Approved: 3-18-10
Date

MINUTES OF THE HOUSE CORRECTIONS AND JUVENILE JUSTICE COMMITTEE

The meeting was called to order by Chairman Pat Colloton at 1:30 p.m. on January 25, 2010, in Room 144-S of the Capitol.

All members were present except:
Representative Bob Bethell- excused
Representative Lance Kinzer- excused

Committee staff present:
Sean Ostrow, Office of the Revisor of Statutes
Jason Thompson, Office of the Revisor of Statutes
Athena Andaya, Kansas Legislative Research Department
Jerry Donaldson, Kansas Legislative Research Department
Jackie Lunn, Committee Assistant

Conferees appearing before the Committee:
State Representative Bill Feuerborn,
Secretary Roger Werholtz, Kansas Department of Corrections
Tom Stanton, Deputy Reno County District Attorney,
Ed Klump, Kansas Chiefs' of Police, Kansas Peace Officers Association & Kansas Sheriff's Association
Debra Billingsley, Executive Director, Kansas Board of Pharmacy

Others attending:
See attached list.

State Representative Bill Feuerborn,
Secretary Roger Werholtz, Kansas Department of Corrections
Tom Stanton, Deputy Reno County District Attorney,
Ed Klump, Kansas Chiefs' of Police, Kansas Peace Officers Association & Kansas Sheriff's Association
Debra Billingsley, Executive Director, Kansas Board of Pharmacy

HB 2503 - Authorizing and requiring the secretary of corrections to supervise parole offices and other release mechanisms and entities.

Chairperson Colloton called the meeting to order and called the Committee's attention to the handouts:
Letter to the Chair from Debra Billingsley, Board of Pharmacy, (Attachment 1)
Written comments submitted by Harold Luce, (Attachment 2)
Written comments submitted by Aubry L. Gabbard, (Attachment 3)
Written article "Investigating a not-so-natural high. (Attachment 4)

She announced to the Committee that a motion was never made to carry **HB 2503** as a Committee bill.

Representative Brookens made a motion to carry HB 2503 as a Committee bill. Representative Spaulding seconded. Motion carried.

She opened the floor for bill introductions.

Chairperson Colloton requested a bill be introduced as a committee bill that would allow risk analysis to be funded at the court services level and raise the fees for the purpose of providing risk analysis training and support though court services.

Representative Brookens made a motion to introduce the bill as a committee bill. Representative Spalding seconded. Motion carried.

HB 2412 - Functional incapacitation release; procedures; notice; conditions; supervision upon release.

Chairperson Colloton opened the hearing on **HB 2412** and introduced State Representative Feuerborn to give

his testimony as a proponent of the bill. Representative Feuerborn presented a written copy of his testimony. (Attachment 5) He stated he introduced this bill because of something that happened during the interim. He was contacted by a gentleman regarding his terminally ill daughter and he was trying to get her out of jail in order to bring her home to die. Representative Feuerborn found out that the current laws regarding this matter were made to take time for the process to work. With the help of Secretary Werholtz, Kansas Department of Corrections, they were able to bring their daughter home and she died the next day. This bill would speed up the process if the illness dictates but would have all the safe guards in it that would allow for a quicker process. In closing, he urged the Committee to support this bill.

Questions and answers followed.

Chairperson Colloton introduced Secretary Werholtz, Kansas Department of Corrections, to give his testimony as a proponent of **HB 2412.** Secretary Werholtz presented written copy of his testimony. (Attachment 6) He explained that the bill provides a procedure for the a release of an inmate in the custody of the Department of Corrections who has a prognosis of dying within thirty days and who is determined to not pose a threat to the public. He stated he wanted the Committee to know how much authority they were giving to the Secretary of Corrections with the application for the release of a terminally ill inmate to be made by the Secretary of Corrections.

Questions and answers followed.

With no further questions or others wishing to testify, Chairperson Colloton closed the hearing on **HB 2412.**

HB 2451 - Adding BZP to the list of schedule I drugs.

Chairperson Colloton opened the hearing on **HB 2451** and introduced Tom Stanton, Deputy Reno County District Attorney, to give his testimony as a proponent of the bill. Mr. Stanton presented written copy of his testimony. (Attachment 7) He explained the bill would add BZP to Schedule I of the Uniform Controlled Substance Act. Johnson County prosecutors have been encountering the drug on a frequent basis, including one situation in which a person was selling 100 BZP tablets at a time. In closing, he urged the Committee to pass the bill.

Questions and answers followed.

Chairperson Colloton introduced Ed Klump, Kansas Chiefs of Police, Kansas Peace Officers Association and the Kansas Sheriffs' Association. Mr. Klump presented written copy of his testimony. (Attachment 8) Mr. Lump stated they are starting to see more in the larger communities and it will be filtering out in the smaller communities. This bill will make it possible to prosecute the smaller cases that the feds won't touch. He urged the Committee to pass this bill.

Chairperson Colloton called the Committee's attention to the written only testimony of Debra Billingsley, Executive Director, Board of Pharmacy, a proponent of **HB 2451.** (Attachment 9)

A lengthy questions and answers session followed.

With no further persons to testify or questions, Chairperson Colloton closed the hearing on **HB 2451.**

HB 2411 - Criminalizing certain synthetic cannabinoids, adding to schedule I controlled substances list.

Chairperson Colloton moved the Committee's attention to **HB 2411** for consideration. She stated there are balloons from the revisors to be addressed.

Representative Kinzer made a motion to pass the bill out favorable. Representative Brookens seconded.

Minutes of the House Corrections and Juvenile Justice Committee at 1:30 p.m. on January 25, 2010, in Room 144-S of the Capitol.

Representative Pauls made a substitute motion to accept the amendment adding BZP to and to add it will be in effect after its publication in the Kansas Register to HB 2411. Representative Spaulding seconded.

After a short discussion, Chairperson Colloton called for a vote. **Motion carried.**

Back on the bill, Representative Kinzer made the motion to pass HB 2411 out favorably as amended. Representative Brookens seconded.

After a short discussion, Chairperson Colloton called for a vote. **Motion carried**.

Chairperson Colloton called on Athena Andaya, Legislative Research, to explain the research she has done on "involuntary commitment" of the mentally ill in Virginia. (Attachment 10) *Virginia's New Statutory Civil Commitment Criteria by Bruce J. Cohen, Richard J. Bonnie and John Manahan* states if the judge or special justice finds by clear and convincing evidence that;

(A) the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future,

(1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if, any, or

(2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, and

(B) all available less restrictive treatment alternatives to involuntary inpatient treatment have been...determined to be inappropriate.

The judge or special justice shall order that the person be admitted involuntarily to a facility for a period of treatment not to exceed 30 days. Ms. Anday addressed questions from the Committee while explaining her research.

Upon the conclusion of Ms. Andaya's explanation, Chairperson Colloton adjourned the meeting at 2:40 p.m. with the next meeting scheduled for January 26, 2010, at 1:30 p.m. in room 144-S.

CORRECTIONS & JUVENILE JUSTICE
GUEST LIST

DATE: 1-25-10

NAME	REPRESENTING
Ed Klumpp	KACP/KPOA/KSA
Tim Madden	KDOC
Tom Stanton	KCDAA/Reno County DA's Office
Richard Summerlin	Kenney & Assoc.
Catie Rech	KNASW
Kelsey Nepp	KNASW
Leigh Keck	Klein Law Firm
Jeremy S Barclay	
John Knox	Sacred Journey
Aubry Gabbard	Self
Kevin Barone	CLG, LLC
Judy Schrock	KSNA

KANSAS

BOARD OF PHARMACY
DEBRA L. BILLINGSLEY, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

January 22, 2010

The Honorable Pat Colloton
Corrections and Juvenile Justice Committee
Capitol Building
Room 151-S
Topeka, KS 66603

RE: HB 2411

Dear Madam Chair:

I was in attendance for the hearing on HB 2411 regarding whether to schedule three synthetic hallucinogenics to Schedule I. I wanted to clarify something for the Committee regarding some of the testimony.

Specifically, there was testimony that Schedule I controlled substances could not be used for research in the United States. The Drug Enforcement Agency and the Kansas Board of Pharmacy have identical license registrations for anyone wishing to conduct chemical analysis with controlled substances 1 through 5. The Pharmacy Board and the DEA issue identical Research and Teaching Registrations and Analytical Lab Registrations for Schedule 1 through V. An applicant must apply and receive both registrations. If the applicant is requesting the ability to analyze a Schedule 1 they will generally receive more scrutiny from the DEA in the Washington office rather than the regional office but there are quite a few individuals and entities analyzing and researching Schedule 1 drugs. The DEA checks to make sure that the protocols are justified before they will issue a registration.

A second issue that came up during the Senate discussion was whether a scheduled drug must have a DEA chemical code identifying number in order to be placed on the Controlled Substance List. The DEA advised me that the four digit number is assigned by the FDA not the DEA. It is for internal federal use and has no relevance to the state. The four numbers correspond to that portion of the controlled substance molecule identified as the "base" drug. The legislature did add Salvia and Gypsum Weed to the Kansas Schedule I list without a corresponding four digit number because those drugs are

LANDON STATE OFFICE BUILDING, 900 SW JACKSON STREET, ROOM 560, TOPEKA, KS 66612-1231
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not scheduled federally and there was no chemical identifying code assigned to them by the FDA.

If I can be of any assistance please feel free to let me know.

Sincerely,

Debra Billingsley

Debra Billingsley
Executive Secretary

Mr. Luce

Madame Chairwoman, and Members of The Committee:

Thank you for affording me an opportunity to speak to you today. The last time I spoke on House Bill 2411, I spoke as a PhD in Physical/Organic Chemistry. I've presented testimony, including two extensive papers reviewing research in the field in the last five years, and three US patents granted in the last seven years, including one granted to a research group funded by the Department of Health and Human Services. Two of the patents are on analogs of the compounds which this bill will outlaw, JWH-018 and JWH-073, which from the clear language of the bill will also be outlawed. This research was funded by grants from the National Institutes of Health, and ultimately by the US taxpayer. Action to outlaw these compounds will help to destroy active research in this area, or to simply drive it overseas, where plenty of research groups are already working on the use of these cannabinoids for medicinal purposes. Instead of the US benefitting from this expenditure of US tax dollars, perhaps the benefit will go to China or some other nation. I've done my best to show that there is important research being done in this field, from understanding brain chemistry to providing cures and treatments for diseases such as Multiple Sclerosis, Alzheimers, and Parkinsons, to providing pain relief for cancer patients as well as treatments for various types of cancer.

I turn now to my work as an attorney. First, I must mention to this committee that the prohibition of compounds JWH-018 and JWH-073 is premature:

Narcotic drugs are defined in K.S.A. 65-4101 (p)(1-4) as:

"(p) "Narcotic drug" means any of the following whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) Opium and opiate and any salt, compound, derivative or preparation of opium or opiate;

(2) any salt, compound, isomer, derivative or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (1) but not including the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) coca leaves and any salt, compound, derivative or preparation of coca leaves, and any salt, compound, isomer, derivative or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions of coca leaves which do not contain cocaine or ecgonine. "

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Synthetic cannabinoids such as JWH-018, JWH-133, JWH-073 and all others, including HU-210, fall outside of the above definition, and are thus classified as non-narcotic drugs. K2 is an herbal smoking preparation which is a carrier for JWH-018 or other synthetic cannabinoid.

