

COMMISSION ON MENTAL HEALTH LAW REFORM

**REPORT OF THE TASK FORCE ON FUTURE
COMMITMENT REFORMS (2009)**

DECEMBER, 2009

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PREFACE

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

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

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

After the General Assembly enacted a major overhaul of the commitment process in 2008, the Commission moved into the second phase of its work. Three new Task Forces were established – one on Implementation of the 2008 Reforms, another on Future Commitment Reforms and one on Advance Directives. In addition, the Commission created a separate Working Group on Transportation. Each of these Task Forces and Working Groups presented reports to the Commission, together with recommendations for the Commission’s consideration.

In December, 2008, the Commission issued a Progress Report reviewing its work in 2008 and providing a status report on the progress of mental health law reform in Virginia during 2008. It summarized the changes adopted by the General Assembly in 2008, reviewed the steps taken to implement them, summarized the available data on the operation of the

commitment system during the first quarter of FY2009, presented the Commission's recommendations for consideration by the General Assembly in 2009, and identified some of the important issues that the Commission will be addressing in the coming year. The 2008 Progress Report can be found at http://www.courts.state.va.us/programs/cmh/2008_1222_progress_report.pdf

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

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

Richard J. Bonnie, Chair
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December 2009

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TABLE OF CONTENTS

SECTION	PAGE
Introduction	7
Mandatory Outpatient Treatment	10
New York Study	10
Therapeutic Jurisprudence Model	13
Future Commitment Reforms Task Force Review	14
Senate Bill 840	17
Expansion of the TDO Time Period	20
Expanding the TDO Period and Establishing a Minimum Time Before a Hearing	20
Changes to Promote Voluntary Treatment	23
Criteria in Related Statutes	26
Jail Transfer Statutes	27
Appendix A: Recommendations	33

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COMMISSION ON MENTAL HEALTH LAW REFORM

REPORT OF THE FUTURE COMMITMENT REFORMS TASK FORCE

Introduction

The Future Commitment Reforms Task Force (“Task Force”) continued its work in 2009 on the following issues remaining unresolved from the 2008 and 2009 General Assembly Sessions:

1. Whether mandatory outpatient treatment (“MOT”) after a period of involuntary inpatient admission and MOT to prevent future involuntary inpatient admissions should be enacted in Virginia. The assessment of this question was accomplished, in part, by a review of the New York Assisted Outpatient Treatment Program Evaluation.
2. Whether Virginia’s temporary detention order maximum timeframe should be extended from 48 hours to 3, 4 or 5 days and whether a minimum time period should be established prior to which a commitment hearing may not be held: Studying this question included assessing the role of the independent evaluator in this process and addressing other changes to encourage voluntary treatment over involuntary treatment.
3. Whether criteria in other statutes should be changed to correspond to the revised civil commitment criteria:
 - a. § 54.1-2400.1(B) (*Tarasoff* reporting): <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2400.1>
 - b. § 22.1-272.1 (schools reporting suicide risks): <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+22.1-272.1>
 - c. § 37.2-1103(A) (ECOs for physical illness): <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-1103>
4. Whether changes should be made to the jail transfer statutes to conform to previous changes in the civil commitment statutes:
 - a. § 19.2-169.6: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+19.2-169.6>
 - b. § 19.2-176: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+19.2-176>
 - c. § 19.2-177.1: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+19.2-177.1>
5. Whether changes should be made to the not guilty by reason of insanity (“NGRI”) conditional release revocation statutes to conform to previous changes in the civil commitment statutes:
 - a. § 19.2-182.8: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+19.2-182.8>

- b. § 19.2-182.9: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+19.2-182.9>

The findings and recommendations of the Task Force on these questions are examined in detail in the following sections of this Report.

I. Mandatory Outpatient Treatment

Last year, the Task Force reviewed MOT² legislation that was introduced during the 2008 General Assembly Session and referred to the Commission on Mental Health Law Reform (“Commission”) for study.³ That proposed legislation would have authorized mandatory outpatient treatment following a period of involuntary inpatient hospitalization and would have established an MOT program, similar to Kendra’s law in New York, the common name for New York’s mandatory outpatient treatment legislation, to mitigate the need for future inpatient involuntary hospitalization. As part of its study, the Task Force considered the extensive literature on this topic, including the divergent opinions of stakeholder groups, and concluded that MOT should not be expanded until (1) research documenting the efficacy of MOT is available and (2) Virginia’s economic picture changes such that an expansion of outpatient mental health services is fully funded. At that time, the Task Force noted that New York State had contracted with Dr. Marvin Swartz of Duke University to conduct a legislatively-mandated external evaluation of its Assisted Outpatient Treatment law and the results were due to be published mid-Summer 2009.⁴

New York Study

The Task Force spent considerable time in 2009 evaluating New York’s experience under Kendra’s law. New York released the New York State Assisted Outpatient Treatment Program Evaluation⁵ (“New York Study”) on June 30, 2009. The New York Study addressed the following questions:

1. Are there regional and cultural differences across the state in Assisted Outpatient Treatment (“AOT”) programs and their implementation?
2. What is the level of service engagement of recipients of mental health services during AOT?

² In Virginia, the term “mandatory outpatient treatment (MOT)” has been coined to refer to court-ordered outpatient treatment. New York’s Kendra’s Law uses the term “assisted outpatient treatment (AOT).” This Report will use the “AOT” when referring to New York’s law and “MOT” when referring to Virginia’s law or any proposed law.

³ The Report of the Future Commitment Reforms Task Force’s review of MOT is found in its Report to the Mental Health Law Reform Commission, dated December 2008, pages 13-20, posted on the Supreme Court’s website at:

http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2008_1201_tf_commitment_rpt.pdf

⁴ *Id.*

⁵ Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. New York State Assisted Outpatient Treatment Program Evaluation, Duke University School of Medicine, Durham, NC, June, 2009.

3. What are the outcomes for people with mental illness who are mandated into AOT versus those who received voluntary enhanced outpatient services?
4. What are the opinions of a representative sample of AOT recipients regarding their experiences with AOT?
5. What is the level of service engagement of recipients of mental health services post-AOT?
6. What is the impact of AOT programs on the availability of resources for individuals with mental illness and perceived barriers to care?

The Task Force's interest in the New York Study was whether, and to what degree, New York's AOT program had lessons for Virginia. It is critical to understand, as the New York Study points out, that New York's AOT program was accompanied by a significant infusion of mental health service dollars and currently features more comprehensive implementation, infrastructure and oversight of AOT than any other program in the country. For that reason, the researchers state that the findings and conclusions of the New York Study cannot be generalized to other states where new service dollars are not available.

It is also important to note that the criteria for issuing an AOT order in New York are very narrow. For an AOT order to be applicable, a person must have a history of noncompliance with treatment that has resulted in (1) psychiatric hospitalization or incarceration at least twice in the past 36 months, or (2) committed serious acts or threats of violence to self or others in the past 48 months. The person must also be found as a result of mental illness to be unlikely to voluntarily participate in treatment and to be in need of AOT to prevent deterioration that would likely result in harm to himself or others. AOT recipients in New York also represent a small proportion of the total adult service population. In 2005, AOT recipients represented only 1.7% of adult service recipients with severe mental illness.

