INTERIM REPORT OF THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES ON

THE STUDY OF COMMITMENT OPTIONS FOR PERSONS WITH PRIMARY SUBSTANCE ABUSE PROBLEMS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 46

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COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

Kay Coles James
Secretary of Health and Human Resources

February 9, 1995

TO: The Honorable George Allen

and

The General Assembly of Virginia

The report contained herein is pursuant to House Joint Resolution 269, agreed to by the 1994 General Assembly.

This report constitutes the response to House Joint Resolution 269 of the Department of Mental Health, Mental Retardation and Substance Abuse Services, working in cooperation with a stakeholders workgroup made up of professionals in the field of substance abuse treatment and representatives of state and local agencies. It is an interim report addressing the request to study community and facility treatment programs, including the clinical appropriateness and cost effectiveness of the current civil commitment process for individuals with substance abuse problems and to make recommendations regarding alternatives. The final report is due to the Governor and the 1996 Session of the General Assembly.

Respectfully Submitted,

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EXECUTIVE SUMMARY

HJR 269 was passed by the 1994 Session of the General Assembly to address the impact persons with primary substance abuse problems have on local services and state mental health facilities. The impetus for the study arose from a prior study, The Impact of Public Inebriates on Community and Criminal Justice Services, Systems (House Document 46, 1994 Session of the General Assembly). In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services began studying the significant number of admissions who were primary substance abusers to state mental health facilities.

Although substance abuse can co-exist with serious mental illness, the individual experiencing primary substance abuse does not present the duration of impaired functioning consistent with serious mental illness. Primary substance abuse does present episodic impairment in functioning. The periodic nature of impairment, even if severe, does not indicate the need for the milieu or ancillary services currently provided by state mental health facilities.

In Virginia, public substance abuse treatment services are provided by a community services board system, which provides mental health and mental retardation and substance abuse services throughout the state. In Fiscal Year 1993, $70,861,482 was allocated for substance abuse treatment to the community services boards which provided substance abuse treatment services to 56,548 individuals. All community services boards must provide, at a minimum, emergency services. All do provide outpatient services, and all have access to residential services such as community based detoxification, primary care and therapeutic communities. However, community programs are generally operating at capacity, and often have waiting lists for services.

In fiscal year 1994, 1,693 admissions occurred to state mental health facilities for persons with primary substance abuse. At an average estimated per diem of $234, and an average length of stay of nearly 26 days, the cost amounted to $10,144,230, resulting in an average cost per admission for a person with primary substance abuse of $5,991. By comparison, the estimated per diem of residential treatment for primary substance abuse in the community is $78, with an average cost per admission of $1,540.

In addition to cost issues, the milieu of state mental health facilities is not clinically appropriate for persons with primary substance abuse. Although these persons do experience life threatening crises, these could probably be addressed more appropriately in community based programs. Admission to state mental health facilities may not be the best intervention, either clinically or from the perspective of cost-effectiveness.

Three major categories of options to changes in the Code of Virginia can be pursued by the study committee:

Option A: Continue current practice of civil commitment for person with primary substance abuse to state mental health facilities;

Option B: Amend the Code to exclude civil commitment to state mental health facilities for persons with primary substance abuse and amend Department policy to exclude voluntary admissions to state mental health facilities with primary substance abuse;

Option C: Amend the Code to establish specific civil commitment options in the community for persons with primary substance abuse and reinvest current department resources in the community in order to insure that capacity and programming are sufficient and appropriate to meet demand created by diverting this population.

It is Option C that best addresses the intent of HJR 269, and so it is this option which the study is designed to explore in detail. The study will utilize survey techniques to select clinical records of patients admitted three or more times during Fiscal Years 1993 and 1994 to state mental health facilities. Information will be collected to indicate the types, levels and capacity and locations of services necessary to serve the patient in the community. In addition, sheriffs and judiciary will also be surveyed to collect information regarding the impact of such a proposed change.

This information will form the basis of recommendations focused on redesigning the substance abuse treatment service delivery system so that persons with primary substance abuse receive the best clinical care at the least burden to the taxpayers of Virginia. These data will provide information regarding the types, capacity and geographic distribution of needed services, the cost of providing them in the community and ideas for funding through reinvestment, the impact on local law enforcement and the judiciary.

The study group will propose amendments to the Code to provide appropriate authority and support for improving the service system. Also, the group will review Department policy and suggest for revisions, with the end result being that commitment to state mental health facilities is eliminated as a commitment option, and community-based commitment options for persons with primary substance abuse are created.

Thorough review and discussion of the information collected in this process will insure that sound, clinically appropriate treatment is available and accessible at the community level for persons with primary substance abuse now being admitted to state mental health facilities, and that available resources are used more efficiently.

I. INTRODUCTION

This document is an interim report on a two year study mandated by the 1994 Session of the General Assembly, House Joint Resolution 269 (Appendix A). To address this mandate, the Department and the Office of the Attorney General have, as instructed, embarked on a comprehensive study to produce empirical information which will thoroughly address the mandates of the study. This interim report will discuss the content and context of the resolution, consider policy options, make policy recommendations congruent with the intent and scope of the resolution, describe the study approach, and status, and describe the experience of other states in providing treatment for persons who are chronic abusers of alcohol and other drugs with respect to civil commitment and community alternatives to state mental health facilities.

Scope of the Resolution

Based on concern about the impact of providing services to persons who chronically abuse alcohol and other drugs on state mental health facilities, local jails, and other systems, this study requests *"the Department of Mental Health, Mental Retardation and Substance Abuse Services, in conjunction with the Office of the Attorney General, to study community and facility treatment programs, including the clinical appropriateness and cost effectiveness of the current civil commitment process for individuals with substance abuse problems and to make recommendations regarding alternatives."*

"The study shall: (i) address the development of an array of services, including community social detoxification and structured short- and long-term inpatient programs which more appropriately respond to the needs of individuals with chronic substance abuse problems; (ii) review the Code of Virginia as it relates to the civil commitment of individuals with primary substance abuse problems and make appropriate recommendations; (iii) recommend clinically appropriate and cost-effective alternatives to facility-based treatment for people who have chronic substance abuse problems; and (iv) develop cost estimates to expand community capacity to serve chronic substance abusers."

This study focuses solely on persons with primary substance abuse, which means that the person is not experiencing the serious and persistent symptoms of major mental illness. This should not be taken to mean, however, that persons with primary substance abuse considered in this study do not experience serious psychiatric problems, such as suicidal thoughts and behaviors, feelings of paranoia, perceptions of grandeur, depression and other mood disorders. The key feature separating these individuals from those with serious mental illness (and for whom civil commitment to a state mental health facility may be appropriate) is the duration of symptoms. It is important to note, in addition, that certain seriously mentally ill persons also abuse alcohol and other drugs. This study does not address their needs, and is in no way intended to bar them from civil commitment or other legal procedures which may assist them.

It is also important to note that people who chronically abuse alcohol and other drugs are not an homogenous group. For this reason, a detailed study of their clinical and support issues is necessary in order to determine how to best divert admission to state mental health facilities, as well as to reduce burdens on local jails.

