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Statement of Richard J. Bonnie
Prepared for the
Behavioral Health Subcommittee
of the
Joint Commission on Health Care
October 23, 2008

Senator Lucas, Delegate Morgan and other members of the Subcommittee:

Thank you for inviting me to appear before you today. I'm sorry I could not be there in person, but I hope you will find my virtual presence to be an acceptable substitute. I very much want to keep you informed about the Commission's plans and activities and to assist you in your own deliberations.

Let me begin with a brief review of the Commission's own schedule over the next few months:

- The Commission will hold its final meeting before the upcoming legislative session next week – on October 30-31.
- Immediately after that meeting, we will be submitting a report to the Senate Committee on Education and Health and the Senate Committee for Courts of Justice on the subject matter of the bills referred to the Commission for study in March at the close of the 2008 session. Our report will also comment on the subject matter of a number of other mental health bills that were carried over last year.
- In mid-December, we will submit to you a Progress Report on Mental Health Law Reform summarizing the Commonwealth's early experience in implementing the 2008 reforms and offering some additional suggestions for consideration by the General Assembly during the upcoming session.

Although the Commission has not taken final action on the matters it currently has under study, I can identify a few items that are likely to be our highest priorities for this session, subject of course to the advice of Senators Lucas, Lambert and Howell and Delegates Hamilton and Suit. With one possible exception, none of them will entail any additional funds.

- Our major proposal will be a bill amending the Health Care Decisions Act to empower people to prescribe specific instructions to guide their health care in the event that their capacity to make health care decisions becomes impaired by mental illness, dementia or other cognitive disability. The existing statute empowers people to designate health care agents and to give specific instructions regarding treatment at the end of life. However, it is silent on the use of instructional directives in other contexts, such as decisions about

mental health care or about placement and treatment in nursing homes. That is the gap that this proposal is designed to fill. Immediately after my statement, you will hear about this proposal from Steve Rosenthal who graciously agreed to chair the Commission's Task Force on Advance Directives.

- The Commission will also offer a few proposals in its continuing effort to improve the commitment process. Some of our proposals will respond to specific issues that have arisen during the process of implementing the 2008 reforms, while others deal with issues that were not addressed in 2008. Jane Hickey, who is chairing our Task Force on Future Commitment Reforms, will summarize some of the key proposals later this morning, but I want to highlight two of them now.

    - The first relates to transportation of individuals involved in the commitment process. As you know, reliance on law enforcement to provide transportation, and the routine use of restraints during this process, has been a major source of discontent among all the stakeholders for many years. As Jane will describe, the Commission is likely to be recommending enabling legislation to facilitate local efforts to develop clinically appropriate alternatives to transport by law enforcement in cases that pose little security risk.

    - Another important issue involves independent examiners. As I mentioned in my last presentation to the Subcommittee at its August meeting, the independent examiners play a critical -- and often determinative -- role in the commitment process. The Commission believes that training is needed to assure compliance with the new evaluation requirements prescribed in 2008 and to promote consistent application of the commitment criteria. Such training should be mandated for <u>all</u> examiners. At the same time, the Commission is very worried that the increased burdens of doing this important work will make it difficult to recruit and retain examiners unless the fee for these examinations is adjusted. Mindful of the deepening recession and accompanying budget constraints, the Commission will be addressing this matter at its upcoming meeting.

- It is also likely that the Commission will recommend some modifications to the Psychiatric Inpatient Treatment of Minors Act, including new procedures for mandatory outpatient treatment that are tailored the special circumstances of juvenile commitments. These proposals have been developed by the Task Force on Children and Adolescents chaired by Judge Deborah Paxson.

Finally, I want to mention three other very important issues that the Commission will continue to study over the coming year.

- As you know, the Commission has endorsed, in principle, the concept of lengthening the TDO period to 4 or 5 days. However, we are attempting to make informed projections regarding the costs and other consequences of such a change, such as how much it would reduce the number of commitment hearings and what impact it would have on the average length of hospitalization.

- The Commission has also endorsed the concept of increasing the range of core services that CSBs are mandated to provide. Obviously this would be a major change in the legal foundation of the community mental health services system, and our Task Force on Access to Services, chaired by Chuck Hall, continues to study it.

- Finally, as you know, a number of bills that were carried over would expand use of mandatory outpatient treatment. However, the Commission believes that it would be premature to expand the use of mandatory outpatient treatment until we have accumulated adequate experience with the extensive new procedures adopted in 2008. Preliminary data indicate that the number of such orders has been very small so far, suggesting that the necessary service capacity has not yet come on line. The Commission

> is supportive, in principle, of permitting conditional discharge after inpatient commitment in appropriate cases, and believes that this would be the next logical step in the use of mandatory outpatient treatment. However, we believe that such a change should be deferred until service capacity has been established and more experience has accumulated. For the same reason, the Commission believes that it would be premature to loosen the front-end commitment criteria for mandatory outpatient treatment as New York and other states have done.

That completes my report. Again, I appreciate the opportunity to appear before you today. I'm sorry I won't be able to hear your comments and suggestions. However, I'm sure that Steve and Jane will be able to fill in the missing pieces.