Consensus Among Stakeholders: A Call for Change in Virginia's Involuntary Civil Admission Process[1]

Final Report

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Executive Summary[2]

This report describes a public dialogue project by the Community Services Boards of Northern Virginia, The National Alliance on Mental Illness of Northern Virginia, and the Institute for Conflict Analysis and Resolution at George Mason University with the purpose of facilitating a consensus building process among major stakeholders involved in the involuntary civil admission process to improve inpatient and outpatient services for persons with mental illness.

Several initiatives to examine this process are currently underway in Virginia and elsewhere. Previous reports and insights have focused on the costs, the legal aspects, and the role of law enforcement of the involuntary commitment process, yet the perspectives of the consumers and their families were missing. Consensus building is a process that ultimately increases buy-in in terms of recommendations or decisions made between and among the various stakeholder groups. Using such a model gives voice to those excluded—in this case, the consumers and their families.

With the assistance of the Community Services Board leaders in various jurisdictions around Northern Virginia we offered six facilitated dialogues—days and evenings—to collect our data. The dialogue sessions included

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representatives of each of the stakeholder groups, and represent a first-of-a-kind model that reflects the complexities of the involuntary commitment process from various points of view. The project brought together a total of 70 people, for the first time, from the City of Alexandria, Arlington, Fairfax (including Cities of Fairfax and Falls-Church) and Prince William Counties) involved in the involuntary civil commitment process. These represented the following stakeholders:

- Consumers of Mental Health Services
- Family Members of Consumers
- Law Enforcement Representatives
- Hospital Providers of Mental Health Services (both non-profit and private)
- Representatives from the Legal System (Magistrates and Special Justices)
- Representatives from the Community Services Boards

Participants were asked to express both their needs and frustrations about the current process. In addition, stakeholders were given the opportunity to reflect upon and articulate what a more desirable process would look like that would work for them. What follows is a summary by stakeholder groups, though in some cases the same issues appear in multiple groups:

Consumers presented the following issues:

- They are fearful, lack trust and feel disrespected.
- They are treated "as criminals," and do not feel valued.
- They need accessible information about involuntary commitment.

- They realize that their cycles of mental illness are part of the problem.

- They feel they are perceived as "outcasts of society"—without voice, rights or privileges.

- Their sense of "identity" is compromised because of their illness.

- They realize, once they have experienced involuntary commitment, that the legal system—the structure that impacts their future—must be carefully navigated so that they can avoid being caught in its web of confusion, disrespect and fear.

- They know that even though they are deteriorating in terms of their own illness, if they report their decline they will end up hospitalized.

- In general they would prefer outpatient treatment that is voluntary and less traumatic.

Law enforcement and its representatives presented the following issues:

- They reported a lack of sufficient bed space for the number in need.

- They resent the amount of time required for hearings to take place and to transport consumers.

- They have a "policing" identity that involves solving crime and protecting civil society. Transporting and staying with patients (required by law) feels like a distraction from their "real work."

- With a limited number of total police available, protection of citizens is significantly neglected when too many police staff are assigned to mental health policing responsibilities.

Family members presented the following issues:

- They either did not agree with or found significant problems with interpreting the current law—especially relating to "imminent danger."

- They know the signs of deterioration but cannot intervene until there is a significant and obvious crisis.

- They are concerned that their expertise—knowledge and experience—about the mental illness of their loved ones is perceived as neither wanted nor valued in the involuntary commitment process.

- They understand they are caught in a legal system and a process with too little knowledge. They ask for legal advocates to help them navigate unchartered waters, especially their first experience with involuntary commitment.

- They believe that the combination of lack of resources, decreased funding and cut-backs in mental health positions decreases the likelihood of having available resources for their loved ones.

Community Services Boards professionals presented the following issues:

- They express discomfort with the level of coercion consumers are subjected to in the TDO process, and generally find it inappropriate when police choose to press legal charges as opposed to bring a consumer to CSB for evaluation.

- They noted multiple structural conditions that impact their work: the need to find qualified independent evaluators, the concern about lack of beds available for commitment, the decline in resources available for mental health crises, and the concern about legal representation when hearings are conducted.

- They would like all stakeholders involved to receive appropriate information, education and training about the involuntary commitment process.

Hospital Providers of Mental Health presented the following issues:

- They reported that temporary detention does not work. The use of force results in a breakdown of trust by consumers and therefore an unwillingness to accept treatment.

- They report that the patient usually has to deteriorate significantly before she or he can receive mental health treatment.

- They plead for a change in the available options for persons with mental illness: a continuum of care possibilities depending on the level of deterioration.

- They ask for funding and additional resources to address the increasing populations of consumers in Northern Virginia.

Legal representatives (Magistrates and Special Justices) presented the following issues:

- They believe that failure of the system to deal with the increasing population of consumers is a significant source of the problem.

- They report that the system needs extra funding to provide adequate resources and appropriate treatment options both for the consumers and their family members.

- They are concerned about legal representation for families of consumers.

The issues articulated in these sessions were analyzed through a process of "mapping" the situation. As a result, we identified several themes that are in need of immediate attention. Theses are:

- A need to redefine the criteria, definition and scope of the law that governs the Involuntary Civil Commitment Process.

- A need for stable (increased) funding and resources for establishing appropriate services for an increasing population of people with mental illness in Northern Virginia.

- A need for a diverse continuum of preventative and treatment options as alternatives to the civil commitment process.

- A need for comprehensive information and training for all parties involved in the process.

- A need for more legal support for family members of consumers and petitioners in the process.

There was significant consensus among all stakeholders on these issues, except for how to define appropriate criteria and scope of the law. Here, the main

disagreements centered on the issues of individual freedom versus public safety concerns.

On the basis of our data collected from the multiple stakeholders we present seven recommendations that can help develop an improved Involuntary Commitment Process in the Commonwealth of Virginia. These are as follows:

Recommendation 1*:* Establish a political dialogue among legislators to explore the criteria, definition and scope of the law that governs the involuntary admission process in order to address the concerns of the various stakeholders involved.

Recommendation 2*:* Provide a continuum of intervention strategies—available earlier in the commitment process—including a variety of outpatient treatment options as alternatives to the current practice of involuntary commitment.

Recommendation 3: Establish a system of legal support for families and petitioners to increase the focus on the consumers' overall welfare, and empower petitioners to become better advocates for the consumers.

Recommendation 4: Establish alternative modes of transportation, and more appropriate and welcoming holding places to reduce fear and

increase the likelihood of consumers accepting treatment. Input from family members also needs to be available in the "holding" process.

Recommendation 5: Create an adequate funding base to support alternatives to the current model. This would require an expert-panel task force of specialists to develop a cost-analysis of various delivery models. [The panel can consider options suggested in the Appendix A of this report.]

Recommendation 6: Increase compensation for independent evaluators and establish more comprehensive psychiatric evaluation procedures.

Recommendation 7: Create an intentional education and training program for all participants in the involuntary commitment process—the consumers, family members, mental health providers, officials in the legal and health delivery systems, and law enforcement responsible for protecting the consumer and members of civil society.

1. Introduction

1.1. Background and Purpose of the Project

Initiatives in every branch of Virginia government at both the state and local levels are underway to reconsider the laws and processes regarding involuntary commitment of persons with mental illness. During their last session the Virginia (2006) General Assembly authorized the governor to appoint an Interagency Civil Admissions Advisory Council (ICAAC). In December 2005, Virginia's Chief Justice held an all-day session to kick off his *Initiative on Involuntary Commitment Reform*. However, at every meeting discussing the purpose of these initiatives, the approach to improve the process by which consumers are hospitalized in Virginia develops a unanimous theme: Virginia must have a mental health system that favors and supports voluntary treatment in the community or at a hospital, with involuntary inpatient or outpatient commitment as a last resort when safety of the consumer and/or the public are otherwise at risk.

Additional money and staff are required to provide sufficient treatment to forestall hospitalization. These, though, are only two requirements. Most professionals agree that for the best treatment, with the best prospect for recovery, consumers need to be willing participants. In the future, consumers may have an enhanced range of available services to choose from—phone counseling from a therapist, an immediate appointment for medication review and adjustment, a short stay at a crisis care center, etc.—but today, and even

anticipating the most ideal system of services, a crisis may require involuntary treatment.

Family and friends may be alone in desiring commitment at the time a consumer's illness escalates or becomes frightening, but consumers and family members, in advance, can collaborate in defining legal and therapeutic processes and procedures that allow consumers a dignified and respectful due process, thereby contributing to long-term recovery. ***An acceptable process for involuntary treatment must be defined. The circumstances are ripe for doing so***.

The purpose of this project was to facilitate a consensus building process among major stakeholders involved in the involuntary civil admission process to improve inpatient and outpatient services for persons with mental illness.

1.2. The Need for a Consensus Building Process

Previous reports and insights have focused on the legal system, the medical process and law enforcement, yet the perspectives of the consumers and their families were missing. Consensus building is a process that ultimately increases buy-in in terms of recommendations or decisions made between and among the various stakeholder groups. Using such a model gives voice to those excluded—in this case, the consumers and their families.

The project identified six groups who not only had an interest in the process of involuntary commitment but also were responsible for some part of it:

- Consumers

- Family members
- Law enforcement
- Community Services Boards staff
- Mental health providers
- Representatives from the legal system

By conducting a series of facilitated dialogue sessions across northern Virginia[3] — Alexandria, Arlington, Fairfax -Falls Church, and Prince William County — that included representatives of each of the stakeholder groups, we could create a first-of-a-kind model that reflects the complexities of the involuntary commitment process from various points of view.

2. The Involuntary Commitment Process: Theory and Practice

2.1. What is Involuntary Commitment?

The Joint Legislative Audit and Review Commission of Virginia's General Assembly uses the following definition:

> Involuntary commitment is the process whereby an individual with a mental illness, who is a danger to self or others, or who is unable to care for self, may be temporarily detained and involuntarily committed to a hospital following a hearing. State statutes govern the process. In Virginia, there are two major stages in the process: the period of temporary detention and the involuntary commitment hearing. The individual is evaluated during the period of temporary detention and the results of the evaluation are the basis for the outcome of the involuntary commitment hearing.[4]

This is the definition we adopted for our research.

2.2. Research on the Involuntary Commitment Process with Modifications

> The capacity to help persons with mental illness in Northern Virginia has significantly declined, especially as the population has grown. The number of psychiatric beds has decreased from 402 in 1990 to 196 today.[5] Unfortunately those who are unable to get treatment become part of the legal system either through civil commitment hearings or criminal charges and jail.[6] Of those in jail, 11% are using psychotropic medications and many more need mental health services.[7]

In the research regarding family members of consumers we found that a significant number of parents of adults are limited in being able to handle the complexities of psychiatric illnesses. Many of these parents know that no law

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[4] *Review of the Involuntary Commitment Process* (1994) Joint Legislative Audit and Review Commission of the Virginia General Assembly. House Document No. 8, 1995 Session, p. 1 - http://jlarc.state.va.us/reports/rpt164.pdf

[5] Tom Jackman, *Commission Targets How State Treats Mentally Ill*. Washington Post Staff Writer, Wednesday, October 11, 2006, page B02

[6] Ibid.

[7] Ibid

now exists that could force treatment upon their children. They feel that in order to provide their loved one with some stability, they must seek programs outside of the home. Unless the person is significantly involved in the system, few mental health programs exist to provide such treatment. [Perhaps this is because there are insufficient funds to implement such programs.]

Family members perceive two opposing choices available to them: 1) abandon the consumer to the mental health system, which is one the consequences of de-institutionalization, or 2) bear most of the burden concerning seeking treatment. This dilemma has created external alternatives such as advocacy of parent groups. Some groups are aimed at people who do have sufficient control over their illnesses to monitor their own recovery, and some are designed for people who require continued support to succeed in the community.

Appendix A of this report provides more than a dozen promising initiatives underway across the country to supplement or modify involuntary commitment processes. Some of these initiatives appear to be very successful (e.g. Kendra's Law and Mobile Crises Units). These models can be used to supplement what we found as effective alternatives to what most consider out-dated or inefficient involuntary commitment customs of mental health treatment. They are a range of options along a continuum of care from least to most restrictive alternatives available for the patient. Through NAMI NoVA, consumer advocacy and VACSB, the General Assembly and DMHMRSAS

have funded and administered some of the promising treatments referenced in this Appendix. In addition, the Virginia DMHMRSAS Office of Inspector General's August 2005 report CSBs and emergency services in Virginia, highlighted current strengths and opportunities for improvements in the continuum of emergency services by building on the existing service system. See *http://www.oig.virginia.gov/documents/SS-ESPFinalReportMay-August2005.pdf* Appendix A provides links to additional information on many programs, some already in operation in many CSBs. The need is to expand the emergency services continuum for all CSBs**.**

An option that is less restrictive than Inpatient Commitment that has shown promise in limited studies is known as the Assisted Outpatient Treatment (AOT) model. Its relative newness has witnessed both advocates and opponents, however. States with the most information about AOT are New York, Virginia, California, North Carolina and New Jersey. (See Appendix B for additional resources and literature references on AOT).

Assisted Outpatient Treatment seems to be effective under certain circumstances: if sustained for six months or more, if it is not a substitute for comprehensive services (in fact, it is effective if combined with at least three or more outpatient professional visits per month), and if it is used with persons with psychotic disorders.

