
Study of Emergency Evaluations

Conducted by Emergency Services Personnel in
Community Services Boards, June 2007

A Report to the Commission on Mental Health Law Reform

Supported by the Department of Mental Health, Mental Retardation and Substance Abuse Services

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Preface

The Commonwealth of Virginia Commission on Mental Health Law Reform (“Commission”) was appointed by the Chief Justice of the Supreme Court of Virginia, Leroy Rountree Hassell, Sr., in October 2006. Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups, including consumers of mental health services and their families, service providers, and the bar. The Commission was directed by the Chief Justice 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.

Goals of reform include reducing the need for commitment by improving access to mental health, mental retardation and substance abuse services, avoiding the criminalization of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers of mental health services to have more choice over the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

The Commission has been assisted by five Task Forces charged, respectively, with addressing gaps in access to services, involuntary civil commitment, empowerment and self-determination, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. In 2007, the Commission established a Working Group on Health Privacy and the Commitment Process (“Working Group”) and, in 2008, established a sixth Task Force on Advance Directives. Information regarding the Commission and its Reports is available at <http://www.courts.state.va.us/cmh/home.html>.

The Commission also conducted three major empirical studies during 2007 under the supervision of its Working Group on Research. The first was an interview study of 210 stakeholders and participants in the commitment process in Virginia. The report of that study, entitled *Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations*, was issued in April 2007. The study is available at http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf.

The second major research project was a study of commitment hearings and dispositions (the “Commission’s Hearing Study”). In response to a request by the Chief Justice, the special justice or district judge presiding in each case filled out a 2-page instrument on every commitment hearing held in May 2007. (There were 1,526 such hearings.) Findings from the Commission’s Hearing Study have been presented to the Commission and have served an important role in shaping the Commission’s understanding of current commitment practice. The study can be found at http://www.courts.state.va.us/cmh/2007_05_civil_commitment_hearings.pdf.

Finally, the Commission’s third project was a study of every emergency evaluation conducted by CSB emergency services staff during June 2007 (the “Commission’s CSB Study”). (There were 3,808 such evaluations.) This report also made a substantial contribution to the Commission’s understanding of the circumstances under which commitment proceedings are initiated and the results of CSB emergency evaluations.

Based on its research and the reports of its Task Forces and Working Groups, the Commission issued its *Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform* (“Preliminary Report”) in December, 2007. The Preliminary Report, which is available on-line at http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf, outlines a comprehensive blueprint for reform (“Blueprint”) and identifies specific recommendations for the 2008 session of Virginia’s General Assembly.

This document is the Report of the Commission’s CSB Study. It is the work of the Research Team and offers no interpretations of the findings presented in the Report. Nor does it propose any recommendations. The report was prepared as a resource for the Commission and for the public and has not been adopted or endorsed by either the Commission or the Supreme Court.

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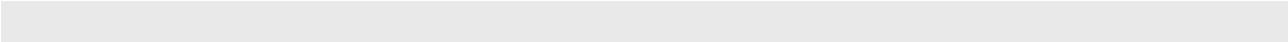
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Alexandria CSB
Alleghany Highlands CSB
Arlington County CSB
Blue Ridge Behavioral Health Care
Central Virginia CSB
Chesapeake CSB
Chesterfield CSB
Colonial CSB
Crossroads CSB
Cumberland Mountain CSB
Danville-Pittsylvania CSB
Dickenson County BHS
District 19 CSB
Eastern Shore CSB
Fairfax-Falls Church CSB
Goochland-Powhatan CSB
Hampton-Newport News CSB
Hanover County CSB
Harrisonburg-Rockingham CSB
Henrico Area MH and RS
Highlands CSB
Loudoun County CSB
Middle Peninsula-Northern Neck CSB
Mt. Rogers CSB
New River Valley CSB
Norfolk CSB
Northwestern CSB
Piedmont CSB
Planning District One
City of Portsmouth, Dept. of BHS
Prince William County CSB
Rappahannock Area CSB
Rappahannock-Rapidan CSB
Region Ten CSB
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Rockbridge Area CSB
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TABLE OF CONTENTS

Preface	
Summary of Findings	i
Overview of the CSB Emergency Evaluations Study	v
Introduction	v
Community Services Boards in Virginia	v
Three Phases of Emergency Evaluation	vi
Pathways to the CSB Emergency Response System	vi
The Emergency Evaluation	vii
Dispositions and Recommendations after the Emergency Evaluation	viii
Methods	ix
Instrument	ix
Procedures	ix
Organization of the Report	ix
Section I: STATEWIDE SUMMARY OF CSB EMERGENCY EVALUATIONS	 1
Section II: ADULT EMERGENCY EVALUATIONS	
Number of Adult CSB Emergency Evaluations	4
CSB Clinician Characteristics	4
Clinician Credentials	4
Clinician Number of Years Experience	5
Characteristics of Adults in Crisis	5
Demographics	5
Living Situation	6
Current Treatment Status	7
Insurance Status	7
Pathways to CSB Crisis Response System	8
Individuals in Police Custody at Time of Evaluation	8
Contacting the CSB for Evaluation	9
Location of Emergency Evaluation	9
Day and Time of the Emergency Evaluation	10
Clinical Presentation of Adults	11
Presentation at Time of Emergency Evaluation	11
Under the Influence of Substances or Showing Psychotic Symptoms	12
Displays of Behaviors that Met June 2007 Involuntary Commitment Criteria	12
Disposition after Emergency Evaluation	13
Type of Action Recommended by the CSB	13
Outcome of Involuntary Action Recommended	14
Actions Taken to Identify a Psychiatric Bed	15
Length of Time Locating Psychiatric Bed	15
No Bed Available	15

Status When Involuntary Treatment Sought but Not Immediately Available	16
Status When Voluntary Treatment Sought but Not Immediately Available	17
Individual's Condition at End of Emergency Evaluation Period	18
Opinion Rating of Individual's Condition	18
Gaps in Service Capacity	20
Services/Resources that Would Have Helped Address Individuals' Needs	20
Section III: ADULT VARIATIONS AMONG COMMUNITY SERVICES BOARDS	
CSB Variations by Characteristics of Adults	22
Living Situation	22
Source of Current Treatment	24
Not Receiving Treatment	25
Insurance Status	26
Individuals in Police Custody at Time of Evaluation	27
Type of Action Recommended by the CSB	28
Involuntary Action Recommended	28
Referral for Voluntary Outpatient Treatment	29
Referral for Voluntary CSB Services	30
Voluntary Hospitalization	31
Length of Time Locating Psychiatric Bed	32
Psychiatric Bed Located within Individual's Region	33
Hospital Locations Compared to CSB	
Emergency Evaluation Incidence	34
Services/Resources that Would Have Helped Address Individuals' Needs	35
Immediate Medication Evaluation	35
Short-Term Crisis Intervention	37
Residential Crisis Stabilization	38
In-Home Crisis Stabilization	39
Temporary Housing	40
Safe Transportation	41
Section IV: JUVENILE EMERGENCY EVALUATIONS	
Number of Juvenile CSB Emergency Evaluations	42
CSB Clinician Characteristics	42
Clinician Credentials	42
Clinician Number of Years Experience	43
Characteristics of Juveniles in Crisis	43
Demographics	43
Living Situation	44
Current Treatment Status	44
Insurance Status	45
Pathways to CSB Crisis Response System	46
Juveniles in Police Custody at Time of Evaluation	46
Contacting the CSB for Evaluation	46
Location of Emergency Evaluation	47
Day of the Emergency Evaluation	47

<i>Clinical Presentation of Juveniles</i>	48
Presentation at Time of Emergency Evaluation	48
Under the Influence of Substances or Showing Psychotic Symptoms	49
Displays of Behaviors that Met June 2007 Involuntary Commitment Criteria	50
<i>Disposition after Emergency Evaluation</i>	51
Type of Action Recommended by CSB	51
Outcome of Involuntary Action Recommended	51
Actions Taken to Identify a Psychiatric Bed	52
Length of Time Locating Psychiatric Bed	52
Status When Treatment Sought but Not Immediately Available	53
<i>Juvenile's Condition at End of Emergency Evaluation Period</i>	53
Opinion Rating of the Youth's Condition	53
CSB Clinician Knowledge of Juvenile after Emergency Evaluation	55
<i>Gaps in Service Capacity</i>	55
Services/Resources that Would Have Helped Address Juveniles' Needs	55

Section V: JUVENILE VARIATIONS AMONG COMMUNITY SERVICES BOARDS

<i>CSB Variations by Characteristics of Juveniles</i>	56
Living Situation	56
Source of Current Treatment	56
Not Receiving Treatment	58
Insurance Status—No Insurance	59
Insurance Status—Medicaid/Disability	60
Insurance Status—Private Insurance	61
Juveniles in Police Custody at Time of Evaluation	62
Type of Action Recommended by CSB	63
Referral for Voluntary Outpatient Treatment	63
Involuntary Action Recommended	65
Voluntary Hospitalization	66
Referral for Voluntary CSB Services	67
Services or Resources that Would Have Helped Address Juveniles' Needs	68
In-Home Crisis Stabilization	68
Short-Term Crisis Intervention	69
Residential Crisis Stabilization	70
Immediate Medication Evaluation	71
Temporary Housing	71
Safe Transportation	72

APPENDICES

A. Community Services Boards Description	74
B. Copy of Data Collection Instrument	78
C. Methods & Statistical Analytic Techniques	81
D. Possible Outcomes of Individual Non-Admission	82
E. Community Services Boards and Localities Served	85
F. Percentile Ranking of Community Services Boards	87
G. Descriptions of Selected Services/Resources at CSBs	89

SUMMARY OF FINDINGS

The following is a summary of the key findings of the Commission on Mental Health Law Reform's *Study of Emergency Evaluations Conducted by Emergency Services Personnel in Community Services Boards, June 2007* (the "Commission's CSB Study").

The Commission's CSB Study was designed to examine characteristics of emergency evaluations at Community Services Boards (CSBs) across Virginia. Community Services Boards are the public entry into mental health, substance abuse and mental retardation services in Virginia. 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". This report examines characteristics of those emergency evaluations such as CSB clinician and client characteristics, client pathways to the CSB emergency response system, clinical evaluation results, CSB recommendations for treatment, and gaps in service capacity. A complete description of the findings is contained in the full report.

SECTION I: STATEWIDE SUMMARY OF CSB EMERGENCY EVALUATIONS

All Emergency Evaluations During June 2007

► During the month of June 2007, a total of 3,808 emergency evaluations were conducted by CSB clinicians on adults and juveniles experiencing mental health crises that could be associated with symptoms of mental illness, substance abuse, and/or mental retardation. Clinicians from all 40 CSBs in Virginia submitted questionnaires on emergency evaluations conducted.

► Eleven percent (11.1%, n=421) of the emergency evaluations were performed on juveniles under the age of 18 years, whereas 87.1% (n=3,317) were performed on adults. Two percent (1.8%, n=70) of the questionnaires submitted in this study did not specify the age of the individual evaluated.

► Hospital staff was most likely to contact the CSB for an emergency evaluation (40.3%). Law enforcement was the next most likely group to contact the CSB for an evaluation (18.5%), followed by friends or family (11.9%), and the individual him or herself (11.4%). CSB clinicians referred an individual for an emergency evaluation in 6.2% of cases and an "other" type of person contacted the CSB in 9.4% of cases. A combination of more than one of the above persons contacted the CSB for an emergency evaluation in 2.3% of cases.

► Individuals were not receiving treatment at the time of the assessment in 41.2% of evaluations conducted. If receiving treatment, individuals were most likely to be receiving treatment from a CSB (28.6%), followed by a private practitioner (15.4%).

► Overall, CSB clinicians certified 86.4% of individuals as presenting with mental illness, 31.5% as presenting with substance abuse, 3.3% as presenting with mental retardation, and 3.8% as presenting with “none” of the above presentations. Many individuals presented with more than one condition.

► When evaluating individuals for overt indications of the involuntary commitment criteria, CSB clinicians determined that 37.4% of all individuals exhibited behaviors that could indicate a danger to themselves, 32.5% exhibited behaviors indicating an inability to care for themselves, and 17.0% exhibited behaviors indicating a danger to others.

► At the time of the emergency evaluation, 25.8% of individuals were in police custody with or without an Emergency Custody Order (ECO). Seventy-four percent (74.2%) of individuals who received an emergency evaluation were not in police custody at the time of the evaluation.

► At the conclusion of the emergency evaluation, clinicians most often recommended an involuntary action to a magistrate (39.3%). Other dispositions recommended were referral for voluntary outpatient treatment (24.3%), voluntary CSB services (19.0%), and voluntary hospitalization (13.7%). In 4.7% of all cases, the individual refused treatment and no involuntary action was recommended.

SECTION II: ADULT EMERGENCY EVALUATIONS

► Forty-two percent (41.6%) of adults were not receiving treatment at the time of the emergency evaluation.

► Four out of 10 adults did not have health insurance at the time of the evaluation (41.1%)

► The majority of adults were not in police custody at the time of the evaluation. Thirteen percent of adults were in police custody without an ECO, and 11.3% of adults were in police custody with an ECO.

► Almost 90% of adults (86.6%) presented with symptoms of mental illness, and one-third (35.6%) presented with substance abuse problems.

- ▶ One of every four adults (25.0%) were under the influence of drugs or alcohol at the time of the emergency evaluation and one-third of them, or 34.5%, exhibited psychotic symptoms.
- ▶ Forty-two percent (42.1%) of adults did NOT show indications of behaviors that met the criteria for civil commitment (i.e., danger to others, danger to self, or an inability to care for self) at the time of the evaluation.
- ▶ Involuntary action was recommended to a magistrate in 41.3% of adult emergency evaluations. Among cases in which involuntary action was recommended by the clinician, a Temporary Detention Order (TDO) was sought and issued 93.4% of the time and an Emergency Custody Order was sought and issued in most of the remaining cases (4.8%).
- ▶ In most cases, or 72.6%, a psychiatric bed was located after contacting one or two facilities and within the time frame of less than two hours. The majority of facilities were located within the same region as the individual's residence.
- ▶ Immediate Medication Evaluation was the most likely response when clinicians were asked what services or resources would have helped them to better address individuals' needs (in 20.3% of adult cases).

SECTION III: VARIATIONS AMONG COMMUNITY SERVICES BOARDS

- ▶ There were significant differences among CSBs in regards to evaluated individual's characteristics, CSB clinicians' recommendations at the conclusion of the emergency evaluation, and services or resources needed at individual CSBS.
- ▶ Rates of homelessness varied from no individuals who were homeless at some CSBs to over 20% of individuals homeless at three CSBs.
- ▶ There was wide variation among CSBs in the percentage of clinicians who recommended an involuntary action following an emergency evaluation, ranging from no recommendations at one CSB to 77.1% of emergency evaluations resulting in a recommendation for involuntary action at another.
- ▶ There were significant differences in the rate of clinician referrals for voluntary CSB services following an emergency evaluation, perhaps showing disparity in the range of CSB services available.
- ▶ Of the possible dispositions following an emergency evaluation, a referral for voluntary hospitalization was recommended the least for adult individuals during the survey month.

▶ In every CSB, there were cases in which the clinician needed more than 2 hours to locate an available psychiatric bed; however, 33% of CSBs experienced difficulty locating beds in a timely fashion in more than a third of their cases.

SECTION IV: JUVENILE EMERGENCY EVALUATIONS

▶ The average age of the 421 juveniles evaluated was 14 years old, with ages ranging from 4 years to 17 years.

▶ Only 8.7% of juveniles had no medical insurance coverage at the time of emergency evaluation.

▶ Hospital staff and family members contacted the CSB for an emergency evaluation in most juvenile cases (32.8% and 25.8%, respectively).

▶ Nearly 9 out of 10 juveniles presented with mental illness at the time of the evaluation; 11.8% presented with substance abuse.

▶ Of exhibited behaviors shown that would meet the criteria for commitment, juveniles displayed behaviors that met criteria for being a “danger to self” most often (35.5%), followed by a “danger to others” (26.3%), and an “inability to care for self” (18.8%).

▶ Among juvenile emergency evaluations, referral for outpatient treatment was the most likely case disposition (34.4%).

▶ Clinicians responded that In-Home Crisis Stabilization was the service that would have most helped them to address the needs of juveniles during the survey month.

SECTION V: JUVENILE VARIATIONS AMONG COMMUNITY SERVICES BOARDS

▶ Differences among CSBs for juvenile emergency evaluations were not as statistically significant as differences among CSBs for adult evaluations; however, statistical differences still existed for many variables such as individual characteristics of persons evaluated, services reported as needed by CSB clinicians, and treatment recommendations for the individual after the assessment.

▶ There were significant differences across CSBs in whether or not juveniles were in police custody at the time of the emergency evaluation. Some CSBs had none of their juveniles evaluated in police custody, and others had over 50% of juveniles in police custody.

Overview of the CSB Emergency Evaluations Study

INTRODUCTION

To better understand the findings of the Commission’s CSB Study, it is important to have a basic understanding of Community Services Boards in Virginia, the CSB emergency services emergency evaluation process, subsequent actions that may result based on a clinician’s evaluation, and terminology related to the process.

Community Services Boards in Virginia

Public community mental health, mental retardation, and substance abuse services are provided in Virginia by Community Services Boards (CSBs), Behavioral Health Authorities (BHAs), or local government departments with policy-advisory CSBs. Thirty-nine CSBs and one BHA serve the entirety of localities within Virginia; this report shall refer to the 40 bodies collectively as “CSBs”.

CSBs are local government agencies that operate under a performance contract with the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)¹. One or more local governments can be served by a single CSB; these governments oversee and in some cases, may make significant contributions of local funds. In 2004, according to the Virginia Association of Community Services Boards, CSBs served 42,075 citizens with mental retardation, 194,431 citizens with mental illness, and 52,266 citizens with substance abuse disorders. More information regarding the establishment and organization of CSBs can be found in Appendix A.

In §37.1-194 of the *Code of Virginia*, it is stipulated that CSBs “shall” provide emergency services, the only core service that is mandated outright. Emergency services must be available 24 hours a day, seven days a week.

¹ Section §37.2-500 of the *Code of Virginia* established CSBs as the single point of entry for publicly funded mental health, mental retardation, and substance abuse services in Virginia.

Three Phases of Emergency Evaluation

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 subsequent recommendations by the CSB clinician, or “disposition after the evaluation”.

Data was collected on all three segments of the emergency evaluation. The following provides an overview of the emergency services evaluation process.

Pathways to the CSB Emergency Response System

The emergency evaluation process usually begins when an individual who is experiencing a mental health or substance abuse crisis is referred to a CSB for an evaluation. An individual can seek services on their own or can 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. Such an individual may be someone who is currently receiving services at the CSB, received CSB services in the past, or has never received CSB services. Generally, when the CSB is contacted by a friend or family member, the individual in crisis is often not willing to come to the CSB to be evaluated. If there is concern that the individual is at risk of harming him or herself or others due to mental illness, 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 a person into custody and transport him to a convenient location so that the CSB emergency services clinician can provide a face-to-face evaluation. At the time of the CSB study, the criteria for a magistrate to issue an ECO was probable cause to believe that a person “(i) has a mental illness, and (ii) presents an imminent danger to himself or others as a result of mental illness or is so seriously ill as to be substantially unable to care for himself”. In 2008, the Virginia General Assembly adopted new civil commitment legislation that altered criteria for issuance of an ECO or Temporary Detention Order (TDO) or to begin civil commitment proceedings.²

²Current criteria for a magistrate to issue an ECO, TDO, or determine need for involuntary commitment is a reason to believe that an 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 the *Code of Virginia* §37.2-808.

By law, the CSB clinician performing the evaluation must be skilled in the assessment and treatment of mental illness, have completed a certification program approved by DMHMRSAS and be able to provide an independent examination of the person.

Many times, individuals in crisis seek assistance by presenting to hospital emergency departments or are taken there by rescue squads or family members. Some hospitals have specialized professional staff to evaluate individuals in psychiatric crisis and may also have inpatient psychiatric units. 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 not willing or is not capable of consenting to voluntary admission, hospital staff contacts a CSB to provide an emergency evaluation. In such cases, a CSB clinician performs an evaluation determining whether the individual meets the commitment criteria described on the previous page. By Virginia Code, if the clinician believes the criteria are met, a TDO can be recommended to a magistrate to place a person in a psychiatric facility on a temporary involuntary basis.

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 but the attending psychiatrist is concerned that the person meets commitment criteria.

Sometimes a person in 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 or 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 be skilled in the diagnosis and treatment of mental illness and have completed a certification program approved by DMHMRSAS.³ They also must be able to provide an independent, neutral evaluation, meaning 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.

³According to Section §37.2-808 B of the *Code of Virginia*

An emergency evaluation begins by the CSB clinician's review of available information on the individual such as CSB contacts and records, rescue squad run sheets, law enforcement reports, hospital records and reports. The clinician also talks to hospital staff, law enforcement, 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 that includes a mental status exam and a risk assessment of dangerousness to self and others. A goal of the CSB is for the clinician to work as collaboratively as possible with the individual, their family and other professionals involved. Documentation of the evaluation is recorded on the *Uniform Preadmission Screening Form*.

Disposition and Recommendations after the Emergency Evaluation

CSB clinicians are mandated to recommend the least restrictive course of intervention or treatment. Least restrictive treatment could include voluntary outpatient mental health or substance abuse services from the CSB or a private practitioner, voluntary inpatient psychiatric hospitalization, or involuntary outpatient treatment. Involuntary hospitalization should be recommended only after all other options are exhausted. When the CSB Study took place during June 2007, commitment criteria under Virginia Code § 37.2-817 mandated that a person had to, "(i) [have] a mental illness, (ii) present an imminent danger to himself or others as a result of mental illness or [be] so seriously mentally ill as to be substantially unable to care for himself and (iii) [be] unwilling to volunteer or incapable of volunteering for hospitalization or treatment."

If the recommendation of the CSB clinician is involuntary hospitalization, the clinician locates an available bed in a detention facility that has been approved by DMHMRSAS and requests that the magistrate issue a TDO to hold the individual in that facility. A petition for a civil commitment hearing is filed with the magistrate and by law a hearing has to take place within 48 hours, or if the TDO occurs over a weekend or holiday, immediately upon the next day that the court is open. A TDO allows additional time for a more extensive clinical evaluation.

Data analyzed in the Commission's CSB Study focuses on the actions described above. The Commission's companion report to the CSB Study, *A Study of Civil Commitment Hearings Held in the Commonwealth of Virginia During May 2007*, describes the events that occur after a CSB emergency evaluation if a civil commitment hearing is determined to be necessary.

METHODS

Instrument

A panel of experts on mental health service delivery and mental health law, in collaboration with members of the Research Advisory Group of the Commission on Mental Health Law Reform, participated in the development of an emergency evaluation documentation form, called the *Emergency Services Face-to-Face Crisis Contact Questionnaire* (“the questionnaire”). The questionnaire included 38 items to document events that occurred during the emergency evaluation. It included information on each clinician’s licensure, degree and number of years experience in the field. Information was also collected on all critical details of the emergency evaluation including socio-demographic information on the individual being assessed, the time and place of the evaluation, the mental condition of the person, the potential involvement of the police, the immediate disposition of the case, possible difficulties with admissions to psychiatric facilities, the individual clinician’s opinion of the person’s condition at the end of the emergency evaluation and an optional check list of needed services or resources that would have been helpful to the clinician in addressing the individual’s condition, but were not available (see Appendix B for a copy of the measure).

Procedures

In all 40 CSBs in the state, Emergency Services Managers agreed to complete the questionnaire on each individual emergency evaluation that they managed during the survey month. Emergency evaluations were referred to as “crisis contacts” to describe the emergency evaluation of a person to determine the need for a civil commitment hearing and to differentiate these clinical contacts from services provided for people who are not in crisis (e.g., assessments for a person coming out of the hospital). At regular intervals, the Emergency Services Managers sent hard copies of the completed questionnaires to the evaluation team in the Department of Public Health Sciences at the University of Virginia. No identifying information on any person evaluated by CSB clinicians during the survey month was provided. Each questionnaire was given an identification code. Hard copies were maintained in files after data entry into *Statistical Package for the Social Sciences* software (SPSS). Following data checking and cleaning, descriptive and inferential statistical analyses were completed.

Organization of the Report

The results of the analyses are reported in the sections that follow:

► Section I provides statewide summary statistics on all emergency evaluations conducted by CSB clinicians during June 2007 in Virginia.

▶Section II presents data from emergency evaluations conducted on adults only, those individuals who are 18 years of age or older. Adults represent 87.1% of all emergency evaluations during the survey month.

▶Section III illustrates the differences among CSBs in Virginia, based on characteristics of adults who were evaluated in emergency evaluations.

▶Section IV provides a summary of emergency evaluations conducted on juveniles only, those individuals under the age of 18 years. Juveniles represent 11.1% of all emergency evaluations during the survey month.

▶Section V illustrates the differences among CSBs in Virginia, based on characteristics of juvenile emergency evaluations.

SECTION I

Statewide Summary of CSB Emergency Evaluations

RESULTS

Section I provides information on all individuals in Virginia who received an emergency evaluation by a CSB clinician during the survey month, combining data collected on both adults and juveniles.

During the month of June 2007, a total of 3,808 emergency evaluations were conducted by CSB clinicians on individuals experiencing mental health crises that could be associated with symptoms of mental illness, substance abuse and/or mental retardation.

► Eleven percent (11.1%, n=421) of the emergency evaluations were performed on juveniles under the age of 18 years, whereas 87.1% (n=3,317) were performed on adults. Two percent (1.8%, n=70) of the questionnaires submitted in this study did not specify the age of the individual evaluated.

► Emergency evaluations were conducted on about the same number of males and females during the survey month, with a difference of just 1% (50.5% were female and 49.5% were male). Individuals who were evaluated were most often Caucasian (65.5%), with the next highest race/ethnic group being African-American at 29.3%. Other race/ethnic groups included Latinos (2.8%) and Asians (1.3%), with Native Americans, individuals who self-identified as multiracial, and “other” each comprising less than 1%.

► Nearly 4 out of 10 evaluated individuals did not have insurance during the survey month (36.4%). If the person did have insurance, Medicaid/Disability coverage was most likely at 22.3%, followed by private insurance (17.0%) and Medicare (7.2%). In 5.0% of cases the clinician did not know whether the person had insurance and in the remaining cases, the person had a combination of insurance types, Veteran’s insurance, or an “other” type of insurance.

► Half of the emergency evaluations conducted during the survey month took place at a hospital (51.1%). The next most frequent evaluation location was the CSB (27.8%), followed by places identified as “other” (8.7%), the police station

(6.4%), the individual's home (4.2%), a public location (1.0%), or a magistrate's office (less than 1%).

► Hospital staff was most likely to contact the CSB for an emergency evaluation (40.3%). Law enforcement was the next most likely group to contact the CSB for an emergency evaluation (18.5%), followed by friends or family (11.9%), and the individual him or herself (11.4%). CSB clinicians referred an individual for an emergency evaluation in 6.2% of cases and an "other" type of person contacted the CSB in 9.4% of cases. A combination of more than one of the above persons contacted the CSB for an emergency evaluation in 2.3% of cases.

► Individuals were not receiving treatment at the time of the emergency evaluation in 41.2% of the emergency evaluations conducted during the survey month. If receiving treatment, individuals were most likely to be receiving treatment from a CSB (28.6%), followed by a private practitioner (15.4%).

► Overall, CSB clinicians certified 86.4% of individuals as presenting with mental illness, 31.5% as presenting with substance abuse, 3.3% as presenting with mental retardation, and 3.8% as presenting with "none" of the above presentations. Many individuals presented with more than one condition.

► When evaluating individuals for overt indications of the involuntary commitment criteria, CSB clinicians determined that 37.4% of all individuals exhibited behaviors that could indicate a danger to self, 32.5% exhibited behaviors indicating an inability to care for themselves, and 17.0% exhibited behaviors indicating a danger to others.

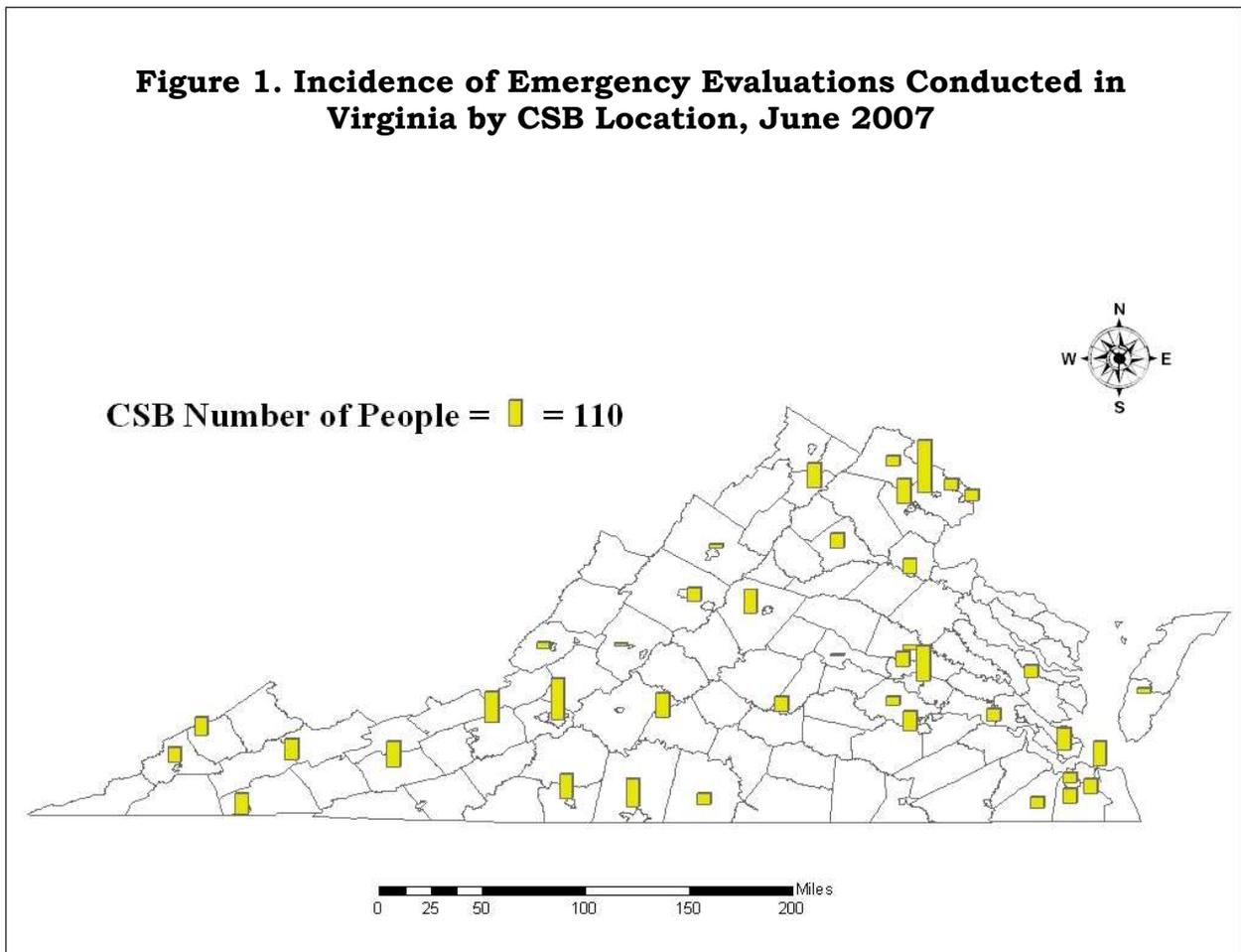
► At the time of the emergency evaluation, less than 1% of individuals were in jail, whereas 25.8% were in police custody with or without an ECO. Seventy-four percent (74.2%) of individuals who received an emergency evaluation during the month were not in police custody at the time of the emergency evaluation.

► Clinicians most often recommended an involuntary action to a magistrate at the conclusion of the emergency evaluation (39.3%). Other dispositions recommended were referral for voluntary outpatient treatment (24.3%), voluntary CSB services (19.0%) and voluntary hospitalization (13.7%). In 4.7% of cases, the individual refused treatment and no involuntary action was recommended.

► Of services or resources which clinicians reported as needed to better meet the needs of the individuals they evaluated, Immediate Medication Evaluation was most often cited, in 19.6% of all emergency evaluations. Short-Term Crisis Intervention was the service next most often requested at 12.8%, followed by Residential Crisis Stabilization (11.7%), In-Home Crisis Stabilization (8.5%), Temporary Housing (6.8%), and Safe Transportation (4.7%).

► Statewide, completed emergency evaluation questionnaires were received from all 40 CSBs. As expected based on the distribution of population in Virginia, there was wide variation in the numbers of emergency evaluations among the respective CSBs. Appendices E and F 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. Numbers of evaluations during the survey month at individual CSBs ranged from as many as 268 evaluations at one CSB to as few as 7 evaluations at another.

