Virginia Civil Commitment Procedure and Practice: Policy Analysis and Recommendations to Increase Voluntary Admission

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Executive Summary

What policy changes can the Virginia Commission on Mental Health Law Reform recommend and implement to reduce the number of involuntary commitments in favor of voluntary admission?

The Commonwealth of Virginia Commission on Mental Health Law Reform (the Commission), is tasked with improving mental health laws, procedure, and policy to better serve people with mental illness. One of the Commission's goals is to increase the fairness and effectiveness of the civil commitment process. All of the analysis presented in this report is the result of extensive inquiry. With the aid of quantitative data, I was able to identify and target areas of the state with large variation in involuntary commitment rates among either Community Service Boards (CSBs) or special justices. I interviewed CSB emergency services managers and special justices about their operating procedures and attitudes concerning civil commitment. I also spoke with mental health experts and hospital officials including doctors, intake coordinators, personnel managers, nurses, and social workers. While current civil commitment procedure in Virginia allows individuals suffering from mental health crises to admit themselves voluntarily, many people do not. There are several reasons beyond a lack of capacity that might influence a person's decision not to agree to care voluntarily. Based on my research and analysis, I recommend five specific policies that the Commission could adopt or recommend to encourage the election of voluntary admission by people with mental illnesses in lieu of involuntary commitment.

Why Voluntary Admission is Better

Voluntary admission is associated with better clinical outcomes, principal among them a reduced chance of future involuntary commitment and greater patient adherence to care. Patients who experience less coercion and trauma in the admission process generally feel more empowered over their care and more trustful of health professionals. Voluntary treatment refers to care or treatment that an individual undergoes willingly, but sometimes a patient's agreement results from overt and/or covert pressure, which can engender feelings of coercion. Any solution aiming to incentivize voluntary admission must not be coercive in order to result in better mental health outcomes. Many individuals view involuntary commitment as frightening, and this traumatic aspect of involuntary commitment can lead to negative treatment outcomes. While there is certainly a preference for voluntary admission, involuntary treatment must remain an option for those whose condition prevents them from recognizing their need for care.

Civil Commitment in Virginia

The Virginia statute governing civil commitment requires a judicial determination by clear and convincing evidence that a person has a substantial likelihood "[of causing] serious physical harm to himself or others . . . or [of suffering] serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs." If the person is determined to be incapable of volunteering or unwilling to volunteer and there is not an appropriate less restrictive alternative, then the person may be involuntarily committed. Special justices base commitment decisions on relevant evidence such as testimony from mental health professionals, the person's history, the CSB pre-screener's report, an independent evaluator's report, and any other information deemed relevant. Should a person require care but be unwilling or incapable of accepting voluntary admission, there are a series of legal steps before the civil commitment hearing to allow for the person to be treated voluntarily by the hospital. CSB emergency services workers become involved with someone suffering a mental health crisis should that person require an Emergency Custody Order (ECO) from a magistrate so the individual can be held for an initial mental health evaluation. If this evaluation concludes that inpatient treatment is needed, a person can admit himself voluntarily. For individuals unwilling to admit themselves or incapable of doing so, a magistrate must find probable cause of

harm to the person or others for the issuance of a temporary detention order (TDO) to hold the individual in a hospital for up to 48 hours. For a TDO, a CSB emergency services official must find an available bed. The individual is generally transported by law enforcement officials, and when beds cannot be located in the immediate area, this can often involve lengthy transportation across the state. The civil commitment hearing is held within 48 hours of the TDO's issuance. The hearing can result in a dismissal, involuntary commitment for a maximum of 30 days, mandatory outpatient treatment, or judicial voluntary admission, which requires the individual to agree to care for a minimum of 72 hours and to give 48 hours notice prior to leaving.

Research Findings

Every region, special justice, CSB, and hospital is different. The overall lack of data and monitoring in the state has created an information deficit concerning the actual practice of civil commitment. There is evidence that commitment decisions may be affected by: financial incentives, behavioral norms, hospital-CSB relationships, Local Inpatient Purchase of Services (LIPOS) funding structures, availability of crisis management services and outpatient care, hospital preferences, distance of CSB from inpatient facilities, a CSB's volume of patients, and personal views of the assigned special justice. Also, in some areas, the schedule of hearings is so inflexible that individuals who may benefit from a hearing at the end of their 48 hour stay are seen within 12 or 24 hours. Thus, a person who could be released or treated voluntarily if the hearing occurred later on is more likely to lack competency and/or be unwilling to agree to voluntary treatment. This variation makes general conclusions about the commitment process extremely difficult.

Adding to this obstacle is the opaqueness of decisions by CSBs on how to proceed with a particular person and by hospitals on which patients to admit. While these decisions can be hard to untangle because of individual patient characteristics, regional variation, and less than full disclosure from all the involved actors, at least in some instances, financial factors influence care decisions made by CSB officials and hospitals. Some hospitals purport to admit everyone "on paper" who is clinically appropriate for their facility, but in reality, many of these same hospitals reject individuals for financial reasons. CSBs say they never let transportation issues or facility availability affect decisions, but there are reports that CSB staff is more likely to recommend a TDO in these situations. Further, the LIPOS structure may incentivize involuntary commitment. While the connection between commitment rates and LIPOS funding is not clear-cut, the manner in which LIPOS is distributed within a region may limit the flexibility of CSBs to accommodate patients and thus, more prone to recommend involuntary hospitalization.

While every special justice conducts hearings with slight differences, special justices' attitudinal predilections are crucial. How special justices conduct their hearings may determine outcomes more than any other factor. For example, one critical difference between special justices is whether they allow individuals to reserve the right to agree to voluntary admission at the end of the hearing when the only other option is involuntary commitment or whether individuals only have one opportunity at the beginning of the hearing.

Policy Recommendations

1. Change funding structure of initial care to be purely need-based and not linked to whether a patient is voluntarily or involuntarily admitted. If a person is in need of inpatient care, she should receive care regardless of whether she admits herself or is admitted pursuant to a TDO. Funding of mental health care at the initial stages should be used for indigent patients who admit themselves voluntarily and meet the commitment criteria.

2. Develop explicit guidelines and an explicit script for special justices to encourage more consistency in the exploration of voluntary admission. By reforming and realigning special justices' understanding of their own role and clarifying the procedures to be used at the hearing, there is potential to decrease the rates of involuntary commitment and standardize judicial process. Special justices have varying views, styles, and practices. With greater consistency to hearing procedure through the use of a step-by-step script, there may be greater consistency in results; if not, there will be, at the very least, more consistency in practice.

3. Allow conversion from TDO status to voluntary admission pursuant to a physician's recommendation. By allowing patients to convert from involuntary status under a TDO to voluntary status, the facility would cancel any upcoming hearing. A "minimum stay" does not need to be included as part of such an agreement; if the patient tries to leave the facility, then a new petition can be filed. This change has the obvious incentive of avoiding the civil commitment hearing altogether, which could reduce individuals' perceptions of coercion. An individual's liberty would not be threatened; patients would be given more control in collaboration with their doctors to determine their care and avoid the often negative, and here unnecessary, experience of a hearing. That said, it would be crucial that doctors do not pressure or coerce individuals into accepting this route.

4. Standardize LIPOS funding across the state so that it is available for patients who meet commitment criteria that are either voluntarily admitted or involuntarily committed. Encouraging Health Planning Regions to change some of the restrictions on LIPOS funds would allow those assets to be used more flexibly and responsively so as to better accommodate patient needs. Funding voluntary admission and involuntary commitment in equal measure will eliminate incentives that may exist within the system to involuntarily commit or recommend TDOs for patients. Such a change will likely involve a shifting of resources not necessarily increased funding.

5. Allow for the extension of the TDO period from 48 hours to 72 hours. With a slightly longer permissible TDO period, some patients' conditions may improve to the point they may be discharged or more inclined to accept voluntary admission. The extension of the TDO period would not necessarily lead to longer hospitalization and actually may lead to shorter stays. Financially, hospitals would not be affected; rather, the change would shift state dollars between two funds.

6. Create and implement centralized data collection and monitoring. There is no overall synthesis or analysis of decision-making norms at each step of the commitment process. Tracking trends in the state and asking questions about standard practices would help to clarify what factors may be driving decisions in some localities and address these differences with sound policy changes.

A. Introduction: Overview of Policy Question and Research Methodology

Policy Question: *What policy changes can the Virginia Commission on Mental Health Law Reform recommend and implement to reduce the number of involuntary commitments in favor of voluntary admission?*

The Commonwealth of Virginia Commission on Mental Health Law Reform (the Commission) was formed in 2006 by the Supreme Court of Virginia. The Commission is tasked with conducting a comprehensive examination of Virginia's mental health laws and services with the goal of improving the law to better serve the needs of people with mental illness.[1] The Commission's goals include: reducing the need for commitment proceedings by improving access to mental health, mental retardation and substance abuse services, decriminalizing the commitment process, improving the fairness and effectiveness of the civil commitment process, giving mental health consumers more choices for mental health care, and preventing young people with mental health problems from worsening.[2] Members of the Commission include officials from all three branches of state government and representatives of private stakeholder groups such as mental health consumers, their families, service providers, and the bar. The Commission is chaired by Professor Richard Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia.

The Commission has released studies on many aspects of mental health services in Virginia. Underlying the Commission's work since its inception is the goal of standardizing commitment laws to improve the system's effectiveness with respect to patient outcomes and the system's fairness. With the Commission's help, as well as the efforts of advocates, lawmakers, and consumers of mental health care, the General Assembly (GA) significantly changed Virginia's mental health laws in 2008. The changes passed by the GA focused on five key areas: commitment criteria, mandatory outpatient treatment, procedural improvements, privacy and disclosure provisions[3], and firearms purchase and reporting requirements.[4] With respect to involuntary commitment, the GA modified the commitment criteria and made extensive procedural changes to promote more consistent application throughout the Commonwealth. Most of the changes enacted were recommended and endorsed by the Commission as well as the Virginia Tech Review Panel.

The purpose of this analysis is to examine what policies Virginia could adopt to replace involuntary commitment with voluntary admission for individuals with mental illness. Current civil commitment procedure in Virginia affords many opportunities for an individual to admit himself voluntarily. Many people do admit themselves voluntarily, but others do not. Some individuals resist voluntary treatment due to their own mental incapacity and incompetence, but other individuals who might seek or accept care voluntarily do not for many reasons. While great strides have been made in improving Virginia's commitment laws, the number of

[1] Fact Sheet on the Virginia Commission on Mental Health Law Reform, available at http://www.courts.state.va.us/programs/cmh/background/home.html, accessed Jan. 10, 2010.
[2] Id.
[3] H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008). The preceding four areas of change were addressed by House Bill 499. *Id.* An identical bill was introduced in the Senate as Senate Bill 246. S.B. 246, Va. Gen. Assembly (Reg. Sess. 2008).
[4] H.B. 815, Va. Gen. Assembly (Reg. Sess. 2008).

consumers who are currently involuntarily committed could be reduced in favor of voluntary admission through changes in current procedures, policies, and laws.

An obvious solution to reducing the number of people involuntarily committed is to provide more extensive and higher quality mental health services earlier in time and to encourage individuals to access these services preventatively. Consumers of mental health care, magistrates, special justices, and mental health professionals all reference the revolving door aspect of mental health treatment: civil commitment often stabilizes a patient in the short term only.[5] It is clearly desirable to reduce the need for hospitalization through more preventative programs and less restrictive mental health treatment options, but expanding and improving mental health services generally is not the topic of this analysis. Rather, this analysis focuses on changes that can be made within the current system to encourage, and perhaps incentivize, individuals who are now involuntarily committed to admit themselves voluntarily.

All of the research and information contained in this report is the result of extensive inquiry and any person identified by name in reference to a quote or contribution has consented. Where experts or officials were willing to speak, but preferred not to have their names cited, I refer to them anonymously. The bulk of my research was comprised of qualitative interviews with academic experts, mental health professionals including doctors and emergency services managers, special justices, mental health consumers, and other well-positioned, knowledgeable officials. The interviews were structured and conducted in a format to elicit peoples' experiences, opinions, and expertise while minimizing influence on the content of their responses. By talking to people in decision-making positions throughout the state, I was able to learn about the practices, procedures, and pressures that combine to influence commitment rates. A key part of my research focused on talking to mental health officials and special justices in areas of the state that displayed significant variation in the outcome of evaluations by CSB professionals and in the outcome of commitment hearings.

To identify the key special justices that I interviewed, I relied on data from the Supreme Court's Case Management System (CMS), which collects information on civil commitment hearings documented by Court clerks at Virginia General District Courts.[6] Through CMS, each District Court records its cases and categorizes them as traffic, criminal, civil, or involuntary civil commitment. Civil commitment hearings are entered in the involuntary civil commitment division of the CMS database, which is maintained by the Office of the Executive Secretary (OES) at the Supreme Court. Reliable CMS data are available starting from the 2009 Fiscal Year (July 1, 2008 onward). In addition, the Commission itself collected data for all commitment hearings conducted during May 2007.[7] When the CMS data was broken down by locality to examine any variation in judicial practice and/or procedure, there is significant variation between special justices in their rates of involuntary commitment and voluntary admission.

