COMMONWEALTH of VIRGINIA

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November 15, 2015

Dear Chairman Deeds and members of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century:

This report was developed in accordance with HB 2368 (Chapter 742, 2015 Acts of Assembly), which requires the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS) to review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission, identify areas of the Commonwealth where significant delays in responding to emergency evaluations are occurring and to develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission.

Please find enclosed the report in accordance with HB2368. Staff at the department are available should you wish to discuss this report.

Sincerely,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
Sarah Stanton
David Cotter
Thomas Stevens

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Dear Chairman Orrock and members of the House Health, Welfare, and Institutions Committee:

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November 15, 2015

Dear Chairman Martin and members of the Senate Committee on Education and Health:

This report was developed in accordance with HB 2368 (Chapter 742, 2015 Acts of Assembly), which requires the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS) to review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission, identify areas of the Commonwealth where significant delays in responding to emergency evaluations are occurring and to develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission.

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November 15, 2015

The Honorable Terry McAuliffe, Governor
Commonwealth of Virginia
Patrick Henry Building
P.O. Box 1475
Richmond, VA 23218

Dear Governor McAuliffe:

This report was developed in accordance with HB 2368 (Chapter 742, 2015 Acts of Assembly), which requires the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS) to review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission, identify areas of the Commonwealth where significant delays in responding to emergency evaluations are occurring and to develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission.

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Jack Barber, M.D.

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Cc: William A. Hazel, Jr., M.D.
Joe Flores
Anna James
Robert Brink

Review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission **(**H.B. 2368**)**

To the Governor and the
Joint Subcommittee Studying Mental Health Services
in the Commonwealth in the 21st Century,
The House Committee on Health, Welfare and Institutions, and
The Senate Committee on Education and Health

November 15, 2015

Review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission

TABLE OF CONTENTS

I. Introduction and Background

This report was developed in accordance with HB 2368 (Chapter 742, 2015 Acts of Assembly), which requires the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS) to review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission, identify areas of the Commonwealth where significant delays in responding to emergency evaluations are occurring and to develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission. Specifically, the language states:

> *§ 1. The Commissioner of Behavioral Health and Developmental Services (the Commissioner) shall, in conjunction with relevant stakeholders including the VACSB, NAMI - Virginia, PSV, VCEP, VHHA, VACP, MSV, and UVA ILPPP, review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission. Such review shall identify community services boards and catchment areas where significant delays in responding to emergency evaluations are occurring or have occurred in recent years. Further, the Commissioner shall develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations.*

General Structure of the Commonwealth's Civil Commitment Process

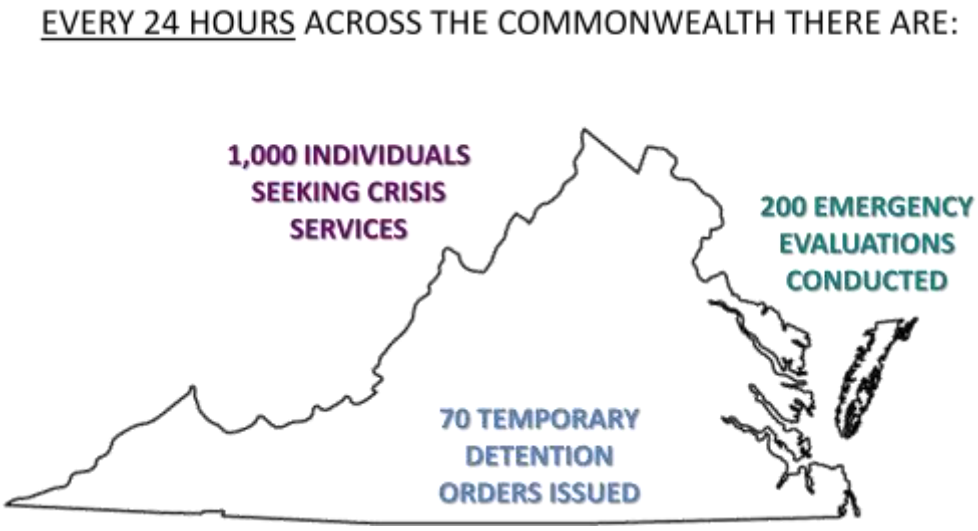
Virginia's civil commitment procedure follows a *judicial* model, characterized by key features including the temporary detention order (TDO), appointment of counsel, opportunity for voluntary admission, formal hearing within 72 hours, mandated evaluation, narrowed criteria (dangerousness and grave disability) for commitment and preference for the least restrictive alternative to hospitalization. However, during the 1980s, multiple criticisms of the commitment process emerged, including inadequate screening that resulted in numerous TDOs and admissions to state hospitals and a lack of community services and supports to prevent unnecessary hospitalization. At the time, the law mandated examination by an independent physician or a psychologist. Because of the criticisms, a series of studies were conducted by the Institute of Law, Psychiatry and Public Policy (ILPPP) at the University of Virginia in 1988, DBHDS in 1990 and the Joint Legislative Audit and Review Committee (JLARC) in 1994. After the JLARC study, the General Assembly required that in all cases, only an evaluation conducted by a community services board (CSB) could lead to the issuance of a TDO and required the CSB to determine the place of hospitalization. The requirement was designed to ensure consideration of less restrictive interventions and avoid unnecessary TDOs.

More recent changes to Virginia's civil commitment laws were made in 2014 when the emergency custody order (ECO) period was extended from four to eight hours and a state hospital bed was required to be made available as a "last resort" for cases in which the ECO expires before a suitable acute care bed has been found. These statutory changes have had a highly positive impact in securing the emergency services safety net. Requirements were also included for improved communication and notification throughout the ECO process.

Since the 2014 reforms were implemented, no individual meeting the criteria for a temporary detention order (TDO) has gone without a hospital bed for crisis treatment. Although this represents a major achievement in behavioral health policy, these changes have also shifted the demands on the behavioral health system in a multitude of ways. In order to provide a sense of the current demands at

early stages of the commitment process, it should be noted that approximately 1,000 individuals seek crisis services, 200 emergency evaluations are conducted, and 70 temporary detention orders are issued each day in Virginia, as shown in Figure 1 below:

Figure 1: Virginia's Psychiatric Emergency System



Overview of the Emergency Evaluation Process

The emergency mental health evaluation process is a complex, multi-stage set of tasks that go beyond conducting a brief meeting with a person in crisis and recommending hospitalization.[1] It is a pivotal point within the larger civil commitment process because, if a TDO is recommended and issued, the individual in crisis is deprived of his or her liberty for days and perhaps weeks, should he or she be civilly committed. The significance of the individual's rights prescribes constraints on the health care and legal decisions involved; emergency evaluations must be comprehensive to assure appropriate disposition but they also must be time-restricted to limit the custody period. As a result, a multitude of aims and tasks are concentrated in the brief 8-hour window allowed under an ECO. To appreciate what a contingency procedure must account for, it is helpful to outline the many elements of this critical but compact stage in the civil commitment process.

For organizational purposes, the emergency evaluation process can be divided into six phases:

1. Referral options
2. Initial notification
3. Assessment conducted
4. Assessment results
5. Disposition reviewed
6. Disposition completed

[1] The process for obtaining a temporary detention order (TDO) for civil commitment of adults is cited in *Virginia Codes* 37.2-808, 37.2-809, 37.2-809.1, 37.2-810, 37.2-813, 37.2-814, 37.2-815, 37.2-816, and 37.2-1104. The *Codes* for minors are 16.1-338, 16.1-339.1, 16.1-340, 16.1-340.1, 16.2-341-16.2-345.

These phases may occur simultaneously, but distinguishing domains of activity is helpful to identify tasks to be included in a comprehensive plan allowing psychiatrists and ED physicians to conduct emergency evaluations. Key requirements of these six phases are summarized below.

In **Phase One – Referral Options**, it is important to recognize the many different entry points into emergency behavioral health services. These entry points can be through routine outpatient services, in a local emergency room, by phone, through law enforcement, or from an inpatient medical unit. Evaluations could be conducted in any of those or other locations.

In **Phase Two – Initial Notification**, when an individual is taken into custody by law enforcement, emergency evaluators are notified of the execution of an emergency custody order (ECO). Each region has protocols for this process to ensure activities are completed within the timeframes required.

In **Phase Three – Assessment Conducted**, an emergency assessment is completed as soon as possible after receiving notification of the need. This process is required to begin within one hour of being contacted in an urban area and within two hours in a rural area. The emergency evaluator must then complete a ten-page pre-screening form before beginning the process of locating a bed when involuntary treatment is deemed necessary.

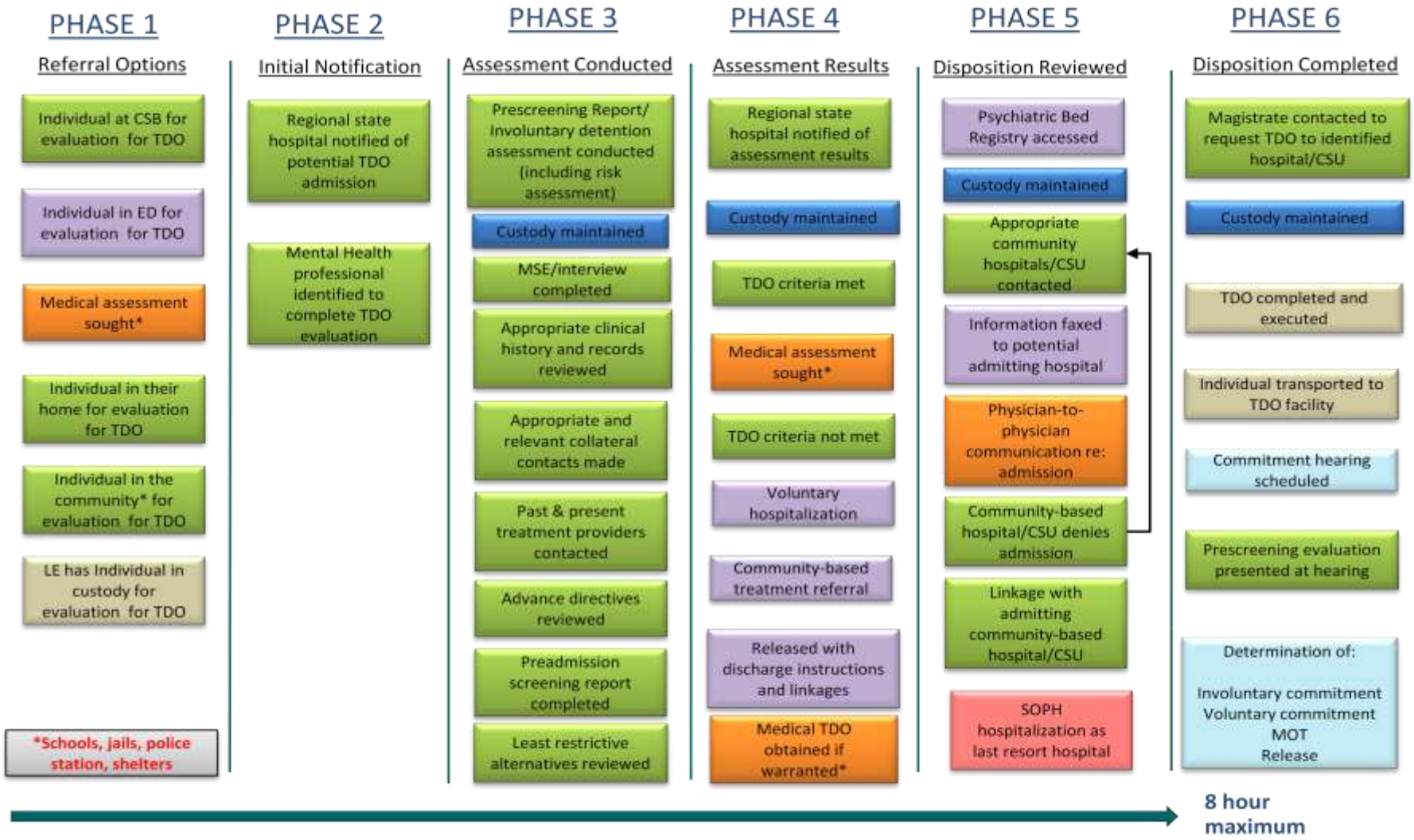
In **Phase Four – Assessment Results**, the evaluator will determine the least restrictive treatment needed and will refer the individual for community based services if the criteria for inpatient treatment is not met. If the evaluation was completed outside of a medical environment, the individual may be taken to a local ED for medical assessment prior to transport to an inpatient psychiatric facility.

