

**Increasing the Temporary Detention Period  
Prior to a Civil Commitment Hearing:**

**Implications and Recommendations for the  
Commonwealth of Virginia  
Commission on Mental Health Law Reform**

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## **Executive Summary**

### **Introduction**

The Commonwealth of Virginia Commission on Mental Health Law Reform (the Commission) was formed in late 2006 by the Supreme Court of Virginia to study the state's mental health system and make recommendations for reform. The Commission is addressing the adequacy of the temporary detention period, among other issues. During the involuntary commitment process, one of the initial proceedings is the issuance of a temporary detention order (TDO) by a magistrate. The TDO allows an individual to be detained for up to 48 hours. By the end of the temporary detention period, a civil commitment hearing must be held. At the civil commitment hearing the patient can be released, involuntarily committed, voluntarily committed or ordered to comply with outpatient commitment.

This report analyzes the current process that occurs during the temporary detention period in Virginia, and what the potential implications are if the Commission recommends increasing the temporary detention period from two days to four days.

### **Background**

Virginia has one of the shortest time periods in the country between the initial detention and the civil commitment hearing. Approximately 90% of states allow five days or longer between the initial detention and the civil commitment hearing. With regard to mental health service delivery, the state has faced a decline of psychiatric beds since the early 1990s. While the official occupancy status does not indicate a need for increased bed space, qualitative evidence suggests a bed shortage exists. This shortage will likely become an increasing problem: the number of involuntary commitment orders increased 35% since 1998.

### **Importance of the Temporary Detention Period**

The temporary detention period is a critical time during which important evaluations and assessments are made regarding whether an individual needs further involuntary hospitalization. Clinicians usually predict the likelihood of a patient inflicting self-harm or harming others during this time period. These decisions are vitally important given the consequences if either a Type I (false positive) or Type II (false negative) error is made. If a Type I error is made, a person is unnecessarily committed against his or her will. If a Type II error occurs, the patient could commit suicide or homicide, or seriously injure himself or others. Furthermore, the temporary detention period allows patients to detoxify, if necessary, which is important in order for clinicians to make an accurate assessment. Finally, patients often stabilize during the temporary detention period, which may facilitate the patient voluntarily agreeing to inpatient treatment, or being released from the hospital.

## **Adequacy of Current Temporary Detention Period**

Evidence from interviews with mental health professionals in Virginia and across the country suggests that the current temporary detention period may be insufficient in order to accurately assess someone's risk. This may lead to errors in the decision-making process leading up to the commitment hearing.

In Virginia, 30.2% of commitment hearings occurred in less than 24 hours after a TDO was issued. This often happens in rural areas where hearings are not held every day. Conducting an evaluation in less than 24 hours does not allow much time to observe a patient, much less collect any type of collateral information. Also, given the diverse array of patients who present with psychiatric symptoms, certain cases require more than 48 hours to conduct an accurate assessment, according to expert medical opinion. The general consensus among the experts I interviewed was that at least a three day temporary detention is necessary for more difficult cases.

## **Empirical Evidence from Virginia and Other States**

I obtained data from facilities in Virginia, Colorado, Massachusetts and Pennsylvania on lengths of stay for individuals admitted on a TDO, or the respective state's equivalent to a TDO. From Maryland, I obtained data on the outcomes of scheduled commitment hearings. These states have various temporary detention period lengths.

Data from the University of Virginia Health System show that less than 10% of patients detained under a TDO were released from the hospital within two days, which suggests that most individuals were involuntarily or voluntarily committed. Within four days, however, almost one-third of patients had been discharged. (In addition, approximately 38% of patients admitted on a Friday were released on the following Monday. For patients admitted very late on a Thursday night or on a Friday, the TDO is extended to 72 hours. The fact that 38% were released by the end of the three day TDO may be an indication that many patients benefited from the extra day of observation and assessment.) At the Colorado Mental Health Institute at Pueblo, 12.7% of detained patients were released within four days. In Pennsylvania, approximately 25% of patients were discharged within four days from Montgomery County Emergency Service, Inc. (MCES). Data from the Maryland Office of Administrative Hearings show that approximately 40% of detained patients converted to voluntary status prior to the hearing and almost 32% of patients were discharged at some point prior to the hearing. Finally, a study conducted in Massachusetts revealed that approximately 23% of detained patients were released within four days.

## **Conclusions Regarding Release or Conversion to Voluntary Status Prior to Hearing**

The data from sites in Colorado, Maryland, Massachusetts, Pennsylvania and Virginia suggest that a longer emergency admissions stay may facilitate release or conversion to voluntary status prior to a civil commitment hearing. However, the percentages of individuals released within four days differ widely – ranging from 12.7% in the Colorado site to 32.8% in the Virginia site. These numbers suggest that a significant number of patients are likely to be released prior to a civil commitment hearing under a four day detention period, but estimating the percentage of

pre-hearing discharges or voluntary conversions based on these comparative data would be highly speculative and should be undertaken with caution. Various factors that might influence these data could not be controlled for.

## Conclusions

- **Two day temporary detention period is not adequate for a thorough assessment in some cases.** Based on expert medical opinion from around the country, some types of patient cases require more than two days to perform an accurate and thorough assessment.
- **Current temporary detention process is of low quality.** Currently, 30% of commitment hearings occur in less than 24 hours. Furthermore, Virginia mental health professionals identified problems such as independent evaluators not reviewing patient medical records because they did not have access to them.
- **An increased temporary detention period should contribute to an improved decision-making process.** An increased temporary detention period will not solve all the problems with the process, but should decrease the number of Type I and II errors that likely occur.
- **Potential for increased short-term bed demand if temporary detention period is increased to four days.** Virginia should be prepared for a potential increase in bed demand during a four day temporary detention period.
- **Other states have effective pre-hearing release measures.** Many of the mental health professionals interviewed discussed the importance and effectiveness of doctors having the ability to release patients prior to their commitment hearing. In order for Virginia and the individuals subject to the temporary detention process to realize the benefits of an increased time period, the state must utilize effective pre-hearing release measures.
- **Lack of information regarding involuntary commitment system.** The research conducted for this report clearly showed the lack of information and data that exists about the civil commitment process, both in Virginia and around the country. Data were extremely hard to find, and were generally not available at the local or state level.

## Recommendations

- The Commission should adopt the Task Force on Civil Commitment's recommendation to increase the temporary detention period from two days to four days.
- Virginia should not increase the temporary detention period to four days without effective and appropriate pre-hearing release measures.
- The Commission should conduct further study and research regarding the potential impact of an increased temporary detention period on bed availability.

- Virginia should implement a data collection system to better understand involuntary commitment trends and plan for future impacts on the system. Furthermore, the data collected should be used to evaluate a four day temporary detention period, if it is enacted.



## **I. Introduction**

### **Commonwealth of Virginia Commission on Mental Health Law Reform**

The Commonwealth of Virginia Commission on Mental Health Law Reform (the Commission) was formed in late 2006 by the Supreme Court of Virginia to review the state's mental health laws and policies. The Commission is charged with specifically addressing access to mental health services, involuntary civil commitment, consumer empowerment, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. Commission members include officials from state government as well as representatives of other stakeholder groups, such as consumers, their families, and service providers.<sup>1</sup>

In conjunction with one of the Commission's goals to make the involuntary treatment process more fair and effective, the Task Force on Civil Commitment (the Task Force), one of five advisory groups to the Commission, examined the issue of the temporary detention period. Currently, a temporary detention order (TDO) is valid for 48 hours (up to 72 hours for a necessary weekend extension). Prior to or by the end of the two day temporary detention, a commitment hearing must be held. In its final report to the Commission in March 2008, the Task Force recommended increasing the temporary detention period from the current two day period, to four days.<sup>2</sup> The Task Force stated that an increased temporary detention period may allow for more thorough evaluations and decrease the number of individuals subject to involuntary commitment. Furthermore, the additional time may allow for greater stabilization and facilitate patients in seeking voluntary inpatient or outpatient treatment.

The Virginia Tech Review Panel also recommended increasing the temporary detention period in its report to Governor Timothy M. Kaine. In the report issued in August 2007, the Review Panel found that the current time frame "impede[s] the collection of vital psychiatric information required for risk assessment."<sup>3</sup> The Review Panel also reported that mental health professionals expressed the need for more time to gather information about the person's history and to complete a more comprehensive independent evaluation. Reducing the number of involuntary commitments would also result in fewer costs associated with commitment hearings.<sup>4</sup>

The purpose of this report is to explore the implications if Virginia increases the temporary detention period from two days to four days, and to assess whether the Commission should recommend a four day temporary detention period. My research included gathering data from Virginia and other states on lengths of stay for patients admitted on an emergency basis, and the percentage of patients who converted to voluntary status prior to a commitment hearing. I also conducted interviews with mental health professionals in Virginia and other states throughout the country to qualitatively inform my analysis. This report also contains information on the current state of the TDO process in Virginia. All of the information contained in this report is the result of extensive inquiry.

Qualitative and quantitative evidence suggest that Virginia would benefit from an increased temporary detention period. Interviews conducted with mental health professionals around the country revealed that assessments, in many, but not all, cases require more than two days in

order to thoroughly evaluate someone's risk to themselves or others. The additional time would also likely reduce false positives and false negatives regarding the decision to involuntarily commit someone.

Data collected from Colorado, Maryland, Massachusetts, Pennsylvania and Virginia indicate that a longer temporary detention period would likely result in a significant number of discharges and conversions to voluntary status prior to a commitment hearing, obviating the need for a commitment hearing in many circumstances. However, an increase in short-term bed demand may also occur.

Based on this evidence, it is my view that the Commission should adopt the Task Force on Civil Commitment's recommendation to increase the temporary detention period from two days to four days. However, effective pre-hearing release measures must be in place and effectively used in order for the benefits of the longer detention period to be realized. I also recommend that the Commission undertake further study to more fully understand the potential impact on bed capacity.

The next two sections give detailed background regarding the involuntary commitment process in Virginia, and why the temporary detention period is important. Then, I detail the adequacy of the current temporary detention period in Virginia, and go on to describe commitment data collected from Virginia, Colorado, Pennsylvania, Maryland and Massachusetts. Finally, conclusions and recommendations are outlined for the Commission.

## **II. Background**

### **Involuntary Commitment Law in Virginia**

According to the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), approximately 308,000 Virginians, or 5.4% of the population, have had a serious mental illness at some point during the last year.<sup>5</sup> Some of these citizens were subject to the involuntary commitment process; approximately 20,000 involuntary commitment hearings were held in 2007.<sup>6</sup> Involuntary commitment is a legal process through which a mentally ill person may be temporarily detained, and through a judicial hearing, may be committed to a hospital against his or her will for a defined period of time.<sup>7</sup> The United States Supreme Court ruled that involuntary commitment is a “massive curtailment of liberty,”<sup>8</sup> and therefore requires due process protection. While all states must adhere to basic standards, state laws differ widely with regard to the exact length of time a person may be temporarily detained and within what time frame a judicial hearing must be held.