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Corrections and Juvenile Justice
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Attachment # 2

K.S.A. 65-4102 regulates the scheduling of drugs by the Board of Pharmacy, the regulating agency: "(a) The board shall administer this act and may adopt rules and regulations relating to the registration and control of the manufacture, distribution and dispensing of controlled substances within this state. All rules and regulations of the board shall be adopted in conformance with article 4 of chapter 77 of the Kansas Statutes Annotated and the procedures prescribed by this act. "

K.S.A. 65-4102 (c) states: "[T]he board shall not include any nonnarcotic substance within a schedule if such substance may be lawfully sold over the counter without a prescription under the federal food, drug and cosmetic act."

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These synthetic cannabinoids are non-narcotic substances, and none of them, except for HU-210, have been scheduled by the DEA in any form. All of the other synthetic cannabinoids, including JWH-018, may be thus lawfully sold over the counter without a prescription, and therefore they cannot be scheduled in any way under the authority of K.S.A. 65-4102, according to section (c) of that statute. The Legislature is acting prematurely, the time is not ripe to schedule any synthetic cannabinoid other than HU-210, under Kansas law. HB-2411 should be tabled or killed unless or until federal scheduling occurs.

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In addition, while it is fairly simple to make an identification of marijuana in order to use it in trial evidence, and to provide expert testimony, since any high school graduate can use a microscope to examine marijuana leaves for certain unique characteristics, use a Duquenois-Levine drug test kit to test for the presence of THC, and present Mass Spectrometric evidence showing a characteristic peak pattern well-known in the literature for tetrahydrocannabinols, cannabidiols, and other psychoactive constituents of marijuana, this is not the case for JWH-018, JWH-073, and like compounds. These compounds will be extremely difficult and expensive for the State's expert witnesses to identify and show presence of in alleged drugs seized from defendants. It is my duty as a criminal defense attorney to make the State perform its Constitutional duty to demonstrate that my clients have possessed such substances beyond a reasonable doubt, and if the evidence does not come up to this high standard, to ask the jury to acquit my client. I intend to take each and every case involving alleged possession of these compounds to a jury trial, as will most, if not all, of my fellow criminal defense attorneys. It is our duty to zealously defend the rights of our clients, and you should be aware that we will do so.

Thank you for your consideration of my remarks. I hope you will remove the compounds JWH-018 and JWH-073 from the legislation at least, and to re-draft the bill or kill it entirely, at most.

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Dear Representatives,

I hope that it is okay that I am writing this late in a process and this late in the night. I would've liked to come to the hearing on Thursday, but I was ill. I am learning the difficult way that leaving this issue alone could not lead to a good night's rest for me.

I am writing because I am hoping you can help me. My name is Aubry Gabbard and the phrase "I would've liked to…but I was ill." has become a staple of my life. Similar to most people who experience chronic illness, though I did not ask for it, I am trying to find the positives in such an experience. So far, I have discovered not to take much for granted. My body has become a battleground, my system placing siege upon itself as I experience my expectations changing with a sort of fascinated terror.

I used to wake up with orange juice and hurrying out the door. Now, mornings must be planned ahead. I must accommodate for the fact that my puzzler's hands can no longer tie shoes or button buttons without worry, that they jerk away from me as if repulsed. I have passed out in my partner's arms. I have gotten too dizzy to stand at my place of work. I have been in too much pain to do anything but lay down a few days a week. My writer's mind has forgotten the word for "cup". My horseback riding legs are bruised from falling out from under me, and I can't forget the day that my hand went numb while my best friend held it. I have slept for 16 hours, and needed more sleep, consistently. I have needed help with every basic aspect of my life: getting dressed and showered, eating, going to the restroom, and even sitting up. Watching friends, family and acquaintances handle illness and disability did not prepare me to understand their bravery. I turned from the volunteer to the volunteered for, the caregiver in a family to patient. I am not yet 20 and I have become prepared to rattle off medications, spend hours looking over insurance paperwork and fight over my emergency call tree. When this first started, it was nothing short of devastating. I felt like my care and cane-free life was over and it only seemed practical that my employment would be.

I've been in testing for a long while, and there is speculation of a neurological illness such as Multiple Sclerosis or Parkinson's, yet I've been out of answers for almost as long-I live without diagnosis. The next failure is that difficulty in confirming diagnosis has produced difficulty in determining a treatment plan or obtaining the medication needed for such a plan. My family history and battery of tests already makes me difficult to insure. You can see where this becomes a cycle. Things didn't get easy, but they got easier, and that is because of K2. K2 is an herbal product which contains JWH-018 and JWH-073, two of the substances that would become schedule 1 if you passed this bill. I was introduced to K2 in June 2009 by a friend of a friend who said nothing more than "it will help the spasticity without getting you lobbed in jail". Skeptical, but willing, I tried K2 first in a tea and then in papers as a smoke. Contrary to the reports that I have heard I did not "trip", "get high", "get stoned" or otherwise "get fucked up". Instead, I found myself in less pain than I'd been in over a year. My legs, which usually wake up in a rigid and spastic state, calmed to a more agreeable position. K2 has been the only successful ally in my battles against spasticity, muscle spasms and intense migraines without causing grogginess or further fatigue. Using K2 has allowed me to return to full time employment and enjoy a few more hours to devote to volunteering, writing, friends and family when I otherwise would've been loopy with painkillers.

As my current insurance coverage comes to a close, I am nervous for the future.

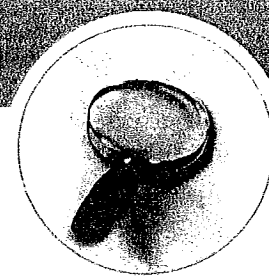
I have great fear for how things will work out for me if this bill is passed and JWH-018 and JWH-073 are made controlled substances, and inaccessible to me and others who use them for medicinal purposes. I am told that a waiver could be obtained, but that it could take 5-6, even 8-10 years. I'm not sure what will happen to me if that were to happen, nor to the surely hundreds and hundreds like me who may seek more desperate and risky means to find relief in the meantime. This appears to be an enforcement nightmare and a success in creating wound-up criminals out of law-abiding people who just wanted to unwind.

JWH-018 and JWH-073 have been the lead knights of my battle against disability and to get my life back. I am worried and disappointed that you may jeopardize something that has been such a useful pain management tool to "protect" high schoolers and other consumers who, if history is honest, will find a way to get high anyways. Please consider the potential and remember to also protect people like me.

Thank you for your time,

Aubry L. Gabbard.

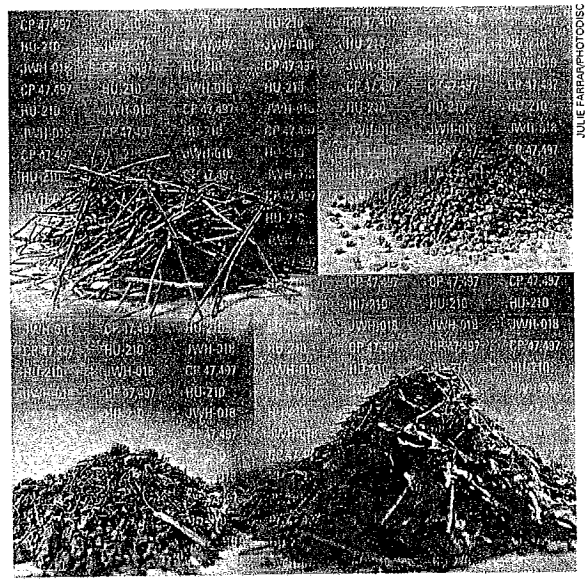
Corrections and Juvenile Justice
Date: 1-25-10
Attachment # 3



Investigating a not-so-natural high

Researchers identify synthetic cannabinoids in herbal incense.

Would you do something wrong if you knew you weren't going to get caught? This prospect tempted thousands of people as word spread about a "legal high"—herbal incense that could be smoked like marijuana. Researchers in several countries failed to find evidence of any common psychotropic compounds when they tested these herbal mixtures. And the urine of people who appeared to have overdosed on the substance did not contain known drug metabolites. But with a lot of analytical chemistry, some Internet research, and a little serendipity, researchers in Germany eventually identified synthetic cannabinoids in several different types of herbal incense; they recently reported their results in the *Journal of Mass Spectrometry* (2009, DOI 10.1002/jms.1558).



JULIE FARRAR/PHOTODISC

A public service announcement backfires?

Reporters for German television probably thought that they were doing society a favor when they broadcast a news story about herbal incense that produced a marijuana-like high but couldn't be detected by common drug screens. But after the August 2008 broadcast, the popularity of the incense soared in Germany. Young people began to show up at emergency rooms across the country with psychosis-like panic attacks and heart and circulatory problems; these patients admitted to smoking or ingesting products marketed as "herbal incense". Despite all signs pointing to marijuana overdose, no delta-9-tetrahydrocannabinol (THC) or any of its metabolites were detected in clinical samples from the patients.

The guinea pigs

Volker Auwärter's laboratory at the Institute of Forensic Medicine at the University Medical Center Freiburg (Germany), together with the Bundeskriminalamt (BKA), Germany's federal criminal police office, performed more extensive testing for psychotropic compounds in the clinical samples from the overdose patients but found nothing. Baffled, Auwärter and colleagues decided to do a controlled self-experiment with one type of herbal incense so they would have clinical samples after a known consumption of the substance. "First, we wanted to know is there a real effect, and if there is a real effect, there has to be a substance that is responsible for it," says Auwärter. The group wanted to collect enough clinical samples over an extended period to be able to perform preliminary kinetic analyses on any metabolites, which are often the only components detectable in urine.

Much to the researchers' surprise, a low dose (0.3 g of the mixture smoked by two of the researchers) produced a psychotropic effect that lasted for 5–6 hours. "It was really cannabis-like from all the symptoms—starting from red conjunctivae, dry mouth, and very high pulse rate," says Auwärter. But again, the scientists did not detect THC or other common psychotropic substances in the clinical samples. The researchers did, however, see some unidentified peaks in the GC/MS analysis of blood; these peaks were traced back to unidentified substances also detected in extracts of the herbal mixtures.

Synthetic cannabinoids

Next, the investigators turned to the Internet, where they found rumors that the herbal mixtures had been spiked with synthetic compounds that could not be detected by drug screens. So the group shifted focus and began to look for synthetic cannabinoid agonists. The researchers tested seven different products and analyzed extracts from the herbal mixtures via GC/electron impact MS, LC/MS^n, UV spectroscopy, and TLC, but they still couldn't determine the identity of three peaks. Auwärter points out that the laboratories could not identify the unknown compounds quickly because the compounds weren't in any of their mass spectra libraries.

According to Auwärter, a critical step in the group's analyses was the isolation of milligram quantities of th unknowns via silica gel chromatography so that they could perform structural analysis by NMR. "We had some information from each method, and that had to be puzzled together," he says. For example, TLC of extracts from three varieties of one brand of incense showed that the amount of two unknown compounds increased with the price of the product; this was a pretty good indication that the com-

10.1021/AC900564U © 2009 AMERICAN CHEMICAL SOCIETY
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pounds were intentionally added to the herbal mixtures. Eventually, the group pieced together a structure for one of those unknowns, but the structure was not related to THC.

Serendipity knocks

In mid-December 2008, the collaborators were still trying to deduce the structures of the unknown compounds when they got lucky. A commercial laboratory in Frankfurt announced that it had identified JWH-018, one of several cannabinoid agonists synthesized at Clemson University, in samples of herbal incense. The city of Frankfurt had asked THC Pharm, a company producing pharmaceuticals based on natural cannabinoids, to analyze the herbal incense. The firm's scientists were able to match the GC/MS spectrum of one peak to spectra they'd previously collected on JWH-018. Auwärter says that the Frankfurt laboratory did see another unidentified peak in the GC/MS spectrum. "They didn't know what it was, but they just suspected it may be some kind of aroma" component, he says.

