REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Final 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
2010

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

Delegate Benjamin L. Cline
Chairman
Kim Snead
Executive Director

900 E. Main Street, 1st Floor
P.O. Box 1322
Richmond, Virginia 23218
804.786.5445/804.786.5538 fax

October 6, 2010

The Honorable Robert F. McDonnell
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 McDonnell 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…." (An interim report was published in 2009 as Senate Document 3.)

The Joint Commission report, completed in response to SJR 42, is enclosed for your review and consideration.

Respectfully submitted,

Benjamin L. Cline

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.

Joint Commission on Health Care 2009 Membership

Chairman
The Honorable R. Edward Houck

Vice-Chairman
The Honorable Phillip A. Hamilton

Senate of Virginia
The Honorable George L. Barker
The Honorable Harry B. Blevins
The Honorable L. Louise Lucas
The Honorable Ralph S. Northam
The Honorable Linda T. Puller
The Honorable Patricia S. Ticer
The Honorable William C. Wampler, Jr.

Virginia House of Delegates
The Honorable Clifford L. Athey, Jr.
The Honorable Robert H. Brink
The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable Rosalyn R. Dance
The Honorable Algie T. Howell, Jr.
The Honorable Harvey B. Morgan
The Honorable David A. Nutter
The Honorable John M. O'Bannon, III

The Honorable Marilyn B. Tavenner
Secretary of Health and Human Resources

Commission Staff

Kim Snead
Executive Director

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Michele L. Chesser, PhD
Senior Health Policy Analyst

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Sylvia A. Reid
Publication/Operations Manager

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." The JCHC study requested in SJR 42 was undertaken by the Commission's Behavioral Health Care Subcommittee.

The tragic Virginia Tech incident in April 2007 brought increased attention to the weaknesses in Virginia's mental health system. Reviews were undertaken by such entities as the Virginia Tech Review Panel and the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services. Moreover, 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 and recommendations of these reviews, significant new funding and statutory changes were introduced during both the 2008 and the 2009 Sessions of the General Assembly. The legislative changes enacted during the 2008 Session were described as "the most sweeping reforms in mental health law since the 1970s" addressing such issues as adult commitment criteria, procedural requirements, disclosure and privacy provisions, and commitment procedures for minors. In addition, nearly $42 million in new funding was appropriated to support reform efforts. (Source: *Mental Health Law Reform: Overview of the 2008 General Assembly Action* presented by Jane D. Hickey, Office of the Attorney General.) During the 2009 Session, additional statutory revisions were enacted; expanding advance medical directives to address mental illness, authorizing transportation by non-law enforcement providers during the commitment process, and allowing for additional crisis stabilization teams.

During its two-year study, JCHC's Behavioral Health Care Subcommittee heard from representatives of the Commission on Mental Health Law Reform; community services boards; the Department of Mental Health, Mental Retardation and Substance Abuse Services; physicians; sheriffs; and special justices regarding both enacted and proposed statutory changes. Given the breadth and import of the legislative activity that was undertaken, Subcommittee members chose not to introduce additional legislation.

In October 2009, JCHC members approved a request for JCHC to provide an "umbrella of oversight" for a proposed 2010 study of mental health issues in higher education. The study will be "coordinated with the State Council on Higher Education and the Department of Education as well as the Commission on Mental Health Law Reform."

Table of Contents

	Page
Authority for the Study	1
Background	1
Review by JCHC's Behavioral Health Care Subcommittee	1
Conclusions	8

Appendices

A. Senate Joint Resolution 42 (2008)

B. Commission on Mental Health Law Reform
Progress Report on Mental Health Law Reform, December 2008

C. Commission on Mental Health Law Reform
Progress Report on Mental Health Law Reform, December 2009

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

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. 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 have been introduced.

Review by JCHC's Behavioral Health Care Subcommittee

The two-year evaluation of changes to Virginia's mental health system was undertaken by JCHC's Behavioral Health Care (BHC) Subcommittee in 2008. Subcommittee members reviewed report findings and recommendations and considered the viewpoints of representatives of community services boards (CSBs), sheriffs, special justices, mental health facilities, and the Commission on Mental Health Law Reform.

An interim JCHC report, detailing the legislative actions taken during the 2008 General Assembly Session, was published in 2009 as Senate Document 3. This report documents the work of the BHC Subcommittee in considering mental health reform initiatives and the statutory changes made during the 2009 and 2010 General Assembly Sessions.

Presentations Considered by the BHC Subcommittee. During the October 2009 meeting of the BHC Subcommittee, Richard Bonnie, L.L.B. Chair of the Commission on Mental Health Law Reform reported on the Commission's major activities as noted in his outline in Figure 1.

In his presentation, Mr. Bonnie indicated that some of the key Reform Commission accomplishments include:

- The consensus developed among the many different parties who have been involved in the review through "habits of collaboration,"
- The collection and analysis of data necessary for setting policy and providing oversight, and
- The development of a "common understanding of problems…and key elements of the solutions."

The Reform Commission expected to continue addressing issues in the areas of emergency services and commitment reform, and empowerment and self-determination. With regard to emergency services and commitment reform, the Commission expected to:

- "Continue to enhance opportunities for intensive intervention services to prevent, ameliorate and stabilize crises without invoking commitment process or initiating criminal process
- Lengthen [the temporary detention order] TDO period to facilitate thorough evaluation and stabilization before scheduled hearing
- Facilitate discharge or conversion to voluntary status in clinically appropriate cases
- Based on experience and available resources, identify most appropriate role for mandatory outpatient treatment
- Develop integrated, stand-alone 'Psychiatric Treatment of Minors Act'
- Continue to reduce reliance on law enforcement transportation through Alternative Transportation Orders."

The Reform Commission continued to work on the implementation and refinement of the Health Care Decisions Act relating to empowerment and self-determination, with special emphasis on advance directive provisions for mental health care. These initiatives are described in more detail in the Reform Commission's *Progress Report on Mental Health Law Reform, December 2009* which is included in Appendix C.

In addition, a request was made by Mr. Bonnie for the Joint Commission to provide an "umbrella of oversight" for a one-year study of mental health issues in higher education. Mr. Bonnie's memorandum describing the study proposal is shown in Figure 2. As noted, the study would be "coordinated with the State Council on Higher Education and the Department of Education as well as the Commission on Mental Health Law Reform" and reported to JCHC's BHC Subcommittee in 2010. Following Mr. Bonnie's presentation, JCHC members voted in favor of the request.

Figure 1

Progress Report to Joint Commission on Health Care
October 7, 2009

Richard J. Bonnie
Chair, Commission on Mental Health Law Reform

Key Accomplishments

- Coordination, consensus-building and habits of collaboration
- Data needed for informed policy-making and oversight
- Common understanding of problems we face and key elements of the solutions

Unfinished Business in Emergency Services and Commitment Reform

- Continue to enhance opportunities for intensive intervention services to prevent, ameliorate and stabilize crises without invoking commitment process or initiating criminal process
- Lengthen TDO period to facilitate thorough evaluation and stabilization before scheduled hearing
- Facilitate discharge or conversion to voluntary status in clinically appropriate cases
- Based on experience and available resources, identify most appropriate role for mandatory outpatient treatment (MOT)
- Develop integrated, stand-alone "Psychiatric Treatment of Minors Act"
- Continue to reduce reliance on law enforcement transportation through Alternative Transportation Orders

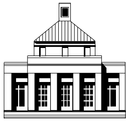
Empowerment and Self-Determination

- Implementation and dissemination of revised Health Care Decisions Act, especially new advance directive provisions for mental health care
- Clarification and refinement of HCDA

Upcoming Plans

- 2009 Progress Report
- Report on Access to Services (2010)
- Commission Final Report (2010)

Figure 2



UNIVERSITY OF VIRGINIA SCHOOL OF LAW

Richard J. Bonnie
Harrison Foundation Professor of Medicine and Law
Hunton & Williams Research Professor
Professor of Psychiatry and Neurobehavioral Sciences
Director of Institute of Law, Psychiatry and Public Policy

Memorandum

To: Senator R. Edward Houck, Chair, Joint Commission on Health Care

Re: Proposed JCHC Study of Mental Health Issues in Higher Education

Date: October 7, 2009

This memorandum supplements my memorandum to you dated August 31, 2009, in which I described a possible study of mental health issues in higher education under the auspices of the Joint Commission on Health Care. Conducting such a study would serve the interests of the people of the Commonwealth and would be timely in light of the opportunity for coordination with the Supreme Court's Commission on Mental Health Law Reform before the Commission completes its work in 2010. I am confident that the study can be carried out successfully within the next year without any JCHC financial support and without diverting staff attention from the Joint Commission's other priorities.

Steering Committee. The proposed study would be directed by a steering committee that I would chair. The members of the steering committee would include Chris Flynn, the director of the counseling service at Virginia Tech (who would chair a task force on access to mental health services); Jim Stewart, the Inspector General for Behavioral Health and Developmental Services), Professor John Monahan, my colleague at UVA who is an expert on empirical research in mental health law; Diane Strickland, a former Circuit Court judge and member of the Governor's Panel on the Virginia Tech Shootings; Jim Reinhard, Commissioner of Behavioral Health and Developmental Services; Ron Forehand, Deputy Attorney General; Susan Davis, an experienced lawyer who also serves as a student affairs officer at UVA (who would chair a task force on legal issues); and any others who may be suggested by the Joint Commission. Joanne Rome, a Staff Attorney in the Supreme Court, will serve as liaison from the Court, but not as a member.

Coordination with Other Agencies. The study would be formally coordinated with the State Council on Higher Education and the Department of Education as well as the Commission on Mental Health Law Reform, facilitating advice and collaboration throughout the process. The Commission will provide assistance and guidance, as needed, regarding data collection and outreach to relevant constituencies and agencies.

Task Forces. As outlined in my previous memorandum, the Steering Committee would oversee the activities of two task forces, one on Legal Issues in College Mental Health and a second on Access to Mental Health Services by College and University Students. Membership would be drawn from colleges and universities of varying sizes and locations, both public and private. The Steering Committee would develop a specific charge for each of the task forces. For the moment, it is perhaps sufficient to say that the task force on legal issues would be charged with addressing the roles and responsibilities of colleges in responding to possible student mental health crises, including notification and sharing of information, threat assessment, initiation and participation in commitment proceedings and follow-up. The task force on access to services would be charged with assessing the current need for mental health services among Virginia's college and university students, and the current availability of services to address these needs.

Each task force would make recommendations for training, institutional policies and practices, and any legislative action that may be needed.

With the direction and guidance of the Steering Committee, the task forces would conduct surveys of colleges and universities in their respective domains, assemble available information regarding these issues, including experience in other states, and would prepare a report and recommendations for consideration by the Steering Committee, review and comment by the Commission on Mental Health Law Reform and other interested parties, and eventual submission to the Joint Commission.

Composition of Task Forces. Our tentative roster for the legal issues task force includes counseling center directors from George Mason and James Madison Universities, campus police officials from Virginia Tech and Christopher Newport, and student affairs officials from UVA, William and Mary, Randolph Macon, ODU, Bridgewater, VCU and Piedmont Community College. Our tentative roster for the access task force includes counseling center directors from Virginia Tech, Longwood University, VCU, Virginia Wesleyan, Virginia State University, Norfolk State, University of Richmond, Radford University, Christopher Newport University, and ODU; two officials from the community college system; and two officials from community services boards. The respective task forces will be advised by representatives of the General Counsel's offices from UVA (legal issues task force) and Virginia Tech (access task force). We will also seek to involve parent organizations and student peer counseling organizations and other stakeholders in the work of the two task forces.

Institutional Support. The legal issues task force will be headquartered at UVA and the access task force will be headquartered at Virginia Tech. I am grateful to each of these institutions for agreeing to provide the core infrastructure support for the study. The responsibility for organizing task force meetings, summarizing deliberations, conducting and analyzing the surveys and drafting and circulating reports would be borne by the respective chairs and by other willing task force members, with the support of their own institutions and agencies. The costs of attending meetings, communications and logistics, and photocopying materials generated by and circulated to task force members will be borne by their respective institutions.

Schedule. If the Joint Commission is willing to provide an umbrella of oversight for the proposed study, the target date for formal appointment of the Task Forces would be the end of October, 2009. Progress reports to the Steering Committee and the Joint Commission Council would be expected in April, 2010 and July, 2010, with the final reports being due in October, 2010.

Legislative Changes Enacted During the 2009 Session. Twenty bills (including companion bills) to amend mental health law were passed during the 2009 Session, as well as 10 of the 11 bills recommended by the Commission on Mental Health Law Reform (Figure 3). Statutory changes addressed such systemic matters as:

- Crisis stabilization to divert individuals from the involuntary civil commitment system.
- Alternatives to transportation by law enforcement for individuals subject to emergency custody orders (ECOs), temporary detention orders, and involuntary commitment orders.
- Expansion of advance medical directives to allow for decisions related to mental health treatment.
- Provision of mandatory outpatient treatment and voluntary admission for minors.

Figure 3

SUMMARY OF 2009 MENTAL HEALTH LAW REFORM LEGISLATION

Crisis Stabilization Teams

SB 1294 (Edwards) — Requires the Department of Criminal Justice Services and the Department of Behavioral Health and Developmental Services (DBHDS) to use available federal or State funding to "support the development and establishment of crisis stabilization team programs in areas throughout the Commonwealth."

Transportation

HB 2460 (O'Bannon)
SB 823 (Cuccinelli) — Allows a family member, friend, CSB representative or "other alternative transportation provider" with trained staff to transport a person subject to an emergency custody order, temporary detention order, or involuntary commitment order.

Emergency Custody and Involuntary Commitment Processes

HB 2486 (Ward)
SB 1079 (Howell) — Authorizes a law-enforcement officer to take into emergency custody, a person being transported following his consent to voluntary admission, if that person revokes consent but meets requirements for emergency custody.

HB 1948 (Shuler) — Adds marriage and family therapists as professionals allowed to "conduct independent examinations of persons who are subject to a hearing for involuntary commitment."

Advance Medical Directives and Voluntary Admission

HB 2396 (Bell)
SB 1142 (Whipple) — Revises the Health Care Decisions Act to add conditions under which an incapacitated person with mental illness can be admitted to a facility for treatment.

HB 2257 (Albo) — Provides that a person's compliance/noncompliance with treatment will be considered in determining whether to allow him to consent to voluntary admission.

Notification and Disclosure

HB 2459 (O'Bannon)
SB 1076 (Howell) — Allows a consumer in a mental health facility to identify a person to be notified of "his general condition, location, and transfer to another facility."

HB 2461 (O'Bannon)
SB 1077 (Howell) — Authorizes disclosure to a family member or friend regarding certain information (such as location and general condition) about a person subject to an emergency custody order, temporary detention order, or involuntary commitment order.

Technical and Administrative Changes

HB 2060 (Hamilton)
SB 1083 (Howell) — Clarifies a number of technical "issues resulting from the overhaul of mental health laws during the 2008 Session."

SB 1081 (Howell) — Clarifies that "a special justice serves at the pleasure of the chief justice of the judicial circuit in which he serves, rather than the specific chief justice that makes the original appointment."

SB 1078 (Howell) — Allows the Supreme Court's Involuntary Civil Commitment Fund to reimburse special justices for "parking, tolls and postage incurred in conducting commitment hearings" (in addition to otherwise authorized fees and mileage).

SB 1082 (Howell) — Clarifies the responsibilities for the Office of the Executive Secretary of the Supreme Court and DBHDS with regard to preparing various documents.

Psychiatric Inpatient Treatment of Minors Act

B 2061 (Hamilton)
SB 1122 (Lucas) — Allows for mandatory outpatient treatment and voluntary admission for treatment of minors for mental illness; clarifies when a "qualified evaluator" must attend the minor's hearing and the circumstances in which the evaluator's report would be admissible.

Legislative Changes Considered During the 2010 Session. Nine mental health related bills were enacted during the 2010 General Assembly Session, including 7 bills recommended by the Commission on Mental Health Law Reform (Figure 4).

Figure 4

SUMMARY OF 2010 MENTAL HEALTH LAW REFORM LEGISLATION

Psychiatric Hospitalization of Jail Inmates

HB 311 (O'Bannon) **SB 87** (Howell)	Repeals *Code* §§ 19.2-176 and 19.2-177.1 and combines "the three separate commitment processes for obtaining psychiatric hospitalization for jail inmates pending trial, convicted and awaiting sentence, and sentenced and serving their time into one section, 19.2-169.6" to be generally consistent with changes made to the civil commitment process in 2008.

Advance Medical Directives and Voluntary Admission

SB 275(Whipple)	Clarifies provisions of the legislation enacted in 2009 to allow an additional means of providing consent for treatment when there is no "health care agent, guardian or relative available to provide consent...."

Appeal of Civil Commitment Order

HB 247 (Kilgore) **SB 63** (Lucas)	Makes a number of changes regarding the appeal of commitment orders (for involuntary commitment, mandatory outpatient treatment, and certification for training center admission), most notably to reduce the time to appeal from 30 to 10 days.

Mandatory Treatment Orders

HB 729 (Albo) **SB 360** (Barker)	Allows "a judge or special justice to authorize a physician to discharge a person to mandatory outpatient treatment if the judge or special justice first finds, among other things, that the person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in that person being subject to an order for involuntary admission. Before discharging the person, the treating physician must determine, among other things, that the person no longer needs inpatient hospitalization, requires MOT to prevent relapse or deterioration of his condition that could likely result in his meeting the commitment criteria and the services are actually available in the community and provider have actually agreed to deliver the services."

Psychiatric Treatment of Minors Act

HB 248 (Kilgore) **SB 65** (Lucas)	Creates "a stand-alone juvenile commitment act…the Psychiatric Treatment of Minors Act and eliminates various cross references to the adult commitment statutes in Title 37.2." Among other things, the bill imported the ECO and TDO procedures into the juvenile law; updated the definition of 'qualified evaluator'; authorized judges and special justices to permit the voluntary admission of juveniles at the commitment hearing; clarified the duties and deadlines regarding service of process and transportation of juveniles; and modified the appeals provisions to conform to many aspects of the adult procedures."

In addition to the legislation enacted in 2010, the following bills were carried over to the 2011 General Assembly Session to allow for additional study and consideration:

- **HB 305 (O'Bannon)**
  Provides that an attending physician may allow a person who is subject to a temporary detention order to be voluntarily admitted to a mental health facility,

prior to his commitment hearing; if the person is willing and able to volunteer for such treatment and is informed of the requirement to provide a 48-hour notice before leaving the facility and of the prohibition against subsequently "owning, possessing, or transporting a firearm."

- **HB 307 (O'Bannon)/SB 85 (Howell)**
  Changes the timeframe for an involuntary commitment hearing to be held from within 48 hours to be no earlier than 24 hours and no longer than 72 hours of the execution of the temporary detention order "to allow for treatment and stabilization of individuals prior to the commitment hearing." The bills were carried over to allow for additional analysis of the likely fiscal impact. While an additional day of TDO hospitalization was estimated to cost an additional $2.1 million per year, the potential savings related to fewer commitment hearings and fewer and/or shorter hospitalizations were not considered.
- **SB 84 (Howell)**
  Combines the provisions of the three previously-described bills into one bill.

Conclusions

During the last three years, 37 mental health bills (including companion bills) have been enacted, resulting in a significant overhaul of the involuntary commitment process. However, a disproportionate proportion of funding continues to be dedicated to addressing crises, providing inpatient care, and unfortunately in incarceration rather than providing community-based supports and recovery-oriented services. Federal health reform legislation has the potential to help in funding mental health care. As noted in the Commission on Mental Health Law Reform's *2009 Progress Report*:

> Federal health reform legislation "could have significant implications for the financing of mental health services. Most importantly, it could provide coverage for a large proportion of people with mental illness who lack insurance of any kind and whose care is subsidized by Commonwealth taxpayers in one way or another. In the Commission's study of emergency evaluations conducted by CSBs during June 2007, 40% of the individuals evaluated were uninsured. Overall, approximately 50% of those with serious mental illness seeking care at CSBs are funded with a combination of state and local dollars."[1]

The Commission on Mental Health Law Reform is expected to wrap up its work in April 2011. Discussions are underway related to establishing a temporary successor to the Reform Commission.

JCHC Staff for this Report

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Kim Snead
Executive Director

[1] Commission on Mental Health Law Reform, *Progress Report on Mental Health Law Reform*, December 2009, pp. 14-15.

Appendix A

2008 SESSION
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 indepth 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.

COMMONWEALTH OF VIRGINIA
COMMISSION ON MENTAL HEALTH LAW REFORM

PROGRESS REPORT ON MENTAL HEALTH LAW REFORM

DECEMBER 2008

This page left blank intentionally

PREFACE

The Commonwealth of Virginia Commission on Mental Health Law Reform ("Commission") was appointed by the Chief Justice of the Supreme Court of Virginia, the Honorable Leroy Rountree Hassell, Sr., in October 2006. Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups. The Commission was directed by the Chief Justice to conduct a comprehensive examination of Virginia's mental health laws and services and to study ways to use the law more effectively to serve the needs and protect the rights of people with mental illness, while respecting the interests of their families and communities. Goals of reform include reducing the need for commitment by improving access to mental health services, avoiding the criminalization of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers of mental health services to have greater choice regarding the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

During the first phase of its work, the Commission was assisted by five Task Forces charged, respectively, with addressing gaps in access to services, involuntary civil commitment, empowerment and self-determination, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. In addition, the Commission established a Working Group on Health Privacy and the Commitment Process ("Working Group"). Information regarding the Commission, its Task Forces and its Reports is available at http://www.courts.state.va.us/cmh/home.html.

The Commission also conducted three major empirical studies during 2007. The first was an interview study of 210 stakeholders and participants in the commitment process in Virginia. The report of that study, entitled *Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations*, was issued in April 2007. The study is available at http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf.

The second major research project was a study of commitment hearings and dispositions (the "Commission's Hearings Study"). In response to a request by the Chief Justice, the special justice or district judge presiding in each case filled out a 2-page instrument on every commitment hearing held in May 2007. (There were 1,526 such hearings). Findings from the Commission's Hearing Study served an important role in shaping the Commission's understanding of current commitment practice. The study can be found at http://www.courts.state.va.us/cmh/2007_05_civil_commitment_hearings.pdf.

Finally, the Commission's third project during this first phase was a study of every face-to-face emergency evaluation conducted by Community Service Board ("CSB") emergency services staff during June 2007 (the "Commission's CSB

Emergency Evaluation Study"). (There were 3,808 such evaluations.) The final report of the CSB Emergency Evaluation Study will also appear on the Commission's website in late 2008.

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

After the General Assembly enacted a major overhaul of the commitment process in 2008, the Commission moved into the second phase of its work. Three new Task Forces were established – one on Implementation of the 2008 Reforms, another on Future Commitment Reforms and one on Advance Directives. In addition, the Commission created a separate Working Group on Transportation. Each of these Task Forces and Working Groups presented reports to the Commission, together with recommendations for the Commission's consideration. The Report of the Task Force on Future Commitment Reforms is posted at http://www.courts.state.va.us/cmh/taskforce_workinggroup/home.html. The Transportation Working Group's Report is posted at http://www.courts.state.va.us/cmh/taskforce_workinggroup/home.html. The other reports will be published on the Commission's web site in due course.

The following Progress Report provides a status report on the progress of mental health law reform in Virginia during the past year. It summarizes the changes adopted by the General Assembly in 2008, reviews the steps taken to implement them, summarizes the available data on the operation of the commitment system, presents the Commission's recommendations for consideration by the General Assembly in 2009, and identifies some of the important issues that the Commission will be addressing in the coming year. The Commission plans to issue another status report in December 2009 and to complete its work by June 30, 2010.

This Progress Report represents the views and recommendations of the members of the Commission on Mental Health Law Reform, and should not be construed as reflecting the opinions or positions of the Chief Justice, the individual Justices of the Supreme Court of Virginia, or of the Executive Secretary of the Supreme Court. Any recommendations or proposals embraced by the Court itself will lie exclusively within the judicial sphere.

Richard J. Bonnie, Chair
Commission on Mental Health Law Reform
December, 2008

TABLE OF CONTENTS

Section	Page
Preface	3
Executive Summary	7
I. Mental Health Law Reform in 2008	11
II. Impact of 2008 Reforms: A Preliminary Report	19
III. Implementation of 2008 Reforms	31
IV. Unfinished Business in Commitment Reform	35
V. Legal Foundation for Individual Choice and Empowerment in Mental Health Services	59
VI. Assuring Access to Services for Children and Adolescents	65
VII. Transforming Community Mental Health Services	67
Appendices	
Appendix A. Recommendations	73
Appendix B. Acronyms	77
Appendix C. Commissioners	79

This page left blank intentionally.

Executive Summary

After the historic overhaul of Virginia's commitment laws in 2008, implementing these changes has gotten off to a good start. However much remains to be done, both to achieve the goals of the 2008 reforms and to address issues and problems that were not addressed in 2008. This Progress Report summarizes how implementation of the 2008 reforms has fared so far, offers recommendations for consideration by the General Assembly in January 2009, and highlights some issues that the Commission will continue to study in the coming year.

First-Quarter Data: The Commission estimates that the number of temporary detention orders executed during the first quarter of FY09 was about 8% higher than during the first quarter of FY08, but it seems likely that this increase, which began in January, 2008, is attributable to factors that preceded the effective date of the new law and that the rate of increase has begun to level off.

About 5720 commitment hearings were conducted during the first quarter of FY09 -- 5,141 ordinary adult hearings, 45 hearings involving jail detainees, and 524 recommitment hearings. In ordinary commitment hearings, about 56% of the cases resulted in involuntary admission, about 24% resulted in voluntary admission and about 19% were dismissed. Only a handful of cases (18) resulted in mandatory outpatient treatment (MOT) orders. In comparison with the Commission's study of commitment hearings conducted during May 2007, there were fewer MOT orders and fewer voluntary hospitalizations, and correspondingly more involuntary hospitalizations and dismissals. It appears that the increase in involuntary admissions may have been offset by a reduction in voluntary admissions, resulting in a constant number of hospitalizations.

Although MOT was relatively infrequent prior to the 2008 reforms, the number appears to have nosedived since July 1, 2008. It is apparent that both CSBs and judges have been hesitant to invoke the new procedures for MOT, and the Commission will carefully monitor the use of MOT during the coming year.

Recommendations for Legislative Consideration in 2009: Revenue constraints preclude immediate efforts to build on the much-needed investment in community mental health services made by the General Assembly in 2008. However, further improvements in the legal foundation of mental health care can be made without additional cost. Therefore, the Commission recommends that the General Assembly consider several proposals to reduce the need for involuntary treatment and to protect individual dignity when involuntary treatment is sought.

- The Commission' s major proposal for 2009 is 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 advance directives 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.

- The Commission also recommends several revenue-neutral proposals in a continuing effort to improve the commitment process. Some of these proposals respond to issues that have arisen during the process of implementing the 2008 reforms, while others deal with issues that were not addressed in 2008.

- One important new proposal addresses transportation of individuals involved in the commitment process. Reliance on law enforcement to provide transportation, and the routine use of restraints during this process, have been major sources of discontent among all the stakeholders for many years. The Commission recommends enabling legislation to facilitate local efforts to develop clinically appropriate alternatives to transport by law enforcement in cases that pose little security risk.

- Another key proposal would permit mental health facilities to admit incapacitated individuals for up to ten days upon the request of a health care agent designated by the individual in an advance directive and specifically given the authority to do so, or upon the request of a guardian specifically authorized to do so in the guardianship order.

- The Commission also recommends modifications to the Psychiatric Inpatient Treatment of Minors Act to incorporate changes that were made to the adult commitment statute in 2008, including new procedures for mandatory outpatient treatment tailored to the special circumstances of juvenile commitments.

Proposals Requiring Further Study: Some of the bills introduced in the 2008 General Assembly were carried over until 2009 and referred to the Commission for review and comment. Some of these bills embody key elements of the blueprint for comprehensive reform outlined by the Commission in its Preliminary Report in December, 2007. However, the Commission believes that legislative action would be premature on the following issues and that they should remain under study in 2009:

.

- The Commission has endorsed the concept of increasing the range of core services that CSBs are mandated to provide. Because this would be a major change in the legal foundation of the community mental health services system, and would require additional state appropriations, the Task Force on Access to Services continues to study it.

- The Commission has endorsed, in principle, the concept of lengthening the TDO period to 4 or 5 days. However, it continues to conduct research to allow 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.

- Finally, a number of bills that were carried over would expand use of MOT. However, the Commission believes that it would be premature to expand the use of MOT until the Commonwealth has accumulated adequate experience with the extensive new procedures adopted in 2008. Preliminary data indicate that the number of MOT orders has been very small so far, suggesting that the necessary service capacity has not yet come on line and that many judges, CSBs and providers are not yet comfortable with the new procedures. The Commission is supportive, in principle, of permitting conditional discharge MOT after inpatient commitment in appropriate cases, and believes that this would be the next logical step in the use of MOT. However, it believes 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 commitment criteria for MOT as a tool for preventing deterioration as New York and other states have done.

This page left blank intentionally.

I. Mental Health Law Reform in 2008

A. Overview of 2008 Reforms

During the 2008 session of the General Assembly, Virginia's mental health laws underwent an historic overhaul, with changes in five key areas: commitment criteria, mandatory outpatient treatment, procedural improvements, privacy and disclosure provisions,[1] and firearms purchase and reporting requirements.[2] In addition, the mental health system received an infusion of more than $41 million to increase service capacity.[3] By all accounts, the mental health reforms of the General Assembly were its most exhaustive and comprehensive in more than thirty years. The key changes include:

- The criteria for involuntary commitment were modified to promote more consistent application throughout the Commonwealth and to allow involuntary treatment in a broader range of cases involving severe mental illness. Evidence had suggested some judges applied unduly restrictive interpretations of the previous criteria.
- The 2008 reforms established clear procedures for ordering, delivering and monitoring less restrictive court-ordered outpatient treatment. These changes are designed to make mandatory outpatient treatment ("MOT") more effective and facilitate a consistent statewide implementation. In addition, these procedures increase oversight by community services boards ("CSBs") and other providers to reduce the risk that a patient will fall through the cracks.
- Extensive procedural changes relating to emergency custody orders ("ECOs"), temporary detention orders ("TDOs"), clinical examinations, and hearings were designed to standardize the process across the Commonwealth and improve the quality and accuracy of decision-making.
- The reforms removed legal impediments to disclosure of relevant information during the commitment process while protecting that information from further disclosure.

Most of these changes were based on the recommendations of the Commission (December, 2007) and the Virginia Tech Review Panel (August, 2007) and had been endorsed by Governor Kaine. After extensive and thorough deliberation by the General Assembly, the reform legislation was enacted by unanimous votes in both houses.

Much remains to be done, however. The Commission, the Governor and the principal patrons of the reform bills enacted in 2008 all emphasized that these changes were only a

---

[1] H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008). The preceding four areas of change were addressed by House Bill 499. *Id.* An identical bill was introduced in the Senate as Senate Bill 246. S.B. 246, Va. Gen. Assembly (Reg. Sess. 2008). This article, however, will refer only to House Bill 499 for the sake of simplicity. House Bill 401 and House Bill 559 are related bills, and this article will reference them only when particularly relevant. H.B. 401, Va. Gen. Assembly (Reg. Sess. 2008); H.B. 559, Va. Gen. Assembly (Reg. Sess. 2008).

[2] H.B. 815, Va. Gen. Assembly (Reg. Sess. 2008).

[3] H.B. 30, Va. Gen. Assembly (Reg. Sess. 2008).

first step (albeit a giant step) in a continuing process of reform. Some key components of comprehensive reform were outlined in the Commission's Preliminary Report. In addition, a number of bills relating to the commitment process were carried over from the 2008 session and the subject matter of these bills was referred to the Commission for further study by the Senate.

In addition, SJR 42 directs the Joint Commission on Health Care to "receive and review" recommendations from various entities, including the Commission, and to submit recommendations to the General Assembly before its 2010 session. The Commission reported to the Joint Commission on its progress in August and October, 2008.

B. Overview of Commission Activities in 2008

As soon as the General Assembly completed its historic work in the spring of 2008, the Commission organized itself for Phase II of the Chief Justice's initiative in mental health law reform. The Commission set out to perform three tasks: (1) implement monitor, evaluate and consolidate 2008 commitment reforms; (2) study possible new modifications of commitment laws; and (3) develop proposals for building a legal foundation for transforming the community services system.

1. Implement Monitor, Evaluate and Consolidate 2008 Commitment Reforms

The proper path of future reforms depends on the effects of the reforms already adopted, as well as on the mechanisms that are set up to provide evaluation and oversight. The Department of Mental Health, Mental Retardation, and Substance Abuse Services ("DMHMRSAS"), CSBs, the Office of the Attorney General ("OAG") and Supreme Court have direct responsibilities to manage and implement these changes successfully, but the Commission can continue to play a useful role by serving the convening and coordination function that it served before and during the legislative process. The Commission has set up two Task Forces to help monitor and steer the implementation and evaluation process.

The Task Force on Implementation of 2008 Commitment Reforms ("Implementation Task Force") is carrying out the following functions:

- Coordinating training
- Provided advice to the OES of the Supreme Court and DMHMRSAS on the drafting of new forms and revision of existing forms
- Providing guidance and facilitating problem-solving
- If needed, making further recommendations to the Commission regarding statutory clarification, training, coordination and oversight

The Task Force on Data, Research and Evaluation is directed to:

- Assist DMHMRSAS, CSBs, and the Supreme Court collect and assemble both aggregated and case-specific information regarding ECOs, TDOs, independent examiner ("IE") certifications, and commitment orders to facilitate monitoring and evaluation
- Monitor and evaluate MOT
- To the extent feasible, estimate fiscal impact of proposals for future reforms under consideration by the Commission

2. Study Possible New Modifications of Commitment Laws

The Commission was formally asked by the Senate to study the subject matter of a number of bills that were introduced in 2008 and carried over to 2009. In addition, many components of the Commission's blueprint were not put forward in 2008 because they needed further study. Finally, other changes to the commitment law and other parts of the Code were proposed by all five Commission Task Forces. Although most of the proposed Code changes relate to commitment, some pertain to other parts of the Code. Two Task Forces and a special Working Group are at work on these projects.

The Task Force on Future Commitment Reforms ("Future Reforms Task Force") was charged with studying all proposals relating to the commitment process, including but not limited to those referred to the Commission by the General Assembly and those included in the Report of the Task Force on Civil Commitment. Among the proposals considered by the Future Reforms Task Force are:

1. **Mandated Special Justice, Attorney and Examiner Training** – whether special justices, attorneys representing persons in commitment hearings and independent examiners should receive mandatory training, including examining the requirements specified in SB 214 (Edwards)(subject matter referred to Commission) mandating training for special justices. Additionally, this proposal includes a review of the content of such training.

2. **Mandated CSB Core Services** – whether, when funding is available, the core services CSBs are mandated to provide in § 37.2-500 should be expanded from emergency services and case management services to include crisis stabilization, outpatient, respite, in-home, and residential and housing support services as provided in SB 64 (Howell)(subject matter referred to Commission).

3. **Counsel for Petitioners** – whether an attorney should be appointed to represent petitioners in civil commitment proceedings, and if so, who should be appointed, including HB 267 (Albo)(subject matter referred to Commission) authorizing appointment of an attorney to represent indigent petitioners and HB 735 (Caputo)(continued to 2009) authorizing 3rd year law students to represent petitioners.

4. **Petitioner Right of Appeal** – whether petitioners in civil commitment proceedings should have a right of appeal, including HB 938 (Gilbert)(subject matter referred to Commission).

5. **Combined Inpatient/Outpatient Commitment Orders** – whether an order of involuntary inpatient treatment may be followed by a period of mandatory outpatient treatment, and if so, what criteria should be used and whether mandatory outpatient treatment would be court-ordered at the time of the commitment hearing or at the time of discharge, or hospital-initiated during the course of an inpatient commitment, including SB 274 (Cuccinelli)(continued to 2009) pertaining to transfers to outpatient treatment and HB 939 (Gilbert)(subject matter referred to Commission) permitting the person to petition for outpatient treatment.

6. **Reduced Criteria for Assisted Outpatient Treatment** – whether assisted outpatient treatment utilizing reduced commitment criteria to prevent involuntary inpatient treatment, including SB 177 (Marsh)(continued to 2009), and procedures should be implemented.

7. **Extension of TDO Period** - whether the period of temporary detention should be extended from 48 hours to four or five days, including SB 143 (Edwards)(subject matter referred to Commission) extending the temporary detention period from 48 hours to 96 hours, SB 333 (Cuccinelli)(subject matter referred to Commission) authorizing the independent examiner to release the person if the IE finds the person does not meet commitment criteria, and SB 335 (Cuccinelli)(subject matter referred to Commission), permitting an offer of voluntary outpatient treatment to a detained person.

8. **Protection of Rights of Persons Subject to Commitment Proceedings –** whether legislation should be enacted to prevent persons from being evicted from their homes as a result of being subjected to emergency custody and temporary detention orders or commitment orders and to protect them from default judgments during this period.

9. **Admission of Incapacitated Persons** – whether persons who lack capacity to consent to voluntary admission should be admitted to inpatient treatment upon the consent of a guardian or other legally authorized representative and, if so, whether a judicial proceeding is needed.

Because of the complexity of the transportation issue and the range of expertise needed to study it, a special ***Working Group on Transportation*** was established to flesh out alternatives to transportation by law enforcement officers in connection with the commitment process.

It is clear that unique problems arise in the context of commitment of college and university students and special procedures may be warranted. A specially constituted group with expertise in student affairs and higher education law as well as mental health law is needed to address them. The Commission has discussed a collaborative study of these issues with the State Council of Higher Education. This conversation has been put on hold but will be revived in 2009.

3. Transforming the Services System

A ***Task Force on Advance Directives*** ("Advance Directives Task Force") was charged with reviewing the recommendations of the Commission's Task Force on Empowerment and Self-Determination and to draft a bill on advance directives for health care decisions in contexts other than end-of-life care, including mental health care. The Advance Directives Task Force includes experts on health care law and elder law as well as mental health law.

Governor Kaine and others characterized the budget increase for CSBs in the 09-10 biennium as a "down payment" on a longer-term investment in community services. A reconstituted ***Task Force on Access to Services*** ("Access Task Force") will continue its important effort to formulate a vision for the Commonwealth's community mental health services, and to create a new legal foundation for the services system. In addition, the access and service capacity issues addressed by the Commission's original Task Forces on Criminal Justice and Children and Adolescents were folded into the reconstituted Access Task Force.

Among other tasks, the Access Task Force will:

- Study successful innovations in other states
- Review the pertinent literature bearing on effectiveness and cost of treatment and support services it identifies as key components of a high-quality community mental health system
- Review and integrate into a single implementation plan proposals relating to community services recommended by Task Forces on Children and Adolescents, Criminal Justice, and Empowerment and Self Determination
- Study whether mental health service needs of military veterans, members of the National Guard and their families are currently being met and recommend any necessary improvements
- Review the mental health service needs of elderly persons, identify promising approaches in the State and elsewhere, and determine whether any additional services or innovations are needed.

The Access Task Force aims to complete its deliberations in the summer of 2009.

C. Criminal Justice Mental Health Transformation

In January 2008, the Governor promulgated Executive Order 62, creating the Commonwealth Consortium for Mental Health and Criminal Justice Transformation as recommended by the Commission and its Criminal Justice Task Force. The Consortium is tasked with identifying and supporting the development, implementation and expansion of programmatic and policy initiatives to enhance outcomes for individuals with mental illness or co-occurring disorders at risk for or involved in the criminal justice system, and thereby promote public safety. The Consortium is also expected to propose a plan for a multi-system "academy without walls" identifying training needs and relevant training initiatives and creating a coordinated system to educate stakeholders and providers in the criminal justice and mental health systems. Membership in the Consortium represents a coalition of leadership from each branch of government, across multiple Secretariats and agencies, stakeholder organizations, and community based programmatic criminal justice/mental health initiatives. Concrete support for these initiatives was reflected in the budget for FY09-10: The General Assembly specifically targeted $6.3 million (15%) of the increased mental health appropriation for jail diversion programs and crisis intervention training. The Secretaries of Health and Human Resources and Public Safety have designated a State Coordinator for Criminal Justice and Mental Health Initiatives charged with providing oversight and assistance to the Consortium.

The Consortium's first initiative was a Governor's Conference, held in May 2008. During that two day event, over 300 community stakeholders and Consortium leadership convened to discuss ways to implement successful evidence-based programs and practices to reduce the involvement of individuals with mental illness in the criminal justice system. Additionally, the Consortium Conference initiated a state-wide effort to engage communities in developing a strong, sustainable base for achieving success with local criminal justice and mental health transformation efforts. The initiative, developed by the National GAINS Center is called Cross Systems Mapping. Its goals are (1) to bring diverse local community CJ/MH stakeholders together in order to develop common knowledge, language and understanding of the CJ/MH systems; (2) to provide stakeholders with an effective process for mapping how an individual with mental illness navigates (or is navigated through) their local mental health and criminal justice systems interface, and identifying strengths or gaps in service needs and local barriers to success; and (3) to develop a targeted, locality-specific action plans for improving system interface and client outcomes. Localities in Virginia and throughout the United States have already benefited from this process. Florida has begun implementation of these local trainings on a state-wide basis.

Cross Systems Mapping is delivered as a one and a half day facilitated workshop for local criminal justice/mental health stakeholders including law enforcement, consumers, family members, mental health service providers, local elected officials and others. DMHMRSAS in partnership with the Department of Criminal Justice services has already trained twenty outstanding facilitators in Virginia who are now certified to provide this training. DMHMRSAS is providing technical assistance to communities in order to guide them through this process and prepare them for creating successful jail

diversion initiatives. Between 10 and 20 programs are being scheduled for the last half of FY09.

The Consortium will also review programmatic activity in the Commonwealth, including those designated for funding under the FY09/10 for jail diversion and crisis intervention training. In establishing the allocation process for those funds, DMHMRSAS targeted opportunities to most efficiently invest valuable resources, demonstrate the effectiveness of criminal justice/mental health collaborative initiatives, and support replicable programs which will lay the foundation for future successful initiatives throughout Virginia. The Consortium leadership, working with Access Task Force's Criminal Justice and Mental Health Initiatives Working Group, reviewed information from Community Service Boards, Community Criminal Justice Programs and advocacy organizations and solicited input from dozens of criminal justice and mental health stakeholders in order to identify currently active and successful programs in each of the 40 CSB service areas.

In planning for funding allocation, DMHMRSAS utilized ten key threshold factors in order to make initial determinations for funding. These are 1) Strength of community mental health/criminal justice collaboration; 2) Participation of key leadership; 3) Diversity of collaboration partner/stakeholder involvement; 4) Presence and impact of active jail diversion program(s); 5) Existence/utilization of compatible programs; 6) Nature and extent of peer involvement; 7) Utilization of evidence based/best practices; 8) Availability/use of additional financial resources/supports; 9) Program emphasis on data/evaluation; and 10) Evidence of demonstrable outcomes measures/results.

