REPORT IN-BRIEF

Review of Emergency Services:

Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment.

Office of the Inspector General
Behavioral Health and Developmental Services

G. Douglas Bevelacqua
Inspector General

This Report summarizes the results of a three-month joint statewide study by the OIG and the DBHDS to follow up on the issue of streeting first profiled in connection with the downsizing of Eastern State Hospital (OIG Report No. 197-10). The complete Report can be found on the OIG website at: www.oig.virginia.gov

The Virginia *Bill of Rights* declares that government "ought to be instituted for the common benefit, protection, and security of the people, nation, or community."[1] The General Assembly and the Governor have honored this promise with extensive statutory language mandating emergency services to address the needs of citizens experiencing mental health crises. These statutory provisions protect individuals determined to be incapable of caring for themselves who pose a danger to themselves or others.

To qualify for a Temporary Detention Order (TDO) there must be a "substantial likelihood…in the near future" that a person is at risk for "serious harm to himself or others…lack the capacity to protect himself… [and be] in need of hospitalization or treatment." (§37.2-809 B, Code of Virginia)

For the most part, this system works as envisioned by the Commonwealth's statutory framework – thanks in large measure to the efforts of the system's *first responders:* the emergency services professionals at the state's Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs).

During the 90-day study, 72 individuals, who specially-trained mental health professionals had determined met the criteria for temporary detention cited above, received less intensive treatment than the hospitalization that was clinically indicated because no state-operated behavioral health hospital or private psychiatric facility would admit these individuals. (Refer to the Report's *Appendix A* for a regional summary.)

To contextualize the 72 failed TDOs, one needs to appreciate that this number is approximately 1½% of the estimated 5,000 TDOs that were successfully executed during the three-months of this study. (Refer to the complete Report's Figure 5 for a regional comparison of failed vs. executed TDOs.)

Each incident, in which a person is denied the level of services determined by trained mental health professionals to be clinically necessary, represents a failure of the system to address the needs of that individual and places the individual, his family, and the community at risk.

Moreover, a failed TDO can rise to the level of a *sentinel event* as defined by the Joint Commission if it "carries a significant chance of a serious adverse outcome."

[1] *Constitution of Virginia, Article 1, Section 3*.

The data collected during this three-month study also documented that an additional 273 (or approximately 5 ½ % of the 5,000 executed TDOs) individuals statewide received TDO's, but after the 6-hour time limit imposed by the *Code* for converting an ECO into a TDO. The average time required to execute a TDO for this group was 16.6 hours

When the OIG commenced this study, we hypothesized that the underlying cause of s*treeting* had its origin in either system capacity or system access issues. The study confirmed that, depending on the region of the state, in fact, the phenomenon is driven by both capacity and access issues.[2]

The study revealed that Hampton Roads (PPR V) and Southwest Virginia (PPR III) have the most difficulty finding a willing behavioral healthcare facility to admit individuals meeting the statutory criteria for temporary detention.

While it is difficult to compare failed TDOs in Hampton Roads with those in Southwest Virginia, they have one thing in common: the state-operated facilities in both regions are frequently at capacity, and unable to provide a safety net psychiatric bed for individuals needing temporary detention and further evaluation pursuant to a TDO.

Hampton Roads and Southwest Virginia represent only 30% of the state's population; yet they accounted for 75% (54/72) of the failed TDOs. Particularly troubling is Southwest Virginia, which is home to only 7% of the state's eight million residents, but accounted for 45% of failed TDOs.

The recent spike in the average length of stay at Southwestern Virginia Mental Health Institute (SWVMHI) is both perplexing and troubling; effectively reducing the southwest's state-facility acute treatment capacity by over 40% in the last 18 months.

An infusion of additional funds for discharge assistance planning (DAP) and the creation of additional community treatment capacity likely will be necessary to free-up adult acute facility beds at Eastern State Hospital and SWVMHI to reconstruct a viable public safety net to receive TDOs in Hampton Roads and Southwest Virginia.

Virginia's emergency services system is a complex array of services delivered by numerous public and private agencies and there is no single solution that will end failed TDOs; but, while there is not one simple driver of the phenomenon, there are important themes that reoccur throughout the state including:

THE STATE-OPERATED FACILITY AND COMMUNITY-BASED SYSTEMS ARE INEXTRICABLY INTERDEPENDENT: The decrease in public and private psychiatric beds during the last decade, while the state's population has increased by over 10%, has not been accompanied by a commensurate expansion of community based programs and resources.

The practical result of this imbalance is that some state facilities are unable to discharge stabilized residents and return them to their communities. Thus, the facility beds occupied by persons who could be otherwise

[2] Wherever possible, the OIG has substituted "failed TDO" for "streeted" because of reasonable objections to the negative connotations attached to the term "streeted." The term "streeted" was used in Hampton Roads to categorize individuals that met criteria for temporary detention who received a less intensive intervention – or no intervention and were released.

housed in a community setting are not available to serve as a safety net for individuals in-crisis meeting TDO criteria.

This outcome is contrary to the standards articulated by the *Olmstead* decision and, moreover, it is making it more difficult to serve the most challenging individuals meeting criteria for temporary detention.

State-operated facilities and CSBs must jointly sharpen their focus on the systemic flow of individuals from the facilities to the communities. Virginia lacks the surplus facility capacity to afford the dubious "luxury" of permitting individuals who are discharge ready to remain in state facilities.

During this study, people in dire need of inpatient psychiatric treatment in state hospitals were denied admission to state hospitals because individuals, who could have been served in the community, occupied the state-facility beds needed to serve some of the state's most challenging TDOs.

THE PROTOCOLS FOR MEDICAL SCREENING AND ASSESSMENT MUST BE STANDARDIZED: The Inspector General met with hospital medical directors and CSB emergency services directors around the state and these healthcare professionals were unanimous in their opinion that the current approach to medical screening and assessment creates unnecessary additional costs and actually contributes to unacceptable outcomes – including failed TDOs and TDOs executed beyond the six-hours contemplated by statute.

This Report recommends updating and prompt implementation of the appended *Medical Screening and Assessment Guidance Materials* (2007) developed by the DBHDS in collaboration with the CSB system, the Hospital and Healthcare Association, and the College of Emergency Physicians (Appendix C).

THE SYSTEM SOMETIMES DISCRIMINATES AGAINST THE CITIZENS MOST IN NEED OF TREATMENT: In a chronically underfunded system subject to iterative budget reductions, the system sometimes defaults to serve selectively the least challenging individuals – the so called "soft-TDOs." Private psychiatric hospitals, state behavioral health hospitals, and the crisis stabilization units all have limitations and restrictions on whom they will serve and under what conditions. These restrictions may screen for age, gender, psychiatric profile, history of assaultive behaviors, suicidal ideation, substance use, security concerns, medical complications, hours of operation, self-care ability, and psychiatric support staff availability.

The 72 failed TDOs, who were denied admission to a state-operated hospital or a private psychiatric facility, may be Virginia's "canary in the coal mine" warning us that the system has yet to create sufficient community capacity to serve our neighbors and family members who, decades ago, would have been treated in state-operated behavioral health facilities.

When viewed collectively, these restrictions can serve to deny services to individuals who most need treatment in a secure psychiatric facility – especially in Hampton Roads and Southwest Virginia where the state facilities are regularly unable to accept TDO admissions because they are at, or beyond, full operating capacity.

ACCOUNTABILITY FOR EMERGENCY SERVICES IS FRAGMENTED: CSB pre-screeners, who are tasked with assessing individuals in crisis, do not have the authority to direct that a facility admit a person meeting TDO criteria. This Report recommends real-time monitoring of TDO outcomes and the designation of a regional senior manager with region-wide responsibility to locate a state-operated or private facility to admit a person meeting criteria for temporary detention.

Additional OIG findings and recommendations appear in the Report. These recommendations include:

- The creation of system quality indicators to monitor unexecuted TDOs and TDOs executed beyond six hours;

- The prompt review, adoption, and implementation of the *2007 Medical Screening and Assessment Guidance Materials;*

- The designation of a senior-level person within each region (and at the DBHDS) with the responsibility and empowered to assure that every citizen in the region meeting TDO criteria is treated at the clinically appropriate level;

- That consideration be given to creating "intensive psychiatric beds" with private psychiatric hospitals in Hampton Roads and Southwest Virginia until a reliable state-operated safety net is recreated for these regions;

- Repeating this study in FY 2013 in Hampton Roads and Southwest Virginia; and,

- That the DBHDS evaluate the unique issues in Southwest Virginia and Hampton Roads and the additional programs and resources needed to create the community capacity required to end the phenomenon of failed TDOs, and restore the Commonwealth's safety net for citizens determined to need temporary detention.

In conclusion, this Report cannot overstate the importance of the Commonwealth's emergency services professionals who, despite formidable obstacles, somehow manage to cobble together creative alternatives to assure the safety of Virginians who are incapable of caring for themselves.

Without the clinical skill and dedication of CSB/BHA emergency staff, our most vulnerable neighbors – and our communities – would have doubtless experienced many tragic outcomes.

2012

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OIG Report No. 206-11

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G. Douglas Bevelacqua
Inspector General
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ACKNOWLEDGEMENTS

Susan Austin, Director of Emergency Services, Mount Rogers CSB

Christine Bradshaw-Earl, Chesapeake CSB

Derek Burton, Regional Manager, PPR III

Brian Dawson, MD, Johnston Memorial Hospital, Emergency Medicine

Sterling Deal, Director Research & Evaluation, DBHDS

John Dool, Regional Manager, PPR V

Kaye Fair, Director of Emergency Services, Fairfax-Falls Church CSB

Shelby Gorham, Emergency Services Program Team Leader, Norfolk CSB

Cathy Hill, Senior Inspector, OIG

Gary S. Kavit, MD, FACEP, ED Medical Director, Riverside Hospital

Betty Long, Vice President, Virginia Hospital and Healthcare Association

Jason Lowe, Behavioral Health Program Analyst, DBHDS

James Martinez, Director, Office of Behavioral Health Services, DBHDS

Russ McGrady, Clinical Director, SWVMHI

Pat Pettie, Office Manager, OIG

John Pezzoli, Assistant Commissioner for Behavioral Health Services, DBHDS

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SECTION ONE

INTRODUCTION

The Virginia *Bill of Rights* declares that government "ought to be instituted for the common benefit, protection, and security of the people, nation, or community."[1] The General Assembly and the Governor have honored this pledge with extensive and thoughtful statutory language mandating emergency services to address the needs of citizens experiencing mental health crises. These statutory provisions promote public safety while protecting and caring for those individuals determined to be presently incapable of caring for themselves.

The *Code of Virginia* § 37.2-500, *Purpose; community services board; services to be provided* specifically requires CSBs to provide emergency services and the DBHDS has made efforts to identify an array of services that should be available to respond to individuals in crisis. The *Code* purposely privileges emergency services above other behavioral health services. The General Assembly has long recognized the incalculable risk for individuals, and the community, for irreparable harm during a mental health crisis. The failure to provide effective and timely emergency services can result in a tragedy affecting the person, the community, and the state.

Following the events at Virginia Tech in 2007, the General Assembly enacted legislative changes that resulted in an increased focus on the provision of emergency services during the detention and commitment process. These changes highlighted the pivotal role of the state's CSBs in the commitment process. In addition, last year the Governor recommended, and the General Assembly appropriated, supplemental funding to create additional community-based safety net programs in the Hampton Roads Region because of the acute shortage created by the 2010 downsizing of Eastern State Hospital and the abrupt loss of approximately a third of the region's civil adult behavioral beds.[2]

[1] The *Constitution of Virginia*, Article 1, Section 3.

[2] Virginia's system of behavioral healthcare is utterly interdependent. If state facility beds are not available, it stresses the private psychiatric providers and the community capacity. Likewise, if community capacity is inadequate, residents of state facilities may have to remain in an institutional setting because there is no community placement available. Thus, the system's hydraulics, or individual movement from facility to community – or community to facility via TDO, are driven by the weakest link in the continuum of care.

It was during the process of investigating the moratorium on admissions at ESH, and the impact that ineffective planning[3] had on the provision of this mandated service, that the OIG was introduced to the term "streeting."[4] The OIG's telephone inquiry of CSBs around the state provided anecdotal estimates supporting the qualified conclusion that approximately 200 individuals had been streeted throughout the Commonwealth during 2010.

These anecdotal reports heightened concerns among CSBs, the DBHDS, and other stakeholders, and the OIG worked closely with all parties to reach agreement on terminology and parameters for a formal expanded review of this issue.

Beginning on July 15, 2011, following a brief pilot program, the OIG and the DBHDS launched a 90-day joint statewide initiative designed to provide empirical data for understanding the extent and identify the contributing factors associated with TDOs not being executed as warranted. All CSBs and BHAs participated in this study and a summary of the results are profiled at Appendix A of this Report.

[3] OIG Report No. 197-10, *A Review of the Downsizing of Eastern State Hospital and the Impact on Hampton Roads*: Appendices IV and V.

[4] The term "streeted" was lifted from the Hampton Roads weekly TDO Report form in our initial commentary concerning the phenomena in HPR V. Some have objected to the term "streeted" suggesting that it is needlessly pejorative and, moreover, does not accurately capture the outcome for all individuals who have been determined to meet criteria for a TDO, but who are not involuntarily detained. Based on these objections, wherever possible, this report uses the term "unexecuted TDO" in lieu of *streeted or streeting*.

SECTION TWO

OVERVIEW AND HISTORY OF EMERGENCY SERVICES

Virginia's behavioral health safety net is a continuum of many different emergency and crisis response services. These services are delivered primarily through CSBs, local psychiatric hospitals, hospital emergency departments (EDs), and the regional state-operated psychiatric hospitals. Public sector agencies, including police and sheriff departments, local courts, and others are a part of the safety net for individuals with mental illness.

The CSB system is the single point of entry into the state's publically funded system of behavioral health care. When an individual with mental illness experiences a psychiatric emergency and may present a danger to themselves, or others, a variety of community agencies likely will contact one of the state's forty CSBs/BHAs. The individuals in-crisis[5] are prescreened by specially-trained CSB emergency services professionals and evaluated to understand their specific needs and recommend the most appropriate disposition – including involuntary temporary detention (TDO), if a person meets statutory criteria.[6]

EMERGENCY SERVICES ARE MANDATED BY *THE CODE OF VIRGINIA*

While the actual range of emergency services provided by the CSBs varies by region and local board, the provision of emergency services is the only core behavioral health service explicitly required by the *Code of Virginia*.[7] In its first report of a series of reviews of licensed community-based services, the OIG conducted a review of

[5] During FY 2011, CSB Emergency Services professionals served an unduplicated total of 58,553 individuals in the Commonwealth.

[6] Pursuant to §37.2-809 B. a person meeting criteria for a TDO must have been determined to"…(i) has [have] a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) **cause serious physical harm to himself or others** as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his **lack of capacity to protect himself** from harm or to provide for his basic human needs, (ii) is **in need of hospitalization or treatment**, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment." [Bold supplied by OIG]

[7] § 37.2-500 of the *Code of Virginia* requires that: "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…." (Bold supplied by OIG)

emergency services programs operated by the CSB system in 2005. The completion of an inventory of available CSB emergency response and crisis services resulted in a number of findings and recommendations designed to support system improvement and highlight gaps in community-based capacity.

The inventory of services was updated in 2011 by the Emergency Response Strategic Initiative Team, a group developed as a part of DBHDS' *Creating Opportunities* initiative. The team's final report was issued in July 2011 and noted the following:

> The survey results show that despite the widespread availability of most baseline services, **insufficient access and capacity are still problematic**. In addition to the general lack of availability of psychiatric evaluation and medication administration within 24 hours and psychiatric crisis consultation, survey respondents also reported the highest priorities for capacity building in the inpatient, residential crisis stabilization, and detox service categories - services that are already widely available. Comments submitted by many CSBs indicate that timely access to available services is further hampered by geography, lack of transportation, special needs of certain individuals or populations (e.g., elderly persons, persons with co-occurring medical conditions, etc.), and other complicating variables. **Taken together, these findings indicate that a safety net of basic services is indeed widely available in Virginia, but just barely.**[8] Despite the availability of basic services, behavioral health providers and other emergency service partners are severely challenged every day to access services for the variety of people they serve. [Bold by OIG]

[8] While basic safety net services may be available to most citizens, safety net services were not accessible for the 72 individuals who, despite meeting statutory criteria for temporary detention, could not be detained for their own safety because no private provider, or state operated facility, would admit these people.

Over the last decade, there have been significant sustained efforts to expand the types, capacity and accessibility of emergency and crisis services. However, both the OIG and DBHDS have documented that not all emergency services are consistently available and accessible to all Virginians.[9] The DBHDS has recognized that there is inadequate community capacity to address the increasing demand for services in a number of key areas, including emergency services, and between January and April 2011 there were approximately 15,881 individuals waiting to receive CSB services.[10] Recent changes in Virginia's public behavioral health emergency services system are highlighted below.