In Virginia, generally the first step in the involuntary civil commitment process is obtaining an emergency custody order (ECO). An ECO allows for a person to be held for up to four hours for a mental health evaluation in a “convenient location,” such as a hospital or jail.<sup>9</sup> A variety of individuals can seek to obtain an emergency custody order from a magistrate for someone they believe is mentally ill and in need of hospitalization, including: 1) family members and friends who contact their local Community Services Board<sup>a</sup> (CSB) or law enforcement officials; 2) CSB emergency services staff; 3) law enforcement officials; 4) private physicians, psychologists and psychiatrists; and 5) magistrates.<sup>10</sup>

Following the end of the ECO, an individual must be released, or a magistrate must issue a temporary detention order. A temporary detention order allows for an individual to be detained in an inpatient hospital for a maximum of 48 hours (if the period ends on a holiday weekend, the person may be held for a maximum of 96 hours). If evidence from the evaluation shows the person is in need of hospitalization and is found by CSB staff within the four hour ECO time frame, a magistrate issues the TDO. At the end of the temporary detention period, the patient must be released or have a commitment hearing.<sup>11</sup>

Before a commitment hearing is held, the individual should be afforded the opportunity to accept voluntary admission and treatment. If the individual is “incapable” or “unwilling” to accept voluntary admission and treatment, then a commitment hearing is held.<sup>12</sup> According to the Task Force’s report, the prevailing view and practice among special justices across Virginia is that a commitment proceeding must be convened, regardless of whether a patient agrees to voluntary treatment prior to the scheduled hearing; the main purpose of the proceeding in such cases is to confirm the patient’s capacity to agree to voluntary admission.<sup>13</sup>

During the commitment hearing, evidence is presented to the special justice regarding the necessity for involuntary commitment. The evidence is gathered during the temporary detention period and includes a report by the CSB staff determining if the commitment criteria are met and

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<sup>a</sup> Community Services Boards are local government organizations that provide mental health services in Virginia.

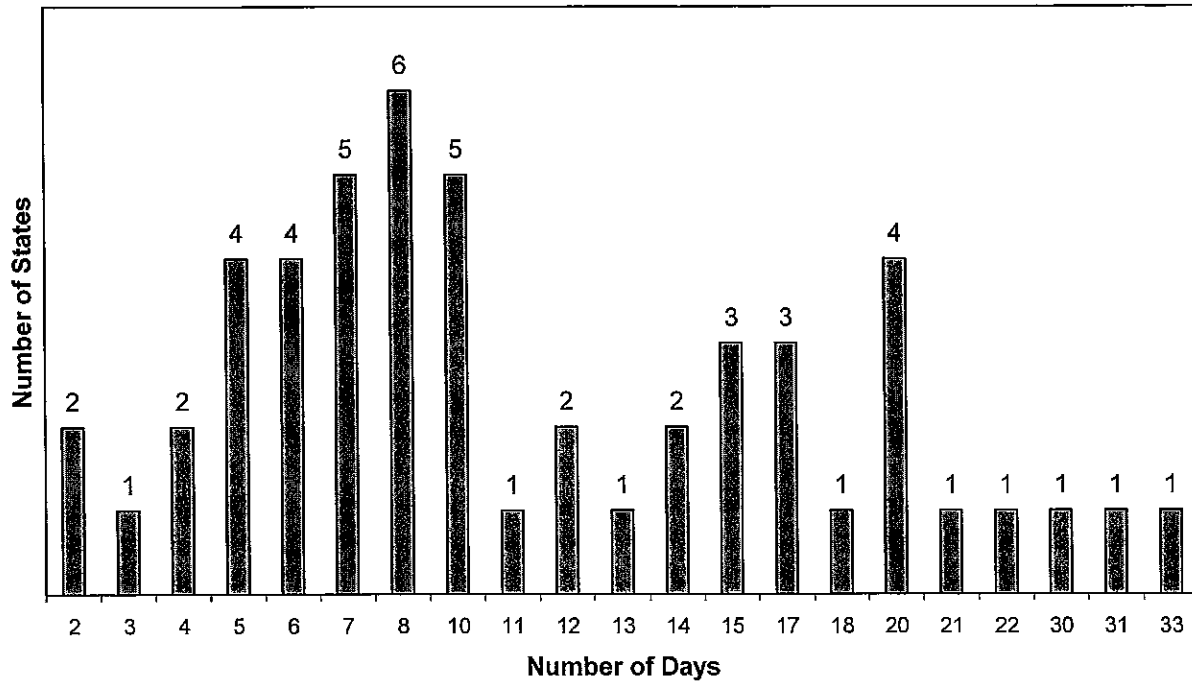
what course of treatment and care the individual should receive.<sup>14</sup> The other piece of required evidence is a written or oral report from an independent evaluation conducted by a psychiatrist, clinical psychologist, or physician. The independent evaluator certifies whether the commitment criteria are met and whether involuntary hospitalization or treatment is necessary.<sup>15</sup>

At the end of the commitment hearing, the special justice delivers a judgment based on a variety of options at her disposal. According to Virginia law, “if it is determined at the commitment hearing that the individual, due to mental illness, presents an imminent danger to self or others, or is substantially incapable of self care, and there is no less restrictive alternative, an order for involuntary commitment is issued, which requires the individual to be hospitalized for up to 180 days.”<sup>16</sup> Other decisions the special justice may render include: 1) involuntary outpatient commitment; 2) voluntary inpatient admission; or 3) release of the individual.<sup>17</sup> For a schematic of the involuntary commitment process, please see Figure A1 in the Appendix.

### **Virginia in Context: Landscape of State Statutes**

Involuntary commitment statutes differ greatly from state to state. In Virginia, the probable cause hearing *and* commitment hearing must occur within two days. This is one of the shortest time periods in the country. Figure 1 shows the total permissible amount of time allowed between an initial detention and the commitment hearing. Almost half of states allow for a time period ranging from five to 10 days. The remaining states, except for five, have total maximum time periods over 10 days. Again, it is important to remember these are maximum time frames, and do not necessarily reflect how long patients are routinely held. However, this overview highlights that even if Virginia increases the length of time under a TDO to four days, it will still be among the shortest time periods in the country.

**Figure 1: Longest Total Permissible Detention before Commitment Hearing**



Source: Pre-hearing Detention, provided to author by Professor Richard Bonnie.

### **Involuntary Commitment Funding Process**

In 1970, the Virginia General Assembly established the Involuntary Mental Commitment Fund (IMCF) to pay for the costs associated with the involuntary commitment process. The IMCF is intended to cover the costs of the uninsured and patients whose insurance does not cover the full cost of services rendered during the ECO and TDO process.<sup>18</sup> The IMCF pays: 1) hospitals for patients' stays during a TDO; 2) psychiatrists, physicians, and psychologists for medical and psychiatric services provided during a TDO; and 3) special justices, attorneys, psychiatrists, physicians, and psychologists who participate in involuntary commitment hearings.<sup>19</sup> The Department of Medical Assistance Services administers the portion of the fund that pays for medical services during the TDO, and the Supreme Court of Virginia administers the portion of the fund that pays for court costs.<sup>20</sup> IMCF expenditures totaled \$13,314,446 in FY2006.<sup>21</sup> As Table A1 in the Appendix shows, IMCF expenditures fluctuated between FY1998 to FY2006, ranging from \$10,375,904 in 2004, to \$13,601,209 in 2003.<sup>22</sup>

When the IMCF reimburses hospitals for costs incurred during the TDO process, the hospital receives the state-established Medicaid inpatient psychiatric services per diem rate. In essence, the TDO rate is the same daily rate they would receive for a Medicaid patient receiving inpatient psychiatric services. The current TDO rate only reimburses hospitals 84% of the average statewide cost of treating a TDO person.<sup>23</sup> Unreimbursed costs for inpatient psychiatric services,

including TDOs, are cited as a potential reason for declining psychiatric bed space.<sup>24</sup> Unreimbursed costs for psychiatric services totaled \$29 million in 2005.<sup>25</sup>

### **Psychiatric Bed Availability and Involuntary Commitment Orders**

The availability of psychiatric beds also affects the temporary detention process. While an adequate number of psychiatric beds are available according to the Virginia Department of Health (VDH), CSB staff asserts that locating beds for individuals under a TDO can be difficult.<sup>26</sup> The Virginia Department of Health uses a 90% occupancy status threshold to assess whether more psychiatric beds are necessary.<sup>27</sup> As of 2005, the occupancy rate was 58%, well below the 90% threshold necessary to consider licensing new beds.<sup>28</sup> However, a CSB survey conducted by DMHMRSAS indicated that 68 people under a TDO were released during September and October 2004 because a psychiatric bed could not be found for them.<sup>29</sup>

Psychiatric beds in Virginia have been declining since 1991. In 1991, 2,587 psychiatric beds in licensed hospitals were available. As of 2005, 1,794 psychiatric beds were available, representing a decrease of 793 beds.<sup>30</sup> State hospital beds also decreased, from 3,434 in 1991 to 1,760 in 2005.<sup>31</sup> While psychiatric beds have declined, involuntary commitment orders have increased. Between 1998 and 2006, the number of involuntary commitment orders issued in Virginia increased by 35 percent. Table 1 shows the annual increase, from 5,308 ICOs in 1998 to 7,159 ICOs in 2006.<sup>32</sup> The recent study by JLARC suggests that the increase in ICOs may signal a future increase in demand for psychiatric beds.<sup>33</sup>

**Table 1: Number of Involuntary Commitment Orders: 1998-2006**

| <b>Year</b> | <b>Involuntary Commitment Orders</b> |
|-------------|--------------------------------------|
| 1998        | 5,308                                |
| 1999        | 4,493                                |
| 2000        | 4,313                                |
| 2001        | 5,403                                |
| 2002        | 5,835                                |
| 2003        | 6,618                                |
| 2004        | 7,004                                |
| 2005        | 7,056                                |
| 2006        | 7,159                                |

Source: Virginia Joint Legislative Audit and Review Commission, "Commission Draft: Availability and Cost of Licensed Psychiatric Services in Virginia," October 9, 2007.

In *Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations*, a focus group study conducted for the Commission, the lack of available beds for severely mentally ill patients was the problem cited by all groups participating in the study. The study cites the "sincere concern, frustration, and annoyance that many consumers are not getting needed treatment."<sup>34</sup>

Specifically, family members in the Northwest, Northern, Central, and Eastern Regions said that a major problem they face is “lack of available beds.”<sup>35</sup> The report also states judges and special justices reporting “a revolving door where patients are admitted for treatment, but released before the medications can work because of the pressure to ‘free up’ a bed.”<sup>36</sup>

The data on involuntary commitment orders suggest that involuntary civil commitments are likely to continue increasing, resulting in further expenditures on the civil commitment process and potential increased demand for psychiatric beds.

### **III. Why Increase the Temporary Detention Period?**

Two main objectives underlie the Task Force's recommendation to increase the temporary detention period from two days to four days. These objectives include: 1) improving the quality of decisions made during the temporary detention period; and 2) reducing the number of involuntary commitments and hearings. Each of these objectives is discussed in greater detail below.

#### **Clinician Judgment/Decision-Making in the Civil Commitment Process**

Clinician decisions and judgments are a crucial component of the civil commitment process. During the temporary detention period, clinicians usually must assess the likelihood that an individual will be harmful to himself or others. These decisions are also important given the significant costs associated when either a Type I (false positive) or Type II (false negative) error occurs in the involuntary commitment process.

