JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION
OF THE VIRGINIA GENERAL ASSEMBLY

INTERIM REPORT:

Review of the Involuntary Civil Commitment Process

INTERIM REPORT OF THE
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

Review of the Involuntary Civil Commitment Process

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

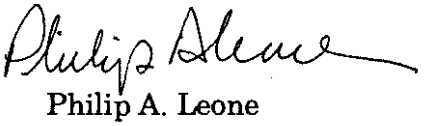
The *Code of Virginia* provides that individuals thought to be dangerous or incapable of self-care due to mental illness can be detained under temporary detention orders (TDOs) for inpatient testing and evaluation. Following the testing and evaluation, a commitment hearing is held which results in the individual being either released or committed to treatment. In the 1970s, the General Assembly established the involuntary civil commitment fund to pay for the medical and legal costs associated with the temporary detention period and the commitment hearing.

Item 15 of the 1993 Appropriation Act directs JLARC to examine the fiscal issues related to the fund and the operational and policy issues involving the involuntary civil commitment process, and to develop recommendations for improved efficiencies in the process. This report is an interim report which focuses primarily on the fiscal issues. A more complete examination of the involuntary commitment process is needed in order to fully support detailed recommendations for improved efficiencies.

The Supreme Court currently administers the involuntary civil commitment fund and made disbursements of more than $9.6 million in FY 1993. However, JLARC staff estimate that nearly $20.1 million was actually expended on the involuntary commitment process in FY 1993. The additional funds were expended by community services boards, sheriffs, the Department of Medical Assistance Services, and the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

The involuntary civil commitment fund was established to be the last source to which hospitals applied for payment. However, initial research suggests that the State may be reimbursing hospitals for services that could be covered by private insurance or Medicaid. In fact, it appears the State may be making duplicate payments from the involuntary civil commitment fund and from Medicaid claims for some hospital stays.

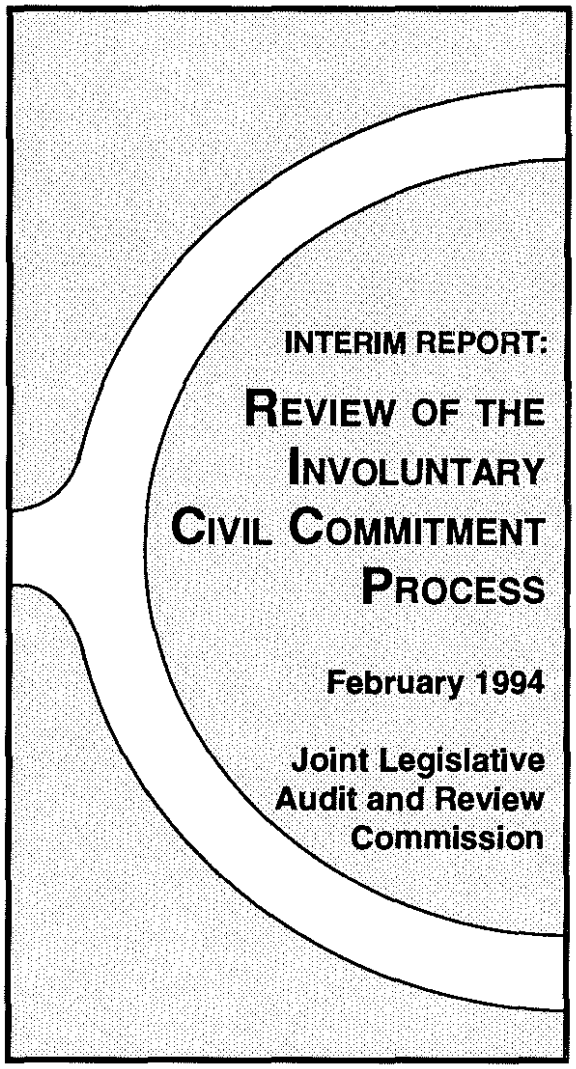
On behalf of JLARC staff, I would like to express our appreciation for the cooperation and assistance provided by the directors and staffs of the Department of Mental Health, Mental Retardation, and Substance Abuse Services; the Supreme Court of Virginia; the Department of Medical Assistance Services; community services boards; and sheriffs and their deputies.



Philip A. Leone
Director

February 15, 1994

JLARC Report Summary



The *Code of Virginia* provides that individuals who are mentally ill and in need of hospitalization may either voluntarily admit themselves or be involuntarily committed to a hospital to receive treatment. According to statute, individuals thought to be in need of involuntary civil commitment are to enter the process through an emergency custody order (ECO) issued by a judge, special justice or magistrate. An ECO directs that an individual thought to be mentally ill and in need of hospitalization be taken into custody and evaluated. Following the evaluation, individuals are either released or a temporary detention order (TDO) is issued, and they are detained for additional evaluation and treatment.

The General Assembly established the involuntary civil commitment fund to pay for the medical and legal costs associated with the temporary detention period and the involuntary civil commitment hearings. The Supreme Court administers the fund and made disbursements of more than $9.6 million in FY 1993.

Item 15 of the 1993 Appropriation Act directs JLARC to examine "fiscal issues related to the Involuntary Commitment Fund and operational and policy issues involving the involuntary mental commitment process." The mandate further directs that the study "promote improved efficiencies" in this area.

This report presents three major preliminary findings. First, the costs of the involuntary civil commitment process are estimated to be approximately $20.1 million, which is more than twice the amount the State directs toward the involuntary civil commitment process through the involuntary civil commitment fund. Second, the State may be making duplicate payments from the involuntary civil commitment fund and from Medicaid claims for hospital stays. Third, while it appears that sheriffs are utilized as the primary method of transport for individuals under TDOs, sheriffs and community services board (CSB) directors agree that a law enforcement role may not always be necessary in this process. However, changes in this area may necessitate changes in other aspects of the current civil commitment procedures. There is a need for a more complete examination of the

involuntary civil commitment processes in order to fully support detailed recommendations for improved efficiencies.

More Than $20.1 Million Was Spent on Involuntary Civil Commitment Activities in FY 1993. While disbursements from the involuntary civil commitment fund totaled $9.6 million in FY 1993, JLARC staff estimate that more than $20.1 million was actually expended in that same year on involuntary civil commitment activities. Expenditure estimates from the sheriffs and CSBs, and data from the Department of Medical Assistance Services (DMAS) and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) indicate that an additional $10.5 million was spent on activities associated with involuntary civil commitment.

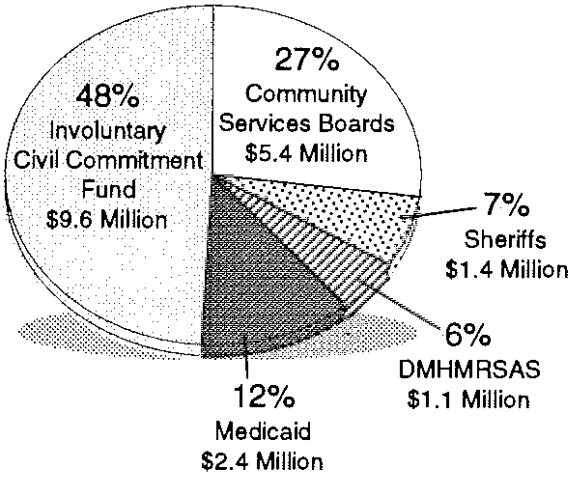
The State May Be Making Duplicate Payments to Hospitals. It appears that the State may be making duplicate payments from the involuntary civil commitment fund and from Medicaid claims for hospital stays. JLARC staff analysis indicates that hospitals may not be subtracting Medicaid reimbursements they have received from the amounts they are billing the Supreme Court. Therefore, the Supreme Court may be reimbursing hospitals for amounts the hospitals have already received through Medicaid payments. DMAS, due to federal restrictions, could not provide data which would allow JLARC staff to match individual cases to determine definitely if duplicate payments are occurring, and if they are occurring, the amount of duplicate payments. Further review of DMAS Medicaid data is necessary to determine the amount of duplicate payments from the State to private hospitals, and to determine if cost savings could be achieved.

Therefore, the following recommendation is made:

Recommendation: *The General Assembly may wish to amend the study language in the Appropriation Act to require the Department of Medical Assistance Services to provide JLARC with the individual data necessary to determine if the State is double-paying for services provided individuals during the temporary detention period.*

Sheriffs Are Divided in Their Opinions on the Extent of the Need for Their Involvement in Transporting TDOs. One hundred fourteen sheriffs responding to a

Involuntary Civil Commitment Costs, FY 1993



JLARC survey on involuntary civil commitment, or 91 percent of the 125 sheriffs statewide, reported that they transported approximately 16,000 mental health patients in FY 1993. The average was approximately 140 transports per department. The majority of these sheriffs reported that they should be involved in the transportation of individuals under ECOs and TDOs. However, sheriffs are divided over what they believe their role should be. Almost half of the sheriffs responding to the JLARC survey on involuntary civil commitment indicated that their role in transporting mental health patients should be reduced or eliminated. Further, 78 percent of the sheriffs who responded to the survey reported that the responsibility of transporting mental health patients causes staffing problems.

The *Code of Virginia* indicates that special justices have the option to assign some transportation responsibilities to parties other than sheriffs, such as CSBs or family members, but it appears that this rarely occurs. Transferring the responsibility from sheriffs to other entities for more of the transports could require some changes to the involuntary civil commitment procedures.

Issues for Further Study. Further analysis is necessary for a complete review of the involuntary civil commitment process. JLARC staff have identified six issues for examination:

- the efficiency and effectiveness of the management of the involuntary civil commitment fund;
- the role community services boards should play in the emergency custody, temporary detention, and involuntary civil commitment processes;
- the role the legal system (including courts, sheriffs, police, judges, special justices, and magistrates) should play in the emergency custody, temporary detention, and involuntary civil commitment process;
- the efficiency and effectiveness of the use of public and private hospitals during the temporary detention process;
- the extent to which the temporary detention process is used for purposes for which it was not originally intended; and
- the options the State has to improve the emergency custody, temporary detention, and involuntary civil commitment processes and procedures.

