# Behavioral Health Care Subcommittee

## Draft Decision Matrix

November 8, 2007
*Revised*

**Purpose of Document:**

A. To review and discuss findings, public comments, and policy options regarding staff reports and other issues that came before the Commission and its Subcommittees in 2007.

B. To develop Commission recommendations to advance to the 2008 General Assembly.

# Behavioral Health Care Subcommittee
# Decision Matrix

## Table of Contents


| | |
|---|---|
| Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and their Families | 3 |
| Staff Report: Autism Work Group Activities and Recommendations | 5 |
| Staff Report: Treatment Needs of Individuals Found Not Guilty by Reason of Insanity | 8 |
| Staff Report: Reentry Assistance for Offenders with BHC Needs | 10 |
| Transition Services for Adolescent Offenders<br>Establishing the Need for Forensic Mental Health Services | 13 |
| Staff Report: Discussion of Mental Health Recommendations Related to the Virginia Tech Tragedy | 15 |

## Report on the "Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and their Families"*

Raymond R. Ratke, Deputy Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services
*This summary of Mr. Ratke's presentation uses his wording except for any underlined wording.

### Recent Efforts to Build and Improve Services

- Pilot evidence-based systems of care demonstration projects in four localities (two urban and two rural) across the state.
- Four child psychiatry fellowships and four child psychology internships with payback provisions to work in underserved areas of Virginia.
    - DMHMRSAS reported that only 5 of the 8 positions have been funded as of early November.
- CSB mental health services are now available at all twenty-three detention centers across the state.
- Virginia's Part C Early Intervention System funding for direct services.
- CSA and DMHMRSAS are collaboratively working on alternatives to residential placement using community based services to eliminate the need for placing children in costly residential settings.
- DMAS was awarded a demonstration grant to help provide community based alternatives to psychiatric residential treatment facilities.
- DMAS amended the State Medicaid Plan to provide Medicaid funds for substance abuse treatment for adolescents.
- DMHMRSAS and the Commission on Youth conducted a system of care and evidence-based services conference September 16-18, 2007 in Roanoke.

### The Unmet Behavioral Health Needs of Virginia's Children

- CSB child and adolescent early intervention treatment services – especially "intermediate level services" - are unavailable in many communities.
- Of the over 30,000 children and adolescents who received mental health or substance abuse treatment services in CSBs in 2006, most received only the most basic services, case management and limited outpatient counseling.
- Many behavioral health clinicians, pediatricians, and other health care providers serving children and adolescents lack specialized knowledge to effectively treat children at risk of serious emotional disturbance (SED) or substance use disorders.
- The lack of child psychiatrists and other specialized child serving clinical staff remains a challenge.

- Unmet behavioral health needs spill over into juvenile justice and educational systems.

**What Works? Community Based Systems of Care**

- Community based systems of care allow localities to reduce their current reliance on high-cost, highly restrictive residential and in-patient treatment and move toward lower cost, evidenced-based services.
- This shift allows all children to be served in settings either at home or in their home community.
    - A fully developed continuum of services and supports allows families to stay together and avoids unnecessary custody relinquishment.

**Priority Funding Recommendations for FY 2009 <u>are shown as Options</u>:**

**Option 1:** Take no action.

**Option 2:** Introduce one or more budget amendments to increase service capacity by funding:

| | | |
|---|---|---|
| 2A. | Intermediate-level community based services | $20.0 M |
| 2B. | 12 systems of care projects | $3.6 M |
| 2C. | MR family support | $2.5 M |
| 2D. | MR waiver slots | $6.0 M |
| 2E. | Part C early intervention | $1.73 M |
| 2F. | 3 additional project LINK programs | $375,000 |
| 2G. | Outpatient substance abuse services | $ 3.0 M |
| 2H. | School-based mental health clinicians in 20 middle schools | $1.8 M |

**Option 3:** Introduce budget amendment ($990,000 suggested) to fund infrastructure in the DMHMRSAS Office of Child and Family Services to support these initiatives statewide.

**Option 4:** Introduce budget amendment ($1,100,000) to fund 4 new child psychiatry fellowship and 2 new child psychology internship slots.