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[5]McGarvey, Elizabeth, Civil Commitment Practices in Virginia: Perceptions, Attitudes, and Recommendations 19 (April 2007); Interviews with patients, patient advocates, and CSB professionals.

[6] Virginia Commission on Mental Health Law Reform, *2008 Progress Report* 20, available at http://www.courts.state.va.us/programs/cmh/home.html (accessed Dec. 17, 2009). [hereinafter 2008 Progress Report]

[7] Meeting with Professor Richard Bonnie, Chair of the Commission (12.17.2009).

For Community Service Board (CSB) officials, I sent surveys via e-mail to the Emergency Services managers across the state. In addition, I relied on data from the Commission's June 2007 study on CSBs throughout the state which provided a snapshot of how many CSB evaluations led to the issuance of a temporary detention order (TDO), voluntary admission, or no further action during that month. While the report is a few years old, the data are considered to be reliable because commitment rates largely remain constant over time.

Part II begins with an exploration of the Commission's policy preference for voluntary treatment over involuntary admission. A detailed account of the statutory admission requirements and procedures in Virginia follows. Part II ends with the criteria crucial to any successful policy change designed to encourage more voluntary admission. Part III gives a detailed account of how psychiatric inpatient care is currently funded in Virginia with special attention to various funding mechanisms. It also examines the decisions made by hospitals in admitting patients and CSBs in placing individuals. Admissions decisions by hospitals and decisions by CSBs can be difficult to untangle, but it appears from the research, that at least some of the time, both actors are influenced by financial factors in making patient care decisions. Part IV presents the qualitative evidence I gathered through interviews and surveys based on the quantitative data mentioned above along with my analysis of the roles of CSB officials, hospitals, and special justices. Part V briefly summarizes the conclusions and Part VI outlines the policy recommendations.

I. Civil Commitment in Virginia

A. Policy Preference for Voluntary Admission over Involuntary Commitment

While involuntary commitment may be necessary and appropriate at times, its potential negative effects can undermine its utility. Generally, individuals with mental illness report a desire to avoid mandatory hospitalization due to the requisite loss of autonomy which is often accompanied by fears of the system.[8] However, even given this desire, many individuals resist voluntary treatment even when they are assured that the only alternative outcome is involuntary commitment. Mandated treatment has been linked to poorer clinical outcomes including non-adherence as well as an increased chance that mental health services consumers will be involuntarily committed in the future.[9] Past participants in involuntary admission proceedings observed in interviews that the hearings were "frightening"—a condition that was often exacerbated by their fragile mental state at the time.[10] This traumatic aspect of involuntary inpatient admission itself can lead to negative treatment outcomes.[11] Involuntary hospitalization also risks undermining the alliance between a mental health care consumer and a health provider

[8] 2008 JLARC Report.
[9] Bonsack, C. & Borgeat, F., *Perceived coercion and need for hospitalization related to psychiatric admission*, 28 Int'l J. of Law and Psychiatry 342-347 (2005).
[10] Id.
[11] Swartz, Marvin S., Jeffrey W. Swanson & Michael J. Hannon, *Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Persons with Schizophrenia and Mental Health Professionals*, 21 Behavioral Sci. and the Law 459, 462 (2003).

by infusing an adversarial undercurrent into the process.[12] It must be noted that the most prevalent barrier to voluntary treatment may not be readily remedied: it is individuals' inability to identify their own conditions as problematic due to a lack of insight.

Voluntary treatment has been linked to better patient outcomes. The following outlines some of the factors that can contribute to the increased effectiveness of mental health care services. Patients are thought to benefit from recasting mental health care as just like all other medical care. In part because of mainstream socialization, mental illness carries a stigma; people often assume that people with mental illness are incompetent, untrustworthy, less intelligent, or socially undesirable. [13] The societal stigma already attached to mental health care and its deterrent effect on individuals seeking care can be exacerbated by the intimate involvement of law enforcement officials in the admission process.

Additionally and perhaps, more importantly, the involvement of law enforcement can increase an individual's perception of both trauma and coercion. For example, persons experiencing a mental health care crisis are transported to and from involuntary commitment hearings or hospitals by law enforcement, often in handcuffs.[14] If mental health care services were re-framed as routine health care services involving greater collaboration, individuals would be more encouraged and empowered to make their own voluntary health care decisions. Throughout the scientific literature, the emphasis on voluntary treatment is premised on the therapeutic benefits stemming from a reduction in coercion. There is some evidence that the disempowerment of individuals resulting from the coercive nature of the civil admission process prevents them from fully participating in any subsequent care rendered.[15] Further, studies have shown that involuntary commitment can have the long term effect of increasing perceived coercion among mental health care consumers thereby reducing their likelihood of better clinical outcomes.[16]

Notably, an individual's perception of coercion might not always correspond to his admission status as either voluntary or involuntary[17] but often is "strongly related to the belief about the justice of the process by which the person was admitted."[18] This belief is often based on whether the consumer believes "that clinical staff acted out of genuine concern, treated the client respectfully and in good faith (truthfulness), and afforded the client the opportunity to tell [her] side of the story."[19] At the same time, a person's decision to admit herself can be the result of

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[12] Swartz, M.S., Swanson, J.W. & Hannon, M.J., *The perceived coerciveness of involuntary outpatient commitment: Findings from an experimental study*, 30 J. of the Amer. Academy of Psychiatry and the Law 207-217 (2002).
[13] Bruce Link, Dorothy Castille & Jennifer Stuber, *Stigma and Coercion in the Context of Outpatient Treatment for people with mental illness*, 67 Social Science & Med. 409, 411 (2008).
[14] See 2008 Progress Report at 35.
[15] Corrigan, Patrick, *How Stigma Interferes with Mental Health Care*, 59 American Psychologist 614, 620 (2004).
[16] Zervakis, Jennifer, et al., *Previous Involuntary Commitment is Associated with Current Perceptions of Coercion in Voluntarily Hospitalized Patients*, 6 Int'l J. of Forensic Mental Health 105-112 (2007); see also Lidz, Charles W, et al., *Factual Sources of Psychiatric Patients' Perceptions of Coercion in the Hospital Admission Process*, 155 Am. J. Psychiatry 1254, 1258 (1998).
[17] Hoge, Steven K., et al., *Perceptions of Coercion in the Admission of Voluntary and Involuntary Psychiatric Patients*, 20 Intl J. of Law and Psychiatry 167 (1997). See also John Monahan, et al., *Coercion and Commitment: Understanding Involuntary Mental Hospital Admission*, 18 Intl J. of Law and Pscychiatry 249, 254-55 (1995).
[18] Patricia A. Galon & N. Margaret Wineman, *Coercion and Procedural Justice in Psychiatric Care*, 0 Archives of Psychiatric Nursing 1-10 (2010).
[19] Id.

coercion or pressure, either formal or informal. For example, a social worker might refuse to distribute social security payments or a housing program might withhold eligibility to qualify for subsidized housing until the individual agrees to treatment. Depending on the circumstances, the person might have felt that she really was coerced despite her classification as a voluntary patient.

The amount of coercion individuals report experiencing is strongly associated with their views of the process.[20] When mental health services consumers believe they have been afforded "procedural justice" by having some role in the process and having been treated fairly by family and mental health care officials, they report significantly less coercion.[21] Further, the nature of pressure that an individual experiences can be influential. For example, there is some evidence that "negative" pressures in the form of threats and force produce feelings of coercion, while more "positive" pressures in the form persuasion and inducements do not.[22] These findings align with the opposition among many consumer advocates to mandatory treatment which focus on the reduced effectiveness of any subsequent clinical care due to the erosion of trust between the consumer and mental health professionals.[23] When an individual has established a more trusting relationship with case managers or CSB workers and feels she has been treated fairly in the process, she is often more willing to agree to voluntary admission.[24]

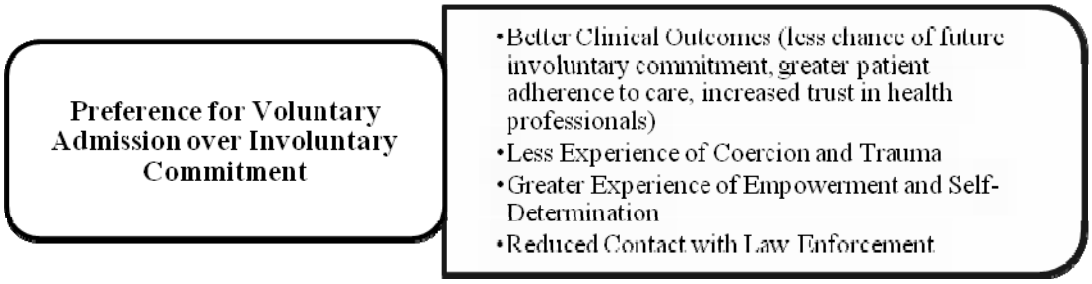
While therapeutic goals are the main factors motivating the push for more voluntary admissions, involuntary admission proceedings are also costlier for the state because of the layers of judicial procedure required to protect the rights of mental health services consumers.[25] In addition to the transportation needs that are often absorbed by local law enforcement (as opposed to separately allocated funds), Virginia procedure requires examinations by a licensed psychiatrist or psychologist (known as the independent examiner) prior to a hearing as well as representation by independent counsel at the hearing for the person for whom involuntary admission is sought. In addition, special justices and counsel for indigent patients are paid fees for each hearing in which they participate. Despite the theoretical advantages for mental health consumers built into legal adjudication such as the protection of procedural due process, individual liberties, and individual representation, the legal setting is often viewed by policymakers and mental health professionals as inappropriate and ill-fitting for mental health determinations.

Regardless of the web of factors that influence individual health outcomes and perceptions of coercion, there is little debate among mental health care officials that voluntary treatment is preferable to involuntary treatment when the person can consent. This consensus among policymakers is likely due to the fact that, on balance, voluntary admission is less likely to be viewed as coercive even if some pressure is placed on the individual. It is critical that any solutions aimed at reforming the civil commitment system are mindful that shifting people from involuntary commitment to voluntary admission alone may not be enough to truly improve

[20] Executive Summary of The MacArthur Research Network on Mental Health and the Law (February 2001), available at http://www.macarthur.virginia.edu/coercion.html (accessed Mar. 27, 2010).
[21] Id.
[22] Id.
[23] Interview with Bonnie Neighbour of VOCAL, 1.15.2010.
[24] Id.
[25] See *O'Connor v. Donaldson*, 422 U.S. 563, 574 (1975); *Humphrey v. Cady*, 405 U.S. 504, 509 (1972); *Specht v. Patterson*, 386 U.S. 605, 608 (1967).

mental health outcomes and should also focus on the reduction of coercion that accompanies such solutions. Figure 1 outlines the overall advantages of voluntary admission over involuntary commitment.

Figure 1



B. Overview of Virginia's Statutory Admission Requirements and Procedure

The Virginia statute governing civil commitment requires a judicial determination by clear and convincing evidence that the person has a mental illness presenting a substantial likelihood that "the person will, in the near future, cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm . . . or suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs", that the person is in need of hospitalization or treatment, and that the person is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.[26] Additionally, the statute requires that "all available less restrictive treatment alternatives to involuntary inpatient treatment have been … determined to be inappropriate."[27,28] In assessing the mental health of the person at issue, the special justice can consider the petition, recommendations from health professionals, the person's mental health history and past actions, any relevant hearsay evidence, and any other information the special justice deems relevant to the determination.[29]

Involuntary commitment refers to either outpatient or inpatient treatment imposed by a court order that may be against a particular individual's wishes. An involuntarily committed person's hospitalization order cannot last longer than 30 days,[30] and, at the end of this period, a recommitment order would be necessary to continue inpatient care. A patient may be released

[26] Virginia Code: Mental Health, Mental Retardation, and Substance Abuse Services, §37.2-809 (B).
[27] Virginia Code § 37.2-817C(b).
[28] In 2008, the Virginia General Assembly changed the statute to provide clearer guidance to special justices and mental health professionals with the goal of correcting much of the variation in commitment practices throughout the state. The statute was also changed due to the view that the previous words were unduly restrictive. See Virginia Code §37.2-817B ("the person presents an imminent danger to himself or others as a result of mental illness OR has been proven to be so seriously mentally ill as to be substantially unable to care for himself"). See also Bruce J. Cohen, Richard J. Bonnie, and John Monahan, Understanding and Applying Virginia's New Statutory Civil Commitment Criteria 1-3, available at http://www.dbhds.virginia.gov/OMH-MHReform/080603Criteria.pdf (accessed 2.27.2010).
[29] Virginia Code §37.2-809C.
[30] Virginia Code § 37.2-817C

prior to that period should medical professionals at the State or licensed hospital determine that certain conditions have been satisfied.[31]

Voluntary treatment refers to care or treatment that an individual undergoes willingly. It is important to note that voluntary admission or treatment carries the connotation of individual autonomy by the treated individual; however, in reality, the decision to accept care voluntarily can be motivated by overt and/or covert pressure. Frequently, mental health officials, judges, or other interested parties apply pressure and use leverage via various avenues to encourage an individual to choose or accept treatment. It is worth noting that there are opportunities for an individual experiencing a mental health crisis to elect voluntary treatment that are not spelled out in the statutes. For example, persons can elect to admit themselves, at times via an advanced directive, to private hospitals or institutions.

