REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Interim Report: Impact of Recent Legislation on Virginia's Mental Health System [SJR 42 (2008)]

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 3

COMMONWEALTH OF VIRGINIA
RICHMOND
2009

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

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The Honorable R. Edward Houck

Vice-Chairman
The Honorable Phillip A. Hamilton

Senate of Virginia
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The Honorable Harry B. Blevins
The Honorable L. Louise Lucas
The Honorable Ralph S. Northam
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April 7, 2009

The Honorable Timothy M. Kaine
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
General Assembly Building
Richmond, Virginia 23219

Dear Governor Kaine and Members of the General Assembly:

The 2008 General Assembly in Senate Joint Resolution 42 approved a two-year study, requesting that the Joint Commission on Health Care "receive, review, and evaluate the impact of certain recommendations and legislation on the mental health system....[and] consider and assess the recommendations of the Chief Justice's Commission on Mental Health Law Reform, the Virginia Tech Review Panel, the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services, other committees and commissions proposing recommendations related to the involuntary commitment process specifically and the system of mental health services in the Commonwealth, and legislation enacted by the 2008 Session of the General Assembly and signed into law by the Governor."

Enclosed for your review and consideration is the interim report requested by Senate Joint Resolution 42. A final report will be submitted in 2010.

Respectfully submitted,

R. Edward Houck

Preface

Senate Joint Resolution 42, introduced by Senator L. Louise Lucas during the 2008 General Assembly Session, was amended to request that the Joint Commission on Health Care (JCHC) complete a two-year study regarding "the impact of certain recommendations and legislation on the mental health system in the Commonwealth." JCHC was directed to complete an interim report during the first year of study.

Numerous studies and reports dating as far back as 1949, have found Virginia's mental health system to be critically lacking in community-based services. A national study, *Grading the States: A Report on America's Health Care System for Serious Mental Illness* (2006) by the National Alliance on Mental Illness (NAMI) gave Virginia an overall grade of "D" for its public mental health system. While the NAMI report considered Virginia's efforts to increase funding and promote recovery-based policies to be positive steps, the report also noted: "Beneath the excitement and hope…lies the reality that Virginia's public system has suffered from years of deep cuts that fell disproportionately on the community system." (Source: *Grading the States: A Report on America's Health Care System for Serious Mental Illness*, p. 171.)

The tragic Virginia Tech incident in April 2007 brought further attention to weaknesses in Virginia's mental health system. A number of investigations of the incident were undertaken, numerous hearings and meetings were held, and the Commission on Mental Health Law Reform (established in 2006 by the Chief Justice of the Supreme Court of Virginia) accelerated its timetable to examine issues related to the civil commitment process. In response to the findings of these investigations and studies, significant new funding and statutory changes were introduced during the 2008 General Assembly Session. This interim report documents the work of JCHC's Behavioral Health Care Subcommittee in considering mental heath law reform initiatives and proposals in 2008.

On behalf of the Joint Commission and staff, I would like to thank representatives of the Commission on Mental Health Law Reform; community services boards; and the Department of Mental Health, Mental Retardation and Substance Abuse Services as well as physicians; sheriffs; and special justices for their participation and contributions to the study effort.

Kim Snead
Executive Director
April 2009

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*Only reports which were electronically submitted are listed and included.

Interim Report:
Impact of Recent Legislation on Virginia's Mental Health System

Executive Summary

Authority for the Study

Senate Joint Resolution 42, introduced by Senator L. Louise Lucas during the 2008 General Assembly Session, was amended to request that the Joint Commission on Health Care (JCHC) complete a two-year study regarding the impact of recent findings and legislation addressing Virginia's mental health system.

SJR 42, as adopted by the General Assembly, directed JCHC to "receive, review, and evaluate the impact of certain recommendations and legislation on the mental health system….[and] consider and assess the recommendations of the Chief Justice's Commission on Mental Health Law Reform, the Virginia Tech Review Panel, the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services, other committees and commissions proposing recommendations related to the involuntary commitment process specifically and the system of mental health services in the Commonwealth, and legislation enacted by the 2008 Session of the General Assembly and signed into law by the Governor."

Background

Numerous studies and reports dating as far back as 1949, have found Virginia's mental health system to be critically lacking in community-based services. *Grading the States: A Report on America's Health Care System for Serious Mental Illness* (2006), a national study conducted by the National Alliance on Mental Illness (NAMI), gave Virginia an overall grade of "D" for its public mental health system. While the NAMI report considered Virginia's efforts to increase funding and promote recovery-based policies to be positive steps, the report also noted: "Beneath the excitement and hope…lies the reality that Virginia's public system has suffered from years of deep cuts that fell disproportionately on the community system." (Source: *Grading the States: A Report on America's Health Care System for Serious Mental Illness*, p. 171.)

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2008 Review by JCHC's Behavioral Health Care Subcommittee

The two-year evaluation of changes to Virginia's mental health system will be reviewed by JCHC's Behavioral Health Care (BHC) Subcommittee. The Subcommittee heard the following presentations during meetings held in 2008.

August 12, 2008 Meeting

STAFF REPORT:
ROLE OF PSYCHIATRISTS AND PSYCHOLOGISTS IN EMERGENCY CUSTODY ORDERS (ECOS), TEMPORARY DETENTION ORDERS (TDOS), AND INVOLUNTARY CIVIL COMMITMENT
Jaime H. Hoyle, Senior Staff Attorney/Health Policy Analyst

OVERVIEW OF 2008 GENERAL ASSEMBLY ACTION
Jane D. Hickey, Office of the Attorney General

COMMISSION ON MENTAL HEALTH LAW REFORM:
PROGRESS REPORT
Richard J. Bonnie, L.L.B., Chair of the Commission on Mental Health Law Reform

October 23, 2008 Meeting

DISCUSSION OF THE EFFECT OF MENTAL HEALTH REFORM CHANGES
James S. Reinhard, M.D., Commissioner, DMHMRSAS
George Braunstein, Public Policy Chair, VA Association of Community Services Boards
Nancy L. Quinn, Esquire, Special Justice (Serving Henrico County)
Sheriff Steve Draper, President, Virginia Sheriffs' Association/Sheriff City of Martinsville
Sheriff Beth Arthur, Arlington County
Sheriff Tommy Whitt, Montgomery County
Gary S. Kavit M.D., FACEP, Riverside Regional Medical Center, Newport News
Chris Nogues, M.D., Riverside Behavioral Health Center

COMMISSION ON MENTAL HEALTH LAW REFORM:
CURRENT AND PLANNED ACTIVITIES
Richard J. Bonnie, L.L.B., Chair of the Commission on Mental Health Law Reform
The Honorable Stephen D. Rosenthal, Esquire, Troutman Sanders LLP
Jane D. Hickey. Office of the Attorney General

Consideration of Mental Health Reform Legislation. Mental health reform legislation enacted during the 2008 General Assembly Session is summarized in the following table (Figure 1: *Summary of 2008 Mental Health Reform Legislation*). The legislation included substantive changes in:

- Commitment criteria by removing "imminent" from the dangerousness criteria.
  - Virginia was 1 of only 5 states that still included "imminent" danger in its requirement for commitment.
- Information/evidence considered for emergency custody orders and temporary detention orders including treating physician's recommendation and relevant hearsay evidence.
- Involuntary commitment process such as the information to be considered by the special justice including the pre-admission screening report and independent examiner's report.
- Requirements for independent examiner and treating physician to attend commitment hearing or be available for questioning; in addition CSB representative must attend the hearing or participate via telephone or "two-way electronic video and audio communication system…."

- Mandatory outpatient treatment plans which are to include the "specific services to be provided" as well as who will provide each service and the CSB responsible for the plan and for reporting "any material noncompliance to the court."
- Psychiatric inpatient treatment of minors by extending the maximum period of temporary detention from 72 to 96 hours and allowing a parent or legal custodian to authorize inpatient treatment for minors 14 and older who are "incapable of making an informed decision…."

FIGURE 1

SUMMARY OF 2008 MENTAL HEALTH LAW REFORM LEGISLATION

NEW COMMITMENT CRITERIA

HB 499 (Hamilton)/SB 246 (Howell)
Removes "imminent" from dangerousness criteria for commitment.

HB 499 (Hamilton/SB 246 (Howell)/HB 559 (Bell)
Adds more specific criteria to "substantially unable to care for self" criteria.

EMERGENCY CUSTODY ORDER CHANGES

HB 499 (Hamilton)/SB 246 (Howell)/HB 583 (Marsden)
Permits magistrate to renew 4-hour ECO for up to 2 additional hours for good cause.

HB 401 (Hamilton)/SB 81 (Cuccinelli)
Permits law enforcement to transfer custody of person to crisis stabilization or other facility under certain circumstances.

INFORMATION/EVIDENCE CONSIDERED FOR ECOS/TDOS

HB 499 (Hamilton)/SB 246 (Howell)/HB 1144 (Fralin)
Adds detailed list of information and evidence, including recommendations of any treating physician and relevant hearsay evidence.

INVOLUNTARY COMMITMENT CHANGES

HB 499 (Hamilton)/SB 246 (Howell)/HB 1144 (Fralin)
Adds detailed list of information and evidence to be considered including pre-admission screening and independent examiner reports.

HB 499 (Hamilton)/SB 246 (Howell)
Provides sufficient time to allow for completion of examiner's report and preadmission screening report and initiation of treatment to stabilize person's psychiatric condition to avoid involuntary commitment.

Defines more specifically the licensed mental health professionals who (if a psychiatrist or licensed psychologist is not available) may complete an independent examination. These professionals include "clinical social worker, licensed professional counselor, psychiatric nurse practitioner, or clinical nurse specialist" and are required to complete a certification program approved by DMHMRSAS.

Provides comprehensive list of what examination must consist of, including clinical assessment and review of TDO facility records, labs and toxicology reports, admission forms and nurses notes.

INVOLUNTARY COMMITMENT CHANGES (CONTINUED)

HB 499 (Hamilton)/SB 246 (Howell)/HB 560 (Bell)

Requires independent examiner, treating physician, and CSB representative to attend hearing or be available for questioning by phone or two-way electronic video and audio communication system.

Allows another CSB to attend the hearing if it is outside the "home" CSB's area with detailed procedures regarding delivery of reports and receipt of orders entered. The Court must provide time and location of hearing to CSB at least 12 hours prior to hearing.

HB 499 (Hamilton)/SB 246 (Howell)
Reduces duration of initial involuntary inpatient treatment order from 180 days to 30 days; any subsequent order for involuntary inpatient treatment shall not exceed 180 days.

MANDATORY OUTPATIENT TREATMENT (MOT) CHANGES

HB 499 (Hamilton)/SB 246 (Howell)
Indicates MOT treatment criteria is the same as for inpatient treatment but MOT must be deliverable on outpatient basis by CSB or designated provider, services must actually be available in community, and providers must actually agree to deliver the services.

Limits MOT duration to 90 days initially unless continued for not more than 180 days (per continuance; MOT order to designate that CSB where person resides is to monitor plan and report material noncompliance to Court.

Spells out MOT requirements for CSB including: development of initial treatment plan and filing of comprehensive plans with Court; detailed requirements for CSB monitoring of compliance and reporting to court; court review hearings; transportation to hearings and exams; and mandatory examination orders and capias.

Requires Court clerk to serve notice of hearings and orders.

HEARING RECORDS AND PRIVACY DISCLOSURES

HB 499 (Hamilton)/SB 246 (Howell)
Requires all court documents to be confidential but permits dispositional order to be provided upon written motion if court finds disclosure in interest of person or public. Requires records to be available to all treatment providers and CSB (including MOT providers).

