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## Southeastern Regional Office

### A STUDY OF THE EMERGENCY MENTAL HEALTH SERVICES AND INVOLUNTARY CIVIL COMMITMENT PRACTICES IN VIRGINIA,

November 1989

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## PREFACE

This report and the research project upon which it is based are one component of a study of the provision of mental health emergency services and involuntary civil commitment practices in Virginia by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). The research project was conducted by the Institute on Mental Disability and the Law under the aegis of the Southeastern Regional Office of the National Center for State Courts. Both the Institute and the Southeastern Regional Office are units of the National Center located at the Center's headquarters in Williamsburg, Virginia.

The National Center for State Courts' purpose is to help state and local courts better serve litigants and the public in an increasingly complex and technological society. It serves as the courts' central resource for improving court administration and operations. Through its regional offices, the National Center services court needs for modernizing and improving judicial administration at the state and local level. The Institute on Mental Disability and the Law was created as a unit of the National Center in 1981 in recognition of the increasing number and complexity of mental health claims and problems facing the courts in criminal, civil, juvenile, and domestic relations proceedings. The Institute's multi-disciplinary staff provides research, program evaluation, policy analysis, consultation, technical assistance, and education to judges, court managers, mental health practitioners and administrators, and others at the state and local level who are involved in justice and mental health

interactions. Through its activities, the Institute aims to improve the interactions of the justice and mental health systems by working toward better coordination, continuity, communication, and cooperation.

Many individuals had a hand in the completion of this report in addition to the individuals listed by name on the title page. During the field research in the catchment areas of five community services boards (CSBs)--Arlington, Central Virginia, Colonial Williamsburg, Northwestern, and Richmond--dozens of individuals helped to explain and demonstrate the emergency mental health services and involuntary civil commitment practices. Many more individuals responded to a state-wide survey and assisted in various project activities. The National Center acknowledges with gratitude the generous contributions of all these participants in the project, and particularly thanks the DMHMRSAS for enabling this effort to improve the mental health emergency services and involuntary civil commitment practices in Virginia.

Because this report presents the results of a project of the National Center, the views expressed and the conclusions drawn in this report are those of the authors and do not reflect necessarily the policies or opinions of the DMHMRSAS.

**PART I**  
**GENERAL INTRODUCTION**

In the fall of 1988, the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) began a study of the provision of mental health emergency services and involuntary civil commitment practices in Virginia. In early 1989, as one component of DMHMRSAS' study, the Department contracted with the Southeastern Regional Office and the Institute on Mental Disability and the Law of the National Center for State Courts (NCSC) to provide a description of the current provision of mental health emergency services and involuntary civil commitment practices throughout Virginia. The purpose of this description was to provide an empirical basis for the review and improvement of policies and procedures governing the delivery and receipt of emergency mental health services and involuntary civil commitment practices in Virginia. This report presents the findings of the NCSC's study. The views expressed and the conclusions drawn in this report are those of the authors and do not reflect necessarily the policies or opinions of the DMHMRSAS.

**Nature of the Study**

This study is not predicated on any particular theory or hypothesis regarding the provision of mental health emergency services and involuntary civil commitment practices in Virginia. Although the tendency to view the complexities of emergency mental health services and the involuntary civil commitment process in abstract, polar terms and dimensions such as personal liberties versus treatment needs, doctors versus lawyers, the legal model

versus the medical model, or the state's police function versus its parens patriae function may be theoretically or historically useful, such dichotomies do not fit the realities facing the public mental health system today and are at odds with signs pointing to a virtual breakdown of that system (e.g., the emergence of a dual system of care for the poor and for those who can afford to pay).

Throughout the country, intense debate and controversy have centered on the factors that mental health professionals, law enforcement officers, and commitment courts legally are required to consider in responding to people in crisis. Most attention has focused on factors that make up the standards, criteria, or "tests" for involuntary civil commitment, factors that many consider the "core" of emergency mental health services and commitment practices. Much of the history of involuntary civil commitment in Virginia and elsewhere has been the working and reworking of these formal "tests" for involuntary civil commitment, with relatively little regard to whether the different legal tests make any difference in actual practice. As one commentator has noted:

Historically, the public civil commitment debate was more crude than sophisticated, often pitting friends, relatives, and neighbors against state and local governments. The views of the mentally disabled person were at best secondary considerations. The options for mentally disabled persons were usually limited to all or nothing types of choices: remain in the home without government assistance or interference; be ostracized to an unknown fate; or be committed to some awful institution.<sup>1</sup>

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<sup>1</sup>Parry, John. Civil Commitment: Three Proposals for Change, 10 Mental and Physical Disability Law Reporter 334-338 (1986).

Rather than focusing on the "law on the books," where most of the debate about emergency services and civil commitment has centered, this study directs attention to the organization and everyday administration of the provision of emergency services and civil commitment practices.

The approach taken in this study has its roots in the Guidelines for Involuntary Civil Commitment,<sup>2</sup> the written product of a national task force assembled by the National Center for State Courts through its Institute on Mental Disability and the Law. In the course of preparing the Guidelines, ideology, doctrine, and theory surrendered ground to pragmatism and empiricism. Most of the recommendations contained in the guidelines can be implemented within existing statutory frameworks, a characteristic that sets them apart from the model for legislative reform proposed by the American Psychiatric Association in 1982 and the Mental Health Law Project in 1977. The Guidelines, and related publications which derived from the seven-year Involuntary Civil Commitment Project, are recommended to the reader of this report who is interested in a national perspective consistent with the approach and findings of this study.<sup>3</sup>

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<sup>2</sup>National Center for State Courts. Guidelines for Involuntary Civil Commitment, 10 Mental and Physical Disability Law Reporter 409-514 (1986).

<sup>3</sup>Arthur, Lindsay G., Haimowitz, Stephan, and Lockwood, Robert. Involuntary Civil Commitment: A Manual for Lawyers and Judges. Washington, D.C.: Commission on the Mentally Disabled, American Bar Association (1988); Stann, Elizabeth, and Keilitz, Ingo. Improving the Practice of Involuntary Civil Commitment. Williamsburg, VA: Institute on Mental Disability and the Law, National Center for State Courts, 1989. Keilitz, Ingo. An Introduction to the National Center for State Courts' Guidelines for Involuntary Civil Commitment, 39 Hospital and Community Psychiatry 397 (1988); Keilitz, Ingo. NCSC Guidelines for Involuntary Civil Commitment: A Workable Framework for Justice in Practice, 39 Hospital and Community Psychiatry 398-402 (1988); Wexler, David B. Reforming the Law in Action Through Empirically Grounded Civil Commitment Guidelines, 39 Hospital and Community Psychiatry 402-405

## Outline of Report

Emergency mental health services and involuntary civil commitment practices involve various components of the mental health, justice, public safety, and social service systems including hospitals, community mental health centers, social service agencies, courts, law enforcement agencies and advocacy groups. The purpose of this study was to describe, organize and define the exceedingly complex and often confusing interactions between and among these various components of the system. This was accomplished by combining qualitative data from in-depth field research in the catchment areas

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(1988); Appelbaum, Paul S., and Roth, Loren H. Assessing the NCSC Guidelines for Involuntary Civil Commitment from the Clinician's Point of View, 39 Hospital and Community Psychiatry 406-410 (1988); Fitch, W. Lawrence. Involuntary Civil Commitment of the Mentally Ill: Implementation of the Law in Winston-Salem, North Carolina, 14 North Carolina Central Law Review 406-472 (1984); Keilitz, Ingo, Conn, D., and Giampetro, Andrea. Least Restrictive Treatment of Involuntary Patients: Translating Concepts Into Practice, 29 St. Louis University Law Journal 691-745 (1985); Keilitz, Ingo, Fitch, W. Lawrence, McGraw, Bradley D. A Study of Involuntary Civil Commitment in Los Angeles County, 14 Southwestern Law Journal 238-314 (1984); Keilitz, Ingo, and Hall, Terry. State Statutes Governing Involuntary Outpatient Civil Commitment, 9 Mental and Physical Disability Law Reporter 378-397 (1985); Keilitz, Ingo, Keilitz, Susan, and McGraw, Bradley D., et al. Improving the Involuntary Civil Commitment Process: Guidelines Balance Individual's Rights With Society's Interests, 7 State Court Journal 15-17, 35-36 (1983); Keilitz, Ingo, and Roach, R. F. Study of Defense Counsel and Involuntary Civil Commitment in Columbus, Ohio, 13 Capital University Law Review 175-202 (1983); Keilitz, Ingo, and Van Duizend, Richard D. Current Trends in Involuntary Civil Commitment, 31 Rehabilitation Psychology 27-35 (1986); McGraw, Bradley D, Fitch, W. Lawrence, Buckley, C.H., et. al. Civil Commitment in New York City: An Analysis of Practice, 5 Pace Law Review 259-307 (1985); McGraw, Bradley, D., and Keilitz, Ingo. The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment, 6 Whittier Law Review 35-70 (1984); Van Duizend, Richard, McGraw, Bradley D, and Keilitz, Ingo. An Overview of State Involuntary Commitment Statutes, 8 Mental and Physical Disability Law Reporter 328-335 (1984); Van Duizend, Richard D., and Zimmerman, Joel. The Involuntary Civil Commitment Process in Chicago: Practices and Procedures, 33 DePaul Law Review 225-276 (1984); and Zimmerman, Joel, and Fitch, W. Lawrence. Involuntary Civil Commitment: The Discerning Eye of the Law, 5(4) State Court Journal 5-7, 24-30 (1981).

of five community services boards (CSBs) -- Arlington, Central Virginia, Colonial Williamsburg, Northwestern and Richmond -- with quantitative data from a state-wide survey of mental health professionals and special justices who are involved in the provision of emergency mental health services and involuntary civil commitment practices. Based on these data, observations and issues were identified for possible consideration by DMHMRSAS. These issues are presented in Part II, immediately following this General Introduction. The field research and the survey data on which the observations and issues are based, are presented in Parts III and IV, respectively.

Throughout the report, for convenience of presentation, the provision of emergency services and involuntary civil commitment practices are discussed in terms of four phases. The first phase consists of the events that take place between the occurrence of a mental health emergency and the decision to provide voluntary care or to request that the individual in crisis be temporarily detained. The second phase includes the procedures and decisions involved in temporarily detaining an individual. The third phase includes the preparation for and conduct of judicial commitment hearings, and the fourth phase includes the events that take place immediately following a hearing. Although the specific events of each phase vary across CSBs and jurisdictions in Virginia; in general, the steps involved in each phase are those that are presented in Figures 1-1, 1-2 and 1-3. Each site report in Part III contains a graphic description that can be compared to this general depiction of the provision of emergency services.

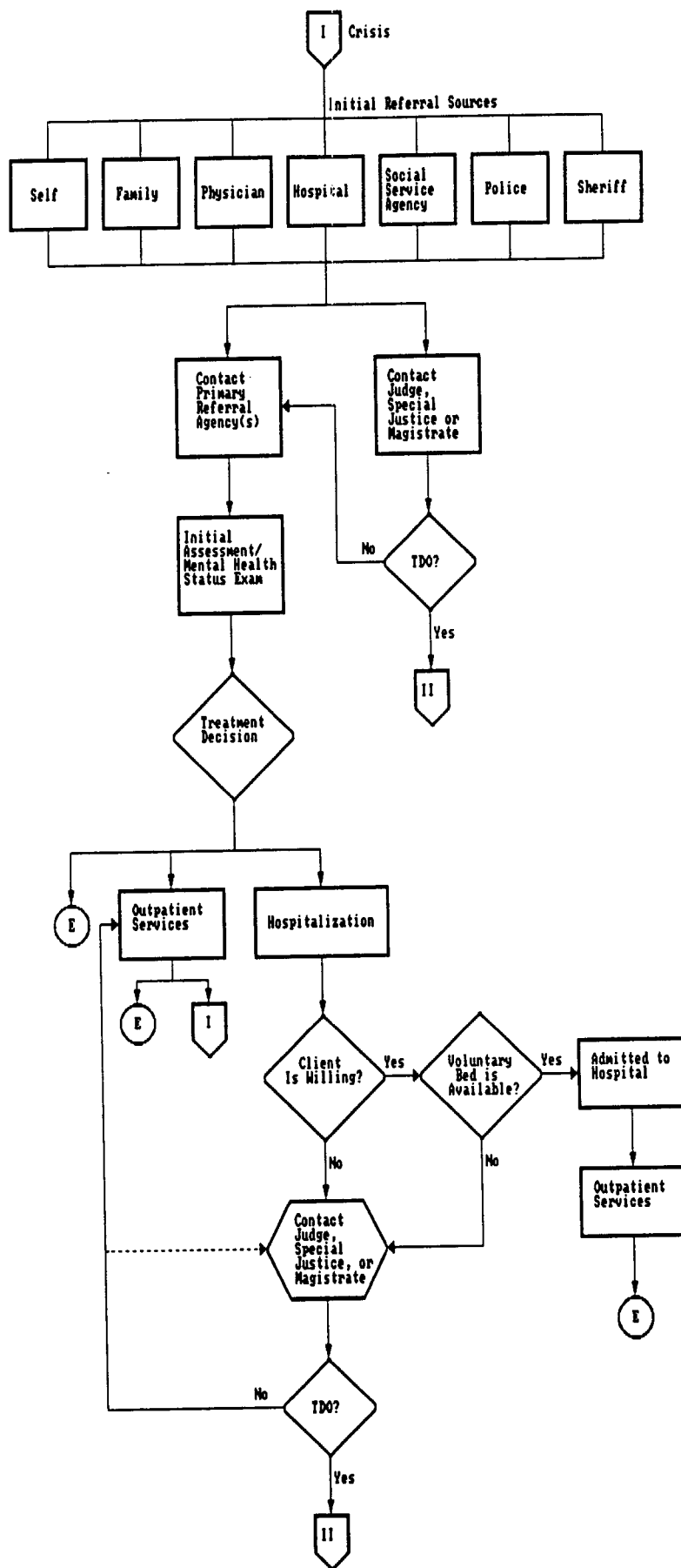


Figure 1-1 Emergency Mental Health Services and Involuntary Commitment Practices - Crisis to Temporary Detention or Voluntary Care



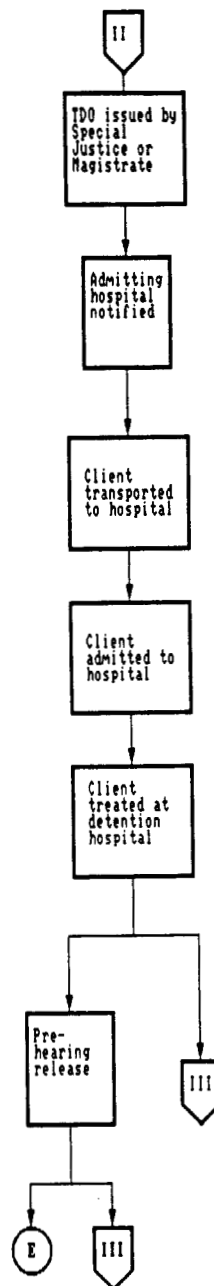


Figure 1-2 Emergency Mental Health Services and Involuntary Commitment Practices -  
Temporary Detention Through Inpatient Services

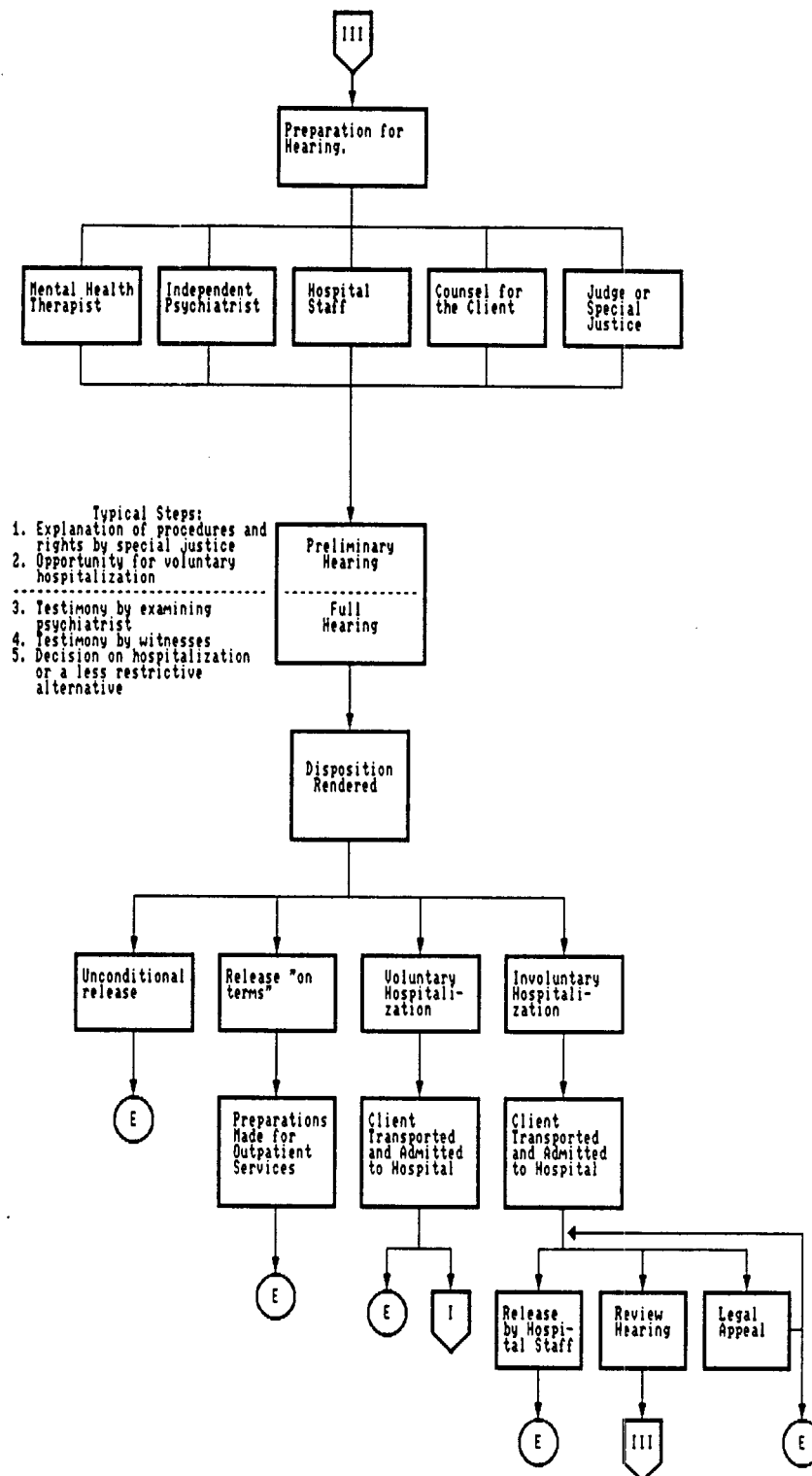


Figure 1-3 Emergency Mental Health Services and Involuntary Commitment Practices - Preparation for Judicial Hearings Through Post-Hearing Matters

## PART II

### OBSERVATIONS

Research entails identifying the problem to be addressed, designing and executing the data collection, analyzing and interpreting the results, making midcourse corrections to follow significant leads, and so forth.

Implementation entails another set of issues and actions--identifying and diagnosing the problem, designing appropriate responses to research results, gaining sponsorship and resources, setting goals, handling "politics," and producing desirable results.<sup>1</sup> This Part focuses on the overlap of research and implementation. It highlights a set of "observations" about the emergency mental health services and involuntary civil commitment practices in Virginia drawn from a series of in-depth descriptive studies in five Virginia localities presented in Part III, and the results of a state-wide survey presented in Part IV. The observations--organized under topical headings--are embedded in commentary drawn from the in-depth studies, the survey results, and other studies conducted by the Institute on Mental Disability and the Law of the National Center for State Courts.

The observations are intended to inform the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)--and its Emergency Services Advisory Committee--in its study of the emergency mental health services and involuntary civil commitment practices in Virginia.

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<sup>1</sup>Milton D. Hakel, Melvin, Sorcher, Michael Beer, and Joseph L. Moses. Making It Happen: Designing Research With Implementation in Mind. Beverly Hills, CA: Sage Publications, 1982.

The observations are presented with implementation and change in mind. However, with a few exceptions--when the observations are tantamount to making recommendations per se--no specific recommendations are made with the understanding that DMHMRSAS is best situated to design and initiate strategies for implementation. Such strategies include: law reform (legislation, litigation, reports of the Attorney General, and local rulemaking), training and education, resource development, funding, policy development, the drafting of procedural guidelines, program evaluation, and research. These may be implemented statewide or at the local level, within and across the various governmental units and private entities responsible for emergency mental health services and involuntary civil commitment practices in Virginia including the DMHMRSAS, the Supreme Court of Virginia, circuit and district courts, community service boards (CSB), public hospitals, private hospitals, mental health centers, and related social services providers.

Because this report is directed to the DMHMRSAS, the observations tend to be systemic rather than procedural. That is, they identify salient aspects of the systems of emergency mental health services delivery and involuntary civil commitment practices rather than the legal, mental health, and related social service procedures and events that make up those systems. For example, lack of procedural uniformity and lack of trained staff are highlighted with regard to the conduct of mental health status examinations rather than perceived flaws in the manner in which such examinations are conducted per se.

The focus of the observations--and the general types of responses suggested by them--can be grouped in the following five categories:

- (1) fragmentation and lack of coordination, continuity, communication, and cooperative arrangements among the elements and components that make up the system of

emergency mental health delivery and involuntary civil commitment practices (e.g., Observations 1 and 7);

- (2) vagueness in the law and policies governing the operation of the systems (e.g., Observations 3, 6, 8, 9, 10, 11, 12, 13, 15, 20, 21, and 22);
- (3) lack of public accountability and quality assurance (e.g., Observations 2, 4 and 16);
- (4) the need for training and continuing education (e.g., Observations 14, 17, 18, and 19); and
- (5) other deficiencies (e.g., Observations 5 and 23).

It is important to recognize that, because the primary aim of this Part of the report is improvement, it tends to emphasize systemic deficiencies and flaws. This is not to say that there is no good to be found in the emergency mental health services and commitment practices in Virginia. To the contrary, the in-depth studies of practices in the five localities described in Part III revealed that most of the people involved in those practices worked conscientiously with the resources at their disposal. Some extraordinary people--CSB professionals, emergency mental health personnel, special justices, and law enforcement officers--are highly motivated to do good and their performance greatly exceeded expectations. The problem is with the system, not with the people charged with operating it.

Ideally, a good system supports good operations and practices. Good practices (e.g., cooperative efforts between emergency mental health personnel and police officers) in the jurisdictions studied appear too often to depend upon extraordinary performances of one or two hard-working people in the system. Without them, good practices may not continue.

As noted in Part I, for clarity and convenience, this Part--as well as the results of the survey and the site reports upon which it is based--is

divided into four segments or phases. The first phase describes the events and procedures that take place between the occurrence of a mental health emergency and the decision to provide voluntary care or to request that an individual in crisis be temporarily detained. The second phase explains the procedures and decisions involved in temporarily detaining an individual. Finally, the third and fourth phases, respectively, describe the commitment hearing and the events that take place following the hearing. The descriptions approximate the chronology of events, decisions, and procedures that are likely to arise when an individual requires emergency mental health services and "penetrates" the mental health and justice systems. To some extent this chronological order is, of course, artificial. Sequences of events may vary from jurisdiction to jurisdiction and from case to case, and some issues are relevant throughout most of these events. Consequently, many of the observations may overlap or be partially redundant.

#### From Crisis To Temporary Detention, Voluntary Care Or Release

This first phase of the emergency mental health services and involuntary civil commitment practices begins when there is a mental health crisis and continues to the point, if necessary, at which a district court judge, special justice, or magistrate makes a decision to issue a temporary detention order (TDO). The objective of this phase is to provide the most appropriate emergency mental health (or other intervention) at a time of mental health crisis.

1. Fragmentation of Emergency Mental Health Services

Who does what, where, and when, in response to a mental health crisis or emergency? Who uses mental health emergency services in Virginia? To what avail? Answering these fundamental questions is problematic for a variety of reasons including a fragmented system of emergency mental health services, a lack of data about those services, and vagueness in the definitions of a mental health crisis or emergency. In the absence of coordination, data, and definitional clarity, decisionmakers and practitioners are relatively free to construct and describe the delivery of emergency mental health services in more or less their own terms. This is precisely what has occurred in the operation of the first phase of the emergency mental health services and involuntary civil commitment practices in Virginia.

OBSERVATION 1. COORDINATION, COMMUNICATION AND COOPERATION AMONG THE VARIOUS AGENCIES INVOLVED IN CRISIS INTERVENTION AND THE PROVISION OF EMERGENCY SERVICES (E.G., POLICE DEPARTMENTS, SHERIFF OFFICES, AND HOSPITAL EMERGENCY ROOMS) ARE LIMITED.

In Williamsburg, Arlington, Richmond and other localities in Virginia, an emergency services program serves, in principle, as the point of contact, control and coordination for mental health crisis intervention in the community. Much can happen to an individual who "presents in crisis," however, before the intervention of the designated emergency mental health program. Generally, a person who is experiencing psychological, emotional, or behavioral difficulties may be referred to the emergency mental health program only after one or more contacts and transfers among "hotline" personnel, private mental health professionals, police, jail personnel, human service

agencies, private practitioners, private hospitals, and family members.<sup>2</sup> The degree of intervention by public and private entities depends upon the nature and severity of the crisis and the function and capability of the person or agency with whom the individual makes initial contact. With some notable exceptions--the relationship between the emergency mental health services program and the police in Arlington and the relationship between the hotline personnel and the Northwestern CSB, for example--few communities in Virginia appear to have formal or informal agreements, or understandings between the various referral sources and the designated mental health emergency services program serving as the point of control and coordination for crisis intervention.<sup>3</sup>

The National Task Force on Guidelines for Involuntary Civil Commitment, a multi-disciplinary group convened by the National Center for State Courts, recognized that meeting the needs of seriously mentally ill persons is increasingly a community concern. The complex nature of emergency mental health services, commitment practices, and the varied needs of persons who become subject to these services require the cooperation and coordination of the various components of the mental health and justice systems in the

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<sup>2</sup>Survey respondents listed over 25 different individuals and agencies as possible sources of reports of mental health crisis. The relationship between the emergency mental health services program designated as the central point of contact, control and coordination for emergency mental health services and these various entities serving as referral sources, "pre-crisis" services and, in many cases, the primary care givers in emergency situations is illustrated in the diagrams in Part III depicting emergency mental health services in the five study sites.

<sup>3</sup>In at least two localities--Richmond and Winchester--private providers may bypass the mental health emergency program completely. If a patient under private care needs hospitalization, the private physician can secure a bed at a hospital with which the physician has admitting privileges.



community. The task force recommended that an interdisciplinary community coordinating council, composed of representatives of all components of the mental health-justice system involved in the provision of emergency services and the involuntary civil commitment process, should be established in each community to address common problems and their possible solutions. The council should make every effort to encourage participation of all agencies and groups involved in the provision of emergency services, including professional agencies and professional organizations, such as patient, family, and volunteer groups, and to foster coordination and cooperation among the members of the council and their representative agencies and organizations.<sup>4</sup>

OBSERVATION 2. THE NUMBER OF MENTAL HEALTH CRISES OCCURRING IN VIRGINIA MAY BE MUCH HIGHER THAN AVAILABLE ESTIMATES INDICATE. THE DIFFERENCE BETWEEN THE ACTUAL NUMBER OF CRISES AND THE REPORTED NUMBER IN EACH CSB DEPENDS ON THE AMOUNT OF COORDINATION AND COMMUNICATION AMONG THE VARIOUS AGENCIES AND INDIVIDUALS INVOLVED IN RESPONDING TO CRISES IN THE CSB.

As Observation 1 pointed out, emergency services programs designated as the point of contact, control and coordination for crisis intervention may serve in that capacity for only some of the persons experiencing mental health crises in a particular locality. Because some reports of mental health crises are diverted from the system or are handled by one or more agencies without ever being "funnelled" to the emergency services program, the emergency services program's statistics on the total number of reports of mental health crises tell only part of the story. This is inadequate for a CSB's assessment of the need for emergency services and its response to that need.

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<sup>4</sup>National Center for State Courts. Guidelines for Involuntary Civil Commitment, 10 Mental and Physical Disability Law Reporter 409-514 (1986).

The estimation of mental health crises in any given CSB depends on the accuracy of the data kept by each agency involved in responding to mental health crises and the amount of integration of data across agencies. For example, although Lynchburg General Hospital and the CSB-operated mental health centers in the Central Virginia CSB collect data on the number of emergency mental health contacts, they do not combine their data in any systematic way. They each produce an annual report, but they report different information and base reported statistics on different time periods.<sup>5</sup> Another common problem in accurately reporting the number of mental health crises is the variation in definitions of "crisis" by different agencies involved in the provision of mental health emergency services. This is the subject of Observation 3.

OBSERVATION 3. A MENTAL HEALTH "CRISIS" OR "EMERGENCY" IS DEFINED DIFFERENTLY WITHIN AND ACROSS LOCALITIES. LACK OF DEFINITIONAL CLARITY CONTRIBUTES TO FRAGMENTED, UNCOORDINATED DELIVERY OF SERVICES.

The terms or concepts of crisis and emergency are, more often than not, used in the absence of precise definitions, so that their meanings are fuzzy. Even when they are defined, definitions vary across practitioners, facilities, and jurisdictions. The problem of definitional clarity is related but separable from the lack of coordination and data. Without a definition of "emergency" or mental health "crisis"--or at least a working understanding among the various entities responsible for delivery of mental health emergency

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<sup>5</sup>Lynchburg General Hospital, 1988 Annual Report of the Department of Emergency Mental Health Consultation Services of Lynchburg General Hospital at IV (1989) and Central Virginia Community Services Board, Annual Report July 1, 1987 - June 30, 1988, at 14 (1988).

services, it is difficult to obtain data about level of need. Without this data, communities are hard pressed to identify needs for emergency mental health services, build programs to respond to those needs, and evaluate the adequacy of their responses.

For example, there is a perception in Arlington County that all emergencies that do not result in a criminal arrest or require medical intervention should wind up in the hands of the Emergency Services Program (ESP) of the Arlington County Department of Human Services. This creates problems for the ESP when referral sources define an "emergency" as any situation that cannot be handled by the referral source. Reportedly, the Northern Virginia Hotline receives approximately 50,000 calls per year. Because the ESP could not handle even a portion of this volume of calls, the ESP director has made a conscious decision not to advertise the services of the ESP. What then is the need for emergency mental health services in Arlington County and the degree to which the ESP is responding to that need?

Two caveats regarding uniform definitions of "crisis" and "emergency" are important to highlight. First, there is a danger that uniform definitions may become in some communities the means for excluding people in need of services from receiving services. Second, the uniform definitions may fly in the face of legitimate needs to preserve local flexibility. For a myriad of reasons, some localities may see fit to restrict or expand the operational definitions of "crisis" and "emergency." These caveats speak only to the need for caution in the range of the applicability of a particular definition. They do not argue against the basic proposition that some uniformity in the definition of mental health "crisis" and "emergency" is desirable over no definition at all.

These observations are consistent with the principles and preliminary recommendations made by the DMHMRSAS's Emergency Services Advisory Committee as well as the National Task Force on Guidelines for Involuntary Civil Commitment. For example, the Committee questioned the amount of information available about and the effectiveness of agreements between local CSBs, law enforcement agencies, and jails in the delivery of emergency mental health services. In addition to the development of detailed working agreements between referral sources and the emergency services program serving as the point of contact, control, and coordination for crisis response, a subcommittee suggested major educational efforts to ensure community members "know how to access crisis services as well as using pre-crisis systems to de-escalate problem situations."<sup>6</sup> Without working agreements or understandings about the definition of "emergencies," without agreements between the various referral sources and the emergency services program regarding their responsibilities, there is unlikely to be reliable data about the number and type of emergencies and crisis interventions that occur.

Recognizing that appropriate case dispositions should be made close to the point of entry into the justice-mental health system (i.e., at a time and place where appropriate dispositions can best be accomplished by qualified professionals well positioned to expedite the appropriate disposition), the National Task Force on Guidelines for Involuntary Civil Commitment recommended that a "mental health screening officer should screen every candidate for

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<sup>6</sup>Memorandum, Emergency Services Subcommittee, Emergency Services Study Advisory Committee, July 6, 1989.

involuntary civil commitment as early in the commitment process as practical" and that:

Every locale should designate or establish an agency, program, or administrative unit charged with the responsibility for screening all candidates for involuntary civil commitment. The screening agency should be the single point of entry for all candidates for involuntary civil commitment and the referral point for all inquiries regarding the initiation of involuntary civil commitment. It should also serve as a source of information about civil commitment and all other alternative services available in the community. A screening agency should divert from commitment those who are not ill and also those who can be helped by other, less drastic measures.

A screening agency should compile and maintain statistics regarding sources and the number of referrals and applications for involuntary civil commitment, the number and types of persons screened, the consequences of screenings (e.g., referrals to social services, diversion to voluntary hospitalization, or short-term hospitalization pending judicial hearing on commitment), and other information of use in assessing the characteristics of the population of persons subject to involuntary civil commitment and the quality of services provided to them.<sup>7</sup>

In conclusion, it should be emphasized that coordination among the various mental health services in a community, a shared understanding of the meaning of "emergency", and effective data collection and use do not necessarily require formal arrangements, and regional or statewide control. The relationship between the Northwestern CSB and the community Hotline illustrate the effectiveness of informal arrangements. Because the Northwestern Hotline is recognized as an important "gateway" to emergency mental health services, the Northwestern CSB has established a close working relationship with the Hotline. The director of emergency services is an ex officio member of the Hotline board of directors, screens applicants and

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<sup>7</sup>National Center for State Courts. Guidelines for Involuntary Civil Commitment, 10 Mental and Physical Disability Law Reporter 409-514 (1986).

trains Hotline staff. He is in daily contact with the director of the Hotline, who maintains a detailed account of the nature and number of all Hotline calls. Consequently, the Northwestern CSB can monitor closely the level of requests for emergency mental health services coming through the Hotline from the community. The Northwestern CSB offers in-service training on the procedures for gaining access to the emergency mental health service in the community and provides regularly updated information to the police, jail personnel and hospital emergency room staff.

## 2. Public Policy Not Informed by Data

The accumulation of information and knowledge about the functioning, and consequences of emergency services and involuntary commitment practices are impeded by the complex nature of the process and the fragmentation of the components of the mental health and justice systems responsible for their administration. Nonetheless, in order to assure quality of service, to account publicly for services rendered and for services met, and to facilitate improvement in the system, reliable and valid information is needed. Unfortunately, this information is not always available.

OBSERVATION 4. EMPIRICAL INFORMATION ABOUT THE INCIDENCE OF CRISES AND THE FREQUENCY AND NATURE OF INTERVENTION IN MOST COMMUNITIES IN VIRGINIA ARE, AT BEST, RUDIMENTARY. BECAUSE OF THIS LACK OF EMPIRICAL INFORMATION, NEEDED IMPROVEMENTS IN THE SYSTEM ARE HAMPERED.

Legal reform has been characterized as policy analysis without benefit of data.<sup>8</sup> Most of the developments in emergency mental health services and involuntary civil commitment practices in Virginia can be similarly characterized. How many mental health emergencies occur in a community? What proportion of these occurrences result in involuntary hospitalization? What proportion should result in involuntary hospitalization? What effect does adequate preadmission screening have on the diversion of individuals from involuntary hospitalization? The various components of the legal system, the mental health system, and the related social service system responsible for emergency mental health services and involuntary civil commitment practices can contribute to meaningful reform and improvement by mobilizing their capacities for generating new information and knowledge to answer these questions. Unfortunately, neither the CSB nor the general district court in most localities regularly maintain data to address these questions. For example, despite the fact that the general district court has jurisdiction over involuntary civil commitment proceedings, many jurisdictions have no record of commitment hearings on file with the general district court.

In order to provide a basis upon which preadmission screening and other CSB interventions, referral, diversion, and release decisions can be monitored and assessed, the CSB, emergency services program, or some other coordinating entity and the general district court should compile and maintain data regarding the flow of persons through this screening process and beyond and should provide this information regularly to the courts, treatment and care

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<sup>8</sup>Saks, Michael J. Legal Policy Analysis and Evaluation, 44 American Psychologist 1010-1017 (1989).

facilities, social services, and DMHMRSAS. The statistics compiled and maintained by the CSB and the general district court--perhaps in conjunction with other entities--may include, but not be limited to, the following:

- (1) estimates of the number of persons in the catchment area reporting a "crisis"--however that term may be defined (e.g., callers to a crisis hotline are "in crisis");
- (2) the number of persons in crisis who have made physical contact with the various units of the mental health and social service system in the community;
- (3) the number of persons referred to the CSB or emergency mental health unit designated as the primary point of contact, coordination and control for emergency mental health in the community for preadmission screening according to referral source (e.g., police and community hospital);
- (4) the differences between (1), (2), (3) above and the nature and frequency of "diversions" from the central point of contact, coordination, and control represented by these differences;
- (5) disposition of the referred cases by the CSB or emergency mental health unit according to type of disposition including:
  - (i) the number of telephone referrals only;
  - (ii) the number of face-to-face interventions;
  - (iii) the number of voluntary outpatient services;
  - (iv) the number of voluntary inpatient admissions;
  - (v) the number of cases recommended for TDO; and,
  - (vi) the number of other dispositions;
- (6) the number of cases for which a TDO is issued;
- (7) the relationship between (5) and (6);
- (8) the number of persons taken into custody who are released before a judicial hearing;
- (9) the number of cases resulting in voluntary admission or release after a preliminary judicial hearing;
- (10) the number of cases receiving preliminary and "full" judicial hearings; and



- (11) disposition of cases by the commitment court(s) according to type of disposition including:
  - (i) number of persons involuntarily committed to inpatient facilities;
  - (ii) number of persons released after a judicial hearing;
  - (iii) number of individuals "released on terms"; and
  - (iv) number of outpatient civil commitments.

3. The Need For Specialized Emergency Mental Health Services for Special Populations

Throughout Virginia, the delivery of emergency mental health services and commitment practices reflects the tendency of components of the mental health and justice systems to define programs and services in unidimensional terms (e.g., mental illness or mental retardation), thereby causing persons with special needs to "fall through the cracks."

OBSERVATION 5. EMERGENCY MENTAL HEALTH SERVICES THROUGHOUT VIRGINIA ARE STRAINED WITH REGARD TO SPECIAL POPULATIONS OF INDIVIDUALS IN NEED OF EMERGENCY MENTAL HEALTH SERVICES INCLUDING CHILDREN AND ADOLESCENTS, PERSONS WITH DUAL DIAGNOSES, NON-ENGLISH SPEAKING PERSONS, HEARING IMPAIRED PERSONS, ELDERLY PERSONS, AND YOUNG ADULTS.

In the state-wide survey, both mental health professionals and special justices rated "lack of specialized services for special needs groups" as one of the most frequently occurring problems in the delivery of emergency services. This concern for "special populations" also was reflected by several of the interviewees. For example, one mental health professional in the Central Virginia CSB indicated that the number of programs and services for young adults in the CSB were very limited.

4. Temporary Detention Process Problematic

OBSERVATION 6. VAGUE AND CONFUSING LAW GOVERNING THE "TDO PROCESS" ENCOURAGES WIDE LATITUDE IN INTERPRETING AND IMPLEMENTING

THE PROCESS BASED ON PERSONAL JUDGMENTS AND PRACTICAL  
CONSIDERATIONS. PRACTICE DEPARTS SHARPLY FROM THEORY.

According to the Code of Virginia (37.1 - 67.1), a judge, special justice, or magistrate may "issue an order requiring any person within his jurisdiction alleged or reliably reported to be mentally ill and in need of hospitalization to be brought before the judge. If such person cannot be conveniently brought before the judge, the judge or magistrate may issue an order of temporary detention." Throughout Virginia very few individuals are brought before a judge before the issuance of a TDO as authorized in the Code of Virginia. Approximately 63 percent of the special justices surveyed indicated that in less than five percent of the cases are individuals brought for a preliminary hearing before a judge or special justice before the issuance of a TDO; 90 percent stated that in 75 percent of the cases, a TDO is issued before a preliminary hearing before a judge. These results are supported by the mental health personnel surveyed. Approximately 88 percent of the mental health respondents indicated that in 10 percent or fewer cases, are individuals brought for a preliminary hearing before a judge before the issuance of a TDO.

This deviation from "spirit" of the law appears to create dilemmas and cause confusion during the TDO process itself and in later stages of the delivery of the emergency mental health services and involuntary civil commitment practices. Individuals involved in emergency mental health services and the involuntary civil commitment process speak about "two-stop TDOs," "two-step TDOs," and even "three-step TDOs." The meaning of these terms varies from jurisdiction to jurisdiction. Throughout Virginia, the TDO process is criticized by some because it is too "cumbersome" and that it

prevents, delays, or complicates the delivery of mental health services, and is criticized by others because it provides inadequate legal safeguards.

For example, in the Central Virginia CSB catchment area, there occasionally is some confusion on the part of family members, private physicians, and others about whom to contact to report a mental health crisis. Consequently, the response to the crisis may be delayed. Family members--often on the advice of their doctors--contact a magistrate to obtain a TDO although only a judge or special justice can issue a TDO without the advice of a qualified mental health professional. Thus, if the family member contacts a magistrate, the magistrate must refer the family member to a qualified mental health professional or contact a special justice who then can issue the TDO without a mental health professional's advice.

The experiences with and reactions to the TDO process of many in Virginia are characterized by the comments of one mental health professional:

The TDO process creates a dilemma. There are no clear cut means to bring a patient before a mental health professional for a prescreening without violating the clients' rights. The TDO authorizes the client to be either brought before a judge or taken to a "facility." When a judge is unavailable, the patient is supposed to be sent directly to the facility without a face-to-face prescreening. This, I feel is a tremendous violation of the clients' rights and should never be done. Additionally, we have agreed with our state hospital that clients sent there will be prescreened prior to admission whether on TDO or civil commitment or voluntary status. In each case in which a judge is unavailable to hold a hearing, we face the problem of how to get the person brought in to be prescreened. This requires "creative" use of the entire system.

It should be noted that this creativity does not necessarily engender problems. For example, a special justice in Richmond initiated a particularly innovative procedure to facilitate the issuance of a TDO. To avoid the necessity of traveling to his office to issue a TDO during the night, he has a

FAX machine in his home enabling him to send a copy of the TDO directly to the police. Richmond police will not transport an individual to a detention facility without possessing the TDO.

OBSERVATION 7. IN SOME, IF NOT MANY, LOCALITIES THROUGHOUT VIRGINIA, THE COMMUNITY SERVICES BOARDS' EMERGENCY MENTAL HEALTH PROGRAMS DO NOT SERVE AS THE POINT OF CONTACT, CONTROL, AND COORDINATION OF REQUESTS FOR A TEMPORARY DETENTION ORDER (TDO). REQUESTS FOR TDOs FREQUENTLY ARE MADE BY PRIVATE PROVIDERS, FAMILY MEMBERS, AND OTHERS THEREBY BYPASSING INVOLVEMENT OF THE EMERGENCY MENTAL HEALTH PROGRAM AND CONTRIBUTING TO A LACK OF COORDINATION, COOPERATION, AND CONTINUITY.

In Richmond, for example, private sector professionals may request the issuance of a TDO directly from a special justice or coordinate their requests through the Richmond Community Mental Health Center's Crisis Intervention/Intake Unit. Reportedly, private physicians account for 35 to 50 percent of all TDO requests. Reportedly, some of the private providers request the TDO through the Community Mental Health Center, but most request it directly from a special justice.

5. Factors Determining Voluntary Placement or Referral Unclear

OBSERVATION 8. FACTORS DETERMINING WHICH AMONG SEVERAL ALTERNATIVE VOLUNTARY SERVICES ARE SELECTED FOLLOWING THE INITIAL CONTACT OF CRISIS INTERVENTION ARE NOT WELL ARTICULATED IN THE STUDY SITES. SUCH FACTORS MIGHT INCLUDE THE NATURE AND THE SEVERITY OF THE PRESENTING PROBLEM, THE LOCUS OF TREATMENT, THE AVAILABILITY OF THIRD-PARTY INSURANCE, AND BED-SPACE AVAILABILITY.

There appears to be a consensus among knowledgeable individuals in Virginia that emergency mental health services should be more than prescreening for hospital admission. CSB emergency services should provide a full range of crisis stabilization and intervention options. A fundamental

principle subscribed to by DMHMRSAS is that the best mental health, mental retardation and substance abuse services are those that help prevent crises and emergencies through the provision of a broad array of nonemergency services. Emergency services should be more than simply prescreening for involuntary hospitalization.

Unfortunately, the factors determining voluntary placement or referral short of involuntary hospitalization are unclear. For example, the locus of treatment and its proximity to the community appears to be a factor determining voluntary placement in the Central Virginia CSB. Both the mental health centers and Lynchburg General Hospital make every effort to keep a person in the community. One option that often is used is the Five Day Acute Inpatient Program offered at the Virginia Baptist Hospital. The mental health centers pay for physicians' fees and one-half of the hospital costs.

#### 6. The Rationing of Voluntary Beds

OBSERVATION 9. THE TDO PROCESS AND THOSE RESPONSIBLE FOR ADMINISTERING IT ARE "RATIONING" LIMITED RESOURCES FOR VOLUNTARY HOSPITALIZATION IN SOME, IF NOT MANY, LOCALITIES IN VIRGINIA.

The Northern Virginia Mental Health Institute, for example, serves as the primary mental health hospital for the Arlington area. Reportedly, "high census" at the facility negatively impacts the mental health service delivery system in Arlington in a number of significant ways. In particular, voluntary admission to the facility is virtually non-existent except by means of the TDO process. That is, a person who seeks voluntary admission typically will not be provided the opportunity to enter the facility without the issuance of a TDO. Because as a practical matter in many localities persons do not appear

before a judge before the issuance of a temporary detention order (TDO), those persons cannot elect voluntary admission until a judicial hearing even though Section 37.1 - 67.2 of the Code of Virginia authorizes election of voluntary admission at the time of a preliminary judicial hearing before temporary detention. If a person does not have third-party insurance and cannot be voluntarily admitted to a private facility, he or she must be subjected to the TDO process even though he or she may be quite willing, given the opportunity, to elect voluntary admission status without the issuance of a TDO.

Thus, "voluntary" admission to a public psychiatric facility in Arlington is unavailable except through the TDO process. A person seeking voluntary admission undergoes involuntary detention and then, at the time of the preliminary hearing, elects voluntary admission. In effect, the commitment system--primarily the TDO process--serves to ration voluntary public in-patient mental health beds.

Within the catchment area of the Central Virginia CSB, voluntary hospital admission rests on the availability of a "voluntary bed." Beds are available at private hospitals (the Virginia Baptist Hospital in Lynchburg, the Roanoke Valley Psychiatric Center, the St. Albans Hospital in Radford, or the Charter Hospital in Charlottesville) if the individual has insurance or can afford to pay for his or her own hospitalization. Voluntary beds are reportedly more difficult to obtain for indigent clients. The only public hospital that will accept indigent clients on a voluntary admission is the Southern Virginia Mental Health Institute. If the Institute does not have any voluntary beds available, the client must be committed involuntarily in order to be admitted to the state hospital. One interviewee in the Central Virginia CSB catchment area estimated that as many as 30 to 40 percent of the

individuals who are committed involuntarily would admit themselves voluntarily if beds were available.

In Richmond, if an individual is referred by the Richmond Community Mental Health Center for voluntary, short-term psychiatric treatment on an inpatient basis but does not have the means for paying for treatment through Medicaid, Medicare, private insurance, or other personal resources, the "rationing" through the TDO process is avoided through the issuance of what is referred to as a "City Grant." In essence, the community center agrees to pay the costs of hospitalization contingent on the individual's compliance with treatment and the appropriateness of short-term hospitalization.

7. Responsibilities for Detention Facilities Diffused

OBSERVATION 10. THE RESPONSIBILITIES FOR THE SELECTION, MONITORING, AND QUALITY ASSURANCE OF DELIVERY OF SERVICES OF TEMPORARY DETENTION (TDO) FACILITIES ARE, AT BEST, DIFFUSED. AS IS TRUE IN OTHER ASPECTS OF THE EMERGENCY MENTAL HEALTH SERVICES AND INVOLUNTARY CIVIL COMMITMENT PRACTICES, SUCH DIFFUSED RESPONSIBILITIES ALLOW DECISIONMAKERS THE FREEDOM TO OPERATE MORE OR LESS ON THEIR OWN TERMS.

Section 37.1 - 67.1 of the Code of Virginia provides that the location of temporary, involuntary detention shall be "in some convenient and willing institution or other willing place for a period not to exceed forty-eight hours prior to a hearing. The institution or other place shall be approved pursuant to regulations of the [State DMHMRAS Board]." The statute does not define the terms "willing" and "convenient." How are these willing and convenient institutions selected or recruited? Once selected, what are the criteria by which patients are matched with these institutions? By what

mechanisms is quality of care assured? To whom are TDO facilities accountable? There are no clear answers to these questions.

In Arlington County, for example, the criteria for selection of TDO facilities do not appear to be well established. Reportedly, selection of facilities in Arlington County is not only a matter of bed-space per se but also involves a facility's capability of accommodating the detainee. Some facilities are better equipped to handle potentially disruptive patients. For example, Dominion Hospital has a specialized intensive, acute care unit to which all involuntarily detained patients are, at least initially, assigned. The Arlington Hospital has two "quiet rooms" to accomodate potentially disruptive patients. Measures of quality of services provided by the TDO facilities are either not available or not widely shared.