**Option 5:** Introduce budget amendment ($700,000) to establish 3 Teaching Centers of Excellence to organize, coordinate, and lead the training of clinicians in evidence-based and promising practices for children's behavioral health treatment statewide.

**Option 6:** Introduce budget amendment ($100,000 suggested) to fund 1.5 FTE for Resource/Service Coordinator and administrative support to assist families in accessing needed services, to educate families about available services and link families with support systems.

**Total Cost - Recommendations $41,831,000**

## Staff Report:
## Autism Work Group Activities and Recommendations

### Review of Findings

**Background**

"Autism spectrum disorders (ASDs) are a group of developmental disabilities defined by significant impairments in social interaction and communication and the presence of unusual behaviors and interests….The thinking and learning abilities of people with ASDs can vary – from gifted to severely challenged. ASD begins before the age of 3 and lasts throughout a person's life. It occurs in all racial, ethnic, and socioeconomic groups and is four times more likely to occur in boys than girls." Source: *Autism Information Center*, Centers for Disease Control and Prevention Website.

The issue of designating an agency to be the State "home" for autism has been raised by a number of groups. The absence of a State home has meant that no one agency has the responsibility or legislative mandate to develop policy, to plan and coordinate service delivery, to request funding or to undertake strategic planning for the needs of the ever-increasing number of Virginians with an ASD.

During the 2007 Session, HR 60 (Shannon and Nutter) commended JCHC on "its study of autism and its efforts to recommend a state agency to be designated as the lead agency on autism services for the Commonwealth." In addition, the Virginia Disability Commission sent a letter endorsing the BHC Subcommittee's efforts.

**2007 Work Group Activities**

Autism work group meetings were held on June 26, July 13, and August 20.

- Staff endeavored to be inclusive and approximately 80 identified parties were invited to attend and participate.
    - However, these were public meetings and everyone who attended or participated by conference call was invited to participate as a work group member.
- A tentative, initial consensus was reached to redesign and rename DMHMRSAS to serve as the lead agency for developmental disabilities (which would include ASD, mental retardation and the other developmental disabilities as defined in federal law).
    - However, the parties involved in reaching consensus did not adequately represent the interests of individuals with ASD or other developmental disabilities. This was demonstrated in the distribution of public comments on the proposed Options as shown on the next page:

| Policy Option | Number of Comments in Support |
|---|---|
| **1** | 0 |
| **2** | 0 |
| **3** | 9<br>(4 actually support 3 and 9) |
| **4** | 0 |
| **5** | 2<br>(1 actually supports 5 and 12) |
| **6** | 0 |
| **7** | 65 |
| **8** | 0 |
| **9** | 4<br>(actually support 3 or 9) |
| **10** | 0 |
| **11** | 31 |
| **12** | 1<br>(actually supports 5 and 12) |
| No Specified Option | 3 |

After the reporting of the public comments, a follow-up meeting was held on October 29.

- After much discussion, a vote of the individuals who attended was taken and individuals who participated by conference call were asked to send an email indicating their vote.
  - **Twenty-four of the 34 individuals in attendance and 7 conference call participants voted in favor or Option 7**. (The other individuals in attendance refrained from voting.)
- A follow-up email was sent out asking anyone preferring an Option other than Option 7 to respond. **No "final" responses were received, other than additional responses in favor of Option 7.**

## Options

**Option 1:** Take no action.

Introduce Joint Resolution and/or Budget Amendment Requesting that the Secretary of HHR Develop & Report to Chairmen of HAC, SFC and JCHC on:

**Option 2:** Implementation Plan to redesign and rename DMHMRSAS to become the primary State agency responsible for serving individuals with autism spectrum disorders. (New responsibility in addition to DMHMRSAS' current responsibilities.)

**Option 3:** Implementation Plan to redesign and rename DMHMRSAS to become the primary State agency responsible for serving individuals with developmental disabilities. (New responsibility in addition to DMHMRSAS' current

responsibilities.)

**Option 4:** Implementation Plan to establish a new agency within the HHR Secretariat to be responsible only for serving individuals with autistic spectrum disorders.

**Option 5:** Implementation Plan to establish a new agency within the HHR Secretariat to be responsible only for serving individuals with developmental disabilities (which would include mental retardation).

