FINAL 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

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DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

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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 group constituted of professionals in the field of substance abuse treatment and emergency mental health services, and representatives of state and local agencies. It is a final report addressing the request to study treatment programs in the community and facilities, to study the clinical appropriateness and cost effectiveness of the current civil commitment process for individuals with substance abuse problems, and to make recommendations regarding alternatives.

Respectfully submitted,

Timothy A. Kelly

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EXECUTIVE SUMMARY

This document is the final report of a study mandated by the 1994 Session of the General Assembly. This report presents background information concerning estimated costs of serving persons with primary substance abuse admitted to state mental health facilities; empirical data concerning the clinical needs of persons with primary substance abuse admitted to state mental health facilities during a two year period, actual costs of providing the care, and estimated costs of providing more appropriate care in the community; data collected from a survey of sheriffs concerning the proportion of transportation resources absorbed by persons with primary substance abuse in the civil commitment process; and data about the cost to the court system of the current civil commitment process related to primary substance abuse collected by the Joint Legislative Audit and Review Commission (JLARC) for its own study of the involuntary commitment process. A review and discussion of legal issues pertinent to amending the Code to develop a separate civil commitment process for primary substance abuse is also included. The report concludes with a summary of findings and recommendations.

The study of clinical needs of persons with primary substance abuse admitted to state mental health facilities determined that more appropriate and cost-effective care could be provided in the community to persons with primary substance abuse who are now admitted to state mental health facilities, contingent upon the availability of appropriate capacity. Anecdotal data, utilization data, and the Department's own study of community capacity indicate that residential substance abuse treatment capacity, which encompasses the types of treatment most needed by persons with primary substance abuse entering state mental health facilities, is in short supply. The survey of sheriffs and review of court data from JLARC both indicate that more than one-third of civil commitment procedures involve persons with primary substance abuse.

The review of legal issues raised complex questions. First, fundamental constitutional questions concerning the reason and purpose for commitment need to be resolved. Issues related to protecting the confidentiality of persons committed for primary substance abuse, in the context of specific federal statutes and regulations in this regard, must be addressed. Since the criminal laws of Virginia already contain provisions for criminal commitment of offenders with substance abuse, the legal relationship between the Code sections would need to be specified. The current Code requires that the least restrictive alternative be utilized prior to civil commitment, yet practical barriers related to lack of community incentives and lack of community capacity often prevent this protection from being fully implemented. Finally, given that persons who seek care for primary substance abuse from state mental health facilities, either involuntarily or voluntarily, may present special medical and psychiatric needs, special attention must be given to facility design, program implementation, case management, and training.

The report concludes with four recommendations for action by the Department:

1. ***Census Reduction Emphasis*** - Future census management projects should place a special emphasis on diverting persons with primary substance abuse from admission to state mental health facilities. The Department has successfully undertaken several projects which provided incentives to community services boards to reduce admissions to state mental health facilities. All of these efforts have focused on persons with serious mental illness. The clinical data in this study clearly indicate that many persons now admitted to state mental health facilities with primary substance abuse could have received services in the community which would have been more clinically appropriate and more cost-effective than admission to a state mental health facility, assuming that capacity for the appropriate community program is adequate.

2. ***Expanded Community-Based Residential Capacity*** - Data from the Department's own study of community capacity indicates that residential substance abuse treatment services for adults are in high demand and short supply. The Department must explore methods of developing and expanding residential treatment capacity, including design and construction of appropriate facilities, program development and implementation, and development of human resources, to address the needs of persons now admitted to state mental health facilities with primary substance abuse. This effort should include detailed regional assessment of need and capacity, and should address the special safety issues, both personal and public, that some persons with primary substance abuse present.

3. ***Civil Commitment for Primary Substance Abuse*** - The Department, in conjunction with the Office of the Attorney General, should continue to explore the development of a civil commitment process for primary substance abuse which is separate and distinct from the process currently used for mental illness.

4. ***Funding*** - Since Virginia ranks above the mean in per capita expenditures for community-based substance abuse treatment, it should be possible to fund new substance abuse treatment services by reinvesting funds currently used for facility care or for substance abuse programs that are not proven to be effective.

HOUSE JOINT RESOLUTION 269: A STUDY OF COMMITMENT OPTIONS FOR PERSONS WITH PRIMARY SUBSTANCE ABUSE

I. INTRODUCTION

This document is the final report of a study mandated by the 1994 Session of the General Assembly, House Joint Resolution 269 (Appendix A). The interim report of this study was published as *The Study of Commitment Options for Persons with Primary Substance Abuse Problems* (House Document No. 46) to the 1995 Session of the General Assembly. This final report will summarize the findings of the interim report, present empirical data collected from the state mental health facilities, review issues related to amending the Code to provide for a separate civil commitment procedure for persons with primary substance abuse, and provide conclusions and recommendations. In keeping with the interim report's emphasis on efficiently utilizing taxpayer dollars, this final report will focus on the following objectives:

- Compare cost benefits of providing community-based treatment services to persons with primary substance abuse in lieu of utilizing services provided by the Department's seven adult mental health facilities;

- Make recommendations regarding the types of community-based services needed to divert primary substance abuse admissions from state mental health facilities;

- Identify and discuss critical issues related to amending the Code of Virginia regarding the commitment of persons with primary substance abuse problems; and

- Make recommendations regarding the impact of the study findings.

Review of Study Resolution

Based on concern about the impact of providing services to persons who chronically abuse alcohol and other drugs in 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."

Impetus for and Context of the Study

The initial legislative impetus for HJR 269 arose from a two year study of the impact of public inebriates on the criminal justice system. (See *The Impact of Public Inebriates on Community and Criminal Justice Services Systems*, House Document No. 46, 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 related to primary substance abuse. During the 1995 Session, the Joint Legislative Audit and Review Commission (JLARC) presented the General Assembly with a report, *Review of the Involuntary Commitment Process* (House Document No. 8, 1995 Session of the General Assembly). In collecting information for the report, JLARC identified that civil commitment for primary substance abuse was a significant issue affecting the civil commitment process, and recommended that the Department "examine the possibility of developing separate involuntary commitment criteria for substance abusers," "...determine how many of the individuals that are issued temporary detention orders would benefit more from being in a detoxication facility than in a psychiatric unit," and "...determine the costs and benefits of establishing and operating additional community-based detoxification units." (Recommendation 16, p. 55). In the same study, JLARC identified that more than 39% of individuals detained in the involuntary commitment process had a debilitating substance abuse problem. (p. 53).

