

**Statement to the Behavioral Health Subcommittee of the Joint Commission on  
Health Care  
Progress Report on Mental Health Law Reform**

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The General Assembly has enacted major initiatives in mental health law reform during the last three legislative sessions. Although the Commission believes some additional legislative actions are needed, the main focus of the reform effort has shifted to implementing the innovations already enacted. Now we are in the trenches trying to translate blueprints for reform into changes in practice.

**Criminal Justice and Mental Health Transformation**

Under Victoria Cochran’s leadership, mechanisms for interagency coordination have been established at the state and local levels to provide outpatient mental services to people with mental illness who have become involved with the criminal justice system and to facilitate mental health interventions in lieu of arrest in appropriate cases. Funding allocated by the General Assembly has been effectively and efficiently spent on implementing Crisis Intervention Training on a statewide basis and supporting model programs for connecting services to jail diversion and reentry. With the help of the nation’s leading scientific experts in this field, Victoria has created an excellent foundation for data collection and program evaluation. Preliminary results are very encouraging both for CIT and the jail diversion programs. Progress is also being made on creating secure drop-off capability for law enforcement personnel to assure immediate placement for persons who need short-term therapeutic assessment and intervention. Such “drop-off” capability would take advantage of the authority conferred by legislation adopted in 2008. Continuing challenges must be faced as we move forward with these important mental health - criminal justice initiatives; they include assuring continuity of care, including consistency in formulary, as clients migrate between community mental health care and jails, prisons or hospitals; and assuring adequate information exchange across these systems.

**Implementing Advance Directives in Mental Health Care**

In 2009, the General Assembly enacted major revisions of the Commonwealth’s Health Care Decisions Act (HCDA) based on Commission recommendations, and added a few clarifying amendments this year. These changes provide a robust legal mechanism for persons with chronic health conditions, including serious mental illness,, to document, while competent, their treatment instructions and preferences, and to authorize a healthcare agent to make treatment decisions for them during periods of incapacity. Research has shown that the execution of advance directives by people with serious mental illness – a genuine exercise of empowerment -- promotes treatment engagement,

reduces the occurrence of mental health crises, and reduces the need for -- and use of -- legal coercion.

Under Commission oversight, an energetic consortium of stakeholders and public agencies is undertaking an unprecedented effort to implement use of advance directives among people with serious mental illness. The Department of Behavioral Health and Developmental Services is supporting initiatives by CSBs to incorporate facilitation of advance directives into routine clinical care. CSBs in three localities (Prince William County CSB, Chesapeake CSB and Region Ten CSB) are serving as “vanguard sites” for these initiatives, and we are also encouraged by the interest being shown in Norfolk.

In addition, advocacy organizations, including NAMI, VOCAL, Mental Health America, and VOPA, are taking steps to facilitate the use of advance directives by members of their organizations and the people they serve. Standardized advance directive forms have been developed under the auspices of the Virginia Health and Hospital Association. Health law experts, including the Office of the Attorney General, are helping to clarify the legal aspects of advance directives for both consumers and facilities, and training workshops have been organized to help disseminate more information about the law to advocates and health care providers. We are also posting all this information on special Virginia Advance Directive Websites. Finally, we are collecting administrative data in the vanguard sites to document facilitation and execution of advance directives.

Because what we are doing in Virginia is of great interest to other states, major national foundations have funded a study by a team of investigators from the University of Virginia and Duke University to assess the effects of these initiatives. The study’s findings will be used to develop specific recommendations to improve implementation of the law in Virginia and will also be disseminated nationally to inform policymaking in other states.

### **Unfinished Business in Commitment Reform**

Virginia’s 48-hour TDO period is the shortest in the country. The norm is 5-7 days. The Commission is convinced that lengthening the TDO period would assure more informed evaluations and would substantially reduce the need for involuntary commitment. The basic idea of lengthening the TDO period was endorsed by both the Virginia Tech Review Panel and the Commission in 2007. However, the Commission decided to postpone a specific recommendation on this matter pending further study of the possible consequences of alternative ways of implementing the basic concept. Last year, the Commission recommended, as a first step, that the TDO period be lengthened to 72 hours and that no hearing be held until 24 hours has elapsed. This approach is incorporated in SB 85 (Sen. Howell) and HB 307 (Del. O’Bannon).