Figure 1 shows CSB locations (by zip code) by the number of emergency evaluations conducted by CSB clinicians.



SECTION II Adult Emergency Evaluations

NUMBER OF ADULT CSB EMERGENCY EVALUATIONS

Community Services Board clinicians who were responsible for conducting emergency evaluations of individuals experiencing a mental health crisis, documented 3,019 adult emergency evaluations during the month of June 2007. The 3,019 cases described below include adults only but exclude those with mental retardation and/or adults who were in jail at the time of the evaluation.

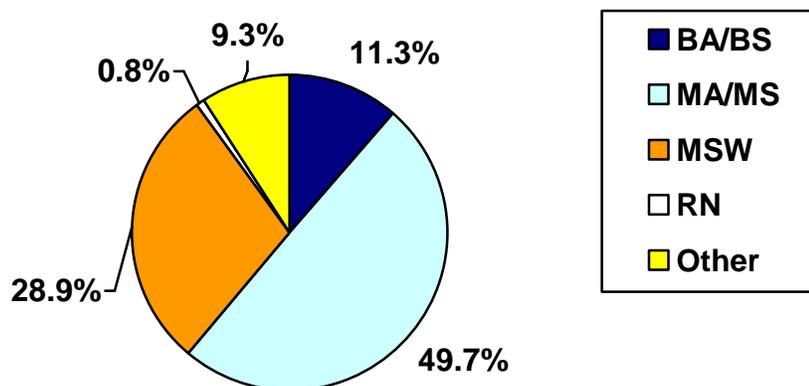
CSB CLINICIAN CHARACTERISTICS

Clinician Credentials

► **Over 75% of CSB clinicians who conducted emergency evaluations had earned a master's degree of some type, whether an M.A., M.S. or M.S.W.**

About half (49.7%) of the evaluations were performed by clinicians who had a master of arts (M.A.) or master of science (M.S.) degree, whereas an additional 28.9% were performed by those with a master of social work (M.S.W.) degree (Figure 2). Eleven percent of staff (11.3%) had no more than a bachelor's degree.

Figure 2. Clinician Credentials

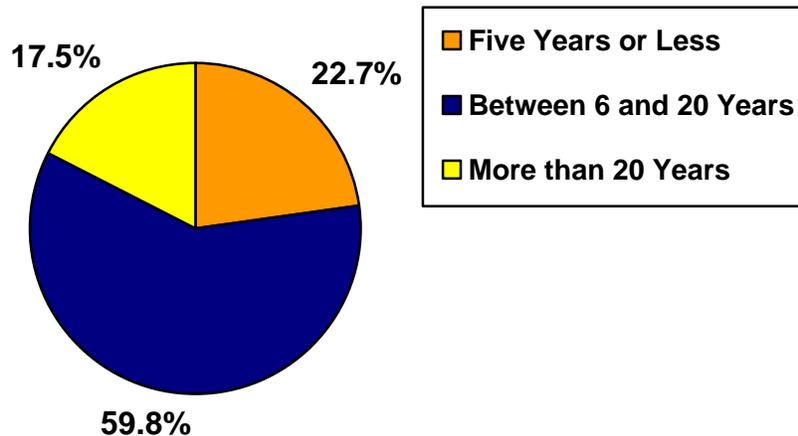


Clinician Number of Years Experience

► **Sixty percent (59.8%) of evaluators reported between six and twenty years of experience, whereas 22.7% had five years of experience or less.**

The average number of years of field experience of clinicians was 13.4 years ($sd=8.6$), ranging from less than one year to 50 years.

Figure 3. Clinician Number of Years Experience



CHARACTERISTICS OF ADULTS IN CRISIS

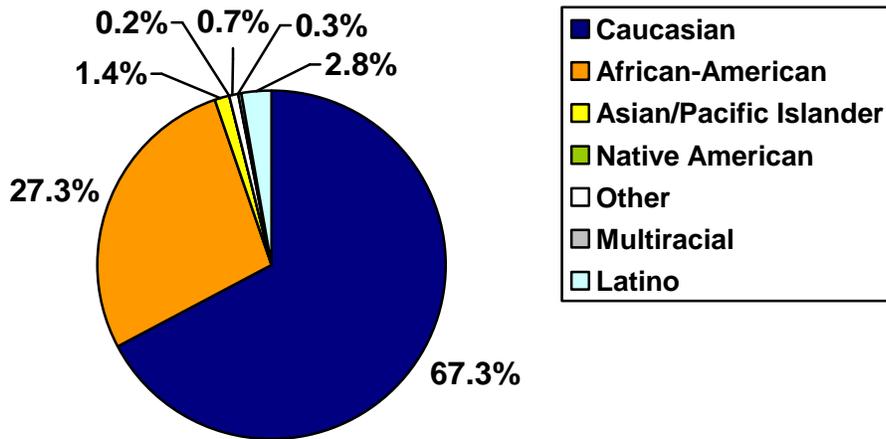
Demographics

► **The average age of adults who received emergency evaluations during the survey month was 40 years old. Slightly more adults were women than men.**

The average age of adults who were evaluated was 40 years old ($sd=15.4$); ages ranged from 18 years to 95 years. Fifty-three percent of those evaluated were female, and 48% were male.

Figure 4 shows the race/ethnic distribution of those evaluated. Two-thirds (67.3%) of the adults were Caucasian, and approximately one-third of remaining individuals were non-Caucasian. The largest non-white minority group was African-American (27.3%).

Figure 4. Race/Ethnic Distribution of Adults

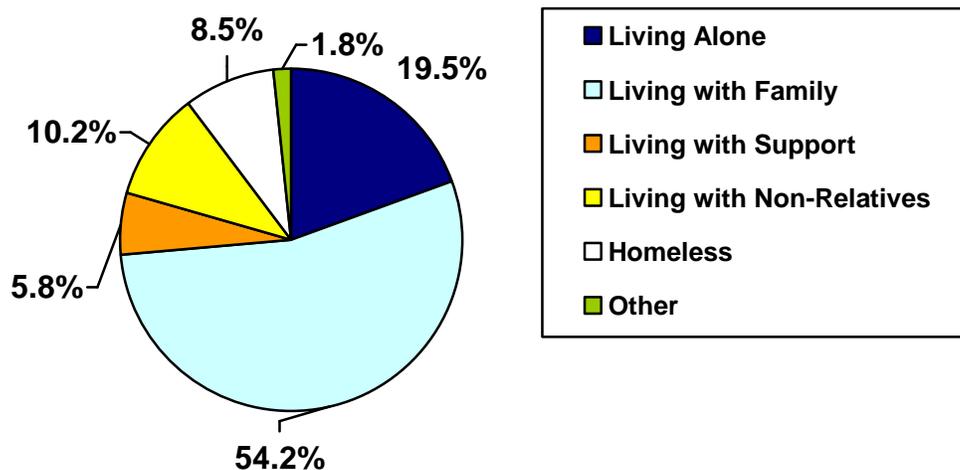


Living Situation

► **Living with family or living alone were the two most likely living situations of adults who received an emergency evaluation during the survey month.**

Figure 5 shows the distribution of the living arrangements of those evaluated. In over half of cases (54.2%), the individual was living with family members. The second most likely living situation was living alone (19.5%). In 5.8% of cases, the person lived in a group home or other supervised setting. In 8.5% of cases, the person was homeless.

Figure 5. Living Situation of Adults

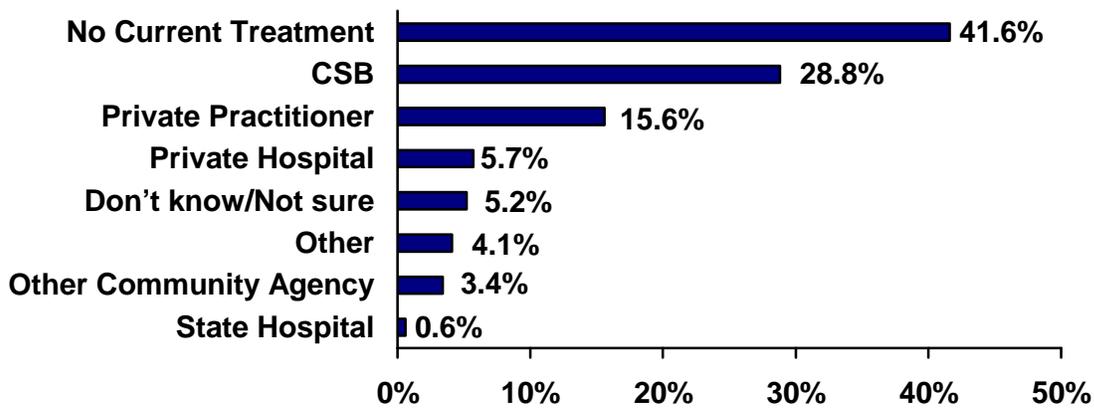


Current Treatment Status

► **Forty-two percent (41.6%) of adults were not receiving treatment at the time of the emergency evaluation.**

Although close to half of the adults were not receiving treatment at the time of their emergency evaluation, almost a third (28.8%) of those evaluated were already receiving treatment services from the CSB. Almost 16% of individuals were receiving services from a private practitioner (15.6%, Figure 6).

Figure 6. Source of Current Treatment

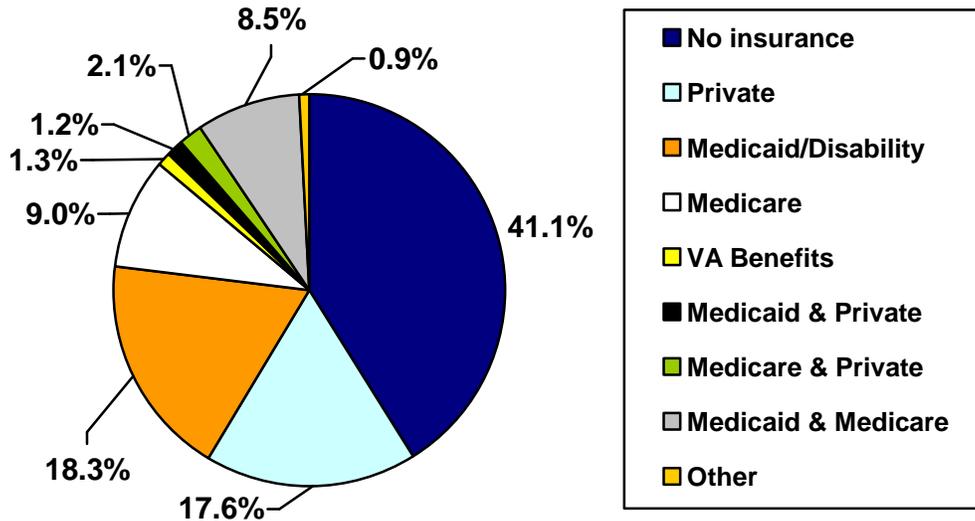


Insurance Status

► **Four out of 10 individuals did not have health insurance at the time of the emergency evaluation (41.1%).**

Approximately 59% of individuals evaluated had some type of health insurance to pay for treatment; 17.6% had private insurance and 41% had some form of public health insurance in part or whole, such as Medicaid/Disability, Medicare, or Veteran's Administration benefits (Figure 7). The rate of individuals who had private insurance compared to those with Medicaid/Disability was nearly equal at approximately 18%.

Figure 7. Insurance Status of Adults



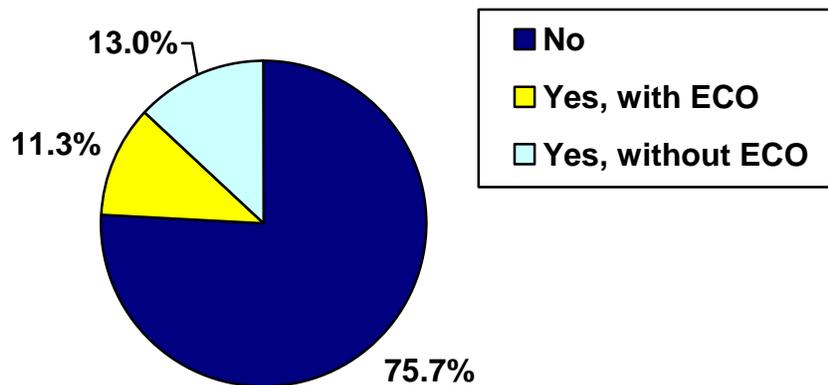
PATHWAYS TO CSB CRISIS RESPONSE SYSTEM

Individuals in Police Custody at Time of Evaluation

► **The majority of individuals were not in police custody at the time of the emergency evaluation.**

Seventy-six percent (75.7%) of people who received an emergency evaluation by a CSB clinician were not in police custody at the time of the assessment. Of those in custody, 11.3% were in custody with a magistrate-issued Emergency Custody Order (ECO) and 13.0% were in custody without a magistrate-issued ECO (Figure 8). Restraints were used in 42.8% of cases in which the person was in police custody.

Figure 8. Adults in Policy Custody at Time of Emergency Evaluation

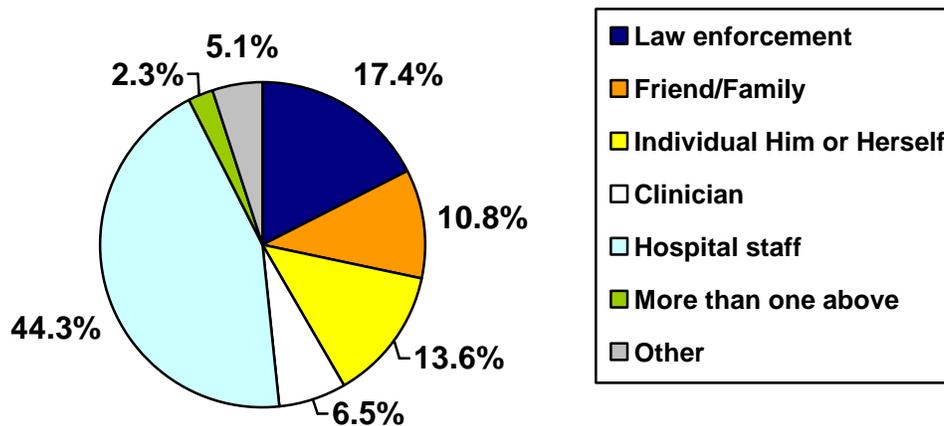


Contacting the CSB for Evaluation

► **CSB emergency evaluations were most often initiated by hospital staff.**

Hospital staff contacted the CSB to evaluate a person in crisis in 44.3% of cases. Law enforcement officers initiated such evaluations in 17.4% of cases, followed by family or friends in 10.8% of cases (Figure 9). The person him or herself sought help from a CSB clinician in 13.6% of the cases.

Figure 9. Contacting CSB for Evaluation

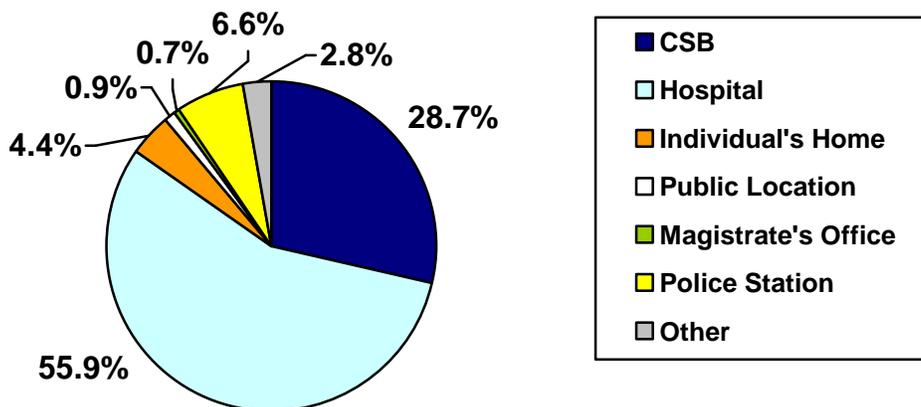


Location of Emergency Evaluation

► **Most emergency evaluations (55.9%) occurred at a hospital.**

Over half of the evaluations took place in a hospital setting, followed by the CSB (28.7%) or other places (Figure 10).

Figure 10. Location of Evaluation

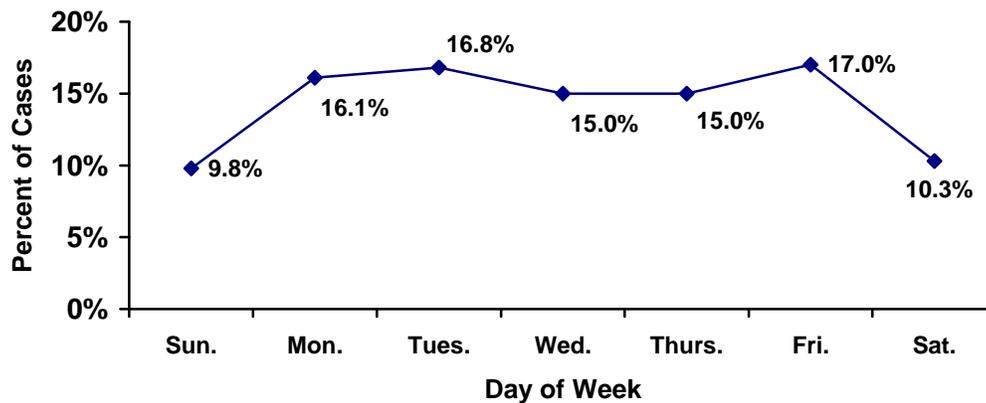


Day and Time of the Emergency Evaluation

► **Emergency evaluations were most likely to occur on weekdays rather than the weekend.**

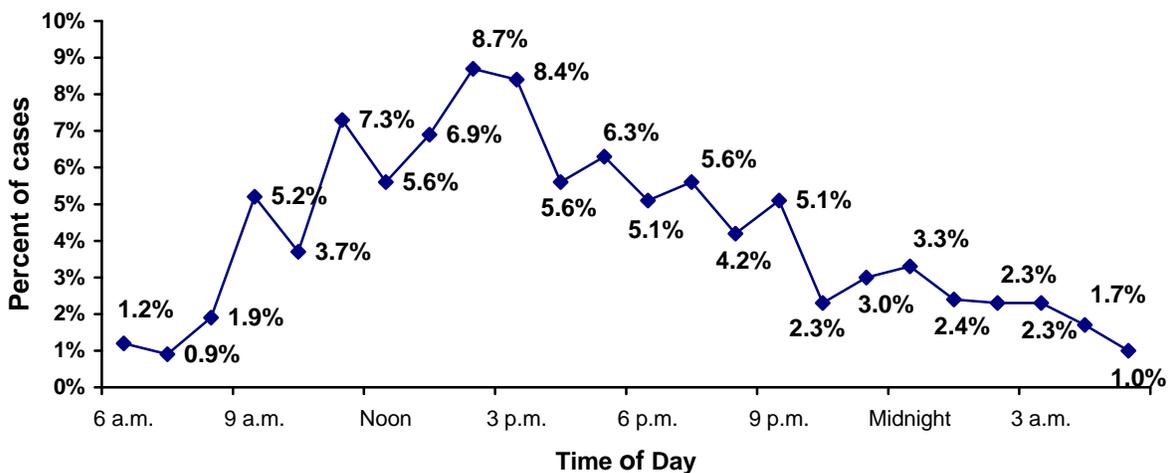
Figure 11 shows the percent of cases that occurred on each day of the week. Fewer emergency evaluations took place on the weekend (i.e., Saturday or Sunday) compared with the other days of the week.

Figure 11. Day of the Week Emergency Evaluation Occurred



The times of the day that emergency evaluations were conducted is shown in Figure 12. Most evaluations occurred during typical work hours, between 9 a.m. and 5 p.m. However, there was a significant influx of evaluations occurring during evening and late-night hours, from 6 p.m. to midnight, about 28.6%.

Figure 12. Time of Day Emergency Evaluation Occurred



CLINICAL PRESENTATION OF ADULTS

Presentation at Time of Emergency Evaluation

► **Almost 90% of the individuals who received an emergency evaluation by a CSB clinician presented with symptoms of mental illness and about one-third presented with symptoms of substance abuse.**

Figure 13 shows the clinician determined presentations of those evaluated for mental illness and/or substance abuse, at the time of the assessment. Among individuals who presented with a disorder at the time of the emergency evaluation, the majority (86.6%) presented with mental illness. Thirty-six percent (35.6%) of individuals presented with substance abuse problems.

Figure 13. Individual's Presentation at Time of Evaluation

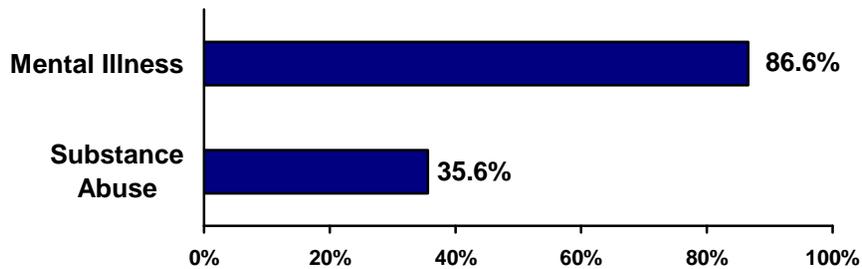
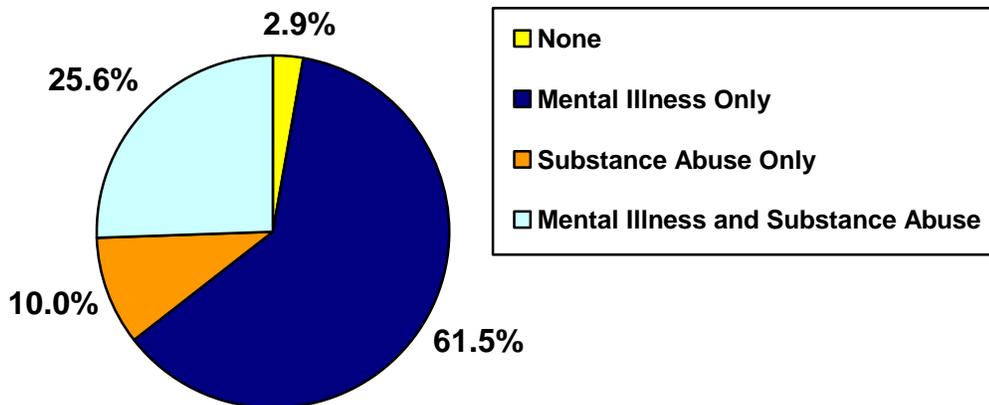


Figure 14 shows all categories of possible crisis-related adult presentations including no mental illness or substance abuse. Over half of individuals (61.5%) evaluated had mental illness only. Twenty-six percent (25.6%) of adults presented with both substance abuse and mental illness, whereas 10.0% had only a substance abuse problem.

Figure 14. Combinations of Individuals' Presentations



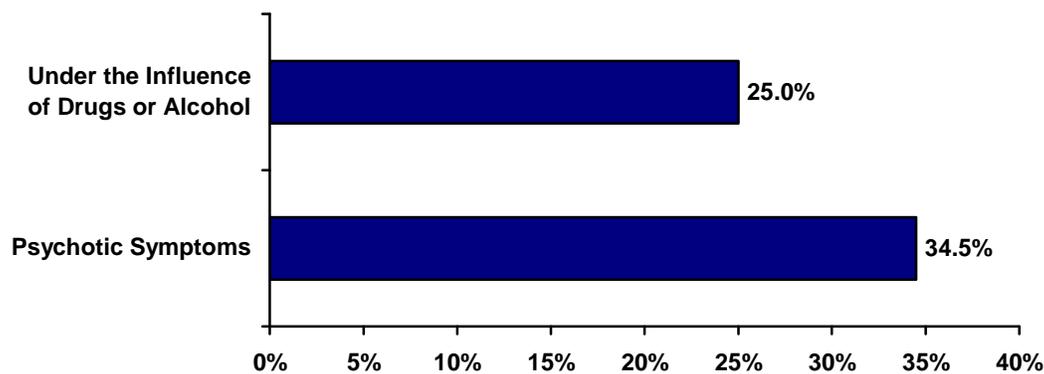
Under the Influence of Substances or Showing Psychotic Symptoms

► **One of every four adults were under the influence of drugs or alcohol at the time of the emergency evaluation and one-third of them exhibited psychotic symptoms (Figure 15).**

It was possible that an individual who received an emergency evaluation by a CSB clinician was currently under the influence of drugs or alcohol at the time of assessment but did not have a diagnosis of a substance abuse disorder. However, there was a strong association between the two: 90.7% of adults who were found to be under the influence of drugs or alcohol at the time of the evaluation were also found to have a substance abuse disorder ($\chi^2=1.19$, $df= 1$, $p<.001$).

Even more highly associated were displaying psychotic symptoms and mental illness. Nearly 100% (98.8%) of individuals with psychotic symptoms were identified by clinicians as presenting with mental illness ($\chi^2=1.92$, $df= 1$, $p<.001$).

Figure 15. Presenting Under the Influence or with Psychotic Symptoms



Displays of Behaviors that Met June 2007 Involuntary Commitment Criteria

► **Forty-two percent (42.1%) of adults who received an emergency evaluation by a clinician did NOT show indications of behaviors that met the criteria for a civil commitment (i.e., danger to others, danger to self, or an inability to care for self) at the time of the evaluation.**

Figure 16 displays the percent of adults who displayed overt indications of the possible commitment criteria. This figure includes individuals who may have been identified as displaying overt indications for more than one of the commitment criteria. Among the commitment criteria, overt indications of danger to self (37.9%) and the person's inability to care for self (34.9%) were

most frequently observed by clinicians. Less than one-fifth of adults evaluated were determined display overt indications of a danger to others (15.7%).

Figure 16. Display of Overt Indications of Commitment Criteria

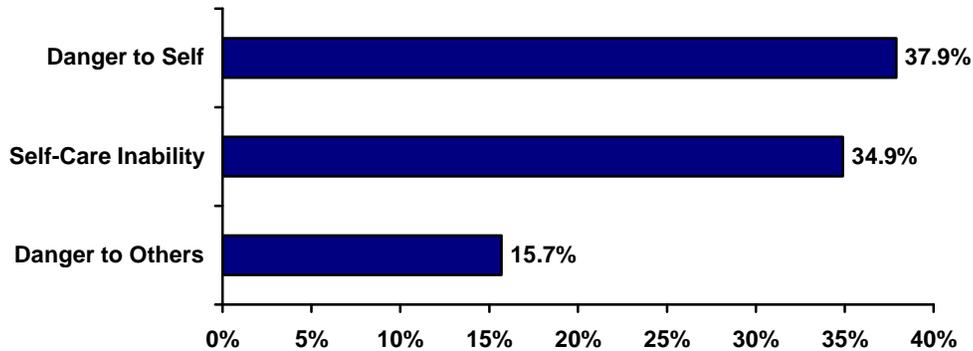
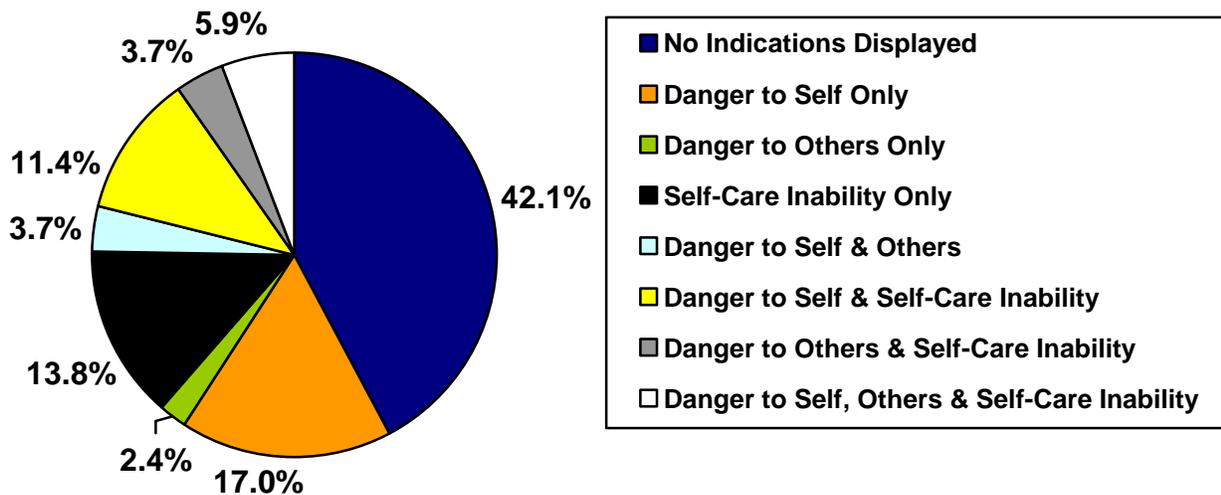


Figure 17 shows a summary of adults who were displaying overt indications of possible combinations for the commitment criteria. Notably, 42.1% of adults presented with no evidence of danger to self/others or inability to care for self.

Figure 17. Display of Overt Indication Combinations



DISPOSITION AFTER EMERGENCY EVALUATION

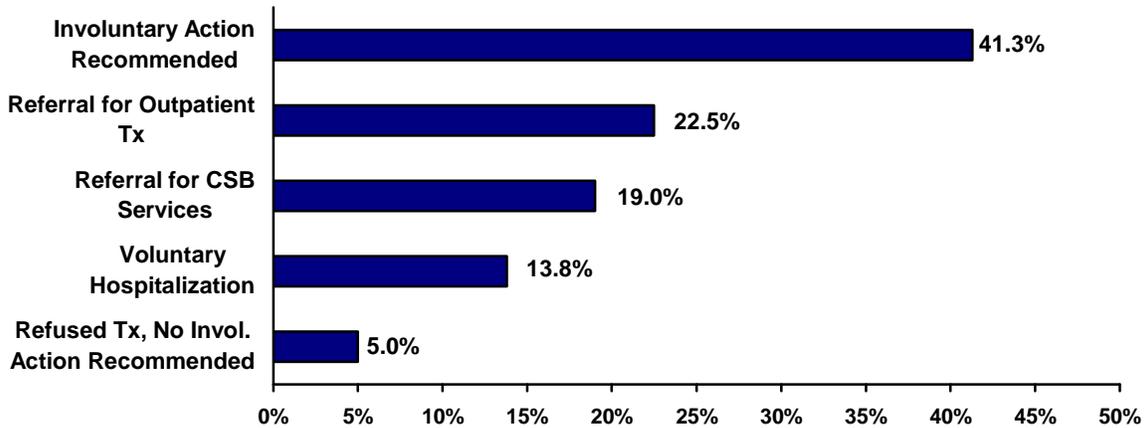
Type of Action Recommended by the CSB

► **Involuntary action was recommended to a magistrate in 41.3% of the emergency evaluations.**

Among cases where a disposition was recorded, 41.3% resulted in the CSB clinician recommending involuntary action to a magistrate. Of the remaining

cases, 13.8% of clinicians sought voluntary hospitalization for the person being evaluated. In 19.0% of cases, the person was referred for CSB services, and in 22.5% of cases, the person was referred for some other voluntary outpatient treatment (Figure 18). An individual who was evaluated and subsequently refused treatment was not recommended for involuntary action in 5.0% of cases.

Figure 18. Case Disposition

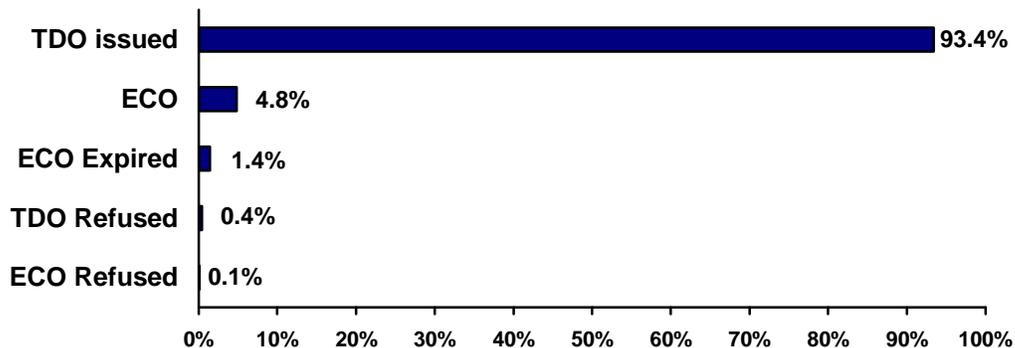


Outcome of Involuntary Action Recommended

► **Among cases in which involuntary action was recommended by the clinician, a Temporary Detention Order was sought and issued 93.4% of the time and an Emergency Custody Order was sought and issued in most of the remaining cases.**

Among the adults for whom involuntary action was recommended, the vast majority (93.4%) were issued a Temporary Detention Order (TDO) by a magistrate (Figure 19). Very rarely, or less than 1% of cases, was either a TDO or Emergency Custody Order (ECO) refused by the magistrate.

