

**REPORT TO THE COMMISSION ON MENTAL  
HEALTH LAW REFORM**

**From the Task Force on Future Commitment Reforms**

**December 2008**

## PREFACE

The Commonwealth of Virginia Commission on Mental Health Law Reform (“Commission”) was appointed by the Chief Justice of the Supreme Court of Virginia, the Honorable Leroy Rountree Hassell, Sr., in October 2006. Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups. The Commission was directed by the Chief Justice 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 and protect the rights 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 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 greater choice regarding the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

During the first phase of its work, the Commission was 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”). Information regarding the Commission, its Task Forces and its Reports is available at <http://www.courts.state.va.us/cmh/home.html>.

The Commission also conducted three major empirical 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 study is available at [http://www.courts.state.va.us/cmh/civil\\_commitment\\_practices\\_focus\\_groups.pdf](http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf).

The second major research project was a study of commitment hearings and dispositions (the “Commission’s Hearings Study”). In response to a request by the Chief Justice, the special justice or district judge presiding in each case filled out a 2-page instrument on every commitment hearing held in May 2007. (There were 1,526 such hearings). Findings from the Commission’s Hearing Study served an important role in shaping the Commission’s understanding of current commitment practice. The study can be found at [http://www.courts.state.va.us/cmh/2007\\_05\\_civil\\_commitment\\_hearings.pdf](http://www.courts.state.va.us/cmh/2007_05_civil_commitment_hearings.pdf).

Finally, the Commission’s third project was a study of every face-to-face emergency evaluation conducted by Community Service Board (“CSB”) emergency

services staff during June 2007 (the “Commission’s CSB Emergency Evaluation Study”). (There were 3,808 such evaluations.) The final report of the CSB Emergency Evaluation Study can be found at [http://www.courts.state.va.us/cmh/2007\\_06\\_emergency\\_eval\\_report.pdf](http://www.courts.state.va.us/cmh/2007_06_emergency_eval_report.pdf).

Based on its research and the reports of its Task Forces and Working Groups, the Commission issued its *Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform* (“Preliminary Report”) in December, 2007. The Preliminary Report, which is available on-line at [http://www.courts.state.va.us/cmh/2007\\_0221\\_preliminary\\_report.pdf](http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf), outlined a blueprint for comprehensive reform (“Blueprint”) and identified specific recommendations for legislative consideration during the 2008 session of Virginia’s General Assembly that focused primarily on the commitment process.

After the General Assembly enacted a major overhaul of the commitment process in 2008, the Commission moved into the second phase of its work. Three new Task Forces were established – one on Implementation of the 2008 Reforms, another on Future Commitment Reforms and one on Advance Directives. In addition, the Commission created a separate Working Group on Transportation. Each of these Task Forces and Working Groups presented reports to the Commission, together with recommendations for the Commission’s consideration.

The accompanying report represents the views and recommendations of the members of the Task Force on Future Commitment Reforms, and should not be construed as reflecting the opinions or positions of the Commission on Mental Health Law Reform, the Chief Justice, the individual Justices of the Supreme Court of Virginia, or of the Executive Secretary of the Supreme Court. Any recommendations or proposals embraced by the Court itself will lie exclusively within the judicial sphere.

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December 2008

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<sup>1</sup> Because of the extensive time commitment task members provided to the Mental Health Law Reform Commission last year, some members have asked to share the work load with others. These members are identified as “(Back-up for \_\_\_\_\_) or w/ \_\_\_\_\_.”

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## I. INTRODUCTION

The Future Commitment Reforms Task Force (“Future Reforms Task Force”) was established by the Commission on Mental Health Law Reform (“Commission”) to (i) complete the work of the prior Task Force on Civil Commitment in areas not addressed during the 2008 General Assembly Session, (ii) study the subject matter of legislation referred to the Commission from the Senate related to adult civil commitment and provide recommendations to the Commission, and (iii) review carry over legislation related to adult civil commitment and provide comment to the Commission in the event the Commission is asked for input.

The Future Reforms Task Force met five times by telephone conference call on July 2, July 23, September 12, September 25, and October 17, 2008 and studied the following issues:

1. **Mandated Special Justice, Attorney and Examiner Training** – whether special justices, attorneys representing persons in commitment hearings and independent examiners should receive mandatory training, including SB 214 (Edwards)(subject matter referred to Commission) mandating training for special justices, and if so, what that training should be.
2. **Mandated CSB Core Services** – whether the core services community services boards (“CSBs”) are mandated to provide in § 37.2-500 should be expanded from emergency services and case management services when funds are available to include crisis stabilization, outpatient, respite, in-home, and residential and housing support services as provided in SB 64(Howell)(subject matter referred to Commission).
3. **Counsel for Petitioners** – whether an attorney should be appointed to represent petitioners in civil commitment proceedings, and if so, who should be appointed, including HB 267 (Albo)(subject matter referred to Commission) authorizing appointment of attorney to represent indigent petitioners and HB 735 (Caputo)(continued to 2009) authorizing 3<sup>rd</sup> year law students to represent petitioners.
4. **Petitioner Right of Appeal** – whether petitioners in civil commitment proceedings should have a right of appeal, including HB 938 (Gilbert)(subject matter referred to Commission).
5. **Combined Inpatient/Outpatient Commitment Orders** – whether an order of involuntary inpatient treatment may be followed by a period of mandatory outpatient treatment, and if so, the criteria that would be used and whether it would be court-ordered at the time of the commitment hearing or at the time of discharge, or hospital-initiated, including SB 274 (Cuccinelli)(continued to 2009) pertaining to transfers to outpatient treatment and HB 939 (Gilbert)(subject matter referred to Commission) permitting the person to petition for outpatient treatment.

6. **Assisted Outpatient Treatment** – whether assisted outpatient treatment utilizing reduced commitment criteria to prevent involuntary inpatient treatment, including SB 177 (Marsh)(continued to 2009) should be implemented.
7. **Extension of the Temporary Detention Order (“TDO”) Period** - whether the period of temporary detention should be extended from 48 hours to four or five days, including SB 143 (Edwards)(subject matter referred to Commission) extending the temporary detention period from 48 hours to 96 hours, SB 333 (Cuccinelli)(subject matter referred to Commission) authorizing the independent examiner to release the person if the IE finds the person does not meet commitment criteria, and SB 335 (Cuccinelli)(subject matter referred to Commission), permitting an offer of voluntary outpatient treatment to a detained person.
8. **Protection of Rights of Persons Subject to Commitment Proceedings** – whether legislation may be enacted to prevent persons from being evicted from their homes as a result of being subjected to emergency custody and temporary detention orders or commitment orders, or to protect them from default judgments during this period.
9. **Admission of Incapacitated Persons** – whether persons who lack capacity to consent to voluntary admission should be admitted to inpatient treatment upon the consent of a guardian or other legally authorized representative, and if so, whether a judicial proceeding is needed.

## **II. MANDATED TRAINING FOR SPECIAL JUSTICES, ATTORNEYS AND INDEPENDENT EXAMINERS**

The Future Reforms Task Force reviewed SB 214 (Edwards), the subject matter of which was referred to the Commission for further study. This bill mandates training for special justices. The Future Reforms Task Force also reviewed the draft Civil Commitment Task Force Report and endorses its recommendations. In order to ensure that the civil commitment process is implemented consistently and fairly statewide, it is imperative that special justices receive extensive training BEFORE they assume their responsibilities on the bench. Because special justices are often appointed from the ranks of attorneys who are appointed to represent respondents in commitment hearings, it is equally important that attorneys be trained and qualified to represent respondents before they assume such responsibilities.

The Future Reforms Task Force believes that special justices and attorneys should be required to complete a training program similar to that required for attorneys serving as guardians *ad litem* for incapacitated adults. This training encompasses a six-hour mandatory course “Representation of Incapacitated Persons as a Guardian *ad Litem*” and six hours of continuing education every two years from the date of original qualification



on any topic related to the representation of incapacitated persons. For special justices and attorneys, the six hours of continuing legal education should be in subjects approved by the Executive Secretary's Office of the Virginia Supreme Court. Such training should also include training provided with the participation of consumers and family members, public and private sector clinicians and community services boards.

The Future Reforms Task Force has been informed that the Judicial Council, the policy entity of the Virginia Supreme Court, is considering mandating that all special justices complete a training program related to their job responsibilities within six months of their appointment and that they receive continuing legal education in commitment related topics every two years. The Supreme Court would also work with the Virginia State Bar and Virginia CLE to establish training programs for attorneys representing petitioners and respondents in these proceedings. The Implementation Task Force is also recommending a number of additional steps, including the evaluation of special justices and a committee composed of mental health professionals, public and private providers, consumers and family members to assist in development of training. Most of these recommendations follow the recommendations of the Civil Commitment Task Force issued in March 2008.

In addition to requiring training certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services ("DMHMRSAS") for the other identified mental health professionals serving as independent examiners ("IEs") under § 37.2-815, the Future Reforms Task Force also strongly recommends that psychiatrists and psychologists serving as IEs receive mandatory training. Psychiatrists and psychologists do not necessarily need training in how to conduct the mandated examinations, but they should be mandated to receive training on the civil commitment criteria and other legal requirements of the civil commitment process, as well as health records privacy, to ensure both compliance with the law and a consistent statewide application of the criteria and the procedural requirements of the law. If the period of temporary detention is extended to 4 or 5 days and IEs are permitted to release an individual from a TDO prior to a hearing, mandatory training for ALL IEs will be even more critical. Continuing education units should be available to all mental health professionals who complete this training. The Future Reforms Task Force is aware and concerned, however, that IEs are only paid \$ 75.00 for the examination and testimony at the hearing. In order to retain qualified IEs and obtain a quality work product, this fee must be increased. Attached, as Appendix A, is draft legislation that would mandate this training.

**Recommendation 1: All independent examiners, including psychiatrists and psychologists, should be required to complete a certification program developed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, and that Continuing Education Units be made available for the training.**

**Recommendation 2: The General Assembly should increase the \$ 75 fee for conducting examinations in civil commitment proceedings as soon as funding is available to do so.**

### III. MANDATED CORE CSB SERVICES

The Future Reforms Task Force reviewed SB 214 (Howell), the subject matter of which was referred to the Commission for further study. The bill would expand the core services CSBs are mandated to provide in § 37.2-500 from emergency services and case management services when funds are available to include crisis stabilization, outpatient, respite, in-home, and residential and housing support services. The Future Reforms Task Force reviewed the prior recommendations of the Commission, the draft Civil Commission Task Force Report and the prior Access Task Force Report and recommends that these services be mandated as soon as the economy of the Commonwealth permits. The services listed are necessary to provide an adequate array of services to persons who want and need them, especially on a voluntary basis, thus reducing the need for the provision of high cost involuntary inpatient services. Due to scarcity of resources, localities are inclined to appropriate additional funding only for services that are mandated. These services will therefore not become available unless and until they are mandated.