Historically, a significant proportion of the Department's resources have been designated to support facility services. According to the Department's application for federal fiscal year 1996 community mental health block grant funds, 64% of its annual budget is expended for facilities, compared to 30% for services provided through community services boards. During 1995, pressed by the need to spend resources more efficiently, the Department initiated and completed a study to identify gaps in the continuum of care available in the community. This study indicates a need for more residential treatment capacity for persons with primary substance abuse problems.

Persons with Primary Substance Abuse Problems Have Different Clinical Needs Than Those With Serious Mental Illness

The Code of Virginia 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.*" § 37.1-203 (2)

Substance abuse sometimes occurs 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 acutely episodic nature of substance abuse, even among persons who have chronic substance abuse problems, which is similar to the persistent nature of serious mental illness. The persistent quality of serious mental illness often indicates a need for an environment which limits stimulation, reduces stress, provides medical and psychiatric attention, appropriate pharmaceutical therapies, and staff skilled in the use of supportive therapeutic approaches.

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 is preferable. When the individual arrives at the state mental health facility, however, staff receiving the patient on the admissions unit have no way of knowing if the behavior which precipitated the Temporary Detention Order is related to primary drug use or a serious mental illness, since facilities often receive no historical or clinical information other than that which relates directly to the Temporary Detention Order.

Description of Current Community-Based System for Substance Abuse Treatment

In Virginia, community-based public substance abuse treatment services are provided by the 40 community services boards (CSBs), which also provide mental health and mental retardation services throughout the state. Established by the Code of Virginia [§ 37.1-194 - 202.1], CSBs operate as entities of local government and offer services on an ability-to-pay basis to the citizens of their respective catchment areas.

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 substance abuse treatment services, such as community based detoxification, primary care and therapeutic communities. However, these community-based programs are generally operating at capacity, and often have waiting lists for services.

Financing

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. 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. Table 1 displays amounts and sources of these revenues for fiscal years 1993, 1994 and 1995 which were expended on community-based substance abuse treatment.

Table 1
Sources and Amounts of Funding
for Community Substance Abuse Treatment, FY '93, '94 and '95

Source of Funds	FY 1993	FY 1994	FY 1995
State	$24,050,928	$24,425,738	$25,476,108
Federal	15,844,757	15,244,290	18,810,835
Local	15,397,455	16,117,428	19,701,851
Fees	5,548,690	6,168,389	6,827,695
Other	747,831	1,771,486	1,058,392
TOTAL	$61,589,661	$63,727,331	$71,874,881

Sources: Community Services Boards 4th Quarter Performance Reports, FY '93, '94 and '95

Utilization

The total unduplicated number of admissions for FY '93 was 56,548, 59,471 in FY '94, and 64,463 in FY '95 (Community Services Board Fourth Quarter Reports, FY '93, FY '94 and "95). 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.

Unmet Need

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 provide services for about $135 per day. These units are usually very limited in bed capacity (about 9 beds), with average lengths of stay of less than 6 days. The limited size and relatively high rate of turnover has the effect of lowering the critical utilization rate, so that a rate of 80% has the effect of seriously limiting access to this necessary treatment component. In addition, many community-based detoxification units are hesitant to admit persons with active symptoms of psychosis, however short-lived, because the physical plants in which they operate are not well suited to provide adequate security for the

patient, and their staffs may not have adequate access to psychiatric resources which could assist them in assessing and addressing the presenting psychiatric symptoms.

During 1995, the Department completed a study to assess the need for services for all three program areas (mental health, mental retardation and substance abuse) served by the Department. For substance abuse, the data indicate a strong need for additional residential services, which includes detoxification as well as other residential components of community-based care important for stabilization and long-term self-reliance.

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 professionals working in primary health care settings are trained to treat substance abuse. Chronic substance abuse, particularly displayed in public, is perceived as 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.

The Current Role of the State Mental Health Facility in Treating Primary Substance Abuse

Persons with substance abuse problems may be admitted to state mental health facilities. The Department of Mental Health, Mental Retardation and Substance Abuse Services directly operates eight adult mental health facilities, with an operational capacity of approximately 2,500 beds. Anecdotal data indicate that substance abuse is often undiagnosed among individuals admitted to state mental health facilities. The reasons for this vary and are usually complex. Patients often arrive at the facility with information relevant only to the Temporary Detention Order, and without any historical information. The individual's behavior may be so erratic that the impact of alcohol or other drugs cannot clearly be distinguished from psychotic behavior. Urine toxicology screens to determine the presence of drugs and blood alcohol levels are not routinely collected at the site at which the individuals are held for the Temporary Detention Order, nor are these tests routinely performed at state hospitals, so that objective data are not available to assist the clinicians in making a substance abuse diagnosis. Medical and psychiatric training do not place a great deal of emphasis on substance abuse, so many physicians are not well equipped to diagnose or treat it. Because of these factors, the numbers of persons admitted to state mental health facilities diagnosed with primary substance abuse may be under reported.

Table 2 displays total admissions to state mental health facilities for persons diagnosed with primary substance abuse, average (mean) length of stay (ALOS) for discharged patients, annual cost, average (mean) cost per diem, and average (mean) cost per admission for fiscal years '92, '93, '94 and '95. Because the DeJarnette Center admits juveniles exclusively, admissions to that facility are not included in these data.

Table 2
ANNUAL SUBSTANCE ABUSE ADMISSIONS
TO STATE MENTAL HEALTH FACILITIES (FY '92-95) *

YEAR	PRIMARY SA ADMISSIONS	INVOL	VOL	FORENSIC	ALOS (days)
FY '92	1,973	1,292	520	161	21.0
FY '93	1,788	1,209	451	128	24.2
FY '94	2,173	1,342	697	134	21.1
FY '95	2,216	1,306	777	133	19.2

Sources: DMHMRSAS Annual Statistical Reports, 1992 , 1993, 1994, 1995
* Does not include DeJarnette Center

Admissions - Currently all of the state's mental health facilities accept admissions for persons with a primary diagnosis of substance abuse. These admissions fall into one of three legal categories: civil involuntary, civil voluntary, or forensic (criminal). Overall admissions for persons with primary substance abuse have been steadily increasing, although some decrease has occurred in the category of forensic admissions. A significant proportion of admissions for primary substance abuse are in the civil involuntary category. Admission data for primary substance abuse probably under represent the number of actual admissions with primary substance abuse diagnosis. 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 21 days. In FY '93, ALOS increased to 24.2 days. In 1994, ALOS decreased slightly to 21.1 days, and decreased again in FY '95 to 19.2 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. These problems occur because many community staff assigned to liaison functions with state mental health facilities are specialized in providing services to persons with serious mental illness and may not be knowledgeable about substance abuse treatment.