Kendra's law was originally designed to prevent relapse or deterioration *before* hospitalization is needed. The New York Study found, however, that in nearly 3/4ths of all cases, AOT is actually used as a discharge planning tool and a transition plan to improve the effectiveness of treatment after hospitalization and to prevent relapse. In addition to a different use of AOT than originally contemplated, the New York Study found geographical variations in the use of AOT. Approximately 70% of all AOT orders are issued in New York City, a figure that far exceeds the City's share of the state population. In other regions of the state, enhanced voluntary services ("EVS") agreements are usually used *in lieu* of a formal AOT order. Only when a person does not comply with the EVS agreement is an AOT order considered. In contrast, EVS agreements in New York City are more often used as a step-down following an AOT order.

Given the caveats and clarifications above, the New York Study did provide some interesting findings related to the efficacy of treatment under AOT. Several variables were examined. For example, the New York Study found that during the first six months on AOT, individuals' engagement in services was comparable to service engagement of

voluntary patients, e.g. those not on AOT. After 12 months or more on AOT, however, service engagement, when combined with intensive services, increased when compared with those receiving voluntary services alone, suggesting that the use of AOT was more effective in obtaining and maintaining participation in treatment than simply encouraging voluntary participation. Further, individuals subject to AOT experienced a substantial reduction in the number of psychiatric hospitalizations and were hospitalized fewer days when hospitalization was needed. In addition, the likelihood of being arrested was reduced for persons on AOT. AOT recipients were also more likely to consistently receive psychotropic medications appropriate to their psychiatric conditions. Further, case managers reported subjective improvements in areas of personal functioning, such as managing appointments, medications and self-care tasks.

The evidence also found that AOT recipients reported feeling neither more positive nor more negative about their mental health treatment experiences than comparable individuals who were not under AOT. This is counter to what many opponents of AOT predicted who suggested that coerced treatment would have significant negative effects. The researchers posited that positive and negative attitudes about treatment during AOT were more likely influenced by other experiences with mental illness and treatment than by recent experiences with AOT itself.

The New York Study further found that sustained improvement after the end of AOT is a function of the length of time the recipient spends under an AOT order. If AOT is discontinued after six months, decreased rates of hospitalization and improved use of psychotropic medications are sustained *only* if the person continues to receive intensive case management services. If AOT orders are continued for longer than six months, however, these improvements were sustained whether or not intensive case management services continued after AOT ends.

A frequent concern raised by opponents of AOT or any mandatory outpatient treatment, is that involuntary treatment orders would drain resources from those seeking services voluntarily. The New York Study, however, was unable to determine whether AOT resulted in resources being diverted away from other adults with severe mental illness. No doubt, this was because implementation of AOT in New York was accompanied by a large infusion of funding, which increased the availability of intensive mental health services for everyone. Nonetheless, in the first several years of AOT, non-AOT recipients were less likely to receive intensive case management services than AOT recipients, especially outside New York City. After the initial increase in intensive community-based services, however, AOT case loads leveled off and then declined making the new treatment capacity available for those seeking voluntary services. However, this broad provision of services to both those seeking care involuntarily and voluntarily may change due to New York's budget constraints. Now that the new service capacity is fully utilized, competition for services between those under AOT and those voluntarily seeking care may intensify with impending budget cuts.

The full report of the New York Study may be viewed at http://www.omh.state.ny.us/omhweb/resources/publications/aot_program_evaluation/.

Therapeutic Jurisprudence Model

The Task Force also reviewed Chapter 9 of Bruce Winick's book *Civil Commitment – a Therapeutic Jurisprudence Model*⁶ that analyzes the impact of outpatient commitment under different models. Winick writes that the concept of outpatient commitment, “known as preventive commitment by its opponents and assisted community treatment by its defenders,” has arisen as a result of the shift in the locus of care for persons with mental illness from the hospital to the community. It was designed to address a revolving-door syndrome in which individuals rotate between the hospital and community,⁷ discontinuing medications, deteriorating and requiring re-hospitalization.⁷ The first outpatient commitment models to emerge were conditional release from involuntary hospitalization and community treatment ordered for individuals who otherwise satisfy the criteria for involuntary hospitalization. Conditional release is based on the theory that hospitalization is no longer necessary, but continued treatment in the community is still needed. Winick analogizes this type of commitment to parole from prison that is conditioned upon the prisoner's willingness to accept parole, in lieu of imprisonment, or, as here, outpatient commitment in lieu of involuntary hospitalization. Violation of parole conditions results in re-imprisonment. For persons discharged from the hospital, violation of outpatient commitment results in re-hospitalization. Community treatment, ordered as a less restrictive alternative to inpatient hospitalization, is justified on the basis that the individual satisfies the civil commitment criteria and the state's interest in protecting the individual and the community from harm. Overall, these two forms of outpatient treatment have been justified as alternative means of accomplishing the state's compelling interests of minimizing the risks to society and the individual in ways that are less restrictive of the individual's liberty interest than involuntary inpatient treatment.

With Kendra's Law in New York, a third model emerges authorizing outpatient commitment for individuals resistant to treatment although they fail to meet the usual commitment criteria. Such outpatient commitments under the Kendra's Law model are based upon a lesser standard and are designed to prevent the person's predicted deterioration and re-hospitalization or incarceration if untreated. Winick questions whether outpatient commitment under this lesser standard is even constitutional, depending upon the nature of the coercive treatment that is authorized and the legal justification. Involuntary psychotropic medication, he argues, may be permitted only based on the government's police power in the presence of compelling government necessity and individuals must be found to be presently dangerous or the violence imminent, and less intrusive alternatives are not available. If an order is sought based upon *parens patriae* grounds, the person must be incompetent to make treatment decisions, the medication must be medically appropriate and in his best interests, significant harm to the individual must be imminent, and there must be no less restrictive

⁶ Bruce J. Winick, *Civil Commitment – A Therapeutic Jurisprudence Model*, Carolina Academic Press (2005).

⁷ *Id.* at 242.

alternative to protect his interest or prevent harm. Although under Kendra's Law no provision is made to force a person to take medication or punish him for noncompliance, Winick suggests individuals may be misled into taking their medications believing they will be forced to take their drugs or be re-hospitalized, raising serious ethical and therapeutic concerns.

Published in 2005 before the New York Study reviewed above, Winick also questions the therapeutic value of a commitment model based on coercion instead of voluntary choice. He argues that outpatient commitment without the availability of intensive treatment services is ineffective. Winick argues the extra resources needed to implement the court and monitoring system would be better used to increase the availability of outreach and case management services designed to persuade individuals to accept treatment voluntarily and to assist them to do so, and treatment should be extended to all who seek it.