Thirteen of 40 CSB Service Areas met the threshold criteria and were asked to submit proposals for funding. In addition to the high scores reflected by the key threshold factors, these CSB service areas offer an array of programmatic activity and reflect the variety of urban, rural, unified and multi-jurisdictional areas. Funding programs in each of these areas is an important consideration in allocating resources so that programs can be replicated in the many diverse areas throughout Virginia. In the final step of the allocation process, the Department, in partnership with representatives from the Department of Criminal Justice Service (DCJS), will analyze the submissions and fund between 6 and 10 programs.

Funding will also be used to create a comprehensive plan for evaluating these programs, providing consistent, reliable data and outcomes measures on which to base future development and investment in jail diversion programs. Nationally and in Virginia, the availability of sufficient data and effective analysis has been an impediment to ongoing support and resourcing of these important initiatives. Virginia is prioritizing this important component of criminal justice and mental health transformation.

The FY09/10 funds will also be used in partnership with the Department of Criminal Justice Services to support statewide development of Crisis Intervention Team programs. Funds specifically designated for crisis intervention training will be allocated

in partnership with DCJS and support a statewide coalition of CIT programs in various stages of development as well as targeting funds for the development and implementation of CIT programs throughout Virginia.

II. Impact of 2008 Reforms: A Preliminary Report

Informed oversight of the civil commitment process requires accurate data regarding the number, distribution and characteristics of ECOs, TDOs, commitment hearings and judicial dispositions. Adequate data were not available before 2008. Since the Commission was established in 2006, the courts and mental health agencies have collaborated to create the data systems needed for proper monitoring and informed policy-making. This process was accelerated in response to direction by the General Assembly after the reform legislation was enacted in 2008.

Significant progress in data collection and oversight has been made, but it will take some months for the DMHMRSAS, Supreme Court and CSBs to modify relevant databases so that they include all the necessary information, and for the agencies to determine which agency is best situated to collect which data. The Supreme Court has recently made changes to their data collection systems to accommodate needed information. The Commission decided to assemble the available data for the first quarter of FY09 to prepare this Progress Report. Even during the fall months leading up to the Progress Report, major improvements had been made, and these improvements will undoubtedly continue throughout FY09. In this section of the Progress Report, the Commission will estimate the numbers of ECOs, TDOs, commitment hearings and dispositions and, to the extent possible, assess whether commitment practices have changed in the wake of the reforms.

Available Databases

Court clerks at General District Courts document civil commitment hearings using the Case Management System ("CMS"). Although it is technically a database for each District Court to track and record its cases[4], the CMS database is maintained by the Office of the Executive Secretary at the Supreme Court. It is divided into four sections for tracking the corresponding types of cases: traffic, criminal, civil, and involuntary civil commitment. Civil commitment hearings and related ECOs and TDOs are entered in the involuntary civil commitment division of the CMS database. Terminals at court clerk offices transmit the data to the Office of the Executive Secretary, which allows the merging of data from all District Courts.

The eMagistrate System is used by magistrates in all thirty-two judicial districts to issue arrest processes, bail processes, and other orders which include ECOs and TDOs. Each time an ECO or TDO is issued, it is entered into the eMagistrate System, initiating the ECO or TDO process by issuing the appropriate documents. ECOs and TDOs are

[4] The CMS database collects special justice pay codes from the DC-60; however, the Supreme Court Fiscal Department is the official collector of this type of information. For the purposes of this report, it was determined that case based information from the CMS database was more appropriate than pay code information.

counted in the eMagistrate System regardless of whether an ECO or TDO is successfully executed.[5]

When data are requested by an outside party, upon approval by the Legislative and Public Relations Director, the Judicial Planning Office accesses the eMagistrate or CMS databases and assembles the needed data elements, which are then put in a format for submission to the party requesting the data.[6]

The Virginia Association of Community Services Boards' Emergency Services Council ("ES Council") voted unanimously to collect data on inpatient commitments and TDOs issued during the first quarter of FY09 after the new mental health legislation went into effect to gain insight into how the new legislation impacts commitment and TDO rates. The ES Council collected data from 39 out of 40 CSBs, each of which tracked the data using their own methods.[7] The "CSB TDO and Commitment Survey" collected the frequencies at each CSB (involving adults only) of TDOs issued by a magistrate and of inpatient or outpatient involuntary admissions ordered at civil commitment hearings that their CSB attended. The rate of admissions reported for a CSB can depend on the number of TDO facilities in the CSB area and the jurisdictions in which the CSB has agreed to attend hearings.

ECOs

The best available source of data regarding written ECOs is the Supreme Court's eMagistrate Data System. According to the eMagistrate database, about 500-600 ECOs were issued per month in the first quarter of FY09. (See Table 1.)[8]

Table 1. Frequency of Adult ECOs During First Quarter: eMagistrate

Month	eMagistrate Data ECOs
Jul	603
Aug	523
Sep	481
Total	1,607

[5] An ECO or TDO is issued by a magistrate but is only deemed successfully executed if the person is detained.

[6] Juvenile and adult data was obtained from the eMagistrate System. Only adult data was obtained from the CMS database.

[7] Eastern Shore CSB did not have any data available.

[8] According to the CMS database, 678 ECOs were issued and 597 were served during the first quarter – about 200/month. However, the Commission believes that the magistrate database is the more reliable of the two for the purpose of counting ECOs. It appears that the number of ECOs in the CMS database is too low to represent all ECOs issued and executed during the quarter. General District Court Clerks are instructed to record all orders, but it seems likely that there was some delay in implementing these new data entry requirements.

When people are taken directly into custody by law enforcement officers and brought to a mental health facility based on the officer's own observations, no formal ECO is executed. (These are called "paperless ECOs.") The number of paperless ECOs is unknown and will have to be ascertained directly from facilities conducting mental health evaluations. For example, in the Commission's June 2007 study of emergency evaluations conducted by CSBs, 24.3% of the individuals evaluated that month were in police custody at the time of the evaluation, but only 46.6% of those individuals were being held under a written ECO. Overall, at the present time, data regarding ECOs are incomplete.

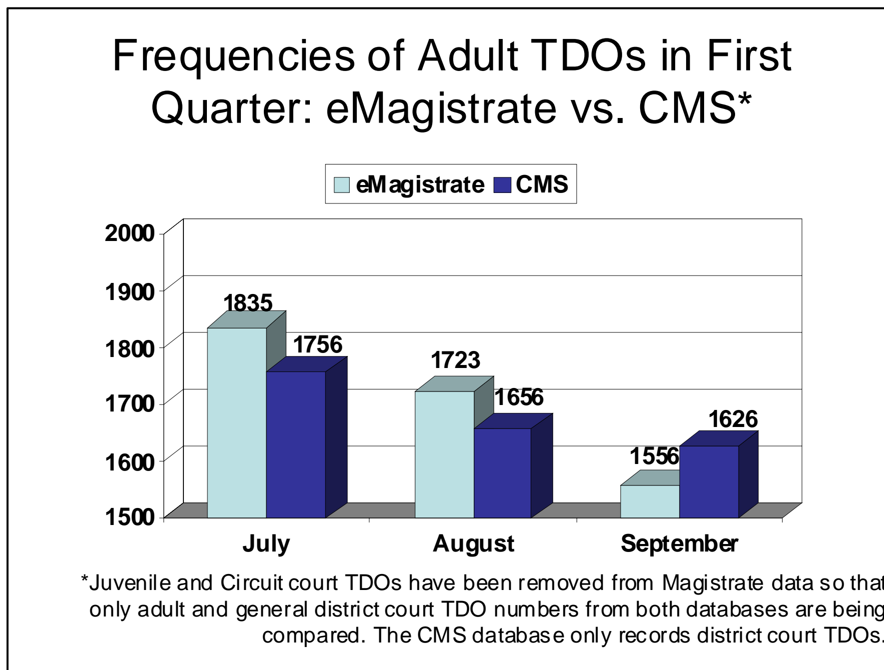
TDOs

The three available sources of data report different numbers for TDOs issued and executed during the first quarter of FY09. The number of TDOs issued for the quarter was 5,038 according to the CMS data, 5,285 according to the CSB data, and 5,157 according to the eMagistrate data. (See Table 2.) As depicted in Figure 1, the discrepancy between the eMagistrate and CMS databases is about 75 cases per month, but it reverses direction in September.

Table 2. Frequencies of Adult TDOs Issued During First Quarter from Available Sources

	Number of Adult TDOs		
	CMS	CSB	eMagistrate
July '08	1,756	N/A	1,850
Aug. '08	1,656	N/A	1,737
Sept. '08	1,626	N/A	1,570
Total First Quarter	5,038	5,285	5,157

Figure 1. eMagistrate vs. CMS: Frequency of Adult TDOs During First Quarter



The most important TDO number is how many TDOs were executed during the first quarter. The CMS data show that number to be 4,847. (See Table 3.) Although the eMagistrate data system and the CSB survey do not include information about execution of TDOs, it appears, based on the rate of execution in the CMS data, that about 5,000 adult TDOs were executed during the quarter. (See Table 4.) The Commission will continue to evaluate the strengths and weaknesses of each data system over the coming months.

Table 3. Frequency of Adult TDOs in CMS

	CMS:Number of Adult TDOs		
	Executed	Unexecuted	Total
July '08	1,715	41	1,756
Aug. '08	1,577	79	1,656
Sept. '08	1,555	71	1,626
Total First Quarter	4,847	191	5,038

Table 4. Frequencies of TDOs Executed
During First Quarter from Available Sources[9]

	Number of Executed TDOs		
	CMS	CSB	eMagistrate
Adults	4,847	5,085*	4,961*
Juveniles	N/A	N/A	324*

*estimated

A key policy question is whether the number of TDOs has increased since the 2008 reforms went into effect. The answer depends on which data system one uses.

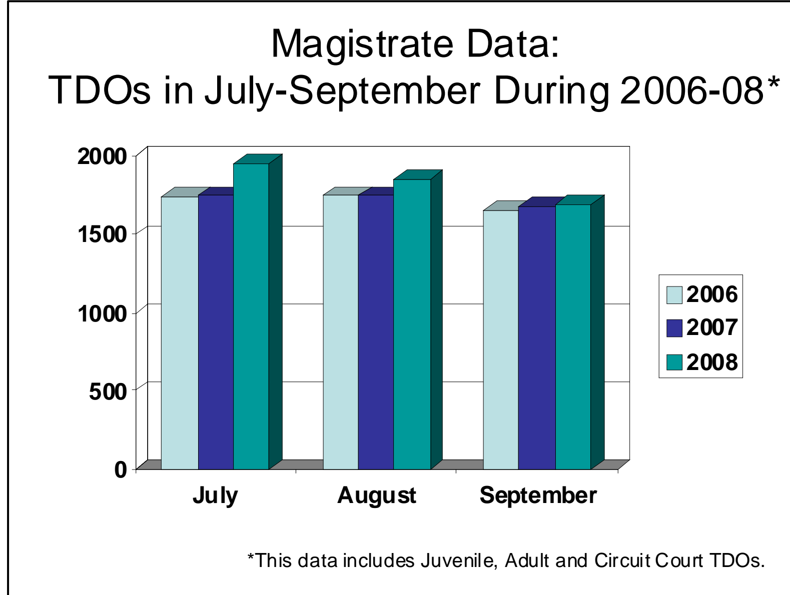
- The Supreme Court's eMagistrate database suggests that the numbers of TDOs during July, August and September of FY09 were somewhat higher (an increase of 7%) than during these same months in FY07 and FY08. (See Figures 2 and 3). However, the numbers of adult TDOs for ALL of calendar year 2008 have been notably higher than those during calendar years 2006 and 2007. In other words, if these data are accurate, the spurt in TDOs began in January 2008, and the rate of increase actually *declined* after the new law went into effect in July 2008 and may have receded entirely in September. This suggests that the increase in adult TDOs during 2008 is attributable to factors that preceded the effective date of the new law.[10] (It is possible that the apparent increase beginning in January 2008

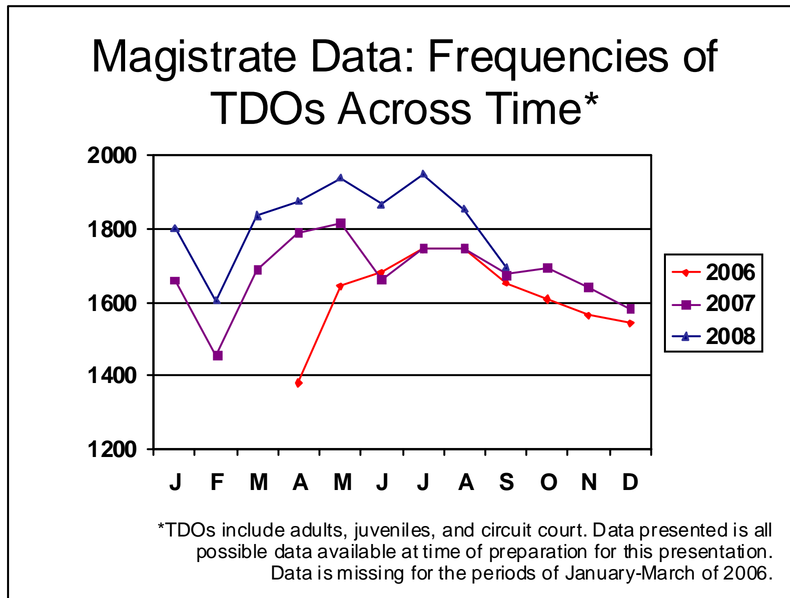
[9] Numbers of executed TDOs in the eMagistrate and CSB data are estimated numbers based on the percentage of TDOs (3.8%) in the CMS database that were unexecuted. The eMagistrate System and CSB TDO and Commitment Survey do not show whether a TDO was executed or unexecuted.

[10] Interestingly, the increase did NOT begin during April or May of 2007 in the wake of the Virginia Tech killings. The TDO numbers during April-December of 2007 were nearly identical to the numbers during April-December, 2006. We surmise that the TDO increase during the first six months of 2008 represents an educational effect – the deliberations in the late fall by the Commission and the General Assembly relating to proposed modifications of the commitment criteria, together with accompanying media coverage, may have heightened awareness of the issues by CSB ES staff and begun to influence their

(including the first quarter of FY09) is a function of improved record-entry practices by magistrates rather than real changes in TDO frequency; however, since a similar increase appears in the CSB survey data (see below), we are inclined to think that there has been a genuine increase in the number of TDOs during 2008).

Figures 2 and 3. Frequencies of TDOs in eMagistrate System





- The CSB data suggest that the number of TDOs may have increased about 8% during the first quarter of FY09 compared to the first quarter of FY08 (although there have been substantial differences among localities). (See Table 5). However,

decisions at the margins in early 2008. Because this effect might otherwise have occurred in July after the modified criteria had been adopted, it might be seen as an anticipatory effect.

FY07 was the first year that most CSBs systematically recorded the number of TDOs, and the numbers for 2007 may be less accurate than the numbers for FY08.

Table 5. Frequency of Adult TDOs in CSB TDO and Commitment Survey[11]

Number of TDOs July-September							
CSB	**2007**	**2008**	**% Increase**	**CSB**	**2007**	**2008**	**% Decrease**
Hanover	32	70	119%	Richmond	489	481	-2%
Highlands	39	71	82%	Mid. Penin.-Northern Neck	91	88	-3%
Arlington	65	107	65%	Norfolk	170	158	-7%
Valley	34	52	53%	Henrico	213	197	-8%
Loudoun	53	81	53%	Crossroads	60	55	-8%
Portsmouth	58	87	50%	Colonial	59	54	-8%
Southside	56	78	39%	Central Virginia	235	215	-9%
Alleghany Highlands	22	29	32%	Prince William	209	190	-9%
Alexandria	44	56	27%	Cumberland Mtn.	86	72	-16%
Virginia Beach	192	237	23%	Harrisonburg-Rockingham	57	48	-16%
Mt. Rogers	210	256	22%	Northwestern	157	129	-18%
Chesapeake	87	106	22%	Planning District One	96	76	-21%
Blue Ridge	423	513	21%	Dickenson	18	14	-22%
Hampton-Newport News	234	273	17%	Goochland-Powhatan	13	8	-38%
District 19	182	211	16%	Rockbridge Area	23	10	-57%
Fairfax-Falls Church	212	245	16%	**Total 2007 TDOs: 4,881** **Total 2008 TDOs: 5,285** **Average Percent Change: 8%**			
Region Ten	92	106	15%				
Piedmont	77	88	14%				
Chesterfield	64	72	13%				
Western Tidewater	103	111	8%				
Rappahannock-Rapidan	145	151	4%				
Rappahannock Area	115	119	3%				
Danville-Pitts.	113	116	3%				
N. Riv. Valley	253	255	1%				

[11] CSBs are listed in order of greatest percentage increase to greatest percentage decrease.

Fairfax-Falls Church CSB has maintained data on TDOs since 2005. As shown in Figure 4 and Table 6, there was a big jump in TDOs in Fairfax-Falls Church during December 2007 and January 2008 and the monthly increase has continued throughout 2008. These data lend further support to the hypotheses that there has been a real increase in TDOs during the past year and that the increase preceded the effective date of the new law.[12]

Figure 4. Frequency of TDOs in Fairfax-Falls Church CSB During 2005-2008

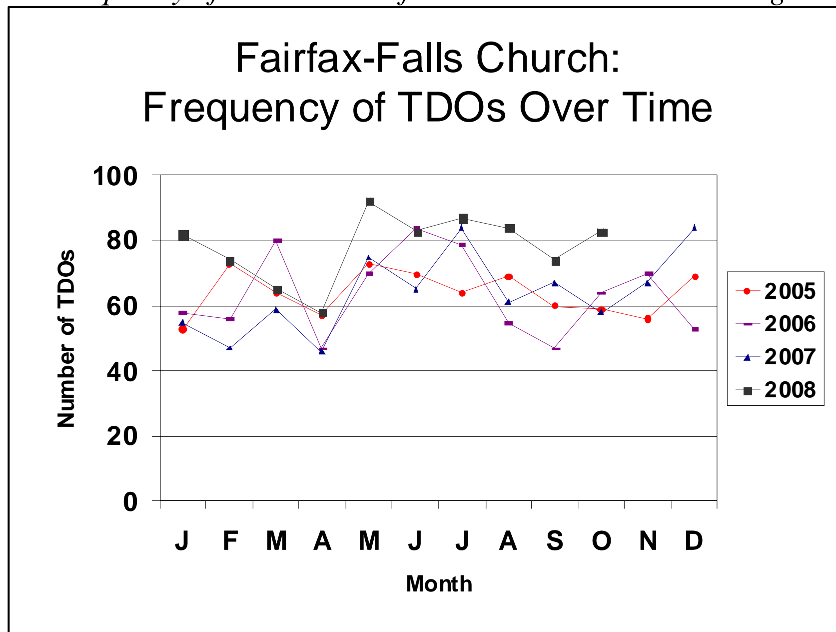


Table 6: Frequency of TDOs in Fairfax-Falls Church CSB During 2005-2008

	CSB:Number of Adult TDOs			
	2005	2006	2007	2008
January	53	58	55	82
February	73	56	47	74
March	64	80	59	65
April	57	47	46	58
May	73	70	75	92
June	70	84	65	83
July	64	79	84	87
August	69	55	61	84
September	60	47	67	74
October	59	64	58	83
November	56	70	67	
December	69	53	84	
Total	767	763	768	782

[12] As noted in footnote 7, why this increase has occurred is an interesting question. One hypothesis that is NOT supported by the data is that the increase is attributable to an increased risk-averseness by CSBs in the wake of the Virginia Tech shootings. Neither the eMagistrate data nor the Fairfax-Falls Church data indicate a rise in TDOs during the summer months in 2007.

Overall, the Commission estimates that TDOs were about 8% higher during the first quarter of FY09 than during the first quarter of FY08, but it seems likely that the rate of increase is receding.

All Adult Commitment Hearings

The best source of data on the number of commitment hearings and the dispositions of these hearings is the Supreme Court's CMS data system. The number of commitment hearings for the quarter was about 5,720. This includes 5,141 ordinary adult hearings, 45 hearings involving jail detainees, and 524 recommitment hearings. (See Table 7.) We have reasonable confidence in the completeness of the CMS data regarding hearings because the number of initial hearings conducted (that is, excluding recommitments) is approximately 5,100, only slightly higher than the estimated number of executed TDOs recorded in the three TDO databases.[13]

Table 7. Frequency of Adult Civil Commitment Hearings in CMS

	CMS:Frequency of Adult Hearings			
	Initial Hearing	Recommitment	Jail Detainees	Total
July '08	1,761	173	23	1,957
Aug. '08	1,720	183	10	1,913
Sept. '08	1,660	231	12	1,903
Total First Quarter	5,141	587	45	5,773

Ordinary Adult Commitment Hearings[14]

We do not have comparable data at hand for FY08, but it seems likely that there were more ordinary commitment hearings in the first quarter of FY09 than during the first quarter of FY08. Based on the data obtained at the time of the Commission's study of commitment hearings during May 2007, and on inferences drawn from TDO data, it is possible that the increase has been in the range of 5-8%. It must be emphasized, however, that this is based almost entirely on inference from other databases rather than from the CMS database itself. We expect the CMS database will be a reliable source of year-to-year comparisons in the coming years. We are also advised that payments by the Supreme Court under the IMC fund are running ahead of last year adding support for a real increase in commitment hearings.

We also have reasonable confidence in the data recorded in the CMS data system regarding dispositions of ordinary adult hearings held in the first quarter of FY09. We say this because of the stability of the data from month to month. As shown in Table 8, during the first quarter, about 56% of the hearings resulted in involuntary admission,

[13] The number of commitment hearings should not be lower than the number of TDOs since very few individuals are either released or allowed to convert to voluntary patients before the scheduled hearing; however, it could be higher because some patients originally admitted as voluntary patients may later he held over objection.

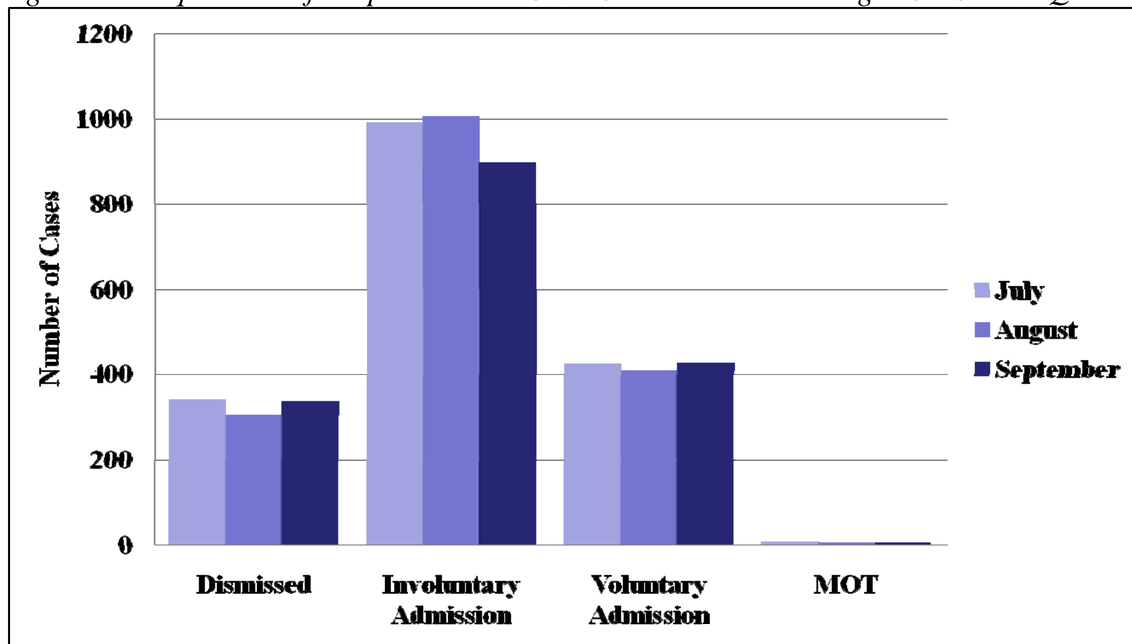
[14] This analysis excludes commitment hearings involving jail detainees and recommitment hearings. These two categories are analyzed separately.

about 24% resulted in voluntary admission and about 19% of the cases were dismissed. A handful of cases (18) resulted in mandatory outpatient treatment (MOT) orders. In comparison with the Commission's study of hearings conducted in May 2007, there were fewer MOT orders and fewer voluntary hospitalizations, and correspondingly more involuntary hospitalizations and dismissals. (See Figure 5.)

Table 8. Frequencies of Dispositions at Civil Commitment Hearings in CMS

2008	**Dismissed**		**Involuntary Admission**		**Voluntary Admission**		**MOT**		**Total Number of Hearings**
	N	%	N	%	N	%	N	%	
July	341	19.36	991	56.27	422	23.96	7	0.40	1,761
August	302	17.56	1,005	58.43	408	23.72	5	0.29	1,720
September	335	20.1	895	53.92	424	25.54	6	0.36	1,660
Total FQ	978	19.02	2,891	56.23	1,254	24.39	18	0.35	5,141

Figure 5. Frequencies of Dispositions at Civil Commitment Hearings: CMS First Quarter



Commitments to Inpatient Treatment

From a resource standpoint, one of the key questions is how many people are committed to inpatient treatment, and whether that number has increased as a result of the 2008 reforms. Again, based on the apparent increase in number of hearings and the apparently increased proportion of hearings resulting in commitment to inpatient treatment (perhaps 5%), it seems likely that there were more people involuntarily committed to hospitals during the first quarter of FY09 than during the first quarter of FY08.[15] The actual numbers, based on CMS data, were about 1,000 people per month in July and August and 900 in September. However, the increase preceded the effective date of the new law and has probably been accompanied by a decline in the number of voluntary admissions.[16]

Mandatory Outpatient Treatment

One of the most striking findings based on the first quarter FY09 data is that MOT orders have been rare. The CMS data indicate that there were only 18 MOT orders during this period and 11 of them occurred in a single jurisdiction. The CSB survey reports only 13, as compared with 78 during the same period in FY08.[17] This finding led the Commission to survey CSBs, inquiring about the possible explanations for the decline in what had already been a relatively rare practice. Thirty CSBs responded to the survey. (See Table 9.)

Table 9. CSB MOT Survey Results: Explanations for Decline in MOT

Explanations for Decline in MOT
Percent of CSB Respondents who Thought Explanation was Most Likely

Explanation	Percent
Burden of new MOT laws on judges	**63.3%**
MOT Criteria same as Commitment Criteria	**60.0%**
Detention period too short to allow consideration/creation of MOT plan	41.3%
Changes to Civil Commitment Criteria	40.0%
Insufficient Behavioral Health Resources	34.4%
Burden of new MOT laws on CSB	33.3%
Judges having to verify whether MOT is available	31.0%
Judges' interpretations of Comm. Criteria	26.6%
Insufficient Funding	20.7%

[15] The CSB database was incomplete for numbers of inpatient commitments. However, the localities reporting numbers of commitments for both FY08 and FY09 reported a 22% increase. The Commission believes that the numbers reported are not reliable; in particular, it is likely that a significant portion of the cases reported as involuntary commitments were cases in which the respondent agreed to voluntary admission.

[16] The Fairfax-Falls Church CSB data also show that a significant increase in involuntary admissions in the first quarter of FY09 was accompanied by a precipitous decline in voluntary admissions, resulting in no overall increase in the number of hospitalizations.

[17] The Commission's hearing study reported that there were 73 MOT orders in May 2007.

It is apparent that both CSBs and judges have been hesitant to invoke the new MOT procedures, especially given the potential demand on CSB resources. However, it seems likely that the number of MOT orders will increase as the participants become more familiar with the process.

Virginia State Police Data on Hearing Dispositions

A second potential source of data on hearing dispositions is the Virginia State Police ("VSP"). The clerks of the District Courts are required to send VSP the names of individuals (1) committed to inpatient or outpatient treatment and (2) who consent to voluntary admission after detention under a TDO. In theory, the numbers should match the numbers in the CMS database for these same dispositions at commitment hearings. However, the Commission decided not to rely on the VSP data for the first quarter because there are significant discrepancies between the CMS data and the VSP data, especially for July, and it is likely that the reporting of this information to the VSP has not yet become streamlined. (See Table 9.) There was also probably a significant backlog of orders sent to the VSP after July 1 for cases heard in June. The Commission will continue to compare the CMS data with the VSP data during the coming year. [18]

Table 9. First Quarter Involuntary Out / Inpatient Treatment: State Police vs. CMS[19]

	Frequency of Adults Admitted to Involuntary In- or Outpatient Treatment	
	State Police	**CMS**
July '08	1,524	1,180
Aug. '08	1,128	1,186
Sept. '08	1,104	1,135
Total First Quarter	3,756	3,501

Recommitments

Figures 6 and 7 display the numbers and dispositions of recommitment hearings during the first quarter of FY09. They are very similar to the numbers and disposition rates in the Commission's May 2007 study. Almost all recommitment hearings result in continued hospitalization.

[18] The data in the two systems are somewhat less discrepant for the numbers of people who agreed to voluntary admission after issuance of a TDO. The VSP data reflect about 1006 such cases for the quarter – less than, but reasonably close to the number of voluntary post-hearing admissions for the quarter (1254) recorded in the CMS database.

[19] For comparison to VSP data, which records *any* involuntary admission or MOT orders, CMS data for the first quarter of FY09 were tabulated to include not only ordinary involuntary inpatient admissions and MOT, but also involuntary admissions and MOT orders from recommitment hearings and involuntary admissions involving people detained in jail.

Figure 6. Frequency of Recommitment Hearings

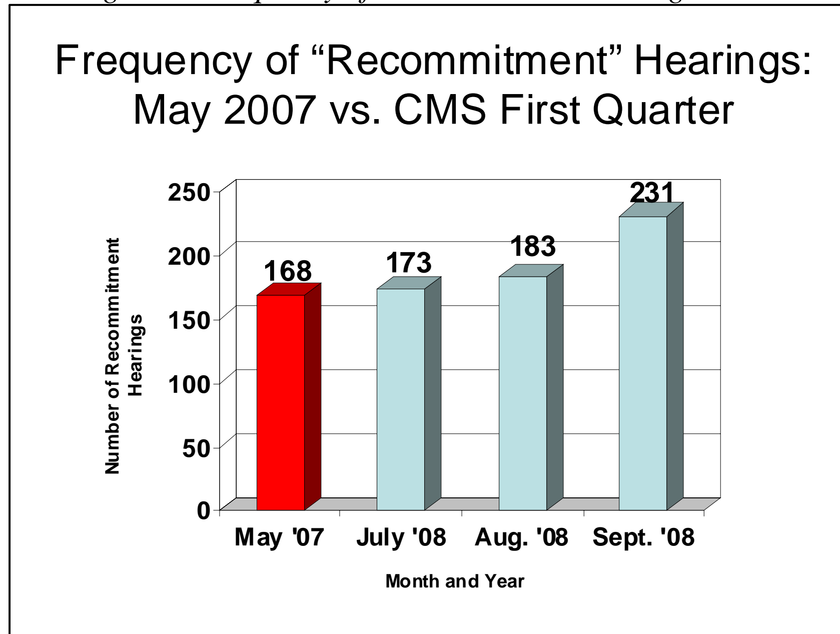
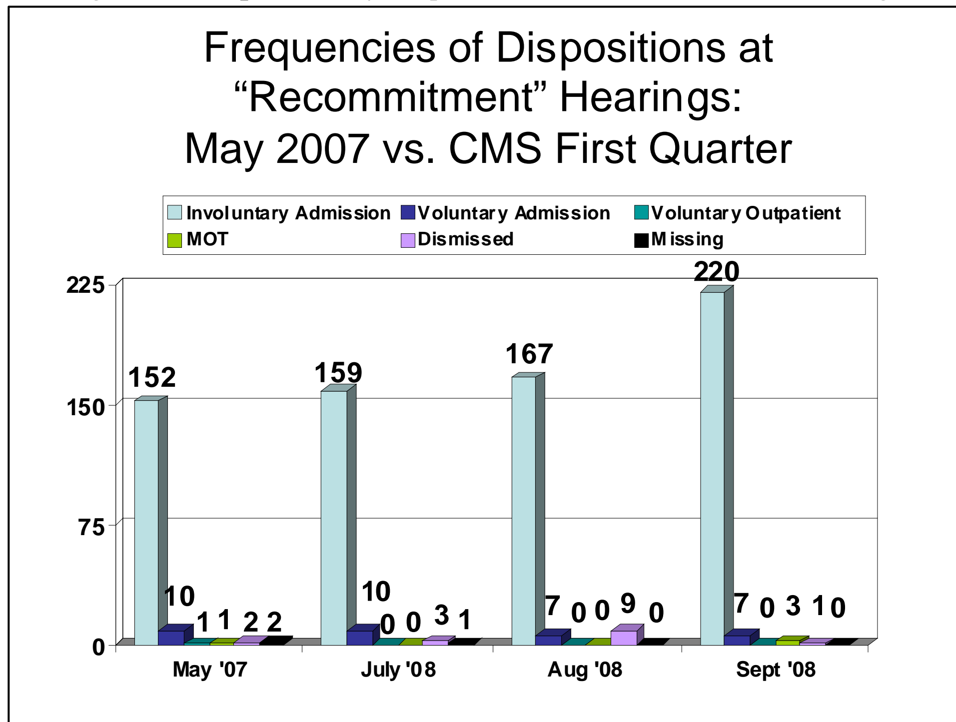


Figure 7. Frequencies of Dispositions at Recommitment Hearings



III. Implementation of 2008 Reforms

In this section of the Report, the Commission reviews the steps that have been taken to implement the 2008 reforms, presents data regarding the administration of the commitment process during the first quarter of FY09, and identifies some of the impediments and challenges that have emerged.

A. Coordination and Oversight

Perhaps the most promising development in 2008 was the development of an organizational structure for coordination and oversight of Virginia's commitment process. Surprisingly, prior to the 2008 reforms, no state entity was charged with these functions, a structural failure that probably contributed to the wide variations in the application of the commitment law that had developed over the past decades. Beginning in December, 2007, the Commission served as the hub for all the stakeholder constituencies, state executive branch agencies and the Office of the Attorney General to monitor the legislative process and reach consensus on issues as they arose. Legislative Task Force members met with Delegates and Senators, attended legislative committee meetings and hearings, prepared and submitted position papers and talking points, drafted language for proposed amendments, and offered testimony to the legislative committees considering the proposed legislation.

During the 2008 General Assembly Session, more than 120 mental health-related bills were submitted by 43 Delegates and Senators. The resulting comprehensive legislative package codified sweeping changes in Virginia's mental health laws. Once the Session concluded, the Legislative Task Force was expanded and reconstituted to address implementation of this new legislation. The initial priorities were to design and coordinate comprehensive training to the numerous stakeholders involved in the implementation of this legislation, and to help guide and coordinate implementation efforts at the local level. The Implementation Task Force participants collaborated on the preparation of training materials and "cross-training" efforts so that all of those involved would receive similar information and advice for implementing the reforms. The Task Force members organized and participated in training events for CSB personnel, district and juvenile court judges, court clerks, magistrates, and special justices, among others. Task Force members also provided comments to the Office of Executive Secretary's Legal Research Department on the creation of new forms and revision of existing District Court forms used in the involuntary commitment process. Before enactment of the 2008 amendments, there were 8 District Court forms applicable to involuntary commitment. Under the new provisions, there are now some 26 district court forms relating to these procedures. DMHMRSAS also changed its CSB preadmission screening form as well as the petition, independent examiner's report and involuntary treatment order forms. Development of a web-based DMHMRSAS certification curriculum for CSB screeners and independent examiners is also well underway, as required by the 2008 amendments.

Implementation efforts were also supported by a "Mental Health Reform" web-page on the DMHMRSAS web-site, where FAQs, training materials, forms, guidance documents and other resources are available to interested stakeholders. Many other actions were taken by Task Force members and their respective agencies and organizations to support a coordinated implementation effort.

B. Issues Requiring Legislative Clarification in 2009

After the mental health legislation enacted by the 2008 General Assembly became effective on July 1, 2008, the Task Force on Implementation of the 2008 Reforms began gathering information on the implementation of the new procedures to gauge the extent to which the new legislation was accomplishing the goals of the Commission and the General Assembly. The Implementation Task Force identified a number of problems arising in implementing the new legislation, either as a result of drafting, interpretation or training issues, and developed recommendations to remedy these problems. The Commission endorsed the Implementation Task Force's recommendations and developed a proposal to address them for consideration by the General Assembly in its upcoming session.

Recommendation 1: The Commission recommends for consideration by the General Assembly a set of procedural amendments to the 2008 legislation designed to clarify legislative intention and thereby promote uniform application of the laws governing involuntary commitment. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

C. Issues Requiring Monitoring and Further Study

The Commission has also identified two areas of concern that require further monitoring before recommendations are offered for consideration by the General Assembly.

1. Training and Oversight for Special Justices and Attorneys

Training. In order to ensure that the civil commitment process is implemented consistently and fairly statewide, it is imperative that special justices receive extensive training BEFORE they assume their responsibilities on the bench. Because special justices are often appointed from the ranks of attorneys who are appointed to represent respondents in commitment hearings, it is equally important that attorneys be trained and qualified to represent respondents before they assume such responsibilities.

The Commission believes that special justices and attorneys should be required to complete a training program similar to that required for attorneys serving as guardians *ad litem* for incapacitated adults. This training encompasses a six hour mandatory course

"Representation of Incapacitated Persons as a Guardian *ad Litem*" and six hours of continuing education every two years from the date of original qualification on any topic related to the representation of incapacitated persons. For special justices and attorneys, the six hours of continuing legal education should be in subjects approved by the Executive Secretary's Office of the Virginia Supreme Court. Such training should also include training provided with the participation of consumers and family members, public and private sector clinicians and CSBs.

The Commission has been informed that the Judicial Council, the policy entity of the Virginia Supreme Court, is considering mandating that all special justices complete a training program related to their job responsibilities within six months of their appointment and that they receive continuing legal education in commitment related topics every two years. The Supreme Court would also work with the Virginia State Bar and Virginia CLE to establish training programs for attorneys representing petitioners and respondents in these proceedings. In light of these initiatives, the Commission sees no reason for legislative action at this time.

Oversight. The Commission is also concerned about the appointment, oversight, support and training of the special justices who conduct involuntary commitment hearings. Special justices are independent judicial officers who serve under the supervision and at the pleasure of the chief circuit court judge. See Code § 37.2-803. The Executive Secretary of the Supreme Court is the administrator of the circuit court system and assists the chief judges in the performance of their administrative duties. See Code § 17.1-502. Special justices also are under the jurisdiction of the Judicial Inquiry and Review Commission, and are subject to discipline or removal for actions violating the Canons of Judicial Conduct. While special justices appointed to conduct commitment hearings are in every sense of the word "judges," who exercise all the powers and duties of judges in the cases over which they preside, ordinary models of oversight or supervision are not directly applicable to these judicial officers. The Implementation Task Force will continue to study this issue and will provide recommendations for consideration by the Executive Secretary and the Commission in 2009

2. Training, Certification and Compensation for Independent Examiners

Before the 2008 amendments, evidence suggested that independent examiners ("IEs") ordinarily spent much less than an hour in conducting the examination and preparing the IE report for the involuntary commitment hearing. In addition, IEs were not statutorily obliged to attend commitment hearings. Under the new procedures enacted in 2008, the typical IE examination now requires at least an hour to assemble the relevant information (e.g., obtaining records and speaking with collateral sources), a task that is apparently performed in most cases by the staff of the TDO facility. Assuming that the necessary information has been assembled by staff, the IE requires about two hours to review the records, conduct the interview and prepare the IE report for the commitment hearing. In addition to the mandated review of additional information about each individual subject to a commitment hearing, IEs are now required to attend the

commitment hearing in person or by audio/video, or otherwise be available by telephone to provide testimony or answer questions.

Notwithstanding the increased time required to handle each commitment case mandated in the 2008 amendments, the compensation rate for IEs ($75 per hearing) was not changed during the 2008 session. The Commission is concerned that the disjunction between the added IE responsibilities and the already low level of compensation could result in a scarcity of qualified professionals willing to participate in the civil commitment process. The Implementation Task Force, with input from the Medical Society of Virginia and other professional groups, is taking steps to monitor this situation and coordinate its findings with DMHMRSAS so the Department and the Commission can determine what remedial steps, if any, might be advisable.

In addition to requiring DMHMRSAS-certified training for the other identified mental health professionals serving as IEs under § 37.2-815, the Commission also strongly recommends that psychiatrists and psychologists serving as IEs receive mandatory training on several issues related to the civil commitment process. Although psychiatrists and psychologists may not need training relating to the clinical aspects of the mental health examinations required under Virginia's civil commitment law, they should be required to receive training on the new civil commitment criteria and other legal requirements of the civil commitment process, as well as the law on health records privacy, to ensure both compliance with the law and to promote a consistent statewide application of civil commitment law. If the TDO period is extended to 4 or 5 days and IEs are permitted to release an individual from a TDO prior to a commitment hearing, mandatory training for all IEs will be even more critical. Continuing education units should be available to all mental health professionals who complete this training.

Recommendation 2: The Commission believes that all independent examiners, including psychiatrists and psychologists, should be required to complete a certification program developed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, that Continuing Education Units should be made available for the training, and that the $75 fee now authorized for independent examinations in civil commitment proceedings should be increased. However, in light of current budget constraints, the Commission believes that these changes should be deferred.

IV. Unfinished Business in Commitment Reform

As noted, the changes enacted in 2008 were only a first step in a continuing process of reform. Some key components of comprehensive reform were outlined in the Commission's Preliminary Report. In addition, a number of bills relating to the commitment process were carried over from the 2008 Session and the subject matter of these bills was referred by the Senate to the Commission for further study. This section summarizes the Commission's views on some of these issues.

A. Transportation

Neither police departments nor sheriffs departments receive specific funding for executing ECOS, TDOS or providing transportation following a commitment hearing. Law-enforcement officers spend up to four hours, and often much longer, in hospital emergency departments waiting for completion of medical assessments and CSB evaluations, and for the CSB to locate a *temporary* detention bed. Thereafter, due to a shortage of psychiatric beds in some localities, even longer hours may be spent transporting individuals outside the jurisdiction to other parts of the state, necessitating taking two officers and a vehicle off of the street and away from other law enforcement duties needed in that locality. Overtime expenses are often incurred in transporting individuals to mental health facilities. In addition, there is substantial evidence that law enforcement transport for what is a health condition unnecessarily "criminalizes" the mental health crisis. Moreover, the routine use of restraints during such transport is both traumatizing and stigmatizing and greatly impairs recovery. The issue of transport related to the civil commitment process is also a great concern of law enforcement due to its enormous burden on law enforcement staffing and other resources. Both police departments and sheriff's departments have recently conducted surveys to better understand the transportation demands related to civil commitment.