**Option 6:** Implementation Plan to establish a new agency within the HHR Secretariat to be responsible only for serving individuals with developmental disabilities other than mental retardation.

**NOTE: OPTION 7 WAS APPROVED BY JCHC MEMEBERS IN THE FOLLOWING AMENDED FORM:**

☑ **Option 7:** ~~Introduce Joint Resolution and/or~~ By letter of the Chairman and by budget amendment request that the Secretary of HHR develop and report to Chairmen of HAC, SFC and JCHC on an Implementation Plan to determine the State agency that should be responsible for serving individuals with autistic spectrum disorders (including whether the agency should serve individuals with any or all developmental disabilities.)

Introduce Legislation and Accompanying Budget Amendment (Language and Funding) to:

**Option 8:** Redesign DMHMRSAS to serve individuals with autism spectrum disorders.

**Option 9:** Redesign DMHMRSAS to serve individuals with developmental disabilities.

**Option 10:** Establish a new agency to serve individuals with autism spectrum disorders.

**Option 11:** Establish a new agency to serve individuals with developmental disabilities except for mental retardation.

**Option 12:** Establish a new agency to serve individuals with developmental disabilities (including mental retardation).

## Staff Report:
## Treatment Needs of Individuals Found Not Guilty by Reason of Insanity

## Review of Findings

**Authority for the Study**
Third year of study requested in Senate Joint Resolution 324 – 2005 (Senator Puller) for the Behavioral Health Care Subcommittee to study the needs of persons found not guilty by reason of insanity (NGRI) and the impact on the mental health system of persons found incompetent to stand trial (IST).

- Legislation based on study findings was introduced by JCHC and enacted by the General Assembly during the 2006 and 2007 Sessions
- BHC Subcommittee voted to include continuation of the study in its 2007 work plan.

For the last three years, NGRI-related issues have been discussed during meetings of DMHMRSAS' Forensic Special Populations Work Group as well as in work groups convened by JCHC staff.

The following DMHMRSAS/legislative issues were suggested in work group meetings or with DMHMRSAS staff.

**Actions that Can Be Taken by DMHMRSAS without Legislative Action**
Some State hospital beds would become available, if additional transitional unit(s) were opened on the grounds of a State hospital. The transitional unit could house acquittees who while not ready for community placement, do not require all the services of a fully-staffed hospital unit.

DMHMRSAS officials indicated interest in providing NGRI-related training for prosecutors, defense attorneys, and other court personnel. If provided, the training could address issues discussed in the work group, including:

- The differences in commitment criteria related to revocation of an acquittee's conditional release and involuntary civil commitment.
- The CSB and Court lack jurisdiction to enforce release conditions for NGRI acquittees allowed to move out-of-state; making unconditional release the most viable alternative for out-of-state placements.
- The need to apply other sanctions (such as contempt of court) for violations of conditional release, when hospitalization is not appropriate.

## Options

**Option 1:** Take no action.

☑ **Option 2:** Introduce legislation to amend *Code of VA* § 19.2-169.3.B to limit to 45 days the treatment provided to restore competency for a defendant charged with a minor, nonviolent misdemeanor offense and to provide the court with options of ordering release or commitment pursuant to Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2 (civil commitment statute).

☑ **Option 3**: Introduce a budget amendment to provide funding of $410,000 GFs for each year of the biennium for DMHMRSAS to fund outpatient restorations for adults (including $20,000 to train additional CSB/BHA staff in completing competency restoration.)

☑ **Option 4:** Introduce legislation to move language clarifying that voluntary admission to a State hospital should not automatically result in revocation of the acquittee's conditional release. Language would be removed from *Code of VA* §§ 19.2-182.8 and 19.2-182.9 and placed in another (possibly new) subsection of the *Code*.

**Note:** No public comments were received regarding the proposed Options.

## Staff Report:
## Reentry Assistance for Offenders with BHC Needs

## Review of Findings

**Background**
Assisting offenders with behavioral health care needs has been of great interest for this Subcommittee (and its precursor the Joint Commission on Behavioral Health Care).

- SJR 97/HJR 142 (2002) included provisions requesting:
    - DOC and DMHMRSAS "to examine ways to ensure offenders' access to [and management of] appropriate medications…when they are released from state correctional facilities."
    - DMAS in conjunction with DOC and DJJ "to examine ways to provide immediate access to Medicaid benefits for eligible offenders when they are released from prisons, jails, juvenile correctional centers or detention centers."

