Statement of Richard J. Bonnie
Chair, Commonwealth of Virginia Commission on Mental Health Law Reform
Presented to the Virginia Tech Review Panel
July 18, 2007

Chairman Massengill and Members of the Panel:

I am pleased to have the opportunity to appear before you in my role as Chair of the Commonwealth's Commission on Mental Health Law Reform. The Commission was established by Chief Justice Leroy Hassell in the fall of 2006 after a lengthy planning process, and has been directed to conduct a comprehensive examination of Virginia's mental health laws – not only as they appear in the Code, but also as they operate in practice – and to offer a comprehensive proposal for reform.

Our specific goals include the following:

- reducing the need for commitment by improving access to mental health services
- reducing unwarranted criminalization of people with mental illness
- redesigning the process of involuntary treatment so that it is more fair and more 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 Chief Justice has also appointed 5 Task Forces to help the Commission develop recommendations in each of the five domains I just mentioned. These Task Forces have been deliberating energetically since October and will be submitting their reports to the Commission in November. (The specific goals of the five Task Forces are listed on the Commission's Statement of Goals, updated in January, 2007.)

The Commission aims to issue its own preliminary report this winter, sketching a general blueprint for reforming Virginia's civil commitment statutes and related aspects of mental health law. A comprehensive, integrated legislative proposal to implement this blueprint will be developed by the fall of 2008. In addition, the Commission's preliminary report is likely to recommend several specific actions to assist the General Assembly in its deliberations this winter; if so, these initial recommendations would pertain primarily to the law governing outpatient commitment and would be fully compatible with the Commission's blueprint for comprehensive reform.

The tragic events of April 16 have focused a spotlight on some of the problems our Commission has been studying. It would not be appropriate for me to comment on the specific facts of the Cho case, including the results of the involuntary commitment proceedings conducted in December, 2005. That is the task of your Panel and, like people

throughout our nation, I await your findings and conclusions about what did and did not happen during the years and months preceding the horrifying violence of April 16. Instead, I will confine my remarks to general observations about Virginia's commitment laws and practices that may bear on your report. In this respect, I can assure you that the Commission is giving careful attention to the findings and accompanying recommendations prepared by the Office of the Inspector General and presented to you by Inspector General Jim Stewart in June.

Before turning to some of the specific issues raised by the OIG report, it might be useful for me to provide a brief overview of the larger context of the Commission's work.

The Need for Commitment Law Reform

Much as been done over the past 35 years to deinstitutionalize public mental health services, reduce unwarranted institutional confinement and protect patients' rights. 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, as we all know, gaps in service access are associated with a higher incidence of acute clinical deterioration, which in turn can lead to costly civil detentions and commitments, unnecessary criminal arrests, and avoidable suffering and harm.

As compared with the situation 35 years ago, the complaints we hear about the mental health system today are more likely to be about unwarranted impediments to clinically indicated intensive treatment than about indiscriminate or prolonged use of hospitalization and abuse of patients' rights – the complaints that properly attracted legislative and judicial attention in the 1970s and 1980s.

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 as well as intensive services to ameliorate crises and stabilize functioning.

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 mental health services 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 one, respectful of individual dignity.

Unfortunately, these goals are not now being met. The weaknesses in the current system are all-too-evident in Inspector General Stewart's recent report to this Panel. 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 the capacities of community mental health agencies, documents substantial variation in agency practices bearing on outpatient commitment, and highlights apparently common deficiencies in the quality of the evaluation and adjudication process.

The Commission recently released a stakeholder 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 among themselves 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's Critical Incident Report for this Panel and the Commission's Stakeholder Interview Study provide convergent 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.

Let me now say a few words about some of the specific issues addressed in the OIG report.

Redesigning the Commitment Process

First, the OIG report raised important questions regarding the overall design of the commitment process. Specific concerns were raised about the sufficiency of the time allotted by the statute for the emergency evaluation process, the role and responsibilities of the independent evaluator, the role of the attending psychiatrist, accessibility of clinical information needed by the independent evaluator and the court for a thorough evaluation and adjudication, and the responsibilities of the various participants at the commitment hearing.

