

DEVELOPMENTS IN MENTAL HEALTH LAW

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Supreme Court Upholds Affordable Care Act; Makes Medicaid Expansion Optional

Medicaid Expansion Would Significantly Impact Behavioral Health Care

On June 28, 2012, Chief Justice John Roberts announced the long-awaited decision of the United States Supreme Court in *National Federation of Independent Businesses, et al. v. Sebelius*,¹ upholding as a tax the mandate contained in the Patient Protection and Affordable Care Act (“ACA” or the “Act”) that individuals maintain minimal essential health insurance coverage (“individual mandate”) or pay a “penalty” to the Internal Revenue Service (“IRS”). In so doing, the Court also found the Medicaid expansion provisions of the Act requiring the States to expand Medicaid coverage to all adults under age 65 with incomes below 133% of the poverty level (“Medicaid expansion”) unduly coercive to the States and therefore unconstitutional under the Spending Clause. Rather than striking down the entire law, the Court found it could strike down only that portion of the law, 42 U.S.C. § 1396c, authorizing the Secretary of Health and Human Services to withhold *all* Medicaid funding from States for both the current and expanded Medicaid program if they fail to properly implement the expansion, and thus maintain the Act’s constitutionality. The Supreme Court effectively turned the mandated Medicaid expansion into a State option program.

¹ 567 U.S. ____ (2012). Slip opinion available at: <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

The ACA has the potential to significantly expand the availability and accessibility of medical care to individuals with behavioral health diagnoses. Service delivery would become more integrated with other health care treatment with a more community-based, person-centered focus. Of the 425,000 individuals the Virginia Health Care Reform Initiative Advisory Council (“Council”) estimates will become newly eligible for Medicaid in Virginia, 34% of these individuals will need mental health and substance abuse services.² If states opt out of the expanded Medicaid provisions, however, the ACA’s impact on behavioral health care may be minimal.

Relevant Provisions of the ACA

The Individual Mandate

The ACA requires most people to maintain a minimum essential level of health insurance for themselves and their dependents each month beginning January 1, 2014.³ This mandate is satisfied by obtaining insurance through an employer-sponsored insurance plan, an individual insurance plan, a plan purchased through new health insurance exchanges operated by the federal and/or state governments, a grandfathered health plan, or government sponsored coverage, such as Medicaid or Medicare.⁴ The ACA also provides for the advance payment of tax credits to people with incomes between 100% and 400% of the federal poverty level (\$23,050 for an individual and \$92,200 per family of four in 2012) to purchase coverage from the health insurance exchanges to be operated by the states or federal government.⁵ The amount of the premium tax credit is based upon a sliding scale. For example, an individual with income between 100% and 133% of the federal poverty level will pay 2% of his or her income, adjusted for family size, toward the insurance premium with the remainder funded through a tax credit.

If a person does not satisfy this individual mandate, he or she must pay a financial “penalty,” called the “shared responsibility payment,” to the Internal Revenue Service (“IRS”). This payment will be filed and assessed each year as part of the individual’s tax return.⁶ The penalty is a percentage of household income subject to a floor and capped at the price of the national average premium for a bronze level health insurance plan on the health insurance exchanges for the year insurance coverage was not obtained. The penalty is the greater of \$95 or 1% of income in 2014, \$325 or 2% of income in 2015, and \$695 or 2.5% of income in 2016, up to the maximum amount of the insurance not obtained, and after 2016 subject to an annual cost-of-living adjustment.⁷

² Presentation to the Health Reform Initiative Advisory Committee, Medicaid Reform Task Force, *Medicaid Reform in Virginia: Eligibility and Benefits under PPACA*, November 9, 2010, slide 26. The Presentation is available at: <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/NovemberMeetingDocs/MedicaidReformInVirginia.pdf>.

³ 26 U.S.C. § 5000A.

⁴ People exempt from the mandate include undocumented aliens, religious objectors, and people who are incarcerated.

⁵ The Henry J. Kaiser Family Foundation, Focus on Health Reform, *A Guide to the Supreme Court’s Affordable Care Act Decision*, July 2012 at 2, available at: <http://www.kff.org/healthreform/upload/8332.pdf>.

⁶ 26 U.S.C. § 5000A(d).

⁷ Those exempt from the shared responsibility payment include individuals for whom the annual insurance premium would exceed 8% of their adjusted gross income, members of American Indian tribes, people who receive financial hardship waivers, people with incomes below the tax filing threshold, and people without insurance for less than three months during a year. The Henry J. Kaiser Family Foundation, Focus on Health Reform, *A Guide to the Supreme Court’s Affordable Care Act Decision*, July 2012 at 3, available at: <http://www.kff.org/healthreform/upload/8332.pdf>.

Medicaid Expansion

Medicaid, unlike Medicare, is a federal-state partnership. Originally enacted in 1965, it has been expanded throughout the years, providing federal funding to the States to assist pregnant women, children, needy families, the blind, the elderly and the disabled to obtain medical care. The Medicaid program is voluntary and States are not required to participate. By 1982, every state had chosen to participate, with Arizona being the last state to do so. In order to participate, a state must comply with certain mandatory requirements and may also provide certain state plan option services. As currently implemented, the States' Medicaid programs offer a hodgepodge of services to its citizens. The federal government reimburses each state based upon the average per capita income of its residents. In Virginia, for example, the federal medical assistance percentage ("FMAP") is, and has been for many years, approximately 50%.

Beginning January 1, 2014, the ACA will expand the Medicaid program coverage groups to include all individuals under age 65 with household incomes at or below 133% of the federal poverty level (\$14,856 for an individual, \$30,657 per year for a family of four in 2012).⁸ Many states, such as Virginia, do not cover individual adults at all unless they meet disability eligibility requirements and have an annual income at or below 80% of the federal poverty level, or are adults with children at or below 30% of the federal poverty level. At 30% of the federal poverty level, Virginia's income eligibility limits for working parents ranks 44th among the states, significantly lower than surrounding states. Tennessee's limit is 134%; Maryland's is 116%, Kentucky's is 62% and North Carolina's is 51%.⁹

The benefits provided to this expanded population must include the ten categories of "essential health benefits" specified in the ACA, including mental health and substance abuse treatment, pharmacy benefits, and rehabilitation services. The nature and extent of the benefit packages and the levels that must be offered will be determined by the Secretary of Health and Human Services. The benefits required to be provided under the ACA to newly eligible individuals are not as expansive, however, as the full Medicaid benefit package, although States may choose to provide them. The federal government will fund 100% of the cost of the expansion between 2014 through 2016, gradually decreasing to 90% of the cost in 2020 and thereafter. As enacted, the ACA provided that, if a State does not comply with the Act's new coverage requirements, the Secretary of Health and Human Services may withhold federal funding not only for the ACA Medicaid expansion, but also *all* the state's Medicaid funds.¹⁰ It is this section of the Act that the Court invalidated essentially making the Medicaid expansion an optional provision for the States.

Procedural History

The ACA was signed by the President on March 23, 2010, and that day the state of Florida and 12 other states, later joined by 13 more states, filed suit challenging the constitutionality of the "individual mandate" and the "Medicaid expansion." They argued that the Medicaid expansion was unduly coercive of the States because it did not give them adequate notice to voluntarily consent or

⁸ *Id.*

⁹ Commonwealth Institute for Fiscal Analysis, *Medicaid Expansion in Virginia under the New Health Care Law*, July 2010, available at <http://www.thecommonwealthinstitute.org/2010/07/>.

¹⁰ 42 U.S.C. § 1396c.

withdraw from the Medicaid program. During the same time period, the National Federation of Independent Businesses and individual plaintiffs who did not currently have health insurance also filed suit in the United States District Court in Florida.

The District Court found that Congress lacked the power under the Commerce Clause of the United States Constitution to enact the individual mandate. The Court also struck down the entire Act, finding that the mandate could not be severed from the remainder of the ACA without harming the entire statutory scheme. The Eleventh Circuit Court of Appeals sitting in Atlanta agreed with the District Court that the individual mandate exceeded Congress's power to regulate commerce. It further found that the penalty was not a tax and therefore that the mandate could not be upheld as an exercise of Congress's taxing power. It disagreed, however, with the District Court finding that the individual mandate could not be severed from the remainder of the Act and therefore let the remainder of the Act stand. The Court of Appeals also held that the Medicaid expansion was a valid exercise of Congress's power under the Spending Clause. Both the federal government and the States petitioned the United States Supreme Court for a writ of *certiorari*, which the Court granted.¹¹

While these two cases were making their way through the courts, the Sixth Circuit and the District of Columbia Circuit Courts of Appeal upheld the mandate as a valid exercise of the Commerce Clause, causing a split in the circuits. Meanwhile, the Fourth Circuit, sitting in Richmond, determined in *Liberty University, Inc. v. Geithner*¹² that the penalty was a tax and held on its own motion that the Anti-Injunction Act prevented the Court's consideration of the constitutionality of the individual mandate until someone has actually paid the "tax," an event that would not occur until 2014. The Virginia Attorney General had also filed suit challenging the individual mandate because it conflicted with a newly enacted Virginia law, Virginia Code § 38.2-3430.1:1, prohibiting any mandate that an individual be required to obtain or maintain an individual policy of insurance coverage. The Fourth Circuit held that Virginia lacked standing to challenge the individual mandate because it imposed no obligation on Virginia itself. Nor did the Virginia statute confer on Virginia a sovereign interest in challenging the mandate.¹³

The Court's Decision

The Individual Mandate

Chief Justice Roberts, joined by Justices Breyer, Kagan, Ginsberg and Sotomayor, upheld the individual mandate as a tax imposed on those without insurance.¹⁴ Although labeled a "penalty," the Court noted that the "shared responsibility payment" looks more like a tax than a penalty. It pointed out that the only consequence of not maintaining health insurance is that the individual must make an additional payment to the IRS; no criminal or other penalties attach. The requirement is located in the Internal Revenue Code and is due only when those who must file a tax return do so. The amount of the

¹¹ Because neither party supported the 11th Circuit holding that the individual mandate could be completely severed from the remainder of the ACA or raised the argument that the Anti-Injunction Act deprived a court of jurisdiction to hear the case, the Supreme Court appointed separate *amicus curiae* to brief and argue these issues. Roberts, C.J., Slip Opin. at 11, note 2.

