

A Preliminary Report and Recommendations

of the

**Commonwealth of Virginia
Commission on Mental Health Law Reform**

December 21, 2007

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COMMONWEALTH OF VIRGINIA

COMMISSION ON MENTAL HEALTH LAW REFORM

Background

This is the first report released by the Commonwealth of Virginia Commission on Mental Health Law Reform (“Commission”). The Commission, appointed by the Chief Justice of the Supreme Court of Virginia, Leroy Rountree Hassell, Sr., in October 2006, is chaired by Professor Richard J. Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia.

This report represents the views and recommendations of the members of the Commission on Mental Health Law Reform, and should not be construed as reflecting the opinions or positions of the Chief Justice, the individual Justices of the Supreme Court of Virginia or of the Supreme Court. The Chief Justice and the Supreme Court of Virginia will be cognizant of the separation of powers doctrine when deciding which recommendations to accept.

Composition: Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups, including consumers of mental health services and their families, service providers, and the bar. The Commission is assisted by five Task Forces charged, respectively, with addressing gaps in access to services, involuntary civil commitment, empowerment and self-determination, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. In addition, the Commission established a Working Group on Health Privacy and the Commitment Process (“Working Group”).

Charge: The Commission was directed to conduct a comprehensive examination of Virginia’s mental health laws and services and to study ways to use the law more effectively to serve the needs of people with mental illness, while respecting the interests of their families and communities.

Goals of reform include reducing the need for commitment by improving access to mental health, mental retardation and substance abuse services, avoiding the criminalization of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers of mental health services to have more choice over the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

Process: Meetings of the Commission were held on October 12-13, 2006 (Williamsburg), December 8, 2006 (Charlottesville), March 15-16, 2007 (Charlottesville), June 21-22, 2007 (Fredericksburg), August 23-24, 2007 (Hampton), November 16, 2007 (Hampton) and November 29-30, 2007 (Charlottesville). Meetings for 2008 have not yet been scheduled.

Research: The Commission conducted three major studies during 2007. The first was an interview study of 210 stakeholders and participants in the commitment process in Virginia. The report of that study, entitled *Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations*, was issued in April, 2007. The second major research project was a study of commitment hearings and dispositions. In response to a request by the Chief Justice, the presiding judge filled out a 2-page instrument on every commitment hearing held in May, 2007. (There were 1,526 such hearings.) Findings from the Hearing Study have been presented to the Commission and have served an important role in shaping the Commission's understanding of current commitment practice. A final report of the Hearing Study will be released in January, 2008. Finally, the Commission's third project was a study of every face-to-face crisis contact evaluation conducted by CSB emergency services staff during June, 2007. (There were 3,808 such evaluations.) Although preliminary findings from that study have been presented to the Commission, a final report will not be available until the early Spring of 2008. The Principal Investigator for these projects was Dr. Elizabeth McGarvey of the University of Virginia School of Medicine.

Reports: This preliminary report outlines a comprehensive blueprint for reform ("Blueprint") and identifies specific recommendations for the 2008 session of the General Assembly. The Commission's Task Force Reports and findings from Commission research will become available in early 2008. The Commission will then prepare a comprehensive plan to implement the Blueprint. Public hearings are planned for the early summer of 2008 and the Commission will submit its final report in the fall of 2008.

Further Information:

Thomas M. Diggs, Commission Staff Director and Assistant Director of Judicial Programs, Office of the Executive Secretary, Supreme Court of Virginia, 100 North Ninth Street, Third Floor, Richmond, Virginia 23219; 804-225-3474, 804-786-4542 (fax), tmdiggs@courts.state.va.us.

INTRODUCTION

The Chief Justice initiated the Supreme Court of Virginia's mental health law reform process two years ago – in December of 2005. The project quickly gathered momentum because so many participants and stakeholders were dissatisfied with the status quo, and recognized that changes were long overdue. A consensus emerged around three aims: closing gaps in community mental health services, using the law more effectively to assure that people in crisis can get the help they need in a timely fashion, and laying a strong legal foundation for a modern, recovery-oriented mental health system.

The Commission was established in the fall of 2006 after a lengthy planning process involving all branches of government and many mental health constituencies. When the Commission and its five task forces began their work, the plan was to engage in intensive study through 2007, to hold public hearings in the spring of 2008, and to issue a final report in the fall of 2008.

The tragic events at Virginia Tech of April 16, 2007, changed everything. The Panel charged with investigating the Virginia Tech shootings found that an aborted episode of involuntary treatment in December of 2005 was one of several missed opportunities to uncover Seung Hui Cho's deepening emotional disorder and distress before it exploded into horrifying violence. Some of the deficiencies of the civil commitment process that the Commission had been studying suddenly burst into full public view. The compelling need for change – long recognized by people within the mental health system – now became evident. Fixing this system became an imperative.

The Commission accelerated its timetable. Although our work has not been completed, we decided to intensify our efforts in order to be in a position to assist the Governor and the General Assembly respond to well-grounded public interest and concern. This preliminary report is the result. In this report we present a Blueprint for Comprehensive Reform that the Commission will continue to develop as it had originally planned. However, the Commission is suggesting that the General Assembly consider expedited statutory changes in a few areas where problems have been clearly identified and solutions seem apparent. In many other areas where reform is clearly indicated, we believe further study is needed, and we therefore recommend caution.

A consensus has clearly emerged on the need to develop a more effective and comprehensive system of community services. Based on the work of the Task Force on Access to Services, the Commission has identified the components of a robust community services system that can help prevent crises, respond to them successfully, and provide intensive services to those who need them to achieve recovery. The Commission recognizes that the Commonwealth is facing a significant shortfall in revenues, and many competing public needs, in the upcoming biennium. Accordingly, for now, the Commission recommends a substantial down payment on the needed investment, together with a commitment to sustain it over the years ahead.

In our final report, we will present a plan for sequential implementation of the proposed Blueprint over several biennia. In the meantime, however, we hope that this Preliminary Report will provide helpful guidance to the members of the General Assembly as they begin the process of reform this year. Members of the Commission and its Task Forces stand ready to assist in whatever way we can.

Richard J. Bonnie, Chair
Commission on Mental Health Law Reform

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RECOMMENDATIONS FOR LEGISLATIVE CONSIDERATION IN 2008

The Commission has identified the following items for consideration in the 2008 Session of the General Assembly.

- 1. Emergency Custody Orders (“ECO”).** Virginia law currently provides that upon a finding of probable cause that a person meets commitment criteria, a magistrate may issue an ECO so that a mental health evaluation can be performed. The ECO only lasts for four hours. In many situations, particularly in rural areas and during bad weather, this time period is too short to allow an adequate evaluation.

Recommendation

The Code of Virginia should be amended so that the four-hour period of detention under an ECO may be renewed one time, for good cause shown and upon application to a magistrate, for an additional period of not more than four hours. The resulting maximum ECO period will be eight hours. (Blueprint III-A-1)

- 2. Transfer of Custody to Crisis Stabilization Facilities or Other Therapeutic Locations with Proper Security.** Virginia law currently requires that law enforcement officers maintain custody of a person during the entire length of the ECO period. This encourages law enforcement officers to arrest individuals rather than taking them to a more therapeutic setting and consumes a significant amount of time that could be better spent on law enforcement activities. Hospital emergency facilities and crisis stabilization facilities with the capacity to receive custody from law enforcement officers can often assist in ending the crisis and thereby avoid the necessity of a temporary detention order or an involuntary commitment. As the Department of Mental Health, Mental Retardation and Substance Abuse Services (“DMHMRSAS”) and the Community Services Boards/Behavioral Health Authorities (“CSBs”) continue to develop a full continuum of crisis stabilization services in each region, they should also create settings suitable for transfer of custody.

Recommendation

*Section 37.2-808 of the Code of Virginia should be amended as follows:
“Upon delivery of the person to the location identified in the emergency custody order, or to an appropriate location if the law enforcement officer has assumed custody of the person under subsection F, the location to which the person is transported may assume custody of the person if it is willing and licensed to provide security to protect the individual and others from harm.” (Blueprint III-A-2)*

- 3. Attendance at Commitment Hearings.** Currently, CSB staff do not attend commitment hearings in a majority of jurisdictions. The absence of these

professionals can lead to missed opportunities for identifying alternatives to hospitalization and for formulating and monitoring outpatient commitment orders. In order to improve the quality of these hearings and the outcomes, the Commission recommends that a CSB staff member be present in person or electronically. In many cases, the Independent Examiner (“IE”) also does not attend the hearings, although his or her report is admitted. This can lead to problems if there are questions about the IE’s report and conclusions. In order to improve the quality of these hearings and the outcomes, the Commission recommends that the IE be present in person or electronically.

Recommendations

A. The Code of Virginia should be amended to require a CSB representative to attend all commitment hearings, in person or electronically. (Blueprint III-E-1)

B. The Code of Virginia should be amended to require the Independent Examiner to attend the hearings, in person or electronically, in cases involving individuals he or she has examined, if his opinion is objected to by the person or his attorney, or if his opinion is contested by the treating physician. (Blueprint III-E-2)

4. Protection of Health Information Privacy During Commitment Process.

Several concerns about the relationship between health information privacy protections under Virginia law and under the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) regulations were raised by the panel investigating the Virginia Tech shootings on April 16, 2007. Based on the report of the Commission’s Working Group on Health Privacy and the Commitment Process, the Commission believes that Virginia law requires clarification in two areas.

