Mental Health System Transformation After The Virginia Tech Tragedy

The Virginia Tech massacre in 2007 has galvanized public support for mental health system reform.

by Richard J. Bonnie, James S. Reinhard, Phillip Hamilton, and Elizabeth L. McGarvey

ABSTRACT: On 16 April 2007, a deeply disturbed Virginia Tech student murdered thirty-two fellow students and faculty and then shot himself. Less than one year later, the Virginia legislature improved the emergency evaluation process, modified the criteria for involuntary commitment, tightened procedures for mandatory outpatient treatment, and increased state funding for community mental health services. The unanswered question, however, is whether the necessary political momentum can be sustained for the long-term investment in community services and the fundamental legal changes needed to transform a system focused on managing access to scarce hospital beds to a community-based system of accessible voluntary services. [*Health Affairs* 28, no. 3 (2009): 793–804; 10.1377/hlthaff.28.3.793]

A forceful legislative response to the massacre at Virginia Tech on 16 April 2007 was politically imperative, and it therefore came as no surprise that Virginia's laws governing civil commitment were overhauled in the spring of 2008. Although tragedy-driven policy making is often misguided and counterproductive, the Virginia Tech tragedy created a political opportunity for much-needed reform in Virginia. It helped galvanize political support for consensus-based proposals that were already being developed by a commission established by the chief justice of the Virginia Supreme Court.

The legislative changes enacted in 2008 have already had some positive effects—by facilitating collaboration between the courts and the services system, establishing data systems for monitoring and oversight of the commitment proc-

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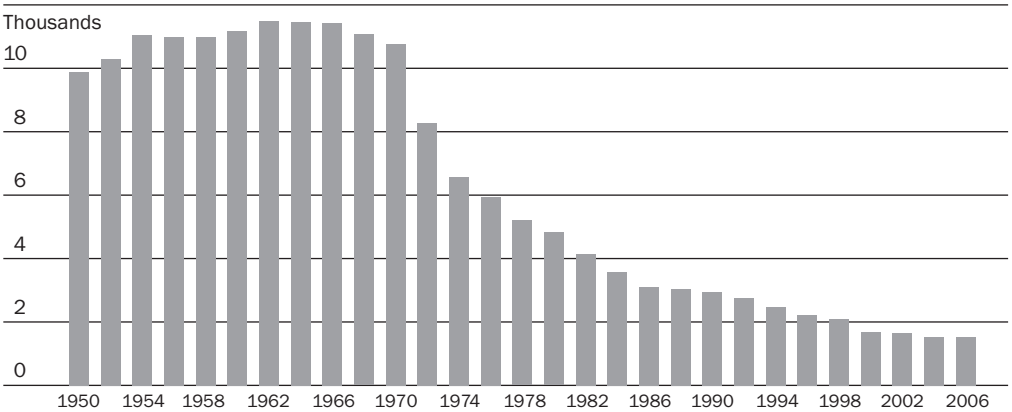
ess, and educating policymakers and the public about the causal connection between gaps in services and the spiraling pressures on hospitals, jails, and courts. The Virginia Supreme Court commission has developed a vision of comprehensive reform that would transform Virginia's mental health services. What has not yet become clear is whether the political support for system transformation can be sustained in the face of competing demands for shrinking public funds.

Virginia's Forty-Year Struggle To Create A Community-Based Mental Health System

Deinstitutionalization of people with mental illnesses has had a marked effect in Virginia (Exhibit 1), albeit a less dramatic effect than in the rest of the country. As a result, Virginia currently has a large number (nine) of mental health facilities and ranks eleventh in its number of public beds per 100,000 population. The commonwealth spends 58 percent of its state service dollars on state hospital inpatient treatment and 42 percent on community mental health services, as compared with the national figures of 27 percent and 70 percent, respectively (Exhibit 2). Virginia also spends much less per capita than other states on community mental health services (currently ranking eleventh lowest).[1]

