COMMONWEALTH of VIRGINIA

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COMMISSIONER

DEPARTMENT OF
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Wednesday, December 22, 2021

The Honorable R. Creigh Deeds, Chair, Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senators Deeds:

Item 320.JJ directs the Department of Behavioral Health and Developmental Services (DBHDS) to establish a workgroup to study the sharing of behavioral health records between community hospitals and community services boards for individuals subject to an evaluation for a temporary detention order. The language states:

> *JJ. The Department of Behavioral Health and Developmental Services shall establish a workgroup to review the current processes and barriers to sharing relevant patient information between community hospitals and Community Services Boards for shared patients subject to an Emergency Custody Order and under evaluation for a Temporary Detention Order. The department shall report its findings and recommendations to the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by December 1, 2021.*

This report details the findings and recommendations of the Behavioral Health Records-Sharing Workgroup. Staff is available to answer any questions.

Sincerely,

Alison G. Land, FACHE

Commissioner, Department of Behavioral Health & Developmental Services

CC:
Vanessa Walker Harris, MD
Susan Massart

Mike Tweedy

Report on Item 320.JJ of the 2021 Appropriations Act

Report of the Behavioral Health Records-Sharing Workgroup

To the Chair of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century or Behavioral Health Commission

Wednesday, December 22, 2021

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Preface

Item 320.JJ directs the Department of Behavioral Health and Developmental Services (DBHDS) to establish a workgroup to study the sharing of behavioral health records between community hospitals and community services boards for individuals subject to an evaluation for a temporary detention order. The language states:

> *JJ. The Department of Behavioral Health and Developmental Services shall establish a workgroup to review the current processes and barriers to sharing relevant patient information between community hospitals and Community Services Boards for shared patients subject to an Emergency Custody Order and under evaluation for a Temporary Detention Order. The department shall report its findings and recommendations to the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by December 1, 2021.*

Executive Summary

Item 320.JJ of the 2021 Appropriations Act directs the Department of Behavioral Health and Developmental Services (DBHDS) to convene a workgroup to review the sharing of patient information between community hospitals and community services boards (CSBs) for individuals subject to an evaluation for a temporary detention order (TDO). Specifically, the workgroup focused on the question of whether the full preadmission screening form completed by a CSB Certified Preadmission Screening Clinician (CPSC) should be consistently shared with the treating physician in the emergency department where the evaluation for TDO takes place.

The workgroup – consisting of representatives from hospitals, emergency department physicians, CSBs, and mental health advocates – was not able to come to a consensus as to whether the full preadmission screening form should be consistently shared. Individual privacy concerns were raised with sharing the full form, though it was agreed that any information collected that would be helpful with treatment should be shared to improve care coordination. Ultimately, these decisions must be made depending on the specific circumstances of each situation.

The workgroup did develop general recommendations related to the sharing of behavioral health records for individuals subject to a TDO evaluation.

1. Consider the development of general guidelines or best practices for care provided to patients undergoing an evaluation for temporary detention in the emergency department.
2. Develop guidelines for CSB evaluators on information sharing that can be posted to the DBHDS website and disseminated to CSBs.
3. Implement the quality-related recommendations of the TDO Evaluator workgroup, including development of centralized oversight of the evaluation process, documentation of discussions related to an individual's care, increased use of peer support specialists, and examination of pathways for enhanced psychiatric clinical management during the length of the emergency custody order.[1]

[1] 320.II of the 2021 Appropriations Act. TDO Evaluator Workgroup, DBHDS. (2021). Report available on December 1, 2021.

Introduction

Item 320.JJ of the 2021 Appropriations Act directs the Department of Behavioral Health and Developmental Services (DBHDS) to convene a workgroup to review the sharing of patient information between community hospitals and community services boards (CSBs) for individuals subject to an evaluation for a temporary detention order (TDO). The workgroup – consisting of representatives from hospitals, emergency department physicians, CSBs, and mental health advocates – reviewed the relevant information that should be shared for patients subject to a TDO evaluation as well as barriers to sharing that information. Finally, the workgroup developed recommendations for improved care coordination for this population of individuals.

Background

The ECO/TDO Process

The purpose of an emergency custody order (ECO) in Virginia is to maintain custody of an individual so that they can undergo an evaluation for a TDO, and this process is a complex, multi-stage set of tasks; individuals who are not under an ECO may also undergo this screening. TDO evaluations are conducted by CSB staff or their designees. Prescreening evaluations must be comprehensive to ensure appropriate disposition, and they also must be completed in a timely manner. As a result, a multitude of aims and tasks are concentrated in the brief 8-hour emergency custody period authorized under an ECO.

The evaluation process can be divided into six phases, which may occur simultaneously. [2] Key requirements of the six phases are summarized below, including approximate amount of time spent on each phase or task.