If a patient is involuntarily committed, the experience causes stigmatization and a permanent court record, and may result in a decreased likelihood of the patient seeking future mental health services for fear of the same outcome. Furthermore, if a Type I error occurs and the patient is unduly committed, the outcome seems particularly egregious: A person was unjustifiably confined against his or her will, and resources were wasted.

If a Type II error occurs, and a patient is not committed who needs to be, his release could result in a variety of serious outcomes. The individual could commit suicide or homicide, or otherwise seriously injure himself or others. Studies have established a link between major mental disorder and violence, although the vast majority of individuals with mental illness are not violent.<sup>37</sup> In addition, a Type II error could result in a higher probability that the individual is a crime victim, as studies show persons with severe psychiatric disorders are more likely to be victimized.<sup>38</sup> Other negative consequences could include homelessness and the missed opportunity to intervene and provide helpful treatment. For a further conceptualization of the TDO period, please see Figure A2 in the Appendix.

Unfortunately, most studies point to the relative inability of mental health professionals to accurately predict dangerousness, and therefore avoid Type I or II errors. In an oft-cited study by John Monahan in 1981, he concluded that,

“psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior [one-third of patients predicted to be violent actually were violent]...among institutionalized populations that had both committed violence in the past...and who were diagnosed as mentally ill.”<sup>39</sup>

In another review of research in 1992, Randy Otto concluded that predictive accuracy was at least 50%, but cautioned that clinicians still make many inaccurate predictions, mainly false positives.<sup>40</sup>



In light of human inaccuracy in making judgments and predictions, many scholars promote the use of statistical or actuarial models to predict the probability of future behavior. Research suggests that statistical predictors are superior to clinical predictions, even when the models are not optimal.<sup>41</sup> However, the use of actuarial models in clinical settings can be hampered by their complex nature and requisite extensive patient information.<sup>42</sup> Literature suggests that clinicians are averse to using actuarial models that involve calculations and/or regression-based formulas, which may be difficult to understand and use in a clinical setting.<sup>43</sup> Furthermore, these models are supposedly costly in terms of the time and effort required to generate a predictive value.<sup>44</sup>

Given their potential value, reliable, yet simple models are being constructed for clinical settings. One example is a screening checklist for assessing risk of violence at the time of psychiatric hospitalization created by McNeil and Binder. Admittedly the checklist is not perfect, but performs better than most studies of clinical assessment of the risk of violence.<sup>45</sup> The authors stress the importance of further research, but proffer the checklist as a step towards improving predictive accuracy in clinical settings. For further results of this study and the checklist components, please see Figure A3 in the Appendix.

More recently, a new software program, the Classification of Violence Risk (COVR), assists clinicians in estimating the risk that an acute psychiatric patient will be violent to others in a several month period after discharge from the hospital.<sup>46</sup> While this software is also intended for a very specific use in a specific setting, its development suggests the trend towards incorporating these models into clinical judgments regarding risk assessment.

Given the research regarding the imperfection of clinical judgments, one cannot be certain that an increased temporary detention period will reduce Type I and II errors. However, it would allow clinicians more time to observe a patient and gather evidence from which to assess a patient's risk, likely reducing Type I and II errors. Furthermore, giving patients more time to detoxify, if necessary, should reduce Type I errors. These may be cases where clinicians recommend involuntary commitment due to intoxication or drug use fueling the psychosis, but might not recommend involuntary commitment if the patient were detoxified.

### **Reducing Involuntary Commitments**

In addition to improving the quality of decisions made during the temporary detention period, reducing the number of involuntary commitments is another important objective. By increasing voluntary commitments, more patients are involved in their treatment, which is a goal of Virginia's recovery-based mental health service delivery model.<sup>47</sup> Reducing involuntary commitments also would decrease the stigma associated with involuntary hospitalization.<sup>48</sup> Finally, by increasing the number of voluntary commitments and allowing patients to convert to voluntary status without a commitment hearing, the number of involuntary commitment hearings and the costs associated with them would decrease. A longer temporary detention period may facilitate more voluntary hospitalizations by allowing patients more time to stabilize and detoxify, if necessary.

## **IV. Adequacy of Current Temporary Detention Period**

Both quantitative and qualitative data suggest that the current temporary detention period may not be an adequate time frame to accurately assess someone's risk, and may lead to errors in the decision-making process leading up to the commitment hearing.

### **Current Practices and Patient Cases**

According to data from the Commission's Study of Commitment Hearings in May 2007, 30.2% of commitment hearings occurred in less than 24 hours after a TDO was issued.<sup>49</sup> Conducting an evaluation in less than 24 hours does not allow much time to observe a patient, much less collect any type of collateral information. Based on interviews with professionals involved in the involuntary commitment process, problems such as hearings occurring in less than 24 hours are particularly acute in rural areas.<sup>50</sup> In many rural areas, hearings are not held every day, and occur on a Monday-Wednesday-Friday schedule, for example. Therefore, if an individual is admitted on a Sunday, a hearing would have to be held on Monday since Wednesday would be past the 48-hour TDO time limit. Another issue for rural areas is having adequate time for independent evaluators to drive to hospitals in their catchment area, which may be three or more hours away.<sup>51</sup> If an evaluator had many cases on a particular day, it may be very difficult for him to complete the evaluations and gather the appropriate information to inform an accurate opinion, largely due to how far the evaluator must travel. Finally, evidence also suggests that some evaluators do not have access to a patient's medical chart or to the treatment team when making a certification.<sup>52</sup>

Given how diverse the patients are who present with psychiatric symptoms, there is not a "one size fits all" time period necessary in order to make an accurate, informed assessment. To illustrate some of the different types of cases that may require more or less time for assessment than the current two day temporary detention period, Dr. Bruce Cohen, Associate Professor of Psychiatry and Neurobehavioral Sciences at the University of Virginia and Civil Commitment Task Force member, provided examples of different types of patient cases.

#### *Type I: Requiring less than two days for accurate assessment*

"...a situation that might require less than 2 days is an acute adjustment disorder leading to an overdose, or a self-injury such as superficial wrist cutting, or simply threats of self-harm, where the patient feels fine the next morning, and so essentially the hospital stay was an extended emergency room visit [since emergency rooms are under length of stay pressures themselves, they generally admit the person to psychiatry to spend the night and be reassessed in the morning as opposed to staying overnight in the emergency room]."<sup>53</sup>

#### *Type II: Requiring two days for accurate assessment*

"An example of a case that might take 2 days would be a manic or schizophrenic or depressed patient who benefits from 1-2 days in the hospital, but feels safe for discharge by the time of the hearing. They might have run out of medication, but had no problems with the medicine they were taking and so we could simply restart the same medication in the same dosages they

previously were taking, without a lot of need to start at a low dose, assess for ability to tolerate the medication etc. Another example would be where the person already has an outpatient psychiatric provider (and no need to get an intake appointment), where the history is well known, and where the patient has a supportive family to return to.”<sup>54</sup>

*Type III: Requiring more than two days for accurate assessment*

“An example of where the assessment might take longer is where the patient is acutely psychotic but really doesn't show a response to treatment for a few days, or where they initially are refusing treatment for the first few days, or where acute substance intoxication or withdrawal might be triggering their psychiatric symptoms but where one can only detoxify a person so quickly if one is to do so safely.”<sup>55</sup>

### **Interviews with Mental Health Professionals<sup>b</sup>**

Qualitative evidence from experts around the country also suggests that the time period in Virginia may not be adequate. I interviewed mental health experts across the country who offered opinions regarding their state's involuntary commitment process, adequate time for evaluation, and other factors influencing the commitment process. The experts represent a variety of states including: California; Colorado; Connecticut; Maryland; Ohio; and Virginia.

While opinions differed as to how much time is needed for an adequate evaluation, most psychiatrists I interviewed suggested that a two day time frame is not adequate to thoroughly assess someone's risk. Given the variability that exists when a patient presents during an acute psychotic episode, no one could give a definitive minimum time period, since some patients will require less time and others more. However, the general consensus was that at least three days is needed for more difficult cases, such as the ones described by Dr. Cohen that would likely require more than two days.

A psychiatrist with over 20 years of experience at Johns Hopkins said that a clinician would absolutely need more than two days in order to observe the patient, and to obtain collateral information such as prior medical records and information from family members.<sup>56</sup> A longer period of time also allows for clinicians to work with patients in order to persuade them to accept treatment. As another psychiatrist said, a longer temporary hold period may allow the treatment team to create an “alliance” with the patient, which is better than the patient “fighting” a commitment.<sup>57</sup>

A psychiatrist in Ohio said that conducting an accurate assessment in two days is a “stretch,” and assessing and determining an outpatient treatment plan would be especially difficult in such a short time frame.<sup>58</sup> This doctor also mentioned that the five day emergency hold in Ohio allows enough time to observe the patient, even if they are not cooperating, while not being “too intrusive” on the patient's liberty. In a similar vein, a Professor of Psychiatry at Yale mentioned that often suicidal patients can “keep things together” for a short period of time and therefore may be able to mask their symptoms under a short temporary detention period.<sup>59</sup>

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<sup>b</sup> For a list of those interviewed, please see Exhibit A1 in the Appendix.

One of the concerns raised in the Task Force on Civil Commitment's report is that patients will be held for the full four days, regardless of whether the patient could be released prior to the commitment hearing. Anecdotal evidence from the interviews suggests this concern would not be realized. Many of the psychiatrists who were interviewed discussed the pressure they are under to decrease length of stay, and only keep patients until they can be safely discharged. One psychiatrist discussed this issue at length, stating that patients used to be kept for up to 30 days, and now it is extremely unusual for patients to stay longer than one week.<sup>60</sup> She cited the changing nature of how inpatient care is defined, which has gone from a focus on treatment, to a focus on stabilization in order for the patient to move to a less restrictive form of care and treatment.

The focus group study conducted by the Commission also revealed similar viewpoints regarding financial pressure to discharge as soon as possible. The report states,

“According to another community psychiatrist, ‘There is extreme pressure for managed care agencies to release patients who are hospitalized. I can get the patient admitted easily because the condition is so severe. I get them stabilized in the hospital because we can't let people suffer, so we medicate them, they get some sleep, and feel somewhat better, but aren't really improved enough to release, but the managed care companies pressure the doctors to explain over and over additional reasons to keep the patient. Unless the patient is imminently suicidal, it is difficult to explain medical judgment to these reviewers.’ Other psychiatrists tend to agree.”<sup>61</sup>

However, it is also important to note that many of the mental health professionals I interviewed in Virginia had reservations regarding the usefulness of extending the temporary detention period to four days. An independent evaluator expressed concern that since patients can refuse treatment, extending the time period to four or five days only means these patients are occupying bed space and having their liberty restrained.<sup>62</sup> A special justice also mentioned that many individuals are drawn into the system that should not be there, such as people who are involved in domestic relations disputes.<sup>63</sup> The current system ensures they are not held for too long.