Because mental health care pursuant to TDOs increasingly is provided by private-sector hospitals, public and private cooperation and planning seem necessary to address these questions. Among the public interests and public policy matters that need to be addressed are the nature, cost, and quality of private sector services; the compatibility of profit motivation and the motivation to provide care as part of the TDO process; and patient selection issues.<sup>9</sup>

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<sup>9</sup>Bickman, Leonard; and Dokecki, Paul R. Public and Private Responsibility for Mental Health Services, 44 American Psychologist, pp. 1133-1137 (1989).



## From Temporary Detention Through Provision of Inpatient Services

This phase of the emergency mental health services and commitment practices encompasses the issuance of a temporary detention order and the period of hospitalization pending a judicial hearing.

### 8. Transportation of Detainees

The purpose of a TDO is to authorize apprehension and transportation of an individual in crisis to a detention facility. The TDO serves to notify and advise the transporting officer and the individual in crisis of the temporary detention. This "service of process" should furnish reasonable notice to the individual of the proceedings and afford him or her the opportunity to respond. Notice is a fundamental concept in law. It refers to formal information, advice, or warning intended to apprise a person of some proceeding in which his or her interests are involved.

OBSERVATION 11. ALTHOUGH FEW, IF ANY, PERSONS IN VIRGINIA ARE APPREHENDED, TRANSPORTED, AND DETAINED INVOLUNTARILY WITHOUT THE ISSUANCE OF A TEMPORARY DETENTION ORDER, THE ACTUAL EXECUTION, EXHIBITION, AND DELIVERY OF THE ORDERS VARY FROM JURISDICTION TO JURISDICTION.

In the catchment area of the Central Virginia CSB, law enforcement officials prefer that TDOs be in writing, though it is possible to detain someone without a written copy of the order "in-hand." A written copy of the order must, however, be on file at the courthouse or in the individual's hospital file. If the individual is already hospitalized, verbal notice of the TDO allows a physician or mental health consultant to provide the client with emergency medical and psychiatric treatment. Thus, an agreement by the judge, special justice, or magistrate to issue a TDO--not the physical

issuance of the TDO--triggers the involuntary, temporary detention. After authorizing temporary detention, the special justice typically calls the central law enforcement dispatch unit which, in turn, notifies the police that a TDO has been written. In most cases a police officer will go to the special justice's office first to obtain the TDO. If someone is experiencing a severe emergency, however, the police officer may be asked to transport the person to the detention facility before physically obtaining the TDO.

**OBSERVATION 12.** ISSUES SURROUNDING WHO IS RESPONSIBLE FOR THE TRANSPORTATION OF DETAINEES, TO WHAT LOCATIONS, AT WHAT TIMES, UNDER WHAT CIRCUMSTANCES, AND BY WHAT FINANCIAL ARRANGEMENTS ARE DEALT WITH ON AN AD HOC BASIS IN MANY COMMUNITIES. OFTEN ISSUES OF TRANSPORTATION "DRIVE" THE DELIVERY OF EMERGENCY MENTAL HEALTH SERVICES AND THE INVOLUNTARY CIVIL COMMITMENT PRACTICES.

Transportation of detainees in response to TDOs is problematic in most jurisdictions throughout Virginia. Section 37.1-71 of the Code of Virginia authorizes a procedure following the execution of a TDO. Upon the issuance of a TDO, a person "may be delivered to the care of the sheriff of the county or city who shall forthwith on the same day deliver such person to the proper hospital or the patient may be sent for by the director. When this is impossible such person shall be kept and cared for by the sheriff in a convenient institution approved pursuant to regulations promulgated by the Board, until such person is conveyed to the proper hospital." The preceding section of the Code (Section 37.1-70) provides that if an examination of a person presented for admission reveals that there is insufficient cause to believe that a person is mentally ill, the person shall be returned to the locality in which the petition was initiated or in which such person resides.

In practice, who transports whom, where, when, and who pays, is complicated by a number of factors including overlapping jurisdictions of law

enforcement agencies responsible for transporting respondents pursuant to a court order, the need to take respondents for medical treatment before detention in a mental health facility, transportation across long distances especially in rural areas, and unclear responsibilities regarding payment of transportation when transportation is made by ambulance.

If an individual under a TDO in the Northwestern CSB requires the services of an ambulance, emergency services staff must seek prior approval of the Sheriff. The CSB does not have the budget for ambulance service. Reportedly, the Sheriff will not pay for the service of an ambulance without prior approval. The requirement that CSB emergency staff seek the prior approval of the Sheriff for ambulance services has proven cumbersome.

In Richmond, the Sheriff and the police divide up transportation responsibilities. Police assume all responsibilities for transportation pursuant to TDOs and the Sheriff transports individuals pursuant to commitment orders.

At least 80% of the CSB professionals and the special justices responding to the state-wide survey reported that the Sheriff often transports and the police occasionally transport detainees to hospitals designated on TDOs. Of the 16 respondents who reported that other methods of transportation were used, 87.5% listed family members and 12.5% listed CSB/mental health workers. One respondent reported that the state police had transported a client.

9. Inadequate Explanations Made To Detainees

OBSERVATION 13. THOUGH THERE IS WIDESPREAD AGREEMENT THAT DETAINEES ARE ENTITLED TO AN EXPLANATION OF WHAT IS HAPPENING TO THEM, WHY, AND WITH WHAT CONSEQUENCES IN ORDER TO REDUCE TO THE GREATEST EXTENT POSSIBLE THE STRESS AND UNCERTAINTY OF THE PERSON,

THE TIMING AND SUBSTANCE OF EXPLANATIONS MADE TO INDIVIDUALS  
SUBJECT TO INVOLUNTARY, TEMPORARY DETENTION IN MANY LOCALITIES IN  
VIRGINIA APPEARS TO BE AD HOC.

Fear of the unknown may debilitate a person who is being taken into custody and temporary detention can exacerbate his or her mental disorder. Section 37.1 - 67.1 of the Code of Virginia provides for the appearance of a person alleged to be mentally ill and in need of hospitalization before a judge. When a person is brought before a judge before the issuance of a TDO, the judge has an opportunity to provide an explanation to the detainee as to the nature and consequences of the temporary detention, the involuntary civil commitment process, the individual's rights in the process, and so forth. Without an appearance before a judge--the norm throughout most of Virginia--a sheriff's deputy or police officer is usually the first or second (if preadmission screening has taken place) representative of the justice and mental health systems confronting the individual about involuntary, temporary detention. In these situations, it is not clear who is responsible for explaining the nature and consequences of the TDO process to the individual.

10. Manner of Taking Custody Varies

Police or sheriff custody can have a traumatic effect on a person, even under the best of circumstances. Consequently, law enforcement officers who apprehend mentally disordered persons should proceed in a manner that minimizes negative effects on the persons being taken into custody.

OBSERVATION 14. THE MANNER OF TAKING CUSTODY OF PERSONS PURSUANT TO COURT ORDERS VARIES ACCORDING TO THE JURISDICTION, THE OFFICER TAKING CUSTODY, AND THE CASE. GENERALLY, STANDARDS AND PROCEDURES FOR APPREHENDING AND TRANSPORTING MENTALLY ILL PERSONS TO A MENTAL HEALTH FACILITY, SOCIAL SERVICE FACILITY, OR COURT ARE NOT CLEAR.

Most law enforcement officers in Virginia reported that they take persons into custody in the most humane, least conspicuous, and least disruptive manner possible. Some of those interviewed indicated that they attempt to keep individuals as calm as possible by telling them that they are not under arrest or in "any kind of trouble." Nonetheless, many of these officers indicated that they would welcome guidance in the handling of mentally ill persons. For example, the use of handcuffs, shackles, and police wagons in the transportation of individuals pursuant to TDOs is problematic. A national task force studying the problem did not preclude the use of restraints in some circumstances, but did suggest that restraints be used only when necessary to protect the respondent or the person taking the respondent into custody. Similarly, it did not preclude taking a person into custody in a public setting, but it did preclude making an example of the respondent or treating the respondent as if he or she had committed a criminal offense.<sup>10</sup>

11. Limited Use of Prehearing Release

OBSERVATION 15. IN SOME CASES, AFTER A BRIEF PERIOD OF HOSPITALIZATION, PERSONS UNDER TEMPORARY DETENTION ORDERS IMPROVE TO THE EXTENT THAT THEY NO LONGER MEET LEGAL CRITERIA FOR INVOLUNTARY HOSPITALIZATION. DECISIONS AND MECHANISMS INVOLVED IN RELEASING SUCH PERSONS FROM DETENTION VARY ACROSS CSBs AND JURISDICTIONS.

Section 37.1-67.1 of the Code of Virginia provides that, prior to a hearing, a judge may release a person on personal recognizance or bond "if it appears from all evidence readily available that such release will not pose an

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<sup>10</sup>National Center for State Courts. Guidelines for Involuntary Civil Commitment, 10 Mental and Physical Disability Law Reporter 409-514 (1986).

eminent danger to himself or others." This provision is seldom used in Virginia as authorized by statute.<sup>11</sup> However, throughout Virginia, individuals who temporarily have been detained but who are for various reasons, no longer fit subjects for involuntary hospitalization are released through various processes. Approximately half of the mental health professionals and the special justices surveyed reported that some kind of pre-hearing release is possible in their respective CSB or jurisdiction. Generally, respondents reported that patients are released when they no longer meet the commitment criteria. In 1988, 191 (32 percent) of the individuals who involuntarily were detained at the Lynchburg General Hospital pursuant to a TDO were released by a physician before a commitment hearing. An intoxicated individual who is detained and subsequently regains sobriety and exhibits no symptoms of mental illness would, for example, be considered a good candidate for prehearing release. Reportedly, physicians at the Lynchburg General Hospital will not release a client without a mental health consultant's recommendation. The reported benefits of "lifting the TDO," as this practice is called, include: (a) the client is not deprived of his or her liberty longer than necessary; (b) a hospital bed becomes available for another person experiencing a mental health crisis; and (c) the number of commitment hearings is reduced.

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<sup>11</sup>Reportedly, in Richmond, in rare cases a special justice will consider releasing a person from hospitalization on bond. In such cases the special justice is persuaded that the individual does not need to remain in the hospital in order to ensure the individual's presence at the commitment hearing. If the special justice is able to obtain legal representation for the person and secure hearing time at the detention facility a bond hearing will be conducted. Clients released on bond must attend the commitment hearing which usually is scheduled for the next day. Reportedly, a commitment hearing never is cancelled once a TDO has been issued.

In other cases, a judge is contacted to rescind the detention order. One respondent indicated that a patient may be released on bond with the condition that he or she receives voluntary treatment. If the patient does not receive treatment within a specified period of time, a commitment hearing will be held. Other respondents noted that some patients are released if they agree to admit themselves voluntarily into a hospital.

12. Lack of Monitoring, Supervision, and Training

OBSERVATION 16. MONITORING AND SUPERVISION OF MANY OF THOSE RESPONSIBLE FOR ADMINISTERING THE COMMITMENT PROCEEDINGS-- PARTICULARLY, SPECIAL JUSTICES, MAGISTRATES, ATTORNEYS, CSB-COURT LIAISONS, AND COURT-APPOINTED MENTAL HEALTH PROFESSIONALS--IS EITHER NONEXISTENT OR CONDUCTED ON AN AD HOC BASIS.

OBSERVATION 17. FEW OPPORTUNITIES FOR TRAINING AND EDUCATION EXIST FOR PROFESSIONALS INVOLVED IN THE DELIVERY OF THE EMERGENCY MENTAL HEALTH SERVICES AND, ESPECIALLY, COMMITMENT PRACTICES (E.G., LAW ENFORCEMENT OFFICERS, SPECIAL JUSTICES, JUDGES, MAGISTRATES, PRESCREENERS, ATTORNEYS, HOSPITAL PERSONNEL, AND OTHERS).

As noted in the context of other observations, many of the professionals involved in the delivery of emergency mental health services and involuntary commitment practices in Virginia--CSB emergency services personnel, law enforcement officers, special justices, preadmission screeners, attorneys, and hospital personnel--typically are not monitored and supervised closely according to widely shared standards and procedures. Most appeared to operate more or less on their own terms, for better or for worse. Educational efforts are limited. Consequently, quality assurance mechanisms are, at best, rudimentary. Special justices, attorneys, and law enforcement officers are among the groups who could benefit from training programs.

Special justices in Arlington, for example, are relatively isolated from their peers. That is, no formal network of special justices exist (like that existing for magistrates) and no formal training mechanisms enable the special justices to increase their knowledge and hone their skills. Personal interests and perhaps the possibility of advancement may be the only incentives motivating the special justices to excel in their work. Except for the monitoring by the local bar association and informal oversight provided by special justices, no formal mechanisms exists to train and supervise attorneys representing persons facing involuntary civil commitment proceedings. Several special justices who were interviewed as part of this study stated that the training for those involved in the involuntary civil commitment process was the single greatest need.

In Williamsburg, the relationships between the CSB and the police appear to be good. However, the transporting officers do not appear to be specially trained or necessarily sensitive to mental health issues. Law enforcement officers are often the first to make contact with mentally disturbed individuals in the community. The identification of and responses to mentally disordered persons and the necessary interaction with mental health and social service providers presents special problems for police. In Arlington, the police have established written policies and procedures for handling persons believed to be mentally ill or mentally retarded. A spokesman of the Richmond Police Department stated that Richmond police are ill equipped to handle mental health emergencies properly because of a lack of formal training. He stated that police are often forced to handle difficult mental health situations in the absence of clear standards for apprehending and transporting mentally ill persons.



13. Loss of Information

OBSERVATION 18. INFORMATION ABOUT AN INDIVIDUAL'S CONDITION AND CIRCUMSTANCES GATHERED BEFORE A HEARING AND DURING THE PERIOD OF TEMPORARY DETENTION SOMETIMES IS EITHER UNAVAILABLE OR NOT USED IN THE SUBSEQUENT STAGES IN THE COMMITMENT PROCESS.

Individuals are usually subject to several examinations as they make their way toward a commitment hearing. First, the individual and a family member may be interviewed by a CSB professional who decides that a TDO is warranted. Then the individual may be transported to a TDO facility where another examination takes place. The judicial hearing may occur at a third site. Finally, hospitalization may occur at yet another site, where the patient is again examined. Often little of the information gathered during one evaluation is passed on to the next evaluation site. In Arlington, for example, there is no consistency among detention facilities in the conveyance of a report of a patient's condition during the time of detention. Typically, no report of the patient's condition during the period of temporary detention is conveyed for use at the hearing. This information is necessary for determining the propriety of commitment and the suitability of mental health care and related services.

Commitment Hearings

This section presents observations about preliminary and full commitment hearings.

14. Nature and Conduct of Hearings Uncertain

Vague law governing the nature and conduct of hearings forces participants in those hearings to structure and conduct them, for better or

for worse, according to exigencies, practical constraints, and their cultural biases and moral values.

OBSERVATION 19. A GREAT VARIATION IN ALMOST ALL ASPECTS OF JUDICIAL HEARINGS EXIST THROUGHOUT VIRGINIA INCLUDING THE LOCATIONS OF HEARINGS, PRESIDING OFFICERS, USUAL PARTICIPANTS, THE EVIDENCE PRESENTED, THE ADHERANCE TO FORMAL RULES OF EVIDENCE, THE LENGTH OF HEARINGS, AND THE GENERAL CONDUCT OF THE HEARINGS. THIS LACK OF UNIFORMITY INCREASES THE RISKS OF LIKE CASES BEING TREATED DIFFERENTLY DEPENDING ON THE JURISDICTIONS IN WHICH THEY ARE HEARD.

The nature and conduct of preliminary and "full" hearings differ dramatically across Virginia. The results of the state-wide survey indicate that in some CSBs/court jurisdictions, commitment hearings are held in court, in other CSBs/court jurisdictions, hearings are held in a mental health facility, and in still others, some hearings may take place in court and some may take place in a mental health facility. Respondents indicated that special justices preside over some of the cases and district court judges preside over others. (See Part IV of this report.)

In part because of a lack of guidance from statutes, case law, and other procedural law (e.g., reports of the Attorney General), special justices, attorneys, CSB personnel, psychiatrists, and others involved in judicial hearings, are uncertain about the nature and conduct of hearings. Should they be adversarial, administrative, or should they resemble the consultation of a mental health treatment team wherein a course of treatment is considered?

OBSERVATION 20. THERE ARE FEW GUIDELINES ESTABLISHING RECOMMENDED PRINCIPLES, PROCEDURAL MECHANISMS, AND PRACTICES TO GOVERN COURT HEARINGS, INCLUDING THEIR TIMING AND LOCATION, NOTICE OF HEARINGS, RIGHTS OF THE RESPONDENT DURING HEARINGS, DUTIES OF COUNSEL, ROLE OF THE PRESIDING JUDICIAL OFFICER, APPLICABLE LEGAL RULES, CALLING OF WITNESSES, PUBLIC ACCESS TO HEARINGS, AND SO FORTH. WHAT GUIDANCE EXISTS IN STATUTES AND LIMITED CASE LAW IS VAGUE.

As noted, involuntary civil commitment is a complex process reflecting the various perspectives of the individuals, groups, agencies, and institutions charged with its administration. Vague law and lack of procedural guidelines contribute to confusion and significant variations among jurisdictions about the roles of special justices, attorneys, court-appointed mental health professionals, hospital personnel, CSB liaison, and others involved in the process.

Sections 37.1-67.2-3 of the Code of Virginia provide for an opportunity for voluntary admission, explanations of the legal bases of detention, notice of the individual's rights, the summoning of an examiner or the acceptance of his or her written report, a prescreening report, and the summoning of witnesses. Except for an implicit requirement of the presence of a respondent at commitment hearings by a federal district court in Evans v. Paderick, 443 F. Supp. 583 (e.d. Va. 1977), no case law sheds light on the nature and conduct of commitment hearings. In a July 31, 1986 report to Robert N. Baldwin, Executive Secretary, Supreme Court of Virginia, the Attorney General stated that under Section 37.1-67.2 of the Code of Virginia, an attorney is required to be present at preliminary hearings and that a physician was not necessarily required to be at every preliminary hearing.

This very limited body of law provides little guidance regarding the nature and conduct of hearings. Apart from the requirement that a respondent must first be provided an explanation of the legal basis of his or her detention and rights, Virginia law makes no mention of how the hearing should proceed. Who should testify first? Should there be an opening statement by counsel? No guidance is provided regarding the nature of the hearing. Should

it be adversarial or administrative? There is no mention as to whether the rules of evidence or civil procedure are to be followed.

Similarly, the roles of the participants in hearings are not clearly defined. In Williamsburg and in Arlington, for example, the role of the CSB's emergency personnel often appear to be that of a "friend of the court" or court investigator, much like that of mental health experts relied upon by criminal and civil courts in insanity, competency to stand trial, and guardianship proceedings. Emergency personnel are discouraged from serving as petitioners in a particular case, but will do so if there is no one to serve as a petitioner or family members would be inappropriate in this role. In Richmond, the mental health hearing liaison serves in the role of a technical advisor or clerk to the special justice. He provides the special justice with information regarding the availability of services, provides the logistical support, and performs other clerical duties without taking an adversarial position. In Williamsburg, CSB personnel often may make specific recommendations regarding commitment.

Given the absence of a district attorney representing the Commonwealth, or an attorney representing the petitioner, commitment proceedings are at best, quasi-adversarial. This deviation from the traditional adversarial proceeding appears to cause problems with role-clarification by both attorneys and special justices.

Beyond the statutory right to a lawyer provided by the Code of Virginia, and the widespread recognition of the key role assumed by defense counsel in involuntary civil commitment cases, the precise nature of the lawyer's role and duties in commitment proceedings remains unclear. The lack of delineation of specific duties is a serious flaw that contributes to any conflicts

attorneys may feel about their role. With regard to the role of an attorney as an advocate and advisor, the National Task Force on Guidelines for Involuntary Civil Commitment issued the following guideline:

Involuntary civil commitment is a complex process reflecting the various perspectives of the individuals, groups, agencies, and institutions charged with its administration. The proper role of the attorney representing the respondent in this process is a controversial issue that engenders much confusion and misunderstanding, even among attorneys themselves. From a legal perspective, the commitment process is adversarial and involves fundamental liberty issues. Thus, the primary role of a respondent's counsel is to represent the perspective of the respondent and to serve as a vigorous advocate for the respondent's wishes.

To assume the proper advocacy role, the attorney must advise the respondent of all available options, as well as the practice and legal consequences of those options. The attorney should also help the respondent define his or her objectives by advising him or her about the probability of success in pursuing any one of those options. If the respondent expresses a desire to seek voluntary mental health treatment or related social services, the attorney should give the respondent the necessary and appropriate advice or assistance to pursue those desires. This role of advocate and advisor should be based on knowledge of the range of services available to the client and, if possible, consultation with a social worker (see paragraph (c) of Guidelines E1) or a mental health screening officer (see Guideline B2).

The attorney's responsibilities to his or her client should continue for as long as the client is an involuntary patient. To the extent that a client is unable or unwilling to express personal wishes, the attorney should advocate the position that best safeguards and advances the client's interests.<sup>12</sup>

Finally, special justices are required to wear two hats during hearings. Because the petitioner is not represented, the special justice often directly questions the petitioner and witnesses. If the patient testifies, the special justice must in effect cross-examine the patient and witnesses. Of course,

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<sup>12</sup>National Center for State Courts. Guidelines for Involuntary Civil Commitment, 10 Mental and Physical Disability Law Reporter 409-514 (1986).

the other role of the special justice is to determine, if legal grounds exist, that involuntary hospitalization is required and that no less restrictive alternative is suitable. He or she thus serves as the trier of fact and, albeit informally, the representative of the state or petitioner.

15. Clarification of Dispositional Criteria and Categories Needed

OBSERVATION 21. THE DISTINCTIONS BETWEEN DISPOSITIONAL CATEGORIES DEFINED IN THE CODE OF VIRGINIA--RELEASE, VOLUNTARY ADMISSION, INVOLUNTARY HOSPITALIZATION, AND COURT-ORDERED OUTPATIENT TREATMENT--ARE BLURRED IN PRACTICE.

The Code of Virginia defines the following dispositional categories applicable to persons involuntarily detained:

- (1) release or discharge;
- (2) voluntary admission to an inpatient facility;
- (3) involuntary hospitalization; and
- (4) court-ordered outpatient treatment including day treatment in hospital, night treatment in the hospital, referral to community mental health clinics, or such appropriate treatment legalities as may be necessary to meet the needs of the individual.

Approximately 74% of the survey respondents reported that a fifth category "release with conditions" or "release on terms" also was an available dispositional option in their respective CSBs and court jurisdictions. The use of "release on terms" without a court order instead of the court-ordered outpatient treatment authorized in Section 31.1-67.1 of the Code of Virginia, is intriguing. Even though special justices are powerless to enforce court-ordered outpatient treatment, why do they prefer "release on terms" which does not have statutory authority? If, in fact, court-ordered outpatient treatment

is thought to be the same thing as "release on terms," why do special justices prefer to use terms and procedures that cannot be located in the statute?

16. Use of Court-Ordered Outpatient Treatment Unclear

OBSERVATION 22. UNCERTAINTY ABOUT AUTHORITY TO ORDER OUTPATIENT COMMITMENT, LACK OF CONTEMPT POWERS FORCING REVOCATION OF OUTPATIENT STATUS, FEAR OF LIABILITY, AND OTHER CONCERNS HAVE CONTRIBUTED TO THE LOW FREQUENCY OF USE OF COURT-ORDERED TREATMENT BY JUDICIAL HEARING OFFICERS IN VIRGINIA.

As noted earlier in relation to Observation 21, Section 31.1-67.3 of the Code of Virginia states that persons who (a) present an imminent danger to themselves or others as a result of mental illness or (b) have otherwise been proven to be so seriously mentally ill as to be substantially unable to care for themselves but (c) who are not in need of involuntary hospitalization "shall be subject to court-ordered out-patient treatment, day treatment in the hospital, referral to a community mental health clinic, or other such appropriate treatment modalities as may be necessary to meet the needs of the individual." Notwithstanding the legitimacy of questioning the merits of involuntary outpatient commitment, the infrequency of the use of the court-ordered outpatient treatment provisions of the Code of Virginia and the use of an unauthorized and questionable procedure referred to as "release on terms" is perplexing.

## Posthearing Matters

This section presents observations about the events that take place following judicial commitment hearings.

### 17. Lack of Appeals

According to Section 37.1-67.6 of the Code of Virginia, any person involuntarily committed has the right to appeal his or her commitment to the circuit court in the jurisdiction wherein he or she was committed. The appeal must be filed within 30 days from the date of the order and, according to the statute, shall be given priority over other pending matters before the court and heard as soon as possible. The appeal is heard de novo. If the person is not represented by counsel, the judge shall appoint an attorney to represent the individual. Counsel so appointed shall be paid a fee of seventy-five dollars and "necessary expenses". Section 37.1-104.2 of the Code of Virginia requires the attorney for the Commonwealth of the county or city in which the hearing is held to defend a commitment appeal when the defense is requested by the "director of the hospital or other institution having or claiming custody of such person."<sup>13</sup>

**OBSERVATION 23.** IN VIRGINIA, NO RECORD OR TRANSCRIPT IS MADE OF INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS HEARD BY THE DISTRICT COURTS. BY ALL ACCOUNTS, APPEALS OF INVOLUNTARY CIVIL COMMITMENTS TO THE CIRCUIT COURTS ARE INFREQUENT. OPINIONS OF THE CIRCUIT COURTS ARE NOT REPORTED. IN THE LAST TEN YEARS, LESS THAN FIVE INVOLUNTARY CIVIL COMMITMENT CASES HAVE BEEN HEARD BY THE VIRGINIA SUPREME COURT--CONSPICUOUSLY FEWER THAN BY THE SUPREME COURTS OF OTHER STATES WITH POPULATIONS COMPARABLE TO VIRGINIA.

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<sup>13</sup>Commonwealth Attorneys. Required to Resist Appeals Filed Under §37.1-67.6. Report of the Attorney General, August 27, 1981.



Because of the time it takes to get on the circuit court docket, the likely mootness of the case because the average time of hospitalization (21-30 days) is less than the appeals process, the lack of monetary incentives for attorneys to appeal cases, and other considerations, appeals are very infrequent in Virginia. One measure of the infrequency of appeals in Virginia is the number of published appellate opinions. During the ten-year period beginning in 1976 and ending in 1986, 840 appeals of involuntary civil commitment cases were reported nationwide.<sup>14</sup> A total of 101 appellate cases arising in Minnesota were reported--a state with roughly the same population as Virginia. During the same period only two reported cases of appeals to the federal and state courts came from Virginia.<sup>15</sup>

Appellate review is important not only for review of particular cases--for the protection of involuntarily committed persons' liberty interests, for example--but also, perhaps more importantly, the settling of points of law interpreted differently by various commitment courts within a jurisdiction. For example, in the case of Rhode Island Department of Mental Health, Retardation and Hospitals V.R.B (549a.2d 1028) (R.I. Sup. Ct. 1988)), the issue on appeal was whether the lower court had the authority under Rhode Island civil commitment statutes to commit a person to a facility for other than inpatient care. Ruling on a point of law relevant to laws and practices in Virginia, the Rhode Island Supreme Court stated that a man whose "continued

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<sup>14</sup>American Bar Association, The Mental and Physical Disability Law Reporter Ten Year Index, Volumes 1-10, 1976-86 (1987).

<sup>15</sup>Evans v. Paderick, 443 F.Supp. 583 (1977); Fisher v. Coleman, 486 F.Supp. 311 (1979).

unsupervised presence in the community would give rise to a likelihood of serious harm to himself and others by reason of mental disability" was properly certified for outpatient commitment at a community mental health center. The certification included clear and convincing evidence of his dangerousness, and the disposition was the least restrictive appropriate alternative, the court stated.

In a field changing as rapidly as mental health law, it may be advisable to encourage development of case law clarifying ambiguous statutory provisions. In jurisdictions where appeals have been discouraged and where expedited appeals are not the common practice, statutory ambiguity and confusion may persist. If clarification is sought at all, it may be sought through repeated trips to the legislature, often an exhausting process.

## PART III

### FIELD RESEARCH

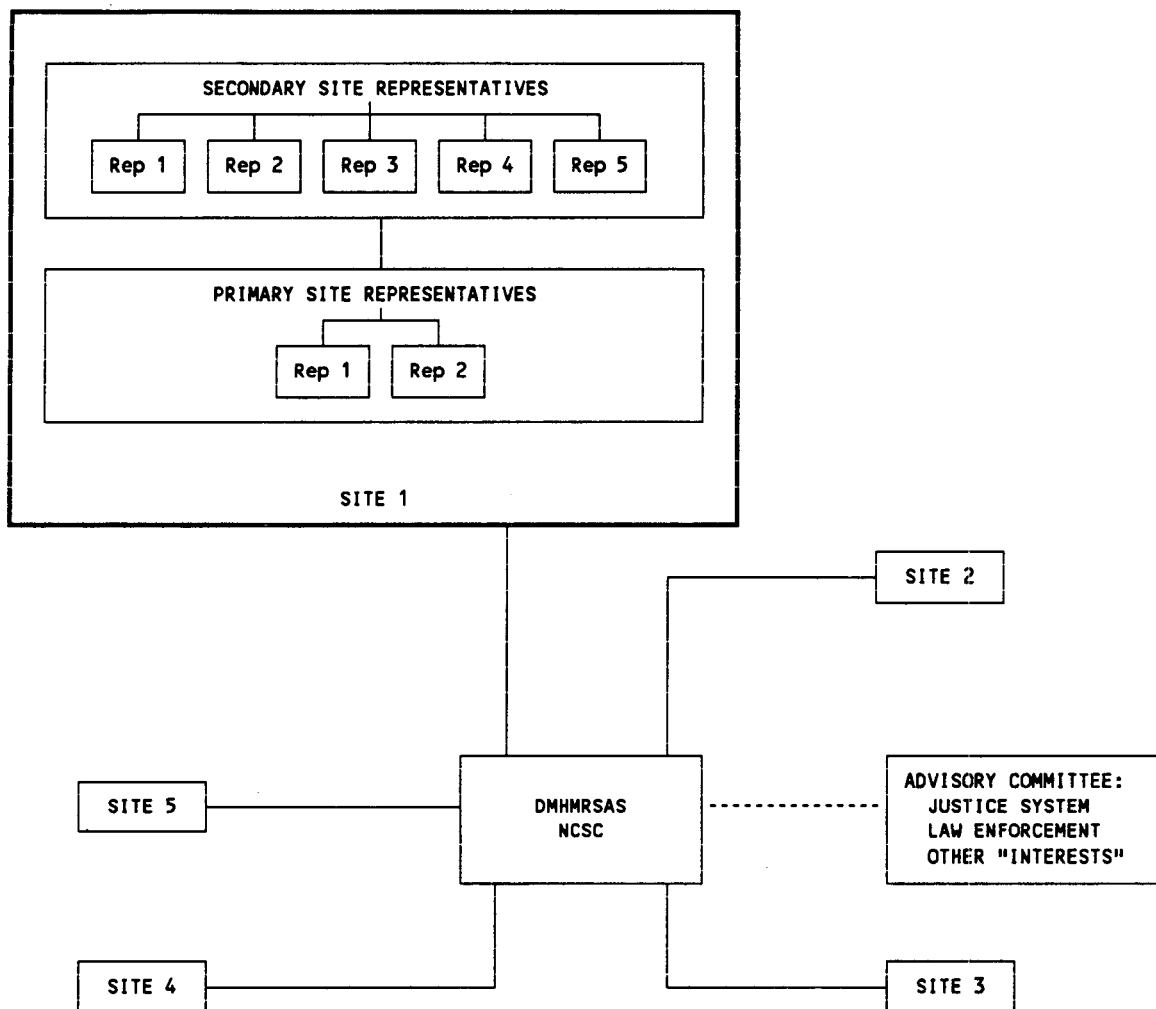
#### Introduction

As noted in PART I, project staff conducted intensive field research in the catchment areas of five community service boards (CSBs) -- Arlington, Central Virginia, Colonial Williamsburg, Northwestern and Richmond -- from February through July of 1989. Interviews were conducted with CSB personnel, special justices, district and circuit court officials, attorneys, police officers, mental health consumer advocates and others. Commitment hearings and other procedures conducted during the field research were observed whenever possible. The results of this intensive field research are presented in the five site reports included in this section.

The design of the field research, including the cooperative arrangements among the DMHMRSAS, the NCSC, the Emergency Services Advisory Committee, and the site representatives is depicted in Figure 3-1. Site selection was based on the following considerations: (a) geographic distribution across all five Service Areas, (b) population densities of sites, and (c) ease of access to sites and expected cooperation of site personnel. Final selection was made jointly by the NCSC and the DMHMRSAS.

Generally, within each of the five sites, two "primary" site representatives, one working primarily within the mental health system and one working primarily within the justice system, were identified and contacted, first by mail and then by telephone. These representatives became the primary contacts for purposes of data collection within the sites. Each of the primary representatives, in turn, identified as many as five "secondary"

Figure 3-1 Obtaining the Detailed Descriptions: Data Collection Arrangements  
Among Study Sites, NCSC, DMHRSAS, and Other Entities



Note. Primary and secondary representatives as depicted in Site 1 are involved in each of the other sites as well.

representatives. The secondary representatives contributed information about the structure, organization, and administration of mental health emergency services and commitment practices about which the primary representatives had limited knowledge. The contribution of the secondary site representatives served to enhance both the trustworthiness and the comprehensiveness of the site descriptions. Through an iterative process including one-day meetings of the primary site representatives at the NCSC's headquarters in Williamsburg, face-to-face interviews and observations in each of the sites, follow-up telephone interviews, and reviews of relevant background documentary materials supplied by the primary site representatives, project staff produced drafts of the site reports. These drafts were submitted for review to all persons interviewed by project staff during the course of the field research. Suggested revisions led to another round of more limited interviews of site personnel.

This iterative process, one element providing a check on the other, enhanced the trustworthiness of the site reports. It is important to note, however, that the people with whom interviews were conducted were not a statistically representative sample in any sense, nor was it feasible for project staff to validate, in a technical sense, whether the interviewees' responses actually coincided with all the practices described, especially those that were not observed by project staff. It is acknowledged, therefore, that the site reports may fail to represent the practices as viewed by those who were not interviewed (or practices as they exist at this writing, several months after the field research). Nevertheless, the approach taken is consistent with the goal of the project to gain insight into the every-day

emergency mental health services and involuntary civil commitment practices in Virginia and to provide an empirical basis upon which improvements may be made.

**Section 1:  
Emergency Mental Health Services and Involuntary  
Civil Commitment Practices in the Arlington CSB**

Central to the emergency mental health services and involuntary civil commitment practices in Arlington County are the Emergency Services Program (ESP) of the Arlington County Department of Human Services, the Arlington County Police Department (ACPD), and the high level of cooperation between both. Early in 1984, the Arlington County Community Services Board (CSB) brought together the Arlington County Department of Human Services and the Arlington County Police Department to create a "formal network to address the problems associated with special populations" (Brewer, 1988). The close cooperation between ESP and ACPD is, in large part, the result of this effort.

This report highlights the central mechanism and "formal network" linking the ESP and the ACPD. It describes in four phases the chronology of events, decisions, and procedures that are likely to arise when an individual requires or seeks emergency mental health services and becomes the subject of the involuntary civil commitment process in Arlington County. These four phases are: 1) crisis to detention; 2) temporary detention, treatment and care; 3) preparation for and conduct of preliminary and full judicial hearings; and 4) post-hearing matters. The text is keyed to accompanying flowcharts.

**Crisis to Temporary Detention or Voluntary Care**

The first phase of the emergency mental health services and involuntary civil commitment practices in Arlington County begins at the point where an

individual experiences a mental health crisis and continues through the point at which a temporary detention order is issued.

1. Point of Initial Contact and Referral

The point of initial contact for assistance provided to an individual experiencing a mental health crisis in Arlington County is most often the police, paramedics, firemen, or hospital emergency room personnel. Assistance may come from any of a number of other sources, including an individual seeking help for himself or herself, a family member or any concerned person, the Arlington County Department of Health, the Department of Social Services, the Office of Housing, homeowners associations, school personnel, clergy, and the National Airport Authority (see Figure 3-1.1). As noted earlier, because the Emergency Services Program (ESP) has an established, effective cooperative relationship with the Arlington County Police Department (ACPD) that facilitates swift assessment and interventions in mental health crises, the ESP itself may frequently be the point of initial contact (see below).

According to the written policies of the ACPD (Procedure No. 5703, Arlington County Police Department Procedures, September 11, 1988), ESP staff (therapists) will assist police officers with individuals "experiencing mental problems or in need of emergency crisis intervention." Specifically, this assistance includes: (1) assessment and emergency treatment of persons thought to be mentally ill; (2) screening, at the request of the Police or Sheriff's Department, those individuals arrested on criminal charges who exhibit symptoms of mental illness; (3) facilitating a voluntary or involuntary hospitalization; (4) referral and linkage to other human resources; and, finally, (5) assisting families experiencing domestic crises,



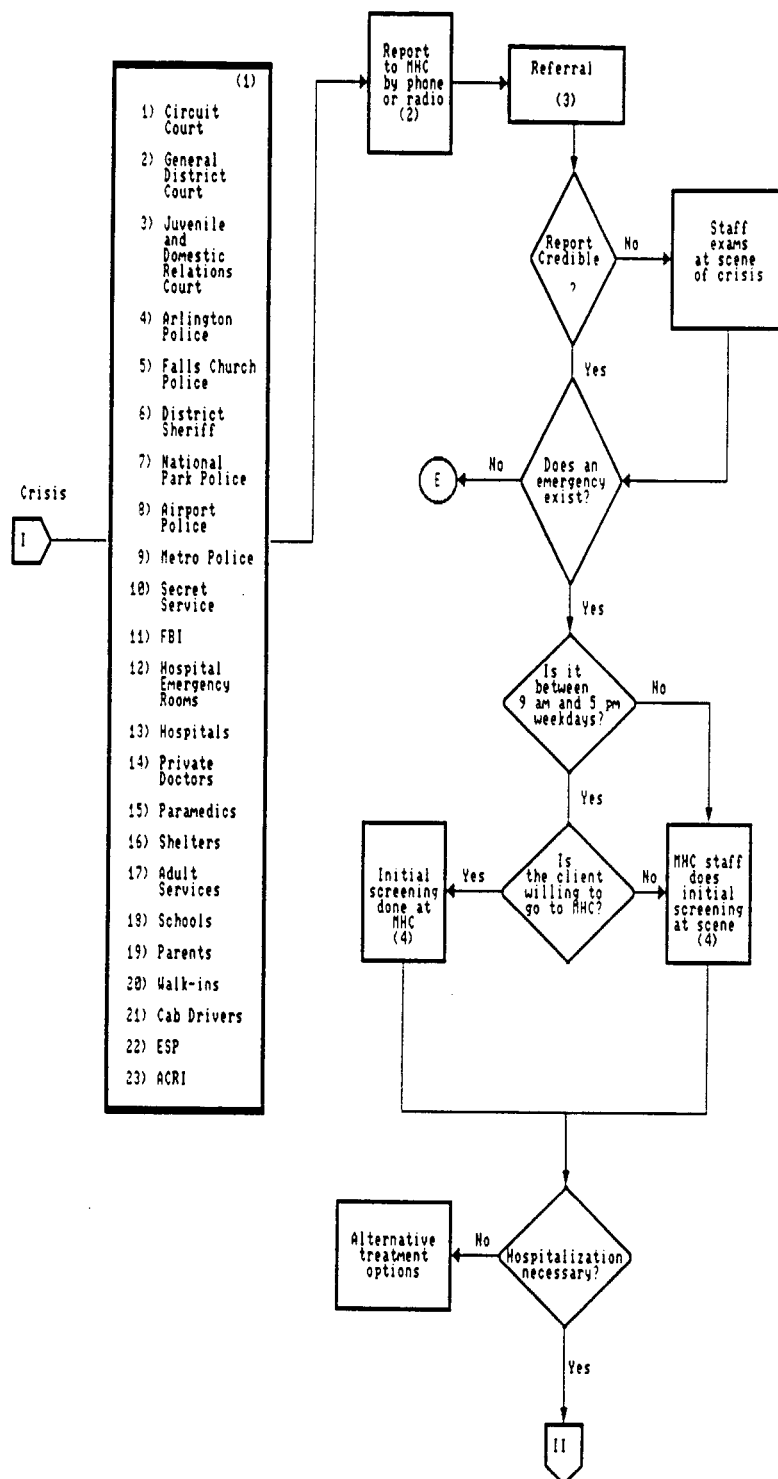


Figure 3-1.1. Emergency Mental Health Services and Involuntary Commitment Practices in Arlington -  
Crisis to Temporary Detention or Voluntary Care

individuals with alcohol or substance abuse problems, runaways, and potential or threatened suicide victims.

In Arlington County, as elsewhere throughout the country, the public expects the police to handle most emergencies because police officers are available 24-hours a day and have the legal authority to intervene and detain individuals. Typically, upon arrival at the scene of an emergency, the responding officer will attempt to restore order. The officer then will determine if the assistance of ESP therapists is required. If the responding officer believes that a criminal act has been committed, the officer is likely to arrest the suspect, transport him or her to the police station, and advise the magistrate on duty of any conduct or behavior that would indicate that the suspect is mentally disturbed.

If the responding officer believes that the individual is a mental patient or that an assessment by the ESP therapist is indicated, the officer will call the emergency therapist directly and describe the situation. According to the established procedures of the police, if a telephone is unavailable or if the therapist is out of the office on another call, or on the street with another officer, the officer may try to establish radio contact with the therapist. Typically, a brief description of the problem is transmitted on the administrative radio channel. Reportedly, the police may also receive walk-in or telephone referrals. In such cases, the ACPD front-counter personnel will attempt to identify the problem and notify the ESP of the potential referral.

ESP therapists are available 24 hours daily, seven days per week. On weekdays, persons experiencing a crisis may refer themselves to the ESP of the mental health center. According to an ESP spokesperson, the fact that the

person can refer himself or herself "tells you something about the severity of the emergency." Understandably, "walk-ins," as a group, represent "lower" levels of emergencies than those usually experienced on the streets during evenings and nights, when most of the emergencies encountered by the police or the ESP reportedly occur. Typically, walk-ins have made previous contacts with other components of the Arlington County Department of Human Services and have contacted the ESP as a last resort with what now constitutes an emergency for those individuals.

According to an ESP spokesperson, after the police, the most frequent points of initial contact for crisis intervention are the Social Service Division of the Arlington County Department of Human Services and hospital emergency rooms in the area. For example, a person may contact a local shelter facility in search of appropriate housing (lack of low-cost housing is reportedly a major problem in Arlington County). The shelter facility will, in turn, contact the Social Services Division. If the social services staff suspect that the person has mental health problems, the staff will refer the individual to the ESP. Emergency staff of local hospitals will refer to the ESP individuals who are recognized as Mental Health Center patients and persons experiencing crises who hospital staff believe are likely candidates for involuntary civil commitment.

## 2. Referral to the Emergency Services

As noted earlier, the ESP is central to the emergency mental health services and involuntary civil commitment system in Arlington County. ESP is one of three programs of the Prevention and Intervention Unit, which is a subdivision of the Division of Mental Health of the Arlington County

Department of Human Services. The Division of Mental Health, as part of the Department of Human Services, serves the residents of Arlington who have mental, emotional, alcohol and drug abuse, and life adjustment problems. The Division provides treatment, crisis intervention, and prevention education services. As part of the Prevention and Intervention Unit of the Division of Mental Health, the ESP provides emergency mental health services directly to the community.

At this writing, the ESP staff included two supervisory therapists and seven emergency therapists (one senior emergency therapist position was vacant). ESP therapists are scheduled to be on duty from 8:00 a.m. to 3:00 a.m. and one therapist is on call from 3:00 a.m. to 8:00 a.m. Because nighttime emergencies often require the on-duty therapist to extend his or her shift past 3:00 a.m., at least one therapist is on-duty 24-hours daily to assist the community with individuals experiencing mental health problems who are in need of emergency crisis intervention.

During business hours, the mental health center offers a walk-in service (see above). ESP staff are available for "walk-in" emergencies and respond to requests for "out of center" assessments. During evenings, nights, and weekends, the ESP emergency therapists operate out of an office located in the ACPD. Typically, however, the ESP therapists are on the streets with the police. They carry ACPD radios and pagers to allow them to be in constant contact with the police and others in the community who might report a mental health emergency. The following account by a ACPD spokesperson describes the close cooperation and working relationships between the ACPD and the ESP.

There was some suspicion and resistance by officers during the initial implementation of this program. However, once officers observed the capable handling of some difficult interventions by the emergency therapists, a mutual respect developed. Adding to

the success of the program was the selection of therapists who were open and personable.

Officers quickly discerned that the therapists are invaluable in terms of saving time. They are able to expedite the commitment process by conducting the prescreening as required by law and by locating available bed space. They provide a myraid of social services alternatives. They often provide support to distraught family members at death and suicide scenes. They also allow officers to return to the service more rapidly by taking the counseling responsibility for non-violent crisis interventions. Officers continue to provide security and transportation for the therapists and refer to them, affectionately, as the "Brain Police."

Another benefit was derived from the interactions of the two agencies. Officers began to express their own frustrations to the therapists. Having this avenue available to ventilate, the officers have been able to deal with job stress in a positive way.

There are several reasons why this secondary relationship developed. First, the officers have first hand observation of the professional abilities of the emergency therapists in handling a variety of crises. Secondly, the officers can confide in someone who is not employed by the Department. This probably raises the perceived level of confidentiality. Finally, both Departments are committed to making the program work. The end result is a high level of cooperation which ultimately encourages acceptance and a positive working environment.

In summary, the network created between the Police and Human Services Departments has had the following benefits:

- o Provided alternative dispositions to the law enforcement community;
- o relieved officers of many of the time consuming responsibilities for non police interventions to handle other law enforcement priorities;
- o reduced the number of formal commitments through early intervention; and,
- o fostered inter-agency cooperation and support. (Brewer, 1988)

The ESP performs preadmission screening (generally referred to as "prescreening") of all individuals referred to the program for admission to a public mental health facility. The ESP has been in existence since February

1984 and, reportedly, is generally well known throughout Arlington County. According to an ESP spokesperson, there is a perception in Arlington County that all emergencies that do not result in a criminal arrest or require medical intervention should wind up in the hands of the ESP. This creates another level of "emergencies" for the ESP when referral sources functionally define "emergencies" as situations that cannot be handled by the referring facility. In view of the fact that Northern Virginia Hotline receives approximately 50,000 calls per year, and the ESP could not handle even a portion of that volume, the ESP director has made a conscious decision not to advertise the services of the ESP.

Accurate data about the source and frequency of referrals are not available. However, as noted earlier, most of the referrals to the ESP come from the police, the Social Service Division of the Arlington County Department of Human Services and local hospital emergency rooms.

### 3. Telephone Contact and Referral

When a person calls the ESP during business hours to report a possible mental health crisis, a therapist makes an initial assessment of the caller's situation. At the time of the writing of this report, the telephone receptionist of the Arlington Mental Health Center--where the ESP is located--transferred all calls that he or she perceived to be of an emergency nature to the ESP. Consequently, many calls received by the ESP did not constitute, from the perspective of the ESP, emergency situations. (Reportedly, plans are underway to have the ESP directly screen calls in the future.)

If the ESP questions whether the caller is reporting a "true" mental health crisis, a member of the ESP staff will determine if he or she should go

to the scene of the alleged crisis to determine if a mental health emergency exists or if the caller is willing and able to come to the mental health center. During the initial telephone conversation with the caller, the ESP staff always consider whether the caller--who may often be reporting that another individual is experiencing a mental health crisis--is in fact the individual who has mental health problems. Reportedly, many calls received by ESP are reports of situations that are not appropriate referrals to the ESP. For example, a private provider who reports that a patient has become distraught in his or her office and wants the ESP to handle the situation so that he or she can see the other patients waiting in the waiting room. If the caller is credible or known to the mental health center, the ESP staff go to the scene of the crisis only if the caller or someone else cannot bring the individual in need of care to the center. When ESP personnel go to the scene they are almost always accompanied by the police.

After business hours and on weekends and holidays, the ESP personnel on duty may be at the ACPD, with the police on patrol, or tending to crises in the community. On the average, emergency therapists reportedly are called to respond to eight cases per night.

Members of the police force are trained to make initial mental status assessments of individuals potentially in crisis. Police officers are instructed by Arlington County Police Department Procedure 570.03 (September 11, 1988) to contact the ESP directly and describe a situation that appears to warrant ESP intervention. If the ESP therapist is at the police station, the officer makes the contact by telephone. If the therapist is away from the station responding to another call, the officer tries to contact the therapist by police radio. The therapist will determine whether to respond by coming to

the scene or having the officer seek the individual's voluntary transportation (preferably by the individual's own means) to the station to speak to the ESP personnel.

If the therapist goes to the scene, the police officer remains in radio contact to advise the therapist while he or she is enroute if intervention no longer is needed or the location of the individual changes. While the therapist is at the scene, the police officer remains at the scene to ensure the safety of the therapist until such protection no longer is necessary. If and when the officer leaves the scene, the therapist can contact the police by radio if the situation changes and the assistance of the police is once again required.

#### 4. Preadmission Screening

As part of the preadmission screening of all individuals who possibly are candidates for hospitalization, the ESP staff conduct a comprehensive assessment of the individual's mental status and possible treatment needs. In about 10 percent of the cases, the emergency therapist decides to seek a temporary detention order (TDO).