After a mental health crisis occurs and a person is in a hospital care setting, a Community Services Board (CSB) pre-admission screener usually evaluates the affected individual.[32] This evaluation can be initiated by the individual herself, a clinician, social services worker, friend, family member, or law enforcement officer. In conducting the pre-admission screening for individuals, CSBs serve as the single point of entry into the publicly-funded system of mental health services.[33] All persons must be screened by a CSB prior to involuntary admission, and the subsequent preadmission screening report is often a critical piece of evidence at commitment hearings. This preliminary screening by the CSB is also required prior to the voluntary admission to a private hospital of an individual who is the subject of a TDO.[34] The number of persons admitted voluntarily without a TDO and with private insurance is hard to know; hospitals would be the obvious source of these numbers. If a person is not willing to go to a hospital for an assessment and it appears that she meets commitment criteria, an Emergency Custody Order (ECO) will need to be obtained. However, when the person is already at the CSB or the hospital, an ECO is rarely needed. The main instance if a person is already at the CSB or hospital in which an ECO is needed is if the individual threatens to leave the CSB or the hospital. Figure 2, at the end of this section, outlines the various paths that can result following a mental health crisis. The Figure shows that people in a mental health crisis might be funneled into the criminal justice system due to behavior resulting in their arrest and detention instead being admitted to a hospital.

An ECO allows for a person to be held up to four hours for a mental health evaluation in a "convenient location" such as a hospital emergency department.[35] ECOs are issued by a magistrate upon a sworn petition that there is "probable cause" of an individual's future physical harm to himself or others due to his mental state or inability to protect himself from harm, the individual's need for treatment, and the individual's unwillingness at that time to submit to treatment or any evaluation.[36] Just as various individuals can initiate a CSB screening for

[31] Virginia Code §§37.2-837-838.
[32] Virginia Code §37.2-809.
[33] Bonnie, Richard, et al., *Mental Health Transformation After the Virginia Tech Tragedy*, 28 Health Affairs 793 (2009).
[34] Bonnie, Richard, et al., *Mental Health Transformation After the Virginia Tech Tragedy*, 28 Health Affairs 793 (2009).
[35] Virginia Code §37.2-809.
[36] Virginia Code §37.2-808 (A). This standard is the same for the issuance of a Temporary Detention Order (TDO).

another person, various people can request an ECO for someone they believe to be in need of hospitalization by providing the necessary sworn petition. After an ECO is issued, the individual is taken into custody for the purpose of conducting the requisite mental health evaluation. In the first quarter of FY 2009, 500-600 written ECOs were issued per month.[37] Law enforcement officers also take individuals into custody on an emergency basis without an ECO and may bring them directly into a CSB for an evaluation.[38]

If the CSB screening finds that the individual requires hospital treatment, the individual can admit himself voluntarily.[39] If individuals do not choose to admit themselves voluntarily but meet the involuntary commitment criteria, a temporary detention order (TDO) must be issued by a magistrate to allow for the individual's detention in an inpatient hospital for up to 48 hours. For a TDO to be issued, there must be an available bed for a patient; the CSB official is tasked with finding a bed.[40] Often, a bed might not be available in the facility in which the patient is currently being held. In these instances, the TDO designates the new facility where the person will be sent as well as the means of transportation to that facility.[41] Even though the magistrate can authorize transportation from private transportation providers, transportation is usually provided by the primary law enforcement agency of the region.[42]

Prior to the TDO's expiration, a civil admission hearing is typically held.[43] At the beginning of the hearing, special justices are required to offer individuals the opportunity to agree to voluntary admission. Pursuant to this hearing, an individual may be released, involuntarily committed, ordered to mandatory outpatient treatment, or voluntarily admitted for a minimum period of treatment. This last option is often referred to as judicial voluntary admission.[44] A judicial voluntary admission at this stage often results from leverage (perhaps the prospect of involuntary commitment) and requires the individual to agree to care for a minimum of 72 hours and to give 48 hours notice prior to leaving. Special justices preside over civil commitment hearings, which are often held in a mental health facility or hospital. Pursuant to Virginia Code § 37.2-803, special justices are required to be licensed attorneys in Virginia, in good standing with the bar, and to complete training requirements set by the Executive Secretary of the Supreme Court of Virginia.[45]

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[37] Virginia Commission on Mental Health Law Reform, *2008 Progress Report*, available at http://www.courts.state.va.us/programs/cmh/home.html (accessed Dec. 17, 2009). [hereinafter 2008 Progress Report]

[38] Id.

[39] Virginia Code §37.2-805.

[40] Virginia Code § 37.2-809.

[41] Virginia Code § 37.2-810.

[42] Even if a private transportation provider is designated, law enforcement must still take custody of the individual and transfer custody to the private transportation provider. Virginia Code § 37.2-810B.

[43] Some hospitals may allow a patient to admit herself voluntarily prior to a commitment hearing without the formality of a hearing, but with the consent of the patient's medical care professionals. Other hospitals may have the hearing simply as a formality where the special justice ensures the patient is competent and ratifies the prior made arrangement. See infra, Part VI for more about allowing conversion from a TDO to voluntary admission without a hearing.

[44] Another term sometimes used is court mandated admission (CMA). Many special justices do not use either term, but for the purposes of this paper, I will use judicial voluntary admission to refer to admission elected by the patient at the civil commitment hearing following a TDO.

[45] Virginia Code §37.2-803, available at http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-803 (accessed Feb. 5 2010).

In comparison to other states, Virginia has a relatively short TDO period. After the issuance of a TDO, but before a hearing, mental health professionals assess and evaluate the individual's condition to determine whether further hospitalization is required.[46] During the TDO period, people may stabilize as a result of gradual detoxification and/or acclimation to medication. This stabilization increases some individuals' chances of being released or choosing admission voluntarily at the hearing.[47] According to data from Fairfax County's CSB and the Case Management System[48], the period in which people were most likely to convert to a judicial voluntary admission occurred after 48 hours. However, data from the Commission's May 2007 study revealed that 30.2% of hearings occurred less than 24 hours after the TDO was issued.[49] A 2008 policy analysis on the length of Virginia's TDO period strongly endorses lengthening the TDO period to 72 hours to allow for more judicial voluntary admissions as opposed to involuntary admissions via the judicial process.[50] With this extra time, many individuals' conditions may improve allowing them to consent to voluntary admission at their hearing either because they are judged to be competent and/or because they have had more time to reach their pre-crisis state and realize they need help. Further, data shows that extending the TDO period would increase dismissals of petitions. Another likely effect of extending the TDO period would be to shorten the post-hearing hospitalization time.[51] Such a change would affect at most 55-60% of cases (these are cases where the hearings occur before 48 hours has elapsed) because about 40-45% of hearings already occur after 48 hours.[52] The law now does not allow for anyone to be held longer than 48 hours without a hearing unless they are admitted before the weekend or a holiday. Additionally, the scheduling of hearings can vary between hospitals and can affect outcomes significantly. For instance, at one state hospital, the special justices hold hearings on Mondays, Wednesdays, and Fridays[53] due to their need to efficiently process the large number of hearings and still practice law. As a result, someone admitted on Sunday evening must have a hearing on Monday as opposed to Wednesday due to the 48-hour limit with the consequence that the person might not have stabilized to the point of being able or willing to consent to voluntary care.[54]

Individuals admitted after a civil commitment hearing before a special justice are automatically included in the state's firearms database which prohibits them from possessing, purchasing, or transporting a firearm. [55] The database includes any person admitted pursuant to a judicial decision regardless of whether that admission is involuntary or voluntary. Because most violent acts in the United States are not perpetrated by persons suffering from mental illness and in the

[46] Barclay, Sarah, Report for the Virginia Commission on Mental Health Law Reform, *Increasing the Temporary Detention Period Prior to a Civil Commitment Hearing: Implications and Recommendations* 8-9 (2008). [hereinafter Barclay Report]
[47] Id.
[48] Id.
[49] Barclay Report at 8-9.
[50] Id. at 9.
[51] See Wanchek, Tanya, Preliminary Results for TDO-Hospitalization Study (Nov. 11, 2009).
[52] Wanchek, Tanya and Bonnie, Richard, The Temporary Detention Period and Treatment for Mental Illness, (2009). [hereinafter TDO Study]
[53] E-mail from Jim Martinez at DBHDS.
[54] Id.
[55] Virginia Code § 18.2-308.

face of the stigma that may be attached to inclusion in the list, some advocates suggest changing the code to exclude persons who agree to admit themselves voluntarily. A crucial aspect of this proposal is to give people the incentive of preserving their right to bear arms by agreeing to admit themselves voluntarily.

While this change would not be barred by federal law[56], public opinion would likely prevent the GA from allowing people who admit themselves voluntarily pursuant to a court order to maintain their right to bear arms. Virginia's current laws include voluntary admission at a hearing within the definition of committed such that these individuals are included within the database.[57] Virginia could change its law not to include people admitted voluntarily under a court order. Such a change could impact the willingness of some people to submit to voluntary care in that in so doing, they could preserve their gun rights. However, in the wake of the Virginia Tech shootings and citizens' fears, such a change would be politically unfeasible and extremely unpopular.

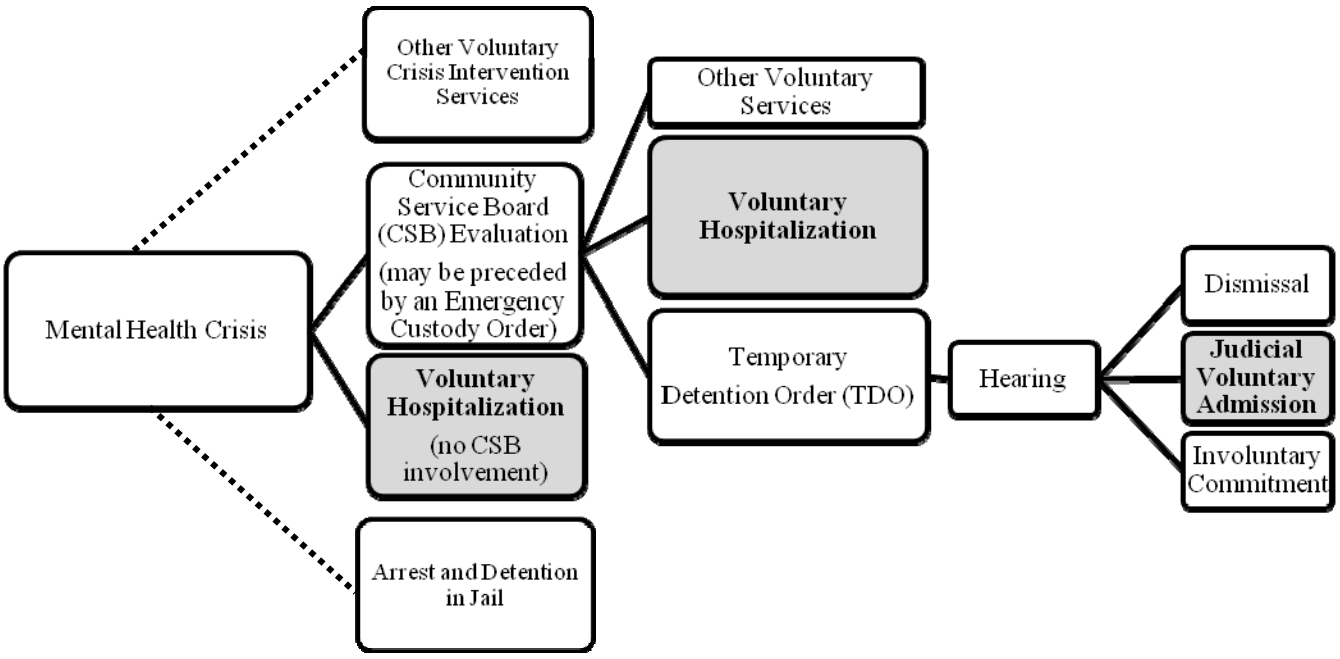
It should be stressed that for an individual to admit himself to a hospital voluntarily, he must possess the requisite capacity to consent. A person's level of psychosis might prevent him from the preliminary determination of mental competence, but additionally he may not yet have stabilized due to his cessation of medication prior to his mental health crisis or due to drug or alcohol intoxication. If an individual lacks the ability to consent, the special justice will simply make a determination of whether inpatient care is appropriate and whether there are any less restrictive alternatives. All special justices give people the ability to agree voluntarily to inpatient care if they are competent. The most common reasons cited for individuals' unwillingness to be hospitalized include a lack of awareness of their own mental illness and need for care, as well as their wish to see if the case would be dismissed (often even when the special justice is upfront about the likely outcome).[58] It is a widespread and persistent trend for people experiencing mental illness to lack insight into their mental states and their real need for mental health care.

