COMMONWEALTH OF VIRGINIA
COMMISSION ON MENTAL HEALTH LAW REFORM

REPORT OF

THE

TASK FORCE ON CIVIL COMMITMENT

March 2008

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COMMONWEALTH OF VIRGINIA
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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, 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, including consumers of mental health services and their families, service providers, and the bar. 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 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, mental retardation and substance abuse 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 more choice over the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

The Commission has been 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 2007, the Commission established a Working Group on Health Privacy and the Commitment Process ("Working Group") and, in 2008, established a sixth Task Force on Advance Directives. Information regarding the Commission and its Reports is available at http://www.courts.state.va.us/cmh/home.html.

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

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

Finally, the Commission's third project was a study of every face-to-face crisis contact evaluation conducted by CSB emergency services staff during June 2007 (the "Commission's Crisis Contact Study"). (There were 3,808 such evaluations.) A final report of the CSB Crisis Contact Study will be released in late 2008.

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

This document is the Report of the Commission's Task Force on Civil Commitment. It was available for Commission consideration in November, 2007 and final drafting was completed in March, 2008. Although the Commission embraced many of the Recommendations of the Civil Commitment Task Force in its Preliminary Report, this Report is the work of the Civil Commitment Task Force and has not been adopted or endorsed by either the Commission or the Supreme Court. It was prepared as a resource for the Commission and for the public.

Many of the recommendations of the Task Force were consensus recommendations. However, in many contexts, the Task Force was not of one mind. In those situations, the Task Force developed optional recommendations. It should not be assumed that each Task Force member endorsed each recommendation.

From my perspective, the Task Force Report was immensely useful to the Commission and provides useful background for an explanation of many of the reforms adopted by the General Assembly in 2008. In addition, many of the Task Force's other recommendations are currently being considered by the Commission as it formulates proposals for the second phase of comprehensive mental health law reform in the Commonwealth.

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

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INTRODUCTION.

A. Background.

Most persons with mental illness are able to live and function in their communities without state interventions. In fact, the paradigm for addressing mental illness has shifted dramatically over the past 50 years from one of relying on long-term custodial care in state mental hospitals to recognizing that 1) recovery is possible for most persons, even for persons with serious mental illnesses[1] and 2) services can and should be provided in the least restrictive community-based setting. Virginia has incorporated both goals as part of its statutory framework for delivering mental health services and serving persons with severe mental illness. However, on occasion, certain persons with severe mental illnesses[2] may, because they pose risks to themselves or other persons, or are substantially unable to care for themselves, trigger the need for state interventions in the form of civil commitment proceedings and treatment either in inpatient or outpatient settings.

According to many nationally representative studies, in any given year, about 5% to 7% of adults have a serious mental illness.[3] Virginia's Department of Mental Health, Mental

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[1] *Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery*. From the President's New Freedom Commission on Mental Health, Final Report, April 2003. See http://www.mentalhealthcommission.gov/reports/reports.htm.

[2] The President's New Freedom Commission on Mental Health defines *adults with a serious mental illness* as *persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R (Diagnostic and Statistical Manual for Mental Disorders), that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.*

[3] According to a 2005 study by the National Institute of Mental Health, approximately 26 percent of the general population has some sort of mental disorder including substance abuse disorders, cognitive impairments such as Alzheimer's disease, and mood disorders

Retardation ad Substance Abuse Services ("DMHMRSAS") estimates that 5.4% of State residents have had a severe mental illness in the past year, translating to 308,000 individuals.[4] Although only a small subset of this population may be subject to the civil commitment process, it is critical for the Commonwealth of Virginia to have the statutory framework, trained professionals, and adequate resources in place to respond to their mental health needs, to prevent and respond to mental health crises, and to promote recovery.

Nationally, estimates are that one-fourth of civil inpatient hospitalizations involve involuntary admissions.[5] There are no comprehensive data on the numbers of individuals for whom civil commitment is sought in Virginia. JLARC reviewing 1993 data from the Commonwealth's 40 Community Service Boards ("CSBs"),[6] reported that of the 246,000

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such as depression. In any given year, a much smaller number, about 5% to 7% of adults, has serious mental illness.

[4] *Virginia's Mental Health System Transformation: 1990's to the Present*, presentation by James Reinhard, MD, Commissioner of DMHMRSAS, at the Virginia House Appropriations Retreat, November 14, 2007. This estimate was based on national prevalence numbers. A similar figure, 298,000 persons with severe mental illness was reached in another state report, *Availability and Cost of Licensed Psychiatric Services in Virginia*, Joint Legislative Audit and Review Commission, (Commission Draft, October 9, 2007).

[5] *Review of the Involuntary Commitment Process*, Joint Legislative Audit and Review Commission of the Virginia General Assembly, House Document. No. 8 (1995) Session). Page 1, citing unspecified national studies.

[6] CSBs are local government agencies that operate under a contract with DMHMRSAS to provide mental health, mental retardation, and substance abuse services to their communities. One or more local governments can be represented by a single CSB, and these governments oversee and fund the CSBs. Thirty-nine CSBs (and one behavioral health authority) exist in Virginia, and all localities are members of one of these CSBs. Virginia Code § 37.2-500 establishes Community Services Boards as the single point of entry for the publicly funded Mental Health, Mental Retardation and Substance Abuse Services System. The statute sets forth the mandated core services to be provided by CSBs including:

- Emergency Services
    - Crisis intervention, stabilization, preadmission screening for hospitalization, discharge planning for consumers in acute inpatient settings, short-term counseling, and referral assistance
- Case Management (subject to availability of appropriations)
    - Assistance with locating, developing or obtaining services and resources for consumers; needs assessments and planning services; coordination of services with service providers, monitoring service deliver, identification of and outreach to individuals and families in need of services

emergency contacts made with the CSBs, approximately 14,000 Temporary Detention Orders were requested. The Commission's studies found that there were 3800 face-to-face crisis contact evaluation in June, 2007, leading to about 1500 commitment proceedings. On an annual basis, the Commission estimates that there were approximately 45,000 face-to-face crisis contact evaluations in 2007, leading to approximately 20,000 commitment proceedings.

The financial and human resource costs in the civil commitment process as well as the medical costs upon involuntarily committing an individual to inpatient care are significant. According to an analysis of civil commitment costs conducted by the Joint Legislative Audit and Review Commission ("JLARC") in 1995,[7] funding related to civil commitment *proceedings*, which include law enforcement, mental health professionals, and District Court personnel to make a determination of whether an individual meets the criteria for involuntary inpatient admission, was estimated to be about 40% of the total costs associated with civil commitment. In 1993, when the JLARC data was collected, these expenditures amounted to over $8 million.[8] No doubt these expenditures are substantially higher today. The direct health care costs are also significant and vary with the nature of the disability, the intensity of the services, the length of the civil commitment, and whether services are provided in the community or an inpatient setting. Once an individual is committed to involuntary inpatient treatment, hospitalization costs, which average more than $50,000 per individual per year, predominate.[9]

The indirect costs associated with appropriately (or inappropriately) addressing the needs of persons with severe mental illness are also significant in the involvement of law

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- In addition, the statute also outlines a comprehensive system of services that *may* be provided by CSBs (§ 37.2-500) including
    - Inpatient services, outpatient services, day support services, residential, prevention and early intervention, and other appropriate mental health, mental retardation and substance abuse services.

[7] Joint Legislative Audit and Review Commission, Review of the Involuntary Commitment Process, House Document No. 8 (1995 Session), http://jlarc.state.va.us/Reports/Rpt365.pdf.

[8] Ibid. page 35-37. JLARC's study found that most of these expenditures were for personnel costs. For example, the 144 responding sheriffs and 44 police chiefs reported they spent $1.5 million making 18,000 mental health transports, 95% of which was for salaries and overtime costs.

[9] According to DMHMRSAS, the average annual cost of care in FY 2006 for persons with mental illness was $3063 per person for CSB community mental health care, $19,779 for individuals with severe mental illness leaving a state facility and receiving intensive community services through CSBs, and $51,738 for individuals receiving inpatient care at a state mental health facility. *Community Mental Health Care in Virginia*, Presentation by Susan Massart, House, House Appropriations Committee Staff, House Appropriations Retreat, November 14, 2007.

enforcement in responding to repeated emergency calls, transporting persons for evaluation, and mercy arrests for misdemeanors, and, occasionally catastrophic failures as happened with the shootings at Virginia Tech. In addition, an estimated 15% of individuals incarcerated in Virginia's jails and prisons have mental illness, some of whom would not be there if their mental health needs were more effectively addressed.[10] An even higher percentage of children in juvenile justice and foster care have mental and emotional disturbances. These issues are addressed more fully by the Commission's Task Force on Criminal Justice and the Task Force on Children and Adolescents.

Because of the high human and financial costs associated with addressing the needs of persons with severe mental illness, the Commission on Mental Health Law Reform's Task Force on Civil Commitment ("CCTF") conducted a review of Virginia's civil commitment law and policy to assess what statutory and policy modifications could make Virginia's system function better. As part of this review, increased use of mandatory outpatient treatment was also explored. The CCTF's analysis included the following:

- Current Virginia law and policy regarding civil commitment and mandatory outpatient treatment
- The legislative history of Virginia law and policy and proposals for reforms
- Key reports and documents issued or requested by DMHMRSAS, the Joint Legislative Audit and Review Commission ("JLARC"), professional organizations, and the Review Panel on the Mass Shootings at Virginia Tech.
- Original research on the practices and procedures of the District Courts conducting commitment proceedings as well as the 40 Community Services Boards that provide the screening of persons believed to be in need of a state intervention as well as playing a significant role in the treatment interventions ordered.
- The law and practice in other jurisdictions addressing civil commitment and mandatory outpatient treatment.

During the course of CCTF's work, in April 2007, the Virginia Tech shootings took place. The review of this critical event revealed Seung Hui Cho's long history of interactions with mental health professionals, a previous temporary detention order, and a subsequent unsuccessfully implemented mandatory outpatient treatment order. Although many of those who were familiar with Cho worked to help him, the review of the

[10] The cost per inmate varies with the type of facility (major institutions, field centers, community corrections facilities) but a Department of Corrections-wide average for 2005 was $21,248. www.vadoc.virginia.gov/about/facts/financial/2005/05percapita.pdf.
The average inmate population in Department of Corrections Institutions in 2004 was 30,760, a figure that does not include jails. *Department of Corrections Division of Operations and Community Corrections, Population Summary*, www.vadoc.state.va.s/about/facts/research/new-popsu,m/2--4/aug04popsummary.pdf.

shootings at Virginia Tech highlighted some of the fault lines in Virginia's mental health law and policy and heightened the importance of making concrete recommendations for policy changes (the "Virginia Tech Reports").[11]

B. Overview of Current Virginia Civil Commitment Law and Practice.

i). Involuntary Inpatient Admission.

The CCTF examined the criteria and procedures for civil commitment provided in the Virginia Code and found both were unusual compared to other states. Virginia's civil commitment criteria requiring *imminent* danger are among the most stringent in the country. In addition, the two-step process for civil commitment as well as the relatively short period allowed for a mental health evaluation is also very different from the procedures used in other states.

Criteria for involuntary admission to an inpatient psychiatric facility provided in Virginia Code §37.2-817 are as follows:

- 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 and
- Alternatives to involuntary inpatient treatment have been investigated and deemed unsuitable and there is no less restrictive alternative to involuntary inpatient treatment.

There are two stages to civil commitment in Virginia:

- A 48-hour prehearing period of temporary detention, often preceded by a 4-hour emergency custody order during which prescreening may take place and
- The involuntary commitment hearing.

During the period of temporary detention, the individual is clinically evaluated and the results of this evaluation are introduced into evidence at the involuntary commitment hearing.[12]

There appears to be considerable variability throughout Virginia in how the civil commitment statutes are interpreted and applied, raising questions as to the fundamental fairness of the process as well as the prudent marshaling of state resources. This variability has been characteristic of the system for some time. For example, a 1988 study

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[11] *Mass Shootings at Virginia Tech*, Report of the Review Panel, August 16, 2007, a report presented to the Governor of Virginia. See http://www.governor.virginia.gov/TempContent/techPanelReport-docs/01%20Inside%20cover.pdf.

[12] Va. Code Ann. §§ 37.2-815 and 37.2-817

of TDO practices, which surveyed CSBs, found "great variation" in the judicial personnel involved.[13] In 1995, the Joint Legislative Audit and Review Commission of the Virginia General Assembly ("JLARC") published its *Review of the Involuntary Commitment Process* in the Commonwealth.[14] In its study, JLARC found that there were few written guidelines for implementing the statutory framework for civil commitment hearings and substantial inconsistencies in how preliminary hearings are conducted, differences in whether petitioners, family members, or others are present and available as witnesses, and variations in availability of the Independent Examiner, the role of CSB staff at the hearings, and the role of the person's attorney.[15] These inconsistencies were echoed in the Virginia Tech Report.

The Commission's Study of Commitment Hearings, May 2007, (the "Commission's Hearings Study")[16] also assessed the practices and outcomes of over 1500 civil commitment hearings in Virginia and found significant variation in the use of personnel, whether CSB representatives or Independent Examiners were present at the commitment hearings, whether family members were involved, what kind of evidence was used, how long the hearings took and the outcomes of commitment hearings. Broadly, the Commission's Hearings Study found most civil commitment hearings resulted in inpatient hospitalization, whether involuntary or voluntary. Overall, 78.2% of cases, persons were hospitalized either *voluntarily* (29%) or *involuntarily* (49.2%). However this average figure resulting in involuntary hospitalization masks the substantial variation across the state, which, according to the Commission's Hearings Study, shows a range of 10.5% to 100%%. Without further research, it is not possible to determine the causes of such great variability but it is unlikely that it represents differences in the underlying prevalence of mental illness.

The Commission's Hearing Study also found a significant variability in the dismissal rate ranging from zero cases dismissed to 60% of cases dismissed with an average dismissal rate of 14.6%. As with the variation in the rate at which inpatient commitments were ordered, it appears that differences in the types of information and personnel involved in the hearings as well as judicial differences in applying the law may be at work.

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[13] *Emergency Detention of the Mentally Ill in Virginia*, Virginia Bar Association, 1988. This report also cited the low frequency at which judicial personnel saw detainees prior to issuing the order, in part, because of concerns about their expertise in evaluating the person. This finding led to 1989 statutory changes establishing Independent Examiners, who are psychiatrists, psychologists, or other mental health professionals, who personally examine detainees and certify those detainees as meeting the statutory criteria for involuntary civil commitment.

[14] *Review of the Involuntary Commitment Process*, Joint Legislative Audit and Review Commission of the Virginia General Assembly, House Document. No. 8 (1995 Session).

[15] Ibid. Introduction.

[16] A report detailing the findings of Commission's Hearing Study will be issued early in 2008.

And 7.2% of cases resulted in outpatient treatment: 5.7% were ordered into mandatory outpatient treatment and an additional 1.5% entered voluntary outpatient treatment.

ii). Mandatory Outpatient Treatment.

Mandatory outpatient treatment ("MOT") in Virginia is governed by Virginia Code §37.2-817(C), which provides that such treatment may be ordered if an individual meets the following criteria:

- The person presents and imminent danger to self or others as a result of mental illness or has been proven to be so seriously mentally as to be substantially unable to care for self and
- Less restrictive alternatives to involuntary inpatient treatment have been investigated and deemed suitable.

In addition, the judge must find that the person:

- Has the degree of competency necessary to understand the stipulations of his treatment
- Expresses an interest in living in the community and agrees to abide by his treatment plan and
- Is deemed to have the capacity to comply with the treatment plan.

Most states have some form of MOT and statutes fall into three categories:

- Conditional release
- Alterative to hospitalization
- Substantial deterioration and need for treatment

Under the first two, the individual criteria for MOT are the same as for the criteria for involuntary inpatient treatment. Virginia's law falls into the second category with an added evaluation of the outpatient resources available. Eleven states, however, have a lower standard for MOT, which philosophically, aims to intervene in cases where individuals, without a treatment invention, are at heightened risk to have their mental status deteriorate and have repeated hospitalizations.[17]

Important issues raised in considering broadening the criteria MOT include, but are not limited to, the following:

- Establishing the criteria for MOT.

[17] Virginia's mandatory outpatient treatment law was last amended in 1995 although since then several bills have been introduced. In 1998, an Institute of Law, Psychiatry, and Public Policy study, *Mandatory Outpatient Treatment: A Legislative Proposal for Virginia*, prepared for the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, January, 1998, proposed broadening the criteria to support preventive outpatient commitment and included draft legislation.

- Expanding outpatient resources and administrative resources to monitor such treatment. Without increasing system capacity, voluntary patients may be displaced.
- Identifying appropriate sanctions for non-adherence to the treatment plan.
- Determining whether forced medication is appropriate.

Clearly, whether the treatment can be delivered on an outpatient basis is a function of the availability of outpatient treatment resources.[18] Data from the Commission's Hearings Study shows that MOT in Virginia, although statutorily authorized, is relatively rare—it was the outcome in 5.1 percent of the cases brought before a judge or Special Justice in May 2007. It is possible that this rate genuinely reflects the numbers of persons who meet the criteria for outpatient treatment. However, this is more likely a function of limitations of community-based resources.

Evidence for the constraints posed by lack of outpatient capacity is indirect but compelling. A 1995 study by JLARC reported that almost half of the Special Justices responding to its survey believed that adequate outpatient options were not available to address the needs of individuals seen in commitment hearings. Outpatient treatment was unavailable at a nearby location 20 percent of the time that outpatient treatment was ordered.[19] This shortfall in outpatient resources has not been bridged in the intervening decade. According to a 2007 review by JLARC, hospital discharge staff reported, "the limited availability of mental health services outside of the hospital limits their ability to discharge some of their existing patients."[20] Furthermore, JLARC's review cited community-based emergency services as being the mechanism that could "most effectively" reduce the demand for inpatient psychiatric care.

It should be noted that although the Virginia statute requires CSBs, BHAs or other designated providers to monitor MOT, the statute is vague about what monitoring consists of and what the consequences of non-adherence to a treatment plan are. Data concerning the "monitoring" of MOT is lacking. As the Review Panel noted in its investigation of the circumstances surrounding the Virginia Tech shootings, Seung Hui Cho was under an order for mandatory outpatient treatment but there was no treatment plan, no entity charged with monitoring compliance with the order, and, as a result, no

[18] Outpatient treatment can take many forms including full outpatient treatment (e.g., appointments with mental health professionals), day treatment in hospitals, night treatment in hospitals, outpatient treatment with anti-psychotic medication, and other appropriate courses of treatment as necessary to address the needs of the person.
[19] Joint Legislative Audit and Review Commission, *Review of the Involuntary Commitment Process*, House Document No. 8. (1995). JLARC found "substantial variations in the availability of alternatives to commitment . . . impact[ed] the ability of decision-makers to find less restrictive alternatives than hospitalization." p. IV.
[20] Joint Legislative Audit and Review Commission, *Availability and Cost of Licensed Psychiatric Services in Virginia* Commission Draft (October 9, 2007), Report Summary, iii.

knowledge he had failed to follow through with an appointment with the psychologist to whom he had been referred.

C. **Organization of the Task Force on Civil Commitment Report**.

The CCTF Report is organized into nine Chapters, each of which provides a description of the current practice and law in Virginia pertaining to that element of the process, reviews the practices in other jurisdictions to provide perspective, identifies key policy issues, analyzes data bearing on those issues, and provides either concrete recommendations for statutory modifications or a set of options for the General Assembly to consider. In some instances the CCTF identifies issues that it believes need further study by the Commission.

Chapter I. Emergency Custody and Assessment. An individual usually enters the civil commitment process in a mental health emergency and is often taken into custody by law enforcement, under an Emergency Custody Order, who transports the individual to a mental health facility or hospital emergency department for an evaluation by CSB staff to assess the person's need for hospitalization or treatment. This assessment is the first step in the process of determining whether an individual meets the criteria for a judicial order for involuntary inpatient admission or mandatory outpatient treatment. The Virginia Code puts the responsibility for this evaluation on professionals at the local CSB under Virginia Code §§ 37.2-808 and 37.2-809. Chapter I examines issues related to law enforcement custody, time periods for ECOs, the information needed for a preadmission evaluation and other issues and makes recommendations for changes.

Chapter II. Certification Process. After the CSB evaluation and a magistrate's determination that probable cause exists that the person meets the commitment criteria, a temporary detention order ("TDO") is issued triggering a clinical evaluation by an Independent Examiner who certifies to the court in a written report whether the individual detained meets the statutory criteria for involuntary inpatient hospitalization. This Chapter looks at the adequacy of the TDO period, the qualifications of the Independent Examiners, the quality of the examination, particularly the types of information that should be reviewed and documented in the certification report.

Chapter III. Hearing and Adjudication. Once the Independent Examiner certifies whether or not a detainee meets the statutory criteria for a civil commitment, several issues emerge including that individual's access to treatment during the detention period, access to family members and other individuals, access to an attorney for both the respondent and the petitioner, the types of material the court should review at the hearing, as well as issues relating to continuances, appeals and whether civil commitment hearing records should be open to the public. Chapter III examines these issues in detail.

Chapter IV. Rights of Patients During Commitment Process. The CCTF considered the following issues that have the potential to adversely impact individuals subject to the civil commitment process and makes recommendations for mitigating their effects:

- The monitoring of medication for adverse side effects
- Payment for involuntary mental health services
- Right to notify designated person of status
- Protection from loss of housing
- Protection from adverse financial consequences
- Freedom from exposure to unreasonable risks while hospitalized

Chapter V. Criteria for Involuntary Hospitalization. Issues considered are fundamental to restructuring how Virginia addresses civil commitment. Several questions are posed including whether the current criteria are consistently applied, whether unduly restrictive interpretation of the current criteria prevents needed treatment and whether unduly expansive interpretation of the current criteria results in unwarranted or unjustified involuntary state intervention.

Chapter VI. Mandatory Outpatient Treatment. By statute, Virginia permits mandatory outpatient treatment ("MOT") as an alternative to involuntary *inpatient* admission under certain specified conditions: the person not only meets the inpatient commitment criteria but, also, the individual understands the conditions for outpatient treatment, is interested in being treated as an outpatient, and is deemed to have the capacity to comply with the treatment plan. However, even if these client-based criteria are met an additional statutory requirement is that suitable outpatient treatment is available in the community and can be adequately monitored by an appropriate community-based provider. Clearly, having adequate outpatient treatment options is a prerequisite to having a robust outpatient option to involuntary inpatient commitments. Chapter VI addresses whether, and if so, under what conditions the criteria for MOT should be modified. In addition, the CCTF reviews the current level of state-supported mental health outpatient infrastructure and provides several options for action.

Chapter VII. Training of Law Enforcement, Legal System, and Mental Health Professionals. Many professionals are involved in the process of civil commitment and it is critically important that all involved have an adequate understanding of Virginia law and policies on civil commitment, mandatory outpatient treatment, and mental illness. The CCTF examined the training requirements and opportunities now in place for law enforcement, CSB professionals, Special Justices, magistrates, Independent Examiners, attorneys, crisis intervention teams, and peer counselors. In addition, a comparative review of the training requirements of attorneys for other proceedings (e.g., guardians *ad litem*) was done. Several proposals to strengthen the training requirements for all professionals involved and to monitor the effectiveness of such training are made. In addition, the CCTF makes recommendations concerning the training of peers.

Chapter VIII. Compensation of Those Involved in the Civil Commitment Process. Some of the professionals involved with the civil commitment process—e.g. CSB staff and law enforcement--are paid salaries through their respective governmental employers. Others, however, are paid on a per case or proceeding basis. Special justices, attorneys,

Independent Examiners serve as independent contractors and payment rates have not been adjusted since 1998. Particularly since other recommendations contained in this Report impose additional training, duties and responsibilities on these professionals, the CCTF concludes that, an increase in compensation is needed to attract well-qualified professionals.

Chapter IX. Oversight. As outlined in this Chapter, there is considerable variation in how the civil commitment process unfolds and a concern that such variation serves neither the interests of the individuals involved nor the Commonwealth of Virginia. Several professional groups are involved in the civil commitment process: law enforcement, health professionals with the Community Services Boards, Independent Examiners, judges, Special Justices, Magistrates, and attorneys. Law enforcement and CSB personnel are formally supervised by the organizations that employ them, although with 40 CSBs and many more law enforcement agencies, there is considerable variation in how the civil commitment procedures are implemented. In addition, Independent Examiners, Special Justices, Magistrates and attorneys function relatively independently. As a result, not only are there inconsistencies in the application of state law but also systematic data collection is generally absent about how the civil commitment process functions. In this chapter, the CCTF makes ten recommendations to improve oversight of the participants, procedures and outcomes of the civil commitment process.

COMMONWEALTH OF VIRGINIA
COMMISSION ON MENTAL HEALTH LAW REFORM

Report of the Civil Commitment Task Force

CHAPTER I. EMERGENCY CUSTODY AND ASSESSMENT

Individuals, often in crisis, typically enter the civil commitment process through an emergency evaluation process. In some cases, this process is initiated through an emergency custody order ("ECO"), which authorizes the person to be detained for up to four hours to decide whether a temporary detention order ("TDO") should be sought. In all but a limited number of cases, however, issuance of a TDO by a magistrate must be preceded by an evaluation by an employee or designee of the community services board. Chapter I describes the statutory requirements, procedures, and practices pertaining to ECOs and the emergency assessment and evaluation stage of the process.

A. Emergency Custody Orders

Under certain circumstances a person suspected of having a severe mental illness may be briefly taken into custody for an evaluation and assessment of the need for treatment. Under Virginia law, upon a determination that there is probable cause to believe a person meets the statutory civil commitment criteria, is in need of hospitalization or treatment, and is unwilling to *volunteer* for that treatment, a magistrate may issue an ECO for a police officer to take the person into custody[21]

Virginia law provides further that a person taken into custody under an ECO shall remain in police custody until either a TDO is issued or until the person is released, but in no event shall the period of custody under the ECO exceed four (4) hours.

During the ECO period, the person detained receives a mental health evaluation from an emergency services employee or designee of the relevant Community Services Board ("CSB"). A skilled clinician can often determine in about 20 minutes whether a person needs to be detained for further evaluation and a judicial determination of whether the civil commitment criteria are met. In such cases a TDO is sought, which provides additional time for the medical and legal determinations.

Most CSB evaluations are done in person. In limited circumstances, such as when the CSB representative cannot safely travel icy roads in a rural jurisdiction within the relevant time, the evaluation is conducted by a two-way audio and video communication system. In order to perform reliable evaluations, however, high quality teleconferencing equipment is essential.

[21] Code of Virginia § 37.2-808.

In addition to the clinical assessment, the CSB emergency services worker is required to determine the person's insurance status. When possible, the CSB prescreener also collects relevant information about the person from family members and other informants. In particular, prescreeners investigate whether the person is a victim of domestic violence.

The information collected by the CSB emergency services staff is used to determine whether the person meets the statutory criteria for a TDO. Before a TDO may be issued, however, the CSB must first identify an appropriate facility for temporary detention. This can be a time-consuming process because there is no central resource to check on bed availability. Instead, to determine the availability of a bed, a representative of the CSB must call each licensed facility until he or she finds one that has a bed available. The Department of Mental Health, Mental Retardation and Substance Abuse Services has entered into a contract with Virginia Health Information to develop a real time on-line database that will provide CSB emergency services staff with access to the location of available beds. This database should be available shortly. Nonetheless, even when a bed is available or located, the receiving facility may require medical clearance to determine the presence of other health issues of the person before admitting him or her. When the receiving facility lacks the medical staff to perform a medical clearance, the person under an ECO must first be transported to a facility, most often a hospital emergency department that can do a medical clearance.

Although the current four-hour period of an ECO is adequate in most cases, in rural areas, in bad weather, or in cases of substantial geographical barriers, the travel time to conduct a person's evaluation can easily consume the four-hour period. An optional additional four hours to complete the work required for the prescreening would be adequate for virtually all cases.

Advantages of the Optional ECO Extension

1. The availability of a four-hour extension of the ECO balances the due process interests of the individual with the following considerations:
    a. More time for evaluation produces better treatment plans or decisions regarding placement and treatment;
    b. It reduces the likelihood of the need for TDOs and the commitment process if a less restrictive alternative to commitment becomes available. The less complete the initial evaluation, the higher the likelihood that the commitment process will commence;
    c. It takes into account the fact that travel time in rural areas because of distance and geographic barriers consumes valuable ECO evaluation time;
    d. It permits service providers who do not want to detain respondents longer than necessary, time to explore alternatives to hospitalization.

2. Assuming secure drop-off centers become available, as recommended elsewhere in this Report, law enforcement may only need to be involved during one-half or less of the allotted ECO period.

Disadvantages of the Optional ECO Extension

1. Persons detained under an ECO may oppose a longer period of initial detention.
2. Under current Virginia law, a person under an ECO is in the custody of law enforcement. Without statutory authority to transfer custody of a person detained under an ECO to a secure facility, a longer ECO detention period will consume more of a law enforcement officer's time that could be spent on the street. In addition to taking much of an officer's time away from other law enforcement activities, extending the ECO period is costly, with an eight-hour period pushing the officer's compensation into overtime status.
3. Many persons under an ECO are detained in hospital Emergency Departments. Hospitals may oppose having persons under an ECO stay in Emergency Departments for longer periods of evaluation.
4. Sometimes it is difficult to reach a magistrate, this may cause problems when reaching a magistrate a second time to request a renewal of the initial ECO.
5. The availability of an ECO extension may be a disincentive to completing the prescreening evaluation in as timely a manner as possible.
6. Without authority to transfer custody of a person under an ECO to a secure drop-off facility, longer ECO periods may be a disincentive for a law enforcement officer to take a person into custody for transport to a facility for evaluation. A more cumbersome medical response may make it easier to simply arrest a person for a petty offense and take him or her to jail.
7. Variability in the length of an ECO should not be based on geography.

The CCTF recommends that the ECO period be renewable for a single four-hour period.

If the ECO period were to be extendable, how should the additional period be authorized? Four alternatives are available:

Alternative 1. Contact a magistrate and request an extension. If the magistrate grants the extension, the authority for the extension can be sent to the requestor electronically.

Alternative 2. The extension can operate as a matter of law without further intervention by a magistrate if the CSB representative completes a written statement demonstrating a valid reason for the extension. The CSB must retain a copy of any such statement for as long as it keeps records on the respondent.

Alternative 3. The extension can operate as a matter of law without further intervention by a magistrate if the CSB representative completes a written statement demonstrating a valid reason for the extension

and presents that statement to a magistrate within the original four-hour period.

Alternative 4. The extension can operate as a matter of law without further intervention by a magistrate if the CSB representative completes a written statement demonstrating a valid reason for the extension and presents that statement to a magistrate within the original four-hour period, unless the magistrate, after a review of the written statement, determines that good cause was not shown. In such a case, the ECO period would end as soon as the magistrate notifies the CSB representative.

The CCTF recommends that the extension be authorized by a magistrate based on a showing of good cause (Alternative 4).

Examples of good cause for an extension

Under the proposed statutory change, there must be a showing of good cause for an extension of the usual four-hour ECO to be granted. The following are examples of what may constitute good cause:

1. The person is initially assessed and found to meet commitment criteria but still requires medical evaluation before a facility will admit him or her.
2. The CSB prescreener is unable to conduct the prescreening in a timely manner due to unavoidable circumstances such as involvement with another prescreening.
3. The person is initially assessed to meet commitment criteria and the CSB prescreener has not been able to locate a suitable bed.
4. To provide time for the CSB to explore alternatives to hospitalization.
5. To provide the opportunity to avoid additional judicial intervention, perhaps by volunteering to go into treatment.

