

Office of the State Inspector General
Report to Governor McAuliffe
and the General Assembly

Critical Incident Investigation
Bath County, Virginia, November 18, 2013

March 2014



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State Inspector General

OSIG Report Number 2014-BHDS-006



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March 27, 2014

The Honorable Terence "Terry" Richard McAuliffe
Governor of Virginia
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
General Assembly Building
Richmond, Virginia 23219

Dear Governor McAuliffe and Members of the General Assembly:

The statues in section (B)(1) of the *Code of Virginia* [§ 2.2-309.1](#) require the Office of the State Inspector General (OSIG) to inspect: "serious incident reports and reports of abuse, neglect, or inadequate care ..." Included herein is the OSIG investigative report into the critical incident that occurred in Bath County, Virginia on November 18, 2013.

The OSIG's investigation had three main objectives, which included establishing a timeline of events, identifying contributing factors, and providing the Commonwealth's psychiatric emergency response system with performance improvement recommendations.

If you have any questions concerning this report, please contact me at (804) 625-3248, or I am always available to meet with you at your convenience.

Respectfully,

A handwritten signature in black ink that reads "Michael F. A. Morehart".

Michael F. A. Morehart
State Inspector General

CC: Paul Reagan, Chief of Staff for Governor McAuliffe
Suzette Denslow, Deputy Chief of Staff for Governor McAuliffe
Senator Linda T. Puller, Chair, Joint Commission on Health Care
Dr. William A. Hazel, MD, Secretary of Health and Human Resources
John Pezzoli, Acting Commissioner, DBHDS
Colonel Steven Fiaherly, Virginia State Police
Dennis Cropper, Executive Director, Rockbridge Area Community Services

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Executive Summary

This report sets forth the results of an investigation conducted by the Office of the State Inspector General (OSIG) of a critical incident that occurred in Bath County, Virginia on November 18, 2013. The OSIG's investigation was conducted pursuant to its authority under the *Code of Virginia (Code)* [§ 2.2-309.1](#)(B)(1).

Media Reports

The OSIG's investigation into this matter was predicated on media reports. According to these reports, on November 18, 2013, an Emergency Custody Order (ECO) was granted by a magistrate and the subject of the ECO was subsequently taken into custody by a Bath County Deputy Sheriff and transported to a local hospital for evaluation. The individual reportedly was evaluated by a mental health professional and determined to meet statutory criteria for temporary detention; however, instead of receiving the clinically indicated involuntary temporary detention to undergo further evaluation, the individual was released from custody at the expiration of the ECO.¹ It was alleged that the community services board (CSB) evaluator was unable to locate a psychiatric facility willing to admit the individual. According to statute, a Temporary Detention Order (TDO) cannot be executed (enforced) unless a receiving facility is identified on the preadmission screening report and on the TDO.²

OSIG Investigative Goals

The OSIG's investigation of the critical incident had three objectives:

1. To establish a timeline of events that occurred on November 18, 2013.
2. To identify contributing factors.
3. To provide the Commonwealth's psychiatric emergency response system with performance improvement recommendations.

¹ This investigative report is intended to comply with the privacy protections afforded individuals under *The Health Insurance Portability and Accountability Act* (1996) (HIPAA) and the *Code of Virginia* and with proper respect for the family's privacy. These commitments may at times result in an awkward and circumspect presentation. The OSIG has segregated all confidential materials acquired during this investigation, and these documents containing personal patient information have been placed in a sealed envelope with restricted access, in compliance with applicable regulations.

² *Code* [§ 37.2-809](#) (E) requires that, "The facility shall be identified on the preadmission screening report and indicated on the temporary detention order." Thus, pursuant to the *Code*, unless a suitable facility can be located to admit a person for temporary detention before the expiration of the ECO, the TDO remains "unexecuted" and the individual cannot be legally detained beyond the six-hour statutory limit.

Contributing Factors

This investigation identified four factors that contributed to the release of a person determined by a CSB evaluator to meet the statutory criteria for temporary detention.

Report No. 206-11: OIG Review of Emergency Services

During 2012 and throughout most of 2013, the DBHDS did not fully or in a timely manner address key recommendations of the former Office of the Inspector General for Behavioral Health and Developmental Services (OIG-BHDS) in [Report No. 206-11, OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment](#) dated February 28, 2012.³ The report highlighted a practice known as “streeting”—an outcome when individuals clinically determined to meet the statutory criteria for a TDO were not admitted to a psychiatric facility or provided the clinically indicated level of care.⁴ The outcome was also referred to as a “failed TDO” in the OIG-BHDS Report.

