter, the defendant has been denied effective assistance of counsel. Wood v. Zahradnick, 430 F. Supp. 107 (E.D. Va. 1977), aff'd, 578 F.2d 980 (4th Cir. 1978).

Where the facts known or reasonably ascertainable by counsel prior to trial were sufficient to inject the issues of whether the defendant was incompetent to stand trial or whether he was not responsible for his acts in the case, counsel had an affirmative obligation to make suitable inquiry to determine whether these defenses could be advanced. Counsel's failure to do so rendered his assistance ineffective within the meaning of the sixth amendment. Wood v. Zahradnick, 430 F. Supp. 107 (E.D. Va. 1977), aff'd, 578 F.2d 980 (4th Cir. 1978).

The defense attorney's failure to explore the mental condition of his client deprived his client of his right to effective assistance of counsel where the trial was certain to result in his conviction unless an insanity defense prevailed and where the circumstances suggested such a defense. Wood v. Zahradnick, 578 F.2d 980 (4th Cir. 1978).

The failure of the defendant's lawyer to explore the matter and adduce evidence in court where there was reason for doubt as to the mental condition of the accused constituted a denial of his right to effective assistance of counsel. Kibert v. Peyton, 383 F.2d 566 (4th Cir. 1967).

Defense of incompetency cannot be waived. — The defense of incompetency to stand trial cannot be waived by the incompetent, and his counsel cannot waive it for him by failing to move for examination of his competency. Kibert v. Peyton, 383 F.2d 566 (4th Cir. 1967).

The due process right to face trial only while capable of understanding and assisting in the proceedings is not subject to waiver. McLaughlin v. Royster, 346 F. Supp. 297 (E.D. Va. 1972).

Effect of evaluation request on speedy trial right. — Where record clearly indicated that the substantial delay of trial was occasioned by defendant's motion for an evaluation pursuant to this section and his conduct in relation to the evaluation, i.e., waiting almost five months to supply information necessary for the examination to commence, no denial of speedy trial occurred. Jones v. Commonwealth, 13 Va. App. 566, 414 S.E.2d 193 (1992).

Defendant may subsequently raise defense of insanity at time of offense. — Even if the trial court determines that the accused has the capacity to stand trial, he is not precluded from, and must be given the opportunity of, raising a defense of insanity at the time of the commission of the offense. Graham v. Gathright, 345 F. Supp. 1148 (W.D. Va. 1972).

On habeas corpus a federal court may, in its discretion, entertain and consider a review of the issue of insanity at the time of trial, even where the state court has previously determined the same issue after hearing. It is not, however, required to do so. Owsley v. Cunningham, 190 F. Supp. 608 (E.D. Va. 1961).

Where no hearing has ever been had in any state court proceeding on the issue of insanity at the time of trial, either at or immediately prior to the trial on the merits or by way of post-conviction remedies in the state court, it seems appropriate that a federal court should grant a plenary hearing. Owsley v. Cunningham, 190 F. Supp. 608 (E.D. Va. 1961).

While the provisions of former §§ 19.2-169 and 19.2-170 were discretionary, the failure of the trial court to exercise such discretion, while reviewable on direct appeal in the event of a clear abuse of judicial discretion, did not preclude the accused from proving his lack of mental capacity under his plea of not guilty, and the jury could find the accused not guilty by reason of insanity. The trial court, in exercising its discretion by denying the motion to commit, conducted a hearing on the reasonable necessity of such commitment for observation and report. Any error of the state court in evaluating the issue of mental competency would not go to jurisdiction; it is only the denial of the opportunity to tender the issue of insanity which affords the right to present the issue of insanity in habeas corpus proceedings. Owsley v. Cunningham, 190 F. Supp. 608 (E.D. Va. 1961).

Since due process entitled an accused to have the matter of sanity thoroughly canvassed and the Commonwealth provided the means for it, a federal court was obliged to scrutinize the procedures by which an accused's claim was rejected. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

Petition for habeas corpus on the grounds of

alleged insanity at the time of trial was entertained by a federal court even though the petitioner never took a direct appeal from his convictions. Thomas v. Cunningham, 313 F.2d 934 (4th Cir. 1963).

When the opportunity to raise the issue of the defendant's sanity has been provided, a federal court in a habeas corpus proceeding need not inquire again into the mental fitness of the state prisoner. Hodnett v. Slayton, 343 F. Supp. 1142 (W.D. Va. 1972), appeal dismissed, 471 F.2d 648 (4th Cir. 1973).

Where the issue is insanity at the time of trial, a federal court is obliged to examine the procedures by which this claim was rejected, but it is not required to review the merits of the determination where the State has done so. Graham v. Gathright, 345 F. Supp. 1148 (W.D. Va. 1972).

Under the rule governing federal habeas corpus proceedings, a federal district court cannot rely upon the state court's findings as sufficient basis to decide a defendant's claim of incompetence to stand trial where no specific finding of fact was made by the state court as to petitioner's condition when he was tried, and where the ruling against petitioner was apparently based upon a restrictive rule of the relevance of evidence, which kept the state court from deciding the central issue of competency. McLaughlin v. Royster, 346 F. Supp. 297 (E.D. Va. 1972).

On the issue of the competency of a petitioner to stand trial, he has the right to a federal hearing. McLaughlin v. Royster, 346 F. Supp. 297 (E.D. Va. 1972).

Liability for expenses where hospitalized under Title 37.1. — A person is liable for the expenses of his care, treatment, and maintenance when confined to a state hospital pursuant to Title 37.1, even though he previously had been confined to the facility pursuant to former § 19.2-169 as a person charged with crime. Commonwealth, Dep't of Mental Health & Mental Retardation v. Jenkins, 224 Va. 456, 297 S.E.2d 692 (1982).

Appointment on prior occasions did not preclude status as "independent" psychiatrist. — Doctor was not precluded from being an "independent" psychiatrist simply because he had been appointed by the court on prior occasions. Hogan v. Commonwealth, 5 Va. App. 36, 360 S.E.2d 371 (1987).

Ordering of examination not a finding of probable cause. — Where the court ordered the psychiatric examination solely because "this is a capital murder case," the court did not, merely by ordering the psychiatric examination pursuant to §§ 19.2-169.1 and 19.2-169.5, as a matter of law, find probable cause. Tuggle v. Commonwealth, 230 Va. 99, 334 S.E.2d 838 (1985), cert. denied, 478 U.S. 1010, 106 S. Ct. 3309, 92 L. Ed. 2d 722 (1986).

Withdrawal of notice of intent did not moot issue of error in denying motion for psychiatric assistance. — The issue of whether the court erred in denying defendant's pre-trial motion for independent psychiatric assistance was not moot, where defendant withdrew his notice of intent to rely on an insanity defense because of his belief that he had not been given sufficient opportunity to develop evidence of his mental state at the time of the offense. Hogan v. Commonwealth, 5 Va. App. 36, 360 S.E.2d 371 (1987).

Issue of whether defendant met burden not addressed on appeal where psychiatrist provided. — It is not necessary to address the issue on appeal whether defendant carried the threshold burden required in Ake v. Oklahoma, 470 U.S. 68, 105 S. Ct. 1087, 84 L. Ed. 2d 53 (1985), where the trial court did, in fact, provide him with the services of an independent psychiatrist. Hogan v. Commonwealth, 5 Va. App. 36, 360 S.E.2d 371 (1987).

§ 19.2-169.2. Disposition when defendant found incompetent. — A. Upon finding pursuant to subsection E of § 19.2-169.1 that the defendant is incompetent, the court shall order that the defendant receive treatment to restore his competency on an outpatient basis or, if the court specifically finds that the defendant requires inpatient hospital treatment, at a hospital designated by the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services as appropriate for treatment of persons under criminal charge. Any reports submitted pursuant to subsection D of § 19.2-169.1 shall be made available to the director of the treating facility.

B. If, at any time after the defendant is ordered to undergo treatment under subsection A of this section, the director of the treatment facility believes the defendant's competency is restored, the director shall immediately send a report to the court as prescribed in subsection D of § 19.2-169.1. The court shall make a ruling on the defendant's competency according to the procedures specified in subsection E of § 19.2-169.1. (1982, c. 653.)

§ 19.2-169.3. Disposition of the unrestorable incompetent defendant. — A. If, at any time after the defendant is ordered to undergo treatment pursuant to subsection A of § 19.2-169.2, the director of the treating facility concludes that the defendant is likely to remain incompetent for the foreseeable future, he shall send a report to the court so stating. The report shall also indicate whether, in the director's opinion, the defendant should be released, committed pursuant to § 37.1-67.3, or certified pursuant to § 37.1-65.1 in the event he is found to be unrestorably incompetent. Upon receipt of the report, the court shall make a competency determination according to the procedures specified in subsection E of § 19.2-169.1. If the court finds that the defendant is incompetent and is likely to remain so for the foreseeable future, it shall order that he be (i) released, (ii) committed pursuant to § 37.1-67.3, or (iii) certified pursuant to § 37.1-65.1. If the court finds the defendant incompetent but restorable to competency in the foreseeable future, it may order treatment continued until six months have elapsed from the date of the defendant's initial admission under subsection A of § 19.2-169.2.

B. At the end of six months from the date of the defendant's initial admission under subsection A of § 19.2-169.2 if the defendant remains incompetent in the opinion of the director, the director shall so notify the court and make recommendations concerning disposition of the defendant as described above. The court shall hold a hearing according to the procedures specified in subsection E of § 19.2-169.1 and, if it finds the defendant unrestorably incompetent, shall order one of the dispositions described above. If the court finds the defendant incompetent but restorable to competency, it may order continued treatment under subsection A of § 19.2-169.2 for additional six-month periods, provided a hearing pursuant to subsection E of § 19.2-169.1 is held at the completion of each such period and the defendant continues to be incompetent but restorable to competency in the foreseeable future.

C. If not dismissed without prejudice at an earlier time, charges against an unrestorable incompetent defendant shall be dismissed on the date upon which his sentence would have expired had he been convicted and received the maximum sentence for the crime charged, or on the date five years from the date of his arrest for such charges, whichever is sooner. (1982, c. 653.)

Liability for expenses when hospitalized under Title 37.1. — A person is liable for the expenses of his care, treatment, and maintenance when confined to a state hospital pursuant to Title 37.1, even though he previously had been confined to the facility pursuant to former § 19.2-169 as a person charged with crime. Commonwealth, Dep't of Mental Health & Mental Retardation v. Jenkins, 224 Va. 456, 297 S.E.2d 692 (1982).

§ 19.2-169.4. Litigating certain issues when the defendant is incompetent. — A finding of incompetency does not preclude the adjudication, at any time before trial, of a motion objecting to the sufficiency of the indictment, nor does it preclude the adjudication of similar legal objections which, in the court's opinion, may be undertaken without the personal participation of the defendant. (1982, c. 653.)

§ 19.2-169.5. Evaluation of sanity at the time of the offense; disclosure of evaluation results. — A. *Raising issue of sanity at the time of offense; appointment of evaluators.* — If, at any time before trial, the court finds, upon hearing evidence or representations of counsel for the defendant, that there is probable cause to believe that the defendant's sanity will be a significant factor in his defense and that the defendant is financially unable to pay for expert assistance, the court shall appoint one or more qualified mental health experts to evaluate the defendant's sanity at the time of the offense and,

where appropriate, to assist in the development of an insanity defense. Such mental health expert shall be (i) a psychiatrist, a clinical psychologist, or an individual with a doctorate degree in clinical psychology who has successfully completed forensic evaluation training as approved by the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services and (ii) qualified by specialized training and experience to perform forensic evaluations. The defendant shall not be entitled to a mental health expert of his own choosing or to funds to employ such expert.

B. *Location of evaluation.* — The evaluation shall be performed on an outpatient basis, at a mental health facility or in jail, unless the court specifically finds that outpatient services are unavailable, or unless the results of the outpatient evaluation indicate that hospitalization of the defendant for further evaluation of his sanity at the time of the offense is necessary. If either finding is made, the court, under authority of this subsection, may order that the defendant be sent to a hospital designated by the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services as appropriate for evaluation of the defendant under criminal charge. The defendant shall be hospitalized for such time as the director of the hospital deems necessary to perform an adequate evaluation of the defendant's sanity at the time of the offense, but not to exceed thirty days from the date of admission to the hospital.

C. *Provision of information to evaluator.* — The court shall require the party making the motion for the evaluation, and such other parties as the court deems appropriate, to provide to the evaluators appointed under subsection A any information relevant to the evaluation, including, but not limited to (i) copy of the warrant or indictment; (ii) the names and addresses of the attorney for the Commonwealth, the attorney for the defendant and the judge who appointed the expert; (iii) information pertaining to the alleged crime, including statements by the defendant made to the police and transcripts of preliminary hearings, if any; (iv) a summary of the reasons for the evaluation request; (v) any available psychiatric, psychological, medical or social records that are deemed relevant; and (vi) a copy of the defendant's criminal record, to the extent reasonably available.

D. The evaluators shall prepare a full report concerning the defendant's sanity at the time of the offense, including whether he may have had a significant mental disease or defect which rendered him insane at the time of the offense. The report shall be prepared within the time period designated by the court, said period to include the time necessary to obtain and evaluate the information specified in subsection C.

E. *Disclosure of evaluation results.* — The report described in subsection D shall be sent solely to the attorney for the defendant and shall be deemed to be protected by the lawyer-client privilege. However, the Commonwealth shall be given the report, the results of any other evaluation of the defendant's sanity at the time of the offense, and copies of psychiatric, psychological, medical, or other records obtained during the course of any such evaluation, after the attorney for the defendant gives notice of an intent to present psychiatric or psychological evidence pursuant to § 19.2-168. (1982, c. 653; 1986, c. 535; 1987, c. 439; 1996, cc. 937, 980.)

Editor's note. — Many of the cases cited in the following annotations were decided under repealed §§ 19.2-169 and 19.2-170.

The 1996 amendments. — The 1996 amendments by cc. 937 and 980 are identical, and in subsection A, in clause (i), deleted "licensed" preceding "psychologist" and deleted "a licensed psychologist registered with the Board of Psychology with a specialty in clinical services" preceding "or an individual with a doctorate degree."

Law Review. — For comment on the insanity defense in Virginia, see 17 U. Rich. L. Rev. 129 (1982).

Due process requires that State must provide adequate means by which accused can raise issue of insanity at the time of trial and at the commission of the alleged

offense. Hodnett v. Slayton, 343 F. Supp. 1142 (W.D. Va. 1972), appeal dismissed, 471 F.2d 648 (4th Cir. 1973).

State must assure indigent defendant access to competent psychiatrist who will conduct an appropriate examination and assist in evaluation, preparation, and presentation of the defense when the defendant demonstrates to the trial judge that his sanity at the time of the offense is to be a significant factor at trial. Tuggle v. Commonwealth, 230 Va. 99, 334 S.E.2d 838 (1985), cert. denied, 478 U.S. 1010, 106 S. Ct. 3309, 92 L. Ed. 2d 722 (1986).

Indigent entitled to psychiatrist in capital case on issue of future dangerousness. — When the prosecution in a capital sentencing proceeding presents psychiatric evidence of an indigent defendant's future dangerousness, due process requires that a state provide the defendant the assistance of a psychiatrist on the issue. Where the Commonwealth presented psychiatric evidence that defendant showed high probability of future dangerousness, even though defendant's trial and direct appeal predated in light of the trial court erred in denying his motion for an independent psychiatrist to rebut the Commonwealth's psychiatric evidence of future dangerousness. Tuggle v. Commonwealth, 230 Va. 99, 334 S.E.2d 838 (1985), cert. denied, 478 U.S. 1010, 106 S. Ct. 3309, 92 L. Ed. 2d 722 (1986).

Ake v. Oklahoma to be applied prospectively. — The rule announced in Ake v. Oklahoma, 470 U.S. 68, 105 S. Ct. 1087, 84 L. Ed. 2d 53 (1985) (that due process of law was denied where no psychiatrist was appointed to examine the defendant, to help him prepare his case, to serve as an expert witness for the defense, and to assist in the defense at trial) should be applied only to those cases tried subsequent to Feb. 26, 1985. Snurkowski v. Commonwealth, 2 Va. App. 532, 348 S.E.2d 1 (1986).

Examination by staff clinical psychologist and mental health professionals satisfied requirements. — The trial court correctly ruled that the examination and evaluation of defendant by a staff clinical psychologist and the mental health professionals at Central State Hospital satisfied the requirements of both subsection A and the due process requirements defined in Ake v. Oklahoma, 470 U.S. 68, 105 S. Ct. 1087, 84 L. Ed. 2d 53 (1985). Funk v. Commonwealth, 8 Va. App. 91, 379 S.E.2d 371 (1989).

Before indigent defendant is entitled to psychiatric assistance, he must make a threshold showing to the trial court that this sanity is likely to be a significant factor in his defense. Tuggle v. Commonwealth, 230 Va. 99, 334 S.E.2d 838 (1985), cert. denied, 478 U.S. 1010, 106 S. Ct. 3309, 92 L. Ed. 2d 722 (1986).

Right of defendant to raise defense of insanity at time of offense despite competency finding. — Even if the trial court determines that the accused has the capacity to stand trial, he is not precluded from, and must be given the opportunity of, raising a defense of insanity at the time of the commission of the offense. Graham v. Gathright, 345 F. Supp. 1148 (W.D. Va. 1972).

The trial court has the inherent power to require defendant to be examined by a psychiatric committee in order that his examiners might report their opinion as to his sanity at the time of his alleged crimes and testify to such opinion if called by the Commonwealth as rebuttal witnesses. Shifflett v. Commonwealth, 221 Va. 760, 274 S.E.2d 305 (1981).

Commonwealth entitled to other sanity evaluations. — Subsection E of this section clearly provides that the Commonwealth is entitled not only to the report ordered under this section, but also to the results of any other evaluation of the defendant's sanity when notice is given by the defense pursuant to § 19.2-168; subsection E of this section cannot be read as applying only to the report ordered. Blevins v. Commonwealth, 11 Va. App. 429, 399 S.E.2d 173 (1990).

Inquiry into competency to stand trial not limited. — Neither former § 19.2-169 nor former § 19.2-170, though preceded by § 19.2-168 requiring notice of an insanity defense, contained any language expressly or impliedly limiting the committee's (now evaluators') inquiry to competency to stand trial, or forbidding it to go into the question of insanity at the time of the alleged offense. Shifflett v. Commonwealth, 221 Va. 760, 274 S.E.2d 305 (1981).

Burden of proving insanity. — An accused is presumed to be sane at the trial and during the commission of the offense, and it is his burden to prove the contrary. Graham v. Gathright, 345 F. Supp. 1148 (W.D. Va. 1972).

The duty of carrying the burden of proving a defendant's insanity at the time of trial falls upon the petitioner's attorney to present the issue to the court when he has reasonable belief that his client's mental condition is of a nature which may render him incompetent to stand trial and which may also raise a question of his client's sanity at the time of the crime. Payne v. Slayton, 329 F. Supp. 886 (W.D. Va. 1971).

The burden of proof on the issue of insanity rests with the accused. Hodnett v. Slayton, 343 F. Supp. 1142 (W.D. Va. 1972), appeal dismissed, 471 F.2d 648 (4th Cir. 1973).

In Virginia, unlike the federal practice, the burden rests upon the accused to prove his mental incompetency. Timmons v. Peyton, 240 F. Supp. 749 (E.D. Va. 1965), rev'd on other grounds, 360 F.2d 327 (4th Cir.), cert. denied, 385 U.S. 960, 87 S. Ct. 396, 17 L. Ed. 2d 305 (1966).

Ordering of examination not a finding of

probable cause. — Where the court ordered the psychiatric examination solely because "this is a capital murder case," the court did not, merely by ordering the psychiatric examination pursuant to § 19.2-169.1 and this section, as a matter of law, find probable cause. Tuggle v. Commonwealth, 230 Va. 99, 334 S.E.2d 838 (1985), cert. denied, 478 U.S. 1010, 106 S. Ct. 3309, 92 L. Ed. 2d 722 (1986).

Effective assistance of counsel. — If reasonable grounds exist for questioning the sanity or competency of a defendant and counsel fails to explore the matter, the defendant has been denied effective assistance of counsel. Wood v. Zahradnick, 430 F. Supp. 107 (E.D. Va. 1977), aff'd, 578 F.2d 980 (4th Cir. 1978).