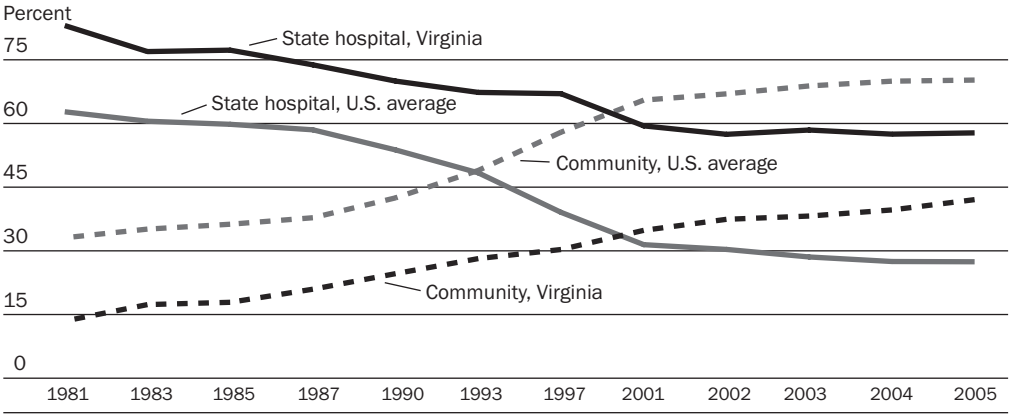
Particularly in lean times, governors or legislators have attempted to close state facilities, but they have routinely been blocked by coalitions of legislators protecting jobs in the affected districts. Virginia's sluggishness in reducing its census in the 1970s and 1980s may have been one factor that contributed to staffing shortages highlighted by U.S. Department of Justice (DOJ) investigators in the 1990s, leading to even more investment in state facilities. A comprehensive study by con-

EXHIBIT 1
Average Daily Number Of People In Virginia Public Mental Hospitals, Fiscal Years 1950–2006



SOURCES: *Report of the Virginia Mental Health Study Commission* (1950–1962); State Hospital Board, "Mental Health in Virginia," vols. 9–23 (1964–1972); House Document no. 14, "The Effects of Deinstitutionalization" (1974); and Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (1976–2005).

EXHIBIT 2
Distribution Of State Mental Health Authority (SMHA)–Controlled Mental Health Spending Between State Mental Hospital Inpatient Care And Community-Based Programs, Virginia And U.S. Average, Selected Fiscal Years 1981–2005



SOURCE: National Association of State Mental Health Program Directors Research Institute.

sultants in the 1990s recommended closure of many state hospitals—to no avail. In addition, during the past forty years, multiple commissions, assigned the task of studying the mental health system, repeatedly called for investment in community services.[2] But the facilities remained open, and no major infusion of state dollars into the community has occurred. When the legislature has increased funding for community services in response to periodic advocacy efforts, it has come in a restricted form (such as crisis stabilization) rather than as an investment in a system of services.

■ **Gatekeeping and involuntary commitment.** In Virginia, local mental health authorities are known as community services boards (CSBs). Their main statutory function is to serve as the "single point of entry in the public mental health system"—that is, as gatekeeper to the state hospitals. In 1988, CSB emergency services staff were assigned the responsibility of screening people before they were admitted, voluntarily or involuntarily, to state psychiatric hospitals. Six years later, the CSB gatekeeping role was extended to private hospital commitments. Although this change appears on its face to be unrelated to the goal of downsizing state hospitals, patients initially committed to private hospitals often end up in state facilities if they have no insurance or if their coverage runs out.[3] As the gatekeeping policy took hold, the involuntary-commitment criteria gradually became the de facto "medical necessity" criteria for both voluntary and involuntary hospitalization, and involuntary commitment effectively became the primary channel of admission to state facilities (more than 80 percent of such admissions are involuntary).

