SUPPLEMENTAL REPORT TO THE COMMISSION ON MENTAL HEALTH LAW REFORM

From the Mental Health Training and Implementation Task Force

October 5, 2009

PREFACE

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

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

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

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

In December, 2008, the Commission issued a Progress Report reviewing its work in 2008 and providing a status report on the progress of mental health law

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

During 2009, the Commission focused on implementation and refinement of the reforms adopted during 2008 and 2009 and on several key issues that had been deferred, including the length of the emergency hospitalization period (the "TDO" period) and the possible expansion of mandatory outpatient treatment. The Commission also continued to study ways of enhancing access to services in an integrated services system. Its Progress Report for 2009 can be found at http://www.courts.state.va.us/programs/cmh/2009_progress_report.pdf.
The Commission plans to complete its work in 2010.

The accompanying Supplemental Repor dated October 5, 2009, represents the views and recommendations of the members of the Task Force on Training and Implementation, and should not be construed as reflecting the opinions or positions of the Commission on Mental Health Law Reform, the Chief Justice, the individual Justices of the Supreme Court of Virginia, or of the Executive Secretary of the Supreme Court. The Commission's recommendations are set forth in its Progress Report for 2009. Any recommendations or proposals embraced by the Court itself will lie exclusively within the judicial sphere.

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

INTRODUCTION

This report supplements the initial Report to the Commission on Mental Health Law Reform from the Legislative, Training and Implementation Task Force dated August 5, 2009. The Initial Report was presented to the Commission at its meeting in Williamsburg on August 5, 2009, and copies of that report are available from the Commission upon request.

The Task Force met again on Wednesday, September 2, 2009, at the Supreme Court Building in Richmond. The agenda items at that meeting of the Task Force included the following.

- Discussion of the proposal to establish a Task Force in the JCHC to continue the Commission's work after June 30, 2010.
- A progress report on the DBHDS "Roundtable Meeting" deliberations to discuss the dissemination, utilization and effectiveness of the Medical Screening and Assessment Guidelines.
- Examination of the OES Case Management System (CMS) data and its implications regarding the consistency of outcomes in commitment proceedings around the Commonwealth.
- A discussion of the need for reforming or improving the process of providing for appeals of involuntary commitment decisions to Circuit Court under Code § 37.2-821.
- Other implementation concerns arising from training, drafting, interpretation, forms or communication issues.

A summary of the Task Force deliberations on each of these items follows.

Continuing the Commission's Work

The Task Force engaged in spirited discussion regarding the proposal to establish a Task Force within the Joint Commission on Health Care to continue the work of the Mental Health Commission after it sunsets on June 30, 2010. Alternative approaches were suggested by several Task Force members, and the group resolved to set up a subcommittee to engage in further discussions on this subject with Professor Bonnie. The outcome of that subcommittee's work will be taken up with the Commission as a separate agenda item later during the course of this meeting.

"Roundtable Meetings" - Medical Screening and Assessment Issues

The "Roundtable Meetings" were initiated by DBHDS as a result of Task Force reports that in some areas, there was a disconnect between emergency room and other physicians, and psychiatric and other admitting facilities, on the scope and need for medical screening and assessment before an individual may be admitted to a facility under a TDO or for other treatment. In early 2007, a work group was convened to create "Medical Screening and Assessment Guidance Materials" to provide some direction for physicians and facilities in order to promote consistency and cooperation in meeting this need. These Guidance Materials were distributed to all relevant users at that time, and are posted on the DBHDS Website. The Task Force has learned, however, that the Guidance Materials have fallen out of use. Accordingly, the Task Force resolved to reconvene the original working group in order to re-examine and update the Guidance Materials as may be needed, and to provide information and education about the guidelines to all relevant users, including the constituents of the Medical Society of Virginia, the Psychiatric Society of Virginia, the College of Emergency Physicians and

the Virginia Hospital and Healthcare Association. Attached for your information, and to highlight some of the issues generated by the screening and assessment process, is an outline of issues and concerns that have been collected from stakeholders and participants. The Medical Screening and Assessment Guidance Workgroup is scheduled to meet on Thursday, October 1, 2009, to discuss these issues and concerns, along with a strategy for updating and disseminating the Guidelines. Jim Martinez, who is convening the group, will provide an oral report to the Commission on the outcome of the group's deliberations at the Commission meeting on Monday, October 5th.