Armed with this new knowledge, Auwärter and colleagues combed through the literature on other synthetic cannabinoids, such as the CP and HU series of compounds synthesized at Pfizer and Hebrew University (Israel), respectively. The group quickly matched its data with published data on cannabinoid agonists. By comparing the NMR spectra, the scientists realized that the structure they had previously pieced together was a homologue of CP 47,497—a compound known to bind to the brain cannabinoid receptor. In the seven products tested, the researchers identified CP 47,497; the C8 homologue of CP 47,497 and its trans diastereomer; JWH-018; and oleamide. The CP 47,497 homologue and its diastereomer were the major components for five out of the seven products tested; for the other two products, JWH-018 was the major component.

The nature of the herbal incense products has changed over time. Originally, Auwärter thought that the first products sold did not contain cannabinoids. But after laboratories knew what to look for and reanalyzed the earlier batches of incense, they detected the spiked cannabinoids. Auwärter says, "It seems like the labs doing the analyses at that time were just not suspicious enough." And batch-to-batch reproducibility was an issue as well. In one brand of herbal incense, sometimes JWH-018 was detected and sometimes it wasn't. After publishing their paper, the researchers found yet another synthetic cannabinoid in a batch of incense.

COURTESY OF VOLKER AUWÄRTER

One of the herbal mixtures tested, Spice Gold.

But the spiked compounds are not the only thing changing. "In the beginning, the Swiss labs were able to find at least some of the herbs which are declared on the back side of the package," says Auwärter. He says that by the time the herbal mixtures laced with cannabinoids became popular in Germany, the mixtures did not even contain the herbs listed in the ingredients. "[The manufacturers] just took any kind of plant material that is cheap," says Auwärter.

Going global

Starting in December 2008, countries including Austria and Switzerland banned the herbal incense. Auwärter's group and the BKA issued a press release about their findings in mid-January 2009. Within days, Germany banned CP 47,497 and its pharmacologically active homologues and JWH-018. France outlawed all of those compounds plus another synthetic cannabinoid, HU-210, in February 2009.

But spiked herbal incense is not just a European phenomenon. The U.S. Customs and Border Protection (CBP) announced in mid-January 2009 that it had seized herbal incense shown to contain HU-210. When CBP officers at the Ohio facility of an international express courier saw the dried plant material inside a shipment, they performed a field test for the presence of THC, but it was negative. Further analysis at the CBP laboratory in Chicago confirmed the presence of HU-210. Over a three-month period, CBP seized >100 lb of HU-210-laced herbal mixtures in five separate shipments. (Interestingly, a narcotics detector dog led authorities to the substance in at least one of the cases.)

Brett Sturgeon, a CBP public liaison officer, says that the agency has made seizures of this substance in other U.S. ports as well. And a couple of weeks after the CBP announcement, scientists at Japan's National Institute of Health Sciences published a paper in the *Chemical and Pharmaceutical Bulletin* (**2009**, *57*, 439–441) identifying the same C8 homologue of CP 47,497 in herbal incense; they did not report the presence of JWH-018 or the diastereomer that Auwärter's group found, however.

How do they do it?

Auwärter hypothesizes that the producers buy cannabinoids from laboratories in China or other countries that offer cheap organic syntheses, dissolve the compounds in a solvent, spray the solution on the plant material, and evaporate the solvent before packaging the herbal mixtures. At a price of 20–30 euros (~$25–40) for a 3-g packet, the incense is significantly more expensive

4-2

than marijuana. Nevertheless, its popularity has spread—probably in no small part because word travels quickly on the Internet.

How do the vendors sell so much of their product without getting caught? "I guess it's the same like with all these pharmaceutical products like Viagra that are sold over the Internet," Auwärter says. "They have a whole system of distribution. Commonly, they have a base overseas ... and from there, they send it from one country to the other. It's very difficult for national authorities to trace back the whole thing."

So the group next plans to do profiling experiments to help pinpoint the source(s) of the synthetic compounds. "Now, almost daily, we get new products which are also declared as herbal incense, with different names, different packaging.... Always, you have some plant material and sometimes you have cannabinoids that are already known," says Auwärter. "And of course, there are some products which do not contain any pharmacologically active compounds, which are just fakes." The researchers will also work on finding metabolites in urine that could be used to detect consumption, even days after the last intake. But with such a variety of synthetic cannabinoids, that will be a challenge. "Now that JWH-018 is controlled, then next on the market may be 'butyl-' or 'hexyl-' instead of 'pentyl-' and so on," says Auwärter. "[Tracing these compounds is] now a rat race."

—Christine Piggee

BILL FEUERBORN
REPRESENTATIVE 5TH DISTRICT
ANDERSON, FRANKLIN, MIAMI COUNTIES

STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
RANKING DEMOCRAT APPROPRIATIONS
MEMBER EDUCATION BUDGET
JOINT COMMITTEE ON STATE
BUILDING CONSTRUCTION
CAPITOL RESTORATION
CLAIMS AGAINST THE STATE

January 25, 2010

Chairman Colloton and Committee Members:

Thank you for allowing me to testify on HB 2412.

I was contacted by a gentleman last year about a problem he was having trying to get his daughter out of jail. She was terminally ill and had been in the hospital for about four (4) weeks. She was unable to walk or stand. A guard was stationed outside of her hospital room.

Mr. Droddy said, "Bill, all we want is for her to be able to die at home with her four children." Mr. Droddy told me that he and his wife had not had a relationship with their daughter for several years because of the bad decisions she had made. He said "we still love her - she is our daughter". I contacted Secretary Werholtz and he told me what he could and could not do. Sec. Werholtz was very helpful but our current laws were, I believe, made to take time for the process to work.

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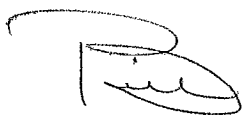
1-800-432-3924 JAN-APRIL
E-MAIL: bill.feuerborn@house.ks.gov

Corrections and Juvenile Justice
Date: 1-25-10
Attachment # 5

I believe it is time to have a process that is responsible but one that can be sped up if the illness dictates. I believe this bill would have all of the safe guards in it but would allow for a quicker process.

Mr. & Mrs. Droddy have left to spend a couple of months in Texas for the winter. They regret very much not being here today. They know this bill will not help their family but they hope no other family will have to go through what they did. They were able to bring their daughter home from the hospital via ambulance. She died the next day.



Rep. Bill Feuerborn

KANSAS
DEPARTMENT OF CORRECTIONS

Mark Parkinson, Governor
Roger Werholtz, Secretary

www.doc.ks.gov

Testimony on HB 2412
to
The House Corrections and Juvenile Justice Committee

By Roger Werholtz
Secretary
Kansas Department of Corrections
January 25, 2010

House Bill 2412 provides a procedure for the release of an inmate in the custody of the Department of Corrections who has a prognosis of dying within thirty days and who is determined to not pose a threat to the public. Currently, the Kansas Parole Board may grant release to a functionally incapacitated inmate who is determined to not pose a threat to the public pursuant to K.S.A. 22-3728. Under current law, the Parole Board may not grant the release until at least 30 days after notification of the application has been given to the prosecutor, court, victim or victim's family and publication in the local newspaper.

HB 2412 provides a procedure for the release of a terminally ill inmate who is not likely to survive the 30 day waiting period required by K.S.A. 22-3728. Both current law and HB 2412 require a finding that the release of the person does not represent a future risk to public safety. In order to implement the release of an inmate likely to die within 30 days in a timely manner, new section 2 of HB 2412 differs from current law:

- A single member of the Board may grant the release.
- Notification of the application is not provided but notification of the granting of the release is to be provided to the prosecutor, court, and victim or victim's family.
- Requiring the prognosis of imminent death by a Kansas doctor licensed to practice medicine and surgery as opposed to the functional incapacitation diagnosis by a medical or mental health practitioner.

The application for the release of a terminally ill inmate must be made by the Secretary of Corrections. Likewise, the release supervision by the Department of Corrections and revocation authority of the Parole Board for the terminally ill released offender is the same as for the functionally incapacitated released offender except that the release of the "terminally ill" offender may be revoked if the illness or condition significantly improves or the person does not die within 30 days.

Kansas County & District Attorneys Association
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Testimony in Support of HB 2451

House Corrections and Juvenile Justice Committee
January 25, 2010

Submitted by Thomas R. Stanton
Deputy Reno County District Attorney
Past-President, Kansas County and District Attorneys Association

Thank you Chairman Colloton and committee members for this opportunity to submit testimony in support of House Bill 2451. This legislation seeks to add benzylpiperazine (BZP) and 1 - (3 [triflouromethylphenyl]) piperazine (TFMPP) to Schedule I of the Uniform Controlled Substances Act. The legislation should be favorably considered by this committee.

BZP is a synthetic drug similar to MDMA (Ecstacy) which has become an increasingly abused drug in Kansas, especially in the urban areas. The DEA website states the drug is ten to twenty times more potent than amphetamine. The drug has already been listed as a schedule I drug on the federal level. Johnson County prosecutors have been encountering the drug on a frequent basis, including one situation in which a person was selling 100 BZP tablets at a time. The prosecutor was unable to prosecute under the uniform controlled substances act because the drug was not scheduled. The need to control BZP is great, and I would request passage of this legislation.

TFMPP is a clandestinely manufactured "Rave" drug, distributed primarily to juveniles and young adults. It has a stimulant effect similar to Ecstacy, but, when taken in greater amounts results in hallucinations. Persons using the drug often ingest large amounts to reach the level where hallucinations result, making the drug highly susceptible to overdose. This drug is also often mixed with BZP to enhance the affects of the BZP. TFMPP was briefly scheduled as a Schedule I drug in 2002 on an emergency basis, but was not permanently added to that schedule. The DEA reportedly intended that the drug be permanently added to Schedule I, but that has not been accomplished. The drug is currently listed as a Schedule I drug in Hawaii. It is controlled in New Zealand, Australia, Denmark and several other countries. Placing TFMPP in Schedule I has an added advantage - several other piperazines can be considered analogs of TFMPP, but not of BZP. I have attached a DEA News Release from March of 2003 for further information on this drug.

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These drugs have no recognized therapeutic value, and are quite addictive. The purpose of controlling such substances is to protect the health and welfare of the citizens of Kansas, and to protect the citizens from the societal consequences resulting from the use of such substances. The primary demographic group affected by the use of these substances appears to be the youth of this State, as is the case with ecstacy and other stimulant or hallucinogenic drugs.

We urge you to give favorable consideration to HB 2451. Thank you for the opportunity to address the committee on this subject and I would be happy to answer any questions.

News Release [print friendly page]
FOR IMMEDIATE RELEASE
March 21, 2003
Contact: S/A David Jacobson

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Safety Advisory Regarding New Club Drug "Molly"

Detroit, MI- Special Agents of the U.S. Drug Enforcement Administration (DEA) working with the Michigan State Police and local law enforcement agencies have recently discovered the presence of a new club drug that is being sold to high school and college age students at "Rave" parties throughout the Detroit and Ann Arbor areas. This substance is known on the street as "Molly", which is 1-(3-Trifluoromethylphenyl) piperazine (TFMPP).