In **Phase Five – Disposition Reviewed**, if the individual meets the criteria for involuntary hospitalization, the evaluator will complete a number of notifications and then begin a bed search, beginning with community hospitals or crisis stabilization units. Each of these facilities must be contacted by phone and followed with a fax of the preadmission screening form (PAS form) and any other supporting documentation for the potential willing facility to review and consider. If no local facility can be located, the state hospital is contacted for a last resort bed.

In **Phase Six – Disposition Completed**, when a facility has been determined, the evaluator then contacts the magistrate for the issuance of a TDO. A commitment hearing is then held after a sufficient time for evaluation and treatment but no later than 72 hours after the TDO is issued.

A graphic depicting this six-phase process can be found on the following page, and a detailed description of the six phases is included in Appendix H.

Figure 2: Elements & Phases of the TDO Assessment Process



Color Codes:

- CSB/ Emergency Services (ES) Clinician
- Emergency Medical Physician/Emergency Department (ED)
- Shared: CSB, ED, Law Enforcement (LE), Emergency Medical Physician
- Shared: CSB, ED, Emergency Medical Physician
- Courts/Magistrate/ Special Justice
- Shared: LE & CSB
- State Operated Psychiatric Hospital

II. Workgroup Process

In response to HB 2368, DBHDS developed a 15-member involuntary commitment workgroup comprised of DBHDS staff and stakeholders with expertise in specific facets of Virginia's complicated involuntary commitment process. In addition to DBHDS staff, which included the commissioner, medical director and assistant commissioner for behavioral health services, stakeholder membership included representation from the following groups:

- The Medical Society of Virginia (MSV): provided perspective of hospital-based psychiatrists.
- The National Alliance on Mental Illness (NAMI) – Virginia: represented perspectives of individuals receiving behavioral health services and their families.
- The Psychiatric Society of Virginia (PSV): represented perspectives of Virginia's association of psychiatrists.
- The Virginia Academy of Clinical Psychologists (VACP): represented perspectives of Virginia's association of clinical psychologists.
- The Virginia Association of Community Services Boards (VACSB): provided an emergency services clinician.
- The Virginia College of Emergency Physicians (VCEP): represented perspectives of Virginia's association of emergency department physicians.
- The Virginia Hospital and Healthcare Association (VHHA): provided policy expertise from the association's staff.
- The Virginia Organization of Consumers Asserting Leadership (VOCAL): represented person-centered perspectives of individuals receiving behavioral health services.
- The University of Virginia Institute of Law and Public Policy (ILPPP): provided three staff researchers and experts in Virginia's civil commitment law.

The primary goal of the workgroup was to determine whether allowing additional mental health professionals to initiate temporary detention orders would improve emergency mental health services quality, efficiency and access. More generally, the group agreed that improvements to Virginia's civil commitment laws should increase the quality of services offered, expand access to emergency services and appropriate dispositions, strengthen efficiency so individuals move seamlessly through the system(s), ensure positive outcomes for the persons being served, minimize unintended impact on effected systems, stakeholders and partners, and ensure the continued utilization of the least restrictive community-based alternatives. More information about the workgroup process and full workgroup membership can be found in Appendix I.

III. Response Time Survey

Among the charges in HB 2368 is to identify the CSBs and catchment areas where significant delays in responding to emergency evaluations are occurring. DBHDS currently requires CSBs to report on cases that resulted in exceptions to a TDO being properly executed. These data show that since the first quarter of FY 2015 no one has been denied services due to lack of an available bed. Although the overall outcomes of TDOs are reported, data are not tracked by DBHDS or the CSBs on the time it takes for emergency services clinicians to respond upon notification of the need to conduct an emergency evaluation. As a result, data about delays in response times are primarily anecdotal.

To collect empirical data on delays, the workgroup conducted a statewide survey of all responses for TDO evaluations during a two week period in June 2015. CSB emergency services clinicians collected information on any event in which emergency services conducted a prescreening of any individual under the following conditions:

1. Under a paperless or paper ECO in any location (A paper ECO is one issued by a magistrate upon hearing evidence from a lay individual, provider, or law enforcement that a person is presenting symptoms of a mental illness causing them to present a danger to themselves or others. A paperless ECO occurs when a law enforcement officer takes custody of an individual to bring them for an evaluation for the same reasons. This can be accomplished as part of the officer's duties and authority and does not require the issuance of any order.); or,
2. In an ED, not under a paperless or paper ECO, when there was a mutual agreement between the ED and the CSB that a prescreening was warranted. (This excludes instances in which the CSB was contacted to provide consultation or other services.)

The survey effort was coordinated by DBHDS and CSB leadership with emergency services clinicians statewide. Results were analyzed by the ILPPP. The survey goal was to identify and quantify delays and pinpoint geographic regions where delays may be occurring.

Survey Results

Results from the two week data collection from CSB emergency services clinicians were compiled and reviewed by the ILPPP. The ILPPP provided the following analysis.

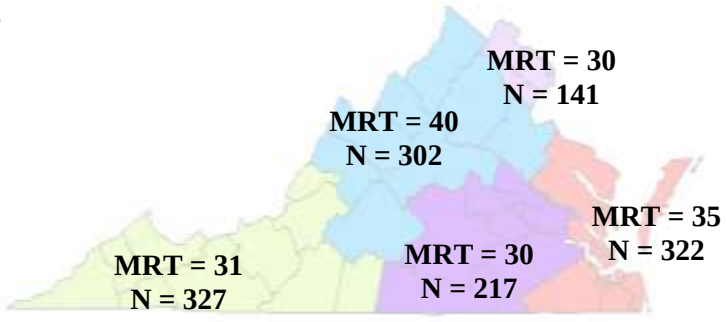
Figure 3: Table of Acronyms and Abbreviations

ART	Average Response Time in Minutes
CIT	Crisis Intervention Team
CSB	Community Services Board
HPR	Health Planning Region
M	Mean
MRT	Median Response Time in Minutes
N	Subsample size
SD	Standard Deviation

Median Response Times for State, HPRs, and CSBs

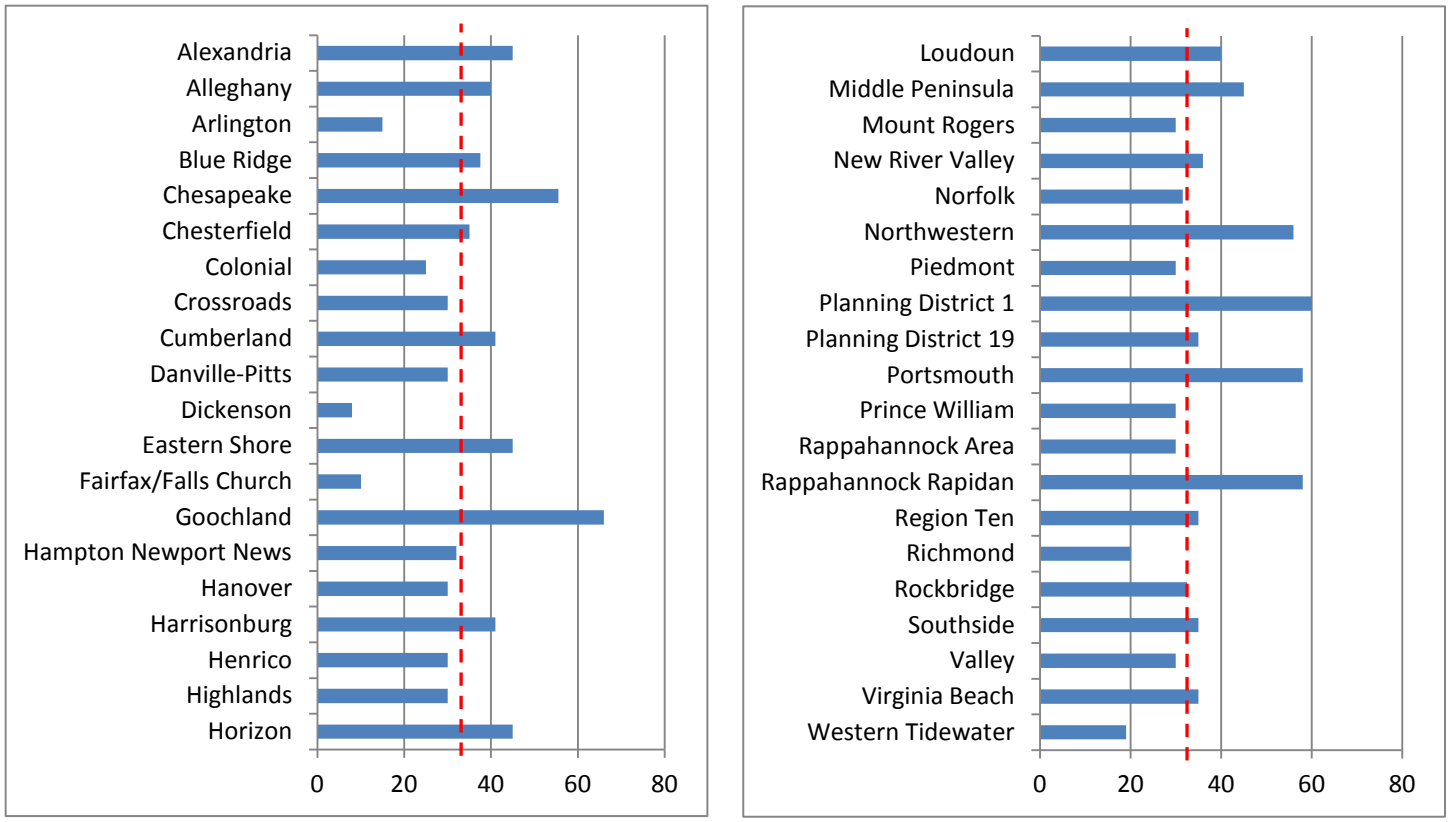
Over the two week course of the survey, 1,309 requests for evaluations were made to the CSBs. The median response time for this statewide sample of evaluation requests was 33 minutes. The average response time, which is affected by a few extreme outliers, was 42 minutes. The number of evaluations conducted within each Health Planning Region (*N*) and the median response times (MRT) for each region is depicted in Figure 4. A list of CSBs in each region is found in Appendix J.

