

# A STUDY OF FACE-TO-FACE EMERGENCY EVALUATIONS 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*



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## PREFACE

I have had the pleasure of working with providers and consumers of mental health services, and the leadership of the public agencies charged with overseeing these services and with protecting public health and safety, for almost four decades. That includes five years as Chair of the Commission on Mental Health Law Reform (2006-2011). Over these years, I have been impressed by the strong commitment to evidence-based decisions that characterizes mental health policymaking in the Commonwealth. This study of emergency evaluations conducted by community service boards in April, 2013 reflects that continuing commitment. It also reveals the habits of collaboration and transparency that have marked the path of mental health law reform in Virginia during the 21<sup>st</sup> century.

Funded by the Department of Behavioral Health and Developmental Services under contract with the University of Virginia's Institute of Law, Psychiatry and Public Policy, this study required active and careful participation by hundreds of emergency services staff in all 40 of the Commonwealth's community services agencies. This remarkable level of engagement might well be impossible to achieve anywhere else in this nation. We are grateful to all of our friends on the front lines of crisis response for their public service and for their contribution to this study.

This study replicates and extends a similar study conducted by the Commission on Mental Health Law Reform in June, 2007. The findings from that study were highly influential in informing the work of the Commission and shaping many of the reforms subsequently enacted by the General Assembly. This new study provides an opportunity to compare the findings of the two surveys and to gather first-time data on some important policy-relevant issues, including the prevalence of advance directives among the population of individuals evaluated and the proportion of persons evaluated who lack decisional capacity.

Like the 2007 study, the 2013 survey had three major policy-relevant objectives. One is to identify rates of involuntary action and the relationship between involuntary action and access to intensive services as alternatives to hospitalization. A second is to document the time spent looking for beds, the frequency and length of law enforcement custody, the extension of ECOs, and the frequency with which individuals are released because no suitable hospital bed could be found within the prescribed time. A third is to ascertain the clinical profiles of persons presented for emergency evaluation and the relationship between these factors and the recommended dispositions, including the grounds for initiating involuntary proceedings.

This report is an overview of study findings and is the first of a series of reports. It 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.

Richard J. Bonnie

September, 2013

## EXECUTIVE SUMMARY

During the month of April 2013, CSB clinicians conducted 4,502 face-to-face emergency evaluations of adults and juveniles experiencing mental health crises that could be associated with symptoms of mental illness, intellectual/ developmental disabilities, and/or substance abuse. Of the total, 203 adults and 21 juveniles were evaluated in crisis more than once over the survey month, leading to a figure of 4,278 individuals receiving emergency evaluation services during the month. Of the total evaluations, data from the following groups were excluded from the analyses in this report since separate reports will be available for each group: 5.4% (n=243) of cases involved individuals who were evaluated for recommitments, 1.9% (n=86) involved persons who were either in jail or a juvenile detention center, and 3.3% (n=148) involved persons with intellectual/developmental disabilities. Clinicians from all 40 CSBs in Virginia participated in the survey. Highlights of the statewide information as well as results on adults and juveniles evaluated are presented separately below.

### Overview of All Evaluations

► Almost fifteen percent (14.6%, n=589) of the emergency evaluations involved juveniles (under the age of 18) and 85.4% of cases (n=3,436) involved adults (18 years and older), with less than two percent (1.4%, n=57) of ages unknown.

► Emergency evaluations were conducted on about the same number of males (49.1%, n=1,937) and females (50.9%, n=2,004). Individuals were most often non-Hispanic Caucasians (65.1%, n=2,555), with the next highest race/ethnic group being African American at 25.6% (n=1,005). Other race/ethnic groups included Hispanic/Latino (4.4%, n=172) and Asian and/or Pacific Islander (1.6%, n=61); Native Americans and “Other” groups each comprised less than 1%, and individuals who self-identified as multiracial were 2.3% (n=90) of the total.

► About half of the emergency evaluations conducted during the survey month took place at a hospital emergency department (47.4%, n=1,902). The next most frequent evaluation locations were the CSB (30.3%, n=1,216), the hospital psychiatric unit (8.1%, n=324), the individual’s home (3.0%, n= 120), and the police station (2.3%, n=94). Nine percent (n=356) of cases were reported to be in an “other” location; half of those (n=177) were in a hospital ICU, a hospital medical unit, or another part of a hospital.

► CSB emergency evaluations were most often initiated by hospital staff (41.2%, n=1,547) or law enforcement officers (20.0%, n=753), followed by the individual himself or herself (12.1%, n=456), friend or family members (8.6%, n=323), clinicians (7.7%, n=288), and someone at a school (2.0%, n=75). Emergency evaluations were initiated by a combination of more than one of the above persons in 2.8% (n=104) of cases.

► Individuals were not receiving mental health treatment at the time of the emergency evaluation in 40.7% (n=1,625) of the cases conducted during the survey month. If receiving

treatment, individuals were most likely to be receiving treatment from a CSB only (25.3%, n=1,010), followed by a private practitioner only (15.7%, n=626). In 6.5% (n=259) of cases, the individual was receiving treatment from more than one provider.

► At the time of the emergency evaluation, less than 2% of individuals were in jail (n=86) and excluded from this report. One out of 4 (27.3%) individuals evaluated was in police custody with magistrate-issued ECO (n=331), a law enforcement-issued (paperless) ECO (n=612), or without an ECO (n=154). Conversely, 72.7% (n=2,928) of individuals who received an emergency evaluation during the month were not in police custody at the time of the emergency evaluation.

## Findings Regarding Adult Evaluations

► The average age among adults was 40.6 years and the standard deviation (*sd*) was 15.9, ranging from 18 years old to 95 years old.

► Forty-two percent (42.2%, n=1,438) of adults were not receiving treatment at the time of the emergency evaluation.

► Fewer than four out of 10 adults did not have health insurance at the time of the evaluation (34.9%, n=1,198).

► CSB emergency evaluations were most often initiated by hospital staff (42.9%, n=1,362), followed by law enforcement (20.0%, n=637) and the individual (14.3%, n=453).

► Advance directives were greatly underutilized. Fewer than three out of 100 (2.6%, n=80) individuals evaluated had an advance directive.

► The majority of adults (72.1%, n=2,478) were not in police custody at the time of the evaluation. Less than four percent (3.6%, n=123) of adults were in police custody without an ECO, 9.0% of adults (n=308) were in police custody with magistrate-issued ECO, and 15.3% (n=527) were in police custody with law enforcement-issued (paperless) ECO.

► In nine out of 10 cases (89.0%, n=3,058), the adult presented with symptoms of mental illness. Overall, 23.6% (n=810) of adults presented with mental illness and substance use/abuse disorder, 65.5% (n=2,248) of adults presented with mental illness but no substance use/abuse disorder, and 7.6% (n=261) of adults presented with substance use/abuse disorder but no mental illness.

► At the time of the emergency evaluation, almost one of every five adults (18.2%, n=624) was under the influence of drugs or alcohol, and another 5.2% (n=180) were suspected to be under the influence. One-third of adults (30.9%, n=1,063) exhibited psychotic symptoms at the time of the evaluation.

► At the beginning of the evaluation based on recent behavior or symptoms in the records and the client interview, one out of two (52.7%, n=1,812) adults displayed behaviors or symptoms indicating an elevated risk of serious physical harm toward self, and one out of three (37.3%, n=1,283) exhibited indicators of an elevated risk of impaired capacity for self-protection or to provide for basic needs. One out of five (20.6%, n=707) adults evaluated presented behaviors or symptoms indicative of an elevated risk of serious physical harm toward others. Twenty-four percent (24.6%, n=844) of adults did not show indicators of elevated risk of any of the criteria for civil commitment (i.e., harm toward others, harm toward self, or an impaired capacity for self-protection or to provide for basic needs) at the time of the evaluation.

► Involuntary action was recommended in 40.2% (n=1,370) of adult emergency evaluations. Treatment recommendations included voluntary hospitalizations in 17.7% (n=603) of cases, some type of crisis intervention in 9.8% (n=336) of cases, and other outpatient treatment in 18.8% (n=642) of cases. No further treatment was needed in 4.4% (n=150) of cases. The client declined treatment and no involuntary action was taken in 3.5% (n=119), and other actions were taken in 5.5% (n=198) of cases.

► Among cases in which involuntary action was recommended by the clinician, a TDO was granted and issued 96.5% (n=1,322) of the time, and 95.2% (n=1,304) of persons recommended for a TDO were eventually admitted to a mental health facility.

► In most cases of adult hospitalization (88.2%, n=1,492), whether involuntary or voluntary, a psychiatric bed was located within four hours or less; in 8.4% (n=142) of cases, finding a psychiatric bed took between four and six hours, and in 3.4% (n=58) of cases, it took more than six hours to find a bed. For cases in which the individual was hospitalized, the majority of facilities (85.2%, n=1,490) were located within the same region as the individual's residence; in 259 cases (14.8%), however, the admitting hospital was not in the same region.

► Of the cases in which the client was referred for involuntary hospitalization (TDO), clinicians reported that hospitalization could have been avoided in 25.8% (n=342 of 1,327) of the cases if certain services/resources had been available. Of the cases in which the client was referred for voluntary admission to a hospital (VA), clinicians reported that the client would have been able to avoid hospitalization in 47.9% (n=261 of 545) of cases if certain services/resources had been available.

► Overall, immediately accessible psychiatric/medication evaluation (14.5%, n=271), partial hospitalization (7.3%, n=137), and residential crisis stabilization (7.3%, n=136) were the most frequently endorsed resources or services that clinicians reported would have avoided the need for hospitalization (voluntary or involuntary) of individuals in crisis.

## Findings Regarding Juvenile Evaluations

- ▶ The average age of the juveniles evaluated was 14.0 ( $sd=2.6$ ) years, with ages ranging from 4 years old to 17 years old.
- ▶ One out of three (31.9%,  $n=187$ ) juveniles was not receiving treatment at the time of the emergency evaluation.
- ▶ Only 7.8% ( $n=46$ ) of juveniles had no health insurance coverage at the time of the emergency evaluation.
- ▶ CSB emergency evaluations of juveniles were most often initiated by hospital staff (31.9%,  $n=185$ ) or a friend/family member (20.5%,  $n=119$ ), followed by law enforcement (20.0%,  $n=116$ ), school (12.9%,  $n=75$ ), and more than one source (2.9%,  $n=17$ ).
- ▶ The vast majority of juveniles (76.4%,  $n=450$ ) were not in police custody at the time of the evaluation. Five percent (5.3%,  $n=31$ ) of juveniles were in police custody without an ECO, 3.9% of them ( $n=23$ ) were in police custody with magistrate-issued ECO, and 14.4% ( $n=85$ ) were in police custody with law enforcement-issued (paperless) ECO.
- ▶ About 9 out of 10 juveniles presented with a mental illness at the time of the evaluation. Overall, 83.8% ( $n=492$ ) of juveniles presented with mental illness but no substance use/abuse disorder, 1.2% ( $n=7$ ) of juveniles presented with substance use/abuse disorder but no mental illness, and 8.9% ( $n=52$ ) of the juveniles presented with both mental illness and substance use/abuse disorder.
- ▶ At the beginning of the evaluation based on recent behaviors or symptoms in the records or in the interview, six out of 10 (59.6%,  $n=351$ ) juveniles evaluated presented behaviors or symptoms indicating an elevated risk of danger to self, while one out of four (24.8%,  $n=146$ ) presented behaviors or symptoms indicating an elevated risk of danger to others. One out of five (20.5%,  $n=121$ ) juveniles evaluated presented indicators of an elevated risk of inability to care for self in a developmentally age appropriate manner. In one out of four (26.8%,  $n=158$ ) cases, the clinician reported that the juvenile did not show behavioral indicators bearing on the civil commitment criteria.
- ▶ At the conclusion of the emergency evaluation, the dispositions recommended were referral for voluntary admission (25.9%,  $n=152$ ), referral for involuntary admission (20.1%,  $n=118$ ), referral for crisis intervention (5.6%,  $n=33$ ), referral for crisis intervention and psychiatric/medication (5.5%,  $n=32$ ), and referral for other outpatient treatment (34.3%,  $n=201$ ). In 4.6% ( $n=27$ ) of all cases, no further evaluation or treatment was required, and in 0.9% ( $n=5$ ) of all cases, the individual refused treatment and no involuntary action was taken.
- ▶ In most cases of juvenile hospitalization (90.4%,  $n=216$ ), whether involuntary or voluntary, a psychiatric bed was located within four hours or less; in 9.2% ( $n=22$ ) of cases, finding a psychiatric bed took between four and six hours, and in only one case (0.4%) did finding a bed

take more than six hours. For cases in which the individual was hospitalized, more than half of the facilities (62.9%, n=156) were located within the same region as the individual's residence; in 92 cases (37.1%), however, the admitting hospital was not in the same region.

► Of the cases in which the juvenile was referred for involuntary hospitalization (TDO), the clinician reported that the juvenile would have been able to avoid hospitalization in 35.1% (n=40 of 114) 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 juvenile would have been able to avoid hospitalization in 48.9% (n=69 of 141) of cases if certain services/resources had been available.

► Overall, residential crisis stabilization (19.7% n=51), immediately accessible psychiatric/medication evaluation (16.2%, n=42) and in-home crisis stabilization (13.9%, n=36) were the most frequently endorsed resources or services that clinicians reported would have avoided the need for hospitalization (voluntary or involuntary) of juveniles in crisis.

## Table of Contents

BACKGROUND.....	1
PURPOSE OF THE STUDY .....	2
METHODS .....	2
Study Instruments.....	2
Procedures.....	3
Study Sample.....	3
Data Analysis.....	4
RESULTS .....	4
Overview .....	4
SECTION 1: ADULT EMERGENCY EVALUATIONS .....	5
Number of Adult CSB Emergency Evaluations .....	5
CSB Clinician Characteristics .....	5
Clinician Credentials .....	5
Clinician Number of Years of Experience in Behavioral Health.....	6
Clinician Number of Years of Experience in Emergency Services .....	7
Characteristics of Adults in Crisis .....	8
Demographics.....	8
Living Situation of Adults .....	10
Current Treatment of Adults.....	11
Insurance Status of Adults.....	12
Pathways to CSB Crisis Response System.....	13
Adults in Police Custody at Time of Evaluation .....	13
Contacting the CSB for Adult Emergency Evaluations.....	15
Location of Adult Emergency Evaluations .....	16
Day and Time of the Adult Emergency Evaluations .....	17
Sources of Information Available to Clinician Prior to the Adult Evaluation .....	19
Clinical Presentation of Adults .....	21
Presentation at Time of Adult Emergency Evaluations .....	21
Adults Under the Influence of Substances .....	22
Adults Presenting Psychotic Symptoms.....	23
Displays by Evaluated Adults of Behaviors Bearing on Involuntary Commitment Criteria .....	23
Disposition After Adult Emergency Evaluations.....	29

Type of Action Recommended by the CSB Clinician for Adults .....	29
Outcome When Involuntary Admission Was recommended .....	30
Outcome When Voluntary Admission Was Recommended .....	32
Actions Taken to Identify a Psychiatric Bed for an Adult .....	33
Length of Time Locating a Psychiatric Bed.....	34
Adult's Status at End of Emergency Evaluation Period.....	35
Clinicians' Opinions Regarding the Client's Status at the End of the Evaluation.....	35
Problems in Accessing Services for Adults .....	38
Services/Resources That Would Have Helped Address Adults' Needs .....	38
Types of Services/Resources That, if Available, Would Have Allowed the Adult to Avoid Hospitalization .....	39
SECTION II: JUVENILE EMERGENCY EVALUATIONS.....	42
Number of Juvenile CSB Emergency Evaluations .....	42
CSB Clinician Characteristics .....	42
Clinician Credentials .....	42
Clinician Number of Years of Experience in Behavioral Health.....	43
Clinician Number of Years of Experience in Emergency Services .....	44
Characteristics of Juveniles in Crisis .....	45
Demographics.....	45
Living Situation of Juveniles .....	47
Current Treatment of Juveniles.....	48
Insurance Status of Juveniles.....	49
Pathways to CSB Crisis Response System.....	50
Juveniles in Police Custody at Time of Evaluation .....	50
Contacting the CSB for Juvenile Emergency Evaluations.....	51
Location of Juvenile Emergency Evaluations .....	52
Day and Time of the Juvenile Emergency Evaluations .....	53
Sources of Information Available to Clinician Prior to the Juvenile Evaluation .....	55
Clinical Presentation of Juveniles .....	57
Presentation at Time of Juvenile Emergency Evaluations .....	57
Juveniles Under the Influence of Substances .....	58
Juveniles Presenting Psychotic Symptoms.....	58
Displays by Evaluated Juveniles of Behaviors Bearing on Involuntary Commitment Criteria .....	58
Disposition After Juvenile Emergency Evaluations .....	64

Type of Action Recommended by the CSB Clinician for Juveniles .....	64
Outcome When Involuntary Action Was Recommended .....	65
Outcome When Voluntary Admission Was Recommended .....	66
Actions Taken to Identify a Psychiatric Bed for a Juvenile.....	67
Length of Time Locating a Psychiatric Bed.....	68
Juvenile’s Status at End of Emergency Evaluation Period .....	70
Clinician Opinions Regarding the Juvenile’s Status at the End of the Evaluation.....	70
Problems in Accessing Services for Juveniles .....	72
Services/Resources That Would Have Helped Address Juveniles’ Needs .....	72
Types of Services/Resources That, if Available, Clinicians Reported Would Have Allowed the Juvenile to Avoid Hospitalization .....	74
Other Results From the CSB 2013 Statewide Study .....	76
Appendix 1.....	77
Overview of the Mental Health System in Virginia.....	77
Virginia Department of Behavioral Health and Developmental Services (DBHDS) .....	77
Community Services Boards and Behavioral Health Authorities in Virginia .....	77
Virginia Association of Community Service Boards (VACSB) .....	77
Three Phases of Emergency Evaluation.....	78
Pathways to the CSB Emergency Response System .....	78
The Emergency Evaluation.....	79
Disposition and Recommendation by the CSB Clinician.....	80
Appendix 2.....	81
ADULT Emergency Services (ES) Face-to-Face Crisis Evaluation Questionnaire .....	81
JUVENILE Emergency Services (ES) Face-to-Face Crisis Evaluation Questionnaire .....	85
Appendix 3.....	89
Localities Served by Community Services Boards.....	89
Appendix 4.....	92
Percentile Ranking of Community Services Boards .....	92
Appendix 5.....	93
Number of Clinicians Participating by CSB for Adults and Juveniles.....	93
Appendix 6.....	94
Flow chart of cases where involuntary admission was recommended for adults .....	94
Flow chart of cases where voluntary admission was recommended for adults.....	94
Flow chart of cases where involuntary admission was recommended for juveniles .....	95
Flow chart of cases where voluntary admission was recommended for juveniles.....	96

## List of Figures

Figure 1. Number of emergency evaluations conducted during the survey month, by CSB location. ....	4
Figure 2. Degrees of clinicians who evaluated adults .....	6
Figure 3. Clinician number of years of experience in Behavioral Health.....	7
Figure 4. Clinician number of years of experience as Emergency Services Clinician .....	8
Figure 5. Distribution of age among adults evaluated during the survey month .....	9
Figure 6. Race/ethnic distribution of adults .....	10
Figure 7. Living situation of adults .....	11
Figure 8. Sources of current treatment of adults .....	12
Figure 9. Insurance status of adults.....	13
Figure 10. Adults in police custody at time of evaluation .....	14
Figure 11. Contacting CSB for emergency evaluations.....	15
Figure 12. Day of the week the emergency evaluations occurred .....	17
Figure 13. Time of day the emergency evaluation occurred .....	18
Figure 14. Length of emergency evaluation.....	18
Figure 15. Sources of information that the clinician had prior to the adult evaluation .....	20
Figure 16. Adult presentation at the time of the evaluation.....	22
Figure 17. Displays by evaluated adults of behaviors bearing on involuntary commitment criteria .....	24
Figure 18. Displays by evaluated adults of behaviors bearing on involuntary commitment criteria, combinations .....	25
Figure 19. Behaviors indicating an elevated risk of serious physical harm toward self .....	26
Figure 20. Behaviors indicating an elevated risk of serious physical harm toward others .....	27
Figure 21. Behaviors/symptoms indicating an impaired capacity for self-protection or ability to provide for basic needs.....	28
Figure 22. Clinician recommended dispositions .....	29
Figure 23. Facilities where adults were admitted after a TDO was granted .....	31
Figure 24. Facilities where adults were admitted after a voluntary admission.....	32
Figure 25. Time spent locating an admitting hospital with an available psychiatric bed .....	34
Figure 26. Clinician opinion at the conclusion of the evaluation (n=3,414) .....	37
Figure 27. Services/resources that would have helped the clinician better address the client's needs (n=1,416) .....	38
Figure 28. Services/resources that, if available, would have allowed the client to avoid hospitalization .....	40
Figure 29. Degrees of clinicians who evaluated juveniles.....	42
Figure 30. Clinician number of years of experience in Behavioral Health .....	43
Figure 31. Clinician number of years of experience as Emergency Services Clinician .....	44
Figure 32. Distribution of age among juveniles evaluated during the survey month .....	45
Figure 33. Race/ethnic distribution of juveniles .....	46
Figure 34. Living situation of juveniles .....	47
Figure 35. Sources of current treatment of juveniles .....	48
Figure 36. Insurance status of juveniles .....	49
Figure 37. Juveniles in police custody at the time of evaluation .....	50

Figure 38. Contacting CSB for emergency evaluations.....	52
Figure 39. Day of the week the emergency evaluations occurred .....	53
Figure 40. Time of day the emergency evaluation occurred .....	54
Figure 41. Length of emergency evaluation.....	55
Figure 42. Sources of information that the clinician had prior to the juvenile evaluation .....	56
Figure 43. Juvenile's presentation at time of evaluation.....	57
Figure 44. Displays by evaluated juveniles of behaviors bearing on involuntary commitment criteria .....	59
Figure 45. Displays by evaluated juveniles of behaviors bearing on involuntary commitment criteria, combinations .....	60
Figure 46. Behaviors indicating an elevated risk of danger to self .....	61
Figure 47. Behaviors indicating an elevated risk of danger to others .....	62
Figure 48. Behaviors/symptoms indicating an inability to care for self .....	63
Figure 49. Clinician recommended dispositions .....	64
Figure 50. Facilities where juveniles were admitted after a TDO was granted (n=114).....	66
Figure 51. Facilities where juveniles were admitted after a voluntary admission.....	67
Figure 52. Time spent locating an admitting hospital with an available psychiatric bed .....	69
Figure 53. Clinician opinion at the conclusion of the evaluation (n=587) .....	72
Figure 54. Services/resources that would have helped the clinician better address the client's needs (n=273).....	73
Figure 55. Services that, if available, would have allowed juvenile to avoid hospitalization ...	74

## List of Tables

Table 1. Degrees of clinicians who evaluated adults .....	6
Table 2. Clinician number of years of experience in Behavioral Health .....	7
Table 3. Clinician number of years of experience as Emergency Services Clinician.....	8
Table 4. Frequency of age of adults evaluated by category .....	9
Table 5. Race/ethnic distribution of adults .....	10
Table 6. Living situation of adults.....	11
Table 7. Sources of current treatment of adults.....	12
Table 8. Insurance status of adults .....	13
Table 9. Client status at the time of the evaluation.....	14
Table 10. Was the ECO extension sufficient? .....	15
Table 11. Contacting CSB for emergency evaluations .....	16
Table 12. Location of the emergency evaluation .....	16
Table 13. Day of the week the emergency evaluations occurred.....	17
Table 14. Length of emergency evaluations.....	19
Table 15. Sources of information that the clinician had prior to the adult evaluation .....	21
Table 16. Adult presentation at the time of the evaluation .....	22
Table 17. Adults presenting under the influence or suspected of being under the influence ...	23
Table 18. Adults presenting psychotic symptoms.....	23
Table 19. Displays by evaluated adults of behaviors bearing on involuntary commitment criteria .....	24
Table 20. Displays by evaluated adults of behaviors bearing on involuntary commitment criteria, combinations .....	25
Table 21. Behaviors indicating an elevated risk of serious physical harm toward self.....	26
Table 22. Behaviors indicating an elevated risk of serious physical harm toward others.....	27
Table 23. Behaviors/symptoms indicating an impaired capacity for self-protection or ability to provide for basic needs .....	28
Table 24. Clinician recommended dispositions.....	30
Table 25. Facilities where adults were admitted after a TDO was granted.....	31
Table 26. Facilities where adults were admitted after a voluntary admission .....	33
Table 27. Number of private facilities contacted for TDO and voluntary admissions.....	33
Table 28. Number of state facilities contacted for TDO and voluntary admissions.....	34
Table 29. Time needed to locate a bed .....	35
Table 30. Clinician opinion regarding the client's status at the end of the evaluation.....	36
Table 31. Clinician opinion regarding the client's ability to make treatment decisions at the end of the evaluation .....	36
Table 32. Ability to address the adult needs with resources available or additional services would help the clinicians. ....	39
Table 33. Services/resources that, if available, would have allowed the client to avoid hospitalization .....	41
Table 34. Number of services/resources that the clinician reported, if available, would have allowed the client to avoid hospitalization .....	41
Table 35. Degrees of clinicians who evaluated juveniles .....	43
Table 36. Clinician number of years of experience in Behavioral Health.....	44

Table 37. Clinician number of years of experience as Emergency Services Clinician .....	45
Table 38. Frequency of age of juveniles evaluated by category.....	46
Table 39. Race/ethnic distribution of juveniles.....	47
Table 40. Living situation of juveniles .....	48
Table 41. Sources of current treatment of juveniles .....	49
Table 42. Insurance status of juveniles .....	50
Table 43 . Juvenile status at the time of the evaluation.....	51
Table 44. Was the ECO extension sufficient? .....	51
Table 45. Contacting CSB for emergency evaluations .....	52
Table 46. Location of the emergency evaluation .....	53
Table 47. Day of the week the emergency evaluations occurred.....	54
Table 48. Length of juvenile emergency evaluation .....	55
Table 49. Sources of information that the clinician had prior to the juvenile evaluation.....	56
Table 50. Juvenile's presentation at the time of the evaluation .....	57
Table 51. Juveniles presenting under the influence or suspected of being under the influence	58
Table 52. Juveniles Presenting Psychotic Symptoms.....	58
Table 53. Displays by evaluated juveniles of behaviors bearing on involuntary commitment criteria .....	59
Table 54. Displays by evaluated juveniles of behaviors bearing on involuntary commitment criteria, combinations .....	60
Table 55. Behaviors indicating an elevated risk of danger to self.....	61
Table 56. Behaviors indicating an elevated risk of danger to others .....	62
Table 57. Behaviors/symptoms indicating an inability to care for self .....	63
Table 58. Clinician recommended dispositions.....	65
Table 59. Facilities where adults were admitted after a voluntary admission .....	67
Table 60. Number of private facilities contacted for TDO and voluntary admissions.....	68
Table 61. Number of state facilities contacted for TDO and voluntary admissions.....	68
Table 62. Time needed to locate a bed .....	69
Table 63. Clinician opinion regarding the juvenile's status at the end of the evaluation.....	70
Table 64. Clinician opinion regarding the juvenile's ability to make treatment decisions at the end of the evaluation.....	71
Table 65. Ability to address the adult needs with resources available or additional services would help the clinicians.....	73
Table 66. Services/resources that, if available, would have allowed the client to avoid hospitalization .....	75
Table 67. Number of services/resources that the clinician reported, if available, would have allowed the juvenile to avoid hospitalization .....	75

## List of Symbols, Acronyms, and Abbreviations

%	Percent
AMA	Against Medical Advice
BHA	Behavioral Health Authority
Commission	Commonwealth of Virginia Commission on Mental Health Law Reform
CSB	Community Services Board
CSU	Crisis Stabilization Unit
DBHDS	Department of Behavioral Health and Developmental Services
DMC	Data Management Committee
ECO	Emergency Custody Orders
ED	Emergency Department
ES	Emergency Services
FY	Fiscal Year
ICU	Intensive Care Unit
IRB	Institutional Review Board
K <sup>+</sup>	Potassium
N/A	did not apply
MA	Master of Art
MS	Master of Science
MSW	Master of Social Work
MU	Medical Unit
n	Frequency or sample meeting characteristics
SBS	Social and Behavioral Sciences
<i>sd</i>	Standard deviation
TDO	Temporary Detention Order or involuntary hospitalization
VA	Voluntary admission to a hospital
VACSB	Virginia Association of Community Services Boards

## BACKGROUND

Under the oversight of the Department of Behavioral Health and Developmental Services (DBHDS), Virginia's public system of mental health, intellectual/developmental disability, and substance abuse services for the Commonwealth of Virginia ([www.dbhds.virginia.gov](http://www.dbhds.virginia.gov)) includes 16 state-operated facilities, 39 Community Services Boards (CSBs), and 1 Behavioral Health Authority (BHA). These 40 CSBs and BHA are all locally operated<sup>1</sup>. The Virginia Association of Community Services Boards (VACSB; [www.vacsb.org](http://www.vacsb.org)) is a membership organization consisting of the 40 CSBs. The VACSB represents the 40 agencies in matters of state and national policy, as well as funding issues. See Appendix 1 for more information regarding Virginia's mental health system, including information about DBHDS and VACSB.

In 2006, the Commonwealth of Virginia Commission on Mental Health Law Reform ("Commission") was appointed by the Chief Justice of the Supreme Court of Virginia and tasked to "...conduct a comprehensive examination of Virginia's mental health laws and services and to study ways to use the law more effectively to serve the needs of people with mental illness, while respecting the interests of their families and communities, ...[and]...making the process of involuntary treatment more fair and effective..."<sup>2</sup> One of the major priorities for the Commission was to develop data systems needed for proper monitoring and informed policy-making related to the commitment process. Annual statistical reports were published by the Commission through fiscal year 2011 (FY 2011). Upon expiration of the Commission in 2011, this responsibility was assumed by the Institute of Law, Psychiatry, & Public Policy of the University of Virginia under a contract with the DBHDS.<sup>3</sup>

In 2007, with support from the Commission, DBHDS, VACSB and other stakeholders collaborated with University of Virginia researchers to facilitate a statewide survey of all face-to-face emergency evaluations conducted by the 40 CSBs in accordance with the Commission's goals. The results of the study were disseminated in a report in 2008<sup>2</sup>. In 2012, the need for replicating and expanding the 2007 study was recognized. A collaborative effort among the leadership of DBHDS, VACSB, and University of Virginia researchers resulted in the successful completion of the DBHDS-funded *Study of Face-to-Face Emergency Evaluations Conducted by Community Service Boards in April, 2013*.

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<sup>1</sup> Throughout this report, the term "CSB" will be used to describe all 40 agencies, including the 39 CSBs and the one BHA.

<sup>2</sup> *Study of Emergency Evaluations Conducted by Emergency Services Personnel in Community Service Boards, June 2007: A Report to the Commission on Mental Health Law Reform*, November 2008, pg.2.

<sup>3</sup> *University of Virginia Institute of Law, Psychiatry and Public Policy, Annual Statistical Report Operation of the Civil Commitment Process in FY 2012*, October, 2012.

## PURPOSE OF THE STUDY

When a person experiences a mental health or substance abuse crisis, he or she may be referred to a CSB for an evaluation from a CSB clinician for an “emergency evaluation” or “assessment.” Although private clinicians and hospital emergency departments also conduct emergency assessments, a CSB evaluation is a necessary step in the Commonwealth’s legal procedure for authorizing involuntary mental health treatment.

The specific aims of this study include: a) documentation of the numbers and characteristics of people needing outpatient, inpatient, voluntary, or court-ordered mental health services, b) determination of the types of services needed and recommended, c) an estimate of gaps in service availability and/or service delivery to meet the needs of individuals evaluated, d) an examination of the use of Emergency Custody Orders (ECO) and Temporary Detention Orders (TDOs) and the outcomes and problems associated with their use.

## METHODS

The study was reviewed by the IRB for Social and Behavioral Sciences at the University of Virginia and approved, SBS Protocol #213-0166, March 2012.

### Study Instruments

A Steering Committee was formed in October 2012 to provide guidance on the work plan and scheduling of the survey. In addition, members of the committee participated in an in-depth review and revision of the two-page instrument used in the 2007 study. Questionnaire items were included on the pathways into the emergency response system (e.g. referral sources), information on the evaluation itself (e.g. length of time), outcome of the evaluation as recommended by the CSB clinician (i.e. “disposition), and gaps in service capacity. As a result, separate data collection instruments were developed for adults and juvenile evaluations, the “ADULT Emergency Services (ES) Face-to-Face Crisis Evaluation Questionnaire” and the “JUVENILE Emergency Services (ES) Face-to-Face Crisis Evaluation Questionnaire” (See Appendix 2). The instruments were field tested at one CSB as acceptable. The questionnaires were submitted to the Data Management Committee (DMC), which is a subcommittee of the Technical Administration Committee that serves “as liaison with DBHDS on data collection and report issues.” Official approval on the instruments was received on March 11, 2013.

## Procedures

A series of statewide training conferences were held with groups of CSB emergency services clinicians by region to review the instruments and the written instruction clarification sheet. For example, the optional response on the questionnaire for “Referred for voluntary admission” was noted to refer only to voluntary hospitalization and not voluntary referral and admission to outpatient services. Trainings were necessary to ensure understanding of each item and provided all clinicians with a venue to question and obtain answers on the process and rationale.

The survey began on April 1, 2013 after midnight of March 31, 2013 and ended on April 30, 2013 at midnight. Study information was gathered using the two questionnaires. CSB emergency service clinicians had the option of providing blind-coded information on each crisis evaluation using either a web-based survey software system, Survey Monkey, which was coded by a Consultant with expertise with the software. The same items contained on the hardcopy questionnaires were programmed into the web-based system. Data entered into Survey Monkey went to a secure server and data were downloaded into Excel and SPSS software at regular intervals throughout the survey month. Optional hard-copy questionnaires were provided to those CSBs selecting not to use the on-line system. Completed questionnaires were returned to the Study Project Coordinator at various intervals.

Data management, data entry, error checking, data cleaning, recoding variables continued from the first week of receiving survey data until July 2013. Data analyses continued thereafter until the reports were completed.

## Study Sample

CSB clinicians submitted blind-coded questionnaires on 4,502 face-to-face emergency evaluations of adults and juveniles experiencing mental health crises that could be associated with symptoms of mental illness, intellectual/ developmental disabilities, and/or substance abuse. Of the total, the following cases were excluded from the analysis in the present report: cases involving persons who were being evaluated for recommitments (5.4%, n=243), cases involving persons who were either in jail or a juvenile detention center (1.9%, n=86), and cases involving persons with intellectual/developmental disabilities (3.3%, n=148). These excluded cases were analyzed with results presented in separate reports. After these cases were excluded, the 2013 CSB survey sample analyzed in this document is 4,025 adults and juveniles. Please note that throughout the report, the total number of cases may not equal 100% due to missing data on that particular item (e.g., the survey ended before the final information was available to the clinician for reporting), due to the fact that the question did not apply (N/A), due to rounding percentages (e.g., 22.155=22.2%), or due to errors in reporting (e.g., skipping an item on the hardcopy version of the instrument).