Inpatient psychiatric bed capacity has decreased

In its 2007 report, the Joint Legislative Audit and Review Commission documented that licensed psychiatric beds in private hospitals had decreased significantly over many years.[11] At the time of this study, JLARC reported that the total available bed capacity statewide was adequate, at 1,794 total beds, but that certain localities and types of patients experienced difficulty accessing available beds. The gradual reduction of licensed bed capacity in private hospitals capacity has continued since the date of the JLARC report, and as of September 2011, there were 1,699 licensed psychiatric beds in operation;[12] however, according to the Virginia Hospital and Healthcare Association, in 2010, private hospitals were only staffed to operate 1,305 private psychiatric beds even though they were licensed to operate 1,540 beds statewide.

Similarly, acute and intensive treatment beds in DBHDS state-operated psychiatric hospitals have also decreased, while the population has grown by approximately 13% during the last decade.[13] It is also significant that forensic inpatients use an

[9] See (1) Report #123-05, *Review of the Virginia Community Services Board Emergency Services Programs*, Office of the Inspector General and (2) *Creating Opportunities Emergency Response Team Report*, DBHDS, July 2011.

[10] *2012-2018 Comprehensive State-Plan for the Department of Behavioral Health and Developmental Services*.

[11] Senate Document 19, *Availability and Cost of Licensed Psychiatric Services in Virginia*

[12] DBHDS Office of Licensing

[13] From DBHDS *Weekly Census Reports by Cost Center* and 2000/2010 U. S. Census.

increasingly large proportion of all DBHDS inpatient beds: currently 36% of all state behavioral health beds are occupied by forensic patients, further limiting access of acute and intensive beds for civil (non-forensic) admissions in DBHDS hospitals.[14]

Changes in funding for emergency services

Several targeted initiatives were undertaken with state funds in recent years to strengthen or increase community-based emergency service and crisis response capacity. These and other initiatives were implemented to provide less restrictive alternatives to hospitalization and also to respond to decreases in inpatient capacity described in the OIG and JLARC reports cited above.

Although CSBs experienced reductions of state funding in many other program areas in recent years, CSB emergency and crisis services were generally exempted from state funding reductions during this time.[15] A high-altitude summary of specific state-funded emergency services and related capacity-building initiatives is provided below by DBHDS:

- Purchase of local inpatient services from private hospitals (LIPOS): Funding allocated to CSBs to purchase inpatient care from local private hospitals has risen from $2,486,847 in FY 2002 to $8,020,484 in FY 2012 (budgeted).

- Residential Crisis Stabilization: Funding to establish and expand residential Crisis Stabilization units (CSUs) has expanded from FY 2006 appropriations of $3,850,000 to the current funding level of $15,529,606.

- Mental Health Law Reform: A portion of FY 2009 funds associated with the Mental Health Law Reform initiative was allocated to strengthen CSB emergency services and implement the 2008 statutory reforms. These funds were $10,051,954 in FY 2009 and are budgeted at $12,122,120 for FY 2012.

- Reinvestment: The mental health Reinvestment initiative began in FY 2003 with $1,974,707 to create community program alternatives (including emergency services) to offset reductions in state hospitals capacity. In FY 2012 Reinvestment funds are budgeted at $8,784,099.

[14] *OIG Review of Behavioral Health Forensic Services*, OIG Report 200-11, October 2011.

[15] It should be noted that CSBs rely heavily on Medicaid, local funds, fees, and other fund sources other than state funds. Reductions in these revenues are not addressed here.

- Jail Diversion: Jail diversion programs were funded in FY 2007 with $480,000 to help reduce arrest and incarceration of persons with mental illness, and subsequent demand on state inpatient services. Currently, these initiatives are budgeted at $2,673,300 for FY 2012.

Mental health law reform

In 2006, in response to concerns about the experiences of older Virginians who were hospitalized through the involuntary admission process, the late-Supreme Court Chief Justice Leroy Hassell established the Commission on Mental Health Law Reform to review and make appropriate changes to Virginia's mental health and related laws. A core guiding principle of the Commission was that improving access to behavioral health services was an essential part of reform, and would help protect consumers, family members and the public from harm and reduce Virginia's reliance on involuntary hospitalization.

The Virginia Tech shootings occurred in April, 2007, and the Commission's attention focused on amending Virginia's involuntary commitment laws. Acting on the work of the Commission and the Virginia Tech Review Panel, the 2008 Legislature enacted extensive changes in many areas of law, some of which are pertinent to this study, including:

- *Criteria for involuntary treatment*: These criteria are the basis for emergency custody, temporary detention, and involuntary admission. The new criteria were considered broader, but also clearer, enabling more uniform application in practice.

- *Emergency custody*: The 2008 amendments added the 2-hour extension to the existing 4-hour period of emergency custody.

- *Evidence:* The 2008 amendments expanded the information that could be considered by officials when issuing involuntary orders, including ECOs.

In addition, new funds were appropriated for FY 2009-10 that were targeted to capacity-building of emergency services (see above), as well as case management and outpatient services to implement mental health law reforms.

SECTION THREE

REVIEW INSTRUMENT AND STUDY METHODOLOGY

The instrument used to collect the data for this study was developed through collaboration among the OIG, DBHDS, and CSB emergency service directors and regional managers from around the state. Through a series of conference calls, stakeholders determined what data was to be collected and the methodology for collecting this data from all CSBs and regions.

Two quality indicators were established by the workgroup and served as the basis of the study. A pilot version of the data collection instrument was tested at several CSBs represented by the stakeholder group. After the pilot test, the data collection instrument, a glossary of terms and definitions, instructions for completion of each data report, and the reporting schedule was distributed to CSBs and regions statewide. Data collection occurred between July 15 and October 13, 2011. [See the Instrument and Glossary of Terms at Appendix F]

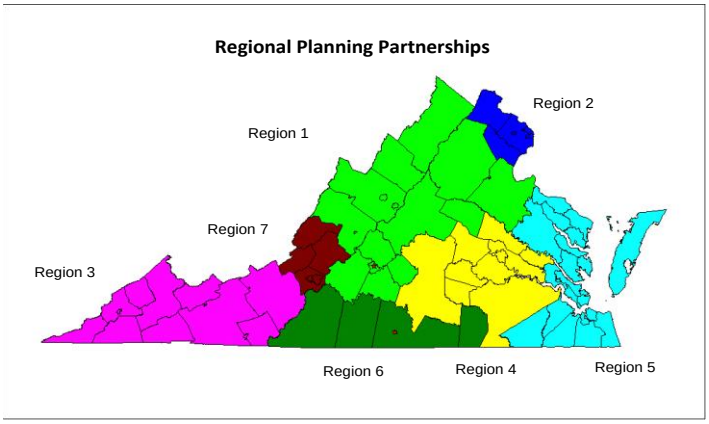
Data was reported at each two-week interval within this three-month period. On each report date, regional managers for the seven Partnership Planning Regions (PPR) submitted completed data for all eligible cases that had occurred within the region during the prior two-week reporting period. The bi-weekly reports were submitted to the OIG, where submissions were reviewed for completeness. Once reviewed, the data were forwarded to DBHDS and compiled into a single master file containing all data for the collection period. OIG and DBHDS developed the report templates for the data, and DBHDS staff performed the data analyses to create these reports.

As noted, the review was designed for the initial data to be routed through the regional managers for the PPRs so that emerging patterns, specific to each region, could be recognized and considered. CSBs & BHAs in each region are as follows:

- PPR 1 (NORTHWESTERN VA) - Central Virginia, Harrisonburg-Rockingham, Northwestern , Rappahannock Area, Rappahannock-Rapidan, Region Ten, Rockbridge Area, and Valley
- PPR 2 (NORTHERN VA) - Alexandria, Arlington, Fairfax-Falls Church, Loudoun County and Prince William
- PPR 3 (SOUTHWESTERN VA) – Cumberland Mtn., Dickenson County, Highland, Mount Rogers, New River Valley and Planning District One

- PPR 4 (CENTRAL VA) – Chesterfield, Crossroads, District 19, Goochland-Powhatan, Hanover, Henrico and Richmond BHA
- PPR 5 (EASTERN VA) – Chesapeake, Colonial, Eastern Shore, Hampton-Newport New, Middle Peninsula-Northern Neck, Norfolk, Portsmouth, Virginia Beach and Western Tidewater
- PPR 6 – (SOUTHERN VA) – Southside, Danville-Pittsylvania and Piedmont Community Services
- PPR 7 (CATAWBA REGION) – Alleghany /Highlands and Blue Ridge Behavioral Healthcare

Figure 1:



SECTION FOUR

STUDY RESULTS AND DISCUSSION

This study focused on individuals who were clinically screened by a qualified mental health professional and determined to meet the criteria for a temporary detention order for extended observation and a more comprehensive evaluation to determine the appropriate level of care needed for treatment; usually to the most restrictive levels of care, either an inpatient hospital setting or another 24-hour secured residential crisis program with psychiatric services.

The reason for issuing a TDO is to safeguard the person experiencing a psychiatric emergency and their community and, as set out earlier in this Report, the criteria for issuance of a temporary detention order are that:

1. A person has mental illness and is likely to harm him/herself or others;
2. Lacks the capacity to protect him/herself; and,
3. Is unwilling, or incapable, of volunteering for treatment. (*Code of Virginia,* § 37.2-809 B)

Two quality indicators were established by the workgroup and served as the basis for the study; each potentially representing a failure to address the needs of the person needing services either by not providing services and supports at the appropriate level of care needed or by failing to execute TDOs in a timely manner. The quality indicators measured by this study were:

I. THE NUMBER OF PERSONS THAT WERE DETERMINED TO MEET THE STATUTORY CRITERIA FOR A TDO -- BUT FOR WHICH THE TDO WAS NOT EXECUTED.[16]

II. **THE NUMBER OF PERSONS THAT WERE DETERMINED TO MEET THE CRITERIA FOR A TDO THAT WAS ULTIMATELY EXECUTED – BUT THE EXECUTION EXCEEDED SIX HOURS.[17]**

[16] This is the group of individuals considered to have been "streeted" as reported in the OIG Semi-Annual Report dated May 11, 2011.

[17] The reason that the six-hour time limit is viewed as a quality indicator is because this is the maximum amount of time allowed by the *Code of Virginia* for an individual to be forcibly detained under an emergency custody order (ECO). During the 6 hour limit, the person remains in custody of law enforcement so that the prescreening and execution of the TDO can occur. Failure to execute the TDO in this timeframe results in the person being released from custody – unless they voluntarily remain in custody.

During the 3-month review period, there were 345 reported cases that met the two study criteria. Seventy-two (72) cases represented individuals determined in need of a TDO due to their presenting clinical risk(s) – but a TDO was not executed. There were 273 cases that resulted in the issuance of a TDO beyond a 6-hour time limit.

Figure 2:

NUMBER OF REPORTED CASES BY PARTNERSHIP PLANNING REGION (PPR)

PPR REGION	Number of TDOs Issued Beyond 6 hours	Number of Unexecuted TDOs	TOTALS
Region I	29	6	35
Region II	15	5	20
Region III	43	32	75
Region IV	21	3	24
Region V	77	22	99
Region VI	12	4	16
Region VII	76	0	76
TOTALS	**273**	**72**	**345**

Hospital emergency departments (EDs) are required by law to accept and stabilize all individuals in need of care.[18] In addition to the traditional role of rapid response to life-threatening and potentially disabling health-related events, EDs have taken on additional responsibilities over time, including being a resource for persons presenting with severe mental disabilities.[19] Individuals presenting in the ED with psychiatric issues require hospitalization more often than those who present with other conditions.[20]

During this study, the majority (68%) of emergency contacts occurred in community-hospital emergency rooms and 57% were initiated with the issuance of an emergency custody order (ECO).

[18] *The Emergency Medical Treatment and Active Labor Act* of 1986 (*EMTALA*)

[19] Salinsky, E., & Loftis, C. (2007). "Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?" *National Health Policy Forum*, Issues Brief 823,1-21, George Washington University, Washington, DC.

[20] Report by the Agency for Healthcare research and Quality – "Mental disorders and/or substance abuse related to one of every eight emergency department cases /Research Activities", September 2010.

Interviews with CSB Emergency Services Directors and ED physicians revealed that the practice of "hospital boarding" – patients remaining in the emergency departments after the decision has been made to transfer them to another facility – is increasing. ED physicians maintain that this practice has a negative impact on access to emergency medical care for all patients – causing extended wait times, increasing frustration and diminishing the operational capacity of hospital staff to care for other patients.

An authorized individual, such as a law enforcement officer, or CSB crisis clinician, can secure an ECO when there is sufficient evidence that an individual is at risk of harming him/herself, or others, due to mental illness and is not willing to participate in a prescreening evaluation. Law enforcement officers can take an individual into custody without a magistrate-issued ECO when the officer determines there is probable cause for seeking a mental health evaluation based on an individual's presenting behaviors.[21] This action is often referred to as a "paperless ECO," and the criteria for issuance of an ECO are the same as for a TDO.

When an ECO is issued, an individual can be detained for four hours while that individual is evaluated. An ECO can be extended for an additional two hours, if good cause – such as a medical assessment is necessary, can be demonstrated.[22]

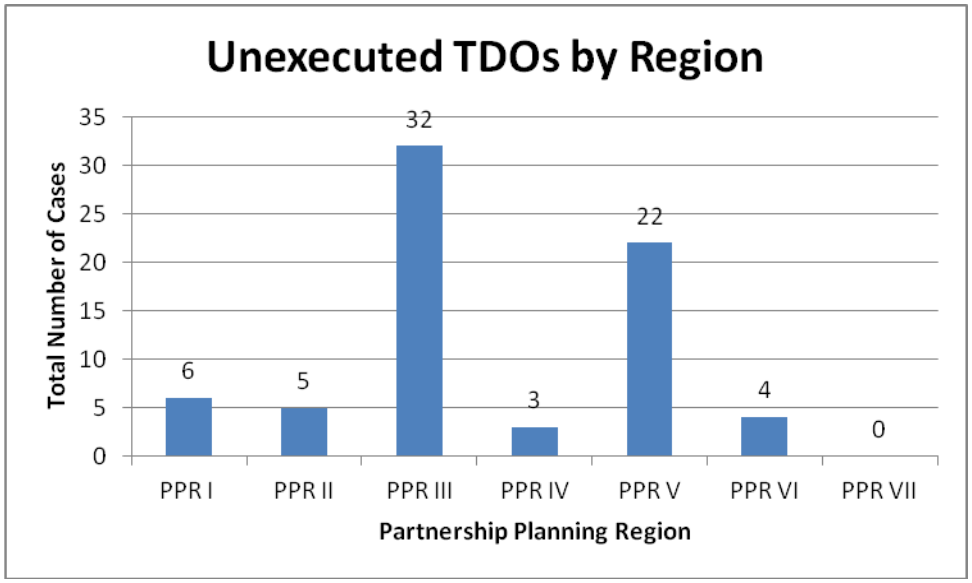
A. QUALITY INDICATOR – UNEXECUTED TDOS

During the three-month study period, seventy-two (72) individuals were determined to need involuntary temporary detention due to their presenting clinical risk(s) but a TDO was not executed for these citizens.[23]

[21] "A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization or treatment without prior authorization." § 37.2-808.G *Emergency custody; issuance and execution of order*. *Code of Virginia.*

[22] "The period of custody shall not exceed four hours from the time the law-enforcement officer takes the person into custody. However, upon a finding by a magistrate that good cause exists to grant an extension, the magistrate shall issue an order extending the period of emergency custody one time for an additional period not to exceed two hours. Good cause for an extension includes the need for additional time to allow (i) the community services board to identify a suitable facility in which the person can be temporarily detained pursuant to § 37.2-809 or (ii) a medical evaluation of the person to be completed if necessary." Ibid

Figure 3:



- For the 72 cases that met the criteria for a TDO, but the TDO was not executed, the primary reason for denial cited by the private psychiatric facilities contacted was there were no beds available at the time of the contact. This involved 40 cases, or 56%, of the total cases.
- The secondary reason cited by the private psychiatric facilities for denial for admission was the acuity level or care needs of the individuals.
- The average number of private psychiatric facilities contacted in an effort to secure a bed in a willing facility for the individuals for whom the TDO was not executed was 10.56 contacts.

Seventy-five percent of the 72 unexecuted TDOs identified in this study occurred in Region III or Region V. Region III had the highest number of cases, 32, where a TDO could not be executed for persons presenting with clinical risk factors warranting a detention order. Region V reported 22 cases involving unexecuted TDOs. These two PPRs are discussed further below.

[23] This suggests an annualized statewide number of 288 failed TDOs and exceeds the OIG's 2011 estimates of 200 based on anecdotal accounts; however, the actual annualized numbers may exceed the three-month extrapolation as LIPOS funding is spent-down in the final quarter of the fiscal year. Historically, several regions spend down their LIPOS funds by the end of the 3rd Quarter, increasing the likelihood that these regions will not have sufficient funds to access inpatient beds in local psychiatric hospitals.

In 2011, the OIG documented the alarming number of failed TDOs ("streeted") in PPR V (Hampton Roads) and, in fact, the scores of failed TDOs in this region gave rise to this study.[24] At the time of Report No. 197-10, the OIG suspected that the large number of failed TDOs in Hampton Roads were likely attributable to the downsizing of Eastern State Hospital (ESH) in 2010 and the abrupt removal of 85 beds at ESH; however, as illustrated by the tables below, subsequent research and analysis failed to establish a consistent correlation between regional per capita psychiatric bed capacity and failed TDOs.