Figure 4.



CSBs' median response times are depicted in Figure 5, in which the state median response time is indicated with a red dotted line for comparison. Statistics for each CSB are available in Appendix A and Appendix B includes a map depicting the CSBs with the 10 shortest median times and 10 longest median times around the Commonwealth.

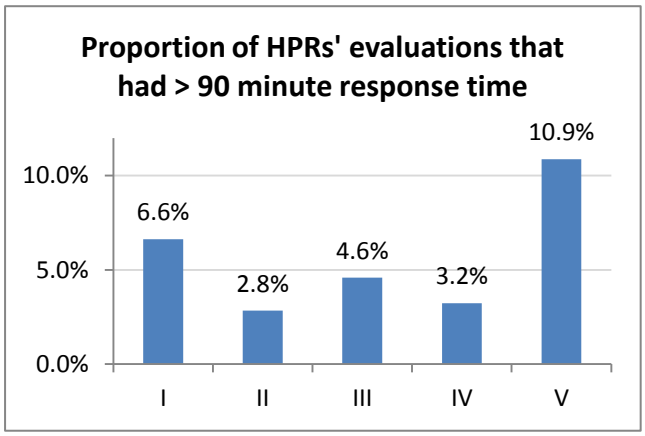
Figure 5: CSBs' Median Response Times

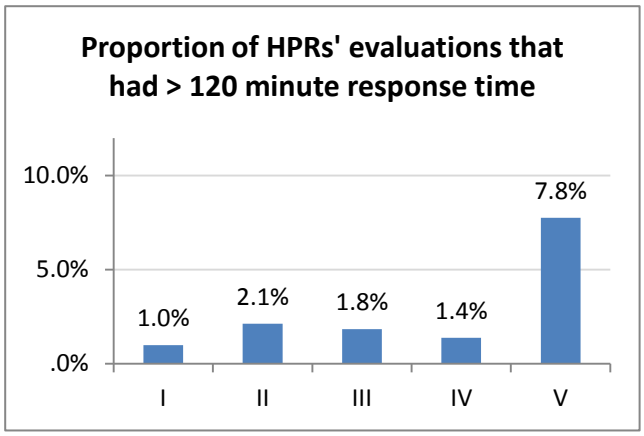


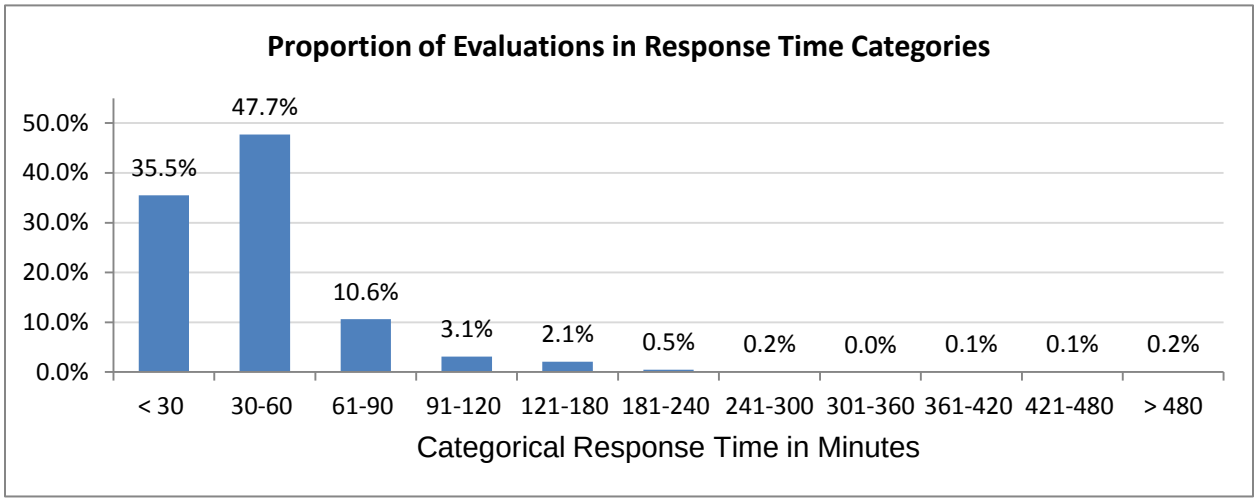
Distribution of Response Times

Nearly 94 percent of evaluations were initiated within 90 minutes of initial request to the CSBs, and 97 percent were initiated within 2 hours. Response times were over 90 minutes in 81 cases, over 120 minutes in 39 cases, and over 240 minutes in 6 cases. (See Appendix C for tables listing CSBs with evaluations over 90 minutes, 120 minutes, and 240 minutes.)

Figures 6-8.







Analysis of Survey Results

Data from this survey of CSB emergency services response times indicate that for the vast majority of cases an emergency services staff person was able to arrive and meet the person to be evaluated within 2 hours. Of over 1,300 cases in two weeks, only six involved response times over 4 hours. The reasons for those extended response times were not recorded as part of this survey, but they appear to be rare occurrences.

As with any self-reported information, there is room for error and inconsistency in the data collected, and results derived from such data are limited. These results are based on a sample of over 1,300 evaluation requests, a sample size which should counterbalance against some irregularity in reporting. Further, the data were reviewed and cleaned before analysis. Nevertheless, future surveys of emergency evaluation response time should include data collection from hospital EDs to provide more comprehensive data and allow for data validation.

In addition to response times, a model was developed to determine what factors are significant predictors of CSB response time. More information on the model and its results can be found in Appendix G. The model included variables for place of service, day of the week, time of day, type of prescreen conducted, CSB budget, population density, whether the CSB has an operational CIT program, and HPR.

Factors associated with *reduced* response times include:

- Evaluation location: Compared to an ED, a response time was likely to be shorter when the evaluation was conducted at a CSB or at a location such as a hospital psychiatric unit.
- Type of prescreen: Compared to a non-ECO-based request for evaluation, a response time was likely to be shorter when the evaluation was requested on the basis of a magistrate-issued ECO.
- CSB budget: Response time by a CSB with a larger budget was likely to be shorter than response time by a CSB with a smaller budget.

Factors associated with *increased* response time:

- Day: Response times on weekends were likely to be longer than Tuesdays through Fridays.
- HPR: Compared to HPR III response times, response times for all other HPRs were likely to be longer.

Secondary to obtaining a contemporary picture of typical response times across the Commonwealth, an important result of this study is the various factors that might be expected to affect response time. Factors such as population density, number of evaluations requested and conducted, budget, or location of evaluation, may be presumed to be driving influences for response time. The current data, however, do not support such suppositions. In fact, when a statistical model was run to assess whether a combination of all such factors can help to explain response time, the model explained only a very small percentage of the variation across the CSBs. In other words, other factors are at play in how quickly a particular CSB responds to evaluation requests. One likely consideration that could not be measured in this study is that of CSB service models. CSBs have put their resources to use in different ways to accommodate their specific circumstances, for example, having an emergency evaluator onsite at a hospital ED, a contract between a CSB and private hospital because of frequent evaluation needs at the hospital, or the use of televideo for evaluations in locations with a high number of evaluations. Future study of CSBs should entail assessment of service models, so that particularly effective models or parts of models can be identified and exported to other CSBs with similar circumstances. Specifically, models of collaborative partnerships between CSBs and EDs that expedite Virginia's existing judicial model should be explored.

Overall, the data suggest that CSB evaluators are able to respond within 90 minutes in approximately 94 percent of cases. In the current study, 1,309 emergency evaluations were conducted over the course of 14 days. Extrapolating from the 6 percent of cases that had response times greater than 90 minutes in the current study, this would suggest that approximately 6 individuals each day, and over 2,000 individuals each year, may experience emergency evaluation response times exceeding 90 minutes.

The current study provides only two weeks of basic time data and, thus, is prone to the effects of extreme cases. In addition, the current data did not provide explanatory information for response times, so longer response times cannot be placed in context (e.g., one unusually busy night shift when only one emergency services staff member was available). Nonetheless, cases of longer response times did occur more frequently for some CSBs and regions than others, such as Blue Ridge Behavioral Health, Chesapeake Integrated Behavioral Health, Hampton-Newport News, Portsmouth, Virginia Beach, and HPR V as a region (see Appendix D). Closer study of long response time cases, and CSBs or regions that appear prone to longer response times should be undertaken to ascertain the particular factors driving response times exceeding 90 minutes. Identifying such factors may encourage targeted remedial steps and create conditions for collaborative problem-solving by the CSBs and the hospitals.

IV. Discussion and Recommendations

Based on language in HB 2368, the workgroup discussion focused on 1) determining where delays may be occurring in responding to emergency custody orders and 2) examining authorization for professionals in addition to CSB emergency services clinicians to conduct evaluations for involuntary commitment where appropriate to expedite emergency evaluations.

Examination of Delays in Responding to Emergency Custody Orders

According to the CSB emergency response time survey results, a study of 1,309 evaluations over a two week period resulted in a median response time of 33 minutes (average of 42 minutes). Nearly 94 percent of evaluations were initiated within 90 minutes of initial request to the CSBs, and 97 percent were initiated within 2 hours. The survey results demonstrate that emergency evaluation delays are

relatively rare. The results also showed cases of longer response times occurring more frequently for some CSBs and regions than others, such as Blue Ridge Behavioral Health, Chesapeake Integrated Behavioral Health, Hampton-Newport News, Portsmouth, Virginia Beach, and HPR V as a region.

