

Richard J. Bonnie
Opening Remarks
Commission on Mental Health Law Reform
Williamsburg, VA
October 12, 2006 (excerpts)

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We are to conduct a comprehensive examination of Virginia's mental health laws – on the books and in practice – and to identify ways for using the law more effectively to serve the needs of people with mental illness, while protecting their rights and respecting the interests of their families and communities.

Our specific goals include the following:

- reducing the need for commitment by improving access to mental health, mental retardation and substance abuse services
- reducing unwarranted criminalization of people with mental illness
- redesigning the process of involuntary treatment so that it is 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.

We aim to complete this assignment within a year, submitting our report to the Chief Justice in October of 2007. It is anticipated that, if we carry out our charge successfully, legislative proposals based on our recommendations will be prepared for the 2008 session of the General Assembly.

During my remarks this morning, I will try to rev up the engines, so to speak, by telling you about the planning leading up this meeting and giving you a roadmap for what lies ahead. Before getting into the particulars, though, I want to say a few words to locate our assignment in its historical context.

The foundation for our existing mental health legislation was laid about 30 years ago. This was a time of great ferment and reform in mental health law throughout the country, spurred in part by the due process revolution undertaken by the U.S. Supreme Court and the supreme courts of the several states, and in part by the revolution in mental health services that we typically call de-institutionalization. These two important developments shaped the civil commitment reform statutes and patients' rights statutes that were adopted during this era in Virginia and every other state.

In 1972, there were more than 500,000 patients in state hospitals nationwide and there were at least 12,000 people in Virginia's state hospitals on any given day.

The legal reforms adopted in the 1970s addressed two major challenges: First, they were designed to create legal safeguards against unwarranted hospitalization, thereby using the law as instrument to spur along the policy of deinstitutionalization. The larger goal was to transform an institution-based mental health services system into a community-based system. Two of the key legal concepts used to achieve this goal were dangerousness-based commitment criteria and the least restrictive alternative doctrine.

A second challenge faced by reformers 30 years ago was to improve the conditions in the state hospitals where most patients were then residing; key legal tools in that effort were enforcement of a right to treatment for those patients who were hospitalized, and the creation of human rights programs to help propel improvements in conditions and to remediate violations of patients' rights.

Much as been done over the past 30 years to deinstitutionalize public mental health services, reduce unwarranted institutional confinement and protect patients' rights. Whether and to what extent these reforms have been *successfully* implemented is a subject for another day. For present purposes, it is enough to note that the challenges we face today are not the same as the ones that were being confronted 30 years ago when the core components of our mental health statutes were adopted. Today, most people being served by the public mental health services system are in the communities, just as the 1970s reformers had hoped. In 2005, for example, about 106,000 people were served by our community mental health services system, while only 5700 people spent any time at all in the state hospitals. The average daily census of the state hospitals is now about 1500, down from 3200 twenty years ago and 12,000 thirty-five years ago.

That is the good news. The bad news, of course, is that there are still major gaps in the community services system. The reformers' vision of a full continuum of community-based mental health and support services remains unrealized. And it is these gaps in community services that pose the major challenge for us today.

As we all know, gaps in service access can lead to clinical deterioration and deficits in functioning, which in turn can lead to crises. In some instances, these mental health crises can lead to avoidable civil detentions and commitments and, even more disturbingly, to avoidable and unnecessary criminal arrests. This is where the courts come into the picture.

Viewed in this context, the challenge we face today is to help people in our communities who have serious mental health problems get the services they need in their communities when they need them. That means services needed to prevent crises. But, sometimes it means intensive services to ameliorate crises, and sometimes it means short-term hospitalization. Today, the complaints we hear about civil commitment are more likely to be about unwarranted impediments to clinically indicated hospitalization than about indiscriminate or prolonged use of hospitalization – the complaints that properly attracted legislative and judicial attention 30 years ago.

As I see it, the challenge we face today is to redesign the procedures governing involuntary treatment to reflect the realities of the services system we now have, rather than the one we had 30 years ago.

Let me hasten to add that I do not mean to say that procedural safeguards in involuntary hospitalization proceedings are unnecessary or superfluous. Quite the reverse. One aspect of the challenge I just mentioned is to take due process seriously, and respect the most fundamental of all rights – the right to be heard -- whenever treatment is ordered over a person’s objection. We can do better than we are now doing in many parts of the state to respect the right to be heard.

This leads me to another important difference between the challenges we face today and those faced by reformers at the dawn of deinstitutionalization. The difference I have in mind is a difference in the values that drive the system. In 1975, the emphasis on the “human rights” of mental patients was an antidote for unthinking use of coercion in an often authoritarian institution-based system. Today, the reformers’ vision is a system in which coercion is used as little as possible and in which the driving value is respect for consumer choice. Collaboration, engagement and empowerment are the attributes of a consumer-driven system. The challenge to us, as I see it, is to establish the legal foundation for a recovery-oriented system, while also recognizing that coercion is sometimes necessary as a last resort. One of our aims is to respect consumer choices even when those choices have been circumscribed by law. One of the legal tools that can be used to do this is a psychiatric advance directive. I invite other ideas about how this goal can be achieved. ...

Opening Remarks by Richard J. Bonnie,
Chair, Commission on Mental Health Law Reform
Meeting of the Commission
June 22, 2007
Fredericksburg, VA
[excerpts]

This is the Commission’s first meeting since the tragedy at Virginia Tech on April 16. The events of that day have focused a spotlight on some of the problems our Commission has been studying and have drawn public attention to the need for increasing the Commonwealth’s investment in community mental health services and for reforming the Commonwealth’s commitment laws. ...