Other options along the continuum of care possibilities from least restrictive to long-term investment include Programs on Assertive Community

Treatment (PACT), Mobile Crises Units, Family Advocates, Crisis Stabilization Centers, On-Site Psychiatric Evaluation Options, Crisis Beds, Housing for People with Mental Illness and Peer Support Programs. (See Appendix A for further explanation of these options).

2.3. The Involuntary Commitment Process in Virginia

Community Services Boards (CSBs) such as the Fairfax-Falls Church CSB provide information for petitioners on involuntary psychiatric hospitalization[8]—a treatment option that is pursued against a consumer's will when all less restrictive treatment options are either unsuitable or have been exhausted. The Virginia legislature established strict requirements for a consumer to be involuntary hospitalized—Code of Virginia, sections 37.2-809 through 37.2-826—based on the situation whereby she or he is an "imminent danger to self or others" or "substantially unable to care for self."

When those conditions occur, the process begins with the issuance of a Temporary Detention Order (TDO) and the scheduling of a Commitment Hearing. A TDO gets initiated by a *petitioner* on the advice of a *recommender*. The petitioner is the person advising involuntary commitment. The recommender must be a mental health provider, employed by the CSB and certified to conduct TDO evaluations. The TDO is a Magistrate-issued court order to have the consumer involuntarily hospitalized in a psychiatric facility for a period of one to

[8] This material is obtained from *Involuntary Psychiatric Hospitalization: Information for Petitioners*, a brochure developed by the Fairfax-Falls Church Community Services Board.

five days. The Magistrate makes the decision based on her or his determination that the patient is mentally ill, in need of treatment, is unwilling to volunteer for treatment, and presents an imminent danger to self or others or unable to care for self.

It is at the Commitment Hearing, held at the end of the detention period, where the status of the consumer is determined and the outcome is either: 1) a court-mandated admission whereby the consumer voluntarily requests admission, agreeing to stay in the hospital for a minimum of 72 hours, or 2) commitment involuntarily requiring the patient to remain in the hospital for a period of no more than 180 days, or 3) a court-ordered out-patient treatment to be monitored by a designated mental health provider, or 4) dismissal of petition if consumer does not meet criteria for involuntary commitment. Attending the hearing is a Special Justice (an attorney who has been given judicial authority to preside and determine the final outcome of the hearing), the patient, a court-appointed attorney (paid by the State and represents the patient at the hearing), a Deputy Sheriff (providing security), an Independent Evaluator (who conducts an evaluation of the patient in order to provide a clinical opinion about imminent danger to self or others or unable to care for self), the Petitioner (who requested the patient be involuntarily hospitalized), and any witnesses brought to the hearing by the petitioner or the consumer. A police officer is responsible for transporting the consumer to the hospital—usually in handcuffs.

3. Project Design and Methodology

3.1. The Use of Dialogues in Public Policy

Dialogue—sharing personal stories—is a widely used technique to improve communication, build trust, increase mutual understanding and find common meaning. Extending personal conversations to larger groups, dialogues are routinely employed as a means to open communication avenues between individuals and the communities in which they live. More than just a method of open interaction, or a chance to vent hostilities, or participate in group gripe sessions, the purpose of a well-facilitated dialogue is to bring about changes in attitudes and behaviors in individuals with the expectation that a derivative change will follow in their respective communities. That is, if individuals are willing and able to make changes themselves, these changes will impact the ecology of the community within which they are engaged. Dialogues can reduce conflicts among interested parties involved in controversial social problems, and can also help legitimize decisions and create more sustainable outcomes.

In the sphere of public policy, dialogues have been successfully employed to build consensus across stakeholder groups in a number of contentious areas such as environmental issues, racial and ethnic tensions, gun control and abortion. Public dialogues are designed to protect individual interests while strengthening relationships and building connections between stakeholders, and to create processes and solutions that work for all parties. There are probably as many approaches to public dialogue as there are problems it addresses. Typical

models are community mediation projects (e.g. dealing with crime and destruction in city neighborhoods), public hearings (e.g. dealing with resistance to new construction of factories and roads), and visioning processes (where people articulate their desired future and ways to get there). An example of a very successful visioning process is the "Chattanooga Venture" that set out to improve economic decline, environmental devastation and racial tension in the city. The process engaged over 400 people setting over 1700 goals to address problems in Chattanooga. Ten years later many of those goals have been accomplished and an estimated $739 million in new investments directly related to the venture were developed. Another type of public dialogue process is the *Listening Project*, in which trained facilitators solicit needs and perspectives from involved parties on a particular issue. (Dukes 1996)

In this project, we employed a "zig-zag" model loosely based on the methodology of listening projects and a visioning process. Participants were asked to express both their needs and frustrations about the current process. They were asked to consider what worked well for them. In addition, stakeholders were also given the opportunity to reflect upon and articulate what a more desirable process would look like that would work for them.

The design was chosen to allow representatives from various groups to hear from others of their experiences with the involuntary commitment process, hoping that we could create a viable model—building on aspects that worked well—to introduce to legislators, that would have increased buy-in because

participants had experienced a place to both tell their own stories and listen to the perspectives of others. With the assistance of the Community Services Board leaders in various jurisdictions around Northern Virginia, we offered six facilitated dialogues—both day and evening times—to collect our data.

3.2. Data Collection

This project engaged three primary sources for data collection: written documents, the National Alliance on Mental Illness-Northern Virginia (NAMI-NoVA) summer Conversations on Involuntary Commitment , and the six facilitated dialogues. Prior to scheduling the first dialogue, project staff reviewed newspaper articles, materials received from various stakeholder groups, and conducted web-based research on the issues and various models used in Virginia as well as other states.

3.2.1 NAMI-NoVA Conversations on Involuntary Commitment

The summer (2006) prior to launching this project, NAMI-NoVA held seven consumer and family workshops to obtain these two stakeholder perspectives on involuntary commitment in Virginia. To assist us in our work they provided a "Quick Look Summary" [9] of the data they collected (acknowledging that it was an incomplete analysis). Their workshops identified seven broad categories impacting the involuntary process:

[9] *Quick Look Report,* NAMI Northern Virginia Study on consumer and family members views of involuntary commitment in Virginia, fall, 2006. (Unpublished manuscript available from author) [Get new title from Carol]

- Definition of the law
- Insurance
- Legal process
- Magistrates and special justices
- Mental health services
- Law enforcement personnel
- Treatment of consumers

3.2.2. Process Design

The dialogue design included six two-hour meetings scheduled both day and evening to accommodate as large attendance as possible. In each session, the Principal Investigator of the project (Sandra Cheldelin) welcomed the participants and asked them to introduce themselves. The initial design separated the dialogue into two parts. The first involved members of same stakeholder groups to meet separately in small groups—family met with family, consumers with consumers, etc. — to identify their needs and concerns regarding the involuntary commitment process. The second part mixed the stakeholders groups. With six to nine per table, representing different stakeholders, we would conduct a facilitated dialogue with a group task to make recommendations about how an involuntary process could address the needs identified by each stakeholder group.

The design was modified, however, once the meetings were set up because there were no meetings where we had representatives of all stakeholder groups (and at several we had only one or two stakeholders present). We changed the design to a facilitated focus group asking all participants to tell their stories about involuntary commitment—what works and what does not, and what would need to be changed to make it work better.

At each session we identified one or two members we would ask to be part of an "expert panel." We thought they would be able to provide feedback to us in terms of our initial analysis of the data. Once a draft of the issues of each stakeholder was compiled, we e-mailed this to the respective stakeholder representative of our expert panel. In each case panel members supported, clarified and in some cases provided additional information.

3.2.3 Stakeholder Populations and Demographics

Six meetings were scheduled around northern Virginia inviting representative members of six interest-based groups: consumers of mental health services, family members, law enforcement (police, sheriff and jail), community service boards, hospital providers (public, private and community) and the legal system (magistrates, judges). Table 1 provides the location, time and date of each meeting. Table 2 presents the stakeholder representation at these meetings. In total, seventy people participated in the facilitated forums.

Table 1: Schedule of Dialogue Meetings

Group	Date	Time	Place
Arlington CSB	Thursday October 12, 2006	6:00 – 8:00 p.m.	Drewry Center – Room 201 1725 N. George Mason Drive Arlington, VA
Fairfax-Falls Church CSB	Monday October 16, 2006	7:00 – 9:00 p.m.	Fairfax County Government Center - 12011 Government Center Parkway - Center Rooms 4/5 Fairfax, VA
Alexandria CSB	Monday October 23, 2006	6:00 – 7:30 p.m.	Community Services Board (MH/MR/SA) 720 N. St. Asaph Street 4th Floor (Large conference room) Alexandria, VA
Fairfax-Falls Church CSB	Monday October 30, 2006	9:30 – 11:30 a.m.	Fairfax County Government Center Conference Room #8
Prince William CSB	Monday November 13, 2006	6:00 – 8:00 p.m.	McCoart Administration Building 1 County Complex Court, Prince William , VA 22192
Prince William CSB	Tuesday November 14, 2006	12:00 – 1:30 p.m.	Prince William Hospital Center Center for Psychiatric and Addictions Treatment, 8700 Sudley Road Manassas, VA 20110

Table 2:
Involuntary Commitment Dialogues – Stakeholder Participation
Total Number of Participants: 70[10]

DIALOGUE SESSION	STAKEHOLDER GROUPS						
	Consumers[11]	*Family Members*[12]	*Law Enforcement*[13]	*Community Services Boards*	*Mental Health Providers*[14]	*Legal System*[15]	*Other (ICAR)*
Arlington CSB Dialogue – 10.12.06	0	4	0	1	0	1 [Chief Magistrate, 7th District of Virginia]	3
Fairfax-Falls Church – CSB Dialogue10.16.06	0	4	0	1	1 [Not involved in IVC process]	0	3
Alexandria CSB Dialogue – 10.23.06	2	1	0	0	0	0	3
Fairfax-Falls Church CSB Dialogue 10.30.06	0	1	4 [2 Police Officers; 2 Sheriff's Deputies]	3	2	0	4
Prince William CSB Dialogue – 11.13.06	20 [All with experience with IVC process]	9	0	3	0	0	3
Prince William CSB Dialogue (Task Force) – 11.14.06	0	2	2 [2 Police Officers]	1	1	2 [2 Special Justices]	4
Total	**22**	**21**	**6**	**9**	**4**	**3**	**5**

[10] The total number reflects that some of the same people participated in several dialogues and have been counted for each time they participated. Facilitators have only been counted once.
[11] Some of these consumers are also NAMI NoVA members.
[12] Includes both members and non-members of NAMI NoVA. At two sessions NAMI NoVA members functioned as observers only.
[13] Includes representatives from the police and sheriff but not from jail authorities.
[14] Includes representatives from both private and non-profit hospitals.
[15] This group includes Magistrates and Special Justices.

4. Overview of Stakeholder Perspectives

4.1 Consumers

Consumers are the subjects of the Involuntary Commitment Process and can be ordered to commit to involuntary psychiatric hospitalization for a defined period of time. This may happen if the consumer is considered an imminent danger to self or others, or is unable to provide for his or her own basic needs.

4.1.1. Fear, Lack of Trust, Respect and Rights

The key themes that emerged from the consumers' perspective regarding the involuntary commitment process are a general fear of the process and lack of trust of both the police and mental health providers. Consumers describe going through the involuntary commitment process as extremely traumatic events. Being detained by police, handcuffed, shackled, transported in police cruisers, and ultimately put in jail, are disturbing and distressing experiences that have a negative impact on their mental illness. Following such an experience, they often refuse treatment and are reluctant to seek help again.

Many consumers reported that they feel treated like criminals—not patients—and handled with unnecessary force by police. Being detained is seen as threatening and abusive, and necessary medication is not always available. Some believe they have fewer rights than other criminals because they are

mentally ill; people don't listen to them or believe what they say. This is reflected in the comment from a consumer:

> We feel that the police have to take the safe route and treat consumers like criminals. Criminals get to go through the system easier because the police know what to do with them but they don't know what to do with the mentally ill so they get treated worse.

Some consumers reported they are treated as if their feelings or opinions do not matter, and treated as incapable of making decisions. As a result, some consumers say they will never ask police, or anyone else who works within the system, for help.

> I have a problem with them coming and getting a person using any means necessary. I feel that the police overuse force and using handcuffs because of the incident where I was forcefully detained and the trucks and police cars came and they came into my house. I will never ask police for help again. I don't trust anyone who works in the system.

One consumer presented a contrasting perspective and said she thought the police had "saved her life" when she was homeless and that being detained and put in jail helped her get back on her feet. This was not a typical consumer perspective, however.

> I was homeless and they put me in jail. If they hadn't I'd probably be dead; one cop recognized that I was mentally ill and put me in a facility and now I'm at the clubhouse working on vocation training.

4.1.2 Medication, Treatment Process and Options

Another major theme that was uncovered in the dialogues was a need for a wider spectrum of services for consumers earlier in the process. Consumers believe they are the experts on their own illnesses and they are aware when their

condition begins to deteriorate. In accordance, many feel there ought to be a diversified approach to treatment beyond detention and involuntary commitment. As one consumer put it, "We just need some help, someone to talk to. Sometimes that is enough." (Consumer). Consumers want more long-term, voluntary and outpatient treatment options and feel there are insufficient "safe and non-threatening" locations to seek help. Consumers made the following remarks:

> If I had received the services I requested in the beginning when I went in voluntarily, things would be a whole lot better.
>
> I go in to talk to a [CSB] representative because I was becoming symptomatic and wanted help before I got worse. Instead, I come to find out a TDO has been issued and instead I am being detained and put in leg irons.