Figure 4:

State and Private Beds and CSU Beds Accepting TDOs

PPR	2010 Pop. Est.*	No. Adult State Facility Beds per 100K	No. Private (operational) Psych. Beds per 100K	No. CSU Beds accepting TDOs per 100K	Total All Beds per 100K
I	1,490,106	16.98	10.67	0.27	27.92
II	2,230,623	5.51	8.16	0.22	13.89
III	579,982	23.45	15.35	1.04	39.84
IV	1,280,768	7.81	25.06	0	32.87
V	1,809,202	8.29	12.55	0	20.84
VI	335,584	20.26	13.71	0	33.97
VII	274,759	21.84	22.57	0.58	44.99

Source: DBHDS
* Based on entire population of PPR, including children, adolescents and adults; assuming a relatively equal distribution of these numbers across all PPRs

[24] *A Review of the Downsizing of Eastern State Hospital and the Impact on Hampton Roads*, OIG Report 197-10.

Figure 5:

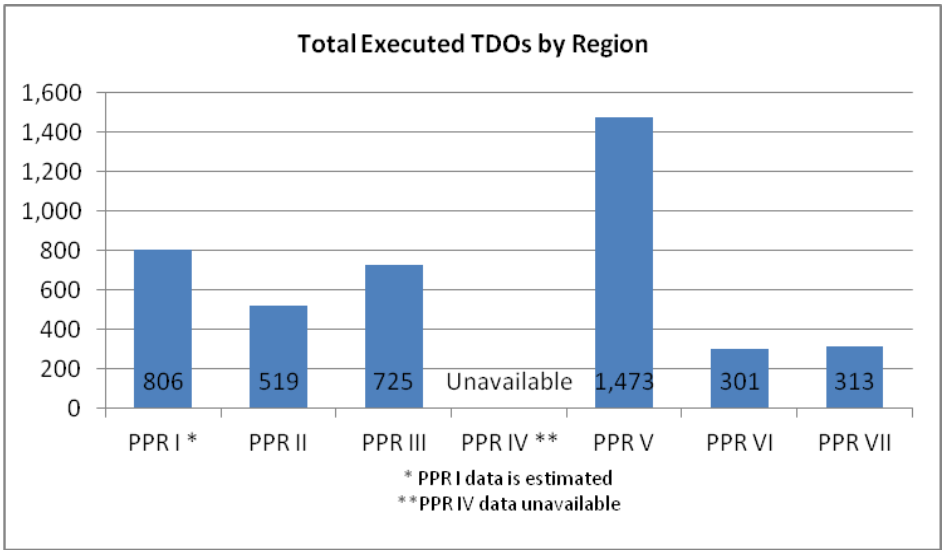
Executed and Failed TDOs by Region

PPR	Adult Pop.*	Executed TDOs	Executed TDOs per 10K	Failed TDOs	Failed TDOs per 10K
I - Northwestern VA	1,144,878	806**	7.04	6	0.05
II - Northern VA	1,713,832	519	3.03	5	0.03
III - Southwestern VA	445,612	725	16.27	32	0.72
IV - Central VA	984,040	data unavailable	0.00	3	0.03
V - Eastern VA	1,390,046	1,473	10.60	22	0.16
VI - Southern VA	257,836	301	11.67	4	0.16
VII - Catawba Region	211,103	313	14.83	0	0.00
Totals	6,147,347	4,137	6.73	72	0.12

* The number of adults in each region was calculated from the 2010 U.S. Census by subtracting the percentage of children statewide (23.17%) from the regional population totals compiled by the DBHDS and also based on the 2010 U.S. Census.
** Estimated based on the number of TDOs executed in the first 6 weeks of the study (370) extrapolated to the 13 week study period.

Figure 6:

Executed TDOs by Region



A comparison of the data contained in these two tables fails to establish a consistent correlation between regional availability of behavioral health beds and the number of TDOs:

- PPR VII has more psych beds than any region in the state and it had recorded no failed TDOs; however, PPR III has the second highest number of psych beds and it had the highest number of failed TDOs per capita.[25]
- For reasons that are not readily apparent, Northern VA has a per capita TDO rate that is materially lower than the rest of the state; however, PPR II has the fewest psych beds of any region.
- One of the questions that leap from the above tables is, "Why does Hampton Roads (PPR V) have a per capita (executed) TDO rate more than double the rest of the state"? The answer to this question is beyond the scope of this Report, but this unexpected observation warrants further analysis.

REGION III: SOUTHWESTERN VIRGINIA

The primary reasons cited for declining TDO admission by **private facilities** in Southwest Virginia were:

No beds available	7
Medical Issues	3
Acuity LOC	3
Unable to confirm	1

The primary reasons cited for declining TDO admission by **state facilities** were:

No bed available	5
Medical issues	4
Unable to confirm	2
No reason listed	3

[25] It is noteworthy that PPR VII had the second highest number of TDOs executed after the six-hour limit, yet not a single failed TDO for this region during the study.

Research into the drivers of the increase in failed TDOs in Southwestern Virginia has yielded a number of emerging trends that warrant further examination including:

- During 2011, 40% of the individuals served at the adult admissions unit of SWVMHI were **first time patients** of the facility, as were 76% of the people served by SWVMHI's geriatric admissions unit;
- A snapshot of SWVMHI's December census revealed that 18 of the 50 beds (36%) at SWVMHI's long term rehab unit were originally Tennessee residents;
- The average length of stay for SWVMHI's acute treatment services has increased from 40 days during the 4th quarter of 2010 to 57 days during the same period in 2011 – effectively reducing the facility's acute treatment capacity by over 40%.

While it is difficult to compare failed TDOs in Hampton Roads with those in Southwestern Virginia, they have one thing in common: The state-operated facilities in both regions are frequently at capacity, and unable to provide a safety net behavioral health bed for individuals needing temporary detention and further evaluation pursuant to a TDO.

CLINICAL OUTCOMES

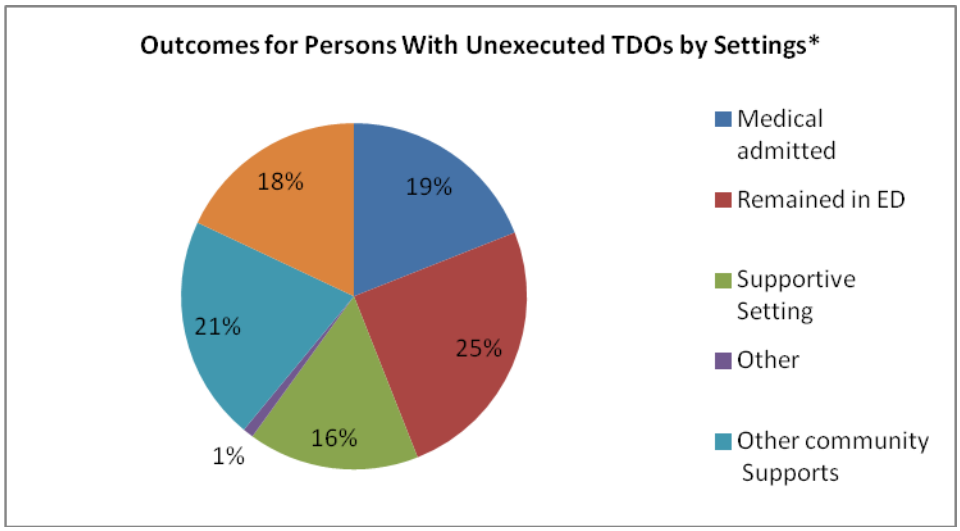
Despite the extraordinary efforts and creativity of crisis clinicians, 72 individuals statewide were unable to access the level of care determined to be appropriate to address their clinical risks – inpatient services. These mental health professionals created treatment alternatives for the individuals under their care with the support of other community providers, such as ED physicians, law enforcement officers and the magistrates. Their skilled interventions, and ability to improvise, doubtlessly averted many worse outcomes, as they worked to assure the safety of the individuals in crisis.

This variable, how these people were actually served, was the most difficult to track because 8 individuals served were transferred to a different level of care, but were eventually detained either as their behavior deteriorated or bed space became available. For example, there were three cases in which individuals were arrested because of pending charges, or their probation status was revoked in order to keep them safe because of their obvious risk factors. This action occurred with the hope, but certainly not the guarantee, that bed space would become available within a reasonable time. The clinical outcomes for some of these individuals cannot be measured from the information gathered in this study.

The following information identifies the setting in which these 72 individuals were served or supported:

- Persons remained in the ED (17)
- Community supports were implemented (15)
- Individuals were medically admitted to the hospital (13)
- Individuals released with no further intervention (13)
- Remained in supportive setting, such as with family (12)
- Individual was arrested (1)
- Admitted to a less intensive level of care (1)

Figure 7:



*The individuals for whom no further intervention occurred are not included in this chart.

BARRIERS TO DISCHARGE

The inability of state-operated facilities to return individuals to the community in a timely-manner is not only detrimental to the recovery process of the individuals, it is a contributing factor in the denial of admission for persons in need of acute or longer term services.

> When there is insufficient community capacity to receive individuals that have been stabilized and are discharge-ready, these people must remain in the state facility occupying a bed that could have been used to admit a person that clinicians had determined to meet criteria for temporary detention (TDO).

Since July 2011, the OIG has been tracking the number of individuals identified as clinically ready for discharge from the state-operated behavioral health facilities.[26] The number of individuals determined ready for discharge, but lacking a suitable discharge plan, is fluid. A monthly average over this six-month monitoring period was approximately 120 individuals; approximately 85 were classified as adult civilly committed individuals and 35 were geriatric patients.[27] According to information provided by DBHDS, the primary barrier to discharge for the adult civilly committed population is the lack of appropriate residential placement, such as residential settings with intensive supports and supervision.

The number of persons in this category includes those accepted, but on waiting lists for placement, those that have social histories that suggest significant risks factors (violent histories, multiple disabilities, and behavioral needs), and persons who require specialized funding due either to a lack of public resources or specialized needs not provided in the community. The primary barrier for the geriatric population is the lack of nursing home placement. This includes waiting list delays, guardianship concerns and resource issues.

As noted above, Virginia's system of behavioral health care is completely interdependent. The system's operating capacity, and the ability of individuals to leave a state facility and return to their community, is controlled by the weakest link (with the least capacity) in the continuum of care. Conversely, the availability of adult acute beds in state facilities to admit temporarily detained individuals is influenced by each facility's ability to transfer stabilized residents to appropriate community based programs.

STATE FACILITIES AS A SAFETY NET

> Of the 72 instances where a TDO was not executed, contact with the state facilities to determine bed availability did not occur in about half of the cases. For the remaining cases where a state facility was contacted, the primary reason for denial was that no bed was available.

[26] A report of findings from inspections at each state-operated behavioral health facility and a review of specific cases over a six-month period is scheduled for release in April 2012.

[27] This number does not include forensic individuals who have not met the criteria for conditional release.

In their role as the single points of entry into publicly funded mental health services, CSBs complete all preadmission screenings for involuntary admission to private and state-operated facilities. Emergency Services Directors informed the OIG that prescreeners are expected to contact all the available private psychiatric facilities within their region, and often beyond, before contacting the state-operated facilities to determine bed availability.

When local services are not available or appropriate, it is the responsibility of the CSBs, in conjunction with DBHDS, to "assure the availability of these safety net services on a sub-regional, regional, or statewide basis."[28] This approach allows the state-operated facilities to be used as the treatment facility of "last resort;" enabling state-facility beds to be used for the most challenging individuals for whom there are no other treatment options.

The *Creating Opportunities* Emergency Response Strategic Initiative Team indicated that one of the identified needs of the current system of care was access to the state-operated facilities for persons under a TDO. In a survey conducted by the team, access to state beds was ranked as the second area of greatest service need behind that of timely, within 24 hours, access to psychiatric evaluations and medication administration for individuals in crisis.

> While the *Creating Opportunities* team did not recommend the expansion of state-operated beds, state-operated beds will remain the only viable option for some of the most challenging persons in psychiatric crisis, until alternatives are available in the community, and, as such, the OIG cautions that additional facility downsizing or budget reductions should not occur until the necessary community-based alternative services are fully operational.

CRISIS STABILIZATION UNITS

There are currently seven crisis stabilization programs (CSUs) across the Commonwealth that accept TDOs; however, it is important to note that the admissions criteria for these programs eliminate many individuals that meet the TDO criteria because the programs will generally not accept individuals that are acutely psychotic, actively suicidal or homicidal with plan and intent, have a recent or past behavioral profile of unpredictable violence, or are highly agitated at the time of admission, are clear escape risks, or have significant medical problems. (A summary of operating CSUs is appended at Appendix D for convenient reference.)

[28] DBHDS State Board Policy 1038 (SYS) 06-1 *The Safety Net of Public Services*

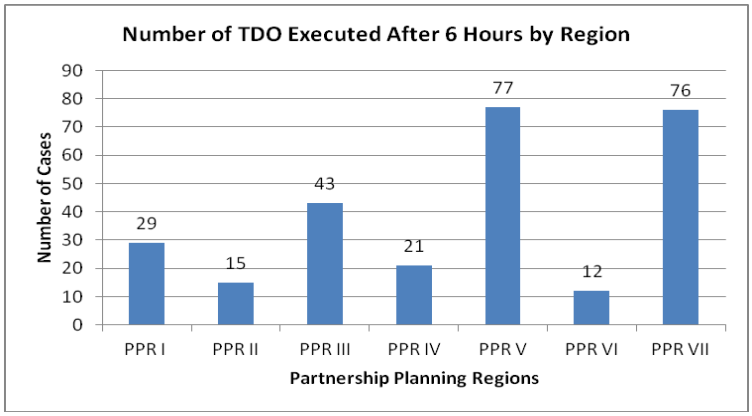
Inasmuch as CSUs typically do not accept the most challenging individuals who are actively in-crisis, the appended summary reflects that there are only 31 CSU beds statewide that currently accept (selected) individuals meeting statutory criteria for a TDO.

B. QUALITY INDICATOR: TDOS EXECUTED BEYOND 6 HOURS

During the ninety-days of this study, there were 273 cases that resulted in the issuance of a TDO beyond the 6-hour time period.

- Region V and Region VII had the highest number of cases in which it took longer than six hours to execute the TDO. The cases in these two regions represented 56% of all reported cases. Region VI had the lowest number of reported cases in this dataset.

Figure 8:



Three of the primary reasons for the delays in securing an inpatient bed in a timely manner are:

1. The length of time it takes to find a "willing" facility with an "appropriate bed";
2. The time involved to complete medical screening and secure medical clearance; and,
3. Challenging populations presenting with complex medical and behavioral profiles.

Each of these issues is discussed in this section.

- The average time for TDOs to be executed for the cases reported was 16.6 hours.
- Region V required the longest time to execute a TDO with an average of 28.3 hours.
- Region IV had the lowest average time of 8.8 hours.[29]

As previously noted, Emergency Services Directors reported that crisis clinicians are expected to contact all available private psychiatric hospital in their region, and often beyond, before contacting the state-operated facilities. This process often requires considerable time. Interviews with the ES Directors revealed that the establishment of a "real time" registry of available beds may substantially decrease the time needed to secure a bed; however, some were skeptical that the bed registry would mitigate the problems securing admission for the most challenging individuals.

The Department continues to move forward with implementation of a statewide on-line psychiatric bed registry. This initiative *theoretically* promises to create a real time summary of the bed availability at private psychiatric hospitals around the state; however, the jury is still out as to whether the bed registry will actually reduce the average time required to locate an "appropriate bed" for the most challenging individuals.

The operational reality for private psychiatric facilities is that they are obliged to consider the safety of current patients and internal staffing capabilities before admitting individuals with the most challenging behavioral profiles. The result is that a private facility may not have an *appropriate bed* for an actively psychotic, suicidal, or assaultive individual because it lacks the essential staff, especially at 2:30 am, to assure the safety of that individual, its current patients, or the facility staff.

It is noteworthy that the state's behavioral health facilities, which serve as the safety net for the most challenging individuals, face the identical operational realities as the private psychiatric hospitals; nevertheless, as the state's safety net, they are expected to maintain the flexibility to receive the most challenging individuals. If the

[29] It is noteworthy that, while there were 273 individuals whose TDOs were not executed in 6 hours, the proxy established for timely execution by the study stakeholders, these were the outliers representing only about 5 ½ % of the approximately 5,000 TDOs executed in a timely manner during this three-month study. That said, the experience of the 273 persons should not be forgotten, or dismissed, because 95% of individuals served had a more timely experience.

state-operated facilities are to serve as a reliable safety net, then they must have the *surge capacity* to respond to the unpredictable demand to serve the most challenging TDO cases 24/7.

During the summer and fall of 2011, the Inspector General crossed the Commonwealth and met with CSB Emergency Services Directors and Medical Directors of Emergency Departments (EDs) at regional hospitals serving persons with serious mental illness, and the issue of medical screening and medical clearance repeatedly surfaced as a significant problem.