Annual Cost - Table 3 displays data related to costs. In FY '92, cost per bed day at state mental health facilities averaged $208, rising slightly to $209 in FY '93. In FY '94 the cost per bed day rose again to $234, and again in FY '95 to $253. Based on the above admission and ALOS information, the average cost of serving a patient with primary substance abuse in FY '92 is estimated to be $4,368, increasing to $5,058 in FY '93. The estimated cost decreased slightly to $4,937 in FY '94, and with another decrease to $4,858 in FY '94. Taken as a group, serving patients with a primary diagnosis of substance abuse cost approximately $8,618,064 in FY '92, $9,043,346 in FY '93, $10,728,970 in FY '94, and

Table 3

ANNUAL COSTS OF ADMISSIONS FOR PRIMARY SUBSTANCE ABUSE TO STATE MENTAL HEALTH FACILITIES, (FY '92-95)*

YEAR	PRIMARY SA ADMISSIONS	ANNUAL COST	COST PER DIEM	AVG COST/ ADMISSION
FY '92	1,973	$37,755,328	$208	$19,136
FY '93	1,788	$34,753,356	$209	$19,437
FY '94	2,173	$47,797,308	$234	$21,996
FY '95	2,216	$53,261,560	$253	$24,035

Sources: DMHMRSAS Annual Statistical Reports, 1992 , 1993, 1994, 1995
* Does not include DeJarnette Center

$10,764,442 in FY '95. The fluctuations in annual cost and in the average cost of serving a primary substance abuse patient in a state mental health facility are directly related to fluctuations in ALOS. [(ALOS x admissions = patient days) x cost per day = annual cost.]

Anecdotal evidence suggests that persons admitted with primary substance abuse may utilize considerable facility resources. Because these patients are often not appropriate for the general milieu of the facility, they may be kept in admissions units longer, where staff to patient ratios are higher, increasing the cost of care. Persons admitted with primary substance abuse may have chronic, serious medical problems associated with chronic use of alcohol or other drugs, such as pancreatitis or ulcers, which require intensive medical intervention. Although lengths of stay are comparatively short, frequency of admission may be greater than for 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.

Clinical Issues Associated With Providing Care for Primary Substance Abuse in State Mental Health Facilities

State Mental Health Facilities May Not Provide Appropriate Treatment - In addition to cost issues, the milieu of state mental health facilities is not clinically appropriate for persons with primary substance abuse. Although some of these persons do experience life threatening crises, their needs could be addressed more appropriately in community-based programs. 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 highly 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, or 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 predate the addiction, a diagnosis of Personality Disorder may be suitable. 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 and careful use of psychopharmaceuticals). 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 by a person with a primary substance abuse problem 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 with a primary substance abuse disorder who presents him or herself for services through the civil commitment process may know that "acting psychotic" will provide a more likely opportunity for admission to a state mental health facility than acknowledging 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. The manipulation may be motivated by a real need related to lack of resources, such as shelter or food.

Primary Substance Abuse is a Multi-Faceted Disorder - 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, presence of other

life trauma such as physical or sexual abuse, and criminal justice history, 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 services are critical to provide the person with timely movement from one modality to another as the treatment needs of the person change over time.

Components of Effective Treatment for Primary Substance Abuse - All effective treatment approaches for primary substance abuse 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. In a well designed program 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 provide opportunities for the client to learn 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).

II. STUDY METHODOLOGY AND RESULTS

As mandated in the study resolution, the study design focused on answering efficacy and cost-benefit questions for three policy areas: clinical treatment services; criminal justice impacts and judiciary impacts. Data for two areas were collected by means of survey instruments specifically designed for these purposes. Because sheriffs provide transportation for persons who are civilly committed, they were surveyed regarding the impact of providing these services. Data addressing judiciary impacts had already been collected by the Joint Audit Legislative Review Commission (JLARC) for its study, *Review of the Involuntary Commitment Process* (House Document No. 8, 1995). The Department gratefully acknowledges the assistance and cooperation of JLARC staff for sharing this information and assisting in its interpretation. The major survey effort focused on identifying the clinical needs of patients with primary substance abuse problems admitted to state mental health facilities serving adults.

Clinical study

Rationale

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 more

efficiently utilized in communities to provide more clinically appropriate, cost-effective treatment. Substance abuse treatment which is effective, either clinically or from a cost perspective, is "matched" to the consumer's needs. Careful matching increases the probability that the consumer will get the appropriate intensity and duration of treatment, reducing the number of ineffective treatment episodes and the number of relapses. This approach assures that the resources used to support substance abuse treatment are used most efficiently. According to the literature and current state-of-the-art practices, the type and level of treatment into which a patient is placed should be based on several critical factors:

- Substance abuse status
    - Type(s) of substances abused
    - History and consequences of substance use
    - Prior treatment history
- Psychiatric status and history
- Criminal history
- Gender and age
- Risk for violence
- Medical condition
- Social stability

The clinical survey was designed to: (1) identify specific services which, if present in the community, might have obviated the need for admission to the state hospital; (2) determine the actual cost of providing services in state mental health facilities to identified patients with primary substance abuse; and, (3) project costs of providing these services in the community.

Methods

To design a system that will divert unnecessary admissions, data reflecting the actual number of persons admitted with primary substance abuse problems, types and frequencies of clinical needs exhibited on admission, and actual costs of these admissions is critical. A subgroup of the Stakeholder Workgroup worked with staff of the Department of Mental Health, Mental Retardation and Substance Abuse Services to design a survey instrument to collect appropriate information from patient records. The survey instrument focused on collecting the minimum amount of clinical information needed to determine appropriate patient placement for substance abuse treatment. A list of the subgroup members is included as a part of Appendix B. The instrument may be obtained by contacting the Office of Mental Health and Substance Abuse Services. Actual costs of providing treatment to the sample were extracted from the Department's Patient Resident Automated Information System (PRAIS).

