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.

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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

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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.

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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.

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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

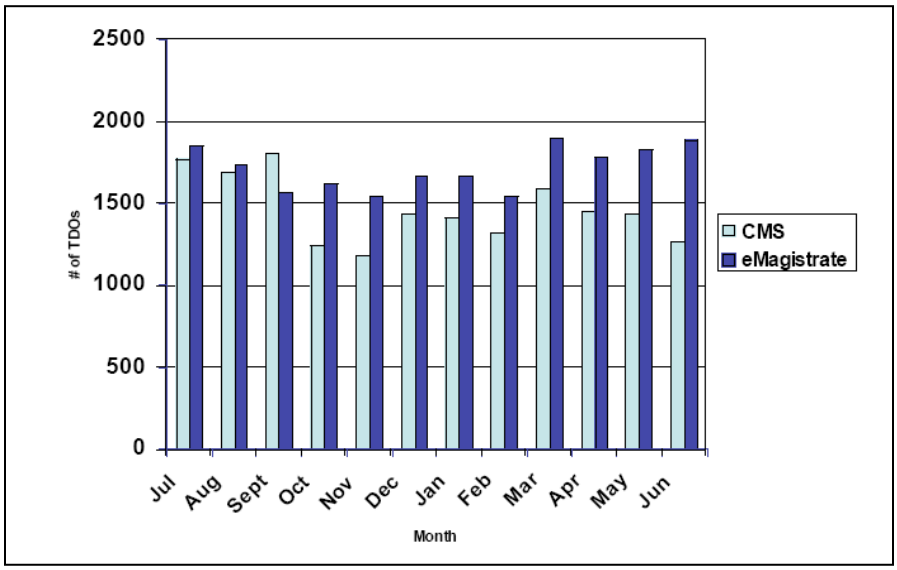
Temporary Detention Orders

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]

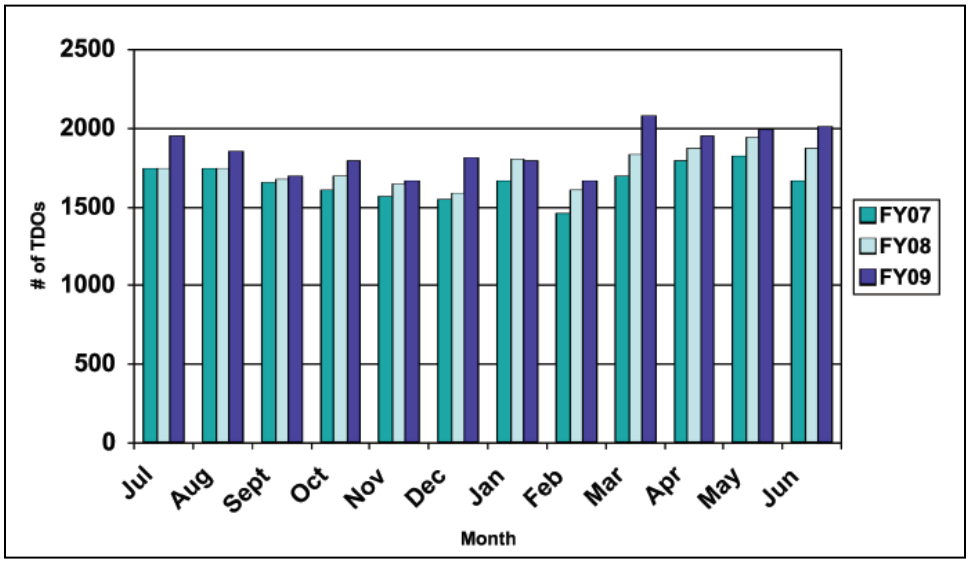
	Estimated Number of Adult TDOs	
	CMS	eMagistrate*
1st Quarter	5,071	4,966
2nd Quarter	3,687	4,605
3rd Quarter	4,140	4,883
4th Quarter	3,963	5,241
Total	16,861	19,695

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.