Where the facts known or reasonably ascertainable by counsel prior to trial were sufficient to inject the issues of whether the defendant was incompetent to stand trial or whether he was not responsible for his acts in the case, counsel had an affirmative obligation to make suitable inquiry to determine whether these defenses could be advanced. Counsel's failure to do so rendered his assistance ineffective within the meaning of the sixth amendment. Wood v. Zahradnick, 430 F. Supp. 107 (E.D. Va. 1977), aff'd, 578 F.2d 980 (4th Cir. 1978).

The defense attorney's failure to explore the mental condition of his client deprived his client of his right to effective assistance of counsel where the trial was certain to result in his conviction unless an insanity defense prevailed and where the circumstances suggested such a defense. Wood v. Zahradnick, 578 F.2d 980 (4th Cir. 1978).

Consideration of insanity in federal habeas proceedings. — While the provisions of former §§ 19.2-169 and 19.2-170 were discretionary, the failure of the trial court to exercise such discretion, while reviewable on direct appeal in the event of a clear abuse of judicial discretion, did not preclude the accused from proving his lack of mental capacity under his plea of not guilty, and the jury could find the accused not guilty by reason of insanity. The trial court, in exercising its discretion by denying the motion to commit, conducted a hearing on the reasonable necessity of such commitment for observation and report. Any error of the state court in evaluating the issue of mental competency would not go to jurisdiction; it is only the denial of the opportunity to tender the issue of insanity which affords the right to present the issue of insanity in habeas corpus proceedings. Owsley v. Cunningham, 190 F. Supp. 608 (E.D. Va. 1961).

§ 19.2-169.6. Emergency treatment prior to trial. — A. Any defendant who is not subject to the provisions of § 19.2-169.2 may be hospitalized for psychiatric treatment prior to trial if:

1. The court with jurisdiction over the defendant's case finds clear and convincing evidence that the defendant (i) is being properly detained in jail prior to trial; (ii) is mentally ill and imminently dangerous to self or others in the opinion of a qualified mental health professional; and (iii) requires treatment in a hospital rather than the jail in the opinion of a qualified mental health professional; or

2. The person having custody over a defendant who is awaiting trial has reasonable cause to believe that (i) the defendant is mentally ill and imminently dangerous to himself or others and (ii) requires treatment in a hospital rather than jail and the person having such custody arranges for an evaluation of the defendant by a person skilled in the diagnosis and treatment of mental illness provided a judge, as defined in § 37.1-1 or, if a judge is not available, a magistrate, upon the advice of a person skilled in the diagnosis and treatment of mental illness, subsequently issues a temporary order of detention for treatment in accordance with the procedures specified in § 37.1-67.1. In no event shall the defendant have the right to make application for voluntary admission and treatment as may be otherwise provided in § 37.1-65 or § 37.1-67.3.

If the defendant is committed pursuant to subdivision 1 of this subsection, the attorney for the defendant shall be notified that the court is considering hospitalizing the defendant for psychiatric treatment and shall have the opportunity to challenge the findings of the qualified mental health professional. If the defendant is detained pursuant to subdivision 2 of this subsection, the court having jurisdiction over the defendant's case and the attorney for the defendant shall be given notice prior to the detention pursuant to a temporary order of detention or as soon thereafter as is reasonable. Upon

detention pursuant to subdivision 2 of this subsection, a hearing shall be held, upon notice to the attorney for the defendant, either (i) before the court having jurisdiction over the defendant's case or (ii) before a judge as defined in § 37.1-1, in accordance with the provisions of § 37.1-67.4, in which case the defendant shall be represented by counsel as specified in § 37.1-67.3; the hearing shall be held within forty-eight hours of execution of the temporary order to allow the court which hears the case to make the findings, based upon clear and convincing evidence, which are specified in subdivision 1 of this subsection. If the forty-eight-hour period herein specified terminates on a Saturday, Sunday or legal holiday, such person may be detained for the same period allowed for detention pursuant to an order for temporary detention issued pursuant to § 37.1-67.1.

In any case in which the defendant is hospitalized pursuant to this section, the court having jurisdiction over the defendant's case may provide by order that the admitting hospital evaluate the defendant's competency to stand trial and his mental state at the time of the offense pursuant to §§ 19.2-169.1 and 19.2-169.5.

B. A defendant subject to this section shall be treated at a hospital designated by the Commissioner as appropriate for treatment and evaluation of persons under criminal charge. The director of the hospital shall, within thirty days of the defendant's admission, send a report to the court with jurisdiction over the defendant addressing the defendant's continued need for treatment as mentally ill and imminently dangerous to self or others and, if so ordered by the court, the defendant's competency to stand trial, pursuant to subsection D of § 19.2-169.1, and his mental state at the time of the offense, pursuant to subsection D of § 19.2-169.5. Based on this report, the court shall either (i) find the defendant incompetent to stand trial pursuant to subsection E of § 19.2-169.1 and proceed accordingly, (ii) order that the defendant be discharged from custody pending trial, (iii) order that the defendant be returned to jail pending trial, or (iv) make other appropriate disposition, including dismissal of charges and release of the defendant.

C. A defendant may not be hospitalized longer than thirty days under this section unless the court which has criminal jurisdiction over him or a judge as defined in § 37.1-1 holds a hearing at which the defendant shall be represented by an attorney and finds clear and convincing evidence that the defendant continues to be (i) mentally ill, (ii) imminently dangerous to self or others, and (iii) in need of psychiatric treatment in a hospital. Hospitalization may be extended in this manner for periods of sixty days, but in no event may such hospitalization be continued beyond trial, nor shall such hospitalization act to delay trial, so long as the defendant remains competent to stand trial. (1982, c. 653; 1986, c. 629; 1987, c. 96; 1990, c. 76; 1995, c. 844.)

The 1995 amendment substituted "§ 37.1-65 or § 37.1-67.3" for "§ 37.1-67.2 or § 37.1-65" at the end of subdivision A 2.

§ 19.2-169.7. Disclosure by defendant during evaluation or treatment; use at guilt phase of trial. — No statement or disclosure by the defendant concerning the alleged offense made during a competency evaluation ordered pursuant to § 19.2-169.1, a mental state at the time of the offense evaluation ordered pursuant to § 19.2-169.5, or treatment ordered pursuant to § 19.2-169.2 or § 19.2-169.6 may be used against the defendant at trial as evidence or as a basis for such evidence, except on the issue of his mental condition at the time of the offense after he raises the issue pursuant to § 19.2-168. (1982, c. 653.)

§§ 19.2-170 through 19.2-174.1 Repealed by Acts 1982, c. 653

Cross references. — For present provisions covering the subject matter of the repealed sections, see §§ 19.2-168.1 and 19.2-169.1 through 19.2-169.7.

§ 19.2-174.1. Information required prior to admission to a mental health facility. — Prior to any person being placed into the custody of the Commissioner for evaluation or treatment pursuant to §§ 19.2-169.2, 19.2-169.6, 19.2-176, 19.2-177.1, 19.2-182.2, and 19.2-182.3, the court or special justice shall provide the Commissioner with the following, if available: (i) the commitment order, (ii) the names and addresses for the attorney for the Commonwealth, the attorney for the person and the judge holding jurisdiction over the person, (iii) a copy of the warrant or indictment, and (iv) a copy of the criminal incident information as defined in § 2.1-341 or a copy of the arrest report or a summary of the facts relating to the crime. The party requesting the placement into the Commissioner's custody or, in the case of admissions pursuant to §§ 19.2-169.6, 19.2-176, and 19.2-177.1, the person having custody over the defendant shall gather the above information for submission to the court at the hearing. If the information is not available at the hearing, it shall be provided by the party requesting placement or the person having custody directly to the Commissioner within ninety-six hours of the person being placed into the Commissioner's custody. (1995, c. 645.)

§ 19.2-175. Compensation of experts. — Each psychiatrist, clinical psychologist or other expert appointed by the court to render professional service pursuant to §§ 19.2-168.1, 19.2-169.1, 19.2-169.5, subsection A of § 19.2-176, §§ 19.2-182.8, 19.2-182.9, 19.2-264.3:1, or § 19.2-301, who is not regularly employed by the Commonwealth of Virginia except by the University of Virginia School of Medicine and the Medical College of Virginia, shall receive a reasonable fee for such service. The fee shall be determined in each instance by the court that appointed the expert, in accordance with guidelines established by the Supreme Court after consultation with the Department of Mental Health, Mental Retardation and Substance Abuse Services. Except in capital murder cases the fee shall not exceed $400, but in addition if any such expert is required to appear as a witness in any hearing held pursuant to such sections, he shall receive mileage and a fee of $100 for each day during which he is required so to serve. An itemized account of expense, duly sworn to, must be presented to the court, and when allowed shall be certified to the Supreme Court for payment out of the state treasury, and be charged against the appropriations made to pay criminal charges. Allowance for the fee and for the per diem authorized shall also be made by order of the court, duly certified to the Supreme Court for payment out of the appropriation to pay criminal charges. (Code 1950, § 19.1-233; 1960, c. 366; 1968, c. 657; 1970, c. 640; 1975, c. 495; 1976, c. 140; 1978, cc. 195, 794; 1979, c. 516; 1982, c. 653; 1986, c. 535; 1990, c. 697; 1995, c. 645.)

The 1995 amendment, in the first sentence, inserted "§§ 19.2-182.8, 19.2-182.9, 19.2-264.3:1, or" following "§ 19.2-176" and deleted "subsections (1) and (2) of § 19.2-181 or § 19.2-264.3:1" following "§ 19.2-301."

Law Review. — For comment on the insanity defense in Virginia, see 17 U. Rich. L. Rev. 129 (1982).

§ 19.2-176. Determination of insanity after conviction but before sentence; hearing. — A. If, after conviction and before sentence of any person, the judge presiding at the trial finds reasonable ground to question such person's mental state, he may order an evaluation of such person's mental state by at least one psychiatrist or clinical psychologist who is qualified by

training and experience to perform such evaluations. If the judge, based on the evaluation, and after hearing representations of the defendant's counsel, finds clear and convincing evidence that the defendant (i) is mentally ill, and (ii) requires treatment in a mental hospital rather than the jail, he may order the defendant hospitalized in a facility designated by the Commissioner as appropriate for treatment of persons convicted of crime. The time such person is confined to such hospital shall be deducted from any term for which he may be sentenced to any penal institution, reformatory or elsewhere.

B. If it appears from all evidence readily available that the defendant is mentally ill and poses an imminent danger to himself or others if not immediately hospitalized, a temporary order of detention may be issued in accordance with subdivision A 2 of § 19.2-169.6 and a hearing shall be conducted in accordance with subsections A and C within forty-eight hours of execution of the temporary order of detention, or if the forty-eight-hour period herein specified terminates on a Saturday, Sunday or legal holiday, such person may be detained for the same period allowed for detention pursuant to an order for temporary detention issued pursuant to § 37.1-67.1.

C. A defendant may not be hospitalized longer than thirty days under this section unless the court which has criminal jurisdiction over him, or a court designated by such court, holds a hearing, at which the defendant shall be represented by an attorney, and finds clear and convincing evidence that the defendant continues to be (i) mentally ill, (ii) imminently dangerous to self or others, and (iii) in need of psychiatric treatment in a hospital. Hospitalization may be extended in this manner for periods of 180 days, but in no event may such hospitalization be continued beyond the date upon which his sentence would have expired had he received the maximum sentence for the crime charged. (Code 1950, § 19.1-234; 1960, c. 366; 1964, c. 231; 1966, c. 715; 1972, c. 295; 1975, c. 495; 1982, c. 653; 1986, c. 629; 1990, c. 76.)

Court must have some evidence available after verdict to authorize this procedure. — After the verdict of the jury has been rendered, when nothing has transpired since the trial which could cause the court to have any reasonable doubt as to his sanity, or authorize it to proceed under this section, the court will not impanel another jury to determine the sanity of the accused, since that question had been directly put in issue under the plea of not guilty, and finding him guilty they necessarily found him to have been sane when the offense was committed. Stover v. Commonwealth, 92 Va. 780, 22 S.E. 874 (1895).

§ 19.2-177: Repealed by Acts 1988, cc. 787, 873.

Cross references. — As to determination of mental illness after sentencing, see now § 19.2-177.1.

§ 19.2-177.1. Determination of mental illness after sentencing; hearing. — A person convicted of a crime who is in the custody of a local correctional facility after sentencing may be the subject of a mental commitment proceeding in accordance with the procedures provided in Chapter 2 (§ 37.1-63 et seq.) of Title 37.1. Such proceeding shall be commenced upon petition of the person having custody over the prisoner. If the person having custody over the prisoner has reasonable cause to believe that (i) the prisoner is mentally ill and imminently dangerous to himself or others and (ii) requires treatment in a hospital rather than a local correctional facility and the person having such custody arranges for an evaluation of the prisoner by a person skilled in the diagnosis and treatment of mental illness, then a judge, as defined in § 37.1-1 or, if a judge is not available, a magistrate, upon the advice of a person skilled in the diagnosis and treatment of mental illness, may issue

a temporary order of detention for treatment in accordance with the procedures specified in subdivision A 2 of § 19.2-169.6.

In all other respects, the involuntary civil detention and commitment procedures specified in Chapter 2 of Title 37.1 shall be applicable, except:

1. Any detention or commitment shall be only to a facility designated for this purpose by the Commissioner;

2. In no event shall the prisoner have the right to make application for voluntary admission and treatment as may be otherwise provided in § 37.1-65 or § 37.1-67.3;

3. The time that such prisoner is confined to a hospital shall be deducted from any term for which he may be sentenced, but in no event may such hospitalization be continued beyond the date upon which his sentence would have expired;

4. Any prisoner hospitalized pursuant to this section who has not completed service of his sentence upon discharge from the hospital shall serve the remainder of his sentence. (1988, c. 787; 1995, c. 844.)

The 1995 amendment substituted "§ 37.1-65 or § 37.1-67.3" for "§ 37.1-67.2 or § 37.1-65" at the end of subdivision 2.

Editor's note. — The cases cited below were decided under former § 19.2-177 or prior law.

Section provides safeguard. — Virginia throws a safeguard around the execution of the death sentence under this section. Timmons v. Peyton, 240 F. Supp. 749 (E.D. Va. 1965), rev'd on other grounds, 360 F.2d 327 (4th Cir.), cert. denied, 385 U.S. 960, 87 S. Ct. 396, 17 L. Ed. 2d 305 (1966).

Prisoner sentenced to death. — This section provides an opportunity for a prisoner who after conviction and sentence to death is so deficient in his faculties that it would be a denial of due process to execute him to raise such question. Snider v. Cunningham, 292 F.2d 683 (4th Cir. 1961).

Applied in Spruill v. Commonwealth, 221 Va. 475, 271 S.E.2d 419 (1980).

§ 19.2-178. Where prisoner kept when no vacancy in facility or hospital. — When a court shall have entered any of the orders provided for in §§ 19.2-168.1, 19.2-169.1, 19.2-169.5, 19.2-169.6, 19.2-176, or § 19.2-177.1, the sheriff of the county or city or the proper officer of the penal institution shall immediately proceed to ascertain whether a vacancy exists at the proper facility or hospital and until it is ascertained that there is a vacancy such person shall be kept in the jail of such county or city or in such custody as the court may order, or in the penal institution in which he is confined, until there is room in such facility or hospital. Any person whose care and custody is herein provided for shall be taken to and from the facility or hospital to which he was committed by an officer of the penal institution having custody of him, or by the sheriff of the county or city whose court issued the order of commitment, and the expenses incurred in such removals shall be paid by such penal institution, county or city. (Code 1950, § 19.1-236; 1960, c. 366; 1975, c. 495; 1995, c. 645.)

The 1995 amendment, in the first sentence, substituted "§§ 19.2-168.1, 19.2-169.1, 19.2-169.5, 19.2-169.6, 19.2-177.1 or" for "§§ 19.2-169, 19.2-170, 19.2-173" and deleted "or § 19.2-177" following "§ 19.2-176."

§ 19.2-179: Repealed by Acts 1981, c. 310.

§ 19.2-180. Sentence or trial of prisoner when restored to sanity. — When a prisoner whose trial or sentence was suspended by reason of his being found to be insane or feebleminded, has been found to be mentally competent and is brought from a hospital and committed to jail, if already convicted, he shall be sentenced, and if not, the court shall proceed to try him as if no delay

had occurred on account of his insanity or feeblemindedness. (Code 1950, § 19.1-238; 1960, c. 366; 1975, c. 495.)

§ 19.2-181: Repealed by Acts 1991, c. 427.

Cross references. — For provisions pertaining to disposition of persons acquitted by reason of insanity, see Chapter 11.1 (§ 19.2-182.2 et seq.).

§ 19.2-182. Representation by counsel in proceeding for commitment. — A. In any proceeding for commitment under this title, the judge before whom or upon whose order the proceeding is being held, shall ascertain if the person whose commitment is sought is represented by counsel. If the person is not represented by counsel, the judge shall appoint an attorney at law to represent him in the proceeding. The attorney shall receive a fee of twenty-five dollars for his services, to be paid by the Commonwealth.

B. Any attorney representing any person in any proceeding for commitment under this title shall, prior to such proceeding, personally consult with such person. (Code 1950, § 19.1-239.1; 1966, c. 715; 1975, c. 495; 1991, c. 427.)

§ 19.2-182.1: Repealed by Acts 1982, c. 653.

CHAPTER 11.1.

Disposition of Persons Acquitted by Reason of Insanity.

Sec.	
19.2-182.2.	Verdict of acquittal by reason of insanity to state the fact; temporary custody and evaluation.
19.2-182.3.	Commitment; civil proceedings.
19.2-182.4.	Confinement and treatment; interfacility transfers; out-of-hospital visits; notice of change in treatment.
19.2-182.5.	Review of continuation of confinement hearing; procedure and reports; disposition.
19.2-182.6.	Petition for release; conditional release hearing; notice; disposition.
19.2-182.7.	Conditional release; criteria; conditions; reports.
19.2-182.8.	Revocation of conditional release.
19.2-182.9.	Emergency custody of conditionally released acquittee.
19.2-182.10.	Release of person whose conditional release was revoked.
19.2-182.11.	Modification or removal of conditions; notice; objections; review.
19.2-182.12.	Representation of Commonwealth and acquittee.
19.2-182.13.	Authority of Commissioner; delegation to board; liability.
19.2-182.14.	Escape of persons placed or committed; penalty.
19.2-182.15.	Escape of persons placed on conditional release; penalty.
19.2-182.16.	Copies of orders to Commissioner.

§ 19.2-182.2. Verdict of acquittal by reason of insanity to state the fact; temporary custody and evaluation. — When the defense is insanity of the defendant at the time the offense was committed, the jurors shall be instructed, if they acquit him on that ground, to state the fact with their verdict. The court shall place the person so acquitted ("the acquittee") in temporary custody of the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services (hereinafter referred to in this chapter as the "Commissioner") for evaluation as to whether the acquittee may be released with or without conditions or requires commitment. The evaluation shall be conducted by (i) one psychiatrist and (ii) one clinical psychologist. The psychiatrist or clinical psychologist shall be skilled in the diagnosis of mental illness and mental retardation and qualified by training and experience to perform such evaluations. The Commissioner shall appoint both evaluators, at

least one of whom shall not be employed by the hospital in which the acquittee is primarily confined. The evaluators shall determine whether the acquittee is currently mentally ill or mentally retarded and shall assess the acquittee and report on his condition and need for hospitalization with respect to the factors set forth in § 19.2-182.3. The evaluators shall conduct their examinations and report their findings separately within forty-five days of the Commissioner's assumption of custody. Copies of the report shall be sent to the acquittee's attorney, the attorney for the Commonwealth for the jurisdiction where the person was acquitted and the community services board serving the locality where the acquittee was acquitted. If either evaluator recommends conditional release or release without conditions of the acquittee, the court shall extend the evaluation period to permit the hospital in which the acquittee is confined and the appropriate community services board to jointly prepare a conditional release or discharge plan, as applicable, prior to the hearing. (1991, c. 427; 1993, c. 295; 1996, cc. 937, 980.)