The 2012 OIG-BHDS report warned that each unexecuted TDO “represents a failure of the system to address the needs of that individual, placing the individual, their family and the community at risk.” The report also cautioned that each failed TDO carried “a significant chance of a serious adverse outcome”—a sentinel event.⁵

Rural Travel Times and a Lack of Coordination

Once a magistrate issues an ECO, the subject of the ECO is taken into custody by a designated law enforcement official. The statutory ECO time limit commences when the person is taken into custody and transported to a convenient location for evaluation to determine if they require temporary detention.

Lack of ECO notification protocols among the Rockbridge Area Community Services (RACS), Bath Community Hospital (BCH), and Bath County Sheriff’s Office, combined with the travel times required for a rural area in Virginia truncated the preadmission screening process from six hours to three hours and 15 minutes.

The record reflects that the ECO was issued at 11:23 a.m., the individual was taken into custody at 12:26 p.m., and the person arrived at BCH at approximately 12:55 p.m. However,

³ *Report No. 206-11, OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment* dated February 28, 2012. Accessed January 10, 2014: <http://www.oig.virginia.gov/documents/SS-EmergencySvcsReview206-11.pdf>.

⁴ Once a clinician determines that a TDO is warranted, the clinician has confirmed that the person is in need of hospitalization and that no less restrictive treatment alternative is available to meet the person’s needs. (Code § 37.2-809 [B]).

⁵ The Joint Commission. Definition of sentinel event. Available at http://www.jointcommission.org/sentinel_event.aspx. Accessed February 27, 2014.

the RACS was not notified that an ECO had been issued or executed until 1:40 p.m., when a family member called the RACS from the hospital to inquire about the evaluation's status.

The record also reflects that the CSB evaluator departed Lexington, VA at 2:00 p.m., and after driving approximately 70 minutes from Lexington, VA to Hot Springs, VA, he arrived at BCH at approximately 3:10 p.m.

The Preadmission Evaluation Process

When a person has been taken into custody under an ECO, the *Code* requires that a CSB evaluator assess the need for hospitalization or treatment for the individual.⁶ According to the CSB evaluator, once he determined hospitalization was necessary, he contacted 10 private facilities in an attempt to locate a psychiatric facility willing to admit the individual under TDO status. Through a review of phone records and interviews with facility staff, the OSIG was able to confirm seven of the 10 contacts claimed by the CSB evaluator; however, the OSIG found no evidence to support the CSB evaluator's contact with the remaining three facilities. Two of these three facilities advised the OSIG that they had beds available that day.

The Commonwealth's Emergency Response System

The Commonwealth's emergency response system for individuals experiencing psychiatric emergencies linked the issuance of a TDO with identifying a facility with an appropriate and available bed. A TDO's primary purpose is clearly indicated by *Code* statutes as assuring safety of persons with mental illness, the safety of others, and that, once a person meets the statutory criteria for detention, the person is expected to receive the clinically indicated hospitalization or treatment.⁷

Locating a psychiatric facility willing to admit a person is a necessary activity, but it does not function as part of the clinical assessment that an individual meets criteria for a TDO. Yet, Report No. 206-11 and the UVA *Face-to-Face Emergency Evaluation* study have confirmed that people meeting TDO criteria have been denied the clinically indicated level of care because a bed could not be located, or because a bed could not be located within the maximum ECO time limit.⁸

⁶ *Code* § 37.2-808 (B)

⁷ Attached for context at [Appendix V](#) is *Toward a Better Understanding of Psychiatric Emergencies, Assessment for Dangerousness and Effective Interventions To Assure Safety and Enable Recovery* authored by Dr. Kent G. McDaniel, MD, PhD, consulting psychiatrist for the OIG-BHDS following the 2007 Critical Incident at Virginia Tech.

⁸ Report No. 206-11, OIG Review of Emergency Services (Footnote 3) and UVA's *A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards* (Footnote 12).

The Commonwealth's maximum six-hour time limit for ECOs is the shortest in the nation.⁹ The events and issues noted above, combined with the statutory maximum six-hour ECO limit, resulted in a critical incident on November 18, 2013, in which a person who met criteria for a TDO was released without the clinically indicated hospitalization and treatment.

