Civil Commitment Practices in Virginia

Perceptions, Attitudes, and Recommendations

A Report for the
Commission on Mental Health Law Reform
Commonwealth of Virginia

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Study and Report

by

Elizabeth L. McGarvey, EdD
Associate Professor
rel8s@virginia.edu

Division of Public Health Policy and Practice
Department of Public Health Sciences
P.O. Box 800717
School of Medicine
University Of Virginia
Charlottesville, Virginia, 22908

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Study Team

Cheryl Koopman, PhD
Research Methods
Associate Professor of Psychiatry & Behavioral Sciences
Stanford University
Palo Alto, CA

Oxana Palesh, PhD
Research Assistant Professor
Department of Psychiatry
University of Rochester
Rochester, NY

Alison Campbell, MSW
Family & Children Mental Health Treatment Social Worker
Charlottesville, VA

Kim Oanh Cook, MSW
Social Worker, Vietnamese Translator
Civil Commitments
Falls Church, VA

Audrey Butler, RN, MSN
Nurse Consultant
Focus Group & Case Study Interviews
Newport News, VA

Dennis Waite, PhD
Clinical Psychologist & Consultant
Adjunct Assistant Professor
Virginia Commonwealth University
Richmond, VA

Judy Salyer
Southwest Virginia Consumer & Family Involvement Advocate
Nickelsville, VA

Marge Balge, PhD
Health Information Researcher
Charlottesville, VA

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Executive Summary

The Commission on Mental Health Law Reform was established by the Supreme Court of Virginia to examine the Commonwealth's existing mental health statutes and to make recommendations for any changes required to establish an accessible service delivery system and a fair and effective process of civil commitment when needed by people experiencing mental health crises. As part of the Commission's work, an evaluation team of faculty and staff at the University of Virginia completed a large scale qualitative study to inform the need and direction of reform. Information about the current system of civil commitment was obtained from all representative stakeholder groups. Two hundred and ten (210) individuals participated in the study.

Overall, there was a consensus that the system of civil commitment in Virginia has many serious flaws, although participants in some regions expressed less frustration and fewer problems than others.

PROFESSIONAL PARTICIPANTS and FAMILY MEMBERS

Stakeholders were asked first whether they had favorable comments about civil commitment in Virginia. Typically they said no, but a few positive observations emerged with probing:

- It is better than no system.
- The commitment process helps some individuals with serious mental illness who are in crisis to get help and may prevent harm to the patient or others.
- Mobile crisis units, if they exist, can provide rapid response in a crisis.
- The system is basically fair once a person is evaluated, but getting to this point may be a challenge.

Most Serious Problems

Following the solicitation of perceptions of what was positive about the system, stakeholders were asked the following question: "*What do you think are the most serious problems with the civil commitment process?*" The most serious problems with Virginia's civil commitment system identified by stakeholders in this study are:

- Lack of available beds.
- Need more time on ECOs (Emergency Custody Order) and TDOs (Temporary Detention Order).
- When a consumer is released after an ECO because of not meeting the criteria for "dangerousness," there are not enough services in place to help this person.
- Requirements for a medical prescreening/clearance cause delays and logistical problems.
- The current 72-hour TDO is used for acute care hospital services . . .

- Medical insurance plans typically do not provide sufficient reimbursements to cover inpatient treatment costs, nor do they cover sufficient lengths of stay to ensure that patients are stabilized on their medications.
- Some hospitals have unofficial "do not admit" lists preventing consumers from obtaining treatment due to concerns about safety of other patients and lack in insurance coverage.
- Too many consumers are in jails, instead of hospitals, as a result of their behavior while mentally ill.
- Current law enforcement transportation practices are stigmatizing, unduly costly, and inefficient.
- The commitment statutes are interpreted and applied inconsistently across the state.
- The civil commitment process is confusing to many stakeholders.
- All stakeholder groups are frustrated by the "revolving door system of consumers in and out, in and out, in and out of the hospital . . .
- Not everyone can "recover," some people need financial support, long-term care, and housing.
- Mandated outpatient treatment could be a good option to prevent deterioration in consumer's mental health and prevent involuntary commitment if it could be enforced, and patient rights protected.
- Protection of patient privacy needs to balanced with the needs of family caregivers to maintain contact with their loved ones following a mental health crisis.
- Reimbursement for law enforcement, community services boards (CSBs), hospitals, psychiatrists, other mental health care providers, attorneys, special justices, judges, independent evaluators, and other professionals is much too low for all the work that is required.
- Many stakeholders could identify many problems, but were not clear about who was "running the system."

Summary

- Stakeholders who participated in this study are very frustrated about the civil commitment process in Virginia.
- Stakeholders believe that the civil commitment system is in crisis.
- Stakeholders believe that current civil commitment practices throughout the Commonwealth are *not* well integrated into a high functioning mental health delivery system that ensures access to care for severely mentally ill people.
- Although some regions appear to have developed some functional "subsystems," serious problems related to civil commitment were identified even in these areas.

CONSUMERS

Although many consumers did not have detailed recollections about their involuntary commitment and hearing due to the acute nature of their illness, they were able to report

their feelings about how they were treated. ***Most consumers who interacted with the civil commitment system reported negative experiences.***

- Consumers report that having a serious mental illness stigmatized them, resulting in ongoing reduced quality of life.
- Individuals who have mental illness are no more alike than individuals who have cancer, but all typically face discrimination and negative reactions of others.
- Many individuals who have mental illnesses are functional but may need help to maintain medical stability so they can keep jobs and avoid hospitalization.
- Individuals experiencing an acute episode of mental illness (e.g., psychotic episode) are too frequently treated like criminals, and feel humiliated and degraded when they are taken to jail instead of the hospital prior to being evaluated and treated.
- Consumers have mixed reports about the effectiveness of the current mental health system in the Commonwealth, citing lack of community resources and long wait times to receive services as only two of many problems.
- Consumers do not want to travel hours to other localities to get treatment, but prefer to get treatment close to their homes.
- Consumers want competent mental health treatment, and to be treated like people with other medical conditions.
- Consumers have varied understanding of Virginia's mental health laws, including the commitment criteria and civil rights issues.
- Many consumers were unaware of advance medical directives related to mental illness.
- Consumer opinions were divided about the "right" amount of coercion to ensure that consumers get the treatment they need. Some supported monitored, mandated outpatient treatment and others strongly opposed it.
- Some consumers suggested that good, ongoing outpatient treatment would prevent the need for many involuntary commitments.
- Consumers want an active role in their treatment and decision-making about what happens to them at all points in the civil commitment process and afterwards.
- Consumers had varying views about the involvement of their family members in their care. However, most consumers agreed that having a peer advocate would be helpful.
- Consumers want more education about mental illness for themselves, their families, and all professional stakeholders.
- Consumers reported poor experiences directly related to the commitment hearing.
    - Legal representation is typically reported to be inadequate.
    - Hearings may be frightening experiences for consumers who are confused (and often psychotic) during the process.
    - Consumers want hearings to be close to their homes.
    - In additional to appropriate, ongoing mental health care to prevent relapse, some consumers wanted help with housing and finding ways "to make a living."
    - Some consumers said that they could not afford to pay for housing and food, much less medication.

FINAL REPORT

Background

For more than twenty years, issues related to the involuntary commitment process in Virginia have been raised and debated by attorneys; state legislators; and staff at state agencies ranging from DMHMRSAS to the community services boards, members of the State Human Rights Committee, advocates, mental health professionals, consumers, family members of consumers, and others. Attempts to effect lasting major reforms to this process have failed.[1] In 2007, there remains an identified need to reform the complex involuntary commitment process in the Commonwealth of Virginia as part of the integrated effort to improve the provision of mental health services throughout the state. To this end, the Commission on Mental Health Law Reform has been formed by the Supreme Court of Virginia (see appendix C).

The Commission is mandated to examine the existing laws as they relate to a fair, effective, and accessible service delivery system that truly meets the needs of the people of Virginia who suffer from serious mental illness. The global goal of the Commission's mandate includes making recommendations related to ". . . reducing the need for commitment by improving access to mental health, mental retardation, and substance abuse services; reducing criminalization of people with mental illness; making the process of involuntary treatment more fair and effective; enabling consumers of mental health services to have more choice over the services they receive; and helping young people with mental health problems and their families before these problems spiral out of control."[2] The Commission is conducting a number of special studies to inform these recommendations.

Purpose of the Focus Group Study

The focus Group Study is one of the special studies being conducted by the Commission on Mental Health Law Reform. The specific aims of the study are as follows:

- Aim A: To describe the current practices of civil commitment from the perspective of members of the various stakeholder groups.

- Aim B: To identify perceived problems with the current civil commitment process from the perspective of members of the various stakeholder groups.

- Aim C: To identify possible solutions to problems identified at all stages of the commitment process, including ways of reducing the need for civil commitment.

- Aim D: To summarize the findings in a report that might be used to inform mental health law reform and, as appropriate, policy decision-making.

Methodology

Human Subjects. This study, assigned project # 2006-0326-00, was reviewed by the Institutional Review Board for the Social and Behavioral Sciences. Approval was obtained to conduct the study as planned.

Participants. The study included individuals representing the stakeholder groups who are directly involved in the civil commitment process in Virginia (see table 1).

Table 1. Participant Groups

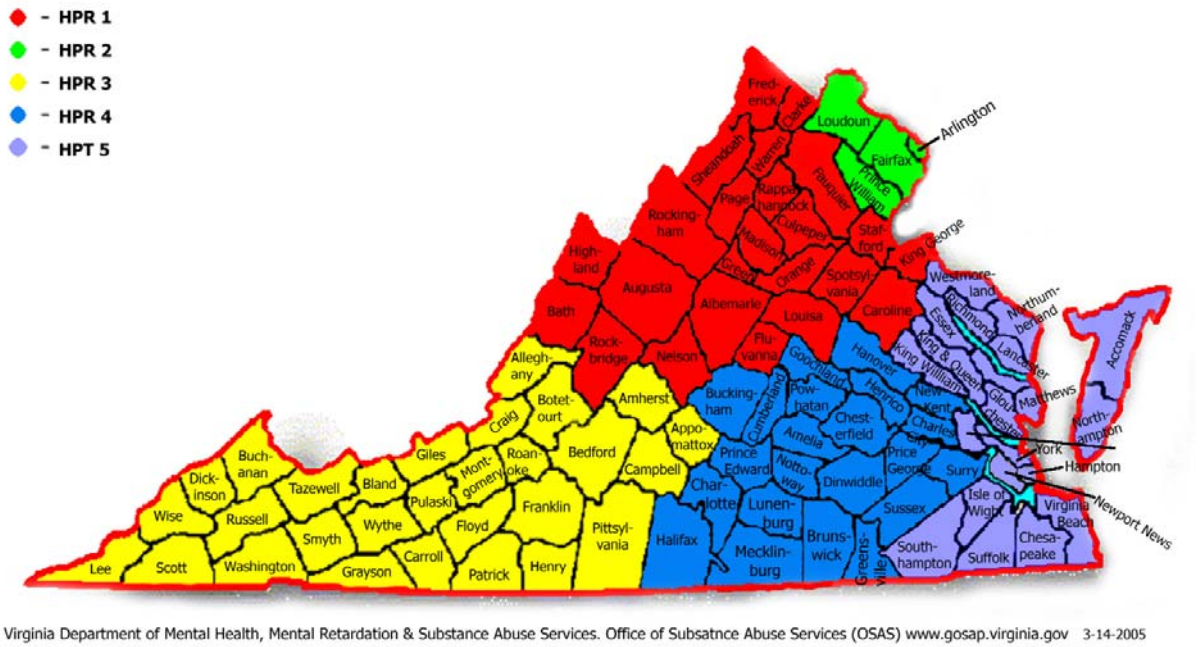
Group	Description
Consumer	An individual who, as a result of an involuntary commitment, has been a patient in a hospital in Virginia that provides psychiatric care, and who volunteers to discuss this experience. An individual who has a serious mental illness and who volunteers to discuss a scenario involving involuntary commitment to a psychiatric facility.
Families of Consumers	Individuals whose family members (e.g., children, spouses, siblings) have been involuntarily committed to a hospital in Virginia, that provides psychiatric care, and who volunteer to discuss this experience. Individuals who have tried but have been unable to facilitate the involuntary commitment of a seriously mentally ill family member.
Community Service Board (CSB) Professionals	Executive directors, psychiatrists, emergency services managers and clinicians, case managers, and others who may be directly involved in providing or facilitating access to mental health and/or related care for people who have been involuntarily committed or evaluated for commitment in Virginia.
Law Enforcement Officials	Sheriffs and police officers who have participated in some aspect of an involuntary commitment of a consumer (e.g., transportation).
Admitting/Attending Psychiatrists, Emergency Department Physicians	Medical professionals who have provided direct services to consumers who have been involuntarily committed for assessment or treatment.
Independent Evaluators	Psychologists, psychiatrists, social workers, etc. who have performed an independent assessment, providing a "second opinion" to the court regarding the psychiatric condition of a person who is under consideration for an involuntary commitment.
Judges, Special Justices, Appointed Counsels, Magistrates	Legal professionals with direct experience with clients who are being considered for an involuntary commitment.

Private Providers (for-profit, non-profit, not-for-profit)	Private hospitals, health care systems, nonprofit agencies, social service agencies, community psychiatrists, and others who provide services to consumers who have been involuntarily committed for psychiatric treatment.

Study Design

Overview. The study follows the guidelines established for participatory research, which has been shown to be effective in addressing community problems and issues of concern.[3] Mixed-methods of qualitative inquiry are used to gain an understanding of phenomena in a holistic manner and to document the labels, range of procedures, definitions, and social settings pertaining to the civil commitment process in Virginia.[8] Documenting the range of experiences of stakeholders in the civil commitment process facilitates the development of a systems approach to examine the relationships among the many components of the mental health service delivery system and its interconnectedness with related systems (e.g., criminal justice).

Approach. The study was planned to include representative group members from the five CSB regions as designated by the Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services. Figure 1 illustrates these regions—Northwest, Northern, Southwest, Central, and Eastern. The seven restructuring planning districts (Catawba, Central, Eastern, Northern Virginia, Southern, Far Southwest, and Western) are contained within the original regions.



Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services. Office of Subsatnce Abuse Services (OSAS) www.gosap.virginia.gov 3-14-2005

In consideration of time limitations, costs, and the feasibility of recruiting samples from the various groups cited above, the following approaches were used:

1) Community meetings and dialogue groups[3]
2) Telephone focus groups and interviews[3]
3) One-on-one in-person interviews[4]
4) Case studies

Sampling and Recruitment. In most cases, purposeful sampling was used to select, by region, the most information-rich cases from within the respective stakeholder groups. For example, in each region active consumer advocacy groups that were identified by consumers were selected for on-site visits to attend meetings and/or to conduct dialogue groups. Also, consumers who had been involuntarily committed and were willing to discuss their personal experiences were identified by various social service agencies and provided with contact information, enabling them to communicate directly with members of the study team. Members of the study team visited homeless shelters, drop-in centers, restaurants, urban streets, and parks in an effort to include, to the extent possible, other consumers who are not involved in advocacy groups or currently undergoing treatment; many of these individuals were willing to talk about mental health services and civil commitment issues in Virginia. Among the professional groups, individuals were randomly selected from within regions; a variety of respondents were obtained from lists provided by multiple public and state-maintained databases. For example, special justices and judges were randomly selected from such a list using a random numbers table and were consecutively contacted until a suitable number agreed to participate in either telephone focus groups or one-on-one interviews. Case study interviews included both consumers, to identify types of experiences, and professionals, for information about types of working relationships across organizations.

Sources of Information. Open-ended questions relating to opinions, attitudes, and beliefs surrounding aspects of the involuntary commitment process were compiled into an interview guide that was adapted to each group (see appendix D). The questions were revised after finding that the length of time needed to include all issues would be much longer than the 60 to 90 minutes specified for the telephone groups. Fewer questions from those listed in the guide were used as prompting questions in certain focus groups to allow more time for discussion, while more questions were used for groups in which the members were reluctant to take the initiative in talking. Minimum data elements obtained from each group included “best” and “worst” features or experiences with the current civil commitment process.

Limitations. The primary limitation inherent in focus group research involves the inability to generalize the results to the total population of interest, such as the consumers or professional group members in this study. Focus group research does not produce information that can answer questions such as "How many group members statewide report a particular experience or belief?" Instead, it is important in identifying key experiences, themes, and issues related to a topic–-in this study, involuntary commitment–-that are suitable for further study.

Data Analysis

Comments made by participants in the respective telephone focus groups were documented by two independent note takers and were typed. A content analysis of the comments was performed using standard research methodology for qualitative research. Cross-group comparisons were made. Major themes were identified. The study's social scientist (McGarvey, University of Virginia) and a consulting research psychologist (Koopman, Stanford University), both with expertise in conducting qualitative research on mental health-related ethnographies, summarized the results and, when possible, conducted comparisons and contrasted differences within and among groups. Other information that was obtained in community meetings, one-on-one interviews, and dialogue groups, is also included. Themes and issues are presented.

Results

Participants. Stakeholders throughout Virginia have been queried about their opinions, beliefs, and concerns regarding the civil commitment process. Further, they have provided information and offered a number of suggestions for ways to improve the system.

Table 2 shows the dates of formal meetings that have been held to date.

Stakeholder Group	**Dates of Focus Groups/Community Meetings/Interviews**	**Total Individuals Reached**
Consumers	10/20; 10/23; 10/24; 10/30; 10/31; 11/01;11/06; 11/15; 11/28; 12/01;01/09; 01/10; 01/11; 01/16; 01/17; 01/22	**86**
Families of Consumers/ Advocacy Groups	11/2; 11/7; 01/15	**60**
CSB professionals	10/18; 11/10; 11/14/; 11/28	**23**
Law Enforcement	11/13	**6**
Psychiatrists/ER Physicians	10/25; 11/29; 12/20; 01/22	**7**
Independent Evaluators	01/22	**2**
Judges/Special Justices	11/17	**6**
Magistrates	11/14	**7**

Appointed Attorneys	11/10; 11/14	**6**
Private Providers (hospitals; mental health centers; psychiatrists in the community)	10/23; 11/16, 1/12, 1/18	**7**
Total		**210**

Organization of the findings. The results of the study are arranged around questions or emergent themes identified with reference to stakeholder groups. The results are a compilation of comments obtained from consumers, families of consumers, and other members of the key stakeholders groups who have recently participated in the process of involuntary commitment in the Commonwealth of Virginia. They reflect a range of different viewpoints. These views were offered either under condition of anonymity or without such guarantees. No attempt was made to confirm the accuracy of any comments made by participants. These views do not necessarily reflect the attitudes, beliefs, or opinions of the study team or any consultant who participated in the data collection, review, and analysis.

In section A, the comments of the professional and family stakeholders in the system are grouped thematically. In section B, the comments and issues of the consumer stakeholders in mental health services are presented.

SECTION A

PROFESSIONAL STAKEHOLDERS AND FAMILIES OF CONSUMERS

The information below came from a series of telephone and face-to-face interviews with stakeholders, including the family members of consumers; consumer advocates; community services boards clinicians (executive directors, psychiatrists, emergency services staff, case managers); psychiatrists at state hospitals and in private practice; emergency room physicians; independent evaluators who provide "second opinions" prior to commitment; judges and special justices; magistrates; sheriffs and police officers; and court-appointed attorneys. Some interviews were with individuals; others were conducted in groups. The questions below were taken from the master list of questions that was used as part of the interview guide.

What works well or is the best feature of the current process of involuntary commitment in Virginia?

Across *all groups* negative comments about the civil commitment process greatly outweighed the positive comments. At meetings and in focus groups, the moderator opened with a question soliciting participants' perceptions regarding positive aspects of the current civil commitment process. There consistently were unusually long pauses or silence until the moderator encouraged the participants to think of at least one positive feature of the system. This tended to be the same across all groups, with the CSB representatives and the private hospital representatives able to most quickly report some positive features. Such positive comments tended to center around "being able to help people in need." As such, probing questions were necessary to get any response with regard to what is currently working well in the civil commitment system.

The following quoted responses marked "theme" indicate a category under which one or more stakeholder comments were grouped. Other verbatim comments of representative stakeholders are presented to illustrate the range in types of comments.

