

A New Era Begins: Mental Health Law Reform in Virginia

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I. INTRODUCTION

Amidst calls for mental health reform and a sense of urgency stemming from the tragic events at Virginia Tech, the 2008 session of the Virginia General Assembly convened. The legislative reaction was overwhelming: Legislators introduced a vast array of bills relating to mental health. By the end of the session, the General Assembly enacted the most sweeping revisions to Virginia's mental health laws since the 1970s.

The Virginia Tech tragedy was not the only impetus for reform. With advocates, individuals with mental illness, family members, and mental health caregivers calling for improvements to our mental health commitment process and service delivery system, the Chief Justice of the Virginia Supreme Court established the Virginia Commission on Mental Health Law Reform in October 2006.¹ The Commission was established to address calls for improvement from the mental health community, to "conduct a comprehensive examination of Virginia's mental health laws and services," and to balance the needs of people with mental illness with the interests of their families and communities.² The Commission was given the task of studying access to services, the civil commitment process, the special needs of children and

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¹ Comm'n on Mental Health Law Reform, Fact Sheet, Oct. 11, 2006, *available at* <http://www.dmhmrhas.virginia.gov/documents/CMHLRFactsheet.pdf> (last visited Apr. 25, 2008).

² *Id.*

adolescents, consumer empowerment and self-determination, and mental health treatment in the criminal justice system.³

To inform the work of the Commission, the University of Virginia's School of Medicine produced a report on commitment practices.⁴ The report painted a gloomy picture of a commitment process in crisis. Most troublesome was the finding that civil commitment practices were not well integrated into a high functioning mental health delivery system that ensured access to care.⁵ With this report in hand, the Commission set out to identify problems within Virginia's mental health system and recommend improvements. At this point, tragic events overtook the work of the Commission.

On April 16, 2007, one student, Seung Hui Cho, killed thirty-two and injured many other students and faculty on the Virginia Tech campus.⁶ In conducting its review of the murders, the Virginia Tech Review Panel noted that Virginia's mental health laws were flawed, services were inadequate, widespread confusion existed as to the requirements of health privacy laws, and the law governing commitment reports made to the Central Criminal Records Exchange in order to prevent the purchase of firearms was inadequate.⁷

By the end of the 2008 General Assembly session, Virginia's mental health laws had undergone an historic overhaul, with changes in five key areas: commitment criteria, mandatory outpatient treatment, procedural improvements, privacy and disclosure provisions,⁸ and firearms

³ *Id.*

⁴ ELIZABETH L. MCGARVEY, UNIV. OF VA., CIVIL COMMITMENT PRACTICES IN VIRGINIA: PERCEPTIONS, ATTITUDES, AND RECOMMENDATIONS 1 (2007), *available at* <http://dls.state.va.us/GROUPS/HWI/meetings/090607/FocusGroup.pdf> (hereinafter MCGARVEY, PERCEPTIONS].

⁵ *Id.* at 2.

⁶ Theresa Vargas & Michael Alison Chandler, *Classes Resume Amid Empty Desks: Mourning Virginia Tech Seeks Normalcy*, WASH. POST, Apr. 23, 2007, at A1.

⁷ VA. TECH REVIEW PANEL, MASS SHOOTINGS AT VIRGINIA TECH: REPORT OF THE REVIEW PANEL 2 (2007), *available at* <http://www.vtreviewpanel.org/report/index/html> (last visited Apr. 25, 2008).

⁸ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____). The preceding four areas of change were addressed by House Bill 499. *Id.* An identical bill was introduced in the

purchase and reporting requirements.⁹ In addition, the mental health system received an infusion of more than \$41 million to increase service capacity.¹⁰ By all accounts, the actions of the General Assembly in this area were its most exhaustive and comprehensive in more than thirty years.

II. ADDITIONAL APPROPRIATIONS

All agree that any reform of Virginia's mental health laws cannot be accomplished without the availability of adequate services in the community to address the needs of persons with mental illness.¹¹ The Virginia Tech Review Panel strongly recommended that Virginia study the level of community outpatient service capacity required and any related costs for an adequate response to both involuntary court-ordered and voluntary referrals for services.¹² The Panel also recommended that the number and capacity of secure crisis stabilization units be expanded to ensure that beds are available for individuals subject to temporary detention orders.¹³ Thus, the General Assembly appropriated over \$41 million¹⁴ in additional funding to provide mental health services in the community.

Senate as Senate Bill 246. S.B. 246, Va. Gen. Assembly (Reg. Sess. 2008). This article, however, will refer only to House Bill 499 for the sake of simplicity. House Bill 401 and House Bill 559 are related bills, and this article will reference them only when particularly relevant. H.B. 401, Va. Gen. Assembly (Reg. Sess. 2008); H.B. 559, Va. Gen. Assembly (Reg. Sess. 2008).

⁹ H.B. 709, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 854, 2008 Va. Acts. ____);

H.B. 815, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 788, 2008 Va. Acts ____).

¹⁰ H.B. 29, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 11, 2008, ch. 827, 2008 Va. Acts ____);

H.B. 30, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of May 9, 2008, ch. 879, 2008 Va. Acts ____).

¹¹ COMM'N ON MENTAL HEALTH LAW REFORM, PRELIMINARY REPORT AND RECOMMENDATIONS 9 (2007), *available at* http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf [hereinafter COMM'N ON MENTAL HEALTH LAW REFORM, PRELIMINARY REPORT].

¹² *See* VA. TECH REVIEW PANEL, *supra* note 7, at 60-61.

¹³ *Id.* at 61.

¹⁴ H H.B. 29, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 11, 2008, ch. 827, 2008 Va. Acts ____); H.B. 30, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of May 9, 2008, ch. 879, 2008 Va. Acts ____). These funds must be used to provide emergency mental health services, crisis stabilization services, and inpatient and outpatient mental health services for individuals in need of emergency mental health services or who meet the inpatient or outpatient criteria. H.B. 29, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as act of Apr. 11, 2008, ch. 827, 2008 Va. Acts ____). The General Assembly also appropriated an additional \$11 million the first year and \$17.3 million the second year of the biennium, which will be matched by the federal Centers for Medicare and Medicaid Services, to establish six hundred additional community waiver slots for persons with mental retardation. *Id.*

III. COMMITMENT CRITERIA

The most significant change enacted by the General Assembly was the removal of the “imminent” requirement from the danger criterion for civil commitment. Virginia and other states began tightening commitment criteria in the late 1960s and early 1970s.¹⁵ The combination of the Civil Rights movement, which emphasized the protection of disenfranchised groups including those with mental illness, and new constitutional law challenges emphasizing treatment and rehabilitation in the least restrictive alternative¹⁶ prompted these changes. By the 1980s, psychiatrists and other mental health advocacy groups began advocating a more therapeutic approach, leading states to begin loosening commitment criteria.¹⁷ Prior to this 2008 session, Virginia was one of only five states requiring a finding of “imminent danger” to commit a person to involuntary hospitalization.¹⁸

A. *Danger Prong*

Under Virginia law prior to this session, an individual could be committed to involuntary inpatient treatment for up to one hundred eighty days if a general district court judge or special justice found by clear and convincing evidence that the individual “presents an imminent danger to himself or others as a result of mental illness.”¹⁹ This criterion is subject to varying interpretations throughout the Commonwealth.²⁰ Some judges and special justices interpret

¹⁵ Mark J. Mills, *Civil Commitment of the Mentally Ill: An Overview*, 484 ANNALS OF THE AM. ACAD. OF POL. & SOC. SCI. 28, 28-30 (1986).