CMS Data Demonstrate Inconsistency in Commitment Outcomes

CMS Commitment Hearing Data from the last three quarters for FY 2009 show that commitment results by locality continue to be widely divergent, in terms of, among other things, the percentages of cases resulting in dismissals, and in terms of cases resulting in voluntary and involuntary commitments. For instance, data from the City of Portsmouth shows that 22.8% of commitment cases were dismissed, while 77% resulted in voluntary or involuntary commitment. Data from the City of Roanoke, on the other hand, indicates a dismissal rate of only 2.2%, with a total of 97% of cases resulting in voluntary or involuntary commitment. Data from other localities likewise shows great differences in the rates of voluntary vs. involuntary commitment outcomes. One of the goals of reform was to promote consistency in the process around the Commonwealth. The Task Force members discussed potential causes for these inconsistencies, including factors such as regional variations in resources and conditions; variations in attitudes and interpretations of the law by particular special justices; variations in attitudes and

evaluation techniques by particular independent examiners; and disparities in the data collection itself. Members of the Task Force expressed the view that these data should be shared with all participants and stakeholders in the involuntary civil commitment process. Accordingly, Professor Bonnie will be providing a review and leading a discussion on the CMS data as a separate agenda item during the October Commission meeting.

Appeals to Circuit Court

The Task Force was asked to take a look at the statutory procedures for appealing a commitment decision to Circuit Court as spelled out in Code § 37.2-821. The Task Force designated a subcommittee, Chaired by Special Justice David B. Bice, of Lynchburg, to examine the practices and procedures under the statute and to offer any input or suggestions they might have for clarifying or improving the process. The topics considered by the subcommittee included, among other things: whether the provisions mandating venue of the appeal should be reconsidered; tightening up the definitions of the parties in the process; whether the procedures for requiring a new or updated preadmission screening report should be revised; whether the language requiring the Attorney for the Commonwealth to "defend" the order should be revised; and whether the 30 day time limit to file an appeal should be reviewed. The subcommittee has prepared an amended version of the statute that is attached to this report. Mr. Bice or one of the members of his subcommittee will be present at the Commission meeting on October 5th to describe the subcommittee's deliberations and to explain the proposed changes to the statute.

SUPPORT AND TRAINING OF SPECIAL JUSTICES, ATTORNEYS AND GUARDIANS AD LITEM

During the course of its deliberations over the last two years, this Task Force has discussed a number of goals and proposals for improving oversight, support and training for special justices, attorneys and guardians ad litem (GALs) involved in the civil commitment process. We are pleased to report that the Supreme Court's Office of the Executive Secretary has implemented certain of these proposals relating to special justices, particularly as concerns clarifying the role of the Chief Judge in each Judicial Circuit to supervise and monitor the performance of the special justices appointed in their jurisdictions.

There is more, however, that remains to be done. Virginia's system of having special justices appointed in each judicial circuit, and vesting those special justices with all the powers of a judge, including the power to deprive a person of his or her liberty through the involuntary commitment process, is unique in many respects. It also presents a unique set of problems, in that, unlike magistrates, district court and circuit court judges, special justices do not have an organization or support system to provide them with staff support, guidance, or research assistance in addressing the weighty issues that come before them in deciding these difficult cases. Accordingly, the Task Force has recommended in the past and continues to recommend that the Supreme Court's Office of Executive Secretary (OES) should consider establishing a position of "Special Justice Advisor" in the OES to serve, like the OES Magistrate Advisors, as a resource to provide

guidance to special justices, and also to implement and coordinate conferences, certification and training events for special justices.