## Data Analysis

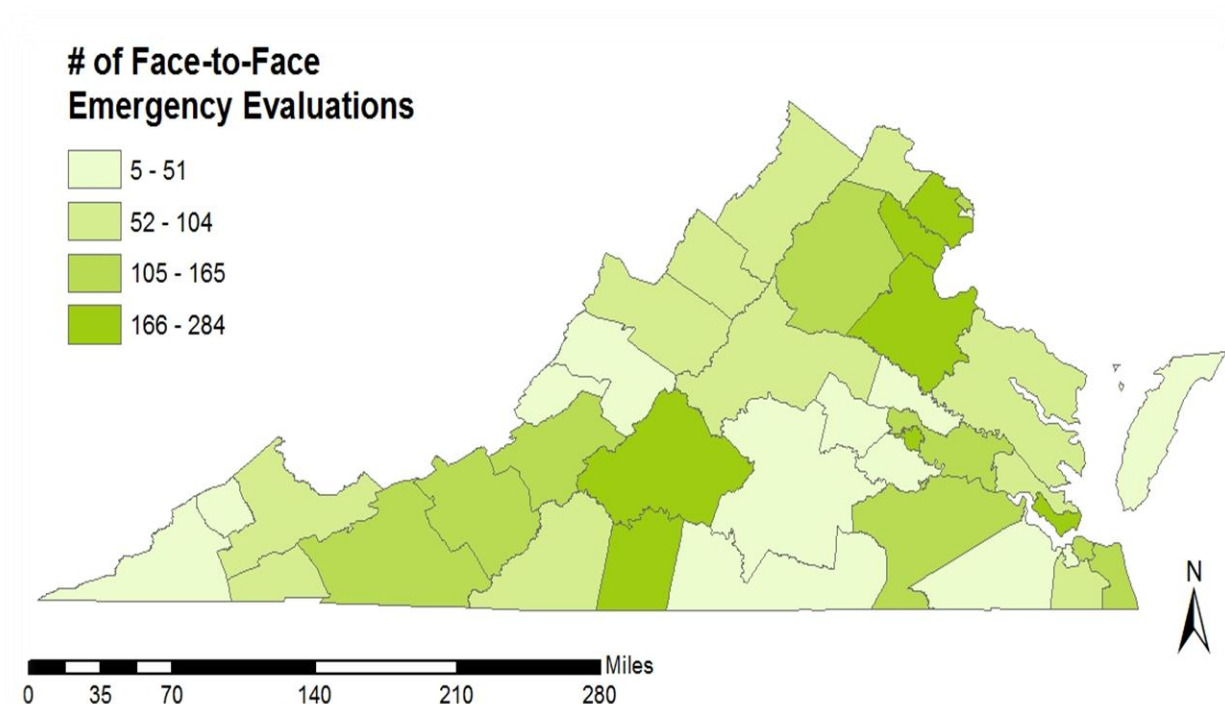
Descriptive analyses such as frequencies and proportions were reported for all variables and graphically displayed. SPSS Version 20 was used in the analyses. ArcGIS and Excel were used for presentation of figures.

## RESULTS

### Overview

As expected based on the distribution of population in Virginia, there was wide variation in the numbers of emergency evaluations among the respective CSBs. Appendix 3 and 4 list the localities served by each CSB and a division of CSBs into quartiles dependent upon the number of emergency evaluations reported during the survey month are shown. Numbers of evaluations during the survey month at individual CSBs ranged from 5 to 284 evaluations. Figure 1 illustrates.

**Figure 1. Number of emergency evaluations conducted during the survey month, by CSB location.**



## SECTION 1: ADULT EMERGENCY EVALUATIONS

### Number of Adult CSB Emergency Evaluations

CSB clinicians documented 3,206 adults who needed an emergency evaluation during the month of April 2013. Of this total, 230 individuals were evaluated more than once over the course of the month, resulting in 3,436 face-to-face emergency evaluations for mental health or substance abuse crises.

Please note that sample size may slightly vary from question to question, even when intending to use the same denominator, because of missing data as described on the study sample section. 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.

### CSB Clinician Characteristics

Across all 40 CSBs, 570 clinicians submitted blind-coded questionnaire data on face-to-face emergency evaluations. A small number of clinicians evaluated adults from two CSBs. Among all evaluators, 4 out of 10 (43.5%, n=246) were licensed. The number of clinicians conducting emergency evaluations (i.e., evaluators) during the survey month at each CSB ranged from 1 to 39, with a mode of 11 and median equal 13. The number of evaluators by CSB is described in Appendix 5 of this document.

### *Clinician Credentials*

► About nine out of 10 (87.7%, n=490) 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 2 and Table 1.

Figure 2. Degrees of clinicians who evaluated adults

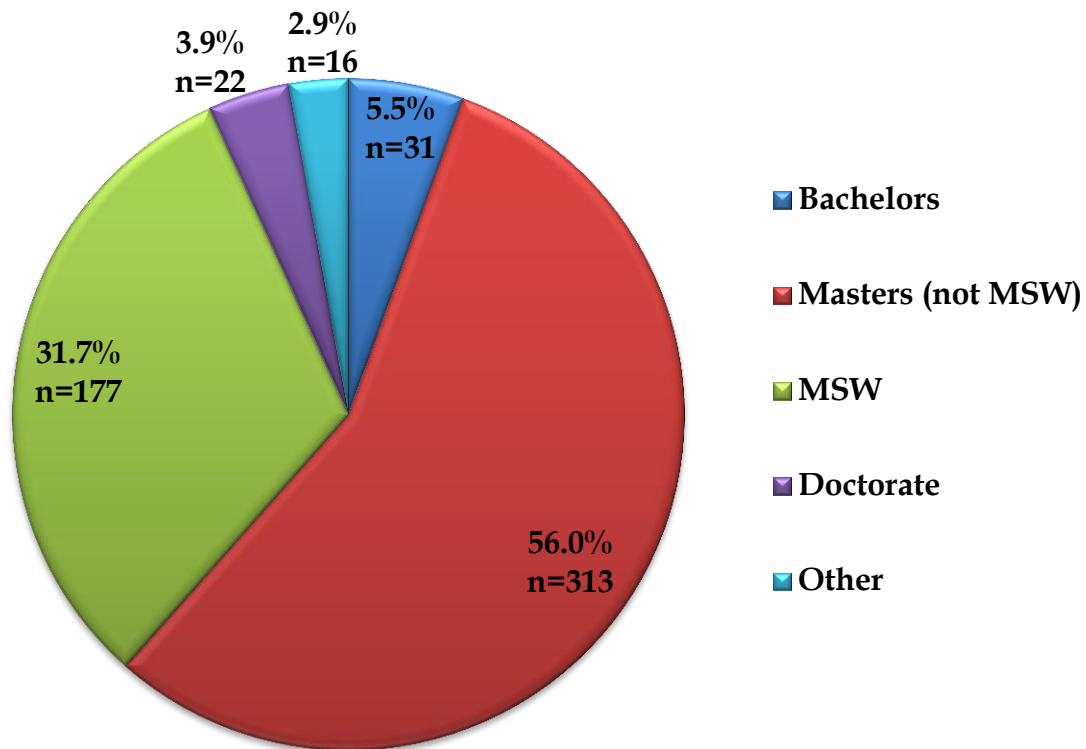


Table 1. Degrees of clinicians who evaluated adults

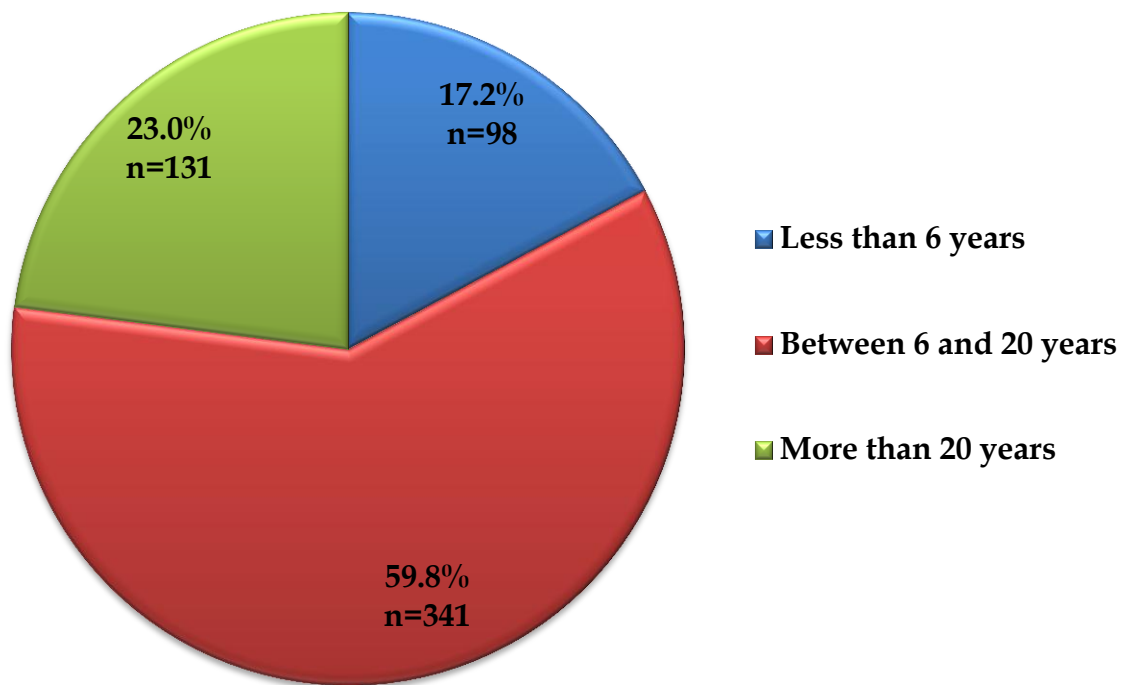
	Frequency	Percent
RN	11	2.0
Bachelors	31	5.5
Masters (not MSW)	313	56.0
MSW	177	31.7
Doctorate	22	3.9
Other	5	0.9
Total	559	100.0

#### *Clinician Number of Years of Experience in Behavioral Health<sup>4</sup>*

► The average number of years of field experience for the clinicians was 14.4 ( $sd=8.8$ ), ranging from no experience ( $n=6$ ) to 40 years ( $n=3$ ). See Figure 3 and Table 2.

<sup>4</sup> In the 2007 CSB report, the term “mental health” was used instead of “behavioral health”.

**Figure 3. Clinician number of years of experience in Behavioral Health**



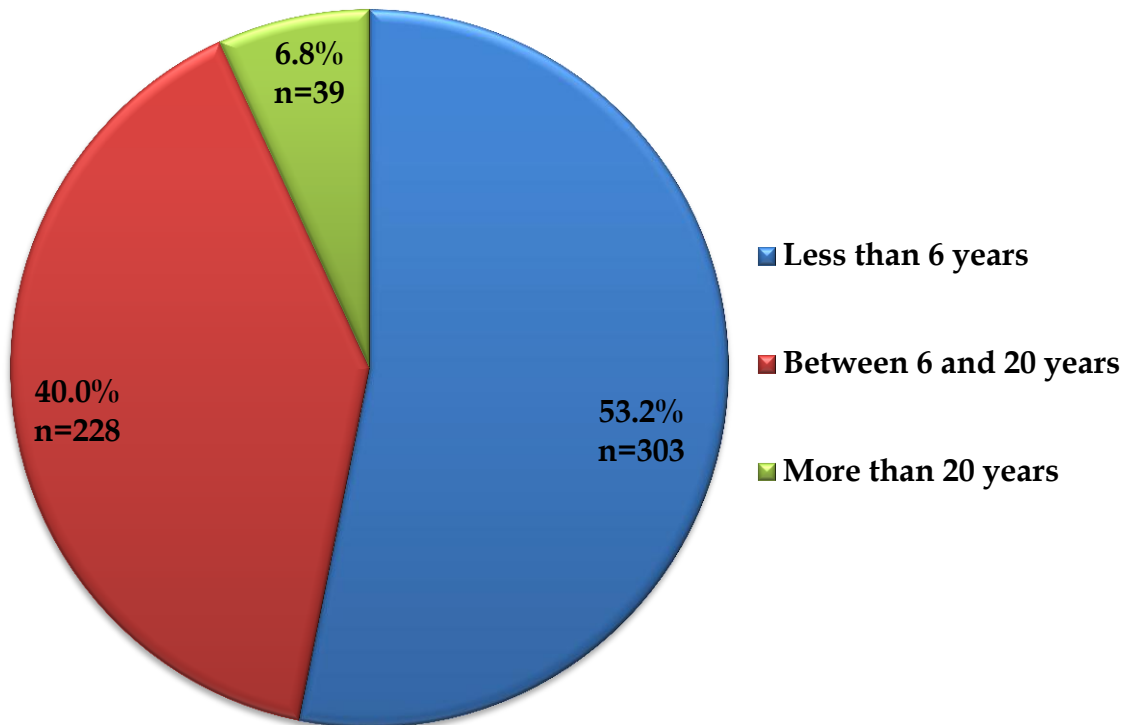
**Table 2. Clinician number of years of experience in Behavioral Health**

	Frequency	Percent
Less than 6 years	98	17.2
Between 6 and 10 years	135	23.7
Between 11 and 15 years	118	20.7
Between 16 and 20 years	88	15.4
Between 21 and 25 years	63	11.1
More than 25 years	68	11.9
Total	570	100.0

#### *Clinician Number of Years of Experience in Emergency Services*

► The average number of years of experience as an Emergency Services Clinician was 7.7 ( $sd=7.3$ ), ranging from no experience ( $n=23$ ) to 33 years ( $n=1$ ). See Figure 4 and Table 3.

**Figure 4. Clinician number of years of experience as Emergency Services Clinician**



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

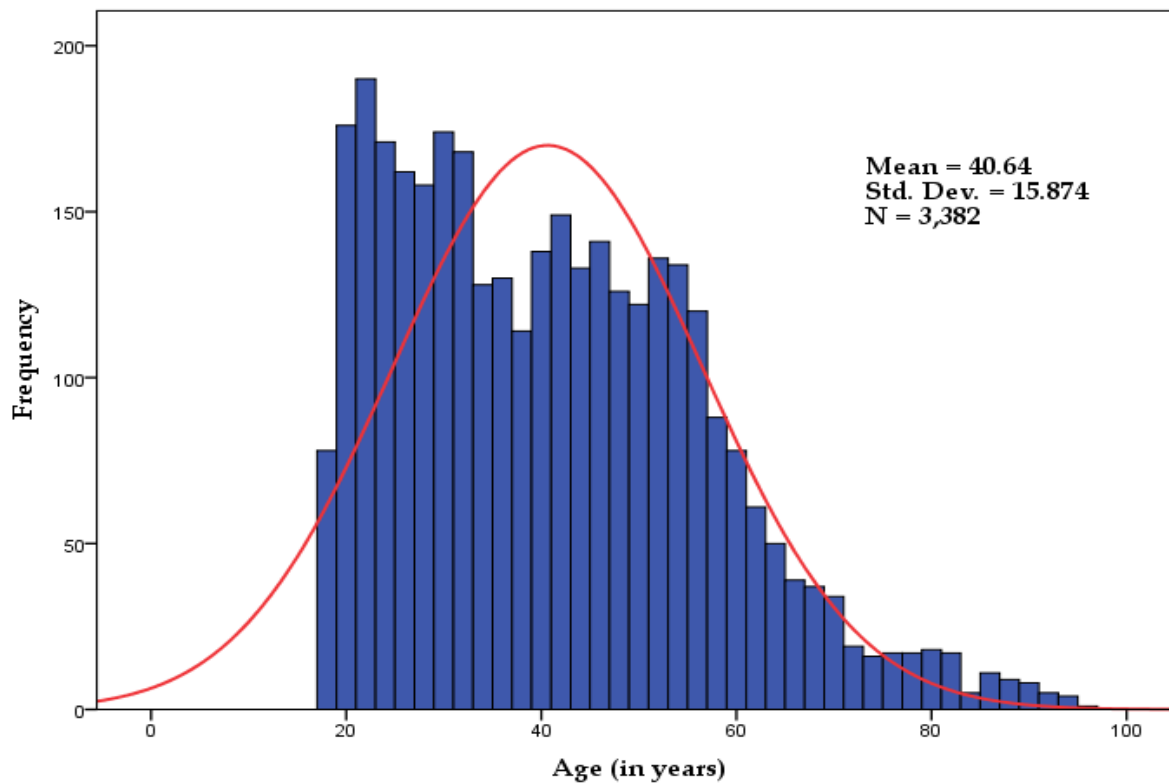
	Frequency	Percent
Less than 1 year	53	9.3
Between 1 and 5 years	250	43.9
Between 6 and 10 years	131	23.0
Between 11 and 15 years	50	8.8
Between 16 and 20 years	47	8.2
Between 21 and 25 years	21	3.7
More than 25 years	18	3.2
Total	570	100.0

## Characteristics of Adults in Crisis

### Demographics

► The average age of the adults evaluated was 40.6 years old ( $sd=15.9$  years). Ages ranged from 18 years ( $n=78$ ) to 95 years ( $n=1$ ). See Figure 5 and Table 4.

**Figure 5. Distribution of age among adults evaluated during the survey month**



**Table 4. Frequency of age of adults evaluated by category**

	Frequency	Percent
Between 18 and 29 years	1,022	30.2
Between 30 and 49 years	1,379	40.8
Between 50 and 64 years	724	21.4
65 years and over	257	7.6
<b>Total</b>	<b>3,382</b>	<b>100.0</b>

► About half (50.1%, n=1,683) of the adults evaluated were female and half (49.9%, n=1,674) were male.

► Two-thirds (66.8%, n=2,234) of the adults evaluated were Caucasian, and one-fourth (25.6%, n=857) were African American. See Figure 6 and Table 5.

Figure 6. Race/ethnic distribution of adults

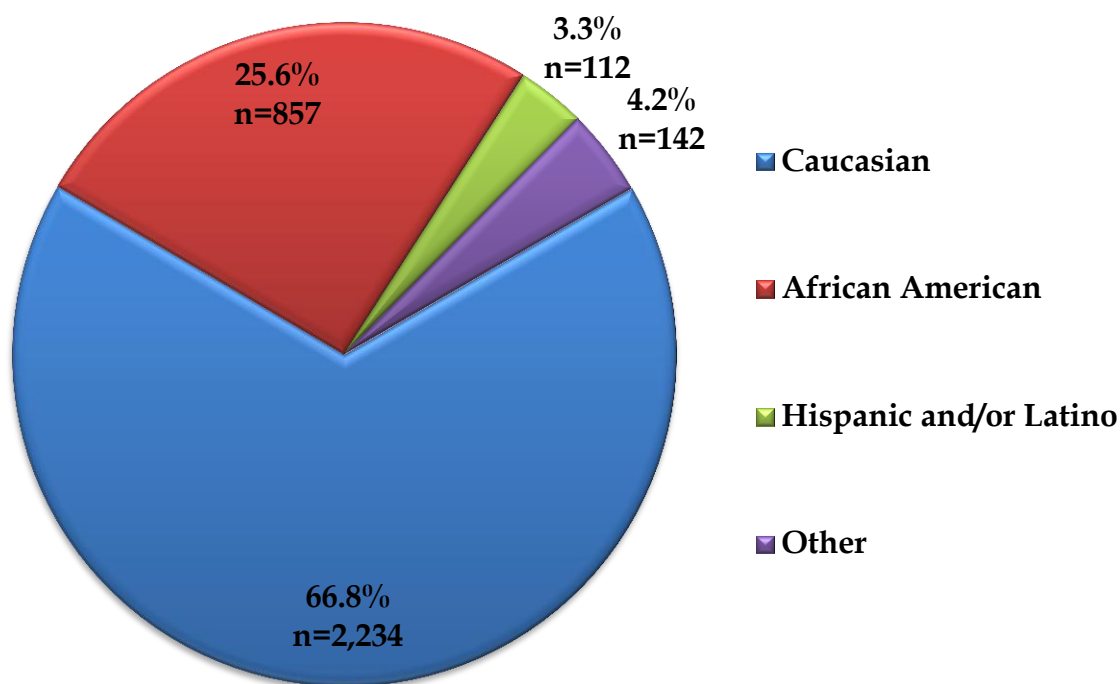


Table 5. Race/ethnic distribution of adults

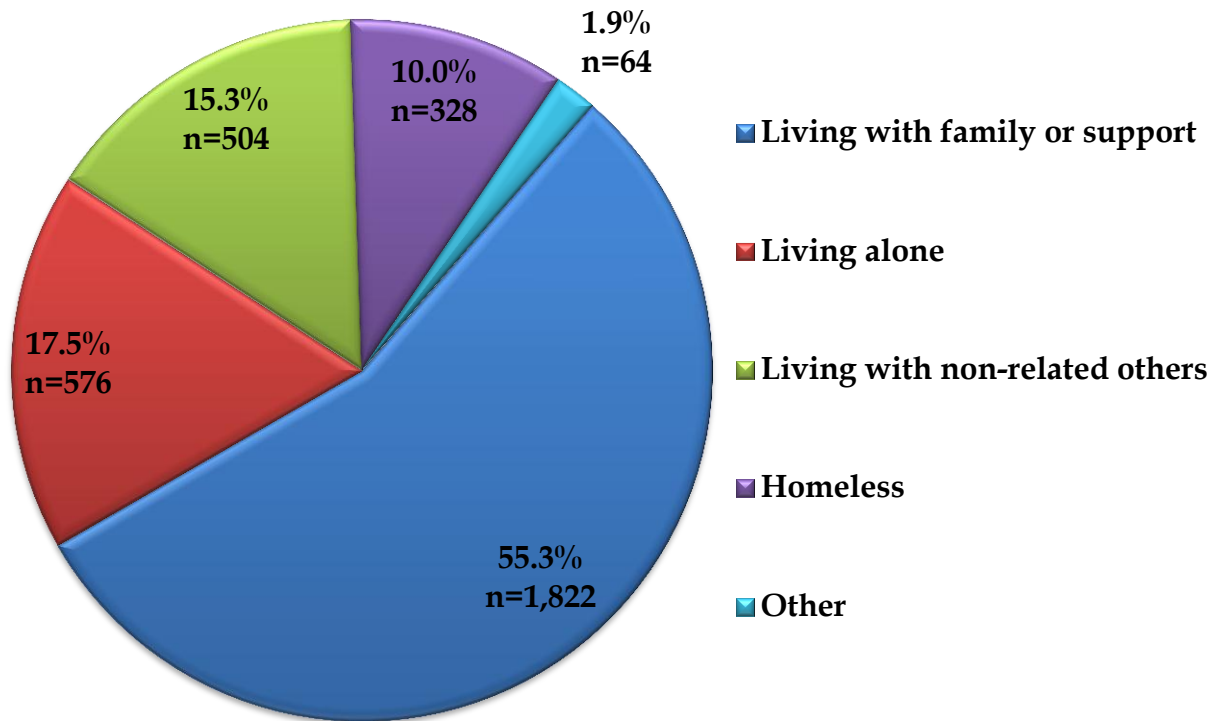
	Frequency	Percent
Caucasian	2,234	66.8
African American	857	25.6
Hispanic and/or Latino	112	3.3
Asian and/or Pacific Islander	52	1.6
Native American	10	0.3
Other (not specified)	26	0.8
Multiracial	54	1.6
Total	3,345	100.0

► Among the adults evaluated, 14.4% (n=478) were Veterans and 0.6% (n=20) were either active military or in the reserve. Most adults had no military involvement (75.3%, n=2,502). The military status of the remaining adults was unknown (9.7%, n=322).

### *Living Situation of Adults*

► Most adults were living with family or support (55.3%, n=1,822) or living alone (17.5%, n=576) at the time of the evaluation. See Figure 7 and Table 6.

**Figure 7. Living situation of adults**



**Table 6. Living situation of adults**

	Frequency	Percent
Living with family	1,642	48.0
Living alone	576	16.8
Living with non-related others	504	14.7
Homeless	328	9.6
Living with support	180	5.3
Don't know	125	3.7
Other	64	1.9
<b>Total</b>	<b>3,419</b>	<b>100.0</b>

### *Current Treatment of Adults*

► Forty-four percent (43.7%, n=1,438) of adults were not receiving treatment at the time of the emergency evaluation. See Figure 8 and Table 7.

Figure 8. Sources of current treatment of adults

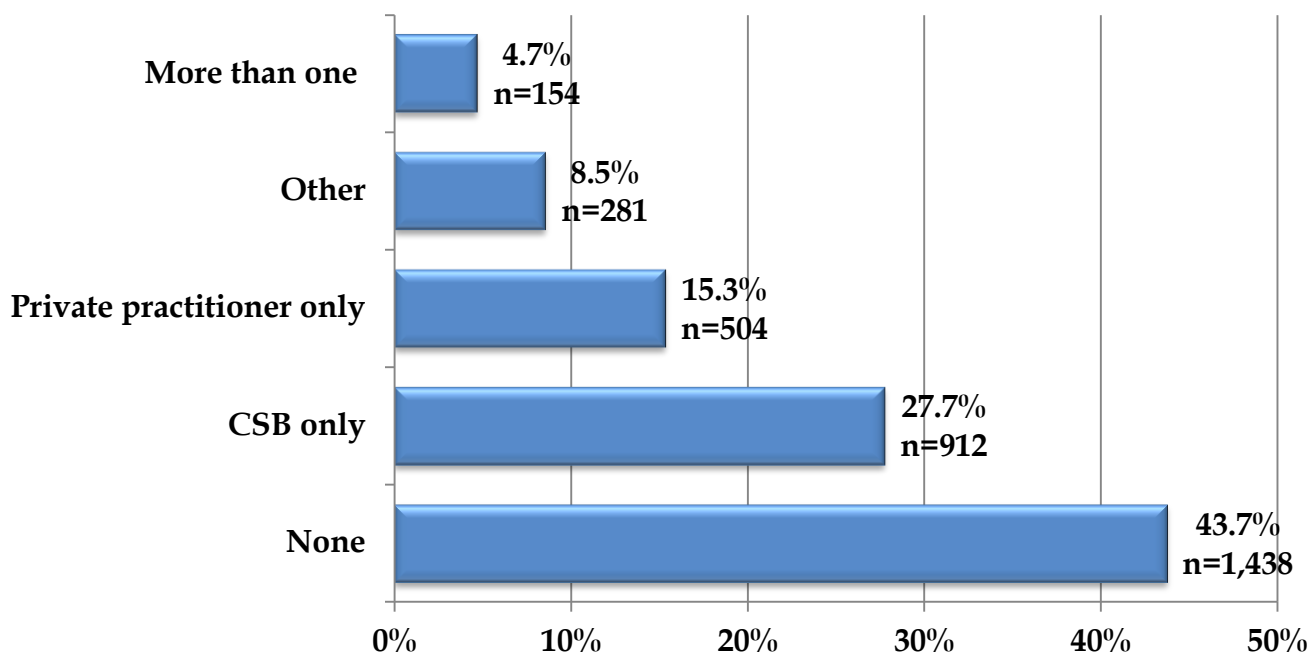


Table 7. Sources of current treatment of adults

	Frequency	Percent
None	1,438	42.2
CSB only	912	26.7
Private practitioner only	504	14.8
More than one	154	4.5
Other:		
DBHDS facility	7	0.2
Other community agency	87	2.6
Private/community psych facility	75	2.2
Non-psychiatric private/community facility	83	2.4
Veterans administration hospital	13	0.4
University counseling	10	0.3
Other (not specified)	6	0.2
Don't know/not sure	122	3.6
Total	3,411	100.0

### *Insurance Status of Adults*

► One-third (36.2%, n=1,198) of adults did not have health insurance at the time of the emergency evaluation. See Figure 9 and Table 8.

Figure 9. Insurance status of adults

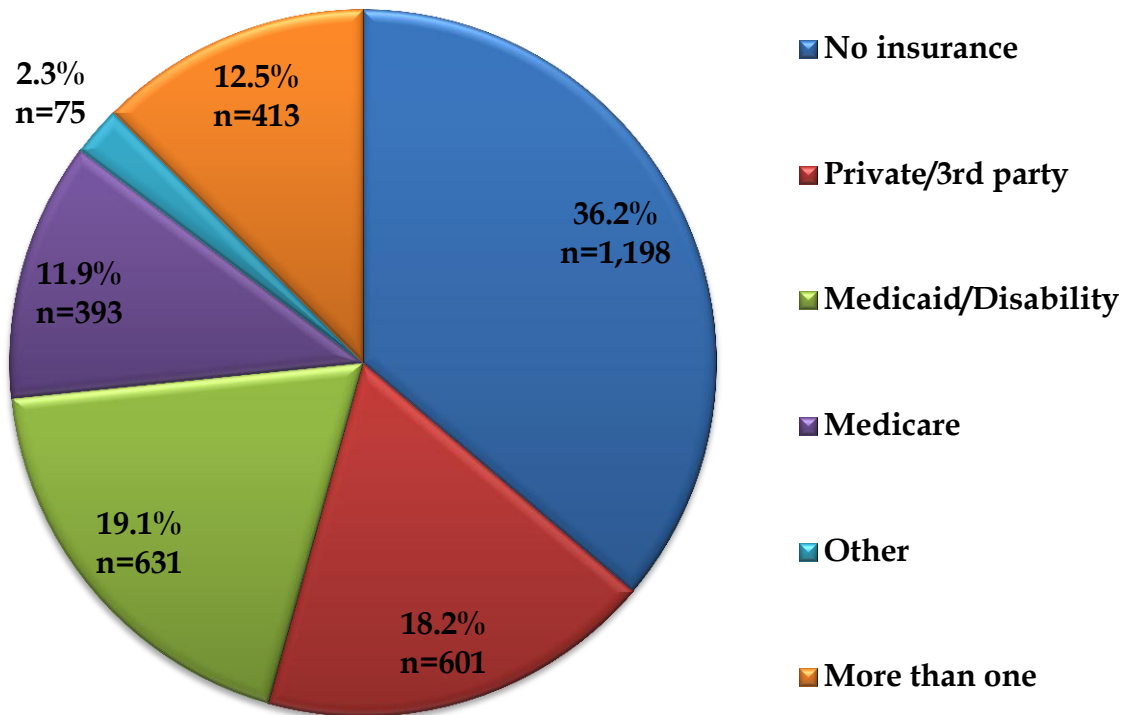


Table 8. Insurance status of adults

	Frequency	Percent
No insurance	1,198	34.9
Medicaid/Disability	631	18.4
Medicare	393	11.4
Private/3rd Party	601	17.5
Other	75	2.2
More than one	413	12.0
Don't know/not sure	125	3.6
Total	3,436	100.0

## Pathways to CSB Crisis Response System

### *Adults in Police Custody at Time of Evaluation*

► Three out of 10 individuals (27.9%, n=958) were in police custody at the time of the emergency evaluation. See Figure 10 and Table 9.

Figure 10. Adults in police custody at time of evaluation

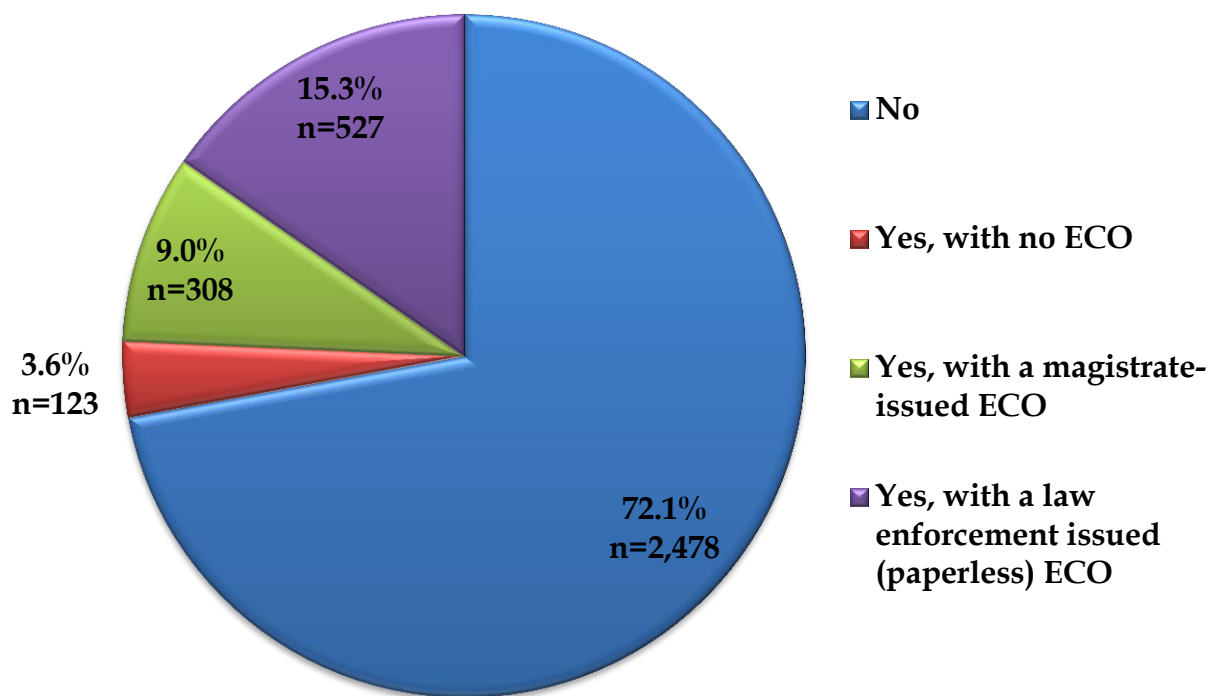


Table 9. Client status at the time of the evaluation

	In police custody	Restraints used	Sought an ECO	ECO was obtained	Initial ECO expired	Sought an extension
Not in police custody	2,478	11	71	67	18	15
Yes, with no ECO	123	33	9	8	2	2
Yes, with magistrate issued ECO	308	104			85	71
Yes, with law enforcement issued (paperless) ECO	527	244			118	98
Total	3,436	392	80	75	223	186

► Of the cases in which an ECO extension was granted (n=184), the extension provided sufficient time to complete the evaluation in 46.2% (n=85) of cases, the extension provided sufficient time to complete the medical screening in 58.2% (n=107) of cases, and the extension provided sufficient time to locate a bed in 66.3% (n=122) of cases. See Table 10.

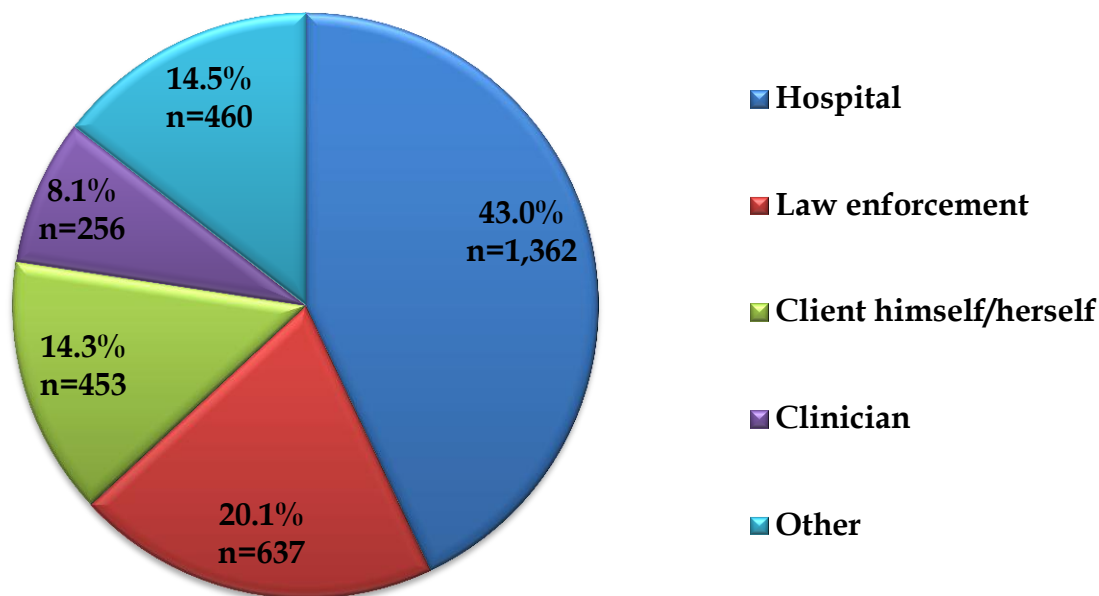
Table 10. Was the ECO extension sufficient?