To assure that the data collected in the clinical survey represented admissions about which ample clinical data was available, the data base for the study included only patients who had been admitted to state mental health facilities two or more times in two years (July 1, 1992 through June 30, 1994) with at least one admission in the last twelve months of the period. Since forensic patients are under the authority of the criminal court and cannot be diverted from admission, they were excluded from the group under study. Using the Department's Patient Resident Automated Information System (PRAIS) data base, 1,728 records of patients meeting this criterion from seven mental health facilities serving adults were identified. (Piedmont Geriatric Hospital was excluded from the sample.) The criterion of multiple admissions was an important one because it indicates high frequency of utilization of state mental health facilities, and because the patients' repeated contact with the state mental health facility system should have provided clinicians working with these patients additional opportunities to identify and correct diagnoses and improve treatment plans for these patients.

Clinical staff in each facility reviewed the clinical record for the most recent admission within the specified two year time period for each of the 1,728 patients to identify patients with a primary substance abuse problem, regardless of the admitting or discharge diagnoses or reason for admission. This step was necessary to provide an independent judgement concerning the diagnosis of substance abuse, since anecdotal data indicated that primary substance abuse is under diagnosed.

Because the focus of the clinical study was on identifying persons for whom community-based treatment might be an alternative, patients were excluded from the study if they were experiencing the serious and persistent symptoms of major mental illness ten days after admission. Although persons with primary substance abuse do experience serious psychiatric problems (such as suicidal thoughts and behaviors, feelings of paranoia, perceptions of grandeur, depression and other mood disorders), these symptoms are typically relatively brief in duration and usually cease soon after the person has detoxified. 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 acute symptoms. [Note: Although certain seriously mentally ill persons also abuse alcohol and other drugs, this study did not address their needs, and its recommendations are in no way intended to bar them from access to appropriate clinical care.]

Of the original 1,728 patients, 353 were included for further analysis using these criteria. Clinicians at each of the participating facilities completed a detailed clinical records inventory survey to identify the clinical and medical needs of these remaining 353 patients.

Findings

Descriptive Statistics - Of the 353 persons with primary substance abuse admitted two or more times in two years, 265 (75.1%) were male. These consumers were predominantly white (70.5%); 28.3% were black. The average age was 35.6 years, with the youngest admission being 18 years of age and the oldest being 70 years of age. The average number of lifetime

admissions to a state mental health facility was 5.7. In 262 cases (74.2%) cocaine was the primary drug of abuse and alcohol was the primary drug of abuse for 70 cases (19.8%).

Clinical Issues - Verbal suicidal threats had been made by 202 patients (57.2%) in the 12 months prior to admission, and suicide attempts had been made by 184 (52.1%) in the same 12 month period.

Of particular note are the Global Assessment of Functioning (GAF) ratings assigned these patients. The GAF scale is a subjective scale which provides clinicians a framework by which to assess the symptomatology and daily functioning of patients admitted to care. The scale ranges from 1, indicating persistent danger of severely hurting self or others or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectation of death, to 90, indicating an absence of minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, and no more than everyday problems or concerns. Because the GAF is a subjective scale, different raters may not agree on the rating they would assign the same patient. The GAF scale does, however, provide an understanding of how the clinician assesses the patient's ability to function at the time of admission. GAF ratings were completed on 270 (76.5%) patients of the 353 included in the study. A GAF rating of 50 or lower indicates serious symptoms.

Thirteen patients (3.68%) had GAF ratings of 90. Nearly 37% of the rated patients had GAF scores above 60, indicating, at worst, moderate symptoms or moderate difficulty in social, occupational, or school functioning.

Security Issues - In the year prior to admission, 101 (28.6%) patients had threatened violence; however, only 14 records indicated assault with a weapon. Arrests for violent behavior were evident in the records of 45 (12.8%) patients with convictions showing for 36 (10.2%). Thirty patients (8.5%) had been incarcerated for violent actions in the 12 months prior to admission.

Utilization and Cost Data - The average length of stay in the state mental health facility for the total sample ranged from 1- 479 days for the most recent admission during the 2 year period under review. The average length of stay was 24.1 days. The total facility charges for all 353 patients in the sample amounted to $2,488,992, with an average daily cost of $292.45.

To assess whether or not community-based care might have been appropriate for these patients, and to develop a basis for cost estimates when community-based care was an appropriate alternative, clinical data related to matching consumers to appropriate levels of treatment from a subsample of 88 randomly selected cases (25% of 353) were sent to 6 volunteer expert clinical reviewers (listed in Appendix B), all of whom are physicians certified by the American Society of Addiction Medicine (ASAM), familiar with nationally accepted treatment placement criteria developed by ASAM, and experienced in working with persons with primary substance abuse problems. Data on five cases was insufficient for the reviewers to determine appropriate treatment. In addition, the facility length of stay for one

case in the subsample was a clear outlier, so that case was also eliminated. These expert reviewers designated the appropriate clinical placements necessary to divert the remaining subsample of 82 cases from admission to a state mental health facility. The placements judged as clinically indicated by the reviewers were categorized by the current taxonomy of services to allow calculation of cost comparisons. These services ranged from outpatient to hospitalization in a short-term facility or a state mental health facility (e.g., long-term). For an explanation of how Virginia Department of Mental Health, Mental Health and Substance Abuse Services Community Services Taxonomy was converted into American Society of Addiction Medicine Patient Placement Criteria Levels (PPC-1), please refer to Appendix C.

Projected Costs of Community Treatment - Table 4 displays the distribution of the 82 patients reviewed by the experts by types of recommended treatment; the average annual per patient cost of the treatment by type of treatment; the projected utilization for the entire sample of 353 cases; and the corresponding projected costs for the entire sample. [1]

Table 4
PROJECTED COSTS OF PROVIDING COMMUNITY-BASED SUBSTANCE ABUSE TREATMENT SERVICES TO SAMPLE POPULATION

	Outpt	Intens Outpt	Social Detox	Shrt-trm Resident	Lng-trm Resident	Shrt-trm Hospital	State MH Facility	Total
Subsample N=82	1	8	20	20	12	20	1	82
Avg. Annual Cost Per Consumer	$691	$1,632	$785	$1,162	$5,889	$1,462	$7,000	$18,621
Subsample Cost	$691	$13,056	$15,700	$23,240	$70,668	$29,240	$7,000	$159,595
Cost For Total Sample (N=353) (4.3 = Sample Adjustment Factor)	$2,971	$56,141	$67,510	$99,932	$303,872	$125,732	$30,100	$686,259

According to the experts, four categories of community-based treatment could have addressed the needs of 73 (88%) of the patients: social detoxification was recommended for 21 (25.3%)

[1] The 82 patients for whom valid data were available represented 23.2% of the 353 patients in the sample. Since these patients were selected at random, it is reasonable to view their clinical and cost data is representative of the larger sample. Data from the subsample were extrapolated to an estimate for the larger sample by means of multiplying each data element by 4.3. (353÷ 82 = 4.3)

patients; long-term residential treatment was recommended for 20 (24.1%) patients; short-term residential treatment was recommended for 12 (14.46%) of the patients, and short-term hospitalization was recommended for 20 (24.1%) patients. Note that the expert reviewers determined that only 1 of the 83 patients needed to be admitted to a state mental health facility for substance abuse treatment.