Requires providers to disclose to one another all information on a person involved in juvenile or adult commitment hearings or jail transfer hearings; ECOs, TDOs, court orders, and health records to be provided to other health care providers and others involved in process. Provides immunity from civil liability for these disclosures unless harm intended or acted in bad faith.

PSYCHIATRIC INPATIENT TREATMENT OF MINORS

SB 247/SB 67/SB 68 (Howell)/HB 400/HB 402 (Hamilton)
Extends maximum period of temporary detention from 72 hours to 96 hours; requires appointment of both counsel and guardian ad litem; allows minor, age 14 or older and incapable of making informed decision to be admitted for inpatient treatment upon parental admission; and removes need for service of petition and notice of hearing when petition withdrawn or dismissed.

The second table (Figure 2: *Summary of Potential 2009 Mental Health Reform Legislation*) summarizes mental health reform bills that were expected (in November 2008) to be considered during the 2009 Session. Legislation proposed during the 2009 Session will be reviewed by the BHC Subcommittee during the second year of this study.

FIGURE 2

SUMMARY OF POTENTIAL 2009 MENTAL HEALTH REFORM LEGISLATION

TASK FORCE ON FUTURE COMMITMENT REFORM

LEGISLATION CARRIED OVER FROM 2008

HB 735 (Caputo) Allowing 3rd year law students to represent petitioners in commitment hearings
SB 274 (Cuccinelli) Transfer to outpatient treatment
SB 177 (Marsh) Assisted outpatient treatment

BILLS REFERRED TO MENTAL HEALTH LAW REFORM COMMISSION

HB 267 (Albo) Appointment of counsel for indigent petitioners in commitment hearings
HB 938 (Gilbert) Petitioner right of appeal
SB 102 (Cuccinelli) 3-tier transportation system
SB 106 (Cuccinelli) Substantial deterioration outpatient commitment criteria
SB 143 (Edwards) Extension of TDO to 96 hours
SB 214 (Edwards) Mandated special justice training
SB 333 (Cuccinelli) Independent examiner authorization to release detained persons
SB 335 (Cuccinelli) Offer of voluntary outpatient treatment to detained person; conditions

TASK FORCE ON ADVANCE DIRECTIVES

LEGISLATION CARRIED OVER FROM 2008

HB 1004 (Bell) Advance mental health directives

BILLS REFERRED TO MENTAL HEALTH LAW REFORM COMMISSION

SB 47 (Whipple/Lucas) Advance mental health directives

TASK FORCE ON ACCESS TO SERVICES

LEGISLATION CARRIED OVER FROM 2008

SB 16 (Edwards) Crisis intervention teams
SB 18 (Edwards) Pilot mental health courts
SB 65 (Howell) MH representation on community criminal justice boards
SB 138 (Puller) DOC to identify medical and psychiatric benefits for prisoners
SB 275 (Cuccinelli) Emergency psychiatric treatment for inmates
SB 440 (McEachin) Emergency psychiatric treatment for inmates

BILLS REFERRED TO MENTAL HEALTH LAW REFORM COMMISSION

SB 64 (Howell) Mandated CSB core services

COMMISSION FOR SPECIAL COLLABORATIVE STUDY WITH SCHEV

HB 751 (Peace) Providing mental health information to colleges and universities
HB 752 (Peace) Medical record release information

POTENTIAL MENTAL HEALTH LAW REFORM COMMISSION LEGISLATION

Transportation
Allow for a 3-tier transportation system to:

- Allow persons and entities other than law enforcement to transport for ECOs/TDOs
- Delete provision providing for cost of transportation to be paid by Commonwealth from jail funds, permitting law enforcement to bill Medicaid

Privacy Proposal
Permit health care providers to notify family members or personal representative of person's location and general condition

Health Care Decisions Act
Would permit health care agent designated by person in advance directive or guardian authorized by circuit court order to admit person who is determined incapacitated to mental health facility for up to 7 days

Independent Examiner Training Proposal
Psychiatrists and psychologists should also be required to complete DMMRSAS certification program

Would provide training on requirements of VA law on commitment and health records privacy

Rights of Persons in Commitment Process
Provide person opportunity to have family member, friend or personal representative notified of hospitalization and transfer

Add to events that permit set aside of default judgment for person involuntarily detained or admitted to mental health facility

Additional Legislation

Allow for extension of TDO to 4 or 5 days

Allow for mandatory outpatient treatment after inpatient commitment

Allow for mandatory outpatient treatment to prevent inpatient hospitalization

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This interim report documents the work of JCHC's Behavioral Health Care Subcommittee in considering mental heath law reform initiatives and legislative proposals made in 2008. The final report, addressing the provisions of SJR 42 (2008), will detail the Subcommittee's work in 2009, including any legislative options proposed for consideration during the 2010 General Assembly.

JCHC Staff for this Report

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Kim Snead
Executive Director

Behavioral Health Care Subcommittee

Joint Commission on Health Care

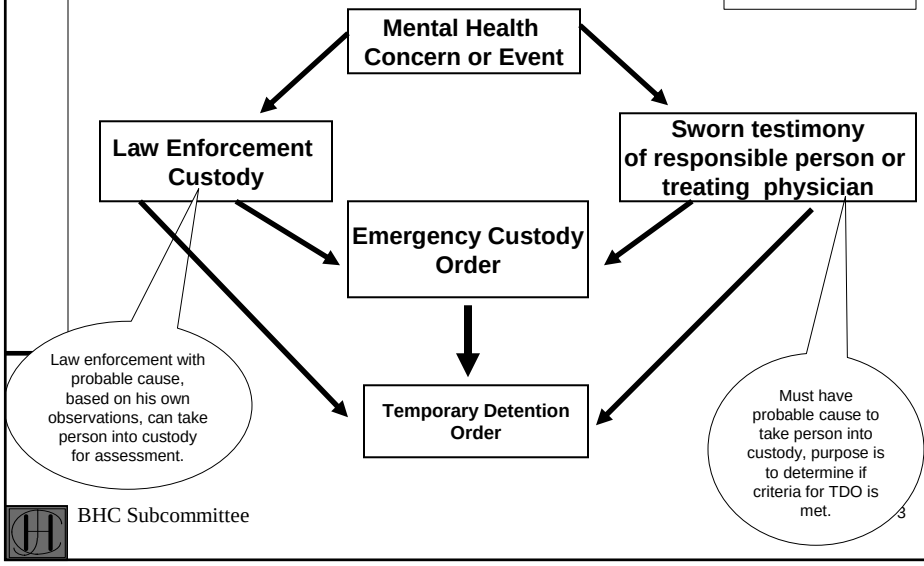
Role of Psychiatrists and Psychologists in Emergency Custody Orders, Temporary Detention Orders and Involuntary Civil Commitment

Jaime Hoyle
Senior Staff Attorney/Health Policy Analyst
August 12, 2008

Background

- Senator Houck and Delegate Hamilton requested, that as part of its 2008 Workplan, JCHC report on:
  - the availability of psychiatrists in Virginia, their role in emergency custody orders (ECOs), temporary detention orders (TDOs) and involuntary commitment hearings, and
  - methods to increase the recruitment and retention of psychiatrists including, but not limited to, the expansion of financial incentives, scholarships and fellowships at the Commonwealth's schools of psychiatry.

Emergency Custody Order Process



Emergency Custody Orders (ECOs)

- Probable cause for an ECO exists when "any person
  - (i) has mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future,
    - (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or
    - (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs
  - (ii) is in need of hospitalization or treatment, and
  - (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment." *Code of Virginia* § 37.2-808

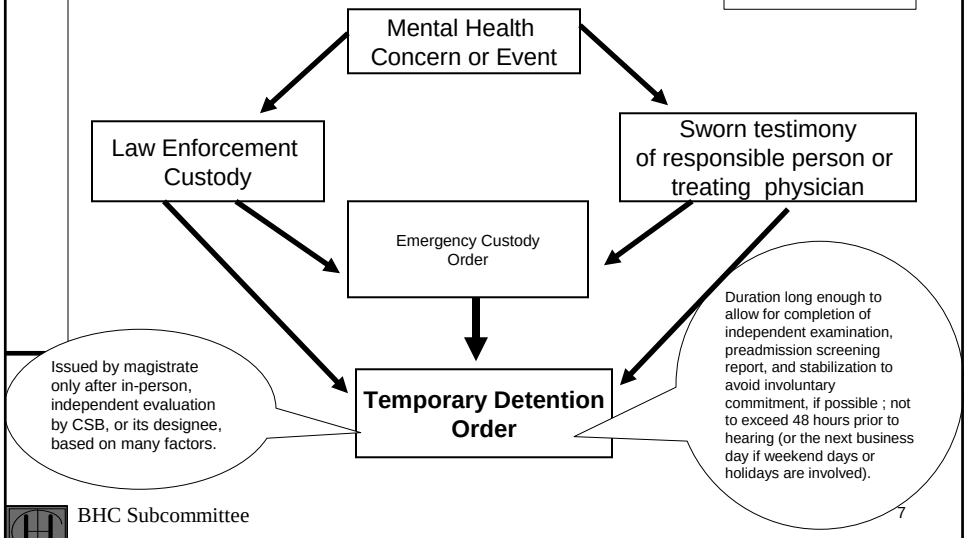
ECO Determination

- "When considering whether there is probable cause to issue an emergency custody order, the magistrate may, in addition to the petition, consider:
  (1) The recommendations of any treating or examining physician or psychologist licensed in Virginia, if available,
  (2) Past actions of the person,
  (3) Any past mental health treatment of the person,
  (4) Any relevant hearsay evidence,
  (5) Any medical records available,
  (6) Any affidavits submitted, ….
  (7) Any other information available." *Code of Virginia* § 37.2-808

Once ECO Issued

- Once an ECO is issued, the person is taken to a convenient location "to be evaluated to determine whether the person meets the criteria for temporary detention." *Code of Virginia* § 37.2-808
- "The person shall remain in custody until a temporary detention order is issued, until the person is released, or until the ECO expires." *Code of Virginia* § 37.2-808
  - If an ECO is not executed within four hours of its issuance, the order shall be void.

Temporary Detention Process



TDO Evaluation

- The in-person evaluation to determine whether a TDO should be issued is completed by an employee or designee of the local community services board (CSB).
  - The CSB evaluator must be "skilled in the assessment and treatment of mental illness" and must complete a certification program approved by DMHMRSAS.

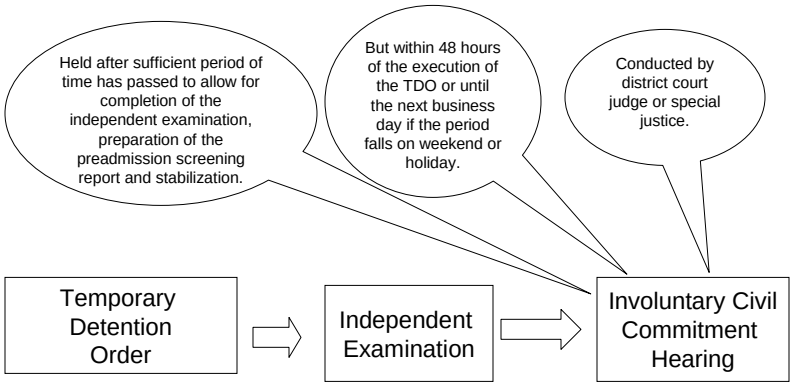
    Code of Virginia § 37.2-809
  - The CSB evaluator is more likely to be a licensed clinical social worker or licensed professional counselor rather than a psychologist or psychiatrist.

