RENEWED COMMITMENT: THE LATEST CHAPTER IN REFORMING VIRGINIA'S MENTAL HEALTH SYSTEM

*The Honorable Jennifer L. McClellan**

* Member, Virginia House of Delegates, 71st District.

I. INTRODUCTION

With the establishment of the first public institution dedicated to the mentally ill in Williamsburg in the 1770s, mental health services have been a core responsibility of the Commonwealth of Virginia.[1] Since then, Virginia's mental health system has evolved from one focused primarily on institutionalization towards a single, integrated "system of care, with increased emphasis on the establishment of community services and more effective and efficient use of state facilities.[2] Today, Virginia's "public mental health, intellectual disability and substance abuse services system" is comprised of 16 state facilities and 40 locally-run community services boards ("CSBs") that "serve children and adults who have or are at risk of mental illness, serious emotional disturbance, intellectual disabilities, or substance abuse disorders."[3] State facilities are only one of several resources in an overall continuum of care that also includes the CSBs, local psychiatric hospitals, hospital emergency departments, law enforcement, and the court system.[4] This evolution, however, has been slow; it typically occurs in bursts of activity, including studies by experts and bold calls for action by executive leadership once the community has been confronted with a tragedy that highlights gaps in the system.

In the wake of the highly publicized Virginia Tech tragedy, the 2008 General Assembly Session adopted mental health reforms that focused on the provision of emergency services during the detention and commitment process, and an increase in funding to implement these reforms and strengthen emergency services.[5] Despite the reforms, the issue of inadequate capacity to meet the increasing demand for mental health services

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[1]S.J. Res. 47, 2014 Gen. Assemb., Reg. Sess. (Va. 2014).

[2]See State Operated Facilities, Va. Dep't of Behavioral Health and Developmental Servs, http://www.dbhds.virginia.gov/SVC-StateFacilities.htm (last visited July 10, 2014); Mira E. Signer, Virginia's Mental Health System: How It has Evolved and What Remains to Be Improved, 90 Va.Servs News Letter, no. 3, 2014, at 3.

[3]*About Us*, VA. DEP'T OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVS, http://www.dbhds.virginia.gov/AboutUs.htm (last visited July 10, 2014). These state facilities include seven behavioral health facilities, five training centers, a psychiatric facility for children and adolescents, a medical center, a psychiatric geriatric hospital and a center for behavioral rehabilitation. These facilities provide highly structured, intensive services for Virginia citizens who have mental illness, intellectual disability or are in need of substance abuse services. *Id.*

[4]*State Operated Facilities*, *supra* note 2; *see also* G. DOUGLAS BEVELACQUA, OFFICE OF THE INSPECTOR GEN. BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVS., REPORT NO. 206-11, OIG REVIEW OF EMERGENCY SERVICES: INDIVIDUALS MEETING STATUTORY CRITERIA FOR TEMPORARY DETENTION NOT ADMITTED TO A PSYCHIATRIC FACILITY FOR FURTHER EVALUATION AND TREATMENT 6 (Feb. 28, 2012) [*hereinafter* OIG Report No. 206-11], *available at* www.oig.virginia.gov/documents/SS-EmergencySvcsReview206-11.pdf.

[5]OIG Report No. 206-11, *supra* note 4, at 4.

remains in a number of key areas, including emergency services and a decline in in-patient psychiatric bed capacity while population growth continues.[6]

As a result of these gaps in services, the system continued to fail periodically, but the public barely noticed. In February 2012, the Office of the Inspector General ("OIG") highlighted one such failure—referred to as "streeting"—in which individuals clinically determined to meet the criteria for temporary detention were not admitted to a psychiatric facility nor were they provided the clinically indicated level of care because no state-operated behavioral health hospital or private psychiatric facility would admit these individuals.[7] A study conducted by the OIG determined that 72 such cases occurred over a 90-day period, representing 1.5 percent of the estimated 5,000 temporary detention orders ("TDOs") successfully executed over the same period.[8] However, the OIG warned that each incident "represents a failure of the system to address the needs of that individual placing the individual, his family, and the community at risk," and "can rise to the level of a *sentinel event* . . . if it 'carries a significant chance of a serious outcome.'"[9] The study also showed that 273 individuals—or 5.5 percent of the 5,000 executed TDOs—received TDOs after the 6-hour statutory time limit for converting an emergency custody order ("ECO") into a TDO, averaging 16.6 hours.[10]

In November 2013, the system failed the son of a State Senator. This failure began on the morning of November 18th when Senator Creigh Deeds called the Rockbridge Area Community Services Board expressing concern about his son's behavior and started the process for emergency services.[11] A failure to implement 2012 recommendations to address streeting, rural travel times, a lack of coordination between the local CSB, hospital, and law enforcement, the inability to find a psychiatric facility willing to admit Gus Deeds, and the Commonwealth's requirements for issuing emergency custody orders and temporary detention orders contributed to Gus Deed's

[6]OIG Report No. 206-11, *supra* note 4, at 8.
[7]OIG Report No. 206-11, *supra* note 4, at 2.
[8]OIG Report No. 206-11, *supra* note 4, at 1.
[9]OIG Report No. 206-11, *supra* note 4, at 1.
[10]OIG Report No. 206-11, *supra* note 4, at 2.
[11]OFFICE OF THE STATE INSPECTOR GEN., COMMONWEALTH OF VA., REPORT TO GOVERNOR MCAULIFFE AND THE GENERAL ASSEMBLY, OSIG REPORT NUMBER 2014-BHDS-2006, CRITICAL INCIDENT INVESTIGATION, BATH COUNTY, VIRGINIA, NOVEMBER 18, 2013 5 (Mar. 2014) [hereinafter OSIG REPORT NO. 2014-BHDS-2006]; Paige Lavender, *Creigh Deeds Released from Hospital*, HUFFINGTON POST, Nov. 22, 2013, http://www.huffingtonpost.com/2013/11/22/creigh-deeds-health_n_4323215.html.

release without emergency psychiatric services that day.[12] Thirteen hours later, Gus stabbed his father 13 times and killed himself at his Bath County home.[13]

In response to this tragedy, the 2014 Virginia General Assembly Session passed several mental health reforms and infused new funding into the system.[14] These measures addressed the most pressing gaps in the system, but are merely a first step in reforming Virginia's mental health system to meet the needs of its citizens in the twenty-first Century.