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I. Introduction

The *Code of Virginia* provides that individuals who are mentally ill and in need of hospitalization may either admit themselves voluntarily or be involuntarily committed to a hospital to receive treatment. According to the *Code*, the involuntary civil commitment process is initiated by an emergency custody order (ECO). Any responsible person can request an ECO from a judge, special justice, or magistrate. An ECO directs that an individual thought to be mentally ill and in need of hospitalization be taken into custody and evaluated. The *Code* also states that a law enforcement officer may take a person into custody for emergency evaluation, without an ECO, if there is probable cause. Following the evaluation, individuals are either released or a temporary detention order (TDO) is issued, and they are detained for additional evaluation and treatment. During the period of detention, a commitment hearing takes place, after which involuntary treatment may be initiated.

The General Assembly established the involuntary civil commitment fund in the 1970s to cover the costs associated with the medical and legal services provided individuals during the temporary detention period and the costs of the civil commitment hearings. The Supreme Court administers the fund and made disbursements of more than $9.6 million in FY 1993. However, community services boards (CSBs), sheriffs, the Department of Medical Assistance Services (DMAS), and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) reported that an additional $10.5 million was used to cover additional costs for involuntary civil commitment activities during this same year.

Item 15 of the 1993 Appropriation Act (Appendix A) directs JLARC to examine "fiscal issues related to the Involuntary Commitment Fund and operational and policy issues involving the involuntary mental commitment process". The mandate further directs that the study "promote improved efficiencies" in this area.

For this interim report, JLARC staff focused on estimating the costs of the involuntary civil commitment process, and on the issues raised by the sheriffs regarding the transportation of individuals whose mental health status indicates they may need involuntary hospitalization. However, modifications in transportation or in administering the involuntary civil commitment fund could necessitate changes in other aspects of the current civil commitment process. A more complete examination of the involuntary civil commitment processes is needed in order to fully address the study mandate and make detailed recommendations for improved efficiencies.

OVERVIEW OF THE INVOLUNTARY CIVIL COMMITMENT PROCESS

The involuntary civil commitment process is the procedure through which adults and juveniles are mandated to receive involuntary mental health treatment.

Individuals entering the involuntary civil commitment process generally enter through an emergency custody order or a temporary detention order. While an ECO allows an individual to be detained for an evaluation for no more than four hours, a temporary detention order provides for the detention of an individual in an inpatient hospital generally for a period not to exceed 48 hours for the purpose of evaluating the individual's mental status.

The Supreme Court reports that the number of temporary detention orders that they processed rose from 7,070 in FY 1992 to 7,661 in FY 1993. However, these numbers represent the number of invoices received by the Supreme Court from private hospitals for reimbursement for treatment during the temporary detention periods, and not the total number of these orders issued throughout the State. A single individual could have more than one invoice during the course of a year. The Supreme Court does not pay for TDOs at State psychiatric hospitals, and detention costs that are paid in full by private insurance are not included in the data. There is no aggregated information on the number of TDOs issued throughout the State, or on the percentages of them which result in involuntary civil commitments.

The *Code of Virginia* directs how the process should operate for both adults and juveniles. There is substantial variation in the adult commitment processes in place throughout the State, but without additional analysis, it is not clear whether this variation is problematic. Community services boards play major roles in the process in all localities while sheriffs are involved in most localities.

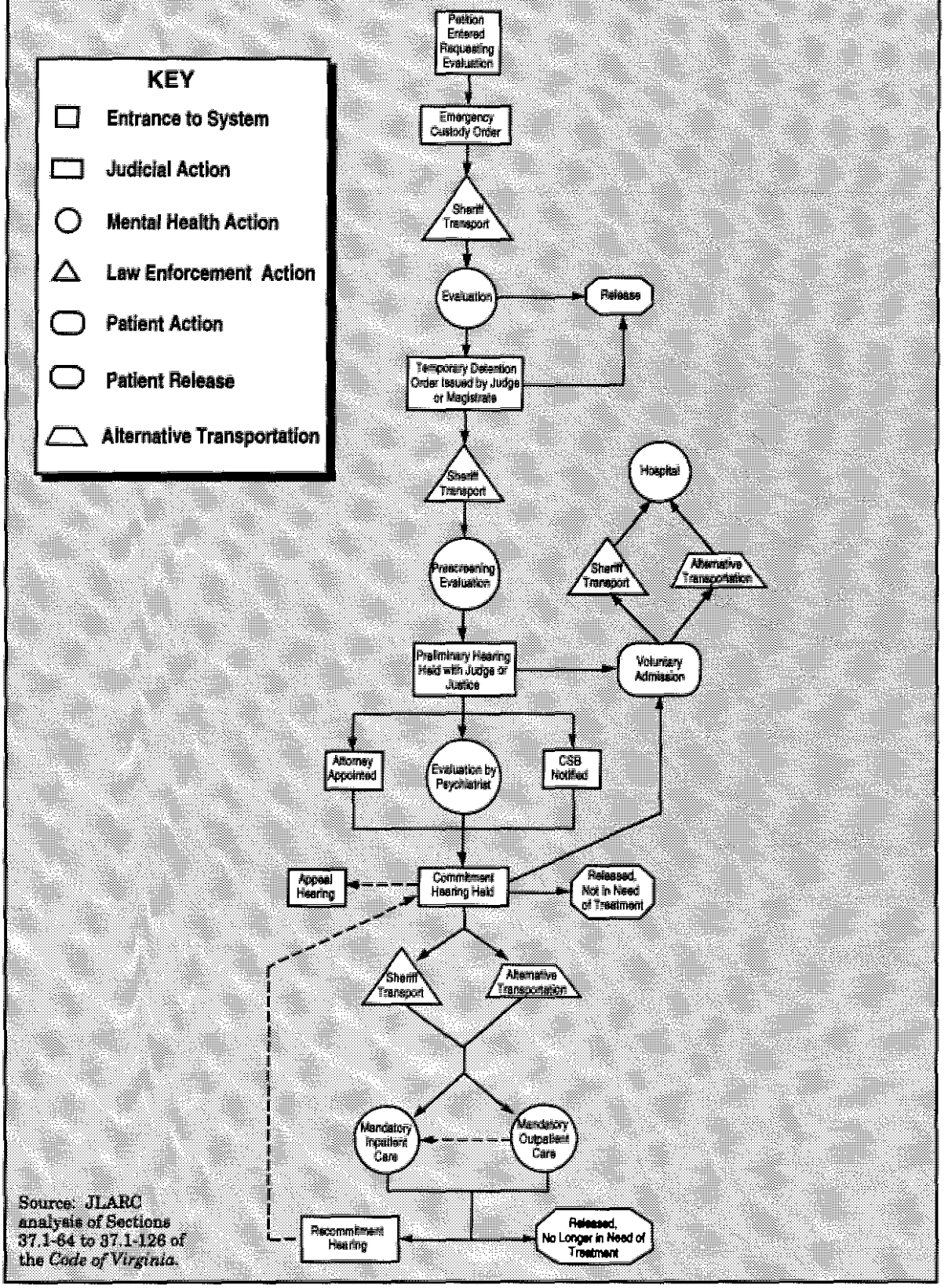
The *Code of Virginia* allows for the appointment of special justices by the chief circuit court judges. While magistrates and others may have more limited roles in the process, the special justices appear to be involved in all major aspects leading up to the determination of commitment. However, there is no formalized mechanism for training special justices, ensuring the standardization of the adult hearings, or providing oversight.

The Adult Civil Commitment Process

Sections 37.1-67.1 et. seq. of the *Code of Virginia* direct the involuntary civil commitment process (Appendix B). According to the statute, any person having probable cause to believe that an individual is mentally ill and in need of emergency evaluation for hospitalization may request a magistrate or judge to issue an emergency custody order for that individual (Figure 1). The emergency custody order requires that the detainee be taken into custody and evaluated within a four-hour period by a mental health professional designated by the community services board in that region. A law enforcement officer may take a person into emergency custody directly, without an ECO, if there is probable cause. The person shall remain in custody until a temporary detention order is issued, or until the person is released. If it appears from all available evidence that the person is mentally ill and in need of hospitalization, the judge or magistrate may then issue a temporary detention order on the individual.

Figure 1

The Statutorily Defined Pocess for Temporary Detention Orders and Involuntary Commitment



Source: JLARC analysis of Sections 37.1-64 to 37.1-126 of the *Code of Virginia*.

Before issuing a TDO, a magistrate or special justice is required to receive the advice of a mental health professional who has conducted an in-person evaluation of the individual. The magistrate may omit the evaluation if the individual has been examined in the last 72 hours by a mental health professional or if contact with the individual would pose a significant risk to those involved.

After a TDO is issued, a law enforcement officer is required to execute the order. The order may be executed by the law enforcement authority in any area of the Commonwealth and is valid for 24 hours after it is issued. If it is not executed in that time, it expires and a new order must be issued. Individuals detained under a TDO are taken to an inpatient hospital for evaluation.

Generally within 48 hours of the issuance of a TDO, the patient must accept voluntary admission or be given a commitment hearing. If a TDO is issued during a weekend or holiday, the time limit may be extended to 96 hours.

The commitment hearing is usually conducted by a special justice. Prior to the commitment hearing, a special justice must notify the individual of the right to obtain counsel or have one appointed, the right to apply for voluntary admission, and the right to a commitment hearing and other due process and procedural details. This notification constitutes the preliminary hearing. The commitment hearing follows the preliminary hearing.

During the period between the preliminary hearing and the commitment hearing, the detainee is to be interviewed by legal counsel. This period is to be used by the detainee and legal counsel to prepare a case based upon the detainee's wishes. The special justice requires that a licensed psychiatrist or psychologist perform an evaluation on the detainee. Additional independent psychological evaluations may be performed at the expense of the detainee.