Although questioning the appropriateness of coercive treatment, generally, Winick advocates diversion programs for those who commit minor offenses, such as the Memphis Crisis Intervention Team model for police officers, whereby specially trained uniformed officers serve as primary or secondary responders to every call in which mental illness is deemed a factor. Rather than arresting and jailing individuals who commit minor crimes as a result of their mental illness, police take them to mental health treatments facilities to obtain the services they need. For individuals who are arrested, mental health courts induce individuals to accept needed treatment and facilitate its delivery. Even in these cases, however, Winick argues that strategies should be employed to encourage individuals to voluntarily engage in treatment rather than reverting to preventive outpatient commitment. For those jurisdictions that have enacted preventive outpatient commitment, procedures should be designed to minimize the anti-therapeutic effects of coercion and maximize the potential that the individual feels treatment is being accepted on a voluntary basis. Individuals should be treated with fairness, dignity, and respect, attempting to motivate them to accept treatment rather than coercing them to do so. Service providers should attempt to negotiate with patients prior to filing petitions in an effort to persuade them to accept voluntary treatment and should make creative use of behavioral contracting to facilitate motivation and compliance. In other words, a therapeutic jurisprudence model should be applied in ways to make outpatient commitment less an instrument of compulsion, and more a mechanism of assisted community treatment.

Future Commitment Reforms Task Force Review

It must be emphasized again that Kendra's Law in New York was not limited to a statutory change, but provided a significant and sustained infusion of new dollars into the system to improve services. As a result, simply broadening the circumstances for involuntary outpatient treatment in Virginia will not duplicate the positive results noted in the New York Study. As Virginia's Inspector General for Behavioral Health and Developmental Services documented in his 2005 Review of the Virginia Community

Services Board Emergency Services Programs⁸ (the “IG’s CSB Study”) the scarcity of non-emergency support and clinical services across Virginia seriously overburdens the emergency crisis services system. The IG’s CSB Study found that in all but a few CSBs only emergency response, referral and inpatient care was available. Very few CSBs offer the critical mid-range of services needed to prevent unnecessary hospitalizations or arrests. In spite of the IG’s CSB Study and many other reports documenting the need for additional outpatient mental health service capacity, only following the tragedy at Virginia Tech in 2008 were significant funds appropriated to expand community services. Although this appropriation was labeled a “down payment” for critically needed services, repeated budget cuts since have undermined this “down payment” and threaten further improvements to mental health services. As noted in the New York Study, sustained availability of intensive outpatient services is essential to the success of AOT. The New York Study documented that the benefits of AOT are apparent only after individuals receive 12 months or more of services, and only when combined with intensive outpatient services for at least the first 12 months. As a result, the enactment of legislation similar to Kendra’s law in Virginia must be tightly paralleled with a significant and sustained infusion of service dollars into the system.

Task Force members also noticed that although new mental health funding in New York was spread out evenly among all markets, only certain areas, particularly New York City (70%), used the increased mental health services funding for AOT. Members posited that smaller, rural areas might be able to become more involved with individuals and provide them with more support than urban areas, thereby avoiding the need for AOT. AOT may be more appropriate in urban areas where individuals and their needs tend to get lost in the crowd.

A significant finding of the New York Study was that although Kendra’s law permits broader use of AOT, in 3/4ths of all cases, AOT was used as a discharge planning tool, a transition or “step-down” plan to improve the effectiveness of treatment after hospitalization and to prevent relapse. The New York experience suggests that the best use of AOT may be in the post-hospitalization phase. Task Force members agree that many people leaving the hospital in Virginia would benefit from a higher level of support than they now receive and many members believe that an AOT program could provide this support for at least a subset of this population. AOT may also help people establish a better sense of community and peer support and give them a reason to go to their appointments. In addition to providing a supportive function for clients, AOT could serve to better engage some CSBs in providing services. There are 40 CSBs, each with a different history of working with people who need more intensive follow-up after hospitalizations. Some CSBs do a good job; however, others tend to avoid engaging more difficult clients, perhaps because of resource limitations, often resulting in re-hospitalizations. Because an AOT program would impose requirements not only upon the subject of the order, but also on the CSB and treatment providers, it may lead CSBs to enhance their efforts for individuals who are more treatment resistant.

⁸ OIG Report # 123-05 at <http://www.oig.virginia.gov/documents/SS-ESPFinalReportMay-August2005.pdf>.

Although some of the New York Study results are intriguing, there is basic disagreement among Task Force members about whether MOT or AOT should be enacted in any form -- either to prevent involuntary inpatient treatment or as a step-down from involuntary inpatient treatment. Among opponents, many believe the coercive nature of the AOT or MOT model is antithetical to the concept of recovery. Forced treatment, it is argued, is ineffective when the individual is not engaged or committed to treatment.⁹ Further, given the limited availability of outpatient mental health services across Virginia, forcing treatment on persons diverts treatment resources from those who want and need services and would participate voluntarily. In addition, mandating treatment without ensuring greater availability of services would doom the effectiveness of such a program. Outpatient mental health resources are so scarce in Virginia already that people may be ordered to receive treatment that is simply unavailable or is ineffective for them. Programs of Assertive Community Treatment (“PACT”)¹⁰ teams and intensive case management services are not available throughout Virginia and the PACT services that were originally established over the last several years were based upon a one-time infusion of funds. PACT slots are mostly full and are not available.

Task Force members who are skeptical about the benefits of the MOT proposal also note the following:

- Results of the New York Study are not transferable to other states;
- Each state’s law exists in its own context;
- We do not know why AOT works for some people and not for others;
- We cannot unravel the effects of the order from the quality, availability or effectiveness of the treatment actually provided to measure whether it was the order that was effective or something else; and
- AOT will not address concerns about refusal to take medication.

Proponents of MOT state that for a small number of people, AOT appears to work in NY but its effectiveness requires the provision of services over an extended period of time. An ancillary benefit is that MOT orders may nudge providers to provide services, or more intense or focused services, to individuals with challenging clinical profiles that otherwise would not have been provided, thereby holding providers accountable. Proponents also note that the basics of a closely monitored outpatient treatment system, as embodied in the PACT team model, already exist in Virginia. Even so, PACT or enhanced outpatient services at that intensity level is not always necessary for many individuals discharged from the hospital, many of whom do not fit the profile of persons

⁹ See, however, the New York Study results reported earlier in this Report.

¹⁰ Program of Assertive Community Treatment is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious mental illness such as schizophrenia. Professionals including those in social work, rehabilitation, counseling, nursing and psychiatry provide PACT services. Among the services are: case management, initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other services and supports critical to an individual’s ability to live successfully in the community. An evidence based practice, PACT has been extensively researched and evaluated and has proven clinical and cost effectiveness. (From the ACT website: <http://www.actassociation.org>.)

served by PACT teams. MOT may help those people who simply need a little more motivation to stick to the treatment regimen or a little more structure, which is currently being provided to them in the hospital, to keep their appointments or follow their treatment plan. MOT also provides structure for providers. When individuals are discharged from the hospital, a discharge plan is already required to be in place and the individual and providers must agree with the plan. But follow-up as to whether the treatment identified in the plan is actually provided is often lacking, leading to the individual's relapse and re-hospitalization. A step-down MOT order will mandate that the treatment actually be provided.

Furthermore, MOT proponents note, Virginia has a mental health bed shortage. An individual may need just a little more support or structure to live safely outside the hospital but must remain in the hospital longer until his clinical condition improves so he does not need the services upon discharge or space can be freed up in those programs that do exist so the individual can be served. Discharging the individual under MOT may enable the individual to be discharged a little earlier, enabling services to be provided in a less restrictive setting, thus relieving some of the bed shortage problem.