Figure 19. Outcome of Involuntary Action Recommended



Actions Taken to Identify a Psychiatric Bed

A bed in an acute-care psychiatric facility was sought in 52.5% of adult emergency evaluations. In most of these cases, the bed needed to be in a facility willing and authorized to take custody of a person under a Temporary Detention Order (a “TDO bed”). In the remaining cases, the bed was being sought for a person who had agreed to voluntary hospitalization.

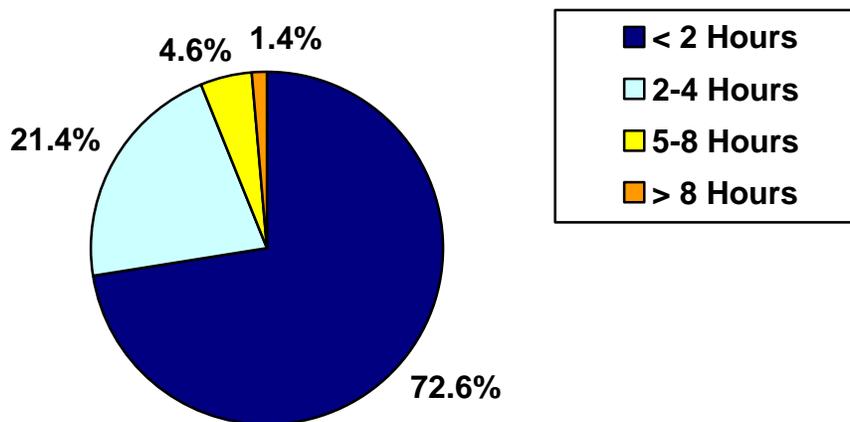
Length of Time Locating Psychiatric Bed

► In most cases, a psychiatric bed was located after contacting one or two facilities and within the time frame of less than an hour to 2 hours. The majority of facilities were located within the same region as the individual’s residence.

Once hospitalization was sought, the average number of facilities contacted by the clinician was between one and two ($M=1.89$, $sd=1.63$), ranging between one and nine facilities contacted. A facility with a psychiatric bed was located within two hours 72.6% of the time (Figure 20). It took 5 or more hours to locate a psychiatric bed in 6.0% of cases.

When a facility with a psychiatric bed was identified, the majority of facilities (88.3%) were located in the same region as the individual’s residence, and 11.7% were outside the region.

Figure 20. Length of Time Locating Psychiatric Bed for Treatment



No Bed Available

► In 3.8% of the cases in which voluntary or involuntary hospitalization was sought, the CSB clinician had extensive difficulty locating a bed in a timely manner.

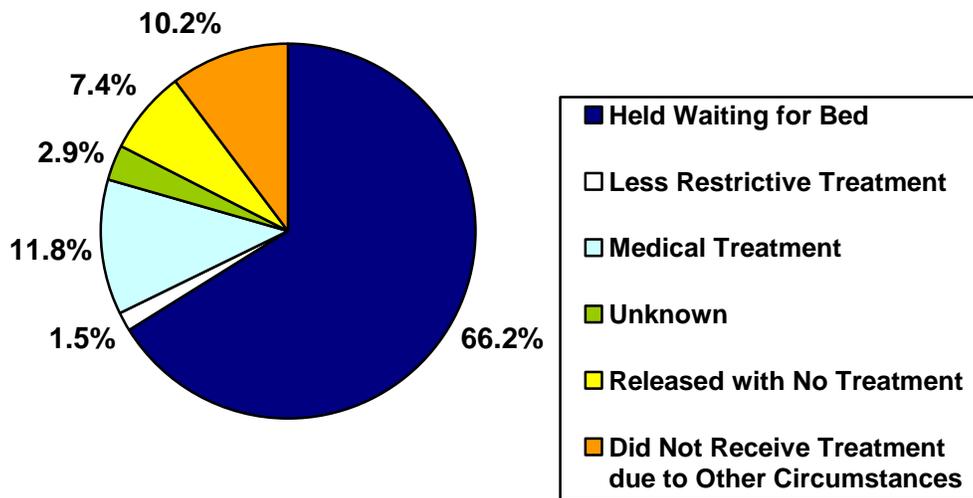
In 60 cases, the CSB clinician could not locate a bed after calling numerous hospitals or could not locate a bed within the amount of time a person could be legally held in custody. Most of these cases (70.0%) were involuntary cases in which a TDO bed was being sought. The next section explains situations in which an individual was not immediately admitted due to a bed not being available or due to other reasons.

Status When Involuntary Treatment Sought but Not Immediately Available

Figure 21 illustrates the various outcomes that resulted when an individual was in need of involuntary treatment but was not admitted due to beds being unavailable and for other reasons (individuals were not immediately admitted in 5.8% of involuntary cases during the survey month).

Figure 21.

Status when Involuntary Treatment Initially Sought But Did Not Occur



Of the 68 cases in which an individual was not immediately admitted to involuntary treatment, the majority was held waiting for a bed (45 cases or 66.2%). Next most frequent were those situations in which an individual was released without treatment, which happened in 12 cases during the survey month. In the figure above, 7.4% of such cases were due to a bed not being available; the other 10.2% of individuals were released due to other reasons such as an individual being incarcerated, leaving the facility, being uninsured or one reason not specified.

Admitting the person for medical treatment instead of or prior to psychiatric treatment occurred 11.8% of the time (in 8 cases). This included times when a person was admitted to medical detoxification.

One person was released to lesser restrictive treatment upon finding that no TDO bed would become available (1.5%). In 2 cases, or 2.9%, it was unknown what happened when a TDO bed was unavailable.

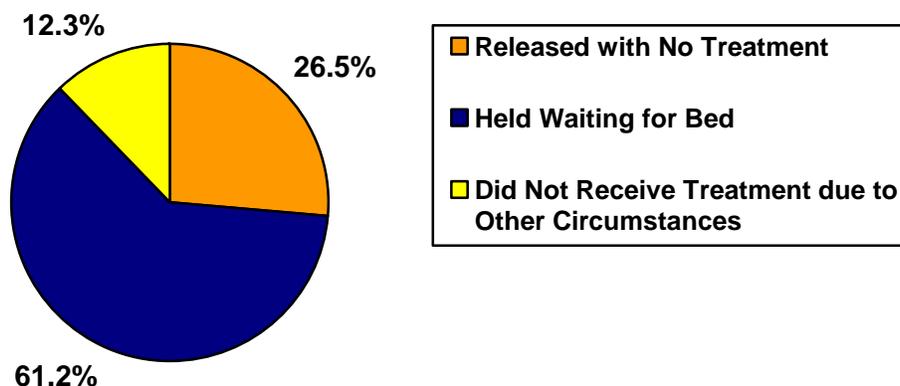
Of all individuals ordered into involuntary inpatient treatment during the survey month, 94.2% were successfully admitted to a detention facility.

Status When Voluntary Treatment Sought but Not Immediately Available

Figure 22 illustrates the various outcomes that resulted when an individual was in need of voluntary treatment but was not admitted due to a bed not being available or for other reasons (individuals were not immediately admitted in 12.1% of voluntary cases during the survey month).

Figure 22.

Status when Voluntary Treatment Initially Sought But Did Not Occur



Of the 49 cases in which an individual was not immediately admitted to voluntary treatment, the majority was held waiting for a bed (30 cases or 61.2%). The remaining individuals were released without treatment due to a bed not being available (6 individuals or 12.3%) or for other reasons (13 individuals or 26.5%). Other reasons included 7 unspecified reasons, 2 individuals who refused admission after originally agreeing to voluntary treatment, and 4 individuals who left the facility against medical advice.

Of all individuals during the survey month who agreed to voluntary inpatient treatment following an emergency evaluation by the clinician, 87.9% were admitted to a treatment facility.

Appendix D further details the possible pathways taken when involuntary or voluntary hospitalization was sought.

INDIVIDUAL’S CONDITION AT END OF EMERGENCY EVALUATION PERIOD

Opinion Rating of Individual’s Condition

► **At the end of the emergency evaluation, CSB clinicians opined that almost three-fourths of those assessed were “definitely or probably” experiencing severe mental or emotional distress or dysfunction and that 57.7% of them “definitely or probably” needed hospitalization.**

The clinician was asked to rate on a five-point scale (0= “definitely no” to 5= “definitely yes”) his or her agreement with five statements about the person’s condition at the conclusion of the emergency evaluation and two statements about the clinician’s probable actions. The percentages of responses for each rating by statement are presented in Table 1. Below is a summary of findings based on responses of “probably” or “definitely yes”:

- 83.4% stated that they were able to address the person’s crisis needs with available resources,
- 73.5% stated that the individual was experiencing severe mental or emotional distress or dysfunction,
- 57.7% reported that the individual’s condition warranted hospitalization,
- 41.3% noted that the individual was a danger to him or herself,
- 38.1% noted that the individual was unable to care for him or herself,
- And 18.7% noted that the individual was a danger to others.

Table 1. Clinician Opinion Ratings at End of Crisis

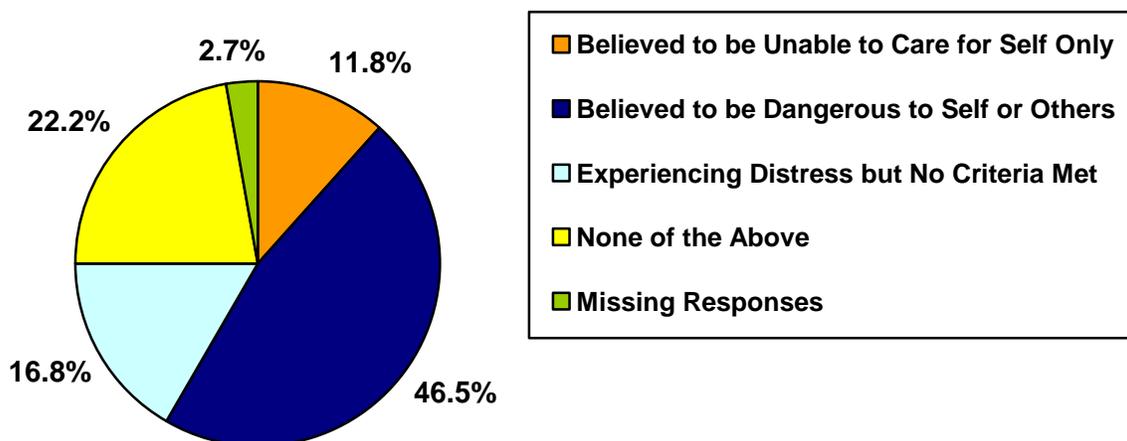
	Definitely No (%)	Probably No (%)	No opinion (%)	Probably Yes (%)	Definitely Yes (%)
Individual presented danger to self	24.1	31.0	3.6	18.8	22.5
Individual presented danger to others	44.7	32.7	3.9	10.3	8.4
Individual unable to care for self	35.3	21.8	4.8	14.2	23.9
Individual experiencing severe mental or emotional stress or dysfunction	8.6	13.2	4.7	28.2	45.3
Individual’s condition warranted hospitalization	25.5	14.4	2.4	14.3	43.4

	Definitely No (%)	Probably No (%)	No opinion (%)	Probably Yes (%)	Definitely Yes (%)
Would have sought involuntary action if individual refused services	31.8	13.7	3.5	12.0	39.0
Able to address individual's crisis needs with available resources	5.6	5.0	6.0	29.7	53.7

Figure 23 shows clinician opinion ratings that have been recoded into five mutually exclusive categories that connect perceived clinical severity of the individual's condition with the commitment criteria:

- (1) Any person who was found (definitely or probably) to be a danger to self or others even if such persons also exhibited a self-care inability, were recoded into the "Believed to be Dangerous to Self or Others" category.
- (2) After individuals designated by clinician opinions as a danger to self or others were removed, the remaining cases were recoded into a category of "Believed to be Unable to Care for Self Only".
- (3) Individuals 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) were recoded into two categories:
 - a. Cases in which individuals who were evaluated were found to be experiencing severe mental or emotional distress or dysfunction but did not meet the commitment criteria ("Experiencing Distress but No Criteria Met"),
 - b. Or cases in which individuals were not found to be experiencing severe distress or dysfunction and did not meet the commitment criteria ("None of the Above").

Figure 23. Clinician Opinion at End of Crisis



CSB Clinician Knowledge of Individual after Emergency Evaluation

In June 2007, when the Commission’s CSB Study was conducted, no mental health laws existed that mandated CSBs to track or monitor individuals who were not hospitalized following an emergency evaluation, even in cases that resulted in orders for involuntary outpatient treatment. Despite this, 82.7% of clinicians reported knowing the person’s whereabouts or status when he or she had not been hospitalized after the evaluation.

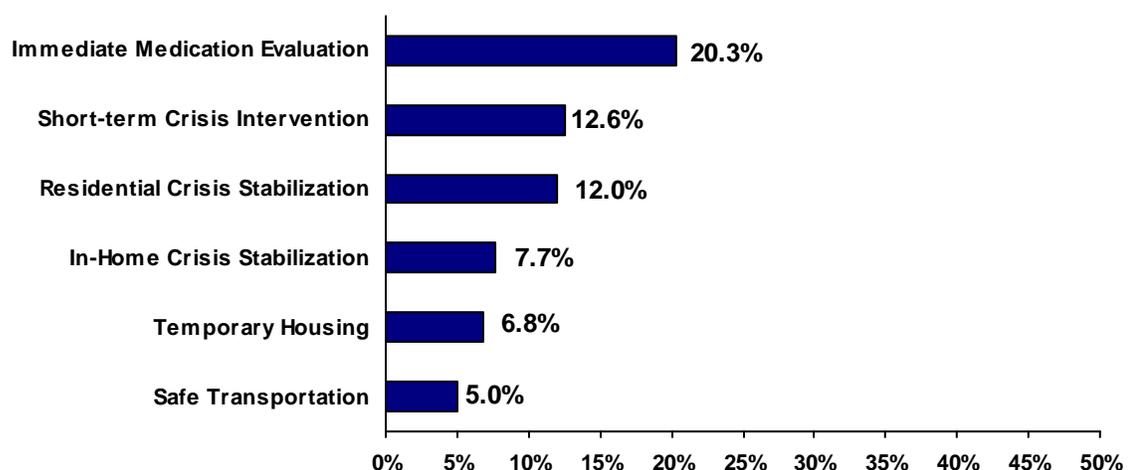
GAPS IN SERVICE CAPACITY

Services/Resources that Would Have Helped Address Individuals’ Needs

► **Immediate Medication Evaluation was the most likely response when clinicians were asked what services or resources would have helped them to better address individuals’ needs.**

Clinicians were asked what, if any, services or resources would have helped them to better address the needs of the person whom they were evaluating. They responded to the question using a checklist of needs and were able to select multiple resources or services needed as well as listing other needs not included on the list. Clinicians most frequently mentioned the need for an Immediate Medication Evaluation (i.e., psychotropic) as the resource that would have helped them address an individual’s needs (20.3%, Figure 24). The need for Safe Transportation was the least likely resource to be needed (5.0%).

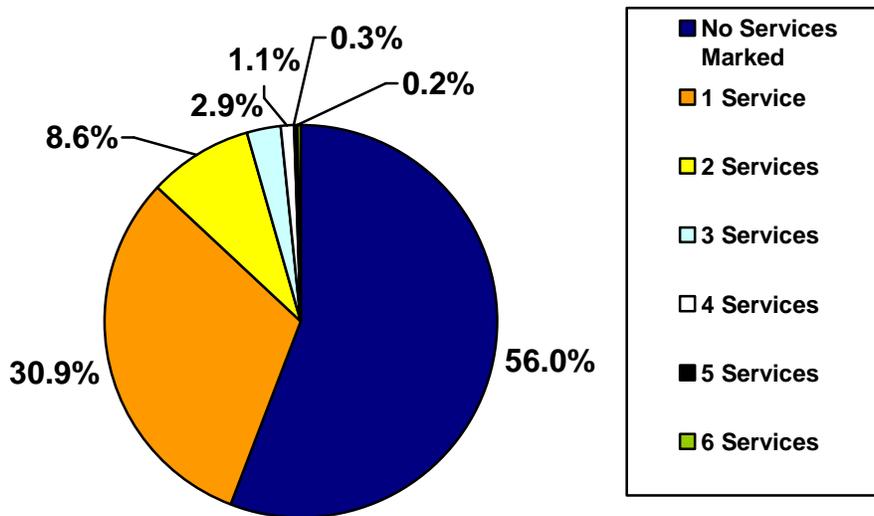
Figure 24. Services/Resources That Would Address Individuals’ Needs



When clinicians were asked whether they were able to address the individual’s needs with the resources available, 83.4% responded “definitely” or “probably” yes. When prompted to identify any resources or services that may have helped

them better serve the person who was being evaluated, 56.0% of clinicians indicated NO needs for additional services at their site and 30.9% indicated the need for at least one service or resource out of the six possible responses. Figure 25 shows the distribution of the number of services that clinicians reported would have helped them meet the need of the person in crisis. A description of the various services is available in Appendix G.

Figure 25. Number of Unavailable Services Reported as Needed by Clinicians



SECTION III

Variations of Adult Characteristics Among Community Services Boards

In the figures that follow, variations in adult emergency evaluations across Virginia Community Services Boards are illustrated. All CSBs, regardless of the number of adult emergency evaluations that occurred during the month of June 2007 were included in the analysis. CSBs are identified by a random corresponding number and color. The number of adult emergency evaluations on which complete data were available is presented in each figure.⁴ The state average for each characteristic is represented by a **red bar** located on the left side of each figure.

CSB VARIATIONS BY CHARACTERISTICS OF ADULTS

Persons who undergo emergency evaluations by the 40 CSBs in Virginia differ from one another in the ways summarized in Section II of this report—demographically and in relation to their living situation, insurance status, participation in mental health treatment and other ways. One important question is whether some CSBs are especially likely to see individuals with particular characteristics—e.g., more people who are homeless, uninsured or uninvolved in the mental health system. This section presents data bearing on a few of these questions.

Living Situation

► Rates of homelessness varied from no individuals who were homeless at some CSBs to over 20% of individuals homeless at three CSBs.

Living situations of individuals evaluated were highly similar among CSBs; therefore, only one figure is included to illustrate individuals' living situations, those individuals who were homeless. On average, 8.5% of people who received an emergency evaluation were homeless at the time of the assessment (Figure 26). However, three CSBs had rates of homelessness greater than the Virginia average, ranging from roughly 21 to 26%. These CSBs varied in their number of cases during the survey month: CSB code 4 reported the greatest number of cases at 159, code 18 had 19 cases (a quarter of which were homeless individuals), and code 30 had 42 cases. Seven CSBs reported “none” or less

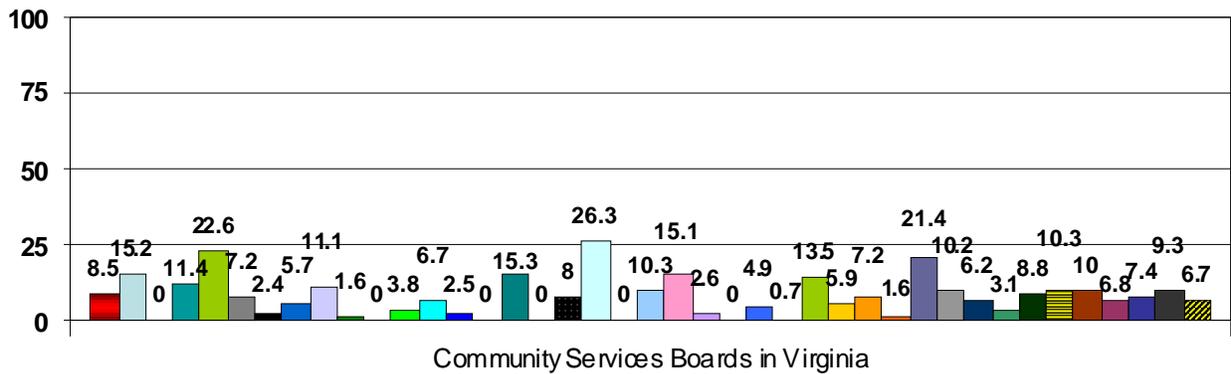
⁴ All Section III figures have chi-squares significant at less than 0.001.

than 1% of those seen during the survey month as being homeless at the time of the evaluation.

Across the Commonwealth, over half of individuals who were evaluated (54%) lived with family members at the time of the evaluation. The highest percentages of individuals who were living with family members (72% to 79%) were found in codes 2, 10 and 22.

Among all CSBs, the percentage of individuals evaluated who lived alone tended not to vary more or less than 15 percentage points in either direction. Overall, 20% of individuals evaluated lived alone. Seven CSBs reported that between 5 and 11% of those evaluated lived alone. As would be expected, other categories of living situations were altered by higher or lower percentages of people living alone or being homeless, etc. For example, the lower percentage of individuals found to be living alone in code 22 (5%) also coincides with its high percentage of individuals who were living with family (77%).

Figure 26. Percent of Emergency Evaluations in which Individual's Living Situation was Homeless, by CSB



STATE, n=2783	1, n=46	2, n=28	3, n=44	4, n=159	5, n=97
6, n=42	7, n=35	8, n=54	9, n=63	10, n=39	11, n=105
12, n=75	13, n=79	14, n=19	15, n=209	16, n=6*	17, n=88
18, n=19	19, n=18	20, n=58	21, n=86	22, n=39	23, n=52
24, n=103	25, n=137	26, n=52	27, n=102	28, n=97	29, n=64
30, n=42	31, n=98	32, n=65	33, n=64	34, n=102	35, n=136
36, n=10	37, n=44	38, n=54	39, n=108	40, n=45	

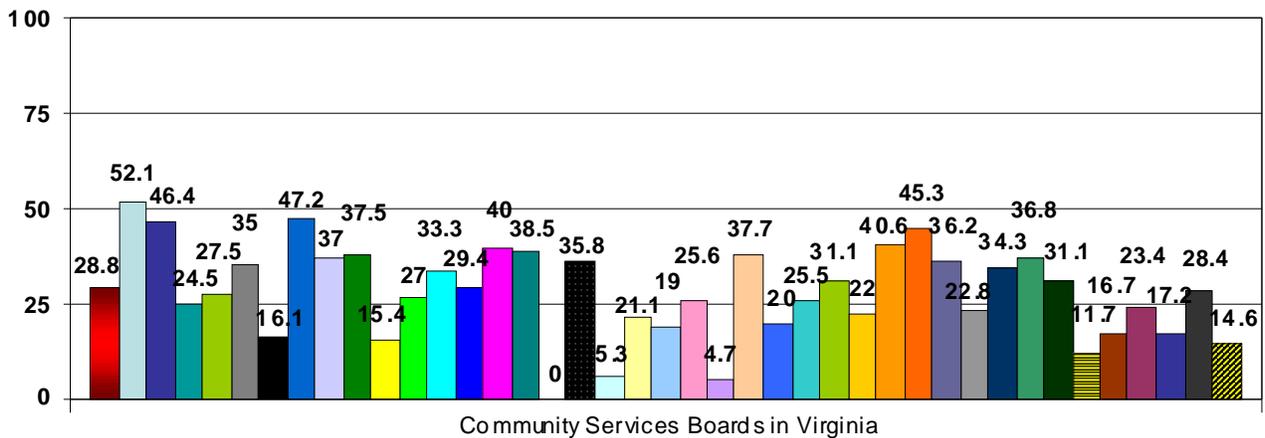
*CSB has less than 10 cases

Source of Current Treatment

► Among the 40 CSBs, there was considerable variation in the percentages of individuals who were receiving treatment from the CSB at the time of the evaluation.

If an individual was receiving treatment at the time of the evaluation, the most common source of treatment was a CSB. On average, 28.8% of adults were receiving treatment from a CSB. However, the variation among CSBs ranged from none of the individuals (0%) to over half of the individuals being evaluated who were current CSB clients (Figure 27). CSB code 16, in which only 6 individuals were evaluated during the month, reported that none of its evaluated individuals were receiving treatment from CSBs, and two-thirds were not currently receiving any treatment. CSB codes 18 and 22 also reported particularly low rates, with only about 5% of individuals reporting that the CSB was the treatment source.

Figure 27. Percent of Emergency Evaluations in which Individual was Receiving Treatment from the CSB, by CSB



STATE, n=2986	1, n=48	2, n=28	3, n=49	4, n=178	5, n=103
6, n=62	7, n=36	8, n=54	9, n=64	10, n=39	11, n=122
12, n=78	13, n=85	14, n=20	15, n=226	16, n=6*	17, n=95
18, n=19	19, n=19	20, n=63	21, n=90	22, n=43	23, n=53
24, n=115	25, n=137	26, n=61	27, n=109	28, n=106	29, n=64
30, n=47	31, n=101	32, n=67	33, n=68	34, n=103	35, n=154
36, n=12	37, n=47	38, n=58	39, n=109	40, n=48	

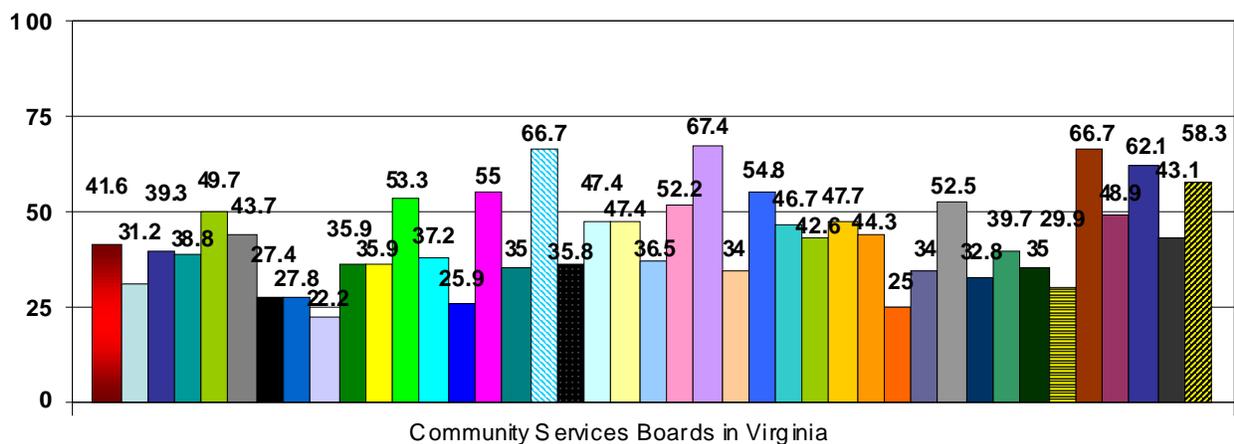
*CSB has less than 10 cases

Not Receiving Treatment

► **About 4 out of every 10 adults evaluated were not receiving any type of treatment at the time of the evaluation (41.6%).**

On average in Virginia, 41.6% of adults evaluated were not receiving any type of treatment at the time of the evaluation. Figure 28 shows the percentage of individuals at each CSB who were not receiving any treatment at the time of the assessment. Some CSBs had significantly fewer individuals without any current treatment than others. CSBs that had roughly a quarter of individuals who were not receiving any type of treatment and that evaluated between 36 and 85 individuals during the survey month included CSB codes 6, 7, 8, 13 and 29. Five CSBs reported that in roughly 60% to two-thirds of evaluations the individual had no current treatment: codes 16 and 36 (6 and 12 cases, respectively), and codes 22, 38 and 40 (each reporting about 50 cases).

Figure 28. Percent of Emergency Evaluations in which Individual was Not Receiving Any Type of Treatment, by CSB



STATE, n=2987	1, n=48	2, n=28	3, n=49	4, n=179	5, n=103
6, n=62	7, n=36	8, n=54	9, n=64	10, n=39	11, n=122
12, n=78	13, n=85	14, n=20	15, n=226	16, n=6*	17, n=95
18, n=19	19, n=19	20, n=63	21, n=90	22, n=43	23, n=53
24, n=115	25, n=137	26, n=61	27, n=109	28, n=106	29, n=64
30, n=47	31, n=101	32, n=67	33, n=68	34, n=103	35, n=154
36, n=12	37, n=47	38, n=58	39, n=109	40, n=48	

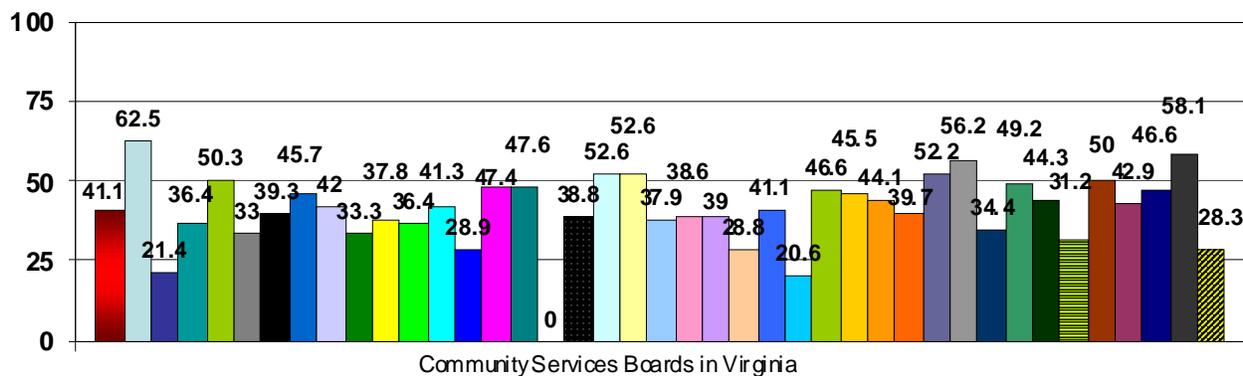
*CSB has less than 10 cases

Insurance Status

► In 20% of the CSBs (n=8) in Virginia, half or more of the individuals who received an emergency evaluation did not have health insurance.

Among CSBs in Virginia, 41.1% of individuals who received an emergency evaluation during the survey month had no health insurance when evaluated. There was wide variability in the percentage of uninsured among CSBs (Figure 29). Of the 8 CSBs with half or more than half of evaluated individuals not having health insurance, codes 4 and 36 reported 50% of their 173 and 12 cases respectively as not having health insurance. Remaining CSBs were code 1 (62.5% of its 40 cases), codes 18 and 19 (each with 52.6% of 19 cases), and codes 30, 31 and 39 (between 52 to 58% of their 46 to 105 cases). Only one CSB (code 16) reported that all evaluated individuals had health insurance. However, it is important to note that this CSB saw only 6 cases during the survey month. Other CSBs that reported the lowest rates of uninsured individuals were codes 2 and 25, both of which reported roughly 21% of cases as being uninsured.

Figure 29. Percent of Emergency Evaluations in which Individual had No Insurance Coverage, by CSB



STATE, n=2846	1, n=40	2, n=28	3, n=44	4, n=173	5, n=97
6, n=61	7, n=35	8, n=50	9, n=63	10, n=37	11, n=121
12, n=75	13, n=83	14, n=19	15, n=212	16, n=6*	17, n=85
18, n=19	19, n=19	20, n=58	21, n=83	22, n=41	23, n=52
24, n=112	25, n=136	26, n=58	27, n=101	28, n=102	29, n=63
30, n=46	31, n=96	32, n=64	33, n=63	34, n=97	35, n=144
36, n=12	37, n=42	38, n=58	39, n=105	40, n=46	

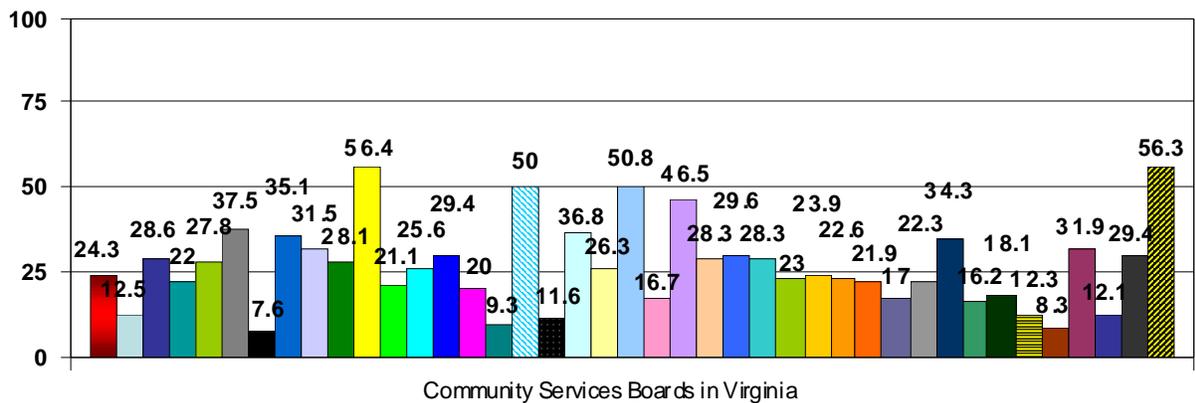
*CSB has less than 10 cases

Individuals in Police Custody at Time of Evaluation

► **In 10% of the CSBs (n=4), half or more than half of the individuals in crisis were in police custody during the emergency evaluation.**

On average, 1 out of 4 adults during the survey month were in police custody at the time of the evaluation (24.3%). Figure 30 shows the percentage of individuals in police custody with or without an ECO at the time of the emergency evaluation. Four CSBs reported that between 50% and 56% of individuals who received an emergency evaluation were in police custody during the assessment (codes 10, 16, 20 and 40).⁵ Seven CSBs had rates at least 10 percentage points below the Virginia average of 24.3%, all with about 1 in 10 individuals in police custody at the time of the assessment. These CSBs include code 1 (48 people), code 6 (66 people), code 15 (227 people), code 17 (95 people), code 35 (155 people), code 36 (12 people), and code 38 (58 people).