A number of alternatives to hospitalization are available for the emergency therapist to consider and recommend to the individual. If the individual's most immediate need is medical attention, the therapist may arrange for him or her to be transported to a hospital emergency room. All hospitals in the Arlington area have an emergency room except for Dominion Hospital in Fairfax County, which has an "on-call" internist. If the individual is in stable condition and not in need of emergency treatment, the therapist may recommend that the individual schedule an appointment with the



Division of Mental Health of the Arlington County Department of Human Services for an evaluation of his or her needs. The Division provides a variety of treatments including individual and group psychotherapy, family therapy, marital counseling, medication, and milieu day-treatment. The objective of treatment is to ameliorate the symptom or problem using any combination of services provided by the division and affiliated agencies such as the Division of Social Services, as well as programs such as Alcoholics Anonymous and Alternative House. Among the other services available in the Arlington area are the Arlington Temporary Shelter (TACT) (for battered women and women in other crises), Arlington Community Residence, Inc. (ACRI-CARE), and Social Detox, a five-day nonmedical detoxification service in Alexandria. ACRI-CARE is used as an alternative to hospitalization. At the facility, clients are able to receive 24-hour care and develop a treatment plan to prevent hospitalization.

If the emergency therapist decides that the individual should be detained for emergency mental health care and evaluation, he or she must find a "TDO bed" for the individual. Treatment facilities distinguish between TDO beds and "commitment beds." TDO beds are those available to ESP for detention of persons who have not had a judicial hearing. Commitment beds, as the name implies, are used for individuals who have been judicially committed. Reportedly, six to ten TDO beds in three facilities are regularly available to the ESP (see below). TDO beds have been in short supply in the past, but area hospitals make available as many commitment beds as are required by commitment hearing dispositions. When no TDO beds are available, the emergency therapist must contact an ESP supervisor and try to make arrangements for the individual's safety and care out of the catchment area. If the person has

medical insurance, the ESP staff may encourage the individual to seek voluntary hospitalization. If the person is in a location where he or she can be held temporarily, such as a hospital emergency room, the person may remain there until the ESP staff can find a TDO bed. If the situation merits it, the ESP staff or a police officer will stay with the individual until arrangements are made for a TDO bed and transportation.

The Northern Virginia Mental Health Institute (NVMHI) serves as the primary public mental health hospital for the Arlington area. Reportedly, "high census" at NVMHI negatively impacts the mental health service delivery system in Arlington County in a variety of ways. Voluntary admission to NVMHI is virtually nonexistent. That is, a person who seeks voluntary admission typically will not be provided the opportunity to enter the facility without the issuance of a TDO. If a person does not have third-party insurance and cannot be voluntarily admitted to a private facility, he or she must be subjected to the TDO process even though the individual, if given the opportunity, is willing to elect voluntary admission status without the issuance of a TDO.

Thus, "voluntary" public psychiatric beds generally are unavailable in the Arlington area except through the TDO process. That is, a person seeking voluntary admission undergoes temporary involuntary detention and then, at the time of the preliminary hearing, elects voluntary admission (see below). In effect, the ESP and the commitment system serve to ration voluntary psychiatric beds through the TDO process.

Because involuntary commitment beds are in greater supply than are TDO beds, and because some individuals may require immediate hospitalization when no TDO beds are available, the ESP reportedly sometimes seeks to hold a full

commitment hearing right away if there is room on the court's docket and arrangements can be made for all parties to be present. The necessary parties include counsel for the individual, a judge or special justice, the petitioner, and a doctor to testify.

### Temporary Detention Through Inpatient Services

This phase begins with the issuance of a temporary detention order by a magistrate, special justice or District Court judge and ends with the provision of inpatient treatment services by a hospital (see Figure 3-1.2).

#### 5. Issuance of Temporary Detention Order

When an ESP emergency therapist has made arrangements for an individual's detention, he or she calls the magistrate, whose office is in the ACPD, to request that a TDO be issued. In most cases, the magistrate issues the TDO after conferring with the ESP emergency therapist and completing a form, the "Magistrate Report." The magistrate developed this form for his records. It contains information about the circumstances under which the TDO was issued, the petitioner's name address and relationship to the detainee, the detainee's current behavior, mental health history, diagnosis, medication and dates and places of previous hospitalizations. The magistrate gives the TDO to a police representative who may relay the information verbally to the police officer who will then pick up the TDO and transport the individual to the hospital. According to the ACPD's standard operating procedures, once the TDO is issued, it will be given to a police officer for service and transport of the individual to the detention facility named in the order.

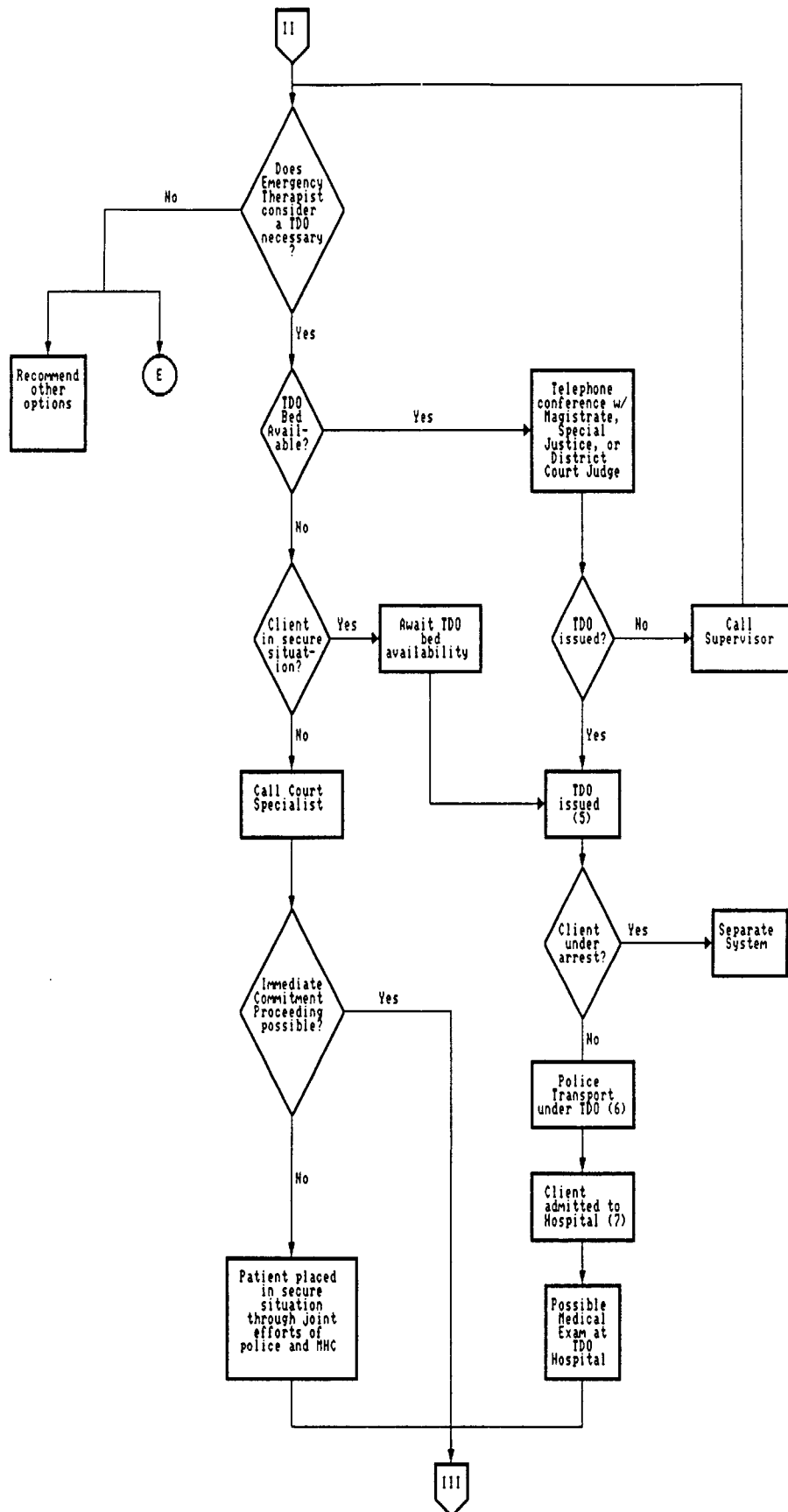


Figure 3-1.2. Emergency Mental Health Services and Involuntary Commitment Practices in Arlington - Temporary Detention Through Inpatient Services

The transporting police officer typically "serves" the TDO by making it known to the individual that he or she has a signed TDO. Reportedly, the actual TDO is not presented to the patient until after his or her arrival at the receiving detention facility. Once the police officer serves the TDO, one copy is returned to the magistrate. The remaining copies stay with the patient at the hospital. A copy of the prescreening form also is left with the patient at the detention facility.

#### 6. Transportation to Detention Facility

In 90 percent of the cases, the police transport the individual to the hospital in a paddy wagon. If transportation in a paddy wagon is inappropriate (e.g., the patient is elderly, frail, or severely depressed), the police may transport him or her in a squad car or, in rare instances, an ambulance. Police squad cars are used in about eight percent of the cases and ambulances are used about two percent of the time. Police transport individuals to the hospital from the scene of the mental health crisis, but a sheriff's deputy always transports the individual from the hospital to the judicial hearing in the Arlington District Court, where all commitment hearings are held (see below).

Section 37.1-67.1 of the Code of Virginia provides for the involuntary, temporary detention persons in "some convenient and willing institution or other willing place for a period not to exceed forty-eight hours prior to a hearing. The institution or other place shall be approved pursuant to regulations of the Board [State Mental Health, Mental Retardation and Substance Abuse Services Board]." Mental health facilities willing and able to detain temporarily individuals in Arlington who are in need of mental

health services include: the Northern Virginia Mental Health Institute (NVMHI), Springwood Hospital, Western State Hospital, Arlington Hospital, Dominion Hospital, Alexandria Hospital, Prince William Hospital, Loudoun Memorial Hospital, Winchester Medical Center, Charter Westbrook, Richmond Memorial Hospital, DeJarnette Center, Eastern State Hospital in Williamsburg, and within the last few months, Northern Virginia Doctor's Hospital.

Reportedly, availability of bed space in these facilities is not only a matter of space per se but also involves the facility's capability of accommodating the detainee. Some facilities are better equipped to handle potentially disruptive patients. For example, Dominion Hospital has a specialized intensive, acute care unit to which all involuntarily detained patients are, at least initially, assigned. Arlington Hospital has two "quiet rooms" to accommodate potentially disruptive patients.

#### 7. Admission

Reportedly, a patient's mental health status, not necessarily his or her legal status (i.e., a person who is the subject of a TDO), determines the nature of the hospital admission procedures, the prehearing treatment and care of TDO detainees. Specific procedures vary among the detention facilities. In general, when an individual is brought to a hospital under a TDO, he or she receives the same treatment as any other patient. Typically, a mental health technician or nurse questions and examines the patient for purposes of hospital admission. At some point in time before the judicial hearing, a staff physician examines the patient to determine his or her medical condition and a psychiatrist assesses the individual's mental status.

### Preparation for and Conduct of Judicial Hearings

This phase begins with the preparations by the ESP staff for the judicial hearings and ends with a decision by a judge or special justice following a full judicial hearing (see Figure 3-1.3).

#### 8. Preparation for the Judicial Hearings

ESP staff notify witnesses to appear for a judicial hearing. An emergency therapist who assessed the individual at the scene of the crisis often will have obtained the names and addresses of potential witnesses. He or she also prepares a report of the crisis and other background information about the individual and arranges for someone--if ESP is not the petitioner--to act as the petitioner for involuntary civil commitment. The ESP, reportedly, will serve as the petitioner if another agency or individual is not available or would not be an appropriate petitioner. A family member or acquaintance of the individual, though a willing petitioner, may be an inappropriate petitioner because of mental illness or his or her relationship with the individual. ESP serves as the petitioner as needed. As an internal check, and to avoid conflict, the ESP therapist who served as the preadmission screener and recommended the issuance of the TDO is reportedly never asked to serve as petitioner.

Early on the day of hearings, the ESP court specialist leaves word with the District Court assistant who, in turn, contacts the special justice, the Sheriff, the independent examiner (a psychiatrist or Ph.D. psychologist) who will evaluate the individual and testify at the hearing, the attorney representing the individual for whom mental health treatment is

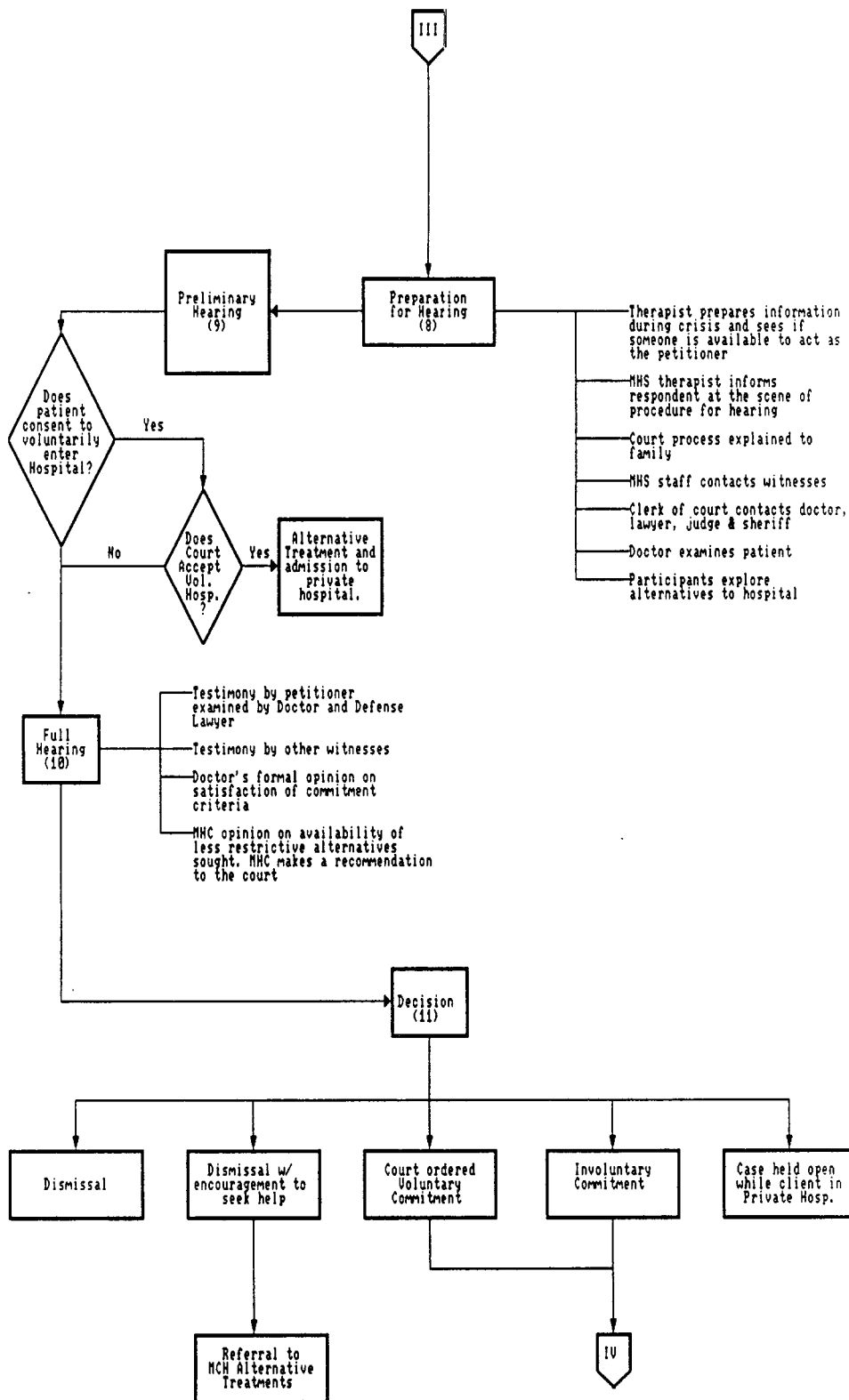


Figure 3-1.3. Emergency Mental Health Services and Involuntary Commitment Practices in Arlington - Preparation For and Conduct Of Judicial Hearings



sought. The magistrate will furnish the District Court with the TDOs issued for the individuals whose hearings are scheduled that day.

One of two special justices regularly presides over commitment hearings in Arlington. Once or twice a year, reportedly because of scheduling conflicts of the special justices, the Chief Judge or other judge of the Seventeenth Judicial District Court presides over the commitment hearings. Another district judge has been designated, albeit informally, as the supervisor of the special justices in Arlington.

The special justices in Arlington are relatively isolated from their peers. That is, no formal network of special justices exists and no formal training mechanisms enable the special justices to increase their knowledge and hone their skills. Reportedly, personal interest and perhaps the possibility of advancement (in the past, a special justice in Arlington was elevated to the Juvenile and Domestic Relations District Court) may motivate the special justices to perform.

Unless the individual has retained a private attorney, defense attorneys usually do not interview the individual until the day of the hearing. If the attorney does not have sufficient time to prepare for the hearing, and he or she may move the court for a continuation of the commitment proceedings. Such motions reportedly are always granted.

At the time of the writing of this report, nine attorneys were on a list of attorneys available to represent respondents in Arlington. The list is compiled and maintained by the assistant to the Chief Judge of the Seventeenth Judicial District Court. Except for the monitoring by the local bar association and informal oversight provided by the special justices, no formal

mechanisms exist to train and supervise attorneys representing respondents in Arlington.

Three independent psychiatrists and one clinical psychologist are on call to examine respondents and to testify at the hearings. The professional on call usually performs a mental health evaluation of the individual the morning before the hearings. Patient interviews are conducted in and around the hearing room approximately an hour in advance of the actual hearing. Testimony at the hearing is based upon this evaluation.

Typically, a hearing day in Arlington begins at 6:30 a.m. with the ESP court specialist contacting a "willing" and "convenient" detention facility (e.g., NVMHI) to reserve the number of beds necessary to accommodate the number of cases to be heard that day. The court specialist then conveys a message to the District Court assistant regarding the identities of the petitioners, the location of reserved beds, and other information such as the need for language interpreters. As noted earlier, the assistant then prepares the paper work to assure the transportation of the respondents by the Sheriff and the appearance at the hearing of the psychiatrist or psychologist and the lawyers. He/she will also notify the hospital regarding the Sheriff's pick-up of the respondent(s) and the ESP court specialist regarding the timing of the hearing. The ESP court specialist, in turn, will then call the petitioners and witnesses regarding the time and location of the hearing. They are instructed to call the General District Court for the specific time of the hearing.

Reportedly, there is no consistency among detention facilities in the conveyance of a report of the patient's condition during the time of detention. Two facilities may, though not consistently, convey to the ESP

court specialist a single-sheet report that indicates whether the patient elected voluntary patient status, the alleged dangerousness of the patient, and the necessity of further treatment. Typically, however, there is no report of the patient's condition conveyed by the detention facilities in Arlington. According to an ESP spokesperson, the detention facilities' failure to convey patients' records may be attributable to their concerns about preserving the confidentiality of the records.

The Sheriff's Office makes contact with the General District Court between 8:15 a.m. and 8:30 a.m. At that time, the Sheriff's Office is notified of the number and location of patients detained, the time of the start of the hearings. Any unique information regarding the condition or known complicating factors are provided to the Sheriff's Office at this time (e.g., need for a wheelchair or deafness of a patient). Transportation orders are picked up by sheriff deputies directly from the judge's chambers. Deputies are then dispatched to the facilities to pick up the patient and transport him or her to the court at the designated times of hearings. Reportedly, as a general rule, patients are not handcuffed; however, the use of restraints is left to the discretion of the transporting officers.

#### 9. Preliminary Judicial Hearing

As is the case in most jurisdictions throughout Virginia, the preliminary and "full" commitment hearings are held "back-to-back." The hearings take place in Room 104 of the General District Court except when the respondent is clinically unable to be transported to the court--in such cases the hearing is held in the hospital. Whether or not a preliminary hearing "continues" into a full hearing depends upon the acceptance of a motion,

typically made by the respondent's counsel, regarding the respondent's willingness to accept voluntary patient status.

In all of the five hearings observed by project staff on June 23, 1989, a special justice presided over the hearings. He sat on a dais, flanked to his right by the district court assistant. The psychiatrist sat at a table in front of the bench facing the respondent and his or her attorney sat at a table approximately twelve feet away. The ESP court specialist, the sheriff deputies, witnesses, other individuals (including respondents) awaiting hearings, and members of the public sat on benches separated from the courtroom area by a wooden divider.

Based on the observations of the hearings and the reports of interviewees, a preliminary hearing typically begins with the special justice explaining to the respondent his or her rights including, in particular, the right to elect voluntary hospitalization. Typically, upon motion of the respondent's counsel for voluntary admission, concurrence by the psychiatrist that voluntary admission would be advisable (viz., the individual is likely to comply with the voluntary admission requirements), the special justice either (a) accepts the motion for voluntary admission and asks the individual and attorney to sign the appropriate forms or (b) rejects the motion and proceeds to a "full" hearing.

In one preliminary hearing observed by project staff, the special justice, upon request of the attorney, continued (held open) a case for one week to effect a guarantee regarding the individual's compliance with the terms of voluntary admission. He issued an order dismissing the petition only if no action is taken to bring to his attention the individual's noncompliance. At the other observed preliminary hearings, the special

justice queried the ESP court specialist regarding the individual's likelihood of complying with proposed voluntary admission, called witnesses regarding the issue of compliance, and directly questioned the respondent, his or her attorney, and the psychiatrist about various matters pertaining to the case.

The ESP staff will present the pre-admission screening report and make specific dispositional recommendations to the courts. Whenever possible, family members will be encouraged to participate in the commitment process as petitioners. ESP staff will assist families in understanding and in preparing for the hearing. When no other person is available, ESP staff will serve as petitioners. When ESP staff serve as petitioners, one staff member will assume the role of petitioner and another will make the pre-admission screening report.

In sum, at the preliminary hearing the special justice decides whether the individual is capable of choosing voluntary commitment. Reportedly, the special justice relies primarily on the ESP's report and the evidence presented at the hearing in reaching this decision. If the individual cannot or does not agree to voluntary hospitalization, a "full" commitment hearing is held.

#### 10. Full Judicial Hearing

Full hearings typically begin with the special justice announcing that a commitment petition has been filed in the case. After swearing in all witnesses present, the special justice typically first turns to the examining psychiatrist who, in effect, serves as the representative of the state. The psychiatrist questions the petitioner regarding the particulars of the petition. The special justice may make direct inquiries of the psychiatrist

and any other witnesses. The attorney representing the individual then cross examines the petitioner. Reportedly, in the vast majority of cases, no witnesses except the petitioner and the psychiatrist testify.

Following the testimony of the petitioner and any witnesses, the special justice asks the examining psychiatrist if he or she has formed an opinion about the individual's mental status and his or her suitability for commitment. He or she then asks if the attorney wishes to cross examine the psychiatrist. Finally, the special justice may, on occasion, inquire whether the proposed disposition is the least restrictive alternative for the individual.

Following all testimony and questioning, the attorney may confer with his or her client before making his or her final argument. At the conclusion of the final argument by the attorney, the special justice makes and explains his decision to the individual and his or her attorney. Typically, the special justice will, if necessary, directly make whatever necessary explanation to the individual including his or her right to appeal the commitment decision.

#### 11. Disposition Rendered

The special justice may dispose of the petition for commitment in several ways: (a) dismissal of the petition and release of the individual; (b) voluntary hospitalization (typically, this disposition is achieved at the end of a preliminary hearing); or (c) involuntary hospitalization (i.e., involuntary civil commitment).

If commitment criteria have not been met, the court must uncondition-

ally release the individual. In such cases, the court usually urges the individual to seek mental health treatment voluntarily; however, the court also may continue the case to ensure that the individual follows through and seeks treatment. As noted earlier, in such cases the court will issue an order dismissing the petition on a date and time certain if it receives no report that the individual has failed to comply with the conditions of treatment and care imposed for the period of time the case is continued. The special justice informs the individual that he or she will be subject to involuntary commitment if treatment is not sought in order to encourage the individual to obtain treatment in a private hospital. Reportedly, the ESP staff consider this disposition favorably because it permits the imposition of at least some court authority over an individual receiving voluntary outpatient treatment and care.

If the individual agrees to voluntary commitment, the court can order the individual to report for a minimum of five days of treatment. Finally, if the criteria for civil commitment have been met, the special justice can commit the individual to involuntary treatment for a period not to exceed 180 days. A special justice generally does not commit an individual for involuntary treatment in a private hospital because private hospitals do not have lock-up facilities and do not provide security. Only one private hospital, Springwood Hospital, has the necessary lock-up facilities and is willing to accept involuntary patients. Reportedly, at least one private facility in the Arlington area meets the security requirements but because of zoning restrictions is not able to accept involuntary patients.

According to an inter-departmental memorandum by the ESP (Arlington Inter-departmental Memorandum dated February 8, 1989), and as noted in the

table below, the Arlington District Court heard a total of 273 commitment cases in 1988, four more than the total in 1987.

Table 1  
COMMITMENT CASES HEARD IN THE  
ARLINGTON DISTRICT COURT IN 1988 ACCORDING TO DISPOSITION

Involuntary Hospitalization (Commitment)	136
Voluntary Hospitalization	101
Dismissal	<u>36</u>
Total	273

Of the 136 individuals who were involuntarily hospitalized, 100 were committed to the Northern Virginia Mental Health Institute, 34 to Western State Hospital, and 2 were committed to Springwood Hospital. The 101 voluntary hospitalizations occurred in seven mental health facilities as follows: Northern Virginia Mental Health Institute--54 patients; Western State Hospital--10 patients; Arlington Psychiatric Treatment Unit--17 patients; Dominion Hospital--13 patients; Alexandria Hospital--4 patients; Psychiatric Institute of Washington--2 patients; and Prince William Hospital--1 patient.

A total of 36 petitions were dismissed by the court. Only seven of these involve cases that did not, according to the ESP inter-departmental memorandum noted above, meet the statutory criteria for commitment. Three of the cases were dismissed for the lack of a petitioner or first-hand testimony (reportedly, all three were re-detained and hospitalized within a week of the first hearing). The remaining 26 of the dismissed cases were reportedly referred for voluntary outpatient mental health or substance abuse services to private psychiatrists or mental health centers in the Arlington area or in the jurisdiction where the individuals resided.



### Post-Hearing Matters

At the conclusion of the hearing, the patient will be transported by the sheriff's deputies wherever the special justice or judge directs. The deputies will take the necessary paperwork (given to them by the court) and turn it over to the appropriate personnel (usually admission office staff if the individual is hospitalized) of the facility the court directs the patient to be transported. The district court assistant prepares paper work as to the disposition of the case (e.g., voluntary admission papers) and prepares vouchers for the special justice, attorney, independent evaluator, and language translators if appropriate. ESP staff will contact the facility at the conclusion of the hearing with the disposition of the case. If the individual is returning to the facility, the estimated time of his or her arrival will also be conveyed.

The period of time that a patient remains in the hospital is controlled by the hospital staff who may release him or her when they determine that hospitalization no longer is necessary. After 180 days, the hospital must release the individual or seek another commitment. Re-commitment or review hearings are--reportedly because of convenience--held in the hospital where the individual is detained. The ESP is notified if the hospital plans to institute commitment proceedings but it does not participate in the re-commitment process (see Figure 3-1.4).

The mental health center maintains regular contact with its clients while they are hospitalized. When the hospital staff determines that the individual will be released, the center's Aftercare Unit begins to plan for treatment support after the individual is released from hospital care. This support may include providing temporary shelter and finding employment. The

prescreening form completed by the emergency therapist during his or her initial assessment of the individual provides the information required to develop a post-hospitalization plan. Many of the alternatives to hospitalization noted in Part I of this report may be included in this plan.

Finally, appeals are heard by the Seventeenth Judicial Circuit Court, which sits in Arlington. Reportedly, they are rare.

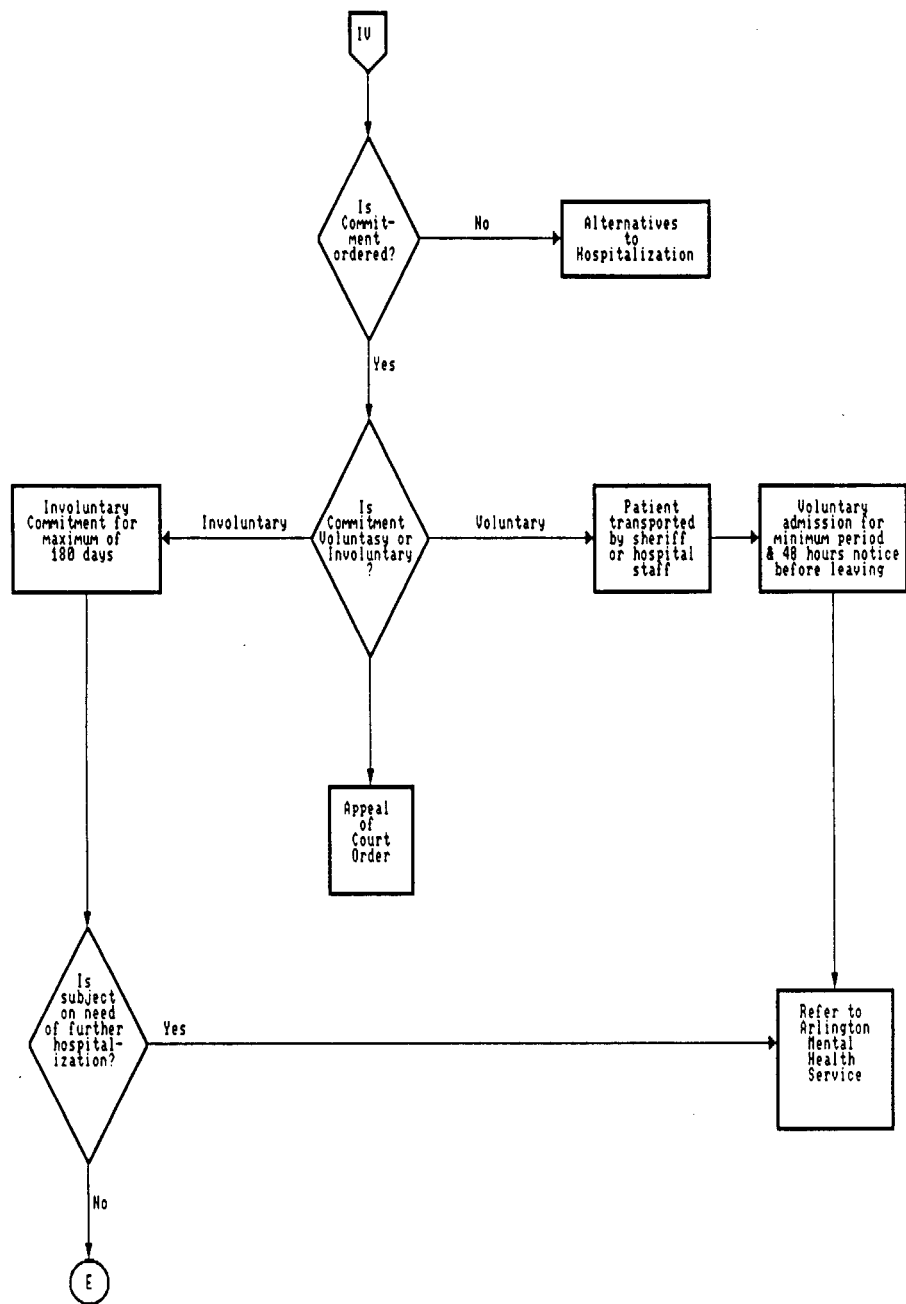


Figure 3-1.4. Emergency Mental Health Services and Involuntary Commitment Practices In Arlington - Post-Hearing Matters

#### REFERENCES

1. Brewer, G. "Arlington County Emergency Services." Virginia Police Chief, Summer 1988, 23-25, 24.

## Section 2: Emergency Mental Health Services and Involuntary Civil Commitment Practices in the Central Virginia CSB

This report describes the provision of emergency mental health services in the Central Virginia Community Services Board (CSB) catchment area. This area includes the counties of Amherst, Appomattox, Bedford, and Campbell and the cities of Bedford and Lynchburg. The county of Appomattox is in the Tenth Judicial District, and the remaining counties are in the Twenty-Fourth Judicial District.

### From Crisis to Temporary Detention, Voluntary Care Or Release

Figure 3-2.1 presents nine major steps involved in reporting, referring and evaluating a mental health crisis situation.

#### 1. Point of Initial Contact and Referral

In the Central Virginia CSB, reports of emergency mental health crises usually are made by the person experiencing the crisis; a concerned family member or friend; a police officer; a sheriff of the Amherst, Appomattox, Bedford, or Campbell County Jail or the Lynchburg City Jail; an employee of a criminal detention facility such as the Lynchburg General Detention Home; or an employee of a human services agency or facility such as the Carey House shelter for homeless women.

Reports of mental health emergency situations also are made by private practitioners and by medical personnel from the Bedford Memorial, Lynchburg General and Virginia Baptist private hospitals. Sometimes a report is made to several people before it is referred for services. For example, someone

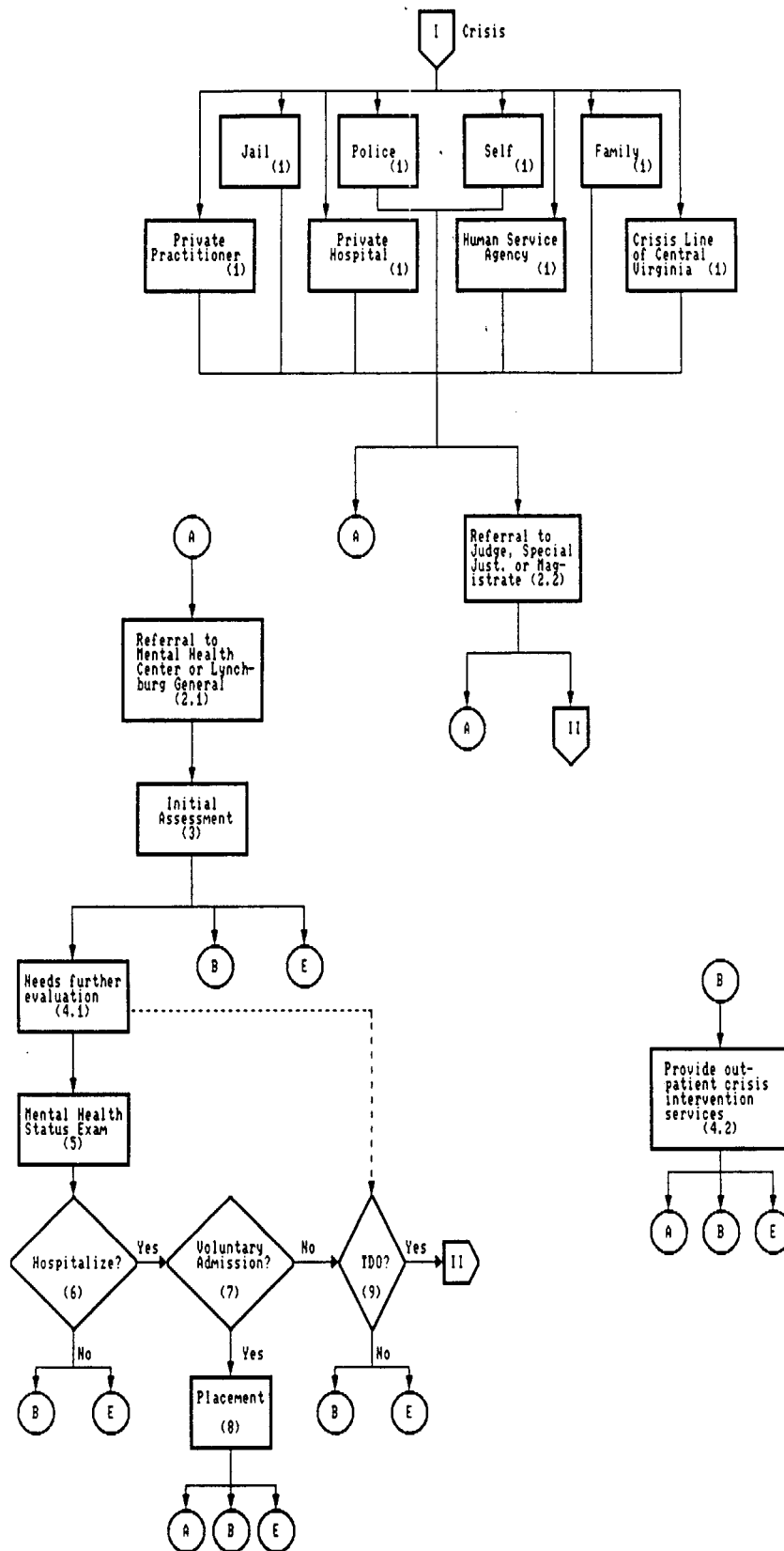


Figure 3-2.1 Emergency Mental Health Services and Involuntary Commitment Practices in Central Virginia CSB --- Crisis to Temporary Detention or Voluntary Care

experiencing a mental health crisis may tell a family member who, in turn, may report the crisis to the police. A police officer then may refer the case for evaluation.

Occasionally reports are referred from Crisis Line, a telephone service, staffed by volunteers, that provides help to individuals in the community who are experiencing problems. The CSB contracts with Crisis Line to provide phone contact in the evening for CSB clients who may be having difficulty. Generally, the calls are from clients who need someone to talk with and not from clients who are in crisis.

## 2. Referral of Reports

### 2.1 Primary Referral Facilities

The majority of reports of mental health emergencies are made to the Department of Emergency Mental Health Consultation Services (EMHCS) of Lynchburg General Hospital or to the geographically closest CSB-operated mental health center. Roughly 50% to 75% of the reports initially are made by phone; the remaining reports are made in-person.

Lynchburg General, a private hospital, provides emergency mental health consultation services for its patients on a 24-hour basis, every day of the year. It also has a contractual agreement with the CSB to handle emergency mental health crises for the mental health centers if a crisis occurs after regular business hours (after 5:00 pm on weekdays and all day on weekends and holidays) or if a crisis involves a dangerous or otherwise unmanageable client. EMHCS has a full-time Director, a full-time administrative Coordinator of Emergency Mental Health Services, and twelve "on-call" Mental Health Consultants (psychologists, social workers or nurses) who are involved

in providing emergency mental health services. The Emergency Department also has seven psychiatrists and eight physicians on staff. In calendar year 1988, Lynchburg General provided mental health consultation services for 1,552 clients.<sup>1</sup>

The CSB-operated mental health centers are located in Lynchburg, Bedford, Rustburg, Appomattox and Amherst. With the exception of Appomattox, which is open three days-a-week, the mental health centers provide emergency mental health services from 8:30 am to 5:00 pm five days-a-week. The mental health centers provide only outpatient services; they do not have inpatient facilities.

Because of the volume of mental health emergencies in Lynchburg, the Lynchburg Mental Health Center has established an Acute Care Team to handle crisis intervention and the provision of emergency mental health services. The Lynchburg Mental Health Center currently has two full-time, master's level emergency services staff; a third staff member is expected to be added before the end of the year. The mental health centers in the other counties are staffed with a therapist, a case manager and a secretary. The therapist and case manager who provide all the individual, family and group counseling also are responsible for providing mental health emergency services for individuals in crisis. Generally, the therapists have a master's degree, and the case managers have a bachelor's degree. In addition, the CSB has a full-time psychiatrist on contract to provide services for the mental health centers' clients. During fiscal year 1987-1988, the mental health centers provided

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<sup>1</sup>Lynchburg General Hospital, 1988 Annual Report of the Department of Emergency Mental Health Consultation Services of Lynchburg General Hospital, at iv (1989).



emergency mental health services for 774 clients in crisis.<sup>2</sup> Roughly 75% of these were from Lynchburg.

Although in theory, during regular business hours, Lynchburg General handles only the most dangerous cases for the Central CSB, in practice the hospital's Emergency Department often is contacted to handle any mental health emergency that occurs. Reportedly, Lynchburg General handles all of the mental health emergency referrals from approximately 150 private physicians and most, if not all, of the emergency mental health referrals from the area's law enforcement officers. Because Lynchburg General offers 24-hour emergency mental health consultation services, has secure inpatient rooms available, and is the primary facility for providing temporary detention beds for clients awaiting a commitment hearing, it often is considered the primary facility for handling all mental health emergencies. This has created some problems for the hospital, the mental health centers and other community agencies in defining their respective roles in receiving, managing and responding to reports of emergencies. The mental health centers currently are working with Lynchburg General to better coordinate the provision of mental health emergency services.

## 2.2 Initial Referral to Judge, Special Justice or Magistrate

The majority of reports of mental health emergencies are made to Lynchburg General or one of the mental health centers. Occasionally, however, a report is made directly to a judge, special justice or magistrate. For example, if a police officer is on a call and someone has a mental health

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<sup>2</sup>Central Virginia Community Services Board, Annual Report July 1, 1987 - June 30, 1988, at 14 (1988).

emergency, the police officer will encourage the person to seek help. If the person refuses and remains in crisis, the officer will contact a special justice and request that a temporary detention order (TDO) be issued. The TDO allows the officer to take the person in crisis to the Emergency Department of Lynchburg General where the person will receive care in a secure setting while awaiting a commitment hearing.

If a report is made to a magistrate by someone other than a qualified mental health professional, the magistrate will refer the person in crisis to the appropriate mental health center, to the Emergency Department of Lynchburg General or, in a few cases, call a special justice and request that a TDO be issued for the person in crisis. This latter situation occurs when, for example, the police bring someone before the magistrate who was arrested for a minor criminal offense but who seems to be more mentally ill than criminal. Because the police officers are not qualified mental health professionals, the magistrate will contact the special justice to obtain a TDO to ensure that the person is seen by a mental health professional.

Occasionally, there is some confusion on the part of family members, some private physicians and others about whom to contact to report an emergency. Because of this, a report of a crisis may be delayed in receiving a response. For example, family members, often on the advice of their doctor,<sup>3</sup> contact a magistrate to obtain a TDO, but only a judge or special justice can issue a TDO without the advice of a qualified mental health professional. If the family members contact a magistrate, the magistrate must

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<sup>3</sup>One interviewee noted that a few of the Emergency Department physicians at Lynchburg General also mistakenly refer family members to a magistrate rather than to a special justice. Other interviewees, however, disagreed with this statement.

refer them to a qualified mental health professional or contact a special justice who can issue the TDO without the mental health professional's advice. This legal distinction between magistrate and special justice causes some frustration for those who are referred elsewhere while seeking help for a family member or friend in crisis.

### 3. Initial Assessment

Neither Lynchburg General nor the mental health centers screen incoming reports of mental health emergencies. Any report that is made to a mental health center or Lynchburg General is handled by a mental health professional.

An initial assessment of the immediate situation is done quickly over the phone or in-person. The assessment includes a determination of whether the crisis is potentially life-threatening, whether there was a triggering event that led to the crisis, what unusual behaviors the person is exhibiting, how involved the person is with his or her problem, and a determination of the person's coping skills. In many cases, the mental health center or Lynchburg General has a history with the person in crisis. In these cases, the initial assessment is based on knowledge of the client's prior mental health history as well as information about the immediate situation. In other cases, however, the mental health professional must make a determination of the seriousness of the emergency from only a phone conversation. In particularly critical situations, mental health consultants at Lynchburg General can call "911" and request assistance via the telephone company if they think a person in crisis may be suicidal.

#### 4. Results of Initial Assessment

Depending on the severity of the crisis, the mental health professional may determine that no referral services are needed because the crisis is over, refer the person for crisis intervention services or request that the person in crisis be brought to the mental health center or Lynchburg General, if not already there, for further evaluation. If it is determined that the crisis is over and no referral for services is made, the person exits the mental health emergency services system at this point. If the person is not considered dangerous and is referred for outpatient services, arrangements are made to see the person and possibly involve him or her in one or more treatment programs such as the Hudson House Psychosocial Rehabilitation Center, a clubhouse program designed to teach members responsibility and help them eventually enter the work force, and the Residential Group Home, a slow and progressive program for long-term mentally ill which teaches independent living skills.

If it is determined that the person in crisis is potentially self-destructive or presents a danger to someone else, further evaluation, in-person, will be necessary. If the initial report of the crisis was made by phone, the person is encouraged to go to a mental health center or Lynchburg General. If someone is deemed particularly violent or self-destructive, mental health professionals at the mental health centers will instruct the person to go to Lynchburg General because it has secure facilities.

The mental health centers and Lynchburg General currently do not have the ability to transport someone in crisis to the mental health center or to

the Emergency Department of Lynchburg General.<sup>4</sup> For many cases, this does not present a problem. Most people are able to go to the mental health center or Lynchburg General on their own accord, or they have someone who can transport them there. Most of the serious cases that involve a person who is not capable of transporting him or herself to a facility are reported by someone other than the person in crisis, and the reporter usually is willing to transport the person to a mental health center or Lynchburg General, if necessary.

Reportedly, however, the lack of transportation increasingly is becoming a problem. Lynchburg General estimates that it receives approximately forty calls a month from individuals in crisis. Some of these callers do not have transportation to the Emergency Department. Lynchburg General reports that it handles these calls on a case-by-case basis; some are referred to the mental health centers, others are given other referral information or encouraged to find transportation to the Emergency Department. If the number of these calls continues to grow, some type of mobile outreach program will be necessary.

In a few rare cases, if a person is not well enough to go to a mental health center or Lynchburg General on his or her own and has no other transportation, or the person seems suicidal and refuses to go to a mental health center or the hospital, a mental health professional from the mental health center or Lynchburg General will ask a magistrate or special justice to

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<sup>4</sup>The Central Virginia CSB has a mobile treatment team that provides outreach services for the long-term mentally ill. The mobile treatment team does not do crisis intervention. The counties cannot access the mobile treatment team for the purpose of transporting people in crisis to mental health centers. The only time that the mobile unit would transport someone to a mental health center is if someone experiences a crisis while under the care of the mobile treatment team.

issue a TDO even though the individual has not had a face-to-face mental health status examination (see below). The TDO allows the police to transport the person to one of the mental health centers or Lynchburg General. (All persons from Lynchburg are taken to Lynchburg General Hospital.) Reportedly, this happens in fewer than 10% of the cases and only in cases in which the mental health professional and the magistrate or special justice have had contact with the person in the previous few days. (These cases are represented by the dotted line between boxes 4.1 and 9 in Figure 1.)

Although mental health center professionals usually require the person experiencing the crisis to come to the mental health center, an exception is made if the person is experiencing the crisis while incarcerated in jail. A mental health professional will go to the jail to provide emergency services for the incarcerated person, particularly if the individual is considered dangerous or an escape risk. This is not true in Lynchburg, however, because there are no private offices available in the jail to conduct a counseling session. Inmates in Lynchburg may be escorted to the mental health center by two deputies and be provided emergency services there, or they may be brought to EMHCS at Lynchburg General. Lynchburg General reports that many of the inmates seen by EMHCS are referred back to the court to be assessed by the criminal rather than the civil justice system.

## 5. Mental Health Status Examination

Each person who is referred for further evaluation by a mental health professional from a mental health center or Lynchburg General is given a mental health status examination. This examination includes a clinical assessment of the person's mental status, a review of services and treatment

that previously have been provided and recommendations for further treatment. The examination must be conducted by a qualified mental health professional, but the examiner does not have to be a licensed psychologist or a psychiatrist.

6. Recommendation for Hospitalization or Other Services

Based on the results of the mental health status examination, the mental health professional recommends whether the person should be released without referral because the crisis has ended, receive outpatient crisis intervention services or be hospitalized. If the crisis has ended and no services are warranted, the person exits the emergency services system. If it is recommended that the person receive outpatient services, the person is referred to the mental health center. If hospitalization is recommended, the mental health professional must determine whether the person would be willing to be hospitalized voluntarily.

7. Voluntary Hospitalization

If the mental health status examination indicates that the client should be hospitalized, the client is encouraged to go voluntarily. The decision to be committed voluntarily, however, rests on the availability of a "voluntary bed" as well as the client's decision. Voluntary beds are available at private hospitals such as Virginia Baptist Hospital in Lynchburg, the Roanoke Valley Psychiatric Center, St. Albans Hospital in Radford, or Charter Hospital in Charlottesville, if the client has insurance or can afford to pay for his or her hospital stay. Voluntary beds are more difficult to obtain for indigent clients. The only public hospital that will accept indigent clients

on a voluntary admission is Southern Virginia Mental Health Institute. If Southern Virginia does not have any voluntary beds, the client must be committed involuntarily in order to be admitted to a state hospital.<sup>5</sup>

According to one source, the lack of voluntary beds may be a result, at least partially, of the state's reimbursement system for hospitals. The state reimburses public hospitals for the care of involuntary patients but not for the care of voluntary patients. Therefore, a hospital will do better financially if involuntary beds are filled. The hospital is not likely to be reimbursed for voluntary beds because most of the patients have no insurance or other resources for payment.

A second possible reason for fewer "voluntary beds", at least in the state hospitals, may be related to liability issues. Voluntary patients can leave the hospital at any time, and, therefore, they are perceived by hospital staff as presenting more of a liability risk to the hospital than an involuntary patient. A hospital may be concerned about its liability in cases in which, for example, a voluntary patient leaves the hospital and subsequently commits suicide. The only way to prevent the patient from leaving the hospital is for the hospital to initiate a commitment hearing on hospital grounds, which creates another set of bureaucratic problems.

On the other hand, the mental health centers have been told by the state hospitals that the hospitals prefer to serve the most severely disturbed patients. The hospitals consider a patient who is willing to seek help voluntarily, less severely disturbed than the patient who must be committed to

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<sup>5</sup>One interviewee estimated that as many as 30% to 40% of the individuals who are committed involuntarily would admit themselves voluntarily if beds were available.



recieve care. Therefore, the hospitals dedicate their beds to the involuntary clients in an effort to help those who need it the most.

