Early Impact Analysis of 2008 Revisions to Virginia's Civil Commitment Laws

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CONTENTS

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ACRONYMS & ABBREVIATIONS

ECO: Emergency Custody Order

TDO: Temporary Detention Order

MOT: Mandatory Outpatient Treatment

CSB: Community Services Board

DMHMRSAS, or the Department: Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services

DPB: Virginia Department of Planning and Budget

EXECUTIVE SUMMARY

During the 2008 legislative session, the Virginia General Assembly passed a set of comprehensive reforms of the state's civil commitment statutes designed to remedy problems that came to light following the April 2007 shootings at Virginia Tech. These reforms included:

- A revision of the civil commitment standard;
- Detailed procedures for implementing and monitoring mandatory outpatient treatment orders;
- A provision for the renewal of emergency custody orders;
- A reduction of the initial inpatient commitment period from 180 days to 30 days;
- A certification requirement for some independent examiners;
- A requirement of community services board (CSB) attendance at all commitment hearings; and
- Expanded authorization for the use of two-way audiovisual communication technology for examinations and hearing appearances.

This report represents a preliminary budget impact analysis of these statutory changes, and addresses the following policy questions:

- Have the 2008 revisions to Virginia's civil commitment standard resulted in a change in the number of persons committed or temporarily detained?
- How is mandatory outpatient treatment being used, and how does this impact the Commonwealth's budget?
- How have the requirements of CSB attendance at commitment hearings, the reduction of the initial commitment period, and other key procedural changes affected workloads for CSBs, state hospitals, and other participants in the commitment process?

In order to evaluate the fiscal impact of the statutory revisions, we used the 2008 Fiscal Impact Statement as a baseline for comparison. The fiscal impact statement estimated increases in costs for CSBs due to hearing attendance and mandatory outpatient treatment services. It also recognized that costs could change with changes in ECOs, TDOs, hearings, and commitments that may result from the mental health law reform, but did not quantify an estimate for those changes. The total projected fiscal impact of the mental health law reform came to $7.1 million. To evaluate the accuracy of this original estimate, we used case studies of community services boards, a literature review, available data on civil commitment proceedings, and analyses of proposed spending provided by the community services boards.

Case Studies

Our case studies were based on structured qualitative interviews of a stratified sample of community services boards. While our case studies shed light on several consistent concerns and observations shared by community services boards across the state, two observations were particularly relevant.

Mandatory outpatient treatment is not used more extensively: Estimates of the law reform's impacts indicated that usage of MOT could increase by as much as 3,750 consumers per year. Our case studies do not support a substantial increase in MOT, which could have significant ramifications for the budget.

The capacity for inpatient treatment is not adequate for some boards across the state: Finding bed space in state and private hospitals is a challenge for several boards in our case study. Given that initial estimates of the law reform's impacts pointed to a potential increase in demand for mental health services, a small supply of available space and resources for services could nullify any expected increase in demand. This may have significant ramifications for future impacts of Virginia's mental health law reform. If, for example, demand for mental health services is ultimately a function of supply (supply being institutional capacity), then community services boards will only be able to provide help for those consumers they can accommodate. Thus, even if more consumers meet reformed commitment criteria, the number of consumers served by the system may not reflect the true, total population of consumers in need of help; instead, it will reflect what the system can handle.

Fiscal Analysis and Conclusions

Based upon the case studies, data analysis, and literature review, the following findings constitute the main conclusions of our report:

Some costs associated with the mental health law reform were not included in the initial estimate: The initial fiscal impact statement accounted for costs related to the need for CSBs to attend all hearings and to the provision of mandatory outpatient services. The estimates for demands created by hearing attendance were accurate. Mandatory outpatient orders have not been as numerous as expected. At the same time, several costs have resulted from the law reforms that were not included in the fiscal impact statement.

First, there have been significant costs associated with increased paperwork, data collection, and data reporting. This creates costs for community services boards, independent evaluators, and the court system. Second, more frequent recommitment hearings impose costs on CSBs, hospitals, and other stakeholders. Finally, new responsibilities placed on special justices for mandatory outpatient treatment increase their responsibility and time commitment without an increase in compensation.

Expected costs associated with mandatory outpatient treatment may not be incurred: It is still too early to tell how much mandatory outpatient treatment will be utilized, but so far there have been very few MOT orders after the mental health law reform. Unless major policy changes are implemented to facilitate and encourage the use of MOT, the actual increase in MOT usage will likely be far below the original estimate. Our literature review echoes the experiences in Virginia and the reasons CSBs cite for the lack of MOT orders, strengthening the projection that MOT utilization will likely remain low (less than .5% of all hearing dispositions).

Commitments are likely more of a function of funding and institutional capacity than statutory language: The literature review, reports from community services boards, and data analysis all point to the possibility that the numbers and types of commitment orders issued are more a

function of institutional capacity and funding than of the language of the civil commitment standard. Institutional capacity in Virginia's mental health system has not significantly increased. In fact, many CSBs reported difficulty finding necessary inpatient beds and funding for medication. The ability of community and state facilities to provide certain inpatient and outpatient services also affects the special justices' decisions regarding commitment.

There are no evident changes in ECOs, TDOs, hearings, or dispositions since July 1, 2008, but more data are needed before any conclusions can be reached: According to the data that were available, there have been no significant changes in the numbers of ECOs, TDOs, or hearings, or the breakdown of commitment dispositions since the statutory changes went into effect. Some small changes that may be significant given data covering more time include a potential increase in TDOs and the development of a greater proportion of involuntary commitments relative to voluntary admissions.

The availability of data to reveal changes in civil commitment proceedings since July 1, 2008 is very limited. The only baseline data available for several indicators are from May 2007. In addition to this limitation, at the time of this study, only preliminary data from the first quarter following the implementation of the statutory changes were available. Due to seasonal trends in service provision, an entire year's worth of data would be required in order to conduct a complete evaluation of the impact of the statutory revisions.

Questions for Future Study

During the course of our study, several policy questions surfaced that were beyond the scope of our analysis but may warrant further study. These issues include:

- Usefulness of mandatory outpatient treatment
- Availability of inpatient bed space
- Availability of medication funding
- Reimbursement rates for independent evaluators and special justices.

I. INTRODUCTION

On April 16, 2007, Virginia Tech student Seung Hui Cho shot 32 students and faculty to death before turning the gun on himself.[1] Two years earlier, a judge had found that Cho suffered from a mental illness which posed a danger to himself or to others, and had ordered him to undergo outpatient treatment. Cho, however, had only showed up for a single appointment.[2] The shootings brought Virginia's mental health care system into the national spotlight.[3] The attention of the national media, policymakers, the panel convened by Governor Tim Kaine to investigate the shootings, and the state judicial branch's Commission on Mental Health Law Reform focused on a general lack of funding for mental health services in the Commonwealth, hospital bed shortages, a lack of available evidence at commitment hearings, and difficulties in enforcing court-ordered outpatient treatment regimes. There was also concern that Virginia's standard for civil commitment was unclear and overly narrow, making it difficult for judges to order the hospitalization of many seriously ill individuals. The standard was also interpreted unevenly throughout the state.[4] In response to these concerns, the Virginia General Assembly enacted a number of mental health reforms during its 2008 session.[5]

This report presents a preliminary budget impact analysis of the 2008 omnibus mental health law bill.[6] The bill's key provisions include:

- A revision of the civil commitment standard;
- Detailed procedures for implementing and monitoring mandatory outpatient treatment orders;
- A provision for the renewal of emergency custody orders;
- A reduction of the initial inpatient commitment period from 180 days to 30 days;
- A certification requirement for some independent examiners;
- A requirement of community services board (CSB) attendance at all commitment hearings; and
- Expanded authorization for the use of two-way audiovisual communication technology for examinations and hearing appearances.

This report draws upon the following sources of information:

- Structured qualitative interviews with representatives of ten CSBs and one state hospital;
- The omnibus mental health law bill's original fiscal impact statement;

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[1] VIRGINIA TECH REVIEW PANEL, MASS SHOOTINGS AT VIRGINIA TECH 1 (2007).
[2] *Id*. at 58-59.
[3] *See, e.g.*, Brigid Schulte & Chris L. Jenkins, Cho Didn't Get Court-Ordered Treatment, WASH. POST, May 7, 2007, at A01; Chris L. Jenkins, *Cho Case Shows Flaws in System, Court Panel Says*, WASH. POST, June 23, 2007, at B2.
[4] Jenkins, *supra* note 3.
[5] *See* VA. DEP'T OF MENTAL HEALTH, MENTAL RETARDATION & SUBSTANCE ABUSE SERV., 2008 LEGISLATIVE REPORT: MENTAL HEALTH RELATED BILLS (2008), http://www.dmhmrsas.virginia.gov/OMH-MHReform/2008LegSummary.pdf [hereinafter LEGISLATIVE REPORT].
[6] H.B. 499/S.B. 246, Gen. Assemb., 2008 Sess. (Va. 2008).

- Proposed CSB budgets for additional appropriations made during the 2008 legislative session;
- Caseload data provided by the Virginia Supreme Court and the Commission on Mental Health Law Reform; and
- A review of the literature analyzing the impact of revisions to other states' civil commitment statutes.

This report addresses the following policy questions:

- Have the 2008 revisions to Virginia's civil commitment standard resulted in a change in the number of persons committed or temporarily detained?
- How is mandatory outpatient treatment being used, and how does this impact the Commonwealth's budget?
- How have the requirement of CSB attendance at commitment hearings, the reduction of the initial commitment period, and other key procedural changes affected workloads for CSBs, state hospitals, and other participants in the commitment process?

Section II of this report presents a brief overview of Virginia's public mental health care system. Section III explores the statutory revisions and their potential impacts on the Commonwealth's budget. Section IV summarizes the findings from the structured qualitative interviews of CSB representatives. Section V presents a detailed qualitative analysis of the fiscal impact of the omnibus mental health law bill. Section VI explains the revised assumptions and summarizes the conclusions of the study. Finally, Section VII lists key policy issues that merit further consideration.

II. VIRGINIA'S PUBLIC MENTAL HEALTH CARE SYSTEM

The Commonwealth's public mental health care system is supervised by the Department of Mental Health, Mental Retardation and Substance Abuse Services (hereinafter the Department). The two principal components of this system are local community services boards (CSBs) and state hospitals. Many citizens of the Commonwealth also receive mental health care services outside of the publicly funded system, through private hospitals and practitioners.

Community Services Boards: Together, Virginia's 40 local community services boards serve as the single point of entry into the public mental health care system.[7] CSBs are required by law to provide emergency mental health services.[8] They may also provide inpatient services, outpatient and case management services, day support services, residential services, and prevention and early intervention services for mental illness, intellectual disabilities, and substance abuse.[9] Most CSBs function as agents of the local governments that originally established them, but do not constitute departments of those local governments.[10] The Department distributes federal and state funding and provides oversight to all 40 CSBs through performance contracts.[11] CSBs are also authorized to charge fees for the services they provide and to raise funds from other sources.[12] In fiscal year 2006, a total of 118,732 consumers received mental health services through CSBs.[13]

State Hospitals: In Virginia, private and community hospitals provide the majority of inpatient mental health services. Consumers[14] who are difficult to place in private and community hospitals for reasons such as a lack of health insurance or Medicaid coverage or a history of violence may receive inpatient treatment at one of Virginia's ten state mental health facilities. These facilities include seven mental health facilities, specialized pediatric and geriatric psychiatric hospitals, and a behavioral rehabilitation center.[15] In fiscal year 2007, more than 5,900 consumers were treated at state mental health facilities, with an average daily census of 1,511.[16]

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[7] VA. CODE ANN. § 37.2-500 (2008). In this report, the term "Community Services Board" also includes Behavioral Health Authorities and local government departments with policy advisory CSBs. *See* VA. DEP'T OF MENTAL HEALTH, MENTAL RETARDATION & SUBSTANCE ABUSE SERV., 2007 OVERVIEW OF COMMUNITY SERVICES DELIVERY IN VIRGINIA 2 (2007), http://www.dmhmrsas.virginia.gov/documents/reports/OCC-CSB-Overview2007.pdf [*hereinafter* 2007 CSB OVERVIEW].

[8] VA. CODE ANN. § 37.2-500 (2008).

[9] Va. Dep't of Mental Health, Mental Retardation & Substance Abuse Serv., Community Services Boards, http://www.dmhmrsas.virginia.gov/SVC-CSBs.asp (last visited Nov. 21, 2008).

[10] 2007 CSB OVERVIEW, *supra* note 7, at 2.

[11] VA. CODE ANN. § 37.2-508 (2008).

[12] VA. CODE ANN. § 37.2-504 (2008).

[13] 2007 CSB OVERVIEW, *supra* note 7, at 23.

[14] VA. CODE ANN. § 37.2-100 (2008) defines a "consumer" as "a current direct recipient of public or private mental health … treatment or habilitation services." The term "consumer" will be used throughout this report to refer to voluntary and involuntary patients in Virginia's public and private mental health care systems.

[15] Va. Dep't of Mental Health, Mental Retardation & Substance Abuse Serv., State Facilities, http://www.dmhmrsas.virginia.gov/SVC-StateFacilities.htm (last visited Nov. 21, 2008).

[16] STAFF OF VA. S. FINANCE COMM., FUNDING FOR VIRGINIA'S MENTAL HEALTH SERVICES 16 (2007).

Involuntary Admissions

Consumers who do not consent, or are unable to consent, to inpatient admission for diagnosis and treatment are subject to judicially ordered temporary detention and long-term commitment. Virginia law also provides for court-ordered mandatory outpatient treatment. All forms of involuntary admission are governed by the same legal standard. Figure 1 provides a visual overview of the involuntary admissions process.

Emergency custody order (ECO): An emergency custody order (ECO) is issued by a magistrate and authorizes law enforcement to take a consumer into custody for preliminary evaluation by a CSB designee. The purpose of the evaluation is to determine whether the consumer meets the requirements for temporary detention and to assess the need for hospitalization or treatment. Prior to July 1, 2008, a consumer could be held under an ECO for up to four hours.[17]

Temporary detention order (TDO): A temporary detention order (TDO) allows for the detainment of a consumer in a medical facility for a detailed examination by an independent evaluator and the completion of a preadmission screening report in preparation for a commitment hearing. Treatment may also be initiated in order to stabilize the consumer's condition and avoid the potential for involuntary commitment. A TDO is typically issued after the consumer's preliminary evaluation (voluntary or involuntary) by a CSB designee, but an ECO is not a prerequisite to a TDO. The consumer may be held under a TDO for up to 48 hours, or longer if the 48-hour period expires during a weekend or legal holiday.[18]

Inpatient commitment: If a consumer presents a danger to himself or to others, is unable to care for himself, and/or is unlikely to comply with less restrictive treatment options, a special justice may order the consumer to be committed for inpatient treatment.[19] Prior to the commitment hearing, the consumer must be examined by an independent evaluator,[20] and the consumer's local CSB must complete a preadmission screening report including recommendations for care and placement.[21] The consumer has a statutory right to legal representation at the commitment hearing.[22]

Mandatory outpatient treatment (MOT): If the consumer meets the standard for inpatient commitment but is willing and able to comply with court-ordered outpatient treatment, the special justice may order mandatory outpatient treatment (MOT) in lieu of inpatient commitment.[23] The consumer's local CSB is responsible for monitoring compliance with the MOT order.[24]

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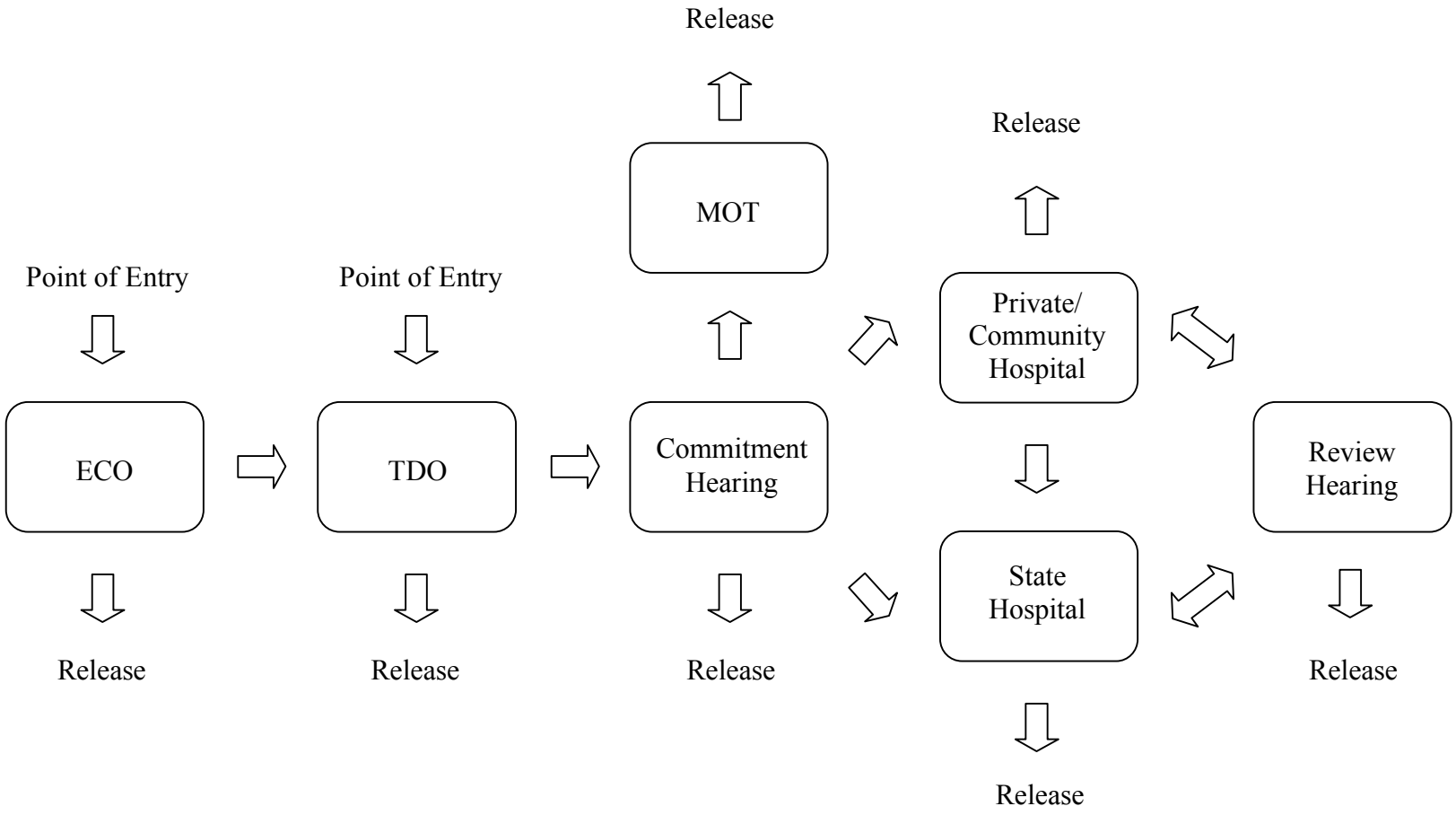
[17] VA. CODE ANN. § 37.2-808.
[18] VA. CODE ANN. § 37.2-809 (2008).
[19] VA. CODE ANN. § 37.2-817(C) (2008).
[20] VA. CODE ANN. § 37.2-815 (2008).
[21] VA. CODE ANN. § 37.2-816 (2008).
[22] VA. CODE ANN. § 37.2-814(C) (2008).
[23] VA. CODE ANN. § 37.2-814(D) (2008).
[24] VA. CODE ANN. § 37.2-817.1 (2008).