Several consumers reported positive experiences in working with case managers at their local Community Services Boards, however. One example:

> I heard of some people talking about reticence in hospitals and one of the reasons I am doing the best that I can is because I work with two of the best case managers because working with them gives me a sense of self worth and self value and I hope to keep working with them. I have received some good services in my 25 years and I am grateful to them because they ask my input.

4.1.3 Need for Information

Consumers also described a need for more information about each of the steps in the treatment process. One of their requests was to let consumers look at their Temporary Detention Orders. They think incidents may not be accurately reported because the doctor's and/or the CSB personnel's opinions trump the

patient's rights and concerns. Forcing treatment and medication without explanation is traumatizing and will lead to patients refusing medication and treatment. The following comments from consumers reflect this:

> Between the police community and the mental health staff there might be false reporting between all of the people involved. I think there is a need to regulate what is communicated. Is it exactly what the patient said, or is it restated or paraphrased?

> After they took me in the hospital and pending seeing the person from the CSB, I was disruptive a little bit, and they shot me with an anti-psychotic (bipolar and PMDD). Then, I had allergic reactions to anti-psychotics. I've had them in the past, even, but they gave them to me again even though I strongly asked to have a medication change.

With proper access to information and being treated with respect, consumers say that they may be more willing to accept treatment and it may build trust in the mental health system.

There is also a need for Consumers to be better informed about their medication, including the side effects and interaction effects of different types of medication:

> How can I have feedback with my doctor if I'm on 4 meds and I don't know the implications of each one? There is a lack of communication between doctors and patients about their meds; this is the case whether its voluntary or involuntary commitment. I had to look at the manufacturer's label to even understand what it is for and the doctors don't tell you things like that. It creates a culture of mistrust between patients and doctors.

4.1.4 Cycles of Mental Illness and Working the System

Many consumers go through cycles in their mental illness. There are times when they function very well, and as a result, decide to stop taking their medication.

Then they deteriorate into a state where they no longer are able to care for themselves. Consumers report they want help before they reach this state but few services are available besides involuntary commitment. The criterion of the law—*imminent danger*—does not recognize the inability to care for self. Because consumers do not want to be involuntary committed, they learn quickly how to "work the system" and how to "hold it together" and "what to say in court and to evaluators" to avoid entering the system involuntarily. As a result, many end up on the streets and then get detained by police, put into the system, stabilized on their medications and released. This cycle of behavior is repeated for years without any qualitative change in the consumers' conditions.

The problem becomes a conflict between the consumers' right to make their own decisions, and concerns (especially from loved ones) about their ability to care for themselves. Consumers expressed conflicting views on who should be involved in making decisions. This is reflected in the following comments:

> I have a big confusion with that because I cannot decide for myself, because I am not separate from my family. My decision may not be sufficient if I don't include my family[16]. (Consumer)

> Whenever I talk to my psychiatrist about certain things, like about suicidal thoughts, I am restricted or discouraged from talking about them. I'm told that if I continue to talk about these things, that the psychiatrist would have to follow protocol and err on the side of caution and have me committed to a hospital. Therefore I feel limited in what I can talk about with my psychiatrist or that I cannot share my deep feelings. If I cannot share these things with the person that is supposed to be treating me, then

[16] This consumer comes from a culture in which an individual cannot be identified as separate from his or hers family. As a consequence, the consumer feels that the family has to be involved in this decision independent of how the he or she feels about it.

> the only solution is for me to deal with them myself in the way I see most helpful. (Consumer)
>
> I've been around the system for 25 years through a son having a mental illness. We need to take little steps first. Even though it's good to verbalize your story, its good therapy, but little things that take place in support groups help prevent your therapists from breaking the cycle. My son's thing is he's been in the system so long that he's addicted to the treatment and medications, and too many consumers have that problem—who have been in the system too long and then get addicted and get treated for the addiction rather than the mental illness. You have to be treated for life, like cancer. Here, it's a "treat and street" system. Until its recognized as a long-term disease, and the care reflects that, then we're gonna have a problem." (Father of Consumer)

4.2. Family Members

Family members of consumers desire to play a larger role in providing appropriate information and care about their loved ones to others involved in the involuntary commitment process. Their goal is to shed light on the situation to improve conditions for the consumers.

4.2.1. Access, Information and Diagnosis

A major challenge reported by numerous family members is their inability to access or contact family members once they are detained and/or hospitalized. Privacy laws prevent mental health providers from disclosing information about their clients (even to family members). The inability to know about what is happening to consumers and to be able to provide information about their illnesses to providers leaves family members distraught, helpless and fearful. This is reflected in these family members' comments:

> Consult the families! Inform their patients that they have permission to let them talk to the families, like, ask them "who would you like us to let know you are here?" (Family member)

> Last February my son became suicidal while in a university in Charlottesville. The school called for crisis intervention, which picked my son up. Because he was 21, they would not tell me anything. It was horribly alarming. I wasn't told whether he attempted suicide or was just feeling suicidal (because of privacy issues). My son developed what is called faulty insight and displaced on me all his blame for what happened to him. I was afraid of losing him in the system. I didn't know if it would be three days or three months. I couldn't find out anything. I was told to just sit and do nothing, which I did, just waiting every day, hour, minute for him to come home. (Mother of Consumer)

Family members are typically familiar with their consumers' overall situation and can provide useful data during the commitment process and hearings. They know the symptoms, cycles, and history of the mental illness and believe that their input is important for appropriate care. The current opinion is that families are not able to be involved in the commitment process, as reflected in these remarks:

> I have found that the doctor is with him for thirty minutes at best, so they might only be seeing one phase or part of the illness. They need to spend more time with the consumer or they could ask a spouse or family about the progression of the illness, but I do not feel like we are consulted by the authorities or the doctors. (Spouse of Consumer)

> We have found that if they [consumers] refuse to cooperate, they don't have the resources to get to their family member, even if the family thinks they [the consumers] don't have the capacity to handle everything themselves; they don't notify the family because they must comply with privacy and protecting patient's rights. Sometimes they might get the "run around" (CSB say call the police; police say call CSB and then the person may or may not be evaluated, and things get worse until they end up getting arrested). (Mother of Consumer)

4.2.2. Understanding the Process/Legal Advocate

Many family members expressed frustration about their lack of fully understanding the procedures and legal intricacies of the involuntary commitment process. While the consumer has the right to counsel during the process, family members do not. Some family members are of the opinion that the consumer is not able to appropriately articulate his or her best interest when in a crisis. Lawyers are required to follow the wishes of their clients rather than craft a solution that may be best for the consumer's illness in the long-term. Families have no input in this process and expressed a desire to have access to an advocate of their own, legal or otherwise.

In addition to legal advice, they believe that an informational system for families would be helpful—a place they could call to get support and information about the steps in the commitment process. This is supported by other stakeholder representatives:

> There needs to be an information system in place to notify the average family about how to access the system to their advantage; so many people do not know what to do. (Family member)

> The Court appointed attorney and court appointed psychiatrist have about five minutes max and limited information on what happened, what triggered the situation. The attorney advises the client to keep his or her mouth shut or they will be locked up. So when the consumer meets with the psychiatrist, he or she won't speak to the psychiatrist, goes into the courtroom, and then cannot be committed during the hearing based on no information. Catch 22. (Family member)

> Overall, they [family members] feel powerless. If being detained you have twenty minutes to explain the process and therefore their introduction to mental health system is poor and disparaging, as there is

> no one to guide them through the process. The attorney represents the patient, and is not obliged to help families. (Police Officer)
>
> Having them [family] represented by an attorney might make them feel more confident in the process but the pay for those who represent the patients' needs to be increased. Brochures are available to hand out to families made by CSB. These are really the only prior education methods available to the community. (CSB Representative)

4.2.3. Interpretation of the Law

Virginia Code Ann. § 37.2-808 states that

> Any magistrate may issue, upon the sworn petition of any responsible person or upon his own motion, an emergency custody order when he has probable cause to believe that any person within his judicial district (i) has mental illness, (ii) presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself, (iii) is in need of hospitalization or treatment, and (iv) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment[17].

Many remarked that the language in the law leaves room for significant subjective interpretation—especially when operationally defining "imminent danger"—and there is a clear conflict between the protection of consumers' individual rights versus the protection of self and others (public safety). For family members this conflict plays out as a disagreement on whether the law is too strict or too lax. Some expressed frustration that they had not been able to get their ill family members committed because they would not agree to it when they (consumers) both desperately needed it and clearly were unable to care for themselves. Their argument is that people with mental illness, especially in

[17] Virginia Code § 37.2-808. Emergency custody; issuance and execution of order. http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-808

crises, are unable to make sound decisions about themselves. Family members in several of the dialogues presented this concern:

> My background is as a lawyer and family member. My wife committed suicide after a bout with manic depression. I called her psychiatrist to say she needed hospitalization and he told me that she needed to agree or we could not do anything; that even if she were brought in against her will, she could only be held for 3 days which would not be long enough to stop her current med which wasn't working and to try a new one and have it work over a long enough trial period. I begged my wife to let me take her to the hospital. It affects cognition and yet the system expects them to think rationally and properly.

> The standards should be along lines of a higher burden of proof and is truly beneficial for the person to be hospitalized/treated. Is the person better off out in the world or treated? Order hospitalization that makes sense medically. Accept the realities that sometime adults with extremely high IQs reach a point where they cannot make decisions for themselves. The law tests for lots of things. It's just not that difficult to put together sensible criteria but the current system just doesn't do this.

Some argued that the interpretation of the phrasing of "imminent danger" should be reworked so that they could have more options regarding getting treatment. Family members are often able to recognize when a consumer is deteriorating and would like to have a broader range of options before their consumer has to be committed. However, families have no means to force care for a consumer.

A caution was mentioned that if the language of the law would change (e.g. remove *imminent*), more consumers will be eligible to be committed, but bed space and resources are still the same. Therefore, unless services are provided, a change in language could create an even bigger problem.

> If there is no place to put someone in my wife's situation, a judge is going to figure out a way NOT to order involuntary commitment. (Family member)

4.2.4. Early Intervention and Range of Treatment Options

There was broad consensus among family members that there must be a continuum of care made available before the consumers' mental conditions completely deteriorate, resulting in involuntary commitment. Comments below reflect these attitudes and beliefs:

> Good treatment is less costly than poor treatment because you don't keep on having these repeat offenders, and what not, because you give them the services they need and make sure that they keep getting them. (Family member)

> He is 25 years old so he can do what he wants but he's deteriorating; he likes to go in and get stabilized but like I said, there's no follow-up services. They need a continuum of services because there is no cure for mental illness and they can't be half-hearted because that means it'll just happen over and over again. Let's learn to be effective. (Father of Consumer)

Critical to success is having access to housing programs, and jobs or job training. Some argued that people with mental illnesses who have housing would generally accept treatment and do fairly well in the local community. They believe that increasing community-level outpatient services would keep consumers stable and out of the hospital (lowering costs at the commitment end of the cycle).

4.2.5. Lack of Resources, Decrease in Funding and Mental Health Positions

Perhaps the greatest concern among family members is the lack of (and systematic decrease in) resources within the mental health system. The problem is that community services and hospital beds are very limited, and budget cuts and elimination of positions within the mental health services are increasing. In addition, public support for mental health services is in short supply. Lack of resources in the system means that consumers will not receive appropriate care, either within the involuntary system or voluntarily as outpatients. Lack of resources is reflected in these remarks at one of the dialogue forums:

> Good models for treatment and legislation exist, but will not be implemented until funding is available. (Representative of the Legal System)

> Alabama did drastically change the standards through police training, [and] liberalized commitment criteria such that it can be applied when someone is deteriorating. (Representative of the Legal System)

A consequence of the lack of funding is that more people with mental illness will be captured by the criminal system, which in turn exacerbates the problem.

> We see what we can do to force treatment but through jail setting without adequate mental health treatment. For example, a person can come into jail on medications and be pretty stable; but in jail, this person is only going to get certain medications; all are not available—mostly generics, etc.—and then while in jail, this person, off of regular meds, whirls into an unstable state and the cycle begins again. (Representative of the Legal System, Arlington)

4.3. Mental Health Providers

Hospitals and other mental health providers assist in evaluating consumers and provide a wide range of treatment and services for persons with mental illness.

4.3.1. Temporary Detention, Acceptance, and Trust in Treatment Processes

The experience of going through the Temporary Detention Process, where some consumers are handled with force, handcuffed and put in shackles, is very traumatic and often "cures" people from accepting treatment, trusting mental health providers, and trusting the system. Providers see this as counter-therapeutic to what they are trying to do because the result is often that consumers refuse treatment. Providers explained it like this:

> People going through detention – they have been jaded. They are handcuffed and brought through to the unit. It's horrible. It's so counter-therapeutic to what we are trying to do. We try to talk people into voluntary treatment. (Mental Health Service Provider)

> People equate it with being arrested. They are being treated as a criminal. [They] will never seek treatment again, nor say how they feel. (CSB Representative)

4.3.2. Imminent Danger, Dismissals, Legal Representation for Petitioners

An increasing number of cases in court hearings in the involuntary commitment process end up being dismissed. Often the case is dismissed because of a technicality (lack of signature, petitioner does not show up, etc.). Dismissals seem problematic because the burden falls on facilities to troubleshoot whereas attorneys are only concerned about the patient's "rights."