	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	4	10	8	14
Yes, with no ECO		2		2
Yes, with magistrate issued ECO	26	33	54	71
Yes, with law enforcement issued (paperless) ECO	55	62	60	97
<b>Total</b>	<b>85</b>	<b>107</b>	<b>122</b>	<b>184</b>

### *Contacting the CSB for Adult Emergency Evaluations*

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

Figure 11. Contacting CSB for emergency evaluations



**Table 11. Contacting CSB for emergency evaluations**

	Frequency	Percent
Hospital	1,362	42.9
Law enforcement	637	20.0
Client himself/herself	453	14.3
Clinician	256	8.1
Friend/family member	204	6.4
Other (e.g., Legal Aid)	169	5.3
More than one above	87	2.7
Don't know/not sure	10	0.3
<b>Total</b>	<b>3,178</b>	<b>100.0</b>

### *Location of Adult Emergency Evaluations*

► Most adult emergency evaluations (62.9%, n=2,154) took place at a hospital. See Table 12.

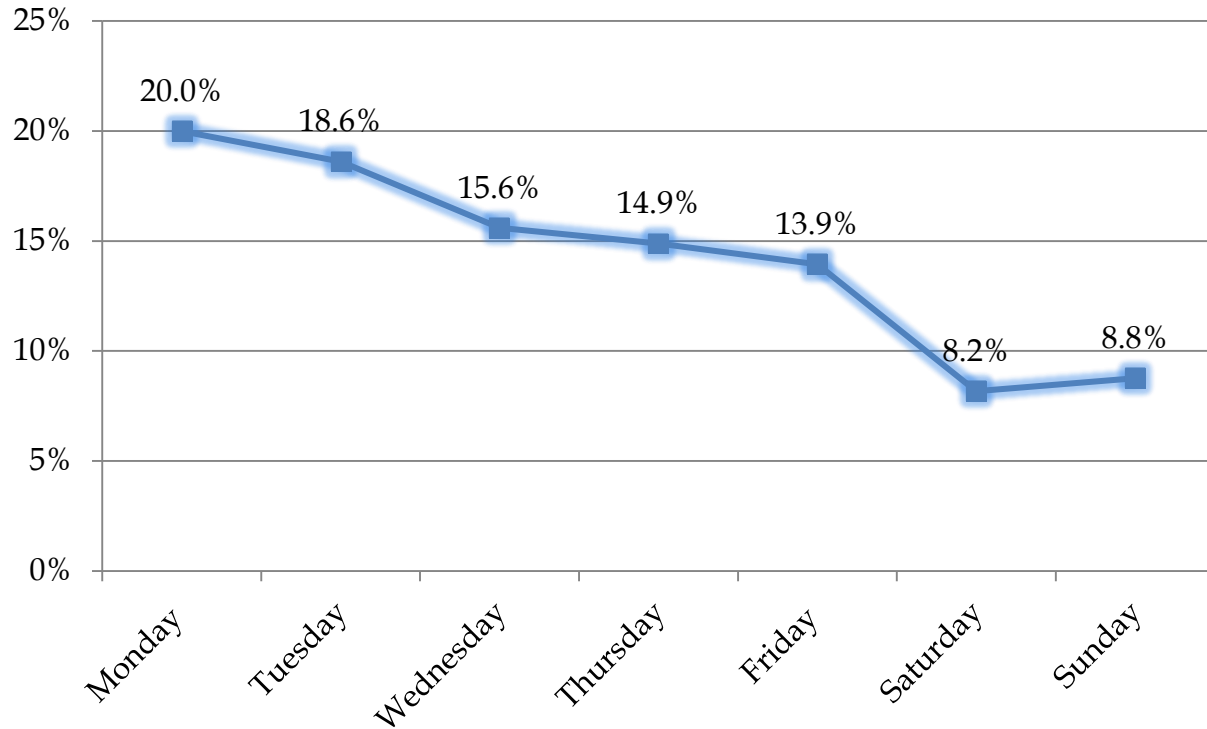
**Table 12. Location of the emergency evaluation**

	Frequency	Percent
CSB	964	28.1
Client's home	112	3.3
Hospital Psychiatric Unit	290	8.5
Police Station	77	2.2
Hospital Emergency Department	1,669	48.7
Public location	29	0.8
Magistrate's Office	6	0.2
Other:		
CIT-trained police	16	0.5
Assisted Living Facility	19	0.6
Crisis stabilization	24	0.7
Hospital ICU	52	1.5
Hospital and Medical unit	119	3.5
Detox or Substance abuse facility	7	0.2
Outpatient	17	0.5
Shelter, group home, etc.	10	0.3
Court hearing	2	0.1
Probation	5	0.1
Telephone	1	0.0
College campus	6	0.2
<b>Total</b>	<b>3,425</b>	<b>100.0</b>

### *Day and Time of the Adult Emergency Evaluations*

► Adult emergency evaluations were most likely to occur on weekdays rather than the weekend. See Figure 12 and Table 13.

**Figure 12. Day of the week the emergency evaluations occurred**

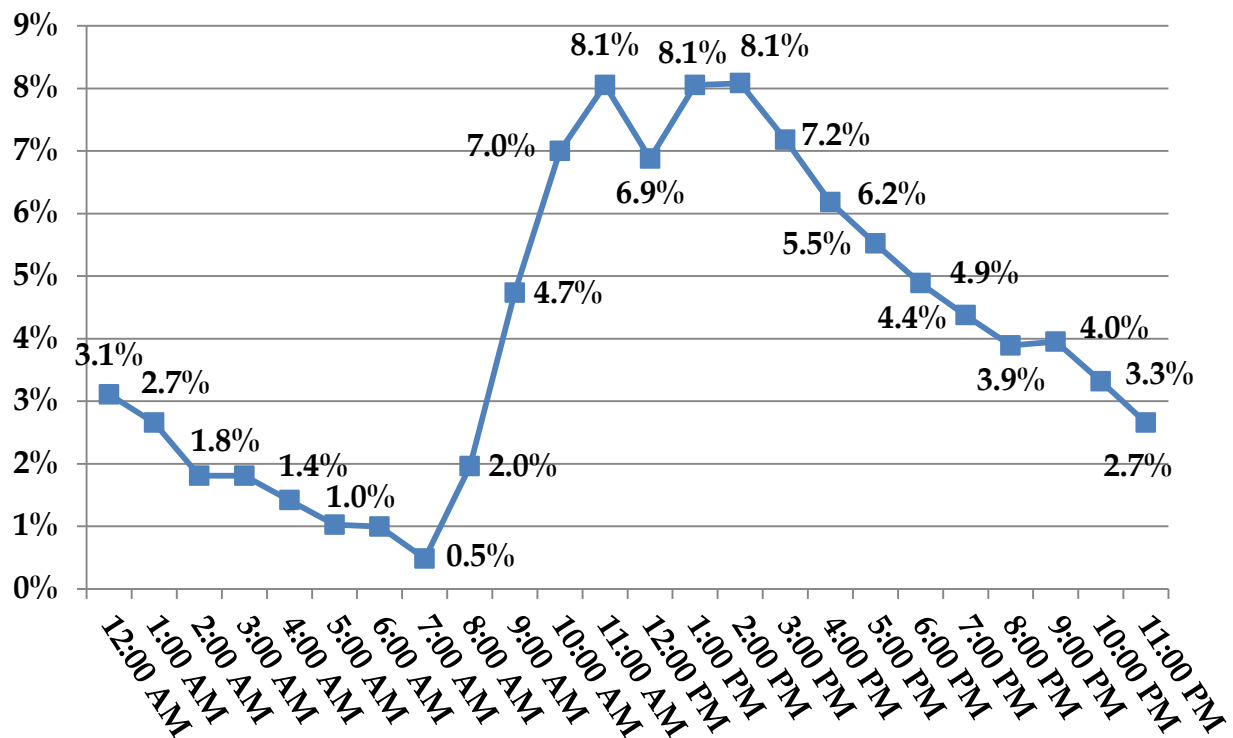


**Table 13. Day of the week the emergency evaluations occurred**

	Frequency	Percent
Monday	677	20.0
Tuesday	630	18.6
Wednesday	528	15.6
Thursday	504	14.9
Friday	472	13.9
Saturday	277	8.2
Sunday	297	8.8
Total	3,385	100.0

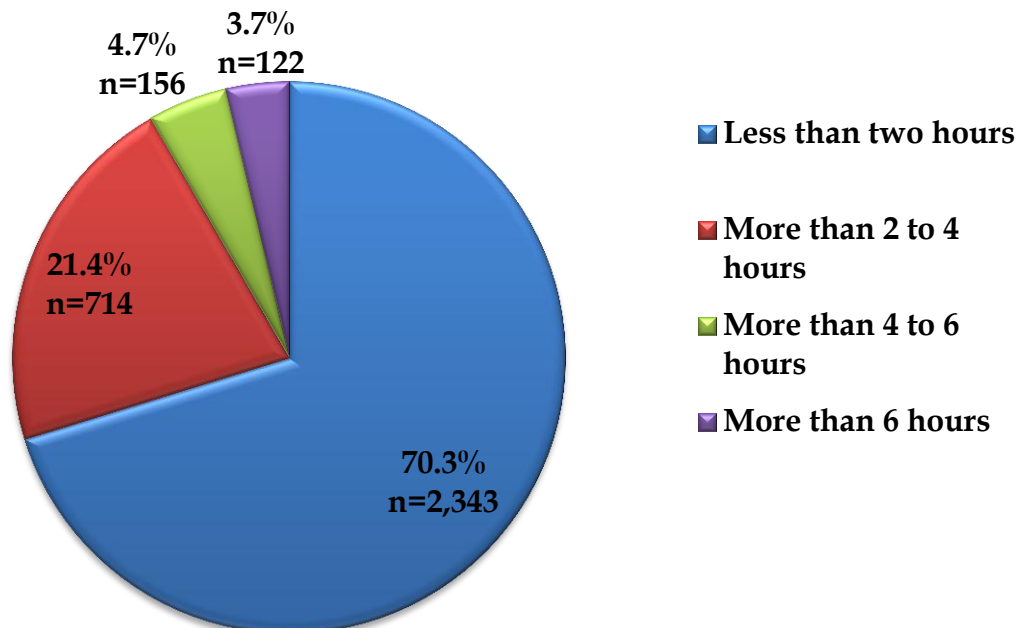
► Adult emergency evaluations were most likely to occur during standard work hours (i.e., between 9 a.m. and 5 p.m.). See Figure 13.

**Figure 13. Time of day the emergency evaluation occurred**



► The average length of time of an adult emergency evaluation was 2 hours and 10 minutes ( $sd=2:20$ ), ranging from 10 minutes to over 24 hours. Nine out of 10 (91.4%,  $n=3,057$ ) adult evaluations were completed within four hours. See Figure 14 and Table 14.

**Figure 14. Length of emergency evaluation**



**Table 14. Length of emergency evaluations**

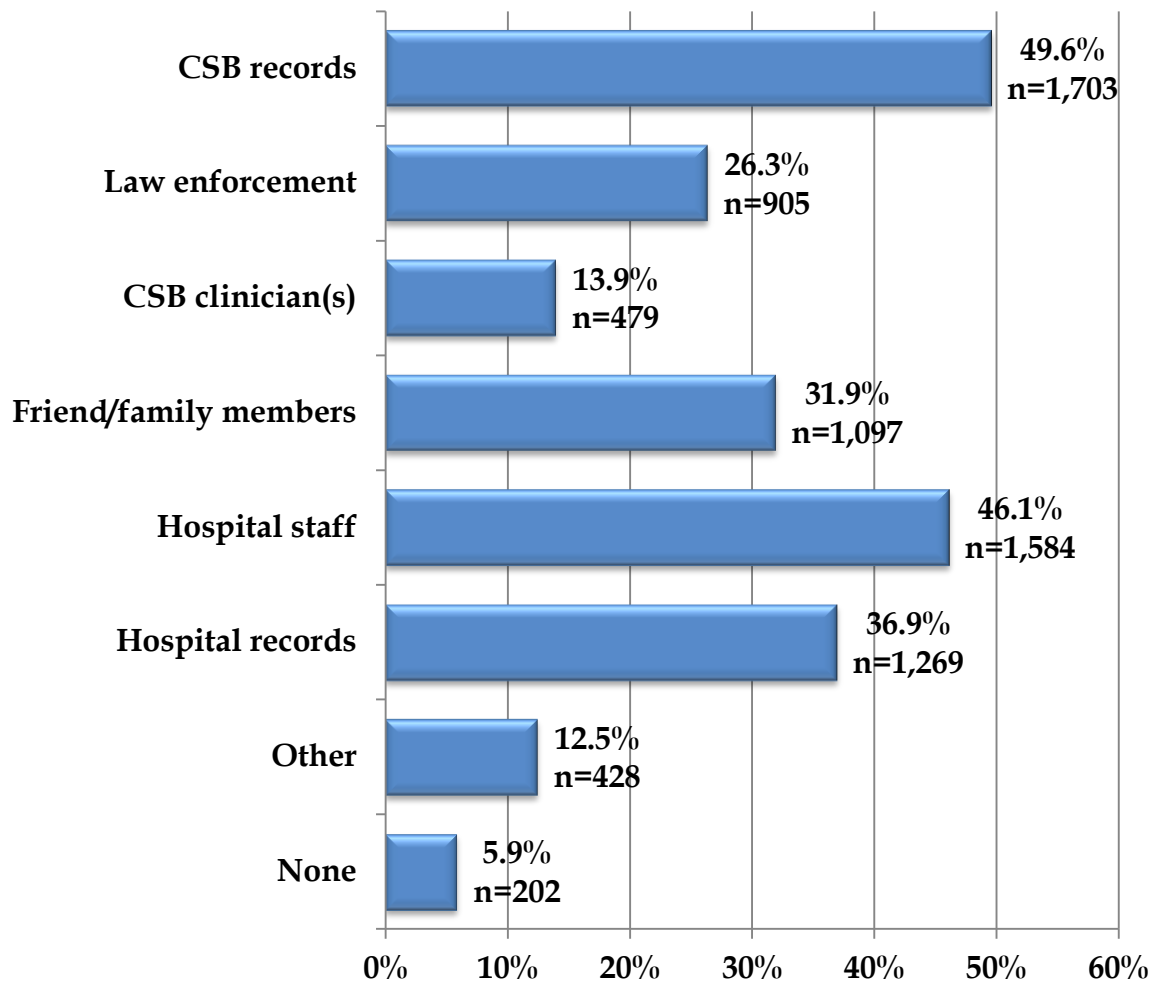
	<b>Frequency</b>	<b>Percent</b>
<b>One hour or less</b>	1,188	35.6
<b>Between 1 and 2 hours</b>	1,155	34.6
<b>More than 2 to 3 hours</b>	467	14.0
<b>More than 3 to 4 hours</b>	247	7.4
<b>More than 4 to 5 hours</b>	111	3.3
<b>More than 5 to 6 hours</b>	45	1.3
<b>More than 6 to 9 hours</b>	41	1.2
<b>More than 9 to 12 hours</b>	11	0.3
<b>More than 12 to 15 hours</b>	47	1.4
<b>More than 15 to 18 hours</b>	15	0.4
<b>More than 18 to 21 hours</b>	3	0.1
<b>More than 21 hours</b>	5	0.1
<b>Total</b>	<b>3,335</b>	<b>100.0</b>

*Sources of Information Available to Clinician Prior to the Adult Evaluation*

► Advance Directive were greatly underutilized. Fewer than three out of 100 (2.6%, n=80) individuals evaluated had an Advance Directive.

► On average, the clinician had two sources of information available prior to the evaluation (*average*=2.2, *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 15 and Table 15.

**Figure 15. Sources of information that the clinician had prior to the adult evaluation**



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

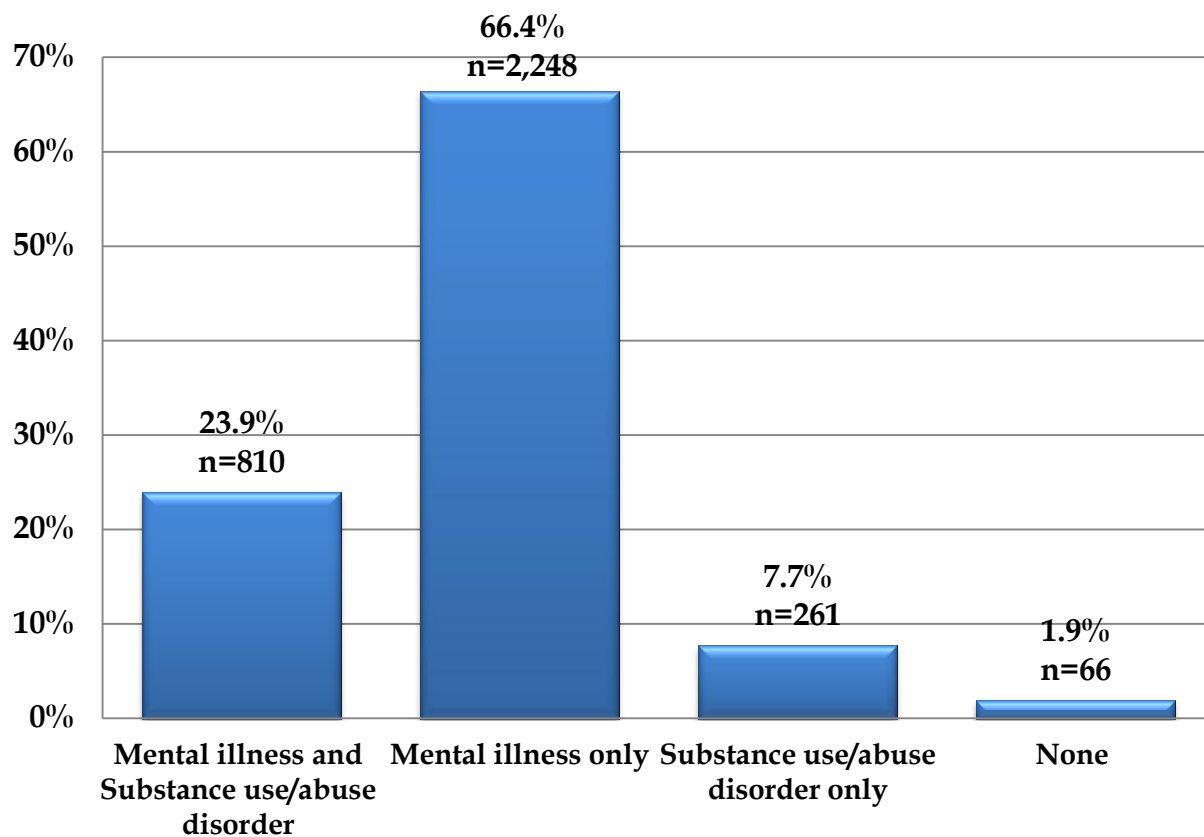
	Frequency	Percent
CSB records	1,703	49.6
Law enforcement	905	26.3
CSB clinician(s)	479	13.9
Friend/family members	1,097	31.9
Hospital staff	1,584	46.1
Hospital records	1,269	36.9
None	202	5.9
Other:		
Other providers	169	4.9
Other clinical records	129	3.8
Assisted Living (non-medical)	9	0.3
Adult care worker or record	8	0.2
Adult Protection Services	4	0.1
Other people (e.g., airline staff)	10	0.3
Any mental health worker	21	0.6
Client	27	0.8
College or university counselor	7	0.2
Legal document, ECO, magistrate, probation	14	0.4
Jail, police, or security officer	7	0.2
Nursing Home	5	0.1
PACT (Program Assertive Community Treatment)	1	0.0
Physician PCP psychiatrist	6	0.2
Other (not specified)	11	0.3
<b>Total</b>	<b>3,436</b>	<b>100.0</b>

## Clinical Presentation of Adults

### *Presentation at Time of Adult Emergency Evaluations*

► **In nine out of 10 cases (89.0%, n=3,058), the adult presented with symptoms of mental illness.** Overall, 23.6% (n=810) of adults presented with mental illness and substance use/abuse disorder, 65.5% (n=2,248) of adults presented with mental illness but no substance use/abuse disorder, and 7.6% (n=261) of adults presented with substance use/abuse disorder but no mental illness. In less than 2% of cases (1.9%, n=66), the clinician reported that the adult presented with neither a mental illness nor substance use/abuse disorder, and in 1.4% (n=47) of cases, the clinician reported that the adult presented with other unspecified conditions. See Figure 16 and Table 16.

**Figure 16. Adult presentation at the time of the evaluation**



**Table 16. Adult presentation at the time of the evaluation**

	Frequency	Percent
Mental illness and Substance use/abuse disorder	810	23.6
Mental illness only	2,248	65.5
Substance use/abuse disorder only	261	7.6
None	66	1.9
Other	47	1.4
Total	3,432	100.0

### *Adults Under the Influence of Substances*

► Less than 25% (23.4%, n=804) of adults 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. Adults presenting under the influence or suspected of being under the influence

	Frequency	Percent
Under the influence of drugs or alcohol	624	18.2
Suspected of being under the influence of drugs or alcohol	180	5.2
Not under the influence of drugs or alcohol	2,491	72.6
Unknown	137	4.0
<b>Total</b>	<b>3,432</b>	<b>100.0</b>

### *Adults Presenting Psychotic Symptoms*

► About one-third (30.9%, n=1,063) of the adults evaluated presented with psychotic symptoms. Of the 3,058 adults who presented with a mental illness, 34.0% (n=1,041) also showed psychotic symptoms. See Table 18.

Table 18. Adults presenting psychotic symptoms

	Frequency	Percent
Psychotic symptoms	1,063	30.9
No psychotic symptoms	2,373	69.1
<b>Total</b>	<b>3,436</b>	<b>100.0</b>

### *Displays by Evaluated Adults of Behaviors Bearing on Involuntary Commitment Criteria*

► One out of two (52.7%, n=1,812) evaluated adults presented displayed behaviors indicating an elevated risk of serious physical harm toward self. See Figures 17-18 and Tables 19-20.

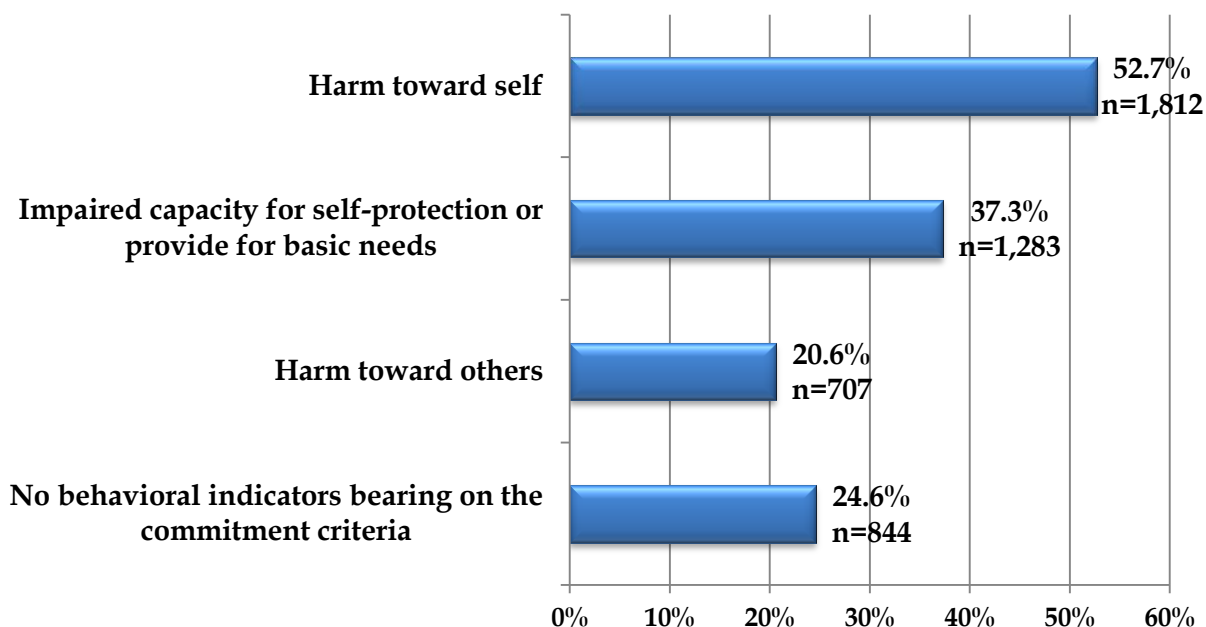
► One out of three (37.3%, n=1,283) evaluated adults displayed behaviors indicating an impaired capacity for self-protection or provide for basic needs. See Figures 17-18 and Tables 19-20.

► One out of five (20.6%, n=707) evaluated adults displayed behaviors indicating an elevated risk of serious physical harm toward others. See Figures 17-18 and Tables 19-20.

► One out of four (24.6%, n=844) evaluated adults did not show behavioral indicators bearing on the civil commitment criteria. See Figure 17 and Tables 19-20.

Clinicians reported in three separate questions whether or not the evaluated adult revealed recent behaviors or symptoms as shown in the available records or during the adult interview that had a bearing on the commitment criteria. An adult evaluated could meet one or more of the commitment criteria. Therefore, these responses are not mutually exclusive. See Figure 17-18 and Table 19-20.

**Figure 17. Displays by evaluated adults of behaviors bearing on involuntary commitment criteria**



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

	Frequency	Percent
Harm toward self	1,812	52.7
Impaired capacity for self-protection or provide for basic needs	1,283	37.3
Harm toward others	707	20.6
No behavioral indicators bearing on the commitment criteria	844	24.6
<b>Total</b>	<b>3,436</b>	<b>100.0</b>

Figure 18. Displays by evaluated adults of behaviors bearing on involuntary commitment criteria, combinations

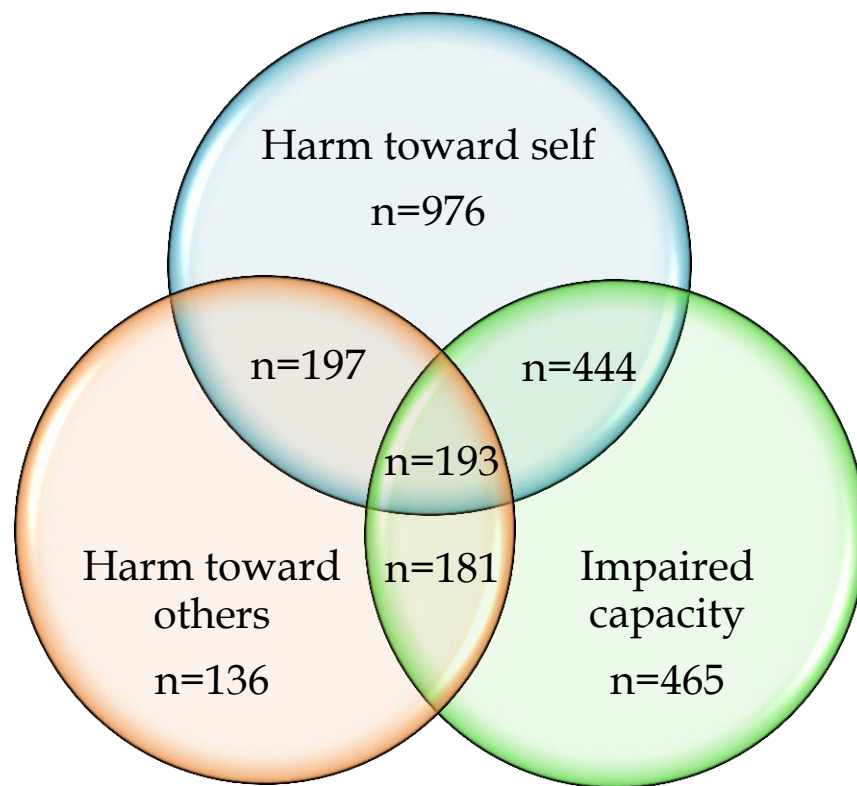


Table 20. Displays by evaluated adults of behaviors bearing on involuntary commitment criteria, combinations

	Frequency	Percent
No indicators displayed	844	24.6
Harm toward self only	976	28.4
Harm toward others only	136	4.0
Impaired capacity for self-protection or provide for basic needs only	465	13.5
Harm toward self and Harm toward others	197	5.7
Harm toward self and Impaired capacity for self-protection or provide for basic needs only	444	12.9
Harm toward others and Impaired capacity for self-protection or provide for basic needs only	181	5.3
Harm toward self, Harm toward others, and Impaired capacity for self-protection or provide for basic needs only	193	5.6
Total	3,436	100.0

► Of the cases in which the client displayed behaviors indicating an elevated risk of serious physical harm toward self (n=1,812), 18.2% (n=329) ingested pills or poison, 8.8% (n=160) injured self with a sharp object, 10.8% (n=196) demonstrated other self-injurious behavior. See Figure 19 and Table 21.

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

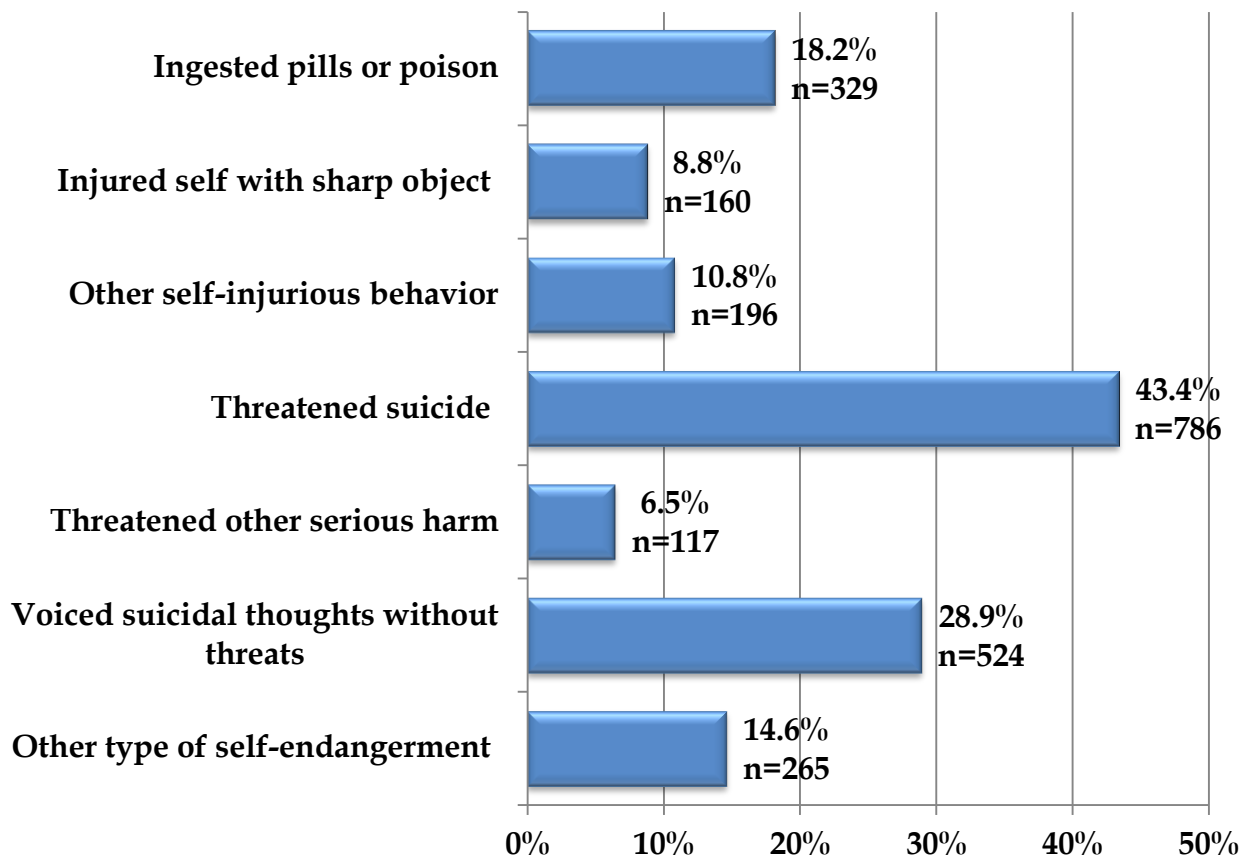
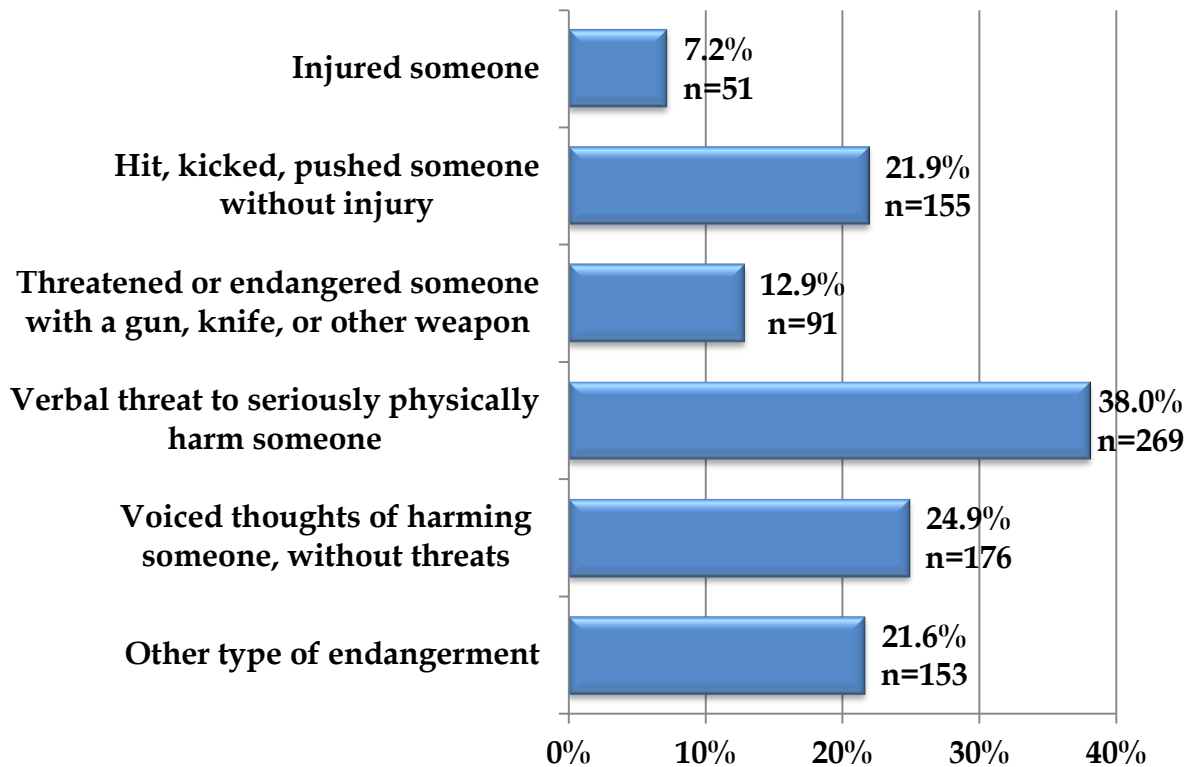


Table 21. Behaviors indicating an elevated risk of serious physical harm toward self

	Frequency	Percent
Ingested pills or poison	329	18.2
Injured self with sharp object	160	8.8
Other self-injurious behavior	196	10.8
Threatened suicide	786	43.4
Threatened other serious harm	117	6.5
Voiced suicidal thoughts without threats	524	28.9
Other type of self-endangerment	265	14.6
Total	1,812	100.0

► Of the cases in which the client displayed behaviors indicating an elevated risk of serious physical harm toward others (n=707), 7.2% (n=51) injured someone and 21.9% (n=155) hit, kicked, or pushed someone without injury. See Figure 20 and Table 22.