Phase	Action	Description	Approximate Time Spent within the 8-hr ECO period[3]
1	**Referral – Initiation of the ECO**	There are many different entry points into emergency behavioral health services, including 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.	30 minutes (from issuance of the ECO to initiation of the assessment by the CPSC)
2	**Notification of the CPSC**	When an individual is taken into custody by law enforcement, CSB Certified Preadmission Screening Clinicians (CPSCs) are notified of the execution of an ECO. Each region has protocols for this process to ensure activities are completed	

[2] The process for involuntary civil admission of adults is set forth in Articles 4 and 5 of Title 37.2 of the Code Virginia Code. For minors, the process is set forth in Article 16 of Title 16.1 of the Code of Virginia Code. 5

[3] A follow-up review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission. DBHDS. (2016).

		within the timeframes required. If the individual is not under an ECO, a CSB may still conduct a preadmission screening upon request.	
3	**Conducting the TDO Evaluation** (in-person or through a two-way electronic audio and video communication system)	An evaluation is completed as soon as possible after receiving notification of the need. Under the current performance contract between DBHDS and the CSBs, the assessment is required to begin within one hour of being contacted in an urban area and within two hours in a rural area.	55 minutes
4	**Evaluation Results & Development of a Plan**	The CPSC will determine the least restrictive treatment needed and will refer the individual for community-based services if the criteria for inpatient commitment are not met. If the evaluation was completed outside of a medical environment, the individual may be taken to a local emergency department for medical assessment prior to transport to an inpatient psychiatric facility. The CPSC must then complete a nine-page preadmission screening report[4] form before beginning the process of locating a bed when involuntary inpatient treatment is deemed necessary. Community treatment or voluntary inpatient treatment may also be possible dispositions.	20 minutes
5	**Execution of the Plan**	If the individual meets the criteria for involuntary inpatient 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 other placement can be found, the state hospital will be notified and it will serve as the facility of last resort. Individuals who do not meet the criteria for temporary detention will be referred to appropriate community services by the CPSC.	Up to 370 minutes (average 240 minutes)
6	**Disposition Completed**	When a facility has been identified, the CPSC then contacts the magistrate to request the issuance of a TDO. If no facility is identified prior to the expiration of the ECO, the state hospital is designated as the facility of last resort.	

[4] Preadmission Form, accessible at: http://www.dbhds.virginia.gov/behavioral-health/mental-health-services/protocols-and-procedures

Post-TDO issuance	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.	Up to 72 hours for adults and 96 hours for minors

Information sharing between hospitals and CSBs

In Virginia, the majority of evaluations for temporary detention are conducted in emergency departments. When this occurs, CSB pre-screening staff or a designee generally comes to the emergency department to conduct the TDO evaluation. The treating physician in the emergency department may find some or all of the information shared with the CSB during the evaluation process to be valuable to the patient's treatment plan while he or she remains in the emergency department.

A copy of the preadmission screening form is available in Appendix B. This 9-page form was developed in 2017 in collaboration with the University of Virginia's Institute of Law, Psychiatry, and Public Policy with the goal of developing a comprehensive tool to most accurately assess an individual and come to a decision on his or her disposition in the TDO process. The form is used primarily as a legal document presented to magistrates and courts by the CSB evaluator. The types of information captured in the form include:

- Personal information such as name, address, and primary language of the individual being evaluated
- Encounter information, including CSB contact information and final disposition
- Contact information for the individual and health care agents such as family members, guardians, etc.
- Health care information and medical history, including whether the individual has an advanced directive, medications, and allergies
- Legal status
- Reason for referral
- Risk indicators for ideation/behavior of suicide, physical harm, and inability to care for self
- Substance use assessment
- Current and historical psychiatric treatment
- Current symptoms and mental status
- Feasibility of less restrictive alternatives
- Summary of presenting situation
- CSB recommendations
- Documentation of notifications

In some cases, CSBs may share the completed preadmission screening with the treating physician in the emergency department – often this is by request. In other cases, the local disposition form – which varies from locality to locality in its format and the information it

contains – is shared with the treating physician. Some share separate written forms with requested information or may share information verbally. The level of communication and information sharing between the CSB and the treating physician in the emergency department varies by location and with each individual situation.

Legal Considerations for the Sharing of Patient Records

CSBs or their designees conduct the TDO evaluation – and complete the preadmission screening form – as required by Virginia Code §§ 37.2-505, 37.2-808(B), and 37.2-816. There is no question that under both state and federal law, health care providers are permitted to share protected health information where necessary in connection with care of the individual, unless another law prohibits it. *See* Va. Code § 32.1-127.1:03(D)(7). In addition, Virginia Code § 37.2-804.2 goes one step further and requires that, "Any health care provider, as defined in § 32.1-127.1:03, or other provider who has provided or is currently evaluating or providing services to a person who is the subject of proceedings pursuant to this chapter shall disclose information that may be necessary for the treatment of such person to any other health care provider or other provider evaluating or providing services to or monitoring the treatment of the person." Therefore, the CSB and the treating physician at the emergency department must share any information that may be necessary for the treatment of the individual subject to the TDO evaluation. It is up to each provider to determine what information they think may be necessary for treatment in any particular case, with the goal being a collaboration of care that best serves the individual.