The first issue concerns disclosures of otherwise confidential health information in connection with the commitment proceedings. Virginia law and HIPAA now authorize disclosures of mental health information to the CSB pre-screeners and the IE by health care providers to allow an informed evaluation process. However, the Working Group concluded that disclosure of this information to the special justice or judge at the commitment hearing – although implicitly authorized by Virginia law – may not be authorized by HIPAA unless Virginia law is modified to specifically require providers to make such disclosures. The Commission recommends that Virginia law be so modified.

The second issue concerns public access to otherwise confidential personal health information introduced in commitment proceedings in the absence of the respondent’s explicit consent. Under current law, the court is directed to keep such records confidential, *but only if requested by the subject or his counsel* (Va. Code § 37.2-818(B)). It appears that, under current practice, most respondents are unaware of their rights, do not make a specific request to invoke their right to keep their medical records confidential and, as a result, these highly sensitive records are now open to public view. The Working Group recommends that the presumption now set in Va. Code § 37.2-818(B) be reversed and that the

commitment records be presumed to be confidential. In addition, existing judicial authority to close the hearings when private health information is being discussed should be codified. The Working Group recognized that members of the public (e.g., family; concerned individuals; educational institutions) sometimes have a legitimate interest in knowing the *outcome* of the proceedings. However, in such cases, the Working Group concluded that public access should be limited to the dispositional order and only upon an appropriate showing, and that this limitation should be codified. The Commission agrees.

Recommendations

A. Virginia law should be modified to require health care providers to disclose relevant health information to judicial officers in commitment proceedings. (Blueprint III-G-1)

B. Virginia law should limit public access to records of commitment proceedings to the dispositional order and then only upon a showing that disclosure is in the interest of the respondent or that the public interest overrides the respondent's privacy interest. (Blueprint III-G-2)

5. **Commitment Criteria.** The current criteria for commitment (which apply to both inpatient and outpatient treatment) are unnecessarily vague and confusing, and are being applied inconsistently across the Commonwealth. In addition, there is evidence that the phrase “imminent danger” is being given an unduly restrictive interpretation in some jurisdictions. The Commission recommends that the General Assembly modify the existing criteria to provide greater specificity and to avoid unduly restrictive applications of the commitment law.

Recommendation

Revise Va. Code § 37.2-817.B to read as follows:

“A person may be involuntarily admitted to a psychiatric inpatient facility for treatment upon a finding of the court by clear and convincing evidence that:

(1) he or she has a mental illness and as a result of such mental illness:

(a) there is a substantial likelihood that, in the near future, he or she will cause serious physical harm to himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; or

(b) there is a substantial likelihood that, in the near future, he or she will suffer serious harm due to substantial deterioration of his or her capacity to protect himself or herself from such harm or to provide for his or her basic human needs; and

(2) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been investigated and judged to be inappropriate.” (Blueprint III-I)

6. **Mandatory Outpatient Treatment (“MOT”).** Under current law, MOT is “a less restrictive alternative” to inpatient treatment, but it is rarely used. (Data from Commission’s Study of Commitment Hearings in May of 2007 indicates that only

5% of commitment hearings result in MOT). One reason that it is not used regularly is that the CSBs lack capacity to provide the services and to monitor outpatient treatment. There has been debate regarding whether MOT should be increased or, to the contrary, should be abandoned altogether, even as an alternative to inpatient treatment.

Recommendations

A. Retain use of mandatory outpatient treatment as a less restrictive alternative to involuntary admission, while clarifying the conditions under which such orders may be issued. (Blueprint III-J)

B. Use mandatory outpatient treatment as a supplement to short-term acute hospitalization or residential stabilization, perhaps as a component of a single commitment order. (Blueprint III-J)

- 7. Procedures for Implementing Mandatory Outpatient Treatment.** There is confusion over the proper procedure for monitoring and implementing outpatient treatment orders. If the number and size of crisis stabilization units are increased and additional outpatient services are funded, this clarification will become even more necessary.

Recommendation

The Commission has drafted a detailed proposal specifying procedures for ordering, monitoring and terminating outpatient treatment orders. It includes, among other requirements, the following: A copy of the treatment plan should be attached to the order. The order should designate the provider, the community services board responsible for monitoring the order and should be provided to community services board and other providers. The length of the mandatory outpatient treatment order and the consequences of non-compliance should be specified. (Blueprint III-K)

- 8. Length of Commitment.** Currently, the law provides for commitment up to 180 days. There is no mechanism for reviewing a commitment prior to 180 days. The Commission felt this was too long a period of time, and that a better approach would be to have a shorter order for the first episode of treatment, with a mechanism for orders of continuation as necessary.

Recommendation

The first order for inpatient commitment in a particular episode of treatment should not exceed 30 days. The first order of mandatory outpatient treatment (or a combined order of acute hospitalization followed by mandatory outpatient treatment) should not exceed 90 days. Subsequent consecutive orders for commitment would not exceed 180 days. (Blueprint III-F)

- 9. Increases in Service Capacity.** In order to secure meaningful improvements in the Commonwealth's mental health system, the Commission recommends an increase in the services available to people in the community. The Commission's

Blueprint identifies the core services that should be available in each locality and urges the General Assembly to increase state funding for these services over a period of three biennia. In the upcoming biennium, the Commission encourages the General Assembly to give immediate priority to crisis stabilization services, outpatient treatment services and case management services.

Recommendations

A. The General Assembly should consider funding crisis stabilization facilities in each CSB region of the Commonwealth. (Blueprint I-D-1)

B. Case management services are insufficient in many localities and should be increased to enable caseloads to be reduced. (Blueprint I-D-3)

C. Funding for outpatient services is necessary to enable the CSBs to carry out and monitor mandatory outpatient treatment orders. (Blueprint I-D-2)

D. Currently, the only mandated services provided for in the Code are emergency services and case management services, if funding exists for the latter. The General Assembly should consider immediately requiring case management services and outpatient treatment services to be provided as a CSB mandated service. (Blueprint I-A)

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A BLUEPRINT FOR COMPREHENSIVE REFORM

This Blueprint for reform is organized to reflect the work of each of the Commission's five Task Forces. The Task Force reports will be released in due course in early 2008. However, based on the work of the Task Forces, the Commission has formulated the components of a plan for putting the Commonwealth on the track toward fundamental improvements of the mental health services system and reform of its legal architecture. Over the next year, the Commission will develop a more detailed proposal for fleshing out these recommendations and implementing them in sequential steps over a 6-year period.

The first section of the Blueprint addresses **access to services**. Reforms to the legal process will make very little difference unless the Commonwealth closes the major gaps that continue to exist in community mental health services. The services system envisioned by the Commission is one in which people who need mental health services seek them on their own. They are drawn to the services system because it serves their needs, and there is correspondingly less emphasis on pushing unwilling people into services by force of law or by informal mechanisms of coercion. A guiding element of a reformed system – indeed, a transformed system – is that recipients of services exercise meaningful control over the services they receive. Accordingly, the second section of the Blueprint focuses on **empowerment and self-determination**.

A reformed system will use coercion as little as possible, but coercion will always be needed in some instances because mental illness sometimes undermines a person's capacity to exercise rational judgment about his or her own interests. When coercion is needed, it should be exercised effectively, fairly and with respect for human dignity. Those are principles that guide the portion of the blueprint addressing the **civil commitment process**.

One of the most troubling features of the present crisis on mental health services is the drift toward criminalization of people with mental illness. The best estimates suggest that 15% of inmates in jails and prisons have serious mental illness. Perhaps the greatest challenges we face are to develop tools for keeping people with mental illness out of the criminal justice system and for delivering the services that they need if they are in the custody or supervision of the criminal justice system. The fourth section of the Blueprint addresses strategies for **realigning the mental health and criminal justice systems**.

Finally, the last section of the Blueprint addresses the entire array of issues just mentioned in the context of serving the needs of **children, adolescents and their families**.

It bears emphasis that the elements of the Blueprint are formulated at a level of generality that obscures many important issues that need to be addressed before they can be offered as concrete proposals. The Commission will be developing these proposals

over the next year. However, the raw material for the Commission's work in most of the areas covered by the Blueprint can be found in the Task Force Reports.

I. ASSURING ACCESS TO SERVICES

Increasing pressure on the emergency services system including hospital emergency rooms and the civil commitment process, a disturbing trend toward criminalization of people with mental illness, and its spillover effects on the criminal justice system are all symptoms of gaps in the community mental health services system. In order for any mental health law reforms to be successful, access to community mental health services must be greatly enhanced. The Commonwealth's mental health system should aim to assure access to recovery-oriented services needed by persons with mental illness, should facilitate individual choice by recipients of services, and should protect individuals with mental illness and others from harm. A blueprint for achieving this goal should have the following components

I-A Increase CSB Mandated Services

The Commission recommends revising Va. Code §§ 37.2-500 and 37.2-601 to expand the array of services required for voluntary and involuntary access to services that must be provided by community services boards and behavioral health authorities ("CSBs") and supported by the Commonwealth of Virginia. State grant funding should provide the foundation of support for these mandated services:

The core of services provided by community services boards within the cities and counties that they serve shall include *emergency, crisis stabilization, case management, outpatient, respite, in-home, residential and housing support services*. The core of services may include a comprehensive system of inpatient, prevention, early intervention, and other appropriate mental health, mental retardation, and substance abuse services necessary to provide individualized services and supports to persons with mental illnesses, mental retardation, or substance abuse.
(Recommended for consideration in 2008.)