TDO Determination by Magistrate

- "When considering whether there is probable cause to issue a temporary detention order, the magistrate may, in addition to the petition, consider
  - (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available,
  - (ii) any past actions of the person,
  - (iii) any past mental health treatment of the person,
  - (iv) any relevant hearsay evidence,
  - (v) any medial records available,
  - (vi) any affidavits submitted, if the witness is unavailable and it so states in the affidavit, and
  - (vii) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue a temporary detention order."

  Code of Virginia § 37.2-809

Involuntary Civil Commitment Hearing



Independent Examination

- The district court judge or special justice "shall require an examination of the person who is the subject of the [commitment] hearing."
- The independent examiner is required to be a "psychiatrist or a psychologist who is licensed in Virginia by the Board of Medicine or the Board of Psychology and is qualified in the diagnosis of mental illness, or

Independent Examination

- If such a psychiatrist or psychologist is not available, a mental health professional who
  - (i) is licensed in Virginia through the Department of Health Professions as a clinical social worker, professional counselor, psychiatric nurse practitioner, or clinical nurse specialist,
  - (ii) is qualified in the assessment of mental illness, and
  - (iii) has completed a certification program approved by" DMHMRSAS. *Code of Virginia* § 37.2-815

Independent Examination

- The examination is required to be a comprehensive evaluation that consists of

"(i) a clinical assessment that includes a mental status examination;

determination of current use of psychotropic and other medications;

a medical and psychiatric history; a substance use, abuse, or dependency determination; and

a determination of the likelihood that, as a result of mental illness, the person will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs;

Independent Examination

(ii) a substance abuse screening, when indicated;

(iii) a risk assessment that includes an evaluation of the likelihood that, as a result of mental illness, the person will, in the near future, cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any;

(iv) an assessment of the person's capacity to consent to treatment, including his ability to maintain and communicate choice, understand relevant information, and comprehend the situation and its consequences;

Independent Examination

(v) a review of the temporary detention facility's records for the person, including the treating physician's evaluation, any collateral information, reports of any laboratory or toxicology tests conducted, and all admission forms and nurses' notes;

(vi) a discussion of treatment preferences expressed by the person or contained in a document provided by the person in support of recovery;

(vii) an assessment of alternatives to involuntary inpatient treatment and

(viii) recommendations for the placement, care, and treatment of the person." *Code of Virginia* § 37.2-815

Independent Examination

- The judge or special justice "shall summons the [independent] examiner who shall certify that he has personally examined the person and state whether he has probable cause to believe that the person

  (i) has a mental illness and that there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, and

  (ii) requires involuntary inpatient treatment."

  Code of Virginia § 37.2-815

Mental Health Law Reform

Overview of 2008 General Assembly Action

Jane D. Hickey
Office of the Attorney General
August 12, 2008

1

2008 General Assembly Action

- General Assembly made most sweeping reforms in mental health law since the 1970s
- Addressed all Virginia Tech Review Panel recommendations
- Appropriated just under $ 42 Million new dollars for:
  - Emergency mental health services, including crisis stabilization services
  - Increased case managers, clinicians
  - Children's mental health services
  - Jail diversion projects

2

2008 General Assembly Action

- Substantive law changes related to:
  - Commitment criteria for adults
  - Procedural requirements
  - Mandatory outpatient treatment
  - Disclosure and privacy provisions
  - Firearms reporting
  - Juvenile commitment procedures
- Most changes contained in Omnibus Bills HB 499(Hamilton)/SB 246(Howell)

3

New Commitment Criteria

- "Imminent" Removed from Dangerous Criteria:

"the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any"

HB 499 (Hamilton)/SB 246 (Howell)/ HB 559(Bell)

4

Commitment Criteria

- More specificity added to Substantially Unable to Care for Self criteria:

"the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs"

HB 499 (Hamilton)/SB 246 (Howell)/ HB 559(Bell)

5

Emergency Custody Order Renewals

Permitted magistrate to renew 4-hour ECO for up to 2 additional hours (6 hours total) for good cause:

- For CSB to identify suitable TDO facility, or

- Completion of medical evaluation

HB 499(Hamilton)/SB 246(Howell)HB 583(Marsden)

6

ECO Custody Transfer

- Law enforcement permitted to transfer custody of person to crisis stabilization or other facility if:
  - Facility licensed to provide security
  - Is actually capable of providing security needed
  - Has entered into agreement with law enforcement agency

HB 401(Hamilton)/SB 81(Cuccinelli)

7

Information/Evidence Considered for ECOs/TDOs/Commitment

- Lists in detail information magistrate may consider when issuing an ECO or TDO, including
  - recommendations of any treating physician
  - relevant hearsay evidence
- Lists in detail evidence special justice must consider, including
  - Pre-admission screening report
  - Independent examiner report

HB 499(Hamilton)/SB 246(Howell)/HB 1144(Fralin)

8

No Minimum Timeframe for Conducting Commitment Hearing

- Still shall not exceed 48 hours or until close of business on next day that is not Sat.,Sun., or holiday
- No minimum time - but sufficient time to allow for completion of examiner's report, preadmission screening report and initiation of treatment to stabilize person's psychiatric condition to avoid involuntary commitment where possible

HB 499(Hamilton)/SB 246(Howell)

9

Examiner – Qualifications

- Specified qualifications of independent examiner:
- Psychiatrist or Psychologist licensed in Va. and qualified in diagnosis of MI
- If not available:
  - Licensed clinical social worker
  - Licensed professional counselor
  - Psychiatric nurse practitioner
  - Clinical nurse specialist, and
  - Must complete certification program approved by DMHMRSAS

HB 499(Hamilton)/SB 246(Howell)

10

Examination Requirements

- Provided a comprehensive list of what examination must consist of, including clinical assessment and review of TDO facility records, labs and toxicology reports, admission forms and nurses notes

HB 499(Hamilton)/SB 246(Howell)

11

Examiner/Physician Attendance at Hearing

- Required examiner and treating physician to attend the hearing or be available for questioning by telephone or two-way electronic video and audio communication system

HB 499(Hamilton)/SB 246 (Howell)/HB 560(Bell)

12

CSB Attendance at Hearing

- Required CSB to attend hearing in-person, or if impracticable, by telephone or two-way electronic video and audio communication system
- Provided detailed procedures when hearing outside CSB area and another CSB attends on behalf of CSB of person's residence, including provisions for delivery of reports and receipt of orders entered
- Court must provide time and location of hearing to CSB 12 hours prior to hearing

HB 499(Hamilton)/SB 246(Howell)/HB 560(Bell)

13

Length of Inpatient Treatment

- Reduced duration of initial involuntary inpatient treatment order from 180 days to 30 days
- Any subsequent order for involuntary inpatient treatment shall not exceed 180 days

HB 499(Hamilton)/SB 246(Howell)

14

Mandatory Outpatient Treatment Criteria

Same commitment criteria as for inpatient treatment; plus

Ordered treatment must be deliverable on outpatient basis by CSB or designated provider

- Services must actually be available in community, and
- Providers of services must actually agree to deliver the services

HB 499(Hamilton)/SB 246 (Howell)

15

Mandatory Outpatient Treatment Duration

- Provided for duration of MOT not to exceed 90 days (Any continuances not to exceed 180 days)
- Required MOT order to designate CSB <u>where person resides</u> to:
  - Monitor implementation of MOT plan, and
  - Report any <u>material</u> noncompliance to court

HB 499(Hamilton)/SB 246(Howell)

16

MOT Requirements

- Required CSB to develop initial treatment plan and comprehensive plans filed with court and attached to order
- Provided detailed requirements for:
  - CSB monitoring of compliance and reporting to court
  - Court review hearings, including provisions for extension or rescission of orders, transfer of venue
  - Transportation to hearings and exams
  - Mandatory examination orders and capias
  - Requires Clerk service of notices of hearings and orders

HB 499(Hamilton)/SB 246(Howell)

17

Hearing Records

- Required special justice to record only one hearing per tape - SB 142(Edwards)
- Permitted person subject of hearing to obtain copy
- Required all court documents maintained confidential. Person may waive in writing
- Permitted dispositional order only to be provided upon written motion if court finds disclosure in interests of person or public
- Required records be available to all treatment providers and CSB, including MOT providers

HB 499(Hamilton)/SB 246(Howell)

18

Privacy Disclosures

- Required all providers to disclose to one another all information for a person involved in juvenile or adult commitment hearings, or jail transfer hearings and to:
  - Magistrate, juvenile intake officer
  - Court
  - Attorney, guardian ad litem
  - Evaluator, examiner
  - CSB
  - Law enforcement officer (limitations on information provided and its use

  HB 499(Hamilton)/SB 246 (Howell)/HB 576(Watts)

19

Privacy – ECOs, TDOs, Court Orders

- Also required all ECOs, TDOs and court orders to provide for disclosure of health records to other health care providers and to those involved in process.

HB 499(Hamilton)/SB 246(Howell)/HB 576(Watts)

20

Privacy Disclosures - Immunity

- Provided immunity from civil liability for health care providers disclosing records as part of process unless
- Intended harm or acted in bad faith

HB 576(Watts)

21

Reports to CCRE

- Required Clerk to forward prior to close of business on day of receipt, any order for
  - Involuntary admission to facility
  - Mandatory outpatient treatment
  - Any person volunteering for admission who was subject of TDO, or
  - Found incompetent to stand trial under 19.2-169.2

  HB 815(Albo)/SB 216(Edwards)

22

Restoration of Firearms Rights

- Provided a process by which person may petition general district court for restoration of right to possess firearm
- De novo right of appeal to circuit court
- Specified criteria for restoration of rights

HB 815(Albo)/SB 216(Edwards)

23

Psychiatric Inpatient Treatment of Minors Act

- Extended maximum period of temporary detention from 72 hours to 96 hours

  HB 582(Marsden)/SB 276(Cuccinelli)
- Required appointment of both counsel and guardian ad litem for minor in commitment hearing

  SB 247(Howell)

24

Psychiatric Inpatient Treatment of Minors Act

- Closed gap making minor incapable of making informed decision treated as parental admission of objecting minor age 14 or older

  HB 400(Hamilton)/SB 67(Howell)
- Provided no need for service of petition and notice of hearing when petition withdrawn in addition to dismissed

  HB 402(Hamilton)/SB 68(Howell)

25

Commission on Mental Health Law Reform: Progress Report to Joint Commission on Health Care

Richard J. Bonnie, Chair

August 12, 2008

Outline of Presentation

- Overview of the Reform Effort
- Summary of Commission Activities and Plans
- Status Report on Proposals Currently under Study

2

Overview of Status and Pace of Reform

Where We Now Stand

- Major first step taken in 2008, but much remains to be done
- Keep in mind goals of comprehensive reform

Goals of Comprehensive Reform

- Reduce need for commitment and other types of judicial involvement and prevent criminalization of mental illness by enhancing access to services to prevent crises or ameliorate them… and by drawing people into services by their own choice – system transformation is also "law reform"
- Provide needed mental health services to seriously mentally ill persons within CJS
- Redesign commitment process so that is more fair and effective: Coercion should be used as last resort, and only when necessary….
  - but when it is needed, it should be used and…
  - when it is used, it should be used effectively…AND fairly