There was Task Force consensus that the Commission should focus its considerations on the use of MOT only as a step-down option from involuntary inpatient commitment. Further, any utilization of MOT should be limited to a very small minority of persons with severe mental illness. The New York law strictly limits the individuals who can be considered for AOT. In its application, the New York Study found that although it was designed as a preventive measure to limit hospitalizations, AOT is used instead primarily as a step down from inpatient treatment, suggesting this was the most effective application of the law.

Senate Bill 840/House Bill 2257

The Task Force does not recommend that the Commission pursue enactment of AOT or MOT following inpatient hospitalization, at least in the 2010 legislative Session, given the poor economic climate and the scarcity of outpatient services. It is aware, however, that there are proponents in the General Assembly who may reintroduce legislation in the 2010 Session and the Commission should be prepared to respond. The Task Force therefore created a small work group composed of Ruth Ann Bates, Kaye Fair, Bill Farrington, Betty Long, Jim Martinez, Bonnie Neighbour, Sharon Koehler, Allyson Tysinger and Jane Hickey to review this issue in more depth and to determine whether changes to SB 840 introduced by Senator Ken Cuccinelli and HB 2257 introduced by Delegate David Albo during the 2009 General Assembly Session might be utilized as the basis for a recommendation for post-hospitalization MOT.

The only major differences between SB 840 and Kendra's Law are the criteria and the categories of persons who may serve as the petitioner:

Criteria in SB 840/HB2257:

1. the person has mental illness
 2. no longer needs inpatient hospitalization but requires mandatory outpatient treatment to prevent rapid deterioration of his condition that would likely result in his meeting the criteria for inpatient treatment
 3. is not likely to obtain outpatient treatment unless the court enters an order, and
 4. is likely to comply with an order
- Services must actually be available in the community, and providers of services must have actually agreed to deliver the services

Criteria in Kendra's Law:

1. is 18 years of age or older
2. is suffering from a mental illness
3. is unlikely to survive safely in the community without supervision, based on a clinical determination
4. has a history of lack of compliance with treatment for mental illness that has:
 - a. prior to the filing of the petition, at least twice within the last 36 months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated; or
 - b. prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last 48 months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; and
5. is, as a result of his or her mental illness, unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community
6. in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others, and
7. is likely to benefit from assisted outpatient treatment.

SB 840/HB 2257 Petitioners:

1. director of the treating facility or his designee
2. the community services board
3. the person who is subject of an order for involuntary admission

Kendra's Law Petitioners:

1. any person 18 years of age or older with whom the person resides
2. the parent, spouse, sibling 18 years or older, or child 18 years or older

3. director of a hospital in which the person is hospitalized
4. director of any public or charitable organization, agency or home providing mental health services to the subject of the petition or in whose institution the subject of the petition resides
5. a qualified psychiatrist who is either supervising the treatment of or treating the person for a mental illness
6. a psychologist or social worker who is treating the person for a mental illness
7. the director of community services, or his designee, or the social services official of the city or county in which the person is present
8. a parole officer or probation officer assigned to supervise the person

Recommendation I.1. The Commission should not introduce legislation establishing MOT to prevent inpatient commitment or as a step-down procedure following a period of inpatient treatment, but the Commission should be prepared with a proposal or response if substantial support for such legislation emerges in the General Assembly.

Recommendation I.1.A: Any proposal developed or supported by the Commission should focus only on “step-down MOT” following a period of inpatient hospitalization, and should not endorse “pre-commitment MOT” designed to prevent a person from deteriorating and meeting the commitment criteria for inpatient hospitalization.

Recommendation I.1.B: The criteria should be strictly limited to individuals who meet criteria similar to Kendra’s law as outlined above, and not the more expansive criteria in SB 840. (Because the criteria in Kendra’s Law in 4.a and b above uses the phrase “or period ending in the last six months” to apply to pre-hospitalization MOT orders, this phrase and “was or” should be struck).

Recommendation I.1.C: The provision that services must be actually available and providers have agreed to provide the services must be included.

Recommendation I.1.D: A hearing at which the step-down MOT order is issued must occur just prior to the discharge, and not as part of the original hearing resulting in involuntary inpatient treatment. The original hearing is much too early to make a determination about whether MOT should be used, what services the individual wants and needs and development of that plan. The hearing need not be held if all agree on an MOT order, as provided in SB 840.

Recommendation I.1.E: The petitioner should be limited to the director of the treating facility or his designee, the CSB, or the individual as provided in SB 840 (the petitioner’s listed in Kendra’s law are more designed for the preventive MOT before commitment than as a step-down process).

The Task Force agreed that if any MOT legislation is enacted, an essential component of such legislation should be a mechanism to monitor and evaluate its effectiveness and cost. The monitoring and evaluation should include assessing whether the MOT plans ordered are effective, i.e. whether and under what circumstances MOT has reduced the need for further inpatient treatment and whether individuals participating in MOT are moving towards recovery.

Recommendation I.2: The Task Force recommends that if the General Assembly enacts MOT legislation, it should appropriate funding to collect data in several jurisdictions to assess its effectiveness and cost.

II. Expansion of the TDO Time Period

Expanding the TDO Period and Establishing a Minimum Time Before a Hearing

The Task Force reviewed whether the maximum period of temporary detention should be expanded from the current 48 hours to three, four, or five days. The goal throughout the involuntary commitment process should be to afford the individual, whenever possible, the opportunity for voluntary treatment, at which point the involuntary commitment process should be terminated. Fiscal incentives, however, often result in forcing an individual into involuntary treatment, rather than affording voluntary treatment and should be eliminated. The purpose of expanding the TDO timeframe before a commitment hearing is held would be to decrease the need for involuntary hospitalizations by (i) providing more time for individuals to be treated and stabilized, permitting a safe discharge plan to be developed, and either negating the need for hospitalization altogether or increasing the likelihood of voluntary admission, and (ii) giving examiners time to conduct a more thorough evaluation, as required in § 37.2-815, to guide the court's decision if a commitment hearing is necessary. As part of this review, the Task Force also considered whether, if the TDO period were lengthened, the role of the independent examiner would need to be expanded to permit the examiner to release individuals who do not meet the commitment criteria and for whom an extended period of involuntary hospitalization during the TDO period would be neither necessary nor appropriate. In addition, the Task Force studied whether a minimum time period within the TDO, such as 24 hours, should be established before which a commitment hearing may not be held to ensure adequate time for evaluating the individual's condition and medical history, and to develop an outpatient treatment plan, if possible

The purpose of temporary detention has evolved from simply affording a safe place to hold a person until a commitment hearing can be held. Evaluation and treatment should begin immediately upon admission under a TDO. Accreditation standards and licensure require that evaluation and treatment be initiated immediately upon admission regardless of whether the person is admitted under a temporary detention order, and best practice principles support it. The temporary detention period provides an opportunity to stabilize the acute crisis. Once the acute crisis has stabilized, a more thorough assessment can be done in which the individual can fully participate. A longer temporary detention period decreases the likelihood of involuntary hospitalizations by increasing the

likelihood of developing a safe plan permitting the individual to be discharged from the temporary detention, or encouraging the individual to volunteer for a period of inpatient hospitalization, without being involuntarily committed. Changes in the Code of Virginia, discussed below, should be implemented to encourage this. If a commitment hearing is found to be necessary, a longer temporary detention period will provide the CSB with additional time to determine, in conjunction with the individual, his or her family, and treatment providers, whether an outpatient treatment plan might be a feasible alternative. The current 48-hour temporary detention period often precludes the development of such an outpatient treatment plan, which would afford the individual a less restrictive alternative to involuntary inpatient admission.