The 1996 amendments. — The 1996 amendments by cc. 937 and 980 are identical, and rewrote clause (ii) in the first sentence which formerly read: "one licensed clinical psychologist or licensed psychologist registered with the Board of Psychology with a specialty in clinical services" and inserted "clinical" following "psychiatrist or" in the third sentence.

Editor's note. — The cases annotated below were decided under prior law.

Court of appeals had no jurisdiction of appeal from commitment order. — The court of appeals had no jurisdiction of an appeal from a commitment order under subsection (1) of former § 19.2-181; an examination of § 17-116.05 revealed no proceeding remotely resembling the proceeding at issue. Antzes v. Commonwealth, 13 Va. App. 172, 409 S.E.2d 172 (1991) (decided under prior law).

Court of appeals had no jurisdiction of an appeal from a subsection (1) of former § 19.2-181 commitment order, as none has been conferred by the legislature; if the hearing held under subsection (1) of former § 19.2-181 was criminal in nature, the court of appeals had no jurisdiction, as there had been no final conviction of a crime from which to appeal (see § 17-116.05:1 (i)); furthermore, conferral of jurisdiction on the court of appeals by subsection (5) of former § 19.2-181 did not apply to a commitment proceeding under subsection (1) of former § 19.2-181. Antzes v. Commonwealth, 13 Va. App. 172, 409 S.E.2d 172 (1991) (decided under prior law).

Administrative procedures under this section not proper as jury instructions. — The detailed administrative procedures to be followed by the court and the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services under this section when a defendant is acquitted by reason of insanity are directed to the court and are not the concern of the jury and thus are not proper as jury instructions. Spruill v. Commonwealth, 221 Va. 475, 271 S.E.2d 419 (1980).

Trial court properly refused to instruct jury on the consequences of a verdict of not guilty by reason of insanity although defendant argued that the jury should have been told that, pursuant to a finding of not guilty by reason of insanity, defendant would not be set free but instead would be committed to the custody of state mental health authorities. As interpreted by the Virginia Supreme Court, the language in the statute that details these consequences specifically directs itself to the attention of the court. Furthermore, the court of appeals presumed that the jury conscientiously followed the explicit cautionary instruction. Miller v. Commonwealth, 15 Va. App. 301, 422 S.E.2d 795 (1992), aff'd, 246 Va. 336, 437 S.E.2d 411 (1993) (decided under former § 19.2-181).

Commitment procedures for insanity acquittees distinguished from that for other persons. — Virginia's scheme for the commitment of insanity acquittees is different in a number of respects from its scheme for the commitment of persons other than insanity acquittees. A person other than an insanity acquittee may be committed only if the factfinder determines that there is clear and convincing evidence that the person is insane and dangerous; he is given the right to a jury trial at the precommitment stage; he is automatically released after 180 days and if the State wishes to confine him for a longer period, it must initiate a fresh commitment proceeding every 180 days; and, finally, before the 180-day period has run, he has an unlimited right to seek release. Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).

Differences in standards for incarceration constitutional. — It is not a denial of due process for a person who has committed a criminal act to be incarcerated as long as he is considered dangerous. This aspect of Virginia's scheme does not deny equal protection because a different standard (i.e., insane and dangerous) is used for persons other than insanity acquittees. The fact that an insanity acquittee

has already been shown beyond a reasonable doubt to have committed at least one dangerous act justifies the distinction Virginia has drawn. Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).

Person may not be incarcerated solely because he is insane (at least in the absence of any showing that an involuntary confinement is necessary to ensure his own survival or safety or to alleviate or cure his illness). Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).

Hearing rights of insanity acquittees generally. — While the Code of Virginia does not explicitly guarantee to insanity acquittees the right to receive advance notice of hearings, to present evidence, and to cross-examine experts, neither does it explicitly deny them. Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).

Denial of jury trial and automatic release constitutional. — The denial of a jury trial at the precommitment stage and the denial of automatic release after 180 days are clearly not unconstitutional as denying due process, nor equal protection of the laws. The fact that an insanity acquittee has already been shown beyond a reasonable doubt to have committed at least one dangerous act provides a rational basis for the distinctions drawn by the General Assembly. Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).

Standard of proof under former section held constitutional. — The requirement of subsection (3) of former section 19.2-181 that the judge be "satisfied" that the insanity acquittee qualified for commitment invoked at least the preponderance-of-the-evidence standard, and the use of that standard was constitutionally permissible. Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).

Although clear-and-convincing standard used for other committees. — The clear-and-convincing-evidence standard is required for the commitment of persons other than insanity acquittees, but the situation of an insanity acquittee is distinguishable because an insanity acquittee has already been shown beyond a reasonable doubt to have committed at least one dangerous act. Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).

One-per-year restriction does not deny equal protection. — That no similar restriction is imposed on committed persons other than insanity acquittees does not make the rule limiting applications for discharge to one-per-year unconstitutional under the equal protection clause. The obvious rationale for this restriction is to encourage the patient who has demonstrated dangerousness to cooperate with the treating physicians in curing his ills, and the General Assembly could rationally have distinguished between insanity acquittees and other committed persons in evaluating the wisdom of imposing such a restriction. Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).

Nor due process. — The force of the argument that the one-per-year restriction on applications for a release order denies due process because it creates the possibility that an insanity acquittee will remain committed for almost a year after the justification for his commitment has ceased to exist is substantially diluted by the fact that the hospital where the insanity acquittee is committed is free to apply for his release as often as it wishes. Harris v. Ballone, 681 F.2d 225 (4th Cir. 1982).

Burden of proof. — Both in habeas corpus proceedings and other statutory proceedings for the release of a person committed to a mental institution after his acquittal of a criminal offense on the ground of insanity, the burden of proving eligibility for release rests on the petitioner. Blalock v. Markley, 207 Va. 1003, 154 S.E.2d 158 (1967).

Where language of the statute improperly placed upon insanity acquitee the burden of proving, even if she was not insane, that she was not dangerous, it violated protections of the Due Process Clause. Williams v. Commonwealth, 18 Va. App. 384, 444 S.E.2d 16 (1994) (decided under former § 19.2-181).

§ 19.2-182.3. Commitment; civil proceedings. — Upon receipt of the evaluation report and, if applicable, a conditional release or discharge plan, the court shall schedule the matter for hearing on an expedited basis, giving the matter priority over other civil matters before the court, to determine the appropriate disposition of the acquittee. Except as otherwise ordered by the court, the attorney who represented the defendant at the criminal proceedings shall represent the acquittee through the proceedings pursuant to this section. The matter may be continued on motion of either party for good cause shown. The acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. The hearing is a civil proceeding.

At the conclusion of the hearing, the court shall commit the acquittee if it finds that he is mentally ill or mentally retarded and in need of inpatient hospitalization. For the purposes of this chapter, mental illness includes any

mental illness, as this term is defined in § 37.1-1, in a state of remission when the illness may, with reasonable probability, become active. The decision of the court shall be based upon consideration of the following factors:

1. To what extent the acquittee is mentally ill or mentally retarded, as those terms are defined in § 37.1-1;

2. The likelihood that the acquittee will engage in conduct presenting a substantial risk of bodily harm to other persons or to himself in the foreseeable future;

3. The likelihood that the acquittee can be adequately controlled with supervision and treatment on an outpatient basis; and

4. Such other factors as the court deems relevant.

If the court determines that an acquittee does not need inpatient hospitalization solely because of treatment or habilitation he is currently receiving, but the court is not persuaded that the acquittee will continue to receive such treatment or habilitation, it may commit him for inpatient hospitalization. The court shall order the acquittee released with conditions pursuant to §§ 19.2-182.7 through 19.2-182.9 if it finds that he is not in need of inpatient hospitalization but that he meets the criteria for conditional release set forth in § 19.2-182.7. If the court finds that the acquittee does not need inpatient hospitalization nor does he meet the criteria for conditional release, it shall release him without conditions, provided the court has approved a discharge plan prepared jointly by the hospital staff and the appropriate community services board. (1991, c. 427; 1993, c. 295.)

§ 19.2-182.4. Confinement and treatment; interfacility transfers; out-of-hospital visits; notice of change in treatment. — Upon commitment of an acquittee for inpatient hospitalization, the Commissioner shall determine the appropriate placement for him, based on his clinical needs and security requirements. The Commissioner may make interfacility transfers and treatment and management decisions regarding acquittees in his custody without obtaining prior approval of or review by the committing court. If the Commissioner is of the opinion that a temporary visit from the hospital would be therapeutic for the acquittee and that such visit would pose no substantial danger to others, the Commissioner may grant such visit not to exceed forty-eight hours. The Commissioner shall notify the attorney for the Commonwealth for the committing jurisdiction in writing of changes in an acquittee's course of treatment which will involve authorization for the acquittee to leave the grounds of the hospital in which he is confined. (1991, c. 427; 1993, c. 295.)

§ 19.2-182.5. Review of continuation of confinement hearing; procedure and reports; disposition. — A. The committing court shall conduct a hearing twelve months after the date of commitment to assess each confined acquittee's need for inpatient hospitalization. A hearing for assessment shall be conducted at yearly intervals for five years and at biennial intervals thereafter. The court shall schedule the matter for hearing as soon as possible after it becomes due, giving the matter priority over all pending matters before the court.

B. Prior to the hearing, the Commissioner shall provide to the court a report evaluating the acquittee's condition and recommending treatment, to be prepared by a psychiatrist or a psychologist. The psychologist who prepares the report shall be a clinical psychologist and any evaluating psychiatrist or clinical psychologist shall be skilled in the diagnosis of mental illness and qualified by training and experience to perform forensic evaluations. If the examiner recommends release or the acquittee requests release, the acquittee's condition and need for inpatient hospitalization shall be evaluated by a second

person with such credentials who is not currently treating the acquittee. A copy of any report submitted pursuant to this subsection shall be sent to the attorney for the Commonwealth for the jurisdiction from which the acquittee was committed.

C. The acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. Written notice of the hearing shall be provided to the attorney for the Commonwealth for the committing jurisdiction. The hearing is a civil proceeding.

According to the determination of the court following the hearing, and based upon the report and other evidence provided at the hearing, the court shall (i) release the acquittee from confinement if he does not need inpatient hospitalization and does not meet the criteria for conditional release set forth in § 19.2-182.7, provided the court has approved a discharge plan prepared jointly by the hospital staff and the appropriate community services board; (ii) place the acquittee on conditional release if he meets the criteria for conditional release, and the court has approved a conditional release plan prepared jointly by the hospital staff and the appropriate community services board; or (iii) order that he remain in the custody of the Commissioner if he continues to require inpatient hospitalization based on consideration of the factors set forth in § 19.2-182.3. (1991, c. 427; 1993, c. 295; 1996, cc. 937, 980.)

The 1996 amendments. — The 1996 amendments by cc. 937 and 980 are identical, and in subsection B, in the second sentence, deleted "qualified as" following "the report shall be," deleted "licensed" following "a," deleted "or licensed psychologist registered with the Board of Psychology with a specialty in clinical services" following "clinical psychologist" and inserted "clinical" following "any evaluating psychiatrist."

§ 19.2-182.6. Petition for release; conditional release hearing; notice; disposition. — A. The Commissioner may petition the committing court for conditional or unconditional release of the acquittee at any time he believes the acquittee no longer needs hospitalization. The petition shall be accompanied by a report of clinical findings supporting the petition and by a conditional release or discharge plan, as applicable, prepared jointly by the hospital and the appropriate community services board. The acquittee may petition the committing court for release only once in each year in which no annual judicial review is required pursuant to § 19.2-182.5. The party petitioning for release shall transmit a copy of the petition to the attorney for the Commonwealth for the committing jurisdiction.

B. Upon receipt of a petition for release, the court shall order the Commissioner to appoint two persons in the same manner as set forth in § 19.2-182.2 to assess and report on the acquittee's need for inpatient hospitalization by reviewing his condition with respect to the factors set forth in § 19.2-182.3. The evaluators shall conduct their evaluations and report their finding in accordance with the provisions of § 19.2-182.2, except that the evaluations shall be completed and findings reported within forty-five days of issuance of the court's order for evaluation.

The Commissioner shall give notice of the hearing to any victim of the act resulting in the charges on which the acquittee was acquitted or the next of kin of the victim at the last known address, provided the person submits a written request for such notification to the Commissioner.

C. Upon receipt of the reports of evaluation, the court shall conduct a hearing on the petition. The hearing shall be scheduled on an expedited basis and given priority over other civil matters before the court. The acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during

the hearing, and the right to introduce evidence and cross-examine witnesses. Written notice of the hearing shall be provided to the attorney for the Commonwealth for the committing jurisdiction. The hearing is a civil proceeding.

At the conclusion of the hearing, based upon the report and other evidence provided at the hearing, the court shall order the acquittee (i) released from confinement if he does not need inpatient hospitalization and does not meet the criteria for conditional release set forth in § 19.2-182.3, provided the court has approved a discharge plan prepared jointly by the hospital and the appropriate community services board; (ii) placed on conditional release if he meets the criteria for such release as set forth in § 19.2-182.7, and the court has approved a conditional release plan prepared jointly by the hospital and the appropriate community services board; or (iii) retained in the custody of the Commissioner if he continues to require inpatient hospitalization based on consideration of the factors set forth in § 19.2-182.3.

D. Persons committed pursuant to this chapter shall be released only in accordance with the procedures set forth governing release and conditional release. (1991, c. 427; 1993, c. 295.)

§ 19.2-182.7. Conditional release; criteria; conditions; reports. — At any time the court considers the acquittee's need for inpatient hospitalization pursuant to this chapter, it shall place the acquittee on conditional release if it finds that (i) based on consideration of the factors which the court must consider in its commitment decision, he does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization; (ii) appropriate outpatient supervision and treatment are reasonably available; (iii) there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified; and (iv) conditional release will not present an undue risk to public safety. The court shall subject a conditionally released acquittee to such orders and conditions it deems will best meet the acquittee's need for treatment and supervision and best serve the interests of justice and society.

The community services board serving the locality in which the acquittee will reside upon release shall implement the court's conditional release orders and shall submit written reports to the court on the acquittee's progress and adjustment in the community no less frequently than every six months. (1991, c. 427.)

§ 19.2-182.8. Revocation of conditional release. — If at any time the court which released an acquittee pursuant to § 19.2-182.7 finds reasonable ground to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, it may order an evaluation of the acquittee by a psychiatrist or clinical psychologist, provided the psychiatrist or clinical psychologist is qualified by training and experience to perform forensic evaluations. If the court, based on the evaluation and after hearing evidence on the issue, finds by a preponderance of the evidence that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) is mentally ill or mentally retarded and requires inpatient hospitalization, the court may revoke the acquittee's conditional release and order him returned to the custody of the Commissioner.

At any hearing pursuant to this section, the acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the

right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. Written notice of the hearing shall be provided to the attorney for the Commonwealth for the committing jurisdiction. The hearing is a civil proceeding. (1991, c. 427; 1993, c. 295; 1996, cc. 937, 980.)

The 1996 amendments. — The 1996 amendments by cc. 937 and 980 are identical, and in the first paragraph, in clause (ii), substituted "or" for "licensed" following "acquittee by a psychiatrist," deleted "or licensed psychologist registered with the Board of Psychology with a specialty in clinical services" following "clinical psychologist" and inserted "clinical" following "provided the psychiatrist or."

§ 19.2-182.9. Emergency custody of conditionally released acquittee. — When exigent circumstances do not permit compliance with revocation procedures set forth in § 19.2-182.8, any judge as defined in § 37.1-1 or a magistrate may issue an emergency custody order, upon the sworn petition of any responsible person or upon his own motion based upon probable cause to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) requires inpatient hospitalization. The emergency custody order shall require the acquittee within his judicial district to be taken into custody and transported to a convenient location where a person designated by the community services board who is skilled in the diagnosis and treatment of mental illness shall evaluate such acquittee and assess his need for inpatient hospitalization. A law-enforcement officer who, based on his observation or the reliable reports of others, has probable cause to believe that any acquittee on conditional release has violated the conditions of his release and is no longer a proper subject for conditional release and requires emergency evaluation to assess the need for inpatient hospitalization, may take the acquittee into custody and transport him to an appropriate location to assess the need for hospitalization without prior judicial authorization. The evaluation shall be conducted immediately. The acquittee shall remain in custody until a temporary detention order is issued or until he is released, but in no event shall the period of custody exceed four hours. If it appears from all evidence readily available (i) that the acquittee has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) that he requires emergency evaluation to assess the need for inpatient hospitalization, the judge as defined in § 37.1-1, or magistrate upon the advice of such person skilled in the diagnosis and treatment of mental illness, may issue an order of temporary detention authorizing the executing officer to place the acquittee in an appropriate institution for a period not to exceed forty-eight hours prior to a hearing. If the forty-eight-hour period terminates on a Saturday, Sunday or legal holiday, the acquittee may be detained until the next day which is not a Saturday, Sunday or legal holiday, but in no event may he be detained for longer than seventy-two hours or ninety-six hours when the legal holiday occurs on a Monday or Friday. For purposes of this section, a Saturday, Sunday or legal holiday shall be deemed to include the time period up to 8 a.m. of the next day which is not a Saturday, Sunday or legal holiday.

The committing court or any judge as defined in § 37.1-1 shall have jurisdiction to hear the matter. Prior to the hearing, the acquittee shall be examined by a psychiatrist or licensed clinical psychologist, provided the psychiatrist or clinical psychologist is skilled in the diagnosis of mental illness, who shall certify whether the person is in need of hospitalization. At the hearing the acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence

and cross-examine witnesses at the hearing. Following the hearing, if the court determines, based on a preponderance of the evidence presented at the hearing, that the acquittee (i) has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) is mentally ill or mentally retarded and is in need of inpatient hospitalization, the court shall revoke the acquittee's conditional release and place him in the custody of the Commissioner. When an acquittee on conditional release pursuant to this chapter is taken into emergency custody, detained or hospitalized, such action shall be considered to have been taken pursuant to this section, notwithstanding the fact that his status as an insanity acquittee was not known at the time of custody, detention or hospitalization. Detention or hospitalization of an acquittee pursuant to provisions of law other than those applicable to insanity acquittees pursuant to this chapter shall not render the detention or hospitalization invalid. If a person's status as an insanity acquittee on conditional release is not recognized at the time of emergency custody or detention, at the time his status as such is verified, the provisions applicable to such persons shall be applied and the court hearing the matter shall notify the committing court of the proceedings. (1991, c. 427; 1993, c. 295; 1996, cc. 937, 980.)

The 1996 amendments. — The 1996 amendments by cc. 937 and 980 are identical, and in the second paragraph, in the first sentence, inserted "or" following "examined by a psychiatrist" and deleted "or licensed psychologist registered with the Board of Psychology with a specialty in clinical services" following "licensed clinical psychologist."

§ 19.2-182.10. Release of person whose conditional release was revoked. — If an acquittee is returned to the custody of the Commissioner for inpatient treatment pursuant to revocation proceedings, and his condition improves to the degree that, within thirty days of resumption of custody following the hearing, the acquittee, in the opinion of hospital staff treating the acquittee and the supervising community services board, is an appropriate candidate for conditional release, he may be, with the approval of the court, conditionally released as if revocation had not taken place. If treatment is required for longer than thirty days, the acquittee shall be returned to the custody of the Commissioner for a period of hospitalization and treatment which is governed by the provisions of this chapter applicable to committed acquittees. (1991, c. 427; 1993, c. 295.)

§ 19.2-182.11. Modification or removal of conditions; notice; objections; review. — A. The committing court may modify conditions of release or remove conditions placed on release pursuant to § 19.2-182.7, upon petition of the supervising community services board, the attorney for the Commonwealth, or the acquittee or upon its own motion based on reports of the supervising community services board. However, the acquittee may petition only annually commencing six months after the conditional release order is issued. Upon petition, the court shall require the supervising community services board to provide a report on the acquittee's progress while on conditional release.

B. As it deems appropriate based on the community services board's report and any other evidence provided to it, the court may issue a proposed order for modification or removal of conditions. The court shall provide notice of the order, and their right to object to it within ten days of its issuance, to the acquittee, the supervising community services board and the attorney for the Commonwealth for the committing jurisdiction and for the jurisdiction where the acquittee is residing on conditional release. The proposed order shall become final if no objection is filed within ten days of its issuance. If an objection is so filed, the court shall conduct a hearing at which the acquittee,

the attorney for the Commonwealth, and the supervising community services board have an opportunity to present evidence challenging the proposed order. At the conclusion of the hearing, the court shall issue an order specifying conditions of release or removing existing conditions of release. (1991, c. 427.)