**Figure 20. Behaviors indicating an elevated risk of serious physical harm toward others**



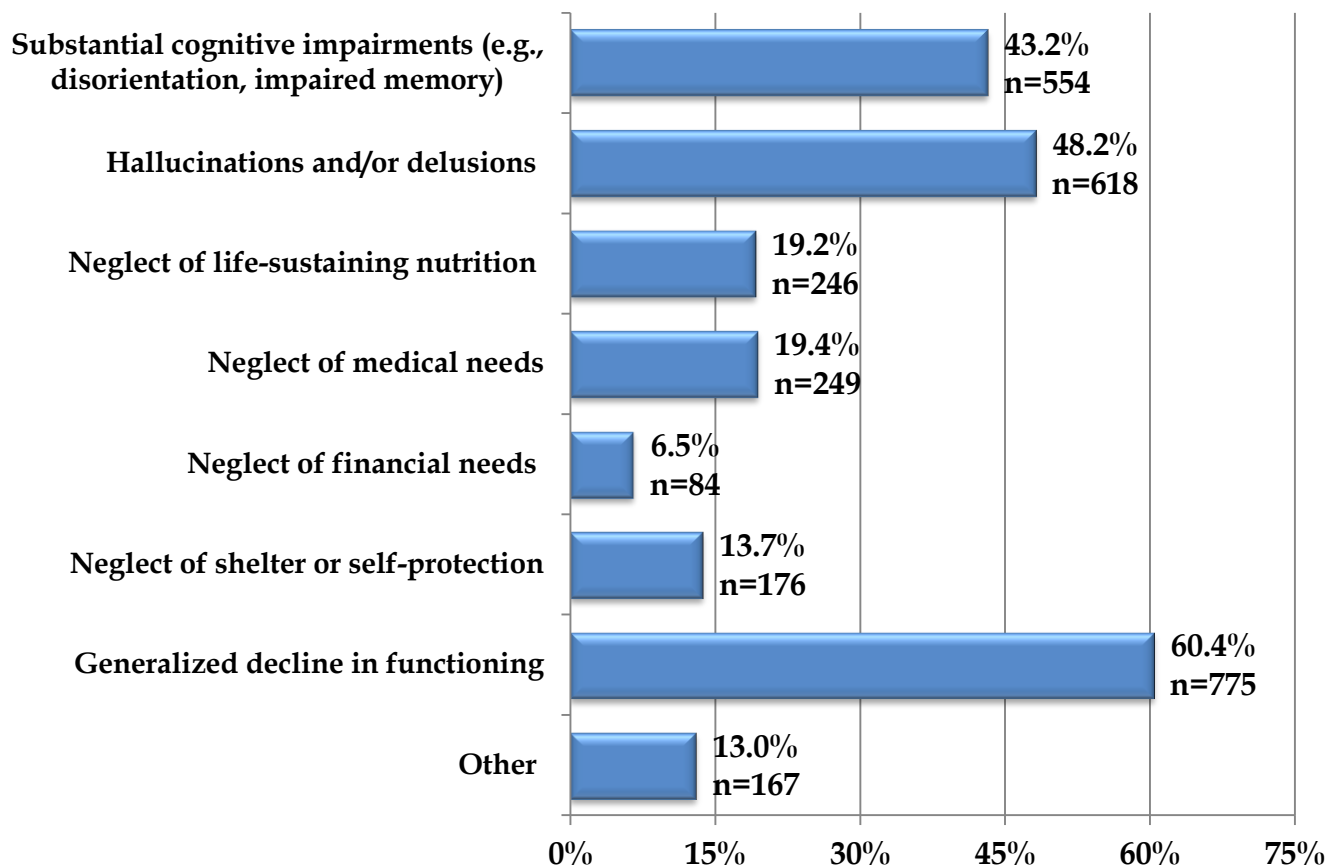
**Table 22. Behaviors indicating an elevated risk of serious physical harm toward others**

	Frequency	Percent
Injured someone	51	7.2
Hit, kicked, pushed someone without injury	155	21.9
Threatened or endangered someone with a gun, knife, or other weapon	91	12.9
Verbal threat to seriously physically harm someone	269	38.0
Voiced thoughts of harming someone, without threats	176	24.9
Other type of endangerment	153	21.6
<b>Total</b>	<b>707</b>	<b>100.0</b>

► 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 (66.3%, n=2,279). Only 6.8% (n=233) of adults were determined by the clinician to own or have easy access to a firearm. In the remaining cases 26.9% (n=924) of cases, the clinician was unable to determine whether the client had access to firearms.

► Of the cases in which the evaluated adults displayed behaviors indicating impaired capacity for self-protection or to provide for basic needs (n=1,283), 60.4% (n=775) presented with a generalized decline in functioning. See Figure 21 and Table 23.

**Figure 21. 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**

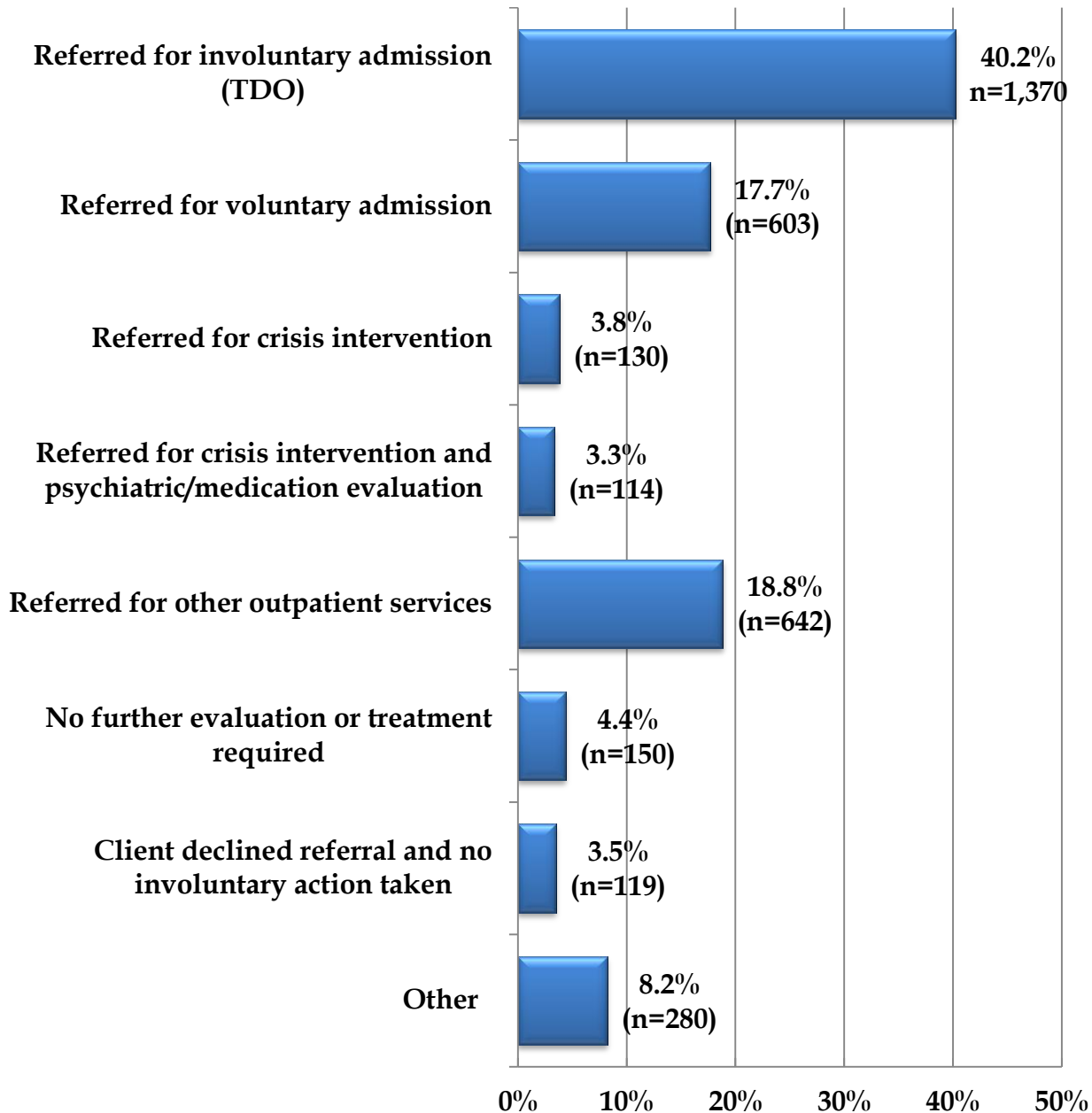
	Frequency	Percent
Substantial cognitive impairments (e.g., disorientation, impaired memory)	554	43.2
Hallucinations and/or delusions	618	48.2
Neglect of life-sustaining nutrition	246	19.2
Neglect of medical needs	249	19.4
Neglect of financial needs	84	6.5
Neglect of shelter or self-protection	176	13.7
Generalized decline in functioning	775	60.4
Other	167	13.0
<b>Total</b>	<b>1,283</b>	<b>100.0</b>

## Disposition After Adult Emergency Evaluations

### *Type of Action Recommended by the CSB Clinician for Adults*

► Involuntary action was recommended to a magistrate in 4 out of 10 adult evaluations. See Figure 22 and Table 24.

Figure 22. Clinician recommended dispositions



**Table 24. Clinician recommended dispositions**

	<b>Frequency</b>	<b>Percent</b>
<b>Referred for involuntary admission (TDO)</b>	1,370	40.2
<b>Referred for voluntary admission</b>	603	17.7
<b>Referred for crisis intervention</b>	130	3.8
<b>Referred for crisis intervention and psychiatric/medication evaluation</b>	114	3.3
<b>Referred for other outpatient services</b>	642	18.8
<b>No further evaluation or treatment required</b>	150	4.4
<b>Client declined referral and no involuntary action taken</b>	119	3.5
<b>Other:</b>		
<b>Medical admission</b>	48	1.4
<b>Client stayed in hospital</b>	7	0.2
<b>Released with safety plan</b>	18	0.5
<b>Released to family</b>	8	0.2
<b>No bed</b>	4	0.1
<b>Substance abuse treatment or Detox</b>	37	1.1
<b>Arrested jailed</b>	23	0.7
<b>Left before treatment against medical advice</b>	5	0.1
<b>In ER</b>	9	0.3
<b>Help but not medical or psych</b>	14	0.4
<b>Crisis stabilization of some kind</b>	92	2.7
<b>Other (e.g., insurance issues)</b>	15	0.4
<b>Total</b>	<b>3,408</b>	<b>100.0</b>

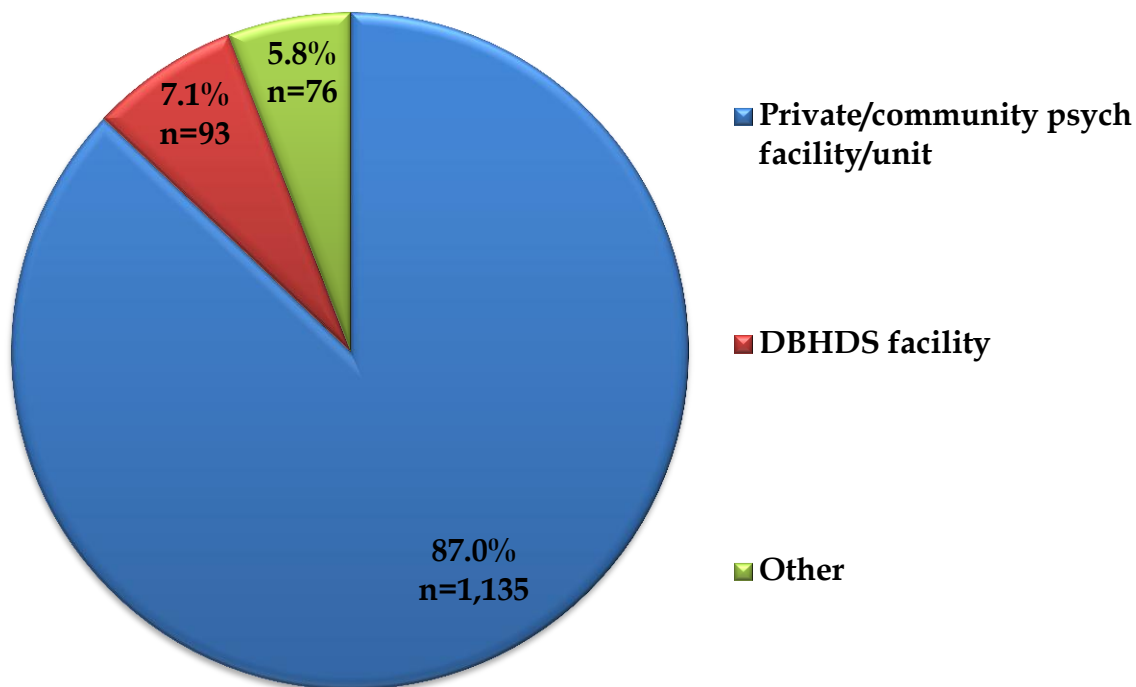
### *Outcome When Involuntary Admission Was recommended*

► Among cases in which involuntary admission was recommended by the clinician (n=1,370), a Temporary Detention Order (TDO) was granted 96.5% (n=1,322) of the time. It was not granted in only 1.4% (n=19) cases. In the remaining 29 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=1,322), the individual was admitted to a facility 98.6% (n=1,304) of the time. See Table 24-25.

► In about nine of 10 (87.0%, n=1,135) 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 23 and Table 25.

**Figure 23. Facilities where adults were admitted after a TDO was granted**



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

	Frequency	Percent
DBHDS facility	93	7.1
Private/community psych facility/unit	1,135	87.0
Emergency Department or medical unit of private/ community hospital	44	3.4
Crisis Stabilization Unit	8	0.6
Other facility	24	1.8
<b>Total</b>	<b>1,304</b>	<b>100.0</b>

► In the 1.4% (n=19) of cases in which the TDO was reported NOT to have been granted, the recorded reason the TDO was not granted was typically associated with the need for medical evaluation and treatment.

► There were only 18 cases 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, typically because the client was still undergoing medical evaluation and treatment in an ED. In 8 cases, the client was still in the ED; in one case, the client left and in another the TDO expired. (Information was unrecorded in another 8 cases.)

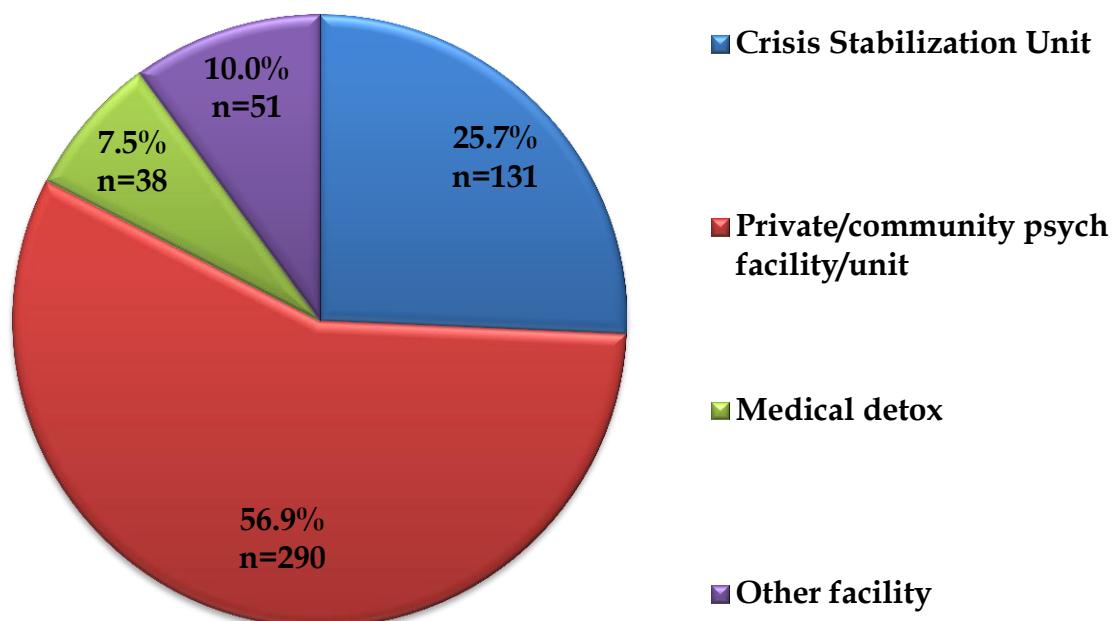
See Appendix 6 for further details regarding the cases in which (1) a TDO was recommended but was not granted and (2) a TDO was issued but the patient had not been admitted at the end of the evaluation. Information in Appendix 6 is based solely on the questionnaire responses received by the end of the survey month. There were a number of cases in which the “information was not available at the time of the study” due to a number of reasons (e.g. the evaluation was still in process at the end of the month when data collection ended or the case was not yet resolved).

### *Outcome When Voluntary Admission Was Recommended*

► Among the adults for whom voluntary action was recommended (n=603), the vast majority (84.6%, n=510) were admitted. See Figure 24 and Tables 26. 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 about six of 10 (56.9%, n=290) 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 24. Facilities where adults were admitted after a voluntary admission



**Table 26. Facilities where adults were admitted after a voluntary admission**

	Frequency	Percent
DBHDS facility	25	4.9
Crisis Stabilization Unit	131	25.7
Private/community psych facility/unit	290	56.9
Non-psychiatric private/community facility	6	1.2
Medical detox	38	7.5
Other facility	20	3.9
<b>Total</b>	<b>510</b>	<b>100.0</b>

Appendix 6 outlines what happened to clients in the cases where voluntary hospitalization was recommended but the client had not been admitted at the close of the evaluation.

### *Actions Taken to Identify a Psychiatric Bed for an Adult*

► In 64.3% (n=751) of cases for TDO admission to private facilities, it was necessary to call only one hospital to locate a bed, compared to 81.0% (n=299) of voluntary cases. However, in 21.1% (n=246) of TDO cases, and 10.6% (n=39) of voluntary cases, it was necessary to call 3 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	751	64.3	299	81.0
2	171	14.6	31	8.4
3	84	7.2	18	4.9
4	50	4.3	3	0.8
5	27	2.3	6	1.6
Between 6 and 10	56	4.8	9	2.4
Between 11 and 20	26	2.2	3	0.8
More than 20	3	0.3	0	0.0
<b>Total</b>	<b>1,168</b>	<b>100.0</b>	<b>369</b>	<b>100.0</b>

► In 88.2% (n=112) of cases for TDO admission to state facilities, one hospital was called to locate a bed, compared to 75.5% (n=37) of voluntary cases. See Table 28.

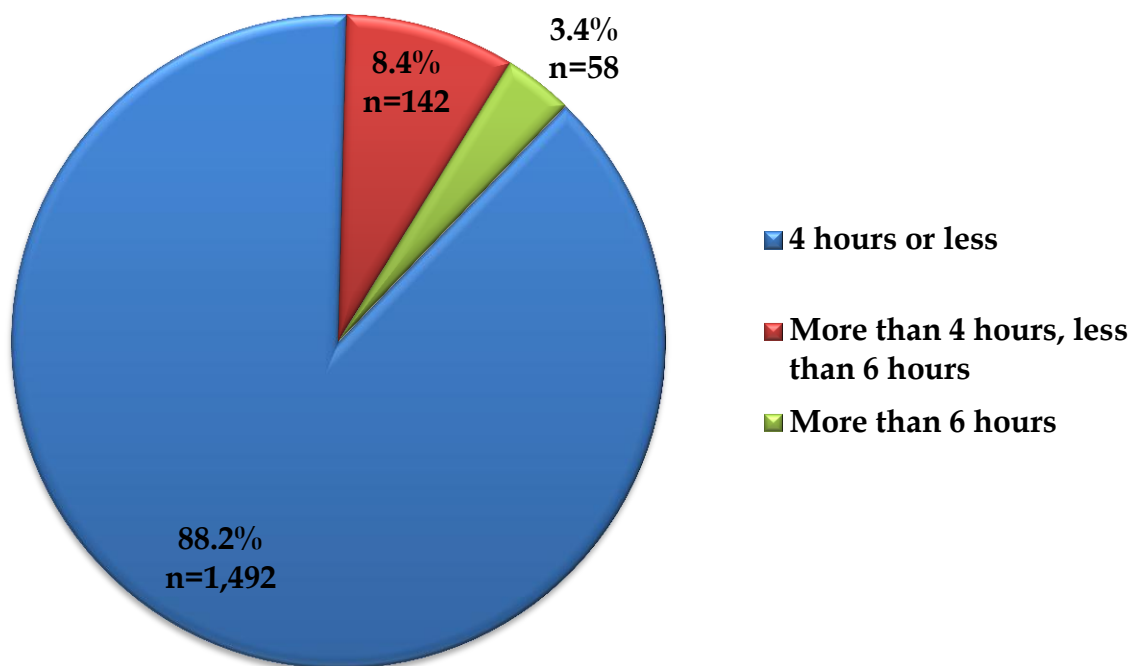
**Table 28. Number of state facilities contacted for TDO and voluntary admissions**

Number of state (DBHDS) facilities contacted	Referred for involuntary admission (TDO)		Referred for voluntary admission	
	Frequency	Percent	Frequency	Percent
1	112	88.2	37	75.5
2	9	7.1	3	6.1
3	6	4.7	9	18.4
<b>Total</b>	<b>127</b>	<b>100.0</b>	<b>49</b>	<b>100.0</b>

### *Length of Time Locating a Psychiatric Bed*

► In 88.2% (n=1,492) of cases, a psychiatric bed was located within four hours. See Figure 25 and Table 29.

**Figure 25. 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
<b>4 hours or less</b>	1,092	86.5	400	93.0	1,492	88.2
<b>More than 4 hours, less than 6 hours</b>	124	9.8	18	4.2	142	8.4
<b>More than 6 hours</b>	46	3.7	12	2.8	58	3.4
<b>Total</b>	<b>1,262</b>	<b>100.0</b>	<b>430</b>	<b>100.0</b>	<b>1,692</b>	<b>100.0</b>

► In the vast majority of cases (85.2%, n=1,490), the admitting psychiatric facilities were located within the same region as the individual's residence.

► In 72.4% of adult cases (n=1,285), a medical evaluation or treatment was required prior to hospital admission.

## Adult's Status at End of Emergency Evaluation Period

### *Clinicians' Opinions Regarding the Client's Status at the End of the Evaluation<sup>5</sup>*

► At the end of the emergency evaluations, CSB clinicians found that 56.9% (n=1,943) of individuals who were evaluated warranted hospitalization. See Table 30.

► At the end of the emergency evaluations, CSB clinicians found that 40.3% (n=1,377) 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 15.8% (n=540) 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 33.5% (n=1,144) of the cases, the individual evaluated was unable to protect self from harm and/or provide for basic needs. See Table 30.

<sup>5</sup> 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**

	<b>Frequency</b>	<b>Percent</b>
<b>Client presented a substantial likelihood of causing serious physical harm to self in the near future</b>	1,377	40.3
<b>Client presented a substantial likelihood of causing serious physical harm to others in the near future</b>	540	15.8
<b>Client was unable to protect self from harm</b>	996	29.2
<b>Client was unable to provide for basic needs</b>	886	26.0
<b>Client was experiencing severe mental or emotional distress or dysfunction</b>	2,230	65.3
<b>Client lacked the capacity to make treatment decisions</b>	1,113	32.6
<b>Client condition warranted hospitalization</b>	1,943	56.9
<b>I would have sought involuntary action (TDO) if client had refused voluntary services</b>	900	46.0
<b>I was able to address this person's crisis needs with the resources available to me</b>	3,000	87.9
<b>Total</b>	<b>3,414</b>	<b>100.0</b>

► Clinicians determined that in most cases (67.4%, n=2,301), the client had the capacity to make treatment decisions; conversely, in 1,113 cases (32.6%), 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 <sup>6</sup>**

	<b>Frequency</b>	<b>Percent</b>
<b>Client lacked ability to maintain and communicate choice</b>	663	59.6
<b>Client lacked ability to understand relevant information</b>	697	62.6
<b>Client lacked ability to understand consequences</b>	848	76.2
<b>Total: Client lacked the capacity to make treatment decisions</b>	<b>1,113</b>	<b>100.0</b>

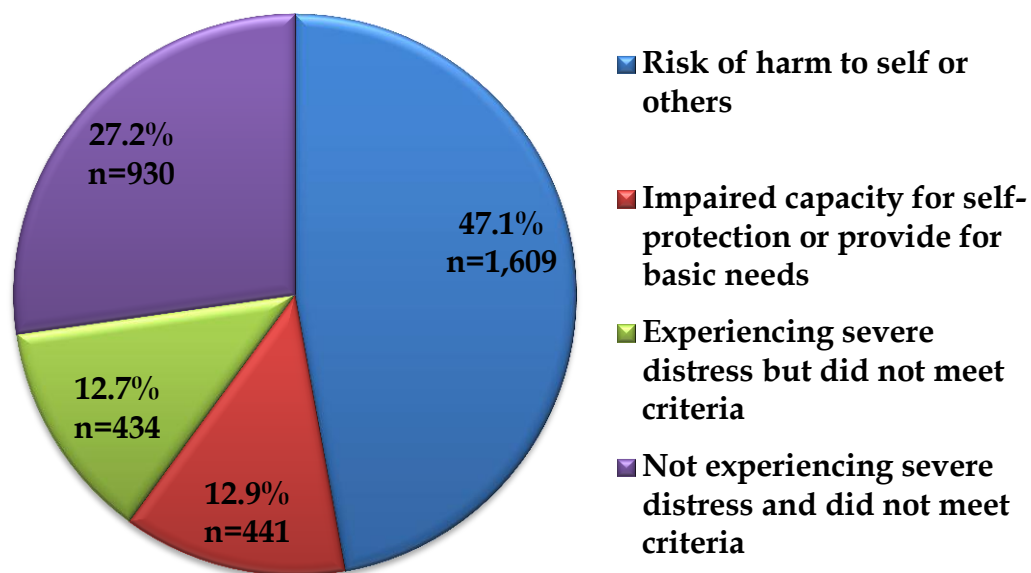
Figure 26 shows clinician opinion after recoding into four mutually exclusive categories that connects perceived clinical severity of the individual's condition with the commitment criteria:

- (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 provide for basic needs was recoded into the "Risk of harm to self or others" category.

<sup>6</sup> Clinicians were instructed to answer the three additional questions (indented to the right within Table 31) 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:
- 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
  - 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 26. Clinician opinion at the conclusion of the evaluation (n=3,414)**

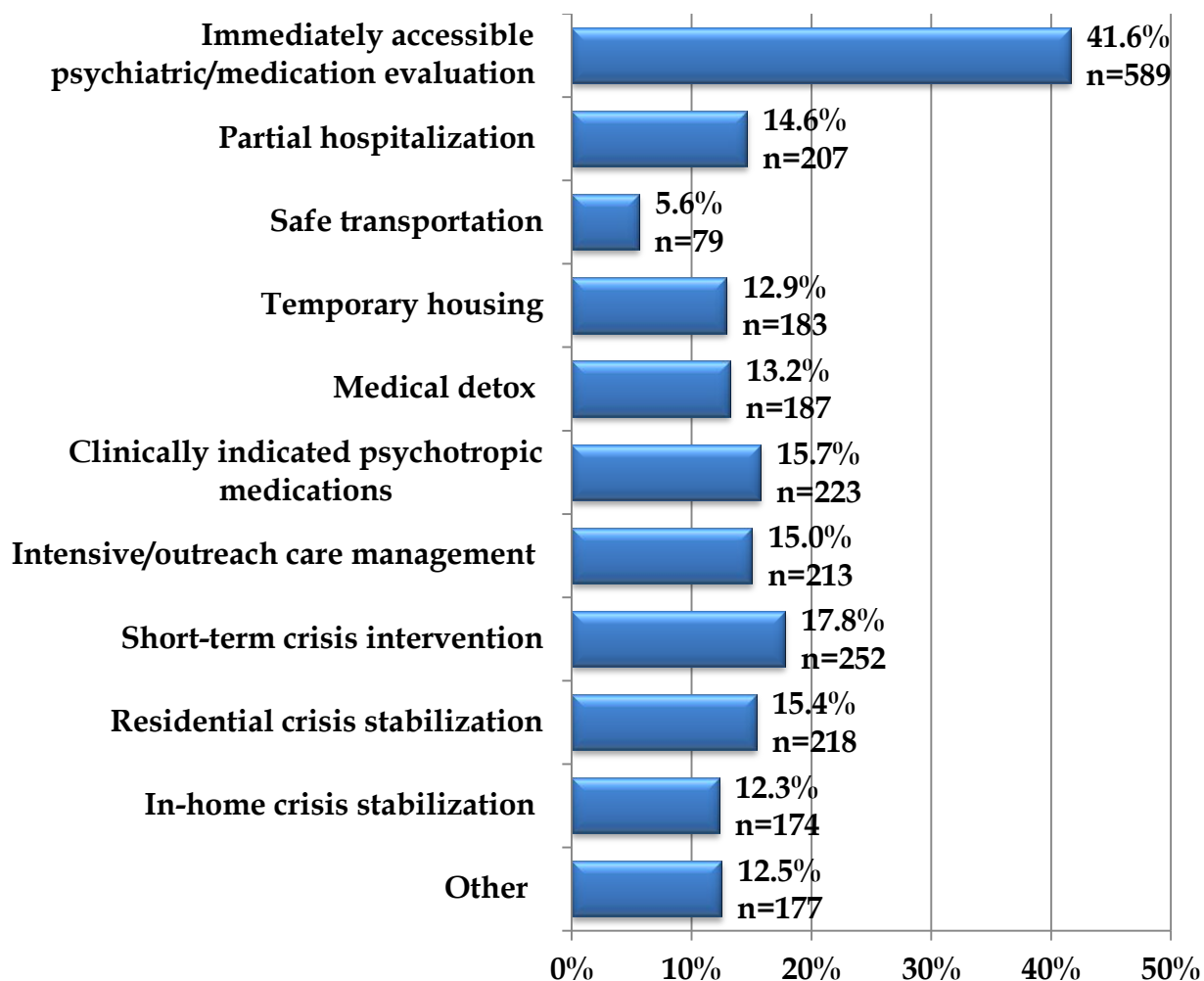


## Problems in Accessing Services for Adults

### *Services/Resources That Would Have Helped Address Adults' Needs*

► In 41.5% (n=1,416) of cases the clinician needed additional services to address the client needs better. Immediate 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 27. Services/resources that would have helped the clinician better address the client's needs (n=1,416)



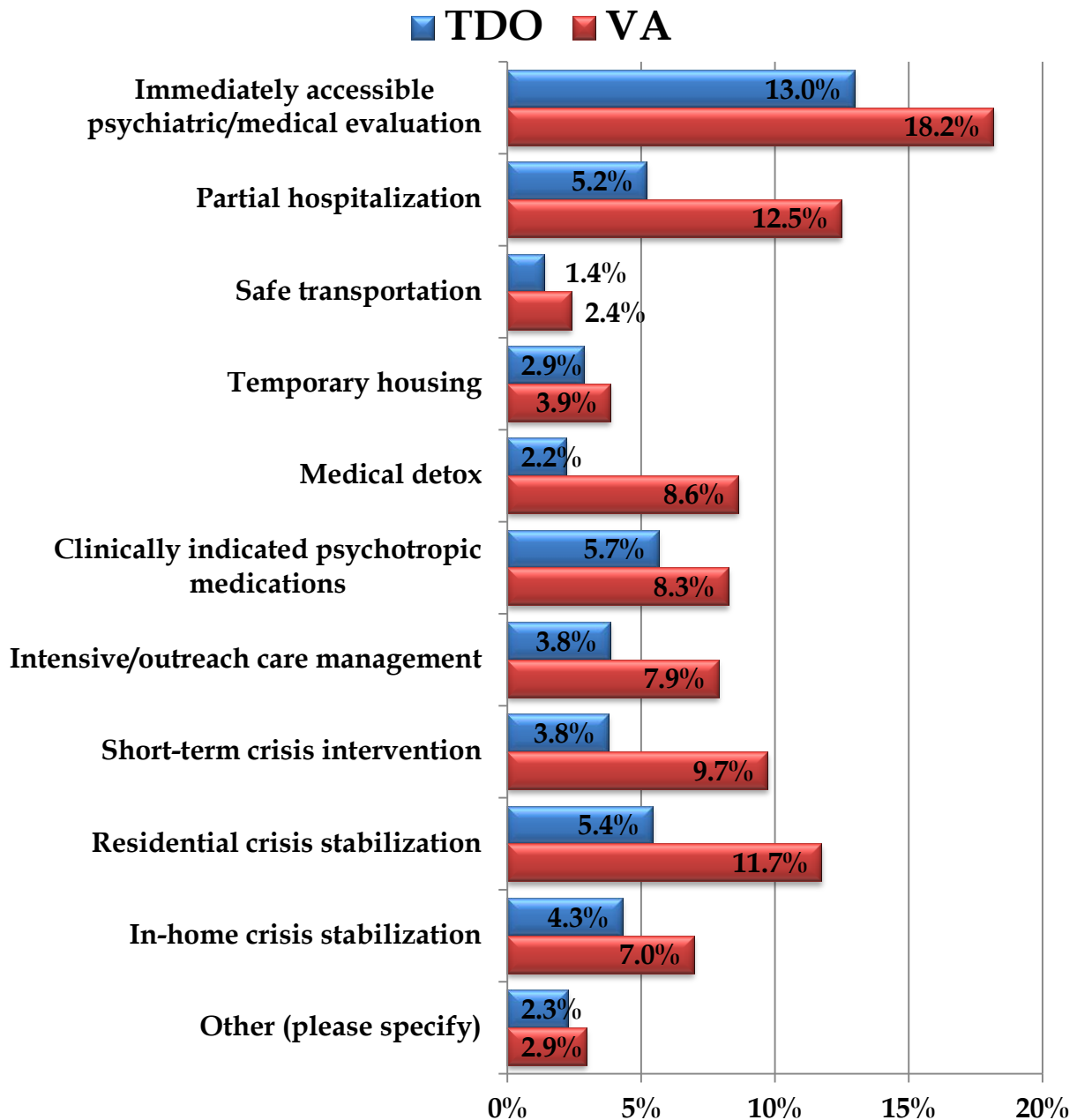
**Table 32. Ability to address the adult needs with resources available or additional services would help the clinicians.**

		Able to address the crisis needs with current resources available		Total
		Yes	No	
Additional services would help to address better	Yes	39.3% n=1,178	57.3% n=238	1,416
	No	60.7% n=1,822	42.7% n=177	1,999
Total		3,000	415	3,415

*Types of Services/Resources That, if Available, Would Have Allowed the Adult 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 25.8% (n=342 of 1,327) 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 47.9% (n=261 of 545) of cases if certain services/resources had been available. See Figure 28 and Table 33.