At the commitment hearing, the special justice hears evidence from numerous sources concerning the mental state of the detainee and various treatment or disposition options. The psychologist or psychiatrist requested by the court to perform an evaluation presents the evaluation either orally or in a written report. Additional reports by a mental health professional contracted by the detainee may also be reported in the hearing. The community services board in the home region of the detainee is requested to submit a report on the individual. Finally, counsel for the detainee present the detainee's wishes.

At the conclusion of the commitment hearing, the special justice renders a judgment. If the special justice decides that the individual, as a result of mental illness, presents an imminent danger to self or others, or is incapable of self care, and alternatives to involuntary confinement and treatment have been deemed unsuitable and there is no less restrictive alternative, an order for involuntary inpatient commitment is issued. Inpatient commitment may be for no longer than 180 days and must be to a facility designated by the community services board that serves the political subdivision of the detainee. Involuntary outpatient commitment may also be ordered if less restrictive treatment alternatives exist and are suitable.

All patients have a right to appeal the outcome of their commitment hearings. These appeals can be made to either a jury or a judge at the circuit court level. The appeal must be filed within 30 days of a commitment ruling.

If at the end of 180 days of inpatient treatment an individual is still thought to be in need of involuntary care, a petition may again be filed, and a recommitment hearing is conducted. Recommitment hearing procedures are the same as the initial hearing with the exception of the preliminary hearing. No preliminary hearing is held in the recommitment process.

Role of Community Services Boards. CSBs are local government organizations which provide services for mental illness, mental retardation, and substance abuse. There are 40 CSBs throughout the State which serve either an individual locality or a group of contiguous localities such that every county and city in Virginia is served by a CSB (Figure 2). Each CSB receives funding from a variety of local and federal sources. CSBs are appropriated matching State funds through the Department of Mental Health, Mental Retardation and Substance Abuse Services.

As part of their statutory mandate, CSBs are involved in involuntary civil commitment activities. Activities performed by the CSBs related to involuntary civil commitment include providing emergency services, requesting orders for emergency custody and temporary detention, initiating transportation requests, and recommending hospitals to special justices for detention and commitment.

If an individual enters the involuntary civil commitment process through a CSB, the process usually is initiated as part of emergency services. Section 37.1-197.1 of the *Code of Virginia* mandates that CSBs provide emergency services. Accordingly, all 40 CSBs reported providing emergency services. This service typically involves 24 hour telephone and walk-in services for individuals experiencing a mental health crisis. The service is staffed by professionals and paraprofessionals trained in dealing with individuals experiencing acute mental illness. These services provide assessment and referral for individuals in need of emergency treatment. In FY 1993, the CSBs reported that an estimated 246,000 contacts were made to CSB crisis services, and that approximately 18 percent of these contacts resulted in either an emergency custody order, a temporary detention order, or both. However, these estimates would result in more than six times the number of TDO invoices than the Supreme Court reports it processed the same year. There are several factors that could potentially account for some of this difference, including the fact that not all ECOs result in a TDO; that the Supreme Court data do not include payments for TDOs at State psychiatric hospitals or that are paid by private insurance; or the number reported by CSBs may be substantially overstated. Additional analysis is needed to assess the reasons for this difference.

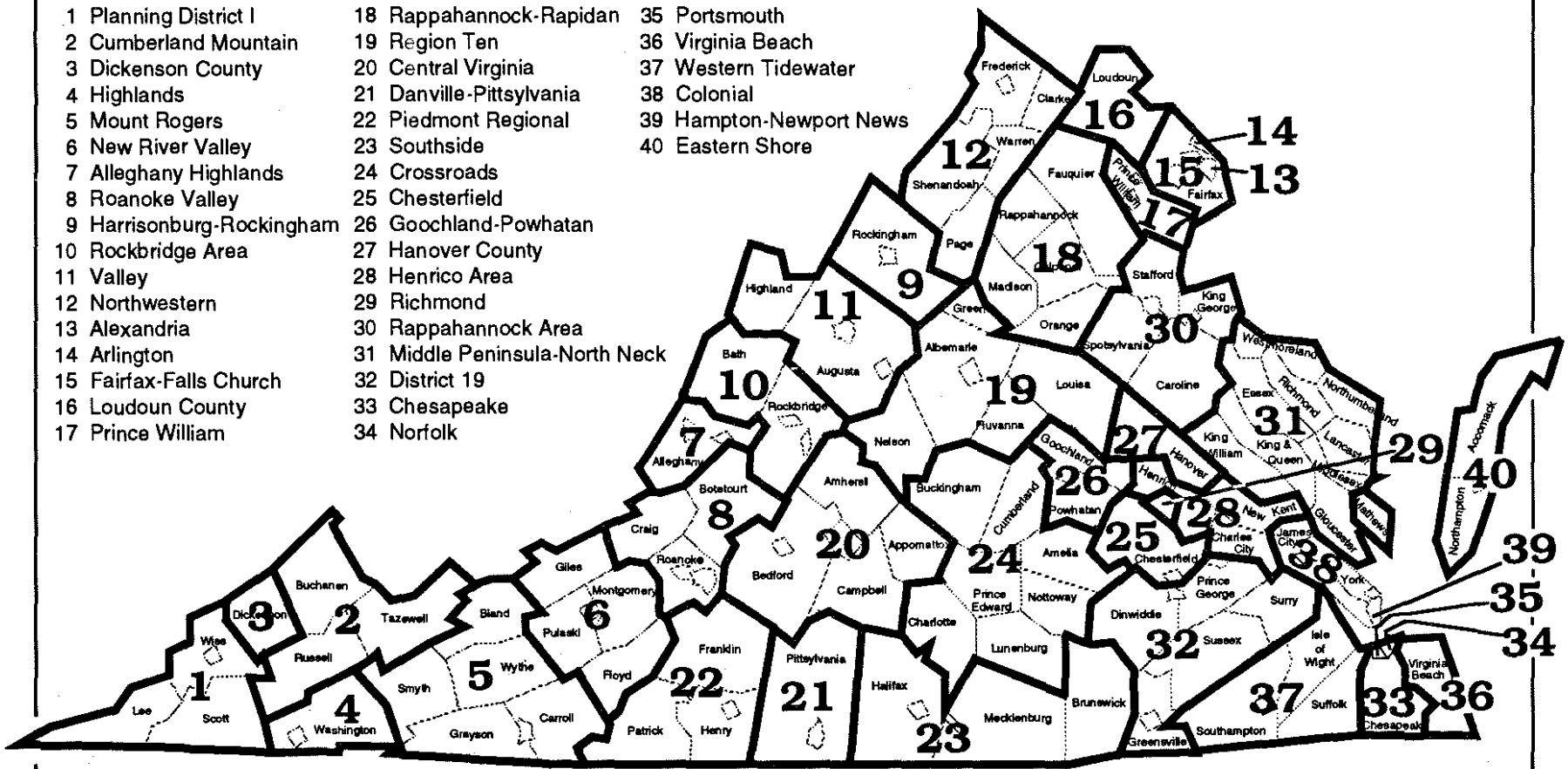
Thirty-six (90 percent) of the CSBs indicated that they provide evaluation services during the ECO period. Thirty-seven (93 percent) of the CSBs reported that they request ECOs on clients in emergency services who appear to be experiencing a mental health crisis. Three CSBs (Norfolk, Portsmouth, and Richmond) reported that they do not request ECOs. In addition, one executive director noted that his CSB did request

Figure 2

CSB Service Areas

Key to Community Service Boards

1 Planning District I
2 Cumberland Mountain
3 Dickenson County
4 Highlands
5 Mount Rogers
6 New River Valley
7 Alleghany Highlands
8 Roanoke Valley
9 Harrisonburg-Rockingham
10 Rockbridge Area
11 Valley
12 Northwestern
13 Alexandria
14 Arlington
15 Fairfax-Falls Church
16 Loudoun County
17 Prince William
18 Rappahannock-Rapidan
19 Region Ten
20 Central Virginia
21 Danville-Pittsylvania
22 Piedmont Regional
23 Southside
24 Crossroads
25 Chesterfield
26 Goochland-Powhatan
27 Hanover County
28 Henrico Area
29 Richmond
30 Rappahannock Area
31 Middle Peninsula-North Neck
32 District 19
33 Chesapeake
34 Norfolk
35 Portsmouth
36 Virginia Beach
37 Western Tidewater
38 Colonial
39 Hampton-Newport News
40 Eastern Shore



Source: JLARC analysis of Virginia Association of Community Services Board, Inc. data, April 1993.

ECOs but that judicial officials in localities in the catchment area would not issue the orders. Consequently, the CSB staff must request a TDO instead.

All of the CSBs reported that they offer TDO screenings and write reports on these screenings. Thirty-three of the 40 CSBs reported that their staff remain active throughout the civil commitment process by attending the hearings. Thirty-two CSBs reported arranging placements for individuals who are committed.

CSBs typically petition special justices or magistrates for the emergency custody and temporary detention orders. The orders are then written which usually require the sheriff or police to transport these individuals during the ECO, TDO, and civil commitment periods. CSBs can request that a special justice issue an ECO, which would usually direct the police or sheriff to take an individual into custody and to present this individual at the CSB for an evaluation. The results of the evaluation are used to determine if an individual is released or a TDO is requested. If a TDO is issued, the special justice or magistrate directs the sheriff's office on where to transport the detained individual for hospitalization. When a TDO is issued without a prior ECO, then the sheriff is requested by the special justice or magistrate to execute the TDO on the individual and to perform the transport.

Sections 37.1-67.1 and 37.1-67.3 of the *Code of Virginia* require that CSBs recommend to the special justices and magistrates the locations for evaluation, detention, and treatment of individuals under an ECO, a TDO, or for involuntary civil commitment. In FY 1993, CSBs recommended a total of 60 hospitals be used for detention during TDO periods and 64 hospitals be used for civil commitments. These hospitals were a mix of both public and private facilities. Sometimes the recommended facilities were within the CSB catchment area, and other times they were not. For example, the Mount Rogers CSB, which has a catchment area that includes Wythe, Bland, Smyth, Grayson, and Carroll counties, and the city of Galax, reported recommending six facilities for hospitalization during the TDO period. These hospitals included the Southwest Virginia Mental Health Institute located in Marion, St. Albans Hospital in Radford, the Twin County Community Hospital and the Life Center of Galax both in Galax, the Lewis Gale Hospital in Roanoke, and Central State Hospital in Petersburg. The Rappahanock-Rapidan CSB, which serves a catchment area including Rappahanock, Fauquier, Culpeper, Madison, and Orange counties, reported that they recommend five private facilities for TDO hospitalization. These hospitals were located in Fredericksburg, Culpeper, Richmond, and Charlottesville. In addition, they recommended two public facilities, Western State Hospital in Staunton and Central State in Petersburg.