II. EVOLUTION OF VIRGINIA'S MENTAL HEALTH SYSTEM – 1766-2013

A. Phase I: Origins of a State Hospital System

In colonial Virginia, persons found of unsound mind were treated as orphans or widows.[15] A person was determined to be "a Lunatic or ideot" based on the testimony of a survey of 12 citizens, at which point the court would appoint a guardian, oversee the finances of the person's estate, if any, and some funds received would be preserved for the person if and when they recovered.[16] Influenced by the Enlightenment movement, Royal Governor Francis Fauquier called for a public response to mental illness.[17] Believing that science could be used to cure "persons who are so unhappy as to be deprived of their reason,"[18] Governor Fauquier addressed the House of Burgesses on November 6, 1766, recommending a public hospital for the mentally ill.[19] On November 20, 1766, the House agreed to a resolu-

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[12]OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at ii–iv; Lavender, *supra* note 11.

[13]Luke Johnson, *Creigh Deeds Stabbed, Son Dead*, HUFFINGTON POST, Nov. 19, 2013, http://www.huffingtonpost.com/2013/11/19/creigh-deeds-stabbed_n_4302273.html; Jenna Portnoy, *Creigh Deeds Signals that He May Sue over His Mentally Ill Son's Treatment and Death*, WASH. POST, May 15, 2014, http://www.washingtonpost.com/local/virginia-politics/creigh-deeds-signals-that-he-may-sue-over-his-mentally-ill-sons-treatment-and-death/2014/05/15/1bc4a2a2-dc64-11e3-8009-71de85b9c527_story.html.

[14]Annys Shin, *Mental-Health Advocates Fear Fundamental Problems in Virginia Have Been Left to Fester*, WASH. POST, Mar. 9, 2014, http://www.washingtonpost.com/local/mental-health-advocates-fear-fundamental-problems-in-virginia-have-been-left-to-fester/2014/03/09/c956dc72-a63c-11e3-9cff-b1406de784f0_story.html.

[15]Jeremy Wacksman, *A Most Curious Choice: The Mystery Surrounding the Establishment of the Eastern State Hospital in Williamsburg*, http://www.resnet.wm.edu/~jjwack/history.html (last visited Aug. 28, 2014).

[16]*Id.*

[17]*Public Hospital*, COLONIAL WILLIAMSBURG, http://www.history.org/almanack/places/hb/hbhos.cfm (last visited July 3, 2014).

[18]*Id.*

[19]HOUSE OF BURGESSES OF VIRGINIA, JOURNAL OF THE HOUSE OF BURGESSES OF VIRGINIA 1766-1769 11, 12 (John Pendleton Kennedy ed., 1906).

tion "[t]hat a hospital be erected for the reception of persons who are so unhappy as to be deprived of their reason," and ordered the Committee on Propositions and Grievances to "prepare and bring in a bill, or bills" pursuant to the resolution.[20] However, the House did not take any further action, and the Governor renewed his request in a speech on April 11, 1767.[21]

It took another two years before the House of Burgesses acted upon Governor Fauquier's recommendation; on November 15, 1769, the House instructed the Committee of Propositions and Grievances to prepare a bill "to make Provision for the Support and Maintenance of Ideots, Lunatics, and other Persons of unsound mind."[22] Finally, on June 4, 1770, a bill was presented to "Make the Provision and Support and Maintenance of Ideots, Lunaticks, and other Persons of unsound Minds, which passed June 27, 1770."[23] On October 12, 1773, the Public Hospital for Persons of Insane and Disordered Minds admitted its first patient, becoming the first public hospital in North America devoted to the treatment of the mentally ill.[24]

In January 1825, the General Assembly enacted legislation establishing a second mental health facility in the western part of the state, which opened in 1828 as Western Lunatic Asylum.[25] By 1920, the Commonwealth had opened four additional facilities: Central State (1870), Southwestern Virginia Mental Health Institute (1887), Catawba (1909) and Piedmont (1919)[26]

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[20]*Id.* at 33.

[21]*Id.* at 131.

[22]*Id.* at 259. Unfortunately, Governor Fauquier did not live to see this action, as he died on March 3, 1768. Francis Fauquier, Fauquier.com, http://www.fauquier.c om/about/history_info/francis_fauquier (last visited Aug. 28, 2014).

[23]John E. Ranson, *Beginning of Hospitals in the United States- Part II*, 16 HOSPITALS 74, 78–79 (1942), *available at* http://www.aha.org/content/00-10/beginhospus-p2.pdf.

[24]*See id.* at 78–79. The building housed 24 cells, each designed for the security and isolation of patients who were considered dangerous, but treatable. Treatment consisted of restraint, strong drugs, plunge baths and other "shock" water treatment, bleeding, blistering salves, and eventually electro-static treatments. Between 1773 and 1790, about 20 percent of the inmates were discharged as cured. Although in a different facility, the hospital still operates today as Eastern State Hospital. *Public Hospital*, COLONIAL WILLIAMSBURG FOUND., http://www.history.org/almanack/places/hb/hbhos.cfm (last visited Aug. 14, 2014).

[25]Historical Information, *in* A GUIDE TO THE RECORDS OF WESTERN STATE HOSPITAL 1825-2000 (Library of Va. 2012) *available at* http://ead.lib.virginia.edu/vivaxtf/view?docId=lva/vi00937.xml (last visited Aug. 29, 2014). This facility is today known as Western State Hospital. *Id.*

[26]*See id.* at 78–79. The building housed 24 cells, each designed for the security and isolation of patients who were considered dangerous, but treatable. Treatment consisted of restraint, strong drugs, plunge baths and other "shock" water treatment, bleeding, blistering salves, and eventually electro-static treatments. Between 1773 and 1790, about 20 percent of the inmates were discharged as cured. Although in a different facility, the hospital still operates today as Eastern State Hospital. *Public Hospital*, COLONIAL WILLIAMSBURG FOUND., http://www.history.org/almanack/places/hb/hbhos.cfm (last visited Aug. 14, 2014).