The actual costs of treating these consumers in state mental health facilities (derived from state facility fiscal records) were compared to costs associated with the projected alternative, community-based treatment (where clinically appropriate). The costs of the alternative services were based on the statewide averages for all community services boards for these types of services.

Based on these projections, the cost of diverting admissions to appropriate community treatment, assuming available capacity, could have been accomplished for the entire sample of 353 at a cost savings of $1,802,733 compared to the actual cost of treatment provided at state mental health facilities. The following displays this calculation:

$2,488,992	Actual cost of providing treatment to sample in a state mental health facility
- 686,259	Estimated cost of providing diversionary treatment in community
$1,802,733	Estimated savings available to invest in community resources to divert primary substance abuse patients from inappropriate admissions to state mental health facilities

It is important to note that facility costs are for a single episode of inpatient care, while community-based cost estimates are based on the average annual cost of providing a specific service for a consumer.

It is likely that consumers who were treated in a state mental health facility also incurred costs related to community-based services prior to, or after, the hospitalization. In addition, since each patient was admitted to a state facility at least twice during the two-year period under consideration, there is the possibility that some of the subjects may have been admitted more than once within a given year. Thus, the reported costs are probably an underestimate of total service-related costs for those consumers when seen in the context of a typical year of services.

On the other hand, the community-based costs are based on the specific service the consumer would have needed at the point of hospitalization. The ASAM model assumes that consumers treated at one level of services (for instance, short-term residential) typically require lower-level services (for instance, outpatient) following completion of the higher-level services. Thus, it is quite possible that other services might have been required during the year. Such services would, most likely be at a lower level of cost (for example., outpatient average annual cost of $691 as compared to short-term residential at $1,162 per year). Additionally, since a typical course of nonhospital treatment lasts less than a year, and annualized costs were used in calculations, the results reflect the high end of possible costs. When taken

together, these factors indicate that the current data probably represent an underestimate of the costs incurred for hospitalized consumers and an overestimate of costs for these same consumers if they had been treated in appropriate community-based settings.

Discussion of Clinical Data

Thirty-seven percent of the 353 patients in the sample had a GAF score above 60, indicating moderate or milder symptoms of mental illness. This fact alone raises serious questions about the appropriateness of treating these patients in a state mental health facility, regardless of the reason for admission.

As has been discussed at several points, existing residential substance abuse treatment services are well utilized. Data from the Department's own study of the community treatment continuum indicate a lack of appropriate intensive residential treatment resources for substance abuse. If the issue of capacity is not addressed, state mental health facilities (and fiscal resources) will continue to be utilized inappropriately.

Based on the ASAM experts' assessment of the subsample, the overriding conclusion is that appropriate, community-based, residential substance abuse treatment services could have addressed the clinical needs of more than half (63.9%) of the patients in the subsample. When these services are costed out using the Department's cost data on similar services, the potential for significant savings and improved clinical services becomes evident.

Development of additional appropriate community capacity is a key factor in recognizing these savings. As these data strongly indicate, appropriate clinical services could be delivered in the community at a significant savings. Although a number of persons in the sample presented with suicidal indicators on admission, appropriate community-based facilities and programs could address these issues in a way which would be clinically responsible, without compromising patient or public safety.

Survey of Sheriffs

While conducting a previous legislative study, *The Impact of Public Inebriates on Community and Criminal Justice Systems (House Document No. 46, 1994)*, the Department conducted several surveys to identify alternatives to arrest for public inebriates. The results of this study indicate that, while arrests for public intoxication are declining, the economic impact of the public inebriate to the health care, treatment and criminal justice systems is significant and increasing.

To address the purposes of HJR 269, the Department, with the support and assistance of the Virginia Sheriffs' Association, conducted a survey of sheriffs' departments in September, 1995. Sheriffs were asked to estimate the percentage of civil commitment transports conducted by their departments related to the abuse of alcohol or other drugs. Taking into account that sheriffs' departments do not gather information on the clinical status of

individuals, over half the respondents indicated that more than one-third of transports for civil commitment were related to alcohol or drug use.

Impact on the Court System

Virginia has established a fund to support the medical and legal costs associated with temporary detention and involuntary commitment hearings. A study recently conducted by the Joint Legislative Audit and Review Commission (JLARC), *Review of the Involuntary Commitment Process* (1995), focused special attention on the costs and policy issues associated with operating this fund. Among the findings of this study, JLARC noted that "many emergency custody and temporary custody orders are executed for individuals who may be a danger to themselves or others due to substance abuse, although the treatment provided these individuals in mental health units is not directed at substance abuse problems." In a survey conducted as part of the JLARC study, special justices, magistrates, psychiatrists, psychologists, and physicians involved in the involuntary commitment process estimated that over 39% of all individuals detained have a debilitating substance abuse problem (pp 52-53). Based on FY '94 figures on expenditures from the involuntary mental commitment fund provided by the Supreme Court of Virginia, the expenses associated with processing and detaining these individuals could amount to more than $5 million each year.

III. DISCUSSION OF POTENTIAL CHANGES TO THE CODE

Options to Changes in the Code

When the stakeholder group met, three major categories of policy options were discussed, as listed below. A complete discussion of the implications of each of these options can be found in the interim report, House Document No. 46, 1995.

Option A: Continue the current practice of civil commitment for persons 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.

The Stakeholder Workgroup agreed that Option C best addressed the intent of HJR 269. This conclusion was supported by the Joint Audit and Legislative Review Commission Report, *Review of the Involuntary Commitment Process* (House Document No. 8, 1995), p. 55.