Some members of the Future Reforms Task Force also recommend that the definition of core services include the full continuum of services, including inpatient, because the need for inpatient care will always exist. If a full array of outpatient services is mandated, state and local government will place a higher priority on funding those services thereby exacerbating bed shortage problems.

**Recommendation 3: The Commission should continue to study the potential benefits and costs of increasing mandated core services through the Task Force on Access to Services.**

### IV. APPOINTMENT OF COUNSEL TO REPRESENT PETITIONERS

The Future Reforms Task Force reviewed HB 267 (Albo) that was referred to the Commission for study. HB 267 would amend § 37.2-814 requiring the court to appoint competent counsel to represent indigent petitioners. The Future Reforms Task Force also reviewed HB 735 (Caputo) that was continued to 2009 and would amend § 54.1-3900 to permit third-year law students to represent petitioners in commitment hearings without compensation and provide them with immunity except for intentional malfeasance.

Only two states, Alabama and Indiana, provide for the appointment of counsel for indigent petitioners. In 26 states, however, a government attorney, such as the local prosecutor, county or city attorney, attorney general, or a combination thereof, provides representation at the hearing either for the petitioner or represents the interests of the people, the public interest or the state. In 13 states, the government attorney represents the people, the public interest or the state's interest at the commitment hearing. In two of those states, the county attorney is the actual petitioner. When the attorney general represents the petitioner or the state's interest, it is usually when the hearing takes place

at a state facility. In three states, the government attorney represents an agency or facility, but not an individual petitioner. In six states, the government attorney represents the petitioner, whether it is an individual who is the petitioner, a government entity or a treatment facility. Four states do not specify whom the attorney represents.

The Study of Civil Commitment Hearings Held in the Commonwealth of Virginia during May 2007 (“Hearings Study”) revealed that approximately 15% of commitment petitions were dismissed. The Hearings Study also revealed, however, a wide discrepancy throughout the Commonwealth in the number of dismissals with some judicial districts reporting a 60% dismissal rate and others reporting 0%. For example, in five districts more than 1/3 of cases were dismissed, whereas in six courts, no cases were dismissed. Future Reforms Task Force members from jurisdictions where there are a large number of dismissals are very much in favor of the appointment of counsel for the petitioner. Those from other areas where most hearings result in commitment believe that providing an attorney for the petitioner is “overkill,” conveying the impression to respondents that they do not have a chance to avoid commitment and the hearing “is stacked against them.”

The Future Reforms Task Force reached no consensus on this topic. Many members strongly believe that it is important that the petitioner be represented so that all the relevant evidence may be properly presented to the court. If the petitioner is represented, the special justice will not be placed in the role of assisting the petitioner in the presentation of evidence, and will not be required to question the witnesses, which otherwise may give the respondent the impression that the special justice is favoring the petitioner. Other members believe that provision of any attorney to represent the petitioner will make consumers feel more “ganged up upon” and “railroaded” than they already feel.

A cost-effective way to address the issue of counsel for the petitioner is to permit the special justice to appoint private counsel when the special justice, especially in areas with a high dismissal rate, believes such appointment would aid the commitment process. In those areas where the commitment rate is already high, special justices may determine that appointment of counsel is not necessary and would therefore not be required to appoint them. Private counsel would be paid the same as counsel appointed for the respondent, currently \$ 75.00. (Consideration should also be given to increasing payment for attorneys, as well as special justices.) This would obviate the need for local government to hire additional full-time attorneys in either Commonwealth’s Attorneys’ or city/county attorneys’ offices. The Future Reforms Task Force recommends, however, that the attorney not be tasked with representing the petitioner but with representing the interests of the public or state in the proceeding, even though such a role is usually the role of an elected official, such as the Commonwealth’s Attorney or Attorney General. Given that attorneys are not appointed for petitioners in other civil cases, such as domestic violence cases that are arguably just as important as these proceedings, authorizing appointment of counsel for petitioners in civil commitment cases could be a “slippery slope.” The members could not reach consensus on whether attorneys should be

appointed for indigent petitioners in civil commitment proceedings and therefore offers no recommendation.

The Future Reforms Task Force also reviewed HB 735 (Caputo) that would amend § 54.1-3900 to permit third-year law students to represent petitioners in commitment hearings unsupervised and to provide them with immunity. Some members believe that permitting law students to represent petitioners would be a start and would be better than no representation until provisions for representation by attorneys can be made. They suggest that this proposal be tried in a couple of areas in the state to see how it works. Most other members believe that permitting unsupervised law students to undertake this activity diminishes the importance of commitment hearings and provides no opportunity for oversight by the Virginia State Bar for ineffective and harmful representation. It would also not be an effective solution statewide because law schools are not conveniently located near every hearing site. If used in areas where law schools are located, supervision is absolutely necessary.

A number of CSBs, including the Fairfax/Falls Church CSB, have also prepared information or fact sheets for petitioners about what to expect at the hearing and what will be expected of them as petitioners. The Future Reforms Task Force supports this initiative and encourages all CSBs to develop similar information for petitioners.

**Recommendation 4: Unsupervised law students should not be permitted to represent petitioners in commitment proceedings. Instead law students should be encouraged to provide this service with attorney supervision in areas where law schools are located. In addition, the Virginia State Bar should encourage *pro bono* representation of petitioners by members of the Bar.**

## **V. PETITIONER RIGHT OF APPEAL**

The Future Reforms Task Force reviewed HB 938 (Gilbert), the subject matter of which was referred to the Commission for study. HB 938 would amend § 37.2-821 to permit any party to a civil commitment proceeding or a proceeding to certify the admission of a person with an intellectual disability to a training center to appeal the decision to the circuit court.<sup>2</sup> Currently, this statute is being interpreted to permit a right of appeal only to respondents in civil commitment proceedings.

To assess the proposed legislation permitting an appeal, the Future Reforms Task Force first reviewed the statutes from other states. Seven states specifically permit the petitioner to appeal: Connecticut, Delaware, Indiana, Kentucky, North Carolina, South Carolina and Wisconsin. Nine other states specifically state that appeals may be taken as in other appellate cases. Presumably, since either party in a civil proceeding normally

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<sup>2</sup> Subsection C also requires the order appealed from to be defended by the Commonwealth's Attorney. If this bill moves forward in the General Assembly, the role of the Commonwealth's attorney will need to be reconsidered when the party appealing is the petitioner, i.e. whether he is representing the petitioner or the public interest. The Commonwealth's Attorney would also not then be defending the order appealed from because he would not be representing the respondent who has private counsel appointed to represent him.

has the right of appeal, petitioners in these states would be permitted to appeal. This reference could, however, be interpreted to mean that the same procedures as in other appeals would be followed without addressing one way or another whether petitioners could appeal. These states are: Arkansas, Colorado, Kansas, Massachusetts, Montana, New Mexico, Oklahoma, Pennsylvania and Tennessee.

One reason given for permitting petitioner appeals is that there are very few appellate cases interpreting commitment law. The traditional way to provide oversight in judicial decision-making is through the appellate process, thus producing a body of case law interpreting the statutory law. Such case law also enables more uniformity of interpretation and implementation statewide. Commitment appeals conducted under § 37.2-821, however, are appeals *de novo* in the circuit court, meaning that all of the evidence is heard again as of the date of the appellate hearing, rather than a “true appeal” of legal issues based upon the lower court record. The Future Reforms Task Force also determined that with the 2008 amendment limiting the duration of the initial commitment order to 30 days, most appeals by respondents would be dismissed as moot before the appeal is heard, regardless of whether the respondent or petitioner appeals. The right of appeal will in reality only be effective for persons who may be recommitted for up to 180 days. Therefore, the extent to which interpretations of the law may be written and disseminated -- thereby leading to effective oversight of judicial decision making and statewide uniformity -- is not clear. For this reason, the Future Reforms Task Force does not recommend according petitioners a right of appeal simply to produce a body of appellate case law.

Considering the data on rates of dismissal in the Hearings Study, many Future Reforms Task Force members believe it would be more effective to provide attorneys for petitioners in areas of the Commonwealth with high dismissal rates than to provide for a petitioner right of appeal. Other members believe that the right of appeal is a matter of fundamental fairness that should be afforded to all participants.

Practical considerations are also a concern. Would the person remain involuntarily hospitalized until the appeal is heard, and if so, under what authority? One would assume not since the petition would have been dismissed. How would the person be returned to involuntary hospitalization if the decision to dismiss the petition was reversed and the person ordered to involuntary inpatient hospitalization or mandatory outpatient treatment? How would the person’s appearance at the appeal hearing be assured? Those members who support the right of appeal indicate that notice and attendance at the hearing would be addressed in the same manner as for all other civil appeals. Although a majority of the members recommend that petitioners not be afforded the right of appeal, the members did not reach consensus on this issue.

## **VI. MANDATORY OUTPATIENT TREATMENT FOLLOWING INVOLUNTARY INPATIENT TREATMENT**

The Future Reforms Task Force reviewed HB 939 (Gilbert) according an individual under an involuntary inpatient order a right to petition for mandatory

outpatient treatment (“MOT”), which was referred to the Commission for further study, and SB 274 (Cuccinelli) permitting a facility director to petition for transfer to outpatient commitment, which was continued to the 2009 General Assembly Session.

The Future Reforms Task Force also reviewed the law related to MOT in the other states. Sixteen states permit a facility or treating physician to discharge a person to MOT. Seven of these states permit this in the form of convalescent leave or trial visits. Six states require a court order before discharge to MOT, one of which, Oklahoma permits the person to petition as proposed in HB 939. Two states permit either the court to order MOT or the treating facility to discharge to MOT. Three states permit the court to order a combined inpatient and outpatient order at the time of the original order.

## **Criteria**

The Future Reforms Task Force then considered what the appropriate criteria should be for MOT and whether the person must continue to meet the commitment criteria for involuntary inpatient hospitalization in order to be discharged to MOT. Note there are several possible applications for MOT: as an alternative to inpatient hospitalization; as a means to ensure follow-up care after a period of hospitalization; and as a preventive intervention when the commitment criteria are not met. The 2008 reforms addressed the second application, permitting MOT as an alternative to inpatient hospitalizations. At issue in many discussions of the use of MOT is what criteria should be used in each application.

Outpatient treatment *following* inpatient treatment is best suited for those who are stabilized during inpatient treatment and need additional treatment that does not need to be provided on an inpatient basis. This likely means that the person will no longer meet the criteria for inpatient commitment and lesser criteria will be needed.

Unlike most other states, Tennessee permits a facility and a qualified mental health professional to release a person on MOT, and sets out specific criteria before the person may be discharged on outpatient MOT:

- (A) the person has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission;
- (B) the person’s condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm unless treatment is continued;
- (C) the person is likely to participate in outpatient treatment with a legal obligation to do so;
- (D) the person is not likely to participate in outpatient treatment unless legally obligated to do so; and

(E) mandatory outpatient treatment is a suitable less drastic alternative to commitment.

TN Code 33-6-602. Tennessee has had legislation permitting MOT following involuntary inpatient admission since 1982 and has developed an extensive policy manual on its implementation. The policy emphasizes that MOT is only to be used for a small population of people with mental illness who are likely to participate in outpatient treatment when legally obligated to do so, but are unlikely to do so if not required to do so.