Persons with behavioral health disorders suffer from medical complications at a higher rate than the general population. In fact, life expectancy for individuals with serious mental illness who are served in the public behavioral health system is estimated to be 25 years less than the life expectancy of other Americans.[30] As a result, people with psychiatric disorders frequently enter the health care system with undiagnosed medical conditions. In addition, many serious medical illnesses can create apparent psychiatric symptoms or exacerbate psychiatric disorders.

Thus, individuals with psychiatric disorders present major challenges in terms of evaluation and disposition, and most Virginia psychiatric hospitals will not admit a person unless some level of medical screening and/or medical assessment has been completed; however, medical screening and medical assessment is complicated, and resources and practices vary considerably statewide. In addition, the process can be time-consuming, and sometimes strains the legal limits of emergency custody, as is documented in this report.

To bring some consistency to medical screening and medical assessment practices statewide, DBHDS worked with key stakeholders to develop and issue a *Medical Screening and Assessment Guidance* document on April 6, 2007. Although the intention was to disseminate, adopt and implement this medical screening protocol in each of the seven behavioral health regions, it was not consistently integrated into practice as hoped. In 2010, working with the same stakeholder group, a revision of the *Medical Screening and Assessment Guidance* was begun but not completed**.** The *Guidance Materials* are attached at Appendix C.

This report will address the use of the 2007 *Guidance Materials* in the Findings and Recommendations section, but it is hoped that the DBHDS, working with the CSBs and EDs around the state, will quickly update and implement the pertinent suggestions contained in the *Guidance Materials*.

[30] J.Parks, MD (ed.), et al, *Morbidity and Mortality in People With Serious Mental Illness*, National Association of State Mental Health Program Directors Medical Directors Council, October 2006.

In the judgment of the OIG, the 2007 *Guidance Materials* address most of the issues raised by ED and ES Directors around the state and the consistent implementation of these suggestions will reduce the number of future failed TDOs.

SPECIAL POPULATIONS

A. The Geriatric Population

(*Refer to Appendix E for a case study illustrating the difficulties associated with serving the geriatric population when they are in crisis.)*

Anecdotal information provided by Emergency Services Directors across the state suggests that the placement of individuals over the age of 65 in an inpatient psychiatric setting is often challenging and age is frequently cited as a contributing factor in failed TDOs. This is reportedly due to the often chronic nature of both psychiatric and medical issues of this cohort. Many facilities will not consider admission for persons with cognitive impairments, or dementia, because dementia is considered a medical issue.[31] This is also the case for persons not quite 65 years old that display both psychiatric symptoms and possible early onset dementia that are unable to be served in geriatric facilities because they are "too young."

Securing a willing facility becomes more challenging when a geriatric patient exhibits unruly, socially inappropriate or aggressive behaviors. When there is the potential for violence, geriatric facilities are often unwilling or unable to accept the individual because of the potential risk to the other – frequently frail – persons they serve. In these cases, the person with a high potential for aggression, but in need of skilled and knowledgeable care from geriatric specialists, will be unable to have their needs addressed without access to an appropriate placement.

[31] During the course of this review, the OIG was repeatedly informed by Emergency Services Directors that there was some confusion regarding the availability of Piedmont Geriatric Hospital as a resource for the admissions of persons on a TDO when local resources were not available. This has been clarified by the DBHDS and CSBs informed of the facility's availability to assist with and/or receive hard-to-place individuals under a TDO.

Serving older adults in crisis has been a focus for the Secretary of Health and Human Resources and DBHDS. The Emergency Response Strategic Initiative Team recognized the need to address this further through partnerships with other agencies and groups that serve and support older adults when its July, 2011, report stated:

> The demand for crisis intervention for older adults is rising as more and more individuals move into old age. As individuals with behavioral health disorders and intellectual disabilities age, they are more likely to develop serious, chronic physical conditions for which routine treatment is necessary, and specialized interdisciplinary care that focuses on both physical and mental health care is critical to supporting people at home and reducing inpatient hospitalization. Specialized crisis response services for older individuals with behavioral health disorders are not widely or routinely available. DBHDS continues to work closely with health and long-term care partners to strengthen the continuum of services and supports for these individuals, including emergency and crisis response services.

B. Persons with Intellectual Disabilities

(*Refer to Appendix E for a case study illustrating the difficulties associated with serving persons with ID when they are in crisis.*)

The provision of emergency services for persons with intellectual disabilities has been a subject of concern for the OIG since 2005. The majority of CSBs did not have clear guidelines for access to the state-operated facilities resulting in unnecessary delay in securing the appropriate level of care. Service delays placed the person and the community at risk.

DBHDS has been focusing on establishing guidelines for care and, in FY 2012, $5,000,000 has been appropriated to establish new community crisis intervention services in each region for individuals with intellectual disabilities and co-occurring mental health and behavioral disorders.[32] Each region is asked to develop a proposal that focuses on crisis prevention and intervention for this population. Regional proposals were due to DBHDS by September 1, 2011 and implementation of regional programs are scheduled to be phased in during 2012.

[32] *Creating Opportunities Emergency Response Team Report*, July 27, 2011.

This strategy, based on the START model[33], holds promise of creating a system of care across providers of services and supports for persons with intellectual disabilities that shares expertise and resources towards a common goal of service.

The OIG notes that the recent *Settlement Agreement* between the Commonwealth of Virginia and the U. S. Department of Justice requires the creation of crisis stabilization programs and mobile crisis teams in each HPR to serve individuals with intellectual disabilities.

[33] START (Systematic, Therapeutic, Assessment, Respite and Treatment) is a linkage model to promote a system of care in the provision of community services, natural supports and mental health treatment to people with intellectual and developmental disability and mental health issues (IDD/ MH) (Beasley, Joan. Institute on Disability. University of New Hampshire 2002).

SECTION FIVE

FINDINGS AND RECOMMENDATIONS WITH DBHDS RESPONSE

Finding Number 1: CSB/BHA emergency services staff are the behavioral health system's *first responders* and these professionals routinely overcome formidable obstacles to cobble-together creative solutions to assure the safety of Virginians who are incapable of caring for themselves. Thanks in large measure to their dedication and skill, the majority of emergency services for Virginians in crisis are delivered as contemplated by the *Code*.

Nevertheless, during this study, 72 individuals determined to meet the statutory criteria for temporary detention were denied access to inpatient psychiatric treatment. To contextualize the 72 failed TDOs, one needs to appreciate that this number is approximately 1½% of the estimated 5,000 TDOs that were successfully executed statewide during the three-months of the study. In summary, this study confirmed that access to inpatient treatment is generally, but not always, available to people experiencing psychiatric crises.

When a person, determined by specially-trained clinicians to be incapable of caring for themselves and at risk for harming themselves or others, is unable to secure the recommended treatment and hospitalization, this outcome represents a systemic failure to address the needs of that individual and places the person and his/her community at risk. Moreover, a failed TDO may rise to the level of a *sentinel event* as defined by the Joint Commission.[34]

Finding Number 1a: The study confirmed last year's anecdotal reports of *streeting* and documented that 72 persons, meeting statutory criteria for temporary detention were denied admission to public and private behavioral health facilities.[35]

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[34] "A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." The Joint Commission, January, 2011: (http://www.jointcommission.org)

[35] Wherever possible in this Report, the OIG has substituted "failed TDO" for "streeted" because of reasonable objections to the negative connotations attached to the terms "streeted" or "streeting." The term "streeted" was used in Hampton Roads to categorize individuals that met criteria for temporary detention who received a less intensive intervention than inpatient treatment – or no intervention and were released. In this study, the majority of these 72 cases received a less intensive intervention than inpatient treatment.

Recommendation Number 1a: That DBHDS identify "UNEXECUTED TDO" as a Quality Indicator of access to clinically appropriate services and develop a mechanism that allows for consistent tracking of such incidents at the Board and regional level.

DBHDS Response*: DBHDS supports this recommendation.*

Finding Number 1b: The study documented that TDOs for at least 273 individuals were executed beyond the six-hour time limit imposed by statute: This is approximately 5½% of the estimated 5,000 TDOs executed during the three-month study. The experience for these citizens was that it required a statewide average of 16.6 hours for the order to be executed and for them to be admitted for the clinically indicated services.

Recommendation Number 1b: That DBHDS identify "TDO EXECUTED BEYOND 6 HOURS" as a Quality Indicator for the timely execution of TDOs, and develop a mechanism that allows for consistent tracking of such incidents at the Board and regional level.

DBHDS Response: *DBHDS supports this recommendation.*

Finding Number 2: Ineffective medical screening and clearance processes for persons restrained for evaluation under ECOs and TDOs have been, and remain, a chronic challenge in the Commonwealth. In 2007, the DBHDS published thoughtful *Guidance Materials* addressing many of the issues identified by ED Medical Directors and CSB ES Directors throughout the state in recent discussions with the Inspector General; however, to date, the recommendations of the *Guidance Materials* have not been consistently adopted statewide.

There is broad consensus that adoption of best practices and the common understanding articulated in the *Guidance Materials* will improve outcomes for persons served, bring down costs system wide, and reduce the number of failed TDOs.

Recommendation Number 2a: That the DBHDS assemble an *ad hoc* group of stakeholders to review and update the *Medical Screening and Assessment Guidance* Material *(March 13, 2007)* as necessary, and reissue these constructive guidelines by October 30, 2012.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 2b: That the DBHDS include a provision in its next *Performance Contract* with all CSBs requiring specific local or regional monitoring of problems associated with medical screening and clearance for persons meeting criteria for an ECO or a TDO, and report results to the DBHDS at regular intervals.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 2c: That the DBHDS coordinate an effort among all state-operated facilities to immediately adopt and implement the recommendations and approach of the *Guidance Materials* and develop best practices to drive quality improvement in this vital area.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 2d: That the DBHDS monitor the implementation of the *Guidance Materials* by CSBs and state-operated facilities and publish its report by April 15, 2013, detailing the progress of this initiative.

DBHDS Response: *DBHDS supports this recommendation.*

Finding Number 3: This study revealed that state-operated behavioral health facilities were not consistently contacted, or utilized, as an available resource for individuals assessed as appropriate for inpatient level of care under a temporary detention order. Facilities were not contacted in approximately half of the 72 cases in which a TDO was warranted, but not executed.[36] Failure, or inability, to utilize the state-operated facilities as a safety net may contribute to extended and unnecessary stays in local emergency rooms and placement of individuals in less appropriate levels of care; potentially placing both the individual and the community at risk.

Recommendation Number 3a: It is recommended that DBHDS and the CSBs develop working protocols for assuring that state-operated facilities, or the regional access (utilization) committees, are contacted in each case in which local placement of persons determined to need inpatient care is not secured. The responsibilities of each entity in facilitating a TDO admission to the DBHDS facility should be detailed in the protocols. The protocols should

[36] The survey instrument did not record why state facilities were not contacted – noting only the lack of contact. It may be that some screeners knew from previous conversations that the state facility was at capacity and was not accepting TDO admissions.

be consistent with the intent of State Board Policy 1038 (SYS) 06-1: *The Safety Net of Public Services*.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 3b: It is recommended that DBHDS establish a quality improvement initiative for monitoring TDO admissions to the state-operated behavioral health facilities with periodic reporting to the Commissioner and the OIG.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 3c: It is recommended that, from among each region's CSBs, a senior-level person be designated and empowered to locate a private or state-operated facility with an appropriate bed to admit individuals meeting statutory criteria for temporary detention.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 3d: It is recommended that the DBHDS develop a viable system that responds any time that an individual meeting statutory criteria for temporary detention is denied admission to a state-operated facility. The intent of this recommendation is to empower a senior member of the DBHDS to contemporaneously consult, or to intervene where necessary and appropriate, with regional utilization managers to create an alternative to a failed TDO for persons requiring hospitalization or treatment.

DBHDS Response: *DBHDS supports this recommendation.*

Finding Number 4: PPR III and PPR V had a disproportionate number of failed TDOs compared to other regions of the state – accounting for 75% of the total failed TDOs during the study period.

Recommendation Number 4: That this study be repeated in FY 2013 in PPR III and PPR V to determine what progress has been made to eliminate failed TDOs from these two regions.

DBHDS Response: *DBHDS supports this recommendation and will collaborate with the Office of the Inspector General on study implementation.*

Finding Number 5: That private psychiatric hospitals regularly lack an *appropriate bed* to serve some of the most challenging individuals. The regional state facilities in PPR III (SWVMHI) and PPR V (ESH) are regularly at full operating capacity and unable to admit persons meeting criteria for temporary detention. The lack of private or public beds to receive TDOs contributes to the number of failed TDOs in these two regions of the state.

> **Recommendation Number 5:** That immediate consideration be given by the Regional Access Committees in PPR III and PPR V to developing performance contracts with one or more private facilities in PPR V and PPR III to create a category of "intensive beds" in a milieu and environmental setting that can serve some of the most challenging individuals admitted under a TDO – without jeopardizing the safety of other patients, staff, or the person.
>
> ***DBHDS Response:*** *DBHDS supports increased access to inpatient or other clinically appropriate treatment settings in the community for persons needing this level of care and will work with CSBs and regions to help identify needs, develop options, and identify needed resources.*

Finding Number 6: In Southwest Virginia and Hampton Roads, the state-operated facilities are, at times, unable to provide safety net admissions for individuals that are incapable of caring for themselves because Eastern State Hospital (ESH) and Southwest Virginia Mental Health Institute (SWVMHI) are regularly at, or beyond, their operating capacities.

In the judgment of the OIG, if the Commonwealth is to eliminate failed TDOs, and the attendant risk to the person, their family, and the community, and to provide a reliable safety net for its citizens, it must create additional community capacity to serve discharge-ready individuals currently residing at ESH and SWVMHI.

> **Recommendation Number 6:** That the DBHDS evaluate the relevant issues at SWVMHI, ESH, and each region's unique problems and identify the additional programs and resources necessary to create the community capacity needed to allow these state-operated facilities the census flexibility to become reliable safety nets for individuals determined to need temporary detention and treatment.
>
> ***DBHDS Response:*** *DBHDS supports this recommendation.*

Finding Number 7: Anecdotal reports suggest that, in some locales, this study has raised the consciousness of some CSBs that consumers were not receiving the services deemed necessary to assure their safety and the safety of others. To their credit, these CSBs report sharpening their focus on failed TDOs, and they have commenced closely monitoring the treatment and outcomes for these individuals.

No recommendation associated with this Finding

APPENDIX A

Total Statewide Cases Reported by CSB

Appendix A - Total Statewide Cases Reported by CSB (Figure 9):

PPR	CSB	2010 Pop. Est.*	Total Cases	Cases TDO Was Not Obtained	Cases over 6 Hours
I	Central VA	252,634	4	0	4
I	Northwestern	222,152	11	3	8
I	Rapp-Rapidan	166,054	5	2	3
I	Region Ten	234,712	12	1	11
I	Rockbridge	40,730	2	0	2
I	Valley	120,823	1	0	1
I	Rapp-Area	327,773	0	0	0
I	Harrisonburg-Rockingham	125,228	0	0	0
Subtotal		**1,490,106**	**35**	**6**	**29**
II	Alexandria	139,966	3	1	2
II	Arlington	207,627	3	0	3
II	Loudoun	312,311	1	0	1
II	Prince William	454,096	13	4	9
II	Fairfax-Falls Church	1,116,623	0	0	0
Subtotal		**2,230,623**	**20**	**5**	**15**
III	Cumberland Mtn	98,073	13	11	2
III	Dickenson County	15,903	6	5	1
III	Highlands	72,711	3	1	2
III	Mt. Rogers	120,884	28	6	22
III	New River Valley	178,237	17	6	11
III	Planning District 1	94,174	8	3	5
Subtotal		**579,982**	**75**	**32**	**43**
IV	Crossroads	104,609	4	2	2
IV	Hanover	99,863	1	0	1
IV	Henrico	332,620	7	0	7
IV	District 19	173,463	2	1	1
IV	RBHA	204,214	10	0	10
IV	Chesterfield	316,236	0	0	0
IV	Goochland	49,763	0	0	0
Subtotal		**1,280,768**	**24**	**3**	**21**
V	Chesapeake	222,209	3	1	2
V	Colonial	158,691	2	0	2
V	Eastern Shore	45,553	6	6	0
V	Hampton NN	318,155	11	4	7
V	MPNN	141,255	1	0	1
V	Norfolk	242,803	28	4	24
V	Portsmouth	95,535	4	1	3
V	VA Beach	437,994	41	4	37
V	Western Tidewater	147,007	3	2	1
Subtotal		**1,809,202**	**99**	**22**	**77**
VI	Danville-Pitts	106,561	9	4	5
VI	Piedmont	142,621	4	0	4
VI	Southside	86,402	3	0	3
Subtotal		**335,584**	**16**	**4**	**12**
VII	Alleghany-Highlands	22,211	1	0	1
VII	Blue Ridge	252,548	75	0	75
Subtotal		**274,759**	**76**	**0**	**76**
	TOTAL	**8,001,024**	**345**	**72**	**273**

* Based on entire population of PPR, including children, adolescents and adults; assuming a relatively equal distribution of these numbers across all CSBs

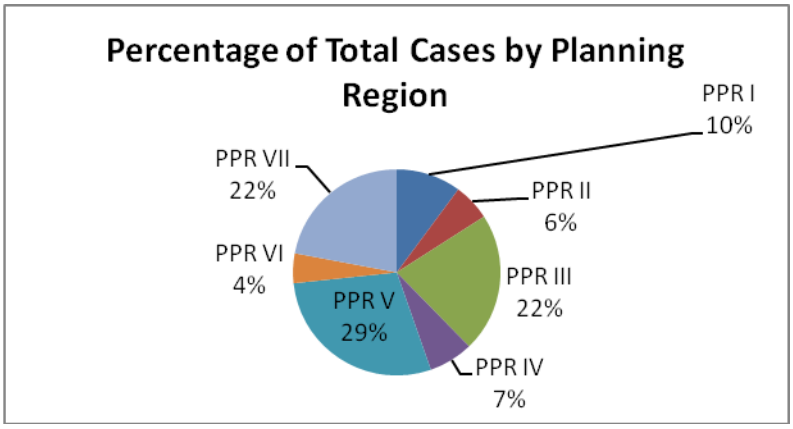
APPENDIX B

Summary of Statewide Survey Data Reported by CSBs

Appendix B – SUMMARY OF STATEWIDE SURVEY DATA REPORTED BY CSBS

- During the 3-month review period, there were 345 reported cases that met the two criteria established by this study.
    - Region V had the highest number of total cases (99). The region's cases represented 29% of all the reported cases that met the two criteria established by the study. Region II and Region VI had the lowest number of total cases with 20 (6%) and 16 (4%).