5

Key Elements of Comprehensive Reform

- Make crisis stabilization alternatives to hospitalization and outpatient services for urgently needed care and other needed services and supports readily accessible
- Facilitate mental health interventions in appropriate cases by law enforcement officers through training and use of crisis stabilization facilities with "drop-off" capability
- Provide services to people who need them while incarcerated or under community supervision
- Modify commitment criteria to avoid unduly restrictive interpretations and promote greater consistency
- Improve quality and fairness of commitment decision-making
- De-stigmatize and "decriminalize" transportation of people with mental illness
- Give patients more opportunity to choose the treatment they receive, even when under commitment orders
- Use MOT as meaningful "less restrictive" alternative to hospitalization in appropriate cases

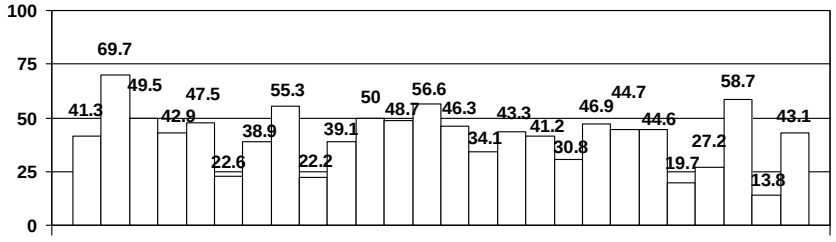
6

The Challenge of Implementing Reforms Adopted in 2008

- Lack of coordination and oversight has been a major problem, as illustrated by Cho case
- New reforms will fail without fundamental improvement in coordination and training across systems at state and local levels
- Responsible state and local agencies and courts have responded very well; these efforts must be sustained
- Wide local variations in local procedures and outcomes, often reflecting different interpretations of commitment criteria, illustrate the challenges we face

7

Percent of Crisis Contacts in which Involuntary Action was Taken by CSB



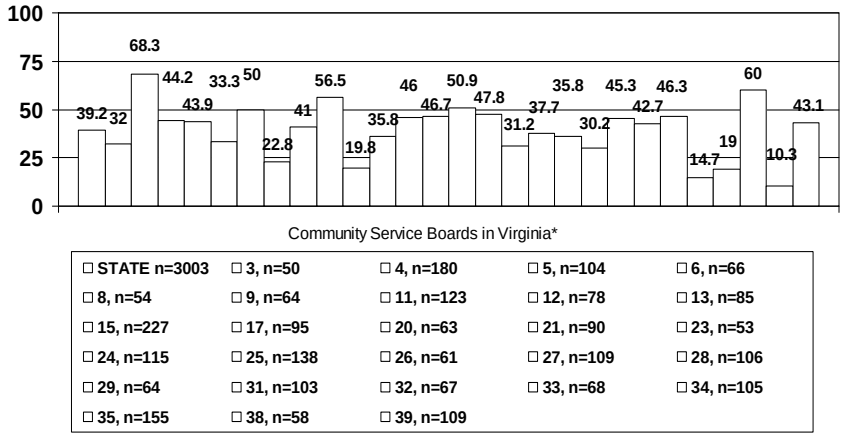
Community Service Boards in Virginia*

☐ STATE, n=2867	☐ 4, n=175	☐ 5, n=103	☐ 6, n=56
☐ 9, n=61	☐ 11, n=115	☐ 12, n=72	☐ 13, n=85
☐ 15, n=216	☐ 17, n=87	☐ 20, n=62	☐ 21, n=76
☐ 23, n=53	☐ 24, n=108	☐ 25, n=138	☐ 26, n=60
☐ 27, n=97	☐ 28, n=104	☐ 29, n=64	☐ 31, n=103
☐ 32, n=65	☐ 33, n=66	☐ 34, n=103	☐ 35, n=138
☐ 38, n=58	☐ 39, n=109		

*Only those CSBs with 50 cases or more

CSB Study 2007

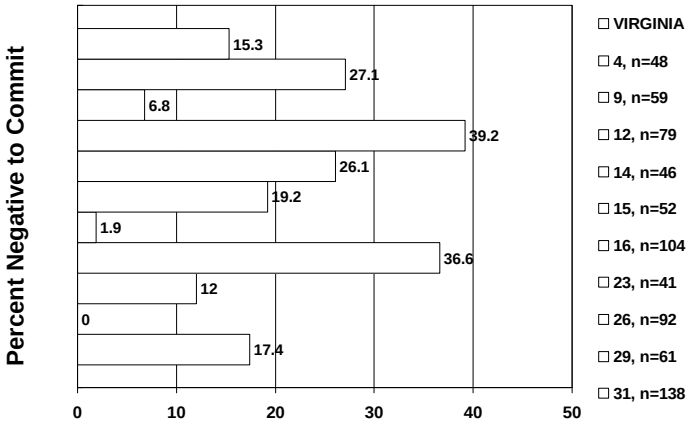
Percent of Crisis Contacts in which a TDO was Obtained by CSB



*Only those CSBs with 50 cases or more

CSB Study 2007

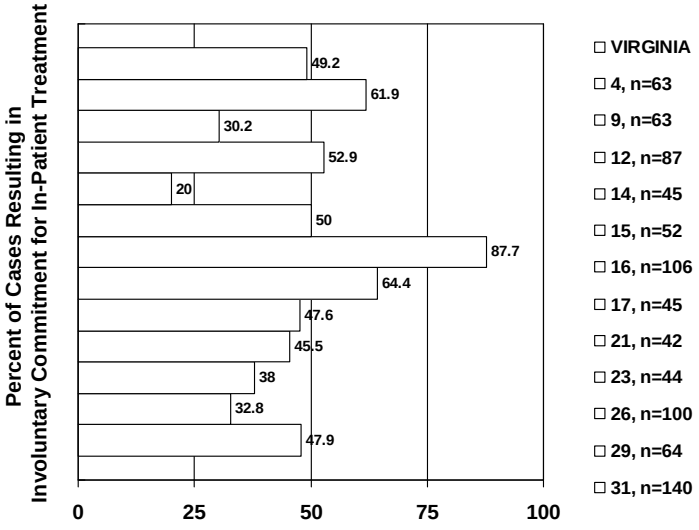
Negative Independent Examiner Certifications by District Court*



District Court Hearing Study 2007

*District Courts with 40 or more cases

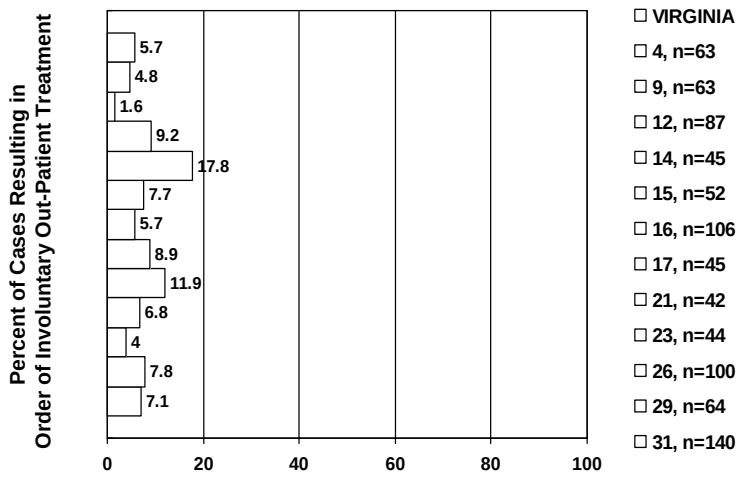
Hearing Disposition by District Court,
Involuntarily Committed to Inpatient Treatment*



District Court Hearing Study 2007

*District Courts with 40 or more cases

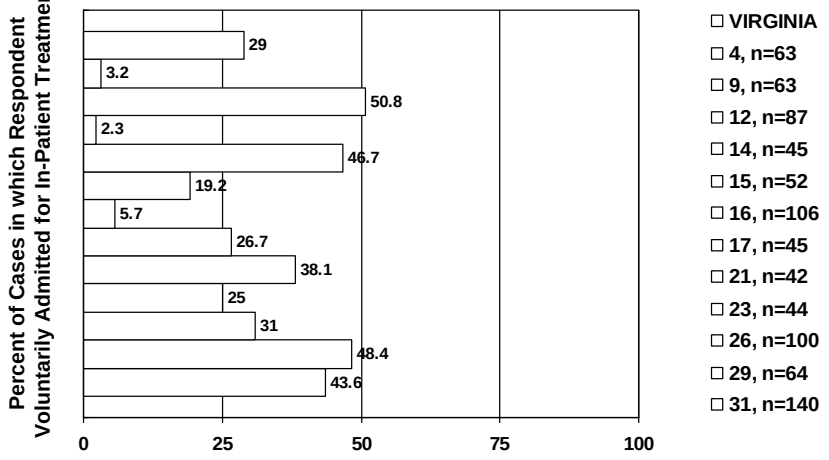
Hearing Disposition by District Court,
Ordered to Obtain Outpatient Treatment*



District Court Hearing Study 2007

*District Courts with 40 or more cases

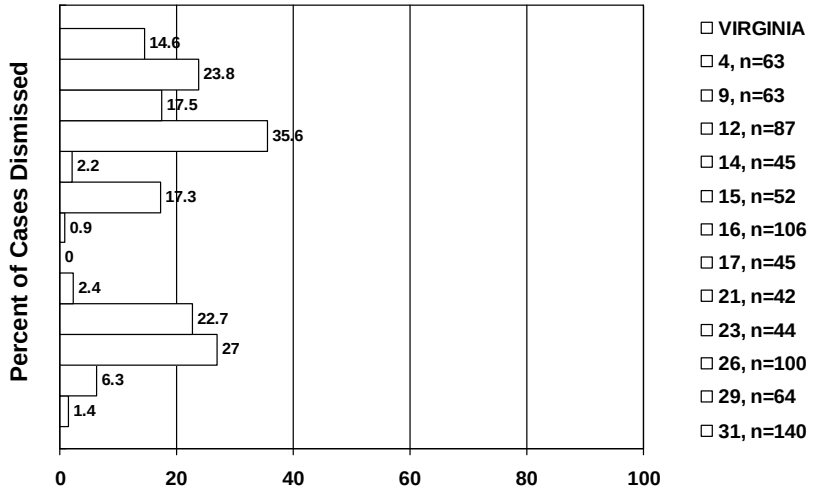
Hearing Disposition by District Court,
Voluntarily Admitted for Inpatient Treatment*



District Court Hearing Study 2007

*District Courts with 40 or more cases[13]

Hearing Disposition by District Court,
Case Dismissed and Respondent Released*

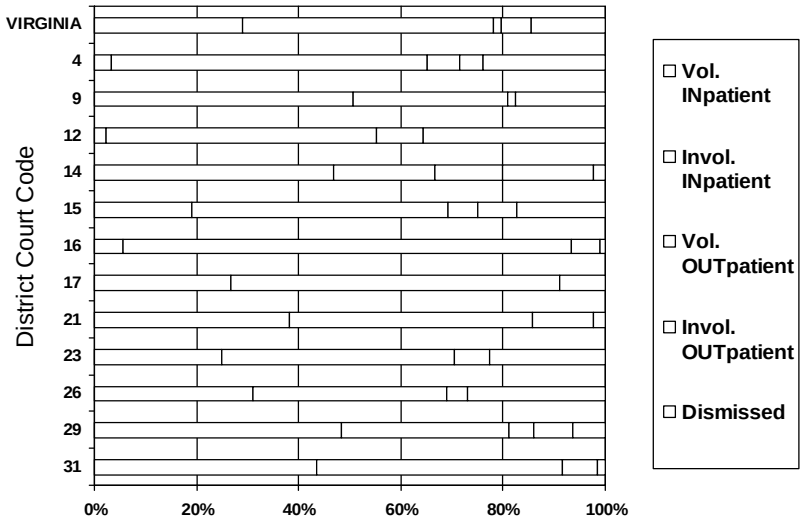


District Court Hearing Study 2007

*District Courts with 40 or more cases[14]