However, in view of the state budget shortfall and in recognition of the inability of state agencies to create new positions or establish new programs, the Task Force proposes that, until changing circumstances allow new initiatives to be considered or new positions to be established, the OES should consider the following suggestions, utilizing existing resources, to provide staff support and direct assistance to special justices in the Commonwealth. The Task Force wishes to make clear that these proposals have not been reviewed or approved by the Executive Secretary or the Supreme Court of Virginia.

1. Establish an E-Mail List Serv for Special Justices.

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

2. The Office of the Executive Secretary should provide research and support services to special justices.

The Office of the Executive Secretary, through its Department of Legal Research, provides confidential staff support, direct assistance and legal research for trial court judges in Virginia, including Circuit Court Judges, General District Court judges, and Juvenile and Domestic Relations District Court Judges, who preside over involuntary

civil commitment cases in their jurisdictions. OES does not presently provide such services to part time judicial officers who are also practicing attorneys, such as substitute judges or special justices. However, the Task Force understands that there are many more substitute judges than special justices who serve in the Commonwealth. Special justices, by statute, have all the powers and duties of a district judge in handling involuntary commitment cases, including the power to deprive persons of their liberty. Code § 37.2-803. Therefore, the Task Force recommends, as a first step, that special justices should be given access to the same support and resources in deciding involuntary commitment cases that is provided for sitting judges. The Task Force understands that this proposal may have direct and indirect fiscal implications and would present a policy change for the Supreme Court and OES, because these services have never been provided to such part-time judicial officers. However, given the critical need for support and assistance to Virginia's special justices, the Task Force wishes to put this proposal on the table for review and consideration by OES and the Court.

3. Create an Advisory committee to provide input in designing the training curriculum for judicial officers, including magistrates, judges and special justices.

The OES over the last three years has greatly improved the programs and opportunities for training provided for judicial officers in the involuntary commitment process, especially for special justices. During this last year, the OES Department of Educational Services for the first time administered the training programs conducted on May 21st and May 28th for special justices hearing adult and juvenile cases. The Department of Educational Services, however, does not establish the substantive content or curriculum for its training programs. Rather, it relies on OES staff with expertise in

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

4. Ensure that Support and Training are Provided for Attorneys and GALs Assisting Petitioners and Respondents in Adult and Juvenile Commitment Cases.

The Virginia State Bar and Virginia CLE should be encouraged to establish and maintain a curriculum of regular programs and CLE events to provide certification and training for attorneys and guardians ad litem providing representation and assistance to petitioners and respondents in adult and juvenile civil commitment cases.

Task Force Members

The following persons have participated as regular members of the Task Force, or have participated from time to time in Task Force conference call meetings or subcommittee deliberations.

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

Honorable Humes J. Franklin, Jr.
Chief Judge, Staunton Circuit Court

Honorable Isaac St. C. Freeman
Judge, Smyth Circuit Court

Honorable Dorothy Clarke
Judge, Arlington General District Court

Honorable Charles Warren,
Judge, Mecklenburg General District Court

Honorable David B. Bice,
Special Justice, City of Lynchburg

Honorable Mark Bodner,
Special Justice, Fairfax County

Joanne Rome, Esquire
Staff Attorney, Supreme Court of Virginia

Jane Hickey, Senior Assistant Attorney General and Chief
Office of the Attorney General

Allyson Tysinger, Senior Assistant Attorney General
Office of the Attorney General

Bonnie Neighbour, VOCAL

Mira Signer, NAMI

Kate Acuff, UVA Institute of Law, Psychiatry and Public Policy

James Reinhard, Commissioner
Department of Behavioral Health and Developmental Services (DBHDS)

Ray Ratke, DBHDS

Jim Martinez, DBHDS

Ruth Anne Walker, DBHDS

Mary Ann Bergeron
Virginia Association of Community Services Boards (VACSB)

Jennifer Faison, VACSB

Kaye Fair, VACSB

Rebecca Bowers-Lanier, Esquire, Macaulay & Burtch, P.C.