¹² 671 F.3d 391 (4th Cir. 2011).

¹³ *Commonwealth of Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253 (4th Cir. 2011).

¹⁴ Although the majority held that the individual mandate was a tax, all nine justices agreed that the Anti-Injunction Act did not deprive the Court of jurisdiction to hear the case at this time.

payment is determined by such factors as taxable income, number of dependents and filing status. The IRS must also assess and collect the payment in the same manner as taxes.

Based on these facts, the Court held that the “shared responsibility payment” is not a “penalty,” but a “tax” regardless of the label put on it by Congress. This is so, it found, because 1) the amount due will be far less than the price of insurance and, by statute, can never be higher; 2) the mandate does not depend on whether the person intentionally fails to purchase insurance; and 3) the tax is collected only by the IRS through its normal means of taxation, except the IRS cannot use its most punitive sanction of criminal prosecution.¹⁵ The Court found that a “penalty” means punishment for an unlawful act or omission. Here, the ACA attaches no negative legal consequences to not buying health insurance other than making a payment to the IRS. An individual can comply with the ACA by either obtaining health insurance or making a payment to the IRS. “[I]f someone chooses to pay rather than obtain health insurance, they have fully complied with the law.”¹⁶ In his dissent, Justice Scalia, joined by Justices Kennedy, Thomas and Alito, found that the “shared responsibility payment” was indeed a “penalty” because Congress framed it as such and it is imposed for violating the law, namely, the requirement to obtain health insurance.¹⁷

Medicaid Expansion

Seven Justices concluded that Congress exceeded its authority under the Spending Clause in enacting the Medicaid expansion by coercing the States to adopt and administer a federal regulatory scheme. If a state failed to do so, the Secretary of Health and Human Services could have withheld funding for the state’s *entire* Medicaid program, not just the Medicaid expansion. Only Justices Ginsburg and Sotomayor disagreed.

Under the Spending Clause, Congress has the power “to pay the Debts and provide for the...general Welfare of the United States.”¹⁸ The Court has long recognized that Congress may use this power to grant funds to the States upon conditions it establishes. Such grants of funding are in the nature of a “contract,” but the States must voluntarily and knowingly accept the terms of the “contract.” “Congress may use its spending power to create incentives for States to act in accordance with federal policies. But, as here, when ‘pressure turns into compulsion,’..., the legislation runs contrary to our system of federalism.”¹⁹

The Court next determined that the Medicaid provisions are not just an alteration or expansion of the Medicaid program but a whole new health care program. The Court pointed out that the current Medicaid program covers only certain discrete categories of needy individuals with no mandatory coverage for childless adults. The States also have flexibility with respect to coverage levels. Under the ACA, however, all States would have been required to cover all individuals under age 65 with incomes below 133% of the federal poverty level.²⁰ In addition, the Act also mandates that the States provide an

¹⁵ Roberts, C.J., Slip Opin. at 35-36

¹⁶ Roberts, C.J., Slip Opin. at 37.

¹⁷ Joint Dissent, Slip Opin. at 20.

¹⁸ U.S. Const., Art. I, § 8, cl.1.

¹⁹ Roberts, C.J., Slip Opin. at 47.

²⁰ 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

essential health benefits package to all new Medicaid recipients at a level sufficient to meet the individual mandate requirements.

The Court acknowledged that the original Social Security Act establishing the Medicaid program contains a clause reserving the right to alter, amend or repeal any provision of the Social Security Act, which, it noted, Congress has done many times throughout the years. The Court indicated, however, that while the federal government will pay 100% of the cost of the expansion through 2016 reducing to 90% in 2020 and thereafter, Congress may amend the program at any time. The Court stated that Medicaid spending currently accounts for over 20% of many State's budgets with the threat of the loss of 100% of those funds, not just those associated with the expansion. As a result, the Court determined that Medicaid is "no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage."²¹

Rather than declare the entire provision unconstitutional, however, five of the Justices, Justices Roberts, Breyer, Kagan, Ginsburg and Sotomayor, determined that they could uphold the law by striking down only the provision in § 1396c that permits the Secretary to withhold funds applicable to the current Medicaid program to cure the constitutional defect. The Secretary may continue to withhold funds from States for failure to comply with the current program. She may also withhold funds from States that have chosen to participate in the Medicaid expansion but fail to comply with provisions of the ACA, but one is not dependent upon the other.

This decision is the first time the Supreme Court has ever invalidated Spending Clause legislation as unconstitutionally coercive of the States. The Court did not set out any test, however, to be applied in future challenges to the limits of Congress's spending power. It simply found that in this case Congress went too far. Until these limits are established in future cases, Spending Clause legislation through which Congress grants funds to the States to carry out certain federal programs will be ripe for challenge.

The Commerce and Necessary and Proper Clauses

Prior to upholding the ACA as a tax, the Supreme Court declared that the ACA violated the Commerce Clause. Nor was it a permissible exercise of Congress's power under the Necessary and Proper Clause. Although the Court did not need to reach this issue, the government had primarily argued that the individual mandate was constitutional based on the Commerce Clause. The lower courts had also relied upon the Commerce Clause in either upholding or striking down the ACA. The Chief Justice felt compelled therefore to decide these issues.

The Commerce Clause of the Constitution provides that "Congress shall have Power...to regulate Commerce with foreign Nations, and among the several States, and with Indian Tribes."²² Courts have upheld Commerce Clause legislation when Congress has a rational basis to believe that the activity to be regulated is in the stream of or substantially affects interstate commerce. Chief Justice Roberts and Justice Scalia in a separate opinion, joined by Justices Kennedy, Thomas and Alito, held, however, that requiring individuals to enter the insurance market by compelling them to buy a product

²¹ Roberts, C.J., Slip Opin. at 53.

²² U.S. Const. Art. I, § 8.

and thus enter into commerce exceeded Congress's power under the Commerce Clause.²³ Justice Ginsberg, joined by Justices Breyer, Sotomayor and Kagan, disagreed arguing that all individuals at some time in their life would obtain health care and their failure to obtain health insurance impacted the entire health insurance industry.²⁴

The same Court majority also held that the ACA was not justified under the Necessary and Proper Clause. That Clause provides that "Congress shall have Power...to make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof."²⁵ The majority found that because Congress had no valid underlying power to regulate commerce in this instance, the Necessary and Proper Clause could not be relied upon to bootstrap the power it lacked under the Commerce Clause.²⁶

Impact of the ACA on Behavioral Health Care

Approximately 26.2% of adults experience a diagnosable mental disorder each year. Approximately 6%, or 1 in 17 adults, has a serious mental illness, such as schizophrenia, major depression or bipolar disorder. Mental illness and substance use disorders affect an individual's ability to work or care for themselves. As a result, large numbers of these individuals are unemployed or underemployed, and they and their families do not have the benefit of employer-sponsored health plans. Many are single adults who do not meet the disability requirements or low income limits currently needed to qualify for Medicaid.²⁷ In addition, research conducted by the National Association of State Mental Health Program Directors ("NASMHPD") found that adults with serious mental illness have a life expectancy averaging 25 years below that of the general population, due in large part to chronic medical conditions, such as diabetes, heart disease, pulmonary disease, asthma and cancer, with little to no access to primary care.²⁸ Without access to treatment, people with mental illnesses and substance use disorders experience crises more frequently and must rely on expensive emergency room care and inpatient psychiatric care.²⁹ Moreover, individuals with untreated mental illness are 4-6 times more likely to be incarcerated for crimes related to mental illness.³⁰ A 2005 survey of jail inmates in Virginia revealed that 16% had serious mental illness.³¹ Substance use disorders further contribute significantly

²³ Roberts, C.J., Slip Opin. at 27; Joint Dissent, Slip Opin. at 11-12.

²⁴ Ginsburg, Slip Opin. at 18.

²⁵ U.S. Const., Art. I, § 8.

²⁶ Roberts, C.J., Slip Opin. at 30.

²⁷ National Alliance on Mental Illness (NAMI) Virginia, *Health Care Reform, What Does It Mean for People Living with Serious Mental Illness?* August 2010, at 2, available at: <http://namivirginia.org/assets/pdfs/NAMIVirginiaHealthCareReformReport.pdf>.

²⁸ National Association of State Mental Health Program Directors, Medicaid Directors Council, *Morbidity and Mortality in People with Serious Mental Illness*, October 2006, available at: http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf.