Role of Sheriffs. The responsibilities of sheriffs in Virginia include law enforcement, court security, jail administration, and process service in their respective localities. However, not all sheriffs are responsible for all of these functions. Currently, 125 sheriffs serve Virginia's 136 localities. Of these sheriffs, 30 serve cities and 95 serve counties. In 11 counties, sheriffs also serve one or more independent cities within or adjacent to their respective counties.

As part of their duties, Section 37.1-71 of the *Code of Virginia* cites sheriffs as responsible for transporting citizens who are certified for admission to a hospital.

Although Section 37.1-72 of the *Code of Virginia* indicates that responsible persons other than sheriffs may be used to transport these individuals, sheriffs reported that special justices utilize sheriff's departments as the primary means for transporting those individuals, as well as individuals under TDOs. Sheriffs in some cities reported that the local police departments perform the transports.

In addition, sheriffs reported that they transport individuals who are under orders to be detained at public hospitals but must first receive medical clearance prior to being admitted at a public hospital. Sheriffs and deputies also transport individuals committed within their jurisdictions whose homes are more than 100 miles away from the site of the commitment hearing.

Role of Special Justices. Section 37.1-1 of the *Code of Virginia* states that the civil commitment process in Virginia is to be adjudicated by judges; associate judges; substitute judges of the general district courts; and in juvenile cases, juvenile and domestic relations judges. In addition, the chief judge of each judicial circuit may appoint special justices who have the powers of the circuit court in executing their duties in the civil commitment process. Magistrates, special justices, and judges all can issue ECOs and TDOs. However, the special justices and judges are also responsible for adjudicating preliminary and civil commitment hearings, and deciding who will perform the mental health transport. In some areas special justices provide extensive services and access. For example:

> *In the City of Richmond there are three special justices who alternate weeks, with each justice serving every third week. During the week they are on duty the special justices hear cases, issue ECOs and TDOs 24 hours a day, and issue medical treatment orders. The justices have facsimile machines in their homes so that they are available at all times to issue orders.*

Special justices receive no mandated training on mental health law. The Supreme Court, and the Department of Mental Health, Mental Retardation and Substance Abuse Services, in cooperation with the Institute on Law, Psychiatry, and Public Policy at the University of Virginia and the Office of the Attorney General, provide mental health law training several times a year at various locations around the State. Some special justices attend these optional seminars.

Special justices are paid $28.75 for each preliminary and commitment hearing they adjudicate. This payment is made by the Supreme Court from the involuntary civil commitment fund. In FY 1993 Supreme Court staff made disbursements from the involuntary civil commitment fund totaling $942,719 to 142 special justices across the State.

The Juvenile Commitment Process

Sections 16.1-339 through 16.1-345 of the *Code of Virginia* outline the processes for involuntarily committing juveniles. The involuntary civil commitment process

outlined in Section 16.1-341 begins when a petition is filed with a juvenile and domestic relations court. The petition may be filed by a parent, or if the parent is not available or is unable or unwilling to file a petition, by any responsible adult. The petition sets forth in specific terms why the petitioner believes the minor meets the criteria for involuntary commitment.

Upon the filing of the petition, the juvenile and domestic relations court schedules a hearing which shall occur no sooner than 24 hours and not later than 72 hours from when the petition is filed. Following the filing of the petition, the juvenile and domestic relations court directs the community services board serving the area in which the minor is located to arrange for an evaluation by a qualified evaluator. The evaluator cannot be familiar with the juvenile and must not have any significant financial interest in the facility where the minor would be committed. A report indicating the evaluator's opinion on whether the juvenile should be committed is submitted at least 24 hours prior to the commitment hearing. The evaluator is required to attend the hearing as a witness.

The minor's attorney is required to interview the minor, the minor's parents, the evaluator, and any witnesses as far as possible in advance of the hearing. Counsel approved by the court is compensated in accordance with the previously indicated reimbursement schedule.

All testimony at the hearing is under oath and the hearing is closed to the public unless the minor and petitioner request that it be open. The court orders the involuntary commitment of the minor to a mental health facility for treatment for a period not to exceed 90 days if it finds, by clear and convincing evidence, that:

- Because of mental illness, the minor (i) presents a serious danger to self or others to the extent that severe or irremediable injury is likely to result, or (ii) is experiencing a serious deterioration in the ability for self-care.

- The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment.

- If inpatient treatment is ordered, such treatment is the least restrictive alternative that meets the minor's needs.

If the parent or parents with whom the minor resides are not willing to approve the proposed commitment, the court orders inpatient treatment only if it finds, in addition to the criteria specified in this section, that such treatment is necessary to protect the minor's life, health, or normal development. The minor has the right to appeal any decision within 30 days. Under Section 16.1-340, emergency admissions may be accomplished through the procedure set forth in Section 37.1-67.1 and described earlier in this report.

Previous Studies

The involuntary civil commitment process has been the object of many studies over the last decade. There have been both internal Department of Mental Health, Mental Retardation, and Substance Abuse Services studies and reviews by outside evaluators.

Two studies, *Civil Commitment in Virginia* and *Civil Commitment Reform in Virginia*, were conducted by the Institute on Law, Psychiatry, and Policy at the University of Virginia. These studies, published in 1982 and 1983, addressed all aspects of the commitment process except the involuntary civil commitment fund. They recommended a substantial redesign of the involuntary civil commitment process which resulted in efforts to reform the sections of the *Code of Virginia* that relate to civil commitment.

In 1989, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, as part of its comprehensive study of emergency services, contracted with the National Center for State Courts (NCSC) to conduct an analysis of emergency mental health services and civil commitment in Virginia. This study is the most expansive of the reports on civil commitment in Virginia to date. The report's findings are based on observations of the civil commitment process in five community services board areas: Arlington, Central Virginia, Williamsburg, Northwestern Virginia, and Richmond.

The findings of the NCSC report indicate that there is a need to examine the entire commitment process. The central finding of the report indicates that there is substantial variation across the Commonwealth in the provision of emergency (crisis response) services by the community services boards. Further, there appears to be a lack of coordination and communication among the various groups involved in the civil commitment process. There is no common definition of emergency services or mental health crisis statewide or within localities. The NCSC report suggests that the lack of a uniform point of contact for civil commitment procedure contributed to the growth of a disjointed process.

Further, the NCSC report states that judicial decisions vary from case to case and locality to locality. It suggests that this could possibly be attributed to a lack of training on the part of the special justices, and that the *Code of Virginia* is ambiguous and vague concerning the manner in which commitment procedures should be conducted.

The NCSC report is critical of the lack of accountability of those responsible for administering the commitment proceedings. The report is especially critical of the lack of supervision of special justices and attorneys. DMHMRSAS used these studies to develop legislation which resulted in statutory changes and in some improvements to the process.

The most recent report related to the civil commitment process is the 1992 Virginia State Crime Commission report. This report primarily studies transportation of the mentally ill and offers recommendations for some minor changes to the *Code of Virginia*, which have been incorporated. The report also recommends additional staff

resources, and administrative procedures with regard to civil commitment and transporting individuals with mental illness.

JLARC REVIEW

Item 15 of the 1993 Appropriation Act directs JLARC to "examine the fiscal issues related to the Involuntary Mental Commitment Fund and operational and policy issues involving the involuntary mental commitment process." The mandate states that a report should be submitted to the 1994 General Assembly.

This report is an interim report which focuses primarily on the cost of involuntary civil commitment. The report also presents the views of sheriffs regarding their role in transporting individuals who may be involuntarily committed. The sheriffs' role in civil commitment activities has been a continuing issue which was most recently examined in the 1992 report by the State Crime Commission.

Study Issues

Two issues were developed to address the two major concerns which resulted in the study mandate. These issues were:

- to determine the total amount being expended on involuntary civil commitment, and

- to determine the mechanism which should be used to transport individuals under emergency custody orders, temporary detention orders, and involuntary commitments.

The second issue, the mechanism for transportation, is not fully addressed in this report due to the fact that major changes in the method of transportation could result in changes in other aspects of civil commitment. Further, while conducting observations of hearings, and collecting information from sheriffs, CSB staffs, and other interested and involved parties, other issues were identified. These issues included potential variations between *Code of Virginia* provisions and actual practice, and variations in commitment hearings. Questions to address these issues can be found in Chapter II and could be explored in the second phase of the study.

Research Activities

Several research activities were undertaken to address the cost and transportation issues. These were mail surveys, financial data reviews, and in-person interviews.

Mail Surveys. Two mail surveys were used for this portion of the study. One survey was designed to collect information from CSBs and another to collect information

from sheriffs. Both surveys stated that estimates would be accepted. Given that no aggregated data on the services provided by CSBs and sheriffs are available, these estimates appear to be the best information available to date. However, there are substantial differences between the Supreme Court data and the data reported by CSBs and sheriffs. These differences indicate the need for additional verification.

The survey mailed to the CSBs was developed to collect information on staffing, mental health services provided, roles in emergency custody and temporary detention activities, costs of these activities, and interactions with sheriffs' departments in their catchment areas. The survey requested estimates if actual numbers were not available, and that the executive director of each CSB review and sign their completed response. CSBs which had not responded by the due date on the questionnaire were mailed a reminder post card. Two weeks following this date all remaining non-responding CSBs were sent a reminder letter and a second copy of the survey. All 40 CSBs responded to the survey.