[56] Id. Federal law requires that someone be listed in the database if the person is "[a]djudicated as a mental defective" or if the person "has been committed to a mental institution."[56] The first prong focusing on adjudication refers to "[a] determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease: (1) is a danger to himself or to others; or (2) lacks the mental capacity to contract or manage his own affairs." Under the federal guidelines, the first prong focusing on adjudication includes persons judged to be incompetent to manage their affairs in guardianship proceedings, incompetent to stand trial, or not guilty by reason of insanity. The decision to issue a TDO is essentially a judicial procedure based on a determination of probable cause by magistrate after receiving advice from the CSB evaluator; and thus, alone the TDO hearing would not require a person's inclusion in the federal database. The second prong focusing on commitment is a question under federal law which looks to the substance of a state's commitment proceedings and not the form to determine if the person has been committed.

[57] While 2nd Amendment arguments could be persuasive given the Supreme Court's decision in *District of Columbia v. Heller*, 129 S. Ct. 2419 (2009), there are avenues through with gun rights can be reinstated (both under federal and state law) which would also weigh in the balance.

[58] Qualitative Data from Interviews with over 30 Special Justices in Virginia, March 2010.

Figure 2. Opportunities for Inpatient Voluntary Admission



C. Criteria

Any policy change designed to promote voluntary treatment must meet the criteria below, which focus on protecting individuals' rights, maximizing the benefit they receive from care, and assuring the political and financial viability of the alternative itself. For a policy change to be most effective, it will ideally incentivize voluntary hospital admissions for mental health services consumers as well as CSB staff, hospitals, and special justices.

- **Improve Mental Health Outcomes:** The primary goal of the Commission as well as the CSB clinicians, special justices, and hospital professionals is to improve psychiatric care outcomes. With the large amount of "repeat customers" and the current strain on available resources, improving mental health treatment results is an ethical goal of treatment and a necessary reality. There are two subsidiary requirements to any policy designed to improve patient outcomes:
  - **Reduce Individuals' Perception of Coercion:** In recommending alternatives to involuntary commitment, one of the crucial factors identified by researchers as a driver of better clinical outcomes is the individual's level of perceived coercion. It is crucial that any option improve persons' perceptions of procedural fairness and minimize any necessary coercive aspects of the process.

- **Promote Patient Empowerment:** The promotion of patient empowerment over care decisions has been linked to improvements in care outcomes; any policy change must increase patients' ability to participate in decision-making.

- **Protect Patient Rights:** The civil commitment process is designed with the goal of protecting patients' rights and respecting patient autonomy. Because patients' liberty interests are at stake, due process is required before commitment orders can be issued. Any change to the procedure or statutes must assure that patients, their families, and petitioners have a meaningful opportunity to be heard throughout the process.

- **Minimize Financial Impact:** Like many other states, Virginia is experiencing significant budget shortfalls. Virginia's General Assembly has already enacted spending cuts that reduce health care for the poor and increase class sizes in schools.[59] Any change requiring legislation and/or political support must not depend on an increased allocation of funds. In other words, any proposal must be budget neutral if it requires passage by the Virginia General Assembly. In addition, any proposal that requires shifting of funds must ensure that it would not create any potentially harmful or problematic gaps in other services.

- **Maximize Political Feasibility:** Any change must be politically feasible. Not surprisingly, not all the relevant stakeholders in the mental health care system view the civil commitment process in the same way. While unanimous support for any proposal is unrealistic, it is essential that any change not draw substantial opposition from any constituency.

II. Financial Structure of Commitment in Virginia

A. Cost and Financing of Psychiatric Care

When individuals present themselves either to an emergency or an outpatient clinic, a doctor will conduct an evaluation. Every hospital that accepts Medicare patients and has an emergency department (ED) is required by the Emergency Medical Treatment and Active Labor Act (EMTALA) to treat and stabilize patients.[60] Consequently, hospitals must be capable of providing these services 24 hours a day to patients with psychiatric conditions, even if the hospital does not have any licensed psychiatric beds or a licensed psychiatrist on staff.[61] At this point, care for indigent patients who qualify for Medicaid is reimbursed through Emergency Medicaid if the patient is eligible for Medicaid but not enrolled in the program.[62] Should the

[59] Tyler Whitley & Jeff E. Schapiro, *Health care, education in for more budget cuts,* Richmond Times Dispatch, Feb. 21, 2010, available at http://www2.timesdispatch.com/rtd/news/state_regional/state_regional_govtpolitics/article/BUDG22_20100221-222406/325942/ (accessed Mar. 4, 2010).

[60] 42 U.S.C. §1395dd.

[61] See 2007 JLARC Report at 11.

[62] As noted, psychiatric care is not provided at every hospital or is provided, but only on a limited basis (often because it is not financially practicable); so if a patient needs psychiatric care to be stabilized, she must be

patient need more extensive inpatient care to be stabilized, the hospital is charged with finding a willing facility to accept that person.[63] However, in transferring the patient, other facilities are not mandated to admit the patient and can deny admission to the patient. Additionally, while general hospitals are reimbursed for inpatient care to Medicaid-eligible patients, community or freestanding psychiatric hospitals are not.[64]

If an individual is hospitalized under an ECO or a TDO, a licensed hospital is reimbursed for the cost of psychiatric and medical care through the patient's private insurance if he is insured or through the state's Involuntary Mental Commitment Fund (IMCF) if he is uninsured.[65] CSB officials are uniform in reporting that they always strive to use the least restrictive alternatives. Hospital officials may vary in their willingness to accept individuals without a TDO in part due to the amount of financial liability they assume. Despite a patient's voluntary agreement to inpatient care, in some instances a facility will only accept that person under a TDO as opposed to a voluntary admission.[66] Often, the facility cites "risk factors" that a particular individual possesses, which make the hospital wary of admitting the person voluntarily. As discussed in some detail below, it is difficult to determine how often the availability of public funding increases the inclination of doctors or CSB officials to seek a TDO if individuals are unable to pay, but from investigations for this study, it happens at least some of the time.[67]

CSBs are required by statute to provide emergency services including crisis stabilization, prescreening evaluations and written reports for individuals as part of the civil commitment process, discharge planning for anyone in a State hospital, and case management "subject to the availability of funds."[68] According to CSB reports, three quarters of case management services are underwritten by fees, the payments of which are mostly drawn from Medicaid funds.[69] A small number of hospital officials suggested that at times CSBs may be disinclined to recommend a TDO for a patient because a TDO requires them to allocate resources to coordinating that patient's care, but such instances appear to be exceptions rather than the rule.[70] If inpatient care is needed, CSB emergency services staff work to place individuals by calling facilities throughout the state. At times, some CSBs have trouble placing involuntary patients

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transferred. See Moran, Mark, *Psychiatric Hospitals Could Gain Right to Medicaid Reimbursement*, Psychiatric News (Oct. 2003).

[63] See 2007 JLARC Report at 11.

[64] There is an exclusion in the Medicaid laws that prohibits a psychiatric facility from claiming federal reimbursement for any services rendered to a patient who is a Medicaid beneficiary between the ages of 21 and 64. Known as the Institution for Mental Diseases (IMD) exclusion, this provision denies federal Medicaid reimbursement for all health services provided by the psychiatric facility. Further, this exclusion applies even if the patient needs emergency medical care or sustains an injury or illness that requires treatment in another facility while he is still a patient of the IMD. See Farley, Rebecca, *Medicaid Reimbursement for Health Services in Institutions for Mental Disease*, Alliance for Children and Families and United Neighborhood Centers of America Policy Paper (2009), available at http://www.alliance1.org/Public_Policy/Health/IMD_Exclusion.pdf (accessed Apr. 3, 2010). See also Moran, Mark, *Psychiatric Hospitals Could Gain Right to Medicaid Reimbursement*, Psychiatric News (Oct. 2003).

[65] VA Code Section 37.2-804.

[66] Interview with Anonymous CSB Officials, 3.5.2010.

[67] Many different parties can act as petitioners. At this stage, the cost consideration analysis is focused on instances where the hospital or the CSB official act as the petitioning parties.

[68] Virginia Code § 37.2-500, et seq.

[69] See 2007 JLARC Report at 7-8.

[70] Interview with Anonymous Hospital Official, 1.2010.

due to a lack of facilities with appropriate clinical care to manage patients with more pronounced behavioral problems, a history of violent incidents, or extensive case management needs.[71]

Once the TDO period expires and a hearing has been held, payment for an individual's care must be secured from other sources regardless of whether the person is admitted voluntarily or involuntarily. The vast majority of patients, more than 90 percent, admitted to a psychiatric bed in a licensed hospital had some form of health insurance which includes private commercial insurance as well as Medicaid or Medicare.[72] However, almost across the board, psychiatric services result in losses for hospitals due to low and below-market reimbursement rates by these payers.[73] Because of both the unprofitability of psychiatric care and reform pushing for less restrictive alternatives, the number of psychiatric beds in the state has been decreasing.[74] It can be harder for CSBs to place patients without insurance due to hospitals' unwillingness to admit them; sometimes patients are forced to remain at their current facility until a bed with the appropriate services can be located.

Overall, statewide data do not show a bed shortage in Virginia, but the picture is complicated by regional differences in bed availability.[75] In some localities, there are documented bed shortages and CSB staff report that at times, a TDO is not issued for a person under an ECO and he is released simply due to the lack of bed. The person does not receive inpatient care and instead is referred to outpatient treatment that may or may not be available.[76] A 2005 review of hospitals in Virginia concluded that licensed hospitals, defined as general and freestanding hospitals with licensed psychiatric beds, are the most important service providers of acute care for psychiatric patients. At that time, there were 8 state hospitals and 38 licensed hospitals serving adult psychiatric patients.[77] The University of Virginia and Virginia Commonwealth University are state-owned general hospitals that function as teaching hospitals. Licensed psychiatric beds are dispersed among the following types of facilities: 41 percent in not-for-profit general hospitals; 32 percent in proprietary freestanding hospitals; 20 percent in proprietary general hospitals, and the remaining 7 percent in the two aforementioned teaching hospitals.[78]

Hospitals are reimbursed for the care of all patients during their inpatient stays pursuant to an ECO and/or a TDO, but, after a hearing, funding from the state is not always available. As one Psychiatric Admissions Coordinator observed, it is often easier to place individuals who are in crisis; for a TDO to be issued, there must be a bed available. Although there are some exceptions, particularly in regions without many psychiatric beds, most CSBs are able to locate this initial bed fairly quickly.[79] However, some CSBs report that while it is easier to place a

[71] Interviews with Case Managers from Prince William Community Services Board, 1.19.2010.
[72] 2007 JLARC Report at 14.
[73] Id. at 14.
[74] Id. at 20-21.
[75] Id. at 29-30.
[76] Interviews with CSB officials and several special justices, 3.2010; Study of Emergency Evaluations, June 2007, available at http://www.courts.state.va.us/programs/cmh/2007_06_emergency_eval_report.pdf (accessed Mar. 10, 2010). [hereinafter Emergency Evaluations Study]
[77] 2007 JLARC Report at 29-30.
[78] Id.
[79] Interview with Brenda Barrett of UVA Hospital, Psychiatric Care and Admissions Coordinator, 1.29.2010; see also Emergency Evaluations Study.

patient initially admitted involuntarily to the hospital, after the hearing, it can be more difficult to locate a bed for a person who has been involuntarily committed. Some hospitals recognize the financial disincentives of providing psychiatric care; courts do not have any legal authority to order a private provider to accept individuals under a TDO or an involuntary commitment order.[80]

Longer hospital stays, whether voluntary or involuntary, can be problematic for CSB workers, who are charged with finding longer term beds for individuals that require inpatient hospitalization.[81] First, private insurance may not cover longer stays or certain case management services. Second, some facilities might lack the necessary services for individuals requiring more intensive treatment or for individuals who tend to be non-compliant such as refusing to take medication or agreeing to any care at all.[82] In such instances, a State hospital might be a patient's only real option.[83]