I-B Strengthen the Role of DMHMRSAS

The Commission recommends conferring responsibility on the Department of Mental Health, Mental Retardation and Substance Abuse Services ("DMHMRSAS") to establish and sustain core community-based mental health services. DMHMRSAS should be responsible for sustaining the core components of community-based mental health services, including, at a minimum, emergency services, crisis stabilization, case management, outpatient, respite, in-home, residential, and housing support services.

I-B-1 Broaden Goals of Comprehensive State Plan. DMHMRSAS, under its statutory obligation (Va. Code § 37.2-315) to develop a comprehensive state plan, should focus planning efforts on the development of a

comprehensive, accessible community-based system of services provided through a combination of direct services, interagency collaboration, community partnerships and services contracts with both private and public providers.

I-B-2 Strengthen CSB/ Performance Contracts. DMHMRSAS performance contracts for mental health, mental retardation and substance abuse services should:

- a. reflect DMHMRSAS's role in creating, funding, sustaining and reporting on an expanded array of core community-based services required by Va. Code §§ 37.2-500 and 37.2-601, revised in accord with the Commission's recommendation to include, at a minimum: emergency, crisis stabilization, case management, outpatient, respite, in-home, residential and housing support services.
- b. reflect the role of DMHMRSAS as the locus of coordination for ensuring that the service standards and core expectations for each of the mandated core services are defined, promulgated, contracted for, measured and reported to the various stakeholders including, but not limited to, the Secretary of Health and Human Resources for the Commonwealth and each local government which is party to a CSB performance contract.

I-B-3 Facilitate Coordination and Continuity of Care. DMHMRSAS should be charged with responsibility for developing, implementing, and overseeing strategies to facilitate coordination of services across sectors and assuring continuity of care and should be provided with adequate staffing to carry out this function.

I-C Increase Role of Insurance in Financing Mental Health Services

I-C-1 Require Parity in Benefits. The General Assembly should consider legislation requiring parity in health insurance coverage and benefits for treatment of mental and addictive disorders. Mental health and substance abuse treatment services should be reimbursed at a level that is equitable with other medical specialties.

I-C-2 Expand Medicaid Eligibility. The General Assembly should consider expanding Medicaid eligibility for the population classified as aged, blind and disabled by raising the eligibility criterion from the present 80% of the federal poverty level to 100% of the federal poverty level.

I-D Core Services

All CSBs should have the capacity to provide the following core services:

- I-D-1** All CSBs should have the capacity to provide a full range of crisis response services accessible 24 hours each day to individuals experiencing a psychiatric crisis. Crisis stabilization, psychiatric urgent care and psychiatric, nursing and medication services are essential components of this recommendation. *(Recommended for consideration in 2008.)*
- I-D-2** All CSBs should have the capacity to provide outpatient psychiatric services and related medical supports in accord with caseload standards established by DMHMRSAS. *(Recommended for consideration in 2008.)*
- I-D-3** All CSBs should have the capacity to provide case management services in accord with caseload standards established by DMHMRSAS. *(Recommended for consideration in 2008.)*
- I-D-4** All CSBs should have the capacity to provide Programs of Assertive Community Treatment, Intensive Community Treatment, and Intensive Case Management in each locality to all persons in need of intensive services.
- I-D-5** Each of Virginia’s local law enforcement agencies should establish certified Crisis Intervention Teams.
- I-D-6** Each CSB should establish a free access number that is consistent throughout the service area or region for all psychiatric crisis responses and referrals.
- I-D-7** Each CSB should have the capability within its continuum of crisis stabilization services to receive custody of persons under an ECO from law enforcement officers.
- I-D-8** Each of the seven DMHMRSAS regions should establish and support a community-based regional geriatric-psychiatric continuum of care.
- I-D-9** The CSBs should give a high priority to improved access to adequate permanent housing for individuals with mental illness. Va. Code § 63.2-800 should be revised to authorize a portable Auxiliary Grant for housing supports, and the policies of the Virginia Department of Social Services, 22 Va. Admin. Code § 40-25-10, should be revised accordingly.

I-E Cultural Competency

The cultural and demographic diversity of the Commonwealth’s citizens is changing rapidly. There are significant differences in the way that minority populations experience illness and seek services. The Commission recommends that all training components include training on cultural competency.

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II. ENHANCING EMPOWERMENT AND SELF-DETERMINATION

The need for involuntary treatment and the tremendous individual and social costs of untreated mental illness can be substantially reduced by engaging people with mental illness in the services system and giving them a meaningful measure of control over the services they receive. Empowerment, voluntariness and respect for human dignity are among the hallmarks of a high-quality services system. Emphasizing empowerment and respect will not eliminate the need for coercion, but it will reduce the occurrence of mental health crises, will facilitate voluntary treatment when crises occur, and will draw people with mental health needs into the system rather than driving them away.

II-A Individual Choice

Whenever possible, the Commonwealth’s mental health statutes, regulations, policies and practices should emphasize individual choice and empowerment. Title 37.2 of the Code of Virginia and the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by DMHMRSAS, 12 VAC 35-115 et seq. (“Human Rights Regulations”), should be reviewed and revised to emphasize individual choice and decrease stigmatization to the maximum extent consistent with the legislative purpose.

II-B Advance Directives

Advance directives are legal instruments that may be used to document a competent person’s specific instructions or preferences regarding future health treatment. They are most commonly used in end-of-life decision-making, but are increasingly being advocated for other circumstances as well. The Commission recommends facilitating the use of crisis plans and advance directives in the event of impaired decisional capacity and making discussions of such plans a standard part of treatment while promoting and respecting individual choice.

II-B-1 The Commission recommends that the Health Care Decisions Act be amended to authorize a competent person to execute a “stand-alone” (agent optional) instructional advance directive to govern any type of health care decisions. This is to supplement, and not to replace, the provision governing end-of-life care (“living wills”) and health care powers of attorney already permitted under Virginia law. This non-end-of-life directive would apply to all types of health care decisions, not just those involving psychiatric care.

II-B-2 The Secretary of Health and Human Resources should establish an effective program for informing stakeholders about advance directives for health care, including peer-provided advance directive facilitation services for individuals with mental illness who wish to complete the documents. The program should regularly offer and provide free facilitation services

to, at a minimum, all public sector consumers of mental health services who are willing and able to make an advance directive.

II-B-3 The Commonwealth should create or support a single, secure, electronic repository for advance directives. This would enable health care providers to identify quickly patients with advance directives and to access these documents in an emergency. Individuals would be able to choose whether to have their advance directive stored in the repository.

II-C Support and Involvement by Family and Close Associates

The Commission recommends enhancing the support and involvement of family members and close associates to the maximum extent consistent with the individual's preferences.

II-C-1 All public and private facilities and providers should facilitate opportunities for families and other close associates to be involved in the treatment of an individual with mental illness to the maximum extent desired by that individual. These opportunities should include education, training and support groups.

II-C-2 DMHMRSAS and CSBs should require staff education regarding the benefits of facilitating support from families and close associates and regarding protocols for inviting discussions with consumers and offering them opportunities to identify individual(s) whom they desire to be informed and involved regarding their treatment.

II-D Peer Support

Peer Support is the provision of services by self-identified mental health consumers to others with mental illness. It has been shown to facilitate the engagement and empowerment of individuals with severe mental illness in a way that other mental health services cannot. The Commission recommends that the use of peer support services be encouraged and supported through all aspects of the mental health system. Below are some more specific ways to accomplish this goal:

II-D-1 The Department of Medical Assistance Services and DMHMRSAS should review the recent ruling by the federal Center for Medicare and Medicaid Services allowing services provided by qualified peer support providers to be billed as a distinct service and should prescribe the necessary criteria for billing peer support as a stand-alone service.

II-D-2 DMHMRSAS should encourage and provide financial support for widespread use of peer support services throughout the mental health system, should obtain specific data on peer specialists and other peer

providers and the peer support services they provide, and should establish a peer specialist training program in Virginia, with clear qualification guidelines for enrollment. The General Assembly should provide sufficient funding for such training to assure that the Commonwealth has an adequate workforce of peer support providers.

II-D-3 Peer support specialists should be available to serve as advocates for respondents during the commitment process upon request.

II-E Public Education

A consortium of public and private organizations should pool their resources to design and implement a high-quality mental health media campaign on a continuing basis. The Commonwealth Mental Health Campaign should be designed to encourage people and families with mental health problems to seek treatment, to reduce and counteract public misunderstanding about the nature and effects of mental illness, to highlight the aspirations of people with mental illness and their prospects of recovery, and to support the dignity and equality of people with mental illness.

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III. REFORMING THE CIVIL COMMITMENT PROCESS

III-A Emergency Screening and Intervention

III-A-1 Emergency Custody Orders. The current emergency custody order (“ECO”) period of 4 hours is too short to allow an adequate evaluation in many situations, particularly in rural areas. The Commission recommends the current 4-hour ECO period be renewable for one additional 4-hour period upon application to and approval by a magistrate. *(Recommended for consideration in 2008.)*

III-A-2 Transfer of Custody to Crisis Stabilization Facilities or Other Therapeutic Locations with Proper Security. Virginia law currently requires that law enforcement officers maintain custody of a person during the entire length of the ECO period. This encourages law enforcement officers to arrest individuals rather than taking them to a more therapeutic setting and consumes a significant amount of time that could be better spent on law enforcement activities. Based on its study of best practices in other states, the Commission has found that hospital emergency facilities and crisis stabilization facilities with the capacity to receive custody from law enforcement officers can often assist in ending the crisis and thereby avoid the necessity of a temporary detention order or an involuntary commitment. As DMHMRSAS and the CSBs continue to develop a full continuum of crisis stabilization services in each region, they should assure that some of these settings are suitable for transfer of custody of individuals in crisis from law enforcement officers. In order to provide the legal foundation for such “drop-off” capability, the Commission recommends the consideration of legislation to amend Va. Code § 37.2-808 so that law enforcement officers can turn over custody under an ECO to facilities that have been licensed to receive custody and conduct the necessary evaluation and interventions. In addition, the General Assembly should consider providing sufficient resources to fund crisis stabilization facilities with such “drop-off” capacity in each CSB region of the Commonwealth. *(Recommended for consideration in 2008.)*

III-A-3 Temporary Detention Period. The current Temporary Detention Order (“TDO”) period of 48 hours is one of the shortest in the nation. In certain localities, commitment hearings are held less than 24 hours after the TDO is issued. The Commission is concerned that stabilization and a proper evaluation cannot be completed in such a short time frame.