The Future Reforms Task Force also reviewed the criteria for Virginia's forensic conditional release program, which has had good success and is considered a model for other states. The criteria are somewhat similar to the Tennessee criteria:

- (i) the acquittee does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization;
- (ii) appropriate outpatient supervision and treatment are reasonably available;
- (iii) there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified; and
- (iv) conditional release will not present an undue risk to public safety.

Virginia Code § 19.2-182.7.

Most members of the Future Reforms Task Force, and especially family member and state hospital representatives, believe that a provision permitting a period of MOT would be beneficial for certain people who need follow-up treatment to their inpatient commitments and must have structure or an external source of help in order to prevent relapse. Such MOT may serve to prevent relapse and thus reduce some of the dependence on expensive inpatient services. This post-hospitalization application of MOT is the next logical step in implementing MOT augmenting last year's enactment of MOT procedures as an alternative to outpatient treatment. The Future Reforms Task Force agreed that a combination of the above criteria would be appropriate. In addition, the services must actually be available in the community and the providers must agree to deliver the services.

### **Duration of MOT**

Most other states that permit MOT following inpatient treatment limit the period of MOT to the length of the inpatient commitment period, or now 30 days in Virginia. If MOT following inpatient treatment is enacted, the consensus of the Future Reforms Task Force is that the MOT outpatient period (following the period of hospitalization) should be 90 days in order to be effective. Limiting the period of outpatient treatment to the 30-day length of inpatient commitment would be ineffective because there is inadequate time to provide the person with outpatient treatment after the period of inpatient treatment.

## **Court Review**

The Future Reforms Task Force also considered whether a court should have the option of ordering MOT following a period of inpatient treatment at the time of the original commitment hearing. Most members expressed concern that the issuing of an MOT order at the time of the initial commitment hearing would become routine, as has been reported in other states, with the courts routinely issuing generic MOT orders and with no check on abuses. Although requiring another judicial hearing for MOT would add to the workload of special justices and clerks, it would also discourage MOT orders from becoming routine and would provide justification for imposing a period of MOT longer than the 30 days combined with the period of inpatient treatment.

All members agree that CSBs, rather than the inpatient facility, should be responsible for developing an MOT plan and monitoring the person's adherence to MOT as is now required in Virginia. Because state law identifies CSBs and the entities legally responsible for monitoring compliance with an MOT plan, most CSBs are concerned that if there is no judicial review of an MOT plan, private hospitals may discharge individuals to MOT over the CSB's objection, thus committing CSB services, resources and monitoring capacity when the resources do not exist. Judicial review of MOT orders would be a mechanism to prevent this from occurring. Provision could also be made, however, that if the person, the treatment facility and CSB all agree to the MOT plan, it could be filed with the court without the need for a further hearing.

## **Petitioners**

Another concern is who would be permitted to petition for MOT following the period of inpatient hospitalization. Clearly, the CSB, inpatient facility and the person himself/herself should be permitted to do so. Permitting the person to petition may be a valuable recovery tool. Whether family members, guardians, health care agents, and legally authorized representatives should also be permitted to do so was a matter of concern to Future Reforms Task Force members. If acting in a representative capacity on behalf of the person, they should be permitted to do so. Some limit on successive petitions should be imposed.

## **Research**

Future Reforms Task Force members also expressed concern that the efficacy of MOT has not been established in the literature and that many professional and advocacy groups are either opposed to any use of MOT or are recommending further evidence-based research and efforts to develop a more comprehensive community-based service delivery system before consideration is given to enacting MOT.

The International Association of Psychosocial Rehabilitation Services opposes the utilization of involuntary outpatient commitment laws, believing they "will be ineffective, will abuse the rights of large numbers of people with mental illness, and will



fail to address the core problem – poor access to effective services.”<sup>3</sup> Mental Health America, formerly the National Mental Health Association, recognizes that involuntary treatment may sometimes be necessary, but opposes the use of involuntary outpatient treatment. It believes that the best hope for recovery from mental illness comes from access to voluntary mental health treatment and services that are comprehensive, community-based, recovery-oriented and culturally competent.<sup>4</sup> In addition, the Bazelon Center for Mental Health Law opposes MOT stating, “it appears that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. There is currently no evidence of cost effectiveness. People receiving compulsory community treatment were, however, less likely to be victim of violent or non-violent crime.”<sup>5</sup>

The National Association of State Mental Health Program Directors takes no position on the enactment of MOT, but its Medical Directors Council issued a Technical Report on Involuntary Outpatient Commitment in August 2001 (“MOT Report”), finding that “current research fails to provide strong evidence that involuntary outpatient commitment is the best remedy for consumer non-compliance in treatment.” The MOT Report based its conclusions on the principle that treatment compliance is meaningful only if adequately-funded, effective community services are available.<sup>6</sup> Similarly, the American Association of Community Psychiatrists recommends that more research is needed concerning the clinical and rehabilitative benefits of MOT. It recognizes that limited research shows benefits in reducing hospitalization days and violence among some individuals, but clinical benefits, such as improvement in individual functioning and compliance with MOT have not as yet been shown.<sup>7</sup>

By contrast, the American Psychiatric Association endorses MOT, indicating that it is “a useful intervention for a small subset of patients with severe mental illness.” The American Psychiatric Association does note that more research is necessary in order to fully understand whether success attributed to MOT is the result of enhanced community services.<sup>8</sup> The Treatment Advocacy Center reports that assisted MOT reduces hospitalization, homelessness, arrests, violence, and victimization and also improves

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<sup>3</sup> Position Statement of the International Association of Psychosocial Rehabilitation Services on Involuntary Outpatient Commitment, <http://www.uspra.org/files/public/commitmentPos.pdf> (last visited December 4, 2008).

<sup>4</sup> Mental Health America, Position Statement 22: Involuntary Mental Health Treatment, <http://www.nmha.org/go/position-statements/p-36> (last visited December 4, 2008).

<sup>5</sup> Studies of Outpatient Commitment are Misused, The Bazelon Center for Mental Health Law, Revised July 3, 2001, <http://www.bazelon.org/issues/commitment/moreresources/studies.htm> (last visited December 8, 2008).

<sup>6</sup> Technical Report on Involuntary Outpatient Commitment, National Association of State Mental Health Program Directors Medical Director’s Council, August, 2001.

<sup>7</sup> Position Paper: Involuntary Outpatient Commitment, American Association of Community Psychiatrists, June 2001, <http://www.comm.psych.pitt.edu/finds/ioc.html> (last visited December 5, 2008).

<sup>8</sup> Resource Document on Mandatory Outpatient Commitment, American Psychiatric Association Model Guidelines (December 1999), as quoted in National Health Policy Forum, Issue Brief No. 757, Outpatient Commitment in Mental Health: Is Coercion the Price of Community Services?, the George Washington University, a discussion featuring John Monahan, Ph.D., Chris Koyanagi, Ron Honberg, John Tauriello, and Lawrence Fitch, July 11, 2000.

treatment compliance and substance abuse treatment.<sup>9</sup> In addition, the Treatment Advocacy Center reports that anosognosia, or unawareness of illness, is the most important reason individuals do not take medication for their illness. The Treatment Advocacy Center relies on numerous studies indicating that the presence of anosognosia increases the incidence of violent behavior “both because it is associated with medication non-adherence and because it appears to directly increase violent behavior.”<sup>10</sup>

There have been only two scientific studies on the effectiveness of MOT. One study was conducted at Bellevue Hospital in New York City, and the other in North Carolina by Duke University. The New York investigators compared outcomes, such as rates of hospitalization, arrests, quality of life, psychiatric symptoms, and homelessness for two groups of people, those with MOT orders and those without mandatory orders but receiving intensive services. The New York study found no significant differences between the two groups. The Duke study also found no significant difference between the two groups when subjects were under MOT orders for less than 180 days. Study results suggest, however, that those persons subject to MOT for greater than or equal to 180 days who received outpatient services (including case management) averaging greater than three services per month, showed a significant reduction in both total hospital admissions and total hospital days.<sup>11</sup>

At the request of the State of California, the RAND Institute reviewed the effectiveness of MOT, reviewing the empirical evidence from eight states (“RAND Study”). Notably, in the eight states surveyed, MOT was used most frequently as a “step-down” program from inpatient commitment and was used only infrequently *prior to* hospitalization. The RAND Study also determined that “involuntary outpatient commitment, when combined with intensive mental health services, can be effective in reducing the risk of negative outcomes.” After reviewing both the New York and North Carolina studies, however, the RAND Study concluded that the North Carolina Study does not reveal whether court orders *without* intensive treatment have any effect.<sup>12</sup>

New York has contracted with Dr. Marvin Swartz and others at Duke University to conduct a legislatively-mandated external evaluation of its Assisted Outpatient Treatment (“AOT”) law, also known as “Kendra’s Law.”<sup>13</sup> Kendra’s Law provides for AOT for certain people with mental illness who, in view of their treatment history and present circumstances, are found to be unlikely to survive safely in the community

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<sup>9</sup> *Assisted Outpatient Treatment*, Treatment Advocacy Center Briefing Paper, March 2005, [www.psychlaws.org/Briefing Papers/BP21.htm](http://www.psychlaws.org/Briefing%20Papers/BP21.htm) (last visited October 27, 2008).

<sup>10</sup> *Anosognosia as a cause of violent behavior in individuals with severe psychiatric disorders*, Treatment Advocacy Center Briefing Paper, April 2007, [www.psychlaws.org/Briefing Papers/BP21.htm](http://www.psychlaws.org/Briefing%20Papers/BP21.htm) (last visited October 27, 2008).

<sup>11</sup> Schwarz, M., Swanson, J., Hiday, V., Wagner, H.R., Burns, B & Borum, R. (2001). A randomized controlled trial of outpatient commitment in North Carolina. *Psychiatric Services*, 52, 325-329.

<sup>12</sup> Ridgely, M.Susan, Randy Borum, John Petrila. *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*. Santa Monica, CA, RAND, MR-1340-CSCR, 2001.

<sup>13</sup> MOT may also be used to prevent future involuntary inpatient admission, as has been done in several other states such as Wisconsin, North Carolina, and most notably through Kendra’s Law in New York.

without supervision. The purpose of the AOT Study is to examine the process and outcomes of AOT programs in New York State, by addressing specific research questions in five areas of investigation: 1) regional and cultural differences in AOT programs and their implementation, 2) engagement in Mental Health Services Post-AOT, 3) outcomes for people with mental illness who receive enhanced outpatient services and for those who are mandated into outpatient treatment, 4) opinions of a representative sample of AOT recipients regarding their experiences with AOT, and 5) the impact of AOT programs on the availability of resources for individuals with mental illness and perceived barriers to care. The AOT Study is scheduled for completion in April 2009 with a release date not expected until mid-Summer 2009.