A sub-group of patients have multiple illnesses—consumers with compounded illnesses and special circumstances—including combinations of physical and mental illness, violent behavior, are elderly, pregnant, and so on. Many facilities do not accept these clients. Therefore, there is a need for specialized services for these types of patients. Finding the right services for very ill patients is very difficult. Good services for compounded illnesses are scarce, if present at all, in Northern Virginia or in the greater metropolitan Washington DC area. For example, in extreme cases it takes up to 75 applications to find one placement.

Another challenge seemingly increasing in some counties is consumers whose primary language is not English and who may or may not be legal residents, yet need care. Lack of communication and shared language compounds an already difficult process in which people do not trust the system.

4.3.3. Continuum of Treatment Options

Providers talked about a need to be able to offer other services and treatment options than involuntary and inpatient treatment. They believe many more consumers would accept treatment if it did not involve "force." The stigma of being on a psychiatric unit is problematic by itself, while the experience of having been detained is clearly additive.

4.3.4. Funding, Resources and Increasing Population of Consumers

Key challenges are the lack of funding, lack of bed space, and lack of other resources (both in support and treatment) that mental health providers need in order to be able to offer the care and services necessary to accommodate the growing variety of consumers. Budget cuts, decreases in services, and loosing mental health positions within the system seem to be a growing trend, while at the same time there is a growing population of consumers with challenging needs.

4.3.5. Decentralization versus Centralization of Mental Health Facilities

Another challenge in the current system is that consumers often have to be transported long distances to state and private inpatient facilities that accept TDOs and commitments. This is a problem not only for the police and sheriffs that provide transportation, but also a problem for the quality of the treatment as consumers are taken out of their communities, often transported several times between various places as beds open up. Many feel that a decentralization of hospital facilities would be more advantageous for all involved. Some suggested that a hospital in each county hold rotation of people, or a regional facility be designated instead of three state hospitals. Providers noted that centralization might work well for Fairfax, but for other "spread out" counties, something less centralized might work better. They asked, though, just how decentralized should the services be?

4.4. Law Enforcement

Police Officers and Sheriff's Deputies play a critical role in the involuntary commitment process. Police enforce Temporary Detention Orders (TDO's) when a candidate is mentally ill, in need of hospitalization, presents as in imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self, and the person is incapable of volunteering or unwilling to volunteer for treatment.

A Temporary Detention Order is issued by the Magistrate in the jurisdiction where the consumer resides or an event occurs, and instructs a Police Officer to take a subject [consumer] into custody and to transport him or her to a "facility of temporary detention." The decision of what facility to take them to is determined by an employee of the local Community Services Board (CSB), depending on availability of bed space in the region.

Anybody can petition the Magistrate to issue a temporary detention order and petitioners often include spouses, parents or other family members. After a decision is made that the person should be detained and committed to a psychiatric facility for treatment, it is the responsibility of the Sheriff's Deputies to transport the consumer to the designated facility. Once a TDO is issued by a Magistrate, the police execute it and transport the consumers to a facility to await the hearing. This must be accomplished within 72 hours. If determination is made by a judge or special justice to commit, as a result of the hearing, the CSB

then attempts to find another bed for them for a longer-term stay. The Sheriff's Department is responsible for making the transport to the TDO facility.

Police officers also respond to situations in which no TDO has been issued, but where consumers are causing a public disturbance, are seen as threats to public safety, or are said to be a danger to themselves and/or others. In these situations, police officers have to assess the situation and make a decision whether to take them to be evaluated, let them go, or place them in police custody (and jail).

If a decision is made to evaluate the mental state of the person, the police need to transport the person to a hospital, CSB or emergency services location (depending on how the system is set up in the particular county where the disturbance occurred). Officers must find an appropriate evaluator and stay with the consumer until the evaluation is complete. This process can take up to eight hours depending on the availability of evaluators and the location where the assessment is conducted.

4.4.1. Time and Resources

Enforcing TDO's and properly evaluating and processing mental health consumers are very time consuming and can take officers away from their primary function of responding to calls for service crimes for up to eight hours. Processing consumers through law enforcement agencies also takes away large resources, as police officers have to stay with the consumer until the process is

complete. For each case, one or two officers will be tied up until the evaluation is complete (minimum four to eight hours). Currently there are several such cases a day. The option of taking them through the criminal system can be less time consuming than doing a mental health evaluation, and is sometimes preferred by officers. At the same time, there is recognition that using the criminal system path is not the right thing to do and Police officers feel conflicted between "doing the right thing" (taking consumers to be evaluated) and "doing their job" (protecting society from criminal behavior). As one officer stated:

> The officer on the scene will make the decision whether someone is a danger to themselves or others. It's always easier to go criminal. But we know that now we are putting them in jail and passing the problem off. If they are not going to be held, we just leave them on the street unless they are a threat. It seems so subjective—who is a threat and who is not a threat. (Police Officer)

4.4.2. Lack of Bed Space and Transportation

Transportation and time are perhaps the biggest challenges for law enforcement in their role in the involuntary commitment process. It is the responsibility of the Sheriff's Deputies and Police to transport consumers to the psychiatric facility after they have had their hearing and been evaluated. Because there is a lack of bed space, this often requires transports that are far away and out of the jurisdiction they work.

Consumers also need to be transported to and from court hearings. In the greater Washington Metropolitan and Northern Virginia region, the area traffic

poses large time constraints for officers transporting consumers. Police are responsible for getting the consumers to the hearing and back to the "holding" facility after the hearing. Rush hour traffic usually coincides with the peak time for Police calls for service. This is reported in one jurisdiction:

> The number of hearings has increased over the last one and a half years, especially in the morning, which leads to bed shortages. Therefore, patrols have to borrow other transports because there is one cruiser per patient and you can have anywhere from 2-13 patients. Shifts have to transfer patients from cruiser to another because of the times of the hearings. Officers are tied up from 5 a.m. to 1 p.m. This is on a daily basis, which also draws people from patrol areas. Overall, the patient can be transported up to 6 times. (Police Officer)

> Lack of bed space may mean they [police] have to take them [consumers] out of jurisdiction, which can mean a long trip (up to 2 hours). This wears on officers and patients because they are treated like criminals (searched, detained, tossed around). (Police Officer)

4.4.3 Familiarity with Steps of Temporary Detention Process

Many police officers expressed a lack of familiarity with the specific criteria and steps in the TDO process, and believe there is too much room for subjective interpretation by Justices in the process. Police reported the following concerns:

> There is a lack of consistency in decisions. The petitioner can't appeal if the decision is wrong; only the patient can. We hope better training or clarification of court expectations or interpretations can keep time from being wasted. Interpreting things goes to those who have power. (Police Officer)

> There is a lot of wiggle room in interpretation in this area as well. It becomes a conflict between the mental health system and the courts. This seems more like a legal process than a way to gain treatment. (Police Officer)

4.4.4 Training

Another challenge is the lack of training to properly identify and assess mental health consumers. While some police officers report they receive some training—it is briefly included in their basic training at the Police Academy—they are aware that training is uneven across-the-board. Police officers expressed a need for more information about the criteria for TDO, and the actual steps in the process, and suggested that some roll call training or in-service refresher courses would be helpful to most, especially for officers who do not deal with consumers on a frequent basis. One noted at the Fairfax forum that the training should reach a broader group:

> Even if the law was changed (Supreme Court of Virginia), if the judges are not trained or told what is required, things will not change. We want better training, guidelines for judges and lawyers, and special justices.

4.5 Community Services Boards

The Community Services Boards (CSBs) have a significant role in coordinating the Involuntary Commitment Process. CSB staff are responsible for providing to the court recommendations as to whether or not a consumer should or should not be held for hearing, completes hospital prescreenings, locates TDO hospital beds, and in certain cases may act as petitioner and attend the hearing to offer testimony. Prior to the hearing, the CSB will arrange for an Independent Evaluator to conduct an evaluation independent of theirs and attend the hearing. This process must take place within 48 to 72 hours after the issuance of the TDO.

If the consumer is found to meet the criteria for involuntary commitment, the next step is finding a bed and getting the consumer transported to the facility by the Sheriff's Department.

The CSBs possess the most comprehensive knowledge of the system and the consumers, and are thus often perceived as being in charge and responsible for all aspects of the process. However, they have no real power in the decision-making process and some feel like they have been left "holding the bag" and compelled to play a larger role at every step than necessary because others are abdicating their responsibilities.

4.5.1 Decisions and Responsibility

Some CSB members expressed feeling conflicted about being in the position to make decisions about whose civil liberties should be taken away and who should be set free. Even though they may have comprehensive criteria for making sound judgments, sometimes, unexpected things happen:

> You think someone will be okay because they are telling you that they have a different perspective . . . and they convince you. It's not like you are whimsically making a decision, but you think they are going to be okay and you work with them on outpatient basis, and then they kill themselves. (CSB representative)

> The whole idea of sharing the risk with the client is something we need to develop further. In today's society, we like for professionals to be the ones who carry the responsibility. And there is always a fear of lawsuits, and that drives the system. The doctor is protecting his or herself, so they don't let someone go or let someone enter as an outpatient. If someone commits suicide, [the doctors] could be accused of not doing their job or being negligent. (CSB representative)

4.5.2 Detention of Consumers, Consistency in Enforcement

Community Services Board representatives also believe that the way some police officers enforce TDO's (i.e. use handcuffs and shackles) are detrimental to the mental health condition of consumers. Not everyone who is mentally ill is dangerous in that way. Many individuals of mental illness are depressed and have suicidal thoughts, but they are not necessarily trying to harm other people. Some believe that coercive treatment is not helpful and would like to look at other safe alternatives. [Consumers equate harsh enforcement with being arrested and treated as a criminal and report they will not seek treatment again or tell anyone how they feel.]

Many CSB staff also reported frustration in the way the courts and judges enforce TDOs and argued that there was a lack of consistency in policy and decision making processes. The TDO process is confusing and there is a need for better guidelines and information about it for all parties involved (e.g. police, special justices, lawyers and petitioners). Though some training already exists, more in-depth education needs to be implemented across the board.

4.5.3 Funding and Resource Allocation

Most of the challenges in the process can be traced back to a lack of, or too low a funding base, and an increasing trend to cut budgets for mental health services. The Community Services Boards are responsible for locating beds for consumers in need. The availability of bed space can depend on the consumers' insurance

(many do not have insurance but still need to be served), the jurisdiction where they are picked up, zoning limitations, and voluntary versus involuntary commitment. These problems arise because there is a serious lack of resources including availability of bed space.

CSBs frame this as largely a "funding issue." They do not believe they have adequate resources. For example, enough resources need to be available so that consumers can access them easily and don't have to wait until the point of crisis. This is both a funding and a need for increased funding for mental health services in general at both the state and local levels. In addition, often private insurance does not include crisis stabilization in their benefit plans , and other in-between services that are, ironically, not as expensive as inpatient services.

Another problem focuses on independent evaluators who are supposed to play a major role in advising the Special Justice. It is difficult to recruit evaluators due to the low compensation offered for the job ($75 per case). In order to secure qualified evaluators, some CSBs are picking up what they see as the state's responsibility and have to pay up to $300 per case.

4.5.4 Preventive Care and Range of Treatment Options

Representatives of CSBs expressed frustration over an overloaded emergency situation and not having the continuum of care options needed for people. While the state is trying to make some significant changes and provide some

alternatives to inpatient treatment, there is disagreement as to whether to offer more inpatient beds or more outpatient services.

CSBs would like to be able to offer more preventive services when consumers are in a deteriorating phase (before crisis). Sometimes consumers come in voluntarily because they know they need help, but if doctors are reluctant to release them, these consumers become involuntarily committed. When this happens, a consumer finds other ways to survive in the future. They won't seek help.

4.5.5 Consumers in the Criminal System

Though not directly related to the civil commitment process another issue brought up was the lack of mental health services in jails. Some counties have one or two mental health professionals on a full-time basis at the jail, and can provide some treatment. Some counties have a professional working just a few hours each week. One county recently got their mental health position for the jail cut from the budget, and report this is becoming a trend across the Commonwealth. There are large numbers of consumers in jail and mental health providers are only able to address crises, not provide quality, sustained treatment. This is a significant problem. Many CSBs do not have a presence in the jail unless there is a crisis or they temporarily relieve a jail-based professional while she or he is on vacation.

Sometimes people will sit at the jail for days waiting for a bed or a transfer. Lack of access to medication becomes an issue and the result is often deterioration of the consumers' mental health.

4.6. Magistrates and Special Justices

Two types of representatives from the legal system attended the dialogue sessions: a Magistrate and two Special Justices. The penal system is also a large stakeholder in the process, but no representatives from this agency participated.

The Civil Mental Commitment law that governs the roles of the Special Justices (and Magistrates, too) is the same throughout Virginia. Different jurisdictions, however, have adapted some of their own practices and customs in carrying out those laws.

