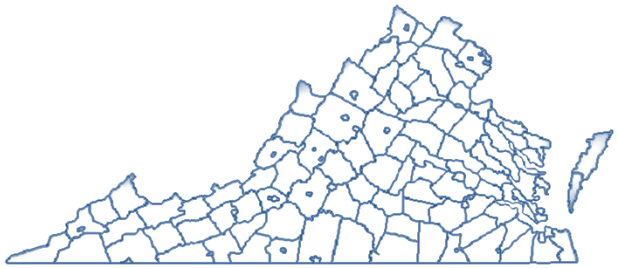

A Study of Face-to-Face Emergency Evaluations of Veterans Conducted by Community Services Boards in April 2013

Funded by the Virginia *Department of Behavioral Health and Developmental Services*, and in collaboration with the *Virginia Association of Community Services Boards*

University of Virginia

DBHDS
Virginia Department of Behavioral Health and Developmental Services

Virginia Association Of Community Services Boards, Inc.
Making a Difference Together

October, 2014

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Colonial Services Board
Crossroads Community Services Board
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New River Valley Community Services
Norfolk Community Services Board
Northwestern Community Services
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PREFACE

This is a companion report to the 2013 study regarding emergency evaluations at the 40 Community Services Boards throughout the Commonwealth of Virginia. This is one of two companion reports focusing on emergency evaluations of veterans from the main study.

This report provides a descriptive overview of emergency evaluations of veterans conducted by Community Services Boards (CSBs) in April, 2013. It includes data on the numbers and characteristics of veterans needing outpatient, inpatient, voluntary, or court-ordered mental health services, the types of services needed and recommended by clinicians, and the prevalence of the use of Emergency Custody Orders (ECOs) and Temporary Detention Orders (TDOs) in this population.

Like other reports from this series, this report is the work of the Research Team and offers no interpretations of the findings; nor does it propose any recommendations. The report was prepared as a resource for policymakers and all the stakeholder organizations in the field. Please feel free to distribute this report to interested parties. It is hosted at http://cacsprd.web.virginia.edu/ILPPP/PublicationsAndPolicy/Index/Policy, and can be shared directly with others using this download link: http://cacsprd.web.virginia.edu/ILPPP/PublicationsAndPolicy/DownloadPDF/70.

The brief veteran companion report, *A Comparison of Face-to-Face Emergency Evaluations of Veterans and Non-Veterans Conducted by Community Services Boards in April 2013* is also available. This report describes significant differences between veterans and non-veterans, as well as regional variations in the number and proportion of veteran evaluations. It can be found at http://cacsprd.web.virginia.edu/ILPPP/PublicationsAndPolicy/DownloadPDF/69.

Please also note that the full-length report, *A Study of Face–to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013*, can be found at http://cacsprd.web.virginia.edu/ILPPP/PublicationsAndPolicy/DownloadPDF/66.

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OVERVIEW OF THE CURRENT REPORT

In April 2013, a study regarding emergency evaluations at the 40 Community Services Boards throughout the Commonwealth of Virginia took place. The current report presents the findings from this study for veterans only.

For information on the purpose and methodology behind the 2013 study, please see *A Study of Face–to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013*. This full-length report includes data collected on all emergency evaluations of individuals experiencing a mental health or substance abuse crisis in Virginia in April 2013. Data for adults are found in Section I, and data for juveniles are found in Section II. For information about the difference between veterans' and non-veterans' evaluations, please refer to *A Comparison of Face-to-Face Emergency Evaluations of Veterans and Non-Veterans Conducted by Community Services Boards in April 2013.* This report also features information about regional variations in the number and proportion of veteran evaluations in the Commonwealth of Virginia.

Please note that sample size may slightly vary from question to question, even when intending to use the same denominator, because of missing data. In addition, the percentages shown in some of the figures may differ from the percentages presented in the corresponding tables; this may happen for two reasons. First, the "Don't know/not sure" responses have been removed from the figures to present the information that was actually documented by the clinicians in the study (i.e., the valid percent). Second, we have collapsed some of the least-endorsed response items into single categories in some of the figures so that they are easier to view; the tables, however, include all of the responses provided. Additionally, the percentages in a table might not add up to 100.0% because of rounding (e.g., 22.155%=22.2%) or because the answer choices were not mutually exclusive (i.e., the question instructed the clinician to "Check all that apply"). For reference, the study questionnaire can be found in Appendix 1.

RESULTS

Number of Veteran CSB Emergency Evaluations

CSB clinicians documented 445 veterans who needed an emergency evaluation during the month of April 2013. Of this total, 33 individuals were evaluated more than once over the course of the month, resulting in 478 face-to-face emergency evaluations of veterans for mental health or substance abuse crises.

CSB Clinician Characteristics

Across all 40 CSBs, 90 clinicians submitted blind-coded questionnaire data on face-to-face emergency evaluations. Among all evaluators, 4 out of 10 (44.9%, n=40) were licensed. The number of clinicians conducting emergency evaluations (i.e., evaluators) during the survey month at each CSB ranged from 1 to 13, with a mode of one and median of two.

Clinician Credentials

►About four out of five (83.0%, n=73) CSB clinicians who conducted emergency evaluations reported that their highest educational degree was a Master's degree (i.e., MA, MS, MSW, etc.). See Figure 1 and Table 1.

Figure 1. Degrees of clinicians who evaluated veterans

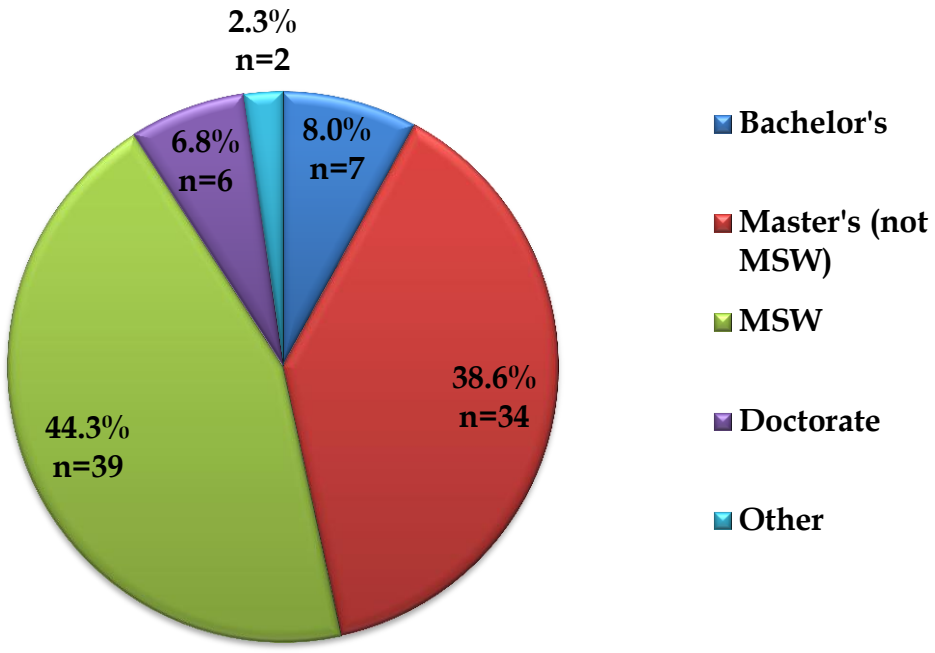


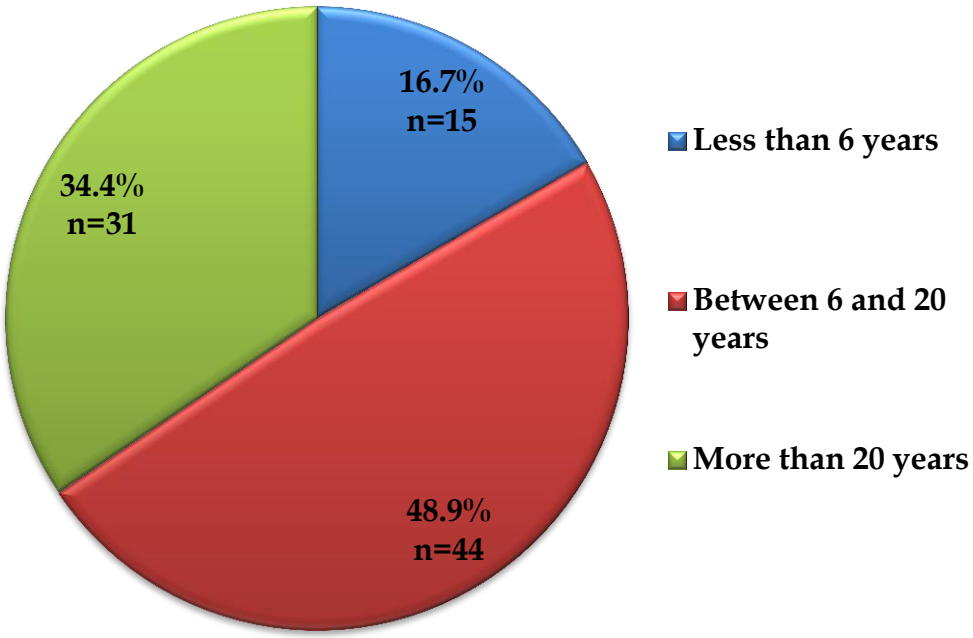
Table 1. Degrees of clinicians who evaluated veterans

	Frequency	Percent
Bachelor's	7	8.0
Master's (not MSW)	34	38.6
MSW	39	44.3
Doctorate	6	6.8
Other	2	2.3
Total	**88**	**100.0**

Clinician Number of Years of Experience in Behavioral Health[1]

►The average number of years of field experience for the clinicians was 16.6 (*sd*=10.1), ranging from no experience (n=2) to 40 years (n=3). See Figure 2 and Table 2.

Figure 2. Clinician number of years of experience in Behavioral Health



[1] In the 2007 CSB report, the term "mental health" was used instead of "behavioral health".

Table 2. Clinician number of years of experience in Behavioral Health

	Frequency	Percent
Less than 6 years	15	16.7
Between 6 and 20 years	44	48.9
More than 20 years	31	34.4
Total	**90**	**100.0**

Clinician Number of Years of Experience in Emergency Services

►The average number of years of experience as an Emergency Services Clinician was 8.3 (*sd*=8.1), ranging from no experience (n=4) to 30 years (n=1). See Figure 3 and Table 3.

Figure 3. Clinician number of years of experience as Emergency Services Clinician

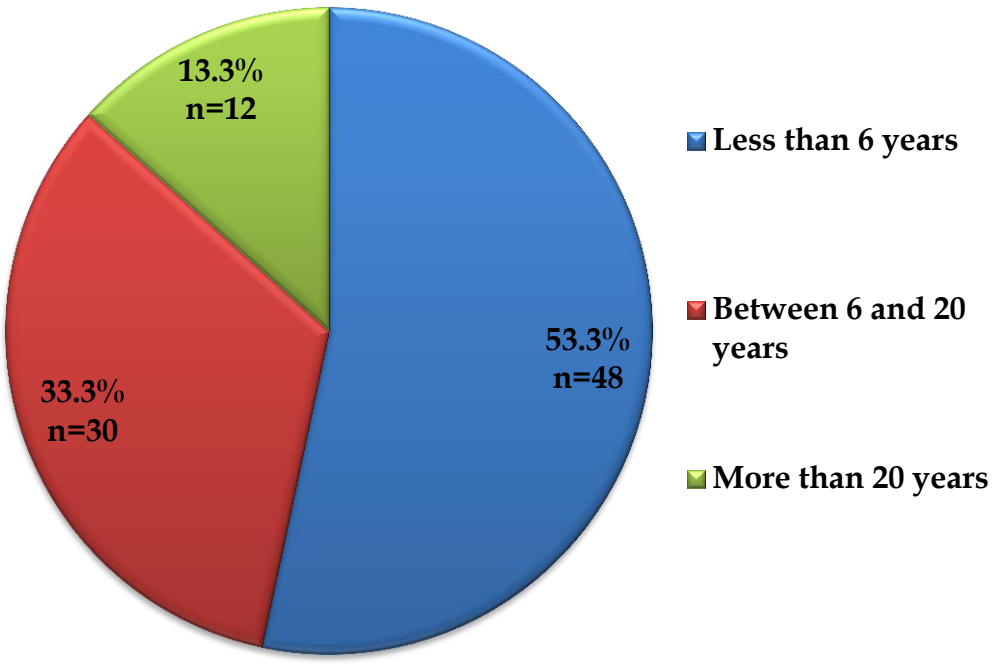


Table 3. Clinician number of years of experience as Emergency Services Clinician

	Frequency	Percent
Less than 6 years	48	53.3
Between 6 and 20 years	30	33.3
More than 20 years	12	13.3
Total	**90**	**100.0**

Characteristics of Veterans in Crisis

Demographics

►The average age of the veterans evaluated was 43.5 years old (*sd*=16.8 years). Ages ranged from 18 years (n=5) to 95 years (n=1). See Figure 4 and Table 4.

Figure 4. Distribution of age among veterans evaluated during the survey month

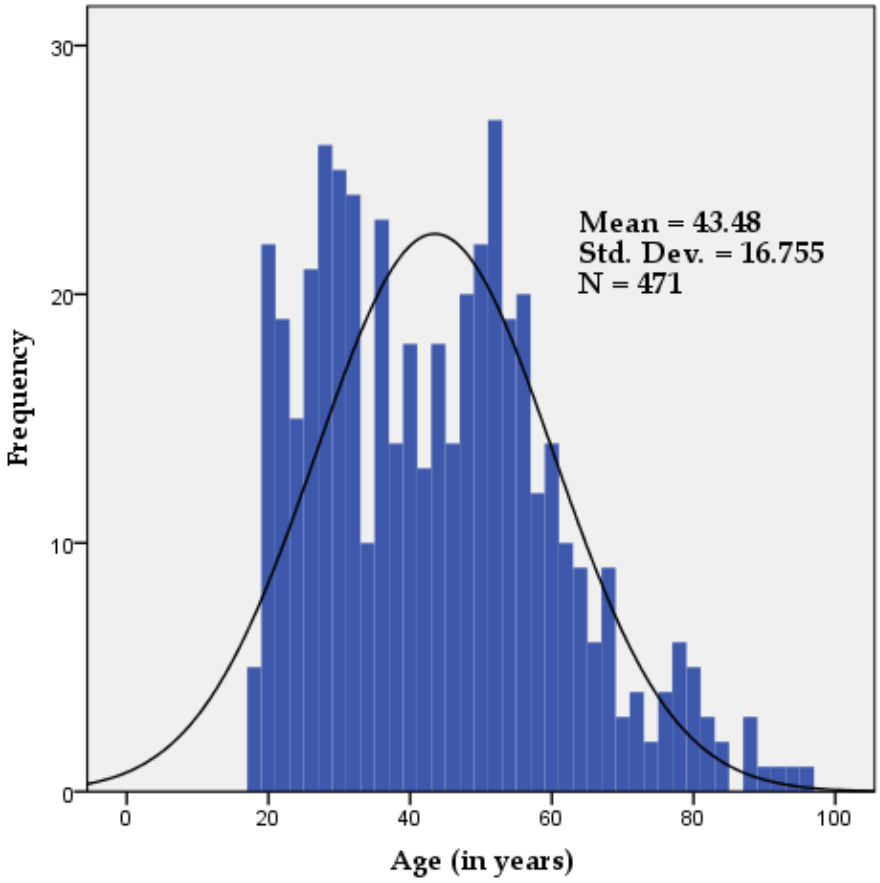


Table 4. Frequency of age of veterans evaluated by category

	Frequency	Percent
Between 18 and 29 years	119	25.3
Between 30 and 49 years	182	38.6
Between 50 and 64 years	119	25.3
65 years and over	51	10.8
Total	**471**	**100.0**

►About four out of ten (38.7%, n=180) of the veterans evaluated were female and six out of ten (61.3%, n=285) were male.