- a. The Commission recommends that the TDO period be lengthened to 4 or 5 days to allow more time for adequate evaluations, and to promote voluntary engagement and expeditious discharge after a patient is stabilized. It is believed that by lengthening this period, the number of commitment hearings will decline, but further study

is needed to project the consequences of such a change. While the 4-5 day extension is being studied, the General Assembly may wish to consider extending the 48 hour period to 72 hours as a way of facilitating a more thorough evaluation.

- b. The Commission believes that a hearing should not ordinarily be held less than 24 hours after the execution of a TDO. However, the Commission is considering whether any exceptions should be permitted.

III-B Evaluation and Certification

III-B-1 Qualifications of the Independent Examiner. Many people feel the Independent Examiner (“IE”) should be a psychiatrist or licensed clinical psychologist, and, at a minimum, a licensed clinical social worker. Others feel that the specific discipline is not as important as the training, and that a licensed professional counselor with the proper training could provide an adequate evaluation. The Commission recommends further study of this issue.

III-B-2 Electronic Evaluations. The Commission considered the advantages of using electronic evaluations, particularly in rural areas where there is a shortage of evaluators. Permitting these evaluations would save considerable time, and would make it easier to recruit qualified IEs in rural areas. Some Commission members are concerned that such evaluations may be less informative than in-person evaluations in some cases, and that a respondent might not want such an evaluation. In the Commission’s view, while in-person examinations should be conducted whenever feasible, electronic evaluations using state-of-the-art equipment do provide a suitable alternative to an in-person evaluation under some circumstances. The Commission will study this matter further.

III-B-3 Prerequisites of Evaluation. The Commission is concerned that not all IEs review a respondent’s medical history before deciding whether there is probable cause for concluding that the commitment criteria have been met. The Commission recommends that the Code be amended to require the IE to review the prescreening report and all readily available and relevant records and collateral information, including the relevant medical records of the TDO facility, and any available advance directive. The IE’s evaluation should identify all records that were reviewed.

III-B-4 Discharge after Negative Certification. The Commission recommends further study of the possibility of discharge within the TDO period when a person is determined not to meet the commitment criteria by the treating psychiatrist and the IE. In examining this issue, the Commission will also

study whether the role of the IE should be changed to that of a quasi-judicial official in order provide the IE with protection from liability.

III-C Bed Management

DMHMRSAS is currently developing a statewide web-based psychiatric bed tracking system that will enable CSB emergency services workers to determine more efficiently what facilities may have vacant beds that might be suitable for the person they are seeking to admit. The Commission supports this initiative. Assuming such a system is implemented and therapeutic drop-off centers become available, the Code should be amended so that where a magistrate determines that a respondent meets commitment criteria but that a suitable and available bed for that respondent has not been located within the maximum time allowed under the ECO, the magistrate would be able to issue a TDO without identifying a specific bed for the respondent.

III-D Transportation

III-D-1 Three-Tiered Approach. The Commission recommends that the Code of Virginia be amended to permit a three-tiered transportation model. This will permit different parties to transport the respondent during the various stages of the commitment process depending upon the level of risk involved in each individual's circumstances. When there is a low level of risk of danger of harm to the respondent or others, the respondent could be transported by friends, family, or taxi. When there is a medium level of risk of danger of harm to the respondent or others, the respondent could be transported by ambulance attended by CSB staff or by personnel specially trained in the use of techniques and restraints necessary to meet an emergency. When there is a high level of risk of danger of harm to the respondent or others, the respondent could be transported by properly trained law enforcement officers using secure but unmarked vehicles. Designation of the appropriate level of transport would be made by the magistrate, special justice or judge upon the advice of CSB screeners or other designated experts.

III-D-2 Training. DMHMRSAS should include in the training required for CSB prescreeners a module on risk assessment for purposes of determining the appropriateness of the use of restraints and appropriate mode of transportation for individuals subject to the commitment process at any stage. Such training should include the risk to individuals of using restraints.

III-D-3 Reduce Use of Restraints

- a. With consultation from the Department of Criminal Justice Services ("DCJS"), DMHMRSAS should prepare policies,

procedures, and guidelines to minimize the unnecessary use of restraints for transportation of individuals subject to any stage of the commitment process when that transportation is provided by anyone other than law enforcement officers.

- b. DCJS should adopt regulations or issue guidelines to minimize the unnecessary use of restraints for transportation of individuals by law enforcement officers during any stage of the commitment process. Until such regulations are adopted or guidelines are issued, local law enforcement agencies should consider allowing the transporting officer to exercise his or her discretion in deciding whether restraints are necessary for the protection of the individual being transported or others.

III-D-4 Assurance of Transportation. The Commission recommends that the Code of Virginia be amended to assure that transportation is provided to those who are subject to any part of the commitment process, including transportation following discharge.

III-E Commitment Hearing

III-E-1 Attendance of CSB Staff. Currently, CSB staff do not attend commitment hearings in a majority of jurisdictions. The absence of these professionals can lead to missed opportunities for identifying alternatives to hospitalization and for formulating and monitoring outpatient commitment orders. In order to improve the quality of these hearings and the outcomes, the Commission recommends that a CSB staff member be present in person or electronically. (*Recommended for consideration in 2008.*)

III-E-2 Attendance of Independent Examiner. In many cases, the IE does not attend the hearings, although his or her report is admitted. This can lead to problems if there are questions about the IE's report and conclusions. In order to improve the quality of these hearings and the outcomes, the Commission recommends that the IE be present in person or electronically if the IE report is objected to by the person or his attorney, or if the IE's opinion is contested by the treating physician. (*Recommended for consideration in 2008.*)

III-E-3 Advocacy for Respondent. Assurance of the rights of the individual involved in the commitment process should be guaranteed through vigorous advocacy of the person's wishes, conscientious and ongoing notification of his or her rights throughout the process, and thorough presentation of evidence and argument before the special justice.

III-E-4 Family Participation. Family and close associates whom the individual wants to be present should be notified of the commitment hearing, and opportunities for their participation should be arranged. Consent of the respondent is not required for petitioners or family members whose testimony is sought by petitioners.

III-E-5 Attorneys for the Petitioner. Some Commission members are concerned that the neutrality of the special justice or judge presiding over the commitment hearing is adversely affected when the petitioner is not represented by counsel. For example, the special justice or judge may be inclined to assist the petitioner in presenting his or her case, or may be inclined to commit a respondent in the absence of clear and convincing evidence due to concerns that the respondent might present a safety risk to self or others despite weakness in the case presented. The Commission recommends further study regarding whether the Commonwealth should fund an attorney to represent the petitioner at commitment hearings. Possible choices for these attorneys include city and county attorneys or the appointment of private attorneys trained in mental health law and procedures. Due to concerns about criminalizing mental illness, the Commission believes Commonwealth's Attorneys should be considered only if no other attorneys are available to represent the petitioner.

III-F Duration of the Commitment Order

The Commission believes the current commitment period of 180 days is too long. The first order for inpatient commitment in a particular episode of treatment should not exceed 30 days. The first order of mandatory outpatient treatment (or a combined order of acute hospitalization followed by mandatory outpatient treatment) should not exceed 90 days. Subsequent consecutive orders for commitment would not exceed 180 days. (*Recommended for consideration in 2008.*)

III-G Protection of Health Information Privacy During Commitment Process

Several concerns about the relationship between health information privacy protections under Virginia law and under the federal Family Educational Rights and Privacy Act ("FERPA") and the Health Insurance Portability and Accountability Act ("HIPAA") regulations were raised by the panel investigating the Virginia Tech shootings on April 16, 2007. The Commission appointed a special working group to look into these issues. Based on the report of the Working Group on Health Privacy and the Commitment Process, the Commission recommends that Virginia law be clarified in two areas.

III-G-1 Disclosures in Judicial Process. Virginia law and the federal HIPAA Privacy Rule now authorize disclosures of mental health information to

the CSB pre-screeners and the Independent Examiner by health care providers to allow an informed evaluation process. However, the Working Group concluded that the disclosure of such information to the special justice or judge at the commitment hearing – although implicitly authorized by Virginia law – may not be authorized by HIPAA unless Virginia law is modified to specifically require providers to make such disclosures upon request. The Commission recommends that Virginia law be so modified. (*Recommended for consideration in 2008.*)

III-G-2 Confidentiality of Hearing Records. Under current law, the court is directed to keep records of commitment hearings confidential, *but only if requested by the subject or his counsel* (Va. Code § 37.2-818(B)). The Working Group recommends that the presumption of Va. Code § 37.2-818(B) be reversed and that the commitment records be presumed to be confidential. Similarly, the Working Group recommends that hearings be closed to protect the respondent’s medical privacy. Although judges already have authority to close the hearings when private health information is being discussed, the Working Group recommends that this authority be codified.