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

Researchers at the University of Virginia conducted a study of the temporary detention period using a combination of Virginia court data and Medicaid claims filed to determine whether longer TDO periods reduce the length and frequency of involuntary commitments by providing greater opportunity to stabilize and evaluate individuals (“Temporary Detention Study”).¹¹ This study indicates that longer TDO periods are more likely to result in dismissals rather than hospitalizations; 2) longer TDO periods increase the likelihood of an individual agreeing to voluntary rather than involuntary hospitalization; and 3) longer TDO periods are correlated with shorter post-TDO hospitalizations, although there is a modest increase in the net inpatient time as the length of the TDO increases.

The Temporary Detention Study also finds that when hearings are held after an individual is in custody for less than 24 hours, a high percentage, 75%, result in involuntary commitments with 7% resulting in dismissals and 19% resulting in voluntary admissions. This skew toward involuntary commitments when hearings occur within 24 hours is much reduced when hearings take place following 72 hours of hospitalization as shown by the following data: 47% involuntary commitments, 24% dismissals, and 32% voluntary admissions. This difference in hearing outcomes supports the premise that very short TDO time periods lead to excessive involuntary hospitalizations. These data indicate that prescribing a minimum 24-hour period time before a hearing is permitted to occur and lengthening the maximum TDO period to 72 hours or more would reduce the need for involuntary coercive treatment. This increase provides additional time to

¹¹ Wanchek, Tanya, and Bonnie, Richard. The Temporary Detention Period and Treatment for Mental Illness, December 1, 2009. (This paper is currently undergoing scientific peer review. A summary will appear on the Commission’s web site.)

evaluate the person and stabilize the crisis, and reduces the need for coercive legal action. Analysis is continuing to determine whether an increase in the TDO period would result in a net increase on days of hospitalization and, if so, whether the cost of any increase in days of hospitalization would be offset by a reduction in costs associated with the commitment process itself.

The University of Virginia, School of Medicine also conducted a review of Mandatory Outpatient Treatment Orders issued between July 1, 2008 and November 30, 2009.¹² Use of MOT orders has decreased significantly since the enactment of new procedural requirements in 2008. CSB representatives indicate that implementing MOT might be less challenging if they had a longer time to develop the comprehensive treatment plan that must be filed and approved by the Court. Significantly, the Prince William County General District Court issues the most MOT orders in the state. Unlike other jurisdictions, Prince William County almost always waits a full 48 hours before holding the civil commitment hearing. In addition, the Prince William County CSB performs a second evaluation of the individual immediately prior to the hearing. They have found that it is often during this second prescreening that the person expresses a willingness to participate in outpatient treatment and an initial treatment plan can then be submitted to the special justice at the hearing.¹³ This study also supports the supposition that if the TDO period is increased, a better discharge plan can be developed and a lesser restrictive mandatory outpatient treatment might be more readily available to prevent involuntary inpatient treatment.

The Task Force's consensus was that the General Assembly should extend the TDO time period to 72 hours (or three days). Together, the data collected so far indicates that longer TDO periods decrease the likelihood of commitment. Having a longer TDO period would also allow for better discharge planning. Currently, Virginia has one of the shortest TDO periods in the country. As reported in the December 2008 Task Force Report, Virginia is one of three states that require a commitment hearing within 48 hours of the probable cause determination. Three states require a hearing within 30 days with most states requiring a hearing within 4-8 days of the probable cause determination.¹⁴ Although some states have TDO periods longer than 72 hours, this initial recommended increase to 72 hours would permit time to develop additional data to assess the impact on outcomes for people with mental illness as well as the economic impact, before any consideration of moving to a four or five day TDO period.

It was also a Task Force consensus that the above data support imposition of a minimum of 24 hours before a commitment hearing can be held. That is, in addition to lengthening the permitted TDO period, the Task Force recommends setting a required minimum time necessary for evaluation before a commitment hearing can be held. Individuals whose commitment hearings are held within 24 hours are almost always

¹² Askew, Amy Liao, MOT Summary Report, University of Virginia, School of Medicine, Department of Public Health Sciences, December 15, 2009.

¹³ *Id.* at 9.

¹⁴ Commission on Mental Health Law Reform, Report of the Task Force on Future Commitment Reforms (Dec. 2008) at 20-21.

involuntarily hospitalized. If the hearing is held in less than 24 hours, people do not receive the evaluation required under § 37.2-815, blood work is not completed, and people with substance abuse issues might still be intoxicated. If a minimum of 24 hours is imposed, an extension to 72 hours would be needed to accommodate the schedules of courts that hold hearings only on a Monday, Wednesday, or Friday.

Some Task Force members were concerned as to whether increasing the TDO time frame would exacerbate the bed shortage problem. However, the consensus was that additional time occupying mental health beds during the longer TDO period would be more than balanced by a decrease in the involuntary hospitalization rate. As the evidence supports, if people held less than 24 or 48 hours are disproportionately committed to inpatient hospitalization, they will occupy valuable bed space, often unnecessarily. The Task Force agreed that the total number of bed days would likely even out or even decrease.

Another concern was whether the increased TDO period would increase the burden on the Involuntary Mental Commitment Fund managed by DMAS and funded by state general funds. If a person has insurance or is eligible for Medicaid, third party payers will already pay the cost of hospitalization during the TDO period. If an individual is indigent, the DMAS operated Involuntary Mental Commitment Fund pays the cost during the TDO period. After commitment, the indigent person's hospitalization is paid with Local Inpatient Purchase of Service ("LIPOS") funds or the person is hospitalized at a state hospital, which is also paid with state general funds. It appears therefore that there should be a sum even transfer of state general fund dollars. An adjustment of funding between DMAS' Involuntary Mental Commitment Fund, LIPOS and state inpatient hospital funds may need to be made.

Changes to Promote Voluntary Treatment

The Task Force also discussed whether the structure of LIPOS funds prevents individuals from agreeing to voluntarily admission if they cannot pay for their treatment since LIPOS funding may, in some areas, only be available for involuntary treatment. Frank Tetrick, Assistant Commissioner for the Department of Behavioral Health and Developmental Services, and Betty Long from the Virginia Hospital and Healthcare Association are chairing a workgroup composed of a cross-section of public and private providers around the state that is looking at ways to increase uniformity of practice ("LIPOS Workgroup"). The LIPOS Workgroup will examine, for example for whom and under what circumstances should LIPOS funds be used, how LIPOS decisions are made, and how LIPOS fund utilization is managed. The LIPOS Workgroup is also considering ways to maximize service capacity, including assessing whether there are enough hospital beds, residential crisis and other non-hospitals alternatives, both voluntary and involuntary. The Task Force recommends that the use of LIPOS funding not be conditioned upon the involuntary commitment of the individual and the LIPOS Workgroup should continue to study the issues raised above.