The HIPAA Privacy Rule, which sets national standards for the sharing of individual health information, does not prevent the sharing of information between the CSB and hospital for the purposes of effective treatment of the individual subject to a TDO evaluation.[5]

Federal substance use confidentiality regulations may also apply to information sharing for individuals subject to a TDO evaluation. [6] Per these rules, if the information that would otherwise be shared contains portions that would identify an individual as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person, those portions must be redacted or withheld unless the individual authorizes its sharing or one of the limited exceptions in 42 CFR Part 2 applies.[7]

Because the information shared pursuant to this exception must be necessary to treatment, and because certain portions may be subject to the more stringent confidentiality requirements of the federal substance use disorder confidentiality laws, the particulars of each individual situation, including what exact types of information are disclosed and for what purpose, determine the feasibility of sharing. Therefore, it is impossible to develop a single standard for what should be shared between the CSBs and hospitals for all individuals subject to a TDO evaluation. In all

[5] HIPAA Privacy Rule, 45 CFR Part 160 and Subparts A and E of Part 164.
[6] Confidentiality of Substance Use Disorder Patient Records,
42 CFR Part 2.
[7] Although 42 CFR Part 2 does not currently permit disclosure for general treatment coordination purposes without authorization, it does allow disclosure to medical personnel "to the extent necessary to meet a bona fide medical emergency in which the patient's prior written consent cannot be obtained…" 42 CFR 2.51.

instances, however, the valid authorization of the individual or their authorized representative, if applicable, would permit the CSBs and hospitals to freely share information, so this possibility should not be overlooked.

Workgroup Overview

The Behavioral Health Records-Sharing Workgroup met three times between May and July of 2021 to review barriers to information sharing and develop recommendations for improved coordination between hospitals and CSBs, specifically for individuals subject to TDO evaluations. Representatives from Virginia's hospitals, emergency rooms, and advocates participated. A full list of workgroup participants is available in Appendix A.

The workgroup began by discussing the legal considerations for information sharing between hospitals and CSBs and reviewed the current preadmission screening form for the types of information collected. The workgroup discussed potential concerns with sharing the full form, including concerns among advocates and individuals with lived experience that much of the information included was not necessary to their treatment in the emergency department and that its disclosure would therefore unnecessarily violate their privacy.

Finally, the workgroup reviewed other methods of information sharing, including work being completed through the Emergency Department Care Coordination Program (EDCC) to facilitate real-time, secure collaboration among hospital emergency departments, CSBs, and other community providers. The EDCC is already working with several CSBs to facilitate information sharing with area emergency departments, allowing the CSB to access basic information on their patients to enable prompt follow-up for better outcomes and reduced hospitalizations. While the bulk of the workgroup focused on the content of information being shared, it was noted that there is a significant opportunity through the EDCC to facilitate immediate and effective care coordination using technology more secure than faxes or paper forms.

Key Takeaways

The workgroup did not come to a consensus as to whether there should be specific standards for information sharing between hospitals and CSBs when an individual is subject to a TDO evaluation in the emergency department. In general, the hospitals and emergency department physicians on the workgroup thought that the information provided in the preadmission screening form would be valuable to the individual's treatment and advocated for consistent sharing of the entire form between the CSB and the emergency department. There was also some discussion about the value of the preadmission screening form in aiding with any decision to disagree with the findings of the CPSC per Virginia § 37.2-809.

However, CSBs and advocates made the point that the level of information sharing should vary based on each individual's particular situation and that the individual's privacy should be prioritized equally to provider-to-provider communication. Some of the concerns expressed included where the information in the preadmission screening form goes after being shared with the emergency department and whether the individual can opt-out or opt-in to the sharing of the full preadmission screening form. Currently, however, there is no legal standard dictating where the information in the preadmission screening form goes once it leaves the hands of the CPSC. It likely goes into the individual's medical record at the hospital, and though an individual can

request a restriction on what happens with his or her protected health information pursuant to HIPAA, providers do not always have to honor those restrictions depending on the particular circumstances. There is, however, a provision in Va. Code § 32.1-127.1:03 stating that health information cannot be re-disclosed beyond the purpose for which the information was originally received unless permitted by an authorization or some other provision of law. In general, CSBs and advocates in the workgroup felt that a statewide mandate with regard to the sharing of the preadmission screening form would not be advisable and could violate individuals' privacy.

Given the differing perspectives among the workgroup as well as the legal considerations for information sharing, the workgroup's key takeaways reflect the balance of individual privacy and effective care coordination and honor the unique arrangements for information sharing developed between each CSB and emergency department.