The Working Group recognized that members of the public (*e.g.*, family; concerned individuals; educational institutions) may sometimes have a legitimate interest in knowing the *outcome* of the proceedings. However, in such cases, the Working Group concluded that public access should be limited to the dispositional order and only upon an appropriate showing, and that this limitation should be codified. The Working Group also concluded that concerns about oversight and accountability are adequately protected by the unfettered opportunity of the respondent and his or her lawyer to open the proceedings and by the obligation of the Supreme Court to oversee the process. The Commission concurred in this conclusion, albeit not unanimously. The Commission acknowledges the argument that public access to these proceedings may be protected by the First Amendment, but believes that the individual interest of the respondent in privacy of highly personal health information provides a compelling reason to restrict access to the hearings and records as proposed, just as it does in the context of child custody proceedings and in proceedings involving the treatment of minors. (*Recommended for consideration in 2008.*)

III-H Protections for Respondents

The Commission recommends further study of ways to protect persons who are the subject of involuntary commitment from harm, including the adverse collateral effects of involvement in commitment proceedings.

III-H-1 Monitoring of Medication Side Effects. The Commission recommends that DMHMRSAS continue to implement the Community Resource Pharmacy, Pharmacy and Therapeutics Committee for reviewing practice and distribution issues and expand its use to monitor patients for adverse side effects as part of an overall quality assurance program. The Commission further recommends that this Committee be established pursuant to Va. Code § 8.01-581.16 and that the CSBs be encouraged to participate in this or other regional or privately affiliated psychopharmacological review committees.

III-H-2 Costs of Involuntary Services. It seems to be widely acknowledged that individuals who are subject to involuntary treatment should not bear the personal costs of unwanted treatment. The Commission recommends that DMHMRSAS review current laws, policies and practices regarding patient/client responsibility for the costs of involuntary services and identify mechanisms (e.g., uniform criteria that would be included in local reimbursement policies or ability to pay criteria) for adjusting the person's liability while preserving the ability of providers to recover their costs for these services from third-party payers.

III-H-3 Housing and Credit. The Commission recommends that the Code of Virginia and applicable regulations be amended to protect persons under TDOs or involuntary commitment orders from loss of housing or other adverse financial consequences attributable solely to the occurrence of commitment proceedings.

III-I Commitment Criteria

The current criteria for commitment are unnecessarily vague and confusing, and are being applied inconsistently across the Commonwealth. In addition, there is evidence that the phrase "imminent danger" is being given an unduly restrictive interpretation in some jurisdictions. The Commission recommends that the General Assembly consider modifying the existing commitment criteria to provide greater specificity and to avoid unduly restrictive applications of the commitment law. (*Recommended for consideration in 2008.*)

The proposed commitment criteria recommended by the Commission are as follows:

A person may be involuntarily admitted to a psychiatric inpatient facility for treatment upon a finding of the court by clear and convincing evidence that:

(1) he or she has a mental illness and as a result of such mental illness:

(a) there is a substantial likelihood that, in the near future, he or she will cause serious physical harm to himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; or

(b) there is a substantial likelihood that, in the near future, he or she will suffer serious harm due to substantial deterioration of his or her capacity to protect himself or herself from such harm or to provide for his or her basic human needs; and

(2) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been investigated and judged to be inappropriate.

III-J Mandatory Outpatient Treatment

The Commission recommends that the Commonwealth retain the existing use of mandatory outpatient treatment (“MOT”) as a less restrictive alternative to involuntary hospitalization, while clarifying the conditions under which such orders may be issued. *(Recommended for consideration in 2008.)* The Commission also recommends that MOT be available as a supplement to short-term acute hospitalization or residential stabilization, perhaps as a component of a single commitment order. *(Recommended for consideration in 2008.)*

The Commission is also favorably inclined toward broader use of MOT for persons who are experiencing pronounced clinical deterioration but do not meet the criteria for involuntary hospitalization, as has been authorized recently in several other states. These laws have the laudable purpose of using mandated outpatient intervention to prevent the person from declining to the point of needing involuntary admission. However, the Commission believes that such a substantial change in commitment practice should not be adopted unless and until the CSBs have adequate capacity to provide outpatient treatment services and to monitor compliance with outpatient treatment orders.

III-K Procedures for Implementing Mandatory Outpatient Treatment

The procedures for monitoring and implementing MOT orders should be improved.

The Commission recommends that the name of the CSB ordered to monitor compliance be designated in the order; that the treatment plan be attached to the order; and that a copy of the order and attached treatment plan be provided to the respondent, the CSB and any other providers at the hearing, with a form acknowledgment to be signed by each. If not present, the clerk should provide copies following the hearing. The order should also specify the length of commitment not to exceed 90 days, the particular conditions that the respondent must meet, and the consequences of non-compliance.

The Commission also recommends that procedures for the CSB to report noncompliance to the court be clarified, including requiring that CSBs and providers disclose protected health information to the court and permitting the CSB to request the magistrate to issue a mandatory examination order when it is

unable to determine whether the respondent is complying with the order. The Commission further recommends that procedures be enacted for conducting noncompliance hearings, extending orders when necessary, terminating orders when they are no longer needed, and providing the respondent with an appeal. In addition, the Commission recommends that special justices, court-appointed attorneys, independent examiners and interpreters be paid for this additional work. (*Recommended for consideration in 2008.*)

III-L Training

Meaningful reform of the civil commitment process cannot occur without adequate training for all participants, including special justices, attorneys, magistrates, independent examiners, CSB pre-screeners, peer counselors, law enforcement officers, and crisis intervention teams. The Commission recommends that the Supreme Court, the Office of the Attorney General and DMHMRSAS develop specific programs for training and certifying all participants in the commitment process.

III-M Compensation

Fees for special justices, attorneys, psychologists and other professional participants in the commitment process are woefully inadequate in relation to the quality of the service that should be expected. The Commission recommends further study on ways to improve the compensation rates for the professionals involved in the civil commitment process.

III-N Oversight

The Commission has documented substantial variations from locality to locality in interpretation of the commitment statutes and in commitment practices. A key component of successful reform is improved oversight of the entire commitment process and of all the parties involved in it. Elements of improved oversight include data collection, monitoring, training, and reporting. The Commission believes that much of this oversight function should be performed by the Supreme Court of Virginia as it relates to the judicial process. However, the quality of the emergency screening and evaluation process as well as the implementation of mandated treatment orders should rest with the mental health services system. In this respect, direct responsibility lies with the CSBs subject to standard-setting and coordination by DMHMRSAS.

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IV. REALIGNING THE MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS

The Commission's main goals with respect to the criminal justice system are to divert individuals with mental illness from the criminal justice system to the maximum extent consistent with the aims of criminal justice and to increase access to appropriate mental health services for individuals with mental illness while detained, incarcerated or under community supervision.

IV-A Mental Health/Criminal Justice Coalitions

The Commission recommends creation of and support for mental health/criminal justice coalitions (including participation by persons with mental illness, family members, interested community partners and advocates) at state, regional and local levels to facilitate diversion of persons with mental illness from the criminal justice system and the delivery of mental health services to persons with mental illness incarcerated or under criminal justice supervision throughout the Commonwealth.

IV-A-1 State Coordinating Council. At the State level, the Commission recommends that the Secretary of Health and Human Resources, the Secretary of Public Safety, and the Chief Justice of the Supreme Court should work cooperatively through a Coordinating Council on Mental Health and Criminal Justice (“Coordinating Council”) The duties of the Coordinating Council should include identifying and advocating for policies, laws and programs that facilitate diversion and access to services and supporting and overseeing the efforts of local and regional partnerships.

IV-A-2 Local and Regional Partnerships. At the regional or local level, the Commission recommends that the Community Criminal Justice Board (“CCJB”) (or a comparably constituted entity) should plan, implement and monitor diversion and treatment at every point in the criminal process—including crisis response, pretrial proceedings, adjudication, sentencing, incarceration, forensic hospitalization, re-entry planning, and community supervision upon release. These partnerships should be multi-disciplinary and should include representatives with experiences and expertise in mental health, including public and private providers, consumers, family members and mental health advocates. If CCJBs serve as the coordinating entity, Va. Code § 9.1-178 should be amended to add at least two representatives with mental health expertise or experience.

IV-B Training

The Commission recommends that the Coordinating Council establish a Criminal Justice Mental Health Training Academy (“Training Academy”) to facilitate

training for law enforcement, court, jail, prison and mental health professionals at the interface of mental health and criminal justice and to oversee public education and outreach efforts throughout the Commonwealth. This Training Academy should be supported jointly by the Department of Criminal Justice Services, the Supreme Court, and DMHMRSAS, with direction by the Coordinating Council.

IV-C Programs and Services

The Coordinating Council should conduct a continuing review of programs aiming to facilitate diversion of persons with mental illness from the criminal justice system and to deliver services to person with mental illness in the criminal justice system, in the Commonwealth or elsewhere, and should assess their effectiveness and cost. Based on these assessments, the Coordinating Council should take necessary steps to help communities implement evidence-based or other promising practices, services and programs.

IV-D Initial Contact with Persons in Crisis

Law enforcement officers should be trained to recognize signs of mental illness, to respond to crisis situations, to collaborate with mental health agencies, and, when appropriate, to take the person to a treatment facility rather than pressing charges. In order to facilitate therapeutic referrals, each CSB region should establish one or more secure therapeutic drop-off centers with authority to take custody of the individual from law enforcement officers.