In theory, the gatekeeping policy has a sound rationale: the CSBs are uniquely aware of the full array of services available in their communities. It was inevitable, however, that the CSB gatekeeping role would become a point of friction in the

system, as patients and their families who lack access to private care are also unable to access care in the public system. However, the real issue is not the gatekeeping policy itself. Rather, there are substantial gaps in treatment and support services in the communities that could prevent deterioration in the first place or ameliorate a crisis to avert hospitalization.

■ **Weak legal structure in the policy.** The weakness in the existing policy is epitomized by its legal structure. The state's statutory obligation is to operate the public hospitals and to contract with CSBs to provide the services for which state general funds have been appropriated. However, the only services that the CSBs are required to provide by state statute are emergency services, and a major portion of those services are tied up with the gatekeeping function. Furthermore, an increasing proportion of CSB funding comes from Medicaid fees, with oversight of those dollars in a separate state agency. Although the state mental health authority (SMHA) and the local CSBs collaborate as best they can to make the best use of the state dollars appropriated for mental health services, no one is responsible for operating an integrated services system.

Gaps In Community Services

■ **Crisis intervention services.** A 2005 study of emergency services found that the majority of CSBs do not provide a comprehensive range of crisis intervention services.[4] Specifically, very few CSBs offer the midrange community crisis stabilization programs that can effectively respond to difficult crises in the community as an alternative to costly, more restrictive inpatient care. Only three residential crisis stabilization programs were in operation in 2005, but the Virginia General Assembly appropriated funds for eight additional programs in 2005, and about half of the CSBs had at least one such program in operation in 2007.[5] Since these intensive alternatives still do not exist in many localities, where the hospital remains the only option, there continues to be a bed shortage in some regions.

Although almost all CSBs provide less-intensive crisis response, resolution, and referral services, capacity limitations severely reduce the effectiveness of these services, especially in Virginia's vast rural areas. Specifically, the Virginia Office of the Inspector General (OIG) found that in 2005 the vast majority of CSBs did not have adequate psychiatric coverage for emergency services; fewer than half of the CSBs offered routine mobile crisis services, and many of those provide crisis services only on a limited basis to jails or hospital emergency departments (EDs); and only eight CSBs were staffed around the clock.

■ **Case management services.** Advocacy efforts focused attention on the importance of case management services as a tool for facilitating discharge from state hospitals and reducing rehospitalization of chronic patients. In 2002, the General Assembly added fairly weak language to the CSB statute "mandating" CSBs to provide case management services "subject to the availability of funds appropriated for them." However, dedicated appropriations were not forthcoming, and the OIG

found in 2006 that average mental health case management loads in most CSBs greatly exceeded national standards.

■ **Nonemergency outpatient services.** Although state funding for CSBs doubled from 1997 to 2006, a 2007 OIG survey showed that more than half of CSBs reported that their capacity to provide nonemergency services—particularly outpatient services—had declined over this period. More than 60 percent of the CSBs had fewer than two full-time-equivalent (FTE) staff per 50,000 population to provide outpatient services.[6] The average waiting time for an outpatient clinical appointment was about thirty days and exceeded two weeks even for postemergency care.

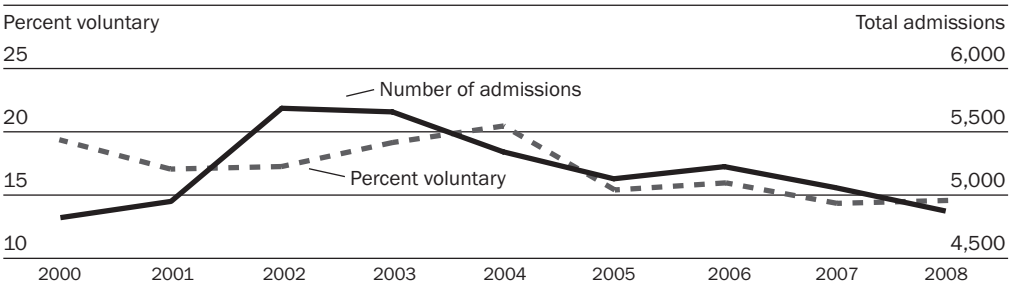
■ **Link to mental illness among jail inmates.** Although the causal connection is difficult to demonstrate, these gaps in access to mental health services are widely thought to be associated with increasing prevalence of severe mental illness among inmates in local jails (an estimated 16 percent) and increasing numbers of judicial referrals of jail detainees for mental health evaluation and treatment.