¹⁶ See, e.g., *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982); *O’Connor v. Donaldson*, 422 U.S. 563, 575-76 (1975); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1103 (E.D. Wis. 1972).

¹⁷ See Jennifer Honig & Susan Stefan, *New Research Continues to Challenge the Need for Outpatient Commitment*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 109, 117 (2005).

¹⁸ VA. CODE ANN. § 37.2-817(B) (Repl. Vol. 2005); Treatment Advocacy Center, Summary of State Assisted Treatment Standards: 50 States and DC, <http://psychlaws.org/LegalResources/ATCriteria.htm> (last visited June 10, 2008).

¹⁹ VA. CODE ANN. § 37.2-817(B) (Repl. Vol. 2005).

²⁰ See *infra* notes 21-23 and accompanying text.

“imminent danger” to mean “immediate” danger²¹ while one circuit court judge writes, “an imminent danger is a danger which is likely to occur within a reasonably short, but not immediate period of time unless appropriate treatment is provided.”²² Critics of the current standard argue that it prevents the use of involuntary treatment until it is too late.²³ They further argue that it inappropriately channels individuals from the mental health system into jails and prisons where mental health issues are not addressed adequately.²⁴

The Virginia Tech Review Panel recommended that the criteria for involuntary commitment “be modified in order to promote more consistent application of the standard and to allow involuntary treatment in a broader range of cases involving severe mental illness.”²⁵ The General Assembly agreed. Effective July 1, 2008, the danger prong of Virginia’s commitment statute is relaxed to require the judge or special justice to find that “the person has a mental illness and there is a *substantial likelihood* that, as a result of mental illness, the person will, *in the near future*, (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any”²⁶

The phrase “in the near future” is further limited by requiring evidence of “recent behavior

²¹ *But cf.* Memorandum from Charles E. Poston, Judge, Circuit Court of the City of Norfolk to Chief Judge (July 7, 2003) (on file with the Supreme Court of Virginia) (noting the existing process for defining “imminent danger” and the lack of support for the interpretation meaning “immediate”).

²² Memorandum from Charles E. Poston, Judge, Circuit Court of the City of Norfolk to Chief Magistrate (July 15, 2003) (on file with the Supreme Court of Virginia).

²³ *See generally* COMM’N ON MENTAL HEALTH LAW REFORM, DRAFT REPORT OF THE CIVIL COMMITMENT TASK FORCE (2008) [hereinafter COMM’N ON MENTAL HEALTH LAW REFORM, CIVIL COMMITMENT] (describing proposals to revise the standards for involuntary mental health treatment).

²⁴ *See id.* at 53.

²⁵ VA. TECH REVIEW PANEL, *supra* note 7, at 60.

²⁶ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ___) (emphasis added); *see also* H.B. 559, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 779, 2008 Va. Acts ___). The phrase “in the near future” replaces the term “imminent.” For those judges and special justices defining the term “imminent” to mean “immediate,” the time frame has been significantly broadened, but is arguably akin to “within a reasonably short, but not immediate period of time unless appropriate treatment is provided.” *See supra* notes 22-24 and accompanying text.

causing, attempting, or threatening harm.”²⁷ The General Assembly believed, however, that this language might be too limiting.²⁸ Therefore, the phrase “and other relevant information, if any,” was added to ensure that courts could consider any relevant information related to the potential for harm in the near future.

The states are split on the inclusion of a temporal requirement, such as “in the near future,” in civil commitment laws.²⁹ Case law interpreting the term is limited and varies from state to state.³⁰ For example, Illinois interprets the temporal requirement as “within a reasonable time”³¹ and requires a reasonable expectation that a person will engage in future dangerous conduct.³² The mere presentation of past acts is insufficient without a prediction of future dangerousness.³³

Thirty-four states also require an act or some behavior to meet the commitment standard.³⁴ New Mexico, for example, defines “substantial likelihood of serious harm to oneself” as “more likely than not that *in the near future* the person will . . . cause serious bodily

²⁷ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____).

²⁸ Compare H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (as introduced Jan. 7, 2008), with H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (as amended on the Senate floor Mar. 3, 2008).

²⁹ Twenty-eight states have a temporal requirement but the remaining states have none. Treatment Advocacy Center, Summary of State Assisted Treatment Standards: 50 States and DC, <http://psychlaws.org/LegalResources/ATCriteria.htm> (last visited June 10, 2008). Of the states with a temporal requirement, nine use “near future.” Letter from William C. Mims, Chief Deputy Attorney General, Virginia Office of the Attorney General to Robert B. Bell, Delegate, Virginia General Assembly (Jan. 17, 2008) (on file with author).

³⁰ See *infra* notes 32-34 and accompanying text.

³¹ In the matter of Gregorovich, 89 Ill. App. 3d 528, 533, 411 N.E.2d 981, 985 (Ill. App. Ct. 1980).

³² In re Barnard, 247 Ill. App. 3d 234, 255-56, 616 N.E.2d 714, 729 (Ill. App. Ct. 1993); Sullivan v. Hay, 140 Ill. App. 3d 1007, 1010, 489 N.E.2d 889, 891 (Ill. App. Ct. 1986).

³³ In re Interest of Blythman, 208 Neb. 51, 58, 303 N.W.2d 666, 671 (Neb. 1981).

³⁴ Treatment Advocacy Center, Summary of State Assisted Treatment Standards: 50 States and DC, <http://psychlaws.org/LegalResources/ATCriteria.htm> (last visited June 10, 2008). Eight states use the newly adopted Virginia criteria requiring a recent act or behavior causing, attempting, or threatening harm to show that the commitment standard is met. *Id.*

harm to [himself] by violent or other self-destructive means”³⁵ “as evidenced by [recent] behavior causing, attempting or threatening the infliction of serious bodily harm to himself.”³⁶

B. *Inability to Care for Self Prong*

The General Assembly also changed the second prong of the commitment criteria to have more specificity. The “substantially unable to care for self” language was changed to require that the person “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, . . . suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs”³⁷ The serious harm described is not limited to physical harm and potentially may be broad enough to encompass other harms like serious financial harm resulting from a person in a manic state spending his life savings.³⁸ Similarly, basic human needs are not limited to food, clothing, or shelter, thereby permitting commitment in circumstances such as medically necessary treatment.³⁹ Finally, an individual may be ordered to involuntary inpatient treatment for a period of time not to exceed thirty days.⁴⁰ Additional consecutive orders of involuntary inpatient treatment may be entered for periods of up to one hundred eighty days each.⁴¹

IV. MANDATORY OUTPATIENT TREATMENT

³⁵ N.M. STAT. ANN. § 43-1-3(M) (1978) (emphasis added).