Amending the Code of Virginia may be necessary to improve both cost efficiencies and the quality of care for persons with primary substance abuse who are now civilly committed to state mental health facilities. Developing and implementing a separate statute focusing solely on substance abuse, apart from other mental illnesses, raises some very complex issues requiring careful consideration. Some of these concerns focus on specific constitutional provisions, and have been previously addressed by various courts around the country, including a dictum from the Supreme Court. Other considerations are related to the impact such a shift in policy would have on the capacity and types of services which would be required in the community.

Constitutional Issues Related to the Use of Civil Commitment for Substance Abuse

The practice of civil commitment for mental illness, including alcoholism and other drug dependence, is based on the legal doctrine of *parens patriae*, which provides that the state should act "as a parent" to protect persons judged to be incompetent from causing harm to themselves. In addition, the government has a fundamental obligation to protect its citizens from harm from others, which may include committing a person who threatens harm due to mental illness. These concepts raise several important issues when applied to utilizing civil commitment to address the problem of substance abuse.

1. *Reason for Commitment*

- *Status as an "addict"*
  In *Robinson v. California*, 370 U.S. 660, 666 (1962), the Supreme Court ruled that the status of addiction is not adequate grounds for criminal prosecution. A dictum in this opinion indicates, however, that being an addict, per se, is adequate grounds for compulsory treatment on a civil basis. The Code of Virginia includes drug addiction and alcoholism in the definition of mental illness. (§ 37.1-1)

- *Dangerousness as an essential element*
  Several court decisions have indicated that dangerousness is also an essential element for civil commitment, although what specifically constitutes dangerousness varies from state to state. Virginia standards require a finding that the person " (I) presents an imminent danger to himself or others as a result of mental illness, or (ii) has been proven to be so seriously mentally ill as to be substantially unable to care for himself."

2. *Purpose of Commitment Limited to Rehabilitation*

Several court decisions support the purpose of commitment for rehabilitation. For example, New York State Courts have ruled that being an addict is adequate grounds for civil commitment as long as the purpose of the commitment is for rehabilitation. [*Narcotic Addiction Control Commission v. James*, 22 N.Y. 2d 545, 293 N.Y.S. 2d 531, 240 N.E. 2d 29 (1968); [*People v. Fuller*, N.Y. 2d 292, 300 N.Y.S. 2d 102, 248 N.E. 2d 102, 248 N.E. 2d 17 (1969)]. Under *Wyatt v. Stickney*,

confinement of mentally ill persons for custodial purposes is not permissible; confinement must occur "for treatment purposes only." [325 F. Supp. 781 (M.D. Ala 1971)]. Under *Rouse v. Cameron*, the facility receiving the commitment must only demonstrate a bona fide effort to cure or improve the condition of the person under commitment. [*Rouse v. Cameron*, 373 F. 2d 451 (D.C. Cir., 1966)]

At present, the Department's state mental health facilities struggle to develop and maintain appropriate programs for the treatment of primary substance abuse. While a few have dedicated bed space and specifically trained staff for this purpose, most work with these patients without any established program. As explained elsewhere in this report, state mental health facilities and their staffs are generally not equipped, either by facility design, program design, or staff training to treat persons with primary substance abuse problems most effectively.

Other Legal Issues

1. <u>*Confidentiality*</u>

Federal law prohibits the disclosure of identity of a person receiving treatment for substance abuse by any entity receiving any federal funds. (42 U.S.C. 290dd-3; 42 U.S.C. 290ee-3; 42 CFR Part 2) The rationale for these laws and regulations are to protect persons seeking treatment for substance abuse, which may involve illegal activity, from surveillance which could lead to prosecution. If seeking treatment were a de facto admission of guilt, then few would seek it. The regulations contain specific procedures to share information for clinical reasons, as well as to obtain clinical records for law enforcement purposes.

The Code of Virginia specifies that "the relevant medical records, reports, and court documents pertaining to the hearings provided for in this section (§ 37.1-67.3) and § 37.1-67-2 shall be kept confidential by the court if so requested by such person, or his counsel, with access provided only upon court order for good cause shown. Such records, reports, and documents shall not be subject to the Virginia Freedom of Information Act (§ 2.1-340 et seq.)."

Persons who are committed for substance abuse are covered by the federal statutes and regulations, but in practice, their records go unprotected because they and their attorneys may not be aware of this fact and may not engage in the procedural steps necessary to protect them. The federal laws protect "the identity, diagnosis, prognosis, or treatment of any patients" participating in any substance abuse "function conducted, regulated, or directly or indirectly assisted by any department of the United States..." Since the state receives federal funding in many forms, any person receiving treatment for substance abuse in any state facility is covered by this law. If the Code were amended to specifically address civil commitment for substance abuse treatment, a

provision to address the applicability of the federal confidentiality statutes and the relevant regulations should be included.

2. *Relationship between civil commitment for substance abuse treatment and criminal statutes which provide for compulsory treatment as a part of criminal sanctions for drug related crime*

As *Robinson v. California* suggests, some states have attempted to consolidate laws pertaining to compulsory treatment of substance abuse into one section of their code. Prior to *Robinson,* California's laws on this subject were in the section for Penal Institutions. After *Robinson* and the accompanying dictum, the California Code was amended so that the problematic section was moved to the Welfare and Institutions Code. In both cases, the code contained provisions concerning compulsory treatment for narcotic addicts facing criminal conviction. At one time the New York State Code also had a complicated law which combined civil and criminal sanctions concerning narcotic addiction. These laws have since been amended, as well.

The Code of Virginia is clearly bifurcated between criminal and civil codes regarding compulsory treatment for substance abuse. The criminal code makes provisions for suspension of adjudication for first offenders with a requirement "to enter a screening, evaluation and education program" (§ 18.2-251); criminal commitment for treatment of drug and alcohol abuse (§ 18.2-254) and civil commitment for mental illness (§ 37.1-63 et seq.) Courts around the state frequently utilize the criminal code provisions for commitment. Persons who are criminally committed are typically sent to community-based residential substance abuse programs which are very intensive. Staff work closely with assigned Department of Corrections Probation Officers to monitor client behavior, and intermediate sanctions are utilized. These facilities, although not secure in the same sense as a jail cell, are often licensed and under contract with the Department of Corrections, as well as being licensed to provide substance abuse treatment by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

3. *"No less restrictive alternatives"*

In addition to the requirements that the person be either dangerous to himself or others, or be unable to care for himself, the Code of Virginia includes a third requirement for commitment, "(iii) that alternatives to involuntary commitment and treatment have been investigated and deemed unsuitable and there is no less restrictive alternative to institutional confinement and treatment." (§ 37.1-67.1) Use of this provision in the Code could redirect costly and clinically inappropriate commitments for primary substance abuse from state mental health facilities to community programs which would offer specifically designed programs at a reduced cost.