Two CSB employees with over 40 years of combined experience expressed concerns that a temporary detention period of more than three days would exacerbate a bed availability system that is already strained.<sup>64</sup> The independent evaluator, special justice and CSB clinicians agreed that no hearings should be held within 24 hours of an individual's confinement, and most thought that increasing the temporary detention period to three days would be an improvement, but would oppose an increase beyond three days.

## **V. Empirical Evidence from Virginia and Other States**

In order to ascertain what the potential implications and outcomes may be if Virginia increases the temporary detention period, I focused my research on collecting quantitative data from sources outside of Virginia.

Ideally, quantitative data such as the number of TDOs, the number of patients released or voluntarily committed before a hearing, and of the remaining patients, the number who are involuntarily committed, voluntarily committed, or released at the hearing would provide the most utility. Furthermore, for patients who are released or convert from involuntary to voluntary status prior to a commitment hearing, it would be helpful to know what day they are released prior to a hearing (i.e., out of a five day detention, are they released on the third or fifth day). These types of data would serve as a useful guide for Virginia in estimating outcomes such as the number of patients who would be released or convert to voluntary status prior to a commitment hearing, and how many fewer commitment hearings would be necessary. Unfortunately, this information was extremely difficult to identify and gather.

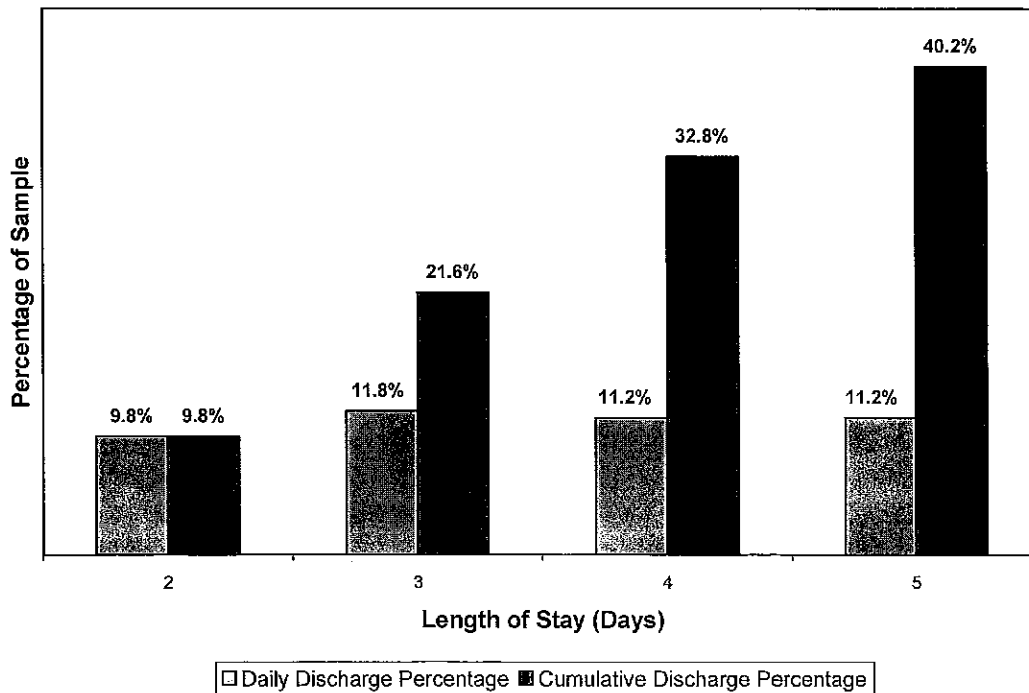
In conducting my research, it became apparent that these types of data are not routinely collected at a local or state level, but are best found in individual hospitals. I obtained two data sets from hospitals in Colorado and Pennsylvania. The Colorado data are from the Colorado Mental Health Institute at Pueblo. The Pennsylvania data come from Montgomery County Emergency Service, Inc. (MCES), in southeastern Pennsylvania. In addition, I obtained administrative data from Maryland that delineate the number of involuntary commitment hearings scheduled over a two week time period and the outcomes of those hearings. Furthermore, I gleaned data from a study conducted in Massachusetts, which provide information on length of stay and patient release dates. In order to have a basic comparison between Virginia and the other states, I also gathered data on TDO admissions from the University of Virginia Health System. All of these data sets and sources are described in more depth in the next section.

## Virginia

The data I obtained for Virginia are from the University of Virginia (UVA) Health System. The sample includes the total number of TDO admissions from December 1, 2006 to December 31, 2007, which is a total of 338 admissions. The average length of stay was 9.4 days and the median length of stay was seven days. Unfortunately, these data do not give an indication of when a patient had a hearing, the result of the hearing, or the status of the patient at the time of their discharge (voluntary or involuntary). Sometimes discharged patients are transferred to Western State Hospital for a longer length of stay. Therefore, some patients who are discharged from UVA in this sample may have longer lengths of stay that are not reflected in these data.

As Figure 2 indicates, less than 10% of patients are released within two days at the University of Virginia hospital, which suggests that most individuals were involuntarily or voluntarily committed. Within four days, almost one-third of patients were discharged. One cannot be certain that these discharge rates would be the same under a four day temporary detention period, or that they would occur without a hearing. However, the cumulative percentages do give a sense of approximately how many patients might be released under an increased temporary detention period, if effective pre-hearing release measures are in place and effectively used. Given that much variation exists in the civil commitment process throughout the state, these numbers should not necessarily be extrapolated as indicative of what would occur in any particular Virginia locality or hospital.

**Figure 2: Length of Stay Distribution at University of Virginia from December 1, 2006 - December 31, 2007**



Source: University of Virginia Health System

For patients admitted very late on a Thursday evening, or on a Friday, a TDO usually is extended to 72 hours. Given that this naturally occurs throughout the sample, I analyzed the data to determine whether individuals who had a three day TDO, as opposed to a two day TDO, had shorter lengths of stay. While many factors contribute to length of stay, a shorter length of stay under a three day TDO may be due to the extra time the patient has to stabilize and/or detoxify, and then may allow the clinician to make a more accurate assessment of the patient’s need for involuntary commitment.

**Table 2: Average and Median Length of Stay by Admission Date**

| <b>Day of Week</b> | <b>Number of Admissions</b> | <b>Average LOS (Days)</b> | <b>Median LOS (Days)</b> |
|--------------------|-----------------------------|---------------------------|--------------------------|
| Sunday             | 27                          | 5.9                       | 4.0                      |
| Monday             | 59                          | 10.2                      | 8.0                      |
| Tuesday            | 65                          | 8.6                       | 7.0                      |
| Wednesday          | 54                          | 11.4                      | 7.5                      |
| Thursday           | 51                          | 8.6                       | 7.0                      |
| Friday             | 47                          | 9.6                       | 6.0                      |
| Saturday           | 35                          | 10.4                      | 7.0                      |

Source: University of Virginia Health System

As Table 2 indicates, patients who are admitted on a Sunday have the shortest average and median lengths of stay. Patients who are admitted on a Friday, presumably under a three day TDO, have the second-shortest median length of stay at six days, but have the fourth-shortest average length of stay. However, approximately 38% of patients admitted on a Friday were released on the following Monday. This number may be an indication that many patients benefited from the extra day by not being held beyond the three day TDO.

### **Colorado**

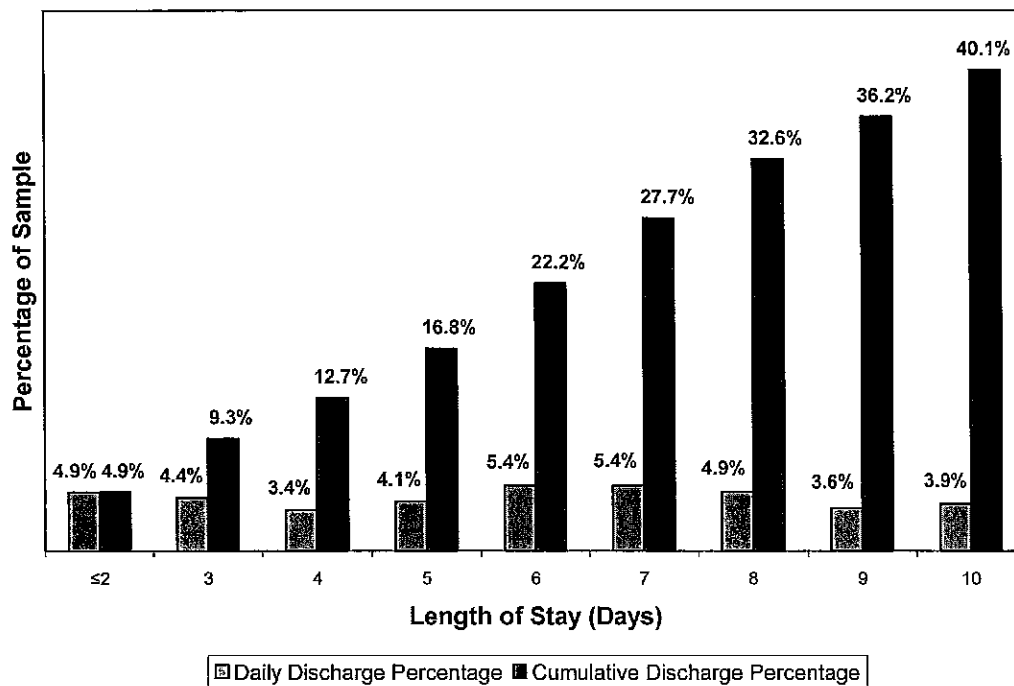
In Colorado, a person can be held for a 72-hour period of treatment and evaluation. By the end of the 72-hour period, the patient must be released, admitted as a voluntary patient, or certified for further treatment by a doctor. A short term treatment certification is for no longer than three months. A patient certified for short term treatment, or his attorney, may at any time file a request that the certification be reviewed by the court. According to Colorado law, the court shall hear the case within ten days after the request.<sup>65</sup> Anecdotal information suggests that the court system in Colorado is generally not equipped to hear the requests within ten days – it usually takes longer.<sup>66</sup>

The Colorado data are from the Colorado Mental Health Institute at Pueblo (CMHIP), one of Colorado’s two state psychiatric hospitals.<sup>67</sup> Prior to admission at CMHIP, patients are generally screened at one of Colorado’s mental health centers.<sup>68</sup> The data from CMHIP are from calendar year 2007 and cover patients admitted on an emergency hold (Colorado’s equivalent to Virginia’s TDO) from January 2, 2007 through November 30, 2007. All patients in the data report who were admitted during this time frame were discharged between January 8, 2007 and March 10, 2008. A total of 589 emergency admissions are in this sample frame.

Length of stay varied from one day to 383 days. The average length of stay was 24.9 days, and the median length of stay was 13 days. As Figure 3 indicates, within the three day emergency hold period, 9.3% of the patients were released. Within four days, 12.7% were released. Almost one-third of patients in this sample were released within eight days.

Lengths of stay at the Colorado Mental Health Institute at Pueblo may be longer than non-state psychiatric hospitals that are analyzed in this report.