²⁹ National Alliance on Mental Illness (NAMI) Virginia, *Health Care Reform, What Does It Mean for People Living with Serious Mental Illness?* August 2010, at 2, available at: <http://namivirginia.org/assets/pdfs/NAMIVirginiaHealthCareReformReport.pdf>.

³⁰ *Id.* at 3.

³¹ Morris, James J., Ph.D., 2005 Survey of Jail Mental Health Treatment Needs and Services, Department of Behavioral Health and Developmental Services, available at: <http://www.dbhds.virginia.gov/documents/reports/adm-JCHCMorris061206.pdf>.

to crime and incarceration rates throughout the country. Furthermore, 20 to 25% of the homeless population has some form of serious mental illness.³²

The ACA with the Medicaid expansion will have the most significant impact on the service delivery system for people with mental illness and substance use disorders. For those eligible for Medicare, the doughnut hole for prescription drugs provided under Medicare Part D has now been closed allowing seniors to obtain expensive psychiatric medications they may need.³³ Currently, many people with mental illness and substance use disorder diagnoses are excluded from obtaining coverage due to their pre-existing conditions, or if they can obtain insurance, the premiums are so exorbitant as to be out of reach. Beginning in 2014, pre-existing condition exclusions will be prohibited in all health plans and premiums may no longer be based on health status.³⁴ More than half of all individuals currently served by state substance abuse agencies are uninsured and most, if not all, will be eligible for Medicaid coverage.³⁵

In addition, the Mental Health Parity and Addiction Equity Act of 2008 prohibits financial requirements and treatment limitations for mental health and substance abuse benefits in group health plans from being more restrictive than those placed on medical and surgical benefits. These provisions will apply to coverage available under the health benefits exchanges, as well as to Medicaid managed care programs and expanded Medicaid programs. Most importantly, the ACA requires the inclusion of mental health and substance use treatment services in the list of the ten essential benefits that health care exchanges must offer, and as a consequence provided through the Medicaid expansion.³⁶ Other mandated benefits include rehabilitative services, prescription drugs and preventive services, services extensively needed by individuals with mental illness and substance use disorders.³⁷

The Medicaid expansion will greatly increase the number of individuals eligible for the Medicaid benefits package, which must include the essential benefits package listed above, but only if States opt in. That means that all adults under age 65 with incomes less than 133%³⁸ of the federal poverty level will qualify. Currently that level in Virginia is 80% for those eligible adults with disabilities, and 30% for adults with dependent children. In many states, including Virginia, childless adults are excluded. Many of these adults have a behavioral health diagnosis, especially those with substance use disorders

³² National Alliance on Mental Illness (NAMI) Virginia, *Health Care Reform, What Does It Mean for People Living with Serious Mental Illness?* August 2010, at 3, available at:

<http://namivirginia.org/assets/pdfs/NAMIVirginiaHealthCareReformReport.pdf>.

³³ Grohol, John M., PsyD., *What the Affordable Care Act Means to Mental Health*, PsychCentral, available at:

<http://psychcentral.com/blog/archives/2012/06/29/what-the-affordable-care-act-means-to-mental-health/>. PsychCentral.

³⁴ Mental Health America, Issue Brief: *The Health Care Reform Law: A Summary of Provisions and Advocacy Strategies for Behavioral Health Advocates*, available at: <http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/healthcare-reform/issue-brief-health-care-reform/issue-brief-health-care-reform>.

³⁵ Buck, Jeffrey A. *The Looming Expansion and Transformation of Public Substance Abuse Treatment under the Affordable Care Act*, *Health Affairs*, Vol. 30, No. 8, 1402, 1403, August 2011.

³⁶ *Id.* at 1403.

³⁷ Mental Health America, Issue Brief: *The Health Care Reform Law: A Summary of Provisions and Advocacy Strategies for Behavioral Health Advocates*, available at: <http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/healthcare-reform/issue-brief-health-care-reform/issue-brief-health-care-reform>.

³⁸ Although the threshold is 133% of the federal poverty level, 5% of an individual's income is disregarded effectively raising the limit to 138% of the federal poverty level. The Kaiser Commission on Medicaid and the Uninsured, *Who Benefits from the ACA Medicaid Expansion?* June 20, 2012, available at: http://www.kff.org/medicaid/quicktake_aca_medicaid.cfm.

who do not now qualify for Social Security Disability Insurance (“SSDI”) or Supplemental Security Income (“SSI”) due to their primary substance use disorder diagnosis.

The ACA could have the most significant impact on the administration and delivery of substance use treatment services as a result of the requirements of expanded substance abuse coverage along with the expansion of Medicaid eligibility, if the states opt in. Under the ACA, Medicaid expenditures would greatly increase while state revenue and funding under the Substance Abuse Prevention and Treatment Block Grant will decline in importance, due to the high rate of federal Medicaid reimbursement under the Medicaid expansion.³⁹ This change will cause a fundamental shift in the way substance abuse services are organized and delivered. Currently, these services are generally administered by state substance abuse authorities which primarily fund designated providers through grants and contracts that support a specified number of treatments.⁴⁰ This model will be replaced through payment methods and requirements characteristic of a health plan. Services are currently delivered primarily by many small providers with little competition. This should lead to the consolidation of services with these small providers being acquired by larger, better-operated programs with better information technology investment, business administration, and newer evidence-based practices. Because these services will be paid for through private health plans and Medicaid, services will be more medically-oriented with greater participation by physicians, psychologists and other health care professionals. Services that now consist mainly of education and psychosocial support, often provided by peer or lay counselors, will not qualify for Medicaid reimbursement as medical services.⁴¹

Health homes will also provide more integrated, person-centered services and more generalized health centers will expand into the substance abuse service system.⁴² Additional funding for federally qualified health centers from 2011 to 2015 will significantly expand the number and capacity of these centers that provide a variety of medical and support services for the medically underserved. These centers will begin to incorporate substance abuse treatment into the services they offer. Substance abuse services and providers will therefore likely be treated more like other health care professionals and less like a separate subsystem of care.⁴³

The ACA also contains a number of state plan options, grants and demonstration projects. These provisions are designed to increase service delivery through integrated systems of care, with a whole-person orientation to care, including the integration of substance abuse and mental health services with general medical care.⁴⁴ For, example a new Medicaid plan option will permit Medicaid enrollees with at least two chronic conditions, or at least one serious mental illness, to designate a provider as a “health home.”⁴⁵ These primary and specialty care services could be co-located in community-based mental health and behavioral health settings.

³⁹Buck, Jeffrey A. *The Looming Expansion and Transformation of Public Substance Abuse Treatment under the Affordable Care Act*, Health Affairs, Vol. 30, Issue No. 8, 1402, 1405, August 2011.

⁴⁰ *Id.*

⁴¹ *Id.* at 1406.

⁴² *Id.*

⁴³ *Id.* 1408.

⁴⁴ Report of the Virginia Health Reform Advisory Council, December 20, 2010 at 57-58. The Report is available at <http://www.hhr.virginia.gov/initiatives/healthreform/docs/VHRIFINAL122010.pdf>.

⁴⁵ 42 U.S.C. § 5604.

Virginia Medicaid Expansion Issues

Medicaid in Virginia served more than one million low-income people in 2010 at a cost of more than \$6.6 billion and is the second largest item in the Commonwealth's budget.⁴⁶ Nonetheless, Virginia operates a very lean program compared with the rest of the states due to its limited categorical and income eligibility requirements. It ranks 12th in the country in total population and 7th in per capita income, but 48th in the number of Medicaid recipients as a percentage of population and expenditures per recipient.⁴⁷ At 30% of the federal poverty level, Virginia's income eligibility limits for working parents is significantly lower than surrounding states, ranking 44th among the states.⁴⁸ The federal government currently reimburses its Medicaid expenditures at a rate of 50%.⁴⁹ As a result, with 100 % federal reimbursement through 2016 reducing to 90% in 2020, Virginia, if it opts in, stands to gain more than most other states from the Medicaid expansion.⁵⁰

The Commonwealth of Virginia Health Reform Initiative Advisory Council ("Council") appointed by Governor Bob McDonnell in 2010 to study and make recommendations concerning implementation of the Affordable Care Act and other health initiatives, reports that approximately 520,000 individuals in Virginia will gain coverage through the ACA. Approximately 425,000⁵¹ of these individuals, or over 75%, will become eligible through expanded Medicaid coverage and 100,000 through private insurance. The Association of Community Services Boards estimates that approximately 34% of the Medicaid expansion population will have mental health or substance abuse treatment needs.⁵² If Virginia opts out of the Medicaid program, approximately 425,000 Virginians will therefore continue to be without coverage, unless they have incomes at 100% of the federal poverty level and can afford to purchase insurance on the exchanges with subsidies.⁵³ Approximately 145,000 of these individuals would not have access to mental health or substance abuse services through Medicaid. Currently, approximately 60% of mental health and substance abuse treatment in the Commonwealth is

⁴⁶ Report of the Virginia Health Reform Advisory Council, December 20, 2010 at v. The Report is available at <http://www.hhr.virginia.gov/initiatives/healthreform/docs/VHRIFINAL122010.pdf>.

⁴⁷ *Id.*

⁴⁸ Commonwealth Institute for Fiscal Analysis, *Medicaid Expansion in Virginia under the New Health Care Law*, July 2010, available at <http://www.thecommonwealthinstitute.org/2010/07/>.