As mentioned, due to the State's deinstutionalization of mental health services, there has been a transfer of patients from State hospitals to licensed hospitals. To fund this shift of patients, the State has allocated money through the Local Inpatient Purchase of Services (LIPOS) program for the purchase of psychiatric beds at licensed hospitals for individuals who otherwise would have been treated by state hospitals.[84] In 2003, the Department of Behavioral Health and Developmental Services (DBHDS)[85] divided the State into seven regions based on the service areas for the seven State hospitals in an effort to invest in services beyond state institutions and promote further deinstitutionalization.[86] The goal of these regional partnerships is to improve resource management around state facilities.[87]

The CSBs in each region are given State funds to purchase beds for patients in licensed hospitals through the LIPOS program. CSBs generally enter into memoranda of understanding (MOU) with the State hospital in their assigned region to determine who is eligible for admission to that State hospital and who is eligible for LIPOS funds.[88] In addition, historically, some CSBs have contracted individually with some private providers for LIPOS beds.[89] Now, it is more typical for CSBs to contract with private providers of local inpatient psychiatric treatment services on a regional basis to purchase a certain number of LIPOS beds.[90] Through the regional partnerships, CSBs act together to negotiate contracts with private providers for these services

[80] 2007 JLARC Report at 103.
[81] See infra Part IV, Section A.
[82] Interview with Case Managers from Prince William Community Services Board, 1.19.2010; Emergency Evaluations Study.
[83] As noted in the next sections, financial considerations might also make the State hospital the only viable option.
[84] 2007 JLARC Report at 115.
[85] At that time, the Department was known as the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). For the purposes of this policy analysis, the department will be known by its current name, the Department of Behavioral Health and Developmental Services (DBHDS).
[86] 2007 JLARC Report at 119-20. See Figure 21 at 120 for a map of the regions.
[87] Id.
[88] Id. at 120.
[89] Annual Report on Community Services Board Contracts for Private Inpatient Psychiatric Treatment Services to the Chairmen of the House Appropriations and Senate Finance Committees of the General Assembly, Presented by Commissioner James S. Reinhard of DBHDS (2009). [hereinafter 2009 DBHDS Annual Report]
[90] Id. at 4.

and use regional review and management resources to monitor the cost effective use of LIPOS funds and the appropriateness of purchased inpatient psychiatric treatment for individuals receiving these services.[91]

The structure of allowing the partnerships of CSBs to negotiate on a regional basis with licensed hospitals and State hospitals produces variation across the state in how the regional partnerships use their LIPOS funds. For example, Region IV, which has 7 CSBs, uses its LIPOS funds for uninsured patients that meet the TDO criteria.[92] It tries to look at the overall need and allocate the funds based on clinical necessity. A regional authorization committee provides oversight for the distribution of funds; LIPOS funds are not plentiful enough to serve as a source of unlimited health care funds, but rather are reserved for the most serious mental conditions. About 80% of the funds are used for uninsured patients in need of involuntary hospitalization and 20% are used for uninsured patients who are voluntarily hospitalized and meet the commitment criteria of probable cause needed for a TDO. The rules can be complicated; for example, if an individual is admitted to the hospital initially without CSB involvement, but then a TDO is issued, LIPOS funds might not be provided, but may only be available at the discretion of the regional oversight committee.[93] In contrast, some regions restrict their LIPOS funds only to individuals who have been admitted involuntarily.[94] Still, some other regions allow their LIPOS funds to be applied to in-crisis stabilization programs. In addition, some areas have a set number of days of hospital stays to which their LIPOS funds can be applied while others have no set time period, and instead closely monitor the utilization of the funds through case management. Thus, how CSBs and hospitals might be influenced by financial incentives varies tremendously between planning regions and may lead to different incentive structures.

B. Hospital Admissions Decisions: the Financial Burden of Civil Commitment and Patient Management Concerns

The economics of psychiatric care have changed as the State has deinstitutionalized mental health care by promoting the use of licensed hospitals instead of State mental hospitals. Involuntary stays twenty years ago could span anywhere from three weeks to three months, but now most inpatient psychiatry is focused on rapidly stabilizing people in crisis with the goal of discharging them to outpatient services.[95] It should be stated that making generalizations about hospitals can be misleading because private hospitals, research institutions, and State hospitals each have financially distinct structures and each may employ different criteria in deciding whether to admit individuals. With deinstitutionalization, the shift from State hospital beds to more inpatient treatment in private facilities changed the financial picture of inpatient care.[96] Private facilities are subject to different pressures such as meeting payroll and ensuring that the individuals who are admitted have medical needs that they can meet; these standards are separate from civil commitment laws. The result is a narrower range of options for inpatient treatment

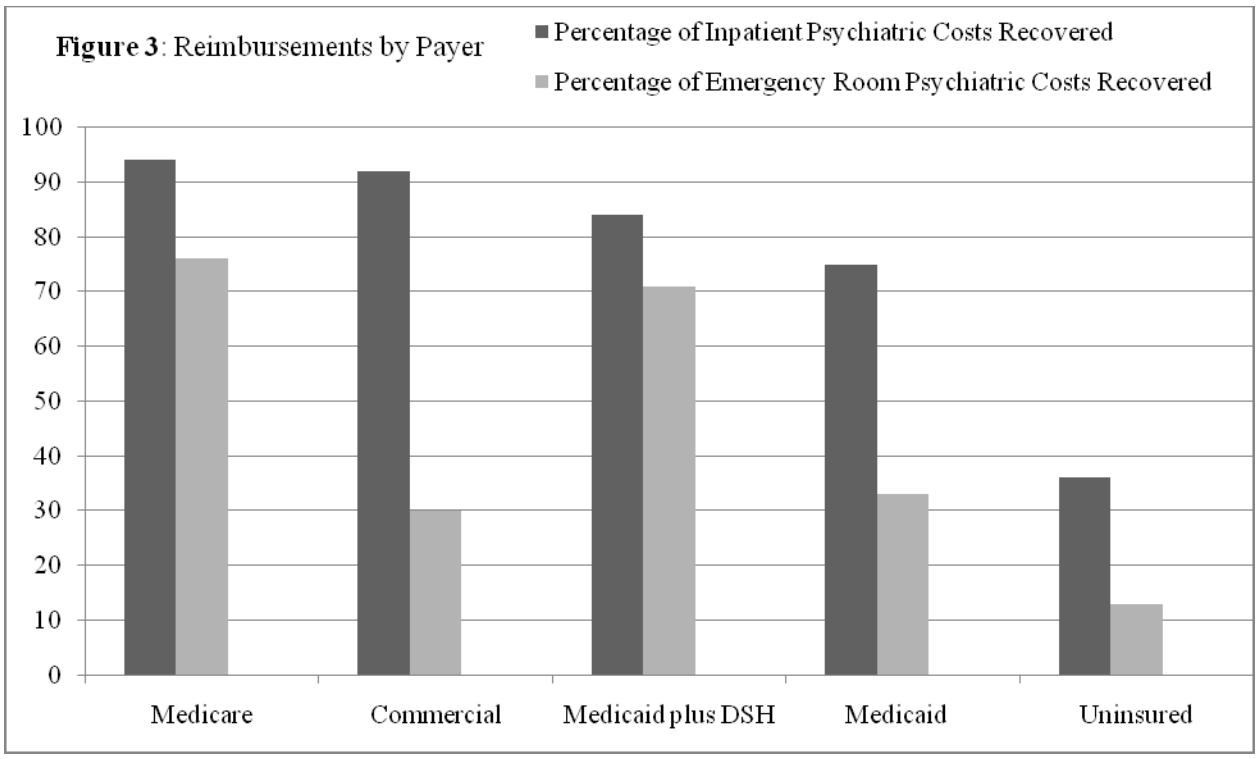
[91] Id.
[92] Interview with Chesterfield CSB Official, 1.20.2010.
[93] Reinvestment Project, Case Managers Manual for HPR IV, 2.17.2010.
[94] Interview with Susan Ward and Betty Long of the Virginia Hospital and Healthcare Association, 2.18.2010. Interview with CSB official from HPR 3.
[95] Interview with Dr. David Hamilton of UVA Hospital, 1.21.2010.
[96] Interview with Kevin Young, former Commission member and Hospital employee, 3.4.2010.

and a shifting of funding for those most in need from the state to private institutions and community hospitals.

Most licensed hospitals in Virginia report unreimbursed costs from psychiatric care as a result of both uninsured patients and under-reimbursements from commercial insurers. In 2005, licensed hospitals reported $25 million of unreimbursed costs from providing inpatient psychiatric services. Of hospitals' unreimbursed costs, uninsured patients comprised 29% of total costs while commercially insured patients accounted for 16%.[97] While hospitals report unreimbursed costs, the overall financial picture of hospitals does not seem as dire. In fact, a large majority of the licensed hospitals reporting unreimbursed costs for psychiatric care made an overall profit on all other services.[98] In addition, individuals for whom inpatient care is the only appropriate option and who require longer hospitalizations can pose a greater financial burden on hospitals. Hospitals' loss of money on psychiatric care is critical because it means that hospitals lack incentives to expand, or even maintain, their psychiatric services.[99] Without enough beds at licensed hospitals, people may be prevented from getting care altogether or be shifted to State hospitals.

According to data from Virginia Health Information (VHI), inpatient psychiatric patients are more likely than other patients to have Medicaid or be uninsured. In contrast to many other inpatient hospital rates, psychiatric reimbursement rates use a per diem system whereby each hospital receives a set daily payment regardless of a particular person's medical needs.[100] In addition, the rate is adjusted so that hospitals really only recover 80% of their costs. Some hospitals qualify for higher reimbursements if it is determined that they serve a high number or disproportionate share of Medicaid patients. Interestingly, two-thirds of these disproportionate share payments made on account of hospitals' increased share of Medicaid patients in Virginia went to the state's two teaching hospitals.[101] In contrast to these hospitals, the uninsured percentage of patients at freestanding psychiatric hospitals only amounted to 2 percent in 2005.[102] The reimbursement rate for payments from the IMCF is tied to the Medicaid reimbursement rate.[103] Similarly, LIPOS reimbursements are below the actual cost of care. For example, Region Ten reimburses UVA Hospital at a rate of $800 per day via LIPOS, but the cost of the hospital bed alone is $1,000 per day, a figure that excludes labs or medication.[104] Figure 3, reproduced from an official State report, outlines the overall reimbursement rates that hospitals receive depending on the patients' payer source. [105]

[97] 2007 JLARC Report at v.
[98] Id. at 59.
[99] For more information on unreimbursed costs for psychiatric patients' secondary medical conditions and the financial strain on hospitals, see 2007 JLARC Report at 63.
[100] 2007 JLARC Report at vi.
[101] Id at 55.
[102] Id, Appendix I at 181.
[103] Id. at vi.
[104] Interview with Dr. Zach Dameron of UVA Hospital, 2.4.2010.
[105] Reproduced from 2007 JLARC Report at v (drawing on data from 2005 financial surveys of psychiatric facilities).



Despite whatever financial incentives may exist, hospital officials stress that they make recommendations for patient care strictly based on clinical factors relevant to the individual's situation. In the context of initial admission and care decisions, hospitals report being primarily concerned with the safety and best interests of the patient as well as any perceived risk to the public by the patient.[106] At emergency rooms or outpatient clinics, if clinicians are on the fence and the patient refuses to be admitted to the hospital, the doctor will most likely admit the patient under a TDO. Hospitals are under significant pressure due in part to the limited availability of community mental health services outside of the hospital, which may force them to choose between providing mandated care or no care at all.[107] For some mental health professionals, the decision to release an individual prior to a hearing may include the fear of future liability if the patient lacks other treatment options, fails to follow through with any available treatment or simply fails to stabilize.[108] At times there may be genuine disagreement between CSB officials and physicians due to the individual's medical needs. For example, some CSB officials reported that there are instances in which they believe that a suicidal patient voluntarily agreeing to care does not need a TDO, but the hospital may refuse to admit the person without a TDO.[109] Hospital intake coordinators emphasize that they do not consider payment sources when deciding whether to admit a particular person. However, for a magistrate to issue a TDO, there must be

[106] Interview with Dr. Zack Dameron of UVA Hospital, 2.4.2010.
[107] See 2007 JLARC Report at 123.
[108] See 2007 JLARC Report at 123; Interview with Dr. Zack Dameron, 2.4.2010 (referencing *Tarasoff v. Regents of Univ. of Cal.*).
[109] Interviews with CSB Officials conducted throughout February and March 2010.