►Two-thirds (66.0%, n=306) of the veterans evaluated were Caucasian, and one-fourth (26.9%, n=125) were African American. See Figure 5 and Table 5.

Figure 5. Race/ethnic distribution of veterans

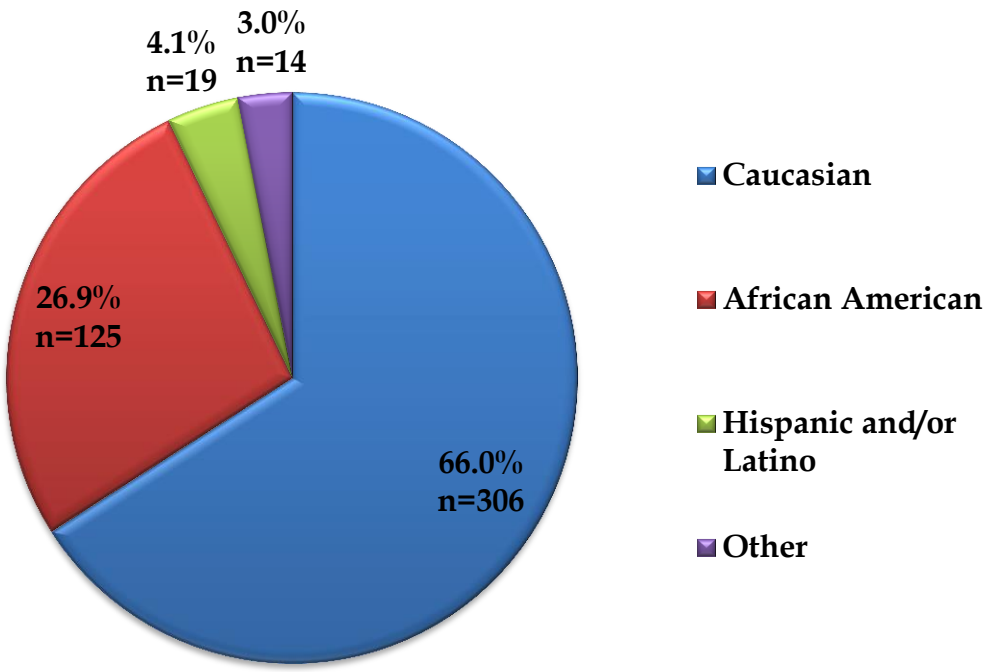


Table 5. Race/ethnic distribution of veterans

	Frequency	Percent
Caucasian	306	66.0
African American	125	26.9
Hispanic and/or Latino	19	4.1
Asian and/or Pacific Islander	5	1.1
Native American	1	0.2
Other (not specified)	3	0.6
Multiracial	5	1.1
Total	**464**	**100.0**

Living Situation of Veterans

►Most veterans were living with family (48.2%, n=222) or living alone (18.2%, n=84) at the time of the evaluation. See Figure 6 and Table 6.

Figure 6. Living situation of veterans

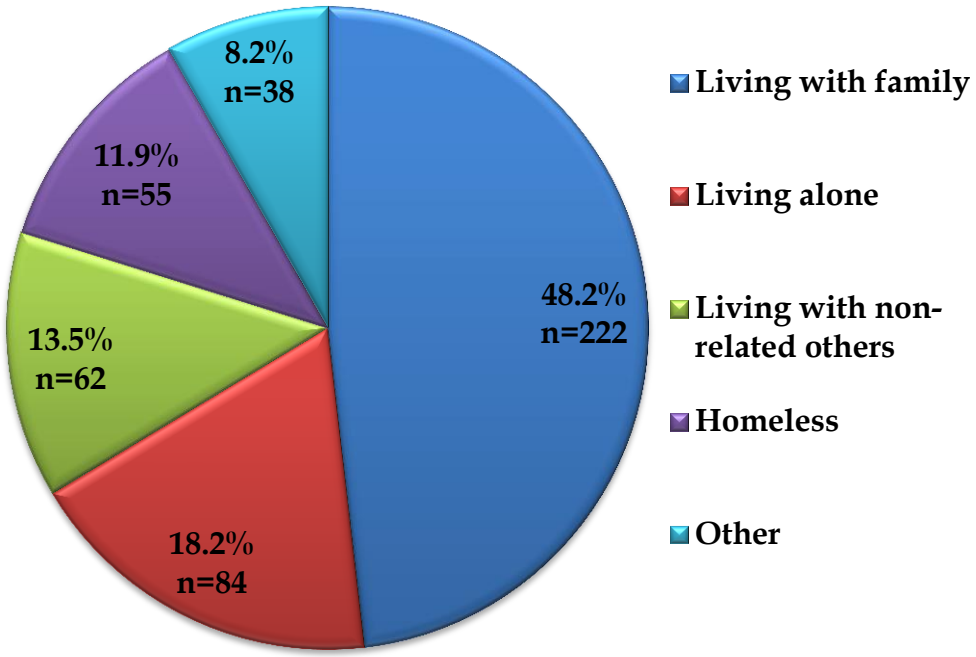


Table 6. Living situation of veterans

	Frequency	Percent
Living with family	222	46.5
Living alone	84	17.6
Living with non-related others	62	13.0
Homeless	55	11.5
Living with support	25	5.2
Don't know	16	3.4
Other	13	2.7
Total	**477**	**100.0**

Current Treatment of Veterans

►Forty-four percent (43.9%, n=201) of veterans were not receiving treatment at the time of the emergency evaluation. See Figure 7 and Table 7.

Figure 7. Sources of current treatment of veterans

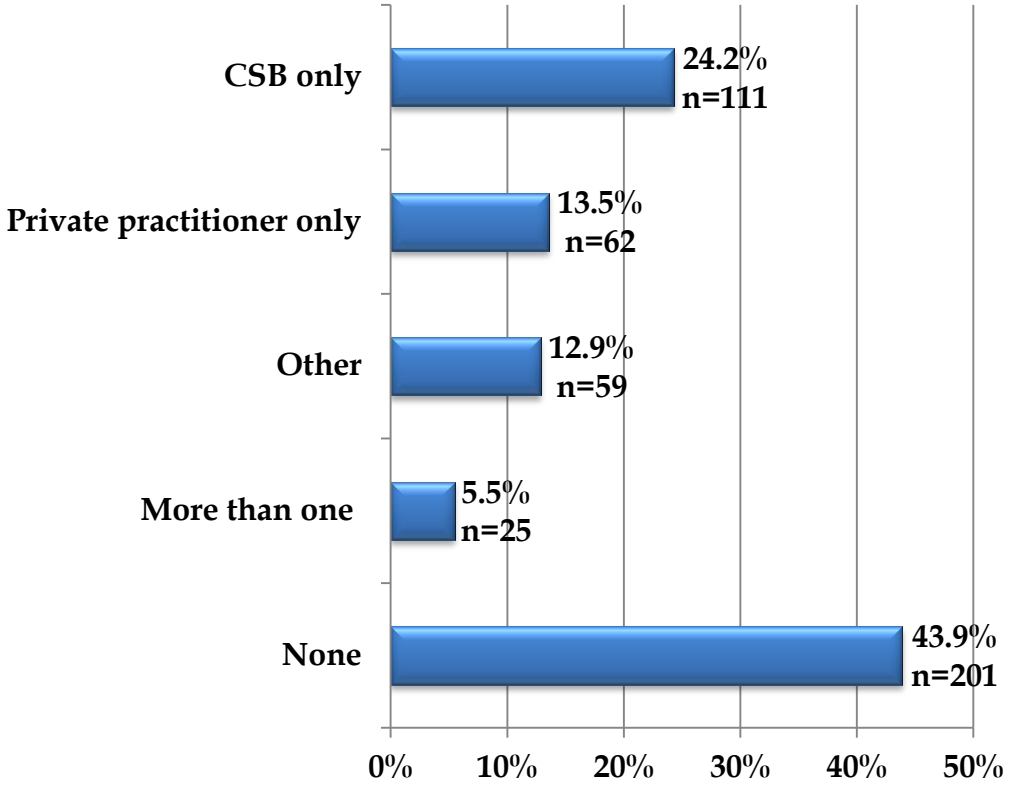


Table 7. Sources of current treatment of veterans

	Frequency	Percent
None	201	42.3
CSB only	111	23.4
Private practitioner only	62	13.1
More than one	25	5.3
Other:		
DBHDS facility	1	0.2
Other community agency	20	4.2
Private/community psych facility	12	2.5
Non-psychiatric private/community facility	12	2.5
Veterans administration hospital	11	2.3
University counseling	2	0.4
Other (not specified)	1	0.2
Don't know/not sure	17	3.6
Total	**475**	**100.0**

Insurance Status of Veterans

►One-third (32.2%, n=147) of veterans did not have health insurance at the time of the emergency evaluation. See Figure 8 and Table 8.

Figure 8. Insurance status of veterans

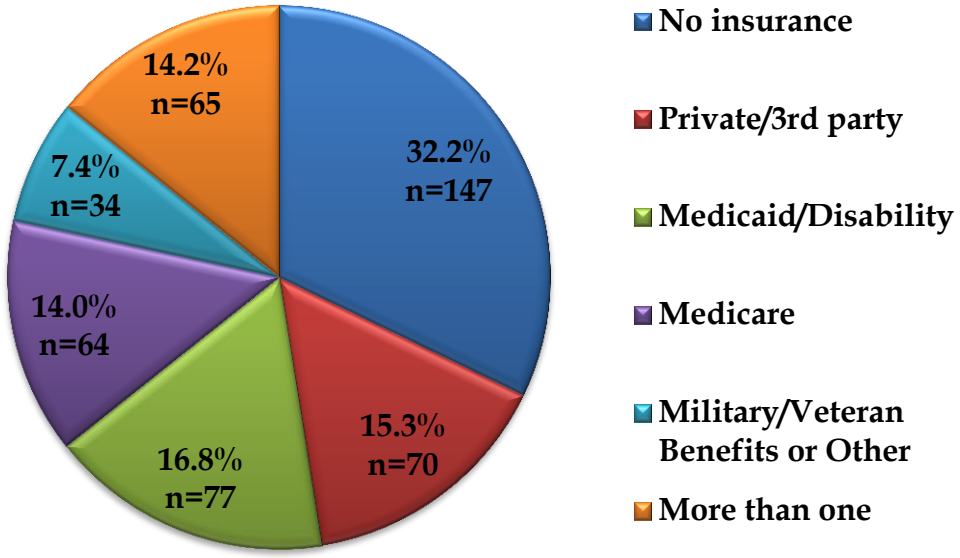


Table 8. Insurance status of veterans

	Frequency	Percent
No insurance	147	30.8
Medicaid/Disability	77	16.1
Medicare	64	13.4
Private/3rd Party	70	14.6
Military/Veteran benefits	32	6.7
More than one (total)	65	13.6
Military/Veteran benefits and other	*19*	*4.0*
Other	2	0.4
Don't know/not sure	21	3.6
Total	**478**	**100.0**

Pathways to CSB Crisis Response System

Veterans in Police Custody at the Time of Evaluation

►One-third of individuals (32.6%, n=156) were in police custody at the time of the emergency evaluation. See Figure 9 and Table 9.

Figure 9. Veterans in police custody at time of evaluation

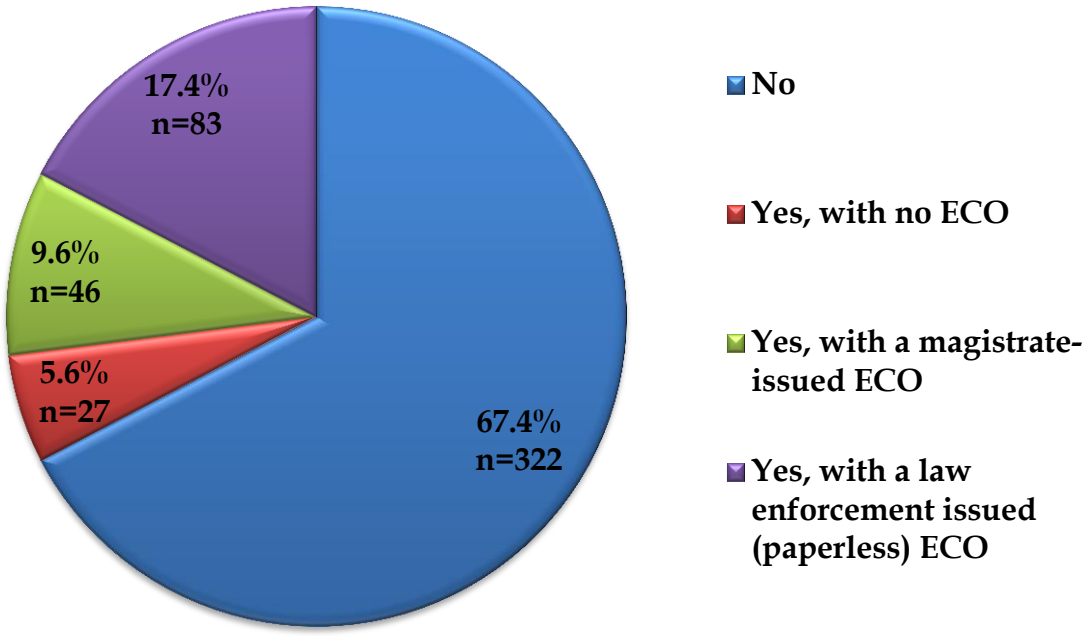


Table 9. Client status at the time of the evaluation

	In police custody?	Restraints used	Sought an ECO	ECO was obtained	Initial ECO expired	Sought an extension
Not in police custody	322	1	12	11	3	3
Yes, with no ECO	27	7	0	0	14	
Yes, with magistrate issued ECO	46	15	-	-	12	12
Yes, with law enforcement issued (paperless) ECO	83	36	-	-	29	10
Total	**478**	**59**	**12**	**11**	**58**	**25**

►Of the cases in which an ECO extension was granted (n=25), the extension provided sufficient time to complete the evaluation in 60.0% (n=15) of cases, the extension provided sufficient time to complete the medical screening in 48.0% (n=12) of cases, and the extension provided sufficient time to locate a bed in 56.0% (n=14) of cases. See Table 10.