Magistrates issue Temporary Detention Orders (TDOs). A TDO instructs a Police Officer to take a subject into custody and to transport him or her to a facility of temporary detention in order to be evaluated and await a ruling on whether to be involuntary committed. The decision of what facility to take them to is determined by an employee of the local CSB. Within 48 hours a psychiatrist sees the consumer and a court hearing is set to determine whether to involuntary commit.

An Emergency Custody Order (ECO) is another venue for individuals to be detained for evaluation in order to be involuntary committed. An ECO is issued when a person needs evaluation (e.g., danger to self or others). The police

pick the person up and can hold him or her for four hours. Within four hours, the person needs to be evaluated by the CSB and a decision as to whether to proceed with a TDO made and communicated to the magistrate. If this is not accomplished within four hours she or he must be let go. [The Police can execute an ECO on their own, but they are not authorized to break into an apartment or house to get the subject.]

Except in rare circumstances, a TDO can be issued **only after the clinician has made an in-person evaluation of the patient within the preceding 24 to 72 hours.** If the clinician, as a result of the evaluation, concludes that the patient meets the legal criteria, he or she recommends to the Magistrate that the TDO be issued and coordinates the TDO process. The results of the evaluation are documented in a preadmission screening report ("prescreening") completed by the clinician and sent to the hospital. In order to issue the TDO the Magistrate, based on all the evidence readily available and on the recommendation of the clinician, must decide that the patient:

1. **Is mentally ill, <u>and</u>**
2. **Is in need of hospitalization or treatment, <u>and</u>**
3. **Is unwilling to volunteer <u>or</u> incapable of volunteering for hospitalization or treatment, <u>and</u>**
4. **Presents an imminent danger to self or others as a result of mental illness, <u>or</u> is so seriously mentally ill as to be substantially unable to care for self.**

Defining "imminent danger" and "inability to care for self" is a matter for each individual Magistrate. Typically, they look for evidence that the patient is engaging in recent or current behavior that could result in serious physical harm, disability or death[18].

Special Justices preside over the hearings that determine whether the person will be committed or not after they have been detained under a temporary detention order for 48 hours. Their role is to interpret the law, upholding it as best as possible, while still acting in the best interest of the patient. Special Justices will call witnesses at the hearing if they are present. Witnesses include family members, police officers, doctors, therapists, caretakers, friends, or independent witnesses from the community. Although the consumer can object to the witness(es)' presence at the hearing, this will not stop the testimony. Instead, the Special Justice imposes a *Rule on Witnesses*. The witness waits outside of the hearing until she or he is called to testify, and leaves the hearing again after giving testimony. The end result of the process is a ruling regarding treatment for the consumer. Regional statistics show that one third of cases lead to involuntary commitment, another third to Court Mandated Admission (a process in which the consumer can consent at hearing rather than risk involuntary commitment) and the last third of cases are dismissed.

[18] Information about the TDO process in this section is taken from: Involuntary Psychiatric Hospitalization: Information for Petitioners. A brochure developed by the Fairfax-Falls Church Community Services Board.

4.6.1 Lack of Resources and Appropriate Treatment Options

Magistrates and Special Judges report that the lack of bed space and appropriate treatment options are major challenges. If the result of a hearing is that a person needs to be involuntary committed and there are no available beds, the Special Justices can commit the consumer to the care and custody of the Commission of Health and Mental Retardation. The result is then that the onus falls back on the CSB to find an appropriate bed for the consumer. As the Magistrate stated:

> The problem is that there is no avenue for Magistrates to issue TDO's without a locked facility available. Bed space in northern Virginia, including Arlington County, has declined over the last 2 years: Northern Virginia Community Hospital has 22 beds; Alexandria Hospital has 24, but is shutting down. The psychiatric hospital business is not profitable. This is part of the problem. (Magistrate)

In addition to a lack of bed space, some that are available have specific restrictions. Some facilities will not accept certain types of consumers. The Emergency Rooms, for instance, do not accept individuals that are known to be violent, while others accept only "light" cases, and not individuals that also have physical ailments or are elderly. In other words, even if there are beds available, some consumers cannot be taken there because they do not qualify. A Magistrate mentioned that in instances where there were no bed spaces available and the only option was keeping them in jail, he was reluctant to issue a TDO. As long as consumers are seen as not doing harm to themselves or others, they are seen as being better off wandering the streets than the alternative of being arrested and put in criminal detention.

Magistrates and Special Justices focused on the lack of resources as a systemic problem that needs to be resolved in the legislature by increasing funding even for programs currently in place. There is a need to educate legislators that money can be saved by adequately funding alternatives rather than wait and pay whatever it costs to house someone for a day. Good legislation exists in other states and jurisdictions, but cannot be implemented until more funding is available. One Special Justice noted that persons with mental illness are seen as the least desirable elements of society. There is no money for them, and the legislature does not want to spend any money on them. They would rather "warehouse" them. Until there is more money allocated, he did not see how we are going to be able to address the issues in appropriate ways.

Lack of appropriate treatment options is also a problem that originates in the way the law is written. As one Special Justice noted:

> We don't have appropriate treatment. But the way the [state] code is written, it doesn't really allow for it. It is very antiquated and doesn't fit the society today. We could use some definitions and changes. There are no teeth to outpatient treatment. Nobody is there to enforce it, and those who are familiar with the system know how to work it. (Special Justice)

This was supported by the Magistrate who said:

> If we could change the wording, change the evaluation criteria wording, then we would need more qualified evaluators to bring out the conditions and problems and someone able to argue for the fact, to argue before the Chief Justice to get the order. There needs to be an avenue for people to get help when they need it. (Magistrate)

4.6.2 Evaluation of Consumers and Weighing Evidence

Special Justices may not always be provided with sufficient medical or psychiatric evidence regarding the consumer. They weigh all of the evidence presented to them, along with their own observations and judicial notice of common facts. They weigh the strength of the evidence and decide how much value to attribute to it. Often more weight is given to the behavior of the person, witnesses, family members, CSB worker, etc. than the written certification of the doctor because there is no written or testimonial facts given to support the conclusions stated in the Doctor's Certification. Some Special Justices tend not to put much stock in the psychiatric certifications (due to the pro forma nature of the evaluation) as foundation for their rulings.

Sometimes the psychiatric evaluation certificate is a few days old when the person comes to court and the situation has changed. Sometimes the consumer may deteriorate in detention while other times the situation may have improved due to treatment administered during the detention period. A Special Justice reflected on the process:

> I don't put a lot of stock in the psychiatric certifications because it is pro forma. The inability to care for yourself—I will sometimes find that the person is borderline and could deteriorate into harming self or others if they are not committed. You know as soon as you release them that you will see them a week later. When a lot of these people are committed, it's for up to six months, but I can't remember anyone staying that long. They are usually in for 60 days, or even out within a week. It's just a question of getting them back on track: hooked back into CSB or their private therapist and do what they need to do to stay relatively stable. (Special Justice)

A consequence of not being committed due to lack of evidence or technicalities in the process is that the consumer will most likely be back in the system a week later, in a more deteriorated stage. Alternatively, if the consumer has been given medication, he or she is more likely to agree to voluntary treatment. Usually, if the person testifies, it becomes a fairly easy decision, as consumers' behavior and demeanor can be easily observed. Most of the releases are usually on a CSB recommendation.

4.6.3 Legal Representation

The challenge in the legal representation of consumers is that lawyers are following the wishes of their clients—as it is their duty—rather than crafting a solution that may be in their clients' best interests. Lawyers acting as guardians *ad liter*, would be able to act in the clients' best interest regardless of the clients' wishes.

Also, lawyers are not well compensated for doing this job (relative to their other legal fees and services) and the legislature has not allocated much funding for this responsibility.

4.6.4 Increasing Population of Consumers in the System

There seem to be an increasing population of new and, at the moment, "invisible" consumers in need of appropriate mental health services. The parents and family members are currently caring for one group of consumers. As their

parents become elderly or disabled and cannot care for the consumer anymore, there will be an increase in the need for group homes and other outpatient services. As one Special Justice observed:

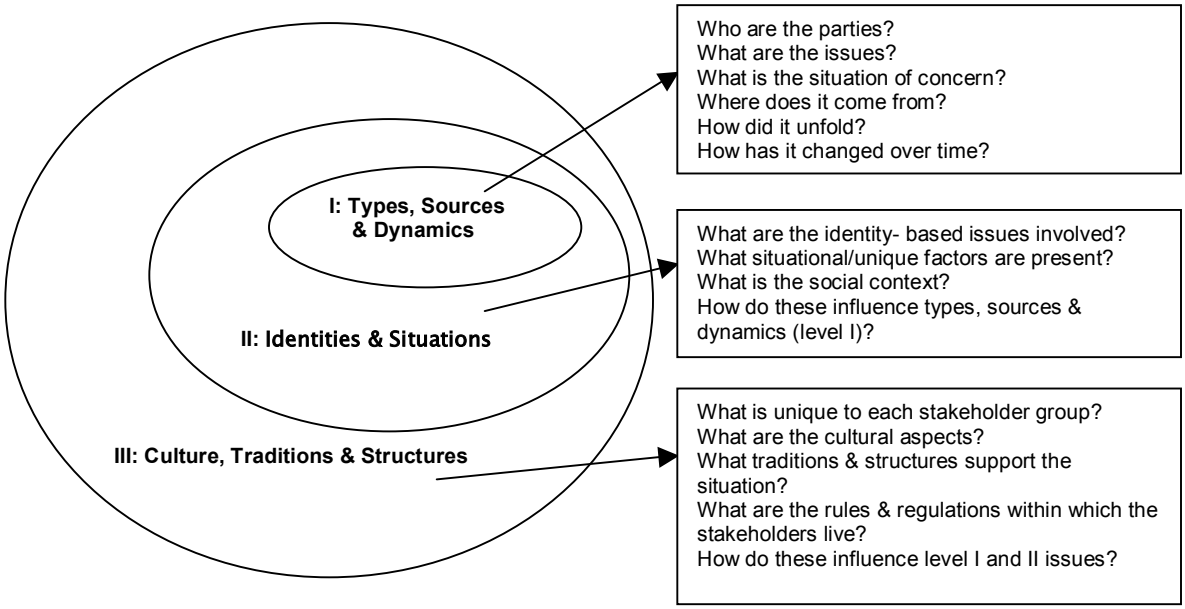
> We are seeing new problems: several women post-partum, that's becoming regular. A couple of men recently released from local jails or prison within a week were out on a rampage to rape, plunder, whatever. It was kind of disturbing to think that he just got through the system and, basically, I don't know if there is any stopgap for that until they end up in our end of the system. There are lots of holes. (Special Justice)

5. Data Analysis

5.1 Framework for Analysis: Description and Usefulness

Making sense of the data collected from the literature, pilot interviews and dialogues is helped through a process of "mapping" the situation. Mapping is essential in developing an informed judgment about the feasibility of any recommendations for intervention. A thorough understanding of the issues helps identify the critical components of the map. Figure 1 reflects the model we used in the analysis of our data. It considers three levels of analysis. Level I—micro level concerns—includes the types, sources, and dynamics of the situation unveiled—in this case, the involuntary commitment process in the Commonwealth of Virginia. Here we identify the presenting issues and the various stakeholder preferences. Level II —the meso level—middle circle of the diagram—considers the situational and identity related aspects of those involved in the process. Level III —the macro level (the outer circle) we map the issues specific to culture, traditions, and structures that are involved in the situation. This framework reflects the embedded nature of the three levels in most complex situations such as making a decision for involuntary commitment.

Figure 1
A Framework for Analysis Mapping[19]



5.1.1. Level I: Types, Sources and Dynamics of Involuntary Commitment

Analysis of any complex situation with various stakeholder positions and perspectives begins by considering the issues reflected in the inner core circle: the types, sources and dynamics of the situation. We seek answers to such questions as:

- What is the problem?
- Where does it come from?
- How did it unfold?
- How has it changed over time?
- What has been the result?

[19] This model is adapted from Sandra Cheldelin and Ann Lucas, *Conflict Resolution*, 2004, Jossey Bass

By organizing these questions in terms of types, sources, and dynamics, we gain a greater understanding of the social and psychological dimensions of the situation.

Level I analysis is an attempt to understand the various parties' motivations and behavior. How do they view the rights, values, and concerns of individuals impacted by the involuntary commitment decision-making process? Where is the locus of this situation? For example, is the problem that the consumer is not coping well with her or his own issues and concerns? Is it primarily between two people—the consumer and the family member? Is it between members within the family unit? Does it present itself between groups such as CBS, family, law, and mental health providers?

To determine conflictual sources we study the stakeholders' relationships, needs, interests, values and ideologies that can serve as constraints to effective communication and collaborative teamwork. [Few complex situations have a single source; the most protracted and enduring problems nearly always have multiple sources.] When the primary source is relationship-based the parties demonstrate tension, lack of trust, hostility, anger, frustration and resentment towards each other. When people have differing needs and interests, their motivational involvement in the situation becomes the driving force. When values vary, the parties operate from contradictory assumptions about the world and often these different ideological positions make finding a resolution more difficult.

When there are real and significant differences in interests, power, perceived injustices, and needs, the situation is ripe for conflict to erupt. It is the dynamics—the interaction of these perceived differences and injustices—that escalate predisposing conditions to actual conflicts, often seeming as if the conflict takes on a "life of its own." Similarly, when interests, values or needs are not being met—what the parties think is desirable for them—and when there is an imbalance of power and perceived injustice, conflict is predictable.