This is an extremely dangerous drug, which is clandestinely manufactured and marketed in "Rave Clubs" as a more intense form of Ecstasy. This drug is an off-white powder generally sold in a gelatin capsule. TFMPP and Benzylpiperazine (BZP) were both given emergency controlled substance scheduling by the U.S. Drug Enforcement Administration in September 2002. TFMPP was given Schedule I status, meaning it has a high potential for abuse and no accepted medical use. This drug first appeared on the West Coast of the United States and these recent seizures in Michigan are the first indication of its presence in the metropolitan Detroit area. TFMPP also goes by the names "legal E", "legal X" or "A2". TFMPP can cause increased heart rate, blood pressure and body temperature.

"Molly" has properties similar to the stimulant effects of Ecstasy, but taken in larger doses it promotes hallucinogenic reactions. This poses an even greater risk to young adults who have taken Ecstasy previously and accidentally overdose by trying to achieve the hallucinogenic effects. DEA is currently conducting "Operation X-Out", which is a nationwide initiative to increase education and enforcement operations involving club and predatory drugs. Drug distributors have invaded the Internet with misinformation regarding the dangers of club and "date rape" drugs that are marketed toward young people. Effective information campaigns are essential to inform young Americans about club drugs such as GHB, Ecstasy, Ketamine and TFMPP, which are promoted by individuals who disguise their deadly effects.

"This is another example of individuals exploiting our young people with dangerous mixtures of chemicals that have the potential for deadly consequences. The DEA working closely with state and local law enforcement agencies, will do everything in our power to protect our children," said Michael A. Braun, Special Agent in Charge of the DEA Detroit Field Division.

####

For more information on club and predatory drugs visit the DEA (313) 234-4220 website at www.dea.gov

Kansas Association of Chiefs of Police
PO Box 780603
Wichita, KS 67278
(316)733-7301

Kansas Sheriffs Association
PO Box 1853
Salina, KS 67402
(785)827-2222

Kansas Peace Officers Association
PO Box 2592
Wichita, KS 67201
(316)722-8433

TESTIMONY TO THE KANSAS HOUSE OF REPRESENTATIVES CORRECTIONS AND JUVENILE JUSTICE COMMITTEE IN SUPPORT OF HB2451 ADDING BZP AND TFMPP TO SCHEDULE 1

January 25, 2010

The Kansas Association of Chiefs of Police, the Kansas Sheriffs Association, and the Kansas Peace Officers Association fully supports HB2451 placing BZP and TFMPP on the list of schedule 1 drugs. BZP has been on the DEA list of schedule 1 drugs since 2004.

BZP (benzylpiperazine) is a synthetic drug. It is a stimulant, producing effects comparable to amphetamines with euphoria and cardiovascular effects. It is a recreational drug with no legitimate medical use. Acute psychosis and seizures are reported side effects. It is generally ingested orally and the effects last from 6-8 hours.

TFMPP (Trifluoromethylphenylpiperazine) is a recreational drug most commonly used with BZP. When added to BZP it produces effects very much like MDMA (Ecstacy). While it is sometimes sold as a legal alternative to MDMA, (street named "Legal-X") when used by itself it has common and dreadful side effects including vomiting, headaches, muscle aches, and anxiety. TFMPP by itself produces a hallucinogenic effect. It is not used medically.

These drugs of abuse are most commonly used by teenagers and young adults. They are often used in party settings much the same as MDMA. We are seeing these drugs more and more in Kansas, usually in the combination form and most often in the metropolitan areas.

Adding them to the state drug schedule will allow law enforcement to take action on these drugs when found in quantities insufficient for federal prosecution.

We encourage you to add these two drugs of abuse to schedule 1 as proposed in HB2451. This can be accomplished either through this bill or by combining HB2411 and HB2451 and report the resulting bill favorably for passage.

Ed Klumpp

Ed Klumpp
Ks Association of Chiefs of Police - Legislative Committee Chair
Ks Peace Officers Association – Legislative Liaison
Ks Sheriffs Association – Legislative Liaison
eklumpp@cox.net
Phone: (785)640-1102

Corrections and Juvenile Justice
Date: 1-25-10
Attachment # 8

KANSAS

BOARD OF PHARMACY
DEBRA L. BILLINGSLEY, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

January 22, 2010

The Honorable Pat Colloton
Corrections and Juvenile Justice Committee
Capitol Building
Room 151-S
Topeka, KS 66603

RE: HB 2451

Dear Madam Chair:

Last year the Board submitted a recommendation concerning the classification of substance N-Benzylpiperazine (BZP) as a schedule I controlled substance for purposes of the Kansas Controlled Substance Act.[1] The Legislature did not schedule BZP in 2009 so the Board recommended that the Legislature classify BZP as a schedule I controlled substance in 2010.

The U.S. Drug Enforcement Administration (DEA) classified this substance as a schedule I controlled substance in 2004. See, 21 C.F.R. 1308(f)(2). In proposing to the Legislature that BZP be classified as a schedule I controlled substance, the Board relies on the following factors set forth in K.S.A. 65-4102(b) and the information provided by the DEA's Acting Deputy Administrator based on recommendation by the Department of Health and Human Services and DEA as reported in the Federal Register, 69 Fed. Reg. 12794 (March 18, 2004)(attached hereto as Exhibit A).

I. Potential for abuse.

BZP has a high potential for abuse, BZP has no legitimate medical use in the state of Kansas, and the use by individuals for the psychoactive effects it produces is considered abuse.

[1] The Board has taken action at the request of law enforcement and pursuant to K.S.A. 65-4102(e) to schedule BZP by regulation. Notwithstanding, the Board believes the Legislature should take action to include BZP among the substances listed in K.S.A. 65-4105.

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LANDON STATE OFFICE BUILDING, 900 SW JACKSON STREET, ROOM 560, 1
Phone 785-296-4056 Fax 785-296-8420 www.kansas.gov/pharmacy pharmacy@pharmacy.ks.gov

II. Scientific evidence of BZP's pharmacological effect.

The available scientific evidence regarding BZP suggests that the pharmacological effects of BZP are substantially similar to amphetamine. BZP has no legitimate medical. BZP acts as a stimulant in humans and produces euphoria and cardiovascular changes including increases in the heart rate and systolic blood pressure. The effects of BZP in amphetamine-trained monkeys suggest that BZP can be up to 20 times more potent than amphetamine in producing these effects.

III. State of current knowledge regarding BZP.

BZP is likely to share the same public health risks as amphetamine. The risks to the public health associated with amphetamine abuse as well known. Both the DEA and the Department of Health and Human Services have found that sufficient scientific, trafficking and abuse data exists to place BZP in schedule I.

IV. History and current pattern of abuse.

Stimulant/hallucinogenic substances have been a major problem in Europe since the early 1900's. BZP was first reported in the U.S. in late 1996 in California. BZP has increasingly been found in similar venues as the popular club drug MDMA, also known as Ecstasy. BZP is sold as an alternative to MDMA and is targeted to youth populations and has been encountered in powder and tablet form and sold on the Internet. BZP is popular at all night parties, including raves. BZP is a concern of the KBI and was recently discovered in Geary, Jackson, and Douglas Counties.

V. Scope, duration and significance of abuse.

The abuse of stimulant/hallucinogenic substances including MDMA and its analogues has been associated with acute and long-term public health and safety problems. The raves have also become venues for the trafficking and abuse of other controlled substances. The Acting Deputy Administrator of the DEA found that BZP has a high potential for abuse, has no currently accepted medical use in treatment in the United States, and lacks accepted medical safety for use under medical supervision.

VI. Risk to public health.

BZP has no accepted medical use in treatment in the United States. BZP poses the same well known risks to the public health associated with amphetamine abuse.

VII. Potential of BZP to produce psychological or physiological dependence liability.

"Stimulants, including BZP decrease appetite, dilate pupils, and increase blood pressure and heart and respiration rates. Other effects include anxiety, blurred vision,

dizziness, and insomnia. Chronic abuse of stimulants can cause irregular heartbeat and can lead to delusions, hallucinations, and paranoia.

VIII. Whether the substance is an immediate precursor of a substance already controlled under the Kansas Controlled Substance Act.

The risks associated with BZP abuse are similar to those associated with amphetamine abuse. BZP is often used at raves, nightclubs, private parties, and other venues where the use of other controlled substances, e.g., club drugs such as MDMA, is well established.

If I can provide further information please feel free to contact me.

Sincerely,

Debra Billingsley

Debra L. Billingsley
Executive Secretary

FR Doc 04-6110 [Federal Register: March 18, 2004 (Volume 69, Number 53)] [Rules and Regulations] [Page 12794-12797] From the Federal Register Online via GPO Access [wais.access.gpo.gov] [DOCID:fr18mr04-7]

DEPARTMENT OF JUSTICE
Drug Enforcement Administration
21 CFR Part 1308
[Docket No. DEA-247F]
Schedules of Controlled Substances; Placement of 2,5-Dimethoxy-4- (n)-propylthiophenethylamine and N-Benzylpiperazine Into Schedule I of the Controlled Substances Act
AGENCY: Drug Enforcement Administration (DEA), Department of Justice.
ACTION: Final rule.

SUMMARY: This final rulemaking is issued by the Acting Deputy Administrator of the Drug Enforcement Administration (DEA) to place 2,5-dimethoxy-4-(n)-propylthiophenethylamine (2C-T-7) and N- benzylpiperazine (BZP) into Schedule I of the Controlled Substances Act (CSA). This action by the DEA Acting Deputy Administrator is based on a scheduling recommendation by the Department of Health and Human Services (DHHS) and a DEA review indicating that 2C-T-7 and BZP meet the criteria for placement in Schedule I of the CSA. This final rule will continue to impose the regulatory controls and criminal sanctions of Schedule I substances on the manufacture, distribution, and possession of 2C-T-7 and BZP.
EFFECTIVE DATE: March 18, 2004.
FOR FURTHER INFORMATION CONTACT: Christine A. Sannerud, Ph.D., Chief, Drug and Chemical Evaluation Section, Office of Diversion Control, Drug Enforcement Administration, Washington, DC 20537, Telephone (202) 307- 7183.
SUPPLEMENTARY INFORMATION: On September 20, 2002, the Deputy Administrator of the DEA published two separate final rules in the Federal Register (67 FR 59161 and 67 FR 59163) amending Sec. 1308.11(g) of Title 21 of the Code of Federal Regulations to temporarily place 2C-T-7, BZP and TFMPP (1-(3-trifluromethylphenyl)piperazine into Schedule I of the CSA pursuant to the temporary scheduling provisions of 21 U.S.C. 811(h). These final rules, which became effective on the date of publication, were based on findings by the Deputy Administrator that the temporary scheduling of BZP, TFMPP and 2C-T-7 was necessary to avoid an imminent hazard to the public safety. Section 201(h)(2) of the CSA (21 U.S.C. 811(h)(2)) requires that the temporary scheduling of a substance expires at the end of one year from the effective date of the order. However, if proceedings to schedule a substance pursuant to 21 U.S.C 811(a)(1) have been initiated and are pending, the temporary scheduling of a substance may be extended for up to six months. On September 8, 2003, the Administrator published a notice of proposed rulemaking in the Federal Register (68 FR 52872) to place BZP, TFMPP and 2C-T-7 into Schedule I of the CSA on a permanent basis. The temporary scheduling of BZP, TFMPP and 2C-T-7 which would have expired on September 19, 2003, was extended to March 19, 2004 (68 FR 53289). One comment was received regarding the proposed placement of these substances in Schedule I of the CSA.
The DEA has gathered and reviewed the available information regarding the pharmacology, chemistry, trafficking, actual abuse, pattern of abuse and the relative potential for abuse for 2C-T-7, BZP and TFMPP. The Administrator has submitted these data to the Assistant Secretary for Health, Department of Health and Human Services (DHHS). In accordance with 21 U.S.C. 811(b), the Administrator also requested a scientific and medical evaluation and a scheduling recommendation for 2C-T-7, BZP and TFMPP from the Assistant Secretary of DHHS. On March 10, 2004, the Acting Assistant Secretary for Health recommended that 2C-T-7 and BZP be permanently controlled in Schedule I of the CSA. However, under recommendation of the Food and Drug Administration (FDA) and a scientific evaluation of the National Institute on Drug Abuse (NIDA), the DHHS did not recommend control of TFMPP. Accordingly, TFMPP will no longer be controlled under the CSA after March 19, 2004.
BZP is a piperazine derivative. This substance has not been evaluated or approved for medical use in the U.S. The available scientific evidence suggests that the pharmacological effects of BZP are substantially similar to amphetamine.
BZP is self-administered by monkeys maintained on cocaine and fully generalizes to amphetamine's discriminative stimulus in monkeys. The effects of BZP in amphetamine-trained monkeys strongly suggest that BZP will produce amphetamine-like effects in humans. BZP acts as a stimulant in humans and produces euphoria and cardiovascular changes including increases in heart rate and systolic blood pressure. BZP is about 20 times more potent than amphetamine in producing these effects. However, in subjects with a history of amphetamine dependence, BZP was found to be about 10 times more potent than amphetamine. The risks to the public health associated with amphetamine abuse are well known and documented. BZP is likely to share these same public health risks.