### **Diversion of Resources**

Future Reforms Task Force members also expressed concern that AOT and other types of MOT would divert already scarce outpatient treatment resources away from those persons seeking voluntary treatment. In many localities, access to a psychiatrist or psychologist for outpatient treatment is non-existent. When a person is discharged from inpatient treatment, it may take months for that person to be assigned a case manager. Outpatient services must be available for MOT to work and those subject to an MOT order will likely be given priority access to services, making such treatment inaccessible to patients seeking treatment voluntarily. Indeed, it has been postulated that some inpatients may even petition for services themselves in order to access services.

### **Implementation Issues**

Extensive changes to Virginia's commitment process were enacted by the 2008 General Assembly including modifications of the requirements for MOT. There has not yet been sufficient time to assess the effectiveness of the reforms but early data suggest that use of MOT as an alternative to involuntary inpatient admission is being used less than prior to the enactment of the new procedures.<sup>14</sup> Given the preliminary data cover only the first quarter of implementation of reforms, it is not surprising that the various actors involved may need some time to fully understand and become familiar with the changes. The Future Reforms Task Force urges restraint in enacting further MOT legislation at this time for a variety of reasons beyond the lack of meaningful data about the 2008 MOT reforms. These include the variability in access to mental health services, generally, throughout the Commonwealth, the significant regional differences in how the commitment process operates, Virginia's challenging economic climate, the limited mental health services available to persons voluntarily seeking them, plus the inconsistent research on the effectiveness of MOT. Should the Commission recommend

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<sup>14</sup> Progress Report on Mental Health Law Reform, Commonwealth of Virginia Commission on Mental Health Law Reform, Impact of 2008 Reforms: A Preliminary Report, December, 2008. The Commission's Progress Report, December 2008, contains preliminary data assessing the impact of the 2008 reforms. Data in the Case Management System maintained by the Executive Secretary of the Virginia Supreme court indicates that only 18 MOT orders were entered from July 1, 2008 through September 30, 2008, and 11 of those orders were entered in a single jurisdiction. A Community Services Board survey reports entry of only 13 orders compared with 78 during the same period in 2007.

consideration of legislation authorizing MOT following a period of inpatient admission, a draft proposal is attached, as Appendix B, for consideration.

**Recommendation 5: The General Assembly should not enact legislation in 2009 authorizing mandatory outpatient treatment following involuntary inpatient admission. Expanding the circumstances for MOT should not be undertaken until research documenting the efficacy of MOT is available and Virginia's economic picture changes such that an expansion of outpatient mental health services is funded.**

## **VII. MANDATORY OUTPATIENT TREATMENT TO PREVENT INVOLUNTARY INPATIENT ADMISSION**

The Future Reforms Task Force also reviewed SB 177 (Marsh) that would create a program of AOT (Kendra's Law), designed to *prevent* involuntary inpatient admissions. This bill was carried over to the 2009 General Assembly Session. As indicated in Part VI above, to date, the efficacy of neither MOT nor AOT has been convincingly established.

The same concerns related to MOT following a period of involuntary inpatient admission also apply to using MOT to prevent involuntary inpatient treatment (also referred to as AOT), particularly that persons subject to MOT would displace those voluntarily seeking services. This preventive use of MOT could have the paradoxical consequence of fostering mental health crises among a population being maintained successfully in the community who are voluntarily seeking services. Without an expansion of community-based services adequate to accommodate both those who voluntarily seek services and those who might benefit from court-ordered treatment, an expansion of MOT at this time is premature

**Recommendation 6: The General Assembly should not enact further reforms to MOT for the purpose of preventing involuntary inpatient admission until further research demonstrates its effectiveness and until a fuller array of outpatient services become more widely available.**

## **VIII. EXTENSION OF TDO TO 4-5 DAYS**

SB 143 (Edwards), the subject matter of which was referred by the Senate to the Commission for study, would extend the 48-hour period of detention under a TDO to 96 hours. The Future Reforms Task Force reviewed several sources of information relating to this proposal, including the Report of the Civil Commitment Task Force issued in March 2008. That report also addressed the possibility of extending the TDO period to four days and expanding the authority of an independent examiner to release a person from the TDO prior to the hearing with the concurrence of the attending physician that the person did not meet the commitment criteria. The Future Reforms Task Force also reviewed the laws related to TDOs from other states. Virginia is one of three states that require a commitment hearing within 48 hours of the probable cause determination.

Three states require a hearing within 30 days, with most states requiring a hearing within four to eight days of the probable cause determination.

The report prepared by Sarah E. Barclay for the Mental Health Law Reform Commission was also considered.<sup>15</sup> After reviewing data from Virginia, Colorado, Massachusetts and Pennsylvania on lengths of stay in inpatient facilities both before and after commitment hearings, she concluded that in some cases Virginia's two-day TDO period is both much shorter than the "hold" period in other states and is regarded by experts elsewhere as inadequate for a thorough assessment. Ms. Barclay also noted that in Virginia 30% of commitment hearings occur in less than 24 hours. The 2008 reforms in Virginia, which became effective July 1, 2008, did not impose a minimum of 24 hours before a commitment hearing can be held, but mandated that the hearing be held only after a sufficient period of time has passed to allow for completion of the independent examination, preadmission screening report, and initiation of treatment to stabilize the person's psychiatric condition. However, anecdotal reports indicate that this practice of speedy assessments and commitment hearings is still prevalent. This is, perhaps, due to the pre-set Monday/Wednesday/Friday hearing schedules that many special justices maintain. Maintaining this schedule for hearings coupled with the 48-hour holding limit under a TDO means that a person arriving for an assessment on a Tuesday afternoon, for example, would necessarily have his/her commitment hearing the next day, truncating an already short assessment period.

Ms. Barclay postulates, and the Future Reforms Task Force agrees, that increasing the TDO period would improve the civil commitment decision-making process. A longer TDO period might also increase the use of MOT by permitting additional time for clinical stabilization as well as for assessing the availability of community-based services necessary for the development of MOT plans. As suggested earlier in this Report, some localities report that the decrease in the volume of mandatory outpatient treatment orders entered since July 2008 is reflective of an inability to develop an adequate outpatient treatment plan within the 48-hour TDO period, especially if the person is temporarily detained in a location other than his place of residence, which is often the case.

The Barclay Report recommends, as did the Civil Commitment Task Force Report, that if the TDO period is increased, an effective pre-hearing release measure must be put in place. If stabilizing treatment can be provided during a lengthened TDO period, a person may be able to be discharged to the community without involuntary hospitalization and the associated stigma and trauma of the commitment process. In addition to permitting some individuals to be stabilized and released without a commitment hearing, a longer TDO period would also encourage the development of effective outpatient treatment plans, as well as increasing the number of persons consenting to voluntary admission and treatment, both of which would reduce the burden on the courts. Data from other states appears to confirm this.

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<sup>15</sup> Sarah E. Barclay, *Increasing the Temporary Detention Period Prior to a Civil Commitment Hearing: Implications and Recommendations for the Commonwealth of Virginia Commission on Mental Health Law Reform*, April 2008.

It is possible, however, that simply extending the TDO period might lead to routine detention for the maximum period even if it is clear that the crisis has abated and the commitment criteria are no longer met. One way of mitigating this problem would be to extend the responsibility and authority of the IE to permit the person to be released from the TDO upon finding that (a) the person no longer meets the commitment criteria or (b) the person is capable of and willing to accept voluntary inpatient or outpatient treatment, and such treatment is appropriate and the treating physician agrees. A commitment hearing would then not be necessary.

The Commission's research team is studying the possible fiscal consequences of increasing the TDO period. The key questions relate to how the increase in the authorized TDO period would affect the actual TDO periods in practice and how any lengthened period under a TDO would affect the frequency of commitment hearings and the average length of stay for people hospitalized (voluntarily or involuntarily) after the TDO period. For example, if the average TDO period does increase, individuals' conditions may be stabilized, obviating the need for hearings and for further expensive inpatient hospitalizations thereby reducing the costs of further involuntary hospitalizations. A firm recommendation would be premature until these issues have been carefully studied.

There are other challenges that would need to be addressed by an extension of the 48-hour TDO period. Virginia continues to experience psychiatric bed shortages and extending the TDO time period may exacerbate this problem. Furthermore, imposing additional duties on IEs without raising their fee from \$ 75.00, might also meet resistance. Qualified IEs are already extremely difficult to locate and additional responsibilities will intensify this problem.

In an effort to balance the benefits of a lengthened period to assess and stabilize persons in a mental health crisis to avoid costly court proceedings and inpatient hospitalizations with the infringement of liberty of the persons held and the added resource burdens longer TDO periods might generate, the Future Reforms Task Force suggests a middle course. As an interim measure, Future Reforms Task Force members suggest prohibiting commitment hearings from occurring in less than 24 hours, while extending the TDO time period to 72 hours, as now occurs on weekends and holidays.<sup>16</sup> This would provide more time to ensure a more thorough assessment, but would not extend the TDO period sufficiently that it would require an additional pre-release measure.

**Recommendation 7: Given current economic conditions, the continued shortage of psychiatric hospital beds in certain localities, and the difficulty predicting the fiscal impact of extending the TDO period to 4 or 5 days, the Commission should continue to study the issue. The Commission should also consider, as an interim measure, prohibiting commitment hearings from being held within 24 hours of a person's admission to an emergency facility and extending the TDO period to 72 hours.**

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<sup>16</sup> The Virginia Code permits a 72-96 hour TDO period when the usual 48-hour period falls on a weekend or a holiday.

## **IX. RIGHTS OF RESPONDENTS IN COMMITMENT PROCEEDINGS**

The Civil Commitment Task Force Report found that individuals involved in the civil commitment process suffer consequences in addition to their loss of liberty and dignity, and trauma. They often face other disruptions in their lives as well, including housing, financial and medical challenges. For example, some may be subject to eviction from their homes for non-payment of rent or foreclosure for non-payment of their mortgage, or discharge from an assisted living facility or nursing home. The Future Reforms Task Force reviewed a number of these issues for possible legislative change.

**A. Default judgments:** Financial problems can arise from prolonged hospitalization. Virginia Code § 8.01-428.A permits a default judgment to be set aside upon proof that the defendant was, at the time of service of process or entry of judgment, a person in the military service of the United States. This section could be amended to provide a mechanism to have the default judgment set aside if the person is the subject of a temporary detention order or was involuntarily committed at the time served or when the default judgment was entered. A draft legislative proposal is attached as Appendix C.

**Recommendation 8: The General Assembly should enact legislation that would permit a court to set aside a default judgment against a person who was the subject of a temporary detention order or an order of involuntary hospitalization at the time of service or entry of the default judgment.**

**B. Notification of Family and Friends:** One way to ameliorate these adverse consequences is to assure that a respondent in commitment proceedings has the opportunity to designate a person to be notified of his/her whereabouts at all times, including transfers to a different facility. Although individuals have the right through Virginia's Human Rights Regulations to notify whomever they choose of their whereabouts at all times, including when they are transferred to a different facility, this right could be emphasized and clarified by including it in § 37.2-400 related to rights of consumers. Attached, as Appendix D, is a legislative proposal that would amend § 37.2-400 to afford a consumer the opportunity to have a family member, personal representative or close friend notified of his general condition and location and transfer to another facility.