The Virginia Association of Chiefs of Police conducted a survey in 2008 to ascertain the frequency with which local police agencies, sheriffs' departments, EMS agencies, or others provide transportation for ECOs and TDOs (the "Police Survey"). The Police Survey indicates local police provide transportation for ECOs and TDOs approximately 75% of the time and sheriffs' departments provide transportation the remainder of the time. (Sheriffs always provide transportation *following* the commitment hearing.) Of Police Chiefs that reported another entity provides transportation, most often that entity is EMS because of a physical injury or medical complication. Even in cases where a medical transport is necessary, however, law enforcement continues to maintain custody and an officer will either ride in the ambulance with the patient or follow behind in a squad car. The Police Survey also indicated that use of restraints for persons being transported in the civil commitment process is mandatory policy for 61% of police personnel providing transportation and is at the officer's discretion in approximately 29% of police departments. In those jurisdictions where an officer has discretion concerning the use of restraints, specific policy guidance to guide the officer's discretion is lacking and it is unclear how often that discretion is used to forgo restraints.

As noted above, sheriffs' departments undertake about a quarter of the ECO and TDO-related transports and are required to transport all individuals following a hearing. Given that there are at least 20,000 civil commitment hearings in Virginia annually, this represents a significant demand on sheriffs' resources. To better understand this, the Sheriffs' Association completed a staffing study during the spring of 2008 (the "Sheriff's Study") finding that 26.3 *additional* full time equivalent (FTE) positions are needed for Sheriffs' Departments statewide to provide necessary services related to Virginia's involuntary civil commitment process.[20] The Sheriffs' Study did not include an assessment of any additional staffing required as a result of the 2008 legislation permitting extension of temporary detention orders to 6 hours or execution of the new mandatory examination order and *capias* requirements.

A justification for any law enforcement transport is that in some cases of a mental health emergency there may be some danger to the individual in question or to others. However, this public safety concern has resulted in assuming everyone is a risk, an outcome that overburdens law enforcement and traumatizes individuals involved. All stakeholders agree that law enforcement should be utilized only when a public safety issue is presented and not as the primary source of transportation. As a result, the Commission endorsed the concept of a safe, cost-effective three-tiered statewide transportation system in its Preliminary Report of December 2007[21] based on the proposals made by the Task Force on Civil Commitment.("Civil Commitment Task Force").[22]

The goal is to develop a civil commitment transportation plan that could be implemented by 2012 that would be designed: (1) to "decriminalize" transportation and reduce stigma through reducing Virginia's over-reliance on law-enforcement agencies and the use of restraints in transporting individuals in the civil commitment process, while at the same time ensuring the safety of the person, the transporter and the public, and (2) to promote the recovery of the individual by enabling the provision of voluntary services in the least restrictive manner and setting. The basic outline of the transportation plan is to permit transportation by persons or entities other than law enforcement based on an assessment of the status of the individual involved and the safety needs in each situation as follows:

> ***First tier:*** transportation by family and friends, community services boards (CSBs), taxi service, and Medicaid vendor transportation.
>
> ***Second tier*:** ambulance service or step-down service similar to a wheelchair or stretcher transport and the impact of requirements related to the Emergency Medical Treatment and Active Labor Act (EMTALA).

---

[20] The study covers only Sheriffs' Departments and not local police agencies that also provide a significant amount of transportation for ECOs and TDOs.

[21] http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf,

[22] http://www.courts.state.va.us/cmh/taskforce_workinggroup/2008_0918_tf_rpt_civil_commitment.pdf.

***Third tier*:** Use of law enforcement for transportation, including potential for creation of "mental health officers," and use of restraints in transportation.

The Commission anticipates that any transportation plan will require gradual implementation, including pilot projects. After the 2008 General Assembly Session, the Commission appointed a special Transportation Working Group to flesh out the proposed three-tiered plan. The Transportation Working Group also reviewed the provisions of SB 102 (Cuccinelli), a transportation bill essentially embracing the Commission's three-tiered plan. (The Senate had referred SB 102 back to the Commission for further study.)

Transportation in the civil commitment process by non-law enforcement entities is utilized in other states, although most states continue to rely heavily upon law enforcement. At least 27 states permit transport by family, friends, mental health professionals, ambulances, and public and private transportation companies.

Currently, Virginia Code § 37.2-808(C) requires a magistrate issuing an emergency custody order to specify the primary law-enforcement agency and jurisdiction to execute the ECO and provide transportation. Subsection D of that statute also requires the magistrate to "order the primary law-enforcement agency from the jurisdiction serviced by the community services board …to execute the order and provide transportation." Similarly, § 37.2-810(A) requires a magistrate issuing a temporary detention order to specify the law-enforcement agency and jurisdiction that shall execute the TDO and provide transportation."

Section 37.2-808 was amended by the General Assembly in 2008 by adding a new Subsection E to permit the law-enforcement agency providing transportation to transfer custody of the person to the facility or location to which the person is transported for evaluation under certain specified circumstances. This provision may have the effect in the future of relieving law-enforcement of some of the time involved in waiting for evaluations to occur, but it does not relieve it of the primary responsibility for providing transportation for both ECOs and TDOs. Unless §§ 37.2-808 and -810 are amended, alternatives other than law-enforcement transportation will not be permitted.

Section 37.2-830 does permit a judge or special justice following the commitment hearing to place a person in the custody of any responsible person, including a representative of the facility in which he was detained, for the sole purpose of transporting the person to the commitment facility. The preceding section, § 37.2-829, permits the judge or special justice to consult with the person's treating physicians and the CSB regarding the person's dangerousness and whether the sheriff should transport or whether other alternatives authorized in § 37.2-830 may be utilized.

Recommendation 3: The Commission recommends that the General Assembly consider amending the Code provisions relating to transportation of persons involved in the commitment process to permit and strengthen the use of transportation by responsible individuals and organizations other than law

enforcement officers. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Family members have suggested that if they were notified that their family member is in crisis, in some cases they could provide the transportation themselves or, diffuse the situation or provide alternative care, thereby reducing the need for emergency custody, detention and involuntary hospitalization. Although the HIPAA Privacy Rule, 45 C.F.R. § 164.510(b)(ii), and the Virginia Health Records Privacy Act, § 32.1-127.1:03, permit such a disclosure, apparently it does not appear clear to mental health professionals that this disclosure can occur. As a result, they often decide not to notify family members.

Recommendation 4: The Commission recommends that the General Assembly consider legislation amending §§ 37.2-127.1:03 and 37.2-804.1 to authorize family members to be notified when their relative is involved in the commitment process. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009."[23])

First Tier: Increasing access to voluntary services supported by "first-tier" transportation services (such as families, CSBs, taxi services, and other private vendors) will reduce the need for crisis intervention services and the corresponding need for law enforcement intervention and transportation. Access to such a service may prevent an individual's condition from deteriorating to the point that crisis intervention and more restrictive and costly hospitalization is needed. The Transportation Working Group first explored the frequency with which transportation by family and friends, CSBs, taxi services and Medicaid vendors is currently being used, and the costs of doing so. It then examined other transportation options. Based on the Transportation Working Group's research and analysis, the Commission makes the following recommendations:

Recommendation 5: The Commission recommends that CSBs consider the cost-effectiveness of developing contracts with taxi services or other regional transportation providers to provide transportation and/or vouchers for transportation to medical appointments and other needed mental health services.

Recommendation 6: The Commission urges CSBs to consider changing their policies to specify when and under what circumstances CSB crisis workers, case managers and other employees may transport persons in government owned and personal vehicles as part of the delivery of mental health services. CSBs that have not done so should consider becoming Medicaid transportation providers.

---

[23] The language used in the Commission's proposal is taken directly from the HIPAA Privacy Rule. A provision is included to prohibit disclosure if the health care provider knows that a protective order has been entered preventing contact between the family member and the person in crisis.

Recommendation 7: The Commission recommends that DMAS develop written guidance as soon as possible on the requirements and conditions under which Medicaid will reimburse for routine, urgent and emergency mental health assessment and treatment. CSBs that have not already done so should assess whether it would be fiscally advantageous to become a Medicaid provider of transportation services for their consumers and encourage, where possible, private transportation providers to develop such services. Police and sheriffs' departments should also assess whether it is feasible for them to become Medicaid providers in these circumstances.

Recommendation 8: The Commission urges CSBs, private providers and other stakeholders in each locality or region to explore the feasibility of alternative methods of financing and providing transportation services for consumers, including use of peer counselors, off-duty law enforcement officers, and private mental health service providers, to determine whether they would be available and feasible in their area for providing needed transportation services for consumers.

***Second Tier*:** Second-tier transportation services would include transportation by ambulance or a form of medical transportation, similar to a wheelchair or stretcher van, not requiring a basic or advanced life support vehicle or the level of trained staff needed for life-threatening conditions. The Office of Emergency Medical Services in the Department of Health certifies all Emergency Medical Services agencies in the Commonwealth, permits all vehicles, and certifies four levels of professionals providing services: First responders, emergency medical technicians, intermediate level, and paramedic level. Although no regulations specifically cover response to mental health emergencies, it appears that EMS transportation is often provided for persons with psychiatric illnesses upon request of law enforcement, albeit with unknown frequency.

The Transportation Working Group concluded that, at the present time, use of ambulance services on a routine basis for transportation in mental health crises would not be cost-effective and would not be favored by consumers who are not suffering from a physical illness or injury. At the same time, it concluded that wheelchair or stretcher van transport is not a safe or practical alternative for use in psychiatric emergencies. However, the Transportation Working Group is intrigued by a new initiative by Physicians Transport Services located in Northern Virginia. That group has identified and purchased a prototype vehicle that could be used in providing psychiatric transports and for other medical conditions. The vehicle costs approximately half that of an ambulance. It is unmarked and can carry two persons in wheelchairs and one person on a stretcher. It has a bench for an attendant, which would always be necessary in a psychiatric transport, to monitor the passengers. Plexiglas would need to be installed to separate the driver from passengers. DMAS representatives and members of the Transportation Working Group have inspected the vehicle and believe it would meet the requirements for a psychiatric transport and Medicaid reimbursement. A pilot project, described below, utilizing this vehicle is being developed in Northern Virginia.

***Third Tier*:** Law enforcement officers, of course, will continue to be needed in some cases to provide safe transportation for people experiencing psychiatric emergencies or otherwise in custody under the commitment laws. The key question in these cases is whether and when use of restraints is needed. The Transportation Working Group reviewed the laws of other states and, in particular, the system in Vermont. Vermont law requires that secure transport be done in a manner that prevents physical and psychological trauma, respects the privacy of the individual, and represents the least restrictive means necessary for the safety of the patient. 18 V.S.A. § 7511. By law, the Mental Health Commissioner in Vermont is responsible for providing transportation of persons in the civil commitment process and contracts with law enforcement to provide transportation on a per transport basis. A qualified mental health professional or designated hospital professional conducts an assessment and determines what type of transport will be provided and whether "humane restraints," such as Velcro or polyurethane should be used. Vermont has developed an assessment check list for this purpose. The Transportation Working Group has reviewed the Vermont plan as a well as the available literature and is continuing to study this issue.

Pilot Projects: Stakeholder groups in Northern Virginia are developing a pilot project to be implemented in Arlington, Alexandria, Fairfax and Falls Church as soon as legislation is enacted permitting entities other than law enforcement to provide transportation. The Northern Virginia group has developed draft Psychiatric Transfer Guidelines with two goals: (1) to provide a clear decision pathway for case workers, law enforcement officers and magistrates to help determine with reasonable certainty the safest and most appropriate means of transferring a person with psychiatric needs while protecting the rights and dignity of the person; and (2) to effectively utilize law-enforcement officers (LEO) and emergency services workers (EMS) when appropriately serving citizens in need while reducing the care costs to the person and the Commonwealth. As noted above, Physicians Transport Service has also purchased two prototype vehicles that can be utilized to provide transportation in psychiatric emergencies cases requiring back-up medical support. The Commission strongly endorses this proposed pilot project, including the provision of Medicaid reimbursement for these services.

B. Extension of TDO Period

Virginia is one of three states requiring a commitment hearing within 48 hours of the probable cause determination. Most states require a hearing within four to eight days of the probable cause determination while a few states do not require one for as long as 30 days.

In its Blueprint for Comprehensive Reform in 2007, the Commission endorsed extending the TDO period from the current 48 hours to 4 or 5 days to permit a better evaluation and stabilization of the individual before a decision about civil commitment is required. During the 2008 session of the General Assembly, Senator Edwards introduced SB 143 to implement a longer TDO period, extending it to 4 days. The subject matter of this bill was referred by the Senate to the Commission for further study which assigned it

to the Task Force on Future Commitment Reforms ("Future Commitment Reforms Task Force"). The Future Commitment Reforms Task Force also reviewed the Civil Commitment Task Force Report (released in March 2008) that had previously considered a proposal to extend the TDO period to four days and an accompanying proposal to authorize an IE to release a person from the TDO prior to the commitment hearing upon concluding that the person did not meet the commitment criteria, and with the concurrence of the attending physician.

The Future Commitment Reforms Task Force also considered the consultant's report prepared by Sarah E. Barclay for the Commission on this issue.[24] After reviewing data from Virginia, Colorado, Massachusetts and Pennsylvania on lengths of stay, Ms. Barclay concluded that the two-day temporary detention period is not adequate for a thorough assessment in some cases. Ms. Barclay also noted that 30% of commitment hearings in Virginia occur in less than 24 hours. Anecdotal reports since the change in the law effective July 1, 2008 indicate that this rapid processing of civil commitment cases remains prevalent due to the Monday/Wednesday/Friday hearing schedules that many special justices maintain. Ms. Barclay postulates, and the Future Commitment Reforms Task Force agrees, that an increased temporary detention period would contribute to an improved decision-making process. A longer TDO period would also help better identify cases in which a mandatory outpatient treatment ("MOT") order might be appropriate. Some localities report that the decrease in the volume of MOT orders entered since July 2008 reflects an inability to develop an adequate outpatient treatment plan within the 48-hour TDO period, especially if the person is temporarily detained in a location other than his place of residence, which is often the case.

It is widely agreed that, if the TDO period is increased, it should be accompanied by an effective pre-hearing release measure. Some individuals may be stabilized and no longer meet the criteria for civil commitment, or may not have met the criteria in the first instance, but without a pre-hearing release mechanism they may be held for the full statutorily permitted TDO period until a commitment hearing is held.. One recommendation would be to extend the responsibility and authority of the IE to permit the IE to release the person from the TDO if the person does not meet the commitment criteria, or if the IE finds that the person is capable and willing to accept voluntary inpatient or outpatient treatment, such treatment is appropriate and the treating physician agrees. A commitment hearing would then not be necessary.

The Commission's research team is studying the possible fiscal consequences of increasing the TDO period. The key questions include: how the increase in the authorized TDO period would affect the actual TDO periods in practice; how any lengthened TDO period would affect the frequency of commitment hearings; and how a lengthened TDO period would affect the average length of voluntary or involuntary hospital stays after the TDO period. For example, if the average TDO period is increased, a longer TDO period may promote the stabilization of some individuals in crisis, obviating the need for

[24] Sarah E. Barclay, *Increasing the Temporary Detention Period Prior to a Civil Commitment Hearing: Implications and Recommendations for the Commonwealth of Virginia Commission on Mental Health Law Reform*, April 2008.

hearings and for further expensive inpatient hospitalizations.. As a result of the unknowns, however, a Commission recommendation would be premature until these issues have been carefully studied.

Another issue that a lengthened TDO period might affect is the availability of psychiatric beds. Virginia continues to experience psychiatric bed shortages in some areas of the state. Extending the TDO time period may exacerbate this problem. In addition, requiring further work by IEs during a longer TDO period, as discussed earlier, would exacerbate the concerns related to their compensation for civil commitment cases.

The Commission is also considering some alternatives to extending the TDO to 4 or 5 days. For example, it is possible to require that commitment hearings occur no less than 24 hours of admission of the patient under the TDO, while extending the TDO time period up to 72 hours, as now occurs when the 48-hour requirement now in the statute falls on weekends and holidays. A 72-hour TDO period would be an intermediate step toward assuring more thorough assessments without extending the time period so long that it would have to be accompanied by an additional pre-release measure. Because even this modest change would have uncertain fiscal implications, however, the Commission is not recommending any action on this issue in 2009.

Recommendation 9: Given current economic circumstances, the continued shortage of psychiatric hospital beds, and the difficulty predicting the fiscal impact of extending the TDO period, the Commission recommends no statutory change to the TDO period in 2009.

C. Mandatory Outpatient Treatment

The Commission continues to study use of, and possible expansion of MOT in Virginia. In 2008, the Commission recommended that the use of MOT be strengthened as a "less restrictive alternative" for individuals found to meet the criteria for involuntary admission to a facility but who agreed to adhere to a prescribed treatment plan in the community. However, the Commission concluded that proposals to allow people to be committed to MOT based on a less demanding standard would be premature in the absence of (1) additional funding for CSB outpatient services, (2) a stronger body of evidence demonstrating the effectiveness of "preventative" MOT in other states, and (3) a documented successful implementation of the 2008 MOT reforms in Virginia.

In the spring of 2008, the Senate referred the subject matter of HB 939 (Gilbert) to the Commission for further study. (HB 939 would entitle an individual under an involuntary inpatient order to petition for mandatory outpatient treatment.). In addition, SB 274 (Cuccinelli) (permitting a facility director to petition for transfer to outpatient commitment) was carried over to the 2009 Session. The Commission assigned the subject matter of these bills to the Future Commitment Reforms Task Force.

1. Mandatory Outpatient Treatment Following Involuntary Inpatient Treatment

In its Blueprint for Reform in December, 2007, the Commission stated:

> "The Commission recommends that the Commonwealth retain the existing use of mandatory outpatient treatment ("MOT") as a less restrictive alternative to involuntary hospitalization, while clarifying the conditions under which such orders may be issued. The Commission also recommends that MOT be available as a supplement to short-term acute hospitalization or residential stabilization, perhaps as a component of a single commitment order." [Recommendation III-J]

Conditional discharge is not a common practice in the United States and state laws vary substantially in the states that authorize it. Sixteen states currently permit a facility or treating physician to discharge a person to MOT. Seven of these states permit this in the form of convalescent leave or trial visits. Six states require a court order before discharge to MOT, one of which (Oklahoma) permits the person to petition as proposed in HB 939. Two states permit either the court to order MOT or the treating facility to discharge to MOT. Three states permit the court to order a combined inpatient and outpatient order at the time of the original order. The Future Reforms Task Force studied these statutes and the practices in several states in the course if its deliberations.

Criteria and Duration**:** A key issue in designing a conditional discharge statute is whether the person must continue to meet the commitment criteria for involuntary inpatient hospitalization in order to be discharged to MOT. MOT following inpatient treatment is best suited for those who are stabilized during inpatient treatment and need additional treatment that does not need to be provided on an inpatient basis. This likely means that the person will no longer meet current criteria and lesser criteria will be needed.

Unlike most other states, Tennessee, which permits the facility and a qualified mental health professional to release a person on MOT, sets out specific criteria before the person may be discharged on outpatient MOT:

> (A) the person has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission;
> (B) the person's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm unless treatment is continued;
> (C) the person is likely to participate in outpatient treatment with a legal obligation to do so;
> (D) the person is not likely to participate in outpatient treatment unless legally obligated to do so; and
> (E) mandatory outpatient treatment is a suitable less drastic alternative to commitment.

TN Code 33-6-602.

The criteria for Virginia's forensic conditional release program are similar to the Tennessee criteria:

(i) the acquittee does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization;
(ii) appropriate outpatient supervision and treatment are reasonably available;
(iii) there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified; and
(iv) conditional release will not present an undue risk to public safety.

Virginia Code § 19.2-182.7.

The Commission believes that a short period of MOT could be beneficial for certain people who need follow-up treatment and must have structure or an external source of help in order to prevent relapse and thereby reduce the drain on expensive inpatient services. This type of MOT is the next logical step in implementing MOT based on the model adopted in 2008 under which the services must actually be available in the community and the providers must agree to deliver the services.

Most other states that permit MOT following inpatient treatment limit the period of mandatory outpatient treatment to the length of the commitment period, or now 30 days in Virginia. If MOT following inpatient treatment is enacted, the MOT outpatient period should be 90 days in order to be effective. Limiting the period of outpatient treatment to the current length of commitment or 30 days would be ineffective because there is virtually no time to provide the person with outpatient treatment after the period of inpatient treatment.

***Procedures*.** Different procedural approaches to conditional discharge to MOT can be envisioned. One possibility is to allow the committing judge to enter a sequential order for MOT at the time of commitment to an inpatient facility. The downside of this approach, however, is that such a sequential order could become routine, as has been reported in other states, with almost everyone being ordered to MOT. Although requiring another judicial hearing after a period of inpatient care before a MOT order would add to the workload of special justices and clerks, it would discourage the routine coupling of inpatient commitment orders with MOT orders and, necessarily, would provide justification for imposing a period of mandatory outpatient treatment longer than 30 days.

If a conditional discharge approach to MOT were to be adopted, the CSB (not the inpatient facility) should be responsible for developing an MOT plan as well as monitoring the person's adherence to the MOT plan. A concern of CSBs is that permitting the inpatient facility to discharge to MOT, without a separate judicial proceeding, could lead to MOT orders over the CSB's objection, thus committing CSB services, resources and monitoring capacity when the resources to implement the MOT order are absent. Judicial review would reduce the risk that this will occur. Only if the

person involved, the inpatient treatment facility and CSB all agree to an MOT plan, should it be filed with the court without the need for a further hearing.

Another question is who would be permitted to petition for MOT following the period of inpatient hospitalization. Clearly, the CSB, inpatient facility and the person himself/herself should be permitted to do so. Permitting the person to petition for MOT may be a valuable recovery tool. Whether family members, guardians, health care agents, and legally authorized representatives should also be permitted to do so was a matter of concern to Future Commitment Reform Task Force members. If acting in a representative capacity on behalf of the person, other individuals should be permitted to do so. Some limit on successive petitions should be imposed, however.

Concerns. The Commission remains concerned that significantly increasing the use of MOT after an inpatient stay would divert already scarce outpatient treatment resources away from persons voluntarily seeking treatment. In many localities, access to a psychiatrist or psychologist is non-existent or nearly so. Upon discharge from inpatient treatment, it often takes months for that person to be assigned a case manager in the community. In addition, the availability and scope of community-based mental health services is critical for effective MOT. The concern is, however, that candidates for an MOT order will be given priority access to services, lengthening the queue for those voluntarily seeking treatment.

An expanded use of MOT is also of concern since there has not been sufficient time to evaluate the implementation of the extensive changes to MOT implemented July 1, 2008. As noted earlier in this Report, use of MOT as an *alternative* to involuntary inpatient admission since the new MOT legislation is being used even less than it was before. Given the variability in access to services and the potential disruption to those now voluntarily seeking outpatient mental health services, the substantial variability in how the civil commitment process is implemented throughout the Commonwealth, and the challenging economic climate, the Commission believes it prudent for the General Assembly to wait at least another year before expanding the use of MOT following a period of involuntary inpatient admission. If, however, the General Assembly decides to authorize MOT following a period of inpatient admission, the Commission has prepared a model of such a proposal for legislative consideration.

Recommendation 10: The Commission believes that legislation authorizing mandatory outpatient treatment following involuntary inpatient admission would be premature until the Commonwealth's economic picture changes, CSB outpatient services become more readily available, and research demonstrates the effectiveness of mandatory outpatient treatment.

2. Mandatory Outpatient Treatment to Prevent Involuntary Inpatient Admission

SB 177 (Marsh), which would create a program of "assisted outpatient treatment," designed to prevent involuntary inpatient admissions, was carried over to the 2009 General Assembly Session. The potential utility of MOT to prevent deterioration and

eventual hospitalization by individuals with a history of relapse and rehospitalization has been a core controversy in mental health law for more than 20 years. White papers were prepared on the issue in Virginia in 1988 and then again in 1998. Over the past few General Assembly Sessions, bills introduced by Senator Marsh and others have garnered the strong support of some stakeholders and have aroused the opposition of others. The Commission's Civil Commitment Task Force reviewed the issues and the literature and advocates and opponents debated the use of MOT to prevent inpatient admissions before the Commission. In its Blueprint for Reform issues in December, 2007, the Commission stated:

> "The Commission is also favorably inclined toward broader use of MOT for persons who are experiencing pronounced clinical deterioration but do not meet the criteria for involuntary hospitalization, as has been authorized recently in several other states. These laws have the laudable purpose of using mandated outpatient intervention to prevent the person from declining to the point of needing involuntary admission. However, the Commission believes that such a substantial change in commitment practice should not be adopted unless and until the CSBs have adequate capacity to provide outpatient treatment services and to monitor compliance with outpatient treatment orders."

The Commission's views remain the same. In addition, the Commission believes it would be wise to wait until further evidence accumulates regarding the effectiveness of preventive MOT. Although the efficacy of MOT has been supported in a series of path-breaking studies in North Carolina,[25] its general cost-effectiveness has not yet been convincingly established.[26] In addition professional and advocacy associations are

---

[25] Swartz and Swanson, Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data? Canadian Journal of Psychiatry 49:585-91 (2004).

[26] The National Association of State Mental Health Program Directors Medical Directors Council issued a Technical Report on Involuntary Outpatient Commitment in August 2001. It found that "current research fails to provide strong evidence that involuntary outpatient commitment is the best remedy for consumer non-compliance in treatment." The NASMHPD report based its conclusions on the principle that treatment compliance is is meaningful only if adequately-funded, effective community services are available. Similarly, the American Association of Community Psychiatrists recommends that more research is needed concerning the clinical and rehabilitative benefits of MOT. It recognizes that limited research shows benefits in reducing hospitalization days and violence among some individuals, but clinical benefits, such as improvement in individual functioning and compliance with MOT have not yet been shown. Position paper: Involuntary Outpatient Commitment, American Association of Community Psychiatrists, June, 2001, http://www.comm.psych.pitt.edu/finds/ioc.html, last visited December 5, 2008.

The Treatment Advocacy Center on the other hand reports that assisted outpatient treatment reduces hospitalization, homelessness, arrests, violence, and victimization. It also improves treatment compliance and substance abuse treatment. *Assisted Outpatient Treatment*, Treatment Advocacy Center Briefing Paper, March 2005, www.psychlaws.org/Briefing Papers/BP21.htm. (Last visited October 27, 2008.) In addition, the Treatment Advocacy Center reports that anosognosia, or unawareness of illness, is the most important reason individuals do not take medication for their illness. The Center relies on numerous studies indicating that the presence of anosognosia increases the incidence of violent behavior "both because it is associated with medication non-adherence and because it appears to directly increase violent behavior." *Anosognosia as a cause of violent behavior in individuals with severe psychiatric disorders*,

opposed to it.[27] A new study of New York's Kendra's law is currently underway with expected release of its findings in mid-summer 2009. New York has contracted with a research team headed by Dr. Swartz to conduct a legislatively-mandated external evaluation of its Assisted Outpatient Treatment (AOT") law, also known as "Kendra's Law." The purpose of the study is to examine the process and outcomes of AOT programs in New York State, by addressing specific research questions in five areas of investigation: 1) regional and cultural differences in AOT programs and their implementation, 2) engagement in Mental Health Services Post-AOT, 3) outcomes for people with mental illness who receive enhanced outpatient services and for those who are mandated into outpatient treatment, 4) opinions of a representative sample of AOT recipients regarding their experiences with AOT, and 5) the impact of AOT programs on the availability of resources for individuals with mental illness and perceived barriers to care. The study is scheduled for completion in April 2009 with a release date not expected until mid-Summer 2009.

The concern expressed above relating to MOT following a period of involuntary inpatient admission apply even more forcefully to mandatory outpatient treatment to prevent involuntary inpatient treatment. There is a concern that already scarce mental health outpatient services would divert services from patients who want and need voluntary services, and persons subject to involuntary orders will take priority over those seeking voluntary services. In order to be effective, an array of community services not now available must also be developed. Substantial changes were enacted in the 2008 General Assembly Session to implement MOT, but sufficient time has not passed to determine the effectiveness of those procedures. Indeed, it appears that use of MOT has significantly declined. Given the current economic climate, and the lack of proven effectiveness, it would appear prudent to delay enactment of MOT to prevent involuntary inpatient admissions until the budget situation improves and a wider array of outpatient services become available.

Recommendation 11: The Commission recommends that MOT to prevent involuntary inpatient admission be delayed until further research demonstrates its effectiveness and a fuller array of outpatient services becomes more widely available.

D. Petitioners' Rights in Commitment Proceedings

1. Appointment of Counsel to Represent Petitioners

HB 267 (Albo), which would amend § 37.2-814 requiring the court to appoint competent counsel to represent indigent petitioners, was referred to the Commission for

---

Treatment Advocacy Center Briefing Paper, April 2007, www.psychlaws.org/Briefing Papers/BP21.htm. (Last visited October 27, 2008.)

[27] The International Association of Psychosocial Rehabilitation Services, Mental Health America and the Bazelon Center for Mental Health Law are opposed to MOT. The American Psychiatric Association favors it.

study by the Senate, and assigned to the Future Commitment Reforms Task Force . The Future Commitment Reforms Task Force also reviewed HB 735 (Caputo), which had also been carried over in 2008; that bill would amend § 54.1-3900 to permit third year law students to represent petitioners in commitment hearings without compensation and provide them with immunity except for intentional malfeasance.

Only two states, Alabama and Indiana, provide for the appointment of counsel for indigent petitioners. In 26 states, however, a government attorney, such as the local prosecutor, county or city attorney, attorney general, or a combination thereof, provides representation at the hearing either for the petitioner or represents the interests of the people, the public interest or the state. In 13 states, the government attorney represents the people, the public interest or the state's interest at the commitment hearing. In two of those states, the county attorney is the actual petitioner. When the attorney general represents the petitioner or the state's interest, it is usually when the hearing takes place at a state facility. In three states, the government attorney represents an agency or facility, but not an individual petitioner. In six states, the government attorney represents the petitioner, whether it is an individual who is the petitioner, a government entity or a treatment facility. Four states do not specify whom the attorney represents.

Although no consensus could be reached on this topic by members of the Future Commitment Reforms Task Force, the Commission considered various options, including permitting appointment of private counsel when the special justice believes such appointment would aid the process. In those areas where the number of commitments is already high, special justices may determine that appointment of counsel is not necessary and would therefore not be required to appoint them. Under the proposal, the attorney's charge would be to represent the interests of the public or state in the proceeding, even though such a role is usually the role of an elected official, such as the Commonwealth's Attorney or Attorney General. The appointed attorney would be paid the same as counsel appointed for the respondent, currently $ 75.00, obviating the need for local government to hire additional full time attorneys in either Commonwealth's Attorneys' or city/county attorneys' offices.

The Commission rejected this proposal for several reasons. First, it does not believe that provision of counsel to present the case for commitment is among the best uses of additional resources to improve the overall fairness of the commitment process – improving the quality of independent examinations, and compensation for the IEs is a much higher priority as are training and increased compensation for the special justices and attorneys for respondents. Moreover, the Commission is doubtful that appointment of counsel for petitioners in this context is sound public policy: Given that attorneys are not appointed for petitioners in other civil cases, such as domestic violence cases that are arguably just as important as these proceedings, authorizing appointment of counsel for petitioners in civil commitment cases could be a "slippery slope."

Recommendation 12: The Commission does not support appointment of state-subsidized counsel for indigent petitioners in civil commitment proceedings at this time. Improving other features of the process, such as increasing fees for

independent examiners and providing oversight for special justices, have a higher priority. As a public policy matter, the Commission doubts the wisdom of appointing counsel for petitioners in civil commitment proceedings when counsel are not appointed for petitioners in other civil cases, such as domestic abuse cases.

The Future Commitment Reforms Task Force also reviewed HB 735 (Caputo) that would amend § 54.1-3900 to permit third year law students to represent petitioners in commitment hearings unsupervised and to provide them with immunity. The Commission believes that permitting unsupervised law students to undertake this activity diminishes the importance of commitment hearings and provides no opportunity for oversight by the Virginia State Bar for ineffective and harmful representation. It would also not be an effective solution statewide because law schools are not conveniently located near every hearing site. If used in areas where law schools are located, supervision is absolutely necessary.

Recommendation 13: The Commission does not support proposals to allow unsupervised law students to represent petitioners in commitment proceedings. Instead, the Commission encourages law schools to work with the local bar to provide to set up programs to this service with supervision in areas where law schools are located. The Commission also recommends that steps be taken to encourage *pro bono* representation of petitioners by members of the Bar.

2. Petitioner Right of Appeal

HB 938 (Gilbert), the subject matter of which was referred to the Commission for study by the Senate, would amend § 37.2-821 to permit any party to a civil commitment proceeding or a proceeding to certify the admission of a person with an intellectual disability to a training center to appeal the decision to the circuit court.[28] Currently, this statute is being interpreted to permit a right of appeal only to respondents in civil commitment proceedings. This topic was referred by the Commission to the Future Commitment Reforms Task Force.

The Future Commitment Reforms Task Force first reviewed the statutes from other states. Seven states specifically permit the petitioner to appeal, and nine other states specifically state that appeals may be taken as in other appellate cases. Presumably, since either party in a civil proceeding normally has the right of appeal, petitioners in these states would be permitted to appeal. The Future Commitment Reforms Task Force also considered various arguments for giving petitioners a right to appeal, but ultimately concluded that the granting such a right is not a practical solution to any of the perceived problems to which it is designed to respond – vindicating the petitioner's legal interests in securing a commitment or helping to generate appellate oversight and guidance for the

[28] Subsection C also requires the order appealed from to be defended by the Commonwealth's Attorney. If this bill moves forward in the General Assembly, the role of the Commonwealth's attorney will need to be reconsidered when the party appealing is the petitioner, i.e. whether he is representing the petitioner or the public interest. The Commonwealth's Attorney would also not then be defending the order appealed from because he would not be representing the respondent who has private counsel appointed to represent him.

commitment process. Moreover, even if a useful purpose would be served by allowing petitioners to seek a de novo commitment hearing in the Circuit Court, there would be significant costs of doing so, not only in litigation costs, but also in added restrictions of respondents' liberty interests pending the new hearing. The model of typical civil litigation is an imperfect fit for the commitment process.

Recommendation 14: The Commission does not support proposals to afford petitioners the right to appeal a decision favorable to the respondent in a commitment proceeding.

E. Rights of Respondents in Commitment Proceedings

The Civil Commitment Task Force Report found that individuals involved in the civil commitment process suffer consequences in addition to their loss of liberty and dignity, and trauma. They often face other disruptions in their lives as well, including housing, financial and medical challenges. For example, some may be subject to eviction from their homes for non-payment of rent or foreclosure for non-payment of their mortgage, or discharge from an assisted living facility or nursing home. The Task Force reviewed a number of these issues for possible legislative change and these proposals were assigned to the Future Commitment Reforms Task Force for further study.

1. Default judgments: Financial problems can arise from prolonged hospitalization. Section 8.01-428.A permits a default judgment to be set aside upon proof that the defendant was, at the time of service of process or entry of judgment, a person in the military service of the United States. This section could be amended to provide a mechanism to have the default judgment set aside if the person was detained under a TDO or was hospitalized under an involuntary commitment order at the time served or when the default judgment was entered.

The Commission will continue to study legislation that would permit an individual to set aside a default judgment if he or she was the subject of a temporary detention order or an order of involuntary hospitalization at the time of service or entry of the default judgment.

2. Notification of Family and Friends: One way to ameliorate these adverse consequences is to assure that a respondent in commitment proceedings has the opportunity to designate a person to be notified of their whereabouts at all times, including when they are transferred to a different facility. Although individuals have the right through the Human Rights Regulations to notify whomever they choose of their whereabouts at all times, including when they are transferred to a different facility, this right could be emphasized and clarified by including it in § 37.2-400 related to rights of consumers. The Commission has prepared a legislative proposal that would amend § 37.2-400 to afford a consumer the opportunity to have a family member, personal representative or close friend notified of his general condition and location and transfer to another facility.

Recommendation 15: The Commission recommends that the General Assembly consider legislation that would afford an individual the opportunity to have an individual of their choice notified of their general condition, location and transfer to another facility. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

F. Public Access to Commitment Hearings

In 2008, the General Assembly embraced the Commission's recommendation that the records of commitment proceedings be regarded as confidential and that access to these records be significantly restricted. One issue that was not addressed is access to the commitment hearing itself. The current statute provides insufficient guidance on this issue. While the statute appears to establish a presumption that commitment hearings are open to the public,[29] the circumstances under which attendance can be restricted are not specified. There are sound policy and practical reasons for the hearing being open, including the public's right to know about potential threats to public safety, the need to assure that courts fairly uphold the rights of the subject of the hearing, and the general public interest in accountability of the judicial branch of government. However, there are also strong countervailing policy and practical reasons for the hearing being closed, including the spectacle of the public airing of the subject's most private and confidential information, and the danger of stigma and embarrassment to the subject.

The Working Group on Health Privacy and the Commitment Process ("Health Privacy Working Group") was not of one mind about this issue and nor was the Commission. Some people feel strongly that all judicial proceedings should be open to the public, while others feel that commitment proceedings are essentially therapeutic in nature and should be presumptively confidential, like the records themselves. Under the latter view, commitment proceedings involving adults should be governed by the same strong protections of privacy that govern juvenile proceedings. State laws vary widely on this issue. The issue does not appear to be addressed at all in the statutes of half of the states. In the other half, the predominant approach is to exclude the public – 16 states exclude the public by law, 8 states prescribe open hearings and one state permits the respondent to elect to close the hearing.

The Health Privacy Working Group and the Commission also debated the constitutional issues, with one side arguing that the First Amendment requires public

[29] "The [commitment] hearing [for involuntary admission] provided for pursuant to §§ 37.2-814 through 37.2-819 may be conducted by the district court judge or a special justice at the convenient facility or other place open to the public provided for in § 37.2-809, . . ." Va. Code § 37.2-820.

The presumption of open hearings applies to adult commitment proceedings only. The presumption for juvenile commitment proceedings is that the hearings are closed – "The hearing shall be closed to the public unless the minor and petitioner request that it be open." Va. Code § 16.1-344. Different public policy concerns apply to minors, and the Working Group's discussion and recommendations as to the openness of hearings do not address the juvenile commitment process.

access to commitment proceedings, as it does for criminal proceedings and ordinary civil litigation, and the other side arguing that a state may constitutionally close ordinary commitment proceedings (as opposed to sex offender commitment proceedings or other commitment proceedings associated with criminal cases). Neither the U.S. Supreme Court nor the Virginia Supreme Court has addressed the issue, and the only applicable precedents in the Fourth Circuit pertain to ordinary civil litigation.[30] The Health Privacy Working Group examined the constitutionality of closing civil commitment hearings, and found no constitutional impediment to a rule closing such hearings upon motion of the respondent. State statutes closing commitment hearings have withstood constitutional scrutiny. For example, under North Carolina law, both outpatient and inpatient civil commitment hearings are "closed to the public unless the respondent requests otherwise." N.C. Gen. Stat. §§ 122C-267(f) (outpatient) and 122C-268(h) (inpatient). These statutes have been upheld against constitutional attack.[31]

After discussing the issue at several meetings, the Commission rejected a proposal to require commitment hearings to be closed upon motion of the respondent or respondent's counsel and sided with the view that commitment proceedings should be presumptively open, as they now are. However, the Commission also recognized that the presiding judge currently has, and should have, the discretion to close all or part of the hearing or restrict attendance upon a showing of an overriding privacy interest in a particular case,[32] but only on motion of the respondent or respondent's counsel. In addition, the respondent should have the option of having any person present at the hearing.

In effect, the Commission proposes to retain both the statutory presumption favoring open commitment hearings and the discretion of the presiding judge to restrict attendance at all or part of a particular hearing upon motion of the respondent based upon a showing of good cause. However, in order to provide better guidance to the district courts and promote consistent practice, the Commission is proposing a standard to guide the exercise of judicial discretion, as follows:

> "Upon request of the respondent or his attorney, the district court judge or a special justice may restrict attendance at all or part of the hearing to persons whose participation is required for proper conduct of the hearing and those whose presence is requested by the respondent upon finding that (a) such a restriction is necessary to protect the respondent's health, safety or privacy and (b) the respondent's interest in the restriction outweighs the public's interest in attendance by any person who would be excluded.'

---

[30] *Stone v. Univ. Maryland Medical System*, 855 F.2d 178 (4th Cir. 1988) and *Virginia Department v. Washington Post*, 386 F.3d 567 (4th Cir. 2004)

[31] *In re Belk*, 107 N.C. App. 448, 420 S.E.2d 682 (1992). *See also*, *People v. Dixson*, 148 Cal. App. 4th 414; 56 Cal. Rptr. 3d 33 (2007).

[32] The Attorney General of Virginia, acknowledging that civil commitment hearings are generally open to the public, has opined that a judge may order a civil commitment hearing closed for good cause. 2003 OP. VA. ATT'Y GEN. 124.

Recommendation 16: The Commission recommends that the General Assembly consider legislation preserving the current statutory presumption that commitment hearings be open to the public while prescribing a standard to guide judges in exercising their discretion to close these hearings upon the respondent's motion. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

G. Admission of Incapacitated Persons to Mental Health Facilities

In most other health care contexts, it is not necessary to obtain specific judicial authorization to provide health care to a person who lacks the capacity to make health care decisions. These decisions can be made by various legally authorized decision-makers pursuant to the applicable statutory requirements. There are basically three categories of such decision-makers: (1) persons designated by the patient (when s/he had decision-making capacity) as a health care agent under the Health Care Decisions Act (Title 54.1-2982 et seq); (2) a person appointed by the Circuit Court as a guardian under the guardianship statute (Title 37.2-1000 et seq); and (3) persons designated as authorized decision-makers under 54.1-2986 after a medical determination of incapacity regarding a patient who has not executed an advance directive and does not have a guardian. However, none of these decision-makers is currently authorized by Virginia law to admit a currently incapacitated patient to a mental health facility, even if the patient is not protesting. In other words, if a patient lacks the capacity to give informed consent to the admission, s/he can be admitted only through the commitment process. This legal requirement has been a continuing source of concern to families, especially in relation to patients with dementia or severe depression, particularly in light of the fact that neither hospitalization in medical units nor placement in nursing homes is subject to such restrictions. Of course, it is important to recognize the liberty interests at stake in psychiatric hospitalization when the individual objects, and the role of judicial scrutiny in preventing abuse of a surrogate decision-maker's authority (even when the individual is not objecting).