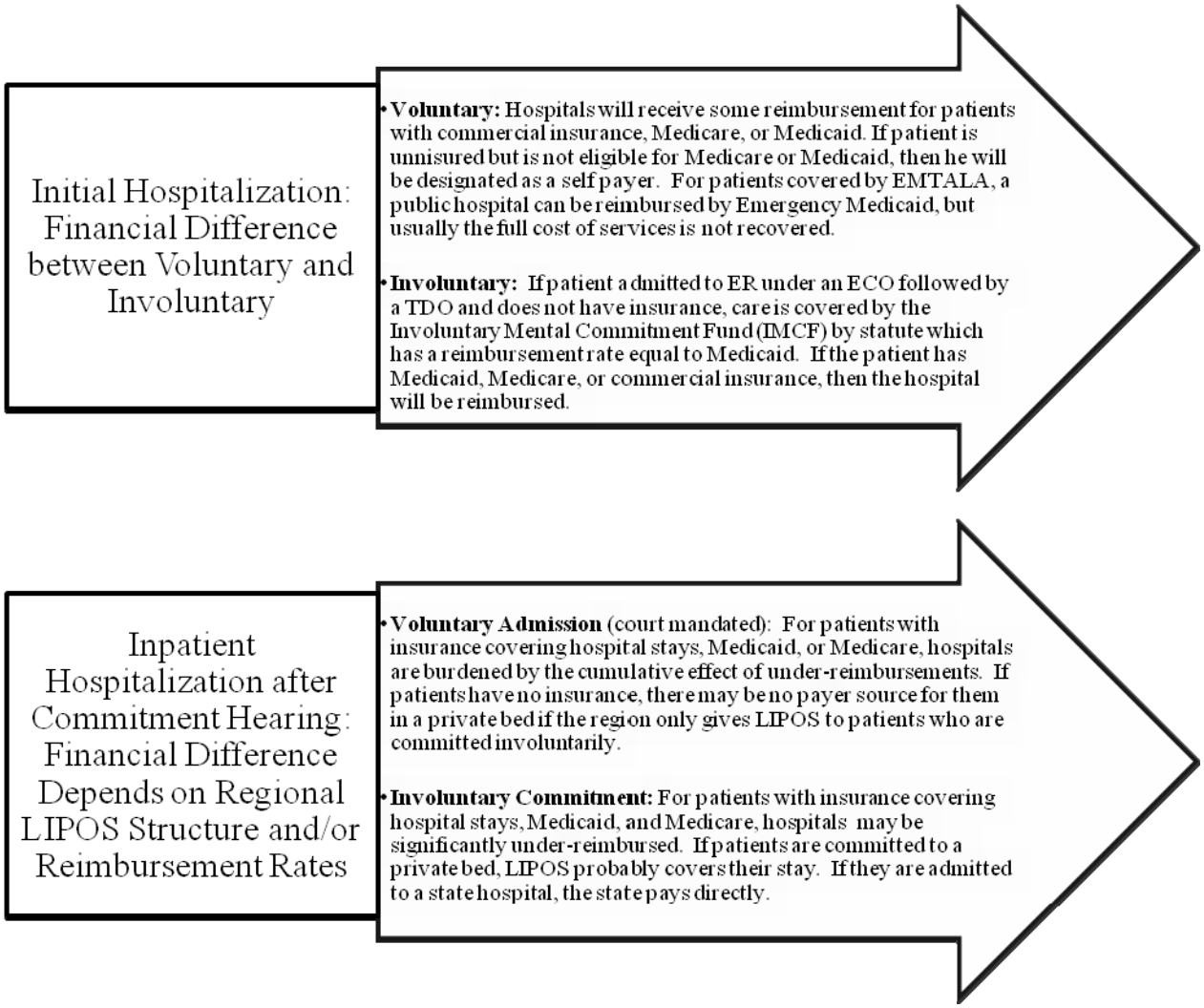
some showing of probable cause as well as an available bed, and the lack of a bed itself can prevent a TDO from being issued according to psychiatrists across the state.[110]

State hospitals have specific guidelines developed by DBHDS determining which psychiatric patients they can admit. These guidelines require that patients meet one of the following conditions: (1) the patient meets the statutory civil commitment criteria, (2) the patient has a condition that requires intensive monitoring because of a newly prescribed drug that has a high rate of complications or adverse reactions, or (3) the patient has a condition requiring monitoring and intervention because of toxic effects resulting from therapeutic psychotropic medication.[111] In all of these instances, it must also be determined that there is no suitable less restrictive care alternative for the individual. There is some anecdotal evidence that at least, some State hospitals almost never admit a person voluntarily, which might skew CSB officials or medical personnel towards the involuntary route.[112] Also, some interviews with CSB officials and special justices revealed informal policies or hospital preferences of State hospitals for involuntarily committed patients.

At least some freestanding and licensed hospitals appear to limit their admissions to individuals under a TDO.[113] These restrictions may be financially motivated because patients' care is financed by the state when they are hospitalized pursuant to a TDO. Other hospitals, such as the University of Virginia Hospital, do not consider legal or financial status when admitting people but, rather, focus intake decisions on the acuity of the patient's clinical needs and what services are currently available within the hospital.[114] UVA Hospital is a teaching hospital and carries more of an obligation to provide indigent and charity care, factors which may make it more willing to take on potential financial burden. Licensed hospitals also have some duty to provide charity care but, notably, under-reimbursements are not considered charity care.[115] Rather, charity is defined by the Virginia Department of Health as care for which no payment was expected.[116]

[110] Civil Commitment Practices report at 18. Interview with Crisis Care Supervisor at Winchester Medical Center, 2.15.2010. This problem does occur, but it should be noted that it does not appear to be widespread.
[111] 12 Virginia Administrative Code § 35-200 (Regulations for Respite and Emergency Care Admissions to Mental Retardation Facilities).
[112] Phone Interview with Rita Romano and Heidi Friedman, 1.15.2010.
[113] Interview from anonymous source that works in nearby hospital.
[114] Interview with Dr. Bruce Cohen, Associate Professor of Psychiatry and Neurobehavioral Sciences University of Virginia Director, Electroconvulsive Therapy Service Director, Forensic Psychiatry at UVA Hospital, 1.19.2010.
[115] See 2007 JLARC Report at 58.
[116] Id.

Figure 4: Financial Aspects of Involuntary v. Voluntary Hospitalization



Further complicating this picture are the preferences of some privately licensed hospitals during the initial hospitalization stage for taking only voluntary patients and for refusing patients under a TDO. One CSB official reported that "hospitals examine our clinical findings closely to see if they agree with our assessment of a referral being a voluntary admission" because "[t]hey are hesitant to accept a voluntary admission if they believe that they will have difficulty managing the client and possibly have to initiate TDO proceedings from their hospital."[117] This decision seems to be motivated by clinical concerns surrounding patient management, but financial considerations are not always absent. Some facilities will only take voluntary patients who have insurance.[118] A summary of the financial incentives at a patient's initial hospitalization and after a hearing that may affect outcomes are shown above in Figure 4.

In contrast to some facilities' preference to admit only persons who are not under a TDO, some CSB officials report that some hospitals prefer involuntarily committed patients because they

[117] Interview with Chesapeake CSB's Emergency Services Coordinator.
[118] Interview with Anonymous Rural CSB official.

view involuntary patients as easier to control and manage.[119] If an individual is admitted on a voluntary basis without a hearing, then she could cut her treatment short by simply leaving the hospital, even against medical advice. Should the doctors believe she still meets commitment criteria, they may pursue an ECO and a TDO to keep the individual from harming herself or others. If a person is admitted voluntarily as the result of a hearing, she is required to undergo a minimum treatment period of 72 hours.[120] After 72 hours, the individual can elect to end her inpatient care, but she must give the facility 48 hours' notice prior to leaving.[121] If the facility believes the patient is still in need of care and meets commitment criteria, the doctors can reinitiate the civil commitment process. When a hospital thinks an individual will be difficult to manage, often due to a patient's refusal to take medications or a patient's attempt to leave as soon as 72 hours have elapsed, the hospital may outright refuse or hesitate to accept her on a voluntary basis.[122] Transportation can also be an obstacle, especially in rural areas, but it is easily overcome if the person is involuntarily committed. For patients who have been involuntarily committed, transportation is provided by law enforcement at no inconvenience or expense to the CSB or the hospital.[123]

Hospitals' often cited reason that patients who are involuntarily committed are easier to manage should be qualified. Individuals under an involuntary commitment order are not able to give notice after the minimum stay of 72 hours, but rather must stay at the facility pursuant to the physicians' recommendations for the length of the commitment order (usually the order is the maximum of 30 days). Involuntarily committed patients can still refuse medical treatment if a judicial authorization for medical treatment order was not issued at their hearing.[124] While the judicial authorization to treat is a separate proceeding, it is sometimes, but not often, requested at the initial involuntary commitment hearing. Most of the special justices report that they seldom if ever issue this authorization order in the initial civil commitment hearing. More than one special justice said that they have never issued a judicial authorization to treat.[125] There are outliers: at one CSB, of the 35 involuntary commitments over a 6 month period 23 included judicial authorizations for medical treatment.[126] If someone admitted involuntarily without this authorization refuses to take medications or accept treatment, then the hospital would file a petition for the order. Alone, this obstacle seems insufficient to demand a person be admitted involuntarily. As one special justice noted, "*almost* every case presents evidence of the respondent's refusal to consent to all or part of the proffered treatment," and, even given this evidence, judicial authorization hearings are "infrequent" and occur "randomly".[127]

Overall, teasing out what drives admission decisions at all stages of the commitment process is difficult; the system is quite opaque because doctors are making multi-factored decisions, and it may not always be possible to identify all of the considerations. Each case presents its own set

[119] Extensive interviews with at least 10 CSB Emergency Services Managers throughout the state.
[120] Virginia Code § 37.2-814 (B).
[121] Id.
[122] Interviews with numerous CSB officials and hospital officials. This is discussed in further detail in the following section describing trends among CSBs.
[123] Interview with anonymous rural CSB official.
[124] Virginia Code §37.2-1101. Judicial authorization of treatment.
[125] Interviews with special justices in late March of 2010.
[126] Data from Harrisonburg-Rockingham CSB sent via e-mail on Mar. 18, 2010.
[127] E-mail from Special Justice from area with a high rate of commitment hearings, Mar. 18, 2010.

of factors including but not limited to the person's clinical condition, history with the involved provider, understanding of patient's needs, and hospital's capability to accommodate those needs. Further, there may be idiosyncratic aspects to care decisions, such as a hospital only admitting a female patient for a particular space due to a shared room or preferring patients under or above a specified age. It is hard to say the extent to which cost enters the calculus of various decision-makers, but it would be contrary to the anecdotal evidence to conclude that cost does not have some influence in patient outcomes. There are clear financial consequences for hospitals in admitting individuals with insurance, with Medicaid, with Medicare, or without any insurance at all. At various points in the process, hospitals' decisions might be influenced by the different financial incentives in admitting someone who is under a TDO or a judicial commitment order either involuntarily or voluntarily. Because of the many factors involved in a hospital's decision to admit one person as well as the considerations hospitals make based on their aggregate patient population, teasing apart the drivers of and reasons behind decisions requires more data, in depth research, and analysis.

III. Qualitative Evidence and Variation in Virginia

A. Community Service Boards

1. Quantitative and Qualitative Data

The Commission on Mental Health Law Reform recorded the outcome of every emergency evaluation conducted by CSB emergency services staff during June 2007. In total, there were 3,808 evaluations and, of those evaluations, 1,623 people were deemed to meet commitment criteria. Overall, 296 people or 18.2% of those persons who met commitment criteria were hospitalized voluntarily and 1,327 or 81.8% were hospitalized involuntarily.[128] The Tables below are drawn from the study. The data are only representative of the outcomes of evaluations by each CSB for one month in 2007. For the purposes of this analysis, the reader should assume that neither the number of emergency evaluations nor the rates of voluntary hospitalization have changed significantly.

[128] Study of Emergency Evaluations, June 2007, available at http://www.courts.state.va.us/programs/cmh/2007_06_emergency_eval_report.pdf (accessed Mar. 10, 2010). [hereinafter Emergency Evaluations Study]

Table 1. CSBs with Lower Rates of Voluntary Hospitalization (Among People Who Met Commitment Criteria)

	Total Number of People who Met Commitment Criteria	Voluntary Hospitalizations	
		Total Number	Percentage
Blue Ridge Healthcare	129	8	6.2%
Highlands	41	4	9.8%
Middle Peninsula-Northern Neck	36	5	13.9%
Mt. Rogers	54	4	7.4%
New River Valley	64	8	11.1%
Norfolk	34	4	11.8%
Planning District One	34	3	8.8%
Rappahannock Area	37	2	5.4%
Western Tidewater	37	2	5.4%

Table 2. CSBs with Highest Rates of Voluntary Hospitalization (Among People Who Met Commitment Criteria)

	Total Number of People who Met Commitment Criteria	Voluntary Hospitalizations	
		Total Number	Percentage
Alexandria	24	10	41.7%
Chesapeake	39	11	28.2%
Danville-Pittsylvania	59	18	30.5%
Henrico	47	14	29.8%
Portsmouth	31	17	54.8%

Based on the above numbers, I surveyed CSB Emergency Services Managers to investigate what factors might be influencing such disparate rates of voluntary admissions. Some of the major limits placed on my analysis stemmed from an overall lack of centralized data on trends concerning commitment rates and practices. While some CSBs or regions keep monthly records on the number of initial voluntary hospitalizations, hospitalizations pursuant to a TDO, dismissals, voluntary admissions, and involuntary commitments, many CSBs did not have this information in a readily accessible format.