The abuse of BZP was first reported in late 1996 in California. Since that time, the DEA, state and local law enforcement agencies have encountered BZP in California, Connecticut, Florida, Illinois, Indiana, Iowa, Louisiana, Minnesota, Missouri, Nevada, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, Washington, DC, and Wisconsin. Since 2000, there have been 83 cases involving the seizure of nearly 18,000 BZP tablets and over 600,000 grams of BZP powder. Seizures involving the combination of TFMPP and BZP include over 55,000 tablets and over 80 grams of powder.

BZP has increasingly been found in similar venues as the popular club drug MDMA (also known as Ecstasy). BZP, often in combination with TFMPP, is sold as MDMA, promoted as an alternative to MDMA and is targeted to the youth population. BZP (alone or in combination with TFMPP) has been encountered in powder and tablet form and sold on the Internet.

2C-T-7 is the sulfur analogue of 4-bromo-2,5- dimethoxyphenethylamine (2CB) and shares structural similarity with other Schedule I phenethylamine hallucinogens including 2,5-dimethoxy- 4-methylamphetamine (DOM) and 1-(4-bromo-2,5-dimethoxyphenyl)-2- aminopropane (DOB). Based on its structural similarity to 2CB, one would expect 2C-T-7's pharmacological profile to be qualitatively similar to 2CB.

2C-T-7 is abused for its action on the central nervous system (CNS), and for its ability to produce euphoria with 2CB-like hallucinations. 2C-T-7 has not been approved for medical use in the United States by the FDA and the safety of this substance for use in humans has never been demonstrated.

Drug discrimination studies in animals indicate that 2C-T-7 is a psychoactive substance capable of producing hallucinogenic-like discriminative stimulus effects (i.e., subjective effects). 2C-T-7's subjective effects were shown to share some commonality with LSD; it partially substituted for LSD up to doses that severely disrupted performance in rats trained to discriminate LSD. In rats trained to discriminate DOM, 2C-T-7 fully substituted for DOM and was slightly less potent than 2CB in eliciting DOM-like effects. The ability of 2C- T-7 to function as a discriminative stimulus has been evaluated in rats trained to discriminative 1.0 mg/kg of 2C-T-7 from saline. After stimulus control was established, 2C-T-7, 2CB (0.6, 1.0, and 2.0 mg/Kg) and LSD (0.1 mg/kg) were substituted for 2C-T-7. Results suggest that both 2CB and LSD share 2C-T-7-like discriminative stimulus effects. 2CB generalized to the 2C-T-7 stimulus cue; 96 percent 2C-T-7-appropriate responding was observed. LSD elicited 95 percent 2C-T-7-appropriate responding.

The subjective effects of 2C-T-7, like those of 2CB and DOM, appear to be mediated through central serotonin receptors. 2C-T-7 selectively binds to the 5-HT receptor system. Users indicate that the hallucinogenic effects of 2C-T-7 are comparable to those of 2CB and mescaline.

The abuse of stimulant/hallucinogenic substances in popular all night dance parties (raves) and in other venues has been a major problem in Europe since the 1990s. In the past several years, this activity has spread to the United States. MDMA and its analogues, are the most popular drugs abused at these raves. Their abuse has been associated with both acute and long-term public health and safety problems. These raves have also become venues for the trafficking and abuse of other controlled substances. 2C-T-7 has been encountered at raves in Wisconsin, California, and Georgia.

The abuse of 2C-T-7 by young adults in the United States began to spread in the year 2000. Since that time, 2C-T-7 has been encountered by law enforcement agencies in Wisconsin, Texas, Tennessee, Washington, Oklahoma, Georgia, and California. 2C-T-7 has been purchased in powder form over the Internet and distributed as such. In the United States, capsules containing 2C-T-7 powder have been encountered.

2C-T-7 can produce sensory distortions and impaired judgment can lead to serious consequences for both the user and the general public. To date, three deaths have been associated with the consumption of 2C- T-7 alone or in combination with MDMA. The first death occurred in Oklahoma during April of 2000; a young healthy male overdosed on 2C-T-7 following intranasal administration. The other two 2C-T-7 related deaths occurred in April 2001 and resulted from the co-abuse of 2C-T-7 with MDMA. One young man died in Tennessee while another man died in the state of Washington. In 2002, law enforcement data identified an Internet site that sold 2C-T-7. This site was traced to individual in Indiana who had been selling large quantities of this substance since January 2000. Sales through this Internet site were thought to be the major source of this drug in the U.S. After further investigation, one clandestine laboratory was identified in Las Vegas, Nevada who was the supplier of 2-C-T-7 for the individual in Indiana.

The DEA received one comment from an organization in response to the proposed placement of 2C-T-7, BZP and TFMPP into Schedule I of the CSA. This organization did not support the proposed placement of these drugs into Schedule I on the following basis: (1) They felt insufficient data exists to support placement into Schedule I as the mere use of these substances was not abuse and (2) Prohibiting the possession of these substances is a substantial infringement of the fundamental right of adults to freedom of thought. Both the DEA and the DHHS have found that sufficient scientific, trafficking and abuse data, as summarized herein, does exist to place 2C-T-7 and BZP in

Schedule I of the CSA on a permanent basis. As these substances have no legitimate medical use in the U.S., the trafficking in, and use by individuals for the psychoactive effects they produce, is considered abuse. In addition, the control of these substances in Schedule I of the CSA does not violate any legally protected right.

Based on all the available information gathered and reviewed by the DEA and in consideration of the scientific and medical evaluation and scheduling recommendation by the Assistant Secretary of the DHHS, the Acting Deputy Administrator has determined that sufficient data exist to support the placement of 2C-T-7 and BZP into Schedule I of the CSA pursuant to 21 U.S.C. 811(a). The Acting Deputy Administrator finds:

(1) 2C-T-7 and BZP have a high potential for abuse.

(2) 2C-T-7 and BZP have no currently accepted medical use in treatment in the United States.

(3) 2C-T-7 and BZP lack accepted medical safety for use under medical supervision.

In accordance with 21 U.S.C. 811(h)(5), the Acting Deputy Administrator hereby vacates the orders temporarily placing 2C-T-7, BZP and TFMPP into Schedule I of the CSA published in the Federal Register on September 20, 2002.

The Acting Deputy Administrator of the DEA hereby certifies that the placement of 2C-T-7 and BZP into Schedule I of the CSA will have no significant impact upon entities whose interests must be considered under the Regulatory Flexibility Act, 5 U.S.C. 601 et seq. This action involves the control of two substances with no currently accepted medical use in the United States.

This final rule is not a significant regulatory action for the purposes of Executive Order (E.O.) 12866 of September 30, 1993. Drug Scheduling matters are not subject to review by the Office of Management and Budget (OMB) pursuant to provisions of E.O. 12866, section 3(d)(1).

This action has been analyzed in accordance with the principles and criteria in E.O. 13132, and it has been determined that this rulemaking does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Regulatory Requirements

With the issuance of this final order, 2C-T-7 and BZP continue to be subject to regulatory controls and administrative, civil and criminal sanctions applicable to the manufacture, distribution, dispensing, importing and exporting of a Schedule I controlled substance, including the following:

1. Registration. Any person who manufactures, distributes, dispenses, imports or exports 2C-T-7 and BZP or who engages in research or conducts instructional activities with respect to 2C-T-7 and BZP or who proposes to engage in such activities must submit an application for Schedule I registration in accordance with part 1301 of Title 21 of the Code of Federal Regulations (CFR).

2. Security. 2C-T-7 and BZP are subject to Schedule I security requirements and must be manufactured, distributed and stored in accordance with Sec. Sec. 1301.71, 1301.72(a), (c), and (d), 1301.73, 1301.74, 1301.75 (a) and (c) and 1301.76 of Title 21 of the Code of Federal Regulations.

3. Labeling and Packaging. All labels and labeling for commercial containers of 2C-T-7 and BZP which are distributed on or after April 19, 2004, shall comply with requirements of Sec. Sec. 1302.03-1302.07 of Title 21 of the Code of Federal Regulations.

4. Quotas. Quotas for 2C-T-7 and BZP are established pursuant to Part 1303 of Title 21 of the Code of Federal Regulations.

5. Inventory. Every registrant required to keep records and who possesses any quantity of 2C-T-7 and BZP is required to keep an inventory of all stocks of the substances on hand pursuant to Sec. Sec. 1304.03, 1304.04 and 1304.11 of Title 21 of the Code of Federal Regulations. Every registrant who desires registration in Schedule I for 2C-T-7 and BZP shall conduct an inventory of all stocks of 2C-T-7 and BZP.

6. Records. All registrants are required to keep records pursuant to Sec. Sec. 1304.03, 1304.04 and Sec. Sec. 1304.21-1304.23 of Title 21 of the Code of Federal Regulations.

7. Reports. All registrants required to submit reports in accordance with Sec. 1304.31 through Sec. 1304.33 of Title 21 of the Code of Federal Regulations shall do so regarding 2C-T-7 and BZP.

8. Order Forms. All registrants involved in the distribution of 2C- T-7 and BZP must comply with the order form requirements of part 1305 of Title 21 of the Code of Federal Regulations

9. Importation and Exportation. All importation and exportation of 2C-T-7 and BZP must be in compliance with part 1312 of Title 21 of the Code of Federal Regulations.

10. Criminal Liability. Any activity with 2C-T-7 and BZP not authorized by, or in violation of, the Controlled Substances Act or the Controlled Substances Import and Export Act occurring on or after March 18, 2004, will

continue to be unlawful.

List of Subjects in 21 CFR Part 1308

Administrative practice and procedure, Drug traffic control, Reporting and recordkeeping requirements.

- Under the authority vested in the Attorney General by Section 201(a) of the CSA (21 U.S.C. 811(a)), and delegated to the Administrator of the DEA by the Department of Justice regulations (28 CFR 0.100) and re-delegated to the Deputy Administrator pursuant to 28 CFR 0.104, the Acting Deputy Administrator amends 21 CFR Part 1308 as follows:

PART 1308--SCHEDULES OF CONTROLLED SUBSTANCES

- 1. The authority citation for Part 1308 continues to read as follows:

Authority: 21 U.S.C. 811, 812, 871(b) unless otherwise noted.