Table 10. Was the ECO extension sufficient?

	Extension sufficient for CSB evaluation	Extension sufficient for medical screening	Extension sufficient for locating a bed	Total Number of ECO extensions granted
Not in police custody	1	1	2	3
Yes, with no ECO				
Yes, with magistrate issued ECO	6	5	7	12
Yes, with law enforcement issued (paperless) ECO	8	6	5	10
Total	**15**	**12**	**14**	**25**

Contacting the CSB for Veteran Emergency Evaluations

►Hospital staff, followed by law enforcement, most often initiated CSB emergency evaluations. See Figure 10 and Table 11.

Figure 10. Contacting CSB for emergency evaluations

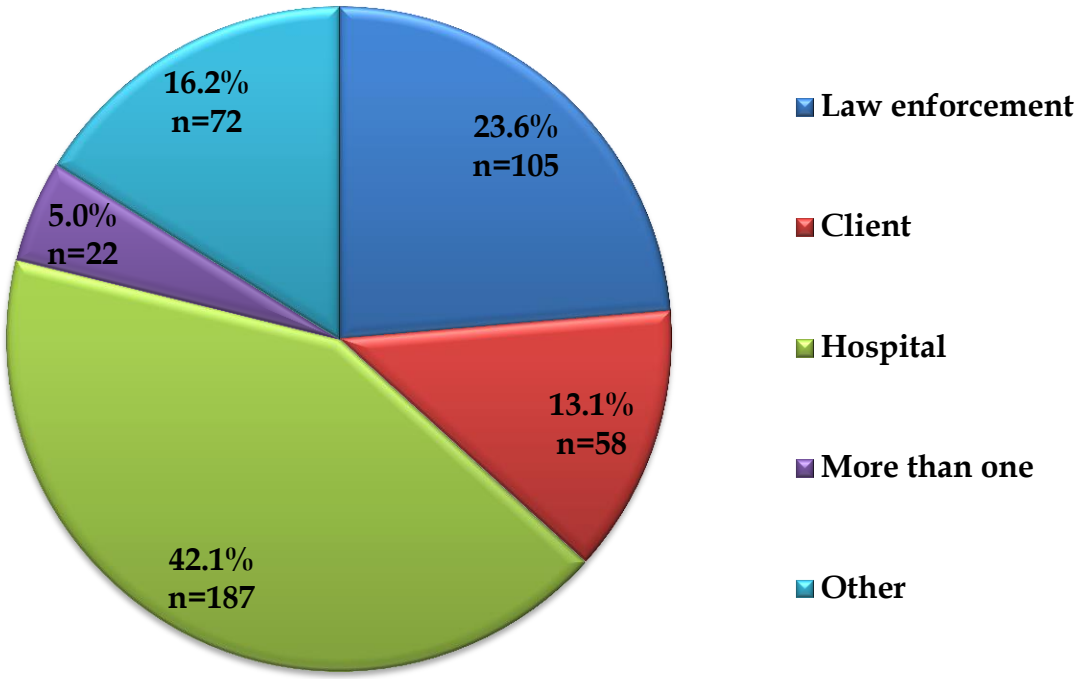


Table 11. Contacting CSB for emergency evaluations

	Frequency	Percent
Hospital	187	42.1
Law enforcement	105	23.6
Client himself/herself	58	13.1
Clinician	32	7.2
Friend/family member	18	4.1
Other (e.g., Legal Aid)	22	5.0
More than one above	22	5.0
Total	**444**	**100.0**

Location of Veteran Emergency Evaluations

►Most adult emergency evaluations (63.2%, n=301) took place at a hospital. See Table 12.

Table 12. Location of the emergency evaluation

	Frequency	Percent
CSB	125	26.3
Client's home	15	3.2
Hospital Psychiatric Unit	48	10.1
Police Station	13	2.7
Hospital Emergency Department	236	49.6
Public location	9	1.9
Magistrate's Office	2	0.4
Other:		
CIT-trained police	3	0.6
Assisted Living Facility	2	0.4
Crisis stabilization	1	0.2
Hospital ICU	2	0.4
Hospital and Medical unit	15	3.2
Detox or Substance abuse facility	1	0.2
Outpatient	3	0.6
Shelter, group home, etc.	1	0.2
Total	**476**	**100.0**

Day and Time of the Emergency Evaluations

►Veteran emergency evaluations were most likely to occur on weekdays rather than the weekend. See Figure 11 and Table 13.

Figure 11. Day of the week the emergency evaluations occurred

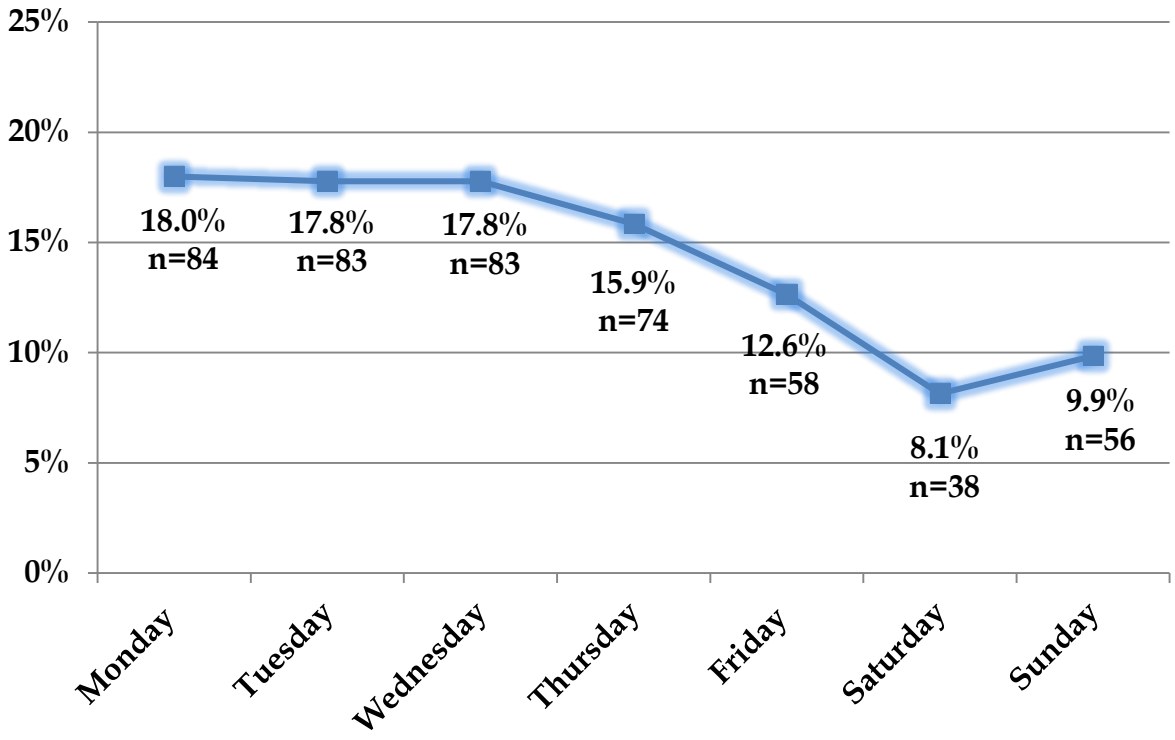
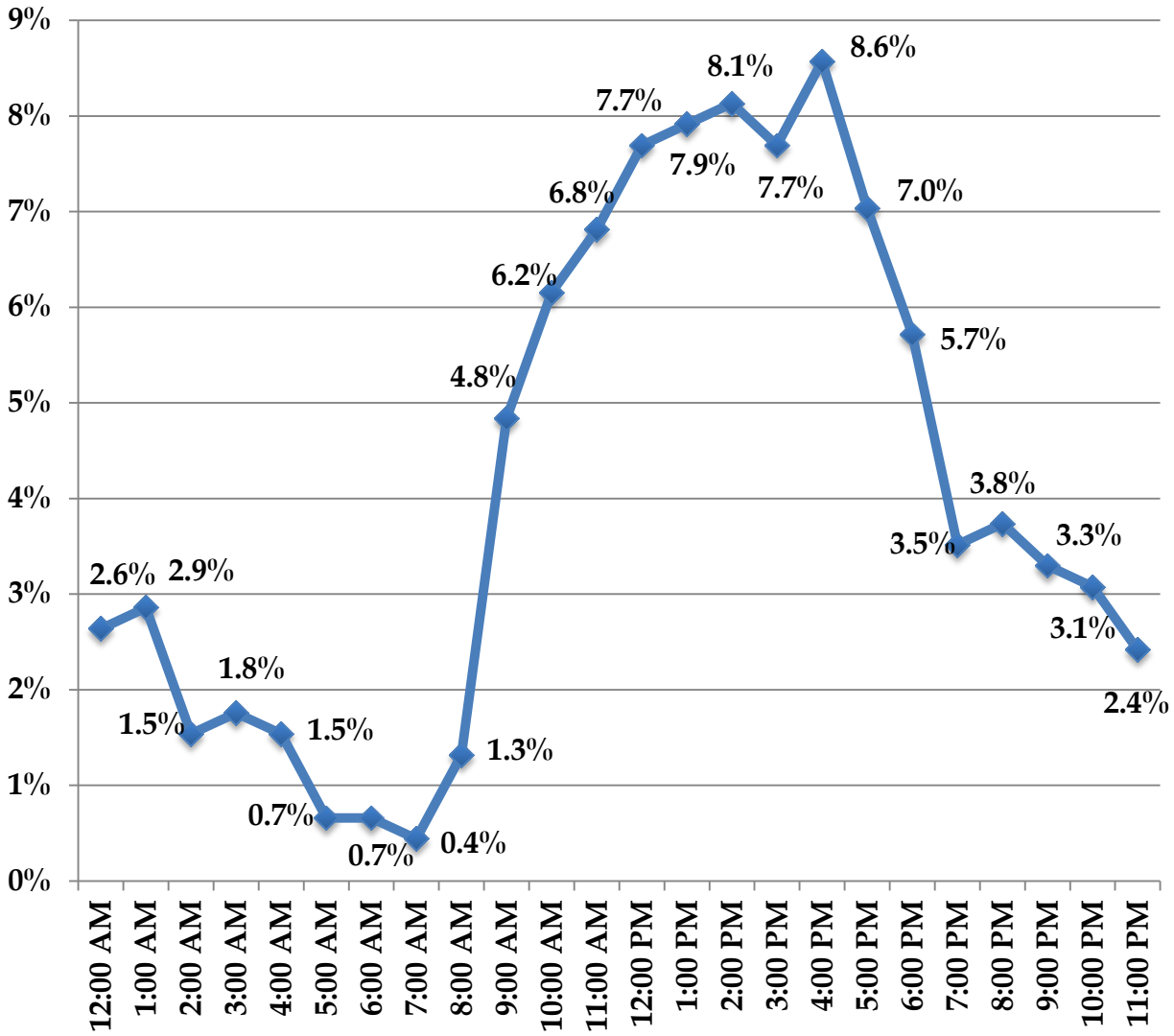


Table 13. Day of the week the emergency evaluations occurred

	Frequency	Percent
Monday	84	18.0
Tuesday	83	17.8
Wednesday	83	17.8
Thursday	74	15.9
Friday	59	12.6
Saturday	38	8.1
Sunday	46	9.9
Total	**467**	**100.0**

►Veteran emergency evaluations were most likely to occur during standard work hours (i.e., between 9 a.m. and 5 p.m.). See Figure 12.

Figure 12. Time of day the emergency evaluation occurred



►**The average length of time of an emergency evaluation was 1 hour and 59 minutes (*sd*=2:23), ranging from 15 minutes to over 15 hours.** Nine out of 10 (93.9%, n=433) veteran evaluations were completed within four hours. See Figure 13 and Table 14.

Figure 13. Length of emergency evaluation

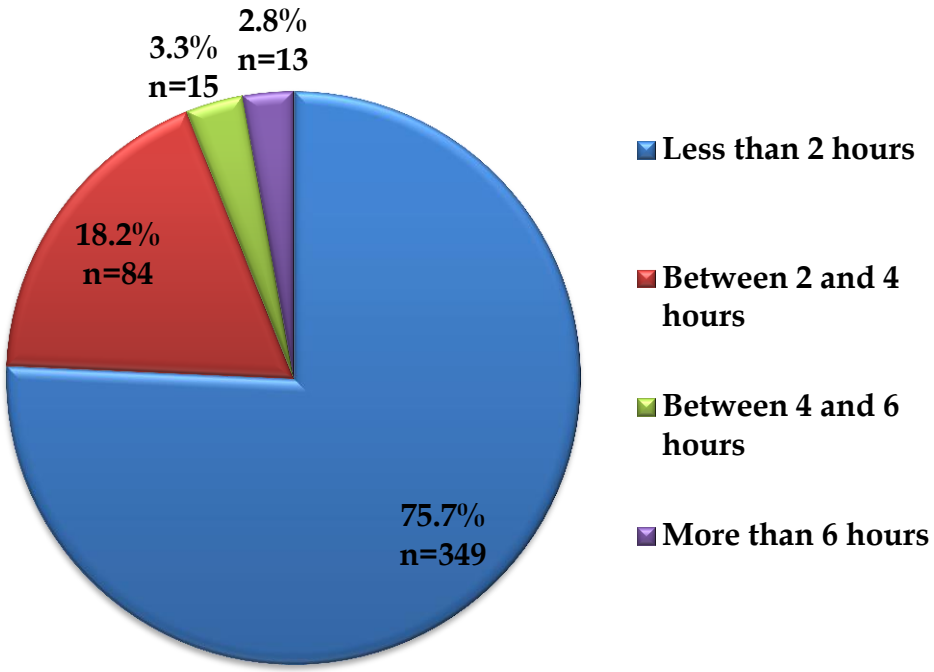


Table 14. Length of emergency evaluation

	Frequency	Percent
One hour or less	177	38.4
Between 1 and 2 hours	172	37.3
More than 2 to 3 hours	55	11.9
More than 3 to 4 hours	29	6.3
More than 4 to 5 hours	9	2.0
More than 5 to 6 hours	6	1.3
More than 6 to 9 hours	3	0.7
More than 9 to 12 hours	1	0.2
More than 12 to 15 hours	7	1.5
More than 15 to 18 hours	2	0.4
Total	**461**	**100.0**

►Advance Directives were greatly underutilized. Fewer than four out of 100 (3.5%, n=15) individuals evaluated had an Advance Directive.