It is best to think about potential solutions to this set of problems in the three surrogate decision-making contexts described earlier. The first issue is whether people who execute advance directives under the Health Care Decisions Act should be empowered to authorize their designated agents to admit them to a mental health facility, even if they were to object. As discussed in greater detail below (Part IV), the Commission strongly supports the principle of individual empowerment in this context and has encountered no opposition to this position. Accordingly, the Commission is proposing a new section 37.805.1 that would that would permit persons who have been determined incapacitated under the Health Care Decisions Act to be admitted to a psychiatric facility by their designated health care agent for up to ten days if they have specifically conferred this authority in the directive in conformity with the Health Care Decisions Act, and the proposed facility is willing to admit the person. If admission to a state facility is proposed, a CSB pre-admission screening would also be required

The second issue is whether a guardian who has been appointed by the circuit court for an incapacitated person should have the authority to consent to the admission of the person for up to ten days if the facility agrees to the admission. The Commission recommends that a guardian have such authority if and only if the guardianship order specifically confers this authority based on findings that the person has dementia or another severe and persistent mental disorder that significantly impairs his or her capacity to exercise judgment or control, the condition is not likely to improve in the foreseeable future, and the guardian has formulated a plan for providing ongoing treatment of the person's mental illness in the least restrictive setting suitable for the person's condition. If admission to a state facility is proposed, a CSB pre-admission screening would also be required.

While all states have a procedure for the involuntary treatment of mental illness, including but not always limited to commitment to a mental hospital, not all states require use of this procedure when a guardian is the individual making the decision. About 20 states specifically reference the involuntary treatment and commitment statutes in enumerating a guardian's powers to denote that the guardian must use such existing procedures to authorize involuntary treatment. Another 20 states authorize the guardian to consent to medical treatment and are silent with respect to mental health treatment, presumably allowing the guardian to admit the ward to a mental health facility, and consent to treatment, even over objection. The remaining the states have specific procedures authorizing guardians to consent to mental health treatment, often based on specific authorization by the court in the guardianship order.[33] The Commission's proposal would fall in this latter category.

At an early stage in the development of this proposal, it would also have permitted surrogate decision-makers other than health care agents and guardians to authorize such admissions. However, the Task Force on Future Commitment Reforms was concerned that since this is the first initiative to permit inpatient admissions of incapacitated persons through a substitute decision-maker, such admissions should be limited to health care agents and guardians.

Recommendation 17: The Commission recommends that the General Assembly consider legislation that would permit mental health facilities to admit incapacitated individuals for up to ten days upon the request of a health care agent designated by the individual in an advance directive and specifically given the authority to do so, or upon the request of a guardian specifically authorized to do so in the guardianship order. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

H. Involuntary Treatment of Minors

[33] Catherine Anne Seal, CELA, Review of Guardians' Authority under State Guardianship Statutes, Kirtland & Seal, LLC, Colorado Springs, Colorado; see also Sarah B. Richardson, Health Care Decision-Making: A Guardian's Authority at http://www.abanet.org/aging/.

Children are subject to involuntary psychiatric in-patient commitment or mandatory outpatient treatment just as adults are. Children have the same constitutional rights of due process as adults since a child's liberty interests are implicated in the commitment process just as an adult's are. However, the juvenile commitment process, both from a policy perspective and from a procedural technical perspective, is very different for a number of reasons. Clearly, one difference is that juveniles are still within the custody of their parents or guardians whose rights then become involved in the child's commitment process. However, children who are aged 14 or older, are recognized by the law, in some respects, to have reached the "age of reason" and thus are given the right to object to involuntary commitment.

Procedurally, a child's commitment to in-patient psychiatric treatment or mandatory outpatient treatment may be initiated, as in an adult case, through an emergency or a temporary detention order issued by a magistrate. This action triggers the commitment hearing if the child or if the parent objects. Alternatively, unlike the case with an adult, a juvenile already held in secure detention can have a petition for involuntary commitment reviewed by a JDR judge.

The procedures for a child's commitment are detailed in a statutory scheme separate from that for adults (Virginia Code Section 16.1-3 et seq.). However, although some of the commitment and hearing procedures for children are unique, other procedures parallel those for adults. As a result, the juvenile statutes sometimes explicitly "bridge" to the adult statutes (by cross reference) rather than restate the procedure in the juvenile code. Although this effort was, no doubt, to promote efficiency in the Code, "bridging" frequently results in confusion in statutory interpretation. The need to bridge the juvenile and adult commitment statutes, which requires juggling different statutes located in different Code volumes, results in variability in interpretation among JDR Court judges and judicial officers. As a result, the CA Task Force recommended amending the juvenile commitment code to a freestanding statutory section with the "bridges" eliminated. The Commission supports this proposal and will offer amendments to this effect in 2010.

The Commission made several recommendations for changes to the Virginia Code as part of the reform package proposed in December 2007, and these proposals were subsequently enacted by the General Assembly during its 2008 session. This year, the Commission has focused on revising the Psychiatric Inpatient Treatment of Minors Act to include the changes made to the adult commitment statutes in 2008 insofar as they reflect the special considerations arising in the treatment of minors. A full explication of the proposed changes appears in the Report of the Task Force on Children and Adolescents.

Although involuntary outpatient treatment orders (also called mandatory outpatient treatment orders or "MOT") for juveniles are rare (only 5% of all involuntary commitment orders issued),[34] recent events in Virginia have demonstrated the need to

[34] See the Commission's Hearings Study.

better monitor court-ordered involuntary outpatient treatment. Unfortunately, the infrastructure for monitoring that MOT is not well developed. If a JDR Court orders MOT, it is difficult for the judge to monitor whether the juvenile complies with the MOT and actually undergoes treatment. And, although CSBs are required to monitor the outpatient treatment for juveniles on Medicaid, no state entity is responsible for monitoring juveniles with private insurance, and it is very difficult for JDR Courts to enforce monitoring with private practitioners. The latter category, juveniles with private health insurance, is not insignificant. Of the juveniles assessed by the CSBs in June 2007, 28.1% had private insurance.[35]

In 2008, the General Assembly amended the adult civil commitment code to include extremely detailed procedures for monitoring mandatory outpatient treatment for adults. These new procedures, however, do not apply to juveniles. Although there are many helpful elements of these new procedures that can be modified to apply to juveniles, the CA Task Force does not recommend their wholesale adoption and their application to juveniles. Instead he Task Force adapted the MOT provisions to the special circumstances involving minors. Key elements of the proposed changes include:

- A CSB or DSS representative should be present at all hearings where juvenile outpatient commitment is being considered.
- The CSB should file a preliminary treatment plan at the commitment hearing where juvenile outpatient commitment is being considered.
- Mandatory outpatient treatment should not be ordered for a juvenile unless the provider in the home jurisdiction has the resources and agrees to provide them.
- The CSB in the juvenile's home jurisdiction should be responsible for monitoring compliance with juvenile mandatory outpatient treatment orders.

Recommendation 18: The Commission recommends that the General Assembly consider modifications to the Psychiatric Inpatient Treatment of Minors Act, including new procedures for mandatory outpatient treatment that are tailored to the special circumstances of juvenile commitments. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

I. Commitment of College and University Students

It is clear that unique problems arise in the context of commitment of college and university students and special procedures may be indicated. A specially constituted group with expertise in student affairs and higher education law as well as mental health law is needed to address them. The Commission and the State Council on Higher Education are discussing the possibility of a collaborative study of these issues.

---

[35] The Commission's Study of CSBs across Virginia, June 2007 ("The CSB Emergency Evaluation Study").

The proposed Task Force on Emergency Evaluation and Commitment of College and University Students would be charged with addressing particular issues such as (1) the need for specific statutory provisions relating to the issuance of ECOs and TDOs, and the associated transportation issues, in cases involving college and university students; (2) the appropriate role of college mental health professionals in commitment proceedings involving college and university students, and access of institutions of higher education to information regarding commitment proceedings involving their students; (3) implementation of the newly revised provisions relating to mandatory outpatient treatment in cases involving college and university students; and (4) the need for further clarification regarding permissible disclosure of health information by student mental health services and by college and university officials for the purpose of protecting students or other persons.

A decision will be made about whether to establish such a Task Force in the spring of 2009 after the end off the 2009 session of the General Assembly.

This page left blank intentionally.

V. Legal Foundation for Individual Choice and Empowerment in Mental Health Services

Virginia law currently authorizes patients to execute written Advance Directives ("AD") that address their wishes for end-of-life care when the patient in determined to be in a terminal condition, regardless of whether an agent is appointed to make decisions in accordance with those wishes. Virginia law does not, however, currently contain a legally recognizable mechanism for patients to execute similar ADs for other types of health care decisions in which the patient does not have a terminal condition. As a result, one of the Commission's major goals from the outset has been to facilitate the use of advance directives by individuals with mental illness or age-related cognitive impairment who would like to direct the health care decisions made on their behalves when they lack decisional capacity. The Commission's Task Force on Empowerment and Self-Determination ("ESD Task Force") devoted a substantial part of its Report to this subject and identified the key principles that ought to guide the drafting of a legislative proposal. A key feature of the ESD Task Force's approach was to incorporate the new provisions on instructional directives in the Health care Decisions Act rather than adopt a "stand-alone" statute on "psychiatric advance directives" (PADs) as many states have done. [36]

The Commission embraced the basic approach taken by the ESD Task Force in its Preliminary Report in December, 2007:

> "Advance directives are legal instruments that may be used to document a competent person's specific instructions or preferences regarding future health treatment. They are most commonly used in end-of-life decision-making, but are increasingly being advocated for other circumstances as well. The Commission recommends facilitating the use of crisis plans and advance directives in the event of impaired decisional capacity and making discussions of such plans a standard part of treatment while promoting and respecting individual choice.
>
> Recommendation II-B-1**:** The Commission recommends that the Health Care Decisions Act be amended to authorize a competent person to execute a "stand-alone" (agent optional) instructional advance directive to govern any type of health care decisions. This is to supplement, and not to replace, the provisions governing end-of-life care ("living wills") and health care powers of attorney already permitted under Virginia law. This non-end-of-life directive would apply to all types of health care decisions, not just those involving psychiatric care."

After the 2008 session of the General Assembly, the Commission established a new Task Force on Advance Directives ("AD Task Force") charged with developing a specific legislative proposal pertaining to instructional ADs for health care decisions in contexts other than end-of-life care based on the recommendations of the Task Force on Empowerment and Self-Determination. The two major clinical contexts in which such an instructional directive are expected to be especially useful are:

---

[36] http://www.courts.state.va.us/cmh/taskforce_workinggroup/2008_0919_tf_empower_slfdtrmntn_rpt.pdf

(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.

Additionally, in an effort to promote use of ADs by patients and to facilitate compliance with applicable law on ADs by providers, the AD Task Force sought to improve the flow of the Health Care Decisions Act and to address several issues that are ambiguous in the current law, while carefully avoiding any substantive changes to the law governing decision-making about end-of-life care.

The AD Task Force circulated successive drafts of its proposal to relevant constituencies and organizations, incorporated their ideas and suggestions, and developed a proposal that has been uniformly and enthusiastically supported by all the interested groups. The Commission approved the proposal on October 30, 2008, subject to any further technical changes approved by the Task Force. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

The key elements of the proposal are:

1. The proposal clarifies the process for determining whether a patient is incapable of making an informed decision, and the circumstances in which an incapable patient may be determined to be capable of making informed decisions again. The underlying premises of this section are that these procedures should be crafted against the backdrop of a policy of encouraging and facilitating execution of ADs, a preference for self-determination, and a presumption that people have the capacity to make health care decisions. Of particular note:

- A determination that a patient is incapable of making an informed decision must be based on proper examinations by two clinical experts, and such a determination may be limited to a particular health care decision or may be more global in nature depending on the person's condition at that time.

- Notice of the person's incapacity must be provided to the patient as well as either the patient's named agent or statutory decision-maker(s) before someone else is authorized make decisions about the person's health care.

- A single physician, on personal examination, is authorized to determine that an incapable patient has become capable of making an informed decision again.

2. The proposal coordinates the Health Care Decisions Act, including the effect of ADs, with the involuntary commitment statutes in Title 37.2, which are also being amended to address the interplay between these two statutes. First, a person may not use an AD to nullify or override the laws permitting involuntary treatment. However, the AD is to be given effect to the extent that it does not conflict with the commitment statutes. Second, authority conferred by the Health Care Decisions Act, including that conferred by an AD, may be used to authorize admission to a mental health facility only if it is also authorized by Title 37.2.

3. Assuming that Title 37.2 is amended to allow it[37], an AD may be used to permit admission to a mental health facility and to provide treatment over the person's later objection if the AD specifically confers such authority and certain other safeguards are satisfied. That is, a patient may 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. This so-called "Ulysses clause" is based upon the concept that a capable patient may anticipate his later protest to a particular health care treatment or decision and may direct that the treatment be provided over his later objection.

When this situation arises, an agent, but not a statutory designee, may authorize the treatment that the patient is now protesting if:

- The decision does not involve withholding or withdrawal of life-prolonging procedures; and
- The patient's AD explicitly states that the AD should govern, even over his later protest; and
- The patient's AD was signed by the patient's attending physician or licensed clinical psychologist who attested that the patient was capable of making an informed decision and understood the consequences of the provision, using substantially the following language: "The above declarant is my patient and I believe, based on a personal examination of the patient, that he/she is capable of making an informed decision about healthcare and he/she also understands the implications of authorizing the above-specified health care even if he/she later protests it."; and
- The proposed health care is determined and documented by the patient's attending physician to be medically appropriate; and

[37] The Commission is also recommending a companion proposal to amend Title 37.2 to allow such admissions. See proposed section 37.2-815.1, discussed supra.

- The proposed health care is otherwise permitted by law.

Because of the significance of treating the patient over his protest, the authority to make such a decision is granted only to the agent that the patient has entrusted with surrogate decision-making, and not to a statutory designee.

4. The proposal also addresses a more general problem involving treatment of patients, typically in nursing homes, who are not capable of making health care decisions, object to a particular medical procedure, but have not executed an AD with a Ulysses clause. Specifically, this subsection is designed to provide a non-judicial mechanism for addressing the clinical "stalemate" situation that can arise under the current statute (*i.e.*, a protest must be honored even if it is uttered by a patient who is incapable of making informed decisions—unless the provider obtains a court order for treatment).

When this situation arises, either an agent or a statutory designee (if there is no agent) may authorize the treatment that the patient is now protesting if:

- The decision does not involve withholding or withdrawal of life-prolonging procedures
- The decision is based on the patient's religious beliefs and basic values and any preferences previously expressed by the patient regarding such health care, when he was capable of making an informed decision, to the extent they are known, and, if unknown or unclear, on the patient's best interests; and
- The health care has been affirmed and documented as being ethically acceptable by the health care facility's ethics committee, if one exists and, otherwise, by two physicians who are not currently involved in the treatment of the patient and who did not make the determination that the patient was incapable of making an informed decision.

5. Because of the contexts in which a Ulysses clause would be important in carrying out the wishes of the patient, the proposal distinguishes between a protest of a particular treatment or decision, on the one hand, and revocation of the AD, on the other. A protest does not revoke an AD, which can only be revoked when the patient makes clear his intent to revoke his AD, in accordance with the statute.

6. The proposal also addresses a problem arising under the current statute in identifying a family member to make decisions for a person who becomes incapable of making a decision but does not have an advance directive or a judicially appointed guardian. The proposal augments the list of statutory default decision-makers to include non-family members, where no family members are known, willing, or able to serve as decision-maker. Using model language, the list now includes, as the residual default category, any adult who has exhibited special care and concern for the patient and who is familiar

with the patient's religious beliefs and basic values, but who is not a participant in the patient's health care.

Recommendation 19: The Commission recommends that the General Assembly consider legislation that would amend the Health Care Decisions Act to empower people to execute advance directives to guide their health care if they become incapable of making health care decisions, to clarify the relationship between the Health Care Decisions Act and the Commonwealth's mental health statutes, and to provide better guidance to health care providers in providing treatment to patients who may lack the ability to make health care decisions. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

This page left blank intentionally.

VI. Assuring Access to Services for Children and Adolescents

Children with mental health needs are among the most vulnerable members of society. The failure to provide early screening, diagnosis and treatment of their disorders is a missed opportunity to intervene and not only promote the health of affected children and their families but, also, to minimize or even prevent poor school performance, truancy, engagement with foster care and the juvenile justice system. Furthermore, inadequate access to community-based mental health services simultaneously increases the likelihood of a child coming before a Juvenile and Domestic Relations Court ("JDR Court")—whether under a foster care, CHINS, juvenile justice, or involuntary commitment proceeding—and constrains the options available to Intake Officers and JDR Courts in determining the appropriate disposition of a case. This result is skewing public policy toward judicially orchestrated interventions that, too often, are institutionally based.

This is a tragic and costly outcome. Tragic because, according to the Surgeon General's Report on Children's Mental Health,[38] the President's New Freedom Commission on Mental Health,[39] and countless other studies, early screening and intervention enables the vast majority of children with mental health needs to successfully live in their communities, complete school, and avoid judicial involvement as well as the stigma associated with it. It is costly, because judicial and institutional interventions have a higher price tag in the short run and, for many children, a lower success rate. In addition, the long–term costs of not treating or under-treating children with mental health needs includes higher rates of school drop-outs and substance abuse, repeated inpatient hospitalizations and encounters with juvenile justice, and a higher likelihood of graduating to the adult criminal justice system.

The Commission's Task Force on Children and Adolescents ("CA Task Force") examined these policy barriers and developed a comprehensive set of recommendations designed to facilitate mental health interventions, minimize judicial involvement, and enable JDR Courts to better achieve their statutory mandate to construe the law "liberally and as remedial in character." The Commission endorsed the key principles guiding their Task Force in its Blueprint for Reform in December, 2007.[40] The Commission will be releasing the CA Task Force Report for public comment in the near future. In the meantime, the Commission has taken steps in this Report to implement the CA Task Force's recommendations regarding the involuntary treatment of minors (see Recommendation 18, above). In the coming months, the Commission plans to decide

[38] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[39] New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report* (DHHS Pub. No. SMA-03-3832). Rockville, MD .

[40] http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf,

what further steps it should take to enable Virginia to more effectively address the mental health needs of the Commonwealth's children and adolescents.

VII. Transforming Community Mental Health Services

In its Preliminary Report in December, 2007, the Commission observed:

> "A consensus has clearly emerged on the need to develop a more effective and comprehensive system of community services. Based on the work of the Task Force on Access to Services, the Commission has identified the components of a robust community services system that can help prevent crises, respond to them successfully, and provide intensive services to those who need them to achieve recovery. The Commission recognizes that the Commonwealth is facing a significant shortfall in revenues, and many competing public needs, in the upcoming biennium. Accordingly, for now, the Commission recommends a substantial down payment on the needed investment, together with a commitment to sustain it over the years ahead. In the Commission's final report, we will present a plan for sequential implementation of the proposed Blueprint over several biennia."

The Task Force on Access to Services will continue its effort to develop this plan in 2009. However, the following brief progress report reproduces the recommendations from the 2007 Report and summarizes the initiatives being undertaken by the Access Task Force:

A. Commission's 2007 Recommendations:

I-A Increase CSB Mandated Services

The Commission recommends revising Va. Code §§ 37.2-500 and 37.2-601 to expand the array of services required for voluntary and involuntary access to services that must be provided by community services boards and behavioral health authorities ("CSBs") and supported by the Commonwealth of Virginia. State grant funding should provide the foundation of support for these mandated services:

> The core of services provided by community services boards within the cities and counties that they serve shall include *emergency, crisis stabilization*, *case management, outpatient, respite, in-home, residential and housing support services*. The core of services may include a comprehensive system of inpatient, prevention, early intervention, and other appropriate mental health, mental retardation, and substance abuse services necessary to provide individualized services and supports to persons with mental illnesses, mental retardation, or substance abuse.

I-B Strengthen the Role of DMHMRSAS

The Commission recommends conferring responsibility on the Department of Mental Health, Mental Retardation and Substance Abuse Services ("DMHMRSAS") to establish and sustain core community-based mental health services. DMHMRSAS should be responsible for sustaining the core components of community-based mental health services, including, at a minimum, emergency services, crisis stabilization, case management, outpatient, respite, in-home, residential, and housing support services.

I-B-1 Broaden Goals of Comprehensive State Plan. DMHMRSAS, under its statutory obligation (Va. Code § 37.2-315) to develop a comprehensive state plan, should focus planning efforts on the development of a comprehensive, accessible community-based system of services provided through a combination of direct services, interagency collaboration, community partnerships and services contracts with both private and public providers.

I-B-2 Strengthen CSB/ Performance Contracts. DMHMRSAS performance contracts for mental health, mental retardation and substance abuse services should:

a. reflect DMHMRSAS's role in creating, funding, sustaining and reporting on an expanded array of core community-based services required by Va. Code §§ 37.2-500 and 37.2-601, revised in accord with the Commission's recommendation to include, at a minimum: emergency, crisis stabilization, case management, outpatient, respite, in-home, residential and housing support services.

b. reflect the role of DMHMRSAS as the locus of coordination for ensuring that the service standards and core expectations for each of the mandated core services are defined, promulgated, contracted for, measured and reported to the various stakeholders including, but not limited to, the Secretary of Health and Human Resources for the Commonwealth and each local government which is party to a CSB performance contract.

I-B-3 Facilitate Coordination and Continuity of Care. DMHMRSAS should be charged with responsibility for developing, implementing, and overseeing strategies to facilitate coordination of services across sectors and assuring continuity of care and should be provided with adequate staffing to carry out this function.

I-C Increase Role of Insurance in Financing Mental Health Services

I-C-1 Require Parity in Benefits. The General Assembly should consider legislation requiring parity in health insurance coverage and benefits for

treatment of mental and addictive disorders. Mental health and substance abuse treatment services should be reimbursed at a level that is equitable with other medical specialties.

I-C-2 **Expand Medicaid Eligibility.** The General Assembly should consider expanding Medicaid eligibility for the population classified as aged, blind and disabled by raising the eligibility criterion from the present 80% of the federal poverty level to 100% of the federal poverty level.

I-D Core Services

All CSBs should have the capacity to provide the following core services:

I-D-1 All CSBs should have the capacity to provide a full range of crisis response services accessible 24 hours each day to individuals experiencing a psychiatric crisis. Crisis stabilization, psychiatric urgent care and psychiatric, nursing and medication services are essential components of this recommendation.

I-D-2 All CSBs should have the capacity to provide outpatient psychiatric services and related medical supports in accord with caseload standards established by DMHMRSAS.

I-D-3 All CSBs should have the capacity to provide case management services in accord with caseload standards established by DMHMRSAS.

I-D-4 All CSBs should have the capacity to provide Programs of Assertive Community Treatment, Intensive Community Treatment, and Intensive Case Management in each locality to all persons in need of intensive services.

I-D-5 Each of Virginia's local law enforcement agencies should establish certified Crisis Intervention Teams.

I-D-6 Each CSB should establish a free access number that is consistent throughout the service area or region for all psychiatric crisis responses and referrals.

I-D-7 Each CSB should have the capability within its continuum of crisis stabilization services to receive custody of persons under an ECO from law enforcement officers.

I-D-8 Each of the seven DMHMRSAS regions should establish and support a community-based regional geriatric-psychiatric continuum of care.

I-D-9 The CSBs should give a high priority to improved access to adequate permanent housing for individuals with mental illness. Va. Code § 63.2-800 should be revised to authorize a portable Auxiliary Grant for housing supports, and the policies of the Virginia Department of Social Services, 22 Va. Admin. Code § 40-25-10, should be revised accordingly.

I-E Cultural Competency

The cultural and demographic diversity of the Commonwealth's citizens is changing rapidly. There are significant differences in the way that minority populations experience illness and seek services. The Commission recommends that all training components include training on cultural competency.

B. Activities of Access Task Force in 2008

The Task Force on Access Task Force was reconstituted in 2008 to flesh out this blueprint and assemble pertinent evidence about effectiveness and cost of implementing these recommendations. Another part of this work focuses on the specific access needs of populations and issues considered by other Task Forces—particularly persons with severe mental illness involved with the criminal justice system and children and adolescents with severe emotional and behavioral disorders. It also, however, includes Working Groups that focus on particular issues needed to effectively expand access to mental health care. The Access Task Force now has the following five Working Groups that have met over the past year:

- Criminal Justice and Mental Health
- Children and Adolescents
- Workforce Development
- Mental Health Parity
- Role of State Government in Promoting Access to Mental Health Services (Included here is an examination of Medicaid)

In addition to full Working Groups, the Access Task Force has sought White Papers and other information about two other groups for whom there may be unique access issues. These are returning service members and their families and the psychogeriatric population.

The Access Task Force and its Working Groups are:

- identifying the policies and services in place throughout the Commonwealth
- examining models of providing mental health services that work—whether in Virginia or in other states
- reviewing the literature on mental health services—including the impact of inadequate services on law enforcement, courts, schools, foster care, juvenile justice, nursing homes, etc.

- developing a long-range set of Recommendations that can be phased in over several budget cycles coupled with the appropriate evaluations to determine what works

The ultimate goal of mental health law reform is to reduce unnecessary encounters with the courts, law enforcement, foster care, juvenile justice, emergency services and other crisis response agencies of persons with severe mental illness or children with serious emotional and behavioral disorders. The Commission is convinced that most of these encounters, which are costly in both economic and human terms, could be avoided if adequate access to community-based mental health services were available throughout the Commonwealth. The Task Force on Access to Services aims to construct a plan to accomplish this over the coming decade

This page was intentionally left blank.

APPENDIX 1

SUMMARY OF RECOMMENDATIONS

Recommendation 1: The Commission recommends for consideration by the General Assembly a set of procedural amendments to the 2008 legislation designed to clarify legislative intention and thereby promote uniform application of the laws governing involuntary commitment. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 2: The Commission believes that all independent examiners, including psychiatrists and psychologists, should be required to complete a certification program developed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, that Continuing Education Units should be made available for the training, and that the $75 fee now authorized for independent examinations in civil commitment proceedings should be increased. However, in light of current budget constraints, the Commission believes that these changes should be deferred.

Recommendation 3: The Commission recommends that the General Assembly consider amending the Code provisions relating to transportation of persons involved in the commitment process to permit and strengthen the use of transportation by responsible individuals and organizations other than law enforcement officers. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 4: The Commission recommends that the General Assembly consider legislation amending §§ 37.2-127.1:03 and 37.2-804.1 to authorize family members to be notified when their relative is involved in the commitment process. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.

Recommendation 5: The Commission recommends that CSBs consider the cost-effectiveness of developing contracts with taxi services or other regional transportation providers to provide transportation and/or vouchers for transportation to medical appointments and other needed mental health services.

Recommendation 6: The Commission urges CSBs to consider changing their policies to specify when and under what circumstances CSB crisis workers, case managers and other employees may transport persons in government owned and personal vehicles as part of the delivery of mental health services. CSBs that have not done so should consider becoming Medicaid transportation providers.

Recommendation 7: The Commission recommends that DMAS develop written guidance as soon as possible on the requirements and conditions under which Medicaid will reimburse for routine, urgent and emergency mental health assessment and treatment. CSBs that have not already done so should assess whether it would be fiscally advantageous to become a Medicaid provider of transportation services for their consumers and encourage, where possible, private transportation providers to develop such services. Police and sheriffs' departments should also assess whether it is feasible for them to become Medicaid providers in these circumstances.

Recommendation 8: The Commission urges CSBs, private providers and other stakeholders in each locality or region to explore the feasibility of alternative methods of financing and providing transportation services for consumers, including use of peer counselors, off-duty law enforcement officers, and private mental health service providers, to determine whether they would be available and feasible in their area for providing needed transportation services for consumers.

Recommendation 9: Given current economic circumstances, the continued shortage of psychiatric hospital beds, and the difficulty predicting the fiscal impact of extending the TDO period, the Commission recommends no statutory change to the TDO period in 2009.

Recommendation 10: The Commission believes that legislation authorizing mandatory outpatient treatment following involuntary inpatient admission would be premature until the Commonwealth's economic picture changes, CSB outpatient services become more readily available, and research demonstrates the effectiveness of mandatory outpatient treatment.

Recommendation 11: The Commission recommends that MOT to prevent involuntary inpatient admission be delayed until further research demonstrates its effectiveness and a fuller array of outpatient services becomes more widely available.

Recommendation 12: The Commission does not support appointment of state-subsidized counsel for indigent petitioners in civil commitment proceedings at this time. Improving other features of the process, such as increasing fees for independent examiners and providing oversight for special justices, have a higher priority. As a public policy matter, the Commission doubts the wisdom of appointing counsel for petitioners in civil commitment proceedings when counsel are not appointed for petitioners in other civil cases, such as domestic abuse cases.

Recommendation 13: The Commission does not support proposals to allow unsupervised law students to represent petitioners in commitment proceedings. Instead, the Commission encourages law schools to work with the local bar to provide to set up programs to this service with supervision in areas where law schools are located. The Commission also recommends that steps be taken to encourage *pro bono* representation of petitioners by members of the Bar.

Recommendation 14: The Commission does not support proposals to afford petitioners the right to appeal a decision favorable to the respondent in a commitment proceeding.

Recommendation 15: The Commission recommends that the General Assembly consider legislation that would afford an individual the opportunity to have an individual of their choice notified of their general condition, location and transfer to another facility. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 16: The Commission recommends that the General Assembly consider legislation preserving the current statutory presumption that commitment hearings be open to the public while prescribing a standard to guide judges in exercising their discretion to close these hearings upon the respondent's motion. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 17: The Commission recommends that the General Assembly consider legislation that would permit mental health facilities to admit incapacitated individuals for up to ten days upon the request of a health care agent designated by the individual in an advance directive and specifically given the authority to do so, or upon the request of a guardian specifically authorized to do so in the guardianship order. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 18: The Commission recommends that the General Assembly consider modifications to the Psychiatric Inpatient Treatment of Minors Act, including new procedures for mandatory outpatient treatment that are tailored to the special circumstances of juvenile commitments. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 19: The Commission recommends that the General Assembly consider legislation that would amend the Health Care Decisions Act to empower people to execute advance directives to guide their health care if they become incapable of making health care decisions, to clarify the relationship between the Health Care Decisions Act and the Commonwealth's mental health statutes, and to provide better guidance to health care providers in providing treatment to patients who may lack the ability to make health care decisions. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

APPENDIX 2

ACRONYMS

AD	Advance Directive
AOT	Assisted Outpatient Treatment
BHA	Behavioral Health Authority
CSB	Community Services Board
CIT	Crisis Intervention Teams
DMAS	Department of Medical Assistance Services
DMHMRSAS	Department of Mental Health, Mental Retardation, and Substance Abuse Services
ECO	Emergency Custody Order
EMS	Emergency Medical Services
HIPAA	Health Insurance Portability and Accountability Act
IE	Independent Examiner
JDR	Juvenile and Domestic Relations (Courts)
JLARC	Joint Legislative Audit and Review Commission
MOT	Mandatory Outpatient Treatment
OAG	Office of the Attorney General
OES	Office of the Executive Secretary of the Supreme Court
TDO	Temporary Detention Order
VSP	Virginia State Police

This page left blank intentionally.

Appendix 3

Commonwealth of Virginia
Commission on Mental Health Law Reform

Commissioners

Chair

Richard J. Bonnie
Harrison Foundation Professor of Medicine and Law, Professor of Psychiatry and Neurobehavioral Sciences, and Director of Institute of Law, Psychiatry and Public Policy
University of Virginia
School of Law
Charlottesville, VA

Honorary Co-Chairs

The Honorable William T. Bolling
Lieutenant Governor of Virginia
Richmond, VA

The Honorable Robert F. McDonnell
Attorney General of Virginia
Richmond, VA

Members

Ronald A. Allison
Executive Director
Cumberland Mountain Community Services
Cedar Bluff, VA

Jack W. Barber, M.D.
Director
Western State Hospital
Staunton, VA

Mark Bodner, Esquire
Special Justice
Fairfax, VA

Victoria Huber Cochran, J.D.
Cochran Consulting and Facilitation Services
Blacksburg, VA

Patrick W. Finnerty
Director
Department of Medical Assistance Services
Richmond, VA

Vicky Mitchell Fisher, Ph.D., RN, APRN
Director of Nursing
Catawba Hospital
Roanoke, VA

The Honorable Isaac St. C. Freeman
Judge
Smyth County Circuit Court
Marion, VA

Terry Grimes, Ed.D.
President
Empowerment for Healthy Minds
Blacksburg, VA

Karl R. Hade
Executive Secretary
Supreme Court of Virginia
Richmond, VA

Charles A. Hall, M.Ed., CAS
Executive Director
Hampton-Newport News Community Services Board
Newport News, VA

The Honorable Phillip A. Hamilton
Delegate, 93rd District
House of Delegates
Newport News, VA

Jane D. Hickey, Esquire
Senior Assistant Attorney General and Chief of Health Services Section
Office of the Attorney General
Richmond, VA

The Honorable Gerald S. Holt
Sheriff
Roanoke County
Salem, VA

The Honorable Janet D. Howell
Senator, District 32
Senate of Virginia
Reston, VA

The Honorable Catherine M. Hudgins
Fairfax County Board of Supervisors
Reston, VA

The Honorable Terry G. Kilgore, Esquire
Delegate, 1st District
House of Delegates
Gate City, VA

The Honorable L. Louise Lucas
Senator, District 18
Senate of Virginia
Portsmouth, VA

Gregory E. Lucyk, Esquire
Chief Staff Attorney
Supreme Court of Virginia
Richmond, VA

Charlotte V. McNulty
Executive Director
Harrisonburg-Rockingham Community Services Board
Harrisonburg, VA

The Honorable Deborah M. Paxson
Judge
Juvenile and Domestic Relations District Court
Virginia Beach, VA

James S. Reinhard, M.D.
Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services
Richmond, VA

James W. Stewart, III
Inspector General
Office of the Inspector General
Richmond, VA

Byron Stith
P.O. Box 1175

Mechanicsville, VA

F. Carol Ulrich, Esquire
President
NAMI-Northern Virginia
Herndon, VA

Kevin Young, BSW, MHA, CBHE
Corporate Director of Behavioral Health
Neuroscience Center of Excellence
Valley Health
Winchester, VA

Advisors

Katherine Acuff
Health Policy Consultant
Commission Editor
Charlottesville, VA

Thomas L. Hafemeister, J.D., Ph.D.
Associate Professor of Law
University of Virginia School of Law
Director of Legal Studies
Charlottesville, VA

Catherine K. Hancock, APRN, BC
Mental Health Policy Analyst
Department of Medical Assistance Services
Richmond, VA

Richard E. Hickman, Jr.
Deputy Staff Director
Senate Finance Committee
General Assembly Building, 10th Floor
Richmond, VA

James M. Martinez, Jr.
Director, Office of Mental Health Services
Department of Mental Health, Mental Retardation and Substance Abuse Services
Richmond, VA

Susan Massart
Legislative Fiscal Analyst
House Appropriations Committee
Richmond, VA

Raymond R. Ratke
Deputy Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services
Richmond, VA

Interim Staff Director
Joanne Rome
Staff Attorney
Supreme Court of Virginia
Richmond, VA

COMMONWEALTH OF VIRGINIA
COMMISSION ON MENTAL HEALTH LAW REFORM

PROGRESS REPORT ON MENTAL HEALTH LAW REFORM (2009)

DECEMBER, 2009*

As originally posted in December, 2009, Chapter III of the report and Appendix C contained some erroneous data. These errors were corrected on June 14 and the report was reposted.

This page left blank intentionally.

PREFACE

The Commonwealth of Virginia Commission on Mental Health Law Reform ("Commission") was appointed by the Chief Justice of the Supreme Court of Virginia, the Honorable Leroy Rountree Hassell, Sr., in October 2006. Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups. The Commission was directed by the Chief Justice to conduct a comprehensive examination of Virginia's mental health laws and services and to study ways to use the law more effectively to serve the needs and protect the rights of people with mental illness, while respecting the interests of their families and communities. Goals of reform include reducing the need for commitment by improving access to mental health services, avoiding the criminalization of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers of mental health services to have greater choice regarding the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

During the first phase of its work, the Commission was assisted by five Task Forces charged, respectively, with addressing gaps in access to services, involuntary civil commitment, empowerment and self-determination, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. In addition, the Commission established a Working Group on Health Privacy and the Commitment Process ("Working Group"). Information regarding the Commission and Reports of the Commission and its various Task Forces are all available at http://www.courts.state.va.us/programs/cmh/home.html

The Commission also conducted three major empirical studies during 2007. The first was an interview study of 210 stakeholders and participants in the commitment process in Virginia. The report of that study, entitled *Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations*, was issued in April 2007. The study is available at http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf.

The second major research project was a study of commitment hearings and dispositions (the "Commission's Hearings Study"). In response to a request by the Chief Justice, the special justice or district judge presiding in each case filled out a 2-page instrument on every commitment hearing held in May 2007. (There were 1,526 such hearings). Findings from the Commission's Hearing Study served an important role in shaping the Commission's understanding of current commitment practice. The study can be found at http://www.courts.state.va.us/programs/cmh/2007_05_civil_commitment_hearings.pdf

Finally, the Commission's third project during this first phase was a study of every face-to-face emergency evaluation conducted by Community Service Board

("CSB") emergency services staff during June 2007 (the "Commission's CSB Emergency Evaluation Study"). (There were 3,808 such evaluations.) The final report of the CSB Emergency Evaluation Study appear at http://www.courts.state.va.us/programs/cmh/2007_06_emergency_eval_report.pdf

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

After the General Assembly enacted a major overhaul of the commitment process in 2008, the Commission moved into the second phase of its work. Three new Task Forces were established – one on Implementation of the 2008 Reforms, another on Future Commitment Reforms and one on Advance Directives. In addition, the Commission created a separate Working Group on Transportation. Each of these Task Forces and Working Groups presented reports to the Commission, together with recommendations for the Commission's consideration. The 2008 Report of the Task Force on Future Commitment Reforms is posted at http://www.courts.state.va.us/cmh/taskforce_workinggroup/home.html. The 2008 Transportation Working Group's Report is posted at http://www.courts.state.va.us/cmh/taskforce_workinggroup/home.html. The 2008 Report of the Task Force on Training and Implementation is posted at http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2008_1219_tf_training_impl_rpt.pdf

In December, 2008, the Commission issued a Progress Report reviewing its work in 2008 and providing a status report on the progress of mental health law reform in Virginia during 2008. It summarized the changes adopted by the General Assembly in 2008, reviewed the steps taken to implement them, summarized the available data on the operation of the commitment system during the first quarter of FY2009, presented the Commission's recommendations for consideration by the General Assembly in 2009, and identified some of the important issues that the Commission will be addressing in the coming year. The 2008 Progress Report can be found at http://www.courts.state.va.us/programs/cmh/2008_1222_progress_report.pdf

During 2009, the Commission focused on implementation and refinement of the reforms adopted during 2008 and 2009 and on several key issues that had been deferred, including the length of the emergency hospitalization period (the 'TDO" period) and the possible expansion of mandatory outpatient treatment. The Commission also continued to study ways of enhancing access to services in an integrated services system. The Commission plans to complete its work in 2010.

This Progress Report for 2009 represents the views and recommendations of the members of the Commission on Mental Health Law Reform, and should not be construed as reflecting the opinions or positions of the Chief Justice, the individual Justices of the Supreme Court of Virginia, or of the Executive Secretary of the Supreme Court. Any recommendations or proposals embraced by the Court itself will lie exclusively within the judicial sphere.

Richard J. Bonnie, Chair
Commission on Mental Health Law Reform
December, 2009

This page left blank intentionally.

TABLE OF CONTENTS

Section	Page
Preface	3
Executive Summary	9
I. Mental Health Law Reform in 2009	17
II. Civil Commitment Practices and Outcomes in FY2009	23
III. Continuing Concerns about Implementation of Commitment Reforms	41
IV. Commitment Reform Phase 3: Proposals for 2010	55
V. Advance Directives and Health Care Decisions Act Reform	65
VI. Parallel Reform Initiatives	69
VII. System Integration and Access to Services	81
VIII. Concluding Observations	93
APPENDICES	
Appendix A. Commissioners	95
Appendix B. Recommendations	99
Appendix C. Initial Hearing Dispositions, Fy10 1st Qtr, By District Court (N $\geq$ 50)	103
Appendix D. Acronyms	105

This page left blank intentionally.

EXECUTIVE SUMMARY

This Progress Report of the Commission on Mental Health Law Reform ("Commission") in the Commonwealth summarizes reforms enacted in 2009, reviews data on commitment practices and outcomes, outlines the actions recommended for consideration by the General Assembly in 2010, and explains why reducing social costs of untreated mental illness and costly judicial involvement in mental health treatment ultimately requires enhancing access to community services as soon as resources permit.

Reform Legislation in 2009

The 2009 General Assembly session was very productive for mental health law reform. Ten of the eleven bills recommended by the Commission were enacted into law. A major priority was enactment of a bill permitting persons or providers other than law enforcement (such as family members, friends, community service board ("CSB") representatives, or other transportation providers) to transport persons who are under an ECO or a TDO or a commitment order.[1] Other important bills provide a consumer receiving mental health services with the right to have a person of his/her choice notified of his/her condition, location or transfer to another location and clarify Virginia Health Privacy Act and HIPAA[2] requirements so health care providers may notify family members of a person's location and general condition under certain circumstances when the person is subject to civil commitment process.

Virginia's Health Care Decisions Act ("HCDA") was amended to increase opportunities for individuals to make health care decisions in advance directives. The legislation was developed by the Commission's Task Force on Advance Directives based on previous recommendations by the Commission's Task Force on Empowerment and Self-Determination. The main objective of the new legislation is to empower people to guide decisions about their health care if they lose decision-making capacity due to mental health conditions or neurological disorders such as dementia. The revised statute also prescribes procedures for assessing decision-making capacity, addresses special situations where a patient who lacks decision-making capacity protests a care recommendation, clarifies procedures for revoking advance directives, and protects decision-makers and providers who act in good faith to carry out patient direction. The bill also permits a guardian to admit a person to a mental health facility for up to 10 days

[1] An emergency custody order ("ECO") is the statutory mechanism whereby an individual can be detained for up to 4 hours for a mental health evaluation. Following the evaluation, the person must be released or a judge, special justice, or magistrate must issue a temporary detention order. A temporary detention order ("TDO") is a statutory mechanism that permits the detention of an individual for up to 48 hours for clinical evaluation and certification of whether the criteria for civil commitment are met.

[2] The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191) [HIPAA] was enacted by the U.S. Congress in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. The rules governing disclosure of health information by "covered entitles" are specified in the "HIPAA Privacy Rule," 45 C.F.R. Section 164.506 et seq.

if the guardianship order specifically authorizes the guardian to do so after making other specified findings. This bill was a major priority for the Commission in 2009.

Other Commission bills were designed to clarify and amend provisions adopted in the major overhaul of commitment law in 2008 and to establish mandatory outpatient treatment ("MOT") procedures for minors similar to those for adults.