Based on extended and careful research, the Commission is certain that lengthening the TDO period to 72 hours and requiring a minimum period of hospitalization of 24 hours before a hearing is held will increase the proportion of cases that are dismissed at the

hearing and will increase the proportion of cases in which the respondent agrees to voluntary admission at the hearing. It is also likely that elongating the TDO period will lead to somewhat more MOT orders. All of these patterns will reduce the occurrence of involuntary hospitalization.

We have also undertaken a variety of studies to project the overall fiscal impact of adopting SB 85 and HB 307. It is clear that the proposal will increase the aggregate number of TDO hospitalization days covered by the Involuntary Commitment Fund. However, it is also clear that this increase will be offset by a reduction in the aggregate number of post-TDO hospitalization days due to the increased number of dismissals and MOT orders. We think we have a reasonable basis for quantifying these projected effects, which may result in a net savings.

What is NOT clear, however, is how these reductions in post-TDO hospitalization costs will affect expenditures of state general funds. The reason for the uncertainty is the difficulty of determining exactly which budgets are now paying for what proportion of post-TDO hospitalization days (whether voluntary or involuntary), and how the change in the TDO period would affect these respective funding sources.

We will continue to study this complicated issue and make informed estimates. However, in light of the compelling policy virtues of the basic proposal, and the net savings in overall hospitalization costs that it is likely to achieve, the Commission strongly recommends that the bill be adopted even if the net effect on state general funds is somewhat uncertain.

### **Measuring and Improving Performance**

In previous reports to the Joint Commission, I have emphasized the critical importance of developing information systems on CSB emergency services, ECOs, TDOs and commitment proceedings to monitor trends and the impact of reforms and also to develop performance indicators to assess progress in each locality. With the extraordinary support of the Office of the Executive Secretary of the Supreme Court, we have made great progress, but much remains to be done. For example, although we have excellent data on order issues by magistrates and on hearings conducted by special justices, we are still missing important data on the decisions by CSB staff and independent examiners, as well as admission and discharge data from facilities admitting patients under TDOs and commitment orders.

An important goal of a good data system is to facilitate oversight and accountability. From this standpoint, one problem that we have been studying carefully is variation in commitment dispositions across the Commonwealth. After reviewing the data for two years, we are convinced that the variations are substantial and persistent. We now need to understand why and to decide how to address them. Over the summer, the DBHDS, CSBs and the Supreme Court conducted training activities to acquaint facilities, clinicians and judges with the legislation that went into effect in July. In the course of these training activities, we also took the opportunity to acquaint the decision-makers in

the commitment process with evidence showing that outcomes in commitment hearings vary substantially across the Commonwealth, and to elicit their views about the most likely explanations for these variations. As a result of these highly informative conversations, we are developing strategies for promoting greater consistency in practice while taking account of inevitable differences in resources and service capacity across the Commonwealth. One specific step that we have already taken is to establish a Task Force on Proposed Rules of Court for Involuntary Commitment Hearings. This Task Force will be charged with drafting proposed rules aiming to promote more uniform interpretation and application of the commitment statute in accord with the purposes sought by the General Assembly.

### **Looking Forward**

The Commission's work will come to an end at the end of FY 2011, but much remains to be done. How will we sustain the reform process afterwards? The Chief Justice and the Supreme Court have provided the leadership and served the convening function for this important effort. However, in light of the Commonwealth's continuing budget woes, it is unlikely that funds will be available in the short term to establish another entity to provide coordination and oversight, monitor practice and performance, and recommend changes in law or policy. Until such funds are available and an inter-agency oversight body can be created, the Commission will work with the DBHDS, the OAG and the Supreme Court to maintain the habits of collaboration and joint oversight that have emerged over the last four years.

One final word about the connection between commitment law reform and the underlying challenge of increasing access to services. Many of the changes that have already been adopted will not have their intended impact unless preventive outpatient services and supports (including outpatient treatment, integrated medical and psychiatric care, and case management services) become more accessible and more widely utilized, thereby reducing the occurrence of mental health crises and relieving the pressure on an overburdened emergency services system and the spillover effects on the criminal justice and social welfare systems.

The Commission hopes that changes in the financing and structure of health care that occur in the wake of the federal health care legislation will reinforce and accelerate the transformations already underway in the Commonwealth's public mental health services. When public funds once again become available, investment in community mental health services should be among the top priorities. Our goal is to assure that these services are accessible to everyone in need of these services, regardless of income.

Thank you for the opportunity to appear before you today, and thank you for your continuing interest in the Commission's work.