Finally, an underlying essential premise of this study is that existing resources, now utilized to provide care to chronic substance abusers in state mental health facilities, can be reinvested in communities to provide more clinically appropriate, cost-effective treatment. The study will make recommendations concerning the mechanisms and sequences which such a transition should follow and maintain a cost neutral impact on the larger services system. Since demand for community-based substance abuse treatment currently exceeds current capacity, recommendations for transition will be included as well.

Impetus for the Study

The initial legislative impetus for HJR 269 arose from a two year study of services to public inebriates and the impact of this population, who are primarily chronic abusers of alcohol, on the criminal justice system. (See The Impact of Public Inebriates on Community and Criminal Justice Services Systems, House Document No. 46, presented to the 1994 Session of the General Assembly.) A recommendation of this study provided the basis for HJR 269.

Simultaneously, the Department was increasingly aware that many of the persons admitted to its mental health facilities were not experiencing serious and persistent symptoms of mental illness for which the state mental health facilities were designed, but were instead persons who were experiencing problems due to primary substance abuse.

The Code of Virginia § 37.1-203 (2) defines "substance abuse" as "*the use, without compelling medical reason, of any substance which results in psychological or physiological dependency as a function of continued use, in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior.*"

Substance abuse can and does occur in combination with other psychiatric disorders, including serious mental illness, complicating treatment for both. In the case of primary substance abuse, however, the abuse of alcohol or other substances is the primary cause of the symptoms presented. These symptoms may include serious suicide attempts, delusions, paranoia, and other symptoms typically associated with serious mental illnesses. Nevertheless, once the substance has left the body, and its effects have diminished, the behavior in question recedes. This pattern does not diminish the person's need for help, nor the seriousness of the symptoms, but it does point out the episodic nature of substance abuse, even among persons who have chronic substance abuse problems, as opposed to the persistent nature of serious mental illness. The persistent quality of serious mental illness often indicates a need for a milieu providing limited stimulation, reduced stress, and medical and psychiatric attention to provide appropriate pharmaceutical therapies, and supportive staff.

The needs of the person with primary substance abuse, however, are very different. Although their most seriously disturbed behavior does indicate the need for a safe, secure place similar to those needed by a seriously mentally ill person, these symptoms usually diminish in a matter of days. At that point, a less restrictive environment providing more stimulation and more opportunities for responsible interaction are preferable. State mental health facility staff report that persons with primary substance abuse tend to disrupt the facility programming by being demanding, manipulative, and exhibiting other behaviors more typical of persons with addiction problems. Furthermore, in some state mental health facilities, the same individuals with primary substance abuse disorders seek admission repeatedly with no indication of involvement with appropriate community programs. Since these individuals arrive under court order for commitment, the state facilities have no choice but to admit them. The Department, therefore, in examining the best use of resources to provide the most effective treatment, has begun to examine the issue of how best to serve persons with primary substance abuse who are being committed, either involuntarily or voluntarily, to its state mental health facilities.

Description of Virginia's Public Substance Abuse Treatment System

Publicly funded substance abuse treatment services are available through the 40 community services boards (CSBs) located throughout the state. CSBs, established by the Code of Virginia (§ 37.1-194 - 202.1), also provide publicly funded mental health and mental retardation services to the citizens of their catchment areas, and are entities of local government. These services are available on an ability-to-pay basis. The Department of Mental Health, Mental Retardation and Substance Abuse Services allocates public funding and provides technical assistance to the CSBs. Emergency services is the only service the CSBs are mandated to provide (§ 37.1-194), however all CSBs provide, at a minimum, outpatient substance abuse services, either directly or through contract with a nonprofit or governmental provider. In addition, all CSBs may participate in a purchase of service program to access residential services, such as community-based detoxification or residential treatment. The total unduplicated number of admissions for FY '93 was 56,548. Since successful treatment for alcohol or other drug abuse may require that a person participate in several types of treatment, many of these individuals may have been admitted to several different programs or facilities within a given year.

Although CSBs are designed to make services available to all citizens regardless of ability to pay, all boards accept third-party payment when it is available. In rural areas of the state, where the population is sparse and health care resources are rare, CSBs may provide the only source of mental health, substance abuse or mental retardation care, regardless of the citizen's economic or social status. Substance abuse treatment activities in CSBs are largely supported by state General Funds, federal Substance Abuse Prevention and Treatment Block Grant Funds, local revenues and fees. Table 1 below displays amounts for fiscal years 1993 and 1994.

Table 1
Sources and Amounts of Funding
for Community Substance Abuse Treatment, FY 93 and 94

Source of Funds	FY 1993	FY 1994
State	$25,746,966	$27,008,016
Federal	20,430,408	21,743,805
Local	17,095,998	17,745,232
Fees	6,344,586	7,403,965
Other	1,243,524	3,349,954
TOTAL	$70,861,482	$77,250,972

Sources: 4th Quarter Performance Reports, FY '93 and Statement of Grants Summary Report, FY '94

Most community services board affiliated programs report waiting lists for services. This factor is especially critical for community-based residential programs, which could often provide clinically appropriate and cost-effective alternatives to state mental health facilities, and are especially important in providing stabilization services to persons once discharged from state mental health facilities. Recent utilization data indicate that community-based detoxification centers, which can provide services for about $135 per day, are usually operating at over 80 percent capacity. Considering that these programs often operate units which are quite small, about 9 beds, and that their clients stay less than 6 days, this is a very high rate of utilization, seriously reducing accessibility of this necessary treatment component.

Persons with primary substance abuse who are treated in public sector programs are generally medically indigent. Although the State Medicaid Plan authorizes payment for medically necessary detoxification, few community general hospitals want to admit these patients, and few physicians or other health professions working in primary health care settings are trained to treat substance abuse. Chronic substance abuse, particularly displayed in public, is threatening to the public and has been associated with increased rates of crime. In many communities where community social detoxification programs operate, local law enforcement will pick-up and transport pubic inebriates to community programs. When these resources are not available or accessible, however, the person may end up incarcerated in local jails or, through the commitment process, may be admitted to a state mental health facility.

II. CURRENT PROBLEM

Utilization of Facility Resources by Primary Substance Abuse Patients

Substance abuse is often undiagnosed among individuals admitted to state mental health facilities. The reasons for this vary and are usually complex: a physician may be sensitive to the stigma of substance abuse and may fear that the individual will be discharged without appropriate access to community services; the physician may literally fail to recognize the signs and symptoms due to his or her own ignorance; the individual's behavior may be so erratic that the impact of alcohol or other drugs cannot be clearly distinguished from psychotic behavior. Finally, the nature of training for most psychiatrists leads them to think of substance abuse as a secondary condition, one that is caused by an underlying emotional problem, as opposed to substance abuse causing erratic, life threatening behavior. Because of these factors, data indicating the numbers of persons admitted to state mental health facilities diagnosed with primary substance abuse must be interpreted in the context of severe under-reporting.

Table 2 displays annual voluntary and involuntary admissions to state mental health facilities for persons diagnosed with primary substance abuse, average length of stay ALOS (mean), annual cost, average cost per diem, and estimated cost per admission, for fiscal years '92, '93 and 94.