■ **Petitions for involuntary commitment.** A system without accessible preventive or crisis intervention services is also likely to produce more petitions for involuntary treatment. First, patients with severe symptoms who are not engaged with the services system and who are not offered less restrictive alternatives when they are in crisis are likely to resist hospitalization. Second, the gatekeeping responsibilities of the CSBs and subsidization of involuntary commitment by state funds both reflect an implicit prioritization of involuntary services over voluntary ones and lead people to invoke the involuntary process to gain access to services (including transportation) that are not accessible to them voluntarily (Exhibit 3).

Challenges Of Mental Health Law Reform

It can easily be seen that gaps in services produce major pressures on the courts—judges see the spillover effects of untreated mental illness daily, and courts are viewed by families and patients as gateways to treatment that is not

EXHIBIT 3
Number Of Virginia Psychiatric Hospital Admissions, And Percentage That Are Voluntary, 2000–2008



SOURCE: Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, 2008.
NOTE: The solid line (number of admissions) relates to the right-hand *y* axis; the dotted line (percent voluntary) relates to the left-hand *y* axis.

otherwise accessible. This explains why many judges (in all states) become strong advocates for diverting people with mental illnesses from jails and for leveraging treatment through judicial orders. Juvenile and family court judges are especially troubled because families so often need to seek judicial assistance to get access to mental health services for children and adolescents (for example, by relinquishing custody of their children).

■ **Complaints about the commitment process.** In Virginia, complaints about the commitment process escalated in the 1990s, as the state gradually reduced state hospital capacity and the CSBs assumed a more potent gatekeeping role. Families complained that CSBs, independent examiners, and judges in some parts of the commonwealth were interpreting the commitment criteria ("imminent danger to self or others or substantial inability to care for oneself") in an unduly restrictive manner. People who were subject to commitment proceedings complained bitterly about the stigmatizing effect of being transported in law enforcement vehicles and the routine use of mechanical restraints while in law enforcement custody. Law enforcement officers, EDs, patients, and families complained about the amount of time that people were held in police custody waiting for the CSBs to track down a bed for emergency admission. Stakeholders also complained about the quality of the independent examination process, which was often a fifteen-minute interview conducted within minutes of the hearing itself. Patients and families complained that commitment hearings were often unfair because they did not have an adequate opportunity to be heard and because the CSB screeners and independent examiners were not often present at the proceedings. Stakeholders also complained about inconsistencies in the interpretation and application of the commitment law. Judges, examiners, and attorneys complained about the low fees they received, and the hospitals who help patients awaiting hearings complained about the low reimbursements.[7] Everyone complained about the lack of coordination and oversight by either the mental health system or the judicial system.

■ **Defining the problems and options for reform.** This crescendo of complaints led the chief justice of the Virginia Supreme Court to convene a major conference of stakeholders in December 2005, at which he announced his intention to establish a commission to study these problems and propose necessary reforms.[8] A working group set up to recommend the structure, composition, and goals of such a commission realized almost immediately that many of the problems that had motivated the chief justice were spillover consequences of gaps in community mental health services and could not be solved solely by tinkering with the law.