District Court Variations of All Possible Hearing Dispositions*

Percent of Cases Resulting in a Particular Disposition



District Court Hearing Study 2007

*District Courts with 40 or more cases

15

Frequency of Dismissal by Judge

# of Judges	# of Cases Heard	# Dismissed/Rate
All (66)	1284	187 (14.6%)
8	326	99 (30.4%)
7	390	5 (1.3%)

16

Looking Forward

- Reform is a long-term process, and should proceed incrementally but purposefully
- This year, we need to consolidate 2008 reforms and continue to move forward in fiscally responsible way
- Commission is likely to focus on small number of revenue-neutral proposals for consideration by General Assembly in 2009, deferring more substantial proposals until 2010

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II. Commission Activities and Plans

- Phase I: 9/06-4/08
- Phase II: 4/08-6/10

18

III. Status Report on Proposals Currently under Study

- Bills formally referred to Commission by Senate
- Other bills carried over and under study
- Other proposals under study

19

DMHMRSAS
Commonwealth of Virginia Department of
Mental Health, Mental Retardation and Substance Abuse Services

Allocation of Funding for Mental Health Law Reform

Joint Commission on Health Care
October 23, 2008

James Reinhard, M.D.
Commissioner, DMHMRSAS

DMHMRSAS
Commonwealth of Virginia Department of
Mental Health, Mental Retardation and Substance Abuse Services

2008 MH Reforms

- Changing criteria for emergency custody, temporary detention, and commitment from “imminent danger” to “substantial likelihood that in the near future he will:
  a) cause serious physical harm to himself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm, or
  b) suffer serious harm due to substantial deterioration of his capacity to protect himself from such harm or provide for his basic human needs”.
- Allowing an emergency custody order to be extended from four to six hours.

DMHMRSAS
Commonwealth of Virginia Department of
Mental Health, Mental Retardation
and Substance Abuse Services

2008 MH Reforms

- Clarifying responsibilities of CSBs and independent examiners throughout the civil commitment process, including mandatory outpatient treatment.
- Requiring CSB staff to attend commitment hearings.
- Requiring independent examiners and treating physicians of TDO patients to be available during hearings.
- Authorizing information disclosure among providers to deliver, coordinate or monitor treatment, and between providers and courts to monitor service delivery and treatment compliance.

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Commonwealth of Virginia Department of
Mental Health, Mental Retardation
and Substance Abuse Services

Civil Commitment Reform Allocation

The biennium budget included **$28.3M** in Item 316.KK to offset the fiscal impact of civil commitment reforms, including:

- emergency services
- crisis stabilization services
- case management, and inpatient and outpatient services for individuals who are in need of emergency mental health services

DMHMRSAS
Commonwealth of Virginia Department of
Mental Health, Mental Retardation
and Substance Abuse Services

Collaboration

To determine the funding allocation, DMHMRSAS:

- Sought input from CSB executive directors.
- Consulted with stakeholders, including:
  - VACSB
  - VA Hospital & Healthcare Assn
  - Office of the Exec. Secretary of the Supreme Court
  - DMAS
  - VA Sheriff's Assn
  - Medical Society of VA
- Established a reporting mechanism to track these funds during FY09-FY10.

DMHMRSAS
Commonwealth of Virginia Department of
Mental Health, Mental Retardation
and Substance Abuse Services

FY09 – FY10 Allocation Overview

FY 2009	**$10.3M**
Partial-year funds allocated to the 40 CSBs	**$9.9M**
Partial-year implementation of Southside VA Crisis Residential Stabilization program	**$250,000**
Funds set aside for unanticipated costs related to Code changes documented during implementation	**$141,713**
FY 2010	**$18,006,164**
Full-year funds for allocations to the 40 CSBs	**$12.1M**
Additional targeted services based on FY09 implementation evaluation	**$4,873,639**
Full-year funding of Southside VA Residential Crisis Stabilization program	**$750,000**
Funds set aside for unanticipated costs related to Code changes documented during implementation	**$250,000**

DMHMRSAS
Commonwealth of Virginia Department of
Mental Health, Mental Retardation
and Substance Abuse Services

FY09 – FY10 Allocation Methodology

Population size was used because:

- Population has a reasonable relationship to increased workload in implementing reforms.
- Using a straight per capita allocation would not give small CSBs sufficient funds to implement reforms.
- CSBs first grouped into 4 categories of population size (small, medium-small, medium-large and large) to ensure a base level of adequate resources for all CSBs (CSB leadership approved this methodology).
- Additional funds were added to FF/FC CSB's existing allocation as a large CSB based on its exceptionally large population size.

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Commonwealth of Virginia Department of
Mental Health, Mental Retardation
and Substance Abuse Services

FY09 – FY10 Allocation Methodology

FY 2009 and FY 2010 Individual CSB Allocations		
CSB Population Group	**FY2009**	**FY 2010**
Small (0 - 84,579)	$162,430	$198,895
Medium-Small (84,580 - 169,158)	$216,575	$265,194
Medium-Large (169,159 - 253,737)	$270,718	$331,492
Large (253,738+)	$324,862	$397,862
Fairfax-Falls Church	$433,149	$530,387
Total for all 40 CSBs	$9,908,286	$12,132,525

DMHMRSAS
Commonwealth of Virginia Department of
Mental Health, Mental Retardation
and Substance Abuse Services

FY09 – FY10 Allocation Methodology

CSBs must use their allocations to achieve the following broad goals:

1. Address Code changes (Ch. 8 of Title 37.2) related to the civil involuntary commitment process, such as attendance at commitment hearings and initiation of treatment during TDO period.
2. Address Emergency Services and Case Management Services Performance Expectations and Goals in Exhibit B of the FY09 performance contract, and
3. Increase mandatory outpatient treatment capacity.

DMHMRSAS
Commonwealth of Virginia Department of
Mental Health, Mental Retardation
and Substance Abuse Services

Accountability

- CSBs submitted proposed uses of individual allocations for DMHMRSAS approval
- Disbursements of the allocations are being included in CSBs' semi-monthly payments
- Each CSB must also submit a quarterly status report on its implementation of the approved proposals

DMHMRSAS
Commonwealth of Virginia Department of
Mental Health, Mental Retardation and Substance Abuse Services

FY09 Approved CSB Proposals

Service	FTEs	Consumers	State $	Total Cost*
Emergency Services	91	22,292	$5.6M	$6.62M
Outpatient Services	32	5,084	$2.6M	$3.98M
Case Management	31	3,061	$1.7M	$1.81M
Total	**154**	**30,437**	**$9.9M**	**$12.41M**

*** Total Cost reflects funds added by CSBs to the state allocations**

Page 11

Virginia Association Of Community Services Boards, Inc.
Making a Difference Together

Premier Mental Health, Mental Retardation, and Substance Abuse Services in Virginia's Communities

Impact of 2008 Actions-CSBs

George Braunstein, VACSB
Public Policy Committee Chair

October 23, 2008

Topics Included

- Overview of CSB/BHA service data
- Actions Taken as Result of Legislation
- CSB/BHA Accountability
- Trends Since July 1
- Major Challenges
- Budget Impact
- Next Steps

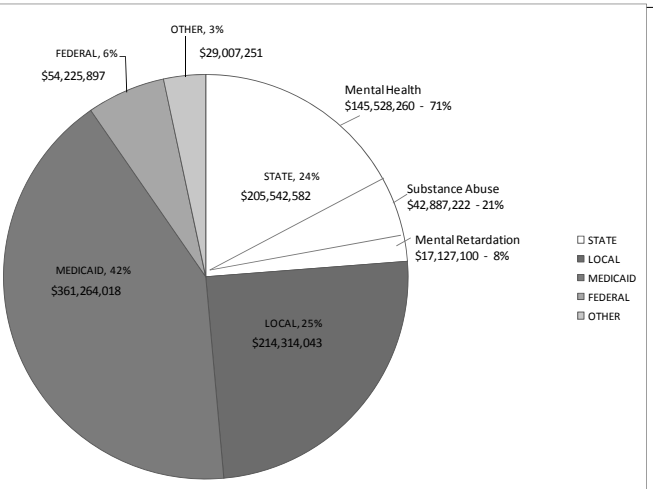
Virginia Association Of Community Services Boards, Inc.
Making a Difference Together

CSB/BHA Services

- In 2006-07, served 185,287 individuals
- 126,363 in mental health services
- 27,619 in intellectual disabilities
- 53,905 in services for substance use disorders
- Focused prevention services serve children of all ages and families-specific

Virginia Association Of Community Services Boards, Inc.
Making a Difference Together

3



Virginia Association Of Community Services Boards, Inc.
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Results of Legislation

- CSBs spearheaded community meetings to work through local processes of all involved
- Statewide training-in person, web-based, video/DVD based
- DMHMRSAS website contains FAQs and Answers vetted by experts

Results cont'd

- CSBs attend all commitment hearings via telephone or in person, even with geographic constraints
- Increase in recommitment hearings, especially at state hospitals due to 30 day initial commitment period

CSB Accountability

Certain emergency services standards are written into the DMHMRSAS/CSB Performance Contract

- Phone response time for qualified pre-screener: within 15 minutes
- Face-to-face response when indicated: within 1 hour (2 hours in a rural area)

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CSB Accountability

Data required by budget language now included in CSB data submissions to DMHMRSAS on a quarterly basis

- Number of ECOs, TDOs,
- Number of inpatient commitments and mandatory outpatient commitments

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Trends Since July 1

- Increase in requests for TDOs, often misunderstood by those requesting
- Increase in numbers of inpatient commitments
- No overall increase in Mandatory Outpatient Commitments
- Use of technology increased

Major Challenges

- Increased demand for scarce inpatient beds
- Inadequate supply of crisis stabilization beds
- Current deficit in Local Inpatient Purchase of Service (LIPOS) funds in every region
- Reinvestment has stalled
- Legal system still working through changes in Code
- Need for services continues to rise

Possible Budget Impact

- While a crisis continuum may continue, the next “level” of services may be reduced with more potential crises as a result
- In hard economic times, more individuals need mental health and basic support services
- Loss of jobs and insurance translate to greater demand placed upon public system

Services for Stability

- Case management
- Psychiatry and medications
- Housing
- Day support/psycho-social services
- Education
- Employment

Next Steps

- Working with DMHMRSAS to maintain Emergency Service, Acute Inpatient and Crisis Stabilization capacity as a system priority
- Continuing to meet the goals and expectations set out with the new Mandatory Outpatient Commitment laws
- Working with private providers to maintain/improve a coordinated response to consumers who are in crisis
- Expand community support capacity once the economy improves

Virginia Association Of
Community Services Boards, Inc.
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13