The workgroup decided to define a delay as waiting for the CSB emergency services clinician to arrive at longer than 90 minutes from the execution of the emergency custody order.

Additional Authorizations to Conduct Evaluations

The workgroup's discussion focused on continuing to require the setting for conducting an evaluation to be in a hospital emergency department to maintain the integrity of the current system. While the workgroup agreed there are other professionals who are clinically capable of conducting an evaluation, the workgroup was unable to conclude how to operationalize this change in procedure. The three broad areas CSB emergency services clinicians are currently charged with during the evaluation include:

1. **Conducting the evaluation and determining the individual's disposition** including whether or not they should be involuntary admitted to a psychiatric hospital for further treatment under a temporary detention order.

   The workgroup agreed that in addition to CSB emergency services clinicians, the professionals most qualified to conduct evaluations include psychiatrists called to the emergency department from another floor, emergency department physicians, licensed psychologists practicing in an emergency department and social workers licensed at the doctoral level.

2. **Searching for a treatment facility and securing the least restrictive treatment option**

   Conducting the bed search takes time by the CSB emergency services clinician. The online psychiatric bed registry is a very useful tool in conducting the search, but it does not preclude the need to contact facilities directly to determine if that facility is willing to accept the patient. Factors such as age, gender, behavioral challenges, medical complications and severity of diagnosis are all considerations for a facility of temporary detention. In addition, records of past studies into this issue (e.g. JLARC, 1994) show that the requirement for CSBs to conduct the evaluation was designed to avoid unnecessary temporary detention orders and to reduce costs.

   The workgroup did not determine which clinician(s) should be responsible for conducting the bed search and securing the least restrictive treatment option for the individual in crisis.

3. **Completing the pre-admission screening forms**

   Psychiatric hospitals – both public or private – require the completion of preadmission screening forms. The forms generally take 45-60 minutes to complete. Completing the forms would be difficult, if not impossible, for a physician in a busy emergency department. If the professional who completes the forms is not conducting the evaluation, that professional would need to agree with the disposition in the evaluation. The issue of who would testify at the individual's civil commitment hearing is also a significant issue. The person who testifies must have expert clinical knowledge of the decision to involuntarily commit the individual to further treatment under a TDO. Also, the workgroup discussed that physicians may be able to contribute to the forms through the use of their electronic health record (EHR) system. However, CSBs are not required to have the same EHR. In fact, CSBs in the Central Virginia region, for example, have at least four different

EHR systems. Similarly, private hospitals may have different EHR systems. Different systems may present a problem in the event the forms could be upgraded and streamlined to incorporate submissions, such as clinical notes, from EHRs.

The workgroup was unable to come up with a viable alternative to physicians completing the pre-admission screening forms or who would testify at the individual's commitment hearing.

Concerns

Throughout the discussion, workgroup members continued to have several overarching concerns about making changes to Virginia's existing civil commitment process at this time, including:

- **Concerns for complexities of Virginia's civil commitment system –** Workgroup members expressed concerns that authorizing additional professionals to conduct evaluations further complicates an already complicated system. Virginia's civil commitment system was changed significantly in the 1990s as a result of studies completed by JLARC and other entities. A focus on the ability of psychiatrists and emergency department physicians to conduct evaluations addresses only one aspect of a very complex process and may adversely impact other aspects of the process. A truly meaningful review of any proposed change to the civil commitment process will need to address myriad operational challenges, the balance between civil liberty and public safety, and other unintended consequences. For example, due to changes required in the 1990s, CSB evaluators must be trained not only how to determine the appropriate disposition of the individual and what treatment setting is most appropriate, but also how to best match the individual's treatment needs with available resources in the least restrictive environment possible. Without these assurances, the system risks become both detrimental to the people receiving services and risk becoming inefficient if more people are committed to more restrictive, more expensive settings such as state hospitals.

- **Concerns for the individuals experiencing the crisis –** Workgroup members expressed concerns that without a thoughtful, measured approach to any proposed changes, care may be fractured and the overall patient experience worsened for individuals experiencing a mental health crisis. Workgroup members expressed concerns that having even more people involved in an evaluation would oblige individuals to tell their stories multiple times, adding further stress to an already tremendously stressful situation. Consumers and advocacy members of the workgroup noted that being asked to recount the details of one's crisis over and over for each new provider or procedure is an often-cited criticism of the current emergency mental health system. There were also significant fears in the workgroup that such a change in existing civil commitment laws would result in over-hospitalizing people because of a lack of consideration of all available alternatives.

- **Concerns for system accountability –** Workgroup members expressed concerns that further complicating the system may contribute to accountability issues. Specifically, although emergency department physicians and psychiatrists are fully capable of conducting an evaluation, given extreme demands on their time, they may not be able to complete every step of the civil commitment process. Should the process be handled by more than one individual, this may increase the risk of someone "dropping the ball." Also, the system becomes even more difficult to control and potentially risks decreased accountability if it were expanded to include private providers sending people to state-funded facilities.

- **Concerns that collaborative efforts are the more effective way to reduce outlier delays –** Advances and improvements to Virginia's emergency mental health system are already underway in several localities. For example, several CIT assessment sites have opened allowing law enforcement officers to return to duty and evaluations to be undertaken in a timely way. Also, psychiatric emergency services units within at least two hospitals have been undertaken and a CSB has improved its emergency response time by contracting with two hospitals in its area. A defining feature of such changes is the collaborative nature in which multiple stakeholders bring their perspectives and resources together. Given the many systems and partners involved in response to mental health crises, collaborative strategies are more efficient than and preferable to approaches that further split and redistribute responsibilities.

Recommendations

According to data collected in June 2015 and analyzed by the ILPPP, instances when the CSB emergency services clinician is delayed longer than 90 minutes from the execution of the ECO are rare in Virginia. Therefore, changing current statutes to expand the professionals authorized to conduct emergency evaluations would not have a significant impact on expediting emergency evaluations. In addition, Virginia's civil commitment system is very complex and altering one aspect may adversely affect the system as a whole, and the people served by it. Furthermore, the civil commitment process is carefully designed to protect the liberty interests of the individual not only by prescribing time limits on custody but also by assuring a thorough evaluation of the individual's status and needs and considerations about the alternatives to hospitalization. In addition to this comprehensive evaluation, the emergency evaluator must document his or her findings and recommended disposition (which typically takes 45-60 minutes) and, if a temporary detention order is recommended, identify a willing treatment facility and testify at the civil commitment hearing.

Despite the workgroup's research into response times, it did not design a comprehensive plan for completing the evaluations. Recognizing that psychiatrists and ED physicians are hard-pressed for time, the workgroup attempted to outline a procedure for assessing alternatives to hospitalization, documenting findings and recommendation, and identifying placements. However, because of various complexities, the workgroup was unable to address all facets of the problem satisfactorily. For example, the benefit of expediting the emergency evaluation by relying on an ED physician could very easily be lost in the inefficiency of handing off tasks to one or more other providers (e.g., CSB emergency clinician, nursing or social work staff).

The workgroup has agreed to continue to meet and study this issue. The overall performance of the current emergency evaluation system can be improved without altering its basic legal structure. As a result, the workgroup has identified areas of continued focus, including:

- **Additional Response Time Survey** – Conduct another response time survey of a longer duration, concentrating on CSBs or regions that appear prone to longer response times. In addition, the survey should include explanatory information for response times so longer responses can be placed in context. Also, the review should consider studying CSB service models so that particularly effective models or parts of models can be identified and exported to other CSBs with similar circumstances.

- **Updating the Prescreening Form** – Review, along with a representative from the Supreme Court of Virginia, possible updates to the prescreening form, including:

    - Determine if the prescreening form may be reduced in length without sacrificing quality.
    - Explore the ability of the prescreening form to be electronic, including its ability to interface with numerous electronic health records so that information input may occur from the EHR directly to the form. This change would require mobile data entry, field equipment, and consistent internet access in multiple work locations.
    - Discuss amending the prescreening form to allow emergency room physicians to agree or disagree with the assessed disposition by the CSB emergency services clinician.

- **Viable Alternative to Shared Responsibility –** Continue discussions to identify a viable alternative of shared responsibility between CSBs and EDs in which other qualified professionals conduct emergency evaluations in those localities that are unable to reduce persistent delays.

- **Training and Certification** – Examine training options for additional professionals, including obtaining specific certification, to ensure thorough understanding of the statutory requirements and community alternatives that must be considered. Such training and certification would help maintain system oversight, quality and to meet least restrictive obligations. Any training curriculum should be developed with consultation from individuals receiving services.

- **Testimony** – Review including a requirement for magistrates to accept the telephone testimony of emergency department physicians and psychiatrists who consult in an emergency department.