Figure 30. Percent of Individuals who were In Police Custody With or Without an ECO at the Time of the Evaluation by CSB



Community Services Boards in Virginia

STATE, n=3003	1, n=48	2, n=28	3, n=50	4, n=180	5, n=104
6, n=66	7, n=37	8, n=54	9, n=64	10, n=39	11, n=123
12, n=78	13, n=85	14, n=20	15, n=227	16, n=6*	17, n=95
18, n=19	19, n=19	20, n=63	21, n=90	22, n=43	23, n=53
24, n=115	25, n=138	26, n=61	27, n=109	28, n=106	29, n=64
30, n=47	31, n=103	32, n=67	33, n=68	34, n=105	35, n=155
36, n=12	37, n=47	38, n=58	39, n=109	40, n=48	

*CSB has less than 10 cases

⁵ CSB code 16 had only 6 cases.

Type of Action Recommended by the CSB

►Of possible dispositions resulting from an emergency evaluation, CSB clinicians most often recommended that an involuntary action be taken to ensure that treatment is provided for the person in crisis.

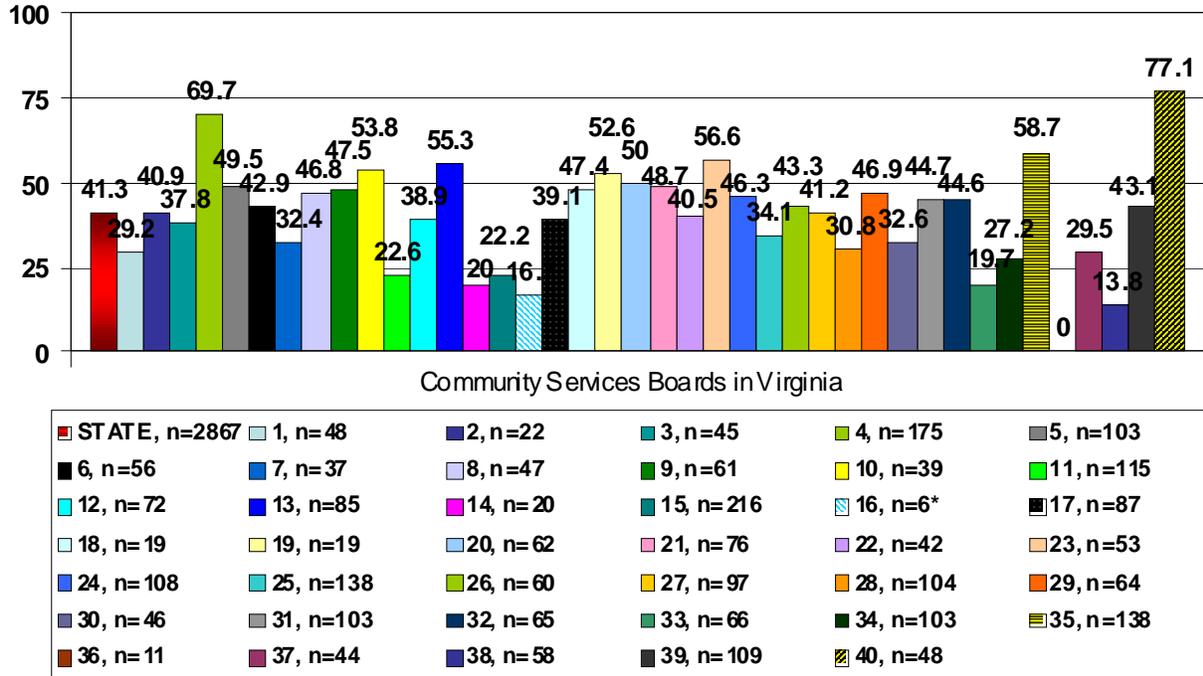
A referral for voluntary outpatient treatment was the second most frequent recommendation, followed by voluntary CSB services and voluntary hospitalization. Of individuals who were evaluated but refused recommended treatment, CSBs did not seek involuntary action in 5% of cases, on average.

Involuntary Action Recommended

►There was wide variability among CSBs in the percentage of clinicians who recommended an involuntary action following an emergency evaluation, ranging from no recommendations at one CSB to 77.1% of emergency evaluations resulting in a recommendation for involuntary action at another.

On average, clinicians made recommendations for an involuntary action for 4 out of every 10 people who received an emergency evaluation. Figure 31 shows the percentage of emergency evaluations in which the CSB clinician thought an individual possibly met criteria to be committed involuntarily and would not otherwise agree to treatment. Three CSBs were more likely to recommend involuntary action by 20 to 30 percentage points above Virginia's average: CSB code 4 recommended involuntary actions in 69.7% of its 175 cases, CSB code 35, in 58.7% of its 138 cases, and CSB code 40, in three-quarters (77.1%) of its 48 cases. Many CSBs were less likely to recommend involuntary action, with averages ranging from slightly more than 1 in 10 cases (CSB code 38) to roughly 2 in 10 cases (CSB codes 11, 14, 15, 16 and 33). CSB code 36 never reported recommending involuntary action in its 11 cases during the survey month.

Figure 31. Percent of Emergency Evaluations in which CSB Clinician Recommended Involuntary Action, by CSB



*CSB has less than 10 cases

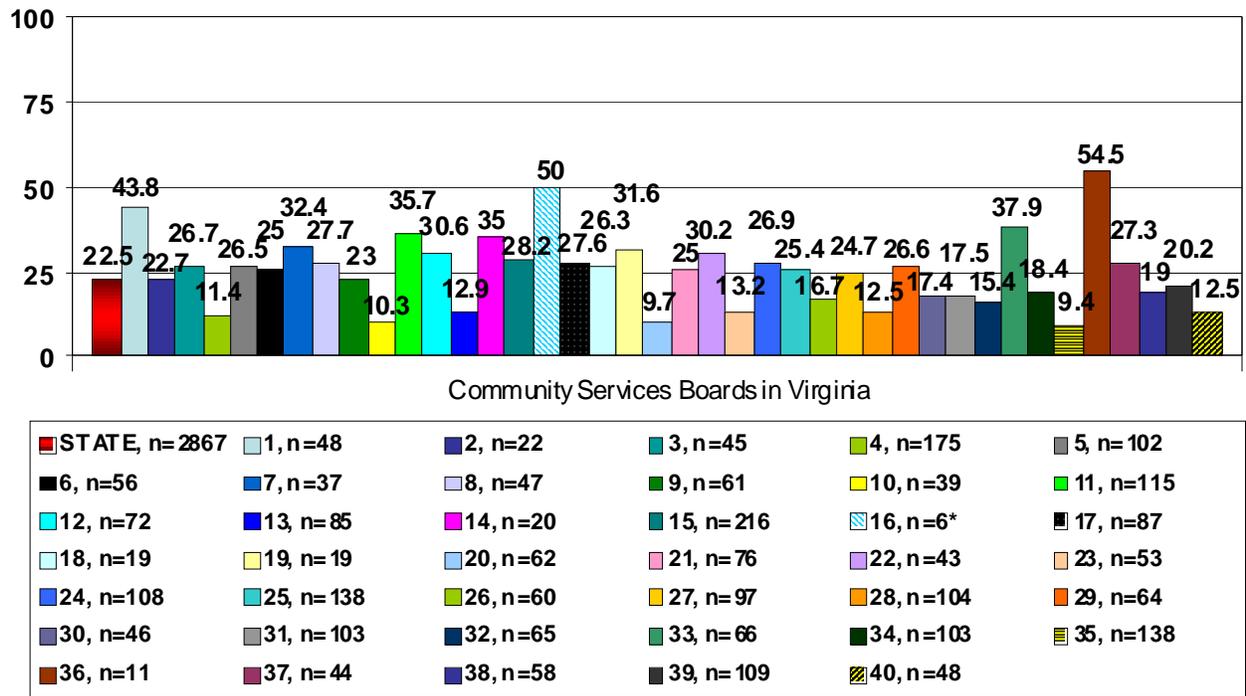
Referral for Voluntary Outpatient Treatment

► **Roughly one-fifth (22.5%) of individuals who received an emergency evaluation by a CSB clinician were recommended for voluntary outpatient services during the survey month.**

CSB clinicians are mandated to use the least restrictive course of treatment possible when recommending appropriate care for individuals in need of mental illness or substance abuse treatment. Figure 32 shows the percentage of individuals who were referred to voluntary outpatient services (the figure does not include voluntary CSB services). As might be expected, many of the CSBs that had high rates of recommended involuntary actions also showed lower rates of referrals for voluntary outpatient treatment. These CSBs include CSB 4, which referred 11.4% of its 175 evaluated individuals to voluntary outpatient services, CSB 35, which referred 9.4% of its 138 individuals, and CSB 40, which referred 12.5% of its 48 individuals. Other CSBs with lower rates for voluntary outpatient referrals include CSB codes 10, 13, 20, 23 and 28, all of which referred roughly 10% of their evaluated individuals. Some CSBs also had higher percentages of referrals to voluntary outpatient treatment in comparison to the

state average: CSB code 1 referred 43.8% of its 48 cases, CSB code 16 referred half of its 6 cases, and CSB code 36 referred just over half of its 11 cases.

Figure 32. Percent of Emergency Evaluations in which CSB Clinician Referral was for Voluntary Outpatient Treatment by CSB



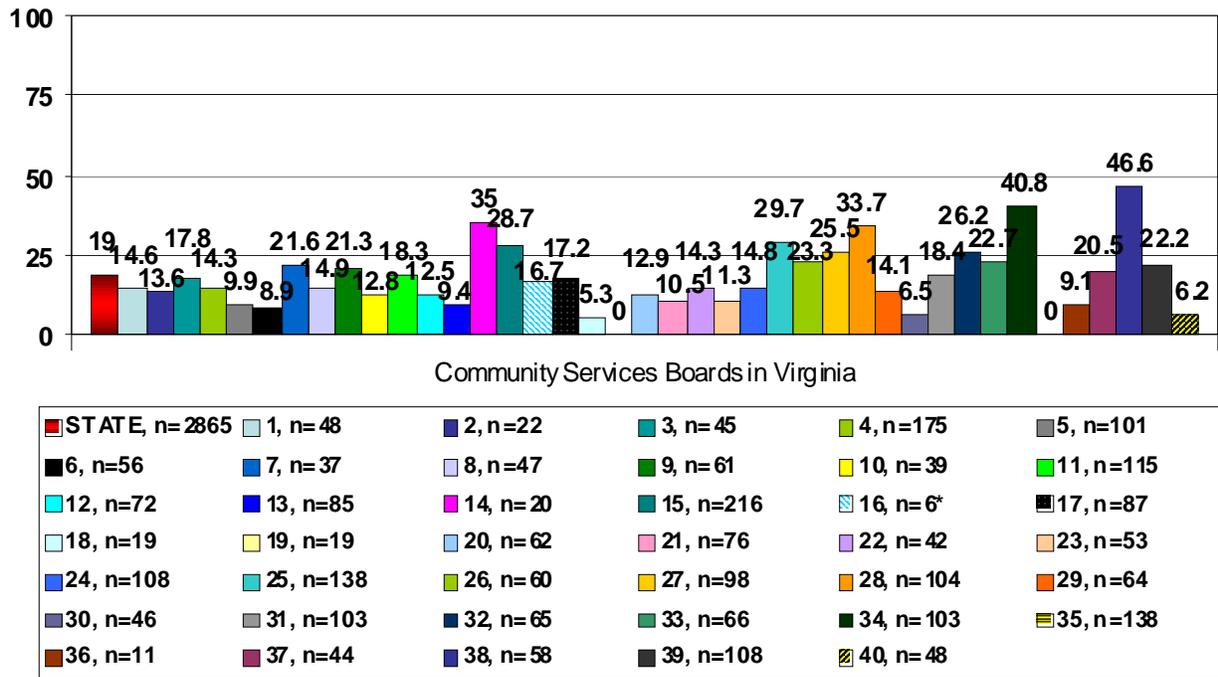
*CSB has less than 10 cases

Referral for Voluntary CSB Services

► **Among CSBs, there were significant differences in the rate of clinician referrals for voluntary CSB services following an emergency evaluation, perhaps showing disparity in the range of CSB services available.**

CSB clinicians recommended voluntary CSB services for those people evaluated in about 1 out of 5 cases (19.0%) during the survey month, as shown in Figure 33. Clinicians at two CSBs never referred evaluated individuals to CSB services: CSB 19 with 19 cases and CSB 35 with 138 cases. Six additional CSBs reported clinician referral of individuals to voluntary CSB services in less than 10% of cases (CSB code 6, 13, 18, 30, 36 and 40). The CSB which had the highest percentage of cases referred to CSB services was CSB code 38, with nearly half of its 58 cases referred. Other CSBs with high referral rates were CSB code 14 at 35.0% and CSB code 34 at 40.8%.

Figure 33. Percent of Emergency Evaluations in which CSB Clinician Referral was for Voluntary CSB Services by CSB



*CSB has less than 10 cases

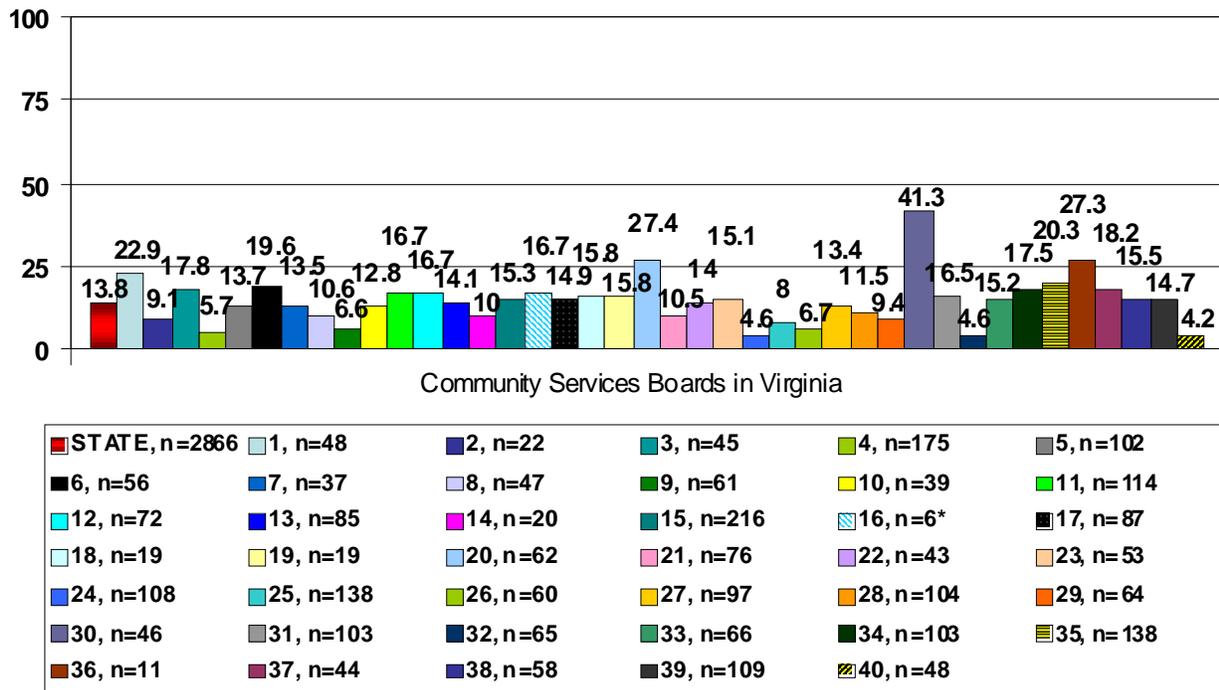
Voluntary Hospitalization

► **Of the possible dispositions following an emergency evaluation, a referral for voluntary hospitalization was recommended the least for adult individuals during the survey month.**

Just over 1 in 10 cases (13.8%) ended with an agreement between the clinician and the individual that he or she accept voluntary hospitalization, as shown in Figure 34. In three CSBs, voluntary inpatient hospitalization was recommended in over a quarter of cases. These CSBs included codes 20 and 36, with voluntary inpatient treatment found in one-quarter of their 62 and 11 cases respectively, and CSB code 30, in which roughly 4 out of 10 cases were referred to voluntary inpatient treatment. Of CSBs that had high rates of involuntary hospitalizations, CSB codes 4 and 40 had correspondingly low rates of voluntary hospitalization (each had about 5% of cases agree to voluntary hospitalization). Two other CSBs

had rates as low as 5%, but not quite as high rates of involuntary hospitalization: CSB code 24 with 108 cases and CSB code 32 with 65 cases.

Figure 34. Percent of Emergency Evaluations in which Individual Agreed to Voluntary Hospitalization by CSB



*CSB has less than 10 cases

Length of Time Locating Psychiatric Bed

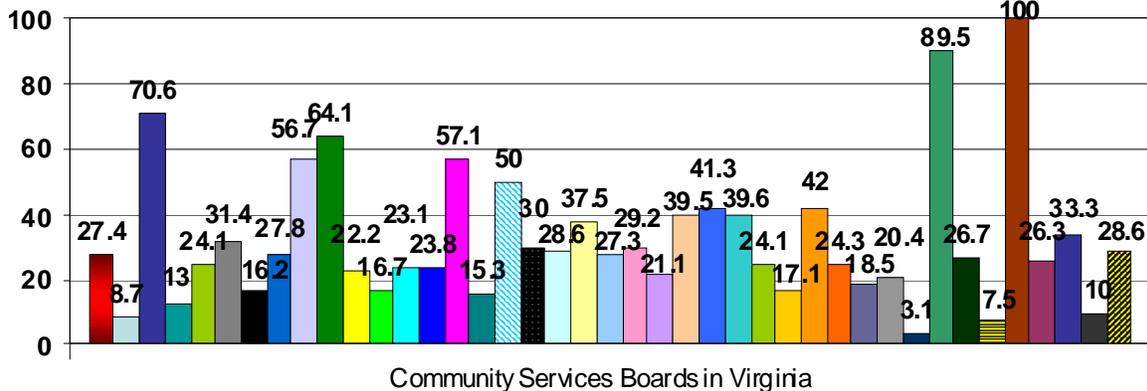
► **In every CSB, there were cases in which the clinician needed more than 2 hours to locate an available psychiatric bed; however, 33% of CSBs experienced difficulty finding beds in a timely fashion in more than a third of their cases.**

Figure 35 shows the percentage of cases in which it took 2 or more hours to locate an available psychiatric bed following an emergency evaluation. Seven CSBs reported between 50% and 100% of cases in which locating a bed took 2 or more hours (codes 2, 8, 9, 14, 16, 33 and 36).⁶ Other CSBs reported 10% or fewer cases requiring a 2 hour or more search time: CSB code 1 had 8.7% of its

⁶ CSB codes 14, 16 and 36 each had less than 10 cases, with code 36 having only 1 case in which a clinician reported time spent searching for a psychiatric bed.

23 cases resulting in a 2 hour or more search time; code 32, 3.1% of its 32 cases; code 35, 7.5% of its 67 cases; and code 39, one-tenth of its 60 cases.

Figure 35. Percent of Emergency Evaluations in which Clinician Spent 2 or More Hours Locating a Psychiatric Bed, by CSB



STATE, n=1428	1, n=23	2, n=17	3, n=23	4, n=112	5, n=51
6, n=37	7, n=18	8, n=30	9, n=39	10, n=27	11, n=42
12, n=39	13, n=42	14, n=7*	15, n=72	16, n=2*	17, n=50
18, n=14	19, n=8*	20, n=44	21, n=48	22, n=19	23, n=38
24, n=63	25, n=53	26, n=29	27, n=41	28, n=50	29, n=37
30, n=27	31, n=54	32, n=32	33, n=19	34, n=30	35, n=67
36, n=1*	37, n=19	38, n=9*	39, n=60	40, n=35	

*CSB has less than 10 cases

Psychiatric Bed Located within Individual's Region

► **Although 88% of cases overall result in an individual's hospitalization at a psychiatric facility within the region where he or she resides, certain CSBs report much more difficulty than others in locating a bed within their region.**

The CSB with the most reported difficulty locating a psychiatric bed within the region where the individual lived was CSB code 2, in which only 20% of its 15 cases (i.e., 3 of every 15 individuals evaluated) were able to be hospitalized for treatment within the region. Other CSBs included CSB code 9 with roughly 40% of individuals hospitalized within its region, and codes 23, 25, 36 and 37 which had between roughly 60% and 74% of individuals hospitalized within their regions. The remaining 34 CSBs each reported that between three-fourths and

100% of individuals who were evaluated were hospitalized at facilities within their region.

Hospital Locations Compared to CSB Emergency Evaluation Incidence

► **Figure 36 shows a greater concentration of hospitals and CSBs in more populated regions of the state. A small number of CSBs are shown to be a greater distance to hospitals than the majority of the state.**

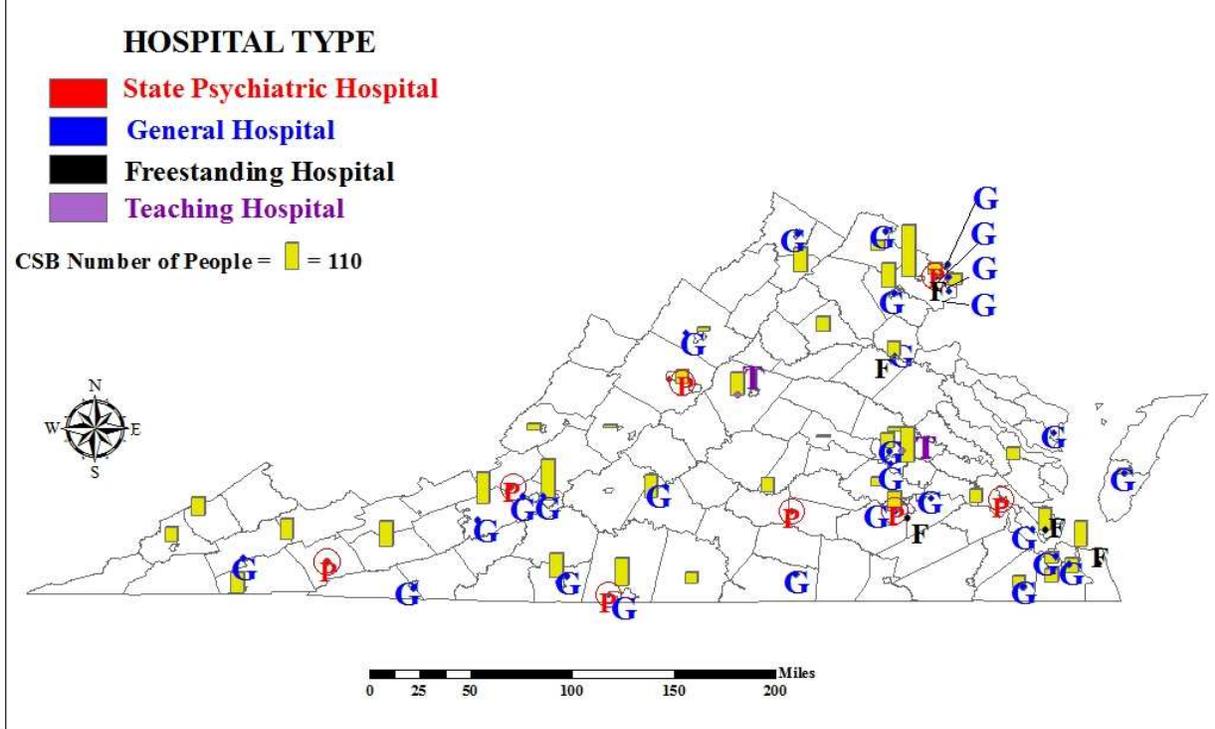
Figure 36 provides a visual snapshot of the density of emergency evaluations across Virginia and the CSB locations in relation to locations of hospitals with psychiatric units (mapped by zip code). The map provides a sense of the geographic availability of psychiatric units that provide services for individuals who need treatment for acute and/or long term care for mental illness.

The four types of hospitals with psychiatric units shown on the map are categorized by tax status: state hospitals, general hospitals, freestanding hospitals and teaching hospitals. There are eight state hospitals with psychiatric units: Northern Virginia Mental Health Institute, Eastern State Hospital, Southern Virginia Mental Health Institute, Southwestern Virginia Mental Health Institute, Western State Hospital, Catawba Hospital, Central State Hospital and Piedmont Geriatric Hospital. Two hospitals, University of Virginia and Virginia Commonwealth University, are considered teaching hospitals, have licensed psychiatric beds, and are also state owned.⁷ The general hospitals shown on the map are those with licensed psychiatric beds. General hospitals focus on an acute care model (patient stay of seven to 30 days), unlike the long-term care model which is used in state hospitals. The five freestanding hospitals shown specialize in both acute and long-term psychiatric care.⁸

⁷ Eastern Virginia Medical School is not considered a teaching hospital for the purposes of this map. It is included as a general hospital for its location at Sentara Norfolk General Hospital.

⁸ Hospital information as of 2006. All data pertaining to hospital types and locations was obtained from the *Availability and Cost of Licensed Psychiatric Services in Virginia*, Report by the Joint Legislative Audit and Review Commission to the Governor and the General Assembly of Virginia, October 2007.

Figure 36. Incidence of Emergency Evaluations by CSB Location and Types of Hospitals Across Virginia, June 2007



Services/Resources that Would Have Helped Address Individuals' Needs

► **CSB clinicians stated that the resource that was not available to them that they *most* needed to address the needs of an individual with a mental health crisis was an Immediate Medication Evaluation.**

Other needed services, in order of highest percentage of responses among adult cases, were Short Term Crisis Intervention, Residential Crisis Stabilization, In-Home Crisis Stabilization, Temporary Housing, and Safe Transportation. Appendix G provides a description of these services.

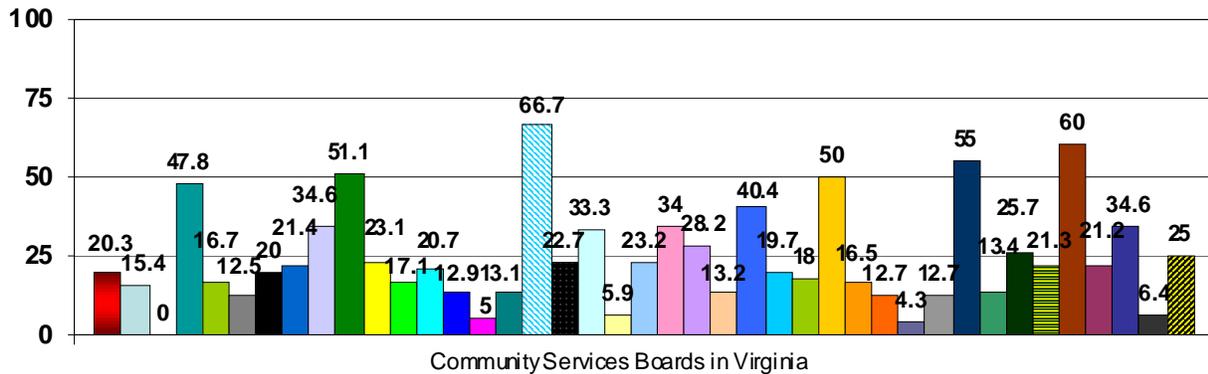
Immediate Medication Evaluation

► **In 39 of the 40 CSBs, an Immediate Medication Evaluation was indicated as a needed resource by clinicians who conducted emergency evaluations of individuals during the survey month.**

Immediate Medication Evaluation was indicated as a much needed resource by clinicians for approximately 1 out of 5 individuals (20.3%) who received an

emergency evaluation. Figure 37 shows the percentage of responses among all CSBs in which clinicians reported that an Immediate Medication Evaluation would have helped them to better address the needs of the person in crisis. Seven CSBs indicated that clinicians needed a significantly higher number of Immediate Medication Evaluations than the state average of 20.3%. CSB code 24 reported a need for Immediate Medication Evaluation in 4 out of 10 cases, whereas CSB codes 3, 9 and 27 reported a need in approximately half of their 23 to 45 cases. With even greater percentages of need, three additional CSBs indicated needs in 55% to two-thirds of cases (CSB code 32 with 40 cases, code 36 with 5 cases, and code 16 with 6 cases). Every CSB except for CSB code 2 reported at least some need for currently unavailable Immediate Medication Evaluation. Other CSBs with fewer numbers of Immediate Medication Evaluation needs were CSB code 14, which needed the service in 5.0% of its 20 cases, and CSB codes 19 and 39, which needed the service in about 6% of their 17 and 109 cases, respectively.

Figure 37. Percent of Emergency Evaluations in which CSB Clinician Reported Need for Immediate Medication Evaluation by CSB



STATE, n=2166	1, n=39	2, n=15	3, n=23	4, n=144	5, n=80
6, n=15	7, n=14	8, n=26	9, n=45	10, n=39	11, n=70
12, n=29	13, n=85	14, n=20	15, n=183	16, n=6*	17, n=22
18, n=12	19, n=17	20, n=56	21, n=50	22, n=39	23, n=53
24, n=57	25, n=137	26, n=61	27, n=42	28, n=85	29, n=63
30, n=46	31, n=102	32, n=40	33, n=67	34, n=74	35, n=89
36, n=5*	37, n=33	38, n=26	39, n=109	40, n=48	

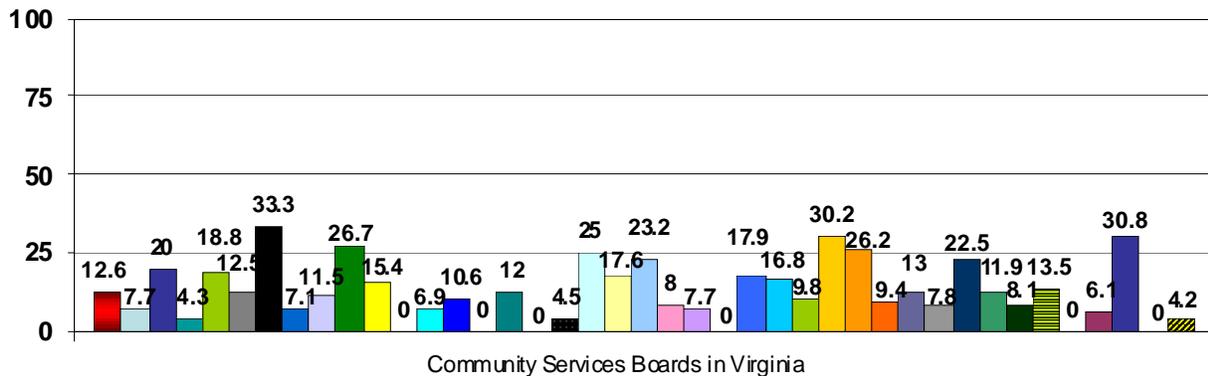
*CSB has less than 10 cases

Short-Term Crisis Intervention

► **CSB clinicians report that Short-Term Crisis Intervention was the second-most needed type of service or resource currently unavailable, with 8 CSBs reporting this need for over 20% of individuals who were evaluated during the survey month (Figure 38).**

In only 6 of the 40 CSBs (CSB codes 11, 14, 16, 23, 36 and 39) did clinicians report NO need for Short-Term Crisis Intervention services to help them address the needs of those individuals evaluated in a mental health crisis. The highest rate in which clinicians reported a need for the service was approximately one-third of cases (CSB code 6 which had 15 cases). This rate was similar to rates in two other CSBs: CSB codes 27 and 38 each reported a need for the service for approximately 30% of the individuals who were evaluated. In CSB codes 18 and 28, clinicians indicated that Short-Term Crisis Intervention would have been helpful in one-fourth of their 12 and 84 emergency evaluations, respectively.