FY 2009 Mental Health Law Reform Individual CSB Allocations (Item 316.KK)		
CSB	**Population Size**	**Allocation**
Alexandria Community Services Board	Medium Small	$216,575
Alleghany Highlands Community Services Board	Small	$162,430
Arlington County Community Services Board	Medium Large	$270,718
Blue Ridge Behavioral Healthcare	Medium Large	$270,718
Central Virginia Community Services	Medium Large	$270,718
Chesapeake Community Services Board	Medium Large	$270,718
Chesterfield Community Services Board	Large	$324,862
Colonial Services Board	Medium Small	$216,575
Crossroads Community Services Board	Medium Small	$216,575
Cumberland Mountain Community Services Board	Medium Small	$216,575
Danville-Pittsylvania Community Services	Medium Small	$216,575
Dickenson County Behavioral Health Services	Small	$162,430
District 19 Community Services Board	Medium Large	$270,718
Eastern Shore Community Services Board	Small	$162,430
Fairfax-Falls Church Community Services Board	Large+	$433,149
Goochland-Powhatan Community Services	Small	$162,430
Hampton-Newport News Community Services Board	Large	$324,862
Hanover County Community Services Board	Medium Small	$216,575
Harrisonburg-Rockingham Community Services Board	Medium Small	$216,575
Henrico Area Mental Health & Retardation Services Board	Large	$324,862
Highlands Community Services	Small	$162,430
Loudoun County Community Services Board	Large	$324,862
Middle Peninsula-Northern Neck Community Services Board	Medium Small	$216,575
Mount Rogers Community MH and MR Services Board	Medium Small	$216,575
New River Valley Community Services	Medium Large	$270,718
Norfolk Community Services Board	Medium Large	$270,718
Northwestern Community Services	Medium Large	$270,718
Piedmont Community Services	Medium Small	$216,575
Planning District One MH and MR Services Board	Medium Small	$216,575
Portsmouth Department of Behavioral Healthcare Services	Medium Small	$216,575
Prince William County Community Services Board	Large	$324,862
Rappahannock Area Community Services Board	Large	$324,862
Rappahannock-Rapidan Community Services Board	Medium Large	$270,718
Region Ten Community Services Board	Medium Large	$270,718
Richmond Behavioral Health Authority	Medium Large	$270,718
Rockbridge Area Community Services	Small	$162,430
Southside Community Services Board	Medium Small	$216,575
Valley Community Services Board	Medium Small	$216,575
Virginia Beach Community Services Board	Large	$324,862
Western Tidewater Community Services Board	Medium Small	$216,575
Total Amount for 40 CSBs		$9,908,286

Population Size: Small = 0 - 84,579; Medium Small = 84,580 -169,158;
Medium Large = 169,159 - 253,737; Large = 253,738 +
Source: Weldon Cooper Center for Public Service (UVA) Final 2006 Population Estimates

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Hampton-Newport News Community Services Board	Large	$397,790
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Source: Weldon Cooper Center for Public Service (UVA) Final 2006 Population Estimates

MENTAL HEALTH TALKING POINTS
Sheriff Beth Arthur, Arlington County

Our jail ADP is 550 35-38% of our inmates have been diagnosed with a Serious Mental Illness. i.e. Schizophrenia, Bi-Polar, Major Depression.

About 164 out of approximately 550 inmates are on psychotropic medications in the Jail.

The specialized MH unit has close to a 100% occupancy rate on the male side and could easily fill an additional 15-20 beds.

Jails do not have a right to refuse and end up being the default place for a lot of the Seriously Mentally Ill (SMI)

We have found that people in jail with SMI spend significantly longer time incarcerated than those without for the same offense.

It is difficult to treat people in the jail environment because of the design; confinement structure, supervision and routine (SO don't have the staff/training to manage these individuals safely). This can lead to serious tragedies such as serious assaults, suicide, and self destructive behavior.

We are fortunate to have a 30 bed mental unit with forensic staff for those who are unstable and in crisis. Most jails do not have units designed for housing this population or the staff. Our forensic staffing includes a MH supervisor and two therapists

Forensic and medical care for those in jail is expensive and can deplete budgets causing overruns or shifting of funds from other priorities. SO do not have the budgets to absorb these issues. It currently costs $146 per day to house an individual in the ACDF and this does not include medical issues above basic care.

We spent $96,664.80 in 2007 for medications for SMI.

Many inmates also have a dual diagnosis of substance abuse disorder making it difficult to treat one without the other.

Examples of this are:

Example #1: A Young Vietnamese man who had a liver transplant at the age of 13. He also has seizures which may be related to his renal issues. He is diagnosed with Schizophrenia but has trouble with medications because of the way that they are filtered through his system.

Additionally he is a cocaine abuser. He has family whom he lives with but he chooses to go to the local Vietnamese shopping area where he is banned from. This leads to repeat incarcerations. His typically is arrested for Trespass which is a misdemeanor and leads to him being incarcerated. He goes to the GDC and the court orders him to be evaluated for a 19.2-169.1 Motion. The court psychiatrist meets with the inmate and determines that he is unable to stand trial and reports his/her findings back to the court. The court orders a 19.2-169.1 motion and forwards the order to our Transportation Section Supervisor. Our Transportation Section Supervisor notifies Western State Hospital and faxes a copy of the order. Western or Central State Hospital then assigns the inmate to the waiting list. The wait time to facilitate a transfer of an inmate to Western State Hospital or Central State Hospital is between 3-6 weeks if not longer. The inmate is transported to Western or Central State Hospital stabilized and then returned back to the ACDF. The inmate returns to court and is often given a time served sentence. The mentally ill inmate often spends more time in the jail and the criminal justice system then a non mental health inmate charged with the same offense.

Example #2: A Male who is diagnosed with Major Depressive Disorder and Borderline Personality Disorder comes into the jail on a number of charges related to drug use. He is an active heroin addict who was extremely high when he was incarcerated. He became suicidal and was placed in the crisis cell. Attempted to do a forensic TDO to Western but he would not pass medical clearance as he was HIV+ and had Hepatitis C. We had to manage him in the jail over the weekend. We were able to stabilize him without hospitalization.

Example #3: A Paraplegic male is incarcerated after an attempted "death by cop." He is actively suicidal throughout his detainment. He has Major Depressive Disorder as well as ongoing medical needs to include basic hygiene, bed turning and movement assistance. He attempted to kill himself many times during his incarceration. **He was given s state sentence and later committed suicide while serving his sentence at the DOC.**

We have not had much success at placing people in state facilities in emergency situations. One of the common issues is that they do not want to take anyone who is not medically cleared. When we take individuals to Virginia Hospital Center for a medical clearance the inmate often refuses to get vitals and such done so that he/she can be medically cleared. The state facility is then hesitant to take the person because they are "not a stand alone medical facility" and they would have to hospitalize the person if need be. Jails are not stand alone medical

facilities either. Again, the locality then foots the medical bills (and often the charges are for minor offenses).

Sheriffs play a key role in the Temporary Detention Order (TDO) Process

Each month we average 57 civil transports for those with SMI.

The shortage of psychiatric beds in our jurisdiction and the region present **huge** challenges and stress on Law Enforcement.

Deputies end up traveling thousands of miles transporting those with SMI across the state.

We conduct mental health civil commitment hearings on M,W, & F

I'd like to share these comments from our Lead Transportation Deputy:

The situations are always the same. The mental hearings are conducted. The Person is committed and there is no bed space. We wait for hours on bed space. Often due to various delays with the courts/medical clearance/locating a bed we spend much of our day waiting. Then have to leave Arlington as late as 5:00 p.m. to take mental patients to Rappahannock General Hospital in Kilmarnock, VA (2hrs 50 min one way, 140.49 miles one way without traffic) or Piedmont Geriatric Hospital in Amelia County (2 hrs 49 min one way, 161.25 miles one way). Often before you can get on the road down state you also have to make local stops to places like, Virginia Hospital Center, Dominion, Northern Virginia Mental Health Institute, Prince William and Snowden before beginning our journey to the long distance hospitals. The times are map quest estimates used to compile monthly reports and do not take in to consideration traffic.

We work very closely with our legislatures at appropriate times and constantly with our Community Services Board who we have a great partnership with.

For over two years the CSB Executive Director has chaired a monthly Mental Health Criminal Justice Committee with Judges, CA's Office, Sheriff, Police, Chief Magistrate, Dept. of Human Services, and Community Advocates exploring resources and alternatives. Thus far we have had two Forensic Case Managers funded by the State who work on jail diversion and links to services for those getting released. Our goal is ultimately to develop a Crisis Intervention Center (CIC) with collaboration from all of the above. There is a lack of funding for the CIC, but we continue forward with components of the overall program. New police officers have been trained in recognizing SMI and jail diversion.

Currently we are working on funding for and developing a Sequential Intercept Model for a Post Booking Magistrate Program to divert non violent SMI inmates to treatment.

Other ACDF initiatives include:

- ACDF is being considered to host the American Jail Association class "managing mental health inmates in your jail" in June of 2009.
- Established peer support groups for MH patients through NAMI.
- All new deputies and current special management unit deputies go through management training specific to the population they supervise.
- 8 deps/supervisors who work with the mental health inmates have gone through the new Crisis Intervention Team (CIT) training to recognize and work with the special management inmates. Program offered through DHS. Though since we are not the primary LE agency in Arlington it is not uncommon for PD to make an arrest hence brining individuals to the ACDF so that they do not have to deal with the TDO process (I can't blame them but it puts the burden on me).
- We are currently looking into the TOMAR program – a program that is very successful in Maryland that provides mental health, substance abuse, and trauma treatment for men and women in jail. This was a presentation at the governor's consortium on mental health. (Free training) – 15 week program. Contact – Dr. Joan Gilece @ 703-739-9333

At this point – we are unable to determine the impact of laws passed in July. But, there has been no impact to date in dealing with TDO's and 169 motions due to the lack of MH beds available in Northern Virginia.

19.2-169.1. raising question of competency to stand trial or plead; evaluation and determination of competency.

A. Raising competency issue; appointment of evaluators. - If, at any time after the attorney for the defendant has been retained or appointed and before the end of trial, the court finds, upon hearing evidence or representations of counsel for the defendant or the attorney for the Commonwealth, that there is probable cause to believe that the defendant, whether a juvenile transferred pursuant to § 16.1-269.1 or adult, lacks substantial capacity to understand the proceedings against him or to assist his attorney in his own defense, the court shall order that a competency evaluation be performed by at least one psychiatrist or clinical psychologist who is qualified by training and experience in forensic evaluation.

B. Location of evaluation. - The evaluation shall be performed on an outpatient basis at a mental health facility or in jail unless the court specifically finds that outpatient

evaluation services are unavailable or unless the results of outpatient evaluation indicate that hospitalization of the defendant for evaluation on competency is necessary. If the court finds that hospitalization is necessary, the court, under authority of this subsection, may order the defendant sent to a hospital designated by the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services as appropriate for evaluations of persons under criminal charge. The defendant shall be hospitalized for such time as the director of the hospital deems necessary to perform an adequate evaluation of the defendant's competency, but not to exceed 30 days from the date of admission to the hospital.

C. Provision of information to evaluators. - The court shall require the attorney for the Commonwealth to provide to the evaluators appointed under subsection A any information relevant to the evaluation, including, but not limited to (i) a copy of the warrant or indictment; (ii) the names and addresses of the attorney for the Commonwealth, the attorney for the defendant, and the judge ordering the evaluation; (iii) information about the alleged crime; and (iv) a summary of the reasons for the evaluation request. The court shall require the attorney for the defendant to provide any available psychiatric records and other information that is deemed relevant. The court shall require that information be provided to the evaluator within 96 hours of the issuance of the court order pursuant to this section.

D. The competency report. - Upon completion of the evaluation, the evaluators shall promptly submit a report in writing to the court and the attorneys of record concerning (i) the defendant's capacity to understand the proceedings against him; (ii) his ability to assist his attorney; and (iii) his need for treatment in the event he is found incompetent but restorable, or incompetent for the foreseeable future. No statements of the defendant relating to the time period of the alleged offense shall be included in the report.