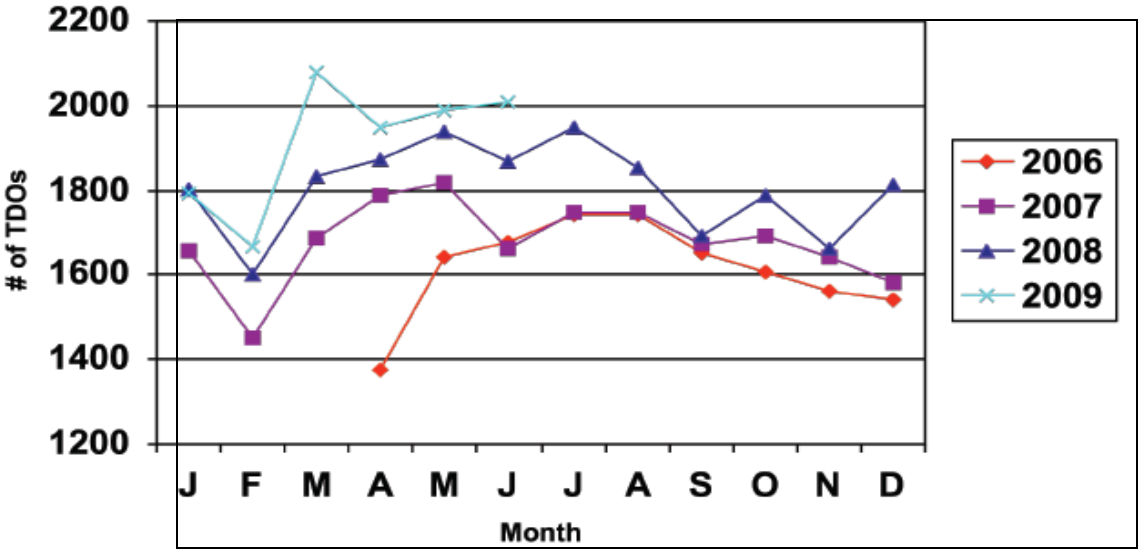
TDOs began in January 2008, and the rate of increase actually *declined* after the new law went into effect in July 2008, followed by a period of irregularity from September through December 2008, when TDO rates went up and down. This suggests that the increase in adult TDOs during 2008 is attributable 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

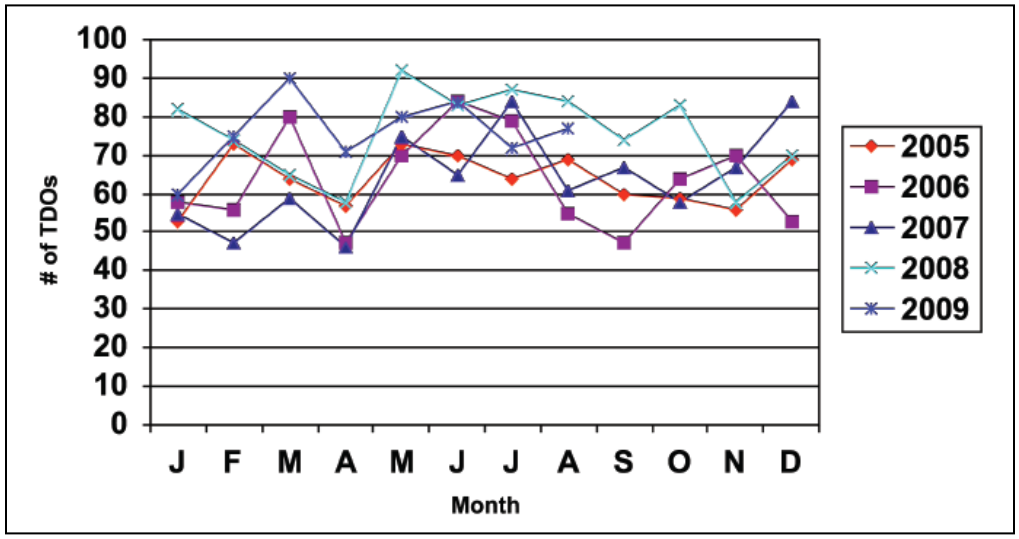


Table 6: Frequency of TDOs in Fairfax-Falls Church CSB, 2005-2009

	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.

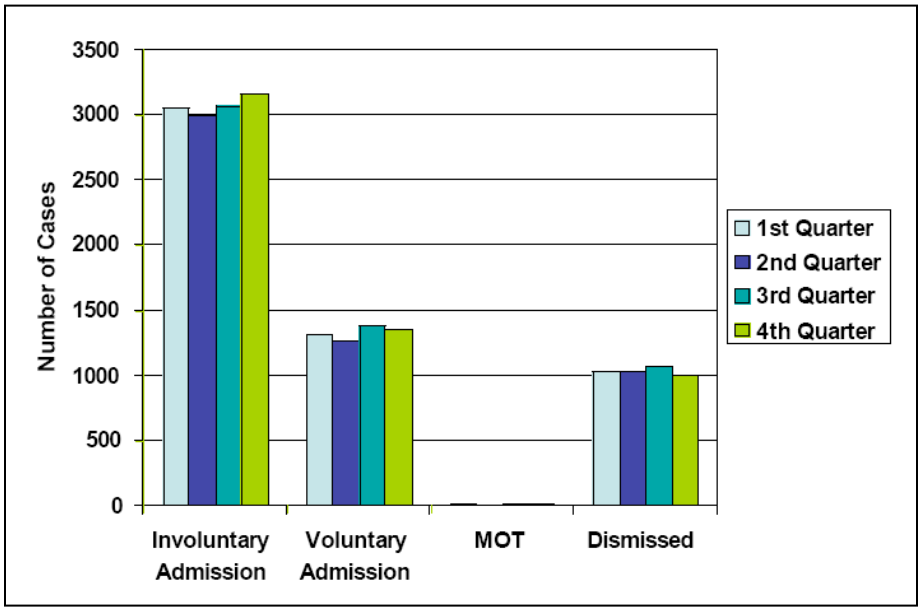
[16] Payments increased from $1,946,291 in FY08 to $2,305,391 in FY09 (18.5%), but we believe that this is an overestimate of the increase in civil commitment hearings. Payments are made to special justices when the paperwork is submitted to the Supreme Court, not necessarily when the hearing occurs,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

