Virginia Department of Behavioral Health & Developmental Services

# A follow-up study of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission (HB 2368 (2015))

**November 1, 2017**

***DBHDS Vision: A Life of Possibilities for All Virginians***

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# Executive Summary

Since the 2014 civil commitment law reforms were implemented, every individual meeting the criteria for a temporary detention order (TDO) has been provided with a hospital bed for crisis treatment. These efforts represent meaningful progress in strengthening the behavioral health system and Virginia's safety net. However, the hydraulics of Virginia's complicated behavioral health system often cause actions that help in one area to create challenges in others. Most notably, the "last resort" legislation passed in 2014 requiring state hospitals to accept admissions of individuals under a TDO if no alternate treatment location is found within the eight hour emergency custody order period has led to significant increases in statewide state hospital censuses. In fact, Virginia's nine state mental health hospitals are under tremendous strain with a 224 percent increase in TDO admissions and a 58 percent increase in total admissions since FY 2013. The system has also experienced significant increases in demands at the early stages of the commitment process: Currently, approximately 263 emergency evaluations are conducted and 71 TDOs are issued each day in Virginia. In FY 2017, the community services boards (CSBs) conducted 93,482 face-to-face emergency evaluations and Virginia magistrates issued 25,852 TDOs.

In response to legislative directives contained in HB 2368 (2015), the Department of Behavioral Health and Developmental Services (DBHDS) formed a stakeholder workgroup in 2015 to review the practice of conducting emergency evaluations for individuals subject to emergency custody orders and identify areas in Virginia where significant delays in responding to emergency evaluations are occurring or have occurred in recent years. As required by HB 2368, the efforts of the workgroup were intended to inform the DBHDS commissioner in developing a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations.

The resulting report, "*Review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission,*" included outcomes from a June 2015 time study on response times for community services board (CSB) evaluators to initiate an emergency evaluation.[1] The report states: *"The empirical data collected through the workgroup showed delayed responses are rare across Virginia."* The report also states, *"Nearly 94 percent of evaluations were initiated within 90 minutes of initial request to the CSBs, and 97 percent were initiated within 2 hours."* This survey was not designed to gather information about the causes for any situations resulting in delays, but only to identify response times.

## *2015 Report Recommendations*

Because of the significant complexity and multi-step processes involved in the involuntary civil admission process contained in Virginia *Code*, the HB 2368 workgroup was unable to recommend expanding who could conduct emergency evaluations. Recommendations that the workgroup made included: (1) continuing to study the issue to further reduce or eliminate delays and explore whether there is a viable alternative for shared responsibility; (2) obtaining more

[1] http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3872015/$file/RD387.pdf

complete data about the reasons for delays in initiating an evaluation as well as looking at other factors that slow down the process of moving a person from an emergency department (ED) to a treatment facility; (3) updating and looking for opportunities to reduce the length of the required Prescreening Form for emergency evaluations; (4) instituting a program of training and certification for emergency evaluators; and (5) allowing telephone testimony at the commitment hearing.

*Addressing the 2015 Recommendations and Follow Up Workgroup*

In response to the report findings and recommendations, DBHDS addressed recommendations three, four, and five by implementing a new program of training and certification for emergency evaluators, updating the prescreening form, and providing technical assistance, support, and coordination for those courts who allow telephone testimony at commitment hearings. In June 2016, DBHDS Interim Commissioner Barber convened a second workgroup to better understand any delays in evaluator response time wherever they may occur, and to develop additional recommendations to reduce or eliminate them.

As a first step, this workgroup conducted a second time study on emergency evaluations. It found that the majority of evaluations took place in hospital emergency departments (ED) (70.8 percent) and in crisis intervention assessment centers (CIT Assessment Centers) (23 percent). The median response time from the point of contact requesting the evaluation to the time the evaluator arrived at the evaluation site was 30 minutes. This study also found that 93 percent of TDO evaluations began within two hours compared to the June 2015 survey which found that 97 percent of emergency evaluations were started within two hours. Of the reasons given for delays exceeding more than two hours, respondents cited multiple concurrent evaluations as the primary reason (53.4 percent). Of the reasons for such delays, 35 percent were attributed to for the need for medical assessment or treatment or delays in transporting the individual to the evaluation site, both of which are not within the emergency evaluators' sphere of control.

*2017 Recommendations and Response*

In addition to the second time study, another major focus of the workgroup was to provide additional recommendations for continuing to improve the emergency response system for individuals in psychiatric crisis. After reviewing the results of both time studies, the workgroup provided the following recommendations: (1) develop and implement standardized medical screening protocols; (2) increase uniformity in crisis stabilization units (CSUs) screening and admission processes; (3) revise and simplify the prescreening form used by emergency evaluators; (4) continue evaluating TDO and admission trends in an effort to find ways to reduce delays in finding an appropriate bed in a willing hospital; and (5) expand the use of CIT assessment sites to relieve the burden on EDs.

In collaboration with Virginia Hospital and Healthcare Association (VHHA) and the CSBs, DBHDS is developing a standard protocol for preadmission medical screening with a goal of acceptance by all private and state psychiatric facilities. DBHDS has implemented uniform guidelines for CSU screening and admissions processes and revised the prescreening form used by emergency evaluators. As a result of the data obtained from both time studies, DBHDS is

working with the CSBs to identify, address, manage, and monitor delays resulting from concurrent requests for emergency evaluations. Since 2014, DBHDS has supported the development of 30 new CIT assessment site programs. DBHDS will continue to provide technical assistance and oversight to these programs in order to promote the increased use of CIT as a site for emergency evaluations. Finally, DBHDS will reconvene all relevant stakeholders in the spring of 2018 to review the status of each of these actions and incorporate additional recommendations for strengthening the crisis response system.

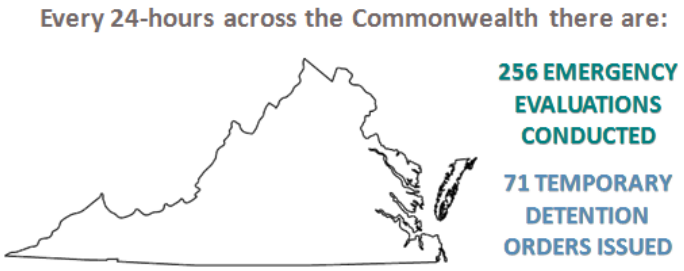
# Introduction and Background

## The General Structure of the 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 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 (and therefore too many TDOs and too many admissions to state hospitals) and 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 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 temporary detention orders.

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 "last resort" state hospital bed was required to be made available as a safety net 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 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 263 emergency evaluations are conducted and 71 TDOs are issued each day in Virginia. In fiscal year (FY) 2017, the CSBs conducted 93,482 face-to-face emergency evaluations and the Virginia magistrates issued 25,852 TDOs.




## Findings and Recommendations from the Initial Report

In 2015, HB 2368 (2015), required 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 were occurring and to develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission. Specifically, that language stated:

> *§ 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.*

In response to legislative directives contained in HB 2368 (2015), the Department of Behavioral Health and Developmental Services (DBHDS) formed a stakeholder workgroup in 2015 to review the practice of conducting emergency evaluations for individuals subject to emergency custody orders and identify areas in Virginia where significant delays in responding to emergency evaluations are occurring or have occurred in recent years. As required by HB 2368, the efforts of the workgroup were intended to inform the DBHDS commissioner in developing a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations.

The resulting report, titled, "*Review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission,*" included the results of a June 2015 time study on response times for community services board (CSB) evaluators to initiate an emergency evaluation.[2] The report states: "*The empirical data collected through the workgroup showed*

[2] http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3872015/$file/RD387.pdf

*delayed responses are rare across Virginia."* The report also states, *"Nearly 94 percent of evaluations were initiated within 90 minutes of initial request to the CSBs, and 97 percent were initiated within 2 hours."* This survey was not designed to gather information about the possible causes for the small number of delays, but only to identify any delays in response times.

Because of the significant complexity and multi-step processes involved in the involuntary civil admission process in Virginia *Code*, the HB 2368 workgroup was unable to recommend expanding who could conduct emergency evaluations. Recommendations that the workgroup made included: (1) continuing to study the issue to further reduce or eliminate delays and explore if there is a viable alternative for shared responsibility; (2) obtaining more complete data about the reasons for delays in initiating an evaluation and looking at other factors that slow down the process of moving a person from an emergency department (ED) to a treatment facility; (3) updating and looking for opportunities to reduce the length of the required Prescreening Form for emergency evaluations; (4) instituting a program of training and certification for emergency evaluators; and (5) allowing telephone testimony at the commitment hearing.