**Recommendation 9: The General Assembly should enact legislation that would afford an individual the opportunity to have an individual of their choice notified of their general condition, location and transfer to another facility.**

**C. Housing:** The Future Reforms Task Force considered a potential amendment to the Virginia Residential Landlord Tenant Act, § 55-248.33 that would prohibit a landlord from treating a property as abandoned if the landlord was aware that the tenant was voluntarily or involuntarily admitted to a mental health facility. After discussing the

amendment with Legal Aid attorneys, it appeared that individuals currently have the option of designating someone who may be notified should a landlord believe that rental property is abandoned. The proposed legislation may not be needed. In addition, some members worried that notification of a landlord of a tenant's admission to a mental health facility may result in discrimination and loss of the housing the amendment was designed to protect.

**Recommendation 10: The Commission's Task Force on Access to Services should continue to study methods of making safe, affordable, non-congregate housing available to persons with mental illness.**

## **X. ADMISSION OF INCAPACITATED PERSONS TO MENTAL HEALTH FACILITIES**

The Future Reforms Task Force reviewed a proposal drafted by the Advance Directive Task Force permitting persons found incapacitated under the Health Care Decisions Act to be admitted to a willing psychiatric facility upon the request of the person's authorized health care agent or guardian for up to ten days. Sections 54.1-2984 and 54.1-2986(C) of Virginia's Health Care Decisions Act currently do not authorize admissions to a mental health facility by either a health care agent or a guardian. Further, § 2.2-713 expressly prohibits a public guardian from admitting an incapacitated person to a psychiatric hospital or mental health facility without a civil commitment proceeding.

State laws generally grant guardians broad health care decision-making powers, but most either restrict decisions in certain areas or require additional layers of judicial review. Twenty-six states require judicial review for placement of a person in an institution for the mentally ill.<sup>17</sup> Three states allow a guardian to admit the person to a mental health facility temporarily, pending a civil commitment proceeding or other hearing.<sup>18</sup> For example, New Hampshire permits the guardian to admit the person, provided notice is given to the court within 72 hours and a hearing is held within 60 days<sup>19</sup>. North Dakota authorizes a guardian to admit a person for up to 45 days without a commitment proceeding.<sup>20</sup> Six states, Florida,<sup>21</sup> Illinois,<sup>22</sup> Massachusetts,<sup>23</sup> Missouri,<sup>24</sup> Nevada<sup>25</sup> and Wyoming,<sup>26</sup> permit a guardian to admit a person by court order, as is being proposed here.

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<sup>17</sup> Richardson, Sarah B., *Health Care Decision-Making: A Guardian's Authority* (2002).

<sup>18</sup> Seal, Catherine Anne, CELA, *Review of Guardians' Authority under State Guardianship Statutes*, Kirtland & Seal, LLC, Colorado.

<sup>19</sup> N.H.Rev.Stat. Ann. § 464-A:25.

<sup>20</sup> N.D.Cent.Code § 30.1-28-12(2).

<sup>21</sup> Fla.Stat.ch. 744.3215(4).

<sup>22</sup> Ill.rev.Stat.ch.755 para.5/11a-14.1.

<sup>23</sup> Mass.Gen.L Chap. 201 § 6(b).

<sup>24</sup> Mo.Rev.Stat. § 474.121.

<sup>25</sup> Nev.Rev.Stat. § 159.0805.

<sup>26</sup> Wyo. Stat. § 3-2-202(a).



Under the proposal presented by the Advance Directives Task Force (“AD Proposal”), a person who has given an agent appointed in an advance directive the specific authority to consent to his or her admission to a mental health facility, may be admitted for up to 10 days without going through the involuntary civil commitment process. In addition, a guardian who has been appointed by the circuit court for an incapacitated person may also consent to the admission of the person if the guardianship order specifically authorizes the person’s admission. Before so ordering, however, the court must find that 1) the person has dementia or another severe and persistent mental disorder that significantly impairs the person’s capacity to exercise judgment or control, 2) the condition is not likely to improve in the foreseeable future, and 3) the guardian has formulated a plan for providing ongoing treatment of the person’s mental illness in the least restrictive setting suitable for the person’s condition. A guardian who has a professional relationship with an incapacitated person or is employed by or affiliated with a facility where the person resides may not be granted such authority. In both situations, the proposed admitting facility must be willing to admit the person. Furthermore, under the AD Proposal, if admission to a state facility is proposed, a CSB pre-admission screening is required. If the person is not discharged from the facility at the end of ten days, the person must be involuntarily committed.

The AD Task Force’s original proposal also would have permitted surrogate decision-makers other than health care agents and guardians to authorize such admissions. However, the Future Reforms Task Force was concerned that since this is the first initiative to permit involuntary inpatient admissions through a substitute decision-maker, such admissions should be limited. In addition, the Future Reforms Task Force was concerned that permitting a relative in descending order of priority or another person familiar with the person’s basic beliefs and values to consent to a person’s admission, as originally proposed, may be subject to abuse. Thus, the Future Reforms Task Force decided that such authority should be limited to agents appointed in an advance directive if the advance directive provides such authority and to guardians in limited circumstances if the court provides for such authority in the guardianship order.

The Future Reforms Task Force considered whether the appropriate length of admission in cases of incapacity should be seven or ten days. Most patients who are admitted to psychiatric hospitals are discharged within seven days, but in order to avoid situations where a weekend precludes discharge or a person may need just one more day of stabilization and the necessity for a full commitment proceeding, the consensus was that the maximum duration of such admissions be ten days.

Another concern was the amount of due process protection needed to permit someone other than the individual himself or herself to admit a person to a mental health facility without prior judicial review, especially if the person is objecting to the admission. Because the individual has designated an agent in an advance directive to make health care decisions on his or her behalf, and if the individual has also stated in the advance directive that the agent has this authority even over his or her objection, this is a clear indication of that individual’s wishes and values. The proposed amendments to the Health Care Decisions Act with safeguards permitting an individual to preauthorize

treatment even over his or her own objections should therefore be adequate. Similarly, absent an advance directive, this proposal would also require a circuit court hearing before a guardian would be authorized to admit the incapacitated person to a mental health facility. Moreover, the mental health facility itself would need to agree that inpatient treatment is necessary, and in the case of state facilities, a CSB prescreening would be required. Should the list of persons authorized to admit an incapacitated person or the circumstances under which this type of admission could occur be expanded, additional safeguards would need to be put into place to guard against any erroneous deprivation of liberty.

**Recommendation 11: The General Assembly should enact legislation permitting individuals who have been determined to be incapacitated to be admitted to a mental health facility for up to ten days if they have authorized an agent designated to do so in an advance directive to consent to the admission, or if a circuit court has authorized a guardian to do so under certain limited circumstances. The legislation should provide that the proposed admitting facility must be willing to admit the person, and for admissions to state facilities, the CSB must conduct a pre-admission screening.**

## APPENDIX A

### Mandated Independent Examiner Training

11-7-2008 Draft (still under revision)

§ 37.2-804. Fees and expenses.

A. Any special justice, retired judge sitting by designation pursuant to § [16.1-69.35](#), or any district court substitute judge who presides over hearings pursuant to the provisions of §§ [37.2-809](#) through [37.2-820](#) or Article 16 (§ [16.1-335](#) et seq.) of Chapter 11 of Title 16.1 shall receive a fee of \$86.25 for each hearing thereunder and his necessary mileage and \$43.25 for each certification hearing and each order under Chapter 11 (§ [37.2-1100](#) et seq.) ruling on competency or treatment and his necessary mileage.

B. Any physician, psychologist ~~or other mental health professional~~ clinical social worker, professional counselor, psychiatric nurse practitioner, or clinical nurse specialist, or any interpreter, appointed pursuant to § [37.2-802](#) for persons who are deaf, who is not regularly employed by the Commonwealth and is required to serve as a witness or as an interpreter in any proceeding under this chapter shall receive a fee of \$75 ~~125~~ and his necessary expenses for each commitment hearing for involuntary admission and each certification hearing in which he serves and \$43.25 and necessary expenses for each certification hearing in which he serves. Any interpreter, appointed pursuant to § [37.2-802](#) for persons who are deaf, who is not regularly employed by the Commonwealth and is required to serve as an interpreter in any proceeding under this chapter shall receive a fee of \$75 and his necessary expenses for each commitment hearing for involuntary admission in which he serves and \$ 43.25 and necessary expenses for each certification hearing in which he serves.

C. Other witnesses regularly summoned before a judge or special justice under the provisions of this chapter shall receive the compensation for their attendance and mileage that is allowed witnesses summoned to testify before grand juries.

D. Every attorney appointed under § [37.2-806](#) or §§ [37.2-809](#) through [37.2-820](#) shall receive a fee of \$75 and his necessary expenses for each hearing thereunder and \$43.25 and his necessary expenses for each certification hearing and each proceeding under Chapter 11 (§ [37.2-1100](#) et seq.).

E. Except as hereinafter provided, all expenses incurred, including the fees, attendance, and mileage aforesaid, shall be paid by the Commonwealth. When any such fees, costs, and expenses, incurred in connection with an examination or hearing for an admission pursuant to § [37.2-806](#) or §§ [37.2-809](#) through [37.2-820](#), to carry out the provisions of this chapter or in connection with a proceeding under Chapter 11 (§ [37.2-1100](#) et seq.), are paid by the Commonwealth, they shall be recoverable by the Commonwealth from the person who is the subject of the examination, hearing, or proceeding or from his estate. Collection or recovery may be undertaken by the Department. When the fees,

costs, and expenses are collected or recovered by the Department, they shall be refunded to the Commonwealth. No fees or costs shall be recovered, however, from the person who is the subject of the examination or hearing or his estate when no good cause for his admission exists or when the recovery would create an undue financial hardship.

§ 37.2-815. Commitment hearing for involuntary admission; examination required.

A. Notwithstanding § [37.2-814](#), the district court judge or special justice shall require an examination of the person who is the subject of the hearing by a psychiatrist or a psychologist who is licensed in Virginia by the Board of Medicine or the Board of Psychology and is qualified in the diagnosis of mental illness or, if such a psychiatrist or psychologist is not available, a mental health professional who (i) is licensed in Virginia through the Department of Health Professions as a clinical social worker, professional counselor, psychiatric nurse practitioner, or clinical nurse specialist, ~~and~~ (ii) is qualified in the assessment of mental illness, ~~and (iii)~~. ~~The examiner appointed shall have~~ has completed a certification program approved by the Department. Any psychiatrist or psychologist serving as an examiner as of the effective date of this legislation shall have six months to complete the certification program. The examiner chosen shall be able to provide an independent clinical evaluation of the person and recommendations for his placement, care, and treatment. The examiner shall (a) not be related by blood or marriage to the person, (b) not be responsible for treating the person, (c) have no financial interest in the admission or treatment of the person, (d) have no investment interest in the facility detaining or admitting the person under this chapter, and (e) except for employees of state hospitals, the U.S. Department of Veterans Affairs, and community service boards, not be employed by the facility. For purposes of this section, the term "investment interest" shall be as defined in § [37.2-809](#).