Summary

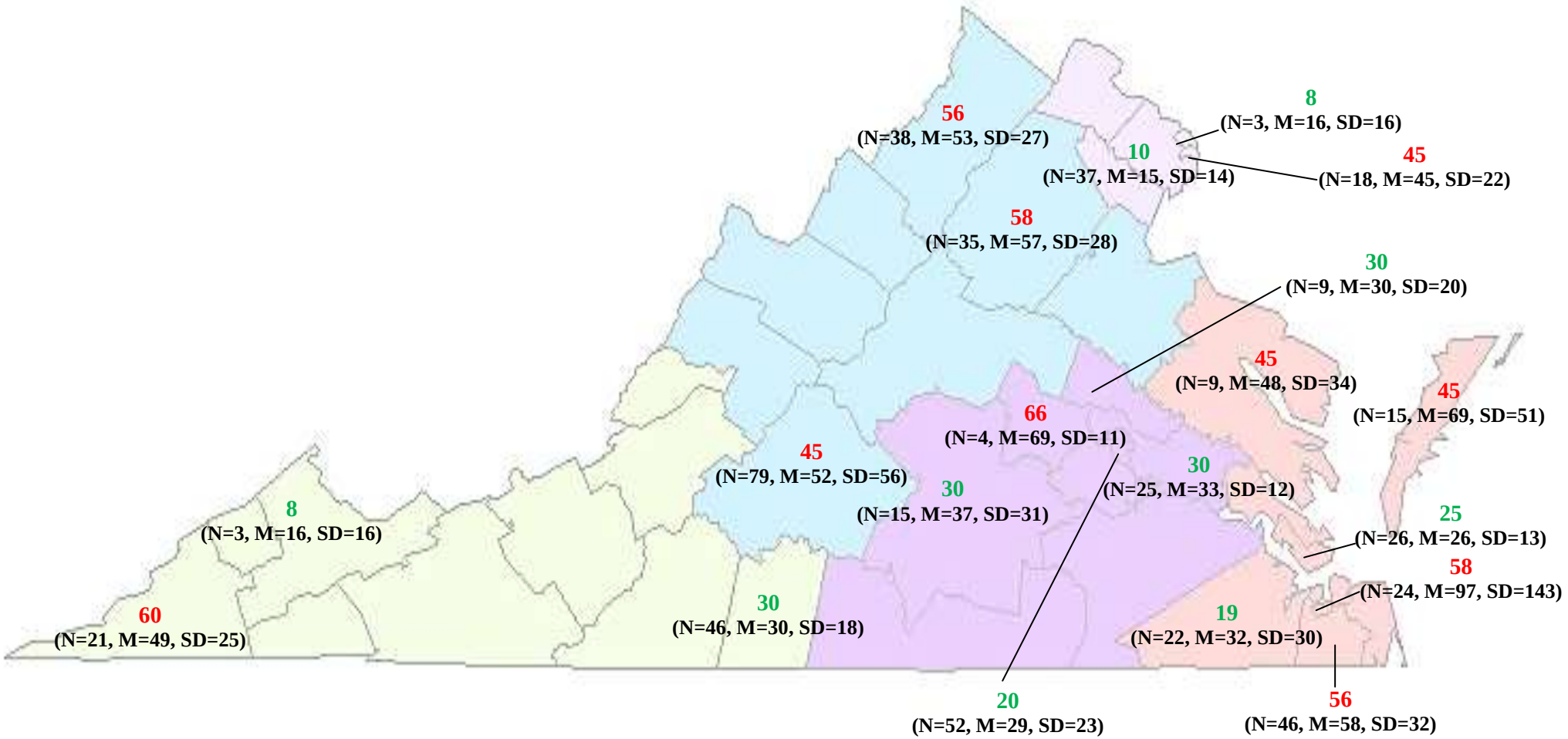
The primary impetus for this legislation was concern about undue delays in CSB emergency assessments of persons admitted to emergency departments. The empirical data collected through the workgroup showed delayed responses are rare across Virginia. The workgroup agreed to continue to meet to study those regions where there are more frequently occurring cases of longer response times in addition to continuing to review other areas of improvement to the civil commitment process. Overall performance of the current emergency evaluation system can be improved without altering its basic legal structure. Finally, the inquiry triggered by this legislation has already yielded substantial benefits by facilitating data collection and increasing system stakeholders' shared understanding of the strengths and weaknesses of the current process, including impediments to timely evaluation.

Appendix A: CSBs in Order from Shortest to Longest Median Response Time

CSB	*N*	MRT	ART	*SD*	Shortest	Longest
Dickenson	3	8.0	16.3	16.2	6.0	35.0
Fairfax/Falls Church	37	10.0	15.1	13.7	1.0	60.0
Arlington	7	15.0	14.7	7.4	5.0	28.0
Western Tidewater	22	19.0	31.6	29.7	0.0	89.0
Richmond	52	20.0	28.7	22.7	0.0	105.0
Colonial	26	25.0	25.8	13.2	5.0	51.0
Crossroads	15	30.0	36.5	30.5	0.0	123.0
Danville-Pitts	46	30.0	30.2	18.2	0.0	65.0
Hanover	9	30.0	30.0	19.8	0.0	60.0
Henrico	25	30.0	33.0	12.1	5.0	60.0
Highlands	31	30.0	40.7	44.5	0.0	175.0
Mount Rogers	55	30.0	33.4	26.8	0.0	120.0
Piedmont	34	30.0	35.2	29.2	1.0	105.0
Prince William	52	30.0	35.3	25.8	0.0	135.0
Rappahannock Area	49	30.0	25.7	13.4	0.0	60.0
Valley	29	30.0	37.3	27.3	0.0	100.0
Norfolk	42	31.5	42.1	37.6	5.0	190.0
Hampton Newport News	65	32.0	45.5	**49.4**	0.0	270.0
Rockbridge	14	32.5	42.8	32.1	0.0	106.0
Chesterfield	23	35.0	31.9	17.7	0.0	54.0
Planning District 19	49	35.0	40.8	21.2	1.0	105.0
Region Ten	41	35.0	42.3	40.2	0.0	235.0
Southside	40	35.0	43.8	**47.6**	0.0	210.0
Virginia Beach	73	35.0	47.9	38.2	5.0	160.0
New River Valley	51	36.0	40.7	27.9	0.0	108.0
Blue Ridge	66	37.5	52.4	**72.3**	0.0	492.0
Alleghany	7	40.0	41.6	7.0	30.0	50.0
Loudoun	27	40.0	50.8	41.6	16.0	185.0
Cumberland	13	41.0	50.4	33.0	0.0	114.0
Harrisonburg	17	41.0	39.8	27.6	0.0	90.0
Alexandria	18	45.0	45.2	21.6	1.0	87.0
Eastern Shore	15	45.0	69.1	**51.0**	15.0	180.0
Horizon	79	45.0	51.6	**55.7**	0.0	461.0
Middle Peninsula	9	45.0	48.3	34.0	10.0	120.0
Chesapeake	46	55.5	57.8	32.2	15.0	150.0
Northwestern	38	56.0	52.8	27.4	0.0	150.0
Portsmouth	24	58.0	96.7	**143.0**	5.0	703.0
Rappahannock Rapidan	35	58.0	57.0	27.5	10.0	104.0
Planning District 1	21	60.0	49.0	24.8	2.0	90.0
Goochland	4	66.0	68.5	11.3	59.0	83.0

Note: Standard deviations over 45, indicating wide variation, are bolded. 68% of a CSB's evaluations fall within ART ± *SD*.

Appendix B: 10 CSBs with Shortest Median Times and 10 CSBs with Longest Median Times



Appendix C: CSB Evaluation Response Times

Evaluations with response times > 90 minutes

CSB	# of cases > 90 minutes	% of that CSB's cases
Blue Ridge	4	6.1
Chesapeake	6	13.0
Crossroads	1	6.7
Cumberland	2	15.4
Eastern Shore	4	26.7
Hampton-Newport News	5	7.7
Highlands	5	16.1
Horizon	8	10.1
Loudoun County	2	7.4
Middle Peninsula-Northern Neck	1	11.1
Mount Rogers	1	1.8
New River Valley	2	3.9
Norfolk	3	7.1
Piedmont	1	2.9
District 19	2	4.1
Portsmouth	6	25.0
Prince William	2	3.8
Rappahannock Rapidan	4	11.4
Region Ten	3	7.3
Richmond	1	1.9
Rockbridge	2	14.3
Southside	3	7.5
Valley	1	3.4
Virginia Beach	10	13.7

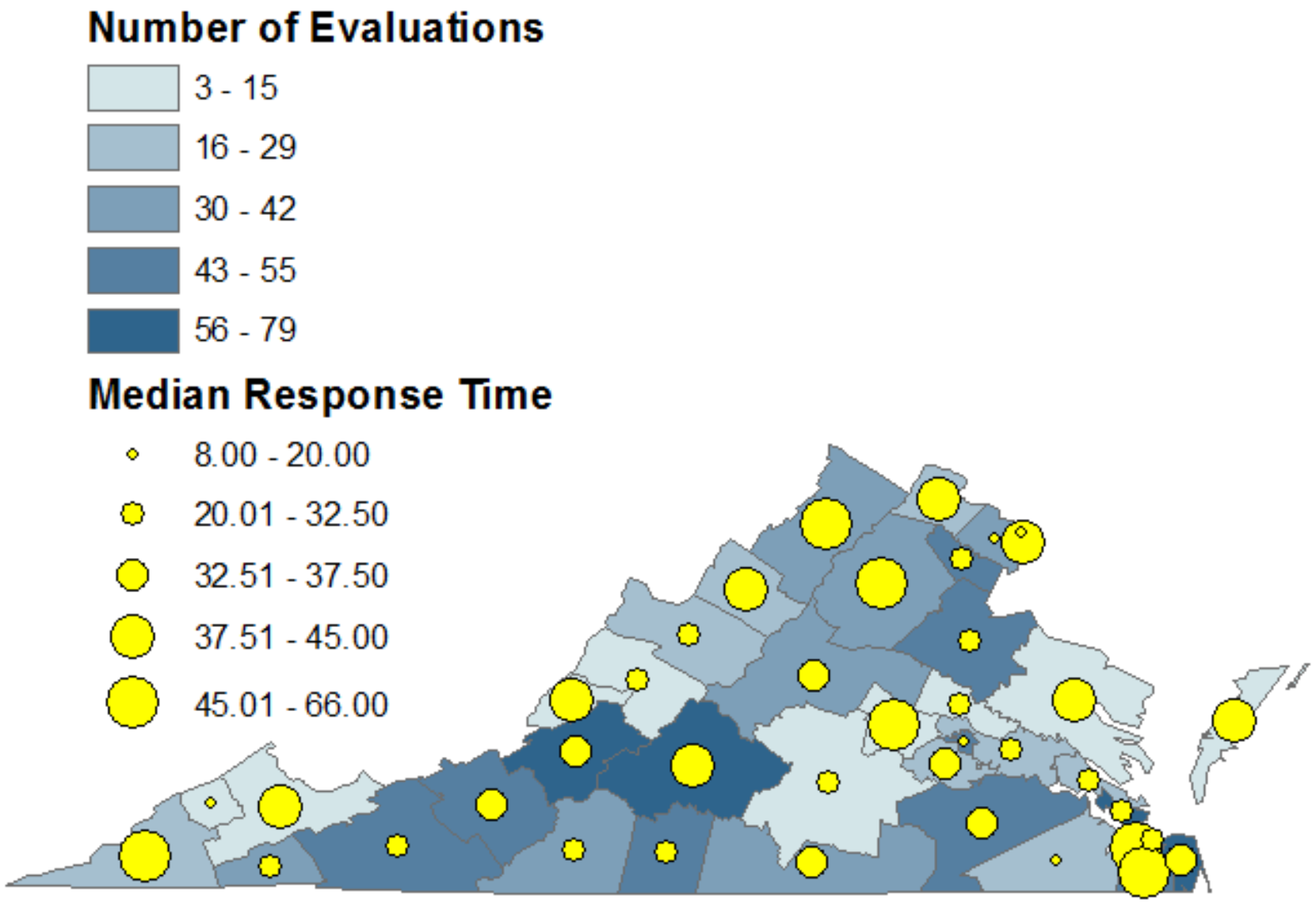
Evaluations with response times > 120 minutes