8. Voluntary Placement

Both the mental health centers and Lynchburg General make every effort to keep the person in the community. One option that often is used is the Five Day Acute Inpatient Program offered at Virginia Baptist Hospital. The mental health center pays for physicians' fees and half of the hospital costs (approximately \$200 to \$250 a day). As mentioned earlier, other private hospital alternatives are Charter Hospital in Charlottesville, the Roanoke Valley Psychiatric Center, and St. Albans in Radford, and the only state hospital alternative for indigent voluntary clients is the Southern Virginia Mental Health Institute in Danville.

9. Decision to Issue Temporary Detention Order

If the mental health status examination indicates that the person should be hospitalized, but the client refuses; the mental health professional will contact a judge, special justice<sup>6</sup> or, after hours, a magistrate to request that a TDO be served to the client. The CSB provides the courts with a list of professionals in the area who are skilled in the diagnosis and treatment of mental illness. This is particularly helpful to the magistrates who can issue a TDO only if it is based on the advice of a qualified mental health

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<sup>6</sup>The special justices are attorneys in private practice. They are not organized in any formal way. At one point, because of the number of requests for the names of the special justices, the magistrate's office compiled a list of special justices and distributed it to agencies involved in the temporary detention and civil commitment process.

professional. A TDO usually is issued<sup>7</sup> based on a mental health professional's recommendation that there is probable cause for the findings of mental illness and need for hospitalization. Generally, TDOs are refused only if the mental health professional does not provide sufficient evidence of probable cause (e.g., the person in crisis sounds more drunk than mentally ill).

#### From Temporary Detention Through Provision of Inpatient Services

Figure 3-2.2 presents four major steps (boxes 10 through 13) involved in temporarily detaining a person for a commitment hearing.

#### 10. Issuance of Temporary Detention Order

Once the judge, special justice, or magistrate (hereinafter "justice" unless otherwise specified) agrees to issue a TDO, the TDO becomes law and allows the police to detain the person experiencing the emergency. Although law enforcement officials prefer that the order be in writing, it is possible to detain someone without a written copy of the order "in-hand." A written copy of the order must be on file at the courthouse or in the individual's hospital file. If the person already is at a mental health center or Lynchburg General, the verbal notice allows a physician or mental health consultant to provide the client with emergency medical and psychiatric treatment.

After authorizing temporary detention, the justice calls the central law enforcement dispatch which notifies the police that a TDO has been written.

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<sup>7</sup>Although the percentages differ somewhat across the various justices and magistrates, on average, TDOs are approved in at least 90% of the cases.

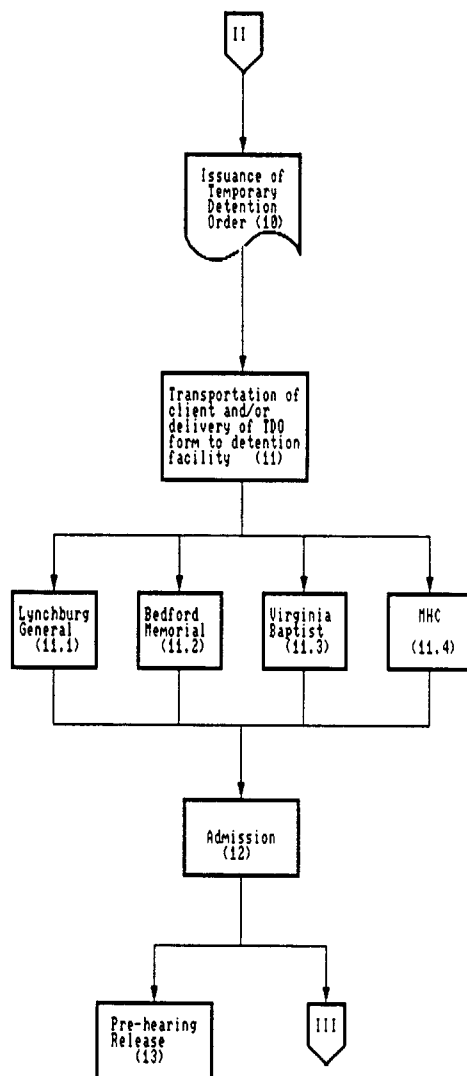


Figure 3-2.2 Emergency Mental Health Services and Involuntary Commitment Practices in Central Virginia CSB - Temporary Detention Through Inpatient Services

In most cases a police officer will go to the justice's office first to obtain the TDO. If someone is experiencing a severe emergency, however, the police officer may be asked to transport the person to the detention facility before physically obtaining the TDO.<sup>8</sup>

#### 11. Transportation to Detention Facility

The TDO authorizes the police officer to bring the named person to the specified detention facility.<sup>9</sup> Often the person is already at the detention facility; in these cases, the police officer brings the TDO form to the appropriate facility. In most cases, the officer delivers both the TDO form and the client to the facility; in extreme emergencies, one officer will transport the client to the detention facility (knowing that a TDO exists), and one officer will deliver the TDO to the facility.

The client must be transported to a licensed psychiatric detention facility. These include the Lynchburg General Hospital Emergency Department, the Bedford Memorial Hospital Emergency Department, the Virginia Baptist Hospital Psychiatric Unit or one of the mental health centers. State hospital officials strongly discourage TDO admissions to Central State Hospital. They will take admissions only if there are no beds available in any of the other facilities.

In ninety-nine percent of the cases, the client is detained at Lynchburg General Hospital. If Lynchburg General does not have room, it will request

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<sup>8</sup>An officer will not transport an individual without a TDO or a chargeable criminal offense, unless the person is willing to go voluntarily.

<sup>9</sup>The Sheriff is responsible for transporting individuals under a TDO who are in the Sheriff's custody (e.g., individuals awaiting trial).

that a client be detained at Virginia Baptist Hospital. In 1988, 603 clients were detained at Lynchburg General and 25 clients were transferred to Virginia Baptist.<sup>10</sup> If a client already is a patient at Virginia Baptist Hospital or Bedford Memorial Hospital, the justice usually will order the client detained at the hospital in which the client is a patient.

Because the mental health centers do not have inpatient facilities, they handle very few temporary detentions.<sup>11</sup> In a few cases, in which a mental health center is familiar with a client, the TDO will list both the mental health center and Lynchburg General Hospital as the detention facilities. The detention is handled by the mental health center unless the client becomes violent, in which case the police will transport the client to the more secure facilities at Lynchburg General.

## 12. Admission

After the client is transported (if not already there) to the Emergency Department of Lynchburg General, he or she is examined by an Emergency Department physician and a mental health consultant.<sup>12</sup> The mental health consultant conducts a preadmission screening evaluation<sup>13</sup> and recommends to

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<sup>10</sup>Lynchburg General Hospital, supra note 1, at 7.

<sup>11</sup>The Lynchburg Mental Health Center no longer handles any TDOs. In July 1989, the Lynchburg Mental Health Center and the Lynchburg General Hospital agreed to send all Lynchburg clients on a TDO directly to the Emergency Department of Lynchburg General. The change was made in an effort to better coordinate the delivery of services for those involved in the system.

<sup>12</sup>The mental health consultant will conduct an examination only if one is requested by a physician.

<sup>13</sup>In the Central Virginia CSB, preadmission screening evaluations routinely (in more than 50% of the cases) are conducted after an individual has been temporarily detained.

the physician whether hospitalization is warranted. This evaluation is essentially an update of the mental health status evaluation conducted earlier. If the mental health consultant recommends hospitalization, he or she must complete a Preadmission Screening Form on the person.<sup>14</sup> On the form, the mental health consultant records the statutory criteria for voluntary or involuntary hospitalization that were met in the case and the specific behaviors exhibited by the client which led to the decision. While the client is in custody at Lynchburg General, he or she remains under the care of the physician and/or mental health consultant who provided the initial examination. Unless they pose a danger to themselves or others, clients are placed in regular beds away from the EMHCS seclusion rooms.

With the exception of a physical examination, the admission process is essentially the same at the mental health centers. The client is given a preadmission screening evaluation by a therapist or the psychiatrist, and the mental health professional recommends a disposition on the Preadmission Screening Form.

### 13. Pre-Commitment Hearing Release

In 1988, 191 (32%) of the clients who were detained at Lynchburg General on a TDO, were released by a physician without having a commitment hearing

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<sup>14</sup>If a mental health center therapist already has started a preadmission screening form on a client who subsequently is detained at Lynchburg General, the preadmission form is given to EMHCS at Lynchburg General. The mental health consultant at Lynchburg General simply completes the form started by the mental health center. If the therapist at the mental health center and the EMHCS mental health consultant differ in their diagnosis of and recommendations for the client, the differences are noted on the form.

because "the order was not substantiated that the patient was mentally ill."<sup>15</sup> For example, a drunken client who is detained and subsequently regains sobriety and exhibits no symptoms of mental illness would be considered a good candidate for release. Reportedly, the physician will not release a client without a mental health consultant's recommendation. The benefits of "lifting the TDO," as this practice is called include: a) the client is not deprived of his or her liberty longer than necessary, b) a hospital bed becomes available for another person experiencing a mental health crisis and c) the number of commitment hearings is reduced. This last factor helps the approximately 4-5 special justices in the area who conduct civil commitment hearings keep up with the increases in the total number of hearings each year.<sup>16</sup>

The practice of releasing clients before a commitment hearing has been held, has not escaped some complaints. One person interviewed noted that it is possible for a client to be served two or three TDOs in one week before the client is given a commitment hearing. There is some concern that the practice will increase the number of TDOs that are written and processed -- creating more work for the system as a whole. However, a spokesperson from Lynchburg General indicated that there have been very few cases of a client being readmitted to the hospital on a second TDO during the same week.

#### Preparation for and Conduct of Judicial Hearings

Figure 3-2.3 presents four major steps involved in conducting a

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<sup>15</sup>Lynchburg General Hospital, supra note 1.

<sup>16</sup>The number of commitment hearings at Lynchburg General increased 36% from 1986 to 1988, supra note 1, at 1.

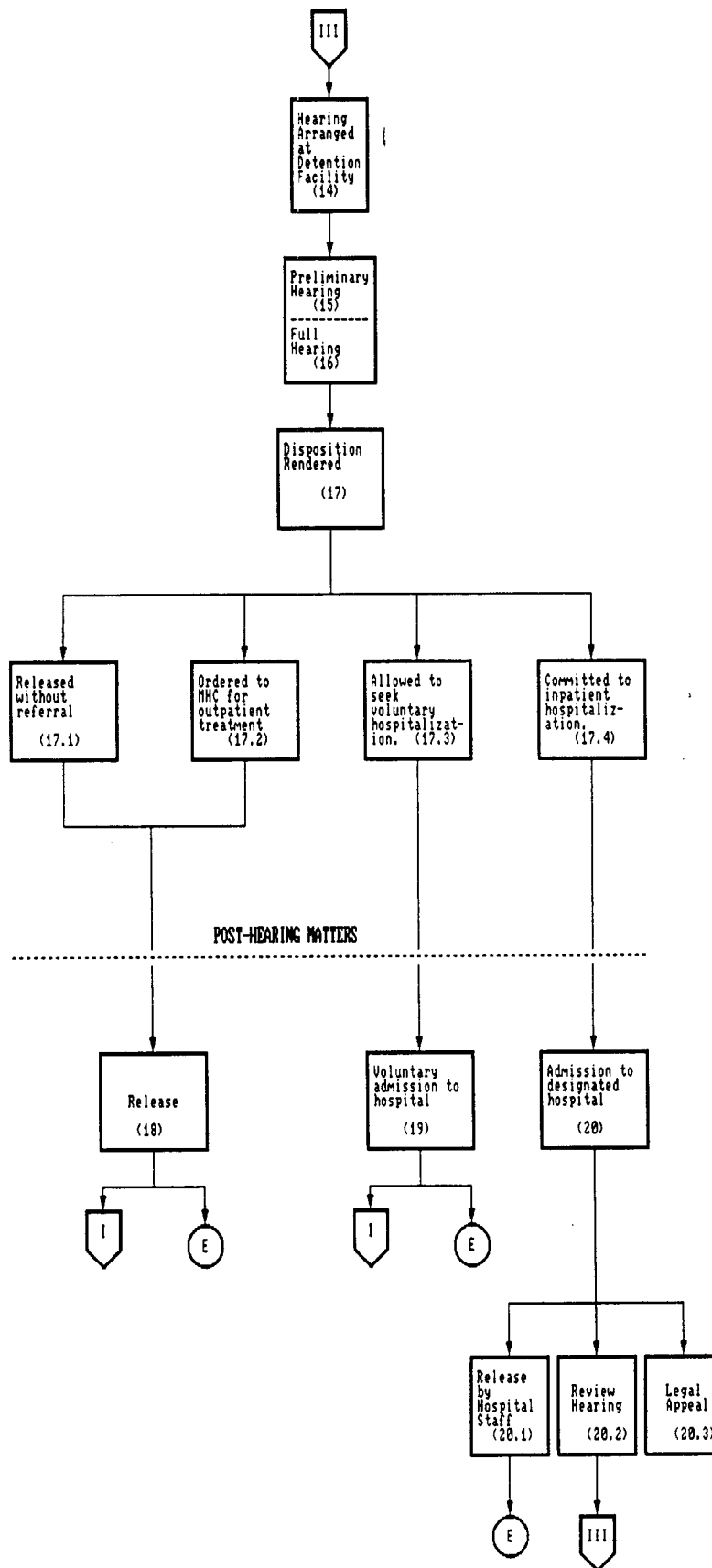


Figure 3-2.3. Emergency Mental Health Services and Involuntary Commitment Practices in Central Virginia CSB - Preparation for Judicial Hearings Through Post-Hearing Matters



commitment hearing (boxes 14 through 17), and three major steps that occur once the hearing has been completed (boxes 18 through 20). Steps 14 through 17 are discussed under this section, and steps 18 through 20 are discussed in the following section.

#### 14. Preparation for the Judicial Hearing

The commitment hearing takes place at the detention facility where the client is being held. Usually this is the Department of EMHCS at Lynchburg General Hospital. A nurse in the Emergency Department contacts a special justice to make arrangements for holding the hearing. Once notified of the hearing, the special justice will appoint counsel and an examiner for the case.

The appointment of counsel sometimes can be difficult. There is a small number of experienced attorneys in Lynchburg who are willing to represent clients at commitment hearings. Most of these are handling many cases in private practice, and, consequently, it is difficult to find one available for a hearing on short notice. At one point, the attorneys tried a schedule where each was available for a particular time and day. However, this proved unsatisfactory because other business was lost or went undone, whether a commitment hearing was held or not. Under the present procedure, the special justices call attorneys until they find someone who can work the commitment hearing into his or her schedule. Because the schedule often is tight, attorneys usually do not have an opportunity to meet with their clients until immediately before the hearing is held.

The appointment of an independent examiner usually is not as difficult a task. The examiner must be a licensed psychiatrist, licensed clinical

psychologist or licensed physician skilled in the diagnosis of mental illness. In most cases the court-appointed examiner is the attending physician for the case. Occasionally, however, the attending physician may not think that he or she has the expertise to diagnose a particular client's mental condition and, consequently, will not agree to be the independent examiner for the court. In these cases, another physician must be located to examine the client for the court. Another physician who is willing to examine the client can be difficult to obtain on short notice.

In preparation for the hearing, the mental health consultant identifies which institutions have beds available and makes a decision where to send the client if commitment is ordered. Southern Virginia Mental Health Institute is the primary facility for accepting adult commitments. Central State Hospital is used as a back-up to Southern Virginia and also as the primary facility for adolescent commitments. DeJarnette, a public facility in Staunton, will accept commitments of children 13-years old or younger, and Catawba, a public facility in Roanoke, will accept geriatric clients. In addition, the private hospitals Virginia Baptist, Roanoke Valley Psychiatric Center, St. Albans, and Charter will accept clients if they are reimbursed for services.

If a bed is available at more than one hospital, the mental health consultant considers the following factors in deciding which hospital to recommend: the client's prior treatment in other facilities, the preferences of the client's family, the client's financial situation, and the client's personality and current stress levels. Most of the individuals interviewed expressed considerable dissatisfaction with the quality of care and general monitoring provided at Central State Hospital. Clients are sent to Central State from the Central Virginia CSB only as a last resort.

Finally, before the commitment hearing is held, the mental health consultant makes sure that the preadmission screening evaluation has been completed, and that a Preadmission Screening Form has been filled out for the court.

15. Preliminary Judicial Hearing

During the preliminary hearing, the special justice or judge records the appointment of the attorney and the examiner for the case. The justice explains the general purpose of the hearing and also advises the client of his or her rights during the proceedings. Specifically, the client is told that he or she has the right to another attorney, the right to speak or not to speak during the hearing, and the right to appeal the special justice's decision. The hearings are held at the client's bedside, in the area in which EMHCS is located or in one of the seclusion rooms depending upon the client's condition. In general, the hearings follow the format of a criminal trial but tend to be much less formal.

At the start of the hearing, the justice will offer the client an opportunity for voluntary admission to an inpatient facility.<sup>17</sup> If the client agrees, the court must determine whether the client is capable of making such a decision. This is done as evidence is presented during the "full" hearing. Technically, there is no formal demarcation between the preliminary and full

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<sup>17</sup>By the time a client has reached this stage in the mental health emergency services system in the Central Virginia CSB, he or she probably is indigent and cannot afford voluntary admission to a private hospital. (Southern Virginia Mental Health Institute is the only facility that allows voluntary admissions of indigent clients, and it has only a limited number of beds available for voluntary patients.) Most of the clients who could afford voluntary admission are screened out of the system at earlier steps.

hearings in the Central Virginia CSB.

16. Full Judicial Hearing

The hearings are attended by the special justice, the client, the client's attorney, the mental health consultant, and the court-appointed examiner. If the client was seen by a therapist from one of the community mental health centers, the therapist also may be present. In addition, other witnesses and the client's family members may attend. If the client has a private physician, the physician may be present. However, private physicians often are available only by phone.

During the hearing, the court-appointed examiner testifies about the client's condition, and the mental health consultant usually presents at least some portion of the prescreening evaluation report. Other witnesses are heard from as appropriate for the case. If the client is coherent, the special justice will direct questions to the client. For example, the client may be asked whether he or she has threatened suicide or threatened others and whether he or she thinks hospitalization would be helpful. The hearings can last several hours, but, in general, they usually take an hour or less.

17. Disposition Rendered

Based on the evidence presented, the special justice or judge will order one of four dispositions: (a) released without referral, (b) ordered to the mental health center for outpatient services, (c) allowed to seek voluntary hospitalization or (d) involuntarily committed to a state or willing private psychiatric facility. The last disposition is used the most frequently. Depending on the special justice presiding at the hearing, between 50% and 85%

of the commitment hearings result in involuntary commitment. Of the 603 clients detained at Lynchburg General in 1988, 352 (58.4%) were committed involuntarily to a state hospital, and 107 (17.7%) were committed involuntarily to a private hospital.<sup>18</sup>

For the other dispositional categories, depending on the special justice who conducts the hearing, 2% to 15% of the clients are released, 3% to 20% of the clients are released with a warning or on condition that they seek outpatient services, 2.5% to 5% are ordered to seek outpatient services, and 5% to 15% are committed voluntarily to a hospital. These dispositional categories probably are used less frequently because many of the TDO clients are released, referred for services, or voluntarily committed before a commitment hearing is held. Therefore, the clients who actually proceed to the commitment hearing tend to be those who will require involuntary commitment.

#### Post-Hearing Matters

##### 18. Client Released

If the client is released without referral, the client is free to leave the hospital as soon as the hearing is completed. There are no papers that the client must complete before leaving. Hospital staff note on the client's mental status examination record or Preadmission Screening Form that the client was released. The mental health consultant will help the client arrange transportation, if necessary, and answer any questions the client may have.

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<sup>18</sup>Lynchburg General Hospital, supra note 1, at 7.

If the client has been referred for outpatient services, the client is told to contact the closest mental health center and arrange an appointment. In some cases, the EMHCS at Lynchburg General will call the mental health center and arrange an appointment for the client. Individuals who are ordered to outpatient treatment are responsible for following the treatment plan designed by the mental health center. However, no one formally keeps track of whether or not clients adhere to outpatient commitment orders.

19. Voluntary Inpatient Treatment

If the judge or special justice has agreed to allow the client to seek voluntary admission to a hospital, and a bed was not located prior to the hearing, the mental health consultant will try to locate a bed following the hearing. In some cases, the client may have to remain in the detention facility for an extra day until a voluntary bed becomes available at another hospital.<sup>19</sup>

Once a bed becomes available, the mental health consultant notifies the receiving hospital that the client has agreed to be admitted to the facility. Transportation to the facility is arranged by the client's family, or the client is transported to the hospital by private ambulance. The client is responsible for the cost of the ambulance.

The client is admitted to the hospital and is free to leave after 72 hours unless hospital staff discharge the client earlier. If the client elects to leave and hospital staff do not agree with the client's decision,

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<sup>19</sup>If a family member or other support person is available to care for the client, and there is no risk of suicide or other violent behavior, the client may leave the detention facility and wait at home for an available hospital bed.

the hospital may request a TDO and initiate involuntary commitment procedures.

## 20. Involuntary Inpatient Treatment

If involuntary commitment is ordered, the judge or special justice also will issue a transportation order. The transportation order requires the Sheriff of the client's jurisdiction to transport the client to the facility designated on the commitment order. Generally, the charge nurse from the detention hospital notifies the Sheriff that a client is ready to be transported to a commitment facility.

In an effort to avoid more than one trip to the same facility on the same day, the Sheriff calls Lynchburg General every day to determine how many clients may need to be escorted to another facility. The Sheriff tries to consolidate trips during the same day. Each trip requires two officers, and a round-trip to Central State Hospital in Petersburg takes five hours. If the transporting officers work past 5:00 pm, they are paid overtime. However, because TDO beds are limited, Lynchburg General prefers to have a client transported to another facility as soon as possible in order to make a bed available for another client.<sup>20</sup> This means that the Sheriff is not always able to consolidate the number of trips to each hospital on any given day. The problems associated with the coordination and cost of transporting clients to hospitals have created many headaches for the Sheriff's Office.

Any necessary papers for admitting the client are transported with the client and delivered to the admitting clerk at the receiving hospital.

### 20.1 Release by Hospital Staff

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<sup>20</sup>This is particularly important if a violent individual is detained and the three seclusion rooms already are occupied.

Hospital staff may release a client who has been committed to the hospital if the client recovers, is judged not mentally ill, or is no longer considered a threat to self or others. In general, clients stay in the hospital approximately two weeks. A predischARGE plan is prepared for the client and may include outpatient services provided by the client's mental health center.

Because of the short commitment period, several of the individuals interviewed complained of "revolving door" mental health care. Reportedly, individuals often are released only to be detained on another TD0.

## 20.2 Review Hearing

If the client remains hospitalized after 180 days, a recommitment hearing is held to determine whether the client should be released or recommitted to the hospital. The procedures for the recommitment hearing are essentially the same as for the original commitment hearing.

## 20.3 Legal Appeal

At the end of the commitment hearing, the special justice informs the client that he or she may appeal the decision to commit within thirty days of the order. The special justice tells the client to contact the patient advocate at the hospital to help the client with his or her appeal. Reportedly, appeals are sought rarely, given that most clients are released during the thirty-day period in which an appeal can be filed.



**Section 3:  
Emergency Mental Health Services and  
Involuntary Civil Commitment Practices in the Williamsburg CSB**

The Williamsburg area is served by the Colonial Mental Health and Mental Retardation Services of the Colonial Services Board--the Community Services Board (CSB) serving the cities of Williamsburg and Poquoson and the counties of James City and York. Williamsburg is the site of Eastern State Hospital. Eastern State Hospital (ESH), located in James City County, serves a population of 1.9 million in ten cities and 16 counties, including Williamsburg, Poquoson and the counties of James City and York. ESH provides voluntary and court-ordered in-patient treatment to residents of this catchment area who cannot pay for hospitalization at a private facility. Because ESH is the only public residential facility available in the area (except for a limited number of transitional living apartments maintained by the CSB), because both voluntary and involuntary patients are hospitalized in ESH, and because all involuntary commitment hearings are held in the admissions building on the campus of ESH, the hospital is central to the emergency mental health services and involuntary commitment practices in the Williamsburg area.

This section describes the emergency services and commitment system in the Williamsburg area in terms of four phases: (1) crisis; (2) temporary detention, treatment, and care; (3) preparation for and conduct of preliminary and full judicial hearings; and (4) posthearing matters--and the 27 steps that approximate the chronology of events, decisions, and procedures likely to arise as an individual becomes a patient/client/respondent of the emergency mental health services and involuntary civil commitment system. These four

phases and 27 steps are described below by narrative text and figures keyed to the text.

### Crisis to Temporary Detention or Voluntary Care

The first phase of the emergency mental health services and involuntary civil commitment practices in Williamsburg, like those in most communities in Virginia, begins with the occurrence of a mental health crisis and continues to the point at which a district court judge or a special justice makes a decision to issue a temporary detention order (TDO). As depicted in Figure 3-3.1, eight major steps and events define this first phase: (1) the points of initial contact or referral sources; (2) referrals to the Community Services Board (CSB); (3) telephone contacts and referrals by the CSB; (4) face-to-face crisis intervention and, if appropriate, voluntary hospitalization, substance abuse services, outpatient mental health services, medical services, and non-emergency support services such as housing, food, income supports, vocational services, and transportation services; (5) preadmission screening; (6) commitment criteria decisionmaking; (7) telephone contacts with a special justice or district court judge; and finally, (8) decision to issue, or not to issue, a temporary detention order (TDO).

#### 1. Point of Initial Contact or Referral

An individual who "presents in crisis" (one who is experiencing acute psychological, emotional or behavioral difficulties) is likely to make contact, enter, and "penetrate" the emergency mental health services and involuntary civil commitment system in Williamsburg by one of several approaches. First, a person may contact or present himself or herself to the

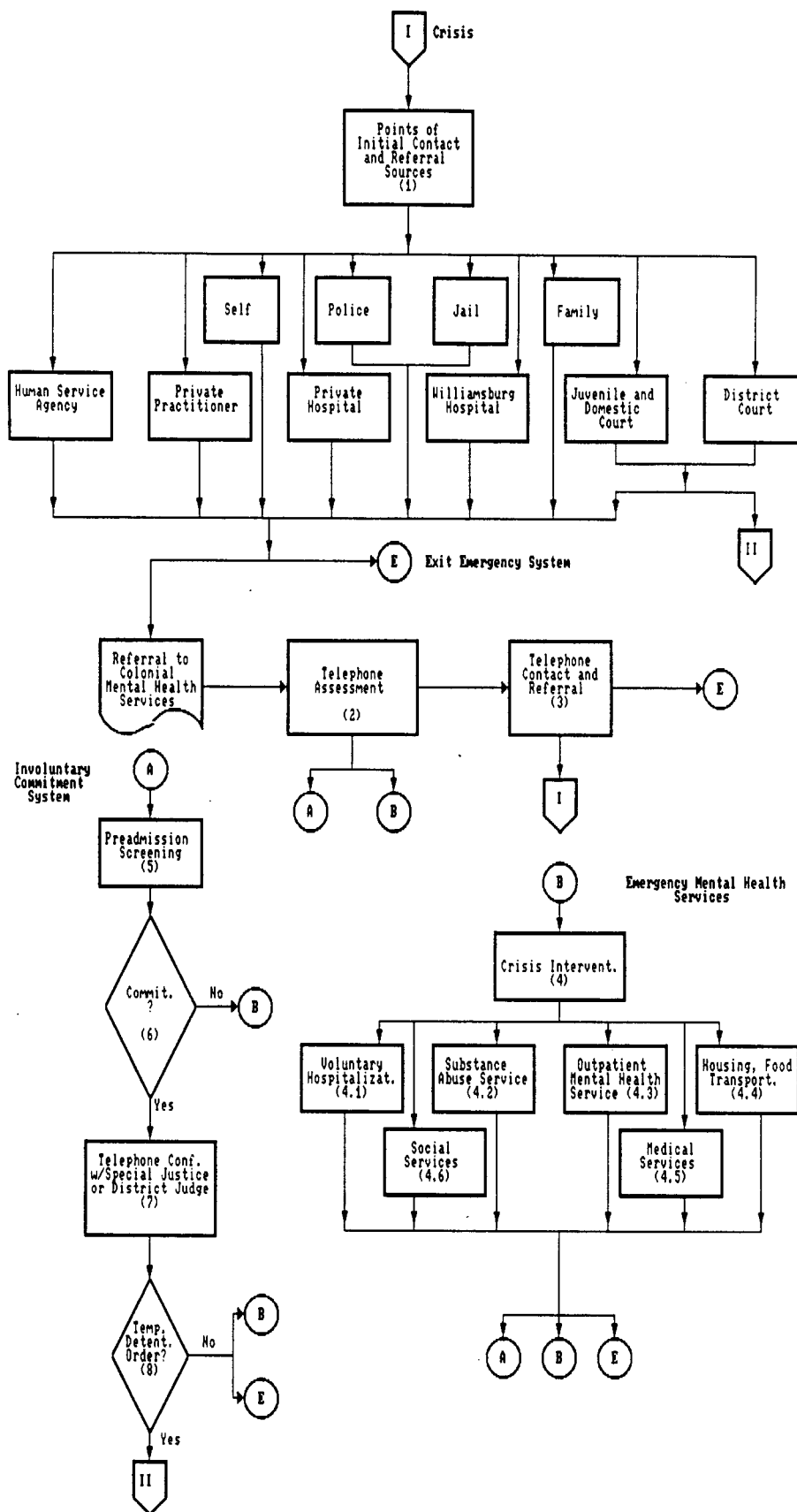


Figure 3-3.1. Emergency Mental Health and Involuntary Commitment Practices in Williamsburg - Crisis to Temporary Detention or Voluntary Care

mental health division of the Colonial Mental Health and Retardation Services or ESH. According to an ESH spokesperson, if an individual presents himself or herself to the admissions unit of ESH during regular working hours, a social worker and physician will evaluate the individual. They may make attempts to contact and bring the individual to the attention of the "home" CSB. Most of the individuals who reportedly present themselves to ESH are referred, sometimes with a bus ticket, to the home CSB. A minority of these individuals are admitted to ESH as voluntary patients.

Second, someone may initially make contact with police, jail personnel, human service agencies, private practitioners, private hospitals, the Williamsburg Community Hospital, ESH, the juvenile and domestic relations district court, or family members and then be referred to the CSB. For example, a police officer may observe and apprehend a person who appears agitated or who is behaving in a bizzare fashion. The officer may first ask the person, "What building do you live in?" in order to determine whether the person may have escaped or "wandered off" from ESH. If the officer suspects severe mental illness or alcohol abuse, he or she will contact the CSB "prescreener" through the police dispatcher.

Third, a person who is experiencing psychological, emotional, or behavioral difficulties may be referred to CSB only after one or more contacts and transfers between the police, the Williamsburg Community Hospital, and the other points of initial contact or referrals noted in Figure 3-3.1. For example, police may apprehend a person who is agitated or distressed and transport that person to the emergency room of the Williamsburg Community Hospital for emergency medical treatment. After examining and treating the individual, as may be appropriate, the hospital staff may or may not refer the

person to the CSB depending on the condition of the individual. Reportedly, hospital emergency room staff will first treat the individual's physical problems. If it is determined that that individual has mental health problems in addition to physical problems, emergency room staff will attempt to ascertain whether the individual is currently receiving mental health treatment. The emergency room staff member will then attempt to contact the provider to seek advice as to what course of action should be taken. Typically, the mental health provider, or his or her designee, will advise one of the emergency room staff to administer psychotropic medication. Though relatively infrequently, the mental health provider will come to the hospital and "take charge of the situation."

Finally, a person may make contact with one of the facilities or agencies without further referral or "penetration" of the emergency mental health services and the involuntary civil commitment system. Data on the frequency of use of these four approaches unfortunately, are unavailable. Once an individual "presents in crisis," and before the involvement of the CSB, the degree of intervention by public and private entities depends upon the person or agency the individual makes his or her first contact, the nature and severity of the crisis, and the function and capability of the person or agency with whom the individual makes contact.

Of course, no data exist on the frequency with which crises occur that are unknown except to the individual or his or her family. Family members may "deal" with a mental health crisis after making contact with one of the aforementioned entities with or without referring the individual to the CSB.

As indicated in Figure 3-3.1, though it may not be the point of first contact for mental health crises in Williamsburg, the CSB's emergency service

serves as the point of control and coordination for crisis intervention in the Williamsburg area. No reliable data are available on the frequencies of referrals from the various referral sources. Reportedly, however, the CSB receives the overwhelming majority of its referrals from the police, the emergency room of the Williamsburg Community Hospital, and from family members. The CSB has established a formal agreement for a referral for emergency services with only one of its referral sources--the Williamsburg Hospital. Informal understandings and experience reportedly govern the referral procedures used by police and the other referral sources noted in Figure 3-3.1.

Although seldom done in Williamsburg--once or twice a year--it is possible, as noted in Figure 3-3.1, for a district court judge to bypass the "gatekeeping" function of the CSB by issuing an order to have a person directly transported to and detained in ESH. Reportedly, this only occurs in life-threatening situations.

## 2. Referral to Emergency Services

Once the decision is made to refer an individual to the Williamsburg CSB, the person making the referral contacts the "on-call" CSB staff member by telephone. CSB emergency staff are on call 24 hours per day. A preliminary disposition of the case is made by the "on-call" CSB staff member on the basis of a "phone assessment." During this assessment, the staff member attempts to gather demographic information about the individual being referred and to ascertain the nature and severity of the presenting problem (including such considerations as the precipitating event or events, mental status of the

individual, present or previous mental health treatment and care, and present living conditions of the individual).

As indicated in Figure 3-3.1, the "phone assessment" by the CSB emergency staff results in one of two general preliminary dispositions: (1) telephone contact with the referral source and a referral of the individual to one or more of the CSB services or to another agency or other local resources; or (2) face-to-face contact and direct intervention with the individual. The latter is done in pursuit of two alternatives: involuntary civil commitment (indicated by a circled letter "A" in Figure 3-3.1) or emergency mental health services and crises intervention short of involuntary civil commitment (indicated by the circled letter "B"). The steps involved in these dispositions are described below and in Figure 3-3.1.

### 3. Telephone Contact and Referral

Not all persons who experience a mental health crisis in the Williamsburg area are referred to the CSB, though it serves as the "gatekeeper" to the emergency mental health services and involuntary civil commitment system in Williamsburg. Similarly, not all individuals who are referred enter the "gate" to emergency mental health services or involuntary civil commitment. As noted in Figure 3-3.1, at least some individuals referred to the CSB exit the system (at least temporarily) following telephone consultation with CSB. Cases of alcohol intoxication are examples. When a CSB representative is contacted by the police, family members or others, and it is clear that the referred individual is intoxicated but does not exhibit other mental health, social service, or medical care needs, the CSB representative will recommend that the referring party contact an alcohol

treatment center. That is, the CSB representative advises the party contacting the CSB as to what he or she deems to be the best alternative source of voluntary substance abuse treatment.

#### 4. Face-to-Face Intervention Short of Commitment

The Virginia Code requires that CSB's screen all persons who wish to become voluntary patients at a state mental hospital or mental retardation facility. The screening procedure primarily entails the preparation of a "prescreening report" that is used by the CSB's with other information to determine if treatment in a state institution is appropriate for the individual seeking admission. In practice, prescreening reports are generally submitted for all persons who may be admitted voluntarily or involuntarily to ESH, its Hancock Geriatric Treatment Center, or one of the institutions that serve mentally retarded persons. The Colonial CSB prescreens all allegedly mentally ill adults or mentally retarded persons who reside in the Williamsburg area. Because of its proximity to ESH, the CSB also prescreens persons from other areas brought to the hospital under detention orders who have not been prescreened by the CSB in the individual's home locality. CSBs located close to state institutions reportedly bear the extra burden of greater prescreening duties in contending with former patients who do not return after discharge to their original communities (Institute on Mental Disability and the Law, 1984).

CSB emergency personnel make face-to-face contacts and arrangements for emergency mental health services (circled letter "B" in Figure 3-3.1) with persons "presenting in crisis" in Williamsburg in one of several locations



including the offices of the Colonial Mental Health and Mental Retardation Services, the admissions unit of ESH, the local jail, the emergency room of the Williamsburg Community Hospital, or other sites arranged during the telephone assessment (see above). These contacts may be made with or without law enforcement escorts. Based on the information obtained during the telephone assessment (see above), the CSB emergency staff member will attempt to assess the individual's immediate needs for voluntary hospitalization, substance abuse services, outpatient mental health treatment and care services, housing, food, transportation, social services, or physical/medical care needs. These services are described below.

4.1. Voluntary Hospitalization. If a CSB staff member determines that an individual needs to be hospitalized, but not necessarily involuntarily committed, he or she will urge the individual to seek voluntary hospital care. In any event, the CSB representative must conduct a preadmission screening (see below) and complete the necessary reports before a person can be admitted to a hospital.

In addition to ESH, voluntary hospitalization may be arranged at the Peninsula Psychiatric Hospital, Riverside Hospital, or the Charter Colonial Institute. If a bed is available for a voluntary admission to Eastern State Hospital or, alternatively, if it is determined that the individual has insurance coverage and a private hospital is willing and able to accept the voluntary admission, the CSB staff member will make arrangements for a taxi to transport the individual to the hospital (the CSB has a contractual arrangement with the Colonial Cab Company to provide such transportation). If it is known to the CSB staff member that ESH or other facilities do not have

the bed space available to accept a voluntary admission, he or she will attempt to arrange for outpatient treatment through the CSB (see below).

Reportedly, in addition to the nature and severity of the individual's mental disorder, the decision to seek voluntary admission is governed by the availability of "voluntary" beds in the Williamsburg area and the availability of third-party insurance to defray the costs of hospitalization.

4.2. Substance Abuse Services. Substance abusers typically are referred to one or two programs of the Substance Abuse Services of the CSB. The Outpatient Substance Abuse Services are offered to individuals experiencing problems of alcohol or drug abuse, as well as family members and concerned persons. Programs include: individual, group and family counseling; psychiatric and psychological evaluation; 24-hour emergency services; school-based services; substance abuse education; referral and information services; consultation services; prevention services; and employee assistance programs. As part of the programs, clinicians frequently recommend involvement in peer support programs such as Alcoholics Anonymous, Narcotics Anonymous, Alanon, and Alateen.

The Substance Abuse Partial Hospitalization Program is offered to individuals with more severe problems of alcohol and drug abuse. Services offered by the program include: substance abuse education; independent living skills; group therapy; individual counseling, family counseling; 24-hour emergency services; psychological and psychiatric evaluations; and evening sessions.

Individuals under the age of 19 are referred to Bacon Street, a private, not-for-profit agency providing treatment services to youth with alcohol and other drug abuse problems. Bacon Street is affiliated by contract with the

Williamsburg CSB. Finally, inpatient detoxification programs are available at Eastern State Hospital, Riverside Hospital, and Peninsula Psychiatric Hospital.

4.3. Outpatient Mental Health Services. Those individuals with new or existing psychiatric problems who are not in need of immediate in-patient treatment typically are referred to the outpatient mental health services of the CSB. Outpatient treatment services available through CSB include extended care services, counseling services, adult substance abuse services, and Bacon Street (see above). The primary focus of the CSB's counseling services is to meet the needs of individuals and families experiencing emotional or behavioral difficulties in managing their everyday lives and relationships. It offers a full range of clinical services for children, adolescents, adults, and the elderly, including family therapy, marital therapy, individual therapy, group therapy, play therapy, 24-hour emergency services, hospital admission screening, psychiatric and psychological evaluation, consultation/education and prevention services, and employee assistance programs. Adult services include face-to-face consultations to hospital emergency rooms, jails, public and private psychiatric facilities, and community agencies concerned about mental health problems and the populations they serve. Extended Care Services (also referred to the Vocational Training and Employment Program) is a specialized rehabilitation program designed to offer training and employment opportunities to "mentally restore" individuals who desire to rejoin the workforce but have experienced barriers in obtaining employment in their community. Outpatient treatment services are also provided by Family Services and by private providers in the catchment area.

4.4. Housing, Food, and Transportation Services. Individuals in need of these services are referred to local churches, the Salvation Army, or the Union Mission. These services are also available through the Bacon Street Hotline, Ecumenical Outreach Services, York Ministerial, Social Services, and supervised and semi-supervised apartments maintained by the CSB.

The CSB may also assist persons in need of housing, food, and transportation. For example, a person who has traveled from outside of the Williamsburg area seeking voluntary admission at Eastern State Hospital may have been denied admission. The CSB may assist such persons in transportation and, if necessary, overnight accommodations. Similarly, police may transport persons who are in need of housing, food, or transportation, but who are not mentally ill, to the CSB. In such cases, a CSB representative will assist the person in securing shelter and food.

4.5. Medical Services. Individuals who exhibit physical/medical care needs are advised to consult with a private physician or referred to the emergency room of the Williamsburg Community Hospital. If the person has serious medical problems, a CSB staff member will call an ambulance before conducting a prescreening examination. Reportedly, the CSB representative later will contact the hospital to ascertain if the individual has mental health problems, in addition to his or her physical problems, that require attention.

4.6. Social Services. If the face-to-face assessment by the "on-call" staff member indicates crisis intervention social services are needed, the individual is referred to the Adult Protective Services. If a CSB staff member is made aware of a problem of spouse or child abuse, or serious financial problems, the individual may be referred to the appropriate Social

Service agency for assistance. Reportedly, these types of crisis interventions by CSB are rarely required.

5. Preadmission Screening (MSE)

An individual's first contact with the involuntary civil commitment system in Williamsburg typically occurs through face-to-face screening by an "on-call" CSB emergency staff member who has determined that voluntary crisis intervention services are inappropriate and that involuntary hospitalization needs to be pursued. As noted earlier, the decision to pursue involuntary hospitalization may have been made before, during, or after the CSB emergency staff member makes face-to-face contact with an individual.

Reportedly, the preadmission screening (referred to as "prescreening") typically includes a face-to-face mental status examination of the individual and, in some cases, interaction with family members and other persons familiar with the individual. If the individual is capable of accepting and is willing to accept voluntary crisis intervention services, the CSB staff member conducting the preadmission screening usually will pursue such services as a less restrictive alternative.

The primary function of the preadmission screening, according to policy reportedly subscribed to by the CSB, is to ensure that the most effective and appropriate use of inpatient psychiatric resources and that any crisis intervention is the least restrictive available option that is appropriate for the individual. The intent of the preadmission screening is to create a uniform method of entry--a single portal of entry--into mental health facilities.

A friend, relative of the person, or a law enforcement officer typically brings the person who is to be screened to the CSB or, if this is not possible, the "prescreener" will go to where the person is. The person may already be at ESH, at the Williamsburg Community Hospital, in jail, or at home. Sometimes the person is already a client of the CSB and his or her therapist has decided that the person may need a more restrictive environment or more intensive care.

The Department of Mental Health, Mental Retardation, and Substance Abuse Services has designed the prescreening report form to reflect the prescreener's assessment of three areas that correspond to statutory commitment criteria: (1) the person's capability of caring for himself or herself; (2) the danger the person poses to himself or herself, or to others; and (3) the availability and appropriateness of less restrictive alternatives to hospitalization. The CSB prescreener primarily bases his or her assessment on the person's current level of functioning, including whether the person is presently under medication or is participating in any mental health treatment programs and whether he or she has family or other support available. The prescreener also takes into account any history of mental health problems and the person's record of performance in previous treatment settings. The CSB forwards the completed prescreening report to ESH where it becomes part of the individual's medical records and a significant part of the information the special justices use to determine if the person should be hospitalized.

The consensus among participants in the commitment process at ESH is that the CSB produces excellent, reliable prescreening reports. However, while the CSB prescreening reports are sufficiently thorough, they often state that there are no less restrictive residential treatment settings because few

alternative facilities exist presently in the Williamsburg area. One administrator at ESH expressed the opinion that Williamsburg has had little incentive to develop alternative residential facilities because of its proximity to ESH.

A study conducted in 1984 revealed that the procedures for screening elderly persons are not followed as consistently as procedures for screening the mentally ill under age 65 and the mentally retarded. The following is an excerpt from the report of that study.

According to a social worker at Hancock Geriatric Treatment Center, the preadmission screening committee at Hancock would prefer to screen all admissions. Presently the committee screens only about half of those admitted, and the other half are screened only in their communities. According to three professionals at Hancock, many of those supposedly screened in the community actually have been civilly committed solely on the basis of a local physician's report that the person is substantially unable to care for himself or herself. Hancock sources complained that in these cases the communities virtually ignore the requirement that the person be mentally ill. Williamsburg reportedly is not guilty of such subversion of prescreening procedures.

When prescreening procedures proceed properly, the local community mental health center first evaluates the allegedly mentally ill person. If the person appears to require mental health treatment and no appropriate treatment alternatives are available in the community, the local mental health center prepares an application for admission to Hancock and presents it to Hancock's preadmission screening committee. The committee consists of a psychiatrist, a registered nurse, a psychologist and a social worker who coordinates the committee and communicates admissions decisions to the local mental health center and the applicant's family. If the committee determines that the person would benefit from treatment at Hancock, he or she is admitted. If the applicant would not benefit from such treatment, the committee refers the applicant to other appropriate agencies and also recommends that the community further explore local treatment alternatives. The committee rejects about one third of the applicants it screens. A psychiatrist and an administrator at Hancock indicated that a few of these rejected applicants are admitted eventually to Hancock through inappropriate detention orders and commitment hearings.

The Colonial Community Mental Health Center apparently has a relatively good relationship with Hancock. Mental Health Center administrators indicated that its staff not only prescreens all

the Williamsburg area clients who apply for admission to Hancock but also attends the staffings of clients admitted to Hancock. The Mental Health Center also has a full-time geriatrics coordinator whose efforts to serve the elderly were corroborated by two social workers not affiliated with the Mental Health Center. Unfortunately, alternative treatment settings for the elderly mentally ill in Williamsburg-James City County are as lacking as are such facilities for other mentally disabled persons (Institute on Mental Disability and the Law, 1984).

6. Commitment Criteria Decisionmaking

Preadmission screening is conducted, in part, to determine whether or not the statutory standards for involuntary civil commitment are met in a particular case. To come to a decision about involuntary hospitalization, the CSB preadmission screener establishes the following (though not necessarily in the formal and systematic sense suggested by their organization): (a) whether or not the individual is, in fact, mentally ill or inebriate (substance abuse is included in the statutory definition of mental illness); (b) whether or not the individual poses a danger to himself or herself or to others as a result of his or her mental illness; (c) whether or not there is any less restrictive alternative to involuntary hospitalization; and, (d) whether or not less restrictive alternatives have been adequately explored. As noted in Figure 3-3.1, if the preadmission screening results in a decision not to pursue involuntary hospitalization, the individual is urged to seek voluntary mental health services, such as the counseling services offered by the CSB, as described above.

7. Conference with Special Justice or District Court Judge

If the CSB staff member determines that involuntary hospitalization is appropriate, he or she telephones the general district court judge (during



regular business hours or at night if special justices are not available), a special justice or, if no one else is available, the magistrate. District court judges are elected by a majority of members of the General Assembly for six year terms. General district court judges (including the juvenile and domestic relations judges) are empowered by statute to make all critical decisions throughout the involuntary commitment process. They may preside over the TDO procedure, the preliminary hearing, and the final hearing.

In Williamsburg-James City County, the chief judge of the circuit court has appointed three practicing attorneys to serve as special justices. Though the circuit court judge appoints the special justices, he has no further involvement in the civil commitment process except to hear appeals of the special justices' decisions (see below). Special justices are empowered to carry out the duties of a general district court judge with regard to involuntary detention, admission, and treatment. Special justices must be licensed to practice law in Virginia. They serve under the supervision and at the pleasure of the chief judge making the appointment.

The principle function of magistrates is to provide an independent, unbiased review of complaints brought to them by police officers, sheriffs, deputies, and citizens. Most magistrates are not lawyers; however, they are trained to perform such duties as search warrants, subpoenas, arrest warrants, summonses, and setting bail. Magistrates, along with judges and special justices, have authority to issue orders of temporary detention (TDOs) of persons reliably reported to be mentally ill and in need of hospitalization. It is noteworthy that the criteria for the issuance of a detention order by a magistrate is somewhat stricter than for a judge or special justice. Before

magistrates may issue detention order, they must have received advice from a person skilled in the diagnosis or treatment of mental illness.

Typically, the CSB staff member will make a specific recommendation to the special justice or district court judge who, in turn, is likely to follow the recommendation. Generally speaking, the judge, special justice or magistrate will refuse the CSB prescreener's request for a temporary detention order (TDO) only if he or she is not entirely confident that the individual meets commitment criteria. Otherwise, the prescreener's recommendation that a detention order be issued almost always results in the judge, special justice, or magistrate issuing the TDO.

Section 31.1-67.1 of the Code of Virginia authorizes a judge or magistrate to "issue and order requiring any person within his jurisdiction alleged or reliability reported to be mentally ill and in need of hospitalization to be brought before the judge." If, however, the person "cannot be conveniently brought before the judge," the judge may issue an order of detention without the person's appearance before the judge. Reportedly, individuals in the Williamsburg area for whom CSB staff members recommend temporary detention seldom, if ever, are brought before the District judge prior to their temporary detention.