B. The examination conducted pursuant to this section shall be a comprehensive evaluation of the person conducted in-person or, if that is not practicable, by two-way electronic video and audio communication system as authorized in § [37.2-804.1](#). Translation or interpreter services shall be provided during the evaluation where necessary. The examination shall consist of (i) a clinical assessment that includes a mental status examination; determination of current use of psychotropic and other medications; a medical and psychiatric history; a substance use, abuse, or dependency determination; and a determination of the likelihood that, as a result of mental illness, the person will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (ii) a substance abuse screening, when indicated; (iii) a risk assessment that includes an evaluation of the likelihood that, as a result of mental illness, the person will, in the near future, cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any; (iv) an assessment of the person's capacity to consent to treatment, including his ability to maintain and communicate choice, understand relevant information, and comprehend the situation and its consequences; (v) a review of the temporary detention facility's records for the person, including the treating physician's evaluation, any collateral information, reports of any laboratory or toxicology tests conducted, and all admission forms and nurses' notes; (vi) a

discussion of treatment preferences expressed by the person or contained in a document provided by the person in support of recovery; (vii) an assessment of alternatives to involuntary inpatient treatment; and (viii) recommendations for the placement, care, and treatment of the person.

C. All such examinations shall be conducted in private. The judge or special justice shall summons the examiner who shall certify that he has personally examined the person and state whether he has probable cause to believe that the person (i) has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, and (ii) requires involuntary inpatient treatment. The judge or special justice shall not render any decision on the petition until the examiner has presented his report. The examiner may report orally at the hearing, but he shall provide a written report of his examination prior to the hearing. The examiner's written certification may be accepted into evidence unless objected to by the person or his attorney, in which case the examiner shall attend in person or by electronic communication.

## APPENDIX B

### MOT Following Involuntary Inpatient Admission

§ 37.2-817. Involuntary admission and mandatory outpatient treatment orders.

A. The district court judge or special justice shall render a decision on the petition for involuntary admission after the appointed examiner has presented the report required by § [37.2-815](#), and after the community services board that serves the county or city where the person resides or, if impractical, where the person is located has presented a preadmission screening report with recommendations for that person's placement, care, and treatment pursuant to § [37.2-816](#). These reports, if not contested, may constitute sufficient evidence upon which the district court judge or special justice may base his decision. The examiner, if not physically present at the hearing, and the treating physician at the facility of temporary detention shall be available whenever possible for questioning during the hearing through a two-way electronic video and audio or telephonic communication system as authorized in § [37.2-804.1](#).

B. An employee or a designee of the local community services board, as defined in § [37.2-809](#), that prepared the preadmission screening report shall attend the hearing in person or, if physical attendance is not practicable, shall participate in the hearing through a two-way electronic video and audio or telephonic communication system as authorized in § [37.2-804.1](#). Where a hearing is held outside of the service area of the community services board that prepared the preadmission screening report, and it is not practicable for a representative of the board to attend or participate in the hearing, arrangements shall be made by the board for an employee or designee of the board serving the area in which the hearing is held to attend or participate on behalf of the board that prepared the preadmission screening report. The community services board that prepared the preadmission screening report shall remain responsible for the person subject to the hearing and, prior to the hearing, shall send the preadmission screening report through certified mail, personal delivery, facsimile with return receipt acknowledged, or other electronic means to the community services board attending the hearing. Where a community services board attends the hearing on behalf of the community services board that prepared the preadmission screening report, the attending community services board shall inform the community services board that prepared the preadmission screening report of the disposition of the matter upon the conclusion of the hearing. In addition, the attending community services board shall transmit the disposition through certified mail, personal delivery, facsimile with return receipt acknowledged, or other electronic means.

At least 12 hours prior to the hearing, the court shall provide to the community services board that prepared the preadmission screening report the time and location of the hearing. If the representative of the community services board will be present by telephonic means, the court shall provide the telephone number to the board.

C. After observing the person and considering (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person, (iii) any past mental health treatment of the person, (iv) any examiner's certification, (v) any health records available, (vi) the preadmission screening report, and (vii) any other relevant evidence that may have been admitted, if the judge or special justice finds by clear and convincing evidence that (a) the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, and (b) all available less restrictive treatment alternatives to involuntary inpatient treatment, pursuant to subsection D, that would offer an opportunity for the improvement of the person's condition have been investigated and determined to be inappropriate, the judge or special justice shall by written order and specific findings so certify and order that the person be admitted involuntarily to a facility for a period of treatment not to exceed 30 days from the date of the court order. Such involuntary admission shall be to a facility designated by the community services board that serves the city or county in which the person was examined as provided in § [37.2-816](#). If the community services board does not designate a facility at the commitment hearing, the person shall be involuntarily admitted to a facility designated by the Commissioner. Upon the expiration of an order for involuntary admission, the person shall be released unless he is involuntarily admitted by further petition and order of a court, which shall be for a period not to exceed 180 days from the date of the subsequent court order, or such person makes application for treatment on a voluntary basis as provided for in § [37.2-805](#) or is ordered to mandatory outpatient treatment pursuant to subsection D.

D. After observing the person and considering (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person, (iii) any past mental health treatment of the person, (iv) any examiner's certification, (v) any health records available, (vi) the preadmission screening report, and (vii) any other relevant evidence that may have been admitted, if the judge or special justice finds by clear and convincing evidence that (a) the person has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (b) less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and are determined to be appropriate; and (c) the person (A) has sufficient capacity to understand the stipulations of his treatment, (B) has expressed an interest in living in the community and has agreed to abide by his treatment plan, and (C) is deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services; and (d) the ordered treatment can be delivered on an outpatient basis by the community services board or designated provider, the judge or special justice shall by

written order and specific findings so certify and order that the person be admitted involuntarily to mandatory outpatient treatment. Less restrictive alternatives shall not be determined to be appropriate unless the services are actually available in the community and providers of the services have actually agreed to deliver the services.

E. Mandatory outpatient treatment may include day treatment in a hospital, night treatment in a hospital, outpatient involuntary treatment with anti-psychotic medication pursuant to Chapter 11 (§ [37.2-1100](#) et seq.), or other appropriate course of treatment as may be necessary to meet the needs of the person. The community services board that serves the city or county in which the person resides shall recommend a specific course of treatment and programs for the provision of mandatory outpatient treatment. The duration of mandatory outpatient treatment shall be determined by the court based on recommendations of the community services board, but shall not exceed 90 days. Upon expiration of an order for mandatory outpatient treatment, the person shall be released from the requirements of the order unless the order is continued in accordance with § [37.2-817.4](#).

F. Any order for mandatory outpatient treatment shall include an initial mandatory outpatient treatment plan developed by the community services board that completed the preadmission screening report. The plan shall, at a minimum, (i) identify the specific services to be provided, (ii) identify the provider who has agreed to provide each service, (iii) describe the arrangements made for the initial in-person appointment or contact with each service provider, and (iv) include any other relevant information that may be available regarding the mandatory outpatient treatment ordered. The order shall require the community services board to monitor the implementation of the mandatory outpatient treatment plan and report any material noncompliance to the court.

G. No later than five days, excluding Saturdays, Sundays, or legal holidays, after an order for mandatory outpatient treatment has been entered pursuant to this section, the community services board where the person resides that is responsible for monitoring compliance with the order shall file a comprehensive mandatory outpatient treatment plan. The comprehensive mandatory outpatient treatment plan shall (i) identify the specific type, amount, duration, and frequency of each service to be provided to the person, (ii) identify the provider that has agreed to provide each service included in the plan, (iii) certify that the services are the most appropriate and least restrictive treatment available for the person, (iv) certify that each provider has complied and continues to comply with applicable provisions of the Department's licensing regulations, (v) be developed with the fullest possible involvement and participation of the person and reflect his preferences to the greatest extent possible to support his recovery and self-determination, (vi) specify the particular conditions with which the person shall be required to comply, and (vii) describe how the community services board shall monitor the person's compliance with the plan and report any material noncompliance with the plan. The community services board shall submit the comprehensive mandatory outpatient treatment plan to the court for approval. Upon approval by the court, the comprehensive mandatory outpatient treatment plan shall be filed with the court and incorporated into the order of mandatory outpatient treatment. Any subsequent



substantive modifications to the plan shall be filed with the court for review and attached to any order for mandatory outpatient treatment.

H. If the community services board responsible for developing the comprehensive mandatory outpatient treatment plan determines that the services necessary for the treatment of the person's mental illness are not available or cannot be provided to the person in accordance with the order for mandatory outpatient treatment, it shall notify the court within five business days of the entry of the order for mandatory outpatient treatment. Within two business days of receiving such notice, the judge or special justice, after notice to the person, the person's attorney, and the community services board responsible for developing the comprehensive mandatory outpatient treatment plan shall hold a hearing pursuant to § [37.2-817.2](#).

I. Prior to the expiration of an order for involuntary admission, the court that entered the involuntary admission order or the court where the person resides may enter an order of mandatory outpatient treatment for a period not to exceed 90 days under the following conditions:

1. Upon the petition of the director of the treating facility or his designee, the community services board or the person, the court may enter an order of mandatory outpatient treatment if it finds by clear and convincing evidence, based on the person's current condition and treatment history, including the person's past compliance with treatment, that the person (i) has mental illness; (ii) no longer needs inpatient hospitalization but requires mandatory outpatient treatment to prevent rapid deterioration of the person's condition that would likely result in the person meeting the inpatient criteria in subsection C; (iii) is not likely to obtain outpatient treatment unless the court enters a mandatory outpatient treatment order; (iv) is likely to comply with a mandatory outpatient treatment order, and (v) services are actually available in the community and providers of services have actually agreed to deliver the services. The community services board where the person resides shall develop a comprehensive mandatory outpatient treatment plan in accordance with subsection G that shall be filed with the petition. The comprehensive mandatory outpatient treatment plan shall be approved by the court and incorporated into the order. Any subsequent substantive modifications to the plan shall be filed with the court for review and attached to any order for mandatory outpatient treatment. The community services board where the person resides shall monitor the person's compliance with the plan in accordance with the provisions of § [37.2-817.1](#).

2. If the person who is the subject of the petition, the director of the treating facility or his designee and the monitoring community services board join in the petition, the court shall grant the petition and enter an order of mandatory outpatient treatment following inpatient admission.

3. If the person who is the subject of the petition, the director of the treating facility or his designee, or the monitoring community services board does not join in the

petition, the hearing shall be conducted in accordance with subsections A and B of § 37.2-817.2.

I.J. Upon entry of any order for mandatory outpatient treatment, the clerk of the court shall provide a copy of the order to the person who is the subject of the order, to his attorney, and to the community services board required to monitor compliance with the plan. The community services board shall acknowledge receipt of the order to the clerk of the court on a form established by the Office of the Executive Secretary of the Supreme Court and provided by the court for this purpose.

