COMMONWEALTH OF VIRGINIA
COMMISSION ON MENTAL HEALTH LAW REFORM

PROGRESS REPORT ON MENTAL HEALTH LAW REFORM

DECEMBER 2008

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PREFACE

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

During the first phase of its work, the Commission was assisted by five Task Forces charged, respectively, with addressing gaps in access to services, involuntary civil commitment, empowerment and self-determination, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. In addition, the Commission established a Working Group on Health Privacy and the Commitment Process ("Working Group"). Information regarding the Commission, its Task Forces 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. 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 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 during this first phase was a study of every face-to-face emergency evaluation conducted by Community Service Board ("CSB") emergency services staff during June 2007 (the "Commission's CSB

Emergency Evaluation Study"). (There were 3,808 such evaluations.) The final report of the CSB Emergency Evaluation Study will also appear on the Commission's website 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, 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. The Report of the Task Force on Future Commitment Reforms is posted at http://www.courts.state.va.us/cmh/taskforce_workinggroup/home.html. The Transportation Working Group's Report is posted at http://www.courts.state.va.us/cmh/taskforce_workinggroup/home.html. The other reports will be published on the Commission's web site in due course.

The following Progress Report provides a status report on the progress of mental health law reform in Virginia during the past year. It summarizes the changes adopted by the General Assembly in 2008, reviews the steps taken to implement them, summarizes the available data on the operation of the commitment system, presents the Commission's recommendations for consideration by the General Assembly in 2009, and identifies some of the important issues that the Commission will be addressing in the coming year. The Commission plans to issue another status report in December 2009 and to complete its work by June 30, 2010.

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

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

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Executive Summary

After the historic overhaul of Virginia's commitment laws in 2008, implementing these changes has gotten off to a good start. However much remains to be done, both to achieve the goals of the 2008 reforms and to address issues and problems that were not addressed in 2008. This Progress Report summarizes how implementation of the 2008 reforms has fared so far, offers recommendations for consideration by the General Assembly in January 2009, and highlights some issues that the Commission will continue to study in the coming year.

First-Quarter Data: The Commission estimates that the number of temporary detention orders executed during the first quarter of FY09 was about 8% higher than during the first quarter of FY08, but it seems likely that this increase, which began in January, 2008, is attributable to factors that preceded the effective date of the new law and that the rate of increase has begun to level off.

About 5720 commitment hearings were conducted during the first quarter of FY09 -- 5,141 ordinary adult hearings, 45 hearings involving jail detainees, and 524 recommitment hearings. In ordinary commitment hearings, about 56% of the cases resulted in involuntary admission, about 24% resulted in voluntary admission and about 19% were dismissed. Only a handful of cases (18) resulted in mandatory outpatient treatment (MOT) orders. In comparison with the Commission's study of commitment hearings conducted during May 2007, there were fewer MOT orders and fewer voluntary hospitalizations, and correspondingly more involuntary hospitalizations and dismissals. It appears that the increase in involuntary admissions may have been offset by a reduction in voluntary admissions, resulting in a constant number of hospitalizations.

Although MOT was relatively infrequent prior to the 2008 reforms, the number appears to have nosedived since July 1, 2008. It is apparent that both CSBs and judges have been hesitant to invoke the new procedures for MOT, and the Commission will carefully monitor the use of MOT during the coming year.

Recommendations for Legislative Consideration in 2009: Revenue constraints preclude immediate efforts to build on the much-needed investment in community mental health services made by the General Assembly in 2008. However, further improvements in the legal foundation of mental health care can be made without additional cost. Therefore, the Commission recommends that the General Assembly consider several proposals to reduce the need for involuntary treatment and to protect individual dignity when involuntary treatment is sought.

- The Commission' s major proposal for 2009 is a bill amending the Health Care Decisions Act to empower people to prescribe specific instructions to guide their health care in the event that their capacity to make health care decisions becomes impaired by mental illness, dementia or other cognitive disability. The existing advance directives statute empowers people to designate health care agents and to give specific instructions regarding treatment at the end of life. However, it is

silent on the use of instructional directives in other contexts, such as decisions about mental health care or about placement and treatment in nursing homes. That is the gap that this proposal is designed to fill.

- The Commission also recommends several revenue-neutral proposals in a continuing effort to improve the commitment process. Some of these proposals respond to issues that have arisen during the process of implementing the 2008 reforms, while others deal with issues that were not addressed in 2008.

- One important new proposal addresses transportation of individuals involved in the commitment process. Reliance on law enforcement to provide transportation, and the routine use of restraints during this process, have been major sources of discontent among all the stakeholders for many years. The Commission recommends enabling legislation to facilitate local efforts to develop clinically appropriate alternatives to transport by law enforcement in cases that pose little security risk.

- Another key proposal would permit mental health facilities to admit incapacitated individuals for up to ten days upon the request of a health care agent designated by the individual in an advance directive and specifically given the authority to do so, or upon the request of a guardian specifically authorized to do so in the guardianship order.

- The Commission also recommends modifications to the Psychiatric Inpatient Treatment of Minors Act to incorporate changes that were made to the adult commitment statute in 2008, including new procedures for mandatory outpatient treatment tailored to the special circumstances of juvenile commitments.

Proposals Requiring Further Study: Some of the bills introduced in the 2008 General Assembly were carried over until 2009 and referred to the Commission for review and comment. Some of these bills embody key elements of the blueprint for comprehensive reform outlined by the Commission in its Preliminary Report in December, 2007. However, the Commission believes that legislative action would be premature on the following issues and that they should remain under study in 2009:

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- The Commission has endorsed the concept of increasing the range of core services that CSBs are mandated to provide. Because this would be a major change in the legal foundation of the community mental health services system, and would require additional state appropriations, the Task Force on Access to Services continues to study it.

- The Commission has endorsed, in principle, the concept of lengthening the TDO period to 4 or 5 days. However, it continues to conduct research to allow informed projections regarding the costs and other consequences of such a

change, such as how much it would reduce the number of commitment hearings and what impact it would have on the average length of hospitalization.

- Finally, a number of bills that were carried over would expand use of MOT. However, the Commission believes that it would be premature to expand the use of MOT until the Commonwealth has accumulated adequate experience with the extensive new procedures adopted in 2008. Preliminary data indicate that the number of MOT orders has been very small so far, suggesting that the necessary service capacity has not yet come on line and that many judges, CSBs and providers are not yet comfortable with the new procedures. The Commission is supportive, in principle, of permitting conditional discharge MOT after inpatient commitment in appropriate cases, and believes that this would be the next logical step in the use of MOT. However, it believes that such a change should be deferred until service capacity has been established and more experience has accumulated. For the same reason, the Commission believes that it would be premature to loosen the commitment criteria for MOT as a tool for preventing deterioration as New York and other states have done.

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I. Mental Health Law Reform in 2008

A. Overview of 2008 Reforms

During the 2008 session of the General Assembly, Virginia's mental health laws underwent an historic overhaul, with changes in five key areas: commitment criteria, mandatory outpatient treatment, procedural improvements, privacy and disclosure provisions,[1] and firearms purchase and reporting requirements.[2] In addition, the mental health system received an infusion of more than $41 million to increase service capacity.[3] By all accounts, the mental health reforms of the General Assembly were its most exhaustive and comprehensive in more than thirty years. The key changes include:

- The criteria for involuntary commitment were modified to promote more consistent application throughout the Commonwealth and to allow involuntary treatment in a broader range of cases involving severe mental illness. Evidence had suggested some judges applied unduly restrictive interpretations of the previous criteria.
- The 2008 reforms established clear procedures for ordering, delivering and monitoring less restrictive court-ordered outpatient treatment. These changes are designed to make mandatory outpatient treatment ("MOT") more effective and facilitate a consistent statewide implementation. In addition, these procedures increase oversight by community services boards ("CSBs") and other providers to reduce the risk that a patient will fall through the cracks.
- Extensive procedural changes relating to emergency custody orders ("ECOs"), temporary detention orders ("TDOs"), clinical examinations, and hearings were designed to standardize the process across the Commonwealth and improve the quality and accuracy of decision-making.
- The reforms removed legal impediments to disclosure of relevant information during the commitment process while protecting that information from further disclosure.

Most of these changes were based on the recommendations of the Commission (December, 2007) and the Virginia Tech Review Panel (August, 2007) and had been endorsed by Governor Kaine. After extensive and thorough deliberation by the General Assembly, the reform legislation was enacted by unanimous votes in both houses.

Much remains to be done, however. The Commission, the Governor and the principal patrons of the reform bills enacted in 2008 all emphasized that these changes were only a

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[1] H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008). The preceding four areas of change were addressed by House Bill 499. *Id.* An identical bill was introduced in the Senate as Senate Bill 246. S.B. 246, Va. Gen. Assembly (Reg. Sess. 2008). This article, however, will refer only to House Bill 499 for the sake of simplicity. House Bill 401 and House Bill 559 are related bills, and this article will reference them only when particularly relevant. H.B. 401, Va. Gen. Assembly (Reg. Sess. 2008); H.B. 559, Va. Gen. Assembly (Reg. Sess. 2008).

[2] H.B. 815, Va. Gen. Assembly (Reg. Sess. 2008).

[3] H.B. 30, Va. Gen. Assembly (Reg. Sess. 2008).

first step (albeit a giant step) in a continuing process of reform. Some key components of comprehensive reform were outlined in the Commission's Preliminary Report. In addition, a number of bills relating to the commitment process were carried over from the 2008 session and the subject matter of these bills was referred to the Commission for further study by the Senate.

In addition, SJR 42 directs the Joint Commission on Health Care to "receive and review" recommendations from various entities, including the Commission, and to submit recommendations to the General Assembly before its 2010 session. The Commission reported to the Joint Commission on its progress in August and October, 2008.

B. Overview of Commission Activities in 2008

As soon as the General Assembly completed its historic work in the spring of 2008, the Commission organized itself for Phase II of the Chief Justice's initiative in mental health law reform. The Commission set out to perform three tasks: (1) implement monitor, evaluate and consolidate 2008 commitment reforms; (2) study possible new modifications of commitment laws; and (3) develop proposals for building a legal foundation for transforming the community services system.

1. Implement Monitor, Evaluate and Consolidate 2008 Commitment Reforms

The proper path of future reforms depends on the effects of the reforms already adopted, as well as on the mechanisms that are set up to provide evaluation and oversight. The Department of Mental Health, Mental Retardation, and Substance Abuse Services ("DMHMRSAS"), CSBs, the Office of the Attorney General ("OAG") and Supreme Court have direct responsibilities to manage and implement these changes successfully, but the Commission can continue to play a useful role by serving the convening and coordination function that it served before and during the legislative process. The Commission has set up two Task Forces to help monitor and steer the implementation and evaluation process.

The Task Force on Implementation of 2008 Commitment Reforms ("Implementation Task Force") is carrying out the following functions:

- Coordinating training
- Provided advice to the OES of the Supreme Court and DMHMRSAS on the drafting of new forms and revision of existing forms
- Providing guidance and facilitating problem-solving
- If needed, making further recommendations to the Commission regarding statutory clarification, training, coordination and oversight

The Task Force on Data, Research and Evaluation is directed to:

- Assist DMHMRSAS, CSBs, and the Supreme Court collect and assemble both aggregated and case-specific information regarding ECOs, TDOs, independent examiner ("IE") certifications, and commitment orders to facilitate monitoring and evaluation
- Monitor and evaluate MOT
- To the extent feasible, estimate fiscal impact of proposals for future reforms under consideration by the Commission

2. Study Possible New Modifications of Commitment Laws

The Commission was formally asked by the Senate to study the subject matter of a number of bills that were introduced in 2008 and carried over to 2009. In addition, many components of the Commission's blueprint were not put forward in 2008 because they needed further study. Finally, other changes to the commitment law and other parts of the Code were proposed by all five Commission Task Forces. Although most of the proposed Code changes relate to commitment, some pertain to other parts of the Code. Two Task Forces and a special Working Group are at work on these projects.

The Task Force on Future Commitment Reforms ("Future Reforms Task Force") was charged with studying all proposals relating to the commitment process, including but not limited to those referred to the Commission by the General Assembly and those included in the Report of the Task Force on Civil Commitment. Among the proposals considered by the Future Reforms Task Force are:

1. **Mandated Special Justice, Attorney and Examiner Training** – whether special justices, attorneys representing persons in commitment hearings and independent examiners should receive mandatory training, including examining the requirements specified in SB 214 (Edwards)(subject matter referred to Commission) mandating training for special justices. Additionally, this proposal includes a review of the content of such training.

2. **Mandated CSB Core Services** – whether, when funding is available, the core services CSBs are mandated to provide in § 37.2-500 should be expanded from emergency services and case management services to include crisis stabilization, outpatient, respite, in-home, and residential and housing support services as provided in SB 64 (Howell)(subject matter referred to Commission).

3. **Counsel for Petitioners** – whether an attorney should be appointed to represent petitioners in civil commitment proceedings, and if so, who should be appointed, including HB 267 (Albo)(subject matter referred to Commission) authorizing appointment of an attorney to represent indigent petitioners and HB 735 (Caputo)(continued to 2009) authorizing 3rd year law students to represent petitioners.

4. **Petitioner Right of Appeal** – whether petitioners in civil commitment proceedings should have a right of appeal, including HB 938 (Gilbert)(subject matter referred to Commission).

5. **Combined Inpatient/Outpatient Commitment Orders** – whether an order of involuntary inpatient treatment may be followed by a period of mandatory outpatient treatment, and if so, what criteria should be used and whether mandatory outpatient treatment would be court-ordered at the time of the commitment hearing or at the time of discharge, or hospital-initiated during the course of an inpatient commitment, including SB 274 (Cuccinelli)(continued to 2009) pertaining to transfers to outpatient treatment and HB 939 (Gilbert)(subject matter referred to Commission) permitting the person to petition for outpatient treatment.

6. **Reduced Criteria for Assisted Outpatient Treatment** – whether assisted outpatient treatment utilizing reduced commitment criteria to prevent involuntary inpatient treatment, including SB 177 (Marsh)(continued to 2009), and procedures should be implemented.

7. **Extension of TDO Period** - whether the period of temporary detention should be extended from 48 hours to four or five days, including SB 143 (Edwards)(subject matter referred to Commission) extending the temporary detention period from 48 hours to 96 hours, SB 333 (Cuccinelli)(subject matter referred to Commission) authorizing the independent examiner to release the person if the IE finds the person does not meet commitment criteria, and SB 335 (Cuccinelli)(subject matter referred to Commission), permitting an offer of voluntary outpatient treatment to a detained person.

8. **Protection of Rights of Persons Subject to Commitment Proceedings –** whether legislation should be enacted to prevent persons from being evicted from their homes as a result of being subjected to emergency custody and temporary detention orders or commitment orders and to protect them from default judgments during this period.

9. **Admission of Incapacitated Persons** – whether persons who lack capacity to consent to voluntary admission should be admitted to inpatient treatment upon the consent of a guardian or other legally authorized representative and, if so, whether a judicial proceeding is needed.

Because of the complexity of the transportation issue and the range of expertise needed to study it, a special ***Working Group on Transportation*** was established to flesh out alternatives to transportation by law enforcement officers in connection with the commitment process.

It is clear that unique problems arise in the context of commitment of college and university students and special procedures may be warranted. A specially constituted group with expertise in student affairs and higher education law as well as mental health law is needed to address them. The Commission has discussed a collaborative study of these issues with the State Council of Higher Education. This conversation has been put on hold but will be revived in 2009.

3. Transforming the Services System

A ***Task Force on Advance Directives*** ("Advance Directives Task Force") was charged with reviewing the recommendations of the Commission's Task Force on Empowerment and Self-Determination and to draft a bill on advance directives for health care decisions in contexts other than end-of-life care, including mental health care. The Advance Directives Task Force includes experts on health care law and elder law as well as mental health law.

Governor Kaine and others characterized the budget increase for CSBs in the 09-10 biennium as a "down payment" on a longer-term investment in community services. A reconstituted ***Task Force on Access to Services*** ("Access Task Force") will continue its important effort to formulate a vision for the Commonwealth's community mental health services, and to create a new legal foundation for the services system. In addition, the access and service capacity issues addressed by the Commission's original Task Forces on Criminal Justice and Children and Adolescents were folded into the reconstituted Access Task Force.

Among other tasks, the Access Task Force will:

- Study successful innovations in other states
- Review the pertinent literature bearing on effectiveness and cost of treatment and support services it identifies as key components of a high-quality community mental health system
- Review and integrate into a single implementation plan proposals relating to community services recommended by Task Forces on Children and Adolescents, Criminal Justice, and Empowerment and Self Determination
- Study whether mental health service needs of military veterans, members of the National Guard and their families are currently being met and recommend any necessary improvements
- Review the mental health service needs of elderly persons, identify promising approaches in the State and elsewhere, and determine whether any additional services or innovations are needed.

The Access Task Force aims to complete its deliberations in the summer of 2009.

C. Criminal Justice Mental Health Transformation

In January 2008, the Governor promulgated Executive Order 62, creating the Commonwealth Consortium for Mental Health and Criminal Justice Transformation as recommended by the Commission and its Criminal Justice Task Force. The Consortium is tasked with identifying and supporting the development, implementation and expansion of programmatic and policy initiatives to enhance outcomes for individuals with mental illness or co-occurring disorders at risk for or involved in the criminal justice system, and thereby promote public safety. The Consortium is also expected to propose a plan for a multi-system "academy without walls" identifying training needs and relevant training initiatives and creating a coordinated system to educate stakeholders and providers in the criminal justice and mental health systems. Membership in the Consortium represents a coalition of leadership from each branch of government, across multiple Secretariats and agencies, stakeholder organizations, and community based programmatic criminal justice/mental health initiatives. Concrete support for these initiatives was reflected in the budget for FY09-10: The General Assembly specifically targeted $6.3 million (15%) of the increased mental health appropriation for jail diversion programs and crisis intervention training. The Secretaries of Health and Human Resources and Public Safety have designated a State Coordinator for Criminal Justice and Mental Health Initiatives charged with providing oversight and assistance to the Consortium.

The Consortium's first initiative was a Governor's Conference, held in May 2008. During that two day event, over 300 community stakeholders and Consortium leadership convened to discuss ways to implement successful evidence-based programs and practices to reduce the involvement of individuals with mental illness in the criminal justice system. Additionally, the Consortium Conference initiated a state-wide effort to engage communities in developing a strong, sustainable base for achieving success with local criminal justice and mental health transformation efforts. The initiative, developed by the National GAINS Center is called Cross Systems Mapping. Its goals are (1) to bring diverse local community CJ/MH stakeholders together in order to develop common knowledge, language and understanding of the CJ/MH systems; (2) to provide stakeholders with an effective process for mapping how an individual with mental illness navigates (or is navigated through) their local mental health and criminal justice systems interface, and identifying strengths or gaps in service needs and local barriers to success; and (3) to develop a targeted, locality-specific action plans for improving system interface and client outcomes. Localities in Virginia and throughout the United States have already benefited from this process. Florida has begun implementation of these local trainings on a state-wide basis.

Cross Systems Mapping is delivered as a one and a half day facilitated workshop for local criminal justice/mental health stakeholders including law enforcement, consumers, family members, mental health service providers, local elected officials and others. DMHMRSAS in partnership with the Department of Criminal Justice services has already trained twenty outstanding facilitators in Virginia who are now certified to provide this training. DMHMRSAS is providing technical assistance to communities in order to guide them through this process and prepare them for creating successful jail

diversion initiatives. Between 10 and 20 programs are being scheduled for the last half of FY09.

The Consortium will also review programmatic activity in the Commonwealth, including those designated for funding under the FY09/10 for jail diversion and crisis intervention training. In establishing the allocation process for those funds, DMHMRSAS targeted opportunities to most efficiently invest valuable resources, demonstrate the effectiveness of criminal justice/mental health collaborative initiatives, and support replicable programs which will lay the foundation for future successful initiatives throughout Virginia. The Consortium leadership, working with Access Task Force's Criminal Justice and Mental Health Initiatives Working Group, reviewed information from Community Service Boards, Community Criminal Justice Programs and advocacy organizations and solicited input from dozens of criminal justice and mental health stakeholders in order to identify currently active and successful programs in each of the 40 CSB service areas.

In planning for funding allocation, DMHMRSAS utilized ten key threshold factors in order to make initial determinations for funding. These are 1) Strength of community mental health/criminal justice collaboration; 2) Participation of key leadership; 3) Diversity of collaboration partner/stakeholder involvement; 4) Presence and impact of active jail diversion program(s); 5) Existence/utilization of compatible programs; 6) Nature and extent of peer involvement; 7) Utilization of evidence based/best practices; 8) Availability/use of additional financial resources/supports; 9) Program emphasis on data/evaluation; and 10) Evidence of demonstrable outcomes measures/results.

Thirteen of 40 CSB Service Areas met the threshold criteria and were asked to submit proposals for funding. In addition to the high scores reflected by the key threshold factors, these CSB service areas offer an array of programmatic activity and reflect the variety of urban, rural, unified and multi-jurisdictional areas. Funding programs in each of these areas is an important consideration in allocating resources so that programs can be replicated in the many diverse areas throughout Virginia. In the final step of the allocation process, the Department, in partnership with representatives from the Department of Criminal Justice Service (DCJS), will analyze the submissions and fund between 6 and 10 programs.

Funding will also be used to create a comprehensive plan for evaluating these programs, providing consistent, reliable data and outcomes measures on which to base future development and investment in jail diversion programs. Nationally and in Virginia, the availability of sufficient data and effective analysis has been an impediment to ongoing support and resourcing of these important initiatives. Virginia is prioritizing this important component of criminal justice and mental health transformation.

The FY09/10 funds will also be used in partnership with the Department of Criminal Justice Services to support statewide development of Crisis Intervention Team programs. Funds specifically designated for crisis intervention training will be allocated

in partnership with DCJS and support a statewide coalition of CIT programs in various stages of development as well as targeting funds for the development and implementation of CIT programs throughout Virginia.

II. Impact of 2008 Reforms: A Preliminary Report

Informed oversight of the civil commitment process requires accurate data regarding the number, distribution and characteristics of ECOs, TDOs, commitment hearings and judicial dispositions. Adequate data were not available before 2008. Since the Commission was established in 2006, the courts and mental health agencies have collaborated to create the data systems needed for proper monitoring and informed policy-making. This process was accelerated in response to direction by the General Assembly after the reform legislation was enacted in 2008.

Significant progress in data collection and oversight has been made, but it will take some months for the DMHMRSAS, Supreme Court and CSBs to modify relevant databases so that they include all the necessary information, and for the agencies to determine which agency is best situated to collect which data. The Supreme Court has recently made changes to their data collection systems to accommodate needed information. The Commission decided to assemble the available data for the first quarter of FY09 to prepare this Progress Report. Even during the fall months leading up to the Progress Report, major improvements had been made, and these improvements will undoubtedly continue throughout FY09. In this section of the Progress Report, the Commission will estimate the numbers of ECOs, TDOs, commitment hearings and dispositions and, to the extent possible, assess whether commitment practices have changed in the wake of the reforms.

Available Databases

Court clerks at General District Courts document civil commitment hearings using the Case Management System ("CMS"). Although it is technically a database for each District Court to track and record its cases[4], the CMS database is maintained by the Office of the Executive Secretary at the Supreme Court. It is divided into four sections for tracking the corresponding types of cases: traffic, criminal, civil, and involuntary civil commitment. Civil commitment hearings and related ECOs and TDOs are entered in the involuntary civil commitment division of the CMS database. Terminals at court clerk offices transmit the data to the Office of the Executive Secretary, which allows the merging of data from all District Courts.

The eMagistrate System is used by magistrates in all thirty-two judicial districts to issue arrest processes, bail processes, and other orders which include ECOs and TDOs. Each time an ECO or TDO is issued, it is entered into the eMagistrate System, initiating the ECO or TDO process by issuing the appropriate documents. ECOs and TDOs are

[4] The CMS database collects special justice pay codes from the DC-60; however, the Supreme Court Fiscal Department is the official collector of this type of information. For the purposes of this report, it was determined that case based information from the CMS database was more appropriate than pay code information.

counted in the eMagistrate System regardless of whether an ECO or TDO is successfully executed.[5]

When data are requested by an outside party, upon approval by the Legislative and Public Relations Director, the Judicial Planning Office accesses the eMagistrate or CMS databases and assembles the needed data elements, which are then put in a format for submission to the party requesting the data.[6]

The Virginia Association of Community Services Boards' Emergency Services Council ("ES Council") voted unanimously to collect data on inpatient commitments and TDOs issued during the first quarter of FY09 after the new mental health legislation went into effect to gain insight into how the new legislation impacts commitment and TDO rates. The ES Council collected data from 39 out of 40 CSBs, each of which tracked the data using their own methods.[7] The "CSB TDO and Commitment Survey" collected the frequencies at each CSB (involving adults only) of TDOs issued by a magistrate and of inpatient or outpatient involuntary admissions ordered at civil commitment hearings that their CSB attended. The rate of admissions reported for a CSB can depend on the number of TDO facilities in the CSB area and the jurisdictions in which the CSB has agreed to attend hearings.

ECOs

The best available source of data regarding written ECOs is the Supreme Court's eMagistrate Data System. According to the eMagistrate database, about 500-600 ECOs were issued per month in the first quarter of FY09. (See Table 1.)[8]

Table 1. Frequency of Adult ECOs During First Quarter: eMagistrate

Month	eMagistrate Data ECOs
Jul	603
Aug	523
Sep	481
Total	1,607

[5] An ECO or TDO is issued by a magistrate but is only deemed successfully executed if the person is detained.

[6] Juvenile and adult data was obtained from the eMagistrate System. Only adult data was obtained from the CMS database.

[7] Eastern Shore CSB did not have any data available.

[8] According to the CMS database, 678 ECOs were issued and 597 were served during the first quarter – about 200/month. However, the Commission believes that the magistrate database is the more reliable of the two for the purpose of counting ECOs. It appears that the number of ECOs in the CMS database is too low to represent all ECOs issued and executed during the quarter. General District Court Clerks are instructed to record all orders, but it seems likely that there was some delay in implementing these new data entry requirements.

When people are taken directly into custody by law enforcement officers and brought to a mental health facility based on the officer's own observations, no formal ECO is executed. (These are called "paperless ECOs.") The number of paperless ECOs is unknown and will have to be ascertained directly from facilities conducting mental health evaluations. For example, in the Commission's June 2007 study of emergency evaluations conducted by CSBs, 24.3% of the individuals evaluated that month were in police custody at the time of the evaluation, but only 46.6% of those individuals were being held under a written ECO. Overall, at the present time, data regarding ECOs are incomplete.

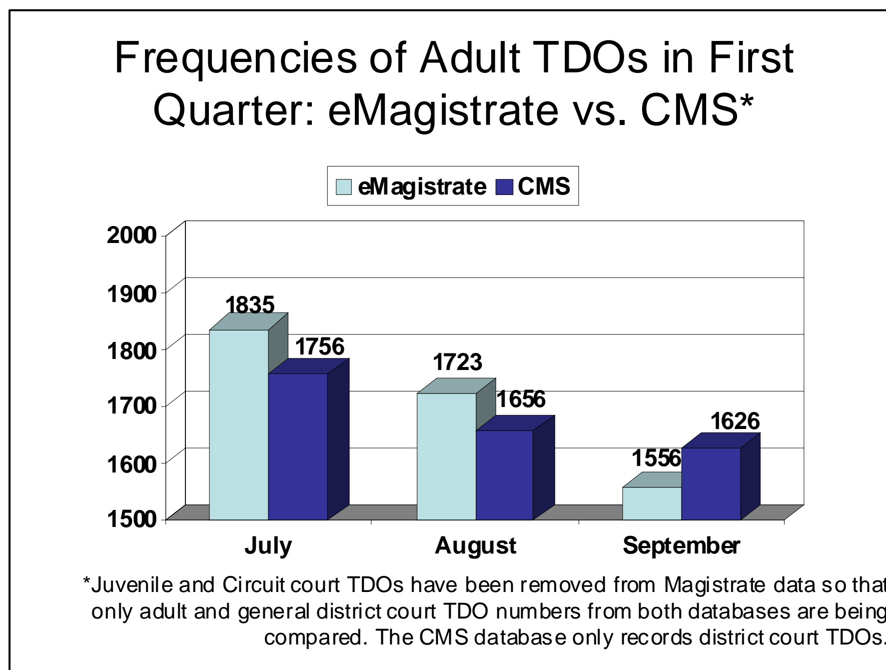
TDOs

The three available sources of data report different numbers for TDOs issued and executed during the first quarter of FY09. The number of TDOs issued for the quarter was 5,038 according to the CMS data, 5,285 according to the CSB data, and 5,157 according to the eMagistrate data. (See Table 2.) As depicted in Figure 1, the discrepancy between the eMagistrate and CMS databases is about 75 cases per month, but it reverses direction in September.

Table 2. Frequencies of Adult TDOs Issued During First Quarter from Available Sources

	Number of Adult TDOs		
	CMS	CSB	eMagistrate
July '08	1,756	N/A	1,850
Aug. '08	1,656	N/A	1,737
Sept. '08	1,626	N/A	1,570
Total First Quarter	5,038	5,285	5,157

Figure 1. eMagistrate vs. CMS: Frequency of Adult TDOs During First Quarter



The most important TDO number is how many TDOs were executed during the first quarter. The CMS data show that number to be 4,847. (See Table 3.) Although the eMagistrate data system and the CSB survey do not include information about execution of TDOs, it appears, based on the rate of execution in the CMS data, that about 5,000 adult TDOs were executed during the quarter. (See Table 4.) The Commission will continue to evaluate the strengths and weaknesses of each data system over the coming months.

Table 3. Frequency of Adult TDOs in CMS

	CMS:Number of Adult TDOs		
	Executed	**Unexecuted**	**Total**
July '08	1,715	41	1,756
Aug. '08	1,577	79	1,656
Sept. '08	1,555	71	1,626
Total First Quarter	4,847	191	5,038

Table 4. Frequencies of TDOs Executed During First Quarter from Available Sources[9]

	Number of Executed TDOs		
	CMS	**CSB**	**eMagistrate**
Adults	4,847	5,085*	4,961*
Juveniles	N/A	N/A	324*

*estimated

A key policy question is whether the number of TDOs has increased since the 2008 reforms went into effect. The answer depends on which data system one uses.

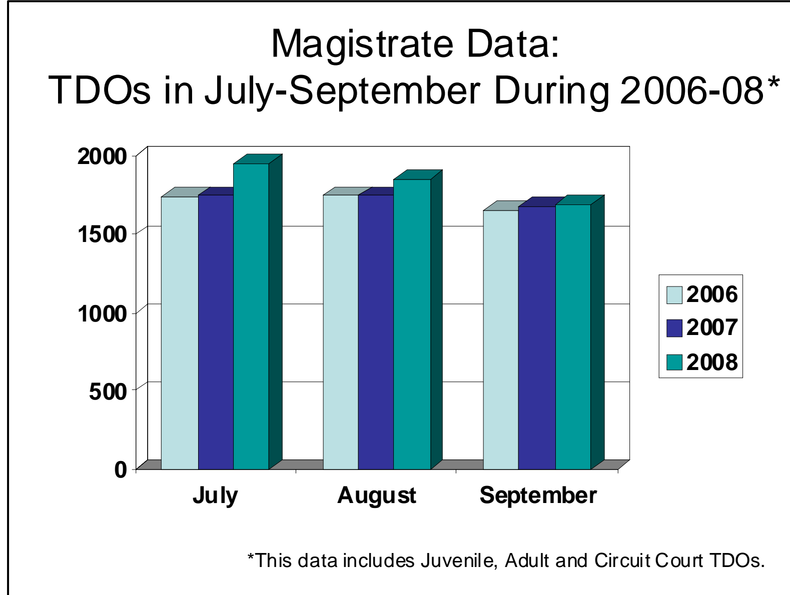
- The Supreme Court's eMagistrate database suggests that the numbers of TDOs during July, August and September of FY09 were somewhat higher (an increase of 7%) than during these same months in FY07 and FY08. (See Figures 2 and 3). However, the numbers of adult TDOs for ALL of calendar year 2008 have been notably higher than those during calendar years 2006 and 2007. In other words, if these data are accurate, the spurt in TDOs began in January 2008, and the rate of increase actually *declined* after the new law went into effect in July 2008 and may have receded entirely in September. This suggests that the increase in adult TDOs during 2008 is attributable to factors that preceded the effective date of the new law.[10] (It is possible that the apparent increase beginning in January 2008

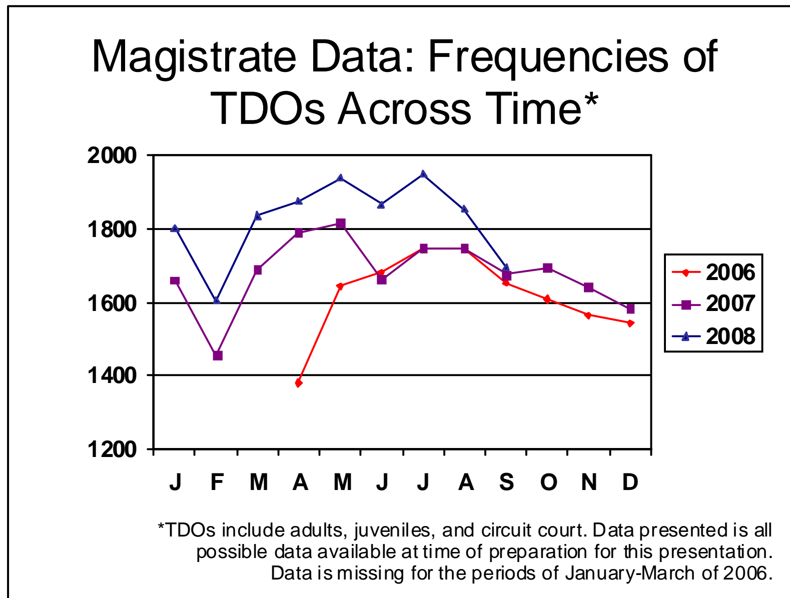
[9] Numbers of executed TDOs in the eMagistrate and CSB data are estimated numbers based on the percentage of TDOs (3.8%) in the CMS database that were unexecuted. The eMagistrate System and CSB TDO and Commitment Survey do not show whether a TDO was executed or unexecuted.

[10] Interestingly, the increase did NOT begin during April or May of 2007 in the wake of the Virginia Tech killings. The TDO numbers during April-December of 2007 were nearly identical to the numbers during April-December, 2006. We surmise that the TDO increase during the first six months of 2008 represents an educational effect – the deliberations in the late fall by the Commission and the General Assembly relating to proposed modifications of the commitment criteria, together with accompanying media coverage, may have heightened awareness of the issues by CSB ES staff and begun to influence their

(including the first quarter of FY09) is a function of improved record-entry practices by magistrates rather than real changes in TDO frequency; however, since a similar increase appears in the CSB survey data (see below), we are inclined to think that there has been a genuine increase in the number of TDOs during 2008).

Figures 2 and 3. Frequencies of TDOs in eMagistrate System





- The CSB data suggest that the number of TDOs may have increased about 8% during the first quarter of FY09 compared to the first quarter of FY08 (although there have been substantial differences among localities). (See Table 5). However,

decisions at the margins in early 2008. Because this effect might otherwise have occurred in July after the modified criteria had been adopted, it might be seen as an anticipatory effect.

FY07 was the first year that most CSBs systematically recorded the number of TDOs, and the numbers for 2007 may be less accurate than the numbers for FY08.

Table 5. Frequency of Adult TDOs in CSB TDO and Commitment Survey[11]

Number of TDOs July-September							
CSB	**2007**	**2008**	**% Increase**	**CSB**	**2007**	**2008**	**% Decrease**
Hanover	32	70	119%	Richmond	489	481	-2%
Highlands	39	71	82%	Mid. Penin.-Northern Neck	91	88	-3%
Arlington	65	107	65%	Norfolk	170	158	-7%
Valley	34	52	53%	Henrico	213	197	-8%
Loudoun	53	81	53%	Crossroads	60	55	-8%
Portsmouth	58	87	50%	Colonial	59	54	-8%
Southside	56	78	39%	Central Virginia	235	215	-9%
Alleghany Highlands	22	29	32%	Prince William	209	190	-9%
Alexandria	44	56	27%	Cumberland Mtn.	86	72	-16%
Virginia Beach	192	237	23%	Harrisonburg-Rockingham	57	48	-16%
Mt. Rogers	210	256	22%	Northwestern	157	129	-18%
Chesapeake	87	106	22%	Planning District One	96	76	-21%
Blue Ridge	423	513	21%	Dickenson	18	14	-22%
Hampton-Newport News	234	273	17%	Goochland-Powhatan	13	8	-38%
District 19	182	211	16%	Rockbridge Area	23	10	-57%
Fairfax-Falls Church	212	245	16%	**Total 2007 TDOs: 4,881** **Total 2008 TDOs: 5,285** **Average Percent Change: 8%**			
Region Ten	92	106	15%				
Piedmont	77	88	14%				
Chesterfield	64	72	13%				
Western Tidewater	103	111	8%				
Rappahannock-Rapidan	145	151	4%				
Rappahannock Area	115	119	3%				
Danville-Pitts.	113	116	3%				
N. Riv. Valley	253	255	1%				

[11] CSBs are listed in order of greatest percentage increase to greatest percentage decrease.

Fairfax-Falls Church CSB has maintained data on TDOs since 2005. As shown in Figure 4 and Table 6, there was a big jump in TDOs in Fairfax-Falls Church during December 2007 and January 2008 and the monthly increase has continued throughout 2008. These data lend further support to the hypotheses that there has been a real increase in TDOs during the past year and that the increase preceded the effective date of the new law.[12]

Figure 4. Frequency of TDOs in Fairfax-Falls Church CSB During 2005-2008

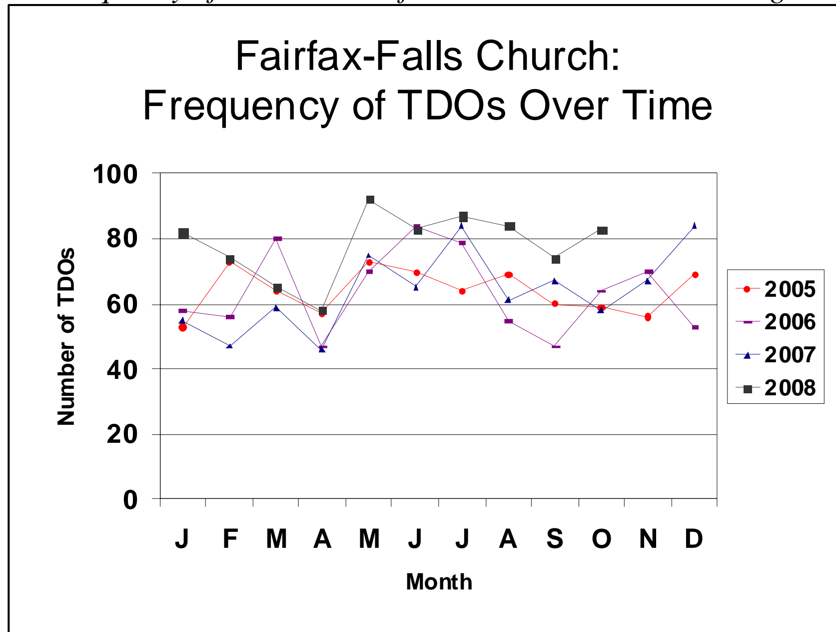


Table 6: Frequency of TDOs in Fairfax-Falls Church CSB During 2005-2008

	CSB:Number of Adult TDOs			
	2005	2006	2007	2008
January	53	58	55	82
February	73	56	47	74
March	64	80	59	65
April	57	47	46	58
May	73	70	75	92
June	70	84	65	83
July	64	79	84	87
August	69	55	61	84
September	60	47	67	74
October	59	64	58	83
November	56	70	67	
December	69	53	84	
Total	767	763	768	782

[12] As noted in footnote 7, why this increase has occurred is an interesting question. One hypothesis that is NOT supported by the data is that the increase is attributable to an increased risk-averseness by CSBs in the wake of the Virginia Tech shootings. Neither the eMagistrate data nor the Fairfax-Falls Church data indicate a rise in TDOs during the summer months in 2007.

Overall, the Commission estimates that TDOs were about 8% higher during the first quarter of FY09 than during the first quarter of FY08, but it seems likely that the rate of increase is receding.

All Adult Commitment Hearings

The best source of data on the number of commitment hearings and the dispositions of these hearings is the Supreme Court's CMS data system. The number of commitment hearings for the quarter was about 5,720. This includes 5,141 ordinary adult hearings, 45 hearings involving jail detainees, and 524 recommitment hearings. (See Table 7.) We have reasonable confidence in the completeness of the CMS data regarding hearings because the number of initial hearings conducted (that is, excluding recommitments) is approximately 5,100, only slightly higher than the estimated number of executed TDOs recorded in the three TDO databases.[13]

Table 7. Frequency of Adult Civil Commitment Hearings in CMS

	CMS:Frequency of Adult Hearings			
	Initial Hearing	Recommitment	Jail Detainees	Total
July '08	1,761	173	23	1,957
Aug. '08	1,720	183	10	1,913
Sept. '08	1,660	231	12	1,903
Total First Quarter	5,141	587	45	5,773

Ordinary Adult Commitment Hearings[14]

We do not have comparable data at hand for FY08, but it seems likely that there were more ordinary commitment hearings in the first quarter of FY09 than during the first quarter of FY08. Based on the data obtained at the time of the Commission's study of commitment hearings during May 2007, and on inferences drawn from TDO data, it is possible that the increase has been in the range of 5-8%. It must be emphasized, however, that this is based almost entirely on inference from other databases rather than from the CMS database itself. We expect the CMS database will be a reliable source of year-to-year comparisons in the coming years. We are also advised that payments by the Supreme Court under the IMC fund are running ahead of last year adding support for a real increase in commitment hearings.

We also have reasonable confidence in the data recorded in the CMS data system regarding dispositions of ordinary adult hearings held in the first quarter of FY09. We say this because of the stability of the data from month to month. As shown in Table 8, during the first quarter, about 56% of the hearings resulted in involuntary admission,

[13] The number of commitment hearings should not be lower than the number of TDOs since very few individuals are either released or allowed to convert to voluntary patients before the scheduled hearing; however, it could be higher because some patients originally admitted as voluntary patients may later he held over objection.

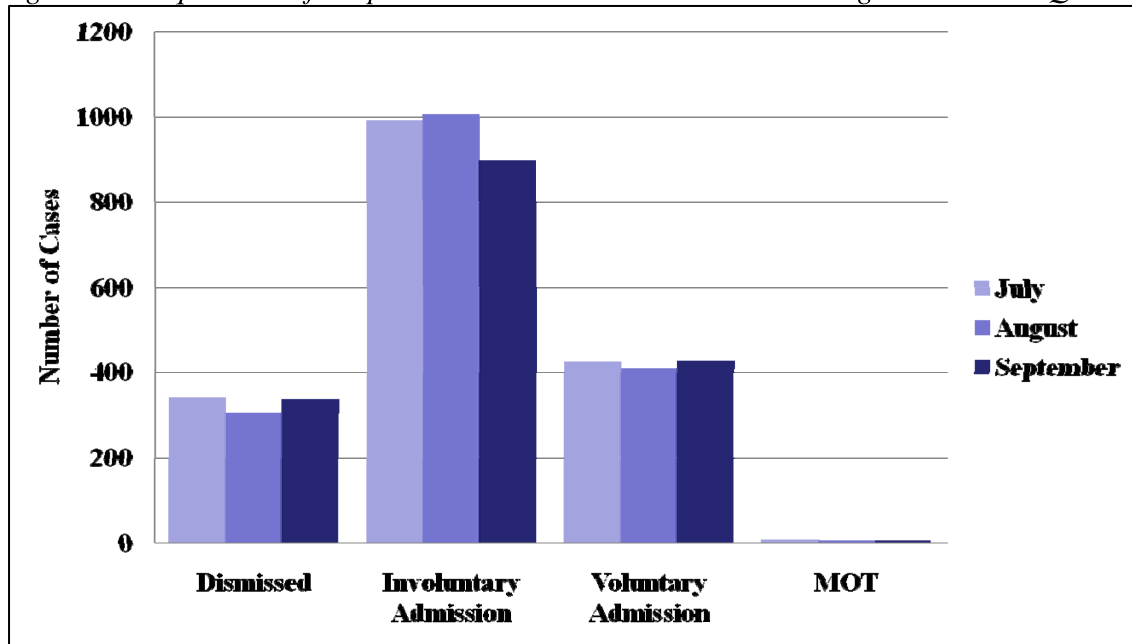
[14] This analysis excludes commitment hearings involving jail detainees and recommitment hearings. These two categories are analyzed separately.

about 24% resulted in voluntary admission and about 19% of the cases were dismissed. A handful of cases (18) resulted in mandatory outpatient treatment (MOT) orders. In comparison with the Commission's study of hearings conducted in May 2007, there were fewer MOT orders and fewer voluntary hospitalizations, and correspondingly more involuntary hospitalizations and dismissals. (See Figure 5.)

Table 8. Frequencies of Dispositions at Civil Commitment Hearings in CMS

2008	Dismissed		Involuntary Admission		Voluntary Admission		MOT		Total Number of Hearings
	N	%	N	%	N	%	N	%	
July	341	19.36	991	56.27	422	23.96	7	0.40	1,761
August	302	17.56	1,005	58.43	408	23.72	5	0.29	1,720
September	335	20.1	895	53.92	424	25.54	6	0.36	1,660
Total FQ	978	19.02	2,891	56.23	1,254	24.39	18	0.35	5,141

Figure 5. Frequencies of Dispositions at Civil Commitment Hearings: CMS First Quarter



Commitments to Inpatient Treatment

From a resource standpoint, one of the key questions is how many people are committed to inpatient treatment, and whether that number has increased as a result of the 2008 reforms. Again, based on the apparent increase in number of hearings and the apparently increased proportion of hearings resulting in commitment to inpatient treatment (perhaps 5%), it seems likely that there were more people involuntarily committed to hospitals during the first quarter of FY09 than during the first quarter of FY08.[15] The actual numbers, based on CMS data, were about 1,000 people per month in July and August and 900 in September. However, the increase preceded the effective date of the new law and has probably been accompanied by a decline in the number of voluntary admissions.[16]

Mandatory Outpatient Treatment

One of the most striking findings based on the first quarter FY09 data is that MOT orders have been rare. The CMS data indicate that there were only 18 MOT orders during this period and 11 of them occurred in a single jurisdiction. The CSB survey reports only 13, as compared with 78 during the same period in FY08.[17] This finding led the Commission to survey CSBs, inquiring about the possible explanations for the decline in what had already been a relatively rare practice. Thirty CSBs responded to the survey. (See Table 9.)

Table 9. CSB MOT Survey Results: Explanations for Decline in MOT

Explanations for Decline in MOT
Percent of CSB Respondents who Thought Explanation was Most Likely

Explanation	Percent
Burden of new MOT laws on judges	**63.3%**
MOT Criteria same as Commitment Criteria	**60.0%**
Detention period too short to allow consideration/creation of MOT plan	41.3%
Changes to Civil Commitment Criteria	40.0%
Insufficient Behavioral Health Resources	34.4%
Burden of new MOT laws on CSB	33.3%
Judges having to verify whether MOT is available	31.0%
Judges' interpretations of Comm. Criteria	26.6%
Insufficient Funding	20.7%

[15] The CSB database was incomplete for numbers of inpatient commitments. However, the localities reporting numbers of commitments for both FY08 and FY09 reported a 22% increase. The Commission believes that the numbers reported are not reliable; in particular, it is likely that a significant portion of the cases reported as involuntary commitments were cases in which the respondent agreed to voluntary admission.

[16] The Fairfax-Falls Church CSB data also show that a significant increase in involuntary admissions in the first quarter of FY09 was accompanied by a precipitous decline in voluntary admissions, resulting in no overall increase in the number of hospitalizations.

[17] The Commission's hearing study reported that there were 73 MOT orders in May 2007.

It is apparent that both CSBs and judges have been hesitant to invoke the new MOT procedures, especially given the potential demand on CSB resources. However, it seems likely that the number of MOT orders will increase as the participants become more familiar with the process.

Virginia State Police Data on Hearing Dispositions

A second potential source of data on hearing dispositions is the Virginia State Police ("VSP"). The clerks of the District Courts are required to send VSP the names of individuals (1) committed to inpatient or outpatient treatment and (2) who consent to voluntary admission after detention under a TDO. In theory, the numbers should match the numbers in the CMS database for these same dispositions at commitment hearings. However, the Commission decided not to rely on the VSP data for the first quarter because there are significant discrepancies between the CMS data and the VSP data, especially for July, and it is likely that the reporting of this information to the VSP has not yet become streamlined. (See Table 9.) There was also probably a significant backlog of orders sent to the VSP after July 1 for cases heard in June. The Commission will continue to compare the CMS data with the VSP data during the coming year. [18]

Table 9. First Quarter Involuntary Out / Inpatient Treatment: State Police vs. CMS[19]

	Frequency of Adults Admitted to Involuntary In- or Outpatient Treatment	
	State Police	**CMS**
July '08	1,524	1,180
Aug. '08	1,128	1,186
Sept. '08	1,104	1,135
Total First Quarter	3,756	3,501

Recommitments

Figures 6 and 7 display the numbers and dispositions of recommitment hearings during the first quarter of FY09. They are very similar to the numbers and disposition rates in the Commission's May 2007 study. Almost all recommitment hearings result in continued hospitalization.

[18] The data in the two systems are somewhat less discrepant for the numbers of people who agreed to voluntary admission after issuance of a TDO. The VSP data reflect about 1006 such cases for the quarter – less than, but reasonably close to the number of voluntary post-hearing admissions for the quarter (1254) recorded in the CMS database.

[19] For comparison to VSP data, which records *any* involuntary admission or MOT orders, CMS data for the first quarter of FY09 were tabulated to include not only ordinary involuntary inpatient admissions and MOT, but also involuntary admissions and MOT orders from recommitment hearings and involuntary admissions involving people detained in jail.

Figure 6. Frequency of Recommitment Hearings

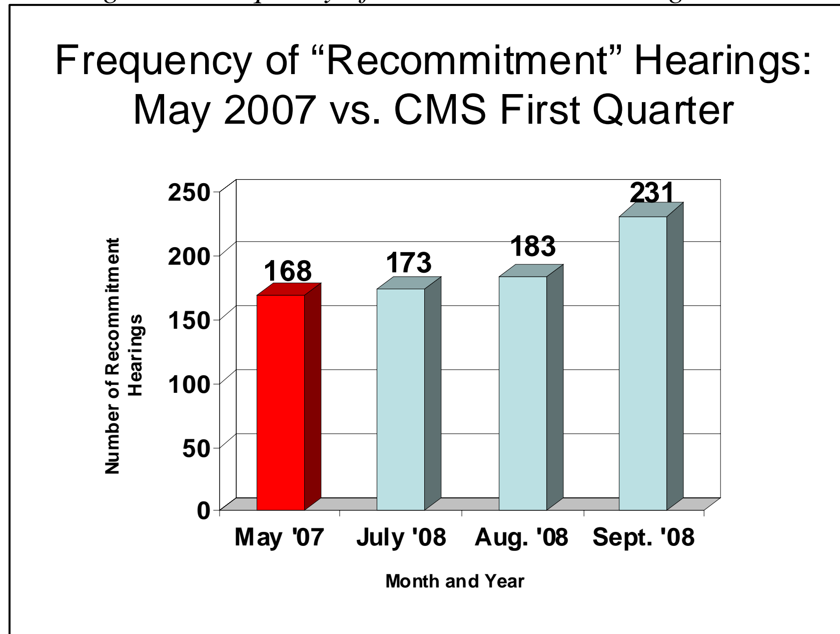
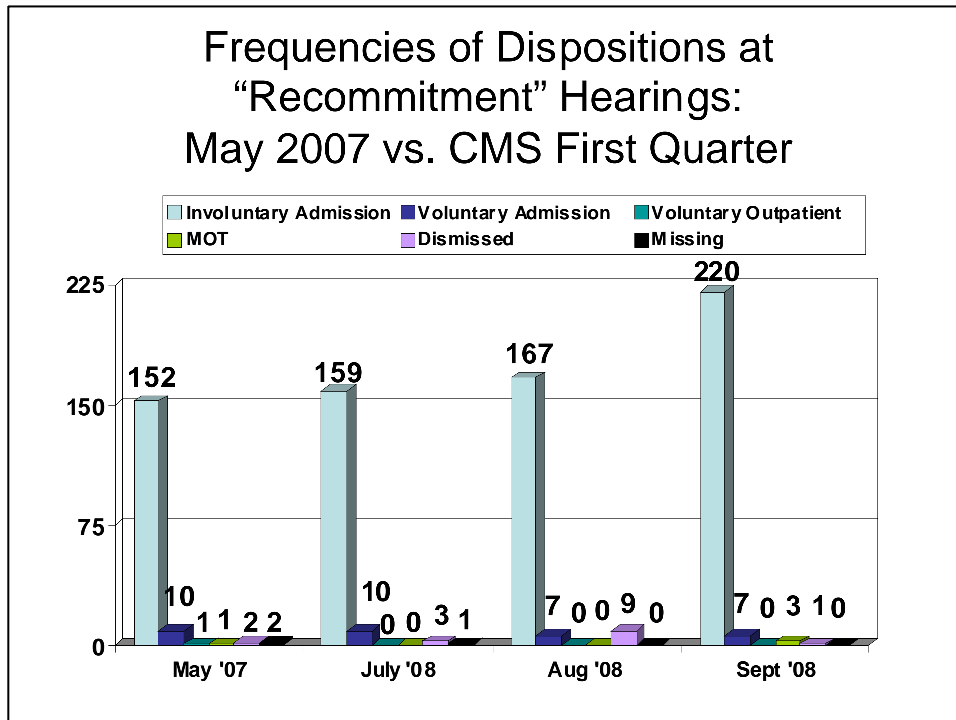


Figure 7. Frequencies of Dispositions at Recommitment Hearings



III. Implementation of 2008 Reforms

In this section of the Report, the Commission reviews the steps that have been taken to implement the 2008 reforms, presents data regarding the administration of the commitment process during the first quarter of FY09, and identifies some of the impediments and challenges that have emerged.

A. Coordination and Oversight

Perhaps the most promising development in 2008 was the development of an organizational structure for coordination and oversight of Virginia's commitment process. Surprisingly, prior to the 2008 reforms, no state entity was charged with these functions, a structural failure that probably contributed to the wide variations in the application of the commitment law that had developed over the past decades. Beginning in December, 2007, the Commission served as the hub for all the stakeholder constituencies, state executive branch agencies and the Office of the Attorney General to monitor the legislative process and reach consensus on issues as they arose. Legislative Task Force members met with Delegates and Senators, attended legislative committee meetings and hearings, prepared and submitted position papers and talking points, drafted language for proposed amendments, and offered testimony to the legislative committees considering the proposed legislation.

During the 2008 General Assembly Session, more than 120 mental health-related bills were submitted by 43 Delegates and Senators. The resulting comprehensive legislative package codified sweeping changes in Virginia's mental health laws. Once the Session concluded, the Legislative Task Force was expanded and reconstituted to address implementation of this new legislation. The initial priorities were to design and coordinate comprehensive training to the numerous stakeholders involved in the implementation of this legislation, and to help guide and coordinate implementation efforts at the local level. The Implementation Task Force participants collaborated on the preparation of training materials and "cross-training" efforts so that all of those involved would receive similar information and advice for implementing the reforms. The Task Force members organized and participated in training events for CSB personnel, district and juvenile court judges, court clerks, magistrates, and special justices, among others. Task Force members also provided comments to the Office of Executive Secretary's Legal Research Department on the creation of new forms and revision of existing District Court forms used in the involuntary commitment process. Before enactment of the 2008 amendments, there were 8 District Court forms applicable to involuntary commitment. Under the new provisions, there are now some 26 district court forms relating to these procedures. DMHMRSAS also changed its CSB preadmission screening form as well as the petition, independent examiner's report and involuntary treatment order forms. Development of a web-based DMHMRSAS certification curriculum for CSB screeners and independent examiners is also well underway, as required by the 2008 amendments.

Implementation efforts were also supported by a "Mental Health Reform" web-page on the DMHMRSAS web-site, where FAQs, training materials, forms, guidance documents and other resources are available to interested stakeholders. Many other actions were taken by Task Force members and their respective agencies and organizations to support a coordinated implementation effort.

B. Issues Requiring Legislative Clarification in 2009

After the mental health legislation enacted by the 2008 General Assembly became effective on July 1, 2008, the Task Force on Implementation of the 2008 Reforms began gathering information on the implementation of the new procedures to gauge the extent to which the new legislation was accomplishing the goals of the Commission and the General Assembly. The Implementation Task Force identified a number of problems arising in implementing the new legislation, either as a result of drafting, interpretation or training issues, and developed recommendations to remedy these problems. The Commission endorsed the Implementation Task Force's recommendations and developed a proposal to address them for consideration by the General Assembly in its upcoming session.

Recommendation 1: The Commission recommends for consideration by the General Assembly a set of procedural amendments to the 2008 legislation designed to clarify legislative intention and thereby promote uniform application of the laws governing involuntary commitment. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

C. Issues Requiring Monitoring and Further Study

The Commission has also identified two areas of concern that require further monitoring before recommendations are offered for consideration by the General Assembly.

1. Training and Oversight for Special Justices and Attorneys

Training. In order to ensure that the civil commitment process is implemented consistently and fairly statewide, it is imperative that special justices receive extensive training BEFORE they assume their responsibilities on the bench. Because special justices are often appointed from the ranks of attorneys who are appointed to represent respondents in commitment hearings, it is equally important that attorneys be trained and qualified to represent respondents before they assume such responsibilities.

The Commission believes that special justices and attorneys should be required to complete a training program similar to that required for attorneys serving as guardians *ad litem* for incapacitated adults. This training encompasses a six hour mandatory course

“Representation of Incapacitated Persons as a Guardian *ad Litem*” and six hours of continuing education every two years from the date of original qualification on any topic related to the representation of incapacitated persons. For special justices and attorneys, the six hours of continuing legal education should be in subjects approved by the Executive Secretary’s Office of the Virginia Supreme Court. Such training should also include training provided with the participation of consumers and family members, public and private sector clinicians and CSBs.

The Commission has been informed that the Judicial Council, the policy entity of the Virginia Supreme Court, is considering mandating that all special justices complete a training program related to their job responsibilities within six months of their appointment and that they receive continuing legal education in commitment related topics every two years. The Supreme Court would also work with the Virginia State Bar and Virginia CLE to establish training programs for attorneys representing petitioners and respondents in these proceedings. In light of these initiatives, the Commission sees no reason for legislative action at this time.

Oversight. The Commission is also concerned about the appointment, oversight, support and training of the special justices who conduct involuntary commitment hearings. Special justices are independent judicial officers who serve under the supervision and at the pleasure of the chief circuit court judge. See Code § 37.2-803. The Executive Secretary of the Supreme Court is the administrator of the circuit court system and assists the chief judges in the performance of their administrative duties. See Code § 17.1-502. Special justices also are under the jurisdiction of the Judicial Inquiry and Review Commission, and are subject to discipline or removal for actions violating the Canons of Judicial Conduct. While special justices appointed to conduct commitment hearings are in every sense of the word “judges,” who exercise all the powers and duties of judges in the cases over which they preside, ordinary models of oversight or supervision are not directly applicable to these judicial officers. The Implementation Task Force will continue to study this issue and will provide recommendations for consideration by the Executive Secretary and the Commission in 2009

2. Training, Certification and Compensation for Independent Examiners

Before the 2008 amendments, evidence suggested that independent examiners (“IEs”) ordinarily spent much less than an hour in conducting the examination and preparing the IE report for the involuntary commitment hearing. In addition, IEs were not statutorily obliged to attend commitment hearings. Under the new procedures enacted in 2008, the typical IE examination now requires at least an hour to assemble the relevant information (e.g., obtaining records and speaking with collateral sources), a task that is apparently performed in most cases by the staff of the TDO facility. Assuming that the necessary information has been assembled by staff, the IE requires about two hours to review the records, conduct the interview and prepare the IE report for the commitment hearing. In addition to the mandated review of additional information about each individual subject to a commitment hearing, IEs are now required to attend the

commitment hearing in person or by audio/video, or otherwise be available by telephone to provide testimony or answer questions.

Notwithstanding the increased time required to handle each commitment case mandated in the 2008 amendments, the compensation rate for IEs ($75 per hearing) was not changed during the 2008 session. The Commission is concerned that the disjunction between the added IE responsibilities and the already low level of compensation could result in a scarcity of qualified professionals willing to participate in the civil commitment process. The Implementation Task Force, with input from the Medical Society of Virginia and other professional groups, is taking steps to monitor this situation and coordinate its findings with DMHMRSAS so the Department and the Commission can determine what remedial steps, if any, might be advisable.

In addition to requiring DMHMRSAS-certified training for the other identified mental health professionals serving as IEs under § 37.2-815, the Commission also strongly recommends that psychiatrists and psychologists serving as IEs receive mandatory training on several issues related to the civil commitment process. Although psychiatrists and psychologists may not need training relating to the clinical aspects of the mental health examinations required under Virginia's civil commitment law, they should be required to receive training on the new civil commitment criteria and other legal requirements of the civil commitment process, as well as the law on health records privacy, to ensure both compliance with the law and to promote a consistent statewide application of civil commitment law. If the TDO period is extended to 4 or 5 days and IEs are permitted to release an individual from a TDO prior to a commitment hearing, mandatory training for all IEs will be even more critical. Continuing education units should be available to all mental health professionals who complete this training.

Recommendation 2: The Commission believes that all independent examiners, including psychiatrists and psychologists, should be required to complete a certification program developed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, that Continuing Education Units should be made available for the training, and that the $75 fee now authorized for independent examinations in civil commitment proceedings should be increased. However, in light of current budget constraints, the Commission believes that these changes should be deferred.

IV. Unfinished Business in Commitment Reform

As noted, the changes enacted in 2008 were only a first step in a continuing process of reform. Some key components of comprehensive reform were outlined in the Commission's Preliminary Report. In addition, a number of bills relating to the commitment process were carried over from the 2008 Session and the subject matter of these bills was referred by the Senate to the Commission for further study. This section summarizes the Commission's views on some of these issues.

A. Transportation

Neither police departments nor sheriffs departments receive specific funding for executing ECOS, TDOS or providing transportation following a commitment hearing. Law-enforcement officers spend up to four hours, and often much longer, in hospital emergency departments waiting for completion of medical assessments and CSB evaluations, and for the CSB to locate a *temporary* detention bed. Thereafter, due to a shortage of psychiatric beds in some localities, even longer hours may be spent transporting individuals outside the jurisdiction to other parts of the state, necessitating taking two officers and a vehicle off of the street and away from other law enforcement duties needed in that locality. Overtime expenses are often incurred in transporting individuals to mental health facilities. In addition, there is substantial evidence that law enforcement transport for what is a health condition unnecessarily "criminalizes" the mental health crisis. Moreover, the routine use of restraints during such transport is both traumatizing and stigmatizing and greatly impairs recovery. The issue of transport related to the civil commitment process is also a great concern of law enforcement due to its enormous burden on law enforcement staffing and other resources. Both police departments and sheriff's departments have recently conducted surveys to better understand the transportation demands related to civil commitment.

The Virginia Association of Chiefs of Police conducted a survey in 2008 to ascertain the frequency with which local police agencies, sheriffs' departments, EMS agencies, or others provide transportation for ECOs and TDOs (the "Police Survey"). The Police Survey indicates local police provide transportation for ECOs and TDOs approximately 75% of the time and sheriffs' departments provide transportation the remainder of the time. (Sheriffs always provide transportation *following* the commitment hearing.) Of Police Chiefs that reported another entity provides transportation, most often that entity is EMS because of a physical injury or medical complication. Even in cases where a medical transport is necessary, however, law enforcement continues to maintain custody and an officer will either ride in the ambulance with the patient or follow behind in a squad car. The Police Survey also indicated that use of restraints for persons being transported in the civil commitment process is mandatory policy for 61% of police personnel providing transportation and is at the officer's discretion in approximately 29% of police departments. In those jurisdictions where an officer has discretion concerning the use of restraints, specific policy guidance to guide the officer's discretion is lacking and it is unclear how often that discretion is used to forgo restraints.

As noted above, sheriffs' departments undertake about a quarter of the ECO and TDO-related transports and are required to transport all individuals following a hearing. Given that there are at least 20,000 civil commitment hearings in Virginia annually, this represents a significant demand on sheriffs' resources. To better understand this, the Sheriffs' Association completed a staffing study during the spring of 2008 (the "Sheriff's Study") finding that 26.3 *additional* full time equivalent (FTE) positions are needed for Sheriffs' Departments statewide to provide necessary services related to Virginia's involuntary civil commitment process.[20] The Sheriffs' Study did not include an assessment of any additional staffing required as a result of the 2008 legislation permitting extension of temporary detention orders to 6 hours or execution of the new mandatory examination order and *capias* requirements.

A justification for any law enforcement transport is that in some cases of a mental health emergency there may be some danger to the individual in question or to others. However, this public safety concern has resulted in assuming everyone is a risk, an outcome that overburdens law enforcement and traumatizes individuals involved. All stakeholders agree that law enforcement should be utilized only when a public safety issue is presented and not as the primary source of transportation. As a result, the Commission endorsed the concept of a safe, cost-effective three-tiered statewide transportation system in its Preliminary Report of December 2007[21] based on the proposals made by the Task Force on Civil Commitment.("Civil Commitment Task Force").[22]

The goal is to develop a civil commitment transportation plan that could be implemented by 2012 that would be designed: (1) to "decriminalize" transportation and reduce stigma through reducing Virginia's over-reliance on law-enforcement agencies and the use of restraints in transporting individuals in the civil commitment process, while at the same time ensuring the safety of the person, the transporter and the public, and (2) to promote the recovery of the individual by enabling the provision of voluntary services in the least restrictive manner and setting. The basic outline of the transportation plan is to permit transportation by persons or entities other than law enforcement based on an assessment of the status of the individual involved and the safety needs in each situation as follows:

> ***First tier:*** transportation by family and friends, community services boards (CSBs), taxi service, and Medicaid vendor transportation.
>
> ***Second tier*:** ambulance service or step-down service similar to a wheelchair or stretcher transport and the impact of requirements related to the Emergency Medical Treatment and Active Labor Act (EMTALA).

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[20] The study covers only Sheriffs' Departments and not local police agencies that also provide a significant amount of transportation for ECOs and TDOs.
[21] http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf,
[22] http://www.courts.state.va.us/cmh/taskforce_workinggroup/2008_0918_tf_rpt_civil_commitment.pdf.

***Third tier*:** Use of law enforcement for transportation, including potential for creation of "mental health officers," and use of restraints in transportation.

The Commission anticipates that any transportation plan will require gradual implementation, including pilot projects. After the 2008 General Assembly Session, the Commission appointed a special Transportation Working Group to flesh out the proposed three-tiered plan. The Transportation Working Group also reviewed the provisions of SB 102 (Cuccinelli), a transportation bill essentially embracing the Commission's three-tiered plan. (The Senate had referred SB 102 back to the Commission for further study.)

Transportation in the civil commitment process by non-law enforcement entities is utilized in other states, although most states continue to rely heavily upon law enforcement. At least 27 states permit transport by family, friends, mental health professionals, ambulances, and public and private transportation companies.

Currently, Virginia Code § 37.2-808(C) requires a magistrate issuing an emergency custody order to specify the primary law-enforcement agency and jurisdiction to execute the ECO and provide transportation. Subsection D of that statute also requires the magistrate to "order the primary law-enforcement agency from the jurisdiction serviced by the community services board …to execute the order and provide transportation." Similarly, § 37.2-810(A) requires a magistrate issuing a temporary detention order to specify the law-enforcement agency and jurisdiction that shall execute the TDO and provide transportation."

Section 37.2-808 was amended by the General Assembly in 2008 by adding a new Subsection E to permit the law-enforcement agency providing transportation to transfer custody of the person to the facility or location to which the person is transported for evaluation under certain specified circumstances. This provision may have the effect in the future of relieving law-enforcement of some of the time involved in waiting for evaluations to occur, but it does not relieve it of the primary responsibility for providing transportation for both ECOs and TDOs. Unless §§ 37.2-808 and -810 are amended, alternatives other than law-enforcement transportation will not be permitted.

Section 37.2-830 does permit a judge or special justice following the commitment hearing to place a person in the custody of any responsible person, including a representative of the facility in which he was detained, for the sole purpose of transporting the person to the commitment facility. The preceding section, § 37.2-829, permits the judge or special justice to consult with the person's treating physicians and the CSB regarding the person's dangerousness and whether the sheriff should transport or whether other alternatives authorized in § 37.2-830 may be utilized.

Recommendation 3: The Commission recommends that the General Assembly consider amending the Code provisions relating to transportation of persons involved in the commitment process to permit and strengthen the use of transportation by responsible individuals and organizations other than law

enforcement officers. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Family members have suggested that if they were notified that their family member is in crisis, in some cases they could provide the transportation themselves or, diffuse the situation or provide alternative care, thereby reducing the need for emergency custody, detention and involuntary hospitalization. Although the HIPAA Privacy Rule, 45 C.F.R. § 164.510(b)(ii), and the Virginia Health Records Privacy Act, § 32.1-127.1:03, permit such a disclosure, apparently it does not appear clear to mental health professionals that this disclosure can occur. As a result, they often decide not to notify family members.

Recommendation 4: The Commission recommends that the General Assembly consider legislation amending §§ 37.2-127.1:03 and 37.2-804.1 to authorize family members to be notified when their relative is involved in the commitment process. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009."[23])

First Tier: Increasing access to voluntary services supported by "first-tier" transportation services (such as families, CSBs, taxi services, and other private vendors) will reduce the need for crisis intervention services and the corresponding need for law enforcement intervention and transportation. Access to such a service may prevent an individual's condition from deteriorating to the point that crisis intervention and more restrictive and costly hospitalization is needed. The Transportation Working Group first explored the frequency with which transportation by family and friends, CSBs, taxi services and Medicaid vendors is currently being used, and the costs of doing so. It then examined other transportation options. Based on the Transportation Working Group's research and analysis, the Commission makes the following recommendations:

Recommendation 5: The Commission recommends that CSBs consider the cost-effectiveness of developing contracts with taxi services or other regional transportation providers to provide transportation and/or vouchers for transportation to medical appointments and other needed mental health services.

Recommendation 6: The Commission urges CSBs to consider changing their policies to specify when and under what circumstances CSB crisis workers, case managers and other employees may transport persons in government owned and personal vehicles as part of the delivery of mental health services. CSBs that have not done so should consider becoming Medicaid transportation providers.

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[23] The language used in the Commission's proposal is taken directly from the HIPAA Privacy Rule. A provision is included to prohibit disclosure if the health care provider knows that a protective order has been entered preventing contact between the family member and the person in crisis.

Recommendation 7: The Commission recommends that DMAS develop written guidance as soon as possible on the requirements and conditions under which Medicaid will reimburse for routine, urgent and emergency mental health assessment and treatment. CSBs that have not already done so should assess whether it would be fiscally advantageous to become a Medicaid provider of transportation services for their consumers and encourage, where possible, private transportation providers to develop such services. Police and sheriffs' departments should also assess whether it is feasible for them to become Medicaid providers in these circumstances.

Recommendation 8: The Commission urges CSBs, private providers and other stakeholders in each locality or region to explore the feasibility of alternative methods of financing and providing transportation services for consumers, including use of peer counselors, off-duty law enforcement officers, and private mental health service providers, to determine whether they would be available and feasible in their area for providing needed transportation services for consumers.

***Second Tier*:** Second-tier transportation services would include transportation by ambulance or a form of medical transportation, similar to a wheelchair or stretcher van, not requiring a basic or advanced life support vehicle or the level of trained staff needed for life-threatening conditions. The Office of Emergency Medical Services in the Department of Health certifies all Emergency Medical Services agencies in the Commonwealth, permits all vehicles, and certifies four levels of professionals providing services: First responders, emergency medical technicians, intermediate level, and paramedic level. Although no regulations specifically cover response to mental health emergencies, it appears that EMS transportation is often provided for persons with psychiatric illnesses upon request of law enforcement, albeit with unknown frequency.

The Transportation Working Group concluded that, at the present time, use of ambulance services on a routine basis for transportation in mental health crises would not be cost-effective and would not be favored by consumers who are not suffering from a physical illness or injury. At the same time, it concluded that wheelchair or stretcher van transport is not a safe or practical alternative for use in psychiatric emergencies. However, the Transportation Working Group is intrigued by a new initiative by Physicians Transport Services located in Northern Virginia. That group has identified and purchased a prototype vehicle that could be used in providing psychiatric transports and for other medical conditions. The vehicle costs approximately half that of an ambulance. It is unmarked and can carry two persons in wheelchairs and one person on a stretcher. It has a bench for an attendant, which would always be necessary in a psychiatric transport, to monitor the passengers. Plexiglas would need to be installed to separate the driver from passengers. DMAS representatives and members of the Transportation Working Group have inspected the vehicle and believe it would meet the requirements for a psychiatric transport and Medicaid reimbursement. A pilot project, described below, utilizing this vehicle is being developed in Northern Virginia.

***Third Tier*:** Law enforcement officers, of course, will continue to be needed in some cases to provide safe transportation for people experiencing psychiatric emergencies or otherwise in custody under the commitment laws. The key question in these cases is whether and when use of restraints is needed. The Transportation Working Group reviewed the laws of other states and, in particular, the system in Vermont. Vermont law requires that secure transport be done in a manner that prevents physical and psychological trauma, respects the privacy of the individual, and represents the least restrictive means necessary for the safety of the patient. 18 V.S.A. § 7511. By law, the Mental Health Commissioner in Vermont is responsible for providing transportation of persons in the civil commitment process and contracts with law enforcement to provide transportation on a per transport basis. A qualified mental health professional or designated hospital professional conducts an assessment and determines what type of transport will be provided and whether "humane restraints," such as Velcro or polyurethane should be used. Vermont has developed an assessment check list for this purpose. The Transportation Working Group has reviewed the Vermont plan as a well as the available literature and is continuing to study this issue.

Pilot Projects: Stakeholder groups in Northern Virginia are developing a pilot project to be implemented in Arlington, Alexandria, Fairfax and Falls Church as soon as legislation is enacted permitting entities other than law enforcement to provide transportation. The Northern Virginia group has developed draft Psychiatric Transfer Guidelines with two goals: (1) to provide a clear decision pathway for case workers, law enforcement officers and magistrates to help determine with reasonable certainty the safest and most appropriate means of transferring a person with psychiatric needs while protecting the rights and dignity of the person; and (2) to effectively utilize law-enforcement officers (LEO) and emergency services workers (EMS) when appropriately serving citizens in need while reducing the care costs to the person and the Commonwealth. As noted above, Physicians Transport Service has also purchased two prototype vehicles that can be utilized to provide transportation in psychiatric emergencies cases requiring back-up medical support. The Commission strongly endorses this proposed pilot project, including the provision of Medicaid reimbursement for these services.

B. Extension of TDO Period

Virginia is one of three states requiring a commitment hearing within 48 hours of the probable cause determination. Most states require a hearing within four to eight days of the probable cause determination while a few states do not require one for as long as 30 days.

In its Blueprint for Comprehensive Reform in 2007, the Commission endorsed extending the TDO period from the current 48 hours to 4 or 5 days to permit a better evaluation and stabilization of the individual before a decision about civil commitment is required. During the 2008 session of the General Assembly, Senator Edwards introduced SB 143 to implement a longer TDO period, extending it to 4 days. The subject matter of this bill was referred by the Senate to the Commission for further study which assigned it

to the Task Force on Future Commitment Reforms ("Future Commitment Reforms Task Force"). The Future Commitment Reforms Task Force also reviewed the Civil Commitment Task Force Report (released in March 2008) that had previously considered a proposal to extend the TDO period to four days and an accompanying proposal to authorize an IE to release a person from the TDO prior to the commitment hearing upon concluding that the person did not meet the commitment criteria, and with the concurrence of the attending physician.

The Future Commitment Reforms Task Force also considered the consultant's report prepared by Sarah E. Barclay for the Commission on this issue.[24] After reviewing data from Virginia, Colorado, Massachusetts and Pennsylvania on lengths of stay, Ms. Barclay concluded that the two-day temporary detention period is not adequate for a thorough assessment in some cases. Ms. Barclay also noted that 30% of commitment hearings in Virginia occur in less than 24 hours. Anecdotal reports since the change in the law effective July 1, 2008 indicate that this rapid processing of civil commitment cases remains prevalent due to the Monday/Wednesday/Friday hearing schedules that many special justices maintain. Ms. Barclay postulates, and the Future Commitment Reforms Task Force agrees, that an increased temporary detention period would contribute to an improved decision-making process. A longer TDO period would also help better identify cases in which a mandatory outpatient treatment ("MOT") order might be appropriate. Some localities report that the decrease in the volume of MOT orders entered since July 2008 reflects an inability to develop an adequate outpatient treatment plan within the 48-hour TDO period, especially if the person is temporarily detained in a location other than his place of residence, which is often the case.

It is widely agreed that, if the TDO period is increased, it should be accompanied by an effective pre-hearing release measure. Some individuals may be stabilized and no longer meet the criteria for civil commitment, or may not have met the criteria in the first instance, but without a pre-hearing release mechanism they may be held for the full statutorily permitted TDO period until a commitment hearing is held.. One recommendation would be to extend the responsibility and authority of the IE to permit the IE to release the person from the TDO if the person does not meet the commitment criteria, or if the IE finds that the person is capable and willing to accept voluntary inpatient or outpatient treatment, such treatment is appropriate and the treating physician agrees. A commitment hearing would then not be necessary.

The Commission's research team is studying the possible fiscal consequences of increasing the TDO period. The key questions include: how the increase in the authorized TDO period would affect the actual TDO periods in practice; how any lengthened TDO period would affect the frequency of commitment hearings; and how a lengthened TDO period would affect the average length of voluntary or involuntary hospital stays after the TDO period. For example, if the average TDO period is increased, a longer TDO period may promote the stabilization of some individuals in crisis, obviating the need for

[24] Sarah E. Barclay, *Increasing the Temporary Detention Period Prior to a Civil Commitment Hearing: Implications and Recommendations for the Commonwealth of Virginia Commission on Mental Health Law Reform*, April 2008.

hearings and for further expensive inpatient hospitalizations.. As a result of the unknowns, however, a Commission recommendation would be premature until these issues have been carefully studied.

Another issue that a lengthened TDO period might affect is the availability of psychiatric beds. Virginia continues to experience psychiatric bed shortages in some areas of the state. Extending the TDO time period may exacerbate this problem. In addition, requiring further work by IEs during a longer TDO period, as discussed earlier, would exacerbate the concerns related to their compensation for civil commitment cases.

The Commission is also considering some alternatives to extending the TDO to 4 or 5 days. For example, it is possible to require that commitment hearings occur no less than 24 hours of admission of the patient under the TDO, while extending the TDO time period up to 72 hours, as now occurs when the 48-hour requirement now in the statute falls on weekends and holidays. A 72-hour TDO period would be an intermediate step toward assuring more thorough assessments without extending the time period so long that it would have to be accompanied by an additional pre-release measure. Because even this modest change would have uncertain fiscal implications, however, the Commission is not recommending any action on this issue in 2009.

Recommendation 9: Given current economic circumstances, the continued shortage of psychiatric hospital beds, and the difficulty predicting the fiscal impact of extending the TDO period, the Commission recommends no statutory change to the TDO period in 2009.

C. Mandatory Outpatient Treatment

The Commission continues to study use of, and possible expansion of MOT in Virginia. In 2008, the Commission recommended that the use of MOT be strengthened as a “less restrictive alternative” for individuals found to meet the criteria for involuntary admission to a facility but who agreed to adhere to a prescribed treatment plan in the community. However, the Commission concluded that proposals to allow people to be committed to MOT based on a less demanding standard would be premature in the absence of (1) additional funding for CSB outpatient services, (2) a stronger body of evidence demonstrating the effectiveness of “preventative” MOT in other states, and (3) a documented successful implementation of the 2008 MOT reforms in Virginia.

In the spring of 2008, the Senate referred the subject matter of HB 939 (Gilbert) to the Commission for further study. (HB 939 would entitle an individual under an involuntary inpatient order to petition for mandatory outpatient treatment.). In addition, SB 274 (Cuccinelli) (permitting a facility director to petition for transfer to outpatient commitment) was carried over to the 2009 Session. The Commission assigned the subject matter of these bills to the Future Commitment Reforms Task Force.

1. Mandatory Outpatient Treatment Following Involuntary Inpatient Treatment

In its Blueprint for Reform in December, 2007, the Commission stated:

> "The Commission recommends that the Commonwealth retain the existing use of mandatory outpatient treatment ("MOT") as a less restrictive alternative to involuntary hospitalization, while clarifying the conditions under which such orders may be issued. The Commission also recommends that MOT be available as a supplement to short-term acute hospitalization or residential stabilization, perhaps as a component of a single commitment order." [Recommendation III-J]

Conditional discharge is not a common practice in the United States and state laws vary substantially in the states that authorize it. Sixteen states currently permit a facility or treating physician to discharge a person to MOT. Seven of these states permit this in the form of convalescent leave or trial visits. Six states require a court order before discharge to MOT, one of which (Oklahoma) permits the person to petition as proposed in HB 939. Two states permit either the court to order MOT or the treating facility to discharge to MOT. Three states permit the court to order a combined inpatient and outpatient order at the time of the original order. The Future Reforms Task Force studied these statutes and the practices in several states in the course if its deliberations.

***Criteria and Duration*:** A key issue in designing a conditional discharge statute is whether the person must continue to meet the commitment criteria for involuntary inpatient hospitalization in order to be discharged to MOT. MOT following inpatient treatment is best suited for those who are stabilized during inpatient treatment and need additional treatment that does not need to be provided on an inpatient basis. This likely means that the person will no longer meet current criteria and lesser criteria will be needed.

Unlike most other states, Tennessee, which permits the facility and a qualified mental health professional to release a person on MOT, sets out specific criteria before the person may be discharged on outpatient MOT:

> (A) the person has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission;
> (B) the person's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm unless treatment is continued;
> (C) the person is likely to participate in outpatient treatment with a legal obligation to do so;
> (D) the person is not likely to participate in outpatient treatment unless legally obligated to do so; and
> (E) mandatory outpatient treatment is a suitable less drastic alternative to commitment.

TN Code 33-6-602.

The criteria for Virginia's forensic conditional release program are similar to the Tennessee criteria:

(i) the acquittee does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization;
(ii) appropriate outpatient supervision and treatment are reasonably available;
(iii) there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified; and
(iv) conditional release will not present an undue risk to public safety.

Virginia Code § 19.2-182.7.

The Commission believes that a short period of MOT could be beneficial for certain people who need follow-up treatment and must have structure or an external source of help in order to prevent relapse and thereby reduce the drain on expensive inpatient services. This type of MOT is the next logical step in implementing MOT based on the model adopted in 2008 under which the services must actually be available in the community and the providers must agree to deliver the services.

Most other states that permit MOT following inpatient treatment limit the period of mandatory outpatient treatment to the length of the commitment period, or now 30 days in Virginia. If MOT following inpatient treatment is enacted, the MOT outpatient period should be 90 days in order to be effective. Limiting the period of outpatient treatment to the current length of commitment or 30 days would be ineffective because there is virtually no time to provide the person with outpatient treatment after the period of inpatient treatment.

Procedures. Different procedural approaches to conditional discharge to MOT can be envisioned. One possibility is to allow the committing judge to enter a sequential order for MOT at the time of commitment to an inpatient facility. The downside of this approach, however, is that such a sequential order could become routine, as has been reported in other states, with almost everyone being ordered to MOT. Although requiring another judicial hearing after a period of inpatient care before a MOT order would add to the workload of special justices and clerks, it would discourage the routine coupling of inpatient commitment orders with MOT orders and, necessarily, would provide justification for imposing a period of mandatory outpatient treatment longer than 30 days.

If a conditional discharge approach to MOT were to be adopted, the CSB (not the inpatient facility) should be responsible for developing an MOT plan as well as monitoring the person's adherence to the MOT plan. A concern of CSBs is that permitting the inpatient facility to discharge to MOT, without a separate judicial proceeding, could lead to MOT orders over the CSB's objection, thus committing CSB services, resources and monitoring capacity when the resources to implement the MOT order are absent. Judicial review would reduce the risk that this will occur. Only if the

person involved, the inpatient treatment facility and CSB all agree to an MOT plan, should it be filed with the court without the need for a further hearing.

Another question is who would be permitted to petition for MOT following the period of inpatient hospitalization. Clearly, the CSB, inpatient facility and the person himself/herself should be permitted to do so. Permitting the person to petition for MOT may be a valuable recovery tool. Whether family members, guardians, health care agents, and legally authorized representatives should also be permitted to do so was a matter of concern to Future Commitment Reform Task Force members. If acting in a representative capacity on behalf of the person, other individuals should be permitted to do so. Some limit on successive petitions should be imposed, however.