IV-E Post-Arrest Evaluation and Treatment in Jail

Each CSB should have staff available to evaluate the needs of all inmates at the earliest point of entry in jail in order to assess those who might be appropriately released pre-trial and to determine what services are needed for those who cannot otherwise be released. Standardized screening and evaluation tools should be used throughout the Commonwealth to determine the presence of a mental illness and co-occurring disorders. Jail staff should be trained to administer initial screening tools. Inmates should have access to the same level of care and medications as individuals being served in a state psychiatric hospital or by a CSB. All jails should have sufficient resources to meet the basic standards for mental health services established by national jail accreditation organizations, such as the American Correctional Association. The mental health services in the jail should be linked with services in the community to facilitate continuity of treatment during incarceration and at the point of diversion from the jail. Expedient placement in a licensed psychiatric hospital should be available for inmates who meet civil commitment criteria and would be hospitalized but for their incarceration, or who otherwise cannot be safely stabilized in a jail.

IV-F Therapeutic Leverage in Adjudication

The local CCJB or other designated entity, specifically including judges from circuit and district courts, should explore ways of linking the defendant's adherence to treatment with the disposition of the criminal case, including formal pre-plea or post-plea diversion agreements, and prescribed treatment as a condition of bond or probation. Any local initiatives exploring mental health courts or other specialized dockets should be carefully studied by the Coordinating Council.

IV-G Recovery-Oriented Re-entry

Jails and prisons and CSBs should work together to facilitate successful community integration for all individuals with mental health and co-occurring disorders. Pre-release planning should include review of the individual's eligibility for federal and state benefits. CSBs should be responsible for overseeing the community re-entry of persons with mental illness from the criminal justice system and should be given sufficient resources to provide appropriate and effective treatment, peer support and other needed services. Protocols for communication and oversight among CSBs, jails, prisons and courts should be developed under the guidance of the State Coordinating Council based, whenever possible, upon existing formal agreements and contractual relationships. Upon release, individuals should be provided with a reasonable supply of medications prescribed in the jail or prison to cover the period before medical treatment in the community can begin.

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V. SERVING CHILDREN, ADOLESCENTS AND THEIR FAMILIES

V-A Access to Services

The Commission believes that all children and adolescents with mental health and/or substance abuse service needs should have access to services so that they and their families are not forced to seek judicial assistance to obtain needed services or go without services. Nor should children¹ be brought into the juvenile justice system for the sole purpose of accessing services. Early identification and intervention services should be available in schools without regard to income or insurance status. Children who are in the juvenile justice system should have access to mental health evaluations and treatment. In order to accomplish these goals, the Commission recommends:

V-A-A The General Assembly should consider amending the Code of Virginia to mandate additional CSB services, including crisis stabilization, family support, respite, in-home and psychiatric care.

V-A-2 Communities should be encouraged to limit the use of long-term residential care for children. The money saved can be used to fund new services in the community

V-A-3 CSBs should become the front door for accessing mental health services, regardless of insurance status.

V-A-4 The Secretary of Health and Human Resources should direct the Office of Comprehensive Services to develop policy for an aggressive, clinically knowledgeable case management and utilization management system, especially with regard to use of residential services by the Comprehensive Services Act.

V-A-5 Collaboration between Community Policy and Management Teams and universities should be encouraged in order to develop local programs from promising models, and to evaluate existing programs.

V-B Workforce Problems

There is currently a major shortage of qualified mental health care providers for children in Virginia. According to a recent Joint Legislative Audit and Review Commission report, Availability and Cost of Licensed Psychiatric Services in Virginia, Commission Draft (October 9, 2007), 87 localities in Virginia do not have any child psychiatrists, and 47 localities do not have any psychiatrists at all. Because of this shortage, many children are being treated by professionals without expertise regarding the specific treatment needs of children. The General

¹ “Children” refers hereafter to children and adolescents.

Assembly should consider funding additional psychiatric fellowships, and DMHMRSAS should support training for family practitioners, pediatricians, and adult psychiatrists regarding safe and effective use of medication for children with mental health needs, and for psychologists, licensed clinical social workers, and licensed professional counselors who evaluate and work with children.

V-C Relinquishment of Custody

In the past, parents have often had to relinquish custody of their children in order to access mental health services for them due to the lack of community-based services. The State Executive Council has prepared and released guidelines providing that children who meet the definition of a “child in need of services” (“CHINS”), and who have emotional and behavioral health problems should receive needed services without parents having to relinquish custody. It is anticipated that legislation will be proposed in the coming session of the General Assembly to create a separate mandate for these children so they do not fall under the legal umbrella of foster care services. The Commission endorses legislation to accomplish this goal.

V-D Diverting Children from the Juvenile Justice System

The Department of Juvenile Justice (“DJJ”) has become the single largest provider of residential mental health services for children in the Commonwealth. Forty-three percent of all children committed by the courts to DJJ are diagnosed with mental and emotional disorders, and 70% are diagnosed with a substance abuse disorder. These statistics indicate that the Commonwealth is failing to identify and treat children with serious mental and emotional problems before those problems lead or contribute to misconduct by those children. In order to enable the Juvenile and Domestic Relations District Court (“J&DR Court”) system to divert minors who need mental health and/or substance abuse services from the judicial system, the following steps are needed:

V-D-1 Police officers, judges, attorneys, and intake officers should be trained so that they are able to recognize signs of possible mental and emotional disorders in children and are familiar with available mental health services in their communities so they can divert a child to mental health care when appropriate.

V-D-2 Emergency mental health and substance abuse services for children should be available at CSBs on a 24-hour basis for referral and intervention in crisis situations.

V-D-3 The Department of Social Services should have an array of services available in the community to address a placement crisis when a child’s family situation has deteriorated to the point that the child cannot return home but does not meet the criteria for detention.

V-E Treating Children in the Juvenile Justice System

Children who cannot be diverted from the juvenile justice system should receive appropriate treatment and services while in the system, and their families should be engaged to facilitate their re-entry to the community. In order to assure that these goals are met, the following steps should be taken:

- V-E-1** DMHMRSAS should continue to provide stable funding for mental health clinicians assigned to detention facilities.
- V-E-2** DMHMRSAS should work with the Virginia Council on Juvenile Detention to develop standards regarding qualifications, responsibilities and activities of detention center mental health clinicians, and should establish appropriate caseload standards for them.
- V-E-3** The Office of the Executive Secretary of the Supreme Court, the Indigent Defense Commission, and the Virginia State Bar should provide training for judges and attorneys regarding the developmental process and mental and emotional disorders of children as they may affect the child's ability to participate in judicial proceedings.
- V-E-4** The General Assembly should consider providing sufficient funding to ensure that community-based restoration services are available in every jurisdiction to evaluate and treat children who have been found to lack competence for adjudication in the least restrictive setting.
- V-E-5** The Commission recommends that Va. Code § 16.1-269.1(A) be amended to require Juvenile Court judges making transfer decisions to specify the basis for their findings regarding the following: (1) whether the juvenile can be retained in the juvenile justice system long enough for effective treatment and rehabilitation; (2) the appropriateness and availability of the services and dispositional alternatives in both the criminal justice and juvenile justice systems for dealing with the juvenile's problems; and (3) the extent, if any, of the juvenile's degree of mental retardation or mental illness. Failure to do so would be grounds for an appeal of the transfer decision.
- V-E-6** The Crime Commission should collect data on children transferred for prosecution as adults, and review the transfer laws to determine whether more specific standards should be developed so that children with mental illness and serious emotional disturbances who can benefit from rehabilitation are able to remain in the juvenile justice system. Juvenile judges should have the discretion to deny transfer when mental illness is a factor.

V-E-7 The General Assembly should consider amending the Code of Virginia to authorize and enable counsel for an indigent juvenile who is facing transfer to obtain, through Court order, an evaluation of the juvenile regarding the juvenile's mental retardation, mental illness, and mental and emotional maturity, and the availability of treatment for the juvenile, if counsel is able to show: (1) the juvenile has a history of mental illness or mental retardation, and (2) there is reason to believe that the juvenile's behavior was a reflection of this underlying condition.

V-E-8 The DJJ should screen all children who have been adjudicated as CHINS or delinquent for mental health issues and substance abuse problems.

V-E-9 The General Assembly should consider authorizing and providing funding for drug court programs for juveniles in all jurisdictions that request such a program.

V-F Involuntary Commitment of Minors

Many of the Commission's recommendations relating to the adult commitment process will also apply to the commitment of minors. These include the time period of a TDO (III.A.3), transportation (III.D), and the presence of the IE at the commitment hearing (III.E.2). However, some unique problems arising in cases involving minors also need to be addressed. In general, the Commission aims to improve the quality of evaluations, facilitate parental involvement and understanding, and improve the quality of adjudication when court intervention is necessary.

V-F-1 Location of Involuntary Commitment Hearings. The Commission recommends that Va. Code § 16.1-340 be amended so that the juvenile commitment hearing can be held in either the home court or the court where the child is located, keeping both options open. The default jurisdiction should be where the child is located. The home court would have 24 hours, or until the next business day if the 24-hour period ends on a holiday or weekend, to claim jurisdiction, otherwise the hearing would be held in the jurisdiction where the child is located. If the home court holds the hearing, the use of video-conferencing should be encouraged to avoid transporting the child great distances.