Senator Martin (as approved by this Subcommittee last year) requested:

- The Secretary of HHR and Commissioner of DSS "find ways to simplify and expedite Medicaid eligibility determination for juveniles and adults being released from correctional or psychiatric facilities."
- Representatives participate in a work group to make recommendations to improve community support for offender treatment needs.

**Work Group Activities**
Representatives of these agencies/associations were appointed to the work group:

Department of Corrections
Department of Criminal Justice Services
Department of Juvenile Justice
Department Medical Assistance Services
Department of Mental Health, Mental Retardation and Substance Abuse Services
Department of Social Services
Virginia Association of Regional Jails
Virginia Community Service Boards
Virginia Council Juvenile on Detention
Virginia Juvenile Justice Association
Virginia Probation and Parole Association
Virginia Sheriffs' Association

Work group meetings were held on July 24 and August 31.

**Other Initiatives Are Underway to Address Offender Reentry Needs**
In 2003, Virginia was 1 of 7 states selected to participate in the National Governors Association's Prisoner Reentry Policy Academy.

- Responsibility for establishing "an integrated system for coordinating the planning and provision of offender transitional and reentry services" was added as a statutory responsibility of the Secretary of Public Safety in 2005 (*Code of VA* § 2.2-221.1).

In 2006, Virginia was selected as 1 of 4 states to participate in the NGA Prisoner Reentry Continuation Policy Academy:

- Pilot programs are working to develop and provide community resources for offenders being released from 5 correctional facilities.

SJR 273 (Senator Puller) established in 2005 a legislative joint subcommittee which in "conducting its study…shall continue the work of the Policy Academy in identifying and developing strategies to address key needs and overcome barriers for offenders, prior to and upon leaving prison, to reduce the incidence of reincarceration and increase their successful social adaptation and integration into their communities."

- The Joint Subcommittee has received continued authorizations for the last two years. The Subcommittee is expected to have recommendations to be considered during the 2008 Session.

HB 2245/SB 843 (2005) required the Board of Juvenile Justice to promulgate regulations for developing transition plans for juvenile "residents" with BHC needs being released from correctional facilities.

- The administrative regulations (6 VAC 35-180) will be effective in January 2008.
- Residents with a recognized BHC need will qualify for transition services by meeting one of the following criteria:
    - MH professional provides a diagnosis of a mental illness likely to cause significant "impairment in the resident's functioning in the community" or the resident is taking medication for a significant mental illness (as just described) that will need to be continued after release.
- Court service units and detention centers with a post-dispositional program will enter into a MOU with the public agencies that participate in the Community Policy and Management Team (CPMT). Key provisions of the MOU include:
    - Specification of the BHC services that the agencies will make available.
    - The process that will be followed (including the entities who will be responsible) in making referrals and assisting with applying for services.
    - A timeline for service implementation.
    - Funding sources for needed services including private insurance and/or Medicaid.
- Enhanced transition plans will be developed no later than 30 days prior to the resident's expected release date.

**Recent Actions by DMAS to Facilitate Medicaid Eligibility Determination**

- Policy now allows eligibility for Medicaid to be determined by the locality in which the offender lived prior to incarceration.

- Disability determination for Medicaid eligibility through the Department of Rehabilitative Services can be requested prior to release. (If found to be disabled, Medicaid eligibility can be approved, but the federal programs of SSI/SSDI will have to be applied for separately.)
- Work is underway to develop "a quicker disability determination process [for Medicaid eligibility] for inmates who need to have a medical placement (i.e. nursing home, dialysis, etc.) upon their release."
- Support provided for having out-stationed Medicaid workers (local social services staff) in several adult correctional facilities on a pilot basis.
- Discussions are underway with DJJ to assist with Medicaid eligibility for juveniles who are close to release.

**Findings**
The work group focused on the following issues:

Improve assistance with accessing entitlements such as Medicaid and SSI

- Procedural changes to simplify Medicaid eligibility determination and the potential of having out-stationed eligibility workers are promising new developments.
- As noted, DJJ is discussing with DMAS ways in which juvenile offenders can be assisted with Medicaid eligibility determination.