1. At all times, the information-sharing preferences of the individual receiving services should be considered, if known, and the privacy of the individual must take priority along with the quality of services he or she receives. Virginia's *Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services*[8] apply to all providers licensed, operated, or funded by DBHDS, including the CSBs, and specifically require consideration of an individual's preferences in all aspects of service delivery.
2. Under both state and federal law, health care providers are permitted to share protected health information where necessary in connection with care of the individual, unless another law prohibits it. This would therefore allow the CSB to share information from the TDO evaluation with the treating physician in the emergency department if it is necessary to the treatment of the patient and the disclosure is not prohibited by any other law.
3. The information that the CSB shares with the hospital depends on the level of treatment being provided in the emergency department, which can vary widely depending on available resources at hospitals across Virginia. The specific level of information being shared will likely vary on a case-by-case basis depending on the treatment needs of the individual and the resources of the treating hospital. The decision regarding what information is "necessary for treatment" should be ascertained through a dialogue between providers; however, the ultimate decision on what to disclose rests with the provider that would disclose the information because they are the ones legally responsible for safeguarding protected health information that they possess.
4. 42 CFR Part 2 regulations related to substance use disorder records have stricter information-sharing standards. In cases in which the information being shared contains substance use disorder information, this information may need to be withheld or redacted. It may be disclosed pursuant to an individual's authorization or if the particular information being disclosed is necessary to meet a bona fide medical emergency.

[8] 12VAC35-115

Recommendations

The workgroup developed three general recommendations related to the sharing of behavioral health records for individuals subject to a TDO evaluation. Notably, as the workgroup was divided on the subject of whether the full preadmission screening form should be consistently shared in each situation, there was no final recommendation on this point. However, multiple strategies were discussed with the goal of improving care coordination between CSBs and emergency departments in order to ultimately improve outcomes for individuals subject to TDO evaluations. When considering the timing for adoption of these recommendations, consideration should be given to the significant barrier caused by the fact that Virginia, and the rest of the country, is currently experiencing extreme workforce shortages largely due to the impact of the COVID-19 pandemic.

1. **Consider the development of general guidelines or best practices for emergency psychiatric care provided to patients undergoing an evaluation for temporary detention in the emergency department**. This would likely begin with high-level suggestions, as hospitals vary in their available psychiatric resources. A group of clinicians representing community hospitals, CSBs, and state facilities could work together to consider best practices and make recommendations related to:
    - Medication management of individuals presenting in an emergency department and experiencing a mental health crisis;
    - How to provide a therapeutic and safe environment for these individuals;
    - Support services that are effective in easing the anxiety of individuals subject to a TDO evaluation; and
    - Consideration of individuals' advanced directives or other pre-planning documents such as Wellness Recovery Action Plans (WRAP).
2. **Develop guidelines for CSB evaluators on information sharing that can be posted to the DBHDS website and disseminated to CSBs.** This should include:
    - Encouraging CSBs to consult with their legal counsel if they have questions about whether particular information can be shared pursuant to state and federal privacy laws.
    - Suggestions for information that may be especially relevant to the treatment of individuals in the emergency department subject to a TDO evaluation and that should be shared in writing, such as:
        - Current medications and known medication history, including any side effects or allergies;
        - Any information on advanced directives, powers of attorney, guardianship, advocates, and emergency contacts;
        - Information on the individual's regular psychiatric provider; and

- The individual’s disposition.

3. **Implement the quality-related recommendations of the TDO Evaluator workgroup**.[9] These include:

    - Development of centralized oversight of the evaluation process to promote consistency in evaluations and track data on evaluations;
    - Documentation of discussions with an individual’s guardian, emergency department treating physician, referring hospital, and other relevant sources of helpful information;
    - Increased use of peers during the TDO evaluation to advocate for and support the individual undergoing the evaluation and his or her preferences; and
    - Examination of pathways for enhanced psychiatric clinical management during the length of the ECO, including initiation of treatment in the emergency department.

Conclusion

The workgroup agreed that effective coordination between CSBs and emergency departments is critical to providing the best treatment of individuals subject to evaluations for temporary detention. However, local variability in emergency department psychiatric resources and variability in each individual’s particular circumstances makes it difficult to come to a consensus conclusion about whether a particular form, such as the preadmission screening form, or particular categories of information should be consistently shared in all cases. Still, the workgroup agreed that taking steps towards greater consistency in the treatment provided in the emergency department, the quality of the individual’s experience during the ECO period, and the collaborative relationships between CSBs and emergency departments are worthy goals and should continue to be pursued.

[9] 320.II of the 2021 Appropriations Act. TDO Evaluator Workgroup, DBHDS. (2021). Report available on December 1, 2021.