³⁶ In the Matter of Pernell, 92 N.M. 490, 496, 590 P.2d 638, 644 (N.M. Ct. App. 1979).

³⁷ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ___); H.B. 559, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 779, 2008 Va. Acts ___).

³⁸ The mental health reform bills do not contain any language limiting the type of harm required under the inability to care for self prong to physical harm. See H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ___); H.B. 559, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 779, 2008 Va. Acts ___).

³⁹ This statutory change reflects the fact that over half of involuntary commitments were based upon the inability to care for self, rather than the dangerousness, criteria. See ELIZABETH L. MCGARVEY, UNIV. OF VA., A STUDY OF CIVIL COMMITMENT HEARINGS HELD IN THE COMMONWEALTH OF VIRGINIA IN THE MONTH OF MAY 2007 18 (2008), available at http://www.courts.state.va.us/cmh/2007_05_civil_commitment_hearings.pdf [hereinafter MCGARVEY, CIVIL COMMITMENT].

⁴⁰ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ___).

⁴¹ *Id.*

The most important element of this session's mental health law reform was the establishment of clear procedures for ordering, delivering and monitoring less restrictive court-ordered outpatient treatment. These changes make mandatory outpatient treatment more usable and ensure a consistent statewide implementation. In addition, these procedures will increase oversight by community services boards (CSBs) and other providers to ensure that no one falls through the cracks. Most importantly, it may reduce hospitalizations and mental health crises for many people.

A. Criteria for Mandatory Outpatient Treatment

There are three types of mandatory outpatient treatment. First, a person may be ordered to mandatory outpatient treatment as a least restrictive alternative to inpatient treatment utilizing the same commitment criteria as for involuntary inpatient treatment, as is the case in Virginia.⁴²

Second, many states, including North Carolina, employ mandatory outpatient treatment as a supplement to short-term acute hospitalization.⁴³ The General Assembly considered enacting this provision but opted to study the matter further.⁴⁴

Third, a separate and less rigid criteria may be utilized to impose mandatory outpatient treatment for individuals who do not yet meet the involuntary inpatient criteria to prevent future involuntary inpatient admission, a commitment scheme enacted in various states, most notably in New York as Kendra's Law.⁴⁵ The General Assembly also considered enacting this type of legislation, but due to the potential fiscal impact associated with this scheme and the current

⁴² See, e.g., VA. CODE ANN. § 37.2-817(C) (Repl. Vol. 2005).

⁴³ N.C. GEN. STAT. § 122C-261, 267 (2007). Here, the court orders involuntary inpatient treatment followed upon discharge by a period of mandatory outpatient treatment. *Id.*

⁴⁴ See S.B. 274, Va. Gen. Assembly (Reg. Sess. 2008).

⁴⁵ N.Y. MENTAL HYG. LAW § 9.60 (Consol. 2007). Under this type of outpatient commitment scheme, the person is experiencing a substantial deterioration in his previous level of functioning that has led to involuntary inpatient admission in the past that will occur again unless some type of involuntary treatment is imposed. *Id.* § 9.60(c)(3)-(7).

paucity of outpatient services for those seeking treatment on a voluntary basis, the matter was carried over to the 2009 General Assembly session.⁴⁶

The General Assembly did, however, clarify current law specifying the conditions under which mandatory outpatient commitment can be ordered as an alternative to inpatient treatment.⁴⁷ Most importantly, the General Assembly provided: “less restrictive alternatives shall not be determined to be appropriate unless the services are actually available in the community and providers of the services have actually agreed to deliver the services.”⁴⁸

Therefore, the court may not order mandatory outpatient treatment unless the services are actually—not theoretically—available in the community and the treatment providers have agreed to provide the services. The duration of the mandatory outpatient treatment order should be determined by the court based upon the recommendation of the CSB but shall not exceed ninety days.⁴⁹

The change in the commitment criteria may also increase the use of mandatory outpatient treatment orders. At present, mandatory outpatient treatment is ordered only 5.7% of the time.⁵⁰ Many special justices indicate that, because of the very restrictive criteria employed in Virginia,

⁴⁶ See S.B. 177, Va. Gen. Assembly (Reg. Sess. 2008).

⁴⁷ The new law provides:

(b) less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of [the person’s] condition have been investigated and are determined to be appropriate, and (c) the person (A) has sufficient capacity to understand the stipulations of his treatment, (B) has expressed an interest in living in the community and has agreed to abide by his treatment plan, and (C) is deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services, and (d) the ordered treatment can be delivered on an outpatient basis by the [CSB] or designated provider

H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____).

⁴⁸ *Id.*

⁴⁹ *Id.* Orders may be extended for consecutive periods up to 180 days. *Id.*

⁵⁰ MCGARVEY, CIVIL COMMITMENT, *supra* note 39, at 17. This study was conducted just after the shootings at Virginia Tech when the Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Office of the Attorney General were receiving anecdotal reports of increased use of mandatory outpatient treatment. *Id.*

individuals for whom involuntary treatment was sought were too dangerous or impaired to be ordered to outpatient treatment.⁵¹

Lack of outpatient service capacity has been cited as another key reason for the low number of mandatory outpatient treatment orders. The Inspector General for Mental Health, Mental Retardation and Substance Abuse Services reported in his *2005 Review of the Virginia Community Services Board Emergency Services Programs* that the majority of CSBs do not provide a comprehensive range of emergency services.⁵² The Inspector General followed this report with a *2007 Survey of CSB Outpatient Service Capacity and Commitment Hearing Attendance* revealing that at least two CSBs do not offer any outpatient services to adults.⁵³ The lack of success is compounded by extremely long wait times for appointments with clinicians and psychiatrists.⁵⁴ With the additional appropriations and lowered commitment criteria, mandatory outpatient treatment will become more widely used in Virginia as outpatient services are increasingly available to individuals with severe mental illness.

B. Monitoring Mandatory Outpatient Treatment

The Virginia Tech Review Panel also highlighted the need for greater specificity in monitoring mandatory outpatient treatment (MOT) orders.⁵⁵ The Panel recommended clarification of the appropriate recipients of orders, the party responsible for certifying orders, the party responsible for reporting noncompliance and to whom noncompliance is reported, the mechanism for returning noncompliant persons to court, sanctions for noncompliance, and the

⁵¹ See *id.* at 19 (indicating that only 26.2% of those cases resulting in an involuntary outpatient order posed a danger to others).

⁵² OFFICE OF THE INSPECTOR GEN., REVIEW OF THE VIRGINIA COMMUNITY SERVICES BOARD EMERGENCY SERVICES PROGRAM 3 (2005), available at <http://www.oig.virginia.gov/documents/SS-ESPFinalReportMay-August2005.pdf>.

⁵³ OFFICE OF THE INSPECTOR GEN., SURVEY OF CSB OUTPATIENT SERVICE CAPACITY AND COMMITMENT HEARING ATTENDANCE 21 (2007), available at <http://www.oig.virginia.gov/documents/VATechRpt141-v2.pdf>.