B. Phase II – Deinstitutionalization and the Rise of "Continuum of Care"

As early as 1857, advocates began calling for a shift in Virginia's mental health system from institutions to community-based care.[27] In that year, Dr. John Galt, superintendent of the re-named Eastern Lunatic Asylum wrote that "[a] large number of insane, instead of rusting out their lives in the confines of some vast asylum, should be placed... in the neighboring community... were any other class of persons than the insane collected together in such large numbers as is the case in some asylums, we are satisfied that the greatest disorder would be likely to ensue." [28] However, Dr. Galt was unable to convince the Hospital's Court of Directors to agree. [29] It took nearly 100 years for the Commonwealth to begin considering this shift. Finally, in 1949 Governor William Tuck received a report from his Chief of Staff calling for Virginia to "expand its capacity to serve individuals in their own communities with coordinated behavioral health and developmental programs and supports." [30]

A movement towards deinstitutionalization began in earnest at the federal level with the publication of a report by the Joint Commission on Mental Health in 1961 entitled *Action for Mental Health,* which recommended a national program and policies to provide mental health services in community-based clinics, to triple mental health spending in ten years, and increased training to build a workforce to serve those needing mental health services.[31] On February 5, 1963, President John F. Kennedy announced that he would ask Congress to adopt "a wholly new national approach" for men-

[27]*See History of Eastern State*, EASTERN STATE HOSPITAL, http://www.esh.dbhds.virginia.gov/History.html (last visited on July 9, 2014).

[28]*See generally*, William A. Hazel, Jr., M.D., *Virginia's Publicly- Funded Behavioral Health and Developmental Services System*, VA. DEP'T OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERV. 20 (2010), http://www.dbhds.virginia.gov/documents/100331Orientation.pdf (referencing Charles J. Duke, Chief of Staff to Governor William Tuck, *Report on the Department of Mental Hygiene and Hospitals and the Mental Institutions* (1949)).

[29]*See generally*, William A. Hazel, Jr., M.D., *Virginia's Publicly- Funded Behavioral Health and Developmental Services System*, VA. DEP'T OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERV. 20 (2010), http://www.dbhds.virginia.gov/documents/100331Orientation.pdf (referencing Charles J. Duke, Chief of Staff to Governor William Tuck, *Report on the Department of Mental Hygiene and Hospitals and the Mental Institutions* (1949)).

[30]*See generally*, William A. Hazel, Jr., M.D., *Virginia's Publicly- Funded Behavioral Health and Developmental Services System*, VA. DEP'T OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERV. 20 (2010), http://www.dbhds.virginia.gov/documents/100331Orientation.pdf (referencing Charles J. Duke, Chief of Staff to Governor William Tuck, *Report on the Department of Mental Hygiene and Hospitals and the Mental Institutions* (1949)).

[31]*See* ACTION FOR MENTAL HEALTH: REPORT OF THE JOINT COMMISSION ON MENTAL HEALTH vii-viii, x, xiv (Basic Books 1961).

tal illness and mental retardation with an emphasis on prevention, treatment and rehabilitation services in the community.[32]

President Kennedy called on Congress to authorize grants to the states for the construction and initial staffing of comprehensive community programs to provide diagnostic and evaluation services, emergency psychiatric units, outpatient and inpatient services, day and night care, foster home care, rehabilitation, consultative services to other community agencies, and public education on mental health.[33] In response, Congress passed legislation authorizing funds for the construction of facilities to serve as community mental health centers ("CMHCs") and funds to staff the centers.[34]

Virginia's deinstitutionalization efforts began in 1968 with the passage of comprehensive community mental health center legislation establishing the community service boards,[35] and legislation establishing the Commission on Mental Indigent and Geriatric Patients to conduct a study of the care of the mentally ill in Virginia in state institutions and clinical institutions.[36] Two years later, the Commission presented a "blueprint . . . to improve Virginia's mental health services . . . requir[ing] a total commitment to the concept of a coordinated system of care focused on the patient rather than the agency or institution."[37] In its second report, the Commission's recommendations included increased funding to address shortages in trained mental health professional and community-based services, and steps to be taken in order to have community service boards serving every locality in Virginia.[38]

The reforms adopted by the General Assembly during this time were designed "to create legal safeguards against unwarranted hospitalization," and to "transform an institution based mental health services system into a

[32]Special Message to the Congress on Mental Illness and Mental Retardation (Feb. 5, 1963), *in* PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES, JOHN F. KENNEDY 126, 126–28 (1963).

[33]*See id.* at 4–5.

[34]*See* Community Mental Retardation and Community Mental Health Center Construction Act of 1963, Pub. L. No. 88-164, 70 Stat. 717; Community Mental Health Centers Construction Act Amendments of 1965, Pub. L. No. 89-105, 77 Stat. 282.

[35]*See* Act of Apr. 4, 1968, ch. 477, 1968 Va. Acts 645.

[36]*See* Act of Apr. 4, 1968, ch. 587, 1968 Va. Acts 893.

[37]VA. COMM'N ON MENTAL, INDIGENT AND GERIATRIC PATIENTS, THIS COMMONWEALTH'S COMMITMENT, A STUDY OF MENTAL, INDIGENT AND GERIATRIC PATIENTS AND THE SERVICES AND SURROUNDINGS PROVIDED THEM BY THE COMMONWEALTH OF VIRGINIA 4–5 (1969).

[38]VA. COMM'N ON MENTAL, INDIGENT AND GERIATRIC PATIENTS, HOPE FOR VIRGINIA'S VOICELESS CITIZENS 6 (1971).

community-based system" using a dangerousness-based commitment criteria and the last restrictive alternative doctrine.[39]

Additionally, during the "due process revolution" in the courts, concerns over individual's civil rights and the conditions in institutions led to litigation restricting involuntary commitment and setting minimum requirements for the care and treatment of individuals so committed.[40] For example, in *O'Connor v. Donaldson*, the United States Supreme Court held that a state cannot constitutionally confine a non-dangerous individual who is capable of surviving safely in freedom by themselves or with the help of willing and responsible family members or friends.[41] Justice Stewart explained:

> A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom . . . .In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.[42]

In *Youngberg v. Romeo,* the United States Supreme Court considered for the first time "substantive rights of involuntarily committed mentally retarded persons under the Fourteenth Amendment."[43] The Court found that such an individual has constitutionally protected liberty interests under the Due Process Clause to reasonable care and safety, reasonably nonrestrictive confinement conditions, and such minimally adequate training as reasonably may be required by these interests.[44]

These reforms laid the foundation for Virginia's current "continuum of care" mental health system where individuals were involuntarily committed or detained based on a showing that they pose a danger to themselves or others.