⁴⁹ Report of the Virginia Health Reform Advisory Council, December 20, 2010 at 43. The Report is available at <http://www.hhr.virginia.gov/initiatives/healthreform/docs/VHRIFINAL122010.pdf>.

⁵⁰ Commonwealth Institute for Fiscal Analysis, *Medicaid Expansion in Virginia under the New Health Care Law*, July 2010, available at <http://www.thecommonwealthinstitute.org/2010/07/>. See also, Rephan, Terance J., *Economic Effects of Health Care Reform on Virginia*, Weldon Cooper Center for Public Service, University of Virginia, January 14, 2011, at 13, available at: <http://www.coopercenter.org/econ/publications/economic-effects-health-care-reform-virginia>.

⁵¹ The Council estimates a low to high range of from 271,000 to 426,000 individuals may become eligible for Medicaid.

Presentation to the Health Reform Initiative Advisory Committee, Medicaid Reform Task Force, *Medicaid Reform in Virginia: Eligibility and Benefits under PPACA*, November 9, 2010, slide 7. The Presentation is available at: <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/NovemberMeetingDocs/MedicaidReformInVirginia.pdf>.

⁵² *Id.* at slide 26.

⁵³ The ACA makes no provision for premium subsidies for individuals to purchase insurance whose income is under 100% of the federal poverty level, assuming they would be eligible for Medicaid, although it did so for documented aliens because they do not qualify for Medicaid. McInerney, John and Cassidy, Michael J., *Making the Right Choice on Medicaid, Refusing Expansion Would Be a Costly Mistake for Virginia*, The Commonwealth Institute for Fiscal Analysis, July 2012, available at: <http://www.thecommonwealthinstitute.org/>.

paid through the State's general fund.⁵⁴ If they individuals receive these services at all, the cost would be covered from additional state general fund dollars.

The Council also estimates that the cost to Virginia of implementing the Medicaid expansion to be \$2 billion at the low end and \$2.8 billion at the high end through 2022.⁵⁵ Because the Secretary of Health and Human Services has not as yet issued regulations specifying the extent of services that will be necessary to comprise the minimum essential benefit packages, the cost cannot be accurately predicted at this time. The ultimate cost, however, would be offset by approximately \$625.9 million in savings from three major categories -- the Children's Health Insurance Program ("CHIP") match rate increases; pharmacy rebate changes; and Virginia's share of disproportionate share ("DSH") reductions, which Virginia should realize whether or not it opts out of the Medicaid expansion. Savings should also be available in other areas not yet calculated by the Council.⁵⁶ Significantly, the federal government will reimburse Virginia between \$18.4 billion to \$29.2 billion, adding billions in new federal dollars to Virginia's economy. If Virginia opts out of the Medicaid expansion, it will lose the benefit of these new dollars of economic stimulus. In addition, a portion of the federal income tax dollars paid by Virginia's citizens each year will go to other states to support their Medicaid expansion efforts.⁵⁷

Moreover, Virginia's academic medical centers and other Virginia hospitals that serve indigent patients will lose approximately \$14 billion in Medicaid DSH payments over 10 years.⁵⁸ In 2011, Virginia's hospitals received over \$87.7 million in DSH payments.⁵⁹ When enacted, the ACA anticipated that these loses would be made up through payments from those who will now qualify for insurance or be covered by Medicaid. If Virginia opts out of the Medicaid expansion, over 75% of Virginians who would have been Medicaid-eligible will either receive no care or will continue to receive free care, care largely subsidized by increases in insurance premiums paid by those who do have coverage or by the State general fund dollars. Approximately 2% of the nation's hospitals serve the majority of the uninsured or Medicaid recipients with 25% of the cost of that care as uncompensated.⁶⁰ In Virginia, 42.9% of Virginia Commonwealth University Health Systems' inpatients are either uninsured or underinsured, followed by the University of Virginia at 28.5%.⁶¹ In 2011, Virginia's

⁵⁴ Commonwealth Institute for Fiscal Analysis, *Medicaid Expansion in Virginia under the New Health Care Law*, July 2010, available at <http://www.thecommonwealthinstitute.org/2010/07/>.

⁵⁵ Presentation to the Health Reform Initiative Advisory Committee, Medicaid Reform Task Force, *Medicaid Reform in Virginia: Eligibility and Benefits under PPACA*, November 9, 2010, slide 7. The Presentation is available at: <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/NovemberMeetingDocs/MedicaidReformInVirginia.pdf>.

⁵⁶ *Id.* at slide 8.

⁵⁷ Commonwealth Institute for Fiscal Analysis, *Medicaid Expansion in Virginia under the New Health Care Law*, July 2010, available at <http://www.thecommonwealthinstitute.org/2010/07/>.

⁵⁸ Retchin, Sheldon M., M.D., CEO VCU Health Systems, *Impact of Health Care Reform on Virginia's Academic Medical Centers*, Briefing to the Senate Finance Committee Subcommittee on Health and Human Resources, August 24, 2010, at slide 8. The briefing is available at: <http://sfc.virginia.gov/pdf/health/2010%20SEssion/August24%20Jt%20Mtg/No5VCU.pdf>.

⁵⁹ McInernery, John, and Cassidy, Michael J., *Making the Right Choice on Medicaid, Refusing Expansion Would be a Costly Mistake for Virginia*, The Commonwealth Institute for Fiscal Integrity, July 2012, available at <http://www.thecommonwealthinstitute.org/wp-content/uploads/2012/07/Making-the-Right-Choice-on-Medicaid.pdf>.

⁶⁰ Retchin, Sheldon M., M.D., CEO VCU Health Systems, *Impact of Health Care Reform on Virginia's Academic Medical Centers*, Briefing to the Senate Finance Committee Subcommittee on Health and Human Resources, August 24, 2010, at slide 9. The briefing is available at: <http://sfc.virginia.gov/pdf/health/2010%20SEssion/August24%20Jt%20Mtg/No5VCU.pdf>.

⁶¹ *Id.* at slide 11.

general fund spent \$68.4 million funding indigent care.⁶² If Virginia opts out of the Medicaid expansion, 75% of that amount, plus the amount of the lost federal DSH payments to MCV and UVA will need to be made up from the state's general fund, or services at those hospitals will need to be drastically cut.

The ACA has the potential to afford people with behavioral health diagnoses greatly expanded access to mental health and substance use treatment in an integrated and community-based setting, with a person-centered treatment focus. Further, these individuals will no longer need, or will need to a lesser degree, inpatient psychiatric services, and those currently in state-operated institutions, jails and prisons will be able to access treatment in the community upon discharge or release, preventing relapse and recidivism. The quality of life for individuals with behavioral health diagnoses and their families would therefore significantly improve. Depending upon how robust the Secretary determines these services must be, Virginia as a result may be able to begin to consolidate and close its costly mental health institutions. Moreover, more pervasive access to substance abuse treatment will significantly impact those in the criminal justice system or who are homeless. Because 60% of mental health and substance abuse treatment in the Commonwealth is paid through the State's general fund, Virginia's mental health and criminal justice systems could realize significant savings, but only if Virginia opts in to the Medicaid expansion.

Lieutenant Governor Bolling⁶³ and Attorney General Cuccinelli⁶⁴ have both recommended that Virginia reject the Medicaid expansion because it is too costly. Governor McDonnell has declined to call a special session of the General Assembly to authorize a state-operated health insurance exchange and to decide whether Virginia will opt into the Medicaid expansion. Given election year politics, such a decision is probably wise. Postponing the decision until the 2013 General Assembly Session will give Virginia officials time to carefully balance the costs of Medicaid expansion with the losses Virginia's hospitals, especially its academic medical centers will face, and the savings that may be realized for the behavioral health and criminal justice systems. It will also give legislators time to consider the benefits the ACA and the Medicaid expansion will afford to a significant number of Virginia's citizens and the positive impact of these services on their quality of life.

Study Presented to JCHC Finds Longer Periods of Temporary Detention Lead to Reduction in Civil Commitments

A Study presented to the Virginia General Assembly's Joint Commission on Health Care on June 28, 2012 finds that longer periods of temporary detention lead to a reduction in involuntary civil commitments.⁶⁵ Funded by the Virginia Commission on Mental Health Law Reform and published in *Psychiatric Services* in July 2012,⁶⁶ Dr. Tanya Wanchek with the Weldon Cooper Center for Public

⁶² *Id.* at slide 12.

⁶³ Richmond Times-Dispatch, July 13, 2012.

⁶⁴ Richmond Times-Dispatch, July 14, 2012.

⁶⁵ The presentation to the Joint Commission on Health Care is available on the Commission's website at: http://services.dlas.virginia.gov/User_db/frmView.aspx?ViewId=2991.

⁶⁶ Wanchek, Tanya Nicole, Ph.D., J.D., Bonnie, Richard J. LL.B. *Use of Longer Periods of Temporary Detention to Reduce Mental Health Commitments*, *Psychiatric Services*, Vol. 63, No. 7, July 2012. An abstract of the article is available at: <http://ps.psychiatryonline.org/Article.aspx?ArticleID=1151384>.

Service at the University of Virginia and Professor Richard J. Bonnie, Harrison Foundation Professor of Law and Medicine, University of Virginia School of Law, matched data from the Virginia Supreme Court's Court Management System ("CMS") to the Commonwealth of Virginia Medicaid claims database for July 1, 2008 through March 30, 2009. The data revealed that longer periods of temporary detention were correlated with an increased probability of a dismissal of a civil commitment petition rather than further psychiatric hospitalization.