FIGURE 1. INVOLUNTARY ADMISSIONS FOR MENTAL HEALTH TREATMENT IN VIRGINIA



III. SUMMARY OF 2008 STATUTORY REVISIONS

In response to numerous concerns with Virginia's civil commitment process raised by the Virginia Tech Review Panel and the Commission on Mental Health Law Reform's Task Force on Civil Commitment, state legislators introduced dozens of bills during the 2008 General Assembly session.[25] The omnibus mental health reform bill, which includes provisions from 23 other bills, was implemented on July 1, 2008 and represents the most significant potential budgetary impact of the bills enacted.[26] The key provisions of the omnibus bill are a revision of the civil commitment standard, an expansion of the procedures associated with mandatory outpatient treatment, and several other procedural changes. Table 1 summarizes these changes and their potential budgetary impacts.

TABLE 1. KEY 2008 REVISIONS TO VIRGINIA'S MENTAL HEALTH LAW

Statutory change	Potential budgetary impact
Revised civil commitment standard ***Old*: Imminent danger to self or others, or substantially unable to care for self** ***New*: Substantial likelihood of physical harm to self or others in near future, or substantial likelihood of serious harm due to lack of capacity to protect self or provide for basic needs**	Increases costs if interpreted more broadly
Clearer MOT procedures and enhanced monitoring	Reduces costs if MOT is substituted for inpatient commitment Increases costs if MOT is ordered for patients who would not otherwise be committed
2-hour ECO renewal	Little impact
Reduction of initial commitment period from 180 to 30 days	Increases costs if recommitment proceedings are more frequent
Certification of some independent examiners	Increases administrative and training costs
CSB attendance at commitment hearings required	Increases costs for CSBs not previously attending all hearings
Video examinations and CSB appearances permitted	Expenditures for equipment and training, if used May reduce CSB personnel costs

[25] *See* LEGISLATIVE REPORT, *supra* note 5.
[26] H.B. 499/S.B. 246, Gen. Assemb., 2008 Sess. (Va. 2008).

Is the Revised Civil Commitment Standard Broader or Clearer?

The focal point of the 2008 effort to reform Virginia's mental health law was a revision of the civil commitment standard. Under the original standard, a consumer could be committed if a special justice found clear and convincing evidence that "the person presents an imminent danger to himself or others as a result of mental illness or has been proven to be so seriously mentally ill as to be substantially unable to care for himself."[27] As of early 2008, Virginia was one of just five states in the nation still employing the restrictive "imminent danger" standard.[28]

Both the Virginia Tech Review Panel and the Task Force on Civil Commitment found the "imminent danger" standard to be ambiguous and subject to inconsistent interpretation. Mental health service professionals and special justices interviewed by the Virginia Tech Review Panel reported that the "imminent danger" standard "is not clearly understood and is subject to differing interpretations," and suggested that the standard be revised to require "'a substantial likelihood' or 'a significant risk' that the person will cause serious injury to himself or others 'in the near future.'"[29] Similarly, the Task Force on Civil Commitment noted that there was disagreement even amongst its own members as to the time horizon for the anticipated harm implied by the word "imminent:" some equated "imminent" with "immediate," arguing that commitment was only possible if the anticipated harm would occur within a matter of hours, while others believed the time horizon was somewhat longer.[30]

The Virginia Tech Review Panel also found that the "imminent danger" standard was too restrictive and did not allow for commitment in some cases of "serious illness accompanied by substantial impairment of cognition, emotional stability, or self-control."[31] The Panel recommended that the standard for involuntary commitment "be modified in order to promote more consistent application of the standard and to allow involuntary treatment in a broader range of cases involving severe mental illness."[32] The Task Force on Civil Commitment, on the other hand, was unable to reach a consensus on whether to broaden the standard, or to formulate a single recommendation on how to address the standard's inherent ambiguity.[33]

The omnibus mental health bill imposes a new standard under which the consumer may be committed if he has a mental illness and there is a substantial likelihood that, as a result of mental illness, he will, in the near future, either

> (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or;
> (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs.[34]

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[27] VA. CODE ANN. § 37.2-817 (2007) (amended 2008).
[28] JANE D. HICKEY, VA. OFFICE OF THE ATT'Y GEN., CIVIL COMMITMENT CRITERIA 3 (2008), http://www.dmhmrsas.virginia.gov/OMH-MHReform/080604Hickey.pdf.
[29] VIRGINIA TECH REVIEW PANEL, *supra* note 1, at 56.
[30] VA. COMM'N ON MENTAL HEALTH LAW REFORM, REPORT OF THE TASK FORCE ON CIVIL COMMITMENT 66 (2008).
[31] VIRGINIA TECH REVIEW PANEL, *supra* note 1, at 56.
[32] *Id.* at 60.
[33] VA. COMM'N ON MENTAL HEALTH LAW REFORM, *supra* note 30, at 68-78.
[34] VA. CODE ANN. § 37.2-817(C) (2008).

The temporal requirement that harm must be anticipated "in the near future" replaces the ambiguous term "imminent danger," but the "near future" is not precisely defined. "Danger" is replaced by the more specific "physical harm." The new standard also adds an evidentiary requirement of "recent behavior" indicating likelihood that the consumer poses a danger to himself or others; this evidence may be supplemented by other evidence, including past behavior.

From the statutory language alone, it is difficult to determine whether the new standard will be interpreted either more uniformly or more broadly than the previous standard. If magistrates and special justices are in fact interpreting the standard more broadly, a larger number of ECOs, TDOs, civil commitment orders, and MOT orders will be issued, increasing caseloads for CSBs and state hospitals. A broader interpretation of the civil commitment criteria can also be expected to increase the total number of petitions for both temporary and commitment orders, increasing state costs for magistrates, special justices, independent examiners, CSB pre-screeners, appointed counsel, state hospital personnel, and other participants in the judicial process.

Mandatory Outpatient Treatment Procedures Are More Clearly Defined

The shootings at Virginia Tech brought Virginia's existing provisions for mandatory outpatient treatment under intense scrutiny. At his commitment hearing, Cho was ordered by the special justice to comply with outpatient treatment, but the order merely stated that Cho was "to follow all recommended treatments," and contained no information on what specific treatment was to be provided, who was to monitor the treatment, or how the plan was to be enforced. Cho attended a triage appointment at the campus counseling center following his commitment hearing, but never returned for further treatment. The counseling center maintains that it had no notice of the court order for outpatient treatment; even if there *was* notice, the counseling center had no legal obligation to report Cho's failure to continue treatment to the court.[35]

Prior to the 2008 revisions, the MOT statute permitted special justices to order involuntary outpatient treatment in lieu of inpatient commitment and designated monitoring responsibility to CSBs, but did not specify the duration of MOT orders, require treatment providers to be informed of the existence of an MOT order, require the monitoring CSB to report noncompliance, or provide an enforcement mechanism.[36] In order to be eligible for MOT, the patient had to meet the criteria for civil commitment and, at the same time, be sufficiently competent "to understand the stipulations of his treatment," express an interest in living in the community, and be capable of complying with the treatment plan. In addition, the special justice had to determine that outpatient treatment was appropriate and that the CSB or another designated provider had the capacity to provide the treatment.[37] Because only a small number of patients who were ill enough to qualify for inpatient commitment were still capable of complying with MOT orders, monitoring and enforcement provisions were virtually nonexistent, and few

[35] VIRGINIA TECH REVIEW PANEL, *supra* note 1, at 58-59.
[36] VA. CODE ANN. § 37.2-817.C (2007) (amended 2008).
[37] *Id.*

CSBs had sufficient resources to support MOT orders, the MOT option was rarely if ever used.[38] The Virginia Tech Review Panel recommended that the MOT statute

> … be amended to clarify—
> - the need for specificity in involuntary outpatient orders.
> - the appropriate recipients of certified copies of orders.
> - the party responsible for certifying copies of orders.
> - the party responsible for reporting non-compliance with outpatient orders and to whom noncompliance is reported.
> - the mechanism for returning the noncompliant person to court.
> - the sanction(s) to be imposed on the noncompliant person who does not pose an imminent danger to himself or others.
> - the respective responsibilities of the detaining facility, the CSB, and the outpatient treatment provider in assuring effective implementation of involuntary outpatient treatment orders.[39]

The Task Force on Civil Commitment was hesitant to recommend that MOT usage be expanded, but agreed that MOT standards and procedures must be clarified before the implementation of any policy to encourage the use of MOT.[40]

The omnibus bill incorporates extensive language clarifying the procedures surrounding MOT. Its key provisions include:

- MOT cannot be ordered unless "providers of the services have actually agreed to deliver the services."
- The CSB must present a detailed mandatory outpatient treatment plan meeting specific requirements.
- The duration of the initial MOT order may not exceed 90 days. The order may subsequently be continued for 180 days.
- Service providers are required to report material noncompliance to the monitoring CSB, and the CSB must report material noncompliance to the court.
- Material noncompliance triggers a review hearing during which the special justice may order involuntary commitment, modify the MOT order, or rescind the MOT order as appropriate.
- Formal procedures are established for the review and rescission of MOT orders.[41]

In conjunction with the revised civil commitment standard, the new MOT provisions may increase the use of MOT. If MOT is used as a direct substitute for inpatient commitment, significant budgetary savings may result. If used to support follow-up care after release from inpatient commitment, MOT may also prevent patients from deteriorating and requiring subsequent recommitment. On the other hand, if special justices interpret the new civil commitment standard more broadly and begin ordering MOT for patients who would formerly

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[38] VA. COMM'N ON MENTAL HEALTH LAW REFORM, *supra* note 30, at 80-82.
[39] VIRGINIA TECH REVIEW PANEL, *supra* note 129, at 61.
[40] VA. COMM'N ON MENTAL HEALTH LAW REFORM, *supra* note 30, at 82-85.
[41] VA. CODE ANN. §§ 37.2-817(D)-(K), 37.2-817.1 (2008).

have been released without any court order, resource demands will increase. If, however, CSBs are unwilling or unable to support MOT orders or special justices remain hesitant to order MOT, the changes to the MOT statute will have little effect on the Commonwealth's budget.

Key Procedural Changes May Have Budgetary Impacts

An ECO may be renewed for two additional hours: To accommodate cases in which CSB personnel require additional time to evaluate the consumer and arrange a TDO placement, the Task Force on Civil Commitment recommended that magistrates be permitted to order a four-hour extension of the initial four-hour ECO period upon a showing of good cause.[42] The revised statute permits a two-hour ECO extension for good cause.[43] Because magistrates are paid on a per-case basis rather than by the hour, ECO extension proceedings should not increase expenditures for magistrates. There may be costs to the court system associated with tracking the renewal orders, and CSB personnel may expend additional time petitioning for ECO renewals and possibly conducting more detailed pre-screening evaluations or investigating TDO placement options in more depth. These costs, however, are likely to be minimal.

The initial commitment period is reduced to 30 days: In accordance with the recommendation of the Task Force on Civil Commitment,[44] the omnibus bill reduces the maximum duration of an initial inpatient commitment from 180 days to 30 days.[45] Subsequent orders may still be up to 180 days in duration.[46] If this provision causes an increase in the number of recommitment hearings, all participants (including the court system, CSBs, and state hospitals) will realize an increase in costs.

Some independent examiners must be certified: Under previous law, if a psychiatrist or psychologist was unavailable, the independent examination could be conducted by "any mental health professional who is (i) licensed in Virginia through the Department of Health Professions and (ii) qualified in the diagnosis of mental illness."[47] No specific certification was required of independent examiners. The omnibus bill specifies that an independent evaluator other than a psychiatrist or psychologist must be a "clinical social worker, professional counselor, psychiatric nurse practitioner, or clinical nurse specialist" who is "qualified in the assessment of mental illness" and has completed a certification program approved by the Department. This new certification requirement is not expected to increase expenditures for the evaluations themselves, but may be associated with administrative and training costs to the Department and the court system.

CSB representatives must attend commitment hearings: The Virginia Tech Review Panel expressed concern that very little evidence was available to the special justice at Cho's commitment hearing and that no CSB representative attended it.[48] It recommended that the CSB pre-screener or another CSB representative be required to attend every commitment hearing, and

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[42] VA. COMM'N ON MENTAL HEALTH LAW REFORM, *supra* note 30, at 21-24.
[43] VA. CODE ANN. § 37.2-808(H) (2008).
[44] VA. COMM'N ON MENTAL HEALTH LAW REFORM, *supra* note 30, at 53-54.
[45] VA. CODE ANN. § 37.2-817(C) (2008).
[46] *Id.*
[47] VA. CODE ANN. § 37.2-815(A) (2007) (amended 2008).
[48] VIRGINIA TECH REVIEW PANEL, *supra* note 1, at 56-58.

that certain records be presented at the hearing.[49] The Task Force on Civil Commitment also recommended that CSB representatives be required to attend commitment hearings.[50] In accordance with these recommendations, the omnibus bill requires a CSB representative to attend the commitment hearing.[51] Because less than half of CSBs previously sent representatives to all commitment hearings in their jurisdictions, and nearly one-quarter did not attend any commitment hearings,[52] the new requirement is expected to result in a significant need for more CSB staff.

Two-way audiovisual communication systems may be used for examinations and hearings: Finally, the omnibus bill permits the use of two-way audiovisual communication systems for pre-screening and independent examinations as well as for CSB appearances at commitment hearings. Although such appearances were previously permitted for parties and witnesses at commitment hearings,[53] the new statute explicitly authorizes two-way video appearances for CSB representatives,[54] and expands the use of this technology to pre-screening[55] examinations.[56] If two-way videoconferencing is used, costs will be incurred to purchase and operate the equipment and to train users, but these costs may be offset in the long run by savings in travel and time for CSB representatives.

[49] *Id.* at 61.
[50] VA. COMM'N ON MENTAL HEALTH LAW REFORM, *supra* note 30, at 131.
[51] VA. CODE ANN. §37.2-817(B) (2008).
[52] VA. COMM'N ON MENTAL HEALTH LAW REFORM, *supra* note 30, at 47.
[53] VA. CODE ANN. §37.2-804.1 (2008).
[54] VA. CODE ANN. §37.2-817(B) (2008).
[55] VA. CODE ANN. §809(B) (2008).
[56] VA. CODE ANN. §37.2-815(B) (2008).

IV. Case Studies of Community Services Boards

The following section outlines the commonly observed impacts the statutory revisions to civil commitment have had on a sample of the community services boards in Virginia. These observations are presented within the context of the initial estimates of the revised statute's impact made by the Department and the Virginia Department of Planning and Budget (DPB).

At the onset of our analysis, specific numerical data on commitments and caseloads were not readily available. Given the data collection efforts of the Department and the significant reporting demands already placed on the community services boards, we did not want to duplicate these efforts or add to the demand on CSBs. Instead, we determined that case studies of a sample of community services boards would be the best means of painting a picture of the reform's impact on the primary organizations implementing these new policies. Such a picture would effectively highlight their major areas of concern and eventually serve as a useful companion document to the Department's own impact analysis.

Methodology

We utilized a stratified sampling technique to draw the sample for our case studies. Each stratum consisted of all community services boards of a given budget size. We chose to classify CSBs according to budget size because budget size best reflects a board's service capacity. Our sample itself included six large budget boards, two medium budget boards, and two small budget boards. Each case study is a summary of a structured qualitative interview conducted either in person or via conference call. For two boards, we used e-mail surveys. For most interviews, both the Executive Director of the board and emergency services personnel were present. The interviews were structured to allow the CSBs to answer questions by topic area and to comment on any developments that have resulted from the statutory changes.

Expected Impact of Statutory Revisions

When the General Assembly revised the civil commitment criteria in Virginia, a number of tentative assumptions were made about the future impact on community services boards and the state budget. Three of these assumptions are especially relevant to our analysis. In their 2008 Fiscal Impact Statement (available in Appendix A), the Department and DPB estimated the statutory revision's impacts based on the following assumptions:

Assumption #1: If the civil commitment criteria are interpreted more broadly in practice, then this might increase the demand for local and state hospital inpatient beds. However, DPB and the Department estimated that any potential increase in demand for inpatient beds could be reasonably offset by use of mandatory outpatient treatment and the addition of new crisis stabilization beds and emergency psychiatric services proposed in the Governor's FY 2008-2010 biennial budget.

Assumption #2: The new requirement to attend all hearings in a board's jurisdiction may increase the costs incurred by community services boards that have not previously attended all commitment hearings in their jurisdiction. In their Fiscal Impact Statement, analysts noted that staffing levels in these boards were the most significant barriers to hearing attendance. It

speculated that all boards, even those that had previously attended all hearings, would require at least two additional case managers.

Snapshot: Bed Space at a Small Budget Community Services Board

This board must severely ration beds in state facilities in order to have space for the individuals who need it the most. Private providers will turn away people with violence in their profile; this board often gets law enforcement to hold such individuals until a bed can be made available.

Assumption #3: The statutory revisions to the civil commitment criteria may increase the use of mandatory outpatient treatment. Some communities did not have the capacity to implement and enforce MOT treatment plans prior to the changes in the law, so DPB and the Department were not sure if MOT would be ordered more frequently in all jurisdictions. They estimated a maximum increase of 3,750 consumers ordered into MOT per year, creating about 700 new service hours of work per board per year.