5.1.2. Level II: Identities and Situations Related to Involuntary Commitment

Returning to Figure 1, the second level of mapping analysis considers contextual issues—the setting within which the problem occurs. Two contextual issues are especially important at this level: identity and situation. Here we explore such questions as:

- What are the *identity* concerns of the stakeholders?
- How does the way they think about themselves influence the problem?
- What is the *situation* in which they are in conflict?
- What is the social context of the problem?
- In what ways are these second level issues—identities and situations—influencing the first level components—types, sources and dynamics of the issue?

Identity is at the heart of people's sense of themselves: how they define themselves, how they relate to and make order of their environment, and ultimately, how they feel safe both physically and psychologically in the world.

Level II analysis moves beyond these psychological frames to consider stakeholder members' social identities. When the identities are in conflict, threatened parties may become defensive and aggressive. Often there is evidence of personal accusations, threats, and retaliation and they escalate quickly.

When we consider situations we are trying to understand factors of the various stakeholders' social contexts that may be influencing their behaviors. This includes the parties' *environment, time pressures, relationships with each other and with authority,* and *roles.* It also includes any perceived *opportunities for conversation* and *problem solving*. Do the stakeholder representatives believe there will be *repercussions*? Is there any negotiation flexibility? Does the behavior of the stakeholders in the process remain fairly consistent in other contexts? Do the responses seem unusual? If there is little evidence that the parties involved engage in these behaviors most of the time, it suggests that the situation needs greater exploration.

The sociological and contextual issues of situations and identities (Level II) and social and psychological issues of types, sources and dynamics (Level I) are usually nested in an even larger socio-political and structural context. This context is Level III of the mapping analysis.

5.1.3. Level III: Culture, Traditions and Structures of Involuntary Commitment

Macro-issues influencing the involuntary commitment process are the social, organizational, political and economic aspects of its environment. We consider such questions as:

- What is unique to this process?
- What are the *cultural aspects* of mental health delivery that help us understand this particular situation? What are the *subcultures* that exist?
- What traditions and structures are in place that support or enhance the problem?
- What are the *traditions, rules*, and *regulations* to consider that can and will escalate or deescalate the situation?

Social scientists define culture as the *laws, customs, belief systems,* and *language* people acquire. Our mapping framework considers culture in the context of the Commonwealth's method of dealing with persons with mental illness when they are in imminent danger to themselves or others and may need to be involuntarily hospitalized. When we consider the larger context of traditions, we are talking about the *deeply rooted* and *persistent behaviors* in the mental health and legal system over a long period of time. Organizations have characteristics that compel members to act in certain ways. Structures of the involuntary commitment process are the *laws, policies, procedures,* and *rules* that get implemented, and specifically, the ways these encourage or impede conflict for various stakeholder groups.

5.2 The Complexity of the Problem

The Framework of Figure 1 allowed us to articulate the complexity of the problems with the involuntary commitment process by mapping the significant issues. For example, at the inner most circle, Level I (*types, sources and dynamics*), of the six stakeholder groups—consumers, law enforcement, legal representatives, family members, CSBs and mental health providers—we found that all six stakeholder representatives articulated concerns about the types, sources and/or dynamics of the involuntary commitment process. Level II (*identities and situations*) was the location of four stakeholder concerns. Level III (*culture, traditions and structures*) located the greatest number of substantive concerns across stakeholder groups.

A summary of concerns by stakeholder groups includes the following for **Level I** issues:

- **Consumers** are fearful, lack trust and feel disrespected, are "treated as criminals," do not feel valued, need information, and find that their cycles of mental illness are part of the problem.

- **Law Enforcement** representatives were concerned that the lack of bed space and issues of traffic forced them to spend time away from real "policing" activities because of waiting for hearings or being delayed in heavy traffic.

- **Family Members** found significant problems with interpreting the law—especially relating to "imminent danger." They know the signs of deterioration but cannot intervene until there is a crisis.

- **Community Services Boards Representatives** reported that detaining consumers and placing them into the criminal justice system was a significant source of the problem.

- **Mental Health Professionals** reported that the temporary detention, acceptance of and trust in the treatment process were broken.

- **Legal Representatives** (Magistrates and Special Justices) noted that the increasing population of consumers in the system was a significant source of the problem—including the lack of resources to address this increase.

Level II of our map—situations and identities—found four of the six stakeholder groups identifying concerns of these related to the involuntary commitment process:

- **Consumers** reported that others perceived them as outcasts of society—without voice, rights and privileges. Their sense of "identity" was compromised because of their illness

- **Law Enforcement** has a "policing" identity that involves solving crime and protecting civil society. Transporting and staying with patients (required by law) feels like a distraction from their "real work."

- **Family Members** also voiced concern that their expertise—knowledge and experience—about the mental illness of their consumer is not perceived wanted in the process, nor valued.

- **Mental Health Professionals** report that the situational nature of involuntary commitment is problematic. The patient usually has to deteriorate significantly before she or he can receive mental health treatment.

Though Level I issues were represented by all six stakeholders, the Level III—culture, tradition and structures—had by far the greatest substantive representation in our map of the issues involved in involuntary commitment. By stakeholder groups, a summary of concerns for **Level III** includes the following:

- **Consumers** realize, once they have experienced involuntary commitment, that the legal system—the structure that impacts their future—must be carefully navigated so that they can avoid being caught in its web of confusion, disrespect and fear. They know that even though they are

deteriorating in terms of their own illness, if they report their decline they will end up hospitalized.

- **Law Enforcement** speak to the lack of beds available. This impacts the quality of their own work-life taking time away from policing their respective communities. The laws (structures) require that they stay with consumers for extended periods of time including transporting them from place-to-place, often in high traffic volume periods.

- **Family Members** understand they are caught in a legal system and process with little knowledge. They asked for legal advocates to help them navigate unchartered waters, especially their first experience with involuntary commitment. They also appreciate that lack of resources, decreased funding and cut-backs in mental health positions decreases resources available to their loved ones.

- **Community Services Boards** professionals are aware of the multiple structural conditions that impact their work: the need to find qualified independent evaluators, the concern about lack of beds available for commitment, the decline in resources available for mental health crises, and the concern about legal representation when hearings are conducted.

- **Mental Health Professionals** are pleading for a change in the available options for the mentally ill, in particular, a continuum of care options from least to most restrictive. They ask for funding and additional resources to address the increasing populations of consumers in Northern Virginia.

- **Legal Representatives** (Magistrates and Special Justices) believe that the system needs extra funding to provide adequate resources and appropriate treatment options for consumers. They are concerned about legal representation and the increasing population of consumers in the system.

As a result of the mapping we identified five major issues in need of immediate attention: 1) legal issues dealing with the definition of the law, 2) improvement in the overall detention processes, 3) increased treatment options that reflect a continuum of care, 4), funding and increased resources, and 5) adequate information and training available to all stakeholders.

6. Recommendations

6.1. Definition of the Law and the Legal Process

The primary concern that frames this recommendation is voiced most clearly from interviews with family members of mental health consumers. Their understanding and interpretation of the law regarding "imminent danger" inhibits early interventions—when signs of deterioration of their loved ones begin. The interpretations of "imminent danger" vary among all involved in the process (police, CSBs, consumers, and judges). Family members most clearly desire a stricter definition of "imminent danger and inability to care for self" as a criterion for involuntary commitment, while consumers, police, judges and some hospital providers believe that the issue is less clear and represents a conflict between individual freedom and public and individual safety. Whether to expand or limit the definition of the law is thus a larger societal question. Our results show there are different perspectives on this issue among the stakeholders involved, thus further dialogue is warranted to find common ground.

> **Recommendation 1**: Establish a political dialogue among legislators to explore the criteria, definition and scope of the law that governs the involuntary civil admission process in order to address the concerns of the various stakeholders involved.

To address the major concerns raised by family members for more information and better support during the legal commitment process there is a need to establish a system of legal advocates for families and petitioners so they can adequately represent themselves (and in extension, their consumers). This potentially would result in a better process and help put to rest much of the fear and anxiety that family members feel when their consumer is in the process of involuntary commitment.

> **Recommendation 2:** Establish a system of legal support for families and petitioners to increase the focus on the consumers' overall welfare, and empower petitioners to become better advocates for the consumers.

6.2. Treatment Options and Continuum of Care

We learned from the dialogues there needs to be great attention given to early intervention strategies—peer support, counseling, adjustment of medication, etc.—as well as long term care and outpatient alternatives. Family members and mental health professionals were concerned that patients had to deteriorate significantly before receiving treatment. Appendix A provides a number of options other jurisdictions are using to increase the possibilities for care along a continuum of least to most restrictive.

Recommendation 3: Provide a continuum of intervention strategies—available earlier in the commitment process—including a variety of outpatient treatment options as alternatives to the current practice of involuntary commitment.

6.3. The Detention Process

The primary issues that need to be addressed in the detention process relate to the consumers' reported lack of trust, and experience of fear and disrespect when subjected to the process. A number of stakeholders noted that the detention process, as it currently exists, is counterproductive to treatment. Consumers' encounter with police, handcuffed and experiencing themselves in a criminal system initiates the process of fear that may lead to deterioration of their condition and eventual refusal of treatment. Alternative ways of transporting and holding consumers—with input from family members—under temporary detention orders are critical. To combat this situation several stakeholders showed significant interest in private contracted transportation or mobile crisis units.

Recommendation 4*:* Establish alternative modes of transportation, (e.g. besides the police cruisers), and more appropriate and welcoming holding places so to reduce fear and increase the likelihood of consumers accepting treatment.

6.4. Funding and Increased Resources

A significant problem with the current protocol is that there are too few resources at various stages of mental health deterioration to be creative in providing mental health alternatives. New models for funding and a re-organization of mental health services need to be considered. This involves such controversial issues as:

- the degree and focus on centralization versus decentralization of the process,
- the development of community level services that can handle diverse patient populations (e.g. elderly, those with multiple physical illnesses, dual diagnosed patients, and patients with other languages as their primary mode of communication),
- an increase in the number of available mental health personnel—at all levels of providing services including jails,
- public support for mental health services that acknowledge the fact that good outpatient services are ultimately cheaper than involuntary treatment and placing consumers into the criminal system (by default).

Recommendation 5: Create an adequate funding base to support alternatives to the current model. This would require an expert-panel task force of specialists to develop a cost-analysis of various delivery models. [The panel can consider options suggested in the Appendix A of this report.]

6.5. Information and Training regarding the Involuntary Commitment Process

It is clear from multiple stakeholder members attending our focus groups that training and information dissemination about the actual process of involuntary commitment needs to be enhanced and made clearer at multiple levels:

- Police and other law enforcement,
- Special justices and defense attorneys,
- Family members of consumers, and
- Consumers, themselves.

Recommendation 7: Create an intentional education and training program for all participants in the involuntary commitment process—the consumers, family members, mental health providers, officials in the legal and health delivery systems, and law enforcement responsible for protecting the consumer and members of civil society.

7. Summary and Conclusions

This report described a public dialogue project by the Community Services Boards of Northern Virginia, The National Alliance on Mental Illness in Northern Virginia, and the Institute for Conflict Analysis and Resolution at George Mason University with the purpose of facilitating a consensus building process among major stakeholders involved in the involuntary civil admission process to improve inpatient and outpatient services for persons with mental illness.

The project brought together 70 stakeholders, for the first time, from the City of Alexandria, Arlington, Fairfax (including Cities of Fairfax and Falls Church) and Prince William Counties) in Northern Virginia involved in the involuntary civil commitment process. These were:

- Consumers of Mental Health Services
- Family Members of Consumers
- Law Enforcement Representatives
- Hospital Providers of Mental Health Services
- Representatives from the Legal System (Magistrates and Special Justices)
- Representatives from the Community Services Boards

The goal of the process was to identify the challenges faced by each and to explore areas of consensus among stakeholders on how to articulate a process that would work better for all parties involved. The major challenges identified by the stakeholders were:

- A need to redefine the criteria, definition and scope of the law that governs the Involuntary Civil Commitment Process.

- A need for stable (increased) funding and resources for establishing appropriate services for an increasing population of people with mental illness in Northern Virginia.

- A need for a diverse continuum of preventative and treatment options as alternatives to the civil commitment process.

- A need for comprehensive information and training for all parties involved in the process.

- A need for more legal support for family members of consumers and petitioners in the process.

There was significant consensus among all stakeholders on all issues, except for how to define appropriate criteria and scope of the law. Here, the main disagreements centered on the issues of individual freedom versus public safety concerns. This discussion is political in nature and reflects the values of the larger society in which these issues are embedded.

Northern Virginia is experiencing rapid population growth and influx of new and diverse populations that may require both more funding and diversified options of treatment. At the same time, resource allocation to mental health services seems to decline (e.g. positions have been eliminated). This can potentially become an explosive situation that can be prevented by taking action now. We have offered seven recommendations to do this.

