Depression and Bipolar Support Alliance

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Via Hand

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To: Delegate Chuck Caputo, District 67
Member, Health Welfare and Institutions Committee
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Reforming Mental Health Laws in Virginia

Mental Health Overview

Mental illnesses are medical conditions that disrupt a person's thinking, feeling, moods and ability to relate or function or a daily basis. Just like cancer or diabetes, illnesses in the brain are medical conditions that are diminish an individual's capacity for coping with the ordinary demands of life. Most mental illnesses are treatable through a process of medication management, support, therapy and recovery.

Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan.

Serious mental illnesses include, but are not limited to, major depression, bipolar disorder, schizophrenia and post traumatic stress disorder. In the case of post traumatic stress disorder, clinicians are reporting an increase in the number of new patients, particularly from the military, since the beginning of the war in Iraq.

Mental illnesses can affect individuals of any age, race, religion or income. Mental Illnesses are not the result of personal weakness. They are biologically based brain disorders that cannot be overcome through will power and are not related to a person's character or intelligence. Mental disorders fall along a long continuum of severity. According to the National Comorbidty Survey, republished in 2002, nearly half of all Americans reported experiences the symptoms of a mental illness defined in the Diagnostic and Statistical Manual of Mental Disorders at some point in their lives. But a much smaller percentage, about six percent of Americans – or 1 in 17 – reported suffering from a serious mental illness, the group of the population most likely to encounter mental health laws. The study found that one in five American families is affected by mental illness.

The World Health Organization has reported that four of the top 10 leading causes of disability in the United States and other developed countries are mental disorders, and that by 2020, major depressive illness will be the leading cause of disability in the world for women and children.

Mental illnesses usually strike individuals in the prime of their lives, often during adolescence and young adulthood, while clusters of illnesses are more likely to strike children and the elderly.

Research has shown that without treatment the consequences of a mental illness for an individual and society are staggering and include implications on disability, unemployment, the legal system, unemployment, substance abuse, homeless, incarceration, suicide and other less intangible costs.

Economics working with the United States Department of Health and Human Services have estimated the cost of untreated mental illness at more than $100 billion a year.

According to the National Alliance on the Mentally Ill, the best treatments for mental illness are effective – meaning a significant reduction in symptoms -- in between 70 and 90 percent of the individuals surveyed.

Almost all mental health organizations believe that early identification and treatment of mental illness is important because of the consequences and scientifically shown atrophy that can be caused in the brain.

Stigma erodes confidence in mental health professionals and the mental health system, and the very notion that these disorders are treatable.

DBSA-Northern Virginia

DBSA-Northern Virginia, also known as the Bipolar Support Group of Northern Virginia, is a non-profit, self-help organization serving individuals with bipolar disorder and their families and friends. We help people accept their illness, manage their illness and improve their quality of life. We are an independent affiliate of the national Depression Bipolar Support Alliance.

Our support groups are for those with bipolar and their loved ones. Our support groups serve to enhance their lives of those with bipolar disorder and their loves ones through sharing, learning , helping and growing with a group of people who have been through similar experiences. We also have speaking events and a local hospital outreach program where we educate patients and loved ones about community support.

We were founded in 2005 by Jayson Blair, who has bipolar disorder, and his mother, Fran Blair. The Blairs received the idea of a support group from a man named Bob Mills in North Carolina, who is a member of a similar group. In January 2006, the first support groups met – one for love ones and one for those with bipolar – in Centreville. The month before the group affiliated with DBSA.

The groups quickly grew to include parents, children, husbands, wives and other relatives, as well as those with bipolar. The groups were peer-run, but were assisted by professional advisors who worked in the mental health field. In the summer of 2007, DBSA-Northern Virginia appointed a 10-member board of directors and began two new support groups for those with bipolar, with one meeting at a Prince William County government building in Woodbridge and the other meeting at Ashburn Psychological Services in Ashburn.

Mental Health in Virginia

Two recent events have changed the mental health landscape in Virginia.

On May 9, 2006, a young mentally ill Centreville man named Michael Kennedy walked into the parking lot of the Sully District Police Station with an assault rifle and other guns and shot dead a police officer and police detective, and wounded others. Kenney was killed by other officers after a prolonged period of shooting.

A little less than a year later, on April 16, 2007 a Centreville man named Seung Hui Cho killed 33 people in a dorm building and engineering hall at Virginia Tech before committing suicide.