Observed Impact of Statutory Revisions

Below is a synopsis of the initial impacts the revisions to civil commitment in Virginia have had on our sample. These impacts are compared to the estimates in the Fiscal Impact Statement.

Evaluation of Assumption #1: The demand for local and state hospital inpatient beds has not increased substantially for the boards in our sample; despite this, most community services boards in our sample have trouble reserving bed space for their consumers.

Most of the boards in our sample saw little change in the number of consumers ordered into temporary detention or emergency custody. Two boards saw a decrease in the number of ECOs and TDOs in their jurisdictions; representatives from one of these boards believed that TDOs decreased in their region because of the lack of available hospital beds and their preference for providing less restrictive treatment alternatives, such as crisis stabilization, for their consumers. Two boards saw a slight increase in the number of TDOs and ECOs in their jurisdictions, but both these boards were hesitant to attribute that increase to the statutory changes. Instead, representatives from these boards explained these increases by recent increases in population and previously observed seasonal patterns.

Snapshot: Bed Space at a Large Budget Community Services Board

Reserving bed space for consumers is a problem for this board, especially when it comes to temporary detentions. Private hospitals in particular do not want to accept a consumer if he or she is violent. This board generally looks to its state psychiatric hospital to serve as a safety net and option of last choice. Currently, 25 percent of consumers at this state hospital have health insurance. Additionally, due to an increase in private hospital per diem rates, this board is projected to run out of Local Inpatient of Service funds in March of 2009.

Despite this relatively constant demand for bed space, several of the boards in our sample described having to call throughout the state from time to time to find a bed for a consumer in crisis. This is particularly problematic because if a consumer is hospitalized two hours away, for example, attending his hearing is very difficult. Bed space in state hospitals often has to be severely rationed in order to make it available for those consumers who need it the most. Bed space is particularly difficult to reserve in private hospitals. Private hospitals often turn away consumers with violence in their profiles, making it difficult to detain these individuals. Several of the boards in our sample were concerned about funding for the Local Inpatient Purchase of Service (LIPOS)

program.[57] One board used to be able to buy bed space for a consumer for a full 30 days. Now, it can only afford to buy bed space for a consumer for four days.

Snapshot: Mandatory Outpatient Treatment at a Medium Budget Community Services Board:

This board has seen an increase in new consumers as a result of the broader commitment criteria. However, since this board's staff does not know these new consumers, they do not feel comfortable ordering them into a treatment regimen where they have little ability to monitor them. This board also does not have a PACT team, which would make monitoring of even the consumers they know well much easier. The representatives we interviewed believed that the most useful time for MOT would be after discharge from inpatient treatment. That, however, may require loosening the criteria for MOT relative to inpatient commitment.

Evaluation of Assumption #2: The new requirement to attend all hearings has created a sizeable increase in workload for roughly half of the community services boards in our sample. In addition, attendance at re-commitment/certification hearings has created significantly more work for several boards. While staffing levels do seem to be the most direct obstacle to hearing attendance, not all boards have hired new staff members to handle this responsibility. Some have hired one new staff member solely to attend hearings. Other boards have opted to spend their money to hire staff members in other areas of need or to increase their general service capacity.

Evaluation of Assumption #3: None of the boards in our sample saw a substantial increase in the use of MOT in their jurisdictions. They either saw no orders for MOT after July 1st, 2008, similar numbers of MOT orders as they had prior to that same time period, or a slight increase in the number of orders for MOT relative to previous years. Many explanations for the lack of orders for MOT were put forth by the representatives we interviewed. The most commonly cited reasons are as follows:

- *Inpatient and outpatient criteria are the same:* Almost all of the board representatives we interviewed told us that special justices are reluctant to order mandatory outpatient treatment, even if they had ordered it prior to the legislative changes to civil commitment. If a consumer is substantially likely to harm himself or others, or is unable to take care of himself, many special justices do not feel it is appropriate to order him into treatment on an outpatient basis. Representatives from one board also expressed concern about the potential liability issues associated with releasing a person who meets civil commitment criteria back into the community.

- *Planning for MOT is difficult:* If a special justice believes that an MOT order is appropriate, the community services board, available mental health practitioners, and the attorneys present must all agree on the appropriate treatment plan, determine who will administer the treatment and how it will be administered, determine how the community services board will track the consumer's progress, and any other details. This is time consuming. It is especially

[57] LIPOS is a program designed to reduce the use of state hospitals. It allows CSBs to purchase beds for eligible patients in private hospitals with state funds; regional memoranda of understanding agreements between these boards and their local hospitals determine the eligibility requirements for this program. These regional agreements also establish the per diem rates for LIPOS-funded hospital stays. VIRGINIA JOINT LEGISLATIVE AUDIT AND REVIEW COMM'N, JLARC REPORT SUMMARY: AVAILABILITY AND COST OF LICENSED PSYCHIATRIC SERVICES IN VIRGINIA ix-x (2007), *available at* http://jlarc.state.va.us/Summary/Sum365.pdf.

time-consuming for the special justice and independent evaluator, who are only paid per individual case.

Snapshot: Medication Funding at a Large Budget Community Services Board

This board does not have the capability to provide instant medication because it does not have the funds, and it does not have a 24-hour psychiatrist on staff. Much of the payment for medication for patients without a payment source comes from a local church/charitable organization. This board relies very heavily on their goodwill to cover costs of expensive medication for its mentally ill consumers.

- *Enforcement of MOT is difficult:* Mandatory outpatient treatment falls into a grey area between inpatient commitment and voluntary treatment. If the consumer chooses not to comply, how a board and special justice should respond is uncertain. Should they criminalize him for not following a court order, commit him to inpatient treatment, or let him go without punishment? They are opposed to criminalizing the mentally ill.

Other Common Observations

Least restrictive treatment: Almost all of the boards in our sample expressly stated their preference for providing the least restrictive method of treatment possible to their consumers. Representatives from one board believe that the statutory changes have highlighted a pre-existing need for an increase in funding for crisis stabilization services.

Snapshot: Focus on Least Restrictive Treatment at a Medium Budget Community Services Board

This board has been developing a 24-hour crisis stabilization unit that will accept TDOs. This center, which is co-located with a medical detox center, will expand the crisis prevention and response efforts of this board with a focus on triage, assessment, crisis intervention, and detoxification. It currently has ten beds in detox and six beds in crisis stabilization, as well as 24-7 counselors on site and peer support specialists. The goal of this project is to resolve emergency incidents to avoid civil commitment.

Compensation for special justices and independent evaluators: Representatives from several boards in our sample were very concerned about the role of independent evaluators in light of the increase in what is asked of them, particularly because their pay has not increased from $75 per case. Several boards are having trouble keeping independent evaluators.

Performance contract and data collection: Completing requirements in the performance contract has created a sizeable increase in workload for several boards in our sample. These boards have had to retool their data management systems and train their staff in data entry. In general, these boards felt that the stipulations for data collection are time consuming and redundant in many cases.

Medication funding: Finding a payment source for medication for consumers is a significant problem for almost all of the boards in our sample. The Community Resource Pharmacy (CRP) provides medication for consumers who have been discharged or diverted from a state hospital or training center but who are not able to pay for them. However, CRP does not cover all consumers.[58] One large budget board is currently overspent in its medication allotment for

58 This program is administered by the Department and is funded by State general funds and Medicaid collections. *See* 2007 Innovation Awards Program Application, http://ssl.csg.org/innovations/2007/2007applications/Southapplications2007/07S31VACOMMUNITYRESOURCEPHARMACY.pdf.

Community Resource Pharmacy medications by roughly $500,000. Another problem associated with medication funding is a consistent lack of funding for sufficient psychiatric staff to *prescribe* medication. One board has about two and a half full time equivalents per prescriber; the wait for a doctor visit at this board is typically three to four weeks. Another board told us that psychiatrists who accept private insurance have waitlists of six to eight weeks.

Rural vs. urban boards: Boards in rural areas appear to have more difficulty than boards in urban areas with hiring licensed clinicians. The rural boards in our sample have trouble hiring and keeping independent evaluators. They also typically have lighter emergency services coverage.

More detailed descriptions of each community services board in our sample can be found in Appendix B.

V. FISCAL IMPACT ANALYSIS

This section analyzes the fiscal impact of the mental health law reform. The changes took effect July 2008, so only preliminary data are available from the first quarter of fiscal year 2009. These data include the number of ECOs, TDOs, commitment hearings, and the dispositions of those hearings. Due to the way data were collected in the past, there are no baseline data from this quarter in prior years to serve as a benchmark for comparison.

In order to compensate for the limitations of the data, we conducted a qualitative rather than a quantitative analysis of the budgetary impact of the statutory revisions. First, we outline the assumptions underlying the original fiscal impact statement for the omnibus bill and analyzes how the CSBs planned to spend the additional appropriations associated with the statutory reforms. Next, we use information from our CSB interviews, as well as caseload data obtained from the Virginia Supreme Court, to evaluate the validity of the Department's fiscal impact assumptions. Next, we discuss Virginia's experiences in terms of national trends through a literature review. Finally, we revise the budgetary impact assumptions based upon the results of our analysis.

Initial Assumptions and Estimates of Fiscal Impact[59]

The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Planning and Budget developed the 2008 Fiscal Impact Statement in an effort to quantify the impact the mental health law reform would have on costs. The assumptions that were built into this statement were identified and analyzed, serving as the foundation for both the case studies and the fiscal analysis. The assumptions identified during the case studies are included here, and the estimated dollar values associated with the resulting costs are listed below in Figure 2. In addition to the $7.1 million accounted for below, the impact statement identified other funds necessary to community services boards operations, but they are outside the scope of this analysis because they were not a direct result of the change in law. Instead, they were the result of a recognition that the mental health system in Virginia was underfunded in certain areas prior to the statutory changes.

There were three main categories of expected impacts. The first category of expected impacts were those resulting from any changes in the numbers of ECOs, TDOs, commitment hearings, and commitments. A change in frequency of any of these factors could have significant fiscal impacts, and changes are likely to occur since the revision of the commitment standard. However, the changes were unpredictable, so while they were expected to occur, there are no quantified estimates included in the initial impact statement.

The second expected impact was an increase in the costs associated with CSB staffing. It was estimated that each community services board would need an average of two additional case managers to handle hearing attendance and case management, for a total of 80 system-wide. Costs in these two areas were expected to increase because CSB representatives are now required to attend all hearings whereas they previously were not required to do so. The Office of the

[59] Information in this section is from the 2008 Fiscal Impact Statement, included in Appendix A.

Inspector General reported that about half of the boards were not attending hearings on a regular basis prior to the change in law. With an estimated cost of $50,000 per case manager, the total estimated cost for two additional case managers at all CSBs came to $4 million per year.

The third expected impact was an increase in the use of mandatory outpatient treatment. Recognizing that the effects of the statutory changes in mandatory outpatient treatment orders are difficult to predict, the Department estimated that the maximum increase in the number of people committed under mandatory outpatient treatment could be as high as 3,750 per year. The minimum number of service hours expected equals 7.5 for each consumer (ten office visits of 45 minutes each), totaling an average of 700 new hours of service for each CSB annually. The Department carefully analyzed other administrative costs that would be involved with service provision.[60] In total, the system-wide costs of service provision were estimated at $1.7 million per year, and annual case management costs were estimated to total an additional $1.4 million per year.

FIGURE 2. 2008 FISCAL IMPACT STATEMENT

This is not the full fiscal impact statement, but only highlights of the estimates in necessary spending that are a direct result of the law reform on the civil commitment process.

CSB attendance at hearings:

Each CSB needs 2 additional case managers to effectively attend = 80 caseworkers system-wide

Cost of $50,000 per case manager..…... $ 4 million per year

Mandatory Outpatient Treatment – commitment and monitoring:

Maximum increase in number committed estimated at 3,750

For each individual committed, minimum of 7.5 hours of service: 10 visits at 45 min. each

On average, 700 new hours of service for each CSB, plus administrative work = 1075 total hours

Cost per CSB about $42,000 per year……... $ 1.7 million system-wide

Additional $35,000 per CSB for case management…… $ 1.4 million system-wide

Total Impact: $ 7.1 million

Source: VA Department of Planning and Budget. 2008 Fiscal Impact Statement for SB246.

Anticipated Changes Among Community Services Boards

The community services boards implementing these changes are a great source of knowledge for predicting how the statutory changes will play out at the ground level and affect their resources. While data on the real impacts and changes since July 1, 2008 are still forthcoming, analysis of

[60] Va. Dep't of Mental Health, Mental Retardation & Substance Abuse Serv., HB 499 Added CSB Time (unpublished document, on file with authors).

the proposals each CSB submitted explaining how they expected to use their new funding illustrates the new demands CSBs were anticipating and how they intended to respond to them.

The anticipated expenditures presented are only for new funds distributed by the state to community services boards for the purpose of preparing for and responding to changes brought about by the mental health law reform. Funds were distributed to the boards based on the population size of the communities they serve.

In order to make these data useful, the CSBs were grouped in meaningful ways, and the proportion of state mental health law reform funds (MHLR) each board intended to devote to each category was totaled across these groups. For these calculations, each CSB was weighted equally so that the numbers would reflect how the new funds were distributed within all CSBs. The boards were grouped by three different criteria: budget size, population size, and classification (rural or urban).

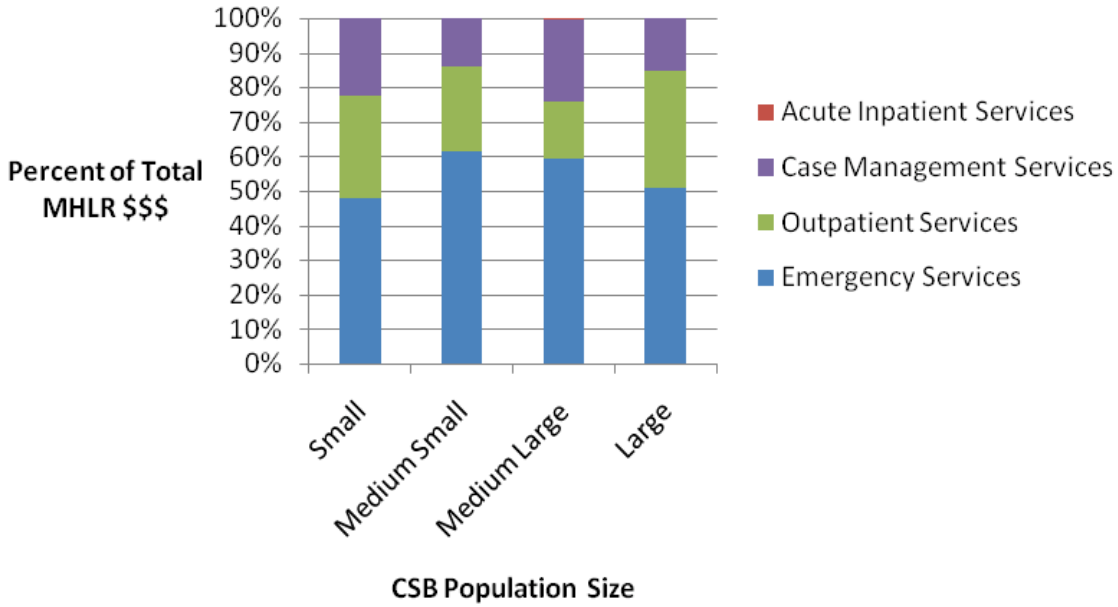
Anticipated spending was constant across major spending categories, but differences between boards were evident based on anticipated spending within major categories: We analyzed the data separately in each of these divisions in order to isolate any trends in spending and resources that may vary between groups, and to prevent our findings from being sensitive to how the boards are grouped.

Figures 3-5 illustrate the finding that boards vary little on how they expected to distribute total MHLR funding among the major categories of case management, outpatient services, and emergency services. The relative distributions are affected very little by CSB characteristics and are not largely dependent on how they are grouped. There is more variation in the figures when CSBs were grouped by population size. Part of this outcome may be attributed to the fact that the bars are showing average distributions, and in the population chart, there are more categories, resulting in fewer boards being averaged within each category.

Slightly more than half of total funds are expected to be used for emergency services in nearly all charts. The only time it dips below half is for small population boards. The most variation found between boards is with the anticipated distribution of funds between case management services and outpatient services. On average, more funds are budgeted toward outpatient services, but the figures for case management are very similar, and some groups of boards anticipate more spending for case management. Only one CSB reported allocating new funds to acute inpatient care, so it is not a significant contribution to total anticipated expenditures. Acute inpatient services are a very small share of total expenditures because they are not required services and few boards have them on site.

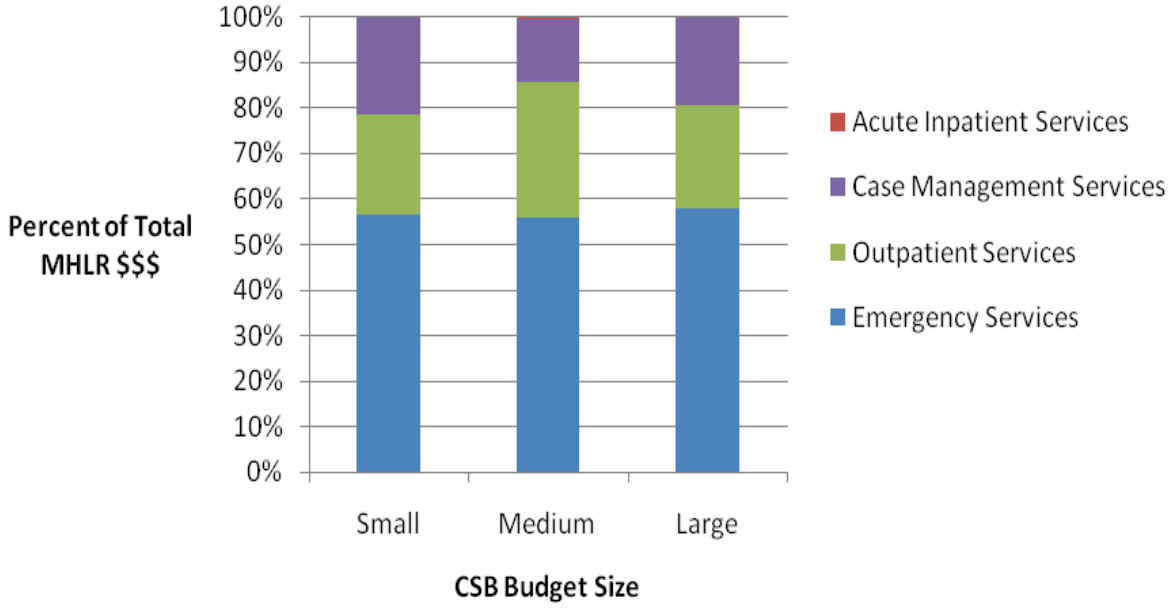
While anticipated spending does not notably vary between large categories, it does vary significantly within categories. Figures 6-8 display the breakdown of projected spending within the largest category, Emergency Services, according to the different grouping criterion. Depending on the way in which community services boards are grouped, some subcategories of spending may not appear in the pie charts because no funds were allocated to that purpose by those boards.