- 2. Section 1308.11 is amended by:
- A. Removing paragraphs (g)(3), (4) and (5) and redesignating paragraphs (g)(6) and (7) as (g)(3) and (4) respectively;
- B. Redesignating existing paragraphs (d)(6) through (d)(31) as paragraphs (d)(7) through (d)(32) respectively;
- C. Adding a new paragraph (d)(6),
- D. Redesignating existing paragraphs (f)(2) through (f)(7) as paragraphs (f)(3) through (f)(8) respectively; and
- E. Adding a new paragraph (f)(2) to read as follows:

Sec. 1308.11 Schedule I.

* * * * *

(d) * * *

(6) 2,5-dimethoxy-4-(n)-propylthiophenethylamine (other name: 2 2C-T-7) 7348

* * * * *

(f) * * *

(2) N-Benzylpiperazine (some other names: BZP, 1- benzylpiperazine) 7493

Dated: March 15, 2004.

Michele M. Leonhart,

Acting Deputy Administrator.

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9-7

Understanding and Applying Virginia's New Statutory Civil Commitment Criteria

by

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In 2008, Virginia's General Assembly enacted significant amendments to the Commonwealth's civil commitment statute, based on the recommendations of the Commission on Mental Health Law Reform (the "Commission"). This document is designed to review the statutory language that modified the civil commitment criteria, provide examples of how the new language in the statute might be applied, and promote a common understanding of the commitment criteria across the Commonwealth.

I. Background

Previous commitment criteria (from § 37.2-817B):[1]

> "After observing the person and obtaining the necessary positive certification and considering any other relevant evidence that may have been offered,
>
> if the judge or special justice finds by clear and convincing evidence that
>
> > (i) **the person presents an imminent danger to himself or others as a result of mental illness OR has been proven to be so seriously mentally ill as to be substantially unable to care for himself** and . . .
> >
> > (ii) ... there is no less restrictive alternative to involuntary inpatient treatment,
>
> the judge or special justice shall order that the person be admitted involuntarily to a facility for a period of treatment not to exceed 180 days ..."

New commitment criteria (from § 37.2-817C):

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[1] Under the old and new versions of the statute, the same criteria apply to involuntary admission to a facility for inpatient treatment and to mandatory outpatient treatment as a less restrictive alternative to inpatient treatment. The quoted portions of the statute pertain to involuntary admission to a facility.

The revised statute amended the language of both prongs of the previous civil commitment criteria. The new statute provides the following (several key phrases discussed below are in **bold**):

> "After observing the person and considering (i) the recommendations of any treating physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person, (iii) any past mental health treatment of the person, (iv) any examiner's certification, (v) any health records available, (vi) the preadmission screening report, and (vii) any other relevant evidence that may have been admitted,
>
> if the judge or special justice finds by clear and convincing evidence that
>
> > (a) **the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future,**
> >
> > > (1) **cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, OR**
> >
> > > (2) **suffer serious harm due to his lack of capacity** to **protect himself from harm or to provide for his basic human needs**, and . . .
> >
> > (b) all available less restrictive treatment alternatives to involuntary inpatient treatment have been ... determined to be inappropriate,
>
> the judge or special justice shall order that the person be admitted involuntarily to a facility for a period of treatment not to exceed 30 days ..."

Why were the civil commitment criteria revised?

The 2008 General Assembly made several changes to the civil commitment legislation designed to address two key problems.

- First, research conducted by the Commission documented striking variations on civil commitment procedures and outcomes throughout the Commonwealth.[2] This variability raises serious questions of fairness as well as how well the state was addressing the

[2] The Commission conducted an interview study of 210 stakeholders and participants in the commitment process in Virginia. The report of that study, entitled *Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations*, was issued in April 2007. The study is available at http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf. A second major research project was a study of commitment hearings and dispositions (the "Commission's Hearings Study"). In response to a request by the Chief Justice, the special justice or district judge presiding in each case filled out a 2-page instrument on every commitment hearing held in May 2007. (There were 1,526 such hearings). The Commission's Hearings Study can be found at http://www.courts.state.va.us/cmh/2007_05_civil_commitment_hearings.pdf.

needs of persons with serious mental illness. It also suggested the need for greater statutory specificity to guide the various professionals involved with civil commitment proceedings.

- Second, the phrase "imminent danger" to oneself or others (used in the previous statute) was widely regarded as unduly restrictive.

To promote more uniform application of the civil commitment criteria as well as broadening the circumstances that could lead to civil commitment, the General Assembly modified the criteria for civil commitment based on proposals recommended by the Commission. [3]

What is the expected impact of these changes?

Some have expressed concerns that the changes in the criteria will significantly increase the number of requests for ECOs and TDOs and the number of petitions, hearings and commitment orders. Obviously, we will have to wait and see what happens, but a substantial increase in such proceedings or in commitment orders appears unlikely to occur in our opinion. For one thing, empirical research in other states has repeatedly shown that changes in the wording of commitment criteria, standing alone, are not associated with major changes in the number or rate of commitment orders. This finding is generally thought to indicate that the major determinants of involuntary hospitalization rates are system and resource factors, such as number of available beds and the availability of suitable alternatives to hospitalization, not the legal criteria for commitment. If outcomes change as a result of modifying statutory criteria, these changes are at likely to occur at the margins.

Second, the changes enacted by the General Assembly in 2008 may have the effect in many localities of tightening the current criteria in some respects while loosening them in others, adding further support to the idea that the overall impact of these changes will be felt at the margins in close cases rather than in a wholesale lowering of the threshold for involuntary treatment. Third, incremental increases in funding for crisis stabilization programs and outpatient services should help, over time, to reduce pressure on the commitment process as these services come on line. It would be gratifying if those outcomes begin to emerge in the coming year.

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[3] Based on its research and the reports of its Task Forces and Working Groups, the Commission issued its *Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform* ("Preliminary Report") in December, 2007. The Preliminary Report, which is available on-line at http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf, outlined a comprehensive blueprint for reform ("Blueprint") and identified specific priorities for consideration by Virginia's General Assembly in 2008.

Finally, one key source of uncertainty about the effect of the 2008 reforms concerns the new provisions relating to mandatory outpatient treatment (MOT) orders. Even though MOT is still available only as a less restrictive alternative for people who meet the inpatient commitment criteria, the detailed new procedures under the statute are likely to lead to more such orders than were issued under the prior statute. (In May, 2007, such orders were entered in about 6% of hearings, mostly in a few jurisdictions). However, the effect of any increase in the number of MOT orders on the number of in-patient commitments remains to be seen.

II. Some Considerations Regarding the Meaning of the New Language

One of the major goals of the civil commitment reforms adopted in 2008 is to promote more consistent interpretation of the law throughout the Commonwealth. In order to help achieve that goal, the Supreme Court and the Department of Mental Health, Mental Retardation and Substance Abuse Services intend to conduct ongoing training activities for all participants in the process. The purpose of this paper is to highlight key questions that can be expected to arise concerning the meaning of the civil commitment criteria and, on occasion, to offer some opinions regarding the interpretation intended by the General Assembly.

1. A necessary condition for involuntary commitment under the both the previous and revised statute is the finding that **the person has a "mental illness"** and that he or she presents a **risk of harm "as a result of mental illness."** Although this statutory language remains unchanged, promoting a common understanding of the meaning of this language will support more uniform application of the statute. As a result, it is important to review some of the conditions that might affect a determination of whether an individual has a mental illness and is covered by the civil commitment statute in the first place.

Like most state commitment statutes, Virginia's commitment statute defines "mental illness" relatively broadly to mean "a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others" (Section 37.2-100). In general terms, any psychiatric diagnosis of a major mental disorder that is listed in Axis I of the American Psychiatric Association's diagnostic manual (DSM-IV-TR) would meet this definition. (Axis I basically includes all mental disorders except personality disorders and mental retardation, including schizophrenia, bipolar disorder, depression, anxiety disorders, and eating disorders.) It must be remembered, though, that even if a person has a mental illness, the symptoms must be severe enough to meet the above definition. For example, the symptoms of depression (such as sadness, nihilistic thinking, suicidal thoughts, and cognitive impairment) in major depressive disorder can range in severity, from being so mild that the individual is able to continue to meet all social and occupational demands to being so severe that the individual is acutely psychotic or catatonic. In addition, some mental illnesses (such as panic disorder) can present with symptoms that are more

circumscribed, such that they are severe but nonetheless do not impair judgment, behavior, the capacity to recognize reality, etc. Therefore, an individual would *not* be subject to civil commitment *unless* (1) he or she has a mental illness, (2) the symptoms of the illness are significant enough to impair the individual's functioning as described above, and (3) he or she presents a risk of harm, specifically "as a result of mental illness" (as opposed to posing a chronic threat of harm for unrelated reasons).

Issues that sometimes arise in assessing whether some action is "a result of mental illness" are whether a person whose primary diagnosis is personality disorder, substance abuse or dependence, or certain neurological conditions has a "mental illness" and meets the threshold required for the civil commitment statute. Consider the following examples:

- ***Personality disorders***. The issue of personality disorder is an important one. A severe personality disorder, such as borderline personality disorder, is associated with marked instability in interpersonal relationship, self-image, moods, and impulse-control. While most individuals with the diagnosis of borderline personality disorder are treated as outpatients, during periods of interpersonal crisis and/or in the context of other superimposed psychiatric problems such as mood disorder or substance abuse, they pose an increased risk of engaging in potentially harmful behavior toward themselves or others. Twenty percent of psychiatric inpatients meet the diagnostic criteria for borderline personality disorder, and 10% of individuals with borderline personality disorder ultimately die by suicide. An individual with more a severe form of personality disorder who is experiencing impairment in "judgment, behavior, capacity to recognize reality, or ability to address basic life necessities," therefore. would be potentially appropriate for civil commitment. However, if the personality disorder contributes to a chronically increased risk of engaging in violent behavior (but the increased risk is not attributable to the types of impairment just mentioned, as is the case for many individuals with antisocial personality disorder), the person would not be appropriate for civil commitment.

- ***Substance-related disorders***. The fact that an individual has a history of or current substance-related disorder (alcohol or drug abuse or dependence) would not in itself constitute a basis for civil commitment. However, chronic substance use, acute substance intoxication, and/or substance withdrawal all constitute important risk factors in assessing an individual's risk either of causing serious physical harm to himself or others or suffering serious harm due to a lack of capacity to protect himself from harm or provide for his basic human needs. As with mood disorders, anxiety disorders, or psychotic disorders, the symptoms of substance-related disorders occur along a continuum of severity, from non-problematic social drinking to "problem drinking" and ultimately all the way to severe substance addiction. Substance abuse in its more severe forms can

cause mood swings similar to those seen in major depressive disorder (including hopelessness and suicidal ideation), can cause psychotic symptoms (including voices telling one to kill himself), and can cause cognitive impairment as severe as that seen in other forms of dementia. In addition, other psychiatric illnesses, such as mood disorders, psychotic disorders, or personality disorders, can be dramatically exacerbated by substance abuse. In summary: A person's "status" as a substance abuser per se is not a sufficient predicate for commitment but (a) acute and chronic medical complications of drinking could lead to an increased risk a harm to oneself or others, and (b) substance abuse can complicate other psychiatric illnesses, thereby contributing to an increased risk of violence.