## DBHDS Response to Initial Workgroup Recommendations

In response to these findings and recommendations, DBHDS implemented a new certification and training program for emergency evaluators on July 1, 2016 (See Appendix A). DBHDS partnered with the CSBs and experts at the ILPPP to revise and improve the emergency evaluation form in order to eliminate any unnecessary information, allow for succinct documentation, promote best practices in clinical evaluation and risk assessment and meet the various legal and clinical purposes of the emergency evaluation process and prescreening form. DBHDS senior leadership receives and reviews reports on all high risk events that occur during the emergency evaluation process, trends such events, and identifies areas for potential improvement statewide. These trends and areas for potential improvement are reported to the Virginia Association of Community Services Boards and the DBHDS Quality Council. Additionally, when requested, DBHDS has provided technical assistance to the special justices, other court personnel, hospital staff, and emergency evaluations regarding the use of telephone testimony at commitment hearings.

In June 2016, Interim Commissioner Barber convened a second workgroup to better understand delays wherever they may occur in the process and to develop additional recommendations to reduce or eliminate them. Workgroup membership consisted of DBHDS staff, CSB executive and emergency services staff, the ILPPP staff, representatives of the Virginia Health and Hospital Association (VHHA) and the Virginia College of Emergency Physicians (VCEP). When advocacy organizations that had participated in the original workgroup were unable to participate in the second effort, a peer representative from DBHDS's Office of Recovery Services was added to the group to ensure the important perspective of individuals with mental illness were included in the process.

This workgroup identified and discussed a number of issues that influence how quickly a disposition can be reached and implemented so that a person in crisis can transition from an ED to an appropriate treatment setting. These issues included: (1) a need for further quantifying and

understanding the causes of delays in a emergency evaluators being able to commence and complete an evaluation; (2) delays due to medical screening requirements at receiving facilities [often referred to as medical clearance] and disagreements between physicians about when a patient is stable enough to be discharged from the emergency department; (3) delays in finding a willing facility; and (4) delays in gaining access to a patient to be evaluated. In addition to delays affecting the emergency evaluation process, the group expanded the discussion to include referrals to crisis stabilization units (CSUs) and other requests from local emergency rooms. As a result of these discussions, the workgroup decided to conduct a second time study to measure and understand the time associated with various steps in the emergency evaluation process. Along with the study, the discussions resulted in five specific recommendations.

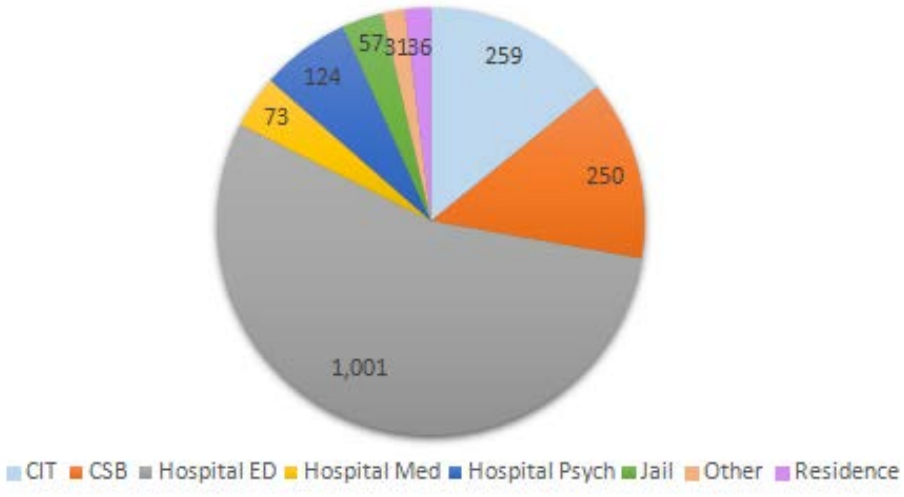
## The Second Time Study

A time study was conducted from November 7-20, 2016, with emergency evaluators statewide completing a survey developed by the ILPPP that reported various time stamps, other important variables and indicated the reason for delayed response times. Any time an emergency evaluation was undertaken, except in the case of recommitment hearings, a one-page survey form was completed capturing the time and other data. An attempt was made to have all CSB emergency evaluators complete this survey and ED staff complete a comparable survey on all emergency evaluations to allow cross-validation of data. EDs were largely unable to participate; however, all but two of the CSBs submitted all of their forms in time for analysis, yielding 95 percent participation. Survey forms were completed for 1,837 emergency evaluations undertaken during the two weeks. *Importantly, it should be noted that November typically has a lower volume of emergency evaluations, and that the numbers from this study should not be used to extrapolate annual frequencies.*

**Appendices B through D contain a detailed description of the data obtained by the November 2016 time study**. A brief overview of the time study results follow:

- The study found that the majority of the emergency evaluations took place in a hospital ED (70.8 percent) and in crisis intervention assessment centers (23 percent). See Figure 1 below for more details.

**Figure 1:** Number of emergency evaluations at each evaluation site indicated in the survey (n=1837).



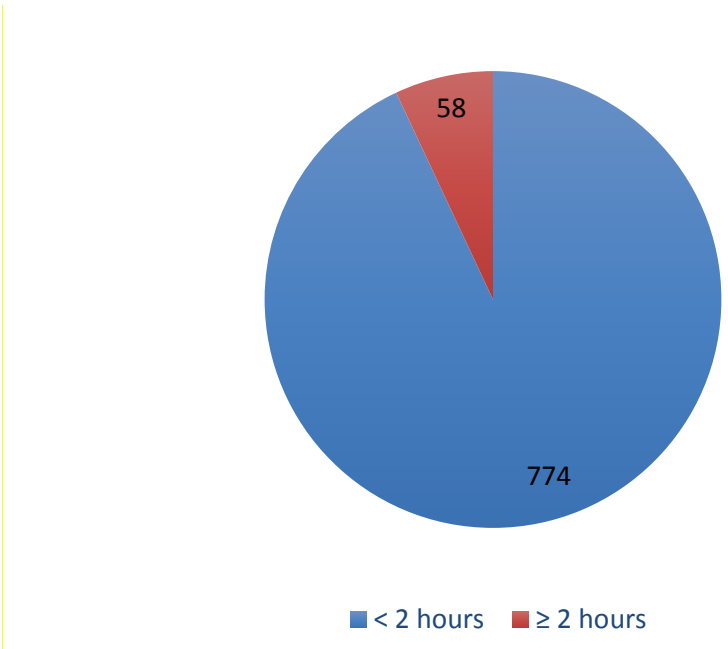
- The median response time from the point of contact requesting the evaluation to the time the evaluator arrived at the evaluation site was 30 minutes. See Figure 2 below for more details.

**Figure 2:** Time taken (in minutes) for different components of the emergency evaluation process up until end of evaluation, where the evaluation site is a Hospital ED. This data includes all 1,001 ED emergency evaluations.

| Evaluation Component | Median Time |
|---|---|
| From Contact to arrival at the ED | 30 |
| From Arrival on site to start of Evaluation | 5 |
| From Start of Evaluation to start of FTF part of evaluation | 0 |
| From start of FTF part of evaluation to end of evaluation | 55 |
| Total time from Contact to End of Evaluation | 110 |
| *FTF=Face-to-Face | |

- This study also found that 93 percent of the emergency evaluations began within two hours compared to the June 2015 survey which found that 97 percent of emergency evaluations were started within two hours. See Figure 3 below for more details.

**Figure 3:** Number of ED-based TDO emergency evaluations where time from initial contact to start of evaluation took more than two hours.



- Thirty-five percent of the reasons attributed to such delays were the need for medical assessment or treatment or delays in transporting the individual to the evaluation site, both of which are not within the emergency evaluators' sphere of control. See Figure 4 below for more details.

**Figure 4:** Reasons for delay, defined as two hours between initial contact and the start of the evaluation (n=58), among ED-based emergency evaluations.

| Reason | Number | Percent* |
|---|---|---|
| Multiple evaluations received simultaneously | 31 | 53.4 |
| Awaiting arrival of person by transport | 9 | 15.5 |
| Medical stabilization/treatment | 7 | 12.1 |
| Distance travelled | 7 | 12.1 |
| Non-Mandated Screen | 9 | 15.5 |
| Shift change early in the emergency evaluation | 2 | 3.4 |
| Communication Difficulties | 2 | 3.4 |
| Other | 2 | 3.4 |
| No Reason Given | 12 | 20.7 |

As a result of this data, and as a first step in reducing delays, DBHDS is working with the CSBs with the highest rates of delays to continue identifying the specific factors which contribute to that CSB's delays, develop specific strategies for reducing those delays, and implement a process for monitoring those delays.

## Additional Work Group Recommendations

Based on the review of the survey findings and ongoing discussions, the workgroup makes the following recommendations. Where possible, DBHDS, in collaboration with the workgroup, has already begun working on these recommendations.