Theme: "Not much"

Across groups, families of consumers were readily able to outline many gaps and problems with the current system. They agreed that, in general, "not a lot" works well in the current system. Many, in fact, questioned whether there really was "a system." One family member said that the only good thing about the civil commitment process was that it "even exists," suggesting that it was "better than nothing." Family members of consumers in all regions mentioned positive experiences with at least one contact person in their respective CSBs. "They worked closely with us as a family," is a typical comment. Another mother said that the system had "helped her son who had been committed twice, once in another state and once in Virginia." She was thankful that they kept him in the hospital until his medications started to work and he could think clearly. However, there were other family members who vocally did not agree. For example, one family member said, "Parents are 'co-opted' by the CSB staff to think that their loved one is receiving appropriate services. . . . CSB services are too 'office oriented' . . . individuals who are not aggressive do not receive treatment." ***(Families of Consumer)***

"In some cases, [the best option would be] to institutionalize them, but this is not an option. The current system does not work. The benefit of closing psychiatric hospitals is financial. It is not being done for the benefit of the patients." ***(Emergency Room Physician)***

None of the law enforcement personnel who participated named anything positive about the current civil commitment system. ***(Law Enforcement)***

One psychiatrist said, "We have so many problems. We are struggling with this process." Another psychiatrist in a different region remarked, "I have difficulty answering that . . . there are so many problems. . . . " ***(Psychiatrists/ER Physicians)***

The *Northern Region* participant said that he had no problems with the CSB, and that once he got the same attorney to volunteer at the same time every week, things "went smoothly." He said that he and the attorney understood each other, and that the CSB did not put anyone into the system who did not belong there. This meant that he could hold three to five hearings in 30 minutes. ***(Judges/Special Justice)***

"It's (the hearing) an opportunity for people to get together (to talk) about a patient." The *Southwest* participant agreed that having good relationships with those working in the system helped to achieve the goal of getting the person treatment. "We have a responsive CSB and great special justices. The CSB follows up on patients who are discharged from state and private facilities, depending on the case." ***(Private Provider)***

Theme: "Getting an advocate for a family member"

A *Southwest* family member said that advocates for consumers restored their dignity and described them as "really important." ***(Family Member)***

Theme: "Getting free mental health treatment"

Some family members reported that their loved ones had been stabilized during a mental health crisis. "It (being committed) helped my son recover" according to one parent, a theme that was echoed by family members in other regions. ***(Family Members)***

Theme: "Enables helpful professional relationships to occur"

The *Northwest* participant said that working together to resolve involuntary commitment cases creates "strong linkages with the hospital" as well as increased awareness of the many problems in the system. "Some partnerships that we have been forced into are working. . . . " reported the participant from the *Central Region*. The *Eastern Region* participant spoke highly of the fact that the CSB had been written into the police officer's order, requiring the CSB and police to work in tandem. He described this as helpful. In this locality, the CSB has a mobile crisis team that assesses individuals in their homes, on the street, wherever the need arises. This person reported that it was a good thing that they were able to be "mobile with 98% of the calls going to people's homes." In the *Northern Region*, there was also talk of successful

ongoing planning, police training, and problem-solving meetings with professionals involved in the process (i.e., CSB personnel, police, judges). ***(CSB Professionals)***

The *Southwest Region* participant reported that he didn't have many complaints about the system because he compared their situation with what he heard about the rest of the state, which he characterized as "not good." He said that he personally had "benefited from the state's Civil Commitment Seminars" where he had an opportunity to see what the rest of the state was doing and to "recharge (his) batteries." ***(Judges/Special Justices)***

This doctor reported**,** "In general, the emergency room doctors at this hospital have a good working relationship with the local CSB's emergency services clinicians and 'work well as a team.' The emergency services clinicians [from this CSB] have master's level training. The CSB also has a clinician who works on-site at the hospital, which he described as 'helpful.'" ***(Emergency Room Physicians)***

Theme: "Commitment hearings at the hospital works reasonably well"

A *Northern Region* psychiatrist said, "Once they get to the hospital, it (the system) works reasonably well. We are able to present the diagnosis to the judge for recommitment or continuation. If discharged, the patient remains a danger to themselves and/or others." A second psychiatrist in the *Northwest Region* agreed that the hospital hearing worked fairly well, and that he had established a relationship with the judge so that the hearings went fairly quickly. ***(Psychiatrist):***

A *Central* Virginia attorney said, "The hearing process in the hospital isn't that bad." Another attorney said that doctors are not adequately compensated and need to be paid more so they will come to court for hearings. ***(Appointed Attorney)***

Theme: "Video-conferencing speeds things up"

Magistrates cited the use of video-conferencing to speed communication, save money, and avoid transportation problems as the best overall feature of the involuntary commitment process. The *Northern Region* magistrate particularly liked video-conferences to get TDOs or for the "hearings themselves before the judge." The *Southwest* participant said they also use video-conferencing to link CSB personnel, police, and magistrates during the ECO and TDO process. The participant from the *Northern Region* emphasized that their CSB operates 24 hours a day, which enables police officers to obtain ECOs, then call for TDOs without delay. This helps to ensure that the consumer begins receiving treatment as quickly as possible. The *Central Region* participant mentioned that the magistrate and the CSB use video-conferencing during the TDO process as a way of involving the family. The consumer, however, is not always present during this part of the process. ***(Magistrates)***

A number of family members of consumers, consumers, a CSB clinician, a psychiatrist, and a judge reported not liking or using the video–conferencing system because of perceived problems with the system. These included the difficulties posed by trying to evaluate a consumer without the kinds of visual cues that an in-person, face-to-face assessment can

provide, the unreal or confusing aspect of this type of assessment for the consumer (e.g., a psychotic person who believes that people on his television talk to him, has this confirmed by the assessment when the person on the video screen who is conducting the assessment *really* does engage him in conversation), and the impersonal nature of this type of assessment (e.g, "I am not worth someone coming to talk to me in person." ***(Consumer)***

Theme: "Statewide, the care of the seriously mentally ill is a problem"

One physician's comments reflect those of other stakeholders. He said that individuals with serious mental illness have been released from state institutions into the community to fend for themselves on an "outpatient" basis. Many who formerly were institutionalized are now in prison or are homeless. The mentally ill are less likely to have health insurance coverage because health insurance is an employer-based system. This puts them at a disadvantage in obtaining care. In addition, people with serious mental illness are "the least savvy at accessing the health care system." As such, the seriously mentally ill frequently "get the brush-off" where medical care is involved. It is easier to miss significant medical problems with an individual who is seriously mentally ill. Their illnesses are much harder to manage because they have trouble getting prescriptions filled, taking their medication as prescribed, and following up with appointments and referrals. It is difficult to find primary care physicians to take individuals with serious mental illness, so it is difficult for them to receive appropriate ongoing care. ***(Psychiatrist)***

Theme: "More consumers, particularly "repeat patients," appear to have dual diagnoses, meaning that they suffer from both substance abuse and mental illness"

Stakeholders from all groups mentioned the problem of consumers with dual diagnoses, specifically, substance abuse and mental illness. There ". . . has been a 'huge' increase" in the number of individuals that he sees who have been diagnosed with serious mental illness and are addicted to drugs. Because of the lack of available mental health resources, many of these individuals self-medicate with alcohol and street drugs (i.e., crack) and become addicted. They go from having a serious mental illness, which is challenging in itself, to struggling with a serious mental illness and a serious addiction problem. When these individuals are brought to the hospital, they are "train wrecks." ***(Independent Evaluator)***

Theme: "The stigma of mental illness continues to be a barrier to treatment and funding of treatment"

"There is still a terrible stigma to mental illness." ***(Family Member)***
"People don't believe that severe mental illness is biological, brain problems. . . . " ***(Family Member)***

"People need to know that mental illness is often a chronic disease. Education is the key. It is a lifetime illness, like diabetes, and it can take a long time to get meds right and treatment in

place. Patients should not be punished when they go off meds and end up in inpatient settings." ***(Family Member)***

"The judge would not let anyone in our family speak at the hearing and appointed an attorney who spent minimal time [with our son] and sought no input from us." ***(Family Member)***

"Better education is needed for magistrates, judges, lawyers, police, and even psychiatrists." ***(Family Members, Consumers, Various Health Care Professionals)***

Theme: "Lack of beds"

The moderators asked participants in each group to identify the number-one problem with the civil commitment process. Most participants felt that there were too many problems to single out just one. The section that follows presents those issues that were endorsed by most members of the groups. Without exception, the "lack of available beds" in hospitals for severely mentally ill patients was the problem that *all* groups mentioned early on and with extensive examples. The sincere concern, frustration, and annoyance that many consumers are not getting needed treatment was expressed by participants repeatedly. With the "lack of available beds," an interesting phenomenon is noted: Mental illness was sarcastically reported to be "curable" with "unavailable beds." It was mentioned by members of several groups, who will remain anonymous, that "consumers are judged to be fit at times and released despite displaying significant symptoms of their mental illness because there are no beds available."

"Beds are all about money. Each region was given an x-amount of money to go to CSBs. No information about how that was done. There is a constant struggle . . ."

Family members can't get needed treatment for their loved ones because there are not enough beds available to meet the need. Family members of consumers in the *Northwest, Northern, Central,* and *Eastern Regions* reported that the most critical problem they face is "lack of available beds," which is a barrier to getting family members treated when they need it. ***(Families of Consumers)***

CSB professionals spend many hours diligently calling around the state for available beds. The lack of beds is an issue for the CSBs. "The law says that the local CSB or someone who is designated by the CSB is responsible for determining where a consumer will be placed during the detention. However, it doesn't say what happens if a place cannot be found. . . . " "It says that the CSB shall designate a facility, but if they do not, the person 'shall be placed in a hospital or other facility designated by the Commissioner.'" CSB participants say this is "a joke." An *Eastern* participant provides an example, saying that "they [the state] bought beds. Now, every CSB worker makes about 57 calls to find out who will take one patient. There aren't enough beds for the region. There is a 'disconnect' between responsibility and authority." The CSB personnel are not trained in legal issues but have the responsibility to find beds without the authority to mandate help and often the magistrates won't cooperate**.** ***(CSB Professional)***

Law enforcement officers spend many hours and travel many miles driving consumers all around the state due to lack of beds. All law enforcement personnel agreed that transporting patients took too much time and resources. The *Eastern* participant said, "Lack of bed space is the number-one problem because it locks up the process. It might be one hour or 12 hours of time for an officer to be involved because of the time requirement resulting from looking for beds." The *Northwest* participant agreed that "the time to find bed spaces is a problem that runs between four and 12 hours. The CSB will come in and do the job, jump through hoops to find a bed, and eventually end up putting the person in the state hospital, which is where we are located. However, there are rules that the CSB has to look all over the place for beds before going to the Western State option." The *Central* participant also agreed that beds are a problem. In Richmond, the sheriff's department "took over the ECO/ TDO process from the police to free them up, to leave them enough officers to do law enforcement. When officers are off the street dealing with patients who are off meds, they can't be doing the job of law enforcement, which is what they are hired to do." The *Southwest* participant further explained that for them, "There are only about 14 road officers to cover about 540 square miles and the needs of 25,500 people. There are two small police departments nearby. According to the code, the sheriff's department is responsible for transporting patients. We get stuck with doing the medical as well as the transport. Since we have so few officers, we sometimes send only one officer to transport the person, which we know is a safety issue for the officer, but there is really no choice." ***(Law Enforcement Officers)***

Psychiatrists express concern that it is the TDO, which is tied to the availability of hospital beds, and not the condition, that determines treatment for seriously mentally ill patients. A *Central* psychiatrist reports that, "We call the magistrate and they cannot issue a TDO unless there is an available bed: it's not based on the patient's condition." *Northwest*: "The biggest thing from a community perspective is the medical assessment process. If I have a patient who meets psych TDO criteria in their home, we call the magistrate. We are told that they cannot issue a TDO without a bed. I think TDO decisions need to be issued on clinical issues." ***(Psychiatrists)***

Independent evaluators point to the "lack of bed space" as a critical issue. One clinician, who currently is an independent evaluator, worked at a state hospital over 30 years ago, when the hospital census was 5,000 patients. The census now is approximately 800 patients with plans to decrease it to 200. With the decrease in beds at state hospitals, the care of these patients "blows back on the localities, which do not have the money to care for them." Patients were deinstitutionalized, but "the money never followed." This is a "huge" problem for the community services boards and the consumers who need care. ***(Independent Evaluators)***

An emergency room physician immediately said that the main problem with the current system of involuntary civil commitment is bed capacity—the lack of available hospital beds for psychiatric patients. He stated that when CSB staff and the emergency room doctor cannot locate a bed, or a hospital will not agree to admit a patient, the patient "can end up sitting in the ER for days." As soon as the TDO is completed and the CSB worker agrees to commit the individual, the police leave. At this point, the patient becomes the hospital's responsibility and it falls to hospital staff to keep the patient under control. The police are eager to leave long before the process is completed. In a rural county, the police officer who transports an

individual to the hospital on an ECO may be the only officer on duty in his locality. He is averse to staying at the hospital for four hours because it creates a lack of police coverage in his region. This doctor recognizes that this is a difficult problem for the police. He said that when the police pick up an individual with symptoms of serious mental illness, they often give him/her a choice (i.e., "you can go to jail or to the emergency room") and bring him/her to the hospital without getting an Emergency Custody Order from the magistrate. When they get to the hospital, the policeman says to the triage nurse, "you'd better watch this guy" and leaves. The hospital then has the responsibility for the patient. The police are not obligated to stay because there is no ECO in place. ***(Emergency Room Physician)***

"Because of the limited number of psychiatric beds, hospitals are very restrictive about who they will accept. The screening required varies depending on the facility. A patient can be examined in the emergency room and be medically cleared, but the admitting hospital may decide they want the patient to have a CT scan or they won't admit him/her because the results of drugs-of-abuse screening have not yet been obtained. This is a complication that is related to the capacity of the system." ***(Emergency Room Physician)***

Judges and special justices report a revolving door where patients are admitted for treatment, but released before the medications can work because of the pressure to "free up" a bed. One *Northern Region* participant said, "We can put them in, but nobody wants to keep them. They are back on the street shortly after being committed due to lack of beds and funding." While those participating from the *Southwest* tend to be somewhat more "able to find beds," they recognized that some consumers come into and out of the system with some regularity. In a number of cases, judges, special justices, and attorneys reported "knowing" the consumers as a result of the "revolving door mental health treatment plan." Some psychiatrists in the community and hospital made a similar remark. ***(Judges and Special Justices)***

Magistrates struggle to balance the needs of consumers with the reality of the fact that there is nowhere to send them due to lack of available beds. Magistrates from *all Regions* agreed that this was a primary problem affecting the commitment process. TDOs cannot be issued unless beds are available in an appropriate facility and that facility has to be named on the TDO document. Some magistrates felt that the CSBs should be responsible for locating beds *before* they send patients to magistrates. Magistrates reported that they are trying to follow the law while appreciating the fact that the lack of beds ties up police who are holding patients on ECOs. The *Eastern Region* participant said that many of their patients ended up in ERs because there were no beds. One *Northern Region* magistrate said they had an agreement with a hospital to take patients, but the hospital did not want to admit violent/aggressive people; this means that limited police resources are tied up for two days transporting a consumer to a state mental health facility. The extended discussion of the bed space issue focused on lack of funding for hospitals and staff. Most regions acknowledged that hospitals were closing and/or cutting beds because of a lack of funding—or even changing specialization to concentrate on treatments that were more profitable (such as cardiac care). ***(Magistrates)***

Court-appointed attorneys note that lack of beds and adequate insurance are key, and that mandated outpatient treatment is not really an option. "If a particular hospital did not have

beds, patients could be shipped farther away, which required traveling there for the hearings." ***(Court-Appointed Attorney)***

Theme: "Nobody wants to pay for mental health service delivery"

"Managed care companies have a primary goal to get patients out of the hospital as soon as possible so they can make money, whether or not it is in the best interest of the patient." ***(Psychiatrist)***

According to another community psychiatrist, "There is extreme pressure for managed care agencies to release patients who are hospitalized. I can get the patient admitted easily because the condition is so severe. I get them stabilized in the hospital because we can't let people suffer, so we medicate them, they get some sleep, and feel somewhat better, but aren't really improved enough to release, but the managed care companies pressure the doctors to explain over and over additional reasons to keep the patient. Unless the patient is imminently suicidal, it is difficult to explain medical judgment to these reviewers." Other psychiatrists tend to agree. A number of sources also said that reimbursement for hospital stays is a problem. One psychiatrist, who is in practice with six other clinicians, said that his group works with insurance providers that operate payment plans for mental health services that they did not like because there is basically no other choice in the current managed care system. Apparently, some managed care companies will only pay for three or four days in the hospital for certain conditions; they base their payments on the average length of stay for their patient population over a certain period of time. According to the psychiatrists, this works well for the managed care company but it doesn't work well for every patient or ensure that doctors get paid for their time. The community psychiatrist said, "It only takes one or two patients to stay one or two weeks and our group is in the red; because patient care is my responsibility, we keep them in." There is one significant advantage for a set fee for patient care regardless of whether the patient is there for three days or six days. It significantly reduces " the hassle of paperwork and trying to get paid." ***(Psychiatrist)***

Private insurance companies force consumers out of the hospital before the medications can "kick in." People objected to this and provided examples of how the person would soon return through the ER. ***(Family Member)***

A number of families who participated in this study were relatively well off financially and had had, at some time, private insurance for their loved one who needed mental health treatment. A number of participants shared that they had facilitated getting their family members on Medicare or Medicaid when possible, by whatever means they could. They noted that Medicaid and Medicare provide consumers with more ongoing care than private insurance providers. Under the Medicaid and Medicare system, once the consumer is stabilized in the hospital, the CSB is required to provide him/her with case management services. Private insurance companies provide no such continuity of services and the family is left on their own to figure things out as best they can. One woman in the *Northwest Region* noted that her daughter had been in and out of the hospital 12 times in one year, and asked "How can that be cost effective?" A man in the *Northern Region* made a similar comment about his wife's numerous hospital stays. ***(Family Member)***

CSBs are under-funded and tend to try to get clients who can be put on Medicaid**.** Other comments suggested that some patients who come in appearing psychotic due to drug abuse might be coded for psychosis since the reimbursement was greater even though it was known to be substance abuse related. ***(Community Non-Profit Agency)***

Theme: "Need more time on ECOs and TDOs"

In one region, a "dual track" system currently is used to evaluate patients presenting to the emergency room with symptoms of serious mental illness. If the emergency room doctor thinks that an individual is a threat to him/herself, rather than admit the individual, he is required to call in an independent evaluator (i.e., an emergency services clinician) from the local community services board to do an assessment. (When there is a difference of opinion, the CSB emergency services clinical was said to "win" with regard to placement of the patient). This has not always been the case. Ten to fifteen years ago, one way for hospitals to get payment for providing treatment was to admit the individual to the hospital under a Temporary Detention Order. This mandated the state to pay for the first 72 hours that the individual was hospitalized. At that time, for-profit hospitals were admitting "all" of their psychiatric patients and discharging them after 72 hours. The involvement of the community services board provides a check on this process. ***(Emergency Room Physician*)**

Medical staff on the psychiatric unit call the independent evaluator when they have patients who need to be evaluated. The independent evaluator sees the patient after he/she has been admitted to the psychiatric unit at the local hospital. The independent evaluator usually sees the patient the day after he/she is admitted or the following day. On any given day, this clinician averages three evaluations. He and his colleague usually see from 10 to 15 patients per week. When he is called in to evaluate a patient, he reviews the prescreening form that was completed by the CSB's emergency services clinician during the ECO/TDO and the admissions note in the patient's hospital medical chart. The independent evaluator then speaks with the resident and interviews the patient. He makes recommendations about commitment based on these factors. He fills out a standardized form that addresses the patient's symptoms and self-care. This process takes from 20–30 minutes per patient, depending on the number of evaluations that are pending. The most evaluations this clinician has performed in one day is ten—seven at one hospital, three at the other. He described this as "a nightmare." After his evaluation is complete, the patient goes before the judge. As a general rule, the hearings "go pretty well." The independent evaluator does not go to the patient's hearing. He said that it is "very rare" for a patient to bring in their own psychiatrist or their own attorney. Attorneys are usually appointed by the court. ***(Independent Evaluator)***

Several Vietnamese consumer families in the *Northern Region* who had been through involuntary commitments spoke through a translator. They described the process as "overwhelming, frightening, confusing." A number of family members had been held longer than four hours due, in part, to language problems. ***(Families of Consumers)***

Participants from *all regions* agreed that the time frames for ECOs are too short and should be extended to at least eight hours or more. Across *most regions,* comments included: "(the) ECO clock starts when the person is taken into custody. Law enforcement has four hours to execute the order—take the person into custody—or the order expires. Better time frame would be eight hours." Distance is a factor in the time problems with ECOs. "The ECO process involves officers bringing people in from very long distances. We only have two hours to evaluate them and find a bed. With the four-hour limit, that might be OK for an evaluation, but more time is needed to find a bed." However, one person said that the time didn't really matter, "If you can't find a bed in four hours, you won't find one in 24 hours." ***(CSB Professionals)***

"Needs to be longer, like from four to 12 hours . . ." ***(Law Enforcement)***

"With the person who is ECOed, which only allows a time frame of four hours, the crisis team is working constantly to obtain the TDO. However, the police cannot hold them longer than this time frame. Some magistrates refuse to extend the time if necessary and state that if it can't be done within the required time frame, then the patient does not need the hospitalization. Therefore, they would have to be released back into the community." Another doctor agreed, "If there is a TDO issued on Friday or Saturday night, there are no ER services for this patient, so that it is impossible to assess the mental status within the required time frame." ***(Psychiatrists)***

Participants considered if it would be helpful to extend the period of evaluation for ECOs and TDOs up to four or five days, accompanied by a "preliminary hearing" by an independent clinical evaluator. The two *Northern Region* participants agreed that if the consumer were *very severely ill*, it would be appropriate to extend the time, but not for that long a period. Otherwise, they opposed it. The *Southwest* participant opposed the idea saying, "I see many we dismiss after four hours, especially if the problems began as a drunk. Four or five days is way too long here. [A] short time frame causes much rushing around and little time to consider the condition and rights of the person." ***(Judges/Special Justices)***

Participants from *all regions* agreed that the four-hour time line for executing ECOs is generally inadequate. It takes longer than that to find beds, and police officers are tied up while CSBs or magistrates try to locate a facility that will take the patient. Technically an officer does not have to stay with the patient when the timeline expires, but that obviously presents other problems. Even increasing the four-hour time frame to eight hours might not alleviate the gap between obtaining an ECO and then getting the TDO. In rural areas much of the time allotted to the ECO might be taken up with simply transporting the patient to the CSB. ***(Magistrates)***

Theme: "The current 72-hour TDO is used for acute care hospital services, which can be a problem for some ER doctors"

A frustration for emergency room physicians is that they are managing patients as primary care doctors, a specialty that they were not trained in. This doctor said he has had to learn primary care medicine because this is the service he provides for individuals with serious

mental illness. He feels that, as emergency room doctors, their "role is defined by what our patients need." He added that not all emergency room doctors would agree with this approach. Some doctors do not consider providing primary care "an emergency." He thinks that this requires a change in mindset. ***(Emergency Room Physician)***

"I have gotten good at learning about local resources—the free clinic, the Salvation Army, doctors who will accept patients who do not have insurance . . . negotiating for patients". In the end, however, "you do what you can and then discharge them to the lobby, knowing that little planning for follow-up can take place." He said that he wonders if resources were deployed in a different way, how much better the situation might be for individuals with mental illness. ***(Emergency Room Physician)***

Independent source data: DMHMRSAS CSB Survey of ECO and TDO experiences; date of report: December 6, 2004.

- Of 40 CSBs in Virginia, 32 of them reported having seen at least one consumer for whom a TDO was recommended but for whom an inpatient or other facility could not be found that would admit them within four hours.
- Twenty (20) CSBs had at least one consumer who was released outright from a TDO because a facility could not be found.
- Overall, within a two-month period, 4,991 people were prescreened in Virginia for emergency mental health care, with 49% resulting in a recommended TDO disposition.

Theme: "Some hospitals have unofficial 'do not admit' lists"

It is also reported that some hospitals use the requirement of medical clearance to avoid accepting a patient, denying that patient a bed that is otherwise available. Members of several groups noted an awareness of "unofficial 'do not admit lists'" that included patients with certain behavioral profiles. While the participants who provide treatment criticized this practice, the hospital administrators and even some psychiatrists could understand how this situation had evolved.