⁵⁴ The Inspector General found that outpatient treatment capacity for adults actually decreased at 60% of the CSBs. *Id.*

⁵⁵ VA. TECH REVIEW PANEL, *supra* note 7, at 58.

responsibilities of the CSB and treatment providers in assuring effective implementation of orders.⁵⁶

The General Assembly addressed each of these issues, placing specific monitoring and accountability responsibilities on CSBs. Any MOT order must require the CSB where the person resides to monitor implementation of the MOT plan and report material noncompliance to the court.⁵⁷ The CSB must file a comprehensive MOT plan with the court for approval within five work days of entry of the order.⁵⁸ Any subsequent substantive modifications, such as a change in service provider, must be filed with the court for review and attached to the order.⁵⁹ If the CSB determines that necessary services are not available or cannot be provided, it must notify the court within five days of the MOT order's entry.⁶⁰

General district court clerks also received significant new responsibilities. The clerk is required to provide a copy of the MOT order to the person subject to the order, his attorney, and the CSB responsible for monitoring compliance.⁶¹ In addition, the court entering the MOT order may transfer jurisdiction to the court where the person resides at any time after entry of the MOT

⁵⁶ *Id.* at 61.

⁵⁷ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____). Further, the MOT order must include an initial treatment plan that describes arrangements made for the initial in-person appointment or contact with each service provider, identifies the specific services, identifies the provider who has agreed to provide each service, and includes any other relevant information available regarding the treatment ordered. *Id.*

⁵⁸ *Id.* The comprehensive plan must

(i) identify the specific type, amount, duration, and frequency of each service . . . , (ii) identify the provider that has agreed to provide each service . . . , (iii) certify that the services are the most appropriate and least restrictive treatment available for the person, (iv) certify that each provider has compiled and continues to comply with applicable [licensing] provisions . . . , (v) be developed with the fullest possible involvement and participation of the person and reflect his preferences to the greatest extent possible to support his recovery and self-determination, (vi) specify the particular conditions with which the person shall be required to comply, and (vii) describe how the [CSB] shall monitor . . . compliance with the plan and report any material noncompliance

Id.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.* The CSB must, in turn, acknowledge receipt of the order on a form provided by the court. *Id.*

order.⁶² The CSB must remain responsible for monitoring compliance with the order until the local CSB receiving jurisdiction acknowledges the transfer to the clerk of court.⁶³

The General Assembly also enacted a new section defining CSB monitoring obligations and requiring service providers identified in the MOT plan to report material noncompliance to the CSB.⁶⁴ If the CSB determines the person has materially failed to comply, it must petition the court for a review of the MOT order within three days—or twenty-four hours if the person is hospitalized under a temporary detention order—and recommend an appropriate disposition to the court.⁶⁵ If the CSB determines the person is not complying materially with the MOT order and also meets the commitment criteria, it shall immediately request an emergency custody order pursuant to Virginia Code section 37.2-808 or a temporary detention order pursuant to section 37.2-809.⁶⁶

The General Assembly further established a court review process covering all proceedings related to the MOT order.⁶⁷ The court will be required to hold a hearing to review the MOT order within five days of receiving the petition.⁶⁸ The clerk is required to provide notice of the hearing to the person, the CSB, all treatment providers, and the original petitioner.⁶⁹ Preference should be given to appointing the attorney who represented the person at the initial hearing, but the same judge or special justice who presided at the hearing at which the MOT order was entered is not required to conduct the review hearing.⁷⁰

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.* According to the bill, “if the fifth day is a Saturday, Sunday, or legal holiday, the hearing shall be held by the close of business on the next day that is not a Saturday, Sunday, or legal holiday.” *Id.* If the person is detained, the timeframe for holding a hearing for persons under a temporary detention order applies. *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

If requested by the person, the CSB, a treatment provider listed in the MOT plan, or the original petitioner, a new examiner must be appointed to conduct the same evaluation required under section 37.2-815 and advise the court whether he believes the person continues to meet the commitment criteria.⁷¹ In addition, the CSB must offer to provide transportation to the examination if the person is not detained and has no other means of transportation.⁷² If the person fails to appear at the examination, the CSB must notify the court and the court is required to issue a mandatory examination order and *capias* directing the primary law enforcement agency to transport the person to the examination.⁷³ If the person fails to appear at the hearing, the court must reschedule the hearing, issue an emergency custody order, or issue a temporary detention order.⁷⁴

At the conclusion of the hearing, the court must order involuntary admission if the person meets the commitment criteria, renew the MOT order if the person meets the criteria while making any necessary modifications acceptable to the CSB or treatment providers, or rescind the MOT order.⁷⁵

The CSB may petition the court to rescind the MOT order at any time if it determines the person has complied with the MOT order and no longer meets the criteria or the order is no longer necessary.⁷⁶ If the court agrees with the CSB, it must rescind the order; otherwise, it must schedule a hearing for review of the order in accordance with section 37.2-817.2 of the Code of

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.* If the court is not available, the magistrate is responsible for issuing the mandatory examination order and *capias*. *Id.* Detention under this order may not exceed four hours. *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.* Transportation to the inpatient treatment facility, if ordered, is provided by the sheriff or other responsible person. VA. CODE ANN. § 37.2-829 (Repl. Vol. 2005).

⁷⁶ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____).

Virginia.⁷⁷ The subject of the order may also petition the court to rescind the order thirty days after entry of the MOT order, but only once in a ninety day period.⁷⁸

Within thirty days prior to the MOT order's expiration, the CSB, any treating physician, or other responsible person may petition to continue the MOT order.⁷⁹ If the court schedules a hearing, it must appoint an examiner to conduct another evaluation as provided in Virginia Code section 37.2-815.⁸⁰ The CSB must also provide a preadmission screening report.⁸¹ The court may continue the MOT order for up to 180 days, making any changes necessary in the order.⁸² If the MOT order expires before the hearing can be held, the MOT order in effect at the time the petition for continuation is filed remains in effect until the hearing.⁸³

V. PROCEDURAL ASPECTS

In addition to modification of the commitment criteria and improvements to mandatory outpatient treatment, the General Assembly addressed procedural aspects of the civil commitment process. These amendments will standardize the process across the Commonwealth and remedy problematic aspects of the process.

The issuance of an emergency custody order is often the first step in the civil commitment process. An emergency custody order is issued by a magistrate upon a finding of probable cause to believe that an individual meets the commitment criteria.⁸⁴ The order

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.* If the person and the CSB, when the CSB is not the petitioning party, agree to the extension, the court must continue the order without a hearing. *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ VA. CODE ANN. § 37.2-808(A) (Repl. Vol. 2005 & Supp. 2007).

authorizes law enforcement to take the individual into custody and transport him for evaluation by a CSB designee skilled in the diagnosis and treatment of mental illness.⁸⁵

Under current law, the period of custody under an emergency custody order cannot exceed four hours from the order's execution.⁸⁶ Much occurs during the four hour period. The individual first must be transported to a location where an assessment of the need for treatment can occur.⁸⁷ Once transportation is complete, the individual will undergo a thorough mental health evaluation.⁸⁸ If the evaluation determines the individual meets the commitment criteria, the CSB employee or designee must locate a bed for temporary detention during the emergency custody period.⁸⁹ The search for a facility of temporary detention is often challenging and time-consuming. Frequently, transportation, performance of medical and mental health evaluations, and locating a temporary detention bed requires more time than the statutory four hour period. The CSB employee or designee is then left with the Hobson's choice of releasing an individual meeting the commitment criteria or detaining him further without legal authority.