#### 8. Decision to Issue Temporary Detention Order

Based upon the information imparted to the special justice or district judge by the CSB staff member conducting the preadmission screening, the special justice or judge will make a decision whether or not to issue a temporary detention order. The decision is conveyed to the CSB staff member by telephone. If a temporary detention order is issued, the process moves on

to the next step (see below). If a TDO is not issued, the CSB emergency staff member must determine whether to pursue further care in the form of crisis intervention, some other form of treatment, or to leave the individual to his own care or to the care of his or her family.

Although a number of factors influence a judge's or special justice's decision, the expertise of the person requesting the TDO reportedly carries the most weight. A special justice or general district court judge will only issue a TDO upon being contacted by a CSB staff member known to him or her. Reportedly, if an individual contacts a judge or special justice who is not known to him or her, the judge or justice will not issue a TDO upon that person's request. When a family member requests a TDO, the judge or special justice routinely requires a preadmission screening by the CSB.

#### Temporary Detention Through Inpatient Services

As indicated in Figure 3-3.2, this phase of the emergency mental health services and involuntary commitment practices in Williamsburg includes four steps beginning with the issuance of a temporary detention order (TDO) by a special justice or district court judge and ending--if the individual continuous to "penetrate" the system--with the provision of inpatient treatment services by ESH.

#### 9. Issuance of Temporary Detention Order

Once the district court judge or a special justice has decided to issue a temporary detention order (TDO), the prescreener, judge, or special justice will then contact the police or, infrequently, the sheriff, to transport the respondent to ESH. It is standard operating procedure for the police to

obtain the TDO from the judge or special justice before picking up the respondent. Only in the most exigent situations will the police dispense with picking up the TDO before transporting the respondent to the hospital.

10. Transportation to Detention Facility

Once the police officer has obtained the TDO or, alternatively, the issuance of a TDO has been communicated to him or her by the judge or a special justice, the officer will proceed to the scene and transport the individual to the admissions unit of ESH. Reportedly, police officers do not have a formal, prepared statement explaining the nature and consequence of the custody-taking procedure. Whatever explanations are provided to the individual are discretionary and depend upon the apprehending officer and nature of the case.

Police officers will almost always have the TDO in their possession when they pick up the respondent and transport him or her to ESH. Upon arrival at the hospital, the police officer will present the TDO to the admissions staff of the hospital. Frequently, the police officer may ask the hospital representative to sign an acknowledgement of the transportation provided to the person. Reportedly, the time transporting officers spend in the admissions unit of the hospital is relatively brief.

In cases where the police have not yet obtained the actual detention order from the judge, special justice, or magistrate, the police will obtain possession of the order as soon as is possible and then present the TDO to the appropriate personnel at Eastern State Hospital.

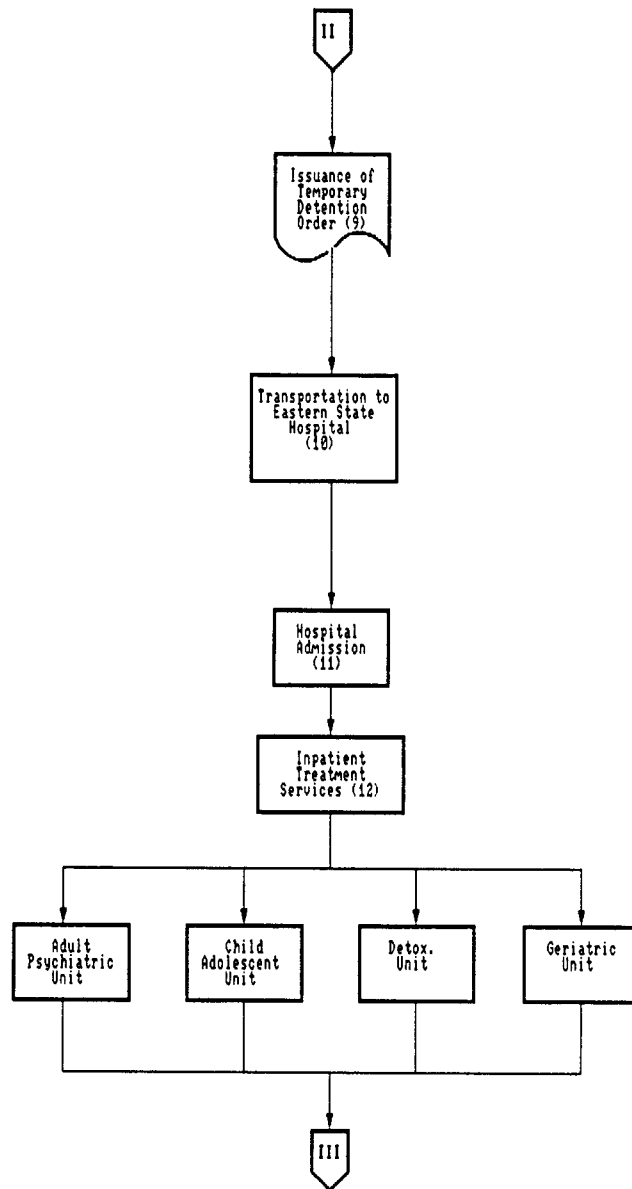


Figure 3-3.2. Emergency Mental Health and Involuntary Commitment Practices in Williamsburg - Temporary Detention Through Inpatient Services

#### 11. Admission

All persons arriving at ESH with a TDO are subjected to the hospital admissions process. The process begins with a clerk acquiring demographic information and a nurse's aide cataloguing the possessions the individual has on his or her person, checking vital signs, and so forth. Within several hours of the detainee's arrival, he or she is examined either by a staff physician during working hours or by a physician on call after regular business hours. Reportedly, temporary "detainees" receive the same care as voluntary patients during the admission process.

At the time of hospital admission or shortly thereafter, hospital personnel or the CSB emergency screener will seek to obtain the individual's authorization to release information for the purpose of developing and implementing treatment and discharge plans. Explanations are given to the individual with regard to his or her status as an involuntary patient on an as-needed basis.

#### 12. Inpatient Treatment Services

Once the admissions process is concluded, the individual is sent to the hospital's adult psychiatric unit, the geriatric unit, the child and adolescent unit, or the detoxification unit. The person is held for a maximum of 48 to 72 hours before a judicial hearing.

After ESH transfers the individual from the admissions unit, a psychiatrist performs a complete physical and mental examination. The psychiatrist evaluates the individual's communication skills and attempts to determine whether he or she suffers from hallucinations, delusions or "thought blocking." As in the case of the initial examination in the admissions unit,

the psychiatrist reportedly must release the person if insufficient cause exists to believe the person is mentally ill, though this rarely happens. ESH has on occasion released a detained person at this point in the commitment process, but never without the permission of the judge or special justice who issued the TDO.

Reportedly, special justices in Williamsburg generally disfavor conducting hearings when the respondent is under sedation or otherwise heavily medicated. Because the involuntary detainees receive the same care as other patients in the hospital, however, appropriate sedation or heavy medication may be prescribed if deemed necessary by the staff of the hospital.

With very few exceptions, ESH is the only site for involuntary detention. In rare cases, the district court judge--reportedly not the special justices--will order a person detained in a private or public facility outside of his or her jurisdiction. In such cases, the judicial hearing is conducted in jurisdictions wherein the involuntary detention facility is located.

#### Preparation for and Conduct of Judicial Hearings

As shown in Figure 3-3.3, this phase of the emergency mental health services and involuntary civil commitment practices in Williamsburg includes nine steps beginning with preparations by the staff of ESH and by the CSB for the judicial hearings and ending with the issuance of a court order at the conclusion of the full judicial hearing.

A number of steps and procedures during this phase take place almost simultaneously. For purposes of explanation, they are described separately below.

According to the district court, a total of 297 hearings were conducted in Williamsburg in 1988, up from 238 in 1987. In March 1989--a typical month according an ESH spokesperson--a total of 26 hearings were conducted at ESH. Ten individuals were committed, eight to ESH and two to private facilities. (According to an ESH spokesperson, the two individuals committed to private facilities had third-party insurance.) Seven of the 26 individuals whose cases were heard were granted voluntary admission status (two of these individuals were assigned to ESH's detoxification unit). Finally, nine individuals did not meet involuntary commitment criteria and were discharged.

13. Hospital Staff Prepare Commitment Petition

In accordance with the policy of the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) that discourages CSB personnel from serving as petitioners for involuntary civil commitment, the Williamsburg CSB typically does not perform this role. Instead, ESH's staff involved in the examination and treatment of the individual who is temporarily detained will prepare the commitment petition and serve as petitioners. Reportedly, the original petition remains in the possession of the hospital staff until the judicial hearing. The petition, the prescreening report, and the individual's medical chart typically constitute the entirety of the documentary evidence available at the hearing.

14. Special Justice and Attorney Assignment

Members of the hospital staff will contact one of three special justices and one of sixteen attorneys (the number at the time of the writing of this report) assigned to involuntary civil commitment cases in Williamsburg.



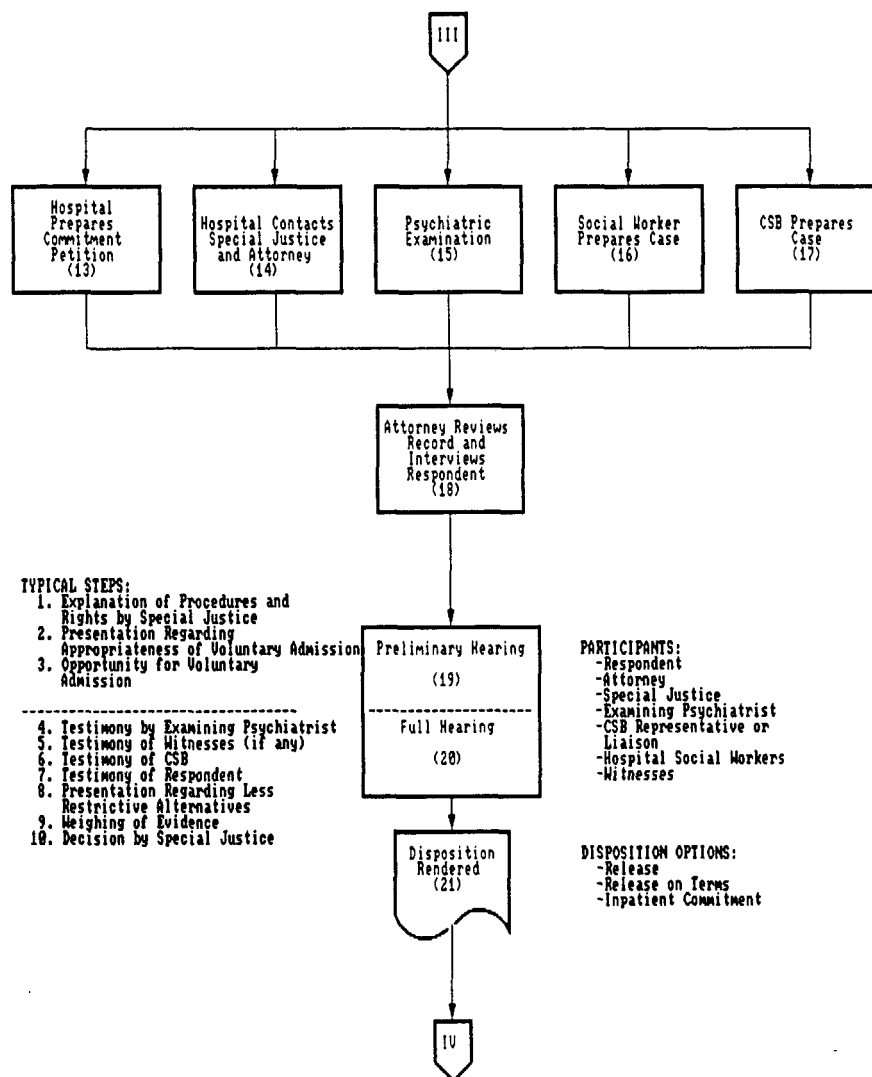


Figure 3-3.3. Emergency Mental Health Services and Involuntary Commitment Practices in Williamsburg - Preparation for and Conduct of Judicial Hearings

Attorneys are appointed by one of the special justices who serves as the "chief special justice." Attorneys are assigned to cases on a rotating basis. The hospital staff member will inform the special justice and the attorney of the number of hearings scheduled and the times and dates for the hearings.

15. Psychiatric Examination

Prior to a hearing, an ESH psychiatrist examines the respondent for the purposes of providing a factual basis for the petition and, because the examining psychiatrist reportedly also serves as the individual's treating doctor during the period of temporary detention, to provide a basis for a treatment plan. The examining psychiatrist will later testify at the commitment hearing as to whether or not the respondent meets the commitment criteria (see below). Persons involuntarily detained pursuant to a TDO are not released or afforded the opportunity for voluntary admission and treatment before a judicial hearing.

16. Hospital Social Worker Prepares Case

Typically, the CSB case manager and the hospital liaison worker collaborate in preparing the necessary background information for the judicial hearing. They typically perform a "clinical field assesement" on or before the hearing in order to assess the respondent's suitability for voluntary treatment, to identify treatment and care other than that provided by ESH, to record any behaviors of the respondent observed by hospital and CSB staff, to indicate any medication taken by the respondent, and to communicate the diagnosis and recommendation of the examining psychiatrist(s).

An ESH social worker will meet with the respondent in advance of the judicial hearing and will inform him or her about the nature and consequences of the upcoming proceedings. The social worker will answer any questions the respondent may have and will assist him or her in preparing for the hearing by inquiring about any witnesses or other information that the respondent may wish to have available for the hearing.

The social worker is also responsible for determining whether or not the respondent has any insurance so that the respondent can, if he or she so chooses, be committed to a private facility willing and able to admit the person. If the respondent has insurance, the social worker will contact private facilities to make the necessary arrangements contingent upon the outcome of the hearing.

#### 17. CSB Prepares Case

Once a person is admitted and involuntarily detained at ESH, CSB representatives typically have little contact with the case until the judicial hearing. A CSB representative will, however, provide information and support to the family members or petitioners, distribute the court report to the hospital, the attorney, and the district court, bring other pertinent information to the court, and testify at the judicial hearing if requested to do so. He or she will ensure that the special justice has a copy of the prescreening report, meet with the respondent, and examine the respondent's medical charts relevant to the commitment proceedings. Based on his or her knowledge of the respondent's situation, the CSB representative will explore the possibility of less restrictive alternatives to inpatient commitment.

Finally, the CSB representative will prepare to testify as to his or her evaluation of the respondent's case at the hearing.

18. Attorney Reviews Records and Interviews

Immediately before the hearing--typically, about one half-hour--the attorney meets with the respondent for the first time. Reportedly, the attorney covers much the same ground as the social worker covered in his or her meeting with the respondent (see above). Usually, if the patient is planning to call any witnesses, the social worker has already contacted them. The attorney may contact additional witnesses if he or she deems necessary.

Immediately prior to the hearing, the special justice receives the paperwork and the petition prepared by the ESH staff. The special justice can issue subpoenas for witnesses that the respondent intends to call. Subpoenas are typically issued at the time of the hearing when the respondent indicates that he or she wishes to have a witness appear who is unwilling to testify. In such cases, the special justice postpones the hearing until the witness can be brought to the hearing.

19. Preliminary Judicial Hearing

The preliminary and "full" commitment hearings provide the forum for examining the evidence from all interested parties and for officially determining whether any less restrictive alternatives to involuntary commitment of the individual exist. Hearings are conducted in a conference room in a building on the grounds of ESH. The room contains a large conference table and chairs to accommodate the respondent, his or her counsel, a representative of the ESH and the CSB, a hospital social worker, and a

security guard. Typically, the respondent and his or her counsel sit at one end of the table and the special justice at the other. The psychiatrist or other hospital representatives and witnesses usually sit along the side of the conference table. CSB representatives, the hospital social workers, the security guard, other witnesses, and guests sit in chairs along the walls of the conference room.

On the day of the hearing, the ESH worker or the hospital liaison worker communicates with the hospital, family members and others with regard to the time and the place of the hearing. As indicated in Figure 3-3.1, the typical steps of a preliminary hearing include: (a) an explanation provided by the special justice about the procedures to be followed; (b) an explanation of the rights of the individual; (c) presentations regarding the appropriateness of voluntary admission; (d) and an opportunity provided to the respondent to elect to become a voluntary patient.

The preliminary hearing ends if the person elects voluntary hospitalization and, if the special justice requires, the psychiatrist testifies that the individual has the requisite competence to make this decision. If the person, or his or her attorney, declines the election of voluntary hospitalization, the preliminary hearing proceeds immediately into the "full" hearing. Typical of most jurisdictions throughout the state, distinctions between preliminary and full hearings are blurred in Williamsburg. Indeed, the two hearings are conducted in the same session with no clear distinctions between the two.

Two of the three special justices presiding over the preliminary hearing commences by informing the respondent of his or her rights and by explaining the purpose and nature of the proceedings to the respondent. The other

special justice hearing cases in Williamsburg will often dispense with this aspect of the preliminary hearing.

Following any explanations by the special justice, the psychiatrist who conducted the examination of the respondent is typically called by the special justice and asked whether the patient has the requisite mental ability to accept or deny voluntary admission. If it is determined that the patient has the requisite mental ability, the respondent is asked whether or not he or she is willing to accept voluntary commitment. If the patient accepts voluntary commitment, the preliminary hearing comes to an end and the patient is sent to the appropriate unit of ESH. If the respondent does not or cannot accept voluntary treatment the process immediately proceeds to the "full" hearing.

#### 20. Full Judicial Hearing

Full hearings in Williamsburg, generally speaking, are not conducted as formal trials. Adherence to rules of procedure is loose. Hearings resemble a roundtable discussion where witnesses speak freely and are not subject to cross examination. However, reportedly some attorneys do proceed formally with direct and cross-examinations and adhere to evidentiary rules. Typically, the first person to testify at the full hearing is the examining psychiatrist. He or she testifies as to the results of the examination and, using the commitment criteria as points of reference, informs the special justice whether or not the individual meets the requisite commitment criteria. If the psychiatrist's professional opinion is that the person should not be committed, the psychiatrist will recommend to the judge less restrictive care that may be appropriate. Once the psychiatrist has concluded his or her

testimony, the special justice or the respondent's counsel calls any witnesses.

Once the witnesses have concluded their testimony, a CSB representative may offer testimony concerning any information he or she may have acquired during the course of interviewing or treating the respondent. Next, the respondent is given an opportunity to speak on his or her own behalf. Finally, the judge typically asks the hospital social worker and the CSB representative whether or not there are any less restrictive alternatives to commitment that should be considered and whether or not the respondent has insurance and is thus able to be placed in a private psychiatric facility.

In the period from May 17 through June 21, 1989, a project staff member observed a total of 18 commitment hearings conducted at ESH. In all of the observed hearings, the respondents were unrestrained and were seated at the end of a conference table next to their counsel opposite the special justice. The proceedings during the hearings varied considerably depending upon the presiding special justice, the nature and extent of the respondent's alleged mental health problem, and other facts and circumstances of the case.

Table 1 indicates the characteristics of the 18 observed hearings in four major categories and numerous minor categories, according to the special justice who presided over the hearings. Special Justice Number One presided over a total of eight hearings; Special Justice Number Two presided over seven hearings; and Special Justice Number Three presided over three hearings. The table suggests (the limited sample of cases observed does not allow the drawing of firm conclusions) considerable variation among special justices in the preliminary explanations provided to respondents, the conduct of both the preliminary and full hearings, and the average duration of full hearings. For

example, while two of the three justices informed all respondents of the right to appeal a commitment order, one special justice apparently made no such explanations.



Table 1

Characteristics of 18 Commitment Hearings Conducted in Eastern State Hospital, May 17-June 21, 1989

Characteristics	Hearing Officer		
	Number 1	Number 2	Number 3
<u>Preliminary Explanation of Rights by Special Justice</u>			
Is the respondent informed of:			
1) The basis for his/her detention?	3	7	3
2) The standard upon which he/she may be detained?	1	7	3
3) The right to appeal any commitment order to the circuit court?	0	7	3
4) The right to a jury on appeal within the 30 day filing period?	0	7	0
5) The right to reject appointed counsel if they desire to retain their own or if appointed counsel is deficient?	0	7	0
6) The right to a continuance to compel the appearance of necessary witnesses?	0	7	0
<u>Preliminary Hearing</u>			
1) Is respondent asked whether he/she is willing to accept voluntary commitment?	8	7	3
2) Is respondent informed of the duration and conditions of voluntary commitment?	2	7	0
3) Does the respondent express desire to voluntarily commit him/herself?	4	2	1
4) Is respondent requests voluntary, is a psychiatrist asked to testify as to the respondent's legal capacity to accept voluntary commitment?	1	2	1*
5) Does respondent's counsel offer any assistance to the respondent during the preliminary hearing?	2	0	0
<u>Full Hearing</u>			
Total Number of Cases that Proceeded to the Full Hearing	4	5	3
1) Does a psychiatrist testify as to the respondent's mental state and whether the respondent meets the statutory commitment criteria?	3	5	3
a) Cross-examined by counsel?	2	1	2
b) Questioned by special justice?	0	1	2
2) Does a representative from the CSB testify?	1	2	1
a) Cross-examined by counsel?	0	0	1
b) Questioned by special justice?	1	2	1
3) Do other witnesses testify?	1	0	2
-Eastern State social worker	1	0	0
-Respondent's family members	0	0	2
a) Cross-examined by counsel?	0	0	2
b) Questioned by special justice?	0	0	2
3) Is respondent permitted to testify?	2	5	3
a) Direct-examination by counsel?	1	0	0
b) Questioned by special justice?	2	3	0
4) Ruling:			
a) Committed	3	3	2
b) Released on Terms	1	1	0
c) Released Unconditionally	0	1	1
5) Is respondent reminded of his right to appeal?	0	3	2
6) Is respondent informed of the procedure for pursuing an appeal by the special justice?	0	3	2
<u>Duration of Hearing</u>			
1) 0 - 5 min.	2	0	0
2) 5 - 10 min.	1	2	0
3) 10 - 15 min.	1	3	2
4) 15 - 30 min.	0	1	0
5) over 30 min.	0	1	1

\*In this case the psychiatrist testified that the respondent lacked the requisite mental ability to accept voluntary commitment.

21. Disposition Rendered

At the conclusion of all testimony, the special justice renders one of three decisions: (1) release the individual unconditionally; (2) release the individual "on terms" (such "terms" might include outpatient care and regular visits to the CSB); or (3) commit the individual to a psychiatric facility.

Apparently, an individual's release "on terms" in the Williamsburg area, as in other parts of Virginia, is understood to be an admonishment and recommendation of the court that has no formal, legal force. It is not, apparently, the type of "court-ordered outpatient treatment, day treatment in a hospital, night treatment in a hospital, referral to the community mental health clinic, or other such appropriate treatment modalities," authorized by Section 37.1-67.3 of the Code of Virginia. Technically, no formal court order accompanies a person's release "on terms." The special justice reportedly simply writes instructions on the reverse of the order releasing the individual.

Special justices in Williamsburg complained that the release on terms cannot be enforced. That is, they have no authority to apply sanctions when a person fails to comply with the terms of release.

When the decision is to commit, the special justices draft their orders in different ways. One notes the facility and orders commitment for a specific duration (not necessarily the statutory maximum). Another special justice specifies the facility but automatically orders the maximum 180-day commitment period. The third special justice in Williamsburg, who is relatively new to the job, reportedly has ordered the maximum 180-day commitment period in the relatively few cases he has heard.

Following the decision, the respondent is informed by the special justice of the consequences of the decision. If commitment is ordered, two of the justices remind the respondent of his or her right to an automatic, de novo appeal of the decision. The other justice does not always inform the respondent of this right (see Table 1).

Following explanations, the committed respondent is escorted back to the unit. If the individual has been released unconditionally or on terms, the person is removed from the hearing room and processed for release. A three-part form (DMH 226), completed at the time of discharge by the hospital social worker and the CSB representative present at the hearing, constitutes a discharge or release plan. The first part of the form, "Discharge Plan and Referral Summary," denotes demographic information about the patient (name, address, date of admission and discharge), referral information, discharge diagnosis, types of regimen of medication, and special instructions and recommendations. This part of the form is signed and dated by the treating physician. The second part of the form, "Community Services and Support Needs," indicates the community services and support which are needed by the patient upon discharge and available to the patient in the community if needed. Also this part of the form indicates whether the patient is willing to use the services and whether the patient, if willing, also has the means or the capability to access and utilize the services needed. Lastly, this part of the form indicates if a referral or application has been initiated for the services needed. The third part of the form requires a description of the community service and support plans which have been initiated or completed to meet the patient's identified needs as described in the second part of the form. It requires the identification of responsible providers and dates for

all planned services and supports, and the status of current plans. This last part of the form requires the signature or authorization of the facility, the CSB, and the patient. The patient's signature acknowledges his or her understanding that the form will be transmitted to the CSB serving the facility to which the patient will be discharged.

### Post-Hearing Matters

What happens after a hearing? The last phase of the emergency mental health services and involuntary civil commitment practices in Williamsburg includes five steps involving the events, decisions, and practices following a full judicial hearing (see Figure 3-3.4). As noted above, at the conclusion of the commitment hearing, if the detained person has not agreed to voluntary admission, the court will order either the release or hospitalization of the person. The release order may be unconditional, or it may require the person to seek outpatient treatment. If the person is hospitalized either voluntarily or involuntary, he or she remains at ESH.

#### 22. Client Released

If ESH admits an individual, plans for discharge reportedly begin immediately. ESH assigns the patient a treatment team composed of a psychiatrist, a psychiatric resident, psychologist, a social worker, a nurse, and other appropriate persons. The treatment team holds an evaluation, planning, and discharge conference shortly after the person is admitted.

If, the individual has been granted release, hospital staff initiate the person's discharge from ESH. Hospital staff evaluate the respondent to determine if further psychiatric or case management is indicated. If further

treatment is warranted, staff determine if inpatient or outpatient services are needed and make the appropriate referrals. Also, they explore alternatives with the family (e.g., court ordered treatments, warrants, and in-jail treatment). Discharge procedures typically take less than 15 minutes to complete. If the individual is released on terms or conditions, he or she is reminded of the terms at this time.

Reportedly, cooperation between ESH and the CSB is good. The two organizations have discharge agreements describing each other's general responsibilities for discharge planning and follow-up. A CSB case manager regularly attends the evaluation, planning, and discharge conferences of clients from her geographical area.

### 23. Involuntary Hospitalization

If the individual is ordered committed to ESH, the respondent is escorted back to the ward, or is transported to a private psychiatric facility. If the respondent is not committed to ESH, hospital staff coordinate the admission of the individual to the receiving hospital and exchange any necessary information to facilitate the transfer. Reportedly, ESH staff will also begin discharge planning with the receiving hospital treatment team.

Transportation to a facility other than ESH is provided by ESH or, much less frequently, by the sheriff. Even less frequently, the receiving facility makes arrangements to pick up the patient at ESH and transport him or her to the receiving facility.

24. Release by Hospital Staff

Respondents are involuntarily held for treatment until, such time as the hospital staff determines that he or she has adequately recovered and can be released, or until the end of the commitment period, at which time the respondents are afforded another judicial review hearing (see below).

25. Legal Appeal

A respondent may exercise his or her right to an appeal by filing an appeal in the circuit court within 30 days of the special justice's order. The appeal is heard de novo by the circuit court and the respondent is entitled to a jury.

Orders issued by special justices and the district judge in Williamsburg almost always stand because patients rarely appeal decisions to the circuit court. According to a circuit court judge in Williamsburg, the court hears no more than ten appeals per year, most frequently by patients who resided outside of the Williamsburg area. He stated that he has never conducted a jury trial on the issue of an involuntary civil commitment. The special justices in Williamsburg were unaware of any appeals of their orders within the recent past. An ESH spokesperson speculated that attorneys may be discouraged to appeal a special justice's commitment order because a patient is likely to be released long before the appeal is heard. Further, lack of express instructions about the mechanics of filing an appeal may contribute to the infrequency of appeals. On the other hand, the lack of appeals might indicate that the process is working well in Williamsburg because the special justices do a good job of preventing inappropriate admissions (Institute on Mental Disability and the Law, 1984).

26. Review Hearing

At the end of the commitment period, if the respondent is still in the commitment facility as an involuntary patient, a review hearing must be held. This review hearing follows the same procedures as the initial hearing.

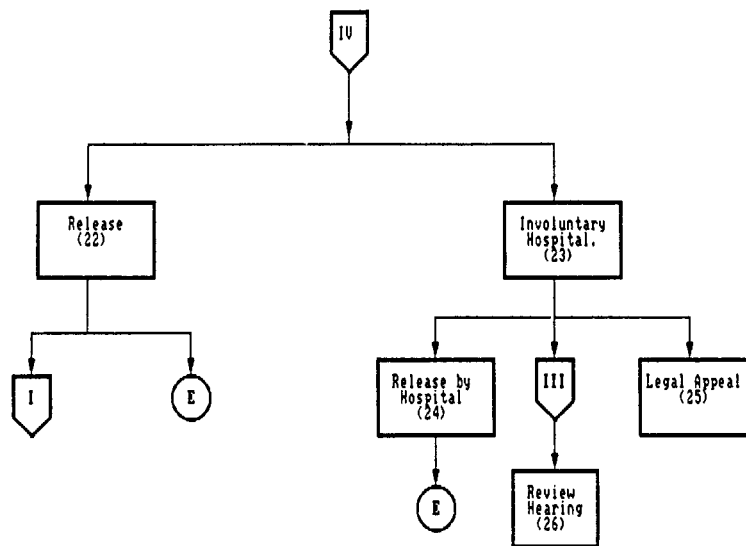


Figure 3-3.4. Emergency Mental Health Services and Involuntary Commitment Practices in Williamsburg - Post-Hearing Matters



#### **Section 4: Emergency Mental Health Services and Involuntary Civil Commitment Practices in the Northwestern CSB**

This report describes the provision of emergency mental health services and involuntary civil commitment practices in the catchment area of the Northwestern Community Services Board (Northwestern CSB). For clarity and convenience, this report is divided into four sections. The first section describes the events that take place between the occurrence of a mental health emergency and the decision to provide voluntary care or to request that the individual in crisis be temporarily detained. The second section explains the procedures and decisions involved in temporarily detaining an individual. The third and fourth sections, respectively, describe the commitment hearing and the events that take place following the hearing. Each section is described in a set of steps that approximates the chronology of events, decisions, and procedures that are likely to arise when an individual requires emergency mental health services and enters the involuntary civil commitment process.

##### **Crisis to Temporary Detention or Voluntary Care**

The first phase of emergency mental health services and involuntary civil commitment practices begins when someone reports that an individual is experiencing a mental health crisis and continues through the point at which a magistrate or a special justice decides to issue a temporary detention order (TDO). Figure 3-4.1 presents the five major steps involved in reporting, referring and evaluating a mental health crisis.

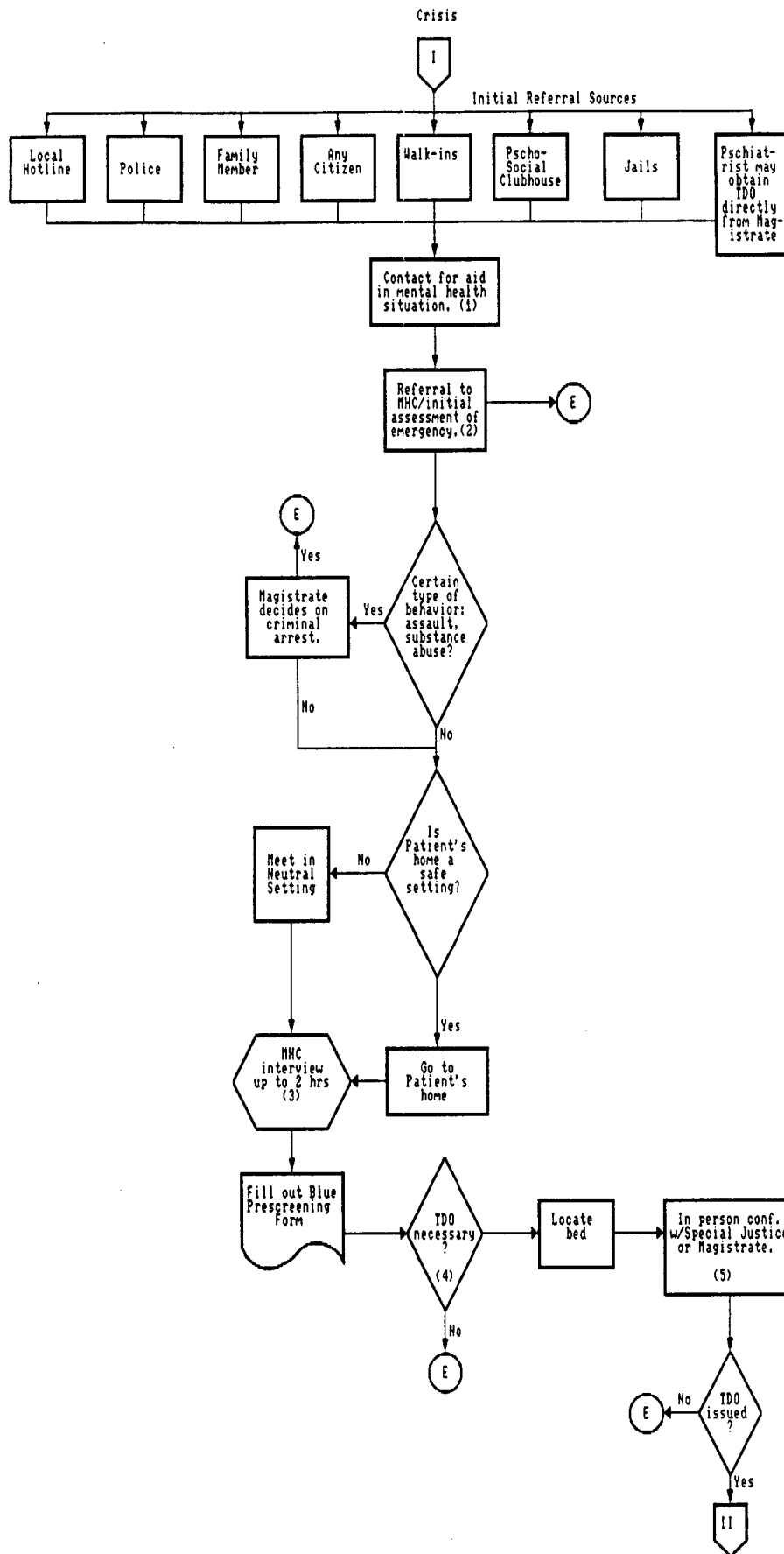


Figure 3-4.1. Emergency Mental Health Services and Involuntary Civil Commitment Practices In Northwestern CSB - Crisis to Temporary Detention or Voluntary Care

### 1. Point of Initial Contact and Referral

As in all Virginia jurisdictions, the initial request for emergency mental health services for a particular individual can come from any member of the public. The individual who is in need of services also may seek them out directly. Fifty percent of the referrals to the Northwestern CSB flow through the community hotline, which is called "Concern." In Fiscal Year 1989, the hotline referred 363 calls to the Northwestern CSB (see Attachment 1, page 2). Because the hotline serves as an important "gateway" to emergency mental health services, the Northwestern CSB has a very close working relationship with the hotline. The director of emergency services serves as an ex officio member of the hotline's board of directors, screens applicants for the hotline, and trains hotline staff. He is in daily contact with the director of the hotline, who maintains a detailed account of the nature and number of all hotline calls. Consequently, the Northwestern CSB can monitor closely the level of requests for emergency mental health services coming through the hotline from the community.

Other referral sources include psycho-social clubhouses (2%), the police responding to a call in the community (10%), magistrates (2%), hospital emergency room employees (18%), jail personnel (10%) and family members (10%). The George Washington Home for Adults and other homes for adults served by the Northwestern CSB also occasionally refer residents for mental health services. The Northwestern CSB offers in-service training on the procedures for accessing the emergency mental health system and provides regularly updated information to the police, jail personnel and hospital emergency room staff.

## 2. Referral to Emergency Services

Persons seeking emergency mental health services for themselves or another individual may call or walk in to the Northwestern CSB's mental health center (MHC) during business hours. They also often call the community hotline number or a hospital. The individuals answering these calls take the caller's name and telephone number and relay this information to the mental health center. A MHC staff member contacts the caller to determine what steps need to be taken to handle the reported problem. If a magistrate receives a call about an individual before the MHC has been contacted about that person, the magistrate will notify the MHC or refer the caller to the MHC.

During the workday, three emergency services therapists serve four offices in the Northwestern CSB catchment area. To handle evening and weekend emergencies, the Northwestern CSB has established five six-day shifts per month for on-call staff therapists and a separate backup system of therapists willing to be called when they could respond to an emergency more conveniently than could the on-call therapist. One therapist and one supervisor are on call during each shift.

The mental health center has a special answering service number for nights and weekends. When the on-call therapist receives a message from the answering service, he or she can call a supervisor for assistance and consultation. The therapist also may contact one of approximately 12 other Northwestern CSB mental health therapists who may be closer to the scene to see if they are available to handle the incident. Hospital emergency room personnel and police officers who call the MHC's answering service number generally indicate whether the situation requires an immediate response or

whether the person in need of mental health services can safely await the arrival of the on-call staff member who may be in a distant area of the catchment area.

### 3. Preadmission Screening (MSE)

The mental health center completes approximately 500 preadmission screenings per year. In most cases, the emergency services therapist interviews the individual in person. In perhaps as many as 25 percent of the cases, however, the individual may be uncooperative, violent, in hiding or otherwise unavailable for a face-to-face mental health assessment. In these circumstances the therapist usually seeks from at least two reliable sources corroboration of the individual's apparent need for emergency mental health services.

In most cases, family, friends or the police bring the individual to a neutral setting (e.g., a hospital emergency room or the magistrate's office). During the workday interviews may be conducted at the MHC. Normally, the therapist will interview the individual at the individual's home only if the individual is known to the MHC and the therapist ascertains that the home will be a safe setting for the assessment. The police occasionally accompany therapists to the scene of a mental health crisis. In cases involving substance abuse or assaultive behavior, the therapist may consult first with the magistrate to determine if the more appropriate response to the individual's conduct might be a criminal arrest.

#### 4. Commitment Criteria Decisionmaking

The time required to complete the mental health assessment ranges from fifteen minutes to two hours. The entire intervention process can take up to four hours if the therapist decides to proceed with a request for a temporary detention order (TDO).

As the mental health assessment proceeds, the therapist records the necessary information on a preadmission screening form, called the Blue Form. (If the patient is not detained for a commitment hearing, the Blue Form becomes part of the emergency services records.) If the therapist determines that the individual is under the care of a mental health care provider or is receiving other services, he or she will attempt to contact the providers for their recommendations about the individual's treatment needs.

An important function of the prescreening is to evaluate the appropriateness of treatment alternatives that are less restrictive than inpatient care. The therapist may conclude that the individual should not be detained but that he or she requires one or more of several alternative treatments such as drug or alcohol detoxification, outpatient medication services, participation in a psycho-social clubhouse or case management services.

The primary criteria upon which the therapist decides whether the individual is in need of mental health treatment and involuntary hospitalization are whether the individual is: (1) dangerous to himself/herself or others; 2) unable to care for himself or herself; or 3) rapidly decompensating. In Fiscal Year 1989, 365 of approximately 500 prescreenings reportedly resulted in petitions for a commitment hearing. Although the percentage of prescreenings that led to temporary detention

orders appears to be high, two levels of screening (the hotline staff and an MHC therapist) usually have occurred before a therapist performs a prescreening.

The therapist also may recommend that the individual enter hospitalization voluntarily. If the individual agrees to voluntary hospitalization, the therapist will provide assistance to the individual in seeking admission to Winchester Medical Center or another private facility. If the individual is an eligible veteran, the therapist may assist him or her in obtaining treatment at the Veterans Administration Center in Martinsburg, West Virginia if that facility offers services appropriate to the individual's needs. (The Veterans Administration Center in Martinsburg is used for voluntary admissions because it is closer to Winchester than is the Veterans Administration Center in Salem, Virginia.) At a minimum, the therapist usually recommends that the individual undergo an outpatient mental health evaluation.

If the therapist decides to recommend to the magistrate that a TDO be issued, he or she searches for an available temporary detention bed in one of twelve facilities. When arrangements with the institution have been made, the therapist notes on the prescreening form the name of the hospital official authorizing the use of the bed. The facilities that most often are used to detain an individual are Western State Hospital and the Winchester Medical Center, the closest and largest private hospital in the Northwestern CSB catchment area. Other facilities that occasionally provide a temporary detention bed are the Shenandoah Memorial Hospital psychiatric unit; Charter Westbrook; Charter Charlottesville; Blue Ridge Hospital; Chippenham Hospital; Springwood Hospital; New Hope Detoxification Center on the grounds of Western

State Hospital (but not after September 1, 1989); Dominion Hospital; Mountainwood Hospital; and DeJarnette Center. Charter Westbrook, Charter Charlottesville, Dominion, and Mountainwood also provide treatment for children, and DeJarnette is a state hospital for the treatment of minors.

According to a Northwestern CSB spokesperson, in Fiscal Year 1989 approximately 165 individuals were detained in Western State Hospital; about 150 were taken to Winchester Medical Center and about 50 individuals were admitted to one of the other facilities listed above.

##### 5. Conference With Magistrate

The therapist contacts the magistrate, if he or she is not already available, to set up a meeting time and place for discussing the need to issue a TDO. The therapist usually meets with the magistrate in the magistrate's office. Depending on the jurisdiction in which the TDO is sought, the magistrate may go to the location of the individual, often a hospital emergency room. Unless the therapist has had to rely on uncorroborated information for his or her assessment of the individual's need for emergency mental health treatment, the magistrate usually follows a recommendation to issue a TDO. On a few occasions a magistrate reportedly has refused to issue a TDO because he or she was more familiar with the individual than was the therapist and disagreed with the therapist's conclusions about the individual's need for emergency mental health treatment.

The majority of TDO's are issued only after preadmission screening by a Northwestern CSB therapist, but psychiatrists who wish to obtain a detention order for a patient under their care who is unwilling to accept voluntary mental health treatment may contact the magistrate directly for a TDO. If the



patient will be treated in a private hospital the MHC does not become involved in the commitment process unless the case is referred to the MHC. If commitment to a state facility is sought by a private facility treating the patient, the MHC completes a prescreening of the patient before he or she is transferred to the state facility.

### Temporary Detention Through Inpatient Services

The second phase of the emergency mental health services and involuntary civil commitment process begins with the delivery of the TDO to the sheriff and ends with the admission and treatment of the detained individual in a hospital pending a judicial hearing of his or her case. Figure 3-4.2 depicts the four steps in this phase.

#### 6. Issuance of Temporary Detention Order

Once the magistrate issues the TDO, he or she contacts the sheriff's department, which sends the sheriff or a deputy for the TDO. The TDO states in which facility the individual will be detained. The TDO remains in effect for 96 hours. Four copies of the TDO are issued: one for the individual who will be detained, two for the detention facility, and one for the district court after the hearing. The TDO is accompanied by a petition for emergency mental health services which is called the "Yellow Form." The petitioner is usually a parent, or other relative, but could be an interested party who reported the incident, a law enforcement officer, or in extremely rare cases, the therapist who performed the prescreening. If the situation so warrants, the magistrate may issue a TDO on his or her own authority, but reportedly,

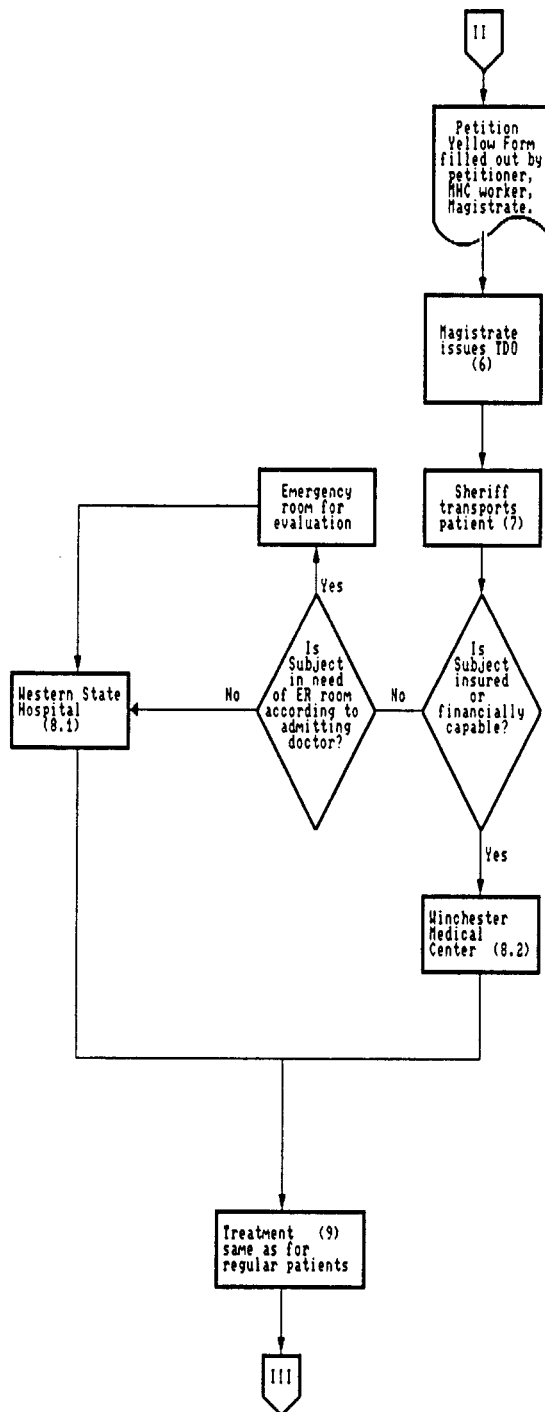


Figure 3-4.2. Emergency Mental Health Services and Involuntary Commitment Practices in Northwestern CSB - Temporary Detention, Treatment and Care

most magistrates are very reluctant to issue a TDO in the absence of a petitioner.

7. Transportation to Detention Facility

The sheriff of the jurisdiction in which the emergency situation arose picks up the individual and transports him or her to the detention facility designated on the temporary detention order. In several cases, the individual's medical condition has required that he or she be transported to the hospital by ambulance. The use of an ambulance causes complications regarding transportation costs and use of sheriff's deputies to transport the individual. MHC therapists have been instructed not to support requests for transportation by ambulance and to inform doctors or deputies who are considering using an ambulance that they must contact the sheriff directly for permission. The MHC takes the position that patients whose medical condition is not sufficiently stable for transportation by police or sheriff's cruiser require medical treatment locally until they can be transported by cruiser.

If the individual will be detained at Western State Hospital (WSH) and is a geriatric patient, a chronic substance abuser, or has taken an overdose of drugs, WSH may not take him or her until a screening for medical stability or treatment of a medical condition has been performed. WSH requires the medical screening because its medical facility is open only from 8:15 am to 5 pm Monday through Friday and is not equipped to handle medical emergencies or serious medical problems. Reportedly, about 20-25% of those individuals who are not already in a hospital when the mental health crisis occurs require medical screening or treatment. (Approximately 18%, or 90, of the 500 referrals to MHC reportedly are from hospitals; based on these figures, the

number of individuals requiring medical attention prior to transportation to WSH is estimated to be between 82 and 102.)

A spokesperson for WSH reported that differing interpretations of Virginia law regarding transportation under a temporary detention order have created complications in treating individuals before their arrival at WSH. When WSH requires a medical screening or treatment the sheriff must take the individual to the closest hospital emergency room and wait there until hospital staff have examined the individual. This process can take several hours and often causes the sheriff's department considerable aggravation. When a medical emergency develops on the way to WSH or after the individual's arrival there, the individual is taken to the University of Virginia Medical Center in Charlottesville, about an hour's drive from WSH.

## 8. Admission

Because most individuals (86%) in the Northwestern CSB catchment area who are detained for a judicial hearing are taken to Western State Hospital or the Winchester Medical Center, the admissions procedures and inpatient treatment services for these two facilities are described in this part.

### 8.1 Western State Hospital

Individual's brought to Western State Hospital are taken first to the admissions office. The admissions interview and assessment process generally requires two hours. A hospital social worker will have assembled all available information about the individual in anticipation of the individual's arrival at WSH. This body of information includes records of any previous admissions to WSH and any information provided by others. (A WSH spokesperson reported that social workers at Winchester Medical Center usually provide

information on patient's who have been transferred to WSH from that facility.) Upon the individual's arrival, an admissions office clerk first reviews the TDO and petition and clarifies any questions he or she might have about either document with the magistrate or special justice who issued the TDO. Reportedly, TDOs often state that the individual shall be detained in "any willing institution"; when this occurs the clerk calls the magistrate or special justice to determine if WSH was the intended detention facility.

While any problems related to the TDO are addressed, a registered nurse begins a lengthy "nursing assessment". This assessment is designed to evaluate the patient's physical health, ascertain his or her ability to care for himself or herself, and determine what environmental factors might be affecting the patient (e.g., living situation, diet, medical conditions, problematic relationships). From this assessment the nurse makes recommendations regarding the patient's diet, exercise and home environment. These recommendations are used later in discharge planning for the individual.

Following the nursing assessment a psychiatric aide performs a brief mental status examination, which consists of 30 items designed to determine the patient's orientation to his or her environment (e.g., the season of the year, the date, the state, and the name of the hospital). The psychiatric aide also searches the patient's belongings to remove any objects with which the patient could harm himself or herself.

After these initial assessments have been completed a psychiatrist performs a more complete mental status examination and a physical examination (laboratory tests are done the morning following admission). In performing these examinations, the psychiatrist relies in part on the nursing assessment and the psychiatric aide's brief mental exam.