V-F-2 Voluntary Admission. The Code currently does not permit children in detention to be voluntarily admitted. Instead, they must go through an involuntary commitment hearing. The Commission recommends deleting the language in Va. Code § 16.1-345 that prevents these juveniles from being voluntarily admitted. Also, Va. Code §§ 16.1-338 and -339 should be amended to clarify that after a minor who has been detained is hospitalized, the minor will be returned to detention after the necessary treatment is completed. Voluntary admission should be encouraged.

V-F-3 Monitoring of Involuntary Outpatient Treatment. The Commission recommends consideration of legislation requiring CSBs to monitor compliance for all juveniles, not just indigent ones. Any court order requiring outpatient treatment must specify the provider and who is responsible for monitoring compliance with the order. CSBs should report noncompliance to the JDR court through the filing of a petition to show cause.

V-F-4 Oversight and Training of Special Justices. OES should require ongoing training every two years, and should survey consumers on a regular basis to determine satisfaction with the process. The General Assembly should consider amending the Code to make the Chief Judge of the J&DR Court the supervising judge for these special justices, and should require that the Chief Judge of J&DR Court be consulted on appointments of special justices hearing juvenile commitments.

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APPENDIX 1

COMMISSION RESPONSE TO VIRGINIA TECH REVIEW PANEL'S RECOMMENDATIONS RELATING TO MENTAL HEALTH

IV-12: The state should study what level of community outpatient service capacity will be required to meet the needs of the commonwealth and the related costs in order to adequately and appropriately respond to both involuntary court-ordered and voluntary referrals for those services. Once this information is available it is recommended that outpatient treatment services be expanded statewide.

The Commission's Task Force on Access to Services is studying this issue. The Commission's Blueprint (paragraph I-A) recommends that CSBs be mandated to provide outpatient services. The Commission also identifies increasing CSB capacity to provide outpatient services as one of the highest priorities for funding mental health services in 2008.

IV-13: Va. Code § 37.2-808 (H) and (I) and § 37.2-814 (A) should be amended to extend the time periods for temporary detention to permit more thorough mental health evaluations.

The Commission's Blueprint (paragraph III-A-3-a) recommends that the TDO period be lengthened to 4 or 5 days to allow more time for adequate evaluations, and to promote voluntary engagement and expeditious discharge after a patient is stabilized.

IV-14: Va. Code § 37.2-809 should be amended to authorize magistrates to issue temporary detention orders based upon evaluations conducted by emergency physicians trained to perform emergency psychiatric evaluations.

This recommendation, which originated with the American Academy of Emergency Room Physicians, was reviewed by the Commission's Task Force on Civil Commitment, and was disapproved. Emergency room physicians are not trained to do these types of evaluations, are not familiar with least restrictive treatment options in the community, and may often be more concerned about maintaining order in the emergency department. Community services board staff are trained to do these screenings and are usually available 24/7 to do them. The General Assembly has previously passed legislation making the CSBs the single point of entry into the public mental health system to serve as a gatekeeper. This action would be contrary to previous action the General Assembly has taken.

IV-15: The criteria for involuntary commitment in Va. Code § 37.2-817(B) should be modified in order to promote more consistent application of the standard and to allow involuntary treatment in a broader range of cases involving severe mental illness.

The Commission agrees with this recommendation. The Commission's Blueprint (paragraph III-I) recommends that the commitment criteria be modified as follows:

“A person may be involuntarily admitted to a psychiatric inpatient facility for treatment upon a finding of the court by clear and convincing evidence that:

- (1) He or she has a mental illness and as a result of such mental illness:*
 - (a) there is a substantial likelihood that, in the near future, he or she will cause serious physical harm to himself to herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; or*
 - (b) there is a substantial likelihood that, in the near future, he or she will suffer serious harm due to substantial deterioration of his or her capacity to protect himself or herself from such harm or to provide for his or her basic human needs; and*
- (2) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been investigated and judged to be inappropriate.”*

This proposal eliminates the requirement that a respondent be shown to present an “imminent danger” to himself or others, thereby permitting treatment intervention before the person's condition deteriorates to that extreme. The proposal also provides more specificity which will provide judges and special justices with more guidance and should thereby lead to more consistent decisions. Consideration of this recommendation is being sought in 2008.

IV-16: The number and capacity of secure crisis stabilization units should be expanded where needed in Virginia to ensure that individuals who are subject to a temporary detention order do not need to wait for an available bed. An increase in capacity also will address the use of inpatient beds for moderately to severely ill patients that need longer periods of stabilization.

The Commission agrees with this recommendation and regards it as a high priority for legislative consideration in 2008. (Commission's Blueprint paragraph I-D-1)

IV-17: The role and responsibilities of the independent evaluator in the commitment process should be clarified and steps taken to assure that the necessary reports and collateral information are assembled before the independent evaluator conducts the evaluation.

The Commission agrees with this recommendation. The Commission's Blueprint (paragraphs III-B-1 to 4) recommends that the Code be amended to require the IE to review the prescreening report and all readily available and relevant records and collateral information, including the relevant medical records of the TDO facility, and any available advance directive.

IV-18: The following documents should be presented at the commitment hearing:

- ***The complete evaluation of the treating physician, including collateral information.***
- ***Reports of any lab and toxicology tests conducted.***
- ***Reports of prior psychiatric history.***
- ***All admission forms and nurse's notes.***

The Commission's Task Force on Civil Commitment studied this issue and gave specific consideration to the following proposal:

The judge or special justice shall also consider to the extent available, the complete evaluation of the treating physician, including collateral information, reports of any lab and toxicology tests conducted, reports of prior psychiatric history, and all admission forms and nurse's notes.

However, the Task Force unanimously declined to endorse this proposal on the ground that this information should be admitted only if they have been offered according to the customary rules of evidence. In addition, the Task Force concluded that the proper way for this information to be considered is through the testimony of mental health professionals, including the IE. Requiring the IE to be present at the hearing, in person or electronically, is a full and proper response to the Tech Panel's concerns.

IV-19: The Virginia Code should be amended to require the presence of the pre-screener or other CSB representative at all commitment hearings and to provide adequate resources to facilitate CSB compliance.

The Commission agrees with this recommendation. The Commission's Blueprint (paragraph III-E-1) recommends that the Code be amended to require a CSB staff member to be present in person or electronically. Section 37.2-816 would be amended to add a new subsection as follows:

"An employee or designee of the community services board or behavioral health authority that prepared the preadmission screening report shall attend the hearing either in person or by electronic means. If the hearing is held outside the jurisdiction of the community services board or behavioral health authority and a representative of that community services board or behavioral health authority cannot attend in person or by electronic means, arrangements shall be made for a representative of the community services board or behavioral health authority where the hearing takes place to attend the hearing on behalf of the community services board or behavioral health authority preparing the report. The judge or special justice may waive this requirement if it appears practically impossible for a representative of the community services board or behavioral health authority to attend."

This change is also recommended for consideration in 2008.

IV-20: The independent evaluator, if not present in person, and treating physician should be available where possible if needed for questioning during the hearing.

The Commission agrees with this recommendation in part. The Commission's Blueprint (paragraph III-E-2) recommends that the Code be amended to require the IE to be present in person or electronically if his report is objected to by the person or his attorney, or if his opinion is contested by the treating physician:

“If the independent examiner has determined that the person does not meet commitment criteria and that opinion is objected to by the treating physician, the independent examiner shall attend the hearing in person or by means of a telephonic communication system as provided in § 37.2-804.1 to determine whether his response would change based upon the evidence presented at the hearing. In all other circumstances, the examiner's written certification may be accepted into evidence unless objected to by the person or his or her attorney in which case the examiner must attend in person or by electronic communication.”

This change is also recommended for consideration in 2008.

IV-21: The Virginia Health Records Privacy statute should be amended to provide a safe harbor provision which would protect health entities and providers from liability or loss of funding when they disclose information in connection with evaluations and commitment hearings conducted under Va. Code § 37.2-814 et seq.

IV-22: Virginia Health Records Privacy and Va. Code § 37.2-814 et seq. should be amended to ensure that all entities involved with treatment have full authority to share records with each other and all persons involved in the involuntary commitment process while providing the legal safeguards needed to prevent unwarranted breaches of confidentiality.

The Commission appointed a Working Group on Health Privacy and the Commitment Process to consider these Recommendations. Based on the Working Group's review, the Commission concluded that the commitment statute and the Virginia Health Records Privacy Act should be modified to clarify the authority of health care entities and providers to disclose records and information in connection with the commitment process and, in so doing, to remove any doubt about their authority to do so under the federal HIPAA Privacy Rule. (See the Commission's Blueprint, paragraph III-G-1). The Specific proposal appears in the Report of the Working Group. This change is recommended for consideration in 2008.

IV-23: Va. Code § 37.2-817(C) should be amended to clarify –

- *the need for specificity in involuntary outpatient orders.*
- *the appropriate recipients of certified copies of orders.*
- *the party responsible for certifying copies of orders.*

- *the party responsible for reporting noncompliance with outpatient orders and to whom noncompliance is reported.*
- *the mechanism for returning the noncompliant person to court.*
- *the sanctions(s) to be imposed on the noncompliant person who does not pose an imminent danger to himself or others.*
- *the respective responsibilities of the detaining facility, the CSB, and the outpatient treatment provider in assuring effective implementation of involuntary outpatient treatment orders.*

The Commission agrees with this recommendation. The Commission's Blueprint (paragraph III-K) recommends that the Code be amended to overhaul the provisions governing the issuance and implementation of mandatory outpatient treatment orders. A detailed proposal appears in the Report of the Task Force on Civil Commitment. This change is recommended for consideration in 2008.