8. Appendix A: Promising Treatment Initiatives Currently Under Way – Nationwide

While the main focus of this project was identifying the challenges faced by the various stakeholders in the involuntary commitment process in Virginia, we also asked participants in the workshops to articulate initiatives and programs that seem to be working better to address some of the concerns they experience, either in their own communities or in other states. As mentioned in section 2.2. above, NAMI NoVA, consumer advocacy and VACSB, the General Assembly and DMHMRSAS have funded and administered some of the promising treatments referenced in this Appendix. In addition, the Virginia DMHMRSAS Office of Inspector General's August 2005 report CSBs and emergency services in Virginia, highlighted current strengths and opportunities for improvements in the continuum of emergency services by building on the existing service system. See *http://www.oig.virginia.gov/documents/SS-ESPFinalReportMay-August2005.pdf* Appendix A provides links to additional information on many programs, some already in operation in many CSBs. The need is to expand the emergency services continuum for all CSBs.

In the next sections we list some of these initiatives and programs. It is not our intention to advocate or take a position on any of them; we only provide a brief description and some resources for the readers to explore and evaluate for themselves. However, we have organized them by levels of restriction on consumers as options along a continuum of services.

8.1. Less Restrictive Options to Involuntary Commitment

8.1.1. Program on Assertive Community Treatment (PACT)

Assertive community treatment refers to a multi-disciplinary and comprehensive treatment program with mental health professionals organized as a mobile unit providing the treatment, rehabilitation, and support services that persons with severe mental illnesses need to live successfully in the community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, PACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation.

Web resources on Assertive Community Treatment include the following:

- http://www.d19csb.com/ics/pact.htm
- http://www.nami.org/pact/pact.htm
- http://pb.rcpsych.org/cgi/content/full/24/9/359
- http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/
- http://www.actassociation.org/
- http://www.omh.state.ny.us/omhweb/ebp/adult_act.htm
- http://download.ncadi.samhsa.gov/ken/pdf/KEN01-0084/KEN01-0084.pdf
- http://www.psychservices.psychiatryonline.org/cgi/content/full/52/10/1394
- http://www.psychlaws.org/GeneralResources/fact13.htm

8.1.2. Mobile Crisis Units

Mobile Crisis Units are also at the community level with multi-disciplinary programs. They respond to consumers in crisis and perform psychiatric evaluations without first taking consumers to the emergency room or a hospital.

This reduces pressure on hospitals and prevents the consumer from being held while waiting to be evaluated.

Web resources on Mobile Crisis Units include the following:

- http://www.masspsy.com/leading/0410_ne_mobile.htm
- http://www.commongroundsanctuary.org/press_releases
- http://amh.health.state.hi.us/Public/REP/EvaluationInstruments/CER-TV%20Manual.pdf

8.1.3. Kendra's Law

Kendra's Law (also known as the *New York Mental Hygiene Law*) allows a court to order someone—who meets very specific criteria—into community-based mental health treatment. This court-ordered treatment is also called assisted outpatient treatment (AOT) (further discussed in section 2.2 of the text).

Web resources on Kendra's Law include the following:

- http://www.psychlaws.org/PressRoom/presskits/Kendra'sLawPressKit/kendraslaw.htm
- http://www.omh.state.ny.us/omhweb/Kendra_web/KHome.htm
- http://www.mcmanweb.com/article-66.htm
- http://www.psychlaws.org/StateActivity/NewYork/GuideKL.htm
- http://psychservices.psychiatryonline.org/cgi/content/full/56/7/791
- http://community-2.webtv.net/stigmanet/KENDRASLAW/

8.1.4. Family Advocate

Family advocates provide a variety of support services for family members of persons with mental illness. They may offer education and advocacy to cope while helping their relative, as well as providing information on mental illness and the mental health system: how to care for themselves while caring for their

relative, how to reduce stress, and how to strengthen their problem solving skills.

Web resources on Family Advocate include the following:

- http://www.slvmhc.org/consumer-familyadvocate.htm
- http://www.mhapc.com/programs.htm
- http://psychservices.psychiatryonline.org/cgi/content/full/49/6/764
- http://hotjobs.yahoo.com/jobs/IA/Des-Moines//JP1LKFRQI
- http://heapro.oxfordjournals.org/cgi/content/abstract/21/1/70

8.1.5. Specialized Mental Health Training for Law Enforcement and Special Justices

Sworn officers who have special mental health training can help provide crisis intervention services and act as liaisons to the formal mental health system. Some of these programs used additional services as a secondary response.

Web resources on Specialized Mental Health Training for Law Enforcement and Special Justices include the following:

- http://www.parliament.vic.gov.au/lawreform/Warrant/Submissions/Submissions%20in%20PDF%20format/32s%20springvale%20monash%20legal%20service.pdf
- http://www.schizophrenia.com/sznews/archives/001091.html
- http://ajp.psychiatryonline.org/cgi/content/abstract/137/2/228
- http://news.communitypress.com/apps/pbcs.dll/article?AID=/20061205/NEWS05/612050308/1077
- http://abclocal.go.com/wls/story?section=community&id=4566576
- http://www.jaapl.org/cgi/content/full/33/1/50
- http://psychservices.psychiatryonline.org/cgi/content/full/55/1/49
- http://www.psychservices.psychiatryonline.org/cgi/content/citation/57/6/883
- http://www.state.tn.us/mental/mhs/CJTFReportJan2001.pdf

8.1.6. Consumer-Run Drop-In Centers

Consumer-run drop-in centers refer to peer-run programs providing education and training on recovery and wellness for adults with mental illness that include providing skills for monitoring symptoms, decreasing the severity and frequency of symptoms, and improving the quality of life.

Web resources on Consumer Run Drop-In Centers include the following:

- http://www.mentalhealthrecovery.com/
- http://www.healthyplace.com/Communities/Depression/mhrecovery/articles7.asp
- http://www.copelandcenter.com/whatiswrap.html
- http://www.copelandcenter.com/conference_handouts/Copeland_WRAPOverview.pdf
- http://psychcentral.com/library/id255.html

8.2. Moderately Restrictive Options to Involuntary Commitment

8.2.1. Crisis Stabilization Centers

Crisis Stabilization centers are inpatient programs that provide assessment and short-term crisis stabilization for patients who are unable to function in their environment. Programs normally divert local and state hospitalizations at a cost substantially below that of a hospitalization.

Web resources on Crisis Stabilization Units/Crisis Beds include the following:

- http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/crisis.shtml
- http://www.netcareaccess.org/services_crisis_stabilization.htm
- http://www.mcmentalhealth.org/Services/CrisisServices/CSU.htm
- http://www.rimrock.org/programs/crisis.shtml
- http://www.doh.state.fl.us/Environment/community/group/crisis.htm

- http://www.peopleincorporated.org/PI%20Program%20Info%20Documents/PI%20Hewitt%20Crisis%20Stabilizaton%20Services%20-%20Updated%206-2005.htm

8.2.2. Forensic Evaluators

Forensic Evaluators have specialized certification training and stature in providing forensic mental health evaluations, and expert court testimony. Two commonly described service models are the integrated model (forensic specialists working within community mental health teams) and the parallel model (forensic specialists working on a separate specialist team).

Web resources on Forensic Evaluators include the following:

- http://www.nbfe.net/
- http://www.slshealth.com/forensics/home/forensic_evaluations_and_the_law.asp
- http://www.nationalcac.org/professionals/model/forensic_eval.html
- http://www.jaapl.org/cgi/content/abstract/34/2/231
- http://www.ilppp.virginia.edu/ExpDir/

8.2.3. On-Site Psychiatric Evaluation Options

To combat the significant side-effects of transporting consumers from place to place to be evaluated (e.g. police time and resources, hand-cuffing and shackling consumers), participants in the workshops mentioned several alternatives:

- "Batching"—holding hearings and evaluations in one location (e.g. a hospital) so that law enforcement officers could reduce the time and resources they spend on transporting consumers and waiting for evaluations to be completed. For consumers this could reduce the time spent in police cruisers being hand-cuffed.

- "Video conferencing"—conducting hearings over closed circuit TV. This is an option successfully used in the criminal justice system.

- "Traveling the circuit"—the courts and special justices are conducting the hearings at the facilities where the consumers are located.

Web resources On-Site Psychiatric Evaluation Options include the following:

- http://www.oag.state.va.us/OPINIONS/2003opns/03-103w.pdf
- http://www.ncjrs.gov/pdffiles1/bja/182504.pdf

8.2.4. Rehabilitative Therapy

Rehabilitative Therapy offers assessment and treatment by occupational and activities therapists designed to promote the development of social and coping skills in addition to basic living, vocational, and leisure skills. Inpatient, outpatient, partial hospitalization, and community reintegration services are available to patients of all ages.

Web resources on Rehabilitative Therapy include the following:

- http://www.homelessnessandtrauma.com/pdfs/Day%202--October%2027/900am-1030am/Recovery-Oriented%20Psychiatric%20PDF-Anthony%20DeLong.pdf
- http://www.psychservices.psychiatryonline.org/cgi/content/abstract/48/3/335
- http://www.springerlink.com/content/w710167824662365/
- http://books.google.com/books?hl=en&lr=&id=J-WxUXWYWxkC&oi=fnd&pg=PT5&sig=BhfyrlmTUySHIVPNOQ1YLIYAxQw&dq=Rehabilitative+Therapy+,+mental+illness

8.2.5. Crisis Beds

Crisis beds refer to a specially designated number of beds in either a hospital or independent facility that offers short-term medical care

specifically for patients of mental illness suffering a crisis. It can also be an independent facility that provides the same treatment options but without the consumer having to be *admitted* to the hospital. Here patients can receive immediate and appropriate treatment to begin recovery.

Web resources on Crisis Beds include the following:

- http://psychservices.psychiatryonline.org/cgi/content/abstract/45/4/351
- http://www.metrokc.gov/dchs/mhd/respite.htm
- http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9347421&dopt=Abstract

8.3. Long-term Care Options

8.3.1. Housing for People with Mental Illness

Several participants mentioned the importance of having a stable housing situation as a prerequisite for being capable of dealing with mental illness.

Web resources on Housing for People with Mental Illness include the following:

- http://www.npr.org/news/specials/housingfirst/whoneeds/mentallyill.html
- http://www.dmhas.state.ct.us/medicaid/grouphomes.htm
- http://pn.psychiatryonline.org/cgi/content/full/40/1/19
- http://www.usdoj.gov/crt/housing/final8_1.htm
- http://www.theadvocacyalliance.org/pages/061401letter.shtml
- http://www.psychservices.psychiatryonline.org/cgi/content/abstract/50/5/64
- http://mentalhealth.samhsa.gov/publications/allpubs/ken98-0048/default.asp#1

8.3.2. Peer Support Programs

Peer support programs are peer-based mutual support programs led by consumers for consumers.

Web resources on Peer Support Programs include the following:

- http://www.nami.org/Template.cfm?section=Education_Training_and_Peer_Support_Center&lstid=332
- http://www.mhaarizona.org/program/cs_peer_support.html
- http://www.mhah.org/programs_peer.aspx
- http://www.gacps.org/Home.html
- http://www.mentalhealthpeers.com/pdfs/peersupport.pdf
- http://www.mentalhealthpeers.com/pdfs/peersupport.pdf
- http://www.state.tn.us/mental/recovery/dropin.html
- http://www.dhhs.state.nh.us/DHHS/BBH/peer-support-agencies.htm

9. Appendix B: Resources and Literature on Assisted Outpatient Treatment[20]

OVERVIEWS OF ASSISTED OR INVOLUNTARY OUTPATIENT TREATMENT

GENERAL ARTICLES

- Mandated Community Treatment: Beyond Outpatient Commitment. John Monahan, Ph.D., Richard J. Bonnie, LL.B., Paul S. Appelbaum, M.D., Pamela S. Hyde, J.D., Henry J. Steadman, Ph.D., Marvin S. Swartz, M.D., http://www.macarthur.virginia.edu/article.pdf

ARTICLES SUPPORTING AOT

- Mentally Ill Find More Doors Shut: Strict treatment rules can exacerbate Despair. William Branigan, Washington Post. June 24, 2002

- Involuntary Outpatient Commitment, Community Treatment Orders & Assisted Outpatient Treatment: What's in the Data. Marvin S. Swartz, MD, Jeffrey W. Swanson, PH.D. Canadian Journal of Psychiatry, Vol. 49, No. 9, September 2004.

- Assisted Outpatient Treatment "A Step in the Right Direction." Judge Randy T. Rodgers and Jonathan Stanley, JD. May 12, 203

- Forced Mental Health Treatment Has a Place. Leonard Holms, Ph.D., February 23, 2004. http://mentalhealth.about.com/cs/schizophrenia/a/commit204_p.htm

ARTICLES CHALLENGING AOT

- Kendra's Law, Not Ours, with Comments: McMan's Depression & Bipolar Web. Last comment October 10, 2004.

- Bazelon Center

    - Position Statement on Involuntary Commitment. Last update April 2000.