***Recommendation One**: Develop and Implement Standardized Medical Screening Protocols*

All private and public psychiatric hospitals as well as the16 DBHDS-funded crisis stabilization units (CSUs) require what is generally called "medical clearance" as part of the process of acceptance for admission. Due to issues of access and timeliness during the limited emergency custody order (ECO) and TDO timeframes, medical screening most often occurs in an emergency room. This is to assure that the receiving hospital has the capacity to meet the needs of the individual and that acute medical issues presenting as psychiatric conditions are identified. Psychiatric providers frequently require more extensive screening and medical testing than emergency department (ED) physicians believe is medically necessary. In addition to the general medical examination and history, various lab tests are ordered. There has been no general

agreement on what lab tests should be routine. In addition, there can be disagreement between the ED physician and the psychiatrist both about the extent of testing required and what clinical test values indicate an individual is appropriate for transfer to a psychiatric hospital. This can result in a time consuming correspondence, perhaps waiting for additional test information. ED physicians are concerned about inefficient use of resources that this may cause.

VHHA and DBHDS are currently working on developing a standard protocol for preadmission medical screening with a goal of acceptance by all private and state psychiatric facilities. This would include lab values (e.g. blood alcohol level) that would be generally acceptable. If medically necessary, other tests or procedures would be added. The standardized screening protocols should include a dispute resolution process when sending and receiving facilities' physicians disagree.

These standardized protocols should be included in DBHDS' *Medical Screening and Medical Assessment Guidance Materials*.[3]

***Recommendation Two**: Increase Uniformity in CSUs' Screening and Admission Processes*

The lack of uniformity and clarity of processes and criteria among CSUs was discussed as a problem. While absolute uniformity among the 16 CSUs overseen by DBHDS is not possible, the workgroup believed there should be greater consistency in key areas. Following a study of the practices and challenges at CSUs, DBHDS developed expectations for CSUs that will be incorporated in the DBHDS/CSB performance contracts[4]. Progress in these areas will improve access to CSU screening and admission. These expectations include:

- The CSU will have a well-defined written plan for continuous psychiatric coverage. The plan must address contingency planning for vacations, vacancies, illnesses and other extended absences of the primary psychiatric provider.
- The CSU will have a well-defined written plan for continuous coverage of nursing and clinical staff. The plan must address contingency planning for vacations, vacancies, illnesses, and other extended staff absences.
- The CSU will review and streamline their current admission process to allow for admissions 24 hours a day seven days a week.
- The CSU will develop well-defined written policies and procedures for reviewing requests for admission. The CSU will maintain written documentation of all requests and denials. Admission denials must be reviewed by the clinical manager and other appropriately designated staff within 72 hours of the denial decision.
- The CSU will participate in regional collaboration with other CSUs at least quarterly to share successes and resources in order to optimize individual program functioning and to increase inter-program consistency.
- The CSU will develop a well-defined written process for building collaborative relationships with private and state facilities, emergency services staff, and local EDs in their catchment area. Ideally, these collaborative relationships will facilitate the flow of

[3] http://www.dbhds.virginia.gov/library/mental%20health%20services/140401medicalscreeningguidance%20(2).pdf
[4] http://www.dbhds.virginia.gov/professionals-and-service-providers/office-of-support-services

referrals to the CSU for diversion and step down from a hospital setting and to transition an individual from a CSU to a higher level of care. The written process should include a face to face meeting at least twice per year and may include tours of the unit and reciprocal training for staff on program strengths and limitations.

***Recommendation Three**: Revise and Simplify the Prescreening Form Used By Emergency Evaluators*

DBHDS engaged experts at the ILPPP to work with DBHDS, emergency services managers and emergency evaluators to revise and improve the prescreening form in order to eliminate any unnecessary information, allow for succinct documentation, promote best practices in clinical evaluation and risk assessment and meet the various legal and clinical purposes of the emergency evaluation process and form.

The form is required by the court and by all receiving psychiatric facilities. It is used to determine if an individual meets the legal criteria for temporary detention and to provide that information and supporting data to a magistrate and the court. It serves to provide referral data to hospitals that require it in order to consider accepting the individual. It is also an instrument for required data collection by DBHDS, which allows DBHDS to provide oversight regarding the appropriateness and quality of assessments and serves to promote as much continuity of care as possible as the individual transitions between various levels of care. The revised form will also serve as a prompt to emergency evaluators to assure attention to the various considerations and notices that the General Assembly has mandated in its last two sessions as well as assure that less restrictive alternatives are considered and used when appropriate. After being reviewed and approved by the Office of the Attorney General, and undergoing a two week field trial, the revised form was implemented on July 1, 2017.

***Recommendation Four**: Continue Evaluating TDO and Admission Trends in an Effort to Find Ways to Reduce Delays in Finding an Appropriate Bed in a Willing Hospital*

The efficiency and effectiveness of Virginia's process for temporary detention is reliant on both the private and public sectors. Currently and historically private hospitals accept and treat 80-90 percent of those held under a TDO. Payment for this is either through private insurance, Medicaid or the Supreme Court's Involuntary Commitment Fund. State hospitals serve as a "last resort" option for those for whom no willing private hospital bed is available or those that private hospitals judge to exceed their capacity to manage. Given this distribution of cases a relatively small percentage of change for the private hospital system can cause a large increase for the much smaller number of state psychiatric hospitals. This has been the case in late FY 2016 and early FY 2017 when an increase in the number of TDOs issued and a reduction in the percentage of TDO admissions admitted to private hospitals resulted in the state hospitals operating at or above capacity. This interdependence highlights the necessity of a close working relationship and partnership between DBHDS and VHHA and the hospitals it represents. As a result, the workgroup has recommended that DBHDS, in collaboration with stakeholders, continue to track and evaluate the pattern of TDOs issues, the number of admissions to state hospitals, and partner with the private hospitals to address these challenges. Data regarding the TDO and admission trends are found in Appendix E.

Notably, Virginia's emergency custody order (ECO) period is among the shortest in the nation. In a 2012 study from Emergency Medicine International, the length of stay nationwide in emergency departments for psychiatric admissions was 18 hours. In 2014, the Governor's Taskforce on Improving Mental Health Services and Crisis Response recommended that Virginia increase its ECO period to 12 hours. The General Assembly instead increased the ECO period to eight hours, and included the "last resort" requirements for state psychiatric hospitals. While no person has gone without a bed since July 1, 2014, the state hospitals have seen a dramatic 224 percent increase in TDO admissions and a 58 percent increase in total state hospital admissions since FY 2013. Today, the statewide state hospital bed utilization reached unsafe levels of 99 percent with three state hospitals over capacity in February 2017. DBHDS is working to recommend broad measures to relieve pressure on the state hospitals and decrease the censuses. Another important avenue to help manage censuses that DBHDS could explore and the General Assembly may consider is an extension to the current ECO period. Any additional time will give emergency evaluators more time to locate a willing TDO facility and fully meet Virginia Code requirements to assure consideration of less restrictive interventions and avoid unnecessary TDOs and hospitalizations.

***Recommendation Five**: Expand the Use of CIT Assessment Sites to Relieve Burden on EDs*

The time study supported anecdotal information that finding a bed is a time consuming part of the overall process. It is not uncommon for an emergency evaluator to provide referral information to 20 facilities before defaulting to the "last resort" of a state psychiatric hospital.

It was noted that finding a bed has become more difficult. Severe behavioral issues or co-morbid medical issues are the most common causes of delay or refusal by a psychiatric hospital. The time study found that the CIT assessment sites had few instances of delayed evaluations. These sites are specifically equipped and staffed to receive and manage persons under an ECO. Expansion of the use of CIT assessment sites would relieve some of the burden on EDs.

As a result of the data obtained from both time studies, DBHDS is working with the CSBs to identify, address, manage, and monitor delays resulting from concurrent requests for emergency evaluations. As previously noted, since 2014, DBHDS has supported the development of 30 new assessment site programs. DBHDS will continue to provide technical assistance and oversight to these programs in order to promote the increased use of CIT as a site for emergency evaluations.

## Summary and Next Steps

Since the 2014 civil commitment law reforms were implemented, every individual meeting the criteria for a TDO has been provided with a hospital bed for crisis treatment. This represents a major achievement in behavioral health policy and these significant changes have also shifted the demands on the behavioral health system in a multitude of ways. DBHDS has engaged relevant stakeholders in reviewing the systemwide impact of these changes, identifying and making recommendations for those areas of this complex and multi-faceted process which need improvement. A major focus has been obtaining empirical data about the response time for

emergency evaluations, identifying those factors which contribute to delays, and implementing changes in practice to reduce such delays. In the first year, the stakeholder workgroup identified five areas for potential improvement and DBHDS has implemented those recommendations. In the second year, the workgroup continued its analysis of civil commitment process and made five additional recommendations. DBHDS is in the process of implementing those recommendations. In the spring of 2018, DBHDS will reconvene all relevant stakeholders to review the status of each of these actions and incorporate additional recommendations for strengthening the crisis response system.