Kennedy was a 2005 graduate of Westfield High School. Many of his friends, including a member of our group, said he had been suffering from hallucinations, had talked about aliens and appeared to be suffering from other symptoms of what may have been schizophrenia. Months before the shooting Kennedy had been served a criminal warrant for shooting the family dog. Kennedy and his family tried to get help.

In February 2006, Kennedy was evaluated twice at the Woodburn Center for Community Mental Health in Annandale and twice at Prince William Hospital in Manassas. He was turned away each time, according to a lawyer for his family, Richard F. MacDowell. He was not given medication or a treatment plan.

Woodburn is a part of the Fairfax-Falls Church Community Services Board, with mental health professionals available all day to evaluate people, and, if necessary to carry out temporary detention orders that can led to involuntary commitment. Prince William Hospital has its own psychiatric inpatient ward.

Kennedy, with the help of his parents, checked into the Potomac Ridge Behavioral Health Center in Gaithersburg, Md. On April 18, he broke out of that hospital and carjacked a vehicle. MacDowell said that Kennnedy was never officially given a diagnosis.

In December 2005, Cho was involved in an incident where the police were called to warn him to stop communicating with a fellow Virginia Tech student. After the confrontation, one of Cho's roommates called the police and reported that he was suicidal. On Dec. 13, a special magistrate at the New River Valley Community Services Board found that Cho was "mentally ill and in need of hospitalization,"

The physician who examined Cho reported that he had a flat affect and depressed mood, while Cho denied suicidal thoughts and did not believe his thinking was disorganized. The magistrate ruled that Cho was "an imminent danger to [him]self or others." Cho involuntarily committed to Carilion St. Albans Behavioral Center on a temporary detention order pending a commitment hearing before a court.

The court agreed that Cho presented "an imminent danger to himself as a result of mental illness," but instead recommended treatment for Cho as an outpatient. On Dec. 14, Cho was released from Carilion St. Albans and was involuntarily ordered to seek outpatient treatment at the Virginia Tech Counseling Center. The counseling center, as is practice, was not notified that he was required to show up for involuntary outpatient treatment. HisHe's exact diagnosis, if one was made, is not known.

These two incidents expose several flaws in Virginia's the mental health system. At the same time, in correcting those flaws, it would be a mistake to reverse some of the positive gains that have been made in the Virginia mental health system since the 1960s.

We have become increasingly convinced that Virginia's new laws will have a ripple effect similar to that of California's Lanterman-Petris-Short Act of 1967, which became the basis for the "danger to one's self or others" and "imminent danger" provisions in virtually every state's involuntary commitment laws. This standard, as you know, is subject to change because the United States Supreme Court, in *Donaldson v. Florida*, only endorsed civil rights safeguards that protect the mentally ill from indefinite custodial confinement of a non-dangerous mentally ill person who is "safely in freedom by himself or with the help of willing and responsible family and friends." There is flexibility within the *Donaldson* decision to roll back part of the civil rights gains, including provisions about judicial review of civil commitments, vigorous legal advocacy, and forced medical treatment.

We have taken the position that Virginia's laws can best be served by ensuring that the best practices that currently take place within certain jurisdictions of the state—such as Fairfax, Loudoun, Prince William, and Arlington counties and the City of Alexandria—be adopted in other areas of the state. This, including limiting outpatient commitment or creating mechanisms to ensure compliance with outpatient commitment, can be achieved as a matter of state public policy or law. We recognize that involuntary civil commitment can be improved, but we also recognize that hysteria can roll back protections that have for several decades prevented the warehousing of patients without treatment, improper medical procedures, and commitments for reasons other than medical necessity. We believe the potential exists for the development of a new wave of laws that could be even worse than the mental health institutionalization period of American history.

The Law

Virginia law states in § 37.2-809 *Involuntary temporary detention; issuance and execution of order* that a magistrate may issue, upon the sworn petition of any responsible person or upon his own motion and only after an in-person evaluation by an employee or designee of the local community services board, a *temporary detention order* if it appears from all evidence readily available, including

recommendations from treating clinicians, that a person (1) has a mental illness, (2) presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself, (3) is in need to hospitalization or treatment and (4) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.