Figure 10:

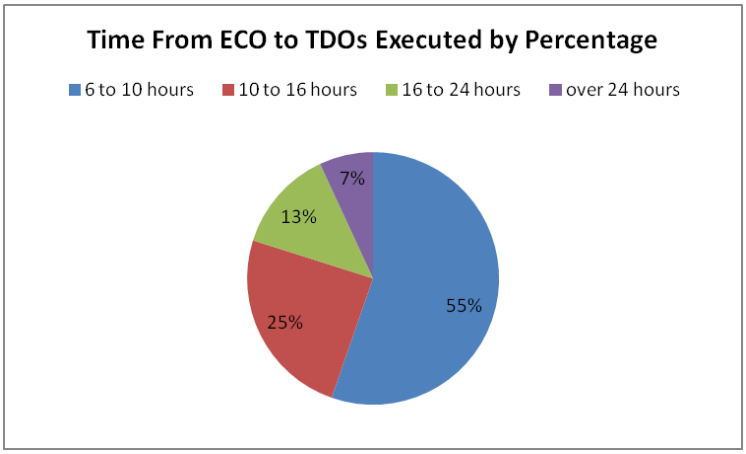


- Fifty-seven percent or 198 cases were initiated through an emergency custody order.
    - Of the 198 cases initiated by the issuance of an emergency custody order, 159 or 80% resulted in the issuance of a TDO.
- The average amount of time from the issuance of the ECO to the execution of the TDO for the 159 reported cases was 12.6 hours.
    - The longest average time from ECO to the execution of a TDO was 19.41 hours. This was in Region V.
    - Region VI had the lowest average time at 8.1 hours.
        - The average time from ECO to the execution of the TDO for the Regions were as follows:
            - PPR I – 9.03 hours
            - PPR II – 11.19 hours
            - PPR III – 10 hours

- PPR IV – 11.57 hours
- PPR V – 19.41 hours
- PPR VI – 8.1 hours
- PPR VII – 12.81 hours

- Eighty-eight or 55.35% of the reported cases that began with an ECO took between 6 to 10 hours for the TDO to be executed; 39 or 24.53% took between 10 to 16 hours for the TDO to be executed; 21 or 13.21% took between 16 to 24 hours for the TDO to be executed; and 11 or 6.92% took over 24 hours for the TDO to be executed.

Figure 11:

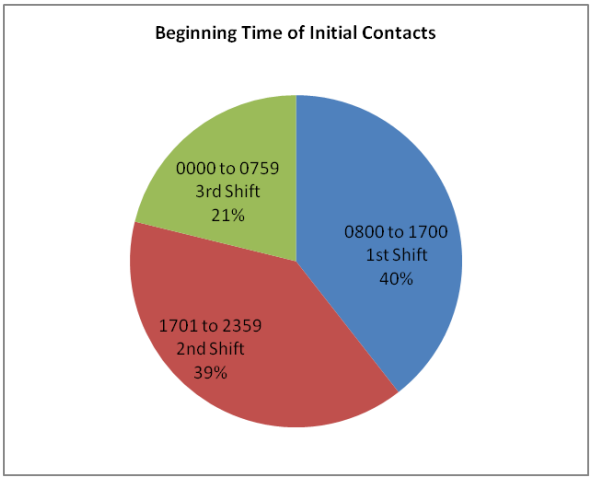


- The vast majority, 68.12%, of the initial contacts occurred in community-hospital emergency rooms. Additional settings included:

  - Other Community Settings, such as a licensed program or CSB office (13.91%)
  - Law Enforcement Settings (8.12%)
  - Non- state hospital units, either medical or psychiatric (6.96%)
  - Non-state psychiatric facilities (1.74%)

- There were 136 contacts initiated during the day shift (0800 to 1700) and 136 contacts initiated during the evening shift (1701 to 2359), representing 39.42% of the total contacts each shift. There were fewer contacts, 73 or 21.16%, initiated during the night shift (0000 to 0759).

Figure 12:



- The average age for the individuals in this study was 44.39 years old. The youngest person was 20 years old and the oldest was 78 years old. There was not a significant difference in ages of the individuals.

    - 52 individuals or 15.07% of the total were between the ages of 18 and 25
    - 78 or 22.61% were between the ages of 26 to 35
    - 66 or 19.13% were between the ages of 36-45
    - 61 or 17.68% were between the ages of 46 to 55
    - 40 or 11.59% were between the ages of 56 to 65
    - 48 or 13.91% were over the age of 65.

- 246 (71.30%) of the 345 cases that met both criteria had a payor source.

    - 78 individuals or 22.61% of the cases had Medicare
    - 126 individuals or 36.52% of the cases had Medicaid
    - 32 individuals or 9.28% had private insurance
    - 5 individuals or 1.45% had coverage through Veteran's Affairs
    - 34 individuals or 9.86% were identified as self-pay
    - 63 individuals or 18.26% were identified as indigent, no insurance and no self pay
    - LIPOS or other project funding was used for 5 individuals or 1.45% of all the cases

Unexecuted TDOs

- Seventy-two cases represented individuals determined in need of a TDO due to their presenting clinical risk(s) for which a TDO could not be executed.

Figure 13:

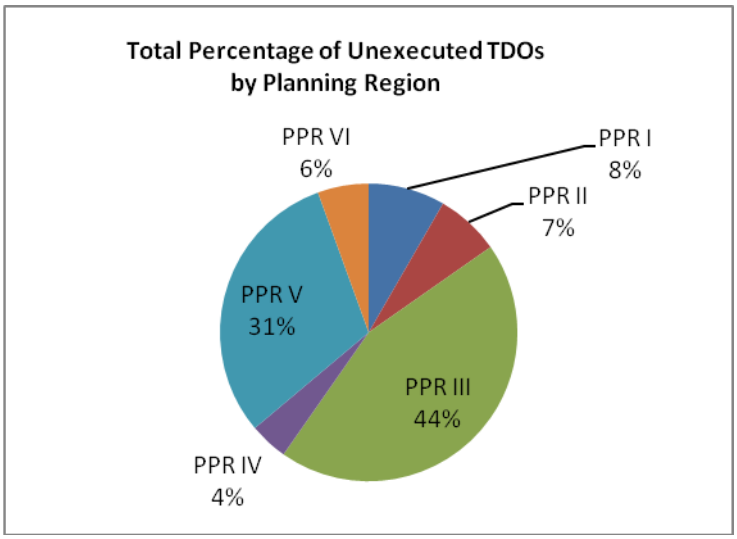


Figure 14:

ADMISSIONS TO STATE FACILITIES BY REGION

	PPR I	PPR II	PPR III	PPR IV	PPR V	PPR VI	PPR VII	TOTAL
CAT	1	0	2	0	0	0	19	**22**
CSH	0	0	0	7	0	0	0	**7**
ESH	0	0	0	0	7	0	0	**7**
NVMHI	0	5	0	0	0	0	0	**5**
SVMHI	0	0	0	0	0	6	0	**6**
SWVMHI	0	0	26	0	0	0	0	**26**
WSH	5	0	0	0	0	0	0	**5**
TOTAL	**6**	**5**	**28**	**7**	**7**	**6**	**19**	**78**

- Of the 72 cases in which a TDO was not executed, contact with the state facilities to determine if a bed was available did not occur in half of the cases.
    - For the remaining cases in which a state facility was contacted, the primary reason for denial at the time of the request for assistance was that no bed was available.

Figure 15:

Non-Executed TDOs for Which State Facilities not Contacted

CSB	Region	# Incidents in Which State Facility not Contacted
Northwestern	1	1
Rapp-Rapidan	1	1
Region Ten	1	1
Subtotal		**3**
Prince William	2	1
Subtotal		**1**
Cumberland Mt.	3	7
Dickenson Cty	3	2
Subtotal		**9**
Chesapeake	5	1
Eastern Shore	5	5
Hampton NN	5	4
Norfolk	5	4
Portsmouth	5	1
VA Beach	5	4
Western Tidewater	5	1
Subtotal		**20**
Danville-Pitts.	6	3
Subtotal		**3**
	Total	**36**

- The average number of private psychiatric facilities contacted in an effort to secure a bed in a willing facility was 10.56 calls.

    - For the 72 cases that met the criteria for a TDOs but the TDO was not executed, the primary reason for denial cited by the private psychiatric facilities contacted was there were no beds available at the time of the contact. This involved 40 cases or 56% of the total cases.

    - The secondary reason cited by the private psychiatric facilities for denial for admission was the acuity level or care needs of the individuals.

- Of the 72 cases in which a TDO was not executed, 39 cases (54%) were initiated through the issuance of an emergency custody order (ECO).

- The majority (61%) of persons for which a TDO could not be executed had insurance coverage.
    - 24 individuals or 33.3% had Medicare
    - 27 individuals or 37.5% had Medicaid
    - 8 individuals or 11.1% had private health insurance
    - 2 individuals or 2.8% had coverage through Veteran's Affairs
    - Of the remaining 11 individuals, 3 or 4.2% were classified as self pay and 8 or 11.1% were considered indigent care, uninsured and no self pay

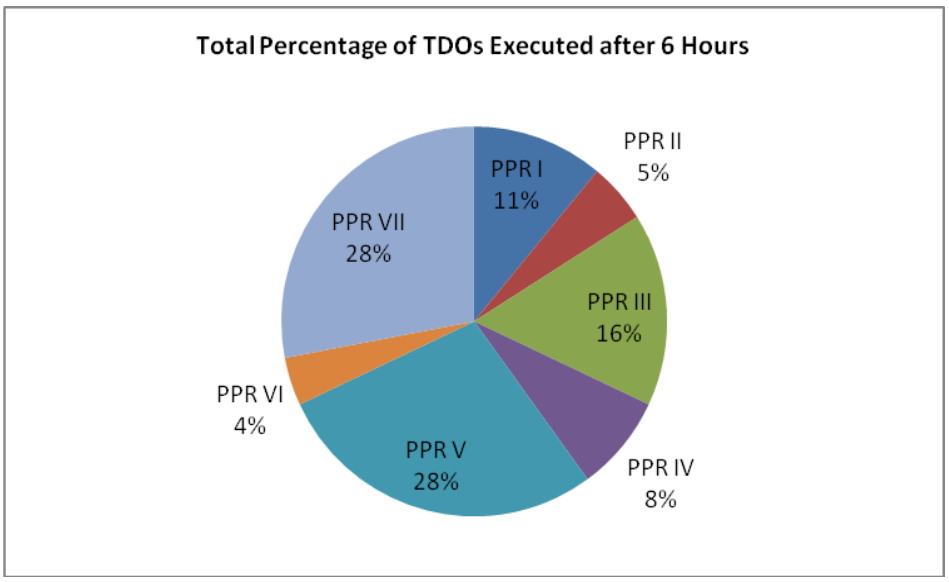
<u>TDOs Issued Beyond 6-Hour Time Period</u>

- There were 273 cases that resulted in the issuance of a TDO beyond a 6-hour time period.

    - Region V and Region VII had the highest number of cases, 77 and 76 cases respectively, in which it took longer than six hours to execute the TDO. The cases in these two regions represented 56% of all reported cases.

    - Region VI had the lowest number of reported cases (12) in this dataset.

Figure 16:



- The average length of time it took for TDOs to be executed for the cases reported was 16.6 hours.
    - Region V showed the highest length of time for executing a TDO which on average took 28.3 hours.
    - Region VI had the lowest average length of time which was 8.8 hours.
    - The average length of time for TDO cases to be executed by region is as follows:
        - PPR I – 9.2 hours
        - PPR II – 11.5 hours
        - PPR III – 11.7 hours
        - PPR IV – 15.3 hours
        - PPR V – 28.3 hours
        - PPR VI – 8.8 hours
        - PPR VII – 12.9 hours
- 225 or 82.42% of all the executed TDO were to a willing facility within the CSB's region.
- Of the 273 cases that involved an executed TDO, 78 or 29% were admitted to a state facility.

APPENDIX C

Medical Screening and Assessment: Guidance Materials

Medical Screening and Assessment

Guidance Materials

Developed by

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

Virginia Association of Community Services Boards

Virginia Hospital and Healthcare Association

Virginia College of Emergency Physicians

March 13, 2007

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This *Medical Screening and Assessment Guidance* was produced by a workgroup representing the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the Virginia Association of Community Services Boards (VACSB), the Virginia Hospital and Healthcare Association (VHHA), the Virginia College of Emergency Physicians (VCEP), and the Virginia Department of Medical Assistance Services (DMAS). Special appreciation is given to the following individuals who made valuable contributions to this work:

Virginia DMHMRSAS

Cheryl Chittum, Director of Community & Clinical Services, Southern Virginia MH Institute
David Brady, MD, Staff Psychiatrist, Southwestern Virginia MH Institute
James Martinez, Director, Office of Mental Health, DMHMRSAS
George Martin, MD, Medical Director, Southwestern Virginia MH Institute
Jane McDonald, Community Support Specialist, Office of Mental Health, DMHMRSAS
Rosemarie Bonacum, Director, Office of Facility Operations, DMHMRSAS
Jerry Deans, Assistant Commissioner, Division of Facility Management, DMHMRSAS
Yad Jabbarpour, MD, Chief of Staff, Catawba Hospital
James Evans, MD, Medical Director, Office of Health and Quality Care, DMHMRSAS
Cynthia McClaskey, PhD, Director, Southwestern Virginia MH Institute

Virginia Association of Community Services Boards

Mary Ann Bergeron, Executive Director, VACSB
Joe Scislowicz, Director of Clinical Treatment Services, Western Tidewater CSB
Rita Romano, Emergency Services Division Manager, Prince William County CSB
Lillian Mezey, MD, Medical Director, Valley CSB

Virginia Hospital and Healthcare Association

Betty Long, Vice President, VHHA
Lynn Szostek, Administrator, Tucker Pavilion, CJW Medical Center
Susan Ward, JD, Vice President and General Counsel, VHHA
Dan Harrington, MD, Medical Director, Carilion Behavioral Health
Mark Kilgus, MD, PhD, Chair, Dept. of Psychiatry and Behavioral Medicine, Carilion Clinic

Virginia College of Emergency Physicians

Gary S. Kavit, MD, FACEP, Riverside Hospital
Gwen Harry, Executive Director, VCEP

Virginia Department of Medical Assistance Services

Catherine Hancock, Mental Health Policy Analyst, DMAS

PART 1: INTRODUCTION

1.1 Why Is Medical Screening and Assessment of Persons in the Mental Health System Important?

People can enter the health system with what appears to be a psychiatric disorder when an underlying (and possibly life-threatening) primary medical or surgical problem, masking itself as a disturbance of affect, cognition or behavior, is the real cause of the problem. Treatment should be medical and surgical, and not involve admission to a psychiatric setting. In addition, people with psychiatric disorders frequently enter the health care system with undiagnosed medical conditions. The medical literature documents that persons with mental illness have more concurrent medical illness than the general population, and individuals with mental illness can present significant challenges in terms of evaluation and disposition. Many serious or life threatening medical illnesses can create or exacerbate psychiatric symptoms, as well as complicate the symptomatic presentation of the individual or represent severe disease requiring urgent treatment. For these reasons, psychiatric hospitals today justifiably emphasize the importance of careful medical screening and assessment prior to admission of any person, and most hospitals will not admit a person unless such screening has been completed.