Current anecdotal information, coupled with data from this and other studies, suggest that the following scenarios impact interpretation of this part of the statute.

a. *The present system of financing community-based treatment does not provide incentives for community-based services to be utilized in lieu of admission to state mental health facilities for persons with chronic, albeit manageable, substance abuse issues.*

In some cases, community capacity is present to provide the appropriate treatment to the substance abusing person, but the particular person at hand may have utilized these resources on many prior occasions with little noticeable improvement. The community services board may believe that its resources should be focused on assisting persons who present a more optimistic prognosis, and, therefore, arranges to commit the chronic, substance abusing person to the state mental health facility at no expense to its own resources.

b. *Appropriate community capacity is lacking.*

As described elsewhere in this report, persons with primary substance abuse problems present with a wide array of perplexing symptoms in addition to dependence on alcohol or other drugs. These may include serious medical or psychiatric problems. Given that most of these persons are medically indigent, few community services boards have the resources to integrate care for serious medical or psychiatric problems (even short-term psychiatric crises) into their treatment programs. However, state mental health facilities are also not equipped to provide secondary or tertiary health care, and they are certainly not equipped to provide trauma care or intensive cardiac care. In addition, the psychotic symptoms which may accompany alcohol and other drug use are often acute in nature and could be resolved in a community-based setting, such as a psychiatric intensive care unit, in a few days. Less intensive residential care is in short supply statewide, however, mechanisms exist for community services boards to purchase the existing capacity from each other and from designated vendors.

c. *The alcoholic or addict may seek commitment as a refuge from the community.*

As economic stressors hit certain communities, certain persons with primary substance abuse, who have been living "on the fringe" of the community, may find it difficult to sustain themselves and may "arrange" to be committed by voicing suicidal or homicidal ideations or feigning psychotic behavior. In other cases, a person with primary substance abuse may suspect or have reason to know that he or she is under criminal investigation, and make seek refuge in the state mental health facility by means suggested above.

4. *Use of community-based programs in lieu of state mental health facilities as "willing institutions" to accept civil commitment for substance abuse*

In cases in which less restrictive outpatient alternatives are found to be appropriate (e.g., the person meets the first two criteria for civil commitment, but not the third), "the judge shall order such treatment, which includes outpatient commitment, day treatment in a hospital, night treatment in a hospital, outpatient involuntary treatment with anti-psychotic medication pursuant to § 37.1-134.5, or order such other appropriate course of treatment *as may be necessary to meet the needs of the individual.*" (§ 37.1-67-3) The following discussion presents some of the logistical issues which would need to be addressed to make application of this legal option practical.

a. *Development of capacity and special programs*

Virginia's public system lacks adequate substance abuse treatment capacity, especially residential services. Special programs which would include special provisions for security, would have to be developed and implemented, and existing capacity expanded, especially in the area of community-based short-term hospitalization for acute medical and psychiatric stabilization and residential treatment. Access to community psychiatric and psychological services would need to be expanded and improved around the state, to assure that patients were getting complete care.

b. *Security and special health and safety issues*

If criminally committed persons can be assigned to community-based care, contingent on meeting certain prescribed standards under the supervision of a probation officer, a similar model could be employed for civilly committed persons. To assure that the patient's physical and health needs were appropriate addressed, as well as to insure public safety from persons which could be dangerous to others, the Department, working with the Office of the Attorney General, the State Supreme Court, and provider associations would need to develop guidelines or standards for community-based programs wishing to become "willing institutions" for the commitment of persons with primary substance abuse problems. These standards would focus on architectural appropriateness (i.e., "close watch" areas for persons in danger of harming themselves; adequate physical security to protect the public from those who have threatened to harm others), appropriate staff training and ratios, appropriate programming and appropriate monitoring systems.

c. *Improved case management systems*

For "outpatient" commitment to be effective, patients would require intensive levels of ongoing assessment, monitoring of service delivery and progress in treatment. In addition to linking with the patient and special justice at the hearing, the case manager would arrange for the client to be thoroughly assessed, design a treatment service plan, work with appropriate treatment providers and other health and human service personnel to address the needs of the patient, monitor the patient's progress through treatment, arranging for transfers from one type of treatment to another when necessary (e.g., detoxification to intensive day treatment, housing, economic supports), and report back to the special justice as needed.

d. *Training for special justices*

In the criminal court system which allows for persons to be criminally committed to treatment pending sentencing or as a part of the sanction, training the judiciary about substance abuse and the range of services available has been a crucial element of success. Following this model, training for special justices would also be important in implementing this model.

Summary of Legal Issues

Separating substance abuse from other types of mental illness for the purpose of civil commitment presents challenging issues. Court decisions around the country have indicated that civil commitment for addiction is appropriate, as long as the purpose of the confinement is for rehabilitative purposes. Meeting the conditions of civil commitment for substance abuse may require a more specific legal standard regarding "dangerousness". The federal confidentiality statutes raise important questions about how the rights of individuals civilly committed for substance abuse are protected in the current system. Furthermore, because many activities related to substance abuse are illegal, the relationship between the civil commitment law and the criminal commitment law needs further examination. The criminal code and its implementation does suggest some models for designing and implementing a civil code specific to primary substance abuse.

Virginia's civil code already contains the provision for "outpatient" commitment which could be utilized more frequently if certain barriers were addressed. These barriers include lack of fiscal incentives for communities to control facility utilization by persons with primary substance abuse; lack of appropriate community capacity; and, practices which, in some cases, allow persons with primary substance abuse to manipulate the civil commitment procedure to gain admission to state mental health facilities. In addition, special treatment programs would need to be developed and implemented to address the needs of persons with primary substance abuse problems who are now entering the state mental health facility system. Some of these programs would need to pay special attention to implementation of

appropriate patient safety and security measures for patients needing a secure level of care. Case management systems of an intensive level would need to developed and implemented to address the complex needs of this patient group. Finally special justices would need to be extensively trained about substance abuse and utilizing appropriate community-based treatment resources.