Explore the ability to access the DMHMRSAS aftercare pharmacy until other means of accessing medication can be arranged.

Assist in accessing BHC services upon release

- As noted, there are a number of offender reentry and transition programs and studies underway.
    - Although some programs are not limited to offenders with BHC needs, much can be learned from their reentry experiences.
    - DJJ will implement transition plans for juvenile offenders beginning in January.

## Transition Services for Adolescent Offenders
## Establishing the Need for Forensic Mental Health Services

Joanne Smith, President
Virginia Council on Juvenile Detention
*This summary of Ms. Smith's presentation uses his wording except for any underlined wording.

**Background**
All local detention facilities conduct mental health screening for all admissions using the Massachusetts Youth Screening Instrument, second edition (MAYSI-2).

**MAYSI-2 Data - FY07**
There were 13,516 reports (Henrico County and James River Detention are not included):

- Drug/Alcohol Scale: 2,213 needed service
  597 needed immediate treatment
- Angry-Irritable Scale: 2,646 needed service
  843 needed immediate treatment
- Depressed/Anxious: 2,079 needed service
  533 needed immediate treatment
- Somatic Complaints: 3,506 needed service
  638 needed immediate treatment
- Suicide Ideation: 461 need services
  920 needed immediate treatment
- Thought Disturbance: 1,521 needed service
  (males only) 642 needed immediate treatment
- Traumatic Experiences 7,958
  - Witness or victim of abuse, rape, murder, etc.
  - Powerful predictor of substance abuse, mental health and behavior problems

**Transition Regulations for Incarcerated Juveniles (to become effective January 1, 2008)**

**General Concerns**

- Will the treatment resources be available in the community?
- Will they be public, private, a combination?
- Will indigent consumers be able to access services?
- What will be the priority for this population?

**System Capacity Questions**

- How many juveniles are identified as needing services after release?
- How many are referred?
- Does the juvenile have an appointment scheduled prior to release?
- What is the wait time between release and the appointment?

- How many actually receive services?
- Will indigent consumers be able to access services?
- What will be the priority for this population?

**Community Services Boards**

- Levels of service are not consistent across the Commonwealth
- Only Emergency Services and Case Management are required to be provided, funds available
- Legislative Action
  - Expand the menu of required services for Community Services Boards.
  - Services will be provided regardless of the ability to pay.
  - The forensic population will be a priority population.
  - Include predisposition youth in the transition services eligibility category.
  - Fund CSBs to provide services or purchase services from private providers or other public providers.
  - Provide a revolving pool of funds to support services pending approval of Medicaid or Supplemental Services Income or other payment arrangements.

**Alternative Process**

- Let the funding follow the juvenile
- Establish a pool for services that allows the Probation or Parole officer, the Correctional Center or a local Detention Center to purchase services from a qualified private or public provider pending the securing of private or public funding or for continuing services for indigent juveniles
- Given the inconsistent array of services provided by Community Services Boards across the Commonwealth, private providers must be included as an option for transition services.
  - If the CSB is to be the entry point for services, transition services need to be mandated and prioritized. Additional funding for purchase of service or service provision will be needed.
  - If the CSB is NOT the designated entry point, funding is needed to follow the child pending arrangements for other payment streams and for children with no resources.

## Staff Report:
## Discussion of Mental Health Recommendations
## Related to the Virginia Tech Tragedy

## Review of Findings

**Background**
In the wake of the tragedy at Virginia Tech (VT) on April 16, 2007, two workgroups were convened to review the events, understand what went wrong, and make recommendations for improvement and prevention: the Virginia Tech Review Panel and the Virginia Tech Internal Review.

- The Supreme Court's Commission on Mental Health Law Reform (subsequently referred to as the MHLR Commission), which was convened prior to the tragedy, will issue a preliminary report on civil commitment this winter.
- In addition the House Health, Welfare and Institutions Committee and the House Courts of Justice Committee met to hear presentations and study findings related to the VT tragedy.