J.K. The court may transfer jurisdiction of the case to the district court where the person resides at any time after the entry of the mandatory outpatient treatment order. The community services board responsible for monitoring compliance with the mandatory outpatient treatment plan shall remain responsible for monitoring the person's compliance with the plan until the community services board serving the locality to which jurisdiction of the case has been transferred acknowledges the transfer and receipt of the order to the clerk of the court on a form established by the Office of the Executive Secretary of the Supreme Court and provided by the court for this purpose.

K.L. Any order entered pursuant to this section shall provide for the disclosure of medical records pursuant to § [37.2-804.2](#). This subsection shall not preclude any other disclosures as required or permitted by law.

§ 37.2-817.1. Monitoring mandatory outpatient treatment; petition for hearing.

A. The community services board where the person resides shall monitor the person's compliance with the mandatory outpatient treatment plan ordered by the court pursuant to § [37.2-817](#). Monitoring compliance shall include (i) contacting the service providers to determine if the person is complying with the mandatory outpatient treatment order and (ii) notifying the court of the person's material noncompliance with the mandatory outpatient treatment order. Providers of services identified in the plan shall report any material noncompliance to the community services board.

B. If the community services board determines that the person materially failed to comply with the order, it shall petition the court for a review of the mandatory outpatient treatment order as provided in § [37.2-817.2](#). The community services board shall petition the court for a review of the mandatory outpatient treatment order within three days of making that determination, or within 24 hours if the person is being detained under a temporary detention order, and shall recommend an appropriate disposition. Copies of the petition shall be sent to the person and the person's attorney.

C. If the community services board determines that the person is not materially complying with the mandatory outpatient treatment order or for any other reason, and there is a substantial likelihood that, as a result of the person's mental illness that the person will, in the near future, (i) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting or threatening harm and other relevant

information, if any, or (ii) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, it shall immediately request that the magistrate issue an emergency custody order pursuant to § [37.2-808](#) or a temporary detention order pursuant to § [37.2-809](#).

§ 37.2-817.2. Court review of mandatory outpatient treatment plan.

A. The district court judge or special justice shall hold a hearing within five days after receiving the petition for review of the mandatory outpatient treatment plan; however if the fifth day is a Saturday, Sunday, or legal holiday, the hearing shall be held by the close of business on the next day that is not a Saturday, Sunday, or legal holiday. If the person is being detained under a temporary detention order, the hearing shall be scheduled within the same time frame provided for a commitment hearing under § [37.2-814](#). The clerk shall provide notice of the hearing to the person, the community services board, all treatment providers listed in the comprehensive mandatory outpatient treatment order, and the original petitioner for the person's involuntary treatment. If the person is not represented by counsel, the court shall appoint an attorney to represent the person in this hearing and any subsequent hearings under §§ [37.2-817.3](#) and [37.2-817.4](#), giving consideration to appointing the attorney who represented the person at the proceeding that resulted in the issuance of the mandatory outpatient treatment order. The same judge or special justice that presided over the hearing resulting in the mandatory outpatient treatment order need not preside at the noncompliance hearing or any subsequent hearings. The community services board shall offer to arrange the person's transportation to the hearing if the person is not detained and has no other source of transportation.

B. If requested by the person, the community services board, a treatment provider listed in the comprehensive mandatory outpatient treatment plan, or the original petitioner for the person's involuntary treatment, the court shall appoint an examiner in accordance with § [37.2-815](#) who shall personally examine the person and certify to the court whether or not he has probable cause to believe that the person meets the criteria for involuntary inpatient admission or mandatory outpatient treatment as specified in subsections C and D of § [37.2-817](#), or if the petition for review involves an order of mandatory outpatient treatment following inpatient admission, whether or not he has probable cause to believe that the person meets the criteria specified in subsection I of § 37.2-817. The examination shall include all applicable requirements of § [37.2-815](#). The certification of the examiner may be admitted into evidence without the appearance of the examiner at the hearing if not objected to by the person or his attorney. If the person is not detained in an inpatient facility, the community services board shall arrange for the person to be examined at a convenient location and time. The community services board shall offer to arrange for the person's transportation to the examination, if the person has no other source of transportation and resides within the service area or an adjacent service area of the community services board. If the person refuses or fails to appear, the community services board shall notify the court, or a magistrate if the court is not available, and the court or magistrate shall issue a mandatory examination order and *capias* directing the primary law-enforcement agency in the jurisdiction where the person resides to transport the person to the examination. The person shall remain in custody until a temporary

detention order is issued or until the person is released, but in no event shall the period exceed four hours.

C. If the person fails to appear for the hearing the court shall, after consideration of any evidence from the person, from the community services board, or from any treatment provider identified in the mandatory outpatient treatment plan regarding why the person failed to appear at the hearing, either (i) reschedule the hearing pursuant to subsection A, (ii) issue an emergency custody order pursuant to § [37.2-808](#) or (iii) issue a temporary detention order pursuant to § [37.2-809](#).

D. After hearing the evidence regarding the person's material noncompliance with the mandatory outpatient treatment order and the person's current condition, and any other relevant information referenced in subsection C of § [37.2-817](#), the judge or special justice shall make one of the following dispositions:

1. Upon finding by clear and convincing evidence that the person meets the criteria for involuntary admission and treatment specified in subsection C of § [37.2-817](#), the judge or special justice shall order the person's involuntary admission to a facility designated by the community services board for a period of treatment not to exceed 30 days;

2. Upon finding that the person continues to meet the criteria for mandatory outpatient treatment specified in subsection D or I of § [37.2-817](#), and that a continued period of mandatory outpatient treatment appears warranted, the judge or special justice shall renew the order for mandatory outpatient treatment, making any necessary modifications that are acceptable to the community services board or treatment provider responsible for the person's treatment. In determining the appropriateness of outpatient treatment, the court may consider the person's material noncompliance with the previous mandatory treatment order; ~~or~~

3. Upon finding that neither of the above dispositions is appropriate, the judge or special justice shall rescind the order for mandatory outpatient treatment.

Upon entry of an order for involuntary inpatient admission, transportation shall be provided in accordance with § [37.2-829](#) or [37.2-830](#).

### § 37.2-817.3. Rescission of mandatory outpatient treatment order.

A. If the community services board determines at any time prior to the expiration of the mandatory outpatient treatment order that the person has complied with the order and no longer meets the criteria for involuntary treatment, or that continued mandatory outpatient treatment is no longer necessary for any other reason, it shall file a petition to rescind the order with the court that entered the order or to which venue has been transferred. If the court agrees with the community services board's determination, the court shall rescind the order. Otherwise, the court shall schedule a hearing and provide notice of the hearing in accordance with subsection A of § [37.2-817.2](#).

B. At any time after 30 days from entry of the mandatory outpatient treatment order, the person may petition the court to rescind the order on the grounds that he no longer meets the criteria for mandatory outpatient treatment as specified in subsection D or I of § [37.2-817](#). The court shall schedule a hearing and provide notice of the hearing in accordance with subsection A of § [37.2-817.2](#). The community services board required to monitor the person's compliance with the mandatory outpatient treatment order shall provide a preadmission screening report as required in § [37.2-816](#). After observing the person, and considering the person's current condition, any material noncompliance with the mandatory outpatient treatment order on the part of the person, and any other relevant evidence referred to in subsection C of § [37.2-817](#), shall make one of the dispositions specified in subsection D of § [37.2-817.2](#). The person may not file a petition to rescind the order more than once during a 90-day period.

§ 37.2-817.4. Continuation of mandatory outpatient treatment order.

A. At any time within 30 days prior to the expiration of a mandatory outpatient treatment order, the community services board that is required to monitor the person's compliance with the order, the treating physician, or other responsible person may petition the court to continue the order for a period not to exceed 180 days.

B. If the person who is the subject of the order and the monitoring community services board, if it did not initiate the petition, join the petition, the court shall grant the petition and enter an appropriate order without further hearing. If either the person or the monitoring community services board does not join the petition, the court shall schedule a hearing and provide notice of the hearing in accordance with subsection A of § [37.2-817.2](#).

C. Upon receipt of the petition, the court shall appoint an examiner who shall personally examine the person pursuant to subsection B of § [37.2-815](#). The community services board required to monitor the person's compliance with the mandatory outpatient treatment order shall provide a preadmission screening report as required in § [37.2-816](#).

D. If, after observing the person, reviewing the preadmission screening report and considering the appointed examiner's certification and any other relevant evidence, including any relevant evidence referenced in subsection D of § [37.2-817](#), the court shall make one of the dispositions specified in subsection D of § [37.2-817.2](#). If the court finds that a continued period of mandatory outpatient treatment is warranted, it may continue the order for a period not to exceed 180 days. Any order of mandatory outpatient treatment that is in effect at the time a petition for continuation of the order is filed shall remain in effect until the disposition of the hearing.

## APPENDIX C

### Default Judgments

11-5-2008 draft

(Awaiting comments from constituent organizations)

§ 8.01-428. Setting aside default judgments; clerical mistakes; independent actions to relieve party from judgment or proceedings; grounds and time limitations.

A. Default judgments and decrees pro confesso; summary procedure. - Upon motion of the plaintiff or judgment debtor and after reasonable notice to the opposite party, his attorney of record or other agent, the court may set aside a judgment by default or a decree pro confesso upon the following grounds: (i) fraud on the court, (ii) a void judgment, (iii) on proof of an accord and satisfaction, ~~or~~(iv) on proof that the defendant was, at the time of service of process or entry of judgment, a person in the military service of the United States for purposes of 50 U.S.C. app. § 502, or (v) on proof that the defendant was detained or involuntarily admitted to a facility pursuant to §§ 37.2-809 or 37.2-817 at the time of service of process or entry of judgment. Such motion on the ground of fraud on the court shall be made within two years from the date of the judgment or decree.

B. Clerical mistakes. - Clerical mistakes in all judgments or other parts of the record and errors therein arising from oversight or from an inadvertent omission may be corrected by the court at any time on its own initiative or upon the motion of any party and after such notice, as the court may order. During the pendency of an appeal, such mistakes may be corrected before the appeal is docketed in the appellate court, and thereafter while the appeal is pending such mistakes may be corrected with leave of the appellate court.

C. Failure to notify party or counsel of final order. - If counsel, or a party not represented by counsel, who is not in default in a circuit court is not notified by any means of the entry of a final order and the circuit court is satisfied that such lack of notice (i) did not result from a failure to exercise due diligence on the part of that party and (ii) denied that party an opportunity to pursue post-trial relief in the circuit court or to file an appeal therefrom, the circuit court may, within 60 days of the entry of such order, modify, vacate, or suspend the order or grant the party leave to appeal. Where the circuit court grants the party leave to appeal, the computation of time for noting and perfecting an appeal shall run from the entry of such order, and such order shall have no other effect.