1.2 The Context of Medical Screening and Assessment in Virginia's Public Mental Health System Today:

At present, medical screening and assessment is difficult to accomplish in a timely and effective manner. There are a number of underlying factors contributing to the present situation, including the following:

- In general, emergency health and mental health care systems in Virginia are straining to meet current demands for service;
- There is no explicit consensus on what constitutes appropriate medical screening and assessment, and different psychiatric hospitals may impose different medical screening and assessment requirements based upon their ability to assess and manage medical and surgical issues;
- Medical and psychiatric screening and assessment resources vary considerably among hospitals and communities across Virginia;
- The medical treatment capacity of many psychiatric hospitals, including state hospitals, has been significantly reduced in recent years;
- Emergency Departments, psychiatric units and hospitals may be unaware of each others' abilities (and limitations) to meet the medical and surgical needs of consumers;
- Virginia statutes governing emergency custody, temporary detention and involuntary commitment of persons with mental illness contain no explicit standards and procedures for ordering or carrying out medical screening and assessment;
- There is no consensus on who is responsible for which components of the medical screening and assessment process;

- Medical screening and assessment, when completed, can be time-consuming and the persons involved can be tied up for prolonged periods. The time taken to complete the medical screening and assessment process often stretches legal limits and law enforcement officers are severely strained to maintain custody of the person, provide transportation, and safeguard patient, staff and community safety;
- The interests of consumers often seem the least important;
- Mechanisms to resolve operational and policy issues regarding medical screening and assessment are not uniformly in place at state, regional and local levels. Communication between providers is often haphazard, and unresolved issues contribute to frustration and conflict between the parties involved, vs. collaboration and partnership.
- Hospitals must comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) and are concerned about EMTALA and related issues.

1.3 *Office of Inspector General's 2005 Review of Medical Screening and Assessment:*

The above-referenced problems have been well documented but unresolved for many years. Most recently, the Office of the Inspector General's 2005 *Review of the Virginia CSB Emergency Services Programs* found that "*the delays, costs, legality and inconsistency among hospitals of* [medical screening and assessment] *practices are a major source of concern among stakeholders, hospital medical emergency rooms, and consumers.*" In response to this finding, the Office of the Inspector General (OIG) recommended that "*...DMHMRSAS develop and implement clear and consistent standards regarding medical clearance for all state hospitals and work with the Virginia Hospital and Health Care Association, and other appropriate bodies, to achieve a similar outcome for private hospitals.*" This guidance responds to the above recommendation.

1.4 *Development of This Guidance:*

This medical screening and assessment guidance was developed jointly by clinical and administrative representatives of the Department of MH, MR and SA Services; the Virginia Association of Community Services Boards; the Virginia Hospital and Healthcare Association; and the Virginia College of Emergency Physicians. The Department of Medical Assistance Services also reviewed this guidance.

1.5 *Intended Use of This Guidance:*

This guidance is intended for use by state and community psychiatric hospitals, hospital emergency departments, and community services board providers. Its objectives are to create a common understanding of medical screening and assessment, to delineate clearly the responsibilities and expectations for medical screening and assessment among key partners, and to support consistent application of medical screening and assessment procedures by all parties in responding to persons with mental illness in emergency situations. This protocol applies only to the medical screening and assessment components of the evaluation process that occurs prior to admission of an individual to a psychiatric hospital.

PART 2: MEDICAL SCREENING AND ASSESSMENT: GENERAL INFORMATION

2.1 Purpose of Medical Screening and Assessment:

The primary purpose of medical screening and assessment is safety, i.e., to prevent someone with an illness or medical condition from being sent to a treatment facility that cannot manage the person's illness or condition, thereby exposing the person and the system to the risk of a medical or surgical condition going undiagnosed and untreated. Failure to detect and diagnose underlying medical disorders may result in significant and unnecessary morbidity and mortality, invasion of an individual's life and constitutionally guaranteed liberties and liability to community systems and transferring physicians. Effectiveness, efficiency and timeliness are also important dimensions of the medical screening and assessment process that are necessary to ensure safety and quality.

2.2 What is Medical Screening and Assessment?

Medical screening and *medical assessment* are terms that describe two different levels of inquiry about a person's health or medical condition:

- *Medical screening* is the collection of information about the non-psychiatric medical condition of an individual to determine whether there is a need for a further *medical assessment* before a decision is made regarding referral to another provider. In practice, medical screening may be performed by non-medical or non-physician clinical staff or by a licensed physician.

- *Medical assessment* is an in-depth assessment of an individual's non-psychiatric medical condition that occurs after *medical screening* and is only performed by a licensed physician.

Medical screening and assessment is ongoing until it has been determined that the individual is stabilized, or until the individual is discharged or transferred. This process must be clearly and completely documented in the individual's record.

2.3 "Medical Screening and Assessment" vs. "Medical Clearance":

Medical clearance is another term that is frequently used by providers in this context. It is instructive that the Massachusetts College of Emergency Physicians found the term *medical clearance* to be widely misunderstood, but so widely used in the field that it probably could not be eliminated. In its "Consensus Statement on Medical Clearance", the MACEP group strongly cautioned providers that "*the term medical clearance may convey unwarranted prospective security regarding the absence of any prospective medical risks*" and narrowed its applicability to the following: "*Medical clearance reflects short term but not necessarily long term medical stability within the context of a transfer to a location with appropriate resources to monitor and treat what has been currently diagnosed.*" A careful description of the person's actual medical condition is always more informative than saying "this person has *medical clearance*" or " this person is *medically clear*".

2.4 Medical Screening and Assessment Domains:

Comprehensive medical screening and assessment of persons with mental illness in emergencies involves collecting and developing information in four domains:

- The person's history:
- A mental status exam:
- A physical exam (including neurological exam, based on clinical need), and
- Laboratory and radiological studies (these studies should be judicious, and based on clinical need).

Practitioners should think about the person being examined and understand this process holistically rather than in terms of psychiatric *vs.* medical. The goal is to complete a good overall evaluation to discover what is occurring with the individual in question, and to determine the best way to treat this person.

PART 3: THE MEDICAL SCREENING AND ASSESSMENT PROCESS

3.1 The Medical Screening and Assessment Process:

Medical screening and assessment starts with the assumption that each individual is or may be suffering from an underlying medical or surgical condition. Medical screening and assessment must also take into account multiple variables, including the context of the individual's medical condition, including the gravity of behavioral issues, the risks associated with whatever medical condition may or may not exist, the medical treatment capacity of any receiving facility, the time needed to transport the person to any given facility, and the individual's own resiliency.

Notwithstanding the above, standardized testing applied to all persons is wasteful and inefficient. Standardized laboratory testing should be avoided. Rather, the medical screening and assessment procedures that are performed by practitioners should be based on the person's individual circumstances at that time and related factors such as how well the practitioner knows the person already, or how reliable or accessible are other sources of information, etc. The individualized medical screening and assessment process includes the following steps:

3.2 *Medical Screening:*

Medical screening occurs in conjunction with a complete mental status examination. With the person's consent, the *medical screening* process follows these steps:

1. A designated clinician (may be non-physician) obtains information about the person's past medical illnesses and conditions, previous psychiatric and medical hospitalizations, psychoactive and other medications used, and substance use or dependence.

2. The designated clinician obtains information about present medical illnesses (such as and especially diabetes, hypertension, seizure disorder) and medical conditions (such as pain, bleeding, blurring of vision, trouble urinating, etc.), psychoactive and other medications currently being used and recent substance use or dependence (including alcohol, cannabis, opiates).

3. The designated clinician obtains basic vital signs including pulse, temperature, blood pressure, and respiration.

4. The designated clinician observes the person's overall physical condition (e.g., sweating, red in the face, unable to stand up, slumped over, drowsy, overactive or agitated, etc.).

5. The designated clinician evaluates the person for delirium (e.g., sudden onset of symptoms, fluctuating consciousness, etc).

6. If the observations and findings from steps 1-5, above, indicate a need for any further medical evaluation, then the designated clinician refers the person to a physician for further *medical assessment*.

Note: The medical screening process, findings and decisions must be clearly and completely documented in the consumer's record and communicated to the appropriate personnel to ensure that there is continuity of care and a smooth disposition for further treatment.

3.3 *Medical Assessment:*

If further *medical assessment* is indicated based on the observations and findings from the medical screening process, above, then the following steps are completed by a physician with the consent of the person:

1. The physician obtains a medical history.

2. The physician performs a general physical exam, including mental status and neurologic exams therein.

3. The physician obtains selective laboratory and other diagnostic tests, as indicated.

4. The physician consults with pertinent on-call physicians and other health providers.

5. The physician re-assesses the individual prior to discharge or transfer if necessary.

Note: The medical assessment must be clearly and completely documented in the consumer's record and communicated to the appropriate personnel to ensure that there is continuity of care and a smooth disposition for any further treatment.

3.4 Sources of Information for Medical Screening and Assessment:

Clinicians performing medical screening and assessments should gather medical information about a person from several sources, including

- The person;
- The person's family, friends and others;
- Community service board staff and other care providers;
- CSB and other care provider records;
- Law enforcement officers who may be involved.

PART 4: IMPLEMENTING MEDICAL SCREENING AND ASSESSMENT: PRACTITIONER GUIDANCE

4.1 Responsibility for Medical Screening:

All involuntary admissions and many voluntary admissions to psychiatric facilities require CSBs to complete a preadmission screening of the person prior to hospitalization. If the person with mental illness is examined in any setting other than a hospital Emergency Department, inpatient or nursing facility when the decision is made to evaluate the need for psychiatric hospitalization, and regardless of the person's legal status at the time of the evaluation (i.e., whether under voluntary circumstances, in law officer custody or under ECO), CSB emergency services staff should also carry out as much of the medical screening process as possible (see medical screening steps, above). Using whatever resources they can, CSB staff should collect as much medical screening information as possible as quickly as possible during the course of the evaluation process.

It should be emphasized that the responsibility of CSB emergency service staff regarding the medical screening process outlined above is to *gather* and *report* medical information, not *evaluate* and *interpret* this information.

When the person is already in an inpatient hospital or nursing facility, medical screening information will be obtained by the designated facility staff. CSB emergency services staff, however, will need to communicate the medical screening information to the receiving psychiatric facility. Notwithstanding the above, EMTALA[1] regulations regarding evaluation and treatment, including medical screening and assessment, will apply whenever a person is seen in a hospital Emergency Department. Any medical screening undertaken in this circumstance should be based on current clinical need.

4.2 Responsibility for Medical Assessment:

Medical assessment, as described above, must be completed by a licensed physician.

4.3 Communicating Individual Medical Screening and Assessment Information:

When a person experiencing a psychiatric emergency is evaluated in a hospital emergency department, EMTALA regulations will apply. Many emergency interventions by CSB clinicians take place in non-medical settings as well. In either case, decisions about specific tests and other medical assessments that should be undertaken should be based on an understanding of each person's specific medical situation and his/her clinical needs at that time. Thus, timely and effective communication among CSB emergency clinicians, hospital ED medical staff, and referring and admitting hospital medical staff is essential to facilitate the decision-making and disposition process. Key elements of this communication include:

[1] *Emergency Medical Treatment and Active Labor Act* (1985) and subsequent amendments.

- *Communication should start immediately:* Communication between referring and receiving clinicians and facilities should be initiated immediately by CSB staff, at the beginning of the screening process, so that medical and other staff can evaluate the significance of any findings in terms of the receiving facility's ability to manage and treat the person's presenting symptoms and condition.

- *Communication should be directly between fact-finders and decision-makers:* All findings of the person's history and examinations that are identified during the medical screening and assessment process should be reported directly to an appropriate medical staff member at the receiving psychiatric facility who is empowered to make medical determinations and admission decisions, and who can resolve disagreements.

- *Medical testing and lab work should be decided through communication between physicians on a case-specific basis:* Any additional physician evaluation, laboratory work or other testing that is *in addition to* the medical screening process should be based on clinical need determined through direct communication and consultation between the referring and receiving physicians.

- *Communication should be person-specific and clear:* Communications to admitting psychiatric hospitals should clearly describe the person's actual condition and needs. Similarly, hospitals should clearly articulate their capabilities to meet those needs. Statements such as "[This person] has medical clearance" or "[This person] is medically clear" should be avoided.

4.4 Consent for Medical Screening and Assessment:

Medical examinations or tests for which the individual's consent is required shall not be performed over the person's objections. If the individual is incapable of consenting and objects to the examination or testing, an order must be obtained pursuant to §37.2-1104 to conduct any necessary testing, observation or treatment.

4.5 Resolution of Disagreements Between Practitioners and Facilities:

Practitioners involved in the medical screening and assessment process (i.e., general hospital staff, CSB staff, emergency department staff, and psychiatric hospital staff) will not always agree on the level of medical risk associated with a person's condition and/or what should be done next to provide safe, effective and timely care. When these situations occur, practitioners must resolve the disagreement quickly. General hospitals, emergency departments and state and local psychiatric hospitals should have in place at all times an empowered physician decision-maker who is available immediately to discuss and resolve disagreements when they arise.

4.6 Reimbursement for Medically Necessary Medical Screening and Assessment:

Language in the *Code of Virginia* and the 2007-2008 *Appropriations Act* allows reimbursement for medically necessary medical screening and assessment services provided to individuals during the period of emergency custody or temporary detention. Reimbursement is through the Involuntary Mental Commitment Fund administered by the Department of Medical Assistance Services. Specific procedures for reimbursement for medical screening and assessment services are found in Appendix B of the *Hospital Provider Manual* published by the Virginia Department of Medical Assistance Services. This information can be found at the following web-address:

http://websrvr.dmas.virginia.gov/manuals/HOS/hos_TOC.htm

4.7 System-level Information-Sharing:

State and private psychiatric hospitals should routinely share information with referring community services boards, hospital emergency departments, law enforcement agencies and courts about their medical treatment capabilities. Communicating this information on a regular basis, outside the context of individual cases or crises, will increase understanding and collaboration, and improve the efficiency with which individual cases are handled.

4.8 Systematic Quality Improvement:

Local and regional collaboration between several agencies and organizations is needed to implement an effective emergency and crisis response system for people with mental illness. In addition, medical screening and assessment is only one of many procedures and processes that need to be efficiently operationalized to have an effective "safety net" in place. The involved entities include CSBs and other mental health and substance abuse service providers, state and private hospitals and emergency rooms, police and sheriffs, courts, and others. These stakeholders should periodically assess their local emergency and crisis response system performance, and make adjustments when necessary to improve service delivery.

APPENDIX D

Summary of CSUs Reflecting Those Accepting TDOs

CSU/CSB	Accepting TDOs	# of Accepted TDOs in December 2011	Medical Personnel Involved in Admission	Dr on call for med eval	Dr available for face to face assessment
Cornerstone/Mt.Rogers (PPR 3)	No - Had purchased property to build for new location for CSU so that they could handle TDOs. Due to neighborhood issues they have had to change the location and are in process of remodeling another site for the CSU. When remodel and move is complete - they will begin taking TDOs	n/a	Yes - Nursing staff who also calls Dr for orders	Psychiatrist available Monday thru Friday and on call 24/7	Psychiatrist available Monday thru Friday and on call 24/7
Arbor House/Harrisonburg-Rockingham (PPR1)	Yes	0(zero)	Yes - Nursing staff on duty 24/7	No but a Nurse Practitioner is available	No but a Nurse Practitioner is available and supervised by an MD
Sunshine Lady House/Rappahannock Area (PPR 1)	No	n/a	Involve medical director or nurse practitioner as needed. Plan to involve on-call doctor when they start taking TDOs RACSB Emergency staff are gatekeepers for the program	24/7 on call	No
New Horizons/New River Valley (PPR 3)	No	n/a	24/7 on call psychiatrist who approves every admission after staff have determined person appropriate	Yes, psychiatrist	Currently on call status for med evals; Face to face assessments will begin March 1
Brandon House/Prince William (PPR 2)	Yes	0 (zero)	Yes - Physcian and psychiatric nurse on staff	Staff psychiatrist on call 24/7	Physician and nurse can be called to come in if needed
Norfolk CS (PPR 5)	No	n/a	Yes - RNs, psychiatrists,and interns/physicians are involved. MD does H&P within 24 hrs of admission	Psychiatrist and a non-psychiatrist MD are on call 24/7 for psychiatric or medical medication needs	Full time psychiatrist available onsite 8 hrs a day and on call 5 nites a wk. On other days/weekends/holidays they have part time psychiatrists that cover face to face admission and medication evals. They are also available on call
Courtland Center/CVCSB (PPR 4)	Yes	4 (four)	Yes - RNs and LPNs on unit 24/7 and handle initial part of admission process. An LMHP or RN approves all referrals. Psychiatrist contacted only in unusual situations.	Yes. MD/NP on call 24/7	Yes
Blue Ridge Behavioral Healthcare (PPR 7)	Yes	1(one) in Dec. 5 so far in January	Yes - nurses on site and doctors on call	Doctors on call 24/7 for medical emergencies	Doctors are on site for some period of time daily.
Residential Recovery Svcs - Cumberland Mtn. (PPR 3)	Yes	2 (two)	Yes - nurses help with admission. Psychiatrist or nurse practitioner can be contacted for staffing. All clients seen within 24 hours by MD or NP	Medical dr available by phone for medication issues. Nurse practitioner or psychiatrist can be contacted by phone also	24/7 Nurse Practitioner and physician coverage when needed
Recovery Center/VA Beach (PPR 5)	No - they are licensed to take TDOs and will do so as soon as some safety equipment needs are installed.	They stay at capacity most times and will likely have little room for TDOs. They do a lot of step down admissions	Yes - psychiatrist, physician (who is additionologist) and nurse practitioners, RNs and LPNs	yes - prescribers available 24/7 on-call for medication evals	No