For LIPOS funding, the DBHDS is required to report to the Virginia General Assembly the details of contracts made between CSBs and private providers for inpatient psychiatric treatment. This report lists the hospitals throughout the state and the amount of LIPOS funds each received. In FY 2009, CSBs reported paying $12,185,998 to 34 private providers for 17,402 bed days of inpatient psychiatric treatment for 3,290 individuals.[129] Beyond this report, there does not appear to be much significant oversight or monitoring of the specific use of LIPOS funds by the state.

2. Factors Influencing Whether a Person is Hospitalized under a TDO or Voluntarily: Facility Preferences, CSB Decisions, and LIPOS Structure

Many CSBs officials spoke with candor about the mental health care system and its flaws; their candor was not intended to indict particular hospitals or CSBs, but rather to shed light on what is occurring throughout the state. CSB officials were asked the following question: excluding age or medical issues, do hospitals accept individuals regardless of their status as either voluntary or involuntary? In some regions, CSB officials reported that hospitals accepted individuals regardless of whether they are voluntarily admitted or admitted pursuant to a TDO. However, it was not uncommon for CSB officials to note that a good number of hospitals purport to admit

[129] 2009 DBHDS Annual Report at 2.

everyone "on paper", but, in reality, they do not—both at the TDO stage and post-commitment hearing stage.[130] Additionally, one CSB reported that a hospital in its region did admit almost everyone the CSB sent there but only because of longstanding relationships between the two entities. Other CSB officials revealed that some hospitals will not accept people agreeing to voluntary care before a TDO unless those persons have insurance; these hospitals will generally take indigent patients who are hospitalized pursuant to a TDO.

Hospitals' reluctance to take individuals who would not be admitted with a TDO sometimes only applies to people from outside their region. For example, one hospital will accept anyone from the nearby CSB if it is medically appropriate but makes it clear to CSBs from other areas of the state that it will only accept other patients under a TDO. Interestingly, one CSB reported that if they have someone in a non-hospital facility who meets criteria, but the CSB is having trouble locating a bed at that moment, they have resorted to sending the person to an ER.[131] Because it can be difficult to place people who lack insurance and who are admitted voluntarily, CSB officials reported that sometimes individuals become the subject of a TDO inappropriately.[132] An individual admitted involuntarily automatically sidesteps two obstacles: funding and transportation. This latter obstacle is prevalent in rural parts of the state where the admitting hospital may be located at some distance from the potential patient. Many CSBs reported that they did not ever seek a TDO for people who did not meet criteria, even when individuals might be on the borderline. However, other CSB officials said that many CSBs are notorious for this practice, but could be expected not to be honest about it.

The main reason why hospitals prefer individuals to be admitted involuntarily seems to be financial. However, as noted above, hospitals' admission decisions can be opaque and it can be difficult to separate one driver as responsible especially given the variability of individuals and their conditions. This conclusion requires further investigation—it certainly occurs, but from the data available it is impossible to report the weight and prevalence of financial factors in influencing admission decisions. Further, not all CSBs or hospitals are frank in admitting this factor as a driver, and I was not able to separate those actors whose reports may not have been as forthright. Thus, more in depth investigation is certainly required to make an evidence-based conclusion instead of an informed inference.

The lack of systematic information also limits the conclusions that can be reached on the potential effect of LIPOS funding on treatment decisions. As illustrated in the data above, some interesting trends did emerge when I examined the survey results by grouping the CSBs by their relative rates of voluntary admissions. For example, of the CSBs with the highest rates of voluntary hospitalizations, I was able to confirm that four of them (Alexandria, Henrico, Chesapeake, and Danville-Pittsylvania) are able to utilize LIPOS funds for both judicial voluntary admissions and involuntary commitments. To be accurate, the Chesapeake CSB official noted that their region's version of LIPOS is called "reinvestment" funding, which covers "voluntary admission to a crisis stabilization center . . . at anytime and only requires a prescreening to be conducted with a referral to the crisis stabilization center of choice."[133] In

[130] Interviews with CSB officials conducted throughout February and March of 2010.
[131] As noted, if a person presents themselves to a hospital's ER, EMTALA requires the hospital care for them.
[132] Interviews with CSB officials conducted throughout February and March of 2010.
[133] Survey Response from Chesapeake CSB Official.

addition, an indigent client who meets involuntary commitment criteria can also be sent to a reinvestment facility when committed.[134] In short, what seems critical for Chesapeake, as well as the other CSBs noted above, is that funding is not tied to an individual's hospitalization or commitment status. Often, it appears that an involuntarily committed indigent patient would first be directed to a state facility, but, if that facility had no beds or was medically inappropriate, the individual could access LIPOS money regardless of his commitment status. The Henrico CSB can also use LIPOS funds for voluntary and involuntary referrals: for the former, the funds are applied at the time of admission, and, for the latter, the funds are accessed immediately after the hearing. For Henrico, there are no limits on the number of days for which the funds can be used, but the region and the CSB closely monitor the utilization of the funds.

In contrast, some (but not all) of the CSBs with the lowest rates of voluntary commitment were unable to use their LIPOS dollars as freely or had little access to this pot of money.[135] These CSBs are subject to more restrictions for LIPOS dollars and may be able to use the funds only if the person has been committed involuntarily. The Planning District One CSB can only use LIPOS funds for individuals that are committed involuntarily. The Highlands CSB reported a recent change in its use of LIPOS funds in that they can now be used for crisis stabilization units. Until then, LIPOS funding was limited to adult patients with a primary diagnosis of mental illness who were not deemed to be appropriate for involuntary admission to the state facility. However, the CSB official noted that, in the past, these funds ran out "months before the end of the fiscal year." Another CSB reported that it does not have LIPOS funds at its disposal becayse the money is used to fund the region's crisis stabilization units.[136] While the region has funds for purchasing inpatient private beds, there is not enough money in the region overall and the CSB official predicted that they may have to return the diversion project funds to the regional utilization committee.

One CSB with a relatively higher rate of involuntary hospitalizations explained the rate as misleading by noting that they never recommend a TDO for people based on the need for transportation. Rather, the CSB is "fairly stringent on TDO criteria" and only seeks TDOs when individuals really need them and when there is no less restrictive option. The LIPOS funding in this CSB's region provides up to four days of funding for involuntary commitments and judicial voluntary admissions. Of course, a CSB's LIPOS structure is not the only piece of the puzzle.

There is some regional monitoring of the use of LIPOS funds that can help with understanding current trends. For example, Partnership Planning Region II (PPR II) includes the CSBs in Alexandria, Arlington, Fairfax-Falls Church, Loudon, and Prince William.[137] For the first quarter of FY 2010, there were 804 commitment hearings with a monthly average of 201 hearings.[138] Of these 804 hearings, 41% resulted in voluntary admission, 34% in involuntary commitment, 22% in dismissal, and 3% in mandatory outpatient treatment. Interestingly, while 62% of persons who were committed either voluntarily or involuntarily have insurance, only

[134] Id.
[135] Northwestern CSB can use its LIPOS funds for patients admitted involuntarily or under a voluntary admission subsequent to a TDO hearing.
[136] Interview with CSB official from Health Planning Region V, 3.10.2010.
[137] Regional Utilization Report for the Regional Management Group, Northern Virginia Regional Projects, received via e-mail from Cindy Koshatka, Feb. 1, 2010.
[138] Id. For this region, there was a monthly average of 199 hearings for FY 2009.

25% of the patients sent to state facilities had insurance. This correlation may merely reflect the tendency of persons with mental illness to lack financial means and/or a way to access health insurance, but it also could signal the lack of availability of private hospital beds for uninsured mental health patients. This unavailability could be a result of hospitals' financial pressures, hospitals' unwillingness to accept these patients, hospitals' inability to provide appropriate care for these patients, and/or an overall lack of LIPOS funding to move indigent patients into private beds.

LIPOS funding is a complicated web, and there is no consistent trend between its availability and the rates of hospitalization. While many CSBs are subject to the policies set by the regional partnerships and not all the CSBs within each grouping display similar rates, it is also true that not all CSBs within a region receive the same amount of LIPOS funds. That said, the correlation could be more than a coincidence and in and of itself, requires further examination. It is also possible that there are informal understandings and expectations that infiltrate decisions. For example, if LIPOS funds cannot be used outside of involuntary inpatient commitment, there may be no other alternatives for indigent patients besides hospitalization. Without less restrictive available alternatives, these individuals might more readily become candidates for a TDO and later, involuntary commitment. At times, LIPOS appears to factor in CSBs' decisions to recommend a TDO for someone who might not otherwise need a TDO. This decision may not necessarily lead to an involuntary commitment order, but as discussed below in the materials on special justices and hearings, it very well could.

B. Special Justices and Treatment Decisions at the Hearing Stage

1. Quantitative and Qualitative Data

Based on the Case Management System (CMS) data from the first two quarters of Fiscal Year 2010, there were 11,104 hearings throughout the state. Of those hearings, 59.9% (6,597) resulted in involuntary commitment, 22.5% (2,482) resulted in voluntary admission, 17.1% (1884) resulted in dismissals, and 0.4% (51) resulted in Mandatory Outpatient Treatment (MOT). District courts with the highest and lowest rates compared to the state average are listed in Tables 3—4. A survey querying special justices' practices, views, and procedures was administered to special justices in each of those locales in order to understand and explain the observed differences.

From the quantitative data presented below and the surveys with special justices across the state, it is clear that there is a large amount of variation in how special justices view their own roles in the system and perform their duties.[139] Some mental health professionals point to the lack of supervision of special justices as a contributing factor to such variation, as well as the lack of any incentives for internal and external consistency.

[139] Virginia compensates special justices and other participants in the hearing process on a per case basis. It is generally accepted that the fee's amount is significantly less than the value of the work required, but it is possible that this compensation method encourages more hearings, and as a consequence more involuntary treatment orders, particularly in certain jurisdictions where the volume of cases is relatively high. A recommendation has already been made to the Commission from the Civil Commitment Task Force of the CMLR to consider a cap on these fees. See Virginia Commission on Mental Health Law Reform, *Report of the Task Force on Civil Commitment*, (March 2008).

Table 3. District Courts with Highest Rates of Involuntary Commitment

	Total Number of Hearings	Total Number of Hospitalizations (Voluntary + Involuntary)	% Involuntary Hospitalizations
Hopewell	213	211	94.7%
Smyth	654	453	89.8%
Petersburg	613	573	87.6%
Richmond	1078	1010	87.6%
Chesapeake	347	282	82.7%
Virginia Beach	501	482	76.7%
Norfolk	115	115	76.2%

Table 4. District Courts with Lowest Rates of Involuntary Commitment Rates

	Total Number of Hearings	Total Number of Hospitalizations (Voluntary + Involuntary)	% Involuntary Hospitalizations
Fairfax County	369	302	37.7%
Galax	285	32	37.5%
Mecklenburg	181	148	35.1%
Prince William	317	232	34.5%
Russell	109	90	34.4%
Bristol	229	229	32.3%
Montgomery	264	249	26.1%
Winchester	172	135	8.9%

2. Judicial Orientation and Variations in Practice

The short answer to the question of whether special justices' practices and opinions affect treatment outcomes is sometimes, but not always. The following section explores the questions to which special justices gave uniform answers and different answers. It also points out when the variation between judges may affect or be correlated with hearing outcomes.

Many of the responses from the special justices were consistent without respect to whether the special justice had a relatively low or high rate of involuntary commitments. Almost every special justice professed routinely offering voluntary admission to the individual at the beginning of every hearing should the patient demonstrate capacity to consent. When people do not agree to treatment, the reasons given by the special justices are usually that the person thinks she does not need treatment, has a lack of insight into her own condition, and/or wants to try to have her case dismissed. Sometimes individuals reportedly do not agree to voluntary treatment even when their attorney has assured them that the outcome is most likely to be inpatient treatment. Overall, patient populations do not appear to be significantly different. Most special justices reported a diverse range of ages and illnesses with schizophrenia, bipolar disorder, and other psychotic predispositions as the most prevalent mental illnesses. Additionally, many special justices noted the high rates of substance abuse, self-medication, and anger management issues among individuals. It was also common for special justices to note that they often see the same people, whom they often refer to as "frequent flyers."

Special justices tended to agree that the length of the period a person is hospitalized before a commitment hearing could often affect the hearing outcome. Most special justices noted that when an individual has been in the hospital long enough to stabilize due to detoxification or medication, he is more likely to be deemed competent and either agree to treatment or be dismissed. Additionally, the majority of special justices responded that the new commitment criteria have not radically changed their commitment rates, but a few justices said that the criteria give them more discretion such that at times, borderline cases might more often result in them recommending inpatient treatment. Overall, almost all of the special justices reported that they still have a fair amount of discretion in applying the commitment criteria and that this discretion has not been altered by the revisions. Lastly, almost unanimously, the special justices rejected the idea that the lack of case law on civil commitment was problematic and regarded any additional training as unnecessary.