D. Other judgments or proceedings. - This section does not limit the power of the court to entertain at any time an independent action to relieve a party from any judgment or proceeding, or to grant relief to a defendant not served with process as provided in § [8.01-322](#), or to set aside a judgment or decree for fraud upon the court.

E. Nothing in this section shall constitute grounds to set aside an otherwise valid default judgment against a defendant who was not, at the time of service of process or entry of judgment, a servicemember for purposes of 50 U.S.C. app. § 502.

## APPENDIX D

### Rights of Persons to Notify Family Member or Friend

§ 37.2-400. Rights of consumers.

A. Each person who is a consumer in a hospital, training center, other facility, or program operated, funded, or licensed by the Department, excluding those operated by the Department of Corrections, shall be assured his legal rights and care consistent with basic human dignity insofar as it is within the reasonable capabilities and limitations of the Department, funded program, or licensee and is consistent with sound therapeutic treatment. Each person admitted to a hospital, training center, other facility, or program operated, funded, or licensed by the Department shall:

1. Retain his legal rights as provided by state and federal law;
2. Receive prompt evaluation and treatment or training about which he is informed insofar as he is capable of understanding;
3. Be treated with dignity as a human being and be free from abuse or neglect;
4. Not be the subject of experimental or investigational research without his prior written and informed consent or that of his legally authorized representative;
5. Be afforded an opportunity to have access to consultation with a private physician at his own expense and, in the case of hazardous treatment or irreversible surgical procedures, have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his health;
6. Be treated under the least restrictive conditions consistent with his condition and not be subjected to unnecessary physical restraint and isolation;
7. Be allowed to send and receive sealed letter mail;
8. Have access to his medical and clinical treatment, training, or habilitation records and be assured of their confidentiality but, notwithstanding other provisions of law, this right shall be limited to access consistent with his condition and sound therapeutic treatment;
9. Have the right to an impartial review of violations of the rights assured under this section and the right of access to legal counsel; ~~and~~
10. Be afforded appropriate opportunities, consistent with the person's capabilities and capacity, to participate in the development and implementation of his individualized services plan; and

11. Be afforded the opportunity to have an individual of his choice notified of his general condition and location and his transfer to another facility.

The Board shall adopt regulations to implement the provisions of this subsection after due notice and public hearing, as provided for in the Administrative Process Act (§ [2.2-4000](#) et seq.).

B. The Board shall adopt regulations delineating the rights of consumers with respect to nutritionally adequate diet; safe and sanitary housing; participation in nontherapeutic labor; attendance or nonattendance at religious services; participation in treatment decision-making, including due process procedures to be followed when a consumer may be unable to make an informed decision; notification to others of the consumer's choice of his general condition and location and his transfer to another facility; use of telephones; suitable clothing; possession of money and valuables; and related matters.

C. The human rights regulations shall be applicable to all hospitals, training centers, other facilities, and programs operated, funded, or licensed by the Department; these hospitals, training centers, other facilities, or programs may be classified as to consumer population, size, type of services, or other reasonable classification.

D. The Board shall adopt regulations requiring public and private facilities and programs licensed or funded by the Department to provide nonprivileged information and statistical data to the Department related to (i) the results of investigations of abuse or neglect, (ii) deaths and serious injuries, (iii) instances of seclusion and restraint, including the duration, type, and rationale for use per consumer, and (iv) findings by state or local human rights committees or the Office of Human Rights in the Department of human rights violations, abuse, or neglect. The Board's regulations shall address the procedures for collecting, compiling, encrypting, and releasing the data. This information and statistical data shall be made available to the public in a format from which all provider and consumer-identifying information has been removed. The Board's regulations shall specifically exclude all proceedings, minutes, records, and reports of any committee or nonprofit entity providing a centralized credentialing service that are identified as privileged pursuant to § [8.01-581.17](#).



## APPENDIX E

### Admission of Incapacitated Persons

§ 37.2-801. Admission procedures; forms.

~~A. Any person alleged to have a mental illness to a degree that warrants treatment in a facility may be admitted to a facility by compliance with one of the following admission procedures:~~

~~1. Voluntary admission by the procedure described in § 37.2-805, or~~

~~2. Involuntary admission by the procedure described in §§ 37.2-809 through 37.2-820.~~

~~B. The Board shall prescribe and the Department shall prepare the forms required in procedures for admission. These forms, which shall be the legal forms used in admissions, shall be approved by the Attorney General and distributed by the Department to the clerks of the general district courts and juvenile and domestic relations district courts of the Commonwealth and to the directors of the state facilities.~~

#### § 37.2-805.1 Voluntary Admission of Incapacitated Persons Pursuant to Advance Directives or by Guardians

A. When a person has executed an advance directive in accordance with the Health Care Decisions Act (§54.1-2981 et seq) authorizing that person's agent to consent to his admission to a facility, and such person is later determined to be incapable of making an informed decision, the agent may consent to the person's admission to a facility for no more than ten calendar days if (i) prior to admission, a physician on the staff of or designated by the proposed admitting facility examines the person and states, in writing, that the person (a) has a mental illness, (b) is incapable of making an informed decision regarding admission, and (c) is in need of treatment in a facility; and (ii) the proposed admitting facility is willing to admit the person. For admission to a state facility, the person shall first be screened by the community services board that serves the city or county where the person resides or, if impractical, where the person is located in accordance with § 37.2-805.

B. When a guardian has been appointed for an incapacitated person under Chapter 10 of this Title and the guardianship order specifically authorizes the guardian to consent to the admission of such person to a facility, as provided in § 37.2-1009, the guardian may consent to admission of that person to a facility for no more than ten calendar days if (i) prior to admission, a physician on the staff of or designated by the proposed admitting facility examines the person and states, in writing, that the person

(a) has a mental illness, (b) is incapable of making an informed decision regarding admission, and (c) is in need of treatment in a facility; and (ii) the proposed admitting facility is willing to admit the person. For admission to a state facility, the person shall first be screened by the community services board that serves the city or county where the person resides or, if impractical, where the person is located in accordance with § 37.2-805.

- C. A person admitted to a facility under this section must be discharged no later than ten calendar days after admission unless, within that time, the person's continued admission is authorized under other legal authority.

§ 37.2-1009. Court order of appointment; limited guardianships and conservatorships.

The court's order appointing a guardian or conservator shall: (i) state the nature and extent of the person's incapacity; (ii) define the powers and duties of the guardian or conservator so as to permit the incapacitated person to care for himself and manage property to the extent he is capable; (iii) specify whether the appointment of a guardian or conservator is limited to a specified length of time, as the court in its discretion may determine; (iv) specify the legal disabilities, if any, of the person in connection with the finding of incapacity, including but not limited to mental competency for purposes of Article II, Section 1 of the Constitution of Virginia or Title 24.2; (v) include any limitations deemed appropriate following consideration of the factors specified in § [37.2-1007](#); and (vi) set the bond of the guardian and the bond and surety, if any, of the conservator.

The court may appoint a limited guardian for an incapacitated person who is capable of addressing some of the essential requirements for his care for the limited purpose of medical decision making, decisions about place of residency, or other specific decisions regarding his personal affairs.

Unless the guardian has a professional relationship with an incapacitated person or is employed by or affiliated with a facility where the person resides, the court's order may authorize the guardian to consent to the admission of the person to a facility subject to the conditions set out in § 37.2-805.1, upon finding by clear and convincing evidence that (i) the person has dementia or another severe and persistent mental disorder that significantly impairs the person's capacity to exercise judgment or self control, as confirmed by the evaluation of a licensed psychiatrist; (ii) such condition is unlikely to improve in the foreseeable future; and (iii) the guardian has formulated a plan for providing ongoing treatment of the person's illness in the least restrictive setting suitable for the person's condition. A guardian shall not have the authority to consent to the person's admission to such a facility in the absence of specific authorization by court order under this section.

A guardian need not be appointed for a person who has appointed an agent under an advance directive executed in accordance with the provisions of Article 8 (§ [54.1-2981](#) et seq.) of Chapter 29 of Title 54.1, unless the court determines that the agent is not acting

in accordance with the wishes of the principal or there is a need for decision making outside the purview of the advance directive.

The court may appoint a limited conservator for an incapacitated person who is capable of managing some of his property and financial affairs for limited purposes specified in the order.

A conservator need not be appointed for a person (i) who has appointed an agent under a durable power of attorney, unless the court determines pursuant to § [37.2-1018](#) that the agent is not acting in the best interests of the principal or there is a need for decision making outside the purview of the durable power of attorney or (ii) whose only or major source of income is from the Social Security Administration or other government program and who has a representative payee.

## APPENDIX F

### RECOMMENDATIONS

**Recommendation 1.** All independent examiners, including psychiatrists and psychologists, should be required to complete a certification program developed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, and that Continuing Education Units be made available for the training.

**Recommendation 2.** The General Assembly should increase the \$ 75 fee for conducting examinations in civil commitment proceedings as soon as funding is available to do so.

**Recommendation 3.** The Commission should continue to study the potential benefits and costs of increasing mandated core services through the Task Force on Access to Services.

**Recommendation 4.** Unsupervised law students should not be permitted to represent petitioners in commitment proceedings. Instead law students should be encouraged to provide this service with attorney supervision in areas where law schools are located. In addition, the Virginia State Bar should encourage *pro bono* representation of petitioners by members of the Bar.

**Recommendation 5.** The General Assembly should not enact legislation in 2009 authorizing mandatory outpatient treatment following involuntary inpatient admission. Expanding the circumstances for MOT should not be undertaken until research documenting the efficacy of MOT is available and Virginia's economic picture changes such that an expansion of outpatient mental health services is funded.

**Recommendation 6.** The General Assembly should not enact further reforms to MOT for the purpose of preventing involuntary inpatient admission until further research demonstrates its effectiveness and until a fuller array of outpatient services become more widely available.

**Recommendation 7.** Given current economic conditions, the continued shortage of psychiatric hospital beds in certain localities, and the difficulty predicting the fiscal impact of extending the TDO period to 4 or 5 days, the Commission should continue to study the issue. The Commission should also consider, as an interim measure, prohibiting commitment hearings from being held within 24 hours of a person's admission to an emergency facility and extending the TDO period to 72 hours.

**Recommendation 8.** The General Assembly should enact legislation that would permit a court to set aside a default judgment against a person who was the subject

**of a temporary detention order or an order of involuntary hospitalization at the time of service or entry of the default judgment.**

**Recommendation 9. The General Assembly should enact legislation that would afford an individual the opportunity to have an individual of their choice notified of their general condition, location and transfer to another facility.**

**Recommendation 10. The Commission's Task Force on Access to Services should continue to study methods of making safe, affordable, non-congregate housing available to persons with mental illness.**

**Recommendation 11. The General Assembly should enact legislation permitting individuals who have been determined to be incapacitated to be admitted to a mental health facility for up to ten days if they have authorized an agent designated to do so in an advance directive to consent to the admission, or if a circuit court has authorized a guardian to do so under certain limited circumstances. The legislation should provide that the proposed admitting facility must be willing to admit the person, and for admissions to state facilities, the CSB must conduct a pre-admission screening.**