Recommendation I.1. The Code of Virginia should be amended so that the four-hour detention period under an ECO should be renewable once, for good cause shown and upon application to a magistrate, for an additional period of not more than four hours. The resulting maximum ECO period would be eight hours.

B. Crisis Stabilization Facilities

Crisis stabilization facilities are important tools in helping those in mental health crises. They provide a safe environment where mental health professionals can help those in crisis end the crisis and, in many – perhaps most – situations, avoid the necessity of a TDO or an involuntary commitment. They also may provide an environment more conducive to recovery than hospitals for many who use them.

Crisis intervention is best viewed as a continuum.

As additional crisis stabilization facilities are established, each facility should be required to submit an annual report to the DMHMRSAS reflecting measures of clinical and cost effectiveness as well as client satisfaction. The results should be measured against relevant data from jurisdictions without these facilities to determine their effectiveness.

One or more crisis stabilization facilities in each community or region should have the capacity to accept custody from law enforcement officers and to conduct the necessary evaluation and referral, either voluntarily or under a TDO. In general, the CCTF refers to this capacity as a "drop-off" capability. If a crisis stabilization facility were to have all the components needed to accept custody, conduct triage evaluations and to provide services to help the person become stabilized, it might aim to include all of the following components:

1. "Walk-ins" should be encouraged;
2. "Hand offs" from law enforcement with a "no refusal" from the facility should be permitted to secure units at the facilities;
3. Staffing levels sufficient to provide evaluations within a short period of time;
4. Facilities to deal with those with needs ranging from short term stabilization to inpatient treatment for the ECO/TDO period;
5. Relevant staff designated as conservators of the peace;
6. Care to those present in the jurisdiction without regard to their permanent residence.

Recommendation I.2. The General Assembly should fund one or more crisis stabilization facilities with drop-off capability in each region of the Commonwealth.

C. Transfer of Custody to Mental Health Facilities

Under Virginia Code § 37.2-808, only a law-enforcement agency specified by the magistrate may take custody of an individual under an ECO and the officer is required to maintain custody throughout the emergency custody period.[22] As a result, law enforcement officers often sit for four hours or longer in hospital emergency departments, waiting for the CSB prescreening activities to be completed—the mental health evaluation, locating a suitable facility for admission under a TDO and, perhaps, waiting for medical clearance. Upon location of a TDO bed and issuance of a TDO, law enforcement must then transport the person to the facility with the bed. This often requires transport across the state. According to a 1995 JLARC Report, law enforcement made nearly 20,000 mental health transports in 1993, almost 90% for persons detained under and ECO. TDO or under a civil commitment order.[23] The time requirements for law enforcement under ECOs and TDOs may encourage law enforcement officers to

[22] JLARC, 1995 Report. See footnote 14.
[23] Ibid.

arrest individuals with mental illness so that they may return immediately to patrol or their other law enforcement duties rather than taking them to a therapeutic setting.

A key alternative to having law enforcement retain custody of persons under ECOs and in encouraging police to utilize therapeutic rather than law enforcement alternatives for persons with mental illness is the availability of secure drop-off centers, which can assume custody. Drop-off centers are a central feature of many crisis intervention models, some of which are in place in Virginia. For example, crisis intervention teams ("CIT") have been implemented or are in the process of being implemented in four jurisdictions in Virginia, namely in the New River Valley, Mount Rogers, Portsmouth and Charlottesville.[24] One component of the CIT and other programs is the development of non-refusal therapeutic drop-off centers that encourage trained law enforcement officers to transport persons with mental illness to such centers rather than to jail. This cannot be done under current Virginia law. Amending Virginia law to permit another facility or entity to assume custody during the ECO period would permit law enforcement officers to transport appropriate individuals with mental illness to a crisis stabilization facility or other therapeutic drop off center,[25] freeing up valuable law enforcement time. Under this proposal, more individuals would likely be diverted from the jails and criminal justice system.

A law enforcement officer's obligation to maintain custody under temporary detention orders ceases upon delivery of the person to the temporary detention facility. There should be no reason why a secure facility could not also assume custody of the individual during the ECO period. If there is a concern about the adequate provision of security, the State Mental Health, Mental Retardation and Substance Abuse Services Board could adopt regulations to license programs that are capable of providing adequate security to provide this service.

Recommendation I.3. Section 37.2-808 of the Code of Virginia should be amended as follows:

> **"Upon delivery of the person to the location identified in the emergency custody order, or to an appropriate location if the law enforcement officer has assumed custody of the person under subsection F, the location to which the person is transported may assume custody of the person if it is willing and licensed to provide security to protect the individual and others from harm."**

[24] Many more localities have expressed an interest in developing such a program, a variation thereof or other programs using crisis stabilization units or other therapeutic drop off centers, such as that implemented in Montgomery County, Pennsylvania.
[25] The CCTF expects that some CSBs may want to use secure facilities with drop-off capability other than crisis stabilization facilities.

Advantages

1. Providing hand offs from law enforcement will permit those officers to spend more time on law enforcement duties;
2. Reduces the likelihood of premature TDOs;
3. Reduces the likelihood of unnecessary commitments;
4. Speeds treatment since priority of other patients in ER may delay treatment;
5. Provides time to recover from substance abuse;
6. Provides time to get prescribed medication and have it take effect;
7. Provides more opportunity for diversion.

Disadvantages

1. If not licensed as a residential facility, those needing more than 23 hours of care must be sent elsewhere.
2. Facilities may be concerned about the potential for liability for the actions of those accepted from law enforcement personnel.

D. Bed Management

When a person is evaluated under an ECO and found to be in need of treatment such that a TDO is appropriate, the CSB then must locate a facility with a bed available and suitable for that person. Only when such a bed is identified may a magistrate issue a TDO. Although all public and private facilities licensed for psychiatric beds are known to the various CSBs and Behavioral Health Authorities ("BHA"s), the employees of the CSBs and BHAs do not know which facilities have psychiatric beds available when they need to find such a bed. There is no central database of psychiatric beds.

When searching for an available mental health bed, CSB and BHA employees are constrained by the four-hour ECO time period. This can be a challenge. Even when a mental health bed is available (meaning not-occupied), it must also be appropriate for the person who needs it. For example, if a facility has only one bed available in a double room, where a woman already occupies the other bed, the facility may reasonably accept only another woman. The other principal factor controlling bed availability is staffing. Even the most conscientious facilities have to deal with employees who find themselves too sick to come to work and are then unable to find substitutes for those employees. In such circumstances those facilities may have beds "available" but without adequate staffing, they cannot accept patients to fill those beds.

Recommendation I.4. There should be a psychiatric bed reporting system for all licensed facilities in the Commonwealth.

Elements of the system should include:

1. Real time updating of availability by the licensed facilities, with a minimum of an update at the beginning of every work shift;
2. Reporting by categories such as women, men, non-violent men to ensure the appropriateness of those beds;
3. Wait-list management;
4. Full search capabilities on each data element;
5. Certified operating capacity;
6. Actual available capacity;
7. Operational or qualified capacity;
8. Reasons for operational capacity below actual capacity or for qualifications on admissions.

Constraints of the system should include:

1. Access to the system should be limited to designated employees of all participating hospitals (free-standing, general, and state), CSBs, BHAs, and the DMHMRSAS;
2. Available beds would require verification by phone with assurances that changes in availability would not cause liability to attach;
3. Responsibility for maintaining and monitoring the system should be the responsibility of the hospital charge nurse and the DMHMRSAS program specialist respectively;
4. The data should not otherwise be available, except as needed by the DMHMRSAS;
5. The server on which the system operates should be maintained by the DMHMRSAS;
6. Any trending or systemic issues should be handled only by the hospitals in conjunction with the DMHMRSAS (these issues should be examined with equal vigor for private and state hospitals);
7. Regulations for licensure should be rewritten to include a requirement for participating in the system and a regulation applicable to state hospitals should be implemented.

A significant concern in implementing such a system is that private hospitals often want to know more about patients before accepting them.

The variations considered in developing this proposal included limiting the system to an electronic request for available beds rather than a real time availability database and a system that indicated which facilities did not have available beds.

There is an existing database in use by all hospitals for emergency bed management that is quite robust. It has the capability of being modified to provide specialized reporting for psychiatric beds. The DMHMRSAS is actively pursing a bed reporting system and has contracted with Virginia Health Information to develop a psychiatric bed reporting system.

Recommendation I.5. Assuming a state-wide psychiatric bed management system is implemented, the Code of Virginia should be amended so that when a magistrate determines that a respondent meets commitment criteria and a bed for that respondent has not been located within the maximum time allowed for the respondent's ECO, the magistrate would be able to issue a TDO without first identifying a specific bed for the respondent.

Advantages

1. This will allow full utilization of the statewide psychiatric bed management system.
2. This will prevent release of a respondent who appears to meet commitment criteria simply because a bed has not been located.

Disadvantages

1. This creates a disincentive to locate a bed before a respondent's TDO hearing.
2. This imposes the burden of holding the respondent at the ECO location until a bed may be located, if ever.
3. Without authority to transfer custody of a respondent to a secure facility, this could significantly increase the time a law enforcement officer must spend with the respondent.

E. Transportation

Transportation of individuals in the commitment process is one of the clearest entanglements of law enforcement and mental health professionals. Many persons in the civil commitment process find transport by law enforcement both traumatizing and stigmatizing. However, law enforcement agencies are designated by the Magistrate or Special Justice to transport the respondent through the various stages of the commitment process, ECO, TDO, commitment hearing and following the disposition of the case.[26]

Part of the trauma and stigma associated with the requirement for law enforcement transport is the usual practice of restraining individuals who are being transported, often when there is no risk to law enforcement, the public or to the individuals. The CCTF believes that alternative transportation modes are warranted.

In addition, the costs associated with a blanket requirement of law enforcement transport are high. Although complete data are unavailable, a recent study by an organization of Virginia law enforcement agencies estimated the costs of current transportation in commitment proceedings at approximately $128.00 per transport. Although this estimate is not insignificant considering the numbers of such transports needed, the general sense of the CCTF was that this substantially underestimates the actual costs of such

[26] Virginia Code §§ 37.2-809, 37.2-810 and 37.2-813 through 829.

transportation. Moreover, the methodology used to arrive at the estimate was flawed as transportation costs from various jurisdictions used to arrive at the figure shown did not use consistent criteria and the mode of transportation varied.

A representative of a Richmond ambulance service, which has a contract with the City, and confines its service to that jurisdiction, advised the CCTF that the costs of a transport are about $400.00. All units providing the transport are equipped for advanced life support. This organization rates each call according to the priority of need, with diversions made by referrals to a nurse, a doctor, self-care, *etc*.

Anecdotal evidence was presented to show that a number of clients of the CSB arrive by taxi. The CCTF believes that additional research is necessary to ascertain accurate costs of transportation. The costs should be categorized by rural, suburban, and urban. There will need to be appropriated funds to cover the costs for providing transportation.

Based on the Commission's CSB Crisis Contact Study in June, 2007, 26% of those receiving a prescreening evaluation were in police custody at the time of the CSB evaluation.

Recommendation I.6. The Code of Virginia should be amended to permit a three-tiered transportation model for persons in the civil commitment process. This will permit different parties to transport the respondent during the various stages of the commitment process depending upon the level of risk involved in each individual's circumstances.

This recommended three-tiered transportation model is described more fully below:

When there is a low level of risk of danger of harm to the respondent or others, the respondent could be transported by friends, family, or taxi.

When there is a medium level of risk of danger of harm to the respondent or others, the respondent could be transported in a humane manner with the minimum use of restraints necessary by:

1. Ambulance attended by CSB staff or by personnel specially trained in the use of techniques and restraints necessary to meet an emergency;
2. Ambulances or other vehicles for transport would be unmarked to eliminate the stigma associated with the commitment process;
3. Such vehicles would be equipped with necessary medical equipment.

When there is a high level of risk of danger of harm to the respondent or others, the respondent could be transported by:

1. Law enforcement where danger is a serious risk under the circumstances;

2. Officers trained in CIT approaches and using secure but unmarked vehicles would provide the transportation.

The Magistrate, Special Justice or Judge would make designation of the appropriate level of transport upon the advice of CSB screeners/experts.

When law enforcement personnel transport individuals in connection with an ECO or a commitment hearing, law enforcement almost always places those individuals in restraints. This CCTF Recommendation seeks to limit the routine use of restraints to only those who present a high risk of danger of harm to themselves or others. Further, those who present a medium risk of danger of harm to themselves or others will be individually evaluated for the need for restraints.

Recommendation I.7. The DMHMRSAS should include in the training and certification of CSB prescreeners the process of risk assessment for purposes of determining the appropriateness of the use of restraints and level of transportation of individuals subject to any stage of the commitment process applicable to all CSBs and BHAs. Such assessment must include the risk to individuals of using restraints.

Recommendation I.8. The Department of Criminal Justice Services should develop policies and procedures to minimize the use of restraints for transportation of individuals subject to any stage of the commitment process applicable to all law enforcement agencies in the Commonwealth.

These Recommendations remove the potential for ambiguity in the use of restraints.

Virginia law provides for specific transports for persons in the commitment process. Other key events in the commitment process trigger the need for transportation services, not all of which require the Commonwealth to provide transportation. In many cases, persons are swept into the commitment process because they do not have access to and cannot afford such necessary transportation. The following is a list of events requiring transportation:

1. Voluntary treatment not involving admission to a facility;
2. Voluntary admissions before an ECO or TDO issues;
3. Transport for an ECO evaluation;
4. Transport to a detention facility pursuant to a TDO;
5. Transport to the commitment hearing;
6. Transport for transfers between treatment facilities;
7. Transport home after expiration of an ECO or TDO or following dismissal of the petition at a commitment hearing.

Recommendation I.9. The Code of Virginia should be amended to reflect that the Commonwealth must provide transportation to those who are subject to any part of the commitment process, including transportation following discharge.

CHAPTER II. EVALUATION AND CERTIFICATION

After an in-person evaluation by the CSB, a magistrate may issue a TDO if "it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has mental illness, (ii) presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself, (iii) is in need of hospitalization or treatment, and (iv) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment."[27] The TDO is effective for a maximum period of 48 hours, with additional time allowed if it expires on a weekend or holiday.[28] Prior to the hearing, the person is evaluated by an Independent Examiner to determine whether he or she believes that the person meets the criteria for involuntary inpatient or mandatory outpatient treatment.

In his Investigation of the April 16, 2007 Critical Incident at VA Tech, the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services ("Inspector General") found that the mental health examinations performed by the Independent Examiner in connection with commitment hearings are often very brief and fail to capture potentially important information about the individual in question. As evidence of this, the Inspector General noted that the Physician's Examination section for the Proceedings for Certification for Involuntary Admission form requires no recent history to understand stressors that may have precipitated the psychiatric emergency, or any stressors that the individual may face upon discharge. The OIG report recommended study of the post-TDO evaluation and certification process, including whether the TDO period (48 hours) is sufficient to permit a thorough evaluation.

A. Temporary Detention Period

In his Investigation of the April 16, 2007 Critical Incident at VA Tech, the Inspector General found that

> "[w]hile up to 48 hours (72 hours on weekends) is allowed for temporary detention, it is not unusual for the time from admission to the commitment hearing to last less than 24 hours. This makes it very difficult, if not impossible, to collect and consider additional collateral information about

[27] Code of Virginia § 37.2-809B.
[28] Code of Virginia § 37.2-809G.

> the individual. This also makes it difficult to complete the physical exam and psychiatric evaluation, assessment and treatment plan before the commitment hearing is held."

Preliminary data from the Commission's Study of Commitment Hearings in May 2007 ("Commission's Hearings Study") supports this conclusion, finding that 30.2% of commitment hearings occurred less than 24 hours after execution of the TDO.[29]

Like the Inspector General, many participants believe that the involuntary hospitalization process moves too quickly to effectively identify and address a person's needs. In some cases, the evaluation under a TDO is completed within 24 hours. If the commitment hearing is held in less than 24 hours, as occurs in 30.2% of the cases in Virginia, insufficient time is available to obtain prior medical information and an adequate history to assess the person's current condition and determine the best course of treatment. Although the swiftness of the process may benefit individuals in that their liberty interests are curtailed for the least amount of time, the rapid rush to the commitment hearing may result in many individuals being involuntarily admitted to an inpatient setting who do not need to be hospitalized and who instead may benefit from a shorter stay of crisis stabilization. The Virginia Tech Review Panel has also recommended that the time frames for evaluation be increased in its Recommendation IV-13.[30]

Although infrequently used in Virginia, additional time to develop an effective outpatient treatment plan is also important with mandatory outpatient treatment orders. Furthermore, a longer TDO evaluation period may permit stabilization of individuals without the need to commit them involuntarily to an inpatient setting. According to many mental health professionals, individuals often are stabilized and return home from a period of inpatient treatment within 3-10 days. Others may become stable enough to seek voluntary inpatient or outpatient treatment within a few days of the initial detention. As a result, extending the period of temporary detention from 48 hours to four or five days may reduce the numbers of persons involuntarily committed and permit the individual to participate in development of his or her own treatment plan, thereby giving individuals the ability to direct their own recovery. Reducing involuntary inpatient admissions would also reduce the stigma attached to such treatment and avoid the undue need for law enforcement transportation with the humiliation that often entails. Extending the TDO period will foster a substantial shift from a court/law enforcement focus to a voluntary model, enhancing Virginia's stated goal of recovery-based mental health service delivery.

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[29] Commission's Hearings Study, May 2007.

[30] The Review Panel's Recommendation IV-13 states the following:

> Va. Code 37.2-809 should be amended to extend the time periods for temporary detention to permit more thorough mental health evaluations.

Recommendation II.1. The Code of Virginia should be amended so that the maximum time for a TDO would be four days with the necessary extensions if the period ends on a weekend or holiday.

If the goals of this proposal are to be realized -- more thorough evaluations for individuals involved in the civil commitment process, development of more effective voluntary inpatient and outpatient treatment plans, and fewer involuntary commitments, thereby reducing the stigma associated with involuntary treatment and facilitating the recovery model of person centered/person driven treatment – it must be accompanied by other changes in the design of the certification process. They include improvements in the evaluation process, appointment of counsel for the person earlier in the process, an opportunity to discharge the person under a TDO before the hearing, and increased compensation for Independent Examiners and probably counsel.

Under a longer TDO period, the role of the Independent Examiner would likely be greatly increased, and that of the person's attorney would be somewhat increased. If such an expansion of the TDO period is endorsed, the Independent Examiner and respondent's attorney should be paid significantly more than the current $75.00 and $86.25 respectively per case and must receive significantly more specialized training in their roles. The case for both additional compensation and training is made in later Chapters of this Report.

Recommendation II.2. The Code of Virginia should be amended so that no hearing can be held less than twenty-fours (24) hours after the execution of a TDO.

Advantages

1. The minimum time allows for a respondent to complete detoxification, if such detoxification is needed.
2. The minimum time allows for a more complete evaluation and a minimally adequate period of observation of the respondent.
3. The long-term costs associated with a respondent's treatment may be less. For example, there may be less relapse.
4. A longer period of an individual's detention for evaluation under a TDO may be acceptable to reduce the number of hearings where the person no longer needs inpatient treatment or has agreed to voluntary treatment.
5. Time in the hospital, even without medication, is likely to help the respondent stabilize.
6. Independent Examiners may not want to conduct evaluations in the first 24 hours of the TDO period so they can collect collateral contact information/hospital assessments.
7. If there will be an outpatient treatment recommendation, there is more time to prepare the treatment plan;
8. The CSBs will have more time to prepare a discharge plan.

Disadvantages

1. The short-term cost for the longer hospitalizations during TDOs will increase.
2. It is possible that the longer time period will be misused resulting in more hearings held on the last day of the TDO period rather than earlier even if all information is available.
3. Wrongfully detained respondents may stay in custody as long as four days.
4. Those with serious chronic medical conditions who are not able to communicate their medical needs may have their health compromised by being kept longer in a non-medical facility.
5. This may discourage people from obtaining treatment for their mental illness.
6. People with trauma histories will be more traumatized by a longer stay.
7. There is no evidence that an extension of time will produce positive results.
8. The shortage of mental health beds may be exacerbated.
9. A longer period of hospitalization for some people will lead to deterioration and trauma and some who would not be committed under a two-day TDO might be committed under a four-day TDO.

B. Evaluation by Independent Examiner

The CCTF recommends changes both to the statutorily specified qualifications of the professionals who evaluate persons detained under a TDO as well as the substance of the evaluation.

1. Qualifications of the Evaluator

As currently provided in Virginia Code § 37.2-815, a person detained under a TDO must be evaluated and certified as meeting the civil commitment criteria by an Independent Examiner. The "independence" requirement is relates primarily to the concern that the examiner should not have a financial interest in the facility to which the person under a TDO might be involuntarily admitted placed.[31] Further the statute requires the Independent Examiner to be a psychiatrist or psychologist who is qualified in the diagnosis of mental illness, but if such a psychiatrist or psychologist is not available, the examination may be performed by any mental health professional who is licensed through the Department of Health Professions, is qualified in the diagnosis of mental illness, and meets all of the other requirements in that section.

[31] The reasons for prohibiting Independent Examiners with financial interests in the facility to which the person may be committed or who are employed by the facility may no longer exist now that psychiatric beds are scarce and the financial incentives of the 1980s and 1990s to fill beds no longer exist.

Prior to his or her appointment, any such Independent Examiner appointed should complete a certification program approved by the Department. Currently the Independent Examiner is not required to obtain any commitment related training. Examinations by licensed clinical social workers and licensed professional counselors are alternatives to examination by a psychiatrist or psychologist. Psychiatric nurse practitioners and physician assistants are other alternatives.

Concerns have been raised about the qualifications, training, and availability of the Independent Examiner. Most people agree that the Independent Examiner should be, if at all possible, a psychiatrist or licensed clinical psychologist. However, in many rural areas, professionals with these qualifications are not readily available and the option to use an otherwise qualified mental health professional is needed. There is a clear tension between limiting the professionals who may serve as the Independent Examiner and in ensuring the availability of professionals who may conduct mental health evaluations under the short TDO period. Some members of the CCTF believe this tension can be addressed by modifying the Virginia Code to permit evaluations not only by psychiatrists and psychologist but, also, when these professionals are unavailable, by licensed clinical social workers. Some members recommend deleting evaluations by any mental health professional licensed by the State of Virginia. Other members recommend that the qualifications remain the same.

In addition to concerns about the underlying qualifications and availability of Independent Examiners, anecdotal evidence suggests that many Independent Examiners are not well trained and do not have adequate time to perform this job.

Recommendation II.3. The Code of Virginia § 37.2-815 should be amended as follows:

> **Notwithstanding § 37.2-814, the district court judge or special justice shall require an examination of the person who is the subject of the hearing by a psychiatrist or a psychologist who is licensed in Virginia by the Board of Medicine or the Board of Psychology and is qualified in the diagnosis of mental illness or, if such a psychiatrist or psychologist is not available, ~~any mental health professional who is (i) licensed in Virginia through the Department of Health Professions and (ii)~~ the examination may be conducted by a licensed clinical social worker who is qualified in the diagnosis of mental illness. Prior to his or her appointment, any such examiner appointed shall complete a certification program approved by the Department.~~The examiner chosen shall be able to provide an independent examination of the person. The examiner shall (a) not be related by blood or marriage to the person, (b) not be responsible for treating the person, (c) have no financial interest in the admission or treatment of the person, (d) have no investment interest in the facility detaining or admitting the person under this chapter, and (e) except for~~

~~**employees of state hospitals, the U.S. Department of Veterans Affairs, community service boards, and behavioral health authorities, not be employed by the facility. For purposes of this section, the term "investment interest" shall be as defined in § 37.2-809**~~

2. Procedures for the Evaluation

(i) Electronic Evaluation: Under Virginia law, the examination of a person under a TDO must be done personally and in private.[32] Although Independent Examiners normally conduct in-person examinations, some conduct their examinations by videoconference when there are extenuating circumstances preventing in-person examinations, such as bad weather. Although the CCTF recognizes that in-person examinations may not always be feasible, it is divided on whether special findings by the court should be required for such evaluations. Some members believe that videoconferencing as an alternative should be rare, and that the court should decide whether to permit an alternative to an in-person examination in advance based on extenuating circumstances. Under this view, when the court believes an alternative is appropriate, the parties would be given notice before the permission is granted. Other CCTF members believe that an electronic evaluation can be as accurate as in-person evaluations if the best available technology is used.

Electronic Evaluation Option 1 (a): The Code of Virginia should be clarified to ensure that the Independent Examiner must conduct an in-person examination of persons detained under a TDO. In those rare circumstances where it is not physically possible to do so, the Independent Examiner can seek the prior approval of the court to conduct the evaluation electronically. Notice must be provided to the parties before permission is granted for an electronic evaluation.

Electronic Evaluation Option 1(b). The Code of Virginia should be clarified to permit the Independent Examiner to conduct an evaluation electronically as long as the equipment being used has been certified as being adequate for this purpose by the DMHMRSAS.

Arguments for Electronic Evaluation Option 1 (a)

1. Electronic evaluations may be less informative.
2. Respondents may not want to be evaluated by video.

Arguments for Electronic Evaluation Option 1 (b)

1. An electronic evaluation can permit a hearing to proceed on schedule and not require a continuance.
2. It clarifies the requirement that the respondent receive multiple evaluations.
3. In some circumstances electronic evaluations can be more informative.

[32] Code of Virginia § 37.2-815.

4. In rural areas electronic evaluations can enable the IE to evaluate more people.

(ii) Records to be Reviewed: Independent Examiners should review the CSB's prescreening report and must interview the person as part of the TDO evaluation and commitment certification process. However, the CCTF believes that the evaluation should include both interviews with others with knowledge of the person detained as well as the examination of additional materials. Although the TDO evaluation time is limited and certain individuals may be unavailable, the Independent Examiner also should attempt to interview a variety of persons who might have important information about the individual. Such interviews might include the petitioner, any relevant collateral informants, the inpatient treatment team and CSB staff knowledgeable about the individual's treatment history. At times the inpatient medical record and prescreening report may be sufficiently thorough and further interview of these clinicians is not necessary. The Independent Examiner should be able to use his or her judgment in these circumstances. However, it appears that many Independent Examiners spend only minutes examining the person and reviewing the records, making additional examination requirements necessary. The Virginia Tech Review Panel has also recommended in IV-17 that necessary reports and collateral information be assembled before the independent evaluator conducts the evaluation.[33]

Recommendation II.4. The Code of Virginia should be amended to require the Independent Examiner to review the prescreening report and all readily available and relevant records and collateral information, including an available advance directive or the respondent's preferences if there is no advance directive and trauma history. At a minimum, the Independent Examiner should review the relevant medical records of the TDO facility regarding a respondent. The Independent Examiner's evaluation should also identify all records, which were reviewed.

Advantages

1. This will provide more complete reviews.

Disadvantages

1. This may be a disincentive for serving as an Independent Examiner.
2. This poses a heavy burden on the Independent Examiners given that a respondent's medical records may be voluminous.

[33] Recommendation IV-17. The role and responsibilities of the independent evaluator in the commitment process should be clarified and steps taken to assure that the necessary reports and collateral information are assembled before the independent evaluator conducts the evaluation.

(iii) Promptness: As already indicated, the CCTF believes that the personal evaluation should not ordinarily be conducted until 24 hours have elapsed, to allow sufficient time to review the records. However, the respondent should be seen promptly within the TDO period to determine whether the civil commitment criteria are met.

Recommendation II.5. The Code of Virginia should be amended to require that an Independent Examiner appointed by the court should examine the person within 48 hours of execution of the temporary detention order issued by the magistrate, and sufficiently in advance of the hearing to ensure the evaluation will be complete before the beginning of the hearing. The examination must occur at the treatment facility where the person is being detained.[34] (Some members believe that this should occur whether or not the time frame for conducting the commitment hearing is extended.)

C. The Certification Process

The certification process is designed to determine whether a person meets civil commitment criteria. Under Virginia law, the Independent Examiner has the responsibility of certifying to the court that there is "probable cause to believe that the person (i) does or does not present an imminent danger to himself or others as a result of mental illness or is or is not so seriously mentally ill as to be substantially unable to care for himself and (ii) requires or does not require involuntary inpatient treatment." [35]

Although the CCTF did not reach consensus on changes to the certification process, it did reach consensus on some fundamental principles regarding the process:

- An opportunity for release should be made available early in the process if the individual is determined to not or no longer meet commitment criteria.
- Opportunities for electing voluntary treatment should be made available early in the process and should be offered throughout the process.

Some CCTF members believe that any examination where the person is non-communicative must involve every possible means of soliciting that person's active involvement in the examination, including the use of written materials.

Possible changes to the certification process can usefully be organized to track the various outcomes of the process:

[34] This Recommendation is contingent on an appropriate increase in compensation for the examination as it will require a commitment of time that is not adequately compensated under the current system.
[35] Code of Virginia § 37.2-815.

1. Respondent does not meet commitment criteria

Under current practice, once a TDO is issued, even if the individual is found by the Independent Examiner *not* to meet the commitment criteria, the person is detained until the commitment hearing, at which time the Special Justice or magistrate will order his or her release. This practice not only unnecessarily infringes upon the individual's liberty interests, but also uses resources in hospitals or emergency departments while the person waits for the hearing. This problem would be magnified if the TDO period were lengthened to four or five days. As a result, the CCTF recommends changing the Virginia code making it explicit that the Independent Examiner has the authority to release the individual if the criteria are not met.

Recommendation II.6. The Code of Virginia should be amended to permit the Independent Examiner to authorize the release of an individual from a TDO if that person does not meet commitment criteria.

Under this proposed change, based upon an examination of the respondent and other relevant information the Independent Examiner shall first determine whether the individual meets either the inpatient or outpatient commitment criteria. If the Independent Examiner determines that the individual does not meet the commitment criteria, he may authorize the person's release from the TDO subject to the conditions specified in the following paragraphs.[36] In releasing the person, the Independent Examiner should encourage the person to seek voluntary treatment and services from the inpatient facility, CSB or other treatment provider, if treatment is clinically appropriate. Any treatment should be designed to prevent future crises similar to the one that led to issuance of the TDO. The person should be free to leave and should not feel coerced into considering voluntary admission. The Independent Examiner must notify the clerk of the court in which the TDO petition was filed that the person has been released and the court should dismiss the petition.

However, if the treating physician or CSB opposes the release, the treating physician should be required to notify the court and Independent Examiner as soon as practicable. If such notice has been given, the person under the TDO should not be released. In such a case, the Independent Examiner should be required to attend the commitment hearing to determine whether his response would change based upon the evidence presented at the hearing. The testimony of the Independent Examiner would be that of a clinical expert; the positive certification of the Independent Examiner would not be required, and the court would render a decision based upon all of the evidence presented.[37]

Only if the pre-hearing discharge is opposed by the attending physician should a commitment hearing be required. Attending or treating physicians are more familiar with

[36] In order to attempt to address liability issues, the role of the Independent Examiner should be established in statute as a quasi-judicial officer with immunity from liability.
[37] This is contingent upon extending the statutory TDO period.

the person's treatment history and may be better able to assess a person's dangerousness than an Independent Evaluator who is examining the person for the first time. In such a case, the hearing should be expedited and must be held within 48 hours. The person could be confined up to four days under the TDO in such circumstances. Requiring a hearing within 24 hours, however, may be practically impossible.

Recommendation II.7. The Code of Virginia should be amended to provide that the role of the Independent Examiner should be established as a quasi-judicial officer with immunity from liability.