To help remedy this practical problem, the legislation authorized magistrates to grant a one time extension of an emergency custody order for up to two hours upon a finding of good cause.⁹⁰ Good cause for an extension is defined to include the need for additional time to identify a facility of temporary detention or to complete a medical evaluation.⁹¹

⁸⁵ *Id.* § 37.2-808(B)-(C).

⁸⁶ *Id.* § 37.2-808(I).

⁸⁷ *Id.* § 37.2-808(B). In rural or heavily congested areas, transportation can take a substantial portion of the four hour period. COMM'N ON MENTAL HEALTH LAW REFORM, PRELIMINARY REPORT, *supra* note 11, at 1.

⁸⁸ VA. CODE ANN. § 37.2-808(B) (Repl. Vol. 2005 & Supp. 2007). In some circumstances, individuals in medical distress will require a medical evaluation prior to the mental health evaluation.

⁸⁹ *See* VA. CODE ANN. §§ 37.2-808(H), 37.2-809(D) (Repl. Vol. 2005 & Supp. 2007). If the CSB does not locate a facility to place the person, a temporary detention order cannot issue and law enforcement must release the person. *See* VA. CODE ANN. §§ 37.2-808(H), 37.2-809(D) (Repl. Vol. 2005 & Supp. 2007).

⁹⁰ H.B. 583, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 784, 2008 Va. Acts ____). The extension can be requested by a family member of the individual, an employee or designee of the CSB, a treating physician, or a law enforcement officer. *Id.*

⁹¹ *Id.*

During the emergency custody period, the transporting law enforcement officer maintains custody of the individual.⁹² This can create a hardship when officers are taken away from regular patrol duties for four or more hours. Many law enforcement officers were understandably concerned about extending the emergency custody period beyond the statutory four hours.⁹³ To address these concerns, the legislation adds a provision to permit the law enforcement agency transporting an individual to transfer custody to the receiving facility “if it is licensed to provide the level of security necessary to protect the individual and others from harm,” is “capable of providing the level of security necessary,” and has entered into a transfer of custody agreement with the law enforcement agency.⁹⁴

After a temporary detention order has been issued, an individual will have an independent clinical evaluation. Under current law, a psychiatrist, psychologist, or any mental health professional licensed through the Department of Health Professions and qualified in the diagnosis of mental illness if a psychiatrist or psychologist is not available can serve as the independent examiner.⁹⁵ Beyond stating that the examiner must personally examine the individual and certify whether he meets the commitment criteria, current law is silent on what the examination is to include.⁹⁶ As a result, independent examinations vary considerably in thoroughness and content.

In considering the qualifications to be an independent examiner, the General Assembly limited the types of mental health professionals who can serve in such a role. Under the amended law, if a psychiatrist or psychologist is not available, only a licensed clinical social

⁹² VA. CODE ANN. § 37.2-808(H) (Repl. Vol. 2005 & Supp. 2007).

⁹³ See DEPT. OF PLANNING AND BUDGET, 2008 FISCAL IMPACT STATEMENT: HB 401 (2008), *available at* <http://leg1.state.va.us/cgi-bin/legp504.exe?081+oth+HB401FH1122+PDF>.

⁹⁴ H.B. 401, Va. Gen. Assembly (Reg. Sess. 2008).

⁹⁵ VA. CODE ANN. § 37.2-815 (Repl. Vol. 2005 & Supp. 2007). There is no requirement that the professional appointed complete training or certification regarding his responsibilities as an independent examiner or the performance of the evaluation. *See id.*

⁹⁶ *See id.*

worker, professional counselor, psychiatric nurse practitioner, or clinical nurse specialist can qualify.⁹⁷ In addition, a professional other than a psychiatrist or psychologist must have completed a certification program approved by the Department of Mental Health, Mental Retardation, and Substance Abuse Services.⁹⁸

The legislature also added detailed provisions requiring the independent examination to include a clinical assessment; substance abuse screening, if indicated; risk assessment; assessment of the person's capacity to consent to treatment; review of the temporary detention facility's records; discussion of the person's treatment preferences; assessment of alternatives to involuntary inpatient treatment; and recommendations for the placement, care, and treatment of the person.⁹⁹ This added specificity will hopefully standardize independent examinations across the Commonwealth.

Another concern for both the Virginia Tech Review Panel and the Commission on Mental Health Law Reform was that neither the CSB prescriber, nor the independent examiner, is required to attend the commitment hearing.¹⁰⁰ Without their presence, clinical questions that may arise during the hearing cannot be answered. It was also feared that without the attendance of CSB personnel there would be an absence of oversight particularly in cases where an individual is ordered to mandatory outpatient commitment.¹⁰¹

In response to these concerns, the General Assembly mandated the attendance of CSB personnel at all commitment hearings, either in person or through electronic means.¹⁰² The CSB that prepared the prescreening report must send a representative to the hearing unless it is held

⁹⁷ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____).

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ COMM'N ON MENTAL HEALTH LAW REFORM, PRELIMINARY REPORT, *supra* note 11, at 1-2; VA. TECH REVIEW PANEL, *supra* note 7, at 57, 61.

¹⁰¹ COMM'N ON MENTAL HEALTH LAW REFORM, PRELIMINARY REPORT, *supra* note 11, at 1-2.

¹⁰² H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____).

outside of its service area.¹⁰³ Otherwise, arrangements shall be made for a representative of the CSB serving the area where the hearing is held to attend the hearing on behalf of the prescreening CSB.¹⁰⁴ In addition, the independent examiner and the treating physician at the temporary detention facility must be available during the hearing for questioning whenever possible through electronic means.¹⁰⁵

VI. CONFIDENTIALITY AND DISCLOSURE PROVISIONS

The purpose of Virginia's civil commitment process is to provide treatment to an individual and protect the individual and the public from harm that the individual could potentially inflict upon himself or others.¹⁰⁶ Privacy issues abound in the civil commitment context.¹⁰⁷ On the one hand, individuals with mental illnesses are understandably concerned with the stigma and prejudice that can result from a disclosure of their mental health information. On the other hand, evaluators and courts need personal information to perform their roles effectively in the civil commitment process. After the tragedy at Virginia Tech, questions also arose regarding the extent to which the public should be able to access information regarding commitment hearings.¹⁰⁸

Many health care providers questioned their ability to share health information with others involved in the civil commitment process given the restrictions imposed by the HIPAA Privacy Rule.¹⁰⁹ The Virginia Tech Review Panel found that while the federal law may not be an

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ The Supreme Court of the United States has permitted states to use two justifications for civil commitment laws consistent with constitutional due process protections. The first is the police power of the state to "treat the individual's mental illness and protect him and society from his potential dangerousness." *Jones v. United States*, 463 U.S. 354, 368 (1983). The second is the state's legitimate interest in "providing care to its citizens who are unable because of emotional disorders to care for themselves." *Addington v. Texas*, 441 U.S. 418, 426 (1979).

