

Comments on History of Civil Commitment in Virginia
Richard J. Bonnie
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Civil Commitment Reform in the United States (1965-2015): Overview

1. Models and Approaches

- “Medical certification” and “judicial certification” models; easily recognized in “pure” type although differences have become blurred in many states
- The procedural models used to be linked to different substantive models (paternalistic v libertarian), but this is less true now.

2. Focus of attention in civil commitment law has shifted over the last few decades from safeguards against unwarranted long-term hospitalization (which produced the due process revolution in mental health law in 1970s) to procedures governing short-term emergency hospitalization (and mandated outpatient treatment).

3. Law “in the books” vs law “in practice”

- One can’t predict outcomes (e.g., rates of commitment or LOS) simply by comparing state statutes. Actual practices are determined mainly by resources, geography and other practical considerations.
- Commitment tends to be a highly localized process with significant practice variations

4. Overlapping and intersecting policy conversations, involving both system and services reforms and design and operation of commitment process. For example, libertarian changes in commitment laws in 1970s and 1980s were clearly instruments of deinstitutionalization; today changes to the commitment law are typically related to the shortage of acute care hospital beds or intensive alternatives to hospitalization. Quite often, when dissatisfaction is expressed about the operation of the commitment process, the real problem is a gap in availability and financing of services.

Evolution of Virginia Commitment Law (with a particular focus on the ECO/TDO process)

Pre 1974 – involuntary admission by medical certification (of need for hospitalization) with “endorsement” by a judge (SJ) that individual has been informed of right to a hearing and counsel [or, in absence of medical certification, judge can authorize person to be taken into custody and admitted]. Person has to be examined within 24 hours and then medical director decides whether to retain or not. If director retains, and the person requests a hearing, it must be held within 60 days; otherwise the person can remain up to 6 months, when judicial review is mandatory.

1974 – conversion to a fairly tight judicial, “due process” model. Basic model and criteria remain today: petition, custody, TDO and hospitalization (48 hours), appointment of counsel, opportunity for voluntary admission, formal hearing, mandated expert (physician) certification, libertarian criteria (dangerousness and grave disability, least restrictive alternative), admission up to 180 days.

1980 – CSB prescreening required -- implements both system reform and civil commitment reform [focus was on the hearing disposition, not on TDO beds at this point]

Statute has been amended and modified almost every session and many issues have been addressed, but I will focus on the pre-hearing process of clinical screening and evaluation.

Current structure took shape in 1988-95 after a failed reform effort in 1982-84

1980s – multiple criticisms emerged and we still hear echoes of all of them today:

- Inadequate and poor quality screening -- too many TDOs and too many admissions to state hospitals
- Criminalization and need for alternative forms of transportation
- Poor quality of procedural justice at hearings, with wild variation in procedures and outcomes, perhaps based subjective values of the judges (1982 ILPPP study; Stambaugh initiative)
- Concerns about narrowness of criteria and outcomes particularly objections to libertarian criteria from psychiatrists and families -- “dying with their rights on”
- Failures to create community services and supports to prevent re-hospitalization -- and new debate arose over potential value of MOT

1982-84 -- failed reform effort [focused on a blend of the 2 models – a more medical approach to emergency hospitalization, coupled with more treatment-oriented criteria, coupled with more procedural due process

**Major focus emerged in late 80s on emergency evaluation process: 1988 ILPPP/VBA report, 1989 NCSC and 1990 ES report in DMHMRSAS

**1990 amendments - ECO created and requirement of face-to-face CSB evaluation before magistrate-issued TDO except in a few situations

12/1994 – Highly influential JLARC study

**1995 amendments –

- narrow criteria for TDO
- Allow facilities to release if clinically appropriate before hearing
- Require CSBs to determine place of TDO hospitalization

- Eliminate TDOs issued by SJs, thereby requiring CSB evaluation before TDOs are issued in all cases
- Assure independence of expert examiner

Why require CSB evaluation as necessary condition in all cases?

- JLARC report mentions that SJs were issuing TDOs without clinical advice and expertise
- JLARC observed that TDOs were sought directly by psychiatrists and psychologists in some cases. Report does not explicitly mention concerns about conflicts of interest, but that issue was fully vetted when psychiatric society sought an exception for cases in which the patient was under care of a psychiatrist who recommended commitment
- There is no indication that ED physicians were involved in 1994-95.
- Records show clearly that the requirement for CSB screening in all cases was designed to avoid unnecessary TDOs and to reduce costs, thereby promoting efficiency as well as fairness

2008 - 2015: Continued Reform: Further refinements but the basic structure created in 1990/92/95 remains in place. Continued refinements to improve quality, efficiency and fairness.

- Supreme Court Commission conducted comprehensive study; see Report of TF on CC; provided foundation for action by GA
- Duration of ECO (and last resort process)
- Duration of TDO
- ATOs (Alternative Transportation Orders)
- Modify criteria (clarification and greater specificity)
- Detailed procedures for MOT – need highlighted by Cho case
- Increase quality assurance
- Bolster privacy protection, while assuring necessary access to information

Unfinished Business/Priorities in Commitment Reform and Crisis Response

- Access to safe, non-stigmatizing transportation
- Alternatives to EDs for crisis evaluations, especially custodial evaluations
- Remove impediments to voluntary admission, especially for uninsured
- Facilitating execution and activation of advance directives
- Continued improvement in data regarding emergency evaluations, ECOs, TDOs, commitment hearings to facilitate oversight, quality assurance, program evaluation and evidence-based policy-making

Concluding Observations on Commitment History

1. As indicated at outset, policy debate about civil commitment today bears little resemblance to the debates in 70s and 80s.
2. Focus has shifted to the procedure for acute admissions since long-term hospitalization is no longer the norm, average LOS is 5-7 days, and all fiscal pressures tend to discourage hospitalization.
3. Value conflicts remain but they are now at the fringes (e.g., criteria for MOT). Key issues are effectiveness (in preventing harm and distress) and fairness
4. Procedural protections (including access to counsel, independent evaluation, and judicial decision-making) are needed as safeguards against unwarranted confinement. But these protections also serve other important purposes – they protect the right to be heard, demonstrate respect for human dignity, and can have significant therapeutic benefits.
5. Main innovations in recent years are mandated outpatient treatment, ATOs, and advance directives, but the benefits of those innovations cannot be realized without service improvements