Virginia is currently one of only three states in the country requiring a civil commitment hearing within 48 hours of execution of a temporary detention order.⁶⁷ Three other states allow a hearing within 30 days but most states require a hearing within four to eight days of the person's detention, with the mid-range being 7-10 days. Although Virginia law requires hearings to be held within 48 hours of execution of a temporary detention order, that time period may be extended to 72 or 96 hours if the detention falls on a weekend or long holiday weekend. This extension provided a natural variation in TDO length based on local practice and the occurrence of weekends and holidays upon which the Study could rely to correlate longer detention stays with shorter stays.

One goal of mental health reform is to improve health outcomes, reduce coercion and stigma associated with the involuntary delivery of mental health treatment, and encourage voluntary treatment. From its inception in 2006, the Virginia Commission on Mental Health Law Reform has studied whether extension of the 48-hour time frame would lead to better outcomes for people in mental health crisis.⁶⁸ Advantages of increasing the TDO period would provide more time for thorough evaluation and for the person's condition to stabilize, thereby 1) increasing the likelihood of discharge to outpatient treatment, 2) increasing the likelihood that any subsequent hospitalization will be voluntary, and 3) decreasing the length of post-commitment hospitalization. A Study completed for the Mental Health Law Reform Commission also found that many commitment hearings took place in many localities in less than 24 hours. As a result of conducting a commitment hearing in less than 24 hours, the individual's condition did not have time to stabilize, the person was not willing or yet capable of volunteering for admission, and outpatient treatment options could be explored or put in place. The person was therefore almost automatically involuntarily committed.⁶⁹ The Virginia Inspector General for Mental Health, Mental Retardation and Substance Abuse Services⁷⁰ found in his Investigation of the April 16, 2007 Critical Incident at Virginia Tech⁷¹ that the short period from detention to commitment hearing made it very difficult, if not impossible, to obtain an adequate assessment of the detained individual. For the same

⁶⁷ Virginia Code § 37.2-809.

⁶⁸ A Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform (December 21, 2007) at 17-18 Available at: http://www.courts.state.va.us/programs/cmh/reports/2007_0221_preliminary_report.pdf; Task Force on Future Commitment Reforms; Report to the Commission on Mental Health Law Reform (December 2008) at 20-22. Available at: http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2008_1201_tf_commitment_rpt.pdf; Barclay, SE: 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 (April 2008). Available at: http://www.courts.state.va.us/programs/cmh/reports/2008_04_tdo_period_barclay_report.pdf Future Commitment Reforms; Report to the Commission on Mental Health Law Reform (December 2009) at 20-23. Available at: http://www.courts.state.va.us/programs/cmh/taskforce_workinggroup/2009_1201_tf_commitment_rpt.pdf;

⁶⁹ A Study of Commitment Hearings Held in the Commonwealth of Virginia during May 2007 (June 30, 2008). Available at: http://www.courts.state.va.us/programs/cmh/reports/2007_05_civil_commitment_hearings.pdf.

⁷⁰ The Inspector General's name was changed in 2009 to Inspector General for Behavioral Health and Development Services.

⁷¹ Investigation of April 16, 2007 Critical Incident at Virginia Tech, OIG Report No. 140-07, available at: <http://www.oig.virginia.gov/documents/VATechRpt140-07.pdf>.

reason, the Virginia Tech Review Panel investigating the shootings at Virginia Tech also recommended that Virginia law be amended to extend the time periods for temporary detention to permit more thorough evaluations.⁷² Even now, severity of the person's illness does not dictate how soon a commitment hearing is scheduled. Rather scheduling of hearings varies by local administrative practice in each jurisdiction with convenience of the court system, and not clinical concerns, being the controlling factor.

A match of the Court's CMS outcome data submitted by special justices following commitment hearings with the Medicaid claims file for inpatient hospitalizations, yielded 508 matches for this Study. The Medicaid claims file provided information on the length of stay that immediately followed the commitment hearing as well as information on the age, sex, race, and primary diagnosis of the Medicaid recipient. Among individuals whose hearing occurred in less than 24 hours, and often in less than 12 hours, the probability of involuntary commitment was 73%, and only 9% of these individuals had their cases dismissed. After a three-day detention period of 72-96 hours, the percentages of dismissed cases, voluntary hospitalizations and involuntary commitments were about equal. After a four-day TDO, the probability of involuntary commitment dropped to 43%. After four or five days, 50% of cases were dismissed, and another 25% of individuals voluntarily admitted themselves. Results from the Study thus demonstrate that longer TDO periods are correlated with a lower probability of hospitalization following the commitment hearing.

The second aspect of the Study focused on the cost of extending the TDO time period. If the number of permitted TDO days increased, the cost of hospitalization for those additional days would naturally be expected to increase. However, this increase in TDO days could legitimately be expected to decrease the number of hospital days post-hearing due to increased dismissals of petitions, increased availability of outpatient treatment, and voluntary admissions. Matching of the CMS date with the Medicaid claims file provided a method to correlate the length of TDOs with the length of subsequent hospitalizations after the commitment hearing. Among those hospitalized, longer TDOs are correlated with shorter post-hearing hospital stays. When the TDO length increased from less than one day to one full day, subsequent hospital stays decreased by 1.33 days. Increasing TDO length from less than one day to two days was associated with a reduction in subsequent hospitalization of 1.25 days. Increasing TDO length from less than one to three days was associated with a reduction of 2.22 days of hospitalization.

Using these findings as a basis for extrapolation, the Study then sought to ascertain the total hospitalization time, including the TDO period and the post-TDO hospital stay, if a 72-hour TDO period had been in effect in FY 2010. The researchers assumed that all commitment hearings would be held after 72 hours, which will not always be the case. Based on this assumption, the number of TDO days in FY 2010 would have increased by 26,288 days. However, the number of hospital days following the commitment hearing would have been reduced to 24,506 days due to fewer hospitalizations as well as reduced length of post-hearing hospitalization. This would have resulted in a net increase of 1782 days of total hospitalization for all people who had been subject to TDOs in FY 2010. However, since only about half of TDOs are paid by the involuntary commitment fund, the net number of additional days that would have been paid from the involuntary commitment fund would have been about 873, a modest

⁷² The full report of the Virginia Tech Review Panel on Mass Shootings at Virginia Tech April 16, 2007, Presented to Governor Kaine, Commonwealth of Virginia, is available at: <http://www.governor.virginia.gov/tempcontent/techPanelReport-docs/FullReport.pdf>.

increase. Because not all commitment hearings would occur at the maximum of 72 hours, this projected increase is a conservative one.

If improving health outcomes, reducing coercion and stigma associated with the involuntary delivery of mental health treatment, and encouraging voluntary treatment are important policy goals, extending the period of temporary detention will reduce involuntary hospitalizations. Longer TDO periods were correlated with increased rates of dismissal. When hospitalization occurred, the stay was more likely to be voluntary rather than involuntary. Longer TDO periods were also associated with shorter subsequent hospital stays. The time has therefore come to increase the 48-hour maximum TDO period, the shortest in the country, to 72 hours and beyond as previously recommended by the Virginia Tech Review Panel, the Inspector General for Behavioral Health and Developmental Services and the Virginia Commission on Mental Health Law Reform.

Inspector General Presents “Failed TDO,” Barriers to Discharge and Forensic Services Reports to JCHC

G. Douglas Bevelacqua, Virginia Inspector General for Behavioral Health and Developmental Services (“IG”), presented the joint study on Emergency Services and Failed TDOs, conducted by his Office and the Department of Behavioral Health and Developmental Services (“DBHDS”), to the Virginia General Assembly’s Joint Commission on Health Care on June 28, 2012.⁷³ This Study, conducted between July 15 and October 13, 2011, found that 72 individuals who met statutory criteria for the issuance of a temporary detention order (“TDO”)⁷⁴ did not receive emergency inpatient hospitalization because no state-operated behavioral health hospital or private psychiatric facility would admit them. In addition, 273 individuals, or 5 ½ % of the TDOs issued during that three month period, were executed beyond the 6-hour time limit for converting an emergency custody order (“ECO”)⁷⁵ to a TDO.

At the same meeting, the Inspector General also presented a six-month study into the Extraordinary Barriers to Discharge at the DBHDS facilities. He found that the inability of state facilities to discharge residents who are clinically ready for discharge in a timely manner undermines the state facilities’ ability to serve as a safety net for individuals in crisis and may violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132, as interpreted by *Olmstead v. L.C.*, 527 U.S. 581 (1999)(“*Olmstead* Decision”). The IG also observed that the shortage of acute-care beds in “failed

⁷³ The full report Review of Emergency Services: *Individuals Meeting Statutory Criteria for Temporary Detention Not Admitted to a Psychiatric Facility for Further Evaluation and Treatment*, OIG Report No. 206-11 (February 28, 2012) is available at: <http://www.oig.virginia.gov/documents/SS-EmergencySvcReview206-11.pdf>.

⁷⁴ Criteria for issuance of a TDO under Virginia Code § 37.2-809 requires the person to have a mental illness “and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information , if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs. In addition, the person must be unwilling to volunteer or be incapable of volunteering for hospitalization or treatment.