In exercising his authority to facilitate voluntary treatment and release the person from detention, the Independent Examiner must be afforded immunity from liability. Currently treatment providers may release the person before the commitment hearing but seldom do because of liability concerns.

The prevailing view among Special Justices is that a hearing is required whenever a TDO is issued, even if the Independent Examiner does not certify probable cause for commitment. Generally a hearing is held to dismiss a petition for involuntary commitment.

Recommendation II.8. The Code of Virginia should be amended to clarify that a TDO does not require a hearing. A respondent can be released from the TDO at any time during the TDO period without a hearing where (1) the treating physician or other person if specified by a facility's protocol discharges the respondent prior to the time the Independent Examiner conducts his or her evaluation; (2) the Independent Examiner does not certify probable cause for commitment and there has been no written recommendation to the contrary made by the treatment provider[38]; (3) the respondent agrees to voluntary treatment and the treating physician agrees that voluntary treatment is appropriate; or (4) no petition is filed. The CSB and the petitioner will be given notice of the release of the respondent from the TDO prior to the respondent's release.

The intent of (1) is to clarify that a treating physician can discharge an individual who is clearly not in need of commitment before an Independent Examiner has had an

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[38] (Option A) ***A new form should be prepared so both the Independent Examiner and the treatment provider both have check boxes: yes there is probable cause and no there is no probable cause; where both choose no, the respondent would be released; where one says no, there should be an expedited hearing; where both say yes, the hearing would be scheduled in the ordinary course of docketing.***
(Option B) ***A new form should be prepared so both the Independent Evaluator and the treatment provider both have check boxes: yes there is probable cause and no there is no probable cause; where both choose no, the respondent would be released; in all other cases the hearing would be scheduled in the ordinary course of docketing.***

opportunity to conduct an evaluation. In such instances there is no need for the Independent Examiner to perform the evaluation.

The intent of (2) is to clarify that a treating physician can release an individual who is clearly not in need of commitment after an Independent Examiner has had an opportunity to conduct an evaluation and both the Independent Examiner and treating physician agree that there is no probable cause for commitment.

The intent of (3) is to clarify that a respondent who chooses voluntary treatment is getting *voluntary* treatment and there is no need for a hearing to ratify the choice. To enter voluntary treatment without a hearing, the treating physician must agree that the treatment is appropriate. The opportunity to volunteer for treatment should be made available either before or after the Independent Examiner performs the evaluation.

The intent of (4) is to clarify that a hearing is not appropriate when no petition is filed.

2. Respondent meets commitment criteria and chooses voluntary inpatient treatment

If the Independent Examiner determines that the person meets the inpatient commitment criteria, he should next determine whether the individual is willing and capable of seeking voluntary inpatient treatment. If the Independent Examiner permits the person to accept voluntary inpatient treatment, he should notify the clerk of the court in which the petition was filed that the person has been released from the TDO and the court should dismiss the petition.

The CCTF favors some fail-safe when individuals choose to voluntarily enter inpatient treatment in the context of a commitment process to permit some time for reflection prior to being permitted to leave treatment.

Recommendation II-.9. The Code of Virginia should be amended to provide that if an individual chooses voluntary inpatient treatment under any circumstances after an ECO or TDO is issued, that person must give 24 hours notice before leaving treatment. In cases where the facility determines a release is appropriate, the facility may release the person prior to the end of the 24 hours.

Beyond a minimum period of 24 hours for change of mind, the CCTF is divided on whether a longer minimum period of treatment should be permitted. The CCTF identified three options:

Treatment Period Option 1 (a). ***If the individual is willing and capable of seeking inpatient treatment, he shall agree to accept a minimum of five days of inpatient treatment, and after at least three days of treatment, give the inpatient facility a minimum of 48 hours notice prior to leaving the facility, beginning at the time that the***

person signs the voluntary agreement. The voluntary agreement shall be a contract entered into between the person and the inpatient facility agreeing to admit the person. This agreement shall not become part of the court's record but may be used in evidence at any subsequent hearing seeking an order for the person's involuntary inpatient admission or mandatory outpatient treatment.

Treatment Period Option 1 (b). ***If the individual is willing and capable of seeking inpatient treatment, he shall agree to inpatient treatment. The treatment will be purely voluntary and the person may refuse treatment at any time.***

Treatment Period Option 1 (c). ***The current scheme of voluntary admission should not be modified.***

Currently only the court may permit the person to accept involuntary inpatient treatment. If the court finds that the person is both willing and capable of seeking voluntary admission, the judge or special justice must require the person to accept voluntary admission for a minimum period of treatment not to exceed 72 hours and to give the facility 48 hours notice prior to leaving. The 48-hour time period gives the person time to reflect on his or her decision to leave and provides the facility with sufficient time to obtain a TDO if necessary.

3. Respondent meets commitment criteria and chooses voluntary outpatient treatment

If the Independent Examiner determines that the person meets the outpatient commitment criteria, he should next determine whether the individual is willing and capable of seeking voluntary outpatient treatment and should have the authority terminate the commitment proceedings if he or she concludes that the person has the necessary capability.

The CCTF formulated a draft provision to implement voluntary outpatient treatment as an option for a person who is certified to meet the commitment criteria:

> If the Independent Examiner, in consultation with the community services board or behavioral health authority, determines that the person meets the inpatient commitment criteria but less restrictive alternatives exist to inpatient admission, and that the person is willing and capable of seeking voluntary outpatient treatment and the criteria for outpatient commitment are otherwise met, the Independent Examiner may authorize the release of the person from the TDO. The voluntary agreement shall be entered into between the person and the community services board, or behavioral health authority, and shall contain an initial treatment plan. If a provider other than the community services board or behavioral health authority will be providing the treatment, the person shall also authorize the provider, as part of the agreement, to disclose all relevant treatment

information, including the level of participation on the part of the person, to the community services board or behavioral health authority, the Independent Examiner and the court at any future commitment hearings should they become necessary. This agreement shall not become part of the court's record but may be used in evidence at any subsequent hearing seeking an order for the person's involuntary inpatient admission or mandatory outpatient treatment. The person shall be advised that failure to adhere to outpatient treatment may result in his or her involuntary inpatient admission. Failure of the person to adhere to the outpatient treatment agreement may be used against the person at a subsequent commitment hearing.

.If the Independent Examiner permits the person to accept voluntary outpatient treatment, he shall notify the clerk of the court in which the petition was filed that the person has been released from the TDO and the court should dismiss the petition. If, after notice from the Independent Examiner, the inpatient-treating psychiatrist, treating CSB or private provider, oppose the voluntary outpatient treatment, the person shall not be released.

4. The Independent Examiner determines the respondent meets commitment criteria and that voluntary admission is requested but not appropriate or is not requested

If the Independent Examiner certifies that the respondent meets the commitment criteria and that voluntary admission is not appropriate, the case will proceed to a hearing.

Recommendation II.10. The Independent Examiner must certify his findings to the court in writing and be available to present testimony if the Special Justice requests in-person testimony. (See Recommendation III.3.)

CHAPTER III. HEARING AND ADJUDICATION

After an Independent Examiner has assessed an individual, a civil commitment hearing must be held before a judge or Special Justice who decides whether to issue an order for involuntary inpatient admission or mandatory outpatient treatment. Chapter III describes this process.

A. Treatment Pending Hearing

Recommendation III.1. The current Virginia Code provisions regarding treatment pending a hearing should remain unchanged. If the maximum period of temporary detention is extended to 4-5 days and the person is incapable of consenting to treatment during the period of temporary detention, and no individual is readily available to serve as the person's authorized representative, or if the person is capable of consenting to treatment but refuses to do so, the attending physician or Independent Examiner may request the court to expedite the hearing. Upon receiving such notice from the attending physician or independent examiner, the court shall hold a hearing within 48 hours.

When an individual is in custody pursuant to a TDO, the facility where that individual is detained may provide emergency medical and psychiatric services within its capabilities, in accordance with Virginia Code § 37.2-809(E), when the facility determines that the services are in the best interests of the person within its care. The *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services* (Human Rights Regulations) also govern the provision of treatment without the consent of the individual. The Human rights Regulations define "emergency" in 12 VAC 35-115-30 (effective September 19, 2007) as "a situation that requires a person to take immediate action to avoid harm, injury, or death to an individual or to others." The TDO facility may, therefore, provide emergency treatment to the person in accordance with the procedures outlined in 12 VAC 35-115-70.B (5) of the Human Rights Regulations. If the person is incapable of making an informed decision regarding treatment, the facility may designate an authorized representative to provide consent on behalf of the individual in accordance with 12 VAC 35-115-146.

B. The Hearing

Under current law, at the beginning of the commitment hearing, the court is required to advise the person of his or her right to apply for voluntary admission and treatment. The judge must ascertain whether the person is then willing and capable of seeking voluntary admission and treatment. If so, the judge or special justice must require the person to accept voluntary admission for a minimum period of treatment not to exceed three days and require him to give 48 hours notice prior to leaving the facility. Virginia law is silent as to whether and under what circumstances the court may permit a person to accept voluntary outpatient treatment. Many members of the task force believe that if the person is willing and capable of accepting outpatient treatment and the conditions for outpatient treatment are otherwise met, the court should also be permitted to allow the person to accept outpatient treatment either with or without conditions.

The Virginia Tech Review Panel found that in addition to the general absence of a CSB pre-screener, the Independent Examiner, the treating physician, the family and witnesses also were generally not present at the commitment hearing. The Review Panel's Recommendation IV-19 called for amending the Virginia Code to require the presence of the pre-screener or other CSB representative at all commitment hearings and to provide adequate resources to facilitate CSB compliance.[39]

(i) CSB Staff: In his investigation of the April 16, 2007 *Critical Incident at Virginia Tech*, the Inspector General found that only 40% or 16 of the 39 CSBs and one Behavioral Health Authority ("BHA") attended 96-100% of commitment hearings, and 22.5% or nine attended 0% of the hearings. The Commission's Hearings Study confirmed the Inspector General's report finding that CSB representation at commitment hearings was only 52.4%. If CSBs or BHAs do not routinely attend commitment hearings, however, it is not clear how they can recommend specific courses of treatment or programs for the provision of mandatory outpatient treatment and its follow-up.

When individuals are detained outside the CSB's or BHA's catchment area, it may be impossible for representatives of that CSB or BHA to attend the commitment hearing. Audiovisual and telephone conferencing equipment should be used whenever available in such circumstances. In cases where this is not possible, the CSB or BHA should make arrangements for the CSB or BHA where the hearing is held to be present at the hearing on behalf of the absent CSB or BHA, especially if the court is hearing that CSB's or BHA's other cases at that time. It would also be preferable if the CSB or BHA employee or designee that prepared the pre-screening report were present at the commitment hearing. This may also not be possible because of the volume of cases and the fact that the same staff may not be working at the time of the commitment hearing. Therefore, allowances need to be made when it is impossible for CSB or BHA staff to attend the hearing and when the employee or designee preparing the prescreening report is not available to attend the hearing due to work schedule or other reasons.

[39] Virginia Tech Review Panel Recommendation IV-19: The Virginia Code should be amended to require the presence of the prescreener or other CSB representative at all commitment hearings and to provide adequate resources to facilitate CSB compliance.

Recommendation III.2. The Code of Virginia should be amended to require a CSB representative to attend all commitment hearings.

Recommendation III.2 may be addressed using the following statutory language:

> **An employee or designee of the CSB or BHA that prepared the preadmission screening report shall attend the hearing either in person or if unable to attend in person by using a telephonic communication system as provided in § 37.2-804.1. If the hearing is held outside the jurisdiction of the CSB or BHA and a representative of that CSB or BHA cannot attend in person or by using a telephonic communication system, arrangements shall be made for a representative of the CSB or BHA where the hearing takes place to attend the hearing on behalf of the CSB or BHA preparing the report. The judge or special justice may waive this requirement if it appears practically impossible for a representative of the CSB or BHA to attend.**

(ii) Independent Examiner:

Under the Virginia Code, the Independent Examiner must certify that the criteria for civil commitment are met. However, the statute is silent about whether the Independent Examiner should attend the commitment hearings. The Commission's Hearing Study found that, overall, Independent Examiners attended commitment hearings 64.3% of the time, which means that in more than a third of all cases individuals subject to civil commitment proceedings have no opportunity to challenge the Independent Examiner's findings.

Recommendation III.3. The Code of Virginia should be amended to require the Independent Examiner to attend the hearings of individuals he or she has examined, in person or electronically, if the person or his attorney objects to his report, or if the treating physician contests his opinion.

Recommendation III.3 may be addressed with the following statutory language:

> **If the independent examiner has determined that the person does not meet commitment criteria and that opinion is objected to by the treating physician, the independent examiner shall attend the hearing in person or by means of a telephonic communication system as provided in § 37.2-804.1 to determine whether his response would change based upon the evidence presented at the hearing. In all other circumstances, the examiner's written certification may be accepted into evidence unless objected to by the person or his or her attorney in which case the examiner must attend in person or by electronic communication.**

In addition to the initial assessment, the Independent Examiner should make a quick reassessment of the respondent prior to and during the hearing to assure that his or her determination of probable cause is accurate at the time of the hearing.[40]

(iii) Other Witnesses: Attendance of family members or other possible witnesses at commitment hearings is rare limiting access to potentially important information about the respondent. The Commission's Hearings Study found that these individuals attended commitment hearings only 15.4% of the time.

Some of the CCTF members think that respondents should be able to present information from their private providers at the commitment hearing telephonically or by affidavit, facsimile or deposition.

Recommendation III.4. The Code of Virginia should be amended to facilitate electronic testimony by other witnesses, including the Respondent's treatment providers.

Recommendation III.4 may be addressed with the following statutory language:

> **In addition to CSB or BHA representatives, witnesses, including family members and private providers familiar with the person's condition or services provided, may testify at the hearing using a telephonic communication system as provided in § 37.2-804.1 if they are unable to attend in person. The court shall also admit into evidence when offered by the person who is the subject of the hearing statements from the person's treatment providers submitted by facsimile or by deposition.**

C. Documents required to be considered at the commitment hearing.

The Virginia Tech Review Panel found that in addition to the CSB pre-screener, the Independent Examiner, the treating physician, the family and other witnesses generally being absent and unavailable for questioning at the commitment hearing, very little documentation of the respondent's history other than the prescreening report and the Independent Examiner's certification was available to the Special Justice at the hearing. The Review Panel further noted that because this was not unusual in commitment hearings in Virginia, the Special Justice needed more complete information about the respondent and the circumstances than is currently provided to make better decisions in these cases.

Recommendation III.5. Section 37.2-817.A. of the Code of Virginia should be amended as follows:

[40] This Recommendation also is contingent upon an appropriate increase in compensation for the time taken for conducting the examination.

The district court judge or special justice shall render a decision on the petition for involuntary admission after the appointed Independent Examiner has presented his report, orally or in writing, pursuant to § 37.2-815 and after the community services board or behavioral health authority that serves the county or city where the person resides or, if impractical, where the person is located has presented a preadmission screening report, orally or in writing, with recommendations for that person's placement, care, and treatment pursuant to § 37.2-816. These reports shall be admitted into evidence, and if not contested, may constitute sufficient evidence upon which the district court judge or special justice may base his decision.

The Virginia Tech Review Panel recommended that the following language be added to the Code: "The judge or special justice shall also consider to the extent available, the complete evaluation of the treating physician, including collateral information, reports of any lab and toxicology tests conducted, reports of prior psychiatric history, and all admission forms and nurse's notes."

The CCTF members unanimously believe this is beyond the expertise of a Special Justice. Some members believe that the Special Justice should not be required to admit any of these items unless they are properly offered into evidence. Instead the Independent Examiner should read and interpret these documents to the extent they have the expertise.

D. Appointment of an Attorney for the Respondent

It is important that individuals in the civil commitment process be adequately represented.

Recommendation III.6. The Supreme Court shall establish standards of practice and establish certification criteria for respondent's attorneys. (Some CCTF members prefer this requirement to be codified.)

Recommendation III-7. Immediately upon the filing of the petition or execution of the TDO, whichever occurs first, the court shall appoint an attorney to represent the person, if the person is unable to employ one, and advise the person of the attorney's name and contact information.

The CCTF discussed a variety of scenarios for appointing attorneys, when those attorneys should meet with their clients, and what information the attorney should convey to his or her client. There was no consensus on these specifics but the following are some of the ideas discussed:

- Where possible, each jurisdiction shall provide a list of approved attorneys to the magistrate's office so the magistrate issuing the TDO can contact the attorney and inform him or her of the appointment.

- A court-appointed attorney should meet with the respondent within 24 hours of appointment.
- A court-appointed attorney should meet with the respondent within 24 hours of appointment (or within 48 hours if the TDO period is extended).
- During the initial meeting with the client, the attorney shall advise the respondent of his right to apply for voluntary inpatient or outpatient treatment. The attorney shall also advise the respondent of his other rights currently enumerated in § 37.2-814.D. The attorney shall also review the respondent's inpatient record and any other readily available medical information, and to the extent possible prior to the hearing, interview the petitioner, collaterals with information about the respondent, CSB staff with knowledge about the person's treatment history, and the Independent Examiner.

E. Appointment of an Attorney for the Petitioner

Although the respondent in a civil commitment hearing has the right to an attorney, that is not the case for the person or entity filing a commitment petition. The CCTF believes that the petitioner should also have representation.

Recommendation III.8. The Commonwealth should fund an attorney to represent the petitioner at all commitment hearings. [41]

Option III-8 (a). Choices for attorneys for petitioners should include city and county attorneys.

Option III-8 (b). In addition to the attorneys listed in Option III.8 (a), Commonwealth's Attorneys should be considered if no other attorneys are available to represent the petitioner. [42]

The principal reason for providing counsel for petitioners is to remove the Special Justice from the position of "needing" to assist the petitioner in presenting his or her case.

The CCTF considered some of the possible candidates for attorneys to represent petitioners. City or county attorneys represent CSBs. However, if they represent petitioners who are not CSB employees, there could be a conflict of interest. There would be no conflict if the CSB is the petitioner and, therefore, in such cases, the city or county attorney could be called upon to provide representation to the CSB petitioner at the hearing and upon appeal.

[41] Some CCTF members believe providing counsel for petitioners, especially if the Commonwealth's Attorney provides that representation is a bad idea.

[42] The appointment of a Commonwealth Attorney is opposed by some CCTF members due to the potential that this would be viewed as criminalizing the process.

Commonwealth's attorneys typically prosecute criminal cases. Their use could have the appearance of "criminalizing" the commitment process, further traumatize the respondent, and could possibly prejudice the Commonwealth's Attorneys against the respondent based upon prior encounters with that individual. On the other hand, requiring Commonwealth's Attorneys to provide the representation would provide consistency. This option provides the greatest economy since assistants are available, although additional assistants may need to be employed in localities with large volumes of commitment hearings.

Another alternative would be to appoint private attorneys who currently represent respondents in hearings. If the attorneys who serve as the respondent's counsel may also serve as counsel for the petitioner, there may be a higher number of disqualifications for conflicts if the attorney has previously represented either the petitioner or the respondent. However, this may be the only realistically available pool of attorneys to serve as counsel for petitioners.

F. Continuances

A Virginia Attorney General's opinion supports a continuance where the constitutional rights of a respondent are implicated.[43] Such a circumstance may arise when the respondent wants to retain counsel and that counsel cannot be present for the hearing within the TDO period. The respondent may thus waive his or her right to a hearing within the TDO period in order to employ counsel. The CCTF makes three Recommendations concerning continuances and where it was unable to reach consensus provides Options to be considered further.

Recommendation III.9. If the court grants a continuance on the request of a respondent, the court shall have the authority to order continuation of the respondent's detention until the hearing occurs, even if it occurs after the TDO expires. Any additional payments due to the facility shall be paid from the Involuntary Mental Commitment Fund. [44]

Option III-9 (a). If the court grants a continuance at the request of any party for good cause shown, the court shall have the authority to order continuation of the

[43] 1996 VA AG 154; 1996 VA AG 166,170

[44] Virginia's Involuntary Mental Commitment Fund ("IMCF") was created in the 1970s to facilitate de-institutionalization and operates under Virginia Code § 37.2-809 and intended to act as a payment source of last resort for individuals detained under a TDO show are uninsured or not fully covered for the costs incurred. Originally the IMCF was administered by DMHMRSAS but that function was transferred to the Supreme Court of Virginia in 1980. Joint Legislative Audit and Review Commission, *Availability and Cost of Licensed Psychiatric Services in Virginia*, Commission Draft (October 9, 2007), p. 80.

respondent's detention until the hearing occurs, even if it occurs after the TDO expires. Any additional payments due to the facility would be paid from the IMC Fund.

Option III-9 (b). If the court grants a continuance on its own motion, the court shall have the authority to order continuation of the respondent's detention until the hearing occurs, even if it occurs after the TDO expires. Any additional payments due to the facility shall be paid from the IMC Fund.

Recommendation III.10. If the court grants a continuance, the hearing shall be scheduled by the court in its discretion, but in no event shall the hearing be held later than forty-eight hours after the end of the TDO, weekends and holidays excepted.

Recommendation III.11. If the court grants a continuance, the report of the Independent Examiner must be redone if the rescheduled hearing occurs five days after the original report was prepared. The Independent Examiner shall be paid for the second evaluation.

G. Duration of the involuntary inpatient admission order

Under current Virginia law, an individual may be involuntarily admitted to an inpatient facility for up to 180 days. The CCTF agreed that, too often, longer than necessary orders for involuntary admission are issued and recommends that the bias should be in favor of the shortest possible involuntary commitments. It has two Recommendations reflecting this view:

Recommendation III.12. The original involuntary inpatient admission order should be interpreted to authorize a treatment facility to move a person subject to inpatient treatment to outpatient treatment when such a move is medically appropriate and all other conditions of outpatient treatment are applicable.

Recommendation III.13. The first order for involuntary inpatient admission in a particular episode of treatment should be for up to 30 days. Orders continuing the involuntary inpatient admission the first time should be for up to 90 and 180 days thereafter. Orders continuing involuntary inpatient admission for those completing a 180-day commitment may be issued for an additional 180 days. Orders continuing involuntary inpatient admission must be for up to the duration next in the sequence. Orders continuing involuntary inpatient admission must be based on the respondent's condition at the time of the subsequent commitment hearings and applied to the criteria for commitment. A treating facility must file a written petition for continuation of the involuntary inpatient admission at least 7 days before an existing order of commitment expires. A TDO is not required but all procedures required for the initial hearing in conjunction with a TDO are required for each hearing for continuation of involuntary inpatient admission. An individual subject to the order shall be offered the opportunity to accept voluntary treatment

at any hearing for continuation of the involuntary admission just as is required at the initial commitment hearing. (All times frames are to be considered as the maximum time permitted for involuntary inpatient admission; respondents can be discharged earlier if medically appropriate.)

Advantages

1. This provides greater flexibility for treatment.
2. A shorter initial commitment will result in more timely discharge planning.
3. It will provide hope to those subject to orders of involuntary inpatient treatment.
4. It may encourage the person's voluntary participation in treatment.
5. It may reduce the number of appeals.

Disadvantages

1. Subsequent involuntary inpatient admission orders that require the respondent to meet commitment criteria may result in continuation orders not being issued for some who may still need treatment, but who in a controlled environment are stable and do not meet commitment criteria.
2. It will increase the number of commitment hearings.

H. Location of Commitment Hearings

There is a difference of opinion concerning where commitment hearings should be held. Below are two Options:

Location Option 1. All hearings should be held at the facility where the person subject to the TDO is being detained.

Location Option 2. Hearings should continue to be held at any convenient facility or the court house.

I. Appeals

According to the Commission's Study of Commitment Hearings, May 2007, and discussions with individuals involved in the commitment process, appeals of commitment orders are very rare. There were only two appeals to circuit courts during the month of May. One controversial issue is whether petitioners should have a right to appeal when the petition is dismissed. The CCTF did not reach a consensus on a Recommendation on this issue. .

Appeals Option 1. Petitioners should have a right to appeal the decision of the commitment hearing.

J. Confidentiality:

The CCTF Procedure's Subcommittee discussed confidentiality recognizing that the Commission has established a Privacy Work Group that may issue recommendations. The following are some of the Options considered by the CCTF Subcommittee:

Confidentiality Option 1. TDOs should be sealed unless the respondent requests otherwise.

Confidentiality Option 2. The hearings should be open to the public without restriction. There is a constitutional basis for keeping the hearings open. (Some CCTF members believe that closing the hearings to the public provides potential for abuse of human rights and that there is no constitutional basis for closing the hearings.)

Confidentiality Option 3. The presumption should be that the hearings remain open to the public, but the Special Justice should be able to close them in the interest of respondent's privacy only when discussing the respondent's medical records and information. The decision to close the hearing may be on a motion from any party or on the Special Justice's own motion. The respondent should have the option to have any person present. An Attorney General's Opinion,[45] which supports closing hearings on an individual basis, should be codified in 37.2-820 and 16.1-345. The public should be excluded only when discussing the reports of the medical experts.

Confidentiality Option 4. The default position should be that the hearings are closed except to the public (aside from parties and witnesses) and that all records are confidential unless the respondent requests otherwise.

Confidentiality Option 5. If the records are not confidential by default, the special justice should be required to ask the respondent if the records should be sealed.

J. Reporting of Commitment Orders to CCRE

The Virginia Tech Review Panel report includes the following recommendation:

> ***IV-25: Virginia Code § 37.2-819 should be amended to clarify that the clerk shall immediately upon completion of the commitment hearing complete and certify to the Central Criminal Records Exchange, a copy of any order for involuntary admission or involuntary outpatient treatment.***

The Governor issued Executive Order 50 (2007) clarifying this issue. Assuming that the General Assembly decides that the Code ought to be amended, Section 37.2-819 could be

[45] 203 VA AG 124

amended to clarify the duties of the clerk in certifying orders of involuntary inpatient admission and mandatory outpatient commitment to the Central Criminal Records Exchange, and clarifying which clerk's responsibility it is, as follows:

> **The clerk <u>of the general district court in the locality that conducted the hearing</u> shall certify and forward ~~forthwith~~ to the Central Criminal Records Exchange, on a form provided by the Exchange, a copy of any order for involuntary admission to a facility <u>or order of mandatory outpatient treatment immediately following the commitment hearing</u>. The copy of the form and the order shall be kept confidential in a separate file and used only to determine a person's eligibility to possess, purchase, or transfer a firearm.**

The Virginia Tech Review Panel also recommended:

> IV-26: A comprehensive review of the Virginia Code should be undertaken to determine whether there exist additional situations where court orders containing mental health findings should be certified to the Central Criminal Records Exchange.

The CCTF does not recommend any further amendments.

CHAPTER IV. PROTECTIONS FOR SUBJECTS OF INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS

Individuals who find themselves the subjects of TDOs and involuntary inpatient admission orders lose not only their liberty but may face other disruptions in their lives as well. Some of these disruptions also apply to those ordered to mandatory outpatient treatment. During temporary detentions and involuntary inpatient hospitalizations, these individuals may as a result also face housing, financial and medical challenges. For example, some may be subject to eviction from their homes for non-payment of rent or foreclosure for non-payment of their mortgage, or discharge from an assisted living facility or nursing home. Individuals may also find themselves subjected to unwanted medications with both temporary and permanent side effects, some of which may be life threatening. In addition, they may be forced to pay the cost of unwanted treatment and medication provided in connection with the involuntary inpatient admission or mandatory outpatient treatment order.

The CCTF considered a number of issues that may adversely impact individuals caught up in the civil commitment process including:

- Monitoring medication for adverse side effects
- Payment for involuntary mental health services
- Right to notify designated person of status
- Protection from loss of housing
- Protection from adverse financial consequences
- Freedom from exposure to unreasonable risks while hospitalized

This Chapter will examine each and make recommendations, where possible, to mitigate these adverse consequences.

A. Monitoring Medication for Adverse Side Effects

Adverse side effects of medication are a major concern in treatment of major mental disorders, regardless of source of financing or legal involvement in the person's care. However, the legal and ethical concerns raised by the risk of medication-related harm are accentuated when the treatment is ordered over the patient's objection or when their capacity to provide informed consent is impaired. Some members of the CCTF believe that there is a special need for independent medical monitoring and follow-up of persons

who have been subject to commitment when that commitment includes treatment with antipsychotic medication. Although these concerns arise in cases involving extended hospitalization, judicially-mandated treatment in community settings under long-term orders presents new challenges. Accordingly, some CCTF members propose that the CSB overseeing the outpatient commitment process should contract with physicians to monitor each client's medical condition.

This issue also was referred to the Access Task Force for its consideration. Although agreeing that monitoring for adverse effects is important, the Access Task Force members believe that monitoring the effects of psychotropic medications is an integral part of the responsibilities of psychiatrists who are prescribing them and believe that superimposing another physician's judgment would serve only to cloud issues of responsibility while providing little protection to the patients.

Nevertheless, there is an existing infrastructure that provides some of this oversight and could be strengthened. The DMHMRSAS has established the Community Resource Pharmacy ("CRP") Pharmacy and Therapeutics Committee ("P&T") to review practice and medication distribution issues in the community services system. The CRP P&T Committee establishes guidelines and quality improvement recommendations, where appropriate, and recommends policy improvements to the DMHMRSAS Commissioner. The functions and objectives of the CRP P&T Committee follow:

A. Serves as a single accountable structure empowered to implement approved policies and practices in the community pharmacy system that supports consumer clinical needs.
B. Promotes and encourages a level of consistency and best practice among prescribing practitioners throughout the community system and facilities.
C. Ensures that access to pharmacy services is within policy guidelines and consistent throughout the community system.
D. Provides a review and advisory function regarding policy, funding and resource allocation, both regarding overall budgeting and regarding overall pharmacy operations.
E. Ensures that the Community Resource Pharmacy Formulary is well coordinated with the DMHMRSAS Facility formularies as applicable.
F. Serves as a source for Technical Assistance and Clinical Consultation to Community Services Boards and Behavioral Health Authorities as requested

The CRP P&T Committee is limited, however, to monitoring the prescribing practices of physicians for medications dispensed from the DMHMRSAS' Community Resource Pharmacy and only under very broad parameters, such as polypharmacy practices and generic versus branded drugs. It does this from an existing database of drugs ordered from the CRP, which is only a very small percentage of the medications prescribed by the CSB system. As a result, the CRP P&E Committee has no input directly or indirectly into

the prescribing patterns that pertain to medications dispensed outside of the CRP, which is by far the larger number.

P&T Committees at the state hospitals may also serve as models for the community system. In addition to monitoring and providing baselines for the prescribing practices of its physicians, it also assists in controlling spiraling pharmacy costs. P&T Committees are established pursuant to Virginia Code § 8.01-581.16, which recognizes such committees as "duly constituted by one or more public or licensed private hospitals, community services boards, or behavioral health authorities, or with a governmental agency." As treatment in community settings becomes more widespread, and the medical conditions of individuals served become more complex, community services boards may take advantage of the quality improvement and risk management advantages P&T Committees or private patient safety organizations provide.

Recommendation IV.1. As a result of the existing infrastructure at DMHMRSAS to monitor policies and practices in the community pharmacy system, the CCTF recommends that the DMHMRSAS continue to implement the Community Resource Pharmacy ("CRP") Therapeutics and Formulary Committee ("P&T") for reviewing practice and distribution issues and its use be expanded to monitor patients for adverse side effects as part of an overall quality assurance program. The CCTF further recommends that the CRP P&T Committee be statutorily established pursuant to Virginia Code § 8.01-581.16 and that the Community Services Boards be encouraged to participate in this or other regional or privately affiliated psychopharmacological review committees.