CSB	# of cases > 120 minutes	% of that CSB's cases
Blue Ridge	4	6.1
Chesapeake	3	6.5
Crossroads	1	6.7
Eastern Shore	3	20.0
Hampton-Newport News	5	7.7
Highlands	2	6.5
Horizon	1	1.3
Loudoun County	2	7.4
Norfolk	2	4.8
Portsmouth	6	25.0
Prince William	1	1.9
Region Ten	1	2.4
Southside	2	5.0
Virginia Beach	6	8.2

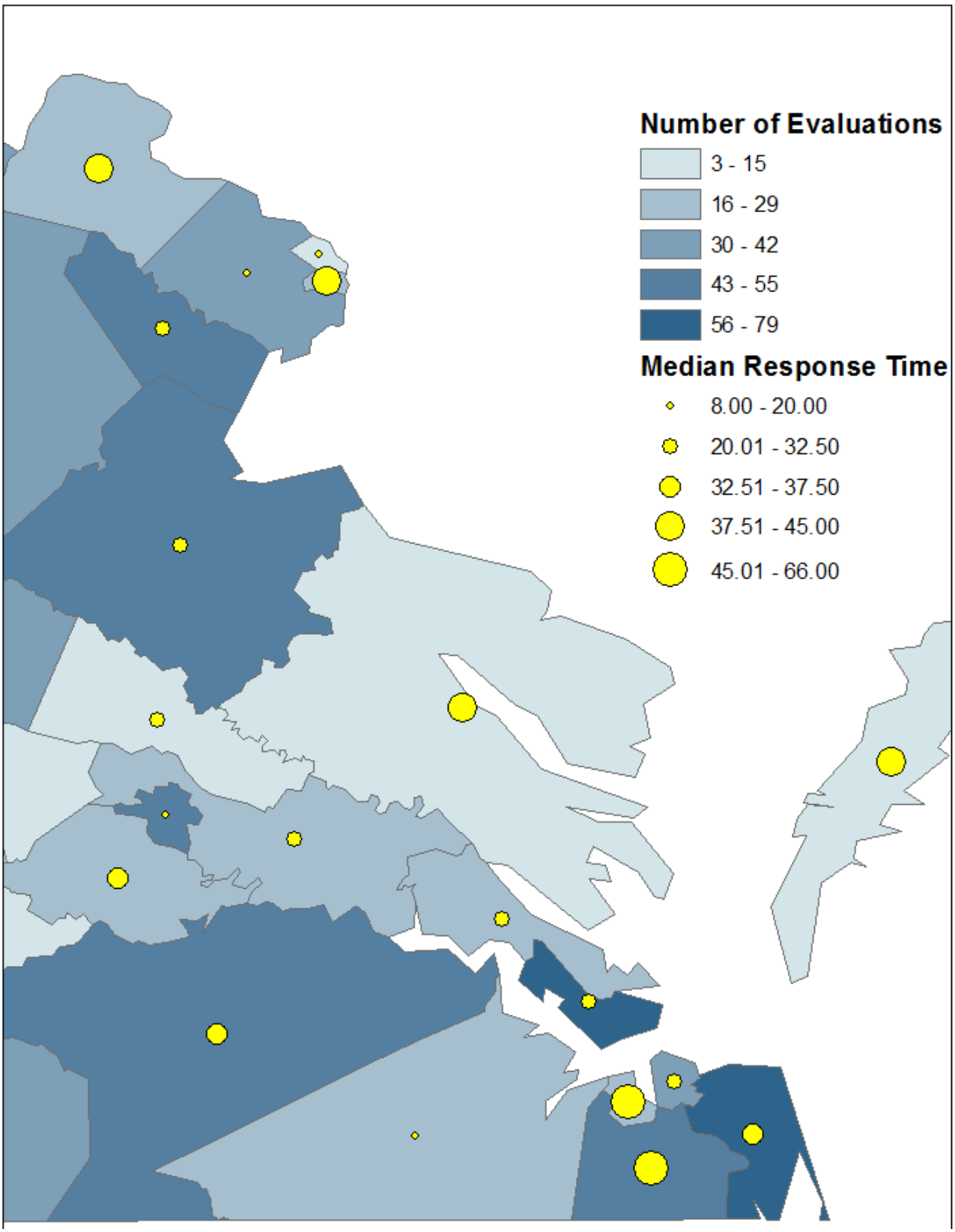
Evaluations with response times > 240 minutes

CSB	# of cases > 240 minutes	% of that CSB's cases
Blue Ridge	2	3.0
Hampton-Newport News	1	1.5
Horizon	1	1.3
Portsmouth	2	8.3

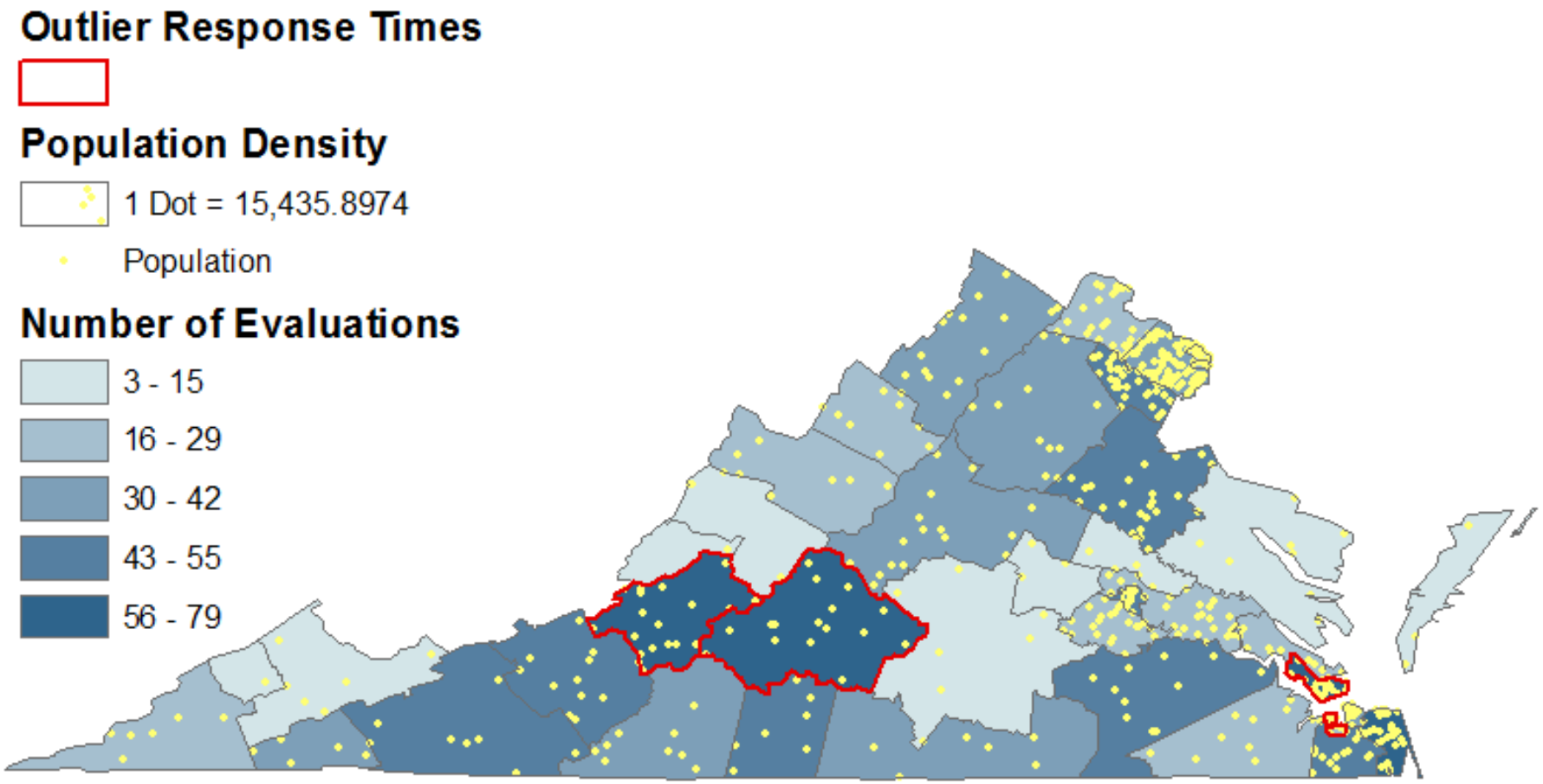
Appendix D: Number of evaluations per CSB and CSB median response times



Appendix E: Number of Evaluation Per CSB and CSB Median Response Times, Close-Up

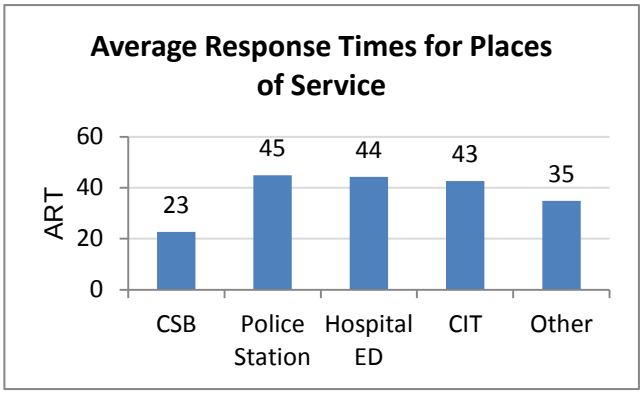


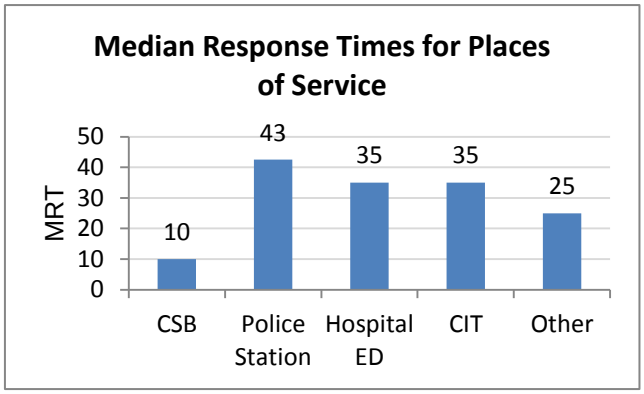
Appendix F: Number of Evaluations Per CSB, CSB Population Density, and CSBs With Evaluation Response Times > 240 Minutes