Concerns. The Commission remains concerned that significantly increasing the use of MOT after an inpatient stay would divert already scarce outpatient treatment resources away from persons voluntarily seeking treatment. In many localities, access to a psychiatrist or psychologist is non-existent or nearly so. Upon discharge from inpatient treatment, it often takes months for that person to be assigned a case manager in the community. In addition, the availability and scope of community-based mental health services is critical for effective MOT. The concern is, however, that candidates for an MOT order will be given priority access to services, lengthening the queue for those voluntarily seeking treatment.

An expanded use of MOT is also of concern since there has not been sufficient time to evaluate the implementation of the extensive changes to MOT implemented July 1, 2008. As noted earlier in this Report, use of MOT as an *alternative* to involuntary inpatient admission since the new MOT legislation is being used even less than it was before. Given the variability in access to services and the potential disruption to those now voluntarily seeking outpatient mental health services, the substantial variability in how the civil commitment process is implemented throughout the Commonwealth, and the challenging economic climate, the Commission believes it prudent for the General Assembly to wait at least another year before expanding the use of MOT following a period of involuntary inpatient admission. If, however, the General Assembly decides to authorize MOT following a period of inpatient admission, the Commission has prepared a model of such a proposal for legislative consideration.

Recommendation 10: The Commission believes that legislation authorizing mandatory outpatient treatment following involuntary inpatient admission would be premature until the Commonwealth's economic picture changes, CSB outpatient services become more readily available, and research demonstrates the effectiveness of mandatory outpatient treatment.

2. Mandatory Outpatient Treatment to Prevent Involuntary Inpatient Admission

SB 177 (Marsh), which would create a program of "assisted outpatient treatment," designed to prevent involuntary inpatient admissions, was carried over to the 2009 General Assembly Session. The potential utility of MOT to prevent deterioration and

eventual hospitalization by individuals with a history of relapse and rehospitalization has been a core controversy in mental health law for more than 20 years. White papers were prepared on the issue in Virginia in 1988 and then again in 1998. Over the past few General Assembly Sessions, bills introduced by Senator Marsh and others have garnered the strong support of some stakeholders and have aroused the opposition of others. The Commission's Civil Commitment Task Force reviewed the issues and the literature and advocates and opponents debated the use of MOT to prevent inpatient admissions before the Commission. In its Blueprint for Reform issues in December, 2007, the Commission stated:

> "The Commission is also favorably inclined toward broader use of MOT for persons who are experiencing pronounced clinical deterioration but do not meet the criteria for involuntary hospitalization, as has been authorized recently in several other states. These laws have the laudable purpose of using mandated outpatient intervention to prevent the person from declining to the point of needing involuntary admission. However, the Commission believes that such a substantial change in commitment practice should not be adopted unless and until the CSBs have adequate capacity to provide outpatient treatment services and to monitor compliance with outpatient treatment orders."

The Commission's views remain the same. In addition, the Commission believes it would be wise to wait until further evidence accumulates regarding the effectiveness of preventive MOT. Although the efficacy of MOT has been supported in a series of path-breaking studies in North Carolina,[25] its general cost-effectiveness has not yet been convincingly established.[26] In addition professional and advocacy associations are

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[25] Swartz and Swanson, Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data? Canadian Journal of Psychiatry 49:585-91 (2004).

[26] The National Association of State Mental Health Program Directors Medical Directors Council issued a Technical Report on Involuntary Outpatient Commitment in August 2001. It found that "current research fails to provide strong evidence that involuntary outpatient commitment is the best remedy for consumer non-compliance in treatment." The NASMHPD report based its conclusions on the principle that treatment compliance is is meaningful only if adequately-funded, effective community services are available. Similarly, the American Association of Community Psychiatrists recommends that more research is needed concerning the clinical and rehabilitative benefits of MOT. It recognizes that limited research shows benefits in reducing hospitalization days and violence among some individuals, but clinical benefits, such as improvement in individual functioning and compliance with MOT have not yet been shown. Position paper: Involuntary Outpatient Commitment, American Association of Community Psychiatrists, June, 2001, http://www.comm.psych.pitt.edu/finds/ioc.html, last visited December 5, 2008.

The Treatment Advocacy Center on the other hand reports that assisted outpatient treatment reduces hospitalization, homelessness, arrests, violence, and victimization. It also improves treatment compliance and substance abuse treatment. *Assisted Outpatient Treatment*, Treatment Advocacy Center Briefing Paper, March 2005, www.psychlaws.org/Briefing Papers/BP21.htm. (Last visited October 27, 2008.) In addition, the Treatment Advocacy Center reports that anosognosia, or unawareness of illness, is the most important reason individuals do not take medication for their illness. The Center relies on numerous studies indicating that the presence of anosognosia increases the incidence of violent behavior "both because it is associated with medication non-adherence and because it appears to directly increase violent behavior." *Anosognosia as a cause of violent behavior in individuals with severe psychiatric disorders*,

opposed to it.[27] A new study of New York's Kendra's law is currently underway with expected release of its findings in mid-summer 2009. New York has contracted with a research team headed by Dr. Swartz to conduct a legislatively-mandated external evaluation of its Assisted Outpatient Treatment (AOT") law, also known as "Kendra's Law." The purpose of the study is to examine the process and outcomes of AOT programs in New York State, by addressing specific research questions in five areas of investigation: 1) regional and cultural differences in AOT programs and their implementation, 2) engagement in Mental Health Services Post-AOT, 3) outcomes for people with mental illness who receive enhanced outpatient services and for those who are mandated into outpatient treatment, 4) opinions of a representative sample of AOT recipients regarding their experiences with AOT, and 5) the impact of AOT programs on the availability of resources for individuals with mental illness and perceived barriers to care. The study is scheduled for completion in April 2009 with a release date not expected until mid-Summer 2009.

The concern expressed above relating to MOT following a period of involuntary inpatient admission apply even more forcefully to mandatory outpatient treatment to prevent involuntary inpatient treatment. There is a concern that already scarce mental health outpatient services would divert services from patients who want and need voluntary services, and persons subject to involuntary orders will take priority over those seeking voluntary services. In order to be effective, an array of community services not now available must also be developed. Substantial changes were enacted in the 2008 General Assembly Session to implement MOT, but sufficient time has not passed to determine the effectiveness of those procedures. Indeed, it appears that use of MOT has significantly declined. Given the current economic climate, and the lack of proven effectiveness, it would appear prudent to delay enactment of MOT to prevent involuntary inpatient admissions until the budget situation improves and a wider array of outpatient services become available.

Recommendation 11: The Commission recommends that MOT to prevent involuntary inpatient admission be delayed until further research demonstrates its effectiveness and a fuller array of outpatient services becomes more widely available.

D. Petitioners' Rights in Commitment Proceedings

1. Appointment of Counsel to Represent Petitioners

HB 267 (Albo), which would amend § 37.2-814 requiring the court to appoint competent counsel to represent indigent petitioners, was referred to the Commission for

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Treatment Advocacy Center Briefing Paper, April 2007, www.psychlaws.org/Briefing Papers/BP21.htm. (Last visited October 27, 2008.)

[27] The International Association of Psychosocial Rehabilitation Services, Mental Health America and the Bazelon Center for Mental Health Law are opposed to MOT. The American Psychiatric Association favors it.

study by the Senate, and assigned to the Future Commitment Reforms Task Force . The Future Commitment Reforms Task Force also reviewed HB 735 (Caputo), which had also been carried over in 2008; that bill would amend § 54.1-3900 to permit third year law students to represent petitioners in commitment hearings without compensation and provide them with immunity except for intentional malfeasance.

Only two states, Alabama and Indiana, provide for the appointment of counsel for indigent petitioners. In 26 states, however, a government attorney, such as the local prosecutor, county or city attorney, attorney general, or a combination thereof, provides representation at the hearing either for the petitioner or represents the interests of the people, the public interest or the state. In 13 states, the government attorney represents the people, the public interest or the state's interest at the commitment hearing. In two of those states, the county attorney is the actual petitioner. When the attorney general represents the petitioner or the state's interest, it is usually when the hearing takes place at a state facility. In three states, the government attorney represents an agency or facility, but not an individual petitioner. In six states, the government attorney represents the petitioner, whether it is an individual who is the petitioner, a government entity or a treatment facility. Four states do not specify whom the attorney represents.

Although no consensus could be reached on this topic by members of the Future Commitment Reforms Task Force, the Commission considered various options, including permitting appointment of private counsel when the special justice believes such appointment would aid the process. In those areas where the number of commitments is already high, special justices may determine that appointment of counsel is not necessary and would therefore not be required to appoint them. Under the proposal, the attorney's charge would be to represent the interests of the public or state in the proceeding, even though such a role is usually the role of an elected official, such as the Commonwealth's Attorney or Attorney General. The appointed attorney would be paid the same as counsel appointed for the respondent, currently $ 75.00, obviating the need for local government to hire additional full time attorneys in either Commonwealth's Attorneys' or city/county attorneys' offices.

The Commission rejected this proposal for several reasons. First, it does not believe that provision of counsel to present the case for commitment is among the best uses of additional resources to improve the overall fairness of the commitment process – improving the quality of independent examinations, and compensation for the IEs is a much higher priority as are training and increased compensation for the special justices and attorneys for respondents. Moreover, the Commission is doubtful that appointment of counsel for petitioners in this context is sound public policy: Given that attorneys are not appointed for petitioners in other civil cases, such as domestic violence cases that are arguably just as important as these proceedings, authorizing appointment of counsel for petitioners in civil commitment cases could be a "slippery slope."

Recommendation 12: The Commission does not support appointment of state-subsidized counsel for indigent petitioners in civil commitment proceedings at this time. Improving other features of the process, such as increasing fees for

independent examiners and providing oversight for special justices, have a higher priority. As a public policy matter, the Commission doubts the wisdom of appointing counsel for petitioners in civil commitment proceedings when counsel are not appointed for petitioners in other civil cases, such as domestic abuse cases.

The Future Commitment Reforms Task Force also reviewed HB 735 (Caputo) that would amend § 54.1-3900 to permit third year law students to represent petitioners in commitment hearings unsupervised and to provide them with immunity. The Commission believes that permitting unsupervised law students to undertake this activity diminishes the importance of commitment hearings and provides no opportunity for oversight by the Virginia State Bar for ineffective and harmful representation. It would also not be an effective solution statewide because law schools are not conveniently located near every hearing site. If used in areas where law schools are located, supervision is absolutely necessary.

Recommendation 13: The Commission does not support proposals to allow unsupervised law students to represent petitioners in commitment proceedings. Instead, the Commission encourages law schools to work with the local bar to provide to set up programs to this service with supervision in areas where law schools are located. The Commission also recommends that steps be taken to encourage *pro bono* representation of petitioners by members of the Bar.

2. Petitioner Right of Appeal

HB 938 (Gilbert), the subject matter of which was referred to the Commission for study by the Senate, would amend § 37.2-821 to permit any party to a civil commitment proceeding or a proceeding to certify the admission of a person with an intellectual disability to a training center to appeal the decision to the circuit court.[28] Currently, this statute is being interpreted to permit a right of appeal only to respondents in civil commitment proceedings. This topic was referred by the Commission to the Future Commitment Reforms Task Force.

The Future Commitment Reforms Task Force first reviewed the statutes from other states. Seven states specifically permit the petitioner to appeal, and nine other states specifically state that appeals may be taken as in other appellate cases. Presumably, since either party in a civil proceeding normally has the right of appeal, petitioners in these states would be permitted to appeal. The Future Commitment Reforms Task Force also considered various arguments for giving petitioners a right to appeal, but ultimately concluded that the granting such a right is not a practical solution to any of the perceived problems to which it is designed to respond – vindicating the petitioner's legal interests in securing a commitment or helping to generate appellate oversight and guidance for the

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[28] Subsection C also requires the order appealed from to be defended by the Commonwealth's Attorney. If this bill moves forward in the General Assembly, the role of the Commonwealth's attorney will need to be reconsidered when the party appealing is the petitioner, i.e. whether he is representing the petitioner or the public interest. The Commonwealth's Attorney would also not then be defending the order appealed from because he would not be representing the respondent who has private counsel appointed to represent him.

commitment process. Moreover, even if a useful purpose would be served by allowing petitioners to seek a de novo commitment hearing in the Circuit Court, there would be significant costs of doing so, not only in litigation costs, but also in added restrictions of respondents' liberty interests pending the new hearing. The model of typical civil litigation is an imperfect fit for the commitment process.

Recommendation 14: The Commission does not support proposals to afford petitioners the right to appeal a decision favorable to the respondent in a commitment proceeding.

E. Rights of Respondents in Commitment Proceedings

The Civil Commitment Task Force Report found that individuals involved in the civil commitment process suffer consequences in addition to their loss of liberty and dignity, and trauma. They often face other disruptions in their lives as well, including 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. The Task Force reviewed a number of these issues for possible legislative change and these proposals were assigned to the Future Commitment Reforms Task Force for further study.

1. Default judgments: Financial problems can arise from prolonged hospitalization. Section 8.01-428.A 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. This section could be amended to provide a mechanism to have the default judgment set aside if the person was detained under a TDO or was hospitalized under an involuntary commitment order at the time served or when the default judgment was entered.

The Commission will continue to study legislation that would permit an individual to set aside a default judgment if he or she was the subject of a temporary detention order or an order of involuntary hospitalization at the time of service or entry of the default judgment.

2. Notification of Family and Friends: One way to ameliorate these adverse consequences is to assure that a respondent in commitment proceedings has the opportunity to designate a person to be notified of their whereabouts at all times, including when they are transferred to a different facility. Although individuals have the right through the Human Rights Regulations to notify whomever they choose 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. The Commission has prepared a legislative proposal that would amend § 37.2-400 to afford a consumer the opportunity to have a family member, personal representative or close friend notified of his general condition and location and transfer to another facility.

Recommendation 15: The Commission recommends that the General Assembly consider legislation that would afford an individual the opportunity to have an individual of their choice notified of their general condition, location and transfer to another facility. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

F. Public Access to Commitment Hearings

In 2008, the General Assembly embraced the Commission's recommendation that the records of commitment proceedings be regarded as confidential and that access to these records be significantly restricted. One issue that was not addressed is access to the commitment hearing itself. The current statute provides insufficient guidance on this issue. While the statute appears to establish a presumption that commitment hearings are open to the public,[29] the circumstances under which attendance can be restricted are not specified. There are sound policy and practical reasons for the hearing being open, including the public's right to know about potential threats to public safety, the need to assure that courts fairly uphold the rights of the subject of the hearing, and the general public interest in accountability of the judicial branch of government. However, there are also strong countervailing policy and practical reasons for the hearing being closed, including the spectacle of the public airing of the subject's most private and confidential information, and the danger of stigma and embarrassment to the subject.

The Working Group on Health Privacy and the Commitment Process ("Health Privacy Working Group") was not of one mind about this issue and nor was the Commission. Some people feel strongly that all judicial proceedings should be open to the public, while others feel that commitment proceedings are essentially therapeutic in nature and should be presumptively confidential, like the records themselves. Under the latter view, commitment proceedings involving adults should be governed by the same strong protections of privacy that govern juvenile proceedings. State laws vary widely on this issue. The issue does not appear to be addressed at all in the statutes of half of the states. In the other half, the predominant approach is to exclude the public – 16 states exclude the public by law, 8 states prescribe open hearings and one state permits the respondent to elect to close the hearing.

The Health Privacy Working Group and the Commission also debated the constitutional issues, with one side arguing that the First Amendment requires public

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[29] "The [commitment] hearing [for involuntary admission] provided for pursuant to §§ 37.2-814 through 37.2-819 may be conducted by the district court judge or a special justice at the convenient facility or other place open to the public provided for in § 37.2-809, . . ." Va. Code § 37.2-820.

The presumption of open hearings applies to adult commitment proceedings only. The presumption for juvenile commitment proceedings is that the hearings are closed – "The hearing shall be closed to the public unless the minor and petitioner request that it be open." Va. Code § 16.1-344. Different public policy concerns apply to minors, and the Working Group's discussion and recommendations as to the openness of hearings do not address the juvenile commitment process.

access to commitment proceedings, as it does for criminal proceedings and ordinary civil litigation, and the other side arguing that a state may constitutionally close ordinary commitment proceedings (as opposed to sex offender commitment proceedings or other commitment proceedings associated with criminal cases). Neither the U.S. Supreme Court nor the Virginia Supreme Court has addressed the issue, and the only applicable precedents in the Fourth Circuit pertain to ordinary civil litigation.[30] The Health Privacy Working Group examined the constitutionality of closing civil commitment hearings, and found no constitutional impediment to a rule closing such hearings upon motion of the respondent. State statutes closing commitment hearings have withstood constitutional scrutiny. For example, under North Carolina law, both outpatient and inpatient civil commitment hearings are "closed to the public unless the respondent requests otherwise." N.C. Gen. Stat. §§ 122C-267(f) (outpatient) and 122C-268(h) (inpatient). These statutes have been upheld against constitutional attack.[31]

After discussing the issue at several meetings, the Commission rejected a proposal to require commitment hearings to be closed upon motion of the respondent or respondent's counsel and sided with the view that commitment proceedings should be presumptively open, as they now are. However, the Commission also recognized that the presiding judge currently has, and should have, the discretion to close all or part of the hearing or restrict attendance upon a showing of an overriding privacy interest in a particular case,[32] but only on motion of the respondent or respondent's counsel. In addition, the respondent should have the option of having any person present at the hearing.

In effect, the Commission proposes to retain both the statutory presumption favoring open commitment hearings and the discretion of the presiding judge to restrict attendance at all or part of a particular hearing upon motion of the respondent based upon a showing of good cause. However, in order to provide better guidance to the district courts and promote consistent practice, the Commission is proposing a standard to guide the exercise of judicial discretion, as follows:

> "Upon request of the respondent or his attorney, the district court judge or a special justice may restrict attendance at all or part of the hearing to persons whose participation is required for proper conduct of the hearing and those whose presence is requested by the respondent upon finding that (a) such a restriction is necessary to protect the respondent's health, safety or privacy and (b) the respondent's interest in the restriction outweighs the public's interest in attendance by any person who would be excluded.'

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[30] *Stone v. Univ. Maryland Medical System*, 855 F.2d 178 (4th Cir. 1988) and *Virginia Department v. Washington Post*, 386 F.3d 567 (4th Cir. 2004)

[31] *In re Belk*, 107 N.C. App. 448, 420 S.E.2d 682 (1992). *See also*, *People v. Dixson*, 148 Cal. App. 4th 414; 56 Cal. Rptr. 3d 33 (2007).

[32] The Attorney General of Virginia, acknowledging that civil commitment hearings are generally open to the public, has opined that a judge may order a civil commitment hearing closed for good cause. 2003 OP. VA. ATT'Y GEN. 124.

Recommendation 16: The Commission recommends that the General Assembly consider legislation preserving the current statutory presumption that commitment hearings be open to the public while prescribing a standard to guide judges in exercising their discretion to close these hearings upon the respondent's motion. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

G. Admission of Incapacitated Persons to Mental Health Facilities

In most other health care contexts, it is not necessary to obtain specific judicial authorization to provide health care to a person who lacks the capacity to make health care decisions. These decisions can be made by various legally authorized decision-makers pursuant to the applicable statutory requirements. There are basically three categories of such decision-makers: (1) persons designated by the patient (when s/he had decision-making capacity) as a health care agent under the Health Care Decisions Act (Title 54.1-2982 et seq); (2) a person appointed by the Circuit Court as a guardian under the guardianship statute (Title 37.2-1000 et seq); and (3) persons designated as authorized decision-makers under 54.1-2986 after a medical determination of incapacity regarding a patient who has not executed an advance directive and does not have a guardian. However, none of these decision-makers is currently authorized by Virginia law to admit a currently incapacitated patient to a mental health facility, even if the patient is not protesting. In other words, if a patient lacks the capacity to give informed consent to the admission, s/he can be admitted only through the commitment process. This legal requirement has been a continuing source of concern to families, especially in relation to patients with dementia or severe depression, particularly in light of the fact that neither hospitalization in medical units nor placement in nursing homes is subject to such restrictions. Of course, it is important to recognize the liberty interests at stake in psychiatric hospitalization when the individual objects, and the role of judicial scrutiny in preventing abuse of a surrogate decision-maker's authority (even when the individual is not objecting).

It is best to think about potential solutions to this set of problems in the three surrogate decision-making contexts described earlier. The first issue is whether people who execute advance directives under the Health Care Decisions Act should be empowered to authorize their designated agents to admit them to a mental health facility, even if they were to object. As discussed in greater detail below (Part IV), the Commission strongly supports the principle of individual empowerment in this context and has encountered no opposition to this position. Accordingly, the Commission is proposing a new section 37.805.1 that would that would permit persons who have been determined incapacitated under the Health Care Decisions Act to be admitted to a psychiatric facility by their designated health care agent for up to ten days if they have specifically conferred this authority in the directive in conformity with the Health Care Decisions Act, and the proposed facility is willing to admit the person. If admission to a state facility is proposed, a CSB pre-admission screening would also be required

The second issue is whether a guardian who has been appointed by the circuit court for an incapacitated person should have the authority to consent to the admission of the person for up to ten days if the facility agrees to the admission. The Commission recommends that a guardian have such authority if and only if the guardianship order specifically confers this authority based on findings that the person has dementia or another severe and persistent mental disorder that significantly impairs his or her capacity to exercise judgment or control, the condition is not likely to improve in the foreseeable future, and the guardian has formulated a plan for providing ongoing treatment of the person's mental illness in the least restrictive setting suitable for the person's condition. If admission to a state facility is proposed, a CSB pre-admission screening would also be required.

While all states have a procedure for the involuntary treatment of mental illness, including but not always limited to commitment to a mental hospital, not all states require use of this procedure when a guardian is the individual making the decision. About 20 states specifically reference the involuntary treatment and commitment statutes in enumerating a guardian's powers to denote that the guardian must use such existing procedures to authorize involuntary treatment. Another 20 states authorize the guardian to consent to medical treatment and are silent with respect to mental health treatment, presumably allowing the guardian to admit the ward to a mental health facility, and consent to treatment, even over objection. The remaining the states have specific procedures authorizing guardians to consent to mental health treatment, often based on specific authorization by the court in the guardianship order.[33] The Commission's proposal would fall in this latter category.

At an early stage in the development of this proposal, it would also have permitted surrogate decision-makers other than health care agents and guardians to authorize such admissions. However, the Task Force on Future Commitment Reforms was concerned that since this is the first initiative to permit inpatient admissions of incapacitated persons through a substitute decision-maker, such admissions should be limited to health care agents and guardians.

Recommendation 17: The Commission recommends that the General Assembly consider legislation that would permit mental health facilities to admit incapacitated individuals for up to ten days upon the request of a health care agent designated by the individual in an advance directive and specifically given the authority to do so, or upon the request of a guardian specifically authorized to do so in the guardianship order. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

H. Involuntary Treatment of Minors

[33] Catherine Anne Seal, CELA, Review of Guardians' Authority under State Guardianship Statutes, Kirtland & Seal, LLC, Colorado Springs, Colorado; see also Sarah B. Richardson, Health Care Decision-Making: A Guardian's Authority at http://www.abanet.org/aging/.

Children are subject to involuntary psychiatric in-patient commitment or mandatory outpatient treatment just as adults are. Children have the same constitutional rights of due process as adults since a child's liberty interests are implicated in the commitment process just as an adult's are. However, the juvenile commitment process, both from a policy perspective and from a procedural technical perspective, is very different for a number of reasons. Clearly, one difference is that juveniles are still within the custody of their parents or guardians whose rights then become involved in the child's commitment process. However, children who are aged 14 or older, are recognized by the law, in some respects, to have reached the "age of reason" and thus are given the right to object to involuntary commitment.

Procedurally, a child's commitment to in-patient psychiatric treatment or mandatory outpatient treatment may be initiated, as in an adult case, through an emergency or a temporary detention order issued by a magistrate. This action triggers the commitment hearing if the child or if the parent objects. Alternatively, unlike the case with an adult, a juvenile already held in secure detention can have a petition for involuntary commitment reviewed by a JDR judge.

The procedures for a child's commitment are detailed in a statutory scheme separate from that for adults (Virginia Code Section 16.1-3 et seq.). However, although some of the commitment and hearing procedures for children are unique, other procedures parallel those for adults. As a result, the juvenile statutes sometimes explicitly "bridge" to the adult statutes (by cross reference) rather than restate the procedure in the juvenile code. Although this effort was, no doubt, to promote efficiency in the Code, "bridging" frequently results in confusion in statutory interpretation. The need to bridge the juvenile and adult commitment statutes, which requires juggling different statutes located in different Code volumes, results in variability in interpretation among JDR Court judges and judicial officers. As a result, the CA Task Force recommended amending the juvenile commitment code to a freestanding statutory section with the "bridges" eliminated. The Commission supports this proposal and will offer amendments to this effect in 2010.

The Commission made several recommendations for changes to the Virginia Code as part of the reform package proposed in December 2007, and these proposals were subsequently enacted by the General Assembly during its 2008 session. This year, the Commission has focused on revising the Psychiatric Inpatient Treatment of Minors Act to include the changes made to the adult commitment statutes in 2008 insofar as they reflect the special considerations arising in the treatment of minors. A full explication of the proposed changes appears in the Report of the Task Force on Children and Adolescents.

Although involuntary outpatient treatment orders (also called mandatory outpatient treatment orders or "MOT") for juveniles are rare (only 5% of all involuntary commitment orders issued),[34] recent events in Virginia have demonstrated the need to

[34] See the Commission's Hearings Study.

better monitor court-ordered involuntary outpatient treatment. Unfortunately, the infrastructure for monitoring that MOT is not well developed. If a JDR Court orders MOT, it is difficult for the judge to monitor whether the juvenile complies with the MOT and actually undergoes treatment. And, although CSBs are required to monitor the outpatient treatment for juveniles on Medicaid, no state entity is responsible for monitoring juveniles with private insurance, and it is very difficult for JDR Courts to enforce monitoring with private practitioners. The latter category, juveniles with private health insurance, is not insignificant. Of the juveniles assessed by the CSBs in June 2007, 28.1% had private insurance.[35]

In 2008, the General Assembly amended the adult civil commitment code to include extremely detailed procedures for monitoring mandatory outpatient treatment for adults. These new procedures, however, do not apply to juveniles. Although there are many helpful elements of these new procedures that can be modified to apply to juveniles, the CA Task Force does not recommend their wholesale adoption and their application to juveniles. Instead he Task Force adapted the MOT provisions to the special circumstances involving minors. Key elements of the proposed changes include:

- A CSB or DSS representative should be present at all hearings where juvenile outpatient commitment is being considered.
- The CSB should file a preliminary treatment plan at the commitment hearing where juvenile outpatient commitment is being considered.
- Mandatory outpatient treatment should not be ordered for a juvenile unless the provider in the home jurisdiction has the resources and agrees to provide them.
- The CSB in the juvenile's home jurisdiction should be responsible for monitoring compliance with juvenile mandatory outpatient treatment orders.

Recommendation 18: The Commission recommends that the General Assembly consider modifications to the Psychiatric Inpatient Treatment of Minors Act, including new procedures for mandatory outpatient treatment that are tailored to the special circumstances of juvenile commitments. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

I. Commitment of College and University Students

It is clear that unique problems arise in the context of commitment of college and university students and special procedures may be indicated. A specially constituted group with expertise in student affairs and higher education law as well as mental health law is needed to address them. The Commission and the State Council on Higher Education are discussing the possibility of a collaborative study of these issues.

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[35] The Commission's Study of CSBs across Virginia, June 2007 ("The CSB Emergency Evaluation Study").

The proposed Task Force on Emergency Evaluation and Commitment of College and University Students would be charged with addressing particular issues such as (1) the need for specific statutory provisions relating to the issuance of ECOs and TDOs, and the associated transportation issues, in cases involving college and university students; (2) the appropriate role of college mental health professionals in commitment proceedings involving college and university students, and access of institutions of higher education to information regarding commitment proceedings involving their students; (3) implementation of the newly revised provisions relating to mandatory outpatient treatment in cases involving college and university students; and (4) the need for further clarification regarding permissible disclosure of health information by student mental health services and by college and university officials for the purpose of protecting students or other persons.

A decision will be made about whether to establish such a Task Force in the spring of 2009 after the end off the 2009 session of the General Assembly.

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V. Legal Foundation for Individual Choice and Empowerment in Mental Health Services

Virginia law currently authorizes patients to execute written Advance Directives ("AD") that address their wishes for end-of-life care when the patient in determined to be in a terminal condition, regardless of whether an agent is appointed to make decisions in accordance with those wishes. Virginia law does not, however, currently contain a legally recognizable mechanism for patients to execute similar ADs for other types of health care decisions in which the patient does not have a terminal condition. As a result, one of the Commission's major goals from the outset has been to facilitate the use of advance directives by individuals with mental illness or age-related cognitive impairment who would like to direct the health care decisions made on their behalves when they lack decisional capacity. The Commission's Task Force on Empowerment and Self-Determination ("ESD Task Force") devoted a substantial part of its Report to this subject and identified the key principles that ought to guide the drafting of a legislative proposal. A key feature of the ESD Task Force's approach was to incorporate the new provisions on instructional directives in the Health care Decisions Act rather than adopt a "stand-alone" statute on "psychiatric advance directives" (PADs) as many states have done. [36]

The Commission embraced the basic approach taken by the ESD Task Force in its Preliminary Report in December, 2007:

> "Advance directives are legal instruments that may be used to document a competent person's specific instructions or preferences regarding future health treatment. They are most commonly used in end-of-life decision-making, but are increasingly being advocated for other circumstances as well. The Commission recommends facilitating the use of crisis plans and advance directives in the event of impaired decisional capacity and making discussions of such plans a standard part of treatment while promoting and respecting individual choice.
>
> Recommendation II-B-1**:** The Commission recommends that the Health Care Decisions Act be amended to authorize a competent person to execute a "stand-alone" (agent optional) instructional advance directive to govern any type of health care decisions. This is to supplement, and not to replace, the provisions governing end-of-life care ("living wills") and health care powers of attorney already permitted under Virginia law. This non-end-of-life directive would apply to all types of health care decisions, not just those involving psychiatric care."

After the 2008 session of the General Assembly, the Commission established a new Task Force on Advance Directives ("AD Task Force") charged with developing a specific legislative proposal pertaining to instructional ADs for health care decisions in contexts other than end-of-life care based on the recommendations of the Task Force on Empowerment and Self-Determination. The two major clinical contexts in which such an instructional directive are expected to be especially useful are:

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[36] http://www.courts.state.va.us/cmh/taskforce_workinggroup/2008_0919_tf_empower_slfdtrmntn_rpt.pdf

(1) cases in which individuals anticipating incapacity from dementia want to give advance instructions regarding their future care; and

(2) cases in which individuals with histories of periodic decisional impairment related to acute exacerbation of mental illness want to give advance instructions regarding their health care, including their mental health care, for those periods when they are incapacitated.

Additionally, in an effort to promote use of ADs by patients and to facilitate compliance with applicable law on ADs by providers, the AD Task Force sought to improve the flow of the Health Care Decisions Act and to address several issues that are ambiguous in the current law, while carefully avoiding any substantive changes to the law governing decision-making about end-of-life care.

The AD Task Force circulated successive drafts of its proposal to relevant constituencies and organizations, incorporated their ideas and suggestions, and developed a proposal that has been uniformly and enthusiastically supported by all the interested groups. The Commission approved the proposal on October 30, 2008, subject to any further technical changes approved by the Task Force. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

The key elements of the proposal are:

1. The proposal clarifies the process for determining whether a patient is incapable of making an informed decision, and the circumstances in which an incapable patient may be determined to be capable of making informed decisions again. The underlying premises of this section are that these procedures should be crafted against the backdrop of a policy of encouraging and facilitating execution of ADs, a preference for self-determination, and a presumption that people have the capacity to make health care decisions. Of particular note:

- A determination that a patient is incapable of making an informed decision must be based on proper examinations by two clinical experts, and such a determination may be limited to a particular health care decision or may be more global in nature depending on the person's condition at that time.

- Notice of the person's incapacity must be provided to the patient as well as either the patient's named agent or statutory decision-maker(s) before someone else is authorized make decisions about the person's health care.

- A single physician, on personal examination, is authorized to determine that an incapable patient has become capable of making an informed decision again.

2. The proposal coordinates the Health Care Decisions Act, including the effect of ADs, with the involuntary commitment statutes in Title 37.2, which are also being amended to address the interplay between these two statutes. First, a person may not use an AD to nullify or override the laws permitting involuntary treatment. However, the AD is to be given effect to the extent that it does not conflict with the commitment statutes. Second, authority conferred by the Health Care Decisions Act, including that conferred by an AD, may be used to authorize admission to a mental health facility only if it is also authorized by Title 37.2.

3. Assuming that Title 37.2 is amended to allow it[37], an AD may be used to permit admission to a mental health facility and to provide treatment over the person's later objection if the AD specifically confers such authority and certain other safeguards are satisfied. That is, a patient may request adherence to AD instructions that were made when the patient was capable of making an informed decision ("capable patient"), even though the patient is now incapable of making an informed decision ("incapable patient") and protests the treatment that the AD authorized. This so-called "Ulysses clause" is based upon the concept that a capable patient may anticipate his later protest to a particular health care treatment or decision and may direct that the treatment be provided over his later objection.

When this situation arises, an agent, but not a statutory designee, may authorize the treatment that the patient is now protesting if:

- The decision does not involve withholding or withdrawal of life-prolonging procedures; and
- The patient's AD explicitly states that the AD should govern, even over his later protest; and
- The patient's AD was signed by the patient's attending physician or licensed clinical psychologist who attested that the patient was capable of making an informed decision and understood the consequences of the provision, using substantially the following language: "The above declarant is my patient and I believe, based on a personal examination of the patient, that he/she is capable of making an informed decision about healthcare and he/she also understands the implications of authorizing the above-specified health care even if he/she later protests it."; and
- The proposed health care is determined and documented by the patient's attending physician to be medically appropriate; and

[37] The Commission is also recommending a companion proposal to amend Title 37.2 to allow such admissions. See proposed section 37.2-815.1, discussed supra.

- The proposed health care is otherwise permitted by law.

Because of the significance of treating the patient over his protest, the authority to make such a decision is granted only to the agent that the patient has entrusted with surrogate decision-making, and not to a statutory designee.