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[39]Richard J. Bonnie, Opening Remarks at the Commission on Mental Health Law Reform 2 (Oct. 12, 2006). Reforms also sought to improve conditions at the state in-patient facilities through enforcement of a right to treatment for hospitalized patients and creation of human rights programs to improve conditions in the facilities and address any violations of patient's rights. *Id.*

[40]*See, e.g.*, SENTENCING PROJECT, MENTALLY ILL OFFENDERS IN THE CRIMINAL JUSTICE SYSTEM: AN ANALYSIS AND PRESCRIPTION 4 (2002) *available at* http://www.sentencingproject.org/doc/publications/sl_mentallyilloffenders.pdf (analyzing the "criminalization" of the mentally ill and the subsequent impact on the criminal justice system).

[41]O' Connor v. Donaldson, 422 U.S. 563, 576 (1975).

[42]*Id.* at 575–76.

[43]Youngberg v. Romero, 457 U.S. 307, 314 (1982).

[44]*Id.* at 324.

C. Phase III: The Modern Mental Health System

Virginia's de-institutionalization efforts can be considered a success because the average daily census in state hospitals declined and more people are served in the community than in the state hospitals.[45] However, community-based mental health and support services were unable to fully meet the need, leading to unwarranted civil detentions and commitments or leaving individuals to fall through the gaps into the criminal justice system.[46] Indeed, in 2006 a national review of the states gave Virginia's mental health system an overall grade of "D" noting that "Virginia's public system has suffered from years of deep cuts that fell disproportionately on the community system."[47]

In October 2006, Chief Justice Leroy R. Hassell of the Supreme Court of Virginia established the Commission on Mental Health Law Reform (the "Hassell Commission") to conduct a comprehensive review of Virginia's mental health laws and services "and to study ways to use the law more effectively to serve the needs of people with mental illness, while respecting the interests of their families and communities."[48] Chaired by Professor Richard J. Bonnie, Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia, the Hassell Commission was divided into five task forces to address the following goals: (i) reducing the need for commitment by improving access to mental health, mental retardation and substance abuse services; (ii) reducing criminalization of people with mental illness; (iii) making the process of involuntary treatment more fair and effective; (iv) enabling consumers of mental health services to have more choice over the services they receive; and (v) helping young people with mental health problems and their families before these problems spiraled out of control.[49]

Six months into the Hassell Commission's review, on April 16, 2007, Seung Hui Cho, an angry and disturbed student at Virginia Tech, shot to death 32 students and faculty, wounded 17 more, and then killed himself. [50]

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[45]*See* Bonnie, *supra* note 39, at 2.

[46]*See* Bonnie, *supra* note 39, at 2.

[47]NAT'L ALLIANCE ON MENTAL ILLNESS, GRADING THE STATES: A REPORT ON AMERICA'S HEALTH CARE SYSTEM FOR SERIOUS MENTAL ILLNESS 171 (2006).

[48]*Concluded: Commission on Mental Health Law Reform*, VA.'S JUDICIAL SYS., http://www.courts.state.va.us/programs/concluded/cmh/home.html (last visited July 10, 2014).

[49]*Id.*; *Guiding Principle*, COMM'N ON MENTAL HEALTH LAW REFORM, http://www.courts.state.va.us/programs/concluded/cmh/background/2007_02_goals.pdf (revised Jan. 2007); *Commissioners*, COMM'N ON MENTAL HEALTH LAW REFORM, http://www.courts.state.va.us/programs/concluded/cmh/members.pdf (last visited July 10, 2014).

[50]*Mass Shootings at Virginia Tech, April 16, 2007, Report of the Virginia Tech Review Panel: Presented*

Not only did this tragedy focus the work of the Hassell Commission, particularly the Task Force on Civil Commitment, but it also prompted Governor Timothy Kaine to form the Virginia Tech Review Panel ("VA Tech Panel") to conduct an independent review of the tragedy and make recommendations regarding improvements to the Commonwealth's laws, policies, procedures, systems and institutions, governmental agencies, and private providers.[51] In a summary of its key findings in its August 2007 Report, the VA Tech Panel described Virginia's mental health system as follows:

> Virginia's mental health laws are flawed and services for mental health users are inadequate. Lack of sufficient resources results in gaps in the mental health system including short term crisis stabilization and comprehensive outpatient services. The involuntary commitment process is challenged by unrealistic time constraints, lack of critical psychiatric data and collateral information, and barriers (perceived or real) to open communications among key professionals.[52]

Four months later, the Hassell Commission issued its Preliminary Report, outlining a "Blueprint for Comprehensive Reform," proposing nine specific recommendations for legislation consideration by the 2008 General Assembly to reform the civil commitment process and increasing access to services.[53]

In response to the recommendations of the Hassell Commission and the Virginia Tech Review Panel, the 2008 General Assembly invested over $41

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to Timothy M. Kaine, Governor, Commonwealth of Virginia, VA. TECH REVIEW PANEL, at 1, 5 *available at* http://www.washingtonpost.com/wp-srv/metro/documents/vatechreport.pdf (Aug. 2007) [hereinafter Report of the Review Panel].