**Access to Community-Based Services**
Numerous studies and reports have indicated that Virginia's mental health system lacks needed community-based services. Recent studies indicate the following:

- Most community services boards (CSBs) "do not provide a comprehensive range of crisis intervention services for those with mental illness and substance abuse disorders….As a result, ESPs [emergency services programs] deal with crisis situations that could have been prevented if the consumer had received more intensive or a different array of services." (Source: *Review Of Community Services Board Mental Health Case Management Services for Adults,* Office of the Inspector General For Mental Health, Mental Retardation & Substance Abuse Services.)
- Virginia has an inadequate number of practicing psychiatrists -- 47 Virginia localities have no practicing psychiatrists and 87 Virginia localities have no practicing child psychiatrists.
    - "Medicaid rates for professional psychiatric services have generally been flat for over the last 6 years…[and] may contribute to the shortage of psychiatrists." Additionally, higher rates are "paid by Medicare and other insurers." (Source: JLARC study, *Availability and Cost of Licensed Psychiatric Services in Virginia)*

**The Involuntary Commitment Process**
<u>Emergency Custody Orders (ECOs) (*Code of VA* § 37.2-808)</u>
ECOs are issued by a magistrate who has probable cause to believe that a person:

- Has mental illness; and
- Is in need of hospitalization or treatment; and

- Is unwilling to volunteer or incapable of volunteering for hospitalization or treatment; and
- 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.

The CSB/BHA is responsible for conducting or arranging for the ECO evaluation. The person subject to an ECO is held until a Temporary Detention Order is issued or until released, but the period of custody cannot exceed 4 hours.

Temporary Detention Orders (*Code of VA* § 37.2-809)

A TDO may be issued upon the sworn petition of any responsible person or upon the magistrate's own motion. The magistrate can issue a TDO, if the criteria are met (which is the same as that for the issuance of an ECO), only after an in-person, independent evaluation by an employee or designee of the local CSB.

Once the TDO has been approved, *Code of VA* § 37.2-809.G requires a hearing to be held within 48 hours unless the expiration occurs on a weekend or legal holiday. (The hearing would then be held the next day that was not a weekend or legal holiday.) This timeframe has been criticized as being too short to allow for a thorough assessment of the individual; the MHLR Commission is specifically examining the timeframe. Any increase in the timeframe would have a fiscal impact as State funding for the hospital services is provided for individuals who do not have health insurance.

The VT Review Panel found there was little interaction or sharing of information by the hospital staff with the independent evaluator while the individual is being held in the hospital. The Panel recommended to:

- Clarify the role and responsibilities of the independent evaluator in the commitment process;
- Clarify the steps required to assure that the necessary reports and collateral information are assembled before the independent evaluator conducts the evaluation;
- Include the following documents so they can be presented at the commitment hearing:
    - The complete evaluation of the treating physician, including collateral information; reports of any lab and toxicology tests; reports of prior psychiatric history; and all admission forms and nurse's notes.

In addition, the VT Review Panel recommended amending the Virginia Health Records Privacy Act to:

- Provide a safe harbor provision which would protect health entities and providers from liability or loss of funding when they disclose information in connection with evaluations and commitment hearings.
- Ensure all entities involved with treatment have full authority to share records with each other and all persons involved in the involuntary commitment process, while providing the legal safeguards needed to prevent unwarranted breaches of confidentiality.
- Expressly authorize treatment providers to report non-compliance with involuntary outpatient orders.

The MHLR Commission is reviewing the question of whether the involuntary commitment process is a health-related or judicial proceeding which would affect privacy questions.

**Involuntary Commitment Standard and Hearing Procedures**

Virginia's involuntary commitment standard is one of the most restrictive in the nation; the *Code of Virginia* § 37.2-817.B requires the judge or special justice to find:

> "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."

The VT Review Panel recommended modifying the criteria for involuntary commitment to promote more consistent application of the standard and to allow involuntary treatment in a broader range of cases involving severe mental illness.

The MHLR Commission is examining Virginia's involuntary commitment standard to offer options for the Reform Commission's consideration. Four preliminary proposals were developed and presented in August as no consensus had been reached by the Commitment Task Force members at that time.