Table 3
ANNUAL SUBSTANCE ABUSE ADMISSIONS
TO STATE MENTAL HEALTH FACILITIES

YEAR	TOT. PRIM. SA ADM	ALOS (days)	ANNUAL COST	COST PER DIEM	AVG COST/ ADMISSION
FY '92	1,714	30.0	$10,695,360	$208	$6,240
FY '93	1,542	31.3	10,072,339	209	6,532
FY '94	1,693	25.6	10,144,230	234	5,992

Sources: DMHMRSAS Annual Statistical Reports, 1992 , 1993, 1994

Admissions - Currently all of the state's mental health facilities accept civil commitment admissions for persons with a primary diagnosis of substance abuse. In FY '92, 498 patients were admitted voluntarily with primary substance abuse, and 1,216 were civilly committed. In FY '93, the number of primary substance abuse patients admitted decreased to 1,542 (427 voluntary; 1115 civil commitments). In FY '94, 1,693 admissions with primary substance abuse occurred (1,077 civil commitments, 616 voluntary). It is important to note, however, that this number probably under represents the number of persons with primary substance abuse actually admitted to state mental health facilities. During a crisis, it is often difficult for even the most sophisticated clinician to detect whether the presenting crisis is caused by a psychiatric disability, use of alcohol or another drug, or a combination.

Average Length of Stay (ALOS) - In FY '92, the ALOS for patients with a primary diagnosis of substance abuse was 30 days for both voluntary admissions and involuntary commitments. In FY '93, ALOS increased to 31.3 days. In 1994, ALOS decreased slightly to 25.6 days. Staff at facilities and community services boards agree that many patients with primary substance abuse stay in state mental health facilities longer than clinically needed. They attribute the delay in discharge to a lack of appropriate community treatment capacity, as well as to poor linkages between community substance abuse treatment programs and state mental health facilities.

Annual Cost - In FY '92, cost per bed day at state mental health facilities averaged $208, rising slightly to $209 in FY '93, and to $234 in FY '94. Based on the above admission and ALOS information, the cost of serving a primary substance abuse patient averaged $6,240 in FY '92, rose to approximately $6,531 in FY '93, and declined slightly to $5,992 in FY '94 . Taken as a group, serving patients with a primary diagnosis of substance abuse costs approximately $10,695,360 in FY '92, $10,072,339 in FY '93 and $10,144,230 in FY '94. [(ALOS x admissions = patient days) x cost per day = annual cost.]

Anecdotal evidence suggests that per diem costs for persons admitted for primary substance abuse to state mental health facilities may actually exceed the state average. Because these patients are not appropriate for the general milieu of the facility, they may be kept in admissions units longer, where staff to patient ratios are higher. In addition, these patients may have chronic, serious medical problems, such as diabetes or ulcers, which require more medical intervention than the average patient. These individuals are suspected to be admitted more frequently than persons with serious mental illness. Finally, just as indications are that individuals with primary substance abuse are admitted to state mental health facilities as a last resort because adequate community-based capacity is not available or accessible, this same lack of capacity limits clinically appropriate discharge options for these individuals, resulting in longer lengths of stay than may be clinically indicated.

The cost of care in a state facility includes overhead for buildings and grounds maintenance, food services, laundry services, and extensive ancillary medical, mental health and rehabilitation services available to patients at state facilities. Although all of these supports and services are available to all patients, some are not needed by persons with diagnoses of primary substance abuse, and may, in fact, be contraindicated, as they may impede therapeutic progress toward the high level of self sufficiency which these patients are capable of achieving. For instance, in community substance abuse treatment programs staff provide supervision to clients as they prepare meals and execute housekeeping tasks and simple maintenance tasks. These activities serve a therapeutic purpose as they provide opportunities for clients to become increasingly self sufficient and learn responsibility.

Primary substance abuse patients admitted to state mental health facilities would most likely use a combination of community residential treatment programs such as medical/social detoxification, primary care, and the therapeutic community. Other necessary services not included in this cost are case management and primary medical care. Upon completion of

residential treatment, the person would also need housing, assistance finding employment or support, and ongoing substance abuse treatment in day treatment, intensive outpatient, or outpatient programs. The study group will undertake comparative review of the costs of providing these services in the community as opposed to state mental health facilities.

Clinical Appropriateness

As the above discussion on costs suggests, facility care and community care differ in important ways regarding approach to treatment. Most sources agree that only a very small proportion of persons with primary substance abuse require the treatment environment provided by a mental health facility. In fact, nearly all can be treated within an array of modalities that operate successfully without the ancillary services provided by mental health facilities. By definition, these persons present for admission in the midst of crisis. Once this crisis has passed, they do not require intensive mental health intervention. More significantly, the approach to care which is appropriate for persons experiencing mental health crisis due to serious mental illness is contraindicated for persons needing help for a primary substance abuse problem. As a basis for understanding the clinical needs of the primary substance abuse patient, a brief, general description is in order.

A person with an addiction problem is mostly invested in obtaining the substance of choice and feeling its effects. Most of his or her behaviors are concentrated on this objective. He or she typically has difficulty focusing on the long range effects of his or her actions. The impact of using alcohol or other drugs today does not seem related to future health or functioning. The addicted person may not connect the impulse which leads to criminal activity with loss of opportunity and freedom in the future. These persons are rarely able to conceptualize that their behavior has impact on others they care about , such as loss of income to the landlord, loss of shelter for family. The person may be self-centered in the extreme, and may seek to manipulate others to meet basic needs for food and shelter, as well as for personal attention. Typically, the individual is in denial concerning the seriousness of his or her disorder. Finally, in order to accomplish these "quick return" objectives, a person experiencing primary substance abuse may deliberately, intentionally and consciously lie, making self-reported information unreliable.

These behaviors may be solely symptomatic of the addiction and may disappear if the addiction is appropriately treated, or they may be symptomatic of a class of mental disorder, Personality Disorders, characterized by many of the same behaviors attributed to addictive behavior. If these behaviors predated the addiction, then a diagnosis of personality disorder may be in order. Although the short-term crisis of addiction (e.g., alcoholic toxicity, drug-induced psychosis) can be remedied with appropriate care, the personality disorder per se is generally not amenable to treatment (although its effects can sometimes be ameliorated with skillful psychotherapy). The one notable exception may occur when a diagnosis of personality disorder is accompanied by a diagnosis of clinical depression, which may create enough discomfort to motivate the patient to make substantive necessary behavioral changes.

Thus, the type of pathological behavior displayed is very different from that of the patient with serious mental illness, and requires a very different kind of care. First, because persons with primary substance abuse frequently lie, detection of the disorder itself or its extent and type is frequently under diagnosed in state mental health facilities. Procedures, such as routine urine toxicology screening at the Temporary Detention site or on admission, are not in place. The referring community services board may misdiagnose the individual, either out of ignorance or because appropriate community capacity is not available or accessible. The individual presenting for services may know that "acting psychotic" will provide a better opportunity for admission to a state mental health facility than admitting that he or she has a severe problem with alcohol or other drugs, and may deliberately mislead the professional conducting the assessment for Temporary Detention. Furthermore, once appropriately assessed, persons with diagnoses of primary substance abuse are not a homogenous group. Differences such as the type of substances used, severity of addiction (to include the duration of use), pre-addiction functioning, relationship history and current status, physical health, the presence of other life trauma such as physical or sexual abuse, criminal justice history, etc., must be taken into account in assessing the type of treatment appropriate for each person. Treatment which considers gender and ethnicity and is appropriate in terms of intensity, content, duration and setting is essential if it is to be effective. Finally, access to a broad array of treatment and case management are critical to provide the person with timely movement from one modality to another as the treatment needs of the person change over time.