[51]Va. Exec. Order No. 53 (2007) *available at* http://digitool1.lva.lib.va.us:1801/view/action/singleViewer.do?dvs=1404134934074~84&locale=en_US&show_metadata=true&VIEWER_URL=/view/action/singleViewer.do?&DELIVERY_RULE_ID=4&application=DIGITOOL-3&forebear_coll=1505&frameId=1&usePid1=true&usePid2=true.; *id.* at vii-viii. On June 8, 2007, Governor Kaine issued Executive Order 53 reaffirming the establishment of the Virginia Tech Review Panel and clarifying its scope and authority. *See* Va. Exec. Order No. 53. The Office of the Inspector General for the Department of Mental Health, Mental Retardation and Substance Abuse Services also conducted an independent review of the Virginia Tech incident and developed a set of recommendations for improving the involuntary commitment process and mental health services in the Commonwealth. *See* OFFICE OF THE INSPECTOR GEN. FOR MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVS, 140-07, INVESTIGATION OF APRIL 16, 2007 CRITICAL INCIDENT AT VIRGINIA TECH, 13–27 (Va. 2008) *available at* http://www.oig.virginia.gov/documents/VATechRpt-140.pdf.

[52]Report of the Review Panel, *supra* note 50, at 2.

[53]COMMONWEALTH OF VA. COMM'N ON MENTAL HEALTH LAW REFORM, A PRELIMINARY REPORT AND RECOMMENDATIONS, 1–5 (Dec. 21, 2007) *available at* http://www.courts.state.va.us/programs/concluded/cmh/reports/2007_0221_preliminary_report.pdf. These legislative proposals included reforms to (1) the maximum length for an ECO, (2) transfer of custody to crisis stabilization facilities or other therapeutic locations with proper security, (3) attendance of CBS staff at commitment hearings, (4) protection of health information privacy during the commitment process, (5) clarifying the commitment criteria, (6) use of mandatory outpatient treatment orders, (7) procedures for implementing mandatory outpatient treatment, (8) modifying the length of commitment orders, and (9) increasing service capacity. *Id.*

million to increase community-based mental health services and enacted sweeping reforms to improve the emergency evaluation process, the involuntary commitment criteria, mandatory outpatient treatment procedures, privacy and disclosure provisions, and firearms purchase and reporting requirements.[54] The General Assembly also approved a two-year study directing the Joint Commission on Health Care to receive, review, and evaluate the impact of certain recommendations and legislation on the mental health system, and consider and assess the recommendations of the Chief Justice's Commission on Mental Health Law Reform, the Virginia Tech Review Panel, the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services, other committees and commissions proposing recommendations "related to the involuntary commitment process specifically and the system of mental health services in the Commonwealth . . . ."[55] In 2009 and 2010, the General Assembly passed additional legislation expanding advance medical directives to address mental illness, authorizing transportation by non-law enforcement providers during the commitment process, allowing for additional crisis stabilization teams and units, and creating a stand-alone juvenile commitment act.[56]

Presciently, in reflecting on the impact of the 2008 reforms a year later, Professor Bonnie queried "whether the political support for system transformation can be sustained in the face of competing demands for shrinking public funds."[57] It was not. In its final report, the Joint Commission on Health Care concluded:

> During the last three years, 37 mental health bills (including companion bills) have been enacted, resulting in a significant overhaul of the involuntary commitment process. However, a disproportionate proportion of funding continues to be dedicated to addressing crises, providing inpatient care, and unfortunately

[54]Jane D. Hickey, Allyson K. Tysinger, & William C. Mims, *A New Era Begins: Mental Health Law Reform in Virginia*, 11 Rich. J.L. & Pub. Int. 101, 101–24 (2007-2008) *available at* http://rjolpi.richmond.edu/archive/Volume_XI_Issue_4.pdf. For a comprehensive overview of these reforms, see *id.* and Richard J. Bonnie, James S. Reinhard, Phillip Hamilton, & Elizabeth L. McGarvey, *Mental Health System Transformation After the Virginia Tech Tragedy*, 28 HEALTH AFFAIRS 793, 793–804 (2009) *available at* http://content.healthaffairs.org/content/28/3/793.full.pdf+html.

[55]S.J. Res. 42, 2008 Session, (Va. 2008) *available at* http://lis.virginia.gov/cgi-bin/legp604.exe?081+ful+SJ42+pdf. The Joint Commission provided an interim report on April 7, 2009 as Senate Document 3 and its final report on October 6, 2010 as Senate Document 3. JOINT COMM'N ON HEALTH CARE, FINAL REPORT: IMPACT ON VIRGINIA'S MENTAL HEALTH SYSTEM [SJR 42 (2008)], S. Doc. No. 3-2010, 2010 Reg. Sess. (Va. 2010) *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/SD32010/$file/SD3.pdf; JOINT COMM'N ON HEALTH CARE, INTERIM REPORT: IMPACT OF RECENT LEGISLATION ON VIRGINIA'S MENTAL HEALTH SYTEM [SJR 42 (2008)], S. Doc. No. 3-2009, 2009 Reg. Sess. (Va. 2009) *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/SD32009/$file/SD3.pdf.

[56]A summary of mental health legislation passed in 2009 and 2010 is provided in the final report of the Joint Commission of Health Care in Senate Document 3.Va. S. Doc. 3-2010, at 6–7.

[57]Bonnie, et. al., *supra* note 54, at 794.

> in incarceration rather than providing community-based supports and recovery-oriented services. Federal health reform legislation has the potential to help in funding mental health care.[58]

III. OVERVIEW OF THE COMMITMENT AND DETENTION PROCESS AFTER THE 2008 REFORMS

The CSBs serve as the single point of entry into the Commonwealth's publically funded mental health, developmental, and substance abuse services.[59] The primary focus of CSBs is emergency services.[60] When an individual experiences a mental health crisis, specially trained CSB emergency services professionals prescreen and evaluate the individual to determine his or her specific needs and recommend a course of action.[61]

If an individual in crisis does not voluntarily seek emergency services, a "responsible person" or treating physician may petition a magistrate to issue an emergency custody order ("ECO").[62] The magistrate will issue an ECO if there is probable cause to believe that the individual

> (i) has 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, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.[63]

When an ECO is issued, the individual is taken into custody by the local law enforcement and transported to a "convenient location" to be evaluated

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[58]Va. S. Doc. 3-2010, at 8.

[59]Va. Code Ann. § 37.2-500 (2012).