**Figure 3: Length of Stay Distribution at Colorado Mental Health Institute at Pueblo from January 2, 2007 to November 30, 2007**



Source: Colorado Mental Health Institute at Pueblo

## Pennsylvania

Pennsylvania law provides for a five day temporary hold, called a Section 302. In order to subject someone to an involuntary emergency hold, a petitioner must state in writing the behavior they have witnessed within the past 30 days that puts the respondent in clear and present danger to himself or others. Upon receiving the petition, a County Mental Health Delegate decides if a warrant should be issued. A warrant compels someone to undergo a psychiatric examination, and the physician would determine whether the individual needed to be hospitalized. A person held on a Section 302 may be discharged at any time during the five day period, if they are deemed to no longer need treatment. If a person is believed to need further treatment beyond the five day period, a hearing is held to determine whether further treatment is



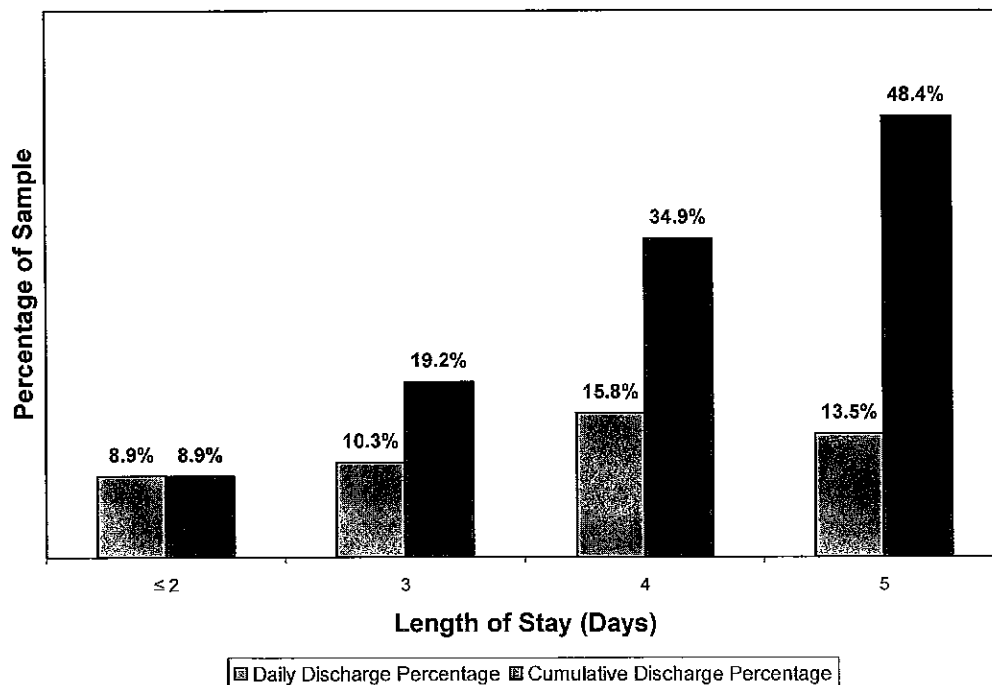
warranted. Up to 20 days of inpatient or outpatient treatment can be ordered by the court as a result of this hearing.

Montgomery County Emergency Service, Inc. (MCES) is a free-standing, nonprofit behavioral health services provider, located in southeastern Pennsylvania. In FY 2006-2007, the average length of stay was 11 days.<sup>69</sup> At MCES, approximately 90% of those evaluated involuntarily are found to need hospitalization.<sup>70</sup> Dr. Edward Kantor of the University of Virginia, who is very familiar with MCES, believes there is a significant amount of up-front diversion built into the MCES model that does not occur in Virginia.<sup>71</sup> While I could not adjust the data to account for this discrepancy, it is important to take this into consideration when analyzing the data.

The MCES data are from 2005 through 2007, and include all patients who were admitted on a Section 302, which is Pennsylvania’s equivalent to the TDO in Virginia. In 2005, 772 admissions under Section 302 occurred. The average length of stay was 10.2 days and the median length of stay was five days. In 2006, there were 1,125 Section 302 admissions. The average length of stay was 11.7 days and the median length of stay was six days. A total of 1,093 Section 302 admissions occurred in 2007, with the average length of stay 10.2 days and the median five days.

Figure 4 shows the length of stay distribution for patients admitted under Section 302 from 2005 through 2007. A significant number of patients were discharged within the five day temporary detention period – upwards of 50%.

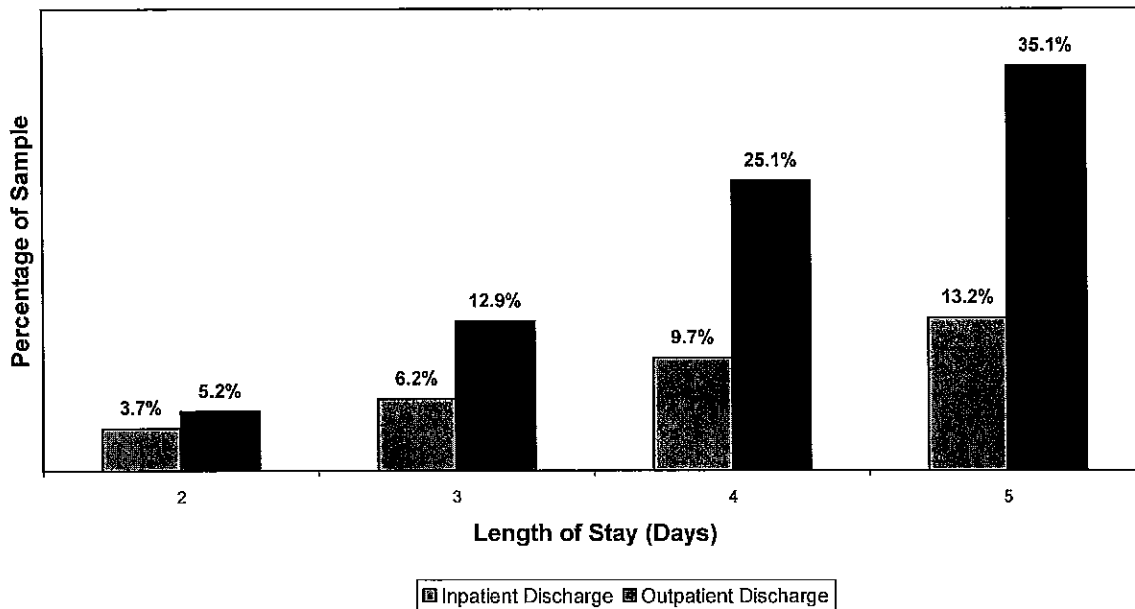
**Figure 4: Length of Stay Distribution at Montgomery County Emergency Service from 2005-2007**



Source: Montgomery County Emergency Service, Inc.

However, some of these patients were discharged as inpatients to another facility, and therefore had longer lengths of stay than the numbers from Figure 4 indicate. The remaining patients were discharged on an outpatient basis – either they were free to go, or had an outpatient order resulting from a commitment hearing. Figure 5 gives the breakdown between inpatient and outpatient discharges. Of the almost 50% who were discharged within five days, slightly more than one-third of these patients were discharged on an outpatient basis. Within four days, approximately 25% of patients were discharged on an outpatient basis.

**Figure 5: Length of Stay Distribution at Montgomery County Emergency Service by Cumulative Inpatient and Outpatient Discharge 2005-2007**



Source: Montgomery County Emergency Service, Inc.

## Maryland

In Maryland, an individual may be involuntarily held for up to 10 days. A hearing is generally held within the 10 day temporary detention, but the hearing may be postponed for up to seven days for good cause.<sup>72</sup> Dr. Jeffrey Janofsky, Director of the Psychiatry and Law Program and Co-Director of the Short Stay Unit at Johns Hopkins, suggested that approximately 70% of patients initially admitted as involuntary patients are discharged or converted to voluntary status prior to their hearing.<sup>73</sup> He based this observation on his experience overseeing the involuntary commitment hearings at Johns Hopkins for over 20 years.

Data from the Office of Administrative Hearings suggest that Dr. Janofsky's estimation of the number of patients discharged or converted to voluntary status is correct. During the week of January 14-25, 2008, 209 commitment hearings were scheduled in Maryland.<sup>74</sup> A significant

number of patients, 40.2%, converted to voluntary status prior to the hearing. As Table 3 shows, 31.6% of patients were discharged at some point prior to the hearing, because they no longer met the criteria for involuntary hospitalization. Therefore, 71.8% of patients were either converted to voluntary status or discharged prior to the scheduled hearing. For those who had a commitment hearing, 14.8% were found by the Administrative Law Judge to meet the commitment criteria, and therefore were retained for further involuntary treatment, and 4.3% were released as a result of the hearing, because the Administrative Law Judge found that the commitment criteria were not met for those patients.

**Table 3: Outcomes of Civil Commitment Hearings  
Scheduled in Maryland State from January 14-25, 2008**

| <b>Reason Case Closed</b> | <b>Number of Cases</b> | <b>Percentage of Total Cases</b> |
|---------------------------|------------------------|----------------------------------|
| Cancelled/Withdrawn       | 19                     | 9.1                              |
| Discharged                | 66                     | 31.6                             |
| Released/Dismissed        | 9                      | 4.3                              |
| Retained                  | 31                     | 14.8                             |
| Voluntary commitment      | 84                     | 40.2                             |
| Total                     | 209                    | 100.0                            |

Source: Maryland Office of Administrative Hearings

Cancelled/Withdrawn: Hospital indicated that the hearing was no longer necessary (example: if a patient signs to accept voluntary treatment at the hearing and the hospital accepts it, the hearing is cancelled and labeled as such).

Discharged: Hospital staff found that the patient no longer met the commitment criteria prior to the hearing.

Released/Dismissed: The Administrative Law Judge found that the patient did not meet the commitment criteria.

Retained: The Administrative Law Judge found that the patient met the commitment criteria.