⁷⁵ Virginia Code § 37.2-808 authorizes a magistrate to issue an emergency custody order, or a law enforcement officer to take custody of an individual, when they have probable cause to believe a person meets the TDO and civil commitment criteria, and to transport that person to a convenient location for evaluation and issuance of a TDO, if needed.

TDOs” is probably related to the inability of state behavioral health facilities to discharge people deemed discharge-ready due to a lack of sufficient and appropriate residential placements with intensive supports and supervision.

Finally, the Inspector General also presented a study of the use of the recovery model and person-centered planning in the delivery of forensic services.

Emergency Services and Failed TDOs Study

The IG replaced the pejorative term “streeting” used in a previous report with the term “failed TDO” to describe the situation in which individuals are not detained but are released at the expiration of an ECO, allegedly to the “street,” due to the inability of community services board (“CSB”) emergency services staff to find an appropriate bed for the person in a willing facility. He did so in response to comments he received that “streeting” did not accurately reflect the services actually provided to these individuals or that many individuals received the inpatient services they needed but after expiration of the ECO. The IG used the term “streeting” after discovering its use in the Hampton Roads weekly TDO Report form used to describe this situation during his investigation of the impact of the moratorium on admissions at Eastern State Hospital in 2010.⁷⁶

The data submitted by CSB emergency services workers to regional managers for the seven Partnership Planning Regions (“PPRs”) throughout the state during this three-month period revealed the heavy reliance of the emergency services system on hospital emergency departments (“EDs”). During this study, the majority, or 68% of emergency contacts, occurred in EDs, and 57% of these contacts were initiated through issuance of an ECO.

Failure of TDOs for Lack of Available Beds

For those 72 individuals who could not access inpatient psychiatric services, the IG found that emergency services workers, hospital EDs and law enforcement officers made extraordinary efforts to create treatment alternatives for them while waiting for bed space to become available. Seventeen individuals remained in the ED, leading to the phenomenon called “hospital boarding.” For 15 people, community supports were implemented. Thirteen were medically admitted to the hospital; twelve remained in supportive settings, such as with family; one individual was arrested and one was admitted to a less intensive level of care. Unfortunately, thirteen were released with no further intervention.

Of these 72 failed TDOs during this period, the reason given for 40 of the failures, or 56% of the total number of cases, was no bed availability at the time of contact. The second reason given was that the acuity level or care needs of the individuals exceeded the ability of the psychiatric facilities to provide them. Strikingly, 75% of the failed TDOs occurred in only two regions, Southwest Virginia (PPR III) with 32 cases, and Hampton Roads (PPR V) with 22 cases. Both of these regions represent only 30% of the State’s population. It was, in fact, the alarming number of failed TDOs in the Hampton Roads area in 2011 that led to this study. At that time, the IG suspected that the large number of failed TDOs in this region was attributable to the downsizing of Eastern State Hospital in 2010. At that time, that region lost one third of its inpatient bed capacity, but his subsequent research and analysis into bed

⁷⁶ The OIG Report No. 197-10, A Review of the Downsizing of Eastern State Hospital and the Impact on Hampton Roads, is available at: <http://www.oig.virginia.gov/documents/FR-ESH-197-10.pdf>.

capacity does not support such a conclusion. Furthermore, Hampton Roads has a per capita TDO rate more than double the rest of the State. The IG is recommending that more research and analysis of this situation in Hampton Roads be done to determine the reasons for this anomaly.

Although Hampton Roads and Southwest Virginia differ significantly in population and geography, one factor they have in common is that the state-operated facilities in both regions are frequently at capacity and are therefore unable to provide safety net detention services. At Southwestern Virginia Mental Health Institute (“SWVMHI”) during 2011, 40% of individuals hospitalized on the adult admissions unit and 76% of those served on its geriatric admissions unit were first time patients. In addition, the average length of stay for the acute treatment services increased from 40 days during the 4th quarter of 2010 to 57 days during the 4th quarter of 2011, reducing the facility’s acute treatment capacity by over 40%. December’s census at SWVMHI further revealed that 36% of patients in SWVMHI’s long term rehabilitation unit were originally Tennessee residents.⁷⁷

The IG identified the major reason for the denial of admission for persons in need of acute or longer term services as the inability of state-operated facilities to discharge individuals to the community in a timely manner. “When there is insufficient community capacity to receive individuals that have been stabilized and are discharge-ready, these people must remain in the state facility occupying a bed that could have been used to admit a person that clinicians had determined to meet criteria for temporary detention (TDO).”⁷⁸

Since July 2011, the IG has been tracking the number of individuals identified as clinically ready for discharge from state-operated facilities. Although a fluid number, the monthly average during this six-month period was approximately 120 individuals, of which 85 were adult civilly committed individuals and 35 were geriatric patients. The primary barrier preventing the adult population from being discharged was the lack of appropriate residential placements with intensive supports and supervision. Many of these individuals are on waiting lists for placement and many have significant risk factors, such as violent histories, multiple disabilities, and behavioral needs. The primary barrier for geriatric patients is the need for nursing home placement, including waiting list delays, guardianship concerns and resource issues.

Other reasons were identified for the inability of state facilities to serve as a safety net. In about half of the 72 instances of failed TDOs, a state facility was not contacted to determine bed availability. When a state facility was contacted, the primary reason given for denial was lack of bed availability. Emergency services workers are expected to contact all available private psychiatric facilities in their region, and often beyond, before contacting a state facility. In their failed attempt to secure a bed, emergency services workers had to contact an average of 10.56 private psychiatric facilities. While this practice allows state facilities to serve as the treatment facility of last resort, reserving state-operated beds for the most challenging individuals for whom there are no other treatment options, if they are not even contacted, they cannot be used.

⁷⁷ Subsequent inquiry indicates that Assisted Living Facilities (“ALFs”) in this region have advertised availability of their services in bordering states, which has led to an influx of Tennessee residents whose service needs may exceed the ability of some ALFs to meet. Further review of this situation is ongoing.

⁷⁸ Review of Emergency Services: *Individuals Meeting Statutory Criteria for Temporary Detention Not Admitted to a Psychiatric Facility for Further Evaluation and Treatment*, OIG Report No. 206-11 (February 28, 2012) at 21.

The more newly established crisis stabilization units (“CSUs”) are also unable to serve this safety net function. At the time of this study, only seven CSUs out of 16 across the state accepted TDOs with a total of only 31 CSU beds available to serve individuals meeting the TDO criteria. Even if the CSU admits individuals under a TDO, the admission criteria for even these CSUs often eliminate many individuals who meet the TDO criteria. CSUs generally will not accept individuals that are acutely psychotic, actively suicidal or homicidal, have past behavioral problems of unpredictable violence or are highly agitated, are clear escape risks or have significant problems because they are often beyond the capacity of the CSU to treat.

Custody Beyond 6-Hour Limit

Under Virginia Code § 37.2-808.J, an individual may be taken into custody under an ECO for only four hours for an evaluation to determine whether he or she meets the criteria for temporary detention. A magistrate may extend that four-hour time period to six hours for good cause, including the need for additional time to allow the CSB to identify a suitable facility in which to detain the person or for completion of a medical evaluation. If the four hours, or additional two hours, expires, the person should be released from custody. The IG found that during the 90-day study period, 273 cases resulted in the issuance of a TDO beyond the 6-hour time frame mandated under the law. For these individuals it took an average of 16.6 hours to obtain a TDO after an ECO was issued. Again, the Hampton Roads region took the longest time with an *average* of 28.3 hours. Hampton Roads and PPR VII (encompassing Blue Ridge CSB and the Roanoke area) represented 56% of all reported cases. PPR VII has the highest number of psychiatric beds in the state, and as should be expected, it reported no situations in which a person was released for lack of a suitable TDO bed. For an undetermined reason, however, PPR VII had the second highest number of TDOs executed beyond the 6-hour limit.

Three primary reasons were given for delays in obtaining TDOs: 1) the length of time taken to find a “willing” facility with an “appropriate bed”; 2) the time involved to complete medical screening and secure medical clearance; and 3) challenging individuals with complex medical and behavioral needs.

Bed Registry

As indicated above, an emergency services worker had to contact on average 10.56 private facilities searching for an available bed to no avail. Establishment of a “real time” bed registry has been recommended for years by the Mental Health Law Reform Commission⁷⁹ and others with no success due to budget cuts. As proposed, data on bed availability would be entered into the registry at least once per shift by designated hospital staff with enough information to inform CSB emergency services workers of the number and types of beds available at each facility, thereby reducing the number of calls needed to be made and the time spent searching for an available and appropriate bed. DBHDS reports that the registry is now in the implementation stage with one hospital and one CSB being brought online at a time, with full implementation expected in the Fall 2012. Whether TDO facilities will be able to keep the registry updated often enough to really assist CSB workers in locating a bed and whether the information will be transparent enough to reflect actual bed availability, especially if those facilities want to retain flexibility to reject individuals with challenging behaviors, remains to be seen.

⁷⁹A Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform (December 21, 2007) at 19; Report of the Task Force on Civil Commitment (March 2008) at 27.