E. The competency determination. - After receiving the report described in subsection D, the court shall promptly determine whether the defendant is competent to stand trial. A hearing on the defendant's competency is not required unless one is requested by the attorney for the Commonwealth or the attorney for the defendant, or unless the court has reasonable cause to believe the defendant will be hospitalized under § 19.2-169.2. If a hearing is held, the party alleging that the defendant is incompetent shall bear the burden of proving by a preponderance of the evidence the defendant's incompetency. The defendant shall have the right to notice of the hearing, the right to counsel at the hearing and the right to personally participate in and introduce evidence at the hearing.

The fact that the defendant claims to be unable to remember the time period surrounding the alleged offense shall not, by itself, bar a finding of competency if the defendant otherwise understands the charges against him and can assist in his defense. Nor shall the fact that the defendant is under the influence of medication bar a finding of competency if the defendant is able to understand the charges against him and assist in his defense while medicated.

(1982, c. 653; 1983, c. 373; 1985, c. 307; 2003, c. 735; 2007, c. 781.)

Joint Commission's
Behavioral Healthcare Subcommittee
Gary S. Kavit M.D. FACEP
October 23, 2008

My name is Gary Kavit. I am an Emergency Physician from Riverside Regional Medical Center in Newport News where I have been the Medical Director for over 10 years. I have served on the Interagency Civil Admissions Advisory Council and the Future Commitment Reforms Task Force. I have represented the Virginia College of Emergency Medicine on mental health issues for the past 4 years. Personally, I have an immediately family member who is Bipolar and a consumer of mental health services.

I believe there has been great effort in the past year to produce initiatives that will be meaningful for those requiring psychiatric services in the Commonwealth. The Task Force on Future Commitment Reforms has been working diligently to this end. Many of the issues being addressed by this committee however are issues not directly affecting the Emergency Medicine community that I represent. Emergency Physicians across the state still struggle with the delivery of care to there psychiatric patients. In light of budget cuts, we perceive the next 24 to 48 months will actually be a period of further deterioration of services, which will place an even greater burden on departments already struggling to be the healthcare safety net.

Our psychiatric patients deserve timely response to evaluations and disposition. The time to reach a disposition on a psychiatric patient, at around 8 hours on average, remains twice the time it did 6 to 7 years ago.

In a recent web survey sponsored by the Virginia College of Emergency Physicians 68% of those ED leaders that responded reported having experienced difficulties in CSB responding in person to perform prescreening when requested. In my area we have recently come to an understanding that this was not acceptable by meeting directly with our local CSB. It was made clear to me that this was a tenuous agreement in light of coming budget cuts. The fact may be that cuts may be so deep that this may prove difficult to maintain. In a medical sense, conducting an evaluation of a patient that is not face to face is sub-standard and **WILL** lead to medical errors. It was clear from our survey that this issue was widespread across geographic areas. There are areas that denied having an issue. I suspect that these

are areas that have also opened up a dialog with their local CSBs as we have done. It is my understanding that the law prescribes CSBs to provide performance contracts to the city or county they serve. Further they are to enter into contracts with other providers for the delivery of service. I do not think this is happening. I would encourage local dialog of CSBs and other providers. I am disappointed to see no product from the $500,000 allocated from last year's law reform for CSB oversight.

Even before we get into this year's budget cut we are very concerned of the lack of care provided for those consumers that are uninsured. If you present to an Emergency Department acutely as a mental health consumer, but do not meet TDO criteria you have a high degree of likelihood not to receive a psychiatric intervention. This is especially true if you do not have a pre-existing relationship with CSB. In light of the current economic climate, one can only assume we will be seeing clients new to mental health. There are instances where patients are being admitted under a TDO, in order to get services, where they might otherwise have been admitted voluntary. When they have their hearing days later they are often change to voluntary but are deemed ineligible for HPR-V funding. The psychiatric facilities are suffering significant losses to charity work, undermining their financial stability and health. In **one month** over the summer, the psychiatric hospital associated with our health system suffered losses equal to ½ of all of their charity work for 2007. This is not a recipe for survival. Dr Chris Nogues is here from Riverside Behavioral Health and could speak to this.

On a positive note, I do believe the crisis stabilization units are meeting the needs of some of the patients. Unfortunately open beds are few and qualifying patients often are left stagnant in the ER. In our case, our health system psychiatric facility will often absorb such a charity case as an inpatient, increasing their losses to benefit the patient and the health system.

Having given you my perspective on the current state of affairs, I would suggest the following points make reasonable sense and should be considered:

Begin monitoring strategies to focus on Performance Contracts with CSB's around the state. (The $500,000 allocated should be used for this project)

Require CSB Regions meet with key healthcare providers; Physicians, Healthcare Organizations etc. to enhance communication and strategize to improve coordination of care.

Recognize that communities may decrease the need for inpatient care, but this will not totally eradicate the need for hospital acute services. The health of these organizations is in jeopardy.

Recognize that cuts in crisis stabilization will result in fewer beds that already cannot meet the need of the communities. This will result in consumers' needs not being met.

In closing, Healthcare should be consistent, and provide the same appropriate level of care for all patients who willingly seek it. Voluntary patients need services just as involuntary patients do. I do not believe it was the intent of the re-investment project to transfer the burden of acute care from the state psychiatric facilities to the communities, now only to abandon their needs.

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Statement of Richard J. Bonnie
Prepared for the
Behavioral Health Subcommittee
of the
Joint Commission on Health Care
October 23, 2008

Senator Lucas, Delegate Morgan and other members of the Subcommittee:

Thank you for inviting me to appear before you today. I'm sorry I could not be there in person, but I hope you will find my virtual presence to be an acceptable substitute. I very much want to keep you informed about the Commission's plans and activities and to assist you in your own deliberations.

Let me begin with a brief review of the Commission's own schedule over the next few months:

- The Commission will hold its final meeting before the upcoming legislative session next week – on October 30-31.
- Immediately after that meeting, we will be submitting a report to the Senate Committee on Education and Health and the Senate Committee for Courts of Justice on the subject matter of the bills referred to the Commission for study in March at the close of the 2008 session. Our report will also comment on the subject matter of a number of other mental health bills that were carried over last year.
- In mid-December, we will submit to you a Progress Report on Mental Health Law Reform summarizing the Commonwealth's early experience in implementing the 2008 reforms and offering some additional suggestions for consideration by the General Assembly during the upcoming session.

Although the Commission has not taken final action on the matters it currently has under study, I can identify a few items that are likely to be our highest priorities for this session, subject of course to the advice of Senators Lucas, Lambert and Howell and Delegates Hamilton and Suit. With one possible exception, none of them will entail any additional funds.

- Our major proposal will be a bill amending the Health Care Decisions Act to empower people to prescribe specific instructions to guide their health care in the event that their capacity to make health care decisions becomes impaired by mental illness, dementia or other cognitive disability. The existing statute empowers people to designate health care agents and to give specific instructions regarding treatment at the end of life. However, it is silent on the use of instructional directives in other contexts, such as decisions about

mental health care or about placement and treatment in nursing homes. That is the gap that this proposal is designed to fill. Immediately after my statement, you will hear about this proposal from Steve Rosenthal who graciously agreed to chair the Commission's Task Force on Advance Directives.

- The Commission will also offer a few proposals in its continuing effort to improve the commitment process. Some of our proposals will respond to specific issues that have arisen during the process of implementing the 2008 reforms, while others deal with issues that were not addressed in 2008. Jane Hickey, who is chairing our Task Force on Future Commitment Reforms, will summarize some of the key proposals later this morning, but I want to highlight two of them now.

    - The first relates to transportation of individuals involved in the commitment process. As you know, reliance on law enforcement to provide transportation, and the routine use of restraints during this process, has been a major source of discontent among all the stakeholders for many years. As Jane will describe, the Commission is likely to be recommending enabling legislation to facilitate local efforts to develop clinically appropriate alternatives to transport by law enforcement in cases that pose little security risk.

    - Another important issue involves independent examiners. As I mentioned in my last presentation to the Subcommittee at its August meeting, the independent examiners play a critical -- and often determinative -- role in the commitment process. The Commission believes that training is needed to assure compliance with the new evaluation requirements prescribed in 2008 and to promote consistent application of the commitment criteria. Such training should be mandated for <u>all</u> examiners. At the same time, the Commission is very worried that the increased burdens of doing this important work will make it difficult to recruit and retain examiners unless the fee for these examinations is adjusted. Mindful of the deepening recession and accompanying budget constraints, the Commission will be addressing this matter at its upcoming meeting.

- It is also likely that the Commission will recommend some modifications to the Psychiatric Inpatient Treatment of Minors Act, including new procedures for mandatory outpatient treatment that are tailored the special circumstances of juvenile commitments. These proposals have been developed by the Task Force on Children and Adolescents chaired by Judge Deborah Paxson.

Finally, I want to mention three other very important issues that the Commission will continue to study over the coming year.

- As you know, the Commission has endorsed, in principle, the concept of lengthening the TDO period to 4 or 5 days. However, we are attempting to make informed projections regarding the costs and other consequences of such a change, such as how much it would reduce the number of commitment hearings and what impact it would have on the average length of hospitalization.

- The Commission has also endorsed the concept of increasing the range of core services that CSBs are mandated to provide. Obviously this would be a major change in the legal foundation of the community mental health services system, and our Task Force on Access to Services, chaired by Chuck Hall, continues to study it.

- Finally, as you know, a number of bills that were carried over would expand use of mandatory outpatient treatment. However, the Commission believes that it would be premature to expand the use of mandatory outpatient treatment until we have accumulated adequate experience with the extensive new procedures adopted in 2008. Preliminary data indicate that the number of such orders has been very small so far,

suggesting that the necessary service capacity has not yet come on line. The Commission is supportive, in principle, of permitting conditional discharge after inpatient commitment in appropriate cases, and believes that this would be the next logical step in the use of mandatory outpatient treatment. However, we believe that such a change should be deferred until service capacity has been established and more experience has accumulated. For the same reason, the Commission believes that it would be premature to loosen the front-end commitment criteria for mandatory outpatient treatment as New York and other states have done.

That completes my report. Again, I appreciate the opportunity to appear before you today. I'm sorry I won't be able to hear your comments and suggestions. However, I'm sure that Steve and Jane will be able to fill in the missing pieces.

COMMONWEALTH OF VIRGINIA
COMMISSION ON MENTAL HEALTH LAW REFORM

TASK FORCE ON ADVANCE DIRECTIVES

PROPOSED RECOMMENDATIONS

October 21, 2008

I. CHARGE

Without changing existing Virginia law on advance directives ("AD") for end-of-life care ("EOLC"), the Task Force was charged with drafting legislation pertaining to instructional ADs for health care decisions in contexts other than EOLC, based on the recommendations of the Task Force on Empowerment and Self-Determination. Two major clinical contexts in which such an instructional directive could be especially useful are: (1) cases in which individuals anticipating incapacity from dementia want to give advance instructions regarding their future care; and (2) cases in which individuals with histories of periodic decisional impairment related to acute exacerbation of mental illness want to give advance instructions regarding their health care, including their mental health care, for those periods when they are incapacitated.

II. OVERVIEW OF STATUTORY RECOMMENDATIONS

Although the Task Force proposed several revisions to improve the flow of the Act and to address several issues that are ambiguous in the current law, it made no substantive changes to the law on EOLC ADs. Rather, the principles applicable to EOLC have been used to facilitate use of ADs in the non-EOLC context. The key elements of the recommendations are:

- Without making substantive changes, the draft consolidates frequently used phrases into definitions that are then used in place of the phrases, resulting in clearer, more concise and compact statutes. *See, e.g.*, § 54.1-2982 – *"Capable of making an informed decision"*; *"Health care"*; *"Incapable of making an informed decision."* Section 54.1-2982.