§ 19.2-182.12. Representation of Commonwealth and acquittee. — The attorney for the Commonwealth shall represent the Commonwealth in all proceedings held pursuant to this chapter. The court shall appoint counsel for the acquittee unless the acquittee waives his right to counsel. The court shall consider appointment of the person who represented the acquittee at the last proceeding. (1991, c. 427; 1993, c. 295.)

§ 19.2-182.13. Authority of Commissioner; delegation to board; liability. — The Commissioner may delegate any of the duties and powers imposed on or granted to him by this chapter to an administrative board composed of persons with demonstrated expertise in such matters. The Department of Mental Health, Mental Retardation and Substance Abuse Services shall assist the board in its administrative and technical duties. Members of the board shall exercise their powers and duties without compensation and shall be immune from personal liability while acting within the scope of their duties except for intentional misconduct. (1991, c. 427.)

§ 19.2-182.14. Escape of persons placed or committed; penalty. — Any person placed in the temporary custody of the Commissioner pursuant to § 19.2-182.2 or committed to the custody of the Commissioner pursuant to § 19.2-182.3 who escapes from such custody shall be guilty of a Class 6 felony. (1993, c. 295.)

Cross references. — As to punishment for Class 6 felonies, see § 18.2-10.

§ 19.2-182.15. Escape of persons placed on conditional release; penalty. — Any person placed on conditional release pursuant to § 19.2-182.7 who leaves the Commonwealth without permission from the court which conditionally released the person shall be guilty of a Class 6 felony. (1993, c. 295.)

Cross references. — As to punishment for Class 6 felonies, see § 18.2-10.

§ 19.2-182.16. Copies of orders to Commissioner. — Copies of all orders and notices issued pursuant to this chapter shall be sent to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. (1993, c. 295.)

CHAPTER 15.

TRIAL AND ITS INCIDENTS.

Article 4.1.

Trial of Capital Cases.

Sec.
19.2-264.2. Conditions for imposition of death sentence.
19.2-264.3:1. Expert assistance when defendant's mental condition relevant to capital sentencing.
19.2-264.4. Sentence proceeding.

§ 19.2-389

Dissemination of criminal history record information

A. Criminal history record information shall be disseminated, whether directly or through an intermediary, only to:

1. Authorized officers or employees of criminal justice agencies, as defined by § 9-169, for purposes of the administration of criminal justice and the screening of an employment application or review of employment by a criminal justice agency with respect to its own employees or applicants, and dissemination to the Virginia Parole Board, pursuant to this subdivision, of such information on all state-responsible inmates for the purpose of making parole determinations pursuant to subdivisions 1, 2, 3, and 5 of § 53.1-136 shall include collective dissemination by electronic means every thirty days;

2. Such other individuals and agencies which require criminal history record information to implement a state or federal statute or executive order of the President of the United States or Governor that expressly refers to criminal conduct and contains requirements and/or exclusions expressly based upon such conduct, except that information concerning the arrest of an individual may not be disseminated to a noncriminal justice agency or individual if an interval of one year has elapsed from the date of the arrest and no disposition of the charge has been recorded and no active prosecution of the charge is pending;

3. Individuals and agencies pursuant to a specific agreement with a criminal justice agency to provide services required for the administration of criminal justice pursuant to that agreement which shall specifically authorize access to data, limit the use of data to purposes for which given, and ensure the security and confidentiality of the data;

4. Individuals and agencies for the express purpose of research, evaluative, or statistical activities pursuant to an agreement with a criminal justice agency which shall specifically authorize access to data, limit the use of data to research, evaluative, or statistical purposes, and ensure the confidentiality and security of the data;

5. Agencies of state or federal government which are authorized by state or federal statute or executive order of the President of the United States or Governor to conduct investigations determining employment suitability or eligibility for security clearances allowing access to classified information;

6. Individuals and agencies where authorized by court order or court rule;

7. Agencies of any political subdivision of the Commonwealth for the conduct of investigations of applicants for public employment, permit, or license whenever, in the interest of public welfare or safety, it is necessary to determine under a duly enacted ordinance if the past criminal conduct of a person with a conviction record would be compatible with the nature of the employment, permit, or license under consideration;

8. Public or private agencies when and as required by federal or state law or interstate compact to investigate applicants for foster or adoptive parenthood subject to the restriction that the data shall not be further disseminated by the agency to any party other than a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination;

9. To the extent permitted by federal law or regulation, public service companies as defined in § 56-1, for the conduct of investigations of applicants for employment when such employment involves personal contact with the public or when past criminal conduct of an applicant would be incompatible with the nature of the employment under consideration;

10. The appropriate authority for purposes of granting citizenship and for purposes of international travel, including but not limited to, issuing visas and passports;

11. A person requesting a copy of his own criminal history record information as defined in § 9-169 at his cost, except that criminal history record information shall be supplied at no charge to a person who has applied to be a volunteer (I) with a Virginia affiliate of Big Brothers/Big Sisters of America,(ii) with a volunteer fire company or volunteer rescue squad, (iii) as a court-appointed special advocate, or (iv) with the Volunteer Emergency Families for Children;

12. Administrators and board presidents of and applicants for licensure or registration as a child welfare agency as defined in § 63.1-195 for dissemination to the Commissioner of Social Services' representative pursuant to § 63.1-198 for the conduct of investigations with respect to employees of and volunteers at such facilities, caretakers, and other adults living in family day-care homes or homes approved by family day-care systems, and foster and adoptive parent applicants of private child-placing agencies, pursuant to § 63.1-198.1, subject to the restriction that the data shall not be further disseminated by the facility or agency to any party other than the data subject, the Commissioner of Social Services' representative or a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination;

13. The school boards of the Commonwealth for the purpose of screening individuals who are offered or who accept public school employment;

14. The State Lottery Department for the conduct of investigations as set forth in the State Lottery Law (§ 58.1-4000 et seq.);

15. Licensed nursing homes, hospitals and home care organizations for the conduct of investigations of applicants for compensated employment in licensed nursing homes pursuant to § 32.1-126.01, hospital pharmacies pursuant to § 32.1-126.02, and home care organizations pursuant to § 32.1-162.9:1, subject to the limitations set out in subsection E;

16. Licensed homes for adults, licensed district homes for adults, and licensed adult day-care centers for the conduct of investigations of applicants for compensated employment in licensed homes for adults pursuant to § 63.1-173.2, in licensed district homes for adults pursuant to § 63.1-189.1, and in licensed adult day-care centers pursuant to § 63.1-194.13, subject to the limitations set out in subsection F;

17. The Alcoholic Beverage Control Board for the conduct of investigations as set forth in § 4.1-103.1;

18. The State Board of Elections and authorized officers and employees thereof in the course of conducting necessary investigations with respect to registered voters, limited to any record of felony convictions;

19. The Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services for those individuals who are committed to the custody of the Commissioner pursuant to §§ 19.2-169.2, 19.2-169.6, 19.2-176, 19.2-177.1, 19.2-182.2, 19.2-182.3, 19.2-182.8 and 19.2-182.9 for the purpose of placement, evaluation, and treatment planning;

20. Any alcohol safety action program certified by the Commission on the Virginia Alcohol Safety Action Program for (I) assessments of habitual offenders under § 46.2-360, (ii) interventions with first offenders under § 18.2-251, or (iii) services to offenders under § 18.2-266 or § 18.2-266.1;

21. Residential facilities for juveniles regulated or operated by the Department of Social Services, the Department of Education, or the Department of Mental Health, Mental Retardation and Substance Abuse Services for the purpose of determining applicants' fitness for employment or for providing volunteer or contractual services;

22. The Department of Mental Health, Mental Retardation and Substance Abuse Services and facilities operated by the Department for the purpose of determining an individual's fitness for employment pursuant to departmental instructions;

23. Pursuant to § 22.1-296.3, the governing boards or administrators of private or parochial elementary or secondary schools which are accredited by a statewide accrediting organization recognized, prior to January 1, 1996, by the State Board of Education; and

24 Other entities as otherwise provided by law.

Upon an ex parte motion of a defendant in a felony case and upon the showing that the records requested may be relevant to such case, the court shall enter an order requiring the Central Criminal Records Exchange to furnish the defendant, as soon as practicable, copies of any records of persons designated in the order on whom a report has been made under the provisions of this chapter.

Notwithstanding any other provision of this chapter to the contrary, upon a written request sworn to before an officer authorized to take acknowledgments, the Central Criminal Records Exchange or the criminal justice agency in cases of offenses not required to be reported to the Exchange, shall furnish a copy of conviction data covering the person named in the request to the person making the request; however, such person on whom the data is being obtained shall consent in writing, under oath, to the making of such request. A person receiving a copy of his own conviction data may utilize or further disseminate that data as he deems appropriate. In the event no conviction data is maintained on the data subject, the person making the request shall be furnished at his cost a certification to that effect.

B. Use of criminal history record information disseminated to noncriminal justice agencies under this section shall be limited to the purposes for which it was given and may not be disseminated further.

C. No criminal justice agency or person shall confirm the existence or nonexistence of criminal history record information for employment or licensing inquiries except as provided by law.

D. Criminal justice agencies shall establish procedures to query the Central Criminal Records Exchange prior to dissemination of any criminal history record information on offenses required to be reported to the Central Criminal Records Exchange to ensure that the most up-to-date disposition data is being used. Inquiries of the Exchange shall be made prior to any dissemination except in those cases where time is of the essence and the normal response time of the Exchange would exceed the necessary time period. A criminal justice agency to whom a request has been made for the dissemination of criminal history record information that is required to be reported to the Central Criminal Records Exchange may direct the inquirer to the Central Criminal Records Exchange for such dissemination. Dissemination of information regarding offenses not required to be reported to the Exchange shall be made by the criminal justice agency maintaining the record as required by § 15.1-135.1.

E. Criminal history information provided to licensed nursing homes, hospitals and to home care organizations pursuant to subdivision A 15 shall be limited to the convictions on file with the Exchange for any offense specified in §§ 32.1-126.01, 32.1-126.02 and 32.1-162.9:1.

F. Criminal history information provided to licensed adult care residences, licensed district homes for adults, and licensed adult day-care centers pursuant to subdivision A 16 shall be limited to the convictions on file with the Exchange for any offense specified in §§ 63.1-173.2, 63.1-189.1 or § 63.1-194.13.

APPENDIX F

CASE MANAGEMENT CSB and Related PRAIS Data Elements

CASE MANAGEMENT CSB and Related PRAIS

Data Elements

Definitions, Values, Procedures and

Interpretive Guidelines

June 2, 1994

CASE MANAGEMENT CSB (CASEMGT CSB)	
DEFINITION	• The CSB which is responsible for case management, i.e., serves as CSB liaison during hospitalization, responsible for development and implementation of discharge plan, etc. • The CSB to which bed day utilization is assigned for current episode of hospitalization, beginning on the day of admission. • CASEMGT CSB field is a required entry for all admissions.
VALUES	• Values include CSB Codes, "Interstate Transfer" admissions, or "Out-of-State" admissions, or "Unassigned".
PROCEDURES AND INTERPRETIVE GUIDELINES	• Value may be reset by facility staff to another CSB at each readmission to state facility. • CASEMGT-CSB designation may be changed by facility staff within 48-hours following current admission to allow for new or corrected information. • An "Unassigned" value for CASEMGT-CSB must be reset to a CSB code value or "out-of-state" admission value within 48-hours following current admission. When the CASEMGT CSB value is reset to a CSB code, then facility staff must contact the CASEMGT CSB to confirm CASEMGT CSB designation during the 48-hour period. • CASEMGT-CSB designation may be changed at a later point during the current episode of hospitalization <u>ONLY</u> to correct data entry errors. • Admission date (ADM DATE) serves as the effective starting date from which bed day accruals are counted even if CASEMGT-CSB designation is changed during the current episode of hospitalization.

PROCEDURES AND INTERPRETIVE GUIDELINES	• CSB Code in CASEMGT CSB field must match CSB Code in SE-ORG-CODE field in PRAIS Security Database in order for CASEMGT-CSB to access patient/resident record. • CASEMGT-CSB designation is made by Prescreening CSB during the Preadmission Screening Process and is noted, with the appropriate PRAIS CSB Code, on Preadmission Screening Form (DMH224 Rev. 4/94), Section I on line labeled "Case Management CSB". • CASEMGT-CSB is the CSB serving the area in which the individual resides. If the living situation is unknown or can not be determined, then the CASEMGT-CSB is the CSB which conducted the prescreening. • CASEMGT-CSB for individuals in jail, in local hospitals or VA facilities, or in regional treatment/detox programs is the CSB serving the catchment area in which the individual resided prior to incarceration or admission to local hospital, VA facility or regional treatment/detox program. • CASEMGT-CSB for individuals who are transient or homeless is the CSB serving the catchment area in which the individual is living or sheltered at the time of the preadmission screening. When a CSB other than the Prescreening CSB is continuing to provide services and supports to a client who is living or sheltered in the catchment area of the Prescreening CSB, then the CASEMGT CSB is the CSB providing ongoing services and supports. • When the CASEMGT CSB is a different CSB than the Prescreening CSB, then the Prescreening CSB must contact the CASEMGT CSB during the Preadmission Screening Process to confirm the CASEMGT designation. Documentation of the name of the person contacted should be made on the last line of Section I, on the Preadmission Screening Form (Form 224 rev. 4/94).

PROCEDURES AND INTERPRETIVE GUIDELINES	• The Prescreening CSB will document confirmation of CASEMGT CSB designation on the Preadmission Screening Form, Section I on line labeled "Case Management CSB Contact". • When the CASEMGT CSB is a different CSB than the Prescreening CSB, then the facility staff, immediately upon admission, will notify CASEMGT CSB to confirm CASEMGT designation. • When an "Unassigned" value for CASEMGT CSB is reset to a CSB code value, then the facility staff, within 48 hours after current admission, must notify CASEMGT CSB to confirm CASEMGT CSB designation. • CASEMGT CSB designation for individuals who are from out of state is coded "Out of State". The Prescreening CSB will reflect the "Out-of-State" designation on the Preadmission Screening form in Section I, under "Case Management CSB" along with the "Out-of-State" PRAIS Code, and in Section VI under "CSB Serving the Area where Client Resides". • CASEMGT-CSB designation for admissions through the Interstate Transfer process is coded "Interstate Transfer" by facility admissions/medical records staff. • CASEMGT-CSB for transfers between DMH facilities is the CSB serving the catchment area in which the individual resided prior to the current episode of hospitalization, as above. • When a client chooses to reside in a catchment area served by a CSB that is different from CASEMGT CSB, CASEMGT CSB designation for current episode of hospitalization is not changed and bed day accruals are not transferred to the CSB in whose catchment the client chooses to reside upon discharge. In such cases, all appropriate client service management protocol involving coordination, communication and consent among the involved CSBs, facility staff and the client will apply.

PRESCREENING CSB (PRE CSB)	
DEFINITION	• The CSB which conducts the preadmission screening. • PRE-CSB field is a required entry for all admissions.
VALUES	• Values include CSB Codes, or "Unassigned".
PROCEDURES AND INTERPRETIVE GUIDELINES	• Determination made by hospital staff from information noted on Preadmission Screening Form, Section VI, under "Prescreening Agency or Board", or other admissions information.

ADMITTING CITY/COUNTY CODE (ADM CCC)	
DEFINITION	• The city or county in which the individual is physically located upon transport to the state facility. • ADM-CCC field is a required entry for all admissions.
VALUES	• Values include all city and county codes in Virginia, "Unknown", or "Out-of-State".
PROCEDURES AND INTERPRETIVE GUIDELINES	• ADM-CCC designation is made by Facility admissions/medical records staff and is derived from admissions information reflected on admissions documents such as Temporary Detention Orders or Involuntary Commitment papers, the preadmission screening form, etc.

DISCHARGE CITY/COUNTY CODE (DIS CCC)	
DEFINITION	• The city or county to which the individual is discharged. • DIS CCC field is a required entry for all discharges from state facilities.
VALUES	• Values include all city and county codes in Virginia, "Transfer to DMH Facility", or "Out-of-State".
PROCEDURES AND INTERPRETIVE GUIDELINES	• DIS CCC designation is made by facility medical records staff based on the address at which the individual will reside upon release from the facility. • DIS CCC designation for individuals discharged to jails, local hospitals, DMHMRSAS facilities, VA facilities, or regional treatment/detox programs is the city/county in which the facility/program is located.

PATIENT CITY/COUNTY CODE (PAT CCC)	
DEFINITION	• The city or county of the individual's residential or mailing address prior to admission to the state facility • PAT CCC field is a required entry for all admissions.
VALUES	• Values include all city and county codes in Virginia, "Unknown", or "Out-of-State".
PROCEDURES AND INTERPRETIVE GUIDELINES	• PAT CCC designation is made by facility admissions/medical records staff and is derived from the individual's address as noted on the Preadmission Screening Form, Section I, on line labeled "Address". • Jails, hospitals, and regional treatment/detox programs are excluded as address/residence options. In such cases, PAT CCC designation is the city or county of the residential or mailing address prior to incarceration or admission to the hospital or regional treatment program. • PAT CCC designation for individuals who are transient or homeless is the city or county in which the individual is living or sheltered at the time of the preadmission screening or transport to the state facility. • PAT CCC designation for individuals who are from out of state is coded "Out-of-State". The Prescreening CSB will reflect the "Out-of-State" designation on the Preadmission Screening Form, Section I, under "Address". • PAT CCC designation for admissions through the Interstate Transfer process is coded "Interstate Transfer" by facility admissions/medical records staff • PAT CCC designation for transfers between DMH facilities is the city or county in which the individual resided prior to current hospitalization.

DISCHARGE CSB (DIS CSB)

DEFINITION	• The CSB to which the individual is discharged. • DIS CSB is a required entry for all discharges from state facilities.
VALUES	• Values include CSB Codes, "Out-of-State", "Interstate Transfer", or "Unassigned".
PROCEDURES AND INTERPRETIVE GUIDELINES	• DIS CSB designation is made by facility medical records staff and is most often based on the CSB serving the city/county in which the individual will reside upon discharge from the facility. • DIS CSB designation for individuals discharged to jails, local hospitals, DMHMRSAS facilities, VA facilities, or regional treatment/detox programs is the CSB serving the city or county of the residential or mailing address prior to the current episode of hospitalization. In such cases, the default DIS CSB as derived from DIS CCC may <u>not</u> be correct and the correct code must be entered to change the field. • DIS CSB designation for individuals who are discharged out-of-state through the Interstate Transfer process is coded "Interstate Transfer".

APPENDIX G

Philosophy/Values of System of Care: Principles of Service Delivery (Mental Health Plan 1996)

ADULT SERVICE SYSTEM

Philosophy/Values of System of Care

As outlined in Virginia's previous Mental Health Plans, DMHMRSAS has articulated a philosophy to guide mental health service development in Virginia. This philosophy has been developed and refined each year through the Planning Council process, and is summarized in the following four value statements:

- The system of services must be consumer and family-oriented, emphasizing choice, involvement, and individualization for those needing services.

- The system of services must be community-centered, maximizing opportunities for recovery and integration into full community life, and providing services in the most natural, least restrictive environment.

- The system of services must be accessible, coordinated, and comprehensive; basic needs for housing, income supports, education, meaningful activity or employment, and social supports must be met in a manner compatible with the needs of diverse cultural and special need groups.

- The system of services must provide care and supports of the highest quality at the least cost to the taxpaying citizens of the Commonwealth.

Principles of Service Delivery

Using the mission and values previously stated as a foundation for service system development, mental health services and supports for adults with serious mental illness can be best be provided through a community support system based on the following principles of service delivery:

- Personal Dignity - Services are designed, implemented and delivered in ways which demonstrate respect for the dignity and value of the individual.

- Self-determination - Consumer needs and preferences are the basis for program funding, design, and evaluation.

- Indefinite duration - Services are available whenever, and for as long as, needed.