Medical Screening and Assessment

The length of time involved in medical screening and assessment was the second reason given for the added time required for issuance of a TDO, due especially to inconsistent and conflicting policies and practices utilized throughout the state. In 2007, DBHDS worked with key stakeholders to issue a *Medical Screening and Assessment Guidance Document* dated April 6, 2007, but this guidance was never been implemented statewide. Because of ongoing problems with medical screening and complaints about hospitals refusing admission without “medical clearance,” DBHDS convened another work group in 2010 composed of key stakeholders, including the Virginia Hospital and Healthcare Association, the College of Emergency Room Physicians, Community Services Board emergency services workers, and hospital admissions coordinators and admitting physicians, to update the Guidance. DBHDS has agreed to complete this update and disseminate the Guidance by this Fall. In order to then be widely implemented, adequate training must be provided and the provisions incorporated into the admissions policies of all public and private psychiatric facilities. TDO facilities must also be willing to give up their mandatory and rigid requirements that every individual be “medically cleared” before admitting them.

Possible Solutions and the Burden on Law Enforcement

The IG study did not mention the extraordinary burden failed TDOs place on law enforcement. Sheriffs and local police departments have long complained about the drain on man-hours needed to maintain custody of an individual, sometimes without statutory authority, while waiting for a TDO facility to be identified and/or medical assessment to occur, then often followed by a long drive across the state to the TDO facility. This study confirms their complaints and quantifies the problem. In addition, the Opinion of the Attorney General issued in October 2011 to the County Attorney for Wise County in Southwest Virginia⁸⁰ adds to this burden for town police departments that may not have sufficient staff to carry out their responsibilities, and who have been unable to enter into mutual aid agreements with neighboring jurisdictions.

The impact of the AG opinion on town police could be fixed legislatively, but would only serve to shift the burden back on other law enforcement agencies. The four to six hour ECO time limit could also be extended to eight hours, as originally proposed by the Mental Health Law Reform Commission, or longer. While doing so would increase the number of hours law enforcement can legally hold someone, it would not come close to addressing the burden the 16.6 hours average length of custody, or the 28.3 hours in the Hampton Roads area, imposes. Legislation could also be introduced permitting magistrates to issue a TDO without naming the TDO facility or amending the TDO if the originally contemplated facility is not available. This again would not relieve the burden on law enforcement but would only make an illegal situation legal for a longer period.

The IG notes that Virginia’s system of behavioral health care is completely interdependent and that “the availability of adult acute beds in state facilities to admit temporarily detained individuals is influenced by each facility’s ability to transfer stabilized residents to appropriate community-based

⁸⁰ The Opinion of the Attorney General, Opn. No. 11-123 (October 21, 2011), to Karen T. Mullins, County Attorney, Wise County, is available at: <http://www.oag.state.va.us/Opinions%20and%20Legal%20Resources/Opinions/2011opns/11-123-Mullins.pdf>.

programs.”⁸¹ While this is partly true, efforts continue to need to be made to incrementally add additional crisis intervention services in the community as identified in the IG’s 2005 study of emergency services that identified service gaps in the emergency services system.⁸² Measures include increasing the capacity of CSUs to admit individuals with challenging behaviors and serve as “no refusal drop-off centers,” increasing the numbers of mobile crisis teams, developing a tiered rate structure to encourage community-based psychiatric facilities to admit more challenging individuals, and expanding the availability of routine psychiatric and support services in the community for individuals before they reach the crisis stage.

Barriers to Discharge Study

Simultaneous with and as a corollary to his Review of Emergency Services and Failed TDOs, the IG also reviewed the Extraordinary Barriers to Discharge from State-Operated Adult Behavioral Health Facilities during the time period of July 2011 through December 2011.⁸³ The IG found that the inability of state facilities to discharge residents who are clinically ready for discharge in a timely manner undermines the state facilities’ ability to serve as a safety net for individuals in crisis. He also found that it may violate Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132, as interpreted by *Olmstead v. L.C.*, 527 U.S. 581 (1999)(“*Olmstead* Decision”) and puts Virginia at risk for another Department of Justice investigation similar to the one DOJ just completed in New Hampshire.

In FY 2011, the IG reported that the average daily census in Virginia’s eight operated adult behavioral health facilities was 1319, with a final facility census on December 31, 2011 of 1252. Treating clinicians had determined that an average of 165 of these individuals had received maximum benefit from their hospitalization and were discharge-ready. Of these 165 individuals, 87 or 53% were adult civil patients with the remaining being either individuals found not guilty by reason of insanity (“NGRI”)(45 individuals or 27% of the population), or geriatric patients (33 individuals or 20% of the population.) The IG further reported that Virginia has maintained an Extraordinary Barriers to Discharge List for over ten years and the numbers of individuals on that list have remained relatively constant since at least 2007 at 12% to 14% of facility operating capacity. The IG thus hypothesized that the discharge of these adult civil patients would free up 13% of the state’s facility beds sufficient to create safety net beds for individuals meeting TDO criteria.

In completing this study, the IG monitored individuals on the monthly ready for discharge lists maintained by DBHDS from July to December 2011. He also made unannounced visits to each of the eight DBHDS adult psychiatric facilities and conducted an in-depth review of 75 of these individuals’ records, including their individualized treatment plans, discharge plans and documented barriers. He also interviewed key staff at each facility engaged in discharge planning; observed treatment teams to see whether discharge planning was being actively addressed during team meetings; and monitored these 75 individuals for a 90-day period to measure progress toward discharge.

⁸¹ Review of Emergency Services: *Individuals Meeting Statutory Criteria for Temporary Detention Not Admitted to a Psychiatric Facility for Further Evaluation and Treatment*, OIG Report No. 206-11 (February 28, 2012) at 22.

⁸² The Review of the Virginia Community Services Board Emergency Services Program, OIG Report # 123-05, is available at: <http://www.oig.virginia.gov/documents/SS-ESPFinalReportMay-August2005.pdf>.

⁸³ The Review of the Barriers to Discharge in the State-Operated Adult Behavioral Health Facilities, OIG Report No. 207-12 (April 25, 2012) is available at: <http://www.oig.virginia.gov/documents/Syst-Rev-207-12.pdf>.

Of the 75 individual cases the IG reviewed for this study, 44 or 59% were male and 31, or 41%, were female. Thirty-one individuals, or 42%, were adult civil patients; 25 or 33% were geriatric patients, and 19 or 25% were NGRI. Forty-five percent had at least one previous admission and 25% had multiple previous admissions, with one individual having been hospitalized 25 times. Fifty-seven percent had a primary thought disorder diagnosis (schizophrenia, schizoaffective), 21% a primary mood disorder diagnosis (major depressive or bi-polar), and 23% were diagnosed with dementia. One individual was diagnosed with borderline personality disorder. Sixteen individuals, or 21%, were identified as having a co-occurring mental health and substance use disorder; and 12 individuals had been on the list before, but removed after their conditions deteriorated while awaiting discharge.

Of the 153 individuals on the Extraordinary Barriers List in July 2011, 56, or 36%, had been on the list for longer than six months. Twenty-four individuals, or 16%, had been on the list for longer than one year. Of the 75 individuals reviewed by the IG, 36 or 48% remained on the list for up to 60 additional days and 21 or 28% remained on the list for 90 days. And as of April 2012, 39% remained on the list 1-90 days; 18% 91-180 days; 22% 181-365 days; and 21% longer than a year.

Discharge Process

The DBHDS *Discharge Protocols for Community Services Boards and State Hospitals* (2010)⁸⁴ and the performance contracts DBHDS enters into each year with the CSBs require CSB case managers to facilitate discharge planning for individuals in state-operated facilities. According to the Protocols, discharge planning must begin at the initial interdisciplinary team meeting at which time the Needs upon Discharge Form (DBH 226) which identifies the services and supports necessary for the person to successfully reside in the community is completed. The Form must include the anticipated date of discharge from the facility; identification of the services and supports needed for successful community placement; and specify the public and private providers that will provide these services. The expectation is that the individual will be discharged within 30 days of the date the individual's clinicians determine he or she is ready for discharge. Individuals whose discharge exceeds the 30-day time limit and the barriers that prohibit their timely discharge are placed on the Extraordinary Barriers to Discharge Form (DBH 1192). The CSB is expected to outline specific steps to address each individual's barriers, and periodic case reviews are scheduled until the person is discharged.

Ninety-eight percent of the records the IG reviewed revealed that the CSB discharge liaisons and case managers are actively involved with the individuals throughout their hospitalization. Identified needs were routinely discussed and options for placement and services were most often identified long before the person became clinically ready for discharge. The IG found each facility has established procedures for identifying, monitoring and addressing each individual's situation until discharge occurs at the level of the treatment team or at a regional utilization group or committee. Specialized case conferences occur for individuals who have been on the Extraordinary Barriers List for longer than six months and include DBHDS central office staff.

The IG also determined that Western State and Central State Hospitals have the most comprehensive approach to discharge planning. The discharge planning process at these two facilities is an integrated part of treatment planning and is part of the complete treatment focus. Both hospitals rate

⁸⁴ The Protocols are available on the DBHDS website at: <http://www.dbhds.virginia.gov/documents/OMH-DischargeProtocols.pdf>.

each person on a 1 to 4 scale according to their readiness for discharge, with the most clinically ready designated as a 1. Discharge barriers are readily identified and resolutions are sought well before anticipated discharge dates. Western State Hospital, Central State Hospital, and Southwestern Virginia Mental Health Institute had the smallest number of individuals on the barriers list per 100 patients with 7.6%, 3.8% and 5% respectively. SWVMHI, however, reported no forensic patients on the Extraordinary Barriers List during this six-month period.