IV. SUMMARY OF STUDY FINDINGS

House Joint Resolution 269: *The Study of Commitment Options for Persons with Primary Substance Abuse* was developed to focus attention on the impact of primary substance abuse on the civil commitment process, including clinical resources, law enforcement and the judiciary. The study emanated from a prior legislative study which had focused on the public inebriate and was conducted during a time when the Department was already concerned about the high utilization of state mental health facilities. The Joint Legislative Audit and Review Commission (JLARC) was conducting its own study, *Review of the Involuntary Commitment Process*, and had raised issues about the high proportion of persons with substance abuse problems who entered state mental health facilities through that venue.

As directed by the resolution, the study assessed the impact of current civil commitment practices for persons with primary substance abuse in four key areas:

- The impact on state mental health facilities;
- The impact on law enforcement; and
- The impact on the judiciary.
- Consideration of amending the Code to establish a distinct civil commitment process for persons with primary substance abuse.

The study identified the clinical needs of persons with primary substance abuse which are distinctly different from those with mental illness, although some persons suffer with both disabilities. The current community-based substance abuse treatment system has most of the appropriate components to provide treatment, but adequate capacity is lacking, as reported by the Department's own study of the community-based system, and by the fact that many programs report high utilization. Although state mental health facilities admit persons with primary substance abuse, their facilities, programs and services are, for the most part, designed to meet the needs of persons with serious mental illness, and do not provide comprehensive care for persons with primary substance abuse. Persons with primary substance abuse need to be provided with a stimulating, structured environment which emphasizes the consequences of substance abuse and clearly designates opportunities for responsibility in daily functioning early in the treatment experience. Thorough assessment

and matching of clinical needs with the appropriate treatment setting is essential if treatment is to be is clinically effective and cost-efficient.

Data gleaned from the review of 353 facility records of persons admitted to state mental health facilities with primary substance abuse problems indicate that nearly all could have received clinically appropriate treatment in community-based programs at significantly less cost, assuming that appropriate community capacity were available. In most cases, some type of residential treatment would have addressed the needs of the patient at significantly less cost. Moreover, many of the persons with primary substance abuse entering state mental health facilities appear to be functioning fairly well.

With the assistance of the Virginia Sheriffs' Association, sheriffs throughout the Commonwealth were surveyed concerning the impact of transporting persons with primary substance abuse involved in civil commitment procedures. Participating sheriffs estimated that over one-third of transports were related to primary substance abuse.

Data collected by the Joint Legislative Audit and Review Commission (JLARC) for its 1995 report, Review of the Involuntary Commitment Process, were used to assess the impact of current civil commitment procedures for persons with primary substance abuse. The special justices, magistrates, psychiatrists, psychologists and physicians, surveyed in that study identified that more than 39% of individuals detained in the civil commitment process have a primary substance abuse problem. Based on the expenditures from the Supreme Court's involuntary mental commitment fund for fiscal year 1994, expenses associated with processing and detaining individuals with primary substance abuse amounted to nearly $5 million annually.

Discussion of changing the Code to develop a separate civil commitment procedure for primary substance abuse identified many challenging and complex issues. Among these are: constitutional issues related to the reason and purpose of the commitment; protecting the confidentiality of the detained person; the relationship between the civil commitment procedure and the criminal commitment process for substance abusing offenders; the requirement that least restrictive alternatives be explored and its impact on the limited community capacity; and, development of facilities other than state mental health facilities to accept civil commitments for primary substance abuse.

V. RECOMMENDATIONS

1. ***Census Reduction Emphasis*** - Future census management projects should place a special emphasis on diverting persons with primary substance abuse from admission to state mental health facilities. The Department has successfully undertaken several projects which provided incentives to community services boards to reduce admissions to state mental health facilities. All of these efforts have focused on persons with serious mental

illness. The clinical data in this study clearly indicate that many persons now admitted to state mental health facilities with primary substance abuse could have received services in the community which would have been more clinically appropriate and more cost-effective than admission to a state mental health facility, assuming that capacity for the appropriate community program is adequate.

2. ***Expanded Community-Based Residential Capacity*** - Data from the Department's own study of community capacity indicates that residential substance abuse treatment services for adults are in high demand and short supply. The Department must explore methods of developing and expanding residential treatment capacity, including design and construction of appropriate facilities, program development and implementation, and development of human resources, to address the needs of persons now admitted to state mental health facilities with primary substance abuse. This effort should include detailed regional assessment of need and capacity, and should address the special safety issues, both personal and public, that some persons with primary substance abuse present.

3. ***Civil Commitment for Primary Substance Abuse*** - The Department, in conjunction with the Office of the Attorney General, should continue to explore the development of a civil commitment process for primary substance abuse which is separate and distinct from the process currently used for mental illness.

4. ***Funding*** - Since Virginia ranks above the mean in per capita expenditures for community-based substance abuse treatment, it should be possible to fund new substance abuse treatment services by reinvesting funds currently used for facility care or for substance abuse programs that are not proven to be effective.

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 STAKEHOLDERS WORKGROUP

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CONVERSION OF DMHMRSAS TAXONOMY SERVICE CATEGORIES AND COSTS TO ASAM SERVICE CATEGORIES FOR COST ESTIMATION OF PROVIDING COMMUNITY-BASED TREATMENT ALTERNATIVES TO STATE MENTAL HEALTH FACILITY-BASED TREATMENT

ASAM CATEGORY	DMHMRSAS TAXONOMY	PATIENTS SERVED	PROPORTION BY ASAM CATEGORY	AVG COST PER PT PER YEAR	PORTION OF COMBINED COSTS	SINGULAR/ COMBINED COSTS
Outpatient	Outpatient			$691	n/a	$691
Intensive Outpatient	Day Treatment			$1,632	n/a	$1,632
Detoxification	Medical/Social Detoxification			$785	n/a	$785
Short-term Residential	Primary Care	3508	93.14%	$1,028	$957	$1,162
	Group Home	258	6.86%	$2,981	$204	
Long-term Residential	Residential Rehabiliatation	670	41.80%	$4,669	$1,952	$5,889
	Long-term Habilitation	933	58.20%	$6,765	$3,937	
Short-term Hospitalization	Local Hospital Inpatient	116	36.59%	$1,887	$690	$1,475
	Community Hospital Detoxification	201	63.41%	$1,238	$785	
Long-term Hospitalization	State Mental Health Facility					

Source: Fourth Quarter Performance Reports, FY '94