The Commission's Task Force on Civil Commitment is actively considering all these questions, and we are also currently analyzing a study of more than 1500 commitment hearings conducted throughout the Commonwealth in May. It would be premature for me to try to forecast the likely outcome of the Task Force deliberations or, eventually, of the Commission's own deliberations, on these complicated and interconnected issues. I can say, however, that the deficiencies of the present commitment process are now well-documented and that a fundamental redesign does appear to be indicated. Key features of a redesigned commitment statute would probably include modified time frames, clarification and redefinition of the role of the independent evaluator, and specific guidance regarding the collection of clinical records and information and the presentation off this evidence at the hearing. (Let me say, in passing, that the federal HIPAA privacy rule is not an obstacle to full disclosure of information in the commitment process.)

Improving Outpatient Commitment

I will now address another cluster of issues explored in the OIG report -- those relating to outpatient commitment.

It may be of interest to the Panel to learn that outpatient commitment (or, as I prefer to call it, mandatory outpatient treatment) has been one of the most controversial issues in mental health law throughout the country over the last decade. The central policy question in the debate is whether commitment to outpatient treatment should be allowed when a person with mental illness is experiencing a clinically significant decline in functioning (often precipitated by discontinuation of medication) but does not yet meet the criteria for commitment to inpatient treatment. Studies thus far conducted suggest that mandated outpatient treatment can be effective for some patients when intensive treatment services are provided. Meanwhile, its opponents insist that mandated treatment would not be necessary in the first place if high-quality outpatient services were available because people would take advantage of them voluntarily. Everyone agrees on one point, though -- *outpatient commitment cannot be effective unless it is accompanied by adequate services.*

Under current Virginia law, outpatient commitment is permitted only as a less restrictive alternative to inpatient commitment and only if the same criteria are met – imminent dangerousness to self or others or substantial inability to care for oneself. In most cases where these narrow criteria are met, outpatient treatment is probably not a clinically suitable alternative to a period of acute hospitalization. However, even in those situations where outpatient commitment might be clinically suitable -- either in lieu of or as a complement to short-term inpatient stabilization-- the OIG report shows that adequate capacity is not now in place in most communities to effectuate outpatient commitment orders.

It should come as no surprise, then, that outpatient commitment is rarely used in the Commonwealth of Virginia today. Statewide data collected by the Commission's study of commitment proceedings show that, among people committed in May, 2007, only 8% were committed to outpatient treatment. It therefore strikes me as somewhat ironic that the Cho case has focused public attention on such an under-utilized feature of current commitment law. Be that as it may, a key issue before the Commission is whether mandatory outpatient treatment should play a greater role in the Commonwealth's mental health services system than it now does, and, if so, how to assure that adequate services are available to carry it out effectively. That is one of the main issues we are considering at our upcoming meeting in August

Whether or not use of outpatient commitment is increased, the current statutory provisions governing the implementation of mandatory outpatient treatment orders need to be clarified. The Commission's Commitment Task Force is considering the Inspector General's recommendations and will be developing a variety of amendments to the current statute along the following lines:

- outpatient commitment should be ordered only if the court finds, in each case, that the treatment provider has agreed to the treatment plan and has adequate capacity to carry it out, and that the community services board has agreed to monitor the person's compliance with the treatment plan;
- outpatient commitment orders should describe the treatment plan and specify the particular conditions with which the patient is expected to comply;
- responsibilities of the treatment provider and the community services board, respectively, for monitoring and reporting to the court should be clarified; and
- procedures for reporting non-compliance with the court order, and for responding to reported non-compliance should be specified.

The Commission intends to include recommendations on these matters in its preliminary report this winter.

Thank you for the opportunity to appear before you today. The Commission stands ready to assist you in nay way we can, and I will be happy to answer your questions.