The Law in Practice

Five regional trainings were conducted in 2009, with all the participants and stakeholders in the commitment process were invited. The Supreme Court authorized and encouraged judicial branch officers to attend the regional trainings, including district court clerks and magistrates. The Mental Health Training and Implementation Task Force ("Implementation Task Force") found that having most stakeholders from a geographic region attending the trainings together allowed the presenters to focus on issues particularly relevant regionally, promoting a common understanding of the new procedures and better interactions among the stakeholders. The Commission believes that this regional approach is the most efficient and effective means for addressing local program implementation issues, and should serve as a model for future mental health training efforts. It will be especially important to encourage special justices to attend these programs in the future.

Informed oversight of the civil commitment process requires accurate data regarding the number, distribution and characteristics of ECOs, TDOs, commitment hearings and judicial dispositions. Since the Commission was established in 2006, the courts and mental health agencies have collaborated to create the data systems needed for proper monitoring and informed policy-making. This process was accelerated in response to direction by the General Assembly after the reform legislation was enacted in 2008, and the Supreme Court made major improvements to its data collection systems during 2009. As a result, the Commonwealth now has reliable data systems that enable policymakers to monitor and evaluate the commitment process.

The Commission estimates that there were about 7% more TDOs were during FY09 than during FY08. However, it seems likely that the increase preceded the effective date of the new commitment law and that this unexplained increase in the numbers of TDOs is receding. It also seems likely that there were more initial commitment hearings in FY09 than in FY08. Based on the data obtained at the time of the Commission's study of commitment hearings during May 2007, and on inferences drawn from TDO data, it is likely that the increase in initial commitment hearings has been in the range of 5-8%.

The Supreme Court data also clarifies what the dispositions of commitment hearings were. During FY09, about 80% of commitment hearings resulted in hospitalizations. More than half, about 56% of initial commitment hearings, resulted in involuntary admission, while about 24% resulted in voluntary admission. About 19% of the cases were dismissed. Only a handful of the total cases for which there was a

commitment hearing (less than ½ of one percent) resulted in "MOT" orders. If the Commission's study of hearings conducted in May 2007 ("Hearings Study")[3]was representative of hearing practice and outcomes in FY 2007, there were proportionately fewer MOT orders and voluntary hospitalizations (about 5% fewer of each), and correspondingly more involuntary hospitalizations and dismissals (about 5% more of each) in FY 2009 than in FY 2007.

Based on the review of data concerning commitment proceedings from FY 2009 and the first quarter of FY 2010, the Commission believes that two aspects of current commitment practice require critical attention – the infrequency with which mandatory outpatient treatment is ordered, and the wide variations in the outcomes of commitment proceedings among district courts.

MOT in Virginia is conceptually structured as a "less restrictive alternative" to involuntary hospitalization but in practice it is infrequently employed (half of 1% of individuals in commitment hearings). The reasons for the infrequent utilization of MOT are likely due to several factors including Virginia's criteria for MOT eligibility, the relatively brief TDO period and limited access to community-based mental health services and supports.

Under the Virginia model for MOT, individuals who meet the criteria for involuntary admission but are willing to agree to comply with an order for MOT are eligible. However, given the acuity of clinical dysfunction and distress that typically characterizes individuals who meet Virginia's commitment criteria, discharge from the hospital with and order for MOT is questionable both clinically and legally. MOT orders generally are issued after Virginia's 48 hour maximum assessment period permitted under a TDO. Forty-eight hours permits little time to stabilize a person's mental status, fully assess an individual's suitability for MOT, and identify community-based providers willing to provide the needed MOT services. However, MOT orders may be clinically appropriate more often if (1) the duration of the TDO period were lengthened to 72 or 96 hours permitting more time for assessment, stabilization and planning; and (2) CSB capacity to provide intensive outpatient services, including medication, were increased. The Commission favors lengthening the TDO period to 72 hours (96 on weekends or holidays) for a variety of reasons, including the prospect that doing so will avoid unnecessary commitment to involuntary hospitalization. The Commission also favors expanding access to community-based mental health services, including strengthening the mental health workforce.

Other models for MOT than that Virginia now uses could be considered but are controversial. For example, MOT orders could be available in cases in which the individual does not currently meet Virginia's criteria for involuntary hospitalization but may be at risk for meeting those criteria without intervention. There are at least two

---

[3] A Study of Civil Commitment Hearings Held in the Commonwealth of Virginia During May 2007, *A Report to the Commission on Mental Health Law Reform,* Supported by the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Supreme Court of Virginia, June 30, 2008.

situations where MOT could be used for individuals not meeting the commitment criteria that would likely lead to an increase in MOT orders. The first is a "preventive MOT" and might be employed if a person's condition were deteriorating even though they do not yet meet the criteria for inpatient admission. The second is known as a "step-down" MOT used when a person already under a commitment order is stabilizing but would not yet be suitable for discharge in the absence of mandated intensive services. The Commission regards the "step-down" MOT as the next logical extension of current policy, but remains opposed to either of these approaches at the present time due to lack of service capacity.

The Supreme Court's data document substantial variations in many aspects of commitment practices across the Commonwealth raising concerns about fairness in the application of the law. Variations in dismissal rates among district courts (literally from zero to 100%) clearly demonstrate that the commitment criteria are applied inconsistently across the state. Among respondents whose cases are not dismissed, variations in the proportion of individuals who are voluntarily, instead of involuntarily, hospitalized suggest that special justices have different perspectives on the threshold for allowing the voluntary option. (To some extent, these outcome discrepancies may be a function of differences of perspective among independent examiners and CSB emergency services staff as well as special justices.) In addition to substantial outcome variations, the Commission has also been informed of what appear to be systematic variations in evidentiary and procedural rulings among special justices.

The Commission believes that there is an urgent need for coordinated training, support and assistance for the special justices presiding over civil commitment cases in Virginia.

Reform Proposals in 2010

From the outset of its deliberations, the Commission has studied whether the maximum period of temporary detention should be expanded from the current 48 hours to three, four, or five days in order to (1) to give more time for individuals to be treated and stabilized, thereby negating the need for involuntary hospitalization and permitting either discharge or conversion to voluntary status; and (2) to give CSB staff and independent examiners time to conduct a more thorough evaluation to guide the court's decision if a commitment hearing is necessary.

As part of this review, the Commission also considered whether independent examiners should be authorized to release individuals who do not meet the commitment criteria and for whom the full length of involuntary hospitalization permitted under a TDO is not necessary or appropriate. Based on its review of the potential benefits of extending the TDO period, the Commission has several TDO-related recommendations. First, the maximum period of temporary detention should be increased to 72 hours or until the end of the next business day if the 72-hour time period ends on a Saturday, Sunday, or holiday. Second, the TDO facility should be permitted to release an

individual from custody if the responsible physician, after an evaluation and consultation with the petitioner and CSB, determines that the person does not meet commitment criteria. Third, an individual under a TDO should be permitted to consent to voluntary admission and that the commitment proceedings be terminated upon conversion to voluntary status. Fourth, if a person under a TDO is converted to voluntary status prior to the commitment hearing, the Involuntary Civil Commitment Fund managed by DMAS should continue to pay for the person's hospitalization and treatment at least through the time the commitment hearing would have been held. In addition, the Commission found that too often commitment hearings were conducted within the first 24 hours of detention under a TDO raising serious questions about the adequacy of time to conduct thorough evaluations as well as to stabilize individuals with the goal of minimizing inpatient admissions. As a result, the Commission recommends that no commitment hearing be held in less than 24 hours. The Commission projects that implementation of these recommendations will increase discharges and conversions to voluntary status and will also reduce commitment hearings, largely offsetting any modest increase in length of hospitalization for patients who remain hospitalized.

The Commission recommends that the multiple provisions of the Virginia Code permitting individuals incarcerated in local or regional jails to be transferred to a mental health facility (§§ 19.2-169.2, 19.2-176 and 19.2-177.1) be amended to remove the inconsistencies, to clarify the procedural requirements, and to make the process as congruent as possible with the civil commitment process. Finally, the Commission also recommends that the statutes governing commitment of juveniles be consolidated and clarified.

The 2009 mental health reforms included significant changes to Virginia's advance directives legislation. During the Commission's vigorous efforts to educate the public and pertinent stakeholder groups about the new advance directive law and to promote successful implementation, it received many comments and suggestions to improve and clarify the Health Care Decisions Act. The Commission will offer language for bill to take the necessary corrective action and to alleviate unnecessary costs.

System Integration and Access to Services

Many of the problems involving people with mental illness confronted by the judicial system are ultimately traceable to gaps in access to mental health services. This is especially so for people without health insurance. Untreated mental illness not only results in suffering by the individuals and families involved but also misdirects resources toward crisis response -- dispatching law enforcement to take the person into custody, conducting emergency evaluations in over-burdened emergency departments or other facilities, holding hearings before judicial officers, consuming many thousands of hours of judicial time and resources, and resulting far too often in costly inpatient care or incarceration. Although a significant investment in emergency services is a necessity even in the most enriched services system, Virginia's system is tilted disproportionately toward crisis response.

More effort should be directed toward reducing the likelihood and intensity of mental health crises. The Commonwealth should aim to assure a safety net of accessible recovery-oriented services and supports for adults with serious mental illness and children with or at risk of serious emotional disturbances. By so doing, it will reduce harms associated with mental illness and facilitate productive participation in social and economic life.

It is generally recognized that more resources are needed for public mental health services. But what is not so widely recognized is that the current dollars being spent are not being used as efficiently as they could be due to failure to fully align incentives to favor investments in community services. The public investment in the mental health safety net needs to be managed so that the existing structure of multiple service tracks is replaced by a single, integrated system managed to use the dollars efficiently to provide mental health services to people with serious mental illness in the most cost-effective manner.

In the Commission's view, the Commissioner of DBHDS should have the requisite authority to coordinate and facilitate integration of the services provided by state facilities and CSBs and other public and private agencies in accordance with the comprehensive state plan. Specifically, the Commissioner should be authorized to spend state funds budgeted for public mental health services in a manner that will strengthen financial incentives to serve clients in the community rather than in state facilities to the maximum extent compatible with the safety of the client and the community. This recommendation builds on the successful transformation and reinvestment initiatives developed by DBHDS over the last several years.

The General Assembly and local governments should strengthen emergency services and case management services provided by CSBs as first steps in a multi-year strategy of strengthening the safety net of public mental health services**.** As soon as resources are available, the General Assembly should explicitly require CSBs to provide a broad array of emergency services, including crisis stabilization, as well as case management services. DBHDS should also continue to use performance contracts for CSB-provided mental health, mental retardation and substance abuse services to help CSBs develop and sustain a full array of culturally competent, recovery-oriented emergency services, including crisis stabilization, and case management services and, over time, outpatient, day support and residential services, including specialized for children and adolescents, elderly persons, and persons under criminal charge, in jail or under supervision of the community justice system. These contracts should assure that the service standards and core expectations for each mandated core service are defined, promulgated, contracted for, measured and reported to the various stakeholders including, but not limited to, the Secretary of Health and Human Resources for the Commonwealth and each local government which is party to a CSB Performance Contract.

Comprehensive health insurance reform legislation currently under consideration in Washington, D.C. could have significant implications for the financing of mental

health services. Most importantly, it could provide coverage for a large proportion of people with mental illness who now lack insurance of any kind and whose care is subsidized by Commonwealth taxpayers in one way or another. In the Commission's study of emergency evaluations conducted by CSBs during June, 2007, 40% of the individuals evaluated were uninsured. Overall, approximately 50% of those with serious mental illness seeking care at CSBs are funded with a combination of state and local dollars.

The Commission also recommends responsible public agencies work together to remove barriers to providing housing supports to persons with serious mental illness, both to facilitate discharge from state facilities and to strengthen the prospects of successful community adjustment.

Over the coming year, the Commission will work with other public and private agencies to support and implement reforms of mental health services for children and adolescents; to conduct a systematic review of mental health needs of college and university students and legal impediments to meeting those needs; and to implement and strengthen programs to provide mental health services to individuals in lieu of or in conjunction with processing in the criminal justice system.

This page left blank intentionally.

I. MENTAL HEALTH LAW REFORM IN 2009

The 2009 General Assembly session was very productive for mental health law reform. Ten of the eleven bills recommended by the Commission were enacted into law. Below is a summary of the Commission bills that were enacted, followed by an overview of the activities undertaken by the Commission and public and private stakeholders to implement the new legislation.

A. Civil Commitment "Clean Up Changes."

HB 2060 (Hamilton)/SB 1083 (Howell) included a number of provisions designed to clarify and amend provisions adopted in the major overhaul of commitment law in 2008. It:

1. Amends § 37.2-808 to reaffirm that the emergency custody period when a law enforcement officer takes a person into custody based on his own observations without the prior issuance of an ECO is up to 4 hours. The bill also makes clear that a magistrate may extend the 4 hour period of emergency custody for persons held in custody on the initiative of law enforcement (without the prior issuance of an ECO) for an additional 2 hours for good cause shown (this extension authority for law enforcement initiated custody was inadvertently omitted from the 2008 bill). Good cause includes the need for additional time to allow (i) the CSB to identify a suitable TDO facility or (ii) to complete a medical evaluation if necessary.

2. Amends § 37.2-815 to make clear that the independent examiner attending a civil commitment hearing shall not be excluded from the hearing when the court issues an order to exclude witnesses.

3. Makes clear that the employee or designee of the CSB attending the commitment hearing shall not be excluded from the hearing when the court enters an order to exclude witnesses.

4. Amends § 37.2-816 to specify that the preadmission screening report is required to be admitted as evidence and made a part of the record in a civil commitment hearing, and is not just "admissible" in the discretion of the court. The purpose of this provision is to ensure that this critical report is available for all subsequent proceedings, such as recommitments or outpatient treatment determinations.

5. Amends § 37.2-817 to make clear that while a representative or designee of the community services board that prepared the preadmission screening report is required to attend the commitment hearing, the actual CSB employee or designee in attendance need not be the same person who prepared the report.

6. Amends § 37.2-819 to give District Court Clerks additional time to fulfill their reporting duties under this Code section. This provision amends the law to require the clerk of court upon receipt to certify and forward to the Central Criminal Records

Exchange (CCRE) as soon as practicable, but no later than the close of business on the next following business day, a copy of any order for involuntary admission to a facility or certification of any person who has been the subject of a TDO and subsequently agreed to voluntary admission. However, any order for MOT shall continue to be forwarded to the CCRE prior to the close of business on the day of receipt. This bill was requested by the District Court Clerks in order to address enormous difficulties encountered in attempting to comply with the "same day" CCRE reporting requirement for all commitment orders.

7. Amends § 19.2-182.9 to permit a judge, special justice or magistrate to extend the period of emergency custody for a person found not guilty by reason of insanity ("NGRI") of a criminal offense who is on conditional release one time for an additional two hours for good cause. Good cause includes additional time 1) to permit the CSB to identify a suitable TDO facility or 2) completion of a medical evaluation.

B. MOT for Juveniles

HB 2061 (Hamilton)/SB 1122 (Lucas) establishes MOT procedures for minors similar to those for adults. One significant difference from the adult procedures is that follow-up hearings and monitoring of MOT orders shall only be done by J&DR Court judges, not special justices. This bill also amended § 37.2-808 and 37.2-809 to state that magistrates issuing ECOs and TDOs for juveniles must apply the juvenile commitment criteria. This bill was a recommendation of the Commission's Children and Adolescents Task Force.

C. Protecting Human Dignity during the Commitment Process

HB 2460 (O'Bannon)/SB 823 (Cuccinelli) permits persons or providers other than law enforcement (such as family members, friends, CSB representatives, or other transportation providers) to transport persons who are under an ECO or a TDO or a commitment order. It also establishes procedures for service of ECOs and TDOs and transfer of custody from law enforcement to an alternative transportation provider. This was a recommendation of the Commission's Transportation Task Force and was a major legislative priority for the Commission during the 2009 Session.

HB 2459 (O'Bannon)/SB 1076 (Howell) provides a consumer receiving mental health services with the right to have a person of his/her choice notified of his/her condition, location or transfer to another location, and requires the DBHDS Board to amend the Human Rights Regulations to so provide.

HB 2461 (O'Bannon)/SB 1077 (Howell) clarifies Virginia Health Privacy Act requirements so health care providers may notify family members of a person's location and general condition under certain circumstances when the person is subject to civil commitment process, (i.e., when the person agrees to the notification, or when it is determined that notification is in the person's best interests).

D. Other Modifications of Commitment Statutes

HB 2486 (Ward)/SB 1079 (Howell) covers transportation situations where law enforcement is transporting a person voluntarily outside the law enforcement officer's jurisdiction. In such cases, law enforcement is permitted to take custody of person using law enforcement initiated custody authority if such person, who initially agreed to such transport subsequently revokes consent and provided such custody otherwise meets the requirements of the ECO statute.

SB 1078 (Howell) permits a special justice to collect, in addition to his fee and necessary mileage, any parking expenses, tolls and postage incurred in conducting commitment hearings. The House added an enactment clause providing that these costs would be absorbed by the Supreme Court's Involuntary Civil Commitment Fund.

SB 1081 (Howell) provides that a special justice serves at the pleasure of Chief Judge of circuit, rather than the Chief Judge who made the appointment. This amendment eliminates confusion over who had supervisory authority when a Chief Judge retired or the position rotated to a different judge.

SB 1082 (Howell) requires the Office of Executive Secretary of the Supreme Court to develop the petitions, orders and legal forms for custody, detention and involuntary admission. However, DMHMRSAS (DBHDS) retains the duty to develop the preadmission screening report, examination and other clinical forms.

E. Enhancing Self-Determination under the Health Care Decisions Act

SB 1142 (Whipple)/HB 2396 (Bell) empowers individuals to execute advance directives for mental health care. It also permits a health care agent to admit an incapacitated person, even over objection, to a mental health facility for up to 10 days if the person has authorized his/her agent to do so in an advance directive, under certain specified conditions. The new statute also makes a number of other changes to the Health Care Decisions Act and related statutes. One provision bearing on the commitment process permits a guardian to admit a person to a mental health facility for up to 10 days if the guardianship order specifically authorizes the guardian to do so after making other specified findings. This bill was a major priority for the Commission in 2009.

A number of other bills related to the Commission's work but not based on specific Commission Recommendations were also enacted: HB 2257 (Albo) permits judge or special justice to consider person's prior compliance or noncompliance with treatment when determining whether person is capable of accepting voluntary admission prior to the commitment hearing. Provisions in the original bill that related to MOT following a period of inpatient hospitalization were struck from the bill. HB 1948 (Shuler) expands the list of professionals who may conduct independent examinations

when psychiatrists and psychologists are unavailable to include licensed marriage and family therapists. These professionals will also be required to complete a certification program approved by DMHMRSAS (DBHDS).

F. Crisis Intervention Training

SB 1294 (Edwards) authorizes the Department of Criminal Justice Services to establish Crisis Intervention Teams ("CIT") throughout the Commonwealth from state and federal funds appropriated for that purpose. While the Commission did not recommend this bill for introduction in the 2009 Session due to a general budget concerns, the Commission did endorse the bill in Committee based on its support for CIT programs. On May 20, 2009, Governor Kaine announced CIT grants for the following areas:

* Alexandria CSB - $48,000.00
* Chesapeake CSB - $26,122.00
* Henrico MHMRS - $49,593.00
* Richmond BHA - $50,163.00
* Valley CSB (Staunton) - $26,122.00

G. Training and Implementation

At the conclusion of the General Assembly session, the Commission's Task Force on Training and Implementation ("Implementation Task Force" turned its attention to coordinating efforts to train the various stakeholders on the new laws. Much as they did in 2008, Implementation Task Force participants collaborated on the preparation of training materials and "cross-training" efforts so that all of those involved would receive similar information and advice for implementing the reforms. Implementation Task Force members also provided comments to the Office of Executive Secretary's Legal Research Department on the creation of new forms and revision of existing district court forms used in the involuntary commitment process.

Five regional trainings were conducted, and all the participants and stakeholders in the commitment process were invited to these trainings. The Supreme Court authorized and encouraged judicial branch officers to attend the regional trainings, including district court clerks and magistrates. The Implementation Task Force found that having most stakeholders from a geographic region present in one room at the same time allowed the presenters to focus on issues relevant to the particular region and to promote a common understanding of the new procedures. The Commission believes that this regional approach is the most efficient and effective means for addressing local program implementation issues, and should serve as a model for future mental health

training efforts. It will be especially important to encourage special justices to attend these programs in the future.

After the initial burst of training activity subsided, the Implementation Task Force turned its attention to monitoring the implementation and effectiveness of the mental health law reforms adopted in 2008 and 2009 to ascertain problems being encountered. Among the implementation issues carried over from 2008 and new issues arising as a result of the 2009 legislative changes that may require monitoring, are medical screening and assessment, communications between CSBs and emergency department physicians, recruitment and payment of independent examiners, and a possible shortage of attorneys in some jurisdictions.

This page left blank intentionally.

II. COMMITMENT PRACTICES AND OUTCOMES IN FY 2009

Informed oversight of the civil commitment process requires accurate data regarding the number, distribution and characteristics of ECOs, TDOs, commitment hearings and judicial dispositions. Adequate data were not available before 2008. Since the Commission was established in 2006, the courts and mental health agencies have collaborated to create the data systems needed for proper monitoring and informed policy-making. This process was accelerated in response to direction by the General Assembly after the reform legislation was enacted in 2008.

Significant progress in data collection and oversight has been made, but it will take time for the DBHDS, Supreme Court and CSBs to modify existing data collection protocols to ensure that all the necessary information is included, and for the agencies to resolve any issues that arise in the data collection processes. The Supreme Court made major improvements to its data collection systems to ensure that proper data was being collected. However, problems with local data entry are continually being identified and these problems have to be taken into account in interpreting the data presented here. Improvements will undoubtedly continue in FY10.

In this Progress Report, the Commission will estimate the numbers of ECOs, TDOs, commitment hearings and dispositions for FY 2009 and, to the extent possible, will assess whether commitment practices have changed in the wake of the reforms. (A full report on commitment data and dispositions for FY 2009 will be available on the Commission's web site.)

Available Databases

Court clerks at General District Courts document civil commitment hearings using the Supreme Court's Case Management System ("CMS"). Although it is technically a database for each District Court to track and record its cases[4], the CMS database is maintained by the Office of the Executive Secretary at the Supreme Court. It is divided into four sections for tracking the corresponding types of cases: traffic, criminal, civil, and involuntary civil commitment. Civil commitment hearings and related ECOs and TDOs are entered in the involuntary civil commitment division of the CMS database. Terminals at court clerk offices transmit the data to the Office of the Executive Secretary, which allows the merging of data from all District Courts.

The eMagistrate System is used by magistrates in all thirty-two judicial districts to issue arrest processes, bail processes, and other orders, which include ECOs and TDOs. Each time an ECO or TDO is issued, it is entered into the eMagistrate System, initiating

---

[4] The CMS database collects special justice pay codes from the DC-60; however, the Supreme Court Fiscal Department is the official collector of this type of information. For the purposes of this report, it was determined that case-based information from the CMS database was more useful than pay code information.

the ECO or TDO process by issuing the appropriate documents. ECOs and TDOs are counted in the eMagistrate System regardless of whether an ECO or TDO is successfully executed.[5]

The Virginia Association of Community Services Boards' Emergency Services Council ("ES Council") voted unanimously to collect data on inpatient commitments and TDOs issued during the first quarter of FY09 after the new mental health legislation went into effect to gain insight into how the new legislation affected TDO and commitment rates. The ES Council collected data from 39 out of 40 CSBs, each of which tracked the data using their own methods.[6] The "CSB TDO and Commitment Survey" collected the frequencies of TDOs (involving adults only) at each CSB and of inpatient or outpatient involuntary admissions ordered at civil commitment hearings attended by their staff. The rate of admissions reported for a CSB can depend on the number of TDO facilities in the CSB area and the jurisdictions in which the CSB has agreed to attend hearings. This data is available only for the first quarter of FY09.

In addition to the ES Council data, certain Community Services Boards collect and maintain their own permanent databases on civil commitment cases for their CSB. In this report, we also included data from Fairfax-Falls Church CSB as a comparison to the statewide data systems.

Emergency Custody Orders

The best available source of data regarding written ECOs is the Supreme Court's eMagistrate Data System. According to the eMagistrate database, there were about 500-600 ECOs per month during FY09. (See Table 1.)[7]

When people are taken directly into custody by law enforcement officers and brought to a mental health facility based on the officer's own observations, no formal ECO is executed. (These are called "paperless ECOs.") The number of paperless ECOs is unknown and will have to be ascertained directly from facilities conducting mental health evaluations. For example, in the Commission's June 2007 study of emergency evaluations conducted by CSBs, 24.3% of the individuals evaluated that month were in police custody at the time of the evaluation, but only 46.6% of those individuals were being held under a written ECO. Overall, at the present time, data regarding ECOs are incomplete.

[5] An ECO or TDO is issued by a magistrate but is only deemed successfully executed if the person is detained.
[6] Eastern Shore CSB did not have any data available.
[7] The Commission believes that the magistrate database is more reliable than the CMS database for the purpose of counting ECOs. It appears that the number of ECOs in the CMS database is too low to represent all ECOs issued and executed during the fiscal year. Although General District Court Clerks are instructed to record all orders, it appears that all ECO paperwork may not be making it to the court clerks for entry.

Table 1. Frequency of Adult ECOs During FY09 (eMagistrate)

Month	eMagistrate Data ECOs
July	603
August	523
September	481
1st Quarter Total	1,607
October	476
November	449
December	522
2nd Quarter Total	1,447
January	502
February	475
March	571
3rd Quarter Total	1,548
April	550
May	571
June	620
4th Quarter Total	1,741
Total	6,343

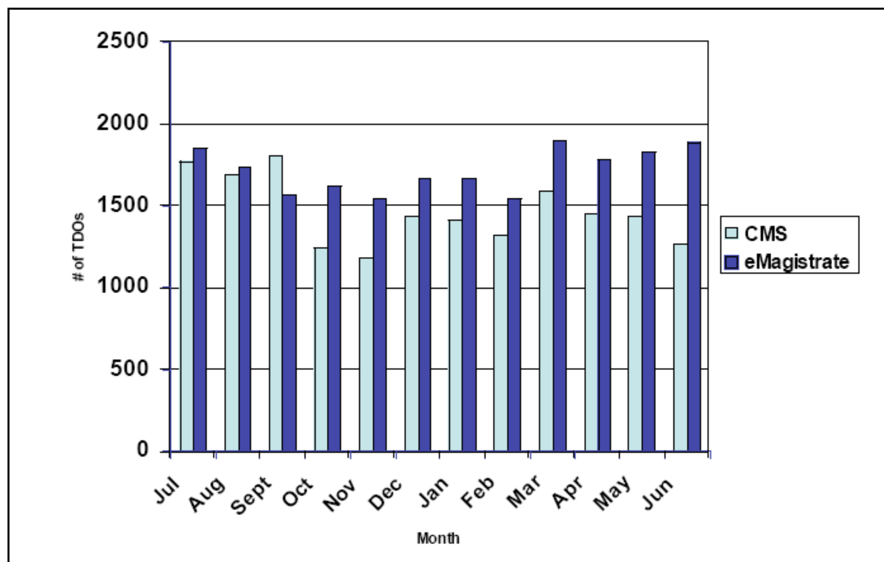
Temporary Detention Orders

The two databases maintained by the Supreme Court report different numbers for TDOs issued and executed during FY09. The number of TDOs issued for the fiscal year was 17,638 according to the CMS data, and 20,614 according to the eMagistrate data. (See Table 2.) As depicted in Figure 1, the eMagistrate typically records more TDOs in each quarter than the CMS database. One possible explanation for the eMagistrate picking up more cases is that TDOs are entered in the eMagistrate system as soon as they are issued, whereas the district court clerks enter the data in the CMS only when they receive the orders from the magistrates after the orders have already been issued or executed. As a result, it appears that some TDOs are not recorded in the CMS, either because the magistrates are not delivering the orders to the clerks or because the clerks are recording only one entry in the CMS (for the hearing) when they receive the TDO and the commitment order simultaneously.

Table 2. Frequencies of Adult TDOs Issued During FY09 (CMS and eMagistrate)

Month	CMS	eMagistrate
July	1,769	1,850
August	1,689	1,737
September	1,808	1,570
1st Quarter Total	5,266	5,157
October	1,243	1,627
November	1,189	1,540
December	1,444	1,674
2nd Quarter Total	3,876	4,841
January	1,419	1,668
February	1,326	1,541
March	1,591	1,905
3rd Quarter Total	4,336	5,114
April	1,451	1,783
May	1,445	1,832
June	1,264	1,887
4th Quarter Total	4,160	5,502
Total	17,638	20,614

Figure 1. CMS vs. eMagistrate: Frequency of Adult TDOs During FY09



The most important TDO number is how many TDOs were actually executed during FY09. The CMS data show that number to be 16,861. (See Table 3.) While the eMagistrate system more accurately documents the number of TDOs issued, the CMS system is the only database that records whether or not the TDO was executed. Based on the rate of execution in the CMS data, we estimate that at least 19,638 adult TDOs were executed during the fiscal year. (See Table 4.)

Table 3. Frequency of Adult TDOs in CMS during FY09

	CMS: Number of Adult TDOs		
	Executed	Unexecuted	Total
July	1,727	42	1,769
August	1,609	80	1,689
September	1,735	73	1,808
1st Quarter Total	5,071	195	5,266
October	1,179	64	1,243
November	1,133	56	1,189
December	1,375	69	1,444
2nd Quarter Total	3,687	189	3,876
January	1,353	66	1,419
February	1,261	65	1,326
March	1,526	65	1,591
3rd Quarter Total	4,140	196	4,336
April	1,394	57	1,451
May	1,375	70	1,445
June	1,194	70	1,264
4th Quarter Total	3,963	197	4,160
Total	16,861	777	17,638

Table 4. Estimated Number of TDOs Executed During FY09 (CMS and eMagistrate)[8]

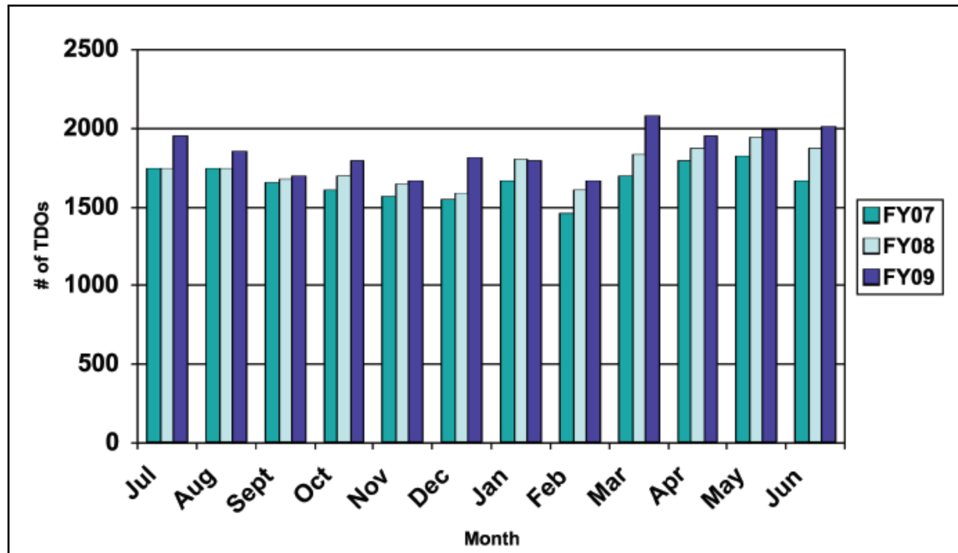
	Estimated Number of Adult TDOs	
	CMS	**eMagistrate***
1st Quarter	5,071	4,966
2nd Quarter	3,687	4,605
3rd Quarter	4,140	4,883
4th Quarter	3,963	5,241
Total	16,861	19,695

A key policy question is whether the number of TDOs has increased since the 2008 reforms went into effect. The Supreme Court's eMagistrate database suggests that the numbers of TDOs in almost every month of FY09 were somewhat higher (an increase of about 5%) than during those same months in FY07 and FY08. (See Figures 2 and 3.) However, the numbers of adult TDOs for ALL of calendar year 2008 were notably higher than those during calendar years 2006 and 2007. If these data are accurate, the spurt in

[8] Numbers of executed TDOs in the eMagistrate and CSB data are estimated numbers based on the percentage of TDOs in the CMS database that were unexecuted (3.7% in the first quarter, 4.88% in the second quarter, 4.52% in the third quarter, and 4.74% in the fourth quarter). The eMagistrate System does not show whether a TDO was executed or unexecuted.

TDOs began in January 2008, and the rate of increase actually *declined* after the new law went into effect in July 2008, followed by a period of irregularity from September through December 2008, when TDO rates went up and down. This suggests that the increase in adult TDOs during 2008 is attributable to factors that preceded the effective date of the new law.[9] It is possible that the apparent increase beginning in January 2008 (including the first quarter of FY09) is a function of improved record-entry practices by magistrates rather than real changes in TDO frequency; however, since a similar increase appears in calendar year 2009 and in the CSB survey data (see below), we are inclined to think that there has been a genuine increase in the number of TDOs since January, 2008.

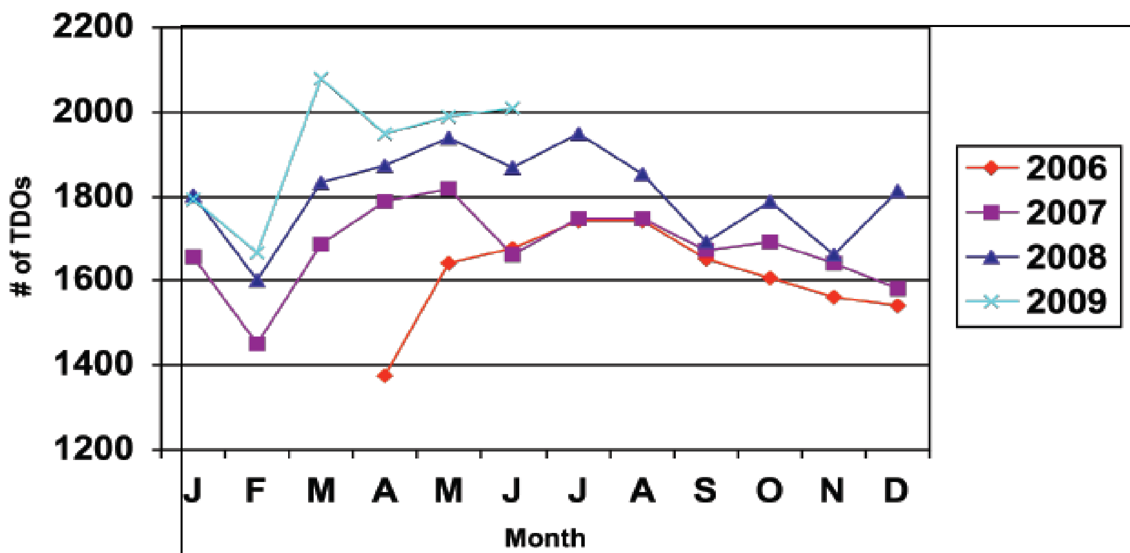
Figure 2. Frequencies of TDOs by Month for FY07 through FY09 (eMagistrate)



---

[9] Interestingly, the increase did NOT begin during April or May of 2007 in the wake of the Virginia Tech killings. The TDO numbers during April-December of 2007 were nearly identical to the numbers during April-December, 2006. We surmise that the TDO increase during the first six months of 2008 represents an educational effect – the deliberations in the late fall by the Commission and the General Assembly relating to proposed modifications of the commitment criteria, together with accompanying media coverage, may have heightened awareness of the issues by CSB ES staff and begun to influence their decisions at the margins in early 2008. Because this effect might otherwise have occurred in July after the modified criteria had been adopted, it might be seen as an anticipatory effect.

Figure 3. Frequencies of TDOs in eMagistrate System, 2006 – 2009



The CSB data, which were only available for the first quarter of FY09, suggest that the number of TDOs may have increased about 8% compared to the first quarter of FY08 (although there have been substantial differences among localities). (See Table 5.) However, FY07 was the first year that most CSBs systematically recorded the number of TDOs, and the numbers for 2007 may be less accurate than the numbers for FY08.

Table 5. Frequency of Adult TDOs in CSB TDO and Commitment Survey[10]

Number of TDOs July-September							
CSB	**2007**	**2008**	**% Increase**	**CSB**	**2007**	**2008**	**% Decrease**
Hanover	32	70	119%	Richmond	489	481	-2%
Highlands	39	71	82%	Mid. Penin.-Northern Neck	91	88	-3%
Arlington	65	107	65%	Norfolk	170	158	-7%
Valley	34	52	53%	Henrico	213	197	-8%
Loudoun	53	81	53%	Crossroads	60	55	-8%
Portsmouth	58	87	50%	Colonial	59	54	-8%
Southside	56	78	39%	Central Virginia	235	215	-9%
Alleghany Highlands	22	29	32%	Prince William	209	190	-9%
Alexandria	44	56	27%	Cumberland Mtn.	86	72	-16%
Virginia Beach	192	237	23%	Harrisonburg-Rockingham	57	48	-16%
Mt. Rogers	210	256	22%	Northwestern	157	129	-18%
Chesapeake	87	106	22%	Planning District One	96	76	-21%
Blue Ridge	423	513	21%	Dickenson	18	14	-22%
Hampton-Newport News	234	273	17%	Goochland-Powhatan	13	8	-38%
District 19	182	211	16%	Rockbridge Area	23	10	-57%
Fairfax-Falls Church	212	245	16%	**Total 2007 TDOs: 4,881** **Total 2008 TDOs: 5,285** **Average Percent Change: 8%**			
Region Ten	92	106	15%				
Piedmont	77	88	14%				
Chesterfield	64	72	13%				
Western Tidewater	103	111	8%				
Rappahannock-Rapidan	145	151	4%				
Rappahannock Area	115	119	3%				
Danville-Pitts.	113	116	3%				
N. Riv. Valley	253	255	1%				

Fairfax-Falls Church CSB has maintained its own data on TDOs since 2005. As shown in Figure 4 and Table 6, there was a big jump in TDOs in Fairfax-Falls Church during December 2007 and January 2008, and the increase continued in 2008. In general,

[10] CSBs are listed in order of greatest percentage increase to greatest percentage decrease.

however, the TDO rates in 2009 have so far been slightly lower than those of 2008, with the exception of March and April 2009. Even so, the 2009 TDO rates in Fairfax-Falls Church continue to show an increase from previous years. These data lend further support to the hypotheses that there has been a real increase in TDOs during the past year and that the increase preceded the effective date of the new law.[11]

Figure 4. Frequency of TDOs in Fairfax-Falls Church CSB, 2005-2009

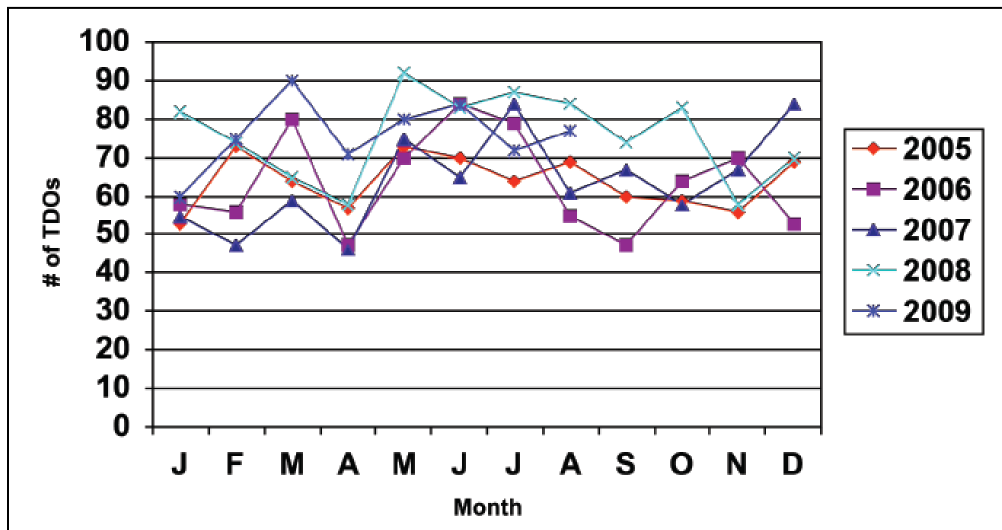


Table 6: Frequency of TDOs in Fairfax-Falls Church CSB, 2005-2009

	Frequency of Adult TDOs in Fairfax-Falls Church CSB				
	2005	2006	2007	2008	2009
January	53	58	55	82	60
February	73	56	47	74	75
March	64	80	59	65	90
April	57	47	46	58	71
May	73	70	75	92	80
June	70	84	65	83	84
July	64	79	84	87	72
August	69	55	61	84	77
September	60	47	67	74	
October	59	64	58	83	
November	56	70	67	58	
December	69	53	84	70	
Total	767	763	768	910	

[11] As noted in footnote 7, why this increase has occurred is an interesting question. One hypothesis that is NOT supported by the data is that the increase is attributable to an increased risk-averseness by CSBs in the wake of the Virginia Tech shootings. Neither the eMagistrate data nor the Fairfax-Falls Church data indicate a rise in TDOs during the summer months in 2007.

From all of these data sources, the Commission estimates that TDOs were about 7% higher during FY09 than during FY08. However, it seems likely that the rate of increase is receding.

All Adult Commitment Hearings

At this time, the best source of data on the number of commitment hearings and the dispositions of these hearings is the Supreme Court's CMS data system. The number of commitment hearings for FY09 was about 24,213. This includes 21,821 initial adult hearings, and 2,347 recommitment hearings.[12] (See Table 7.) We have reasonable confidence in the completeness of the CMS data on commitment hearings because there is no indication of under-reporting of hearing data by the district court clerks. [13]

[12] The number of recommitment hearings in the 2nd, 3rd, and 4th quarters were determined using a paycode that special justices designate for recommitment hearings. This may not be the most reliable way to determine a recommitment hearing, but it is the best method that was available to us given the data constraints.

[11] The number of initial hearings conducted (that is, excluding recommitments) is somewhat higher (about 10%) than the estimated number of executed TDOs recorded in the eMagistrate database. One possible explanation is that some patients originally admitted as voluntary patients may later he held over objection. Another reason that the number of commitment hearings may be higher than the number of TDOs is that prisoners are not issued TDOs before a civil commitment hearing. (Jail hearings are included in the 2nd, 3rd, and 4th quarter numbers.) Finally, when hearings are transferred to a different jurisdiction, they are sometimes entered twice – once in the district where the TDO occurred and once in the district to where the hearing is transferred.