Figure 38. Percent of Emergency Evaluations in which CSB Clinician Reported Need for Short-Term Crisis Intervention, by CSB



STATE, n=2167	1, n=39	2, n=15	3, n=23	4, n=144	5, n=80
6, n=15	7, n=14	8, n=26	9, n=45	10, n=39	11, n=71
12, n=29	13, n=85	14, n=20	15, n=183	16, n=6*	17, n=22
18, n=12	19, n=17	20, n=56	21, n=50	22, n=39	23, n=53
24, n=56	25, n=137	26, n=61	27, n=43	28, n=84	29, n=64
30, n=46	31, n=102	32, n=40	33, n=67	34, n=74	35, n=89
36, n=5*	37, n=33	38, n=26	39, n=109	40, n=48	

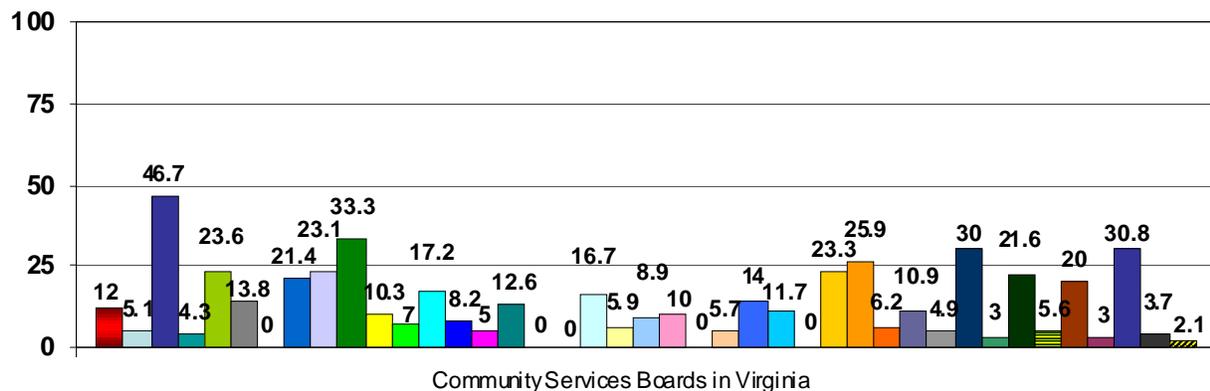
*CSB has less than 10 cases

Residential Crisis Stabilization

► **CSB clinicians reported a need for Residential Crisis Stabilization services at about the same rate as they reported the need for Short-Term Crisis Intervention.**

Statewide, clinicians indicated a need for Residential Crisis Stabilization for 12.0% of the individuals evaluated over the survey month; however, there was much variation among individual CSBs, as is shown in Figure 39. For instance, CSB code 2 reported the need in nearly half (46.7%) of its 15 cases, followed by code 9, in one-third (33%) of its 45 cases. Similarly, CSB codes 32 and 38 reported the need for Residential Crisis Stabilization in 3 out of 10 cases. CSBs which indicated a need in 5% or less of cases included code 1 (39 cases), code 14 (20 cases), code 31 (102 cases), and codes 33, 37, 39 and 40, which reported a need in 2 to 4% of cases. Five CSBs did not indicate any need for Residential Crisis Stabilization (codes 6, 16, 17, 22 and 26).

Figure 39. Percent of Emergency Evaluations in which CSB Clinician Reported Need for Residential Crisis Stabilization by CSB



STATE, n=2169	1, n=39	2, n=15	3, n=23	4, n=144	5, n=80
6, n=15	7, n=14	8, n=26	9, n=45	10, n=39	11, n=71
12, n=29	13, n=85	14, n=20	15, n=183	16, n=6*	17, n=22
18, n=12	19, n=17	20, n=56	21, n=50	22, n=39	23, n=53
24, n=57	25, n=137	26, n=61	27, n=43	28, n=85	29, n=64
30, n=46	31, n=102	32, n=40	33, n=67	34, n=74	35, n=89
36, n=5*	37, n=33	38, n=26	39, n=109	40, n=48	

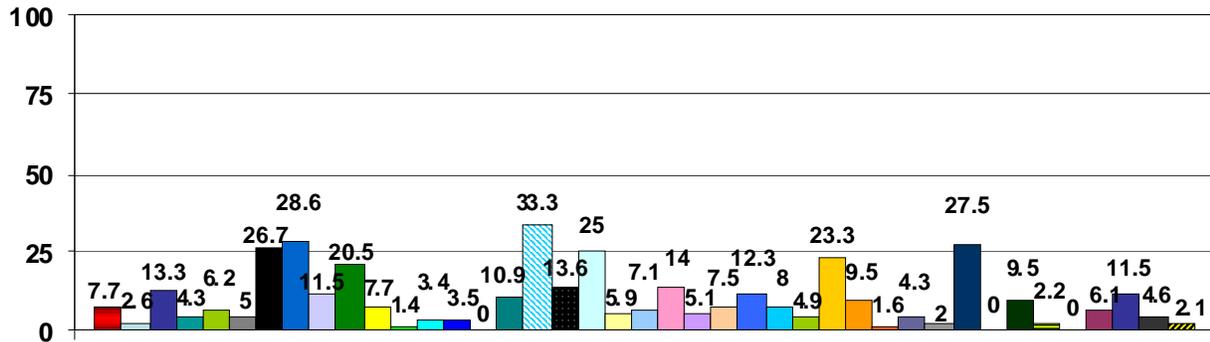
* CSB has less than 10 cases

In-Home Crisis Stabilization

► **In-Home Crisis Stabilization was a reported need in fewer cases on average than the three previous services, but was reported as needed in more individual CSBs than Short-Term Crisis Intervention or Residential Crisis Stabilization.**

In-Home Crisis Stabilization was reported as a needed service for individuals in 37 of 40 CSBs, with an average across Virginia of less than 1 in 10 cases (7.7% of all cases, Figure 40). CSB codes 14, 33, and 36 did not report a need in any of their 5 to 67 cases. Of CSBs which reported greater needs for In-Home Crisis Stabilization, the greatest percentage was one-third of cases in CSB code 16 with 6 cases. CSB codes 6 and 7 each had roughly 15 cases and reported a need in nearly 3 out of 10 cases (CSB code 6, in 26.7% of cases and code 7, in 28.6% of cases).

Figure 40. Percent of Emergency Evaluations in which CSB Clinician Reported Need for In-Home Crisis Stabilization by CSB



Community Services Boards in Virginia

STATE, n=2168	1, n=39	2, n=15	3, n=23	4, n=145	5, n=80
6, n=15	7, n=14	8, n=26	9, n=44	10, n=39	11, n=71
12, n=29	13, n=85	14, n=20	15, n=183	16, n=6*	17, n=22
18, n=12	19, n=17	20, n=56	21, n=50	22, n=39	23, n=53
24, n=57	25, n=137	26, n=61	27, n=43	28, n=84	29, n=64
30, n=46	31, n=102	32, n=40	33, n=67	34, n=74	35, n=89
36, n=5*	37, n=33	38, n=26	39, n=109	40, n=48	

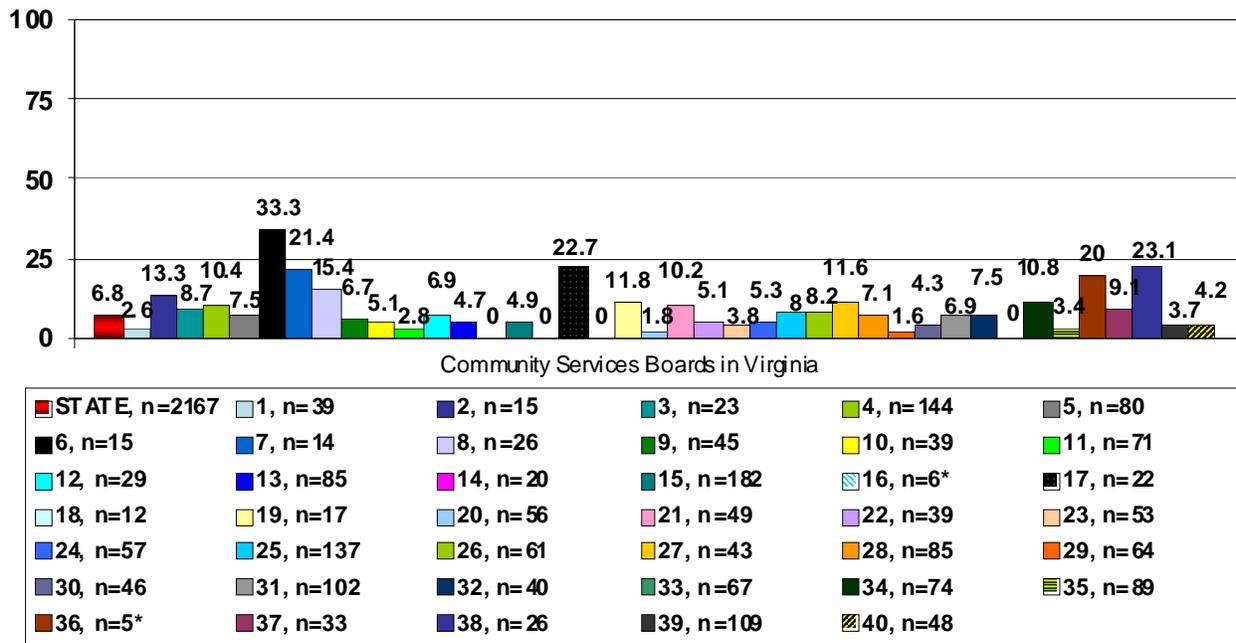
*CSB has less than 10 cases

Temporary Housing

► **The need for Temporary Housing for individuals who received emergency evaluations was reported by clinicians for 6.8% of individuals, on average.**

As Figure 41 shows, Temporary Housing was indicated as a needed service for evaluated individuals in 36 of the 40 CSBs across Virginia. Only four CSBs had clinicians who reported no need for Temporary Housing for those evaluated over the survey month. The highest numbers of individuals noted by clinicians to need Temporary Housing never exceeded more than one-third of those evaluated (CSB code 6 with 15 cases). In four CSBs, clinicians indicated a need for Temporary Housing in roughly 1 in 5 cases (CSB code 7, in 21.4% of its 14 cases; code 17, in 22.7% of 22 cases; CSB code 36, in 20.0% of 5 cases; and CSB code 38, in 23.1% of 26 cases).

Figure 41. Percent of Emergency Evaluations in which CSB Clinician Reported Need for Temporary Housing, by CSB



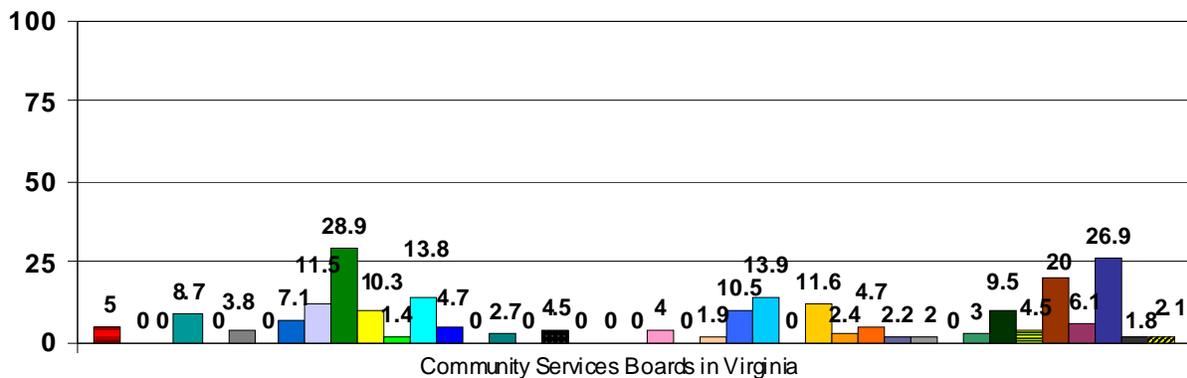
*CSB has less than 10 cases

Safe Transportation

► Safe Transportation was reported as a needed service in 5.0% of the emergency evaluations conducted by CSB clinicians across Virginia.

Figure 42 shows the variation among CSBs of clinicians' indications for greater need of Safe Transportation than was available over the survey month. Overall, clinicians at 12 CSBs reported that none of the individuals evaluated had needs that could be better addressed by Safe Transportation during the survey month (CSB codes 1, 2, 6, 14, 18, 19, 20, 22, 26 and 32). CSB codes 9 and 38 reported the highest need among all CSBs for Safe Transportation, in over one-quarter of their cases.

Figure 42. Percent of Emergency Evaluations in which CSB Clinician Reported Need for Safe Transportation by CSB



STATE, n=2169	1, n=39	2, n=15	3, n=23	4, n=144	5, n=80
6, n=15	7, n=14	8, n=26	9, n=45	10, n=39	11, n=71
12, n=29	13, n=85	14, n=20	15, n=183	16, n=6*	17, n=22
18, n=12	19, n=17	20, n=56	21, n=50	22, n=39	23, n=53
24, n=57	25, n=137	26, n=61	27, n=43	28, n=85	29, n=64
30, n=46	31, n=102	32, n=40	33, n=67	34, n=74	35, n=89
36, n=5*	37, n=33	38, n=26	39, n=109	40, n=48	

*CSB has less than 10 cases

SECTION IV Juvenile Emergency Evaluations

NUMBER OF JUVENILE CSB EMERGENCY EVALUATIONS

Community Services Board clinicians documented 421 juvenile emergency evaluations during the survey month. The results below include juveniles only, including those with mental retardation but excluding any juveniles who were in jail at the time of the evaluation.

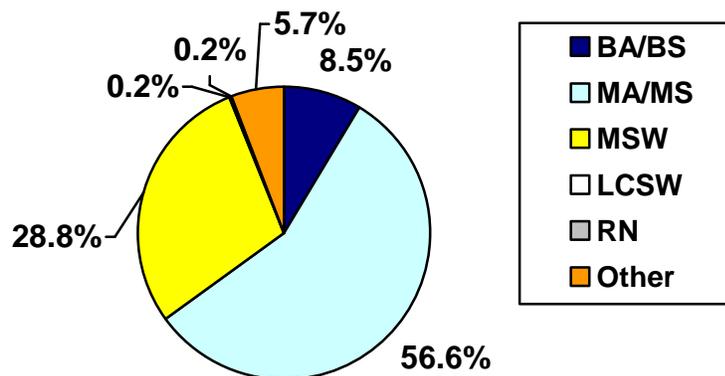
CSB CLINICIAN CHARACTERISTICS

Clinician Credentials

► **Clinicians who conducted emergency evaluations on juveniles over the survey month were more likely to have Master's degrees compared to clinicians who evaluated adults. Over 85% of evaluators in juvenile cases had an M.S., M.A., or M.S.W.**

Over half (56.6%) of the emergency evaluations were performed by clinicians who reported having a master's degree (e.g., M.A., M.S.), whereas an additional 28.8% were performed by clinicians with a M.S.W. (Master's in Social Work) degree (Figure 43). About nine percent (8.5%) of clinicians report their highest education was a bachelor's degree. Those in the other category (5.7%) included those with doctorate level training.

Figure 43. Clinician Credentials

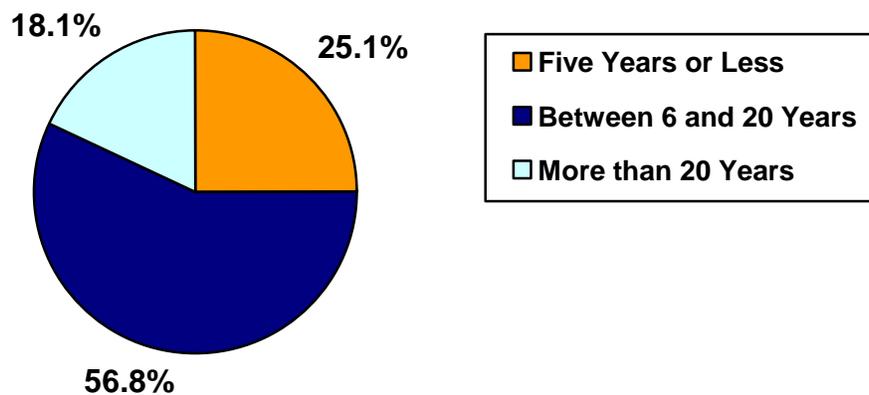


Clinician Number of Years Experience

► **The distribution of number of years experience reported by clinicians who evaluated juveniles was similar to that of clinicians who evaluated adults (i.e., each rate differed no more than 3%).**

The average number of years of field experience was 12.8 years ($sd=8.7$), ranging from less than one year to 38 years.

Figure 44. Clinician Number of Years Experience



CHARACTERISTICS OF JUVENILES IN CRISIS

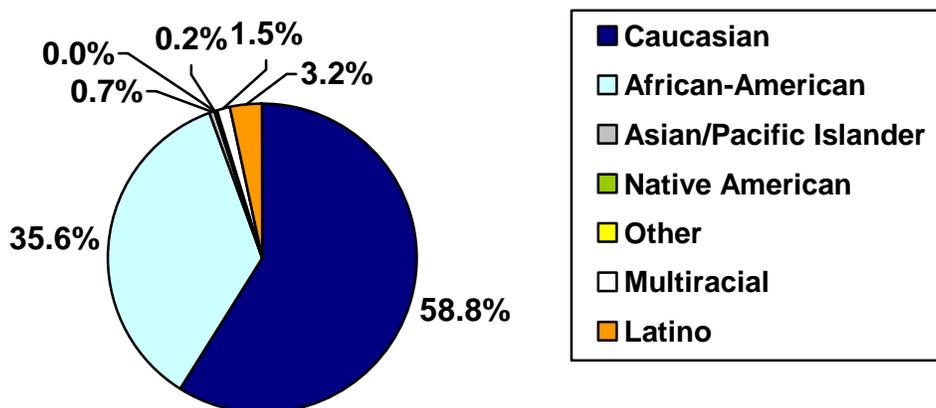
Demographics

► **The average age of the 421 juveniles was 14 years old. More juveniles who received an emergency evaluation were male than female.**

The average age of juveniles evaluated over the survey month was 14 years old ($sd=2.85$), ranging from 4 years to 17 years. Forty-seven percent of juveniles were female, 53% were male.

Figure 45 shows the race/ethnic distribution of juveniles who received an emergency evaluation over the survey month. Three out of five (58.8%) juveniles were Caucasian, and the remaining 41% of youth were from other race/ethnic groups. The largest minority group represented was African-American (35.6%).

Figure 45. Race/Ethnic Distribution of Juveniles

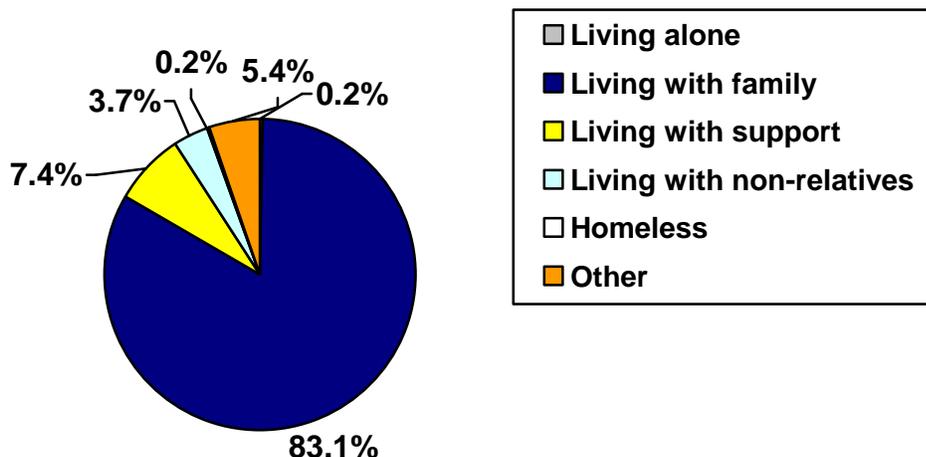


Living Situation

► **Juveniles were most likely to be living with family at the time of the emergency evaluation.**

As shown in Figure 46, the majority of juveniles were living with family (83.1%) at the time of the assessment. In 7.4% of cases the youth lived in a group home or other supervised setting. Relatively few juveniles were “living alone” or “homeless” at the time of the evaluation.

Figure 46. Living Situation of Juveniles

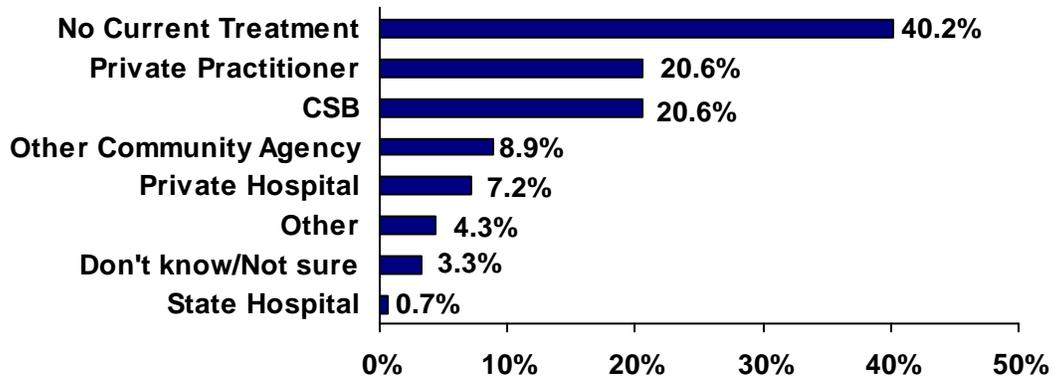


Current Treatment Status

► **Juveniles were less likely than adults to be currently receiving treatment from a CSB and were more likely to be currently receiving treatment from a private practitioner.**

Forty percent (40.2%) of youth were not receiving treatment at the time of their evaluation, similar to the rate of adults not receiving any treatment (42%). Among juveniles receiving treatment, they were equally likely to be receiving treatment from a private practitioner or CSB (20.6%). Figure 47 includes juveniles who were receiving treatment from more than one source.

Figure 47. Source of Juvenile’s Current Treatment

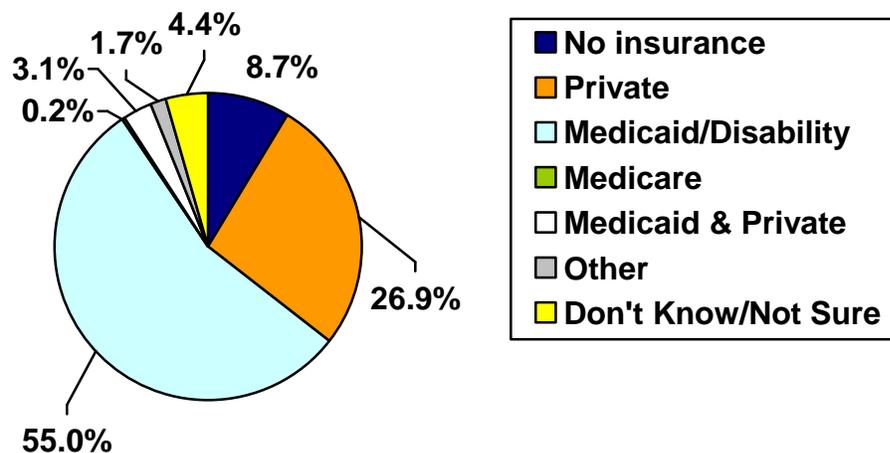


Insurance Status

► **Only 8.7% of juveniles had no medical insurance at the time of the emergency evaluation, compared to 41% of adults with no insurance.**

About nine percent (8.7%) of youth were not medically insured at the time of the emergency evaluation. The remainder of juveniles had an insurance plan—either private or public—to pay for treatment, including: 26.9% with private insurance, and 58% with some form of public health insurance in part or whole (e.g., Medicaid/Disability, Figure 48).

Figure 48. Insurance Status of Juveniles



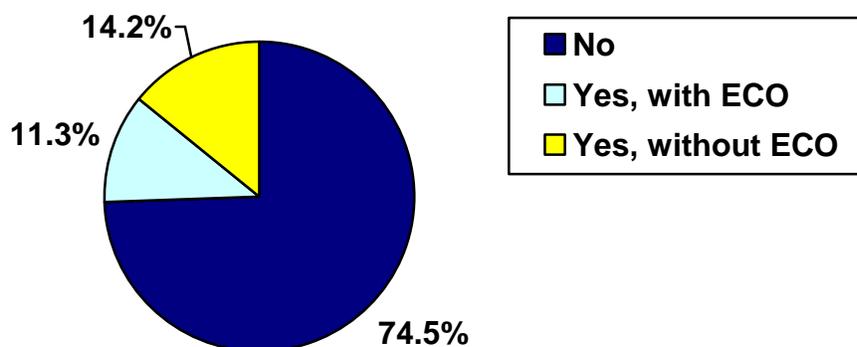
PATHWAYS TO CSB CRISIS RESPONSE SYSTEM

Juveniles in Police Custody at Time of Evaluation

► **Three-quarters of juveniles who received an emergency evaluation during the survey month were not in police custody at the time of the evaluation.**

About seventy-five percent (74.5%) of juveniles were not in police custody at the time of the assessment. Roughly one out of every four juveniles was in police custody at the time of the emergency evaluation; 11.3% were in custody with a magistrate-issued ECO and 14.2% were in custody without a magistrate-issued ECO (Figure 49). Of those juveniles who were in police custody at the time of the assessment, restraints were used in 45.5% of cases. Rates of police custody among juveniles were similar to rates among adults; differences were no more than 1%.

Figure 49. Juveniles in Police Custody at Time of Evaluation

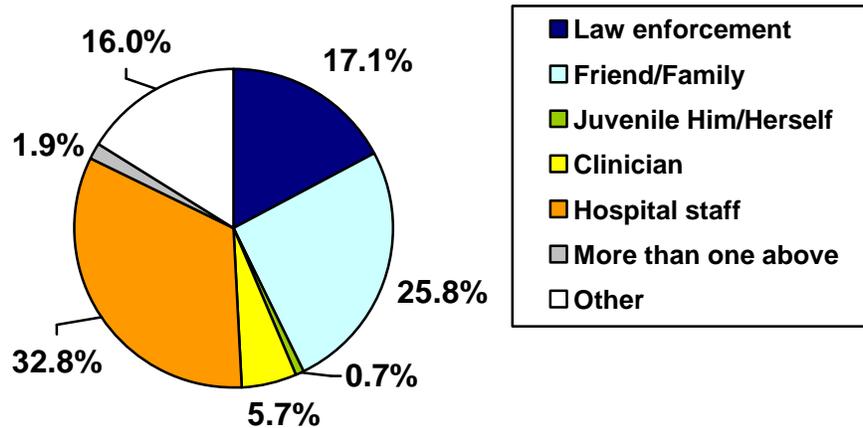


Contacting the CSB for Evaluation

► **Hospital staff and family members contacted the CSB for an emergency evaluation in most juvenile cases.**

In about one-third (32.8%) of cases, the hospital staff contacted the CSB for an assessment, followed by 25.8% of contact from family members and friends (Figure 50). In adult cases, hospital staff was most likely to contact the CSB, followed by law enforcement.

Figure 50. Contacting CSB for Evaluation

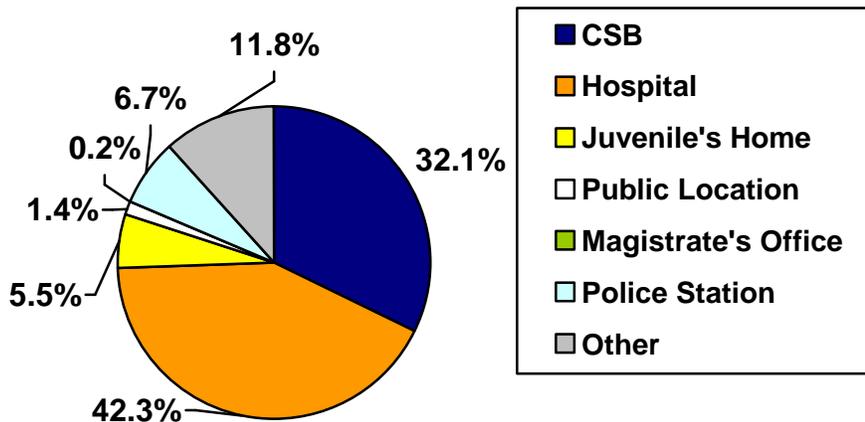


Location of Emergency Evaluation

► **In comparison to adult evaluations, juvenile evaluations were less likely to take place at a hospital and slightly more likely to take place at a CSB.**

Forty-two percent of the emergency evaluations took place in a hospital setting, followed by the CSB (32.1%, Figure 51). Evaluations which took place at police stations occurred at the same rate among adults and juveniles (roughly 7%).

Figure 51. Location of Evaluation



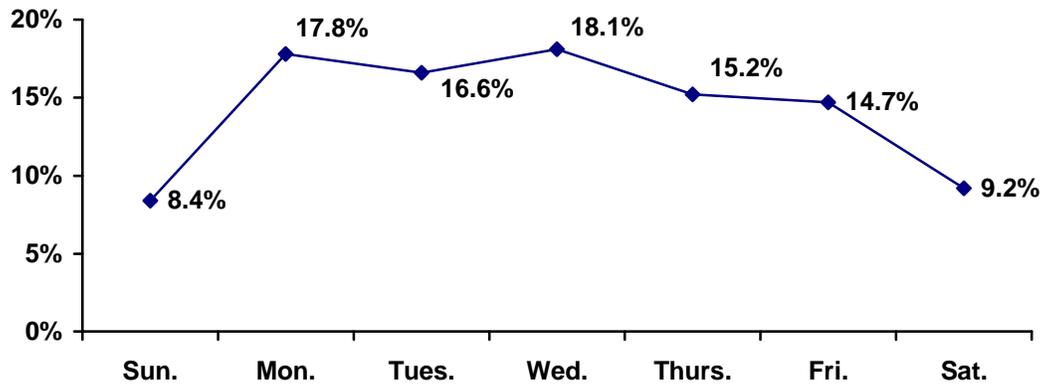
Day of the Emergency Evaluation

► **Juvenile emergency evaluations were most likely to occur on Mondays or Wednesdays.**

Figure 52 shows the percent of cases that occurred on each day of the week. Juvenile emergency evaluations were most likely to occur at the beginning of the

work week (i.e., Monday, Tuesday, or Wednesday) and were slightly less likely to occur on weekends.

Figure 52. Day of the Week Emergency Evaluation Occurred



CLINICAL PRESENTATION OF JUVENILES

Presentation at Time of Emergency Evaluation

► **Nearly 9 out of 10 juveniles presented with mental illness at the time of the evaluation.**

Among youth who presented with a disorder at the time of the assessment, the majority (86.8%) presented with mental illness, and 11.8% presented with substance abuse problems (Figure 53). In 3.6% of cases, the youth presented with mental retardation. Youth may have presented with co-occurring disorders as is shown in Figure 54.

Figure 53. Juvenile's Presentation at Time of Evaluation

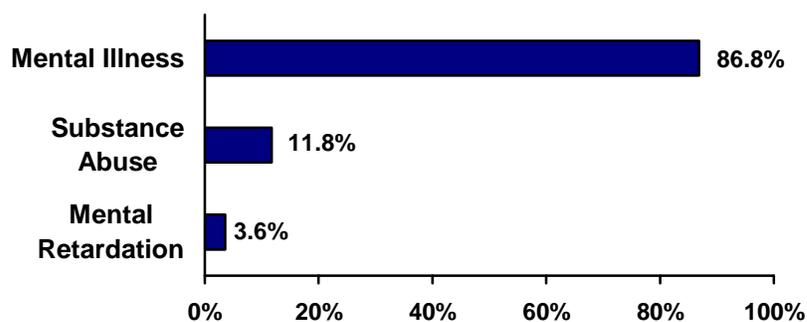
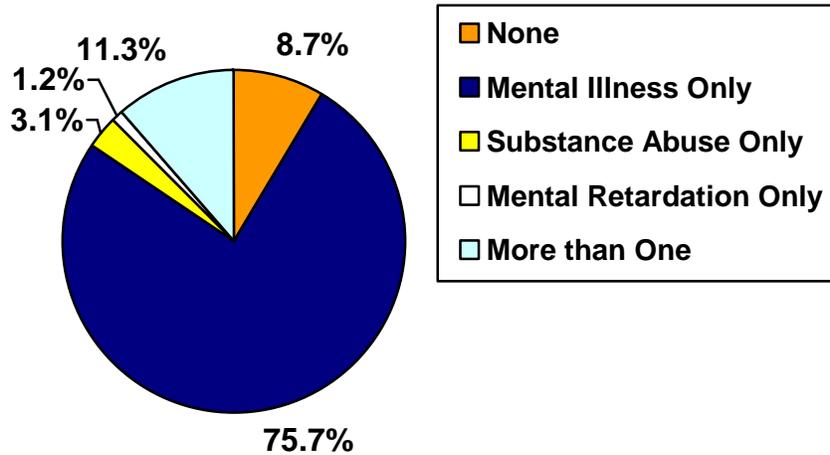


Figure 54. Combinations of Juvenile's Presentations



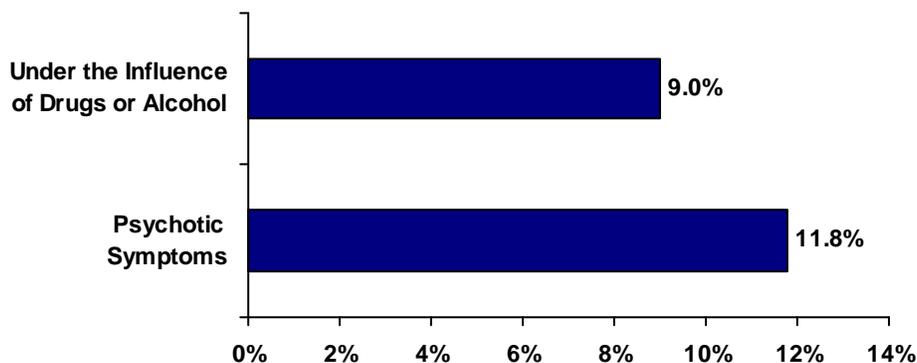
Under the Influence of Substances or Showing Psychotic Symptoms

► Juveniles presented under the influence of substances or with psychotic symptoms less often than did adults.