Appendices

Appendix A: Workgroup Members

Workgroup Chair:
Heidi Dix, Deputy Commissioner for Quality Assurance and Government Relations, DBHDS

DBHDS Representatives:
Mary Begor, Crisis Services Coordinator
Alex Harris, Policy and Legislative Affairs Director

Workgroup Members

Organization	Member
Virginia Hospital & Healthcare Association	Cindy Estes
	Jennifer Wicker
	Kurt Hooks
	Madeline Jones
	Molly Huffman
Self-Advocates	Bonnie Neighbor
	Jennifer Spangler
Virginia College of Emergency Room Physicians	Dr. Bruce Lo
	Dr. Joran Sequeira
Virginia Association of Community Services Boards	Curt Gleeson
	Jennifer Faison
	Mary Cole
	Sarah Gray
VOCAL	Elizabeth Bouldin-Clopton
National Alliance for Mental Illness – Virginia	Kathy Harky
Mental Health America – Virginia	Bruce Cruser

Other Stakeholders

Organization	Member
Office of the Attorney General	Allyson Tysinger
Office of the Attorney General	Karen Taylor
Office of Senator Creigh Deeds	Tracy Eppard

Appendix B: Virginia Preadmission Screening Form

Available at: https://dbhds.virginia.gov/assets/Behavioral-Health/sj47/FINAL-Preadmission-Form-2.2.17(rev).pdf

1. PERSONAL INFORMATION

Name: ______________________________ DOB: ____________ Age: _______

First Middle Last

Address: ____

Street City State Zip code County

SSN: _______ - _____ - _______ Gender: ____________ Race: ______________ Hispanic origin? _________

(Optional)

Primary language: ________________ Height _______ Weight _______ Hair Color________ Eye Color_______

Phone: (____)____________ Marital status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Military Status: _______________ VA contacted: ☐ No ☐ Yes (________________________________)

Name Phone

2. PREADMISSION SCREENING ENCOUNTER INFORMATION

Date: ____________ Evaluation start time: _________ Evaluation end time: ________ Location: _____________

Referral Source: _______________ Evaluating CSB/BHA: _______________ Consumer ID# ____________

CSB of Residence: ______________ CSB Code #: _____ Contacted?: ☐No ☐ Yes (_____________________)

Name Phone

REACH program contacted: ☐ N/A ☐ No ☐ Yes (________________________________)

Name Phone

Petitioner Name/Contact Information:____

ECO: ☐ No ☐ Yes: ☐ Magistrate issued ☐ Law enforcement initiated; Date/Time ECO Executed:_____________

Disposition: ☐ Release ☐ Referral ☐ Safety Plan ☐ CSU ☐ Voluntary ☐ Recommitment ☐ TDO

☐ Other ____________________ Psych Bed Registry Query # ____________ Facility: ______________

Case/TDO # ____________ If change of facility, name of new facility:_____________________________

3. CONTACT INFORMATION & COLLATERAL SOURCES (including health care agent(s))

Name: __________________________ Relationship: _________________ Phone: (____)____________

Address: ____

Street City State Zip code County

Name: __________________________ Relationship: _________________ Phone: (____)____________

Address: ____

Street	City	State	Zip code	County

Source(s) of Medical History, Medication, & Collateral Information	☐ Person ☐ Family member (name and relationship): ______________________________________ ☐ Others (e.g., medical staff, law enforcement):____ ☐ Medication containers ☐ Medical records (specify): ____ ☐ Collateral sources were unavailable **>> Explain:**

4. HEALTHCARE INFORMATION AND MEDICAL HISTORY

Advance Directive: ☐ No ☐ Yes ☐ Unknown If yes, obtained? ☐ No ☐ Yes

If not obtained, location: __________________________________

If obtained, AD includes: ☐ Medical ☐ Mental health ☐ End-of-life

Insurance: ☐ Medicaid ☐ Medicare ☐ None ☐ Other: _________________________ ☐ Unknown

First plan # _____________________________ If applicable, second plan #: ______________________________

Income: ☐ SSI ☐ SSDI ☐ Unknown

Medical History and current medical issues (☐ *If checked, see attached medical information*)

Allergies(including food) or adverse side effects to medications: ☐ Yes ☐ No ☐ Unknown

If yes, explain:

Is the person pregnant? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Current Medications: ☐ No ☐ Yes ☐ *If checked, see attached medication list*

Name	Dose	Schedule	Prescriber

Recent medication change? ☐ Unknown ☐ No ☐ Yes >> Explain:

5. LEGAL STATUS

Code value: __________ Details:

Contact Person:

B. RISK ASSESSMENT DETAILS

1. REASON FOR REFERRAL

2. CURRENT AND HISTORICAL RISK INDICATORS

>> Suicidal Ideation/Behavior: Screen for Current and Historical <<

Current & Historical Thoughts and Means	**Comments** (details for each item that is applicable, including timeframe)	None known /
Suicidal Thoughts		☐
Suicide Plan		☐
Suicidal Intent		☐
Access to Means		☐
Self-Harm		☐
Suicide Attempt(s)	(including if attempt was stopped by someone or something, or attempt made when others around)	☐

Additional information, if applicable. *(In cases where the risk assessment cannot be completed, you may document the reason(s) here.)*