- ***Medical conditions with psychiatric features.*** Another important point to consider relates to the relation between mental and physical disorders, such as Alzheimer's disease. Medical conditions and psychiatric diagnoses are not mutually exclusive under the modern understanding that mental illnesses (the more severe ones at least) have a biological basis. Alzheimer's disease or brain injury would qualify as a mental illness under the commitment statute if the patient has impaired "judgment, behavior, capacity to recognize reality, or ability to address basic life necessities." The issue sometimes presented in these cases is whether a mental health facility is the proper placement for a person with a neurological or other medical condition with psychiatric features. In practice, such patients are admitted to acute care psychiatric hospitals when they are (1) medically stable enough to be managed on a psychiatric unit rather than a medical unit and (2) when the primary problem leading to admission is emotional or behavioral problems that need to be addressed, similar to any other mental illness being admitted. Sometimes, the primary treatment provided to such an individual while on the psychiatric unit is medical. For example, it is quite common for Alzheimer's patients in a nursing home to acutely become more agitated and to be admitted to a psychiatric unit. Rather than simply starting medications to treat the agitation, the first step of treatment is to elucidate the cause. Often a medical problem such as a bladder infection is enough to trigger worsening of cognitive impairment and increased aggression and the primary treatment is to prescribe an antibiotic rather than a psychotropic medication. Even though this is "medical care," it's a part of overall psychiatric treatment. So, psychiatric treatment is defined by the nature of the presenting complaints and not whether the underlying cause is medical or psychiatric. The decision about whether care should be delivered on a medical unit or a psychiatric unit is a medical triage decision based on where treatment can most safely be provided, rather than simply a categorical distinction with a bright line. For example: Does the patient require intensive medical monitoring due to medical instability? Is the patient an elopement risk who would best be treated on a locked psychiatric unit rather than an open medical unit?

Once an individual is found to meet the threshold of having a "mental illness" under the civil commitment statute, the criteria for commitment must then be applied to the facts of the case to determine the appropriate course of action.

2. The revised statute replaces the term "imminent danger to himself or others" with the phrase **"substantial likelihood that . . . he or she will cause serious physical harm to himself or others...."**

The basis for this change was that the term "danger" was considered to be excessively vague on two crucial grounds. First, it provided no indication of how likely the anticipated harm must be. Second, it provided no indication of how serious that harm must be in order for commitment to be justified. In contrast, the revised statutory language specifies that the harm must have a "substantial likelihood" of occurring (not just any likelihood, no matter how small). In other words, the potential harm to oneself or others must be regarded as probable, not simply possible. In this section of the statute, the new language also specifies that the harm must be of a "serious physical" nature -- trivial injury or emotional harm will not qualify. But neither is it necessary that the predicted harm be lethal, as in suicide or homicide.

The revised statute does not spell out a specific percentage risk as to what would constitute a "substantial likelihood," and this remains a legal term of art. Nor does the statute specify or define the level of injury to oneself or others that would amount to "serious" physical harm. In actual practice, clinicians and legal decision-makers tend to employ a sliding scale model, in which the more serious the harm, the lower its likelihood needs to be in order to trigger civil commitment.

Example: Suppose the clinician is evaluating a patient with a likely diagnosis of borderline personality disorder who recently has cut himself superficially on the forearm. The clinician is aware that this patient has cut himself repeatedly over the years in order to relieve tension -- without suicidal intent or major personal injury. Under these circumstances, the clinician might reach the conclusion that there is a very high likelihood that the patient will cause physical harm to himself in the near future, but that there does not appear to be a substantial likelihood of *serious* physical harm.

However, suppose this same individual, following a recent relationship breakup, cuts himself more deeply, to the point that sutures were required, and also overdoses on medications. Suppose further that, in the emergency room, he describes having few social supports and describes his outlook as still being pretty hopeless. He then declines voluntary hospitalization and says that his actions

were impulsive and that he "thinks he'll be safe at home." Now the examiner is seriously concerned about the risk of *serious* physical harm. He feels that it is not a remote risk, but that it is difficult to quantify. When pushed to make a "ballpark" estimate, he says that there probably is about a one-in-four risk of another such incident occurring over the next few days. Is this a "substantial likelihood" of serious harm? What if he said one-in-five? One-in-ten? What level of risk of this kind of harm warrants involuntary hospitalization?

Another example: Suppose a man gets into an argument with his wife and then shoots himself in the chest? In the Intensive Care Unit (once off of the ventilator and able to speak), he reports that he was very angry at his wife and just "wanted to get her attention" by pointing the loaded gun at his chest, but that the gun then went off accidentally. Let us assume that the evaluator concludes that the patient is telling the truth, that the patient was and remains seriously depressed, and that his risk that he will engage in another act of serious self harm over the next few days is about one-in-ten. Given the severity of his recent self-harm, however, should this risk be considered a substantial enough likelihood of harm to justify involuntary hospitalization, at least for a day or two of further assessment?

Our Opinion: Admittedly, the examples are a bit artificial because clinicians do not have the ability to make quantitative probability estimates as precise as "one-in-four" or "one-in-ten" in these situations; at best, they are able to sort cases into risk levels based on qualitative clinical judgments. However, it is useful heuristically to attach probability estimates to such qualitative judgments. In our view, a "one-in-four" estimated risk of serious harm in the near future is sufficient, particularly when the harm being threatened is potentially fatal, as opposed to cutting, burning, or punching oneself. A "substantial risk" is *not* meant to mean "more likely than not" (51%). On the other hand, a very remote chance of serious harm is not sufficient. The estimates presented in the examples (one-in-ten or one-in-five) are meant to be illustrate that the seriousness of the harm and the acuity of the danger inevitably affect judgments regarding whether there is a "substantial likelihood" of serious harm. Certainly a genuine short-term risk of serious harm, as in the second example, justifies detention for further evaluation.

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3. The revised statute replaces the term "imminent" with the phrase **"in the near future."**

The basis for this change was the evidence that some clinical evaluators and legal decision-makers were interpreting the term "imminent" to mean that the feared harm was

expected to occur "immediately" or "within 24 hours."[4] In addition, the narrow interpretation of "imminent" has been a major target of criticism by clinicians and families of people with mental illness over the years. In fact, the Commission's research found that Virginia's statute was among the most restrictive in the country. Very few states require a showing of "imminent" danger, and several states that previously used the "imminent danger" standard have loosened their criteria in recent years. The Commission therefore concluded that that "immediate" was an unduly narrow criterion, and that the term "imminent" should be omitted from the statute in order to assure that this restrictive approach would be discarded.

However, the Commission did not wish to leave the time frame for anticipated harm open-ended. Thus, the language proposed by the Commission, and adopted by the General Assembly, specifies that the harm must be anticipated to occur "in the *near* future," indicating that harm believed likely to occur in the more distant future (weeks to months) would not provide a sufficient predicate for commitment. Exact specificity (e.g. "in the next 48 hours") was deemed to be unworkable. So, what does "in the near future" mean? A significant consideration in interpreting this phrase is that mental health experts generally concede their inability to predict an individual's dangerous behavior related to acute mental illness beyond a period of about a week. Accordingly, a reasonable interpretation of "near future" would involve a time frame, generally speaking, of up to about one week. At the same time, assessment of violence risk inevitably involves fact-bound clinical judgments regarding the individual's clinical course within the context of his or her environment, especially interactions with other people. It would therefore be a mistake to embrace an absolute rule; periods slightly longer than a week are not precluded by the statutory language.

In general, the intended meaning of these statutory phrases is best understood by grounding their interpretation in a clinical context. Requests for involuntary treatment typically arise when people with serious mental illness are experiencing a significant decline or deterioration of functioning associated with impaired judgment, emotional distress, diminished grasp of reality, loss of self-control, and other symptoms. The question posed by the commitment criteria is whether this downward spiral, as evidenced by recent behavior as well as by mental and emotional symptoms, raises serious concern about harm "in the near future" if the deterioration were to continue without therapeutic intervention and without major amelioration of stresses in the environment. *The assessment of risk must always be grounded in an understanding of the person's recent*

[4] This is certainly a plausible interpretation of the phrase. Indeed, the definition for "imminent" provided by the Merriam-Webster's Collegiate Dictionary is "ready to take place; *especially*: hanging threateningly over one's head <was in *imminent* danger of being run over>."

clinical course and in an assessment of the most likely clinical course in the near term – a horizon of about one week.

4. The revised statute specifies that the finding that there is a substantial likelihood of serious physical harm … must be **"evidenced by recent behavior causing, attempting or threatening harm and other relevant information, if any."**

Under the previous statute, there was no language indicating what constitutes an acceptable evidentiary basis for concluding that a person is "dangerous." The revised statute specifies that a clinical judgment that someone presents a "substantial likelihood" of causing harm in the near future must be "evidenced by recent behavior causing, attempting, or threatening harm." This requirement is designed to anchor the clinical risk assessment in the person's "recent behavior" and thereby avoid unfettered speculation.

A. The phrase **"recent behavior"** implies that harmful acts occurring long ago, although providing an important context, do not in themselves provide a sufficient evidentiary basis for civil commitment at the present time. A recent overt act or statement must be documented. However, actual harm need not already have occurred in order for commitment to be justified – recent acts or statements attempting or threatening harm will also suffice.

B. Recent behavior "causing' or 'attempting" harm is likely to be easy to identify and document. However, the phase **"threatening harm"** is broader and more subtle, and several issues regarding the meaning of this phrase are likely to arise:

> **Example**: Consider a person with a documented history of paranoid schizophrenia who voices the belief that her neighbors actually are foreign agents who are spying on her, has called 911 repeatedly to complain about them, and now has purchased a hunting knife and a rifle in order to "defend myself against them if it comes to that." Is she subject to commitment at the present time?

Our Opinion: Admittedly, this woman has not caused or attempted to harm her neighbors. However, has she engaged in conduct "threatening harm"? The first point to be noted is that the revised statute does <u>not</u> require evidence that the individual has made a specific threat against a particular identifiable individual; a generalized expression of intention or inclination to cause serious harm to anyone as a result of mental illness would be sufficient.[5] In this case, the woman's conduct would provide a sufficient

[5] A threat to a specific person would be required to trigger a *duty* to take precautionary action under VA §54.1-2400.1, but such a specific threat has never been required as a predicate for civil commitment in Virginia or elsewhere

behavioral basis for commitment as long as the totality of the evidence supports the necessary finding.

The woman in the hypothetical case is subject to involuntary commitment if, as a result of her illness, there is a "substantial likelihood" that, if not treated, she will cause serious harm to the neighbors or someone else in the near future. Purchasing the weapon and making these statements under the circumstances would suffice to establish a recent behavioral basis for the prediction ("recent behavior... threatening harm") even though she has not yet caused or attempted harm and has not yet identified a specific victim of an increasingly likely dangerous act. Whether this woman can be shown, by clear and convincing evidence, to present a "substantial likelihood" of casing serious harm in the near future would depend on the full clinical picture, including her history of violence. The point being made here is that the statements and assembling of weapons would provide a sufficient behavioral basis for such an otherwise supported clinical judgment.

> **Example:** Suppose an individual who has a well-documented history of mania has just this afternoon fired a gun into the air in his yard "as a warning" to the world at large that he is 'in charge." However, he is not at this point verbally threatening to shoot any specific individual. Assume that the clinician has a high level of concern that the person will, if not treated, fire his weapon impulsively and recklessly when other people would be at risk. Has the person engaged in "recent behavior causing, attempting or threatening harm?" His recent behavior did not cause harm. Did he attempt to cause harm? Is a concrete "verbal threat" necessary under these circumstances?