Roughly 1 out of every 11 juveniles was under the influence of drugs or alcohol at the time of the assessment (9.0%, Figure 55). Of juveniles who were under the influence of drugs or alcohol, 60% were classified as presenting with substance abuse ($\chi^2=1.02$, $df=1$, $p<.001$).

About 1 out of every 10 juveniles, or 11.8%, presented with psychotic symptoms at the emergency evaluation. Of juveniles displaying psychotic symptoms, 98% were classified as presenting with mental illness ($\chi^2=6.00$, $df=1$, $p<.01$).

Figure 55. Presenting Under the Influence or with Psychotic Symptoms



Displays of Behaviors that Met June 2007 Involuntary Commitment Criteria

► Of exhibited behaviors shown that would meet the criteria for commitment, juveniles displayed behaviors that met criteria for being a “danger to self” (35.5%) most often, followed by “danger to others” (26.3%) and “inability to care for self” (18.8%).

Figure 56 displays the percent of juveniles who displayed overt indications for each of the possible commitment criteria. This figure includes juveniles who may have been identified as presenting behaviors indicating more than one of the commitment criteria.

Figure 56. Juveniles’ Display of Overt Indications of Commitment Criteria

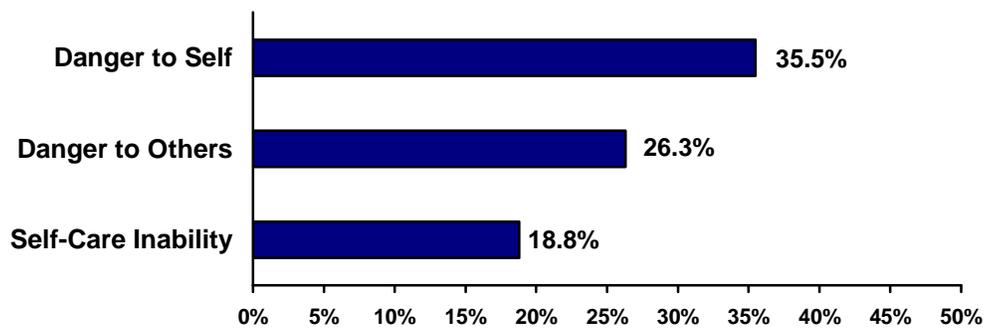
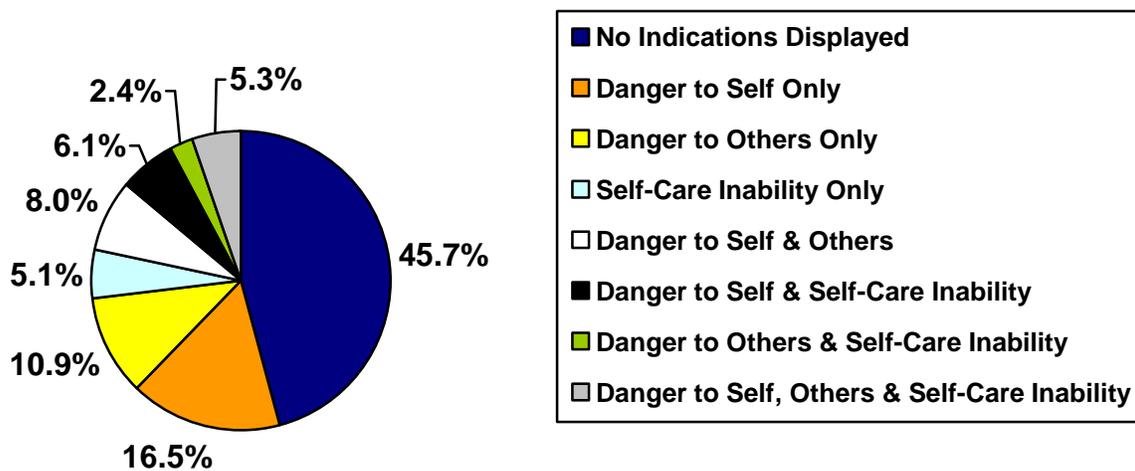


Figure 57 shows all mutually exclusive categories for possible commitment criteria as indicated by juveniles’ overt indications during the emergency evaluation.

Figure 57. Juveniles’ Overt Indication Combinations



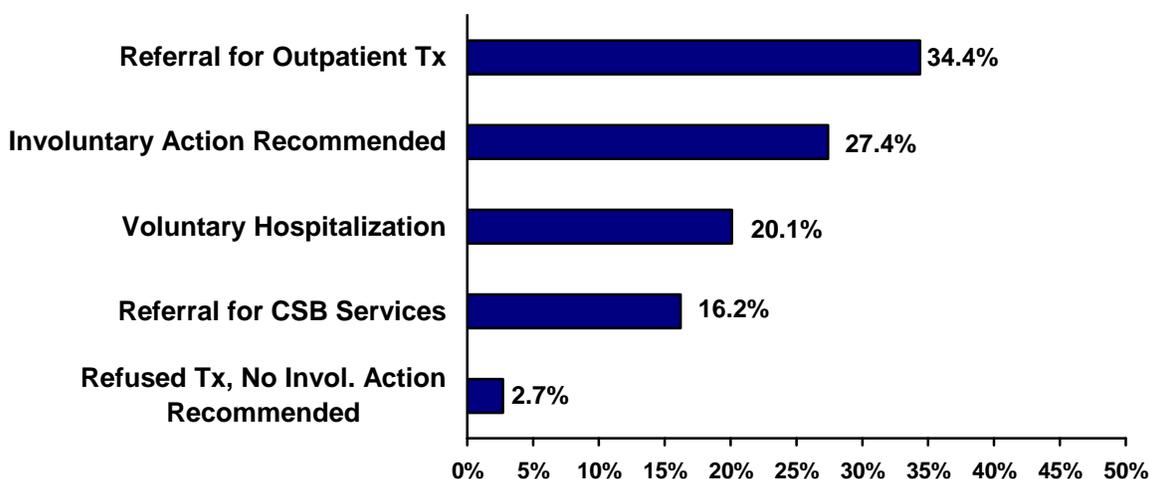
DISPOSITION AFTER EMERGENCY EVALUATION

Type of Action Recommended by CSB

► **Among juvenile emergency evaluations, referral for outpatient treatment was the most likely case disposition.**

Among cases where a disposition was recorded, 34.4% resulted in referral for outpatient treatment somewhere other than the CSB, whereas 16.2% of evaluated youth were referred to a CSB for services (Figure 58). In 27.4% of cases, involuntary action was recommended to a magistrate. The individual refused treatment and no involuntary action was recommended in 2.7% of cases. Juveniles agreed to voluntary hospitalization in 20.1% of emergency evaluations.

Figure 58. Case Disposition

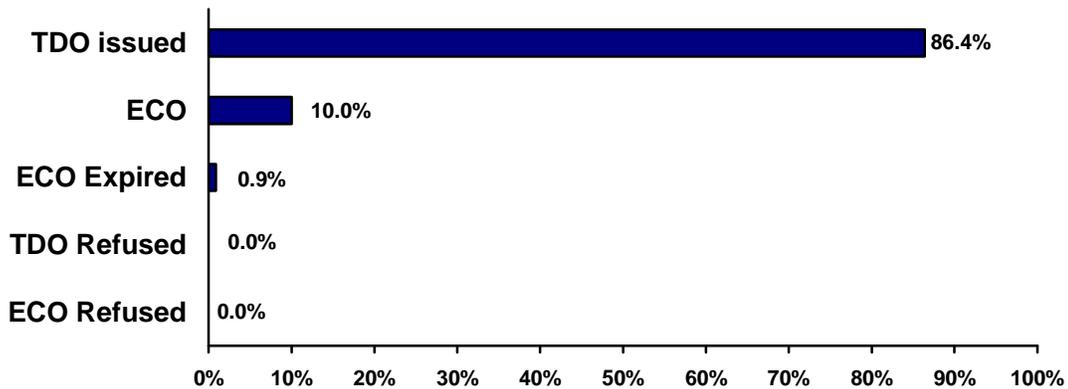


Outcome of Involuntary Action Recommended

► **Almost 9 out of 10 juvenile cases in which involuntary action was recommended resulted in a Temporary Detention Order.**

Among the juveniles for whom involuntary action was recommended to a magistrate, 86.4% were issued a Temporary Detention Order (TDO, Figure 59). Ten percent of juveniles for whom involuntary action was recommended were issued an Emergency Custody Order (ECO). None of the recommendations for a TDO or ECO were refused.

Figure 59. Outcome of Involuntary Action Recommended



Actions Taken to Identify a Psychiatric Bed

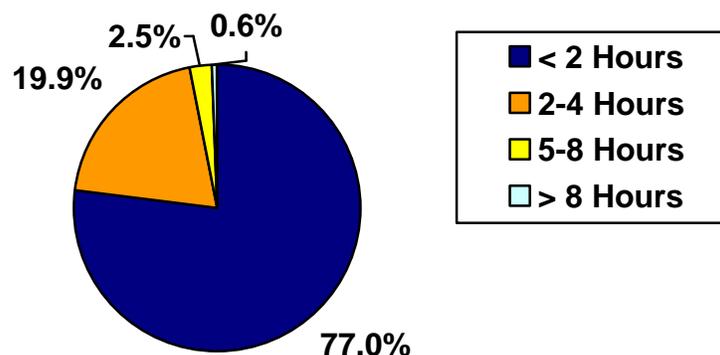
A bed in an acute-care psychiatric facility was sought in approximately 45% of juvenile emergency evaluations. A slight majority of juveniles required a facility willing and authorized to take custody of individuals under a Temporary Detention Order (a “TDO bed”). In the remaining cases, the bed being sought was for an individual who had agreed to voluntary hospitalization.

Length of Time Locating Psychiatric Bed

► **The time spent locating a psychiatric bed was greater than 4 hours in approximately 3% of cases.**

Of the cases where hospitalization—either voluntary or involuntary—was ordered, the average number of facilities contacted was approximately two ($M=1.94$, $sd=1.76$), ranging between one and nine facilities contacted. Among the cases where attempts were made to seek hospitalization (i.e., a facility was contacted), 77.0% of the time a facility with a psychiatric bed was located within two hours and in 19.9% of cases between two and four hours (Figure 60).

Figure 60. Length of Time Locating Psychiatric Bed for Treatment



Among the cases where a youth was admitted to a hospital, the majority (69.2%) of facilities were located in the same region where the person lived, whereas 30.8% were outside the individual’s region.

Status When Treatment Sought but Not Immediately Available

Among the cases where hospitalization was sought, 23 cases resulted in an individual not immediately being admitted to the facility. Table 2 displays possible reasons for a juvenile not being immediately admitted and the final status of each emergency evaluation.

Table 2. Status When Juvenile Not Immediately Admitted

Not Immediately Admitted Due to...	Total Number of Cases	Final Status
No Voluntary Bed Available	3 cases	1 Released
		1 Admitted to less restrictive treatment
		1 Further information was not provided
No TDO Bed Available	2 cases	1 Admitted to less restrictive treatment
		1 Further information was not provided
“Other” Reason Not Immediately Admitted	18 cases	6 Released
		2 Admitted to less restrictive treatment
		3 Held waiting in emergency department
		3 Held waiting in medical unit
		1 Held waiting at police station
		1 Waiting for medical clearance
		2 Further information was not provided

JUVENILE’S CONDITION AT END OF EMERGENCY EVALUATION PERIOD

Opinion Rating of the Youth’s Condition

► Clinicians reported an opinion that a youth was not a danger to others, responding “definitely no” or “probably no”, in 64.3% of juvenile cases. They stated that the youth was still a danger to others in 30.9% of cases.

The clinician was asked to rate their opinion or agreement with several statements about the youth’s condition at the conclusion of the evaluation on a five-point scale (0=“definitely no” to 5=“definitely yes”). The percentage of responses for each rating on each statement is presented in Table 2. Below is a summary of findings based on responses of “probably yes” or “definitely yes”:

- 84.5% reported that they were able to address the juvenile’s crisis needs with available resources,
- 67.1% reported that the juvenile was experiencing severe mental or emotional distress or dysfunction,
- 49.8% reported that the juvenile’s condition warranted hospitalization,
- 37.7% of clinicians reported that the juvenile was still a danger to him or herself,
- 30.9% reported that the juvenile was a danger to others,
- And 23.3% of clinicians reported that the juvenile was unable to care for him or herself.

Table 3. Clinician Opinion Ratings at End of Crisis

	Definitely No (%)	Probably No (%)	No opinion (%)	Probably Yes (%)	Definitely Yes (%)
Juvenile presented danger to self	22.6	37.5	2.2	18.0	19.7
Juvenile presented danger to others	33.5	30.8	4.8	15.2	15.7
Juvenile unable to care for self	47.4	23.6	5.7	10.6	12.7
Juvenile experiencing severe mental or emotional stress or dysfunction	11.8	18.0	3.1	32.0	35.1
Juvenile’s condition warranted hospitalization	33.0	15.7	1.5	15.3	34.5
Would have sought involuntary action if juvenile refused services	33.2	16.6	4.9	13.1	32.2
Able to address juvenile’s crisis needs with available resources	6.1	4.3	5.1	32.1	52.4

CSB Clinician Knowledge of Juvenile after Emergency Evaluation

During the survey month, no laws yet existed which mandated CSBs to track or monitor youth who were not hospitalized following an emergency evaluation, even in cases which resulted in orders for involuntary outpatient treatment. Despite this, 86.0% of clinicians reported knowing the juvenile's whereabouts or status when the youth was not hospitalized after the emergency evaluation.

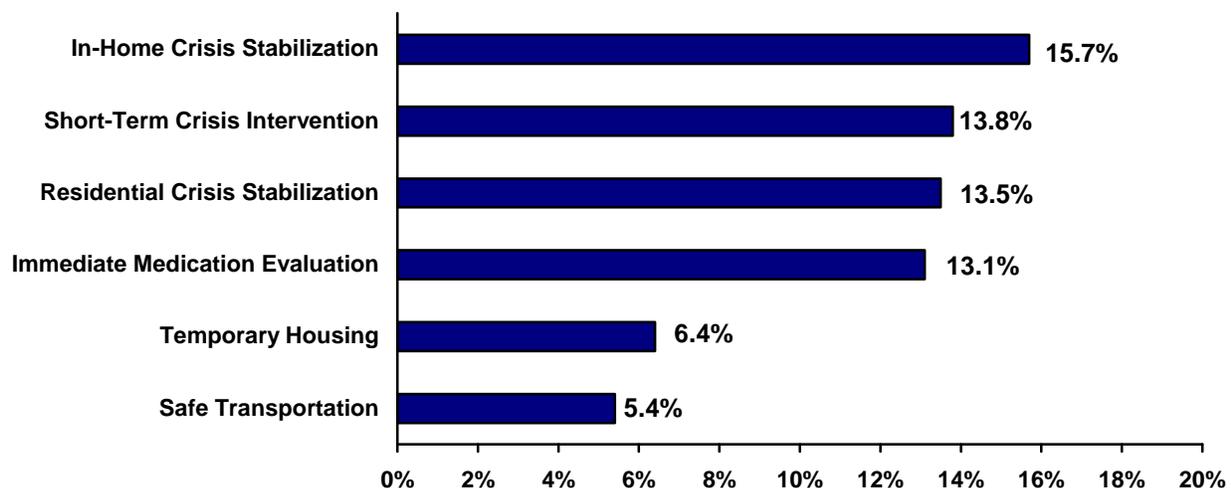
GAPS IN SERVICE CAPACITY

Services/Resources that Would Have Helped Address Juveniles' Needs

► Among juvenile cases, clinicians responded that In-Home Crisis Stabilization was the service that would have most helped them to address the needs of juveniles who were evaluated during the survey month.

Clinicians were asked what, if any, services or resources would have helped them to better address needs of juveniles evaluated. In-Home Crisis Stabilization was indicated most often by clinicians (15.7%), next followed by Short-Term Crisis Intervention (13.8%), Residential Crisis Stabilization (13.5%), and Immediate Medication Evaluation (13.1%, Figure 61). Temporary Housing and Safe Transportation were each reported by clinicians as needed services in roughly 5 to 6% of cases.

Figure 61. Services/Resources That Would Address Juveniles' Needs



SECTION V Variations of Juvenile Characteristics Among Community Services Boards

In the figures that follow, variations in juvenile emergency evaluations performed by Virginia Community Services Boards are illustrated. All CSBs, regardless of the number of juvenile emergency evaluations which occurred at a particular CSB during the month of June 2007, were included in the analysis. CSBs are identified by a random corresponding number and color. The number of juvenile emergency evaluations on which complete data were available is presented in each figure.⁹ The state average for each characteristic is represented by a **red bar** located on the left side of each figure.

CSB VARIATIONS BY CHARACTERISTICS OF JUVENILES

Characteristics of juveniles who were evaluated are summarized in Section IV of this report. This section illustrates how individual CSBs differ across Virginia and whether individual CSBs are more or less likely to treat juveniles with particular characteristics.

Living Situation

► Juveniles lived with their family in 83.0% of cases during the survey month. Fourteen CSBs had 100% of the juveniles evaluated documented as living with their family.

Two CSBs, each of which had one case reported for living situation, had none of the juveniles evaluated shown as living with family. These two juveniles were both living with support (e.g., in a group home or supervised living). The remaining 24 CSBs had between 50% and 96% of cases in which the living situation was living with family. Any other living situations, such as living alone, living with support, living with non-related others, or homeless, occurred very infrequently.

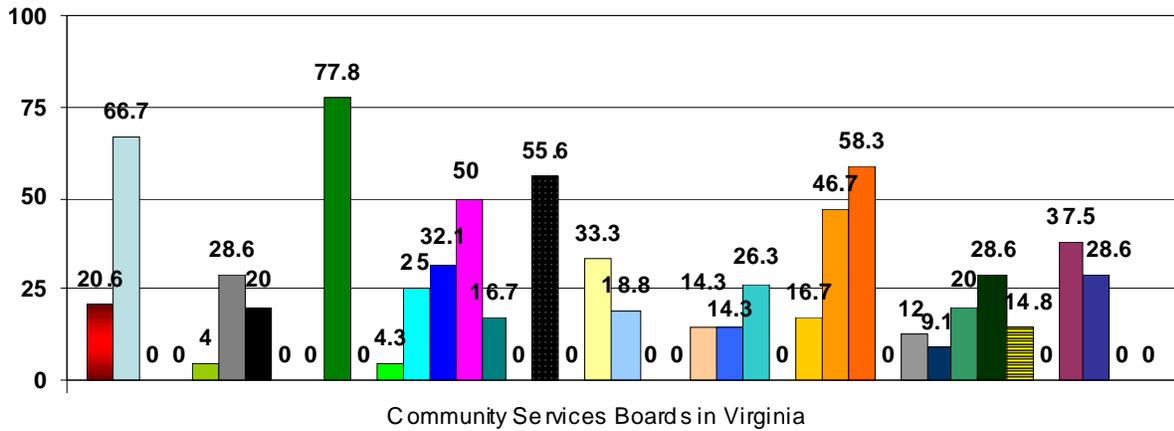
Source of Current Treatment

► Juveniles who were receiving treatment at the time of the evaluation had treatment from the CSB and private practitioners equally, at 20.6%. Of

⁹ All Section V figures have chi-squares significant at less than 0.01, except where indicated.

all juveniles receiving treatment from the CSB or from private practitioners, 3.5% of cases were receiving treatment from both sources concurrently.

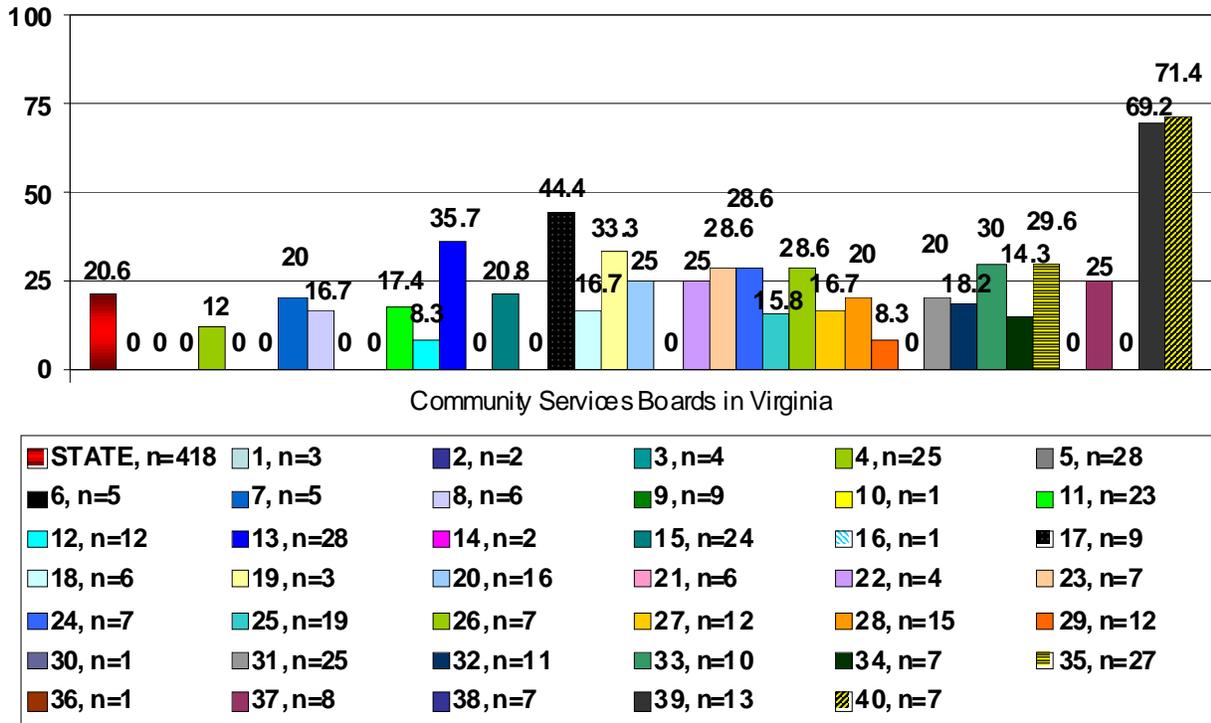
Figure 62. Percent of Juvenile Emergency Evaluations in which Juvenile was Receiving Treatment from a CSB, by CSB



STATE, n=418	1, n=3	2, n=2	3, n=4	4, n=25	5, n=28
6, n=5	7, n=5	8, n=6	9, n=9	10, n=1	11, n=23
12, n=12	13, n=28	14, n=2	15, n=24	16, n=1	17, n=9
18, n=6	19, n=3	20, n=16	21, n=6	22, n=4	23, n=7
24, n=7	25, n=19	26, n=7	27, n=12	28, n=15	29, n=12
30, n=1	31, n=25	32, n=11	33, n=10	34, n=7	35, n=27
36, n=1	37, n=8	38, n=7	39, n=13	40, n=7	

Fourteen CSBs had no juveniles receiving treatment from the CSB at the time of the evaluation (Figure 62), and similarly, thirteen CSBs had no juveniles receiving treatment from private practitioners (Figure 63). In some such cases, if a juvenile was not receiving treatment from a CSB, he or she was receiving treatment from a private practitioner and vice versa. Seven CSBs did not have juveniles receiving treatment from either the CSB or a private practitioner; these juveniles were receiving treatment from another source such as another community agency, a private hospital or a state hospital. Three CSBs (codes 2, 3 and 10) had all of their combined seven cases receiving no current treatment.

Figure 63. Percent of Juvenile Emergency Evaluations in which Juvenile was Receiving Treatment from a Private Practitioner by CSB

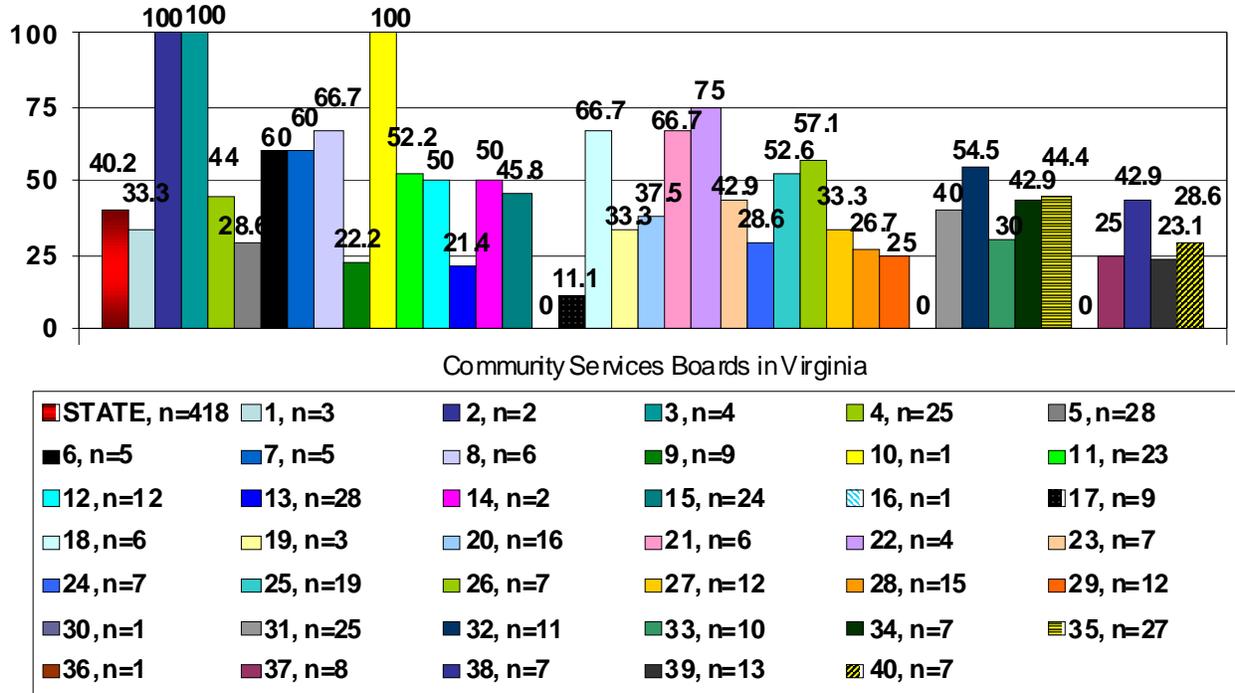


Not Receiving Treatment

► **On average, 40.2% of juveniles evaluated were not receiving treatment at the time of the emergency evaluation.**

Figure 64 shows the percent of emergency evaluations at each CSB in which youth were not receiving treatment from any source. It is important to consider the number of cases at each CSB during the survey month. For example, of the three CSBs with 100% of juveniles receiving no current treatment, there are only seven cases among them. More significant are CSB codes 4, 11, 15 and 35, which have roughly half of their approximately 25 cases each in which juveniles were receiving no treatment.

Figure 64. Percent of Juvenile Emergency Evaluations in which Juvenile was Not Receiving Treatment from any Source by CSB



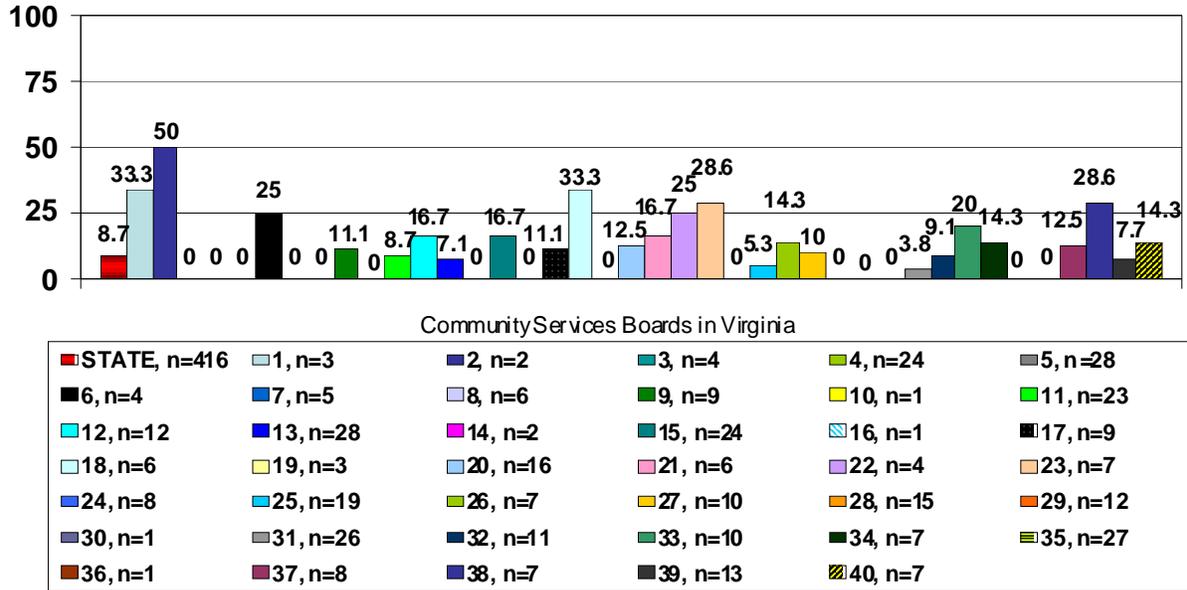
The rate of juveniles who were not receiving treatment was not significantly different across CSBs.

Insurance Status—No Insurance

► There were 15 CSBs in which all juveniles evaluated had health insurance coverage.

Among other CSBs, rates of no health insurance coverage ranged from 3.8% to 50.0% of youth without insurance, as shown in Figure 65. However, CSB code 2, with half of juveniles having no insurance, only had 2 youth who were evaluated as a result of a mental health crisis. The next highest percentages of those evaluated who had no insurance coverage were at CSB codes 1 and 18 with 33.3% of juveniles not having insurance. The average for Virginia was 8.7% of juveniles evaluated with no health insurance coverage, or roughly 1 out of every 11 youth.

Figure 65. Percent of Juvenile Emergency Evaluations in which Juvenile had No Insurance Coverage by CSB

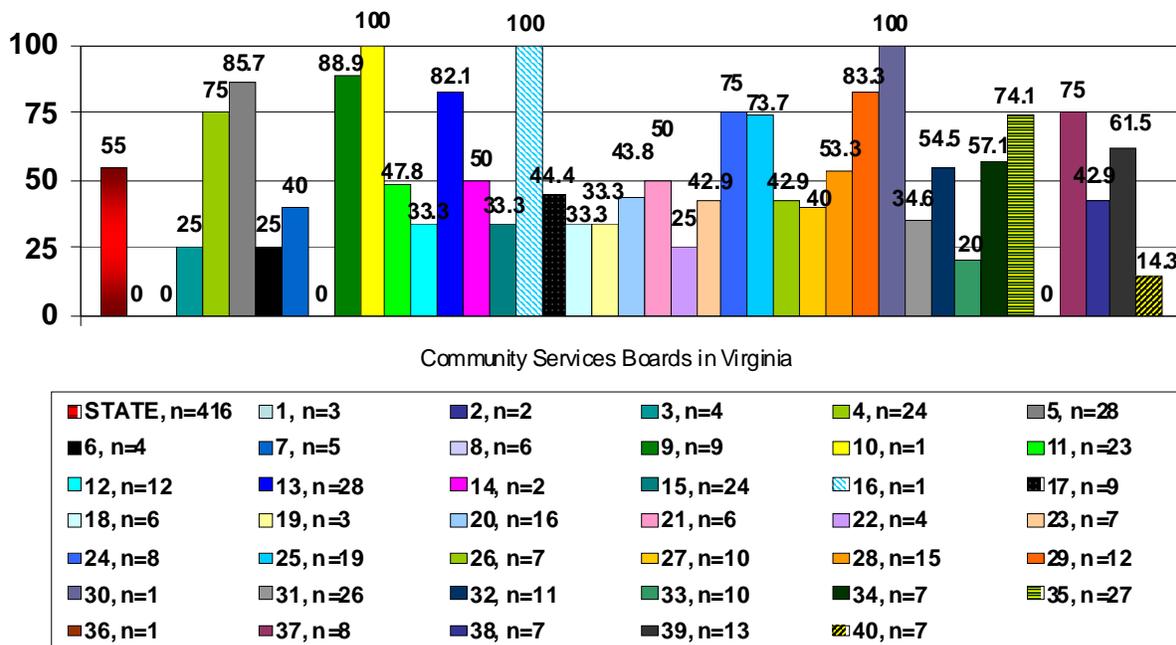


Insurance Status—Medicaid/Disability

► **Over half of juveniles evaluated had Medicaid and/or Disability insurance at the time of the emergency evaluation. Roughly six out of 11 juveniles had Medicaid and/or Disability as insurance coverage.**

Figure 66 illustrates the Virginia average, 55.0%, of juveniles evaluated who had Medicaid/Disability as their insurance coverage. Very few CSBs had extreme percentages of youth with or without Medicaid/Disability (i.e., zero or 100%), and if so, these CSBs have a small number of cases. Among CSBs with more central rates, percentages range from roughly 25% to 85% of youth with Medicaid/Disability.