"We recognize that the lack of beds is a problem, but violent, aggressive psychiatric patients in hospitals that are not equipped to handle them is also a problem." "Capital Medical Center in downtown Richmond had 62 mental health beds at one time. When it sold, the beds were not reopened. No one picked up the commitment beds. Some beds were purchased at hospitals but not even half of what was lost. Now, no one is 'playing nice.' And no one knows what is going on." *Eastern* and *Northwest* providers noted that aggressive patients, who may have co-occurring substance abuse and mental illness, can be a danger to other patients. Health care providers might have beds, but not beds that can be safely used to provide services. *Southwest* noted: "Because of the intensity of the patients, there is no means to move the patient to hospital facilities. When our facility was opened, it was for people with no violence and acting out. Our hospital beds were designed to take *less severe* mentally ill patients. Now, insurance won't pay. Now, we take violent patients. [We] have a seclusion room, a 20-bed unit that is not equipped for aggressive patients. It is a problem for everyone. Like when we get someone on a TDO on a Saturday [night] order and can't get another one to get the person

to a state hospital because of the violent behavior. We have to file an assault and battery to get them off the unit to protect the other patients. We don't want to do it. Why doesn't the state hospital take them?" ***(Private Providers)***

Theme: "Transportation-related problems"

"The word 'emergency' is vague and open to different interpretations by different magistrates," so there are consumers who really need to go to the ER who are not transported because it is not obvious (e.g., no bleeding gunshot wound) that there is an emergency condition. ***(State Hospital Psychiatrist)***

Regions might make different calls on transporting a consumer to an ER unless he or she had a *proven (or visible)* emergency medical condition. ***(CSB, Psychiatrists, Families*, *Police Magistrates)***

Requirements to be "public transportation drivers" (provide public transportation) keep law enforcement officers from being available to do their jobs. Transportation issues related to the ECO/TDO process cause problems among regions' police and sheriffs' departments. Some regions have reciprocal agreements on reimbursements for transporting patients outside of their residence areas, others do not. Overall, sheriffs would prefer not to be involved in providing consumer transportation unless a crime has been committed. Consumers and family members also tend to prefer that law enforcement not be involved, except in cases where the family members "cannot be managed in any other way." Two parents in two separate regions offered examples where law enforcement officers were necessary to subdue "out of control" family members. Sheriffs reported that "family members call because they want the police to 'be the heavy'; they don't want their family members to blame them even though the family needs help." ***(Law Enforcement Officials)***

Consumers are shuffled all around the state, and sometimes out of the state. *Southwest* notes that "the closest psych ward is outside the state in Tennessee, an hour and 20 minutes away, and this is a problem because of [rules related to]transporting out of state." Other complaints are related to the distances that consumers are transported, which makes it very difficult for families to see their loved ones, participate in their treatment, and monitor their progress. ***(Law Enforcement Officials)***

There is a problem with the legal code whereby clients are delivered for an evaluation but not necessarily returned to wherever they came from if they are found to be mentally competent. There is a statute that deals with transporting the consumer to the ECO, TDO, and commitment (hearing), but it doesn't address transporting the person back. So, an individual can be sent two hours away from where they live for an evaluation on an ECO. If they are found to be not mentally ill, they can just be left there. In the *Northern Region,* consumers have been given a "bus token." In the *Southwest Region,* the consumer is more likely to be "shown the door," or given nothing. ***(Attorneys, Judges, Special Justices)***

One independent evaluator, who assesses individuals outside his locality ". . . from Richmond, Colonial Heights . . . who have been "schlepped there by local police," reports that

how resources are allocated is a huge problem." When patients are ready to leave, the police are not obligated to transport them. "They are put on a bus with instructions to follow up with their community services board and end up being dumped in Petersburg. Who knows if they do[(follow up]; they are not monitored." ***(Independent Evaluator)***

Theme: "Medical prescreening/clearance"

Admitting psychiatric hospitals require that patients be medically cleared prior to accepting them. This doctor stated that medical clearance is an issue that emergency room doctors take very seriously. Often individuals are brought in presenting with symptoms consistent with a serious mental illness. It is assumed that they are mentally ill, when in fact sometimes they are not. Their symptoms are related to a medical illness. There is a tendency, with patients who are known to be mentally ill, to assume that their symptoms are related to their mental illness. This doctor stressed that there is "no immunity (to other illnesses) conferred by mental illness." ***(Emergency Room Physician)***

"It's after the TDO, and after the bed is found, (that) the patient *must* have a medical prescreen before a psych hospital will take the person." This is reported by participants in 100% of the cases in the *Eastern Region*, 95% of the time in the *Northwest Region*, and 75% of the time in *Southwest Region*. ***(Law Enforcement)***

Central Region psychiatrist: "Before anyone will take a patient, they expect that the patient [to] also be assessed medically. Sometimes there is no mechanism to have the medical assessment done. Our hands are tied. We may suggest that they go through the emergency room, but the magistrate will not issue a TDO for medical emergency prescreening." ***(Psychiatrists)***

Medical prescreening is needed, but everyone doesn't agree about the rationale or details**.** "The problem lies in that there is *no clear legal mechanism* to obtain [a] medical assessment for persons who are refusing, and who lack the capacity, to make this decision. The magistrate can issue a TDO so that the person can be taken to a psychiatric hospital on an involuntary basis, but the psychiatric inpatient service will not accept the person until a medical assessment is completed, for safety reasons. And there is no legal mechanism to have the person taken to an emergency room involuntarily (unless there is a proven acute medical crisis)." Psychiatrists and physicians say that medical prescreening of patients prior to admission to a psychiatric facility or unit is necessary because it is not "easy" to determine if a consumer has an acute or serious medical condition that may only appear to be a psychiatric condition. In addition, one psychiatrist also mentioned that the medical prescreen was important to him, because when the patient was admitted to the psychiatric unit, he then had the legal liability for the patient and didn't want to get a patient who suddenly died from some undiagnosed medical condition that would result in his being sued. . . . ***(Psychiatrists, Physicians, Private Providers)***

"In other regions, other areas (i.e., Tidewater), the education level of emergency services staff at other CSBs varies (i.e., some clinicians reportedly have only a high school education), which can be problematic. At times, the relationship between emergency room doctors and

emergency services clinicians can be adversarial. When the doctor and CSB clinician disagree about the need for commitment, the system does *not* work well. The emergency services clinician has the deciding vote in this process. When the emergency room doctor disagrees, he usually writes a statement in the chart to the effect, "I strongly recommended that the patient be admitted and advised against discharge, but was overruled by the CSB's emergency services clinician." ***(Emergency Room Physician)***

ER physicians and psychiatrists do not always agree when the patient is "medically cleared." At times, there is a difference of opinion between the ER doctors who deal with acute care issues and the psychiatrist regarding when the patient is "good to go." Other professionals seem to understand this problem, because the ER physicians are trained to treat acute problems and may not consider chronic conditions that might be related to strokes, etc. As such, it can create frustrating situations. "It is like mediation to get the ER doc and the psych doc to agree," reports one source. Another source reported that the "ER doctor asked, 'What am I medically clearing? Would I let them leave the hospital?" ***(Psychiatrists, Emergency Room Physician)***

It is possible to use the medical clearance requirement to prevent a consumer from being admitted to a hospital. When TDOs are issued, a consumer must be transported to a hospital and obtain emergency medical evaluation or treatment prior to admission to an inpatient psychiatric unit. As such, several groups members said that hospitals sometimes use the required medical prescreening and medical clearance prior to admission to the psychiatric facility to "slow down" the process when a hospital does not want to accept a patient they deem to be too aggressive and/or too severely ill. One CSB staff member sees a "need for a unified solution to medical screening based on real-life situations." Another CSB clinician expressed that the CSB should not be required to obtain medical clearance because staff need to "focus on evaluations and recommendations to the magistrate," which is an enormous responsibility in itself. ***(CSB Staff, Psychiatrists)***

Theme: "Infringement of patients' rights: jails are turning into mental health institutions"

"Law enforcement officers often are not equipped to handle individuals with serious mental illness. They may be frightened [of mental illness] or fear for their own safety. The sensitivity of the police in these situations varies. Some are borderline abusive to individuals with mental illness. . . . " ***(Independent Evaluator)***

Reports across participant groups point to the connection between the lack of effective community- and hospital-based mental health screening, consumer mental health treatment, and the jail system. The *Southwest* participant reported that they "did not have many mentally ill people in the jails, but it was sometimes a contributing factor in crimes." The *Northern* participant suggested training jail and prison physicians to recognize mental health problems, but was not convinced that many mentally ill people were in jail. ***(Special Justices, Attorneys, Law Enforcement)***

"Patients are held in jail cells waiting for evaluations." According to a number of sources in this study, it is not uncommon for patients to end up in jail cells waiting for ECO evaluations. CSB personnel expressed that "it is a punitive system . . . the ECO/TDO structure confuses criminal issues with mental health issues." ***(CSB Personnel, Law Enforcement, Attorney)***

"There are more individuals in Virginia's prisons and jails, based on their diagnoses, than in all of the state's public and private hospitals combined" ***(Psychiatrist)***

One *Southwest* sheriff said, "No one likes it here. But the way it works is that the person is picked up and put in a cell. It's a holding area that is not padded or suitable for patients." *Eastern Region* law enforcement agreed that it is an unwanted problem for them. "Jail facilities are not suitable to hold people who have mental illness. We sometimes take their clothes and keep them on suicide watch. We have no staff to evaluate them. Sometimes even when the CSB says that [the person] doesn't seem suicidal, we still keep them on watch, since in the jail, it is difficult to tell if this is accurate." ***(Law Enforcement)***

"Our jails do not have the funds to screen people for mental illness—or to treat them once they are there." Individuals who have a mental illness and/or untreated mental illness and co-occurring alcohol and drug addictions frequently end up in jail. It is not clear how many of these people have a prior criminal history. According to one sheriff, "there is no measure by which to determine how many mentally ill people are in jail. I call the CSB into the jail to deal with only the most severe problems. There is no screening process in the state to determine how much of a problem is strictly a mental illness." Sometimes law enforcement officers working in the jail only become aware that a person is mentally ill because someone else who has been arrested will report that a cell mate, "is talking to himself and acting crazy." ***(Law Enforcement)***

From the various stakeholder groups, it is clear than some number of consumers are arrested for offenses such as trespassing, breaking and entering, disturbing the peace, and assault and battery because they have gone "off (their) medications" or have substance abuse problems. ***(All Stakeholders)***

Law enforcement who were randomly selected to participate in this study reported not liking to incarcerate those who were mentally ill. However, if law enforcement is going to be called on to assume this responsibility, it became apparent from their comments that they would do so using all of their skills and training. The sheriffs noted that their skills and training are *not* a good fit for dealing with mental health services consumers. In a situation with an aggressive person who is mentally ill, for example, one sheriff explained, "If you come at me with a stick, I'm not going to come back at you with a stick. We go up [one measure of force] to get control of the situation. This is *our training*." ***(Law Enforcement)***

"Some patients are treated like criminals." There were many examples of consumers being handled by law enforcement officers in the same way that criminals are treated. Individuals with serious mental illness, who by definition suffer from disordered thinking, are treated like criminals, who by definition knowingly break the law. Issues about handcuffing patients were

debated among the consumers, families, and law enforcement officers, and others. ***(Law Enforcement, Family Members, Attorneys, CSB Workers)***

A number of family members in different regions suggested that law enforcement officers' knowledge of mental illness and mental illness co-occurring with substance abuse problems needed to be improved. Most people gave examples of incidents when officers had handcuffed consumers. However, they also cited instances when law enforcement officers were not appropriately responsive when family members called for assistance. For example, one woman was annoyed because the police did *not* handcuff her 20-something son, who had bipolar disorder, allowing him to escape and run away. In this instance, the police followed, chasing her son into the woods. When they finally chased him down, her son laid down and refused to move; the arresting officer resorted to using a Taser on him to make him get up. She reported that her son was very angry and later made more efforts to avoid mental health treatment, citing this experience as an example of bad treatment. The mother blamed the police for not handcuffing her son in the first place and attributed this to their lack of knowledge about mental health issues. She also shared that her son never agreed that he had a mental health problem. ***(Family Members)***

The *Southwest* magistrate observed that hospitals often refuse to accept patients, even *with orders from the magistrate*—they want them in jail. The *Central Region* magistrate agreed, saying that jails and prisons have become "dumping grounds" and this seemed to be particularly true for indigent patients. ***(Magistrates)***

Sheriffs report that they "carry law enforcement restraints (i.e., restraints appropriate for individuals who knowingly commit a crime and are a danger to the community), not mental illness restraints." ***(Sheriffs)***

"Some patients are criminals." Some mental health consumers have long-term criminal records plus have mental health and substance use disorders. It is difficult to determine which came first—criminal behavior or severe mental illness. ***(Psychiatrist, Law Enforcement, Special Justices, Attorneys)***

"Appeals are a joke. If an appeal is set, it needs to happen. Often, it doesn't. . . . There are judges who will continue a case in hopes that there will not have to be an appeal, then it is dismissed." ***(Attorney)***

- "Need an appeal process in place for the CSB to help people when the magistrate is obstructive." ***(Attorney)***

- "There are legal disabilities that arise in an involuntary commitment, like they can't own guns [after being committed involuntarily] . . . could hurt a military personnel's career if it is a drunk and threatening case. . . " ***(Attorney)***

- One attorney was careful to inform law enforcement officers, for example, of the dangers to their careers following an involuntary commitment, and to convince them to voluntarily go into treatment for mental illness or a substance abuse disorder.

- "Some consumers don't show up for appeals. The *Eastern* docket is heavy. Appeals are at the bottom of the pile. It is very discouraging. Three hours sitting and the client has been released. The court thinks this is the least important thing. Seems very non-cost effective." ***(Attorney)***

- "When a person loses his rights, the appeal is necessary. . . . " ***(Attorney)***

- During the hearing, everything is rushed. "The attorney has 15 minutes. Prescreen gets two minutes. Not much prep time. When I have a client that gets ECT treatment, I automatically appeal them all. Forcing them to go undergo electric shock. . . ." [indicating ECT is terrible, which is a bias of the attorney]. ***(Attorney)***

Theme: "Reduce all the 'red tape'"

Participants from most of the study groups expressed some frustration with how complicated, "unworkable," and slow the current system is. One director of a recovery house in the *Eastern Region* suggested, "Reduce [the] red tape involved in qualifying people for these services. It's intimidating, discourages them, and is difficult when trying to get assistance. Facilities are so far away. The assessment process is too slow or nonexistent. Rights are violated." ***(Recovery-House Staff)***

Procedural problems are an issue**.** As one independent evaluator put it, "The coordination between medical staff at the local hospitals and the state hospital is often done in a haphazard way." Patient transfers are often unpredictable. Twenty minutes after he has left the psychiatric unit at the local hospital, the independent evaluator may get a call asking him to come back to the unit to evaluate a patient. In the interim, the psychiatric unit has received a call from the state hospital indicating that they now have space and can admit the patient. There is some urgency for the staff at the local hospital, because the state hospital may fill the bed if the independent evaluator is not able to evaluate the patient immediately. It is a "feast or famine" situation. Because he maintains a private practice, the independent evaluator cannot "be at their (the local hospital's) beck and call." If he cannot do the evaluation, the psychiatric unit at the local hospital keeps the patient until the following day when the patient can be seen. In some cases, this can be problematic. He cited a recent case. He did his first evaluation on a patient at one of the local hospital's psychiatric units on December 11. On January 19, he was called in to do a second evaluation on this individual, who had spent approximately five weeks at the local hospital, waiting for transfer to the state hospital. ***(Independent Evaluator)***

Theme: "Money matters"

Some providers do not get paid in a timely fashion. "TDOs get charged off to the Supreme Court. It is hard to get payment. I'm forever looking at records to get payment."

Many consumers cannot afford health insurance**.** "The wealthy clients tend to be able to get services, like other medical care, while the low-income have no options." ***(CSB Staff, Psychiatrist, Family Members)***

CSBs do not have enough staff. Across the state, there are numerous cases "where the prescreening ran right down to the wire, so the person had to be released. The big issue is staffing. The CSB is helpful, but they don't have enough staff." Some case managers have overwhelming case loads, as many as 60 to 80 clients, and the paperwork is also overwhelming, to the detriment of the client. ***(CSB Staff, Families, Psychiatrists, Attorneys, Law Enforcement)***

Special justices only get $68 for hearing cases and retired judges who hear cases get no compensation from the state. Attorneys only get $75 for representing a consumer client at a commitment hearing. One attorney said that if the consumer is to have better representation, the attorney needs better compensation. A second attorney said that he obviously didn't do these cases for the money, but once he had to go to court to represent a consumer client on a day when he normally was not there. After four hours in court, he came out to find a ticket on his car for the exact amount of his pay for the day, which he found rather irritating. ***(Attorneys, Special Justices, Judges)***

Patients often do not have health insurance. If they are lucky, they have a case manager or family member who helps them navigate the system and obtain Medicaid benefits. When the consumer improves, is stabilized in the community, and even obtains employment, he or she is terminated from Medicaid almost immediately. If the person doesn't remain mentally healthy, he or she loses the job and is back without health care insurance and has to repeat the long, complicated process once again. ***(Family Members, Community Agency, CSB)***

Theme: "The buck stops nowhere"

Across groups, stakeholders were aware of the mental health laws concerning their own responsibilities, however**,** most participants expressed frustration that no one seemed to be in charge of improving the system. The following quotes are examples:

- "Many groups (are) involved in the civil commitment process, but no one has responsibility for the patient."
- **"**There is no system, just a bunch of little parts. There is no sense of an overall system."
- "Fixing the problem is not as simple as removing or adding beds on wards. There is no clear understanding or direction. The path is jumbled up. *No* one knows . . ."
- "Criteria for who gets into the state hospital is 'elusive.' Rules change minute to minute. Who is in charge?"

- "The entire commitment process has too many hoops to jump through and in 20 years will probably be viewed as a form of medical torture. The focus should be on the client and trying to help them; instead, CSB personnel [have to] spend 75–90 percent of their time trying to make the process work—filling out forms for data collection, doing medical screening, etc. The entire process has become adversarial and the client is lost in the process. Bean counters have taken over the process."

Theme: "Statewide, there are not sufficient community-based mental health services available for consumers"

There is an endless revolving door of acute psychiatric admissions. An independent evaluator said that many of the individuals he evaluates he sees repeatedly. Why? Their "compliance (with medication) is not good; the level of supervision they receive (in the community) is not good. They are not getting real help. Nothing goes on. Their meds are 'tweaked' (while they are hospitalized)." "It comes down to money. The local community services board staff are working their rear ends off on a shoestring budget." When patients return to the community, they decompensate or have a crisis and are back in the system. If they commit an offense, they are sent to jail. The jail's budget for psychotropic medication is "through the roof." The individual with serious mental illness may be segregated from the other inmates. His condition deteriorates because he needs the interaction with others, but the other inmates also must be protected. ***(Independent Evaluator)***

"The issue is the under-funding of the state mental health system. Mental health services are 'stretched' and the CSBs have to fight for their budgets. Most of the individuals who have serious mental illness are uninsured because they are unable to maintain regular employment. If they become very ill, eventually they receive benefits from Social Security, but this is a long process." ***(Emergency Room Physician)***

There is a lack of good local placement options for teenagers. One emergency room physician remarked that this lack of services results in ". . . [teenagers being] sent out of the area, which strains police resources and makes it difficult for family members to participate in their treatment." ***(Emergency Room Physician)***

There is a lack of good local placement options for adults experiencing a mental health crisis who might be at risk for sexually offending children**.** One emergency room doctor cited a recent complicated case. An individual presented to the emergency room. He was homeless and said he thought he was at risk of sexually abusing children. Every psychiatric facility contacted was unwilling to take him. He was "not appropriate" for their facility. There are no pedophiliac units. He was in the emergency room for 18 hours. The emergency room doctor notified one police agency which "punted him to the local shelter." The Salvation Army would not take him because they house children and their families. Another police department sent investigators, but there were no outstanding warrants on this individual. They said they would "keep an eye out for him." The emergency room doctor contacted the hospital risk management department and the hospital's general counsel. The consensus was that this individual was not acutely psychotic; he had not threatened a specific person, so there was no "duty to warn;" and there was no indication for admission. The individual was discharged to

the lobby and told to follow up with his local community services board, located 30-plus miles from the hospital. ***(Emergency Room Physician)***

Theme: "Court-ordered, monitored outpatient treatment has 'no teeth'"

The idea of mandated outpatient treatment provoked a range of comments in all stakeholders groups. Many expressed concerns about possible human rights violations that might result in people being treated with drugs against their will, a risk that some people did not think worth taking. On the other side, stakeholders also reported beliefs that mandated outpatient treatment would protect the human rights of consumers by keeping them out of jails and inpatient hospital wards. Most of the participants in the professional and family stakeholder groups supported court-ordered, monitored outpatient treatment. ***(Judges, Special Justices, Attorney, Families of Consumers)***

Other problems related to civil commitment and mental health service delivery in general.

Theme: "Patient's privacy rights versus needs of family caregivers"

Confidentiality issues, laws, and policies for those over age 18 need to be reconsidered**.** Families of consumers who are between the ages 18 and 24 were unanimous in their opinions that something needed to be done to ensure that the family has access to medical information about their loved one, since they were directly involved in providing care and, often, in paying their bills. This issue was raised repeatedly by the parents of young adults who were struggling with a recent diagnosis of serious mental illness. Many provided examples about not being given any information about children who were of legal age, but were in crisis in the hospital. It was reported that the psychiatrist often would not release information to the family until the judge approved the sharing of information. This impacts family members' ability to participate in their loved one's treatment and to provide valuable information to mental health professionals who are making decisions about the best course of treatment. ***(Families of Consumers)***

Theme: "Insurance and liability issues"

"In the short term, there is an effort in the current legislative session to make community services board clinicians and emergency room physicians work more as a team. At present, the community services clinician has the final decision about commitment; this proposal would give the emergency room physician greater power. This goes back to the issue of past abuse of the system, i.e., it is a conflict of interest for the emergency room physician to have sole power in this process because the hospital benefits financially from admitting the patient. The community services board has a fiduciary responsibility to the state, and their clinicians are under pressure to not admit patients to the hospital." This physician says that there should be a way to resolve this issue when both parties are acting in good faith. What happens if the individual is not admitted and there is a bad outcome? As state employees, CSB personnel are

protected. Emergency room doctors have malpractice insurance and some protection from their hospital affiliation. ***(Emergency Room Physician)***

SUGGESTIONS

Many suggestions were made by members of the respective groups with regard to making improvements to the civil commitment process. There are not summaries of the findings or suggestions from the evaluation team. In addition, these suggestions are not in any particular order; i.e., their order does not imply that one comment should be considered more significant than any other.

- "Make more beds available."
- "Create a computerized central clearing house for available beds statewide."
- "Provide an excellent range of community health services, which currently does not exist, so people get treatment earlier and don't end up needing an inpatient hospital bed."
- "Make more preventive services available that are not PACT (Program of Assertive Community Treatment) to avoid involuntary commitment."
- "Extend the time requirements for ECOs and TDOs."
- "If families cannot get a TDO, get them help somehow to cope with the immediate crisis."
- "Fund an adequate number of facilities that are appropriate for high risk, sometimes aggressive, and difficult-to-manage patients."
- "Establish a network of psychiatrists or doctors in the community to provide consultation and medication during a crisis so involuntary commitment can be avoided."
- "Private insurance companies need to pay for a longer approved time in the hospital for those with serious mental illness, such as the 21 days that it takes for certain medications to be effective."
- "Get the Medicaid hospital reimbursement rates increased so that hospitals will be adequately paid for the beds. Other states' Medicaid pays much higher reimbursement rates for beds."
- "Reinhardt is seeking $1 million or more dollars to purchase acute (care) beds, but the rate of reimbursement is set by DMAS, and the hospitals, including the private sector, don't make enough money to want to open more beds unless the rate goes up."
- "Fund the CSBs and hospitals to buy vehicles and pay security-trained drivers and only call law enforcement when there is a crime."
- "Provide significant additional funding to law enforcement to hire and train special mental health transportation personnel."
- "Call the sheriff or police when a person commits a crime *and* is aggressive and seemingly dangerous. Screen the person for a criminal background and triage to either a psych prescreening facility attached to the jail or to a forensic unit, or if no history, take the usual steps to complete the evaluation. Don't ignore the past criminal record to evaluate for safety risk."
- "Change the statute to make sure the consumer is returned home if found mentally competent."
- "Clarify the definition of what constitutes an 'emergency condition' in the statute related to the fact that the TDO may include transportation of the person to a facility for an emergency evaluation or treatment."

- "Need clarification of what constitutes medical clearance."
- "Establish a clear legal mechanism to obtain medical clearance for consumers under consideration for an involuntary commitment even if there is not an obvious acute condition."
- "Change the language to: 'Such order *shall* include transportation of the person to such other medical facility as may be necessary to obtain *medical assessment* or treatment prior to placement.'"
- "Clarify the phrase 'as may be necessary' to specifically state that this should be a *clinical* decision. Possible wording could state 'as deemed necessary by a medical or mental health clinician.'"
- "Change the statute to allow justices to get treatment for patients under 'conference' terms with a conditional order that permits you to pick up a person if they do not comply."
- "States should keep Medicaid available for consumer/clients who are stable and can work. They should not be cut off and have to reapply every time their situation changes. Social Security's 'ticket-to-work' benefits might be used as a model."
- "Advance directives should be used by patients and families and be done when the patient is competent."
- "Educate people about advance directives and WRAP (Wellness Recovery Action Plans) plans."
- "'Wellness Recovery Action Plan' should be used."
- "Make law changes to protect doctors against lawsuits when they involve family in direct patient care."
- "Add a 'kind' guardianship provision to the mental health law making it easier for the family member to obtain guardianship of the person." Participants cited the federal government's decisions to name the parent as the payee for their adult child's SSI checks as an example of the federal government making a decision that the consumer was not competent enough to manage his/her own money.
- "There is a need for consumer education, especially about the commitment process and the laws." At the same time, "there is a need for education on the part of the judges and magistrates and law enforcement about mental illness."
- "Get the police out of the process or provide training for them about mental illness, like CIT."
- "Keep on fighting the stigma of mental illness."
- "Make the system more 'welcoming.'"
- "Involve family members in the process, and educate them, too."