Figure 28. 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	172	13.0	99	18.2	271	14.5
Partial hospitalization	69	5.2	68	12.5	137	7.3
Safe transportation	18	1.4	13	2.4	31	1.7
Temporary housing	38	2.9	21	3.9	59	3.2
Medical detox	29	2.2	47	8.6	76	4.1
Clinically indicated psychotropic medications	75	5.7	45	8.3	120	6.4
Intensive/outreach care management	51	3.8	43	7.9	94	5.0
Short-term crisis intervention	50	3.8	53	9.7	103	5.5
Residential crisis stabilization	72	5.4	64	11.7	136	7.3
In-home crisis stabilization	57	4.3	38	7.0	95	5.1
Other	30	2.3	16	2.9	46	2.5
None	985	74.2	284	52.1	1,269	67.8
<b>Total</b>	<b>1,327</b>	<b>100.0</b>	<b>545</b>	<b>100.0</b>	<b>1,872</b>	<b>100.0</b>

► In 16.6% (n=310) of cases, the clinician reported that the client would have been able to avoid hospitalization if one specific service/resource had been available. Of those referred for involuntary admission, 12.5% (n=166) of cases more than 1 services would have helped to avoid hospitalization compared to 23.3% (n=127) 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	%	frequency	%	
None	985	74.2	284	52.1	1,269
One service	176	13.3	134	24.6	310
Two or more	166	12.5	127	23.3	293
<b>Total</b>	<b>1,327</b>	<b>100.0</b>	<b>545</b>	<b>100.0</b>	<b>1,872</b>

## SECTION II: JUVENILE EMERGENCY EVALUATIONS

### Number of Juvenile CSB Emergency Evaluations

Community Services Board clinicians documented 568 juvenile who needed an emergency evaluation during the month of April 2013. Of this total, 21 juveniles had more than one evaluation resulting in 589 mental health face-to-face crisis encounters over the survey month. Please note that sample size may slightly vary from question to question as in the adult section of the report for the same reasons.

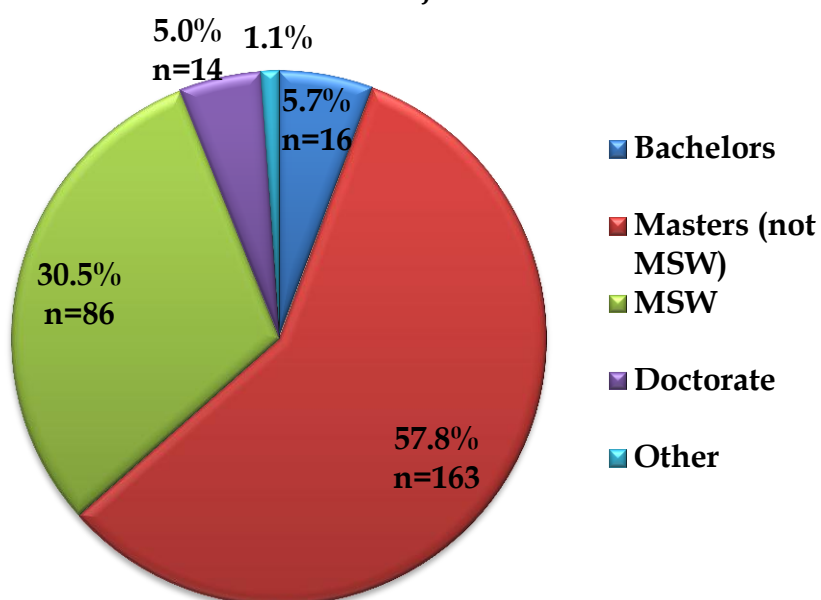
### CSB Clinician Characteristics

Across 397 CSBs, 285 clinicians submitted completed questionnaire information on face-to-face emergency evaluations. Among all evaluators, 4 out of 10 were licensed (43.8%, n=124). The number of clinicians conducting emergency evaluations (i.e., evaluators) during the survey month at each CSB ranged from 1 to 25, with a mode of 9 and median equal 6. The number of evaluators listed by CSB is described in Appendix 5 of this document.

#### *Clinician Credentials*

► About nine out of 10 (88.3%, n=249) CSB clinicians who conducted emergency evaluations reported that their highest educational degree was a Master's degree (i.e., M.A., M.S., M.S.W, etc.). See Figure 29 and Table 35.

Figure 29. Degrees of clinicians who evaluated juveniles



<sup>7</sup> One CSB did not report any juvenile evaluations over the course of the survey month.

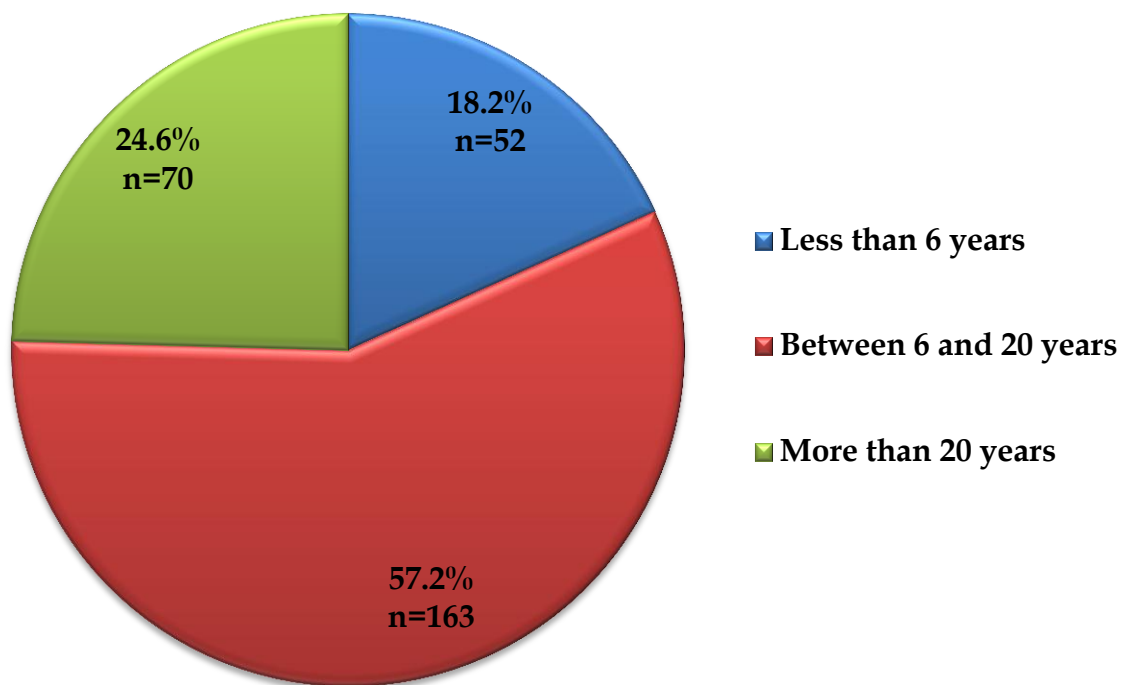
Table 35. Degrees of clinicians who evaluated juveniles

	Frequency	Percent
RN	2	0.7
Bachelors	16	5.7
Masters (not MSW)	163	57.8
MSW	86	30.5
Doctorate	14	5.0
Other	1	0.4
Total	282	100.0

*Clinician Number of Years of Experience in Behavioral Health<sup>8</sup>*

► The average number of years of field experience for the clinicians was 14.4 ( $sd=8.9$ ), ranging from no experience ( $n=6$ ) to 40 years ( $n=1$ ). See Figure 30 and Table 36.

Figure 30. Clinician number of years of experience in Behavioral Health



<sup>8</sup> In the 2007 CSB report, the term “mental health” was used instead of “behavioral health”.

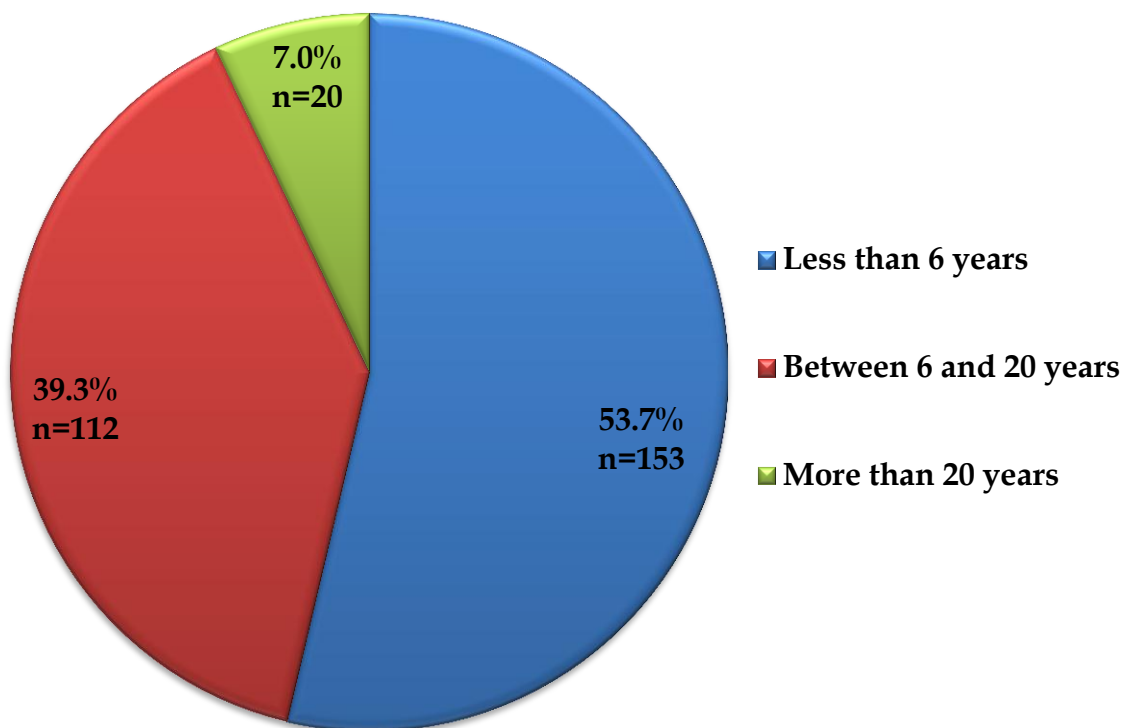
**Table 36. Clinician number of years of experience in Behavioral Health**

	Frequency	Percent
Less than 6 years	52	18.2
Between 6 and 10 years	68	23.9
Between 11 and 15 years	53	18.6
Between 16 and 20 years	42	14.7
Between 21 and 25 years	38	13.3
More than 25 years	32	11.2
<b>Total</b>	<b>285</b>	<b>100.0</b>

*Clinician Number of Years of Experience in Emergency Services*

► The average number of years of experience as an Emergency Services Clinician was 7.8 ( $sd=7.3$ ), ranging from no experience ( $n=11$ ) to 31 years ( $n=1$ ). See Figure 31 and Table 37.

**Figure 31. Clinician number of years of experience as Emergency Services Clinician**



**Table 37. Clinician number of years of experience as Emergency Services Clinician**

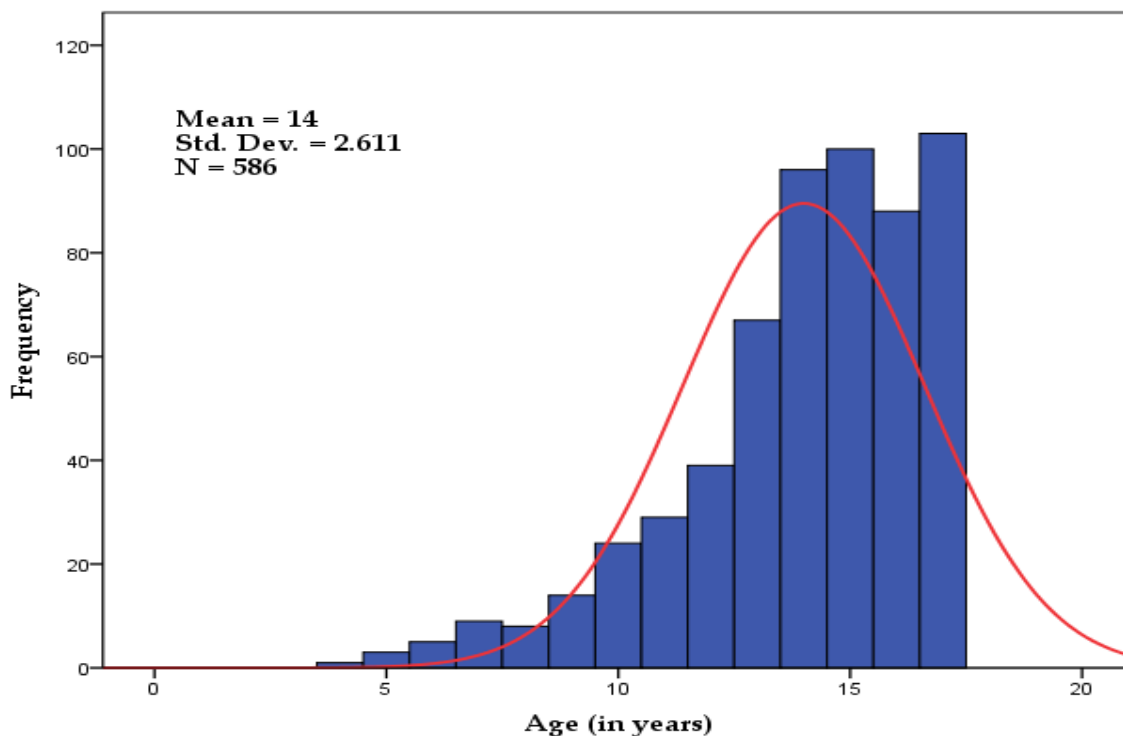
	Frequency	Percent
Less than 1 year	18	6.3
Between 1 and 5 years	135	47.4
Between 6 and 10 years	58	20.4
Between 11 and 15 years	25	8.8
Between 16 and 20 years	29	10.2
Between 21 and 25 years	14	4.9
More than 25 years	6	2.1
Total	285	100.0

## Characteristics of Juveniles in Crisis

### Demographics

► The average age of the juveniles evaluated was 14.0 years old ( $sd=2.6$  years); ages ranged from 4 years ( $n=1$ ) to 17 years ( $n=103$ ). See Figure 32 and Table 38. Among 509 juveniles who were in grades 1-12, the average grade was 8.3 ( $sd=2.5$ ) ranging from grades 1 to 12. Eighty juveniles were either in kindergarten or out of school. Two out of ten (19.8%,  $n=107$ ) juveniles were in special education.

**Figure 32. Distribution of age among juveniles evaluated during the survey month**



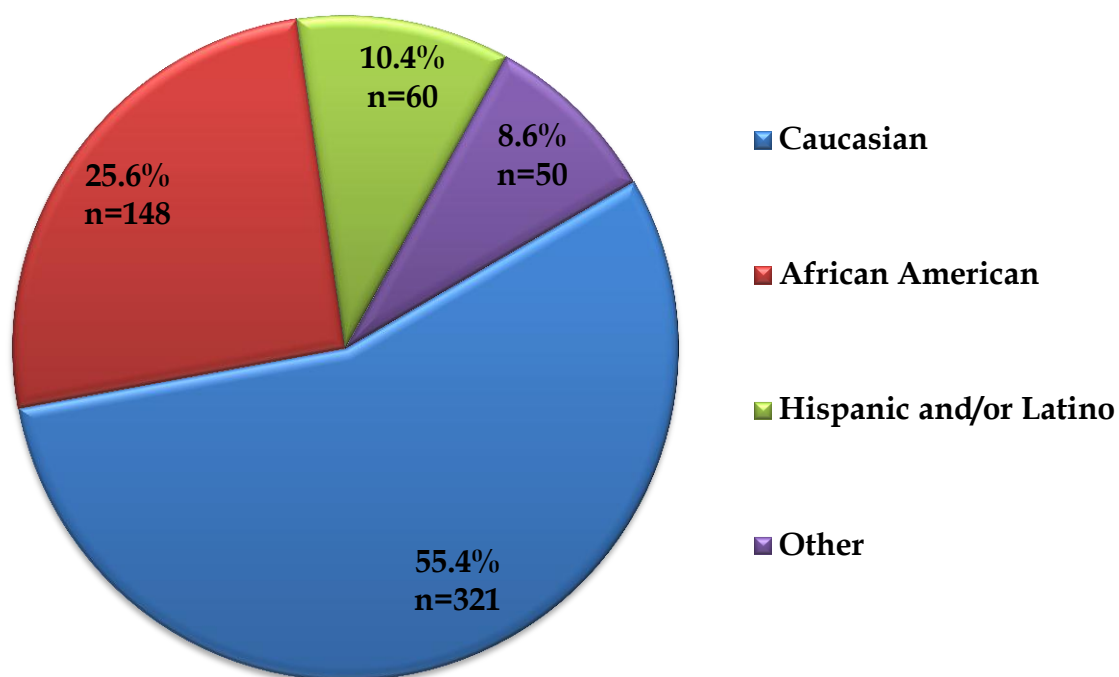
**Table 38. Frequency of age of juveniles evaluated by category**

	Frequency	Percent
Between 4 and 9 years	40	6.8
Between 10 and 14 years	255	43.5
Between 15 and 17 years	291	49.7
Total	586	100.0

► About half (55.0%, n=321) of the juveniles evaluated were female and half (45.0%, n=263) were male.

► About half (55.4%, n=321) of the juveniles were Caucasian, and one-fourth (25.6%, n=148) were African American. See Figure 33 and Table 39.

**Figure 33. Race/ethnic distribution of juveniles**



**Table 39. Race/ethnic distribution of juveniles**

	Frequency	Percent
Caucasian	321	55.4
African American	148	25.6
Hispanic and/or Latino	60	10.4
Asian and/or Pacific Islander	9	1.6
Native American	2	0.3
Other (not specified)	3	0.5
Multiracial	36	6.2
<b>Total</b>	<b>579</b>	<b>100.0</b>

### *Living Situation of Juveniles*

► Nine out of 10 (91.1%, n=535) juveniles were living with family at the time of the evaluation. None of the juveniles evaluated lived alone. See Figure 34 and Table 40.

**Figure 34. Living situation of juveniles**

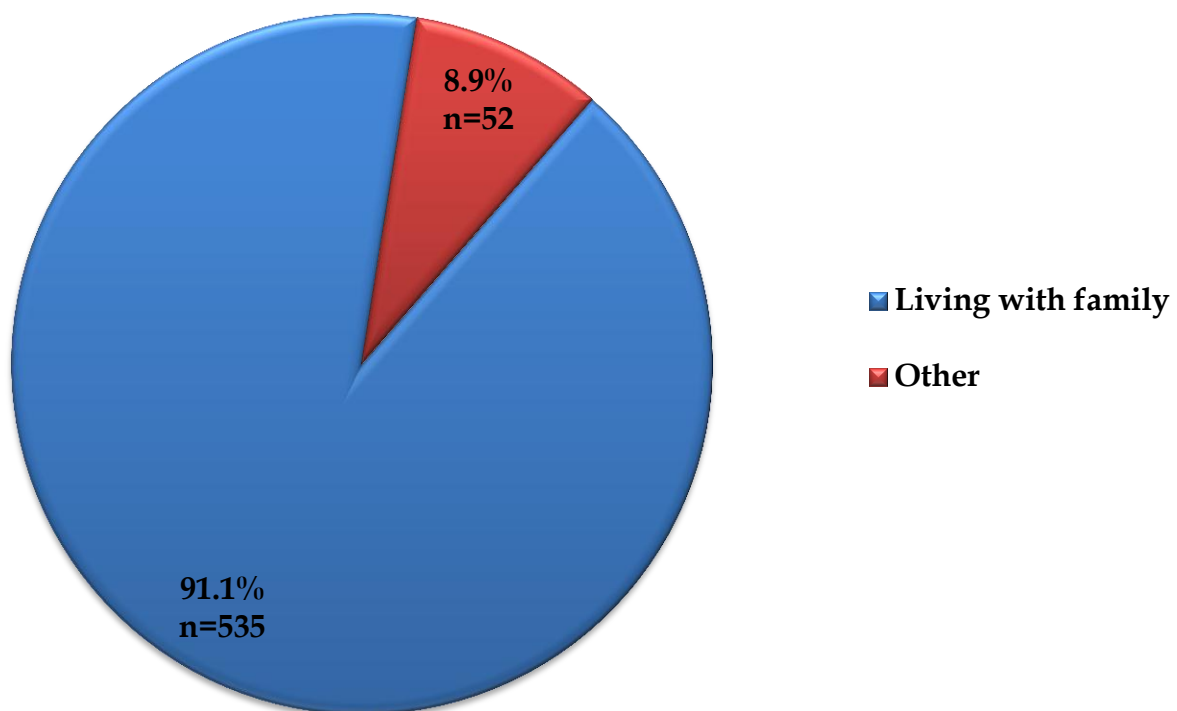


Table 40. Living situation of juveniles

	Frequency	Percent
Living with family	535	91.0
Foster care	22	3.7
Living with support (e.g., group home, supervised living)	14	2.4
Homeless/recently un-domiciled	2	0.3
Living with non-related others	5	0.9
Other (e.g., school)	9	1.5
Don't know	1	0.2
Total	587	100.0

### Current Treatment of Juveniles

► One out of three (31.9%, n=187) juveniles were not receiving treatment at the time of the emergency evaluation. Twenty-eight percent (n=164) of juveniles were currently receiving treatment from a CSB (either by itself or in conjunction with another source of treatment), compared with 29.6% of adults. Twenty-seven percent of juveniles were currently receiving treatment from a private practitioner. See Figure 35 and Table 41.

Figure 35. Sources of current treatment of juveniles

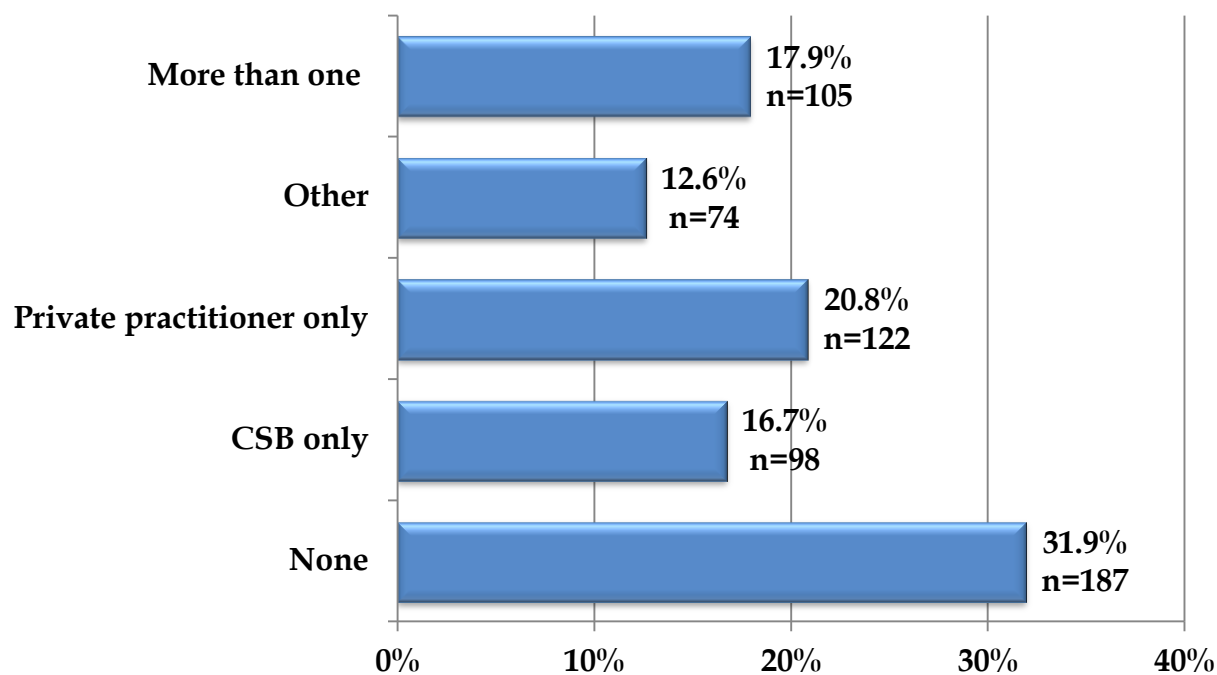


Table 41. Sources of current treatment of juveniles

	Frequency	Percent
None	187	31.9
CSB only	98	16.7
Private practitioner only	122	20.8
More than one	105	17.9
Other:		
School services	27	4.6
Other community agency	19	3.2
Private/community psych facility	20	3.4
Non-psychiatric private/community facility	4	0.7
Probation	2	0.3
Safety plan or residential treatment	2	0.3
Total	586	100.0

### *Insurance Status of Juveniles*

► Only 8% (n=46) of juveniles did not have health insurance at the time of the emergency evaluation, compared to 36.2% (n=1,978) of adults. See Figure 36 and Table 42.

Figure 36. Insurance status of juveniles

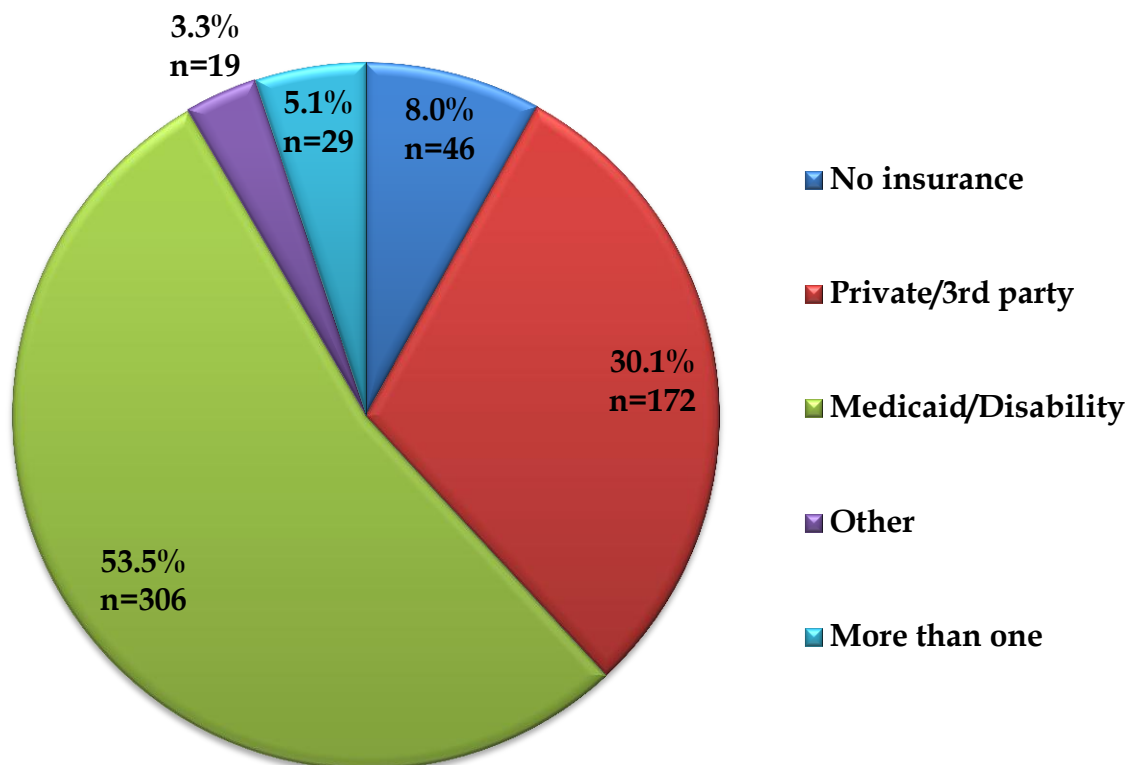


Table 42. Insurance status of juveniles

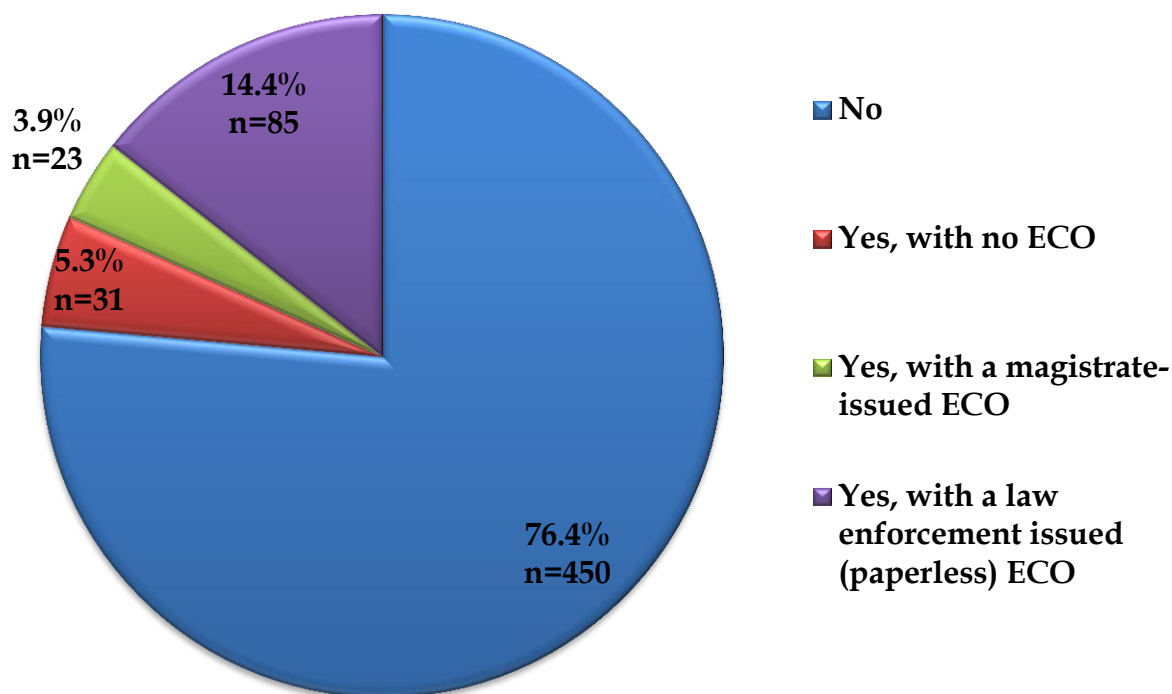
	Frequency	Percent
No insurance	46	7.8
Private/3rd party	172	29.2
Medicaid/Disability	306	52.0
Other	19	3.2
More than one	29	4.9
Don't know/not sure	17	2.9
Total	589	100.0

## Pathways to CSB Crisis Response System

### *Juveniles in Police Custody at Time of Evaluation*

► One-quarter (23.6%, n=139) of juveniles were in police custody at the time of the emergency evaluation. See Figure 37 and Table 43.

Figure 37. Juveniles in police custody at the time of evaluation



**Table 43 . Juvenile 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	450	1	9	8	1	
Yes, with no ECO	31	9				
Yes, with magistrate issued ECO	23	9			7	6
Yes, with law enforcement issued (paperless) ECO	85	36			12	11
<b>Total</b>	<b>589</b>	<b>55</b>	<b>9</b>	<b>8</b>	<b>20</b>	<b>17</b>

► Of the cases in which an ECO extension was granted (n=17), the extension provided sufficient time to complete the evaluation in 41.2% (n=7) of cases, the extension provided sufficient time to complete the medical screening in 41.2% (n=7) of cases, and the extension provided sufficient time to locate a bed in 82.4% (n=14) of cases. See Table 44.

**Table 44. 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 granted
Not in police custody				
Yes, with no ECO				
Yes, with magistrate issued ECO	2	2	5	6
Yes, with law enforcement issued (paperless) ECO	5	5	9	11
<b>Total</b>	<b>7</b>	<b>7</b>	<b>14</b>	<b>17</b>

### *Contacting the CSB for Juvenile Emergency Evaluations*

► CSB emergency evaluations were most often initiated by hospital staff, followed by friend/family member and law enforcement. See Figure 38 and Table 45.

Figure 38. Contacting CSB for emergency evaluations

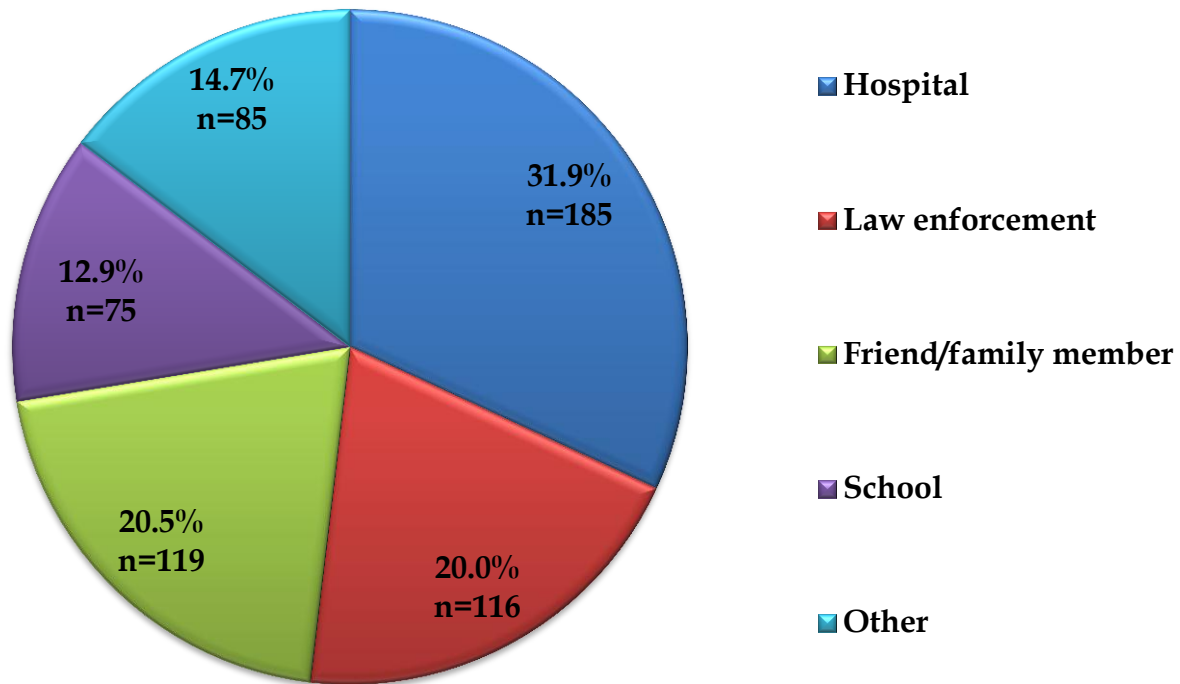


Table 45. Contacting CSB for emergency evaluations

	Frequency	Percent
Hospital	185	31.9
Law enforcement	116	20.0
Client himself/herself	3	0.5
Clinician	32	5.5
Friend/family member	119	20.5
Other (e.g., Legal Aid)	33	5.7
School	75	12.9
More than one	17	2.9
Total	580	100.0

#### *Location of Juvenile Emergency Evaluations*

► Approximately half (46.5%, n=273) of juvenile emergency evaluations took place at a hospital, compared to 62.9% of adult emergency evaluations. See Table 46.

**Table 46. Location of the emergency evaluation**

	Frequency	Percent
Hospital Emergency Department	233	39.7
CSB	252	42.9
Juvenile's home	8	1.4
Public location	3	0.5
Hospital psychiatric unit	34	5.8
Police station	17	2.9
Magistrate's office	1	0.2
Other:		
CIT officer	5	0.9
Adolescent facility	19	3.2
Hospital	6	1.0
Court intake and probation	2	0.3
Treatment program	5	0.9
Other program	2	0.3
<b>Total</b>	<b>587</b>	<b>100.0</b>

#### *Day and Time of the Juvenile Emergency Evaluations*

► Juvenile emergency evaluations were most likely to occur on weekdays rather than the weekend. See Figure 39 and Table 47.