## 8.2 Winchester Medical Center

A high percentage of detained individuals are taken to Winchester Medical Center's psychiatric unit (WMC) because it is the largest and closest private hospital. As noted earlier, about 150 of the approximately 365 individuals detained in Fiscal Year 1989 were taken to WMC. Individuals detained at WMC are admitted under the same procedures as are other patients. When an individual arrives at WMC, he or she is seen first by hospital admitting personnel. In some cases, the individual is taken directly to the psychiatric unit and is seen first by a psychiatric nurse. The admitting staff completes an admission registration form that contains such demographic data as the patient's name, address, telephone number, insurance provider, financial resources, and the names of interested parties.

## 9. Inpatient Treatment Services

### Western State Hospital

After the admissions process is completed, the patient is sent to one of the following five receiving wards: all male forensic; male admissions; female admissions; co-ed admissions; and co-ed geriatric. All of these wards are locked.

A treatment team assesses the patient's condition and treatment needs the first business day after the patient's admission (i.e., patients admitted Sunday through Thursday are seen the next morning; those admitted on Friday or Saturday meet with the treatment team on Monday morning). The treatment team consists of a nurse, a mental health worker, a social worker, a psychiatrist, a psychologist, a dietitian, and other specialists (e.g., a music therapist). Students from various disciplines usually also participate on the treatment

team. If the patient is violent or unable to cope with a group of people, the members of the treatment team meet with him or her individually. Medications usually are not administered to the patient until after the treatment team has completed its assessment.

During the treatment team's assessment the patient is asked to talk about himself or herself, recount the events that led to his or her admission, and describe feelings and understandings of the situation. The team advises the patient that he or she can request that particular individuals can be present at the hearing to testify on his or her behalf. The patient also is advised of his or her right to hire an attorney or use the services of a court appointed attorney.

After the team has completed its assessment, an initial treatment plan is written. The psychiatrist writes a note on the patient's mental and physical status, which will be used as evidence at the hearing. This note includes recommendations regarding the patient's need for voluntary or involuntary hospitalization.

#### Winchester Medical Center

After a patient has been admitted to Winchester Medical Center, he or she is taken to the psychiatric unit where a psychiatric nurse completes a Nursing Admission Assessment. This assessment results in a record of the patient's physical health history and is completed for all patients admitted to WMC. It seeks information about medications the patient has taken, the patient's neurological and bodily functions, past surgical procedures performed on the patient, whether the patient is diabetic or an alcoholic, whether the patient was admitted from another health care facility, and how he or she came to be at WMC.

After the physical health history is obtained, a psychiatric nurse completes a Psychiatric Nursing Admission Assessment. This assessment is performed for all patients admitted to WMC's psychiatric unit. It essentially is a brief mental health history that contains information such as the number of previous admissions to other hospitals, deaths in the family, and other information that the nurse is able to ascertain from the individual. At this time the patient or interested parties also receive a booklet about WMC that explains the patient's rights, privileges and responsibilities. The booklet also contains other basic information such as the hospital telephone number and visiting hours.

All patients admitted to WMC receive a physical examination. If the patient has a personal physician, that physician may perform the examination. If the physician is not available, or the patient has no personal physician, a physician on the staff of WMC performs the examination.

Two psychiatrists who have admitting privileges at WMC rotate on-call shifts. (As of July, 1989, an adolescent psychiatrist also has admitting privileges at WMC.) Whenever possible, one psychiatrist is the treating physician and the other serves as the independent evaluator who performs a mental status exam in preparation for the hearing. On weekends, however, only one psychiatrist is on duty. Patients admitted on the weekend therefore are treated and evaluated by the same psychiatrist. Within 24 hours of admission to WMC, the psychiatrist who is on call or the attending psychiatrist examines the patient and develops a preliminary treatment plan. The treatment plan may include orders for medications, various laboratory tests, e.g., blood work and EKG's, and a special diet. The preliminary treatment plan also includes a discharge goal.



While awaiting the judicial hearing, the individual receives treatment and care that is necessary for his or her medical stability. In some cases, the prescriber who contacted the on-call psychiatrist regarding the availability of a TDO bed may have given the psychiatrist sufficient information about the patient's needs so that the psychiatrist can give advance orders that can be carried out directly upon the patient's admission. In any case, however, orders will have been obtained from the psychiatrist within one hour of admission to WMC.

### Preparation for and Conduct of Judicial Hearings

Phase three begins with the preparation for the judicial hearings by hospital staff and concludes with the disposition of the petition for involuntary civil commitment. Figure 3-4.3 presents the four major steps in this phase.

#### 10. Preparation for the Judicial Hearings

Hearings are regularly scheduled on Monday, Wednesday, and Friday at Winchester Medical Center's psychiatric unit and at Western State Hospital. In a very few cases, the hearing takes place in the county where the individual resides instead of in these two facilities. (For example, if an individual was detained at Charter Charlottesville Hospital, the therapist who arranged the temporary detention bed will also have negotiated with the Region 10 CSB to handle the commitment hearing.)

#### Western State Hospital

At WSH recommitment hearings are held the same days as commitment hearings. WSH also handles all commitments from Augusta County as well as all

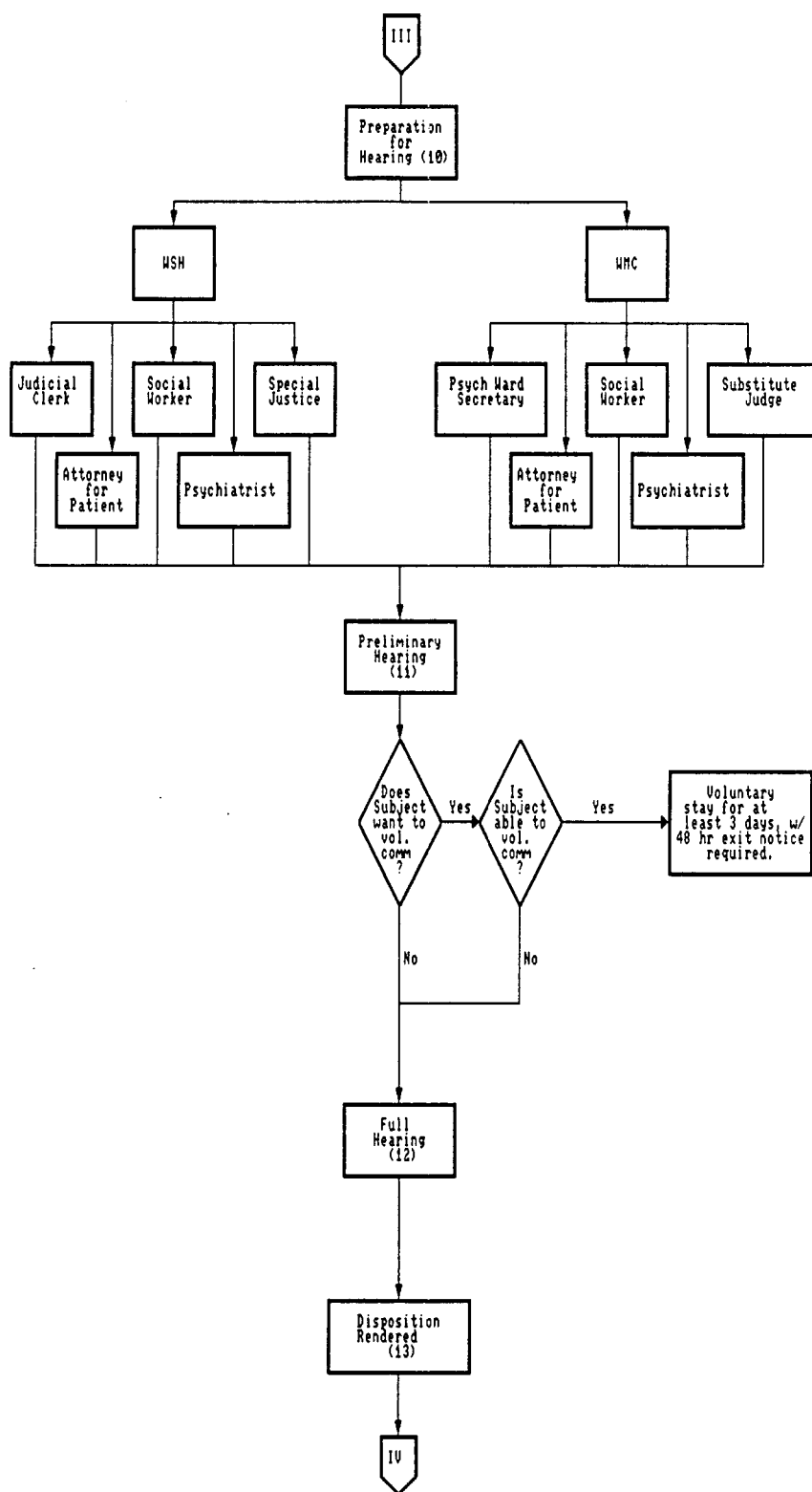


Figure 3-4.3. Emergency Mental Health Services and Involuntary Civil Commitment Practices in Northwestern CSB - Preparation For and Conduct Of Judicial Hearing

commitments to the Veterans Administration Hospital because the VA Hospital in Salem will not accept patients on TDO's. Because WSH has the responsibility for all of these hearings, discussions among the local bar, the court and the hospital aimed at holding hearings Monday through Friday instead of only Monday, Wednesday, and Friday, have taken place over the past two years.

The "judicial clerk," who is an employee of WSH, arranges the hearings. She reviews the paperwork regarding the patient and contacts the special justice, the attorney and the private practitioner who will provide an independent evaluation of the patient. (One of three private physicians usually serves as the independent evaluator.) If the patient has hospitalization insurance and wishes to be treated in a private hospital if he or she is committed to involuntary treatment or chooses to volunteer, the judicial clerk tries to find an available bed in a private facility. The judicial clerk also informs the hospital staff of any contacts she has made with the patient's family, witnesses or others.

The hospital social worker assists the patient in contacting witnesses and a personal physician, psychiatrist or an attorney if the patient is unable to make these arrangements for himself or herself. If the treatment team anticipates that the patient will neither volunteer for treatment nor be committed, and the patient cannot obtain transportation from WSH to his or her home, the social worker arranges for a bus ticket to be purchased. The money to pay for the ticket is available from a hospital fund set up for this purpose.

The psychiatrist's preparation for the hearing consists of his initial examination of the patient, the treatment team's assessment and the note the

psychiatrist prepares based on the treatment team's recommendations. The psychiatrist usually does not attend the hearing.

One special justice presides over the hearings two days per week and another special justice presides on the third day. On a typical hearing day, the special justice will hear five or six recommitment cases and two to three petitions for involuntary hospitalization. Five or six court-appointed attorneys regularly serve as counsel at commitment and recommitment hearings. Reportedly, less than five percent of the individuals detained for a commitment hearing retain their own attorney. Each of the court-appointed attorneys serves two or three days per month. Using a list of recommitment hearings provided by Western State Hospital, the secretary for the special justice who hears cases twice a week coordinates the attorneys' schedules. The attorneys do not meet with their clients until the afternoon of the hearing.

#### Winchester Medical Center

At the Winchester Medical Center (WMC) the secretary for the psychiatric unit notifies the substitute judge and the attorney that a hearing will take place. A psychiatric social worker meets with the patient to explain that a judicial hearing will take place and answer any questions the patient might have and obtain background information about the patient. The social worker often also talks with the patient's relatives or friends to gather additional information and to explain the judicial proceedings. She records her findings on the patient's chart in the section for progress notes. Patients may have anyone they wish come to the hearing, but they generally must call them on a hospital pay phone. If the patient is incapable of making the call(s), someone on the hospital's staff will assist the patient in reaching those he

or she wants to contact. In some instances, individuals have requested to be at the hearing whom the patient does not want to be present. In these circumstances, the substitute judge honors the patient's wishes and prohibits the individual(s) from attending the hearing.

The psychiatrist who did not perform the initial examination of the patient also completes a mental status evaluation in preparation for the judicial hearings. (As noted above, except on weekends, one psychiatrist serves as the treating psychiatrist and one serves as the independent evaluator.) In this evaluation, the psychiatrist provides his recommendation regarding the need to commit the individual for mental health treatment. The mental status examination may be performed at the same time as the preliminary treatment plan is made, or the psychiatrist may decide to postpone the examination until the patient's condition has become more stable. In very rare circumstances, the postponement of the mental status examination would delay the judicial hearing beyond the 48-hour statutory limit on holding hearings. In these few cases, the substitute judge reportedly has held a hearing on a day hearings are not normally scheduled or on a holiday to accommodate the need for additional time to evaluate the patient.

The court-appointed attorney accompanies the substitute judge to the hearings held at the WMC psychiatric unit. Two attorneys, appointed by the Circuit Court judge, alternate months in which they serve as counsel to detained individuals. Each attorney fills in for the other if one of the attorneys is unavailable for a hearing during his assigned month. The attorney does not meet with the detained individual unless he or she refuses voluntary treatment and the substitute judge holds a full hearing on commitment.

11. Preliminary Judicial Hearing

Western State Hospital

Hearings are held at WSH in the hearing/conference room located next to the admissions office. Hearings are held on the receiving ward if the patient is unable to come to the hearing/conference room. The hearing/conference room is comprised of a small outer room where the judicial clerk sits and a larger room with a long table with four chairs and several other chairs placed around the perimeter of the room. The special justice, the attorney, the detained individual and the independent evaluator all sit at the table during the preliminary and commitment hearings. Hospital staff, family members and witnesses sit in the chairs away from the table.

Hospital personnel escort the patients to the hearing/conference room. The individuals usually are not restrained, but they may be medicated. The special justice begins the hearing by asking the individual if he or she knows where he or she is and why. He then explains the purpose of the detention order and the hearing, the commitment process, and the patient's right to a court-appointed attorney and independent evaluator. The special justice also informs the patient of his or her right to volunteer for hospitalization and to appeal a commitment order. After these explanations, the patient is given time to talk with his or her attorney. The special justice does not impose any time limit on the attorney/client conference, but he will inquire about the need for additional time if the conference lasts longer than 20 minutes.

After the attorney/client conference, the special justice asks the patient if he or she understands all of his or her rights. If the patient appears to understand, the special justice asks him or her if he or she would

be willing to accept voluntary treatment in the hospital. If the patient says that he or she would like to volunteer for treatment, the independent evaluator interviews the patient during the proceedings reviews his or her records to determine if the patient is capable of voluntarily committing himself or herself to hospitalization. If the independent evaluator finds that the patient is capable of making this choice, the special justice explains to the patient what his or her obligations under a voluntary commitment are and the hearing ends at that point.

In cases where the independent evaluator finds that the patient cannot volunteer for treatment, the patient's attorney often cross-examines the independent evaluator regarding his finding. The special justice then decides the issue. If the patient chooses not to volunteer or the special justice accepts the independent evaluator's recommendation against voluntary treatment, the special justice proceeds to hold a "full" commitment hearing.

#### Winchester Medical Center

At the Winchester Medical Center the hearing is held in a room on the psychiatric unit. If the patient is unable to come to the hearing room, the substitute judge, who presides at the preliminary hearing, will conduct the hearing in the patient's room. During the preliminary hearing, the substitute judge informs the individual of his or her rights and offers the individual the opportunity to become a voluntary patient. If the individual agrees to become a voluntary patient, he or she must stay in the hospital at least three days and give 48 hours written notice of his or her intention to leave. Except in extraordinary circumstances, the substitute judge accepts the individual's decision to become a voluntary patient.

If the individual does not choose to become a voluntary patient, or if the substitute judge determines that the individual is not capable of making that choice, the substitute judge recesses the hearing to allow the attorney to consult with the patient in preparation for the full hearing. The judge allows the attorney as much time as is needed to prepare for the hearing.

12. Full Judicial Hearing

Western State Hospital

In addition to the special justice who presides over the commitment hearing, the patient's attorney, the independent evaluator and witnesses, a representative of the treatment team usually attends the hearing. The psychiatrist who wrote the "staffing note," which is based on the treatment team's evaluation of the patient, generally does not attend the hearing. If no hospital staff are present at the hearing and questions arise regarding the staffing note, the special justice may call a member of the treatment team and ask him or her to come to the hearing/conference room to address the questions raised.

The special justice begins the hearing by asking the independent evaluator to interview the patient and review the patient's records. If the independent evaluator determines that the individual should be committed to hospitalization, he or she recommends to the special justice that he issue a commitment order. If, based on the interview and review of the patient's records, the independent evaluator does not have a clear recommendation for commitment or release, the special justice will ask for testimony from hospital staff, family members, and other witnesses with relevant information about the patient's need for mental health treatment. The patient's attorney



has the opportunity to cross-examine all witnesses, including the independent evaluator. The patient also is given an opportunity to speak. Occasionally the special justice questions the patient. The patient may choose to volunteer for treatment at any time during the commitment hearing if the independent evaluator has determined that the patient has the capability to make this decision.

#### Winchester Medical Center

At the commitment hearing the participants are the substitute judge, the individual and his or her counsel and witnesses. Unless the substitute judge requests the presence of the therapist who performed the preadmission screening, Northwestern CSB has no staff at the hearing. A written psychiatrist's report usually is submitted in lieu of a psychiatrist's live testimony. Additional documents relied upon at the hearing are the prescreening form and the patient's hospital chart, which contains progress notes from social workers, nurses and physicians providing treatment during his or her detention in the hospital before the hearing.

#### 13. Disposition Rendered

At the conclusion of the presentation of evidence, the special justice or substitute judge renders a decision regarding the individual's need for involuntary mental health treatment. At Winchester Medical Center the substitute judges's decision rests primarily on information contained in the psychiatrist's report, the prescreening form and the hospital chart. At Western State Hospital, the special justice considers the staffing note, the independent evaluator's recommendation and all testimony. If the special justice or substitute judge finds that the individual does not meet the

statutory commitment criteria the individual is released, usually with a recommendation that he or she voluntarily seek mental health treatment. At Winchester Medical Center if the patient's behavior and testimony indicate that the patient is no longer a danger to himself/herself or others the judge reportedly may order the patient to be released despite a recommendation from the psychiatrist that the patient requires in-patient mental health treatment. In such instances, the psychiatrist is notified and the patient is asked to indicate on the discharge form that he or she is leaving the hospital against medical advice (AMA).

If the special justice or substitute judge determines that the individual meets the commitment criteria, he orders the individual be committed involuntarily for a period not to exceed 180 days. The disposition of the case is recorded on the petition (Yellow Form). At Western State Hospital the special justice reportedly reminds the patient that he or she may appeal the order by contacting his or her attorney and explains that the patient will have to remain in the hospital during the appeal process. A spokesperson at Western State Hospital reported that 60 to 70 percent of the individuals are committed to hospital treatment and 30 to 40 percent either volunteer or are released.

#### Post-Hearing Matters

This phase begins after the special justice or substitute judge enters his or her disposition of the petition for civil commitment. The three steps in this phase are presented in Figure 3-4.4.

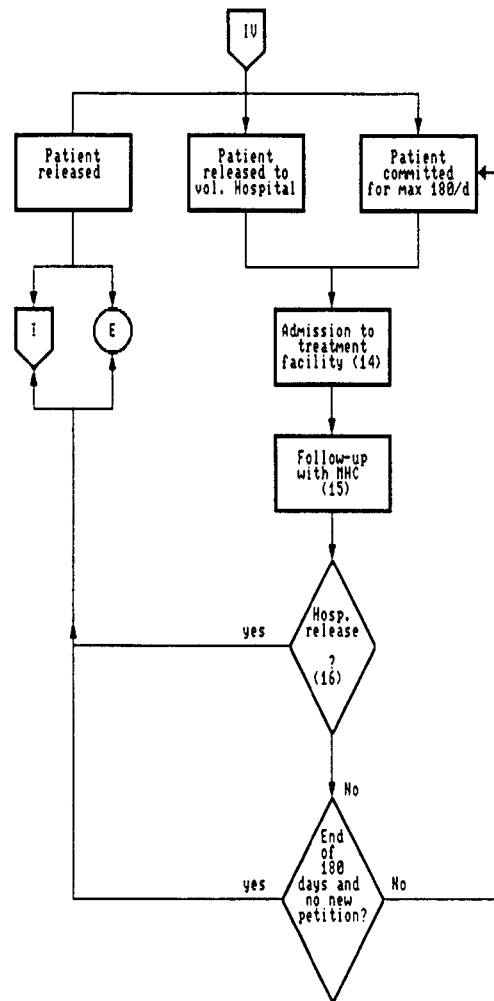


Figure 3-4.4. Emergency Mental Health Services and Involuntary Civil Commitment Practices in Northwestern CSD - Post-Hearing Matters

14. Admission to Treatment Facility

If the special justice or substitute judge orders that the individual be committed, he or she usually is admitted to a facility immediately. The sheriff provides transportation. At Winchester Medical Center the secretary on the psychiatric unit makes arrangements with the sheriff. If hospital staff have determined in advance that commitment to another facility will be the likely disposition of the petition for commitment, the secretary alerts the sheriff before the hearing.

If the individual has mental health care insurance or other financial resources, he or she may be admitted to a private institution. If the individual does not have insurance, will require hospitalization longer than 28 days, has a history of nonresponsiveness to treatment, or is considered to be unmanageable, he or she is committed to Western State Hospital or the state facility that serves the catchment area in which the individual resides. Minors may be committed to DeJarnette Hospital, Charter Westbrook, Charter Charlottesville, Dominion Hospital, or Mountainwood Hospital. Veterans may be committed to the Veteran's Administration Hospital in Salem, Virginia.

According to a spokesperson for Western State Hospital, by the fall of 1988 all of the state facilities in Virginia were either fully occupied or over their capacity. In response to the overcrowding at WSH, the Commissioner of Mental Health provided \$150,000 to Western State Hospital in November, 1988 to purchase services in the private sector. The admissions office administered these funds, which were used to pay for a variety of services, including bed-days in private facilities. The funds were depleted within six months. WSH requested an additional \$300,000 for the fiscal year beginning

July 1, 1989, but the Commissioner was not able to provide these funds. The spokesperson for WSH expressed concern that WSH will again have a critical shortage of space in the fall of 1989, particularly in light of the fact that after September 1, 1989, the New Hope Detoxification Center on the grounds of WSH no longer will accept any patients admitted under a TDO or an involuntary civil commitment order.

15. Follow-up and Coordination With the Mental Health Center

According to a Northwestern CSB spokesperson, a copy of the petition should be sent to the Northwestern CSB after the hearing, but this procedure is never followed. (A spokesperson for Winchester Medical Center stated that WMC staff were not aware of this requirement.) If the individual is a Northwestern CSB client, Northwestern CSB staff will follow the progress of the individual during his or her hospitalization and develop a plan for the individual's treatment after release from the hospital. The client's post-hospitalization plan may include these elements: 1) participation in a psycho-social clubhouse; 2) outpatient medication and nursing services; 3) arrangements for a residential facility; 4) securing SSI benefits; 5) developing family support; 6) participation in a social club, and 7) case management. If the individual resides in the catchment area of another local mental health center, arrangements are made with that center to follow-up on the individual after his or her release.

A spokesperson for Western State Hospital reported that the frequency of visits to patients from their local mental health center depends on the proximity of the mental health center to WSH. For example, therapists from the mental health center for Augusta County visit their clients twice a week,

whereas therapists from the Charlottesville mental health center see their clients once every two weeks. One day per month reportedly is designated Northern Virginia Day. On this day therapists from mental health centers in northern Virginia confer with WSH social workers in the morning and meet with their clients in the afternoon.

16. Release by Hospital Staff

The hospital has the authority to release involuntary patients anytime before 180 days have elapsed. Once 180 days period has expired, the hospital must either release the patient or petition for a new commitment hearing. The MHC usually is not directly involved in recommitments. In some cases, however, the MHC reportedly has played a role in the recommitment process.

Before a patient is released from Western State Hospital, arrangements must be made for the patient to have shelter and a means of support. An appointment within the first week of the patient's discharge also is set up with the patient's local mental health center.

## Attachment 1

CONCERN Hotline, Inc  
HOTLINE STATISTICS:

TYPES OF CALLS

FISCAL YEAR ENDING JUNE 30 1989

% TOTAL	TYPE OF CALL	JUL.	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	YEAR
4.9%	ABUSE-PHYSICAL/MENTAL ADULT.....	44	24	23	24	21	18	28	25	14	12	13	18	265
1.1%	CHILD.....	1	5	3	9	6	5	4	5	9	4	4	2	57
0.6%	ABUSE-SEXUAL.....ADULT.....	1	0	0	1	5	3	2	6	1	1	8	2	30
0.5%	CHILD.....	4	1	0	3	2	2	4	1	3	2	0	4	26
0.5%	ADOLESCENTS/TEENS.....PEERS.....	4	2	3	3	0	3	1	2	2	5	1	1	27
0.4%	FAMILY.....	1	4	0	1	0	0	1	2	2	6	2	1	20
0.2%	AGING [Senior Citizens].....	1	1	1	0	6	1	1	0	0	0	0	1	12
0.0%	BUSINESS.....CONSUMERS.....	0	0	0	0	0	0	0	0	0	1	1	0	2
0.1%	SERVICES.....	0	0	0	0	0	0	0	1	0	1	0	1	3
0.5%	COUNSELING.....	0	1	1	0	1	2	4	6	1	2	6	2	26
0.0%	EDUCATIONAL.....	0	0	0	0	0	0	0	0	1	0	1	0	2
1.6%	FAMILY PROBLEMS.....CHILDREN.....	1	10	4	8	9	12	4	8	6	10	8	6	86
3.6%	SPOUSE.....	22	21	21	12	17	20	14	13	19	7	11	17	194
0.0%	GOVERNMENT.....	0	0	0	0	0	0	0	1	1	0	0	0	2
0.2%	GRIEVING.....	0	0	0	0	0	0	1	1	3	3	4	1	13
0.9%	LEGAL PROBLEMS.....	1	5	6	5	4	3	4	5	2	4	4	5	48
0.1%	MATERIAL NEEDS...CLOTHING/FOOD...	2	2	0	1	1	0	0	0	0	0	0	0	6
0.0%	ELECTRIC/FUEL...	0	0	0	1	0	0	0	0	0	0	0	1	2
0.7%	JOBS/MONEY.....	5	1	2	3	1	2	9	7	1	1	1	4	37
0.4%	MEDICAL.....	0	0	2	2	1	2	2	2	2	0	1	5	19
2.2%	SHELTER.....	10	9	14	10	15	21	7	4	9	6	8	4	117
0.3%	TRANSPORTATION...	0	1	2	1	1	4	0	1	2	1	0	1	14
3.4%	MENTAL/EMOTIONAL...DEPRESSION.....	7	12	9	17	17	13	7	17	20	33	21	11	184
2.3%	EMOTIONAL.....	10	11	11	10	11	7	11	11	8	14	10	8	122
0.2%	HANDICAP.....	0	4	2	0	0	1	2	0	0	1	1	0	11
1.7%	LOVELINESS.....	17	9	6	7	8	2	3	3	2	10	5	19	91
4.9%	PSYCHIATRIC.....	30	21	15	20	17	27	10	27	24	12	30	24	261
0.4%	PHYSICAL/MEDICAL...ILLNESS.....	4	3	4	1	0	1	4	2	1	1	1	1	23
0.1%	HANDICAP.....	0	1	1	0	0	0	1	0	1	1	0	0	5
0.7%	PREGNANCY - ABORTION/ADOPTION...	1	3	2	3	0	3	2	6	6	9	1	2	38
0.0%	RECREATION.....	0	0	0	0	0	0	0	0	0	1	0	0	1
0.9%	SEXUAL.....IDENTITY.....	9	4	4	4	9	8	1	1	1	1	4	0	46
0.5%	RELATIONSHIPS...	6	6	0	7	1	1	2	1	2	2	0	1	29
4.8%	SUBSTANCE ABUSE...ALCOHOL.....	28	25	36	17	18	21	27	33	12	16	14	10	257
3.1%	DRUGS.....	16	11	13	19	12	12	12	18	12	18	8	13	164
0.2%	SPIRITUAL/RELIGIOUS.....	0	0	2	0	0	1	1	0	2	2	1	3	12
1.4%	SUICIDAL.....SELF.....	8	7	12	6	4	9	5	3	9	6	4	1	74
1.0%	ANOTHER.....	4	2	3	5	2	1	7	1	11	10	1	6	53
0.4%	ATTEMPT/INTERVENE...	2	1	3	1	0	2	5	0	2	4	2	1	23
6.9%	TALK / LISTEN.....	24	26	22	24	30	15	26	43	41	32	46	40	369
51.6%	TOTAL SERIOUS TYPE CALLS:	263	233	227	225	219	222	212	257	232	239	222	220	2771
11.2%	HOTLINES/INFORMATION.....	52	22	29	37	52	55	61	81	69	47	42	56	603
0.2%	OBSCENE CALLS.....	0	3	1	1	1	0	2	0	0	1	1	0	10
0.2%	PRANK CALLS.....	0	0	1	0	1	1	2	0	4	2	0	1	12
1.4%	FROM CONCERN AIDES.....	11	8	6	7	3	5	4	4	10	3	3	9	73
7.4%	TO N.W.C.S. EMERGENCY SERVICES...	34	21	31	50	26	26	31	31	58	31	31	25	395
6.7%	FROM N.W.C.S. EMERGENCY SERVICE..	34	21	31	27	23	21	29	29	56	34	30	24	359
3.8%	FOR OTHER AGENCIES.....	39	10	27	24	21	8	20	3	17	10	15	10	204
1.6%	FROM OTHER AGENCIES.....	10	0	6	4	4	0	10	12	9	14	12	6	87
0.7%	OTHER. THANK YOU'S ETC. ....	10	3	5	4	5	0	0	1	2	3	2	0	35
15.2%	HANG-UPS.....	55	53	47	52	44	41	61	58	85	96	81	140	813
0.1%	SILENT CALLS.....							0	1	1	0	1	1	4
92.3%	TOTAL CALLS REPORTED:	508	374	411	431	399	379	432	477	543	480	440	492	5366
	OPERATOR'S CALL COUNT:	510	378	413	444	418	405	440	490	568	518	569	660	5813
	% LS REPORTED BY AIDES:	99.6%	98.9%	99.5%	97.1%	95.5%	96.6%	98.2%	97.3%	95.6%	92.7%	77.3%	74.5%	92.3%

CONCERN HOTLINE, INC.  
HOTLINE STATISTICS:

FISCAL YEAR ENDING JUNE 30, 1989

PAGE 2 OF 7

% TOTAL	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	YEAR
<b>REFERRALS MADE:</b>													
13.5% Alcoholics Anonymous / Al-Anon.	38	14	41	21	15	21	25	22	12	14	12	13	248
2.3% Alcohol/Drug Treatment Facility	11	1	4	1	1	2	2	9	5	3	1	3	41
0.3% American Red Cross	2	0	0	0	0	0	0	2	0	1	0	1	7
0.9% Back-Up Counselors	0	0	2	2	1	0	2	6	0	1	1	2	17
0.1% Blue Ridge Hospice	0	0	0	0	0	0	1	0	0	0	0	0	1
1.5% C-Cap	4	2	2	2	2	4	7	1	2	0	1	0	37
0.2% Clergy	0	1	0	0	0	0	0	0	0	1	0	1	3
0.0% Councils on Domestic Violence:													
3.6% RESPONSE	21	6	5	4	5	7	4	5	5	4	0	1	67
5.9% The Shelter..	12	9	11	11	9	11	7	6	4	6	8	14	106
2.0% Warren CoDV..	8	7	5	2	1	2	2	4	1	1	0	4	37
1.0% Detoxification Center	3	0	4	1	0	2	2	0	2	3	1	1	19
0.5% Free Medical Clinic	1	2	0	0	0	1	2	0	0	0	1	2	9
0.7% Hospital Emergency Room	3	3	0	0	0	0	2	0	0	0	1	3	12
19.8% N.W.C.S. EMERGENCY SERVICES	34	21	31	27	23	21	29	31	58	31	31	26	363
0.8% Parents Anonymous	0	4	1	1	2	2	0	0	3	2	0	0	15
1.2% Pregnancy Services	1	2	0	0	0	2	2	1	4	8	0	2	22
0.8% Rape Victim Companions	1	1	3	0	0	0	2	4	1	0	0	3	15
1.3% Rescue Mission	3	2	4	1	3	6	3	0	0	1	1	0	24
0.4% Rescue Squads	3	3	0	0	0	0	0	0	1	0	0	0	7
0.7% Salvation Army Front Royal.	1	1	2	1	2	3	2	0	0	1	0	0	13
3.5% Winchester..	6	6	8	8	10	12	5	1	1	3	2	2	64
1.8% Sheriff/Police Departments	4	2	3	8	3	1	1	0	5	3	1	2	33
2.6% Social Services / Welfare	3	8	3	7	4	4	6	0	1	4	5	3	48
0.4% Widowed Persons Service	0	1	2	1	0	0	1	0	1	1	0	0	7
12.8% Mental Health	33	28	24	15	8	21	26	8	18	20	18	16	235
2.1% Private Psychiatrist	5	1	3	2	0	1	4	6	3	2	9	3	39
2.2% Private Psychologist	5	2	3	2	1	1	3	9	4	1	5	4	40
17.1% OTHER REFERRALS:	32	31	45	28	29	39	26	11	18	22	12	21	314
<b>TOTAL REFERRALS MADE:</b>	<b>234</b>	<b>158</b>	<b>206</b>	<b>145</b>	<b>119</b>	<b>163</b>	<b>166</b>	<b>126</b>	<b>149</b>	<b>133</b>	<b>110</b>	<b>127</b>	<b>1636</b>
8.3% CRISIS INTERVENTIONS	48	34	41	39	20	29	39	28	68	42	31	29	448
5.3% CHRONIC CALLERS	15	11	19	17	30	17	19	20	18	41	38	40	285
33.6% SEX OF CALLER: MALE	144	127	127	125	129	124	110	141	148	113	94	101	1483
66.4% FEMALE	282	192	214	227	203	193	261	268	310	272	264	250	2936
<b>AGE OF CALLERS:</b>													
0.4% Under 10	5	3	0	0	2	2	3	1	4	1	1	0	22
4.9% From 11-20	26	34	21	13	15	27	24	19	33	28	13	11	264
22.2% From 21-30	132	100	102	111	94	95	93	96	99	117	84	70	1193
27.7% From 31-40	161	85	137	129	132	133	134	131	144	107	98	98	1489
12.7% From 41-50	63	66	56	61	67	42	53	72	63	48	51	38	680
5.4% From 51-60	27	24	18	30	10	13	16	30	34	16	43	28	289
2.9% Age 61 Plus	12	7	7	8	12	5	10	17	21	15	21	22	157
23.7% UNKNOWN	82	55	70	79	67	62	99	111	145	148	129	225	1272
<b>CALLS REPORTED BY AIDES:</b>	<b>508</b>	<b>374</b>	<b>411</b>	<b>431</b>	<b>399</b>	<b>379</b>	<b>432</b>	<b>477</b>	<b>543</b>	<b>480</b>	<b>440</b>	<b>492</b>	<b>5366</b>
92.3% PERCENTAGE CALLS REPORTED/AIDES	99.6%	98.9%	99.5%	97.1%	95.5%	93.6%	98.2%	97.3%	95.6%	92.7%	77.3%	74.5%	
<b>CALLS FROM AREAS SERVED:</b>													
0.0%													
22.8% SHENANDOAH COUNTY	123	127	103	113	119	113	85	111	104	106	94	127	1325
21.8% WARREN COUNTY	116	165	81	96	102	91	97	94	102	111	112	99	1266
55.4% WINCHESTER/FREDERICK/CLARKE	271	86	229	235	197	201	258	285	362	301	363	434	3222
<b>OP: ORS CALL COUNT</b>	<b>510</b>	<b>378</b>	<b>413</b>	<b>444</b>	<b>405</b>	<b>440</b>	<b>490</b>	<b>568</b>	<b>518</b>	<b>569</b>	<b>660</b>	<b>5813</b>	



Section 5:  
Emergency Mental Health Services and Involuntary  
Civil Commitment Practices in the Richmond CSB

This report describes the provision of emergency mental health services and involuntary civil commitment practices in the catchment area of the Richmond Community Services Board (CSB) which covers the City of Richmond and the Thirteenth Judicial District.

From Crisis to Temporary Detention, Voluntary Care Or Release

The first phase of the emergency mental health services and involuntary civil commitment practices in Richmond begins at the point of the mental health crisis. Figure 3-5.1 presents eight major steps involved in reporting, referring and evaluating a mental health crisis situation.

1. Point of Initial Contact and Referral

A report of someone experiencing a mental health crisis may come from a number of sources. The person in crisis may ask for help directly (approximately 25% of reports), or a family member or significant other (approximately 15% of reports) may request help for the person. Reports of individuals experiencing acute emotional or psychiatric distress also may come from private practitioners/hospitals (approximately 20% of reports), human services agencies (approximately 5% of reports), the police (approximately 10% of reports), employees of the Richmond City Jail (approximately 10% of reports), the juvenile or district court (approximately 10% of reports), the City Lock-up (approximately 5% of reports) or the Juvenile Detention Center (less than 1% of reports). Sometimes a report is made across sources before

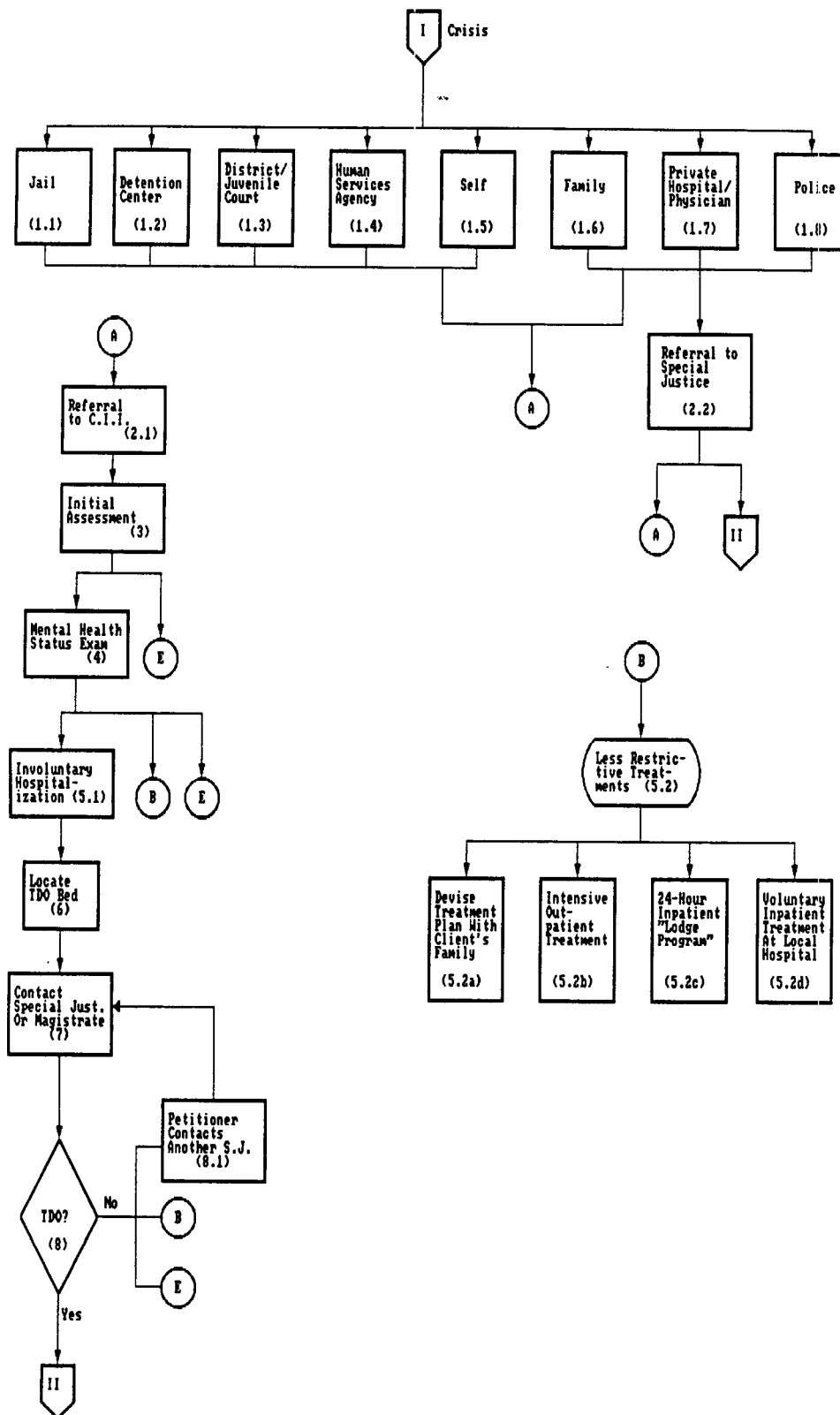


Figure 3-5.1 Emergency Mental Health Services and Involuntary Commitment Practices in the Richmond CSB - Crisis to Temporary Detention or Voluntary Care

it is referred for services. For example, a family member may contact the police,<sup>1</sup> who then may refer the individual in crisis to the Crisis Center (see below) for evaluation.

## 2. Referral of Crisis

Most reports of mental health crises eventually are made to Crisis Intervention/Intake (C.I.I.) of the Richmond Community Mental Health Center. In fiscal year 1988, C.I.I. responded to 23,844 telephone calls and 3,028 "walk-ins" to the office. In addition, C.I.I. made 927 home visits.<sup>2</sup> C.I.I. operates on a 24-hours basis and has a staff of seventeen therapists, two mental health case managers, and one administrative worker. At least three therapists usually are on duty daily except during the day shift (7:30 am to 3:30 pm) on Saturday and Sunday which is staffed with two therapists. Each therapist has completed a master's degree in psychology, social work, counseling, or a related field, has had one year or more of work-related experience, depending on the position, or has had an equivalent combination of training and experience.

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<sup>1</sup>There is some disagreement between the police and the Sheriff about who is primarily responsible for handling these cases. The Police Department maintains that Virginia Code (section 37.1-71 (1950)) holds the Sheriff's Department primarily responsible. The police interpret their role as backup when the Sheriff is not available. The Sheriff's Department, however, maintains that the Police Department has exclusive law enforcement responsibility (except within the jail) in the City of Richmond. The Sheriff does not patrol streets and is not contacted by the public (as it is in more rural areas) in emergency situations. Therefore, the Police Department, according to the Sheriff, is in a better position to respond to mental health emergencies.

<sup>2</sup>C.I.I. has a vehicle available for responding to mental health emergencies 24-hours a day. The vehicle is equipped with a cellular phone which helps C.I.I.'s response time.

Although the majority of referrals are made to C.I.I., in some cases C.I.I. is bypassed, and a report is made directly to a special justice. Most of these reports are made by private physicians and psychiatrists who have admitting privileges at one of Richmond's four private hospitals (Richmond Community Hospital, Richmond Metropolitan Hospital, Tucker's Pavilion at Chippenham Hospital and Westbrook Hospital) or the local public hospital (Medical College of Virginia) which all have psychiatric units.

The physicians directly contact a special justice or magistrate for the purpose of obtaining a temporary detention order (TDO). A TDO allows the physician to detain a patient until a judicial hearing determines whether the patient is in need of hospitalization. Reportedly, at least 35% to 50% of all TDO requests come directly from private physicians. The special justice will issue a detention order for a private physician only if: (1) the physician has admitting privileges at a hospital with a psychiatric ward and (2) the special justice is familiar with the mental health professional and is confident that he or she has the requisite credentials to properly request a TDO. If the requisitioning physician fails to meet either of these two criteria and the physician wishes to pursue a TDO further, the special justice will refer the private practitioner to C.I.I.

In addition to reports from private physicians, special justices receive direct requests (requests that have not been processed through C.I.I.) for

TDOs from the police (approximately 5% of all requested TDOs)<sup>3</sup> and, in rare cases, from a disgruntled family member (less than 1% of all requested TDOs). The special justice usually refers reports from police and family members to C.I.I.

### 3. Initial Assessment

When a referral is made to C.I.I., a therapist first tries to establish whether the person in crisis is within Richmond City limits and is a Richmond City resident. If the person is not within the city limits and is not a city resident and his or her situation is not deemed life-threatening, the C.I.I. therapist will refer the individual to the "correct" CSB. If the person is not a resident of Richmond City but is within city limits and his or her condition is very serious, the C.I.I. therapist will proceed with a mental health status examination and attempt to contact the appropriate CSB at the same time.

If the individual is a resident of Richmond City, the therapist will ascertain whether the individual is under the care of a private mental health professional. If so, C.I.I. will encourage the individual to contact his or her primary care provider. Because C.I.I. advertises that it is a 24-hour emergency facility, it often is contacted after regular business hours and on weekends even by individuals who already are under the care of a physician.

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<sup>3</sup>Because C.I.I. has a mobile unit that can bring a therapist to the scene of the crisis, the percentage of cases handled by the police without C.I.I. involvement is decreasing. In the past, the police either would have to arrest the person in crisis for some minor violation or contact a special justice for a TDO. Now if the police are with someone who is in crisis, they contact C.I.I., and C.I.I. will take charge of the situation. If the situation warrants a TDO, C.I.I. will contact the special justice.

If an individual already is receiving treatment from a private physician, C.I.I. will provide treatment only in a crisis situation when the private physician or the designated back-up cannot be reached.

During the initial assessment, the therapist will determine whether the individual needs to see someone immediately, whether the person can wait for a regular appointment with a therapist at the Mental Health Center or whether the crisis is over and the person is no longer in need of services. This determination is based on whether the person is a danger to him or herself or to others (e.g., any indications of violence or the involvement of weapons), whether immediate medical care is needed, whether there are other responsible individuals with the caller, and whether transportation is available. If the person has any immediate medical needs, the therapist will contact a local ambulance company or call "911". If the person's situation qualifies as a mental health crisis, the therapist will initiate a mental health status examination. If the person cannot or will not go to C.I.I. for an examination, a C.I.I. therapist will conduct an assessment on-site. C.I.I. has a 24-hour mobile unit available for this purpose.

#### 4. Preadmission Screening

If the C.I.I. therapist must conduct the mental health status examination on-site in a potentially violent situation (e.g., the individual in crisis has a history of violence or C.I.I. has been notified that the person is violent), police backup is requested. Police backup also is requested when a mental health status examination is conducted on a potentially violent person at the Crisis Center.

The mental health status examination includes a clinical assessment of

the person's mental health status, a review of services and treatment that previously have been provided and recommendations for further treatment. If voluntary or involuntary hospitalization is warranted given the results of the mental health status examination, the C.I.I. therapist will complete a Preadmission Screening Form on the individual. The statutory criteria for voluntary or involuntary hospitalization that are met in the case and the specific behaviors exhibited by the individual which led to the decision are recorded on the form.

#### 5. Results of the Preadmission Screening

The results of the mental health status examination indicate what type of treatment plan is warranted for the person. If the crisis has ended and the person is no longer in need of services, the person will exit the emergency services system at this point. If the person is in need of treatment, the evaluating therapist will suggest one of several options, starting with the least restrictive alternative appropriate for the case.

In the least serious cases, C.I.I. will devise a treatment plan involving the client's family. The client remains in the community, and the family is assisted in developing a better response to the client's mental illness or other psychiatric problem. In other cases, the client may be referred for intensive outpatient treatment. These treatment programs vary with individual needs (e.g., support system behavioral intervention planning, frequent therapy sessions or treatment contracts, day support programs, and medication management). For more serious cases, C.I.I. may recommend that the individual enter into the "Lodge" program, a 24-hour supervised care program. The "Lodge" program offers individualized treatment interventions within a

structured environment. The program is entirely voluntary; the client is not restrained and essentially is free to leave if he or she chooses to do so.

For the most serious cases, C.I.I. will recommend hospitalization. If hospitalization is necessary, the client is encouraged to go voluntarily. If the person has insurance or the ability to pay, C.I.I. will contact the local hospitals to determine whether bed space is available. The local hospitals include Richmond Community Hospital, Richmond Metropolitan Hospital, Tucker's Pavilion at Chippenham Hospital, Westbrook Hospital, and the Medical College of Virginia, a public hospital. In some cases, a voluntary admission is delayed until local bed space becomes available. If local bed space is not immediately available and the client's condition is critical, C.I.I. may recommend that the client enter the "Lodge" program for crisis stabilization. Reportedly, the availability of local beds for voluntary admission varies widely. Availability tends to be the worst during the winter months, especially after the holidays. Once a bed becomes available, C.I.I. arranges transportation for the client to the hospital and ensures that any necessary documentation, such as the client's prescription records and treatment plan, is forwarded to the hospital. Unless the client specifically requests treatment by another psychiatrist, the client will be under the care of a hospital psychiatrist who is under contract with C.I.I. If another psychiatrist is requested, C.I.I. will contact the doctor and ask him or her to arrange the client's admission to the hospital.

If the client is uninsured, the C.I.I. supervisor on-duty or the Richmond Community Mental Health Center Special Services Director must be contacted for authorization to issue a City Grant. Once the City Grant is authorized, C.I.I. contacts the local hospitals to determine bed space



availability. As is the case with insured clients, sometimes voluntary admission is delayed until a bed becomes available. In these cases, C.I.I. may recommend that the uninsured client enter the "Lodge" program while waiting for voluntary admission to a hospital. When a hospital bed becomes available, C.I.I. arranges or provides transportation for the client to the hospital. A C.I.I. staff member or responsible family member or friend accompanies the client to the hospital. The admissions office at the hospital is notified that the client will be admitted under a City Grant and is provided with any other necessary information (e.g., prescription records, treatment plans) about the client. The client must sign a City Payment Authorization Agreement which is submitted to the C.I.I. Supervisor. All voluntary City Grant clients are under the care of the Richmond Community Mental Health Center contract psychiatrists at the hospital unless a client specifically requests treatment by another psychiatrist. If another psychiatrist is requested, the psychiatrist is contacted to arrange the client's admission. These "non-contract" psychiatrists also are paid by the Richmond Community Mental Health Center.