Appendix G: Potential Correlates and Predictors of CSB Response Time

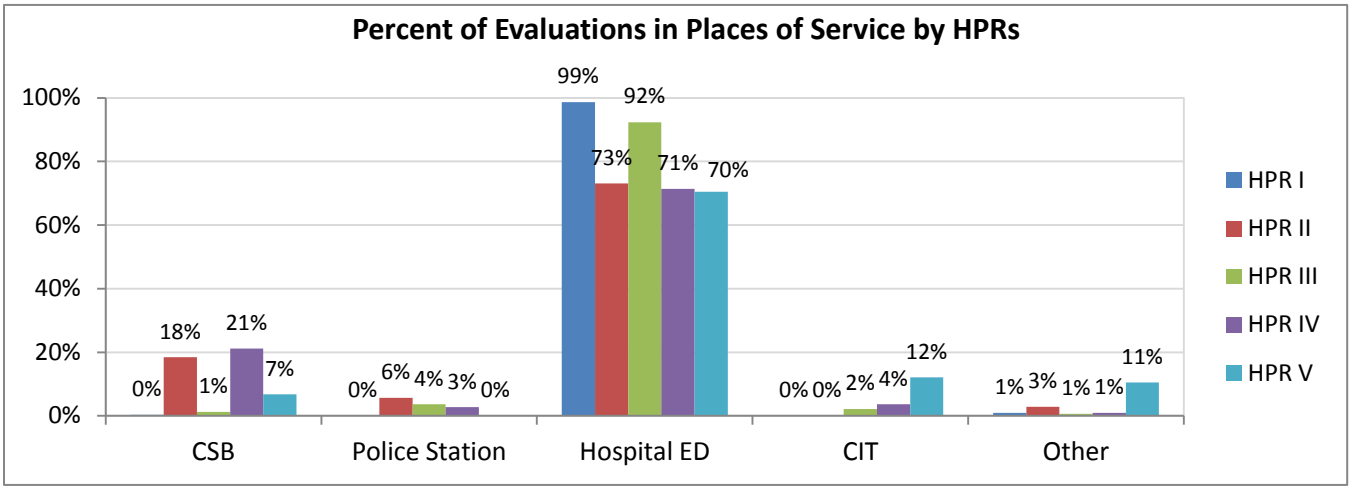
Response time was not correlated with the number of evaluations conducted in each CSB, $p = .33$.[2] Response time was weakly positively correlated[3] with the number of evaluations in each HPR, $r(1307) = .102$, $p < .0001$.[4]





Response time was not correlated with population density of CSBs' areas served, $p = .389$.[5] Response time was weakly negatively correlated with the population density of the HPRs, $r(1307) = -.056$, $p = .042$.[6] (See Appendix D.) Response time was weakly negatively correlated with CSB budget, $r(1309) = -.11$, $p < .001$.[7] Response time was statistically significantly related to location of the evaluation, $F(4, 1308) = 6.41$, $p < .001$. Response time for CSB-based evaluations was significantly shorter than for Emergency Department-based evaluations, $p < .0001$, and for CIT site-based evaluations, $p = .048$.

Figures 9-11.



[2] Correlation remains non-significant when extreme outliers removed, $p = .64$.
[3] Positive correlations indicate that as the variable increased, so did the response time, whereas negative correlations indicate that as a variable increased the response time decreased.
[4] Correlation remains significant when extreme outliers removed, $p < .0001$.
[5] Correlation remains non-significant when extreme outliers removed, $p = .503$.
[6] Correlation remains significant when extreme outliers removed, $p = .029$.
[7] Correlation remains significant when extreme outliers removed, $p < .001$.

Response time was statistically significantly related to day of week, $F(6, 1306) = 3.30$, $p = .003$. Response time for Saturday (ART = 55) was significantly higher than response time for Monday, $p = .005$, Tuesday, $p = .014$, Thursday, $p = .008$, and Friday, $p = .022$.

The highest volume of evaluations occurred in the afternoon and evening, but response time was not statistically significantly related to time of day, $p = .69$.

Response time was statistically significantly different by prescreen type, $F(2, 799) = 11.71$, $p < .0001$. Response time for magistrate-issued ECOs (ART = 34, MRT = 30) was lower than for officer-initiated ECOs, ART = 42, MRT = 35, $p = .001$, and for non-ECO prescreens, ART = 46, MRT = 35, $p < .0001$.

On the basis of the data and variables available from this initial CSB response time survey, a preliminary linear regression model was built to determine what factors are significant predictors of CSB response time. The model included variables for place of service, day of the week, time of day, type of prescreen conducted, CSB budget, population density, whether the CSB has an operational CIT program, and HPR. Extreme outliers were omitted from the regression. The model did not have good predictive capacity, only explaining approximately 8 percent of the total variation seen in observed response times. Nonetheless, some variables emerged as statistically significant predictors of CSB response time:

Factors associated with *reduced* response time:

- Evaluation location: Compared to an ED, a response time was likely to be shorter when the evaluation was conducted at a CSB ($p < .0001$) or at some "other" location, such as a hospital psychiatric unit ($p = .003$).
- Type of prescreen: Compared to a non-ECO-based request for evaluation, a response time was likely to be shorter when the evaluation was requested on the basis of a magistrate-issued ECO ($p = .022$).
- CSB budget: Response time by a CSB with a larger budget was likely to be shorter than response time by a CSB with a smaller budget ($p < .0001$).

Factors associated with *increased* response time:

- Day of week: Response times on weekends were likely to be longer than response times on Tuesdays through Fridays ($p = .002$).
- HPR: Compared to HPR III response times, response times for all other HPRs were likely to be longer ($p < .05$ for each HPR).

Appendix H: Virginia's Six Phase Emergency Evaluation Process

The emergency mental health evaluation process is a complex, multi-stage set of tasks that go beyond conducting a brief meeting with a person in crisis and recommending hospitalization.[8] It is a pivotal point within the larger civil commitment process because, if a TDO is recommended and issued, the individual in crisis is deprived of his or her liberty interests for multiple days and perhaps several weeks, should he or she be civilly committed. The significance of the individual's rights at issue prescribes constraints on health care and legal decision makers involved—emergency evaluations must be comprehensive to assure appropriate disposition but they also must be time-restricted to limit the custody period. As a result, a multitude of aims and tasks are concentrated in the brief 8-hour window allowed under an ECO. To best appreciate what a contingency procedure must account for, it is helpful to outline the many elements of this critical but compact stage in the civil commitment process.

For organizational purposes, the emergency evaluation process can be divided into phases:

1. Referral options
2. Initial notification
3. Assessment conducted
4. Assessment results
5. Disposition reviewed
6. Disposition completed

These phases may occur simultaneously, but distinguishing domains of activity is helpful for identifying tasks to be included in a comprehensive plan allowing psychiatrists and ED physicians to conduct emergency evaluations.

Phase One – Referral Options

There are many different entry points to the emergency behavioral health services in Virginia. Individuals experiencing a crisis may seek help voluntarily or through an emergency custody process. The identification of an individual in crisis may occur during routine outpatient service provision. Individuals may self-identify needs for behavioral health emergency services and seek services in an outpatient environment, local emergency room or in primary care physician offices. Individuals may present either alone or with loved ones. Individuals or their loved ones may also contact CSB emergency services (ES) directly by phone requesting assistance for a behavioral health crisis. ES are available 24 hours a day in all areas of the Commonwealth. Individuals may seek assistance for a behavioral health crisis from a community emergency department with a presenting issue which may or may not be reported as a behavioral health crisis but is determined to be one by the medical personnel in the emergency department. Individuals and families may contact police for assistance if they are unaware of how to access the behavioral health crisis system. Individuals who have been admitted to inpatient medical units may need emergency evaluation upon the conclusion of the acute medical condition and this is usually requested by the attending physician. Anyone can petition a magistrate for an ECO for an individual who may be in need of assessment for a TDO.

Law enforcement may identify an individual experiencing a behavioral health crisis through routine

[8] The process for obtaining a temporary detention order (TDO) for civil commitment of adults is cited in *Virginia Codes* 37.2-808, 37.2-809, 37.2-809.1, 37.2-810, 37.2-813, 37.2-814, 37.2-815, 37.2-816, and 37.2-1104. The *Codes* for minors are 16.1-338, 16.1-339.1, 16.1-340, 16.1-340.1, 16.2-341-16.2-345.

patrol, interactions with the public or through dispatch with a request for services. Officers may take individuals into emergency custody under a paperless ECO or seek a magistrate issued ECO. Others in the community are able to petition the magistrate for an ECO including ES evaluators, if needed. Not all individuals experiencing a behavioral health crisis or a suspected behavioral health crisis will be seen under an ECO.

The Commonwealth's 40 CSBs all operate slightly differently regarding the location for emergency evaluations. They all conduct these evaluations but not all are done in hospital emergency departments. Some CSB ES departments operate a mobile crisis team. These teams evaluate individuals anywhere within their catchment area at the request of law enforcement or anyone who asks. These mobile evaluations are limited in Virginia. There are some CSBs who will see an individual anywhere, some only in secure locations such as hospitals, jails, CSB programs or nursing homes, and others will only see individuals within the confines of a hospital. Some localities have Crisis Intervention Team secure assessment centers with varying operational hours. These centers are staffed with an individual who is able to assume custody of an individual under an ECO and emergency evaluator(s). Secure assessment centers are sometimes located within an emergency department, on local community hospital grounds or are free-standing with no affiliation with a community hospital.

Most individuals admitted to any facility, public or private, will be sent to an emergency department for medical assessment, testing and treatment prior to the psychiatric admission. This may occur after the emergency evaluation if the individual is not in an emergency room when the evaluation is conducted. The medical evaluation prior to acceptance by private and state facilities is typically performed in an emergency department unless the individual has been admitted to an inpatient medical unit prior to the request for an emergency evaluation.

Phase Two – Initial Notifications

When an individual is taken into emergency custody by law enforcement, emergency evaluators are notified by law enforcement or a representative of the local law enforcement as soon as practical of the execution time of the order. The execution of the ECO begins the ECO time period with a maximum of eight hours of custody. ES programs designate an evaluator qualified to perform the evaluation and proceed to the location of the individual in custody. If the individual is not subject to an ECO, the place where the individual is located (emergency departments, medical units, schools, adult homes, nursing homes, etc.) contacts the CSB's ES to request an evaluation and an emergency evaluator is designated to complete the evaluation which may include family and friends of the individual.

Each region of the state has established protocols outlining the notification of the regional state facility of any possible involuntary admission as soon as possible after being notified for the assessment being done for an individual subject to an ECO. The emergency evaluator then notifies the regional state operated psychiatric hospital (SOPH) to alert them of the pending evaluation.

Phase Three – Assessment Conducted

The emergency evaluator begins the evaluation as quickly as possible upon receiving notification of need for assessment. The CSBs are contracted with DBHDS to perform the evaluation within one hour for urban and two hours for rural areas after notification.