¹⁰⁷ COMM'N ON MENTAL HEALTH LAW REFORM, PRELIMINARY REPORT, *supra* note 11, at 21-22.

¹⁰⁸ *See* VA. TECH REVIEW PANEL, *supra* note 7, at 63.

¹⁰⁹ *See id.* at 65.

actual barrier to disclosure there was a perception that disclosure was not permitted which resulted in needed information not being shared.¹¹⁰

To ensure that all parties with a role in the civil commitment process can access appropriate health information, the General Assembly enacted mandatory disclosure provisions in title 16.1 for juvenile commitments,¹¹¹ title 19.2 for forensic commitments,¹¹² and title 37.2 for adult commitments.¹¹³ A complimentary provision was also added to the Virginia Patient Health Records Privacy Act.¹¹⁴ The new provisions require any health care provider supplying present or past services to a subject of a civil commitment proceeding to disclose any information that is necessary and appropriate for the performance of such duties to a magistrate, the court, the person's attorney, the independent examiner, the CSB, or a law enforcement officer upon request.¹¹⁵ In addition, health care providers shall disclose information that may be necessary for a person's treatment to any other health care provider responsible for evaluating, providing services to, or monitoring the treatment of the person.¹¹⁶

The added provisions were carefully drafted to meet the requirements of the HIPAA Privacy Rule. Under the HIPAA Privacy Rule, health care providers may disclose health information for treatment purposes.¹¹⁷ As stated in the preamble to the Rule, health care providers are "permitted to disclose protected health information for treatment purposes

¹¹⁰ *Id.* at 63.

¹¹¹ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____). The provision will amend section 16.1-377 of the Virginia Code. *Id.*

¹¹² *Id.* The Virginia Code section affected by this provision is 19.2-169.6. *Id.*

¹¹³ *Id.* The provision will add section 37.2-804.2 to the Virginia Code. *Id.*

¹¹⁴ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____).

¹¹⁵ *Id.*; H.B. 576, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 782, 2008 Va. Acts ____).

¹¹⁶ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____); H.B. 576, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 782, 2008 Va. Acts ____); S.B. 246, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 870, 2008 Va. Acts ____).

¹¹⁷ 45 C.F.R. § 164.506 (2007). Treatment is defined as the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party. 45 C.F.R. § 164.501 (2007).

regardless of to whom the disclosure is made.”¹¹⁸ Thus, the HIPAA Privacy Rule allows providers to disclose health information to the entities and individuals involved in the civil commitment process, including the court, in order to obtain and deliver treatment for the individual.

Although the HIPAA Privacy Rule provision permitting disclosures for treatment purposes is sufficient to permit the mandatory new disclosure provisions of House Bill 499, other HIPAA provisions also are applicable. Providers can make disclosures under the HIPAA Privacy Rule to avert a serious threat to the health or safety of a person or the public.¹¹⁹ This exception applies to many of the disclosures contained within House Bill 576. In addition, providers may disclose health information to law enforcement as required by law.¹²⁰ Finally, the HIPAA Privacy Rule permits providers to disclose health information as required by law.¹²¹

To further ease a provider’s concerns about disclosing health information in the context of a civil commitment proceeding, the General Assembly mandated that orders entered in the civil commitment process, such as emergency custody orders, temporary detention orders, and commitment orders, provide for disclosures of health records pursuant to the new disclosure provisions.¹²² Because court orders will require the disclosure of health information in the civil commitment process, such disclosures are permissible under the HIPAA Privacy Rule provision permitting disclosures pursuant to court orders.¹²³

¹¹⁸ Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. 53182 (proposed Aug. 14, 2002) (to be codified at 45 C.F.R. pts. 160, 164).

¹¹⁹ 45 C.F.R. § 164.512(j) (2007).

¹²⁰ 45 C.F.R. § 164.512(f)(1)(i) (2007).

¹²¹ 45 C.F.R. § 164.512(a) (2007).

¹²² H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ___); H.B. 583, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 784, 2008 Va. Acts ___).

¹²³ 45 C.F.R. § 164.512(e)(1)(i) (2007).

Concerns were raised that the disclosure provisions, as they pertained to law enforcement, were overly broad.¹²⁴ Therefore, the General Assembly enacted limitations on law enforcement's access to health information.¹²⁵ Officers may only receive information necessary to protect the officer, the individual, or the public from physical injury or address the health care needs of the individual.¹²⁶ Any information disclosed to an officer cannot be used for any other purpose, disclosed to others, or retained.¹²⁷

While ensuring that necessary information is available to all parties involved in the civil commitment process, the General Assembly also took steps to protect the privacy of information contained in court records.¹²⁸ Under current law, the court is required to keep medical records, reports, and court documents pertaining to civil commitment hearings confidential only if the individual makes such a request.¹²⁹ If the request is not made, the records are presumed to be open and accessible by the public.¹³⁰ In an attempt to better balance the privacy rights of individuals with the public's interest in knowing the outcome of commitment proceedings, the General Assembly reversed the presumption of openness.

Under the new amendments, the court's records, including any medical records and reports, must be kept confidential unless the individual waives confidentiality in writing.¹³¹ A person may seek to obtain the dispositional order by filing a motion with the court explaining why access is needed. The court may grant the motion and order disclosure of the dispositional

¹²⁴ Compare H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (as introduced Jan. 7, 2008), with H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____).

¹²⁵ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____).

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ VA. CODE ANN. § 37.2-818 (Repl. Vol. 2005).

¹³⁰ *See id.*

¹³¹ H.B. 499, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 23, 2008, ch. 850, 2008 Va. Acts ____).

order upon a finding that the disclosure is in the best interests of the subject of the commitment hearing or of the public.¹³²

VII. FIREARMS

In reviewing the tragedy at Virginia Tech, the Virginia Tech Review Panel found that the gunman was prohibited by federal law from purchasing a firearm because a court determined he was a danger to himself as a result of mental illness and ordered him to receive outpatient treatment.¹³³ The Panel concluded, however, that it was unclear as to whether Cho's outpatient commitment precluded him from purchasing a gun under Virginia law.¹³⁴ Further, it was unclear whether outpatient commitment orders must be reported to the Central Criminal Records Exchange or the division of the state police charged with gathering criminal records and other information for the background checks database used for potential firearms purchases.¹³⁵ Multiple bills were introduced to clarify Virginia's firearms laws with regard to the mentally ill.¹³⁶

Virginia's current law prohibits any person who has been involuntarily committed from purchasing a firearm.¹³⁷ The General Assembly amended this law to further clarify that any person admitted to a facility or ordered to MOT as a result of a finding of incompetence to stand trial or as a result of a commitment hearing is prohibited from purchasing, possessing or transporting a firearm.¹³⁸ An additional provision was included, making it unlawful for a subject

¹³² *Id.*

¹³³ VA. TECH REVIEW PANEL, *supra* note 7, at 71.