>> Physical Harm Ideation/Behavior: Screen for Current and Historical <<

Current & Historical Behavior	**Comments** (details for each item that is applicable, including ability to carry out thoughts/plans and timeframe)	None known /
Threats; thoughts or plans to harm		☐

Expressions of aggression or anger		☐
Fight or attempted fight		☐
Other:		☐
Past physical harm ideation/ behavior		☐

Additional information, if applicable. *(In cases where the risk assessment cannot be completed, you may document the reason(s) here.)*

reported

>> Inability to Care for Self: Screen for Current and Historical <<

Evidence of decreased ability to provide for basic needs and/or protection as a result of mental illness:

☐ None known/reported ☐ Unable to seek basic nourishment ☐ Unable to seek shelter (not just lack of access) ☐ Clothing unsuitable for weather ☐ Recklessness (spending, safety) ☐ Serious neglect of hygiene/ADL's ☐ Serious neglect of medical care ☐ Other:

Comments:

**For minors, ability to care for self is defined in terms of what would be expected for a minor of a similar age and inability is evidenced by delusionary thinking or a significant impairment of functioning hydration, nutrition, self-protection, or self-control.*

3. OTHER HISTORICAL RISK FACTORS

Evidence of Impulsivity/Self-Control

Behavior	Comments (details for each item that is applicable)	None known / reported
Non-suicidal self-injury		☐
Reckless behavior		☐
Difficulty following through with safety plans		☐
Revocation/violation of probation, supervised release, or other such supervision		☐
Did not follow recommended treatment plan *(e.g., MOT, outpatient)*		☐

Substance Use Assessment

☐ No current use reported ☐ No history of use reported ☐ Historical use *only* ☐ Declined to answer

Drug	Frequency	Amount	Method	Last Use Date	Age of 1st Use

History of significant withdrawal symptoms:

☐ Seizures ☐ DTs ☐ Other:____

Lab Results:

Blood alcohol level: ______________ Toxicology screen: _______________

Other Risk and Historical Factors

☐ None known/reported ☐ Family or peer suicide ☐ Childhood abuse/neglect

☐ Other trauma: ____

☐ Recent discharge from inpatient psychiatric (within last 60 days) ☐Owns or has access to firearm ☐ Other:

4. PSYCHIATRIC TREATMENT

Is the person currently in treatment? ☐Yes ☐ No ☐ Unknown

If yes: Name of facility/provider: ____

Date treatment began: ________________________ Frequency of treatment: ____________________

History of treatment? ☐Yes ☐ No ☐ Unknown

If yes, list most recent providers/facilities, type of treatment, and dates of service:

Provider or Facility	**Treatment type** (e.g., outpatient, inpatient, detox)	**Dates of service**

History of treatment…

with psychiatric medication? ☐Yes ☐ No ☐ Unknown

in state hospital? ☐Yes ☐ No ☐ Unknown (name and date: ____________________________________)

in a crisis stabilization unit? ☐Yes ☐ No ☐ Unknown (name and date: ____________________________)

Does the person express treatment preferences? ☐Yes ☐ No ☐ Unknown

If yes, the person's preferences are:

5. CURRENT SYMPTOMS AND MENTAL STATUS

Diagnosis (ICD-10; (P) for provisional, (H) for historical)

Symptoms (Check all that apply)

☐ High anxiety, stress, emotional pain ☐ Hopelessness ☐ Anger ☐ Feeling burdensome to others ☐ Negative appraisal of illness or recovery ☐ Social withdrawal ☐ Increased depressive symptoms

Capacity (For adults and minors age 14 and older)

☐ The individual appears to have capacity to consent to voluntary psychiatric admission because able to: ☐ Maintain and communicate choice,

☐ Understand relevant information, and

☐ Understand consequences

☐ The individual appears to lack capacity

Mental Status (Check all that apply)

Appearance	☐WNL	☐unkempt	☐poor hygiene	☐tense	☐rigid	☐other:
Motor	☐WNL	☐psychomotor retardation	☐psychomotor agitation	☐tremor	☐restless	☐other:
Behavior	☐WNL	☐agitated	☐guarded	☐manic	☐distracted	☐impulsive
	☐tearful	☐easily startled	☐other:			
Orientation	☐WNL	☐time disorientation	☐place disorientation	☐person disorientation	☐situation disorientation	☐other:
Speech	☐WNL	☐pressured	☐slowed	☐soft	☐loud	☐incoherent
	☐slurred	☐other:				
Mood	☐WNL	☐depressed	☐angry	☐hostile	☐euphoric	☐anxious
	☐withdrawn	☐anhedonic	☐other:			
Affect	☐WNL	☐constricted	☐blunted	☐flat	☐labile	☐incongruent with situation
	☐other:					