**Figure 39. Day of the week the emergency evaluations occurred**

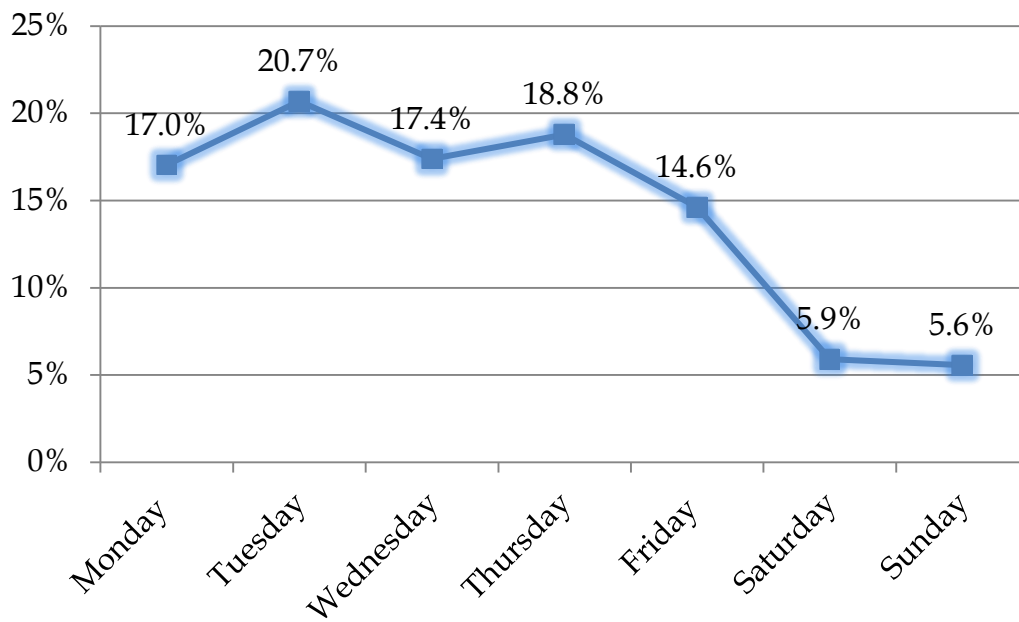
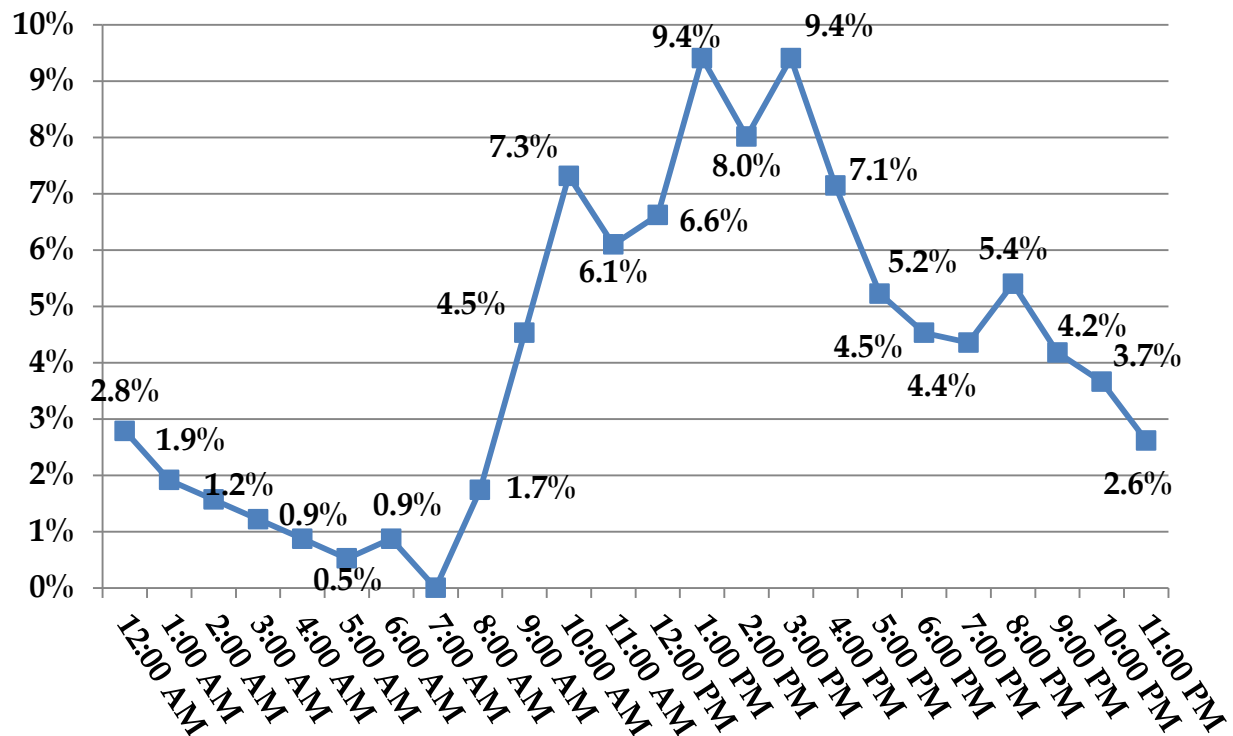


Table 47. Day of the week the emergency evaluations occurred

	Frequency	Percent
Monday	98	17.0
Tuesday	119	20.7
Wednesday	100	17.4
Thursday	108	18.8
Friday	84	14.6
Saturday	34	5.9
Sunday	32	5.6
Total	575	100.0

► Juvenile emergency evaluations were most likely to occur during standard work hours (i.e., between 9 a.m. and 5 p.m.). See Figure 40.

Figure 40. Time of day the emergency evaluation occurred



► The average length of time of a juvenile emergency evaluation was 2 hours and 9 minutes ( $sd=1:55$ ), ranging from 20 minutes to over 16 hours. Nine out of 10 (93.1%,  $n=535$ ) juvenile evaluations were completed within 4 hours. See Figure 41 and Table 48.

Figure 41. Length of emergency evaluation

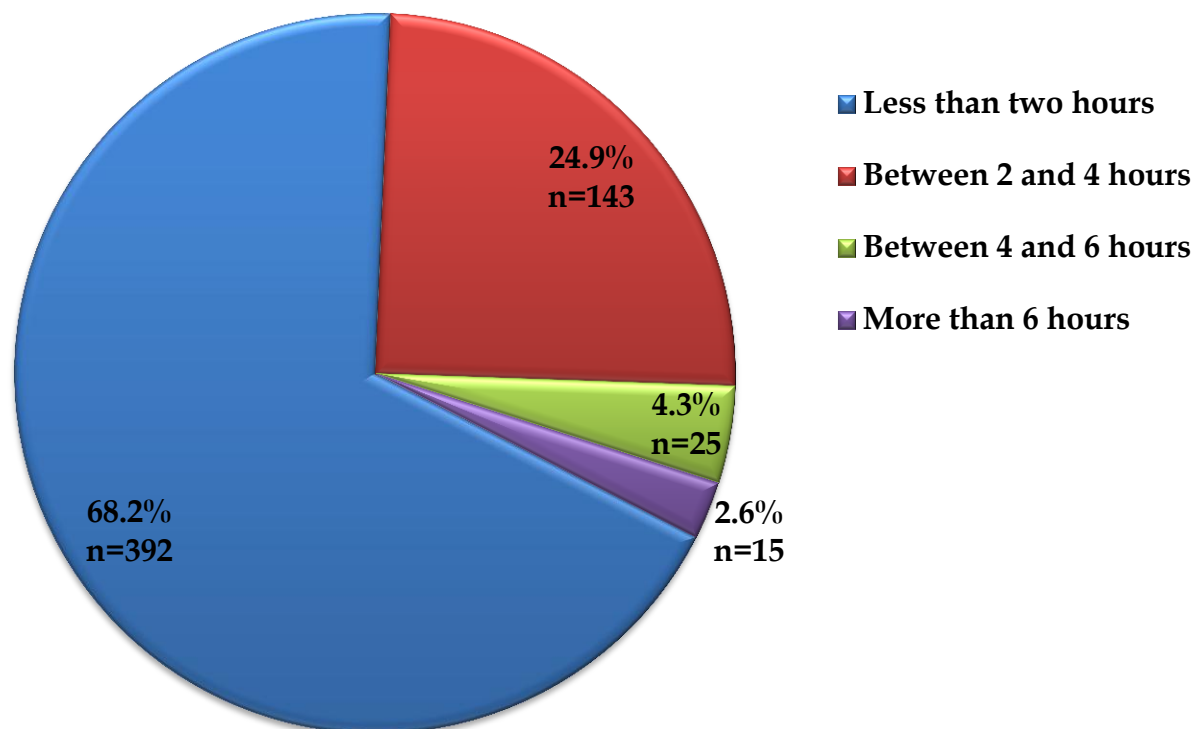


Table 48. Length of juvenile emergency evaluation

	Frequency	Percent
One hour or less	163	28.3
Between 1 and 2 hours	229	39.8
More than 2 to 3 hours	89	15.5
More than 3 to 4 hours	54	9.4
More than 4 to 5 hours	14	2.4
More than 5 to 6 hours	11	1.9
More than 6 to 9 hours	6	1.0
More than 9 to 12 hours	1	0.2
More than 12 to 15 hours	6	1.0
More than 15 to 18 hours	2	0.3
Total	575	100.0

#### *Sources of Information Available to Clinician Prior to the Juvenile Evaluation*

► On average, the clinician had two sources of information available prior to the evaluation (*average*=2.2, *sd*=1.2), ranging from none to seven sources. The two most common sources of information available to the clinician prior to the juvenile evaluation were friend/family members and CSB records. See Figure 42 and Table 49.

Figure 42. Sources of information that the clinician had prior to the juvenile evaluation

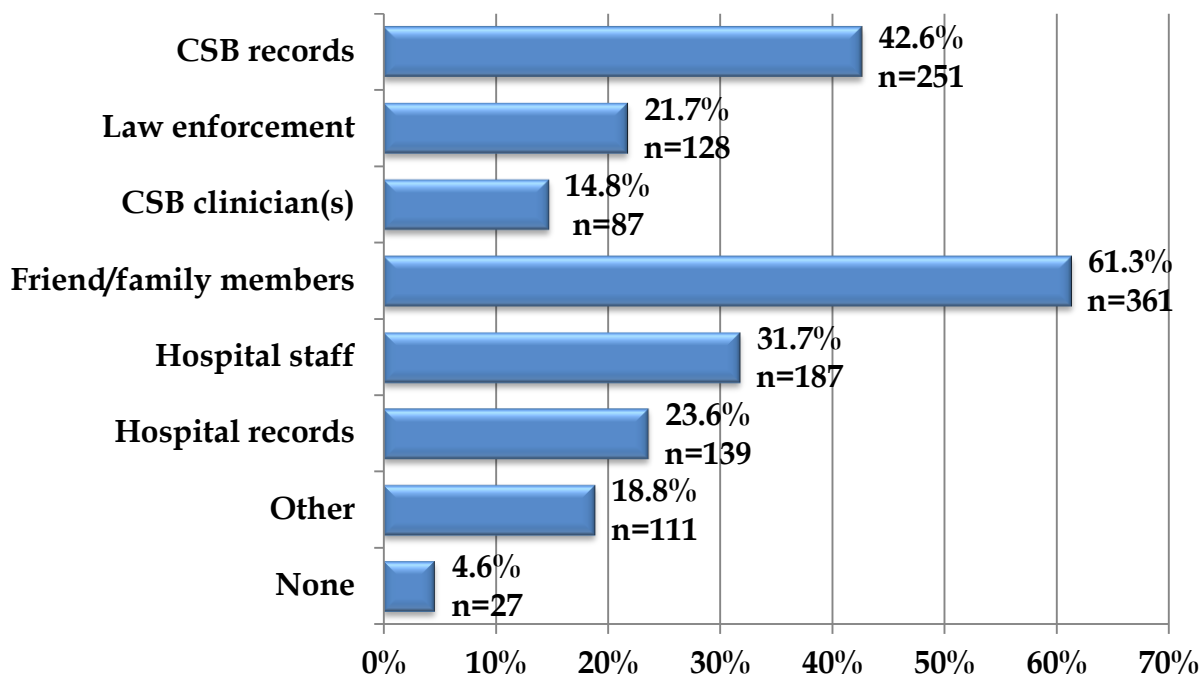


Table 49. Sources of information that the clinician had prior to the juvenile evaluation

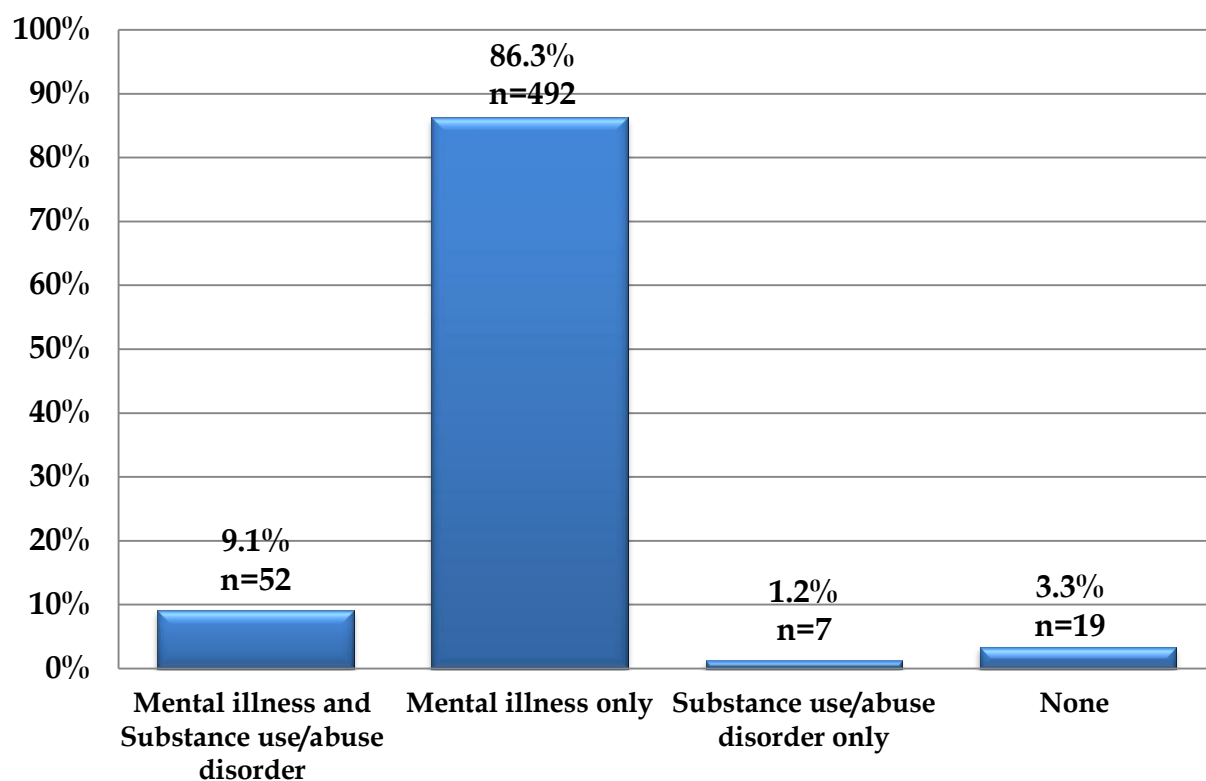
	Frequency	Percent
CSB records	251	42.6
Law enforcement	128	21.7
CSB clinician(s)	87	14.8
Friend/family members	361	61.3
Hospital staff	187	31.7
Hospital records	139	23.6
None	27	4.6
Other:		
Other providers	63	10.7
Other clinical records	20	3.4
School	22	3.7
Department of Social Services	4	0.7
Other non-clinician records	2	0.3
Total	589	100.0

## Clinical Presentation of Juveniles

### *Presentation at Time of Juvenile Emergency Evaluations*

► In 92.7% (n=544) of cases, the juvenile presented with symptoms of mental illness, either alone or co-occurring with symptoms of substance use/abuse disorder. Overall, 83.8% (n=492) of juveniles presented with mental illness but no substance use/abuse disorder, 1.2% (n=7) of juveniles presented with substance use/abuse disorder but no mental illness, and 8.9% (n=52) of the juveniles presented with both mental illness and substance use/abuse disorder. See Figure 43 and Table 50.

**Figure 43. Juvenile's presentation at time of evaluation**



**Table 50. Juvenile's presentation at the time of the evaluation**

	Frequency	Percent
Mental illness and Substance use/abuse disorder	52	8.9
Mental illness only	492	83.8
Substance use/abuse disorder only	7	1.2
None	19	3.2
Other	17	2.9
Total	587	100.0

### *Juveniles Under the Influence of Substances*

► About six percent (5.8%, n=34) of juveniles were under the influence or suspected to be under the influence of drugs or alcohol at the time of the emergency evaluation. See Table 51.

**Table 51. Juveniles presenting under the influence or suspected of being under the influence**

	Frequency	Percent
Under the influence of drugs or alcohol	20	3.4
Suspected of being under the influence of drugs or alcohol	14	2.4
Not under the influence of drugs or alcohol	541	91.9
Unknown	14	2.4
Total	589	100.0

### *Juveniles Presenting Psychotic Symptoms*

► Of the 544 juveniles who presented with a mental illness, 10.5% (n=57) also showed psychotic symptoms. About one out of 10 (9.9%, n=58) of juveniles presented with psychotic symptoms, compared to 30.9% of adults. See Table 52.

**Table 52. Juveniles Presenting Psychotic Symptoms**

	Frequency	Percent
Psychotic symptoms	58	9.9
No psychotic symptoms	527	90.1
Total	585	100.0

### *Displays by Evaluated Juveniles of Behaviors Bearing on Involuntary Commitment Criteria*

► In one out of four (26.8%, n=158) cases, the clinician reported that the juvenile did not show behavioral indicators of risk bearing on the civil commitment criteria. See Figure 44 and Tables 53-54.

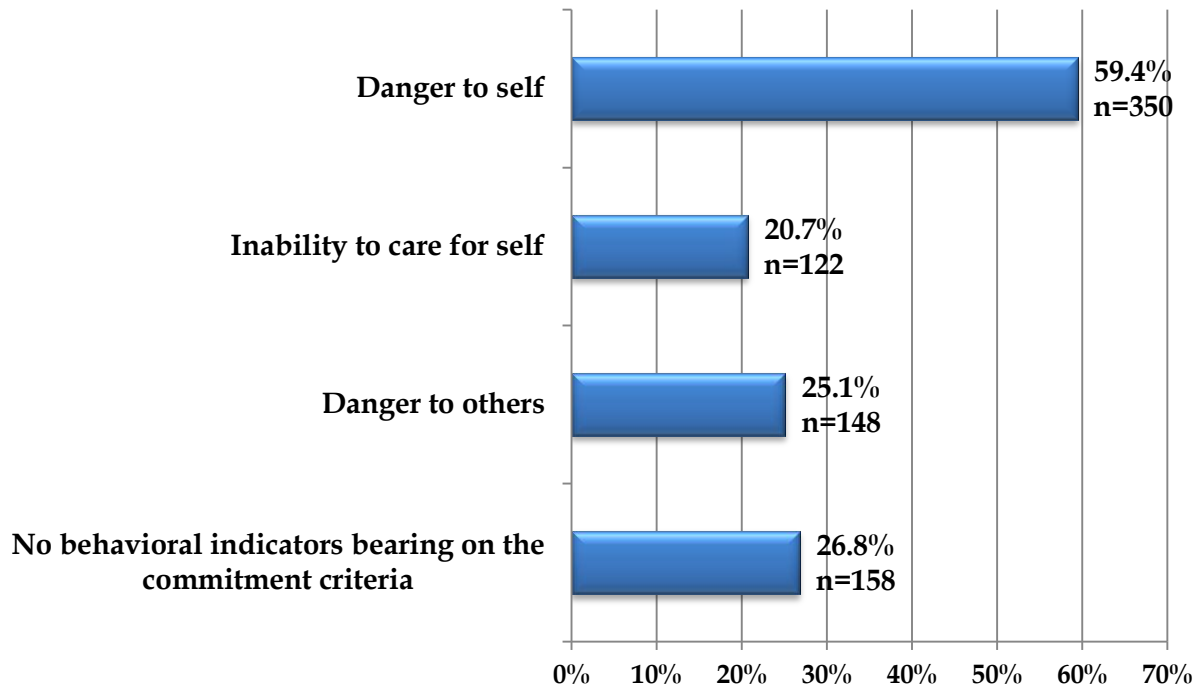
► Six out of 10 (59.4%, n=351) juveniles evaluated presented an elevated risk of danger to self. See Figures 44-45 and Tables 53-54. A higher rate of danger to self was found in juveniles (59.4%) than in adults (52.7%).

► One out of four (24.8%, n=146) juveniles evaluated presented an elevated risk of danger to others. See Figures 44-45 and Tables 53-54. A higher rate of danger to others was found in juveniles (24.8%) than in adults (20.6%).

► Two out of 10 (20.5%, n=121) juveniles evaluated presented an inability to care for self in a developmentally age appropriate manner. See Figures 44-5 and Tables 53-54. A lower rate of inability to care for self was found in juveniles (20.5%) than in adults (37.3%).

Clinicians reported in three separate questions whether or not the evaluated juvenile revealed recent behaviors or symptoms as shown in the available records or during the juvenile interview that had a bearing on the commitment criteria. A juvenile evaluated could meet one or more of the commitment criteria. Therefore, these responses are not mutually exclusive. See Figure 44-45 and Table 53-54.

**Figure 44. Displays by evaluated juveniles of behaviors bearing on involuntary commitment criteria**



**Table 53. Displays by evaluated juveniles of behaviors bearing on involuntary commitment criteria**

	Frequency	Percent
Danger to self	351	59.6
Inability to care for self	121	20.5
Danger to others	146	24.8
No behavioral indicators bearing on the commitment criteria	158	26.8
Total	589	100.0

Figure 45. Displays by evaluated juveniles of behaviors bearing on involuntary commitment criteria, combinations

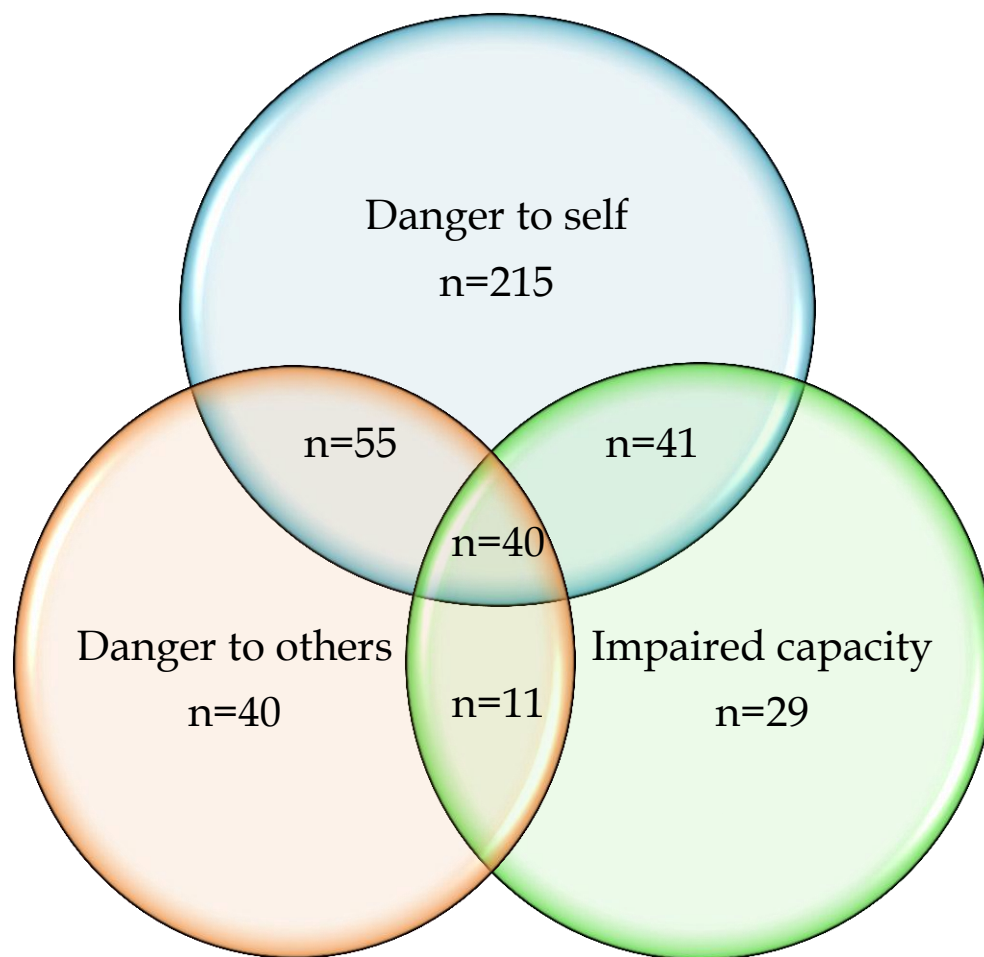


Table 54. Displays by evaluated juveniles of behaviors bearing on involuntary commitment criteria, combinations

	Frequency	Percent
No indicators displayed	158	26.8
Danger to self only	215	36.5
Danger to others only	40	6.8
Inability to care for self only	29	4.9
Danger to self and Danger to others only	55	9.3
Danger to self and Inability to care for self only	41	7.0
Danger to others and Inability to care for self only	11	1.9
Danger to self, Danger to others, and Inability to care for self only	40	6.8
Total	589	100.0

► Of the cases in which the juvenile presented an elevated risk of danger to self (n=351), 15.4% (n=54) ingested pills or poison, 18.2% (n=64) injured self with a sharp object, and 15.4% (n=54) demonstrated other self-injurious behavior. See Figure 46 and Table 55.

Figure 46. Behaviors indicating an elevated risk of danger to self

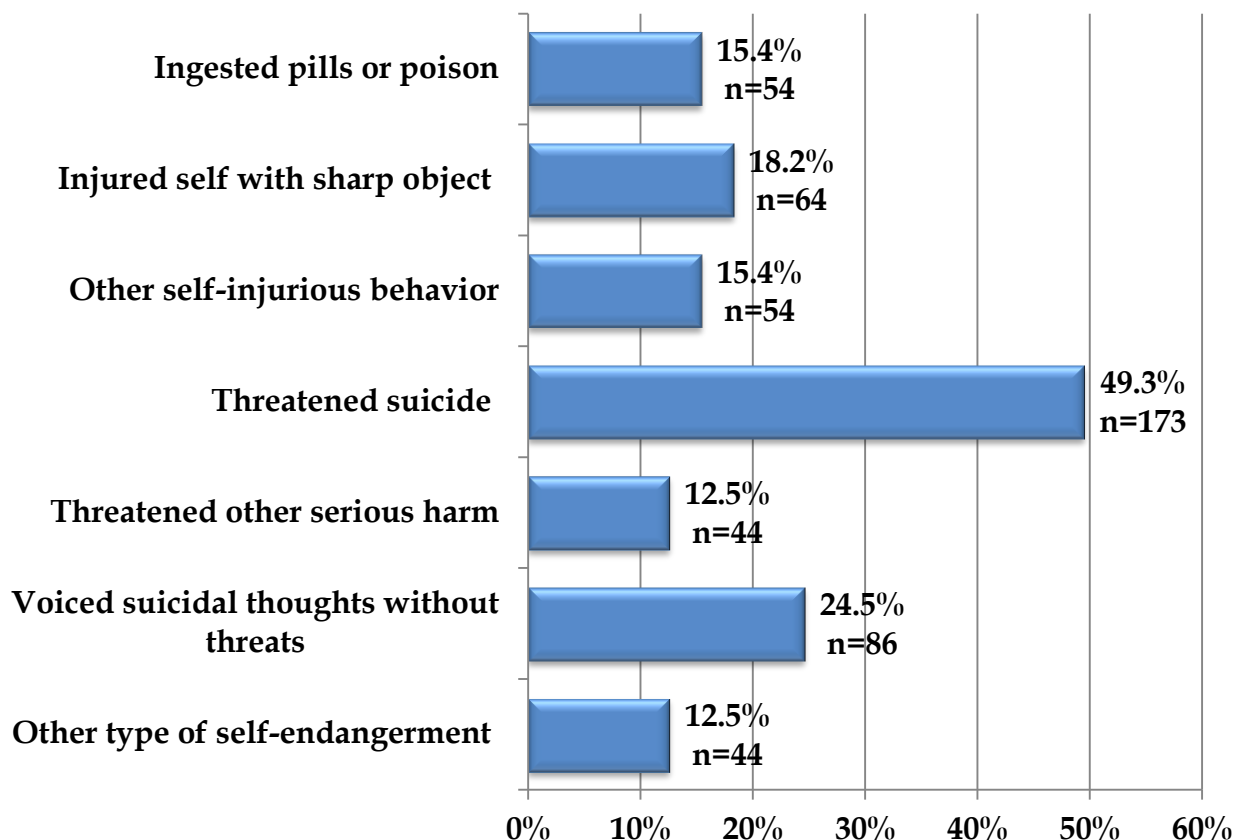


Table 55. Behaviors indicating an elevated risk of danger to self

	Frequency	Percent
Ingested pills or poison	54	15.4
Injured self with sharp object	64	18.2
Other self-injurious behavior	54	15.4
Threatened suicide	173	49.3
Threatened other serious harm	44	12.5
Voiced suicidal thoughts without threats	86	24.5
Other type of self-endangerment	44	12.5
Total	351	100.0

► Of the cases in which the juvenile presented an elevated risk of danger to others (n=146), 17.1% (n=25) injured someone and 29.5% (n=43) hit, kicked, or pushed someone without injury. See Figure 47 and Table 56.

Figure 47. Behaviors indicating an elevated risk of danger to others

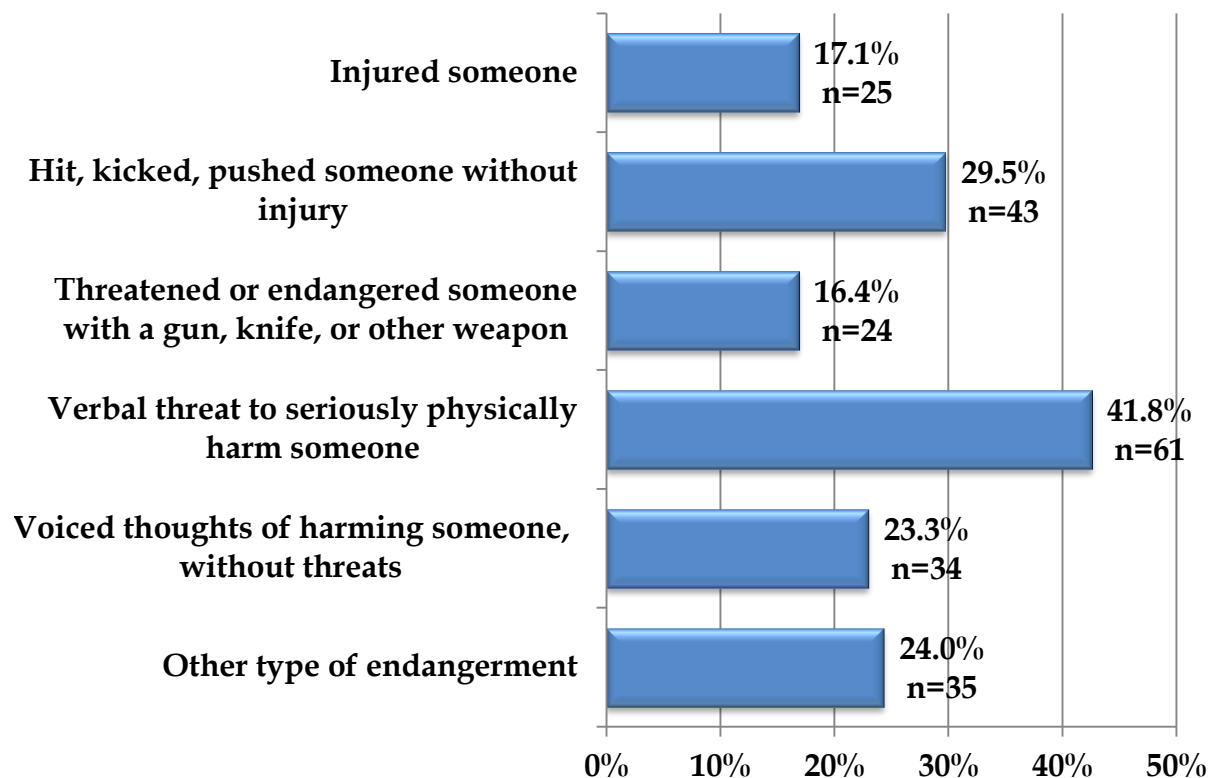


Table 56. Behaviors indicating an elevated risk of danger to others

	Frequency	Percent
Injured someone	25	17.1
Hit, kicked, pushed someone without injury	43	29.5
Threatened or endangered someone with a gun, knife, or other weapon	24	16.4
Verbal threat to seriously physically harm someone	61	41.8
Voiced thoughts of harming someone, without threats	34	23.3
Other type of endangerment	35	24.0
<b>Total</b>	<b>146</b>	<b>100.0</b>

► Only 3.4% (n=20) of juveniles were determined to have owned or had access to a firearm. In 83.0% (n=489), the juvenile was determined to not own or have access to a firearm. In the remaining 13.6% (n=80) of cases, the clinician was unable to determine whether the juvenile had access to firearms.

► Of the cases in which the client presented an inability to care for self in a developmentally age appropriate manner (n=121), 77.7% (n=94) presented with an impairment in self-control. See Figure 48 and Table 57.

Figure 48. Behaviors/symptoms indicating an inability to care for self

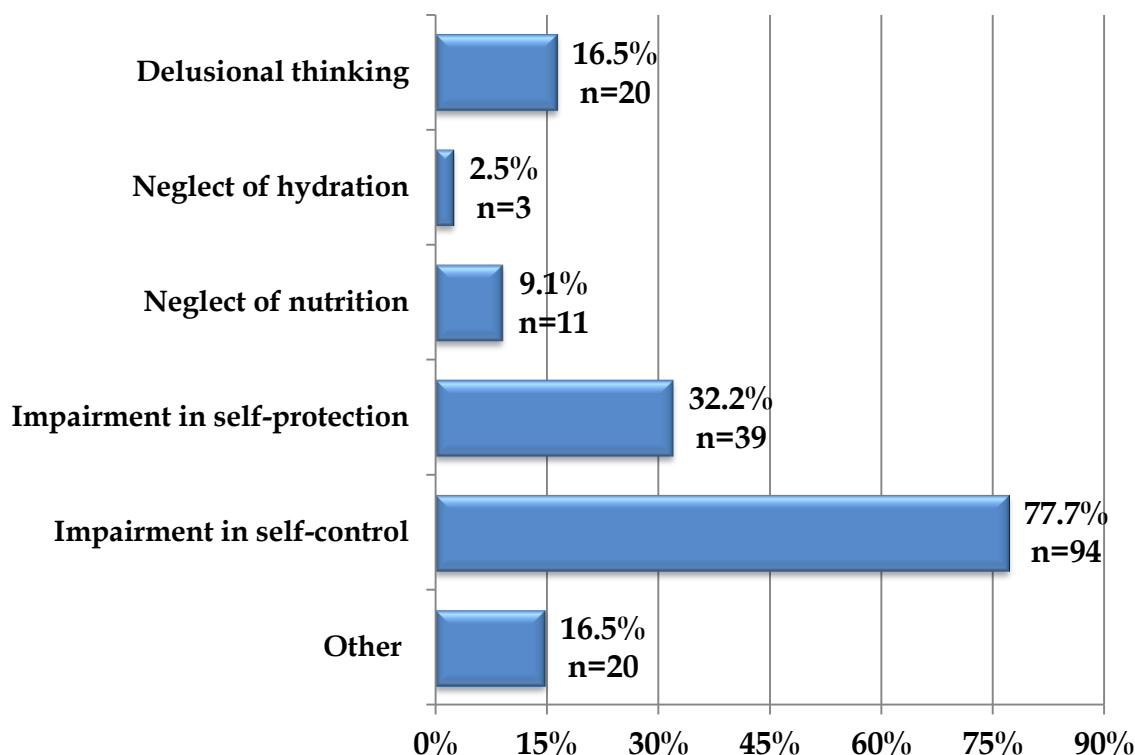


Table 57. Behaviors/symptoms indicating an inability to care for self

	Frequency	Percent
Delusional thinking	20	16.5
Neglect of hydration	3	2.5
Neglect of nutrition	11	9.1
Impairment in self-protection	39	32.2
Impairment in self-control	94	77.7
Other	20	16.5
<b>Total</b>	<b>121</b>	<b>100.0</b>

► In 94.8% (n=533) of emergency evaluations, the juvenile's parent(s) or guardian(s) were consulted. In 2.5% (n=14) of cases, the juvenile's parent(s) or guardian(s) was unable to be contacted, and in 2.7% (n=15) of cases, the juvenile's parent(s) or guardian(s) was not contacted.