¹³⁴ *Id.*

¹³⁵ *Id.* at 72.

¹³⁶ *See, e.g.*, H.B. 535, Va. Gen. Assembly (Reg. Sess. 2008); H.B. 709, Va. Gen. Assembly (Reg. Sess. 2008); H.B. 835, Va. Gen. Assembly (Reg. Sess. 2008); H.B. 1054, Va. Gen. Assembly (Reg. Sess. 2008).

¹³⁷ VA. CODE ANN. § 18.2-308.1:3 (Supp. 2007).

¹³⁸ H.B. 815, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 788, 2008 Va. Acts ____). The commitment hearing should be conducted according to section 37.2-814.

of a temporary detention order who subsequently agrees to voluntary admission pursuant to Virginia Code section 37.2-805 to purchase, possess, or transport a firearm.¹³⁹

Further, the General Assembly clarified that the clerk of court must forward orders for treatment to restore competency, involuntary admission to a facility, and mandatory outpatient treatment to the Central Criminal Records Exchange.¹⁴⁰ The clerk of court must also send certification of any subject of a temporary detention order who agreed to voluntary admission to the Central Criminal Records Exchange.¹⁴¹

VIII. INPATIENT PSYCHIATRIC TREATMENT OF MINORS ACT

In addition to sweeping changes to the commitment scheme for adults, the General Assembly also clarified a number of issues related to the Psychiatric Inpatient Treatment of Minors Act.¹⁴² Most significantly, it extended the maximum period of temporary detention from seventy-two to ninety-six hours to permit additional time for a thorough assessment of the minor's need for inpatient admission, especially when the child is hospitalized at a significant distance from home, such as at the Commonwealth Center for Children and Adolescents.¹⁴³ New legislation also requires the court to appoint both an attorney to represent the child's position in a commitment hearing as well as a guardian ad litem to represent the best interests of the child before the court.¹⁴⁴

The General Assembly also closed a gap in the commitment scheme by adding a definition for a minor incapable of making an informed decision in section 16.1-336; the same bill provides that such a minor be treated as an objecting minor age fourteen or older and

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² VA. CODE ANN. §§ 16.1-335 to -348 (Repl. Vol. 2003 & Cum. Supp. 2007).

¹⁴³ H.B. 582, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 783, 2008 Va. Acts ____).

¹⁴⁴ S.B. 247, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 807, 2008 Va. Acts ____).

requires court review under sections 16.1-339 for admission to a psychiatric facility.¹⁴⁵ By adding the incapable of consenting category to minors objecting under section 16.1-339, the General Assembly has insured that the child will now have a guardian ad litem appointed for him and a review hearing to protect his rights. In other legislation, the General Assembly clarified that the petition and notice of hearing must be served as required under section 16.1-341 if the petition has not been dismissed or withdrawn.¹⁴⁶

IX. COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES

In addition to the calls for reform of the mental health system for adults, the need to establish a continuum of appropriate community services for children and adolescents peaked in 2006 and 2007. As a result of this lack of community services, parents were often required to relinquish custody of their children in order to obtain urgently needed mental health treatment for them in residential facilities.¹⁴⁷ As a result, the Attorney General issued an opinion to the Honorable William H. Fralin, Jr. on December 6, 2006, which advised that “statutory and constitutional provisions require mandated services . . . be provided to eligible children who are in need of mental health services without their parents having to relinquish custody to local social services agencies.”¹⁴⁸ The opinion went on to find that some localities interpreted the definition of a child in need of services too narrowly, requiring a juvenile and domestic relations district court judge to make such a finding.¹⁴⁹ Even so, section 16.1-281 still requires the filing of a foster care plan with the court whenever a public agency designated by a community policy

¹⁴⁵ H.B. 400, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 774, 2008 Va. Acts ____).

¹⁴⁶ H.B. 402, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 2, 2008, ch. 776, 2008 Va. Acts ____).

¹⁴⁷ See 2006 Op. Va. Att’y Gen. 206, 212 (2006).

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 210-11.

and management team places a child in residential care where legal custody remains with the parents.¹⁵⁰

Consequently, the General Assembly enacted House Bill 1489 to remove the requirement of filing foster care plans and court reviews of those plans for CSA-funded residential placements when parents retain custody of their child and the case management is done by an agency other than the local department of social services.¹⁵¹ As a result, parents will be relieved of the burden of having to appear in court simply to justify the need for mental health services.

On January 10, 2007, the Joint Legislative Audit and Review Commission (JLARC) issued a report evaluating children's residential services delivered through the Comprehensive Services Act (CSA).¹⁵² JLARC found that one-quarter of the 16,272 children served through the CSA received services in residential care, the most restrictive setting, at a cost of \$194 million.¹⁵³ In addition, JLARC concluded that better mechanisms were needed to control expenditures and that "addressing gaps in the availability of community-based services would reduce program costs decreasing the frequency of residential placements for children."¹⁵⁴

As a result of these findings, legislators introduced a number of bills that ultimately were rolled into two identical bills passed by both the House and Senate, which require, among other things, the State Executive Council to oversee the development and implementation of mandatory uniform guidelines for intensive care coordination services for children at risk of entering, or who are placed in, residential care through the CSA-program and each local

¹⁵⁰ See VA. CODE ANN. § 16.1-281 (Repl. Vol. 2003 & Supp. 2007).

¹⁵¹ H.B. 1489, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Mar. 27, 2008, ch. 678, 2008 Va. Acts ____). The federal government's definition of foster care applies only to those children who are being case managed by a local department of social services. 45 C.F.R. § 1355.20 (2007).

¹⁵² JOINT LEGISLATIVE AUDIT & REVIEW COMM'N OF THE GEN. ASSEMBLY OF VA., EVALUATION OF CHILDREN'S RESIDENTIAL SERVICES DELIVERED THROUGH THE COMPREHENSIVE SERVICES ACT, H.D. 12 (2007), available at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD122007/\\$file/HD12.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD122007/$file/HD12.pdf).

¹⁵³ *Id.* at i.

¹⁵⁴ *Id.* "Providing a more complete continuum of care would help children access services best suited to meet their needs and realize the CSA program's original intent of serving youths in their homes and communities." *Id.*

community policy and management team to establish policies for providing intensive care coordination services for these children.¹⁵⁵ In addition, these bills require each local family assessment and planning team (FAPT) to identify children at risk of entering, or who are placed in, residential care that can be served appropriately and effectively in their homes or the community.¹⁵⁶ The FAPT must then implement a plan for returning the child to his home or the community at the earliest appropriate time that addresses the child's needs.¹⁵⁷

Most importantly, the General Assembly reduced the local match rate—the rate each locality must pay towards the cost of services provided under the CSA program—for community based services by fifty percent beginning July 1, 2008.¹⁵⁸ Beginning January 1, 2009, however, the local match rate for residential services will be increased by fifteen percent after a locality has incurred \$100,000 in residential care expenditures and by twenty-five percent after a locality has incurred \$200,000 in residential expenditures, thus providing financial incentives to localities to deliver services in community-based settings.¹⁵⁹

X. RESTRUCTURING OF MAGISTRATE SYSTEM

The General Assembly also approved a sweeping restructuring of the magistrate system, placing magistrates under the supervision of the Executive Secretary of the Virginia Supreme Court.¹⁶⁰ Among other things, magistrates will be appointed by the Executive Secretary, in consultation with, rather than by, the chief judge of the circuit.¹⁶¹ Magistrates employed after July 1, 2008 will be required to have bachelor's degrees, and chief magistrates must have law

¹⁵⁵ H.B. 503, Va. Gen. Assembly (Reg. Sess. 2008); S.B. 487, Va. Gen. Assembly (Reg. Sess. 2008) (incorporating Senate Bills 480, 488, 489, and 658).