- Individualization - Services are individualized and adapted to the unique and changing needs and preferences of each consumer.

- Normalization - Services are provided in normal environments whenever possible, maximizing opportunities for recovery and full participation in the community.

- Least Restrictive Approach - Services are provided in the least restrictive manner and incorporate natural supports whenever available.

- Comprehensiveness - The service system provides equitable access for all Virginians to a comprehensive array of services, including housing and supportive services such as employment related services, as well as advocacy and assistance with income support needs.

- Coordination - Services maximize intra- and inter-agency relationships and resources to ensure an integrated, coordinated system of care. Consumers have access to extensive case management services which ensure service coordination and continuity and help "wrap services around" consumers who need them.

- Availability and Accessibility - Effective services are organized around people, not places, and outreach is used to help connect people with services.

- Non-discrimination - Services are responsive to the diverse characteristics of the wide range of people who have serious mental illness, respecting racial and cultural diversity and special needs.

- Protection and Advocacy - Prompt, responsive protection and advocacy services safeguard the rights of consumers and families while respecting the public safety concerns of citizens and communities in Virginia.

- Consumer and Family Involvement - Planning involves consumers and families at all levels, ranging from system, policy and evaluation issues to individual service planning and delivery.

- Accountability for Outcomes - The service system is accountable to the consumers and taxpayers of Virginia. Services are carefully monitored and evaluated to ensure positive consumer outcomes, quality of care, relevance to priorities, and efficiency in the use of resources.

- Quality of Care - Service planning and development is based on thorough needs assessment, systematic evaluation, and current research. The commitment to quality includes a focus on human resource development because well-trained professionals familiar with state-of-the-art service delivery approaches are essential.

CHILD AND ADOLESCENT SERVICE SYSTEM

Philosophy/Values

The system of care for children and adolescents with or at risk of developing serious emotional disturbances and their families should represent a philosophy about the way in which services are delivered for children, adolescents, and their families. The system of care should be guided by basic core values and guiding principles. It is critical that these values be clearly articulated so that they may be used to guide the character and quality of the system of care.

First, basic core values of the system of care must be that the system is child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided. This represents a commitment to adapt services to the child and family, rather than expecting children and families to conform to pre-existing service configurations. It also represents a commitment to providing services in an environment and in a manner that enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services.

Another basic core value of the system of care must be that the system is community-based, allowing for the least restrictive and most normal environment possible. While institutional care may be indicated for certain children at various points in time, in most cases appropriate services can be provided in other, less- restrictive settings within the home community.

In order to develop a child-centered, family-focused, and community-based system of care, funding must be sufficient to provide quality services to address the multiple and changing needs of this population. A solid financial base needs to be established within the Commonwealth so that energies may be placed in the areas of program development and service delivery.

Principles

In addition to the basic core values for the system of care, ten principles have been identified which need to govern the operation of the system of care for children, adolescents, and their families. They are as follows:

> Children and adolescents with or at risk of developing serious emotional disturbances and their families should have access to a comprehensive array of services that addresses the child's physical, emotional, social, and educational needs.

2. Children and adolescents with or at risk of developing serious emotional disturbances and their families should receive individualized services in accordance with the unique strengths and needs of each child and family and in accordance with an individualized service plan.

3 Children and adolescents with or at risk of developing serious emotional disturbances and their families should receive services within the least restrictive and most normal environment that is clinically appropriate.

4. The families and surrogate families of children and adolescents with or at risk of developing serious emotional disturbances should be full partners in all aspects of the planning and delivery of services.

5 Children and adolescents with or at risk of developing serious emotional disturbances and their families should receive services that are integrated with both financial and programmatic linkages between child-serving agencies including mechanisms for planning, developing and coordinating services.

6. Children and adolescents with or at risk of developing serious emotional disturbances and their families should be provided with case management to ensure that multiple services are delivered in a coordinated and therapeutic manner and to ensure that they can move through the system of services in accordance with their changing strengths and needs.

7. Early identification and intervention for children at risk of developing serious emotional disturbances and their families should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Adolescents with serious emotional disturbances and their families should be ensured smooth transitions to the adult service system as the adolescents reach maturity.

9. The rights of children and adolescents with or at risk of developing serious emotional disturbances and their families should be protected, and effective advocacy efforts for this population should be promoted.

10. Children and adolescents with or at risk of developing serious emotional disturbances and their families should receive services without regard to race, religion, national origin, sex, physical disability, sexual orientation, and other characteristics and preferences; and these services should be sensitive and responsive to cultural differences and special needs.

APPENDIX H

Forms Related to Continuity of Care

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

WARRANT
Sections 37.1-76, 37.1-126, 16.1-246 Code of Virginia

_____
Facility

_____ Virginia _____ 19 ____

COMMONWEALTH OF VIRGINIA

County/City of _____ to wit:

To Sheriff/Police Department of
City or County of _____

WHEREAS, _____ Reg. No. _____
Name of Patient/Resident SSN _____

formerly confined in the _____
Name of Facility Address

Virginia, did escape from said facility on _____ 19 ___ or was released on temporary pass or convalescent leave and said pass or convalescent leave was revoked by the Director on _____ 19 ____

These are, therefore, in the name of the Commonwealth of Virginia, to command you forthwith to apprehend the body of the said _____ and deliver him/her into the custody of _____
Name of Patient/Resident

at _____ Signed: _____
Physician

Signed: _____
Director or Designee

PATIENT/RESIDENT DESCRIPTION:

Race ____ Sex ____ Age/DOB _____ Height Weight ____Hair Eyes

Special physical features/Identifying Marks: _____

Date, Time, Place Last Seen: _____

Patient Last Seen Wearing: _____

Special Behaviors/Risk Factors (check if known):

Suicidal Homicidal __ Vulnerable __ Dangerous Medical Complications: _____

Assistive Devices, i.e., eye glasses, hearing aid, cane, etc. _____

Last Known Address: _____ Present Location: _____

Tel #

State Police Notified: Does Patient Speak English?

Warrant No: _____ Yes ___ No

Warrant Called In At: To: _____ Picked Up At: By: _____

PREADMISSION SCREENING FORM

The Preadmission Screening form is to be completed by qualified professionals designated by the Community Services Board for individuals who have been found to meet criteria for voluntary or involuntary admission to a state psychiatric hospital. Please refer to the **Guidelines for Mental Health and Substance Abuse Preadmission Screening and Discharge Planning.** Also attach the Geriatric Prescreening Supplement or the Child and Youth Prescreening Supplement when indicated.

I. Personal Data

Name _____ Age _____ DOB _____

Address _____
Street City or County Zip

Sex _____ Marital Status _____

Social Security No. _____

Occupation/Employer _____ Monthly Income _____

SSI or SSDI $ _____ Payee _____

Hospitalization Insurance Co. _____

Veteran _____ Yes _____ No

Medicaid Benefits _____ Yes _____ No _____ Unknown

Medicare Benefits _____ Yes _____ No _____ Unknown

In Case of Emergency, Notify _____
Name

_____
Street City or County State Zip

Phone (___) _____ Relationship to Client _____

Case Management CSB _____ PRAIS CASEMGT CSB Code ☐ ☐ ☐ ☐

Case Management CSB Contact _____

II. Clinical Assessment: Identify behaviors or symptoms indicating mental illness and elaborate in the space provided

___ paranoia	___ grandiose	___ bizarre behavior	___ sleep disturbance	___ suicidal ideation
___ delusions	___ poor self care	___ loose associations	___ withdrawn	___ flight of ideas
___ disoriented	___ hallucinations	___ impaired judgement	___ depressed	___ pressured speech
___ agitated	___ impaired impulse control	___ appetite disturbance	___ anxiety	___ homicidal ideation

_____

_____

_____

_____

Precipitating events and/or stressors

_____

_____

_____

_____

Drugs or controlled substances which are abused by the client and pattern of abuse

_____

_____

_____

_____

Documentation of Need for Voluntary Hospitalization: Check appropriate criteria for voluntary or involuntary hospitalization and describe specific behaviors which document this conclusion in the space provided.

____ A By reason of mental illness or substance abuse, the client is dangerous to self or others

____ B By reason of mental illness or substance abuse, the client is unable to care for self (i.e., unable or refuses to accept interventions which would meet minimum needs for food, clothing, shelter)

____ C By reason of mental illness, the client is suffering or is likely to suffer substantial deterioration in ability to function if not treated immediately

____ D The Community Services Board is unable to provide treatment, continuous supervision, monitoring, or protection in a community-based treat modality

_____

_____

_____

RECOMMENDATIONS

The client is in need of hospitalization and is either unwilling to accept voluntary inpatient treatment or is incapable of making an informed decision regarding such treatment

B The client is in need of hospitalization and is willing to accept voluntary inpatient treatment and is capable of making an informed decision regarding such treatment

C The client does not meet criteria for hospitalization and/or commitment and will be encouraged to participate in community-based services. Services to be offered would include:

_____

_____

_____

_____

IV. Legal Data

Are there criminal charges pending against individual? ___ Yes ___ No ___ Unknown

Nature of charges. _____

Date of hearing if known. _____ Location _____

Is individual serving a sentence? ___ Yes No Unknown

Subject to a court order? ___ Yes ___ No

Name of committee or guardian if known _____
Name

_____
Address Phone

V. Current or Previous Treatment History

Identify current service providers (i.e. CSB, CSB contractual agency, private provider, etc.) and services and/or treatment being provided:

Service Provider	Services/Treatment Provided
1. _____	_____
2. _____	_____
3. _____	_____

Diagnosis (DSM III) if known or provisional diagnosis

Axis I _____

Axis II _____

Medical problems _____

_____

_____

Current prescribed medications (include dosage, schedule, etc.)

_____

_____

Known allergies or adverse side-effects to medications _____

_____

Has client complied with recommended treatment plans? Yes No

If no, describe nature of non-compliance _____

_____

Previous inpatient treatment (facilities, length of hospitalization) _____

_____

_____

VI. Treatment and Discharge Planning

Individuals who can assist in treatment and discharge planning (i.e. family, case manager, therapist, family physician, etc.) .

Name	Phone #	Relationship to Client
3.		

Inpatient treatment recommendations and goals _____

_____

_____

_____ _____

Anticipated length of hospitalization _____

Current living situation _____

Recommended living situation on discharge

_____

_____

Services to be considered in planning for discharge

_____ medication management
_____ psychosocial/day treatment
_____ case management
_____ psychotherapy (individual, family, group)
_____ substance abuse services
_____ mental retardation services
_____ housing/residential services
_____ financial support/entitlements
_____ adult or child protective services
_____ medical/dental/nutritional services
_____ legal assistance/advocacy
_____ transportation
_____ vocational/educational training
_____ employment services
_____ recreational/social opportunities
_____ nursing home care

_____ Other: _____

_____

Identify persons who provided information for this assessment and their relationship to the client

_____

_____

_____

Client's primary therapist or case manager: _____

_____ Signature of Prescreener

_____ Prescreening Agency or Board

_____ Print Name Here

_____ Date

_____ Signature of Physician (if a physician is available and the client is under 21 and Medicaid eligible)

_____ Facility or Agency/Board

_____ Print Name Here

_____ Date

. hereby authorize _____ and _____
Community Services Board(s) State Facility(s)

to exchange information to be used in treatment and discharge planning to meet my needs as identified during the course of my hospitalization and follow-up referral. This information will include, but not be limited to, my participation in aftercare programs, my work experience, my family relationships, my treatment history, and an assessment of my overall general health. The release of such information may be verbal, written, or copies of portions of my records.

_____ _____
Signature of Client or his/her Guardian Date

_____ _____
Signature of Witness Date

Check the following if applicable

_____ The client or authorized representative refuses to give consent for the exchange of information described above.

_____ The client is unable to give informed consent for the exchange of information described above.

_____ The judge will be requested to order the exchange of information described above.

_____ The client or authorized representative has been informed that information can be exchanged under court order or Section 37.1-98.2

DMH Form 1006-B 11/87
Approved by the Attorney General

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES
APPLICATION FOR VOLUNTARY ADMISSION TO A STATE HOSPITAL OR OTHER FACILITY IN VIRGINIA
PURSUANT TO SECTION 37.1-67.2, CODE OF VIRGINIA (1950), as AMENDED

TO: The Director _____
(Insert name of Hospital or other Facility)

At _____

I, _____, hereby apply for admission as a
(Name of applicant)

voluntary patient for care and treatment as _____
(Indicate whichever is applicable. Mentally Ill, Mentaly Retarded, Alcoholic or Drug Addict)
and I agree to hospitalization and treatment in the aforementioned facility for 72 hours, unless sooner discharged by the director. Furthermore, I agree to give the facility 48 hours notice of my desire to leave and to remain in the facility during this notice period unless sooner discharged by the director.

Signed _____
Patient

Co-Signed _____
Parent or Guardian, if patient is a minor

The applicant appeared before me this _____ day of _____, 19 _____ and, as required by law, has agreed to accept voluntary admission and treatment at the aforementioned facility under the above terms and conditions.

_____
Judge or Special Justice

(Type or Print)

Name _____

Title _____

Address _____

PATIENT'S ADMISSION INFORMATION

DATE _____ ADDRESS _____
Street, Route No.

_____ City or County _____ Post Office _____ State _____ Zip Code

Race _____ Birth Date _____ Sex _____

I, the Director or authorized admitting physician, certify that the provisions regarding the rights of a voluntary patient have been explained and the above named applicant is accepted as a voluntary patient.

Signed _____
Director or Admitting Physician

Date Admitted _____ 19____ Hour _____ a.m./p.m.

Register Number _____

Commonwealth of Virginia

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

PROCEEDINGS FOR CERTIFICATION FOR INVOLUNTARY
ADMISSION TO A PUBLIC or PRIVATE LICENSED
MENTAL HEALTH FACILITY

PURSUANT TO §§ 37.1 - 67.1 through 37.1 - 67.3, Code of Virginia (1950), as amended.

City
County of _____

To wit:

PETITION

General District Court City

To the Judge or Special Justice of the Juvenile and Domestic Relations District Court of the County

of _____

In the matter of _____
Given Name Middle Name(s) Surname

Soc. Security No. _____ Birth Date _____ Sex Permanent Address _____
St. & Number or Route No

_____ _____ _____
City or Post Office State Zip Code

Legal Resident* of _____ County _____ City

a person alleged to be _____
(indicate whichever applies: Mentally Ill, Alcoholic, Drug Addict)

who is now in the care of _____
Name Address Relationship

The undersigned petitioner alleges that the above person is mentally ill and in need of hospitalization. In support of the allegation, the petitioner, _____ submits the following facts:

☐ Prescreening evaluation has been made and the report recommending hospitalization is attached.

Wherefore, your petitioner prays that the said _____ be examined and accorded such assistance provided by law.

Date _____ 19____ SIGNED _____

Relation to person _____ Address _____

Phone number _____ If public officer, give title _____

The foregoing petitioner, being duly sworn, deposes and says that the statements set forth above are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me on this _____ day of _____, 19 ____.

_____
Judge, Special Justice, or Notary Public

_____
Print Name Phone Number

Commission expires on _____, 19____ Title _____

*§ 37.1-1 (12) "Legal Resident" of Virginia means any person who is a bona fide resident of the Commonwealth of Virginia.

PRINT or TYPE ALL INFORMATION EXCEPT WHERE SIGNATURES ARE REQUIRED.

PREPARE AND SEND TO THE STATE HOSPITAL OR OTHER FACILITY TO WHICH PATIENT IS ADMITTED.

GENERAL INFORMATION

Place of Birth _____

Marital status: Single _____ Married _____ Widowed _____ Divorced _____

Separated _____ Unknown _____

Race _____

Religion: Protestant _____ Catholic _____ Jewish _____ Other _____ Unknown _____

Occupation _____

Nearest Relative or Correspondent _____
Name Address Telephone No. Relationship

PHYSICIAN'S EXAMINATION

Mental Information:

State briefly mental symptoms of patient: _____

_____

_____

_____

When first observed _____ How rapid development _____

Has patient attempted suicide: Yes _____ No _____ If yes—explain _____

_____

Has patient attempted homicide: Yes _____ No _____ If yes—explain _____

_____

If mentally retarded, state intellectual level, if available _____

Has patient had previous psychiatric care? Yes _____ No _____ Unknown _____

If yes — name hospital, clinic or private psychiatrist

_____
Name Address

_____
Name Address

_____
Name Address

Alcoholic habits (state briefly, if known) _____

Drug habits (state briefly, if known) _____

Physical Information:

State briefly any present or recent physical disease, illness or injury _____

_____

_____

Is patient on medication? Yes No _____ If yes—what _____

_____

_____

_____

A. **COMMONWEALTH OF VIRGINIA**

City
County of _____

I, the undersigned physician, do certify that I have this day personally examined the person named in the foregoing petition and as the result of such examination have sufficient cause to believe that he (is/is not) mentally ill; that he (does/does not) present an imminent danger to (himself/others), or (is/is not) substantially unable to care for himself, as a result of mental illness; and that he (does/does not) required involuntary hospitalization. Further, I am not related by blood or marriage to the individual on whom the petition is filed and have no interest in his estate.

Given under my hand this _____ day of _____

19_____ _____ _____

Address Doctor of Medicine (type/print)

_____

Signature

NOTE:
This certification of examination shall not be accepted or used as evidence at any hearing under § 37.1-67.3 of the Code of Virginia (1950), as amended, UNLESS such examination be made within the five (5) days immediately preceding such hearing and provided there is no objection to the acceptance of same by the person or his attorney.
The positive certification of at least one physician is necessary to commit the person named in the petition.

B. I certify that upon the appearance before me of the person named in the petition, on this _____ day of _____ 19_____, I informed him of his right to make application for voluntary admission and treatment as provided for in §37.1-65, his right to a full and impartial hearing in the event that he should refuse to make application for voluntary admission, his right to representation by counsel, the basis for his detention, the standard upon which he may be detained, his right to appeal such hearing to the circuit court, and his right to a jury on appeal. I then ascertained if he was represented by counsel.

(Check One)
- ☐ A voluntary admission requested (complete DMH Form 1006-B)
- ☐ A hearing requested
- ☐ A hearing required due to incapacity to consent to voluntary admission and treatment

(Check One)
- ☐ Represented by counsel of own choosing
- ☐ Counsel appointed

_____

Judge or Special Justice

Title _____

C. I certify that I, an attorney-at-law, served as counsel for the person named in the foregoing petition, that I interviewed such person and all witnesses, if any, in his behalf, prior to any hearing, and that after my employment or appointment as counsel, I did represent the person named in the foregoing petition at all proceedings conducted by the judge or special justice pursuant to the foregoing petition.

_____

Counsel

_____

Address

Subscribed and sworn to before me this _____ day of _____, 19 _____

_____

Judge or Special Justice

Title _____

D. (Execute only if hearing requested.)
I hereby certify that the person named in the foregoing or the attorney-at-law representing such person requested a hearing on the question of his admission. Such hearing was held on this _____ day of _____ 19_____ and the following witnesses were summoned:

Name	Address	Relationship

_____

Judge or Special Justice

Title _____

CERTIFICATION AND ORDER FOR INVOLUNTARY ADMISSION TO A PUBLIC OR LICENSED PRIVATE FACILITY

COMMONWEALTH OF VIRGINIA

City
County of _____

To the sheriff or other authorized officer of said county or city and to the director of

_____
Facility Address

Greetings:
WHEREAS, _____ Judge or Special Justice of _____

court of the said county or city have observed the person named in the foregoing petition, alleged to be in need of care and treatment in a hospital, and have reviewed the medical certifications and statement of facts upon which such certifications are based and have this day found that the person named in the foregoing petition:

- ☐ 1. Presents an imminent danger to himself as a result of mental illness.
- ☐ 2. Presents an imminent danger to others as a result of mental illness.
- ☐ 3. Has otherwise been proved to be so seriously mentally ill as to be substantially unable to care for himself.

Furthermore: (check one and complete)

☐ A. The alternatives to involuntary hospitalization and treatment were investigated and were deemed suitable. I have found that there is a less restrictive alternative to involuntary hospitalization and treatment in this case. I, therefore, direct that the person named in the foregoing petition receive treatment in accord with the following order:

_____

_____

_____

☐ B. The alternatives to involuntary hospitalization and treatment were investigated and were deemed unsuitable. I have found that there is no less restrictive alternative to involuntary hospitalization and treatment in this case.