Table 7. Frequency of Adult Civil Commitment Hearings During FY09 (CMS)[14]

	CMS: Frequency of Adult Hearings		
	Initial Hearing	Recommitment	Total
July	1,772	173	1,968*
August	1,754	195	1,959*
September	1,901	309	2,222*
1st Quarter Total	**5,427**	**677**	**6,149***
October	1,829	202	2,031
November	1,585	180	1,765
December	1,892	207	2,099
2nd Quarter Total	**5,306**	**591**	**5,897**
January	1,797	153	1,950
February	1,687	173	1,860
March	2,062	195	2,257
3rd Quarter Total	**5,546**	**525**	**6,071**
April	1,901	221	2,122
May	1,898	177	2,075
June	1,743	153	1,896
4th Quarter Total	**5,542**	**554**	**6,096**
Total	**21,821**	**2,347**	**24,213***

*These totals include jail detainees

Initial Adult Commitment Hearings[15]

We do not have comparable data at hand for FY08, but it seems likely that there were more initial commitment hearings in FY09 than in FY08. Based on the data obtained at the time of the Commission's study of commitment hearings during May 2007, and on inferences drawn from TDO data, it is possible that the increase has been in the range of 5-8%. It must be emphasized, however, that this is based almost entirely on inference from other databases rather than from the CMS database itself. We expect the CMS database will be a reliable source of year-to-year comparisons in the coming years. We are also advised that payments to special justices by the Supreme Court under the IMC fund increased significantly from FY08 to FY09, adding support for a real increase in commitment hearings..[16]

---

[14] The first quarter data analysis was able to determine the number of hearings involving jail detainees. There were 45 hearings involving jail detainees in the first quarter. We were unable to distinguish jail hearings from initial and recommitment hearings in the data from subsequent quarters, so the 45 jail hearings are not included in the chart as a separate column, but they are added into the totals. We are working with the Supreme Court to get a code added into the CMS database so that we will be able to distinguish jail hearings in the future.

[15] This analysis excludes commitment hearings involving jail detainees and recommitment hearings. These two categories are analyzed separately.

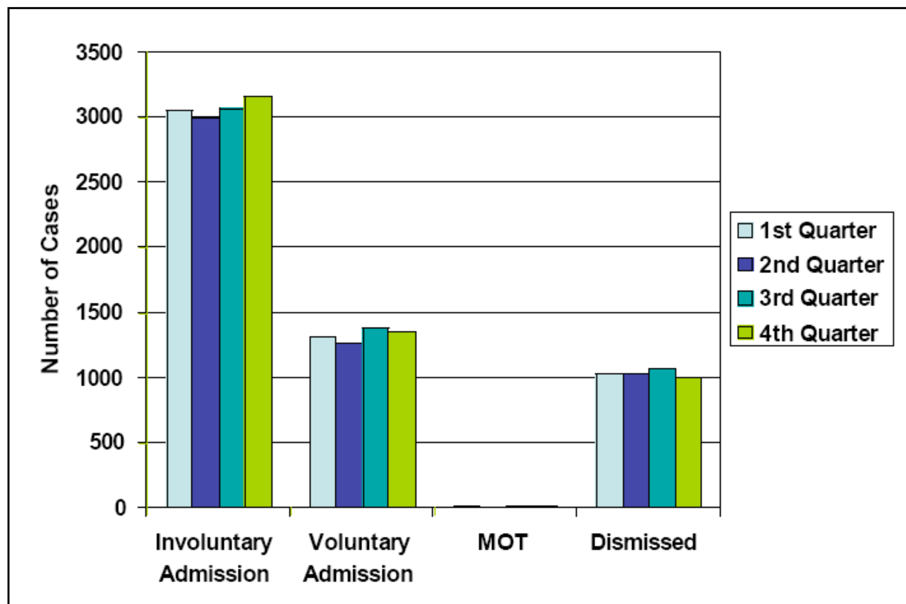
[16] Payments increased from $1,946,291 in FY08 to $2,305,391 in FY09 (18.5%), but we believe that this is an overestimate of the increase in civil commitment hearings. Payments are made to special justices when the paperwork is submitted to the Supreme Court, not necessarily when the hearing occurs, and payments include juvenile hearings as well.

The CMS data system also provides information on the dispositions of initial adult hearings held in FY09. We have reasonable confidence in this data from the CMS system because of the stability of the data from month to month. However, there were data entry and coding issues identified that may affect the accuracy of data in certain districts. (See “Discussion of CMS Data” below). As shown in Table 8, during FY09, about 56% of the hearings resulted in involuntary admission, about 24% resulted in voluntary admission and about 19% of the cases were dismissed. Only a handful of the total cases (less than .5%) resulted in mandatory outpatient treatment (MOT) orders. (See Figure 5.) If the Commission’s study of hearings conducted in May 2007 was representative of hearing practice and outcomes in FY 2007, there were fewer MOT orders and fewer voluntary hospitalizations, and correspondingly more involuntary hospitalizations and dismissals in FY 2007 than in FY 2007.

Table 8. Frequencies of Dispositions at Initial Civil Commitment Hearings for FY09 (CMS)

	Involuntary		Voluntary		MOT		Dismissal		Total
	N	%	N	%	N	%	N	%	
July	998	56.32	423	23.87	7	0.40	344	19.41	1,772
August	1,030	58.72	411	23.43	5	0.29	308	17.56	1,754
September	1,033	54.34	482	25.35	6	0.32	380	19.99	1,901
FQ Total	**3,061**	**56.40**	**1,316**	**24.25**	**18**	**0.33**	**1,032**	**19.02**	**5,427**
October	1,060	57.96	436	23.84	1	0.05	332	18.15	1,829
November	895	56.47	401	25.30	3	0.19	286	18.04	1,585
December	1,045	55.23	432	22.83	6	0.32	409	21.62	1,892
SQ Total	**3,000**	**56.54**	**1,269**	**23.92**	**10**	**0.19**	**1,027**	**19.35**	**5,306**
January	965	53.70	460	25.60	4	0.22	368	20.48	1,797
February	984	58.33	397	23.53	5	0.30	301	17.84	1,687
March	1,125	54.56	533	25.85	3	0.14	401	19.45	2,062
TQ Total	**3,074**	**55.43**	**1,390**	**25.06**	**12**	**0.22**	**1,070**	**19.29**	**5,546**
April	1,104	58.07	440	23.15	12	0.63	345	18.15	1,901
May	1,087	57.27	461	24.29	6	0.32	344	18.12	1,898
June	977	56.05	454	26.05	4	0.23	308	17.67	1,743
FQ Total	**3,168**	**57.16**	**1,355**	**24.45**	**22**	**0.40**	**997**	**17.99**	**5,542**
FY09 Total	**12,303**	**56.38**	**5,330**	**24.43**	**62**	**0.28**	**4,126**	**18.91**	**21,821**

Figure 5. Frequencies of Dispositions at Initial Civil Commitment Hearings: CMS FY09



Commitments to Inpatient Treatment

From a resource standpoint, one of the key questions is how many people are committed to inpatient treatment, and whether that number has increased as a result of the 2008 reforms. Again, based on the apparent increase in number of hearings and the apparent increase in the proportion of hearings resulting in commitment to inpatient treatment (perhaps 5%), it seems likely that there were more people involuntarily committed to hospitals during FY09 than during FY08.[17] The actual numbers, based on CMS data, were about 3,000 people per quarter. However, the increase preceded the effective date of the new law and has probably been accompanied by a decline in the number of voluntary admissions.[18]

Mandatory Outpatient Treatment

One of the most striking findings based on the FY09 data is that MOT orders have been rare. Although a precise figure is not yet available, the Commission estimates that there were approximately 75 MOT orders during FY09 and a majority of them occurred

[17] The CSB database was incomplete for numbers of inpatient commitments. However, the localities reporting numbers of commitments for both FY08 and FY09 reported a 22% increase. The Commission believes that the numbers reported are not reliable; in particular, it is likely that a significant portion of the cases reported as involuntary commitments were cases in which the respondent agreed to voluntary admission.

[18] The Fairfax- Falls Church CSB data also show that a significant increase in involuntary admissions in the first quarter of FY09 was accompanied by a precipitous decline in voluntary admissions, resulting in no overall increase in the number of hospitalizations.

in only a few jurisdictions.[19] Based on the Commission's study of hearings in May, 2007, it is possible that there were as many as 750 MOT orders in FY08.[20] The infrequency of MOT orders is finding led the Commission to survey CSBs during the first quarter of FY09 and then again during the first quarter of FDY 2010, inquiring about the possible explanations for the decline in what had already been a relatively rare practice. The data will be presented in the next section of this Report.

Virginia State Police Data on Hearing Dispositions

A second potential source of data on hearing dispositions is the Virginia State Police ("VSP"). The clerks of the District Courts are required to send VSP the names of individuals (1) committed to inpatient or outpatient treatment and (2) who consent to voluntary admission after detention under a TDO. In theory, the numbers should match the numbers in the CMS database for these same dispositions at commitment hearings. (See Table 10.) However, the Commission decided not to rely on the VSP data because there are significant discrepancies between the CMS data and the VSP data, and it is likely that the reporting of this information to the VSP has not yet become streamlined and there may be a backlog of orders sent to the VSP each month.[21]

---

[19] We have reason to believe that MOTs are underreported in the CMS database. It came to our attention that court clerks in some districts were miscoding MOTs, and that there may be confusion about MOT codes in these districts. An investigation into these coding issues is currently ongoing.
[20] The Commission's hearing study reported that there were 73 MOT orders in May 2007.
[21] The data in the two systems are somewhat less discrepant for the numbers of people who agreed to voluntary admission after issuance of a TDO. The VSP data reflect about 4,783 such cases for the FY09 – less than, but reasonably close to the number of voluntary post-hearing admissions for the quarter (5,330) recorded in the CMS database.

Table 10. First Quarter Involuntary Out / Inpatient Treatment: State Police vs. CMS[22]

	Freq. of Adults Admitted to Involuntary In/Outpatient Treatment	
	State Police	**CMS**
July	1,161	1,187
August	1,161	1,223
September	1,119	1,349
1st Quarter Total	**3,441**	**3,759**
October	1,179	1,255
November	967	1,073
December	1,022	1,244
2nd Quarter Total	**3,168**	**3,572**
January	914	1,114
February	948	1,153
March	1,108	1,316
3rd Quarter Total	**2,970**	**3,583**
April	1,099	1,327
May	1,031	1,263
June	1,109	1,122
4th Quarter Total	**3,239**	**3,712**
Total	12,818	14,626

Recommitments

Figures 6 and 7 display the numbers and dispositions of recommitment hearings during FY09. They are very similar to the numbers and disposition rates in the Commission's May 2007 study. Almost all recommitment hearings resulted in continued hospitalization, and a large majority of cases were involuntary hospitalizations.

[22] For comparison to VSP data, which records *any* involuntary admission or MOT orders, CMS data for FY09 were tabulated to include not only ordinary involuntary inpatient admissions and MOT, but also involuntary admissions and MOT orders from recommitment hearings and involuntary admissions involving people detained in jail.

Figure 6. Frequency of Recommitment Hearings

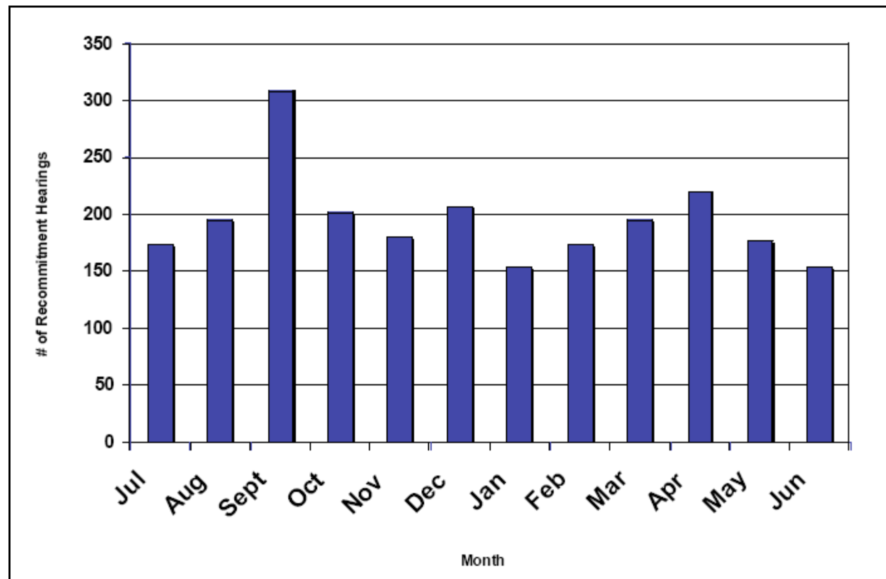
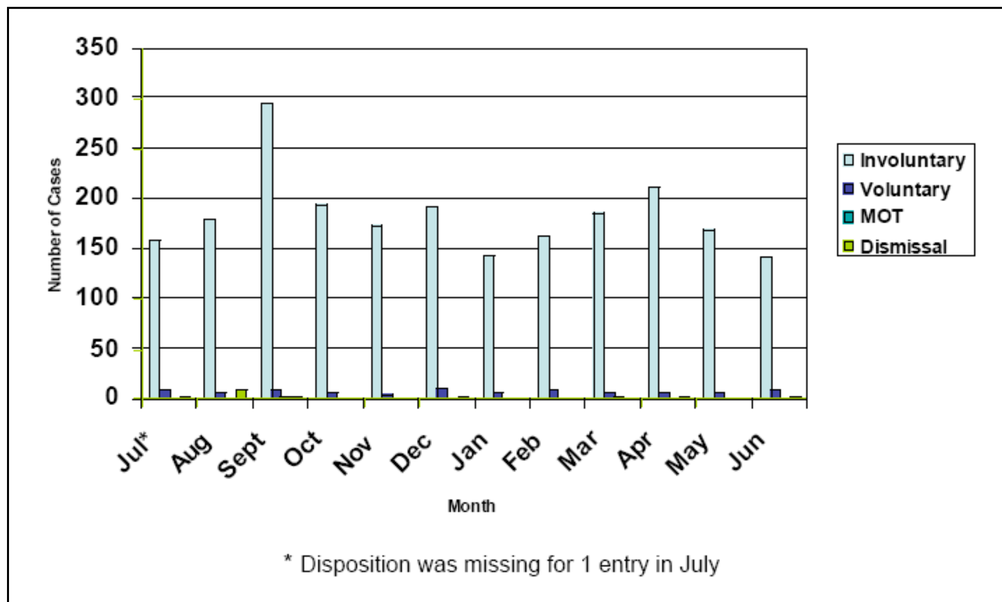


Figure 7. Frequencies of Dispositions at Recommitment Hearings



Summary of Key Findings

The Commission estimates that TDOs were about 7% higher during FY09 than during FY08. However, it seems likely that the increase preceded the effective date of the new commitment law and that the rate of increase is receding. It also seems likely that there were more initial commitment hearings in FY09 than in FY08. Based on the data obtained at the time of the Commission's study of commitment hearings during May 2007, and on inferences drawn from TDO data, it is possible that the increase has been in the range of 5-8%.

During FY09, about 56% of initial commitment hearings resulted in involuntary admission, about 24% resulted in voluntary admission and about 19% of the cases were dismissed. Only a handful of the total cases (less than ½ of one percent) resulted in mandatory outpatient treatment (MOT) orders. If the Commission's study of hearings conducted in May 2007 was representative of hearing practice and outcomes in FY 2007, there were proportionately fewer MOT orders and voluntary hospitalizations (about 5% fewer of each), and correspondingly more involuntary hospitalizations and dismissals (about 5% more of each) in FY 2009 than in FY 2007.

This page left blank intentionally.

III. CONTINUING CONCERNS ABOUT IMPLEMENTATION OF COMMITMENT REFORM

For the first time, civil commitment has become a visible process, subject to review and oversight. The Commonwealth now has reliable data systems that enable policymakers to monitor and evaluate the operation of the commitment process. Based on the review of data from FY 2009 and the first quarter of FY 2010, the Commission believes that two aspects of current commitment practice require critical attention – the infrequency with which MOT is ordered, and the wide variations in the outcomes of commitment proceedings among district courts. Each of these subjects will be addressed below.

A. Mandatory Outpatient Treatment

Before July 1, 2008, MOT (sometimes called "involuntary" outpatient treatment), was an optional disposition in the Virginia civil commitment process, but was ordered infrequently and monitored inconsistently.[23] The 2008 mental health legislation provides detailed procedures for implementing MOT orders under Virginia Code §37.2-817.

Analysis of MOT Orders

Beginning July 1, 2008, the Commission requested the files of every case that resulted in an MOT disposition, asking specifically for copies of the 1006-CO (the commitment order), 1006-IE (the report of the independent examiner) and MOT plan from each of these cases. We received a total of 90 MOT files through 11/30/09[24]; however, not every file included all of the requested information. The data for this report was collected from an extensive review of the MOT case files that were received from the courts.

Form 1006-IE sets forth the independent examiner's assessment of the client's mental health status, but in some cases, it also includes notes on the client's treatment preferences as well as the CSB's treatment preference for the client. The 1006-CO provides information on the hearing. Finally, the MOT plans, when included, provides information on the specific treatment services, conditions, and details on compliance monitoring specified for the client's treatment. More detailed MOT plans also included notes on client treatment preferences. When these forms are unavailable, we attempt to gather relevant information from the available forms wherever possible.

As shown in Table 1, a majority of MOT cases came from the Prince William and Staunton General District Courts.

---

[23] Bonnie, Richard J. Statement prepared for Virginia Tech Review Panel, July 18, 2007.

[24] Data entered for this same period in the Supreme Court's Case Management System record 75 MOT orders from July, 2008 through June, 2009, and 46 for July-November, 2009, a total of 121. This suggests that we are receiving about 75% of the files.

MOT was used most frequently in cases involving clients whom the court determined to be either "likely to harm self" or "lacked the capacity to protect self or provide for basic human needs." In the files where information was available, we found that most of the clients agreed to the use of MOT, signifying that MOT is used when clients express a willingness to accept treatment. Also, in the majority of MOT cases, MOT was ordered in accordance with the independent examiner's recommendation. Only a handful of cases where the independent examiner recommended involuntary hospitalization or dismissal ended up with MOT dispositions.

Table 1. Frequency and Percentage of FY09 MOT Orders Received by Locality

Locality	Frequency	Percentage
Prince William	36	40.0
Staunton	20	22.2
Danville	10	11.1
Fairfax	7	7.8
Russell	5	5.6
Smyth	4	4.4
Lancaster	1	1.1
Montgomery	1	1.1
Richmond	1	1.1
Roanoke	1	1.1
Salem	1	1.1
Missing	3	3.3
Total	90	100.0

More than 40% of the clients placed under MOT were required to receive substance abuse treatment services as well as services for treatment for mental illness. A wide variety of services were offered to clients in their treatment plans, although the degree of detail varied among CSBs. At a minimum, compliance with the treatment plans included the condition that clients "must attend all meetings and appointments;" however there were other conditions specified in the plans according to the client's needs. Although most of the treatment plans involved CSB staff only, a handful of treatment plans included private providers. Compliance was generally monitored through meetings and appointments that were scheduled as part of a client's treatment. A majority of these meetings and appointments occurred once a week. Most CSBs determined a client to be materially non-compliant if the client missed three consecutive appointments without making arrangements to reschedule; however this was not a common occurrence.

Survey of CSBs on MOT

A ten-question survey was conducted using the online survey tool Survey Monkey from November 10, 2009 through November 30, 2009. A total of 32 CSBs responded. A key issue explored in the survey is why MOT is so rarely used. Of the 32

respondents, a large majority (87.5%) reported having a total of five or fewer MOT cases since the new laws went into effect on July 1, 2008. One CSB reported having seven cases and three CSBs reported having more than ten cases. (See Table 8.) This data confirms the finding that a majority of MOT cases are occurring in a very small number of jurisdictions. In fact, 80% of CSB respondents reported that MOT cases at their CSB had stayed the same or decreased since the new laws went into effect.

Table 2. Frequency of MOT Cases at CSBs Since July 1, 2008

# of Reported MOT Cases since July 1, 2008	# of CSBs
None	13
1 – 5	15
6 – 10	1
More than 10	3

When asked for their opinions of why MOT orders might be declining, CSB respondents cited similarities between MOT criteria and inpatient admission criteria, as well as the burden of MOT laws on judges and CSBs. Table 9 shows the explanations and the percent of CSBs who thought the explanation was "highly relevant" or "relevant."

Table 3. Explanations for Decline in MOT Use

Explanation	% of CSBs
MOT criteria are the same as inpatient admission criteria	70.3%
Burden of new MOT laws on judges	66.7%
Burden of new MOT laws on CSB	62.9%
Judges' interpretation of new laws	59.2%
Insufficient behavioral health resources	55.5%
Turnaround time for development of MOT plan is too short	40.7%

The survey results on the services that are being provided to MOT clients corresponded with our analysis of MOT plans. CSB survey respondents indicated that Medication Management, Individual Therapy, and Case Management were the top three services being provided, followed by Substance Abuse Services and PACT/ICT Services. Interestingly, a majority of CSB respondents (73.3%) reported that their CSB had adequate resources to deal with clients under MOT orders. However, respondents also indicated that the availability of the clinical staff to see clients is very limited, and many of the respondents reported that their CSBs would not be adequately prepared to handle additional cases, if MOT use were to increase.

The Commission's survey on MOT also asked CSBs to indicate the most common circumstances for which they would recommend MOT for a patient at their commitment hearing. There were four general circumstances that emerged from their responses. The most common scenario that would warrant a recommendation for MOT is a situation in which a client has been through multiple hospitalizations and failed to comply with outpatient follow-up upon discharge. Some examples of CSB responses that indicated this situation are as follows:

- "When a consumer who has had multiple hospitalizations under a TDO has failed to follow-up with mental health and psychiatric services upon discharge."
- "Long-term clients who have a history of non-compliance and have tried all less restrictive alternatives."
- "Previous history of failure to comply with services, resulting in repeated involuntary hospitalizations, but not currently seen as dangerous."

The second most common circumstance for which CSBs would recommend MOT is when a client is actively engaged in treatment or understands and acknowledges a need for treatment. Some examples of the responses that indicated this situation were: "Individual is active/engaged in treatment; agreeable to MOT; cognitively insightful into own illness and understand need for continued treatment." "If client has capacity and is willing." "Individual is willing to participate, has the capacity to understand, and is not a significant danger to others."

Lastly, noncompliance with outpatient services in general, with or without a history of multiple hospitalizations, was a common circumstance for which MOT would be deemed appropriate by CSB staff. One CSBs respondent said, "Currently or previously having received intensive outpatient services (PACT, Psychiatric rehabilitation) but noncompliant." Another CSB said, "…lack of capacity on the part of the consumer to follow through." Some CSBs indicated that MOTs were recommended to clients who needed "encouragement to participate in outpatient treatment." They viewed MOT as a way to provide "additional motivation for client to attend services."

Interviews with CSB Staff in Prince William and Fairfax/Falls Church

CSB representatives identified a few barriers to the use of MOT since the new laws went into effect. First, some of the special justices are opposed to MOT because they "don't want the headache," and because the MOT cases "keep them on the hook." Special justices are required to approve of the comprehensive treatment plan that is drafted by CSBs after the hearing occurs, and are also responsible for overseeing the compliance process if a client is non-compliant. CSB representatives reported that some special justices have expressed the view that the new MOT statutes involve too many complicated steps and they are not given additional compensation to follow through with each step. However, some CSB representatives also believed that as more MOTs are

ordered, everyone involved becomes more comfortable doing MOTs. In Prince William County CSB, there were 18 MOT orders in the first quarter of FY10 a substantial increase from FY09, when there were only 13 entered during the entire year.

From the perspective of the Fairfax-Falls Church CSB, MOT may be more difficult to implement due to a general lack of resources. Many of the services that are appropriate for a client's treatment have long waiting lists. To further complicate things, CSBs are required to draft a comprehensive MOT treatment plan within 5 days of the commitment hearing. Meeting this 5-day deadline can be especially challenging since the CSB has to get all of the resources in place, all of the providers on board, and the providers, CSB, client and special justice must all agree on a treatment plan. If a particular service is unavailable to the client at the time of the hearing, the CSB often cannot recommend MOT for that client. CSB representatives have expressed that implementing MOT might be less challenging if they had a longer turnaround time to set up the necessary services

At Prince William County CSB, two aspects of their civil commitment process help make MOT more feasible. First, they almost always utilize the full 48-hours TDO period. CSB representatives stated that this period of detention "can be helpful to the client and can change the way the client is thinking and behaving," oftentimes allowing them to become more open to treatment on an outpatient basis. Secondly, in addition to the required prescreening that takes place following a TDO, Prince William County CSB performs a second evaluation of the client immediately prior to the hearing. It is often during this second prescreening that a client might express a willingness to participate in outpatient treatment and the CSB representative will draft an initial treatment plan to submit to the special justice at the hearing.

Prior to the revision of MOT laws, Prince William County CSB would often recommend dismissal for clients who they felt were not exhibiting symptoms severe enough to warrant inpatient treatment. They would then schedule outpatient follow-up care to these clients so that they could monitor the client's progress after the hearing. Now, these clients are the ones who are being recommended for MOT. The revised MOT laws provide a more formal infrastructure for the CSBs to follow-up with and offer outpatient treatment to clients who "fall somewhere in between inpatient and dismissal, almost as a compromise." With few exceptions, clients who are under MOT orders in Prince William County and Fairfax-Falls Church have been very cooperative with treatment.

Assessment

MOT in Virginia is structured as a less restrictive alternative to hospitalization for individuals who meet the criteria for involuntary admission but are willing to agree to comply with an order for mandatory outpatient treatment. Given the acuity of clinical dysfunction and distress that typically characterizes individuals who meet the commitment criteria, discharge from the hospital after 48 hours is not likely to be

clinically appropriate in the great majority of cases.[25] However, even if the law were unchanged, it is conceivable that MOT orders would be clinically appropriate in a somewhat higher proportion of cases than the miniscule fraction (a half of 1%) in which they are being ordered at the present time if (1) the duration of the TDO period were lengthened to 72 or 96 hours; and (2) CSB capacity to provide intensive outpatient services, including medication, were increased. The Prince William experience supports these observations.

As discussed in Chapter 4 of this Progress Report, the Commission favors lengthening the TDO period to 72 hours (96 on weekends or holidays) for a variety of reasons, including the prospect that doing so will avoid unnecessary commitment to involuntary hospitalization. MOT orders would be one of the devices that could be usefully deployed if more hearings were more than 48 hours after the TDO admission.

The key remaining policy question is whether MOT orders should be available in cases in which the individual does not currently meet criteria for involuntary admission. Clearly, use of MOT would increase if such orders were available in cases in which (1) a person's condition were deteriorating even though they do not yet meet the criteria for inpatient admission; or (2) or a person already under a commitment order was becoming stabilized but would not yet be suitable for discharge in the absence of mandated intensive services. The first type of MOT is called "preventative MOT" and the second is called "step down" MOT. The Commission has been studying the possibility of using MOT in these two situations since it was first established in the fall of 2006. As discussed in Chapter 4, the Commission regards "step-down" MOT as the next logical extension of current policy, but remains opposed to either of these approaches at the present time due to lack of service capacity.

B. Variations in Outcomes of Civil Commitment Hearings

In previous reports, the Commission has called attention to the startling variations in disposition of civil commitment hearings among the Commonwealth's district courts. The initial findings documenting these variations were presented in the Commission's report on Civil Commitment hearings conducted during May, 2007. That report can be found at
http://www.courts.state.va.us/programs/cmh/2007_05_civil_commitment_hearings.pdf

After the first wave of commitment law reforms enacted by the General Assembly went into force on July 1, 2008, the Supreme Court began collecting data on the dispositions of civil commitment hearings as part of its Case Management System. During FY 2009, the Commission's research staff worked closely with the Office of the Executive Secretary of the Supreme Court to monitor the coding and reporting of

[25] Even if all other impediments to using MOT were removed, it is unlikely that MOT orders will ever exceed 5% of commitment cases on a statewide basis. Moreover, given the vast differences in outpatient service capacity around the state, MOT orders are always likely to be concentrated in a few localities

disposition data by the district court clerks and to assure that the reported data are accurately interpreted. The Commission has relied on these data in its progress reports on mental health law reform in December, 2008 and in December, 2009.

The CMS data for FY 2009 consistently revealed the same wide variations in disposition previously documented for hearings conducted during in May, 2007. However, in an excess of caution, the Commission decided not to prepare a report on these variation using FY 2009 data because of concerns that the data presented in some jurisdictions may be attributable to coding and reporting errors. Instead, the Commission decided to defer any report on this subject until data were available for FY 2010. In this report, the Commission summarizes the disposition of commitment hearings for the first quarter of FY 2010. The data presented below pertain only to hearings involving adult respondents not under a commitment order or in confinement at the time of the hearing. (In other words, the data exclude recommitment hearings as well as cases involving juveniles and persons in jail.) We refer to these hearings as "initial commitment hearings."

Summary of Findings

There were 5,005 initial commitment hearings conducted during the quarter. Statewide, 17.9% of these hearings resulted in dismissal, 54.4% resulted in involuntary commitment to a hospital, 27.1% resulted in an agreement under the respondent agreed to remain in the hospital voluntarily, and less than 1% resulted in mandatory outpatient treatment orders. The data displayed below present the dispositional rates for the 28 district courts that conducted at least 50 hearings during the quarter. (See Appendices A and B for tables and charts showing hearing dispositions for district courts with at least 50 hearings.)

Rate of Dismissal

As indicated, commitment petitions were dismissed in 17.9% of the hearings conducted throughout the Commonwealth during the first quarter of FY 2010. However, there were significant variations in dismissal rate among the district courts, including 5 district courts where the dismissal rate was more than twice the state average (See Table 1). Conversely, there were seven district courts where the dismissal rate was less than 5%, including 3 districts where there were actually zero dismissals (See Table 2).

Table 1. District Courts with Dismissal Rates More Than Twice State Average

	Total Hearings	Dismissals	
		Count	%
Galax	153	133	86.9
Fredericksburg	143	74	51.7
Hampton	347	137	39.5
Charlottesville	126	47	37.3
Lynchburg	183	67	36.6

Table 2. District Courts with Dismissal Rates Less Than 5%

	Total Hearings	Dismissals	
		Count	%
Roanoke	414	17	4.1
Virginia Beach	257	9	3.5
Salem	223	6	2.7
Hopewell	115	2	1.7
Bristol	116	0	0.0
Danville	200	0	0.0
Norfolk	63	0	0.0

Rate of Involuntary Commitment

Involuntary admission to a mental health facility (also called involuntary commitment) was ordered in 54.4% of all the hearings across the Commonwealth. However, there were significant variations in the involuntary commitment rate among the district courts. As shown in Tables 3 and 4, seven district courts had involuntary commitment rates higher than 70% and 10 had rates lower than 35%. In one district, only 5 (3.3%) of 153 respondents were committed.

Table 3. District Courts with Involuntary Commitment Rates Greater Than 70%

	Total Hearings	Involuntary Commitments	
		Count	%
Hopewell	115	106	92.2
Petersburg	353	292	82.7
Chesapeake	176	145	82.4
Richmond	562	444	79.0
Norfolk	63	46	73.0
Virginia Beach	257	185	72.0
Salem	223	157	70.4

Table 4. District Courts with Involuntary Commitment Rates Less Than 35%

	Total Hearings	Involuntary Commitments	
		Count	%
Mecklenburg	102	34	33.3
Fredericksburg	143	46	32.2
Loudoun	64	20	31.3
Bristol	116	36	31.0
Fairfax County	208	63	30.3
Russell	51	15	29.4
Prince William	168	37	22.0
Montgomery	152	29	19.1
Winchester	98	8	8.2
Galax	153	5	3.3

Rate of Mandatory Outpatient Treatment

There were only 26 MOT orders for the first quarter of FY10, with an average of 8 per month. These MOT hearings occurred among only seven district courts; however, 18 of the 26 MOT cases were in a single jurisdiction (Prince William). Districts with MOTs are shown in Table 5.

Table 5. District Courts with MOT Dispositions

	Total Hearings	MOT	
		Count	%
Prince William	168	18	10.7
Alexandria	52	1	1.9
Fairfax County	208	2	1.0
Danville	200	1	0.5
Roanoke	414	2	0.5
Salem	223	1	0.4
Smyth	352	1	0.3

Rate of Voluntary Hospitalizations among Persons Hospitalized

Because there were so few MOT orders, cases that were not dismissed resulted in continued hospitalization after the TDO. In about 70% of these 4,082 cases, the respondents were placed under an involuntary commitment order, while in the remaining 30%, they were allowed to agree to voluntary hospitalization. However, whether respondents were allowed to agree to voluntary hospitalization is another source of substantial variation among district courts. Among people who were hospitalized, certain districts were much more inclined to allow voluntary admission rather than issue a commitment order. In district courts with at least 50 hearings, the average rate for voluntary admissions among hospitalizations was about 33.3%. However, the voluntary admission rate was 50% or more in ten district courts and 10% or less in four district courts. These districts are shown in Tables 6 and 7.

Table 6. District Courts with Voluntary Admission Rates Greater Than 50%

	Total Hearings	Hospitalizations	
		# of Hospitalizations	% Voluntary Hospitalizations
Winchester	98	81	90.1
Montgomery	152	137	78.8
Galax	153	20	75.0
Prince William	168	123	69.9
Bristol	116	116	69.0
Russell	51	44	65.9
Loudoun	64	57	64.9
Fairfax County	208	170	62.9
Mecklenburg	102	83	59.0
Danville	200	199	58.8

Table 7. District Courts with Voluntary Admission Rates Less Than 10%

	Total Hearings	Hospitalizations	
		# of Hospitalizations	% Voluntary Hospitalizations
Portsmouth	78	54	9.3
Chesapeake	176	159	8.8
Hopewell	115	113	6.2
Lynchburg	183	116	2.6

Assessment and Recommendation

The CMS data reviewed in the previous section document substantial variations in commitment practices across the Commonwealth. Variations in dismissal rates among district courts suggest that the commitment criteria are not being interpreted in a consistent manner across the state. Among respondents whose cases are not dismissed, variations in the proportion of individuals hospitalized on a voluntary basis suggest that special justices in different districts have different perspectives on the threshold for allowing the voluntary option. (Clearly MOT is regarded as a plausible dispositional option in only a few jurisdictions.) Some of these outcome discrepancies may be a function of differences of perspective among independent examiners or CSB emergency services staff. In addition to substantial outcome variations, the Commission has also been informed of what appear to be systematic variations in evidentiary and procedural rulings among special justices.

The Commission believes that there is an urgent need for coordinated training, support and assistance for the Special Justices presiding over civil commitment cases in Virginia, and also for training for attorneys and guardians ad litem ("GALs") providing assistance to petitioners and respondents in adult and juvenile commitment cases.

Training and support for special justices are of particular significance. The Commonwealth vests special justices with all the powers of a judge, including the power to deprive a person of his or her liberty through the involuntary commitment process. The judicial officers conduct 24,000 hearings every year. However, unlike magistrates, district and circuit court judges, special justices do not have any organization, staff or support system to provide them with periodic updates of relevant information or research assistance in addressing the serious issues that come before them in deciding these difficult cases. This is a significant deficiency in Virginia's commitment processes, and is a major contributor, we believe, to the substantial variations in practice and outcome in commitment cases first documented by the Commission in its study of hearings conducted in May, 2007 and that have continued to occur in the Commonwealth.

During the course of its deliberations over the last two years, the Commission's Task Force on Training and Implementation of Commitment Reforms has discussed a number of proposals for improving oversight, support and training for special justices, attorneys and GALs involved in the civil commitment process. The Commission is pleased to report that the Supreme Court's Office of the Executive Secretary ("OES") has supported and implemented some of these proposals. For example, legislation adopted in 2009 clarified the role of the Chief Judge in each Judicial Circuit in supervising and monitoring the performance of the special justices appointed in their jurisdictions.

Much remains to be done, however. Virginia's system of having special justices appointed in each judicial circuit, and vesting those special justices with all the powers of a judge, including the power to deprive a person of his or her liberty through the involuntary commitment process, is unique in many respects. It also presents a unique set of problems, in that, unlike magistrates, district court and circuit court judges, special justices do not have an organization or support system to provide them with staff support, guidance, or research assistance in addressing the weighty issues that come before them in deciding these difficult cases. Accordingly, the Task Force has recommended that the Supreme Court's OES consider establishing a position of "Special Justice Advisor" in the OES to serve, like the OES Magistrate Advisors, as a resource to provide guidance to special justices, and also to implement and coordinate conferences, certification and training events for special justices. The Commission strongly endorses this recommendation. The Commission is aware that the state budget shortfall and the accompanying inability of state agencies to create new positions or establish new programs will delay implementation of this recommendation. However, in the meantime, the OES should consider utilizing existing resources to provide adequate training, staff support and direct assistance to special justices in the Commonwealth.

Recommendation 1: As soon as resources permit, the Supreme Court's Office of Executive Secretary (OES) should consider establishing a position of "Special Justice Advisor" in the OES to serve, like the OES Magistrate Advisors, as a resource to provide information and support to special justices, and also to implement and coordinate conferences, certification and training events for special justices. In the meantime, the OES should consider utilizing existing resources to provide adequate training, staff support and direct assistance to special justices in the Commonwealth.

Training of Special Justices. The OES over the last three years has greatly improved the programs and opportunities for training provided for judicial officers in the involuntary commitment process, especially for special justices. During this last year, the OES Department of Educational Services for the first time administered the training programs conducted for special justices hearing adult and juvenile cases. The Department of Educational Services, however, does not establish the substantive content or curriculum for its training programs. Rather, it relies on OES staff with expertise in relevant subject matter areas, or on Judicial Education committees composed exclusively

of judges from the district or circuit courts. Accordingly, in order to enhance the level of expertise available to design training programs for participants in the adult and juvenile involuntary commitment process, OES should consider establishing a Mental Health Training Advisory Committee for the district and juvenile courts composed of sitting judges or special justices with particular expertise in the involuntary commitment process, and other participants or stakeholders in the process. This committee could be consulted from time to time to assist OES staff in planning and presenting training events for judges, special justices and other judicial officers involved in the involuntary civil commitment process.

Recommendation 2: The Office of the Executive Secretary of the Supreme Court should create an advisory committee to assist in formulating the training curriculum pertaining to civil commitment proceedings for judicial officers, including magistrates, judges and special justices.

Support Services for Special Justices. The Task Force has recommended, and the Commission endorses, OES consideration of the following actions

- E-Mail List Serv for special justices.

A number of special justices have expressed an interest in being able to communicate with other special justices to solicit advice, input and interpretations on legal and administrative issues that arise in implementing the involuntary commitment statutes. A voluntary e-mail List-Serv program, implemented by OES, that would allow special justices who elect to participate, to initiate and respond to inquiries with other special justices, would provide a significant useful tool to enhance communications and share expertise.

- Research and support services for special justices.

The OES, through its Department of Legal Research, provides confidential staff support, direct assistance and legal research for trial court judges in Virginia, including Circuit Court Judges, General District Court judges, and Juvenile and Domestic Relations District Court Judges, who preside over involuntary civil commitment cases in their jurisdictions. OES does not presently provide such services to part time judicial officers who are also practicing attorneys, such as substitute judges or special justices.

Special justices, by statute, have all the powers and duties of a district judge in handling involuntary commitment cases, including the power to deprive persons of their liberty. Therefore, the Implementation Task Force recommends, as a first step, that special justices should be given access to the same support and resources in deciding involuntary commitment cases that is provided for sitting judges. The Implementation Task Force understands that this proposal may have direct and indirect fiscal implications and would present a policy change for the Supreme Court and OES, because these

services have never been provided to such part-time judicial officers. However, given the critical need for support and assistance to Virginia's special justices, the Commission believes that this proposal warrants review and consideration by OES and the Court.

Proper functioning of the commitment process also requires support and training for attorneys and GALs assisting petitioners and respondents in adult and juvenile commitment cases. However, the certification standards for GALs do not presently include any curriculum or instruction on the involuntary commitment processes or mental health issues affecting children or adults. Nor is specialized training required for appointed counsel for respondents in commitment cases. The Commission recommends that the certification standards for GALs be amended to incorporate these mental health components, and that the Office of Executive Secretary, the Virginia State Bar and Virginia CLE establish and maintain a curriculum of regular programs and CLE events to provide the necessary training for attorneys and GALs involved in commitment cases.

Many components of the Commission's Blueprint for Mental Health Law Reform[26] have necessarily been delayed by the recession and will have to compete for legislative attention with many other public demands in the coming years. However, establishing adequate mechanisms for training, support and oversight of special justices is among the Commission's highest priorities for reform and is squarely within the prerogative of the judiciary. The Commission hopes that the Supreme Court will take the necessary steps to implement these recommendations as soon as practicable.

[26] The Commission's 2008 Progress Report On Mental Health Law Reform is available on-line at the Supreme Court's website: http://www.courts.state.va.us/programs/cmh/2008_1222_progress_report.pdf. This document is also referred to as the Commission's Blueprint for Mental Health Law Reform.

This page left blank intentionally.

IV. COMMITMENT REFORM PHASE 3: PROPOSALS FOR 2010

The Task Force on Future Commitment Reforms has been charged with considering further modifications of the commitment process, including major issues that have been under continuing review since the Commission's work began in the fall of 2006.

A. Lengthening the Permissible Duration of TDO Period

From the outset of its deliberations, the Commission has studied whether the maximum period of temporary detention should be expanded from the current 48 hours to three, four, or five days. The basic concept of elongating the TDO period was endorsed by the Commission in its Preliminary Report in 2007 as well as by the Virginia Tech Panel. However, the Commission has stopped short of proposing a concrete recommendation while it has attempted to ascertain the likely effects of different approaches toward implementing the idea.

The goal throughout the involuntary commitment process should be to afford the individual whenever possible the opportunity for voluntary treatment, at which point the involuntary process should be terminated. Fiscal incentives that result in forcing an individual into involuntary treatment, rather than affording voluntary treatment, should be eliminated. The purpose of expanding the TDO timeframe would be (1) to give more time for individuals to be treated and stabilized thereby permitting a safe discharge plan to be developed, negating the need for involuntary hospitalization or permitting the person's voluntary admission, and (2) to give examiners time to conduct a more thorough evaluation, as required in § 37.2-815, to guide the court's decision if a commitment hearing is necessary. As part of this review, the Commission also considered whether the role of the independent examiner would need to be expanded to permit the examiner to release individuals who do not meet the commitment criteria and for whom that length of involuntary hospitalization is not necessary or appropriate. In addition, the Commission studied whether a minimum time period, such as 24 hours, should be established before which a commitment hearing may not be held.

The purpose of temporary detention has long evolved from simply affording a safe place to hold a person until a commitment hearing can be held. Evaluation and treatment should begin immediately upon admission. Accreditation standards and licensure require it, and best practice principles support it. The temporary detention period provides an opportunity to stabilize the acute crisis. Once the acute crisis has stabilized, a more thorough assessment can be done in which the individual can fully participate. It may be possible to put a safe plan in place to permit the individual to be discharged, or the individual may be able to volunteer for a period of inpatient hospitalization, without the necessity of an involuntary commitment hearing. Changes in the Code of Virginia, discussed below, should be implemented to encourage this. If a commitment hearing is necessary, the CSB will also have additional time to determine, in conjunction with the individual, his or her family, and treatment providers, whether an

outpatient treatment plan might be feasible and to develop such a plan, thereby affording the individual a less restrictive alternative to involuntary inpatient admission. Because of the rapid time frame under which commitment hearings are now held, these options are seldom available to the individual.