Our Opinion: It is possible, of course, that the person described in this vignette could be subject to criminal charges for endangerment or discharging a firearm, but let us assume that civil commitment is sought instead. The statutory phrase "recent behavior ... threatening harm" does not require evidence of a specific verbal threat or physical menacing (such as swinging a tire iron and pointing it at someone). The language indicates that the *behavior itself can constitute a threat.* Suppose a person started carrying around a baseball bat without verbally threatening or without suggestively swinging it the direction of his father. If he had previously attacked his father with a baseball bat, this behavior would properly be considered "threatening."

To summarize, the most reasonable interpretation of the overall phrase "as evidenced by recent behavior causing attempting, or threatening harm" is that it refers to any recent behavior that *evidences a threat of harm;* it is designed to anchor the clinical judgment that "there is a substantial likelihood that the person will cause serious physical harm" in recent threatening conduct. Thus the phrase should *not* be read as if it were referring to

the elements of a criminal offense that require a "specific intent" to cause injury, such as attempt, or a purpose to put someone in fear of such harm, such as extortion. Any behavior that is "threatening" when seen in the context of the person's symptoms provides an ample basis for the risk assessment even if it does not amount to a specific verbal threat.

C. What is meant by the phrase **"and other relevant information, if any"?** This phrase is designed to make it clear that "any relevant evidence" may be introduced and used by the decision-maker to support the finding that "there is a substantial likelihood that the person will cause serious physical harm..." as long as the finding is supported *at least* by "recent behavior causing, attempting of threatening harm."[6]

> **Example**: Mr. E, an individual with a longstanding history of schizophrenia, who lives with his father, has a history of a violent assault against his father when he is ill, most recently about one year ago, when he attacked his father with a knife in their home. He was hospitalized voluntarily about 3 weeks ago and was released from the hospital after one week. This most recent hospital stay was much briefer than most of his past hospital stays (one week, compared to previous stays that lasted about 3 months on average). Since his hospital discharge, it appears to Mr. E.'s father that he hasn't been taking his medication. (His father can't say for sure, since Mr. E resists any supervision or outside monitoring of his medication administration.) Mr. E. refuses to attend the outpatient appointment at the local CSB that was arranged upon discharge from the hospital. Over the past week, he has become almost completely mute, looks around him constantly, as if perceiving things that aren't there, and has been glaring intensely at his father with clenched fists. There is no evidence that he is failing to eat or is losing weight. He refuses all offers of outreach services and refuses to go with his father to the emergency room. His father ultimately calls the police, who transport him on an ECO to the emergency room where he is seen by the CSB evaluator. Is there a sufficient evidentiary basis for commitment of Mr. E under the revised statute?

Our Opinion: The revised statute requires a *threshold* finding that the person has engaged in recent behavior causing, attempting, or threatening harm. Conceivably, Mr. E's recent behavior (glaring at his father with clenched fists) does in fact "threaten harm." However, this finding is not, by itself, a sufficient basis for commitment. The

[6] The revised statute requires the magistrate, CSB evaluator and Independent Examiner to consider a wide array of other information in making his or her determination. In addition, the statute makes clear that the judge or special justice is also expected to consider all records, reports and relevant information admitted at the hearing.

ultimate question under the statute is whether there is a "substantial likelihood" that this man will cause serious physical harm to his father or someone else "in the near future." The statute doesn't require one to draw this conclusion solely based upon consideration of the recent behavior in isolation. The modern practice of risk assessment for violence involves looking at a variety of relevant data, including the individual's past history of violence while ill, his current clinical symptoms, and even certain demographic factors, such as age.

In this particular case, Mr. E has begun to demonstrate all of the symptoms that he has demonstrated in the past when ill. In the past while ill, he has become violent toward his father. His current behavior includes actions that indicate persecutory ideas about his father, and in fact he resides with his father. (It might be another matter had he been discharged from the hospital to a group home or shelter.) His most recent hospital stay was much briefer than previous hospital stays (allowing less time for full recovery) and he is refusing to attend outpatient follow-up and likely isn't taking his medication. All of these factors would constitute "other relevant information," and might serve to heighten one's ultimate level of certainty that there is "substantial likelihood of serious physical harm." The evidence, taken as a whole, strikes us as legally sufficient for commitment.

5. In the second set of criteria that can be used as the basis for civil commitment, the revised statutory language replaces the phrase "substantially unable to care for self" with the phrase **"suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs."**

The previous statute did not specify what it meant for a person to be "unable to care for himself." The goal of the new language was to provide greater specificity regarding the circumstances under which a protective intervention would be justified. The new language focuses on the outcome that this prong of the commitment standard seeks to avoid, i.e. "harm" to the individual. It specifies that the predicted harm must be a "**serious harm,**" whether it is attributable to a failure to protect oneself from harm or to a failure to provide for one's basic needs. We think that these two phrases should be read together since the various types of incapacity due to mental illness tend to overlap.

A. What does '**serious harm"** mean? Note that unlike the "danger to self or others" criterion discussed above, which requires a substantial risk of serious *physical* harm, this provision requires evidence of "serious harm." A risk of serious physical injury or death obviously qualifies. However, the omission of the requirement that the harm be physical was intentional. The "suffer serious harm" criterion was originally proposed by the Commission after deliberations in which supporters of the proposed language explicitly

indicated that it was intended to cover harms other than physical harm, such as financial harm. Moreover, the special Mental Health Subcommittee of the Courts of Justice Committee of the House of Delegates rejected a proposal that would have limited the criterion to physical harm. Thus, the key interpretive issues arising under this prong of the commitment criteria relate to the meaning of "serious harm."

If attributable to mental illness, and likely to occur in the near future, the following predicted harms *might* amount to serious harms under this portion of the statute:

- Serious financial harm that could result from a person spending his or her life savings while in a manic state
- Serious medical harm due to failure to seek medical care or take prescribed medications. Failure to take insulin in an individual with longstanding history of diabetes with a past history of life-threatening diabetic ketoacidosis following a previous discontinuation of insulin, likely would qualify, as would the failure to take antibiotics in the context of a current severe pneumonia. By contrast, failure to take antihypertensive medications, which might result in a heart attack or stroke at some point in the next decade, likely would not qualify.
- Eviction from lodging due to the person's grossly inappropriate behavior
- Loss of custody of one's children because of grossly inappropriate or dangerous parenting
- Loss of employment due to grossly inappropriate workplace behavior
- Engaging in illness-related criminal behavior that would be highly likely to lead to arrest and incarceration if the police were to decide when confronted with such behavior to initiate the criminal process.

B. The revised statute states that the individual must **"lack capacity" to protect himself from harm or to provide for his basic human needs.** When does substantial impairment of judgment, cognition or emotional control symptomatic of mental illness amount to a "lack of capacity" to protect oneself? A person who is unconscious or catatonic obviously lacks capacity to protect him or herself. But the cases that typically arise involve people who are both conscious and mobile. In applying this criterion, the focus in should be on deficits in capacities relating to those activities of daily life that, if not carried out, can lead to "serious harm." In the context of emergency civil commitment, the emphasis is likely to be on a recent change in the person's functioning and an associated decline in relevant capacities for self-protection (whether due to symptoms of an acute illness, such as mania, or to the marked decline of capacities in a person with a chronic condition, such as dementia). Its assessment is therefore likely to be focused on whether the person has recently exposed him or herself to serious harm and

on whether interventions designed to prevent harmful behavior have been attempted and failed. If so, this would amount to evidence of "lack of capacity" for self-protection.

C. **The Problem of Homelessness:** Every state has to grapple with problems relating to people with mental illness who are homeless. Being chronically homeless and on the street, for example, likely would not be regarded by most evaluators or decision-makers as demonstrating lack a of capacity to protect oneself from harm or provide for one's basic needs, even though such a person is chronically at risk of harm of one kind or another. However, the scenario might be different in the middle of the winter if the individual isn't agreeing to accept shelter and the lack of self-protection is attributable to mental illness and would otherwise provide a basis for intervention by Adult Protective Services. Moreover, if the person had previously been a high-functioning individual who has recently experienced a severe functional decline over the past few weeks (e.g., left his job, left his home) and is now disoriented and wandering the streets, most evaluators likely would consider this to constitute a significant likelihood of "suffering serious harm" due to severe incapacity attributable to mental illness.

The differences between these two cases lie in the time frame (the latter case is more acute in terms of the decline in functioning), in recent behavioral evidence of this decline in functioning, and in a high likelihood of a downward trajectory. In the latter case, a reasonable observer might conclude that the behavioral change crosses a "threshold of serious concern' and that precautionary action is indicated.

> **Discussion Problem**: What about a homeless woman who, generally, is getting by on the street but is now pregnant? There is, clearly, a risk to the pregnancy -- both the woman's and her fetus's health. Is she committable?
>
> **Discussion Problem:** [7] A 60 year-old woman diagnosed with schizoaffective disorder has been in and out of psychiatric hospitals for the past 15 years. For the past year, the patient has lived in a residential facility and by all accounts has been functioning quite well. However, several weeks ago, she began to intermittently decline medication and become increasingly agitated and bizarre in her behavior. She ultimately was "discharged" from the residential facility because she was "unmanageable." At that time, she refused to take her medications entirely and also refused voluntary psychiatric hospitalization.
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> Upon leaving the facility, she immediately spent $70 and then turned up at her daughter's apartment broke and without a place to stay. Her daughter convinced her

[7] Adapted from Darold Treffert, M.D., Hospital and Community Psychiatry 36:3, 1985, p. 261

to go to the hospital, where she was voluntarily admitted. However, she signed herself out several hours later. At midnight the police called her daughter to inform her that her mother had ordered a lobster dinner and then had left the restaurant without paying. The police had transported her (voluntarily, not on an ECO) to the local CSB, where the CSB evaluator was able to persuade her to sign herself into the hospital voluntarily. However, the next day, she again signed herself out. She remained broke and homeless. Two days later, the police again called her daughter, reporting that she had again ordered a dinner for which she did not pay. They again took her to the ER but at that point she refused voluntary admission, and a TDO is sought. Is the patient committable?

Aftermath: Assume that the prescreener concluded that the patient was not committable, that the magistrate refused to issue a TDO, and that the patient was released. That afternoon she phoned her daughter from the cemetery, insisting that her deceased husband was out of his grave and causing her a lot of trouble. She was arrested for loitering. She appeared unkempt and dirty and was carrying a bag full of garbage. A nurse at the jail called the daughter requesting background information. Because the patient was continuing to decline all psychiatric treatment, she remained off of psychotropic medications while at the jail and was housed throughout her time in jail in segregation. Her daughter feared bonding her out, as her mother at least was in a sheltered setting at that point. A CSB evaluation requested by the jail psychiatrist determined that she did not meet commitment criteria while in her current sheltered setting, as she was eating adequately and had not engaged in assaultive behavior. Ultimately she went to court and the charges were dismissed. She again was homeless after this, sleeping primarily in bus depots. Was this the correct response?

Comment: This case study demonstrates the problems associated with a more restrictive interpretation of "serious harm." Obviously, decision-makers may differ in how they would approach this case. Of note, nobody involved in this case disagreed that (1) this woman had a mental illness, that (2) her illness could potentially benefit from psychiatric treatment, and that (3) she was incapable of providing (or refusing to provide) valid informed consent for psychiatric treatment. What should be done in cases of this kind?

III. Conclusion

This review of Virginia's revised civil commitment criteria is designed to begin the iterative process of developing a common understanding of the new criteria, and thereby minimize the variability in its application across the state. As with any legal innovation,

however, unanticipated questions about the meaning and application of the new provisions will continue to arise, and every effort will be made to establish a mechanism for sharing ideas and information as experience accumulates over the coming months and years. This paper is meant to initiate that ongoing process.