B. Payment for Involuntary Mental Health Services

CCTF members are uniformly troubled by the practice of requiring people involuntarily placed in a hospital or in outpatient treatment to pay their own money for unwanted treatment. Some members argued forcefully that the Commonwealth or CSB should pay for any involuntary treatment, including the costs of judicially-mandated medication.

This issue was also referred to the Commission's Access Task Force. Access Task Force members recognized that service bills, if not paid, can lead to credit problems for consumers and can also affect their ability to get affordable housing. However, they were concerned that this policy, if adopted, could create an incentive for consumers who would otherwise be seeking voluntary treatment to opt for involuntary status in order to avoid whatever costs they would incur as a voluntary patient. Proponents of the Commonwealth payment proposal were skeptical that patients would opt for involuntary status for this reason. Access Task Force members were also concerned that such a policy could pose a problem with Medicare and Medicaid rules that require equivalent policies on payment for those receiving services, and that it would jeopardize the ability of providers to recover their costs from third party payers.

Virginia Code Sections 37.2-511, 37.2-612 and 37.2-715 provide that the income and estate of a consumer is liable for the expenses of services provided by a CSB, Behavioral Health Authority ("BHA") or state facility. Sections 37.2-504(A)(7) and 37.2-605(9) require each CSB or BHA to prescribe a reasonable schedule of fees for services, although they are specifically prohibited from billing for services for time spent participating in commitment hearings. Similarly, the DMHMRSAS must investigate and determine the ability of consumers to pay the expenses of care, treatment, or training in state facilities. It is the State Mental Health, Mental Retardation and Substance Abuse Services Board's policy that all consumers be afforded services based on their identified needs and within available resources and that services cannot be denied to individuals who do not have the ability to pay. The Board requires each CSB to have reimbursement policies and procedures that specifically address ability to pay, but the criteria for determining ability to pay is at the discretion of each CSB. (Policy 6002 (FIN) 86-14)

In addition, Virginia Code § 37.2-808 provides that all expenses incurred in the commitment process, including the fees, costs and expenses, shall be recoverable from the subject of the examination, hearing, or proceeding or from his or her estate. The Code provides an exception from this requirement when no good cause for the person's admission exists or when recovery would create an undue financial hardship. Many CCTF members believe that it is patently unfair to require individuals who are involuntarily subjected to this judicial process to pay the costs of the process, especially when the financial burden of their illness is often overwhelming.

Recommendation IV.2. The DMHMRSAS and the CSBs should study the issue of consumer liability or responsibility for the costs of services received as a result of a court orders for involuntary inpatient admission or mandatory outpatient treatment and should identify mechanisms (e.g. uniform criteria that would be included in local reimbursement policies or ability to pay criteria) for adjusting or "writing off" the consumer's liability for such services while preserving the ability of providers to recover their costs for these services from third party payers. The Commission should also consider recommending the repeal of the provisions in Virginia Code § 37.2-808 requiring an individual who is the subject of civil commitment proceedings to pay the cost of the examination, hearing and proceeding.

Another issue that arises regarding payment is whether a period of involuntary admission should count against Medicare's lifetime limit of 180 days. This matter, however, is beyond the control of state law.

C. Right to Notify Designated Person of Status

It goes without saying that a mental health crisis can be disruptive for a person's personal affairs, and this disruption can be aggravated by involuntary hospitalization under a TDO and subsequent commitment orders. One way to ameliorate these adverse consequences is to assure that respondents in commitment proceedings have the opportunity to

designate a person to be notified of their whereabouts at all times including when they are transferred to a different facility.

The *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services* (Human Rights Regulations) that apply to all licensed programs providing mental health services provides:

> 7. Providers may encourage individuals to name family members, friends, and others who may be told of their presence in the program and general condition or well being. Except for information governed by 42 CFR Part 2, providers may disclose to a family member, other relative, a close personal friend, or any other person identified by the individual, information that is directly relevant to that person's involvement with the individual's care or payment for his health care, if (i) the provider obtains the individual's agreement, (ii) the provider provides the individual with the opportunity to object to the disclosure, and (iii) the individual does not object or the provider reasonably infers from the circumstances, based on the exercise of professional judgment, that the individual does not object to the disclosure. If the opportunity to agree or object cannot be provided because of the individual's incapacity or an emergency circumstance, the provider may, in the exercise of professional judgment, determine whether the disclosure is in the best interest of the individual and, if so, disclose only the information that is directly relevant to the person's involvement with the individual's health care.

12 Virginia Administrative Code (VAC) 35-115-80.B.

Although consumers have the right through the Human Rights Regulations to have whomever they choose be notified of their whereabouts at all times, including when they are transferred to a different facility, this right could be emphasized and clarified by including it in § 37.2-400 related to rights of consumers.

Recommendation IV.3. All health care providers should review their policies and procedures to ensure that they encourage individuals, unless clinically contraindicated, to designate family members, friends and others who may be told of their presence in or transfer to a facility so they may be available to provide support and assistance to this individual.

D. Protection from Loss of Housing

Loss of one's housing is one of the most worrisome possible consequences of involvement in the commitment process.

Recommendation IV.4. The Commission should consider additional protections to be included in the Virginia Code or applicable regulations to protect individuals

subject to temporary detention orders and orders for involuntary inpatient admission from eviction:

1. Apartments and other rental property:

In order to protect the individual from eviction or other adverse consequences related to his or her housing, Virginia Code § 55-248.33, which affords landlords with remedies for a tenant's absence, nonuse or abandonment of rental property, should be amended to exclude from the provisions of this section the circumstance in which an individual is the subject of a temporary detention order or order of involuntary inpatient admission entered pursuant to Virginia Code §§ 37.2-809 or 37.2-817.

2. Assisted Living Facilities:

In order to insure that individuals who are committed to involuntary inpatient treatment are not discharged from their assisted living facility, Virginia Code § 63.2-1805.A (7) should be amended as follows:

"The Board [of Social Services] shall adopt regulations…

7. Establishing a process to ensure that any resident temporarily detained in a facility pursuant to §§ 37.2-809 through 37.2-813 is accepted back in the assisted living facility if the resident is not involuntarily admitted pursuant to §§ 37.2-814 through 37.2-819 <u>or is involuntarily admitted and is discharged within 30 days</u>;"

3. Nursing Homes:

Section 32.1-138.1 related to transfer and discharge policies for nursing homes should be amended in a manner similar to the provision above relating to assisted living facilities. Because Medicare and Medicaid extensively regulate nursing homes, additional study may be needed to determine whether such a provision is permissible.

4. Group Homes:

A provision similar to the one above related to assisted living facilities should be added to § 37.2-400 related to the rights of consumers or included in the DMHMRSAS' *Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services* related to discharge contained in 12 VAC 35-105-860.

E. Protection from Adverse Financial Consequences

Financial problems can arise from prolonged hospitalization. When these problems are attributable to severe mental health problems that have led to involuntary hospitalization, legal relief should available:

1. Protection from default judgments.

Section 8.01-15.2 of the Virginia Code provides servicemen with relief from default judgments under the federal Servicemembers Civil Relief Act (50 U.S.C. § 527 et seq.). Section 8.01-428.A also permits a default judgment to be set aside upon proof that the defendant was, at the time of service of process or entry of judgment, a person in the military service of the United States. These sections could be amended to also prohibit default judgments from being entered against someone who has been temporarily detained or ordered to receive involuntary inpatient treatment under §§ 37.2-809 and 37.2-817, and to provide a mechanism to have the default judgment set aside if the person was detained or committed at the time served or when the default judgment was entered.

2. Protection of credit rating

Hospital or facility social workers and CSB case managers should be encouraged to inform the person's family members or friends of their presence to assist the individual with taking care of paying bills for housing, utilities and other necessities, if the person does not object. If there are no available family members or friends, such assistance should be provided by the social worker or case manager. If financial issues arise due to an involuntary inpatient hospitalization, the human rights advocate of the facility or CSB should assist in addressing these problems.

Recommendation IV.5. The Code of Virginia and applicable regulations should be amended to protect persons under TDOs or involuntary inpatient admission orders from loss of housing or other adverse financial consequences attributable solely to the occurrence of commitment proceedings and subsequent involuntary hospitalization or mandatory outpatient treatment.

E. Freedom from Exposure to Unreasonable Risks while Hospitalized

Virginia's Human Rights Regulations require providers to ask the individual to express his preferences about all aspects of services affecting him or her and to honor these preferences to the extent possible. (12 VAC 35-115-70.B.2) The Human Rights Regulations also give an individual the right to be protected from harm and to live in a humane, safe and sanitary environment. (12 VAC 35-115-50.B.2 and C.3).

Members of the CCTF raised some specific issues that can arise under this provision in the context of involuntary inpatient admissions. For example, providers should honor the individual's preference to be housed on a same sex unit if possible. This is not always possible due to the size and configuration of bed space in particular facilities. CCTF members also raised questions regarding whether patients involuntarily admitted under Title 37.2 should be placed on a unit with patients committed under Title 19.2 (committed from jails with criminal charges pending or committed after acquittal by reason of insanity). However a categorical rule requiring separation of patients may

violate the rights of insanity acquittees from the criminal justice system[46] ("NGRIs"), who, like those in the civil system, are entitled to treatment in less restrictive settings. This often involves transfers to civil units when NGRIs are ready for a less restrictive environment in preparation for discharge. Balancing of individuals' rights in mental health facilities coming from the civil and criminal systems is often a challenge.

[46] Those found "not guilty by reason of insanity."

CHAPTER V. INVOLUNTARY ADMISSION TO A FACILITY

For more than twenty years, many groups of people--state legislatures, staff at state agencies, attorneys, CSBs, mental health professionals, consumers, family members of consumers, and mental health advocates—have raised and debated questions related to involuntary commitment in Virginia. Reforming Virginia's involuntary commitment process is just one part of the integrated effort to improve mental health services throughout the state.

This Chapter will first briefly examine the history and development of civil commitment law in the United States, including the policy behind the current law as well as the issues that are currently in debate. Next, the Chapter will discuss the current commitment criteria for involuntary admission and offer three alternatives for changing them. It will then discuss the duration of orders of involuntary admission (now 180 days) and will conclude with a discussion of who should be considered an involuntary patient.

A. National Trends And Current Debates

Reforms in mental health law in the twentieth century have generally followed a cyclical pattern and are driven primarily by public perceptions and concerns. For example, in the early part of the Twentieth Century, there was greater public concern about whether the mentally ill were able to get needed treatment in a timely manner. As a result, police in many states were able to bypass the courts (at least for the initial emergency hospitalization) if two physicians certified that the patient met the involuntary commitment criteria. In contrast, by the 1930s, the public concern shifted to whether people were being unjustly detained, and reforms reflected the desire for procedural protections akin to those in the criminal justice system, such as the right to notice, the right to counsel, the right to confront and cross-examine witnesses, and the requirement of a warrant prior to detention. However, the substantive standard for commitment remained fairly broad -- whether the person was mentally ill and whether that person needed treatment.

The 1960s and 1970s saw a dramatic shift from prior criteria to the current standard that focuses on dangerousness. This shift accompanied a major transformation in public mental health services (typically called "deinstitutionalization") aiming to help people with mental illness receive treatment and rehabilitation in the communities where they reside. This overall development was set against a backdrop of revolutionary changes in constitutional law, most prominently the civil rights movement that aimed to protect disenfranchised groups, including persons with mental illness. The "dangerousness" standard for commitment, see, e.g., *Lessard v. Schmidt,* 349 F. Supp. 1078 (Wisc.1972)

signified an increased respect for individual liberty. By the end of the 1970s, nearly every state, including Virginia, had established tightened standards for involuntary commitment.

Beginning in the 1980s, however, psychiatrists and other mental health advocacy groups began to express dissatisfaction with the "dangerousness" standard and advocated a more therapeutic approach based on acute clinical deterioration and decline in functioning. The American Psychiatric Association championed this approach in a Model Act promulgated in 1982. Critics of the dangerousness standard argue that it is too narrow because it prevents the use of involuntary commitment until it is almost too late—or in many cases, when it is in fact too late. As Wisconsin psychiatrist Darryl Treffert described, under the current standard, people are "dying with their rights on." Another criticism of the current standard is that it channels people from the mental health system into the criminal justice system, where mental health issues are not adequately addressed. Those in favor of making involuntary commitment standards less restrictive point to certain clinical situations that highlight why this approach is necessary: lack of insight (anosognosia); a history of repeated hospitalizations; and symptoms that present a significant risk of harm such as co-occurring substance abuse.

Those who disfavor the use of involuntary commitment and oppose loosening the criteria point out that most people with mental illnesses are never involved in violent acts and that they are capable of weighing treatment options and making rational choices regarding their own treatment despite alterations in thinking and mood due to psychotic disorders.

This fundamental debate between libertarian and therapeutic approaches to commitment criteria has continued in more or less the same terms for the past 25 years. It comes as no surprise, then, that it was played out in the CCTF.

B. Interpretation of Virginia's Current Criteria

Under Virginia's present criteria for civil commitment, a person is subject to involuntary admission to a facility:

. . . if the judge or special justice finds by clear and convincing evidence that (i) 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 and (ii) alternatives to inpatient treatment have been investigated and deemed unsuitable and there is no less restrictive alternative to involuntary treatment . . .

Section 37.2-817.B. Code of Virginia, 1950, as amended.

The Commission's Stakeholder Attitude Study indicated widespread impression among

all stakeholders that the commitment criteria are not consistently applied throughout the Commonwealth, and that the term "imminent danger" is interpreted in different ways by different special justices. There are no appellate decisions interpreting the commitment criteria in Virginia to provide a guide.

The CCTF's own deliberations tended to reinforce the impression that the existing criteria are subject to varying interpretations. For example, discussions of whether the commitment criteria should be modified ultimately returned to a discussion of what the existing criteria mean and how they are currently being interpreted. Different CCTF members had different views and impressions about the intended meaning and current interpretation of each of the criteria. The requirement of "imminent danger to self or others" provides a good illustration. Some CCTF members believe that this time element focuses the decision-maker's attention on behaviors, actions or conditions occurring very near the time of the evaluation or the hearing and on whether harm is expected to occur within a very short time (a matter of hours) unless the person is hospitalized. Under this view, it might require a finding that the harm is likely to occur "immediately." Others think that this is not the correct interpretation. In fact, a Virginia Circuit Court Judge has opined, "an imminent danger is a danger which is likely to occur within a reasonably short, but not immediate period of time unless appropriate treatment is provided." Still others think that even this interpretation is too narrow because it does not permit involuntary treatment in cases in which the respondent is losing control over his or her behavior and that the course of illness is likely to continue to decline, creating a significant risk of dangerous behavior within the foreseeable future (e.g., a week) absent intervention.

Another issue raised by the language in the commitment criteria is what "danger" means. One CCTF member referred to a police training document prepared by a Virginia county mental health department, which stated that a finding of imminent danger requires "clearly verbalized, or actual, threats to self (suicidal) or others (homicidal) behavior" due to mental illness. Most CCTF members believe that this interpretation is too narrow and other serious harm is included.

Of course, these discussions also tend to be confounded by the stakeholder's opinion regarding whether a more or less expansive interpretation is desirable from a policy standpoint. Some think a more expansive understanding is necessary to reduce unacceptable risks of harm to the patients while other CCTF members think that the requirement of "immediacy" helps to avoid a slippery slope toward commitment of a large number of cases where the need for treatment is neither urgent nor necessary for the protection of the individual or the public.

Similar differences of opinion arise regarding the proper interpretation of the statutory language permitting commitment of a person who is "so seriously mentally ill as to be substantially unable to care for himself" -- an exercise of the Commonwealth's *parens patriae* power to protect persons who cannot care for or help themselves. What functional impairments are relevant? What level of impairment is substantial"? Is this

phrase equivalent to "gravely disabled" under the laws of other states? What conditions does it include? Does it encompass individuals with dementia? People with a primary diagnosis of mental retardation with secondary mental illnesses? People with mental illnesses who fail to attend to serious physical conditions (*e.g*. diabetics, heart patients, patients with kidney failure *etc*.)?

The uncertainty about the meaning of the "inability to care" criterion is an important issue because most commitments are based on this criterion: The Commission's Hearings Study in May, 2007 showed that more than one-half of court orders for involuntary inpatient admission were based *solely* on the individual's inability to care for himself.

When laws are subject to such different interpretations, and can be applied differently even when the same language is used, the value preferences of the individual judges are likely to play a greater role than they would under a more determinate legal standard. That is especially true in the context of involuntary mental health treatment where studies have repeatedly shown that people differ in their biases along a "paternalistic"/"libertarian" dimension. When is it appropriate for the State to step into a person's life and compel that person, over objection, to submit to mental health treatment? Any time that such treatment is considered to be beneficial for the person? Or only when detention and forced treatment is clearly necessary for his safety and that of the community?

Given the variety of interpretations, the vagueness of some of the statutory language, the differences in value preferences among all participants in the commitment process, and the absence of clarifying appellate interpretations, it is inevitable that special justices (and CSB prescreeners and Independent Examiners) are interpreting and applying the statutory criteria in different ways. The CCTF has no direct evidence of these variations since the Special Justices have not been asked to make a commitment determination based on the same evidence about the same case. However, indirect evidence of such variation is available from the Commission's Hearing Study which shows that the rate of involuntary commitment and the rate of dismissal each vary very widely from locality to locality. It is highly unlikely that such variations could be explained by differences in the clinical characteristics of the respondents (all of whom were subject to prescreening and under TDO) or to systematic variations in the evidence introduced that would skew the results in one direction (dismissal) or the other (commitment).]

C. Options Regarding Changing the Commitment Criteria

The CCTF examined and deliberated at length on the existing criteria, as well as several proposals for change in the criteria, all described below. The CCTF did not reach consensus on selection of a particular proposal. Instead, the CCTF has developed three options for the Commission to consider. Option 1 would leave the current criteria unchanged while aiming to facilitate consistent interpretation and application of the law. Option 2 would substantially revise the current criteria for the dual purposes of providing

greater specificity and avoiding unduly restrictive interpretations. Option 3 would build on Option 2 by adding a new ground for inpatient commitment based on a therapeutic perspective.

Commitment Criteria Option 1. Retain Existing Criteria while Taking Steps to Promote Greater Consistency in Interpretation

Some members of the CCTF favor maintaining the current commitment standard unchanged. They believe that the current law has served the Commonwealth well since it was enacted in 1974, and that any uncertainties in its interpretation would be better handled by improved training and more active use of guidelines rather than by revising the statutory criteria.
They point out that Special Justices, magistrates and CSB prescreeners all have been trained in and have had years of experience using existing commitment criteria. Even if they are not giving the statute a uniform interpretation, the situation can be improved through collegial training; and a revised statute could result in even less consistent application of commitment law.

Those who oppose proposals to revise the criteria argue that the uncertainties about their meaning can be clarified through training. For example, they argue that people who claim that the "inability to care for self" criterion is too broad fail to address the language permitting commitment only if the person is specifically found to be *so seriously mentally ill* as to be substantially unable to care for himself (emphasis added). Also, they suggest that proposals to specify particular functional impairments could end up making the criterion too narrow. They argue, the terms of this criterion are sufficiently broad to meet a wide variety of factual circumstances, yet do not require the Commonwealth's intrusion into personal liberty where the individual has the ability, even if less than optimal, to care for himself. These CCTF members emphasize that the Commonwealth may constitutionally exercise its powers to deprive persons of their freedom only for the safety and protection of the community, and not simply to treat and improve, as others see it, the conditions of those who suffer from mental illness.

To the extent that the criterion is subject to unreasonably broad interpretation, proponents of leaving the criterion unchanged suggest that training protocols can provide more guidance as to what factors should be considered, such as inability or failure to provide himself the essential human needs of food, clothing, shelter and medical care. Some CCTF members believed that other elements could include history of multiple hospitalizations, decisional incapacity (especially regarding treatment decisions), severe mental or physical deterioration of the person's ability to function independently (excepting reasons of indigence) or to provide for their basic needs.

As discussed below, some CCTF members believe that the dangerousness criteria should be made less restrictive by removing the term "imminent." These CCTF members stated that the focus on imminence is being interpreted by some decision-makers as precluding

commitment of persons whose actions or behaviors are dangerous but do not meet this exacting time frame because they equate "imminence" as "immediate." Some believe that use of the term "danger" also sets too high a threshold for determination of the need for treatment, and that a standard, discussed in Option 2 below, using the criteria of physical harm would be more workable. In response, proponents of retaining the existing language suggest that it would be better to take steps in training to discourage unusually restrictive interpretations, such as the idea that "danger" refers only to suicide and homicide or the idea that "imminent" means "immediate." Similarly, training protocols could indicate that "danger" includes property damage or serious bodily harm, and that any recent acts or threats of such harm should be taken into account.

Overall, then Option 1 could be summarized as the "retain but train" option.

Commitment Criteria Option 2. Revise current commitment criteria to provide greater specificity and avoid unduly narrow interpretations

Some members of the CCTF believe that the current criteria for inpatient commitment are unnecessarily vague and confusing, and are probably being applied in an unduly restrictive manner in some jurisdictions. They believe that improved training or statutory guidance to the judge or special justice cannot resolve the fatal ambiguities in the law, and that substantial revision of the commitment criteria is necessary. These members favor revising the statute as follows:

A person may be involuntarily admitted to a psychiatric inpatient facility for treatment upon a finding of the court by clear and convincing evidence that:

(1) He or she has a mental illness and as a result of such mental illness:

(a) there is a substantial likelihood that in the near future he or she will cause serious harm to himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; or

(b) there is a substantial likelihood in the near future that he or she will suffer serious harm due to substantial deterioration of his or her capacity to protect himself or herself from such harm or to provide for his or her basic human needs; and

(2) All available less restrictive treatment alternatives, which would offer an opportunity for improvement of his or her condition, have been investigated and judged to be inappropriate.

There are four key features of this proposal in relation to the existing statute:

(1) The proposal replaces the term "danger" with the phrase "substantial likelihood that . . . he or she will cause serious physical harm."

Proponents of Option 2 argue that the term "danger" is excessively vague on two crucial grounds. It provides no indication of *how likely* the anticipated harm must be, and no indication of *how serious* that harm must be in order for commitment to be justified. In contrast, the proposed language specifies that the harm must have a "substantial likelihood" of occurring, not just any likelihood, no matter how small. It also specifies that the harm must be of a "serious physical" nature - trivial harm, or emotional harm, will not qualify. But neither is it necessary that the harm be lethal, as in suicide or homicide. While the proposed language is still subject to interpretation, some CCTF members believe that it is much more straightforward than the current statute's cryptic reference to "danger," and that further specificity (*e.g.* it is "more likely than not" that harm will occur) is unworkable.

Members of the CCTF who favor the "retain but train" option argue that these changes basically substitute one vague phrase for another. For example, the phrase "serious physical harm" is subject to wide, varied and inconsistent interpretation. One person's "serious" harm is but a minor one to another, as with a bruise, they point out. Also, they observe that the CCTF's discussion of the terms "substantial likelihood" ended with no agreement as to what it means. For example, they say, "likelihood" has no clinical definition and "substantial likelihood" does not describe what degree of probability the court is required to find that harm will occur: it could mean more or less than a fifty percent (50%) chance. It could be defined to mean a twenty percent (20%) probability. Finally, they argue that introducing the wildcard of "substantial likelihood" into the commitment criteria muddies the clear and convincing proof required to determine the need for involuntary commitment. See *Addington v. Texas*, 441 U.S. 418, 423 (1979).

(2) The proposal replaces the term "imminent" with the phrase "in the near future."

Proponents of this change argue that the term "imminent" can be understood to mean that the harm is anticipated to occur "immediately." Indeed, among the definitions for "imminent" given at dictionary.com are "likely to occur at any moment" "impending: her death is imminent," and "about to occur." Most CCTF members seem to agree that "immediate" is an unduly narrow interpretation. As noted above, the question is whether a statutory modification is the most sensible response. Proponents of Option 2 point out that very few states require a showing of "imminent" danger and argue that this important matter should not be left unresolved or in the hands of collegial guidance and training. If the term "imminent" is erased, however, some substitute term or phrase is needed so that the time frame for the anticipated harm is not open-ended. Thus, Option 2 specifies that the harm must be anticipated "in the near future," indicating that harm believed likely to occur in the distant future will not qualify for commitment, while any further specificity (*e.g.* "in the next 24 hours") is unworkable. A significant consideration to adoption of the proposed language is that mental health experts generally concede their inability to forecast an individual's dangerous behavior beyond a few days, and certainly less than one week. Nonetheless, some CCTF members object to the "near future" formulation because it could be interpreted to encompass weeks or even months.

(3) The proposal specifies that substantial likelihood of serious harm must be evidenced by recent behavior causing, attempting or threatening such harm.

Proponents of Option 2 argue that the current statute gives no indication of what constitutes acceptable evidence for arriving at the conclusion that a person is "dangerous." The proposed language specifies that a substantial likelihood of future harm must be "evidenced by recent behavior causing, attempting, or threatening such harm." The phrase "recent behavior" implies that long ago harmful acts do not justify commitment. The terms "causing", "attempting" and "threatening such harm" imply that both some overt act or statement indicative of harm must be documented, and that harm itself need not have occurred in order for commitment to be justified - an attempt or threat of harm will suffice as evidence.

CCTF members opposed to this proposal do not believe that threats standing alone should constitute sufficient grounds to deprive one of his liberty. Indeed, what constitutes a threat is often a matter of context and interpretation. The power to detain for speech may easily be abused, they argue, especially where the proof of the language used is contested. They contend that the term "recent behaviors" is also overly vague and subject to misapplication, both as to the time frame concerned, which is not defined with any degree of certainty, and actions which may reflect mental illness but give no indication of harm.

(4) The proposal replaces the phrase "substantially unable to care for himself" with the phrase "suffer serious harm due to substantial deterioration of his or her capacity to protect himself or herself from such harm or to provide for his or her basic human needs."

The current statute does not specify what it means for a person to be "unable to care for himself." Proponents of Option 2 seek to provide greater specificity regarding the circumstances under which a protective intervention is justified. The proposal focuses on the outcome that this prong of the commitment standard seeks to avoid: "harm" to the individual. It specifies that the harm must be "serious," but does not further specify that the harm must be physical in nature, thereby leaving open the issue of whether other forms of serious harm would qualify (*e.g.* serious financial harm that could result from a person spending his or her life savings while in a manic state). The proposal also specifies that the cause of the serious harm must be one of two things: either a "*substantial deterioration of his or her capacity to protect himself or herself*" (*e.g. wandering* in traffic), or a "*substantial deterioration of his or her capacity to . . . provide for his or her basic human needs*." The proposal does not limit these basic human needs to food, clothing or shelter, thereby leaving open the issue of whether other human needs, *e.g.* life-saving medical care, qualify as basic.

CCTF members who prefer to retain the existing inability to care standard make three arguments. First, they argue that the current language is not as open-ended as the critics

claim. They emphasize that the statute now requires the court to find from evidence presented that a person is *so seriously mentally ill* as to be substantially unable to care for himself. Second, they argue that the proposed phrase is itself vague and offers no advantage over the existing language. Specifically, the phrase "*substantial deterioration of his or her capacity to . . . provide for his or her basic human needs"* does not detail or describe what those basic human needs are. Third, they argue that the proposed language permitting hospitalization for financial actions may subject persons subject to not only detention, but also inpatient hospitalization for purchases that are legal for all other persons if this is considered by an expert to be "a substantial deterioration of his or her capacity to protect himself."

In sum, Commitment Criteria Option 2 offers a reformulation both of the existing criteria – dangerousness and inability to care for oneself. Obviously the Commission may choose to adopt only one or the other of the two components of Commitment Criteria Option 2. As a result, Commitment Criteria Option 2 encompasses three different options:

Commitment Criteria Option 2A. Change both the dangerousness and inability to care criteria as proposed in paragraphs (1)(a) and (1)(b);

Commitment Criteria Option 2B. Change the dangerousness standard only, as proposed in paragraph (1)(a);

Commitment Criteria Option 2C. Change the inability to care standard only, as proposed in paragraph (1)(b).

Commitment Criteria Option 3. Substantially Revise Current Commitment Criteria, and Add a New Ground for Commitment

Of CCTF members who favor substantial revision of the current commitment criteria, some would revise the criteria more fundamentally than Option 2 by introducing a new and more therapeutically-oriented ground for involuntary commitment that focuses on the concept of "deterioration" rather than "danger" or "harm." These CCTF members endorse Commitment Criteria Option 2 but would augment the criteria in paragraph (1)(a) and 1(b) with a third ground for inpatient commitment as follows:

A person may be involuntarily admitted to a psychiatric inpatient facility for treatment upon a finding of the court by clear and convincing evidence that:

(1) he or she has a mental illness and as a result of such mental illness:

(a)…
(b)…; or

(c) he or she is unable to comprehend the nature of his or her illness or the need for

treatment, is experiencing a substantial impairment of his or her judgment, reasoning, or behavior, and will, if not treated, suffer or continue to, suffer a substantial deterioration in his or her previous ability to function in the community.

According to its proponents, Commitment Criteria Option 3 would allow for the treatment of individuals with severe mental illness who are not necessarily in a situation of acute risk of harm to themselves or others, but whose illness causes them to have significant cognitive deficits or lack an awareness of having an illness, and who are not able to be treated in the community even with the assistance of family, friends, or clinical outreach programs.

They develop this position as follows: A significant percentage of the homeless and correctional populations consist of individuals with untreated major mental illness. Some of these individuals might be reached through an expansion in community resources, and in particular through housing and outreach services, but many individuals fail to take advantage of these resources even when they are offered.

The classic example is the Joyce Brown case in New York, which involved a forty-year-old homeless woman who lived year-round on the street, where she was noted to be dirty and disheveled, smelled of urine and excrement and used sexually explicit language and exposed herself to passersby. Social service professionals diagnosed her as having a major mental illness that was causing this behavior and she appeared to be deteriorating over time. The New York City Health and Hospital Corporation sought to have Ms. Brown involuntarily committed for care and treatment, opining that such treatment was essential for her welfare, while the New York Civil Liberties Union opposed hospitalization, arguing that she wasn't dangerous or unable to care for herself. The court battle essentially centered on whether or not the behaviors described above could be construed as dangerous to herself or others, while it appeared to several commentators at the time that a more *appropriate* argument would have centered on whether or not (1) she had a mental illness, (2) whether such an illness could potentially benefit from treatment, and (3) whether she was capable or incapable of providing (or refusing to provide) valid informed consent for treatment.

Mental health clinicians not uncommonly encounter similar complaints from families. For example, CCTF member Pete Early has written movingly about similar experiences in seeking treatment for his son and of his having had to "make the case" for his son being acutely dangerous or unable to care for himself when it was clear to all observers that his son was both experiencing active symptoms of a major mental illness and also was demonstrating quite impaired decision-making with regard to his treatment options. Families in such circumstances frequently are advised to not seek a detention order "too soon," as it may be hard to make a strong enough case for dangerousness, but not to wait until it's "too late," as their family member may be arrested rather than hospitalized, after having engaged in violent or disruptive behavior.

Proponents of Commitment Criteria Option 3 point out that several other states over the

past several years have adopted commitment criteria that allow for a greater emphasis on *parens patriae* principles in similar ways to this proposal. To give a few examples, Hawaii has "dangerousness" and "gravely disabled" criteria, but also allows for commitment of those who are "obviously mentally ill," which the statute defines as

"a condition in which a person's current behavior and previous history of mental illness, if known, indicate a disabling mental illness, AND the person is incapable of understanding that there are serious and highly probable risks to health and safety involved in refusing treatment, the advantages of accepting treatment, or of understanding the advantages of accepting treatment and the alternatives to the particular treatment offered, after the advantages, risks, and alternatives have been explained to the person."