Thought Content	☐WNL ☐ obsessions	☐impaired ☐grandiose	☐unfocused ☐phobias	☐preoccupied ☐ideas of reference	☐delusions ☐ paranoid	☐thought insertion ☐other:
Thought Process	☐WNL ☐ impaired concentration	☐illogical ☐circumstantial	☐concrete ☐loose associations	☐incoherent ☐flight of ideas	☐tangential ☐thought blocking	☐perseverative ☐other:
Sensory	☐WNL	☐hallucinations type:____________________		☐illusions	☐flashbacks	☐other:
Memory	☐WNL ☐other:	☐impaired immediate		☐impaired recent		☐impaired remote
Appetite	☐WNL	☐decreased	☐increased	☐weight loss	☐weight gain	☐other:
Sleep	☐WNL	☐insomnia	☐onset problem	☐maintenance problem	☐hypersomnia	☐other:
Insight	☐WNL	☐some	☐little	☐none	☐blaming	☐other:
Judgment	☐WNL	☐impaired	☐poor	☐other:		

Is there a prior episode of psychosis? ☐ No ☐ Unknown ☐Yes (if yes, describe in Mental Status Narrative) Is the person showing symptoms of psychosis? ☐ No ☐ Yes (if yes, describe in Mental Status Narrative)

Mental Status Narrative (description of symptoms checked above):

Engagement, Reliability, Response to Interviewers

Person's report appears reliable and consistent. ☐ Yes ☐ No

Engaged and cooperative with assessment and treatment planning. ☐ Yes ☐ No

Comments (optional):

6. FEASIBILITY OF LESS RESTRICTIVE ALTERNATIVES

	Yes	No	N/A
Suicide			
Available resources are sufficient to address immediate suicide risk and person-specific triggers	☐	☐	☐
Physical Harm			
Available resources are sufficient to address immediate risk of physical harm and person-specific triggers	☐	☐	☐
Inability to care for self and basic needs			
Available resources are sufficient to improve person's ability to care for self and basic needs	☐	☐	☐

Plans for addressing risk in the community -or- **Rationale why less restrictive alternatives not feasible**

(☐ *If checked, see attached safety plan*):

C. PREADMISSION SCREENING SUMMARY

1. PRESENTING SITUATION

Summary of presenting crisis (including person and collateral perspectives):

The person's most significant stressors:

Coping strategies already attempted by the person:

Strengths or moderating factors related to documented risk issues and/or concerns:

Assessment and disposition recommendation summary (including person-specific triggers that could quickly increase risk for suicidal or physical harm or quickly decrease ability to care for self and basic needs, and any available resources or protective factors):

D. CSB RECOMMENDATIONS

ADULT - As a result of the emergency evaluation:
The CSB finds that the person ☐ meets / ☐ does not meet the civil commitment criteria, and the CSB recommends: ☐ No further action at this time ☐ Voluntary community treatment (if known at time of disposition, facility/provider: ______________________) ☐ Voluntary admission to a crisis stabilization program at ____________________ ☐ Voluntary inpatient treatment ☐ Temporary detention order ☐ Recommitment The CSB further recommends: ☐ Consideration of 10-day inpatient admission by health care agent or guardian consent Agent or guardian name: ______________________________ ☐ Alternative transportation by ________________________________
MINOR - As a result of the emergency evaluation, the CSB recommends:

The CSB finds that the minor ☐ meets / ☐ does not meet the civil commitment criteria, and the CSB recommends:

☐ No further action at this time

☐ Voluntary community treatment (if known at time of disposition, facility/provider: ________________________)

☐ Voluntary admission to a crisis stabilization program at ______________________

☐ Voluntary inpatient treatment

☐ Temporary detention order The
CSB further recommends:

☐ Alternative transportation by ___________________________________

☐ An order directing either or both parents/guardian to comply with conditions relating to minor's treatment

E. NOTIFICATIONS

1. Attempt to obtain person's agreement or objection to legally required notifications

(per Va. Code § 32.1-127.1:03(D34))

____ will be contacted with information directly relevant to their involvement with the person's health care, including location and general condition.

☐ Person agrees ☐ Person objects ☐ Person lacks capacity ☐ Emergency makes impractical to agree/object

2. Required notification to family member or personal representative, including agent in healthcare advance directive (per Va. Code §§ 16.1-337 or 37.2-804.2)

☐ Contact was made with ____via _________________________________

☐ Reasonable attempt was made to contact ___________________________________ via ____________________________

Comments:

☐ No notification made because

☐ Notice already provided, or ☐ Contact is prohibited by court order, or ☐ Consent is not available and contact is not in person's best interest, or ☐ Person has capacity and objects

3. Required notification when TDO is <u>not</u> recommended for an adult (per Va. Code §37.2-809)

☐ The evaluator informed

☐ the petitioner (________________________),

☐ the onsite treating physician (________________________), and

☐ the person who initiated emergency custody (____________________________; or check here ☐ if the person was not present).