# Acknowledgements

*DBHDS would like to thank all of the members of the involuntary commitment workgroup for their time and expertise during this process.*

*DBHDS would also like to thank Richard Bonnie and the staff at the University of Virginia Institute of Law, Psychiatry and Public Policy for sharing their wealth of information about Virginia's civil commitment laws and their history, their excellent work assisting with the development of the response time survey and their thorough analysis of the data, all of which were extremely helpful to the work of the group.*

# Appendices

## Appendix A

**Certification of Preadmission Screening Clinicians**

Effective July 1, 2016, anyone conducting a preadmission screening evaluation pursuant to requirements in the Code of Virginia must hold a valid certification from DBHDS as a Certified Preadmission Prescreening Clinician.

Application for this certification must be submitted by a CSB using the designated forms and approved before the individual may independently conduct preadmission screening evaluations. If validly certified, the individual may conduct preadmission screening evaluations for any CSB by which he is employed or under contract and need not seek multiple certifications. For anyone who was certified by the process existing prior to July 1, 2016, the CSB must submit this certification application under these new requirements prior to July 1, 2016 in order to maintain their certification.

Requirements for this certification are outlined below. Upon submission and review of a completed application, DBHDS will issue a Certificate. The certification will be valid for one or two years and must be renewed annually or biannually as specified below. Recertification must be requested prior to the expiration of a current certificate. In addition, various supervisory and continuing education requirements are specified below.

**Enhanced Qualifications for Certified Preadmission Screening Clinicians Beginning 01 July 2016**

All new hires must have educational attainment of a master's or doctoral degree with an associated professional license **OR** educational attainment that would be required for the following:

- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Psychologist (LCP) Revised 5/11/16
- Psychiatric Nurse Practitioner or Psychiatric Clinical Nurse Specialist
- MD/DO
- Bachelors Prepared Registered Nurse (BSN) with five years of experience

The following Master's degrees are deemed to meet these requirements: M.S.W.; PH.D. or PSY. D in clinical or counseling psychology; a clinical degree in counseling from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP); M.S. in Rehab from a CACREP accredited program.

If a CSB executive director has evaluated the transcript and experience of a potential Preadmission Screening Clinician with a master's degree other than one listed above that

includes appropriate clinical training, a request may be submitted to DBHDS for review and a decision whether this requirement is met.

**Process for Retaining Experienced Staff who do not meet the Enhanced Qualifications as of July 1, 2016**

Certified preadmission screening clinicians who do not meet the new minimum educational attainment standards:

- May be retained as a certified preadmission screening clinician provided that they were hired on or before 01 July 2008, have had no interruption in their employment conducting preadmission evaluations and pass all of the other certification requirements.

- May be retained as a certified preadmission screening clinician if hired between July 1, 2008 and July 1, 2016 provided that they met the educational and other requirements required as of July 1, 2008. Those requirements are referenced in the following link: http://www.dbhds.virginia.gov/library/mental%20health%20services/omh-guidance-memo-indep-examin-062608.pdf

- If at any point after 01 July 2016 an individual certified under criteria for retaining experienced staff leaves the CSB that retained the individual or has a break in employment as a certified preadmission screening clinician at that CSB, that person is no longer eligible for employment as a certified preadmission screening clinician unless and until the new minimum educational standards are met.

- For the purpose of meeting these requirements, absence from work for an approved sick leave, workers compensation leave, family medical leave, military or educational leave or a break in service in order to meet administrative requirements in order to change status (e.g. VRS), with intent to continue employment, will not be deemed a break in service. (Revised 5/11/2016)

- Any certified preadmission screening clinician retained through this process will be subject to an enhanced quality review standard which will include annual re-certification, and any other procedures as determined by DBHDS.

If a CSB provides DBHDS with a request for variance demonstrating the need, based on hardship, to retain an individual who neither meets the new minimum educational standards nor fits the retention criteria above, DBHDS will make a decision as to whether to certify that person under these provisions. The CSB will be required to develop a plan to address the situation that has created the hardship and will develop a plan of action to come into compliance.

**Orientation Requirements:**

Before an individual can be certified as a certified preadmission screening clinician, the individual must have completed the requisite on line training modules and an emergency services orientation that meets the requirements of DBHDS.

The orientation process for new certified preadmission screening clinicians shall include the content and experiential components listed below:

- Orientation to civil commitment process, legal requirements and performance contract related requirements
- Orientation to documentation expectations and requirements
- Orientation to expectations for use of clinical consultation with peers and supervisors
- Orientation to local policies and procedures
- Orientation to role and interface with local law enforcement
- Orientation to role and interface with magistrates and special justices
- Orientation to resources for alternatives to hospitalization
- Orientation to bed registry
- Orientation to process for securing local private beds
- Orientation to process for securing state facility beds
- Orientation to process to access LIPOS or SARPOS funding
- Orientation to alternatives for special populations [e.g. children, ID/DD or geriatric]
- Orientation to Federal and State laws about allowed disclosure of information and communication in routine and emergency situations
- Tour of local facilities [e.g. local hospitals, CSU's, jail, REACH, etc.] as relevant

**Experiential Components of Orientation**

Completion of 40 hours of observation of direct emergency services client or collateral contact (including telephone evaluation/triage) conducted by a certified preadmission screening clinician.

Completion of direct observation of the new employee by a qualified certified preadmission screening clinician for 40 hours of direct emergency services work. This cannot commence before #1 is completed.

Completion of a minimum of three prescreening evaluations under direct observation by a qualified certified preadmission screening clinician.

Attestation by their supervisor that, based upon direct observation, the applicant has reached a minimal acceptable level of clinical competence and procedural knowledge to be certified. This includes such things as knowledge of relevant laws, interviewing skills, mental status exam, substance use assessment and risk assessment.

Agreement that for a minimum of three months after certification the newly certified person will consult with a supervisor on any case where he/she intends to recommend a release from an ECO without hospitalization.

Initial orientation will also include successful completion of on line training modules on topics that include legislative and regulatory requirements, disclosure of information and clinical aspects of risk assessment. Individuals certified prior to July 1, 2016 will have met these orientation requirements if they had completed the training modules and orientation process in place at the time they were originally certified. Whenever DBHDS requires all certified preadmission screening clinicians to complete new or updated modules, these must be completed within 60 days of their being posted in order to maintain certification in good standing.

**Recertification**

Each certified preadmission screening clinician must be re-certified every two years unless they are employed under the "process for retaining experienced staff" or under hardship variance provisions, in which case, they must be re-certified annually. In order to be recertified, certified preadmission screening clinicians must be able to demonstrate that they have actually conducted preadmission screening evaluations and been involved in the delivery of emergency/crisis intervention services during the last certification period. In order to be recertified, certified preadmission screening clinicians must be able to demonstrate that they have received the required level of supervision and continuing education specified below.

**Enhanced Quality Standards**

Throughout the year, DBHDS will inspect samples of certification documentation to assure the integrity of the process. This will occur as part of regular licensure reviews, critical incident reviews and at other times as determined by DBHDS. Individuals who directly supervise certified preadmission screening clinicians must be licensed and have a minimum of two years of experience working in emergency services or with persons with serious mental illness and be a certified preadmission screening clinician. An individual who directly supervises certified preadmission screening clinician s is defined as someone who has the authority to direct their work. (Revised 5/11/2016)

All certified preadmission screening clinicians must have 24/7 access to consultation by a licensed certified preadmission screening clinician and by a supervisor vested with decision making authority. In most cases this will be the same individual but when necessary to assure appropriate availability it may be provided by two individuals.

All CSBs must maintain documentation of individual and/or group supervision hours for every certified preadmission screening clinician. Upon re-certification, the CSB must be able to demonstrate through documentation that the individual has received a minimum of 12 hours annually of individual or group clinical supervision. This requirement is waived for supervisory staff.

All CSBs must maintain documentation of continuing education for every certified preadmission screening clinician. Upon re-certification, every certified preadmission screening clinician must be able to demonstrate through documentation the completion of a minimum of 16 hours of relevant continuing education per year.