FIGURE 3. PROJECTED ALLOCATION OF MENTAL HEALTH LAW REFORM FUNDS BY CSB POPULATION SIZE



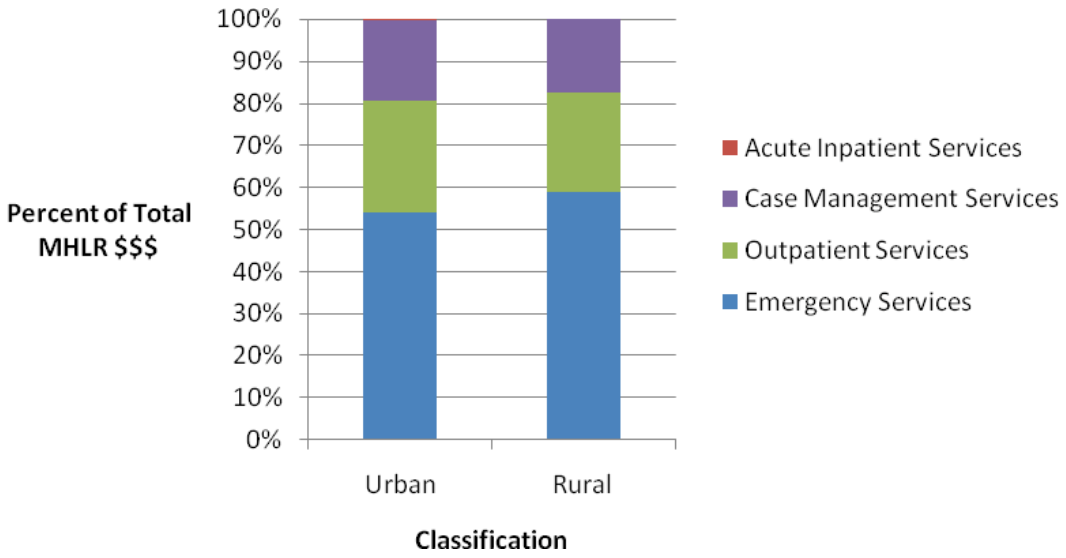
Source: DMHMRSAS, CSB MHLR Proposals.

FIGURE 4. PROJECTED ALLOCATION OF MENTAL HEALTH LAW REFORM FUNDS BY CSB BUDGET SIZE



Source: DMHMRSAS, CSB MHLR Proposals.

FIGURE 5. PROJECTED ALLOCATION OF MENTAL HEALTH LAW REFORM FUNDS BY CSB CLASSIFICATION

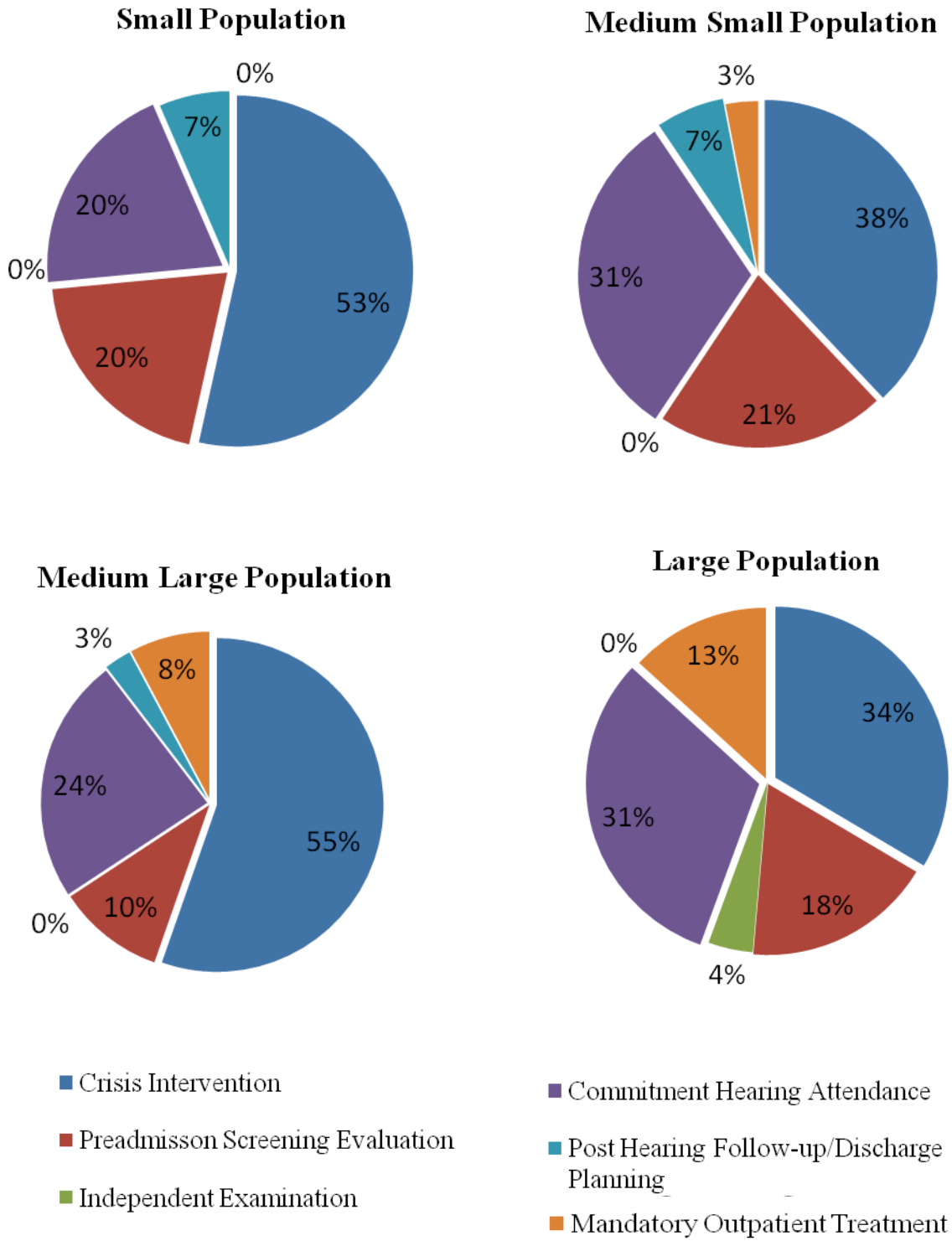


Source: DMHMRSAS, CSB MHLR Proposals.

Some of the notable differences between boards are highlighted below. There are a few possible explanations for the varying preferences for spending of the new money. The first is that some CSBs may be anticipating different impacts from the reform than others. This will occur if one board's practices were already in line with the new changes while another board needs to make significant changes to their daily operations. A second explanation is that funding needs may not match up with the mental health law reform changes. If some boards allocate funding according to where they need it most while others target funding to areas most impacted by the reform, differences may emerge. Finally, differences in projected spending may reflect differences in the populations served by each community service board. Demand for some services may outweigh others within different types of communities.

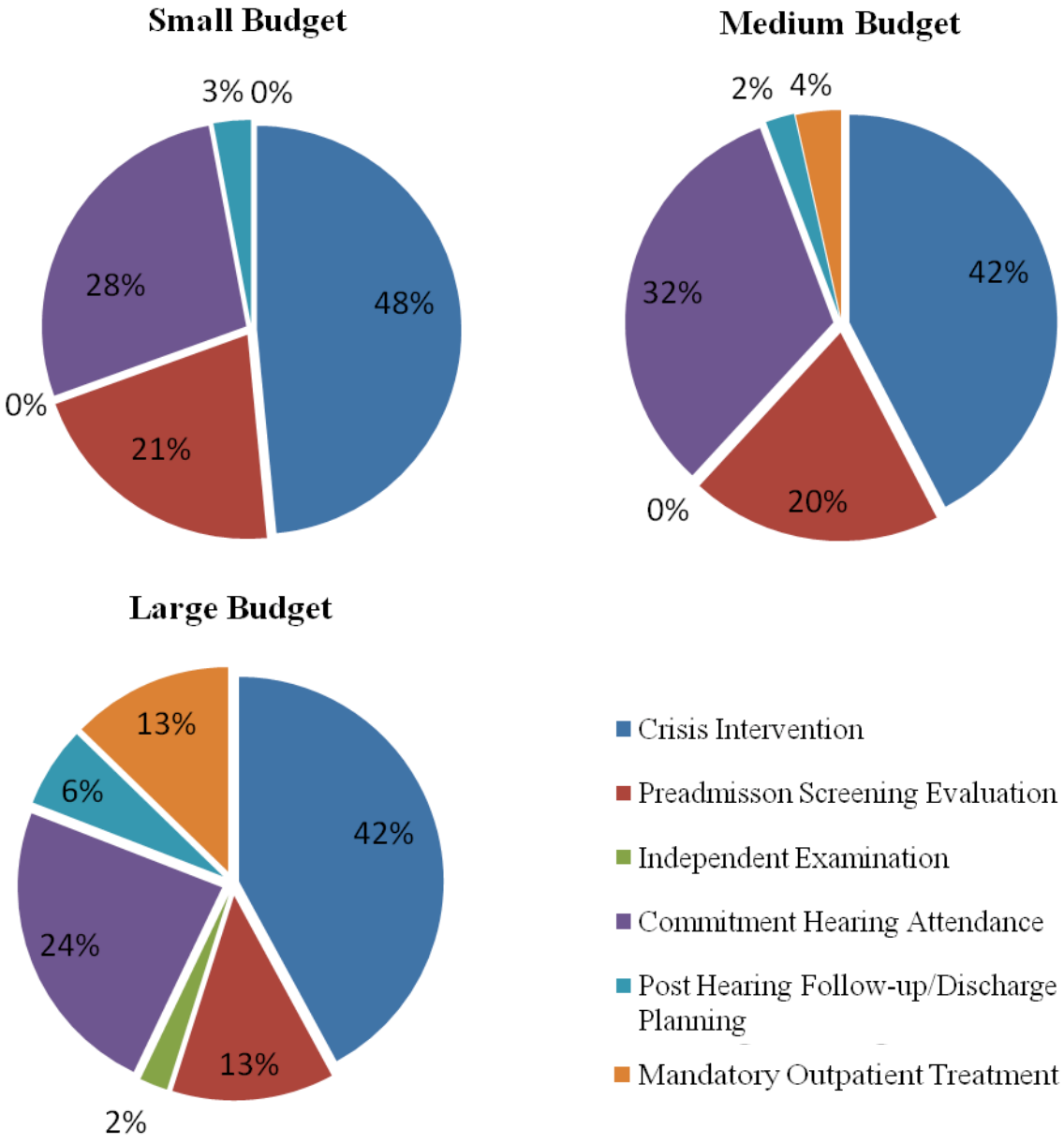
Allocated funding for mandatory outpatient treatment increases notably with the budget size, population size, and population density (urban) of the community services boards. For example, as budget sizes increase from small to medium to large, the percentage of projected funds allocated to MOT increases from 0 to 4 to 13 percent, respectively.

FIGURE 6. PROJECTED SPENDING OF MENTAL HEALTH LAW REFORM FUNDS WITHIN EMERGENCY SERVICES: BY POPULATION SIZE



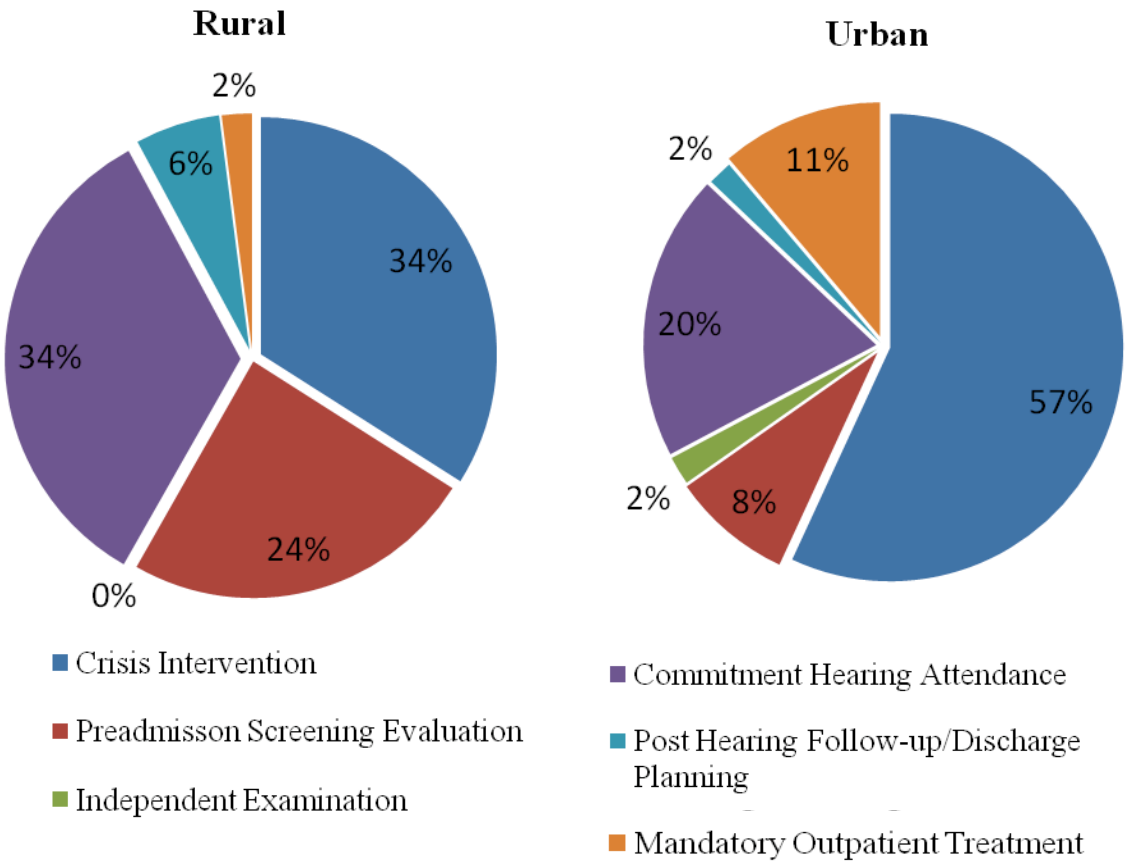
Source: DMHMRSAS, CSB MHLR Proposals.

FIGURE 7. PROJECTED SPENDING OF MENTAL HEALTH LAW REFORM FUNDS WITHIN EMERGENCY SERVICES: BY BUDGET SIZE



Source: DMHMRSAS, CSB MHLR Proposals.

FIGURE 8. PROJECTED SPENDING OF MENTAL HEALTH LAW REFORM FUNDS WITHIN EMERGENCY SERVICES: BY CLASSIFICATION



Source: CSB MHLR Proposals. DMHMRSAS

Rural CSBs target more funds to attendance of commitment hearings than do urban CSBs. This observation is consistent with expectations, given that rural boards tended to be the ones that reported attending fewer hearings prior to the statutory changes than they must now attend.

Generally, larger and more urban community services boards plan on dispersing their funds more broadly among all categories of spending. Funding for independent examination only appears in the figures for large population, large budget, and urban boards. As stated above, funding for mandatory outpatient treatment also increases with size. The data available cannot inform the reasons for all of these differences, but the differences clearly exist. These variations in projected spending are important because they reflect the fact that the impact of the mental health law reform will vary from board to board, and boards with different characteristics will feel the burden of the laws in different ways.

Lessons from Community Services Board Case Studies

The case studies of CSBs provide some valuable insights into the effects of the statutory changes in the absence of hard data. The previous section on case studies highlighted and discussed several of the following observations; the fiscal implications of these trends are discussed here.

CSBs report little to no change in ECOs, TDOs, and hearings: Anecdotal reports that the numbers of ECOs, TDOs, and hearings have not changed since July 1, 2008 indicate that there has not been an increase in the number of people who are being detained and committed under the new commitment standard. Information from the CSBs on usage of the ECO extension was limited, so potential costs resulting from such extensions will need to be calculated once those data are reported to the Department.

If there truly has not been a system-wide increase in the number of people brought into the system, then this has significant budget implications because costs borne during the commitment process due to the volume of cases heard are not changing from their previous levels. If the ECO period is not often extended, then costs are not increasing for ECOs, either.

CSBs report no change in the outcomes of hearings, except for mixed changes with mandatory outpatient treatment: Representatives from the boards in our sample consistently reported that there were no noticeable changes in the outcomes of hearings since the reform went into effect. Many believe that the commitment standard is being interpreted more broadly, but that it has little impact on implementation. One area where some differences were noted was with mandatory outpatient treatment. The magnitude of orders has been very small for all boards, both before and after the reform, but some have seen a slight increase or decrease in MOT since July 1, 2008.

These trends, or the absence of trends, may have a significant impact on the costs of mental health law reform. If there really is no difference in hearing outcomes from before to after the reform, then several anticipated costs and savings will not be realized, and methods of service provision will change very little.

If there is no change, anticipated costs associated with more people being committed due to the broader standard will not be realized. If larger shares of individuals are not ordered into mandatory outpatient treatment as a substitute for involuntary inpatient treatment, then cost savings associated with this substitution will not be realized either.

Hearing attendance is a significant burden on some community services boards: As detailed in the case study summary, attendance at commitment hearings is a new, significant burden for about half of the community services boards in our sample. This results in the addition of significant personnel costs.

New data collection and paperwork requirements increase costs: Most CSBs reported the need to reposition or hire new staff in order to satisfy data collection requirements. A few boards expressed concern that the data reporting was too cumbersome and some was duplicative and unnecessary. Differences in technology systems have created an additional burden because some

data need to be collected manually. In addition to data reporting, the amount of paperwork that must be completed increased as well. The paperwork required of independent evaluators and CSB pre-screeners has increased, consuming more time and resources.