Scott Johnson, Esquire, Hancock, Daniel, Johnson and Nagle

Betty Long, Esquire, Virginia Hospital and Healthcare Assoc.

Susan Ward, Esquire, Virginia Hospital and Healthcare Assoc.

Keith Hare, Medical Society of Virginia

Cal Whitehead, Psychiatric Society of Virginia

The following staff of the Office of Executive Secretary are not members of the Task Force, however, they participate in the meetings and discussions in order to provide information but do not take a position on the proposals and recommendations offered by the Task Force:

Jody Hess
General District Court Division
Judicial Services Department

Gregory Scott, Esquire
Magistrate Coordinator Division
Judicial Services Department

Caroline E. Kirkpatrick, Director
Department of Educational Services

Sandra Karison, Esquire
Assistant Director
Legal Research Department

ATTACHMENT 1

Medical Screening and Related Questions from June 2009 Civil Law Training Programs

(from trainer and participant notes)

1) St. Alban's…. Medicaid reviewers require person to give suicide plan before Medicaid will pay for treatment provided under a TDO or voluntary admission. Another person speculated that there is a Interqual [Internal?} Manual that utilization reviewers use. UR reviewers use admission criteria and continuing care criteria.

2) A Tidewater hospital requires the original petition for the court before it will admit a person. They are obtaining the petition for the court.

3) In Staunton/Augusta, magistrate will not issue a 2-step detention order to obtain medical clearance under §37.2-808 (C) because no facility will agree to admit without medical clearance and no physician has required the medical clearance. He says second sentence trumps the first sentence. They are required to persuade law enforcement to take custody on their own initiative.

> [Note: The relevant statutory language here reads…… *"Transportation under this section shall include transportation to a medical facility as may be necessary to obtain emergency medical evaluation or treatment that shall be conducted immediately in accordance with state and federal law. Transportation under this section shall include transportation to a medical facility for a medical evaluation if a physician at the hospital in which the person subject to the emergency custody order may be detained requires a medical evaluation prior to admission."*]

4) Hospitals in the Valley are requiring the same medical clearance tests for all admissions, regardless of the needs of the person. If the person refuses to have blood drawn or give a urine sample, the TDO facilities all refuse admission and the person must be released, even if the person is extremely dangerous or suicidal. Sometimes the CSB can locate a hospital in the Tidewater area but this poses huge logistical problems.

5) At the Richmond training program, law enforcement raised concerns that when a TDO is issued to a psychiatric unit of a general hospital, law enforcement is required to take the person to the emergency department and often wait 4-6 hours, or longer, for a medical clearance. Law enforcement believes its job should be done when it delivers the person to the TDO facility.

> [Note: see AG Opinion 01-114 to Honorable Robert J. Deeds at http://www.oag.state.va.us/Opinions/2002opns/mar02ndx.htm]

6) During discussion at my table, it was claimed [by a law officer] that some CSBs won't begin the pre-screening process until after medical clearance is complete, thus slowing down the process further. I don't know if this is true and, if so, how widespread the practice may be, but if it's possible to provide some direction re this point, it might be helpful.

7) Another claim that was made [by a law officer at my table] regarding why the ECO process becomes problematic is that some CSBs are unwilling to evaluate a person who has been treated in the ED because they are no longer exhibiting the same symptoms that resulted in their being brought to the ED and pre-screener isn't willing to act based on the doctor's assessment of their person's condition upon arrival.

(written questions from Q & A sessions)

8) Why must the [law] officer stay with the patient during medical clearance? Why are CSBs requiring patients that have used alcohol/drugs be retained in the hospitals for a period of 24 hours before they will be evaluated for a possible TDO? (submitted by Tazewell PD)

9) All ambulances can only transport to an Emergency Room. How are you going to handle getting them transported to the CSB when a transport ambulance could take hours to get there?

10) Are law enforcement agencies required by code to transport individuals to medical facilities for medical clearance before transportation to a facility?