I, therefore, command you, the said sheriff, other authorized officer or responsible person, to make provision for the suitable and proper care of the person named in the foregoing petition and to deliver such person to the director of _____

_____

_____ for involuntary hospitalization and treatment not to
Address

exceed 180 days from this date. Furthermore, if admission is denied pursuant to §§37.1-68 or 37.1-70, you are hereby authorized to return the person named in the foregoing petition to this jurisdiction.

Given under my hand and and seal this _____ day of _____ 19_____

_____
Judge or Special Justice

Name _____

Title _____

Type or Print

Address _____

DISCHARGE PLAN AND REFERRAL SUMMARY

(To be Completed at Time of Discharge)

Patient's Full Name _____ Hospital No. _____
SSN _____ Age _____ Insurance/VA Benefits _____
Date of Admission _____ Admitting CSB _____
Date of Discharge _____ Discharge CSB _____
Name and Address of Correspondent _____
_____
_____ Phone _____

• • • • • •

Patient's Discharge Address _____
_____
_____ Phone _____
Type of Placement/Facility _____
Residential Placement Code (Refer to ARS Residential Placement Codes) _____

• • • • • •

Referral to CSB Mental Health Services? _____ Yes _____ No If No, Why? _____
_____
CMHC and Address _____
_____
_____ Phone _____
Date and Time of Appointment _____
Appointment With (Name of CMHC Personnel) _____
Appointment Confirmed by (Name of Hospital Personnel) _____ Date _____
Other Scheduled Referrals (Include Agency, Date, Time, Name of Personnel)
_____
_____
Other Recommendations/Information _____
_____
_____
Signed Authorization(s) to Release Information: _____ Yes _____ No

• • • • • •

Discharge Diagnosis: Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____
Condition: _____ Recovered _____ Not Recovered, Improved
_____ Unimproved _____ Not Mentally Ill
Medication at Discharge (Types and Regimen) _____
_____
_____
Supply Given: _____ Days Pharmacy Card Mailed (Date) _____
Special Instruction/Other Recommendations/Information _____
_____
_____
_____
_____

_____ Date _____
M.D. Signature

COMMUNITY SERVICE AND SUPPORT NEEDS

(To Be Completed at Time of Discharge)

Patient's Full Name _____ Hospital No. _____
Date of Discharge _____ Discharge CSB _____
Name and Address of CSB Case Manager _____
_____
_____ Phone _____

• • • • • •

In the designated spaces in the columns below, please indicate those community services and supports which are (a) needed by the patient upon discharge, and (b) available to the patient in the community, if needed. Also indicate (c) whether the patient at discharge is willing to use the services needed and (d) whether the patient, if willing, also has the means and/or capability to access and utilize the services needed. Lastly, indicate (e) if a referral or application has been initiated for the service needed.

Please enter "1" if yes and "2" if no, in the corresponding spaces as appropriate.

Services	Patient Needs at Discharge				
	(a) Needs	(b) Available	(c) Willing To Use	(d) Capable Of Using	(e) Referral Initiated
CSB Core Services					
Emergency/Crisis Intervention	___	___	___	___	
Inpatient Mental Health Care	___	___	___	___	
Outpatient Services					
Counseling/Psychotherapy	___	___		___	
Case Management	___	___		___	
Medication	___	___		___	
Day Support Services					
Day Treatment/Partial Hosp.	___	___	___	___	___
Psychosocial Rehabilitation	___	___	___	___	___
Other: _____	___	___	___		
Residential Services					
Type: _____					
Other CSB Services					
Mental Retardation Services	___	___	___	___	
Substance Abuse Services	___	___	___	___	
Non-CSB Services					
Financial/Soc. Services Entitlements					
SSI/SSDI	___	___	___		
Auxiliary Grant	___	___	___		___
Food Stamps	___	___	___		___
Medicaid/Medicare	___	___	___	___	___
Other: _____	___	___	___	___	___
Medical	___	___	___	___	___
Dental	___	___	___	___	___
Other Residential					
Type: _____					
Vocational/Education					
Type: _____					
Nutritional					
Type: _____	___	___	___	___	
Transportation	___	___	___	___	
Legal/Advocacy	___	___	___	___	

COMMUNITY SERVICE AND SUPPORT NEEDS (Continued)

Patient's Full Name _____ Hospital No. _____

Discharge Plan: In the space below, describe the community service and support plans which have been initiated and/or completed to meet the patient's identified needs as shown on Part 2, Page 1. Indicate responsible providers, dates, etc., for all planned services and supports, and status of plans in process. Describe plans/strategies where appropriate to facilitate service delivery to patients where patient is unwilling or unable to access services.

_____ Date _____
Signature/Authorization for Facility

_____ Date _____
Signature/Authorization for CSB

• • • • • •

I, the undersigned, have reviewed and understand the arrangements and recommendations described in Parts 1 and 2 of this document. I also understand that this document will be transmitted to the CSB serving the locality to which I am being discharged.

_____ Date _____
Signature/Authorization of Patient

APPENDIX I

Patient Self-Determination Act: Departmental Instruction No. 120

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

KING E. DAVIS PH.D., LCSW
COMMISSIONER

MAILING ADDRESS
P.O. BOX 1797
RICHMOND VA 232[illegible]
TEL (804) 786-[illegible]

TO: Hospital and Training Center Directors
Commissioner's Staff
Assistant Commissioner's Staff

FROM: King E. Davis, Ph.D. KED
Commissioner

SUBJECT: Departmental Instruction No. 120
PATIENT SELF-DETERMINATION ACT

DATE: November 18, 1991

Attached is the final version of Departmental Instruction No. 120, **PATIENT SELF-DETERMINATION ACT** for implementation December 1, 1991. This incorporates your comments and recommendations and has been reviewed by the Office of the Attorney General.

This instruction provides guidance for implementation of the requirements of the Omnibus Reconciliation Act of 1990 (OBRA '90) to ensure that patients or residents of our facilities are informed of their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute a living will or durable health care power of attorney.

The Office of the Attorney General is available to provide interpretation and guidance for this departmental instruction.

KED/RG/ys

Attachment

cc: Jane Hickey
Julie Stanley
Aubrey Lucas
Sandra Blacker

VOICE
FAX

DEPARTMENTAL INSTRUCTION NO. 120
SUBJECT: PATIENT SELF-DETERMINATION ACT

1 Purpose:
To comply with the requirements of the Omnibus Reconciliation Act of 1990 (OBRA '90) to ensure that patients or residents of facilities are informed of their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute a living will or durable health care power of attorney.

2 Background:
The Patient Self-Determination Act, incorporated into the Omnibus Reconciliation Act of 1990, addresses the concern of many people that their wishes regarding medical treatment and health care decisions, especially at the end of their life, be followed. OBRA '90 encourages communication among patients, families, physicians, and professional care givers on the issues of "advance directives" and requires that all adult individuals receive written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute a living will or durable health care power of attorney.

3. Policy:

A All adult patients or residents will receive written information about their right to accept or refuse treatment as contained in the Rules and Regulations to Assure the Rights of Residents at facilities operated by the Department (the Human Rights Regulations), as well as their right to execute a living will under the Natural Death Act of Virginia and a durable health care power of attorney under the Code of Virginia, § 37.1-134.4.

B. This information will be provided to all adults upon admission or as soon as clinically appropriate. If the patient or resident is incapacitated or is otherwise unable to receive the information, the facility will document this fact in the medical record. Should the patient or resident become no longer incapacitated, such information will be provided to the patient or resident at that time. Information concerning living wills and durable health care powers of attorney will be provided to an incapacitated patient's or resident's authorized representative when they are appointed and in the same manner as the authorized representative is advised of rights provided under the Human Rights Regulations.

C. Each adult patient or resident will be asked whether he or she has executed a living will and/or durable health care power of attórney. The patient's or resident's response will be documented in the medical record. If the patient or resident is unable to communicate whether such a document has been executed, that fact will be recorded in the medical record. This information may be obtained through the routine medical or social history prepared during the admission process.

D. No patient or resident shall be discriminated against based on whether he or she has executed a living will or durable health care power of attorney.

E. Each facility director will ensure that the provisions of any duly executed living will or durable health care power of attorney is followed. Should any questions arise concerning the validity or provisions of any such document, the facility shall consult with the Office of the Attorney General.

F Each facility director shall provide for education of staff and the community.

4. Authority and References:

A. Omnibus Reconciliation Act of 1990, Sections 4206 and 4751

B. *The Code of Virginia, § 37.1-84.1*

C. *The Code of Virginia, § 37.1-134.4*

D. *The Code of Virginia, § 54.1-2981 et seq. Natural Death Act of Virginia*

E. Rules and Regulations to Assure the Rights of Residents of Facilities Operated by the Department

F. DMAS Regulations on Advance Directives

G. "Your Right to Decide," a pamphlet prepared by the Virginia Hospital Association

H. **Virginia's Living Will Declaration**, Virginia Department for the Aging, May 1991 - attached

5. Definitions:

A. "Durable health care power of attorney" is an advance directive or health care proxy given by one individual to another that grants the named individual the right to make treatment decisions for the person when they are not capable of making their own decisions.

B. "Incapable of making an informed decision" means unable to understand the nature, extent or probable consequences of a proposed treatment, or unable to make a rational evaluation of the risks and benefits of alternatives to that treatment.

C. "A Living Will" is a document that directs the care for a person who is in a terminal condition and who is unable to make their own decisions.

6. Procedures:

A. Each facility director shall assure that each patient or resident is provided with written information about their right to accept or refuse treatment as provided in the Rules and Regulations to Assure the Rights of Residents.

B. Each facility director shall assure that all adult patients or residents are provided with written information concerning their rights to execute a living will under the Natural Death Act of Virginia and a durable health care power of attorney under the Code of Virginia, § 37.1-134.4. upon admission or as soon as clinically appropriate. This may be accomplished by providing the patient or resident with the pamphlet "Your Right to Decide."

C. If the patient or resident is not capable of receiving such information, the information will be provided to the patient's or resident's authorized representative in the same manner as is provided in the Human Rights Regulations for advising families and authorized representatives of their rights under the Code of Virginia, § 37.1-84.1 and the Regulations.

D. All adult patients or residents will be asked whether they have executed a living will or a durable health care power of attorney during the admission process or as soon as clinically appropriate. If the patient or resident is unable to respond, that fact will be documented in the medical record.

E. If the patient or resident has a living will or a durable health care power of attorney, the patient's or resident's response will be documented in the patient's or resident's record. The facility will request to see the living will and/or power of attorney, make photocopies, and return the original to the patient or resident or the authorized representative. If the living will or durable power of attorney is not available upon request, the facility will ask that the documents be sent to the facility or will make a reasonable effort to obtain a copy of the documents on the patient's or resident's behalf. Once received, copies of documents will be placed in the patient's or resident's medical record.

F If patient or resident indicated that he or she would like to execute a living will or power of attorney, and the treatment team determines that the patient or resident is capable of making such a decision, the patient or resident will be referred to the advocate for additional information and assistance. The advocate may provide the patient or resident with the attached living will as provided in the Code of Virginia, § 54.1-2984 and assist the patient or resident in executing the document. If the patient or resident would like to alter the suggested form or execute a durable health care power of attorney, the advocate should refer the patient or resident to a private attorney or legal aid society. (Note: Under Virginia law, only a competent adult may execute a living will or power of attorney.) If the facility director is the authorized representative, the facility director may not make any decisions authorizing termination of life prolonging measures under these circumstances without consultation with the Attorney General's Office.

G. If a conflict or disagreement develops between the patient or resident and family members, or if questions arise concerning the validity or any provisions of any document, the facility should consult the Office of the Attorney General concerning further steps that should be taken.

H. When a patient or resident transfers within the Department's system or to other public or private facilities, a copy of the living will and/or durable health care power of attorney shall accompany the patient or resident.

The facility director shall assure that information regarding living wills and durable health care powers of attorney shall be provided to patients or residents admitted prior to December 1, 1991 or to their authorized representatives.

J. Each facility will develop policies and procedures to ensure implementation of the Departmental Instruction, including development of staff and community education programs.

7. Interpretation:
Interpretation and guidance for this Departmental Instruction are available from the Office of the Attorney General.

King E. Davis, Ph.D.
Commissioner

EFFECTIVE DATE: December 1, 1991

VIRGINIA'S LIVING WILL DECLARATION

Declaration made this day of _____ 9

_____ willfully and voluntarily make known my desire and do hereby declare:

CHOOSE ONLY ONE OF THE NEXT TWO PARAGRAPHS AND CROSS THROUGH THE OTHER

If at any time I should have a terminal condition and I am comatose, incompetent or otherwise mentally or physically incapable of communication, I designate (insert person's name here) _____ to make a decision on my behalf as to whether life-prolonging procedures shall be withheld or withdrawn. In the event that my designee decides that such procedures should be withheld or withdrawn, I wish to be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. (OPTION - I specifically direct that the following procedures or treatments be provided to me: _____

_____

OR

If at any time I should have a terminal condition where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. (OPTION - I specifically direct that the following procedures or treatments be provided to me: _____

_____

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

(Signed) _____

The declarant is known to me and I believe him or her to be of sound mind.

Witness _____ Witness _____

Prepare copies as follows (check).

Original copy *Physician's copy* *Attorney's copy* *Famil*

For more information on living wills call the Virginia Department for the Aging toll free 1-800-552-4464 (voice/TDD)

Courtesy of the Virginia Department for the Aging

APPENDIX J

Medical Screening:
Departmental Instruction No. 131

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

TIMOTHY A. KELLY, Ph. D.
COMMISSIONER

P. O. BOX 1797
RICHMOND, VA 23214
(804) 786-3921
(804) 371-8977 VOICE/TDD

MEMORANDUM

TO: CSB Executive Directors

FROM: Timothy A. Kelly TK

SUBJECT: Departmental Instruction 131,
Medical Screening of Individuals Referred for Admission to DMHMRSAS Hospitals and Training Centers

DATE: November 7, 1996

Attached, for your information, is a new Departmental Instruction, No. 131, *Medical Screening of Individuals Referred for Admission to DMHMRSAS Hospitals and Training Centers* which becomes effective November 15, 1996. This Instruction was developed to comply with recommendations of the Joint Legislative Audit and Review Commission that the Department establish a statewide policy and procedures that define the circumstances under which a medical screening is required and the medical screening procedures that must be used.

This Instruction was jointly developed by the DMHMRSAS Office of Mental Health and Substance Abuse Services and the Office of Medical Affairs with considerable input from the Office of Mental Retardation Services and DMHMRSAS hospital and training center Medical Directors. It has undergone two field reviews, both of which included community services boards, and two reviews by the Office of the Attorney General.

Departmental Instructions are DMHMRSAS internal operating policies and procedures and compliance with Instructions is mandatory for Departmental staff. This Instruction differs from other Departmental Instructions in that it is written to define required procedures for facility staff and it also is intended to provide guidance to community services board pre-screeners.

Every effort was made to address the issues and concerns of both facility and community personnel responsible for screening individuals who seek admission to DMHMRSAS hospitals and training centers. Clearly, there are many issues, such as the lack of health care resources for uninsured persons, that this Instruction cannot address. Our objective in writing this Instruction was to clarify, to the extent possible, the roles, responsibilities, and procedures related to medical screening to ensure the safety and well being of those individuals presenting for admission to state hospitals and training centers.

If you have any questions about this Instruction, please contact Harold Carmel, M.D., Director of the Office of Medical Affairs.

Attachment

cc: Jane D. Hickey
James Bumpas
Harold Carmel, M.D.
Karen Mann
Charline Davidson

Departmental Instruction No. 131

Medical Screening of Individuals Referred for Admission to DMHMRSAS Hospitals and Training Centers

131 - 1 Background

- Persons with serious psychiatric disease and/or severe mental retardation often have coexisting non-psychiatric medical/surgical disorders that:
  - complicate the symptomatic presentation of the individual,
  - represent severe disease requiring urgent treatment, or
  - account for the symptoms leading to the referral for admission to a state-operated hospital or training center.

- DMHMRSAS hospitals and training centers vary in the on-site medical/surgical resources available. CSBs possess varying capacities to obtain a local emergency medical evaluation.

- Good medical practice calls for the screening and possible assessment of an individual to identify whether any such non-psychiatric medical/surgical disorders exist before a decision is made regarding admission of an individual to a state-operated hospital or training center.

- CSB pre-screeners are not physicians and are not equipped by training, experience, or license to make medical judgements or treatment decisions.

- In 1995, the Joint Legislative Audit and Review Commission, in its report "Review of the Involuntary Commitment Process," recommended that the DMHMRSAS define the circumstances under which a medical screening is required and the medical screening procedures that must be used.

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131 - 2 Purpose

It is the purpose of this Instruction to define the process by which a CSB seeking to admit an individual to a DMHMRSAS hospital or training center and the hospital or training center to which admission is being sought collaborate to ensure that consideration of the safety and well-being of the individual is the foundation for all admission decisions.

Continued on next page

131 - 3 Definitions

The following definitions shall apply to this Instruction:

Medical assessment	A medical assessment is an assessment of an individual's non-psychiatric medical/surgical condition that is performed by a licensed physician.
Medical screening	The collection of information about the non-psychiatric medical/surgical condition of an individual to determine whether there is a need for a medical assessment before a decision is made regarding admission to a DMHMRSAS hospital or training center.
COBRA/ EMTALA	The Comprehensive Omnibus Budget Reconciliation Act (COBRA) of 1986 (as revised) and the Emergency Medical Treatment and Active Labor Act (EMTALA) establish requirements governing the transfer of patients from hospitals that have emergency departments and are certified for Medicaid or Medicare reimbursement.
Physician designee	The physician to whom the Medical Director has delegated the authority to admit patients to psychiatric hospitals and training centers.

131 - 4 Responsible Authority

Division of community & facility services	The Associate Commissioner for the Division of Community & Facility Services is responsible for ensuring the compliance of state facilities with the provisions of this Instruction.

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Office of Medical Affairs The Director of the DMHMRSAS Office of Medical Affairs is responsible for the interpretation and ongoing monitoring of the efficacy of this Instruction.

Medical Director The hospital or training center Medical Director or designee is responsible for collaborating with the CSB to ensure that an individual referred for admission is promptly screened and admitted. If the individual is not admitted, the Medical Director or physician designee will advise the CSB prescreener on other treatment alternatives.

131 - 5 Specific Guidance

- DMHMRSAS hospitals or training centers should admit individuals with diseases or disabilities that can be managed within the medical resources of the hospital or training center.

- DMHMRSAS hospitals or training centers should not admit any individual whose non-psychiatric medical/surgical condition exceeds the reasonable capacity of the hospital or training center to provide needed medical care.

- Further, DMHMRSAS hospitals or training centers should not admit any individual whose need for emergency treatment in a medical/surgical hospital outweighs the need for admission to a psychiatric hospital or training center.

- The decision to admit an individual to a DMHMRSAS hospital or training center will be based on factors including:
  - the individual's need for the services available at the hospital or training center;
  - the individual's current status (medical/surgical, mental status, behavioral disability);
  - the expected clinical course;
  - the level of medical/surgical need; and
  - the capacity of the DMHMRSAS hospital or training center to meet that medical/surgical need.

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131 - 6 Procedures

The following procedures are to be used for Medical Screening of Individuals for Admission to DMHMRSAS Hospitals and Training Centers:

Collection of information by CSB pre-screeners

- CSB pre-screeners should attempt to gather medical information about a prospective admission to a DMHMRSAS hospital or training center from readily available sources which **may include** the individual and:
  - ❒ family members
  - ❒ a CSB or private therapist
  - ❒ the CSB record
  - ❒ other care providers

- CSB pre-screeners should attempt to obtain information related to:
  - ❒ known medical diseases or other disabilities;
  - ❒ previous psychiatric and medical hospitalizations;
  - ❒ medications;
  - ❒ current use of alcohol and illicit drugs; and
  - ❒ observable physical symptoms that may suggest a medical problem.

- If the information collected raises questions about the non-psychiatric medical/surgical treatment needs of the individual for whom admission is being sought, the pre-screener should arrange for an assessment of the client's medical condition before proceeding with the admission.