There were instances where special justices varied, but the variation did not correspond to relatively higher or lower involuntary commitment rates. Some justices reported that they found the new commitment criteria easier to apply, while others reported they found it more challenging. For example, one special justice said that since the change in the criteria, he viewed the categories as "broadened" and "not as cut and dry." Another justice saw no real difference and viewed the concepts "are inherently elastic," still requiring "a judgment call". Other justices reported no difference in their own application or understanding of the criteria, but found the new criteria easier to explain to patients. Increased support from the Office of the Executive Secretary was a suggestion that was met with mixed reviews, but most justices tended to think it was unnecessary. Lastly, when asked whether hospitals in their area ever currently allow patients under a TDO status to bypass the hearing and admit themselves voluntarily, only some

justices reported that this practice had occurred to their knowledge. Some of the justices did not think that this option was currently allowed under the code as it stands now.

While there is a fair amount of common ground amongst special justices, the differences in their perceptions and views of the civil commitment process are illuminating. Overall, there seem to be divergent views between justices with relatively high rates of involuntary commitments and justices with relatively low rates of involuntary commitments. When questioned whether individuals who are competent agree to voluntary admission, the special justices from areas with high involuntary commitment rates reported that most people do not. Many of them estimated that individuals only agree anywhere from 10%, 20%, or 30% of the time.[140] In contrast, the special justices in areas with lower rates of involuntary commitment estimated that competent individuals agreed to voluntary admission about half of the time.[141] Of course, these answers already confirm the data that more people in certain areas agree to voluntary admission, but what is interesting is that the patient populations at this stage have all been screened by the CSB and determined to meet the civil commitment criteria. Thus, for the purposes of this analysis, it can be assumed that the individual subjects of the commitment hearings are comparable. When asked further about the procedure followed at commitment hearings, many special justices in areas with low rates of involuntary commitment spoke about their commitment to encouraging voluntary admission and their practice of allowing the individual to admit himself voluntarily until the end of the hearing. This practice may result in more individuals agreeing to voluntary admission, but it is possible some people only agree to care at this point in the hearing to avoid involuntary commitment. In contrast, the special justices with higher rates of involuntary commitment tended to allow the person one opportunity to agree to treatment and seemed to be predisposed towards this option. At least one CSB official reported that their special justice uses voluntary admission almost exclusively.

The main difference among special justices is likely most attributable to their perceptions towards the commitment process and their own role in it. Most of the special justices report that they are committed to providing due process to individuals, but their view of how to accomplish this end differs. Some special justices begin hearings with a stronger assumption of a commitment result. Due to the repeat players at the hearing, the participants (the court liaison, CSB official, and the attorney) are probably aware of this tendency, and as a result, assume a less active role. Some special justices are able to get through three hearings in less than 30 minutes. There is no real debate about what the outcome should be. Some reports from CSB officials regard the hearings as purely procedural due to the fact that often, the special justice has already decided the outcome before even speaking with the CSB official. In contrast, other hearings are filled with debate and extended discussions over the outcome, often because the outcome is not as preconceived. Some special justices require the CSB official to testify on what the outcome should be. Also, some special justices require that the independent evaluator's report and/or the second CSB evaluation be completed at the hospital on the day of the hearing so as to assure it is as accurate as possible.[142]

[140] I surveyed 15 special justices from areas with high rates of involuntary commitment
[141] I surveyed 13 special justices from areas with low rates of involuntary commitment.
[142] While this difference could be a result of judicial preference, it is worth noting that in some areas with a high volume of TDO's the time constraints do not always allow for a second evaluation prior to the hearing.

The differences between special justices can be minimized by describing them as purely stylistic, but these attitudinal factors and procedural norms seem to be the key determinants of the outcomes of civil commitment hearings. While some variation between special justices is to be expected, the amount of variation in the civil commitment process is unacceptable. It is important for the Commission to monitor and correct any inappropriate influence that special justices' styles and predilections may currently have on outcomes.

IV. Conclusions

- **There is a lack of centralized data collection and monitoring.** While some CSBs keep records and some Health Planning Regions (HPRs) have extensive data collection, currently there is no overall synthesis or analysis of decision-making norms. Further, the state does not monitor special justices or provide them with information on their commitment rates. This lack of monitoring has resulted in a deficit of reliable information that can inform and improve policy decisions.

- **Variation. Variation. Variation.** Some examples of variation that can and do affect commitment decisions in certain areas include: financial incentives, behavioral norms, hospital-CSB relationships, LIPOS funding structures, availability of crisis management services, hospital preferences, distance of CSB from inpatient facilities, availability of outpatient care, daily volume of patients under the CSB's care, and perspective of the assigned special justice.

- **The real practice of facilities is not always what they say it is.** Some hospitals purport to admit everyone "on paper", but, in reality, turn people away for myriad reasons. One reason a hospital may consider an individual to be a "bad fit" could be based on the person's commitment status, which can be an indicator of future payment stream. Sometimes hospitals have different rules for individuals residing either within or outside of their catchment area. Some CSBs say they never let transportation issues or facility availability affect commitment decisions, but in reality, it seems that CSB officials may be more likely to seek a TDO when such factors are at play.

- **Sometimes, timing matters.** If individuals have not been in the hospital for more than 24 hours before a civil commitment hearing, there is a greater chance that they will not have stabilized. Stabilization can refer either to the person's lack of proper anti-psychotic medications or to the person's abuse of alcohol and/or drugs. In some areas, the schedule of hearings is inflexible such that there is no ability to postpone a hearing without violating the TDO's maximum time limit. Because of the hearing's timing, an individual is more likely to lack competency and to be unwilling to agree to voluntary treatment.

- **Funding at the TDO stage can influence CSB decisions concerning hospitalization.** As detailed by discussions focusing on some hospitals' preferences for which individuals they admit and some CSBs' policies regarding for whom a TDO is recommended, it can be significantly more difficult to locate a bed for an indigent patient. When a patient's care is assured to be reimbursed at a rate of at least 80% through the

State IMCF, placing that person can be much easier. Thus, CSBs might be more prone to recommend a TDO for an individual in such instances.

- **LIPOS structure can create financial incentives for involuntary commitment.** The patterns noted about the availability of LIPOS funding are speculative; however, how LIPOS is distributed within a region may signal the flexibility of CSBs to accommodate individuals due to available financial resources. When LIPOS funds are not tied to commitment status, but can be used for both voluntary and involuntary patients, CSB officials may not be subject to the financial pressures that may exist when LIPOS funds are more restricted. Further, when areas have crisis management services for which LIPOS funds may also be used, decisions are not constrained by either no care or inpatient care.

- **Special justices' attitudinal predilections are crucial.** From the interviews with special justices, it is clear that the manner in which special justices conduct their hearings may be the most significant factor in determining outcomes. One major and critical difference between special justices is whether they give individuals a single opportunity to agree to voluntary admission or reserve that right for them to exercise later in the hearing when it becomes clear that the person will otherwise be involuntarily committed. Having the option preserved may be critical in persuading people to volunteer for treatment who are inclined to "try their luck" by gambling on the outcome.

V. Policy Recommendations

1. **Change funding structure to be purely need-based and not linked to whether a patient is voluntarily admitted or involuntarily committed.** It is undeniable that Virginia's funding of civil commitment has not caught up with changes in thinking and practice about what constitutes the most appropriate care for patients experiencing mental health problems. For people without insurance, the IMCF will fund their initial care, but only if they are admitted to a hospital pursuant to a TDO, which means they are resistant to accepting care. Ideally, if a person is in need of inpatient care, she should receive care regardless of whether she admits herself or is admitted pursuant to a judicial order. Changing the restrictions on the IMCF so that it could be used for indigent individuals who admit themselves and meet the commitment criteria could remove some of the financial incentives that are likely influencing care decisions. Due to strained resources, it is possible that such a plan would be met with some political resistance due to the belief that people with the most pronounced conditions requiring involuntary commitment should be taken care of first. However, by changing the incentives at least initially by funding voluntary care for individuals with serious conditions, it may realign incentives and result in lower costs for patient care in total. In other words, this option may not mean taking money away from the care of involuntarily committed individuals or individuals under a TDO but rather merely shifting resources from LIPOS or other areas to pay for care at the beginning of a mental health crisis.

2. **Develop explicit guidelines for special justices to encourage more consistency in the exploration of voluntary admission.** The lack of uniformity in

commitment outcomes between special justices is unacceptable. There are certainly some justices in the state who have a demonstrably greater tendency to commit individuals involuntarily as opposed to voluntarily. By reforming and realigning special justices' understanding of their own role and practice of the commitment process, there is potential to decrease the rates of involuntary commitment, especially in certain areas of the state. To encourage more consistency, the Office of the Executive Secretary could develop more explicit guidelines. Guiding special justices specifically and instilling greater consistency in the hearing procedure may encourage greater consistency in results. Because of the infrequency in appeals by patients, civil commitment law is not often subject to independent judicial review. Thus, one benefit to explicitly and practically exploring the ideal functioning of the civil commitment process will be to help develop a consensus among special justices regarding civil commitment laws, their meaning, and their intended application.

3. **Allow conversion from TDO status to voluntary admission pursuant to a physician's recommendation.**[143] By allowing individuals to convert from involuntary status under a TDO to voluntary status, the facility would withdraw the petition for a hearing (if it has already been filed) and cancel any upcoming hearing. A "minimum stay" does not need to be included as part of such an agreement; if the person attempts to leave the facility, then a new petition can be filed. There may be a potential problem if the TDO facility staff was not the petitioner, but the law could allow the facility to terminate the proceedings without the consent of the petitioner. A person under a TDO would only be released should the independent evaluator and a responsible physician determine that the person under a TDO is competent to consent to care and that involuntary inpatient treatment is no longer needed. The hearing would be canceled in lieu of these alternative arrangements. This change has the obvious incentive of avoiding the civil commitment hearing altogether, which could reduce individuals' perceptions of coercion. While some special justices supported this policy change, others were strongly opposed to it due to their belief that the hearing structure ensures individuals' rights are protected. Though many special justices seem sincere in their opposition to this alternative, there are some skeptical observers who point out that special justices are motivated to oppose the policy due to the accompanying reduction in hearings and thus, fees. Patients certainly have a liberty interest at stake, but allowing patients to determine their own course of care and avoid the often negative and, here, unnecessary experience of a hearing allows individuals more autonomy. That said, it would be crucial that doctors do not coerce people into accepting this route or apply pressure inappropriately.

4. **Standardize LIPOS funding across the state so that it is used for patients who meet commitment criteria whether they are either voluntarily admitted or involuntarily committed.** Encouraging Health Planning Regions to change some of the restrictions on LIPOS funds will allow the monies to be used more flexibly and thus responsively to patient needs. Funding voluntary admission and involuntary commitment in equal measure will eliminate incentives that may exist within the system. Such a change will involve the shifting of resources. It is a misconception to assume that

[143] This change is a variation on a reform the Commission has been suggesting since 2007.

involuntarily committed persons have more severe mental conditions than persons who are voluntarily admitted so arguments about necessity do not apply.

5. **Allow for the extension of the TDO period from 48 hours to 72 hours.** With a slightly longer permissible TDO period, some individuals' conditions may improve such that they do not meet the guidelines for involuntary admission, and others' conditions may stabilize so that they more inclined to accept voluntary admission. As noted, the extension of the TDO period does not result in longer hospitalization and actually may lead to shorter overall lengths of stay.[144] Financially, hospitals would not be affected; rather, the change would only shift state dollars between two funds. When individuals without insurance or Medicaid coverage are admitted under involuntary conditions, the TDO period is paid for through the IMCF, which is made up of state funds. For those who are admitted involuntarily but lack coverage via private insurance or Medicaid, the costs are paid through LIPOS or state hospital admissions, state-only dollars. Thus, the funds will merely be reallocated.

6. **Create and implement centralized data collection and monitoring.** There is no overall synthesis or analysis of decision-making norms at each step of the commitment process. The collection of data on hearings and hearing outcomes across the state is an important step to improving officials' understanding of the commitment process. However, while hearing outcome data is collected, the state does not provide special justices with information on their commitment rates. While some CSBs keep records and some regions have extensive data collection, there is no analysis or comparison of regional rates of commitment. There needs to be better data collection from facilities and CSBs and macro-analysis of this data. Tracking trends in the state and asking questions about standard practices would help to clarify what factors may be driving decisions in some localities and address these differences with sound policy options.

[144] See Wanchek, Tanya, Preliminary Results for TDO-Hospitalization Study (Nov. 11, 2009).