In studying these issues, the Task Force on Future Commitment Reforms attempted to make an informed judgment regarding the effects of elongating the TDO period. Specifically, a question is whether the likelihood of hospitalization after the TDO, either voluntarily or involuntarily, would decrease with a longer TDO period. The possibility of a TDO period of 72-96 hours arises under current law on weekend and holidays. Data from the few CSBs that record the length of TDOs and their relationship to hearing outcomes tend to show that if the person is held under a TDO less than 48 hours, the person is more likely to be committed than if the TDO period is longer. If the person is held longer than 48 hours, the likelihood that the petition will be dismissed or the person will be hospitalized voluntarily significantly increases.

Researchers at the University of Virginia conducted a study of the TDO period using a combination of Virginia court data and Medicaid claims filed to determine whether longer TDO periods reduce the length and frequency of involuntary commitments by providing greater opportunity to stabilize and evaluate individuals ("TDO Period Study").[27] The TDO Period Study also indicates that longer TDO periods are more likely to result in dismissals rather than hospitalizations; 2) longer TDO periods increase the likelihood of an individual agreeing to voluntary rather than involuntary hospitalization; and 3) longer TDO periods are correlated with shorter post-TDO hospitalizations, although there is a modest increase in the net inpatient time as the length of the TDO increases. The study also finds that hearings held in less than 24 hours result in 75% involuntary commitments, 7% dismissals and 19% voluntary admissions, as compared with 47% involuntary commitments, 24% dismissals, and 32% voluntary admissions following 72 hours of hospitalization, supporting the premise that very short TDO time periods lead to excessive involuntary hospitalizations. The data is therefore consistent with the idea that increasing TDO periods to 72 hours or more would reduce the need for involuntary coercive treatment. This increase provides additional time to evaluate the person and stabilize the crisis, and reduces the need for coercive legal action. Analysis is continuing to determine whether an increase in longer TDO period would result in a net increase on days of hospitalization and, if so, whether the cost of any increase in days of hospitalization would be offset by a reduction in costs associated with the commitment process itself.

Researchers at the University of Virginia, School of Medicine also conducted a review of Mandatory Outpatient Treatment Orders issued between July 1, 2008 and November 30, 2009 ("MOT Study").[28] Use of MOT orders has decreased significantly since the enactment of new procedural requirements in 2008. CSB representatives

---

[27] Wanchek, Tanya, and Bonnie, Richard, The Temporary Detention Period and Treatment for Mental Illness, December 1, 2009.
[28] Askew, Amy Liao, MOT Summary Report, University of Virginia, School of Medicine, Department of Public Health Sciences, December 15, 2009.

indicate that implementing MOT might be less challenging if they have a longer time to develop the comprehensive treatment plan that must be filed and approved by the Court. Significantly, the Prince William County General District Court issues the most MOT orders. Unlike other jurisdictions, Prince William County almost always waits a full 48-hour TDO period before holding the civil commitment hearing. In addition, the Prince William County CSB performs a second evaluation of the individual immediately prior to the commitment hearing. They have found that it is often during this second prescreening that the person expresses a willingness to participate in outpatient treatment and an initial treatment plan can then be submitted to the special justice at the hearing.[29] The MOT Study also supports the supposition that if the TDO period is increased, a better discharge plan can be developed and a lesser restrictive mandatory outpatient treatment might be more readily available to prevent involuntary inpatient treatment.

The Task Force on Future Commitment Reforms recommended that the TDO time period be extended to 72 hours or three days. The data so far indicates that the longer the TDO period, the likelihood of commitment decreases; and the longer the period of detention, the less likely people will be hospitalized at all. Having a longer period of detention would also allow for better discharge planning. Recommending an increase to 72 hours initially would permit time to develop additional data to assess the impact on outcomes for people with mental illness, but also any economic impact, before any consideration of moving to a four or five day TDO period. Virginia has the shortest TDO period in the country. As reported in the December 2008 Civil Commitment Task Force Report,[30] Virginia is one of three states that require a commitment hearing within 48 hours of the probable cause determination. Three states require a hearing within 30 days with most states requiring a hearing within 4-8 days of the probable cause determination.[31]

The Task Force on Future Commitment Reforms also recommended that commitment hearings not be allowed to take place within the first 24 hours of detention under a TDO. Hearings held so quickly almost always lead to hospitalizations. If the hearing is held in less than 24 hours, people do not receive the evaluation required under § 37.2-815, blood work is not completed, and people with substance abuse issues might still be intoxicated. If a minimum of 24 hours is imposed, an extension of the TDO period to 72 hours would be needed to accommodate the schedules of courts that hold hearings only on a Monday, Wednesday, or Friday.

The Task Force on Future Commitment Reforms also examined concerns related to whether increasing the TDO time frame would exacerbate shortages in the availability of mental health beds. While clearly an issue that merits study if the TDO period is extended, the Task Force concluded that the total number of bed days would likely even

---

[29] *Id*. at 9.

[30] The Civil Commitment Task Force's 2008 Report can be found on the Supreme Court's website at : http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2008_0918_tf_rpt_civil_commitment.pdf.

[31] Commission on Mental Health Law Reform, Report of the Task Force on Future Commitment Reforms (Dec. 2008) at 20-21.

out. Under current practices, people held less than 24 or 48 hours are virtually automatically hospitalized and so they already occupy valuable bed space for long periods beyond the initial TDO period. If individuals are held longer under a TDO, the hospitalization rate will likely decrease. Any increase in TDO-related bed-days would likely be more than offset by the lower frequency of both voluntary and involuntary hospitalizations. Concern was further raised as to whether the increase in the TDO period would increase the burden on the Involuntary Civil Commitment Fund managed by DMAS, which is funded by state general funds. If a person has insurance or is eligible for Medicaid, third party payers will already pay the cost of hospitalization during the TDO period. If an individual is indigent, the DMAS operated Involuntary Civil Commitment Fund pays the cost during the TDO period. After commitment, the indigent person's hospitalization is paid with LIPOS funds or the person is hospitalized at a state hospital, which is also paid with state general funds. It appears therefore that there should be a sum even transfer of state general fund dollars. An adjustment of funding between DMAS' Involuntary Civil Commitment Fund, LIPOS and state inpatient hospital funds may need to be made.

Recommendation 3: The General Assembly should increase the maximum period of temporary detention to 72 hours or the end of the next business day if the time period ends on a Saturday, Sunday, or holiday. In so doing, the Commission also recommends that no commitment hearing be held in less than 24 hours.

B. Promoting Voluntary Treatment

Section 37.2-813 now permits the director of any TDO facility to release the person prior to the hearing if the person would not meet the commitment criteria based upon the evaluation of the treating psychiatrist or clinical psychologist. This seldom happens.[32] To encourage this practice, the statute should be amended to permit the treating physician at the inpatient hospital to release the person prior to the hearing based upon his evaluation, and after consultation with the petitioner and the CSB, that the person does not meet commitment criteria without the need for a hearing. The likelihood that any evidence can be presented supporting the person's commitment based upon that determination is remote and no hearing should be necessary.

In North Carolina, if the physician performing the required second examination for commitment determines that the person does not meet the criteria for commitment, the physician releases the person, notifies the clerk of court and the proceedings are terminated.[33] North Carolina has a 10-day detention period. Because Virginia's temporary detention period is much shorter than North Carolina's, the Commission

[32] Section 37.2-813 also permits a judge or special justice to release a person on his personal recognizance or bond if it appears that the person does not meet commitment criteria. This authority appears never to have been invoked. The Task Force on Future Commitment Reforms has recommended that this provision be repealed.
[33]N.C. Gen. Stat. § 122C-266.

recommends that the detention and involuntary process be terminated the same way as provided in North Carolina law, but only after consultation with the petitioner and CSB and not the second physician.

The Task Force on Future Commitment Reforms considered amending Virginia Code § 37.2-813 to permit an individual to volunteer for admission if the individual is willing and capable of agreeing to admission and the TDO facility or another mental health facility agrees to admit the person. The commitment hearing would then be terminated. Most of the members of the Task Force on Future Commitment Reforms favored permitting individuals to volunteer for admission before the commitment hearing, thereby terminating the hearing process. Some worried, however, that the person might be trying to circumvent the hearing process and would change his or her mind as soon as the proceeding was terminated. A majority of the Task Force recommended that individuals be able to volunteer for admission prior to a commitment hearing, thus obviating the need for the hearing, and the Commission agrees. Moreover, if a person converts to involuntary status during the period of temporary detention, the Involuntary Civil Commitment Fund managed by DMAS should continue to pay the cost of hospitalization and treatment for at least as long as the person would have been hospitalized under the TDO, to remove this fiscal impediment to voluntary treatment.

The Task Force on Future Commitment Reforms also discussed whether the person volunteering for admission would or should be prohibited from purchasing, possessing or transporting a firearm under § 18.2-308.1:3. Section 37.2-819 now requires the clerk to report voluntary hospitalizations to which the person agrees before a hearing under § 37.2-814(B). If the person is voluntarily admitted to a hospital before that time, reporting is not required. If reporting of a post-TDO voluntary conversion were to trigger a firearm report under § 37.2-819, the Code would have to be amended to so require. The Commission has not previously taken a position on this issue and declines to do so now. It should be emphasized, however, that neither federal nor state law requires firearm reporting in the ordinary case in which persons seeks voluntary hospitalization. The reporting requirement under § 37.2-814(B) for a person under a TDO who agrees to a voluntary admission before a hearing is the only exception to that rule under the Virginia Code (and such a report is not required by federal law). Whether a report should be triggered by a voluntary conversion before a hearing is a delicate policy question involving a clash of constitutional values.

Finally, the Task Force on Future Commitment Reforms discussed whether the person should be required to accept a minimum period of treatment or to give notice of his intent to leave as is currently required at the commencement of the commitment hearing. It concluded that neither of these requirements should apply. However, while the Commission agrees that no minimum period of treatment should be required, it believes that notice of a desire to be discharged is an inherent feature of physician-patient interactions.

Recommendation 4: The General Assembly should amend Virginia Code § 37.2-813 to permit the facility to release an individual from custody if the responsible physician, after an evaluation and consultation with the petitioner and community services board, determines that the person does not meet commitment criteria. The involuntary commitment proceedings would be terminated.

Recommendation 5: The General Assembly should amend Virginia Code § 37.2-813 to provide that an individual under a TDO be permitted to consent to voluntary admission and that the commitment proceedings be terminated upon conversion to voluntary status. If a person under a TDO is converted to voluntary status prior to the commitment hearing, the Involuntary Civil Commitment Fund managed by DMAS continue to pay for the person's hospitalization and treatment at least through the time the commitment hearing would have been held.

C. Improving Procedures for Commitment of Jail Inmates

Virginia Code §§ 19.2-169.6, 19.2-176, and 19.2-177.1 set out the process for an individual incarcerated in a local or regional jail to be transferred to a mental health facility. Section 19.2-169.6 applies to defendants who are in jail awaiting trial; section 19.2-176 applies to defendants who have been convicted of a crime and are awaiting sentence; and section 19.2-177.1 applies to inmates who have been convicted of a crime and are serving their sentence in jail. Section 19.2-169.6 provides two routes for a jail inmate to be transferred to a mental health facility. Either the court with jurisdiction over the defendant's case may order him committed, or the sheriff or jail administrator may obtain an evaluation from the CSB and then a TDO from a district court judge or special justice, or if not available, from a magistrate. The TDO is followed by a hearing conducted by either the court with jurisdiction over the defendant's criminal case, or by a district court judge or special justice.

Although each of these statutes applies to the same type of inmate, i.e. an inmate in jail in need of treatment in a mental health facility, they are inconsistent with one another:

- The commitment criteria in §§ 19.2-169.6 and 19.2-177.1 were changed in 2008 to incorporate the first prong (dangerousness) of the new commitment criteria enacted that year, but the commitment criteria in § 19.2-176 for the initial hearing remains: the person (i) is mentally ill, and (ii) requires treatment in a mental hospital rather than the jail. At the temporary detention stage and recommitment hearing under § 19.2-176 though, the defendant must meet the first prong of the revised commitment criteria.

- It is not clear whether the "qualified evaluator" referenced in § 19.2-169.6 (A)(1) and (2) is the CSB employee or an independent examiner similar to the examiner required in the civil commitment process, and if so, what the examiner's

qualifications may be. There is no provision for payment for independent evaluations done under § 19.2-169.6, but payment for the evaluation under 19.2-176 is the same as for mental status or competency to stand trial evaluations not to exceed $ 750 and $ 100 for each day the evaluator must appear in court, even though the type of examination, other than a CSB evaluation, or qualifications of the examiner are not mentioned. *See* § 19.2-175. (The Work Group studying this issue discovered that § 19.2-176 is being used by many courts to order a competency to be sentenced evaluation – thus the provision for payment in § 19.2-175 equivalent to that for competency to stand trial and mental status examinations.) The proceedings conducted under § 19.2-177.1 incorporate all of the involuntary admission procedures in chapter 8 of Title 37.2, except the commitment criteria, which would imply that an independent examiner required under § 37.2-815 and payment for the examiner would be the same as in the civil commitment process

- Sections 19.2-169.6 and 19.2-176 are silent as to whether the CSB must attend either the commitment or recommitment hearings and whether pre-admission screenings are required at recommitment hearings. Section 19.2-177.1 incorporates all of the requirements of Chapter 8 of Title 37.2, except the commitment criteria. Therefore all of the requirements related to CSBs, examiners, mandatory outpatient treatment apply in proceedings under this section but not the others.

- It appears that some jurisdictions are using § 19.2-176 to obtain a mental health evaluation for use in determining an appropriate sentence for the inmate. From the Task Force's reading of the statute, it does not appear that this statute was intended for this purpose.

The Commission recommends that the three code sections be combined into one section for consistency and that the statutes conform as closely as possible to the civil commitment process where applicable. The bill proposed by the Commission is described in the report of the Task Force on Future Commitment Reforms. One key issue debated at length is whether an independent evaluator should be required for commitment of persons from jail to a psychiatric hospital. Some members of the Task Force on Future Commitment Reforms strongly believe that an independent examiner should be required in these types of hearings and that jail inmates should be entitled to receive the same types of protections as those in the civil commitment process. They further argue that many CSB pre-admission screeners are not as qualified as independent examiners and are not qualified to diagnose psychiatric disorders. The Task Force on Future Commitment Reforms reviewed Vitek v. Jones, 445 U.S. 480 (1980), a United States Supreme Court decision that requires a due process hearing before a prisoner may be transferred to a state psychiatric hospital, to determine whether the United States Constitution would require an independent examiner. The Court recognized that a prisoner has a 14th Amendment liberty interest in avoiding the "stigma" associated with commitment for mental illness and requires the following minimum procedures:

1. Written notice to the prisoner that a transfer to a mental hospital is being considered;
2. A hearing, sufficiently after the notice to permit the prisoner to prepare, at which disclosure to the prisoner is made of the evidence being relied upon for the transfer and at which an opportunity to be heard in person and to present documentary evidence is given;
3. An opportunity at the hearing to present testimony of witnesses by the defense and to confront and cross-examine witnesses called by the state, except upon a finding, not arbitrarily made, of good cause for not permitting such presentation, confrontation, or cross-examination;
4. An independent decision maker;
5. A written statement by the fact finder as to the evidence relied on and the reasons for transferring the inmate;
6. Availability of legal counsel, furnished by the state, if the inmate is financially unable to furnish his own; and
7. Effective and timely notice of all of the foregoing rights.[34]

Virginia can provide additional due process protections if it wants to do so, but it is not required to do so to meet constitutional requirements. An independent decision maker, not an independent examiner, is required. States are also permitted to treat special classes of individuals differently from individuals subject to involuntary civil commitment.[35]

An informal survey conducted by the emergency services supervisors indicates that when the hearings are held in the locality, no independent examiner is used, but when the hearings are conducted at the state hospitals (i.e. the hospitals designated by the Commissioner as appropriate for treatment of persons under criminal charge), the same independent examiner used in civil commitment hearings conducts the examinations. In two large state hospitals, the examiners are other psychiatrists or psychologists on staff, but not involved in the individual's care. No payment is therefore made to examiners at those hospitals. The vast majority of hearings are conducted at state hospitals. No increase in the numbers of hearings held is anticipated as a result of this proposed legislation. The only fiscal impact will therefore be for those hearings held in the locality where the individual's criminal charges are pending. The fiscal impact may therefore be minimal.

The Commission believes strongly that these statutes must be rationalized and clarified. If any fiscal impact becomes an issue prior to or during the General Assembly Session, the Commission recommends that the requirement for an independent examiner be removed to ensure passage. Lack of an independent examiner in this context, as opposed to the civil commitment context, can be justified because the person has already lost his liberty as a result of his confinement and the CSB pre-admission screening should be sufficient to determine whether an inmate meets the first prong of the commitment criteria and requires treatment in a psychiatric hospital instead of in jail. The risk of an erroneous transfer is therefore minimal. The only concern would be that in those jails

---

[34] Vitek v. Jones at pages 494-495.
[35] Jones v. United States, 463 U.S. 354, 370 (1983).

where the CSB provides the mental health services directly, the CSB employee performing the pre-admission screening should not also be involved in providing treatment to the person. This concern has been addressed in the proposed draft legislation.

Recommendation 6: The General Assembly should amend Virginia Code §§ 19.2-169.2, 19.2-176 and 19.2-177.1 to remove the inconsistencies, to clarify the procedural requirements, and to make the process as congruent as possible with the civil commitment process.

D. Consolidating Statutes Governing Commitment of Minors

Magistrates, judges, attorneys and mental health professionals who participate in juvenile commitment proceedings are confused over exactly which provisions of the adult civil commitment code apply to juveniles, and this confusion has resulted in variations across the state in the manner in which juveniles experience the commitment process. There is also a great deal of confusion among special justices regarding the extent of their authority in placing juveniles. The extensive statutory revisions made to the adult civil commitment statutes over the past two years have aggravated this problem.

In order to address these problems, the Commission directed the Task Force on Children and Adolescents and its Subcommittee on Commitment to draft a stand-alone juvenile commitment statute. The original aim was simply to consolidate the Code language without making any substantive changes. However, as the Subcommittee's work unfolded, it became clear that many of the adult provisions could not be added to the juvenile code without at least some modification primarily because juvenile commitment hearings, unlike adult commitment hearings, must be held where the child is located. In addition, the juvenile commitment law includes party notification requirements (e.g., to parents or custodians) that are not required in adult cases. Furthermore, due to the small number of hospitals that accept children, the place where the commitment hearing is held is often very far from the jurisdiction in which the child and the parents/custodians reside. This location issue leads to many practical complications in accomplishing legal notice and transportation. There were also many areas where the juvenile code was silent on important aspects of the commitment process. The drafting subcommittee attempted to fill these gaps and make any other modifications that were required, including changing the title changed from "Psychiatric Inpatient Treatment of Minors Act" to "Psychiatric Treatment of Minors Act" to better reflect the contents of this law, which permits both inpatient and outpatient treatment. The stand-alone juvenile commitment code, drafted by the subcommittee with the superb technical assistance of the Division of Legislative Services, was reviewed and approved by the Commission for presentation to the General Assembly.

Recommendation 7: The General Assembly should consolidate and clarify the statutes governing commitment of juveniles consistent with the recommendations of the Commission's Task Force on Children and Adolescents.

V. ADVANCE DIRECTIVES AND HEALTH CARE DECISIONS ACT REFORM

Virginia's Health Care Decisions Act ("HCDA") was amended by the 2009 General Assembly to increase opportunities for individuals to make health care decisions in advance directives and otherwise to clarify and streamline the requirements of the Act. The legislation was developed by the Commission's Task Force on Advance Directives based on previous recommendations by the Commission's Task Force on Empowerment and Self-Determination. The main objective of the new legislation is to empower people to guide decisions about their health care if they lose decision-making capacity due to mental health conditions or neurological disorders such as dementia. The revised statute also prescribes procedures for assessing decision-making capacity, addresses special situations where a patient who lacks decision-making capacity protests a care recommendation, clarifies procedures for revoking advance directives, and protects decision-makers and providers who act in good faith to carry out patient directions.

If these changes are to be successfully implemented, much needs to be done to increase awareness among all the stakeholder groups, to educate people about the opportunities afforded them by the HCDA, and to help them execute advance directives ("ADs"). It is particularly important for health care providers and practitioners to understand the purpose, meaning and implications of the changes adopted in 2009. Not only do health care providers carry out the instructions that patients give about their care, but they also are required under federal law to inform patients about their health care decision-making rights. For this reason, the Commission has worked closely with stakeholder groups to educate providers about the new law to design and implement training programs and other implementation activities and will continue to coordinate and support these activities in 2010.

During the course of the Commission's vigorous efforts to educate the public and pertinent stakeholder groups about the law and to implement it successfully, many comments and suggestions were offered about issues on which the HCDA requires clarification or modification. The Task Force on Advance Directives reviewed all of these comments and made recommendations to the Commission for corrective action. The Commission has approved the following amendments to respond to the concerns that have been raised.

A. Corrective Amendments

1. The 2009 legislation authorized guardians to admit their wards to mental health facilities under certain narrowly defined circumstances. The proposed amendment to § 2.2-713 makes it clear that this authority also applies to public guardians.

2. The 2009 legislation allows facilities to treat incapacitated patients over protest under narrow circumstances, including a review by an "ethics" committee to determine if the recommended care is "ethically acceptable." However, the Code does not currently

specify any compositional requirements for an "ethics" committee, and we have discovered that the term itself has some negative connotations. Accordingly, we have renamed the committee to more accurately reflect its function ("health care decisions review committee") and we have prescribed some requirements for its composition in the definitions set forth in § 54.1-2982. We have also proposed to amend the immunity provision in the Act (§ 54.1-2988) to include members of these committees.

3. Section 54.1-2983.3(C) of the 2009 legislation was designed to state clearly that an advance directive could not trump the law governing involuntary commitment. However, it did not do so as clearly as we had thought. Instead, some people have interpreted it to say that "A person's advance directive cannot override an order for involuntary admission to a hospital but it CAN override involuntary treatment while in the hospital, including emergency treatment." Our proposed amendment to § 54.1-2983.3 (C) is designed to clarify the point: it states clearly that the authority conferred by an ECO, TDO or a commitment order would override the advance directive. Under Title 37.2 and applicable regulations, the actual effect of this language is to allow emergency treatment, notwithstanding a contrary instruction in an advance directive; otherwise the patient's advance directive would govern under the Human Rights Regulations.

4. One of the most important provisions in the 2009 legislation was § 54.1-2986.2, but it is also one of the most complicated from a technical standpoint. This provision allows treatment over the protest of an incapacitated person under two narrowly defined circumstances: (1) it allows a person to include a so-called "Ulysses clause" in an advance directive as long as the person's understanding of the clause is certified by his/her physician (or psychologist) when the AD is executed; and (2) it also allows treatment over the protest of an incapacitated patient (even in the absence of an advance directive) when the patient's agent or authorized decision-maker consents to such treatment based on the patient's basic values and best interests, and after the proposed treatment is approved as "ethically acceptable" by the facility's health care decisions review committee or two independent physicians. In the course of our collective efforts to explain the "treatment over protest" section to stakeholders over the past 7 months, we have discovered that there is considerable confusion about the relationship between these two provisions. We also discovered that we failed to make it clear that the second provision was not intended to apply to patients in mental health facilities whose treatment is governed by a separate set of statutes and by the DBHDS Human Rights Regulations. The proposed revision of § 54.1-2986.2 is designed to clarify the meaning and application of the "treatment over protest" provisions.

5. In response to concerns that the Durable Do Not Resuscitate Order (DDNR) provision (§ 54.1-2987.1) did not allow qualified personnel in continuing care retirement communities to honor DDNRs of residents in independent living arrangements (homes/apartments), we have expressly included "licensed health care practitioners at any Continuing Care Retirement Community registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2" among the list of those authorized to follow DDNRs.

B. Ameliorative Amendments

Since first enacted in 1983 (and modified in 1992), the Health Care Decisions Act has required a two-physician certification that a patient lacks decisional capacity. The 2009 legislation required that the second examiner be "independent" of the treatment team. After the law was enacted, many facilities raised serious practical issues related to the two-examiner requirement. While this is not a new requirement, facilities pointed out that they did not have sufficient numbers of physicians and psychologists to comply with it, and that a second opinion is unnecessary to confirm decisional incapacity in the case of a patient in the neurological intensive care unit who is in a coma or is grossly impaired due to a stroke. Because these were legitimate concerns, we have proposed to amend the HCDA as follows:

- We have proposed to omit the second examiner requirement when the patient is unconscious or suffering from a profound impairment of consciousness. See proposed amendment to § 54.1-2983.2 (B).

- We have also broadened the class of professionals who are qualified to provide the second capacity examination to include nurse practitioners and clinical nurse specialists. This is accomplished in § 54.1-2982 by defining "capacity reviewer" to include them.

C. Augmenting the List of Designated Surrogates

One of the provisions stricken from the Commission's bill on the House floor in 2009 (although passed by the Senate) was a proposed amendment to the provision that lists possible surrogates for incapacitated patients who have not designated a health care agent (Section 54.1-2986). The 2009 bill proposed to augment the list to include a non-blood relative or close friend "currently involved in the care of the patient" who "has exhibited special care and concern" for the patient and is familiar with the patient's preferences and values. Under the proposed amendment, these judgments of care and concern and familiarity would be made by the facility's health care decisions review committee (formerly the ethics committee).

During the Commission's discussions with the bill's chief patrons, Senator Whipple and Delegate Bell, it was agreed that this proposed provision (which was not limited to advance directives and would have been applicable to end-of-life care) should receive further study and wider circulation before further legislative consideration. As agreed, the Task Force on Advance Directives circulated the proposal widely over the past year and found strong support among the key stakeholders, including providers, mental health advocacy groups, and especially advocacy groups for the elderly. The

Commission intends to reintroduce this provision this year, either as part of the overall amendment of the HCDA or as a stand-alone bill.[36]

[36] The Commission decided not to reintroducing a companion provision in the 2009 bill that would have conferred authority on the "ethics committee" (now called the health care decisions review committee) to authorize a health care decision when there was no one else available to do so. The Commission concluded that judicial authorization for the health care decision should be required under those circumstances.

VI. PARALLEL REFORM INITIATIVES

Over the coming year, the Commission will be working with other public and private agencies to implement and strengthen programs to provide mental health services to individuals in lieu of or in conjunction with processing in the criminal justice system; to support and implement reforms of mental health services for children and adolescents; and to conduct a systematic review of mental health needs of college and university students and legal impediments to meeting those needs.

A. The Interface between Mental Health and Criminal Justice

Without access to community-based mental health services and supports, many individuals with serious mental illness repeatedly cycle through the mental health hospitals and criminal justice systems at significant cost without receiving the services they need. In 2007, based on the Report of the Task Force on Criminal Justice,[37] the Commission recommended creation and support of a state "coordinating council" for criminal justice mental health initiatives, and for regional and local criminal justice/mental health coalitions.[38] As envisioned by the Commission, the state council would be tasked with, among other matters, "identifying and advocating for policies, laws and programs that facilitate diversion and access to services, as well as supporting and overseeing the efforts of local and regional partnerships." The Commission also recommended development and support of evidence-based and best-practice services, specifically to include (i) pre-booking law enforcement response with secure therapeutic drop off services available in lieu of incarceration (e.g., Crisis Intervention Teams); (ii) post-arrest assessment and evaluation utilizing a universal screening instrument; (iii) improved jail treatment services; (iv) therapeutic leverage in adjudication (i.e., post-booking jail diversion programs and mental health courts); and (v) CSB oversight of community re-entry from the criminal justice system.

In January, 2008, Governor Kaine promulgated Executive Order Number 62 (2008) (EO 62) establishing the coordinating council recommended by the Commission. The Commonwealth Consortium for Mental Health/Criminal Justice Transformation ("Consortium") provides a collaborative framework for transforming Virginia's criminal justice and mental health systems. On October 22nd, in conjunction with the initial meeting of the Consortium's Executive Leadership and in a strong statement of support, the Governor issued EO98, providing for the Consortium's continuation through June, 2011.

---

[37] The Report of the Commission's Task Force on Criminal Justice is available on the Supreme Court's website at:
http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2008_0901_tf_criminal_justice.pdf.

[38] See *Progress Report on Mental Health Law Reform*, December 2008, pp. 15-18, http://www.courts.state.va.us/programs/cmh/2008_1222_progress_report.pdf and *A Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform*, December 21, 2007, pp. 27–29,
http://www.courts.state.va.us/programs/cmh/2007_0221_preliminary_report.pdf),

The Consortium is jointly chaired by the Secretaries of Health and Human Resources and Public Safety. It reaches across the three branches of Government, spans Secretariats, brings together representation from multiple agencies and invites local and regional stakeholder participation in order to create a comprehensive approach to improving access to treatment for individuals with mental illness who are at risk of being or are involved in the criminal justice system. In August, 2008, at the request of the Consortium Chairs, the State Coordinator for Criminal Justice and Mental Health Initiatives (State Coordinator) was charged with overseeing the implementation of the Executive Order. Lead agencies for the Consortium are the Department of Behavioral Health and Developmental Services ("DBHDS") and the Department of Criminal Justice Services ("DCJS").

The goals of the Consortium include creating opportunities for local, regional and state transformation planning, identifying and evaluating jail diversion models, and making recommendations for improving access to treatment, enhancing public safety and creating necessary systems change to attain those goals. Additionally, the Consortium is charged with establishing a CJ/MH Training Academy for the Commonwealth, which will provide a locus for coordinating existing relevant CJ/MH training activities, which now occur disparately across the state.

Under the auspices of DBHDS and DCJS and working with the State Coordinator the Consortium has provided impetus for several key initiatives that implement recommendations offered by the Commission and its Task Force on Criminal Justice: (1) "cross systems mapping"; (2) support, coordination and evaluation of diversion and jail treatment programs; and (3) crisis intervention team ("CIT") programs .

Cross Systems Mapping

The Cross Systems Mapping and Action for Change Workshop ("XSM Workshop") is the mechanism being used to establish the local and regional criminal justice/mental health coalitions for transformation planning under EO 98. In May, 2008, the Consortium held its inaugural meeting as part of a Governor's Conference that also provided initial statewide exposure to the XSM Workshop approach. Cross Systems Mapping provides a common framework for understanding, analyzing and addressing the interface of criminal justice and mental health at the community level at each sequential stage of the criminal process. (This framework is often described in the field as the "sequential intercept model.")

The XSM Workshop approach creates a strong foundation for localities to develop their own criminal justice/mental health coalitions. DBHDS and DCJS have worked collaboratively to implement a state wide XSM Workshop process, begun in August 2008 with an intensive two-day training for facilitators. Cross Systems Mapping Workshops are being provided to localities throughout Virginia as part of the Mental Health Law Reform funds for jail diversion allocated in the FY09/FY10 budget through item 315Y. Mappings have already been provided in 14 communities, representing 38 localities covering approximately 1/3 of the state. For the remainder of FY10 eight

additional XSM Workshops are anticipated. Thus far, all participating communities have responded with overwhelmingly positive post workshop survey results. The majority are working with their local criminal justice and mental health coalitions, following up with their action plans and taking the steps necessary to improve local systems' response and capacity to address the needs of individuals with mental illness and criminal justice involvement.

Jail Diversion and Jail Treatment Programs

The General Assembly allocated general funds in the FY09/10 biennium, through the DBHDS, to support jail diversion programs in the Commonwealth. The effort is a coordinated between DBHDS and DCJS, led by the State Coordinator, and represents significant partnership across the criminal justice and mental health systems at state, local and regional levels. Ten sites (Arlington, Alexandria, Chesterfield, Fairfax, Hampton/Newport News, Middle Peninsula/Northern Neck, New River Valley, Portsmouth, Rappahannock Area and Virginia Beach) were awarded funding to develop and/or enhance jail diversion programs in their catchment areas. Many of the 10 sites are supporting multiple programs and initiatives and, taken all together, they address populations at each of the five intercepts in the sequential intercept model. Among them are seven CIT initiatives, which include enhancing/developing protocols to reduce the investment of officer time in civil commitment processes and the establishment of therapeutic assessment site alternatives to jail in three locations. Two programs include post-booking jail diversion models. Several programs are creating new positions to enhance identification of individuals with mental illness at booking, providing additional services, including competency restoration in the jail, and improving linkages back to the community. There are re-entry-focused aspects in nearly all of the programs. In all, there are 10 program sites and more than twenty separate initiatives impacting 17 local and regional jails across the Commonwealth. For the first quarter of FY10 (the first quarter in which all programs had developed sufficient operational capacity to provide meaningful data), the following preliminary results are documented:

- 304 referred to determine eligibility[39] for services
- 180 found eligible and willing to receive services
- 101 individuals enrolled in services
- 48 enrolled in specialized criminal justice/mental health programs
- Just under 6% of individuals referred and enrolled have veterans status
- 50% of those referred, and 43 % enrolled, have a felony target offense[40]

These preliminary findings in the first three months of FY10 clearly raise a number of issues that will require follow up and further scrutiny over the ensuing months. Additionally, a comparative analysis based on 12-month follow-up data will be analyzed

[39] Reasons for ineligibility, which vary slightly among the programs, may include: No mental illness, target offense charged bars participation (e.g., sex crimes), pending charges in multiple jurisdictions, residence or charges outside of program catchment area, released from incarceration before enrollment, no longer willing to participate

[40] The most serious charge at the time of arrest which results in referral/enrollment

to provide information, which should be helpful to the Commonwealth in developing more effective policies for the criminal justice and mental health interface.

Additionally, under a BJA/DCJS administered Byrne Memorial Grant fund allocation, HPR I has been working with the jails in that region to utilize the validated Brief Jail Mental Health Screen ("BJMHS") as a universal tool for identifying individuals with mental illness at booking. The process has included analysis of screening tool options and identification of the BJMHS, training for jail personnel in the proper utilization of this instrument, development of a process for implementing the BJMHS into the booking process and for determining the impact of this process.

Crisis Intervention Team Programs

Crisis Intervention Team ("CIT") programs are a 'best-practice" law enforcement response to mental health crises and related mental health calls. The program originated in Memphis, TN more than twenty years ago and has been replicated in hundreds of communities throughout the country. CIT is a locally based criminal justice, mental health and community owned program of collaboration, infrastructure development and training that literally changes the way systems address the needs of individuals with mental illness at risk for involvement with the criminal justice system. CIT developed its Virginia roots in the New River Valley, beginning in 2001. Since then CIT programs have grown exponentially. Local grass roots efforts have been aided by investments of Federal, state and local dollars (270,000.00 in General Funds was allocated in the FY09/10 biennium and DCJS administers 5 programs in partnership with DBHDS utilizing those funds. Additionally, DCJS oversees several CIT-related Byrne Memorial Fund grants). But communities have also begun CIT efforts utilizing minimal local resources and volunteers.

Following years of effort to assure uniformity and consistency of CIT practice across the Commonwealth, the General Assembly enacted SB1294 in 2009, requiring minimum standards, joint oversight by DCJS and DBHDS and accountability and reporting. DCJS and DBHDS work with a volunteer coalition of CIT officers, programs and citizens – the VACIT Coalition – to assure that the core elements of CIT programs are in place.

There are 22 distinct CIT initiatives currently underway in Virginia, in catchment areas covering 86 separate cities and counties. Five CIT programs are fully operational having (i) an established community stakeholder task force providing program oversight and community outreach, (ii) a CIT coordinator, (iii) round-the-clock CIT officer response capability, (iv) a therapeutic assessment site or protocols to enhance access to services, (v) data collection policy and practices. Eleven CIT programs are in varying stages of development but are on the way to meeting the above requirements. Six programs are in the initial planning phases of CIT development, identifying their stakeholders, providing CIT training for an initial group of stakeholders and identifying how their community can move forward to achieve operational status.

Across the Commonwealth, over 1000 officers have completed the 40 hour CIT training course; 826 CIT officers are currently serving in their communities; and 129 officers and civilians have completed the Train the Trainer course to become core faculty members for their local CIT training programs.

Specialized Judicial Dockets

It is anticipated that one or more bills to establish so-called Veteran's Courts and Mental Health Courts will be filed in the 2010 session. Proposals for specialized "courts" refer not to separate courts, but rather to specialized dockets for connecting eligible offenders with mental health services while their cases are pending or in connection with community supervision. A developing literature regarding the effectiveness of mental health courts shows that these specialized programs reduce the probability of re-arrest and re-incarceration. [41] One mental health court has been operating for several years in Virginia [42] The Commission's Work Group on Criminal Justice Mental Health Initiatives has identified certain principles that should guide the design and operation of mental health courts.[43] The Commission is supportive of a grant-based program that would (i) rely on grants administered through the Supreme Court or localities with approval of the

---

[41] For a summary of mental health court evaluations, see http://www.ojp.usdoj.gov/BJA/evaluation/psi_courts/mh6.htm.

[42] The Norfolk Mental Health Court studied more than 20 individuals who were followed, post referral, for up to 18 months. It found that the program achieved its four goals: (i) it promoted access to therapeutic and social services for mentally ill offenders who found them helpful, especially the case management services; (ii) it reduced the number of times that mentally ill offenders came into contact with the criminal justice system; 9iii) it reduced the number of days that mentally ill offenders spent in jail; and (iv) it promoted effective interactions between the criminal justice and mental health systems.

[43] These principles include: (1) Each jurisdiction or combination of jurisdictions that intend to establish a mental health court shall establish a local mental health court advisory committee. (2). Each jurisdiction or combination of jurisdictions that intend to establish a mental health court shall, in consultation with and the approval of the local mental health court advisory committee, establish criteria for the eligibility and participation of offenders who have been determined to have a mental illness. Such criteria shall specify and describe (i) clinical eligibility; (ii) charge eligibility, such as misdemeanor, felony, and non-violent offenses; and (iii) the target population, which may include juveniles, veterans, and adults within the jurisdiction of the juvenile and domestic relations court. Subject to the provisions of this section, neither the establishment of a mental health court nor anything herein shall be construed as limiting the discretion of the attorney for the Commonwealth to prosecute any criminal case arising therein which he deems advisable to prosecute, except to the extent the participating attorney for the Commonwealth agrees to do so. (3). Each jurisdiction or combination of jurisdictions shall develop, in consultation with and approval of the local mental health court advisory committee, policies and procedures for the operation of the mental health court that include (i) prompt identification and placement of offenders in accordance with the eligibility criteria; (ii) prompt scheduling of hearings in cases in which an offender meeting the eligibility criteria has agreed to participate in a treatment program operated by the local community services board or behavioral health authority, or by another public or private mental health care provider in agreement with the community services board or behavioral health authority; and (iii) monitoring and disposing of the case under specified conditions or upon successful completion of or participation in the program. (4). Participation by an offender in a mental health court shall be voluntary and made pursuant only to a written agreement entered into by and between the offender and the Commonwealth with the concurrence of the court.

Supreme Court; (ii) vest authority and oversight for monitoring the development and implementation of such courts with the Office of the Executive Secretary; (iii) allow variations in eligibility and legal design to meet the needs of different localities while prescribing minimum requirements; and (iv) build on the drug court model while distinguishing the unique needs of individuals with mental illness or co-occurring disorders.

Recommendation 8: Interested localities should seek grants to fund specialized dockets for criminal cases involving defendants with mental illness charged with non-violent offenders, and the General Assembly should prescribe conditions for establishing and operating these specialized dockets in a manner that provides appropriate services to eligible offenders, including veterans with mental illness, while assuring a fair disposition of their cases.

Assuring Access to Medication

One of the major challenges faced by state and local efforts to provide adequate treatment for individuals with mental illness who become involved with the criminal justice system is assuring consistent access to appropriate and effective medications as these individuals move from community, to jail, or to a mental health facility and back again to the community. When individuals with mental illness end up in jail, the chances of their continuing to receive their current medications in a timely manner are slim. Jails establish limited formularies, often based on resource constraints or preferences of their medical personnel. Many jails have policies prohibiting inmates from bringing their legally prescribed medications into the jail or filling those prescriptions, which a community practitioner has recommended. The medicine regimen is likely to change again if an inmate is subsequently hospitalized on a civil or forensic basis. Upon release, most jails do not provide medication to the departing inmate. Overlaying the prescribing and formulary issues ate additional problems associated with particular funding streams, and staffing limitations, and coordination problems in assuring linkage to services at entry or release. Some facilities and localities have taken steps to address these problems, and there have been many pockets of success (for example, Western State Hospital works diligently with local jails to assure consistency in formulary options). However, there is no comprehensive, statewide approach in place at this time.

The Commission will establish a working group specifically tasked with addressing the means to improve access to medications through better identification and braiding of funding streams, enhancing communication among consumers with criminal justice involvement, public and private mental health providers and local and regional jail staff and developing practices to enhance the availability of consistent formulary options for individuals moving among public and private providers, from community to incarceration and/or hospitalization.

Improving Sharing of Information

Comprehensive reports on criminal justice and mental health interface issues in Texas, Washington State and New York have highlighted the importance of removing barriers to sharing relevant mental health and criminal justice information across systems. In Virginia, April 16th is the only reminder we should need of the critical difference that shared information might have made. However, these issues are complicated, legally and logistically. What medical and criminal justice information needs to be accessible? What are the goals of such information-sharing, at the individual level and at the aggregate level? What are the risks of sharing information, even for good reasons? What databases exist? [44]What is now accessible? What is technologically possible? What are the legal considerations?

The Commission will create a working group specifically tasked with addressing information sharing issues. It will review the goals and available mechanisms for sharing information among various state agency data bases containing information pertaining to individuals with mental illness involved in the criminal justice system without compromising privileged or sensitive health care or criminal justice information.

B. Services for Children and Adolescents

The Report of the Task Force on Children and Adolescents "CA Task Force"),[45] submitted to the Commission in 2008, contained a comprehensive set of Recommendations to improve services and supports for children with, or at risk of, serious emotional disturbance. The overarching theme of the CA Task Force Report was to stimulate improved access to community-based services and to reduce the over-reliance on residential treatment. The availability of community-based services varies greatly throughout the state, with some areas having almost no services for children. When services are available, too often they cannot be accessed because the delivery systems are fragmented and confusing and waiting times are long. Children with untreated mental health problems are at risk for school failure and dropping out, violence, substance abuse, and suicide. Without treatment, children and families often end up in crisis, requiring more intensive and expensive treatment than if interventions had occurred earlier.