Voluntary commitment: The patient signed, and the staff accepted, a voluntary agreement to stay for treatment.<sup>75</sup>

## **Massachusetts**

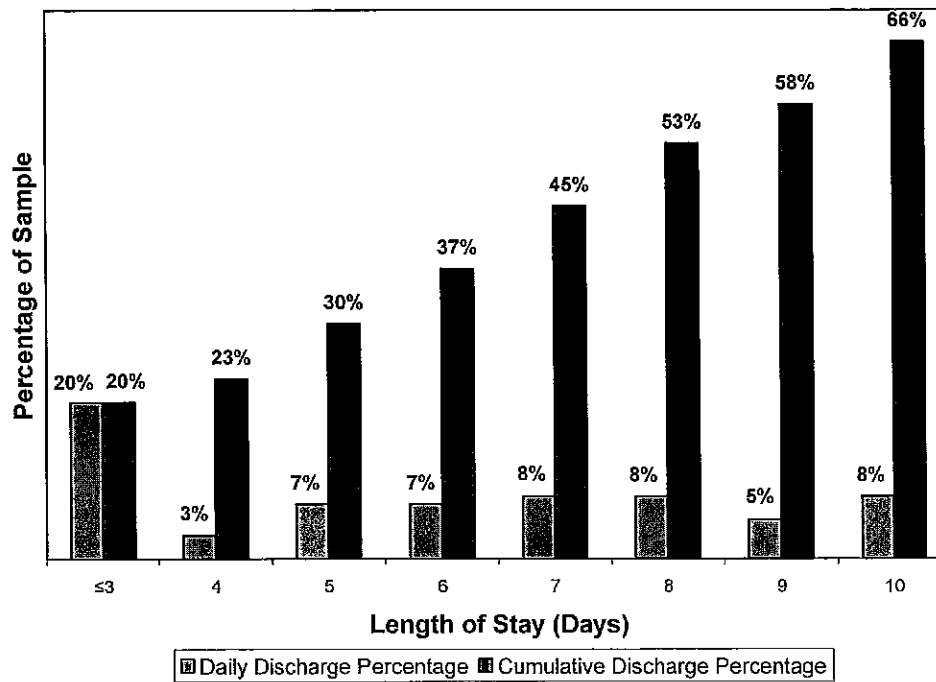
In Massachusetts, a person can be involuntarily hospitalized for a three day period. At any time during that period, the superintendent of the public or private facility can discharge the patient. At the end of the three day period, the patient must be discharged, unless the superintendent of the facility files a petition with the court to keep the patient for further commitment, or the person remains on a voluntary status. Upon receiving the petition, the court must hold a hearing within five business days.<sup>76</sup>

One article regarding insurance status and length of stay for patients who are involuntarily hospitalized includes data not only for patients' lengths of stay, but also a distribution of when patients were released. Fisher, et al. collected a statewide sample of emergency admissions to Massachusetts general and private facilities in March 1998. The final sample included 299

cases, which represented approximately 33% of the emergency admissions to general and private facilities during the given time frame.<sup>77</sup>

The length of stay (LOS) for these patients ranged from one day to 77 days. The median length of hospitalization was almost seven days.<sup>78</sup> The authors highlight that 20% of patients were discharged within three days or less of admission.<sup>79</sup> By the fourth day of admission, approximately 23% of the sample had been discharged.<sup>80</sup> As Figure 6 shows, slightly less than one-third of the patients were discharged within five days. It is important to note that when these data were collected, Massachusetts state law allowed for a longer period of temporary detainment before a commitment hearing had to take place. An individual could be held up to 10 days initially, and up to another 14 days before a commitment hearing was conducted.<sup>81</sup>

**Figure 6: Length of Stay Distribution from Massachusetts Involuntary Hospitalization Study March 1998**



Source: William H. Fisher, et al., "Insurance Status and Length of Stay for Involuntarily Hospitalized Patients," *The Journal of Behavioral Health Services & Research* 28 (3) (2001).<sup>c</sup>

<sup>c</sup> The percentages for percent of sample discharged for Days 4-10 are close approximations. Information containing exact percentages is no longer available.

## Conclusions Regarding Release or Conversion to Voluntary Status Prior to Hearing

The data from Colorado, Maryland, Massachusetts, Pennsylvania and Virginia suggest that a longer emergency admissions stay may facilitate release or conversion to voluntary status prior to a civil commitment hearing. The numbers differ widely regarding the number of patients released within four days. Table 4 summarizes the cumulative percentages of how many patients were discharged within four days from the respective facilities in Colorado, Pennsylvania, Massachusetts and Virginia. The discharge percentages range from 12.7% to 32.8%. These numbers still suggest that a significant number of patients should be released prior to a civil commitment hearing under a four day detention period, although it is difficult to predict the percentage of releases based on these data.

**Table 4: Percentage of Patients Discharged within Four Days of Initial Emergency Detention**

| Facility                                       | Percentage of Patients Discharged within Four Days |
|--|--|
| Colorado Mental Health Institute at Pueblo     | 12.7   |
| Massachusetts Study                            | 23.0   |
| Montgomery County Emergency Service, Inc. (PA) | 25.1   |
| University of Virginia Health System           | 32.8   |

Sources: Colorado Mental Health Institute at Pueblo; Montgomery County Emergency Service, Inc.; William H. Fisher, et al., "Insurance Status and Length of Stay for Involuntarily Hospitalized Patients," *The Journal of Behavioral Health Services & Research* 28 (3) (2001); and University of Virginia Health System.

The data from Maryland also suggest the potential for a significant number of discharges or conversions to voluntary status prior to a hearing. In Maryland, 31.6% of patients were discharged prior to a commitment hearing, and notably 40.2% converted to voluntary status. In Virginia, the Commission found that 29% of hearings result in voluntary commitment.<sup>82</sup> Unfortunately, these data do not give an indication as to when the majority of the discharges or conversions to voluntary status occur. For example, if most of the discharges or conversions happen between the sixth and eighth day of Maryland's 10 day emergency hold, then using these data to predict outcomes for a four day hold is not as useful.

While these data show Virginia what might happen if it employed a system similar to one of the states analyzed in this report, using data from other states to predict potential outcomes for Virginia should be done with caution. Each state's mental health delivery system is unique. Using raw statistics from other states may not account for certain characteristics that influence length of stay, release and voluntary conversion in those states that are not the same or will not have the same effect in Virginia. These factors were not controlled for in this study. Finally, it is important to note that these states have effective pre-hearing release measures, and hearings are not mandatory. (In Virginia, by contrast, some special justices appear to believe the law requires a hearing to be held even if the independent examiner concludes that the commitment criteria are not met; and treating physicians and hospitals appear to be reluctant to release a patient before the hearing due to the lack of legal protection.)

## VI. Conclusions

- 1) **A two day temporary detention period is not adequate for a thorough assessment in some cases.** Based on expert medical opinion from around the country, some types of patient cases require more than two days to perform an accurate assessment. The general consensus among the professionals I interviewed was that a period of at least three days is required for more difficult cases.
- 2) **The current temporary detention process is of low quality.** Currently, 30% of commitment hearings occur in less than 24 hours.<sup>83</sup> These types of hearings often occur in rural areas where hearings are not held every day. If a patient is admitted on a Tuesday morning and hearings are held Monday-Wednesday-Friday, then the hearing must occur on Wednesday. Information gathered by the Commission also showed great variation throughout the state in the amount of time spent on evaluations and the type of information that is collected by independent evaluators in order to certify whether a patient meets the commitment criteria.<sup>84</sup> Evidence also suggests that some evaluators do not have access to a patient's medical chart or to the treatment team when making a certification.<sup>85</sup>
- 3) **An increased temporary detention period should contribute to an improved decision-making process.** Given the important, yet difficult job clinicians face in making accurate involuntary commitment decisions, an increased temporary detention period is likely to contribute to an improved decision-making process, and decrease false positives and false negatives. Given the short time frame in which many patients are assessed, it is likely that some of the cases result in Type I errors, or over-commitments. While more time will not solve all of the problems related to the TDO process, patient outcomes should be improved, by allowing more time for patient observation and collection of collateral information. This will especially be true in rural areas. Of course, the utility of an increased evaluation period partly depends on what is additionally accomplished that currently is not achieved in two days. The extra time must be used effectively in order to truly improve upon the current process.

In particular, patients with substance abuse problems should benefit significantly from an increased temporary detention period. A patient with a substance abuse diagnosis who is experiencing an acute psychiatric crisis may not need to be involuntarily committed, but needs time to detoxify. Alternatively, the patient may need inpatient treatment, but may accept voluntary hospitalization once he is detoxified. A better assessment can be made regarding inpatient treatment once the clinician only has to deal with the psychiatric illness, and not concurrent diagnoses.

In a study of patients arriving at a Psychiatric Emergency Service (PES) in upstate New York, those presenting with active substance abuse were less likely to be hospitalized than patients presenting with psychosis, especially when the patients with active substance abuse symptoms were given time to detoxify before an evaluation occurred.<sup>86</sup> Also of note, the PES has a policy requiring patients not be psychiatrically evaluated until they are sober. The authors state, "this policy appears to be related to the finding that the

person arriving after substance abuse is actually less likely to be psychiatrically hospitalized. Once the disinhibiting effects of the ingested substance have dissipated, the person's acute 'psychiatric condition' (usually suicidality) also dissipates. These patients are then most likely to be referred for substance abuse treatment."<sup>87</sup> While the article focuses on the important "filter" role of the PES, an applicable point is that patients are more likely to be directed to the appropriate treatment when "sufficient time and resources for evaluation and/or stabilization" are available.<sup>88</sup>

A similar policy is in effect at the Colorado Mental Health Institute at Pueblo. Patients are not supposed to be sent to CMHIP until they have detoxified, since clinicians cannot get at the underlying psychiatric and/or medical issues until detoxification is complete.<sup>89</sup>

While these research outcomes and policies do not specify an appropriate time frame to allow for detoxification, they do suggest the importance of allowing patients to detoxify prior to conducting an evaluation. An increased temporary detention period is likely to allow for more complete stabilization of these patients, and better clinical assessments and decisions regarding the need for commitment.

- 4) **Increased short-term bed demand is possible if temporary detention period is increased to four days.** Virginia should be prepared for a potential increase in bed demand during a four day temporary detention period. Clinicians in Virginia are considerably concerned that an increased time period will exacerbate a bed availability situation that is already strained. This concern may be realized if patients are not released in practice if they are found not to meet the commitment criteria by their treating physicians and/or the independent examiners.
- 5) **Other states have effective pre-hearing release measures.** In order to achieve the goal of fewer commitment hearings due to release prior to the hearing, doctors and/or independent evaluators need to have the ability to release patients prior to a hearing. In almost all of the interviews I conducted outside of Virginia, clinicians discussed the importance and effectiveness of doctors having the ability to release patients. This currently does not appear to happen in Virginia. If doctors or independent evaluators do not have the capability or incentives to release individuals prior to the hearing and hearings are not made available throughout the four day detention, then a four day temporary hold will result in a major shortage of beds and a further curtailment of patients' civil liberties.
- 6) **There is a lack of information regarding the involuntary commitment system.** Finally, the research conducted for this report clearly showed the lack of information and data that exists about the civil commitment process, both in Virginia and throughout the country. Data were extremely hard to find, and were generally not available at the local or state level. Furthermore, hospitals generally do not track the information that would be helpful for Virginia, in terms of outcomes of hearings and discharge status. Given the money that is spent on the involuntary commitment process, and more importantly, the health, safety and liberty interests that are at stake, Virginia should implement a robust local or statewide data collection system to better track trends and outcomes regarding the involuntary commitment process.