Against this backdrop, the Commission on Mental Health Law Reform was formed in September 2006 to study current practices and policies and to develop a plan for comprehensive reform by December 2008.[9] The twenty-six-member commission included legislators from both parties and houses of the General Assembly and had strong support from both a Republican attorney general and a Democratic governor. The chief justice and commission chair established five task

forces, comprising an additional seventy-five people, to develop specific recommendations for achieving stated goals relating to civil commitment, intersections between criminal justice and mental health, access to services, special issues relating to children and adolescents, and consumer empowerment (and, later, privacy).

The commission conducted three major empirical studies during 2007: an interview study of 210 stakeholders and participants in the commitment process in Virginia, a survey of every commitment hearing held in May 2007, and a survey of every evaluation conducted by CSB emergency services clinicians during June 2007.[10] Based on these studies, the commission made the following findings: (1) Around 50,000 emergency evaluations are conducted by CSB staff each year (about 5,000 of these involve children). (2) Almost half of these evaluations involve people who are not currently in treatment. (3) More than 40 percent of the people being evaluated have no health insurance. (4) Although most people accept treatment voluntarily while in crisis, commitment proceedings are initiated in about 20,000 cases per year (about 600 involve children). (5) About 80 percent of these proceedings result in hospitalization (50 percent involuntary, 30 percent voluntary). (6) Mandatory outpatient treatment, although permitted by the law as a less restrictive alternative to involuntary hospitalization, is rare (about 5 percent of cases). (7) About 15 percent of cases are dismissed.

Blueprint For Comprehensive Reform

The commission's blueprint for comprehensive reform, based on its findings, contained four main goals.

■ **Improve access to voluntary services.** The need for commitment and other types of judicial involvement can be reduced by improving access to voluntary, recovery-oriented services to prevent crises and ameliorate them in the least restrictive setting when they do occur. The CSBs would be required by state law to provide a broad array of services in addition to emergency services in accord with performance standards prescribed and overseen by the SMHA.

■ **Use recovery paradigm.** Empowerment and self-determination can be promoted based on the recovery paradigm, thereby drawing people who need help into services rather than relying on crisis-generated reliance on involuntary interventions.

■ **Reduce criminalization.** Criminalization of mental illness can be lessened by diverting people with severe mental illnesses to mental health services and providing needed services to those who remain in the criminal justice system. Implementation of this approach would build on established national models, including crisis intervention training for law enforcement officers and linking criminal justice adjudication to treatment.[11]

■ **Redesign civil commitment.** The civil commitment process can be made both fairer and more effective. The commission envisioned a complete overhaul of the commitment statutes, structural changes to facilitate coordination of local

courts and CSBs, and monitoring and oversight by the Supreme Court and the SMHA.

The Virginia Tech Tragedy: Opportunity And Risk

The tragedy on the campus of Virginia Tech on 16 April 2007 highlighted some of the problems the commission was studying, illustrating how gaps in the services system and deficiencies in the legal system can prevent people with serious problems from getting the help they need when they need it.

■ **Missed opportunity for intervention.** The disturbed behavior of Seung Hui Cho, the Virginia Tech gunman, had come to the attention of the campus police in December 2005, and they took him to a mental health facility for a CSB screening. A magistrate issued a "temporary detention order" based on the CSB clinician's judgment that Cho presented a danger to himself or others. The next morning, after an independent examiner concluded that Cho did not meet the commitment criteria, the judge ordered him to undergo outpatient treatment based on a finding that he presented an imminent danger to himself. As everyone subsequently learned, Cho never complied with this order, and his noncompliance went unnoticed.

This missed opportunity for intervention was attributable in part to deficiencies in the commitment process. First, a more thorough evaluation by the independent examiner might have uncovered evidence about Cho's deteriorating and highly disturbed condition. Second, and more important, implementation of the special justice's outpatient treatment order might have provided an occasion for faculty, campus police, and counseling center staff at Virginia Tech to "connect the dots" and undertake an appropriate intervention.