Both community services boards and hospitals are bearing the costs of more frequent recommitment hearings: The shortening of the maximum length of the initial commitment period from 180 to 30 days increases costs significantly for both CSBs and hospitals. In the past, recommitment hearings at hospitals would typically be held once per month. Now hearings must be held at least twice per month, increasing costs for CSB representatives, hospitals, and other participants in the civil commitment process, including independent evaluators, special justices, and attorneys. The absolute number of recommitment hearings may also increase as a result since some consumers that would have been released before a recommitment hearing was needed under the prior commitment length of 180 days may now undergo hearings due to the shorter timeframe.

Discharge planning and monitoring continue to be significant drivers of costs for community services boards: At this point, it is uncertain how much, if at all, the changes in the law have affected discharge planning and monitoring, but boards repeated cited these tasks as sources of difficulty in terms of workload. These services are not limited to individuals ordered into mandatory outpatient treatment. Boards must monitor all individuals that have received their services, and discharge planning must occur for anyone who has been committed. An increase in TDOs, hearings, and commitments could all impact the demand for services in these areas.

Demand for inpatient services has not increased, but current supply does not meet demand: Board representatives are reporting no significant increases in the demand for inpatient services, yet they are very concerned about the availability of inpatient bed space. Even without an increase in demand, it is often difficult to find a bed for consumers in need. This is an important finding because its effects are difficult to measure and largely unknown. If bed space must be rationed, and individuals in the commitment process are aware of this, then this limited supply may have an impact on the number of people being committed and receiving the care they need. It is possible that the statutory changes would have resulted in more commitments but for the lack of available space in mental health facilities.

Observed Changes[61]

Preliminary data on ECOs, TDOs, hearings, and the dispositions of civil commitment hearings are available from the Virginia Court System's Case Management System. For ECOs and TDOs, the only data available to us were for the actual number of orders, not the number of proceedings. Data from the first quarter of FY 2009 is discussed below, along with comparable data collected in May 2007 by the Commission on Mental Health Law Reform (hereinafter the Commission). May 2007 represents the only data for comparison because data reporting requirements before July 1, 2008 did not mandate collection of this information for individuals going through the commitment process. Using the May 2007 data as a baseline, the following inferences can be made:

[61] Data n this section were provided by the Commission on Mental Health Law Reform from the eMagistrate System and General District Court Case Management System

The number of temporary detention orders appears to have increased starting in January 2008, and implications for the long-run are still unknown: The data on temporary detention orders are still inconclusive at this point. Data from three different systems report similar, but different, numbers for temporary detention orders. Therefore, the exact magnitudes are uncertain, but trends in each data set are the same. As displayed below in Figure 9, the numbers of TDOs in each month of 2008 are greater than the numbers in the corresponding months of 2007. At the same time, there is a substantial difference between the data from December 2007 to that of January 2008. Since the numbers and seasonal fluctuations of TDO orders remain fairly stable following January, it is likely that this increase was not a coincidence and that something caused a real increase in orders.

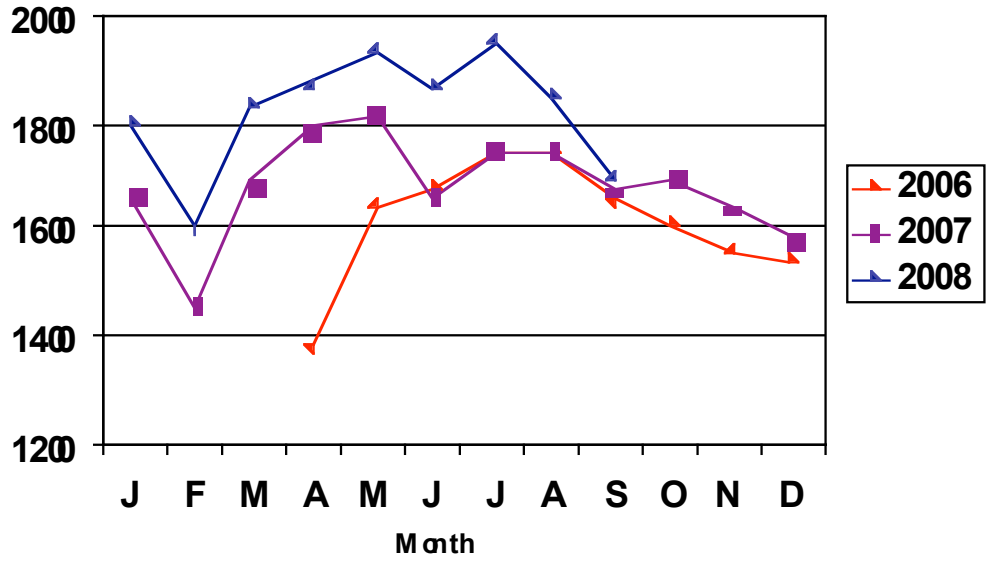
One likely explanation is that data reporting began to improve so the increase is just a change in reporting and not actual orders. However, the Fairfax-Falls Church CSB has been collecting data since 2005, and a plot of their frequencies of CSBs reveals the same increase, suggesting that this change is not simply caused by improvements in data collection. These data are displayed in annual line plots for years 2005-2008 in Figure 10.

Since the change happens in January, the increase in TDOs cannot be a direct result of the change in statutory language because the changes had not yet occurred. The increase may have been part of an anticipatory or publicity effect.[62] Individuals involved in the commitment process may have changed behavior in response to published reports, more training, or increased awareness on upcoming reforms. Regardless, this shift reflects a potential reinterpretation of the old standard or a response to changes in perception to the interpretation of the statute, rather than a response to change in the statutory language itself.

If the increase in January was due to anticipation of the upcoming changes, it is still too early to tell if this change will remain constant. Since July 1, 2008, the number of TDOs has dropped significantly during the first quarter of FY 2009, reaching its 2007 level in September (see Figure 9). Right now, it appears that the number of TDOs increased with anticipation of the law, but then fell closer to historic levels once implementation began. More data are needed in order to support or refute this hypothesis.

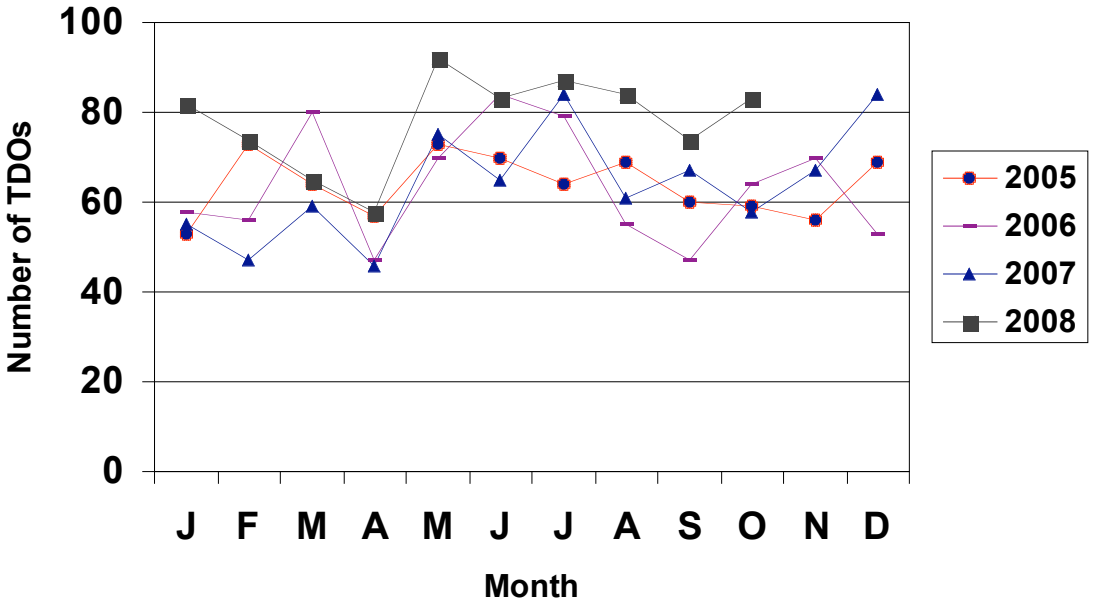
[62] Telephone conversation with Richard Bonnie, Chair, Va. Comm'n on Mental Health Law Reform (Dec. 8, 2008).

FIGURE 9. NUMBER OF TEMPORARY DETENTION ORDERS STATEWIDE: 2006-2008



Source: Va. Comm'n on Mental Health Law Reform, Draft Progress Report B. Impact of 2008 Reforms: A Preliminary Report (on file with authors). Data from eMagistrate System.

FIGURE 10. FAIRFAX-FALLS CHURCH CSB TEMPORARY DETENTION ORDERS: 2005-2008



Source: Va. Comm'n on Mental Health Law Reform, Draft Progress Report B. Impact of 2008 Reforms: A Preliminary Report (on file with authors). Data from eMagistrate System.

There is no strong evidence that the number of hearings has changed: There is no strong evidence available suggesting that the absolute number of hearings has changed in any significant manner as a result of the law reform. Comparisons from the first quarter of fiscal year 2009 do show a slight increase in hearings over May 2007, but the magnitude is unclear. There are not enough data available yet to determine if there is a causal relationship, or if instead, the change is cyclical or a function of an expanding population.[63]

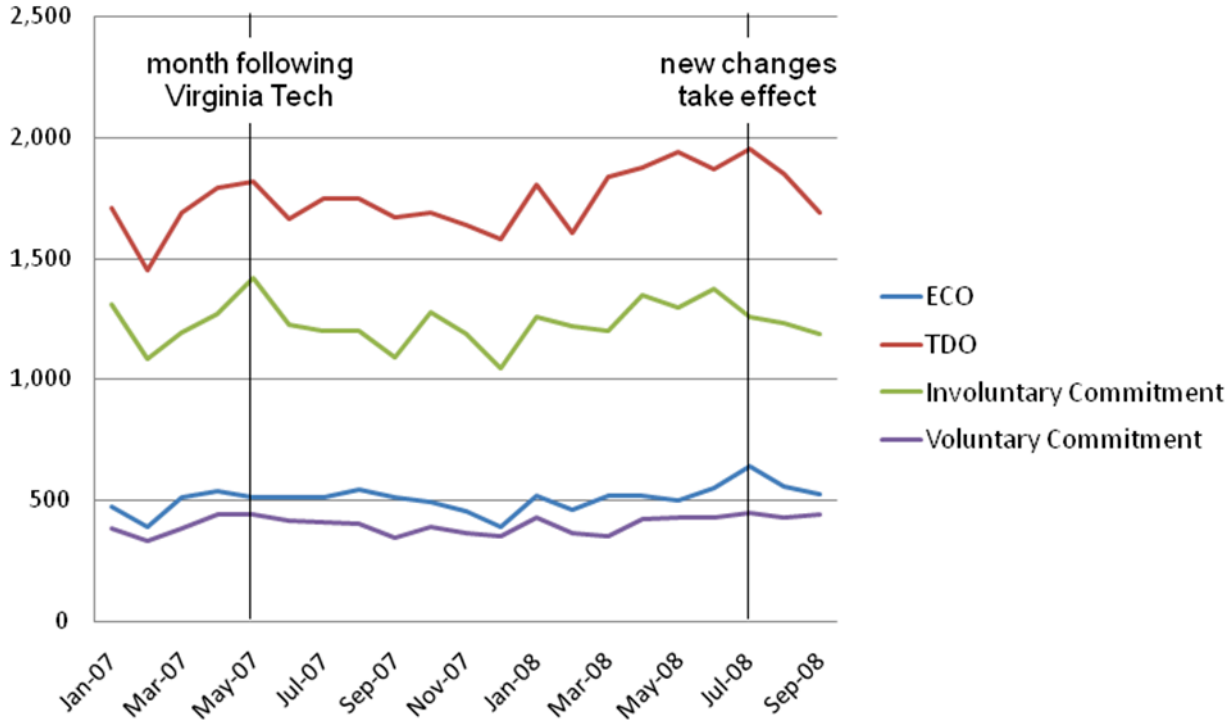
Figure 11, below, plots the changes in numbers of ECOs, TDOs, and commitments since January 2007. The trend lines in this figure display seasonal trends, as well as changes to the number of consumers entering into different stages of the civil commitment process as a result of external events. The first line on the graph at May 2007 indicates the month following the shootings at Virginia Tech. TDOs appear to peak, but the increase may be seasonal since there is also an uptick in May 2008, and the change is not sudden. The second line is at July 2008, when the statutory changes took effect. Here, the number of ECOs and TDOs peak, but commitments remain fairly constant. This may suggest that more people were brought into the commitment process under the assumption that the commitment standard would be interpreted more broadly, thereby increasing the number of hearings initially. However, the number of ECOs and TDOs fall off shortly thereafter, suggesting that the number of hearings should not be significantly higher.

Commitment hearing dispositions have not significantly changed; mandatory outpatient treatment has declined and involuntary inpatient commitment has increased: As Figure 12 below illustrates, the proportion of total dispositions that mandatory outpatient treatment accounts for is very small. (MOT is not plotted in Figure 11 because these data are not available prior to June 2008.) The relative proportions of individuals being dismissed or receiving voluntary or involuntary commitment are also fairly stable, varying little from month to month. The most notable differences from 2007 to 2008 are that the number of MOT orders has fallen significantly, the number of dismissals has increased, and the number of committed individuals has remained relatively constant, but a greater share of them have been involuntary in 2008.

While the number of MOT orders is relatively small and the number of consumers served is few compared to the total number of consumers served by the CSBs, analyzing the trends around this form of treatment is important because anticipated changes to the frequency of MOT orders accounted for a significant portion of the calculated costs of the mental health law reform.

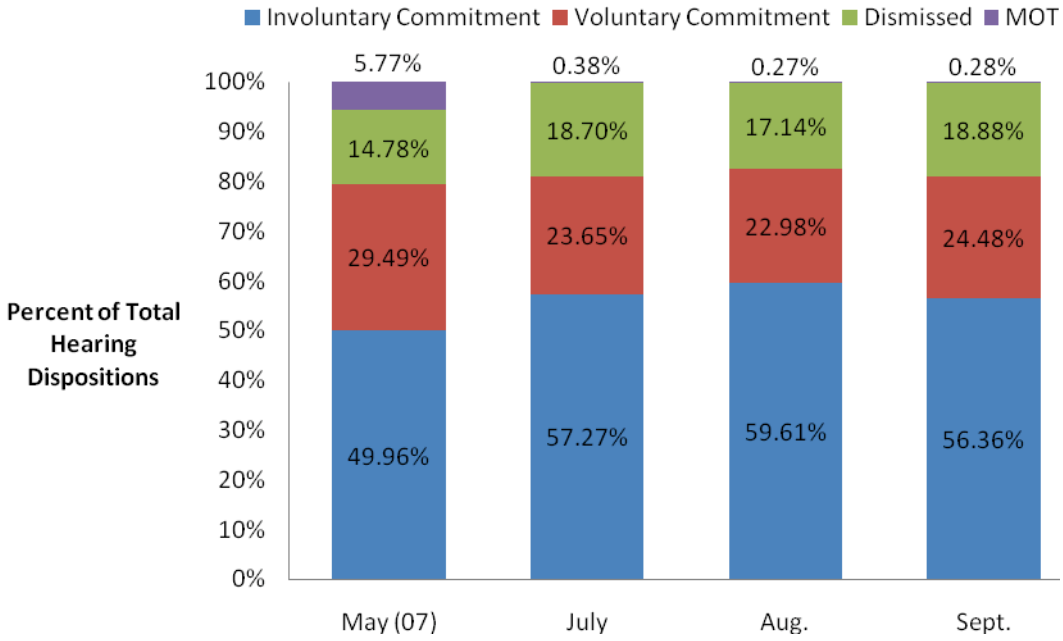
[63] The Commission estimates that an increase has occurred, but this conclusion is based largely on their TDO numbers, which we are hesitant to tie directly to the law reform for reasons listed above. Va. Comm'n on Mental Health Law Reform, Draft Progress Report B, Impact of 2008 Reforms: A Preliminary Report (on file with authors) [hereinafter Draft Progress Report B].

FIGURE 11. NUMBER OF TEMPORARY ORDERS AND COMMITMENTS: 2007-2008



Sources: eMagistrate System and General District Court Case Management System.

FIGURE 12. COMMITMENT HEARINGS DISPOSITIONS: MAY 2007, JULY-SEPT. 2008



Source: Va. Comm'n on Mental Health Law Reform (on file with authors).

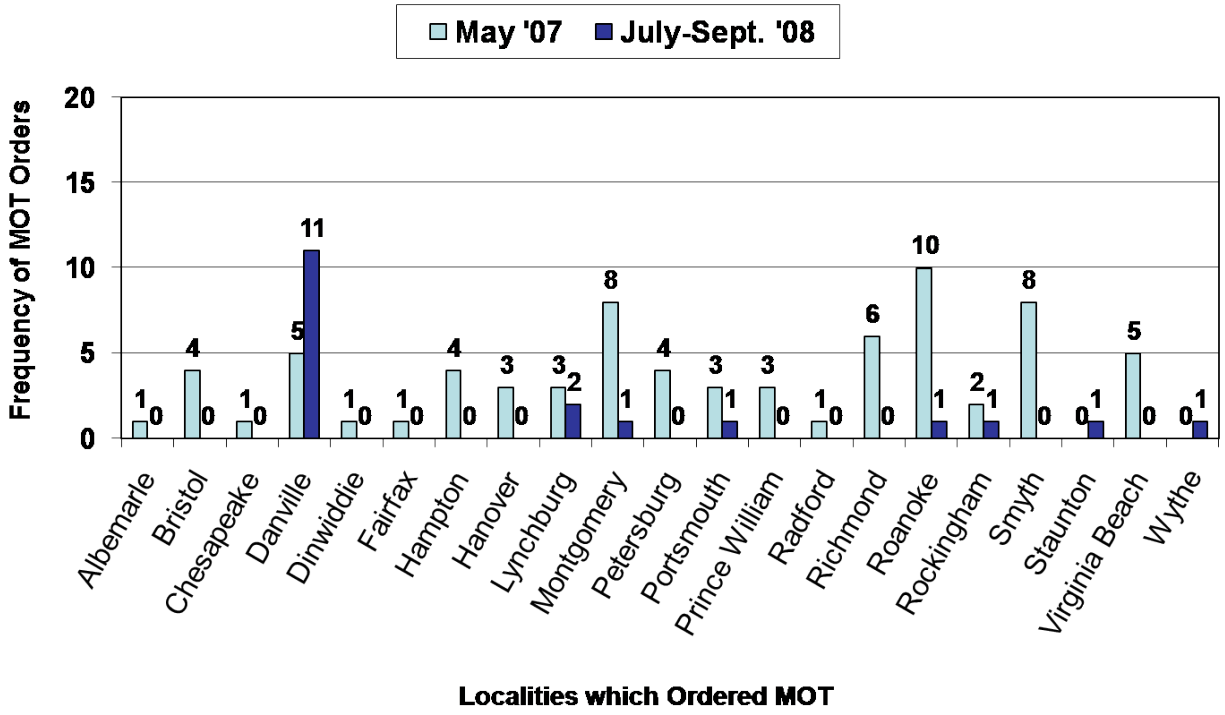
Reasons offered by CSB representatives for the low utilization of mandatory outpatient treatment orders were numerous, and many were discussed in previous sections of the report. Regardless of which factors contribute the most, there may be underlying factors with significant policy implications. Figure 13 charts the frequency of MOT orders within boards that were reported to the Commission in May 2007 and the first quarter of FY 2009. MOT orders are not evenly distributed throughout the state, and are highly concentrated in a few CSBs. Not only are the orders concentrated, but within boards, there is some significant variation in the number of orders from one time period to the next. A likely explanation for this information is that hearing dispositions are largely determined by the individual justices presiding over hearings, and some of these justices were largely responsive to the changes in the statutory language.