Similarly, Washington State's definition of "gravely disabled" includes a definition involving inability to meet one's basic human needs, but *also* provides a second definition, in which the individual "manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." This language also is similar to the approach and language contained in the American Psychiatric Association Model Civil Commitment Law, indicating that this is not simply a minority view, but is an approach to civil commitment that has been advocated for years by the nation's largest psychiatric organization.

Finally, proponents of Commitment Criteria Option 3 note that these criteria echo the recommendations of the National Alliance of the Mentally Ill (NAMI), the nation's largest grassroots mental health organization. NAMI's Policy Platform, while recognizing that whenever possible, people with mental illness should be treated as outpatients or as inpatients on a voluntary basis, recommends:

States should adopt broader, more flexible standards that would provide for involuntary commitment and/or court ordered treatment when an individual, due to mental illness is gravely disabled, which means that the person is substantially unable, to provide for any of his or her basic needs, such as food, clothing, shelter, health or safety; or is likely to substantially deteriorate if not provided with timely treatment; or lacks capacity, which means that, as a result of the brain disorder, the person is unable to fully understand–or lacks judgment to make an informed decision about–his or her need for treatment, care, or supervision.

Current interpretations of laws that require proof of dangerousness often produce unsatisfactory outcomes because individuals are allowed to deteriorate needlessly before involuntary commitment and/or court-ordered treatment can be instituted. When the "dangerousness standard" is used, it must be interpreted more broadly than "imminently" and/or "provably" dangerous.

Members of the CCTF opposed to Commitment Criteria Option 3 argue that the proposed

standard is unconstitutionally overbroad because it authorizes involuntary commitment for those who are able to maintain themselves safely in freedom, though at a level that friends and family members do not approve of. In support, they rely on the United States Supreme Court's decision in *O'Connor v Donaldson* (1975). In this case, Kenneth Donaldson had been confined for 15 years without meaningful treatment or other rationale for hospitalization. At the time that he was appealing his commitment, he also did not appear to be incompetent to make treatment decisions. He also had friends and family willing to help support him. (In other words, this was not a "Joyce Brown" scenario.) The Supreme Court observed "[a] finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement" and continued:

May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends. (citation omitted) *O'Connor v. Donaldson*, 422 U.S. 563, 575-576 (1975).

Opponents of Commitment Criteria Option 3 argue that commitment should require a showing of danger or incapacity for self-care to commit. The aim of treating those who lack insight or capacity is laudable, but misplaced, they argue, because current law already provides protection for persons who are incapable of caring for themselves. The potential harm is that those who function at a level different from past performance may be involuntarily committed even though they pose a danger to no one and are able to care for themselves without assistance in the community. Members opposed to Option 3 find its sweep unnecessarily broad, and doubt its constitutionality.

Whether *Donaldson* precludes a deterioration criterion has been debated for almost 30 years. Some argue that the quoted language requires a showing of danger or incapacity for self-care. However, others point out that the Court was not necessarily going as far in this decision as to say that that a commitment statute involving pure *parens patriae* concerns would be unconstitutional.

They point to the following passage in the Court's opinion:

"The jury found that Donaldson was neither dangerous to himself nor dangerous to others, and also found that, if mentally ill, Donaldson had not received treatment. That verdict, based on abundant evidence, makes the issue before the Court a narrow one. We need not decide whether, when, or by what procedures, a mentally ill person may be confined by the State on any of the grounds which, under contemporary statutes, are generally advanced to justify involuntary confinement of such a person - to prevent injury

to the public, to ensure his own survival or safety, *or to alleviate or cure his illness [emphasis added]*. For the jury found that none of the above grounds for continued confinement was present in Donaldson's case."

In short, the Court stated, "a state cannot constitutionally confine *without more* a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." (Emphasis added).

Chief Justice Burger's concurring opinion in this case emphasized this last point as well, noting that
"it is universally recognized as fundamental to effective therapy that the patient acknowledge his illness and cooperate with those attempting to give treatment; yet the failure of a large proportion of mentally ill persons to do so is a common phenomenon. It may be that some persons in either of these categories, and there may be others, are unable to function in society and will suffer real harm to themselves unless provided with care in a sheltered environment. At the very least, I am not able to say that a state legislature is powerless to make that kind of judgment."

Proponents of Commitment Criteria Option 3 argue that these comments indicate that the *Donaldson* decision was restricting itself to the non-dangerous, competent, patient who is receiving no effective treatment in the hospital and who could survive safely in the community. The Court refrained, they argue, from commenting on a *parens patriae* commitment statute involving the patient who *cannot* competently make treatment decisions and whose illness *could* potentially benefit from inpatient treatment.

Professor Bruce Winick, in his book *Civil Commitment* (2005) has argued that a *parens patriae* standard would be constitutional, provided that it didn't offend the Fourteenth Amendment constitutional limits on state authority involving due process (i.e., the state must justify the deprivation of liberty on a legitimate government objective) and equal protection (i.e., the state must demonstrate, for example, that patients with a "psychiatric" illness aren't being discriminated against, compared to patients with a "medical" illness). He opines that in order to meet these standards, a *parens patriae* statute must demonstrate that the individual in question not simply have mental illness or to have an illness that might benefit from hospitalization or treatment, but also must be found to lack the competence to make autonomous decisions about hospitalization.

The proposed criterion -- paragraph (1)(c) -- therefore requires that the individual not only (i) have a mental illness, but also (ii) be unable to comprehend the nature of his or her illness or the need for treatment, and (iii) be so substantially impaired with regard to his or her judgment, reasoning, or behavior, and that they will continue to suffer or will suffer a substantial deterioration in his or her previous ability to function in the community. In addition, (iv) there has to be no less restrictive alternative to inpatient hospitalization.

The language of the proposed statute would prevent this from being applied, for example,

by a parent to a child who merely has chosen a lifestyle with which the parent disagrees, since it still would have to be demonstrated by clear and convincing evidence that the child's deterioration is substantial, that the deterioration is the result of a mental illness (and not simply a lifestyle choice), and that the child is incompetent to make autonomous decisions about medical treatment. The deterioration standard is meant to further *restrict* paragraph (1)(c), not to be a criterion *in itself*.

D. Duration of Involuntary Admission To a Facility

It is generally agreed that it is not clinically necessary to allow inpatient commitment for up to 180 days in the usual case. The average length of stay is in the range of a week. The Task Force generally favors reducing the period of an initial commitment order substantially, perhaps to 30 days. In the few cases in which long-term commitment is needed, the subsequent commitment order could be for 90-180 days.

E. The Meaning of Involuntary Admission

Members of the CCTF uniformly support a policy preference in favor of voluntary admission for individuals who are willing and capable of accepting voluntary admission. Voluntary admission carries several benefits as compared to involuntary admission. It upholds patient's autonomy in the admissions process by allowing patients rather than judges to make decisions about admissions. Voluntary patients' rights are maximized, including the right to request discharge. There is reduced stigma associated with voluntary psychiatric admission similar to admission to a medical or surgical unit. Some patients who do not meet criteria for involuntary admission may volunteer for admission, thus broadening access to care. Most importantly, voluntary admission encourages a collaborative relationship between patient and treatment provider, rather than the adversarial relationship encouraged by the civil commitment process. Voluntary admission may lead to more favorable treatment outcomes. Voluntary admission avoids the expense associated with requiring a judicial determination for all admissions. The current statute properly requires that all persons subject to involuntary admission be given an opportunity to agree to a voluntary admission, assuming that they are willing and capable of doing so. [47]

Against this backdrop, two issues must be addressed: (1) what should be the criteria governing *voluntary* admission to an acute care psychiatric facility? This issue is addressed by the CCTF on Access to Services. For purposes of this Chapter, the CCTF assumes that voluntary admission to a facility is available to people who need to be stabilized in a hospital setting, even though they do not pose a danger to anyone or satisfy the criteria that would have to be met for involuntary admission. (2) What criteria should

[47] See Section 37.2-814.B. Code of Virginia, 1950, as amended.

be used for a person who lacks the capacity to make an informed treatment decision? Specifically, *should a person "who lacks the capacity to consent to consent to voluntary admission" be regarded as an "involuntary admission"*?

In *Zinermon v. Burch*, the Supreme Court stated that [a] person who is willing to sign forms but is incapable of making an informed decision is . . .in danger of being confined indefinitely without benefit of the procedural safeguards of the involuntary placement process, a process specifically designed to protect persons incapable of looking after their own interests." 494 U.S. 113, 133 (1990). No one disagrees with the Supreme Court's judgment that admission procedures must be designed to protect the interests of a patient who lacks the capacity to protect his own, both during and after the admission process. The questions left unresolved by the Supreme Court are (1) whether a person who lacks the capacity to give informed consent to admission or otherwise to make treatment decisions should be regarded as an "involuntary" patient and therefore subject to the involuntary commitment criteria rather than the more therapeutically oriented criteria that ought to govern voluntary admissions; and (2) whether the procedures used for such admissions should be the same as those governing involuntary admissions.

The CCTF did not take a position on these issues. Strong arguments can be made for not classifying such admissions as involuntary and for using more flexible admission criteria. However, current practice appears to be to treat these cases as involuntary under the "inability to care for self" criterion. If the Commission prefers to continue the present practice, the statutory basis for doing so could be clarified by defining involuntary admission as follows:

"Involuntary admission to a psychiatric inpatient facility refers to the admission of a person who has refused voluntary admission after sufficient explanation of the purpose of admission, or to the admission of a person who lacks the capacity to consent to voluntary admission."

However, alternative approaches may also be suitable, such as use of the guardianship law to achieve "voluntary" admission in cases involving non-protesting patients who lack the capacity to consent to voluntary admission. Current law precludes guardians from admitting their wards to a mental health facility as a voluntary admission, and therefore squeezes these cases into the involuntary admission provisions. The Commission may want to consider allowing admission by a guardian with specified safeguards.

CHAPTER VI. MANDATORY OUTPATIENT TREATMENT

Mandatory outpatient treatment ("MOT"), as an alternative to involuntary inpatient admission, has long been authorized under Virginia law, but it has not played a significant role in Virginia's system of mental health services. Data from the Commission's Hearing Study indicates that MOT was only ordered 5% of the time. Even this low figure probably overstates its customary usage since the Commissions Hearing Study was conducted during the period of time immediately following April 16, 2007, the day of the mass shootings at Virginia Tech. During that post-Virginia Tech period, the DMHMRSAS and the Office of the Attorney General were receiving anecdotal reports of significant increases in outpatient commitment statewide and numerous questions concerning procedures to implement monitoring and enforcement of MOT orders. So significant was the volume of the post-Virginia Tech questions that the DMHMRSAS Commissioner issued a *Guidance to Community Services Boards and State Hospitals Regarding Involuntary Outpatient Commitment and Implementation of IOC Orders* on July 24, 2007 to provide guidance in those areas of practice where Virginia law is silent. There is no reason to assume, however, that the volume of MOT orders has increased from the 5% volume reported in in the Commission's Hearings Study.

In his report issued in 2005 on the Review of the Virginia Community Services Board Emergency Services Program (the "IG CSB Report"),[48] the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services found that the majority of CSBs do not provide a comprehensive range of crisis intervention services. Although he found almost all CSBs offered the least restrictive Crisis Response, Resolution and Referral Services and the most restrictive Inpatient Hospital Services, very few offered the critical mid-range Community Crisis Stabilization Programs that effectively stabilize difficult crisis situations in the community. As a result of this absence of community-based services, the Inspector General found a greater dependence on inpatient hospital care. The Inspector General also found that when CSBs do offer Crisis Services, capacity limitations significantly restrict service effectiveness, especially in rural areas. He further found that Non-Emergency Support and Clinical Services provided in the community, such as Programs of Assertive Community Treatment ("PACT")[49], residential services,

[48] OIG Report #123-05, http://www.oig.virginia.gov/documents/SS-ESPFinalReportMay-August2005.pdf

[49] PACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illness. It is not case management but a multidisciplinary approach for providing individuals with treatment in their own homes and communities. See www.nami.org for more information.

and medication, do not have adequate capacity. As a result, emergency services workers deal with crisis situations that could have been prevented if the consumer had received more intensive or a different array of community-based services.

The Inspector General followed the IG CSB Report with a Survey of Outpatient Service Capacity and Commitment Hearing Attendance.[50] The Inspector General's report, issued September 17, 2007 (the "IG Outpatient Report"), revealed that two of the 40 CSBs do not offer any outpatient services to adults, defined as regular or post-emergency appointments with clinicians. Three of the 40 CSBs do not offer regular psychiatric outpatient services to adults, although all CSBs do offer some form of post-emergency outpatient services.

In addition, the IG Report notes that adults seeking outpatient appointments with clinicians and psychiatrists have long waits for initial appointments and the wait times vary tremendously among the CSBs. Wait times for regular appointments with clinicians range from 7 to 85 days; post-emergency appointments with a clinician range from 1 to 46 days; regular appointments with a psychiatrist range from 5 to 90 days; and post-emergency appointments with psychiatrists range from 0 to 42 days. (As bad as the situation is with adults, service capacity for children and adolescents is much worse.) Notwithstanding the long-documented community-based mental health services limitations,[51] the Inspector General found that over the past 10 years outpatient treatment capacity for adults actually *decreased* at 60% of the CSBs. Reasons given included diversion of funding and staff to other populations with mental health needs identified as a priority by the Commonwealth, primarily those with long-term mental illness and those ready for discharge from state hospitals; decrease in funding from one or more targeted sources; and static funding from one or more sources.

Based on the above, it is apparent that one key reason why MOT is not more widely used in Virginia is that CSBs lack the capacity to provide and monitor outpatient treatment. However, proponents of increasing the use of MOT have argued not only that it should be more widely used as an alternative or supplement to inpatient commitment, but also that it should be used as a mechanism for preventing deterioration that can lead to hospitalization. Whether and under what circumstances MOT should be utilized has been under study in Virginia since the 1990s,[52] and interest has intensified in recent years

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[50] OIG Report #141-07, http://www.oig.virginia.gov/documents/VATechRpt141-v2.pdf.
[51] See Figure I-1 Consensus Recommendations from MHMRSAS Legislative Studies Report to the General Assembly Health, Welfare and Institutions Committee as published in the Access Task Force Report; see, also OIG Report # 128-06; OIG Report # 129-06.
[52] *Mandatory Outpatient Treatment: A Legislative Proposal for Virginia* prepared by the Institute of Law, Psychiatry and Public Policy for the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (1998); The Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services House Document 77 (1998); Report of the Joint Subcommittee to Evaluate the Future

based on the experiences with MOT in other states. The CCTF deliberated extensively on this matter.

The Panel Reviewing the Mass Shootings at Virginia Tech (the Review Panel") issued its report on August 30, 2007 ("Review Panel's Report"). A key finding in the Review Panel's report was that although MOT was ordered for Seung Hui Cho," the order provided no information regarding the nature of the treatment other than to state that Cho was "to follow all recommended treatments." The MOT order neither specified who was to provide the outpatient treatment nor identified who was to monitor the treatment. As a result, there was little accountability when Cho failed to obtain follow-up treatment. The Review Panel's Report includes a number of recommendations for changes to the involuntary detention and civil commitment process, including, but not limited to:

- Amending the Code of Virginia to require the presence of a CSB representative at all commitment hearings
- Requiring more specificity in involuntary outpatient orders
- Developing a mechanism to return the noncompliant person to court
- Imposing sanctions on a noncompliant person who is not a danger to self or others and
- Outlining with more specificity the responsibilities of detaining facilities, CSBs and treatment providers in the outpatient commitment process.

The Review Panel also appeared to acknowledge the lack of availability of outpatient services, recommending that Virginia study what level of community outpatient service capacity will be required to meet the needs of the Commonwealth and the related costs and that outpatient treatment services then be expanded statewide.

Although the CCTF did not reach consensus on the desirability of increasing the use of MOT, it did reach consensus on the conditions that must be met before MOT is used on any significant scale. The remainder of this Chapter is organized in three parts:

A. Guiding Principles for Use of MOT
B. Options for Use of MOT
C. Procedures for Implementing MOT

A. Guiding Principles For Use Of Mandatory Outpatient Treatment

It is the consensus of CCTF members that the following principles guide the Commission when considering any change in Virginia Code regarding the use of MOT:

Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services, House Document 101 (2000).

1. If sufficient resources were made available to provide a comprehensive array of outpatient treatment services, most of the need for MOT would be substantially reduced.
2. Many members of the CCTF oppose any form of MOT because it would likely divert scarce outpatient treatment resources from more effective and less costly uses by people who seek the services voluntarily. Those CCTF members who endorse MOT only do so contingent upon the provision of adequate resources (treatment, legal, infrastructure) to deliver the needed treatment to both voluntary and involuntary clients.
3. Services provided under judicial MOT orders should be of high quality, effective and attractive to the people who use them, and provide adequate choice.
4. Incarceration should never be used as a remedy for non-adherence to an MOT order.
5. Forcible administration of medication should not be permitted.
6. Opportunities to volunteer for services should be incorporated into the process and involuntary services should be converted to voluntary services as soon as appropriate.
7. The quality and accessibility of outpatient services should be equivalent for people who volunteer for services and those who do not.

Recommendation VI.A.1. Require and fund outpatient services as a CSB/BHA mandated service:

Effective outpatient services cannot be provided unless the CSBs are first required to provide them. Prior to consideration of any MOT, Virginia Code §§ 37.2-500 (community services boards) and 37.2-601 (behavioral health authorities) should be amended to require that outpatient services be a mandated service for CSBs and the Behavioral Health Authority ("BHA"). These statutes could be amended as follows:

> The core of services provided by community services boards within the cities and counties that they serve shall include emergency services, outpatient mental health treatment services and~~, subject to the availability of funds appropriated for them,~~ case management services. Subject to the availability of funds appropriated for them, the core of services ~~may~~ shall include a comprehensive system of inpatient, outpatient, day support, residential, prevention, early intervention, and other appropriate mental health, mental retardation, and substance abuse services necessary to provide individualized services and supports to persons with mental illnesses, mental retardation, or substance abuse.

B. Options For Future Use Of Mandatory Outpatient Treatment

Virginia Code § 37.2-817.C currently permits MOT as an alternative to involuntary inpatient admission, if the person meets the inpatient commitment criteria, i.e. if 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. In addition, the following conditions must be met:

1) Less restrictive alternatives to involuntary inpatient treatment have been investigated and are deemed suitable,
2) The person (a) has the degree of competency necessary to understand the stipulations of his treatment, (b) expresses an interest in living in the community and agrees to abide by his treatment plan, and (c) is deemed to have the capacity to comply with the treatment plan, and
3) The ordered treatment can be delivered on an outpatient basis and be monitored by the community services board, behavioral health authority or designated provider.

If these criteria are met, the judge or Special Justice is authorized to order outpatient treatment, which may include day treatment in a hospital, night treatment in a hospital, outpatient involuntary treatment with anti-psychotic medication pursuant to Chapter 11 (Virginia Code § 37.2-1100 et seq.), or other appropriate course of treatment as may be necessary to meet the needs of the person.

The CCTF identified four basic options regarding future use of MOT:

MOT Option VI.B.1. Repeal the existing authority for outpatient commitment and do not replace it with any mandatory outpatient commitment statute.

Advantages

1. If sufficient resources are not made available to adequately fund outpatient commitment, outpatient commitment should not be used.
2. MOT discriminates against one group of individuals with disabilities relative to all other groups of individuals with disabilities or illnesses who could "benefit" from mandated treatment.
3. Virginia's current statute is unclear. There is no clearly defined or workable implementation in place.
4. The MOT criteria are contradictory, as established by fact that it is seldom and inconsistently used across the state. For example, the statute assumes that a person who is substantially unable to care for him/herself is capable of complying with a treatment order.

Disadvantages

1. Repeal would eliminate a constitutionally mandated less restrictive alternative for those who otherwise meet criteria for involuntary admission.
2. Repeal would eliminate an alternative utilized actively in other states.
3. Elimination of MOT would have the potential to increase the number of people diverted into the criminal justice system

<u>MOT Option VI.B.2.</u> Retain use of mandatory outpatient treatment as a less restrictive alternative to involuntary admission, while clarifying the conditions under which such orders may be issued.

Under current Virginia law MOT is viewed as a less restrictive alternative to inpatient commitment. Whether or not the inpatient commitment criteria are changed, the second option is to retain an outpatient treatment order as a less restrictive alternative. However, proponents of this option agree that the current statute has many flaws and should be substantially modified to reformulate the conditions under which mandatory outpatient treatment may be ordered and to clarify the procedures for implementing such orders. Proposals for doing so are offered below

<u>MOT Option VI.B.3</u>. Use of mandatory outpatient treatment could be employed as a supplement to short-term acute hospitalization or residential stabilization.

In addition to authorizing MOT as an alternative to involuntary inpatient admission, the Code of Virginia could be amended to permit MOT as a condition of discharge from an inpatient facility after a period of involuntary admission, or in other words, as a form of conditional release or as a "split" commitment order as used in North Carolina.

In some circumstances, a person who initially meets involuntary inpatient commitment criteria may be able to benefit from treatment on an outpatient basis after a period of inpatient hospitalization in order to prevent relapse. Based upon the person's mental illness and his or her prior treatment history, it is unlikely that the person will seek or adhere to needed treatment upon discharge, thus leading to a relapse in his or her condition again requiring involuntary hospitalization. Under these circumstances, the court may order the person to receive MOT for a specified period of time following a specifically authorized period of inpatient treatment.

The CCTF takes no position on this proposal but outlines the arguments for and against as follows:

Advantages

1. Could expedite early discharge from a hospital to a less restrictive setting
2. Has potential to reduce relapse and likelihood of readmission
3. Has the potential to limit outpatient commitment to those who have met commitment criteria at least once
4. May expand access to inpatient services for other patients by facilitating earlier discharge

Disadvantages

1. Could prolong period of coercive treatment
2. Prone to overuse/abuse
3. Potential conflict of interest for providers if they make the determination for discharge
4. May decrease access to some systems that won't take patients on conditional release
5. May stress inpatient facilities by requiring hospitalization first
6. If applied willy-nilly will interfere with patient's ability to take responsibility for their own treatment
7. De facto change in the criteria for outpatient commitment (Kendra's Law backdoor)

MOT Option VI.B.4. Mandatory Outpatient Treatment Could Be Employed to Prevent Future Involuntary Inpatient Admission.

In addition to MOT as an alternative to involuntary inpatient admission or following a period of inpatient treatment, MOT may also be used to prevent future involuntary inpatient admission, as has been done in several other states such as Wisconsin, North Carolina, and most notably through Kendra's Law in New York.

MOT may be used to prevent the necessity of waiting for an individual to deteriorate to the extent that he or she meets commitment criteria, especially when the person has presented a history of such deterioration in the past. Once an individual's health has deteriorated to the point of meeting commitment criteria, he or she is less likely to be able to benefit from MOT or may be incarcerated before being involuntarily admitted. This process of deterioration can be especially heart wrenching for family members when the outcome is often so predictable.

1. Criteria

In order to prevent people from reaching the dire condition where involuntary inpatient treatment is the only clinically suitable alternative, the MOT criteria must therefore be less restrictive so that treatment may be delivered earlier in the process as follows:

> He or she has a mental illness and as a result of such mental illness is experiencing a substantial impairment of his or her judgment, reasoning, or behavior, leading to such a substantial deterioration in his or her previous ability to function in the community that, if not treated, he or she is likely to meet involuntary inpatient admission criteria in the near future.

Under these criteria, the person must be experiencing a substantial impairment as a result of mental illness that is currently leading to a substantial deterioration is the person's previous level of functioning and that deterioration must predictably be leading to the meeting of commitment criteria. Although not necessary, additional language could be

added restricting the use of preventive MOT to situations in which that person's mental health history has included two or more prior failures to adhere to prescribed treatment leading to inpatient hospitalization. The person's treatment history is also captured in the first condition that provides: "as a result of the person's mental illness, and based on prior treatment history, the person is unlikely to seek or adhere to needed treatment unless the court enters an order for mandatory outpatient treatment."

The conditions that must exist for the court to order preventive MOT should also be the same as the conditions applicable to outpatient commitment ordered as an alternative to involuntary inpatient treatment, except, as stated above, the person, as a result of mental illness, is unlikely to seek or comply with needed treatment unless the court enters an order for MOT. This replaces condition #4 as an alternative to inpatient commitment that the person has sufficient capacity to understand and adhere to the provisions of the proposed treatment plan and agrees to abide by its provisions. If the person were capable of agreeing to abide by the provisions of the treatment plan, there would be no need for this MOT order. The following is the criteria proposed:

> A person may also be ordered to obtain MOT upon a finding by the court by clear and convincing evidence that he or she has a mental illness and as a result of such mental illness is experiencing a substantial impairment of his or her judgment, reasoning, or behavior, leading to such a substantial deterioration in his or her previous ability to function in the community that, if not treated, he or she is likely to meet inpatient admission criteria in the near future. [A finding of "likely to meet involuntary inpatient admission criteria in the near future" must be based upon a finding that on two or more previous occasions, the person's failure to adhere to prescribed psychiatric treatment has necessitated hospitalization for the person's mental illness.]

Prior to ordering MOT, the court must also find that:

1) as a result of the person's mental illness, and based on prior treatment history, the person is unlikely to seek or adhere to needed treatment unless the court enters an order for MOT;
2) a written treatment plan has been prepared by the community services board or behavioral health authority that sets forth the specific type, amount, duration, and frequency of treatment and services the person is to obtain;
3) the proposed treatment is in the person's best medical interest and constitutes the least restrictive appropriate treatment for the person, taking into consideration all relevant circumstances, including any reasonably possible alternative treatments preferred by the person, as expressed in an advance directive or otherwise; and
4) the treatment and service providers are identified in the treatment plan, have agreed to provide the treatment or other services specified in the plan, and have the capacity to provide the prescribed treatment or other services.

The CSB or BHA where the person resides shall monitor the person's adherence to the treatment plan and report any material non-adherence to the court. Any other providers designated in the treatment plan shall report any material non-adherence to the community services board or behavioral health authority, which in turn shall report any material non-adherence to the court.

The duration of the MOT order shall be determined by the court based upon the recommendations of the community services board, behavioral health authority or treatment provider, but in no event shall the length of the order exceed 90 days.

The CCTF takes no position on this proposal but outlines the arguments for and against as follows:

Advantages

1. Could potentially lessen the need for inpatient commitment
2. Could improve the quality of life for the person
3. May reduce incarceration of persons with mental illness
4. Would not require people to deteriorate to level of meeting inpatient commitment criteria before they can get help
5. Extensive research shows benefits
6. Requires a specific treatment plan with identifiable resources and willing service providers
7. Increases provider accountability
8. Better defines outpatient commitment process

Disadvantages

1. Could divert limited resources from voluntary treatment
2. Arguable violates O'Connor commitment criteria
3. Possibly could expand the number of people subject to involuntary process
4. Nonconsensual forced outpatient drugging without adequate supervision could lead to increased injury and death
5. Lack of scientific data to demonstrate effectiveness of proposed treatment
6. No safeguards for non-compliance
7. Same outcome could be accomplished with provision of adequate, voluntary outpatient services
8. None of the options to involuntary outpatient treatment address broader issues of lack of access to housing, education or vocational services.

C. Procedures For Implementing Mandatory Outpatient Treatment as a Less Restrictive Alternative to Involuntary Admission

Whether or not the criteria for involuntary inpatient admission or MOT, or the civil commitment process are changed, the majority of CCTF members believe additional legislation is needed to clarify how MOT orders, even under current law, are monitored and implemented. The lack of specification in current law was highlighted as a result of the Virginia Tech shootings. If crisis stabilization units are expanded and additional outpatient services are funded, this clarification will become even more necessary. The following proposal is drafted on the assumption that the criteria for MOT would remain the same as for involuntary admission and that MOT would continue to serve as a less restrictive alternative to involuntary admission.

1. Necessary Findings

If the Commission endorses this option, the CCTF recommends that the statute be modified to permit a mandatory outpatient treatment order only if the judge makes the following findings:

> If the court finds that the person meets the criteria for involuntary admission to an inpatient facility but available less restrictive alternatives exist which would offer an opportunity for improvement of the person's condition, the court may order a person to obtain mandatory outpatient treatment in lieu of inpatient treatment if the court also finds that:
>
> 1) An initial treatment plan has been developed by the community services board or behavioral health authority that sets forth the specific type, amount, duration, and frequency of treatment and services the person is to obtain;
> 2) The proposed treatment is in the person's best medical interest and constitutes the least restrictive appropriate treatment for the person, taking into consideration all relevant circumstances, including any reasonably possible alternative treatments preferred by the person, as expressed in an advance directive or otherwise;
> 3) The treatment and service providers are identified in the treatment plan, have agreed to provide the treatment or other services specified in the plan, and have the capacity to provide the prescribed treatment or other services; and
> 4) The person has sufficient capacity to understand and adhere to the provisions of the proposed treatment plan and agrees to abide by the provisions of the treatment plan.

The conditions outlined in this MOT Option are an improvement over the conditions currently contained in Virginia law. First, an initial treatment plan must be proposed setting forth the specific type of treatment proposed and its duration. Without knowing the specifics of a treatment plan and its duration, the court cannot realistically determine whether MOT is a valid option for the person. More importantly, the person cannot be expected to agree to, much less adhere to or be held in contempt of, a vague order that merely requires the person to comply with whatever course of treatment is recommended

by the CSB. Moreover, the person is unable to participate in his own recovery when subjected to such a vague order.

In order for a CSB or BHA to be able to develop a realistic proposal, or even a preliminary treatment plan, however, the time period in which the commitment hearing must be held must be extended longer than the current 48 hours or the commitment hearing must be continued to permit this to happen.

The original version of this proposal used the term "written treatment plan." However, clinicians expressed concern that it is often difficult to develop a comprehensive treatment plan for an individual whom they have not previously treated until after several therapeutic visits. Hence the term "initial treatment plan" has been used. As individuals move through recovery, their need for various types of treatment also changes and treatment plans are frequently amended to reflect treatment progress. An alternative term could be "course of treatment." Some CCTF members indicated, however, that most individuals who will be ordered to receive mandatory outpatient commitment are already known to the CSB, and preparation of a written treatment plan would not be difficult.

The second condition requires consideration of the preferences of the person and especially encourages use of advance directives, wellness recovery action plans ("WRAP") or other crisis intervention plans developed by the person himself or herself, thus empowering the individual to participate in and direct his or her own recovery.

Third, treatment and service providers must be identified and agree to provide the MOT services specified in the plan. Providers can then be held accountable for the services to be provided. The specific treatment and services needed to meet this individual's needs must also actually exist in the person's community and with sufficient capacity to accommodate this individual. Otherwise, any MOT order would be ineffective and may subject the individual to an unwarranted contempt proceeding.

Fourth, the person must have sufficient capacity to understand and adhere to the provisions of the treatment plan and agree to abide by them. The reason this condition is not listed first, as is currently provided, is that the person must first be presented with a treatment plan and the names of the treatment providers before he or she can agree to the plan. This condition, however, does not require the informed consent of the individual, because the individual may not currently function at that level of capacity. It merely requires sufficient ability to understand the treatment plan that he or she must adhere to and an ability to do so. Current language related to "degree of competency necessary to understand the stipulations of his treatment" has been interpreted by some people to mean that the person must be competent to provide informed consent. Such a high standard should not be necessary, thereby denying the person the benefit of outpatient treatment and mandating his or her unnecessary confinement in an inpatient setting.