**Record Audits**

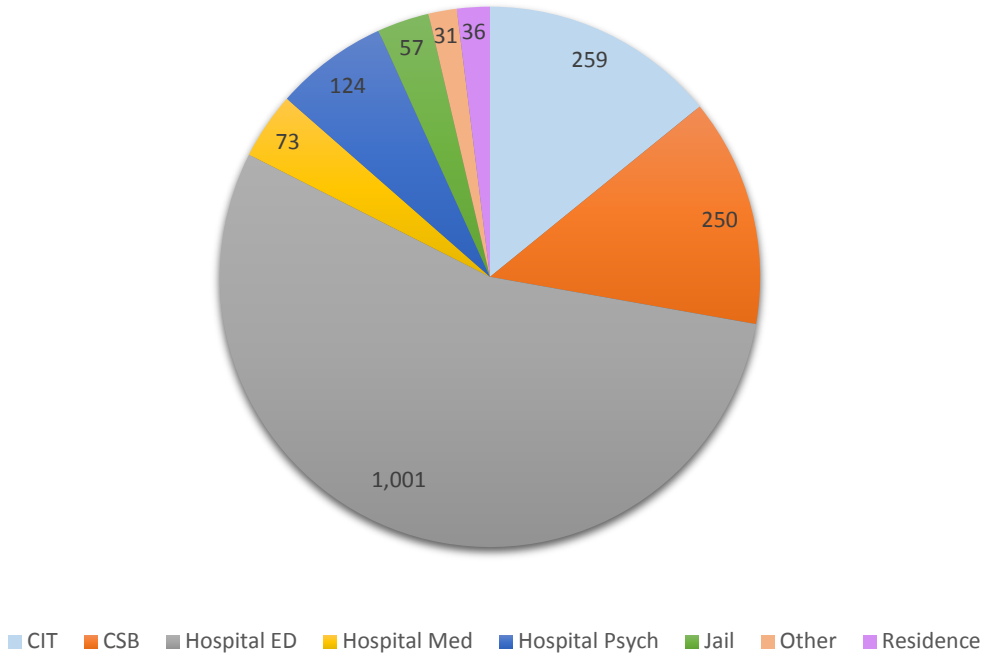
The CSB who employs a certified preadmission screening clinician will annually conduct quality chart review of at least five percent of cases where the certified preadmission screening clinician performed an emergency evaluation. Results of these reviews and any quality improvement activities undertaken as a result of them must be available for review. Understanding that CSBs currently have chart review procedures, DBHDS is not prescribing a form or format for documenting this. What is required is that upon request a CSB can identify, for each preadmission screening clinician, which charts were reviewed and be able to show the content and results of the review.

# Appendix B

A time study was conducted from November 7-20, 2016, with emergency evaluators completing a survey developed by the ILPPP that reported various time stamps, other important variables and indicated the reason for delayed response times. Any time an emergency evaluation was undertaken, except in the case of recommitment hearings, a one-page survey form was completed capturing the time and other data. It should be noted that November typically has a low volume of emergency evaluations and that the numbers from this study should not be used to extrapolate annual frequencies. An attempt was made to have all CSB emergency evaluators complete this survey and ED staff complete a comparable survey on all evaluations to allow cross-validation of data. EDs were largely unable to participate; however, all but two of the CSBs submitted all of their forms in time for analysis, yielding 95 percent participation. Survey forms were completed for 1,837 emergency evaluations undertaken during the two weeks.

Below is a detailed summary of data developed through the November 2016 time study.

**Figure 1:** Number of emergency evaluations at each evaluation site indicated in the survey (n=1837).



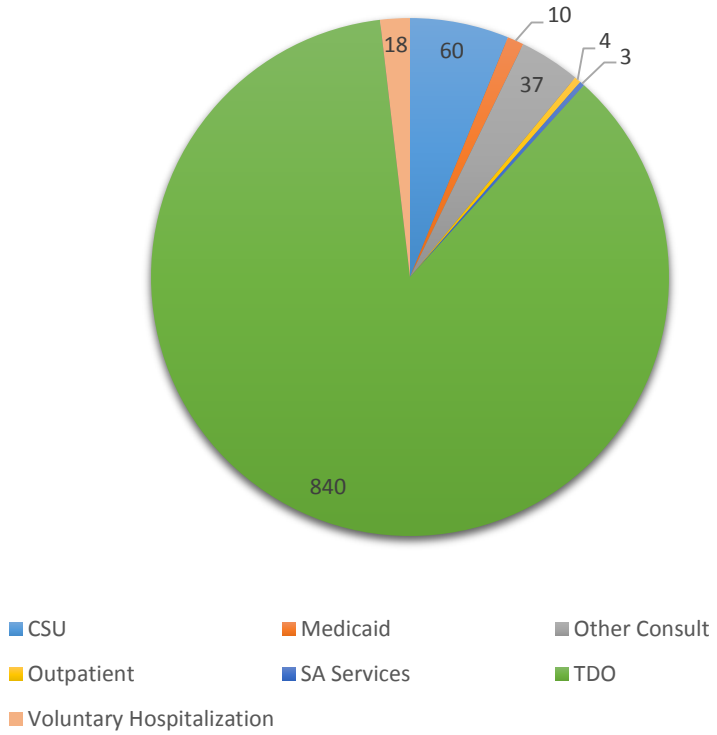

Most of the emergency evaluations in this survey took place in hospital EDs, although there were also a fair number at CIT assessment centers and CSBs. "Other" includes places in the community such as stores, as well as residential and day treatment facilities. Location data was missing from six survey forms.

**Table 1:** Evaluations sites, where the individual was under an ECO when the CSB was contacted (n=469).

| Location | Number | Percent |
|---|---|---|
| CIT | 108 | 23 |
| CSB | 13 | 2.8 |
| Hospital ED | 332 | 70.8 |
| Hospital Med | 2 | 0.4 |
| Hospital Psych | 1 | 0.2 |
| Jail | 11 | 2.4 |
| Other | 2 | 0.4 |

Most of the emergency evaluations of individuals who were under an ECO took place in hospital EDs, with most of the rest taking place at CIT assessment sites.

**Figure 2:** Reasons for emergency evaluation indicated among ED-based surveys (n=1001).




The majority of ED-based emergency evaluations were for TDO screenings. "Other Consult" is a consult in which the petitioner does not have a preconceived idea of what sort of service or placement the patient needs. Twenty-nine survey forms did not indicate a reason for emergency evaluation.

**Figure 3:** ECO status among ED-based TDO evaluations (n=840).

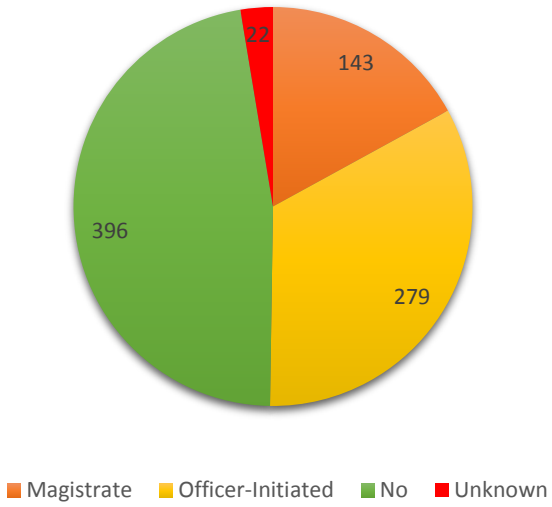
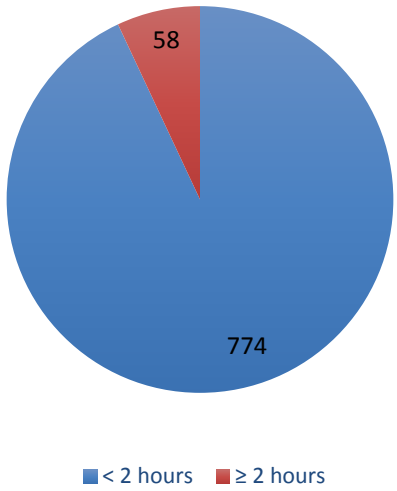



**Figure 4:** Number of ED-based TDO emergency evaluations where time from initial contact to start of evaluation took more than two hours (n=840).




A previous time survey was conducted in June of 2015. In that survey, 97 percent of emergency evaluations began within two hours of initial contact. In the new survey, 93 percent of TDO emergency evaluations began within two hours. Eight of the 840 forms were missing data needed to calculate time to evaluation.

ECO status was associated with lateness (Chi-square=12.37, p=0.0021), with emergency evaluations starting late in 10 percent of cases where there was no ECO, and 4 percent of cases where there was an ECO. Of the 58 that took at least two hours, seven (12 percent) were already

under an ECO when the CSB was contacted and nine more (16 percent) had an ECO executed after the CSB was contacted. Three out of the 58 had missing ECO data.

**Table 2:** Time taken (in minutes) for different components of the emergency evaluation process up until end of evaluation, where the evaluation site is a Hospital ED. This data includes all 1,001 ED emergency evaluations.

| Evaluation Component | Median Time | Interquartile Range | Missing Data |
|---|---|---|---|
| From Contact to arrival at the ED | 30 | 15-55 | 7 |
| From Arrival on site to start of Evaluation | 5 | 0-11 | 5 |
| From Start of Evaluation to start of FTF part of evaluation | 0 | 0-10 | 5 |
| From start of FTF part of evaluation to end of evaluation | 55 | 30-81 | 22 |
| Total time from Contact to End of Evaluation | 110 | 75-152 | 25 |
| *FTF=Face-to-Face | | | |

Interquartile range is a statistical method for defining the middle 50 percent of the data. It shows the range between the lowest quartile and the highest quartile. Contact is defined as the time that the CSB is contacted with a request for an emergency evaluation. If an LEO or ED staff member calls the CSB to alert them to the possibility of a future emergency evaluation request, but does not make the request, that is not considered contact for purposes of this study.

