Joint Commission on Health Care

HJR 682 (O'Bannon): Involuntary Admission of Persons in Need of Substance Abuse Treatment

September 19, 2011

Jaime Hoyle
Senior Staff Attorney/Health Policy Analyst

HJR 682: Study Mandate

- Directs the Joint Commission on Health Care (JCHC) to:
  - Determine whether procedures for emergency custody, involuntary temporary detention, and involuntary admission for treatment are currently being used to commit persons with substance abuse or addiction disorders whose substance use creates a substantial likelihood that the person will cause serious physical harm to himself or others or suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs;
  - If involuntary admission procedures are not being used for such purpose, determine whether individuals with substance abuse or addiction disorders might benefit from use of emergency custody, involuntary temporary detention, and involuntary admission procedures when statutory criteria are met;
  - If use of involuntary commitment procedures are found to offer potential benefits for persons with substance abuse or addiction disorders, provide recommendations for increasing the use of such procedures to protect the health and safety of individuals with substance abuse or addiction disorders and other residents of the Commonwealth.

2

HJR 682: Study Mandate

- Summarizing, HJR 682 directs the JCHC to answer:

1. Whether involuntary commitment procedures are being used to treat substance use disorder;
2. If involuntary commitment procedures are not being used for this purpose, whether they should be; and
3. If involuntary commitment procedures would be beneficial for persons in need of substance abuse treatment, recommend how to increase their use.

3

Background

- Data from the National Survey on Drug Use and Health found
  - In 2006 an estimated 517,000 (approximately 8.38 %) of Virginians, ages 12 and older, abused alcohol and/or illicit drugs and approximately 1800 Virginians died from conditions related to substance abuse.
  - In 2008 an estimated 590,000 Virginians met clinical requirements for abuse or dependence of either alcohol or illicit drugs.
- Virginia's Office of the Chief Medical Examiner reported 331 deaths in 2008 from prescription drug poisoning.

4

Background

- A 2008 JLARC study determined:
  - Untreated substance use disorders cost the Commonwealth millions of dollars.
    - The estimated 2006 cost of $613 million for the criminal justice system did not include costs to the health care system; lost productivity; and the effects on the individual, family, and friends.
  - Substance abuse treatment services provided by community services boards (CSBs) are effective and have the impact of lowering costs.

5

Findings

- The *Code of Virginia* currently allows for the use of involuntary commitment procedures for persons in need of substance abuse treatment.
- Involuntary commitment procedures are not often used for this purpose for a variety of reasons.
- Involuntary commitment to inpatient treatment in most cases is better suited to compel treatment for mental illness; however, mandatory outpatient treatment is potentially a better disposition for persons with substance use disorder.

6

Finding #1

The *Code of Virginia* allows for the use of involuntary commitment procedures for persons in need of substance abuse treatment.

7

Virginia Law

- Individuals who abuse or are addicted to substances may not be willing or able to seek treatment on their own.
  - 35% of people with serious mental illness use substances in a way that compromises stable recovery and 19% of persons with alcohol abuse or dependence meet criteria for a mental illness.
- Virginia law provides for emergency custody, involuntary temporary detention, and involuntary admission for treatment of persons with mental illness.
  - *Code of Virginia* § 37.2-800 provides that for the purposes of the commitment statutes the term "mental illness" encompasses substance abuse also.

8

Involuntary Civil Commitment

- Probable cause for an ECO exists when "any person
  (i) has mental illness and…there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future,

  (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or

  (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs

  (ii) is in need of hospitalization or treatment, and

  (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment." *Code of Virginia* § 37.2-808

9

Involuntary Civil Commitment

- Once an ECO is issued, the person subject to the order is evaluated to determine if he meets the requirements for temporary detention. *Code of Virginia* § 37.2-808
- If TDO is issued, an independent examination and preadmission screening are completed and the TDO subject is stabilized in preparation for the involuntary civil commitment hearing.
  - The independent examination is required to be a comprehensive evaluation that includes "a clinical assessment including a mental status examination;…a medical and psychiatric history; a substance use, abuse, or dependency determination; and a determination of the likelihood that, as a result of mental illness, the person will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs…."

10

Involuntary Civil Commitment

The independent examination can include a substance abuse screening in order to determine "the likelihood that, as a result of mental illness, the person will, in the near future, cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any; [and] an assessment of the person's capacity to consent to treatment, including his ability to maintain and communicate choice, understand relevant information, and comprehend the situation and its consequences.…"

And "alternatives to involuntary inpatient treatment and recommendations for the placement, care, and treatment of the person" are discussed. *Code of Virginia* § 37.2-815

11

Involuntary Civil Commitment

- Involuntary civil commitment hearings are conducted by district court judges or special justices who hear testimony from the independent examiner who certifies "that he has personally examined the person and…whether he has probable cause to believe that the person
  - (i) has a mental illness and that there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, and
  - (ii) requires involuntary inpatient treatment."

Code of Virginia § 37.2-815

12

Current Use of Involuntary Commitment

- According to the Commission on Mental Health Law Reform, in the 21,549 commitment hearings held in FY 2010:
  - 19.5% resulted in dismissal.
  - 57.4% resulted in involuntary commitment.
  - 22.7% resulted in voluntary commitment.
  - <1% resulted in mandatory outpatient commitment.

13

Finding # 2:

Involuntary commitment procedures are rarely used to provide services for persons with substance use disorder.