Review of information by facility

- Hospital or training center personnel shall inquire about, and CSB pre-screeners are expected to provide, medical information when an individual is being considered for admission.

- The hospital or training center Medical Director or physician designee shall review with CSB pre-screeners the medical/surgical status of any individual being considered for admission when there is evidence of a medical problem.

- After reviewing the medical information with CSB pre-screeners, the hospital or training center Medical Director or physician designee may request a medical assessment of the individual being considered for admission before the individual is transported to the facility.

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Advice on alternate placement

When admission to a DMHMRSAS hospital or training center is denied or delayed due to a coexisting non-psychiatric medical/surgical disorder(s), the Medical Director or designee may provide advice to CSB pre-screeners in obtaining a proper assessment and placement of the individual in an appropriate medical setting.

Medical screening of forensic patients

Several types of forensic admissions referred to DMHMRSAS facilities pursuant to the Code of Virginia (1950) do not require preadmission screening by the community services board. These admissions include persons:

- ❒ in jail, convicted and awaiting sentencing;
- ❒ incompetent to stand trial; and
- ❒ involuntarily committed following a finding of Not Guilty by Reason of Insanity.

When a forensic patient who does not require pre-screening is admitted, facility admissions personnel will collaborate with the referral source and/or involved medical personnel to collect the medical information and assess the non-psychiatric medical/surgical condition of the forensic admission.

Transfers from a health care facility

When the referral source is a health care facility, the hospital or training center Medical Director or physician designee shall make appropriate inquiries of the referring facility, prior to approving admission. Inquiries may include:

- ❒ direct contact with the referring physician,
- ❒ review of specific clinical data, and
- ❒ other assessments of current medical/surgical status.

Medically inappropriate admissions

When an individual who would otherwise be considered inappropriate for admission is admitted involuntarily by a Judge or Special Justice to a DMHMRSAS hospital, such admission shall be reviewed using the appropriate hospital mechanism (e.g., utilization review committee). Facilities will document all such cases of medically inappropriate admissions.

continued on next page

Medically inappropriate admissions *(continued)*

When there is a pattern of referrals and admissions of individuals who would otherwise be considered inappropriate for admission, the matter will be referred to the DMHMRSAS Office of Medical Affairs for consultation and further action.

131 - 7 References

- COBRA/EMTALA: 42 U.S.C. §1395 dd.
- Code of Virginia § 37.1-65: Voluntary Admission; and § 37. -67.3: Involuntary Admission and Treatment.
- Code of Virginia §§ 19.2-169.6, 19.2-169.2, 19.2-182.3.
- State MHMRSAS Board Policy 1016(SYS)86-23: Policy Goal of the Commonwealth - Development of a Comprehensive Community-Based System for Serving Mentally Ill, Mentally Retarded and Substance Abusing Citizens

Timothy A. Kelly, Ph.D.
Commissioner

Attachment

Effective Date: November 15, 1996

APPENDIX K

Regional Crisis Stabilization Protocols

MENTAL RETARDATION PROTOCOL
WESTERN STATE HOSPITAL
CENTRAL VIRGINIA TRAINING CENTER
&
HPR I

The intent of the Mental Retardation (MR) Protocol is to assure that patients with Mental Retardation receive the services that they need. The Protocol may indicate the need for inpatient psychiatric hospitalization but it may also mean that the patient may require more extensive MR services, which most psychiatric hospitals do not provide. The goal of this protocol is to secure the best services for the patient, as well as to make the Mental Retardation and Mental Health service providers team together to provide these services.

In order for an MR client to be admitted to our facility, both the MR Case Manager and the MH Case Manager or Emergency Services must agree that the client requires hospitalization. The client must come on a Temporary Detention Order (TDO) within forty eight (48) hours of a TDO being issued. A hearing is held to determine if the client meets criteria for commitment for inpatient psychiatric care. The Case Manager or representative from the Community Services Board (CSB) must attend this Hearing.

From time of admission until the time of Hearing, a team staffing on the Acute Admissions ward is held to determine if the client requires hospitalization for mental illness. A call for consultation is made with Central Virginia Training Center (CVTC) and the CSB. If it is determined that the patient requires inpatient psychiatric services, the client must be committed in order to receive these services. If it is determined by the treatment team that the patient does not require inpatient treatment for mental illness, the CSB is expected to find appropriate placement for the patient the day of the hearing or as soon as possible thereafter. The CSB is given this information as soon as the treatment team meets in order to facilitate placement. If no placement is available and the patient meets the criteria for commitment, he/she will be committed for a short period, as appropriate, so that adequate placement can be found.

If the patient is committed, a community/hospital Prescription Team meeting must be held within ten working days to formulate and discuss an effective treatment/discharge plan. This meeting will include everyone involved with the client, WSH staff, CSB Case Managers, CVTC staff and other possible placement providers.

If CVTC is recommended and the patient is accepted for admission there, transfer will occur immediately. A Judicial Certification hearing may be held at WSH prior to transfer to CVTC or the patient may be admitted to CVTC as an emergency respite admission under (37.1-65.2), as appropriate.

THE MR/MI PROTOCOL SHALL INCLUDE A DIAGNOSTIC TEAM:

The Diagnostic Team is chaired by the MR Protocol Specialist and may include a Clinical Social Worker, Psychologist, Psychiatrist, Program Manager, Team Leader, Mental Health Worker and Nursing staff. This team will be available for consultation within the community on issues pertinent to the Dually Diagnosed MR/MI population. Specifically, issues dealing with Hospital admissions vs Training Center admissions. This team is also available for behavioral treatment planning and consultation in order to keep a client maintained within the community. This may also, and is preferred, in conjunction with CVTC staff. The MR Specialist is also available for Prescription Team meetings with the CSB regions to discuss clients that are not currently in need of inpatient services, but have behavioral and mental deficits.

In addition, the protocol is to be used to help facilitate discharge for patients that are ready to leave the hospital, but need more community involvement. The MR Specialist will attend Treatment Team Meetings and Judicial Hearings when appropriate to help facilitate this involvement and to be a representative for the facility in these proceedings.

THE PROTOCOL IN REVERSE:

The Protocol is also used to assist CVTC with patients that need psychiatric inpatient treatment. This occurs when a patient's mental illness is the primary factor stopping discharge to the community. The patient is assessed and interviewed at CVTC. The information is taken back to WSH and discussed with the Director of Admissions and the Medical Director. Once admission is approved the patient will be committed to WSH and placed on Special Hospitalization for CVTC. CVTC staff along with CSB staff will attend staffing as appropriate. If possible, the client can be discharged to the community from WSH or will return to CVTC once his or her psychiatric condition is stable.

Revised 10/15/95

PROTOCOL FOR PROVIDING EMERGENCY PSYCHIATRIC HELP TO CITIZENS WITH MENTAL RETARDATION APPROVED BY THE NORTHERN VIRGINIA ASSOCIATION OF COMMUNITY SERVICES BOARDS

December 15, 1995

I. Purpose of Protocol

The purpose of this protocol is to establish procedures for helping citizens with a primary diagnosis of mental retardation (referred to hereafter as consumers) who are a danger to themselves or others' or are unable to care for themselves due to a mental illness.

II. Covered persons and circumstances

This protocol applies to consumer residents of Arlington, Fairfax, Prince William or Loudoun Counties or the Cities of Alexandria, Fairfax, Falls Church, Manassas or Manassas Park who are exhibiting symptoms consistent with mental illness.

III. Emergency screening

A. The emergency service of the community services board (referred to hereafter as CSB) in the consumer's county or city shall be responsible for screening. Consumers shall receive emergency psychiatric screening in the same manner as all other citizens of the jurisdiction.

B. If the emergency service staff find that the consumer is a danger to him/herself or others or is unable to care for him/herself due to a mental illness the emergency service staff shall contact the mental retardation case manager or equivalent (e.g., on-call supervisor).

C. If the emergency service staff determines that the consumer needs psychiatric hospitalization, has not been adjudicated incompetent and consents to hospitalization, the emergency service staff arranges for hospitalization. If the consumer has been adjudicated incompetent and the consumer's guardian consents to hospitalization, the emergency service staff arranges for hospitalization.

D. If the emergency service staff determines that the consumer needs psychiatric hospitalization and does not consent, is not able to give consent or if the guardian will not or cannot give consent; the consumer with mental retardation shall be detained in accordance with the Code of the Commonwealth of Virginia.

E. If the emergency service staff determines that consumer does not need psychiatric hospitalization, the emergency service worker shall help the consumer and/or the consumer's care giver to obtain medication, advice and follow-up recommendations, as appropriate.

F. If the consumer is not detained and the consumer, the care giver and/or the mental retardation case manager do not agree with the disposition proposed by emergency service staff, the mental retardation case manager shall follow his/her CSB's procedures for resolving differences in clinical judgements.

The supervisors or the mental retardation director shall attempt to resolve the disagreement. If they are unable to do so, the disagreement shall be referred to the heads of the agencies which employ the disagreeing parties. If the consumer/guardian disagrees, the matter is appealed to the CSB director.

2. There shall be resolution of the disagreement within 10 days of the initial appeal. The consumer may remain in the hospital during the appeal process.

ADMISSION PROCEDURE FOR INDIVIDUALS WITH MENTAL ILLNESS/MENTAL RETARDATION IN CRISIS

HPR III

PRESCREENING

1 When an individual is in crisis in the community, the Prescreening process will include a consultation between the CSB mental health professional and the CSB mental retardation professional to discuss needed services and local options. If this consultation cannot occur, this will not preclude admission to Southwestern Virginia Mental Health Institute (SWVMHI).

2. If community services are not available then the prescreening process would include a consultation between Unit Director or designee from SWVMHI and the CSS prescreener to discuss the individual's current symptoms/behavior, treatment recommendations, least restrictive alternatives.

3 The prescreener and the SWVMHI person taking the call will consult to determine whether the patient needs MR Services. If so, then during normal business hours on the next working day following the admission, SWVMHI and SWVTC or CVTC and a CSS representative will confer and quickly resolve any questions as to which institution can best meet the individual's needs.

4. Once the appropriate facility has been agreed upon, the receiving facility will notify the prescreener of the referring CSB to finalize the admission.

5 The Unit Director of Admissions or designee will meet with the individual's assigned treatment team during the initial staffing of the individual in order to relate information provided through the consultation with the CSB staff. This will provide continuity of care by addressing treatment recommendations, special needs of the individual, discharge planning options, etc.

SWVMHI COMMITMENT HEARING / TREATMENT / DISCHARGE PLANNING

1 As soon as possible after admission to SWVMHI, the following parties will have a representative involved in a telephone conference call:

A) SWVMHI
B) Admitting CSS - MR Services
C) Admitting CSS - MI Services
D) SWVTC or CVTC if the individual requires MR facility services

2. The CSS prescreener or designee as approved by the CSS Mental Health Director will attend and/or participate in the commitment hearing as SWVMHI in accordance with the Client Service Management Guidelines, July 1988, Code of Virginia, 37.1 - 67.3.

3. The admitting CSB will appoint a representative who is qualified to ensure adequate representation of MH/MR issues and resources. This individual will attend and participate in the individual's Comprehensive Evaluation and Treatment Planning Conference which is held within 10 days of admission. This conference will focus on the development of a discharge plan and treatment objectives.

MR FACILITY ADMISSIONS

As soon as possible after admission to SWVTC or CVTC, the following parties will have a representative involved in a telephone conference call:

A) SWVTC or CVTC
B) Admitting CSB - MR Services
C) Admitting CSB - MI Services
D) SWVMHI if the individual requires MI facility services

2. If judicial certification is required, a CSB representative (for both MR & MI issues) will attend and/or participate in the judicial hearing in accordance with 37.7 - 65.1.

3. The admitting CSS will appoint a representative who is qualified to ensure adequate representation of MH/MR issues and resources. This will attend regular treatment team meetings.

RESOURCE ISSUES

1 In some cases the Institute and CSB working together may identify an appropriate discharge/aftercare plan but cannot implement such a plan due to a lack of resources. Assistance will be requested moving progressively upward through administrative levels at both the Institute and the CSB. Once all local options have been exhausted, the CSB and Institute will jointly request assistance from the Directors of the offices of Mental Health, Mental Retardation, (DMHMRSAS).

APPLICABILITY

This agreement will be in effect in the eight (8) CSBs served jointly by SWVMHI, SWVTC, and CVTC in Health Planning Region III

(Nov 92B)

HPR IV CONSORTIUM

COMMUNITY EMERGENCY/CRISIS INTERVENTION FOR INDIVIDUALS WITH MENTAL RETARDATION AND MENTAL ILLNESS

CENTRAL STATE HOSPITAL
PETERSBURG, VIRGINIA
May 31, 1996

I. Individuals Known to the CSB

A. CSB mental retardation and mental health directors will ensure that procedures are in place to notify the CSB's emergency/crisis intervention staff when they anticipate an individual with mental retardation may be at risk for crisis intervention.

Procedures should include sharing relevant information about the consumer, interventions that should be considered, medical information, treating psychiatrist, and, in the event of a crisis, the mental retardation professional(s) to be consulted in the case during regular and after office hours, weekends, and holidays.

B. CSB mental retardation and mental health directors will ensure that procedures are in place for CSB's emergency/crisis intervention staff when a crisis occurs without warning for an active CSB consumer who has mental retardation.

Procedures should include how to access relevant information about the consumer, CSB options for individuals with mental retardation in crisis situations and the mental retardation professional(s) to be consulted during regular and after office hours, weekends, and holidays.

Individuals Unknown to the CSB

A. CSB mental retardation and mental health directors will ensure that procedures are in place for CSB's emergency/crisis intervention staff when a crisis occurs for a person with mental retardation (or who may be perceived as having mental retardation) who is not an active CSB consumer.

Procedures should include information about CSB options for individuals with mental retardation (or who may be perceived as having mental retardation) in crisis situations and the mental retardation professional(s)

to be consulted in crisis cases during regular and after office hours, weekends and holidays.

PRACTICE EXPECTATIONS

Individuals with mental retardation and mental illness who are in crisis are reported to the CSB's emergency/crisis intervention staff.

2. Following, whenever possible, a joint face-to-face evaluation, the CSB's crisis intervention and mental retardation staff will determine whether or not the individual meets the criteria for a TDO.

3. If, as a result of the face-to-face evaluation when a mental retardation professional is not present, the individual does not meet the criteria for a TDO and appears to be able to be maintained in the community, the CSB's emergency/crisis intervention staff will notify an appropriate mental retardation professional of the case. Each CSB will identify the mental retardation professional to be contacted in situations such as this. The CSB's mental retardation staff will follow-up on the case as is appropriate.

4. If, as a result of the face-to-face evaluation, the individual does not meet the criteria for a TDO, and appears to need emergency respite care or services unavailable in the community, a CSB mental retardation professional will apply to Southside Virginia Training Center (SVTC) for immediate respite care. SVTC staff will ensure that procedures are in place to assure immediate access to emergency respite care in these situations.

5. If, as a result of a face-to-face evaluation, a TDO is issued to a private hospital or to Central State Hospital (CSH), the CSB crisis intervention staff, in cases where the individual is known to the CSB, will notify the individual's primary case manager, or, for individuals previously unknown to the CSB, an appropriate mental retardation professional of the case as soon as possible. If feasible prior to the commitment hearing, for the purpose of developing a recommendation for the least restrictive and most therapeutic alternative, the individual's primary case manager or the CSB mental retardation staff will also arrange an interdisciplinary consultation (conference call), to include CSB MR professional, CSB MH professional, CSH designee, SVTC designee, and others as appropriate.

A list of all CSB, CSH, and SVTC designees and phone numbers will be developed and shared with all relevant parties and updated at least annually. Each CSB Crisis Coordinator and SVTC will provide information to CSH, which will assume responsibility for maintaining the regional listing.

6. To the extent possible, CSB mental health and mental retardation staff will be present at the commitment hearing and present a unified recommendation for disposition.

7. The commitment hearing may result in at least four potential dispositions. These are: home/community, SVTC crisis respite, involuntary commitment to a private hospital or to CSH. Action subsequent to each of these dispositions will be as follows:

   a. Home/Community - CSB mental retardation professional assumes case management responsibility and follow-up, and accesses regional expertise at CSH, SVTC, or within the CSB system.

   b. SVTC Crisis Respite - CSB mental retardation professional initiates telephone conference call to SVTC, CSB MH professional and CSH (if individual requires psychiatric support/treatment).

      If judicial certification is required, CSB MR professional will attend and/or participate in the judicial hearing in accordance with 37.1-65.1. The CSB will assure that mental retardation staff attend regular SVTC treatment team meetings.

   c. Private Hospital - CSB MH and MR professionals jointly develop a plan to ensure active treatment.

   d. CSH - CSH will assume responsibility for ensuring that within ten days there will be an individual Comprehensive Evaluation and Treatment Planning Conference. This conference will focus on the development of a discharge plan, treatment objectives, optimum site for implementation (CSH, SVTC, or community) and time frames to implement discharge or transfer to SVTC as indicated. Conference to include CSB, MH, MR, and SVTC designees, and CSH treatment team members. Individuals with mental retardation shall be transferred to SVTC or discharged (if placement is available) as soon as their psychiatric condition is stabilized. Once consumers are stabilized they should not be maintained at CSH pending placement but should be transferred to SVTC or other appropriate facility.

APPLICABILITY

This protocol will be in effect in the eight CSBs served jointly by Central State Hospital and Southside Virginia Training Center in Health Planning Region IV and reviewed annually.

MH/MR HOSPITAL ADMISSIONS AND DISCHARGE PROTOCOL

HPR V

The intent of the Protocol is to insure that dually diagnosed (MI/MR) clients receive appropriate services for their needs. It is designed to address both MR and MH needs and to determine which facilities and/or services could best meet those needs. The goal is to bring MH and MR services together to secure and provide the best services possible for the client. The Protocol addresses the areas of crisis intervention, hospitalization, discharge planning, and MH treatment for SEVTC residents.

CRISIS INTERVENTION

It is recommended that problematic psychiatric behaviors be addressed when they first occur rather than waiting until a crisis develops. When problematic behaviors are first noted, MR case managers should address the situation and call upon any available resources to prevent the situation from escalating further.

When an MR client presents in psychiatric crisis, the emergency services screener shall consult with the MR case manager and both must agree on psychiatric hospitalization. If there is no MR case manager, a representative of MR services shall be consulted. If needed, a TDO will be obtained and a hearing held locally. If the MR case manager and the emergency services worker disagree, the case shall be presented by these workers to their next organizational level for consultation. This is a process in which time is of the essence.

HOSPITALIZATION

From the time of admission to the detention facility until the hearing, the client is to be evaluated by an independent evaluator, according to statutes. The CSB shall consult with the evaluator, SEVTC, and ESH immediately. The MR case manager and a representative from emergency services must attend the commitment hearing. If it is determined that the client requires inpatient psychiatric services, the CSB shall request a 30 day commitment. Whenever possible, commitment to a private facility should be sought, if not possible, then ESH is the commitment facility. If it is determined that the patient does not require inpatient treatment for mental illness, the disposition of the client shall be the responsibility of MR services.

DISCHARGE PLANNING

Discharge planning should not wait until the client's condition is stable. Discharge plans should be in place as soon as possible so that when the client is stable, s/he can be quickly discharged.

If the client is committed to a hospital (public or private), a community/hospital Prescription Team meeting must be held within 72 hours to formulate and discuss an effective treatment and

discharge plan. This meeting will include everyone involved with the client, ESH (or private hospital) staff, CSB MR case managers, hospital liaison, SEVTC staff and other possible placement providers. This meeting may be in the form of a conference call or other technological means.

If at this meeting admission to SEVTC is recommended, the MR case manager will prepare application materials, including a prescreening report, to be submitted to the Training Center. The case manager will request either a regular (judicially certified) admission in accordance with §37.1-65.2 or an emergency (21 day) admission in accordance with §37.1-65.2 . If the client is accepted for regular admission, the Training Center will expedite the admission process. If the client is accepted for emergency care and there is no bed available at SEVTC, the Training Center will request admission to another state facility, as outlined in the DMHMRSAS Regulations for Respite and Emergency Care Admissions to Mental Retardation Facilities. If an emergency admission is arranged at SEVTC or another facility it is the responsibility of the CSB MR services to immediately locate another service option and discharge the client within 21 days.