►On average, the clinician had two sources of information available prior to the evaluation (*average*=2.1, *sd*=1.2). The two most common sources of information available to the clinician prior to the evaluation were CSB records and hospital staff. See Figure 14 and Table 15.

Figure 14. Sources of information that the clinician had prior to the evaluation

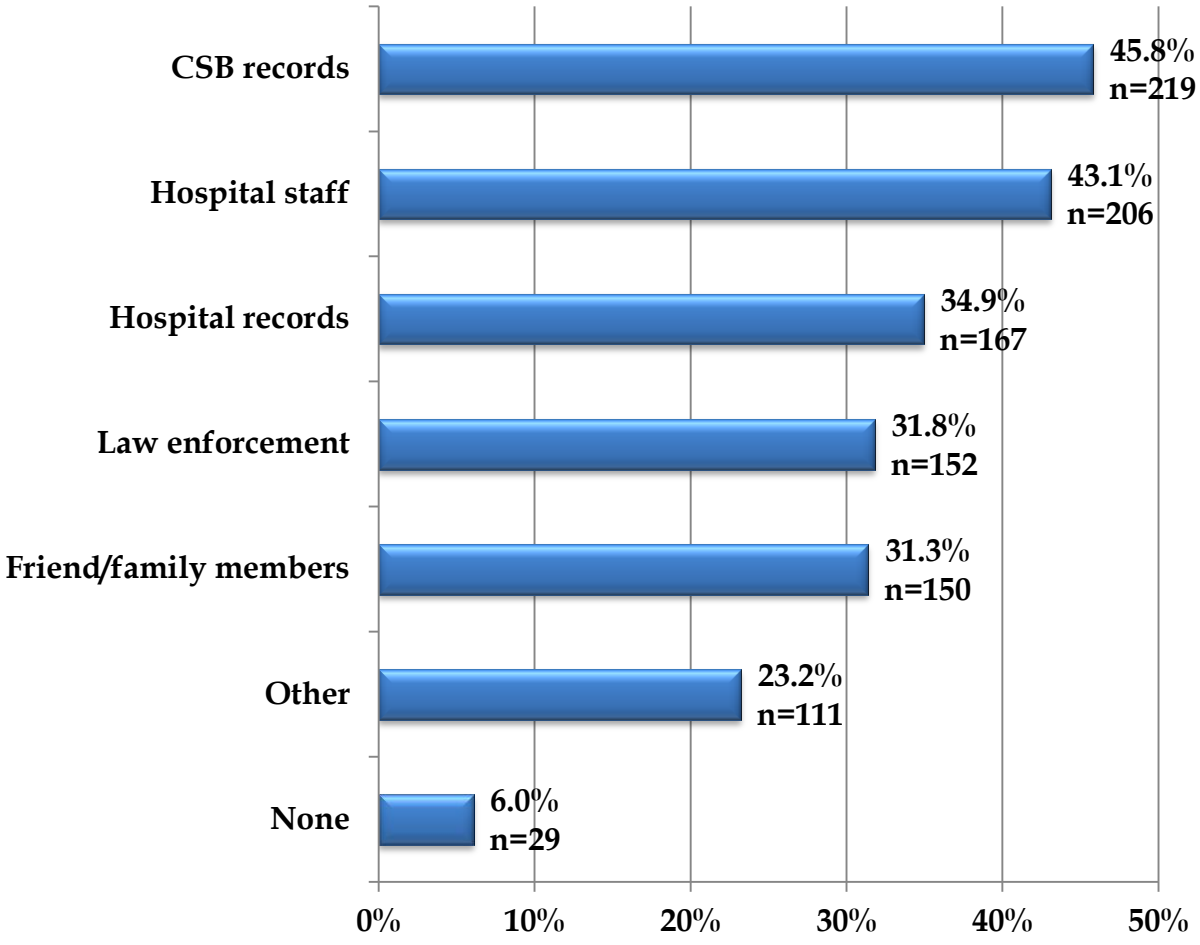


Table 15. Sources of information that the clinician had prior to the evaluation

	Frequency	Percent
CSB records	219	45.8
Law enforcement	152	31.8
CSB clinician(s)	56	11.7
Friend/family members	150	31.4
Hospital staff	206	43.1
Hospital records	167	34.9
None	29	6.1
Other:		
Other providers	17	3.6
Other clinical records	17	3.6
Assisted Living (non-medical)	1	0.2
Adult care worker or record	1	0.2
Adult Protection Services	1	0.2
Other people (e.g., airline staff)	1	0.2
Any mental health worker	7	1.5
Hospital employee or record	3	0.6
Client	5	1.0
Legal document, ECO, magistrate, probation	1	0.2
Nursing Home	1	0.2
Total	**478**	**100.0**

Clinical Presentation of Veterans

Presentation at Time of Veteran Emergency Evaluations

►**In nine out of 10 cases (87.7%, n=419), the veteran presented with symptoms of mental illness.** Overall, 20.9% (n=100) of individuals presented with mental illness and substance use/abuse disorder, 66.7% (n=319) of individuals presented with mental illness but no substance use/abuse disorder, and 6.9% (n=33) of individuals presented with substance use/abuse disorder but no mental illness. In 3.1% of cases (n=15), the clinician reported that the veteran presented with neither a mental illness nor substance use/abuse disorder, and in 2.3% (n=11) of cases, the clinician reported that the veteran presented with other unspecified conditions. See Figure 15 and Table 16.

Figure 15. Veteran presentation at the time of the evaluation

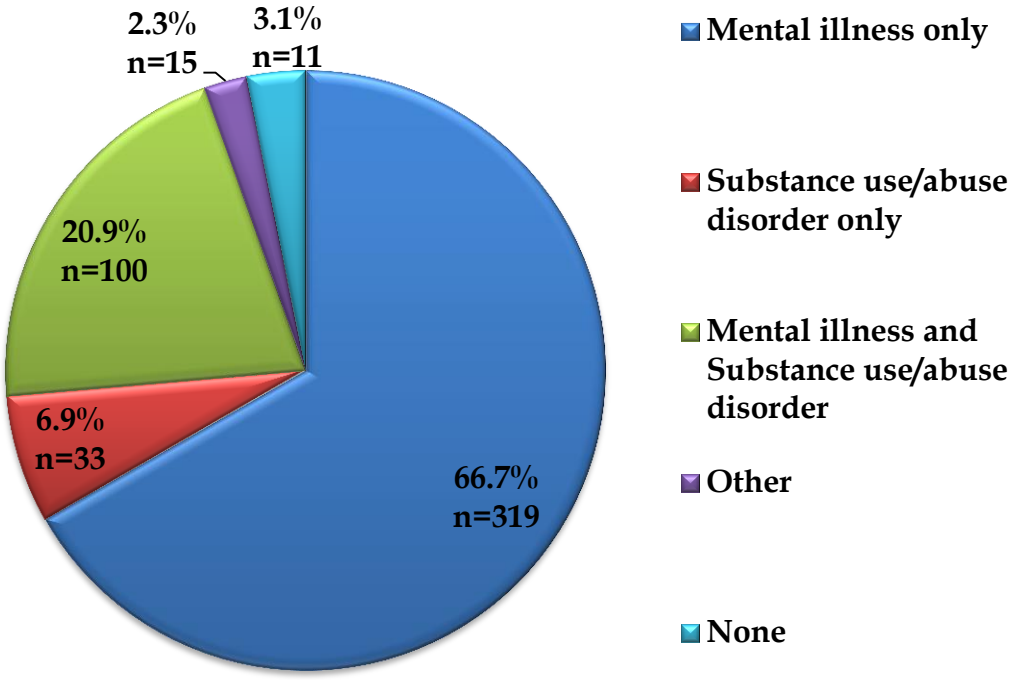


Table 16. Veteran presentation at the time of the evaluation

	Frequency	Percent
Mental illness and Substance use/abuse disorder	100	20.9
Mental illness only	319	66.7
Substance use/abuse disorder only	33	6.9
None	15	3.1
Other	11	2.3
Total	**478**	**100.0**

Veterans Under the Influence of Substances

►Less than 25% (24.2%, n=111) of veterans were under the influence or suspected to be under the influence of drugs or alcohol at the time of the emergency evaluation. See Table 17.

Table 17. Veterans presenting under the influence or suspected of being under the influence

	Frequency	Percent
Under the influence of drugs or alcohol	94	19.7
Suspected of being under the influence of drugs or alcohol	17	3.6
Not under the influence of drugs or alcohol	347	72.6
Unknown	20	4.2
Total	**478**	**100.0**

Veterans Presenting Psychotic Symptoms

►**About one-third (32.2%, n=154) of the veterans evaluated presented with psychotic symptoms.** Of the 419 veterans who presented with a mental illness, 36.5% (n=153) also showed psychotic symptoms. See Table 18.

Table 18. Veterans presenting psychotic symptoms

	Frequency	Percent
Psychotic symptoms	154	32.2
No psychotic symptoms	324	67.8
Total	**478**	**100.0**

Displays by Evaluated Veterans of Behaviors Bearing on Involuntary Commitment Criteria

►**One out of two (51.5%, n=246) evaluated veterans displayed behaviors indicating an elevated risk of serious physical harm toward self. See Figures 16-17 and Tables 19-20.**

►**Four out of ten (40.8%, n=195) evaluated veterans displayed behaviors indicating an impaired capacity for self-protection or ability to provide for basic needs. See Figures 16-17 and Tables 19-20.**

►**One out of four (23.4%, n=112) evaluated veterans displayed behaviors indicating an elevated risk of serious physical harm toward others. See Figures 16-17 and Tables 19-20.**

►**One out of four (24.5%, n=117) evaluated veterans did not show behavioral indicators bearing on the civil commitment criteria. See Figure 16 and Tables 19-20.**

Clinicians reported in three separate questions whether or not the evaluated individual revealed recent behaviors or symptoms as shown in the available records or during the interview that had a bearing on the commitment criteria. An evaluated individual could meet one or more of the commitment criteria. Therefore, these responses are not mutually exclusive. See Figure 16-18 and Table 19-20.

Figure 16. Displays by evaluated veterans of behaviors bearing on involuntary commitment criteria

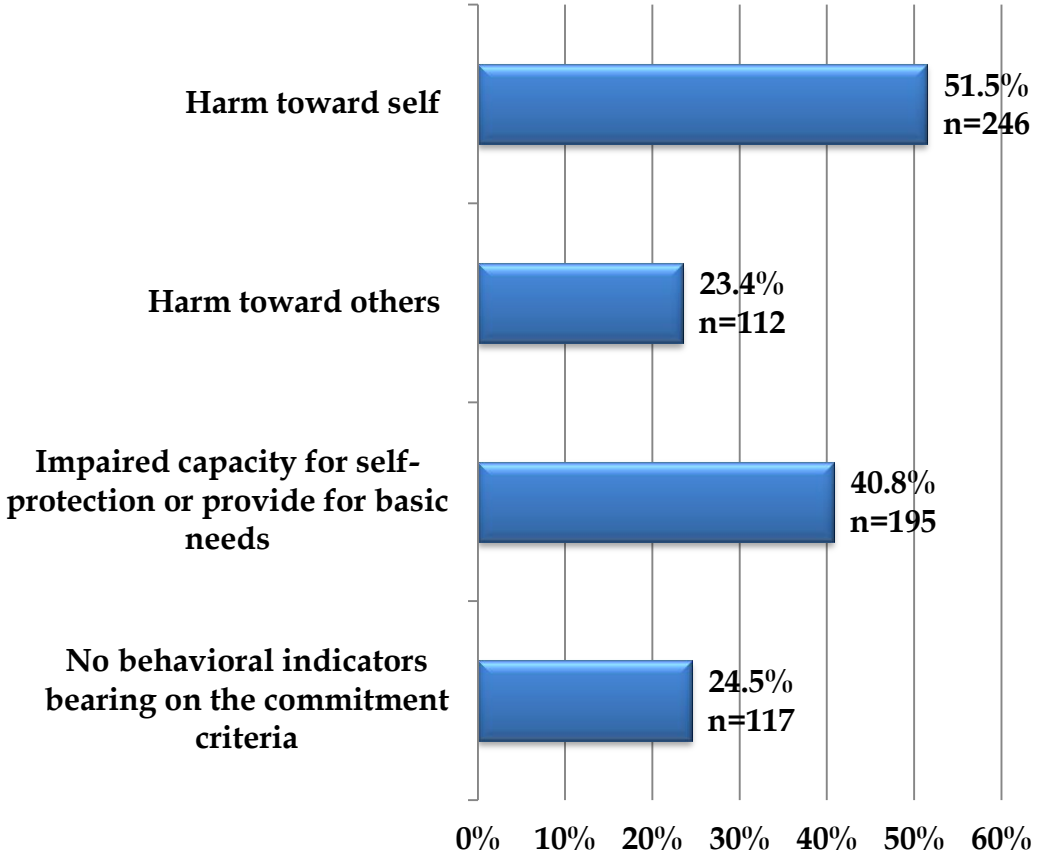


Table 19. Displays by evaluated veterans of behaviors bearing on involuntary commitment criteria

	Frequency	Percent
Harm toward self	246	51.5
Impaired capacity for self-protection or ability to provide for basic needs	195	40.8
Harm toward others	112	23.4
No behavioral indicators bearing on the commitment criteria	117	24.5
Total	**478**	**100.0**

Figure 17. Displays by evaluated veterans of behaviors bearing on involuntary commitment criteria, combinations