► In cases where the juvenile's parent(s) or guardian(s) was consulted, 60.2% (n=320) were willing to approve any proposed admission. In one out of ten (9.8%, n=52) cases, parent(s) and guardian(s) were not willing to approve admission. In the remaining 30.1% (n=160) of cases, clinicians reported that the question did not apply; suggesting that admission for treatment was not needed.

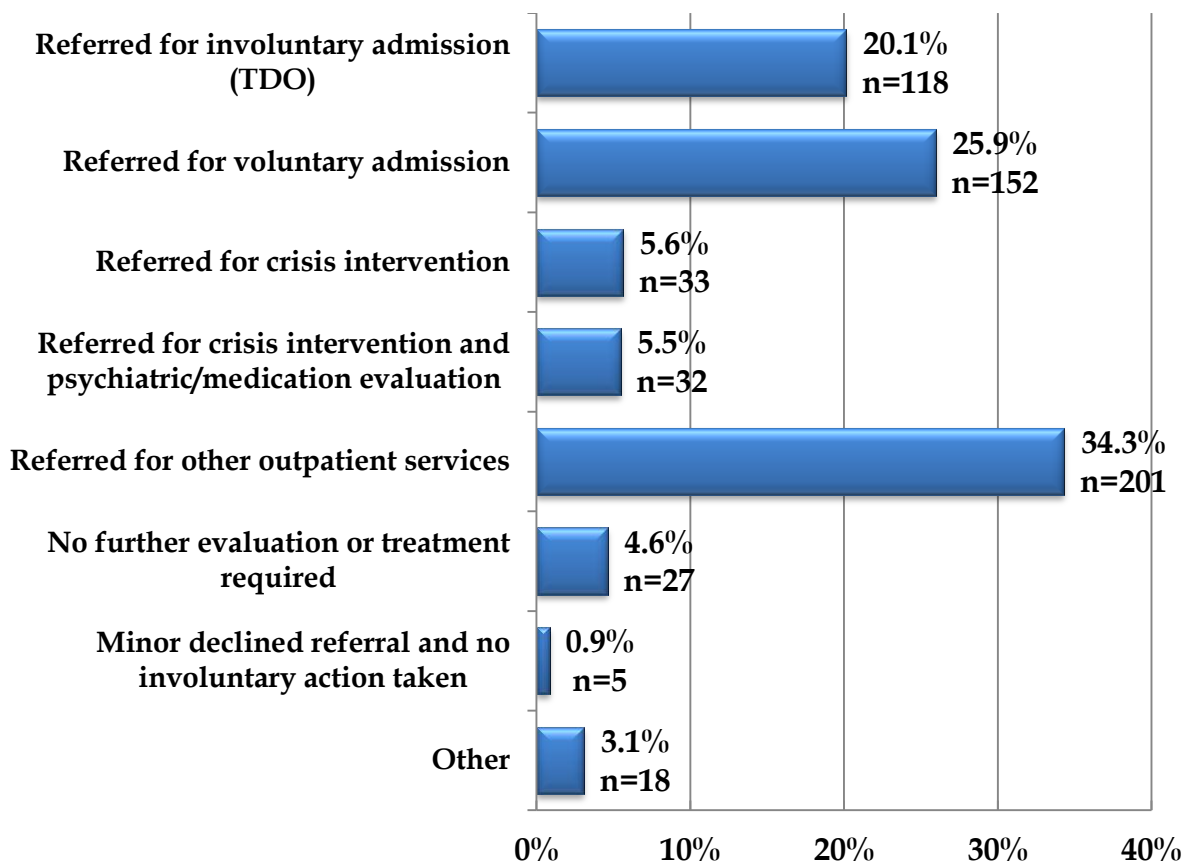
► In almost three out of ten cases (31.4%, n=176), the juvenile's treating or examining physician was consulted. In almost half of the cases (49.2%, n=276), the juvenile's treating or examining clinician was not consulted. In the remaining 19.4% (n=109) of cases, clinician's reported that the question did not apply.

## Disposition After Juvenile Emergency Evaluations

### *Type of Action Recommended by the CSB Clinician for Juveniles*

► Involuntary action was recommended to a magistrate in 20.1% (n=118) of cases. Referral for other outpatient services was the most common recommendation (34.3%, n=201). See Figure 49 and Table 58.

Figure 49. Clinician recommended dispositions



**Table 58. Clinician recommended dispositions**

	Frequency	Percent
Referred for involuntary admission (TDO)	118	20.1
Referred for voluntary admission	152	25.9
Referred for crisis intervention	33	5.6
Referred for crisis intervention and psychiatric/medication evaluation	32	5.5
Referred for other outpatient services	201	34.3
No further evaluation or treatment required	27	4.6
Juvenile declined referral and no involuntary action taken	5	0.9
Other:		
Referred for objecting juvenile admission by parent/guardian	5	0.9
Released to family no bed	2	0.3
In home service	1	0.2
Protective services	1	0.2
Released with safety plan	5	0.9
Detention	2	0.3
Youth shelter	2	0.3
<b>Total</b>	<b>586</b>	<b>100.0</b>

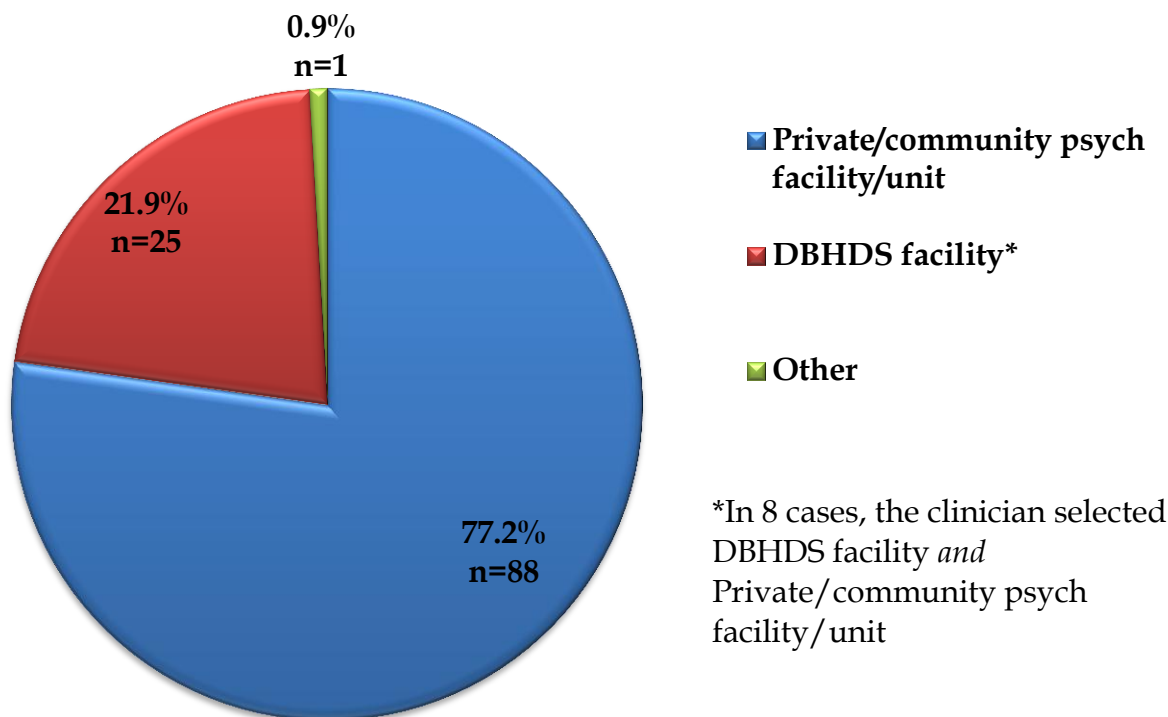
#### *Outcome When Involuntary Action Was Recommended*

► Among cases in which involuntary admission was recommended by the clinician (n=118), a Temporary Detention Order (TDO) was granted 97.5% (n=115) of the time. For the three cases in which the TDO was not granted, the answer was not available by the end of the survey.

► Among cases in which a TDO was granted (n=115), the individual was admitted to a facility 96.6% (n=114) of the time. For the one case in which the TDO was granted but the juvenile was not admitted to the facility, the clinician reported that the juvenile required a medical evaluation or treatment.

► In about eight of 10 (77.2%, n=88) 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 50.

**Figure 50. Facilities where juveniles were admitted after a TDO was granted (n=114)**



► Only 1 case of TDOs was reported NOT to have been granted due to juvenile require medical evaluation or treatment. See Appendix 6 for an overview of cases in which a TDO was recommended.

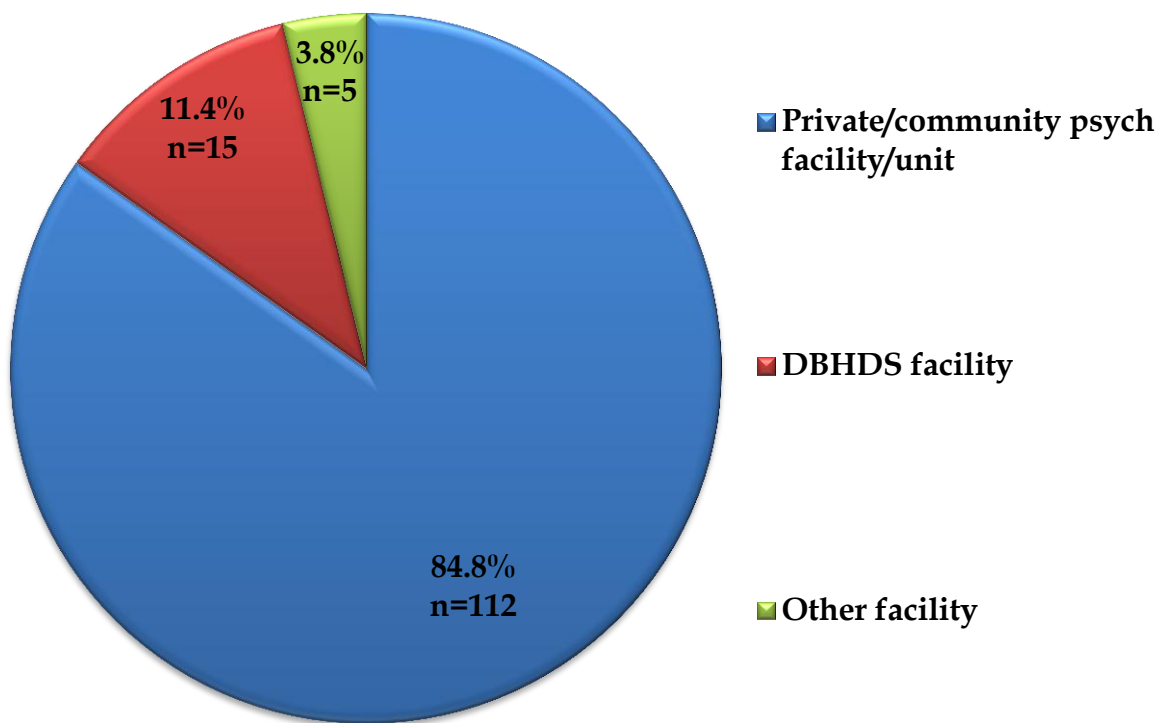
Information in Appendix 6 is based solely on the questionnaire responses received by the end of the survey month. There were three cases in which the “information was not available at the time of the study” due to a number of reasons (e.g. the evaluation was still in process at the end of the month when data collection ended or the case was not yet resolved).

#### *Outcome When Voluntary Admission Was Recommended*

► Among the juveniles for whom voluntary action was recommended (n=152), the vast majority (86.8%, n=132) were admitted. In 5.3% (n=8) of cases, the juvenile was not admitted, and in 2.6% (n=4) of cases, the clinician reported that admission was N/A. In the remaining 5.3% (n=8) cases, the information was not available. See Table 59.

► In about eight of 10 (84.8%, n=112) cases in which the juvenile was voluntarily admitted to a facility, he/she was admitted to a private/community psychiatric facility or unit. See Figure 51 and Table 59.

**Figure 51. Facilities where juveniles were admitted after a voluntary admission**



**Table 59. Facilities where adults were admitted after a voluntary admission**

	Frequency	Percent
DBHDS facility	15	11.4
Crisis Stabilization Unit	2	1.5
Private/community psych facility/unit	112	84.9
Residential program	1	0.8
Other facility	2	1.5
<b>Total</b>	<b>132</b>	<b>100.0</b>

Appendix 6 outlines what happened to juveniles in the cases where voluntary hospitalization was recommended but the juvenile had not been admitted at the close of the evaluation.

#### *Actions Taken to Identify a Psychiatric Bed for a Juvenile*

► In 50.0% (n=46) of cases for TDO admission to private facilities, only one hospital was called to locate a bed, compared to 62.3% (n=79) of voluntary cases. See Table 60.

**Table 60. 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	46	50.0	79	62.7
2	15	16.3	18	14.3
3	15	16.3	11	8.7
More than 3	16	17.4	18	14.3
Total	92	100.0	126	100.0

► In 100% of cases for TDO *and* voluntary admission to a state facility<sup>9</sup>, only one hospital was called to locate a bed. See Table 61.

**Table 61. Number of state facilities contacted for TDO and voluntary admissions**

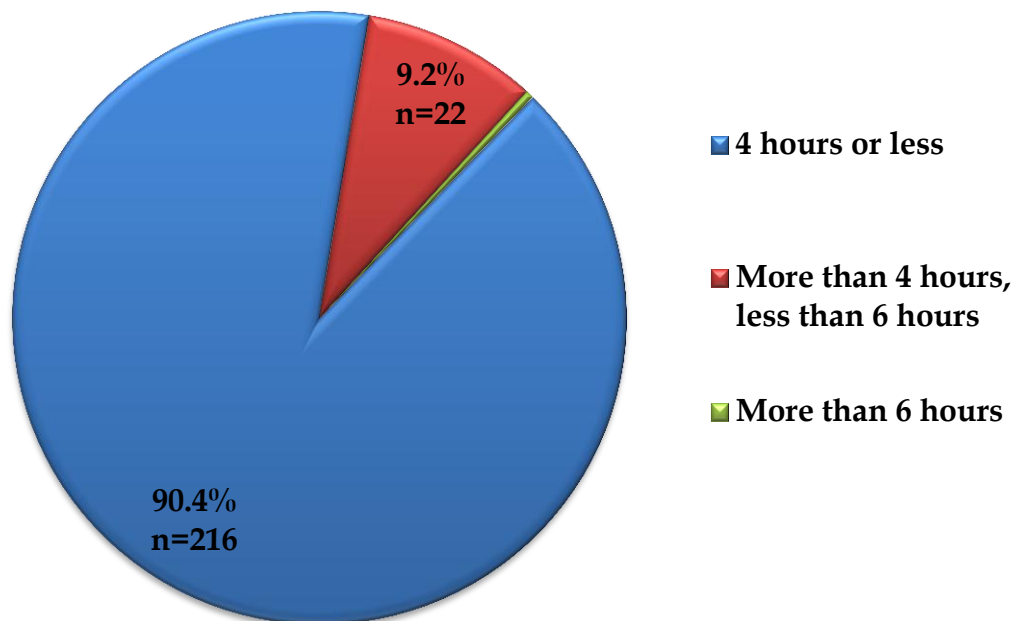
Number of state facilities contacted	Referred for involuntary admission (TDO)		Referred for voluntary admission	
	Frequency	Percent	Frequency	Percent
1	19	100.0	19	100.0
Total	19	100.0	19	100.0

### *Length of Time Locating a Psychiatric Bed*

► In 90.4% (n=216) of cases, a psychiatric bed was located within four hours. See Figure 52 and Table 62.

<sup>9</sup> There is only one state-funded psychiatric facility for minors: *Commonwealth Center for Children & Adolescents*.

**Figure 52. Time spent locating an admitting hospital with an available psychiatric bed**



**Table 62. 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	97	87.4	119	93.0	216	90.4
More than 4 hours, less than 6 hours	13	11.7	9	7.0	22	9.2
More than 6 hours	1	0.9	0	0	1	0.4
Total	111	100.0	128	100.0	239	100.0

► In 60.9% (n=70 of 115) of TDO cases, the admitted psychiatric facilities were located within the same region as the individual's residence, as compared with 64.7% (n=86 of 133) of the voluntary admission cases.

► In 47.0% of cases (n=118), a medical evaluation or treatment was required prior to hospital admission.

## Juvenile's Status at End of Emergency Evaluation Period

### *Clinician Opinions Regarding the Juvenile's Status at the End of the Evaluation<sup>10</sup>*

► At the end of the emergency evaluations, CSB clinicians found that 48.2% (n=283) of juveniles who were evaluated warranted hospitalization. See Table 63.

► In almost half (49.7%, n=292) of the cases, the clinician found that the juvenile was in need of compulsory treatment for a mental illness and was reasonably likely to benefit from the proposed treatment. See Table 63.

► At the end of the emergency evaluations, CSB clinicians found that 41.7% (n=245) of those evaluated presented a risk of danger to self, compared to 59.4% (n=350) who displayed indicators of danger to self at the onset of the evaluation. See Table 63.

Table 63. Clinician opinion regarding the juvenile's status at the end of the evaluation

	Frequency	Percent
Juvenile presented a serious danger to self to the extent that severe or irremediable injury was likely to result	245	41.7
Juvenile presented a serious danger to others to the extent that severe or irremediable injury was likely to result	114	19.4
Juvenile was experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner	107	18.2
Juvenile was experiencing severe mental or emotional distress or dysfunction	345	58.8
Juvenile was in need of compulsory treatment for a mental illness and was reasonably likely to benefit from the proposed treatment	292	49.7
Juvenile's condition warranted hospitalization	283	48.2
I would have sought involuntary action (TDO) if juvenile had refused voluntary services	171	29.1
I was able to address this person's crisis needs with the resources available to me	487	83.0
Total	587	100.0

<sup>10</sup> In this section of the instrument, clinicians were asked to rate their opinion or agreement with several statements about the minor's condition at the conclusion of the evaluation with "Yes," "No," and "N/A" response options.

► At the end of the emergency evaluations, CSB clinicians found that 19.4% (n=114) of those evaluated presented a risk of danger to others, compared to 25.1% (n=148) who displayed indicators of danger to others at the onset of the evaluation. See Table 63.

► At the end of the emergency evaluations, CSB clinicians determined that 18.2% (n=107) of those evaluated presented an inability to care for self, compared to 20.7% (n=122) who displayed indicators of danger to self at the onset of the evaluation. See Table 63.

► Clinicians determined that in only 18.7% (n=73) of cases in which the juvenile was 14 or older, the juvenile did not have the capacity to make treatment decisions; conversely, in most cases (71.3%), clinicians determined that the juvenile *did* have the capacity to make treatment decisions. See Table 64.

**Table 64. Clinician opinion regarding the juvenile’s ability to make treatment decisions at the end of the evaluation<sup>11</sup>**

	Frequency	Percent
Juvenile lacked ability to maintain and communicate choice	32	43.8
Juvenile lacked ability to understand relevant information	32	43.8
Juvenile lacked ability to understand consequences	46	63.0
Total: Juvenile 14 or older <sup>12</sup> lacked the capacity to make treatment decisions	73	100.0

Figure 53 shows clinician opinion after recoding into four mutually exclusive categories that connects perceived clinical severity of the juvenile’s condition with the commitment criteria:

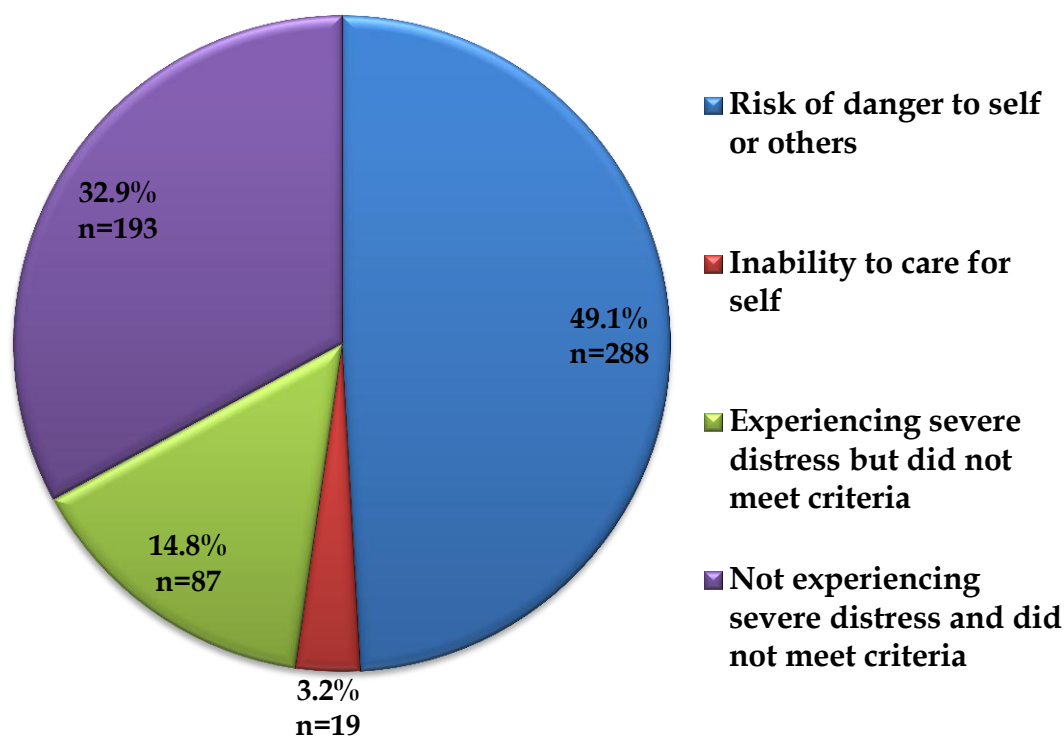
- (1) Any juvenile who was found to be at risk of danger to self or danger to others, even if such persons also exhibited an inability to care for self, was recoded into the “Danger to self or others” category.
- (2) After removing juveniles who were determined to be at risk of danger to self or danger to others, the remaining cases were recoded. The category of “inability to care for self” includes juveniles who exhibited an inability to care for self.
- (3) Once the juveniles above were excluded, cases remained including those who were not assessed by the clinician to meet the commitment criteria (i.e., danger to self, danger to others, and inability to care for self). These were recoded into two categories:

<sup>11</sup> Clinicians were instructed to answer the three additional questions (indented to the right within Table 64 only if they opined that the minor lacked the capacity to make treatment decisions.

<sup>12</sup> There were 391 minors who were age 14 or older; only 73 of them (18.7%) lack the capability to make treatment decisions. Capacity assessment was not legally required for the 196 minors who were under 14 years old.

- a. Cases in which juveniles 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 53. Clinician opinion at the conclusion of the evaluation (n=587)**



## Problems in Accessing Services for Juveniles

### *Services/Resources That Would Have Helped Address Juveniles' Needs*

► In 47.9% (n=273) of cases the clinician needed additional services to address the client needs better. Immediate 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 54 and Table 65.

Figure 54. Services/resources that would have helped the clinician better address the client's needs (n=273)

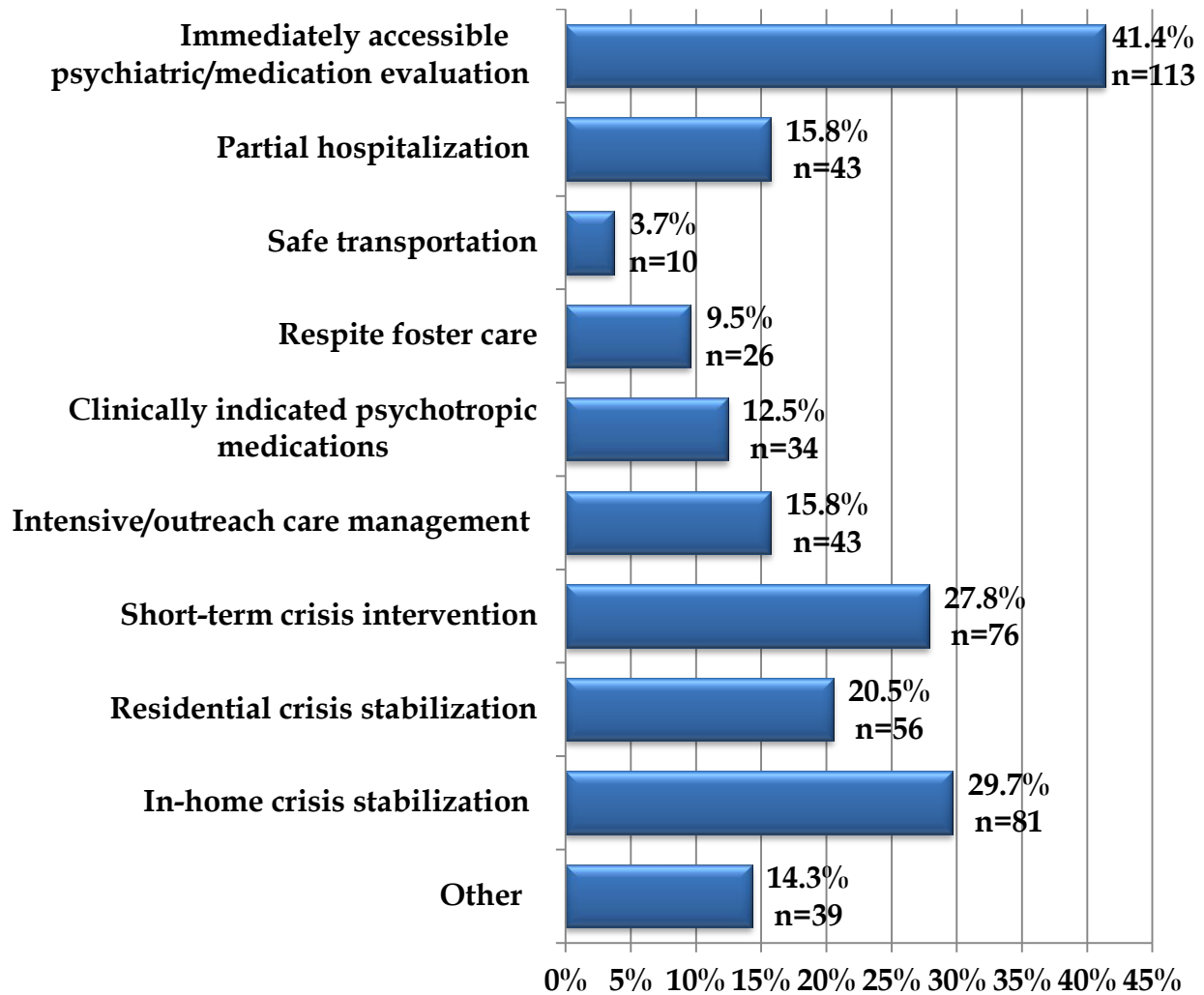


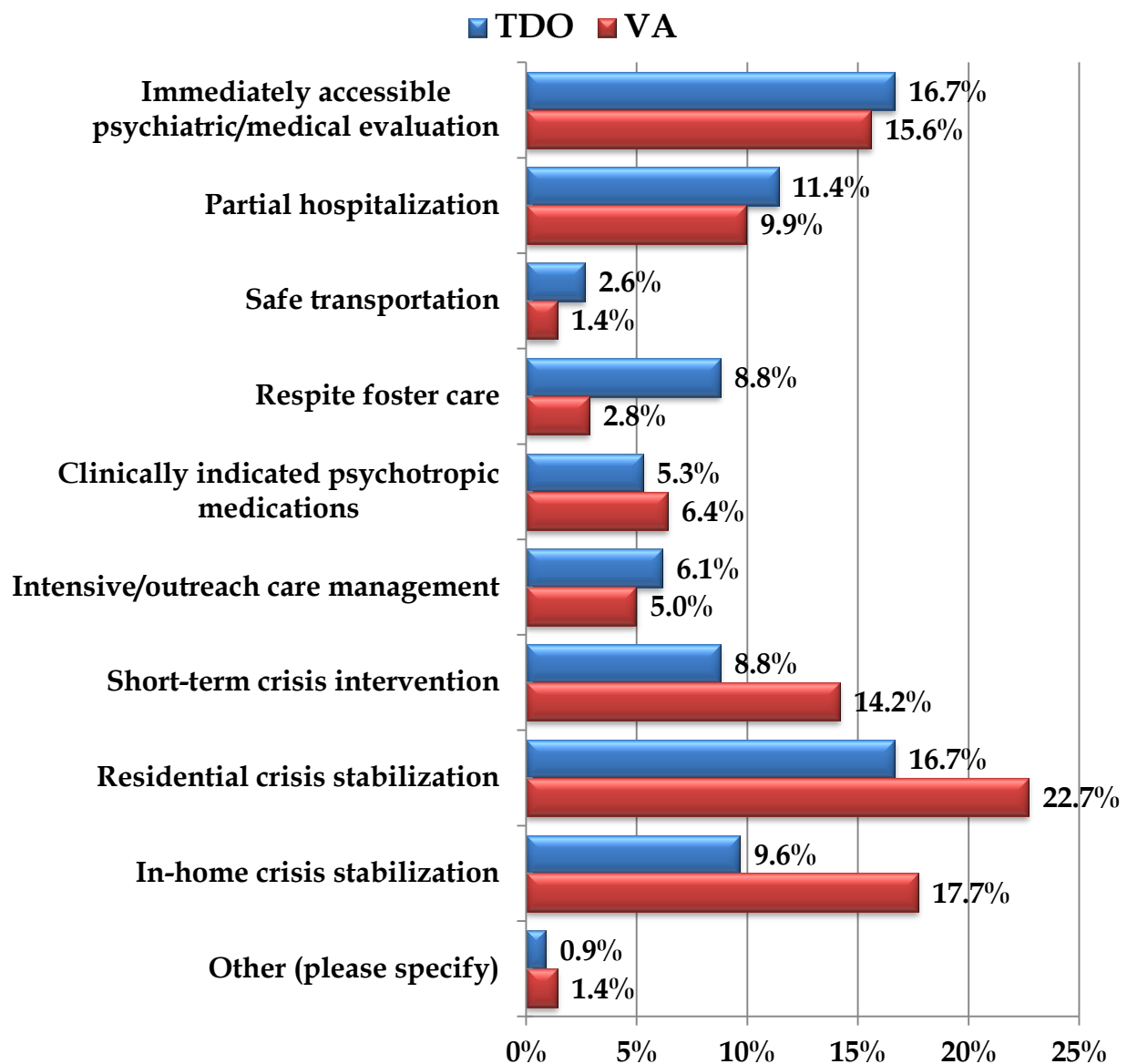
Table 65. Ability to address the adult needs with resources available or additional services would help the clinicians.

		Able to address the crisis needs with current resources available		Total
		Yes	No	
Additional services would help to address better	Yes	45.0% n=219	56.8% n=54	273
	No	55.0% n=268	43.2% n=41	309
Total		487	95	582

*Types of Services/Resources That, if Available, Clinicians Reported Would Have Allowed the Juvenile to Avoid Hospitalization*

► Of the cases in which the juvenile was referred for involuntary hospitalization (TDO), the clinician reported that the juvenile would have been able to avoid hospitalization in 35.1% (n=40 of 114) of cases if certain services/resources had been available. Of the cases in which an objecting juvenile was referred for admission by the parent or guardian, the clinician reported that the juvenile would have been able to avoid hospitalization in 50.0% (n=2 of 4) of cases if certain services/resources had been available. Of the cases in which the juvenile was referred for voluntary admission to a hospital (VA), the clinician reported that the juvenile would have been able to avoid hospitalization in 48.9% (n=69 of 141) of cases if certain services/resources had been available. See Figure 55 and Table 66.

**Figure 55. Services that, if available, would have allowed juvenile to avoid hospitalization**



**Table 66. Services/resources that, if available, would have allowed the client to avoid hospitalization**

	Involuntary admission TDO		Objecting juvenile admission by parent/guardian		Voluntary admission		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percent	Freq.	Percent
Immediately accessible psychiatric/medical evaluation	19	16.7	1	25.0	22	15.6	42	16.2
Partial hospitalization	13	11.4	1	25.0	14	9.9	28	10.8
Safe transportation	3	2.6			2	1.4	5	1.9
Respite foster care	10	8.8	1	25.0	4	2.8	15	5.8
Clinically indicated psychotropic medications	6	5.3			9	6.4	15	5.8
Intensive/outreach care management	7	6.1	1	25.0	7	5.0	15	5.8
Short-term crisis intervention	10	8.8			20	14.2	30	11.6
Residential crisis stabilization	19	16.7			32	22.7	51	19.7
In-home crisis stabilization	11	9.6			25	17.7	36	13.9
Other (please specify)	1	0.9			2	1.4	3	1.2
None	74	64.9	2	50.0	72	51.1	148	57.1
<b>Total</b>	<b>114</b>	<b>100.0</b>	<b>4</b>	<b>100.0</b>	<b>141</b>	<b>100.0</b>	<b>259</b>	<b>100.0</b>

► In 17.8% (n=46) of cases, the clinician reported that the client would have been able to avoid hospitalization if one specific service/resource had been available. Clinicians reported that two or more services would have helped the client to avoid hospitalization in 23.7% (n=27) of cases resulting in involuntary hospitalization, and in 26.2% (n=37) of cases resulting in voluntary admissions. See Table 67.

**Table 67. Number of services/resources that the clinician reported, if available, would have allowed the juvenile to avoid hospitalization**

	Involuntary action (TDO)		Objecting juvenile admission by parent /guardian		Voluntary action	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
None	74	64.9	2	50.0	72	51.1
One service	13	11.4	1	25.0	32	22.7
Two or more	27	23.7	1	25.0	37	26.2
<b>Total</b>	<b>114</b>	<b>100.0</b>	<b>4</b>	<b>100.0</b>	<b>141</b>	<b>100.0</b>

## Other Results From the CSB 2013 Statewide Study

Due to the differences in policies and procedures related to various groups of individuals who experience emergency crisis evaluations, separate analyses were completed. Additional reports are also available, including Statewide Variations in Emergency Evaluations among CSBs and Regions, CSB Emergency Evaluations of Individuals for Recommitments, CSB Emergency Evaluation of Individuals in Jail or in Juvenile Detention, and CSB Emergency Evaluations of Individuals with Intellectual/Developmental Disabilities. These reports will be disseminated following the publication of this report.

Question should be directed to Professor Bonnie at [rjb6f@virginia.edu](mailto:rjb6f@virginia.edu) or [rbonnie@virginia.edu](mailto:rbonnie@virginia.edu).

## Appendix 1

### OVERVIEW OF THE MENTAL HEALTH SYSTEM IN VIRGINIA<sup>13</sup>

The following provides a basic overview of Community Services Boards in Virginia, the CSB Emergency Services emergency evaluation process, subsequent actions that may result from a clinician's evaluation, and terminology related to the process.

#### Virginia Department of Behavioral Health and Developmental Services (DBHDS)

The Virginia DBHDS, established by §37.2 of the Code of Virginia, exists to oversee the Commonwealth's publicly-funded mental health, intellectual disability, and substance abuse services. DBHDS does this by managing 16 state facilities and entering into contracts with federal and local governments to carry out these duties (i.e., CSBs, BHAs).