CSU/CSB	Accepting TDOs	# of Accepted TDOs in December 2011	Medical Personnel Involved in Admission	Dr on call for med eval	Dr available for face to face assessment
Foundation House/Danville Pittsylvania (PPR 6)	No	n/a	Yes - RNs and LPNs involved in all admissions	Have a doctor on call from 9 am to 10 pm for medication evals/needs on anyone he cannot see until next day	Dr. normally sees them the day they arrive or the next day - same on weekends.
Woodburn Place/Fairfax - Falls Church (PPR 2)	Yes	0(zero)	Staff consult with nurse practitioner or psychiatrist as needed. Time of psychiatrist is more limited.	Their program is located next to Woodburn MH clinic with 24/7 emergency services staff and also to INOVA Fairfax Hospital so they have access to consults re: medication or hospital for medical emergencies.	See answer under G
RBHA (PPR 4)	No - they are making changes to enhance security and anticipate beginning to take TDOs in March 2012	n/a	Yes - nursing assessment on all admissions with either RN or LPN who also can contact psychiatrist or nurse practitioner for medication orders.	Yes - Psychiatrist or psychiatric nurse practitioner on call 24/7	The psychiatrist or psych NP make face to face evals daily including weekends
Hampton-Newport News (PPR 5)	No Projected time to begin taking TDOs is June 2012.	n/a	Yes - nursing staff involved in whole process and can also consult with psychiatrist/medical physician as needed.	Yes - MD on call 24/7	All clients have a physical exam within 24 hrs of admission. If emergency arises before then they can send client to ER one mile away.
ACCESS/Arlington (PPR 2)	Yes	0 (zero)	Full time nurse manager is either there or on call and they have a full time program nurse in the evening.	Yes - Arlington's emergency services psychiatrist is available 24/7	Yes
Wellness Recovery Ctr - Region Ten (PPR 1)	Yes	1 (one)	Yes - RNs who can also consult with psychiatrist and psychiatric residents	Psychiatrist available M-F for face to face evals and by consult other times	Psychiatrist on-site M-F for physicals, assessments, med evals etc. Available by consult nights and wkends
Home Recovery/Highlands (PPR 3)	No - is not a residential program	n/a	n/a	n/a	n/a

NOTE RE: LIMITATIONS ON TDOs: Representatives of all the programs have been meeting in person and through conference calls on a regular basis since a planning retreat in the fall of 2010. The group discussed and came to consensus on general guidelines regarding TDO admissions or rejections. Each program has a different physical environment which ranges from a residential home in a neighborhood to a house on a busy commercial intersection to a facility that was originally designed as a detox center and each program has had to consider their physical environment and limitations in applying those guidelines. All the programs indicate that their guidelines for limitations are handled on a case by case basis with consideration given to how well known the individual is to the system and the history of behavior when in crisis. The priamary limitations usually cited by programs are in situations where: an individual has medical conditions the CSU is not able to care for; an individual is so impaired by dementia, psychosis, etc. that they cannot do basic self care; an individual is or has recently been aggressive or assaultive or has a hx of being unpredictable with agression and is assessed to still be at high risk for that behavior; a high level of suicidal ideation with aggressive plans or behaviors to carry out exists and the staffing or physical environment limitations of the program are seen as unsafe for the individual while in that state.

NOTE RE: ONE TIME FUNDS FOR CSUs: Since May of 2011, we have provided over $200,000.00 in one time use funds to the CSUs. The priority for use of funds was to spend it to address concerns or barriers to taking TDOs or, if they were already taking TDOs, to address issues/problems they were discovering. The primary use of the funds went to: 1)installing repairing delayed egress doors; installing, updating, or expanding camera and monitor systems; installing safety equipment in areas or rooms where individuals under TDOs would be staying; changing lock systems on doors to make them more secure and faster to open; repairing potentially unsafe physical plant needs such as ceilings and windows; purchase of equipment that would allow CSUs to screen and admit clients during times they cannot presently admit due to inability to access psychiatrist; equipment that allows CSUs to obtain records/hx from the rest of the system more quickly and completely; and specific training for CSU staff/teams to enable them to respond better to clients who may be escalating in symptoms.

APPENDIX E

Case Studies

Appendix E: CASE STUDIES

1. Geriatric Case Example

In one of the cases reported, the family of an 82 year old male took him to the local emergency room due to persistently aggressive behavior towards family members. Despite efforts to manage him at home, the family became overwhelmed with his aggression and wandering behavior. They sought assistance because his behavior was placing both himself and others at risk. His behavior had become so problematic that someone had to be with him at all times. Even though there had been an escalation of risk behaviors, a number of facilities that were contacted indicated that he did not meet the criteria for an "acute" psychiatric admission. An adult protective services report was filed, but it was reported that it would take at least a week before an alternate placement for the individual could be obtained. However, in spite of multiple efforts, no hospital placement could be obtained and the individual was released back into the care of his family with follow-up scheduled with DSS and the CSB.

2. Person with Intellectual Disabilities Case Example

This case presented numerous difficulties and challenges for a number of reasons and is noteworthy because there were actually two failed attempts at securing a TDO admission within the 6 hour window. A 22-year old gentleman with intellectual disabilities had been residing in a group home in another region after being placed there by his local CSB. On July 18, 2011, he was brought to the emergency room at the local hospital due to severely aggressive behaviors (including biting staff; pouring antifreeze, motor oil, and cleaning fluid on himself; running into traffic; hitting, kicking, and spitting on staff) as well as psychotic symptoms such as hearing voices telling him to harm himself.

It was determined that he met criteria for a TDO admission but he had been turned down by all private hospitals due to either his high level of acuity and aggressive behaviors or capacity issues at the hospitals. One state facility was consulted but denied admission because the person was technically a resident from another region. The CSB where the person was from was consulted, and an attempt was made to facilitate a direct admission to the state-operated facility in the person's region of origin, but this failed and he was denied admission.

After over 9 hours in the ED, the attending physician finally got on the phone and demanded that the facility's psychiatric unit take this person and he was accepted over strenuous objections of the unit. He was involuntarily committed on 7/20 but was released after a few days when his symptoms apparently cleared. On 7/28, he was brought back to the ED by police after he had again assaulted staff and damaged property at the group home. He also struck out at police officers who responded to the

call, stating that he was again hearing voices telling him to "do bad things." This time, the group home stated that they would not be accepting him back to their program due to his dangerous behaviors.

The prescreener contacted 16 private hospitals but was turned down at each, again because of either acuity or capacity issues. The CSB and state-operated facility was again consulted but was told the state-operated facility would not make a decision until the next day. Again, an ECO extension was executed but expired. He remained in the ED for approximately 24 hours, after which he was finally admitted to a medical floor under sedation as there was no other secure placement. In the interim, his group home called to say that they had his belongings packed and wanted to know where to deliver them.

On 7/31, while still a patient on the medical floor, he struck and injured a CNA who was attending to him. At that point, under pressure from the attending physician, he was again admitted via TDO to the associated facility psychiatric unit, approximately 72 hours after he had originally presented in the ER under an ECO.

APPENDIX F

Review Instrument and Glossary of Terms

Regional TDO Outcome Report

A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.	L.	M.	N.	O.	P.	Q.	R.	S.	T.	U.	V.
CSB	Start Date of Crisis Contact (mm/dd/yyyy)	Time of First Contact (hh:mm)	Person's First Name, Middle and Last Initial (ex. Jane L.L.)	Age	Payor Source	Person Under an ECO (Y or N)	Location of CSB Face-to-Face Crisis Contact	TDO Obtained (Y or N)	# of Non-State Facilities Contacted In Effort to Secure Bed (Hospitals, CSUs, De-tox)	Primary Barrier to Timely Detention	Secondary Barrier to Timely Detention	Tertiary Barrier to Timely Detention	# State-Operated Facility Contacted	Primary Barrier to Timely Detention	Secondary Barrier to Timely Detention	Tertiary Barrier to Timely Detention	Outcome for the Client	Accepting Facility (If admitted after 6 hrs)	Is Accepting Facility in CSB Region (Y or N)	End Date of Crisis Episode (mm/dd/yyyy)	End Time of Crisis Episode (hh:mm)

Glossary and Instructions for Regional TDO Outcome Report

General Guidance and Instructions

The Office of the Inspector General recently published its *Semi-Annual Report* for the period ending March 31, 2011. This report indicated that there had been 200 cases statewide of persons in crisis who had been evaluated over the preceding twelve months by CSB emergency services staff and deemed to need involuntary temporary detention, but had been released from custody because no temporary detention facility would admit the persons.

In an effort to better understand the nature and scope of this problem, the Office of the Inspector General, in collaboration with the Department of Behavioral Health and Developmental Services and Community Services Board representatives, has designed this instrument to capture information about certain individuals who are evaluated by CSB emergency staff and deemed to need involuntary temporary detention. Specifically, **data will be collected for two types of cases**:

- Persons for whom a temporary detention order (TDO) is sought but not obtained due to a lack of willing TDO facility; and
- Persons for whom a TDO is obtained and executed but for whom the process takes more than six hours.

Data collection is not required for cases that do not fall into one of the above two categories.

Regional TDO Outcome Report Form

Accompanying this *Glossary and Instructions* is an Excel spreadsheet form titled *Regional TDO Outcome Report (Individual)* which will be used to capture the requested information. The spreadsheet has been intentionally designed to modify some entered data into a format that is necessary for data analysis to be performed later. For those cells (e.g., date and time cells), please do not modify this formatting. Other columns have drop down menus from which response choices can be made from a set of acceptable responses. All the requested data elements should be completed for each reportable case. More information about specific data elements and, where applicable, the acceptable responses to specific questions, can be found below.

Reporting Process

Data collection will be required for the three-month period beginning July 15, 2011, and ending October 13, 2011. Individual CSB reports will be submitted on a bi-weekly basis to the regional manager or regional project director, who will consolidate these reports and submit them to the OIG and DBHDS one week later. The specific reporting timetable is as follows:

Schedule for Regional Reports of ECO & TDO Dispositions			
Reporting Periods		**Due Dates:**	
Start Date:	**Stop Date:**	**CSB to Reg. Mgr.**	**Reg. Mgr. to OIG**
7/15/2011	7/28/2011	8/3/2011	8/5/2011
7/29/2011	8/11/2011	8/17/2011	8/19/2011
8/12/2011	8/25/2011	8/31/2011	9/2/2011
8/26/2011	9/8/2011	9/14/2011	9/16/2011
9/9/2011	9/22/2011	9/28/2011	9/30/2011
9/23/2011	10/6/2011	10/12/2011	10/14/2011
10/7/11	10/13/11	10/18/11	10/21/11

Note: This table is also included in the Excel file containing the form to be completed, titled CSB TDO Report Form, under the tab named Report Schedule.

Start Date shall be at 0001 hours of the date indicated. Reportable events will be driven by this date. (i.e. if an event begins on 07/28/11 at 2300 hours but ends on 07/29/11 at 0800 hours it will be reported on #1 report for date span 07/15/11-07/28/11.
Stop Date shall be 2400 hours of the date indicated. Each 2 week report will only report events that ***began*** within the Start & Stop Dates.
CSB to Reg. Mgr. is the date each CSB's 2 week report is due to the Regional Designee, typically the Project Manager/Coordinator for that PPR. *The CSBs shall have 4 business days to complete their reports.*
Reg. Mgr. to OIG is the date each Region's 2 week report is due to the OIG. *The regional managers shall have 2 business days to complete their reports.* Regional Managers should send competed reports to Pat Pettie at pat.pettie@oig.virginia.gov

Regional Manager Contacts

Contact information for the seven regional managers is shown below:

Project Managers Contact Information		
PPR I	Paul Regan, LPC	pregan@regionten.org
PPR II	Cynthia Koshatka, Ph.D.	cynthia.koshatka@fairfaxcounty.gov
PPR III	Derek Burton, RN	derek.burton@mrcsb.state.va.us
PPR IV	Arnold Woodruff, LMFT	woodruffa@rbha.org
PPR V	John Dool, RN	jdool@hnncsb.org
PPR VI	Cheryl Chittum	cheryl.chittum@dbhds.virginia.gov
PPR VII	Patti Williford, LPC	pwilliford@brbh.org

Note: This table, along with additional contact information, is also included in the Excel file containing the form to be completed, titled CSB TDO Report Form, under the tab named Region Contacts.

Questions

If you have any questions about the information being requested or how to use the features of this spreadsheet, please contact your supervisor or your regional manager.

Data Elements, Definitions and Item-Specific Instructions

COLUMN A - CSB – Please indicate the community service board or behavioral health authority responsible for this case, using the applicable CCS3 CSB designation code (see list of codes at the end of this document).

COLUMN B - Start Date of Crisis Contact – Please indicate the beginning date of CSB face-to-face crisis contact with the individual. This is the beginning date of the crisis contact episode that is the basis for this report.

COLUMN C - Time of First Contact – Using "24 hour" or "Military Time", please indicate in hh:mm format the beginning time of the CSB face-to-face contact with this individual.

COLUMN D - Person's First Name and Middle and Last initial – Please provide the full first name and the first initial of the person's middle and last names (e.g., Jane L.L.)

COLUMN E - Age – Please indicate the current age of the individual in years.

COLUMN F - Payor Source – Please indicate the individual's insurance status by choosing one of the following responses from the drop-down list: Medicare, Medicaid, Private Insurance, Veteran's Affairs, Uninsured/Self Pay, Uninsured/No Self Pay, and LIPOS/Project Funds. [**Note**: The "LIPOS/Project Funds" response should be used only if these funds have been authorized and are available for this individual's care.]

COLUMN G - Person Under Emergency Custody Order (ECO) – Please indicate whether or not the individual was under an emergency custody order (i.e., §37.2-808, or §16.1-340) when the face-to-face crisis contact occurred and/or the decision to pursue temporary detention was made.

COLUMN H - Location of CSB Face-to-Face Crisis Contact – From the choices provided on the drop-down list, please indicate the location at which the CSB face-to-face crisis contact occurred.

COLUMN I - Was a Temporary Detention Order (TDO) Obtained – Please indicate whether or not a TDO was obtained for this individual.

COLUMN J - Number of Non-State Facilities Contacted in Effort to Secure Bed – Please indicate (in numerical digits, not text responses) the total number of non-state facilities that were

contacted in an effort to secure a temporary detention bed for this individual. This figure should include hospitals, detox facilities, and residential crisis stabilization (CSU) programs.

COLUMN K, L, M – Barrier(s) to Timely Detention – Please indicate the primary, secondary and tertiary barriers that prevented timely temporary detention at the non-state facilities that were contacted. Select the barriers from the drop-down list provided. The "primary" barrier should be the predominant barrier in this case. The "secondary" barrier (if any) should be the second most important barrier in this case. The "tertiary" barrier (if any) should be the third most important barrier in this case. Indicate only those barriers that actually applied in this case. **If there is no secondary or tertiary barrier, then leave these cells blank.** The available responses are: No Bed Available; Insurance Barriers; Medical Issues; Acuity or Level of Care Issues; Geography and Distance Barriers; and Unable to Confirm Bed Availability. Each response is further defined at the end of this document.

COLUMN N - Number of State-Operated Facilities Contacted in Effort to Secure Bed – Please indicate (in numerical digits, not text responses) the number of state-operated facilities (i.e., DBHDS hospitals) that were contacted in an effort to secure a bed for this individual.

COLUMN O, P, Q – Barrier(s) to Timely Detention – Please indicate the primary, secondary and tertiary barriers that prevented timely temporary detention at the state facilities that were contacted. Select the barriers from the drop-down list provided. The "primary" barrier should be the predominant barrier in this case. The "secondary" barrier (if any) should be the second most important barrier in this case. The "tertiary" barrier (if any) should be the third most important barrier in this case. Indicate only those barriers that actually applied in this case. **If there is no secondary or tertiary barrier, then leave these cells blank.** The available responses are: No Bed Available; Insurance Barriers; Medical Issues; Acuity or Level of Care Issues; Geography and Distance Barriers; and Unable to Confirm Bed Availability. Each response is further defined at the end of this document.

COLUMN R – Outcome for the Client – Please indicate the disposition outcome for this individual by selecting a disposition from the drop-down list provided. Descriptions of the possible client outcomes are as follows:

1. **Detained** – A willing facility was obtained ***after*** six hours.
2. **Arrested** – Client jailed (e.g. trespassing, assault, etc).
3. **Medically admitted** – Person admitted to a medical facility/unit.
4. **Remained in ED** – Client remained in the emergency department after the ECO period expired.
5. **Less intensive level of care admission** – Client admitted to inpatient care voluntarily or to a crisis stabilization program after six hours of bed searches for a willing and available TDO facility.
6. **Remained in supportive setting** – Client remained in a nursing home, ALF, etc, after the ECO period expired although the client remained in need of a willing TDO facility.

7. **Community supports available & implemented** – Clinician was able to implement wrap-around services, safety or crisis plans. PACT, ACT, intensive CM or increased crisis counseling follow up services was accessible & implemented. Family, friends or other community supports were available and willing to provide additional support.
8. **No further intervention, Against Clinician Advice (ACA)** - Absolutely no supports available (e.g. client is homeless). Client refuses any alternatives, walks away, or whereabouts are unknown. No other means available to keep client engaged in interventions.