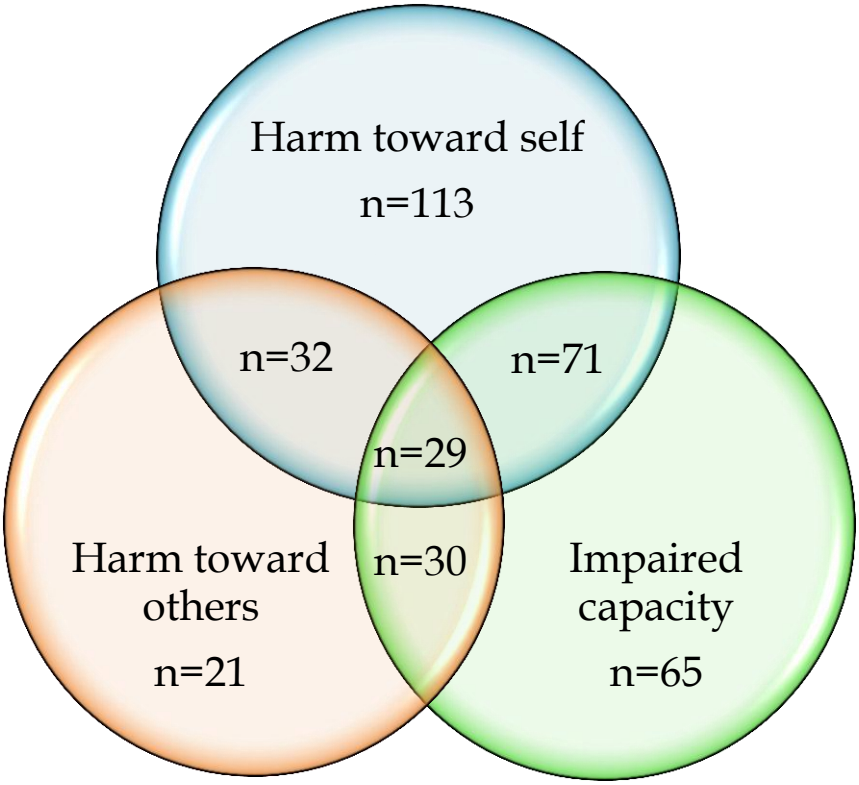


Table 20. Displays by evaluated veterans of behaviors bearing on involuntary commitment criteria, combinations

	Frequency	Percent
No indicators displayed	117	24.5
Harm toward self only	113	23.6
Harm toward others only	21	4.4
Impaired capacity for self-protection or ability to provide for basic needs only	65	13.6
Harm toward self and Harm toward others	32	6.7
Harm toward self and Impaired capacity for self-protection or ability to provide for basic needs	71	14.9
Harm toward others and Impaired capacity for self-protection or ability to provide for basic needs	30	6.3
Harm toward self, Harm toward others, and Impaired capacity for self-protection or ability to provide for basic needs	29	6.1
Total	**478**	**100.0**

►**Of the cases in which the client displayed behaviors indicating an elevated risk of serious physical harm toward self (n=245), 15.0% (n=37) ingested pills or poison, 7.3% (n=18) injured self with a sharp object, and 10.6% (n=26) demonstrated other self-injurious behavior. See Figure 18 and Table 21.**

Figure 18. Behaviors indicating an elevated risk of serious physical harm toward self

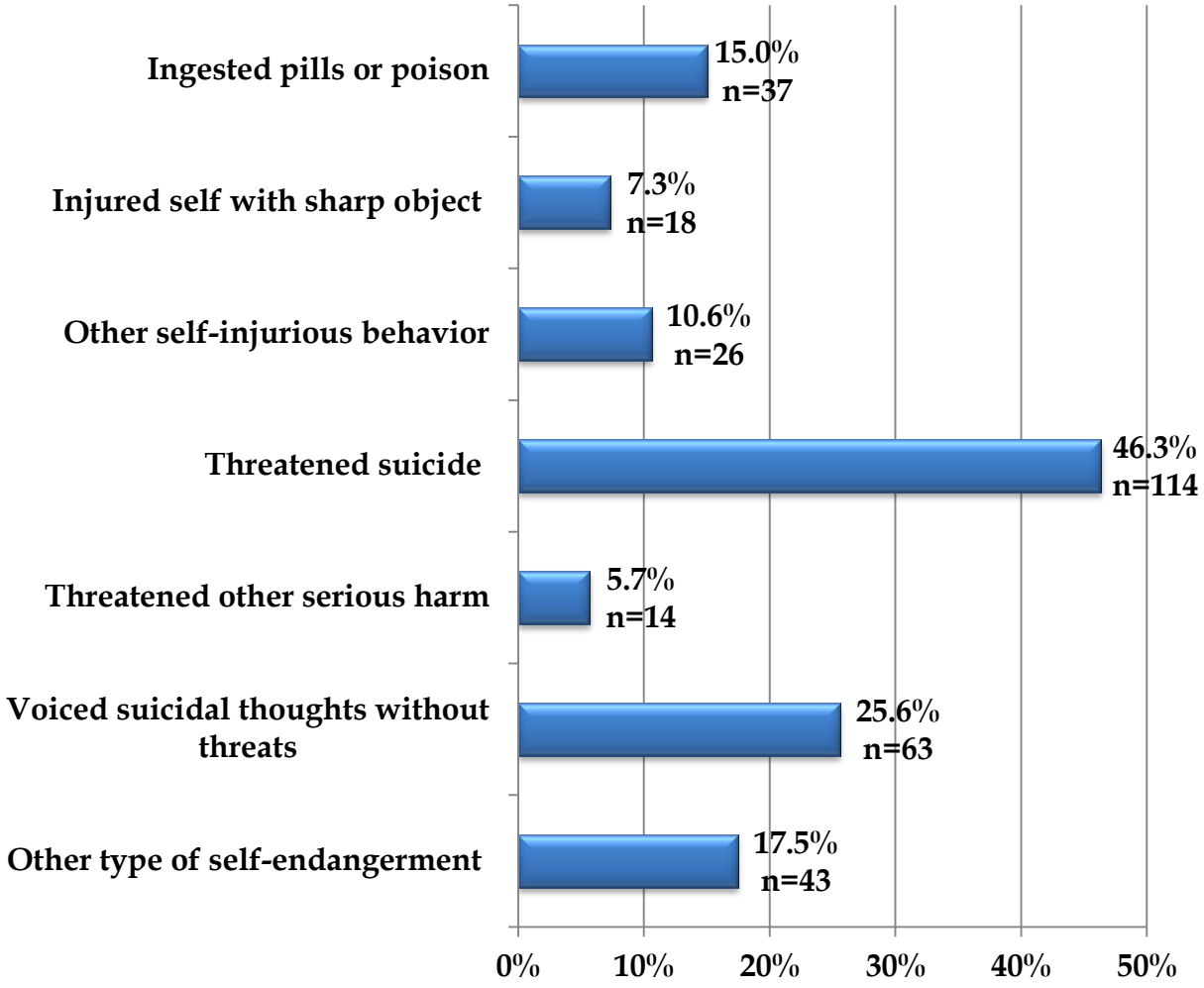


Table 21. Behaviors indicating an elevated risk of serious physical harm toward self

	Frequency	Percent
Ingested pills or poison	37	15.0
Injured self with sharp object	18	7.3
Other self-injurious behavior	26	10.6
Threatened suicide	114	46.3
Threatened other serious harm	14	5.7
Voiced suicidal thoughts without threats	63	25.6
Other type of self-endangerment	43	17.5
Total	**245**	**100.0**

►Of the cases in which the client displayed behaviors indicating an elevated risk of serious physical harm toward others (n=112), 8.9% (n=10) injured someone and 25.0% (n=28) hit, kicked, or pushed someone without injury. See Figure 19 and Table 22.

Figure 19. Behaviors indicating an elevated risk of serious physical harm toward others

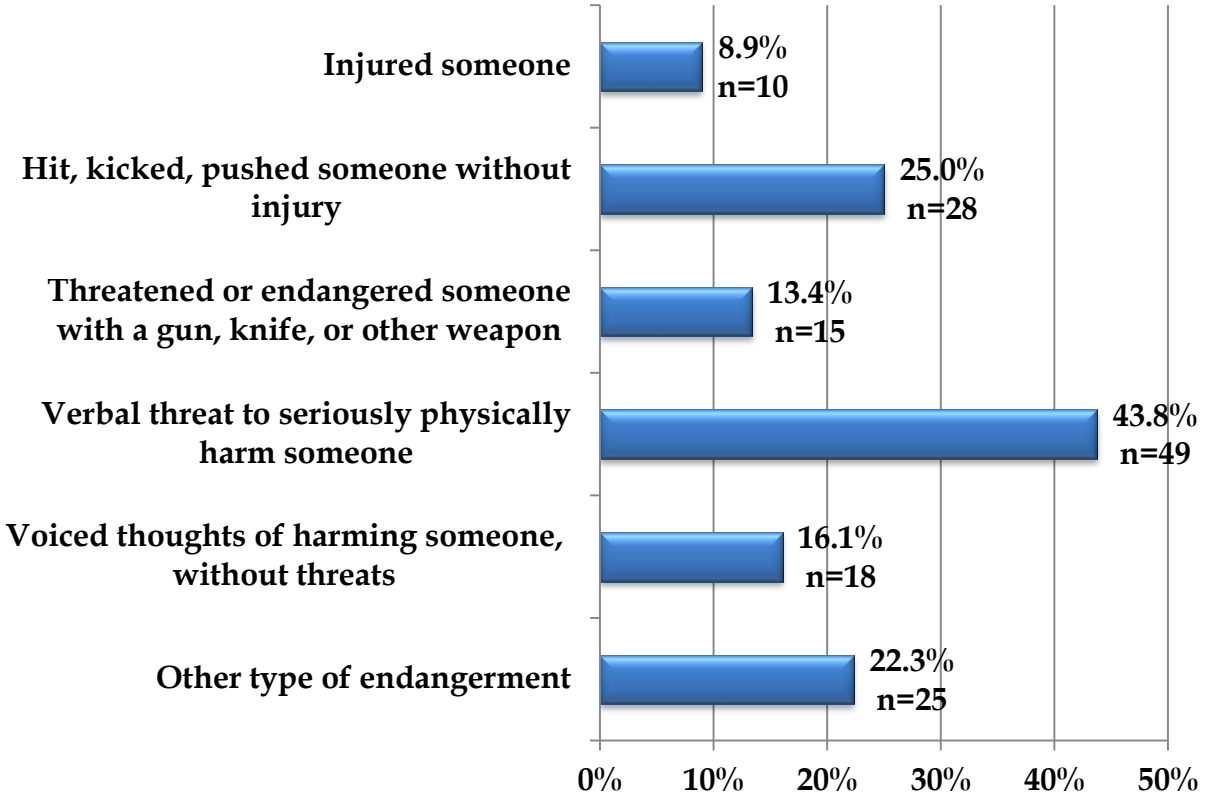


Table 22. Behaviors indicating an elevated risk of serious physical harm toward others

	Frequency	Percent
Injured someone	10	8.9
Hit, kicked, pushed someone without injury	28	25.0
Threatened or endangered someone with a gun, knife, or other weapon	15	13.4
Verbal threat to seriously physically harm someone	49	43.8
Voiced thoughts of harming someone, without threats	18	16.1
Other type of endangerment	25	22.3
Total	**112**	**100.0**

►In two-thirds of the evaluations, the emergency services clinician ascertained that the evaluated adults did not own or have easy access to a firearm (65.5%, n=313). Only 9.4% (n=45) of veterans were determined by the clinician to own or have easy access to a firearm.

In the remaining 25.1% (n=120) of cases, the clinician was unable to determine whether the client had access to firearms.

►Of the cases in which the evaluated veterans displayed behaviors indicating impaired capacity for self-protection or ability to provide for basic needs (n=195), 60.0% (n=117) presented with a generalized decline in functioning. See Figure 20 and Table 23.

Figure 20. Behaviors/symptoms indicating an impaired capacity for self-protection or ability to provide for basic needs

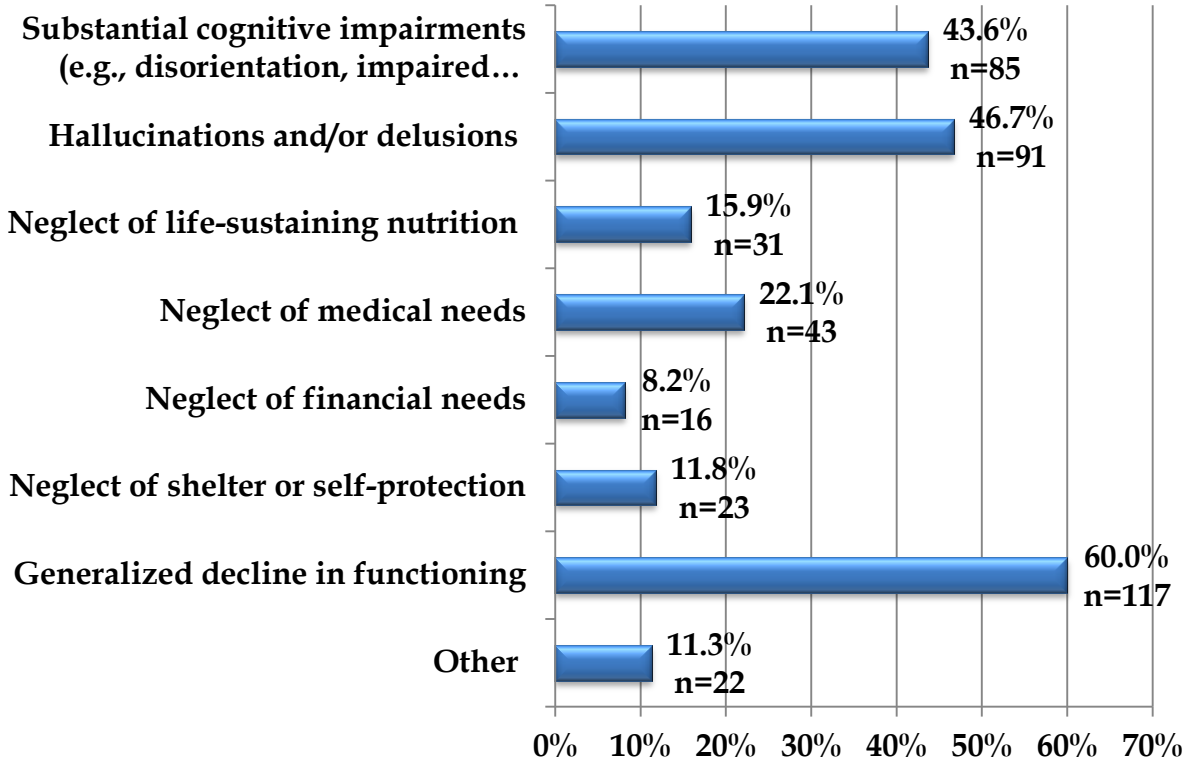


Table 23. Behaviors/symptoms indicating an impaired capacity for self-protection or ability to provide for basic needs

	Frequency	Percent
Substantial cognitive impairments (e.g., disorientation, impaired memory)	85	43.6
Hallucinations and/or delusions	91	46.7
Neglect of life-sustaining nutrition	31	15.9
Neglect of medical needs	43	22.1
Neglect of financial needs	16	8.2
Neglect of shelter or self-protection	23	11.8
Generalized decline in functioning	117	60.0
Other	22	11.3
Total	**195**	**100.0**

Disposition After Veteran Emergency Evaluations

Type of Action Recommended by the CSB Clinician for Veterans

►Involuntary action was recommended to a magistrate in 4 out of 10 veteran evaluations. See Figure 21 and Table 24.