[60]*Id.* In outlining the purpose of and services to be provided by the CSBs,§ 37.2-500 provides: "The core of services provided by community services boards within the cities and counties that they serve shall include emergency services and, subject to the availability of funds appropriated for them, case management services. The core of services may include a comprehensive system of inpatient, outpatient, day support, residential, prevention, early intervention, and other appropriate mental health, developmental, and substance abuse services necessary to provide individualized services, and supports to persons with mental illness, intellectual disability, or substance abuse. Community service boards may establish crisis stabilization units that provide residential crisis stabilization services." *Id.*

[61]OIG Report No. 206-11, *supra* note 4, at 6. CSBs provide pre-admission screening services 24-hours per day, 7 days per week. *Community Services Boards*, VA. DEP'T OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVS, http://www.dbhds.virginia.gov/SVC-CSBs.asp (last visited July 7, 2014).

[62]VA. CODE ANN. § 37.2-808(A) (2013). A magistrate may also issue an ECO upon his own motion. *Id.* A "reasonable person" is defined to include an immediate family member or the principal caregiver of the individual, a community services board or behavioral health authority, any treating physician of the person, or a law-enforcement officer. §§ 37.2-800, 37.2-100.

[63]§ 37.2-808(A).

to determine whether the individual meets the criteria for a temporary detaining order ("TDO") and to assess the need for hospitalization or treatment.[64] Once the individual is taken into custody, the ECO remains in effect for four hours, and may be extended for good cause by a magistrate for an additional two hours.[65] The CSB will designate a person skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by the Department of Behavioral Health and Developmental Science to evaluate the individual.[66] Once an evaluator determines the individual meets the criteria for a TDO, he or she must designate a facility of temporary detention and identify that facility on the preadmission screening report.[67] The magistrate must designate the law-enforcement agency of the jurisdiction in which the individual resides (or, if the nearest boundary of the jurisdiction in which the person resides is more than 50 miles from the nearest boundary of the jurisdiction in which the person is located, the law-enforcement agency of the jurisdiction in which the person is located) to provide transportation to execute a TDO.[68]

[64]§§ 37.2-808(B). The magistrate issuing the ECO must specify the primary law-enforcement agency and jurisdiction to execute the ECO and provide transportation. §§ 37.2-808(C). § 37.2-809(B) provides the criteria for a TDO: "A magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion and only after an evaluation conducted in-person or by means of a two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an employee or a designee of the local community services board to determine whether the person meets the criteria for temporary detention, a temporary detention order if it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has 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, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. The magistrate shall also consider the recommendations of any treating or examining physician licensed in Virginia if available either verbally or in writing prior to rendering a decision. Any temporary detention order entered pursuant to this section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This subsection shall not preclude any other disclosures as required or permitted by law." § 37.2-809(B).

[65]§ 37.2-808(G), (J). Good cause for an extension of the ECO includes the need for additional time to allow the CSB to identify a suitable facility in which the individual can be temporarily detained pursuant to § 37.2-809 or a medical evaluation of the person to be completed if necessary. § 37.2-808(J). The person must remain in custody until a TDO is issued, the person is released, or the ECO expires. § 37.2-808(J).

[66]§ 37.2-808(B). § 37.2-808(A) provides that the evaluator must also be able to provide an independent examination of the person, is not related by blood or marriage to the person being evaluated, has no financial interest in the admission or treatment of the person being evaluated, has no investment interest in the facility detaining or admitting the person, and not be employed by the facility (with the exception of employees of state hospitals and the U.S. Department of Veterans Affairs).

[67]§ 37.2-809(E). The facility must also be identified on the TDO. *Id.*

[68]§ 37.2-810.

IV. THE DEEDS INCIDENT

On the morning of November 18, 2013, Senator Deeds called Rockbridge Area Community Services expressing concern about his son Gus's behavior [69] After unsuccessful attempts to have Gus voluntarily seek services, Senator Deeds went to the Bath County Sheriff's Office to petition the magistrate for an ECO.[70] At 11:23 am, the Alleghany County Magistrate issued an ECO and faxed it to the Bath County Sheriff's Department for assignment and execution. [71] At 12:26 pm, a Bath County Sheriff's Deputy executed the ECO, taking Gus into custody and driving him to a Behavioral Health Center for evaluation.[72] Under Virginia Code § 37.2-808(g), the ECO would expire at 4:26 pm, and could be extended to 6:26 pm.[73] However, even with the extension, lack of coordination protocols between Rockbridge Area Community Services, Behavioral Health Center and the Bath County Sheriff's office and travel times left the assigned CSB evaluator only 3 hours and 15 minutes to conduct an evaluation and call private hospitals to locate an available bed.[74] Within 5 minutes of beginning the preadmission screening, the CSB evaluator began making phone calls to locate a provider with an available bed willing to admit Gus.[75]

The OSIG determined that the limited uninterrupted face time to conduct a clinical risk assessment was insufficient for a thorough deliberative clinical fact-finding process to assess Gus's dangerousness to himself or others, including self-care, and recommend the least restrictive treatment intervention.[76] The OSIG also determined that there were no specific local or statewide standards of practice governing the professional conduct of CSB evaluators, and that while there is an online module that must be completed by each CSB evaluator before they are certified by the Department of Behavioral Health and Developmental Science, there is no follow-up testing or

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[69]A timeline of the events surrounding Gus Deed's attack and suicide is contained in the Office of the Inspector General Report to Governor McAuliffe and the General Assembly, Critical Incident Investigation, Bath County Virginia. OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at 5–18, 30. *See also* Luke Mullins, *For Creigh Deeds, All Politics is Personal*, WASHINGTONIAN (May 5, 2014), http://www.washingtonian.com/articles/people/for-creigh-deeds-all-politics-is-personal/.

[70]OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at 6.

[71]OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at 7. The Bath County magistrate was unavailable, and the Sheriff's Office followed standard practice to facilitate a call between Senator Deeds and the Alleghany County Magistrate to hear the ECO petition. OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at 6.

[72]OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at 8.

[73]§ 37.2-808(g).

[74]OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at ii, 20.

[75]OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at 12–13.