In practice, this means that once an individual is determined to be mentally ill and in need of hospitalization because of one of the three reasons below – danger to self, danger to others or incapable of care – the Community Service Board member asks the individual if they were voluntarily admit themselves into the hospital. A voluntary admission cannot be revoked by the individual without giving the institution they have been admitted to notice and enough time to call for another commitment hearing where they can then be involuntarily committed.

In general, among the Community Service Boards in Northern Virginia, almost all involuntary commitments are to private or state-run locked psychiatric units. In other parts of the state, where psychiatric beds are less available, involuntary commitments are more frequently made on an outpatient basis, putting the ones on the individual to contact the care provider and begin treatment. Care providers say they are not notified of involuntary commitments. Futhermore, even if someone who is committed on an involuntary outpatient basis shows up for treatment and then stops complying there is no way to enforce the treatment plan without getting another temporary detention order and proving again, at the moment of the hearing, that the person is an imminent danger to himself or others or substantially unable to care of himself.

The current law has several gaps.

- The definition of "imminent danger" varies from magistrate. Some require the subject to have done or threatened something dangerous within the past 24 hours. Some require that they must be a danger at the time of the hearing. Others interrupt the imminent standard forward and into the future. This is an area where the Legislature can clarify the law by defining imminent danger to include actions and treats in the past seven days and threats or suggestions of future actions.
- The "substantially unable to care for himself" burden is wildly subjective based on each magistrate's opinion and means that an individual with a family willing to feed, shelter and provide for him has to reach a higher standard for commitment. The law should clarify this standard to make sure that this refers to the individual independent of their support system.
- Outpatient involuntary commitment is a questionable practice given the general lack of compliance with treatment plans among the mentally ill. Virginia's outpatient involuntary compliance particularly has no teeth because it puts the onus on the person being forced into treatment to report to treatment, and it forces the often not notified caregiver to go back to court if the patient does not comply. Furthermore, it must be proved again that the subject meets the standards, at the present time for commitment. If the state allows outpatient involuntary commitment to continue, there should be teeth added that allow a care provider to petition the court – like a contempt citation -- to have a subject's commitment changed from outpatient to inpatient, without going through the commitment process over again, if the subject is not compliment. compliant.

If a patient chooses to voluntarily commit themselves they and/or their insurance are responsible for the hospital bill whether they are at state-run or private facility. If a patient is involuntarily committed, the bill is picked up by the Department of Mental Health Mental Retardation and Substance Abuse Services.

In Northern Virginia, inpatient providers have agreed to send long term cases to the Northern Virginia Mental Health Institute or other state hospitals, and keep most short-term (two weeks or less) cases in private hospitals. All of these involuntary patients are paid for by DMHMRSA funds. In recent years, with the growth of involuntary commitments compared to available funds, the

Community Service Boards and magistrates have had to become more selective about involuntary commitments.

The two options that were looked at before the Virginia Tech shootings were working harder to get mentally ill patients to voluntarily commit themselves, something that has been ongoing, and considering the use of the less restrictive Assisted Outpatient Treatment Model, which is essentially the type of involuntary outpatient commitment that Cho was ordered to receive. Given the events of the past two years, this measure seems, wisely, off the table. The only reasonable answer is to increase DMHMRSA funding for involuntary inpatient commitments and increase the rates paid to private hospitals to encourage them to open more (in what would be increasingly profitable; as opposed to marginally profitable now) psychiatric beds.

Early and Proactive Intervention

As state before, early intervention is a key in mental health cases. Jurisdictions in New York, Florida and other places have worked with Mobile Crisis Teams, Evaluation Programs, Police Mental Health Units and other measures to prevent situations from getting to the point where mental health commitment or crisis is on the table.

In Northern Virginia, the Regional Recovery Workgroup, which is a part of the Northern Virginia Partnership, has spent hundreds of thousands of DMHMRSA funds to create patient-run programs to educate people about mental illness and to prevent crisis. Through groups like the Regional Recovery Workgroup, more money should be set aside for mental health screenings, getting the mentally ill and their loved ones plugged into support groups and to take other steps that reduce commitments, reduce hospitalizations and reduce crisis, and increase compliance.

This would take a significant increase in funding for both the Community Service Boards and the groups funded through the Regional Recovery Workgroup. In the end, the reduction in commitments is likely to have a long-term gain for the state, and the reduction in tragedies would be immeasurable.