COLUMN S - Accepting Facility (if admitted after six hours) – Please insert the name the facility that admitted the individual under temporary detention.

COLUMN T - Is Accepting Facility in CSB Region – Please indicate whether the admitting TDO facility is in the same region where the CSB/BHA is located. The term "region" refers to the seven Regional Partnership Planning Regions, which may also be referred to as the "Reinvestment Project" region, or as a Health Planning Region (HPR).

COLUMN U - End Date of Crisis Episode – Please indicate the ending date of the crisis episode involving the individual. This is the ending date of the crisis contact episode that is the basis for this report.

COLUMN V – End Time of Crisis Episode – Using "24 hour" or "Military Time", please indicate in hh:mm format the time that the crisis episode involving this individual ended.

CSB Codes (Column A)

001	Alexandria
003	Alleghany-Highland
005	Arlington County
007	Central Virginia
009	Chesapeake
011	Chesterfield
013	Colonial
015	Crossroads
017	Cumberland Mountain
019	Danville-Pittsylvania
020	Dickenson County Behavioral Health Services
021	Eastern Shore
023	Fairfax-Falls Church
025	Goochland-Powhatan
027	Hampton-Newport News
029	Hanover County Community Services Board
031	Harrisonburg-Rockingham Community Services Board

033	Henrico Area
035	Highlands
037	Loudoun County Community Services Board
039	Middle Peninsula-Northern Neck
041	Mount Rogers
043	New River Valley
045	Norfolk Community Services Board
047	Northwestern
049	Piedmont
051	Planning District I
053	District 19 Community Services Board
055	Portsmouth
057	Prince William County Community Services Board
059	Rappahannock Area Community Services Board
061	Rappahannock-Rapidan Community Services Board
063	Region Ten Community Services Board
065	Richmond
067	Blue Ridge Behavioral Healthcare
069	Rockbridge Area Community Services
071	Southside Community Services Board
073	Valley Community Services Board
075	Virginia Beach Community Services Board
077	Western Tidewater Community Services Board

BARRIERS TO TIMELY DETENTION (Columns K, L, M, O, P, Q)

1. **No Bed Available:** This refers to the prospective facility being full; having no available bed for the age or gender of the individual being referred; the facility does not serve the individual's place of residence; no anticipated discharges until the next day; etc.

2. **Insurance Barriers:** This refers to a prospective facility being unwilling or unable to accept the consumer's insurance or other payor source. It may include Medicaid IMD issues, or instances where a prospective facility is an out-of-network provider for an insured individual.

3. **Medical Issues:** This refers to a medical (non-psychiatric) condition, or related medical issue, that causes the prospective facility to be unable to accept the consumer. This includes circumstances when an emergency room physician deems an individual to be medically stable but the prospective detention facility disagrees and is unwilling to accept the consumer based on lab reports, presence of certain symptoms, substance abuse issues (e.g., facility is unable to detox), etc; facility has weight limit on consumers; facility has exclusionary criteria such as intellectual disability, Aspergers, autism, dementia, etc.

4. **Acuity or Level of Care Issues:** This refers to the individual consumer's non-medical clinical characteristics or related factors that result in the prospective facility being unable to admit the person. This could include the facility being under-staffed for the level of care required; having too many challenging consumers on the unit already; being unable to provide security or 1:1 care to keep the consumer and staff safe; or facility denies admission based on the individual's prior history at that particular facility.

5. **Geographic and Distance Barriers**: This refers to problems associated with geography and location of a prospective facility relative to the individual's location. For example, a facility may be too far away to coordinate care or transportation; facility policy may restrict admissions to certain geographic areas; or the individual has to be transferred after court and there are distance or location issues involved, etc.

6. **Unable to Confirm Bed Availability:** This refers to an inability to ascertain or confirm bed availability at a prospective facility. It includes instances when the CSB receives no return telephone call from a facility, or return calls are not timely.

APPENDIX G

Pertinent Excerpts from the *Code of Virginia*

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§ 37.2-500. Purpose; community services board; services to be provided.

The Department, for the purposes of establishing, maintaining, and promoting the development of mental health, mental retardation, and substance abuse services in the Commonwealth, may provide funds to assist any city or county or any combinations of cities or counties or cities and counties in the provision of these services. Every county or city shall establish a community services board by itself or in any combination with other cities and counties, unless it establishes a behavioral health authority pursuant to Chapter 6 (§ 37.2-600 et seq.) of this title. Every county or city or any combination of cities and counties that has established a community services board, in consultation with that board, shall designate it as an operating community services board, an administrative policy community services board or a local government department with a policy-advisory community services board. The governing body of each city or county that established the community services board may change this designation at any time by ordinance. In the case of a community services board established by more than one city or county, the decision to change this designation shall be the unanimous decision of all governing bodies.

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, mental retardation, and substance abuse services necessary to provide individualized services and supports to persons with mental illnesses, mental retardation, or substance abuse. Community services boards may establish crisis stabilization units that provide residential crisis stabilization services.

In order to provide comprehensive mental health, mental retardation, and substance abuse services within a continuum of care, the community services board shall function as the single point of entry into publicly funded mental health, mental retardation, and substance abuse services.

(1968, c. 477, § 37.1-194; 1972, c. 498; 1974, c. 404; 1975, c. 200; 1976, cc. 41, 671; 1977, c. 90; 1980, c. 582; 1982, c. 295; 1984, c. 653; 1998, c. 680; 2002, cc. 51, 278; 2005, c. 716; 2010, c. 28.)

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§ 37.2-808. Emergency custody; issuance and execution of order.

A. Any magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion, an emergency custody order when he has probable cause to believe that any 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. Any emergency custody 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.

When considering whether there is probable cause to issue an emergency custody order, the magistrate may, in addition to the petition, consider (1) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (2) any past actions of the person, (3) any past mental health treatment of the person, (4) any relevant hearsay evidence, (5) any medical records available, (6) any affidavits submitted, if the witness is unavailable and it so states in the affidavit, and (7) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue an emergency custody order.

B. Any person for whom an emergency custody order is issued shall be taken into custody and transported to a convenient location to be evaluated to determine whether the person meets the criteria for temporary detention pursuant to § 37.2-809 and to assess the need for hospitalization or treatment. The evaluation shall be made by a person designated by the community services board who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by the Department.

C. The magistrate issuing an emergency custody order shall specify the primary law-enforcement agency and jurisdiction to execute the emergency custody order and provide transportation. However, in cases in which the emergency custody order is based upon a finding that the person who is the subject of the order 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, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, the magistrate may authorize transportation by an alternative transportation provider, including a family member or friend of the person who is the subject of the order, a representative of the community services board, or other transportation provider with personnel trained to provide transportation in a safe manner, upon determining, following consideration of information provided by the petitioner; the community services board or its designee; the local law-enforcement agency, if any; the person's treating physician, if any; or other persons who are available and have knowledge of the person, and, when the magistrate deems appropriate, the proposed alternative transportation provider, either in person or via two-way electronic video and audio or telephone communication system, that the proposed alternative transportation provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner. When transportation is ordered to be provided by an alternative transportation provider, the magistrate shall order the specified primary law-enforcement agency to execute the order, to take the person into custody, and to transfer custody of the person to the alternative transportation provider identified in the order. In such cases, a copy of the emergency custody order shall accompany the person being transported pursuant to this section at all times and shall be delivered by the alternative transportation provider to the community services board or its designee responsible for conducting the evaluation. The community services board or its designee conducting the evaluation shall return a copy of the emergency custody order to the court designated by the magistrate as soon as is practicable. Delivery of an order to a law-enforcement officer or alternative transportation provider and return of an order to the court may be accomplished electronically or by facsimile.

Transportation under this section shall include transportation to a medical facility as may be necessary to obtain emergency medical

evaluation or treatment that shall be conducted immediately in accordance with state and federal law. Transportation under this section shall include transportation to a medical facility for a medical evaluation if a physician at the hospital in which the person subject to the emergency custody order may be detained requires a medical evaluation prior to admission.

D. In specifying the primary law-enforcement agency and jurisdiction for purposes of this section, the magistrate shall order the primary law-enforcement agency from the jurisdiction served by the community services board that designated the person to perform the evaluation required in subsection B to execute the order and, in cases in which transportation is ordered to be provided by the primary law-enforcement agency, provide transportation. If the community services board serves more than one jurisdiction, the magistrate shall designate the primary law-enforcement agency from the particular jurisdiction within the community services board's service area where the person who is the subject of the emergency custody order was taken into custody or, if the person has not yet been taken into custody, the primary law-enforcement agency from the jurisdiction where the person is presently located to execute the order and provide transportation.

E. The law-enforcement agency or alternative transportation provider providing transportation pursuant to this section may transfer custody of the person to the facility or location to which the person is transported for the evaluation required in subsection B, G, or H if the facility or location (i) is licensed to provide the level of security necessary to protect both the person and others from harm, (ii) is actually capable of providing the level of security necessary to protect the person and others from harm, and (iii) in cases in which transportation is provided by a law-enforcement agency, has entered into an agreement or memorandum of understanding with the law-enforcement agency setting forth the terms and conditions under which it will accept a transfer of custody, provided, however, that the facility or location may not require the law-enforcement agency to pay any fees or costs for the transfer of custody.

F. A law-enforcement officer may lawfully go or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing an emergency custody order pursuant to this section.

G. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization or treatment without prior authorization. A law-enforcement officer who takes a person into custody pursuant to this subsection or subsection H may lawfully go or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of obtaining the assessment. Such evaluation shall be conducted immediately. The period of custody shall not exceed four hours from the time the law-enforcement officer takes the person into custody. However, upon a finding by a magistrate that good cause exists to grant an extension, the magistrate shall issue an order extending the period of emergency custody one time for an additional period not to exceed two hours. Good cause for an extension includes the need for additional time to allow (i) the community services board to identify a suitable facility in which the person can be temporarily detained pursuant to § 37.2-809 or (ii) a medical evaluation of the person to be completed if necessary.

H. A law-enforcement officer who is transporting a person who has voluntarily consented to be transported to a facility for the purpose of assessment or evaluation and who is beyond the territorial limits of the county, city, or town in which he serves may take such person into custody and transport him to an appropriate location to assess the need for hospitalization or treatment without prior authorization when the law-enforcement officer determines (i) that the person has revoked consent to be transported to a facility for the purpose of assessment or evaluation, and (ii) based upon his observations, that probable cause exists to believe that the person meets the criteria for emergency custody as stated in this section. The period of custody shall not exceed four hours from the time the law-enforcement officer takes the person into custody. However, upon a finding by a magistrate that good cause exists to grant an extension, the magistrate shall issue an order extending the period of emergency custody one time for an additional period not to exceed two hours. Good cause for an extension includes the need for additional time to allow (a) the community services board to identify a suitable facility in which the person can be temporarily detained pursuant to § 37.2-809, or (b) a medical evaluation of the person to be completed if necessary.

I. Nothing herein shall preclude a law-enforcement officer or alternative transportation provider from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

J. The person shall remain in custody until a temporary detention order is issued, until the person is released, or until the emergency custody order expires. An emergency custody order shall be valid for a period not to exceed four hours from the time of execution. However, upon a finding by a magistrate that good cause exists to grant an extension, the magistrate shall extend the emergency custody order one time for a second period not to exceed two hours. Good cause for an extension includes the need for additional time to allow (i) the community services board to identify a suitable facility in which the person can be temporarily detained pursuant to § 37.2-809 or (ii) a medical evaluation of the person to be completed if necessary. Any family member, as defined in § 37.2-100, employee or designee of the local community services board as defined in § 37.2-809, treating physician, or law-enforcement officer may request the two-hour extension.

K. If an emergency custody order is not executed within six hours of its issuance, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if such office is not open, to any magistrate serving the jurisdiction of the issuing court.

L. Payments shall be made pursuant to § 37.2-804 to licensed health care providers for medical screening and assessment services provided to persons with mental illnesses while in emergency custody.

(1995, c. 844, § 37.1-67.01; 1996, c. 893; 1998, c. 611; 2004, c. 737; 2005, c. 716; 2007, c. 7; 2008, cc. 202, 551, 691, 775, 779, 782, 784, 793, 850, 870; 2009, cc. 21, 112, 383, 455, 555, 607, 697, 838; 2010, cc. 778, 825; 2011, c. 249.)

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§ 37.2-809. Involuntary temporary detention; issuance and execution of order.

A. For the purposes of this section:

"Designee of the local community services board" means an examiner designated by the local community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has completed a certification program approved by the Department, (iii) is able to provide an independent examination of the person, (iv) is not related by blood or marriage to the person being evaluated, (v) has no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment interest in the facility detaining or admitting the person under this article, and (vii) except for employees of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.

"Employee" means an employee of the local community services board who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department.

"Investment interest" means the ownership or holding of an equity or debt security, including shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other equity or debt instruments.

B. 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.

C. When considering whether there is probable cause to issue a temporary detention order, the magistrate may, in addition to the petition, consider (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person, (iii) any past mental health treatment of the person, (iv) any relevant hearsay evidence, (v) any medical records available, (vi) any affidavits submitted, if the witness is unavailable and it so states in the affidavit, and (vii) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue a temporary detention order.

D. A magistrate may issue a temporary detention order without an emergency custody order proceeding. A magistrate may issue a temporary detention order without a prior evaluation pursuant to subsection B if (i) the person has been personally examined within the previous 72 hours by an employee or a designee of the local community services board or (ii) there is a significant physical, psychological, or medical risk to the person or to others associated with conducting such evaluation.

E. An employee or a designee of the local community services board shall determine the facility of temporary detention for all individuals detained pursuant to this section. The facility of temporary detention shall be one that has been approved pursuant to regulations of the Board. The facility shall be identified on the preadmission screening report and indicated on the temporary detention order. Except as provided in § 37.2-811 for inmates requiring hospitalization in accordance with subdivision A 2 of § 19.2-169.6, the

person shall not be detained in a jail or other place of confinement for persons charged with criminal offenses and shall remain in the custody of law enforcement until the person is either detained within a secure facility or custody has been accepted by the appropriate personnel designated by the facility identified in the temporary detention order.

F. Any facility caring for a person placed with it pursuant to a temporary detention order is authorized to provide emergency medical and psychiatric services within its capabilities when the facility determines that the services are in the best interests of the person within its care. The costs incurred as a result of the hearings and by the facility in providing services during the period of temporary detention shall be paid and recovered pursuant to § 37.2-804. The maximum costs reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention.

G. The employee or the designee of the local community services board who is conducting the evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention order, the insurance status of the person. Where coverage by a third party payor exists, the facility seeking reimbursement under this section shall first seek reimbursement from the third party payor. The Commonwealth shall reimburse the facility only for the balance of costs remaining after the allowances covered by the third party payor have been received.

H. The duration of temporary detention shall be sufficient to allow for completion of the examination required by § 37.2-815, preparation of the preadmission screening report required by § 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid involuntary commitment where possible, but shall not exceed 48 hours prior to a hearing. If the 48-hour period herein specified terminates on a Saturday, Sunday, or legal holiday, the person may be detained, as herein provided, until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. The person may be released, pursuant to § 37.2-813, before the 48-hour period herein specified has run.

I. If a temporary detention order is not executed within 24 hours of its issuance, or within a shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if the office is not open, to any magistrate serving the jurisdiction of the issuing court. Subsequent orders may be issued upon the original petition within 96 hours after the petition is filed. However, a magistrate must again obtain the advice of an employee or a designee of the local community services board prior to issuing a subsequent order upon the original petition. Any petition for which no temporary detention order or other process in connection therewith is served on the subject of the petition within 96 hours after the petition is filed shall be void and shall be returned to the office of the clerk of the issuing court.

J. The chief judge of each general district court shall establish and require that a magistrate, as provided by this section, be available seven days a week, 24 hours a day, for the purpose of performing the duties established by this section. Each community services board shall provide to each general district court and magistrate's office within its service area a list of its employees and designees who are available to perform the evaluations required herein.

K. For purposes of this section a healthcare provider or designee of a local community services board or behavioral health authority shall not be required to encrypt any email containing information or medical records provided to a magistrate unless there is reason to believe that a third party will attempt to intercept the email.

L. The employee or designee of the community services board who is conducting the evaluation pursuant to this section shall, if he recommends that the person should not be subject to a temporary detention order, inform the petitioner and an on-site treating physician of his recommendation.

(1974, c. 351, § 37.1-67.1; 1975, cc. 237, 433; 1976, c. 671, § 37.1-67.4; 1980, c. 582; 1981, cc. 233, 463; 1982, c. 435; 1986, cc. 134, 478, 629; 1987, c. 96; 1988, c. 98; 1989, c. 716; 1990, cc. 429, 728; 1991, c. 159; 1992, c. 566; 1995, c. 844; 1996, cc. 343, 893; 1998,

cc. 37, 594, 611; 2004, c. 737; 2005, c. 716; 2007, c. 526; 2008, cc. 331, 551, 691, 728, 779, 782, 793, 828, 850, 870; 2009, cc. 455, 555; 2010, cc. 340, 406, 778, 825.)

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