[76]OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at 21.

recertification for the Commonwealth's hundreds of CSB evaluators.[77] Additionally, there are no statewide protocols to guide the actions of preadmissions screeners or their supervisors when a person is about to be released who has been determined to meet the criteria for involuntary temporary detention.[78]

V. 2014 REFORMS

Upon his return to the General Assembly, Senator Deeds introduced sweeping mental health reform legislation to close the gaps he witnessed during his experiences with Gus.[79] Several other bills were filed, and a number were enacted.[80]

A. Emergency Custody Orders (Senate Bill 260/House Bill 478)

Legislation extended the time that an Emergency Custody Order can be executed to eight hours from its issuance, and extended the time person may be held pursuant to an ECO to eight hours from execution.[81] The law enforcement agency executing the ECO or taking an individual into custody must notify the local community services boards responsible for conducting the evaluation as soon as practicable after the person is taken into custody or the ECO is executed.[82] The individual taken into emergency custody must be given a written summary of the emergency custody procedures and the statutory protections associated with those procedures.[83]

B. Identifying the Facility of Temporary Detention (Senate Bill 260/House Bill 293)

An individual subject to a temporary detention order shall be detained in a state facility unless that facility or an employee/designee of the communo-

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[77]OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at 28.

[78]OSIG REPORT NO. 2014-BHDS-2006, *supra* note 11, at 28.

[79]Michael Sluss, *Creigh Deeds: New Mental Health Law Is Just a Start,* ROANOKE TIMES, Apr. 7, 2014, http://www.roanoke.com/news/politics/creigh-deeds-new-mental-health-law-is-just-a-start/article_c028ba10-be76-11e3-b827-0017a43b2370.html.

[80]Michael Sluss, *Senate Passes Deeds-Sponsored Mental Health Legislation,* ROANOKE TIMES, Feb. 10, 2014, http://www.roanoke.com/news/politics/article_b1706e20-9282-11e3-9d0b-0017a43b2370.html.

[81]S.B. 260, 2014 Gen. Assemb., Reg. Sess. (Va. 2014).

[82]VA. CODE ANN. § 37.2-808(J) (2013).

[83]§ 37.2-808(L).

ty services boards is able to identify an alternative facility that is able and willing to provide temporary detention.[84] Upon notification of the need for an evaluation, the CSB must contact the state facility serving the same area and notify it that the individual will be transported to it upon the issuance of a TDO if an alternative facility cannot be identified by the expiration of the eight hour emergency custody period.[85] Once the evaluation is complete, the CSB must provide the state facility information about the individual to allow a determination of the services the individual will require on admission.[86] The state facility may conduct a search for an alternative facility, including another state facility if it is unable to provide temporary detention and appropriate care.[87] If the state facility finds an alternative facility, it must notify the CSB, which will designate the alternative facility on the preadmission screening report.[88] Under no circumstances shall a state facility fail or refuse to admit an individual who meets the criteria for temporary detention unless an alternative facility has agreed to accept the individual.[89] The state facility and the local community services board may continue to look for an alternative facility for an additional four hours.[90]

C. Temporary Detention – Transportation (House Bill 323)

A magistrate may specify any willing law-enforcement agency that has agreed to provide transportation to execute a temporary detention order and transport the person who is the subject of the order, rather than just the one in the jurisdiction in which the individual resides or is located in the event the individual resides in a jurisdiction that is more than fifty miles from where he or she is located.[91]

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[84] § 37.2-809(E); § 37.2-809.1(B).
[85] § 37.2-809.1(A).
[86] *Id.*
[87] § 37.2-809.1(B).
[88] *Id.*
[89] *Id.*
[90] § 37.2-808(N). The provisions allowing for this additional four-hour period expire on June 30, 2018. *Id.*
[91] § 37.2-810(A).

D. Change of Facility of Temporary Detention (House Bill 1172)

House Bill 1172 established a procedure for transferring custody of an individual subject to a TDO from one facility to another.[92] At any point during the period of temporary detention, the CSB may change the facility of temporary detention and designate an alternative facility if it determines that the alternative facility is more appropriate given the specific security, medical, or behavioral needs of the individual.[93] The CSB must provide notice to the clerk of the court issuing the TDO with the name and address of the alternative facility.[94] If the person has not been transported to the initial TDO facility, the law enforcement or alternative transportation provider who has custody will transport the individual to the alternative facility.[95] If the change in facility is made after the individual has been transported to the initial TDO facility, then the CSB must request the magistrate to enter an order specifying an alternative transportation provider, or if none is available, the local law enforcement agency where the person resides or is located if the person resides in a jurisdiction that is more than fifty miles from the jurisdiction in which the person is located.[96]

E. Temporary Detention (Senate Bill 260/House Bill 478/574)

A person detained must be given a written summary of the temporary detention procedures and the statutory protections associated with those procedures.[97] Commitment hearings must be held within 72 hours of execution of the TDO, extended from 48 hours.[98] If the 72-hour period ends on a weekend, legal holiday, or day on which the court is lawfully closed, the person may be detained until close-of-business on the next business day when the court is open.[99]

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[92]H.D. 1172, 2014 Gen. Assemb., Reg. Sess. (Va. 2014) (amending VA. CODE ANN. §§ 37.2-809 and 37.2-810 (West 2014)).
[93]*Id.* (amending VA. CODE ANN. § 37.2-809 (West 2014)).
[94]*Id.* (amending VA. CODE ANN. §§ 37.2-809 and 37.2-810 (West 2014)).
[95]*Id.* (amending VA. CODE ANN. § 37.2-810 (West 2014)).
[96]*Id.*
[97]H.D. 1172, 2014 Gen. Assemb., Reg. Sess. (Va. 2014) (amending VA. CODE ANN. § 37.2-810 (West 2014)).
[98]H.D. 574, 2014 Gen. Assemb., Reg. Sess. (Va. 2014) (amending VA. CODE ANN. § 37.2-814 (West 2014)); S. 260, 2014 Gen. Assemb., Reg. Sess. (Va. 2014) (amending VA. CODE ANN. § 37.2-814 (West 2014)).
[99]*Id.*

F. Mandatory Outpatient Treatment (Senate Bill 439/House Bill 574)

The Community Service Board required to monitor a person who is the subject of a mandatory outpatient treatment order shall acknowledge receipt of the order within five business days. [100] If the person's case is transferred to another jurisdiction, the community services board serving that jurisdiction shall acknowledge the transfer and receipt of the order within five business days.[101]