All effective treatment approaches for primary substance abuse do have some essential elements in common. These treatment strategies provide concrete contingencies for behavior, combined with group counseling to provide peer feedback and establish appropriate behavioral norms, and concentrate on balancing the patient's own needs with those of the community. The emphasis on self sufficiency regarding basic self care (e.g., laundering one's own clothes, cleaning one's own room, cleaning common areas, performing simple maintenance tasks, preparing food for self and others) is a critical component of treatment for substance abuse. These types of activities, performed under staff supervision, should provide the basis for reward of new privileges or loss of existing ones, increased self reliance, enhanced (appropriate) self esteem, and teach the client about the impact of his or her behavior on others and responsibility to the community at large. In addition, this type of program replaces a pathological frame of reference (active substance abusers and criminals as peers) with a healthier one (people in recovery, constructive problem solving, membership in and responsibility to a larger community).

Few facility staff are trained to develop and conduct these very structured and focused models of treatment. Moreover, facilities by their very nature are limited in the range of modalities they are able to provide. The treatment environment is appropriately designed for the seriously mentally ill person, those who by law are so ill as to be imminently dangerous to themselves or others, or who are not able to care for themselves, and for whom alternatives are not appropriate (Code of Virginia, § 37.1-67.1), and who require intensive mental health intervention. This environment, or milieu, is clinically inappropriate for the

person with primary substance abuse, whose therapeutic needs would be better served in a highly structured environment which provides opportunities for supervised interactions with staff and other patients (group counseling, substance abuse education, counseling with significant others, extensive discharge planning involving the patient and community representatives.) Ancillary facility services such as pre-prepared food, laundry, housekeeping, and maintenance, essential to providing therapeutic care for the seriously mentally ill, are clinically inappropriate for persons with primary substance abuse, once past the initial crisis. Persons with primary substance abuse need to have these types of self and community care issues thrust upon them to provide them with opportunities for learning and practicing responsible behavior. Thus, the environment of the state mental health facility may, in fact, retard or prevent therapeutic progress for persons with primary substance abuse, whose recovery requires assumption of self responsibility (under supervision) within days of a passing crisis.

Once admitted, primary substance abuse patients appear to stay in the hospital longer and be readmitted more frequently than may be clinically warranted, especially given the restrictive nature of the clinical environment. This pattern occurs, just as it does for the seriously mentally ill individual, because appropriate community-based options are not available or accessible. The study group will identify the factors which influence these longer lengths of stay, and will make recommendations concerning the types of community treatment needed, the capacity and the geographic locations.

III. ALTERNATIVES

A thorough analysis of alternatives requires that at least two major options be reviewed: continue to allow for admissions of persons with primary substance abuse to state mental health facilities, or change the Code to deny civil commitment for primary substance abuse to state mental health facilities, and accompany this change with Departmental policy change excluding voluntary admissions to state mental health facilities. A third option, which resolves some of the issues of the first two, and best addresses the intent of the study, is also presented. Each option has significant variations which affect desirability, and which form suboptions. Criteria for evaluating desirability include clinical appropriateness, special legal concerns, effects on the community and facility programs, and cost.

A. Option: Continue the current practice of civil commitment for persons with primary substance abuse to state mental health facilities

1. Suboption: Make no change
   a. Impact on the Community: Communities would continue to send difficult cases to state mental health facilities; access to treatment would continue to be limited; other community resources, such as local criminal justice system, community emergency rooms, and shelters would continue to provide services but without successful outcomes.

b. Impact on State Mental Health Facilities: Facility programs would continue to struggle to treat patients not appropriate for the same treatment milieu appropriate for serious mental illness;

c. Fiscal Impact on the Department: State resources would continue to be inappropriately utilized with no enhancement or expansion of the services system.

d. Impact on the Code: No change.

2. Suboption: Design specialized program units within state mental health facilities for the treatment of persons with primary substance abuse.

a. Impact on the Community: Would reduce community need for expanded resources.

b. Impact on State Mental Health Facilities: Would require dedication of extensive resources:

1. Designated space
2. Specially trained staff
3. Specific milieu
4. Improved screening
5. Special licensing or accreditation

c. Fiscal Impact on the Department: Resource requirements of facilities would increase.

d. Impact on the Code: None.

3. Suboption: Create a financial incentive program to encourage CSBs to divert primary substance abuse from admission and work closely for quick discharge

a. Impact on the Community:

1. Establish a pool of funds available for "draw down" whenever a person with primary substance abuse eligible for admission to state mental health facilities is diverted.

2. Charge CSBs when a primary substance abuse patient is admitted to state mental health facilities

3. Use earned rewards to establish community capacity for primary substance abuse, through purchase of service from existing provider or development of additional service capacity within the CSB's own service systems

b. Impact on State Mental Health Facilities: Could reduce CSB demand on state mental health facilities as long as CSBs only seek admission for individuals for whom state mental health facility care is clinically appropriate.

c. Fiscal Impact on the Department: Would provide resources to communities; facility costs would decrease, but some programming would be duplicative resulting in higher costs due to continued need, at some level, for specific substance abuse programming in state mental health facilities as described in A.2. b.

d. Impact on the Code: No change.

B. Option: Amend the Code to exclude civil commitments to state mental health facilities of persons with primary substance abuse; amend Department policy to exclude voluntary admissions with primary substance abuse.

1. Suboption: Eliminate civil commitment for primary substance abuse and provide no additional community resources.

a. Impact on the Community: Would place primary substance abuse at increased risk for mortality; increase stress on community resources such as jails, shelters, hospital emergency rooms, and might increase the use of criminal commitments for primary substance abuse to state mental health facilities.

b. Impact on State Mental Health Facilities: Might reduce inappropriate admissions, but some individuals would actively seek a psychiatric diagnosis in order to gain admission; some physicians would deliberately misdiagnose, and current problem could be easily recreated.

c. Fiscal Impact on the Department: Continues inappropriate use of resources with little positive outcome, as persons in need of clinical services are diverted to systems not equipped to provide treatment for substance abuse; diverts existing resources (local jails, emergency rooms, shelters) from intended purpose.

d. Impact on the Code: Creates a legal entitlement for services to be provided by community, but provides no resources or capacity.

e. Policy Impact on Department: Would create negative pressure from the Va. State Crime Commission, Va. Sheriff's Association, Department of Criminal Justice Services, Virginia Association of Community Services Boards, Virginia Association of Alcohol and Drug Abuse Programs, and advocacy groups.

2. Suboption: Eliminate civil commitment for primary substance abuse and provide additional community resources to expand capacity; do not amend Code to provide legal alternatives to civil commitment to state mental health facilities.

a. Impact on the Community: Would provide resources to expand community capacity but would not assist individuals who may be endangering self or others (social controls)

b. Impact on State Mental Health Facilities: Might reduce inappropriate admissions, but some individuals would actively seek a psychiatric diagnosis in order to gain admission; some physicians would deliberately misdiagnose, and current problem could be easily recreated.

c. Fiscal Impact on the Department: If resources currently utilized by state mental health facilities were allocated to communities to serve this population, impact would be reduced; absent civil sanctions, though, other systems would continue to be stressed, resulting in inappropriate use of jail, hospital and shelter resources.

d. Impact on the Code: Could increase use of criminal sanctions to address needs of primary substance abuse (e.g., suicidal primary substance abuse); could increase state's liability if deaths occur due to medical/psychiatric problems while incarcerated.

e. Policy Impact on the Department: Would lessen negative pressure to some extent; however, impact of social controls issues would still continue.