Figure 66. Percent of Juvenile Emergency Evaluations in which Juvenile had Medicaid/Disability Coverage by CSB

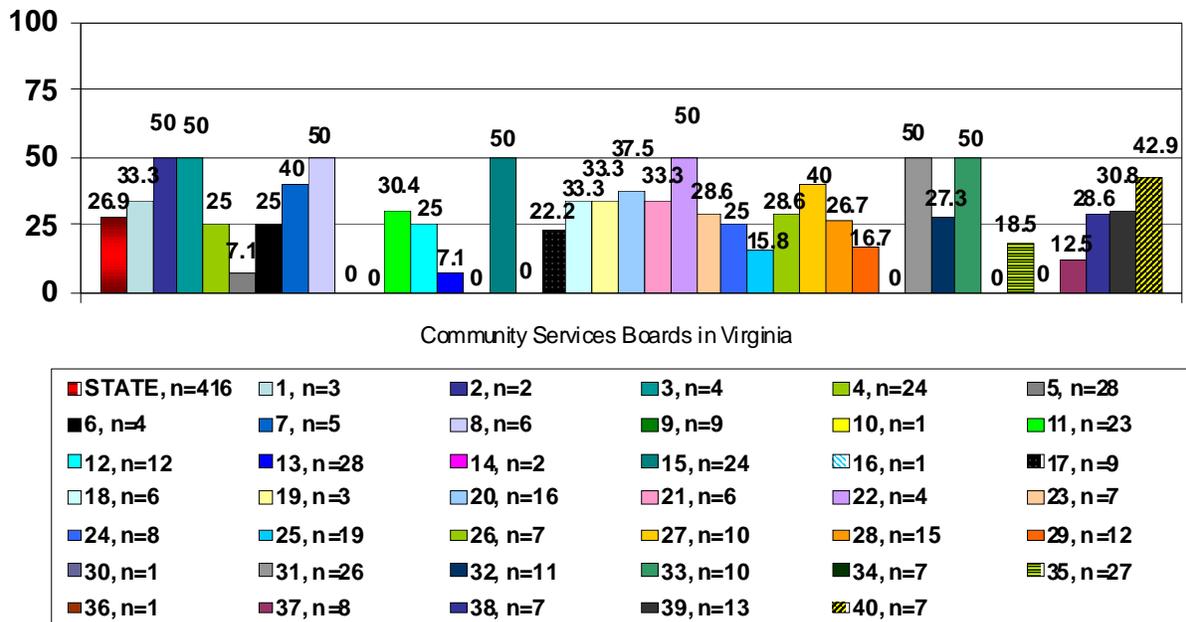


Insurance Status—Private Insurance

► **On average, 3 out of 11 juveniles who received an emergency evaluation had private health insurance coverage.**

Figure 67 shows the rates of private insurance coverage among CSBs. On average, 26.9% of juveniles evaluated in Virginia had private insurance coverage, as shown by the fact that no CSB reported having more than 50% of juveniles with private insurance. Of those CSBs with no youth covered by private insurance, most of them were covered by Medicaid/Disability or other forms of insurance instead (codes 9, 10, 14, 16, 30 and 34), two youth had no insurance coverage (codes 9 and 34), and in three cases the CSB clinician did not know what type or whether a juvenile had insurance (codes 34 and 36). Private insurance coverage was the second most prevalent type of insurance coverage; no form of insurance coverage was ranked third.

Figure 67. Percent of Juvenile Emergency Evaluations in which Juvenile had Private Insurance Coverage by CSB

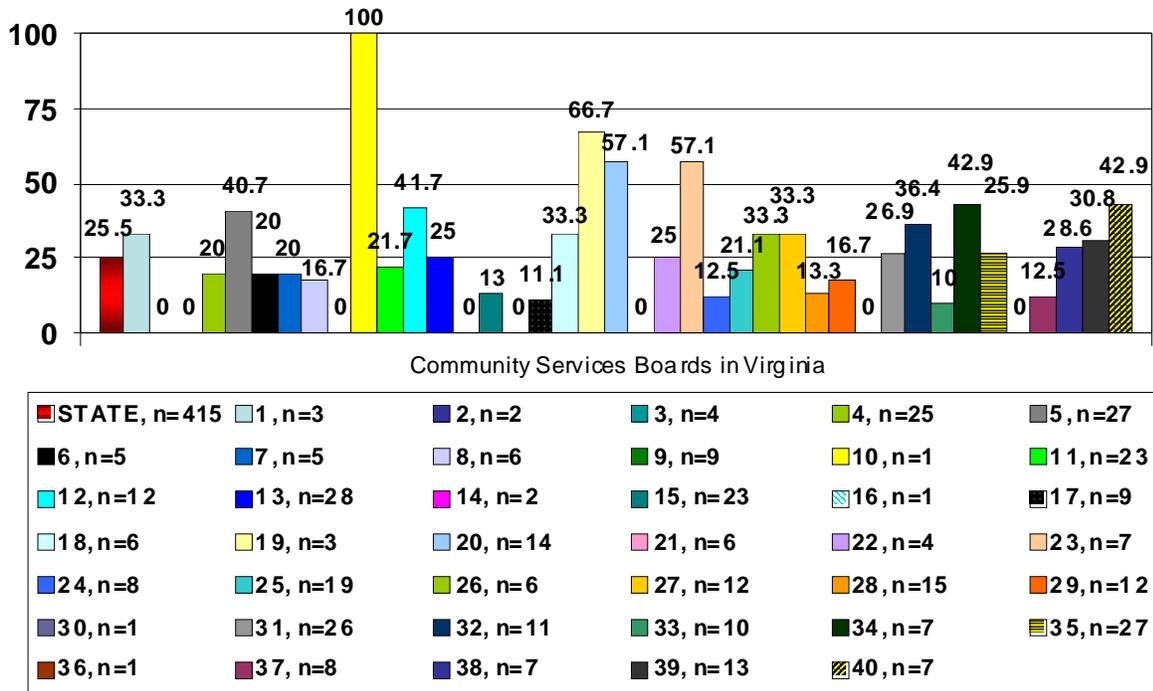


Juveniles in Police Custody at Time of Evaluation

► **There were significant differences across CSBs in whether or not juveniles were in police custody at the time of the emergency evaluation. On average, 1 out of every 4 juveniles was in police custody during the assessment.**

The majority of juveniles, 74.5%, were not in police custody at the time of the evaluation. Eight CSBs (codes 2, 3, 9, 14, 16, 21, 30 and 36) had no juveniles who were in police custody at the time of the emergency evaluation. Figure 68 shows the percentages of youth across CSBs who were in police custody at the time of the assessment with or without an Emergency Custody Order (ECO). Caution must be taken in reading the chart when the CSB reports small numbers of cases. For example, CSB code 10, although immediately prominent with 100% of youth evaluated in police custody, had only one case. CSB code 19 also had a small number of cases and the next highest percentage, 66.7%, or 2 of its 3 cases in police custody. Four CSBs reported approximately 4 out of 10 youth under police custody (codes 5, 12, 34 and 40); CSB code 20 had roughly 6 out of 10 youth evaluated who were in police custody.

Figure 68. Percent of Juvenile Emergency Evaluations in which Juvenile was in Police Custody at Time of Evaluation by CSB



Type of Action Recommended by CSB

► **Of possible case dispositions, CSB clinicians most often referred juveniles to some type of voluntary outpatient treatment.**

Involuntary inpatient treatment was the next type of treatment most often recommended, followed by voluntary hospitalization and voluntary CSB services.

Of juveniles who refused treatment, CSB clinicians did not seek involuntary action in 2.7% of cases. No figure is shown for this disposition because so few cases were involved. Notably, CSB code 35 did not seek involuntary actions when juveniles refused treatment in roughly a quarter of their 25 cases.

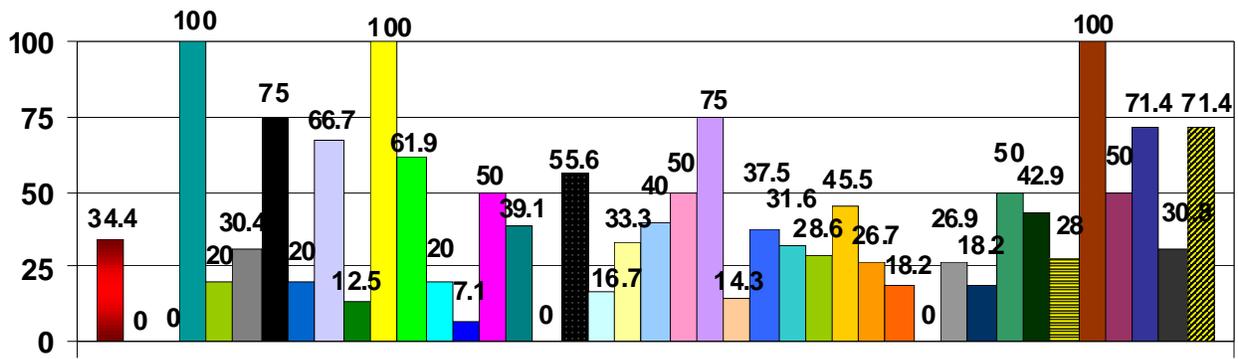
Referral for Voluntary Outpatient Treatment

Types of voluntary outpatient treatment may include services from a private practitioner such as a psychologist, psychiatrist, or counselor, or group services.

This referral category does not include outpatient CSB services; this disposition is illustrated in Figure 72.

There were significant differences among CSBs for referrals to voluntary outpatient services, as shown in Figure 69, with the average for Virginia being 34.4%. Most noticeable is the discrepancy between the 3 CSBs that have 100% of juveniles evaluated referred to voluntary outpatient treatment and the 4 CSBs with no referrals for voluntary outpatient treatment. Six of these 7 CSBs have very few numbers of cases (n=1-2), whereas CSB code 3 had 4 cases, 100% of which were referred to voluntary outpatient services. Two CSBs had percentages below the Virginia average and more significant numbers of cases than other CSBs: CSB code 4 recommended voluntary outpatient services for 20.0% of its 25 youth evaluated and CSB code 13 recommended voluntary outpatient services for 7.1% of its 28 cases. Conversely, CSB code 11 recommended voluntary outpatient services more often than the Virginia average, in 61.9% of cases, and had high numbers of cases (n=21).

Figure 69. Percent of Juvenile Emergency Evaluations in which CSB Referral was for Voluntary Outpatient Treatment, by CSB



Community Services Boards in Virginia

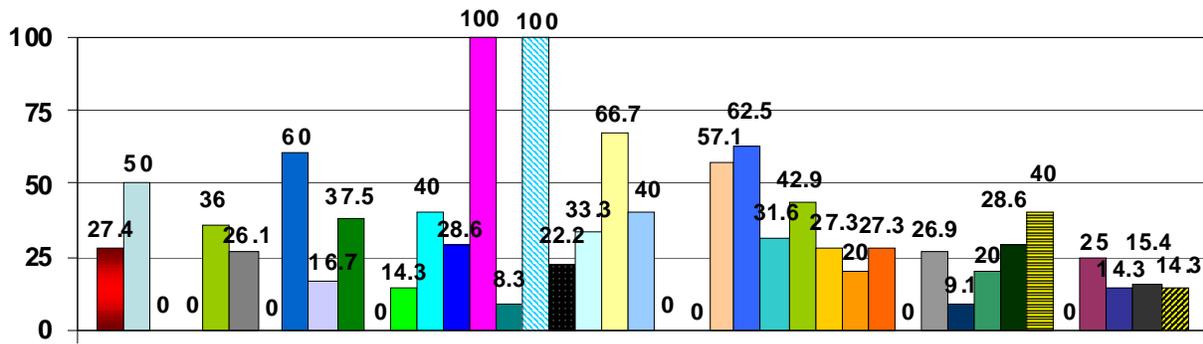
STATE, n=401	1, n=2	2, n=1	3, n=4	4, n=25	5, n=23
6, n=4	7, n=5	8, n=6	9, n=8	10, n=1	11, n=21
12, n=10	13, n=28	14, n=2	15, n=23	16, n=1	17, n=9
18, n=6	19, n=3	20, n=15	21, n=6	22, n=4	23, n=7
24, n=8	25, n=19	26, n=7	27, n=11	28, n=15	29, n=11
30, n=1	31, n=26	32, n=11	33, n=10	34, n=7	35, n=25
36, n=1	37, n=8	38, n=7	39, n=13	40, n=7	

Involuntary Action Recommended

► **CSB clinicians, on average, recommended involuntary action to a magistrate in a quarter of juvenile emergency evaluations.**

Figure 70 shows the variations among percentages of CSB clinicians to seek involuntary action for juveniles evaluated during the survey month. Eight CSBs never recommended an involuntary action, and 2 CSBs recommended an involuntary action 100% of the time. Although most CSBs with extreme percentages of involuntary action (i.e., none or 100%) had one juvenile case during the survey month, four CSBs performed evaluations on 4 to 6 youth during the survey month and never recommended involuntary action (CSB codes 3, 6, 21 and 22). Two CSBs, codes 11 and 15, rarely recommended involuntary action, indicating a need for involuntary action in 14.3% and 8.3% of their roughly 20 cases, respectively. CSB codes 7, 19, 23, and 24 recommended involuntary action in roughly 60% of their cases, with their numbers of cases ranging from 3 to 8.

Figure 70. Percent of Juvenile Emergency Evaluations in which CSB Recommended Involuntary Action by CSB



Community Services Boards in Virginia

STATE, n=402	1, n=2	2, n=1	3, n=4	4, n=25	5, n=23
6, n=4	7, n=5	8, n=6	9, n=8	10, n=1	11, n=21
12, n=10	13, n=28	14, n=2	15, n=24	16, n=1	17, n=9
18, n=6	19, n=3	20, n=15	21, n=6	22, n=4	23, n=7
24, n=8	25, n=19	26, n=7	27, n=11	28, n=15	29, n=11
30, n=1	31, n=26	32, n=11	33, n=10	34, n=7	35, n=25
36, n=1	37, n=8	38, n=7	39, n=13	40, n=7	

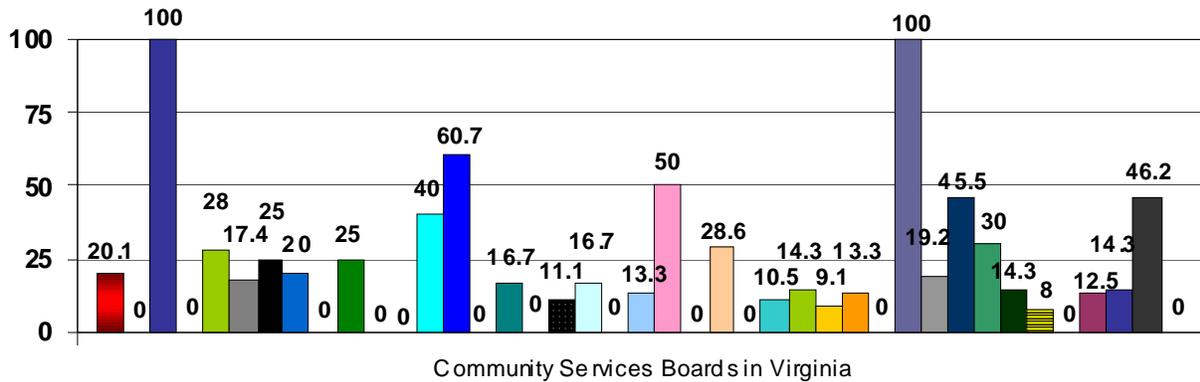
The rate of involuntary action recommended was not significantly different across CSBs.

Voluntary Hospitalization

► **Juveniles who received an emergency evaluation agreed to voluntary hospitalization in one out of every five cases, on average.**

There was more variation in the percentage of voluntary hospitalizations among CSBs in Virginia, than in voluntary outpatient service or involuntary treatment dispositions (Figure 71). For instance, although there were many CSBs with outlying percentages such as 0 or 100%, more CSBs had a significant number of cases. CSB code 11 had 21 cases during the survey month and no agreements to voluntary hospitalization; similarly, CSB codes 8, 24, 29, and 40 also had no voluntary agreements and had numbers of cases ranging between 6 and 11. Alternately, four CSBs had roughly 40% to 50% of their cases result in voluntary hospitalization (CSB codes 12, 21, 32, and 39 with numbers of juveniles evaluated ranging from 6 to 13). Most notable was CSB code 13 with 60.7% of its 28 juveniles evaluated resulting in an agreement for voluntary hospitalization.

Figure 71. Percent of Juvenile Emergency Evaluations in which Juvenile Agreed to Voluntary Hospitalization by CSB



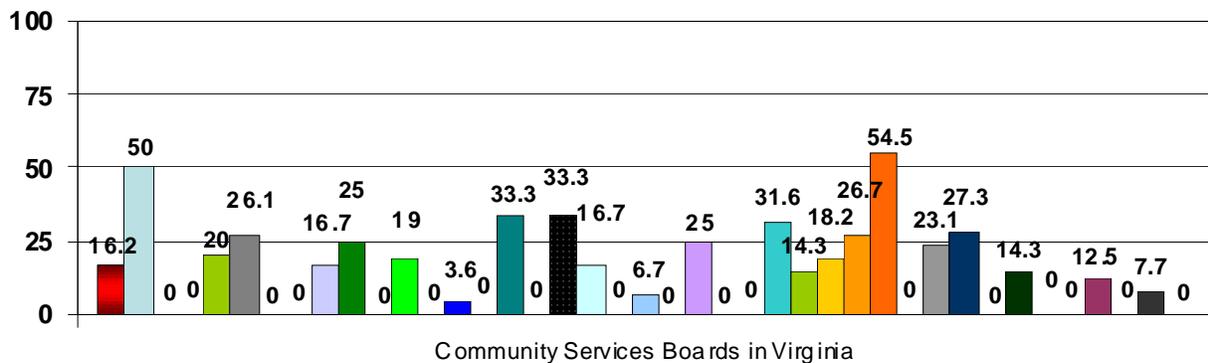
STATE, n=402	1, n=2	2, n=1	3, n=4	4, n=25	5, n=23
6, n=4	7, n=5	8, n=6	9, n=8	10, n=1	11, n=21
12, n=10	13, n=28	14, n=2	15, n=24	16, n=1	17, n=9
18, n=6	19, n=3	20, n=15	21, n=6	22, n=4	23, n=7
24, n=8	25, n=19	26, n=7	27, n=11	28, n=15	29, n=11
30, n=1	31, n=26	32, n=11	33, n=10	34, n=7	35, n=25
36, n=1	37, n=8	38, n=7	39, n=13	40, n=7	

Referral for Voluntary CSB Services

► **Voluntary CSB services was the disposition recommended least by CSB clinicians for juveniles who were evaluated following a mental health crisis.**

The percentage of youth who are referred to voluntary CSB services may depend upon the availability of funding to that CSB and/or the range of services offered, among other factors. Figure 72 displays the percentage of juveniles evaluated by CSB clinicians who were recommended for voluntary CSB services, which on average, accounted for 16.2% of all juvenile cases. Most noticeable are eighteen CSBs that never recommended voluntary CSB services for juveniles evaluated. Of these, CSB code 35 had 25 cases in which clinicians never referred youth for voluntary CSB services. CSB code 13 recommended voluntary CSB services in 3.6% of its 28 cases. Other CSBs recommended voluntary CSB services more often, such as CSB code 29 which referred 54.5% of its juveniles evaluated to voluntary CSB services and CSB codes 15 and 17, which each referred a third of their youth.

Figure 72. Percent of Juvenile Emergency Evaluations in which CSB Clinician Referred Juvenile to Voluntary CSB Services by CSB



Community Services Boards in Virginia

STATE, n=402	1, n=2	2, n=1	3, n=4	4, n=25	5, n=23
6, n=4	7, n=5	8, n=6	9, n=8	10, n=1	11, n=21
12, n=10	13, n=28	14, n=2	15, n=24	16, n=1	17, n=9
18, n=6	19, n=3	20, n=15	21, n=6	22, n=4	23, n=7
24, n=8	25, n=19	26, n=7	27, n=11	28, n=15	29, n=11
30, n=1	31, n=26	32, n=11	33, n=10	34, n=7	35, n=25
36, n=1	37, n=8	38, n=7	39, n=13	40, n=7	

The rate in which clinicians referred juveniles to voluntary CSB services was significant at the 0.05 level.

Services or Resources that Would Have Helped Address Juveniles' Needs

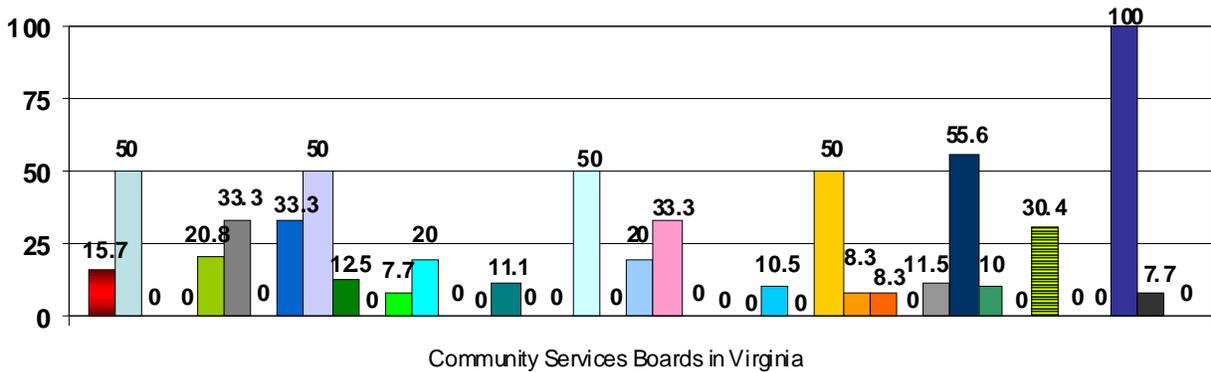
► **CSB clinicians most often responded that In-Home Crisis Stabilization would have helped to better address juvenile needs.**

Other possible services, in order of highest percentage of responses, were Short-Term Crisis Intervention, Residential Crisis Stabilization, Immediate Medication Evaluation, Temporary Housing, and Safe Transportation.

In-Home Crisis Stabilization

Clinicians at 22 CSBs reported at least once that In-Home Crisis Stabilization was needed to address the needs of juveniles (Figure 73). Clinicians at CSB code 38 indicated a need in 100% of their 3 cases. CSBs that indicated a need exceeding the state average of 15.7% and that had a significant number of juvenile cases include codes 4 and 35 (20.8% and 30.4%, respectively).

Figure 73. Percent of Juvenile Emergency Evaluations in which CSB Clinician Reported Need for In-Home Crisis Stabilization by CSB



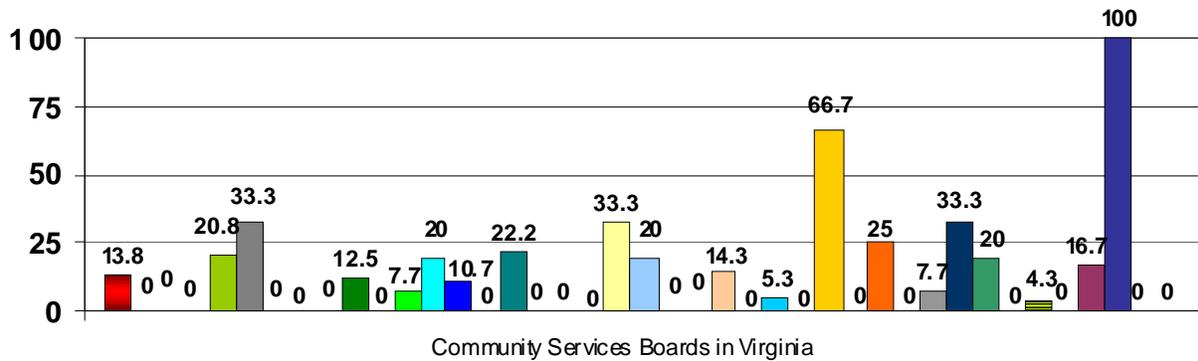
STATE, n=312	1, n=2	2, n=0	3, n=0	4, n=24	5, n=9
6, n=0	7, n=3	8, n=2	9, n=8	10, n=1	11, n=13
12, n=5	13, n=28	14, n=2	15, n=18	16, n=1	17, n=2
18, n=4	19, n=3	20, n=15	21, n=3	22, n=3	23, n=7
24, n=2	25, n=19	26, n=7	27, n=6	28, n=12	29, n=12
30, n=1	31, n=26	32, n=9	33, n=10	34, n=3	35, n=23
36, n=0	37, n=6	38, n=3	39, n=13	40, n=7	

Short-Term Crisis Intervention

► **CSB clinicians, on average, indicated the need for Short-Term Crisis Stabilization in 13.8% of juvenile emergency evaluations.**

As shown in Figure 74, clinicians at 19 CSBs reported on at least one occasion during the survey month that there was a need for Short-Term Crisis Intervention at their CSB to better serve the needs of those evaluated. Of CSBs reporting high needs for Short-Term Crisis Intervention, CSB code 38 reported a need in all cases, CSB code 27 reported a need in two-thirds of cases, and CSB code 4 reported a need in 1 out of 5 cases. There were 21 CSBs who did not report requiring Short-Term Crisis Intervention.

Figure 74. Percent of Juvenile Emergency Evaluations in which CSB Clinician Reported Need for Short-Term Crisis Intervention by CSB



Community Services Boards in Virginia

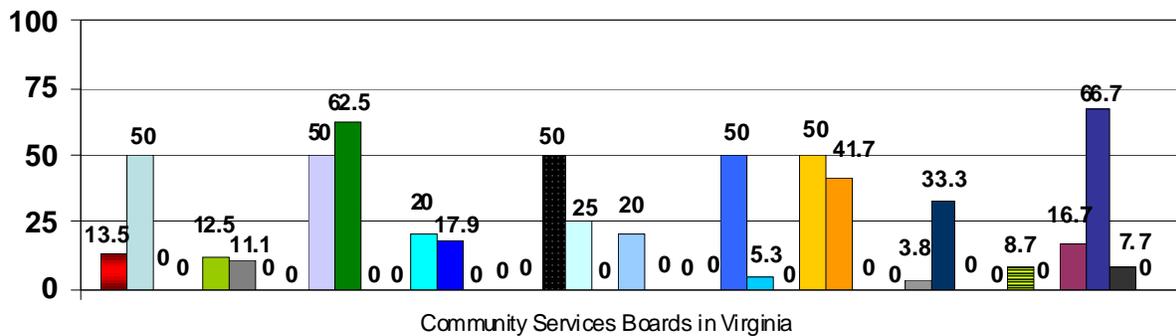
STATE, n=312	1, n=2	2, n=0	3, n=0	4, n=24	5, n=9
6, n=0	7, n=3	8, n=2	9, n=8	10, n=1	11, n=13
12, n=5	13, n=28	14, n=2	15, n=18	16, n=1	17, n=2
18, n=4	19, n=3	20, n=15	21, n=3	22, n=3	23, n=7
24, n=2	25, n=19	26, n=7	27, n=6	28, n=12	29, n=12
30, n=1	31, n=26	32, n=9	33, n=10	34, n=3	35, n=23
36, n=0	37, n=6	38, n=3	39, n=13	40, n=7	

Residential Crisis Stabilization

► **CSB clinicians indicated a need for Residential Crisis Stabilization in 13.5% of juvenile emergency evaluations across the Commonwealth (Figure 75).**

Half of the CSBs had clinicians report that Residential Crisis Stabilization was an additional service needed in at least one of their cases, whereas half of the CSBs never had clinicians indicate further needs for the service. Several CSBs responded that there was a need for services in 40% or more of their cases. Of these CSBs, four had more than 2 cases during the survey month: CSB code 9 indicated a need in 62.5% of its 8 cases; code 27, in half of its 6 cases; code 28, in 41.7% of its 12 cases; and code 38, in two-thirds of its 3 cases.

Figure 75. Percent of Juvenile Emergency Evaluations in which CSB Clinician Reported Need for Residential Crisis Stabilization by CSB



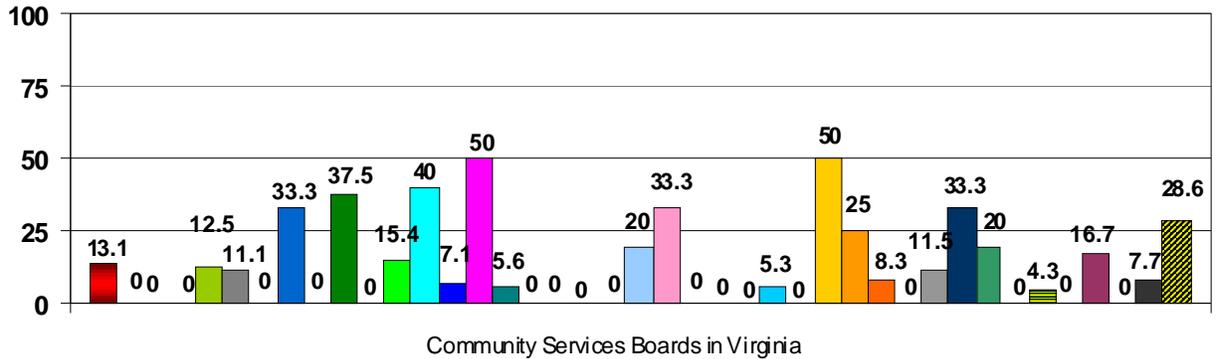
STATE, n=312	1, n=2	2, n=0	3, n=0	4, n=24	5, n=9
6, n=0	7, n=3	8, n=2	9, n=8	10, n=1	11, n=13
12, n=5	13, n=28	14, n=2	15, n=18	16, n=1	17, n=2
18, n=4	19, n=3	20, n=15	21, n=3	22, n=3	23, n=7
24, n=2	25, n=19	26, n=7	27, n=6	28, n=12	29, n=12
30, n=1	31, n=26	32, n=9	33, n=10	34, n=3	35, n=23
36, n=0	37, n=6	38, n=3	39, n=13	40, n=7	

Immediate Medication Evaluation

► **Clinicians at 22 different CSBs reported a need for Immediate Medication Evaluation services to better meet the needs of juveniles, as shown in Figure 76.**

The 18 CSBs in which Immediate Medication Evaluation was never reported as needed had between zero and 7 cases during the survey month. The CSBs with higher numbers of cases in which Immediate Medication Evaluation was most needed were CSB code 27, which reported a need in half of its 6 cases, and code 9, which reported a need in 37.5% of its 8 cases.

Figure 76. Percent of Juvenile Emergency Evaluations in which CSB Clinician Reported Need for Immediate Medication Evaluation by CSB



STATE, n=312	1, n=2	2, n=0	3, n=0	4, n=24	5, n=9
6, n=0	7, n=3	8, n=2	9, n=8	10, n=1	11, n=13
12, n=5	13, n=28	14, n=2	15, n=18	16, n=1	17, n=2
18, n=4	19, n=3	20, n=15	21, n=3	22, n=3	23, n=7
24, n=2	25, n=19	26, n=7	27, n=6	28, n=12	29, n=12
30, n=1	31, n=26	32, n=9	33, n=10	34, n=3	35, n=23
36, n=0	37, n=6	38, n=3	39, n=13	40, n=7	

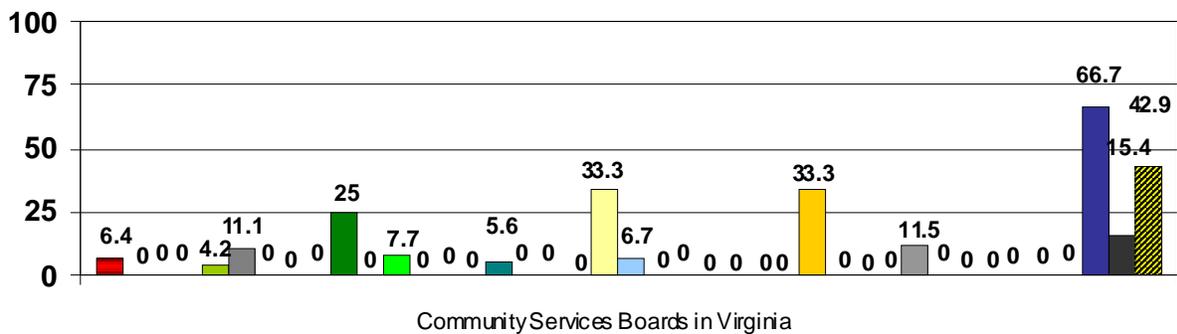
The rate of indicated need for Immediate Medication Evaluation was not significantly different across CSBs.