The most important factor in the length of time between contact and completing the evaluation was the time taken on the evaluation itself (median time = 55 minutes, $r=0.66$, $p=<0.0001$). Time to medical stabilization was a factor in some of the lengthy outliers, but it did not have a meaningful impact overall. Medical stabilization was defined as the time that the attending physician judges the person to be medically stable, not the time that all medical paperwork is prepared for the receiving facility. In the 2015 survey the median response time from contact to meeting the client was 35 minutes for ED-based TDO evaluations.

Non-TDO evaluations did not differ from TDO evaluations to a statistically significant degree in the amount of time it took from contact to the beginning of the evaluation, or in the time from contact to the end of the evaluation. TDO screenings did tend to have longer evaluation times (mean 73 minutes compared to 66).

**Figure 5:** Number of ED-based emergency evaluations in each half hour range for time from contact to evaluation (n=1001).

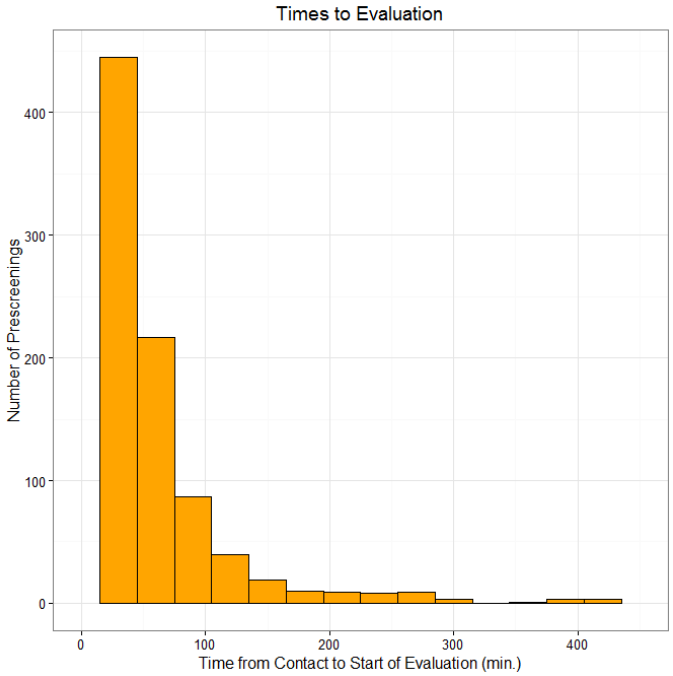



**Figure 6:** Number of ED-based TDO evaluations in each half hour range for time from contact to evaluation, where the person was not under an ECO (n=396).

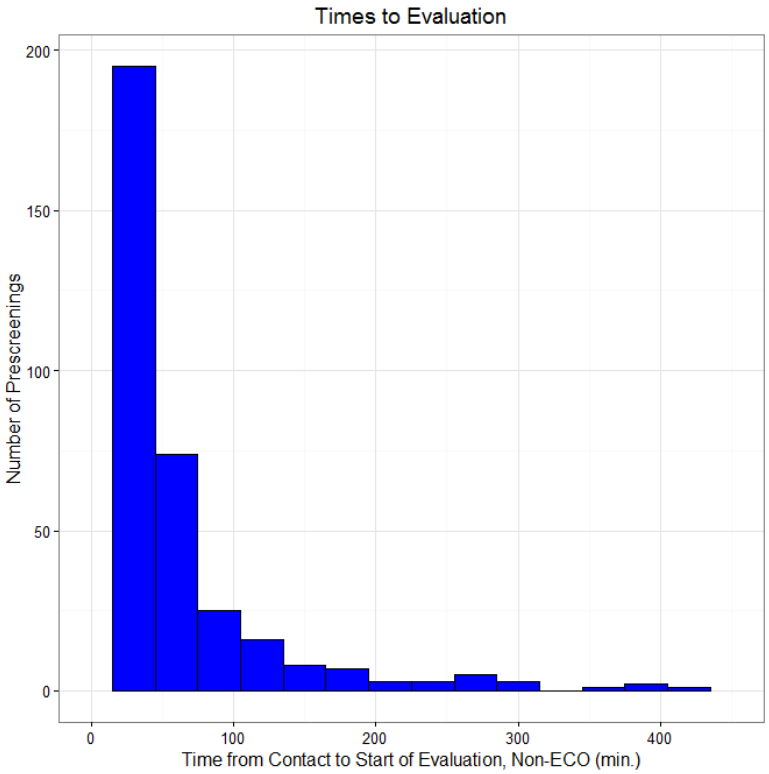


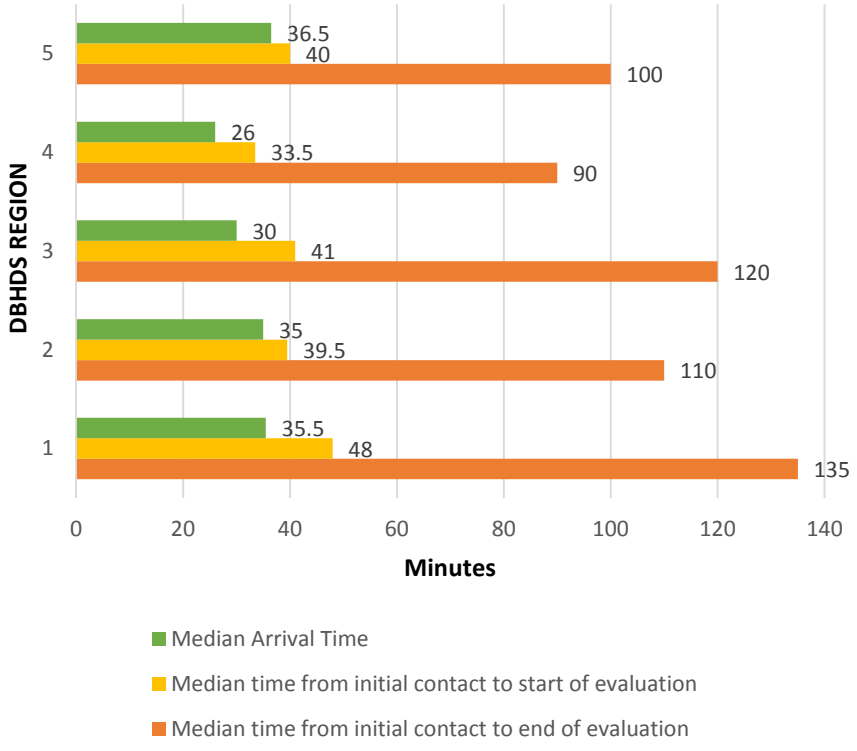
**Table 3:** Median times to evaluation by distance, for ED-based TDO evaluations (n=840).

| Distance | Number | Median Time to Evaluation (minutes) |
|---|---|---|
| 20+ miles | 88 | 74.5 |
| 10 to 20 miles | 133 | 45 |
| <10 miles | 431 | 37 |
| On Site | 159 | 25 |
| Video Conference | 4 | 52.5 |

The median time from initial contact to the beginning of the evaluation is associated with distance (Chi-square=90.7, $p < 0.0001$). The longest times to evaluation are for distances over 20 miles and for video conferences. The shortest times to evaluation are, predictably, for those situations in which the evaluator was already on site.

Among ED-based emergency evaluations, median time from initial contact to the beginning of the evaluation was not associated with rurality, ECO status, time to medical stabilization, or ultimate disposition. ECO status did impact average time to evaluation, though ($F=3.8$, $p=0.0227$), due to outliers among the group without ECOs, who have lengthier times.

**Figure 7:** Median times by DBHDS region for evaluations that took place in a Hospital ED.



Median arrival time varied by DBHDS region (Chi-square=14.2, p=0.0067). Median time to start of evaluation (Chi-square=15.8, p=0.0033) and end of evaluation (Chi-square=53.33, p=<0.0001) also varied. DBHDS Region 4 (Central Virginia) had the shortest times with a median of 33.5 minutes from contact to the beginning of the evaluation, and DBHDS Region 1 (Northwestern Virginia) had the longest at a median of 48 minutes. The unusually short times to evaluation in DBHDS Region 4 are statistically significantly different from those times in DBHDS Region 1 (Z=-3.8, p=0.0002), DBHDS Region 3(Z=-2.1, p=0.0403), and DBHDS Region 5 (Z=-2.1, p=0.0386). There is also a statistically significant difference between the median times to evaluation in DBHDS Region1 and DBHDS Region 2 (Z=-2.2, p=0.0272).