C. *Option: Amend the Code to establish specific civil commitment options in the community for person with primary substance abuse and reinvest current department resources in the community in order to insure that capacity and programming are sufficient and appropriate to meet demand created by diverting this population to the community.*

1. Impact on the Community: Would establish community capacity for persons with primary substance abuse; relieve stressors on other community systems; might support purchase of crisis stabilization from existing hospital-based program. Case management capacity would also need to increase.

2. Impact on State Mental Health Facilities: Would insure appropriate use of state mental health facilities' resources; would assist with downsizing facilities; would provide resources for reinvestment to support development of community capacity; would reduce financial obligations/liabilities of the Department.

3. Fiscal Impact on the Department: Neutral. Resources currently utilized by facilities to provide services to persons with primary substance abuse would be reinvested in communities to develop needed appropriate service capacity. Reinvestment would have to be scheduled to assure that appropriate capacity was available and accessible prior to change in Code.

4. Impact on the Code: Would provide alternate social control mechanism for communities preferable to incarceration in local jail (for public inebriacy); would clearly establish responsibility and authority for management of individuals with primary substance abuse with local communities. Best addresses intent of HJR 269.

5. Policy Impact on the Department: Would increase community responsibility for providing appropriate treatment; would enhance local collaboration among treatment providers; would provide for more appropriate use of public funding by providing mechanism for reinvesting resources in the community; would address social control issues presented by some individuals with primary substance abuse.

A detailed study plan, approved by the Secretary of Health and Human Resources, is included as Appendix B, and outlines methods to be used to explore these options. Three surveys, discussed below, form the basis of the data collection on which feasibility will be determined.

IV. DISCUSSION OF POTENTIAL CHANGES TO THE CODE OF VIRGINIA

Review and Discussion of the Code of Virginia Relating to Civil Commitment for Individuals with Substance Abuse

The Code of Virginia specifically allows voluntary admission of individuals with substance abuse to state mental health facilities, §37.1-65. Although substance abuse in and of itself is not grounds for involuntary civil commitment to a state mental health facility, the inclusion of "any person who is a drug addict or alcoholic" in the Code definition of "mentally ill" (§ 37.1) means that a person with a substance abuse disorder who meets the criteria for civil commitment may be ordered to state mental health facilities for treatment.

For a judge to issue an order for civil commitment, the first or second of the following conditions must be present in addition to the third: (1) the person presents an imminent danger to himself or others as a result of mental illness; (2) the person is judged to be "so seriously mentally ill as to be substantially unable to care for himself"; and, (3) less restrictive alternatives to involuntary inpatient treatment have been investigated and deemed unsuitable. § 37.1-67.3.

In Virginia, the process of civil commitment begins when a concerned person with probable cause alleges that an individual is mentally ill and in need of hospitalization by petitioning a judge or magistrate. If the individual is not present, the judge or magistrate may issue a warrant for a law enforcement officer to bring the individual into custody. Alternatively, a law enforcement officer with probable cause may also take the individual into custody and transport him to an evaluation. The individual may remain in custody awaiting evaluation for up to four hours prior to the Temporary Detention Order being issued by the judge or magistrate. During that four hour period, the individual must be assessed by an evaluator designated by the community services board as to the individual's need for hospitalization. If the evaluator deems that the person is in need of hospitalization, the judge or magistrate issues the Temporary Detention Order, under which an individual is hospitalized in "a willing institution or other willing place" to await a hearing, to be held within forty-eight hours. If the forty-eight hour period ends on a Saturday, Sunday or a legal holiday, the person may be held up to seventy-two hours, or ninety-six hours if the legal holiday falls on a Friday or a Monday. During this period, the individual must be examined by a qualified mental health professional. If the qualified mental health professional finds that the person meets the criteria for civil commitment, the judge offers the individual the opportunity to enter the hospital voluntarily; if the individual chooses not to enter voluntarily, the judge may then civilly commit the person to the care of a "hospital or other facility recommended by the community services board" or one "designated by the Commissioner" [of Mental Health, Mental Retardation and Substance Abuse Services]. The commitment order is limited to 180 days, during which time the person may be discharged upon recommendation of the facility providing treatment.
§ 37.1-67.3

The judge also has the alternative to civilly commit the person to outpatient care if the person is found to meet one of the first two criteria but not the third, e.g., "less restrictive alternatives have been investigated and been found to be suitable." The Code lists these alternatives to include "outpatient treatment, day treatment in a hospital, night treatment in a hospital, outpatient involuntary treatment with anti-psychotic medication pursuant to § 37.1-134.5, or such appropriate course of treatment as may be necessary to meet the needs of the individual." § 37.1-67.3.

Under this statute, persons with primary substance abuse can be committed to community-based substance abuse treatment. In fact, however, this rarely occurs. There are several reasons that this statute is under utilized for this population. First, the period of detention may not be long enough for the effects of chemical dependence to become evident as the cause of the individual's presenting behavior deemed to be "imminently dangerous to self or others". Even if the presence of a mood altering substance is detected, the typical forty-eight hour period may be inadequate for the evaluator to determine if, for instance, the person is suicidal because he is experiencing cocaine withdrawal or because he is psychotic. As previously discussed, an individual with primary substance abuse may deny that he has this problem and may deliberately lie if he prefers the safety and security of the state mental health facility to less comfortable circumstances.

Another reason that the statute is little used for this population is that the publicly funded community capacity to treat substance abuse is strained to the limit in most areas, especially if the person requires detoxification or other residential treatment. (Note: Very few persons with primary substance abuse medically require the ancillary services which would be provided by an inpatient hospital-based facility.) In addition, where such treatment capacity is available, the facilities are not locked, so public safety concerns are not addressed. Finally, anecdotal data suggest that some of the individuals admitted to state mental health facilities for primary substance abuse do need a high level of staff attention for their own safety. Community-based publicly funded treatment programs are not staffed nor physically designed, in terms of life-safety, to provide the kinds of "close watch" precautions necessary to protect someone from committing suicide, regardless of whether the emotions generating the behavior are related to substance abuse or not.

Review of Other States' Codes

If the study indicates that persons with primary substance abuse problems should not be civilly committed to state mental health facilities, the Code of Virginia may need to be amended. To stimulate discussion about alternatives for this population, the stakeholder group made a preliminary review of civil commitment statutes from several neighboring states. Several critical issues were identified: criteria for civil commitment; length of the detention period prior to commitment; and, location of the commitment facility.

Maryland

The Maryland code specifically excludes substance abuse from its definition of "mental disorder." Code of Maryland § 10.21.01.02. An individual may be involuntarily committed to a treatment facility in Maryland if he exhibits (3) three distinct involuntary admission criteria. These criteria are: (1) mental illness; (2) dangerousness to self or others; and (3) the inability or unwillingness to accept voluntary admission. A primary diagnosis of substance abuse is not included among these criteria. A petition for an emergency evaluation is issued by a judge to transport an individual to a public or willing private institution for an initial twenty-four hour detention period. The person must be examined by a physician during the initial detention period to determine if he meets the criteria for involuntary commitment. If he does not, he is released from custody. Code of Maryland § 10.21.01.04.