More information about DBHDS can be found at [www.dbhds.virginia.gov/](http://www.dbhds.virginia.gov/).

#### Community Services Boards and Behavioral Health Authorities in Virginia

Community Services Boards (CSBs) and Behavioral Health Authorities (BHAs) are the points of entry into the publicly-funded services for mental health, intellectual disability, and substance abuse in Virginia. Outlined in Virginia Code §37.2-500 et seq. and §37.2-600 et seq., these 40 agencies are established by every county, city, or a combination of cities and counties, to provide the above services to its constituents.

The CSBs and BHAs operate under a performance contract with DBHDS, which also provides funds to the agencies to help them carry out their purposes.

The two core services that each of the 40 agencies must provide, as outlined in Virginia Code, are emergency services and case management services. The current study is specific to the former. For the purposes of this report, the term "CSB" will be used to designate all 40 of these local agencies, including BHAs.

#### Virginia Association of Community Service Boards (VACSB)

The VACSB is an organization which represents all 40 CSBs in the Commonwealth of Virginia regarding "state and federal public policy matters, including state and federal funding, legislation and regulation." The VACSB serves its 40 constituents through providing advocacy, training and development, and statewide conferences.

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<sup>13</sup> Updated from the 2007 report.

The VACSB provides a statewide network for all departments within a CSB through their Service Councils, which include: Mental Health Services Council, Developmental Services Council, Substance Abuse Services Council, Child & Family Services Council, Prevention Services Council, and Emergency Services Council. Among other responsibilities, these Service Councils identify widespread issues regarding their respective areas of services delivery and promote consistent practices across all 40 agencies. The VACSB also consists of a number of committees, including: Public Policy Committee, Services Development Committee, Regulatory Committee, Development and Training Committee, Administrative Policy and Technical Committee, Finance Committee, and Technical Administration committee.

For the current study, the UVA Research Team partnered closely with the VACSB Emergency Services Council and a subcommittee of the Technical Administration Committee, the Data Management Committee.

More information about VACSB can be found at [www.vacsb.org](http://www.vacsb.org).

### Three Phases of Emergency Evaluation

One of the duties of an agency's Emergency Services department is to evaluate individuals who are amidst mental health, intellectual disability, or substance abuse crises. For the purposes of this study, a typical emergency evaluation is analyzed through segmenting the process into three main parts:

- Pathways to the CSB emergency response system,
- The emergency evaluation itself, and
- The subsequent disposition and recommendation by the CSB clinician.

#### *Pathways to the CSB Emergency Response System*

The emergency evaluation process, which is generally the same for adult and juveniles, usually begins when an individual who is experiencing a mental health or substance abuse crisis is referred to a CSB for an emergency evaluation. An individual may seek emergency services on his/her own or may be referred by a family member, friend, another health professional in the community, or a law enforcement officer.

On many occasions, the person seeking assistance is willing to receive evaluation or treatment services. The individual may be someone who is currently receiving services at the agency, has received CSB services in the past, or has never received CSB services. In many cases in which the CSB is contacted by an outside party, the individual in crisis is often unwilling to come to the CSB to be evaluated. If there is concern that the individual is, due to mental illness or substance abuse, at risk of harm toward self, at risk of harm toward others, or presents an impaired capacity for self-protection or provide for basic needs, the CSB clinician will contact a court magistrate and request that an Emergency Custody Order (ECO) be issued. An ECO allows law enforcement to take the individual into custody and transport him/her to a

convenient location (e.g., CSB, hospital emergency department) so that a CSB Emergency Services clinician can complete a face-to-face evaluation to determine the individual's condition. At the time of the April 2013 CSB Study, the criteria for a magistrate to issue an ECO, a Temporary Detention Order (TDO), or determine need for involuntary commitment are that the individual "has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others...or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment," according to Virginia Code §37.2-808.

By law, the CSB clinician performing the emergency evaluation must: (1) be skilled in the assessment and treatment of mental illness, (2) have completed a certification program approved by DBHDS, and (3) be able to provide an independent examination of the individual. Individuals in crisis may voluntarily seek assistance at a hospital emergency department or be taken there by rescue squads, family members, law enforcement, or others. Some hospitals have specialized professional staff to evaluate individuals in psychiatric crisis and may also have inpatient psychiatric units to which the individual can be diverted. These hospitals can evaluate and admit an individual for inpatient psychiatric services. In the event the hospital does not have a psychiatric unit, the hospital will transfer the individual to another hospital that does have a psychiatric unit. However, if the individual is unwilling to, or is incapable of, consent to voluntary hospital admission, hospital staff will contact the local CSB and request an emergency evaluation. In such cases, a CSB clinician performs an evaluation to determine whether the individual meets the commitment criteria. By Virginia Code, if the clinician believes the criteria are met, a Temporary Detention Order can be recommended to a magistrate to place a person in a psychiatric facility on a temporary, involuntary basis. (This process is described below in *Disposition and Recommendation by the CSB Clinician*.)

Hospital staff may also contact the CSB to conduct an evaluation if an individual who initially went into the hospital on a voluntary basis wants to discharge himself, and the attending psychiatrist is concerned that the person meets the commitment criteria.

At times, an individual experiencing a behavioral health crisis comes to the attention of law enforcement. Virginia Code gives law enforcement officers the power to take a person into emergency custody if he/she has probable cause to believe that the person meets the emergency custody criteria. The law enforcement officer does not need a magistrate-issued ECO in order to take a person into custody or to transport him to an appropriate location to be assessed by CSB clinicians.

### *The Emergency Evaluation*

CSB clinicians who provide evaluations in connection with the involuntary commitment process must, as mentioned above, be skilled in the diagnosis and treatment of mental illness, have completed a certification program approved by DBHDS, and be able to provide an

independent, neutral evaluation. Providing an “independent, neutral evaluation” means that the clinician is not related by blood or marriage to the person being evaluated, has no financial interest in the admission or treatment of the individual, and has no investment interest in the facility detaining or admitting the individual.

An emergency evaluation begins by the CSB clinician’s review of any available information on the individual, such as CSB contacts and records, rescue squad run sheets, law enforcement reports, and hospital records and reports. The clinician may also gather information by speaking with hospital staff, law enforcement officers, family members, and other collateral contacts. During the face-to-face interview with the individual in crisis, the CSB clinician completes a comprehensive mental health and substance abuse evaluation, which includes a mental status exam and a risk assessment of danger to self and others. One goal of the CSB clinician is to work as collaboratively as possible with the individual, his/her family, and other professionals involved in the individual’s care. Documentation of the evaluation is recorded on the *Virginia Preadmission Screening Report*.

### *Disposition and Recommendation by the CSB Clinician*

CSB clinicians may recommend that the individual in crisis be treated with a variety of interventions that he/she has available. Some of these recommended interventions include voluntary outpatient services through the CSB or private practitioner, voluntary inpatient psychiatric hospitalization, or involuntary outpatient treatment. CSB clinicians are mandated to recommend the least restrictive course of intervention or treatment; as a result, involuntary hospitalization should be recommended only after all other options are exhausted.

If the CSB clinician recommends that the individual be involuntarily hospitalized, the clinician then locates an available bed in a DBHDS-approved facility and requests that the magistrate issue a Temporary Detention Order to hold the individual in that facility for up to 48 hours until he/she can attend a civil commitment hearing for involuntary admission to a psychiatric facility. If the 48-hour period terminates on a weekend or legal holiday, then the individual may be detained until the close of business on the next day that is not a weekend or legal holiday. During this 48-hour period, an individual undergoes (1) an evaluation to determine whether he/she meets criteria for involuntary commitment and (2) mental health or substance abuse treatment to stabilize the individual in hopes of avoiding involuntary commitment.

## Appendix 2

### 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 psych 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 commitment 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/3<sup>rd</sup> 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 prior 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 harm toward self?

- ☐ 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

**ADULT Emergency Services (ES) Face-to-Face Crisis Evaluation Questionnaire - Page 2**

Last 4 digits of case #: \_\_\_\_\_

☐ Other type of self-endangerment \_\_\_\_\_  
\_\_\_\_\_

**20. Did the record or client interview reveal recent behavior or symptoms indicating an elevated risk of serious physical harm toward others?**

☐ 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 impaired capacity for self-protection or ability to provide for basic needs?**

☐ 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 not 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:	1	2
<input type="checkbox"/> Client lacked ability to maintain and communicate choice.		
<input type="checkbox"/> Client lacked ability to understand relevant information.		
<input type="checkbox"/> Client lacked ability to understand consequences.		
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
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 \_\_\_\_\_

**ADULT Emergency Services (ES) Face-to-Face Crisis Evaluation Questionnaire - Page 4**

*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 not 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:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# JUVENILE 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. Date of Evaluation (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 3. Evaluation start time: \_\_\_\_\_ am/pm, Evaluation end time: \_\_\_\_\_ am/pm  
 4. Minor age: \_\_\_\_\_ 5. Minor sex (M/F): \_\_\_\_\_ 6. Minor race: \_\_\_\_\_  
 7. Hispanic: No ☐ Yes ☐ 8. Grade \_\_\_\_\_ 9. Special Ed. No ☐ Yes ☐

## 10. Where did the evaluation take place?

- ☐ CSB ☐ Hospital ED  
☐ Minor's home ☐ Public location  
☐ Hospital psych unit ☐ Juv. Detention Center  
☐ Police station ☐ Magistrate's office  
☐ Other \_\_\_\_\_

## 11. What is the minor's current living arrangement?

- ☐ Living with family ☐ Living alone  
☐ Living with non-related others ☐ Homeless/recently undomiciled  
☐ Living with support (e.g., group home, supervised living) ☐ Foster care ☐ Don't know  
☐ Other \_\_\_\_\_

## 12. Was minor in hospital for recommitment hearing?

- ☐ No ☐ Yes → If yes, STOP HERE. Turn in form.

## AT THE TIME OF EVALUATION:

### 13. Minor presented with (Check all that apply):

- ☐ Mental illness (Primary diagnosis: \_\_\_\_\_)  
☐ Intellectual/developmental disability  
☐ Substance use/abuse disorder  
☐ Other ☐ None

### 14. Was the minor under the influence of drugs or alcohol?

- ☐ No ☐ Yes ☐ Suspected ☐ Unknown

### 15. Minor's current treatment (Check all that apply):

- ☐ CSB ☐ Other community agency  
☐ DBHDS facility ☐ Private practitioner  
☐ School services  
☐ Private/community psych facility

- ☐ Non-psychiatric private/community facility  
☐ None ☐ Don't know/not sure  
☐ Other \_\_\_\_\_

### 16. Minor's insurance status (Check all that apply):

- ☐ Medicaid ☐ Private/3<sup>rd</sup> party  
☐ Medicare  
☐ Military/Veteran's Dependent Benefit  
☐ None ☐ Don't know/not sure  
☐ Other \_\_\_\_\_

### 17. Was the minor showing psychotic symptoms?

- ☐ No ☐ Yes

### 18. What sources of information were available to you prior 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 minor interview reveal recent behavior or symptoms indicating an elevated risk of serious danger to self to the extent that severe or irremediable injury is likely to result?

- ☐ 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

**JUVENILE Emergency Services (ES) Face-to-Face Crisis Evaluation Questionnaire - Page 2**

*Last 4 digits of case #:* \_\_\_\_\_

- ☐ 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 danger to others to the extent that severe or irremediable injury is likely to result?**

- ☐ 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 minor own or otherwise have easy access to a firearm?**

- ☐ No ☐ Yes ☐ Unable to determine

**22. Did the record or minor interview reveal recent behavior or symptoms indicating a serious deterioration of his ability to care for himself in a developmentally age appropriate manner?**

- ☐ No ☐ Yes

**If yes, what symptoms, deficits, or behaviors were noted?** (Check all that apply)

- ☐ Delusional thinking
- ☐ Neglect of hydration
- ☐ Neglect of nutrition
- ☐ Impairment in self protection
- ☐ Impairment in self-control
- ☐ Other \_\_\_\_\_

**23. Were the minor's parents/guardians consulted?**

- ☐ No ☐ Yes ☐ Unable to contact

**24. If parent/guardian with whom minor resides was consulted, is he/she willing to approve any proposed admission?**

- ☐ No ☐ Yes ☐ N/A

**25. Was the minor's treating or examining physician consulted?**

- ☐ No ☐ Yes ☐ N/A

**26. Who contacted the CSB for evaluation?**

- ☐ Law enforcement ☐ Minor
- ☐ Clinician ☐ Friend/family member
- ☐ Hospital ☐ Don't know/not sure
- ☐ Other \_\_\_\_\_

**27. Was the minor 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

**28. If minor was in police custody, were restraints used?**

- ☐ No ☐ Yes

**29. If minor was not in police custody at the time of initial contact, did you seek an ECO in order to carry out the evaluation?**

- ☐ No ☐ Yes

**30. If an ECO was sought, was the ECO obtained?**

- ☐ No ☐ Yes

**31. If an ECO was issued, did the initial (4-hour) ECO expire?**

- ☐ No ☐ Yes

**32. If initial ECO expired, did you seek an extension?**

- ☐ No ☐ Yes

**33. If extension was sought, was the extension granted?**

- ☐ No ☐ Yes

**34. 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

# JUVENILE 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 minor's condition AT THE CONCLUSION OF THE CRISIS EVALUATION:

	No	Yes
35. Minor presented a serious danger to self to the extent that severe or irremediable injury was likely to result:	1	2
36. Minor presented a serious danger to others to the extent that severe or irremediable injury was likely to result:	1	2
37. Minor was experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner:	1	2
38. Minor was experiencing severe mental or emotional distress or dysfunction:	1	2
39. Minor was in need of compulsory treatment for a mental illness and was reasonably likely to benefit from the proposed treatment:	1	2
40. Minor 14 or older lacked the capacity to make treatment decisions:	1	2
<input type="checkbox"/> Minor lacked ability to maintain and communicate choice.		
<input type="checkbox"/> Minor lacked ability to understand relevant information.		
<input type="checkbox"/> Minor lacked ability to understand consequences.		
41. Minor's condition warranted hospitalization:	1	2
42. I would have sought involuntary action (TDO) if minor had refused voluntary services:	N/A	1
43. I was able to address this person's crisis needs with the resources available to me:	1	2

44. Which of the following services, if any, would have helped you address this minor's needs better? (Check all that apply) ☐ None

- ☐ Immediately accessible psychiatric/medication evaluation
- ☐ Partial hospitalization
- ☐ Safe transportation
- ☐ Respite foster care
- ☐ Medical detox
- ☐ Clinically indicated psychotropic medications
- ☐ Intensive/outreach care management
- ☐ Short-term crisis intervention
- ☐ Residential crisis stabilization
- ☐ In-home crisis stabilization
- ☐ Other \_\_\_\_\_

45. If hospitalization was the disposition, which of the following services, if available to you, would have allowed the minor to avoid hospitalization? (Check all that apply) ☐ None

- ☐ Immediately accessible psychiatric/medication evaluation
- ☐ Partial hospitalization
- ☐ Safe transportation
- ☐ Respite foster care

- ☐ Medical detox
- ☐ Clinically indicated psychotropic medications
- ☐ Intensive/outreach care management
- ☐ Short-term crisis intervention
- ☐ Residential crisis stabilization
- ☐ In-home crisis stabilization
- ☐ Other \_\_\_\_\_

46. What was the disposition? (Choose one)

- ☐ Referred for involuntary admission (TDO)
- ☐ Referred for objecting minor admission by parent/guardian
- ☐ 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
- ☐ Minor declined referral and no involuntary action taken
- ☐ Other \_\_\_\_\_

*Last 4 digits of case #:* \_\_\_\_\_

**47. If a TDO was sought, was it granted?**

☐ No ☐ Yes

**If TDO was granted, was the minor admitted?**

☐ No ☐ Yes

**If the minor 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 \_\_\_\_\_

**48. If voluntary admission was sought, was the minor 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 \_\_\_\_\_

**49. If hospitalization was sought, # of facilities contacted: Private: \_\_\_\_\_; State (CCCA): \_\_\_\_\_.**

**50. 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: \_\_\_\_\_)

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

**52. Was hospital in minor's region?** ☐ No ☐ Yes

**53. If hospitalization was sought but the minor was not admitted to psychiatric facility, why not?** (check all that apply)

- ☐ No voluntary bed available
- ☐ Insurance limitations
- ☐ No TDO bed available
- ☐ Minor required medical evaluation or treatment
- ☐ Acuity of minor's condition/level of care required
- ☐ Transportation or logistical problems
- ☐ Unable to confirm bed availability in requisite time
- ☐ Other \_\_\_\_\_

**54. If hospitalization was sought but no bed was available within requisite time, what happened to the minor?** (Check all that apply)

- ☐ Minor held by police until bed was available
- ☐ Minor held on medical unit until bed was available or until reevaluated
- ☐ Minor held in ED until bed was available or until reevaluated
- ☐ Minor admitted to a CSU
- ☐ Minor released voluntarily with safety plan (other than to a CSU)
- ☐ Minor released and declined service
- ☐ Minor reevaluated during screening process and no longer met criteria for inpatient treatment; minor released with a safety plan
- ☐ Other \_\_\_\_\_

**Additional comments or suggestions:**

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## Appendix 3

### Localities Served by Community Services Boards

Name	County or City
Alexandria Community Services Board	City of Alexandria
Alleghany-Highlands Community Services Board	County of Alleghany
	City of Clifton
	City of Forge
	City of Covington
Arlington County Community Services Board	County of Arlington
Blue Ridge Behavioral Healthcare	County of Botetourt
	County of Craig
	County of Roanoke
	City of Roanoke
	City of Salem
Chesapeake Community Services Board	City of Chesapeake
Chesterfield Community Services Board	County of Chesterfield
Colonial Behavioral Health Services Board	James City
	York Country
	City of Poquoson
	City of Williamsburg
Crossroads Community Services Board	County of Amelia
	County of Buckingham
	County of Charlotte
	County of Cumberland
	County of Lunenburg
	County of Nottoway
	County of Prince Edward
Cumberland Mountain Community Services Board	County of Buchanan
	County of Russell
	County of Tazewell
Danville-Pittsylvania Community Services	Pittsylvania County
	City of Danville
Dickenson County Behavioral Health Services	Dickenson County
District 19 Community Services Board	County of Dinwiddie
	County of Greensville
	County of Prince George
	County of Surry
	County of Sussex
	City of Colonial Heights
	City of Emporia
	City of Hopewell
	City of Petersburg
Eastern Shore Community Services Board	County of Accomack
	County of Northampton
Fairfax-Falls Church Community Services Board	Fairfax County
	City of Fairfax
	City of Falls Church

Name	County or City
Goochland-Powhatan Community Services	County of Goochland
	County of Powhatan
Hampton-Newport News Community Services Board	City of Hampton
	City of Newport News
Hanover Community Services Board	County of Hanover
Harrisonburg-Rockingham Community Services Board	City of Harrisonburg
	County of Rockingham
Henrico Area Mental Health; Developmental Services	Charles City
	County of Henrico
	County of Kent
Highlands Community Services	Washington County
	City of Bristol
Horizon Behavioral Health	County of Amherst
	County of Appomattox
	County of Bedford
	County of Campbell
	City of Bedford
	City of Lynchburg
Loudoun County Community Services Board	County of Loudoun
Middle Peninsula-Northern Neck Community Services Board	County of Essex
	County of Gloucester
	County of King
	County of Queen
	County of King William
	County of Lancaster
	County of Mathews
	County of Middlesex
	County of Northumberland
	County of Richmond
	County of Westmoreland
Mount Rogers Community Mental Health and Mental Retardation	County of Bland
	County of Carroll
	County of Grayson
	County of Smyth
	County of Wythe
	City of Galax
New River Valley Community Services	County of Floyd
	County of Giles
	County of Montgomery
	County of Pulaski
	City of Blacksburg
	City of Radford
Norfolk Community Services Board	City of Norfolk
Northwestern Community Services Board	County of Clarke
	County of Frederick
	County of Page
	County of Shenandoah
	County of Warren
	City of Winchester

Name	County or City
Piedmont Community Services	County of Franklin
	County of Henry
	County of Patrick
	City of Martinsville
Planning District One Behavioral Health Services	Lee County
	Scott County
	Wise County
	City of Norton
Portsmouth Department of Behavioral Healthcare Services	City of Portsmouth
Prince William County Community Services Board	Prince William County
	City of Manassas
	City of Manassas Park
Rappahannock Area Community Services Board	County of Caroline
	County of King George
	County of Spotsylvania
	County of Stafford
	City of Fredericksburg
Rappahannock-Rapidan Community Services Board	County of Culpeper
	County of Fauquier
	County of Madison
	County of Orange
	County of Rappahannock
Region Ten Community Services Board	County of Albemarle
	County of Fluvanna
	County of Greene
	County of Louisa
	County of Nelson
	City of Charlottesville
Richmond Behavioral Health Authority	City of Richmond
Rockbridge Area Community Services	County of Bath
	County of Rockbridge
	City of Buena Vista
	City of Lexington
Southside Community Services Board	County of Brunswick
	County of Halifax
	County of Mecklenburg
	City of South Boston
Valley Community Services Board	County of Augusta
	County of Highland
	City of Staunton
	City of Waynesboro
Virginia Beach Community Services Board	City of Virginia Beach
Western Tidewater Community Services Board	Isle of Wight County
	County of Southampton
	City of Franklin
	City of Suffolk

## Appendix 4

### Percentile Ranking of Community Services Boards

The following table divides the 40 CSBs into 4 quartiles (10 CSBs each) based on the number of adult emergency evaluations reported during the month of April 2013, including adults and juveniles. The CSBs are listed alphabetically in the quartile under which they placed. Therefore, the CSBs with the least numbers of cases during the survey month fall at or below the 25th percentile and the most numbers of cases during the survey month fall between the 76th and 100th percentiles, and so on.

CSBs contained at or below 25 <sup>th</sup> percentile	Alexandria Community Services Board Alleghany-Highlands Community Services Board Chesterfield Community Services Board Dickenson County Behavioral Health Services Eastern Shore Community Services Board Goochland-Powhatan Community Services Hanover County Community Services Board Portsmouth Department of Behavioral Healthcare Services Rockbridge Area Community Services Southside Community Services Board
CSBs contained at or below 50 <sup>th</sup> percentile	Chesapeake Community Services Board Colonial Services Board Crossroads Community Services Board Cumberland Mountain Community Services Board Harrisonburg-Rockingham Community Services Board Middle Peninsula-Northern Neck Community Services Board Northwestern Community Services Planning District One Behavioral Health Services Valley Community Services Board Western Tidewater Community Services Board
CSBs contained at or below 75 <sup>th</sup> percentile	Arlington County Community Services Board Blue Ridge Behavioral Healthcare Henrico Area Mental Health & Developmental Services Highlands Community Services Loudoun County Community Services Board New River Valley Community Services Norfolk Community Services Board Piedmont Community Services Rappahannock-Rapidan Community Services Board Region Ten Community Services Board
CSBs contained at or below 100 <sup>th</sup> percentile	Danville-Pittsylvania Community Services District 19 Community Services Board Fairfax-Falls Church Community Services Board Hampton-Newport News Community Services Board Horizon Behavioral Health Mount Rogers Community Mental Health and Mental Retardation Prince William County Community Services Board Rappahannock Area Community Services Board Richmond Behavioral Health Authority Virginia Beach Community Services Board

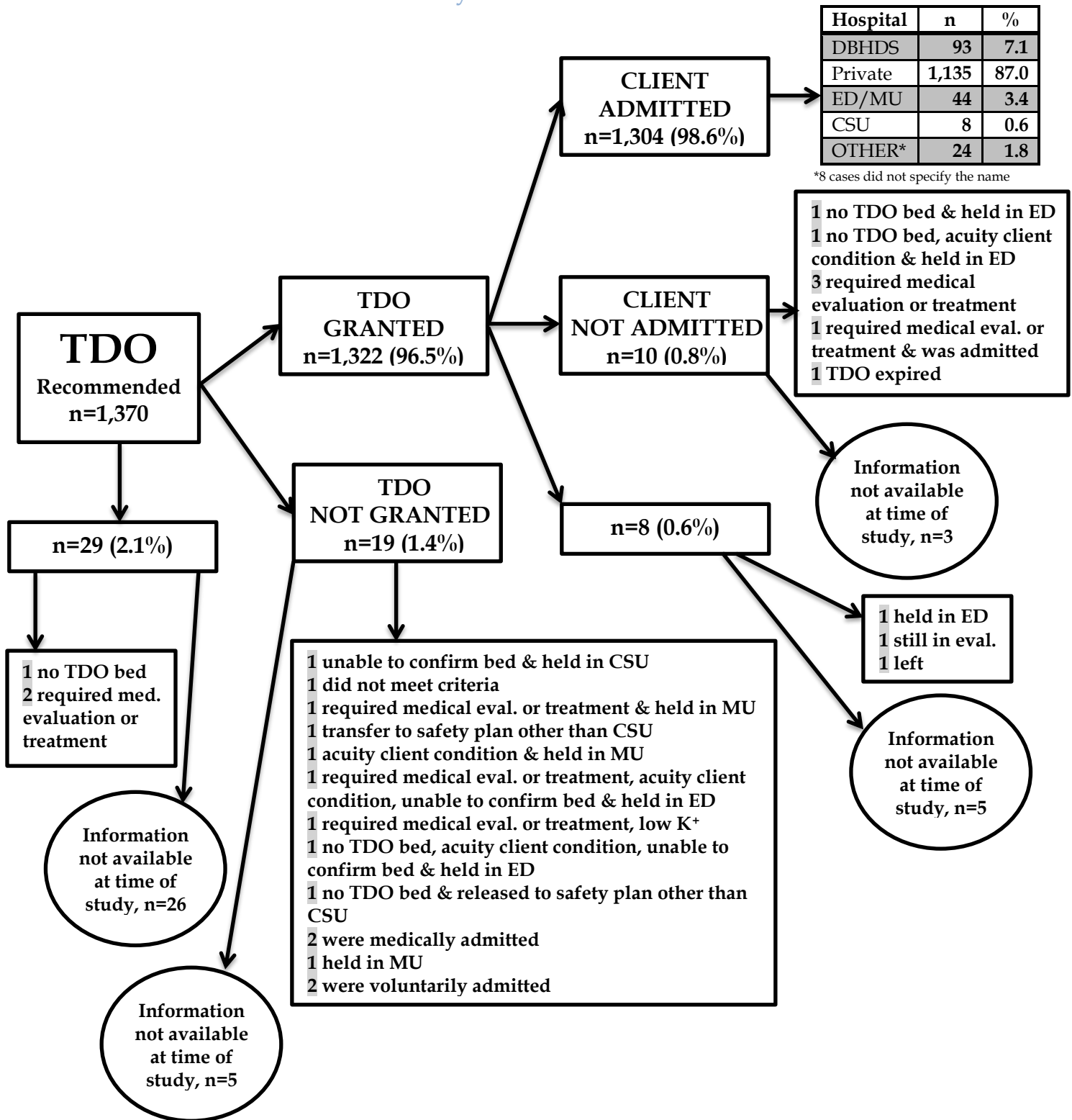
## Appendix 5

### Number of Clinicians Participating by CSB for Adults and Juveniles

CSB	Adult evaluators	Juvenile evaluators
Alexandria Community Services Board	8	5
Alleghany-Highlands Community Services Board	8	3
Arlington County Community Services Board	24	8
Blue Ridge Behavioral Healthcare	19	9
Chesapeake Community Services Board	13	6
Chesterfield Community Services Board	11	4
Colonial Services Board	14	9
Crossroads Community Services Board	15	8
Cumberland Mountain Community Services Board	12	6
Danville-Pittsylvania Community Services	16	9
Dickenson County Behavioral Health Services	1	1
District 19 Community Services Board	15	10
Eastern Shore Community Services Board	8	5
Fairfax-Falls Church Community Services Board	32	25
Goochland-Powhatan Community Services	4	0
Hampton-Newport News Community Services Board	17	7
Hanover County Community Services Board	11	5
Harrisonburg-Rockingham Community Services Board	12	3
Henrico Area Mental Health & Developmental Services	39	15
Highlands Community Services	14	8
Horizon Behavioral Health	12	1
Loudoun County Community Services Board	7	9
Middle Peninsula-Northern Neck Community Services Board	15	6
Mount Rogers Community Mental Health and Mental Retardation	21	9
New River Valley Community Services	14	9
Norfolk Community Services Board	14	10
Northwestern Community Services	9	6
Piedmont Community Services	16	6
Planning District One Behavioral Health Services	11	3
Portsmouth Department of Behavioral Healthcare Services	9	2
Prince William County Community Services Board	22	17
Rappahannock Area Community Services Board	11	11
Rappahannock-Rapidan Community Services Board	13	9
Region Ten Community Services Board	26	9
Richmond Behavioral Health Authority	26	12
Rockbridge Area Community Services	3	2
Southside Community Services Board	11	4
Valley Community Services Board	13	6
Virginia Beach Community Services Board	18	4
Western Tidewater Community Services Board	6	4
<b>Total</b>	<b>570</b>	<b>282</b>

## Appendix 6

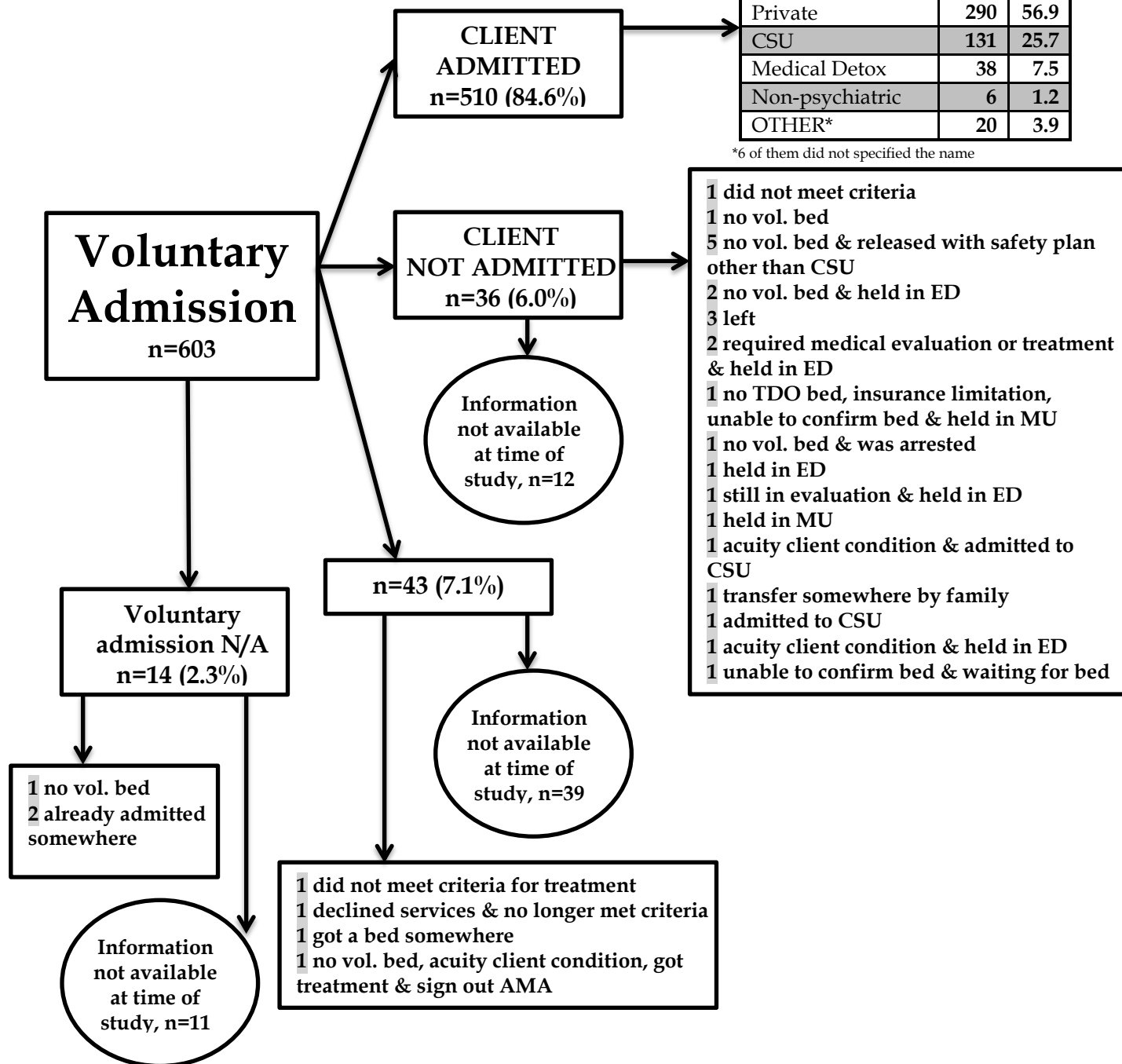
### Flow chart of cases where involuntary admission was recommended for adults



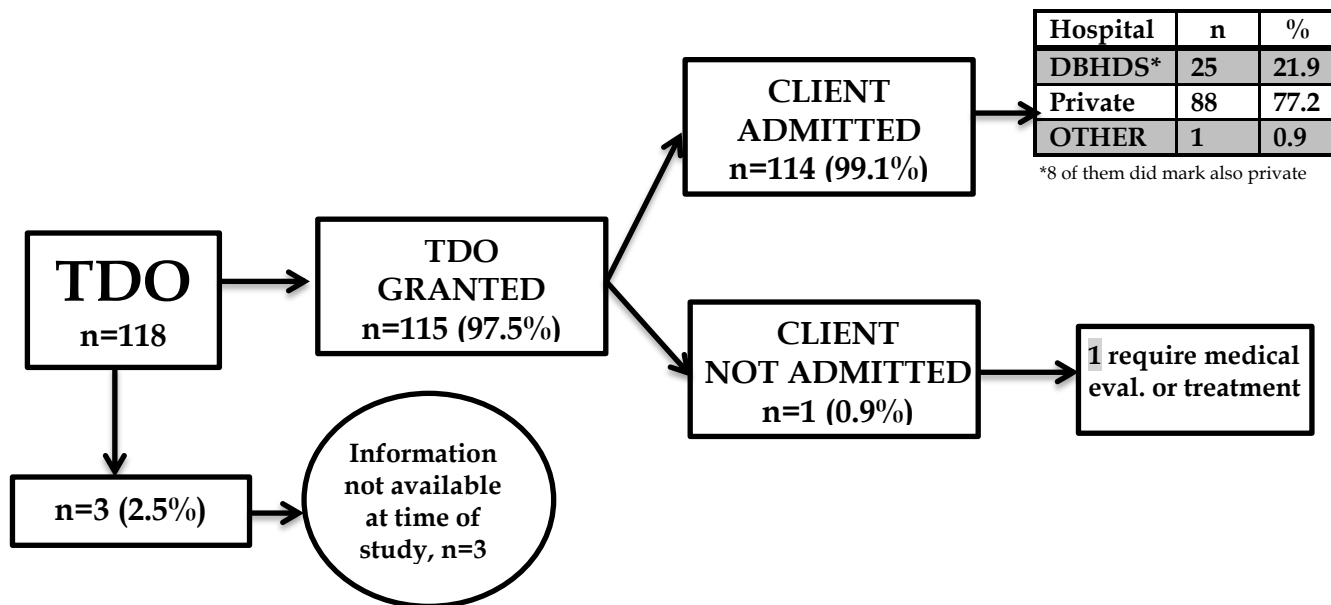
## Flow chart of cases where voluntary admission was recommended for adults

Hospital	n	%
DBHDS	25	4.9
Private	290	56.9
CSU	131	25.7
Medical Detox	38	7.5
Non-psychiatric	6	1.2
OTHER*	20	3.9

\*6 of them did not specified the name



### Flow chart of cases where involuntary admission was recommended for juveniles



### Flow chart of cases where voluntary admission was recommended for juveniles