The criteria for ordering MOT as a supplement to short-term acute hospitalization or residential stabilization as follows:

1) As a result of the person's mental illness, and based on the prior treatment history, the individual will unlikely seek or adhere to needed treatment upon discharge unless the court enters an order for MOT;
2) A written treatment plan has been prepared by CSB or BHA that sets forth the specific type, amount, duration, and frequency of treatment and services the person is to obtain on an outpatient basis;
3) The proposed treatment is in the person's best medical interest and constitutes the least restrictive appropriate treatment for the person, taking into consideration all relevant circumstances, including any reasonably possible alternative treatments; and
4) The treatment and service providers are identified in the treatment plan, have agreed to provide the treatment or other services specified in the plan, and have the capacity to provide the prescribed treatment or other services.

2. Length of Mandatory Outpatient Treatment

The court based upon the recommendations of the CSB, BHA or treatment provider shall determine the duration of the MOT order, but in no event may the length of the order exceed 90 days.

> The CCTF suggests in Chapter V that the length of an initial inpatient commitment period be reduced to 30 days and that recommitment periods of commitment be extended to 90 and then 180 days following a period of continuous successive hospitalizations. However, the majority of the CCTF believes that MOT should be ordered for a minimum of 90 days. If the period of MOT were the same 30 days as the initial period of involuntary inpatient admission, this time frame could easily expire before one could determine if adherence could be obtained. The CSB should not pursue material non-compliance based on a missed appointment, for example, without attempts at engagement. Thirty days is also too short an outpatient treatment tenure for someone who has already been subject to a TDO. Other CCTF members believe that the duration of the MOT order should be no less than 180 days based on Marvin Schwartz' research from North Carolina that MOT for less than 180 days is not effective.[53]
>
> The total period of inpatient and outpatient commitment combined should not exceed 90 days, unless a petition for preventive MOT is thereafter filed as provided below.

3. Outpatient Treatment Agreements

[53] Marvin Swartz and Jeffrey Swanson, Canadian Journal of Psychiatry 49:585-91 (2004).

If MOT becomes a viable option to inpatient admission and outpatient treatment is appropriate, some members of the CCTF believe that individuals should be offered the option to volunteer for outpatient treatment without the necessity of a court mandated "voluntary" agreement filed with the court.

Other CCTF members believe strongly that the voluntary agreement to accept either inpatient or outpatient treatment should remain court mandated, especially when the court must make specific findings before permitting the person to voluntarily accept either inpatient or outpatient treatment. Some CCTF members further believe that a settlement agreement should be used and filed with the court, as is done in Wisconsin, if the court permits a person to accept voluntary outpatient treatment.

Virginia Code § 37.2-814 could be amended as follows to permit voluntary outpatient treatment:

> "B. At the commencement of the commitment hearing, the district court judge or special justice shall inform the person whose involuntary admission is being sought of his right to apply for voluntary admission and treatment as provided for in § 37.2-805 or for outpatient treatment. The judge or special justice shall ascertain if the person is then willing and capable of seeking voluntary outpatient treatment or voluntary inpatient admission and treatment. Prior to permitting the person to voluntarily accept outpatient treatment, the judge or special justice shall ascertain from the community services board or behavioral health authority that (i) treatment and services appropriate to the person's condition are available in the community, (ii) treatment and service providers have agreed to provide the treatment or other services identified as appropriate for the person, and (iii) the person has sufficient capacity to understand and adhere to the provisions of the treatment plan and signs an agreement with the community services board, behavioral health authority or other service provider agreeing to abide by the provisions of the proposed treatment for a period of no less than 30 days. Such agreement [shall not become part of the court's record but] may be used in evidence at any subsequent hearing for involuntary inpatient admission or mandatory outpatient treatment. If the judge or special justice finds that the person is capable and willingly accepts voluntary inpatient admission and treatment, ~~the judge or special justice shall require him to~~ the person shall enter into an agreement with the inpatient treatment provider agreeing to accept voluntary admission for a minimum period of treatment not to exceed 72 hours. The person shall also agree that a~~A~~fter such minimum period of treatment, the person shall give the ~~hospital~~ treatment provider 48 hours' notice prior to leaving the ~~hospital~~ facility. During this notice period, the person shall not be discharged except as provided in § 37.2-837, 37.2-838, or 37.2-840. This agreement [shall not become part of the court's record but] may be used in evidence at any subsequent hearing seeking an order for the person's involuntary inpatient admission or mandatory outpatient treatment. The person shall be subject to the transportation provisions as provided in § 37.2-829 and the requirement for

preadmission screening by a community services board or behavioral health authority as provided in § 37.2-805.

4. Contents of Mandatory Outpatient Treatment Order

The initial treatment plan or course of treatment should be attached to the MOT order so the person who is the subject of the order and CSB monitoring adherence know its provisions. If the CSB or BHA has not had sufficient time to develop and recommend an initial treatment plan at the time of the hearing, either the hearing may be continued or the court may order the person, the CSB or BHA, and any treatment providers to meet and develop a treatment plan that will then be submitted to the court within a certain prescribed time period. It may also be difficult for clinicians to work with an individual to develop a comprehensive treatment plan without more extended contact and interaction than that permitted during the temporary detention period.

The duration of the MOT order should also be specified based upon the recommendation of the CSB or BHA, but in no event should the length of the order exceed 90 days. See discussion in Proposal VI.B.2 above.

Whether or not the CSB or BHA attends the hearing, the CSB or BHA that prepared the pre-screening report or is ordered to monitor the MOT order should be provided a copy of the order with a copy of the treatment plan attached. Any providers designated in the order should also be provided a copy. Most importantly, the person subject to the MOT order and his or her attorney should receive a copy so he or she understands what the expectations for compliance may be. The judge or Special Justice may provide the person, the CSB or BHA, and any designated providers with a copy at the hearing, if they are present, and if not, the clerk shall provide the copy after the hearing. A form acknowledgement of receipt may be given to the person, CSB or BHA and designated providers to sign and give to the judge or Special Justice immediately following the hearing or mail to the clerk for inclusion in the court file. This is also a portion of recommendation IV-23 of the Virginia Tech Review Panel.

A number of commitment hearings are also held at detention facilities located outside the jurisdiction of the CSB where the person resides. If the CSB or BHA monitoring the outpatient commitment order is not located in the jurisdiction that conducted the commitment hearing, jurisdiction to enter any follow-up orders needed as a result of the CSB monitoring of compliance should be transferred to the jurisdiction where the CSB or BHA ordered to monitor compliance with the order is located.

If the court determines that mandatory outpatient treatment is appropriate, it shall enter such an order incorporating the attached initial treatment plan into the order. The order shall also include the name of the community services board or behavioral health authority that has been ordered to monitor compliance with the order and the names of

any treatment providers. If the information available at the time of the hearing is insufficient to enable the community services board or behavioral health authority to recommend, or the court to order, an initial treatment plan, the court shall continue the hearing for up to [seven] days and order the person to meet with the community services board or behavioral health authority and the provider, if other than the community services board or behavioral health authority, to develop the treatment plan, including any provisions for modification of the plan. The court, after considering the recommendation of the CSB or BHA and any objections raised by the person, shall enter a final order for mandatory outpatient treatment. If there are no objections to the plan, the court may enter the order without further hearing.

The following language to accomplish the above objectives could be used:

> The judge or special justice shall provide a copy of the MOT order with the attached treatment plan immediately following the hearing to the person who is the subject of the order, his or her attorney, the community services board or behavioral health authority that either prepared the prescreening report or is required to monitor any order of MOT, and any service providers designated in the treatment plan ordered by the court. If the CSB or BHA or any service providers designated in the treatment plan are not present at the hearing, the clerk of the general district court in the locality that conducted the hearing shall ensure that they receive a certified copy of the order and they shall acknowledge receipt of the order to the clerk on a form provided by the court for that purpose.
>
> The duration of the MOT order shall be determined by the court based upon the recommendations of the community services board, behavioral health authority or treatment provider, but in no event shall the length of the order exceed 90 days.
>
> The court may transfer jurisdiction of the case at any time after entry of an MOT order to the general district court where the person resides or where the CSB or BHA ordered to monitor compliance with the order is located.

5. Monitoring of Mandatory Outpatient Treatment Order

<u>Designation of CSB /BHA required to monitor adherence to order</u>

The Code of Virginia should make it clear that a specifically designated CSB or BHA is required to monitor adherence to a MOT order and report any material non-adherence to the court. In order to overcome any privacy concerns, any providers should also be required to report any material non-adherence to the CSB or BHA monitoring compliance as follows:

> The CSB or BHA shall monitor the person's adherence to the treatment plan and report any material non-adherence to the court. Any other providers designated in the treatment plan shall report any material non-adherence to the CSB or BHA,

which in turn shall report any material non-adherence to the court.

The majority of the CCTF also would like the CSB or BHA to be required to monitor compliance with the order in all cases, rather than a designated private provider, and report any material non-adherence back to the court. Although some private providers have expressed the need to have the same powers as a CSB, the majority of the CCTF believes it is more appropriate for the public entity with gate keeping responsibilities under Virginia law to perform these services for the court rather than a private provider who must maintain a therapeutic relationship with the person. Although CSBs are also interested in maintaining therapeutic relationships with the individuals they serve, they also perform other functions for the court as part of the commitment process, such as preparing pre-screening reports. Monitoring and reporting is also made mandatory to overcome any concerns related to privacy laws and regulations.

6. Response to Non-Compliance

CSB monitoring follow-up; temporary custody; assessment

Before any non-adherence to the treatment plan is reported to the court, the CSB or BHA monitoring compliance should determine why the person has not adhered to treatment and report only material non-adherence to the court. In addition, the CSB or BHA should make reasonable efforts to work with the person to encourage adherence. If it has been unable to do so and the CSB or BHA does not otherwise know the condition of the person, the CSB or BHA may request a law enforcement officer to accompany them to the person's home or other location to assess the person's present condition to determine whether the person needs inpatient treatment or continued outpatient treatment and meets the criteria either for involuntary inpatient admission or continued MOT. The CSB or BHA should also attempt to obtain voluntary compliance at every contact.

If it is not feasible for the CSB or BHA to go to the person's home or other location, and the CSB or BHA does not know the condition of the person, it may request the magistrate to issue a mandatory examination order requiring the local law enforcement agency to transport the person to a convenient location so that the CSB or BSA may assess the person's current condition to determine whether he or she meets the criteria for inpatient treatment or continued outpatient treatment. The maximum period of assessment should correspond with the maximum period of time a person may be held under an emergency custody order. The Code of Virginia could be amended as follows to accomplish this:

> If the CSB or BHA determines that reasonable efforts have been made to contact the person and obtain the person's adherence to the treatment plan and the person without good cause has materially failed to adhere to the mandatory outpatient treatment order , and if the CSB or BHA cannot ascertain the person's current condition, the community services board or behavioral health authority may request a magistrate to issue a mandatory examination order directing a law

> enforcement officer to transport the person to a convenient location designated by the CSB or BHA for the purpose of enabling the CSB or BHA or its designee to assess the person's present condition and to attempt to obtain the person's adherence to the order. The person may not be detained for more than four hours for the performance of this examination, unless an order for the person's temporary detention is issued in accordance with the provisions of § 37.2-809.

Temporary detention

If it appears from the CSB's or BHA's ongoing monitoring or the mandatory examination that the person meets the dangerousness prong of criteria for involuntary inpatient admission, the CSB or BHA may seek and the magistrate may issue a temporary detention order. The relevant Virginia Code provisions in § 37.2-809 related to issuance of temporary detention orders and the transportation provisions in § 37.2-810 would apply. Unless the person is dangerous to himself or others, preference should be given to permitting the person to remain an outpatient, since it was previously determined that mandatory outpatient treatment rather than involuntary inpatient admission was appropriate for this individual. The following language could be inserted in the Code of Virginia:

> If the community services board, behavioral health authority or its designee has probable cause to believe as a result of ongoing monitoring or the mandatory examination referenced above that the person has a mental illness and is a danger to himself or others [meets revised dangerous criteria if adopted]**,** the community services board or behavioral health authority may request the magistrate to issue a temporary detention order in accordance with § 37.2-809. Transportation shall be provided in accordance with § 37.2-810.

Notification to court; appointment of attorney

If the CSB or BHA monitoring the outpatient commitment order believes the person has materially failed to comply with the order without just good cause, this must be reported to the court, along with its recommendations for disposition of the case. Notification in writing should occur as soon as possible, but no later than three days after this determination has been made. If the CSB or BHA has otherwise kept in regular contact with the person and knows his condition, it need not perform the mandatory outpatient examination referenced above before notifying the court. If the person is being held in temporary detention, this notification should occur within 24 hours. In either case, copies of this notification should also be provided to the person and his attorney. If the CSB or BHA determines that the person has not adhered to the treatment plan, but believes that the person does not meet criteria for either involuntary inpatient admission or mandatory outpatient commitment, it may recommend dismissal of the order as its recommendation for disposition of the case.

For purposes of continuity, the attorney who represented the person at the hearing at which the MOT was ordered should, if at all possible, represent the person at the noncompliance hearing, unless the person objects or the attorney is unavailable.

The Code of Virginia could be amended to accomplish this as follows:

> If the person subject to an order for mandatory outpatient treatment has materially failed to adhere to the order without good cause, and the community services board or behavioral health authority has been unable after reasonable efforts to obtain the person's adherence to the order, the community services board or behavioral health authority shall report the person's material non-adherence to the clerk of the general district court in the locality which issued the order or to which venue has been transferred in writing within [three days] of making that determination, or within 24 hours if the person is being detained under a temporary detention order, and shall recommend an appropriate disposition. Copies of the report shall be sent to the person and the person's attorney. The attorney who represented the person at the proceeding that originated the issuance of the mandatory outpatient treatment order shall be considered for re-appointment to represent the person at any subsequent hearings related to the mandatory outpatient treatment order.

Independent Examiner

Because the person may be ordered involuntarily admitted to an inpatient facility, an Independent Examiner should certify whether he has probable cause to believe that the person currently meets involuntary inpatient admission or mandatory outpatient treatment criteria, unless the previous examination performed by the court was recently performed. An assumption may be made that if the person has not received any significant treatment since the initial commitment hearing, it is unlikely that his condition has improved.

If the person is not detained in an inpatient facility, arrangements must be made for the person to be examined at a convenient location before the hearing. Transportation could be provided by family members, friends, or other transportation service that may be recommended by the Commission and for which funds and authority are provided by the General Assembly. The CSB or BHA should logically provide logistics for the examination and transportation.

If a person who has not been detained refuses to appear and be examined without good cause, the court or magistrate may issue an order of mandatory examination directing a law enforcement officer to transport the person to a convenient location for examination.

The Code of Virginia could be amended as follows:

> If more than 10 days has passed since the person's commitment hearing that resulted in the issuance of the mandatory outpatient treatment order, the court shall appoint an independent examiner in accordance with § 37.2-815 who shall personally examine the person and certify to the court whether or not he has probable cause to believe that the person meets the criteria for involuntary admission to a facility or mandatory outpatient treatment as provided in § 37.2-817. The certification of the independent examiner may be admitted into evidence without the appearance of the examiner at the hearing if not objected to by the person or his or her attorney. If the person is not detained in an inpatient facility, the community services board or behavioral health authority shall arrange for the person to be examined at a convenient location and time, and shall offer to arrange for the person's transportation to the examination, if the person has no other source of transportation, and if the person resides within the jurisdiction of the community services board or behavioral health authority or an adjacent jurisdiction. If the person refuses or fails to appear, the community services board or behavioral health authority shall notify the clerk of the general district court in the locality which issued the order or to which venue has been transferred, or a magistrate if the court is not available, and the court or magistrate shall issue an order directing a law enforcement officer in the jurisdiction where the person resides to transport the person to the examination.

Noncompliance hearing

The noncompliance hearing should be held within the time frame for conducting other commitment hearings, if the person is in detention. If not, the hearing may be held within five days of notification of noncompliance because the person's liberty, other than through the MOT, has not been significantly curtailed. If the person is not detained, the clerk should insure that the person, his or her attorney, and any relevant treatment providers and family members receive at least 48 hours notice of the date, time and place of the hearing. While it might be preferable to have the same judge or Special Justice that presided at the hearing that resulted in the MOT order preside at the noncompliance hearing, due to the balancing of interests in protecting the individual's liberty interests in avoiding prolonged detention, the same judge or Special Justice need not conduct the noncompliance hearing. Arrangements as listed above for the person's transportation to the hearing if he or she is not detained should be made by the CSB or BHA. If the person fails or refuses to attend the hearing, the hearing should be able to proceed in his absence without the necessity of the court issuing a *capias* for his arrest or a temporary detention order.

The Code of Virginia could be amended to add the following:

> The judge or special justice shall schedule a hearing within 5 (five) days after receiving the report of material noncompliance; however, if the fifth day is a Saturday, Sunday, or legal holiday, the hearing shall be held by the close of business on the next day that is not a Saturday, Sunday or legal holiday. If the

person is being detained under a temporary detention order, the noncompliance hearing shall be scheduled within the same time frame provided for a commitment hearing under § 37.2-814. If the person is not detained, the person shall be provided at least 48 hours' notice of the hearing. The same judge or Special Justice that presided over the hearing resulting in the mandatory outpatient treatment order need not preside at the noncompliance hearing.

The community services board or behavioral health authority shall offer to arrange the person's transportation to the hearing, if the person is not detained and has no other source of transportation. If the community services board or behavioral health authority believes that the person may be a danger to himself, or others or is unable to determine the clinical condition of the person, it shall notify the clerk of the general district court and the court shall issue an order directing the sheriff in the jurisdiction where the person resides to transport the person to the hearing. If the person fails or refuses to attend or is not able to be located by law enforcement, the hearing may proceed in the person's absence. Nothing herein shall prevent the community services board or behavioral health authority from obtaining either an emergency custody order as provided in § 37.2-808 or a temporary detention order as provided in § 37.2-809, if at any time the community services board or behavioral health authority has probable cause to believe that the person presents an imminent danger to himself or others as a result of mental illness [or meets the dangerous prong in a revised criteria for involuntary inpatient admission].

Disposition; transportation

The relevant evidence at the non-compliance hearing should be whether and to what extent the person has or has not adhered to the ordered outpatient treatment plan, and the reasons why or why not. If the person has not adhered to the treatment plan, the court should next determine the person's current condition, i.e. whether he or she currently meets involuntary inpatient admission or mandatory outpatient treatment criteria. Based upon this evidence, the judge or special justice should 1) order the person's involuntary admission to an inpatient facility for a period not to exceed the maximum length of an order for involuntary admission, 2) renew the order for mandatory outpatient treatment, making any necessary modifications, 3) or rescind the mandatory outpatient treatment order.

If involuntary inpatient admission is ordered, transportation should be provided under Virginia Code §§ 37.2-829 or 37.2-830 as if the person were originally committed. If the person does not appear at the noncompliance hearing, law enforcement would need to locate the person and provide transportation from that location to the inpatient facility.

The Code of Virginia could be amended to read as follows:

After hearing the evidence regarding the person's non-adherence to the order for MOT and the person's current condition, the judge or Special Justice shall make one of the following dispositions:

1. Upon finding by clear and convincing evidence that the person meets the criteria for involuntary admission and treatment specified in § 37.2-817.B, the judge or Special Justice shall order the person's involuntary admission to a facility designated by the community services board or behavioral health authority for a period of treatment not to exceed ~~180~~ 30 days [the maximum length of an order for involuntary admission.]
2. Upon finding that the person continues to meet the criteria for mandatory outpatient treatment specified in § 37.2-817.C, and that a continued period of mandatory outpatient treatment appears warranted, the judge or Special Justice shall renew the order for mandatory outpatient treatment, making any necessary modifications that are acceptable to the community services board, behavioral health authority, or treatment provider responsible for the person's treatment;
3. Upon finding that neither of these dispositions is appropriate, the judge or Special Justice shall rescind the order for mandatory outpatient treatment.

If the judge or Special Justice orders the person's involuntary inpatient admission as specified in paragraph 1 above, transportation shall be provided in accordance with §§ 37.2-829 or 37.2-830.

7. Termination of Mandatory Outpatient Treatment Order

There are questions about what should happen when the person no longer needs the ordered MOT, or the treatment plan is changed because the person has reached the goals of that plan and no longer needs to be under an MOT order. Virginia law provides no limit on the duration of the MOT order and no mechanism to have the order rescinded. Some treatment providers are reluctant to stop or reduce the level of treatment for liability reasons and would like for the court to enter an order terminating the mandatory outpatient treatment order. Some CCTF members believe that the MOT order should be treated the same as an order for involuntary inpatient admission. A person may be discharged by the director of the facility to which he was ordered admitted without further order of the court.

If a procedure is implemented to require the court to rescind the MOT order, it also seems inappropriate to require everyone to return to court for a hearing to rescind the order. A simple notification to the court should be sufficient. If, however, the petitioner, treatment provider, CSB or the court disagrees, the court should schedule a hearing. Because the CCTF is recommending that the CSB or BHA in all cases monitor compliance with the order, and not a designated provider, the designated provider, if there is one, should notify the CSB or BHA which in turn would notify the court. The court would then rescind the outpatient commitment order.

Provision should also be made to permit the person who is the subject of the MOT order to request termination of the outpatient commitment order.

The Code of Virginia could be amended as follows:

> At any time prior to the expiration of the mandatory outpatient treatment order, the treatment provider determines that the person has complied with the mandatory outpatient treatment order and it is no longer necessary, or for any other reason that the order is no longer necessary or applicable, the provider shall notify the community services board or behavioral health authority monitoring the person's compliance with the order. If the community services board or behavioral health authority providing the treatment or monitoring the person's compliance with the order determines, or is notified by the treatment provider that the order is no longer necessary or applicable, it shall so notify the clerk of the general district court that entered the order or to which venue has been transferred and the court shall rescind the order. If the petitioner, treatment provider, community services board or behavioral health authority, disagree that the order should be rescinded, they shall notify the court of their disagreement and the court shall schedule a hearing or the court may schedule a hearing on its own motion.
>
> At any time 30 days after entry of the mandatory outpatient order, the person who is subject to the order may petition the court to rescind the order on the grounds that he or she no longer meets the criteria for entry of the order and the order for mandatory outpatient treatment is no longer necessary.

8. Extension of Mandatory Outpatient Treatment Order:

At times an individual may need to have his or her MOT order extended. In such cases, only the CSB or BHA monitoring the order should have standing to petition the court for an extension. The hearing should be held within approximately 10 days of the filing of the petition, with approximately five days' notice to the person, his or her attorney, the CSB or BHA, and any relevant providers and family members. For continuity, consideration should be given to appointing the same attorney who represented the person at the initial hearing. An Independent Examiner must also be appointed. The same issues related to appearance of the person for the examination and at the hearing as discussed above also arise. If the hearing is not held before expiration of the order, the MOT order should remain in effect pending the hearing. The Code of Virginia could be amended as follows:

> At any time within 10 days before the expiration of an order for mandatory outpatient treatment, the community services board or behavioral health authority that is monitoring the person's compliance with the order may petition the court to extend the order for a period of treatment not to exceed 90 days. If both the

community services board or behavioral health authority and the person who is the subject of the order join in the petition, the court shall grant the petition and enter an appropriate order without further hearing. Otherwise, the court shall schedule a hearing to occur within 10 days of receipt of the petition, and shall provide at least five days' notice of the hearing to the person, the person's attorney, the community services board or behavioral health authority, and any relevant providers and family members. The attorney who represented the person at the proceeding that originated in the issuance of the mandatory outpatient treatment order shall be considered for re-appointment. The court shall also appoint an independent examiner who shall personally examine the person and certify to the court whether or not he has probable cause to believe that the person continues to meet the criteria for mandatory outpatient treatment as provided in § 37.2-817.C. The certification of the independent examiner may be admitted into evidence without the appearance of the examiner at the hearing if not objected to by the person or his or her attorney.

The community services board or behavioral health authority shall arrange for the person to be examined at a convenient location and time, and shall arrange for the person's transportation to the examination, if the person has no other source of transportation. If the person fails or refuses to be examined, the community services board or behavioral health authority may request the magistrate to issue a mandatory examination order as provided in section x above.

Upon finding that the criteria for mandatory outpatient treatment specified in § 37.2-817.C are met, and that a continued period of mandatory outpatient treatment in accordance with the treatment plan approved by the court appears warranted, the judge or special justice shall renew the order for mandatory outpatient treatment for a period not to exceed 90 days. Otherwise, the judge or special justice shall rescind the order for mandatory outpatient treatment. An order that expires prior to the hearing to extend shall remain in effect until the disposition of the petition to extend.

9. Appeal of Mandatory Outpatient Treatment Order:

The person should have the same right of appeal of an order for mandatory outpatient treatment order as for an inpatient order. The Code of Virginia could be amended as follows:

> The person shall have the right to appeal an order of mandatory outpatient treatment or any extension thereof in the same manner as the person has the right to appeal an order of involuntary admission under § 37.2-821.

10. Payment of Special Justices, Court-Appointed Attorneys and Independent Examiners:

Participants in the MOT process should be paid for the services they perform in the same manner as for initial commitment hearings. The Code of Virginia could be amended as follows:

Any special justice presiding over a noncompliance or extension hearing, any attorney appointed to represent a person in a noncompliance or extension hearing, and any independent examiner or interpreter for the deaf participating in a noncompliance or extension hearing shall be paid his or her fee and necessary expenses in accordance with § 37.2-804. Any foreign language interpreter shall be paid in accordance with the guidelines set by the Judicial Council of Virginia and shall be paid out of the state treasury. (See § 37.2-802.B.)

CHAPTER VII. TRAINING

It is the consensus of the CCTF that meaningful reform of Virginia's civil commitment process cannot occur unless everyone involved is adequately qualified and trained. In addition, meaningful training cannot occur without the participation of persons with mental illness and their families involved in the process. Inclusion of consumers and family members in the development and delivery of training should be a priority.

The following summarizes the training that each of the participants in the civil commitment process receives and, as appropriate, provides comparisons with other training practices and requirements, together with CCTF observations:

Special Justices: Special Justices appointed after January 1, 1996 are required to complete a minimum training program concerning the civil commitment process prescribed by the Executive Secretary of the Supreme Court. The training program currently consists of a 1996 videotape prepared by the Institute of Law, Psychiatry and Public Policy at the University of Virginia. The Supreme Court also provided training to Special Justices on June 21 and December 4 and 5, 2007. Some localities provide training to Special Justices, attorneys and professionals on an *ad hoc* basis. Most Special Justices have served as court-appointed attorneys representing individuals in civil commitment hearings for several years before appointments as Special Justices and therefore have received on-the-job training. However, this informal approach to ensuring the expertise of the Special Justices likely contributes to the considerable variation in the conduct of civil commitment proceedings noted in the Commission's Hearing Study.

To get a better perspective on the training requirements, the CCTF examined the Supreme Court's *Standards to Govern the Appointment of Guardians ad Litem for Incapacitated Persons* to determine whether a similar system would be appropriately applied to training for the civil commitment process.[54] To be included on the list of qualified attorneys, attorneys are required to complete a six-hour course "Representation of Incapacitated Persons as a Guardian *ad Litem.*" Thereafter, the attorney must complete six hours of continuing legal education every two years from the date of original qualification on topics related to the representation of incapacitated persons. Topics may include elder law, basic estate planning and estate administration, fiduciary issues, litigation and ethics. Credit for retaking the certification course will be approved

[54] These standards are available on-line at http://www.courts.state.va.us/gal/gal_standards_children_080403.html.

once within a six-year period. Training provided by local departments of social services concerning adult protective services and Medicaid; Area Agencies on Aging issues concerning Medicaid, Medicare, long term care insurance and facility evaluation and selection; and training from the medical community on issues such as gerontology, dementia, etc. may also be approved. Attorneys must also demonstrate familiarity with the court system and a general background in guardianship law by serving as a guardian *ad litem* or providing assistance to a guardian *ad litem* in two cases in the circuit court, service as counsel for the petitioner in two cases, or by appointment as a guardian or conservator for an incapacitated person within two years prior to seeking qualification, or by submitting a certificate of nomination from one circuit court judge before whom the attorney has appeared.

The CCTF also considered ongoing training provided to Substitute Judges in the Commonwealth. Substitute Judges are currently required to participate in one regional training program per year. Because funding for training is limited, training for Substitute Judges occurs in courtrooms and similar locations around the state. Most of the training provided is taped programs from the conferences for judges, on, for example, legislative updates or criminal updates. The live speakers are generally Judicial Inquiry and Review Commission ("JIRC") presentations on ethics, and a one-hour "What's Your Problem" session. Select judges and clerks (typically four) from the area discuss problems/issues that Substitute Judges might encounter.

Attorneys for Respondents: All persons subject to civil commitment proceedings must be provided an attorney and, for 99%, that is an attorney provided by the Commonwealth. Although adequate legal representation is necessary to ensure the liberty interests of the respondent are protected, Virginia neither requires nor provides any specialized training on civil commitment law or mental health issues. In comparison, court-appointed counsel representing indigent defendants in criminal cases in the Circuit, General District and Juvenile and Domestic Relations District Courts are initially required to complete six hours of training developed by the Indigent Defense Commission (10 hours for juveniles) and at least six hours of Commission and MCLE-approved continuing legal education biennially. Experience in serving as lead or co-counsel in a certain number of cases can be substituted for the training.

Magistrates: Magistrates must successfully complete a certification program during their first six-month probationary period. The magistrate certification program consists of four days of training with an examination on the 5th day. Five hours of training on Emergency Custody Orders, Temporary Detention Orders, and other processes related to mental health are provided on the second afternoon of the program. After certification, the guidelines require magistrates to complete 24 hours of continuing education every four-year term. As part of this, one-day regional training programs are presented annually to review new legislation, for which the magistrates earn two continuing education credits. In addition, magistrates can earn two additional credits by attending an annual statewide conference that may include presentations on commitment issues. Because of the number of magistrates and to provide access across the Commonwealth, two statewide

conferences are held back-to-back to reach all of the magistrates. Although the overall training requirements for magistrates appear extensive, because of budget restraints, magistrates now only receive four continuing education credits each year instead of six.

Independent Examiners: The Independent Examiner in a civil commitment hearing is statutorily required to be a psychiatrist or psychologist licensed in Virginia by the Board of Medicine or Psychology and qualified in the diagnosis of mental illness. If neither a psychiatrist nor a psychologist is available, the statute provides that any mental health professional licensed in Virginia and qualified in the diagnosis of mental illness may serve as an Independent Examiner (§ 37.2-815). No specialized training is currently provided or required to serve as an Independent Examiner beyond that required for licensure. Some Independent Examiners receive training in civil commitment as part of their employment with a state facility, CSB or private provider.

The Commission's Commitment Hearing Study, May, 2007, revealed that in 79.2% of the cases the Independent Examiner was either a physician (39.2%) or a clinical psychologist (40%). In 20.8% of the cases, the Independent Examiner was another mental health professional. In 92.3% of the cases, the Independent Examiner was not on staff of the CSB.

An informal survey of state-operated mental health facilities in April 2007 found in seven out of eight hospitals the Independent Examiner was either a physician or a psychologist. At three state facilities, the Independent Examiner was a state hospital psychiatrist/psychologist not involved in the person's treatment, while a community psychologist serves as the Independent Examiner at two facilities, a community family practitioner physician serves as the Independent Examiner at two; and a licensed clinical social worker serves as the Independent Examiner at one. At all but one state facility, the Special Justice is responsible for bringing the Independent Examiner.