If the individual continues to meet the criteria, he is held for an observation status period at a public or willing private institution. He must be examined by two physicians or one physician and one doctorate level psychologist during this ten day period to insure he continues to meet the criteria for involuntary admission. Code of Maryland § 10.21.01.07. If he does not, he is released. The hearing, conducted by an administrative law judge, must be held within ten days of initial confinement. The treating facility staff must provide clear and compelling evidence that the individual continues to meet criteria for involuntary admission and can not be therapeutically treated in a less restrictive setting. Code of Maryland § 10.21.01.09. If this standard is met, evidence exists, and the administrative law judge commits him to a state psychiatric facility. There is currently no provision for outpatient commitment in Maryland. The ten day observation status period, however, allows patients to stabilize or elect to be admitted voluntarily.

North Carolina

North Carolina statutes make a distinction between mental illness and substance abuse. Code of North Carolina § 122C-281 Part 8. An individual with a substance abuse disorder may be involuntarily committed to a treatment facility in North Carolina if two criteria for involuntary commitment are met: (1) a current or previous history of substance abuse problems; and (2) dangerousness to self or others. North Carolina has an initial twenty-four hour detention period. An individual is transported by law enforcement to a area facility, which is a community-based mental health, mental retardation and substance abuse treatment center. He is examined by a physician or eligible psychologist to determine that he meets the criteria for involuntary commitment. If he meets the commitment criteria, the physician or psychologist recommends involuntary commitment to treatment and determines whether the patient will be released or held at a residential treatment facility. Code of North Carolina § 122C-283.

Within twenty-four hours of arrival at a residential treatment facility, the individual is examined by a qualified professional, typically a physician or eligible psychologist. If the qualified professional determines that the individual continues to meet involuntary commitment criteria, the person is either held and treated at the facility or a more appropriate

treatment setting. The involuntary commitment hearing is held within ten days of the day the individual is taken into custody. Clear, cogent and convincing evidence must be presented to demonstrate that the individual continues to meet the commitment criteria. Code of North Carolina § 122C-285.

The court may order commitment to and treatment by an area authority or responsible physician for a period not to exceed one hundred and eighty days. The area authority or responsible physician determines the most appropriate course of treatment (e.g. in-patient, outpatient, or intensive outpatient treatment) for the individual. Persons committed to outpatient treatment who fail to comply with a commitment order may be taken back into custody to determine if they continue to satisfy the commitment criteria and require a more restrictive treatment setting. Code of North Carolina § 122C-287.

South Carolina

The Code of South Carolina makes a distinction between "chemically dependent persons in need of involuntary commitment" and those with mental illness. Code of South Carolina § 44-52-10. South Carolina has parallel involuntary commitment procedures for mentally ill individuals and those with primary substance abuse. A petition may be filed in a county court alleging that an individual is "a chemically dependent person in need of emergency commitment" and meets the criteria for involuntary admission. The involuntary admission criteria for individuals with a substance abuse disorder are (1) evidence of a substance abuse disorder; and (2) a substantial risk of physical harm to self or others. The individual is held for an initial forty-eight hour examination period, during which he must be examined by a physician to determine if he meets the commitment criteria. If he meets these criteria, he is transported by law enforcement to a local treatment facility with an available treatment bed. Code of South Carolina § 44-52-50.

The individual is examined at the local treatment facility by two professionals, one of whom is a licensed physician, to determine if he continues to meet the commitment criteria. A report explaining the clinical findings is submitted to the court where the commitment petition was issued within seven days. If the individual continues to meet the involuntary commitment criteria, the court conducts an involuntary commitment hearing no later than twenty-one days after the filing of the petition. Code of South Carolina § 44-52-60.

If an individual is found to continue to meet the criteria, he can be committed to any licensed publicly operated outpatient and inpatient treatment facility. South Carolina has a network of community based residential and detoxification treatment centers across the state which accept outpatient commitments for varying lengths of stay. An individual may be also be committed to a specialty facility designated as a substance abuse treatment facility for a period not to exceed ninety days. Code of South Carolina § 44-52-120.

Kentucky

The Code of Kentucky makes a distinction between persons who are mentally ill and those who have a primary substance abuse problem not coexisting with a mental illness. The

Kentucky code requires that an individual Kentucky's involuntary commitment criteria are similar to Maryland's in that a primary diagnosis of a substance abuse disorder is not included among the criteria for involuntary commitment. The involuntary admission criteria in Kentucky are (1) mental illness; and (2) danger or threat to self, family or others. KRS 202A.011. A law enforcement officer who has reasonable grounds to believe that an individual meets the criteria for involuntary hospitalization may also transport him to a designated facility for an evaluation by a qualified mental health professional. KRS 202A.041. This examination must occur within a period not to exceed seventy-two hours, excluding holidays and weekends. If the examination reveals that the person meets the grounds for involuntary commitment a petition is filed in district court requesting either sixty or three hundred and sixty days of involuntary hospitalization. In order for three hundred and sixty days to be requested, proof must be presented that the individual had been hospitalized for a minimum of thirty days of psychiatric care within the preceding six months. KRS 202A.051.

If the court believes there is probable cause to involuntarily hospitalize the individual, it orders another examination by a qualified mental health professional, which must occur no later than six days, excluding weekends and holidays, from the time of the individual's initial holding. A final commitment hearing must then be held within twenty-one days of the initial holding. During the period between the preliminary hearing and the final hearing, the court may order that the person be held and examined in a designated hospital or committed to an outpatient treatment program for a variable length of stay. If at any time prior to the final hearing the patient fails to satisfy the criteria for involuntary hospitalization, he must be released. If an individual continues to meet the criteria for involuntary hospitalization at the final hearing, he may be committed for either sixty or three hundred and sixty days of inpatient treatment. KRS 202A.051.

Summary of Code Discussion and Recommendations for Further Study

A review of these states' codes and procedures (see Table 3) suggests that extending the duration of the detention period between the time the Temporary Detention Order is issued and the actual commitment hearing might provide a more realistic time for the individual to be clinically evaluated concerning the presence of substance abuse and its impact on the behavior which prompted the attention of concerned persons or law enforcement personnel. Furthermore, use of facilities other than state mental health facilities presents an alternative both for holding the individual during the time the Temporary Detention Order is in effect and the time the hearing is conducted. Finally use of facilities other than state mental health facilities for civil commitment should be explored, along with identification of special life safety requirements. During the remainder of the study, the stakeholder group will review civil commitment statutes of additional states, discuss implications, and make recommendations for the final report.