The Task Force further reviewed Virginia Code § 37.2-813 that now permits a judge or special justice to release a person on his personal recognizance or bond if it appears that the person does not meet commitment criteria. There is no evidence that this has ever occurred and the Task Force recommends that this provision be repealed.

Virginia Code § 37.2-813 permits the director of any TDO facility to release the person prior to the hearing if the person would not meet the commitment criteria based upon the evaluation of the treating psychiatrist or clinical psychologist. This seldom happens. In order to encourage this practice, we recommend that the statute be amended to permit the treating physician at the inpatient hospital to release the person prior to the hearing based upon his evaluation, and after consultation with the petitioner and the CSB, that the person does not meet commitment criteria. The likelihood that any evidence can be presented supporting the person's commitment based upon that determination is remote. Therefore, no commitment hearing should be necessary.

In North Carolina, if the physician performing the required second examination for commitment determines that the person does not meet the criteria for commitment, the physician releases the person, notifies the clerk of court and the proceedings are terminated.¹⁵ North Carolina has a 10-day detention period. Because Virginia's temporary detention period is much shorter than North Carolina's, the Task Force recommends that the detention and involuntary process be terminated if, after consultation with the petitioner and CSB, the treating physician concludes that the person does not meet the commitment criteria. If the treating physician believes the criteria are met, the case should proceed to a hearing.

The Task Force also discussed amending Virginia Code § 37.2-813 to permit an individual to volunteer for admission if the individual is willing and capable of agreeing to admission and the TDO facility or another mental health facility agrees to admit the person. The commitment hearing would then be terminated. The person would not be required to accept a minimum period of treatment or to give notice of his intent to leave as is currently required at the commencement of the commitment hearing. Most of the members of the Task Force favored permitting individuals to volunteer for admission before the commitment hearing, thereby terminating the hearing process. Some worried, however, that the person might be trying to circumvent the hearing process and would change his or her mind as soon as the proceeding was terminated. There was no consensus on this issue but the majority recommends that individuals be able to volunteer for admission prior to a commitment hearing, thus obviating the need for the hearing. There was consensus that if a person converted to involuntary status during the period of temporary detention, the Involuntary Civil Commitment Fund managed by DMAS should continue to pay the cost of hospitalization and treatment for at least as long as the person would have been hospitalized under the TDO, to remove this fiscal impediment to voluntary treatment.

Under this Recommendation to permit an individual under a TDO to opt for voluntary admission either before the commitment hearing is convened, the person

¹⁵N.C. Gen. Stat. § 122C-266.

volunteering for admission would still be prohibited from purchasing, possessing or transporting a firearm under § 18.2-308.1:3, but a conversion to voluntary status *before* a hearing is convened is not currently subject to the reporting requirements provided in § 37.2-819. Section 37.2-819 would also need to be amended to require the clerk to report such an admission in order to enforce § 18.2-308.1:3. Some Task Force members were also concerned about the criminal prohibition of such persons purchasing, possessing or transporting a firearm, and believed that such a prohibition should not be imposed. Since the Commission has declined to take any position on this issue, the Task Force recommends that these provisions related to firearms simply be amended to accurately reflect Virginia law as it is, taking into consideration this new proposed voluntary admission process.

Finally, § 37.2-805 that deals with voluntary admissions to state hospitals has been a source of confusion, especially those provisions in § 37.2-814(B) related to the opportunity to consent to voluntary admission just prior to the commencement of the commitment hearing. The cross-reference back to § 37.2-805 is confusing because many admissions are to private hospitals and that reference is no longer appropriate. Instead of amending § 37.2-814, the Task Force recommends amending § 37.2-805 to refer to all types of admissions, especially to also include voluntary admissions under § 37.2-805.1 for persons authorizing such an admission under an advance directive or guardianship order that was enacted during the 2009 General Assembly Session.

Recommendation II. 1: The General Assembly should increase the maximum period of temporary detention to 72 hours or the end of the next business day if the time period ends on a Saturday, Sunday, or holiday. In so doing, the General Assembly should provide that no commitment hearing be held in less than 24 hours.

Recommendation II.2: The General Assembly should amend Virginia Code § 37.2-813 to permit the director of the TDO facility to release an individual if the treating physician, after an evaluation and consultation with the petitioner and community services board, determines that the person does not meet commitment criteria. The involuntary commitment proceedings would be terminated and no hearing would be held.

Recommendation II.3: The General Assembly should provide that an individual under a TDO be permitted to consent to voluntary admission without the person being required to accept a minimum period of treatment or to give notice prior to leaving and that the commitment proceedings be terminated upon conversion to voluntary status.

Recommendation II.4: If a person under a TDO is converted to voluntary status prior to the commitment hearing, the Involuntary Mental Commitment Fund managed by DMAS should continue to pay for the person's hospitalization and treatment at least through the time the commitment hearing would have been held.

Recommendation II.5: The General Assembly should update and clarify Virginia Code § 37.2-805 related to voluntary admissions to state facilities to reflect the types of voluntary admission now available in addition to admission to state facilities.

Recommendation II.6: The work group established by DBHDS and VHHA should develop a plan for assuring that use of LIPOS funds is not conditioned upon the involuntary commitment of the individual.

III. Criteria in Related Statutes

A number of individuals have raised questions concerning statutes related to mental health and whether the criteria for reporting or decision-making in those statutes should be amended to correspond with the civil commitment criteria revised in 2008.

Virginia Code § 54.1-2400.1 was first enacted in 1994 in response to the *Tarasoff* decision in California holding that mental health professionals have a duty to protect third parties from harm from their patients with mental illness. Virginia's statute creates a very limited duty to protect third parties and provides immunity from liability to mental health professionals when they take specified precautions to prevent that harm, one precaution being to seek involuntary admission of the person. Subsection B states that mental health providers have a duty to take precautions to protect third parties only when their client has communicated to them "*a specific and immediate threat to cause serious bodily injury or death to an identified or readily identifiable person or persons.*" (Emphasis added.)

The first prong of the civil commitment criteria in effect in 1994 when § 54.1-2400.1 was enacted authorized commitment until 2008 if the person "present[ed] an imminent danger to himself or others." It was changed in 2008 to authorize commitment when "there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any." Thus, the temporal requirement of "immediate threat" or "imminent danger" in the commitment criteria has been changed to "in the near future."

The Task Force discussed the research related to imminent danger criterion and the fact that it is too hard to predict. Some members pointed out that the duty to protect language in § 54.1-2400.1 is much narrower than the commitment context and if the language were changed in § 54.1-2400.1, the duty to take precautions would be expanded, thus imposing more potential liability on mental health providers in a wider range of situations. Although the commitment criteria itself is more expansive than the duty to take precautions, seeking commitment would still provide immunity to the mental health professional.

Recommendation III.1: The Task Force recommends that no change be made to § 54.1-2400.1.