At the request of the CCTF, the Virginia Association of Community Services Boards surveyed each of the 40 CSBs to determine, among other things, the type of mental health professional serving as the Independent Examiner in their area, what their qualifications are, what training they have had, who monitors or oversees the work they perform, and by whom and how much they are paid. Thirty CSBs responded. In the CSB survey, 14 of the Independent Examiners were clinical psychologists; three were psychiatrists; two were physicians; nine were licensed clinical social workers; and nine were licensed professional counselors. Eleven CSBs reported that the Independent Examiners had no training in the civil commitment process; six had some undefined, informal training; four have received training from the University of Virginia's Institute of Law, Psychiatry and Public Policy; two from the DMHMRSAS; and one had other unspecified training.

CSB Prescreeners: CSB prescreeners must complete a certification program approved by the DMHMRSAS (§ 37.2-809). The DMHMRSAS and the Virginia Association of Community Services Board ("VACSB") Emergency Services Council are currently updating this certification program. In addition to the training in mental health, mental

retardation, and substance abuse provided for certification, the DMHMRSAS and the Office of the Attorney General provide a one-and-one-half-day training program on civil commitment in a different area of the state at least annually.

Peer Counselors: Peer counselors, used in many states to provide counseling and support to individuals and their families who are going through the commitment process, are beginning to be used in Virginia. The DMHMRSAS has recently issued a contract for an organization to provide three peer specialist-training programs in Virginia to train consumers to assist other consumers and CSB staff in understanding and implementing recovery-based environments, self-advocacy, wellness management and in building mutual relationships based on hope, trust, empathy and respect.

Ideally, peer counselors should be located at all hospitals that accept temporarily detained individuals and where commitment hearings are held. Often the person's attorney does not meet with the person until the day of the commitment hearing, and, often, only immediately preceding the hearing. A peer counselor can be an advocate and ombudsman for the individual, and can often establish a rapport with the individual in situations when the person's attorney is not able to do so. Peer counselors can talk with individuals early in the commitment process to provide information on the process and what the individual and family should expect to occur. They can help the person think through his or her treatment options and prepare for the hearing. Peer counselors should also serve on local committees of persons involved in the commitment process that meet regularly to discuss the process, identify problems and recommend solutions. The peer counselor can point out areas that are working well for consumers and families and areas needing improvement, acting as advocate for process improvement. The DMHMRSAS and CSBs can contract with consumer run programs to provide this service or CSBs may hire peer counselors on their payroll.

Law Enforcement: Law enforcement is involved in the civil commitment process in at least two ways. First, in emergency situations, law enforcement may take an individual into emergency custody for up to four hours for an assessment of his/her mental status and an initial determination of whether a temporary detention order should be issued. During this period, the individual is formally in the custody of law enforcement and law enforcement must remain on site until this prescreening is completed and the individual is either released or a TDO is issued. If a TDO is issued, law enforcement is also responsible for transporting the individual to the temporary detention facility. Because these activities are time-consuming, arrests and jail may be a more attractive option unless the law enforcement officer can hand over custody to the ECO site.

The Department of Criminal Justice Services ("DCJS") is required under Virginia Code § 9.1-102, to establish minimum compulsory training standards and compulsory minimum curriculum requirements for in-service and advanced courses and programs for all law enforcement officers, including deputy sheriffs (Virginia Code § 15.2-1612.1) and special conservators of the peace (Virginia Code § 19.2-13). In addition, DCJS is required to develop minimum compulsory training standards and publish a model policy for handling

family abuse, domestic violence, sexual assault and stalking cases, and in communicating with and facilitating the safe return of individuals diagnosed with Alzheimer's disease. The Criminal Justice Services Board has a Committee on Training composed of 13 members, including the Executive Secretary of the Supreme Court.

Law enforcement officers must receive 480 hours of minimum basic academy training and 100 hours of field training within 12 months of employment. The basic training program is quite comprehensive. Emergency Custody Orders, Temporary Detention Orders and issues related to persons with mental illness are covered throughout the training, especially under Category 2 "Legal Issues," Category 3 "Communications" and Category 4 "Patrol." Thereafter, law-enforcement officers must receive four hours of legal training and 36 hours of career development/elective training every second year. Unarmed special conservators of the peace must have 24 hours of entry-level training and armed special conservators must have 40 hours of training. Thereafter special conservators must have eight hours of training, four hours on legal authority and four hours of job-related training.

In February 2007, DCJS contacted the 23 law enforcement training academies in Virginia to determine the number and types of in-service trainings related to mental health provided in the past five years. The results showed considerable variability. Responses from 12 of the academies ranged from "none" in Norfolk and Richmond, to several hour-long in-service programs on a variety of issues, especially related to working with Alzheimer's patients and elder and child abuse. In New River Valley mental health was covered in the full 40-hour Crisis Intervention Team ("CIT") training (see below). The Prince William County Criminal Justice Academy described a good model short of the CIT program. Prince William County delivered in-service training to all sworn personnel in 2006 that included on-scene assessment and crisis intervention, accessing county community service board mental health therapists and the court system, non-custodial and custodial police options, and executing detention orders. Prince William County's training is being expanded to two four-hour programs and will be delivered every three years. The training is also supplemented by training videos shown in-service at shift briefings/roll calls. In 2005, two officers were sent to the 40-hour CIT training in Blacksburg. These officers are now working in partnership with the CSB to review and update recruit and in-service training for all civilian personnel to make them capable of identifying observable behaviors that might point to the existence of mental illness, and how to stabilize and de-escalate situations until sworn personnel arrive.

Crisis Intervention Teams (CITs): A law enforcement model of crisis intervention is that of specially-trained crisis intervention teams, a key component of which is a secure drop-off center where law enforcement can transfer custody of detained individuals. As the following descriptions of CIT and CIT-like programs show, extensive, specialized training of a wide variety of law enforcement, mental health and community partners is essential to making this model for mental health crisis intervention work. Many communities, although not fully implementing the CIT model, have undertaken extensive training of key parties similar to model CIT programs. DCJS is supportive of the

expansion of CITs in Virginia but is concerned that federal grant funds to establish pilot projects are drying up. State appropriations will therefore be needed to continue and expand the program.

In 2007, New River Valley CIT is the only fully functioning CIT Program in Virginia, although New River Valley lacks a designated 24/7 therapeutic drop-off location to serve the entire area, typically an integral part of a CIT program. However, because Virginia law currently requires law enforcement officers to maintain custody of individuals throughout the emergency custody period until the person is delivered to a temporary detention facility, this aspect of the program is currently impossible to implement. New River Valley is composed of 14 separate law enforcement agencies and has trained nearly 90 local road officers, supervisors and department staff with over 25% of the area's road officers providing effective 24/7 CIT coverage for mental health calls. The Memphis CIT Mode's Core Elements recommends a minimum of 20% CIT coverage or whatever percentage of a given area's road officers will result in 24/7 coverage. Additional Core Elements replicated in the New River Valley include 100% trained dispatchers, who receive a special 4-hour training (soon to be expanded); annual advanced in-trainings for CIT officers and a modest evaluation process to determine whether CIT skills are improving outcomes and reducing arrest and hospitalization. Most importantly, in order to create and sustain CIT is community, consumer, law enforcement and mental health provider collaboration. New River Valley's CIT has a formal oversight committee that meets regularly to address systemic issues. Informally, participants communicate directly and regularly to assess needs and work through specific incidents and enhance working relationships between law enforcement and mental health with the common goal of improving outcomes for consumers. Additionally, the community collaborative, spearheaded by the local Mental Health Association, provides public education, outreach and annual public recognition for the work of CIT officers and collaborators.

The Thomas Jefferson Area Charlottesville/Albemarle County CIT began in 2001 with a crisis continuum committee meeting every month started by the local Mental Health Association. The CIT was then implemented in 2004 utilizing stakeholder members of its Community Criminal Justice Board. It received a Byrne Justice Assistance Grant in 2006 for $185,000 and has since obtained additional grant monies. This CIT focuses on evaluation and outcome measures, and is working with University of Virginia ("UVA") law students to analyze data. It is also working with the UVA hospital to locate and staff a drop off center there. Training and community collaboration has been developed through partnership with the New River Valley CIT. Both New River Valley CIT and Memphis CIT have assisted in providing training that will allow the Thomas Jefferson Area Charlottesville/Albemarle County CIT program to sustain itself. It is creating its own 40-hour school and is developing its own "train the trainer" program.

Mount Rogers Community Services Board/Wytheville CIT also received a Byrne Justice Assistance Grant in 2006 in the amount of $87,000. They are partnering exclusively with New River Valley CIT. Mount Rogers has focused on training and has sent approximately 15 officers and 6 observers through the New River Valley's 40-hour CIT

training. In mid-April, 15 of those participants will attend a 2 ½ day "train the trainer" curriculum modeled after Memphis CIT, but tailored to address issues that impact Virginia.

Portsmouth has become interested in implementing CIT and began in October 2006 working regularly with a consultant from the New River Valley. Under the leadership of the Community Services Board, a work group began meeting and a broad community oriented and involved group established the base for CIT development. It has obtained funding in the amount of $ 98,000 for two years from the Department of Justice, Bureau of Justice Assistance grant. They have combined this funding with reinvestment funds to develop a crisis stabilization program, Safe Haven, which can be used as a therapeutic drop off for sub-acute clients in crisis. Portsmouth has trained 12 officers and one observer through New River Valley and planned to bring the "train the trainer" program to Portsmouth in the summer of 2007.

The Roanoke County Sheriff's Office has long had CIT-trained officers and provides that training internally after initially working with Memphis CIT. It has not developed any of the other Core Elements of a CIT program. Many other localities have inquired about developing CIT programs and have sent officers to either the New River Valley training program or Memphis. Thirty-seven police departments in Virginia have trained CIT officers, including 90 local road officers, supervisors and department staff. The cost of training per officer is $400.00 for the 40-hour training program. In addition, all dispatchers should receive a minimum of 4 hours of training in order to become familiar with protocols and procedure and begin to de-escalate a crisis situation. "Certified CIT-trained officer" inherently means that the CIT officer is the officer in charge on scene during a crisis intervention.

In addition to the cost of training law enforcement, funding aids in community consensus building, education and outreach that creates a positive context for developing and maintaining a strong CIT program. Also important for a successful CIT program are the funds/resources for a therapeutic drop off location that makes it as timely and efficient for officers to take individuals in crisis for treatment as it is to charge them with minor offenses and bring them to jail. The four active or in-development CIT programs have received the following grant funding:

1. New River Valley CIT: $ 150,000 General Assembly allocation (grant period 7/1/06 – 6/30/07)
2. Charlottesville/Albemarle County CIT: $ 185,554 (grant period 7/1/06 – 6/30/07)
3. Mount Rogers Community Services Board/Wytheville CIT: $ 76,163 (grant period 7/1/06 – 6/30/07)
4. Portsmouth: $ 98,000 for two years

Other localities are implementing programs similar to CIT, but not using the Memphis model. The program implemented in Montgomery County, Pennsylvania, for example,

successfully integrates the services of over 20 different law enforcement jurisdictions in implementing its model. It is critical, however, that in any model employed, a significant number of officers and dispatchers be trained and on duty on all shifts, that the total community supports law enforcement efforts in continuously assuring that this system works, and that a "no refuse therapeutic drop off center" be available that provides an incentive to law enforcement officers on the street to seek treatment for individuals rather than arresting and jailing them. Under Virginia's current system, a law enforcement officer may spend up to four hours, and in some cases much longer, obtaining evaluation and assessment for a person with mental illness when it is much easier to transport them to the police station for booking for minor offenses. The Criminal Justice Task Force is also studying this issue.

Recommendations:

Recommendation VII.1. The Code of Virginia should be amended to require the Virginia Supreme Court to develop an initial certification course and requirements, similar to those for guardians *ad litem* representing incapacitated persons, for attorneys who serve as court-appointed counsel representing respondents in the civil commitment process. Special Justices who have not served on the court-appointed list should also be required to complete the initial certification course within six months of appointment. Special Justices and attorneys should further be required to obtain at least six hours of continuing legal education every two years in courses approved for this purpose by the Supreme Court.

Recommendation VII.2. The Virginia Supreme Court should sponsor statewide conferences for Special Justices once every two years providing Special Justices with the opportunity to obtain updates on the law and the latest initiatives in mental health clinical practice and administration, and to discuss issues they encounter as judges.

Recommendation VII.3. Regional or local conferences should be held once every two years, in the years statewide conferences are not held, for Special Justices, attorneys, magistrates, law enforcement, independent examiners, public and private mental health professionals, consumers and family members for training on updates to the law, local practice and issues of concern in their community.

Recommendation VII.4. Although the training provided to magistrates is comprehensive, it could be improved by providing input from consumers, family members, and mental health professionals and administrators on information related to impact of the system on consumers, family members and other professionals, and providing updates on mental health treatment and service delivery improvements and initiatives.

Recommendation VII.5. The Code of Virginia should be amended to require the Supreme Court to establish an advisory committee of Special Justices, attorneys,

magistrates, public and private mental health professionals, consumers and family members to plan upcoming training programs for Special Justices, attorneys and magistrates, to monitor and oversee the effectiveness of the training and to recommend approval of continuing legal education courses.

Recommendation VII.6. Section 9.1-102 of the Code of Virginia should be amended to require the Department of Criminal Justice Services to develop minimum compulsory training standards and publish a model policy for law enforcement concerning the execution of emergency custody and temporary detention orders and the provision of transportation during the civil commitment process. Training academies should be encouraged to develop routine, ongoing training in CIT interventions.

Recommendation VII.7. The Virginia General Assembly should be requested to appropriate sufficient funds to expand CIT or similar programs statewide, and to integrate these training programs into the law enforcement training academy curricula. "Train the trainer" programs should be developed to further facilitate the training of law enforcement officers statewide. In addition, all law enforcement officers and dispatchers should be trained in addressing issues related to persons with mental illness, even if they do not receive the full CIT 40-hour program.

Recommendation VII.8. The Code of Virginia should be amended to require Independent Examiners to be appointed by the judge or Special Justice and to require them to complete a certification program for Independent Examiners approved by the Department of Mental Health, Mental Retardation and Substance Abuse Services prior to their appointment.

Recommendation VII.9. The DMHMRSAS and the VACSB should continue to update the certification program currently provided to prescreeners and review and update it at regular intervals. All participants in the commitment process, including consumers and family members, should be asked to provide input into development of the curriculum and participate in the training.

Recommendation VII.10. The DMHMRSAS should request additional appropriations and grants to fund peer counselors to serve in inpatient, outpatient and mental health crisis situations to counsel and assist individuals involved in the civil commitment process better understand the process and participate in their own recovery and to advocate for improvements in the system at both the state and local level.

CHAPTER VIII. COMPENSATION FOR SPECIAL JUSTICES, COURT-APPOINTED ATTORNEYS AND INDEPENDENT EXAMINERS

Many of the professionals involved in the civil commitment process are compensated by the Commonwealth of Virginia on a per case basis. The compensation rate is low, has not been increased for a decade, and will be even more inadequate if the additional responsibilities contemplated by the Recommendations of the CCTF are implemented. It is the consensus of the CCTF that unless Special Justices, attorneys, and Independent Examiners are compensated more adequately it will become increasingly more difficult to attract well-qualified professionals to participate in commitment, certification and treatment proceedings. In addition to the increased responsibilities directly related to the civil commitment process, Special Justices, attorneys and mental health professionals cannot be expected to fully participate in the more extensive training programs identified in Chapter VII of this CCTF Report unless they are adequately compensated.

Professionals in the commitment process are currently paid as follows (Virginia Code§ 37.2-804) plus mileage:

Special Justices:	$86.25 for each commitment hearing $43.25 for each Mental Retardation ("MR") certification hearing[55] $43.25 for each treatment authorization hearing[56]
Attorneys:	$ 75.00 for each commitment hearing $ 43.25 for each MR certification hearing $ 43.25 for each treatment authorization hearing
Physicians, psychologists, mental health professionals, deaf interpreters:	

[55] Special Justices may also conduct certification hearings authorizing admission of persons with mental retardation to training centers operated by the DMHMRSAS pursuant to Virginia Code § 37.2-806.

[56] Special Justices are also authorized to conduct hearings authorizing treatment for persons who are incapable of making an informed decision on their own behalf pursuant to the provisions in Chapter 11 of Title 37.2.

$ 75.00 for each commitment hearing
$ 43.25 for each MR certification hearing

Substitute Judges: Substitute judges are paid $ 100 per ½ day of work; $ 200 per full day of work; or may bill per case at the Special Justice rate above.

Compared to the compensation paid to participants in the adult civil commitment process, the compensation paid for court-appointed attorneys in other types of cases is more. Figures from the Supreme Court of Virginia's Chart of Allowances, dated July 1, 2007show the following:

Attorneys for minors in involuntary commitment hearings (§ 16.1-343) are paid $100.00 for each commitment hearing.

Guardians *ad litem* for minors in juvenile and domestic relations district courts (§ 16.1-267) are paid $75.00 per hour in court; and$ 55.00 per hour out of court, up to a maximum of $120 per case. Under certain circumstances, however, this cap may be subject to the additional $120 fee cap waiver as provided in § 19.1-163.

Attorneys for minors in J&DR Ct. (§ 16.1-266) receive $75.00 per hour in court; and an additional$ 55.00 per hour for out-of-court time, up to $120.00, subject to the fee cap waiver as provided in §19.2-163.

Guardians *ad litem* in guardianship proceedings (§ 37.2-1008) are paid $75.00 per hour in court; and$55.00 per hour for out of court time.

Guardians *ad litem* for emergency orders for protective services (§ 63.2-1609) are paid $75.00 per hour in court and $55.00 per hour for out-of-court time.

Attorneys on petitions for isolation for communicable disease (§ 32.1-48.03) are paid $75.00 per case.

It is unclear why attorneys for minors in commitment hearings are paid $100.00 per case when they are paid only $75.00 per case for adult commitment hearings. It is also unclear why Special Justices, attorneys and mental health professionals are paid only $43.25 for hearings certifying admission of persons to mental retardation facilities and $43.25 for judicial authorization for treatment hearings when they are paid more for adult civil commitment hearings. It may be that certification hearings for admission of persons with mental retardation to training centers are not viewed as adversarial. However, protection of these individual's rights to services in a less restrictive setting is important and the fee currently paid barely covers the attorney's or mental health professional's cost of attending the hearing. Defending an individual's right to avoid unwanted antipsychotic medication is also as important and challenging a job, if done properly, as representing an individual in a commitment hearing. Only if a treatment authorization

hearing is held in conjunction with or immediately following a commitment hearing, should a reduction in fee be warranted.

From a review of fees paid to Special Justices and attorneys in FY 2006 and FY 2007, most attorneys and Special Justices are not being paid excessively based upon the work they perform and the time and effort involved. However, in some jurisdictions, such as Hampton, Richmond, Roanoke, Petersburg/Dinwiddie, or Smyth County where there are concentrations of persons with mental illness and/or where hospitals are located, Special Justices and attorneys earn comfortable fees.

In most jurisdictions, Independent Examiners are paid 75.00 per case by the Supreme Court. The payment is the same whether they attend the hearing and testify or not. In one jurisdiction, Independent Examiners are paid under contract with the Community Services Board at $100.00 per hour.

Recommendations:

Recommendation VIII.1. If the duties of Special Justices, attorneys and Independent Examiners in the inpatient and mandatory outpatient commitment process are increased, the fees should be increased commensurate with the increased amount of the time and work required. If no changes are made in the responsibilities and training time requirements for Special Justices, attorneys and Independent Examiners, the CCTF recommends the changes in fees set out in Recommendation VIII.2 below.

Recommendation VIII.2. The Supreme Court should request an additional appropriation from the General Assembly to adequately increase the fees for Special Justices, court appointed attorneys, and Independent Examiners. The CCTF developed two options for determining the fee levels.

> **Option 1. Consideration should be given to increasing the fees paid to Special Justices, court-appointed attorneys and Independent Examiners based on the increase in the consumer price index since 1998.**
>
> **Option 2. In the alternative, consideration should be given to paying Special Justices, court-appointed attorneys, and Independent Examiners comparable to payment made to attorneys in juvenile commitment hearings, or $ 100.00 per case.**

Recommendation VIII.3. Fees in hearings for judicial certification of persons with mental retardation to a training center and in hearings for judicial authorization for treatment should be the same as for those in commitment hearings, except when the judicial authorization for treatment hearing is held in conjunction with, at the same time as, or immediately following a commitment hearing, in which case the fee should be one half the amount of the fee in the commitment hearing.

Recommendation VIII.4. Special Justices and attorneys in areas with high volumes of hearings are paid considerably more overall than those in low volume areas. Fees paid to Special Justices, attorneys and Independent Examiners should therefore be subject to a fee cap. The Supreme Court should review its payment rates to determine where the cap should fall. Consideration should also be given to capping the number of individuals an attorney may be appointed to represent on any given day to ensure he or she has adequate time to devote to advocating the position of each person he represents.

Recommendation VIII.5. Consideration should be given to paying a court-appointed attorney in a jury trial in circuit court (when the original commitment order is appealed) an increased fee of up to $300.00.

Recommendation VIII. The Supreme Court should review the fees paid to Special Justices, court-appointed attorneys, and Independent Examiners at least every four years for adequacy and request increased appropriations when appropriate.

CHAPTER IX. FUTURE OVERSIGHT OF THE CIVIL COMMITMENT PROCESS

Civil Commitment of persons with mental illness engages law enforcement, the courts, mental health professionals, public and private health providers, families and persons with mental illness directly and, also, impacts the broader community and its financial resources. Because the CCTF'S Recommendations for change have broad, multi-systems impact, closely monitoring the efficacy of changes to the system, identifying both the successes and challenges is critically important.

Oversight must occur on a number of levels. First, even if none of the CCTF's Recommendations is implemented, it is important, operationally, to promote the consistent application of Virginia's civil commitment laws. As the Commission's Hearings Study has shown, there is considerable variability across the Commonwealth in the application of existing civil commitment law on a wide range of variables, including how often mandatory outpatient treatment and involuntary admission are ordered, and the presence of various participants including the CSB staff or the Independent Examiner. Should the Recommendations of =the CCTF be adopted, in whole or part, it is unlikely these variations will be substantially reduced without establishing appropriate mechanisms for oversight. It is a matter of fundamental fairness that a person in the southwest be treated similarly to one in northern Virginia.

Secondly, many Recommendations, if implemented, will require training of persons and the development of protocols across several state and local entities. Each of the entities involved must receive supervision and oversight to ensure that they understand how the civil commitment process is intended to work. As noted above, even without statutory or regulatory changes, significant improvements in the training about civil commitment and mental health, generally, is needed and heightened oversight to ensure this happens is key. Third, it is essential to develop databases to monitor the numbers and types of orders being entered and cases being heard at all phases of the process, including the emergency custody and temporary detention stage, the civil commitment hearing, and any follow-up hearings related to outpatient commitment orders. This monitoring of outcomes will provide an important check on how well the civil commitment system is functioning and provide feedback about whether additional modifications should be considered within the various city or county entities as well as at the state level.

Participants

It is important that the professionals involved in assessing individuals for the advisability of involuntary inpatient or outpatient treatment have a good understanding of both civil commitment law and mental health. As documented in this CCTF Report's Chapter IX on Training, there are no standards or formal training in either.

For two of the entities in the civil commitment process, CSBs, and law enforcement, the infrastructure is in place to implement the training of their employees. However, Special Justices, attorneys, magistrates and Independent Examiners function, although largely funded through the District Courts, relatively independently with limited or lacking oversight. The following is a description of the oversight they receive:

> **Special Justices** (§ 37.2-803**)**: There is limited oversight of the performance of Special Justices. Prior to July 1, 2007, the chief judge of the judicial circuit appointed Special Justices for an indefinite period of time. Effective July 1, 2007, however, Special Justices are now appointed to six-year terms and, presumably, any substantial poor performance would preclude a re-appointment. Complaints related to judicial misconduct may be made to the Judicial Inquiry Review Commission ("JIRC") but JIRC does not investigate complaints related substantively to decisions made by Special Justices in their judicial capacity. The usual method for reviewing the substance of judicial determinations, appeals to higher courts, has not been a viable option in civil commitment proceedings The Commission's Hearings Study found that only four commitment appeals were heard by Circuit Courts in May 2007. Appellate courts have played virtually no role in the interpretation of Virginia's commitment statutes or the review of commitment proceedings. The Code of Virginia has been interpreted to preclude a right of appeal for petitioners. Cases appealed by respondents are frequently dismissed based upon mootness.
>
> **Attorneys:** The Virginia Code specifies respondents to a petition for civil commitment have the right to a court-appointed attorney and the state provides attorneys for the 99% of respondents who do not employ a private attorney. Publicly financed attorneys are attorneys in private practice who are appointed by the Special Justice for each civil commitment proceeding. All are licensed and regulated by the Virginia State Bar. Beyond the requirements of professional licensure, however, no oversight of attorneys is provided except as may be provided by the judge or Special Justice who appoints them.
>
> **Magistrates** (§§ 19.2-33 through 19.2-48.1): Magistrates, who serve entire judicial districts, are appointed by the chief judge of the circuit court in consultation with general district and juvenile and domestic relations district court judges. Although the chief circuit court judge has supervisory authority in making these appointments, he or she may delegate this authority to the chief general district court judge. In each district, there is a chief magistrate who supervises other magistrates and has the authority to suspend them without pay

after consultation with chief circuit court judge. The term of appointment is four years.

Magistrates need not be, and generally are not, attorneys. A bachelor's degree or equivalent experience is all that is required. However, there a six-month probationary period during which the magistrate must complete a minimum training program established by the Supreme Court's Committee on District Courts and pass a certification examination. Appointments are revocable at the pleasure of the chief circuit court judge.

The Committee on District Courts also establishes minimum training requirements that the magistrate must complete prior to reappointment. The Executive Secretary of the Supreme Court assists the chief general district court judge in the supervision and mandatory training of magistrates. Although the salaries are fixed by the Committee on District Courts based on workload, an additional 50% may be added by a locality.

Virginia's Supreme Court is in the process of reviewing the operation of the magistrate system. One proposal has been made to establish regional management and supervision of the magistrates. In each geographic region, there would be a supervisor responsible for reviewing the performance of the chief magistrates in that region. The chief magistrates, in turn, would supervise the performance of the magistrates in the region. An individual in the Executive Secretary's Office in Richmond would then supervise or oversee the work of the regional supervisors. The magistrates would be employees whose performance would be evaluated on an annual basis, rather than their being appointed by the chief judge of the circuit for four-year terms. It is believed that statewide and regional supervision would improve consistency in implementation of the process and application of the law, and response to complaints and system improvement would be more effective.

Independent Examiners: Independent Examiners have the statutory responsibility of certifying a person detained under a TDO meets the criteria for civil commitment prior to the civil commitment hearing. Independent Examiners, who must be psychiatrists, clinical psychologists or, in some circumstances, other mental health professionals, come to their role as Independent Examiners from a variety of venues. Some are employees of a state psychiatric hospital. In one instance, the Independent Examiners are contracted for through the local CSB. Some are provided by the Special Justice hearing the case.

There is no formal oversight over Independent Examiners. Oversight, if any, is provided through the Independent Examiner's place of employment or from the judge or Special Justice who appoints them in some localities. Clearly, judges or Special Justices who appoint the Independent Examiner could decline to appoint

them if their services are unacceptable but there are no articulated standards beyond the professional licensure requirements**.**

The role of the Independent Examiners was examined in the Commission's Hearing Study. Based on these survey results, there appears to be substantial variability in the amount of time Independent Examiners spend interviewing the respondents, the type materials reviewed, and whether they attend the civil commitment hearings. For example, although the statute requires the Independent Examiners to examine the person subject to a civil commitment hearing, the law is silent about what this examination should consist of. The CSB survey showed three independent examiners spent less than 30 minutes examining the person; six spent 30 minutes; seven spent 30-60 minutes; three spent 60-120 minutes; and one spent more than 120 minutes. Fourteen attended the commitment hearing; six never attended the hearing; and four sometimes attended.

Although the legal criteria for determining whether a person can be civilly committed are spelled out in the statute, the types of information the Independent Examiner should review to make that determination are not specified. Should a clinical examination be sufficient? Should patient records from other venues or interviews with family members be sought? Should the nature of the examination be documented?

Oversight of the Independent Examiners is inconsistent or lacking altogether. For those who are employed by CSBs or hospitals, a licensed supervisor may oversee their work in general, but not their performance in an involuntary commitment proceeding.

Data Systems and Research

One finding of the CCTF is that there was very little data providing detail about the civil commitment process. As a result, part of the CCTFs work was to work with the Commission's Research Advisory Research Group to design and conduct a survey of District Courts throughout the Commonwealth on civil commitment hearings. [57] Although the Commission's Hearings Study data were very useful and informed the deliberations of the CCTF, the data covered only one month in 2007. This snapshot could not yield information about trends and the brevity of the questionnaire limited the amount of information that could be collected. As a result, and in addition to improved oversight of the participants in the civil commitment process, this CCTF believes establishing systematic data collection systems is essential to promote quality, evaluate the effects of changes in law or policy, measure costs and promote system improvement. Such data collection should focus on all of the various stages of the civil commitment process. The Supreme Court should work with experts to identify the appropriate variables to track and should establish online data entry systems as soon as feasible. It is

[57] Referred to throughout this Report as the Commission's Hearing Study.

essential for the Court to have accurate information regarding the number and type of hearings held in each locality and their outcome. In addition, the billing form itself needs to be revised to collect more accurate and useful data.

Mechanisms for routine data reporting should also be established on issuance of emergency commitment orders, temporary detention orders as well as the results of commitment hearings. In order to continually monitor the emergency evaluation process, one possibility may be to require CSB prescreeners to send the uniform preadmission screening form to a confidential research protected database. Another possibility would be to require emergency services staff or the magistrate to complete a short form with information concerning each emergency custody order and temporary detention order sought, recording the decision made by the magistrate, whether medical assessment and evaluation was ordered, the timeframes involved, and any other needed information. In addition to the above databases, it would be useful for the DMHMRSAS to conduct a Crisis Contact Survey periodically (e.g. in June of each year) modeled after the one conducted by the Commission in June, 2007.

For the commitment hearing itself, it would be useful for the presiding judge or Special Justice in every commitment hearing and judicial authorization for treatment hearing to complete a short form on the disposition of the case. Provisions for protection of the confidentiality of the data would need to be made depending on where the data is housed and the privacy rules that apply to that data. In addition, it would be useful for the Supreme Court to conduct a periodic survey (e.g. in June each year) on the characteristics and dispositions of every hearing. If the Independent Examiner is given dispositional authority as recommended in Chapter II, it will also be important to require the Independent Examiner to submit a similar form setting forth his or her certification and disposition of the case.

In recommending increased data collection and analysis, the CCTF urges, however, that the Commission and Supreme Court keep in mind that data gathering and analysis is time consuming and costly. Information should not be gathered that is not going to be useful. Any data gathered should be kept to a minimum with an eye towards making it accurate, user friendly and as non-invasive as possible.

Finally, there is a genuine question about what entity should assume responsibility for the ongoing monitoring of the system. The Interagency Civil Admissions Advisory Council ("ICAAC") was established in Virginia Code § 2.2-2690 *et seq.*, effective July 1, 2005 to create statewide collaboration over implementation of the commitment process, to address and make recommendations concerning problems of statewide concern and to strive for consistent application of the process statewide. Its specific powers and duties include identifying and discussing issues related to civil commitment in order to improve services, foster increased coordination among all involved, and promote a more effective and cost-efficient approach to meeting the needs of individuals requiring mental health services. However, unless the General Assembly extends the life of the ICAAC in the 2008 Legislative Session, the ICAAC will sunset on June 30, 2008

Since its inception in 2005, the ICAAC has focused on issues related to medical screening and evaluation of persons involved in the emergency custody and temporary detention process, and on law enforcement transportation during the process. Its work has been largely eclipsed this past year by the work of the Commonwealth's Mental Health Law Reform Commission. Whether the ICAAC is the appropriate vehicle to provide system-wide oversight is unclear. Because the commitment process is essentially a judicial process, it is appropriate that the Supreme Court of Virginia be primarily responsible for the management and oversight of the civil commitment process. Without the Court's effective involvement, neither the ICAAC nor any other interagency organization will be of sufficient stature to oversee the system.