SECTION B

CONSUMER STAKEHOLDERS

Overview of Issues

Although a number of psychotic consumers who participated in this study do not have detailed recollections about the involuntary commitment process and the hearing, they do have general emotional reactions to how they were treated.

A number of the consumers interviewed said that they remembered very little about the process of being committed and/or the hearing itself. As one consumer put it, he was "out of it" at the time. While these consumers might not be able to recall the details, they were able to articulate how they felt about the process. For example, it was common to hear participants say that they were "treated poorly" (by various professionals), "treated like a crazy person" (noting the stigma), were "embarrassed by the process," were "disrespected," or were "not listened to." Or, alternatively, other participants recalled that a particular police officer was "kind," that the CSB staff was "friendly and nice." Generally, consumers who would talk to someone on the research team could share how the experience felt to them "emotionally" after the fact, even without clearly being able to talk about details.

With regard to involuntary commitment, most comments of consumers were negative comments. Most, if not all, *Central, Eastern, Northern, Northwest,* and *Southwest Virginia* consumers said "not much" or "nothing" was good about going through the actual civil commitment process.

Theme: "The stigma of mental illness is life-long and reduces one's quality of life"

- Having a mental illness is a stigma that causes a consumer to have problems "all your life."
- Some consumers had tried to hide their mental illness for fear of what others would think of them or the shame that they would bring to their family, before ending up with an involuntary commitment.
- Some consumers expressed embarrassment and shame at being ill and/or addicted to substances, and these feelings were worse if they had to be involuntarily committed.
- Some consumers were angry with their lack of treatment options and are defiant about being stigmatized as "losers" or "scum."
- Some consumers said that the professionals in the civil commitment process think that "they are better than we are," suggesting that consumers felt degraded or "lower class," which they resented.
- Some consumers said there is a double standard; that professionals can be alcoholics (e.g., lawyers) or drug addicts (e.g., doctors) and no one says a word, but consumers who are unemployed or "not rich" and who have mental illness and use substances are held to a different standard.

Representative comments:

"You are labeled for the rest of your life [when you are hospitalized] from a breakdown from a mental illness. People who find out are always waiting for you go 'go crazy' on them. You have an epileptic seizure and you are 'out of it', no one thinks you are crazy . . . they hold it against you." ***(Consumer)***

"People in the community don't understand [mental illness]. They don't want to understand. There's a lot of prejudice." ***(Consumer)***

Theme: "Lack of respect for human dignity"

- One change that would significantly improve the process of civil commitment would be for everyone involved to treat consumers as they would like to be treated if mental illness happened to them ("do unto others . . .")

Representative comments:

"The process of being committed was 'horrible . . . humiliating, and demeaning.'" ***(Consumer)***

"They should treat you more as a human being." ***(Consumer)***

Theme: "Lack of education about mental illness and the civil commitment is a problem"

- Many consumers said that the public, their families, and all professionals needed to be educated about mental illness.
- Some consumers expressed that their mental illness was a "weakness" or made other comments suggesting that they themselves need education about mental illness.
- Many consumers were not clear about what the mental health laws are.

Representative comments:

"We are not informed. We learn after the fact." ***(Consumer)***

"I didn't know that what was wrong with me had anything to do with my brain not working right. How many people know that? I thought I was just crazy, and it was hopeless so I might as well be dead. [The CSB therapist] helped me. I didn't even get it, didn't even know I was just sick. Better to be sick than crazy. . . ." ***(Consumer)***

"I was tricked into going into the hospital. Next thing I was locked up. No warning. That's f*cked." ***(Consumer)***

Theme: "The criminalization of mental illness is a major problem"

- Consumers, even those who had committed crimes, reported that they do not want to be treated like criminals when they act inappropriately due to their illness.
- Most consumers reported not wanting the police involved when they are in a mental health crisis.
- Most consumers mentioned that being transported in a police car, often in handcuffs, was a negative experience,
- Most consumers objected to being locked up in jail due to their irrational behaviors that resulted from a mental health crisis.

Representative comments:

"The police treat you like a common criminal. They handcuff you and put you in a cage car . . . they don't say a single, solitary word to you. . . . Everyone looks at you like you did a crime. You aren't a person to them."***(Consumer)***

"We get treated like people who go to jail. It's [the involuntary commitment process] like booking you to go into jail. You are down in a hole, you don't know how to get out." ***(Consumer)***

Theme: "Consumers were not in agreement about their opinions and feelings about the civil commitment process"

- Some consumers would rather be "left alone" rather than get involved in any way with "the system." The issue was that getting services was too complicated to figure out.
- Some consumers reported that "things speed up" during a mental health crisis and it was difficult to keep track of what was going on.
- Many consumers said that they had to wait too long to get their first appointment to get help at the CSB, unless it was a mental health crisis (commitment).
- Most consumers said they wanted to be able to go to a medical professional in their own community rather than having to travel hours to get help.
- Some consumers said they would go to see a mental health care professional every week to avoid having to go to court for an involuntary commitment.
- Many consumers who are currently getting mental health services at the CSBs said they are satisfied with the service.
- Some consumers said that the CSB staff are sometimes too busy to spend enough time with them. Other consumers said that the CSB staff are the only people they trusted.
- Some consumers were pleased with private care in the community, but said that it was a problem when their medical insurance ran out.

Representative comments:

"I am OK with my case manager [at the CSB], but before I got her, it was court to the psych ward. I was out of it most of the time. Trying now to keep it together. I want to keep my freedom. . . . " ***(Consumer)***

"Going to the court hearing . . . I don't know . . . confusing. I was scared I might go to jail but I wasn't sure why. I was angry, really mad at being in handcuffs and threatened, so I fought it. I see now that I needed to play the game. . . ." ***(Consumer)***

Theme: "Confidence in treatment for mental illness was not high"

- Some consumers reported that the mental health treatment received in the hospital during an involuntary commitment ranges from good to bad.
- Several consumers reported misdiagnoses and inappropriate medication as well as side effects of medications that they did not expect.
- Several consumers mentioned that once in the state hospital they felt as if they were basically ignored.
- Hospital advocates are a good idea, but there is no good system in place to make it happen.

Representative comments:

"[I was] given the wrong meds and the wrong diagnosis." ***(Consumer)***

One individual claimed that he was misdiagnosed as having schizoaffective disorder and put on Haldol. He was TDOd to (the local hospital), then transported to the state hospital. He was heavily medicated at the time and does not remember being transported. He spent five months at the state hospital. He felt that he didn't belong there. His diagnosis was changed to bipolar disorder and he was put on Risperidol and Clozaril, which manage his symptoms. ***(Consumer)***

One woman who was a patient in the hospital reported feeling like she was being ignored by the staff when she was in the hospital on suicide watch. She said that hospital "staff watched TV, played with yarn, and read books." ***(Consumer)***

". . . it can take four to six weeks to talk to the hospital advocate about your concerns." ***(Consumer)***

Theme: "Mental health laws may be 'used'"

- Some consumers used their knowledge of the mental health laws to get treatment, such as threatening or attempting suicide so they would be able to get treatment and medication for their mental illness.
- One consumer self-reported that he was planning to kill a family member so he would be committed to prevent this from happening.

Representative comments:

"My ex-wife got a TDO on me [due to a domestic argument], but I knew that if I went in voluntarily and talked to them that they would let me go. I know how to play the game. I don't want to be medicated . . . so they let me go." ***(Consumer)***

"It was winter. If I tried to kill myself, I'd end up in the hospital or jail. But at least, I wouldn't freeze to death." ***(Consumer)***

Theme: "Mental health laws are not well known or understood"

- Many consumers could not explain the process for an involuntary commitment.
- Some consumers did not think their families understood what the process was for an involuntary commitment.
- Many consumers do not know what advance medical directives related to mental illness might be.

Representative comments:

"People don't know the law. They don't know where to go get help even if they are highly educated."

"There needs to be some way for knowing what will happen, and what their rights are . . ."

Theme: "Mental health laws–relaxing the criteria for 'imminent danger'"

- Some consumers were in favor of relaxing the criteria regarding imminent danger, others were not in favor of it.

Representative comments:

"There needs to be a reallocation of resources . . . Virginia needs a program like in Kendra's Law."
"I am against it. It takes your freedom away . . . "

Theme: "Mental health laws–mandatory, monitored outpatient commitment"

- There was a consensus among participants attending one club house meeting that receiving treatment earlier would be a good thing. They agreed that treatment was needed before they become so ill that they pose a danger to themselves or others—when they might require hospitalization, but for a shorter period of time. They

expressed that this was definitely preferable to experiencing a full-blown relapse that required an extended period in the hospital to regain their stability.
- While some consumers were in favor of mandatory outpatient commitment, others were very opposed to it.
- Consumer opinions were mixed about what is the "right" amount of coercion to ensure that consumers get the treatment they need. These opinions seem to fall somewhat along philosophical lines regarding beliefs about mental illness and/or human rights.

Representative comments:

". . . patients [who] quit taking meds when they leave the inpatient unit. There's no law to make them comply. They are tying up beds for those who want to get better. If you are a repeat customer, they should make them take the meds." ***(Consumer)***

Theme: "Involvement of the family was perceived by some as positive and others as negative"

- Some consumers said that their family made decisions for them about medical treatment that were helpful. Some consumers acknowledged that they had needed to be involuntary committed when psychotic.
- Other consumers did not believe that their family knew what was best for them and were resentful of their involvement in having them committed.
- Some consumers reported lying to their family members and telling them that they were better (fewer symptoms) than was actually the case.
- Some consumers expressed that they would have liked to have had a peer advocate to help them during the process of civil commitment, but *not* their family members.

Representative comments:

"Nobody told me that I could be forced into the hospital when they took be to the ER. I don't remember much about it. My brother was there. No help from him . . . I needed someone to be on *my* side, not just railroad me into a locked ward." ***(Consumer)***

"I didn't want my mother there. A friend who understands would be better." ***(Consumer)***

Theme: "Commitment hearings were not perceived as being fair"

- Most consumers reported wanting the hearing close to their home.
- Most consumers reported preferring the hearing in the hospital, not a court room.
- Hearings may be frightening experiences for consumers who are confused (and often psychotic) during the process. Other consumers reported being angry about the hearing, which made it seem like they were "crazy" when they were just "mad."

- Many consumers, particularly those with court-appointed attorneys, reported that they had not had very good lawyers in commitment hearings, basing their assessment typically on the lack of time preparing the case.
- Some consumers gratefully reported attorneys who worked very hard on their behalf with almost no pay.
- Many consumers reported that their lawyers "did not care" about their cases if they were in jail. Some said that they were "lucky" to get a good attorney who took time on their case.

Representative comments:

"It's pretense . . . more and more lies. Commitment hearings ain't worth squat." "Somebody needs to represent the consumer." ***(Consumer)***

"My doctor should have been allowed to testify, but he wasn't there. . . . " ***(Consumer)***

"My lawyer didn't even ask any questions during the hearing. He just wanted out of there. And that expert evaluator, I didn't ever even talk to her." ***(Consumer)***

"The judge was the only one who listened to what I said." ***(Consumer)***

"I didn't know nothin' about what was going on there." ***(Consumer)***

Theme: "Freedom to choose or denial of mental illness"

- Some consumers said they wanted the freedom not to take medications if they did not like the side effects.
- Some consumers said that they didn't want to take medications because they did not want to be "normal."
- Some consumers said that there was no such thing as mental illness; that they wanted to be left alone if they "didn't hurt anybody."
- When asked if they would be interested in making a choice about how they would be treated if they became ill, most consumers said that they would. However, some consumers said that it would not matter, that it would not make any difference anyway.
- Some consumers express confusion or contempt about the courts ordering drugs to medicate them for a "mental illness" when "they" make it so difficult get other drugs (e.g., marijuana, opiates), which would often be preferred by the consumer for their "mental illness."

Representative comments:

"We should be able to choose which facility to go to." ***(Consumer)***

"I think TDOs are just wrong, because it takes your freedom away." ***(Consumer)***

"They convinced me that I was psychotic, sick, but I don't remember it. I live free now so that is better." ***(Consumer)***

"Get the person to the point that they can participate in what happens to them." ***(Consumer)***

Theme: "Uses of mental health law for malicious purposes"

It is not clear whether the examples below should be cited in the professional or the consumer section of this report. Having talked to these people, it seems likely that one of the parties was a potential consumer of mental health services, but which person is not clear.

- One professional woman who had been married reported that her spouse had tried to get her committed during a divorce, citing that she was suicidal. She had to go through the process even though she had no history of mental illness and was found to be "sane."
- One man who was seeking custody of his children during a divorce got an ECO on his wife to prove that she was "insane" so he could get custody of the children. The wife later sued to retain custody.
- A low-income woman reported that her boyfriend had her arrested for "assaulting him" after she refused to reunite with him after a domestic quarrel.
- One man, age 61, reported that his spouse had gotten a "warrant" out on him saying that he was homicidal during a domestic dispute. Since he was a gun owner, when he discovered that the warrant had been issued, he turned himself in for an evaluation, which took 48 hours. He was released and hired an attorney to sue the spouse.

Other needs

- Some consumers wanted help with housing and finding ways "to make a living." There are many poor, homeless people with mental illness who are a hidden population who are not a "danger to others," so are not noticed.
- Some consumers said that they could not afford to pay for housing and food, much less medication. It is a problem when one tries to get a job, then becomes mentally unstable, loses the job and the insurance. It takes as long as a year to get back on lost government insurance.
- Some consumers say that it is all about money. If you have money, you won't have to go through an involuntary commitment and maybe go to jail first.

Positive Comments from Consumers

When pressed to think of positive outcomes that were separate from the process, a number of consumers were able to report the following "good things" that resulted from civil commitment:

"Getting a place to live"

An *Eastern Region* consumer said that he "ended up getting a place to live with some other people" who have problems similar to his. These problems were not mental illness-related, but were job and housing-related. Several *Central Virginia* homeless consumers, interviewed on the street, mentioned that the "best thing" about being put "in the hospital" or "jail" was getting out of the cold of winter or having food to eat. Another man in the *Eastern Region* said that he was now living in a drop-in center, where, before being committed, he was homeless. ***(Consumer)***

"CSB can be helpful"

One male consumer in the *Northwest Region* said that the CSB PACT team was "great." He said that a 12-member team, made up of a psychiatrist, nurses, social workers, and others worked together to help him find a job and a place to live. They also provided him with therapy every week. He had been in the hospital on a forensic unit for 18 years and was very grateful to have been released. ***(Consumer)***

"Getting an advocate"

A *Northern Region* consumer said that she had an advocate who was "a life saver." ***(Consumer)***

"Getting free mental health treatment"

A consumer in the *Eastern Region* said while he was hospitalized he received medication that helped him; he hadn't been able to get help before being committed for treatment. Two women from the *Central Region,* one who has a history of major depression and PTSD and one who has bipolar disorder, said in separate interviews that being involuntarily committed eventually got them on psychiatric medications, into therapy, and connected with local agencies to help them get job training and find employment. ***(Consumer)***

Summary

This report is submitted so that members of the Committee on Mental Health Law Reform might gain additional information on the issues and themes that are current across stakeholders in the civil commitment process in Virginia. It was not intended to elicit the many positive comments made by individual consumers who are receiving treatment in the community or through contact with the Community Services Boards. Such information is available in other reports and documents. As such, it is important that the reader keep in mind that the information contained in this report focused on issues related to civil commitment and mental health law reform. Other information that is included outside of the focus on the civil commitment process was provided in an effort to place the comments and concerns of the participants of this study into perspective.

End Notes

[1] Edited remarks from the Keynote Address presented on December 9, 2005, in Richmond, Virginia, Conference "Reforming the Involuntary Commitment Process: A Multidisciplinary Effort", sponsored by the Virginia State Bar at the behest of Virginia Chief Justice Leroy Rountree Hassel, Sr.

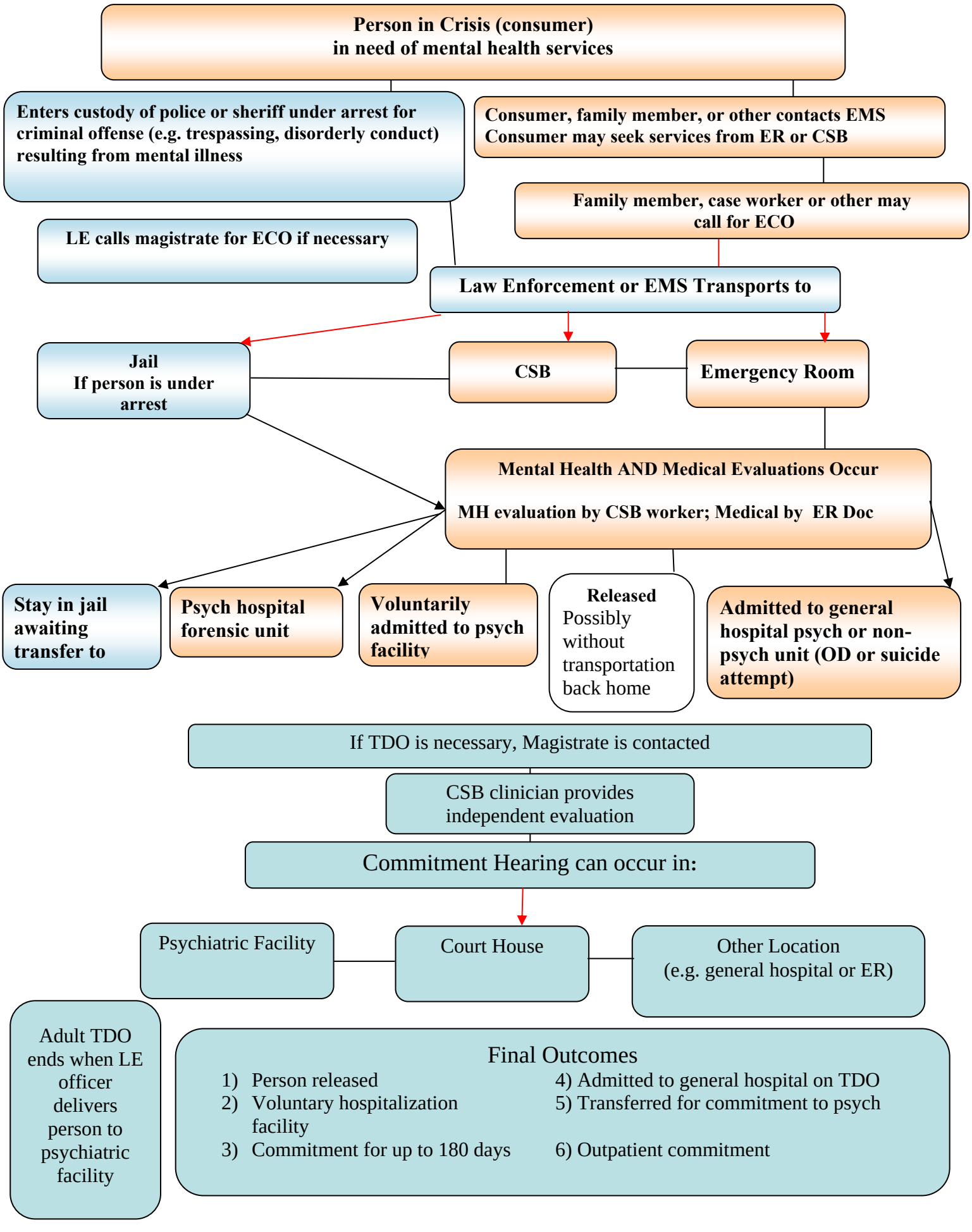
[2] Fact Sheet, Commonwealth of Virginia, Commission on Mental Health Law Reform, 10/11/06.

[3] Cooper, C.P., Jorgensen, C.M., Merit, T.L. (2003) Report from the CDC. Telephone focus groups: An emerging method in public health research. *Journal of Women's Health*. 12(10),945-51.

[4] McGarvey, E.L., Fraser, G., Waite, D., Koopman, C., and McLeod, S. (1999). Inhalant use among adolescents in the U.S.: A study of contextual concerns. *Journal of Substance Use*. 4, 170-177.

APPENDIX A

Flowchart of Consumer in Crisis


Person in Crisis (consumer)
in need of mental health services
Enters custody of police or sheriff under arrest for criminal offense (e.g. trespassing, disorderly conduct) resulting from mental illness
Consumer, family member, or other contacts EMS
Consumer may seek services from ER or CSB
Family member, case worker or other may call for ECO
LE calls magistrate for ECO if necessary
Law Enforcement or EMS Transports to
Jail
If person is under arrest
CSB
Emergency Room
Mental Health AND Medical Evaluations Occur
MH evaluation by CSB worker; Medical by ER Doc
Stay in jail awaiting transfer to
Psych hospital forensic unit
Voluntarily admitted to psych facility
Released
Possibly without transportation back home
Admitted to general hospital psych or non-psych unit (OD or suicide attempt)
If TDO is necessary, Magistrate is contacted
CSB clinician provides independent evaluation
Commitment Hearing can occur in:
Psychiatric Facility
Court House
Other Location
(e.g. general hospital or ER)
Adult TDO ends when LE officer delivers person to psychiatric facility
Final Outcomes
1) Person released
2) Voluntary hospitalization facility
3) Commitment for up to 180 days
4) Admitted to general hospital on TDO
5) Transferred for commitment to psych
6) Outpatient commitment

APPENDIX B

Summary of Themes by Consumer Points of Contact with the System

THEMES BY CONSUMER POINTS OF CONTACT

Qualitative research methods were used to obtain information from all stakeholders groups on the process of involuntary commitment in Virginia. An evaluation team consisting of university researchers and numerous expert consultants collected data during the months of October 2006 through January 2007. The results are loosely organized around the flow of consumers into the system and highlight the main findings.

First Contact with Consumers in Crisis

1. **Person in Crisis (see appendix A)**. Consumers seeking and receiving mental health services in Virginia include people from all races, ethnic, and socioeconomic groups. Some issues are the same across groups. Others—such as the availability or lack of strong family and/or social supports—can profoundly affect the consumer's experience of the process. Based on the comments and discussions among stakeholders groups, it appears that consumers with good family/social supports have the advantage of having unpaid "advocates" to help them (a) maneuver the complexities of the criminal justice system, making it less likely that they will serve jail time because of odd, aggressive, disruptive, or inappropriate public behavior that is symptomatic of their mental illness, (b) maneuver the complexities of the mental health system to get treatment (e.g., identify who to call for help), and (c) maneuver the complexities of the insurance system (e.g., facilitate private or public coverage) to increase the available treatment options or ensure payment for care. By contrast, it appears that those who are without family/social supports, such as homeless persons and individuals who are estranged from family by virtue of their illness, tend to have no such advocates. These consumers seem to be more likely to be incarcerated, where they eventually may be evaluated and receive treatment for their mental illness or may simply be held, undergo no assessment or treatment, and then released back onto the street. It appears that mentally ill consumers with good financial resources and strong family/social supports are less likely to experience an extended period of incarceration prior to receiving evaluation and treatment. However, consumers across groups may be at some risk of jail time because of the pervasive lack of education, understanding, and resources available to individuals with serious mental illness. Issues that emerged in discussions about the experiences of individuals confronting a mental health crisis include:
    a. The stigma of mental illness. "Stigma refers to the negative effects of a label placed on any group" (Hayward & Bright, 1997).[3] There is lack of public and professional (e.g., law enforcement, others) awareness that mental illness is a disorder of the brain, a *medical* illness that can be treated and managed with varying degrees of success. Unlike other serious, chronic illnesses, mental illness, by virtue of its observable behavioral symptoms, stigmatizes those who suffer from it, carries with it negative judgments, and engenders unwarranted fear and ostracism, which impacts the treatment consumers receive during a mental health crisis as well as their day-to-day experience of their illness.
    b. Lack of awareness of immediately available community resources to address the needs of a person experiencing a serious mental health crisis that might involve psychotic delusions or self-harming or aggressive behaviors.

c. Lack of nearby community mental health resources to safely and effectively manage a mental health crisis.
d. Lack of mobile crisis units staffed by mental health professionals who can be called to evaluate *and treat* a person in crisis on site in their home or in the community, at times obviating the need for hospitalization or the involvement of law enforcement.
e. Lack of adequate treatment options in the consumer's community so that deterioration might be averted and crisis hospitalization would be less likely.
f. Lack of understanding that for many consumers, mental illness is a chronic disease that will need to be managed over time to reduce the likelihood of relapse and hospitalization.
g. Lack of consumer input on treatment options. Unless a consumer has been offered the opportunity to sign an "Advance Mental Health Care Medical Directive," his or her preferred course of treatment is unlikely to be known and/or carried out during a mental health crisis.
h. Use of law enforcement to "manage" an individual experiencing a mental health crisis. Families often call law enforcement when they cannot "control" a family member who is experiencing an exacerbation of symptoms and exhibiting aggressive, self-harming, or dangerous behaviors (i.e., attempting to abscond from care).
i. Involvement of concerned citizens. Community members tend to call law enforcement when they observe consumers in public areas exhibiting symptoms of mental illness that suggest the potential for, or likelihood of, harm to self, others, or the inability to care for self.

2. **Arrival of Law Enforcement Personnel**

a. Law enforcement officers are not adequately trained to respond to crises involving individuals with serious mental illness.
b. Law enforcement officers rarely are adequately trained to recognize the symptoms of mental illness, including the attendant illegal acts (i.e., trespassing, creating a public disturbance, breaking and entering) that precipitate police involvement.
c. Law enforcement officers report feeling compelled to serve as de facto "mental health workers," a role they do not feel adequately trained for and would prefer not to take on. They consistently voiced a desire to focus on public safety issues. However, when called on to deal with an individual experiencing a mental health crisis, they try to do the job as best they can.
d. Law enforcement officers have the job of transporting consumers to processing centers (i.e. community services boards (CSBs), mental health clinics, emergency rooms, or jails) and to call the magistrate to obtain an Emergency Custody Order (ECO) when necessary.
e. Throughout the state, law enforcement officers expressed concerns that there are inadequate numbers of law enforcement personnel to handle the transportation of consumers to inpatient treatment facilities and to adequately ensure public safety in their communities.

f. Police and sheriff departments are inadequately reimbursed for the services they provide in the supervision, care, and transportation of mentally ill consumers.
g. Most consumers expressed "feeling like criminals" or being "treated like criminals" due to the involvement of law enforcement during their mental health crisis. There is a consensus among consumers that law enforcement officers are not wanted or, in most cases, appropriate during a mental health crisis.
h. Many families of consumers recognize that the involvement of law enforcement is associated with criminalizing mental illness, but are frustrated by a lack of options when faced with a crisis.

Detention and Evaluation

3. Incarceration of Mentally Ill People

a. Law enforcement officers recognize that a significant, but undetermined, number of individuals who are incarcerated are mentally ill and are in jail, in part, because of the overt behavioral symptoms of their illness or illegal acts they have committed as a result of their illness.
b. Most jails do not have sufficient resources to evaluate and provide appropriate treatment to inmates with mental illness who have committed illegal acts as a result of their illness.
c. Jail and prison staff are not adequately trained to recognize or deal with persons with serious mental illness.
d. Ministers in jails report the problem to the facility's administration but often feel helpless to do anything about it.
e. Some mentally ill persons prefer being in jail to being homeless.

4. Obtaining the ECO from the Magistrate

a. Family members of consumers: Families report that magistrates' decisions are not always driven by a consumer's clinical presentation. Some family members object that magistrates do not take into account the expressed concerns of family members, based on experience with their loved one and knowledge of their mental health issues and treatment history. Families across the regions report very different experiences with specific magistrates. Some of the interactions are very positive, other very negative.
b. Psychiatrists: Some psychiatrists reported problems when magistrates disagree with their clinical assessment of a consumer and make clinical decisions that they have not been trained to make. They expressed concern that some, but definitely not all, magistrates overstep their authority with regard to determining the need for ECOs and Temporary Detaining Orders (TDOs) (i.e, basing it on the availability of an inpatient bed rather than a consumer's clinical need for treatment).

c. Lack of beds: Magistrates seem to be trying to do a good job, but the lack of beds becomes a barrier preventing consumers from receiving needed help during a mental health crisis.

5. Time

a. With the exception of consumers, there seems to be a consensus across groups that the time limit on ECOs is too short and an obstacle to obtaining necessary treatment.

b. Temporary Detention Order (TDO), issued by special justice, allows for a period of up to 96 hours (i.e., 48 plus weekend) in the hospital. This may not provide sufficient time to transport consumers to a treatment facility located at some distance from the consumer's home locality.
c. Law enforcement transports person to the hospital if no other transportation is available (The law enforcement's involvement in the TDO ends when he delivers a person to a psychiatric facility.)
d. Hospital hearings work "fairly well".

6. Emergency Department, Mental Health Clinic, and CSB for Evaluations

a. Throughout stakeholders groups, there was a consensus that the CSB staff appear to do a good job in conducting evaluations. Lack of funding for evaluations continues to be a major problem, resulting in case loads that are often too large to be manageable.
b. Lack of uniformity in criteria for medical clearance. Admitting psychiatric facilities do not require the same tests prior to approving a consumer's admission. As a result, ER physicians may not know what tests or procedures the medical clearance should include, resulting in delays in treatment and complicating transportation and placement when additional tests are required.
c. Psychiatrists are not adequately reimbursed.
d. Independent evaluators are not adequately reimbursed.
e. Independent evaluators may not also conduct an extensive evaluation of the person but may rely on notes only.

7. Mental Health and Medical Evaluation Occur

a. Patients must be evaluated for medical issues.
b. No beds. Across stakeholders groups, the lack of available beds for consumers requiring inpatient psychiatric treatment was cited repeatedly as a critical and growing problem, as psychiatric beds continue to be eliminated throughout the Commonwealth.

Hearings

8. Attorney Is Retained or Appointed

a. Low pay. Court-appointed attorneys stated that they are not sufficiently compensated for the time it takes to prepare an adequate case and represent a mentally ill client.
b. Time issues cited included case preparation and transportation to the location of the hearing, neither of which are judged to be adequate or adequately compensated (see above).
c. Consumer may not fully understand the process or his/her rights.

9. Commitment Hearing is Held

a. Families express concern that their input regarding their loved one's history, presentation, and treatment is ignored.
b. Hearings are held in psychiatric hospitals, courthouses, hospitals, and other locations.
c. Consumers may wait for the hearing in inadequate "holding rooms."

10. Outcomes of Hearings Including the Following:

a. Outcomes: consumer is released, admits self voluntarily to a psychiatric facility, or is involuntarily committed for inpatient treatment.
b. Lack of resources in the community to develop and support an effective system of outpatient commitment leaves judges with few options but to admit consumers for more intensive hospital treatment or release them, mandating treatment that is typically reported to be not enforceable once the consumer leaves the hearing. Judges have few options regarding ordering outpatient commitment because of the lack of community resources.
c. When consumers are released from the hospital, their families have no leverage to ensure that they receive treatment.
d. At present, there appears to be no way to adequately enforce mandated outpatient commitment.
e. The system is a "revolving door" with consumers going in and out of the system at all points, but not getting continuity of care.

Related Issues

11. Hospital-Related Issues

a. Hospital admissions staff claim that there are no available beds for patients who are aggressive.

b. Hospitals maintain informal “do not admit” lists for repeat patients who present with challenging behaviors.
c. HIPAA regulations prevent families from obtaining information about the status or treatment of their loved one if that person is age 18 or older.
d. Consumers are “kicked out” when their insurance coverage ends even if they are not yet stabilized on their medication.
e. Inadequate compensation for doctors and independent evaluators who provide assessment and treatment.

12. Insurance-Related Issues

a. Insurance reimbursements are too low, including Medicaid.
b. Too much red tape-delays payments, etc.
c. “ Pressure by HMOs, all private, state, federal insurance to get patients out of the hospital to save/make money, even when not in best interest of patient.”

APPENDIX C

Commonwealth of Virginia
Commission on Mental Health Law Reform
Fact Sheet

Commonwealth of Virginia
Commission on Mental Health Law Reform
Fact Sheet

Membership: The 26-member Commission on Mental Health Law Reform was appointed by the Chief Justice of the Supreme Court of Virginia, Leroy Rountree Hassell, Sr., in October, 2006. The Commission is chaired by Professor Richard J. Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia. Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups, including consumers and their families, service providers, and the bar. The Commission is assisted by five task forces who will address gaps in access to services, involuntary civil commitment, consumer empowerment, special needs of children and adolescents, and intersections between the mental health and criminal justice systems.

Funding: The Commission is an initiative of the Supreme Court of Virginia and is funded by the Supreme Court. The Commission's research is supported by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Charge: The Commission will conduct a comprehensive examination of Virginia's mental health laws and services and will study ways to use the law more effectively to serve the needs of people with mental illness, while respecting the interests of their families and communities.

Goals of the study include reducing the need for commitment by improving access to mental health, mental retardation and substance abuse services, reducing criminalization of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers of mental health services to have more choice over the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

Process: Meetings of the Commission will he held on October 12-13 (Williamsburg), December 8 (Charlottesville), March 15-16, 2007 (Charlottesville), June 21-22, 2007 (Fredericksburg), and a date to be designated in October, 2007 (Richmond).

Product: The Commission aims to complete its study and submit its final report in October, 2007. It is anticipated that legislative proposals based on the Commission's recommendations will be prepared for the 2008 session of the General Assembly.

Further Information:

Thomas M. Diggs, Commission Staff Director and Assistant Director of Judicial Programs, Supreme Court of Virginia, 804-225-3474, 804-786-4542 (fax), tmdiggs@courts.state.va.us;

Katya Herndon, Director of Legislative and Public Relations, Supreme Court of Virginia, 804-786-7595, 804-786-4542 (fax) kherndon@courts.state.va.us.

Both are at 100 North Ninth Street, Third Floor, Richmond, Virginia 23219

10/11/06

APPENDIX D

Interview Guide for Focus Groups

UVA, Department of Public Health Science

Elizabeth L. McGarvey, Ed.D.
Associate Professor
P.O. Box 800717, Charlottesville, VA 22908-0717
Rel8s@virginia.edu

Interview Guide for Focus Groups on the Virginia Civil Commitment Process

General and specific questions

for multiple stakeholder groups

Focus Group: Consumers

Discussion guidelines and questions for focus groups comprised of consumers and their family members.

Introduction

Following introductions of the PI and Team, the PI will begin the discussion: "We are here today/tonight to talk about ways to provide better mental health services for people in Virginia. The Chief Justice of the Virginia Supreme Court has established the Commission on Mental Health Law Reform to make recommendations about improving the quality of services that are available and to make sure that the people who need these services receive them. We think that the best people to advise the Commission are the people who use these services. So, we want your feedback on what services are needed, what the problems are with the current system, and the best ways to fix those problems so the system meets people's needs. That is why we are here.

"Tonight, we would like to talk with you about the mental health service system in your area. We are particularly interested in your thoughts about involuntary civil commitment. This is the process of being committed to a local or state hospital when one is evaluated by a mental health professional and judged to be a danger to oneself or others. We are talking to people around the state and are putting together a report for the Commission on Mental Health Law Reform that will reflect your concerns, ideas, and suggestions.

"We are guided by the principle that people who need services should be able to get them, that they should have a choice in the care that they receive, and that they and others should be protected from harm. Mental health services should be available to all Virginians who need them, regardless of their age, race, ethnic background, where they live in the state, or how much money they make. We hope that you share your ideas and suggestions with us about ways to improve the current system. This is your opportunity to be heard. And we are here to listen."

Questions

1. Based upon your experience, what do you think works well in the current system of involuntary commitment in Virginia?

2. In your opinion, what are the most serious problems with the process of civil commitment process?

3. What are the most serious problems or special issues faced by families of the consumer of mental health services related to the involuntary commitment process?

4. What is the first thing that would you like to see changed (improved?) about the civil commitment process? Do you feel that your rights were respected/violated? How? At what point in the process? How could it have been handled differently/better?

5. As a consumer, do you have any concerns about how you were treated during the commitment process?

6. Do you think that people should be committed involuntarily if they are willing to be committed and treated on a voluntary basis? Do you see this as a problem? Please explain.

7. How could the rights of consumers be better protected during the civil commitment process? Please give an example.

8. In your opinion, how easy it is to get mental health services in your community? How long is the waiting period to:

    - See a psychiatrist?
    - See a counselor?
    - See a case manager?
    - Get into group therapy?
    - Receive mental health support services or PACT?
    - Be admitted to clubhouse or day support program?

9. Do you think that the availability of community resources is related to the civil commitment process? If so, how?

10. Whose responsibility do you think it is to make sure that people who need mental health services get them, whether voluntary or involuntary?:

    - Federal government?
    - State government?
    - Local government?
    - Friends?
    - Families?
    - The person who needs services?
    - Others?

11. What is the best way to help people with serious problems get the treatment they need while respecting their rights?

12. In your opinion, what would be the best way to measure how well the civil commitment system works?

13. Please tell one story of a civil commitment case that has involved you or a family member personally.

14. How often do you see your psychiatrist, counselor, case manager? Would you prefer to him/her less often? More often? How would that be helpful for you?

Focus Group: Professionals

Discussion guidelines and questions for focus groups comprised of professionals; i.e., hospital staff, judges, special justices, CSB personnel, law enforcement personnel, mental health care professionals, and others.

Introduction

Following introductions of the PI and Team, the PI will begin the discussion: "First, we want to thank you for joining us today to talk about ways to improve mental health services for people in Virginia, particularly with regard to the involuntary commitment process.

"The Chief Justice of the Virginia Supreme Court has established the Commission on Mental Health Law Reform to make recommendations about improving the quality of services that are available and to make sure that the people who need these services receive them. As part of this process, we are interviewing selected individuals from all the stakeholder groups to gather opinions and to identify key issues. The stakeholders are the consumers (aka; patients), families of consumers, magistrates, sheriffs and police, hospital personnel, health care professionals, psychologists, psychiatrists/ER physicians, attorneys, community services board staff (e.g., emergency services managers), special justices, and judges as well as members of various advocacy groups (like the National Association for the Mentally Ill.)

"The specific purpose of the call today is for each of you to participate in the discussion on what you think are key issues, problems, and perhaps possible solutions. We do not need identifying information from anyone, but what region of the state you are from would be helpful since we know that there are regional differences in many areas.
"First, let's go around and share which region you are in and what your specific responsibilities are with regard to involuntary commitments."

General Questions

(To be asked members of all professional focus groups)

1. Based upon your experience, what do you think works well in the current system of involuntary commitment in Virginia?

2. What do you think is the number-one problem overall with the civil commitment process?

3. What do you feel is the biggest problem for (members of your profession) with regard to how the involuntary civil commitment process currently works?

4. What would you like to see changed to improve the process?

5. In your opinion, how would (members in your profession) be involved in an ideal involuntary commitment system?

6. Is there any type of training that you do not currently receive that would be helpful to you in dealing with any aspects of the current involuntary commitment process?

7. ** The following question to be asked of all focus groups, other than judges/special justices:* What do you think would be the effect of loosening the criteria for an involuntary commitment? Perhaps omitting the word "imminent" as suggested by some family members of patients, mental health workers, and others? As you know, the law states the criteria for involuntary commitment to be:

[NOTE: If the person "presents an imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to substantially be unable to care for self, and the person is incapable of volunteering or unwilling to volunteer for treatment)" then, an ECO (Emergency Custody Order) can be executed to hold the person for 4 hrs. until a TDO (Temporary Detention Order) can be issued. TDOs are good for 48 hours, but if the 48 hours ends on a weekend (Saturday, Sunday, or a holiday), the person may be detained until the next day which is not a Saturday, Sunday, or a holiday.]

***Other Issues?

Attorney-specific questions
(In addition to the general questions)

1. If you could change one statute of the current Mental Health Law, which one would it be?

2. Do you think that most clients who are under consideration for an involuntary commitment are adequately represented by MOST attorneys?

CSB-specific questions
(In addition to the general questions)

1. What is your involvement, if any, with people in jail who have mental illness (and substance abuse problems) in your professional capacity at the CSB?

    - How easy or difficult is it to provide adequate mental health services to people in your general area?

    - Do you think most CSB clinicians have adequate training with regard to the process of involuntary commitment?

2. What is your opinion of how well mandated, court-ordered involuntary outpatient treatment would work?

Hospital personnel-specific questions
(In addition to the general questions)

1. If you could change one statute of the current Mental Health Law, which one would it be?

2. How much involvement do you have with people who might have been arrested who have mental illness (and/or substance abuse disorders) and need to be committed for psychiatric evaluation and care?

Judges/special justices-specific questions
(In addition to the general questions)

1. If you could change one statute of the current Mental Health Law, which one would it be?

2. Do you think that most clients who are under consideration for an involuntary commitment are adequately represented by MOST attorneys?

3. How do you think that the criteria for emergency custody, evaluation, and treatment could be modified to improve the system? For example, do you think eliminating the "imminence" requirement, allowing civil intervention for acutely psychotic individuals whose impaired functioning is manifested by criminal conduct would be an improvement to the system?

[NOTE: If the person "presents an imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to substantially be unable to care for self, and the person is incapable of volunteering or unwilling to volunteer for treatment)" then an ECO (Emergency Custody Order can be executed to hold the person for 4 hrs. until a TDO (Temporary Detention Order) can be issued. TDOs are good for 48 hours, but if the 48 hours ends on a weekend (Saturday, Sunday, or a holiday), the person may be detained until the next day which is not a Saturday, Sunday, or a holiday.]

4. How helpful do you think it would be to extend the period of evaluation for ECO and TDOs to 4 or 5 days, accompanied by a "preliminary hearing" by an independent clinical evaluator?

5. What do you think about changes to the code to permit outpatient treatment orders in cases involving demonstrable deterioration in persons with prior history of hospitalization and deterioration?

6. In your opinion, what other ways could safe and efficient transportation during the evaluation and commitment process be accomplished other than by the sheriffs?

7. Do you think that judges, attorneys and clinicians have sufficient training to promote <u>consistent interpretation and administration</u> of the mental health law?

8. How can severely mentally ill offenders be diverted from the criminal justice system before or after arrest?

9. What do you think about mental health courts? Would they be effective?

10. What do you think about a mandated monitored involuntary outpatient treatment?

Magistrate-specific questions
(In addition to the general questions)

1. How much of a problem do you think that mental illness (and substance abuse) among people who are arrested and jailed might be?

- How easy is it to get mental health services in your general area?
- How difficult is it to get people assessed for mental illness and then referred to treatment if needed?

2. Do you think that there is a relationship between the availability of mental health resources and civil commitment? If so, how?

Psychiatrist-specific questions
(In addition to the general questions)

1. What is your opinion of how well mandated, court-ordered involuntary outpatient treatment would work?
2. Where are the mentally ill persons kept while waiting for the decision on involuntary commitment? Is this typically adequate?
3. How difficult is it to distinguish among those who are mentally ill ONLY and those who have criminal behaviors ONLY or those who have both?
4. Without changing the situation, how well do you think that the most seriously ill could be treated in the community? Scale of 0 = not at all to 10 = extremely well.
5. What changes would be needed to adequately facilitate mandated community outpatient treatment?
6. Are you aware if there are enough immediate resources if a patient is ordered for outpatient treatment?
7. What mechanisms are in place to permit doctors to medicate objecting patients BEFORE the TDO? Do you think many doctors do this?
8. Do most doctors know the proper medication to provide considering the civil commitment process?
9. Have you seen or heard of special justices/ judges who tell the patient that they will go to jail unless they comply with orders to take medication? Is this a problem?
10. Do you see any other issues and do you have other ideas for creating a “perfect system”?
11. Are you aware of other states that do it better? If so, please explain.

Sheriff-specific questions
(In addition to the general questions)

1. How much of a problem do you think that mental illness (and substance abuse) among people who are arrested and jailed might be?
    - How easy is it to get mental health services in your general area?
    - How difficult is it to get jailed people assessed for mental illness and then referred to treatment if needed?
2. Do you think that there is a relationship between the availability of mental health resources and civil commitment? If so, how?

Additional Information

Some notes about this project.

Method

Note takers will take notes from the responses of those on the conference call. Speakers will be identified by number to distinguish points made among different speakers.
Each telephone focus group will have a moderator who will lead the session. Research assistants will record the key points and comments on a computer or with paper and pen. No tape recording will be permitted. Dr. McGarvey will lead most of the telephone groups from a private office in the Department of Public Health Sciences on the 3rd floor of Hospital West. All participants will be recruited as volunteers based on their expertise with civil commitments and interest in the project. Only general demographic information will be obtained from those who volunteer to participate. The demographic information collected will be (1) region of the state where the person speaking resides, (2) male or female, (3) number of years working in the field. If additional questions are added to the list above, they will be submitted as a modification to the protocol.

Outcome

We will analyze the content of the information that is provided by the stakeholders in the Civil Commitment process in Virginia and summarize the recommendations in the form of a report to be provided to the Commission of Mental Health Law Reform. Information obtained in the needs assessment will be analyzed by Dr. McGarvey. Dr. McGarvey has worked within the mental health and justice system in Virginia for over 15 years. She has conducted numerous needs assessments for state agencies, and has worked closely on mental health issues in the juvenile justice arena. She has held NIH and other federal funded grants. She has published in this area. There is no identifying information obtained in these data. A computer in Dr. McGarvey's office will be used to write the final report. Anyone interested is welcome to the information. Anonymous data will be available to anyone interested.

Focus Group Interview References

1. Philip Kotler, *Strategic Marketing for Non-Profit Organizations*. Third Edition. (Englewood Cliffs, N.J.: Prentice-Hall, 1987)

2. Richard A. Krueger, Focus *Groups: A practical guide for applied research*. Second Edition. (Newbury Park, CA: Sage Publications, 1994)

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4. David L. Morgan & Richard A. Krueger, *The Focus Group Kit*. (Thousands Oaks, CA: Sage Publications, 1998)

5. Michael Quinn Patton. *How To Use Qualitative Methods in Evaluation*. (Newbury Park, CA: Sage Publications, 1987)

APPENDIX E

Mental Health Law: Title 37.2-808-37.2-849

MENTAL HEALTH LAW: TITLE 37.2-808-37.2-847

The information below was obtained from the Virginia General Assembly Legislative Information System. It is included to provide an easy reference to the Mental Health Code of Virginia.

"37.2-808. Emergency custody; issuance and execution of order.

A. Any magistrate may issue, upon the sworn petition of any responsible person or upon his own motion, an emergency custody order when he has probable cause to believe that any person within his judicial district (i) has mental illness, (ii) presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself, (iii) is in need of hospitalization or treatment, and (iv) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.

B. Any person for whom an emergency custody order is issued shall be taken into custody and transported to a convenient location to be evaluated to assess the need for hospitalization or treatment. The evaluation shall be made by a person designated by the community services board or behavioral health authority who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by the Department.

C. The magistrate issuing an emergency custody order shall specify the primary law-enforcement agency and jurisdiction to execute the emergency custody order and provide transportation. Transportation under this section shall include transportation to a medical facility as may be necessary to obtain emergency medical evaluation or treatment. This evaluation or treatment shall be conducted immediately in accordance with state and federal law.

D. The magistrate shall order the primary law-enforcement agency from the jurisdiction served by the community services board or behavioral health authority that designated the person to perform the evaluation required in subsection B to execute the order and provide transportation. If the community services board or behavioral health authority serves more than one jurisdiction, the magistrate shall designate the primary law-enforcement agency from the particular jurisdiction within the community services board's or behavioral health authority's service area where the person who is the subject of the emergency custody order was taken into custody or, if the person has not yet been taken into custody, the primary law-enforcement agency from the jurisdiction where the person is presently located to execute the order and provide transportation.

E. A law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing an emergency custody order pursuant to this section.

F. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization or treatment without prior authorization. Such evaluation shall be conducted immediately.

G. Nothing herein shall preclude a law-enforcement officer from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

H. The person shall remain in custody until a temporary detention order is issued or until the person is released, but in no event shall the period of custody exceed four hours.

I. If an emergency custody order is not executed within four hours of its issuance, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if such office is not open, to any magistrate thereof.

(1995, c. 844, § 37.1-67.01; 1996, c. 893; 1998, c. 611; 2004, c. 737; 2005, c. 716.)”

§ 37.2-809. Involuntary temporary detention; issuance and execution of order.

A. For the purposes of this section:

"Designee of the local community services board" means an examiner designated by the local community services board or behavioral health authority who (i) is skilled in the assessment and treatment of mental illness, (ii) has completed a certification program approved by the Department, (iii) is able to provide an independent examination of the person, (iv) is not related by blood or marriage to the person being evaluated, (v) has no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment interest in the facility detaining or admitting the person under this article, and (vii) except for employees of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.

"Employee" means an employee of the local community services board or behavioral health authority who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department.

"Investment interest" means the ownership or holding of an equity or debt security, including shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other equity or debt instruments.

B. A magistrate may issue, upon the sworn petition of any responsible person or upon his own motion and only after an in-person evaluation by an employee or a designee of the local community services board, a temporary detention order if it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has mental illness, (ii) presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself, (iii) is in need of hospitalization or treatment, and (iv) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.

C. A magistrate may issue a temporary detention order without an emergency custody order proceeding. A magistrate may issue a temporary detention order without a prior in-person evaluation if (i) the person has been personally examined within the previous 72 hours by an employee or a designee of the local community services board or (ii) there is a significant

physical, psychological, or medical risk to the person or to others associated with conducting such evaluation.

D. An employee or a designee of the local community services board shall determine the facility of temporary detention for all individuals detained pursuant to this section. The facility of temporary detention shall be one that has been approved pursuant to regulations of the Board. The facility shall be identified on the preadmission screening report and indicated on the temporary detention order. Except as provided in § 37.2-811 for defendants requiring hospitalization in accordance with subdivision A 2 of § 19.2-169.6, the person shall not be detained in a jail or other place of confinement for persons charged with criminal offenses.

E. Any facility caring for a person placed with it pursuant to a temporary detention order is authorized to provide emergency medical and psychiatric services within its capabilities when the facility determines that the services are in the best interests of the person within its care. The costs incurred as a result of the hearings and by the facility in providing services during the period of temporary detention shall be paid and recovered pursuant to § 37.2-804. The maximum costs reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention.

F. The employee or the designee of the local community services board who is conducting the evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention order, the insurance status of the person. Where coverage by a third party payor exists, the facility seeking reimbursement under this section shall first seek reimbursement from the third party payor. The Commonwealth shall reimburse the facility only for the balance of costs remaining after the allowances covered by the third party payor have been received.

G. The duration of temporary detention shall not exceed 48 hours prior to a hearing. If the 48-hour period herein specified terminates on a Saturday, Sunday, or legal holiday, the person may be detained, as herein provided, until the next day that is not a Saturday, Sunday, or legal holiday.

H. If a temporary detention order is not executed within 24 hours of its issuance, or within a shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if the office is not open, to any magistrate thereof. Subsequent orders may be issued upon the original petition within 96 hours after the petition is filed. However, a magistrate must again obtain the advice of an employee or a designee of the local community services board prior to issuing a subsequent order upon the original petition. Any petition for which no temporary detention order or other process in connection therewith is served on the subject of the petition within 96 hours after the petition is filed shall be void and shall be returned to the office of the clerk of the issuing court.

I. The chief judge of each general district court shall establish and require that a magistrate, as provided by this section, be available seven days a week, 24 hours a day, for the purpose of performing the duties established by this section. Each community services board or

behavioral health authority shall provide to each general district court and magistrate's office within its service area a list of its employees and designees who are available to perform the evaluations required herein.

(1974, c. 351, § 37.1-67.1; 1975, cc. 237, 433; 1976, c. 671, § 37.1-67.4; 1980, c. 582; 1981, cc. 233, 463; 1982, c. 435; 1986, cc. 134, 478, 629; 1987, c. 96; 1988, c. 98; 1989, c. 716; 1990, cc. 429, 728; 1991, c. 159; 1992, c. 566; 1995, c. 844; 1996, cc. 343, 893; 1998, cc. 37, 594, 611; 2004, c. 737; 2005, c. 716.)

§ 37.2-810. Transportation of person in the temporary detention process.

A. The magistrate issuing the temporary detention order shall specify the law-enforcement agency and jurisdiction that shall execute the temporary detention order and provide transportation. The magistrate shall specify in the temporary detention order the law-enforcement agency of the jurisdiction in which the person resides to execute the order and provide transportation. However, if the nearest boundary of the jurisdiction in which the person resides is more than 50 miles from the nearest boundary of the jurisdiction in which the person is located, the law-enforcement agency of the jurisdiction in which the person is located shall execute the order and provide transportation. The order may include transportation of the person to such other medical facility as may be necessary to obtain emergency medical evaluation or treatment prior to placement. Nothing herein shall preclude a law-enforcement officer from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section. Such evaluation or treatment shall be conducted immediately in accordance with state and federal law.

B. A law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing any temporary detention order pursuant to this section. Law-enforcement agencies may enter into agreements to facilitate the execution of temporary detention orders and provide transportation.

(1974, c. 351, § 37.1-67.1; 1975, cc. 237, 433; 1976, c. 671; 1980, c. 582; 1981, c. 463; 1986, cc. 478, 629; 1987, c. 96; 1988, c. 98; 1989, c. 716; 1990, cc. 429, 728; 1991, c. 159; 1992, c. 566; 1995, c. 844; 1996, cc. 343, 893; 1998, cc. 37, 594, 611; 2004, c. 737; 2005, c. 716.)

§ 37.2-811. Emergency treatment of defendants prior to trial.

A. In any case in which temporary detention is ordered pursuant to § 37.2-809 upon petition of a person having custody of a defendant in accordance with subdivision A 2 of § 19.2-169.6, the magistrate executing the temporary detention order shall place the person in a hospital designated by the Commissioner as appropriate for treatment and evaluation of persons under a criminal charge or, if such facility is not available, the defendant shall be detained in a jail or other place of confinement for persons charged with criminal offenses and shall be transferred to such hospital as soon as possible thereafter.

B. The hearing shall be held, upon notice to the attorney for the defendant, either (i) before the court having jurisdiction over the defendant's case or (ii) before a district court judge or special justice in accordance with the provisions of § 37.2-820, in which case the defendant shall be represented by counsel as specified in § 37.2-814.

(1974, c. 351, § 37.1-67.1; 1975, cc. 237, 433; 1976, c. 671; 1980, c. 582; 1981, c. 463; 1986, cc. 478, 629; 1987, c. 96; 1988, c. 98; 1989, c. 716; 1990, cc. 429, 728; 1991, c. 159; 1992, c. 566; 1995, c. 844; 1996, cc. 343, 893; 1998, cc. 37, 594, 611; 2004, c. 737; 2005, c. 716.)

37.2-812. Temporary detention and involuntary admission of minors.

In any case in which temporary detention is ordered pursuant to § 37.2-809 upon petition for involuntary admission of a minor, the petition shall be filed and the hearing scheduled in accordance with the provisions of § 16.1-341.

(1974, c. 351, § 37.1-67.1; 1975, cc. 237, 433; 1976, c. 671; 1980, c. 582; 1981, c. 463; 1986, cc. 478, 629; 1987, c. 96; 1988, c. 98; 1989, c. 716; 1990, cc. 429, 728; 1991, c. 159; 1992, c. 566; 1995, c. 844; 1996, cc. 343, 893; 1998, cc. 37, 594, 611; 2004, c. 737; 2005, c. 716.)

§ 37.2-813. Release of person prior to commitment hearing for involuntary admission.

Prior to a hearing as authorized in §§ 37.2-814 through 37.2-819 or § 16.1-341, the district court judge or special justice may release the person on his personal recognizance or bond set by the district court judge or special justice if it appears from all evidence readily available that the person will not pose an imminent danger to himself or others. In the case of a minor, the juvenile and domestic relations district court judge may release the minor to his parent. The director of any facility in which the person is detained may release the person prior to a hearing as authorized in §§ 37.2-814 through 37.2-819 or § 16.1-341 if it appears, based on an evaluation conducted by the psychiatrist or clinical psychologist treating the person, that the person would not present an imminent danger to himself or others if released.

(1974, c. 351, § 37.1-67.1; 1975, cc. 237, 433; 1976, c. 671; 1980, c. 582; 1981, c. 463; 1986, cc. 478, 629; 1987, c. 96; 1988, c. 98; 1989, c. 716; 1990, cc. 429, 728; 1991, c. 159; 1992, c. 566; 1995, c. 844; 1996, cc. 343, 893; 1998, cc. 37, 594, 611; 2004, c. 737; 2005, c. 716.)

§ 37.2-814. Commitment hearing for involuntary admission; written explanation; right to counsel; rights of petitioner.

A. The commitment hearing for involuntary admission shall be held within 48 hours of the execution of the temporary detention order as provided for in § 37.2-809; however, if the 48-hour period herein specified terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the person may be detained, as herein provided, until the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed.

B. At the commencement of the commitment hearing, the district court judge or special justice shall inform the person whose involuntary admission is being sought of his right to apply for voluntary admission and treatment as provided for in § 37.2-805 and shall afford the person an opportunity for voluntary admission. The judge or special justice shall ascertain if the person is then willing and capable of seeking voluntary admission and treatment. If the judge or special justice finds that the person is capable and willingly accepts voluntary admission and treatment, the judge or special justice shall require him to accept voluntary admission for a minimum period of treatment not to exceed 72 hours. After such minimum period of treatment, the person shall give the hospital 48 hours' notice prior to leaving the

hospital. During this notice period, the person shall not be discharged except as provided in § 37.2-837, 37.2-838, or 37.2-840. The person shall be subject to the transportation provisions as provided in § 37.2-829 and the requirement for preadmission screening by a community services board or behavioral health authority as provided in § 37.2-805.

C. If a person is incapable of accepting or unwilling to accept voluntary admission and treatment, the judge or special justice shall inform the person of his right to a commitment hearing and right to counsel. The judge or special justice shall ascertain if the person whose admission is sought is represented by counsel, and, if he is not represented by counsel, the judge or special justice shall appoint an attorney to represent him. However, if the person requests an opportunity to employ counsel, the judge or special justice shall give him a reasonable opportunity to employ counsel at his own expense.

D. A written explanation of the involuntary admission process and the statutory protections associated with the process shall be given to the person, and its contents shall be explained by an attorney prior to the commitment hearing. The written explanation shall describe, at a minimum, the person's rights to (i) retain private counsel or be represented by a court-appointed attorney, (ii) present any defenses including independent evaluation and expert testimony or the testimony of other witnesses, (iii) be present during the hearing and testify, (iv) appeal any order for involuntary admission to the circuit court, and (v) have a jury trial on appeal. The judge or special justice shall ascertain whether the person whose involuntary admission is sought has been given the written explanation required herein.

E. To the extent possible, during or before the commitment hearing, the attorney for the person whose involuntary admission is sought shall interview his client, the petitioner, the examiner described in § 37.2-815, the community services board or behavioral health authority staff, and any other material witnesses. He also shall examine all relevant diagnostic and other reports, present evidence and witnesses, if any, on his client's behalf, and otherwise actively represent his client in the proceedings. A health care provider shall disclose or make available all such reports, treatment information, and records concerning his client to the attorney, upon request. The role of the attorney shall be to represent the wishes of his client, to the extent possible.

F. The petitioner shall be given adequate notice of the place, date, and time of the commitment hearing. The petitioner shall be entitled to retain counsel at his own expense, to be present during the hearing, and to testify and present evidence. The petitioner shall be encouraged but shall not be required to testify at the hearing, and the person whose involuntary admission is sought shall not be released solely on the basis of the petitioner's failure to attend or testify during the hearing.

(1976, c. 671, § 37.1-67.3; 1979, c. 426; 1980, cc. 166, 582; 1982, c. 471; 1984, c. 277; 1985, c. 261; 1986, cc. 349, 609; 1988, c. 225; 1989, c. 716; 1990, cc. 59, 60, 728, 798; 1991, c. 636; 1992, c. 752; 1994, cc. 736, 907; 1995, cc. 489, 668, 844; 1996, cc. 343, 893; 1997, cc. 558, 921; 1998, c. 446; 2001, cc. 478, 479, 507, 658, 837; 2004, cc. 66, 1014; 2005, c. 716.)

§ 37.2-815. Commitment hearing for involuntary admission; examination required.

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

All such examinations shall be conducted in private. The judge or special justice shall summons the examiner who shall certify that he has personally examined the person and has probable cause to believe that the person (i) does or does not present an imminent danger to himself or others as a result of mental illness or is or is not so seriously mentally ill as to be substantially unable to care for himself and (ii) requires or does not require involuntary inpatient treatment. Alternatively, the judge or special justice may accept written certification of the examiner's findings if the examination has been personally made within the preceding five days and if there is no objection sustained to the acceptance of the written certification by the person or his attorney. The judge or special justice shall not render any decision on the petition until the examiner has presented his report orally or in writing.

(1976, c. 671, § 37.1-67.3; 1979, c. 426; 1980, cc. 166, 582; 1982, c. 471; 1984, c. 277; 1985, c. 261; 1986, cc. 349, 609; 1988, c. 225; 1989, c. 716; 1990, cc. 59, 60, 728, 798; 1991, c. 636; 1992, c. 752; 1994, cc. 736, 907; 1995, cc. 489, 668, 844; 1996, cc. 343, 893; 1997, cc. 558, 921; 1998, c. 446; 2001, cc. 478, 479, 507, 658, 837; 2004, cc. 66, 1014; 2005, c. 716.)

§ 37.2-816. Commitment hearing for involuntary admission; preadmission screening report.

The district court judge or special justice shall require a preadmission screening report from the community services board or behavioral health authority that serves the county or city where the person resides or, if impractical, where the person is located. The report shall be admissible as evidence of the facts stated therein and shall state (i) whether the person presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill that he is substantially unable to care for himself, (ii) whether the person is in need of involuntary inpatient treatment, (iii) whether there is no less restrictive alternative to inpatient treatment, and (iv) the recommendations for that person's placement, care, and treatment. The board or authority shall provide the preadmission screening report within 48 hours or if the 48-hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. In the case of a person who has been sentenced and committed to the Department of Corrections and who has been examined by a psychiatrist or clinical psychologist, the judge or special justice may proceed to adjudicate whether the person has mental illness and should be involuntarily admitted without requesting a

preadmission screening report from the community services board or behavioral health authority.

(1976, c. 671, § 37.1-67.3; 1979, c. 426; 1980, cc. 166, 582; 1982, c. 471; 1984, c. 277; 1985, c. 261; 1986, cc. 349, 609; 1988, c. 225; 1989, c. 716; 1990, cc. 59, 60, 728, 798; 1991, c. 636; 1992, c. 752; 1994, cc. 736, 907; 1995, cc. 489, 668, 844; 1996, cc. 343, 893; 1997, cc. 558, 921; 1998, c. 446; 2001, cc. 478, 479, 507, 658, 837; 2004, cc. 66, 1014; 2005, c. 716.)

§ 37.2-817. Involuntary admission and outpatient treatment orders.

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

B. After observing the person and obtaining the necessary positive certification and considering any other relevant evidence that may have been offered, if the judge or special justice finds by clear and convincing evidence that (i) the person presents an imminent danger to himself or others as a result of mental illness or has been proven to be so seriously mentally ill as to be substantially unable to care for himself and (ii) alternatives to involuntary inpatient treatment have been investigated and deemed unsuitable and there is no less restrictive alternative to involuntary inpatient treatment, the judge or special justice shall by written order and specific findings so certify and order that the person be admitted involuntarily to a facility for a period of treatment not to exceed 180 days from the date of the court order. Such involuntary admission shall be to a facility designated by the community services board or behavioral health authority that serves the city or county in which the person was examined as provided in § 37.2-816. If the community services board or behavioral health authority does not designate a facility at the commitment hearing, the person shall be involuntarily admitted to a facility designated by the Commissioner. The person shall be released at the expiration of 180 days unless he is involuntarily admitted by further petition and order of a court or such person makes application for treatment on a voluntary basis as provided for in § 37.2-805.

C. After observing the person and obtaining the necessary positive certification and considering any other relevant evidence that may have been offered, if the judge or special justice finds by clear and convincing evidence that (i) the person presents an imminent danger to himself or others as a result of mental illness or has been proven to be so seriously mentally ill as to be substantially unable to care for himself, (ii) less restrictive alternatives to involuntary inpatient treatment have been investigated and are deemed suitable, (iii) the person (a) has the degree of competency necessary to understand the stipulations of his treatment, (b) expresses an interest in living in the community and agrees to abide by his treatment plan, and (c) is deemed to have the capacity to comply with the treatment plan, and (iv) the ordered treatment can be delivered on an outpatient basis and be monitored by the community services board, behavioral health authority or designated provider, the judge or special justice shall order outpatient treatment, which may include day treatment in a hospital,

night treatment in a hospital, outpatient involuntary treatment with anti-psychotic medication pursuant to Chapter 11 (§ 37.2-1100 et seq.), or other appropriate course of treatment as may be necessary to meet the needs of the person. The community services board or behavioral health authority that serves the city or county in which the person resides shall recommend a specific course of treatment and programs for the provision of involuntary outpatient treatment. The community services board, behavioral health authority, or designated provider shall monitor the person's compliance with the treatment ordered by the court under this section, and the person's failure to comply with involuntary outpatient treatment as ordered by the court may be admitted into evidence in subsequent hearings held pursuant to the provisions of this section. Upon failure of the person to adhere to the terms of the outpatient treatment order, the judge or special justice may revoke it and, upon notice to the person and after a commitment hearing, order involuntary admission to a facility.

(1976, c. 671, § 37.1-67.3; 1979, c. 426; 1980, cc. 166, 582; 1982, c. 471; 1984, c. 277; 1985, c. 261; 1986, cc. 349, 609; 1988, c. 225; 1989, c. 716; 1990, cc. 59, 60, 728, 798; 1991, c. 636; 1992, c. 752; 1994, cc. 736, 907; 1995, cc. 489, 668, 844; 1996, cc. 343, 893; 1997, cc. 558, 921; 1998, c. 446; 2001, cc. 478, 479, 507, 658, 837; 2004, cc. 66, 1014; 2005, cc. 458, 716.)

§ 37.2-818. Commitment hearing for involuntary admission; recordings and records.

A. The district court judge or special justice shall make or cause to be made a tape or other audio recording of the commitment hearing and shall submit the recording to the appropriate district court clerk to be retained in a confidential file. Recordings shall be used only to document and to answer questions concerning the judge's or special justice's conduct of the hearing. These recordings shall be retained for at least three years from the date of the commitment hearing.

B. Except as provided in this section and § 37.2-819, the court shall keep its copies of relevant medical records, reports, and court documents pertaining to the hearing provided for in this section confidential if so requested by the person who was the subject of the hearing or his counsel, with access provided only upon court order for good cause shown. Such records, reports, and documents shall not be subject to the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

C. The judge or special justice shall order that copies of the relevant medical records of the person be released to the facility in which he is placed upon the request of the treating physician or director of the facility.

(1976, c. 671, § 37.1-67.3; 1979, c. 426; 1980, cc. 166, 582; 1982, c. 471; 1984, c. 277; 1985, c. 261; 1986, cc. 349, 609; 1988, c. 225; 1989, c. 716; 1990, cc. 59, 60, 728, 798; 1991, c. 636; 1992, c. 752; 1994, cc. 736, 907; 1995, cc. 489, 668, 844; 1996, cc. 343, 893; 1997, cc. 558, 921; 1998, c. 446; 2001, cc. 478, 479, 507, 658, 837; 2004, cc. 66, 1014; 2005, c. 716.)

37.2-819. Order of involuntary admission forwarded to CCRE; firearm background check.

The clerk shall certify and forward forthwith to the Central Criminal Records Exchange, on a form provided by the Exchange, a copy of any order for involuntary admission to a facility.

The copy of the form and the order shall be kept confidential in a separate file and used only to determine a person's eligibility to possess, purchase, or transfer a firearm.

(1976, c. 671, § 37.1-67.3; 1979, c. 426; 1980, cc. 166, 582; 1982, c. 471; 1984, c. 277; 1985, c. 261; 1986, cc. 349, 609; 1988, c. 225; 1989, c. 716; 1990, cc. 59, 60, 728, 798; 1991, c. 636; 1992, c. 752; 1994, cc. 736, 907; 1995, cc. 489, 668, 844; 1996, cc. 343, 893; 1997, cc. 558, 921; 1998, c. 446; 2001, cc. 478, 479, 507, 658, 837; 2004, cc. 66, 1014; 2005, c. 716.)

§ 37.2-820. Place of hearing.

The hearing 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, if he deems it advisable, even though the facility or place is located in a county or city other than his own. In conducting such hearings in a county or city other than his own, the judge or special justice shall have all of the authority and power that he would have in his own county or city. A district court judge or special justice of the county or city in which the facility or place is located may conduct the hearing provided for in §§ 37.2-814 through 37.2-819.

(1976, c. 671, § 37.1-67.4; 1981, c. 233; 1982, c. 435; 1986, c. 134; 1995, c. 844; 2005, c. 716.)

37.2-821. Appeal of involuntary admission or certification order.

A. Any person involuntarily admitted pursuant to §§ 37.2-814 through 37.2-819 or certified as eligible for admission pursuant to § 37.2-806 shall have the right to appeal the order to the circuit court in the jurisdiction where he was involuntarily admitted or certified or where the facility to which he was admitted is located. Choice of venue shall rest with the party noting the appeal. The court may transfer the case upon a finding that the other forum is more convenient. An appeal shall be filed within 30 days from the date of the order and shall be given priority over all other pending matters before the court and heard as soon as possible, notwithstanding § 19.2-241 regarding the time within which the court shall set criminal cases for trial. The clerk of the court from which an appeal is taken shall immediately transmit the record to the clerk of the appellate court. The clerk of the circuit court shall provide written notification of the appeal to the petitioner in the case in accordance with procedures set forth in § 16.1-112. No appeal bond or writ tax shall be required, and the appeal shall proceed without the payment of costs or other fees. Costs may be recovered as provided for in § 37.2-804.

B. The appeal shall be heard de novo in accordance with the provisions set forth in § 37.2-806 or this article. The circuit court may require an independent evaluation of the person pursuant to § 37.2-815, or may rely upon the evaluation report in the commitment hearing from which the appeal is taken. An order continuing the involuntary admission shall be entered only if the criteria in § 37.2-817 are met at the time the appeal is heard. The person so admitted or certified shall be entitled to trial by jury. Seven persons from a panel of 13 shall constitute a jury.

C. If the person is not represented by counsel, the judge shall appoint an attorney to represent him. Counsel so appointed shall be paid a fee of $75 and his necessary expenses. The order of

the court from which the appeal is taken shall be defended by the attorney for the Commonwealth.