¹⁵⁶ H.B. 503, Va. Gen. Assembly (Reg. Sess. 2008); S.B. 487, Va. Gen. Assembly (Reg. Sess. 2008).

¹⁵⁷ H.B. 503, Va. Gen. Assembly (Reg. Sess. 2008); S.B. 487, Va. Gen. Assembly (Reg. Sess. 2008).

¹⁵⁸ H.B. 29, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Apr. 11, 2008, ch. 827, 2008 Va. Acts ___); H.B. 30, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of May 9, 2008, ch. 879, 2008 Va. Acts ___).

¹⁵⁹ *Id.*

¹⁶⁰ S.B. 244, Va. Gen. Assembly (Reg. Sess. 2008) (enacted as Act of Mar. 27, 2008, ch. 691, 2008 Va. Acts ___).

¹⁶¹ *Id.*

degrees.¹⁶² Each must serve a nine month probationary period and meet minimum training and certification requirements.¹⁶³

XI. THE FUTURE

Although the legislation enacted in 2008 was sweeping and historic, the General Assembly continued a number of bills for further study. Most significantly, Senate Bill 177, modeled after Kendra's Law,¹⁶⁴ would establish new commitment criteria and a process to permit mandatory assisted outpatient treatment for persons whose psychiatric condition is deteriorating, but who have not yet met the criteria for involuntary inpatient treatment.¹⁶⁵ Senate Bill 274, permitting a period of mandatory outpatient treatment following a period of involuntary acute hospitalization,¹⁶⁶ and House Bill 1004, establishing mental health advance directives,¹⁶⁷ will be studied this coming year.¹⁶⁸

The Senate also referred the subject matter of a number of bills to the Mental Health Law Reform Commission for further study. These include Senate Bill 47, establishing mental health advance directives;¹⁶⁹ Senate Bill 102, establishing a three-tiered transportation system for persons subject to a petition for involuntary treatment;¹⁷⁰ Senate Bill 143, extending the period of temporary detention from forty-eight to ninety-six hours;¹⁷¹ House Bill 938, creating a right of

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ N.Y. MENTAL HYG. LAW § 9.60 (Consol. 2007).

¹⁶⁵ S.B. 177, Va. Gen. Assembly (Reg. Sess. 2008) (continued to 2009 by the Senate Finance Committee on Feb. 13, 2008).

¹⁶⁶ S.B. 274, Va. Gen. Assembly (Reg. Sess. 2008).

¹⁶⁷ H.B. 1004, Va. Gen. Assembly (Reg. Sess. 2008).

¹⁶⁸ Notably, the General Assembly authorized the establishment of an advance directory registry within the Department of Health to facilitate the accessibility of these directives to health care providers. Act of Mar. 4, 2008, ch. 301, 2008 Va. Acts ____).

¹⁶⁹ S.B. 47, Va. Gen. Assembly (Reg. Sess. 2008).

¹⁷⁰ S.B. 102, Va. Gen. Assembly (Reg. Sess. 2008).

¹⁷¹ S.B. 143, Va. Gen. Assembly (Reg. Sess. 2008).

appeal for petitioners in civil commitment proceedings;¹⁷² and House Bill 267, providing for appointment of counsel for indigent petitioners in the civil commitment process.¹⁷³

Additionally, the Commission on Mental Health Law Reform will continue its work through 2008.¹⁷⁴ The Commission will continue to study a reduced mandatory outpatient commitment criteria and process; a bifurcated commitment process providing for a period of mandatory outpatient treatment following a period of acute inpatient hospitalization;¹⁷⁵ a review hearing, separate from a commitment hearing, for persons adjudicated incapacitated but incapable of consenting to their own admission;¹⁷⁶ extension of the temporary detention period from forty-eight hours to four or five days;¹⁷⁷ and an expanded role for independent examiners.¹⁷⁸ The Commission also plans to continue its study concerning attorney appointment for petitioners in commitment hearings and a possible a right of appeal.¹⁷⁹ It will also examine whether commitment hearings should continue to be open to the public.¹⁸⁰ Details for implementation of a three-tiered transportation system during the commitment process will also be developed with the goal of permitting transportation by family members, by taxi, or by CSBs in non-dangerous situations and wheelchair or ambulance transportation when medical concerns are an issue, reserving law-enforcement transportation for those cases in which the safety of the person and the public is an issue.¹⁸¹

The Commission will also consider expansion of CSB mandated services to include crisis stabilization, case management, outpatient, respite, in-home, residential, and housing support

¹⁷² H.B. 938, Va. Gen. Assembly (Reg. Sess. 2008).

¹⁷³ H.B. 267, Va. Gen. Assembly (Reg. Sess. 2008).

¹⁷⁴ COMM'N ON MENTAL HEALTH LAW REFORM, PRELIMINARY REPORT, *supra* note 11, at iv.

¹⁷⁵ *See id.* at 24.

¹⁷⁶ *See id.* at 21.

¹⁷⁷ *See id.* at 17.

¹⁷⁸ *See id.* at 20.

¹⁷⁹ *See id.* at 21.

¹⁸⁰ *See id.* at 22.

¹⁸¹ *See id.* at 19-20 (noting that a reduction in the use of restraints in transportation will also be a major focus).

services.¹⁸² It will focus on enhancing consumer empowerment and expanding the use of advance directives to govern all types of health care, including mental health care.¹⁸³ It will also address the realignment of the criminal justice system in an effort to divert mentally ill persons who do not belong in either the criminal justice system or jail and seek to develop a recovery-oriented jail re-entry system, which is a paramount concern.¹⁸⁴ Diversion of children from the juvenile justice system will also be a focus of continued study as will the development of strategies to reduce the use of long term residential care for children.¹⁸⁵

From the establishment of the Virginia Commission on Mental Health Law Reform and the reforms prompted by the tragedy at Virginia Tech to the sweeping and historic measures adopted by the General Assembly, 2007 and 2008 were significant years for Virginia's mental health service delivery system. With increased public awareness of this issue and the legislation still to be considered by the General Assembly, Virginia has not seen the end of innovative initiatives in this complex field.

¹⁸² *See id.* at 9.

¹⁸³ *See id.* at 13-15.

¹⁸⁴ *See id.* at 27.

¹⁸⁵ *See id.* at 32.