Many functions relating to the commitment process, beginning with evaluation and continuing through treatment and discharge are within the purview of the mental health services system. The CSBs play a central role in this process, and the role and responsibilities of the CSBs would be increased significantly under the CCTF recommendations for implementing mandatory outpatient treatment.[58] Ultimately the Department of Mental Health, Mental Retardation and Substance Abuse Services, using its various oversight mechanisms, including performance contracts, must oversee the service system responsibilities for evaluation, consultation, monitoring and treatment.

Recommendations:

Recommendation IX.1. The Code of Virginia should be amended to require the Executive Secretary's Office of the Supreme Court to take an active role in the monitoring and oversight of the civil commitment process in Virginia, and to provide guidance to judges, Special Justices, magistrates and clerks on the requirements of the law and its appropriate implementation and enforcement.

Recommendation IX.2. The Supreme Court should continue to review the infrastructure for the training, monitoring and oversight of magistrates and to make changes where appropriate. If the Supreme Court decides to keep the current system in place, the chief judges of the circuit and the Executive Secretary's Office should be required to take a more active role in the monitoring and supervision of the magistrates. Otherwise the magistrate system should be supervised centrally by the Executive Secretary's Office of the Supreme Court.

Recommendation IX.3. Similar to substitute judges, Special Justices should continue to be appointed by the chief judge of the circuit for a six-year term, as enacted during the 2007 General Assembly Session. The Code of Virginia should be amended to require the chief judge of the circuit to monitor and supervise the performance of the Special Justice(s) appointed in that circuit. In order to be reappointed, the Code of Virginia should be amended to require Special Justices to

[58] See Chapter VI.

complete continuing education requirements specified by the Supreme Court. The Code of Virginia should also be amended to require the chief judge of the circuit to solicit feedback concerning the Special Justice's performance through an anonymous survey of members of the local bar, mental health professionals, consumers and family members before reappointment (similar to the survey developed for sitting judges seeking reappointment).

Recommendation IX.4. The Code of Virginia should be amended to require judges and Special Justices to appoint and monitor the performance of court-appointed counsel and Independent Examiners and, in consultation with the chief circuit court and the general district court judges, remove them from the court appointed list or cease to appoint them, when appropriate.

Recommendation IX.5. The Code of Virginia should be amended to require a committee to be established in each judicial district composed of judges, Special Justices, magistrates, law enforcement officers, community services board staff, private providers, peer counselors, consumers and family members that would meet regularly to discuss the operation of the commitment process in that district, address issues or concerns and make recommendations for improvement.

Recommendation IX.6. The Supreme Court should establish an ongoing advisory committee composed of Special Justices, magistrates, clerks of court, public and private mental health professionals, consumers and family members to monitor the quality of implementation of the civil commitment process and to recommend changes to the system. This could be the same committee as recommended in VIII-5. The committee should solicit feedback on a biennial basis from all participants in the process, including individuals who have been the subjects of the proceedings and their family members, through the use of surveys, focus groups or other activities and make recommendations to the Chief Justice for system improvement. The civil commitment process is a judicial process. Unless the Supreme Court retains the responsibility for its implementation, efforts of the legislative and executive branches of government to improve the process will not be effective.

Recommendation IX.7. If the decision is made to continue the Interagency Civil Admissions Advisory Council, its role should be expanded to give it authority to issue guidelines for the consistent application of civil commitment process statewide and to foster cooperation and collaboration among all of the participants. It should also serve as a liaison with the Supreme Court advisory committee referenced in VII.6 and IX.6 above.

Recommendation IX.8. The Code of Virginia should be amended to require the Supreme Court to collect and analyze on an ongoing basis computerized data on numbers and types of hearings conducted, payments made for each type of hearing, and payments made to each participant in the hearing including the Special Justice, court-appointed attorney, and the Independent Examiner. The billing forms should

be revised to provide more accurate and useful information. Online direct entry databases should be established as soon as feasible.

Recommendation IX.9. Databases should be established to ascertain the effects of changes in law or policy, ensure quality assurance, measure costs and promote system improvement. CSB prescreeners should submit the pre-admission screening form or a shorter form to a DMHMRSAS maintained database or magistrates should submit such a form to the Supreme Court to monitor the numbers of emergency custody and temporary detention orders sought, the decisions rendered and other information. Judges or Special Justices should also submit similar short forms on the disposition of each case, including information concerning any outpatient commitment orders entered and follow-up hearings. If Independent Examiners are given dispositional authority, as recommended in Chapter III, the Supreme Court should require the Independent Examiner to submit similar information related to his or her certification and the disposition of the case.

Recommendation IX.10. The DMHMRSAS should conduct a Crisis Contact Survey periodically, similar to the Commission's Crisis Evaluation Study, **June 2007, to take a snapshot of the system on a regular basis.**

Recommendation IX.11. The Supreme Court should also request the judges and Special Justices, and Independent Examiners if their role is expanded, to complete a periodic survey on the characteristics and dispositions of every hearing, similar to the one conducted by the Commission in May 2007.

Recommendation IX.12. In recommending increased data collection and analysis above, the CCTF also urges that the Commission and Supreme Court keep in mind that data gathering and analysis is time consuming and costly. Information should not be gathered that is not going to be useful. Any data gathered should be kept to a minimum with an eye towards making it accurate, user friendly and as non-invasive as possible.

APPENDIX I

CIVIL COMMITMENT TASK FORCE RECOMMENDATIONS

CHAPTER I. EMERGENCY SCREENING

Recommendation I.1. The Code of Virginia should be amended so that the four-hour detention period under an ECO should be renewable once, for good cause shown and upon application to a magistrate, for an additional period of not more than four hours. The resulting maximum ECO period would be eight hours.

Recommendation I.2. The General Assembly should fund one or more crisis stabilization facilities with drop-off capability in each region of the Commonwealth.

Recommendation I.3. Section 37.2-808 of the Code of Virginia should be amended as follows:

> **"Upon delivery of the person to the location identified in the emergency custody order, or to an appropriate location if the law enforcement officer has assumed custody of the person under subsection F, the location to which the person is transported may assume custody of the person if it is willing and licensed to provide security to protect the individual and others from harm."**

Recommendation I.4. There should be a psychiatric bed reporting system for all licensed facilities in the Commonwealth.

Recommendation I.5. Assuming a state-wide psychiatric bed management system is implemented, the Code of Virginia should be amended so that when a magistrate determines that a respondent meets commitment criteria and a bed for that respondent has not been located within the maximum time allowed for the respondent's ECO, the magistrate would be able to issue a TDO without first identifying a specific bed for the respondent.

Recommendation I.6. The Code of Virginia should be amended to permit a three-tiered transportation model for persons in the civil commitment process. This will permit different parties to transport the respondent during the various stages of the commitment process depending upon the level of risk involved in each individual's circumstances.

Recommendation I.7. The DMHMRSAS shall include in the training and certification of CSB prescreeners the process of risk assessment for purposes of determining the appropriateness of the use of restraints and level of transportation of individuals subject to any stage of the commitment process applicable to all CSBs and BHAs. Such assessment must include the risk to individuals of using restraints.

Recommendation I.8. The Department of Criminal Justice Services shall prepare policies and procedures to minimize the use of restraints for transportation of individuals subject to any stage of the commitment process applicable to all law enforcement agencies in the Commonwealth.

Recommendation I.9. The Code of Virginia should be amended to reflect that the Commonwealth must provide transportation to those who are subject to any part of the commitment process, including transportation following discharge.

CHAPTER II. CERTIFICATION PROCESS

Recommendation II.1. The Code of Virginia should be amended so that the maximum time for a TDO would be four days with the necessary extensions if the period ends on a weekend or holiday.

Recommendation II.2. The Code of Virginia should be amended so that no hearing can be held less than twenty-fours (24) hours after the execution of a TDO.

Recommendation II.3. The Code of Virginia § 37.2-815 should be amended as follows:

> **Notwithstanding § 37.2-814, the district court judge or special justice shall require an examination of the person who is the subject of the hearing by a psychiatrist or a psychologist who is licensed in Virginia by the Board of Medicine or the Board of Psychology and is qualified in the diagnosis of mental illness or, if such a psychiatrist or psychologist is not available, ~~any mental health professional who is (i) licensed in Virginia through the Department of Health Professions and (ii)~~ the examination may be conducted by a licensed clinical social worker who is qualified in the diagnosis of mental illness. Prior to his or her appointment, any such examiner appointed shall complete a certification program approved by the Department.~~The examiner chosen shall be able to provide an independent examination of the person. The examiner shall (a) not be related by blood or marriage to the person, (b) not be responsible for treating the person, (c) have no financial interest in the admission or treatment of the person, (d) have no investment interest in the facility detaining or admitting the person under this chapter, and (e) except for employees of state hospitals, the U.S. Department of Veterans Affairs, community service boards, and behavioral health authorities, not be employed by the facility. For purposes of this section, the term "investment interest" shall be as defined in § 37.2-809.~~

Recommendation II.4. The Code of Virginia should be amended to require the Independent Examiner to review the prescreening report and all readily available and relevant records and collateral information, including an available advance directive or the respondent's preferences if there is no advance directive and trauma history. At a minimum, the Independent Examiner must review the relevant medical records of the TDO facility regarding a respondent. The Independent Examiner's evaluation should identify all records, which were reviewed.

Recommendation II.5. The Code of Virginia should be amended to require that an Independent Examiner appointed by the court should examine the person within 48

hours of execution of the temporary detention order issued by the magistrate, and sufficiently in advance of the hearing to ensure the evaluation will be complete before the beginning of the hearing. The examination must occur at the treatment facility where the person is being detained.[59] (Some members believe that this should occur whether or not the time frame for conducting the commitment hearing is extended.)

Recommendation II.6. The Code of Virginia should be amended to permit the Independent Examiner to authorize the release of an individual from a TDO if that person does not meet commitment criteria.

Proposal II.7. The Code of Virginia should be amended to provide that the role of the Independent Examiner should be established as a quasi-judicial officer with immunity from liability.

Proposal II.8. The Code of Virginia should be amended to clarify that a TDO does not require a hearing. A respondent can be released from the TDO at any time during the TDO period without a hearing where (1) the treating physician or other person if specified by a facility's protocol discharges the respondent prior to the time the Independent Examiner conducts his or her evaluation; (2) the Independent Examiner does not certify probable cause for commitment and there has been no written recommendation to the contrary made by the treatment provider[60]; (3) the respondent agrees to voluntary treatment and the treating physician agrees that voluntary treatment is appropriate; or (4) no petition is filed. The CSB and the petitioner will be given notice of the release of the respondent from the TDO prior to the respondent's release.

Recommendation II.9. The Code of Virginia should be amended to provide that if an individual chooses voluntary inpatient treatment under any circumstances after an ECO or TDO is issued, that person must give 24 hours notice before leaving

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[59] This Recommendation is contingent on an appropriate increase in compensation for the examination as it will require a commitment of time that is not adequately compensated under the current system.

[60] (Option A) ***A new form should be prepared so both the Independent Evaluator and the treatment provider both have check boxes: yes there is probable cause and no there is no probable cause; where both choose no, the respondent would be released; where one says no, there should be an expedited hearing; where both say yes, the hearing would be scheduled in the ordinary course of docketing.***
(Option B) ***A new form should be prepared so both the Independent Evaluator and the treatment provider both have check boxes: yes there is probable cause and no there is no probable cause; where both choose no, the respondent would be released; in all other cases the hearing would be scheduled in the ordinary course of docketing.***

treatment. In cases where the facility determines a release is appropriate, the facility may release the person prior to the end of the 24 hours.

Recommendation II.10. The Independent Examiner must certify his findings to the court in writing and be available to present testimony if the Special Justice requests in-person testimony. (See Recommendation III.3.)

CHAPTER III. HEARING AND ADJUDICATION

Recommendation III.1. The current Virginia Code provisions regarding treatment pending a hearing should remain unchanged.

Recommendation III.2. The Code of Virginia should be amended to require a CSB representative to attend all commitment hearings.

Recommendation III.2 may be addressed with the following statutory language.

> **An employee or designee of the CSB or BHA that prepared the preadmission screening report shall attend the hearing either in person or if unable to attend in person by using a telephonic communication system as provided in § 37.2-804.1. If the hearing is held outside the jurisdiction of the CSB or BHA and a representative of that CSB or BHA cannot attend in person or by using a telephonic communication system, arrangements shall be made for a representative of the CSB or BHA where the hearing takes place to attend the hearing on behalf of the CSB or BHA preparing the report. The judge or special justice may waive this requirement if it appears practically impossible for a representative of the CSB or BHA to attend.**

Recommendation III.3. The Code of Virginia should be amended to require the Independent Examiner to attend the hearings of individuals he or she has examined, in person or electronically, if the person or his attorney objects to his report, or if the treating physician contests his opinion.

Recommendation III.3 may be addressed with the following statutory language:

> **"If the independent examiner has determined that the person does not meet commitment criteria and that opinion is objected to by the treating physician, the independent examiner shall attend the hearing in person or by means of a telephonic communication system as provided in § 37.2-804.1 to determine whether his response would change based upon the evidence presented at the hearing. In all other circumstances, the examiner's written certification may be accepted into evidence unless objected to by the person or his or her attorney in which case the examiner must attend in person or by electronic communication."**

Recommendation III.4. The Code of Virginia should be amended to facilitate electronic testimony by other witnesses.

Recommendation III.4 may be addressed with the following statutory language:

In addition to CSB or BHA representatives, witnesses, including family members and private providers familiar with the person's condition or services provided, may testify at the hearing using a telephonic communication system as provided in § 37.2-804.1 if they are unable to attend in person. The court shall also admit into evidence when offered by the person who is the subject of the hearing statements from the person's treatment providers submitted by facsimile or by deposition.

Recommendation III.5. Section 37.2-817.A. of the Code of Virginia should be amended as follows:

The district court judge or special justice shall render a decision on the petition for involuntary admission after the appointed Independent Examiner has presented his report, orally or in writing, pursuant to § 37.2-815 and after the community services board or behavioral health authority that serves the county or city where the person resides or, if impractical, where the person is located has presented a preadmission screening report, orally or in writing, with recommendations for that person's placement, care, and treatment pursuant to § 37.2-816. These reports <u>shall be admitted into evidence as a business records exception to the hearsay rule, and</u> if not contested, may constitute sufficient evidence upon which the district court judge or special justice may base his decision.

Recommendation III.6. The Supreme Court shall establish standards of practice and establish certification criteria for defense attorneys. (Some CCTF members prefer this requirement to be codified)

Recommendation III-7. Immediately upon the filing of the petition or execution of the TDO, whichever occurs first, the court shall appoint an attorney to represent the person, if the person is unable to employ one, and advise the person of the attorney's name and contact information.

Recommendation III.8. The Commonwealth should fund an attorney to represent the petitioner at all commitment hearings. [61]

Option III-8 (a). Choices for attorneys for petitioners should include city attorneys, and county attorneys.

[61] Some CCTF members believe providing counsel for petitioners, especially if the Commonwealth's Attorney provides that representation is a bad idea.

Option III-8 (b). In addition to the attorneys listed in Option III.8 (a), Commonwealth's Attorneys should be considered if no other attorneys are available to represent the petitioner. [62]

Recommendation III.9. If the court grants a continuance on the request of a respondent, the court shall have the authority to order continuation of the respondent's detention until the hearing occurs, even if it occurs after the TDO expires. Any additional payments due to the facility shall be paid from the Involuntary Mental Commitment Fund.

Option III-9 (a). If the court grants a continuance on the request of any party for good cause shown, the court shall have the authority to order continuation of the respondent's detention until the hearing occurs, even if it occurs after the TDO expires. Any additional payments due to the facility shall be paid from the IMC Fund.

Option III-9 (b). If the court grants a continuance on its own motion, the court shall have the authority to order continuation of the respondent's detention until the hearing occurs, even if it occurs after the TDO expires. Any additional payments due to the facility shall be paid from the IMC Fund.

Recommendation III.10. If the court grants a continuance, the hearing shall be scheduled by the court as an exercise of its discretion, but in no event shall the hearing be held later than forty-eight hours after the end of the TDO, weekends and holidays excepted.

Recommendation III.11. If the court grants a continuance, the report of the Independent Examiner must be redone if the rescheduled hearing occurs after the original report expires and the Independent Examiner shall be paid for the second evaluation.

Recommendation III.12. The original inpatient commitment order should be interpreted to authorize a treatment facility to move a person subject to inpatient treatment to outpatient treatment when such a move is medically appropriate and all other conditions of outpatient treatment are applicable.

Recommendation III.13. The first order for inpatient commitment in a particular episode of treatment can be for up to 30 days. Orders of continuation of commitment would be for up to 90 and 180 days. Orders of continuation of commitment for those completing a 180-day commitment may be issued for an additional 180 days. Orders of continuation of commitment must be for up to the

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62 The appointment of a Commonwealth Attorney is opposed by some CCTF members due to the potential that this would be viewed as criminalizing the process.

duration next in the sequence. Orders of continuation of commitment must be based on the respondent's condition at the time of the subsequent commitment hearings and applied to the criteria for commitment. A treating facility must file a written petition for continuation of commitment at least 7 days before an existing order of commitment expires. All procedures required for the initial hearing in conjunction with a TDO are required for each hearing for continuation of commitment. An individual subject to an order of commitment can pursue voluntary treatment at any hearing for continuation of commitment just as permitted in the initial commitment hearing. (All times are to be considered as the maximum time permitted for commitment; respondents can be released earlier if medically appropriate.)

CHAPTER IV. PROTECTIONS FOR SUBJECTS OF INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS

Recommendation IV.1. As a result of the existing infrastructure at DMHMRSAS to monitor policies and practices in the community pharmacy system, the CCTF recommends that the DMHMRSAS continue to implement the Community Resource Pharmacy ("CRP") Therapeutics and Formulary Committee ("P&T") for reviewing practice and distribution issues and its use be expanded to monitor patients for adverse side effects as part of an overall quality assurance program. The CCTF further recommends that the CRP P&T Committee be statutorily established pursuant to Virginia Code § 8.01-581.16 and that the Community Services Boards be encouraged to participate in this or other regional or privately affiliated psychopharmacological review committees.

Recommendation IV.2. The DMHMRSAS and the CSBs should study the issue of consumer liability or responsibility for the costs of services received as a result of a court orders for involuntary inpatient admission or mandatory outpatient treatment and should identify mechanisms (e.g. uniform criteria that would be included in local reimbursement policies or ability to pay criteria) for adjusting or "writing off" the consumer's liability for such services while preserving the ability of providers to recover their costs for these services from third party payers. The Commission should also consider recommending the repeal of the provisions in Virginia Code § 37.2-808 requiring an individual who is the subject of civil commitment proceedings to pay the cost of the examination, hearing and proceeding.

Recommendation IV.3. All health care providers should review their policies and procedures to ensure that they encourage individuals, unless clinically contraindicated, to designate family members, friends and others who may be told of their presence in or transfer to a facility so they may be available to provide support and assistance to this individual.

Recommendation IV.4. The Commission should consider additional protections to be included in the Virginia Code or applicable regulations to protect individuals subject to temporary detention orders and orders for involuntary inpatient admission from eviction.

Recommendation IV.5. The Code of Virginia and applicable regulations should be amended to protect persons under TDOs or involuntary inpatient admission orders from loss of housing or other adverse financial consequences attributable solely to the occurrence of commitment proceedings and subsequent involuntary hospitalization or mandatory outpatient treatment.

CHAPTER V. INVOLUNTARY ADMISSION TO A FACILITY

No Recommendations were made.

CHAPTER VI. MANDATORY OUTPATIENT TREATMENT

No Recommendations were made.

CHAPTER VII. TRAINING

Recommendation VII.1. The Code of Virginia should be amended to require the Virginia Supreme Court to develop an initial certification course and requirements, similar to those for guardians *ad litem* representing incapacitated persons, for attorneys who serve as court-appointed counsel representing respondents in the civil commitment process. Special Justices who have not served on the court-appointed list should also be required to complete the initial certification course within six months of appointment. Special Justices and attorneys should further be required to obtain at least six hours of continuing legal education every two years in courses approved for this purpose by the Supreme Court.

Recommendation VII.2. The Virginia Supreme Court should sponsor statewide conferences for Special Justices once every two years providing Special Justices with the opportunity to obtain updates on the law and the latest initiatives in mental health clinical practice and administration, and to discuss issues they encounter as judges.

Recommendation VII.3. Regional or local conferences should be held once every two years, in the years statewide conferences are not held, for Special Justices, attorneys, magistrates, law enforcement, independent examiners, public and private mental health professionals, consumers and family members for training on updates to the law, local practice and issues of concern in their community.

Recommendation VII.4. Although the training provided to magistrates is comprehensive, it could be improved by providing input from consumers, family members, and mental health professionals and administrators on information related to impact of the system on consumers, family members and other professionals, and providing updates on mental health treatment and service delivery improvements and initiatives.

Recommendation VII.5. The Code of Virginia should be amended to require the Supreme Court to establish an advisory committee of Special Justices, attorneys, magistrates, public and private mental health professionals, consumers and family members to plan upcoming training programs for Special Justices, attorneys and magistrates, to monitor and oversee the effectiveness of the training and to recommend approval of continuing legal education courses.

Recommendation VII.6. Section 9.1-102 of the Code of Virginia should be amended to require the Department of Criminal Justice Services to develop minimum compulsory training standards and publish a model policy for law enforcement concerning the execution of emergency custody and temporary detention orders and the provision of transportation during the civil commitment process. Training

academies should be encouraged to develop routine, ongoing training in CIT interventions.

Recommendation VII.7. The Virginia General Assembly should be requested to appropriate sufficient funds to expand CIT or similar programs statewide, and to integrate these training programs into the law enforcement training academy curricula. "Train the trainer" programs should be developed to further facilitate the training of law enforcement officers statewide. In addition, all law enforcement officers and dispatchers should be trained in addressing issues related to persons with mental illness, even if they do not receive the full CIT 40-hour program.

Recommendation VII.8. The Code of Virginia should be amended to require Independent Examiners to be appointed by the judge or Special Justice and to require them to complete a certification program for Independent Examiners approved by the Department of Mental Health, Mental Retardation and Substance Abuse Services prior to their appointment.

Recommendation VII.9. The DMHMRSAS and the VACSB should continue to update the certification program currently provided to prescreeners and review and update it at regular intervals. All participants in the commitment process, including consumers and family members, should be asked to provide input into development of the curriculum and participate in the training.

Recommendation VII.10. The DMHMRSAS should request additional appropriations and grants to fund peer counselors to serve in inpatient, outpatient and mental health crisis situations to counsel and assist individuals involved in the civil commitment process better understand the process and participate in their own recovery and to advocate for improvements in the system at both the state and local level.

CHAPTER VIII. COMPENSATION FOR SPECIAL JUSTICES, COURT-APPOINTED ATTORNEYS AND INDEPENDENT EXAMINERS

Recommendation VIII.1. If the duties of Special Justices, attorneys and Independent Examiners in the inpatient and mandatory outpatient commitment process are increased, the fees should be increased commensurate with the increased amount of the time and work required. If no changes are made in the responsibilities and training time requirements for Special Justices, attorneys and Independent Examiners, the CCTF recommends the changes in fees set out in Recommendation VIII.2 below.

Recommendation VIII.2. The Supreme Court should request an additional appropriation from the General Assembly to adequately increase the fees for Special Justices, court appointed attorneys, and Independent Examiners. The CCTF developed two options for determining the fee levels.

> **Option 1. Consideration should be given to increasing the fees paid to Special Justices, court-appointed attorneys and Independent Examiners based on the increase in the consumer price index since 1998.**
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> **Option 2. In the alternative, consideration should be given to paying Special Justices, court-appointed attorneys, and Independent Examiners comparable to payment made to attorneys in juvenile commitment hearings, or $ 100.00 per case.**

Recommendation VIII.3. Fees in hearings for judicial certification of persons with mental retardation to a training center and in hearings for judicial authorization for treatment should be the same as for those in commitment hearings, except when the judicial authorization for treatment hearing is held in conjunction with, at the same time as, or immediately following a commitment hearing, in which case the fee should be one half the amount of the fee in the commitment hearing.

Recommendation VIII.4. Special Justices and attorneys in areas with high volumes of hearings are paid considerably more overall than those in low volume areas. Fees paid to Special Justices, attorneys and Independent Examiners should therefore be subject to a fee cap. The Supreme Court should review its payment rates to determine where the cap should fall. Consideration should also be given to capping the number of individuals an attorney may be appointed to represent on any given day to ensure he or she has adequate time to devote to advocating the position of each person he represents.

Recommendation VIII.5. Consideration should be given to paying a court-appointed attorney in a jury trial in circuit court (when the original commitment order is appealed) an increased fee of up to $300.00.

Recommendation VIII. The Supreme Court should review the fees paid to Special Justices, court-appointed attorneys, and Independent Examiners at least every four years for adequacy and request increased appropriations when appropriate.

CHAPTER IX. FUTURE OVERSIGHT OF THE CIVIL COMMITMENT PROCESS

Recommendation IX.1. The Code of Virginia should be amended to require the Executive Secretary's Office of the Supreme Court to take an active role in the monitoring and oversight of the civil commitment process in Virginia, and to provide guidance to judges, Special Justices, magistrates and clerks on the requirements of the law and its appropriate implementation and enforcement.

Recommendation IX.2. The Supreme Court should continue to review the infrastructure for the training, monitoring and oversight of magistrates and to make changes where appropriate. If the Supreme Court decides to keep the current system in place, the chief judges of the circuit and the Executive Secretary's Office should be required to take a more active role in the monitoring and supervision of the magistrates. Otherwise the magistrate system should be supervised centrally by the Executive Secretary's Office of the Supreme Court.

Recommendation IX.3. Similar to substitute judges, Special Justices should continue to be appointed by the chief judge of the circuit for a six-year term, as enacted during the 2007 General Assembly Session. The Code of Virginia should be amended to require the chief judge of the circuit to monitor and supervise the performance of the Special Justice(s) appointed in that circuit. In order to be reappointed, the Code of Virginia should be amended to require Special Justices to complete continuing education requirements specified by the Supreme Court. The Code of Virginia should also be amended to require the chief judge of the circuit to solicit feedback concerning the Special Justice's performance through an anonymous survey of members of the local bar, mental health professionals, consumers and family members before reappointment (similar to the survey developed for sitting judges seeking reappointment).

Recommendation IX.4. The Code of Virginia should be amended to require judges and Special Justices to appoint and monitor the performance of court-appointed counsel and Independent Examiners and, in consultation with the chief circuit court and the general district court judges, remove them from the court appointed list or cease to appoint them, when appropriate.

Recommendation IX.5. The Code of Virginia should be amended to require a committee to be established in each judicial district composed of judges, Special Justices, magistrates, law enforcement officers, community services board staff, private providers, peer counselors, consumers and family members that would meet regularly to discuss the operation of the commitment process in that district, address issues or concerns and make recommendations for improvement.

Recommendation IX.6. The Supreme Court should establish an ongoing advisory committee composed of Special Justices, magistrates, clerks of court, public and private mental health professionals, consumers and family members to monitor the quality of implementation of the civil commitment process and to recommend changes to the system. This could be the same committee as recommended in VIII-5. The committee should solicit feedback on a biennial basis from all participants in the process, including individuals who have been the subjects of the proceedings and their family members, through the use of surveys, focus groups or other activities and make recommendations to the Chief Justice for system improvement. The civil commitment process is a judicial process. Unless the Supreme Court retains the responsibility for its implementation, efforts of the legislative and executive branches of government to improve the process will not be effective.

Recommendation IX.7. If the decision is made to continue the Interagency Civil Admissions Advisory Council, its role should be expanded to give it authority to issue guidelines for the consistent application of civil commitment process statewide and to foster cooperation and collaboration among all of the participants. It should also serve as a liaison with the Supreme Court advisory committee referenced in VII.6 and IX.6 above.

Recommendation IX.8. The Code of Virginia should be amended to require the Supreme Court to collect and analyze on an ongoing basis computerized data on numbers and types of hearings conducted, payments made for each type of hearing, and payments made to each participant in the hearing including the Special Justice, court-appointed attorney, and the Independent Examiner. The billing forms should be revised to provide more accurate and useful information. Online direct entry databases should be established as soon as feasible.

Recommendation IX.9. Databases should be established to ascertain the effects of changes in law or policy, ensure quality assurance, measure costs and promote system improvement. CSB prescreeners should submit the pre-admission screening form or a shorter form to a DMHMRSAS maintained database or magistrates should submit such a form to the Supreme Court to monitor the numbers of emergency custody and temporary detention orders sought, the decisions rendered and other information. Judges or Special Justices should also submit similar short forms on the disposition of each case, including information concerning any outpatient commitment orders entered and follow-up hearings. If Independent Examiners are given dispositional authority, as recommended in Chapter III, the Supreme Court should require the Independent Examiner to submit similar information related to his or her certification and the disposition of the case.

Recommendation IX.10. The DMHMRSAS should conduct a Crisis Contact Survey periodically, similar to the Commission's Crisis Evaluation Study, **June 2007, to take a snapshot of the system on a regular basis.**

Recommendation IX.11. The Supreme Court should also request the judges and Special Justices, and Independent Examiners if their role is expanded, to complete a periodic survey on the characteristics and dispositions of every hearing, similar to the one conducted by the Commission in May 2007.

Recommendation IX.12. In recommending increased data collection and analysis above, the CCTF also urges that the Commission and Supreme Court keep in mind that data gathering and analysis is time consuming and costly. Information should not be gathered that is not going to be useful. Any data gathered should be kept to a minimum with an eye towards making it accurate, user friendly and as non-invasive as possible.

APPENDIX II

ACRONYMS

ACT	Assertive Community Treatment
BHA	Behavioral Health Authority
CCJB	Community Criminal Justice Board
CSA	Comprehensive Services Act
CSBs	Community Service Board
CIT	Crisis Intervention Teams
CLE	Continuing Legal Education
CRP	Community Resource Pharmacy
DCJS	Department of Criminal Justice Services
DOC	Department of Corrections
DMAS	Department of Medical Assistance Services
DMHMRSAS	Department of Mental Health, Mental Retardation, and Substance Abuse Services
ECO	Emergency Custody Order
FPS	Forensic Peer
FERPA	Family Educational Rights and Privacy Act
HIPAA	Health Insurance Portability and Accountability Act
IE	Independent Examiner
ICAAC	The Interagency Civil Admissions Advisory Council
JIRC	Judicial Inquiry Review Commission
JLARC	Joint Legislative Audit and Review Commission
MCES	Montgomery County Emergency Services
MCT	Mobile Crisis Team
MOT	Mandatory Outpatient Treatment
NAMI	National Alliance on Mental Illness
NGRIS	Not Guilty by Reason of Insanity
NIMH	National Institute of Mental Health
OIG	Office of the Attorney General
ORTS	Offender Re-entry and Transition Services
PACT	Program of Assertive Community Treatment
PMI	Person with Mental Illness
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SIM	Sequential Intercept Model
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
SMI	Severe Mental Illness
TDO	Temporary Detention Order
VACSB	Virginia Association of Community Service Boards
VOCAL	Virginia Organization of Consumers Asserting Leadership
WRAP	Wellness Recovery Action Plans