Table 3: Summary of State Codes Relative to Civil Commitment for Substance Abuse

STATE	CRITERIA FOR COMMITMENT	LENGTH OF DETENTION PERIOD	LOCATION OF DETENTION	COMMITMENT FACILITY
Virginia (Definition of Mental Illness in Code includes Substance Abuse)	(1) Imminent danger to self or others; OR (2) Unable to care for self; AND (3) No less restrictive tx setting available.	48 hours; 72 hours for weekend or holiday	Willing institution (public or private)	Commitments are to: (1) State facilities; (2) Designated private facilities; or (3) Outpatient care if patient meets 1 of first 2 criteria but not 3rd.
Maryland (Definition of Mental Illness in Code excludes Substance Abuse)	(1) Mental illness; (2) Danger to self or others; (3) Unable/unwilling to accept voluntary admission.	24 hours; if meets criteria, may have ten (10) day observation period	Willing institution (public or private)	Commitments are to state facilities.
North Carolina (Definition of Mental Illness in Code excludes Substance Abuse)	(1) Current or previous history of SA problems; (2) Danger to self or others.	24 hours; if meets criteria, may have ten (10) day observation period	Area facility (community-based MH, MR or SA center); if meets criteria, held over at residential facility	Commitments are to area facility or responsible physician.
South Carolina (Definition of Mental Illness in Code excludes Substance Abuse)	(1) Evidence of SA disorder; (2) Substantial risk of harm to self/ others.	48 hours; if meets criteria, 21days	Local facility with available bed	Commitments are to any licensed public outpatient or inpatient facility or "186" SA facility operated by state.
Kentucky (Definition of Mental Illness in Code excludes Substance Abuse)	(1) Mental illness; (2) Danger to self, family or others.	72 hours; excluding holidays and weekends	Designated local facility or state hospital	Commitments are to outpatient care or state facility.

V. IMPACT OF DIVERTING PRIMARY SUBSTANCE ABUSE FROM STATE MENTAL HEALTH FACILITIES TO COMMUNITY SERVICES

The Process of the Study

This two year study is designed to efficiently collect and analyze information from resources which will be affected the most by terminating capacity available at the state mental health facilities currently available to serve persons with primary substance abuse. A significant component of this study is the stakeholder group, comprised of representatives from state mental health facilities, community services board mental health, substance abuse and emergency services components, state substance abuse provider organizations, the State Supreme Court and the Virginia Sheriff's Association. A membership list is included as Appendix C. Staff from the Central Office of the DMHMRSAS and the Attorney General's Office are providing staff support. This stakeholder group convened on August 26 and again on October 14. Subgroups to address the specific tasks of the study are forming and meeting throughout the study. The process of data collection and analysis will begin in late 1994.

Data Collection and Analysis

This study is based on the premise that cost-effective treatment must be "matched" to the client's needs. Anecdotal data indicate that persons with primary substance abuse now admitted to state mental health facilities have complex needs and will require access to an array of appropriate services, including extensive case management, to stabilize and begin recovery. Some of the services which may be required include short-term psychiatric care, stabilization, detoxification, primary care (residential treatment of up to six months duration), therapeutic communities (residential treatment lasting from six months to one year duration). The type of treatment depends on the type(s) of substances abused and history of use, prior treatment history, criminal history, gender, age, tendency towards violence, need for ancillary care such as housing, and primary medical care). By definition, these patients will not need extensive inpatient psychiatric care. Anecdotal data indicates that nearly all are medically indigent and that most have a history of prior treatment.

Survey of Patient Records

The data from this survey will assist in determining (1) the types of services and appropriate capacity which must be available to effectively treat persons with primary substance abuse now admitted to the state mental health facilities; (2) where services and capacity should be located to be most accessible to patients needing them; (3) the cost of currently providing these services in state mental health facilities (to estimate available resources for reinvestment); (4) the projected cost of providing these services in the community. DMHMRSAS staff, with assistance from a stakeholder task group, are currently developing a survey instrument. This instrument will be utilized to collect data from records of patients admitted to adult state mental health facilities three or more times during FY '93 and FY '94. Records of patients meeting this threshold will be selected by stratified random sample, based on admission volume to the facilities. Patients admitted by criminal commitment will

be excluded since, by definition, they are not eligible for diversion to the community. Patients whose records indicate the presence of a serious mental illness, as evidenced by a thought disorder, ten days after admission will also be excluded, since these types of symptoms indicate the need for the level of care appropriately provided by state mental health facilities. The ten day period provides adequate time for symptoms associated with serious mental illness but caused by alcohol or other drugs to clear. The estimated sample size is 500.

As a follow-up, 125 records will be reviewed with community services board staff from the board which referred the patient to the facility. This qualitative data will complement the quantitative information collected from the survey of patient charts by adding confirmation and depth not available in facility records. These 125 cases will be distributed proportionately among community services boards based on the number of admissions to state mental health facilities.

Anecdotal evidence about the needs of persons with primary substance abuse who are admitted to state mental health facilities, coupled with known capacity and utilization data, suggests that more community detoxification services are needed. Existing capacity needs to be expanded, and new capacity needs to be established in different geographic regions.

Regional differences are anticipated. It is also entirely possible that the survey will identify the need for new elements in the service array. These new services might include community-based (nonhospital) facilities to accept primary substance abuse patients on Temporary Detention Order, outreach services to shelters, establishing "sober floors" in Single Room Occupancy hotels with supportive outreach services, and development of models for ambulatory detoxification.

Survey of Local Law Enforcement

Because persons with primary substance abuse are integrally involved with local law enforcement, assessing the impact of changing the Code on local law enforcement agencies is an important component of the study. Similarly, local judiciary, including judges, magistrates, and special justices have significant roles in determining the fate of the person with primary substance abuse in the community. Since these judges, special justices and magistrates are a significant impetus in sending persons with primary substance abuse to state mental health facilities, their input is critical in considering any changes.

The data collected from these sources will help address the following questions and concerns:

What gaps currently exist in community services and how can they best be addressed?

1. What services are needed?

2. What services are available?
   (a) Is existing capacity adequate?

(b) Other barriers to access (e.g., distance, cost)

3. What new types of services need to be developed
   (a) Secure stabilization units for primary substance abuse patients exhibiting suicidal behavior (architecture, staffing, training, regulation, support/ancillary services)
   (b) Extensive, specialized case management services
   (c) Other needs to be determined by clinical records review data collection

4. Where do these services need to be located to address regional issues and most effectively divert primary substance abuse to state mental health facilities?

What will the cost be of addressing these needs?

1. Convert identified service needs to costs using CSB 4th Quarter Performance Reports, data from private providers and information from other states.

2. Compare projected costs of providing services in the community with cost of providing service in state mental health facilities.

3. Reinvest adequate resources in communities to develop appropriate services systems to serve persons with primary substance abuse previously admitted to state mental health facilities

What other supports are needed to successfully operationalize this option?

1. Granting of authority to select treatment sites appropriate for TDOs

2. Development and implementation of quality assurance mechanisms for selected sites and for new treatment models

3. Training for prescreeners in identification of primary substance abuse

4. Training for sheriff's staffs and local judiciary involved in the Temporary Detention Order process

5. Identifying resources to improve screening such as urine toxicology screens, Blood Alcohol Content kits, clinical interview instruments

6. Amendments to DMHMRSAS licensure regulations for new services (e.g., community based programs to receive persons on TDO; ambulatory detoxification, etc.)

V. CONCLUSIONS

The critical information which will be produced by HJR 269 will form the basis of recommendations for redesigning the substance abuse treatment service delivery system so that persons with primary substance abuse who are now admitted to state mental health facilities will receive the best clinical care at the least burden to the taxpayers of Virginia. These data will provide information regarding the types, capacity and geographic distribution of needed services, the cost of providing them in the community, and the impact on local law enforcement and the judiciary.

Thorough review and discussion of the information collected in this process will insure that sound, clinically appropriate treatment is available and accessible at the community level for persons with primary substance abuse now being admitted to state mental health facilities, and that available resources are used more efficiently.