With respect to commitments, involuntary commitment appears to have increased slightly, but there appears to also have been a decline in voluntary commitment. In Figure 11, involuntary commitments peak in the month following the shootings at Virginia Tech. This may reflect more caution on the part of stakeholders, who committed more individuals than at other times. However, there is no such peak following the implementation of the law reform, and no increase across the board. The stability in the total number of commitments is consistent with the fact that the supply of bed space is limited. However, there is a shift from voluntary to involuntary commitments that could have serious policy implications depending on the reason for the change. One scenario is that the same individuals who would have been voluntarily admitted before are now being committed involuntarily.[64] Another is that fewer voluntary patients are being admitted as fewer beds are available. The reasons for the shift could be caused by a number of potential factors, and the exact cause is beyond the scope of this study.

Data on recommitment hearings do not measure the burdens reported by community services boards: Data provided to the Commission do not display a significant increase in the actual numbers of recommitment hearings. This is not inconsistent with reports from CSBs and state hospital representatives that the greater *frequency* of recommitment hearings constitutes new demands on their time and resources. The Commission collected data on the number of recommitment hearings from May 2007 and the first quarter of FY 2009. There is little increase in July and August, with a sizable change in September.[65] While real changes in the absolute number of hearings have cost implications, the concerns from representatives of community services boards and hospitals were that costs of monitoring, scheduling, and evaluating patients have increased due to the change in timeframe of the initial commitments. Even in the absence of any changes in the number of hearings, the process has become more burdensome, increasing costs significantly.

[64] One potential reason for the shift may be changes in laws for ownership of firearms. In the past, individuals were told they would be able to keep their firearms if they agreed to voluntary admission, whereas now they would lose the privilege to carry a gun. This may encourage individuals who would have been willing to accept voluntary admission in the past to go through the process of a hearing and potentially be involuntarily committed. Telephone conversation with Richard Bonnie, Chair, Va. Comm'n on Mental Health Law Reform (Dec. 8, 2008).
[65] Draft Progress Report B, *supra* note 63.

FIGURE 13. FREQUENCY OF MANDATORY OUTPATIENT TREATMENT ORDERS: MAY 2007 VS. JULY-SEPT. 2008



Source: Va. Comm'n on Mental Health Law Reform (on file with authors).

Literature Review

Since the reform in Virginia occurred so recently and few data are available, we looked to other states to see how their mental health service systems responded to similar reforms. There are clear limitations to such an approach: the structure of the service system will vary from state to state, as well as the statutory language of commitment laws and the nature of any recent reforms. For this reason, we did not fully extrapolate and directly apply the experiences of any individual states to Virginia.

However, a literature review provided us with a general overview of common trends among states with similar statutes in place. A review of the recent literature on involuntary outpatient treatment throughout the United States revealed that most of the experiences in Virginia, as described above, are common to other states.

Utilization of mandatory outpatient treatment is limited: There is statutory language allowing for outpatient commitment in 38 states and D.C.[66] Research indicates that most states rarely use outpatient commitment, and—in a departure from Virginia—many states use it more as a

[66] M. SUSAN RIDGELY, JOHN BORUM & JOHN PETRILA, RAND CORP., THE EFFECTIVENESS OF INVOLUNTARY OUTPATIENT TREATMENT: EMPIRICAL EVIDENCE AND THE EXPERIENCE OF EIGHT STATES (2008).

discharge-planning mechanism for the transition out of inpatient care than as an alternative to inpatient commitment.[67]

A few general trends with utilization and budgetary impacts also emerged in the literature. A handful of states have different commitment standards for outpatient than inpatient, but nowhere does the proportion of individuals ordered into involuntary outpatient treatment meet or exceed ten percent.[68] The reasons cited for sparse use of outpatient treatment included several factors that mirror those existing in Virginia. Confusion over the best way to enforce compliance was consistently a significant factor. It is expected that mandatory outpatient treatment will continue to account for a small portion of total commitments.[69]

Responses to changes in commitment standards are short-term: In terms of fluctuations in both inpatient and outpatient involuntary commitment, experts in the field have observed several trends in commitment practices in response to changes in the law. One notable trend is that whether or not legislators expand or contract their statutes, the number of people treated increases or decreases for a short period of time and then slowly returns to previous levels.[70]

The graph which displays changes in emergency custody orders, temporary detention orders, and commitments over time suggest that such a bump may have occurred in involuntary commitments after the shootings at Virginia Tech, followed by a smaller one after the changes took effect in July 2008 (See Figure 11). If this is what the graph reflects, then there may be little to no effect on service provision in the long-run.

The number of people committed is more a function of changes in funding levels and institutional capacity than actual changes in the statutory language: Studies suggest that changes in funding levels and institutional capacity affect the number of people committed more than actual changes in the statutory language. A frequently cited contributing factor is that changes in law often require communities to provide services that were not previously available to consumers. However, it is the actual change in services available that impact the number of people being served, not the change in statutory language itself. Similarly, the level of knowledge that local judges have about resources in the community has a large effect on practices, partially explaining the wide variation in hearing dispositions found within states.[71]

Changes to Institutional Capacity

As suggested by the literature review, changes in institutional capacity may help predict changes in commitment and service provision. Institutional capacity refers to the ability of the institutions of mental health to provide services to consumers, and includes both human and physical capital. The four proxies for institutional capacity available for this study include staffing at state facilities, staffing at CSBs, availability of inpatient beds, and mandatory outpatient treatment

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[67] RIDGELY ET AL., *supra* note 66; Bazelon Center for Mental Health Law, Studies of Outpatient Commitment are Misused, http://www.bazelon.org/issues/commitment/moreresources/studies.htm (last visited Nov. 25, 2008).
[68] RIDGELY ET AL., *supra* note 66.
[69] *Id*.; E. Fuller Torrey & Robert J. Kaplan, *A National Survey of the Use of Outpatient Commitment*, 46 Psychiatric Services 778 (1995).; Bazelon Center for Mental Health Law, *supra* note 67.
[70] Rich Daly, *Civil Commitment Changes Only as Good as Funding*, PSYCHIATRIC NEWS , June 6, 2008, at 11.
[71] *Id.*

services. Based on the literature review, increases in these variables in response to the mental health law reform would predict an increase in the number of consumers served. An increase in the number of consumers served would also increase system costs.

Staffing at state facilities has declined: Information on changes in staffing levels are only available for state facilities, not for community services boards or other independent individuals involved in the commitment process.[72] The usefulness of these data is limited since the numbers are aggregate and are not broken down by function. In total, there has been no increase in institutional capacity in state facilities from a staffing standpoint. In fact, total staffing of the seventeen state facilities has decreased from 8863.1 to 8799.5 from June to September of 2008.[73] This decline is less than a one percent decrease, and it also follows several years of fairly consistent total staffing levels.

Staffing at community services boards has increased: All CSBs were provided funding to prepare for changes in workload that resulted from mental health law reform. Most reported hiring people for hearing attendance, case management, and emergency services. Other hiring included personnel for data collection, emergency services and crisis stabilization, and outpatient treatment.

Capacity for inpatient treatment is an issue as finding access to beds becomes increasingly more difficult: The availability of inpatient beds has not increased, and several board representatives expressed concern with the increasing difficulty with finding beds for their consumers. In addition to the limitations based on the number of beds supplied, access is also greatly restricted by funds. The funding base for inpatient beds is eroding as the costs of beds increase faster than funding increases.

On-site mandatory outpatient treatment capabilities and development of service infrastructure are mixed: When a community services board is unable to provide most services required under an MOT order on-site, barriers to utilizing mandatory outpatient treatment may emerge. The capacity to provide mandatory outpatient treatment varies significantly from one board to the next. While all boards are required to monitor consumers with an MOT order, some do not have the capacity to provide counseling services and a private provider must agree to treat the consumer who is under the MOT order. This may present logistical difficulties since the board must continue to monitor the individual while they are treated by an outside party.

This obstacle, and others that may surface, are important because overcoming these barriers increases costs and provides incentives for mandatory outpatient treatment not to be ordered. If the goal of policy is to overcome these disincentives, the costs to overcome the barriers would need to be considered. In boards where more services are provided on-site, the barriers to service will be lower.

The table below lists some common services and how many boards reported having the capability to provide them. Two notable figures are the percentage of boards able to provide

[72] Conversation with DMHMRSAS representative.
[73] DMHMRSAS data on staffing levels by facility by month (on file with authors). Decimals represent less than full-time employment during the month.

PACT services (41.7%) and supervision of services from other sources (33.3%). When boards discussed provision of MOT services, the importance of the ability to perform these two tasks was repeatedly discussed.

TABLE 2. PERCENTAGE OF CSBS ABLE TO PROVIDE SERVICES ON SITE IF MOT ORDERED

Outpatient Service	Percentage of Boards Providing On Site
Individual Outpatient Treatment	91.7%
Case Management Services	91.7%
Medication Services	91.7%
Support Services	79.2%
Group Therapy	75.0%
Short-Term Crisis Intervention	70.8%
PACT/ICT Services	41.7%
Residential Crisis Stabilization	37.5%
Supervision of Services from Other Sources	33.3%
In-Home Crisis Stabilization	29.2%

Source: Richard J. Bonnie, Va. Comm'n on Commission Mental Health Law Reform, Preliminary Data Since Implementation of MH Law Reforms Effective July 1, 2008 (on file with authors).

VI. Revised Assumptions and Conclusions

The assumptions outlined in the initial fiscal impact statement were evaluated using the information detailed above. The table below displays the assumptions from both before and after the analysis, along with a description of the resulting effects on the cost estimates. Each item in the table is explained below.

Table 3. Revised Assumptions and Their Impacts on Cost Estimates

Before	After	Impact on Cost Estimates
Changes in ECO, TDO, hearings (Unknown)	➔	No change
CSB hearing attendance	➔	No change
CSB case managers	➔	No change
Increase in MOT	No increase in MOT	Estimate decreases
	Data collection	Estimate increases
	Recommitment hearings	Estimate increases
	Paperwork for independent evaluators	No impact on state costs, costs to independent evaluators
	Responsibility of special justice for MOT	No impact on state costs, costs to special justices

More data are needed to determine if the number of ECOs, TDOs, and hearings has changed: The preliminary data we have received reveal little to no change in the number of ECOs and hearings. However, some data differ by source, and some of the reports from the CSBs differ with the data we have as well. For these reasons, accurate analysis of the real changes will have to wait until more data and more evidence are available. Similarly, there appears to be an increase in TDOs, but more data are needed to determine whether or not the increase will be sustained in the long run. These estimates are important because the frequency of ECOs, TDOs, and hearings have a large impact on the costs of the commitment process and the costs of providing mental health services.

Demands on community services boards for hearing attendance and case management are on par with expectations: The Department and DPB had estimated an average need of two case managers per CSB to handle the responsibility of attending all hearings and managing cases. Many CSBs were attending most hearings before the change in law, so they have experienced less of an impact, but they are still affected. Within regions, boards will cover hearings for each other if a consumer from one board's jurisdiction is appearing at a hearing located at a hospital or state facility located in a different jurisdiction. This way costs associated with travel and coordinating schedules are diminished, but boards who previously attended all of their own hearings may still experience an increase in the number of hearings they attend for neighboring

boards. Boards that did not attend all prior hearings do report a significant burden on resources, all hiring at least one person for this duty.

In addition to simply attending the hearings, a lot of case management is needed prior to, during, and after the hearings. Nearly all CSBs used some of their funds associated with this reform to hire a case manager in addition to someone to attend hearings. Responsibilities for case managers have increased since the law clarified chains of communication throughout the commitment process and clarified the role of the CSB in monitoring consumers. Reports from the CSBs support the initial estimates made by the Department, so those assumptions and the dollar values associated with them will remain the same.

Costs associated with mandatory outpatient treatment are not being realized: The full effects of changes in mandatory outpatient treatment resulting from changes in utilization vary significantly between localities. Multiple parties were also hesitant to pass judgment on the utilization rate of MOT before the holiday season when consumers for whom MOT would be appropriate may increase. However, even if MOT has increased or remained constant in some localities, or even statewide, such an increase is not yet of the magnitude expected. Therefore, the costs caused by an increase in MOT will likely be less than predicted. Potential inpatient cost savings will likely not be realized since MOT is rarely used as an alternative to inpatient commitment.

Data collection costs are significant: Several CSBs in this sample hired an additional person or reassigned someone to data collection at least part-time. The fiscal impact statement assumed no new costs associated with information sharing across service providers, which is accurate, but the need to collect and report data to the Department has created additional costs for the CSBs. Data that must now be reported in a different fashion than in the past, and some must still be collected manually. Both collecting and reporting the data add additional costs.

New costs associated with more frequent recommitment hearings need to be considered: The time frame for the first recommitment hearing changed from 180 days to 30 days. Prior to July 1, 2008, most inpatient facilities held all recommitment hearings once per month on a designated day. With the change in the law, hearings must now be held more frequently, reportedly twice per month or more. This adds an extra burden to CSB staff because the costs of traveling to and attending these hearings has increased. The hospitals bear costs as well since they must accommodate the hearings in their facilities. With the frequency of hearings increasing, other participants in the civil commitment process, including independent evaluators, special justices, and attorneys incur additional costs as well. These costs were not explicitly considered in the impact on CSB hearing attendance, and the hospitals received no compensation for their increased costs. A hospital we interviewed reported the need to maintain an administrative staff position that had been slated for elimination in order to take care of tracking deadlines and scheduling hearings. The reported increase in burden from these hearings does not show up in the data, but looking at raw numbers of recommitment hearings is not sufficient to capture the administrative and personnel costs associated with more frequent hearings.

Costs to independent evaluators and special justices have increased: Increases in the amount of paperwork independent evaluators must review and fill out have increased the amount of time

necessary to complete each evaluation. Independent evaluators are paid $75 for each case, regardless of the amount of time spent on each case. Reimbursement rates for the evaluators have not changed, so they are bearing the costs as the time demands per case decrease their ability to participate in their private practice. A seasoned independent evaluator noted that the new paperwork requires that he devote an additional hour of time to evaluations per day, eliminating an hour of time that he can spend at his personal practice.[74] As a result, he forgoes the revenue from a private patient each day and is not compensated.

Special justices are also compensated on a capitated basis, meaning they receive $75 per case, regardless of how many times they must sit in on a hearing for that case. Under the new law, this form of reimbursement increases costs for the justices if they order mandatory outpatient treatment because the justice bears more responsibility for the case and must hold review hearings for the individual, but are not compensated at a higher rate.

Preliminary Conclusions

While the exact effects of the statutory changes are unknown, there appears to be little effect on commitments and no increase in mandatory outpatient orders: Reports from the community service boards and our initial data indicate that there has been little to no increase in the number of commitments or mandatory outpatient orders. This information should be reviewed cautiously since only one quarter has passed; just because no change is noticeable so far does not mean that it will not come as special justices become accustomed to the new regulations and community services boards see larger caseloads during the winter months and holiday seasons. Regardless of what occurs in the future, it appears that no new costs are currently being incurred by the mental health delivery system because of changes in commitments.

The mental health law reform resulted in several costs that were not included in the initial estimate that need to be added: The fiscal impact of the statutory changes extends beyond hearing attendance and provision on mandatory outpatient services: increases in the frequency of recommitment hearings increases costs for the hospitals themselves; data reporting requirements increase the number of hours CSB staff must devote to data collection; increases in paperwork increase costs of service provision; and, capitated reimbursement rates increase costs for special justices and independent evaluators.

More data are still needed on several key indicators: Changes in the numbers of ECOs, TDOs, and hearings could significantly impact costs of the mental health law reform. Gathering reliable data on these measures is crucial. Also, collecting and analyzing data over the whole year is an important piece of analysis because there are natural cycles in the service provision of mental health services as the number and nature of people served fluctuates with seasons and holidays. New regulations that seem trivial now may have a significant effect on costs during the winter when the level of consumers increases. The effects are difficult to predict, and the best snapshot could be taken after a full year of practice.

Until all significant data are available, the overall change to the initial estimate of fiscal effects is unknown: In addition to the effects that are still unknown due to missing data, the magnitudes

[74] Telephone conversation with Virginia independent evaluator with more than 20 years' experience.

of the effects that could be identified are unknown. Without data quantifying the magnitude of these changes, it is difficult to estimate how the total fiscal impact would change relative to the initial estimate. While projections could be made based on the available information, data that are currently being collected by the Department will well inform these trends in the very near future.

VII. QUESTIONS FOR FUTURE STUDY

During the development of this report, several policy issues repeatedly surfaced but were beyond the scope of our analysis. We briefly outline a few of those issues here for policymakers to consider as they continue to design policy to improve the provision of mental health services.

Is mandatory outpatient treatment a useful method of treatment? Community services boards support the emphasis on using the least restrictive treatment alternatives, but most representatives do not find mandatory outpatient treatment to be a useful method of treatment. Two factors were consistently cited by board representatives as contributing to its poor utilization rates: enforcement and criteria. As discussed earlier, the best way to enforce an MOT is uncertain, and many are reluctant to criminalize the mentally ill for noncompliance in a civil process. Also, with the standard for commitment to MOT the same as inpatient treatment, the usefulness of the policy declines since an individual passing the threshold for inpatient treatment is most often best suited in an inpatient environment.