If placement in the community is the recommendation, CSB MR services shall be responsible for finding an appropriate facility for the client.

SEVTC RESIDENTS

When a client residing at SEVTC requires psychiatric treatment and those services cannot be accessed through a private facility, the Training Center will contact the ESH Admissions Coordinator to discuss the case and following the discussion, will contact Chesapeake emergency services to request prescreening for a commitment hearing. Any SEVTC resident who is the subject of such a hearing will be committed to ESH with the understanding that s/he will remain on the census of the Training Center on special hospitalization status.

During the time the client resides at ESH, staff from both facilities will maintain close contact regarding the client's progress and will attend discharge planning meetings, as appropriate. Therefore, the 30 day commitment requirement and the meetings described in the above sections will not be necessary because the client will return to SEVTC as soon as s/he is stable. With proper authorization, SEVTC will share information regarding the client's status with his/her case management CSB.

APPENDIX L

Attorney General Opinion on Transportation Under ECO's and TDO's

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

TIMOTHY A. KELLY, Ph. D
COMMISSIONER

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MEMORANDUM

TO: State MHMRSAS Board Members
Community Services Boards Executive Directors
DMHMRSAS Facility Directors
Central Office Directors
Management Team

FROM Timothy A. Kelly Timothy A. Kelly/rek

DATE April 23, 1996

SUBJECT: Attorney General Opinion to Honorable Robert B. Edwards - Transportation of Persons under ECOs and TDOs

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Please find attached a copy of an official Opinion issued recently by Attorney General James S. Gilmore, III, to Judge Robert B. Edwards. This Opinion provides that neither sheriffs' offices nor police departments have primary responsibility to transport persons subject to an emergency custody order or temporary order of detention. Any law enforcement officer requested by the court to execute an ECO or TDO should do so without delay. A sheriff's office or a police department may not limit its execution of these orders to certain times of day.

The Opinion also provides that, should a sheriff be ordered to provide transportation of a person who has been committed to a hospital, transportation must commence within six hours of notification to the sheriff of the certification for admission.

Please share this Opinion with your staff involved in the civil commitment process and any other interested parties.

TAK:ibs

Attachment

pc: The Honorable Robert C. Metcalf
Jane D. Hickey
Julie A. Stanley

COMMONWEALTH of VIRGINIA

James S. Gilmore, III
Attorney General

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February 15, 1996

The Honorable Robert B. Edwards
Judge, Isle of Wight County General District Court
P.O. Box 122
Isle of Wight, Virginia 23397-0122

My dear Judge Edwards

You ask several questions regarding the transportation of persons subject to issuance of either an emergency custody order ("ECO") or an involuntary temporary detention order ("TDO").

You relate that Obici Hospital in Suffolk, Virginia, operates a psychiatric unit serving the Fifth Judicial District and other areas. You also relate that a mental patient subject to an ECO issued in the Fifth Judicial District usually is transported from the site of execution of the ECO to Western Tidewater Mental Health Center in Suffolk for the evaluation required by § 37.1-67.01 of the *Code of Virginia*. Thereafter, if a TDO is issued pursuant to § 37.1-67.1, the patient is transported from Western Tidewater Mental Health Center to either Obici Psychiatric Care Center or other psychiatric facilities located outside the City of Suffolk. Furthermore, you relate that, effective July 1, 1995, the sheriff for the City of Suffolk has refused to transport any mental patients subject to ECOs and TDOs, except during the nonlegal holiday hours from 8 a.m. to 5 p.m., Monday through Friday. By prior agreement between the sheriff and the chief of police, the Suffolk Police Department handles the execution of ECOs in Suffolk and provides transportation to Western Tidewater Mental Health Center for the evaluation. You advise that before July 1, 1995, a deputy sheriff would relieve the police officer, remain with the patient through the evaluation, and transport the patient pursuant to issuance of a TDO. Transportation of ECO and TDO patients in Suffolk is affected, because the sheriff's office refuses to provide transportation, except during the nonlegal holiday hours stated above, and the police department will agree only to provide transportation from the site of execution of an ECO to the site of the evaluation.

You first ask whether the sheriff's office or the police department has primary responsibility for transporting ECO and TDO patients under the provisions of §§ 15.1-131, 15.1-138, 37.1-67.01 and 37.1-67.1. Before the 1995 Session of the General Assembly, § 37.1-67.1 authorized the execution of both ECOs and TDOs, detailing the processes by which such orders were to be issued and served. As a result of the 1995 Report of the Joint Legislative Audit and Review Commission ("JLARC report"),[1]

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[1] *See* 1 H. & S. DOCS., REPORT OF THE JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION ON REVIEW OF THE INVOLUNTARY COMMITMENT PROCESS, HOUSE DOC. NO. 8 (1995) [hereinafter H. DOC. NO. 8]. The JLARC report led to numerous Code revisions, including the enactment of § 37.1-67.01 and the amendment of §§ 37.1-67.1, 15.1-131 and 15.1-138. *See* Ch. 844, 1995 Va. Acts Reg. Sess. 1788.

substantial changes were made to Virginia's civil commitment process, including the enactment of § 37.1-67.01, governing the process by which ECOs are issued and executed, and the revision of § 37.1-67.1, providing authority under which TDOs are handled.[2]

Neither the provisions of § 37.1-67.01 nor § 37.1-67.1, however, explicitly place any greater burden on the local sheriff's office than on the local police.[3] Both provisions refer to a "law-enforcement officer" as the individual permitted to transport persons for evaluation or treatment following issuance of either an ECO or a TDO.[4] Although the General Assembly does not define the term "law-enforcement officer" in § 37.1-67.01 or § 37.1-67.1, §§ 15.1-131 and 15.1-138 specify that police officers may be involved in the transportation process, and that they are included as "law-enforcement officers" referred to in §§ 37.1-67.01 and 37.1-67.1.[5]

Sections 15.1-131 and 15.1-138 are contained in Chapter 3 of Title 15.1, and relate to the authority of police to execute ECOs and TDOs in the manner specified for law-enforcement officers under § 37.1-67.01 or § 37.1-67.1. The first sentence of § 15.1-131 provides:

> Whenever the necessity arises for the enforcement of laws ... *during the execution of the provisions of § 37.1-67.01 or § 37.1-67.1 relating to orders for temporary detention or emergency custody for mental health evaluation ... the policemen and other officers,* agents and employees of any county, city or town ... may, together with all necessary

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[2]*See* 1995 Va. Acts, *supra*, at 1791-94. Former references to ECOs in § 37.1-67.1 have been deleted. *See id.* at 1792-93.

[3]*Compare* §§ 37.1-67.01 *and* 37.1-67.1 (referring to transportation of any person under ECO or TDO by "law-enforcement officer," and containing no requirement that sheriff, as opposed to police, transport such person) *with* § 37.1-71 (providing that, in absence of transportation alternatives, sheriff should transport persons certified for admission to hospital under §§ 37.1-67.3, 37.1-67.4 or § 37.1-67.6); *cf.* 1987-1988 Op. Va. Att'y Gen. 78, 79-80 (concluding that sheriff and police department share responsibility for service of TDO).

[4]Section 37.1-67.01 provides: "A *law-enforcement officer* who ... has probable cause to believe that a person meets the criteria for emergency custody ... may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization ...." (Emphasis added.) Section 37.1-67.01 also allows "[a] *law-enforcement officer* ... lawfully [to] go to or be sent beyond the territorial limits of the county, city or town in which he serves to any point in the Commonwealth for the purpose of executing an order of emergency custody pursuant to this section." (Emphasis added.)

Section 37.1-67.1 similarly provides that "[a] *law-enforcement officer* may lawfully go to or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing any order for temporary detention pursuant to this section." (Emphasis added.)

[5]A prior opinion of the Attorney General analyzes former statutes and concludes that the then existing language of "§ 37.1-67.1 should be read to refer to a sheriff as *the officer* who is required to execute an order of temporary detention." 1979-1980 Op. Va. Att'y Gen. 314, 314 (emphasis added). The 1980 opinion has been effectively negated, however, by more recent statutory language.

> equipment, lawfully go or be sent beyond the territorial limits of such county, city or town ... to assist in meeting such emergency or need ....[6] [Emphasis added.]

Section 15.1-138 clearly establishes the function of a police officer in executing ECOs and TDOs. Although § 15.1-138 initially provides that "[s]uch policeman shall have no power or authority in civil matters," it also creates an exception "that a policeman of a county, city or town may execute and serve an order of temporary detention and an emergency custody order and may exercise such other powers as may be specified for law-enforcement officers pursuant to § 37.1-67.01 or § 37.1-67.1."[7]

By virtue of this exception, the General Assembly has authorized local police to serve civil warrants for emergency custody or temporary detention. Although the General Assembly has not specifically provided for either police departments or sheriffs' offices to assume primary responsibility for serving ECOs or TDOs, survey responses in the JLARC report from 44 police chiefs and 114 sheriffs found that both police officers and sheriffs' deputies were being used by "magistrates and special justices to transport individuals when ECOs and TDOs are issued."[8] The JLARC report concludes that "[l]aw enforcement officers should continue to transport individuals under ECOs and TDOs, because the process is often initiated by an officer and the dangerousness of the individual may not be known."[9] The JLARC report acknowledges, however, that sheriffs' deputies may "remain the primary providers of transportation for temporary detention orders."[10]

It is my opinion that the General Assembly has not placed on either sheriffs' offices or police departments the primary responsibility for transporting persons under ECOs or TDOs, but that, as a practical matter, as noted in the JLARC report, sheriffs may be involved most often with transportation pursuant to a TDO.[11] I am of the opinion that, under the provisions of §§ 37.1-67.01 and 37.1-67.1, any law-enforcement officer requested by a court to execute an ECO or TDO should do so, without delay.

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[6]The General Assembly amended § 15.1-131 in the 1995 Session to cross-reference the specific authorization of the use of "law-enforcement officers" in the execution of ECOs in § 37.1-67.01. *See* 1995 Va. Acts, *supra* note 1, at 1788. *Compare* Ch. 566, 1992 Va. Acts Reg. Sess. 726, 726 (amending § 15.1-131 to allow police to go beyond territorial limits of their respective jurisdictions to execute both ECOs and TDOs, and containing specific reference to § 37.1-67.1, which, at time of amendment, related to both ECOs and TDOs) *with* Ch. 779, 1984 Va. Acts 2121, 2127-28 (containing no mention of police involvement in either ECO or TDO process in amendment to § 15.1-131).

[7]*See also* Ch. 38, 1982 Va. Acts Reg. Sess. 136, 137 (earliest amendment authorizing police officers to execute and serve TDOs issued pursuant to § 37.1-67.1). At its 1992 Session, the General Assembly further amended that section to explicitly authorize policemen to execute ECOs. *See* Ch. 729, 1992 Va. Acts Reg. Sess. 1108, 1109.

[8]H. DOC. NO. 8, *supra* note 1, at 11-12.

[9]*Id.* at IV; *see id* at 56. The 1995 JLARC report recognizes the significant costs associated with transporting persons under ECOs and TDOs, but projects that with the recommended, and now enacted, statutory changes, those costs will diminish. *Id.* at 36 (reporting that sheriffs and police chiefs who responded to study estimated they spent "$1.5 million making 18,000 mental health transports in FY 1993").

[10]*Id.* at 76.

[11]*See id.* at 12.

You next ask whether the sheriff is required to transport mentally ill patients subject to ECOs and TDOs without regard to the time of such transportation, but at a time when police officers are not allowed to provide such transportation. Section 37.1-67.01 unambiguously provides that an order for emergency custody must be executed "within four hours of its issuance," after which it "shall be void and shall be returned unexecuted to the office of the clerk." In addition, a person may be held in custody only until "a temporary detention order is issued or until the person is released, but in no event shall the period of custody exceed four hours."[12] Consequently, the transporting officer in a case involving emergency custody must act within four hours to execute the order. In addition, within a second four-hour period, he must deliver the individual in his custody for psychiatric evaluation. Detention under further order or release must occur within that same time frame.

The provisions of § 37.1-67.1 provide more latitude within which to execute a TDO. A TDO must be "executed within twenty-four hours of its issuance, or within such shorter period as is specified in the order, after which it shall be void and shall be returned unexecuted."[13] A petition for which no TDO or other process is served within ninety-six hours is void and must be returned to the clerk of the issuing court.[14]

It is well-settled that "[i]f the language of a statute is plain and unambiguous, and its meaning perfectly clear and definite, effect must be given to it."[15] It is equally well-settled that "[a statute] which is plain needs no interpretation."[16] It is, therefore, my opinion that these requirements do not allow either a sheriff's office or a police department to limit its ECO- or TDO-related activities to specific, predetermined hours of the day only. Law-enforcement officers should act within a sufficient time frame, in response to court orders, to accomplish timely execution of ECOs and TDOs, and they should provide transportation within the periods specified by the court order or these statutes.

You next ask whether a magistrate has the authority under the provisions of §§ 37.1-67.01 and 37.1-67.1 to designate or order either the sheriff's office or the police department to provide transportation if there is no primary responsibility on either to transport mentally ill patients subject to ECOs and TDOs. Neither statute prevents a magistrate from designating the law-enforcement office to provide transportation for a patient under an ECO or a TDO. Section 37.1-67.01 provides that a magistrate may issue an ECO "requiring any person within his judicial district to be taken into custody and transported to a convenient location" for evaluation of that person's mental condition to assess the need for hospitalization. Likewise, § 37.1-67.1 allows a magistrate to issue a TDO, which may include transporting the person to a facility for medically necessary evaluation or treatment before placement. Neither statute specifies to whom the order must be directed.

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[12]Section 37.1-67.01.

[13]Section 37.1-67.1. This section also allows subsequent orders to be issued "upon the original petition within ninety-six hours after the petition is filed."

[14]Section 37.1-67.1.

[15]*Temple v. City of Petersburg*, 182 Va. 418, 423, 29 S.E.2d 357, 358 (1944); Op. Va. Att'y Gen.: 1994 at 93, 95; 1993 at 256, 257.

[16]*Winston v. City of Richmond*, 196 Va. 403, 408, 83 S.E.2d 728, 731 (1954); *see also* 1993 Op. Va. Att'y Gen., *supra*, and opinions cited therein.

As noted above, the JLARC report found the practice within the Commonwealth to be that magistrates and special justices order either a sheriff or a police officer to execute such orders and to transport the affected individuals.[17] Sheriffs' deputies may "remain the primary providers of transportation"[18] for TDOs, as noted above, but police officers may be equally, if not more, involved in transporting persons in emergency custody situations, because they are more likely to respond to emergency calls from the public.

Your final question is whether a sheriff is required to commence the transportation of a person, certified for hospital admission under § 37.1-67.3, within six hours of being notified of the commitment occurring at 4:45 p.m., or thereafter, as provided in § 37.1-71. Section 37.1-71 allows a judge to determine whether the sheriff should transport the person to the proper hospital. Such certification may be issued by the judge under § 37.1-67.3 or § 37.1-67.4, or following appeal pursuant to § 37.1-67.6, and depending on a determination as to the person's dangerousness, the judge may order alternative means of transportation.[19] Nonetheless, should the judge order transport by the sheriff, § 37.1-71 succinctly and unambiguously requires that "[i]n no event shall transport commence later than six hours after notification to the sheriff of [certification for admission]."

It is unnecessary to resort to any rules of statutory construction when the language of a statute is unambiguous.[20] The clear language of this statute requires no statutory interpretation.[21] When the meaning of a statute is "perfectly clear and definite, effect must be given to it."[22] Accordingly, it is my opinion that § 37.1-71 requires the sheriff to commence transporting any person certified for admission to a hospital within six hours of notification of such certification by the court, regardless of the time of day the certification is made.

With kindest regards, I am

Very truly yours,

James S. Gilmore, III
Attorney General

6:20/54-320

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[17] *See* H. Doc. No. 8, *supra* note 1, at 11-12.

[18] *Id.* at 76.

[19] Section 37.1-71.

[20] *See Ambrogi v. Koontz*, 224 Va. 381, 386, 297 S.E.2d 660, 662 (1982); Op. Va. Att'y Gen.: 1994, *supra* note 15; 1992 at 99, 100 (plain language of statute limits amount of fee celebrant may charge to act of performing marriage ceremony only).

[21] *See, e.g., Winston v. City of Richmond*, 196 Va. at 408, 83 S.E.2d at 731.

[22] *Temple v. City of Petersburg*, 182 Va. at 423, 29 S.E.2d at 358; *see also* Op. Va. Att'y Gen.: 1994, *supra* note 15; 1993, *supra* note 15.

APPENDIX M

State Board Policy 1029, June 1990 - Definition of Serious Mental Illness

POLICY MANUAL

State Mental Health, Mental Retardation and Substance Abuse Services Board
Department of Mental Health, Mental Retardation and Substance Abuse Services

POLICY 1029(SYS)90-2

SUBJECT: Definitions of Priority Mental Health Populations

AUTHORITY: Board Minutes Dated May 23, 1990

Effective Date June 27, 1990

Approved by Board Chairman s/Greer D. Wilson, Ed.D.

REFERENCES: Comprehensive State Plan, 1990-1996
Core Services Taxonomy III, December 20, 1988
Policy 4027 (CSB) 87-11 Community Support Programs for Persons with Serious Mental Illness
Policy 1022 (SYS) 87-10 Long-Term Care of Persons with Mental Disabilities

BACKGROUND: Although there is a wide range of categories and classifications of mental health disorders, the populations defined in this policy are delineated as priority populations for mental health service system development. Given limited state resources and human resources available for the support and expansion of mental health services, it is the intent of this policy to define priority groups for targeting of these resources. These definitions shall be used for purposes of data collection and reporting, budget guidance, resource allocation and other Departmental uses.

PURPOSE: To establish State Board policy that defines the following priority mental health populations: adults with serious mental illness, children and adolescents with serious emotional disturbance and children at risk of developing serious emotional disturbance

POLICY It is the policy of the State Mental Health, Mental Retardation and Substance Abuse Services Board that serious mental illness be defined as follows: Adults with serious mental illnesses are individuals, 18 years of age and older, who have a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or mental retardation are included. The population is defined along three dimensions: (a) diagnosis, (b) level of disability and (c) duration of the illness.

(a) Diagnosis

There is a major mental disorder diagnosable under DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised in 1987), which is a schizophrenic, major affective, paranoid, organic, or other psychotic disorder, personality disorder, or other disorder that may lead to a chronic disability.

(b) Severe, Recurrent Disability Resulting from Mental Illness

The disability results in functional limitations in major life activities. Individuals typically meet at least two of the following criteria, on a continuing or intermittent basis:

(1) Is unemployed, is employed in a sheltered setting or supportive work situation, has markedly limited or reduced employment skills or has a poor employment history.

(2) Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help.

(3) Has difficulty in establishing or maintaining a personal social support system.

Requires help in basic living skills such as hygiene, food preparation or money management.

Exhibits inappropriate behavior which results in intervention by the mental health and/or judicial system.

(c) Duration

Individuals are expected to require services of an extended duration or the treatment history meets at least one of the following criteria:

(1) Has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., crisis response services, alternative home care, partial hospitalization or inpatient hospitalization).

(2) Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly

disrupted the normal living situation.

It is the policy of the State Mental Health, Mental Retardation and Substance Abuse Services Board that serious emotional disturbance in children and adolescents, ages birth through 17, be defined as follows:

(1) A defined serious mental health problem that can be diagnosed under DSM-III-R; and/or all of the following

(2) Problems in personality development and social functioning which have been exhibited over at least one year's time; and

(3) Problems which are significantly disabling based upon the social functioning of most youngsters their age; and

(4) Problems that have become more disabling over time; and

(5) Service needs that require significant intervention by more than one agency.

It is the policy of the State Mental Health, Mental Retardation and Substance Abuse Services Board that children ages 0 through 7, at risk of developing serious emotional disturbances, be defined as those who meet one or more of the following criteria:

(1) Young children who exhibit behavior or maturity that is significantly different from most children their age, and which is not the result of developmental disabilities or mental retardation; or

Young children whose parents, or persons responsible for care, have predisposing factors that could result in their children developing serious emotional or behavioral problems; or

Young children who have experienced physical or psychological stressors which put them at risk for serious emotional or behavior problems.