4. The proposal also addresses a more general problem involving treatment of patients, typically in nursing homes, who are not capable of making health care decisions, object to a particular medical procedure, but have not executed an AD with a Ulysses clause. Specifically, this subsection is designed to provide a non-judicial mechanism for addressing the clinical "stalemate" situation that can arise under the current statute (*i.e.*, a protest must be honored even if it is uttered by a patient who is incapable of making informed decisions—unless the provider obtains a court order for treatment).

When this situation arises, either an agent or a statutory designee (if there is no agent) may authorize the treatment that the patient is now protesting if:

- The decision does not involve withholding or withdrawal of life-prolonging procedures
- The decision is based on the patient's religious beliefs and basic values and any preferences previously expressed by the patient regarding such health care, when he was capable of making an informed decision, to the extent they are known, and, if unknown or unclear, on the patient's best interests; and
- The health care has been affirmed and documented as being ethically acceptable by the health care facility's ethics committee, if one exists and, otherwise, by two physicians who are not currently involved in the treatment of the patient and who did not make the determination that the patient was incapable of making an informed decision.

5. Because of the contexts in which a Ulysses clause would be important in carrying out the wishes of the patient, the proposal distinguishes between a protest of a particular treatment or decision, on the one hand, and revocation of the AD, on the other. A protest does not revoke an AD, which can only be revoked when the patient makes clear his intent to revoke his AD, in accordance with the statute.

6. The proposal also addresses a problem arising under the current statute in identifying a family member to make decisions for a person who becomes incapable of making a decision but does not have an advance directive or a judicially appointed guardian. The proposal augments the list of statutory default decision-makers to include non-family members, where no family members are known, willing, or able to serve as decision-maker. Using model language, the list now includes, as the residual default category, any adult who has exhibited special care and concern for the patient and who is familiar

with the patient's religious beliefs and basic values, but who is not a participant in the patient's health care.

Recommendation 19: The Commission recommends that the General Assembly consider legislation that would amend the Health Care Decisions Act to empower people to execute advance directives to guide their health care if they become incapable of making health care decisions, to clarify the relationship between the Health Care Decisions Act and the Commonwealth's mental health statutes, and to provide better guidance to health care providers in providing treatment to patients who may lack the ability to make health care decisions. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

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VI. Assuring Access to Services for Children and Adolescents

Children with mental health needs are among the most vulnerable members of society. The failure to provide early screening, diagnosis and treatment of their disorders is a missed opportunity to intervene and not only promote the health of affected children and their families but, also, to minimize or even prevent poor school performance, truancy, engagement with foster care and the juvenile justice system. Furthermore, inadequate access to community-based mental health services simultaneously increases the likelihood of a child coming before a Juvenile and Domestic Relations Court ("JDR Court")—whether under a foster care, CHINS, juvenile justice, or involuntary commitment proceeding—and constrains the options available to Intake Officers and JDR Courts in determining the appropriate disposition of a case. This result is skewing public policy toward judicially orchestrated interventions that, too often, are institutionally based.

This is a tragic and costly outcome. Tragic because, according to the Surgeon General's Report on Children's Mental Health,[38] the President's New Freedom Commission on Mental Health,[39] and countless other studies, early screening and intervention enables the vast majority of children with mental health needs to successfully live in their communities, complete school, and avoid judicial involvement as well as the stigma associated with it. It is costly, because judicial and institutional interventions have a higher price tag in the short run and, for many children, a lower success rate. In addition, the long–term costs of not treating or under-treating children with mental health needs includes higher rates of school drop-outs and substance abuse, repeated inpatient hospitalizations and encounters with juvenile justice, and a higher likelihood of graduating to the adult criminal justice system.

The Commission's Task Force on Children and Adolescents ("CA Task Force") examined these policy barriers and developed a comprehensive set of recommendations designed to facilitate mental health interventions, minimize judicial involvement, and enable JDR Courts to better achieve their statutory mandate to construe the law "liberally and as remedial in character." The Commission endorsed the key principles guiding their Task Force in its Blueprint for Reform in December, 2007.[40] The Commission will be releasing the CA Task Force Report for public comment in the near future. In the meantime, the Commission has taken steps in this Report to implement the CA Task Force's recommendations regarding the involuntary treatment of minors (see Recommendation 18, above). In the coming months, the Commission plans to decide

[38] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
[39] New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report* (DHHS Pub. No. SMA-03-3832). Rockville, MD .
[40] http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf,

what further steps it should take to enable Virginia to more effectively address the mental health needs of the Commonwealth's children and adolescents.

VII. Transforming Community Mental Health Services

In its Preliminary Report in December, 2007, the Commission observed:

> "A consensus has clearly emerged on the need to develop a more effective and comprehensive system of community services. Based on the work of the Task Force on Access to Services, the Commission has identified the components of a robust community services system that can help prevent crises, respond to them successfully, and provide intensive services to those who need them to achieve recovery. The Commission recognizes that the Commonwealth is facing a significant shortfall in revenues, and many competing public needs, in the upcoming biennium. Accordingly, for now, the Commission recommends a substantial down payment on the needed investment, together with a commitment to sustain it over the years ahead. In the Commission's final report, we will present a plan for sequential implementation of the proposed Blueprint over several biennia."

The Task Force on Access to Services will continue its effort to develop this plan in 2009. However, the following brief progress report reproduces the recommendations from the 2007 Report and summarizes the initiatives being undertaken by the Access Task Force:

A. Commission's 2007 Recommendations:

I-A Increase CSB Mandated Services

The Commission recommends revising Va. Code §§ 37.2-500 and 37.2-601 to expand the array of services required for voluntary and involuntary access to services that must be provided by community services boards and behavioral health authorities ("CSBs") and supported by the Commonwealth of Virginia. State grant funding should provide the foundation of support for these mandated services:

> The core of services provided by community services boards within the cities and counties that they serve shall include *emergency, crisis stabilization*, *case management, outpatient, respite, in-home, residential and housing support services*. The core of services may include a comprehensive system of inpatient, 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.

I-B Strengthen the Role of DMHMRSAS

The Commission recommends conferring responsibility on the Department of Mental Health, Mental Retardation and Substance Abuse Services ("DMHMRSAS") to establish and sustain core community-based mental health services. DMHMRSAS should be responsible for sustaining the core components of community-based mental health services, including, at a minimum, emergency services, crisis stabilization, case management, outpatient, respite, in-home, residential, and housing support services.

I-B-1 Broaden Goals of Comprehensive State Plan. DMHMRSAS, under its statutory obligation (Va. Code § 37.2-315) to develop a comprehensive state plan, should focus planning efforts on the development of a comprehensive, accessible community-based system of services provided through a combination of direct services, interagency collaboration, community partnerships and services contracts with both private and public providers.

I-B-2 Strengthen CSB/ Performance Contracts. DMHMRSAS performance contracts for mental health, mental retardation and substance abuse services should:

a. reflect DMHMRSAS's role in creating, funding, sustaining and reporting on an expanded array of core community-based services required by Va. Code §§ 37.2-500 and 37.2-601, revised in accord with the Commission's recommendation to include, at a minimum: emergency, crisis stabilization, case management, outpatient, respite, in-home, residential and housing support services.

b. reflect the role of DMHMRSAS as the locus of coordination for ensuring that the service standards and core expectations for each of the mandated core services are defined, promulgated, contracted for, measured and reported to the various stakeholders including, but not limited to, the Secretary of Health and Human Resources for the Commonwealth and each local government which is party to a CSB performance contract.

I-B-3 Facilitate Coordination and Continuity of Care. DMHMRSAS should be charged with responsibility for developing, implementing, and overseeing strategies to facilitate coordination of services across sectors and assuring continuity of care and should be provided with adequate staffing to carry out this function.

I-C Increase Role of Insurance in Financing Mental Health Services

I-C-1 Require Parity in Benefits. The General Assembly should consider legislation requiring parity in health insurance coverage and benefits for

treatment of mental and addictive disorders. Mental health and substance abuse treatment services should be reimbursed at a level that is equitable with other medical specialties.

I-C-2 **Expand Medicaid Eligibility.** The General Assembly should consider expanding Medicaid eligibility for the population classified as aged, blind and disabled by raising the eligibility criterion from the present 80% of the federal poverty level to 100% of the federal poverty level.

I-D Core Services

All CSBs should have the capacity to provide the following core services:

I-D-1 All CSBs should have the capacity to provide a full range of crisis response services accessible 24 hours each day to individuals experiencing a psychiatric crisis. Crisis stabilization, psychiatric urgent care and psychiatric, nursing and medication services are essential components of this recommendation.

I-D-2 All CSBs should have the capacity to provide outpatient psychiatric services and related medical supports in accord with caseload standards established by DMHMRSAS.

I-D-3 All CSBs should have the capacity to provide case management services in accord with caseload standards established by DMHMRSAS.

I-D-4 All CSBs should have the capacity to provide Programs of Assertive Community Treatment, Intensive Community Treatment, and Intensive Case Management in each locality to all persons in need of intensive services.

I-D-5 Each of Virginia’s local law enforcement agencies should establish certified Crisis Intervention Teams.

I-D-6 Each CSB should establish a free access number that is consistent throughout the service area or region for all psychiatric crisis responses and referrals.

I-D-7 Each CSB should have the capability within its continuum of crisis stabilization services to receive custody of persons under an ECO from law enforcement officers.

I-D-8 Each of the seven DMHMRSAS regions should establish and support a community-based regional geriatric-psychiatric continuum of care.

I-D-9 The CSBs should give a high priority to improved access to adequate permanent housing for individuals with mental illness. Va. Code § 63.2-800 should be revised to authorize a portable Auxiliary Grant for housing supports, and the policies of the Virginia Department of Social Services, 22 Va. Admin. Code § 40-25-10, should be revised accordingly.

I-E Cultural Competency

The cultural and demographic diversity of the Commonwealth's citizens is changing rapidly. There are significant differences in the way that minority populations experience illness and seek services. The Commission recommends that all training components include training on cultural competency.

B. Activities of Access Task Force in 2008

The Task Force on Access Task Force was reconstituted in 2008 to flesh out this blueprint and assemble pertinent evidence about effectiveness and cost of implementing these recommendations. Another part of this work focuses on the specific access needs of populations and issues considered by other Task Forces—particularly persons with severe mental illness involved with the criminal justice system and children and adolescents with severe emotional and behavioral disorders. It also, however, includes Working Groups that focus on particular issues needed to effectively expand access to mental health care. The Access Task Force now has the following five Working Groups that have met over the past year:

- Criminal Justice and Mental Health
- Children and Adolescents
- Workforce Development
- Mental Health Parity
- Role of State Government in Promoting Access to Mental Health Services (Included here is an examination of Medicaid)

In addition to full Working Groups, the Access Task Force has sought White Papers and other information about two other groups for whom there may be unique access issues. These are returning service members and their families and the psychogeriatric population.

The Access Task Force and its Working Groups are:

- identifying the policies and services in place throughout the Commonwealth
- examining models of providing mental health services that work—whether in Virginia or in other states
- reviewing the literature on mental health services—including the impact of inadequate services on law enforcement, courts, schools, foster care, juvenile justice, nursing homes, etc.

- developing a long-range set of Recommendations that can be phased in over several budget cycles coupled with the appropriate evaluations to determine what works

The ultimate goal of mental health law reform is to reduce unnecessary encounters with the courts, law enforcement, foster care, juvenile justice, emergency services and other crisis response agencies of persons with severe mental illness or children with serious emotional and behavioral disorders. The Commission is convinced that most of these encounters, which are costly in both economic and human terms, could be avoided if adequate access to community-based mental health services were available throughout the Commonwealth. The Task Force on Access to Services aims to construct a plan to accomplish this over the coming decade

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APPENDIX 1

SUMMARY OF RECOMMENDATIONS

Recommendation 1: The Commission recommends for consideration by the General Assembly a set of procedural amendments to the 2008 legislation designed to clarify legislative intention and thereby promote uniform application of the laws governing involuntary commitment. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 2: The Commission believes that all independent examiners, including psychiatrists and psychologists, should be required to complete a certification program developed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, that Continuing Education Units should be made available for the training, and that the $75 fee now authorized for independent examinations in civil commitment proceedings should be increased. However, in light of current budget constraints, the Commission believes that these changes should be deferred.

Recommendation 3: The Commission recommends that the General Assembly consider amending the Code provisions relating to transportation of persons involved in the commitment process to permit and strengthen the use of transportation by responsible individuals and organizations other than law enforcement officers. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 4: The Commission recommends that the General Assembly consider legislation amending §§ 37.2-127.1:03 and 37.2-804.1 to authorize family members to be notified when their relative is involved in the commitment process. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.

Recommendation 5: The Commission recommends that CSBs consider the cost-effectiveness of developing contracts with taxi services or other regional transportation providers to provide transportation and/or vouchers for transportation to medical appointments and other needed mental health services.

Recommendation 6: The Commission urges CSBs to consider changing their policies to specify when and under what circumstances CSB crisis workers, case managers and other employees may transport persons in government owned and personal vehicles as part of the delivery of mental health services. CSBs that have not done so should consider becoming Medicaid transportation providers.

Recommendation 7: The Commission recommends that DMAS develop written guidance as soon as possible on the requirements and conditions under which Medicaid will reimburse for routine, urgent and emergency mental health assessment and treatment. CSBs that have not already done so should assess whether it would be fiscally advantageous to become a Medicaid provider of transportation services for their consumers and encourage, where possible, private transportation providers to develop such services. Police and sheriffs' departments should also assess whether it is feasible for them to become Medicaid providers in these circumstances.

Recommendation 8: The Commission urges CSBs, private providers and other stakeholders in each locality or region to explore the feasibility of alternative methods of financing and providing transportation services for consumers, including use of peer counselors, off-duty law enforcement officers, and private mental health service providers, to determine whether they would be available and feasible in their area for providing needed transportation services for consumers.

Recommendation 9: Given current economic circumstances, the continued shortage of psychiatric hospital beds, and the difficulty predicting the fiscal impact of extending the TDO period, the Commission recommends no statutory change to the TDO period in 2009.

Recommendation 10: The Commission believes that legislation authorizing mandatory outpatient treatment following involuntary inpatient admission would be premature until the Commonwealth's economic picture changes, CSB outpatient services become more readily available, and research demonstrates the effectiveness of mandatory outpatient treatment.

Recommendation 11: The Commission recommends that MOT to prevent involuntary inpatient admission be delayed until further research demonstrates its effectiveness and a fuller array of outpatient services becomes more widely available.

Recommendation 12: The Commission does not support appointment of state-subsidized counsel for indigent petitioners in civil commitment proceedings at this time. Improving other features of the process, such as increasing fees for independent examiners and providing oversight for special justices, have a higher priority. As a public policy matter, the Commission doubts the wisdom of appointing counsel for petitioners in civil commitment proceedings when counsel are not appointed for petitioners in other civil cases, such as domestic abuse cases.

Recommendation 13: The Commission does not support proposals to allow unsupervised law students to represent petitioners in commitment proceedings. Instead, the Commission encourages law schools to work with the local bar to provide to set up programs to this service with supervision in areas where law schools are located. The Commission also recommends that steps be taken to encourage *pro bono* representation of petitioners by members of the Bar.

Recommendation 14: The Commission does not support proposals to afford petitioners the right to appeal a decision favorable to the respondent in a commitment proceeding.

Recommendation 15: The Commission recommends that the General Assembly consider legislation that would afford an individual the opportunity to have an individual of their choice notified of their general condition, location and transfer to another facility. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 16: The Commission recommends that the General Assembly consider legislation preserving the current statutory presumption that commitment hearings be open to the public while prescribing a standard to guide judges in exercising their discretion to close these hearings upon the respondent's motion. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 17: The Commission recommends that the General Assembly consider legislation that would permit mental health facilities to admit incapacitated individuals for up to ten days upon the request of a health care agent designated by the individual in an advance directive and specifically given the authority to do so, or upon the request of a guardian specifically authorized to do so in the guardianship order. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 18: The Commission recommends that the General Assembly consider modifications to the Psychiatric Inpatient Treatment of Minors Act, including new procedures for mandatory outpatient treatment that are tailored to the special circumstances of juvenile commitments. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

Recommendation 19: The Commission recommends that the General Assembly consider legislation that would amend the Health Care Decisions Act to empower people to execute advance directives to guide their health care if they become incapable of making health care decisions, to clarify the relationship between the Health Care Decisions Act and the Commonwealth's mental health statutes, and to provide better guidance to health care providers in providing treatment to patients who may lack the ability to make health care decisions. (The proposed legislation is contained in a separate document, "Proposals for Consideration by General Assembly in 2009.")

APPENDIX 2

ACRONYMS

AD	Advance Directive
AOT	Assisted Outpatient Treatment
BHA	Behavioral Health Authority
CSB	Community Services Board
CIT	Crisis Intervention Teams
DMAS	Department of Medical Assistance Services
DMHMRSAS	Department of Mental Health, Mental Retardation, and Substance Abuse Services
ECO	Emergency Custody Order
EMS	Emergency Medical Services
HIPAA	Health Insurance Portability and Accountability Act
IE	Independent Examiner
JDR	Juvenile and Domestic Relations (Courts)
JLARC	Joint Legislative Audit and Review Commission
MOT	Mandatory Outpatient Treatment
OAG	Office of the Attorney General
OES	Office of the Executive Secretary of the Supreme Court
TDO	Temporary Detention Order
VSP	Virginia State Police

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Appendix 3

Commonwealth of Virginia
Commission on Mental Health Law Reform

Commissioners

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