Another survey was developed for collecting data from the sheriffs' departments throughout the State. This survey was designed to collect information on staffing, number of trips transporting individuals under ECOs and TDOs, the cost of providing transportation for individuals under ECOs and TDOs, and the appropriate role for law enforcement in these activities. Estimates were accepted when actual numbers were not available. Sheriffs were asked to review and sign their department's survey response. Departments which had not responded by the due date on the questionnaire were mailed a reminder post card. Two weeks following this date all non-responding sheriffs departments were sent reminder letters and second copies of the survey. Surveys were mailed to 125 sheriffs, and 114 sheriffs responded which resulted in a response rate of 91 percent. Sheriffs not responding were from Buena Vista, Charles City, Clifton Forge, Greensville, James City, Louisa, Madison, Nelson, Norfolk, Scott, and Spotsylvania.

Financial Data Review. Financial data were reviewed to determine the uses of the involuntary civil commitment fund, and DMAS expenses for involuntary civil commitments. To conduct this analysis, Supreme Court involuntary civil commitment fund data and DMAS Medicaid payment data were utilized.

The Supreme Court's involuntary civil commitment fund data were cross tabulated to determine total payments to each physician, attorney, special justice, and hospital for the past two fiscal years. These data were also aggregated to provide total cost figures for the fund.

Further, a sample of 359 of the 7,661 hard copy vouchers that were paid by the fund to hospitals during FY 1993 were collected. From these invoices, patient social security numbers and time of stay data were compiled, and provided to DMAS. DMAS staff ran these data against the Medicaid claims history database to determine the number and amount of Medicaid payments for these hospitalizations.

In-Person Interviews. Structured interviews were conducted with the following:

- Supreme Court of Virginia staff responsible for administering the involuntary civil commitment fund;
- DMHMRSAS staff knowledgeable in the involuntary civil commitment process;
- Virginia Compensation Board staff;
- the director of the Virginia Sheriffs Association;
- the director of the Virginia Association of Community Services Boards;
- Department for the Rights of Virginians with Disabilities staff;
- University of Virginia Institute on Law, Psychiatry, and Policy staff;
- Department of Planning and Budget forecasting staff; and
- Department of Medical Assistance Services staff.

Report Organization

This chapter has provided a brief overview of the involuntary civil commitment process and the JLARC review. Chapter II presents preliminary findings regarding cost and transportation issues involved in the involuntary civil commitment process. Examination of these issues has indicated that a more extensive review of the involuntary civil commitment process is needed to fully address the study mandate. Issues which would be examined in this review are presented at the end of Chapter II.

II. Preliminary Findings on Costs and Transportation

The review for this report focused primarily on estimating the cost to the State for the involuntary civil commitment process. The review also examined the role of sheriffs in transporting individuals under emergency custody, temporary detention, and commitment orders.

With regard to the costs of involuntary civil commitment, there are three preliminary findings which resulted from this review. First, the total cost is estimated to be approximately $20.1 million, which is more than twice the amount appropriated for the process through the involuntary civil commitment fund. The additional costs reported by community services boards (CSBs), sheriffs, the Department of Medical Assistance Services (DMAS), and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) indicate that the State is actually expending substantially more than the $9.6 million appropriated to the involuntary civil commitment fund. Second, aggregate data on these additional costs are not compiled on a regular basis and therefore had to be collected for this study. Third, additional data are needed to assess whether the State is making duplicative payments from the involuntary civil commitment fund and from Medicaid.

Examination of the transportation issue indicated that the majority of sheriffs believe that their offices should have a role in the transportation of at least some of the individuals under emergency custody orders (ECOs), temporary detention orders (TDOs), and involuntary commitment orders. Opinions on the extent of that role were evenly divided among the sheriffs, and appeared related to the question of dangerousness. However, a reduction in the sheriffs' role in transportation could necessitate the assigument of responsibility for determination of dangerousness, prior to the execution of an ECO or a TDO.

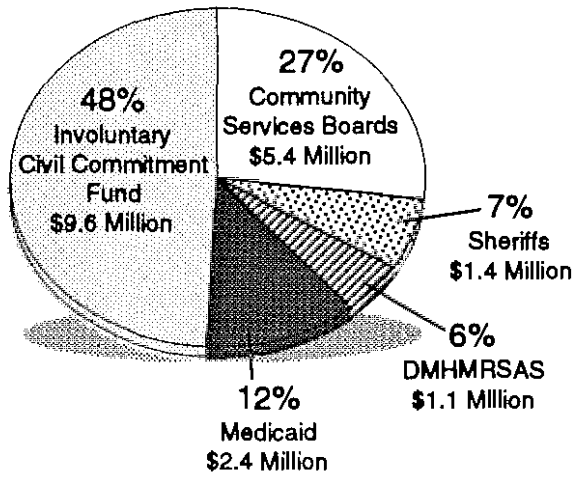
The findings reported in this chapter are preliminary. Further research is necessary to be able to fully address the concerns raised in this chapter, and to determine whether aspects of the involuntary civil commitment process can be modified to reduce costs and improve services.

CIVIL COMMITMENT COSTS

While disbursements from the involuntary civil commitment fund totaled $9.6 million in FY 1993, JLARC staff estimate that more than $20.1 million was actually expended in FY 1993 by the major entities involved in the involuntary civil commitment process (Figure 3). Those reporting costs outside of the involuntary civil commitment fund include sheriffs, community services boards, DMAS, and the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Some municipal police

Figure 3

Involuntary Civil Commitment Costs, FY 1993



Source: JLARC analysis of Supreme Court involuntary civil commitment fund data; JLARC surveys of sheriffs and CSBs; DMHMRSAS TDO data; and DMAS Medicaid claims history database, October 1993.

departments are also involved in transporting mental health patients. However, these costs are not included in this estimate. Estimates for these departments will be collected in the next phase of the study and reported in the final report.

The involuntary civil commitment fund is the only centralized source for involuntary civil commitment cost data. Therefore, JLARC staff developed estimates of the additional costs incurred by sheriffs, CSBs, the Department of Medical Assistance Services, and DMHMRSAS. These estimates were derived using surveys of sheriffs and CSBs, DMAS Medicaid claims information, and DMHMRSAS admission and cost data.

The involuntary civil commitment fund was originally administered by DMHMRSAS. Responsibility for the fund was moved to the Supreme Court in 1980 because it was believed the majority of payments were made to special justices and attorneys. However, given that by far the largest proportion of disbursements in recent years has actually been to hospitals and physicians, responsibility for the fund may need to be reassigned. If this responsibility is not reassigned, the Supreme Court may need to incorporate additional controls to review payment requests.

Involuntary Civil Commitment Fund

The involuntary civil commitment fund was established by the General Assembly in the 1970s to cover the costs associated with the procedures through which adults and juveniles are mandated to receive involuntary mental health treatment. Originally, this fund was managed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services. In 1980, the General Assembly transferred financial management of the fund from DMHMRSAS to the Supreme Court, as it was thought that most

of the payments were made to special justices and attorneys. However, data from FY 1992 and FY 1993 illustrate that this is no longer the case. In both FY 1992 and FY 1993, most of the payments were made to hospitals and physicians.

Hospitals requesting payments from the fund are instructed to exhaust all alternative reimbursements prior to using the fund. Therefore, the fund is supposed to be the last source of payment for the hospitals. However, Supreme Court staff reported that no procedures are routinely followed to ensure that all other sources are exhausted prior to making payments to these entities from the fund. Therefore, the State may be reimbursing hospitals for services that could have been covered by private insurance, or Medicaid.

Involuntary civil commitment fund expenditures have increased from $3.6 million to $9.6 million over the past ten years (Table 1). Disbursements from the involuntary civil commitment fund are made to attorneys, physicians, special justices, and hospitals. These payments are made to cover commitment hearing fees, and costs incurred during the TDO period. The largest single component of the involuntary civil commitment fund is the payment to hospitals, which represents approximately 63 percent of fund disbursements (Figure 4). Total payments from the involuntary commitment fund increased nine percent from FY 1992 to FY 1993. Most of this increase resulted from a 13 percent increase in hospital payments over the two fiscal years. Although there are many hospitals, physicians, attorneys, and special justices providing civil commitment services, a few are receiving the majority of the payments from the fund.

Table 1

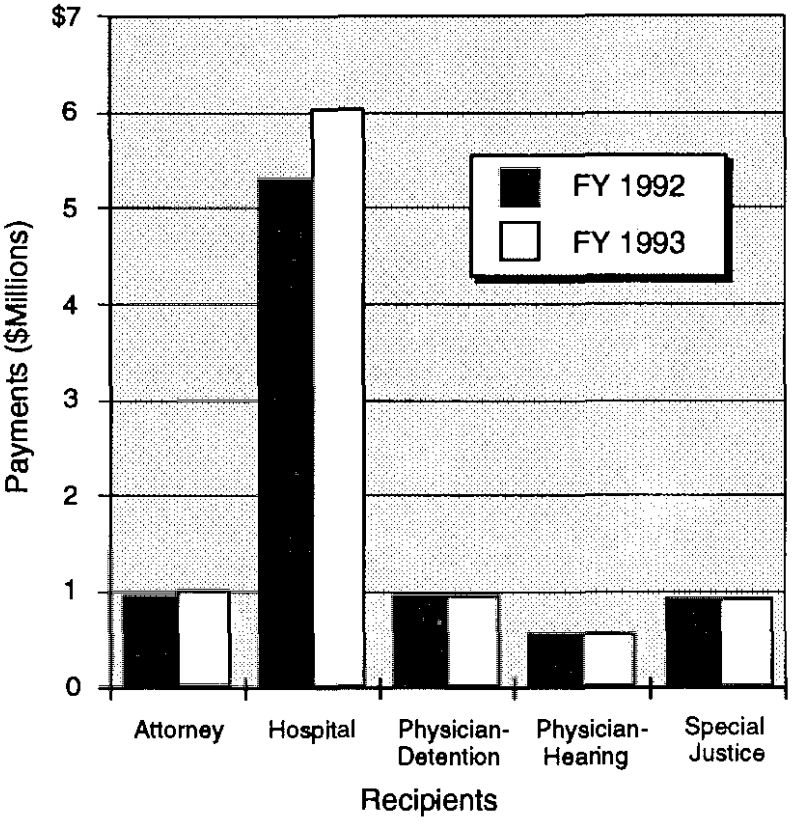
Involuntary Civil Commitment Fund Expenditures FY 1984 to FY 1993

Fiscal Year	Expenditure (in millions of dollars)
1984	$3.6
1985	3.9
1986	4.3
1987	4.9
1988	6.3
1989	7.1
1990	6.3
1991	8.0
1992	8.5
1993	9.6

Source: JLARC analysis of Supreme Court data on involuntary civil commitment fund expenditures, summer 1993.

Figure 4

Involuntary Civil Commitment Fund Payments FY 1992 and 1993



Source: JLARC analysis of Supreme Court data on involuntary civil commitment fund expenditures, summer 1993.

Detention Fees. Detention fees, covering expenses incurred from maintaining patients under a TDO in a hospital, are disbursed to hospitals and physicians. Funds are disbursed to hospitals and physicians based on rates set by the Department of Medical Assistance Services. While the total dollar amount expended is not especially large, small numbers of hospitals and physicians are receiving significant portions of the total.

Payments totaling more than six million dollars were disbursed to 58 hospitals in FY 1993. However, 57 percent ($3.4 million) of the total disbursements were paid to seven hospitals (Poplar Springs, Norfolk Psychiatric Center, Tidewater Psychiatric Institute, Virginia Beach Psychiatric Center, Newport News General Hospital, Charter Westbrook Hospital, and Metropolitan Hospital).

A significant portion of the disbursements to physicians was paid to a few physicians. The involuntary civil commitment fund disbursed a total of $958,509 to 298 physicians and physician groups in FY 1993. However, two percent of the physicians

received 34 percent of the total disbursements. These five physicians received a total of $321,186. The largest amount received was $126,133, paid to one physician group in Petersburg, Virginia.

Hearing Fees. Hearing fees, covering expenses incurred for participation in commitment hearings, are paid on a per-hearing basis, with the exception of special justices who may be paid on either a per-hearing or salary basis. The schedule for per-hearing reimbursement for services is:

Preliminary Hearing	
Special Justice	$28.75
Client's Attorney	$25.00

Commitment Hearing	
Special Justice	$28.75
Client's Attorney	$25.00
Physician or Mental Health Professional	$25.00

In addition, these individuals are reimbursed for expenses incurred as part of the commitment hearing.

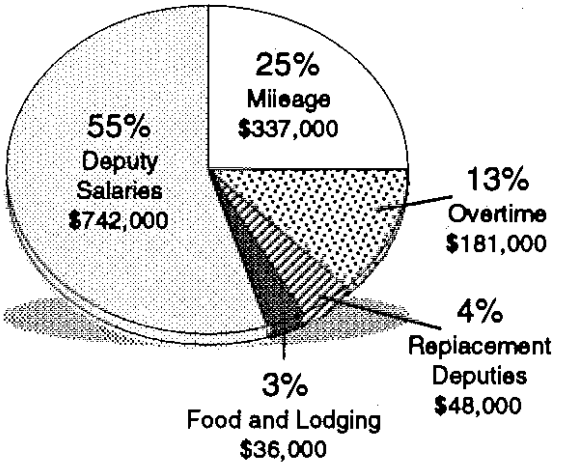
Similar to hospitals and physicians treating detained TDO patients, a few individuals involved in commitment hearings are receiving a large percentage of the payments. For example, three physicians involved in civil commitment hearings received 35 percent of the total disbursements, or $204,212. One percent of attorneys received 26 percent of the total disbursements, or $271,284. Three percent of special justices received 33 percent of the total disbursements, or $314,743. Preliminary review indicates that many of these physicians, attorneys, and special justices are not working full-time on civil commitment.

Sheriffs

The 114 responding sheriff's departments reported they spent an estimated $1.4 million transporting mental health patients in FY 1993 (Figure 5). More than $742,000 (55 percent) involved salaries paid to deputies conducting transports. This is a fixed cost, as it would be a cost for the sheriffs even if the deputies were not conducting transports. However, the figure demonstrates that deputies are spending a fairly significant amount of time conducting mental health transports. The remainder of the responding sheriffs' costs in this area include $337,000 (25 percent) spent on mileage reimbursements for transporting mental health patients, $181,000 (13 percent) in overtime expenses accrued by deputies conducting transports, $48,000 (4 percent) in costs for replacement deputies to cover for those performing transports, and $36,000 (3 percent) for food and lodging for deputies and patients on extended trips.

Figure 5

Sheriffs' Estimated Involuntary Civil Commitment Costs FY 1993



Source: JLARC analysis of survey of sheriffs, fall 1993.

Community Services Boards

The 40 community services boards estimated that they expended more than $5.6 million in FY 1993 on the civil commitment process (Figure 6). CSBs reported that the majority of this expenditure was for personnel costs including overtime associated with providing services to individuals being placed under an ECO, TDO or civil commitment. These costs accounted for 85 percent of the total spent by the CSBs. Other costs included:

- contracts with private clinicians to provide evaluations;
- operating costs for maintaining a crisis center;
- grants to indigent patients for hospitalization in private local hospitals; and
- incidental costs, such as training, mileage, and vehicle maintenance.

CSBs are active in the involuntary civil commitment process from initial patient contact through release of the patient from treatment. The mix of activities and associated costs are unique to each CSB.

DMHMRSAS

JLARC staff estimate that DMHMRSAS spent $1.1 million for patients admitted under temporary detention orders in FY 1993. DMHMRSAS staff report that 2,356 patients were admitted to State psychiatric hospitals under TDOs during FY 1993. Costs for housing and treating these patients are in addition to the involuntary civil commit-

ment fund. DMHMRSAS staff do not specifically calculate expenditures for TDO patients. Therefore, JLARC staff estimated these costs. The estimate was derived by multiplying the number of TDO patients admitted by State psychiatric hospitals in FY 1993 (2,356), by the average daily cost at State psychiatric hospitals for FY 1993 as reported by DMHMRSAS ($237.46), by the typical length of stay for temporary detentions (2 days).

Medicaid

Medicaid covers psychiatric services, including hospital expenses, provided during the period of temporary detention for individuals who meet Medicaid eligibility criteria. JLARC staff estimate that the cost for Medicaid reimbursement for these services totaled more than $2.4 million in FY 1993.

To obtain a rough estimate of these Medicaid costs, JLARC staff collected, from the Virginia Supreme Court's files, a sample of 359 from a total of 7,661 involuntary admission detention invoices sent from hospitals to the Supreme Court in FY 1993. The invoices record hospital expenses and other information related to the detainment of an individual for the psychiatric evaluations required by TDOs (such as the date of admission, the date of release, hospital expenses, and third-party payments including Medicaid). The invoices are submitted by the hospitals, where the patients are detained, to the Supreme Court for reimbursement consideration.

JLARC staff requested that Department of Medical Assistance Services staff match these 359 invoices against the DMAS Medicaid claims history data base. The match indicated that patients listed on 28 of the invoices received Medicaid-covered services during their detainment for TDOs. The cost of the Medicaid reimbursement for the 28 claims totaled $113,439. If these sample figures were projected to the entire population of 7,661 invoices, then 598 invoices would have included Medicaid reimbursements totaling $2,420,752 in FY 1993. Since federal law requires the Commonwealth to pay 50 percent of Medicaid claims, the cost to the Commonwealth would have been $1,210,376.

For these same 359 cases in the sample, hospitals reported to the Supreme Court only seven Medicaid payments totaling $35,546. This would project to 149 Medicaid claims totaling $758,546 for the entire population. Therefore, according to invoices received from hospitals by the Supreme Court, the State cost for Medicaid for these cases would have been $374,273, a difference of more than $836,000.

It appears that hospitals are not always subtracting Medicaid reimbursements they have received from the amounts they bill the Supreme Court. Consequently, it appears the State may be making duplicate payments from the involuntary civil commitment fund and from Medicaid claims. DMAS, due to federal restrictions, could not provide data which would allow JLARC staff to match individual cases to determine the amount of duplicate payments. Further review of DMAS Medicaid data is necessary to determine the amount of duplicate payments from State and federal Medicaid funds to private hospitals, and to determine if cost savings could be achieved.

Recommendation. **The General Assembly may wish to amend the study language in the Appropriation Act to require the Department of Medical Assistance Services to provide JLARC with the individual data necessary to determine if State and federal Medicaid funds are double-paying for services provided individuals during the temporary detention period.**

TRANSPORTATION ISSUES

The *Code of Virginia* directs that law enforcement officers are responsible for transporting individuals who are under emergency custody orders, temporary detention orders, or who have been certified for admission to a hospital through involuntary commitment. Seventy-five percent of the responding sheriffs indicated that transportation of the mentally ill is a duty they should be performing. However, 78 percent of the respondents reported staffing shortages and additional costs due to this responsibility. Further, some CSB staff have expressed concerns regarding sheriffs' involvement in transporting these individuals. These concerns focus on the criminalization of the mentally ill and include adequate determinations of dangerousness, use of restraints, and the training received by law enforcement officers in dealing with mentally ill individuals.

There appear to be several options for alternative transportation mechanisms which could be examined. These options include privatizing the transportation function, utilization of family members, and use of CSB vehicles and personnel. The transportation issue cannot be fully addressed at this time as changes in the transportation responsibilities for sheriffs could result in changes in the responsibilities for other entities. Therefore, further research will be directed at determining the need for, and the feasibility of, transferring some portion of the responsibility for transportation to other parties.

Sheriffs Reported Transporting Nearly 16,000 Mental Health Patients in FY 1993

One hundred fourteen sheriffs, responding to a JLARC survey on involuntary civil commitment, (91 percent of the 125 sheriffs statewide) reported that they transported approximately 16,000 mental health patients in FY 1993, or an average of approximately 140 transports per department. The estimate of the number of transports is substantially higher than the data on processed TDOs supplied by the Supreme Court, and this difference will need to be assessed further. The City of Richmond reported the most transports, with more than 2,500 (Table 2). The City of Falls Church reported the fewest transports, with five. The Falls Church sheriff reported that the municipal police department performed most of the transports for the city. The fewest transports reported by a sheriff who has primary responsibility for transports was Highland County with six.

Table 2

Top Ten Sheriff's Departments in Transports and Miles Driven* FY 1993

Sheriff's Department	Number of Transports	Sheriff's Department	Number of Miles Driven
Richmond City	2527	Arlington	75,000
Newport News	1179	Roanoke City	62,807
Roanoke City	1090	Fairfax County	55,300
Henrico	687	Newport News	50,130
Hampton	590	Danville	47,536
Fairfax County	587	Richmond City	45,950
Chesapeake	357	Pittsylvania	42,022
Henry	325	Henry	40,505
Arlington	322	Washington	35,700
Prince William	287	Hampton	33,178

* This listing is based on the 114 sheriffs that responded to the JLARC survey. Eleven sheriffs did not respond to the survey, including the sheriff of Norfolk. Three of the sheriffs responding to the survey did not respond to the question on the number of transports. Six of the sheriffs responding to the survey did not respond to the question on the number of miles driven. The survey data are estimates that will receive additional verification to resolve differences between these data and Supreme Court data.

Source: JLARC analysis of survey of sheriffs, fall 1993.

Transports were conducted for several purposes:

- Forty-eight percent involved transporting a temporary detention order patient to a hospital;
- Eighteen percent involved transporting an emergency custody order patient to a hospital;
- Twelve percent involved transporting a temporary detention order patient to a private hospital for a medical clearance, then to a public hospital for admittance;
- Eleven percent involved transporting a committed patient from one hospital to another hospital;
- Seven percent involved transporting a forensic patient from a jail to a hospital for screening;
- Three percent involved transporting a forensic patient released from civil commitment to another correctional facility; and

- One percent involved transporting a forensic patient to a hospital under a civil commitment order.

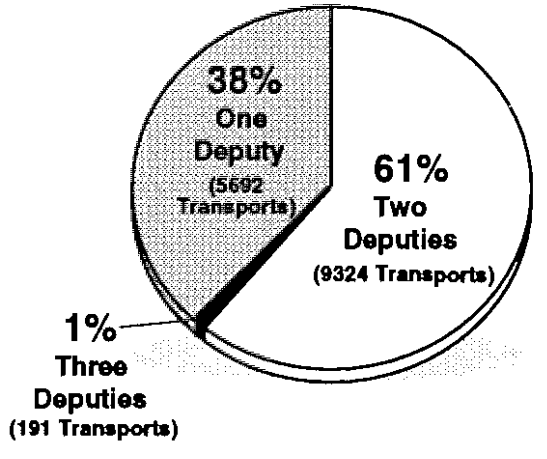
Sheriffs responding to the JLARC survey estimated that personnel in their offices drove more than 1.3 million miles to transport these mental health patients in FY 1993. The Arlington County sheriff reported the most miles driven, with a total of 75,000. The City of Falls Church sheriff reported driving the fewest miles, reporting a total of 190. Again, this is due to the City of Falls Church police department performing most transports. The fewest miles driven, reported by a sheriff whose office has primary responsibility in the county for mental health transports, was Amelia County with 600.

During a typical mental health transport, a mental health worker does not accompany a deputy. Sheriff's departments reported that they generally utilize more than one deputy to conduct the mental health transports. Responding sheriffs reported that 38 percent of all transports involved one deputy, 61 percent involved two deputies, and one percent involved three deputies (Figure 6). Utilizing deputies to transport mental health patients may strain resources for the sheriff's departments. Either a deputy is taken away from providing law enforcement or jail security, or another deputy is brought in at the departments' expense to provide these duties.

Further, many sheriffs reported that the timing of mental health transports caused scheduling and operating problems within their departments. Although 98 percent of responding sheriffs reported that mental health transports typically occur Monday through Friday and therefore do not typically involve weekend overtime, 92

Figure 6

Number of Deputies Used to Conduct Mental Health Transports



Note: While 114 sheriffs responded to the JLARC survey, five sheriffs did not respond to this question.

Source: JLARC analysis of survey of sheriffs, fall 1993.

percent of responding sheriffs reported that the majority of transports occur between noon and midnight. This creates a scheduling problem because many sheriffs would prefer that transports be performed in the mornings when the availability of deputies is greatest. Sheriffs report that this would reduce the need to pay overtime.

Ninety-one percent of the responding sheriffs reported that their deputies restrain mental health patients while they are being transported. Restraints used by sheriffs may include shackles or straight jackets.

Training for dealing with mentally ill individuals is provided at the police academies for all new deputies. The training involves a description of the *Code of Virginia* requirements for involuntary civil commitments, review of the characteristics of mentally ill persons, and basic instructions for dealing with the mentally ill. Fifty-three percent of the CSBs reported that they offer additional training for dealing with mental health patients to sheriffs. However, CSBs reported that only 33 sheriffs' departments participated.

Sheriffs Are Divided in Their Opinions on the Extent of Need for Their Involvement in Transporting TDOs

The majority of sheriffs believe they should be involved in the transportation of individuals under ECOs and TDOs. However, sheriffs do not agree on what they believe their role should be (Table 3). Approximately 51 percent of the responding sheriffs indicate they should remain the primary transportation provider, 24 percent would like a reduced role, and the remaining 25 percent would prefer that sheriffs be removed from all transportation responsibilities. The varying responsibilities and sizes of the sheriff's departments appears to have some effect on sheriff opinions on this issue, but the differences are not dramatic.

As previously indicated, sheriff's departments have different responsibilities which include law enforcement, jail administration, court security, and process service. An analysis of sheriff's departments' opinions indicates some variation based on the responsibility and size of the department. For example, the responding sheriff's departments most supportive of a transport with no exceptions approach were those that have neither law enforcement nor jail administration responsibilities (58 percent support), and those that have law enforcement responsibilities only (58 percent support). The sheriff's departments that were least supportive of a transport with no exceptions approach were departments with jail administration responsibilities (41 percent support among departments with "jail administration only" and 52 percent support among departments with "law enforcement and jail administration"), and large departments (45 percent support). Sheriff's departments with "jail administration only" responsibilities were relatively more supportive of a no transport approach (35 percent, compared to 21 percent of all other departments).

Table 3

Sheriff's Departments' Opinions on the Transportation of Mental Health Patients

Question:
Should Sheriffs Be Responsible for Transporting Mental Health Patients?

	Yes, with no exceptions (percent)	Only if patient is dangerous to self or others (percent)	No, with no exceptions (percent)
All Sheriff's Departments (N=109)*	51%	24%	25%
Sheriff's Departments by Responsibilities			
Law Enforcement only (N=24)	58	21	21
Jail Administration only (N=17)	41	24	35
Law Enforcement and Jail Administration (N=56)	52	25	23
Neither Law Enforcement nor Jail Administration (N=12)	58	33	8
Sheriff's Departments by Size**			
Large (N=35)	45	26	29
Small (N=74)	54	23	23

* A total of 114 sheriffs responded to the survey. However, five did not respond to this question.

** Large sheriff's departments were defined as those departments with more than the average of 44 full-time deputies.

Source: JLARC analysis of survey of sheriffs, fall 1993.

CONCLUSIONS

While expenditures from the involuntary civil commitment fund totaled $9.6 million in FY 1993, the total costs involved in the involuntary civil commitment process are estimated to be approximately $20.1 million. This figure includes what appears to be duplicate payments from the involuntary civil commitment fund and from Medicaid. Further, the Supreme Court has not instituted sufficient controls on payments from the involuntary civil commitment fund. The General Assembly moved the administration of the fund to the Supreme Court when it was thought that the majority of the payments would be for legal services. However, in recent years the majority of the payments have been to hospitals. Therefore, the feasibility of relocating administration of the fund to a State agency more familiar with medical disbursements needs to be further examined.

As previously mentioned, approximately 50 percent of the sheriffs believe their role in transporting mental health patients should be reduced, and about 50 percent do not. Transferring the transportation responsibility from law enforcement could require revisions to the current procedures. For example, since special justices and magistrates currently order law enforcement officers to perform the transports, the dangerousness of the patient is not an issue. If this is changed, it appears that prior to the ECO or TDO transport, an entity could need to be assigned responsibility for determining whether the individual is dangerous to self or others, or lacks the capability for self-care. Therefore, further study is also needed to determine the potential advantages and disadvantages, and the feasibility, of reducing the law enforcement role in this process.

The involuntary civil commitment process has been examined several times in recent years. While modifications have been made in response to these examinations, it appears that there are still problems as evidenced by CSB staffs' and sheriffs' concerns, as well as variations noted by JLARC staff between *Code* requirements and actual practices.

In response to the identification of these concerns, JLARC staff have identified six issues for potential examination and analysis during the next phase of the JLARC review of involuntary civil commitment. These issues have been identified through analysis of surveys of sheriffs and CSB directors; interviews with staffs at the Supreme Court, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Department of Rights for Virginians with Disabilities, the Department of Medical Assistance Services; and interviews with CSB directors, mental health directors, and sheriffs.

The second phase of the study will potentially address these six issues:

- Is the involuntary civil commitment fund being managed efficiently and effectively?

- What role should community services boards play in emergency custody, temporary detention, and involuntary civil commitment processes?

- What role should the legal system (including the courts, special justices, sheriffs, and police) play in emergency custody, temporary detention, and involuntary civil commitment?

- Is the temporary detention process using public and private hospitals in the most efficient and effective manner?

- Is the temporary detention process being used for purposes for which it was not originally intended?

- What options does the State have to improve the emergency custody, temporary detention, and involuntary commitment processes and procedures?

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Appendix A

Item 15, 1993 Appropriation Act

The Joint Legislative Audit and Review Commission shall examine fiscal issues related to the Involuntary Mental Commitment Fund and operational and policy issues involving the involuntary mental commitment process. A report, including such recommendations as may seem appropriate to promote improved efficiencies, shall be presented to the 1994 General Assembly. All agencies, institutions, and departments of the Commonwealth which may be called upon for assistance shall fully cooperate in this review. The Auditor of Public Accounts shall provide such assistance in this review as may be requested.

Appendix B

Statutory Provisions Concerning Involuntary Civil Commitment

Section	Summary of *Code of Virginia* Provisions
37.1-65	Any state hospital shall admit as a patient any person requesting admission who is deemed to be in need of hospitalization by the local community service board (CSB) or the community mental health clinic for mental illness, mental retardation, or substance abuse.
37.1-67.1	Any judge (special justice) or magistrate may, upon the sworn petition of any responsible person or upon the judge's own motion based upon probable cause to believe that a person is mentally ill and in need of hospitalization, issue an emergency custody order (ECO) requiring any person within that person's judicial district to be taken into custody and transported to a convenient location to be evaluated by a person designated by the CSB. The ECO shall be executed within 4 hours of issuance. If hospitalization is determined to be necessary, the judge or magistrate may issue a temporary order of detention (TDO) which may include transportation of the person to such other medical facility as may be necessary to obtain emergency medical evaluation or treatment prior to placement. The TDO shall be executed within 24 hours of issuance.
37.1-67.2	When a person is produced pursuant to 37.1-67.1, the judge shall inform such person of the right to apply for voluntary admission. The judge shall hold a preliminary hearing to ascertain whether the person is willing and capable of seeking voluntary admission. If so, the judge requires such person to accept voluntary admission for treatment.
37.1-67.3	If a person is incapable of accepting or unwilling to accept voluntary admission, the judge shall inform such a person of the right to a commitment hearing, the right to counsel and the right to meet with counsel prior to the hearing. The commitment hearing shall be held within forty-eight hours of the execution of the detention order. Prior to any adjudication, the judge shall require a mental examination of such person and the CSB shall provide a prescreening report. If the judge finds specifically that the person (i) presents a danger to himself or others, (ii) is unable to care for himself, and (iii) less restrictive alternatives have been investigated, the judge shall order an appropriate course of treatment. Commitment hearing decisions can be appealed to a higher court.
37.1-67.4	Hearings may be conducted by a judge at a convenient institution. During temporary detention, hospitals may provide emergency medical and psychiatric services. Hospitals shall first seek reimbursement from any applicable third-party. The Commonwealth shall reimburse the remaining balance (from the involuntary civil commitment fund) pursuant to criteria set by the State Board of Medical Assistance Services. Hearings may be held in the institution by either a judge from the home county of the individual for whom admission is sought or by the judge in whose district the institution is located.
37.1-67.5	An interpretor must be provided for a deaf person alleged to be mentally retarded or mentally ill.
37.1-67.6	Any person involuntarily committed or certified as eligible for admission shall have the right to appeal within 30 days of the order.
37.1-70	Any person presented for admission to a hospital shall be examined within 24 hours. If the examination reveals that such person is mentally ill, the person shall be retained at the hospital.
37.1-71	Sheriffs shall transport all voluntary and involuntary mental commitment patients. Within 6 hours of being called to transport a patient, the sheriff shall go and retrieve the patient. They shall be required to transport up to 100 miles from their locality. Costs of transportation shall come from the budget of the jail. If any hospital is too crowded to accept patients, the Commissioner of DMHMRSAS shall designate a hospital to receive the patients.
37.1-72	Any judge who shall certify an admission may order that such person be placed in the custody of any responsible person or persons for the sole purpose of transporting such person to the proper hospital.
37.1-73	It is unlawful for a sheriff to confine a certified individual in a jail without prior consent of a judge. Judicial approval for confinement should not be for longer than 24 hours.
37.1-74	Confinement should not be with convicts.

Appendix B (continued)

Section	Summary of *Code of Virginia* Provisions
37.1-75	If a certified person shall escape, become sick, die, or be discharged, the Commissioner of DMHMRSAS should be immediately notified. If such person escapes, a warrant for arrest shall immediately be secured.
37.1-76	If a certified person shall escape from a hospital, the chief executive officer of the hospital may issue a warrant for arrest.
37.1-78	Hospitals may transport voluntary patients themselves or they may request a sheriff to transport.
37.1-78.1	Prior to admission, the Commissioner of DMHMRSAS may transfer a patient retained in or by a state hospital to any other hospital.
37.1-84.1	Patients have certain rights in a DMHMRSAS accredited facility.
37.1-88	Special justices may be appointed (37.1-89 discusses fees for special justices, psychologists, witnesses, and lawyers).
37.1-90	Hearings shall be held in the appropriate location.
37.1-93	Veterans found to be mentally ill and eligible for treatment in a VA hospital may be transferred to such a VA hospital.
37.1-98	The person in charge of a private hospital may discharge any patient involuntarily committed who is recovered, or, if not recovered, whose discharge will not be detrimental to the public.
37.1-121	The director of a state hospital may place patients who are not dangerous in homes with private families.
37.1-126	The chief executive officer of any hospital may grant convalescent leave to committed patients.
15.1-131	Policemen may be sent beyond territorial limits to execute a TDO.
15.1-138	Policemen may execute and serve TDOs and ECOs.
16.1-339	A minor fourteen years of age or older who objects to admission may be admitted to a willing facility for up to 72 hours , upon the application of a parent.
16.1-340	A minor may be taken into custody for inpatient treatment pursuant to the procedures for an adult. A hearing shall be held no sooner than 24 hours and no later than 72 hours from the issuance of a TDO.
16.1-341	If a parent is not available ,a petition for commitment of a minor may be filed by any responsible adult. Upon filing of a petition, a hearing may be scheduled and the minor will be informed of the need for counsel, which may be appointed by the court.
16.1-344	Judges may close juvenile hearings to the public.
16.1-345	The court shall order the involuntary commitment of a minor if there is clear evidence that the minor presents a danger to himself or others, if treatment for mental illness is expected to benefit the minor, and such treatment is the less restrictive available. If a minor is committed, a sheriff shall transport the minor.

Source: JLARC staff summary of *Code of Virginia* provisions.

Appendix C

Agency Responses

As part of an extensive data validation process, the Supreme Court of Virginia and the Department of Mental Health, Mental Retardation, and Substance Abuse Services were provided an opportunity to comment on an exposure draft of the report. This appendix contains their responses.

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ASST. EXECUTIVE SECRETARY
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January 5, 1994

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219

Dear Mr. Leone:

I have reviewed the exposure draft of your report, Interim Report: Review of the Involuntary Civil Commitment Process. I commend you and your staff for the exemplary work on this report.

As discussed with your staff during their initial interview, we recognize a number of areas within the involuntary mental commitment process that should be examined and modified where practical.

I am in general agreement of your findings concerning the role of this office. In this regard, I would specifically endorse your findings that an appropriate State agency with an established policy for medical disbursements could more expertly monitor expenditures from State funds by coordinating responsibility of insurance companies and other third-party payers, thereby reducing Commonwealth costs. Further, I support the proposed second phase of this study and will assist your efforts in anyway possible.

I do not believe it necessary for me to respond to the study findings during the Commission meeting on January 7, 1994.

With kind personal regards, I remain,

Very truly yours,

Robert N. Baldwin
Executive Secretary

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

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January 11, 1994

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review
Commission
General Assembly Building, Suite 1100
Richmond, Virginia 23219

Dear Mr. Leone:

I am writing in response to your request for comments on the Interim Report: Review of the Involuntary Civil Commitment Process. We appreciate very much that your office has afforded us an opportunity to review the exposure draft in great detail with your staff, and our comments are limited to the following:

1. The Interim Report does not adequately acknowledge the many significant positive changes to the involuntary civil commitment statutes and state and local operations which have resulted from the studies cited in the report and other recent initiatives. Some examples of these include the following:

   - HB 772 (Chapter 429, 1990) This bill established the emergency custody procedure in Section 37.1-67.1, enabling face-to-face examination of any prospective patient prior to issuance of a TDO. The bill also established provisions for initiating emergency custody without judicial intervention and securing emergency medical care after issuance of a TDO.

   - HB 1016 (Chapter 975, 1990) This bill established a separate inpatient admission and involuntary commitment process for minors in Title 16.1 of the Code.

   - HB 332 (Chapter 566, 1992) This bill established the requirement for face-to-face evaluation of all patients prior to issuance of TDOs by magistrates except under certain conditions.

- Standard Operating Procedures Manual (Virginia State Crime Commission, 1992) This manual established operational guidelines for Virginia sheriffs relating to emergency custody, temporary detention and related procedures.

DMHMRSAS would be pleased to provide additional information to the study team about these and other initiatives.

2. The Interim Report identifies six issues for potential study during the second phase of the review. DMHMRSAS considers the first and last of these issues to be sufficiently clear, but notes that the second, third, fourth and fifth items are somewhat vague and recommends that the underlying issues here be more clearly articulated. DMHMRSAS also recommends that JLARC continue to explore reasonable and appropriate "mechanism[s] which should be used to transport individuals under emergency custody and temporary detention orders," which was one of the phase one study issues listed in the report section entitled "JLARC Review." DMHMRSAS further recommends that JLARC review the approaches used by other states to provide transportation to persons with mental illness under these circumstances.

3. DMHMRSAS has been involved in many state and local initiatives to improve emergency services delivery, including the involuntary civil commitment process. The goals of these initiatives have been to clarify clinical, judicial and law enforcement roles; increase the reliability and timeliness of information needed by decision-makers; balance clinical and due process considerations with community and family interests; maximize efficiency and effective communication; and reduce stigma and the dehumanizing aspects of involuntary commitment. Our approach has been to identify areas of mutual concern and to develop consensus regarding the solutions to these problems. We recommend that the approach outlined above be employed by JLARC in phase two of this study, and that JLARC involve this agency fully in that process.

Again, we appreciate the work of the study team on this project as well as your office's willingness to involve me and my staff so closely in the review of this report. We will continue to be available to the study team as this work progresses.

Sincerely,

King E. Davis, Ph.D.

KED/bb

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