If the mental health status examination indicates that the client meets the State's guidelines for hospitalization, but the client refuses to go voluntarily, the procedures for obtaining a TDO are initiated. A description of these procedures follows.

6. Temporary Detention Bed Located

If C.I.I. recommends hospitalization and the client refuses to go voluntarily, the C.I.I. therapist will seek a TDO. In order to request a TDO, the C.I.I. therapist first must locate an available detention bed. The C.I.I.

therapist will attempt to secure a detention bed in one of the five Richmond hospitals first. Each of these facilities is licensed by the Department of Mental Health and is, by contract, willing to accept individuals under detention orders. If a client is detained at one of these facilities, the Supreme Court of Virginia will reimburse the hospital at a fixed rate for the client's stay.

If there are no TDO beds available in the Richmond hospitals, the client is detained at Central State Hospital. Reportedly, this happens only 15 to 20 times a year. If a person is detained at Central State, the commitment hearing will be conducted at Central State Hospital by the special justice for Dinwiddie County. Thus, it is possible that an individual presenting in crisis in Richmond may be detained and eventually subjected to a commitment hearing conducted outside of the Richmond area.

Occasionally a veteran will be detained at the Hunter Holmes McGuire Veterans Administration Medical Center if the veteran already is a patient there. However, no veteran is ever ordered to be transported to the McGuire Medical Center; the Medical Center does not accept TDOs on veterans from the community.

In general, if a person suffers a mental health crisis in the Richmond City Jail while on trial for a violent offense, the case will be handled through the criminal justice system. If a person is charged with a less serious offense, the mental health crisis may be handled through the civil justice system.<sup>4</sup> In these cases, the psychiatrist at the jail will examine

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<sup>4</sup>There was some disagreement over which cases involving mental health crises are handled by the civil justice system and which are handled by the criminal justice system. One interviewee indicated that anyone charged with a felony or serious misdemeanor would be processed through the criminal justice system. Another indicated that any adult person in need of commitment is

the individual in crisis and, if necessary, contact a special justice for a TDO. Depending on how dangerous the individual is, the special justice will order the person to be detained at one of the Richmond hospitals or will order the person to be detained in the jail. If a hospital bed is not available or the hospital considers the individual too dangerous, the person will be detained in jail.

7. Conference with Special Justice or Magistrate

Once the availability of TDO beds is known, the C.I.I. therapist will contact a special justice or magistrate. Special justices are contacted between 7:00 am Monday and 12:00 pm Saturday; magistrates are contacted during the remaining hours. The C.I.I. therapist will provide the special justice or magistrate with information regarding the client's symptoms and medical needs and the availability of TDO beds.

When a special justice is on duty, private sector professionals may contact the justice directly or go through C.I.I. to obtain a TDO. When a private physician requests a TDO directly from a special justice, the physician supplies the information that C.I.I. provides. As explained under step two, a private physician must have admitting privileges with a hospital's psychiatric ward to detain a patient. In some cases, the patient already is hospitalized and the physician is seeking to change the patient's status from

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within the special justice's jurisdiction. Finally, another interviewee indicated that individuals experiencing a mental health crisis who were convicted of a violent felony offense, were handled through the criminal system and individuals convicted of non-violent felony or misdemeanor offenses were handled through the civil system. In general, though, violent offenders are processed through the criminal justice system, and non-violent offenders are processed through the civil justice system.

voluntary to involuntary. In these cases, the physician generally will request that the patient be detained in the hospital in which the patient has been receiving treatment.

During hours when special justices are not on duty, private sector professionals such as physicians, nurses, social workers, and emergency room workers must call C.I.I. to obtain a TDO for a client. If a TDO bed already has been located and arrangements have been made for the client's hospitalization, C.I.I. has been instructed by the special justices to grant the request without first screening it for less restrictive alternatives. The C.I.I. therapist completes a prescreening form on the client and walks downstairs to the magistrate's office to secure the TDO.

In rare cases, a law enforcement officer or a family member will contact a special justice directly. In these cases, if the special justice decides detention is warranted, the special justice will check on hospital bed availability before issuing the detention order.<sup>5</sup>

#### 8. Decision to Issue Temporary Detention Order

Requests for TDOs by C.I.I. therapists usually are granted. In fiscal year 1988, C.I.I. detained 1,124 clients. In a few cases, requests are denied because the special justice or magistrate has had prior experience with the client and does not think the client can be committed, or the special justice or magistrate does not think the C.I.I. therapist has enough information to warrant a TDO. If C.I.I. petitions for a TDO and the petition is denied, the client usually is referred to one of C.I.I.'s alternative treatment programs.

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<sup>5</sup>Usually family members are referred to C.I.I., and C.I.I. contacts a special justice to request a TDO for the individual in crisis.

If the petition of a private physician, a police officer or a family member is denied, the individual may be referred to C.I.I. for other treatment, the individual may exit the emergency services system, or the petitioning party may try to contact another special justice. Private physicians account for 35% to 50% of all TDO requests. Some of the physicians request the TDO through C.I.I., but most request it directly from a special justice.

#### From Temporary Detention Through Provision of Inpatient Services

Phase two includes five major steps involved in temporarily detaining a person prior to a commitment hearing. These five steps are presented in Figure 3-5.2.

#### 9. Issuance of Temporary Detention Order

Once a TDO is issued, the police will go to the special justice's office or home to pick up the order.<sup>6</sup> If the special justice is holding commitment hearings, the police will have to meet the special justice at one of the Richmond hospitals to obtain the order. If the TDO was issued by a magistrate, the police will pick up the order from the magistrate's office which is located in the same building as the Police Department and C.I.I. As a rule, the police will not transport a client to a detention facility without possessing the order. However, one person interviewed noted that an exception to this rule occurs when the police already are on the scene of a case involving a violent or suicidal individual. In these cases, the officer will

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<sup>6</sup>One special justice has a FAX machine in his home. If he is home when a TDO is requested, he uses the machine to send a copy of the warrant to the police. In these cases, the original TDO documents are delivered to the hospital the same or next day for use in the commitment hearing.

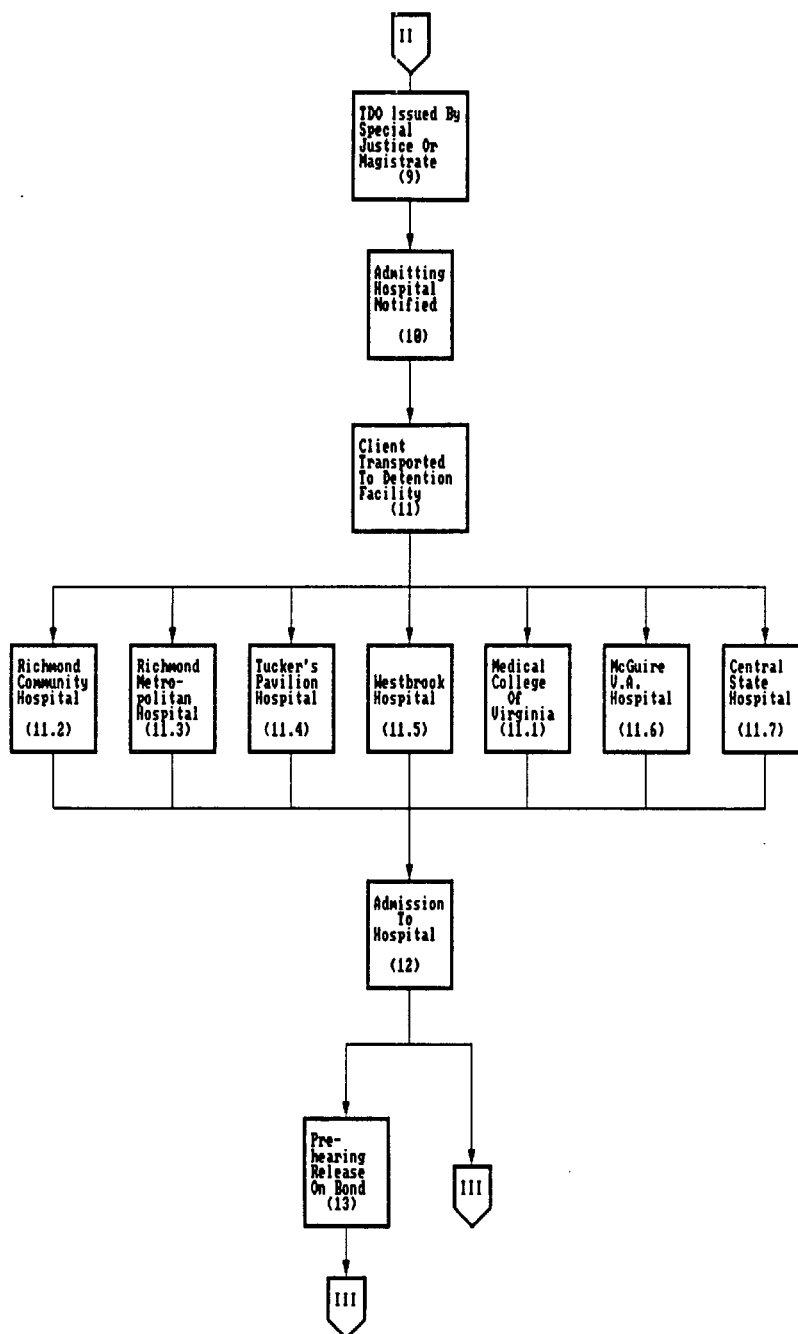


Figure 3-5.2 Emergency Mental Health Services and Involuntary Commitment Practices in the Richmond CSB - Temporary Detention Through Inpatient Services

request a TDO, transport the client to the designated hospital, and serve the TDO when the client arrives at the hospital.<sup>7</sup>

10. Admitting Hospital Notified

C.I.I. contracts with psychiatrists to provide care for TDO clients at each of the private Richmond hospitals. These contract psychiatrists are "Insight Physicians" and other individual psychiatrists working in the Richmond Community Mental Health Center Medication Unit. Once the special justice or magistrate decides to issue a TDO and selects the hospital for temporary detainment, the C.I.I. therapist will contact the Insight or other contract doctor on-call for the admitting hospital to reserve a bed for the client. C.I.I. also will give this doctor information on the client's medical status and psychiatric symptoms.

The police also contact the hospital to let staff know that officers will be transporting a client there. During the call, the police make sure that a bed will be available for the client upon arrival.

11. Transportation to Detention Facility

Upon receipt of the TDO, the police will pick up the client and transport him or her to the Richmond detention facility designated on the order: Richmond Community Hospital, Richmond Metropolitan Hospital, Tucker's Pavilion at Chippenham Hospital, Westbrook Hospital, or the Medical College of

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<sup>7</sup>During business hours, the client usually is transported to the hospital where the special justice is conducting commitment hearings. The special justice prepares the TDO, leaves it with a receptionist at the hospital, and the officer picks it up when he or she delivers the client to the hospital. When a special justice is not already at a hospital, a second police unit will pick up the TDO and meet the first unit at the designated hospital.

Virginia. If the client already is a patient at the McGuire Veterans Administration Medical Center, the TDO will be delivered there. If there are no local beds available, the Sheriff, rather than the police, will transport the client to Central State Hospital. If the client needs medical attention, the TDO will specify that the client be brought to the Medical College of Virginia's emergency room before being taken to the detention facility. The police stay with the client while the client receives medical treatment and then transport the client to the designated hospital.<sup>8</sup>

The police do not use handcuffs or other restraints unless they think it is necessary for their own or the client's safety or to prevent the client from running away. If the client is extremely violent, the police will call an ambulance and strap the client to a stretcher. A police officer will escort the ambulance to the hospital and, if necessary, a police officer will ride in the ambulance with the client. Generally, however, clients are transported to the detention hospital in the "Patrol Wagon" which is run by officers who are more experienced with transporting clients with mental health problems than the average officer.

## 12. Admission

After arriving at the designated facility, the police officer will stay with the client until the appropriate hospital official takes custody of the individual. Sometimes the police officer will escort the client to the designated hospital room. Before leaving the hospital, the officer will sign

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<sup>8</sup>In some cases, the Medical College police will stay with the client while the client is waiting for medical treatment. Once the client has recieved treatment, the City police return to transport the client to the detention hospital.



the TDO and give it to the appropriate hospital official. The patient is admitted and screened for any medical conditions or problems by the Insight or other contract psychiatrist. The psychiatrist conducts a psychiatric examination and provides treatment as necessary. This treatment may include the administration of psychotropic drugs and sedatives. The purpose of the treatment is to speed the client's recovery and eventual release from the system.

#### 13. Precommitment-hearing Release

In rare cases, a special justice will consider releasing a client from the hospital on bond. In these cases the special justice is persuaded that the client does not need to remain in the hospital in order to ensure the client's presence at the commitment hearing. If the special justice is able to obtain the services of an attorney and secure a hearing time at the detention facility, a bond hearing will be conducted. Clients released on bond must attend a commitment hearing, usually scheduled for the next day. A commitment hearing never is cancelled once a TDO has been issued.

#### Preparation for and Conduct of Judicial Hearings

This phase includes four major steps involved in conducting a judicial commitment hearing. They are presented in Figure 3-5.3.

#### 14. Preparation for Judicial Hearing

The commitment hearing takes place at the detention facility where the client is being held. Hearings are conducted Monday through Saturday on an

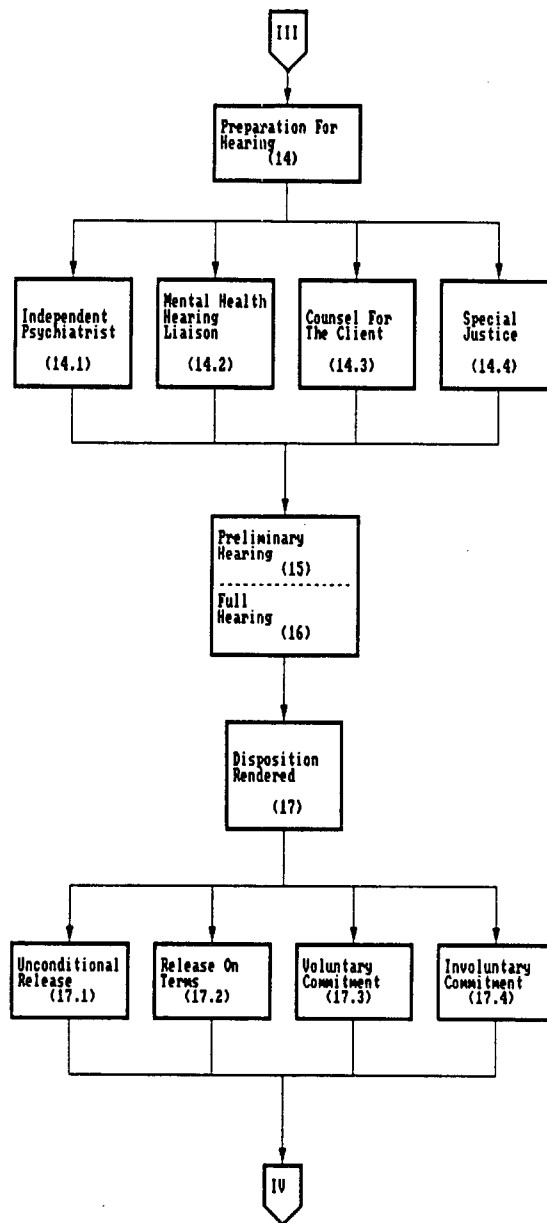


Figure 3-5.3 Emergency Mental Health Services and Involuntary Commitment Practices in the Richmond CSB - Preparation for and Conduct of Judicial Hearings

Prior to the commitment hearing, the Hearing Liaison reviews the client's case and helps prepare the client for the upcoming hearing. He researches the client's background for information that could be helpful to the client in obtaining a less restrictive alternative to commitment. He also picks up the client's Preadmission Screening Form completed by C.I.I., determines whether the client has insurance or whether he needs to be considered for a City Grant, and checks on the availability of beds at the various hospitals. At the hospital, the Hearing Liaison provides the social workers with client information such as the client's medication history and prior case history.

#### 14.3 Counsel for the Client

In over 99% of the cases, clients are represented by court-appointed attorneys. The court-appointed attorneys rotate on a weekly basis with the special justices. Two of the special justices each work with one attorney. The third special justice divides the cases between two attorneys. As noted earlier, the attorney interviews the client with the independent psychiatrist. Generally, the attorneys try to meet with clients on the day before and the day of the hearing. However, the number of times the client is interviewed depends on the attorney's schedule. If the day's scheduled hearings last longer than 5:00 pm, the attorney and the independent psychiatrist will not have a chance to meet with the client before the next day.

#### 14.4 Special Justice

Immediately prior to the hearing, the special justice arrives at the hospital facility and reviews each client's petition and treatment file. The

special justice certifies that the independent psychiatrist and the client's counsel are present and have interviewed the client. Once he has certified the petition, the special justice sets the docket for the hearings at that facility. Cases involving many family members, many witnesses or witnesses (e.g., social workers) from other jurisdictions are heard first in order to keep as few people waiting as possible.<sup>9</sup>

#### 15. Preliminary Judicial Hearing

The special justice begins every proceeding by informing the client of the right to counsel, to a de novo appeal and to a jury on de novo appeal. The special justice explains the nature of the proceedings and the reasons for the client's detention. Once this information is provided, the special justice asks if the client is willing to be admitted to a hospital on a voluntary basis. If the client is willing to accept voluntary admission, the special justice asks the independent psychiatrist whether the client has the requisite mental ability to properly make that decision. If the psychiatrist testifies that the client is capable of making the decision, two of the special justices end the hearing at this point. The third special justice conducts an abbreviated full hearing to determine whether voluntary admission is in the best interest of the client. This consists of asking the client's counsel, and others as appropriate for the case, if voluntary admission is agreeable. If it is agreeable to all parties, as it almost invariably is, the special justice will end the hearing.

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<sup>9</sup>During this time, the special justice also will respond to requests for detention orders that were received enroute to the hospital. The justice prepares the orders and leaves them with the receptionist at the hospital for later retrieval by the police.

If voluntary admission is appropriate, the hearing will end with an explanation of the procedures for voluntary admission. If the special justice denies voluntary admission or the client has refused voluntary admission, the full hearing continues.

16. Full Judicial Hearing

The special justice will ask the independent psychiatrist if he wishes to make a summary statement regarding the client's mental state and behavior. If the psychiatrist consents, the testimony is subject to cross-examination by the client's counsel. In most cases, the independent psychiatrist will choose to interview the client rather than offering a summary statement. The psychiatrist will ask the client questions that indicate the client's mental state and possible compliance with statutory requirements for commitment. This testimony also is subject to cross-examination by the client's attorney. Following the independent psychiatrist's summary statement or interview of the client, counsel may call and directly examine any witnesses for the client's case. These witnesses may include the independent psychiatrist, members of the client's family, social or mental health workers, the Hearing Liaison or any other person with testimony relevant to the client's case. All witnesses are sworn in before offering testimony. Immediately following the testimony, counsel will present his closing argument and attempt to demonstrate why involuntary commitment is not warranted.

The average hearing takes approximately one-half hour. This includes the time it takes to interview the client in preparation for the hearing, the preliminary hearing and the full hearing. If a client decides to go to a hospital voluntarily, the hearing may take only two or three minutes.

If voluntary admission is appropriate, the hearing will end with an explanation of the procedures for voluntary admission. If the special justice denies voluntary admission or the client has refused voluntary admission, the full hearing continues.

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17. Disposition Rendered

Once the evidence has been presented and the closing argument heard, the special justice will enter his decision. The special justice will explain the reasons for, and the consequences of, his decision to the client. If it is clear that the client is catatonic or otherwise unable to understand the explanation, the special justice will waive the explanation. If the client is coherent and the hearing has resulted in commitment, the special justice again will inform the client of the client's right to an appeal and the procedures for obtaining an appeal.

The special justice will order one of four dispositions. First, the special justice may release the respondent unconditionally. Second, the special justice may release the respondent on terms. These terms generally are directions to the client to seek future medical care or outpatient psychiatric care on a regular basis. Third, if the client is willing and capable of accepting voluntary admission and the special justice is convinced that voluntary admission is in the best interest of the client, the special justice will order voluntary hospitalization. Finally, the special justice may order the client to be committed to one of the five mental health facilities or Central State Hospital for a period not to exceed 180 days.

In 1988, there were 2,418 commitment hearings. Of these, 865 cases (35.8%) were released or released on terms, 532 cases (22.0%) were voluntarily committed to a hospital, and 1,021 cases (42.2%) were involuntarily committed to a hospital.

## Post-Hearing Matters

This phase includes what happens once the special justice or magistrate enters a disposition on the case. The two major steps included in this phase are presented in Figure 3-5.4.

### 18. Disposition Documented

Immediately following the hearing, the Mental Health Hearing Liaison updates the Preadmission Screening Form. The Preadmission Screening Form is returned to C.I.I. and placed in the client's case file. C.I.I. retains a Preadmission Screening Form for any individual who was temporarily detained, even if the TDO was requested by a private physician.

The Hearing Liaison also completes a Disposition Form on the client. This form records the independent psychiatrist's diagnosis, the diagnosis of the treating psychiatrist during the client's detention at the hospital, any medications the client received during detention and any discharge recommendations. This form is sent to the client's primary care provider (either a private physician or a therapist with the Richmond Community Mental Health Center) or kept at the hospital if the client is continuing treatment there.

### 19. Disposition Enacted

If the client is ordered released, the client is free to leave the hospital once a nurse obtains a discharge order from a doctor. At this point, the client exits the system.



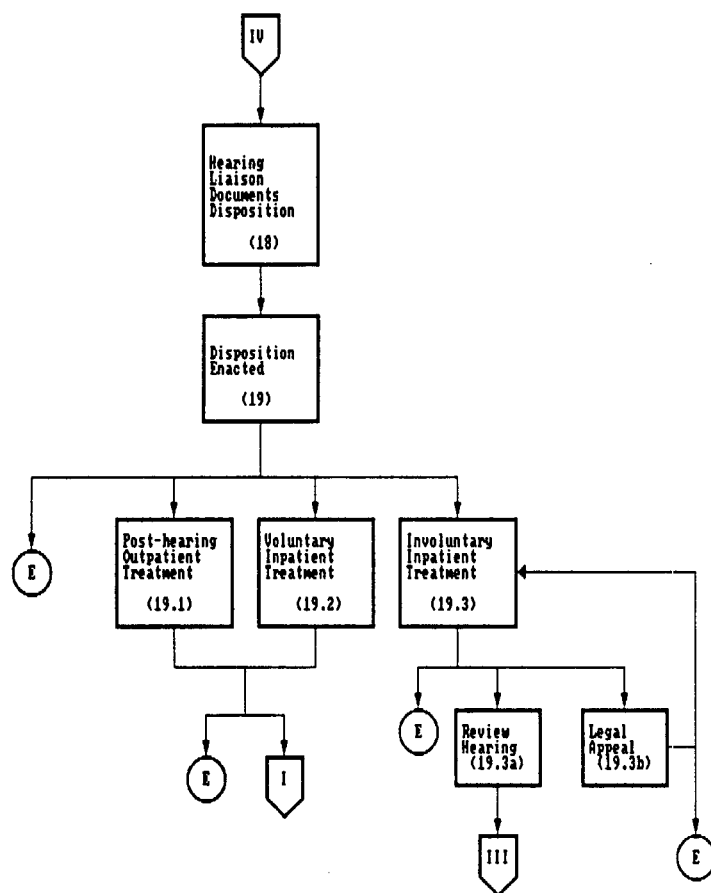


Figure 3-5.4 Emergency Mental Health Services and Involuntary Commitment Practices in the Richmond CSB - Post-Hearing Matters

### 19.1 Post-Hearing Outpatient Treatment

If the client is released with instructions to seek outpatient treatment, and the client is not under the care of a private physician, the Mental Health Hearing Liaison will instruct the client to contact C.I.I. to set up an appointment for follow-up treatment. The Hearing Liaison also notifies C.I.I. of the disposition by phone immediately following the hearing. If the client is under the care of a private physician, the Hearing Liaison notifies the client's doctor about the disposition. If the client is from another CSB, the Hearing Liaison will contact that CSB about the disposition of the case.

In some cases, the client is given a discharge prescription by the physician at the detention hospital. If the client needs the medication immediately, the client will be referred to C.I.I. to obtain the medication from the Richmond Community Mental Health Center outpatient pharmacy. In these cases, a C.I.I. therapist will meet with the client and schedule sessions for post-hospitalization treatment or, if the client already is under treatment, refer the client to his or her primary service provider. The client's Preadmission Screening Form and Disposition Form are transported to C.I.I. with the client.

If a client does not seek outpatient treatment, C.I.I. will write or phone to remind the client of the terms of the disposition. Generally, however, C.I.I. does not have the manpower to make field visits to follow-up with each noncompliant client who is released on terms. Because the special justices cannot hold these clients in contempt for failing to follow through with treatment, the special justices cannot regain jurisdiction over these

clients unless they present in crisis and are temporarily detained again. This is considered one of the biggest problems with the system by both mental health and judicial professionals practicing in the system.

### 19.2 Voluntary Inpatient Treatment

If the client volunteers for hospitalization, he or she usually stays in the hospital where the commitment hearing took place. This ensures continuity of treatment for the client. In these cases, the Hearing Liaison notifies the nursing staff of the hospital. If the client cannot pay for hospitalization,<sup>10</sup> a City Grant may be prepared. These are awarded for voluntary hospitalization on a case-by-case basis. If the client must go to another hospital, the Hearing Liaison will arrange transportation for the client with the Sheriff and notify the receiving hospital.

The client must remain in the hospital for a minimum period set by the special justice not to exceed 72 hours unless the treating physician is willing to release the client before then. If at the end of 72 hours the client wants to leave but the treating physician disagrees, the physician may request that the client be held on a TDO. If the client participates in another commitment hearing as a result of a second TDO, the client is not given the opportunity to accept voluntary hospitalization.

### 19.3 Involuntary Inpatient Treatment

If the special justice orders that the client be committed to a

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<sup>10</sup>The state hospitals rarely take voluntary clients. Because of the limited number of available beds, involuntary clients are given priority over voluntary clients.

hospital, the client will stay at the facility where the hearing took place unless there are no beds or the client has no insurance. The Hearing Liaison determines whether a client has insurance and what hospitals are willing to take that insurance. Some of the local hospitals are not equipped to provide intensive, acute medical care (e.g., Westbrook Hospital); therefore, if the client has medical and psychological problems, he or she would not be committed to these facilities. If the client is indigent and has no insurance or the client was in jail when the mental health crisis occurred, the client will be committed to a state facility. Usually these clients are committed to Central State Hospital. When Central State is full, clients are sent to Eastern State Hospital. Based on information provided by the Hearing Liaison, the special justice determines where the client will be committed and notes the name of the facility on the order. Whether the client is committed to another hospital in Richmond or to a state hospital, the Hearing Liaison will call the Sheriff to arrange transportation.

One officer in the Sheriff's Department primarily is in charge of transporting these clients to the hospital. Reportedly, he has a good rapport with the clients and, consequently, can transport more than one at a time without incident. Generally, clients are not handcuffed unless they are violent.<sup>11</sup> If a client is extremely violent, the Sheriff will call an ambulance and the client will be transported to the hospital strapped to a stretcher. Each client's medical records from the detention hospital, the order signed by the special justice, and any other paperwork that the hospital might have on the client also are transported with the client and given to the

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<sup>11</sup>Clients who are in jail on criminal charges are required to wear handcuffs and leg irons when they are transported to a hospital.

admitting official at the receiving hospital.

Occasionally, the staff at the hospital designated in the commitment order will discover that the client does not have the requisite insurance. In these cases, the hospital staff will contact the special justice and notify him of the mistake. The special justice will advise the client's counsel and will determine whether to hold another hearing to determine an appropriate commitment facility or simply amend the order to designate another facility.

Once the client is admitted to the hospital, he or she is held for 180 days or until a physician decides that the client no longer meets the commitment criteria, whichever is shorter.<sup>12</sup> If the client is still in the hospital at the end of the 180-day commitment period, the client's case will be reviewed to determine if commitment should be continued. The client also may appeal the decision of the original commitment hearing within thirty days of the order. One special justice noted that, at most, ten of his cases had been appealed during a two-and-one-half-year period. One of these included an appeal by a client the special justice refused to commit.

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<sup>12</sup>It is very rare for a client to remain in a private hospital for 180 days. Usually the client will run out of insurance before this time. If the client is very sick, the client is transferred "laterally" by the private hospital to the state hospital or discharged by the private hospital to a residential placement. If the client is discharged and continues to have problems, he or she may be detained for another commitment hearing. If the client has no insurance at this point, he or she probably will be committed to the state hospital.

## PART IV

### SURVEY OF EMERGENCY MENTAL HEALTH SERVICES AND INVOLUNTARY CIVIL COMMITMENT PRACTICES IN VIRGINIA

In order to provide a broad perspective of emergency mental health services and commitment practices throughout Virginia to complement the in-depth information obtained from the five study sites, a state-wide survey of CSB practitioners, special justices and Affiliate Presidents of the Virginia Alliance for the Mentally Ill (VAMI) was conducted. The survey instrument was based on the preliminary graphic and narrative descriptions of the five study sites. In consultation with DMHMRSAS, the instrument was revised several times, and the final version is presented in Appendix A.

The questionnaire was sent to the Executive Director of each of the 40 CSBs,<sup>1</sup> 89 special justices who conduct involuntary civil commitment hearings in Virginia,<sup>2</sup> and 17 Affiliate Presidents (1988-1989) of VAMI. Of these, 33 or 82.5% of the CSB professionals returned the questionnaire, 32 or 35.9% of the special justices returned the questionnaire, and 8 or 47.0% of the Affiliate Presidents returned the questionnaire. Although the VAMI representatives were not expected to know the factual answer to a number of the survey questions, they were included in the sample of respondents in order to obtain their general impressions of the system. Because the number of

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<sup>1</sup>The Executive Directors were asked to forward the survey to an individual in the CSB who had knowledge of the provision of emergency mental health services. Generally, the surveys were completed by the CSB's Mental Health Director or a mental health professional from a crisis intervention center. In discussing the results of the survey, CSB professionals and mental health professionals are used interchangeably.

<sup>2</sup>The list of special justices was obtained from the Executive Secretary of the Supreme Court of Virginia.

surveys from the VAMI representatives was small and because many of the items were left blank, they were not analyzed separately. However, their comments to the open-ended questions are included with those of the other respondents in Appendix B.

The results of the survey are presented in the same general format as the other parts of this report. The survey questions (see Appendix A) and responses are divided into the four phases: crisis to temporary detention, voluntary care or release; temporary detention through provision of inpatient services; preparation of and conduct of judicial hearings; and post-hearing matters.

#### From Crisis to Temporary Detention, Voluntary Care Or Release

This phase includes the events that take place between the occurrence of a mental health emergency and the decision to provide voluntary care or to request that the individual in crisis be temporarily detained.

##### 1. Point of Initial Contact and Referral

Reports of mental health crises in Virginia typically come from family members, law enforcement personnel, public mental health centers/CSBs, public hospitals, private hospitals, and private physicians. In addition to these sources, survey respondents listed over 25 other sources of reports of mental health crises: social and human services agencies, churches and religious organizations, community "hotlines", colleges and universities, private industry, adult homes, shelters, friends, judges, special justices, magistrates, attorneys, courts, jails, the Fire and Rescue Department and National Airport.

## 2. Primary Referral Agencies

Generally, these reports of mental health crises are referred to one or two "clearinghouse" facilities in each CSB. Twenty-three or almost 70% of the survey respondents from the CSBs listed one or two clearinghouse facilities; the remaining respondents from the CSBs listed as few as three and as many as nine facilities. None of the special justices listed more than three facilities. The most frequently mentioned clearinghouse facilities were CSB mental health and crisis intervention centers and hospital emergency rooms. A few respondents also identified state hospitals, private mental health facilities, law enforcement agencies and jails as clearinghouse facilities in their respective communities.

The majority of the CSB respondents indicated that at least 10% or more of the referrals to the clearinghouse facilities are made by the individual in crisis, family members, law enforcement personnel, jail employees, social services agencies and private hospitals. The list was shorter for the majority of special justices: the individual in crisis, family members, law enforcement personnel and community mental health centers. The CSB respondents also estimated the number of individuals who are under the care of a private practitioner when the individuals are referred to a mental health clearinghouse facility for services. Across CSBs, an average of 14.4% of the cases are considered "private sector" cases. Estimates ranged from less than 1% of the cases to 70% of the cases, depending on the CSB.<sup>3</sup>

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<sup>3</sup>Percentages are based on 31 responses from mental health professionals.



### 3. Initial Assessment/Mental Health Status Examination

All of the mental health professionals and 76.7% of the special justices<sup>4</sup> indicated that face-to-face preadmission screening was available 24-hours a day. It was the opinion of the remaining special justices that face-to-face preadmission screening was available only during business hours, Monday through Friday.

In some cases, the preadmission screening indicates that hospitalization is warranted for the person in crisis. If the person is not willing to go to a hospital, the person may be detained temporarily until a commitment hearing determines whether hospitalization is necessary. Typically, the preadmission screening takes place before temporary detention is ordered. This is supported by the data in Table 1: 58.3% of the respondents indicated that the preadmission screening takes place in 90% or more of the cases before temporary detention. However, a number of special justices (51.8%) and a few mental health professionals (12.1%) did indicate that, in their jurisdictions, preadmission screening occurred after temporary detention in at least 25% of the cases.

### 4. Treatment Decision

Both mental health professionals and special justices indicated that the most frequently used crisis intervention options are voluntary outpatient mental health care and voluntary substance abuse services (see Table 2). Both groups rated involuntary temporary detention as the next most often pursued option.

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<sup>4</sup>The percentage is based on the responses of 30 special justices.

Table 1  
Percentage of Time Preadmission Screening  
Is Conducted After Temporary Detention

	CSB Professionals	Special Justices	All Respondents
Never			
-----	8	4	12
-----	24.2%	14.8%	20.0%
Less than 10% of the time			
-----	16	7	23
-----	48.5%	25.9%	38.3%
Between 10% and 25% of the time			
-----	5	2	7
-----	15.2%	7.4%	11.7%
Between 25% and 50% of the time			
-----	3	3	6
-----	9.1%	11.1%	10.0%
More than 50% of the time			
-----	1	11	12
-----	3.0%	40.7%	20.0%
Total number of respondents			
-----	33	27	60
-----	100.0%	100.0%	100.0%

Table 2  
The Frequency\* With Which  
Various Crisis Intervention Options Are Used

	CSB Professionals	Special Justices	All Respondents
Voluntary outpatient mental health care			
Average Frequency Ranking-	1.3	2.4	1.7
Number of Respondents-----	32	16	48
Voluntary substance abuse services			
Average Frequency Ranking-	2.6	3.3	2.9
Number of Respondents-----	32	16	48
Housing, food, clothing, transportation assistance			
Average Frequency Ranking-	4.7	6.1	5.1
Number of Respondents-----	28	10	38
Medical services			
Average Frequency Ranking-	5.8	5.0	5.6
Number of Respondents-----	27	11	38
Social services			
Average Frequency Ranking-	5.0	5.2	5.0
Number of Respondents-----	29	14	43
Voluntary inpatient hospitalization			
Average Frequency Ranking-	4.4	4.7	4.5
Number of Respondents-----	30	13	43
Involuntary detention (TDO)			
Average Frequency Ranking-	4.2	4.1	4.1
Number of Respondents-----	30	17	47

\*Options were rated from 1 to 10  
with 1=most frequently used and 10=least frequently used

Respondents also were asked to rate how often, if ever, identified problems interfered in the delivery of emergency services in their respective CSBs and jurisdictions. Their responses are summarized in Table 3. Both groups rated the "lack of intensive pre-crisis care and support" and the "lack of specialized services for special needs groups" as the most frequently occurring problems. The special justices rated the "unavailability of a face-to-face response" as a problem slightly more often than the mental health professionals. This finding may be related to the finding, noted earlier, that some special justices think face-to-face preadmission screening is unavailable in their jurisdictions on a 24-hour basis. Finally, "unqualified staff" was considered the least frequently occurring problem by both groups.

Twelve of the mental health professionals and four of the special justices listed other problems encountered in the delivery of emergency mental health services. These include: transportation and "outreach" problems; too few staff, attorneys and physicians; the unavailability of judges; the inconsistent interpretation of the Code of Virginia across counties; uncooperative family members; a lack of less restrictive alternatives, available facilities and available beds; and the refusal of state hospitals to take patients when other alternatives have been exhausted.

##### 5. Conference with Judge, Special Justice or Magistrate

If hospitalization is recommended for the person in crisis but the person refuses to go voluntarily, a temporary detention order (TDO) usually is requested. The TDO allows a hospital to detain a person for a short period of time during which a judicial hearing is held to determine whether the person is in need of hospitalization. In order to obtain a TDO, the mental health

Table 3  
 Rated Frequency\* of Potential Problems  
 Occurring in the Delivery of Emergency Services

	CSB Professionals	Special Justices	All Respondents
Untimely response to crisis			
Average Frequency Rating----	1.8	1.6	1.7
Number of Respondents-----	33	24	57
Unqualified staff			
Average Frequency Rating----	1.2	1.3	1.2
Number of Respondents-----	33	25	58
Lack of "pre-crisis" care			
Average Frequency Rating----	2.2	2.0	2.1
Number of Respondents-----	32	23	55
Face-to-face response unavailable			
Average Frequency Rating----	1.4	1.8	1.6
Number of Respondents-----	33	24	57
Conflicts between agencies			
Average Frequency Rating----	2.0	1.7	1.9
Number of Respondents-----	33	24	57
Lack of services for special needs groups			
Average Frequency Rating----	2.2	2.1	2.2
Number of Respondents-----	33	23	56

\*Frequency of problems was rated from 1 to 3  
 with 1=never and 3=often

professional must contact a judicial officer. All of the mental health professionals indicated that they request TDOs from magistrates; 51.5% also request TDOs from special justices; 39.4% request TDOs from district court judges; and 9.1% request TDOs from "other" sources. Of the 32 special justices responding, 87.5% reported that they are requested to issue TDOs, 56.3% reported that magistrates are requested to issue TDOs, 18.8% reported that district court judges are contacted to issue TDOs, and 9.4% reported that someone else is contacted. Based on these data, more CSB professionals contact magistrates and fewer contact special justices than the special justices realize.

The CSB professionals report that an average of 26.9% of the requests for temporary detention are made by phone and 71.6% are made in-person. On the other hand, the special justices report that an average of 63.3% of the requests are made by phone, and 36.7% are made in-person.<sup>5</sup> A possible explanation for the discrepancy between the two groups' estimates may be that CSB professionals contact magistrates more often in-person and special justices more often by phone.

#### 6. Decision to Issue Temporary Detention Order

The CSB professionals estimated that, on average, 51.8%<sup>6</sup> of preadmission screenings result in a recommendation for temporary detention. The special

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<sup>5</sup>The averages are based on the responses of 24 special justices.

<sup>6</sup>The average is based on the responses of 29 mental health professionals. The estimates ranged from 6% to 95%.

justices estimated that, on average, 70.1%<sup>7</sup> result in a TDO recommendation. Table 4 indicates that 87.9% of the CSB professionals and 65.6% of the special justices reported that the prescreener's advice regarding temporary detention is taken in 90% or more of the cases.

According to the Code of Virginia (37.1-67.1), a detention order is not necessary if the person in crisis can be brought conveniently before a judge, special justice or magistrate. Table 5 indicates that the majority of respondents report that this is rarely, if ever, done.

#### From Temporary Detention Through Provision of Inpatient Services

This phase includes the procedures and decisions involved in temporarily detaining an individual.

#### 7. Issuance of Temporary Detention Order

The TDO indicates the name of the facility in which the person will be detained. The person usually is detained in a public, private or state hospital. CSB professionals identified an average of 3.6 facilities within their respective CSBs that are willing to take individuals under a TDO. The number of facilities identified across CSBs ranged from zero<sup>8</sup> to nine. Special justices identified fewer facilities willing to take individuals on a TDO. On average<sup>9</sup>, they listed 2.6 facilities, and their responses ranged only

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<sup>7</sup>The average is based on the responses of 23 special justices. The estimates ranged from 2% to 100%.

<sup>8</sup>Four respondents indicated that there were no public or private facilities within their respective CSBs that are willing to take individuals on a temporary detention basis.

<sup>9</sup>The average is based on 29 responses.

Table 4  
Percentage of Time Judge\* Takes Prescreeners's  
Recommendation for Temporary Detention

	CSB Professionals	Special Justices	All Respondents
Almost always			
-----	22	12	34
-----	66.7%	37.5%	52.3%
More than 90% of the time			
-----	7	9	16
-----	21.2%	28.1%	24.6%
Between 75% and 90% of the time			
-----	4	9	13
-----	12.1%	28.1%	20.0%
Less than 75% of the time			
-----	0	2	2
-----	.0%	6.3%	3.1%
Total number of respondents			
-----	33	32	65
-----	100.0%	100.0%	100.0%

\*District court judge, special justice or magistrate



Table 5  
Percentage of Time an Individual Is Brought Before a Judge\*  
Before a Temporary Detention Order Is Issued

	CSB Professionals	Special Justices	All Respondents
Never			
-----	14	7	21
-----	43.8%	23.3%	33.9%
Less than 5% of the time			
-----	14	12	26
-----	43.8%	40.0%	41.9%
Between 5% and 10% of the time			
-----	1	5	6
-----	3.1%	16.7%	9.7%
Between 10% and 25% of the time			
-----	0	3	3
-----	.0%	10.0%	4.8%
Between 25% and 50% of the time			
-----	2	1	3
-----	6.3%	3.3%	4.8%
Between 75% and 100% of the time			
-----	1	2	3
-----	3.1%	6.7%	4.8%
Total number of respondents			
-----	32	30	62
-----	100.0%	100.0%	100.0%

\*District court judge, special justice or magistrate

from one to four.

8. Transportation to Detention Facility

Table 6 indicates that at least 80% of the CSB professionals and the special justices reported that the sheriff often transports the individual under detention to the hospital designated on the TDO. At least 80% of the respondents reported that the police transport individuals at least occasionally. Of the 16 respondents who reported that other methods of transportation were used, 87.5% listed family members and 12.5% listed CSB/mental health workers. One respondent reported that the state police transported a client on one occasion.

Approximately 75% of the mental health professionals and 50% of the special justices<sup>10</sup> reported that individuals under a TDO sometimes are taken to more than one facility. This happens most often when the individual under a TDO is in need of medical care. The individual usually is taken to an emergency room first and then is transferred to the detention facility. In other situations, the individual is taken to a second facility because the hospital designated on the TDO is full. A few respondents reported that an individual sometimes is taken to one facility for "screening" and then to a second facility for detention. Other responses included taking the individual from the detention facility to the location of the commitment hearing and transferring an individual from a state hospital to a private facility.

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<sup>10</sup>The actual percentages are 75.8% for the 33 mental health professionals who responded and 48.3% for the 29 special justices who responded.

Table 6  
The Frequency With Which Various Options Are Used  
for Transporting Individuals Under a TDO

	Never	Occasionally	Often	TOTAL
<b>CSB Professionals</b>				
Sheriff transports-----	3	2	28	33
-----	9.1%	6.1%	84.8%	100.0%
Police transports-----	5	14	9	28
-----	17.9%	50.0%	32.1%	100.0%
Ambulance transportation---	5	23	0	28
-----	17.9%	82.1%	.0%	100.0%
<b>Special Justices</b>				
Sheriff transports-----	0	6	24	30
-----	.0%	20.0%	80.0%	100.0%
Police transports-----	5	6	14	25
-----	20.0%	24.0%	56.0%	100.0%
Ambulance transportation---	3	18	2	23
-----	13.0%	78.3%	8.7%	100.0%

9. Admission

Generally, hospitals use the same procedures for admitting individuals under a TDO as are used for admitting voluntary patients. The main differences noted by respondents are that more precautionary measures are taken if an individual is violent or likely to attempt to escape. However, one respondent reported that individuals in his or her CSB are handcuffed and required to enter the hospital in a rear entrance, whether or not they are violent. Another respondent reported that the hospital may delay a physical examination if the client is acutely psychotic.

10. Treatment

Of the 28 mental health professionals who responded, 32.1% reported that TDO patients are treated differently than voluntary patients.<sup>11</sup> Only 12 special justices responded to the question; 58.3% reported different treatment. Most of the reported differences were related to the extra security needed for TDO patients.<sup>12</sup> One respondent indicated that TDO patients at one hospital receive a less thorough evaluation. Another respondent reported that medication is withheld, and a second reported that sedation sometimes is administered against the patient's wishes.

11. Precommitment-Hearing Release

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<sup>11</sup>One respondent reported that differences in treatment depended on the patient's level of functioning.

<sup>12</sup>Three of the mental health respondents who reported no differences in treatment between TDO patients and voluntary patients did note that sometimes TDO patients are placed in more secure wards.

Approximately half<sup>13</sup> of the mental health professionals and the special justices reported that some kind of precommitment-hearing release is possible in their respective CSB or jurisdiction. Generally, respondents reported that patients are released who no longer meet the commitment criteria. Sometimes the physician or other hospital staff releases the patient; sometimes the judge is contacted to rescind the detention order. One respondent indicated that a patient may be released on bond with the condition that he or she receive voluntary treatment. If the patient does not receive treatment within a specified period of time, a commitment hearing will be held. Other respondents noted that some patients are released if they agree to admit themselves voluntarily into a hospital.

#### Preparation for and Conduct of Judicial Hearings

This section includes preliminary and full involuntary civil commitment hearing practices.

#### 12. Preparation for Judicial Hearing

In some CSBs/court jurisdictions, commitment hearings are held in the court, in other CSBs/court jurisdictions, hearings are held in a mental health facility, and in others, some hearings may take place in court and some may take place in a mental health facility. When asked where hearings typically are held in their CSB or jurisdiction, 55.4% of the respondents reported the court and 72.3% reported a mental health facility as the place of the hearing. Several respondents (44.6%) also listed other locations such as the special

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<sup>13</sup>Actual figures are 51.5% of the mental health professionals and 53.2% of the special justices.

justice's office, a physician's office, the police station, the Sheriff's Department and nursing homes. One mental health respondent indicated that no commitment hearings are held in his or her CSB catchment area.

Most respondents (87.5% of the mental health professionals and 93.8% of the special justices) indicated that a special justice presides over commitment hearings in their respective CSB or jurisdiction. On average, approximately three or four special justices are available for commitment hearings in these CSBs or jurisdictions. Respondents (62.5% of the mental health professionals and 46.9% of the special justices) also reported that district judges preside over commitment hearings. On average, between two and three district judges conduct commitment hearings in these CSBs or jurisdictions.

Table 7 indicates that attorneys meet with their clients more often immediately prior to the commitment hearing than at any other time. Respondents reported that, on average, attorneys occasionally meet with their clients an hour before the hearing and infrequently meet with their clients the day preceding the hearing.

### 13. Preliminary/Full Hearing

Table 8 indicates that the majority of respondents identified the individual in crisis, the individual's attorney, the petitioner, the prescreener and the court-appointed or independent psychiatrist/psychologist as participants in at least 75% of commitment hearings. A majority of the special justices also reported that other witnesses (in addition to the independent psychiatrist, prescreener, etc.) frequently participate in the hearings.

Table 7  
Frequency\* With Which Attorneys  
Meet With Clients on Various Occasions

	CSB Professionals	Special Justices	All Respondents
Day before hearing			
Average Frequency Rating----	1.6	1.5	1.5
Number of Respondents-----	27	24	51
An hour before hearing			
Average Frequency Rating----	1.9	2.1	2.0
Number of Respondents-----	27	27	54
Immediately preceding hearing			
Average Frequency Rating----	2.8	2.8	2.8
Number of Respondents-----	31	30	61
During the hearing			
Average Frequency Rating----	1.6	1.7	1.6
Number of Respondents-----	28	23	51

\*Frequency was rated from 1 to 3  
with 1=never and 3=often

Table 8  
Number of Respondents Identifying Various Individuals  
As Routine\* Participants in Commitment Hearings

	CSB Professionals (n=33)		Special Justices (n=32)		All Respondents	
Individual in crisis-----	32	97.0%	32	100.0%	64	98.5%
Attorney for the individual---	32	97.0%	31	96.9%	63	96.9%
Prescreener-----	20	60.6%	25	78.1%	45	69.2%
Other CSB personnel-----	10	30.3%	12	37.5%	22	33.8%
Police or sheriff-----	8	24.2%	9	28.1%	17	26.2%
Court-appointed examining psychiatrist/psychologist--	19	57.6%	20	62.5%	39	60.0%
Treating psychiatrist/psychologist--	10	30.3%	9	28.1%	19	29.2%
Hospital social workers-----	6	18.2%	4	12.5%	10	15.4%
Petitioner(s)-----	26	78.8%	22	68.8%	48	73.8%
Other witnesses-----	10	30.3%	17	53.1%	27	41.5%
Other participants-----	4	12.1%	6	18.8%	10	15.4%

\*in approximately 75% of the hearings



#### 14. Disposition Rendered

Almost all of the respondents (see Table 9) reported that "voluntary hospitalization" and "involuntary inpatient hospitalization" are available dispositions in their respective jurisdictions/CSBs. Involuntary hospitalization is used in approximately half of the cases (see Table 10<sup>14</sup>), and voluntary hospitalization is used in about 20% of the cases. Although "release" and "release with conditions" are available dispositions in many CSBs and jurisdictions, reportedly they are used less frequently. Just over half of the respondents reported that "involuntary outpatient commitment" was available as a disposition. However, these respondents indicated that it was used, on average, in only 8.6% of the cases.