If moving toward involuntary outpatient treatment is an important policy goal, reexamining the design in a way that addresses these and other concerns will be a useful endeavor. For more information on community services boards' comments on MOT, please refer to the case studies in Appendix B.

Inpatient bed space: The lack of available bed space was a significant concern among service providers. Although emphasis on less restrictive care is supported, many consumers are ill enough that they still need inpatient care. Maintaining access to inpatient beds for these individuals is critical to their wellbeing.

Funding for medication: Medication is often a crucial component of a treatment plan; but however crucial it may be, medication is also often expensive. Many consumers cannot afford the medications prescribed to them. The State pays for medication for some consumers via the Community Resource Pharmacy (previously known as the After Care Pharmacy). Medicaid and Medicare consumers also receive help paying for their medications. However, many consumers – particularly those that are uninsured – still bear a large burden of the costs of medication. If a consumer who cannot afford medication goes without his advised pharmaceutical treatment regimen, or resorts to cheaper, older versions of medications, this likely increases the risk of him relapsing. If he relapses, he may need to be committed until he stabilizes again. It may be worthwhile to conduct an analysis comparing the costs of increasing state funding for medication to the savings associated with preventing relapses into inpatient treatment.

Reimbursement rates for independent evaluators and special justices: Independent evaluators and special justices play important roles in the civil commitment process and maintaining a skilled cohort is important. Increasing the burden on these two parties without adjusting compensation provides them with a financial disincentive to participate in the civil commitment process or order mandatory outpatient treatment. Additionally, it could result in evaluators and justices spending less time evaluating each individual in order to speed the process along to preserve time to engage in other, more profitable employment. The best solution to this issue may not be to simply increase the reimbursement rate, but to restructure how evaluators and

special justices are compensated so that perverse incentives that favor one form of treatment over another are not created.

APPENDIX A

Department of Planning and Budget
2008 Fiscal Impact Statement

1. **Bill Number:** SB246

House of Origin	X	Introduced	X	Substitute	X	Engrossed
Second House	___	In Committee	X	Substitute	X	Enrolled

2. **Patron:** Howell

3. **Committee:** Passed Both Houses

4. **Title:** Involuntary commitment; establishes new standard for outpatient commitment.

5. **Summary:** Establishes a new standard for involuntary outpatient commitment authorizing involuntary commitment where the person has a mental illness and there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future (i) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm, or (ii) suffer serious harm due to substantial deterioration of his capacity to protect himself from harm or to provide for his basic human needs. This bill also requires a provider of mental health services to disclose records to a magistrate, the court, the person's attorney, the examiner, a community services board (CSB) or behavioral health authority, or law-enforcement officer; authorizes a single four-hour extension of an emergency custody order; provides that a person under a temporary detention order may be released prior to 48 hours after the order is executed if the person does not pose a danger to himself or others; specifies records and evidence that must be reviewed prior to an independent examination; requires that a representative of the CSB preparing the preadmission screening report attend each commitment hearing; establishes additional requirements for outpatient commitment; requires an outpatient treatment plan be filed with the outpatient order; and clarifies the monitoring duty of the community services board.

6. **Fiscal Impact Estimates:** Tentative

7. **Budget Amendment Necessary:** No

8. **Fiscal Implications:** The enrolled version of the bill is substantially the same as the introduced version. It can be broken down into several provisions, some of which will have a fiscal impact on Community Services Boards.

   - **Disclosure and Sharing of Information:**
     No fiscal impact. Affected organizations already have the information available. Provisions will allow for the legal transmission of this data.

   - **Criteria for involuntary inpatient admissions and mandatory outpatient treatment**
     This change may be perceived as broadening the existing criteria which might increase demand for local or state hospital inpatient beds. However, until the changes are put into practice, it is not clear what the impact will be. Other states' experiences have been

require an expansion of emergency services, including emergency consultation capacity. The Department of Mental Health, Mental Retardation and Substance Abuse Services was unable to determine the exact number of new inpatient commitments, however other provisions in the bill will initiate mental health treatment prior to involuntary commitment and may encourage less costly mandatory outpatient treatment. The addition of new crisis stabilization beds, and emergency psychiatric services proposed in the Governor's FY 2008 – 2010 biennial budget, will ameliorate any possible increase in demand.

- **Emergency custody order extension**
  No fiscal impact. Provision reflects or accommodates current practice.

- **Mental health treatment during the temporary detention period - $0.6 million**
  May increase immediate treatment costs for those awaiting trial, but costs should be offset in long-term by diverting individuals from costly involuntary commitments. The Governor's proposed budget includes funding for jail diversion treatment, emergency outpatient services, as well as psychiatric consultations that will enable CSBs to provide evaluation and treatment during the detention period. This provision is similar to the provisions of HB1237/SB440, which has an estimated impact of $647,744.

- **CSB attendance at hearings - $4.0 million annually**
  May increase CSB costs in regions where boards do not currently attending hearings. According to data from the Supreme Court, there are approximately 20,000 commitment hearings on an annual basis. The Office of the Inspector General determined that 50 percent of CSBs do not attend hearings on a regular basis. Urban CSBs are more likely to attend hearings than rural CSBs, and are less likely to be significantly impacted by this provision. Staffing has been noted as a significant barrier. It is estimated that, on average, each CSB would need at least two additional case managers to effectively attend hearings and case manage clients, or 80 system-wide. The cost per case manager is estimated at $50,000, for a total of $4.0 million per year.

  To meet recommended standards for caseload system-wide, the Office of the Inspector General estimated an additional 230 case managers would be needed at a cost of $11.5 million. This increase, however, would address service provision issues beyond those required by this legislation. The Governor's budget provides $8.8 million in funding for 106 new case managers by the end of the biennium.

- **Mandatory outpatient treatment – commitment and monitoring - $1.7 million annually (minimum)**
  While this provision may increase CSB costs, the proposed language generally provides clarity about what is to happen when someone is ordered into MOT, with the focus being on preparation of the treatment plan, identification of providers, monitoring responsibilities, and obligations when there is non-compliance. Of the 20,000 commitment hearings each year, approximately 50% lead to civil commitment.

  It is not known how many additional individuals will be ordered into mandatory outpatient treatment because the availability of appropriate services is still limited in the community. The Department of Mental Health, Mental Retardation and Substance Abuse

Services estimates a maximum increase in the number of individuals committed under mandatory outpatient treatment at 3,750. For every individual committed, it can be assumed the minimum number of hours of service will be 7.5 hours, or 10 office visits of 45 minutes each. Thus, on average, each CSB will be responsible for a minimum of approximately 700 new hours of service per year, or an average of approximately 13.5 service hours per week. It can be assumed that there are additional hours of administrative duties for each client. In total, each CSB will be responsible for a minimum of 1075 total hours, at a cost $42,000 per year. System-wide, the cost is approximately $1.7 million per year. In addition, each CSB would require a minimum of $35,000 for case management (approximately .7 FTE) of these individuals.

To address this cost, the Governor's introduced budget phases in $4.5 million in additional funds to expand and improve outpatient services for adults, in addition to the case management funds listed above. Although it is not anticipated that this will reduce costs at state facilities, it may free beds for individuals who do not meet mandatory outpatient criteria.

9. **Specific Agency or Political Subdivisions Affected:** Department of Mental Health, Mental Retardation and Substance Abuse Services; Community Services Boards

10. **Technical Amendment Necessary:** No

11. **Other Comments:** This bill is a companion to HB499.

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cc: Secretary of Health and Human Resources

APPENDIX B. COMMUNITY SERVICES BOARDS CASE STUDIES

Community Services Board #1			
Classification:	Rural	**Budget Size:**	Small

Basic Changes in Workload

- Hearing Attendance: Representatives from this board did not attend all hearings in their jurisdiction prior to July 1, 2008. However, even though a representative is required at each hearing now, this has not been too taxing because a representative may attend the hearing on the phone.
- Performance Contract: Completing requirements in the performance contract have created a significant burden for this board. The representatives we interviewed believe that the contract has created more work, more pressure, and more capturing of data that seem to be minute. It asks for a lot of specific details that they believe are unnecessary.
    - An example of such a taxing requirement is a mock call to a pre-screener; the goal is to return the call in 15 minutes. This board already tracks how long it takes to return calls. Its representatives felt that such tasks are an inappropriate use of its staff time, especially if the staff is needed in a *real* situation instead. Given the tracking mechanisms already in place for this, they feel this requirement in the performance contract is redundant and time consuming.
    - To meet all the stipulations of the contract, this board's staff has taken on a lot of administrative and data-tracking duties in addition to its regular duties.

Basic Changes in Caseloads

This board has seen a slight increase in pre-screenings, but its representatives were hesitant to attribute this increase to the statutory changes to civil commitment. They feel that it likely has more to do with cyclical patterns that they have seen in previous years, such as spikes in pre-screenings during holidays or during certain seasons.

Basic Changes in Commitments

- Inpatient Treatment: This board has not seen much of a change in the number of individuals committed to inpatient treatment. This board hospitalizes about a third of the people it screens, which its representatives attributed to the efforts of its staff to find the least restrictive method of treatment for its consumers.
- Mandatory Outpatient Treatment: There has been one order for MOT since July 1, 2008. MOT was used sparingly prior to July 1, 2008 as well. Representatives from this board expressed concern about the potential liability issues associated with releasing a person who meets commitment criteria back into the community.

Resources

This board has plans to hire a position that will be half funded with crisis stabilization money and half funded with state money appropriated in conjunction with the legislative changes to civil commitment. It also wants to hire a hospital liaison to assist in discharge planning. It has been hard for this board to fill these positions because it is hard to find licensed clinicians in rural areas. Additionally, this board has also not seen a dire need for these positions when there has been little increase in actual caseload.

- Bed Space: Bed space is a big source of concern for this board. It has to severely ration beds in state facilities in order to have space for the individuals who need it the most. Private providers will turn away people with violence in their profile; this board often gets law enforcement to hold them.
    - This board has utilized the LIPOS program for a while, and it has proven very effective at reducing admission to state facilities by providing funding for service (bed space) in a private psychiatric unit. This program is for people who are seriously ill, but not dangerous or violent. This board also diverts money from substance abuse services to pay for this program if the person's illness is substance related.

Additional Concerns

This board would like to have more discretion in its use of state funds so that it can be creative in providing the least restrictive treatment possible to its consumers. Its representatives believe that it is ineffective for the state to require certain funds be used for certain programs.

This board believes that there is still reason to further extend emergency custody orders. Though they can be extended for just cause, this board's representatives described feeling frantic and slightly panicked waiting for medical clearance and reports while knowing that the person can leave without another order.

Community Services Board #2			
Classification:	Rural	**Budget Size:**	Small

Basic Changes in Workload

- Hearing Attendance: Representatives from this board attended roughly 75 percent of hearings in their jurisdiction prior to the changes made to civil commitment. Attending all of them has proven a significant increase in workload for this board, but being able to attend hearings via technology has eased this burden slightly.

- Performance Contract: Representatives from this board feel that the data collection required by the performance contract is a bit redundant. It is also time consuming; they told us that the information required is not readily available through typical data collections systems and therefore required new data collection protocols. They were glad, however, that they are no longer required to conduct mock go-outs in the middle of the night to test the time it takes for their clinicians to reach a consumer in crisis. That would not have allowed them to be available to real consumers in crisis.

Basic Changes in Caseloads

This board has not seen a significant increase in pre-screenings, TDOs, or ECOs for this quarter. Its representatives believe that this is in part due to the fact that they have always erred on the side of caution.

Basic Changes in Commitments

- Inpatient Treatment: This board has not seen an increase in consumers committed to inpatient treatment.

- Mandatory Outpatient Treatment: This board has seen no orders for MOT since July 1, 2008. It has complied with MOT orders before, but special justices now feel uncomfortable ordering them. If a consumer is substantially likely to harm himself or others, or is unable to take care of himself, special justices do not feel it is appropriate to order him to treatment on an outpatient basis. This board's representatives said they may request mandatory outpatient treatment in the future for certain consumers that they know well and who are traditionally noncompliant.

Resources

This board has hired four new positions with the money allocated to it in conjunction with the legislative changes to civil commitment. One position was in emergency services for the purpose of hearing attendance. One position was a case management position. This board also hired a therapist and an administrative person to handle data collection.

- Bed Space: Bed space is an issue, but not a significant one for this board. Although, from time to time, its representatives will call all over the state to try to find a bed for a

consumer. Additionally, this board's Local Inpatient Purchase of Service program has been stretched thin recently. This board used to be able to buy bed space for a consumer for a full 30 days. Now, it can only afford to buy bed space for a consumer for four days.

Additional Concerns

This board is very concerned about independent evaluators and the increase in what is asked of them, particularly because their pay has not increased. This board has trouble keeping independent evaluators. It is also concerned about the fact that psychologists and psychiatrists do not have to complete a training process before becoming an independent evaluator.

This board is also concerned about the lack of standardization in commitment hearings across the state. In some jurisdictions, independent evaluations are conducted *during* the hearing itself. This is contrary to the law.

Community Services Board #3			
Classification:	Rural	**Budget Size:**	Medium

Basic Changes in Workload

- Hearing Attendance: This board did not attend all commitment hearings in its jurisdiction prior to the statutory changes. This was primarily due to staffing issues. Attending all hearings has increased the workload for the staff at this board; as a result, they hired an additional person to serve as a commitment hearing case manager. Another noteworthy increase in workload for this board has been re-commitment hearings.

Basic Changes in Caseloads

- ECOs and TDOs: This board has not seen an increase in the number of consumers ordered into temporary detention or emergency custody.
- Pre-screenings: This board has experienced a decrease in pre-screenings.

Caseloads are averaging 70 cases per staff member.

Basic Changes in Commitments

- Inpatient Treatment: This board has not seen a change in the number of consumers ordered into inpatient treatment.
- Mandatory Outpatient Treatment: Prior to July 1, 2008, this board facilitated the use of MOT as a step down treatment after inpatient commitment. After July 1, 2008, it has seen two MOTs in its jurisdiction. Representatives from this board told us that mandatory outpatient treatment is often difficult to manage because transportation problems can impede a consumer's ability to meet treatment obligations.

Resources

This board has used the funds allocated to it in conjunction with the statutory revisions to civil commitment to modify the focus of its staff. Instead of a staff that consists of members employed solely for mandated services, this board's staff now includes members who are dedicated to 24-7 crisis services. To do this, this board has employed four new staff members; one new member attends hearings for this board and two other boards, and three are crisis counselors hired to aid this board in its development of a 24- hour crisis stabilization unit that accepts TDOs. This center, which is co-located with a medical detox center, will expand the crisis prevention and response efforts of this board with a focus on triage, assessment, crisis intervention, and detoxification. It has ten beds in detox and six beds in crisis stabilization, as well as 24-7 counselors and peer support specialists. The goal of this project is to resolve emergency incidents to avoid commitment.

- Bed Space: Bed space is not a significant issue for this board largely because its representatives have a very productive working relationship with the state hospital in

their area. They work with the hospital's social work and discharge planning staff to prevent any hospitalizations they deem unnecessary. Representatives from this board expressed gratitude for this comfort with no longer pursuing petitions for hospitalization for certain consumers. This board is then able to divert people from admission into the community and focus on prevention of crisis circumstances. Unfortunately, its prudence does not always pay off regionally because other boards are not as careful with diverting people.

- Medication: This board has trouble with medication funding. It is $30,000 in debt to the Community Resource Pharmacy. Nurses at this board spend a great deal of time applying for medication resource programs and collecting samples for consumers.

Additional Concerns

Representatives from this board are concerned that recruitment and retention of specialized clinical abilities, particularly in rural Virginia, is difficult. It is also hard to ensure that there are enough staff members with these skills.

Community Services Board #4			
Classification:	Urban	**Budget Size:**	Medium

Basic Changes in Workload

- Hearing Attendance: This board has experienced a dramatic increase in the time it dedicates to attending hearings. Hearings and discharge planning are significant burdens on their time and resources. In fact, this board has only one person who attends hearings; this person devotes about 60 percent of his time to this task. Additionally, representatives from this board informed us that all hearings are out of their jurisdiction except for the small number of hearings that take place at the local state hospital.

- Required paperwork for hearings has also proven to be more taxing.

To meet this increased demand on resources, this board has reorganized its staff and hired new employees. One employee was hired to work in crisis stabilization. Another was hired to work in discharge planning and emergency referrals.

Basic Changes in Caseloads

- TDOs: This board has thus far observed a *decrease* in TDOs because of a lack of hospital beds and the emphasis on less restrictive alternatives such crisis stabilization services. The representatives we interviewed stressed that the inpatient safety net is not available like it used to be, even though it is required by law.

Basic Changes in Commitments

- Inpatient Treatment: For this board, institutional *access* is *declining* for inpatient commitment. Funding has remained relatively similar for inpatient treatment, but the costs of inpatient care are rising. This board was particularly concerned about the lack of public and private beds in lieu of the increased demand for commitment services that resulted from broadening the civil commitment criteria. By the end of the month, funding has often run out so consumers often cannot get the beds or the treatment they need.

- Mandatory Outpatient Treatment: Prior to the statutory changes, this board had only three orders for MOT in the last two years. Its representatives detailed several reasons for discouraging its use:

    - *It is not a useful method of treatment:* If a person is ill enough to meet inpatient criteria, then what advantages are there to committing them to mandatory outpatient treatment? Representatives from this board were concerned about enforcing these treatment plans for such ill individuals; for example, would they have to call the police in a situation of noncompliance? If so, does this criminalize the mentally ill? Is that appropriate?

- *It is a difficult treatment regimen to coordinate:* If a special justice believes that an MOT order is appropriate, he must first stop the hearing. Then, the community service board, mental health practitioners, and the attorneys present must all agree on the appropriate treatment plan, determine who will administer the treatment and how it will be administered, how the board will track the consumer's progress, and any other details. This is a time consuming process for all involved. It is very time consuming for the special justice and the independent evaluator, who are only paid per individual case; therefore, there is a financial disincentive for the special justice to order an MOT.

- *It is risky:* This board has seen an increase in new consumers as a result of broader commitment criteria. If they do not know the consumer, they do not feel comfortable ordering him to a treatment regimen where they have little ability to monitor him. They do not have a PACT team that would make monitoring easier.