The fact that an aborted judicial intervention in December 2005 might have prevented the tragedy in April 2007 predictably galvanized public support for mental health law reform. Working with the commission chair, a panel appointed by Gov. Tim Kaine to investigate the massacre and its aftermath identified several key elements of reform in its August 2007 report and passed the baton to the commission to spell out the details. Because immediate action was politically imperative, the commission accelerated its timetable and released a preliminary report in December 2007.[12] Although the report summarized the commission's emerging blueprint for comprehensive reform, it focused its recommendations for the upcoming legislative session entirely on commitment law reform. These recommendations had emerged over a year-long period of consensus building among the commission's constituent stakeholders. Companion bipartisan bills based on the commission's proposals were supported by Governor Kaine and the leadership of both houses (controlled by different parties), and they emerged from the legislative process essentially intact.

■ **The reform package.** Key elements of the reform package were as follows: (1) specific requirements for CSB staff, independent examiners, magistrates, and judges, designed to improve the quality of the decision-making process at each stage of the

proceedings; (2) modified commitment criteria to promote consistency and avoid unduly restrictive interpretations (for example, eliminating the requirement of "imminent" dangerousness); (3) detailed procedures for issuing, reviewing, and terminating mandatory outpatient treatment orders, including specific directions to CSBs for monitoring compliance and reporting noncompliance; (4) required disclosure of health information during the commitment process to facilitate informed decisions while protecting hearing records from further disclosure; and (5) authority for law enforcement officers to "drop off" a person with apparent mental illness at a suitably licensed mental health facility in lieu of arrest. The General Assembly also appropriated an additional $42 million in state funds for the fiscal year 2009–10 biennium, primarily to expand CSB service capacity.

■ **A genuine step forward.** The legislative reforms adopted in 2008 represent a genuine step forward. If properly implemented, these legal reforms should promote greater accuracy, effectiveness, and fairness in the commitment process. The increased resources allotted to the CSBs for emergency services, case management, and outpatient services can begin to close gaps in access. At the same time, the 2008 appropriation should best be viewed as a "down payment" on the investment that is going to be needed to establish the necessary community service capacity, just as the commitment law reforms represent only a first step in comprehensive mental health law reform.

Perhaps the most promising development in 2008 was the emergence of an organizational structure for coordination and oversight of the commitment process. The commission, nested in the Supreme Court, served as the hub for all of the stakeholder constituencies, state executive branch agencies, and the Office of the Attorney General to monitor the legislative process and reach consensus on issues as they arose. After the reforms were enacted, the group was reconstituted and charged with guiding and monitoring implementation of the new reforms. In other words, the commission served the coordination and oversight functions for the commitment process that were not previously being served by any group—a structural failure that probably accounted for many of the problems that had developed.

■ **Risks of focusing on commitment reform.** The decision to focus solely on commitment reform in 2008 does carry two substantial risks. First, legislators may think that these changes "solved" the problem and that public attention may recede; this would mean that the opportunity for comprehensive and sustained reform envisioned by the commission's blueprint would have been squandered until another tragedy revives it. This risk was accentuated by the precipitous decline in the nation's economy during the fall of 2008. Second, the coercion-centered reforms might deepen stigmatization of people with mental illnesses and impede progress toward a voluntary, recovery-oriented system of services. The perceived link between violence and mental illness leads people to frame the policy choices in mental health law as trade-offs between individual liberty and privacy, on the one side, and greater security, on the other. However, although such a trade-off is sometimes posed in cer-

"Reforming the legal structure of the services system and investing in community services need to proceed in tandem."

tain cases, a climate of coercion drives people away from services. The right prescription is to draw people into services by protecting privacy, mainstreaming mental health treatment, and destigmatizing mental illness.

■ **Coercion as a last resort.** Admittedly, coercion is sometimes necessary as a last resort—and an important aim of mental health law reform is to assure that involuntary treatment, while being used only when necessary, occurs expeditiously and effectively when it is necessary. The process of initiating, authorizing, and carrying out involuntary treatment must always be a fair one, respectful of individual dignity. These were the main goals of the 2008 reforms. Although further changes to the commitment law are needed, the next phase of reform will focus on reducing the need for coercion altogether.