We are mindful of the important study now being conducted by the gubernatorial panel investigating the events at Virginia Tech as well as the initiatives being undertaken by various committees of the General Assembly, including the hearings held earlier this week by the House Committee on Health, Welfare and Institutions, chaired by Delegate

Phil Hamilton, a member of this Commission. We have accelerated some aspects of the Commission's work so that the reports and recommendations of our task forces can be shared in a timely fashion with these bodies. We stand ready to assist them in any way we can.

As we begin our deliberations, it is timely to remind ourselves of the Commission's charge and its goals. To boil it down in a few words, the reforms that we propose should meet the following test: They should help people with mental health problems get the help they need, when they need it, so that mental health crises can be prevented or ameliorated and so that suffering and injury can be avoided.

This overall goal can be achieved most successfully by fostering a climate of caring and respect for people who need help, by reducing stigmatization, and by engaging people voluntarily in accessible, recovery-oriented services over which they have a meaningful measure of control. Conversely, this goal can be fatally undermined if there are major gaps in services or if the system is perceived as unduly coercive and drives people away from treatment rather than drawing them into it. The principles of voluntariness, respect and self-determination must always be kept in the very forefront of our thinking.

At the same time, though, coercion is sometimes necessary. Our reforms must therefore assure that involuntary treatment, while being used **only** when necessary, occurs expeditiously and effectively when it **is** necessary. And the process of initiating, authorizing and carrying out involuntary treatment must always be a fair and respectful one.

Unfortunately, these goals are not now being met. The weaknesses in the current system are all-too-evident in Inspector General James Stewart's recent report of his Investigation of the Critical Incident at Virginia Tech on April 16. In addition to the case study of Mr. Cho's December, 2005 commitment, the OIG report also provides a statewide snapshot of the commitment process – it identifies gaps in CSB capacities, documents substantial variation in CSB practices bearing on outpatient commitment, and highlights apparently common deficiencies in the quality of the evaluation and adjudication process.

Today the Commission is releasing the final report of its own study of the current commitment process. This study, undertaken for the Commission by Dr. Elizabeth McGarvey of the University of Virginia School of Medicine, involved intensive interviews with 64 professional participants in the process, 60 family members of persons with serious mental illness, and 86 people who have had the experience of being committed.

According to Dr. McGarvey's report, professional participants and family stakeholders are uniformly frustrated by almost every aspect of the civil commitment process in Virginia. Among the most common complaints were a shortage of beds in willing detention facilities, insufficient time for adequate evaluation, the high cost and

inefficiency of transporting people for evaluation, inadequate compensation for professional participants in the process, inadequate reimbursement for hospitals, inconsistent interpretation of the statute by different judges, and lack of central direction and oversight.

Although consumers of mental health services differ substantially in their views about the potential utility and legitimacy of involuntary treatment, most of those who have had actual experience with the commitment process felt stigmatized and unfairly treated. They identified many of the same concerns as the other stakeholders.

Taken together, the OIG Critical Incident Report and the Commission's Stakeholder Interview Study provide strong qualitative evidence of the infirmities of the civil commitment process in Virginia.

In my opinion, the need for reform is irrefutable. No one is satisfied with the current situation; the only question is how sweeping the reforms should be.

As the Commission has considered various proposals for reform, it has sought to fill in important gaps in information about the characteristics and outcomes of commitment proceedings. For example, what proportion of hearings result in commitment? Does that proportion vary significantly across the state? What proportion of commitment orders are for outpatient treatment, as in Cho's case? Does that proportion vary significantly across the state? What proportion of commitment orders are based on a finding of danger to others? Existing databases do not allow us to answer these important questions.

In order to fill in this information gap, the Commission asked judges and special justices to fill out a 2-page questionnaire on every commitment hearing conducted last month (i.e., May, 2007). Although the data are still being analyzed, we are in a position to present several key preliminary findings at this time:

- At least 1400 commitment hearings were conducted in May
- Representatives of the CSB were present at commitment hearings in less than half of the cases; independent examiners were present at about 60% of the hearings, although they testified in less than half.
- About 60% of the hearings were over in less than 15 minutes and virtually all of them were over in less than 30 minutes.
- About 86% of people against whom commitment petitions are filed were hospitalized, although 30% of those hospitalized agreed to remain in the hospital voluntarily.

- About 10% of the respondents were released because the judges found that the commitment criteria were not met. In 2/3 of these cases, the independent examiner had failed to certify probable cause for commitment.
- Among people committed, only 6% were committed to outpatient treatment

I will use that last point as a springboard to emphasize that Seung Hui Cho's case was atypical in at least two important respects. First, the overwhelming majority of people experiencing mental health crises pose no danger to anyone other than themselves...As those of us who participate in public debate highlight the need for augmenting public mental health services and reforming the commitment process, we should try to do so without stirring up or reinforcing exaggerated associations between mental illness and violence.

A second unusual feature of the Cho case is the very fact that he was committed to outpatient treatment. It is highly ironic that such an atypical case has focused public attention on such an under-utilized feature of current commitment law. Among the issues that the Commission will be addressing today is why outpatient commitment is so rarely used at the present time, and whether mandatory outpatient treatment should play a greater role in the Commonwealth's mental health system than it now does. ...