[20] Prepared by Laura Schmitt, Quality Improvement Business Analyst, Fairfax-Falls Church Community Services Board.

http://www.bazelon.org/issues/commitment/bazelonposition.htm
  - Involuntary Outpatient Commitment. Updated October 24, 2001. http://www.bazelon.org/issues/commitment/ioc/index.htm
  - Studies of Outpatient Commitment are Misused. Revised July 3, 2001. http://www.bazelon.org/issues/commitment/ioc/studies.htm

- Analysis of the Scientific Grounds for Forced Treatment. Letter to the Little Hoover Commission. Michael McCubbin, Ph.D., David Cohen, Ph.D., University of Montreal through the National Association for Rights Protection and Advocacy. February 1, 2000. http://www.narpa.org/cal_ioc.htm

- Issues Relating to Involuntary Outpatient Commitment and Alternatives. Task Force Report pursuant to Public Act 96-215, Submitted on January 1, 1997. http://narpa.org/task.force.report.htm

- Forced Treatment Doesn't Work: The promise of community mental health service was neither funded nor fulfilled. Vicki Fox Wieselthier and Michael Allen. Washington Post, August 5, 1999, Page A23. http://www.narpa.org/forced.treatment.doesn't.work.htm

- Curing the Therapeutic State: Thomas Szasz on the medicalization of American life. Reasononline, July 2000. http://reason.com/0007/fe.js.curing.shtml

- Outpatient Commitment: A view from Another Bridge. Harold A. Maio. February 23, 2004. http://mentalhealth.about.com/cs/legalissuesw/a/commitmaio_p.htm

- National Mental Health Association Position Statement on Involuntary Mental Health Treatment, NMHA Program Policy P-36. http://www.nmha.org/position/ps36.cfm

COMMONWEALTH OF VIRGINIA INFORMATION

- **TREATMENT ADVOCACY CENTER'S STATE BY STATE SUMMARY** *(last updated December 2004)*
  http://www.psychlaws.org/LegalResources/statechart.htm
  Virginia has AOT legislation, same as inpatient, but also requires individual is a) competent to understand the stipulations of treatment, b) wants to live in community, c) agrees to abide by treatment plan, and d) has capacity to comply with treatment plan. Ordered treatment can be delivered on an outpatient basis, and can be monitored by community services boards or designated providers. VA Code Ann: 37.1-67.3 for both inpatient and outpatient. (Source: Treatment Advocacy Center's State by State Summary & Standards tables)

- **TREATMENT ADVOCACY CENTER'S LEGISLATIVE AND POLICY COUNSEL, JOHN SNOOK, ESQ. EMAIL FOLLOW-UP TO TELEPHONE INTERVIEW 7/20/05:**

  - Virginia law only allows for assisted outpatient treatment if an individual with a severe mental illness is first found to pose either an imminent danger to self or others or be substantially unable to care for himself. Reports this stipulation renders the law virtually unusable because it requires that a judge order someone posing an active danger, either to themselves or others, into the community for treatment. Individuals who have deteriorated to such a point typically require hospitalization and stabilization before being capable of living safely in the community. As a consequence, Virginia's judges are hesitant to order such individuals into community care, fearing the headlines that might result if something tragic happened.

  - The trend throughout the country is to allow for AOT for people who have a history of treatment non-compliance before they become dangerous. This allows the state to provide a less expensive and restrictive option than hospitalization – one that allows individuals to maintain ties to the community while still ensuring proper treatment.

  - Virginia's outpatient standard also fails to specify procedures for implementation and use. As a consequence, courts are unlikely to utilize AOT in a consistent manner, if at all. States such as New York have had tremendous success utilizing outpatient standards that clearly delineate the responsibilities and requirements of each aspect of the treatment process.

- **TREATMENT ADVOCACY CENTER'S PREVENTABLE TRAGEDIES DATABASE** Search Results for VA

  - **TREATMENT ADVOCACY CENTER'S STATE ACTIVITY SUMMARIES: VIRGINIA**. http://www.psychlaws.org/StateActivity/Virginia.htm

  - **LETTER**: Mental Health System Cries for Reform. John Snook in the Richmond Times Dispatch. August 3, 2004. http://www.psychlaws.org/GeneralResources/article227.htm

- **VA CODE § 37.1-67.3: INVOLUNTARY ADMISSION AND TREATMENT.**

OTHER STATES

STATES SUPPORTING AOT

CALIFORNIA INFORMATION

- California Treatment Advocacy Coalition Fact Sheet: Assisted Outpatient Treatment. http://www.psychlaws.org/StateActivity/California/factsheet3.htm

- NAMI California's Position on May 18, 2005 MHSA Funding Guidelines issued by Department of Mental Health: Guidelines State MHSA Funding only Can be For Services "Voluntary" in Nature. May 31, 2004

- NAMI California Believes that Involuntary Services Are A Necessary Element of Mental Health Services Act (MHSA) Funding. May 12, 2005

MICHIGAN INFORMATION

- Press Release: Governor Granholm Signs Kevin's Law, Creates New Treatment Options for Mentally Ill. December 29, 2004. http://www.michigan.gov

- Key Aspects of Michigan's Kevin's Law, a Treatment Advocacy Center Briefing Paper. March 2005.

- The Beginning of Hope: Kevin's Law to Aid Mentally Ill. Treatment Advocacy Center News Release. March 30, 2005.

- Senate Bill Numbers 683, 684, 685, 686 (PA 496-497,498, 499). http://www.legislature.mi.gov

NEW JERSEY INFORMATION

- Governor's Task Force on Mental Health Recommends Assisted Outpatient Treatment for New Jersey. TAC News Release-Alicia Aebersold. March 31, 2005.

- Life in One of the Eight States of Despair: With no option for AOT, New Jersey families are fighting for a better law. TAC, Catalyst, Spring/Summer 2005

- Testimony of Cathy & Mark Kastnelson, Mariton, NJ before the Governor's Task Force on Mental Health., January 19, 2005

- Consequences Reduced, But not in New Jersey. Treatment Advocacy Center Briefing Paper. March 2005.

- Modernizing New Jersey's Civil Commitment Law. Treatment Advocacy Center Briefing Paper. March 2005.

- Senate Bill Number 1640, State of New Jersey, 211th Legislature: An Act concerning involuntary outpatient commitment, amending PL 1987, c.116 and PL1991, c.233 and supplementing Title 30 of the Revised Statutes. Introduced June 7, 2004, Sponsorship updated as of November 9, 2004.

NEW YORK INFORMATION

- Kendra's Law, A Final Report on the Status of Assisted Outpatient Treatment. New York State Office of Mental Health, March 2005.

- Assisted Outpatient Treatment Through Kendra's Law: A NAMI New York State White Paper, No Date.

- New York State's Assisted Outpatient Treatment (AOT) Program, Testimony by the New York State Conference of Local Mental Hygiene Directors. April 8, 2005

- Assisted Outpatient Treatment, Results from New York's Kendra's Law, Treatment Advocacy Center Briefing Paper, March 20, 2005.

- IOC in New York State: What Price Refusal (Part 1). Dennis B. Feld & Kim L. Darrow. National Association for Rights Protection & Advocacy. January 2005

- Kendra's Law, Not Ours, with Comments: McMan's Depression & Bipolar Web. Last comment October 10, 2004.

- Help & Hope for Families, Providers, Consumers: After 5 years of AOT, New Yorkers see vast improvements for the sickest. TAC Catalyst Spring/Summer 2005.

WEST VIRGINIA INFORMATION

- **WEST VIRGINIAS SB 191:** Creating a pilot AOT program in four-six judicial circuits under the direction of the Secretary of the Department of Health and Human Resources and the Supreme Court of Appeals. Signed into law May 2, 2005

STATES WITHOUT OR WITH LIMITED AOT LEGISLATION *(last updated December 2004)*
http://www.psychlaws.org/LegalResources/statechart.htm

- **California:** Separate outpatient standard only available in counties that have adopted provisions established through Assembly Bill 1421 (2002) (aka Laura's Law); otherwise mandated outpatient treatment only permitted via conservatorship process

- **Connecticut:** No AOT legislation, only inpatient legislation

- **Kentucky:** Allows only for a 60 day period of AOT and a possible 60 day renewal period that must be agreed to by all parties

- **Maine:** No AOT, only inpatient legislation

- **Maryland:** No AOT, only inpatient legislation

- **Massachusetts:** No AOT, only inpatient legislation

- **Nevada:** No AOT, only inpatient legislation

- **New Jersey:** No AOT, only inpatient ***(EFFORTS AT NEW LEGISLATION SINCE 12/04)***

- **New Mexico:** No AOT, only inpatient legislation

- **Tennessee:** No AOT, only inpatient legislation

TAC RESOURCES

- **TREATMENT ADVOCACY CENTER'S LEGISLATIVE AND POLICY COUNSEL, JOHN SNOOK, ESQ. TELEPHONE INTERVIEW 7/20/05: 703-294-6007**
  He presented to our TDO Task Force on April 22, 2004 (est). Has had some minimal discussion with someone at Hampton Roads CSB. They do get calls from VA families seeking assistance.

  OP Commitment law not widely used in VA. VA has a law on the books, but several issues cause it to be less effective. Law requires same level of dangerousness for OP commitment as for IP commitment.

  Believes VA law could be improved by clarifying standards under which people could be committed (is vague now, standard is same as inpatient) AND by better defining who in the system should do what (case management provided by treatment agencies or courts).

  Suggests we look at New York report and North Carolina research.

  He will send North Carolina peer-reviewed research which shows that in tests of enhanced treatment condition, court order condition, both and neither, it is the court order, NOT the enhanced treatment that makes the difference in compliance & improved outcomes. Conclude that court-ordered clients don't really need the enhanced PACT level of services to benefit. He recalled that they found 3 contacts a month for 180 days was the breakpoint…will send a copy of the research.

  Benefits: Allows courts and providers to provide least restrictive treatment environment. Helps with shortage of inpatient beds. Reduces costs, as commitment allows for increased duration of single treatment series, rather than costs associated with cycling individual through numerous crises at increased expense.

  Responding to question about those opposed (Bazelon 2001, broken links to IASPRS, Rehab groups, etc, mostly older articles): Process has been used more frequently and has gained greater acceptance…has fewer critics. Similar to history of community corrections evolving from strict alternative to incarceration to enhanced community support.

Responding to issues about treatment waiting lists: Florida's law has a provision that the court can't order to a treatment option that doesn't exist or isn't available. Says that in most states where the program works, treatment providers provide the case management/enforcement supervision.

- **TREATMENT ADVOCACY CENTER'S PREVENTABLE TRAGEDIES DATABASE:** http://www.psychlaws.org/

- **TREATMENT ADVOCACY CENTER'S STATE ACTIVITY SUMMARIES: VIRGINIA**. http://www.psychlaws.org/State Activity/Virginia.htm

- **TREATMENT ADVOCACY CENTER BRIEFING PAPERS**
    - Assisted Outpatient Treatment
    - Options for Assisted Treatment
    - What Happens When an Individual is Ordered to Accept Hospitalization or Medication?
    - What Percentage of Individuals with Severe Mental Illnesses are Untreated and Why?
    - Law Enforcement and People with Severe Mental Illness
    - Assisted Outpatient Treatment: Experiences from other states.

- Catalyst: Treatment Advocacy Center newsletter. http://www.psychlaws.org. Spring/Summer 2005. Family Advocates Issue

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Code of Virginia, § 37.2-808. *Emergency custody; Issuance and Execution of Order*. http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-808

Dukes, Franklin E. (1996) "Facilitation of Dialogue", in Franklin E. Dukes, *Resolving Public Conflict. Transforming Community and Governance*. Manchester: Manchester University Press. Pp. 62-75.

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http://mentalhealth.about.com/cs/schizophrenia/a/commit204.htm

Involuntary Psychiatric Hospitalization: Information for Petitioners. A brochure developed by the Fairfax-Falls Church Community Services Board.

Jackman, Tom (2006) *Commission Targets How State Treats Mentally Ill*. Washington Post, Wednesday, October 11, 2006, page B02

Joint Legislative Audit and Review Commission of the Virginia General Assembly (1994) *Review of the Involuntary Commitment Process* House Document No. 8, 1995 Session, p. 1 - http://jlarc.state.va.us/reports/rpt164.pdf

Judge David L. Bazelon Center for Mental Health Law (1997) *Issues Relating to Involuntary Outpatient Commitment and Alternatives*. Task Force Report pursuant to Public Act 96-215, Submitted on January 1, 1997. Washington, D.C.
http://www.narpa.org/task.force.report.htm

Maio, Harold A. (2004) Outpatient Commitment: A view from Another Bridge. February 23, 2004. Internet article.
http://mentalhealth.about.com/cs/legalissuesw/a/commitmaio_p.htm

Martin, Maurice and Lisa Labrecque (2006) Commentaries: Kendra's law for Albuquerque and N.M.? Perspectives for the idea and against the idea. Con: Maurice Martin and Lisa Labrecque. Pro: Mary Zdanowicz. *The Albuquerque Tribune*, September 6, 2006

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Services, Vol. 52, No. 9.
http://psychservices.psychiatryonline.org/cgi/reprint/52/9/1198

NAMI Northern Virginia (2006) *Quick Look Report,* NAMI Northern Virginia Study on consumer and family members views of involuntary commitment in Virginia. (Unpublished manuscript available from author)

Review of the Virginia Community Services Board Emergency Services Programs (2005). Report: #123-05 Prepared by Office of the Inspector General For Mental Health, Mental Retardation And Substance Abuse Services James W. Stewart, III Inspector General http://www.oig.virginia.gov/documents/SS-ESPFinalReportMay-August2005.pdf

Swartz, Marvin S., MD, and Jeffrey W. Swanson, PH.D. (2004) "Involuntary Outpatient Commitment, Community Treatment Orders & Assisted Outpatient Treatment: What's in the Data" *Canadian Journal of Psychiatry*, Vol. 49, No. 9, September 2004.