IV-24: The Virginia Health Records Privacy statute should be clarified to expressly authorize treatment providers to report noncompliance with involuntary outpatient orders.

The Commission agrees with this recommendation. The Commission's proposals governing implementation of MOT orders includes a provision amending Va. Code § 37.2-817.C to provide:

The community services board or behavioral health authority shall monitor the person's compliance with the order and report any material noncompliance to the court. Any other providers designated in the treatment plan shall report any material noncompliance to the community services board or behavioral health authority, which in turn shall report any material noncompliance to the court.

Conforming amendments are also recommended to the Health Records Privacy Act (Va. Code § 32.1-127.1:03.D(12)) as discussed in the responses to IV-21 and IV-22 above.

IV-25: Va. Code § 37.2-819 should be amended to clarify that the clerk shall immediately upon completion of the commitment hearing complete and certify to the Central Criminal Records Exchange, a copy of any order for involuntary admission or involuntary outpatient treatment.

The Governor issued Executive Order 50 (2007) clarifying this issue. The Report of the Task Force on Civil Commitment addresses this issue, observing that Va. Code § 37.2-819 could be amended to clarify the duties of the clerk in certifying orders of involuntary inpatient admission and mandatory outpatient commitment to the Central Criminal Records Exchange, and clarifying which clerk's responsibility it is, as follows:

*The clerk of the general district court in the locality that conducted the hearing shall certify and forward **forthwith** to the Central Criminal Records Exchange, on a form provided by the Exchange, a copy of any order for involuntary*

admission to a facility or order of mandatory outpatient treatment immediately following the commitment hearing. The copy of the form and the order shall be kept confidential in a separate file and used only to determine a person's eligibility to possess, purchase, or transfer a firearm.

IV-26: A comprehensive review of the Virginia Code should be undertaken to determine whether there exist additional situations where court orders containing mental health findings should be certified to the Central Criminal Records Exchange.

Neither the Task Force on Civil Commitment nor the Commission offers any further recommendation on this matter.

V-6: The Commonwealth of Virginia Commission on Mental Health Law Reform should study whether the result of a commitment hearing (whether the subject was voluntarily committed, involuntarily committed, committed to outpatient therapy, or released) should also be publicly available despite an individual's request for confidentiality.

The Panel continued:

Although this information would be helpful in tracking people going through the system, it may infringe too much on their privacy.

As discussed in Chapter IV, and its recommendations to revise Virginia law regarding the commitment process, the law governing hearings should explicitly state that basic information regarding a commitment hearing (the time, date, and location of the hearing and the name of the subject) is publicly available even when a person requests that records remain confidential. This information is necessary to protect the public's ability to attend commitment hearings.

As previously noted, the Commission appointed a Working Group to consider the Tech Panel's recommendations relating to health privacy. Under current law, the court is directed to keep records of commitment hearings confidential, *but only if requested by the subject or his counsel* (Va. Code § 37.2-818(B)). The Working Group recommends that the presumption of Va. Code § 37.2-818(B) be reversed and that the commitment records be presumed to be confidential. Similarly, the Working Group recommends that hearings be closed to protect the respondent's medical privacy. Although judges already have the authority to close the hearings when private health information is being discussed, the Working Group recommends that this authority be codified. The Working Group recognized that members of the public (*e.g.*, family; concerned individuals; educational institutions) may sometimes have a legitimate interest in knowing the *outcome* of the proceedings. However, in such cases, the Working Group concluded that public access should be limited to the dispositional order and then only upon an appropriate showing, and that this limitation should be codified. The Commission agrees. (See the Commission's Blueprint, paragraph III-G-2) The Commission recommends legislative consideration of this matter in 2008.

APPENDIX 2

ACRONYMS

ACT	Assertive Community Treatment
BHA	Behavioral Health Authority
CCJB	Community Criminal Justice Board
CSB	Community Services Board
CHINS	Child in Need of Services
CIT	Crisis Intervention Teams
DCJS	Department of Criminal Justice Services
DJJ	Department of Juvenile Justice
DOC	Department of Corrections
DMAS	Department of Medical Assistance Services
DMHMRSAS	Department of Mental Health, Mental Retardation, and Substance Abuse Services
ECO	Emergency Custody Order
HIPAA	Health Insurance Portability and Accountability Act
ICM	Intensive Case Management
ICT	Intensive Community Treatment
IE	Independent Examiner
J&DRC	Juvenile and Domestic Relations District Court
JLARC	Joint Legislative Audit and Review Commission
MOT	Mandatory Outpatient Treatment
PACT	Program of Assertive Community Treatment
TDO	Temporary Detention Order

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Appendix 3

Commonwealth of Virginia Commission on Mental Health Law Reform

Commissioners

Chair

Richard J. Bonnie
Harrison Foundation Professor of
Medicine and Law, Professor of
Psychiatry and Neurobehavioral
Sciences, and Director of Institute of
Law, Psychiatry and Public Policy
University of Virginia
School of Law
Charlottesville, VA

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Richmond, VA

The Honorable Robert F. McDonnell
Attorney General of Virginia
Richmond, VA

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Senator, District 9 (1986 to 2007)
Senate of Virginia
Richmond, VA

The Honorable Terrie L. Suit
Delegate, 81st District
House of Delegates
Virginia Beach, VA

Members

Ronald A. Allison
Executive Director
Cumberland Mountain Community
Services
Cedar Bluff, VA

Jack W. Barber, M.D.
Director
Western State Hospital
Staunton, VA

Mark Bodner, Esquire
Special Justice
Fairfax, VA

Victoria Huber Cochran, J.D.
Cochran Consulting and Facilitation
Services
Blacksburg, VA

Patrick W. Finnerty
Director
Department of Medical Assistance
Services
Richmond, VA

Vicky Mitchell Fisher, Ph.D., RN,
APRN
Director of Nursing
Catawba Hospital
Roanoke, VA

The Honorable Isaac St. C. Freeman
Judge
Smyth County Circuit Court
Marion, VA

Terry Grimes, Ed.D.
President
Empowerment for Healthy Minds
Blacksburg, VA

Karl R. Hade
Executive Secretary
Supreme Court of Virginia
Richmond, VA

Charles A. Hall, M.Ed., CAS
Executive Director
Hampton-Newport News Community
Services Board
Newport News, VA

The Honorable Phillip A. Hamilton
Delegate, 93rd District
House of Delegates
Newport News, VA

Jane D. Hickey, Esquire
Senior Assistant Attorney General and
Chief of Health Services Section
Office of the Attorney General
Richmond, VA

The Honorable Gerald S. Holt
Sheriff
Roanoke County
Salem, VA

The Honorable Janet D. Howell
Senator, District 32
Senate of Virginia
Reston, VA

The Honorable Catherine M. Hudgins
Fairfax County Board of Supervisors
Reston, VA

The Honorable Terry G. Kilgore,
Esquire
Delegate, 1st District
House of Delegates
Gate City, VA

The Honorable L. Louise Lucas
Senator, District 18
Senate of Virginia
Portsmouth, VA

Gregory E. Lucyk, Esquire
Chief Staff Attorney
Supreme Court of Virginia
Richmond, VA

Charlotte V. McNulty
Executive Director
Harrisonburg-Rockingham Community
Services Board
Harrisonburg, VA

The Honorable Deborah M. Paxson
Judge
Juvenile and Domestic Relations District
Court
Virginia Beach, VA

James S. Reinhard, M.D.
Commissioner
Department of Mental Health, Mental
Retardation and Substance Abuse
Services
Richmond, VA

James W. Stewart, III
Inspector General
Office of the Inspector General
Richmond, VA

Byron Stith
P.O. Box 1175
Mechanicsville, VA

Cheryl Anita Thompson
Chief Magistrate
Sixteenth Judicial District
Charlottesville, VA

F. Carol Ulrich, Esquire
President
NAMI-Northern Virginia
Herndon, VA

The Honorable Janice J. Wellington
Judge
Thirty-first District Juvenile and
Domestic Relations Court
Manassas, VA

Kevin Young, BSW, MHA, CBHE
Corporate Director of Behavioral Health
Neuroscience Center of Excellence
Valley Health
Winchester, VA

Advisors

Thomas L. Hafemeister, J.D., Ph.D.
Associate Professor of Law
University of Virginia School of Law
Director of Legal Studies
Charlottesville, VA

Catherine K. Hancock, APRN, BC
Mental Health Policy Analyst
Department of Medical Assistance
Services
Richmond, VA

Richard E. Hickman, Jr.
Deputy Staff Director
Senate Finance Committee
General Assembly Building, 10th Floor
Richmond, VA

James M. Martinez, Jr.
Director, Office of Mental Health
Services
Department of Mental Health, Mental
Retardation and Substance Abuse
Services
Richmond, VA

Susan Massart
Legislative Fiscal Analyst
House Appropriations Committee
Richmond, VA

Raymond R. Ratke
Deputy Commissioner
Department of Mental Health, Mental
Retardation and Substance Abuse
Services
Richmond, VA

Staff Director

Thomas M. Diggs, Ed.D., J.D.
Assistant Director of Judicial Programs
Office of the Executive Secretary
Supreme Court of Virginia
Third Floor
100 North Ninth Street
Richmond, Virginia 23219-2334
804-225-3474 (direct dial)
804-786-4542 (fax)
tmdiggs@courts.state.va.us