The representatives we spoke to believe that the most useful time for mandatory outpatient treatment would be after discharge from inpatient treatment.

Resources

The money allocated to this board in conjunction with the recent legislative changes to civil commitment criteria was primarily put towards crisis stabilization programs. New money also went to emergency services. It also expanded its psychiatric services with a quarter time position.

- Medication: Finding a funding source for consumers is a significant problem for this board. Its representatives mentioned that some people are falling through the cracks; they are resorting to old, ineffective medications because they cannot afford new ones.

- Long Term Care: This board is concerned about the lack of resources for long term care. Essentially, resources are only available for intervention in a crisis. This board's representatives believe there is a need for build-up of acute inpatient services, as well as acute and long-term inpatient bed space.

Additional Concerns

The primary additional concern expressed by this board was the system's inability to help people who voluntarily seek treatment but do not have insurance. This creates a financial disincentive to provide the least restrictive treatment possible.

Community Services Board #5			
Classification:	Urban	**Budget Size:**	Large

Basic Changes in Workload

- Hearing Attendance: Members from this board always attended hearings prior to the statutory changes to civil commitment, so this board's workload did not change in this respect.

Basic Changes in Caseloads

The caseload for this board has increased, but the representative we interviewed from this board believes that increase has little to do with the changes to the civil commitment laws. Instead, she believes it is a result of increases in population and increases in the number of mentally ill within that population, among other various factors.

Basic Changes in Commitments

- Temporary Detention Orders: This board has seen an increase in consumers ordered into temporary detention.
- Inpatient Treatment: Inpatient commitment rates are about the same for this board as they were prior to the changes in the civil commitment criteria.
- Mandatory Outpatient Treatment: This board has a plan for MOT, but it did not use it before the changes to the law and it has not used it since. Everything is in place for it, but MOT is seen as cumbersome.

Resources

The money allocated to this board in conjunction with the recent legislative changes was primarily used to hire another full time emergency worker, another discharge planner, and another case manager. This board needed these positions filled so that it could increase the hours where staff could be on site.

- Bed Space: Finding available bed space for inpatient consumers is a big problem for this board. It often has to set up special arrangements with local hospitals. This board has utilized a local crisis house for years, which is extremely helpful. This house is not funded by the state; instead, it is funded by the county.
- Medication: This board does not have the capability to provide instant medication because it does not have the funds, and it does not have a 24-hour psychiatrist on staff. Much of the payment for medication for consumers without a payment source comes from a local church/charitable organization. This board relies very heavily on their good will to cover costs of expensive medication for its mentally ill consumers.

Additional Concerns

This board is concerned about its inability to provide around-the-clock services to its community. Despite the recent hires, this board still has a shortage of emergency staff.

Community Services Board #6			
Classification:	Rural	**Budget Size:**	Large

Basic Changes in Workload

Hearing Attendance: Representatives from this board attended all local hearings before the reform, so there were no new demands specifically resulting from the new requirement to attend every hearing. However, the frequency of re-commitment hearings has increased significantly because orders that were previously valid for up to 180 days must now be renewed every thirty days. The number of hearings at hospitals for these consumers has doubled or tripled, consuming significantly larger amounts of time for representatives from this board.

Basic Changes in Caseloads

This board has not observed any changes in its caseload, both in terms of pre-screenings and commitment hearings.

Basic Changes in Commitments

No real changes in the frequency or outcomes of commitment hearings have been observed since July 1, 2008.

- Inpatient Treatment: No real changes in the amount of consumers ordered into inpatient treatment have been observed since July 1, 2008.

- Mandatory Outpatient Treatment: Prior to the statutory changes, this board saw an average of two to three MOT orders per year. It has seen two in one quarter *after* the aforementioned changes. Representatives from this board were careful to note that during April-July of 2007, an unusually large number of MOTs were ordered after the shootings at Virginia Tech made many special justices more risk averse. This spike in the number of MOT orders started to decline in July of 2007.

  Representatives from this board cited several reasons for the absence of a significant increase in MOT orders:

  - *It is difficult to enforce*: Mandatory outpatient treatment falls into a grey area between inpatient commitment and voluntary treatment. If the person chooses not to comply, how the board and special justice should respond is uncertain. Should they criminalize the consumer for not following a court order, commit him to inpatient treatment, or let him go without punishment?

  - *It places new levels of responsibility on special justices*: The commitment process is driven by the special justices. The law reform placed responsibilities on the special justices if they order outpatient treatment that did not previously exist.

  - *Additional challenges:* Private providers are unlikely to want to participate in the MOT process with their current patients; serving an individual ordered to MOT places them in a subordinate position to the board that will monitor their patient,

> and the process requires them to take steps for which there is no reimbursement possible. Two of their six area colleges have communicated with this board that they would be unable to participate in the monitoring process following an MOT order for one of their students. These colleges feel that they do not have enough psychiatric or clinical coverage to appropriately monitor someone who meets criteria for MOT. The special justices in this area and this board are in agreement that the best alternative for follow-up for a MOT is for the board to take responsibility for the patient's treatment, rather than referring this to a private provider.

Representatives from this board did cite one case where they requested mandatory outpatient treatment. The individual for whom this treatment plan was requested was repeatedly noncompliant; he is now compliant under a court order.

Resources

The money allocated to this board in conjunction with the recent legislative changes to civil commitment criteria was used to increase staffing levels in key areas. It helped finance five new positions, four of which fell into the following areas: case management, outpatient services, emergency services, and data collection. The fifth person hired was a police officer, which enables this board to receive ECOs on-site.

In addition to state funds, this board has a large Medicaid population. However, it also has a significant number of consumers who do not qualify for Medicaid and have no other funding source. Providing services to these individuals is a constant challenge for budgeting.

Additional Concerns

This board was very concerned about financial resources. While some new funding was provided to pay for the changes expected to take place with this law reform, state funding was cut from other areas at the same time, leaving total resources relatively unchanged. This board is very concerned about the possibility of further funding cuts and the impact that could have on service provision.

Community Services Board #7			
Classification:	Urban	**Budget Size:**	Large

Basic Changes in Workload

Hearing Attendance: This board attended all hearings prior to July 1, 2008, so the new requirement to attend all hearings did not prove to be a significant increase in workload for this board. This board also covers hearings for nearby boards.

Basic Changes in Caseloads

This board has seen an increase in the number of consumers it screens. Its representatives believe this increase in consumers is a function of the change in perception of eligible people and its increase in available resources for emergency services.

Basic Changes in Commitments

- Inpatient Treatment: This board has not seen an increase in the number of consumers ordered into inpatient treatment.
- Mandatory Outpatient Treatment: This board has the capability to enforce orders for MOT; however, it rarely sees an order for it. This board's representatives believe that MOT is not helpful to consumers as it is currently written. If a consumer is ill enough to meet inpatient criteria, then outpatient treatment would not be helpful for him because he will need hospital supervision. Additionally, special justices are reluctant to order MOT because it is a logistical hassle to come up with a treatment plan, determine who will implement the plan, and coordinate with the relevant CSB to determine how the plan will be enforced.
- Least Restrictive Treatment: This board expressed a strong preference for referring consumers to the least restrictive treatment option available to them. Crisis stabilization, for example, is often used for this board's consumers who are close to meeting commitment standards, but are still capable of voluntarily consenting to their treatment. Crisis stabilization- "mental health emergency rooms" provide the same 24 hour supervision as a hospital and consumers can remain there up to ten days, or until they stabilize.

However, given that MOT is rarely used and crisis stabilization can be utilized up to only ten days, this board sees the same consumers cycling through inpatient treatment over and over again.

Resources

Because this board is a larger board, it has substantial ability to refer people to less restrictive programs. This board considers its ability to extensively utilize less restrictive programs as a very important asset.

- Medication: Finding a funding source for medication for its consumers is a significant problem for this board. State funding can only be accessed if a consumer has been hospitalized in a state facility enough times. This board feels this is unreasonable because funding is therefore only available for those that are very seriously ill.

Additional Concerns

This board is concerned about the fact that CSBs are only required to provide emergency services; only if they have the extra funds will a board also provide adequate case management and other services. The representatives we interviewed from this board are concerned that this requirement lets people down because boards are only required to intervene in a crisis situation.

Community Services Board #8			
Classification:	Urban	**Budget Size:**	Large

Basic Changes in Workload

- Hearing Attendance: This board attended all hearings in its jurisdiction prior to July 1, 2008. The new requirement to attend all hearings did not prove to be a significant increase in workload for this board. Representatives from this board also attend hearings for nearby boards.

- Performance Contract: Requirements in the performance contract have led to a significant increase in workload for this board. It has had to retool its data management system and train its staff in data entry. In addition to the new responsibility of entering a lot of data, this board's management spends a lot of time making sure the data is entered properly.

Basic Changes in Caseloads

- TDOs and ECOs: This board has seen a decrease in the number of TDOs issued in its jurisdiction. In FY 2008, it had a total of 269 TDOs from July to October. In FY 2009, it had a total of 239 TDOs. This board's representatives believe this reduction is largely a result of their efforts to divert hospitalization and to save Local Inpatient Purchase of Service (LIPOS) expenditures.

- Pre-screenings: This board has experienced a slight decrease in the number of emergency consumers evaluated as of July 1, 2008. In FY 2008, 479 pre-screenings were conducted. In FY 2009, 429 pre-screenings were conducted.

Basic Changes in Commitments

- Inpatient Treatment: This board has not seen an increase in the number of consumers ordered into inpatient treatment in actual numbers. However, a larger *percentage* of consumers were ordered into involuntary treatment. In spite of decrease in number of TDOs from FY 2008 to FY 2009, the number of involuntary commitments from July to October in FY 2009 is the same as it was for that period in FY 2008.

- Mandatory Outpatient Treatment: This board has previously seen orders for MOT, but it has not seen an order for MOT since July 1, 2008. This board cited several reasons for the lack of MOT this quarter:

    - *Lack of funding:* This board's county has not allowed it to accept new state money yet. This board does not have sufficient resources to support an MOT.

    - *MOT planning requirements are stringent:* The special justices in this board's region find the law to be onerous not only to themselves, but also to the CSBs. The requirements for the initial treatment plan are also too stringent in their opinion.

Resources

The money allocated to this board in conjunction with the recent legislative changes was primarily used to hire two nurse practitioners, two community-based case managers, and one MOT coordinator.

- Bed Space: Finding bed space for certain consumers is a problem for this board, especially when it comes to temporary detentions. Private hospitals in particular do not want to accept a consumer if he or she is violent. This board generally looks to its state psychiatric hospital to serve as a safety net and option of last choice. Currently, 25 percent of consumers at this state hospital have health insurance. Additionally, due to an increase in private hospital per diem rates, this board is projected to run out of Local Inpatient of Service (LIPOS) money in March of 2009.

- Medication: Finding a funding source for medication for its consumers is a problem for this board. It is currently overspent in its medication allotment for state pharmacy medications by roughly $500,000.

Additional Concerns

- Outpatient Services: Due to the demand for services for seriously mentally ill consumers and limited outpatient resources, this board has had to discontinue outpatient mental health services to all adults who are not seriously mentally ill.

- Budget Cuts: This board's county is facing a 20-33 percent cut in local funding for next year. State funding this year has also been reduced and will likely be reduced next year as well. This will eliminate or reduce many of the services this board provides to its consumers, including mental health, substance abuse, mental retardation, and early intervention services.

- Private Sector Capacity: Private sector capacity is stretched in this board's jurisdiction. Psychiatrists who accept private insurance have waitlists of six to eight weeks. Sliding scales for private practitioner therapists start at $60.

This board is not able to help many adults who are not seriously mentally ill. In order to provide services to this community, this board would need funding for more supported residential services, intensive community treatment or PACT teams, more services for mental retardation and mental health case management services, more substance abuse detoxification services, and more support for crisis stabilization, among other items.

Community Services Board #9			
Classification:	Urban	**Budget Size:**	Large

Basic Changes in Workload

- Hearing Attendance: This board has a lot of trouble covering all commitment hearings; it covers hearings at two hospitals with 36 beds, at private hospitals in the area, and hearings for other nearby boards. Roughly 25 percent of the commitment hearings this board attends are for other boards.

Basic Changes in Caseloads

- TDOs and ECOs: This board has not seen a significant change in the number of consumers ordered into emergency custody or temporary detention as a result of the changes in the criteria for commitment. At *most*, this board estimates it has seen an increase of ten percent in the number of ECOs and TDOs. Representatives from this board also noted that, though they have hospitalized more people in the last full fiscal year, they suspect that increase is due to more to increased risk aversion after the shootings at Virginia Tech than the recent legislative changes to the criteria for civil commitment.

Basic Changes in Commitments

- Inpatient Treatment: Inpatient commitment rates are about the same for this board as they were prior to the changes in civil commitment. The representatives we interviewed attributed this consistency to the variable availability of bed space.

- Mandatory Outpatient Treatment: This board did not see any orders for MOT prior to the legislative changes to civil commitment. It has not seen any orders for MOT on the local level *after* the changes. This is in part because the special justice in this board's area is not supportive of the current MOT statute; he is reluctant to order MOT when the criterion for MOT is the same as for inpatient commitment.

Resources

The money allocated to this board in conjunction with the recent legislative changes to civil commitment was primarily put towards new hires. This board hired a full time position solely to attend hearings. This board also hired a mandatory outpatient coordinator/hospital liaison, as well as a person to coordinate emergency services in the counties in its jurisdiction because its rural clinics in particular have extremely light emergency services coverage. This board also added to its outpatient capacity.

- Bed Space: This board sometimes has to send consumers to another hospital two hours away when there is no space for them in nearby hospitals. This is a significant problem because, if consumers are admitted to a hospital two full hours away, no one from this board can attend their hearings.

- Medication: Finding a payment source for medication is a significant problem for this board; it does not have a budget to pay for emergency services medication. This is especially a problem for consumers in crisis stabilization.
    - Another problem with medication funding for this board is that it lacks funding for a sufficient psychiatric staff to *prescribe* medication; it has about 2.5 FTE's for its prescribers. The wait for a doctor visit is typically three to four weeks.

Additional Concerns

This board expressed concerns about community services board coordination with hospitals. Common examples are as follows:

- If a consumer has violence in his profile, then even if there are beds available in a hospital, it is unlikely that the hospital will admit him. This board sees this often with private hospitals. Sometimes, this means the consumer will get temporarily detained in an emergency room. Sometimes, a reluctant state hospital will admit him.
- If a consumer who is ill enough for civil commitment does not insurance and *voluntarily* consents to treatment, then a private hospital will put a lot of pressure on this board to temporarily detain that consumer even though he does not meet TDO criteria.

This board is also concerned with the occasional micromanagement of the length of commitments by special justices. The special justices may decide on their own when someone is ready for discharge rather than letting doctors determine when the person is ready.

Community Services Board #10			
Classification:	Urban	**Budget Size:**	Large

Basic Changes in Workload

- Hearing Attendance: The new statutory requirement of attendance by a CSB representative at commitment hearings has had little impact on this board's workload. Because this board operates a 24-hour crisis stabilization unit and maintains a close relationship with the local magistrates' office, representatives from this board estimated that they were already sending representatives to 85 to 90 percent of commitment hearings prior to the statutory changes. The most significant burden has been attending re-commitment/certification hearings at state psychiatric facilities.

- Training: This board has not conducted any formal training for its staff on the new paperwork and evaluation requirements. However, training was offered and provided to community behavior healthcare partners who requested it.

- Performance Contract: The inability to track some new data has required manual data collection; this is a significant addition to this board's workload, particularly in emergency services. Representatives from this board stressed the need to improve efficiency and conserve resources by streamlining reporting requirements and eliminating the collection of duplicate data.

Basic Changes in Caseloads

- TDOs and ECOs: This board has not observed any changes in the number of ECO or TDO proceedings since the new civil commitment standard was implemented. From July 1, 2008 to September 30, 2008, there were 81 ECOs and 459 TDOs compared to 76 ECOs and 458 TDOs during the same quarter the previous year. However, representatives from this board said that it may take several more months for any impact of the statutory changes on caseloads to become apparent.

- This board has seen an increase in pre-screenings. 770 pre-screenings were conducted in the first quarter of this year compared to 672 pre-screenings in the first quarter of the previous year.

Basic Changes in Commitments

Neither the number of commitment hearings nor the fraction of hearings resulting in commitment have changed significantly for this board.

- Inpatient Commitment: This board has not seen much of a change in the number of consumers ordered into inpatient commitment. 476 of 561 temporarily detained adult consumers (85 percent) were ordered into inpatient commitment this year compared to 442 of 536 (83 percent) for the same period in the previous year. Increasing inpatient bed day costs threaten this board's ability to maintain Local Inpatient Purchase of Service (LIPOS) throughout the fiscal year.

- Mandatory Outpatient Treatment: Although this board has been capable of supporting MOT for several years, MOT orders were very rare prior to July 1, 2008 (seven adult consumer MOTs for FY 2008) and have not been used since July 1, 2008.
    - Representatives from this board believe that many TDO consumers who are currently being discharged without being committed to inpatient treatment would be appropriate candidates for MOT. An increase in funding for MOT would enable this board to ensure that these consumers received appropriate follow-up care. However, this may require a lower bar for MOT relative to inpatient commitment.

Resources

The funds allocated to this board in conjunction with the legislative changes were used in several different ways. This board increased its capacity in emergency services by two FTEs in anticipation of an increased demand for TDO screenings and lengthier commitment hearings. Funds were also designated for a modest increase in psychiatric hours purchased and for a new outpatient clinician.

- Crisis Stabilization: Representatives from this board believe that the statutory changes have highlighted a pre-existing need for an increase in crisis stabilization funding. This board is in the process of developing a crisis intervention training program for local law enforcement officers. It planned to use a promised budget increase associated with the statutory changes to add a psychologist to its emergency assessment team, but has not yet received the funds.

- Medication: Finding resources for medications for medically indigent consumers, as well as assisting Medicare Part D consumers with co-pay obligations, remains a challenge for this board.

Additional Concerns

Representatives from this board believe that it will take several more months for the full budgetary impact of the statutory revisions to become apparent. In particular, the increase in caseloads typically associated with the winter holidays will increase the general stress on CSBs, making it easier to spot new areas of need.

Area emergency room staff have been reporting on what appears to be an increase in the number of police drop-offs to avoid the ECO process. There have been similar reports of law enforcement leaving or attempting to abandon custody of consumers in emergency rooms who are already under ECOs.