LD1893156

HOUSE JOINT RESOLUTION NO. 269

Offered January 25, 1994

Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), with the assistance and cooperation of the Office of the Attorney General, to study community and facility treatment programs for individuals with chronic substance abuse problems.

Patrons—Cohen, Cranwell, Morgan, Thomas, Van Landingham and Woodrum; Senators: Calhoun and Robb

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Referred to Committee on Health, Welfare and Institutions

WHEREAS, chronic public inebriates and other individuals with chronic substance abuse problems often overwhelm the substance abuse services available in communities and clog the mental health system in addition to jail and other community systems; and

WHEREAS, chronic substance abusers account for a significant number of admissions to intensive mental health facilities and community mental health programs where specific substance abuse services may be lacking; and

WHEREAS, appropriate long-term treatment capacity in Virginia's communities is lacking; and

WHEREAS, detention and commitment laws do not clearly direct the legal management of public inebriates and other chronic substance abusers, who are thereby inappropriately placed in mental health facilities even though they often lack a diagnosis of major mental illness; now therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services, with the assistance and cooperation of the Office of the Attorney General, be requested to study community and facility treatment programs, including the clinical appropriateness and cost effectiveness of the current civil commitment process, for individuals with substance abuse problems and to make recommendations regarding alternatives.

The study shall: (i) address the development of an array of services, including community social detoxification and structured short- and long-term inpatient programs which more appropriately respond to the needs of individuals with chronic substance abuse problems; (ii) review the Code of Virginia as it relates to the civil commitment of individuals with primary substance abuse problems and make appropriate recommendations; (iii) recommend clinically appropriate and cost-effective alternatives to facility-based treatment for people who have chronic substance abuse problems; and (iv) develop cost estimates to expand community capacity to serve chronic substance abusers.

The Department of Mental Health, Mental Retardation and Substance Abuse Services shall complete its work in time to submit its recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

HJR 269
FEASIBILITY STUDY OF ALTERNATIVES TO CIVIL COMMITMENT
FOR PERSONS WITH PRIMARY SUBSTANCE ABUSE TO
STATE MENTAL HEALTH FACILITIES
WORK PLAN

Objective #1: Identify substance abuse treatment needs of persons admitted to state mental health facilities.

Responsibility Randall

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
1. Develop a survey instrument which can be applied to clinical records to assess SA treatment needs	1.A Review literature, including policies and programs of other states 1.B. Identify existing appropriate instruments or instruments which might be adapted (Vermont, ASAM) 1.C. Draft adaptations 1.D Review with stakeholder workgroup	Mellie Randall Randy Koch, Ph D. Sterling Deal	instrument	June 15, '94	September 15, 1994
2. Collect data from clinical records	2 A. Identify surveyors 2.B. Train surveyors 2 C. Coordinate survey with SMHF Directors 2 D Pilot instrument 2 E. Conduct survey 2 F. Compile data	Mellie Randall Linda Redmond Sterling Deal	data	October 15, 1994	February, 1995
3 Review and analyze data	3 A. Sort data by service needed and CSB of residence 3 B Identify existing community resources which might provide needed services 3 C. Identify gaps by region and subregion	Mellie Randall Greg Stoicis Lewis Gallant, Ph D. Stakeholder workgroup	service map	February, '95	March, '95

Appendix B

Objective #2 Assess costs to provide needed and appropriate substance abuse treatment services at community level.

Responsibility: Randall

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
1. Assign costs to identified service	1.A. Sort service needs by type and location 1.B. Identify existing appropriate providers and check capacity and costs 1.C. Identify unmet needs 1.D. Develop costs estimates on addressing these needs	Mellie Randall Sterling Deal Lewis Gallant, Ph.D. Stakeholder workgroup	list of needs sorted by met, unmet, with cost estimates	March, '95	April, '95
2. Draft report section	2.A. Compile data 2.B. Draft preliminary report section 2.C. Internal review 2.D. Stakeholder review 2.E. Incorporate comments	Mellie Randall	draft report	April, '95	May, '95

Objective #3 Conduct cost/benefit analysis of providing substance abuse treatment services at community level instead of State Mental Health Facility

Responsibility: Randall

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
1. Conduct cost comparison on service by service basis.	1.A. Sort service needs by type and location 1.B. Identify existing appropriate providers and check capacity and costs 1.C. Identify unmet needs, e.g., services gaps, buildings, training 1.D. Develop costs estimates on addressing these needs	Mellie Randall Sterling Deal Lewis Callant, Ph.D. Armistead Ransome Stakeholder workgroup	list of needs sorted by met, unmet, with cost estimates	May, '95	June, '95
2. Draft report section	2.A. Draft report section 2.B. Internal review 2.C. Stakeholder review 2.D. Finalize draft	Mellie Randall Sterling Deal	Draft report section	June, '95	July, '95

Objective #4 Collect information from local law enforcement re. impact (e.g., transportation and jails)

Responsibility: Randall

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
1. Construct survey instrument.	1.A. Solicit input from DCJS and Sheriff's Association 1.B. Construct draft instrument 1.C. Pilot instrument 1.D. Make necessary modifications	Mellie Randall J. Randy Koch, Ph.D. Ken Batten	survey instrument	September, '94	October, '94
2. Collect data	2.A. Distribute instrument 2.B. Collect instruments	Mellie Randall Sterling Deal	survey process	October '94	November, '95
3. Analyze data	3.A. Collate data 3.B. Analyze data	Mellie Randall Sterling Deal Ken Batten	data analysis	November, '94	December, '95
4. Draft report section	4.A. Draft report section 4.B. Internal review 4.C. Stakeholder review 4.D. Finalize draft section	Ken Batten	draft report section	January, '95	February, '95

Objective #5 Collect information from local judiciary re: impact (e.g., civil commitment hearings)

Responsibility: Randall

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
1. Construct survey instrument.	1.A. Solicit input from State Supreme Court 1.B. Construct draft instrument 1.C. Pilot instrument 1.D. Make necessary modifications	Mellie Randall J. Randy Koch, Ph.D. Jim Martinez	survey instrument	September, '94	October, '94
2. Collect data	2.A. Distribute instrument 2.B. Collect instruments	Mellie Randall Sterling Deal	survey process	October '94	November '95
3. Analyze data	3.A. Collate data 3.B. Analyze data	Mellie Randall Sterling Deal	data analysis	November, '94	December, '95
4. Draft report section	4.A. Draft report section 4.B. Internal review 4.C. Stakeholder review 4.D. Finalize draft section	Mellie Randall	draft report section	January, '95	February, '95

Objective #6 Draft interim and final reports

Responsibility Randall

TASK	STEPS	PRIMARY RESPONSIBILITY	PRODUCT	BEGIN DATE	COMPLETION DATE
1. Draft interim report	1.A. Present study plan to stakeholder groups for discussion 1.B. Incorporate comments 1.C. Draft interim report 1.D. Distribute internally for comment 1.E. Incorporate comments 1.F. Distribute to stakeholder group for comment 1.G. Incorporate comments and finalize	Mellie Randall	interim report	July, '94	September, '94
2. Draft final report	2.A. Collate section reports and edit 2.B. Distribute internally for comment 2.C. Incorporate comments 2.D. Distribute to stakeholder group for comment 2.E. Incorporate comments and finalize	Mellie Randall	Final report	July '95	September, '95

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