14

Current Use of Involuntary Commitment Procedures for Substance Use Disorder

- According to discussions with CSB staff, involuntary admission for a primary diagnosis of substance use disorder is rare, although individuals involuntarily committed due to mental illness often also have a substance use disorder.
  - The commitment process does not adequately address the needs of persons who are seriously harming themselves due to substance abuse because the behavior does not rise to the standard for commitment.
    - The commitment process focuses on behavior more than diagnosis.
  - By the time of the commitment hearing, the person has often sobered up, is no longer suicidal or dangerous, and does not want treatment.
  - Most of the individuals involuntarily committed have a co-occurring mental illness that is exacerbated by substance use.

15

The Voluntary Versus Involuntary Issue

- There are varying schools of thought as to whether to compel involuntary treatment, especially for a substance use disorder.
  - Civil rights concerns, and
  - The argument that for substance abuse treatment to be effective, the individual must want treatment and must take an active role in his recovery.
    - Bias as to whether substance use disorder is an illness versus a behavior that someone is able to control.
    - To compel treatment to an unwilling participant is a waste of scarce resources.
    - Effective treatment for substance abuse requires adequate resources for follow-up care and on-going treatment.
    - There are not enough resources to address the needs of those willing to pursue treatment.

16

Finding #3:

Involuntary commitment to inpatient treatment in most cases is better suited to compel treatment for mental illness; however, mandatory outpatient treatment is potentially a better disposition for persons with substance use disorder.

Mandatory Outpatient Treatment in Virginia

- *Code of Virginia* § 37.2-817(D) states that mandatory outpatient commitment can be ordered if the person meets the standard for involuntary commitment and "less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and are determined to be appropriate…."
- In addition, the person needs to have sufficient capacity to understand the stipulations of his treatment, express an interest in living in the community and agree to abide by his treatment plan, and have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services.
  - Finally, the ordered treatment must be able to be delivered on an outpatient basis by the community services board or designated provider.

18

Use of Mandatory Outpatient Treatment

- The Commission on Mental Health Law Reform reports that Virginia used MOT in less than 1% of the commitment hearings during 2010.
  - 1/3 required substance abuse treatment in addition to mental health treatment.
- When it was used, the individual expressed a willingness to accept treatment, and it was ordered in accordance with the independent examiner's recommendation.
  - Most of the individuals agreed to outpatient treatment because they did not want to be hospitalized.

19

Use of Mandatory Outpatient Treatment

- CSBs reported that the limited use of MOT was due to numerous factors:
  - Special justices are reluctant to order MOT because of the associated ongoing responsibility of overseeing compliance.
  - Lack of resources
    - Some CSBs will refuse if there are no treatment resources
    - Long waiting lists for services
  - Confusion over the criteria
    - Belief that if the standard for inpatient commitment is met, then the individual needs inpatient commitment, not outpatient treatment.

20

Use of MOT in Prince William County

- Since the 2008 legislative reforms, use of MOT has decreased statewide.
- However, the CSB in Prince William County actually increased the use of MOT.
  - Generally MOT was used when the client was either:
    - "likely to harm self" or
    - "lacking the capacity to protect self or provide for basic human needs."
  - Approximately one-third of the clients placed on MOT were required to receive substance abuse treatment services as well as services for mental illness.

21

Use of MOT in Prince William County

- Prince William County CSB representatives indicated that two aspects of their civil commitment process made MOT more feasible:
  - They waited a full 48 hours before initiating the temporary detention hearing to give clients more time to consider and agree to treatment on an outpatient basis; and,
  - A second evaluation was completed immediately prior to the hearing to give the client another opportunity to express a willingness to participate in outpatient treatment.
- The MOT was found to meet the needs of clients who "fall somewhere in between inpatient care and dismissal" and the clients generally were very cooperative with treatment.

22

Department of Behavioral Health and Developmental Services: Creating Opportunities Program

- Assessing the range of available services, including services for individuals with co-occurring mental illness and substance use disorders.
- Assessing the extent to which CSBs have the capability to provide integrated substance abuse and mental health assessment and treatment.
- Implementing an assessment tool to allow CSBs to screen simultaneously for substance use disorder and mental illness.
- Increasing detox capability.

(Creating Opportunities will be addressed in October BHC meeting.)

23

Commission on Mental Health Law Reform: Findings on Mandatory Outpatient Treatment

- The Commission on Mental Health Law Reform previously indicated that changes will not be recommended to the MOT law until service capacity is increased.
- The Commission has written favorably about:
  - Increasing the TDO period to 72 hours to allow time for patient stabilization, the ability to identify available services, and allowing patients to commit to treatment.
  - Considering implementation of a "preventive MOT" that would allow persons who do not currently meet the standard for involuntary commitment, but would without intervention.

(Commission on MHLR Update to be heard in October BHC meeting.)

24

Policy Options

- **Option 1**: Take no action.
- **Option 2**: Include in the 2012 work plan for the BHC Subcommittee, a study of whether mandatory outpatient treatment can be structured to address more effectively the needs of persons in need of substance abuse treatment.
  - In addition by letter of the JCHC Chairman, request that representatives of the Department of Behavioral Health and Developmental Services, community services boards, and other interested parties participate in the study.

25

Public Comments

- Written public comments on the proposed options may be submitted to JCHC by close of business on October 6, 2011.
- Comments may be submitted via:
  - E-mail: jhoyle@jchc.virginia.gov
  - Fax: 804-786-5538
  - Mail: Joint Commission on Health Care
P.O. Box 1322
Richmond, Virginia 23218
- Comments will be summarized and reported during the JCHC meeting on October 17th.

JCHC website - http://jchc.virginia.gov

26