By contrast, Northern Virginia and Southern Virginia Mental Health Institute had the highest number of individuals on the Extraordinary Barriers List with 22% each. SVMHI would have had the highest at 29% had the comprehensive plan used as the basis for this study reflected its recent reduction in its operating capacity from 96 beds to its current 72 beds.

Forensic Patients

Like other public behavioral health facilities throughout the country, Virginia's forensic population is increasing, consuming a larger proportion of its resources and inpatient beds. Its growth has been cited as a contributing factor in facilities having fewer civil beds for treatment of individuals in crisis or for extended rehabilitation. Forensic patients are those individuals involved in the criminal justice system who have mental illness and either pending criminal charges or have been found NGRI. In FY 2010, DBHDS facilities housed 1165 individuals on forensic status with an average daily census of 469, or 36% of the inpatient population. All of the individuals on the Extraordinary Barriers List were individuals found by courts to be NGRI. Before they may be discharged, an individual in NGRI status must progress through DBHDS' graduated release process and then be approved for discharge by the court that committed them, often subject to a conditional release plan.

Geriatric Patients

The lack of community capacity to adequately address behavioral management needs of geriatric individuals with psychiatric illnesses has resulted in an increased demand for these services in state facilities. Moreover, many private providers tend to admit individuals without psychiatric complications and fewer behavioral demands, even though state facilities work closely with nursing homes and other community providers to support services to these individuals.

Primary Barriers

The primary barriers to discharge listed were the lack of safe, affordable and stable community housing, including supervised settings. Other reasons included lack of discharge assistance funding; the complexity of both psychiatric and medical issues for individuals on the list, which make it difficult to find willing community providers or community settings capable of addressing their specialized needs; challenges in accessing resources such as filing social security benefit applications; increasing numbers of individuals with co-occurring disorders; and delays in completing the gradual release process for individuals found NGRI. Of the adult civil patients on the Extraordinary Barriers List whose records the IG reviewed, all were identified as being hospitalized for more intensive or extended rehabilitation services. Lack of housing options was identified as a barrier for ten of these individuals due to the complexity of the services they needed, including the individuals' history of aggression and violence and/or histories of non-compliance with treatment recommendations in the community.

Facility-to-Community Cost Ratios

The IG reports that the average annual cost to serve an individual in a state-operated facility is currently \$214,000. At the IG's request, Hampton Roads, which has about a third, or 54, of the individuals on the Extraordinary Barriers List, reported its estimate of the cost to serve the individuals for whom it is responsible at approximately \$51,471. This figure includes SSI, SSDI, Medicaid and Medicare benefits. Although there are a few outliers requiring much higher expenditures, the IG's data reflects that most individuals can be served in the community for approximately \$22,000, plus Social Security payments and Medicaid benefits. The IG therefore puts a conservative estimate of the average annual cost of serving someone in the community at \$44,000. These estimates suggest that nine people could be served in the community for the cost of serving one person in a state facility.

The IG found that an individual spent an average of 206 days on the Extraordinary Barriers List. If appropriate supported housing were created, approximately 80% of the adult civil population on the List could reside in the community. An additional \$3 Million in discharge assistance ("DAP") funds, which DBHDS has included in its Strategic Plan, could assist in discharging 70 individuals on the List and would result in a savings of approximately \$12 million. The IG points out, however, that Virginia needs to close units, buildings and facilities to reduce the cost of operating expensive state facilities in order to realize potential savings from these initiatives.

The IG also recommends that DBDHS work with the Department of Housing and Community Development to utilize funds from the \$7 million housing trust fund recently appropriated by the General Assembly to serve people in state facilities with unmet housing needs and homeless individuals at risk of institutionalization.

DOJ Findings in New Hampshire

The IG also reviewed the recent findings of the United States Department of Justice following its investigation of the State of New Hampshire's two state-operated mental health facilities.⁸⁵ DOJ found that New Hampshire is violating the Americans with Disabilities Act by failing to provide services to qualified individuals in the most integrated setting appropriate to their needs. This has led to the needless and prolonged institutionalization of individuals who could be served in the community with adequate services and supports.

Specifically, DOJ found that in New Hampshire, just as the IG has found in Virginia, there is a lack of safe, affordable and stable community housing for persons with mental illness. New Hampshire, like Virginia, continues to fund more costly institutional care even though less expensive and more therapeutic alternatives could be provided in the community. Many individuals in New Hampshire's behavioral health facilities remain there longer than necessary because adequate and appropriate services are not available in sufficient supply in the community. When considering the relative cost of community services versus facility care, New Hampshire could serve about six persons in the community for each individual residing in a state facility, as compared to nine in Virginia. The IG

⁸⁵ The Department of Justice's dated April 7, 2011 to the Attorney General of New Hampshire with its findings of violations of the Americans with Disabilities Act is available at: http://www.justice.gov/crt/about/spl/documents/New_Hampshire_MH_findlet_04-07-11.pdf.

therefore concluded based on these DOJ findings, that Virginia may also be violating the ADA and is also at risk of such an investigation and enforcement action by DOJ.

Forensic Services Study

The IG also presented his Review of Behavioral Health Services⁸⁶ to the Joint Commission on Health Care. Forensic bed utilization is often cited as a contributing factor in reducing the availability of adult civil beds, with forensic patients often remaining in the hospital for five or six years. This review focused exclusively on the quality of DBHDS' commitment to the recovery model of treatment and the delivery of person-centered services.

During FY 2010, 1165 forensic patients were served in the DBHDS' eight state-operated psychiatric facilities with an annual daily census of 469 individuals or 36% of the total number of adults served. Forensic patients are those individuals with either criminal charges pending or who have been found not guilty by reason of insanity ("NGRI"). Individuals who have been found NGRI represent 70% of this population and may be discharged only with the approval of the court that committed them. Others under forensic status include individuals undergoing evaluation for competency to stand trial or mental status evaluations, those found incompetent to stand trial and ordered to be restored to competency, and inmates in local or regional jails in need of inpatient psychiatric treatment.

The IG found that individuals are receiving recovery oriented and person-centered services and supports, but its quality varies significantly and there is no current process in place to identify existing or emerging practices. Unique challenges present themselves in delivering person-centered services to individuals who may spend a number of years in the hospital, moving through the gradual release process and convincing the courts to release them. The IG recommends that DBHDS establish a team of individuals with recovery and person-centered expertise, including professionals providing services to people with intellectual disabilities, to develop strategies to create more integrated experiences for these individuals.

The IG also found that individuals in NGRI status often do not understand the extent of inpatient treatment that may be associated with their NGRI disposition. He speculates that many individuals have received misinformation from their attorneys, who themselves do not understand the consequences of a NGRI defense. He recommends that DBHDS improve attorney understanding of the graduated release process and develop a process for measuring incidents of individuals receiving inaccurate information.

Because of the large numbers of criminal defense attorneys practicing in the Commonwealth, it might also be helpful for DBHDS to work with the Executive Secretary of the Virginia Supreme Court to provide information and training to court-appointed defense attorneys and with the criminal bar on the consequences of an insanity plea, the treatment that can be expected, and the graduated release process that may take years to complete. Often an individual may be released from jail or prison sooner had he or she been convicted of the crime charged and served his or her sentence than being acquitted by reason of insanity and committed to a state mental health facility.

⁸⁶ The OIG Review of Behavioral Health Forensic Services, OIG Report No. 200-11 (October 2011) is available at <http://www.oig.virginia.gov/documents/SS-ForensicReview200-11.pdf>.

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Institute Programs

Please visit the Institute's website at <http://ilppp.virginia.edu/OREM/TrainingAndSymposia> to find announcements and descriptions of programs offered September 2012 through June 2013.

Please consider the following programs (and return to the calendar to see further announcements) :

Basic Forensic Evaluation: Principles and Practice

October 1-5 2012, Charlottesville VA : This five-day program provides foundational, evidence-based training in the principles and practice of forensic evaluation. The agenda includes adjudicative competence, insanity, criminal sentencing, malingering, report writing, courtroom testimony, and ethics in forensic practice. The format combines lectures, clinical case material, and practice case examples.

Symposium: The Prodromal Stage of Psychosis in Adolescence and Early Adulthood: Symptoms, Treatment, and Risk for Conversion

October 26 2012, Charlottesville VA : Jean Addington PhD, Novartis Chair in Schizophrenia Research and Professor of Psychiatry at the University of Calgary (Alberta), will summarize the current research on the identification, predictors, and treatment of this early and often non-diagnosed stage of a psychotic illness - the Prodromal Stage of Psychosis - and review the diagnostic criteria in the context of case studies. The goal of the program is to: (1) familiarize service providers with the common symptoms of this early state; and (2) present options for treatment to minimize the risk for conversion to psychosis and to lessen the effect of the illness should it occur.

Assessing Individuals Charged with Sexual Crimes

February 28-March 1 2013, Charlottesville VA : This two-day program focuses on the assessment and evaluation of sexual offenders, including 19.2-300 pre-sentencing evaluations and 37.2-904 assessment of Sexually Violent Predators (SVPs). The program addresses the legal background relevant to sex-offender evaluation as well as the clinical background including topics such as paraphilias and base rates of reoffending. The program provides training in well-researched sex-offender risk assessment instruments.