Next Steps

The commission's main goal in 2009 is to lay a legal foundation for a mental health system that mainstreams voluntary recovery-oriented services, reduces stigmatization, and gives consumers a meaningful measure of control over the services they receive. Doing so will help avoid crises, facilitate stabilization, and reduce the need for hospitalization and for coercion.

■ **A comprehensive advance directive statute.** Over the past decade or so, more than twenty states have adopted legislation empowering people with mental illnesses to execute so-called psychiatric advance directives (PADs). Although the commission supports the basic aim of these statutes, it has decided that a stand-alone statute for people with mental illnesses is not the right statutory tool because it perpetuates the practice of singling out mental illness for special treatment. The commission sees advance directives as a key legal element of the vision of person-centered services.

The advantages of using advance directives apply to all forms of treatment, not only mental health care. For this reason, the commission proposed a general revision of the Health Care Decisions Act rather than a stand-alone PAD statute to empower people to prescribe specific instructions to guide their health care if their capacity to make decisions becomes impaired by mental illness, dementia, or another cognitive disability. The existing statute empowers people to designate health care agents and to give specific instructions regarding treatment at the end of life. However, it is silent on the use of instructional directives in other contexts, such as decisions about mental health care or about placement and treatment in nursing homes. The commission's proposal, which was designed to fill that gap, was enacted in 2009.

■ **Other elements of the 2009 reform package.** The 2009 reform package also

includes enabling legislation to allow localities to use alternatives to transportation by law enforcement in connection with emergency evaluations and the commitment process, and allow family members and friends to be notified during mental health crises.[13]

■ **Transforming community services.** Beginning in 2010, the commission envisions a long-term plan for gradually increasing the scope of services that CSBs must provide and for conferring responsibility for quality assurance and system oversight on the SMHA commissioner.

■ **Maintaining the momentum.** Mental health system reform has taken only a few steps along a difficult path. Achieving comprehensive reform requires a rhetorical strategy to nurture and sustain public support for a genuine transformation as well as an incremental, sequential political strategy that keeps the train moving forward, however slowly, even in the face of fiscal austerity. The most critical steps lie ahead.

Possible Lessons For Other States

Virginia is not alone in its continuing struggle to create an accessible system of community services, to reduce the need for involuntary intervention and make such interventions fair and effective when used, and to implement cost-effective alternatives to arrest and incarceration of people with severe mental illnesses. What lessons might other states draw from the reform initiative now under way in Virginia?

First, the Virginia experience suggests that leadership from the judiciary—and particularly from the chief justice—can galvanize and harness political energy for reform, while being respectful of the prerogatives of other branches of government. Second, in a field with so many stakeholders across multiple systems, a well-planned consensus-building process with substantial consumer participation can break down customary barriers, facilitate mutual understanding, and mold a genuinely shared vision of reform. Third, the two components of reform—reforming the legal structure of the services system and investing in community services—need to proceed in tandem. Finally, designing reform and implementing it successfully should be seen as a continuous process, characterized by ongoing data collection and analysis and coordinated by a single convening authority.

Before the Virginia Tech tragedy, proponents of reform achieved occasional victories in the biennial scramble for funds, but there was no political momentum for fundamental change. The horrifying events of April 16 could easily have led to polarization within the mental health constituencies and to repressive and counterproductive statutory changes. Instead, the tragedy galvanized political support for consensus-based reforms. The question is whether the momentum for reform can be sustained as the memory of April 16 recedes. In the worst-case scenario, public interest will shift elsewhere, and the mental health

system will drift once again toward crisis. We have outlined a more positive scenario in this paper, one that rests on sustaining a broad political coalition while implementing an incremental but determined approach.

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NOTES

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