## **VII. Recommendations**

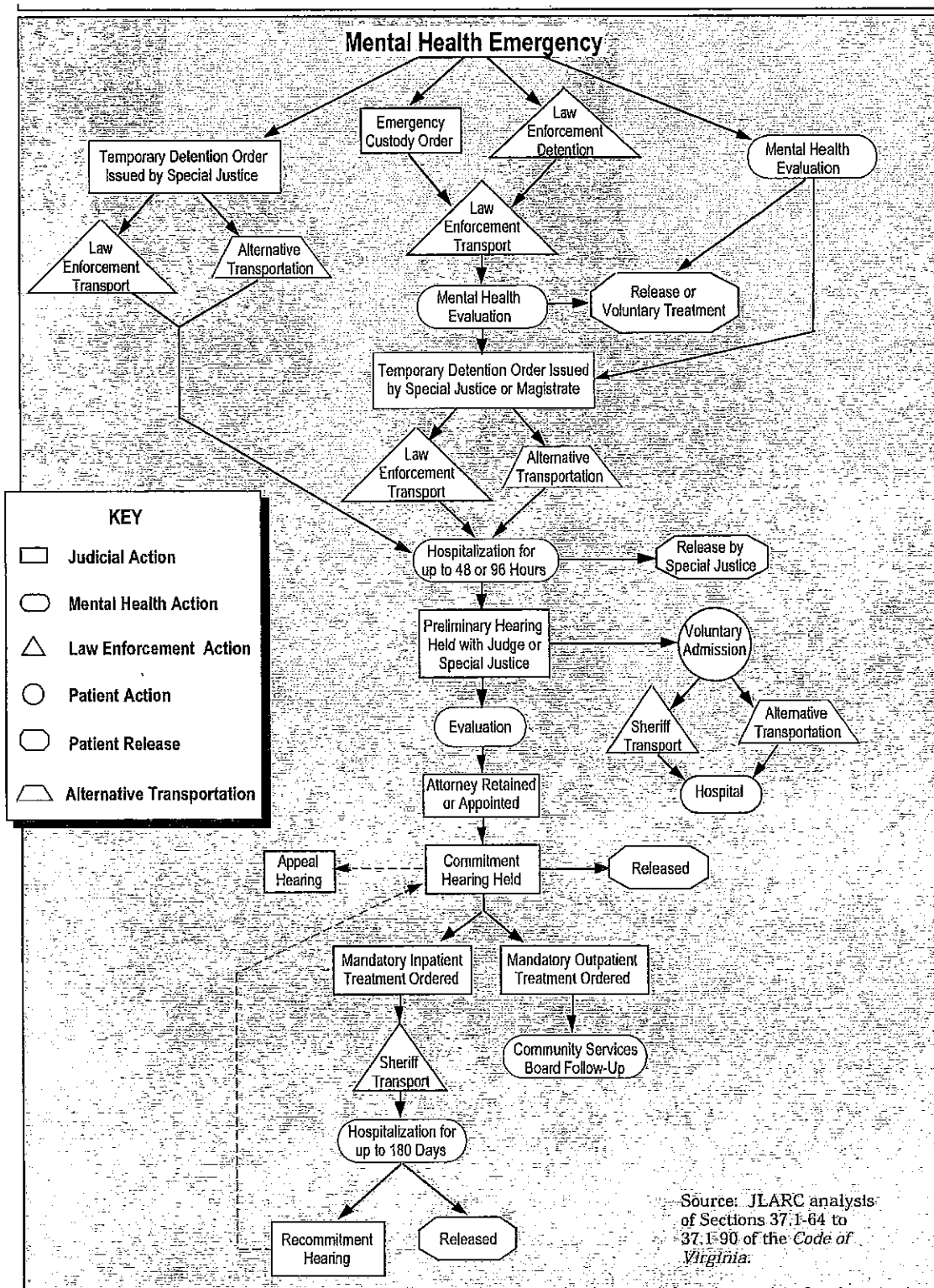
- 1) **The Commission should adopt the Task Force on Civil Commitment's recommendation to increase the temporary detention period from two days to four days.** The evidence suggests that mentally ill patients will benefit from an increased time period, which will still respect their important liberty interests by detaining them for a relatively short amount of time.
- 2) **Virginia should not increase the temporary detention period to four days without effective and appropriate pre-hearing release measures.** Otherwise, goals such as reducing involuntary commitment hearings will not be realized and a further strain on bed availability is likely to occur.
- 3) **The Commission should conduct further study and research regarding the potential impact of an increased temporary detention period on bed availability.** Bed availability is a critical issue, as voiced by Virginia mental health professionals and others who interface with the system. Conducting a more detailed analysis is important so that the state can be prepared for the potential ramifications.
- 4) **Virginia should implement a data collection system.** Virginia and its localities do collect some data with regard to the involuntary commitment system. However, a more uniform and complete collection system would serve to provide a better understanding of involuntary commitment trends and plan for future impacts on the system. Furthermore, the data collected should be used to evaluate a four day temporary detention period, if it is enacted.



# **Appendix**

**Figure A1**

Source: Joint Legislative and Audit Review Commission of the Virginia General Assembly, "Review of the Involuntary Commitment Process," 1994.

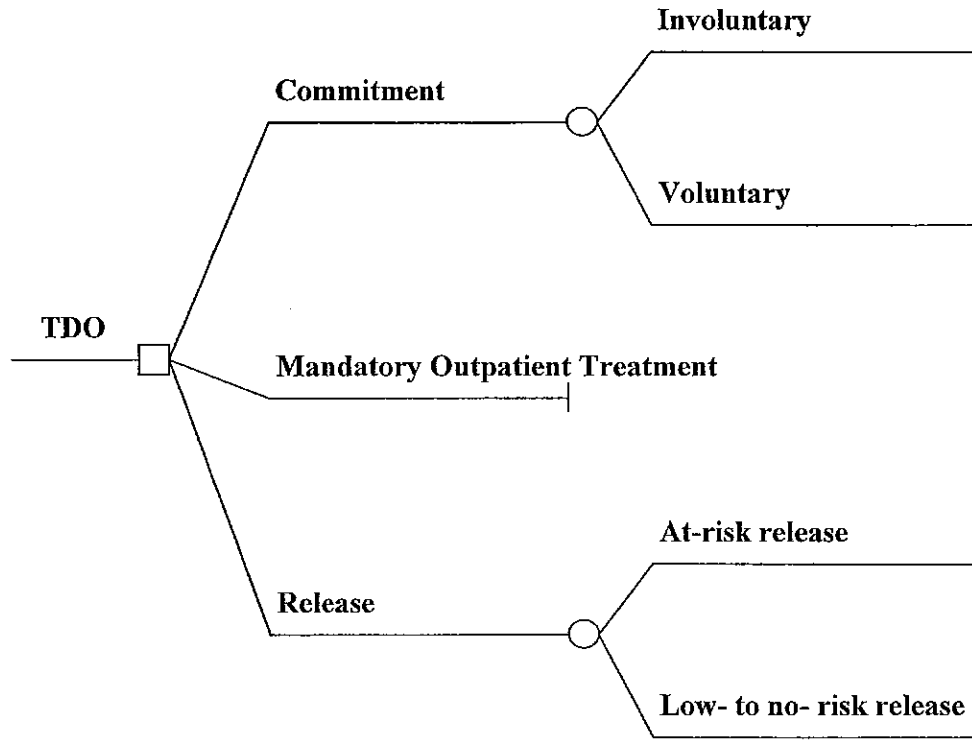


**Table A1: Involuntary Mental Commitment Fund Expenditures: 1998-2006**

| <b>Year</b> | <b>Supreme Court of Virginia</b> | <b>Virginia Department of Medical Assistance Services</b> | <b>Total</b> | <b>Inflation-Adjusted Total (1998 dollars)</b> |
|-------------|----------------------------------|---|--------------|--|
| 1998        | \$2,861,875                      | \$10,401,099  | \$13,262,974 | \$13,262,974                                   |
| 1999        | \$4,146,193                      | \$7,365,675   | \$11,511,868 | \$11,236,135                                   |
| 2000        | \$3,995,702                      | \$6,527,511   | \$10,523,213 | \$9,972,580                                    |
| 2001        | \$3,976,908                      | \$7,550,759   | \$11,527,667 | \$10,615,874                                   |
| 2002        | \$4,497,748                      | \$8,528,023   | \$13,025,771 | \$11,795,559                                   |
| 2003        | \$4,466,608                      | \$9,134,601   | \$13,601,209 | \$12,048,897                                   |
| 2004        | \$4,663,019                      | \$5,712,885   | \$10,375,904 | \$8,948,531                                    |
| 2005        | \$4,816,091                      | \$8,026,081   | \$12,842,172 | \$10,734,739                                   |
| 2006        | \$4,789,465                      | \$8,524,981   | \$13,314,446 | \$10,743,835                                   |

Source: Virginia State of the Judiciary Reports 1999-2006 and Department of Medical Assistance Services Total Program Expenditures by Fiscal Year: FY1970-2006

**Figure A2: Conceptualization of TDO**



A temporary detention order provides an opportunity for mental health professionals to assess the psychological status of a patient by gathering data, in order for an accurate and good decision to be made at the commitment hearing. In addition, the temporary detention period gives a patient time to recover from an acute episode, such as intoxication, which may be inhibiting the clinician from accurately assessing the individual's condition.

A TDO usually results in one of five outcomes for a patient: 1) involuntary commitment; 2) voluntary commitment; 3) mandatory outpatient treatment; 4) at-risk release, such as release due to unavailability of a bed; or 5) low- to no- risk release. For an individual patient, each of these outcomes has a certain probability that it will occur and that an error is made (Type I or II), and a different cost and impact for that patient.

### Figure A3: McNeil and Binder Checklist for Assessing Risk of Violence and Results

#### 5 Variable Checklist:

- 1) History of physical attacks and/or fear-inducing behavior within two weeks before admission?
- 2) Absence of suicidal behavior (attempts, gestures, or threats within two weeks before admission?)
- 3) Schizophrenic or manic diagnosis?
- 4) Male gender?
- 5) Currently married or living together?

#### Results of Study

| Outcome                   | Probability |
|---------------------------|-------------|
| Sensitivity               | 57%         |
| Specificity               | 70%         |
| Positive Predictive Value | 59%         |
| Negative Predictive Value | 71%         |
| Total Predictive Value    | 65%         |

Source: Dale E. McNeil and Renee L. Binder, "Screening for Risk of Inpatient Violence," *Law and Human Behavior* 18 (5) (1994).

*Sensitivity*: probability that the test will give a positive result when the patient later does become violent.

*Specificity*: probability that the test will be negative when the patient does not become violent.

*Positive predictive value*: probability of becoming violent when the test result is positive.

*Negative predictive value*: probability of not becoming violent when the test result is negative.

*Total Predictive value*: probability of any test result being correct.