G. Acute Psychiatric Bed Registry (Senate Bill 260/House Bill 1232)

The Department of Behavioral Health and Developmental Science must develop and administer a web-based acute psychiatric bed registry that will provide real-time information on the availability of acute beds in public and private inpatient psychiatric facilities and residential crisis stabilization units for individuals who meet the criteria for temporary detention.[102] The bed registry must include descriptive and contact information for each inpatient psychiatric facility and crisis stabilization unit.[103] The registry must also include real-time information about the number of beds available, and for each bed, the type of patient that may be admitted, the level of security provided, and any other information to allow identification of appropriate facilities for temporary detention.[104] The registry must allow searches by CSBs, inpatient psychiatric facilities, residential crisis stabilization units, emergency health care providers.[105] State facilities, CSBs, and private inpatient providers licensed by DBHDS must participate in the registry, and must designate employees to submit information to the system and serve as a point of contact.[106] The online registry launched March 3, 2014.[107]

[100] *Id.*
[101] *Id.*
[102] VA. CODE ANN. § 37.2-308.1(A) (Supp. 2014).
[103] § 37.2-308.1(B)(1).
[104] § 37.2-308.1(B)(2).
[105] § 37.2-308.1(B)(3).
[106] § 37.2-308.1(C).
[107] *The Virginia Acute Psychiatric and CSB Bed Registry Initiative Update*, VA. DEP'T BEHAV. HEALTH & DEV. SERVS. 2 (June 4, 2014), http://www.dbhds.virginia.gov/documents/omh-psyBedRegistry-flyer6-4-2014.pdf.

H. Additional Study and Reporting

The Department of Behavioral Health and Developmental Science must submit an annual report on June 30 to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of the provisions of the mental health reform legislation.[108] The report must include the number of notifications of individuals in need of facility services by CSBs, the number of alternative facilities contacted by CSBs and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the lengths of stay, and the cost of the detentions.[109] In addition, DBHDS must review the requirements related to qualifications, training, and oversight of individuals performing preadmission screening evaluations, and to report its findings and recommendations to the Governor and General Assembly by December 1, 2014.[110]

The Governor's Task Force on Improving Mental Health Services and Crisis Response is directed to study issues associated with law enforcement's involvement in the involuntary admission process and make recommendations designed to reduce the burden on law-enforcement resources.[111] Options to be considered by the Task Force include developing crisis stabilization units in all regions and contracting for retired officers to provide transportation.[112] The Task Force must report its findings and recommendations to the Governor and General Assembly by October 1, 2014.[113]

The Secretaries of Public Safety and Health & Human Resources must encourage the dissemination of information about specialized training in evidence-based strategies to prevent and minimize mental health crises to law enforcement, first responders, emergency room personnel, school personnel, and other interested persons.[114] The strategies shall include Crisis Intervention Team training and mental health first aid.[115]

Finally, the General Assembly established a joint subcommittee to study mental health services in the Commonwealth in the 21st Century consisting

[108]2014 Va. Acts 773.
[109]*Id.*
[110]2014 Va. Acts 292.
[111]2014 Va. Acts 761.
[112]*Id.*
[113]*Id.*
[114]H.B. 1222, 2014 Gen. Assemb., Reg. Sess. (Va. 2014).
[115]*Id.*

of 12 legislative members.[116] In conducting its study, the joint committee shall:

- Review and coordinate the work of the Governor's Task Force;
- Review laws governing the provision of mental health services, including involuntary commitment;
- Asses the systems of publicly funded mental health services, including emergency, forensic, long-term, and services in jails and juvenile detention facilities;
- Identify gaps in services and types of facilities and programs needed; and
- Recommend statutory or regulatory changes to improve access to services, quality of services, and outcomes for individuals.[117]

The Joint Committee shall file an interim report with the Governor and General Assembly by December 1, 2015 and a final report by December 1, 2017.[118]

1. Funding

The General Assembly appropriated over $54 million in additional funding for mental health services over the fiscal year 2015-2016 biennium.[119] This funding included approximately $10 million to change the patient mix at Easter State Hospital, $9 million to add 24 crisis intervention "drop-off centers, $8.5 million for use of state hospitals as the provider of last resort for temporary detention, $7.5 million to expand outpatient mental health services for youth ages 17-24, $4.8 million to add four Programs of Assertive Community Treatment, $4.4 million to add a 20-bed unit at Eastern State Hospital, $2.7 million to extend the timeframes for TDOs and ECOs, $2.2 million to expand peer support recovery programs, $1.8 million for tele-psychiatry equipment at CSBs, $1.5 million for children's mental health services, $750,000 each for discharge assistance planning, local in-

[116]S.J. 47, 2014 Gen. Assemb., Reg. Sess. (Va. 2014).
[117]*Id.*
[118]*Id.*
[119]H. APPROPRIATIONS COMM., BRIEFING ON PROPOSED AMENDMENTS TO H.B. 5002 26 (2014), *available at* http://hac.virginia.gov/Committee/files/2014/06-12-14/Briefing_on_Proposed_Amendments_to_HB5002.pdf.

patient purchase of service beds, and additional security staff at CCCA, and $433,000 for the acute psychiatric bed registry.[120]

V. CONCLUSION

The reforms passed this year merely represent the first step. Senator Deeds, who championed longer timeframes for TDOs and ECOs has made clear he will continue to push for more reforms. He also filed a notice of claim against Rockbridge Area Community Services, the first step in potentially bringing a lawsuit that could bring more changes to the system.[121] Moreover, the various studies mandated by the 2014 legislation will undoubtedly lead to more legislation. As Dr. Bonnie observed in 2009, only time will tell if Virginia maintains the political will to provide the resources necessary to meet the mental health needs of all Virginians, or whether this renewed attention will fade as so many times in the past.[122]

[120] *Id.*

[121] *Potential Lawsuit Another Attempt to Change State's Mental Health System*, DAILY PROGRESS, May 17, 2014, http://www.dailyprogress.com/news/potential-lawsuit-another-attempt-to-change-state-s-mental-health/article_fa1137e4-de2d-11e3-9e5d-001a4bcf6878.html.

[122] Bonnie et. al., *supra* note 54, at 803.