(1977, c. 355, § 37.1-67.6; 1979, c. 204; 1980, c. 176; 1985, c. 106; 1990, c. 274; 2005, c. 716; 2006, c. 486.)

§ 37.2-822. Treatment of person admitted while appeal is pending.

Whenever the director of any facility reasonably believes that treatment is necessary to protect the life, health, or safety of a person, treatment may be given during the period allowed for any appeal unless prohibited by order of a circuit court in the county or city wherein the appeal is pending.

(Code 1950, §§ 37-71.2, 37-204.1; 1964, c. 322; 1968, c. 477, § 37.1-85; 1972, c. 639; 2005, c. 716.)

37.2-823. Examination of admission papers by director; examination of persons admitted.

A. Upon the receipt of any order for admission of any person, the director of the facility shall immediately examine the admission papers and, if they are found to be in substantial compliance with the law, he shall forthwith admit the person to the facility.

B. Any person presented for admission to a facility shall be examined within 24 hours after arrival by one or more of the physicians on the facility's staff. If the examination reveals that there is sufficient cause to believe that the person has mental illness, he shall be retained at the facility; but if the examination reveals insufficient cause, the person shall be returned to the locality in which the petition was initiated or in which the person resides.

C. The Board shall adopt regulations to institute preadmission screening to prevent inappropriate admissions to state facilities.

(Code 1950, §§ 37-86.2, 37-90; 1950, pp. 908, 910; 1968, c. 477, §§ 37.1-68, 37.1-70; 1970, c. 673; 1972, c. 639; 1976, c. 671; 1980, c. 582; 2005, c. 716.)

37.2-824. Periodic review of all persons for purposes of retention.

The director of a state facility shall conduct a review of the progress of each person admitted to the facility at intervals of 30, 60, and 90 days after admission of the person, and every six months thereafter to determine whether the person should be retained at the state facility. A record shall be kept of the findings of each review in the state facility's file on the person.

(1974, c. 66, § 37.1-84.2; 1976, c. 671; 2005, c. 716.)

§ 37.2-825. Admission raises no presumption of legal incapacity.

The admission of any person to a facility shall not, of itself, create a presumption of legal incapacity.

(1968, c. 477, § 37.1-87; 1997, c. 801; 2005, c. 716.)

§ 37.2-826. Disposition of nonresidents.

If it appears that the person examined has a mental illness and is not a resident of the Commonwealth, the same proceedings shall be had with regard to him as if he were a resident of the Commonwealth, and, if he is admitted to a state facility under these proceedings, a statement of the fact of his nonresidence and of the place of his domicile or residence or from where he came, as far as known, shall accompany any petition respecting him. The Commissioner shall, as soon as practicable, cause him to be returned to his family or friends, if known, or the proper authorities of the state or country from which he came, if ascertained and such return is deemed expedient by the Commissioner.

(Code 1950, § 37-91; 1950, p. 910; 1968, c. 477, § 37.1-91; 1976, c. 671; 2005, c. 716.)

§ 37.2-827. Admission of aliens.

Whenever any person is admitted to a state facility, the Commissioner shall inquire forthwith into the nationality of the person. If it shall appear that the person is an alien, the Commissioner shall notify immediately the United States immigration officer in charge of the district in which the state facility is located.

Upon the official request of the United States immigration officer in charge of the territory or district in which is located any district court judge or special justice certifying or ordering the admission of any alien to a state facility, the clerk of the court shall furnish, without charge, a certified copy in duplicate of any record pertaining to the case of the admitted alien. This information shall be deemed confidential.

(Code 1950, § 37-91.1; 1950, p. 911; 1968, c. 477, § 37.1-92; 2005, c. 716.)

§ 37.2-828. Receiving and maintaining federal prisoners in state facilities.

The Commissioner is authorized to enter into a contract with the United States, through the Director of the United States Bureau of Prisons or other authorized agent of the United States, for the reception, maintenance, care, and observation in state facilities, or in those designated by the Commissioner for the purpose, of any persons charged with a crime in the courts of the United States sitting in Virginia and committed by the courts to the state facilities for those purposes. All persons so admitted shall remain subject to the jurisdiction of the court by whom they were committed, and they may be returned to that court at any time for hearing or trial.

Any such contract shall require that the United States remit to the State Treasurer for each prisoner admitted specified per diem or other payments, or both, with such payments fixed by the contract.

The director of any state facility to which a prisoner of the United States is admitted shall observe the person and, as soon as possible, report in writing to the court by which he is certified or committed as to his mental condition or other matters as the court may direct.

No contract made pursuant to this section shall obligate the Commonwealth or the Commissioner to receive a federal prisoner into any state facility in which all available beds are needed for persons otherwise admitted, or in any other case where, in the opinion of the

director, the admission of the prisoner would interfere with the care and treatment of other persons admitted or with the proper administration of the state facility.

(Code 1950, § 37-98; 1950, p. 913; 1968, c. 477, § 37.1-95; 1972, c. 639; 1980, c. 582; 2005, c. 716.)

§ 37.2-829. Transportation of person in civil admission process.

When a person has been ordered to be admitted to a facility under §§ 37.2-814 through 37.2-821, a determination shall be made by the judge or special justice regarding the transportation of that person to the proper facility. The judge or special justice may consult with the person's treating mental health professional and any involved community services board or behavioral health authority staff regarding the person's dangerousness and whether the sheriff should transport or whether transportation alternatives as provided in § 37.2-830 may be utilized. If the judge or special justice determines that the person requires transportation by the sheriff, the person may be delivered to the care of the sheriff, as specified in this section, who shall transport the person to the proper facility. In no event shall transport commence later than six hours after notification to the sheriff of the judge's or special justice's order.

The sheriff of the jurisdiction where the person is a resident shall be responsible for transporting the person unless the sheriff's office of that jurisdiction is located more than 100 road miles from the nearest boundary of the jurisdiction in which the proceedings took place. In cases where the sheriff of the jurisdiction of which the person is a resident is more than 100 road miles from the nearest boundary of the jurisdiction in which the proceedings took place, it shall be the responsibility of the sheriff of the latter jurisdiction to transport the person. The cost of transportation of any person ordered to be admitted pursuant to §§ 37.2-814 through

§ 37.2-830. Custody of person ordered to be admitted for purpose of transportation.

Any judge or special justice may order that a person admitted pursuant to this chapter be placed in the custody of any responsible person, including a representative of the facility in which the person is temporarily placed during the temporary detention period, for the sole purpose of transporting the person to the proper facility.

(Code 1950, § 37-79; 1950, p. 907; 1964, c. 640; 1968, c. 477, § 37.1-72; 1976, c. 671; 1995, c. 844; 2005, c. 716.)

§ 37.2-831. Detention in jail after order of admission.

It shall be unlawful for any sheriff, sergeant, or other officer to use any jail or other place of confinement for criminals as a place of detention for any person in his custody for transportation to a facility in accordance with this chapter, unless the person's detention therein, for a period not to exceed 24 hours, is specifically authorized by the judge or special justice who ordered the admission, except that such authority shall not be given by any judge or special justice for the Counties of Augusta, Arlington, and Fairfax and the Cities of Alexandria, Fairfax, Falls Church, Waynesboro, and Staunton.

(Code 1950, § 37-78; 1950, p. 907; 1964, c. 640; 1968, c. 477, § 37.1-73; 1971, Ex. Sess., c. 155; 1972, c. 751; 1976, c. 671; 1979, c. 707; 2005, c. 716.)

§ 37.2-832. Persons with mental illness not to be confined in cells with criminals.

In no case shall any sheriff or jailer confine any person with mental illness in a cell or room with prisoners charged with or convicted of crimes.

(Code 1950, § 37-81; 1950, p. 908; 1968, c. 477, § 37.1-74; 1971, Ex. Sess., c. 155; 2005, c. 716.)

§ 37.2-833. Escape, sickness, death, or discharge of a person ordered to be involuntarily admitted while in custody; warrant for person escaping.

If any person who has been ordered to be involuntarily admitted to a facility escapes, becomes too sick to travel, dies, or is discharged by due process of law while in the custody of a sheriff or other person, the sheriff or other person shall immediately notify the facility of that fact. If any person in the custody of a sheriff or other person pursuant to the provisions of this chapter escapes, the sheriff or other person having that person in custody shall immediately secure a warrant from any officer authorized to issue warrants charging the individual with escape from lawful custody, directing his apprehension, and stating what disposition shall be made of the person upon arrest.

(Code 1950, § 37-85; 1950, p. 908; 1954, c. 668; 1968, c. 477, § 37.1-75; 1971, Ex. Sess., c. 155; 2005, c. 716.)

§ 37.2-834. Arrest of certain persons involuntarily admitted.

If a person involuntarily admitted to a facility escapes, the director may forthwith issue a warrant directed to any officer authorized to make arrests, who shall arrest the person and carry him back to the facility or to an appropriate state facility that is in close proximity to the jurisdictions served by the arresting officer. The officer to whom the warrant is directed may execute the same in any part of the Commonwealth.

(Code 1950, § 37-97; 1950, p. 39; 1968, c. 477, § 37.1-76; 1972, c. 639; 1976, c. 671; 1981, c. 242; 2005, c. 716.)

§ 37.2-835. Arrest without warrant.

Any officer authorized to make arrests is authorized to make an arrest under a warrant issued under the provisions of § 37.2-833 or 37.2-834, without having the warrant in his possession, provided the warrant has been issued and the arresting officer has been advised of the issuance of the warrant by printed message or any form of wire or wireless communication containing the name of the person wanted, directing the disposition to be made of the person when apprehended, and stating the basis of the issuance of the warrant.

(Code 1950, § 37-97.1; 1954, c. 668; 1968, c. 477, § 37.1-77; 2005, c. 716.)

§ 37.2-836. Employees to accompany persons admitted voluntarily to facilities.

When application is made to the director of a facility for admission pursuant to § 37.2-805, he may send an employee from the facility to accompany the person to the facility. If for any reason it is impracticable for an employee to do so, then the director may appoint some suitable person for the purpose, or may request the sheriff of the county or city in which the person resides to convey him to the facility. The sheriff or other person appointed for the purpose shall receive only his necessary expenses for conveying any person admitted to the facility. Expenses authorized herein shall be paid by the Department.

(Code 1950, § 37-87; 1950, p. 909; 1968, c. 477, § 37.1-78; 1971, Ex. Sess., c. 155; 1972, c. 639; 1976, c. 671; 1980, c. 582; 2005, c. 716.)

§ 37.2-837. Discharge from state hospitals or training centers, conditional release, and trial or home visits for consumers.

A. Except for a state hospital consumer held upon an order of a court for a criminal proceeding, the director of a state hospital or training center may discharge, after the preparation of a discharge plan:

1. Any consumer in a state hospital who, in his judgment, (a) is recovered, (b) does not have a mental illness, or (c) is impaired or not recovered but whose discharge will not be detrimental to the public welfare or injurious to the consumer;

2. Any consumer in a state hospital who is not a proper case for treatment within the purview of this chapter; or

3. Any consumer in a training center who chooses to be discharged or, if the consumer lacks the mental capacity to choose, whose legally authorized representative chooses for him to be discharged. Pursuant to regulations of the Centers for Medicare & Medicaid Services and the Department of Medical Assistance Services, no consumer at a training center who is enrolled in Medicaid shall be discharged if the consumer or his legally authorized representative on his behalf chooses to continue receiving services in a training center.

For all individuals discharged, the discharge plan shall be formulated in accordance with the provisions of § 37.2-505 by the community services board or behavioral health authority that serves the city or county where the consumer resided prior to admission or by the board or authority that serves the city or county where the consumer or his legally authorized representative on his behalf chooses to reside immediately following the discharge. The discharge plan shall be contained in a uniform discharge document developed by the Department and used by all state hospitals, training centers, and community services boards or behavioral health authorities. If the individual will be housed in an assisted living facility, as defined in § 63.2-100, the discharge plan shall identify the facility, document its appropriateness for housing and capacity to care for the consumer, contain evidence of the facility's agreement to admit and care for the consumer, and describe how the community services board or behavioral health authority will monitor the consumer's care in the facility.

B. The director may grant a trial or home visit to a consumer in accordance with regulations adopted by the Board. The state facility granting a trial or home visit to a consumer shall not be liable for his expenses during the period of that visit. Such liability shall devolve upon the relative, conservator, person to whose care the consumer is entrusted while on the trial or

home visit, or the appropriate local department of social services of the county or city in which the consumer resided at the time of admission pursuant to regulations adopted by the State Board of Social Services.

C. Any consumer who is discharged pursuant to subdivision A 2 shall, if necessary for his welfare, be received and cared for by the appropriate local department of social services. The provision of public assistance or social services to the consumer shall be the responsibility of the appropriate local department of social services as determined by regulations adopted by the State Board of Social Services. Expenses incurred for the provision of public assistance to the consumer who is receiving 24-hour care while in an assisted living facility licensed pursuant to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2 shall be the responsibility of the appropriate local department of social services of the county or city in which the consumer resided at the time of admission.

(Code 1950, § 37-94; 1950, p. 912; 1968, c. 477, § 37.1-98; 1972, c. 639; 1976, c. 671; 1977, c. 189; 1980, c. 582; 1985, c. 87; 1986, cc. 256, 309; 1993, cc. 957, 993; 1998, c. 680; 2002, cc. 62, 557, 747; 2005, c. 716.)

§ 37.2-838. Discharge of persons from a licensed hospital.

The person in charge of a licensed hospital may discharge any consumer involuntarily admitted who is recovered or, if not recovered, whose discharge will not be detrimental to the public welfare or injurious to the consumer, or who meets other criteria as specified in § 37.2-837. The person in charge of the licensed hospital may refuse to discharge any consumer involuntarily admitted, if, in his judgment, the discharge will be detrimental to the public welfare or injurious to the consumer. The person in charge of a licensed hospital may grant a trial or home visit to a consumer in accordance with regulations adopted by the Board.

(1968, c. 477, § 37.1-99; 1976, c. 671; 1980, cc. 582, 583; 2005, c. 716.)

§ 37.2-839. Exchange of information between community services boards or behavioral health authorities and state facilities.

Community services boards or behavioral health authorities and state facilities may, when the individual has refused authorization, exchange the information required to prepare and implement a comprehensive individualized treatment plan, including a discharge plan as specified in subsection A of § 37.2-837. This section shall apply to all consumers of community services boards, behavioral health authorities, and state facilities.

When a consumer who is deemed suitable for discharge pursuant to subsection A of § 37.2-837 or his guardian or conservator refuses to authorize the release of information that is required to formulate and implement a discharge plan as specified in subsection A of § 37.2-837, then the community services board or behavioral health authority may release without authorization to those service providers and human service agencies identified in the discharge plan only the information needed to secure those services specified in the plan.

The release of any other consumer information to any agency or individual not affiliated directly or by contract with community services boards, behavioral health authorities, or state

facilities shall be subject to all regulations adopted by the Board or by agencies of the United States government that govern confidentiality of patient information.

(1985, c. 87, § 37.1-98.2; 1999, c. 764; 2005, c. 716.)

§ 37.2-840. Transfer of consumers.

A. The Commissioner may order the transfer of a consumer from one state hospital to another or from one training center to another. When so transferred, in accordance with appropriate admission, certification, or involuntary admission criteria as provided in this chapter, a consumer is hereby declared to be lawfully admitted to the state facility to which he is transferred.

B. If the guardian, conservator, or relative of a consumer in a licensed hospital refuses or is otherwise unable to provide properly for his care and treatment, the person in charge of the licensed hospital may:

1. Apply to the Commissioner for the transfer of the consumer to a state hospital, or

2. Apply to the Director of the United States Veterans Affairs Medical Center for the transfer of the consumer to such center.

Upon the transfer, the state hospital or Veterans Affairs Medical Center may admit the consumer under the authority of the admission or order applicable to the licensed hospital from which the consumer was transferred. The transfer shall not alter any right of a consumer under the provisions of Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 nor shall the transfer divest a judge or special justice before whom a hearing or request therefor is pending of jurisdiction to conduct a hearing. Prior to accepting the transfer of any consumer from a licensed hospital, the Commissioner shall receive from that hospital a report that indicates that the consumer is in need of further hospitalization. Upon admission of a person to a state hospital pursuant to this section, the director of the state hospital shall notify the community services board or behavioral health authority that serves the city or county where the admitted person resides of the person's name and local address and of the location of the state hospital to which the person has been admitted, provided that the person or his guardian has authorized the release of the information.

C. Whenever a person is admitted by a state hospital or training center, the Commissioner, upon a recommendation by the community services board or behavioral health authority serving the person's county or city of residence prior to his admission to the hospital or training center, may order the transfer of the person to any other hospital, training center, or Veterans Affairs hospital, center, or other facility or installation. Such other hospital, training center, or Veterans Affairs hospital, center, or other facility or installation may admit the person under the authority of the admission or order applicable to the hospital or training center from which the person was transferred. The transfer shall not alter any right of the person under the provisions of this chapter nor shall the transfer divest a judge or special justice before whom a hearing or request therefor is pending of jurisdiction to conduct such hearing.

(Code 1950, §§ 37-7, 37-126.1; 1950, pp. 900, 918; 1968, c. 477, §§ 37.1-48, 37.1-86, 37.1-99; 1970, c. 673, § 37.1-78.1; 1976, c. 671; 1980, cc. 582, 583; 1984, c. 174; 1986, c. 349; 2005, c. 716.)

§ 37.2-841. Admission of veteran to, or transfer to or from, a Veterans Affairs hospital, center, or other facility or installation.

Whenever it appears that a person with mental illness is a veteran eligible for treatment in a Veterans' Affairs hospital, center, or other facility or installation, the district court judge or special justice may, upon receipt of a certificate of eligibility from that hospital, center, or other facility or installation, order the person to that hospital, center, or other facility or installation, regardless of whether the person resides in Virginia. Any veteran who has been or is in a state hospital and is eligible for treatment in a Veterans Affairs hospital, center, or other facility or installation may be transferred to a Veterans Affairs hospital, center, or other facility or installation with the written consent of its manager. Any veteran admitted to a Veterans Affairs hospital, center, or other facility or installation, if he resided in Virginia prior to his admission and meets the criteria for admission to a state hospital, may be transferred to a state hospital with the written authorization of the Commissioner.

(Code 1950, § 37-73; 1950, p. 905; 1968, c. 477, § 37.1-93; 2005, c. 716.)

§ 37.2-842. Veterans admitted or transferred to Veterans Affairs hospital, center, or other facility or installation subject to rules; power and authority of medical officer in charge.

Every veteran, after admission to a Veterans Affairs hospital, center, or other facility or installation, either upon initial admission or transfer, shall be subject to the regulations of the Veterans Affairs hospital, center, or other facility or installation, and the medical officer in charge of the Veterans Affairs hospital, center, or other facility or installation to which the veteran is admitted or transferred is vested with the same powers authorized by law to be exercised by the director of a state hospital with reference to retention, custody, trial or home visit, and discharge of the veteran so admitted or transferred.

(Code 1950, § 37-74; 1950, p. 905; 1968, c. 477, § 37.1-94; 1972, c. 639; 2005, c. 716.)

§ 37.2-843. Providing drugs or medicines for certain persons discharged from state facilities.

When any consumer is discharged from a state facility and he or the person liable for his care and treatment is financially unable to pay for or otherwise access drugs or medicines that are prescribed for him by a member of the medical staff of the state facility in order to mitigate or prevent a recurrence of the condition for which he has received care and treatment in the state facility, the Department or the community services board or behavioral health authority serving the consumer's county or city of residence may, from funds appropriated to the Department for that purpose, provide the consumer with such drugs and medicines, which shall be dispensed only in accordance with law.

(Code 1950, § 37-92.1; 1958, c. 158; 1968, c. 477, § 37.1-101; 1986, c. 349; 2005, c. 716.)

§ 37.2-844. Habeas corpus as means.

A. Any person held in custody because of his mental illness may by petition for a writ of habeas corpus have the question of the legality of his detention determined by a court of competent jurisdiction. Upon the petition, after notice to the authorities of the facility or other institution in which the person is confined, the court shall determine in a courtroom of the county or city or in some other convenient public place in that county or city, whether the person has a mental illness and whether he should be detained.

B. Any proceeding to challenge the continued secure inpatient treatment of a person held in custody as a sexually violent predator under Chapter 9 (§ 37.2-900 et seq.) of this title shall be conducted in accordance with § 37.2-910.

(Code 1950, §§ 37-122, 37-123; 1950, p. 916; 1968, c. 477, § 37.1-103; 1976, c. 671; 2003, cc. 989, 1018; 2005, c. 716.)

§ 37.2-845. Procedure when person confined in facility or other institution.

A. If the person referenced in § 37.2-844 is held in custody and actually confined in any facility or other institution, he may file his petition in the circuit court of the county or the city in which the facility or other institution is located or in the circuit court of the county or the city adjoining the county or city in which the facility or other institution is located.

B. Any proceeding to challenge the continued secure inpatient treatment of any person held in custody as a sexually violent predator under Chapter 9 (§ 37.2-900 et seq.) of this title shall be conducted in the circuit court wherein the person was last convicted of a sexually violent offense or wherein the defendant was deemed unrestorably incompetent and referred for commitment pursuant to § 19.2-169.3.

(Code 1950, § 37-123; 1950, p. 916; 1968, c. 477, § 37.1-104; 1976, c. 671; 2003, cc. 989, 1018; 2005, c. 716.)

§ 37.2-846. Procedure when person not confined in facility or other institution.

A. In all cases, other than those provided for in § 37.2-845, the person may file his petition in the circuit court of the county or the city in which he resides or in which he was found to have a mental illness or in which an order was entered authorizing his continued involuntary inpatient treatment, pursuant to Article 5 (§ 37.2-814 et seq.) of Chapter 8 of this title.

B. Any proceeding to challenge the continued secure inpatient treatment of any person held in custody as a sexually violent predator under Chapter 9 (§ 37.2-900 et seq.) of this title shall be conducted in the circuit court wherein the person was last convicted of a sexually violent offense or wherein the defendant was deemed unrestorably incompetent and referred for commitment pursuant to § 19.2-169.3.

(Code 1950, § 37-124; 1950, p. 916; 1968, c. 477, § 37.1-104.1; 1976, c. 671; 2003, cc. 989, 1018; 2005, c. 716.)

§ 37.2-847. Duty of attorney for Commonwealth.

In any case to test the legality of the detention of a person pursuant to this article, whether by habeas corpus or otherwise, the attorney for the Commonwealth of the county or city in which

the hearing is held shall, on request of the director of the facility or other institution having or claiming custody of the person, represent the Commonwealth in opposition to any such petition, appeal, or procedure for the discharge of the person from custody.

(Code 1950, § 37-125; 1950, p. 916; 1968, c. 477, § 37.1-104.2; 1972, c. 639; 2005, c. 716.)

APPENDIX F

Consumer Stakeholder Example Source Materials

EXAMPLES OF INFORMATION FROM INTERVIEWS, DIALOGUE GROUPS, AND MEETINGS

On the following pages, more detailed information from some of the data collection sessions is presented to indicate the range of issues that consumers shared with the evaluation team. The comments are representative rather than exhaustive.

Some consumers who might want to get inpatient treatment can't, because there are not enough "psych" beds in local and state hospitals.

The following comment was obtained from a man following a long confinement in a state psychiatric facility. He had been confined after killing a coworker during a psychotic episode over ten years earlier. He now resides in the community.

". . . patients [who] quit taking meds when they leave the inpatient unit. There's no law to make them comply. They are tying up beds for those who want to get better. If you are a repeat customer, they should make them take the meds."

INFORMAL DIALOGUE GROUP
Location: Northwest Region

The following themes were identified from comments obtained at a clubhouse for clients of a local community services board in the *Northwest Region*. This group was comprised of four men and two women; their ages ranged from approximately 35 to 60. A number of themes emerged during this dialogue.

►Mental health treatment received during an involuntary commitment ranges from good to bad and can include misdiagnoses and inappropriate medication.

One man said that he was "given the wrong meds and the wrong diagnosis." He was misdiagnosed as having schizoaffective disorder and put on Haldol. He was TDOd to (the local hospital), then transported to the state hospital. He was heavily medicated at the time and does not remember being transported. He spent five months at the state hospital. He felt that he didn't belong there. He hated having blood work done. His diagnosis was changed to bipolar disorder and he was put on Risperidol and Clozaril, which manage his symptoms.

One woman said that she had been on suicide watch for three weeks the last time she was hospitalized at the state hospital. During that time, she said the staff "watched TV, played with yarn, and read books." Never once, she stated, did she see a psychiatrist during that period. During a three-week hospitalization in a local hospital, she said she saw a psychiatrist twice. She said that she had been taking her medication prior to her hospitalizations, but the

medication stopped managing her symptoms. She said that she does not skip or discontinue her medication because, "I know what happens when I go off my meds."

►The stigma of having a serious mental illness is an ongoing, emotionally painful problem for many consumers.

One woman said, "People in the community don't understand [mental illness]. They don't want to understand. There's a lot of prejudice."

►Commitment hearings are not perceived by many consumers as fair.

One man said, "It's a pretense . . . more and more lies. The lawyers ain't worth squat." Another consumer said that money to hire an attorney or a clinician to provide a second opinion made all the difference.

►Being transported to the hospital is often a degrading, frightening experience.

One woman said, "The police treat you like a common criminal. They handcuff you and put you in a cage car . . . they don't say a single solitary word to you (during the transport)." She said that transportation should be provided by someone who is used to dealing with people with mental illness in a vehicle that is equipped to handle the situation (i.e., an ambulance or similar medically equipped vehicle), *not* a police car.

Another man said that he had been transported to a state hospital in handcuffs with his legs shackled. He said he felt like "people were looking at me like I was a common criminal." When asked about improving the process, he said that police, who provide transportation, "should take their uniforms off and stay there [in the hospital] for 10–15 years" so they can understand what the experience is like. He said, "Unless you've been there, they don't understand shit." He was hospitalized for four-and-a-half months for threatening to kill a family member. He stated, "You are labeled for the rest of your life [when you've been hospitalized for mental illness]."

►Hospital advocates are a good idea, but there is no good system in place to make it happen.

One man said that it can take four to six weeks to talk to the hospital advocate about your concerns. He also expressed concerns about the number of medications prescribed to patients at the state hospital. He said, "The doctors think they are smarter than you. . . . If you don't play the game [i.e., agree to take prescribed medications], you'll be there forever. If you do, you can get out."

Another man said that he was first hospitalized in 1971. At that time he said the conditions at the state hospital were "so horrible" that patients rioted at every meal, "throwing trays, bodies . . ." He said his doctors tried to intimidate him by telling him that he was going to be sent to [one particular] state hospital. At one point he spent four years on the forensics unit at a state hospital because of acts he committed during an exacerbation of his mental illness. He said

that things have greatly improved at [the one]state hospital and that patients now receive education about their illnesses during their hospitalization.

► One change that would significantly improve the process of civil commitment would be for everyone involved to treat consumers as they would like to be treated if mental illness happened to them ("do unto others . . .")

When asked how the process of involuntary civil commitment could be improved, one woman said "They should treat you more as a human being. We get treated like people who go to jail. . . . It's [the involuntary commitment process] like booking you to go into jail. You are down in a hole, you don't know how to get out." She also objected to being told by mental health professionals that they "know" how she feels. She said "[They] ain't got common smarts, [they] got book smarts."

►The "imminent danger" criteria (in the current statute) could delay consumers from getting help before the civil commitment process, which has many problematic features, kicked in.

Removing the imminent danger criteria from the current statute would result in "the opposite ends of extremes," according to one consumer. There was a consensus among participants that receiving treatment earlier would be a good thing. They agreed that treatment was needed when they first begin to show signs of decompensation—before they become so ill that they pose a danger to themselves or others—when they might require hospitalization, but for a shorter period of time. They expressed that this was definitely preferable to experiencing a full-blown relapse that required an extended period in the hospital to regain their stability.

CONSUMER MEETING
Location: Southwest Region

A questionnaire was drafted to explore consumers' experiences with the involuntary civil commitment process in a more structured way. This questionnaire was piloted at a meeting of consumers in Southwest Virginia, by a consumer advocate who regularly coordinates community consumer meetings in her area. She offered to hold a dialogue group for the purpose of pilot testing questions that might be used in a larger survey of consumers. This questionnaire included open-ended questions and a scale for rating services with a goal of obtaining better information from consumers about their experiences with the civil commitment process. A group of approximately 22 consumers that included men and women participated in this meeting.

Included below are excerpts from meetings with different consumer groups. Group member demographics and the format for each group are described as well as the key points made by the participants.

The questions presented to the dialogue group are included below. Verbatim responses are presented after each question.

1. In your opinion, what are the most serious problems faced by consumers of mental health services during the process of involuntary commitment? This means when someone goes to court and is ordered to go into the hospital to received medication.

"I don't remember the process."
"Be able to choose which facility to go to."
"I think the TDO is wrong because it slows your freedom down."

2. What are the most serious problems or special issues faced by family members of consumers of mental health services related to the involuntary commitment process?

"I was sent here when my time was up in prison involuntary."
"Well thay [sic] have me convenced [sic] I was sphcoctic [sic(psychotic)]."
"N/a" [This person didn't remember the process.]
"N/a" [This person didn't remember the process.]
"The [sic] just don't understand."
"Because of force."
"To get help for love ones."

3. What would you change first to improve the civil commitment system?

"Let me go because I was put here buy [sic] anoter [sic] and place."
"I would like it if Parents couldent [sic] buy your commitment."
"More education about it."
"I don't know."
"N/a"
"Do not take to hospital in police car."
"Police car, cuffs, shackeles [sic]."
"Let the person have a write [sic] to make statement."

4. What issues arise concerning the rights of consumers during a civil commitment process?

"Wether [sic] or not you need to be committed."
"Privacy rights would be [outdated??] in the near future."
"There should be someone representing the interest of the consumer."
"N/a"
"Makes you feel like a criminal."
"Police car, cuffs, shacketes [sic]."
"Someone making a des. con [sic] for you."
"They are at a disavanage [sic] because they have no say in court."

5. What steps could be taken to better protect the rights of consumers during the commitment process?

"A officer be in the room with them talking to me and my parents and if they here [sic] them offer money they would arrest [sic] them."
"There should be someone in the process representing the intrest [sic] of the consumer."
"N/a"
"Have more say."

6. How is the availability of community resources related to the civil commitment process?

"They are the community resources too."
"I don't know."
"N/a"
"Not good."
"The resources are good here."

7. What is the best way to facilitate working relationships among all stakeholders in the civil commitment process?

"Ask them to put theirselfs [sic] in our shoes."
"Break into stages. Get the person to the point they can participate then go to the next stage."
"N/a"
"Met [sic] and work together and sent [sic] notes of what going on."

8. Overall, how much better do you think the civil commitment process could be?

"Herington is the best judge if we loose him we've lost everything. . . . continue at bottom of page. . . . I have been hospitalized up here before Herington was Judge It was Hell the things thay [sic] pulled Herington gave us rights and made them stick he took us a long way baby."
"I don't know."
"N/a"
"70% better with including the person?"

9.What barriers exist for consumers to work to improve the civil commitment process in Virginia?

"Gitting [sic] out."
"We are not informed. We learn after the fact."
"N/a"
"Input"
"FEAR"

Thirteen members of this group also agreed to complete a "Satisfaction with Services Survey," described below.

Consumers were asked to rate on a 1 to 5 scale their experiences the last time they received mental health services; they also were asked whether they received these services as the result

of an involuntary commitment. General demographic questions, an open-ended question, and the Perceived Coercion Scale comprised the items on the survey. The rating scale was:

1=strongly agree, 2= agree, 3=neutral or mixed, 4=disagree, 5=strongly disagree.

Participants rated their experiences by responding to the following 5 questions:

1. I felt free to do what I wanted about going to the mental health center.
2. I chose to go to the mental health center.
3. It was my idea to go to the mental health center
4. I had a lot of control over whether I was sent to the mental health center.
5. I had more influence than anyone else on whether I went to the mental health center.

Results: There were 8 men and 5 women who participated. Eight reported their race to be white, the others were African American or from mixed race/ethnic groups. Of these, 9 had received their most recent mental health services because of an involuntary commitment. The ages ranged from 35 years to 63 years. The average age was 49 (SD=9.1).

The data were analyzed to compare responses from consumers who had received services as a result of an involuntary commitment to responses from consumers who did not receive services due to an involuntary commitment. As might be expected, there were statistically significant differences on the items above between the two groups in certain areas.

Table 1 shows that those who didn't feel free to do what they wanted as a result of involuntary commitment were able to articulate the fact. Of interest, one person who sought services without an involuntary commitment also reported not feeling that the decision was "freely made."

Table 1. Consumer responses to item 1 above.

	"Felt free to do what I wanted about going to get mental health services"					Total
Got service because of involuntary commitment	Strongly agree	Agree	Neutral/mixed	Disagree	Strongly disagree	
YES	0	2	0	1	6	9
NO	1	0	1	0	1	3
Total	1	2	1	1	7	12

.

The mean score from all questions above was determined and compared by group:

Table 2 shows that consumers who receive services due to an involuntary commitment reported significantly less control and freedom to obtain services than those who did not

receive services due to an involuntary commitment (based only on questions 4 and 5 above). The score difference between the two groups for questions 1–3 was significant.

Table 2. Mean scale score comparisons by consumers who were involuntarily committed vs. those who were not.

Questions	n		Mean	Std Deviation	Sig (p value)
1. Felt free to do …	yes	9	4.2	1.3	.24
	no	3	3.2	2.0	
2. I chose to go…	yes	9	3.5	1.8	
	no	3	2.3	1.5	.32
3. It was my idea…	yes	9	3.6	1.6	
	no	3	2.3	1.5	.24
4. I had a lot of control…	yes	9	4.1	1.3	
	no	3	1.3	.57	.007
5. I had more influence…	yes	9	4.3	1.1	
	no	3	2.0	1.0	.01

Since the results of this pilot test were from a small sample, they cannot be generalized to all consumers of mental health services. This pilot study does suggest that many consumers are able and willing to provide feedback on their experiences with the civil commitment process. Short, simply stated focused questions are needed.

ONE-ON-ONE INTERVIEW
CASE STUDY
Male Consumer
Location: Eastern Region

A 57-year-old professional male was interviewed about the most important issues to include in a report to inform policy making regarding mental health services and the civil commitment process in Virginia. This consumer was college educated and worked part-time. He was diagnosed with bipolar disorder and was stable on medications. He reports that his professional family members had basically emotionally rejected him because of the stigma of his mental illness, as evidenced by their not including him at family functions and gatherings, etc. When asked what were the three most important issues regarding the civil commitment system, he responded: (1) CSB Emergency Services needs to have ER services on a regular basis to deal with crisis because there was “nothing” private sector in the community.(2) There needs to be a system in place to monitor people and make sure they take their meds. [Related to this he said that he was not supportive of this view until he thoroughly read Kendra’s law. “I think Kendra’s Law is a wonderful idea. It would also cut homelessness in half. They [the general public and some other professionals] don’t care if people are a danger to self or unable to care for themselves, they only care if they are a danger to others.”],(3)

There is a great need for long-term, community based therapy in addition to medications to help people manage and stay employed in the community.

In addition to these points, this individual also shared stories about a number of people he knew personally who also had bipolar disorder. He shared that a number of people "like to be high," and some would take cocaine to "get high" when they were not manic. These people didn't mind being "out of control," they liked it. On the other hand, the individual being interviewed did not like the feeling of mania.

This consumer also reported that "the mentally retarded have made more progress in the recognition of their problems than have the mentally ill.' When asked why this might be so, he suggested that the parents and families of those with mental retardation had demanded rights for their family members, while families andfriends of those with mental illness were just now trying to increase awareness.

He reported the perceptions that many individuals in Virginia with serious mental illness do not know where to go to get help, and that this was across all groups regardless of age, education, or cultural background. One woman he knew had a daughter who was also bipolar who was picked up by the police for disturbing the peace. She was in jail for 90 days, and her mother was unable to get her released. When it went to trial, she was given a 30-day sentence. This is just one example, according to this consumer, of how slow and complicated the present system is. Everything tends to happen too slowly without regard for the individuals with mental illness.

Funding was identified as a critical issue. "Money talks," he reports. In his opinion, the politicians "don't give a damn" about people with mental illness. Partly, it is a lack of education and the stigma that has permeated society since the 1940s. It affects people's ability to obtain a job because of fear on the part of the not-mentally ill of what someone "might do," implying mentally ill people might be dangerous and at risk of harming people. This consumer strongly believes that the general public needs to know that most people with mental illnesses are not dangerous.

ONE-ON-ONE INTERVIEW
CASE STUDY
Female Consumer
Location: Coffee Shop, Northwest Region

The following observations were made by a female consumer during a face-to-face, one-on-one interview in a coffee shop in the *Northwest Region*. She provided her history during the course of the interview.

This young woman was first hospitalized at the age of 13. She stated that she has been hospitalized more than 80 times and that over half of her hospitalizations involved involuntary commitments. She has tried to kill herself 10 times. Her hospital stays have ranged from two

weeks to one month. She is diagnosed with schizoaffective disorder. She has a college degree and is active with a number of mental health organizations including the local community services board, the local human rights commission, and several consumer groups. She works part-time and lives alone in an apartment. Her family is supportive. She sees a private psychiatrist in the community as well as a psychiatrist at the local community services board. She receives an intensive level of services from the CSB.

She described her most recent experience with the involuntary civil commitment process. Approximately two weeks ago she had an appointment with her private psychiatrist. She had been talking with the psychiatrist about feeling depressed but had not had adequate time to fully discuss the issue before the end of her appointment. She did not feel that she was at the point of needing to be hospitalized. Her psychiatrist obtained an Emergency Custody Order "against me." She was at home when she heard a knock at her door. She said that she was slow in getting to the door and asked several times who was at the door. No one responded. When she opened her door she saw eight policemen with their guns drawn. There were "four cop cars and a paddy wagon" outside her apartment. One of the policemen told her to "freeze." She screamed. The police "stormed into (her) apartment." She was handcuffed immediately and informed about the ECO. She starting crying and told the police that she did not need to go to the hospital. The policeman told her she was going "regardless." She "proceeded to not cooperate." She refused to get up and fell on the floor. She was shackled and dragged outside in front of her neighbors. "I thought I was going to jail . . . I couldn't reason with myself." She was taken to the local hospital emergency room. She was crying and "felt totally humiliated." She said she felt like she had "no control" in this situation. One of the policemen said to her, "You need to be quiet; there are sick people in here." She was handcuffed, with her hands behind her back, for the entire four-hour period. She felt that the police were doing it "out of spite," because they usually remove the handcuffs. She said that she was angry at the way the police treated her and provoked them further. When the CSB's emergency services clinician arrived at the hospital, she was released.

When asked about her previous experiences, she said that she usually has not been handcuffed by police when transported to the hospital for evaluation, but has been handcuffed during transport to the state hospital. She said there usually are two policemen involved in the ECO process. Family members have often transported her when she has been TDOd.

Commitment hearings. She described her experience during a TDO commitment hearing. Her attorney "strolled in 5–10 minutes before the hearing." She asked, "How is he going to be able to represent me?" when he devoted so little time to her case. The attorney asked her what she wanted (i.e., to be released, hospitalized, etc.). He didn't ask any questions during the hearing. At the time, she had been seeing a private psychiatrist in the community for more than five years and had seen her doctor shortly before her commitment. She requested a continuance so that she could arrange for her psychiatrist to testify on her behalf. The judge said that this was not a criminal trial and denied her request for a continuance.

She said that sometimes the independent evaluators do not even meet with individuals before they testify and rely on notes provided by emergency services clinicians or hospital staff. She said that she has appealed her commitment in the past, but has been released from the hospital

before the appeal could be heard. One time she "beat" the TDO because hospital staff tried to have her committed during her first day on the ward, before she had had time to stabilize.

Being transported. She described the transportation process during an ECO or TDO as "horrible." She characterized it as "stigmatizing, humiliating, and demeaning," and said that being handcuffed and riding in a police car "makes you feel like a criminal." The police carry guns, sticks, and Tazers, which is intimidating. She said that the process is handled differently depending on the jurisdiction and that some jurisdictions do a better job than others. For example, in some jurisdictions police are required to provide the individual with a ride home if he/she is not TDOd. In other localities, this is not the case. In her experience, female police officers handle these situations better than male police officers. She described female officers as "nicer, more sympathetic."

Should individuals being ECOd or TDOd ever be handcuffed? "Maybe if there are pending legal charges or the individual is a flight risk." She said that individuals should be transported in unmarked police cars if the police must be involved in the transport, or in a vehicle that is more appropriate for someone who is ill. She said that the police should work in collaboration with CSB personnel. It would be very helpful to have a police officer who has adequate training in mental health issues, "someone who is calmer, more patient, who takes our safety into consideration. . . . The police are used to dealing with criminals."

Crisis response teams. She said that ideally, a crisis intervention or emergency response team staffed by trained mental health professionals and police with training and experience in dealing with individuals with mental illness would deal with individuals in crisis and provide transportation to the hospital as needed. She suggested that a CSB emergency services clinician be based at the police station and accompany police on these kinds of calls.

Find a model that works. She described the way an incident was handled by staff at the Department of Social Services as a model for crisis situations. She went to her DSS to talk with her case worker about a problem with her SSDI benefits. Her case worker refused to come out and speak with her. She became increasingly irate and the receptionist said she was going to have to call the police. A DSS staff member came out, talked to her and was able to de-escalate the situation. She feels that often a trained mental health professional can defuse a situation so that police intervention and hospitalization are not necessary

Changing commitment criteria—the issue of "imminent" danger. She was strongly against relaxing the commitment criteria. She said that this would "take (my) rights away and not allow me to get it together." She felt that making criteria less stringent could result in abuse, that family members might commit individuals more frequently because they did not want to deal with the situation. She said her mother used to say to her, "You're not going to school today? Then you are going to the hospital" and would have her committed. She said that her mother would provide a list of her behaviors that was "sensationalized" to the mental health professional who was doing her assessment ("she's not doing this . . . I'm afraid she's going to do this . . ."). When she was 18 or 19, she wrote a letter saying she was going to kill her mother. She said that her mother "held the letter over my head for 3 or 4 years . . . every

time she wanted me to go to the hospital she would threaten to call the judge and have me sent to jail."

Mandatory Outpatient Treatment. She does not support the idea of mandatory outpatient treatment, as she feels that it infringes on an individual's civil rights. She expressed concern that the kind of help individuals receive would be dictated to them ("You need to go to DBT, therapy, . . . "). She said that individuals react differently when they are partners in their treatment and that mandatory outpatient treatment would "create a lot of 'BS-ing' the system."

Improving the commitment process. How could the process of involuntary civil commitment be improved?

1. Provide individuals who are facing commitment with greater access to an attorney prior to their hearing. She noted that people accused of committing a crime are allowed to participate in their defense and are given more time to prepare their case than people facing involuntary civil commitment. She also thinks that individuals should have access to their own doctors and that their doctors should be allowed to provide testimony on their behalf at the commitment hearing.

2. Provide individuals with a court-appointed guardian ad litem. Institute a system similar to CASA to provide the individual with an advocate to ensure that their civil rights are protected. She said that this is important because individuals often do not know what their rights are or are in a condition that they cannot understand the process. "They are accused of being unable to care for themselves, but there is no one there to be sure that their rights are protected."

3. Create mobile crisis intervention teams staffed by mental health professionals. This could avert the need for hospitalization. She said that the last time she was being hospitalized, her friends and family recognized that her condition was deteriorating and contacted the local community services board for help. She felt that a mobile crisis team might have been able to intervene earlier and prevent her hospitalization.

The stigma of having a serious mental illness. "No matter how far I've gotten (in my life), the whole process (of being committed) makes me feel bad. I feel more like a criminal than someone with mental health problems."

ONE-ON-ONE INTERVIEW
CASE STUDIES
Female Consumers
Location: Homeless Shelter, Central Region

The following information was obtained from two female consumers during face-to-face, one-on-one interviews at a homeless shelter in the *Central Region.*

Case 1. It was winter in Virginia. The woman, who was in her late twenties, lived in a city near Richmond with her boyfriend. She had moved there from another state. She was employed; the boyfriend had drinking problems and did not work. The relationship became strained. She rejected him, and he repeatedly raped her over a number of days. Finally, she cut him across the face with a knife and told him to leave, which he did. The next day, he called and asked her if he could come back. She said no. He went and swore out a warrant for assault on her. The police came to arrest her. In the meantime, she had taken photos of the cuts and bruises she had suffered during the violent rapes. She reports that the policeman was "nice" but he had to take her to jail. She was depressed and in withdrawal from drugs while in jail, but did not receive any psychiatric evaluation or medication. She was assigned a 30-something female attorney who tried to get her to agree that she assaulted the boyfriend. "She kept saying, 'just say you did it and you can get out of there tonight, because you have never been arrested before and have no record.'" The woman refused because she believed she was acting in self defense and did not want to lose her "voting rights" by having a felony assault charge against her. So, she refused to plead. She stayed in jail for four months awaiting a trial. During that time, another attorney was appointed to represent her. This attorney spent more time. The judge threw out the case at trial. She was happy to win the case. After she was released from jail, the police in this town drove her to Richmond and dropped her on the street at a homeless shelter. It was a terrible experience because "the homeless men pray [sic] on homeless women. . . ." There were about 60 people in the shelter sleeping on cots . . . stealing during the night. . . . Everyone had to leave at 5 A.M. in the morning. She wandered around during the day and was unable to find work. She was also "out of it." After a few nights, she started walking and ended up in downtown Richmond. She threw herself in front of a car because she wanted to die. Somehow, the car stopped. A policeman who saw this came and handcuffed her on the ground. Soon an ambulance came; "no respect, no dignity" from the police. Her shoulder was dislocated. She was taken to MCV and was an inpatient on the psychiatric unit there for awhile before being released. She resented being taken to the hospital, but later was glad she was alive. She is currently in treatment with a local mental health care provider.

Case 2. A woman in her early 30s, with a criminal felony record for a violent crime, volunteered to talk about her experiences with the mental health system, including involuntary commitment. She reported being involved with the criminal justice system since her early teen years. Her family history has been chaotic—with multiple addresses and living with different family members at various time in her life. She currently had severed all contact with family and had no friends. She admitted having serious problems with drugs and alcohol. She reported that she has been physically and sexually abused by men in her family as well as men on the streets. She particularly mentioned that people were unaware that homeless shelters were dangerous because of the men there who took advantage of weak women. She had been involuntarily committed to a psychiatric hospital after a suicide attempt. She was released and was not able to obtain employment due to her felony record. She reported that she was currently a sex worker because that was the only reliable way to get money to pay for housing and food. She was hoping to get ongoing mental health services and employment training. She said that she had PTSD and depression and that the medication that she received at a free mental health clinic was helping her. The drug addiction was highlighted as her

biggest problem. With regard to her arrest and subsequent involuntary commitment, she said that the police “treated me like a criminal, not a patient” When asked what she thought would help her or women in her situation, she responded, “We need real help with substance abuse. I did crack and alcohol alternatively. We need job training.”