B. Virginia Code § 22.1-272.1 requires licensed staff employed by local school boards to contact at least one parent if they have “reason to believe, as a result of direct communication from a student, that such student is at *imminent risk* of suicide.” (Emphasis added.) The notice to contact the parent is triggered by “imminent” risk. The question is whether imminent risk should be changed to “in the near future.” CSB members of the Task Force indicated that reporting of suicide risk is already happening at a lower level of risk and an amendment is not necessary.

Recommendation III.2: The Task Force recommends that no change be made to § 22.1-272.1.

C. Virginia Code § 37.2-1103 permits a magistrate to issue an emergency custody order for an adult person who is incapable of making an informed decision as a result of a physical injury or illness “when the medical standard of care indicates that testing, observation, and treatment are necessary to prevent imminent and irreversible harm.” A related statute, § 37.2-1104, also permits a court, or magistrate if the court is not available, to issue an order authorizing the temporary detention of the person when the medical standard of care calls for testing, observation, or treatment of the disorder within the next 24 hours to prevent death, disability, or a serious irreversible condition. The issue is whether the standard for the medical emergency custody order should be changed from preventing “imminent and irreversible harm.” The Task Force determined that the medical ECO standard is consistent with the medical TDO standard, that they are not related to the provision of treatment for mental illness, and that this standard need not be changed.

Recommendation III.3: The Future Commitment Reforms Task Force recommends that no change be made to § 37.2-1103.

IV. Jail Transfer Statutes

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

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

- The commitment criteria in §§ 19.2-169.6 and 19.2-177.1 were changed in 2008 to incorporate the first prong (dangerousness) of the new commitment criteria enacted that year, but the commitment criteria in § 19.2-176 for the initial hearing remains: the person (i) is mentally ill, and (ii) requires treatment in a mental hospital rather than the jail. At the temporary detention stage and recommitment hearing under § 19.2-176 though, the defendant must meet the first prong of the revised commitment criteria.
- It is not clear whether the “qualified evaluator” referenced in § 19.2-169.6 (A)(1) and (2) is the CSB employee or an independent examiner similar to the examiner required in the civil commitment process, and if so, what the examiner’s qualifications may be. There is no provision for payment for independent evaluations done under § 19.2-169.6, but payment for the evaluation under 19.2-176 is the same as for mental status or competency to stand trial evaluations not to exceed \$ 750 and \$ 100 for each day the evaluator must appear in court, even though the type of examination, other than a CSB evaluation, or qualifications of the examiner are not mentioned. *See* § 19.2-175. (It also appears that § 19.2-176 is being used by many courts to order a competency to be sentenced evaluation – thus the provision for payment in § 19.2-175 equivalent to that for competency to stand trial and mental status examinations.) The proceedings conducted under § 19.2-177.1 incorporate all of the involuntary admission procedures in chapter 8 of Title 37.2, except the commitment criteria, which would imply that an independent examiner required under § 37.2-815 and payment for the examiner would be the same as in the civil commitment process.
- Sections 19.2-169.6 and 19.2-176 are silent as to whether a CSB representative must attend either the commitment or recommitment hearings and whether pre-admission screenings are required at recommitment hearings. Section 19.2-177.1 incorporates all of the requirements of Chapter 8 of Title 37.2, except the commitment criteria. Therefore all of the requirements related to CSBs, examiners, mandatory outpatient treatment apply in proceedings under this section but not the others.
- The Task Force was also informed that some jurisdictions use § 19.2-176 to obtain a mental health evaluation for use in determining an appropriate sentence for the inmate. From the Task Force’s reading of the statute, it does not appear that this statute was intended for this purpose.

As a result of these implementation issues, the Task Force established a small work group (“Jail Transfer Work Group”) composed of James Morris, DBHDS Director of Forensic Services, Kathleen Sadler, DBHDS Forensic Mental Health Consultant, Kaye Fair, Fairfax County Director of Emergency Services, Rebecca Stredney, Director of Forensic Services at Central State Hospital, and Allyson Tysinger and Jane Hickey, Senior Assistant Attorneys General at the Office of the Attorney General, to make

recommendations for revisions to these statutes, which were then reviewed by the full Task Force and suggested changes were developed.

The Jail Transfer Work Group and Task Force recommend that the three code sections be combined into one section for consistency and that the statutes conform as closely as possible to the civil commitment process where applicable. Attached is a suggested draft that accomplishes these goals:

- The three sections are combined into one section to promote consistency in application and interpretation.
- The term “defendant” in §§ 19.2-169.6 and 19.2-176, and “prisoner” in § 19.2-177.1 are changed to inmate, and “jail” is changed to “local correctional facility.”
- § 19.2-169.2 is amended to include competency to be sentenced with competency to stand trial evaluations where it more appropriately belongs.
- The language is clarified to provide that a hearing is required based upon the petition of the custodian or on the court’s own motion when committed by the court with jurisdiction over the person’s criminal charges. The person must be represented by counsel.
- The language is clarified that an examination by an independent examiner as provided in § 37.2-815 is required for both initial commitments and recommitments and presence at the hearing is the same as in the civil commitment statutes.
- There is a requirement for a CSB pre-admission screening report as provided in § 37.2-816 for both initial commitments and recommitments and requires the presence of the CSB at the hearing as in the civil commitment process.
- Only a magistrate, and not a district court judge or special justice, may issue the TDO, consistent with the civil commitment process.
- The sheriff or jail administrator must notify the court and defense attorney if a TDO is issued.
- An order for mandatory outpatient treatment may not be ordered for a jail inmate.
- Notifications to the court as to the results of competency to stand trial and mental status evaluations deleted from § 19.2-169.6(B) as redundant of requirements in § 19.2-169.1.
- For recommitments, the facility at which the person is hospitalized is required to notify the court with jurisdiction over the criminal case and the defense attorney.
- The person may be recommitted for up to 60 days for inmates awaiting trial, and 180 days for inmates who have been convicted but not sentenced and inmates serving their sentence.
- Provision for payment of the independent examiner is added to § 37.2-804.

The Task Force debated whether to recommend that an independent evaluator be required for commitment of persons from jail to a psychiatric hospital. Some members strongly believe that an independent examiner should be required in these types of hearings and that jail inmates should be entitled to receive the same types of protections as those in the civil commitment process. They further argue that many CSB pre-admission screeners are not as qualified as independent examiners and are not qualified

to diagnose psychiatric disorders. The Task Force reviewed *Vitek v. Jones*, 445 U.S. 480 (1980), a United States Supreme Court decision that requires a due process hearing before a prisoner may be transferred to a state psychiatric hospital, to determine whether the United States Constitution would require an independent examiner. The Court recognized that a prisoner has a 14th Amendment liberty interest in avoiding the “stigma” associated with commitment for mental illness and requires the following minimum procedures:

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

Id. at 494-495. Virginia can provide additional due process protections if it wants to do so, but it is not required to do so to meet constitutional requirements. An independent decision maker, not an independent examiner, is required. States are also permitted to treat special classes of individuals differently from individuals subject to involuntary civil commitment. *Jones v. United States*, 463 U.S. 354, 370 (1983).