## **Exhibit A1: List of Interviewed Mental Health Professionals**

Renee L. Binder, M.D.  
Professor in Residence  
Founder and Director of UCSF Psychiatry  
and the Law Program  
University of California, San Francisco  
Interviewed on: March 4, 2008

Mark Bodner, Esquire  
Special Justice  
Fairfax, Virginia  
Interviewed on: February 1, 2008

Kathryn Burns, M.D., M.P.H.  
System Chief Clinical Officer  
ADAMH Board of Franklin County  
Columbus, Ohio  
Interviewed on: March 5, 2008

Michael Hendricks, Ph.D.  
Independent Evaluator  
Fairfax, Virginia  
Interviewed on: February 8, 2008

Jeffrey S. Janofsky, M.D.  
Associate Professor  
Director, Psychiatry and Law Program  
Co-Director, Short Stay Unit  
The Johns Hopkins Hospital  
Baltimore, Maryland  
Interviewed on: February 8, 2008

Jeffrey L. Metzner, M.D.  
Clinical Professor of Psychiatry  
University of Colorado School of Medicine  
Denver, Colorado  
Interviewed on: February 4, 2008

Rita Romano, LCSW  
Emergency Services Division Manager  
Prince William County Community Services  
Board  
Manassas, Virginia  
Interviewed on: February 1, 2008

Sherry Sanders, LCSW  
Coordinator of Crisis Services  
Cumberland Mountain Community Services  
Cedar Bluff, Virginia  
Interviewed on: February 4, 2008

Howard V. Zonana, M.D.  
Professor of Psychiatry and Clinical  
Professor (Adjunct) of Law  
Yale University  
New Haven, Connecticut  
Interviewed on: February 11, 2008

## Endnotes

- <sup>1</sup> “Commonwealth of Virginia Commission on Mental Health Law Reform Fact Sheet,” provided to author via e-mail from Professor Richard Bonnie.
- <sup>2</sup> “Commonwealth of Virginia Commission on Mental Health Law Reform: Report of the Task Force on Civil Commitment,” March 2008, 35.
- <sup>3</sup> Virginia Tech Review Panel, “Mass Shootings at Virginia Tech: April 16, 2007,” August 2007, 60.
- <sup>4</sup> *Ibid* at 56.
- <sup>5</sup> “Commonwealth of Virginia Commission on Mental Health Law Reform: Report of the Task Force on Civil Commitment,” March 2008, 9-10.
- <sup>6</sup> “Commonwealth of Virginia Commission on Mental Health Law Reform: Report of the Task Force on Civil Commitment,” March 2008, 11.
- <sup>7</sup> Joint Legislative Audit and Review Commission of the Virginia General Assembly, “Review of the Involuntary Commitment Process,” House Document No. 8 (1995 Session): 1.
- <sup>8</sup> *Humphrey v. Cady*, 405 U.S. 504 (1972).
- <sup>9</sup> Elizabeth L. McGarvey, “Civil Commitment Practices in Virginia: Perceptions, Attitudes, and Recommendations,” April 2007, 68.
- <sup>10</sup> Joint Legislative Audit and Review Commission of the Virginia General Assembly, “Review of the Involuntary Commitment Process,” House Document No. 8 (1995 Session): 3-5.
- <sup>11</sup> Joint Legislative Audit and Review Commission of the Virginia General Assembly, “Review of the Involuntary Commitment Process,” House Document No. 8 (1995 Session): 3,5 and Elizabeth L. McGarvey, “Civil Commitment Practices in Virginia: Perceptions, Attitudes, and Recommendations,” April 2007, 17.
- <sup>12</sup> Elizabeth L. McGarvey, “Civil Commitment Practices in Virginia: Perceptions, Attitudes, and Recommendations,” April 2007, 72-73.
- <sup>13</sup> “Commonwealth of Virginia Commission on Mental Health Law Reform: Report of the Task Force on Civil Commitment,” March 2008, 42.
- <sup>14</sup> Joint Legislative Audit and Review Commission of the Virginia General Assembly, “Review of the Involuntary Commitment Process,” House Document No. 8 (1995 Session): 6.
- <sup>15</sup> *Ibid*.
- <sup>16</sup> *Ibid* at 3,7.
- <sup>17</sup> *Ibid* at 7.
- <sup>18</sup> Joint Legislative Audit and Review Commission of the Virginia General Assembly, “Commission Draft: Availability and Cost of Licensed Psychiatric Services in Virginia,” October 9, 2007, 80.
- <sup>19</sup> Joint Legislative Audit and Review Commission of the Virginia General Assembly, “Review of the Involuntary Commitment Process,” House Document No. 8 (1995 Session): 7-8.
- <sup>20</sup> Joint Legislative Audit and Review Commission of the Virginia General Assembly, “Commission Draft: Availability and Cost of Licensed Psychiatric Services in Virginia,” October 9, 2007, 80.
- <sup>21</sup> Virginia State of the Judiciary Report 2006, <http://www.courts.state.va.us/plans.html> and Department of Medical Assistance Services Total Program Expenditures by Fiscal Year: FY1970-2006, [http://www.dmas.virginia.gov/downloads/Stats\\_06/exphist-06.pdf](http://www.dmas.virginia.gov/downloads/Stats_06/exphist-06.pdf).
- <sup>22</sup> Virginia State of the Judiciary Reports 1999-2006 <http://www.courts.state.va.us/plans.html> and Department of Medical Assistance Services Total Program Expenditures by Fiscal Year: FY1970-2006, [http://www.dmas.virginia.gov/downloads/Stats\\_06/exphist-06.pdf](http://www.dmas.virginia.gov/downloads/Stats_06/exphist-06.pdf).
- <sup>23</sup> Joint Legislative Audit and Review Commission of the Virginia General Assembly, “Commission Draft: Availability and Cost of Licensed Psychiatric Services in Virginia,” October 9, 2007, 82.
- <sup>24</sup> *Ibid* at 49.
- <sup>25</sup> *Ibid* at 53.
- <sup>26</sup> *Ibid* at 29.
- <sup>27</sup> *Ibid* at 24.
- <sup>28</sup> *Ibid* at 24.
- <sup>29</sup> *Ibid* at 29.
- <sup>30</sup> *Ibid* at 21.
- <sup>31</sup> *Ibid* at 23.
- <sup>32</sup> *Ibid* at 30.
- <sup>33</sup> *Ibid* at 30.

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- <sup>34</sup> Elizabeth L. McGarvey, "Civil Commitment Practices in Virginia: Perceptions, Attitudes, and Recommendations," April 2007, 16.
- <sup>35</sup> *Ibid.*
- <sup>36</sup> *Ibid.* at 18.
- <sup>37</sup> Hiday, et al., "Victimization: A link between mental illness and violence?," *International Journal of Law and Psychiatry* 24 (2001): 559.
- <sup>38</sup> Virginia Hiday, et al., "Criminal Victimization of Person with Severe Mental Illness," *Psychiatric Services* 50 (1) (1999): 62.
- <sup>39</sup> John Monahan, *The Clinical Prediction of Violent Behavior* (Rockville: National Institute of Mental Health, 1981), 47-48.
- <sup>40</sup> Randy K. Otto, "Prediction of Dangerous Behavior: A Review and Analysis of 'Second-Generation' Research," *Forensic Reports* 5 (1992): 130.
- <sup>41</sup> Robyn M. Dawes, "The Robust Beauty of Improper Linear Models in Decision Making," *American Psychologist* 34 (7) (1979): 571 and Deidre Klassen and William A. O'Connor, "A Prospective Study of Predictors of Violence in Adult Male Mental Health Admissions," *Law and Human Behavior*: 12 (2) (1988): 144.
- <sup>42</sup> Randy Borum, "Improving the Clinical Practice of Violence Risk Assessment," *American Psychologist* 51 (9) (1996): 951.
- <sup>43</sup> William Gardner, et al., "A Comparison of actuarial methods for identifying repetitively-violent patients," *Law and Human Behavior* 20 (1) (1996): 35-36.
- <sup>44</sup> *Ibid.*
- <sup>45</sup> Dale E. McNeil and Renee L. Binder, "Screening for Risk of Inpatient Violence," *Law and Human Behavior* 18 (5) (1994): 585.
- <sup>46</sup> John Monahan, et al., "The Classification of Violence Risk," *Behavioral Sciences and the Law* 24 (6) (2006): 721.
- <sup>47</sup> "Commonwealth of Virginia Commission on Mental Health Law Reform, Report of the Task Force on Civil Commitment," March 2008, 34.
- <sup>48</sup> *Ibid.*
- <sup>49</sup> *Ibid.*
- <sup>50</sup> Telephone interview with Sherry Sanders, 2/4/08.
- <sup>51</sup> Telephone interviews with Sherry Sanders, 2/4/08 and with Michael Hendricks, 2/8/08.
- <sup>52</sup> Telephone interview with Michael Hendricks, 2/8/08.
- <sup>53</sup> E-mail from Dr. Bruce Cohen, 3/31/08.
- <sup>54</sup> *Ibid.*
- <sup>55</sup> *Ibid.*
- <sup>56</sup> Telephone interview with Dr. Jeffrey Janofsky, 2/8/08.
- <sup>57</sup> Telephone interview with Dr. Howard Zonana, 2/11/08.
- <sup>58</sup> Telephone interview with Dr. Kathryn Burns, 3/5/08.
- <sup>59</sup> Telephone interview with Dr. Howard Zonana, 2/11/08.
- <sup>60</sup> Telephone interview with Dr. Renee Binder, 3/4/08.
- <sup>61</sup> Elizabeth L. McGarvey, "Civil Commitment Practices in Virginia: Perceptions, Attitudes, and Recommendations," April 2007, 19.
- <sup>62</sup> Telephone interview with Michael Hendricks, 2/8/08.
- <sup>63</sup> Telephone interview with Mark Bodner, 2/1/08.
- <sup>64</sup> Telephone interviews with Rita Romano, 2/1/08 and with Sherry Sanders, 2/4/08.
- <sup>65</sup> Pre-hearing Detentions, provided to the author from Professor Richard Bonnie.
- <sup>66</sup> Telephone interview with Dr. Jeffrey Metzner, 2/4/08.
- <sup>67</sup> Colorado Mental Health Institute at Pueblo, "About Us," <http://www.cdhs.state.co.us/cmhip/aboutus.htm>
- <sup>68</sup> Telephone interview with David Poulin, Colorado Mental Health Institute, 2/25/08.
- <sup>69</sup> MCES Annual Report, provided to the author via e-mail from Dr. Donald Kline.
- <sup>70</sup> MCES Quest Newsletter: Involuntary Psychiatric Evaluation and Treatment 101: Almost Everything You Should Know, [http://www.mces.org/MCES\\_Quest\\_June\\_2003.pdf](http://www.mces.org/MCES_Quest_June_2003.pdf)
- <sup>71</sup> E-mail from Dr. Edward Kantor, 10/18/07.
- <sup>72</sup> Pre-hearing Detentions, provided to the author from Professor Richard Bonnie.
- <sup>73</sup> E-mail from Dr. Jeffrey Janofsky, 2/2/08.
- <sup>74</sup> Data from Maryland Office of Administrative Hearings, Hunt Valley, MD.



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<sup>75</sup> Definitions provided to the author via e-mail by Wayne Brooks of the Maryland Office of Administrative Hearings, 3/6/08.

<sup>76</sup> Massachusetts General Laws, Chapter 123, Sections 7,12.

<sup>77</sup> William H. Fisher, et al., "Insurance Status and Length of Stay for Involuntarily Hospitalized Patients," *The Journal of Behavioral Health Services & Research* 28 (3) (2001): 339.

<sup>78</sup> Ibid at 340.

<sup>79</sup> Ibid.

<sup>80</sup> Ibid at 342.

<sup>81</sup> Ibid at 338.

<sup>82</sup> "Commonwealth of Virginia Commission on Mental Health Law Reform: Report of the Task Force on Civil Commitment," March 2008, 14.

<sup>83</sup> Ibid at 34.

<sup>84</sup> Ibid at 14.

<sup>85</sup> Telephone interview with Michael Hendricks, 2/8/08.

<sup>86</sup> Richard E. Breslow, et al., "Acute Intoxication and Substance Abuse Among Patients Presenting to a Psychiatric Emergency Service," *General Hospital Psychiatry* 18 (1996): 189.

<sup>87</sup> Ibid at 190.

<sup>88</sup> Ibid.

<sup>89</sup> Telephone interview with David Poulin, Colorado Mental Health Institute at Pueblo, 2/25/08.