Several of the CA Task Force recommendations, all of which have been embraced by the Commission, relate to the enhance CSB capacity to serve the needs of these children in their communities:

---

[44] One key task will be to identify existing databases, e.g., VCIN, the Virginia Criminal Information Network (Virginia State Police); NCIC, the National Criminal Information Center (available to criminal justice agencies maintained by the Federal Bureau of Investigation); LIDS, the Local Inmate Data System utilized by Virginia's local and regional jails and maintained by the State Compensation Board); CCS3, the Consumer Community Submission utilized by the Community Services Boards and maintained by DBHDS.

[45] This Report is available at the Supreme Court's website at http://www.courts.state.va.us/programs/cmh/home.html.

- The Secretary of Health and Human Services should direct the Office of Comprehensive Services to create incentives to limit the use of residential treatment whenever possible, and use the money saved to create more community-based services. (CA Task Force Recommendation I.2)

- The General Assembly should amend the Virginia Code to mandate additional services for Community Services Boards beyond emergency services and case management, and include crisis stabilization, family support, respite, in-home services and psychiatric care. The General Assembly should also insure that funds are available to support these services. (CA Task Force Recommendation I.3).

- The Community Service Boards should make emergency mental health services for children and adolescents available on a 24-hour basis for referral and intervention in crisis situations identified by police officers (and others) as needing immediate mental health services. (CA Task Force Recommendation II.2).

- For those children identified as having significant but non-emergency mental health needs, the Community Services Boards should provide a system for prompt assessment to ensure that a child's condition does not deteriorate during any wait for outpatient services. (CA Task Force Recommendation II.6).

- Community Services Boards should allow case managers and the Department of Juvenile Justice should allow court services staff to make appointments for children for outpatient follow-up. (CA Task Force Recommendation II.10).

Implementation of these recommendations will be delayed by the Commonwealth's fiscal constraints. However, many stakeholder and political leaders are actively seeking ways of bolstering access to services and reducing unnecessary judicial involvement in ways that do not require commitment of additional funds. System Transformation, which grew out of the First Lady Ann Holton's For Keeps Initiative, is one mechanism that is bolstering access.

This work started in December of 2007 with the implementation of a change strategy based on state and local collaboration that included the development of a common vision, regulatory and policy changes, local practice changes, and training. As a result of the efforts of a great many people across the commonwealth, today in Virginia:

- The number of foster care youth in group care settings has been reduced by 40%,
- The percentage of youth being served in group care settings has reduced from 26% to under 17%,
- The percentage of youth being discharged to permanent families has increased by 6%,
- Comprehensive Services Act expenditures went down by 4% in FY 2009 for the first time since the beginning of that program with annual savings of

approximately $36M over what was originally appropriated. As part of this, localities realized an approximate savings of $14M in FY 2009 over what was expended in FY 2008. Much of these savings are as a result of the development of individualized community-based services rather than the use of congregate care.

While there is a great deal of work left to accomplish, child serving systems have begun to demonstrate that they can get better outcomes for kids and families while making the most efficient use of available tax dollars.

Another new initiative is The Campaign for Children's Mental Health ("Campaign"), a coordinated effort to improve Virginia's child mental health system by bringing together advocates, parents, treatment professionals, organizations and all the others who desire to make mental health services more available and accessible to the children who need them. Many of the participating individuals and organizations were members of the Commission's CA Task Force. The overall goal of the Campaign is to make mental health services more available and accessible to the children in Virginia who need them, regardless of where the children live or what "system" identifies their needs. Children who receive services as soon as they begin to show symptoms are less likely to escalate to the point of crisis, which reduces the need for more expensive and restrictive treatments. The Campaign's policy goals are to:

- Increase the array of community-based services (both public and private), particularly intermediate services that avoid over-reliance on residential treatment.

- Establish an integrated and consolidated system within state government with clear authority and adequate resources.

- Increase uniformity of the system statewide so that families throughout Virginia, regardless of the jurisdiction in which they live, can access appropriate services.

- Enhance the training of the current workforce and the capacity of the future workforce to treat children with evidence-based, best practice services.

C. College Mental Health

Mental health issues in higher education have not received the kind of systematic attention given to other domains of mental health policy in recent years. Key questions that needs to be addressed two-and-one-half years after the tragedy at Tech is what our colleges and universities are doing to identify and assist troubled students and whether the law impedes them from taking suitable steps to do so. A study of these issues will be undertaken in 2010 under the auspices of the Joint Commission on Health Care ("JCHC"). The Commission will assist the JCHC study before it completes its work.

The study is being directed by a Steering Committee with participation of individuals who have served on the Governor's Virginia Tech Panel, the Commission on Mental Health Law Reform as well as the Office of the Attorney General and will be formally coordinated with the State Council on Higher Education and the Department of Education. Membership is drawn from colleges and universities of varying sizes and locations, both public and private.

The Steering Committee will oversee the activities of two task forces, one on legal issues in college mental health and a second on access to mental health services by college and university students. The task force on legal issues ("Legal Issues Task Force") is charged with addressing the roles and responsibilities of colleges in responding to possible student mental health crises, including notification and sharing of information, threat assessment, initiation and participation in commitment proceedings and follow-up. The task force on access to services ("Access Task Force") is charged with assessing the current need for mental health services among Virginia's college and university students, and the current availability of services to address these needs. Each task force would make recommendations for training, institutional policies and practices, and any legislative action that may be needed. The Access Task Force is being chaired by Dr. Chris Flynn, the director of Cook Counseling Center at Virginia Tech, and the task force on legal issues is being chaired by Susan Davis, an experienced lawyer who also serves as a student affairs officer at UVA

Both Task Forces will convene stakeholders in order to initiate a statewide conversation about key issues and to develop consensus-based solutions.

Services issues include:

- Taking into account variations in size, location, composition of student bodies and available resources, what should be the goals of college counseling centers throughout the Commonwealth? What services are they now providing and what services should they be trying to provide?

- What relationships do they now have, and should they have, with other provider organizations and facilities, especially CSBs?

Legal issues include:

- Continuing concerns about access to information: What are current concerns and practices regarding disclosure of otherwise protected health or educational information within the institution, to/from the health care system, to/from parents, etc? Our aim is to identify and promote best practices.

- Current practices regarding assessment and intervention: What are current concerns and practices regarding risk assessment and institutional response to troubled students? Again, our aim is to identify best practices in varied settings.

- Under what circumstances is leveraged or mandated treatment now being used? Under what circumstances is it permitted or required?

With the direction and guidance of the Steering Committee, the task forces will conduct surveys of colleges and universities in their respective domains, assemble available information regarding these issues, including experience in other states, and will prepare a report and recommendations for consideration by the Steering Committee, review and comment by the Commission and other interested parties, and eventual submission to the JCHC.

This page left blank intentionally.

VII. SYSTEM INTEGRATION AND ACCESS TO SERVICES

As the Commission has observed often over the past three years, many of the problems involving people with mental illness confronted by the judicial system are ultimately traceable to gaps in access to mental health services. This is especially so for people without health insurance. Unfortunately, the Commonwealth's policies and funding mechanisms have failed to produce the robust and uniform array of community-based services and supports for adults and children envisioned by multiple state study committees and professional consensus statements over the last three decades. Untreated mental illness not only results in suffering by the individuals and families involved but also misdirects resources toward crisis response -- dispatching law enforcement to take the person into custody, conducting emergency evaluations in over-burdened emergency departments or other facilities, holding hearings before judicial officers, consuming many thousands of hours of judicial time and resources, and resulting far too often in costly inpatient care or incarceration. Although a significant investment in emergency services is a necessity even in the most enriched services system, Virginia's system is tilted disproportionately toward crisis response.

More effort should be directed toward reducing the likelihood and intensity of mental health crises. The Commonwealth should aim to assure a safety net of accessible recovery-oriented services and supports for adults with serious mental illness and children with or at risk of serious emotional disturbances. By so doing, it will reduce harms associated with mental illness and facilitate productive participation in social and economic life. This portion of the Commission's Report builds on the foundation laid in its Preliminary Report in 2007 to highlight the key components of a plan for increasing access to community mental health services -- a pressing public policy priority in Virginia.

A. System Integration

While thousands of individuals with mental illness are now living successfully in their communities rather than in state facilities or jails, funding for community services has not kept up with the need for them. The primary statutory obligations of CSBs are to provide emergency evaluation and crisis response, and to serve as gatekeepers to hospitalization through the involuntary admission process. While many localities also provide services needed to help people with serious mental illness maintain community integration, these services are insufficient in many regions and do not exist at all in some. Outpatient services, including psychiatric services, are especially thin throughout the Commonwealth.

Even emergency response resources are inadequate in some Virginia communities, and are threatened by current funding cuts. The effect of these resource constraints will be greater reliance on law enforcement as the first responder to mental health crises, and an overreliance on civil commitment proceedings, the majority of

which end in involuntary hospitalizations. Further, lack of crisis response teams and drop-off centers, intensive case management, and other outpatient treatment options too often leaves people untreated until inpatient commitment becomes the default option.

It is generally recognized that more resources are needed for public mental health services. But what is not so widely recognized is that the current dollars being spent are not being used as efficiently as they could be due to failure to fully align financial incentives to favor investments in community services. Too many service dollars are being spent in less efficient settings. Efficiency (as well as care in the least restrictive setting) cannot be achieved in a financing system that does not require the entities that use services to share in the cost of services. (The same can be said of the costs of incarceration when arrests and detentions serve primarily as a mechanism of responding to untreated mental illness.) The public investment in the mental health safety net needs to be organized so that the existing structure of multiple systems is replaced by a single, integrated system managed to use the dollars efficiently to provide mental health services to people with serious mental illness in the most cost-effective manner. The following two examples illustrate this point, though other examples may also exist.

The Commonwealth now has a dual system of public mental health services – a set of inpatient facilities operated by the state and a network of community services, including local inpatient services purchased from community hospitals, operated by or overseen by local government entities (CSBs). The two systems are funded through their own separate funding streams by a combination of federal, state and local dollars. These separate funding streams reflect an unfinished transition from a "safety net" once comprised of 12,000 beds in state-run hospitals to a community-based system providing a broad array of preventive services and acute care in the least restrictive setting.

Especially in the current economic climate, it is imperative to find ways to prevent utilization of the most expensive services – such as hospitalization - and encourage the use of less restrictive alternatives. Unfortunately, maintaining separate funding streams for CSBs and state facilities reduces flexibility and creates inefficiencies in the management of fiscal and treatment resources. The dual system reduces CSB incentives for seeking alternatives to state hospital treatment since once an individual is admitted to the state facility, the cost of services is shifted to the facility.

As state facilities have been downsized, increased funding for CSB purchase of local inpatient services has to some extent mitigated the incentive to utilize state facilities by enabling CSBs to control their inpatient resources and manage the purchase of private hospital beds. However, this approach cannot be expanded without additional funding. One approach to shifting current incentives to further encourage less restrictive treatment alternatives might be to integrate the funding streams for state hospital and CSB services into a single community services budget. This would enable CSBs to allocate and manage resources in the way that best supports consumers with the most effective, least restrictive and least costly services and supports.

The incentives created by how mental health services are financed also affect

consumers and their families. For example, the state subsidizes treatment during the TDO period, transportation under an involuntary order, and treatment during the period of involuntary commitment. Indeed, uninsured patients and their families, as well as providers, may have an incentive to characterize voluntary service-seeking as involuntary in order to access emergency treatment. If the resources consumed by these involuntary interventions were controlled by CSBs, there would be a financial incentive to develop less costly and less restrictive interventions in the community. The result of these distorted incentives is that involuntary inpatient care, and all too often, the Commonwealth's jails, serve as the ultimate safety net for people whose crises could have been prevented or ameliorated by providing the necessary services and supports in their communities. These and other financial incentives need to be aligned with, and support, treatment goals for consumers.

The *Integrated Strategic Plan* (ISP)[46] for the Commonwealth's behavioral health system states that state and local governments have a collective responsibility for assuring the provision of a "safety net" of appropriate services and supports in safe and suitable settings. The ISP envisions that DBHDS will provide leadership, vision and strategic and policy direction for the services system. The ISP also envisions that "as the single point of entry, CSBs will plan, coordinate, and monitor the provision of publicly funded services in their communities and will integrate and manage the utilization of these services provided by CSB and private sector providers, other local public agencies, and state hospitals and training centers." Regarding funding mechanisms, the ISP envisions "funding incentives and practices [that] support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost-effectiveness" as well as "access to…[services]... through funding streams that lead to the integration of care and alignment with recovery and resilience-oriented and person-centered principles" and "funding allocations [that] include incentives for efficient and cost-effective services that and consistent with evidence-based, best, and promising practices."

The Commission urges the Governor and the General Assembly to support and strengthen fuller integration of services provided by the state facilities and the community services boards and behavioral health authorities, and other public and private agencies, in accordance with the *Integrated Strategic Plan* recommendations described above. Specifically, the Governor and General Assembly should develop approaches to integrate the now separate budgets for public mental health services provided through state facilities and CSBs. The Commissioner of DBHDS should be encouraged to establish and implement the appropriate fiscal policy to accomplish this goal, and should be authorized to allocate and manage state funds budgeted for public mental health services in a manner that strengthens financial incentives to serve individuals in the least restrictive, most effective community-based services to the maximum extent compatible with the safety of the individual and the community.

---

[46] *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System*, 2006. Available at: http://www.dbhds.virginia.gov/documents/reports/OPD-IntegratedStrategicPlan.pdf.

This recommendation builds on the successful transformation and reinvestment initiatives developed by DBHDS and CSBs over many years, which show that aligning financial incentives with policy goals can successfully encourage creation of less restrictive, voluntary community services and supports, reduce reliance on hospitals including state hospitals, and promote overall efficiency and effectiveness of the system.

Recommendation 9: The Governor and the General Assembly should develop approaches to further integrate the funding of public mental health services in the Commonwealth in order to align funding incentives with strategic policy goals. The Governor and General Assembly should authorize the Commissioner, in collaboration with CSBs, to operationalize an integrated approach.

B. Strengthen Emergency Services and Case Management

The General Assembly and local governments should strengthen emergency services and case management services provided by CSBs as first steps in a multi-biennial strategy of strengthening the safety net of public mental health services**.**

State Board Policy 1038[47] recognizes that state and local governments, as well as the private sector, share a joint obligation to provide a safety net of mental health services:

> "It is the policy of the Board that the Department and CSBs, as partners in the public mental health, mental retardation, and substance abuse services system, are jointly responsible for assuring to the greatest extent practicable the provision of a safety net of appropriate public services and supports in safe and suitable settings for individuals with serious mental illnesses, mental retardation, substance use disorders, or co-occurring disorders who:
>
> - are in crisis or have severe or complex conditions;
> - cannot otherwise access needed services and supports because of their level of disability, their inability to care for themselves, or their need for a highly structured or secure environment; and
> - are uninsured, under-insured, or otherwise economically unable to access appropriate service providers or alternatives."

Unfortunately, residents of many regions of the Commonwealth not only lack access to adequate community-based services to maintain persons with serious mental illness in recovery -- a stated goal of the Integrated State Plan as well as other DBHDS

[47] POLICY 1038 (SYS) 06-1 The Safety Net of Public Services. April 7, 2006. POLICY MANUAL, State Mental Health, Mental Retardation and Substance Abuse Services Board Department of Mental Health, Mental Retardation and Substance Abuse Services. Available at: http://www.dbhds.virginia.gov/adm-StateBoardPolicies.htm.

policy statements -- but also lack adequate emergency services in the community to mitigate the adverse consequences of mental health crises. The predictable result is that often persons in crisis end up in jails or in state hospitals distant from home because they are the only options available.

As has been emphasized above, steps can be taken to utilize existing state mental health dollars more efficiently by aligning incentives with the goal of serving people in their communities in the least restrictive setting. However, over time, additional funding through local appropriations and state general grant funds will be necessary to establish the needed services in many parts of the Commonwealth. One key policy instrument for achieving this objective is to gradually broaden the range of core services that CSBs are mandated to provide by statute and under the performance contracts. This basic mechanism would leverage state funds to facilitate innovation and investment at the local and regional levels

Virginia Code §§ 37.2-500 and 37.2-601 currently *require* CSBs to provide emergency services, and case management *to the extent that funding permits*. In addition, the Code lists additional "minimum core services" that CSBs *may* provide using state funds, if such funds are available. We will address both of the currently mandated services in this section and address the additional "core services" in the next section.

Despite the statutory mandate, funding constraints have resulted in limited emergency services and inadequate case management. The types of "emergency services" available throughout the Commonwealth vary greatly. Although there have been improvements in recent years,[48] many CSBs lack adequate crisis-response services at the intensive end of the continuum that could avoid hospitalization or arrest.[49]

In addition, although there is ample evidence-based research documenting the critical importance of case management in maintaining individuals with serious mental illness in recovery, much of the case management available is focused on ensuring a speedy release of individuals from state facilities rather than successful maintenance in the community. As a result, mental health crises are often the most likely route to getting access to any mental health services, including case management. To change this dynamic, both mandates for emergency services and case management must be more specific and broader, and the variability of access to such services across the state needs to be reduced.

---

[48] See 2007 DBHDS survey at http://www.dbhds.virginia.gov/OMH-SurveyCrisisInterv.htm.

[49] Most CSBs provide at least limited levels of less-intensive *crisis* response, resolution, and referral services, although there is great variability across the state, particularly in more rural areas in the services offered and the availability of mental health professionals. A recent study by Virginia's Office of the Inspector General ("OIG") reported the vast majority of CSBs lack adequate psychiatric coverage for emergency services; fewer than half offered routine mobile crisis services, and many of those provide crisis services only on a limited basis to jails or hospital emergency departments; and only eight were staffed around the clock.

Recommendation 10: Strengthen Currently Mandated Services. As soon as resources are available, the General Assembly should revise §§ 37.2-500 and 37.2-601 of the Virginia Code to explicitly require CSBs to provide a broad array of emergency services, including crisis stabilization, as well as case management services.

Section 37.2-500 should be amended as follows as soon as resources are available:

> The core of services provided by community services boards within the cities and counties that they serve shall include a full continuum of emergency services, including day support and residential services for crisis stabilization, and ~~, subject to the availability of funds appropriated for them,~~ case management services. These services shall be provided in conformity with standards prescribed by the Department and included in performance contracts executed pursuant to Section 37.2-.

Section 37.2-601 should be amended in a similar fashion.

C. Gradually Mandate Additional Core Services

Virginia Code § 37.2-500 and § 37.2-601 currently include a list of "core services" that CSBs *may* provide with state funds:

> The core of services may include a comprehensive system of inpatient, outpatient, day support, residential, prevention, early intervention, and other appropriate mental health, mental retardation, and substance abuse services necessary to provide individualized services and supports to persons with mental illnesses, mental retardation, or substance abuse.

To effectively promote recovery of persons with serious mental illness, certain core services – outpatient, day support, and residential services -- should gradually be mandated as soon as state funding is available. State funding should provide the foundation of support for these mandated services, but not the sole support.

Recommendation 11: As soon as resources permit, the General Assembly should gradually require all CSBs to provide outpatient, day support, and residential services, including specialized services for children and adolescents, elderly persons, and persons under criminal charge, in jail or under supervision of the community justice system. State funding should provide the foundation of support for these mandated services.

The General Assembly should provide sufficient resources to DBHDS to assess the

impact of the graduated plan for increasing and strengthening core services and report to the Joint Commission on Health Care.[50]

D. Prescribe Service Standards and Performance Expectations

As the standard-setting process unfolds, the DBHDS should, with the CSBs, continue to refine standards for the emergency services required to be provided by CSBs throughout the Commonwealth and modify state policies, the Core Services Taxonomy, and performance contracts accordingly. The standards should include, but not be limited to, the following:

1. Crisis Response Capacity. All CSBs should have the capacity in funding and workforce to provide a full range of crisis response services accessible 24 hours each day to individuals experiencing a psychiatric crisis. Crisis stabilization, psychiatric urgent care and psychiatric, nursing and medication services are essential components of this Recommendation.

2. Crisis Stabilization Centers with Drop-Off Capability. Each CSB should have the capability within its continuum of crisis stabilization day support and residential services to receive custody of persons under an ECO from law enforcement officers.

3. Hot Line. Each CSB should establish a free access number that is consistent throughout the service area or region for all psychiatric crisis responses and referrals.

Further, DBHDS should specify training requirements, performance standards and acceptable caseloads for caseworkers, both in state facilities and in CSBs, for the various types of case management. To promote efficiency and continuity of care, DBHDS should promote the cross-training of CSB and state facility staff in emergency interventions and case management.

Carrying out these functions will require a major increase in resources for the central office of DBHDS, especially after the budget cuts incurred during the recent recession. Some mechanism needs to be found to enable the Department to carry out these strengthened oversight functions. One possibility is that DBHDS be granted authority to set aside up to 3% of service appropriations for administrative oversight and accountability (i.e., programmatic and fiscal oversight, training and program development, auditing, data infrastructure and reporting, etc.). The Commission will continue to explore various approaches to solving this problem.

[50] These recommendations will be further developed in the Report of the Task Force on Access to Services.

Recommendation 12: Strengthen CSB/ Performance Contracts. DBHDS should continue to use performance contracts for CSB-provided mental health, mental retardation and substance abuse services to help CSBs develop and sustain a full array of culturally competent, recovery-oriented emergency services and case management services and, over time, outpatient, day support and residential services. These contracts should assure that the service standards and core expectations for each mandated core service are defined, promulgated, contracted for, measured and reported to the various stakeholders including, but not limited to, the Secretary of Health and Human Resources for the Commonwealth and each local government which is party to a CSB Performance Contract.

E. Housing

The scientific literature convincingly establishes that providing adequate housing to people with mental illness substantially reduces the risk of re-hospitalization and re-arrest and other poor outcomes, even among the most severely impaired with co-morbid substance abuse problems and histories of chronic homelessness.[51] The Commission recommends responsible public agencies work together to remove barriers to providing housing supports to persons with serious mental illness, both to facilitate discharge from state facilities and to strengthen the prospects of successful community adjustment.

Recommendation 13: The General Assembly should direct the Secretary of Health and Human Resources to take the necessary steps to implement the portability of auxiliary grants.

Va. Code § 63.2-800 should be revised to authorize a portable Auxiliary Grant for housing supports, and the policies of the Virginia Department of Social Services, 22 Va. Admin. Code § 40-25-10, should be revised accordingly.

Recommendation 14: The Governor and General Assembly should require the responsible public agencies to work together to remove barriers to providing housing supports to persons with serious mental illness, both to facilitate discharge from state facilities and to strengthen the prospects of successful community adjustment.

F. Improve Access to Health Insurance

Comprehensive health insurance reform legislation currently under consideration

[51] See, e.g., Tsemberis S.,Gulcur, L., Nakae M., Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with Dual Diagnosis, American J. of Public Health, 94: 651-656 (2004).

in Washington, D.C. could have significant implications for the financing of mental health services. Most importantly, it could provide coverage for a large proportion of people with mental illness who now lack insurance of any kind and whose care is, in effect, subsidized by the taxpayers of the Commonwealth in one way or another. In the Commission's study of emergency evaluations conducted by CSBs during June, 2007, 40% of the individuals evaluated were uninsured. Overall, approximately 50% of those with serious mental illness seeking care at CSBs are funded with a combination of state and local dollars.

Medicaid is a critical financial component to Virginia's public mental health safety net, providing 44 percent of CSB funding and 12 percent of facility funding. However, much more could be done to leverage Medicaid funds to provide community-based mental health services. Currently, Virginia has one of the lowest eligibility levels in the country for its disabled population (80% of the federal poverty level). If federal health insurance reform is adopted, the number of people covered by Medicaid is likely to increase significantly, with the federal government picking up a large portion of the tab, though not all of it. This change is not likely to become fully effective until 2013 or later. In the meantime, however, the General Assembly should consider expanding Medicaid eligibility for the population classified as aged, blind and disabled by raising the eligibility criterion from the present 80% of the federal poverty level to 100% of the federal poverty level.

Although federal mental health legislation requires parity for all private health insurance provided through employers with 50 and more employees and under Medicare, not all Virginia businesses are covered by this legislation. The impact of federal health insurance reform legislation is not yet clear.

Recommendation 15: Require Parity in Mental Health Benefits. The General Assembly should assess the impact of the new federal mental health parity legislation as well as health insurance reform and, if necessary, consider strengthening Virginia's parity legislation for businesses with fewer than 50 employees.

G. Workforce Development

There is broad agreement that adequate access to community-based mental health services is a key to minimizing the inappropriate engagement of the courts and law enforcement in those instances where an individual is experiencing a mental health crisis. Such services, however, depend on a well-trained workforce of supervisory, mental health providers, case management, and peer support personnel. Unfortunately, Virginia's mental health workforce is under-resourced in trained professionals. The Commission believes that targeted measures should be taken to recruit, train, and retain qualified mental health professionals. Factors contributing to the Commission's concerns

about the Commonwealth's mental health workforce include:

- Senior leaders in mid-level management and executive positions are leaving their positions in unprecedented numbers, a trend that is expected to continue into the foreseeable future. The majority of those who move into clinical and administrative supervisory positions for the first time have received no training in supervision and leadership.

- Services and supports provided to individuals with mental illness by persons who have also experienced these conditions and received services (peers) offer a unique and effective method of delivering treatment and rehabilitation. Peer support personnel in Virginia's public mental health system could be better utilized.

- Effective delivery of community-based mental health services requires case managers who provide supportive counseling to the most seriously disabled individuals, provide crisis intervention, coordinate more complex plans of care, and monitor the effectiveness of the entire range services to prevent the need for more intensive and expensive interventions. In Virginia today there is no specialized training for case managers.

- The inability of provider organizations to maintain a full complement of qualified personnel compromises the quality of services delivered and decreases the capacity of the system. The following five critical roles in both public and private organizations continue to be most difficult positions to fill.

  - Physicians/Psychiatrists,
  - Registered Nurses,
  - Licensed Clinical Social Workers,
  - Case Managers (QMHP & QMRP), and
  - Direct Support Professionals

The Access Task Force's Workgroup on Workforce Development has studied these issues in detail and will release its full report and Recommendations in early 2010. Based on the findings already presented by the Workgroup, however, the Commission endorses the following Recommendations:

Recommendation 16: **The Department of Behavioral Health and Disability Services should carry out a wide range of specified activities, including the establishment of a Peer Support Workforce Development Commission, to increase the opportunities for employment of Peer Support personnel within the mental health service delivery system. The General Assembly should amend the Code of Virginia to reduce specific barriers to employment for Peer Support personnel.**

Recommendation 17: The Department of Behavioral Health and Disability Services should establish a Planning Committee to create a program of training and development for case managers in Virginia's behavioral health and intellectual disability services system. The General Assembly should establish a certification requirement for case managers who provide case management services called for in §37.2-500.

Recommendation 18: When resources permit, the General Assembly should support and facilitate the creation of programs to aid in recruiting and retaining mental health professionals in specialties that are in short supply, and particularly in areas of the State where supply is lowest or where turnover is highest. Such programs should include repayment for educational loans, psychiatric fellowships, tax credits and other innovative means of developing and keeping mental health professionals in the State.

This page is left blank intentionally.

VIII. Concluding Observations: Progress and Prospects

The Commission will complete its work in 2010, and plans on issuing a final Progress Report in the fall. As we begin the final phase of our work, a few observations about the current status of reforms and its future prospects are in order. First, the Commonwealth's economic condition has substantially delayed the course of mental health law reform. When the General Assembly enacted the first installment of reform legislation in early 2007, the Commonwealth's elected officials from both branches and both parties agreed that the investments made in community mental health services in FY 09-10 were meant to serve as a "down payment" on the long-term investment that is required. Over the past three years, the Commission has offered ideas about the direction and shape of reform affecting interactions between the legal system and the mental health services system, but ultimately the pace and success of these reforms will be determined by the resources available to implement them.

In the meantime, however, much can be done to set the stage for continuing improvements within the constraints of current resources. Consolidating the progress that has already been made will also enable the reform effort to move forward efficiently and successfully when the Commonwealth's fiscal prospects improve. What should be done to consolidate progress?

First, we need to establish a permanent structure for coordination and problem-solving after the Commission expires. Perhaps the Commission's most important contribution has been to draw together all the stakeholders in task forces and working groups, thereby facilitating coordination, monitoring and oversight, especially at state level. It is important to assure that these habits of collaboration survive after the Commission's work has been completed, and that they are replicated at the local and regional level. The Commission expects to make recommendations on this issue in 2010.

Second, it is important to establish accurate and well-managed data systems to facilitate monitoring, oversight and future policy development. The Commission has helped to stimulate significant improvements in data collection and analysis but much more needs to be done to broaden and sustain the capacity of these data systems.

Finally, we have to put in place measures of system performance. This challenge requires sustained attention during the Commission's final year. What should be our performance indicators in relation to the intersections of mental health and the judicial system? Public discourse about mental health law reform often makes it seem that we have to make trade-offs between public safety and individual liberty and privacy. This seems to imply that increasing the number of involuntary interventions should be regarded as an indicator of success because it would reduces the aggregate risk of harm. However, the Commission's view is strongly to the contrary: The surest path to public safety is <u>not</u> more coercion and less privacy for people with mental health problems, but rather establishing alternatives to hospitalization, making urgent care accessible when needed, and creating conditions that will lead to deeper and more enduring engagement of people with mental health needs in the services system. In the long run, the best

indicator of success of mental health system reforms is fewer TDOs and commitments, not more TDOs and commitments. The Commission also intends to address these issues in 2010.

APPENDIX A

Commonwealth of Virginia
Commission on Mental Health Law Reform

Commissioners

Chair

Richard J. Bonnie
Harrison Foundation Professor of Medicine and Law, Professor of Psychiatry and Neurobehavioral Sciences, and Director of Institute of Law, Psychiatry and Public Policy
University of Virginia
School of Law
Charlottesville, VA

Honorary Co-Chairs

The Honorable William T. Bolling
Lieutenant Governor of Virginia
Richmond, VA

The Honorable William C. Mims
Attorney General of Virginia
Richmond, VA

Members

Ronald A. Allison
Executive Director
Cumberland Mountain Community Services
Cedar Bluff, VA

Jack W. Barber, M.D.
Director
Western State Hospital
Staunton, VA

Mark Bodner, Esquire
Special Justice
Fairfax, VA

Victoria Huber Cochran, J.D.
Cochran Consulting and Facilitation Services
Blacksburg, VA

Patrick W. Finnerty
Director
Department of Medical Assistance Services
Richmond, VA

Vicky Mitchell Fisher, Ph.D., RN, APRN
Director of Nursing
Catawba Hospital
Roanoke, VA

The Honorable Isaac St. C. Freeman
Judge
Smyth County Circuit Court
Marion, VA

Terry Grimes, Ed.D.
President
Empowerment for Healthy Minds
Blacksburg, VA

Karl R. Hade
Executive Secretary
Supreme Court of Virginia
Richmond, VA

Charles A. Hall, M.Ed., CAS
Executive Director
Hampton-Newport News Community Services Board
Newport News, VA

Jane D. Hickey, Esquire
Senior Assistant Attorney General and Chief of Health Services Section
Office of the Attorney General
Richmond, VA

The Honorable Gerald S. Holt
Sheriff
Roanoke County
Salem, VA

The Honorable Janet D. Howell
Senator, District 32
Senate of Virginia
Reston, VA

The Honorable Catherine M. Hudgins
Fairfax County Board of Supervisors
Reston, VA

The Honorable Terry G. Kilgore, Esquire
Delegate, 1st District
House of Delegates
Gate City, VA

The Honorable L. Louise Lucas
Senator, District 18
Senate of Virginia
Portsmouth, VA

Gregory E. Lucyk, Esquire
Chief Staff Attorney
Supreme Court of Virginia
Richmond, VA

Charlotte V. McNulty
Executive Director
The Office of Comprehensive Services
Richmond, VA

The Honorable Deborah M. Paxson
Judge
Juvenile and Domestic Relations District Court
Virginia Beach, VA

James S. Reinhard, M.D.
Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services
Richmond, VA

James W. Stewart, III
Inspector General
Office of the Inspector General
Richmond, VA

Byron Stith
P.O. Box 1175
Mechanicsville, VA

F. Carol Ulrich, Esquire
President
NAMI-Northern Virginia
Herndon, VA

Kevin Young, BSW, MHA, CBHE
Corporate Director of Behavioral Health
Neuroscience Center of Excellence
Valley Health
Winchester, VA

Advisors

Katherine Acuff
Health Policy Consultant
Commission Editor
Charlottesville, VA

Thomas L. Hafemeister, J.D., Ph.D.
Associate Professor of Law
University of Virginia School of Law
Director of Legal Studies
Charlottesville, VA

Catherine K. Hancock, APRN, BC
Mental Health Policy Analyst
Department of Medical Assistance
Services
Richmond, VA

Richard E. Hickman, Jr.
Deputy Staff Director
Senate Finance Committee
General Assembly Building, 10th Floor
Richmond, VA

James M. Martinez, Jr.
Director, Office of Mental Health
Services
Department of Mental Health, Mental
Retardation and Substance Abuse
Services
Richmond, VA

Susan Massart
Legislative Fiscal Analyst
House Appropriations Committee
Richmond, VA

Raymond R. Ratke
Deputy Commissioner
Department of Mental Health, Mental
Retardation and Substance Abuse
Services
Richmond, VA

Interim Staff Director
Joanne Rome
Staff Attorney
Supreme Court of Virginia
Richmond, VA

Page left blank intentionally.

APPENDIX B

2009 PROGRESS REPORT RECOMMENDATIONS

Recommendation 1: As soon as resources permit, the Supreme Court's Office of Executive Secretary (OES) should consider establishing a position of "Special Justice Advisor" in the OES to serve, like the OES Magistrate Advisors, as a resource to provide information and support to special justices, and also to implement and coordinate conferences, certification and training events for special justices. In the meantime, the OES should consider utilizing existing resources to provide adequate training, staff support and direct assistance to special justices in the Commonwealth.

Recommendation 2: The Office of the Executive Secretary of the Supreme Court should create an advisory committee to assist in formulating the training curriculum pertaining to civil commitment proceedings for judicial officers, including magistrates, judges and special justices.

Recommendation 3: The General Assembly should increase the maximum period of temporary detention to 72 hours or the end of the next business day if the time period ends on a Saturday, Sunday, or holiday. In so doing, the Commission also recommends that no commitment hearing be held in less than 24 hours.

Recommendation 4: The General Assembly should amend Virginia Code § 37.2-813 to permit the facility to release an individual from custody if the responsible physician, after an evaluation and consultation with the petitioner and community services board, determines that the person does not meet commitment criteria. The involuntary commitment proceedings would be terminated.

Recommendation 5: The General Assembly should amend Virginia Code § 37.2-813 to provide that an individual under a TDO be permitted to consent to voluntary admission and that the commitment proceedings be terminated upon conversion to voluntary status. If a person under a TDO is converted to voluntary status prior to the commitment hearing, the Involuntary Civil Commitment Fund managed by DMAS continue to pay for the person's hospitalization and treatment at least through the time the commitment hearing would have been held.

Recommendation 6: The General Assembly should amend Virginia Code §§ 19.2-169.2, 19.2-176 and 19.2-177.1 to remove the inconsistencies, to clarify the procedural requirements, and to make the process as congruent as possible with the civil commitment process.

Recommendation 7: The General Assembly should consolidate and clarify the statutes governing commitment of juveniles consistent with the recommendations of the Commission's Task Force on Children and Adolescents.

Recommendation 8: Interested localities should seek grants to fund specialized dockets for criminal cases involving defendants with mental illness charged with non-violent offenders, and the General Assembly should prescribe conditions for establishing and operating these specialized dockets in a manner that provides appropriate services to eligible offenders, including veterans with mental illness, while assuring a fair disposition of their cases.

Recommendation 9: The Governor and the General Assembly should develop approaches to further integrate the funding of public mental health services in the Commonwealth in order to align funding incentives with strategic policy goals. The Governor and General Assembly should authorize the Commissioner, in collaboration with CSBs, to operationalize an integrated approach.

Recommendation 10: Strengthen Currently Mandated Services. As soon as resources are available, the General Assembly should revise §§ 37.2-500 and 37.2-601 of the Virginia Code to explicitly require CSBs to provide a broad array of emergency services, including crisis stabilization, as well as case management services.

Recommendation 11: As soon as resources permit, the General Assembly should gradually require all CSBs to provide outpatient, day support, and residential services, including specialized services for children and adolescents, elderly persons, and persons under criminal charge, in jail or under supervision of the community justice system. State funding should provide the foundation of support for these mandated services.

Recommendation 12: Strengthen CSB/ Performance Contracts. DBHDS should continue to use performance contracts for CSB-provided mental health, mental retardation and substance abuse services to help CSBs develop and sustain a full array of culturally competent, recovery-oriented emergency services and case management services and, over time, outpatient, day support and residential services. These contracts should assure that the service standards and core expectations for each mandated core service are defined, promulgated, contracted for, measured and reported to the various stakeholders including, but not limited to, the Secretary of Health and Human Resources for the Commonwealth and each local government which is party to a CSB Performance Contract.

Recommendation 13: The General Assembly should direct the Secretary of Health and Human Resources to take the necessary steps to implement the portability of auxiliary grants.

Recommendation 14: The Governor and General Assembly should require the responsible public agencies to work together to remove barriers to providing housing supports to persons with serious mental illness, both to facilitate discharge from state facilities and to strengthen the prospects of successful community

adjustment.

Recommendation 15: Require Parity in Mental Health Benefits. The General Assembly should assess the impact of the new federal mental health parity legislation as well as health insurance reform and, if necessary, consider strengthening Virginia's parity legislation for businesses with fewer than 50 employees.

Recommendation 16: **The Department of Behavioral Health and Disability Services should carry out a wide range of specified activities, including the establishment of a Peer Support Workforce Development Commission, to increase the opportunities for employment of Peer Support personnel within the mental health service delivery system. The General Assembly should amend the Code of Virginia to reduce specific barriers to employment for Peer Support personnel.**

Recommendation 17: The Department of Behavioral Health and Disability Services should establish a Planning Committee to create a program of training and development for case managers in Virginia's behavioral health and intellectual disability services system. The General Assembly should establish a certification requirement for case managers who provide case management services called for in §37.2-500.

Recommendation 18: When resources permit, the General Assembly should support and facilitate the creation of programs to aid in recruiting and retaining mental health professionals in specialties that are in short supply, and particularly in areas of the State where supply is lowest or where turnover is highest. Such programs should include repayment for educational loans, psychiatric fellowships, tax credits and other innovative means of developing and keeping mental health professionals in the State.

Page left blank intentionally.

APPENDIX C

INITIAL HEARING DISPOSITIONS, FY10 1ST QTR, BY DISTRICT COURT (N ≥ 50)

		HEARING RESULT			
		Dismissal	MOT	Involuntary Hospitalization	Voluntary Hospitalization
Arlington (n=99)	Count	29	0	43	27
	%	29.3%	0.0%	43.4%	27.3%
Fairfax County (n=208)	Count	36	2	63	107
	%	17.3%	1.0%	30.3%	51.4%
Henrico (n=69)	Count	8	0	48	13
	%	11.6%	0.0%	69.6%	18.8%
Loudoun (n=64)	Count	7	0	20	37
	%	10.9%	0.0%	31.3%	57.8%
Mecklenburg (n=102)	Count	19	0	34	49
	%	18.6%	0.0%	33.3%	48.0%
Montgomery (n=152)	Count	15	0	29	108
	%	9.9%	0.0%	19.1%	71.1%
Prince William (n=168)	Count	27	18	37	86
	%	16.1%	0.0%	33.3%	48.0%
Rockingham (n=81)	Count	9	0	38	34
	%	11.1%	0.0%	46.9%	42.0%
Russell (n=51)	Count	7	0	15	29
	%	13.7%	0.0%	29.4%	56.9%
Smyth (n=352)	Count	110	1	211	30
	%	31.3%	0.3%	59.9%	8.5%
Alexandria (n=52)	Count	14	1	23	14
	%	26.9%	1.9%	44.2%	26.9%
Bristol (n=116)	Count	0	0	36	80
	%	0.0%	0.0%	31.0%	69.0%
Charlottesville (n=126)	Count	47	0	71	8
	%	37.3%	0.0%	56.3%	6.3%
Chesapeake (n=176)	Count	17	0	145	14
	%	9.7%	0.0%	82.4%	8.0%
Danville (n=200)	Count	0	1	82	117
	%	0.0%	0.5%	41.0%	58.5%
Fredericksburg (n=143)	Count	74	0	46	23
	%	51.7%	0.0%	32.2%	16.1%
Galax (n=153)	Count	133	0	5	15
	%	86.9%	0.0%	3.3%	9.8%
Hampton (n=347)	Count	137	0	152	58
	%	39.5%	0.0%	43.8%	16.7%
Hopewell (n=115)	Count	2	0	106	7
	%	1.7%	0.0%	92.2%	6.1%

		HEARING RESULT			
		Dismissal	MOT	Involuntary Hospitalizations	Voluntary Hospitalizations
Lynchburg (n=183)	Count	67	0	113	3
	%	0.0%	0.0%	73.0%	27.0%
Norfolk (n=63)	Count	0	0	46	17
	%	0.0%	0.0%	73.0%	27.0%
Petersburg (n=353)	Count	19	0	292	42
	%	5.4%	0.0%	82.7%	11.9%
Portsmouth (n=78)	Count	24	0	49	5
	%	30.8%	0.0%	62.8%	6.4%
Richmond (n=562)	Count	47	0	444	71
	%	8.4%	0.0%	79.0%	12.6%
Roanoke (n=414)	Count	17	2	226	169
	%	4.1%	0.5%	54.6%	40.8%
Salem (n=223)	Count	6	1	157	59
	%	2.7%	0.4%	70.4%	26.5%
Virginia Beach (n=257)	Count	9	0	185	63
	%	3.5%	0.0%	72.0%	24.5%
Winchester (n=98)	Count	17	0	8	73
	%	17.3%	0.0%	8.2%	74.5%
Total (n=5005)	**Count**	**897**	**26**	**2724**	**1358**
	%	**17.9%**	**0.5%**	**54.4%**	**27.1%**

APPENDIX D

ACRONYMS

AD	Advance Directive
BJMHS	Brief Jail Mental Health Screen
CIT	Crisis Intervention Team
CMS	Case Management System
CSB	Community Service Board
DBHDS	Department of Behavioral Health and Developmental Services
DCJS	Department of Criminal Justice Services
DDNR	Durable Do Not Resuscitate
ECO	Emergency Custody Order
GAL	Guardian *ad litem*
HB	House Bill
HCDA	Virginia’s Health Care Decisions Act
HIPAA	Health Insurance Portability and Accountability Act
MOT	Mandatory Outpatient Treatment
NGRI	Not Guilty By Reason of Insanity
OES	Office of the Executive Secretary of the Supreme Court
SB	Senate Bill
TDO	Temporary Detention Order
VSP	Virginia State Police

Joint Commission on Health Care
900 East Main Street, 1st Floor West
P. O. Box 1322
Richmond, VA 23218
804.786.5445/804.786.5538 (fax)
Website: http://jchc.virginia.gov