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

The Task Force believes strongly that these statutes must be clarified. If any fiscal impact becomes an issue prior to or during the General Assembly Session, it

recommends that the requirement for an independent examiner be removed to ensure passage. Lack of an independent examiner in this context, as opposed to the civil commitment context, can be justified because the person has already lost his liberty as a result of his confinement and the CSB pre-admission screening should be sufficient to determine whether an inmate meets the first prong of the commitment criteria and requires treatment in a psychiatric hospital instead of in jail. The risk of an erroneous transfer is therefore minimal. The only concern would be that in those jails where the CSB provides the mental health services directly, the CSB employee performing the pre-admission screening should not also be involved in providing treatment to the person. This concern has been addressed in the proposed draft legislation.

Recommendation IV.1: The General Assembly should amend Virginia Code §§ 19.2-169.2, 19.2-176 and 19.2-177.1 to remove the inconsistencies, to clarify the procedural requirements and to make the process as congruent as possible with the civil commitment process.

The Task Force also discussed recommending that the second prong of the civil commitment criteria, i.e. that the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, be included in the proposal. Because sheriffs and jail administrators are able to protect from harm certain individuals who are not dangerous but are suffering from mental illness and provide for their basic human needs, these individuals are not transferred to psychiatric hospitals to receive the care they need. Numerous studies have documented deplorable conditions in jail for persons in this category. The Task Force strongly recommends that in the future when economic conditions improve, that the second prong of the commitment criteria be added to these statutes. Because these statutes are in desperate need of revision, however, the task force recommends that they be amended this year with little fiscal impact.

Recommendation IV.2: The Task Force strongly recommends that when economic conditions improve, the General Assembly should add the second prong of the civil commitment criteria to the statute to permit transfers of inmates who, as a result of mental illness, will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs.

V. NGRI Revocation Statutes

While reviewing the Title 19.2 jail transfer statutes, the Task Force discovered that there are implementation problems with the conditional release revocation procedures for persons found not guilty by reason of insanity (“NGRI”) in Virginia Code §§ 19.2-182.8 and 19.2-182.9. A small work group composed of Rita Romano, James Morris, Kathleen Sadler, Beth Dugan, Paulette Skapars and CSB representatives across the state that have the highest numbers of NGRI revocations met and reached a consensus that these statutes need to be revised (“NGRI Work Group”). Concerns include the following:

- Some special justices refuse to participate, deferring to the unavailable NGRI judge
- Civil commitment criteria are applied; the criteria “need of hospitalization” is not defined
- Transportation to state hospital in excess of 100 miles caused sheriff transportation problems
- Voluntary admission is offered by special justices at the revocation hearing
- The role of an independent examiner is unclear in the process; no method exists for payment of independent examiners for services

Additional time is needed to reach consensus on what changes should be made, the extent to which the civil commitment process should be followed to revoke the conditional release, and the extent to which judges and special justices who did not authorize the conditional release and have no knowledge of the underlying NGRI findings should be involved in the revocation hearing. The Task Force will continue to study §§ 19.2-182.8 and 19.2-182.9, the NGRI conditional release revocation statutes with the goal of requesting legislative amendments for the 2011 General Assembly Session.

**APPENDIX A
TASK FORCE ON FUTURE COMMITMENT REFORMS
RECOMMENDATIONS**

MANDATORY OUTPATIENT TREATMENT

Recommendation I.1. The Commission should not introduce legislation establishing MOT to prevent inpatient commitment or as a step-down procedure following a period of inpatient treatment, but the Commission should be prepared with a proposal or response if substantial support for such legislation emerges in the General Assembly.

Recommendation I.1.A: Any proposal developed or supported by the Commission should focus only on “step-down MOT” following a period of inpatient hospitalization, and not “pre-commitment MOT” to prevent a person from deteriorating and meeting the commitment criteria for inpatient hospitalization.

Recommendation I.1.B: The criteria should be strictly limited to individuals who meet criteria similar to Kendra’s law as outlined above, and not the more expansive criteria in SB 840. (Because the criteria in Kendra’s Law in 4.a and b above uses the phrase “or period ending in the last six months” to apply to pre-hospitalization MOT orders, this phrase and “was or” should be struck);

Recommendation I.1.C: The provision that services must be actually available and providers have agreed to provide the services must be included.

Recommendation I.1.D: A hearing at which the step-down MOT order is issued must occur just prior to the discharge, and not as part of the original hearing resulting in involuntary inpatient treatment. The original hearing is much too early to make a determination about whether MOT should be used, what services the individual wants and needs and development of that plan. The hearing need not be held if all agree on an MOT order, as provided in SB 840.

Recommendation I.1.E: The petitioner should be limited to the director of the treating facility or his designee, the CSB, or the individual as provided in SB 840 (the petitioner’s listed in Kendra’s law are more designed for the preventive MOT before commitment than as a step-down process).

Recommendation I.2: The Task Force recommends that if the General Assembly enacts MOT legislation, it should appropriate funding to collect data in several jurisdictions to assess its effectiveness and cost.

EXPANSION OF THE TDO TIME PERIOD

Recommendation II.1: The General Assembly should increase the maximum period of temporary detention to 72 hours or the end of the next business day if the time period ends on a Saturday, Sunday, or holiday. In so doing, the General Assembly should provide that no commitment hearing be held in less than 24 hours.

Recommendation II.2: The General Assembly should amend Virginia Code § 37.2-813 to permit the director of the TDO facility to release an individual if the treating physician, after an evaluation and consultation with the petitioner and community services board, determines that the person does not meet commitment criteria. The involuntary commitment proceedings would be terminated and no hearing would be held.

Recommendation II.3: The General Assembly should provide that an individual under a TDO be permitted to consent to voluntary admission without the person being required to accept a minimum period of treatment or to give notice prior to leaving and that the commitment proceedings be terminated upon conversion to voluntary status.

Recommendation II.4: If a person under a TDO is converted to voluntary status prior to the commitment hearing, the Involuntary Mental Commitment Fund managed by DMAS should continue to pay for the person's hospitalization and treatment at least through the time the commitment hearing would have been held.

Recommendation II.5: The General Assembly should update and clarify Virginia Code § 37.2-805 related to voluntary admissions to state facilities to reflect the types of voluntary admission now available in addition to admission to state facilities.

Recommendation II.6: The work group established by DBHDS and VHHA should develop a plan for assuring that use of LIPOS funds is not conditioned upon the involuntary commitment of the individual.

CRITERIA IN RELATED STATUTES

Recommendation III.1: The Task Force recommends that no change be made to § 54.1-2400.1.

Recommendation III.2: The Task Force recommends that no change be made to § 22.1-272.1.

Recommendation III.3: The Future Commitment Reforms Task Force recommends that no change be made to § 37.2-1103.

JAIL TRANSFER STATUTES

Recommendation IV.1: The General Assembly should amend Virginia Code §§ 19.2-169.2, 19.2-176 and 19.2-177.1 to remove the inconsistencies, to clarify the procedural requirements and to make the process as congruent as possible with the civil commitment process.

Recommendation IV.2: The Task Force strongly recommends that when economic conditions improve, the General Assembly should add the second prong of the civil commitment criteria to the statute to permit transfers of inmates who, as a result of mental illness, will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs.