JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION
OF THE VIRGINIA GENERAL ASSEMBLY

Review of the Involuntary Commitment Process

House Document No. 8 (1995 Session)

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Preface

Involuntary commitment is the process whereby an individual with a mental illness, who is a danger to self or others, or who is unable to care for self, may be temporarily detained and involuntarily committed to a hospital following a hearing. State statutes govern the process.

In Virginia, there are two major stages in the process: the period of temporary detention and the involuntary commitment hearing. The individual is evaluated during the period of temporary detention and the results of the evaluation are the basis for the outcome of the involuntary commitment hearing. Virginia, unlike many other states, has established the involuntary mental commitment fund to pay for the medical and legal costs associated with the temporary detention period and the commitment hearing.

JLARC was directed by Item 15 of the 1993 Appropriation Act to examine the fiscal issues related to the Involuntary Mental Commitment Fund and the operational and policy issues involving the involuntary mental commitment process. A preliminary report was issued in February 1994. This final report was prepared in accordance with Item 15 of the 1994 Appropriation Act, which continued the study.

This review found that overall the process does protect an individual's rights of due process. However, there are five areas where improvements could be made:

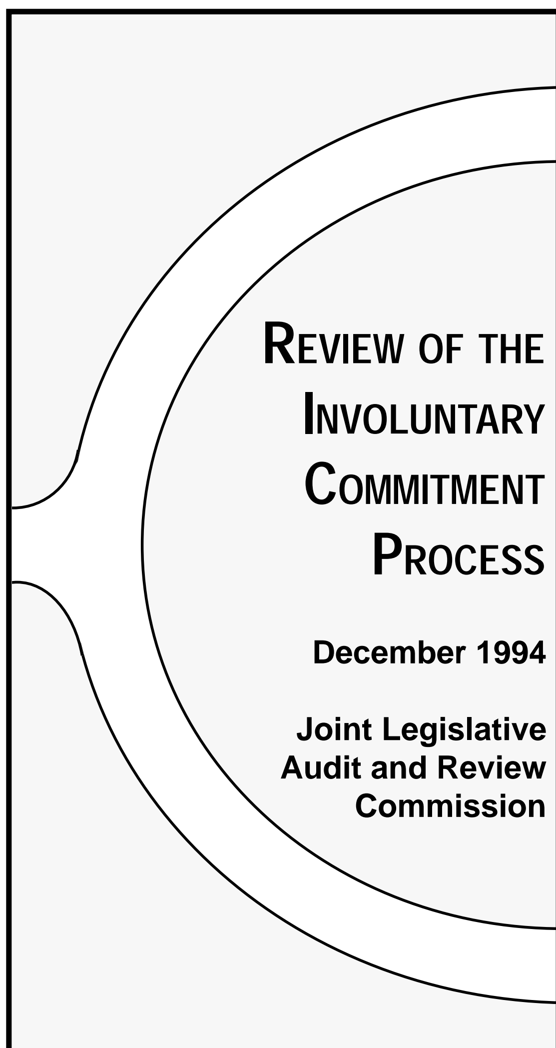
- More effective oversight of the fund could produce cost savings.
- While the statutes provide important due process safeguards, improvements could be made in the implementation of the statutes.
- Law enforcement officers should continue to have a role in transportation but this role could be reduced.
- Changes need to be made in prescreening for detention, detention criteria, and hearing oversight.
- Analysis of the involuntary commitment process raises concerns about the availability of treatment alternatives to inpatient hospitalization.

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 Department of Medical Assistance Services, the Supreme Court of Virginia, the community services boards, magistrates, and sheriffs and their deputies.

Philip A. Leone
Director

December 14, 1994

JLARC Report Summary



Involuntary commitment is a process by which an individual with a mental illness, who is a danger to self or others, or who is unable to care for self, may be temporarily detained and committed to a hospital on an involuntary basis following a hearing. In the United States, there is no federal law or process which specifically addresses involuntary civil commitment. Involuntary commitments are governed by State laws.

The *Code of Virginia*, in §37.1-67.1 through §37.1-90, directs the adult involuntary commitment process in the Commonwealth. There are two major stages in the process: (1) the petition and pre-hearing detention period, and (2) the involuntary commitment hearing. The statutes allow for a short period of involuntary temporary detention during which time the individual is evaluated. The results of the evaluation are the basis for the outcome of the involuntary civil commitment hearing. Unlike many other states, Virginia has established an involuntary mental commitment (IMC) fund to pay for the medical and legal costs associated with the temporary detention period and the involuntary commitment hearings.

Item 15 of the 1994 Appropriation Act continued a study mandate which directed JLARC to "examine the fiscal issues related to the Involuntary Mental Commitment Fund and the operational and policy issues involving the involuntary mental commitment process." The mandate further directs JLARC to make recommendations which are designed to promote efficiencies in the process.

Overall, the Virginia involuntary civil commitment process serves to protect an individual's due process rights. However, there are some areas in which the process could be improved. For example, variations in the process may result in individuals being involuntarily detained who do not present behaviors indicative of mental illness. The recommendations presented in this report build on the strengths of the Virginia process while addressing some current deficiencies in the process. The major findings of this report are:

- Through more efficient and effective use and oversight of the involuntary commitment fund, an estimated annual fund savings of almost $1 million

(with net State savings of more than $500,000) are potentially achievable.

- Although *Code of Virginia* statutes governing the process provide important safeguards, it appears that process improvements could be made to promote equitable treatment of candidates for commitment, and to promote greater efficiency through improved procedures for determining who needs to be detained and held for a commitment hearing.

- Due to the public safety issues involved, law enforcement officers should continue to have a role in the transportation of individuals during the process, but there may be opportunities to reduce the number of transports required.

- Compared to processes in some other states, Virginia's involuntary commitment process has some strengths, including a shorter period of detention prior to the commitment hearing; however, the comparison indicates some areas of weakness, such as pre-screening for detention, detention criteria, and hearing oversight.

- Judicial decisions within the involuntary commitment process are made within the context of available mental health services and decision-makers within the process raise concerns about the availability of treatment alternatives.

Improved Fund Oversight Could Achieve Cost Savings

JLARC staff found that the Supreme Court needs to improve its oversight of the involuntary mental commitment fund. Additional oversight is necessary to ensure that funds are being utilized efficiently and effectively. In fact, JLARC staff estimate that the involuntary mental commitment fund could save nearly $1 million in hospital payments annually (see table, opposite page) if more controls are placed on the fund and if policies regarding treatment of Medicaid recipients were developed. Of this amount, the estimated net State savings are more than $500,000. These savings are based on reducing the practice of placing Medicaid recipients who are involuntary commitment candidates in hospitals that are not Medicaid eligible and on eliminating the erroneous billing for services, such as double-billing. Recommendations related to achieving these fund savings and enhancing fund oversight include: requiring the local community services boards (CSBs) to determine patient insurance status and to ensure its consideration in determining hospital placements; providing instructions to all special justices regarding the appropriate completion of hearing invoices, with provisions for periodic invoice reviews for verification purposes; and having the Supreme Court maintain overall responsibility for the fund but contract with the Department of Medical Assistance Services (DMAS) to review and make payments for the medical and hospital portions of the fund.

Some Process Improvements Are Needed to Promote Equity and Efficiency

JLARC staff reviewed issues pertaining to the detention, evaluation, and hearing procedures for involuntary commitment in Virginia. This review indicates a number of concerns that need to be addressed to promote greater equity in the quality of the hearings available to potential commitment candidates, as well as to obtain efficiencies through better ensuring that those initially detained and those held for a commitment hearing are indeed likely candidates for commitment.

Estimated Cost Savings With Improved Management of the Involuntary Mental Commitment Fund FY 1993

Areas for Possible Cost Avoidance		IMC Fund Cost Avoidance
Ensuring that Medicaid recipients are not temporarily detained in free-standing psychiatric facilities		$652,273[a]
Hospitals double billing Medicaid and IMC Fund	$70,332	
	+	
Acute care hospitals billing IMC fund rather than Medicaid	$273,175[a]	
Eliminating hospitals billing erroneously for services	→	$343,507
TOTAL		**$995,780[b]**

[a]Assumes that the involuntary mental commitment fund provides the $100 co-payment that Medicaid charges for each inpatient hospital admission.

[b]Total State savings would be $533,056 due to the State paying its portion of Medicaid claims for Medicaid recipients.

Temporary Detention Process Not Always Utilized as Intended. A number of study findings indicate that the temporary detention process needs to be refined to ensure that only individuals who are actual candidates for commitment are detained. For example, under current statutory provisions, special justices are allowed to issue a temporary detention order (TDO) without consulting a mental health professional. In some areas of the State, individuals are being detained without a mental health evaluation, by the order of special justices who lack mental health training, and are often times authorizing the request over the telephone. Since many requests for temporary detention orders are made by family members and adult homes for individuals who do not meet the statutory commitment criteria, an evaluation by a CSB staff member is needed to pre-screen all requests for temporary detention orders.

The criteria for temporarily detaining an individual are less stringent than the criteria for involuntary commitment, which allows for inappropriate use of the process. As a result, individuals may be detained who are neither a danger to themselves or others, nor unable to care for themselves and who do not need in-patient psychiatric hospitalization.

Although hospitals have the authority to determine the time of release of patients after commitment, the *Code of Virginia* lacks provisions that would enable hospitals to provide for the release of individuals during the temporary detention period who no longer require hospitalization. Some hospitals, apparently as "allowed" by the special justices in the area, are releasing individuals prior to a commitment hearing if the individuals no longer meet the detention criteria and would not present an imminent danger to themselves or others if released. This practice appears to be appropriate, but is not provided for in the *Code.*

To address these issues, a number of recommendations have been developed. These recommendations include: requiring that CSB staff conduct in-person pre-screening evaluations for all individuals for whom TDOs are requested prior to their issuance; amending the *Code* so the standard for issuing emergency custody orders (ECOs) and TDOs would be probable cause that the individual meets the commitment criteria and is incapable of or unwilling to volunteer for treatment; and amending the *Code* to explicitly allow hospitals to release a patient prior to the commitment hearing if the patient no longer meets the detention criteria and would not present an imminent danger to self or others if released.

Commitment Hearing Procedures Need More Consistency and Oversight. There are few written guidelines to direct the implementation of the statutory sections addressing involuntary commitment hearings. Consequently, a substantial inconsistency in hearing procedures has been noted in some prior reviews of involuntary commitment in Virginia and has been noted again in this report. Inconsistencies exist in areas such as: the conduct of the preliminary hearing; the priority placed upon having petitioners, family members, or others present and available as witnesses; the independence and participation of the mental health examiner; the role of CSB staff in commitment hearings; and the role of the patient's attorney. There also appear to be substantial variations in the availability of alternatives to commitment, which impact the ability of decision-makers to find less restrictive alternatives than hospitalization.

Procedural changes and oversight of the involuntary commitment hearings are needed. Detailed recommendations to address these needs are identified in the report. Among them are recommendations designed to simplify and clarify the process, to provide additional information and/or training related to the role of various participants in the process, and to provide a record of the proceedings to better facilitate oversight and accountability.

Reduction in Transports Is Possible, But Law Enforcement Involvement Is Needed

Law enforcement officers should continue to transport individuals under ECOs and TDOs, because the process is often initiated by an officer and the dangerousness of the individual may not be known. The changes recommended in this report, however, should improve the efficiency of the process, reduce the number of detentions, and thereby reduce the number of transports by law enforcement officers. In addition, following the commitment of an individual, it appears that other modes of transportation may be available. The detention period allows time for assessment and stabilization of the patient. Some other states already utilize alternatives for transporting committed patients, including the use of hospital vehicles, ambulances, and private contract providers. The increased use of transportation alternatives appears to be possible but will require careful, responsible consideration of the dangerousness of each patient to be transported.

Strengths and Weaknesses in Virginia's Process Also Indicated by Other State Comparison

For this study, a survey and statutory review were conducted for selected states in the southeast region, as well as states recognized nationally for their mental health systems. This review indicated several areas where Virginia's process appears to meet or exceed the efficiency and effectiveness of the processes in other states. In other areas, the comparison suggested some deficiencies and some potential alternatives, converging with and reinforcing JLARC study observations about Virginia's process.

The comparison indicated a number of positive aspects of Virginia's approach. For example, Virginia's process detains individuals for a relatively short period of time prior to holding a commitment hearing. The involuntary commitment fund in Virginia is unique, enables individuals where necessary to be detained at private hospitals even without insurance coverage, and reduces the financial responsibility of the individuals to pay for their own involuntary detention or commitment. Conversely, the comparison also indicates that a number of other states have detention criteria that are more consistent with their commitment criteria, require a mental health evaluation prior to detention, and keep records on the proceedings that can be used in general oversight of the process.

Process Decision-Makers Cite Concerns About the Availability of Alternatives

The involuntary commitment process operates within the broader context of what alternative community mental health services are available to meet the needs of candidates for involuntary commitment. The exercise of State authority to involuntarily detain individuals and involuntarily commit them to hospitalization should be reserved for situations in which the individual's mental illness and dangerousness or inability to care for self is compelling. However, involuntary commitment literature indicates that in actuality, decision-makers in the process are reluctant to ignore patient needs and release patients to living arrangements that are not deemed viable. This may result in a tendency of the process to over-commit to hospitalization if there is a lack of viable community alternatives.

A 1986 JLARC report on deinstitutionalization of mental health care found that substantial improvements had been made in Virginia's mental health system since 1979, but that at the local level there was still an overwhelming need for a broader range of services. It was beyond the scope of this JLARC study of the involuntary commitment process to examine the extent to which the availability of services may have improved or diminished since 1986. However, it was clear from this review that a substantial proportion of decision-makers within the involuntary commitment process indicate a concern about the options available to them in making treatment decisions. For example, almost one-half of the special justices responding to a JLARC survey indicated their belief that adequate outpatient treatment options are not available to address the needs of individuals seen in commitment hearings. In addition, the justices indicated that outpatient treatment was not available at a nearby location 20 percent of the time that outpatient treatment was ordered.

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I. Introduction

Involuntary civil commitment is a legally-sanctioned process by which an individual with a mental illness may be temporarily detained and ultimately committed to a hospital on an involuntary basis for a defined period of time. This process may occur if the individual with mental illness is considered dangerous to self or others, or is unable to provide for his or her own basic needs.

In the United States, there is no federal law or process which specifically addresses involuntary civil commitment. Involuntary commitments occur based on state laws. Therefore, including the District of Columbia, there are 51 separate and distinct involuntary commitment statutes that seek to implement the civil commitment of individuals with mental illness who meet the criteria of dangerousness or inability to care for themselves. It has been estimated in national survey data that about one-fourth of civil inpatient hospitalizations for mental health care are involuntary commitments.

An involuntary commitment results in a deprivation of individual liberty. On the other hand, it is argued to be necessary under certain circumstances to ensure the safety and well-being of the individual with mental illness, or of society at large. Because of the freedom and safety issues involved, the subject of involuntary commitment has provoked substantial controversy, study, and debate over the decades, both nationally and in Virginia. National and Virginia studies have suggested a persistent degree of variation between statutory requirements intended to address the issues, and actual local-level commitment practices. Nonetheless, there appear to be opportunities for addressing deficiencies and making improvements to the statutes and actual practice.

Potential solutions to involuntary commitment issues and problems, however, may need to be linked to the surrounding framework of mental health care issues. For example, one involuntary commitment issue of frequent concern is whether the process and/or the participants in it promote "overcommitment." There are a variety of reasons as to why this might occur. However, an important part of the context for decision-makers in involuntary commitment proceedings is the availability of less-restrictive care or community-based mental health service alternatives. Unless there are viable options for patients, at home and/or within the community, decision-makers may be reluctant to commit individuals to treatment other than inpatient hospitalization.

NATIONAL TRENDS IN INVOLUNTARY COMMITMENT

From the time that mental asylums were founded in the United States in the early 1700s, there have been several cycles of reform in commitment practices and in mental health practices generally. Reforms have to some degree reflected variations in attitudes toward some of the central issues involved. One of those central issues for involuntary commitment is the perceived need to protect the public from individuals whose particular mental state may make them a danger to others. Another central issue

is the perceived need to protect the individuals from themselves — for example, individuals whose mental state may lead them to suicide. A third central issue is to provide treatment to individuals in order to stabilize them, address their mental health needs, and return them to society. A final key issue is the civil liberty of the individuals involved. The Fourteenth Amendment to the Federal Constitution provides that no state shall "deprive any person of life, liberty, or property without due process of law." Involuntary commitment has been described as a massive deprivation of liberty, but it is sought to be implemented within a legal framework consistent with due process.

Experts have noted that nationally, the cycle of reform has moved from renewed attention to issues of the deprivation of liberty in the later half of the 1800s, to emphasis upon the need for hospitalization and therapy in the first half of the 1900s, to a wave of involuntary commitment legislation in the 1960s and 1970s intended in part to promote due process rights. These latter reforms occurred during a time when national mental health policy emphasized deinstitutionalization of the mentally ill, or transferring the primary treatment responsibility for the mentally disabled from state mental health and mental retardation facilities to service providers in community-based settings.

Recent commentary at a national level has suggested two themes with regard to improving the involuntary commitment process. One theme has been the difficulty of changing involuntary commitment practices by statutory means. Involuntary commitment literature consistently documents that major differences have been observed between actual practice and statutory requirements.

While there is a potential for misunderstandings of the statutes, as well as the potential for participants in the process to find those provisions inconvenient, explanations for the gap have also focused on the fact that the decision-makers in the involuntary commitment process at the local level operate within the constraints of the community around them. At the time the process goes to a formal involuntary commitment proceeding, the major question becomes what to do with, or for, the individual. And, it is argued, within the context of deinstitutionalized care, the quantity and quality of deinstitutionalized care that is available has an impact. Decision-makers in involuntary commitment processes, it is held, have concerns about releasing patients into communities which are not able to provide care or services to them. It has been suggested that with inadequate community-based services, more commitments may be observed, and scarce resources may be shifted more to involuntary mental health care and treatment and involuntary commitment costs may rise.

A second theme regarding the improvement of involuntary commitment processes, however, has been that further efforts to correct perceived deficiencies or problems in the processes are still possible and worthwhile. For example, the National Center for State Courts in 1986 developed guidelines for involuntary civil commitment, even after recognizing some daunting problems facing the mental health system. The report focused on the involuntary commitment system and "its everyday administration," but its product of guidelines could be incorporated in a number of different ways, including incorporation of certain elements into statute. Task forces of the American Psychiatric Association have examined issues and reported on the potential for improve-

ment in areas such as the use of psychiatric diagnosis and commitments to outpatient treatment.

OVERVIEW OF THE INVOLUNTARY COMMITMENT PROCESS IN VIRGINIA

The involuntary commitment process in Virginia is the procedure through which adults and juveniles are involuntarily hospitalized or committed for outpatient treatment. Sections 37.1-64 through 37.1-90 of the *Code of Virginia* direct the adult involuntary commitment process (Appendix B). Sections 16.1-335 through 16.1-348 of the *Code of Virginia* direct the juvenile process. This study focuses on the adult commitment process.

Individuals entering the involuntary commitment process generally enter through an emergency custody order (ECO) or a temporary detention order (TDO), if someone has probable cause to believe that the individual is mentally ill and in need of hospitalization (Figure 1). Both an ECO and a TDO allow an individual to be detained for a mental health evaluation. An emergency custody order allows an individual to be detained to a convenient location for a mental health 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. Following the temporary detention period, the individual must be released or have a commitment hearing. If it is determined at the commitment hearing that the individual, due to mental illness, presents an imminent danger to self or others, or is substantially incapable of self care, and there is no less restrictive alternative, an order for involuntary commitment is issued.

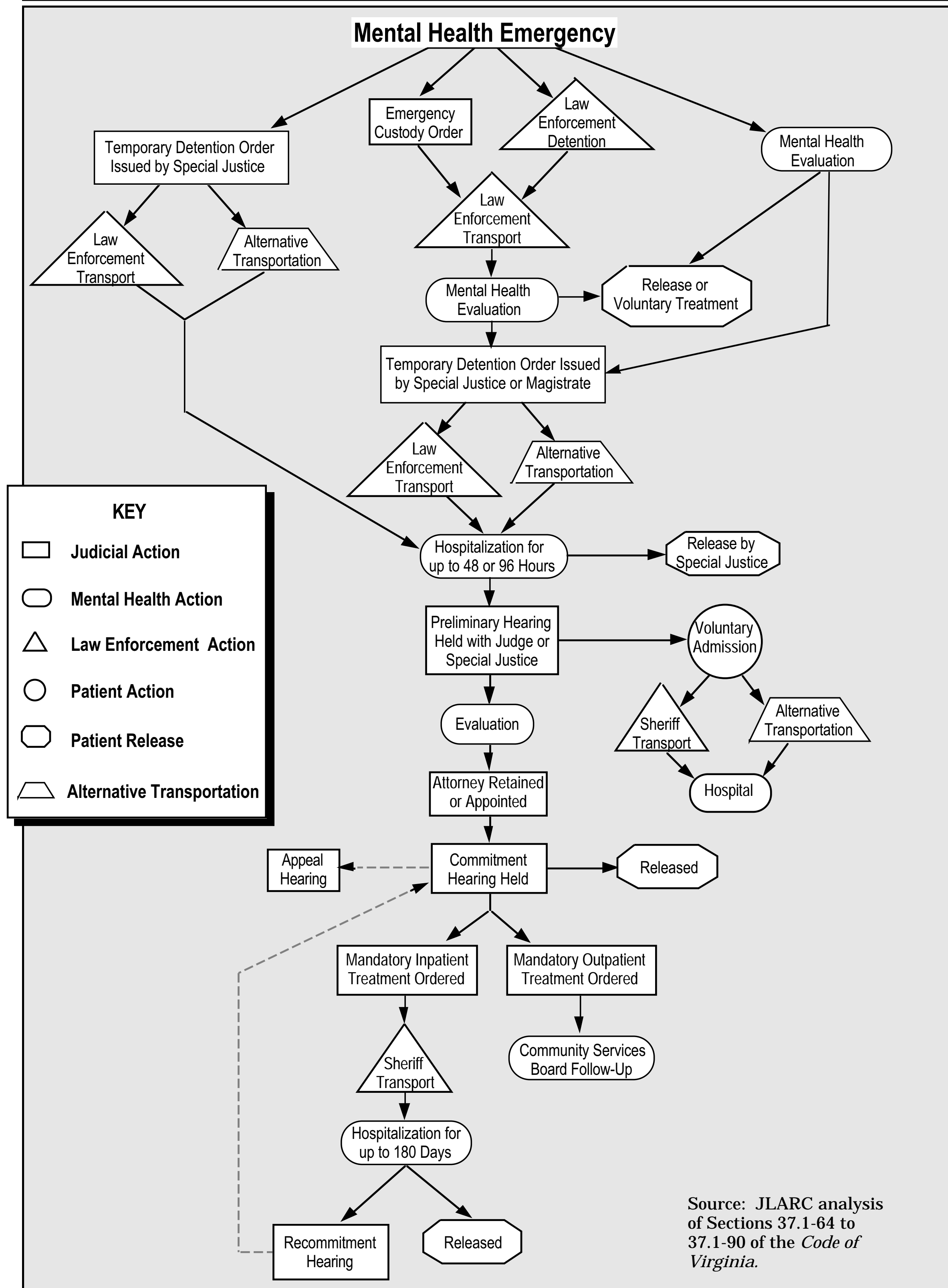
There are no aggregated data on the total number of temporary detention orders issued throughout the State or on the percentage of TDOs which result in involuntary commitments. However, community services board (CSB) staff estimated in their responses to a JLARC survey that more than 14,000 TDOs were issued in FY 1993. This represents most, but not all, TDOs issued because CSBs are not involved in the issuance of all TDOs.

The involuntary mental commitment fund, which is administered by the Supreme Court of Virginia, provides payments to hospitals and physicians providing services during the detention period, and to special justices, attorneys, psychiatrists, psychologists, and physicians participating in involuntary commitment hearings. In FY 1994, the Supreme Court expended $12.2 million for these services.

Petition and Pre-hearing Detention

Section 37.1-67.1 of the *Code of Virginia* outlines the process for temporarily detaining individuals in Virginia due to mental illness. In practice, there are several different ways the process may begin:

Figure 1
The Statutorily Defined Process for Temporary Detention and Involuntary Commitment



Source: JLARC analysis of Sections 37.1-64 to 37.1-90 of the *Code of Virginia.*

- A family member, neighbor, friend, or other responsible adult may contact a local CSB or law enforcement agency to report an emergency situation, which may result in a request for an ECO or TDO;

- CSB emergency services staff may request an emergency custody order or a temporary detention order;

- Private physicians, psychiatrists, or psychologists may request an emergency custody or temporary detention order;

- Law enforcement officers may initiate or request an ECO or request a TDO;

- Magistrates may initiate an emergency custody order upon their own motion, or they may issue a TDO based on the advice of a mental health professional; or

- Special justices or judges may issue either of the two orders upon their own motion.

If the process is initiated with an ECO, Section 37.1-67.1 of the *Code of Virginia* requires that within four hours the individual must be evaluated by a mental health professional. Following the evaluation, the individual must be released or a judge, special justice, or magistrate must issue a temporary detention order. If it then appears from all evidence that the person is mentally ill and in need of hospitalization, the judge, special justice, or magistrate may issue a TDO.

However, the process may also begin with a temporary detention order, without an emergency custody order preceding it. In this situation, Section 37.1-67.1 of the *Code of Virginia* indicates that a magistrate may issue a TDO upon the advice of, and only after an in-person evaluation by, a person skilled in the diagnosis and treatment of mental illness, unless the individual has been examined by a mental health professional within the last 72 hours. The *Code of Virginia* does not require that a judge or special justice obtain the advice of a mental health professional prior to issuing a temporary detention order.

Commitment Hearings

The *Code of Virginia* further indicates that a commitment hearing must be held within 48 hours of the issuance of the temporary detention order. However, if the 48-hour period terminates on a weekend or holiday the commitment hearing must be held the next day which is not a weekend or holiday. In no event may an individual be detained longer than 96 hours without a commitment hearing.

Prior to the commitment hearing, a preliminary hearing must be held. Section 37.1-67.2 of the *Code of Virginia* indicates that a judge or special justice must hold a preliminary hearing to ascertain if the individual is willing and capable of seeking

voluntary admission and treatment. If the person is incapable of accepting or unwilling to accept voluntary admission and treatment, the judge or special justice is required to inform the individual of the right to a commitment hearing and the right to counsel. In practice, the preliminary hearing is generally conducted at the beginning of the commitment hearing. However, in a few locations, the preliminary hearing is held the day before the commitment hearing.

Section 37.1-67.3 of the *Code of Virginia* outlines the procedures for the commitment hearing. While commitment hearings are held in hospitals, in district courts, or at CSB offices, most hearings are held in hospitals. The *Code of Virginia* requires the judge to inform the individual prior to the hearing of the basis for his or her detention; the standard upon which he or she may be detained; the place, date, and time of the commitment hearing; the right of appeal from such hearing to the circuit court; and the right to jury trial on appeal. However, in practice, hospital or CSB staff usually inform the individual of the time and place of the hearing. The special justice informs the individual of the right to appeal, right to counsel, and the right to voluntarily self admit at the beginning of the commitment hearing.

During the hearing, the special justice utilizes evidence from several sources. Sources of evidence include testimony or a report from CSB staff, and a psychiatric examination of the individual conducted in private. Further, the attorney is allowed to question the client, any witnesses, the CSB staff, or the examiner.

Section 37.1-67.3 of the *Code of Virginia* requires community services board staff to provide a prescreening report to the special justice. This report indicates the staff's opinion on whether the individual meets the commitment criteria, and what the recommendations are for the patient's treatment and care. However, the statutes also permit the special justice to conduct the hearing without a prescreening report if it is not received within a specified time period. In many localities, CSB staff attend the hearing to testify on the prescreening report.

Section 37.1-67.3 of the *Code of Virginia* also requires a psychiatrist, clinical psychologist, or physician to conduct an examination of the individual in private. The examiner is required to certify whether the individual meets the commitment criteria and to recommend whether the individual requires involuntary hospitalization or treatment. A report from the examiner is to be presented orally or in writing during the commitment hearing.

Further, the *Code of Virginia* indicates that to the extent possible, during the commitment hearing, the attorney for the individual shall interview the client, the petitioner, the examiner, and any witnesses. The attorney should also present evidence and actively represent his client in the proceedings. Section 37.1-67.3 of the *Code of Virginia* requires special justices to inform individuals of their right to employ private counsel. However, special justices responding to the JLARC survey indicate that only one percent of individuals utilize a private attorney. Therefore, the individuals are usually represented by a court-appointed attorney.

At the conclusion of the commitment hearing, the special justice renders a judgment. The judicial options include:

- involuntary inpatient commitment, which requires an individual to be hospitalized for up to 180 days;

- involuntary outpatient commitment, which requires an individual to follow an outpatient treatment regimen developed by a local community services board;

- voluntary inpatient admission, which allows an individual to voluntarily admit himself or herself to a hospital; or

- release, which dismisses the individual from the hearing without any further requirements.

If the special justice decides that the individual, as a result of mental illness, presents an imminent danger to self or others or is substantially incapable of self care and less restrictive alternatives are deemed unsuitable, an order for involuntary inpatient commitment is issued. This order may be for no longer than 180 days. Involuntary outpatient commitment may be ordered if less restrictive treatment alternatives exist and are suitable.

Section 37.1-67.6 of the *Code of Virginia* states that all individuals who are involuntarily committed have the right to appeal. These appeals must be filed within 30 days of a commitment ruling. However, the 80 special justices responding to a JLARC survey report that only three percent of their cases are appealed.

If at the end of 180 days of inpatient treatment an individual is still thought to be in need of involuntary care, a recommitment hearing may be conducted. A recommitment hearing generally includes the same procedures as the commitment hearing, except that no preliminary hearing is conducted.

The Involuntary Mental Commitment Fund

The involuntary mental commitment fund was established by the General Assembly in the 1970s to fund the costs associated with the procedures through which adults and juveniles are mandated to receive involuntary mental health treatment. Involuntary mental commitment fund expenditures have increased from $3.9 million to $12.2 million over the past ten years, or an average annual increase of 13.5 percent (Table 1).

The fund pays for several different services:

- Private hospitals are paid per diem costs, based on Medicaid reimbursement rates, for detaining individuals under TDOs;

Table 1

Involuntary Mental Commitment Fund Expenditures FY 1985 to FY 1994

Fiscal Year	Expenditures (in millions of dollars)
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
1994	12.2

Source: JLARC analysis of Supreme Court data on involuntary mental commitment fund expenditures, summer 1994.

- Psychiatrists, physicians, and psychologists are paid for medical and psychiatric services provided to individuals during temporary detention periods at public and private hospitals; and

- Special justices, attorneys, psychiatrists, physicians, and psychologists participating in involuntary commitment hearings are paid on a per-hearing basis.

The General Assembly originally directed the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to administer the fund, however, the fund was moved to the Supreme Court in 1980. It was transferred because it was assumed that the majority of payments were made to special justices and attorneys. However, currently the largest single component of the involuntary mental commitment fund involves payments to hospitals. Payments to hospitals totaled approximately 68 percent of fund disbursements in FY 1994 (Figure 2).

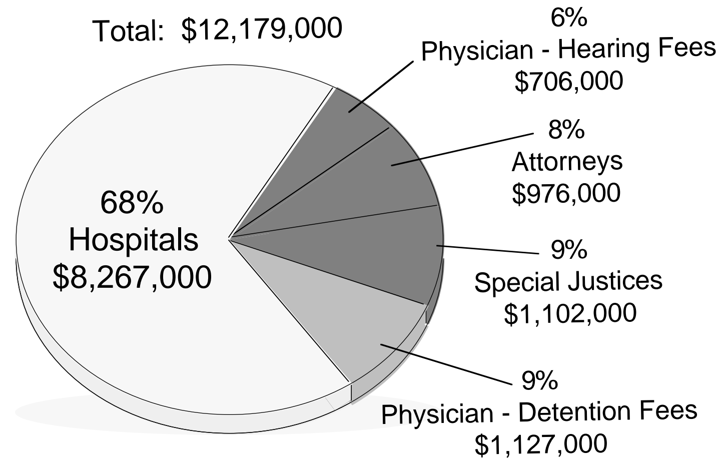
Participants in the Involuntary Commitment Process

There are several participants with major roles in the involuntary commitment process. These include community services boards; law enforcement officers; special justices; attorneys; psychiatrists, psychologists, and physicians; magistrates; hospitals; and the potential candidates, or patients, for commitment.

Community Services Boards. Community services boards are local government organizations which provide services for mental illness, mental retardation, and

Figure 2

Payments from the Involuntary Mental Commitment Fund, FY 1994



Note: Numbers may not add due to rounding.

Source: JLARC analysis of Supreme Court involuntary mental commitment fund data, summer 1994.

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 community services board (Figure 3). CSBs that serve more than one county often have branch offices or contract with mental health professionals in the outlying counties to provide services outside of the county where the community services board is located.

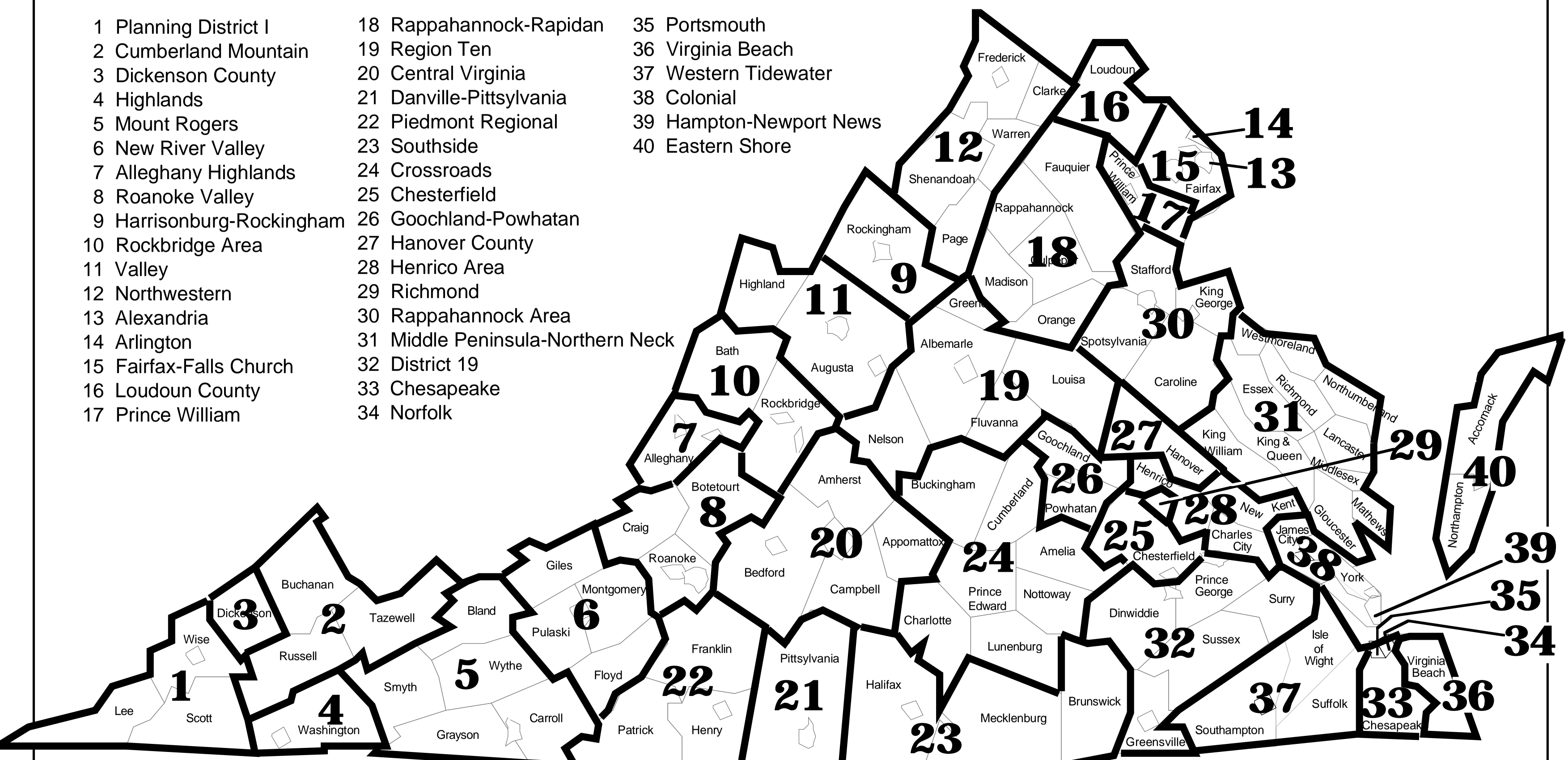
Each CSB receives funding from a variety of local and federal sources. In addition, community services boards are appropriated State funds through the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Section 37.1-194 of the *Code of Virginia* requires CSBs to provide emergency mental health services within their catchment area. Therefore, community services boards are involved in involuntary commitment activities. Activities performed by CSB staff related to involuntary commitment include requesting orders for emergency custody and temporary detention, providing evaluations and prescreening for ECOs and TDOs, recommending hospitals to magistrates and special justices for detention and commitment, providing prescreening reports for commitment hearings, and testifying at commitment hearings.

In FY 1993, the CSBs reported that an estimated 246,000 emergency contacts were made to crisis services. These staff report several different ways that they may be informed of an emergency situation that could result in a TDO:

Figure 3

CSB Service Areas



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

- A citizen may call the community services board on its 24-hour hot-line,
- A CSB case worker may encounter a mental health emergency on a routine home visit to see a client,
- An individual with a mental health emergency may walk into a community services board clinic,
- A hospital emergency room may contact the community services board regarding a mental health emergency,
- A private psychiatrist or psychologist may contact the board regarding a mental health emergency,
- A 911 operator may refer an emergency situation to a community services board, or
- Law enforcement officers may inform a CSB of an emergency situation if they believe mental illness is involved.

However, not all emergency contacts result in a TDO request. Some CSB staff report that when they are contacted regarding a mental health emergency, they may not necessarily respond immediately with a request for temporary detention. In many cases they will attempt to alleviate the situation over the telephone. If that is not successful, an emergency services worker may evaluate the individual face-to-face and provide necessary counseling. The emergency services worker may offer the individual outpatient services as an alternative to involuntary detention. If the individual refuses treatment, cannot afford the treatment recommended, or is imminently dangerous, and the worker believes the individual meets the detention criteria, the worker will complete a prescreening report, and request a temporary detention order. From the estimated 246,000 emergency contacts in FY 1993, CSB staff report that they requested approximately 14,000 TDOs.

The 40 community services boards estimated that they expended more than $5.6 million in FY 1993 providing services in support of the involuntary commitment process. CSB staff reported that the majority of this expenditure was for personnel costs associated with providing services for individuals being placed under an ECO, TDO, or involuntary commitment. To help recover some of these costs, 34 community services boards reported billing individuals for the prescreening services the CSB provided and 14 CSBs reported charging individuals for time spent testifying during commitment hearings.

Law Enforcement Officers. As previously indicated, Section 37.1-67.1 of the *Code of Virginia* indicates that a law enforcement officer may take an individual into custody, without prior judicial authorization, for up to four hours based on probable cause that the individual is mentally ill and in need of emergency evaluation for hospitalization. Further, law enforcement officers are utilized by magistrates and special justices

to transport individuals when ECOs and TDOs are issued. As a result, both sheriffs' deputies and police officers are involved in providing transportation for individuals needing emergency custody and temporary detention.

One hundred fourteen sheriffs (91 percent of the 125 sheriffs statewide) and 44 police chiefs (73 percent of the 60 surveyed) estimated that their deputies transported approximately 18,000 mental health patients in FY 1993. Mental health transports were conducted for several purposes:

- 60 percent involved transporting an individual under a TDO,
- 18 percent involved transporting an individual under an ECO,
- 11 percent involved transporting a committed patient, and
- 11 percent involved transporting a forensic patient (someone who is being held for committing a crime who is also mentally ill) from a jail.

When an officer initiates an emergency evaluation, or transports an individual on an ECO, the individual is in the officer's custody. Therefore, the officer is required to remain with the individual until an evaluation is completed and a TDO is executed, or the individual is released. This may require the officer to remain with the individual for several hours. When transporting an individual under a temporary detention order, the officer is required only to transport the individual to the evaluation site. Law enforcement officers report that the individual is usually handcuffed during the transport due to the custodial relationship involved.

In addition, Section 37.1-71 of the *Code of Virginia* cites sheriffs as responsible for transporting individuals who are certified for admission to a hospital following a commitment hearing. 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 are the primary transportation providers. Some sheriffs' deputies also provide security during the commitment hearings.

The sheriffs and the police chiefs responding to the JLARC survey estimated that they spent $1.5 million transporting individuals under ECOs and TDOs, and for involuntary commitment. Officer salaries, overtime, and mileage expenses for time spent providing transportation comprised 95 percent of these costs.

Special Justices. Sections 37.1-67.1 and 37.1-67.3 of the *Code of Virginia* state that the adult involuntary commitment process in Virginia is to be adjudicated by judges, associate judges, and substitute judges of the general district courts. However, Section 37.1-88 of the *Code of Virginia* states that the chief judge of each judicial circuit may appoint special justices who have the powers of the district court in executing the duties in the involuntary commitment process. The only statutory requirement to be a special justice is to be "licensed to practice law in this Commonwealth." Of the 31 circuit court judges who are currently acting in the capacity of chief judge, 29 responded to the JLARC

survey. These 29 chief judges report they have appointed 96 special justices throughout the State. (Since circuit court judges serve as the chief judge of the court for two-year terms, some of the active special justices were not appointed by the current chief circuit court judge. Therefore, there are more special justices serving than the chief judges reported to JLARC.)

The majority of involuntary commitment hearings in Virginia are conducted by special justices. 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 mental commitment fund. In FY 1994, Supreme Court staff made disbursements from the involuntary mental commitment fund totaling $1.1 million to 160 special justices across the State.

As previously indicated, Section 37.1-67.1 of the *Code of Virginia* states that special justices may issue ECOs and TDOs without having the advice of a mental health professional to issue these orders. As a result, a number of special justices are involved in issuing these orders. In fact, 61 percent of the special justices who responded to the JLARC survey reported that they issue temporary detention orders, and 35 percent reported that they issue emergency custody orders. The Supreme Court does not pay special justices for issuing ECOs and TDOs.

Special justices receive no mandatory training on mental health law. The Supreme Court, and DMHMRSAS, 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.

Attorneys. Section 37.1-67.3 of the *Code of Virginia* indicates that individuals being detained for a commitment hearing have the right to an attorney at the hearing. While individuals have the option to retain their own attorney, special justices report that approximately 99 percent of individuals utilize a court-appointed attorney. The *Code of Virginia* requires the attorney to interview the client, the petitioner, the examiner, and any witnesses, and to actively represent the client during the hearing.

The involuntary mental commitment fund provides payment to attorneys participating in commitment hearings. In FY 1994, the fund disbursed almost one million dollars to 510 attorneys.

Psychiatrists, Psychologists, and Physicians. Section 37.1-67.3 of the *Code of Virginia* requires a private examination of the individual by a psychiatrist, clinical psychologist, or physician. The examiner is required to submit a report indicating whether the individual meets the commitment criteria and to include a recommendation for commitment or release. The examiner is not required to testify at the commitment hearing.

The involuntary mental commitment fund provides payment to psychiatrists, psychologists, and physicians participating in commitment hearings. In FY 1994, the

fund disbursed more than $700,000 to 253 psychiatrists, psychologists, and physicians. More than $1.1 million were also paid to psychiatrists, psychologists, and physicians who treated the patients hospitalized under TDOs.

Magistrates. According to the *Code of Virginia*, the office of the magistrate was created to assume the powers which had previously been awarded justices of the peace. There are magistrates' offices in every judicial district in Virginia, and these offices all operate 24 hours per day, seven days per week (in some rural areas, a magistrate may be on-call rather than in the office 24 hours a day). There is one chief magistrate in every district to provide direct daily supervision over the magistrates.

Section 19.2-45 of the *Code of Virginia* outlines the powers of the magistrate. These powers include:

- issuing process of arrest,
- issuing search warrants,
- admitting bail or committing to jail persons charged with offenses,
- issuing criminal warrants and subpoenas,
- issuing civil warrants,
- administering oaths and taking acknowledgments, and
- acting as conservators of the peace.

In addition, as previously indicated, Section 37.1-67.1 of the *Code of Virginia* allows magistrates to issue ECOs and TDOs. Magistrates may issue temporary detention orders upon the advice of, and only after an in-person evaluation by, a person skilled in the diagnosis and treatment of mental illness. A magistrate, upon the advice of a person skilled in the treatment and diagnosis of mental illness, may issue a TDO without a prior in-person evaluation if: (1) the person has been personally examined within the previous 72 hours by an evaluator designated by the CSB, or (2) there is a significant physical, psychological or medical risk, to the person or to others, associated with conducting such evaluation.

All new magistrates receive basic legal training on the issuance of ECOs and TDOs from the chief magistrate of each judicial district, and from the Supreme Court. Further, the Supreme Court, as part of its annual training for all magistrates, occasionally provides additional training on issues related to the issuance of emergency custody and temporary detention orders. Magistrates are not paid any additional funds for issuing these orders. Magistrates responding to a JLARC survey reported issuing more than 4,000 ECOs, and more than 10,000 TDOs during 1993.

Hospitals. 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 commitment. In FY 1993, CSBs recommended a total of 58 hospitals be used for detention during the temporary detention periods and 56 hospitals be used for involuntary commitments. These hospitals were a mix of State mental health hospitals, private free-

standing mental health hospitals, and mental health units in private and State acute care hospitals (Appendix C).

DMHMRSAS staff report that in FY 1993, 2,356 TDO patients were admitted to State mental health hospitals. Since CSBs report that more than 14,000 TDOs were requested in FY 1993, it appears that private psychiatric and acute care hospitals are utilized more frequently than State mental health hospitals for the detention periods.

The Supreme Court, through the involuntary mental commitment fund, reimburses private hospitals, based on per diem Medicaid rates, for the costs of detention periods that are not covered by an individual's private insurance, Medicaid, or Medicare. In FY 1994, the Supreme Court disbursed more than $8.2 million from the involuntary mental commitment fund to 49 private hospitals for detention periods. However, State mental health hospitals are not reimbursed by the fund. JLARC staff estimate that DMHMRSAS spent $1.1 million in FY 1993 on individuals treated in State mental health hospitals during temporary detention periods. Involuntary mental commitment funds are not used for the period of involuntary commitment, following a commitment hearing.

Involuntary Commitment Candidates. Survey data from a previous JLARC study on deinstitutionalization in Virginia reported a statistical profile for persons in Virginia with serious mental illness. These data indicate that the chronically mentally ill population profile is predominately male (58 percent), single (83 percent), young (average age of 35 years), and has been unemployed prior to admission (85 percent). While this population is only a subset, and not a direct match with the involuntary commitment candidate population, the data are suggestive of how the involuntary commitment population profile in Virginia may look. A sample of 1,226 former involuntary commitment candidates in a North Carolina study produced a similar profile, finding that population to also be predominately male (57 percent), single (77 percent), young (59 percent under 40), and unemployed (68 percent).

Although Virginia's overall profile for involuntary commitment candidates cannot be stated with certainty, such a profile also masks the striking diversity that may exist across Virginia's involuntary commitment candidate population. In attending more than 40 commitment hearings, JLARC staff observed a wide variation in the population of commitment candidates, with regard to characteristics, behavior, and condition. For example:

> *A commitment candidate, an elderly female, had passed out on her front lawn following what was described as an episodic drinking binge. A neighbor sought her temporary detention. These episodes were acknowledged by the commitment candidate and non-resident family as recurrent on particular days, and there was concern as to the candidates' ability to avoid harm to self over the long-term. The special justice ordered her commitment to a mental health unit of an acute care hospital.*

* * *

A middle-aged male, accompanied by his wife, had suffered a stroke and was indicated as having difficulties coping with diminished capabilities relative to his condition. The candidate had several medical problems, was supposed to continue with dialysis treatments, but did not wish to. Further, the candidate had previously appeared before the special justice and had been ordered to continue with dialysis and not to operate a motor vehicle. He was still refusing dialysis and had operated a motor vehicle on his property. There was some discussion at the hearing as to whether or not the candidate should have understood the special justice's instructions to include not driving on the property as opposed to the public roads. The wife of the patient indicated concern and despair as to her husband's increasing anger levels, however, whenever he found himself unable to accomplish certain tasks, and expressed concern as to her ability to continue to care for him. The special justice ordered him committed to a medical unit in an acute care hospital where he was to be placed on dialysis.

* * *

A commitment candidate, a middle-aged unemployed male, was detained for having made a bomb threat. This individual had previously placed a bomb in a post office mail box. The individual was described by the psychiatrist at the hearing as a paranoid schizophrenic. During the commitment hearing, the commitment candidate asked an observer of the proceeding as to why the observer was "giving him a cutting eye." The special justice commented as an aside to observers of the hearing that the difficulty for such individuals is that they have no goals in life. The special justice then turned back to the commitment candidate and asked him what his long-term goals were. The commitment candidate requested, with apparent incredulity, that the special justice repeat the question. The special justice ordered him committed to a mental health unit of an acute care hospital for mental health treatment.

* * *

A young male commitment candidate was stated by the proceeding participants to be mentally retarded and hard of hearing. This individual was alleged to believe that he was a famous comic book hero, as well as a famous religious leader. The individual was not verbally communicating. The special justice expressed doubts about the method to be used for conducting the hearing, due to the perceived difficulties in the patient's ability to understand the proceeding. The special justice ordered him committed to a mental health unit of an acute care hospital for mental health treatment.

* * *

Another young male commitment candidate had been held for indicating violent tendencies while intoxicated the prior evening. At the hearing, the individual appeared lucid, displayed no evident unusual behavior, expressed regret, and was released with an admonition from the special justice to not engage in substance abuse.

The future of the patient constitutes the purpose for these hearings. In the situations described, special justices had the responsibility of determining whether or not and under what conditions the individuals should continue to be hospitalized or could be released from involuntary hospital care. The participation of the patient in the hearing is usually an important part of the hearing. Involuntary commitment proceedings typically do not last very long and there are usually few witnesses. Often the only individuals who testify are the patient and the psychiatrist. Some involuntary commitment literature has suggested that in this context (the juxtaposition of an "expert" and presumably objective witness against an individual coming into the proceeding with a label of potential mental illness), the potential candidate for commitment has little chance. Nonetheless, the ability of the potential candidate to show lucidity and rationality may influence the outcome. In the hearings observed, special justices sometimes sought patient responses to potential outcomes or dispositions to the case, to observe their reactions.

VIRGINIA'S PROCESS COMPARED TO SELECTED OTHER STATES

For this study, JLARC staff surveyed 15 other states, including southeastern states, and states recognized nationally for their mental health systems. These states are: Alabama, Arizona, Florida, Georgia, Kentucky, Maryland, Massachusetts, Minnesota, Mississippi, North Carolina, South Carolina, Tennessee, Vermont, West Virginia, and Wisconsin.

Virginia, and the 15 states surveyed, have statutory provisions directing processes whereby individuals may be temporarily detained, and then involuntarily committed for a period of time to receive mental health treatment. However, the processes by which individuals are involuntarily committed vary among all the states. Differences are evident in the way individuals are temporarily detained, involuntary commitment hearings are held, individuals are transported, and participants in the process are reimbursed.

Information regarding how Virginia's involuntary commitment process compares with the process used in the other 15 states is contained in Appendix D. This comparison reveals several areas in which Virginia's process appears to meet or exceed the efficiency and effectiveness of the processes in other states. However, in many situations, the processes utilized by the other states provide useful alternatives that could be adopted in Virginia.

JLARC REVIEW

Item 15 of the 1993 Appropriation Act originally contained the study mandate for JLARC to "examine the fiscal issues related to the Involuntary Mental Commitment Fund and the operational and policy issues involving the involuntary mental commitment process." This was the first time that JLARC was specifically requested to review the involuntary commitment process. On two prior occasions, in 1979 and 1986, JLARC examined the broader question of mental health deinstitutionalization and community services. The clients served by the mental health system described in these reports included voluntary as well as involuntary candidates for mental health services. The 1986 report found that substantial improvements had been made in the system since 1979, but that "at the local level, the overwhelming need is for a broader range of services to ensure that the continuum of care is available to all clients." The report also contained some specific recommendations, such as the consistent use of pre-admission screening, that were relevant to the involuntary commitment process at that time and still appear relevant today.

To address the 1993 involuntary commitment study mandate, JLARC staff prepared an interim report (*Review of the Involuntary Civil Commitment Process*, House Document No. 77, 1994). Item 15 of the 1994 Appropriation Act then continued the mandate for a JLARC review of the fiscal, operational, and policy issues. The mandate further directs JLARC to make recommendations which are designed to promote efficiencies in the process and states that a report is to be submitted prior to the 1995 Session of the General Assembly. The full text of the mandate can be found in Appendix A.

Study Issues

Six major issues were developed to address the study mandate. These issues were:

- to determine if the management of the involuntary mental commitment fund is efficient and effective,
- to determine what role community services boards should play in the involuntary commitment process,
- to examine the current use of the legal system and determine whether it is appropriate for involuntary commitment,
- to determine if the temporary detention process is using public and private hospitals in the most cost efficient and effective manner,
- to determine if the involuntary commitment process is being used for purposes for which it was not originally intended, and

- to compare the Virginia involuntary commitment process with the involuntary commitment processes in other states.

Research Activities

Several research activities were undertaken to address these issues. These were mail surveys, telephone surveys, site visits, observation of involuntary commitment hearings, financial data reviews, and in-person interviews.

Mail Surveys. Seven mail surveys were developed for this study. These surveys were sent to chief circuit court judges, magistrates, police chiefs, psychiatrists, psychologists, and physicians, special justices, community services boards, and sheriffs. Supreme Court databases were used for the initial mailing lists of chief circuit court judges, magistrates, psychiatrists, psychologists, and physicians, and special justices. The surveys requested data for FY 1993.

Mail surveys were sent to each of the 31 chief circuit court judges. The judges were surveyed to determine the number of special justices appointed for each district, and the rationale for the number appointed. Twenty-nine of the 31 chief circuit court judges responded to the survey, for a response rate of 94 percent.

All 429 magistrates in Virginia were surveyed to determine their role in issuing emergency custody and temporary detention orders. Two hundred seventy-two magistrates responded to the survey, for a response rate of 63 percent.

Mail surveys were sent to 60 police chiefs in cities as well as those on college campuses in Virginia to collect information on the role of police officers in transporting individuals under emergency custody and temporary detention orders and following involuntary commitment, and the estimated costs of these duties. Forty-four police chiefs responded to the survey, for a response rate of 73 percent.

All psychiatrists, psychologists, and physicians who were paid by the involuntary mental commitment fund for participating in involuntary commitment hearings were also surveyed. One hundred seventy-three surveys were mailed. However, the Supreme Court of Virginia's database of psychiatrists, psychologists, and physicians paid from the involuntary commitment fund included some attorneys and special justices, due to coding errors. Further, some individuals on the database had moved or were deceased. As a result, 60 out of an eligible 145 surveys were returned, for a response rate of 41 percent.

All special justices who were paid for conducting involuntary commitment hearings were surveyed. One hundred thirty-four surveys were originally sent. However, the chief circuit court judge survey responses identified 32 additional special justices who were not paid by the involuntary commitment fund in FY 1993, and, therefore, were not on the Supreme Court's database. These 32 special justices were therefore also sent mail surveys. Further, the Supreme Court's database of special

justices paid from the involuntary commitment fund included some attorneys and some psychiatrists, psychologists, and physicians, due to coding errors. In addition, some individuals on the database had moved, retired, or were deceased. Therefore, 80 of an eligible 127 surveys were returned, for a response rate of 63 percent.

In addition, two mail surveys from the interim report were used for this study. One survey was designed to collect information from community services boards and another to collect information from sheriffs. All 40 CSBs responded to the survey of CSBs, which focused on the staffing and costs related to the involuntary commitment process. Ninety-one percent (114) of the 125 sheriffs responded to the survey of sheriffs, which focused on the role of deputies in transporting individuals under emergency custody and temporary detention orders and following involuntary commitment and the estimated costs of these duties.

Telephone Surveys. JLARC staff also conducted two telephone surveys for this study. Telephone surveys were conducted with community services boards and 15 other states.

The emergency services supervisors at all 40 community services boards were surveyed by telephone. The 33 CSBs which were not visited by JLARC staff were surveyed to obtain information regarding their roles in prescreening for the emergency custody and temporary detention processes, determining hospitalization for individuals under temporary detention orders, attending commitment hearings within their catchment area, and charging individuals for services provided relating to temporary detention and involuntary commitment. In addition, the seven CSBs visited by JLARC staff were also surveyed by telephone to determine their policies on charging individuals for services provided relating to temporary detention and involuntary commitment.

JLARC staff also conducted telephone surveys of 15 other states. The states surveyed included other southeastern states and states recognized nationally for their mental health systems. The states surveyed were Alabama, Arizona, Florida, Georgia, Kentucky, Maryland, Massachusetts, Minnesota, Mississippi, North Carolina, South Carolina, Tennessee, Vermont, West Virginia, and Wisconsin. Officials of the state department responsible for mental health commitments and the mental health association in each state were interviewed to determine their states' statutory processes for temporary detention and involuntary commitment, their systems for transporting individuals, and their systems for paying the participants in the process. Therefore, two telephone interviews were conducted for each of the 15 states.

Site Visits. Site visits were conducted at seven community services boards. The Norfolk, Hampton/Newport News, Arlington, and Fairfax/Falls Church CSBs were visited because they are CSBs that reported large numbers of temporary detentions. The Hanover CSB was visited because their emergency custody and temporary detention transportation system had been identified as being effective. The District 19 and Central Virginia CSBs were visited because their catchment areas cover several cities and counties, both urban and rural. During the visits, JLARC staff met with emergency services workers and their supervisors to determine each CSBs role in prescreening for

the emergency custody and temporary detention processes, attending commitment hearings, and determining hospitalization for individuals under temporary detention orders. In addition, JLARC staff also met with the executive directors and/or the emergency mental health services directors of Colonial, Crossroads, Henrico, New River Valley, Norfolk, Prince William, and Richmond CSBs. JLARC staff also met with special justices in Petersburg, Lynchburg, Bedford County, and Campbell County and with magistrates in Lynchburg and Campbell County to determine their roles in issuing ECOs and TDOs.

Observation of Involuntary Commitment Hearings. JLARC staff observed more than 40 commitment hearings at nine different hospitals. Commitment hearings were observed at Central State Hospital, Charter Westbrook Hospital, Lynchburg General Hospital, the Medical College of Virginia, Peninsula Hospital, Poplar Springs Hospital, Richmond Memorial Hospital, Richmond Metropolitan Hospital, and Southside Regional Hospital.

Financial Data Review. Financial data were reviewed to determine the uses of the involuntary mental commitment fund, and Department of Medical Assistance Services' (DMAS) expenses for temporary detention periods for Medicaid recipients. To conduct this analysis, Supreme Court involuntary mental commitment fund data and DMAS Medicaid payment data were utilized.

The Supreme Court's involuntary mental commitment fund data were cross tabulated to determine total payments to each attorney; hospital; psychiatrist, psychologist, and physician; and special justice for the past three 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 compared these data to the Medicaid claims history database to determine the number and amount of Medicaid payments for these hospitalizations. DMAS staff were able to provide JLARC with individual claims data by social security number for each of the 69 Medicaid recipients in the sample.

In-Person Interviews. Structured interviews were also conducted with staff of the Department of Mental Health, Mental Retardation and Substance Abuse Services; Supreme Court of Virginia; Department of Medical Assistance Services; the Virginia Sheriffs' Association; the Virginia Association of Community Services Boards; and the director of regulatory and legal affairs and members of the Virginia Hospital Association.

Report Organization

This chapter has provided a brief overview of the involuntary commitment process and the JLARC review. Chapter II presents study findings regarding the administration of the involuntary mental commitment fund. Chapter III presents study

findings regarding the petition and pre-hearing detention of individuals thought to be mentally ill and in need of hospitalization. Findings regarding the legal procedures related to commitment hearings are presented in Chapter IV.

II. Costs of Involuntary Commitment

The General Assembly established the involuntary mental commitment (IMC) fund to pay for the medical and legal costs associated with the temporary detention period and the involuntary civil commitment hearings. The fund is administered by staff of the Supreme Court. Additional costs associated with the process, not covered by the fund, are borne by law enforcement, community services boards, and State mental health hospitals. In FY 1994, the fund was appropriated $12.2 million, of which more than $8.2 million was paid to private hospitals.

JLARC staff estimate that almost $1 million could be avoided annually in hospital payments from the fund, if more controls were placed on the fund and if policies regarding treatment of Medicaid recipients were developed. Since under the JLARC staff proposal the State would be paying 50 percent of the costs for the Medicaid recipients, rather than the involuntary mental commitment fund paying the total costs of the detention period, the savings to the fund would be larger than the savings to the State. However, JLARC staff estimate that with these proposed changes, the State could achieve annual cost savings of more than $500,000.

Given the fact that the number and complexity of hospital invoices are increasing, the substantial number of Medicaid recipients who are under temporary detention orders, and the need for more coordination between the two funding sources, the Supreme Court should "contract" with the Department of Medical Assistance Services (DMAS) to administer the hospital and medical portion of the fund. This change is proposed during a period when DMAS is undergoing significant changes. The movement of this portion of the fund to DMAS assumes that the department will retain many of its same procedures and processes.

While the medical and hospitalization portion of the fund should be moved, the Supreme Court should retain overall responsibility for the fund and continue to administer the payments for the involuntary civil commitment hearings participants. During the time this study was being conducted, the Supreme Court instituted some improvements on fund administration. However, additional oversight of fund payments is still needed to ensure efficient use of State funds.

MANAGEMENT OF THE INVOLUNTARY MENTAL COMMITMENT FUND

The amount appropriated the involuntary commitment fund has been steadily increasing over the last ten years, from $3.9 million in 1985 to $12.2 million in 1994. In the last three years, expenditures have increased from $8.5 million in 1992 to $12.2 million in 1994, or an increase of about 30 percent. Approximately 80 percent of the $3.7 million growth in the fund during these three years was due largely to increases in billings by hospitals. Hospitals received more than $8.2 million in fund payments in FY 1994.

The involuntary mental commitment fund is administered by the Supreme Court. However, Supreme Court staff view their role as one of processing invoices and payments. The Supreme Court has very few procedures to determine if hospitals are following statutory guidelines which require that the fund be used as a payment source only after all other payment sources have been exhausted.

Supreme Court Provides No Oversight of Payments for Hospital Care

In 1980, the General Assembly moved the administration of the involuntary mental commitment fund from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to the Supreme Court. According to department staff, the General Assembly moved the fund because it was thought that the majority of the payments would be related to the costs of the commitment hearings, which are paid at a predetermined per-hearing rate. The Supreme Court was thought to be a logical entity to make those payments. In recent years, however, the majority of the payments have been to hospitals and physicians.

The Supreme Court's fiscal unit administers the involuntary mental commitment fund. According to the accounts payable administrator, the staff do not routinely audit the medical invoices submitted for payment from the involuntary mental commitment fund. Their policy is to pay the established per-diem to hospitals submitting invoices for services reported as being provided individuals during the temporary detention period. The staff assume that the hospitals are adhering to the statutory provisions in Section 37.1-67.4 of the *Code of Virginia.* This section stipulates that all other sources of payment must be exhausted before submitting invoices for payment from the involuntary mental commitment fund. According to the administrator, the staff require that hospitals submit a copy of the temporary detention order and that a hospital representative sign the form stating that all other sources of payment have been exhausted.

The accounts payable unit has eight employees who process invoices for the four funds which the Supreme Court administers. According to the unit administrator, the involuntary mental commitment fund utilizes approximately 1.5 full-time equivalent positions, none of whom have medical expertise. Their experience with processing medical claims has been learned by processing the invoices for the involuntary commitment fund.

The Supreme Court staff do not perform any utilization review of the services provided. However, the staff acknowledge that utilization review is needed. JLARC staff were informed early in the review that the staff in the accounts payable unit are limited in their ability to effectively review hospital and medical invoices. The unit administrator cited an example of a physician billing the fund for 20 hours of therapy for an individual who was under a two-day TDO. Although the staff thought the bill was questionable, they did not "believe that they had the medical expertise to actually deny the physician's claim."

State Pays for Medicaid Recipients Detained at Hospitals That Are Not Medicaid Eligible

Medicaid, due to federal restrictions and regulations, does not pay for hospital inpatient services provided adult Medicaid recipients at free-standing psychiatric hospitals. Medicaid will pay for covered care provided within psychiatric units of acute care hospitals that are enrolled as Medicaid providers. (All acute care hospitals in Virginia are enrolled as Medicaid providers.)

Nineteen of the 40 CSBs reported that they regularly determine the individual's insurance coverage at the time the TDO is issued. These 19 CSBs use this information as a factor in determining where the individuals should be hospitalized. In the majority of the State, however, third party insurance and Medicaid status are not routinely identified. This has resulted in a substantial number of Medicaid recipients being hospitalized during the period of temporary detention in free-standing psychiatric hospitals rather than in psychiatric units of acute care hospitals. This situation may also occur if the CSB has a contract with a free-standing private psychiatric hospital to provide services for all individuals under TDOs in the locality. For example:

> *One CSB contracts with a private psychiatric group which is affiliated with a free-standing psychiatric hospital. This group decides where individuals under TDOs are hospitalized. Therefore, the CSB sends most of these patients to the free-standing private psychiatric hospital, regardless of whether the individual is a Medicaid recipient.*

As a result, Medicaid payments for hospital services during the temporary detention period cannot be obtained, and payments for hospital services must be provided by the involuntary mental commitment fund. JLARC staff estimate that more than $737,000 in payments from the fund could have been avoided in FY 1993, if Medicaid status had been used to determine where individuals were detained during their temporary detention periods. The State could have avoided $368,500 in costs as State funds cover approximately 50 percent of the Medicaid claim. However, if the involuntary mental commitment fund is used to fund the costs of the Medicaid recipient's co-payment ($100 per hospitalization), the net savings to the fund and the State would be $652,273 and $326,137, respectively.

Methodology to Estimate Cost Savings. If the State implemented a policy to ensure that Medicaid recipients were placed in hospitals enrolled as Medicaid providers, considerable cost savings could be achieved. To estimate how much cost savings could result from this policy change, JLARC staff randomly sampled 359 of the 7,661 TDO invoices paid by the Supreme Court in FY 1993 and performed analyses projecting total cost savings from the sample. (Since these analyses relied on sample data, each estimate has some sampling error associated with it. The sample error and calculations for each estimate can be found in Appendix E).

The sample was used to identify if any of the payments were made on behalf of Medicaid recipients. The invoices were matched against Medicaid recipient files to

identify those persons who had been under temporary detention orders and who had Medicaid coverage. This comparison indicated that 69 of the 359 invoices in the sample (approximately 20 percent) were receiving Medicaid coverage at the time of their confinement on a temporary detention order. Forty of these invoices involved individuals who were eligible for Medicaid reimbursement if they were detained in a facility which was enrolled as a Medicaid provider. However, these forty individuals received their services during the temporary detention period in free-standing psychiatric hospitals so that the State paid for the entire period of hospitalization. The cost of care for these forty individuals in facilities which were not Medicaid providers was more than $34,000.

According to federal regulations, recipients who are hospitalized in Medicaid-enrolled hospitals are responsible for a $100 co-payment for each hospitalization. If it were decided that the involuntary mental commitment fund would be responsible only for the Medicaid patient's co-payment, the net savings to the fund for the sample would have been more than $30,000. In effect, the cost savings to the fund can be calculated by projecting from the sample of 359 to the total population of 7,661 invoices and subtracting the cost of the co-payment. The cost savings to the State could be calculated in the same manner, with the additional step of subtracting the portion of the payment which is the State's share (this is generally 50 percent).

Implications of Potential Cost Savings. The locations of acute care hospitals with psychiatric units and free-standing psychiatric hospitals appear to be in fairly close proximity (Figure 4). Further, given the number of beds available in the psychiatric units of acute care hospitals, it should be possible to place most Medicaid recipients under TDOs in psychiatric beds in acute care hospitals.

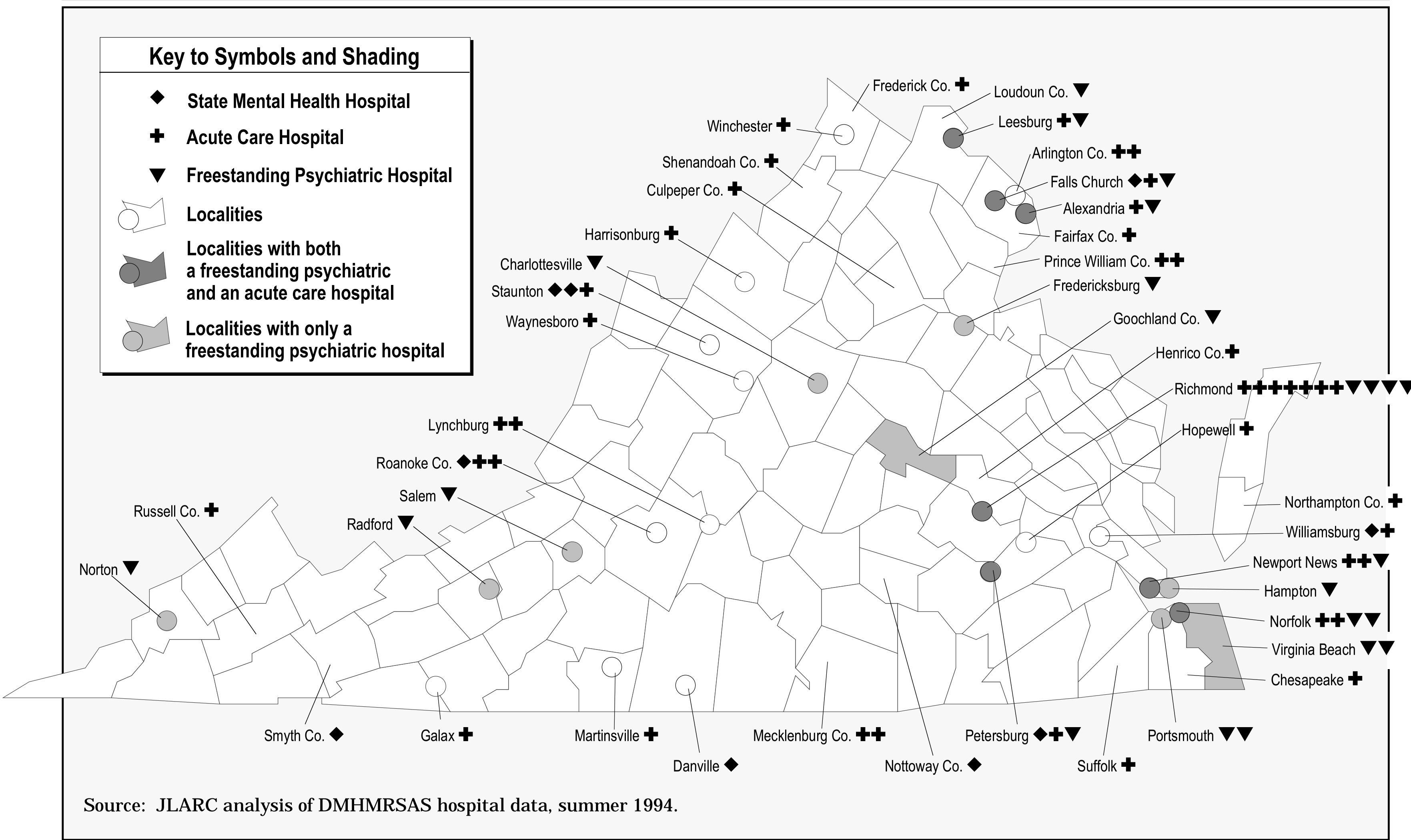
Transportation costs are also higher when free-standing psychiatric hospitals are used for Medicaid recipients who are committed at the hearings. If committed, they would have to be transferred, since the free-standing psychiatric hospitals do not accept involuntarily committed patients who do not have private insurance. Individuals who are sent to these hospitals under temporary detention orders and then subsequently committed must be committed to a psychiatric unit of an acute care hospital. The sheriff must then move the individual from one facility to another, which is a cost borne by the sheriff's department. In addition, the patient suffers from having to adjust to two facilities during a relatively short period of time.

Given both the cost savings to the fund and to the sheriffs' offices, as well as the therapeutic benefit of continuity of treatment, CSBs should determine Medicaid coverage prior to the order for temporary detention. Whenever possible, Medicaid recipients should be hospitalized in facilities that are enrolled as Medicaid providers for their TDO periods. Bed space availability in some areas of the State may sometimes be problematic. However, use of free-standing psychiatric hospitals for the Medicaid population should be the exception, not the normal practice.

CSB staff should determine an individual's insurance situation as part of the prescreening for a TDO. In addition, Medicaid recipients should not be sent to free-

Figure 4

Location of Hospitals Providing Mental Health Care, by Type



Source: JLARC analysis of DMHMRSAS hospital data, summer 1994.

standing private psychiatric hospitals, unless there are no other beds available locally, or the individual requires specialized treatment that is only available at a certain facility.

Recommendation (1). **The Supreme Court should revise the Mental Temporary Detention Order (Form DC491) which directs the hospitalization site for individuals who are under temporary detention orders. The form should include information on insurance coverage as well as Medicaid status for the individual. This information should be available to the individual making the hospitalization decision. Whenever possible, individuals who are Medicaid recipients should be hospitalized for the temporary detention period in a facility which is enrolled as a Medicaid provider.**

Recommendation (2). **The General Assembly may wish to amend Section 37.1-67.1 of the *Code of Virginia* to require community services boards, as part of the prescreening for all temporary detention orders, to determine the individual's insurance situation.**

Recommendation (3). **The General Assembly may wish to amend Section 37.1-67.1 of the *Code of Virginia* to require individuals under temporary detention orders, who are Medicaid recipients, to be placed in hospitals that are eligible to receive Medicaid payments, for the temporary detention period. Only if no local beds are available, or if the individual requires specialized treatment, may individuals be placed in hospitals that cannot accept the individual's insurance.**

Hospitals Found to be Billing Erroneously for Services During Temporary Detention Period

As noted, the *Code of Virginia* requires hospitals to exhaust all other sources of payment prior to billing the involuntary mental commitment fund for services provided during the temporary detention period. However, the Supreme Court has no procedures to systematically audit hospital bills to ensure that all possible third party insurance sources have been billed. Further, the staff have no procedures to determine if the hospital has accounted for all other sources of payment prior to billing the Supreme Court. According to the accounts payable supervisor, Supreme Court staff assume that the bill is accurate if a hospital representative signs the statement to that effect on the form.

The JLARC staff analysis of hospital payments revealed two problems with hospital billing that could have cost the fund more than $343,175 in FY 1993. Again, the actual savings to the fund would have been more than $388,000. However, the additional costs of the co-payment for Medicaid recipients would reduce the savings to more than $343,175. This is in addition to the savings in avoidable fund payments discussed in the previous section.

First, JLARC staff estimate that the fund paid almost $318,000 to hospitals for inappropriate charges in FY 1993. These payments were for individuals who were Medicaid recipients and Medicaid was not billed prior to the hospitals billing the involuntary mental commitment fund. Assuming that the co-payment would be paid by the fund the net savings to the fund would have been $273,175. Second, JLARC staff estimate that in FY 1993, Supreme Court staff paid more than $70,000 for invoices which hospitals submitted for payment to both the involuntary mental commitment fund and DMAS.

To determine the magnitude of the inappropriate charges, JLARC staff used the random sample of involuntary mental commitment invoices referenced previously. Twenty-one of the invoices in the sample involved individuals who were Medicaid recipients who were detained in nine facilities enrolled as Medicaid providers. These providers did not submit Medicaid claims to DMAS for reimbursement for hospital services provided to these individuals, however. Instead these providers billed the Supreme Court for hospital services. Nine hospitals submitted invoices totaling almost $15,000 to the Supreme Court for payment for services provided to 21 Medicaid recipients. These invoices should not have been billed to the fund but submitted to DMAS as Medicaid claims for payment. Therefore, if the problem exists in the same magnitude in the unsampled group, then fund savings would be either approximately $318,000 without the co-payment or $273,175 with the co-payment. Again, the figure was calculated by projecting from the sample of 359 to the total population of 7,661.

The same sample of invoices involving the 21 Medicaid recipients contained seven examples of duplicate billing and six examples of duplicate billing and payment. The seven examples of duplicate billing totaled $4,676 and the duplicate payment totaled $3,298 for the sample. This amount projected to the population produces an estimate of an additional $70,000 in fund savings. Examples of duplicate billing include:

> *One hospital was responsible for three of the six instances of duplicate billing. The hospital inappropriately billed the fund for almost $2,300 and was paid more than $1,300 from the fund for those bills. In these examples, individuals were treated within the same hospital during both their TDO period and their involuntary civil commitment period. The hospital then submitted claims to DMAS for the entire length of stay and an invoice to the Supreme Court for the temporary detention period. Both of the funds paid, resulting in the hospital receiving a duplicate payment for each of the individuals for either one or two days, depending on the duration of the TDO.*

* * *

> *Another hospital billed and received payment for nearly $1,000 from the fund for services which should not have been billed to the fund but billed to Medicaid. An individual who was also a Medicaid recipient was detained at this hospital under a two-day temporary detention*

order. The special justice involuntarily civilly committed the individual to the same hospital. The individual was in the hospital a total of seven days. The hospital billed DMAS for seven days and the involuntary mental commitment fund for two days. Both paid the entire bill, resulting in a duplicate payment of nearly $1,000 to the hospital.

* * *

A third hospital received nearly $500 in duplicate payments from the involuntary mental commitment fund and Medicaid. Again, the individual was a Medicaid recipient who was involuntarily committed to the same facility that was used during the TDO period. The individual was in the hospital for a total of seven days. The hospital billed the involuntary mental commitment fund for two days and billed DMAS for six days. Both paid, resulting in a duplicate payment for one day of hospitalization.

* * *

A fourth hospital billed both the involuntary mental commitment fund and DMAS more than $500 for one day of detention for a Medicaid recipient. The individual was in the hospital for one day on a TDO and was then released by the special justice. The hospital billed both the Supreme Court and DMAS for the one day and both paid the standard per-diem charge for the same one day.

There needs to be coordination between the two sources of payment — Medicaid and the involuntary mental commitment fund — to ensure that instances of inappropriate billing and payment are identified and corrected. The Supreme Court staff should develop instructions for hospitals telling them the procedures for the return of funds which are the result of payments received on bills which the hospitals submitted erroneously.

Recommendation (4). **The Supreme Court staff should revise the forms which are submitted by hospitals to include information on the insurance status of individuals who are under temporary detention orders. The form should instruct hospitals to check types of insurance coverage for each temporary detention order invoice submitted for payment. In addition, the Supreme Court staff should develop written procedures for hospitals to use to ensure that all third-party sources of payment have been exhausted prior to request for payment. Further, the Supreme Court should develop and disseminate guidelines to hospitals which direct the procedures hospitals should use for returning payments to the fund if a third party payment is received subsequent to the payment received by the hospital from the Supreme Court.**

Management of the Medical Portion of the Involuntary Commitment Fund Should Be Moved to the Department of Medical Assistance Services

Inefficiencies exist in the current oversight of the hospital and medical portion of the involuntary mental commitment fund. Many of the deficiencies in the current system for paying for detention-related hospital services stem from the lack of specialized training and knowledge on the part of those paying the medical invoices billed to the fund. The Department of Medical Assistance Services, however, is proficient and experienced in processing and auditing medical invoices. Therefore, the Supreme Court, while continuing to maintain overall responsibility for the involuntary commitment fund, should contract with the Department of Medical Assistance Services to process the hospital and medical claims associated with this fund. Placing the administration of the hospital and medical portion of the IMC fund within DMAS would facilitate coordination between the IMC fund and Medicaid payments and provide for better oversight of the services rendered.

In keeping with their primary function, Supreme Court staff are more proficient in processing invoices related to the court system than in processing hospital and medical invoices. Consequently, the Supreme Court must rely on DMAS for some assistance in evaluating medical payments. DMAS provides the Supreme Court with the reimbursement rates for per-diem expenses for each of the participating hospitals. DMAS also gives the Supreme Court a listing of procedures which hospitals may be reimbursed for providing. The Supreme Court also contacts DMAS when technical questions arise, such as how to handle medical co-payments. Supreme Court staff reported difficulty in getting some of their questions answered by DMAS staff in a timely manner, but could provide no documentation of the problem.

In addition to the information and assistance DMAS currently provides, there are other activities that DMAS could undertake to reduce IMC fund expenditures. As noted previously, a number of the individuals who are held on TDOs are also Medicaid recipients. Currently there is no coordination or cross-checking of the fund with other payment sources to ensure that temporary detention stays for Medicaid recipients are being referred to DMAS (who acts as the third-party payer) as required in Section 37.1-67.4 of the *Code of Virginia*. This lack of coordination has resulted in the IMC fund being used inappropriately and even double payments being made from the IMC fund and DMAS. Placing the hospital and medical payment portions of the IMC fund within DMAS would simplify the process of coordinating payments for Medicaid services and temporary detentions to ensure that these types of problems do not continue.

DMAS staff would also be able to provide better oversight of the services provided by initiating utilization reviews and audits similar to those currently completed for Medicaid bills. Utilization reviews ensure the needed care is being provided at the lowest possible cost. Utilization review involves monitoring the use of services to: (1) guard against unnecessary or inappropriate use by individuals, and (2) prevent excess payments to providers for services.

If the hospital and medical portion of the IMC fund is administered by DMAS, two full-time positions are needed by DMAS to accommodate the increased workload and to provide for additional utilization review for the additional hospital bills. Therefore, DMAS should have its maximum employment level increased by two employees. One position should be transferred from the Supreme Court. The other should be covered by the projected savings to the fund.

Some procedural differences would also be needed to accommodate IMC fund requirements. For instance, currently DMAS does not conduct a utilization review of any hospital stay as short as two days. However, the TDO hospitalization period usually only lasts one or two days, so under the current DMAS system of evaluating bills invoices to the IMC fund would not be routinely audited.

Recommendation (5). **The General Assembly may wish to direct the Supreme Court to transfer a portion of the involuntary mental commitment fund to the Department of Medical Assistance Services for payment and oversight of hospital and medical services related to temporary detentions. Using the FY 1994 figures as a guideline, approximately 76 percent of the funding for FY 1996 could be expected to be spent for hospital and medical services.**

Recommendation (6). **The General Assembly may wish to increase the maximum employment level at the Department of Medical Assistance Services by two full-time employees. One position should be transferred from the Supreme Court. The other should be covered by the projected savings to the fund.**

PAYMENTS TO COMMITMENT HEARING PARTICIPANTS

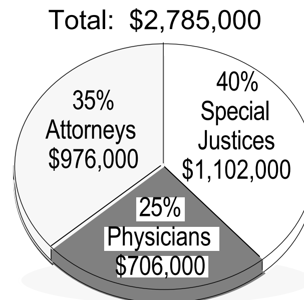
The hearings portion of the involuntary mental commitment fund compensates special justices, attorneys, psychiatrists, psychologists, and physicians for their participation in involuntary commitment hearings. Commitment hearing participants submit involuntary admission hearing invoices to the Supreme Court to receive payment.

Hearing fees are paid on a per-hearing basis. For each preliminary, commitment, and re-commitment hearing, special justices receive $28.75 while attorneys, psychiatrists, psychologists, and physicians receive $25.00. In addition, these individuals are reimbursed for expenses incurred as part of the commitment hearing. In FY 1994, $2.8 million were spent on payments to individuals participating in involuntary commitment hearings. Most of these payments were to special justices (Figure 5).

While Supreme Court staff do not have the expertise to administer the medical and hospitalization payments from the involuntary mental commitment fund, they do have the expertise to administer the payments to commitment hearing participants. Supreme Court staff currently administer three other funds totaling more than $154 million. Further, Supreme Court staff have recently implemented several controls

Figure 5

Payments to Involuntary Commitment Hearing Participants, FY 1994



Note: Numbers do not add due to rounding.

Source: JLARC analysis of Supreme Court involuntary mental commitment fund data, summer 1994.

to monitor payments to commitment hearing participants. The administration of payments to commitment hearing participants should remain with the Supreme Court. However, Supreme Court staff need to implement additional controls to ensure that funds are disbursed appropriately.

Administration of Commitment Hearing Payments Should Remain with the Supreme Court

Supreme Court staff have the expertise necessary to administer the payments made to involuntary commitment hearing participants, and have recently begun implementing several controls over these payments. These controls include maintaining a list of special justices who have signed oaths to be special justices, requiring a judge or special justice to sign all invoices, and implementing computer edits to help ensure that commitment hearing participants are reimbursed the appropriate rate.

The Supreme Court maintains an automated list of all special justices who have a special justice oath on file and will only pay the individuals who are on this list. The computer system installed by the Supreme Court during FY 1994 includes edits to ensure that a special justice submitting an invoice is one that has submitted an oath.

The Supreme Court also requires a judge or special justice to sign all invoices submitted by individuals participating in commitment hearings. According to the accounts payable administrator, the Supreme Court will not pay an individual if the invoice is not signed by a judge or special justice.

Further, the Supreme Court has recently implemented edits to help ensure that commitment hearing participants are reimbursed according to the appropriate rate.

Databases for FY 1992 and FY 1993 provided by the Supreme Court to JLARC included several data entry errors. Some individuals were listed in the files, which are organized by hearing role, who did not perform the hearing role specified by the file. For example, several attorneys and psychiatrists were listed in the special justice file. However, payments were made with a separate coding system, and JLARC staff review of the Supreme Court databases revealed that no participants appeared to be reimbursed at an incorrect rate. As part of the installation of the computer system in FY 1994, Supreme Court staff implemented additional edits to help ensure that participants are reimbursed appropriately, and to improve the accuracy of the database.

Additional Oversight is Needed

While the installation of a new computer system has enabled the Supreme Court to implement additional controls over involuntary commitment hearing payments, further oversight is needed. Specifically, the Supreme Court needs to conduct periodic reviews to ensure that commitment hearings reported have actually been held, and to provide instructions to special justices for the completion of the invoices.

Currently, the only assurance the Supreme Court has that a hearing has been held is that the invoice must be signed by a judge or special justice. In fact, the Supreme Court has made payments in the past to individuals for hearings that were not held. For example:

A special justice was issuing temporary detention orders, but not conducting commitment hearings. He, therefore, should not have billed or received reimbursement for duties performed. However, Supreme Court staff reported that this special justice received payment from the involuntary mental commitment fund by reporting the issuing of temporary detention orders as preliminary hearings. When Supreme Court staff discovered what was happening, they informed the special justice that this practice was improper and could be interpreted as fraud, and that they would no longer reimburse the special justice for issuing temporary detention orders.

* * *

Three other special justices reported that until 1990, special justices were paid for issuing temporary detention orders. They indicated that special justices were paid $25 for each TDO issued. This was the same amount paid for conducting preliminary and commitment hearings at that time. One of the special justices reported that they used to get paid by a "loop in the process" for "informal hearings in the field," which actually involved the issuing of temporary detention orders.

Further, several special justices responding to the JLARC survey misinterpreted the question regarding the number of preliminary hearings held and actually

indicated the number of temporary detention orders issued. Sixty-one percent of the special justices who responded to the JLARC survey issue temporary detention orders. Therefore, instructions need to be provided to special justices clarifying what issuing a temporary detention order involves and indicating that special justices cannot be reimbursed for issuing temporary detention orders.

The accounts payable administrator for the Supreme Court reports that since the Supreme Court began administering the involuntary mental commitment fund in 1982, staff have never knowingly paid for temporary detention orders. Further, the involuntary admission hearing invoices from FY 1993, that JLARC staff reviewed, revealed that none of the special justices who only issued temporary detention orders were paid from the fund. However, the accounts payable administrator also indicated that Supreme Court staff do not verify that the preliminary and commitment hearings indicated on the invoices have actually been held. Therefore, the Supreme Court needs to provide instructions to special justices regarding the completion of the involuntary admission hearing invoices, and periodically check to verify that preliminary and commitment hearings have actually been held by cross referencing the invoices from the various participants in the hearings.

Recommendation (7). **The Supreme Court of Virginia should provide instructions to all special justices regarding the completion of the involuntary admission hearing invoice. The instructions should clarify the meanings of temporary detention orders, and preliminary and commitment hearings. The instructions should also indicate that the involuntary mental commitment fund will not pay for temporary detention orders issued.**

Recommendation (8). **The Supreme Court of Virginia should conduct periodic reviews of the involuntary admission hearing invoices to verify that preliminary and commitment hearings indicated have actually been held. These reviews should consist of contacting special justices to ensure that the special justices have completed the invoices with an understanding of the instructions provided. Supreme Court staff should also contact attorneys, physicians, and psychiatrists to confirm information submitted by special justices on the invoices.**

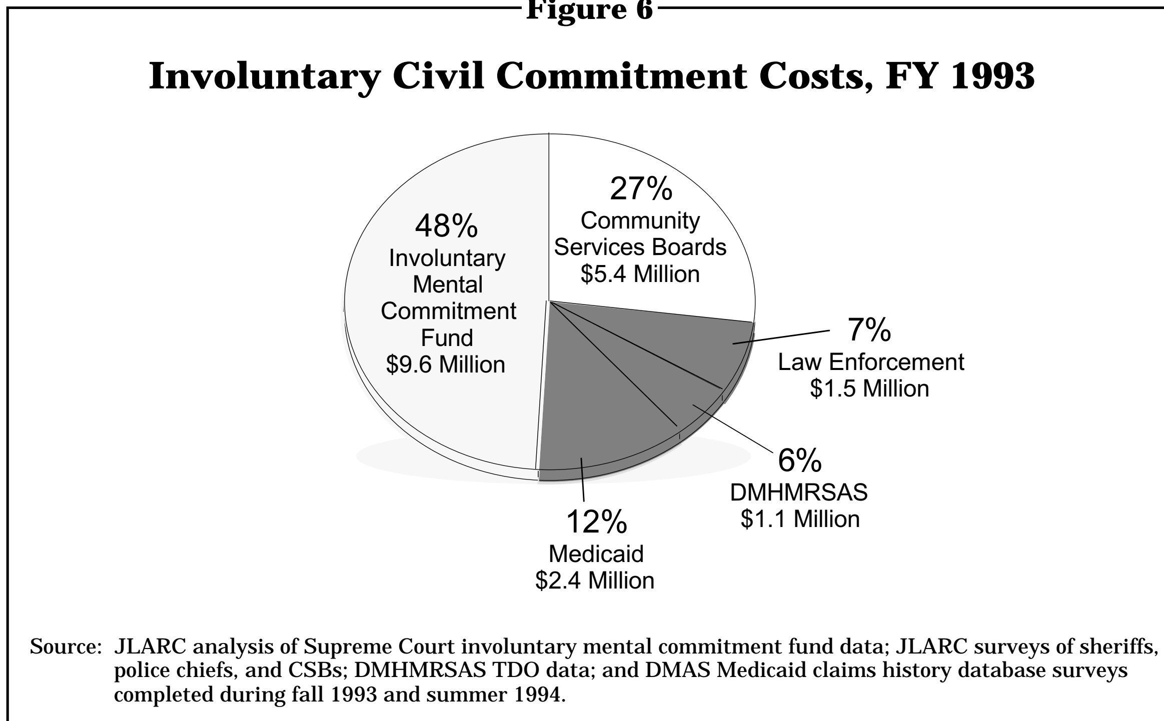
ADDITIONAL COSTS OF THE INVOLUNTARY COMMITMENT PROCESS

As previously indicated, private hospitals, psychiatrists, psychologists, physicians, special justices, and attorneys receive payments from the involuntary mental commitment fund for activities related to the involuntary commitment process. However, there are additional costs of the involuntary commitment process. Law enforcement departments, State mental health hospitals, and community services boards also incur costs related to the process. For this study, JLARC staff sought estimates of the total costs of the involuntary civil commitment process. This effort was begun for the interim JLARC report, and produced an estimate for the total costs for FY 1993.

In FY 1993, $9.6 million was disbursed from the IMC fund. In addition, $2.4 million in State Medicaid funds were expended. Also law enforcement departments, State mental health hospitals, and community services boards reported that they spent an additional $8.2 million in FY 1993 for activities related to the involuntary commitment process (Figure 6).

Figure 6

Involuntary Civil Commitment Costs, FY 1993



Source: JLARC analysis of Supreme Court involuntary mental commitment fund data; JLARC surveys of sheriffs, police chiefs, and CSBs; DMHMRSAS TDO data; and DMAS Medicaid claims history database surveys completed during fall 1993 and summer 1994.

While law enforcement officers do not charge individuals for services provided related to the involuntary commitment process, most community services boards charge individuals for the services they provide. A concern can be raised as to the appropriateness of this practice. It is questionable whether community services boards should charge individuals for services provided once the temporary detention process begins, because these services are being provided to individuals against their will, and the involuntary mental commitment fund was created to assume the costs for individuals being detained involuntarily.

Law Enforcement Costs

The 114 responding sheriffs and 44 responding police chiefs reported they spent an estimated $1.5 million making 18,000 mental health transports in FY 1993. Ninety-five percent of these costs involved salaries and overtime paid to deputies and officers conducting transports, and mileage costs for these transports. Law enforcement departments are not reimbursed specifically for duties performed by officers related to involuntary commitment, and individuals receiving the services are not charged.

State Mental Health Hospital Costs

JLARC staff estimate that the Department of Mental Health, Mental Retardation and Substance Abuse Services spent $1.1 million for 2,356 patients admitted to State mental health hospitals under temporary detention orders in FY 1993. DMHMRSAS staff do not specifically calculate expenditures for patients under temporary detention orders. Therefore, JLARC staff estimated these costs. The estimate was derived by multiplying the number of patients under temporary detention orders admitted by State mental health hospitals in FY 1993 (2,356) by the average daily cost at State mental health hospitals for FY 1993 as reported by DMHMRSAS ($237.46), by the typical length of stay for temporary detention (2 days). Costs for hospitalizing and treating these patients are in addition to the involuntary mental commitment fund.

The State mental health hospitals charge individuals who are temporarily detained and involuntarily committed to a State mental health hospital for hospitalization and treatment during the temporary detention and the commitment periods. Individuals who are temporarily detained who then voluntarily admit themselves to a State mental health hospital are also charged for these services. Individuals who are temporarily detained but are released from a State mental health hospital following the detention period are not charged for services provided during the detention period. Individuals are charged a per diem amount based on Medicaid reimbursement rates. However, DMHMRSAS staff reported that actual collections are based on a sliding scale according to the patient's ability to pay.

Community Services Board Costs

The 40 community services boards estimated that they expended more than $5.4 million in FY 1993 on the involuntary commitment process. Eighty-five percent of this expenditure was for personnel costs including overtime associated with providing services to individuals being placed under emergency custody and temporary detention orders. DMHMRSAS allocated $7.2 million in State funds to CSBs in FY 1993 to provide the emergency services they are statutorily required to provide.

Thirty-four community services boards reported that they charge individuals for prescreening evaluations when a temporary detention order is requested. Further, 14 community services boards reported that they charge individuals for time spent participating in involuntary commitment hearings. Most community services boards reported that individuals are charged on a sliding scale, based on the individual's ability to pay. Therefore, indigent individuals are not expected to pay. JLARC staff were not able to determine the amount collected by community services boards from individuals charged for these services because no aggregated data are available on these revenues.

Department of Medical Assistance Services and community services board staff reported that community services boards began charging individuals for these services in 1990. Since 1975, federal Medicaid funds have been provided to eligible service providers for covered services, as long as all individuals receiving services are charged.

If the service is provided to some individuals at no charge, Medicaid cannot be billed. However, the charge could be based on a sliding scale basis. This method charges individuals based on individual income. In 1990, a pay schedule was set up so that community services boards could receive Medicaid funds for emergency services provided to Medicaid recipients.

This appears to be an effective way for community services boards to receive additional funds for some of the emergency services they provide. However, the involuntary mental commitment fund appears to reflect a State policy commitment to eliminate the individuals' responsibility to pay for involuntary detention. A case can be made that the policy commitment should also be reflected at the local level. Therefore, once emergency custody or temporary detention is initiated against an individual's will, the individual should not be charged by a CSB for any subsequent services. Community services boards should only be charging individuals for time spent conducting initial mental status examinations in response to an emergency situation. Community services boards should not be charging individuals for time spent participating in involuntary commitment hearings. According to DMAS staff, CSB staff participation in the involuntary commitment hearings is not a Medicaid covered service and should not be billed to Medicaid for reimbursement. Therefore, not allowing the CSBs to bill individuals for participation in the hearings should not result in a loss of Medicaid payments.

Recommendation (9). **The General Assembly may wish to amend Section 37.1-197 of the *Code of Virginia* to prohibit community services boards from charging individuals for time spent participating in involuntary commitment hearings.**

III. Petition and Pre-Hearing Detention

The *Code of Virginia* provides that if there is probable cause to believe that an individual is mentally ill and in need of hospitalization, that individual may be involuntarily detained at an inpatient hospital for up to 96 hours, which is the temporary detention period. However, the statutory provisions do not provide sufficient detail to ensure uniformity in the process. As such, there is significant variation across the State in the implementation of this process. In most localities, temporary detention procedures have been developed that emphasize individual rights and efficiently provide services for individuals in need of involuntary commitment and treatment. However, this review has identified three problems with the detention process in some areas due to differing interpretations of statutory language.

First, in some parts of the State detention orders are being written without the involvement of mental health professionals, by special justices who have no training in the diagnosis of mental illness. This results in the detention of individuals who may not need hospitalization, may not be mentally ill, and who could be treated in a less restrictive environment than an in-patient hospital.

Second, the process is not always utilized as intended because the detention criteria are more broad than the commitment criteria. Further, there are no alternatives for detaining serious substance abusers. This results in individuals being detained who may not meet commitment criteria.

Third, in some areas hospitalization decisions for detention periods are being made by special justices who are not considering the treatment needs and the insurance coverage of the individual. Consequently, State funds are not being utilized efficiently, and individuals may not always be receiving the most effective treatment.

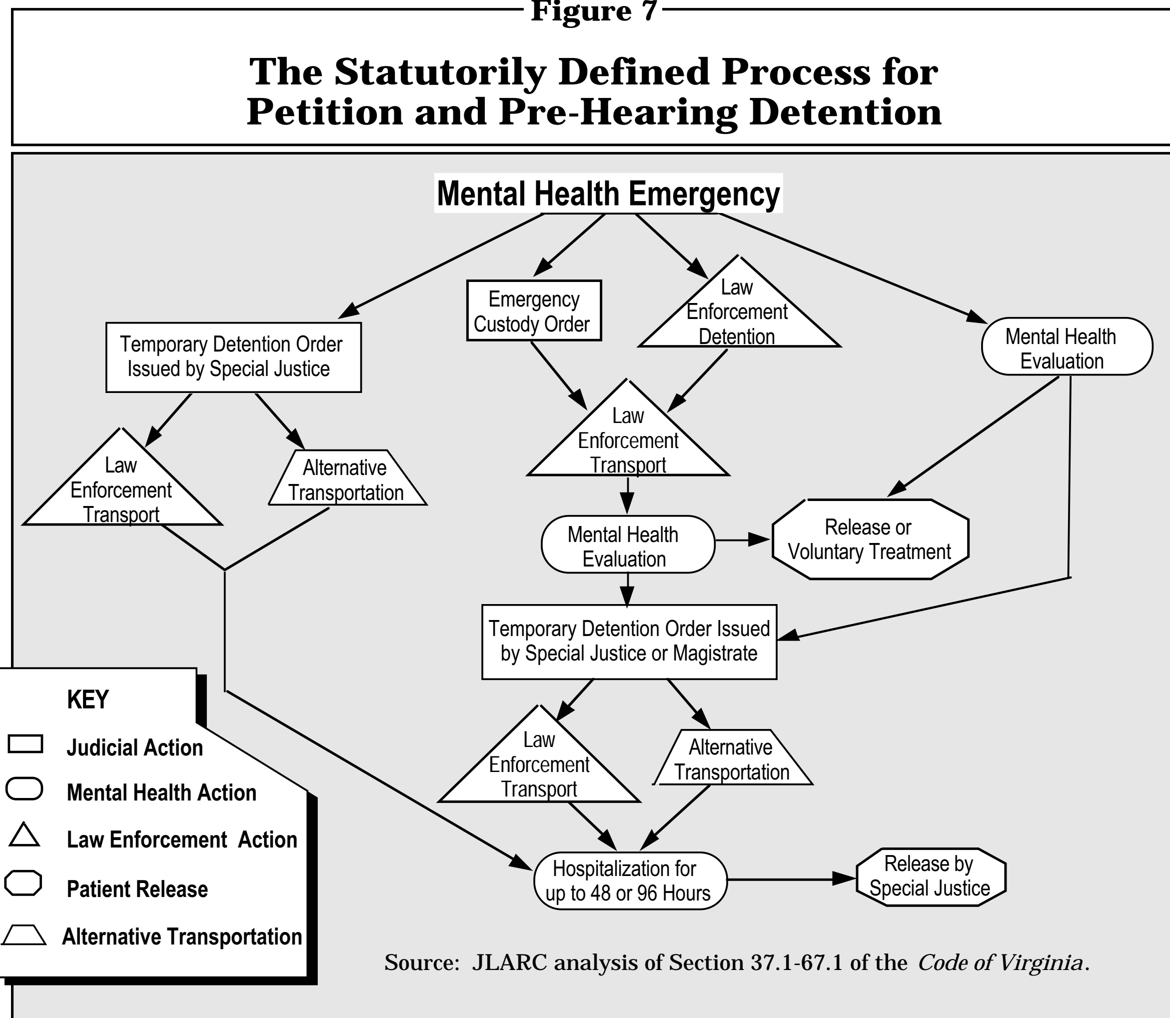
While it was not possible to determine exact cost savings, improving the efficiency of the process should reduce the cost of detaining and treating these individuals. Further, the burden placed on law enforcement departments with officers responding to mental health emergencies and providing transportation for temporary detention, could also be significantly reduced if the involuntary commitment process was more efficient.

EMERGENCY CUSTODY AND TEMPORARY DETENTION ORDERS

Section 37.1-67.1 of the *Code of Virginia* outlines the process by which adults in Virginia who are suspected to be mentally ill and in need of hospitalization may be involuntarily detained and held for up to 96 hours prior to a commitment hearing (Figure 7). Individuals may be involuntarily detained under an emergency custody or a temporary detention order. An emergency custody order requires an individual to be

Figure 7

The Statutorily Defined Process for Petition and Pre-Hearing Detention



Source: JLARC analysis of Section 37.1-67.1 of the *Code of Virginia*.

detained for up to four hours for a mental health evaluation, while a temporary detention order allows an individual to be detained for up to 96 hours for an involuntary commitment hearing.

However, interpretation of the statutory provisions allows for significant variation in the way the detention process operates around the State. Consequently, there are some instances in which there may be violations of individual rights, and other situations in which the process does not operate efficiently.

In some areas, individuals are involuntarily detained without the involvement of any mental health professional. In these localities, attorneys who have been appointed as special justices, but may have limited legal experience and no mental health training, are issuing detention orders. The temporary detention process needs to be improved to ensure that all TDOs are prescreened by CSB staff prior to issuance, and to ensure that all TDOs are issued by magistrates who are adequately trained in the issuance of these orders.

Further, the efficiency of the process needs to be improved. The *Code of Virginia* criteria for emergency custody and temporary detention are too broad to ensure that only individuals who are substantially mentally ill and who meet involuntary commitment criteria are detained. In addition, other individuals may be detained under the commitment statutes due to substance abuse problems, even though there may be no other evidence of mental illness. As a result, some individuals are being detained in psychiatric units who are not likely to benefit from the treatment provided there during the detention period. Law enforcement officers must transport most of these individuals, which causes unnecessary resource constraints on sheriffs' offices and some police departments. Amendments to the *Code of Virginia* are needed to protect the rights of all individuals and to ensure that the process is used as intended.

Community Services Boards Need to Prescreen All TDOs

Section 37.1-67.1 of the *Code of Virginia* currently requires magistrates to obtain the advice of a mental health professional, who has evaluated the individual in-person, prior to the issuance of a temporary detention order. This section of the *Code of Virginia* does not require this advice for special justices issuing TDOs. However, a face-to-face evaluation of an individual by a mental health professional prior to the issuance of a temporary detention order should be required because this review has found that many TDO requests are inappropriate.

In some areas, mental health professionals are not available to provide in-person evaluations, and special justices in these areas are issuing temporary detention orders without the involvement of a mental health professional. Section 37.1-194 of the *Code of Virginia* requires community services boards to provide emergency services within their catchment area. To ensure that only individuals who are substantially mentally ill and need hospitalization will be detained, community services board staff should, as part of the emergency services they are required to provide, prescreen all temporary detention orders by providing in-person mental health evaluations.

CSB staff report that not all emergency situations involve mental illness, and not all emergency situations involving mental illness meet the criteria for a temporary detention order. Consequently, a high percentage of special justices and magistrates indicate that inappropriate TDOs are sometimes requested by family members, adult homes, and nursing homes (Table 2). These data suggest that this is a widespread issue, not limited to just a few localities.

Further, staff from all seven of the CSBs visited by JLARC staff reported that inappropriate TDOs are sometimes sought by family members and friends. For example:

> *Staff from six of the CSBs visited by JLARC staff reported that family members or neighbors may request a TDO on an individual to have them removed from the home or neighborhood, possibly because there has been an argument. In addition, sometimes a TDO may be requested*

Table 2

Inappropriate TDO and Involuntary Commitments Sometimes Requested by Families and Adult Homes

Statement: *TDOs or involuntary commitments are sometimes sought by family members to address behavior that does not involve mental illness, dangerousness, or inability to care for self.*

	Agree	Disagree
Magistrates (N=257[a])	**95%**	**5%**
Special Justices (N=77[b])	**94%**	**6%**

Statement: *TDOs or involuntary commitments are sometimes sought by adult homes or nursing homes to address behavior that does not involve mental illness, dangerousness, or inability to care for self.*

	Agree	Disagree
Magistrates (N=213[c])	**72%**	**28%**
Special Justices (N=68[d])	**68%**	**32%**

[a] 268 magistrates responded to the JLARC survey; however, 257 responded to this question.

[b] 80 special justices responded to the JLARC survey; however, 77 responded to this question.

[c] 268 magistrates responded to the JLARC survey; however, 213 responded to this question.

[d] 80 special justices responded to the JLARC survey; however, 68 responded to this question.

Source: JLARC surveys of special justices and magistrates, spring 1994.

because an individual needs mental health treatment, but has no mode of transportation.

* * *

Staff from one CSB reported that the individual making the request for a TDO of a family member or friend may actually be the one that needs mental health treatment. The emergency services worker reported that until the mental health worker evaluates the individual face-to-face, it is difficult to determine if a TDO is necessary.

Staff from two of the CSBs visited by JLARC staff also reported problems with adult homes requesting inappropriate TDOs. For example:

CSB staff in one city, which has a large number of adult homes, reported significant numbers of inappropriate TDO requests by adult homes. The CSB staff reported 34 percent of all commitment hearings during May, June, and July 1994 involved adult home residents, which they consider to be a significant amount. The CSB staff also reported that

some adult home owners in this area also provide the psychiatric services and receive payment for these services during the temporary detention periods.

* * *

Staff from another CSB reported that there is an adult home in their catchment area that will petition for a TDO for a resident who is somewhat difficult, and then fill that bed prior to the resident's commitment hearing. Subsequently, if the resident is released following the commitment hearing, the adult home would not accept the individual back because there may be no beds available. CSB staff report that the adult home may be doing this to remove individuals who are difficult.

Augmenting the problem that a significant number of TDO requests are inappropriate, is the fact that in several localities CSB staff do not prescreen all temporary detention orders within their catchment area (Table 3). To some extent, this occurs because private psychiatrists and psychologists are requesting TDOs. However, in some areas of the State, mental health professionals are not available, and special justices are conducting evaluations, and issuing temporary detention orders without the involvement of any mental health professional. These special justices report that they have had no mental health training. Further, in one area a special justice reported that attorneys in the area who have the least legal experience are appointed to perform these duties.

Situations in which individuals are detained without the involvement of a mental health professional appear to be occurring in rural areas. For example:

One CSB has contracted with staff at a local hospital to provide emergency services, which includes prescreening of temporary detention orders, for the catchment area. The contract staff provide all services at the hospital. The CSB catchment area includes several rural counties and a city. However, the contract staff reported that they are not able to prescreen TDOs issued outside the city. Further, while the CSB has branch offices in all the counties, the CSB does not have staff in these offices to provide prescreening, and special justices report that there are no mental health professionals available to provide prescreening services in these counties. Therefore, special justices in these counties are issuing TDOs, without the involvement of a mental health professional. Some of these special justices will accompany or meet a law enforcement officer at a particular location, such as a person's home, and decide whether to issue a TDO to the hospital. Other special justices will decide based on a telephone call from a family member or law enforcement officer whether to issue a TDO. These special justices do not conduct commitment hearings, and they have had no mental health training. One of these special justices reported, "I have had no training

Table 3

Community Services Boards' Roles in Pre-Screening Temporary Detention Orders

CSBs That Prescreen All TDOs	CSBs That Prescreen Most, But Not All TDOs	CSBs That Prescreen Some TDOs
Alexandria	Colonial	Central Virginia
Alleghany	District 19	Henrico
Arlington	Fairfax/Falls Church	Region 10
Chesapeake	Goochland/Powhatan	Richmond
Chesterfield	Middle Peninsula	
Crossroads	Northwestern	
Cumberland	Portsmouth	
Danville	Roanoke Valley	
Dickenson		
Eastern Shore		
Hampton/Newport News		
Hanover		
Harrisonburg/Rockingham		
Highlands		
Loudoun		
Mount Rogers		
New River Valley		
Norfolk		
Piedmont		
Planning District I		
Prince William		
Rappahannock		
Rappahannock-Rapidan		
Rockbridge		
Southside		
Valley		
Virginia Beach		
Western Tidewater		

Source: JLARC site visits to CSBs and JLARC survey of CSB emergency service supervisors, summer 1994.

whatsoever. What do I talk to these people about, and how do I determine whether they meet the [detention] criteria?"

* * *

A special justice in another rural county reported that he does not conduct any commitment hearings. His only role as a special justice is

to issue TDOs. The special justice indicated that it is difficult for magistrates serving the county to be involved in issuing TDOs because it is difficult to find a mental health professional available to provide the necessary advice. The special justice reported that the process usually begins with a family member contacting the police regarding an emergency. If the police believe mental illness is involved they will refer the family to the special justice. Based on telephone contact with the family member, the special justice will decide whether to issue a TDO.

A need for more consistent use of pre-admission screenings was noted in the 1986 JLARC report on deinstitutionalization, which recommended that "a pre-admission screening assessment be obtained before any steps to detain or involuntarily commit an individual be taken." DMHMRSAS's response to that report concurred that "prescreening by CSBs is critical in assuring that hospital services are targeted." However, evidence for this report indicates that a lack of pre-admission screening in a number of locations still remains an issue.

Requiring CSB staff to prescreen all temporary detention orders before they are issued will help to ensure that all individuals are evaluated by a mental health professional before they are involuntarily detained. Further, this requirement should enable most inappropriate TDO requests to be screened out. Several CSBs which do not currently prescreen all individuals for whom TDOs are requested may need additional resources to be able to comply with this recommendation. In addition, prohibiting adult homes from filling beds occupied by individuals who have been detained should reduce some inappropriate temporary detention order requests. Consequently, the number of transports required of law enforcement officers and State payments for temporary detention periods should be reduced.

Recommendation (10). **The General Assembly may wish to amend Section 37.1-67.1 of the *Code of Virginia* to require community services board staff to prescreen, with a face-to-face mental health evaluation, all individuals for whom temporary detention orders are requested prior to their issuance.**

Recommendation (11). **The General Assembly may wish to amend Section 63.1-174.001 of the *Code of Virginia* to require adult homes to maintain an open bed for any residents who have been temporarily detained. This bed must remain unfilled until the judicial disposition is made and the individual is involuntarily committed, accepts voluntary admission to a hospital, or is released.**

Magistrates Should Issue All ECOs and TDOs

Section 37.1-67.1 of the *Code of Virginia* allows special justices and magistrates to issue ECOs and TDOs. Magistrates are officers of the court who are empowered to issue civil and criminal warrants. Magistrates, rather than special justices, should issue all emergency custody and temporary detention orders. The use of magistrates is a

practical approach that helps avoid certain issues such as conflict of interest, the lack of objectivity, and mental health training that arise with the use of special justices at this stage of the process.

Specifically, conflict of interest and objectivity issues may arise because special justices are issuing ECOs and TDOs on individuals for whom they may be conducting the involuntary commitment hearing. Since special justices are paid on a per-hearing basis through the involuntary mental commitment fund and for each order written, a hearing is held, there is a financial incentive for special justices who conduct hearings to issue these orders on individuals. In addition, several mental health professionals have questioned whether a special justice can be objective when conducting a hearing for an individual for whom they have issued the ECO or TDO. Magistrates do not have this conflict of interest.

Also, training requirements for magistrates and special justices differ. All magistrates are required to receive basic training from the chief magistrate in each district on the laws regarding the issuance of ECOs and TDOs. In addition, the Supreme Court of Virginia provides certification training for all magistrate trainees, and annual training for all magistrates on various topics, which may include the detention process.

In contrast, there is no comparable training requirement for special justices. The University of Virginia Institute on Law, Psychiatry, and Public Policy provides training regarding the involuntary commitment process several times per year. However, attendance of special justices is not mandatory. If special justices choose to attend the training, it is at their own initiative and expense.

The practicality of using magistrates to completely perform this function is suggested by the fact that 22 of the 40 CSB catchment areas already utilize magistrates to issue all emergency custody and temporary detention orders (Table 4). These include a diversity of CSBs such as the Arlington, Crossroads, Dickenson, Henrico, and Norfolk community services boards. There are magistrates' offices in every judicial district in Virginia, and these offices all operate 24 hours per day. In some areas, magistrates do not issue all temporary detention orders because, as previously mentioned, mental health professionals are not available to provide the necessary evaluation of the individual. However, if community services board staff prescreen all TDOs with a face-to-face mental health evaluation, magistrates should not have difficulty acquiring the advice from a mental health professional, based on an in-person evaluation, that Section 37.1-67.1 of the *Code of Virginia* requires for issuing these orders. In the seven localities where magistrates currently issue only some of the TDOs, additional resources may be required to enable them to issue all TDOs.

Recommendation (12). **The General Assembly may wish to amend Section 37.1-67.1 of the *Code of Virginia* to require magistrates to issue all emergency custody and temporary detention orders, and to eliminate the provision enabling a judge or special justice to issue emergency custody and temporary detention orders.**

Table 4

Magistrates' Roles in Issuing TDOs within CSB Catchment Areas

Areas Where Magistrates Issue All TDOs	Areas Where Magistrates Issue Most TDOs	Areas Where Magistrates Issue Some TDOs
Alleghany	Alexandria	Central Virginia
Arlington	Cumberland	Colonial
Chesapeake	District 19	Danville
Chesterfield	Fairfax/Falls Church	Middle Peninsula
Crossroads	Highlands	Region 10
Dickenson	Loudoun	Richmond
Eastern Shore	New River Valley	Roanoke Valley
Goochland/Powhatan	Northwestern	
Hampton/Newport News	Piedmont	
Hanover	Rappahannock-Rapidan	
Harrisonburg/Rockingham	Valley	
Henrico		
Mount Rogers		
Norfolk		
Planning District I		
Portsmouth		
Prince William		
Rappahannock		
Rockbridge		
Southside		
Virginia Beach		
Western Tidewater		

Source: JLARC site visits to CSBs and JLARC survey of CSB emergency service supervisors, summer 1994.

Communication Needs to Be Improved to Make the Detention Process More Efficient

Currently, in some areas there are difficulties in the implementation of the detention process due to the need for improved communication between CSBs and the magistrates and law enforcement officers involved in the process. Training provided by the State to magistrates and law enforcement officers regarding mental health treatment issues should address communication and should include input from community services board staff and DMHMRSAS. This should help ensure better communication and improve the training currently provided.

Communication Between CSBs and Magistrates. Currently, all magistrates are required to receive basic legal training from the chief magistrates and from the Supreme Court, covering the *Code of Virginia* provisions for the issuance of emergency custody and temporary detention orders. This training provides an adequate introduction to how the process is designed to operate. However, the implementation of the process often depends upon cooperation between CSBs and magistrates. For example, Section 37.1-67.1 of the *Code of Virginia* indicates that magistrates may issue temporary detention orders upon the advice of a mental health professional who has conducted an in-person evaluation of the individual. However, the *Code of Virginia* does not indicate whether the mental health professional may provide that advice to the magistrate over the telephone, or whether the consultation must be in-person.

Thirty-three of the 40 CSBs report that they typically request temporary detention orders from magistrates. Twenty-nine of these CSBs report that the process works well. However, some community services board staff report problems with individual magistrates which may be attributed to a lack of communication between the two entities, and a need for additional training from the community services boards. For example:

> *Magistrates in most localities interpret Section 37.1-67.1 of the* Code of Virginia *to allow them to issue temporary detention orders based on telephone call testimony from community services board staff. However, in one city, magistrates interpret this section to require community services board staff to request a TDO in-person even though the* Code of Virginia *does not require this. The community services board staff indicate this is a problem because an individual may be left in an emergency situation while the community services board employee travels to the magistrate's office to request the temporary detention order. A law enforcement officer may or may not be available to wait with the individual until the temporary detention order can be obtained.*

Requiring the Supreme Court of Virginia to include the Virginia Association of Community Services Boards and DMHMRSAS in the training provided to magistrates should help resolve issues regarding implementation of the *Code of Virginia* sections relating to the temporary detention process.

Recommendation (13). **The Supreme Court of Virginia should include the Virginia Association of Community Services Boards and the Department of Mental Health, Mental Retardation and Substance Abuse Services in developing and conducting training provided magistrates regarding the temporary detention process.**

Communication Between CSBs and Law Enforcement. As previously mentioned, Section 37.1-67.1 of the *Code of Virginia* indicates that if a law enforcement officer has probable cause to believe that an individual is mentally ill and in need of

hospitalization, the officer may take the individual into emergency custody. The individual must then be evaluated within four hours by a mental health professional. Essentially, the *Code of Virginia* indicates that law enforcement officers can execute ECOs without judicial involvement. However, staff from almost one-quarter of the CSBs report that law enforcement officers are reluctant to utilize this provision. It appears that there is potential, through better cooperation in these catchment areas between community services board staff and law enforcement, to achieve the objectives of facilitating the prescreening process of CSBs and facilitating the role of law enforcement personnel by reducing the time the process takes.

Staff from five of the CSBs visited by JLARC staff report that the utilization of emergency custody orders facilitates their ability to conduct prescreenings for TDOs. For example, one CSB reported that if they are not able to respond to an emergency situation immediately it is beneficial to have law enforcement officers initiate an ECO and transport the individual to the CSB or to a hospital emergency room for the evaluation. In addition, when asked how the involuntary commitment process could be improved, six of the 40 CSBs reported that the prescreening would be easier for them if law enforcement officers made greater use of their ability to initiate and execute ECOs.

However, law enforcement officers are sometimes reluctant to execute ECOs. Nine of the 40 CSBs report that officers in their catchment areas seldom utilize ECOs. The primary reason for this appears to be that law enforcement officers, when executing an emergency custody order have to wait, usually for four hours, with the individual until the evaluation is completed. During the time the law enforcement officers are waiting for the mental health professional to conduct an evaluation, the officers are not available to conduct law enforcement duties or administer jails.

Following the evaluation, the law enforcement officer may need to transport the individual to another location. When executing a temporary detention order, the law enforcement officer has to wait only until the individual is admitted to a facility. However, it appears appropriate to require law enforcement to remain with the individual during an ECO, because the evaluation may be at a location where no security is available, and secure transportation may be needed following the evaluation, whether the individual is hospitalized or released.

CSB staff need to continue to work with local law enforcement officials to develop a system that will work for both. The following are contrasting case examples of: (1) a locality in which police officers use ECOs and there has been good cooperation, and (2) a locality in which police officers do not use ECOs and in which there is a perceived need for improvements in the system.

> *Staff from one CSB report they receive good cooperation from the local police department, and that they provide training for new police recruits. Police officers will utilize an ECO to bring individuals to the community services board, a hospital emergency room, or to the police department where the community services board has a branch office. In*

> *addition, community services board staff will often meet a police officer at an emergency scene or may ride along with a police officer to an emergency scene to provide an evaluation.*
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> * * *
>
> *The mental health director from another CSB reported that emergency services staff are not always available to do an on-site evaluation for an emergency. Further, the local police officers do not currently execute emergency custody orders because the officers would have to wait with the individual for up to four hours until the evaluation was completed. The mental health director reported that in some situations, it would be better if the law enforcement officer brought the individual to the community services board or to a hospital emergency room under an ECO, whereby the community services board staff would prioritize the situation and attempt to conduct an evaluation within one hour. Therefore, the CSB would be able to provide emergency services with fewer strains on their staff, and law enforcement officers would generally not have to wait more than one hour for the evaluation to be completed. The community services board is currently working with the local police department to cooperatively develop a system whereby officers will initiate ECOs and bring individuals to a central location for an evaluation.*

Therefore, if the officer is aware that the ECO evaluation will be a priority for the CSB, and that the evaluation will occur within one hour rather than four hours, the officer may be more willing to execute an emergency custody order.

Law enforcement officers receive basic mental health training from the police academy through the Department of Criminal Justice Services (DCJS). In addition, 21 of the 40 CSBs report that they provide additional mental health training to law enforcement officers in their catchment area. However, it appears that requiring DCJS to include the Virginia Association of Community Services Boards and DMHMRSAS in this training should provide an additional forum for community services board staff to work with the officers to develop a system that is beneficial for each.

Recommendation (14). **The Department of Criminal Justice Services should include the Virginia Association of Community Services Board and the Department of Mental Health, Mental Retardation and Substance Abuse Services in developing and conducting training provided to officers involved in emergency situations. A pamphlet describing the role of community services boards in providing emergency services should be distributed to all officers at the training session.**

TDOs Are Being Utilized for Purposes Other than to Detain Individuals for Involuntary Commitment

A review of the *Code of Virginia* provisions for this study indicate that the detention criteria are less restrictive than the commitment criteria. CSB staff report that the broader detention criteria are utilized to detain individuals who cannot afford treatment or do not have transportation to treatment facilities. Information collected for this study also indicate that some individuals are detained for substance abuse under involuntary commitment statutes when mental illness is a secondary diagnosis or no mental illness is evident.

Emergency Custody and Temporary Detention Criteria. The *Code of Virginia* in Section 37.1-67.1 provides that the criteria for the issuance of ECOs and TDOs are "probable cause that an individual is mentally ill and in need of hospitalization." However, the criteria for involuntary commitment contained in Section 37.1-67.3 of the *Code of Virginia* are that:

> if the person is incapable of accepting or unwilling to accept voluntary admission and treatment . . . [and] if the judge finds specifically that the person (i) presents an imminent danger to himself or others as a result of mental illness, or (ii) has been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (iii) that alternatives to involuntary confinement and treatment have been investigated and deemed unsuitable and there is no less restrictive alternative to institutional confinement and treatment, the judge shall by written order and specific findings so certify and order that the person be placed in a hospital or other facility for a period of treatment not to exceed 180 days from the date of the court order.

Thus, there are two different standards applied for detention versus commitment. Virginia is unique in this aspect. All 15 of the states surveyed by JLARC staff reported that their criteria for detention and commitment are more similar. The criteria for ECOs and TDOs in Virginia appear to be too broad to warrant detaining individuals for involuntary commitment. CSB staff report that individuals are being detained who have little chance of being committed, and special justices estimate that a significant number of individuals are not committed following a commitment hearing.

Staff from four of the seven CSBs visited by JLARC staff reported that an individual may be detained on a TDO, even though the prescreener may be aware that there is a small chance that the individual will be committed following a commitment hearing. For example, staff from these CSBs reported that an emergency services worker may request a TDO for an indigent individual who has no insurance and needs short-term mental health treatment, but is not necessarily imminently dangerous and has a small chance of being committed. Further, staff from one of the CSBs visited reported that temporary detention orders are also requested for individuals lacking a means of transportation to a mental health facility. CSB staff report that many of these

individuals would have volunteered for treatment if they had the financial resources and available transportation.

Individuals are able to be involuntarily detained in these situations because the ECO and TDO criteria are so broad. For example:

> *One CSB emergency services supervisor indicated that probable cause to believe that an individual is mentally ill and in need of hospitalization could refer to almost any mentally ill individual, many of whom would not meet commitment criteria. The emergency services supervisor believes that it violates the individuals' rights to detain them against their will if they do not meet at least probable cause for the commitment criteria. Therefore, the emergency service workers utilize the commitment criteria when deciding whether to request a TDO on an individual.*

It appears that the *Code of Virginia* should be amended so that the criteria for ECOs and TDOs are "probable cause that an individual presents an imminent danger to himself or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self, and the individual is incapable of or unwilling to volunteer for treatment." This amendment would help ensure that individuals being detained against their will under emergency custody and temporary detention orders would be more likely to need involuntary commitment.

Recommendation (15). **The General Assembly may wish to amend Section 37.1-67.1 of the *Code of Virginia* to require the standard for the issuance of emergency custody and temporary detention orders to be probable cause that an individual presents an imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self, and the individual is incapable of or unwilling to volunteer for treatment.**

Detention of Substance Abusers. Many emergency custody and temporary detention orders are executed for individuals who may be dangerous due to substance abuse, although the treatment provided these individuals in mental health units is not directed at substance abuse problems. Community services board staff report that individuals detained due to substance abuse are either dually diagnosed with mental illness and a substance abuse problem, have a primary diagnosis of substance abuse with a secondary diagnosis of mental illness, or are substance abusers with no diagnosis of a mental illness. Detained individuals who are dually diagnosed have a likelihood of meeting the commitment criteria, being involuntarily committed, and receiving appropriate treatment. However, detained individuals with a primary or sole diagnosis of substance abuse will often not meet the commitment criteria, and are often released at a commitment hearing. Further, if these individuals are committed, it is unlikely that they will receive substance abuse treatment.

Special justices, magistrates, and psychiatrists, psychologists, and physicians involved in the involuntary commitment process estimate, on average, that more than 39 percent of the individuals detained had a debilitating substance abuse problem (Table 5). Further, DMHMRSAS staff reported that 29 percent of individuals involuntarily committed to State mental health hospitals in FY 1994 had a primary diagnosis of substance abuse. However, since special justices do not keep records on the diagnosis of individuals committed, and no such records are maintained for all hospitals, JLARC staff were not able to determine how many individuals were detained due to substance abuse problems.

Table 5

Estimated Percentage of Individuals Detained Who Have Debilitating Substance Abuse Problems

Respondent	Average of All Responses
Magistrates (N=243)[a]	48%
Psychiatrists and Psychologists (N=56)[b]	39%
Special Justices (N=61)[c]	43%

[a] 268 magistrates responded to the JLARC survey, however 243 responded to this question.

[b] 60 psychiatrists and psychologists responded to the JLARC survey, however 56 responded to this question.

[c] 80 special justices responded to the JLARC survey, however 61 responded to this question.

Source: JLARC surveys of magistrates, psychiatrists and psychologists, and special justices, spring 1994.

JLARC surveys of special justices, magistrates, and CSBs indicate that in some areas, a significant number of individuals with substance abuse problems are detained, and are subsequently released following the commitment hearing. For example:

Staff from one CSB reported they will request a temporary detention order for an individual for substance abuse if the person is dangerous and needs detoxification. A special justice in a city within the catchment area reported that many TDOs are issued on intoxicated individuals who are not mentally ill. The special justice reported conducting three or four commitment hearings per week, a large percentage of which involve intoxicated individuals who are not mentally ill. Many of these individuals are no longer under the influence of alcohol by the time of the hearing, are not mentally ill, and are not dangerous to self or others or substantially unable to care for themselves. Therefore, they are not committed. The special justice reported that 75 percent of hearings conducted resulted in the individual being released without conditions, a large number of whom were detained for being intoxicated.

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A special justice in another city reported that there is a problem with intoxicated individuals being issued TDOs, solely because they are intoxicated and the police do not want to put them in jail. This special justice estimated releasing 30 percent of these individuals at the commitment hearings.

Staff at all seven CSBs visited by JLARC staff report that individuals who have a primary or sole diagnosis of substance abuse are issued TDOs if they are dangerous to themselves or others at the time, and there is no other way to detain these individuals. These staff report that the worker may know that the individual probably will not meet commitment criteria when the individual is no longer under the influence of drugs or alcohol. In addition, in many cases the prescreener is aware that the individual will probably not receive substance abuse treatment during the detention period because many hospitals do not provide substance abuse treatment.

It appears appropriate that an individual with substance abuse problems, who is dangerous to self or others, may need to be involuntarily detained for some period of time. However, increased availability of detoxification units and separate criteria for involuntary detention to a detoxification unit could provide better treatment for those with primary and sole diagnoses of substance abuse, and be more cost efficient and effective. For example:

One CSB in a large city operates an 18-bed detoxification unit. Admission to the unit is voluntary and the unit is rarely full. The mental health director of the community services board estimates that at any given time there are four open beds. CSB staff will request temporary detention orders for individuals who have a primary or sole diagnosis of substance abuse, and these individuals may be detained at a psychiatric hospital at a cost of more than $300 per day. The substance abuse director for the community services board reported that the average cost for a day in the detoxification unit is $85. Therefore, the mental health director reports that if the CSB could involuntarily detain individuals whose primary diagnosis is substance abuse to the detoxification unit, the individual would receive substance abuse treatment, and funds could be better utilized.

While this CSB operates a detoxification unit, such units are not available in most other communities in the State. It appears possible that better treatment could be provided, and funds could be better spent, if the State appropriated funds towards the establishment and operation of detoxification units, and the *Code of Virginia* was amended to provide separate detention and commitment criteria for substance abuse.

The Department of Mental Health, Mental Retardation and Substance Abuse Services has recognized these needs. DMHMRSAS, in its 1994 report, *The Impact of Public Inebriates on the Community and Criminal Justice Services Systems*, stated that:

> Detention and commitment laws do not clearly direct the legal management of public inebriates. They are often used to place them inappropriately in intensive mental health facilities and community mental health programs where specific substance abuse services may be lacking.

Subsequently, House Joint Resolution No. 269 was passed requiring DMHMRSAS to complete a study of community and facility treatment programs for individuals with chronic substance abuse problems. This study is to be completed prior to the 1996 Session of the General Assembly. According to the director of planning for the office of substance abuse services at DMHMRSAS, initial work has begun on this study. This JLARC review has found that separate detention criteria for substance abusers and additional detoxification facilities in the community could be cost effective and provide more appropriate treatment for individuals. Therefore, as part of their study, DMHMRSAS should examine how to develop separate involuntary commitment criteria for substance abusers, and determine the costs and benefits of appropriating additional State funds toward the establishment and operation of community-based detoxification facilities.

Recommendation (16). **As part of its study of community and facility treatment programs for individuals with chronic substance abuse problems, the Department of Mental Health, Mental Retardation and Substance Abuse Services should examine the possibility of developing separate involuntary commitment criteria for substance abusers. The Department should also determine how many of the individuals that are issued temporary detention orders would benefit more from being in a detoxification facility than in a psychiatric unit. The Department should then determine the costs and benefits of establishing and operating additional community-based detoxification units.**

HOSPITALIZATION OF INDIVIDUALS UNDER TEMPORARY DETENTION ORDERS

Following the issuance of a TDO, the individual is placed in a hospital for the detention period. Section 37.1-67.1 of the *Code of Virginia* does not specifically indicate where most individuals should be hospitalized during the temporary detention period, or who should decide where individuals should be hospitalized (the *Code* does address where mentally ill individuals who are serving time in jails should be detained). Subsequently, each locality has developed its own system for determination of temporary detention sites. In some areas special justices are determining which hospitals individuals are detained in based on the special justices' convenience. As a result, in these situations State funds are not being utilized efficiently, and individuals may not always be receiving the most effective treatment.

Following the decision on which hospital the individual should be detained in, the individual must be transported. While the option should remain for family members to transport individuals to the detention facility, law enforcement officers should remain the primary transporters of individuals under TDOs. Many police chiefs and sheriffs report staffing strains due to the responsibilities required by this process. However, implementing the recommendations presented in this report should significantly reduce the burden on law enforcement officers by reducing the number of transports needed, and help ensure that the individuals transported are dangerous to themselves or others. Since some individuals will be detained because they are substantially unable to care for themselves, CSB staff need to encourage law enforcement officers to use restraints only when necessary, due to the potentially detrimental effect of handcuffing a mentally ill individual.

The *Code of Virginia* does not currently allow hospitals to release detained individuals prior to a commitment hearing. Individuals may only be released prior to a commitment hearing if a special justice rescinds a temporary detention order. Therefore, individuals who have stabilized and no longer meet the commitment criteria are generally detained for up to 48 hours even if the mental health professionals at the hospital have no reason to detain the individuals further. However, hospitals may release an involuntarily committed individual at any time it is determined to be clinically appropriate to do so.

Further, CSB staff reported that at three hospitals, special justices allow physicians or psychiatrists to release individuals or allow individuals to voluntarily admit themselves prior to a commitment hearing, without informing the special justice. These staff report that this occurs if the individual no longer meets the commitment criteria and would not present an imminent danger to self or others if released. This practice appears to violate the *Code of Virginia*. However, it may be appropriate to amend the *Code* to allow this practice, as it appears to be an appropriate policy. If it is implemented, it should also reduce the State's cost for the hospitalization and treatment of individuals under temporary detention.

CSBs Should Determine Where All Individuals Are to Be Hospitalized

Section 37.1-67.1 of the *Code of Virginia* requires community services boards to provide to each general district court and magistrate's office within its jurisdiction a list of available facilities for hospitalization during temporary detention periods. In addition, CSBs are to provide a list of evaluators and locations where such evaluations can take place during the ECO period. However, this section does not indicate who should decide where individuals under a temporary detention order are to be hospitalized. As a result, localities utilize different methods for determining at which hospitals individuals are to be detained. In 36 of the 40 CSB catchment areas, community services board staff recommend to the magistrate or special justice where individuals should be hospitalized. This system appears to work well. In one other locality, as previously indicated, the CSB has contracted with a psychiatric group that makes the determinations.

However, in three CSB catchment areas, hospitalization decisions are made by special justices. This approach often results in inefficient use of law enforcement officers for transportation and unnecessary expenses to be borne by State funds:

> *In one large urban area, the special justices will only conduct hearings at one hospital per week. The CSB staff in this city report that the special justices made this decision so they would not have to travel to several hospitals in one day to conduct hearings. The only two hospitals in this city that can handle accepting patients under temporary detention orders for an entire week are free-standing psychiatric hospitals. Therefore, individuals under temporary detention orders are sent to only these hospitals on a weekly basis, rotating hospitals every week. Two local acute care hospitals have 34-and 20-bed psychiatric units respectively, but cannot handle all TDO patients from the city for an entire week. Therefore, they do not accept individuals under temporary detention orders. This causes two significant problems. First, many of the temporary detention orders in the city are initiated at the emergency room at one of the acute care hospitals. Therefore, individuals under temporary detention orders must be transported from that hospital to one of the psychiatric hospitals even though there may be psychiatric beds available at the acute care hospital. Second, Medicaid recipients are sent to the psychiatric hospitals even though these hospitals do not accept Medicaid payments. Therefore, the State is paying for the entire temporary detention period for these individuals, instead of having federal funds pay part if the individual was in an acute care hospital. Further, if the individuals are committed they must be transported to an acute care hospital after the commitment hearing.*

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> *Staff from another CSB report that a local special justice has ordered magistrates to send all individuals under temporary detention orders to a State mental health hospital because that is the only hospital at which this special justice conducts commitment hearings. As a result, the CSB staff report that some individuals who have insurance coverage are sent to the State mental health hospital for the temporary detention period even though there are several private psychiatric and acute care hospitals in the area which accept individuals under temporary detention orders with insurance coverage. (If the individuals with private insurance were sent to the private hospitals the State would only need to pay for any costs not covered by insurance.) However, the CSB staff report that the special justice wants the commitment hearings held at the State mental health hospital because the special justice conducts and is therefore paid for commitment hearings conducted at that hospital.*

In these examples, the convenience of the special justice is being accommodated rather than the appropriate placement of the patient or the cost of the hospitalization. Consequently, requiring CSB staff to determine where individuals under temporary detention orders are to be hospitalized will better ensure more appropriate placements, and promote more efficient use of hospitals.

Recommendation (17). **The General Assembly may wish to amend Section 37.1-67.1 of the *Code of Virginia* to require community services boards to determine where all individuals under temporary detention orders are to be hospitalized. This decision should be provided to the magistrate on the prescreening form and included on the temporary detention order.**

Law Enforcement Officers Should Remain the Primary Transporters for Patients Under Temporary Detention Orders

Once it has been determined where an individual is to be hospitalized under a TDO, the individual must be transported to a hospital. While Section 37.1-67.1 of the *Code of Virginia* indicates that law enforcement officers may transport individuals under temporary detention orders, it does not specifically indicate who should transport these individuals, or how this decision should be made. However, all 40 CSBs report that while some individuals are transported by family members, law enforcement officers are the primary transporters for individuals under temporary detention orders. Community services board staff report that law enforcement officers usually transport these individuals because the process is often initiated by an officer responding to an emergency situation and the dangerousness of the individual may not be known.

The majority of sheriffs and police chiefs surveyed by JLARC staff believe that law enforcement officers should be involved in the transportation of individuals under TDOs. However, sheriffs and police chiefs do not agree on what they believe the role should be. Approximately 51 percent of the responding sheriffs and police chiefs indicate they should remain the primary transportation provider, 26 percent would like a reduced role, and the remaining 23 percent prefer that law enforcement be removed from all transportation responsibilities (Table 6).

Many of the sheriffs and police chiefs who would like a reduced role in transportation reported staffing problems due to the responsibility they have for transporting mental health patients, and that it is sometimes unnecessary for law enforcement officers to provide transportation because the individual may not be dangerous. However, implementing the recommendations proposed in this report should reduce some of this burden. For example, requiring CSBs to prescreen all temporary detention orders prior to issuance should reduce the number of inappropriate TDOs that are currently issued. Therefore, this would reduce the number of temporary detention transports required. In addition, changing the emergency custody and temporary detention criteria should reduce the number of emergency custody orders initiated by law enforcement officers, and the number of emergency custody orders and temporary detention orders requested by community services boards.

Table 6

Sheriffs' and Police Chiefs' Opinions on the Transportation of Mental Health Patients

Question: *Do you think that a law enforcement role is necessary in the mental health commitment process?*

	Yes, with no exceptions	Only if patient is dangerous to self or others	No, with no exceptions
Sheriffs (N=109)[a]	51%	24%	25%
Police Chiefs (N=20)[b]	50%	35%	15%
TOTAL	51%	26%	23%

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

[b] A total of 40 police chiefs responded to the survey. However, 20 did not respond to this question because they are not involved in the involuntary commitment process.

Source: JLARC survey of sheriffs, fall 1993 and JLARC survey of police chiefs, spring 1994.

In addition, several mental health advocates have indicated that they would prefer that law enforcement have a reduced role in transportation because the officers typically handcuff the mentally ill individuals and transport them in patrol cars. Ninety-three percent of sheriffs and police chiefs responding to the JLARC survey report that they typically restrain individuals during mental health transports. Mental health advocates argue that handcuffing mentally ill individuals who have committed no crime is detrimental to their mental state and sheriffs agree that in many cases restraints are not necessary because the individual may not be imminently dangerous. Implementing the recommendations in this report will help ensure that most mental health transports involve individuals who are dangerous to themselves or others. However, some will be detained because they are substantially unable to care for themselves. Therefore, community services boards should encourage law enforcement officers to use restraints only when necessary when executing an emergency custody or temporary detention order.

Many sheriffs and police chiefs indicate staffing problems due to the need for officers to provide mental health transports. However, the incorporation of *Code of Virginia* amendments recommended in this report to help ensure individual rights and to improve the efficiency of the process, should also reduce the number of transports for law enforcement officers. Further, it should also help ensure that most individuals under ECOs and TDOs are dangerous to themselves or others, and require the necessary

security provided by law enforcement officers. Consequently, law enforcement officers should remain the primary transporter for individuals under temporary detention orders. Since some individuals will be detained because they are substantially unable to care for themselves, CSB staff and DMHMRSAS should encourage law enforcement officers to use restraints only when an officer judges that it is necessary.

Recommendation (18). **As part of their input into the training provided to law enforcement officers by the Department of Criminal Justice Services, the Virginia Association of Community Services Boards and the Department of Mental Health, Mental Retardation and Substance Abuse Services should encourage law enforcement officers to use restraints only when necessary when executing an emergency custody or temporary detention order.**

Hospitals Should Be Able to Release TDO Patients Prior to the Commitment Hearing

Section 37.1-67.1 of the *Code of Virginia* indicates that a judge may release an individual prior to a commitment hearing if it appears from all available evidence that such release will not pose an imminent danger to the individual or others. Despite having this option, special justices responding to the JLARC survey reported releasing less than one percent of individuals prior to a commitment hearing. Special justices and community services board staff report that once an individual is committed, the hospital may release the individual at any time it is determined to be clinically appropriate to do so. The *Code of Virginia* does not provide that hospitals may release individuals during the temporary detention period.

However, CSB staff reported that special justices from two different catchment areas allow physicians or psychiatrists at three hospitals to release individuals or to allow individuals to voluntarily admit themselves prior to a commitment hearing without the special justice's consent, if the individual no longer meets the commitment criteria and would not present an imminent danger to him or herself or others if released. For example:

> *CSB contract staff at one hospital report they have an arrangement with the special justice whereby they may release individuals prior to a commitment hearing without consulting with the special justice. The CSB contract staff report that more than 50 percent of the individuals under TDOs are released by the hospital or volunteer for admission, prior to a commitment hearing.*

* * *

> *An emergency services supervisor from another CSB reported that treating psychiatrists at two local psychiatric hospitals will release individuals prior to a commitment hearing if the psychiatrists believe the individual no longer meets the commitment criteria. A special*

> *justice is not notified when an individual under a temporary detention order is released prior to a commitment hearing. The emergency services supervisor estimated that 40 percent of individuals under TDOs are released prior to a commitment hearing.*

These appear to be violations of the *Code of Virginia*, because the individuals are being released by the hospital, rather than by the special justice. However, it appears that allowing hospitals to release individuals prior to a commitment hearing, if they no longer meet the commitment criteria, without the consent of a special justice, is an appropriate practice. Therefore, the *Code of Virginia* should be amended to reflect this.

This appears to be an appropriate practice for two reasons. First, if a physician or psychiatrist believes that an individual no longer meets the commitment criteria, and would not present an immediate danger to self or others if released, there would be no clinical reason to continue detaining the individual. In addition, the State would not have to pay for the remainder of the detention period or a commitment hearing.

Second, this practice only recognizes at an earlier stage the clinical judgment role of the hospital in the release process that is already recognized post-commitment. When a judge or special justice commits an individual, the individual is committed to a facility for up to 180 days. However, the judge or special justice does not specify the actual time an individual will be committed. As previously indicated, hospitals may release the individual at any time within the commitment period. In fact, CSB staff and special justices report that some committed individuals are released from a hospital the same day they were committed. Therefore, hospitals should also have the authority to release an individual prior to a commitment hearing if the individual no longer meets the commitment criteria, and would not present an imminent danger to self or others if released.

Recommendation (19). **The General Assembly may wish to amend Section 37.1-67.1 of the *Code of Virginia* to allow hospitals, based on a recommendation from a physician or psychiatrist responsible for treating the patient during the detention period, to release the patient prior to a commitment hearing if it is their professional opinion that the patient no longer meets the commitment criteria, and the patient would not present an imminent danger to self or others if released. The hospital should be required to notify the appropriate community services board of the release.**

IV. Involuntary Commitment Hearings

Following the pre-hearing detention, the involuntary commitment process encompasses the completion and oversight of preliminary, commitment, and recommitment hearings; the transportation of any individual who is ordered to be involuntarily hospitalized; and any appeals of involuntary commitment orders. The process, as it is designed by statute, is shown in Figure 8. In practice, the process within Virginia frequently involves relatively informal legal proceedings and may not precisely mirror the statutory design. Most of the hearings are conducted by special justices at the hospital in which the individual is being held. Many of the rules of evidence and other formalities which characterize other civil and criminal hearings are not typically applied to involuntary commitment hearings. Recommitment hearings are conducted in the same manner except there is no preliminary hearing involved. Appeals of commitment decisions are heard within the corresponding circuit court.

The informality of the hearings, and the associated lack of oversight of these hearings, has resulted in a number of problems. Generally, there are widespread inconsistencies in practice around the State with special justices establishing their own procedural rules. Fortunately, a number of legal protections have been incorporated within the commitment process which continue to provide important safeguards. The recommendations in this chapter seek to build on the strengths of the process by presenting ways to improve the process. These recommendations address ways to clarify hearing procedures, suggestions for alternative modes of transportation, and improvements in oversight of the hearings.

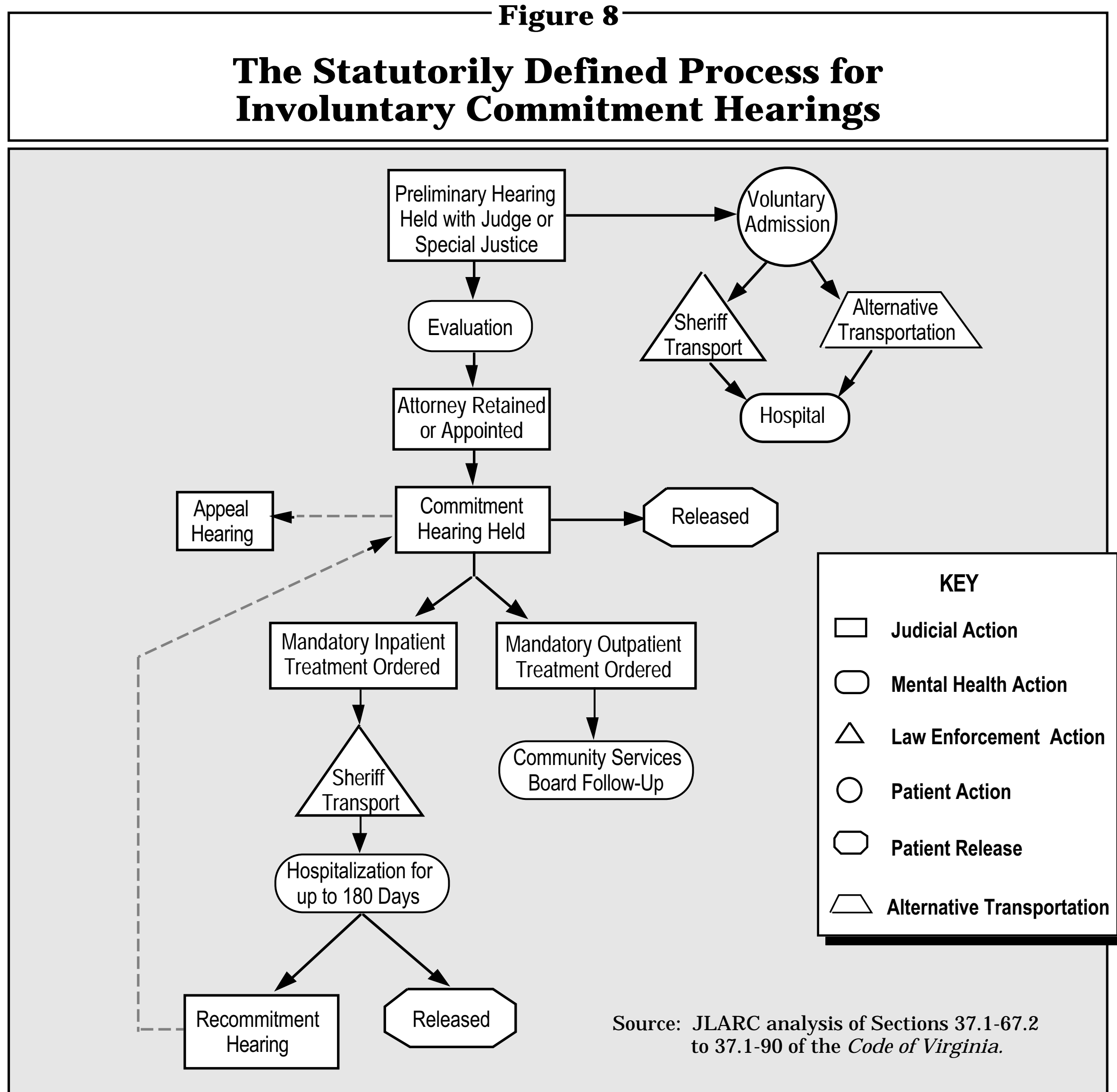
COMMITMENT HEARING PROCEDURES

The *Code of Virginia* provides that individuals who are detained on the basis of a temporary detention order (TDO) are afforded the right to a preliminary hearing which provides an opportunity for voluntary admission for treatment. If the individual does not want to voluntarily admit or is judged to be incapable of making such a decision, a commitment hearing will be held to determine whether the individual meets involuntary commitment criteria.

There are few written guidelines to direct the implementation of the statutory sections addressing involuntary commitment hearings. This has resulted in a process which is inconsistent and varies throughout the State. Hearing components which seem to be particularly problematic include confusion surrounding the conduct of preliminary hearings, inconsistent judicial decisions resulting from a lack of procedural guidelines, and the availability of appropriate treatment which affects the judicial dispositions given.

Figure 8

The Statutorily Defined Process for Involuntary Commitment Hearings



Source: JLARC analysis of Sections 37.1-67.2 to 37.1-90 of the *Code of Virginia.*

Having a Separate Preliminary Hearing Seems Unnecessary and Confusing

The commitment process involves both a preliminary hearing and a commitment hearing. Section 37.1-67.2 of the *Code of Virginia* states that the purpose of the preliminary hearing is to provide the patient with the opportunity to voluntarily admit him or herself for treatment if the special justice determines that the individual is capable as well as willing to accept voluntary admission and treatment. The *Code of Virginia* also notes that if the judge determines that the individual is not capable or willing to be voluntarily admitted, an explanation of the commitment hearing and the individual's rights are to be explained. In practice, JLARC staff found that the distinction between the two hearings is often not clear, that having a separate preliminary hearing often causes confusion, and that generally few explanations and options regarding the commitment hearing are actually given prior to the hearing.

JLARC staff found, based on survey responses and commitment hearing observations, that often there is no distinction made between the preliminary and the commitment hearing. Eighty-nine percent of the 66 special justices who responded to this JLARC survey question, reported that they conduct the commitment hearing immediately after concluding the preliminary hearing. Some of those special justices actually incorporate the components of the preliminary hearing into the commitment hearing. One special justice explained that having two separate hearings simply confused many of the individuals being evaluated for commitment.

Compensating special justices based on two types of hearings also causes confusion among special justices. Special justices are compensated separately at an established rate for each preliminary and commitment hearing conducted. Special justices seemed to be uncertain regarding what to bill the Supreme Court when the individual was allowed to voluntarily admit. Some special justices thought that they should only charge for the preliminary hearing in this instance, while others thought they should charge for both hearings. The Supreme Court does not have a specific, written policy addressing how this situation should be handled but will pay the special justices according to what they put on the invoice. Allowing special justices to charge only one-half as much per patient if there is no commitment hearing creates an incentive to disallow voluntary admissions. This unintended consequence is not desirable.

Having two separate hearings appears to be confusing and unnecessarily complicated, without serving any clear purpose. While the opportunity to allow capable individuals to voluntarily admit themselves is an important component of the hearing, it is not clear that a separate preliminary hearing is needed to provide that option. There are also more effective ways to inform individuals of the purpose of the commitment hearing and their rights related to the commitment process than having the special justice give an oral explanation, which based on observation by JLARC staff, is often rushed and confusing.

For example, if the special justice determines that an individual is not capable or is unwilling to be voluntarily admitted, the special justice is to inform the individual of the right to have a commitment hearing and to have privately-retained or court-appointed counsel. According to the *Code of Virginia* §37.1-67.3 prior to the commitment hearing, the special justice is also required to inform the individual "of the basis of his detention, the standard upon which he may be detained, the right of appeal from such hearing to the circuit court, the right to jury trial on appeal, and the place, date, and time of such hearing." In all but one of the 40 of the involuntary mental commitment hearings observed, JLARC staff found that the individuals were informed of these rights during the commitment hearing rather than prior to that hearing.

It was also observed that the oral delineation of so many provisions, with little time to reflect on the meaning of those provisions appeared to confuse the majority of the patients. This compromised the effectiveness of the protections. The individual's statutory rights would be better protected if an attorney, experienced in representing individuals in commitment hearings, distributed and explained the contents of a written booklet delineating the individual's rights prior to the commitment hearing. The written

booklet should explain the purpose and components of the commitment hearing including the possible outcomes of the hearing, explain that the hearing is not a criminal trial, and delineate all of the individual's rights concerning the process. The booklet should be developed by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) because of its expertise in understanding mental illness and its involvement in the involuntary commitment process.

Recommendation (20). **The General Assembly may wish to consider amending Section 37.1-67.2 of the *Code of Virginia* to eliminate the requirement that a preliminary hearing be conducted as part of the involuntary mental commitment process. If the preliminary hearing is eliminated, its function, to determine whether an individual is capable and willing to be voluntarily admitted, should be incorporated into the commitment hearing.**

Recommendation (21). **The General Assembly may wish to consider amending Section 37.1-89 of the *Code of Virginia* to allow for increased charges for commitment hearing services, if preliminary hearings are eliminated. Under the current payment structure, this would mean that special justices would receive $57.50 while psychiatrists, psychologists, and attorneys would receive $50 for each commitment hearing.**

Recommendation (22). **The Department of Mental Health, Mental Retardation and Substance Abuse Services should develop a written booklet which explains the involuntary mental commitment process and an individual's rights within that process. Included within the booklet should be an explanation of the individual's right to retain private counsel or be represented by a court-appointed attorney, to present any defenses including independent evaluation and expert testimony or the testimony of other witnesses, to be present during the hearing and testify, to appeal any certification for involuntary admission to the circuit court, and to have a jury trial on appeal. The booklet should be written in a simple and straight-forward manner.**

Recommendation (23). **The General Assembly may wish to consider amending Section 37.1-67.3 of the *Code of Virginia* to require appointed attorneys to distribute and explain the contents of a written booklet which explains the involuntary mental commitment process and the statutory protections associated with that process. The booklet should be distributed and explained by an attorney in private consultation with the individual prior to the commitment hearing. The special justices should ascertain at the beginning of the hearing that the individual has had the written material explained to him or her.**

A Lack of Procedural Guidelines Results in Inconsistent Proceedings

Involuntary commitment hearings are not bound by the procedural guidelines that other civil and criminal trials must follow. As noted in the 1989 National Center for State Courts study of Virginia's involuntary commitment process, "There are few

guidelines establishing recommended principles, procedural mechanisms, and practices to govern court hearings." Generally this appears to still be the situation, and the result is that special justices establish their own procedures and practices. In some cases additional statutory guidance appears to be needed to ensure that judicial rulings are more consistent among special justices.

Requirements for the patient, the judge or special justice, and the patient's attorney to be present during the commitment hearing are clearly stated in the *Code of Virginia*. The *Code of Virginia* allows at the judge's discretion for the examining psychiatrist, psychologist, or physician to either attend the hearing and testify or to submit written certification of findings. Community services board (CSB) staff are not required to attend the commitment hearing but are expected to submit a prescreening report which "shall state whether the person is deemed to be mentally ill, an imminent danger to himself or others and in need of involuntary hospitalization, whether there is no less restrictive alternative to institutional confinement and what the recommendations are for that person's care and treatment." However, the *Code of Virginia* also allows special justices to conduct the hearing without the prescreening report if the CSB has not submitted it within a given time period.

The *Code of Virginia* also specifically allows for witnesses and the petitioner to attend the hearing. Section 37.1-67.3 states that the petitioner is to be "given adequate notice of the place, date, and time of the commitment hearing. The petitioner shall be entitled to retain counsel at his own expense, to be present during the hearing, and to testify and present evidence."

General guidance regarding the participation of various parties in involuntary commitment hearings is given, but there are areas in which additional guidance may be needed. Three of these areas include the importance of the petitioner's presence and testimony during hearings, the independence and participation of the mental health examiner, and the role of CSB staff in commitment hearings.

Participation of Petitioners in Commitment Hearings. As noted in the responses of special justices to a JLARC staff survey, petitioners actively participated in 71 percent of the hearings. Staff in several CSBs indicated that it is important for the petitioner to attend and participate in the hearing whenever possible. The CSB staffs noted that when the petitioner is not at the hearing or does not present the circumstances which led to the request for the TDO, the special justice does not always get a clear idea of the full extent of the problems the patient might have presented.

Although it is important for the petitioner to testify at the hearing whenever possible, there are circumstances in which this becomes impractical. A number of involuntary commitment hearings are typically scheduled for a particular day, at times within several different hospitals. It is not possible to know precisely when an individual hearing will be conducted since hearings vary in the time it takes to complete them. Hearings are sometimes held in cities and counties other than the locality that the TDO was requested. This exacerbates both time and transportation problems for some petitioners, particularly in rural areas. Testifying at a commitment hearing, particularly

the hearing of a family member, can also be emotionally difficult and stressful. Thus, for some petitioners it would create a serious hardship to attend and testify at the hearings.

The expectations of the special justices regarding the presence and testimony of petitioners varied. In several jurisdictions in which JLARC staff observed commitment hearings, the petitioners were not present for any of the hearings and the special justice seemed unconcerned about their absence. In another jurisdiction, however, the special justice will release the patient if the petitioner is not available to testify at both the preliminary hearing (which is held the day before the commitment hearing) and the commitment hearing. CSB staff reported that often the released individuals meet commitment criteria and re-enter the process on temporary detention orders soon after their release. This practice is both costly and dangerous because it fails to ensure that dangerously mentally ill individuals receive treatment in a timely manner.

As noted previously, the *Code of Virginia* provides for the petitioner to be present and testify and to be represented by counsel during the hearing. The *Code of Virginia* does not address whether the petitioner is required to attend the hearing and what the judge or special justice should do if the petitioner does not attend the hearing. The Fairfax/Falls Church CSB has developed a form for the petitioner to sign which emphasizes the importance of attending the hearing and explains the commitment process and the judicial dispositions which may result from the process (Appendix F). The use of a similar form, which also includes the petitioner's specific reasons for requesting the TDO, could be required of all CSBs to promote petitioner attendance. Special justices should not release individuals who meet commitment criteria when the petitioner fails to attend the hearing, however, due to the cost and danger this practice entails.

Recommendation (24). **The Department of Mental Health, Mental Retardation and Substance Abuse Services should work with the Virginia Association of Community Services Boards to develop a form for use by all community services boards. The form should explain the commitment process, emphasize the importance of attending the commitment hearing, and specifically record the petitioner's reasons for requesting the temporary detention order. Community services board staff should fill out a form for every temporary detention order that is authorized and require petitioners to sign the form, as is possible.**

Recommendation (25). **The General Assembly may wish to consider amending Section 37.1-67.3 of the *Code of Virginia* to clarify: (1) that petitioners should be encouraged, but not required, to attend and testify at commitment hearings and (2) that special justices should not release patients who meet commitment criteria simply because the petitioner did not testify at the hearing.**

Participation of Mental Health Examiners in Commitment Hearings. A psychiatrist, psychologist, or physician is required either to attend and testify to the findings of the mental health examination or to submit written certification of those

findings for the court's review. The *Code of Virginia* does not address the issue of whether the mental health examiner must be independent of the detaining hospital for adult commitments. Sections 16.1-339 and 16.1-342 of the *Code* states that minors must be examined by an evaluator who is not the treating professional and has no significant financial interest in the hospitalization of that minor. However, in adult commitment hearings, the mental health examination is handled in different ways.

Twenty-one of 36 CSBs responding to a JLARC survey question (four CSBs did not definitively answer the question) noted that the treating psychiatrist, psychologist, or physician from the detaining hospital completes the examination and either testifies during the hearing, has another staff member read the examination findings, or submits a written report of the findings. This approach poses several potential problems. First, the examination, which will significantly influence the special justice's decision to involuntarily commit or not, may have been completed several days before the hearing. Subsequent to that examination the patient may have become less agitated or less intoxicated or received treatment which has helped to stabilize the condition. Thus, the examination findings would not present the patient's mental health status at the time of the hearing. Second, the absence of the examining professional from the hearing reduces the opportunity to ask questions or receive clarification about the examination findings. Third, financial interests may influence the examiner's judgment, particularly if the employing hospital may be allowed to continue to hospitalize the patient if that patient is committed. Examples of these three potential problems have reportedly occurred, according to CSB staff in several jurisdictions.

The remaining 15 CSBs reported, that within their jurisdictions, a psychiatrist or psychologist appointed by the judge or special justice provides an independent examination prior to the commitment hearing. These examinations are often completed minutes before the hearing or in some cases during the hearing. The potential problems with this approach include the often brief nature of the examination and the difficulty of employing qualified professionals to provide this service.

In the JLARC staff survey of mental health examiners, they reported meeting with the patient 1.3 times on average and spending an average of 50 minutes on the examination. Thirty-five percent of the examiners reported spending 30 minutes or less on the examination. Four examiners reported actually completing the examination during the hearing by interviewing the patient at that time. Two of these examiners reported that when the examination was completed during the hearing, it was because the special justice had given the patient the choice of meeting with the psychiatrist privately or with everyone present. Completing the examination of the patient during the hearing violates the provisions of Section 37.1-67.3 of the *Code of Virginia* which require that the mental health examination be conducted in private. Despite some current problems with having an independent mental health evaluator, which can be addressed, this approach appears to present fewer problems than using staff of the detaining hospitals to complete the mental health examinations.

Examinations by independent evaluators are sometimes brief, but ensuring that examinations are held prior to the hearing and that the patients' hospital records

are available for the evaluator's review would help to mitigate problems that might arise due to the brevity of the examination. To ensure that an independent evaluator examined the patient, statutory provisions similar to those included in Section 16.1-342 of the *Code of Virginia* (which requires a mental health evaluator "who is not and will not be treating the minor and who has no significant financial interest in the facility to which the minor will be committed") should be included in the adult commitment statutes. It may be necessary to allow for exceptions to this requirement in areas where an independent evaluator cannot be retained. CSBs should be required to certify that no qualified evaluator can be retained in the few jurisdictions in which that would be a problem. No additional funding should be needed to compensate the independent evaluators, since hospital staff already charge for the services they provide either indirectly within the hospital bill or directly to the involuntary mental commitment fund.

Recommendation (26). **The General Assembly may wish to consider amending Section 37.1-67.3 of the *Code of Virginia* to include language which is similar to restrictions placed on mental health evaluators for minors. Those restrictions, as noted in Section 16.1-342 of the *Code of Virginia* and expanded to be used for adult commitment hearings, could state that a qualified evaluator who is not and will not be treating the individual, who has no significant financial interest, and who is not employed by the facility to which the individual will be committed should complete the mental health evaluation. The independent evaluator should also be expected to attend and testify at the commitment hearing. In the limited number of jurisdictions in which no independent evaluator can be retained, the community services board should certify that to be the case.**

Participation of Community Services Board Staff in Commitment Hearings. Special justices reported, in response to a JLARC staff survey, that CSB staff actively participated in only 68 percent of the hearings. Although there is no requirement in the *Code of Virginia* for CSB staff to attend hearings, most of the CSBs reported that they attempt to send a staff member to at least some commitment hearings. According to the *Code of Virginia* in Section 37.1-67.3, CSB staff are required to complete and submit prescreening reports which include alternatives for treating patients who may be involuntarily committed. However, special justices are allowed to conduct the commitment hearing without the prescreening report if the report is not received within the allotted time period of 48, 72, or 96 hours (depending on whether a weekend and/or a holiday comes between the TDO and the scheduled hearing).

CSB staff, in several jurisdictions, stated that their role in commitment hearings is not clearly delineated and that different special justices use them in different ways.

> *One CSB staff member noted that it was difficult to have influence over the special justices in her area. The special justices have been holding hearings for a long time while the CSB just got involved in the hearings several years ago. Some of the special justices did not want CSB staff to even attend the hearings unless it could be shown to them in the* Code

of Virginia *that CSB staff were specifically allowed to attend. In observing hearings involving that CSB, JLARC staff found that the CSB staff member was not called on to provide testimony and only spoke after requesting permission from the special justice to speak.*

* * *

JLARC staff observed several hearings involving staff within a CSB which participates in hearings which are held in two different localities. In the hearings which were observed, the special justice swore the CSB staff member in and asked him to testify concerning why the TDO was requested and what treatment alternatives were available. The CSB staff member noted however, that he is not always allowed to testify by this special justice and is only allowed to testify one time during the hearing. When the CSB staff member attends hearings in the other locality, with a different presiding special justice, the hearings are less formal in nature and the CSB staff member is allowed to speak anytime during the hearing.

* * *

In commitment hearings, observed by JLARC staff in a third area of the State, the CSB staff member was actively involved in all of the hearings but primarily in an administrative rather than consultative role. The staff member was always asked about the availability of treatment alternatives, the status of the patient's insurance coverage, and any ideas concerning the best interventions to take with the patient.

CSB staff reported that they frequently were not asked to testify in commitment hearings despite their knowledge of the cases, and that when they were allowed to testify it seemed that their comments were not seriously considered by certain special justices. This is despite the fact that 89 percent of special justices responding to a JLARC staff survey stated that they are satisfied with the quality of the CSB prescreening reports. CSB staff typically determine what dispositional alternatives are available to address the problems of the patients being evaluated and are generally considered to be the experts on local and State mental health resources. To the extent that CSB staff are not adequately involved in the hearings and their comments are not given serious consideration, it appears that valuable CSB expertise and resources may be wasted.

Recommendation (27). **The General Assembly may wish to consider amending Section 37.1-67.3 of the *Code of Virginia* to clarify that the prescreening report, prepared by community services board staff, must be received by special justices prior to the commitment hearing. The prescreening report should be considered by the justice in determining the treatment that is ordered. If community services board staff are present at the involuntary commitment hearing, they should be given the opportunity to provide input.**

Appropriate Treatment Options Are Not Always Available

Judicial dispositions provide for one of four general alternatives:

- involuntary inpatient commitment,
- involuntary outpatient commitment,
- voluntary inpatient hospitalization, or
- release.

The treatment options available, within each of the broad judicial dispositions, can significantly affect which disposition is rendered.

The 80 responding special justices reported that involuntary inpatient hospitalization was the judicial disposition they ordered most frequently. Involuntary inpatient hospitalization was used 53 percent of the time followed by voluntary inpatient hospitalization (21 percent). Release was used 18 percent of the time (which includes patients released because the petitioner did not attend the hearing) and involuntary outpatient commitment was used eight percent of the time. According to survey and interview responses, adequate treatment resources are not always available. This is particularly true when inpatient hospitalization for substance abuse and specialized outpatient treatment is needed.

Involuntary Inpatient Commitment Needs. When asked whether adequate inpatient hospitalization options are available and accessible, surveyed special justices and psychiatrists and psychologists noted that was not always the case. Sixty-one percent of special justices and 55 percent of psychiatrists and psychologists responded that adequate inpatient hospitalization options, in both public and private facilities, are not always available to address the needs of committed individuals. Thirty-two percent of special justices and 30 percent of psychiatrists and psychologists disagreed with the statement that when inpatient hospitalization is ordered, it is available at nearby locations within Virginia.

One area of particular concern regarding inpatient treatment needs involves individuals who require substance abuse treatment. Special justices reported that of the individuals who were involuntarily committed in 1993, 43 percent had a debilitating substance abuse problem which contributed to their dangerousness, inability to care for themselves, or mental illness in general. Similarly, psychiatrists and psychologists reported that 39 percent of the individuals they evaluated, related to the involuntary commitment process in 1993, had a debilitating substance abuse problem. Often these individuals have a dual diagnosis of mental illness and substance abuse. As noted previously in Chapter III, there are few detoxification centers available to safely detain individuals who are temporarily dangerous due to intoxication. There are also few hospitalization alternatives, particularly for individuals who do not have private health insurance, for the judge or special justice to use in committing an individual for substance abuse treatment.

The lack of appropriate substance abuse treatment facilities often means that there are few available alternatives which will address the underlying substance abuse problem. The following commitment hearing observation illustrates a number of problems encountered by special justices in dealing with substance abusers.

> *One commitment hearing observed by JLARC staff involved a patient who had been detained after walking into the hospital emergency room complaining of auditory and visual hallucinations. The patient had been receiving treatment at a local substance abuse treatment facility but had left the facility prior to completing the treatment. The examining psychiatrist noted it was a "borderline" call as to whether the patient was imminently dangerous to himself. The psychiatrist also pointed out that the only treatment alternative for the patient was to commit him to the closest State mental health hospital although the hospital would not be able to provide the needed substance abuse treatment.*
>
> *The presiding special justice then explained, to observing JLARC staff, that State mental health hospital staff are not pleased when they are sent a substance abuser who cannot benefit from their program. The patient stated that he had been using drugs for 25 years, was in need of a long-term substance abuse program, and was vehemently opposed to be sent to the State mental health hospital. The patient therefore asked to be allowed to voluntarily admit himself into a substance abuse program within the community.*
>
> *The special justice indicated that he felt that the patient should be committed to the State mental health hospital. After an extended discussion among the special justice, the examining psychiatrist, the attorney, and the patient, the special justice reluctantly agreed to release the patient so he could be admitted into the community program. The special justice told the patient that if he came before the court again and it was clear that he had been using cocaine, that the special justice would see that a criminal charge would be brought which would activate a previous suspended sentence on a criminal drug charge.*

As illustrated, it is sometimes difficult to determine whether a substance abuser is a danger to self or others and although there may be no substance abuse treatment options available, special justices are sometimes reluctant to simply release the patient.

As part of its current study on substance abuse resources, DMHMRSAS should determine the cost-effectiveness of providing or contracting for needed substance abuse treatment for committed individuals. Substance abuse treatment appears to be needed by a significant proportion of the individuals who are currently involuntarily committed for mental health problems.

Involuntary Outpatient Commitment Needs. Involuntary outpatient commitment typically involves requiring an individual to attend any counseling session or other necessary treatment that is scheduled and to take all prescribed medications. As noted previously, special justices reported ordering involuntary outpatient commitment in only eight percent of commitment hearings. It appears that the lack of available outpatient treatment alternatives may be limiting its use by special justices. Forty-eight percent of special justices reported that adequate outpatient treatment options are not available to address the needs of individuals seen in commitment hearings while outpatient treatment was not available at a nearby location 20 percent of the time that outpatient treatment was ordered. A larger percentage of psychiatrists and psychologists noted that adequate outpatient treatment alternatives are not available (according to 74 percent of respondents) and that when outpatient treatment is ordered it is not available at a nearby location (according to 44 percent of respondents).

Some CSB staff also indicated that they are limited in the number of individuals they can serve on an involuntary outpatient basis. Generally few community-based residential facilities are available to address the needs of individuals for short-term, specialized treatment. Staff members indicated that frequent therapy sessions may be needed to prevent the need for hospitalization and that CSB counselors already have large caseloads. Further, many private insurance plans refuse to pay for outpatient mental health treatment. One CSB staff member explained, "the public sector is becoming more and more the provider of first not last resort . . . and this is affecting the public sector's need to provide services."

The development of viable outpatient treatment alternatives to involuntary hospitalization may be a productive, cost-effective effort. Many of the services provided by State mental health hospitals can be provided on an outpatient basis, including therapy and medication management. The diversion of as many individuals as possible to outpatient treatment appears critical, considering that: (1) hospitalization in a State mental health hospital costs $237 per day, (2) there are intermediate interventions that can be effective, and (3) individuals could remain in their communities and avoid many of the potentially debilitating consequences of hospitalization.

Recommendation (28). **The Department of Mental Health, Mental Retardation and Substance Abuse Services should continue to work with community services boards to develop additional outpatient treatment alternatives in order to reduce the number of individuals entering the involuntary commitment process and being hospitalized.**

New Statutory Requirements to Thumbprint Present Logistical Problems

As of July 1, 1994, the *Code of Virginia* requires the thumb-printing of any person who is involuntarily committed. The thumbprint is to be obtained at the commitment hearing site and forwarded with a copy of the involuntary commitment order to the Central Criminal Records Exchange. The order and thumbprint are to be used to prevent individuals who have been involuntarily committed from purchasing

firearms until a circuit court judge has issued an order of restoration of competency or capacity.

A number of special justices have indicated that logistical concerns will keep them from consistently thumb-printing the individuals they commit. Several special justices have written the Supreme Court to register their concerns about the requirement. Some of the statements made in the letters include:

> [The thumb-printing procedure] is, in my opinion, virtually impossible to have any of us carry out. I am certainly not inclined to take thumbprints from any AIDS patients, violent or potentially violent patients, and know of no lawyers who would be so inclined either.
>
> * * *
>
> I am greatly disturbed about this amendment. It appears to have originally been aimed at felony defendants who were acquitted by reason of insanity . . . .
>
> I suppose a Special Justice is not supposed to rule on constitutionality of Statutes, but this one clearly appears to me to violate the patients' rights.
>
> Accordingly, until I receive specific orders from someone to the contrary, I intend to do nothing further myself. If this law is enforced, I will be much more strict in interpreting the commitment laws, which means that most patients will be released . . . . I may just choose to do an end-around and try to talk the patients into signing in voluntarily if they really need help.
>
> More to the point, however, I am disturbed about having to do the thumb printing during a hearing . . . . The patients are always nervous, and I frequently have to assure them that they are in no trouble with the law, that we are just simply trying to help. If I then produce a finger print kit, it is just going to set the patient back for days. Accordingly, unless I am ordered otherwise, I will not permit the finger-printing to take place during the hearing. The Clerk may or may not choose to do so afterwards, but that would be beyond my control.
>
> I certainly wish to obey the law and do my duty, but I consider my primary responsibility to be to the patient, and my decisions will be made accordingly.

Without considering the constitutionality of the thumb-printing requirement, there are a number of logistical problems involved in observing this requirement. When hearings are held in hospitals, as the majority of hearings are, the only security staff who may be available are the staff employed by the hospital. In very few if any cases would

staff who are trained in finger-printing be available. One special justice, in a letter to the Supreme Court, noted that the security staff within the State mental health hospital in which he hears cases "do not have the equipment or training necessary to take finger prints." Hospitals in the community, which lack the level of security personnel that a State mental health hospital has, are likely to be even less prepared to thumbprint patients.

The Supreme Court has received more than 75 inquiries from special justices indicating problems with the thumb-printing requirement. Supreme Court staff have attempted to assist special justices in understanding the statutory requirements that a thumbprint be taken but not in the logistics of how to accomplish it. Supreme Court staff have also consulted with the State Police in revising the form that is to be used for the thumbprint. The original form included fields that were misleading and were subsequently removed and omitted *Code of Virginia* section citations which were applicable and had to be added. As of October 24, 1994, the revised and corrected forms had not been sent to the special justices for their use. This is particularly problematic since thumbprints do not always adhere to the photocopied forms that special justices are using until the new forms become available.

Although Supreme Court staff have provided some assistance in interpreting statutory requirements and in revising the form that is to be used for thumb-printing, many of the special justices' logistical problems remain unresolved. A centralized effort to address how thumbprints should be taken would be a more efficient approach and most likely result in more uniformity in practice than allowing each of the special justices to work out these problems separately.

Recommendation (29). **The Supreme Court should provide guidance and technical assistance for special justices regarding questions and problems they have related to their involuntary commitment duties. The Supreme Court should be especially attentive in communicating legislative changes and how those changes may be implemented.**

TRANSPORTATION OF INDIVIDUALS FOLLOWING COMMITMENT

The transportation of individuals, who have been involuntarily committed for inpatient hospitalization, is typically provided by sheriffs' offices. Section 37.1-72 of the *Code of Virginia* allows any judge or special justice to "order that [the patient] . . . be placed in the custody of any responsible person or persons for the sole purpose of transporting [that patient] . . . to the proper hospital." CSB staff however, indicated that sheriffs' offices are required to provide the transportation the majority of the time.

Although it appears that sheriffs' offices will need to remain the primary providers of transportation for temporary detention orders, other modes of transportation following commitment to a hospital should be used whenever possible. The detention period allows time for assessment and stabilization of the patient. This allows mental

health professionals to make a better judgment on dangerousness and allows many patients to begin medication or otherwise stabilize so they pose less of a risk during transportation.

Alternatives for transporting committed patients are used in five of the other surveyed states. These states include:

- Florida, which statutorily prohibits law enforcement from being involved in transportation following the commitment hearing and requires localities to arrange for alternative transport vehicles,

- Georgia, which allows certified law enforcement officers (who are comparable to conservators of the peace in Virginia) within the state hospital to transport (in addition to sheriffs and police officers),

- Massachusetts, which uses ambulances to transport following the hearing,

- Mississippi, which allows family members to transport if the individual is not considered to be dangerous, and

- Tennessee, which transfers responsibility for transportation from the hospital to each county (a plan for how that transportation will be handled is independently developed by each county).

Using transportation alternatives is not without potential problems, however. There are liability concerns related to situations such as the transportation provider being injured by or because of the patient, the patient escaping and injuring a citizen, the patient being injured if there is an accident, and the patient being injured because of his or her actions. However, other states which have instituted the use of transportation alternatives report that few problems have been encountered and that these problems have not jeopardized the transportation operation.

CSB staff, in conjunction with the examining psychiatrist or psychologist, could advise the special justice regarding which patients should be considered for alternative transport and what options for transportation exist. The special justice could then determine how the patient should be transported. In cases in which the special justice determined that alternative transportation was appropriate, the sending hospital (the hospital in which the patient has been held during detention) should be responsible for determining how the transport should be accomplished. This is already standard practice among hospitals, in dealing with patients who have not been involuntarily committed, and is considered to be part of discharge planning. However, sheriffs' offices would still need to be available to transport patients who remained so dangerous they needed to be restrained during transport.

In addition, there are a number of significant benefits that may be achieved with alternative transportation modes. Alternative transportation modes make the process less coercive and criminalizing; free law enforcement staff, who are often under-staffed,

to perform their law enforcement duties; and some mental health professionals indicate may positively influence the patient's receptiveness to therapy.

A complication for some transports is the potentially time-consuming activity of taking the patient to a hospital emergency room for medical screening prior to transporting to the hospital. Some State mental health hospitals require a medical screening in some or all cases in which a patient is being involuntarily committed to their care. This requirement is complicated by the fact that State mental health hospitals have different guidelines regarding when a medical screening will be required and what that screening will include. The medical screening problems can be resolved. DMHMRSAS should determine under what circumstances a medical screening will be required by any State mental health hospital, what that screening will include, and then establish a policy for all State mental health hospitals to follow on medical screenings.

Recommendation (30). **The General Assembly may wish to amend Section 37.1-72 of the *Code of Virginia* to allow community services board staff and the treating mental health professional to jointly recommend certain involuntarily committed individuals for alternative transportation if those individuals are not deemed to be dangerous to transport. The General Assembly may wish to further amend Section 37.1-72 of the *Code of Virginia* to encourage special justices to allow these individuals to be placed in the custody of any responsible person or persons or any representative or representatives of the facility in which the individual is hospitalized "for the sole purpose of transporting [that individual] . . . to the proper hospital."**

Recommendation (31). **The Department of Mental Health, Mental Retardation and Substance Abuse Services should establish a policy which is to be followed by State mental health hospitals regarding required medical screenings. This policy should define under what circumstances a medical screening would be required and what that screening would include. The policy should be distributed to law enforcement officers, community services boards, and all State mental health hospitals.**

OVERSIGHT OF THE INVOLUNTARY COMMITMENT HEARING PROCESS

A number of due process protections are statutorily provided within Virginia's involuntary commitment hearing process. The following rights are guaranteed for individuals being considered for involuntary commitment:

- to have court-appointed counsel or retain private counsel at their own expense,

- to present any defenses including independent evaluation and expert testimony or the testimony of other witnesses,

- to be present during the hearing and testify,

- to appeal any certification for involuntary admission to the circuit court, and

- to have a jury trial on appeal.

Many of these protections, however, cannot realistically be accessed by individuals who may be extremely agitated or disoriented, poorly educated, or indigent. Compounding these problems is the fact that the process itself operates with little external oversight. Generally the hearings are not open to public scrutiny, no transcript of the hearing is made, and very few of the judicial decisions made are reviewed on appeal.

Improved Oversight of Hearings Is Needed

The oversight of involuntary commitment hearings can take several different forms. Oversight can be relatively informal in nature, including such safeguards as the presence of witnesses, family members, and other observers in the hearings. Other oversight can be more formal in nature, including such aspects as making official transcripts of the hearings and ensuring that client rights are observed and protected through effective legal representation. In Virginia, involuntary commitment hearings tend to be informal, no transcript of the hearing is made and the hearings are often conducted with no outside observers in attendance. Improvements in the oversight of these hearings are needed to ensure that the best interests of the clients are served.

The majority of involuntary commitment hearings for adults are held within the detaining hospital rather than in a district courtroom. This helps to maintain a less intimidating atmosphere for the patient and reduces transportation needs and associated difficulties. It is also conducive to promoting less formal, brief hearings often with no family members or interested parties in attendance. Only a few jurisdictions require the petitioner to attend the hearing. CSB staff reported that commitment hearings typically last from 17 to 38 minutes. The 40 hearings observed by JLARC staff ranged from about three to 60 minutes in length.

In the majority of observed hearings, there were no family members or witnesses in attendance. Typically the State-appointed attorney was the only advocate for the patient at the hearing. Regarding the effectiveness of the attorneys' representation, only three percent of special justices and seven percent of psychiatrists and psychologists responding to JLARC surveys disagreed with the statement that legal counsel is effective in protecting the detainees legal rights and in representing their interests in hearings. However, 65 percent of CSB respondents noted that the attorney does not always seem to represent the wishes of the client in hearings. When asked if the State-appointed attorney ever supports commitment when the client has expressed a desire to be released or objected to the commitment, 45 percent of special justices indicated that it does happen in about 23 percent of their cases.

Another factor which may influence the informality of these hearings is that no transcript of the hearing is made. Virginia was the only state of the 16 examined which made no audio or written transcript of the commitment hearing. Having no transcript of the hearing precludes any review of the proceedings after they have concluded. The taping of the hearings may result in less variation in hearing conduct than currently occurs throughout the State.

Several steps could be taken to increase the oversight that the actual commitment hearings receive. First, more effort could be made to involve family members and other interested parties in the hearings. Some CSB staff reported that they make every effort possible to alert family members and any other individuals, known to be important to the patient, of the commitment hearing. This is not possible in some areas, however, in which the hearing is held early the morning after the detention order has been served. Second, the role of the court-appointed attorney could be clearly delineated as representing the patient's wishes. Currently, the *Code of Virginia* in Section 37.1-67.3 states that the attorney is to "actively represent his client in the proceedings." It appears that some attorneys interpret this to mean that the wishes of the patient are to be represented while other attorneys interpret this to mean that the "best interests" of the patient are to be ascertained and represented. Third, requiring an audio tape be made of all involuntary commitment hearings would be another positive step in instituting oversight of these hearings. All tapes should be considered to be confidential and be retained either in a central location or within the appropriate district court.

Recommendation (32). **Community services board staff should make every reasonable effort to alert the patient's family and any other interested parties of the time and location of the commitment hearing. Special justices should not conduct involuntary commitment hearings until community services board staff have been allowed a reasonable amount of time to alert family members and other interested parties of the hearing.**

Recommendation (33). **The General Assembly may wish to clarify the wording of Section 37.1-67.3 of the *Code of Virginia* to specifically define the role of the client's attorney to be to represent the wishes of the client in the involuntary commitment hearing.**

Recommendation (34). **The General Assembly may wish to consider requiring that an audio tape be made and retained for all involuntary commitment hearings.**

Improved Oversight of Special Justices Is Needed

The appointment of special justices is made by the chief judge of the circuit court. According to Section 37.1-88 of the *Code of Virginia*, special justices "have all the powers and jurisdiction conferred upon a judge by this title and shall serve under the supervision and at the pleasure of the chief judge making the appointment." Having such

a decentralized system, with as many as 31 different entities appointing and supervising special justices, can lead to a lack of comprehensive information being known on a statewide basis, inconsistent training and guidance for process participants, and inconsistent practices during commitment hearings.

Information Collected about Special Justices and their Activities. Currently the Supreme Court, which disseminates some information about the involuntary commitment process, collects very little information about special justices and their activities. Instead, the Supreme Court acts in more of a bill-processing capacity collecting information only as it relates to making payments out of the involuntary mental commitment fund. When JLARC staff asked the Supreme Court for basic statewide statistics regarding special justices and their commitment-related activities, the Supreme Court was unable to provide all of the requested information. Information that could not be provided included:

- the number of special justices that had been appointed,
- the number of emergency custody orders and temporary detention orders issued by special justices,
- the number of hearings conducted by special justices,
- the location where involuntary commitment hearings took place, and
- the judicial dispositions ordered in involuntary commitment hearings.

While the study was underway, the Supreme Court developed an internal computer system which will capture some additional information. Generally, information about any special justices who are paid to conduct hearings and any activities the Supreme Court pays for from the involuntary mental commitment fund will be recorded on the computer system and will be available for FY 1994. Thus the Supreme Court will be able to report the number of TDOs for which reimbursement for the hospitalization is requested, the number of special justices who are paid for conducting hearings, and the number of hearings which are conducted. However, the Supreme Court will not have information on the number of special justices who only issue ECOs and TDOs, and the total number of ECOs and TDOs issued.

Written Guidance and Training for Special Justices. A substantial percentage of special justices indicated the need for additional guidelines and training in the area of involuntary commitment hearings (Table 7). Nearly 70 percent of the special justices responding to the JLARC survey reported that they had received legal guidance or training related to conducting involuntary commitment hearings, but only 38 percent reported receiving similar mental health training. Sixty-eight percent of the responding special justices reported that it would be helpful to receive additional legal or mental health training related to the role of special justice. Special justices gave similar responses when asked specifically about the adequacy of the legal and mental

Table 7

Responses Given by Special Justices Regarding Guidance and Training

Survey Question	**Response Yes**	**Response No**
Have you received legal guidance or training regarding your role and the conduct of involuntary commitment hearings? (n=79)	68%	32%
Have you received mental health training that would assist in adjudicating involuntary commitment hearings? (n=79)	38%	62%
Would it be helpful, in your role as a special justice to have additional legal or mental health training in this area? (n=77)	68%	32%

Survey Statement	**Agree**	**Disagree**	**No Opinion**
The legal training provided has been adequate in meeting my needs as a special justice. (n=76)	54%	37%	9%
The mental health training provided has been adequate in meeting my needs as a special justice. (n=77)	43%	48%	9%
There are adequate guidelines available to special justices to generally ensure uniformity in commitment hearings statewide. (n=79)	57%	42%	1%

Source: JLARC staff survey of 80 special justices, spring 1994.

health training. Only 54 percent agreed with the statement that the legal training they had received met their needs as a special justice, and only 43 percent agreed that the mental health training met their needs.

It is not surprising that special justices reported these needs for additional guidance and training. Written guidance for special justices regarding the involuntary commitment process is restricted to the statutory language in the *Code of Virginia* and there are no mandatory training requirements for special justices. In fact, the Supreme Court does not offer training for special justices. The University of Virginia offers an annual training program on the involuntary commitment process that special justices may attend if they pay the fees themselves and do not expect to be reimbursed for the time they spend at the conference. As a condition of appointment, special justices should be required to attend and pay for the training provided. The special justices should be

awarded the appropriate amount of continuing legal education credit for completion of the training.

Resulting Differences in Practice among Special Justices. The general lack of adequate guidelines, training, and oversight has resulted in substantial differences in practice among the special justices. As shown in Exhibit 1, only 57 percent of special justices agreed that available guidelines were adequate to generally ensure uniformity in commitment hearings statewide. The lack of consistency among special justices in conducting hearings is documented throughout this chapter. The following case studies present two contrasting styles of special justices observed by JLARC staff.

One special justice was observed conducting four hearings at one hospital. There was no discernible preliminary hearing conducted for any of the four patients and the patients were not given the opportunity to voluntarily admit themselves for treatment. In each of the four hearings the special justice explained that the hearing was to determine if the patient's mental status required him to stay in the hospital and that the patient had the right to retain a private attorney, to have a private psychiatric evaluation, and to appeal any decision. None of the patients were actually asked if they wanted to retain a private attorney or have a private psychiatric evaluation. The treating physician did not attend the hearings. Instead the hospital social worker read the physician's notes, which she had picked up from a secretary. The hospital social worker had no contact with the physician regarding the patients. A CSB staff member was also present but was never questioned or asked to give an opinion. Unless the CSB staff member asked to be heard, she was not consulted.

Briefly, the four hearings concluded as follows:

Hearing 1: After the social worker read the psychiatrist's notes which indicated the patient had been suicidal, the special justice asked the patient if he still had suicidal thoughts. The patient indicated that he previously had suicidal thoughts but had none currently. The CSB staff member noted that outpatient treatment had been arranged for the patient and that the patient had agreed to attend. The special justice allowed the patient to be released so that outpatient treatment could be initiated. The attorney did not speak during the hearing which lasted for approximately three minutes.

Hearing 2: After the social worker read the psychiatrist's notes, the special justice asked if the patient was dangerous to himself. The social worker stated that the doctor's notes indicated that he was dangerous to himself and needed to be stabilized. The patient's attorney asked if he heard voices and if he wanted to hurt himself. The patient replied that he was on medication and wanted to go home where he was working

with a social worker. The special justice committed the patient to a State mental health hospital based on the psychiatrist's recommendation. The hearing lasted approximately four minutes.

Hearing 3: The social worker read the psychiatrist's notes. The patient's attorney asked the social worker if the doctor considered the patient to be dangerous and the social worker indicated "yes." The attorney asked the patient if he felt depressed and the patient answered "yes." The special justice asked the social worker what the psychiatrist recommended. Upon hearing that involuntary commitment to the detaining hospital was recommended, the special justice committed the patient to that hospital. The hearing lasted for approximately four minutes.

Hearing 4: The last hearing had to be moved to the patient's room for medical reasons. Before moving into the patient's room, the special justice had the social worker read the psychiatrist's notes. The notes indicated that the patient had been suicidal and had made homicidal threats to his family. The CSB worker noted that she had met with the patient that day and that the patient did not own a gun, was not feeling suicidal any longer, had had a constructive family visit the previous day, and did not want to stay in the hospital. The CSB worker noted that she had talked with the hospital's chief psychiatrist who indicated that the treating psychiatrist had recommended commitment for the patient because "it wouldn't hurt to commit him." The CSB worker stated she did not think the patient should be committed as his problems were medical in nature. The patient's attorney noted that he was not sure his patient met commitment criteria and that if the family had really been afraid of the patient, they would not have gotten along so well the previous day. The special justice did not ask whether family members would be attending the hearing or offer to postpone the hearing until a family member could attend the hearing (since there were no family members in attendance that day). Instead, the special justice allowed the interests of the family to be represented by the attorney.

The hearing was then moved to the patient's room where the patient was in his bed. After the special justice gave his usual opening remarks, he allowed the patient to speak. The patient indicated remorse for his previous threats and began to cry openly. The special justice apologized to the patient for upsetting him and stated he was returning to the hearing room to make a decision. Upon returning to the hearing room, the special justice noted that the psychiatrist had recommended committing the patient so he (the special justice) felt he had to commit the patient. The patient was committed to the detaining hospital and the social worker informed the patient of the decision. The entire hearing process required approximately ten minutes.

* * *

A second special justice was observed conducting one commitment hearing. The special justice began with a preliminary hearing which involved interviewing the emergency services clinician, the (adult) patient's father, and reviewing the treating physician's notes prior to interviewing the patient. The special justice explained the consequences of voluntary admission and the possible hearing outcomes, before asking the patient if he wished to voluntarily admit himself. The patient decided not to voluntarily admit himself.

The special justice then proceeded with the commitment hearing by explaining to the patient why he had been detained, reminding him that he had a court-appointed attorney, explaining how the hearing would proceed, and noting that any adverse decision could be appealed. The special justice and the attorney questioned witnesses including the treating physician, the emergency services clinician, and the patient's father. The patient had been taken off a busy rural highway by sheriff's deputies and returned home. The patient's parents then requested a TDO because they noted that they could not control him when he was off of his medication. The patient had been committed at least three times before and had stopped going to his outpatient appointments and had stopped taking his medication for schizophrenia. The patient's attorney argued for allowing his client to attend voluntary outpatient treatment despite the opinions of the treating physician and CSB worker that the patient met commitment criteria. The patient was allowed to make any additional statements desired before the decision was given. The special justice ordered that the patient be involuntarily committed to a State mental health hospital. The preliminary hearing lasted approximately 15 minutes and the commitment hearing lasted approximately 45 minutes.

As noted in the National Center for State Courts' 1989 study of involuntary commitment, "a great variation in almost all aspects of judicial hearings exist throughout Virginia . . . . This lack of uniformity increases the risks of like cases being treated differently depending on the jurisdictions in which they are heard." As illustrated above, JLARC staff also observed violations of patients' statutory rights (the opportunity to voluntarily admit oneself for treatment and to be present during the commitment hearing), despite attending a limited number of hearings and the fact that the staff member's presence was known to the special justice.

Ways to Reduce Inconsistency in Practice among Special Justices. A relatively large number of special justices currently conduct involuntary commitment hearings. This number could be decreased if special justices were no longer needed to issue ECOs and TDOs (in keeping with a recommendation made in Chapter III). If special justices' only involvement in the involuntary commitment process entailed conducting commitment hearings, the number of positions needed should decrease.

Having a smaller number of special justices would assist in reducing the inconsistency in practice and simplify establishing other means of instituting uniformity, such as ensuring adequate training of all special justices and maintaining statistics on their involuntary commitment activities.

One way to reduce the inconsistency in practice and possibly decrease costs, is to reduce the number of special justices involved in conducting involuntary commitment hearings. In FY 1994, 160 special justices were paid $1.1 million for conducting commitment hearings. Having so many special justices conducting hearings increases the incidence of inconsistency in practice and complicates efforts to institute some uniformity. If responsibility for issuing ECOs and TDOs were assumed by magistrates, the number of special justices needed would decrease. This would allow for better tracking of special justice workloads and potentially facilitate the appointment of half-time, salaried positions, negating the need to reimburse special justices on a per-hearing basis. In some jurisdictions, having half-time positions may result in cost-savings. In one urban area, for example, three special justices were paid a total of nearly $120,000 in FY 1994 for conducting commitment hearings. It is likely that two half-time positions would have been able to conduct all hearings at a lower cost. The Supreme Court, in conjunction with circuit court judges, should develop a staffing plan which delineates the number of special justices needed to conduct involuntary commitment hearings in each judicial district. The focus of the plan should be to reduce the number of appointed special justices and associated costs whenever possible.

Another important means of reducing inconsistency in the process is to provide better training and guidance for special justices. All newly appointed special justices should be required to complete mandatory training. The Supreme Court currently provides 40 hours of intensive training for new magistrates as well as a focused one-day training and two conferences for magistrates each year. The Supreme Court should design and provide or contract for similar training for newly hired special justices.

A third means of reducing inconsistency is to increase the oversight of special justices and their activities. As previously noted, making audio tapes of all hearings, which could then be reviewed for consistency in practice and preservation of patients' statutory rights, would be one way to oversee the activities of special justices. The Supreme Court should also retain better data on their activities. Currently the only information maintained by the Supreme Court on commitment hearings is the information submitted by district courts. Although district courts are not required to report any activity data on involuntary commitment hearings, courts in 23 districts report on some or all commitment hearings held by special justices within their jurisdictions. The Supreme Court reports this information as district court activity, which means that these hearings cannot be distinguished from the hearings which are actually conducted by district court judges. The Supreme Court should maintain statistics on the number of commitment hearings conducted throughout the State by both special justices and district court judges and distinguish between the two.

Recommendation (35). **The General Assembly may wish to require the Supreme Court, in conjunction with circuit court judges, to submit a plan that**

recommends the number of special justices needed and in what districts these justices are needed. The focus of the plan should be to reduce the number of appointed special justices, in conjunction with reductions in their workload related to issuing emergency custody orders and temporary detention orders, and to reduce costs whenever possible. Due to the cost implications of the plan, it should be submitted to the Senate Finance Committee and the House Appropriations Committee prior to the 1996 General Assembly session.

Recommendation (36). **The Supreme Court should directly provide or contract for training for all newly appointed special justices. This training should be mandatory for all new special justices and should be completed as soon as possible but always within three months of appointment as a justice.**

Recommendation (37). **The Supreme Court should institute reporting requirements which will allow for the collection and maintenance of basic statistics about the commitment process. These statistics should be kept according to district or locality and include, at a minimum, the number of emergency custody orders and temporary detention orders issued, the number of special justices who have been appointed, the number of commitment hearings that special justices conduct, the location of each commitment hearing, the number of commitment hearings district court judges conduct, and the judicial dispositions ordered in the commitment hearings.**

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