- Additional detail has been added to address the required determinations for a finding that a patient is incapable of making an informed decision and the circumstances in which a patient may be determined to be capable of making informed decisions again. Section 54.1-2983.1.

    - The draft includes the concept that a determination that a patient is incapable of making an informed decision may be limited to a particular health care decision, or may be all-encompassing.

- The draft consolidates the various provisions that address the authority of agents or authorized decision makers. Section 54.1-2983.2.

- The draft addresses the interplay between the involuntary commitment statutes (Title 37.2) and ADs. Section 54.1-2983.3.

- The draft addresses the ability of a patient to request adherence to AD instructions that were made when the patient was capable of making an informed decision ("capable patient"), even though the patient is now incapable of making an informed decision ("incapable patient") and protests the treatment that the AD authorized. The Task Force has proposed a version of a "Ulysses" clause, with appropriate safeguards, to address that situation. Section 54.1-2983.4.

    - The Ulysses clause is premised upon the concept that an incapable patient may protest a particular health care treatment or decision even though, when he was capable, he authorized that treatment or decision in his AD and anticipated his own protest. Section 54.1-2983.4(B) addresses how that protest and process are to be handled when determining whether to honor the incapable patient's AD and provide treatment over his protest, or whether to honor the patient's protest and withhold treatment.

- The draft includes a provision addressing situations in which a patient who is incapable of making informed decisions protests a particular treatment, but has not executed a Ulysses clause or does not have an AD. Section 54.1-2983.4(C).

- The draft adds a provision that gives a patient the ability to authorize an agent to approve participation in any health care study, subject to appropriate safeguards. Section 54.1-2983.5

- The model form has been edited consistent with the proposed revisions in the Task Force draft: the instructional AD has been expanded beyond EOLC, to include non-EOLC; and the term "living will" has been replaced with the generic phrase "health care instructions." Section 54.1-2984.

- The meaning of revoking an AD has been clarified and now includes provisions for partial revocation. Section 54.1-2985.

- The list of default decision-makers has been expanded to include non-family members, where no family members are known, willing, or able to serve as decision-maker. Section 54.1-2986(A)(7).

- The immunity provision has been expanded to cover the expanded scope of ADs proposed in the Task Force draft. Section 54.1-2988.

COMMONWEALTH OF VIRGINIA
COMMISSION ON MENTAL HEALTH LAW REFORM

TASK FORCE ON ADVANCE DIRECTIVES

STAKEHOLDER DISTRIBUTION LIST

OCTOBER 20, 2008

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Mental Health Law Reform Commission
Possible Legislative Proposals

Jane D. Hickey
Office of the Attorney General
October 23, 2008

Transportation

- SB 102 (Cuccinelli)(3-Tiered Transportation Proposal) Subject Matter Referred to MH Law Reform Commission for Study
  - 20 Members on Transportation Work Group
    - 7 law-enforcement representatives, including Sheriff's Association and Assoc. of Chiefs of Police
    - 3 VDH, EMS, private transportation providers
    - DMAS, DMHMRSAS, VACSB, VHHA
    - Consumer; Family Member

2

Transportation (Continued)

- Currently only law enforcement can transport for ECOs/TDOs
- At least 27 other states permit entities, other than law enforcement to transport
  - Family, friends
  - Mental health providers
  - Ambulances, public/private transportation providers

3

Alternative Transportation Proposal

- Amend §§ 37.2-808(ECOs) and 37.2-810(TDOs) to require magistrate to order transportation by willing family member or friend, CSB, health care provider, facility at which person will be evaluated, transportation provider, when finds that transportation can safely be provided based upon advice of
  - CSB
  - Local law enforcement
  - Petitioner
  - Treating physician
  - Others

4

Alternative Transportation Proposal

- Strengthen provision in § 37.2-830, permitting special justice to place person in custody of any responsible person, and insert at beginning of § 37.2-829 (sheriff's transportation after commitment hearing) requiring consideration of alternative transportation provider before ordering sheriff to transport

5

Alternative Transportation Payment

- Delete provision in § 37.2-829 providing for cost of transportation to be paid by Commonwealth from jail funds
  - Archaic/payment doesn't now come from jail funds
  - Would permit sheriffs/law enforcement to bill Medicaid

    (DMAS developing guidance on how to bill for psychiatric transportation for emergency, urgent and routine care)

6

Pilot Project

- Arlington, Alexandria, Fairfax/Falls Church law enforcement and Medical Transportation Services, LLC, developing pilot project, in consultation with mental health providers, consumers, family members
- Prototype vehicle available to provide transportation at half cost of ambulance
- Ready for implementation as soon as legislation permits
- No additional funding needed

7

Privacy Proposal

- Amend Virginia Health Records Privacy Act (§ 32.1-127.1:03) and § 37.2-804.2 to clearly permit health care providers to notify family members or personal representative of person's location and general condition
- Could permit family members to provide transportation, if appropriate
- Could facilitate alternatives to involuntary hospitalization

8

Future Commitment Reforms Task Force

- Study subject matter of bills referred to MH Commission and bills continued to 2009, and provide blueprint for longer term civil commitment reforms
- Consists of 22 people, including
  - CSB emergency services staff
  - Independent examiners
  - Special justice
  - ER physician and psychiatrist
  - VHHA
  - Consumers and family members

9

Admission of Incapacitated Persons Proposal

- Dovetails with proposed changes to the Health Care Decisions Act, proposed § 54.1-2983.3
- Would permit health care agent designated by person in advance directive or guardian authorized by circuit court order to admit person who is determined incapacitated to mental health facility for up to 7 days when
  - Physician on staff of facility states: person has mental illness, is in need of treatment, does not object to the treatment; and
  - Admitting facility agrees to admission

10

Admission of Incapacitated Persons Proposal (continued)

- Person's advance directive must specifically authorize agent to admit person, or
- Court order must specifically authorize guardian to admit person after finding by court that:
  - person has dementia or another severe and persistent mental disorder
  - person's condition unlikely to improve
  - guardian has developed plan for providing ongoing treatment in least restrictive setting

  CSB pre-admission screening required for state facility admissions

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Independent Examiner Training Proposal

- Psychiatrists and psychologists, in addition to other examiners, should be required to complete DMHMRSAS certification program
- Would provide baseline uniformity and consistency in training, better quality examinations
- Would provide training on requirements of Virginia law on commitment and health records privacy
- CEUs available for psychologists, counselors, social workers; fee for psychiatrists, nurse practitioners
- Concern: $ 75 payment to IEs, discourage participation?
- Recommended by IEs on task force

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Rights of Persons in Commitment Process

- Amend § 37.2-400 (Human Rights Statute) to provide person opportunity to have family member, friend or personal representative notified of hospitalization and transfer to another facility
- Amend § 8.01-428 to add to events that permit set aside of default judgment for person involuntarily detained or admitted to mental health facility (currently fraud, void judgment, accord/satisfaction, military service)

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Extension of TDO 4-5 days

- Task force continues to study
- Virginia one of 3 states with only 48 hours
- Three states have 30 days; most states 4-8 days
- Not clear whether extension will lead to longer lengths of stay, increasing costs and exacerbating bed shortages
- Current 48 hrs not sufficient time to develop MOT plan

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Mandatory Outpatient Treatment After Inpatient

- Next logical expansion of MOT
- Not clear whether MOT works – NY study in progress
- Criteria
  - Person no longer needs inpatient hospitalization to prevent rapid deterioration
  - Not likely to obtain outpatient treatment unless court orders MOT
  - Likely to comply with MOT order
  - Services actually available and providers agree to deliver services

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MOT to Prevent Inpatient Hospitalization

- Same concerns as with MOT following inpatient hospitalization – awaiting NY study
- Must apply to small category of persons as in SB 177 (Marsh)
- Services must actually be available and providers agree to deliver services

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ENROLLED

SENATE JOINT RESOLUTION NO. 42

Directing the Joint Commission on Health Care to receive, review, and evaluate the impact of certain recommendations and legislation on the mental health system in the Commonwealth. Report.

Agreed to by the Senate, March 6, 2008
Agreed to by the House of Delegates, March 6, 2008

WHEREAS, an estimated 26.2 percent of Americans ages 18 and older, or about one in four adults, suffer from a diagnosable mental disorder in a given year, and about six percent, or one in 17, suffer from a serious mental illness; and

WHEREAS, mental disorders are the leading cause of disability in the United States for persons ages 15 to 44; and

WHEREAS, in 2005, more than 106,000 people were served by the Commonwealth's community mental health services system, and approximately 5,700 people were confined in state facilities for the mentally ill; and

WHEREAS, an estimated 16 percent of inmates in state and local correctional facilities in the Commonwealth suffer from some form of mental illness; and

WHEREAS, gaps in the system of mental health services allow many individuals to fall through the cracks and prevent persons who want or need mental health services from receiving the treatment and assistance they need; and

WHEREAS, the costs and impacts of mental illness for the individual and society are significant and severe, including unemployment, substance abuse, homelessness, inappropriate incarceration, suicide, and unnecessary individual suffering and anguish; and

WHEREAS, during 2006 and 2007, the Chief Justice's Commission on Mental Health Law Reform conducted an in-depth study of the Commonwealth's mental health system and provided a series of recommendations for action to improve mental health services in the Commonwealth aimed at reducing the need for involuntary commitment by improving access to mental health services, reducing unwarranted criminalization of persons with mental illness, redesigning the process of involuntary treatment to be more effective and more fair, enabling consumers of mental health services to have more choice over the services they receive, and helping young persons with mental health needs and their families address mental health problems before they spiral out of control; and

WHEREAS, during 2006 and 2007, the Office of the Inspector General for the Department of Mental Health, Mental Retardation and Substance Abuse Services conducted an independent review of and developed a set of recommendations for improving the involuntary commitment process and mental health services in the Commonwealth; and

WHEREAS, during 2007, the Virginia Tech Review Panel conducted a review of and developed a series of recommendations for improving the process of involuntary commitment and the system of mental health services in the Commonwealth; and

WHEREAS, during the 2007 interim a number of commissions, committees, and other groups conducted additional independent reviews of the involuntary commitment process and mental health services in the Commonwealth, some of which resulted in recommendations for improving the involuntary commitment process and mental health services in the Commonwealth; and

WHEREAS, further consideration of the numerous recommendations related to involuntary commitment specifically and the system of mental health services generally is necessary to determine the effects and impacts of those recommendations; and

WHEREAS, a myriad of legislative initiatives relating to various aspects of the mental health system were considered and enacted by the 2008 Session of the General Assembly, and it is prudent to ascertain the potential effect of such laws in the Commonwealth; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to receive, review, and evaluate the impact of certain recommendations and legislation on the mental health system in the Commonwealth. The Commission shall consider and assess the recommendations of the Chief Justice's Commission on Mental Health Law Reform, the Virginia Tech Review Panel, the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services, other committees and commissions proposing recommendations related to the involuntary commitment process specifically and the system of mental health services in the Commonwealth, and legislation enacted by the 2008 Session of the General Assembly and signed into law by the Governor.

Technical assistance shall be provided to the Joint Commission on Health Care by the Department of Mental Health, Mental Retardation and Substance Abuse Services. All agencies of the Commonwealth

shall provide assistance to the Commission for this study, upon request.

The Joint Commission on Health Care shall complete its meetings for the first year by November 30, 2008, and for the second year by November 30, 2009, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Commission on Health Care intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

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