**Table 4:** Percent of all emergency evaluations where the evaluation began more than two hours after initial contact, by DBHDS Region (n=1837).

| Region | Number of emergency evaluations | Number of Late-starting evaluations | % Late |
|---|---|---|---|
| 5 | 474 | 47 | 10.2 |
| 4 | 333 | 8 | 2.4 |
| 3 | 438 | 41 | 9.4 |
| 2 | 286 | 13 | 4.7 |
| 1 | 306 | 19 | 6.4 |

PR 5 has the highest percentage of lateness. DBHDS Region 3 also had a high percentage of lateness.

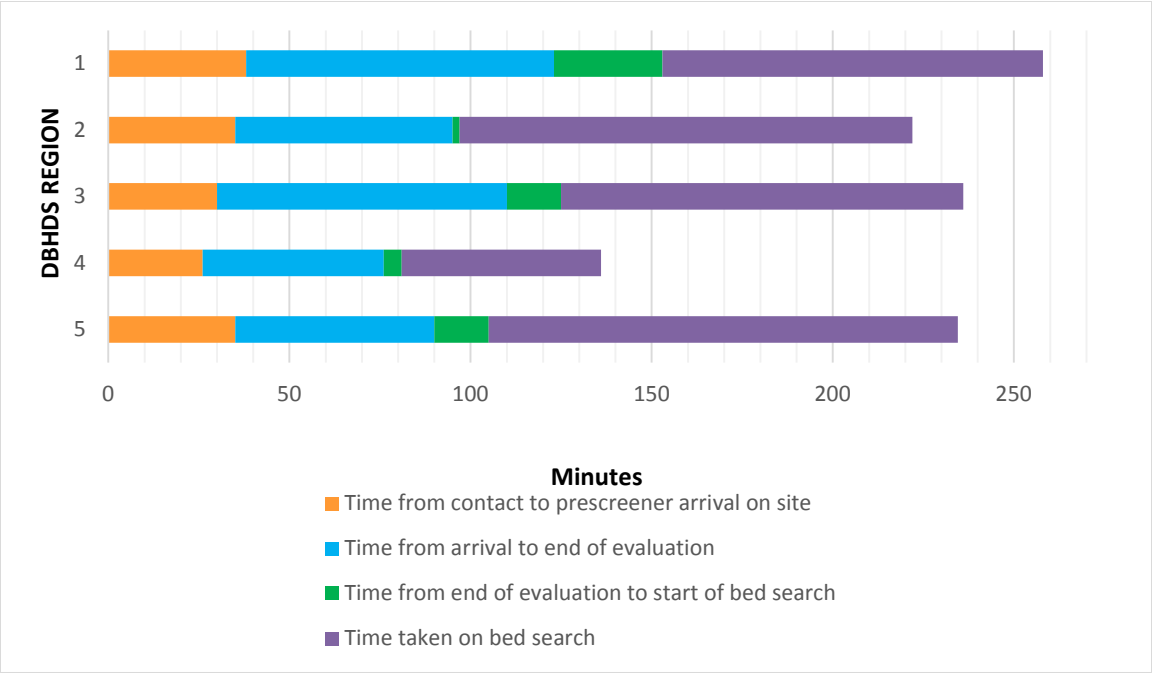
**Table 5:** Time frames in minutes for patients who were recommended for hospitalization and whose evaluations took place in an ED (n=676).

| Timeframe | Median | Interquartile Range | Missing data |
|---|---|---|---|
| Time from the end of the evaluation to the start of the bed search | 15 | 0-50 | 119 |
| Time from the start of the bed search to the evaluee's final acceptance for a hospital bed | 117 | 46-225 | 153 |
| Time from initial contact to final acceptance for a hospital bed. | 270 | 170-396 | 130 |

Some of the missing data is unavailable because, in cases where the person is admitted to a psychiatric facility voluntarily, the ED staff may elect to do the bed search instead of the

evaluator. Among patients who were hospitalized, the most important factor in the time from initial contact to bed acceptance was the bed search (r=0.77, p<0.0001).

**Figure 8:** Time from initial contact to acceptance for a bed for ED patients (n=676).




DBHDS Region 4 had a much lower median bed search time possibly because it had the highest percentage of cases in which the evaluee had a bed prepared for them by the time the evaluation was over (14.3 percent). This is driven by high percentages of ready beds in Richmond (20 percent) and District 19 (17.4 percent), which are DBHDS Region 4's highest volume CSBs.

**Figure 9:** The amount of time spent bed searches (min.) among ED patients (n=676).

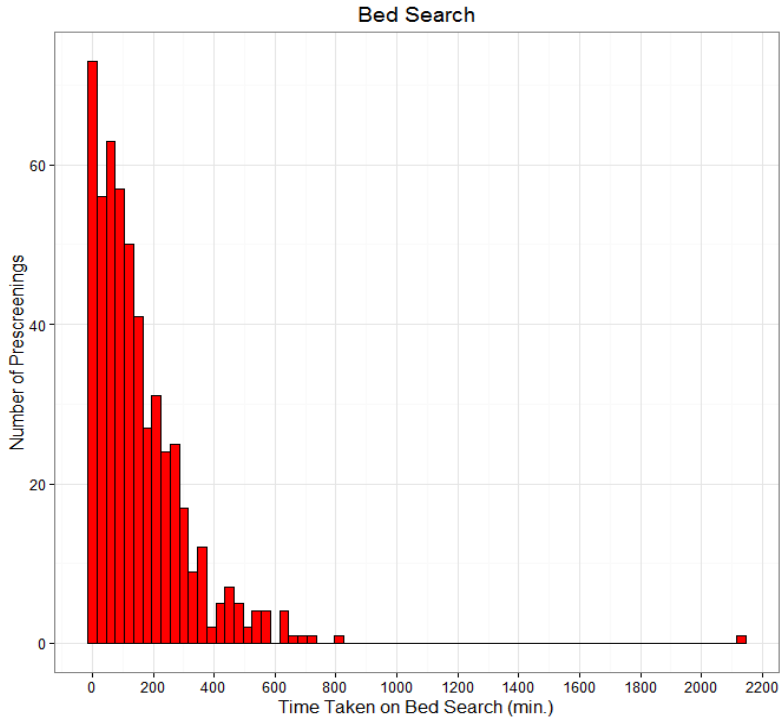



**Table 6:** Disposition Recommendations among ED-based TDO screenings (n=840), by DBHDS Region.

| Recommended Disposition | Region 1 (%) | Region 2 (%) | Region 3 (%) | Region 4 (%) | Region 5 (%) | Total (%) |
|---|---|---|---|---|---|---|
| TDO | 90 (60) | 77 (73) | 152 (57) | 68 (51) | 125 (69) | 512 (61.2) |
| Voluntary Hospitalization | 16(11) | 14 (13) | 23 (9) | 26 (20) | 22 (12) | 101 (12.2) |
| Medically Admitted | 3 (2) | 2 (2) | 10 (4) | 5 (4) | 5 (3) | 25 (3) |
| CSU | 2 (1) | 0 | 14 (5) | 1 (1) | 2 (1) | 18 (2.2) |
| Outpatient | 30 (20) | 11 (10) | 44 (16) | 25 (18) | 20 (11) | 130 (15.5) |
| No treatment needed | 6 (4) | 0 | 17 (6) | 5 (4) | 4 (2) | 32 (3.8) |
| Client Refused Treatment | 2 (1) | 1 (1) | 5 (2) | 3 (2) | 1 (1) | 12 (1.4) |
| Other | 0 | 0 | 4 (1) | 0 | 2 (1) | 6 (0.7) |
| Total | 149 | 105 | 269 | 133 | 181 | 837 |

Disposition was associated with DBHDS region (Chi-square=37.6, p=0.0380); although, DBHDS Region 1 did not differ from DBHDS regions 3 or 4 to a statistically significant degree and DBHDS Region 5 (Southeast) did not differ from DBHDS Region 2 (Washington, D.C. Area), which had the highest TDO percentage. The majority of ED-based TDO emergency evaluations were recommended for temporary detention, although there were a fair number of referrals for outpatient services. "Other" dispositions include day or residential treatment, detox and safety plans. Four forms did not clearly indicate the proposed disposition.

**Table 7:** Disposition Recommendations among ED-based TDO evaluations overall (n=840), and for ED-based evaluations for people under an ECO (n=444).

| Recommended Disposition | ED-based TDO evaluations | | ED-based evaluations where the evaluee was under an ECO | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| TDO | 512 | 61.2 | 292 | 65.9 |
| Voluntary hospitalization | 101 | 12.2 | 49 | 11 |
| Medical admission | 25 | 3 | 19 | 4.3 |
| CSU | 18 | 2.2 | 0 | 0 |
| Outpatient services | 130 | 15.5 | 55 | 12.42 |
| No treatment needed | 32 | 3.8 | 17 | 3.8 |
| Client refused treatment | 12 | 1.4 | 8 | 1.8 |
| Other | 6 | 0.7 | 3 | 0.68 |

ECO evaluations more frequently resulted in a TDO disposition than non-ECO evaluations (Chi-square=5.37, p=0.0205).