- Proposal 1 would not change commitment criteria.
- Proposal 2 would only change the criteria slightly by specifying factors that the Court would be required to consider in reaching its judgment.
- Proposal 3 would substantially change the criteria to make them less vague by including such wording as "substantial likelihood that in the near future" that physical harm would occur to self or others due to the individual's mental illness "as evidenced by recent behavior" or that harm will be suffered due to substantial deterioration or an inability to protect or provide for him/herself.
- Proposal 4 would substantially change the criteria by adding a third criterion for commitment that addresses containing deterioration in the individual's "previous ability to function in the community."

CSB staff is not required in statute to attend involuntary commitment hearings and there is no requirement for CSBs to be notified of hearings. The Inspector General found that "CSB attendance at commitment hearings is inconsistent across the state." Additionally, CSBs reported barriers to meeting attendance:

- 48% cited staffing limitations
- 25% hearings held outside of service area
- 20% distance to hearings within service area.

**Virginia Tech Review Panel Recommendations**

The VT Review Panel recommended amending the *Code of Virginia* to:

- Extend the time periods for temporary detention to allow for more thorough mental health evaluations;
- Authorize magistrates to issue temporary detention orders based on evaluations conducted by emergency physicians trained to perform emergency psychiatric evaluations;
- Require the presence of the pre-screener, or other CSB representative, at all commitment hearings, and to provide adequate resources to facilitate CSB compliance.
    - The independent evaluator, if not present in person, and the treating physician should be available where possible if needed for questioning during hearing.

**Treatment Following Commitment**

As noted in the Inspector General's investigatory report, CSBs are required to develop discharge plans as part of the involuntary commitment process; however:

- There is no requirement to provide CSBs with assessments completed by the independent evaluator or the attending physician;
- The meaning of "course of treatment" is unclear;
- BHA/CSBs or designated providers are required in *Code of VA* § 37.2-817.C to monitor "compliance with the treatment ordered by the court" but there are no statutory provisions regarding actions to be taken if individual does not comply with treatment plan; including no guidance for holding a subsequent commitment hearing unless "there is clear evidence that new behaviors…meet TDO or commitment criteria…."

**Involuntary Outpatient Treatment**

Additional issues related to involuntary outpatient treatment orders as noted by the Inspector General's report include:

- Limited access to involuntary outpatient treatment;
- Average wait times for CSB outpatient treatment services were:
    - Clinician 30.22 days for adults (13.54 days post emergency)
    - Clinician 37.42 days for children (16.5 days post emergency)
    - Psychiatrist 28.16 days for adults (13.54 days post emergency)
    - Psychiatrist 30.36 days for children (15.46 days post emergency)
- Due to the limitations in outpatient treatment capacity:
    - "Often not possible to prevent crises
    - Individuals seeking service lose interest and fail to follow through
    - Staff have limited time to follow up on those who drop out
    - Not possible to meet the needs of the court for outpatient commitment
    - Court ordered treatment will cause delays for those who seek treatment voluntarily."

The VT Review Panel recommended clarifying with regard to involuntary outpatient orders:

- Need for specificity in involuntary outpatient orders.
- Appropriate recipients of certified copies of orders.
- Party responsible for certifying copies of orders.
- Party responsible for reporting non-compliance with outpatient orders and to whom noncompliance is reported.
- Mechanism for returning the noncompliant person to court.
- Sanctions to be imposed on the noncompliant person who does not pose an imminent danger to himself or others.
- Respective responsibilities of the detaining facility, the CSB and the outpatient treatment provider in assuring effective implementation of involuntary outpatient treatment orders.

The MHLR Commission is examining issues related to involuntary outpatient orders within its review.

## Options

**Option 1:** Take no action**.**

**Option 2:** Review any health-related workforce initiatives that are funded to ensure that mental health professionals are included where appropriate:

- In any budget amendments – add or designate funding or add language to allow initiatives to address the need for mental health professionals too.

**Option 3:** Fund additional crisis stabilization units (estimated annual cost of $1 million per unit)

- Statewide coverage may require as many as 24 units, but it has been suggested to begin by funding 4 or 5 units.

**Option 4:** Amend the *Code of Virginia* to require CSB staff participation (while allowing use of video conference or conference call) in all involuntary commitment hearings.

**Option 5:** Increase State funding for CSBs (amount to be specified) to:

- Allow for increased work if changes such as lowering the standard for involuntary commitment are enacted
- Provide for needed community-based services (including those involved in involuntary outpatient treatment orders).