Temporary Housing

► **Of all needed resources or services that were not currently available to clinicians, the services least cited by clinicians to better address the needs of juveniles were Temporary Housing and Safe Transportation.**

Twenty-eight CSBs, including a CSB with as many as 28 youth evaluated during the survey month, never indicated a need for Temporary Housing. CSB clinicians indicated a need for the service in 6.4% of juvenile cases on average (Figure 77). Some CSBs reported a need for Temporary Housing in a quarter to two-thirds of cases. These included CSB code 9 (25.0% of 8 cases), code 19 (one-third of 3 cases), code 27 (one-third of 6 cases), code 38 (two-thirds of 3 cases), and code 40 (42.9% of 7 cases).

Figure 77. Percent of Juvenile Emergency Evaluations in which CSB Clinician Reported Need for Temporary Housing by CSB



STATE, n=312	1, n=2	2, n=0	3, n=0	4, n=24	5, n=9
6, n=0	7, n=3	8, n=2	9, n=8	10, n=1	11, n=13
12, n=5	13, n=28	14, n=2	15, n=18	16, n=1	17, n=2
18, n=4	19, n=3	20, n=15	21, n=3	22, n=3	23, n=7
24, n=2	25, n=19	26, n=7	27, n=6	28, n=12	29, n=12
30, n=1	31, n=26	32, n=9	33, n=10	34, n=3	35, n=23
36, n=0	37, n=6	38, n=3	39, n=13	40, n=7	

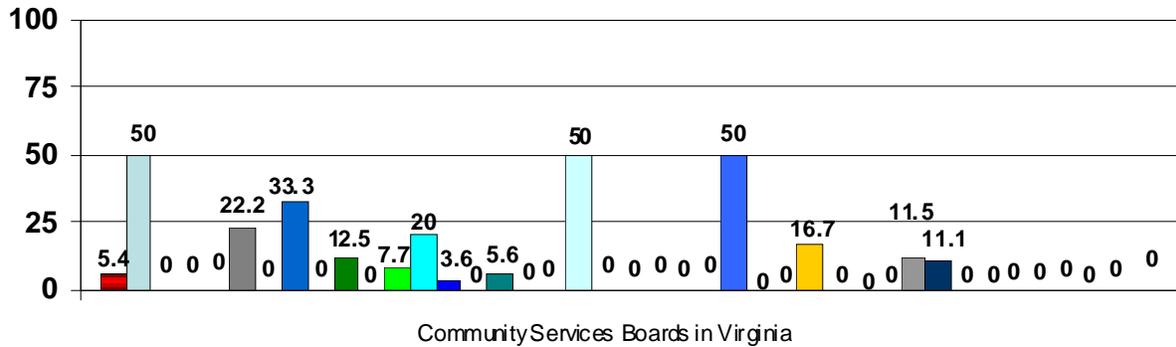
Safe Transportation

► Clinicians at 13 different CSBs reported there was a need for Safe Transportation to better serve juveniles evaluated, resulting in a state average of 5.4% of cases.

The highest percentages were in CSB codes 1, 18 and 24, where CSBs requested Safe Transportation in 50% of cases. CSBs with the next highest needs were CSB codes 5 and 12, each reporting a need for Safe Transportation in roughly 1 out of 5 cases, CSB code 7, reporting the need in one-third of cases, and CSB

31, in 11.5% of its 26 cases. Twenty-seven CSBs never reported a need for Safe Transportation (Figure 78).

Figure 78. Percent of Juvenile Emergency Evaluations in which CSB Clinician Reported Need for Safe Transportation by CSB



Community Services Boards in Virginia

STATE, n=312	1, n=2	2, n=0	3, n=0	4, n=24	5, n=9
6, n=0	7, n=3	8, n=2	9, n=8	10, n=1	11, n=13
12, n=5	13, n=28	14, n=2	15, n=18	16, n=1	17, n=2
18, n=4	19, n=3	20, n=15	21, n=3	22, n=3	23, n=7
24, n=2	25, n=19	26, n=7	27, n=6	28, n=12	29, n=12
30, n=1	31, n=26	32, n=9	33, n=10	34, n=3	35, n=23
36, n=0	37, n=6	38, n=3	39, n=13	40, n=7	

APPENDIX A

Community Services Boards Description

COMMUNITY SERVICES BOARD DESCRIPTION

Public community mental health, mental retardation, and substance abuse services are provided in Virginia by Community Services Boards (CSBs), Behavioral Health Authorities (BHAs), or local government departments with policy-advisory CSBs. Each day, Virginia's Community Services Boards and Behavioral Healthcare Authority (CSBs) provide a range of services to citizens in Virginia. Some of the many benefits of their services include helping children with mental illness to assimilate to their communities, developing occupational community support opportunities for citizens with mental retardation, supporting the care of elderly citizens with mental disabilities, and assisting families to care for members with mental illness, mental retardation, or substance abuse disorders. In 2004, according to the Virginia Association of Community Services Boards, CSBs served 42,075 citizens with mental retardation, 194,431 citizens with mental illness, and 52,266 citizens with substance abuse disorders.

Services Provided

CSBs provide services to people with mental illness, mental retardation, or substance abuse disorders with the purpose of improving an individual's quality of life. They aim to provide individuals in need of services with the most effective, flexible, and efficient care possible in the least restrictive setting. CSBs offer nine core services: emergency, local inpatient, outpatient, case management, day support, employment, residential, prevention and early intervention, and limited services. Four main responsibilities define a CSB's role:

1. "The single point of entry into publicly funded mental health, mental retardation, and substance abuse services for its service area, including access to state hospital and training center services through preadmission screening, case management, and coordination of services.
2. a provider of services, directly and through contracts with other organizations and providers

3. an advocate for consumers and services, and
4. the local focal point of accountability and responsibility for services and resources.” (Department of Mental Health, Mental Retardation and Substance Abuse Services)

A CSB also serves as an advisor to local government, an educator to the community, a community organizer for the development of needed services, a consultant to the local professional community, and an advocate for the expansion of services to meet the needs of the community.

Establishment of CSBs

Although CSBs serve Virginia citizens, CSBs are not operated by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). CSBs are agents of the local governments that established them. Originally, DMHMRSAS established and operated mental health clinics across the state beginning in the late 1940s. After the General Assembly enacted Chapter 10 of Title 37.1 in 1968, DMHMRSAS clinics became CSBs. The first two CSBs were established in 1968 in Arlington and Prince William County. Today, 40 CSBs provide services in every city and county in Virginia, 134 localities in all.

Structure and Organization

An integral aspect of Virginia’s mental health, mental retardation, and substance abuse services is the operational partnership between the CSBs and the DMHMRSAS. Established pursuant to Chapters 5 and 6, of Title 37.2 of the *Code of Virginia*, this collaboration between the central office of the DMHMRSAS, the state hospitals and training centers operated by the DMHMRSAS, and the CSB is the foundation of the Virginia’s public system of mental health, mental retardation and substance abuse services. The DMHMRSAS contracts with CSBs for local services, licenses CSBs to deliver services, monitors operations of CSBs, and provides funds, consultation, technical assistance, and guidance to CSBs.

Within the Community Services Boards, there are classifications that distinguish the relationship between the CSB and its local government or governments. Although CSBs are agents of the local governments that established them, most CSBs are not housed by city or county government departments. Section §37.2-100 of the *Code of Virginia* defines the three types of CSBs: operating community services board, administrative policy community service board, and policy-advisory community service board.

Each type of CSB is appointed by and accountable to the governing body of each city and county that established it through Chapter 5 of Title 37.2 of the *Code of Virginia*. There are 28 operating CSBs that were established for the direct provision of mental health, mental retardation, and substance abuse services.

These operating CSBs employ their own staff and are not city or county government departments. Ten administrative policy CSBs were established to set policy for and administer the provision of mental health, mental retardation, and substance abuse services. The staff of administrative policy CSBs are employees of the local governing body. Seven administrative policy CSBs are designated as city or county government departments whereas three are not local or government departments but use local government staff to provide services.

Policy-advisory CSBs have no operational powers or duties. They serve as an advisory board to the local government department. The Portsmouth Department of Behavioral Healthcare Services is the one local government department with a policy-advisory CSB. A Behavioral Health Authority (BHA) most closely resembles an operating CSB, but has additional powers not given to CSBs. The only BHA is in Richmond, but Chesterfield and Virginia Beach are also authorized to establish BHAs.

BHAs and operating and administrative policy CSBs are guided and administered by boards of directors. Boards of directors consist of no less than six and no more than 18 members who are appointed by the city councils and county boards of supervisors that established the CSB or BHA. Sections §37.2-501 and §37.2-602 of the *Code of Virginia* require that appointments to CSBs or BHAs be broadly representative of the community. One-third of the appointments must be identified consumers, former consumers, family members of consumers or former consumers, and at least one of whom shall be a consumer currently receiving services. The term CSB includes the board members and the organization that provides services.

CSBs can be further classified by the number of cities or counties it serves, the total budget size, and the urban or rural population density.¹⁰

Table 4. Number of Localities Served by CSB

Number of Localities Served	Corresponding CSBs
1 City or County	Alexandria, Arlington, Chesapeake, Chesterfield, Dickenson County, Hanover County, Loudoun County, Norfolk, Portsmouth, Richmond, and Virginia Beach (11 CSBs)
2 Localities	Alleghany Highlands, Danville-Pittsylvania, Eastern Shore, Goochland-Powhatan, Hampton-Newport News, Harrisonburg-Rockingham, and Highlands (7 CSBs)
3 Localities	Cumberland Mountain, Fairfax-Falls Church, Henrico Area,

¹⁰ Information in this summary was obtained from the “2007 Overview of Community Services Delivery in Virginia” by DMHMRSAS and the Virginia Association of Community Services Boards website, <http://www.vacsb.org>.

Number of Localities Served	Corresponding CSBs
	Prince William County, and Southside (5 CSBs)
4 Localities	Colonial, Piedmont, Planning District One, Rockbridge Area, Valley, and Western Tidewater (6 CSBs)
5 Localities	Blue Ridge, New River Valley, Rappahannock Area, and Rappahannock-Rapidan (4 CSBs)
6 Localities	Central Virginia, Mount Rogers, Northwestern, and Region Ten (4 CSBs)
7 Localities	Crossroads (1 CSB)
9 Localities	District 19 (1 CSB)
10 Localities	Middle Peninsula-Northern Neck (1 CSB)

APPENDIX B

Copy of Data Collection Instrument

The following pages contain the questionnaire that was used to collect information on CSB emergency evaluations. It was developed by a team of mental health professionals and experts in mental health law who served as members of the Commissions' Research Advisory Group.

The two-paged instrument was designed for completion by CSB clinicians following all face-to-face crisis contacts, also called emergency evaluations, during June 2007. Questionnaires were completed by clinicians who performed the emergency evaluations and represent all 40 Community Services Boards during the survey month.

The *Emergency Services Face-to-Face Crisis Contact Questionnaire* included 42 items about the specific emergency evaluation. Specific data collection elements included information about the CSB clinician; demographic information about the individual who was evaluated; where and when the evaluation took place; individual's insurance coverage, living arrangements, and current treatment, if any; individual's clinical information; individual's display of commitment criteria; pathways to the evaluation (e.g., who contacted the CSB, whether the individual was in police custody); disposition recommended by CSB clinician; hospitalization information; clinician's opinion ratings at end of crisis; and services/resources that would better address the evaluated individual's needs.

Response options included those that were dichotomous (e.g., yes or no), multi-optional (e.g., checklist of possible people who may have contacted CSB for emergency evaluation), and open-ended (e.g., In addition to services/resources listed, what other services/resources may have helped you address this individual's needs better?).

Emergency Services Face to Face Crisis Contact Questionnaire Page1

Staff Initials _____ Licensure _____ Degree _____ # of Years Experience in field: _____

1. **Date of service (mm/dd/yy):** ___/___/___ 2. **Time of service:** ___:___ pm/am 3. **Day of the week:** _____
Client Initials: _____ 4. **Client Age:** _____ 5. **Client Race:** _____ 6. **Client Sex (M/F):** _____

7. Where did the assessment take place?

CSB Hospital Client's home
Public location Magistrate's office
Police Station Other _____

8. What is client's current living arrangement?

Don't know Living alone
Living with family Living with support (e.g. group home, supervised living)
Living with non-related others Homeless
Other _____

AT THE TIME OF ASSESSMENT:

9. Client presented with (Check all that apply):

Mental illness Substance abuse
Mental retardation None

10. Was the client under the influence of drugs or alcohol? Yes No Unknown

11. Client's current treatment? (Check all that apply): None Don't know/Not sure

CSB Other community agency
State hospital Private/community hospital
Private practitioner
Other _____

12. Client's insurance status: None

Don't know/not sure Private
Medicaid/Disability Medicare Veteran's
Other _____

13. Was client showing psychotic symptoms? Yes No

14. Did client display overt indications of danger to self? Yes No

15. Did client display overt indications of danger to others? Yes No

16. Did client display overt indications of inability to care for self? Yes No

17. Who contacted CSB for assessment?

Law enforcement Friend/Family member
Client Clinician Hospital Staff
Don't know/Not sure Other _____

18. Was client in police custody at the time of assessment? No Yes, with a magistrate-issued ECO Yes, without magistrate-issued ECO

19. If yes, were restraints used? Yes No

20. What was the immediate disposition?

(Check all that apply)

Referral for voluntary CSB services (crisis stabilization, crisis intervention, 23-hour bed etc.)

Referral for other voluntary outpatient treatment

Voluntary Hospitalization

Client refused treatment, no involuntary action taken

Involuntary action taken

21. If involuntary action was taken (Check all that apply):

N/A

TDO

TDO Refused

ECO

ECO Refused

ECO expired

Other _____

22. If hospitalization was sought, number of facilities contacted: _____

23. Approximately how much time did you spend locating psychiatric bed? N/A

Less than 2 hours

2 to 4 hours

More than 4, less than 8 hours

More than 8 hours

24. If admitted, to what facility? _____

25. Was hospital in client's region? Yes No

26. If not admitted to psychiatric facility, why not?

No voluntary bed available

No TDO bed available

Don't know

Other _____

27. If hospitalization was sought or ordered but no bed was available, client was (Check all that apply):

Released

Released with less restrictive disposition

Held in ED until bed available

Held on medical unit until bed available

Held by police until bed available

Other _____

Emergency Services Face to Face Crisis Contact Questionnaire Page2

Please circle option that most closely reflects *your opinion* about client's condition **AT THE CONCLUSION OF THE CRISIS CONTACT:** Definitely No-0 Probably No-1 No opinion-2 Probably Yes-3 Definitely Yes-4

	Definitely No	Probably No	No opinion	Probably Yes	Definitely Yes
28. Client presented a danger to self:	0	1	2	3	4
29. Client presented a danger to others:	0	1	2	3	4
30. Client was unable to care for self:	0	1	2	3	4
31. Client was experiencing severe mental or emotional distress or dysfunction:	0	1	2	3	4
32. Client's condition warranted hospitalization:	0	1	2	3	4
33. I would have sought involuntary action if client refused services: N/A	0	1	2	3	4
34. I was able to address this person's crisis needs with the resources available to me:	0	1	2	3	4

35. What, if any, services/resources would have helped you address this client's needs better?

- Immediate medication evaluation
- Safe transportation
- Temporary housing
- Short-term crisis intervention
- Residential crisis stabilization
- In-home crisis stabilization
- Other:

36. If client was not hospitalized, do you know what happened to this client? Yes No
 N/A

37. If yes, what happened?

38. Other Comments:

APPENDIX C

Methods & Statistical Analytic Techniques

The study was reviewed by the University of Virginia Human Investigation Board and received “exempt” status based on the fact that no identifying information was collected on any person receiving mental health services, and that participation in the survey was voluntary on the part of the clinicians at the individual CSBs.

A paper-and-pencil survey was used in a study of all face-to-face emergency evaluations conducted by CSB clinicians during the month of June 2007. CSB clinicians who evaluated individuals experiencing a mental health or substance abuse crisis and who made treatment recommendations, including recommendations that could lead to civil commitment hearings, agreed to participate by completing the questionnaire. Clinicians who completed the hard copy questionnaires provided fact and opinion based information on the emergency evaluation phase of the civil commitment process. The completed questionnaires were mailed to the UVA research team on a regular basis during the month.

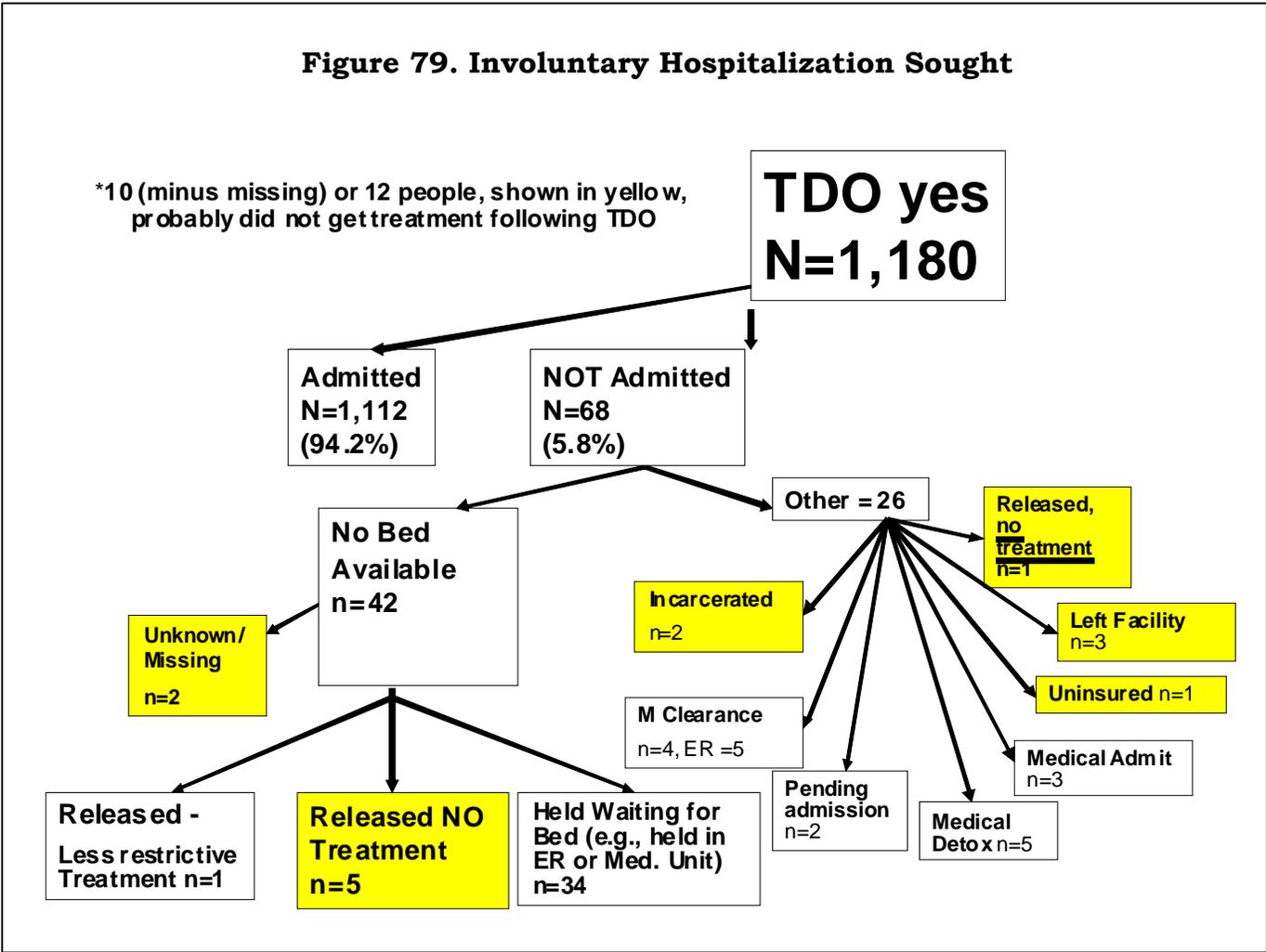
Upon receipt, each questionnaire was given an identification number and filed. Research assistants entered information from the forms into an SPSS database. Once all questionnaires documenting emergency evaluations conducted during the period of June 1, 2007 to June 30, 2007 were entered into the database, error checking and data cleaning proceeded. Descriptive and inferential statistics were used in the analysis of the data.

APPENDIX D

Possible Outcomes of Individual Non-Admission

The subsequent actions that occurred in June 2007 when an individual was recommended for voluntary or involuntary hospitalization following an emergency evaluation but was not immediately admitted to a hospital are illustrated below. Two flowcharts, Figures 79 and 80, show events that occurred during the survey month based on clinician responses. Pages 16-17 of Section II of this report provide a summary based on these flowcharts.

Involuntary Hospitalization Sought



Six broad categories were determined based on the possible outcomes presented in Figure 79 above and are illustrated in Figure 21 (page 16). The categories are as follows:

- (1) “Held Waiting for Bed” includes the 34 original cases described as such, as well as cases described as “pending admission” and waiting for “medical clearance”. This combination resulted in the largest category, 66.2% of cases in which an individual was waiting to be admitted.
- (2) “Released with No Treatment” includes those individuals who were released due to a bed not being available (n=5), 7.4% of cases.
- (3) “Medical Treatment” includes the cases in which an individual was admitted to medical treatment (n=3) or medical detoxification (n=5), resulting in 11.8% of cases.
- (4) The one individual who was released to a less restrictive treatment remained in a single category (1.5%).
- (5) Remaining individuals did not receive treatment due to “other” situations, not because of a lack of beds. This category includes individuals who were incarcerated, who left the facility against orders, who did not have insurance, and one case in which the reason was unspecified (10.2% of cases).

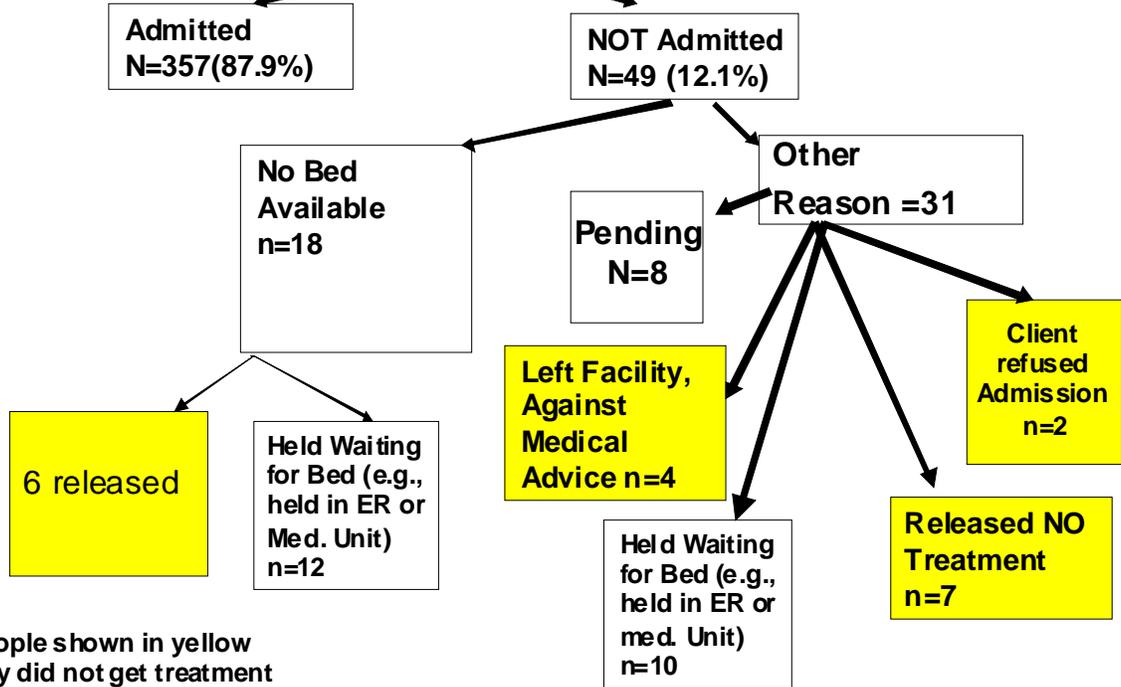
Voluntary Hospitalization Sought

Three broad categories were determined based on the possible outcomes presented in Figure 80 below and are illustrated in Figure 22 (page 17). The categories are as follows:

- (1) “Released with No Treatment” includes the 6 individuals released when no bed was available (26.5% of cases).
- (2) “Held Waiting for Bed” includes the 22 original cases described as such, as well as cases described as “pending admission”. This combination again resulted in the largest category, or 61.2% of individuals were held waiting to be admitted.
- (3) Individuals who left the facility against medical advice, individuals who refused admission, and other unspecified reasons made up the remaining category, “Did Not Receive Treatment due to Other Circumstances”, 12.3% of cases.

**Figure 80.
Voluntary
Hospitalization
Sought**

**Voluntary Inpatient Treatment
N=406 (12.2%)**



APPENDIX E

Community Services Boards and Localities Served

Name of Community Services Board	Localities Served
Alexandria CSB	City of Alexandria
Alleghany Highlands CSB	County of Alleghany, Cities of Clifton Forge and Covington
Arlington County CSB	County of Arlington
Blue Ridge Behavioral Health Care	Counties of Botetourt, Craig, and Roanoke, Cities of Roanoke and Salem
Central Virginia CSB	Counties of Amherst, Appomattox, Bedford, and Campbell, Cities of Bedford and Lynchburg
Chesapeake CSB	City of Chesapeake
Chesterfield CSB	City of Chesterfield
Colonial CSB	James City, York County, Cities of Poquoson and Williamsburg
Crossroads CSB	Counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottaway, and Prince Edward
Cumberland Mountain CSB	Counties of Buchanan, Russell, and Tazewell
Danville-Pittsylvania CSB	Pittsylvania County, City of Danville
Dickenson County BHS	Dickenson County
District 19 CSB	Counties of Dinwiddie, Greenville, Prince George, Surry, and Sussex, Cities of Colonial Heights, Emporia, Hopewell and Petersburg
Eastern Shore CSB	Counties of Accomack and Northampton
Fairfax-Falls Church CSB	Fairfax County, Cities of Fairfax and Falls Church
Goochland-Powhatan CSB	Counties of Goochland and Powhatan
Hampton-Newport News CSB	Cities of Hampton and Newport News
Hanover County CSB	County of Hanover

Name of Community Services Board	Localities Served
Harrisonburg-Rockingham CSB	City of Harrisonburg, County of Rockingham
Henrico Area Mental Health and Retardation Services	Charles City, Counties of Henrico and Kent
Highlands CSB	Washington County and City of Bristol
Loudoun County CSB	County of Loudoun
Middle Peninsula-Northern Neck CSB	Counties of Essex, Gloucester, King and Queen, King William, Lancaster, Matthews, Middlesex, Northumberland, Richmond and Westmoreland
Mt. Rogers CSB	Counties of Bland, Carroll, Grayson, Smyth, and Wythe, City of Galax
New River Valley CSB	Counties of Floyd, Giles, Montgomery, and Pulaski, Cities of Radford and Blacksburg
Norfolk CSB	City of Norfolk
Northwestern CSB	Counties of Clarke, Frederick, Page, Shenandoah and Warren, City of Winchester
Piedmont CSB	Counties of Franklin, Henry, and Patrick, City of Martinsville
Planning District One	Lee, Scott, and Wise Counties, City of Norton
City of Portsmouth Dept. of BHS	City of Portsmouth
Prince William County CSB	Prince William County, Cities of Manassas and Manassas Park
Rappahannock Area CSB	Caroline, King George, Spotsylvania, and Stafford Counties, City of Fredericksburg
Rappahannock-Rapidan CSB	Counties of Culpeper, Fauquier, Madison, Orange, and Rappahannock
Region Ten CSB	Counties of Albemarle, Fluvanna, Greene, Louisa, and Nelson, City of Charlottesville
Richmond BHA	City of Richmond
Rockbridge Area CSB	Rockbridge and Bath Counties, Cities of Buena Vista and Lexington
Southside CSB	Counties of Brunswick, Halifax, and Mecklenburg, City of South Boston
Valley CSB	Augusta and Highlands Counties, Cities of Staunton and Waynesboro
Virginia Beach Human Services	City of Virginia Beach
Western Tidewater CSB	Isle of Wight and Southampton Counties, Cities of Franklin and Suffolk

APPENDIX F Percentile Ranking of Community Services Boards

The following table (continued on page 87) divides the 40 Community Services Boards in Virginia into 4 quartiles by the number of adult emergency evaluations reported during the month of June 2007. The CSBs are listed alphabetically in the quartile under which they placed. Therefore, the CSBs with the most numbers of cases during the survey month fall between the 76th and 100th percentiles, the CSBs with the least numbers of cases during the survey month fall at or below the 25th percentile, and so on.

Table 5. Percentile Ranking of CSBs

CSBs contained at or below 25 th Percentile	Alleghany CSB Chesterfield CSB Cumberland Mountain CSB Hanover County CSB Harrisonburg-Rockingham CSB Eastern Shore CSB Goochland-Powhatan CSB Loudoun County CSB Portsmouth Dept. of Behavioral Healthcare Services Rockbridge Area CSB
CSBs contained at or below 50 th Percentile	Alexandria CSB Arlington CSB Colonial CSB Crossroads CSB Henrico Area MH & MR Services Middle Peninsula-Northern Neck CSB Norfolk CSB Southside CSB Valley CSB Western Tidewater CSB

<p>CSBs contained at or below 75th Percentile</p>	<p>Central Virginia Community Services Chesapeake CSB Dickenson County Behavioral Health Services District 19 CSB Hampton-Newport News CSB Highlands Community Services Planning District One Behavioral Health Services Prince William County CSB Rappahannock Area CSB Rappahannock-Rapidan CSB</p>
<p>CSBs contained at or below 100th Percentile</p>	<p>Blue Ridge Healthcare Danville-Pittsylvania CSB Fairfax-Falls Church CSB Mt. Rogers Community MH & MR Services Board New River Valley Community Services Northwestern Community Services Piedmont Community Services Region Ten CSB Richmond Behavioral Health Authority Virginia Beach Department of Human Services</p>

APPENDIX G

Descriptions of Selected Services/Resources at Community Services Boards

Item 35 on the *Emergency Services Face-to-Face Crisis Contact Questionnaire* asked clinicians which services or resources, if any, would have helped to address individuals' needs better. The services offered as choices were Immediate Medication Evaluation, Safe Transportation, Temporary Housing, Short-Term Crisis Intervention, Residential Crisis Stabilization, and In-Home Crisis Stabilization. The various services described below may not be offered at all CSBs.¹¹

Immediate Medication Evaluation

An Immediate Medication Evaluation provides a psychiatric assessment of the individual and the provision of appropriate psychotropic medication.

Safe Transportation

Safe Transportation would address the need for a trained third party to transport the individual to a proper destination.

Temporary Housing

Temporary Housing can include a variety of services but essentially provides shelter for a limited time frame.

Short-Term Crisis Intervention

Short-Term Crisis Intervention refers to direct intervention to persons who are experiencing serious psychiatric or behavioral problems which jeopardize their current community living situation. The goal is to provide temporary intensive services to avert emergency psychiatric hospitalization.

¹¹Descriptions of the services of Temporary Housing, Short-Term Crisis Intervention, Residential Crisis Stabilization, and In-Home Crisis Stabilization are from *Core Services Taxonomy 7*, a guide published by DMHMRSAS.

Residential Crisis Stabilization

Residential services provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services. Highly Intensive Residential Services provide overnight care with intensive treatment such as crisis stabilization on a short-term basis.

In-Home Crisis Stabilization

In-Home Crisis Stabilization refers to direct intervention to persons at their home who are experiencing serious psychiatric or behavioral problems which jeopardize their current community living situation. The goal is to provide temporary intensive services to avert emergency psychiatric hospitalization.