**Table 8:** Reasons for delay, defined as two hours between initial contact and the start of the evaluation (n=58), among ED-based emergency evaluations.

| Reason | Number | Percent* |
|---|---|---|
| Multiple evaluations received simultaneously | 31 | 53.4 |
| Awaiting arrival of person by transport | 9 | 15.5 |
| Medical stabilization/treatment | 7 | 12.1 |
| Distance travelled | 7 | 12.1 |
| Non-Mandated Screen | 9 | 15.5 |
| Shift change early in the emergency evaluation | 2 | 3.4 |
| Communication Difficulties | 2 | 3.4 |
| Other | 2 | 3.4 |
| No Reason Given | 12 | 20.7 |

"Other" includes traffic and waiting for the ECO to be executed. The most frequently cited reason for lateness was multiple evaluations (53.4%).
* The total is greater than 100 percent as more than one reason may have been checked.

**Figure 10:** Number of CIT-based emergency evaluations where time from initial contact to start of evaluation took more than two hours (n=180).

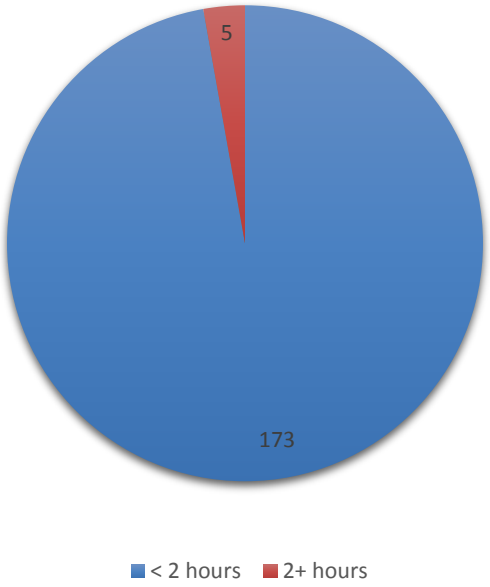



**Table 9:** Time taken (in minutes) for different components of the emergency evaluation process up until end of evaluation, where the evaluation site is a CIT assessment center. This data includes all 259 CIT based evaluations.

| Evaluation Component | Median Time | Interquartile Range | Missing Data |
|---|---|---|---|
| From Contact to arrival at the CIT center | 0 | 0-11 | 6 |
| From Arrival on site to start of Evaluation | 7 | 0-30 | 2 |
| From Start of Evaluation to start of FTF part of evaluation | 0 | 0-9 | 0 |
| From start of FTF part of evaluation to end of evaluation | 60 | 39-95 | 7 |
| Total time from Contact to End of Evaluation | 90 | 68-145 | 13 |

Among CIT-based evaluations, distance travelled, rurality, ECO status, disposition, and time to medical stabilization did not have a statistically significant association with time from contact to

the start of the evaluation. The reason for emergency evaluation was associated with time to the start of the evaluation (Chi-square=25.6, p=0.0001).

**Table 10:** Median times to evaluation by reason for evaluation for CIT-based evaluations (n=259)

| Reason for Prescreen | Number | Median Time to Evaluation (min.) |
|---|---|---|
| CSU | 30 | 30 |
| Medicaid | 4 | 30 |
| Other Consult | 26 | 5 |
| SA Services | 3 | 0 |
| TDO | 180 | 25.5 |
| Voluntary Hosp | 13 | 5 |

**Table 11:** Disposition recommendations for CIT-based emergency evaluations.

| Recommended Disposition | Number | Percent |
|---|---|---|
| TDO | 115 | 65.0 |
| Voluntary Hospitalization | 18 | 10.2 |
| Medically Admitted | 6 | 3.4 |
| Outpatient | 28 | 15.8 |
| None | 2 | 1.1 |
| Refused | 7 | 4.0 |
| Other | 1 | 0.6 |

**Percentages exceed 100% due to multiple reasons given for some delays*

# Appendix C

## Cross-validation by ED staff

Correlations between emergency evaluation timeframes as reported by emergency evaluations and timeframes as reported by ED staff (n=35).

| Timeframe | Median time in minutes, according to evaluators (IQR) | Median time in minutes, according to ED staff (IQR) | Correlation | p-value | Missing data |
|---|---|---|---|---|---|
| Time from contact to meeting patient | 59 (45-105) | 75.5 (50.5-110.5) | 0.73 | <0.0001 | 3 |

This comparison needs to be interpreted with caution. Participation from EDs was very low. Only 35 forms from seven CSB catchment areas, out of a total of 1001 screenings conducted in an emergency department, are represented predominantly from the northern and northwestern parts of Virginia. None of the EDs recorded all of the TDO evaluations that took place there during the survey period.

# Appendix D

Timeliness among TDO evaluators by DBHDS region. A comparison of the 6/2015 and 11/2016 surveys.

| DBHDS REGION | 6/2015 Time Survey | | 11/2016 Time Survey | |
|---|---|---|---|---|
| | Median Time to meeting the client (min.) | % > 2 hours | Median Time to meeting the client (min.) | % > 2 hours |
| 1 | 40 | 1.0 | 51.5 | 4.8 |
| 2 | 30 | 2.1 | 45 | 7.5 |
| 3 | 31 | 1.8 | 45.5 | 9.5 |
| 4 | 30 | 1.4 | 35 | 2.5 |
| 5 | 35 | 7.8 | 43 | 10.3 |

There are several differences between the 2015 and 2016 surveys that should be taken into account. TDO frequencies can be subject to time of year effects, so the fact that the surveys took place in different months might influence results. In the 2015 survey, "meeting" was defined simply as interaction with the client; while, in the 2016 survey, it was defined as beginning the face-to-face part of the evaluation.

# Appendix E

## Comparative Data on TDO Admissions to Public and Private Hospitals

Fiscal Year 2015

| | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | April | May | June |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **FY' 15 State Hospital TDOs** | 136 | 165 | 212 | 202 | 133 | 137 | 153 | 138 | 222 | 215 | 231 | 255 |
| **FY'15 Private Sector TDOs** | 1,915 | 1,941 | 1,973 | 1,891 | 1,721 | 1,825 | 1,889 | 1,620 | 1,986 | 1,966 | 1,988 | 1,972 |
| **FY' 15 Total TDOs Executed** | 2,051 | 2,106 | 2,185 | 2,093 | 1,854 | 1,962 | 2,042 | 1,758 | 2,208 | 2,181 | 2,219 | 2,227 |
| **Percent State Hospital Admits** | 6.6% | 7.8% | 9.7% | 9.7% | 7.2% | 7.0% | 7.5% | 7.8% | 10.1% | 9.9% | 10.4% | 11.5% |

Fiscal Year 2016

| | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | April | May | June |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **FY' 16 State Hospital TDOs** | 229 | 240 | 258 | 267 | 221 | 191 | 263 | 278 | 297 | 376 | 444 | 413 |
| **FY' 16 Private Sector TDOs** | 1,918 | 1,965 | 1,950 | 1,833 | 1,768 | 1,810 | 1,747 | 1,721 | 1,974 | 1,853 | 1,909 | 1,874 |
| **FY' 16 Total TDOs Executed** | 2,147 | 2,205 | 2,208 | 2,100 | 1,989 | 2,001 | 2,010 | 1,999 | 2,271 | 2,229 | 2,353 | 2,287 |
| **Percent State Hospital Admits** | 10.7 % | 10.9 % | 11.7 % | 12.7 % | 11.1 % | 9.5% | 13.1 % | 13.9% | 13.1% | 16.9% | 18.9% | 18.1% |

Fiscal Year 2017

| | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | April | May | June |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **State Hospital TDOs** | 313 | 353 | 285 | 290 | 224 | 242 | 389 | 278 | 307 | 344 | 380 | 421 |
| **Private Sector TDOs** | 1,790 | 1,852 | 1,842 | 1,761 | 1,825 | 1,943 | 1,812 | 1681 | 1958 | 1786 | 1915 | 1696 |
| **Total TDOs Executed** | 2,103 | 2,205 | 2,127 | 2,051 | 2,049 | 2,185 | 2,201 | 1959 | 2265 | 2130 | 2295 | 2117 |
| **Percent State Hospital Admits** | 14.9% | 16.0 % | 13.4 % | 14.1 % | 10.9 % | 11.1 % | 17.7 % | 14.2% | 13.6% | 16.2% | 16.6% | 19.9% |