Emergency evaluators search the CSB's medical records to determine if the individual is known to the

CSB and to review any current and past treatments. Evaluators gather information from collateral sources prior to and after the evaluation. The sources could be the law enforcement officer who is present, family or loved ones, housing providers, physicians in emergency departments or on medical floors, current outpatient providers, nursing staff, etc.

The evaluator completes a comprehensive assessment of the individual's current functioning, mental status, risk assessment, clinical history, past and present treatment supports, medications, substance usage and precipitating events. The evaluator reviews any advance directives of the individual or wellness recovery action plans (WRAP) to determine the individual wishes for psychiatric treatment or to see if there is a designated health care agent. The evaluator seeks to determine the least restrictive alternative for the individual while balancing the individual's need for safety according to the temporary detention criteria as set forth in the *Code of Virginia*.

Upon completion of the evaluation, record reviews, collateral contacts and notifications to health agents or legal guardians if needed, the evaluator must complete the ten page preadmission screening (PAS) report before seeking an appropriate beds when involuntary inpatient treatment is deemed necessary.

Phase Four – Assessment Results

Upon completion of the evaluation, the evaluator will determine the least restrictive alternative for the individual. Individuals are referred to community based treatments and supports when the criteria for inpatient treatment are not met. If the individual is deemed to be in need of inpatient treatment, the evaluator will determine if the individual is voluntary and has the capacity for voluntary admission; if so, the evaluator will assist with locating voluntary hospitalization in a psychiatric hospital or a residential crisis stabilization unit. Optional services may be offered based upon the evaluation. These services may include a referral for mobile or office based crisis stabilization and intervention services, a referral for outpatient therapy with current providers or referral information for outpatient providers if not currently engaged in treatment.

For individuals assessed outside of a medical environment, the individual may be taken to a local emergency department for medical assessment, testing and treatment as needed. During the medical assessment, if the individual is determined to be in need of acute medical care, the individual can be treated by the emergency department or on an inpatient medical unit if the individual agrees to the treatment. If the individual is unwilling to seek medical treatment, a physician can petition a magistrate for a Medical TDO. The medical TDO allows the physician and facility to treat the individual against their will for up to 24 hours when the physician believes there is a risk of death or disability or to treat an emergency medical condition to avoid harm, injury or death and the individual is determined by the physician to be incapable of making an informed decision or is incapable of communicating such a decision due to physical or mental condition.

Phase Five – Disposition Reviewed

If the individual is determined to meet the criteria for a TDO, the evaluator will notify the regional SOPH and begin conducting a bed search of community psychiatric hospitals for an appropriate and willing hospital. The evaluator may consider placement in a residential CSU under a TDO. If the level of care needed exceeds the services available in the CSUs, then private hospitals are contacted according to each region's established protocols. The Psychiatric Bed Registry may be utilized to assist

with locating a bed but offers no guarantee that the hospitals with listed bed space for an individual will be willing and able to accept the individual.

The evaluator must contact each of the facilities by phone and then follow up with a fax of the completed PAS along with any supporting documentation such as lab work, medical reports, etc. Most evaluators contact multiple facilities at one time to locate an appropriate, willing hospital before the regional protocol guides the evaluator to contact the state hospital for the individual to be admitted to the SOPH as a last resort. During this time, the evaluator continues to work to locate a community psychiatric hospital to assist with maintaining the limited bed space within the SOPH. If no community hospital can be located, the evaluator contacts the SOPH about the need to utilize the state hospital as a last resort. The evaluator provides the hospital with all known information on the individual. During this time the evaluator may continue to pursue placement with a private hospital.

The emergency evaluator may assist with facilitating communication between a doctor from a medical facility to a doctor at the proposed psychiatric hospital, if needed. These conversations may need to occur to insure the individual's medical needs can be addressed in an appropriate way at the SOPH.

Phase Six – Disposition Completed

When the facility for detention is determined, the evaluator contacts the local magistrate to request a TDO. Any responsible person or treating physician may petition for a TDO after the emergency evaluation is completed, or the magistrate issue a TDO based upon his or her own motion. Any recommendations by the treating or examining physician shall be considered if available verbally or in writing prior to rendering a decision. The magistrate will render a decision as to whether to issue the TDO. The emergency evaluator may recommend the use of alternate transportation instead of law enforcement transport and the magistrate renders the decision on the use of alternate transportation. Once the magistrate renders a decision on the transportation provider, the TDO is issued. The transportation provider, either law enforcement or alternative provider, is notified to execute the order and transport the individual to the psychiatric hospital identified on the TDO.

Individuals may be released from the TDO prior to the commitment hearing by the facility director based on an evaluation conducted by a psychiatrist or clinical psychologist treating the individual that the commitment criteria would not be met. District court judges or special justices may release an individual prior to a commitment hearing on personal recognizance or bond if the person does not meet the commitment criteria based upon all readily available evidence.

Commitment hearings are to be held after sufficient time for an independent evaluation to be performed, the preadmission screening report is written and treatment has been initiated to stabilize the individual to avoid involuntary commitment. The commitment hearing must be held within 72 hours of the execution of the TDO unless the 72 hours ends on a weekend or holiday, in which case the commitment hearing must be held by the end of the next business day. At the commitment hearing the individual is informed of the right to volunteer for treatment for a minimum of three days and provide 48 hours notice prior to intent to leave the facility. If the individual is incapable or unwilling to accept voluntary hospitalization, the hearing proceeds to determine if the individual will be released, ordered into mandatory outpatient treatment, or involuntarily committed for up to 30 days. The preadmission screening report is admitted into the court as evidence and made part of the record.

Appendix I: Workgroup Structure and Process

In response to HB 2368, DBHDS developed a 15-member involuntary commitment workgroup comprised of DBHDS staff and stakeholders with expertise in specific facets of Virginia's complicated involuntary commitment process. Workgroup membership is included below:

Involuntary Commitment Workgroup Membership	
Name	**Appointing Organization**
Jack Barber, MD	DBHDS
Richard Bonnie	UVA ILPPP
Cleopatra Booker, PsyD	DBHDS
Skip Cummings	VACSB
Debra Ferguson, PhD	DBHDS
Daniel Herr, JD	DBHDS
Adam Kaul, MD	PSV
John Mason, PsyD	VACP
Bonnie Neighbor	VOCAL
Jake O'Shea, MD	VCEP
Mira Signer	NAMI Virginia
Tanya Wanchek, JD, PhD	UVA ILPPP
Jennifer Wicker	VHHA
Thomas Wise, MD	MSV
Heather Zelle, JD, PhD	UVA ILPPP

Meetings

Because the process and requirements of the legislation dealt with extremely complicated and difficult content, DBHDS convened the workgroup before the conclusion of the 2015 General Assembly Session. The group held eight two-hour meetings on a monthly basis, starting in February and concluding in September. Meetings were held in Richmond at the DBHDS Central Office and conference call capabilities were provided to accommodate the group's members. The workgroup began by identifying guiding principles and goals in order to assure that its limited time was productive. The group agreed to adhere to guiding principles to help ensure the results of their work would:

1. Improve the experience of persons served,
2. Maintain system monitoring,
3. Promote practices that produce positive outcomes,
4. Consider impact on related or parallel systems, and
5. Define outcome measures.

The primary goal of the workgroup was to determine whether allowing additional mental health professionals to initiate temporary detention orders would improve emergency mental health services quality, efficiency and access. More generally, the group agreed that improvements brought about by any proposed changes to Virginia's civil commitment laws should increase the quality of services

offered, expand access to emergency services and appropriate dispositions, strengthen efficiency so individuals would move seamlessly though the system(s), ensure positive outcomes for the persons being served, minimize unintended impact on effected systems, stakeholders and partners, and ensure the continued utilization of the least restrictive community-based alternatives. Stakeholder input generated specific issues to explore while shaping a contingency plan for emergency evaluations, including: the need for certification and training of evaluators, the need for oversight and monitoring, the potential of reimbursement/payment consequences, and the development of outcome measures.

The workgroup next reviewed available information about the current state of emergency mental health system, such as DBHDS TDO exceptions reports and the UVa ILPPP report summarizing involuntary commitment activity for fiscal years 2013 and 2014. As a first point in developing a comprehensive contingency plan for emergency evaluations, the workgroup assessed the tasks required of evaluators as well as key considerations for improving system outcomes (e.g., improving access to services, providing oversight of evaluators) in order to outline criteria for conducting emergency evaluations. The workgroup arrived at a consensus about what is required of a professional if he or she is to be a good fit for the emergency evaluation process with the potential to improve system performance.

Throughout its discussions, the workgroup also identified several important interests that should be served by any changes to the emergency evaluation process. Stakeholders noted the need to increase the use of least restrictive alternatives for people in mental health crisis, or at least to avoid any change that would shift toward greater reliance on hospitalization, particularly in the state mental health hospitals. Another theme informing the workgroup's activities was the need to improve users' experience of the emergency mental health system not only in terms of time and delay, but also in terms of quality of services provided. To that end, the workgroup noted the need to use a person-centered perspective when defining the assessment of needs and whether the process is truly serving individuals' needs. The importance of empirical, rather than impressionistic, data was also a key concern for the workgroup, as it sought to inform its recommendations on the basis of objective, supported depictions of the emergency evaluation process. In fact, the workgroup ultimately determined that it was necessary to gather contemporary, specific data on response time (detailed in Section III below) to shore up the lack of relevant data.

Appendix J: Health Planning Regions

Health Planning Region	Community Services Board or Regional Behavioral Health Authority
1	Alleghany Highlands CSB Horizon Behavioral Health Services Harrisonburg-Rockingham CSB Northwestern Community Services Rappahannock Area CSB Rappahannock-Rapidan CSB Region Ten CSB Rockbridge Area Community Services Valley CSB
2	Alexandria CSB Arlington County CSB Fairfax-Falls Church CSB Loudon County CSB Prince William County CSB
3	Cumberland Mountain CSB Dickenson County Behavioral Health Services Highlands Community Services Mount Rogers CSB New River Valley Community Services Planning District One Behavioral Health Services Danville-Pittsylvania Community Services Piedmont Community Services Blue Ridge Behavioral Healthcare
4	Chesterfield CSB Crossroads CSB District 19 CSB Goochland-Powhatan Community Services Hanover CSB Henrico Area Mental Health & Developmental Services Board Richmond Behavioral Health Authority Southside CSB
5	Chesapeake CSB Colonial Behavioral Health Eastern Shore CSB Hampton-Newport News CSB Middle Peninsula-Northern Neck CSB Norfolk CSB Portsmouth Department of Behavioral Healthcare Services Virginia Beach CSB Western Tidewater CSB

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