☐ Person who initiated emergency custody was informed that CSB would facilitate communication with the magistrate upon request

☐ Person who initiated emergency custody requested to speak with magistrate regarding recommendation, so evaluator made arrangements

____ __________ ______________________

Preadmission screening clinician signature Date CSB/BHA

____

Printed name (Not required if electronically signed)

____ __________ ______________________

Preadmission screening clinician signature Date CSB/BHA

____

Printed name (Not required if electronically signed)

F. CSB Report to Court and Recommendations for the Individual's Placement, Care, and Treatment

Name: ____ Date: ______________________ Time: ___________________ ☐am ☐pm ☐ No further treatment required.

☐ Has / ☐Does not have sufficient capacity to accept treatment (N/A for minors under age 14 except for outpatient treatment).

☐ Is / ☐Is not willing to be treated voluntarily (N/A under Virginia Code § 19.2-169.6).

☐ Voluntary community treatment at the ☐ CSB (__________________________) or ☐ other (________________________).

☐ Voluntary admission to a crisis stabilization program (__________________________________).

☐ **Adult:** Voluntary inpatient treatment because individual requires hospitalization and has indicated that he/she will agree to a voluntary period of up to 72 hours and will give the facility 48 hours' notice to leave in lieu of involuntary admission.

☐ **Minor:** Voluntary inpatient treatment of minor younger than 14 or non-objecting minor 14 years of age or older. ☐ **Minor:** Parental admission of an objecting minor 14 years of age or older pursuant to 16.1-339.

Minor 16.1-340.4 ☐ Under age 14 ☐ Age 14 or older

(For inpatient treatment only) Parent or guardian ☐ is / ☐ is not willing to consent to voluntary admission.

Because of mental illness, meets the criteria for involuntary admission or mandatory outpatient treatment as follows:

☐The minor presents a serious danger to self or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats, or ☐The minor is experiencing serious deterioration of his ability to care for himself in a developmentally age appropriate manner, evidenced by: ☐delusional thinking or significant impairment of functioning in ☐hydration ☐nutrition ☐self-protection ☐self-control.

☐The minor is in need of compulsory treatment for mental illness and is reasonably likely to benefit from the proposed treatment.

The parent or guardian with whom the minor resides is willing to approve any proposed commitment.

☐Yes ☐No ☐Unavailable If no, such treatment is necessary to protect the minor's life, health, safety or normal development. ☐Yes ☐No **Therefore, the CSB recommends:**

☐Involuntary admission and inpatient treatment, as there are no less restrictive alternatives to inpatient treatment.

☐Alternative transportation provided by: ____

☐Mandatory outpatient treatment (16.1-345.2) not to exceed 90 days because ☐less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and determined to be appropriate; and ☐providers of the services have agreed to deliver the services. The minor, if 14 years of age or older, and his parents or guardians ☐have sufficient capacity to understand the stipulations of the minor's treatment, ☐have expressed an interest in the minor's living in the community and have agreed to abide by the minor's treatment plan, and ☐are deemed to have the capacity to comply with the treatment plan and understand and adhere to

conditions and requirements of the treatment and services. And ☐the ordered treatment can be delivered on an outpatient basis by the CSB or a designated provider(s) (____). ☐The best interests of the minor require an order directing either or both of the minor's parents or guardian to comply with reasonable conditions relating to the minor's treatment. ☐Yes ☐No

Adult 37.2-816

Because of mental illness meets the criteria for involuntary admission or mandatory outpatient treatment* as follows:

☐There is a substantial likelihood of serious physical harm to ☐self or ☐others in the near future as a result of mental illness as evidenced by recent behavior causing, attempting or threatening harm and other relevant information, if any, or

☐There is substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to lack of capacity ☐to protect him/herself from harm or ☐to provide for his/her basic human needs*

Therefore, the CSB recommends:

☐Involuntary admission and inpatient treatment as there are no less restrictive alternatives to inpatient treatment.

☐Alternative transportation provided by: ____

☐Mandatory outpatient treatment (37.2-817(D)) because ☐less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his/her condition have been investigated and ☐are deemed to be appropriate; and the person ☐has agreed to abide by his/her treatment plan and ☐has the ability to do so. The recommended treatment ☐is actually available on an outpatient basis by the ☐CSB or ☐designated provider(s) (___________________________________).

☐Physician discharge to mandatory outpatient treatment following inpatient admission pursuant to 37.2-817(C1)&(C2). ☐The person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in the person being subject to an order for involuntary admission; ☐in view of the person's treatment history and current behavior, the person is in need of mandatory outpatient treatment following inpatient treatment in order to prevent relapse or deterioration of his condition that would be likely to result in the person meeting the criteria for involuntary inpatient treatment; ☐as a result of mental illness, the person is unlikely to voluntarily participate in outpatient treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment; and ☐the person is likely to benefit from mandatory outpatient treatment.

______________________________________ ____________
Preadmission screening clinician signature Date

____
__________________ Print name here (Not required if electronically signed) CSB/BHA

____
____

Print name here (Not required if electronically signed) CSB/BHA

______________________________________ ____________
Preadmission screening clinician signature Date

*Not applicable under Virginia Code 19.2-169.6