#### Post-Hearing Matters

This phase includes the events that take place immediately following the completion of a commitment hearing.

#### 15. Disposition Enacted

In general, respondents reported that the responsibility for implementing the special justice's decision usually belonged to one or more of the following parties: the prescreener, case manager or other CSB personnel, law enforcement officers, staff at the holding or detention hospital and/or staff of the commitment hospital. The Sheriff's Department usually was noted

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<sup>14</sup>The percentages in Table 10 do not sum to 100% because some respondents did not estimate the number of cases for all of the dispositional categories.

Table 9  
Availability of Various Disposition Options  
in Respondents' CSB/Jurisdiction

	CSB Professionals (n=33)		Special Justices (n=32)		All Respondents	
Voluntary hospitalization-----	32	97.0%	30	93.8%	62	95.4%
Involuntary inpatient hospitalization-----	32	97.0%	32	100.0%	64	98.5%
Involuntary outpatient commitment-----	20	60.6%	18	56.3%	38	58.5%
Release without conditions----	31	93.9%	29	90.6%	60	92.3%
Release with conditions-----	26	78.8%	22	68.8%	48	73.8%

Table 10  
Approximate Percentage of Cases in Each Disposition Category

	CSB Professionals (n=33)	Special Justices (n=32)	All Respondents
Voluntary hospitalization			
Mean response-----	23.7%	18.9%	21.2%
Number of respondents-----	27	28	55
Involuntary inpatient hospitalization			
Mean response-----	55.0%	54.6%	54.8%
Number of respondents-----	27	30	57
Involuntary outpatient commitment			
Mean response-----	6.1%	11.4%	8.6%
Number of respondents-----	17	15	32
Release without conditions			
Mean response-----	9.1%	13.9%	11.5%
Number of respondents-----	28	27	55
Release with conditions			
Mean response-----	13.7%	13.5%	13.6%
Number of respondents-----	22	19	41

as the responsible party for transporting committed patients to the hospital. Once committed, 73.3% of the mental health professionals and 81.3% of the special justices<sup>15</sup> agreed strongly that involuntary patients receive the same quality of treatment as voluntary patients.

CSB mental health personnel were noted by the most respondents<sup>16</sup> as responsible for monitoring, supervising or managing the cases of individuals committed to outpatient mental health care or released with conditions. Almost 14% of the respondents reported that no particular person or agency monitors these cases.

#### 16. Recommitment Hearings

If an individual who has been committed involuntarily to a hospital has not been released within 180 days, a hearing is required to determine whether he or she should be recommitted to the hospital. Of the 27 mental health professionals who responded to the question of whether a recommitment hearing actually takes place, 100% confirmed that it generally does. Only 64.7% of the 17 special justices who responded to the question indicated that recommitment hearings take place. However, many of those who answered negatively indicated that recommitment hearings do not take place because few patients stay in the hospital for 180 days. Both groups agreed that recommitment hearings that do take place generally follow the same procedures

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<sup>15</sup>Percentages are based on the responses from 30 mental health professionals and 16 special justices.

<sup>16</sup>Actual figures are 84.8% of the mental health professionals and 68.8% of the special justices.

as initial commitment hearings.<sup>17</sup>

17. Legal Appeal

Any person involuntarily committed in Virginia has the right to appeal a commitment order to the circuit court in the jurisdiction wherein he or she was committed. Mental health professionals estimated, on average, that 8.6 cases are appealed and 1.6 of these are successful.<sup>18</sup> Special justices estimated that, on average, 6.1 cases are appealed and 1.5 are successful.<sup>19</sup>

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<sup>17</sup>Of the 26 mental health professionals who responded, 80.8% agreed, and of the 11 special justices who responded, 90.9% agreed.

<sup>18</sup>The number of appeals ranged from 0 to 100 based on 26 responses, and the number of successful appeals ranged from 0 to 10 based on 20 responses.

<sup>19</sup>The number of appeals ranged from 0 to 60 based on 19 responses, and the number of successful appeals ranged from 0 to 20 based on 15 responses.

## APPENDIX A

SURVEY OF EMERGENCY MENTAL HEALTH SERVICES  
AND INVOLUNTARY CIVIL COMMITMENT PRACTICES  
IN VIRGINIA

July 25, 1989

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INSTRUCTIONS: The National Center for State Courts' Institute on Mental Disability and the Law (IMDL) is conducting this survey of emergency mental health services and involuntary civil commitment practices in Virginia on behalf of the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). The survey is part of a larger effort by DMHMRSAS to review the emergency mental health services and involuntary civil commitment practices throughout the state. Your responses to the questions on the following pages will contribute to this effort.

We are sending this survey to professionals in Virginia's mental health and judicial systems. If you are a mental health professional, please answer the questions about the Community Services Board (CSB) catchment area in which you work. If you are a court professional, please answer the questions about the judicial district or court in which you work. Please answer as many questions as you can. If you do not know the answer to a question, please ask others who might know or write "don't know" next to the item.

Thank you for helping in this effort to improve the provision of emergency mental health services in Virginia. If you have any questions about any specific item or the survey in general, please contact Pam Casey or Eddie McNelis, Institute on Mental Disability and the Law, National Center for State Courts, Williamsburg, Virginia, (804/253-2000).

Please return the completed questionnaire by Friday, August 18, 1989 in the envelope provided to:

Institute on Mental Disability and the Law  
National Center for State Courts  
300 Newport Avenue  
Williamsburg, VA 23187-8798

A. BACKGROUND INFORMATION

1. Name(s), title(s), affiliation(s), address(es), and telephone number(s) of individual(s) responding to this Survey (use other side if necessary):

Name \_\_\_\_\_

Title \_\_\_\_\_

Affiliation \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

- 2a. If you are a mental health professional, please identify the Community Services Board (CSB) catchment area in which you work:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 2b. If you are a court professional, please name the Judicial district(s) or court(s) in which you work:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please complete the remainder of this questionnaire with respect to the entire catchment area covered by the above mentioned CSB or judicial district.

B. EMERGENCY MENTAL HEALTH SERVICES

3. Throughout Virginia, individuals who experience a mental health emergency make their first contact with one of the following: family members, law enforcement personnel, public mental health centers/CSBs, public hospitals, private hospitals, and private physicians. Please list any other facilities or entities in your community that are the first point of contact for individuals experiencing a mental health crisis. Identify as many as appropriate by name and type of facility.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Regardless of who or what agency was the first point of contact for the person in crisis, most communities have one or two facilities that serve as a "clearinghouse" for all or most mental health emergencies. Please identify the mental health center(s), hospital(s) or other facility or agency which eventually receives all or most referrals of mental health emergencies in your community.

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5. Which of the following sources make at least 10% of the referrals to the "clearinghouse" facility(s) or agency(s) identified in the previous question? Please check all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> Patient (self referral)   | <input type="checkbox"/> Court Personnel                |
| <input type="checkbox"/> Family member             | <input type="checkbox"/> Community mental health center |
| <input type="checkbox"/> Law enforcement personnel | <input type="checkbox"/> Churches                       |
| <input type="checkbox"/> Jail                      | <input type="checkbox"/> Shelter facilities             |
| <input type="checkbox"/> Social Service agency     | <input type="checkbox"/> Other (please specify):        |
| <input type="checkbox"/> Public hospital           |   |
| <input type="checkbox"/> Private hospital          |   |

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- 5a. In some localities, mentally ill individuals under the care of private practitioners are referred to the "mental health clearinghouse" facility/agency for services. Please estimate the number of these private sector cases in your CSB or jurisdiction: \_\_\_\_\_

6. Please check all crisis intervention options available in your community. Then rank the available options from 1 (most frequently used) to as many as 10 (least frequently used).

<u>Disposition Option</u>	<u>Applicable in your Community</u>	<u>Frequency Rank</u>
Voluntary Outpatient Mental Health Care	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary Substance Abuse Services	<input type="checkbox"/>	<input type="checkbox"/>
Housing, Food, Clothing, Transportation Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Medical Services	<input type="checkbox"/>	<input type="checkbox"/>
Social Services (e.g., ?)	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary Inpatient Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Involuntary Detention (TDO)	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify and rank along with others above):	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>



7. How often do the following problems interfere in the delivery of emergency services in your CSB/jurisdiction?

	<u>Never</u>	<u>Occasionally</u>	<u>Often</u>
a. Untimely response to crisis	_____	_____	_____
b. Unqualified staff	_____	_____	_____
c. Lack of intensive "pre-crisis" care and support	_____	_____	_____
d. Face-to-face response unavailable	_____	_____	_____
e. Conflicts between agencies involved in the delivery of services (e.g., mental health centers, courts, police, sheriffs private providers, etc.)	_____	_____	_____
f. Lack of specialized services for special needs groups	_____	_____	_____
g. Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Are face-to-face preadmission screenings available 24-hours a day?

\_\_\_ Yes      \_\_\_ No

If not, what hours/days are they performed?

\_\_\_\_\_

9. Approximately what percentage of preadmission screenings result in recommendations for involuntary temporary detention? \_\_\_\_\_

### C. TEMPORARY DETENTION

10. Approximately how frequently is preadmission screening performed after an individual is temporarily detained in a hospital?

\_\_\_\_\_ never  
 \_\_\_\_\_ in less than 10% of the temporary detentions  
 \_\_\_\_\_ between 10% and 25% of the temporary detentions  
 \_\_\_\_\_ between 25% and 50% of the temporary detentions  
 \_\_\_\_\_ more than 50% of the temporary detentions

11. Recommendations or advice regarding temporary involuntary detention is communicated to:

\_\_\_\_\_ A magistrate  
 \_\_\_\_\_ District Judge  
 \_\_\_\_\_ Special Justice  
 \_\_\_\_\_ Other (specify): \_\_\_\_\_

By whom (title, e.g., preadmission screener): \_\_\_\_\_

12. In what percentage of the cases is the recommendation regarding temporary detention made by phone/in-person?

\_\_\_\_\_ % Phone      \_\_\_\_\_ % In-person

13. How often does the judge or magistrate take the recommendation/advice of the person(s) noted above regarding temporary detention?

\_\_\_\_\_ Almost always  
\_\_\_\_\_ More than 90% of the time  
\_\_\_\_\_ 75% - 90% of the time  
\_\_\_\_\_ less than 75% of the time

14. According to the Code of Virginia (37.1-67.1), a judge or magistrate may "issue an order requiring any person within his jurisdiction alleged or reliably reported to be mentally ill and in need of hospitalization to be brought before the judge. If such person cannot be conveniently brought before the judge, the judge or magistrate may issue an order of temporary detention." How frequently are individuals brought for a preliminary hearing before a judge or special justice before the issuance of a TDO?

\_\_\_\_\_ never  
\_\_\_\_\_ in less than 5% of the cases  
\_\_\_\_\_ 5% - 10%  
\_\_\_\_\_ 10% - 25%  
\_\_\_\_\_ 25% - 50%  
\_\_\_\_\_ 50% - 75%  
\_\_\_\_\_ 75% - 100%

15. How often is the individual transported to the hospital for temporary detention by each of the following:

	<u>Never</u>	<u>Occasionally</u>	<u>Often</u>
Sheriff	_____	_____	_____
Police	_____	_____	_____
Ambulance	_____	_____	_____
Other (please specify):	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

16. Are individuals under a temporary detention order (TDO) ever taken to more than one facility?

\_\_\_\_\_ Yes                                      \_\_\_\_\_ No

If yes, please explain when and how often this occurs.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Please identify all public and private facilities in your judicial district or CSB catchment area that accept individuals under a temporary detention order (TDO), and then rate them according to how often they are used.

<u>Facilities</u>	Frequency of Use		
	<u>Seldom</u>	<u>Occasionally</u>	<u>Often</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

18. Is an individual ever released by a judge, special justice, or a mental health official before a hearing but after the issuance of a TDO?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please give an example.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### D. TEMPORARY DETENTION, TREATMENT AND CARE

19. Once transported to a hospital pursuant to a TDO, are individuals admitted using procedures similar to or different from voluntary admissions?

\_\_\_\_\_ similar \_\_\_\_\_ different

If different, how are the procedures different? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. Once admitted, are temporarily detained individuals treated, cared for, or placed differently than voluntary patients?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how is the treatment different? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

E. COMMITMENT HEARINGS

21. Where are commitment hearings typically held in your county or catchment area? (Check all that apply.)

\_\_\_ Court \_\_\_\_\_

\_\_\_ Mental health facility, please specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other, please specify: \_\_\_\_\_

\_\_\_\_\_

22. For each of the options below, please indicate how frequently attorneys representing individuals facing involuntary civil commitment meet with their clients?

	<u>Never</u>	<u>Occasionally</u>	<u>Often</u>
___ the day before the hearing	___	___	___
___ more than an hour before	___	___	___
___ the hearing	___	___	___
___ immediately preceeding	___	___	___
___ the hearing	___	___	___
___ during the hearing	___	___	___
___ other: _____	___	___	___

23. Who is the presiding officer(s) in these hearings? How many are available in your CSB or jurisdiction ?

\_\_\_ Special Justice (Number \_\_\_\_\_)

\_\_\_ District Judge (Number \_\_\_\_\_)

\_\_\_ Other: \_\_\_\_\_ (Number \_\_\_\_\_)

24. Which of the following individuals generally (i.e., in approximately 75% of the hearings) participate in judicial hearings? (Check all that apply.)

\_\_\_ Individual (respondent)

\_\_\_ Attorney for Individual

\_\_\_ Prescreener

\_\_\_ Other CSB Personnel

\_\_\_ Police/Sheriff

\_\_\_ Court-appointed Examining  
Psychiatrist/Psychologist

\_\_\_ Treating Psychiatrist/Psychologist

\_\_\_ Hospital Social Workers

\_\_\_ Petitioner(s)

\_\_\_ Other Witnesses

\_\_\_ Other (please specify): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## F. CASE DISPOSITION

25. Upon completion of a full commitment hearing, what case disposition categories are available to the judge or special justices in your CSB or jurisdiction? Please check if the disposition category is available and indicate the approximate percentage of cases in each category.

<u>Category</u>	<u>Approximate Percentage</u>
_____ Voluntary Hospitalization	_____
_____ Involuntary <u>Inpatient</u> Hospitalization	_____
_____ Involuntary <u>Outpatient</u> Commitment	_____
_____ Release without Conditions	_____
_____ Release with Conditions ("on terms")	_____
_____ Other (specify) _____	_____
_____	_____
_____	_____

26. Immediately following the judicial hearing, and once the special justice or judge has made his or her decision, who takes responsibility for implementing the case disposition?

\_\_\_\_\_  
 \_\_\_\_\_

## G. POSTHEARING MATTERS

27. In general, once committed to an institution, involuntary patients receive the same quality of treatment as voluntary patients.

Disagree Strongly      Agree in part,  
                                  disagree in part      Agree Strongly

\_\_\_\_\_

28. Who or what agency monitors, supervises, or manages the cases of individuals committed to outpatient mental health care or those individuals released with conditions?

\_\_\_\_\_ CSB mental health personnel  
 \_\_\_\_\_ hospital personnel  
 \_\_\_\_\_ other (please specify): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ No one

29. If an individual, involuntarily committed to a hospital, has not been released within 180 days, a hearing is required to determine whether he or she should be recommitted to the hospital. In most cases, does this hearing take place?

\_\_\_\_ Yes      \_\_\_\_ No

If no, why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If yes, do the recommitment hearings generally follow the same procedures as the initial commitment hearings?

\_\_\_\_ Yes      \_\_\_\_ No

If no, how do they differ? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

30. Any person involuntarily committed in Virginia has the right to appeal a commitment order to the circuit court in the jurisdiction wherein he or she was committed. Within the last five years, approximately how many commitment cases have been appealed in your jurisdiction or mental health catchment area? \_\_\_\_\_

How many were successful? \_\_\_\_\_

31. Please make any additional comments you may have about your experiences with the provision of emergency mental health services.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Question: Are individuals under a temporary detention order (TDO) ever taken to more than one facility? If yes, please explain when and how often this occurs.

Mental Health Professional

- o Yes, Mental Health Center then to the Emergency Room at Lynchburg General Hospital. However this is rare.
- o Yes, People requiring medical clearance prior to hospitalization under TDO are first transported by police to the MCVH Emergency Rooms, then on to the TDO facility.
- o No, Two-step TDO, as of this date, is illegal. It can present problems.
- o Yes, To Emergency Room of local hospital for medical evaluation prior to admission for detox. Also to ER for medical treatment if needed prior to hospitalization.
- o No, We use several facilities, i.e., Southwestern State Hospital, St. Albans, and Bookside for TDO's, but no "individual" is taken to more than one of these facilities on TDO.
- o Yes, 1) To detention facility other than location of commitment hearing, then to site of hearing 2) To medical facility, then to detention facility.
- o Yes, When in need of medical treatment before hospitalization is possible.
- o Yes, Regional Hospital ER and then to a willing institution.
- o No
- o Yes, The subject of the TDO may be taken by an emergency room for medical treatment when the Special Justice issues the TDO 60% to 75% of the time.
- o Yes, To get medically cleared in ER before going onto inpatient psychiatric facility.
- o Yes, If in medical distress, may go to ER first.
- o Yes, If individual is found to have insurance, they are usually transferred from state hospital to private hospital.
- o Yes, If Alex. hospital is full then NUMHI or Dominion Hospital

- o Yes, May be taken to a community hospital for medical clearance before being transported to psychiatric facility. Special Justice in Smyth County will issue a TDO for SWSH only. Therefore, involuntary clients approved for admission to private hospitals are transported to SWSH, admitted, and later transferred to private hospital.
- o Yes, TDO's for S.A. often require ER assessment to make out initial medical needs prior to transport to detox or Western State Hospital Med. Center. Some magistrates will write a two-step TDO for psychiatric cases.
- o No
- o Yes, Often need to be medically cleared at local ER before being sent to detention facility wherein medical services are not readily available or in cases that involve an injury or medical need or suspected medical need or question as to medical stability to be transported (long distance) by non-medical personnel (sheriff) to TDO facility. After hours admissions to NVMHI are via local CSB office (Woodburn Center).
- o Yes, Sheriff will often secure medical clearance at ER prior to taking patient to the TDO facility. However, one TDO facility is located at same hospital as the ER. Also, have had people TDO one facility only to get there and be denied a bed. We then look for a second alternative facility.
- o Yes, Many times the individual is brought to the mental health clinic under a TDO and then transported to an appropriate/willing facility.
- o Yes, WSH refers on to University of Virginia, this occurs rarely. On one occasion client was TDO'ed to one private hospital which then refused to take them and they were sent to another private hospital.
- o No
- o Yes, if a person appears to be in medical difficulty they may be brought to the ER of a hospital and then to Eastern State.
- o Yes, Medical screening carried out at an emergency room prior to psychiatric admission.
- o Yes, once the individual is picked up, the mental health counselor must assess and complete preadmission screening forms fifty (50) percent of the time.
- o Yes, 1) for medical clearance, 5-10% of time. 2) admission to NVMHI, 10%
- o No



- o Yes, 1) for medical clearance, 5-10% of time. 2) admission to NVMHI -10%. (revised survey)
- o Yes, Often to Jail for prescreening. then on to state hospital.
- o No
- o Yes, SA cases in need of medical clearance.
- o Yes, 10% rare occasion for medical clearance.
- o No
- o Yes, Temporary Detention Order brings individual to Mental Health Clinic or Emergency Room for face to face screening by ESCSB staff.

#### Special Justices

- o Yes, To Lynchburg General Hospital principally but occasionally to VA. Baptist or Souther Va. Mental Health Institute if no space is available at Lynchburg General Hospital.
- o Yes, Lynchburg General and Va. Baptist hospitals are now same corporation; on a seldom basis a patient may have to be transported to Va. Baptist if pre-screening official requests psychiatric evaluation prior to commitment hearing.
- o No
- o When?
- o No
- o Yes, In situations where there are physical health concerns patients may be sent to emergency hospital rooms for screening, (heart patients, diabetes, etc.).
- o No
- o Yes, Standard procedure, TDO issued, individual brought to jail seen by CSS for pre-screening, then taken to Doctor, brought back to jail for hearing.
- o No
- o Yes, Initial evaluation at UVA Hospital with ultimate destination at an appropriate facility.
- o Yes, May be taken to family guidance for screening and then to Doctor's office if no psychiatrist is available at family guidance.
- o Yes, Where an individual under a TDO has physical problems not treatable by the temporary holding facility, medical attention is provided by another institution.

- o Yes, Western State Hospital often requires medical clearance for local hospital E.R. prior to transport to Western State Hospital.
- o No
- o No
- o No
- o No
- o No
- o No
- o Yes, Less than 10%.
- o No
- o Yes, Sometimes to detox facility 1st, then Wn. State. sometimes to Wn. State, then to V.A. or private facility.
- o N/A
- o No
- o No
- o Yes
- o N/A
- o Not in my experience
- o Yes, Occasionally a patient will be taken to Lynchburg General Hospital at which time it is realized that the patient has had prior contact with a doctor who practices primarily at Virginia Baptist. To make treatment and evaluation easier, the patient is then transferred to the second hospital.
- o Yes, virtually always the admitting psychiatrist (including Catawba Hospital) requires a medical check done at local E.R. - prior to admission. Virtually never is a patient admitted to a psych. hospital and transferred to another prior to hearing.
- o No
- o Yes

VAMI      Affiliate Presidents

- o Don't know
- o Don't know

- o Yes, Sheriff takes person to Woodburn or Northwest Center, then Hospital.
- o N/A
- o N/A
- o Don't know.
- o N/A
- o Yes, this depends on the availability of beds.

Question: Is an individual ever released by a judge, special justice, or a mental health official before a hearing but after the issuance of a TDO? If yes, please give an example.

Mental Health Professional

- o Yes, After a physician skilled in the diagnosis of mental illness evaluates the client the TDO can be lifted
- o No
- o No
- o No
- o No
- o Yes, The parent of an adult child intervened to present evidence to a District Court Judge the day following detention to earn her release.
- o Yes, Judge will release if brought in due to convincing evidence but upon being seen does not meet the criteria for involuntary treatment.
- o No
- o Yes, On several occasions, the prescriber or psychiatrist was held up and could not get to the court, the Judge allowed the client to walk away only to be detained within 30 minutes. However this rarely happens.
- o Yes, If the prescriber finds the individual to be totally inappropriate for a TDO, that recommendation will be made to the Special Justice.
- o No, I am not aware of such a case recently in our jurisdiction.
- o Yes, Person is brought before a judge and not found to be imminently dangerous (TDO issued by magistrate to bring client before judge)
- o No.
- o Yes, if patient has stabilized prior to commitment hearing and is felt by MD to be noncommittable and has signed in for voluntary care.
- o Yes, On some occasions this occurs if the petitioner drops the petition before a judge and if we, the mental health professional, find no grounds for commitment.

- o Yes, Occasionally persons present better upon arrival at WSH two or more hours after being screened in the local community, and so are discharged by WSH admissions staff.
- o No
- o Yes, When petitioner withdraws petition in adolescent case wherein child is taken to private hospital under TDO and parents sign child.
- o Yes, If medically not clear, or if psychiatric status please, i.e., SA and suicidal.
- o Yes, at times, an individual is brought to the clinic under a TDO for evaluation, is not found to meet the requirements of a TDO and the issuing judge will then rescind the TDO.
- o No
- o No
- o No
- o No
- o Yes, voluntary admission to a private hospital.
- o Yes, When petitioner fails to appear, when the person agrees to go voluntary.
- o No
- o No.
- o Yes, If a person is seen and voluntarily admits himself into the hospital by signing papers.
- o No
- o Yes, Patient private care with insurance physical willing to continue care and hospital has bed and physician calls judge.

#### Special Justices

- o No
- o Yes, often face to face screening, hospitalization is not required.
- o Yes, Police take a person into custody for criminal charge and suspect mental illness and petition for mental treatment (TDO). Person is released on bond with condition that he receive voluntary treatment within specified time or be subject to hearing.

- o Yes, If medical experts believe that patient is able to be treated on out patient basis, hospital can release patient prior to hearing.
- o No
- o N/A, I have admitted some patients to bill.
- o No
- o Yes, In cases where it appears the situation is under control and patient is in no danger.
- o No
- o No
- o Yes, "Spite" petition, i.e., spousal conflict, if patient seen by mental health and found to be not committable before TDO served on patient.
- o No
- o No, If not a candidate for commitment, "hearing" will be held to explain process to individual and to explain that no commitment will occur.
- o No
- o Yes, 1) Prescreening reveals "not committable." 2) Patients seek Voluntary Admission.
- o Yes, Once seen by physician, physician releases if obviously no problem.
- o No
- o No
- o No
- o Yes, When information provided by family member is exaggerated or otherwise unreliable.
- o No
- o Yes
- o No
- o No
- o No

- o Yes, In those cases where a reliable source indicates probable mental illness requiring hospitalization but prescreening reveals otherwise.
- o Yes, If mental health official determines that continuing involuntary hospitalization is not necessary (i.e., does not need to be committed); when patient volunteers hospitalization.
- o Yes, Person may be able to go in voluntarily or may involve alcohol abuse etc. where symptoms clear up before hearing.
- o Yes (rarely)
- o No
- o Yes, the best example I can recall is where a man received a TDO upon information describing his behavior as erratic with him hanging out of the window of his apartment shouting at passers by. Upon being approached by Police, he could only mumble incoherently. In addition it was reported that he had chased a woman up and down the hall of nursing home. After the doctor had examined him, it appeared that the man was intoxicated and had merely misplaced his false teeth. Once he had sobered up, no lasting mental illness remained and of course, once his teeth had been returned to him, he was able to explain his actions. It was believed that the instance rather than waiting for a special justice to ok the lifting of the TDO, that the man could be allowed to return to his apartment. As is often the case, it is the normal practice in the Lynchburg area to give the doctors broad latitude in allowing TDOs to be lifted in order that patients not be detained for inappropriate reasons.
- o Yes, Special justice only: where perjured petition is basis for TDO - happens one time in a thousand, about five times a year - patient will be critically ill medically, with extended medical hospitalization probable, and TDO will be dropped. Special justice only makes this decision.
- o No
- o Yes, CSB Emergency Services personnel will call the Special Justice and explain that the petitioner no longer wants to pursue the commitment. After an explanation of the facts, the Special Justice may determine that a hearing is inappropriate and will dismiss the petition. Happens very infrequently.

VAMI Affiliate Presidents

- o Don't know
- o Do not know.
- o N/A

Question: Once transported to a hospital pursuant to a TDO, are individuals admitted using procedures similar to or different from voluntary admissions? If different, how are the procedures different?

Mental Health Professional

- o Similar, Individuals are always committed to state hospitals from our CSB area. Rarely are they sent on a TDO. Maybe 1-500 on a TDO.
- o Similar
- o Similar
- o Similar
- o Similar
- o Similar
- o Similar
- o N/A
- o Different - They are handcuffed and enter the hospital in a rear entrance whether they are violent or not. Once on the Psychiatric unit they are treated like other patients.
- o Similar
- o Similar - Admitting procedures are the same. Will seek non-sheriff transportation for voluntary client. Involuntary client will always be admitted to the more acute unit of the hospital. Voluntary patients will go to the acute or general units depending on their clinical needs.
- o Similar
- o Similar
- o Similar
- o Similar - Hospitals may delay physical exams for clients who are acutely psychotic.
- o Similar
- o N/A
- o Similar but modified to be less in depth/varies among facilities.



- o Similar - At MHU, may bypass admitting desk.
- o Similar
- o unfamiliar with hospital admission procedures - we are not aware of any differences.
- o Similar
- o Similar
- o Similar
- o Similar
- o N/A
- o Similar - But stricter precautionary measures may be taken to ensure the individual does not escape. Police or sheriff escort to psychiatric unit.
- o N/A (revised survey)
- o Similar
- o Different - Voluntary people sign paper. TDO or detention people do not.
- o N/A
- o Similar - Except transport by sheriff.
- o Similar - But stricter precautionary measures may be taken to ensure the individual does not escape. Police or sheriff escort to psychiatric unit.
- o Cannot respond.

#### Special Justices

- o Different, Security measures and place of confinement are secure.
- o Similar
- o Unknown
- o Different, Patients cannot leave.
- o Don't know
- o Similar
- o Don't know

- o Don't know
- o Different, Depending on danger of patient, e.g., suicidal, need for supervision, if alleged is petitioned and per prescreening, patient kept in closed ward on TDO until full hearing.
- o Similar
- o Unknown
- o Not known
- o Similar
- o ?
- o Similar
- o Do not know
- o N/A
- o Unknown
- o Similar
- o Unknown
- o Similar
- o Similar
- o N/A
- o Don't know
- o Different, If violent or out of control patients are disrobed provided hospital gowns and placed in secured areas
- o N/A/
- o N/A
- o Don't know
- o not sure
- o similar
- o N/A
- o unknown

VAMI Affiliate Presidents

- o Don't know
- o Similar
- o Similar
- o N/A
- o N/A
- o Don't know
- o N/A
- o Similar

Question 20: Once admitted, are temporarily detained individuals treated, cared for, or placed differently than voluntary patients?

Mental Health Professional

- o Yes, once admitted to the ER, the TDO's lifted or the individual is committed to an inpatient facility.
- o Yes, They are kept on locked rather than "open" access units.
- o No
- o No
- o No, Clients are treated as individual with treatment.
- o Yes, All detained persons are placed on restricted, intensive treatment areas, if at all possible.
- o No
- o N/A
- o No
- o No, unless client needs a seclusion room.
- o No, Treatment is not different.
- o Yes, At St Albans, TDO's usually placed on locked unit. Do not receive as thorough an evaluative work-up, i.e., no adjunctive tx on individual basis, usually no psychological evaluation.
- o No.
- o No
- o Yes, St. Albans Hospital and Roanoke Valley Psychiatric Center place all committed clients on locked wards.
- o No
- o N/A
- o Yes, In some facilities may in locked units may use restraints or sedation against clients' wishes in order to keep TDO.
- o Yes, In some detention facilities may be placed into seclusion. In general, those we use admit to locked unit, provide closer observation and security. May or may not medicate.

- o N/A
- o No.
- o No, unless the individual is dangerous, there is no difference.
- o No
- o No, placed on locked unit
- o No
- o Yes, Medication withheld; closer observation; routine use of seclusion; police guard on some occasions.
- o No.
- o No.
- o Depends, It depends on the client level of functioning.
- o N/A
- o No, except those that may need QR or restrains.
- o No
- o Cannot respond.

#### Special Justices

- o Yes, Secure rooms with constant monitors and measures for protection from self destruction or damage to property and persons.
- o Unknown
- o Yes, Locked wards.
- o Don't know
- o Don't know
- o Don't know
- o Yes, Must be kept secure.
- o Yes, See above, in cases where patient is suicidal or homicidal.
- o No
- o Unknown

- o Not known
- o Unknown/don't know
- o ?
- o Yes, Additional caution necessary to keep patient from leaving, strain on the hospital staff.
- o Do not know
- o N/A
- o Unknown
- o No
- o Unknown
- o No
- o I don't know
- o N/A
- o Don't know
- o Yes, Many detained patients are placed in secured rooms and monitored on closed circuit TV.
- o Yes, If patient presents imminent danger to self or others (patients, hospital staff); they are sometimes kept in observation rooms which are locked.
- o N/A
- o N/A
- o Don't know
- o No, other than the staff is made aware that the patient may not leave without TDO being lifted.
- o No
- o N/A
- o N/A

VAMI Affiliate Presidents

- o Don't know
- o Do not know

- o No, K know of no voluntary placements here.
- o N/A
- o N/A
- o N/A
- o N/A
- o Yes, if needed, intensive care (isolation) is utilized.

Question: If an individual, involuntarily committed to a hospital, has not been released within 180 days, a hearing is required to determine whether he or she should be recommitted to the hospital. In most cases, does this hearing take place? If no, why? If yes, do the recommitment hearings generally follow the same procedures as the initial commitment hearings?

Mental Health Professional

- o Yes, if the patient stays 180 days./Yes
- o Yes, Although, I personally have no knowledge of a Richmond CSB client ever being held this long in a local hospital under commitment./Yes, I am sure they would on a local level, and assume they would at our catchment area State facilities.
- o Yes /Yes
- o Yes, our CSB is not notified in all cases, but generally the case manager is notified that hearing will be held./Yes
- o Yes/No.- They are much more brief. Family members are less often present. These hearings are never held in the client's community.
- o Yes/Yes, I assume they do. The results of those rehearings are relayed to the CSB. Our involvement is increasing.
- o Yes/Yes
- o Yes/Yes
- o Yes/Yes
- o Yes/Yes
- o Yes/Yes
- o Yes/Yes
- o We do not attend re-commitment hearings @ SWST but they do take place as far as I know./Unsure
- o Yes/NA
- o Yes/Yes, hearing is held in Stanton Virginia
- o Yes, Recommitment hearings do take place, however, the quality of the hearing in regard to respect for the client and his/her rights is questionable./Yes Often, the quality of initial hearings at SWH is as questionable as that of recommitment hearings.
- o Yes/Yes



- o N/A/N/A
- o Yes/No
- o unknown. CSB emergency not notified. Possibly transitional staff looking at discharge plan has input about re-commitment./N/A
- o N/A/N/A
- o Yes/No, CSB personnel are not present nor informed of hearing date.
- o N/A
- o Yes/N/A
- o Yes/No briefer. Conducted at hospital.
- o Yes/Yes
- o Don't know. Institutional liaison not routinely notified./Don't know.
- o Yes/Yes
- o N/A (revised survey)
- o Yes/Yes
- o yes, Hardly ever happens. They are usually returned to institution before 180 days./Yes
- o Yes/Yes
- o Yes/No, CSB does not attend commitment hearing held w/facility where they are committed.
- o Yes/Yes
- o Yes/Cannot respond.

#### Special Justices

- o Yes, To the best of my knowledge./Yes - To the best of my knowledge.
- o Unknown, I do not believe that very many mentally committed patients stay more than 180 days; if so, I believe the appropriate place for a hearing would be in the jurisdiction where the hospital holding the patient is located which is not in Lynchburg, my jurisdiction./Unknown
- o Yes/No, No preliminary hearing-by statute.
- o N/A, I have no knowledge of any such long term commitments./N/A

- o Don't know/N/A
- o No, situation has not arisen./Has never happened.
- o Yes, As far as I know./Yes, As far as I know.
- o I don't know./N/A
- o No, Usually patient is released after 30-45 days; if released and further problems, new petition/TDO/hearings held./Yes
- o Yes/Yes
- o Unknown/N/A
- o Not known/N/A
- o Unknown/don't know/N/A
- o ??
- o Yes/Yes
- o Yes/Unknown
- o N/A/N/A
- o Don't know/N/A
- o No, Most released prior to 180 days./N/A
- o Unknown/N/A
- o Yes/Yes
- o Yes, I have never presided over a recommitment. That is usually done at Wn. State or other facility./Yes, I assume so.
- o N/A/N/A
- o Yes/Yes
- o Yes/Yes
- o N/A/N/A
- o N/A/NA
- o Never had the experience.
- o No, Always tried as a new hearing to afford patient opportunity of release as any other./NA

- o Yes, in all cases, unless patient agrees to stay voluntarily and is able, in opinion of treatment team, to make that decision./Yes
- o No, patient has been released before 180 days./N/A
- o No, all individuals that have been brought before me were released prior to the 180 days running. Chronic ases usually end up at Western State Hospital, and they do their own commitment hearings./Unknown. If I were to do one, I would follow the exact same procedure.

VAMI Affiliate Presidents

- o Yes/NA
- o Yes/Yes
- o I do not know, no experience./N/A
- o Yes/Yes
- o Yes/No, usually with judge only.
- o Don't know.
- o N/A
- o N/A/Yes

Question: Please make any additional comments you may have about your experiences with the provision of emergency mental health services.

Mental Health Professional

- o Some difficult questions because no uniform or agreed upon data collection system for example question #25. Thank you working on this survey. I trust it got to the practioners of emergency work.
- o N/A
- o Richmond CSB is very fortunate to operate around-the-clock, with qualified mental health professionals (at the graduate level) staffed on-site, and with psychiatrists staffed on-site 8-hrs. a day Mon.-Fri., and 2-hrs. on Sat. and Sun., and on-call to respond to the unit at all other times within 20-minutes. We also have a vehicle available for our use only around-the-clock, and a cellular phone, which both enhance response time. Our physical location, in the same building as the 1st precinct of the Richmond Bureau of Police, the City Health Department, general district courts, the magistrates' office, and lock-up also give us access to frequently needed City contacts. The greatest difficulty for my staff has been educating the public on legal service limitations, and unrealistic expectation regarding what can be done for people refusing services. Many people in the community have the impression we're a para-military outfit, that can break-down doors and haul folks off for detox. and psychiatric treatment forever, against their will, and will not accept any disposition short of a TDO as appropriate. This is common in this field, and generally accepted as something that goes with the territory, but is extremely frustrating for Crisis workers because it is so time consuming and often leads to conflict with dissatisfied others. It really takes a very highly trained, committed clinician to work in an emergency services operation and make it a rewarding career, so we make every effort to hire "the best," and be honest about what people are getting themselves into in order to assure the right team complement.
- o N/A
- o We would like to see a provision allowing an officer to pick up an individual for probable cause, without a TDO, for immediate (within 4 hours) evaluation by a MH professional.

- o The TDO process creates a dilemma. There are no clear cut means to bring a patient before a Mental Health professional for a prescreening without violating the client's rights. The TDO authorizes the client to be either brought before the Judge or taken to a "facility." When a Judge is unavailable, the patient is supposed to be sent directly to the facility without a face to face presecreeening. This, I feel is a tremendous violation of the client's rights and should never be done. Additionally, we have agreed with our state hospital that all clients sent there will be prescreened prior to admission whether on TDO or civil commitment or voluntary status. In each case in which a Judge is unavailable to hold a hearing, we face the problem of how to get the person brought in to be prescreened. This requires "creative" use of the entire system.
- o Greater use of face-to-face evaluation in prescreening might reduce # of detentions slightly. Face-to-face evaluation, in all circumstances, though, are not necessary to establish criteria for detention.
- o 1) Need for uniformity within the state regrading premedical issues. 2) Need for more funding and staff.
- o We are very rural and mountainous and have with few resources which presents opportunity for innovative and challenging processes. Would like to have help with 2 stop TDO
- o We have run the MH program for only 3 years and therefore do not have 5 years of information.
- o N/A
- o A considerable percentage of our time is expended in explaining procedures to the private sector and helping private clients get the back-up and emergency services they need. We attend many hearings on clients from other catchment areas who are in private in patient care and then require transfer to a State hospital or to public care because their insurance resources are exhausted.
- o - A problem that we experience is the 2-stop TDO debate w/magistrates. Magistrates will not have a person picked up for the purposes of preadmission screening based upon advice of mental health professional unless they have seen client face-to-face. They will issue a TDO directly to inpatient facility but then preadmission screening is not possible prior to admission as dictated by rural. We have 4 counties and one city in our jurisdiction. In one county we have 4 special justices, but only one in remaining areas. Therefore, we sometimes have difficulty obtaining

legal assistance in timely fashion./Also we have found that without formalized training, each court and each legal official interprets codes in slightly different manner, thereby "changing the rules in each county. We have found that legislative often does not meet the needs of rural communities who have limited options and limited local detention.

- o Dickenson County has over 40% of families receiving social services highest unemployment rate: Result, many uninsured indigent add a history of violence. Result: Large number of Emergencies are highly likely to involve alcohol, drugs, and/or firearms. Mountainous terrain and other factors make face to face screening of unwilling clients virtually impossible. A change in Law to permit a pick-up order by law enforcement officers would minimize potential for danger and ensure face to face screenings prior to TDO's./After hours hearings are now totally non-existent. A mechanism to house TDO's in local hospital till the next business day would only partially alleviate situation. With one District Court Judge in the county only a couple of days per week and the three special Justices being the busiest Attorneys in town, a full hearing is still extremely difficult to achieve. Further, if our staff is forced to comply with "client service management guidelines" (va dept. of MHMRSAS), our entire staff would spend the majority of their time on the road to SWSH (100 miles and 2 1/2 hours each direction) attending hearings for all clients sent there on TDO. (Refer to requirement that prescreener attend committal hearing.)/In summary, we need a code change to permit magistrates to issue a pick-up order for citizens, based on probable cause, to provide for "face to face" screening/evaluations. Second, we need mechanism to ensure that the "committal hearing" is held in the community rather than at a hospital hundreds of miles away. This will require the legal system ensure that appropriate court authorities are available daily in even the more remote, small jurisdictions.
- o A two attorney system might be preferable - one attorney as an advocate of the patient protective his rights and one attorney acting for the state - ongoing for commitment when mental illness poses a threat to the community law should be expanded to include mentally illness which is severe and likely to worsen without treatment.
- o While numerous groups and organizations have varied and conflicting opinions on the provision of emergency mental health services and involuntary civil commitment practices, there should be consensus on the need for an accurate, quick and safe procedure for assisting the individual in crisis. Obviously issues regarding this subject vary tremendously across the state. Particular attention should be given to the barriers to effective care experienced by rural CSB's.

- o lack of a two-step TDO process is abusive of TDO subjects civil right to a least intrusive inventories. The illusion of an adversial proceeding in the structure of commitment hearings is unfortunate. Either hearings should be adversial on the pretense abandoned and some other means established to insure that the rights of persons are not abused. An incompetent, capricious magistrate is problematic and difficult to remedy.
- o N/A
- o In cases of detention/commitment the CSB therapist has a tremendous amount of responsibility in making arrangements necessary for hearings. I believe we should have much more cooperation or constraints from the court system since this is a legal proceeding. Also, it would be very helpful if more private hospitals in our county (there are only 2 and only one accepts TDO's) accepted TDO pts. & did the psychiatric evaluations. Laws could be more clear as well as stage dept. Guidelines mare voluntary \_\_\_\_\_ would prevent some TDO/commitments (more staff with \_\_\_\_\_ capability)(more staff for better not office hours coverage)
- o 1) Lack of voluntary input. MH/SA resources place much stress on emergency personnel who are forced to case-manage very disturbed clients. 2) Magistrates may sometimes interpret TDO procedure differently than MH staff. 3) Our sheriff's department, other agencies generally view client's needs for treatment accurately and work cooperatively with MH in assuring treatment.
- o N/A
- o N/A
- o The main problem in the delivering of emergency mental health services is the inability to see a person face to face. If the person is not in agreement to come to be seen it makes it difficult to determine the seriousness of this problem. There needs to be a way to have a person hospitalized for evaluation without violating this rights.
- o N/A
- o N/A
- o 1) Statute too narrow - must wait for the individual to completely deteriorate before any intervention, assuming they are unwilling to seek help voluntarily. 2) Transportation for voluntary admissions. 3) Lack of information, different information, or the same information creates conflicts, as each judge, special justice and magistrate reads the laws differently. 4) Refusal to do the two-step TDO. Worker will not be asked to make home visits in these situations due to the potential danger to them. 5) Lack of adequate staff./

- o Non-availability of voluntary beds unless insured. No detention or commitment beds readily available. Insufficient less restrictive options, e.g. crisis care. No detox beds for uninsured. Lack of local hospital, crisis care, or respite care for children. Inadequate facilities for physically handicapped, MR, etc. Magistrates issue TDOs based on criteria for commitment rather than criteria for detention. Magistrates question the expertise of non-physician mental health professionals. Special justices determine person's willingness to go voluntary and ignore his capability to make that decision.
- o Involuntary outpatient commitment is rarely if ever used in the Commonwealth of Virginia and would provide a most useful alternative and allow for treatment in a less restrictive environment. Statutes would need to be clarified and use encouraged prior to any significant use.
- o Non-availability of voluntary beds unless insured. No detention or commitment beds readily available. Insufficient less restrictive options, e.g. crisis care. No detox beds for uninsured. Lack of local hospital, crisis care, or respite care for children. Inadequate facilities for physically handicapped, MR, etc. Magistrates issue TDOs based on criteria for commitment rather than criteria for detention. Magistrates question the expertise of non-physician mental health professionals. Special justices determine person's willingness to go voluntary and ignore his capability to make that decision. (Revised survey)
- o N/A
- o Chesapeake CSB and Judges attempt to follow the statutes as specifically the state. There are seldom difficulties, except when a particular statute is not addressed clearly.
- o N/A
- o Some difficult questions because no uniform or agreed upon data collection system for example question #25. Thank you working on this survey. I trust it got to the practitioners of emergency work.
- o Involuntary outpatient is rarely if ever used in the Commonwealth of Virginia and would provide a most useful alternative and allow for treatment in a less restrictive environment. Statutes would need to be clarified and use encouraged prior to any significant use.
- o The ESCSB requires a local inpatient facility to allow for Temporary Detention Order and local hospitalization.



## Special Justices

- o N/A
- o N/A
- o We believe the system works well in our area.
- o In my two and one half years, about six or possibly ten cases have been appealed that I committed (including one person I refused to commit).
- o N/A
- o N/A
- o N/A
- o For the most part best of a bad situation. I do not know of anyone who has been deprived of rights or treated badly. Most cases are extremely clear cut, either desperately in need of help for acute or chronic treatment (senility) or no treatment needed.
- o Code needs to be made clearer so magistrates know when they can do TDO's; also to allow for oral TDO's by Special Justice at night.
- o N/A
- o N/A
- o Experienced Special Justices are grossly underpaid for their duties and responsibilities when compared with compensation paid others by the state with less obligations.
- o #13 TDO never issued on advice/information from non-professionals, only upon signed, sworn petition.
- o The greatest concern I have is who initiates a TDO when a person is believed to be mentally ill and is in need of immediate physical treatment, e.g. a man who has lain in bed 3 days in his own waste and refuse food and help, or the man who is completely intoxicated in his own home and refuses to allow his family or anyone to enter; the man who walks out of a substance abuse facility, gets drunk and sits on the front steps.
- o N/A
- o Having served as a special justice since 1982, time does not permit... . I have many thoughts about standardization, procedures, training, continuing education, etc. and would be happy to discuss them with your.

- o N/A
- o N/A

VAMI

#### Affiliate Presidents

- o I feel some provision should be made to be able to commit a person before a real crisis exist. It is not right that a loving and caring family has to deal with these experiences for year when help could be available for the individual.

This questionnaire is no more than a set of questions for obtaining statistically useful information for the agency involved. It doe not address the moral rights of people and their families nor any of the needs or to assure sound healthy judgement for mental health.

- o Not well developed in all areas in Central Virginia - poorly implemented in most areas.

The Alliance for the Mentally Ill - Central Virginia (AMI-CV) is now investigating the fatal shooting of Janet Chenault Holden in Hanover County by a deput sheriff. The family of Ms. Holden had called CSB for emergency help in obtaining a green warrant and was referred to the Sheriff's Department. Janet had a knife and was shot by sheriff's deputy approximately 4 to 12 minutes after calling CSB. No emergency help was received. Please advise if you want more information.

- o It has been very difficult to get my son to any MH Center - TDO is very hard to get. The Judge won't give it. The Magistrates are a bit better. It is hard and time consuming to get TDO in time to "catch" my son when he needs catching. TDO expires when not served and then another must be sought. Past experiences don't seem to be important to the judge I last dealt with. My observations are not taken seriously. At the moment the Police in Fairfax County want to help, but can't legally transport without TDO or a willing person. A person behaving in a psychotic manner is not willing and most times not dangerous....just crazy.

The appeal process for a committed person is poor for the original petitioner. There is no notification and if one finds out, he is not allowed to speak.

There is seldom legal help for petitioner. Is not officially told about the need for witnesses or a lawyer.

- o N/A
- o N/A

- o The Middle-Peninsula Northern Neck Counseling Center has always worked well with our family when their services are required. Our Alliance for the Mentally Ill Group is a newly organized, and very small, fledgling group, and as a matter of fact, because of low attendance, we have not had any meetings in about 5 months.
- o No crisis intervention center in area. No holding place for 72 hour period.
- o Not all catchments have the training to properly deal with the Mentally Ill. In all cases, the sheriff/police should work closely with the Mentally House CSB.
- o In this county, it is nearly impossible to get a judge, lawyer & doctor together. Family members or other petitioners are usually unwilling to get involved. Result is TDO to hospital or nothing.
- o N/A
- o CSB does fine job; one stop TDO inconvenient due to distance; commitment area is from Western State Hospitals.
- o N/A
- o Magistrates should exercise to greater extent power to issue "pick-up" orders; split fee system for voluntary vs. involuntary committals (for court-appointed lawyers & special justices) subject to constitutional challenge under Tumey v. Ohio.
- o We have an extreme problem where a report of someone with problem is received, but person will not come in voluntarily to Mental Health and Mental Health will not go out for prescreening. We are advised not to use TDO to bring patient in for screening, but most S/J in this area do not like to use TDO to send patient directly to hospital without Mental Health having a chance to see the subject. S/J should have authority to send patient to Mental Health for exam prior to entry of TDO to hospital.
- o N/A
- o N/A
- o There should be a local holding facility for TDO's if our caseload should grow much more. There should be a staff person available for each locality. Our PD-IX is too large geographically for 10 or 2 staff after hours.
- o N/A

- Pay structure makes it very difficult to get qualified attorneys and medical personnel to participate in hearings. Pay structure is inadequate for all personnel in semi rural areas where cases arise sporadically. Also Special Justices should receive some compensation for considering (as opposed to issuing) TDO requests.
- As a Special Justice, I do not have actual knowledge of some of the above questions, we issue TDOs and hold hearings and draft orders.
- N/A
- N/A