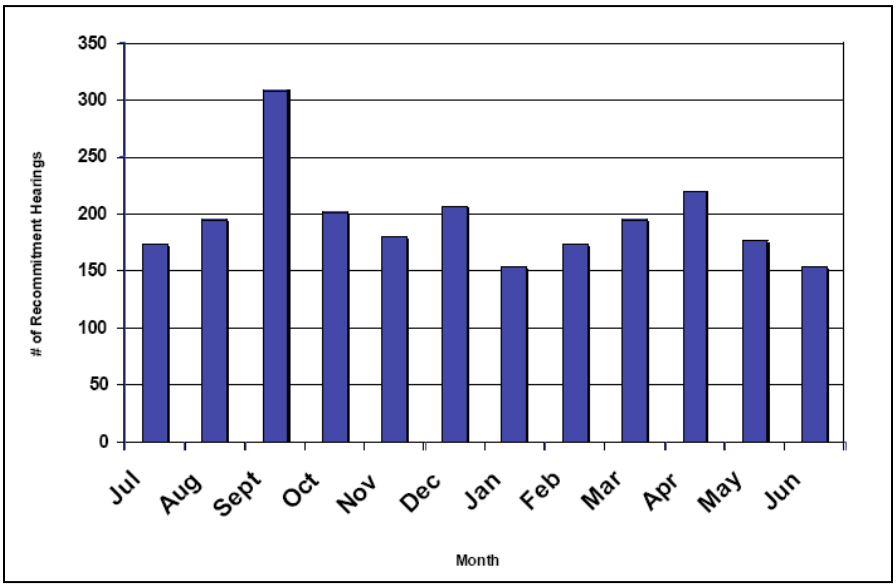
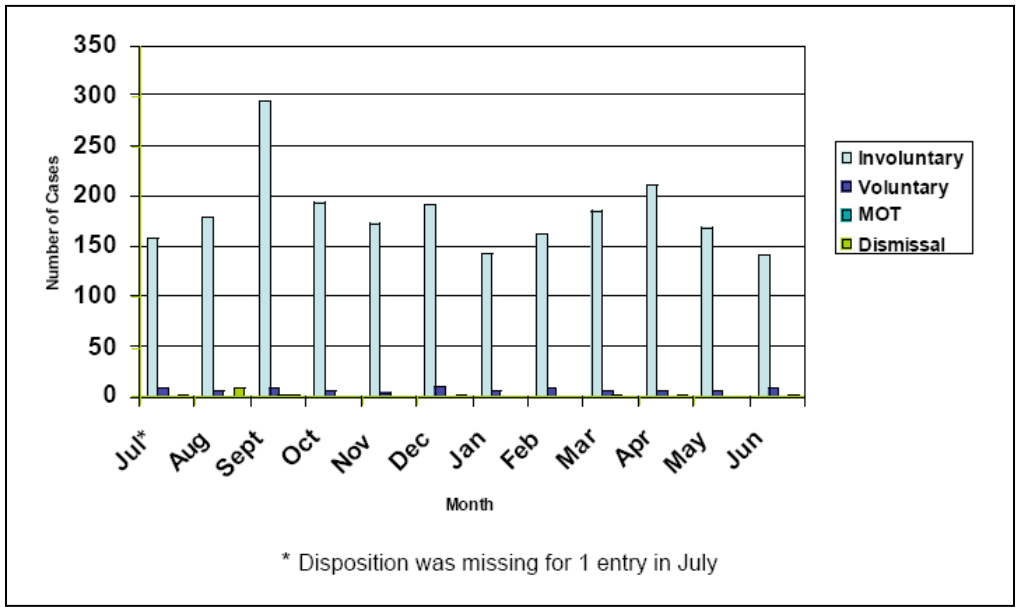


Figure 7. Frequencies of Dispositions at Recommitment Hearings



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.

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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.

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[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.

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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

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[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.

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[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:

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[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.

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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.

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[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:
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> - 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.

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[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.

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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

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The Honorable Isaac St. C. Freeman
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Senior Assistant Attorney General and Chief of Health Services Section
Office of the Attorney General
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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
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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.

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adjustment.

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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.

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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