Figure 21. Clinician recommended dispositions

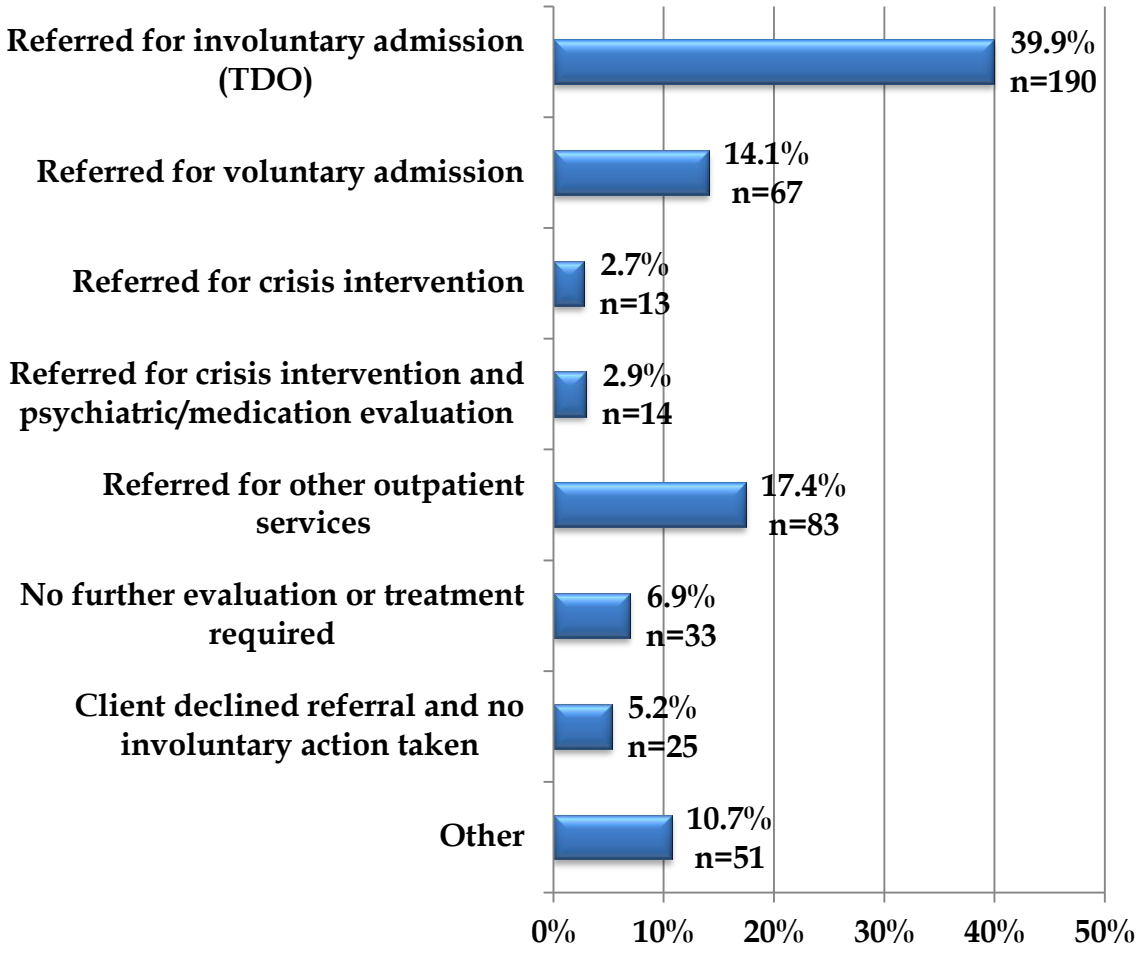


Table 24. Clinician recommended dispositions

	Frequency	Percent
Referred for involuntary admission (TDO)	190	39.9
Referred for voluntary admission	67	14.1
Referred for crisis intervention	13	2.7
Referred for crisis intervention and psychiatric/medication evaluation	14	2.9
Referred for other outpatient services	83	17.4
No further evaluation or treatment required	33	6.9
Client declined referral and no involuntary action taken	25	5.3
Other:		
Medical admission	3	0.6
Client stayed in hospital	2	0.4
Released with safety plan	3	0.6
Released to family	1	0.2
No bed	2	0.4
Substance abuse treatment or Detox	8	1.7
Arrested jailed	7	1.5
Left before treatment against medical advice	2	0.4
In ER	3	0.6
Help but not medical or psych	3	0.6
Crisis stabilization of some kind	14	2.9
Other (e.g., insurance issues)	3	0.6
Total	**478**	**100.0**

Outcome When Involuntary Admission Was Recommended

►Among cases in which involuntary admission was recommended by the clinician (n=190), a Temporary Detention Order (TDO) was granted 95.8% (n=182) of the time. It was not granted in only 1.6% (n=3) of cases. In the remaining five cases, whether the TDO was granted was unknown or unrecorded at the time the evaluation ended.

►Among cases in which a TDO was granted (n=182), the individual was admitted to a facility 97.8% (n=178) of the time. See Table 24-25.

►In about four out of five (83.7%, n=149) cases in which the individual was admitted to a facility on a TDO, he/she was admitted to a private/community psychiatric facility or unit. See Figure 22 and Table 25.

Figure 22. Facilities where veterans were admitted after a TDO was granted

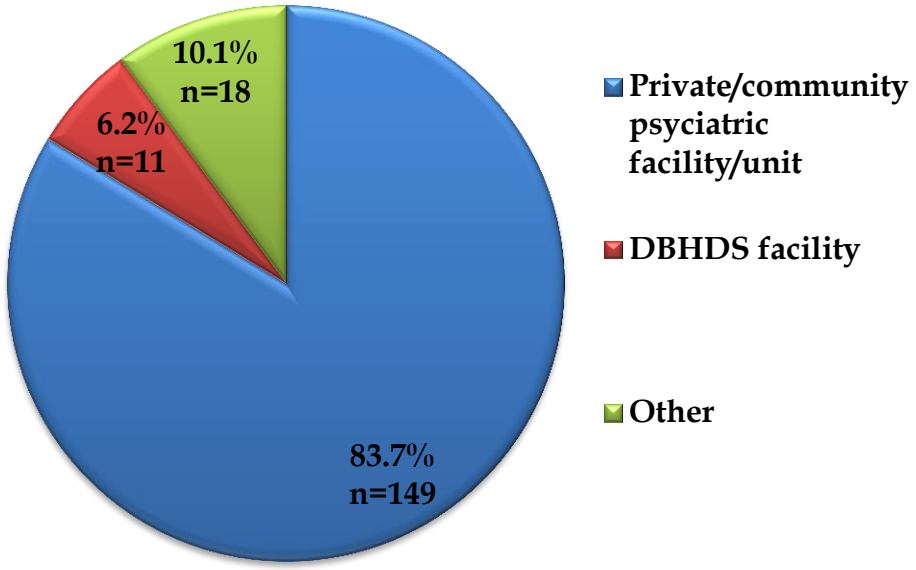


Table 25. Facilities where veterans were admitted after a TDO was granted

	Frequency	Percent
DBHDS facility	11	6.2
Private/community psych facility/unit	149	83.7
Emergency Department or medical unit of private/ community hospital	13	7.3
Crisis Stabilization Unit	1	0.6
Other facility	4	2.2
Total	**178**	**100.0**

►In the 1.6% (n=3) of cases in which the TDO was reported NOT to have been granted, the recorded reason the TDO was not granted was associated with the need for medical evaluation and treatment, the acuity of the client's condition/level or care required, or an inability to confirm bed availability in the requisite time.

►There was only one case in which a TDO was reported to have been granted but the client had not been admitted to a mental health facility at the time the survey form was completed; no information was available about why the client had not been admitted. In three cases, whether the client was admitted was unknown or unrecorded at the time the evaluation ended.

Outcome When Voluntary Admission Was Recommended

►Among the veterans for whom voluntary action was recommended (n=67), the vast majority (86.6%, n=58) were admitted. See Figure 23 and Table 26. In nine cases, voluntary admission was recommended, but the veteran was not admitted to a facility. In most of these cases, the client had not been admitted to a mental health facility when the evaluation was completed due to the need for medical evaluation prior to admission and the complexity of the client's needs.

►In half (n=29) of cases in which the individual was voluntarily admitted to a facility, he/she was admitted to a private/community psychiatric facility or unit. See Figure 25 and Table 27.

Figure 23. Facilities where veterans were admitted after a voluntary admission

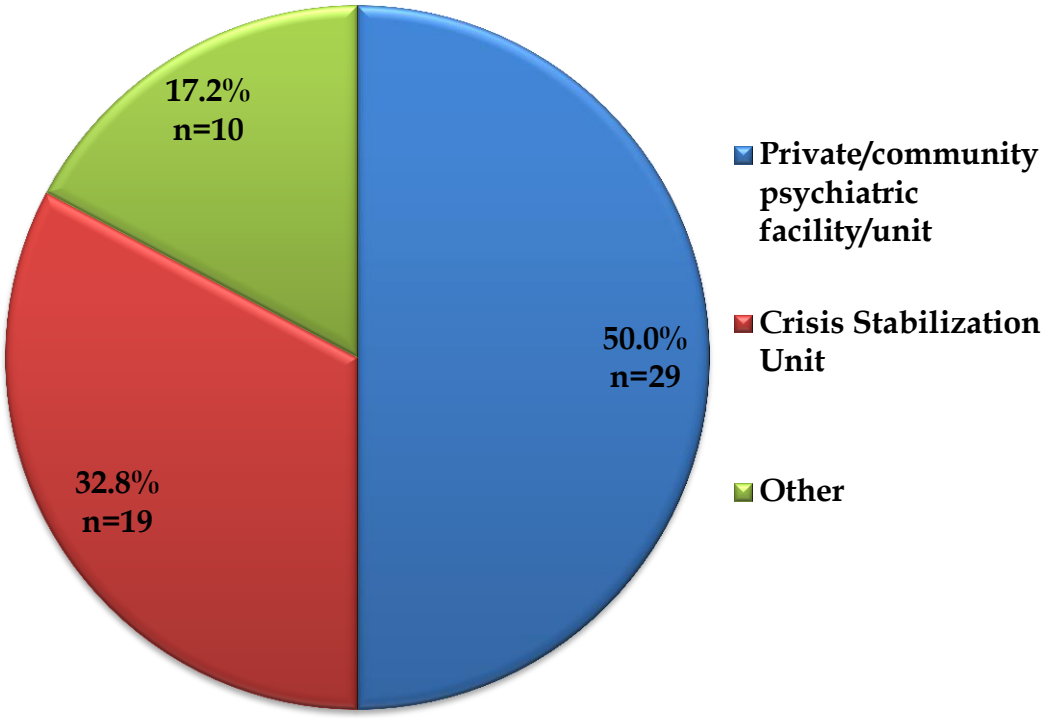


Table 26. Facilities where veterans were admitted after a voluntary admission

	Frequency	Percent
DBHDS facility	3	5.2
Crisis Stabilization Unit	19	32.8
Private/community psych facility/unit	29	50.0
Non-psychiatric private/community facility	1	1.7
Medical detox	4	6.9
Other facility	2	3.5
Total	**58**	**100.0**

Actions Taken to Identify a Psychiatric Bed for a Veteran

►In 60.1% (n=95) of cases for TDO admission to private facilities, it was necessary to call only one hospital to locate a bed, compared to 78.1% (n=32) of voluntary cases. However, in 25.3% (n=40) of TDO cases, and 9.8% (n=4) of voluntary cases, it was necessary to call three or more private facilities. See Table 27.

Table 27. Number of private facilities contacted for TDO and voluntary admissions

Number of private facilities contacted	Referred for involuntary admission (TDO)		Referred for voluntary admission	
	Frequency	Percent	Frequency	Percent
1	95	60.1	32	78.1
2	23	14.6	5	12.2
3	7	4.4	4	9.8
4	12	7.6	0	0.0
5	7	4.4	0	0.0
Between 6 and 10	9	5.7	0	0.0
Between 11 and 20	5	3.2	0	0.0
Total	**158**	**100.0**	**41**	**100.0**

►In 94.1% (n=16) of cases for TDO admission to state facilities, one hospital was called to locate a bed, compared to 80.0% (n=4) of voluntary cases. See Table 28.

Table 28. Number of state facilities contacted for TDO and voluntary admissions

Number of state (DBHDS) facilities contacted	Referred for involuntary admission (TDO)		Referred for voluntary admission	
	Frequency	Percent	Frequency	Percent
1	16	94.1	4	80.0
2	1	5.9	0	0.0
3	0	0.0	1	20.0
Total	**17**	**100.0**	**5**	**100.0**

Length of Time Locating a Psychiatric Bed

►In 88.6% (n=202) of cases, a psychiatric bed was located within four hours. See Figure 24 and Table 29.

Figure 24. Time spent locating an admitting hospital with an available psychiatric bed

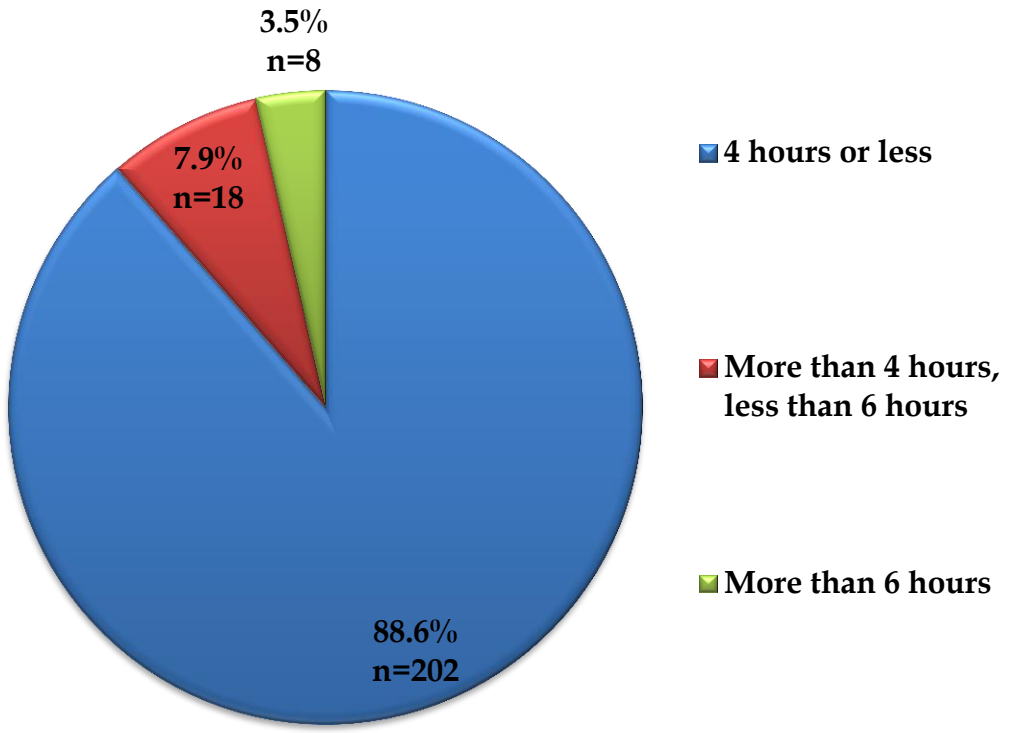


Table 29. Time needed to locate a bed

	Referred for involuntary admission (TDO)		Referred for voluntary admission		All Cases	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
4 hours or less	151	85.8	48	98.0	202	88.6
More than 4 hours, less than 6 hours	17	9.7	1	2.0	18	7.9
More than 6 hours	8	4.6	0	0.0	8	3.5
Total	**176**	**100.0**	**49**	**100.0**	**228**	**100.0**

►In the vast majority of cases (84.3%, n=198), the admitting psychiatric facilities were located within the same region as the individual's residence.

►In 73.1% of cases (n=174), a medical evaluation or treatment was required prior to hospital admission.

Veteran's Status at End of Emergency Evaluation Period

Clinicians' Opinions Regarding the Client's Status at the End of the Evaluation[2]

►At the end of the emergency evaluations, CSB clinicians found that 55.0% (n=262) of individuals who were evaluated warranted hospitalization. See Table 30.

►At the end of the emergency evaluations, CSB clinicians found that 38.4% (n=183) of those evaluated presented a substantial likelihood of causing serious physical harm to self in the near future.

►At the end of the emergency evaluations, CSB clinicians found that 18.5% (n=88) of those evaluated presented a substantial likelihood of causing serious physical harm to others in the near future. See Table 30.

►At the end of the emergency evaluations, CSB clinicians found that in 36.6% (n=174) of the cases, the individual evaluated was unable to protect self from harm and/or provide for basic needs. See Table 30.

[2] In this section of the instrument, the clinician was asked to rate their opinion or agreement with several statements about the individual's condition at the conclusion of the evaluation with yes, no, and N/A response options.

Table 30. Clinician opinion regarding the client's status at the end of the evaluation

	Frequency	Percent
Client presented a substantial likelihood of causing serious physical harm to self in the near future	183	38.4
Client presented a substantial likelihood of causing serious physical harm to others in the near future	88	18.5
Client was unable to protect self from harm	154	32.4
Client was unable to provide for basic needs	129	27.1
Client was experiencing severe mental or emotional distress or dysfunction	308	64.7
Client lacked the capacity to make treatment decisions	153	32.1
Client condition warranted hospitalization	262	55.0
I would have sought involuntary action (TDO) if client had refused voluntary services	127	46.5
I was able to address this person's crisis needs with the resources available to me	403	84.7
Total	**476**	**100.0**

►Clinicians determined that in most cases (67.9%, n=323), the client had the capacity to make treatment decisions; conversely, in 153 cases (32.1%), the clinician found that the client did not have capacity to make treatment decisions. See Table 30 and 31.

Table 31. Clinician opinion regarding the client's ability to make treatment decisions at the end of the evaluation [3]

	Frequency	Percent
Client lacked ability to maintain and communicate choice	88	57.5
Client lacked ability to understand relevant information	99	64.7
Client lacked ability to understand consequences	114	74.5
Total: Client lacked the capacity to make treatment decisions	**153**	**100.0**

Figure 25 shows clinician opinion after recoding into four mutually exclusive categories that connects perceived clinical severity of the individual's condition with the commitment criteria:

(1) Any person who was found to be at risk of harm toward self or harm toward others, even if such persons also exhibited an impaired capacity for self-protection or to provide for basic needs was recoded into the "Risk of harm to self or others" category.

[3] Clinicians were instructed to answer these three additional questions only if they found that the client lacked the capacity to make treatment decisions.

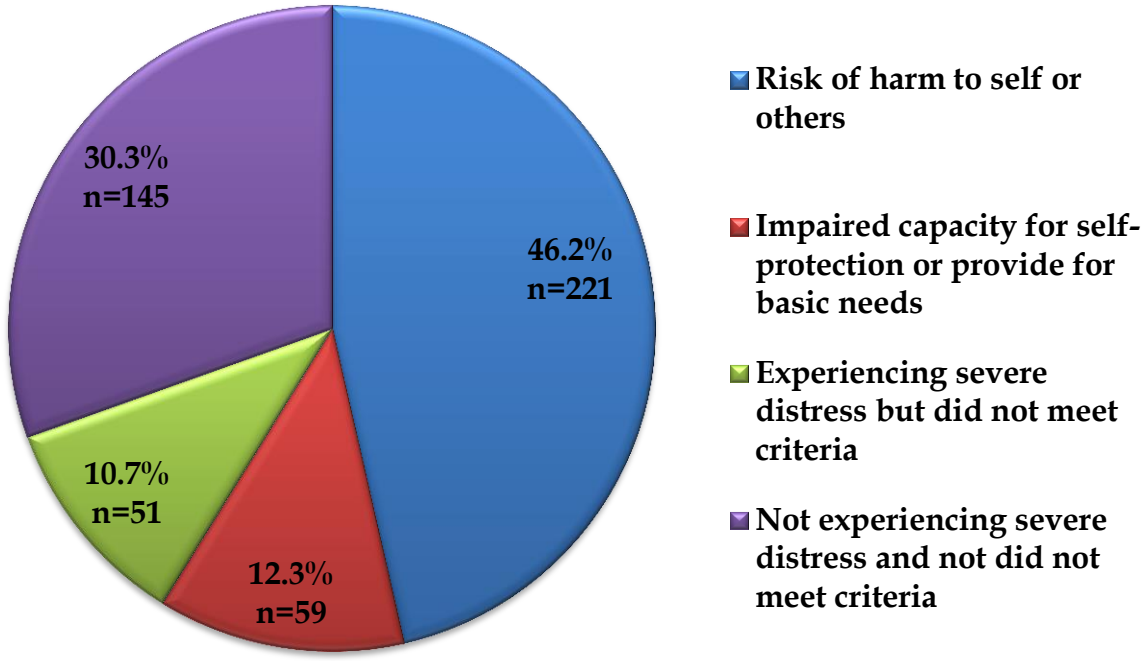
(2) After removing individuals who were determined to be at risk of harm to self or others, the remaining cases were recoded. The category of "Impaired capacity for self-protection or to provide for basic needs" includes individuals who exhibited an inability for self-care as unable to protect themselves from harm, or to provide for basic needs.

(3) Once the individuals above were excluded, cases remained including those who were not assessed by the clinician to meet the commitment criteria (i.e., harm toward self, harm toward others, and impaired capacity for self-protection or to provide for basic needs). These were recoded into two categories:

a. Cases in which individuals were found to be experiencing severe mental or emotional distress or dysfunction but did not meet the commitment criteria ("Experiencing severe distress but did not meet criteria"), or

b. Cases in which individuals were not found to be experiencing severe distress or dysfunction and did not meet the commitment criteria ("Not experiencing severe distress and did not meet criteria").

Figure 25. Clinician opinion at the conclusion of the evaluation (n=476)



Problems in Accessing Services for Veterans

Services/Resources That Would Have Helped Address Veterans' Needs

►In 42.6% (n=203) of cases the clinician needed additional services to address the client's needs better. Immediate psychiatric/medication evaluation was the most common response when clinicians were asked. In most cases, clinicians selected only one service when they could select more than one. See Figure 27 and Table 32.

Figure 26. Services/resources that would have helped the clinician better address the client's needs (n=452)

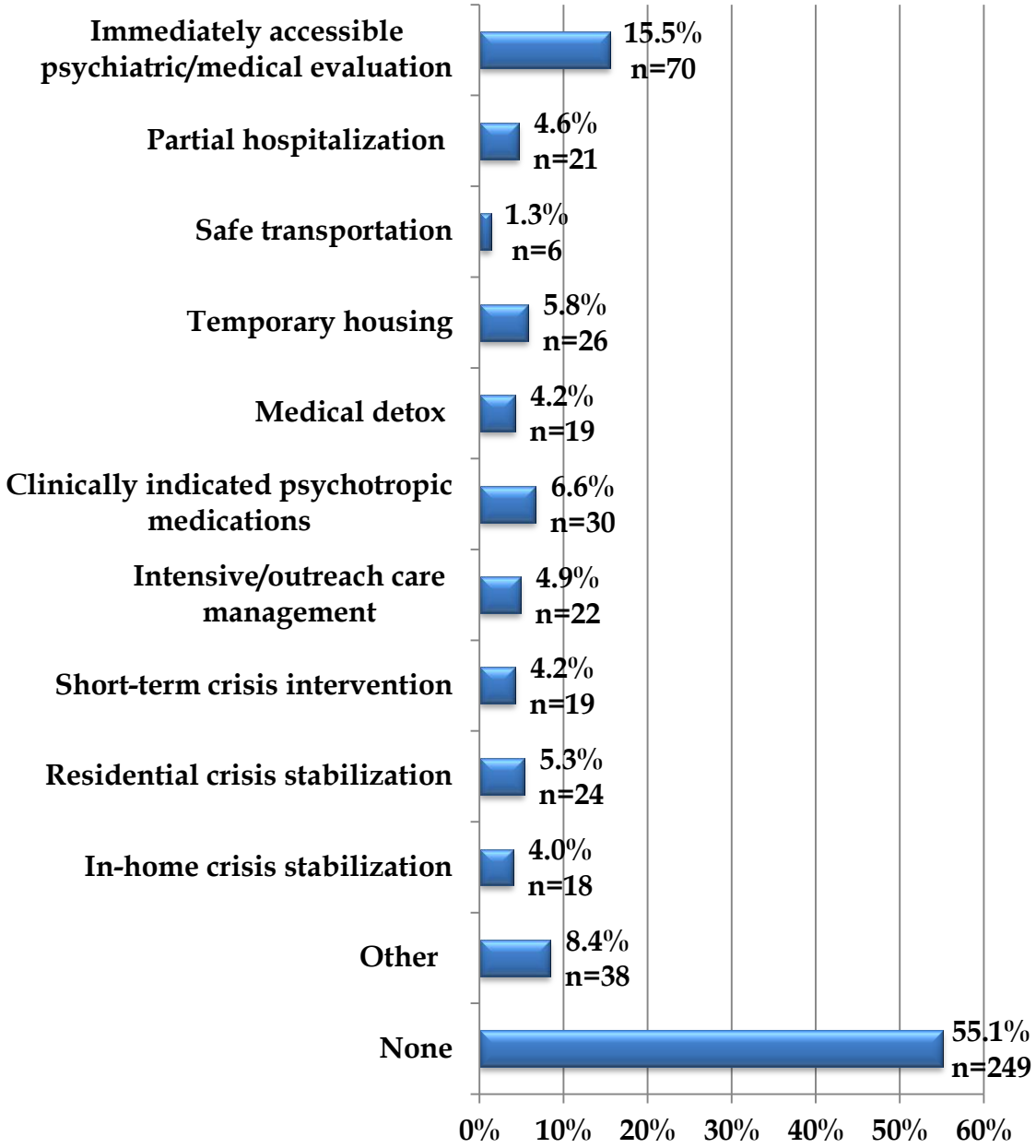


Table 32. Ability to address the veteran's needs with resources available and whether additional services would help the clinicians.

		Able to address the crisis needs with current resources available		Total
		Yes	No	
Additional services would help to address better	Yes	40.9% n=165	52.1% n=38	203
	No	59.1% n=238	47.9% n=35	273
Total		403	73	476

Types of Services/Resources That, if Available, Would Have Allowed the Veteran to Avoid Hospitalization

►Of the cases in which the client was referred for involuntary hospitalization (TDO), the clinician reported that the client would have been able to avoid hospitalization in 25.7% (n=46 of 179) of cases if certain services/resources had been available. Of the cases in which the client was referred for voluntary admission to a hospital (VA), the clinician reported that the client would have been able to avoid hospitalization in 44.8% (n=26 of 58) of cases if certain services/resources had been available. See Figure 27 and Table 33.

Figure 27. Services/resources that, if available, would have allowed the client to avoid hospitalization

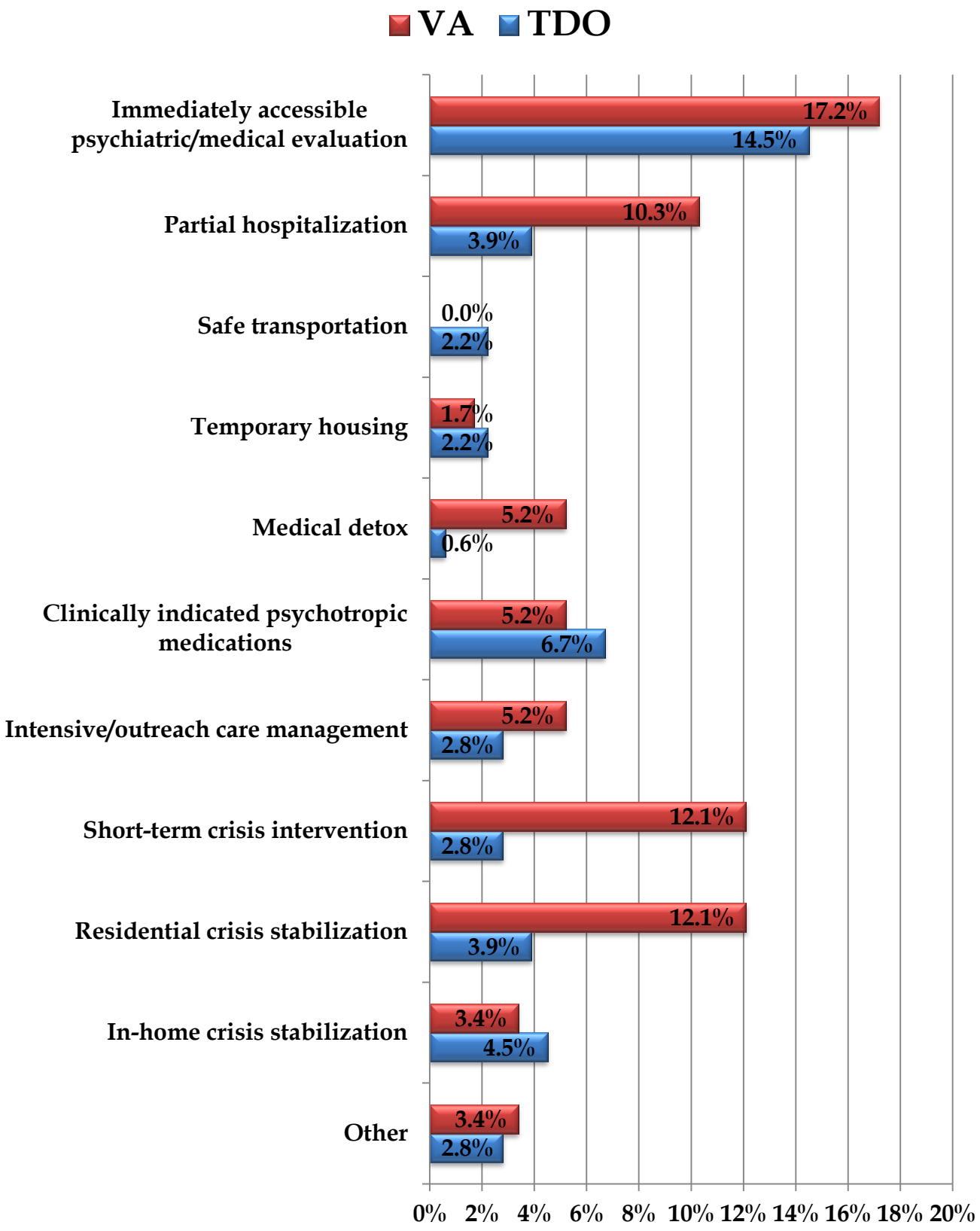


Table 33. Services/resources that, if available, would have allowed the client to avoid hospitalization

	Involuntary admission (TDO)		Voluntary admission		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Immediately accessible psychiatric/medical evaluation	26	14.5	10	17.2	36	15.2
Partial hospitalization	7	3.9	6	10.3	13	5.5
Safe transportation	4	2.2	0	0.0	4	1.7
Temporary housing	4	2.2	1	1.7	5	2.1
Medical detox	1	0.6	3	5.2	4	1.7
Clinically indicated psychotropic medications	12	6.7	3	5.2	15	6.3
Intensive/outreach care management	5	2.8	3	5.2	8	3.4
Short-term crisis intervention	5	2.8	7	12.1	12	5.1
Residential crisis stabilization	7	3.9	7	12.1	14	5.9
In-home crisis stabilization	8	4.5	2	3.4	10	4.2
Other	5	2.8	2	3.4	7	3.0
None	133	74.3	32	55.2	165	69.6
Total	**179**	**100.0**	**58**	**100.0**	**237**	**100.0**

►**In 15.6% (n=37) of cases, the clinician reported that the client would have been able to avoid hospitalization if one specific service/resource had been available.** Two or more services would have helped 14.0% (n=25) of cases referred for involuntary admission avoid hospitalization, compared to 17.2% (n=10) for voluntary admissions**.** See Table 34.

Table 34. Number of services/resources that the clinician reported, if available, would have allowed the client to avoid hospitalization

	Involuntary admission (TDO)		Voluntary admission (VA)		Total
	Frequency	Percent	Frequency	Percent	
None	133	74.3	32	55.2	165
One service	21	11.7	16	27.6	37
Two or more	25	14.0	10	17.2	35
Total	**179**	**100.0**	**58**	**100.0**	**237**

Appendix 1

ADULT Emergency Services (ES) Face-to-Face Crisis Evaluation Questionnaire - Page 1

CSB Code: _____ Staff Initials: _____ Licensed: No ☐ Yes ☐ Degree: _____
# of years experience in BH: _____ # of years experience as an ES clinician: _____

1. **Last 4 digits of case #**: _____ 2. **Advance Directive:** No ☐ Yes ☐
3. **Date of Evaluation (mm/dd/yy):** _____/_____/_____
4. **Evaluation start time:** _____ am/pm, **Evaluation end time:** _____ am/pm
5. **Client age:** _____ 6. **Client sex (M/F):** _____ 7. **Client race:** _____
8. **Hispanic:** No ☐ Yes ☐ 9. **Military status:** Active/reserve ☐ Veteran ☐ None ☐ Unknown ☐

10. **Where did the evaluation take place?**
☐ CSB ☐ Hospital ED
☐ Client's home ☐ Public location
☐ Hospital psyc unit ☐ Jail
☐ Police station ☐ Magistrate's office
☐ Other _____

11. **What is the client's current living arrangement?**
☐ Don't know ☐ Living alone
☐ Living with non-related others ☐ Homeless/recently undomiciled
☐ Living with support (e.g., group home, supervised living) ☐ Living with family
☐ Other _____

12. **Was client in hospital for recommitment hearing?**
☐ No ☐ Yes → If yes, STOP HERE. Turn in form.

AT THE TIME OF EVALUATION:
13. **Client presented with** (Check all that apply):
☐ Mental illness
(Primary diagnosis: _____)
☐ Intellectual/developmental disability
☐ Substance use/abuse disorder
☐ Other ☐ None

14. **Was the client under the influence of drugs or alcohol?**
☐ No ☐ Yes ☐ Suspected ☐ Unknown

15. **Client's current treatment** (Check all that apply):
☐ CSB ☐ Other community agency
☐ DBHDS facility ☐ Private practitioner
☐ Private/community psych facility
☐ Non-psychiatric private/community facility
☐ None ☐ Don't know/not sure
☐ Other _____

16. **Client's insurance status** (Check all that apply):
☐ Medicaid ☐ Private/3rd party
☐ Medicare ☐ Military/Veteran's Benefit
☐ None ☐ Don't know/not sure
☐ Other _____

17. **Was the client showing psychotic symptoms?**
☐ No ☐ Yes

18. **What sources of information were available to you <u>prior</u> to the evaluation? Information from** (Check all that apply):
☐ CSB records ☐ Law enforcement
☐ CSB clinician(s) ☐ Friend/family member(s)
☐ Hospital staff ☐ Hospital records
☐ Other providers ☐ Other clinical records
☐ Other _____ ☐ None

19. **Did the record or client interview reveal recent behavior or symptoms indicating an elevated risk of serious physical <u>harm toward self</u>?**
☐ No ☐ Yes
If yes, what were the behaviors? (Check all that apply)
☐ Ingested pills or poison
☐ Injured self with sharp object
☐ Other self- injurious behavior _____
_____
☐ Threatened to commit suicide
☐ Threatened other serious harm
☐ Voiced suicidal thoughts without threats

☐ Other type of self-endangerment _____
_____

20. **Did the record or client interview reveal recent behavior or symptoms indicating an elevated risk of serious physical <u>harm toward others</u>?**
☐ No ☐ Yes
If yes, what were the behaviors? (Check all that apply)
☐ Injured someone
☐ Hit, kicked, pushed someone without injury
☐ Threatened or endangered someone with a gun, knife, or other weapon
☐ Verbal threat to seriously physically harm someone
☐ Voiced thoughts of harming someone, without threats
☐ Other type of endangerment _____
_____

21. **Did the client own or otherwise have easy access to a firearm?**
☐ No ☐ Yes ☐ Unable to determine

22. **Did the record or client interview reveal recent behavior or symptoms indicating <u>impaired capacity for self-protection or ability to provide for basic needs</u>?**
☐ No ☐ Yes
If yes, what symptoms, deficits, or behaviors were noted? (Check all that apply)
☐ Substantial cognitive impairments (e.g., disorientation, impaired memory)
☐ Hallucinations and/or delusions
☐ Neglect of life-sustaining nutrition
☐ Neglect of medical needs
☐ Neglect of financial needs
☐ Neglect of shelter or self-protection
☐ Generalized decline in functioning
☐ Other _____
_____

23. **Who contacted the CSB for evaluation?**
☐ Law enforcement ☐ Client
☐ Clinician ☐ Friend/family member
☐ Hospital ☐ Don't know/not sure
☐ Other _____

24. **Was the client in police custody at the time the evaluation was initiated?**
☐ No
☐ Yes, with no ECO
☐ Yes, with a magistrate-issued ECO
☐ Yes, with a law enforcement issued (paperless) ECO

25. **If client was in police custody, were restraints used?** ☐ No ☐ Yes

26. **If client was <u>not</u> in police custody at the time of initial contact, did you seek an ECO in order to carry out the evaluation?** ☐ No ☐ Yes

27. **If an ECO was sought, was the ECO obtained?** ☐ No ☐ Yes

28. **If an ECO was issued, did the initial (4-hour) ECO expire?** ☐ No ☐ Yes

29. **If initial ECO expired, did you seek an extension?** ☐ No ☐ Yes

30. **If extension was sought, was the extension granted?** ☐ No ☐ Yes

31. **If extension was granted, was the extension sufficient for:**
CSB evaluation? ☐ No ☐ Yes ☐ N/A
Medical screening? ☐ No ☐ Yes ☐ N/A
For locating a bed? ☐ No ☐ Yes ☐ N/A

ADULT Emergency Services (ES) Face-to-Face Crisis Evaluation Questionnaire - Page 3

Last 4 digits of case #: _____

Please circle the option that most closely reflects ***your opinion*** about the client's condition AT THE CONCLUSION OF THE CRISIS EVALUATION:		No	Yes
32. **Client presented a substantial likelihood of causing serious physical harm to self in the near future:**		1	2
33. **Client presented a substantial likelihood of causing serious physical harm to others in the near future:**		1	2
34. **Client was unable to protect self from harm:**		1	2
35. **Client was unable to provide for basic needs:**		1	2
36. **Client was experiencing severe mental or emotional distress or dysfunction:**		1	2
37. **Client lacked the capacity to make treatment decisions:** ☐ **Client lacked ability to maintain and communicate choice.** ☐ **Client lacked ability to understand relevant information.** ☐ **Client lacked ability to understand consequences.**		1	2
38. **Client's condition warranted hospitalization:**		1	2
39. **I would have sought involuntary action (TDO) if client had refused voluntary services:**	N/A	1	2
40. **I was able to address this person's crisis needs with the resources available to me:**		1	2

41. **Which of the following services, if any, would have helped you address this client's needs better?** (Check all that apply) ☐ None
- ☐ Immediately accessible psychiatric/ medication evaluation
- ☐ Partial hospitalization
- ☐ Safe transportation
- ☐ Temporary housing
- ☐ Medical detox
- ☐ Clinically indicated psychotropic medications
- ☐ Intensive/outreach care management
- ☐ Short-term crisis intervention
- ☐ Residential crisis stabilization
- ☐ In-home crisis stabilization
- ☐ Other _____

42. **If hospitalization was the disposition, which of the following services, if available to you, would have allowed the client to avoid hospitalization?** (Check all that apply) ☐ None
- ☐ Immediately accessible psychiatric/ medication evaluation
- ☐ Partial hospitalization
- ☐ Safe transportation
- ☐ Temporary housing
- ☐ Medical detox
- ☐ Clinically indicated psychotropic medications
- ☐ Intensive/outreach care management
- ☐ Short-term crisis intervention
- ☐ Residential crisis stabilization
- ☐ In-home crisis stabilization
- ☐ Other _____

43. **What was the disposition?** (Choose one)
- ☐ Referred for involuntary admission (TDO)
- ☐ Referred for voluntary admission
- ☐ Referred for crisis intervention
- ☐ Referred for crisis intervention and psychiatric/medication evaluation
- ☐ Referred for other outpatient services
- ☐ No further evaluation or treatment required
- ☐ Client declined referral and no involuntary action taken
- ☐ Other _____ _____

Last 4 digits of case #: _____

44. **If a TDO was sought, was it granted?**
☐ No ☐ Yes
If TDO was granted, was the client admitted?
☐ No ☐ Yes
If the client was admitted, to which of the following facilities:
☐ DBHDS facility
☐ Private/community psych facility/unit
☐ ED or medical unit of private/community hospital
☐ Crisis Stabilization Unit
☐ Other_____

45**. If voluntary admission was sought, was the client admitted?**
☐ No ☐ Yes
If admitted, to which of the following:
☐ DBHDS facility
☐ Crisis Stabilization Unit
☐ Private/community psych facility/unit
☐ Non-psychiatric private/community facility
☐ Medical detox
☐ Other _____

46. **If hospitalization was sought, # of private facilities contacted: _____; # of state (DBHDS) facilities contacted: _____.**

47. **Approximately how much time did you spend locating a psychiatric bed?**
☐ 4 hours or less
☐ More than 4 hours, less than 6 hours
☐ More than 6 hours (# of hours, if known: _____)

48. **Was medical evaluation or treatment required prior to admission?** ☐ No ☐ Yes

49. **Was hospital in client's region?** ☐ No ☐ Yes

50. **If hospitalization was sought but client was <u>not</u> admitted to psychiatric facility, why not? (**check all that apply)
☐ No voluntary bed available
☐ Insurance limitations
☐ No TDO bed available
☐ Client required medical evaluation or treatment
☐ Acuity of client's condition/level of care required
☐ Transportation or logistical problems
☐ Unable to confirm bed availability in requisite time
☐ Other _____
_____

51. **If hospitalization was sought but no bed was available within requisite time, what happened to client?** (Check all that apply)
☐ Client held by police until bed was available
☐ Client held on medical unit until bed was available or until reevaluated
☐ Client held in ED until bed was available or until reevaluated
☐ Client admitted to a CSU
☐ Client released voluntarily with safety plan (other than to a CSU)
☐ Client released and declined service
☐ Client reevaluated during screening process and no longer met criteria for inpatient treatment; client released with safety plan
☐ Other _____
_____

Additional comments or suggestions:
_____
_____
_____
_____
_____
_____
_____
_____