Recommendations

Based on the results of its investigation into the November 18 critical incident in Bath County, VA, the OSIG makes the following recommendations:

- Implement the recommendations of OIG-BHDS Report No. 206-11 ([Appendix II](#)) contains a summary of this report's findings and recommendations.
- Create a web-based psychiatric bed registry for the Commonwealth.
- Develop policies, procedures, and guidelines with respect to coordination among CSBs, law enforcement, and TDO assessment sites.
- Create a workgroup to establish CSB evaluator standards of practice, training, supervision, and recertification.
- Uncouple the bed search from the execution of the TDO.

Based on an examination of the available evidence, the OSIG suggests that implementing these recommendations will improve the effectiveness of the Commonwealth's emergency services system and facilitate access to clinically appropriate treatment, including inpatient hospitalization.

⁹ Governor's Task Force on Mental Health Services and Crisis Response. Opening testimony of Senior Assistant Attorney General Allyson K. Tysinger. January 2014. Available at: <http://www.dbhds.virginia.gov/MHSCRTTaskforce.htm>. Accessed March 3, 2014.



The Critical Incident

On November 19, 2013, the Virginia State Police (VSP) announced that a member of the Virginia Senate had been stabbed multiple times during an altercation with his son, and that the son, despite the efforts of first responders, died of a self-inflicted gunshot wound at the scene of the incident. At the time of the press conference, the VSP spokesperson reported the incident was under investigation as a probable attempted murder and suicide.

Media reports indicated that on November 18, 2013, after an Emergency Custody Order (ECO) was granted by a local magistrate, the subject of the petition was taken into emergency custody by a Bath County Deputy Sheriff and transported to Bath Community Hospital (BCH) for a preadmission evaluation.¹⁰

These reports revealed that Rockbridge Area Community Services (RACS) emergency services personnel had conducted a preadmission screening of this individual and that the community services board (CSB) evaluator had recommended that the individual be detained in an inpatient setting under a Temporary Detention Order (TDO) for further evaluation. However, the TDO was not executed, and the individual was released from custody after the expiration of the ECO because the evaluator was unable to locate a public or private psychiatric facility willing to admit the individual.¹¹

Since the unexecuted TDO, three psychiatric facilities in the region have stated to the media that they had beds available on November 18, 2013, but that they had not been contacted by the CSB evaluator.

¹⁰ A preadmission evaluation is required by the *Code* to determine the appropriate level of care for an individual in a psychiatric crisis. DBHDS. Preadmission Screening Report Form. Available at <http://www.dbhds.virginia.gov/documents/forms/Preadmission%20Screening%20Form%202001-22-2013.pdf>. Accessed March 3, 2014.

¹¹ According to the *Code*, a person can only be detained under an ECO for four hours—unless granted an extension of two additional hours by a magistrate, making it a maximum of six hours—and a TDO cannot be executed, or authorized by the presiding magistrate, unless the TDO identifies the facility where an individual is to be detained. Thus, according to the *Code*, absent a facility willing to admit an individual held under an ECO, that individual cannot be involuntarily held after six-hours and detained involuntarily pursuant to a TDO.



The Investigative Process

The OSIG's investigation of this critical incident, which was coordinated with the VSP, was limited to those activities occurring on November 18, 2013, between 9:10 a.m. and 6:39 p.m.

Interviews

The OSIG's investigation included interviews of RACS staff who either were involved in the November 18, 2013 prescreening process, or who could provide an understanding of established emergency services policies and procedures. The individuals contacted and interviewed included the following:

- RACS employees
 - Executive Director
 - Clinical Director
 - Emergency Services Supervisor
 - CSB evaluator who conducted the November 18, 2013 preadmission screening
 - Director of Quality Improvement and Corporate Compliance
- Bath County Sheriff's Department
 - Sheriff
 - Senior staff
 - Deputy who transported the individual pursuant to the ECO
- Bath County Department of Social Services and Public Health Department
 - Community services providers
- BCH staff
 - Legal
 - Administrative
- Virginia State Police
 - Investigative team lead
- Roanoke Medical Examiner's Office
 - Medical Examiner
- Family members of the individual

The OSIG reviewed the Office of the Secretary of Health and Human Resources (HHR) *Review of Incident Following Emergency Custody Order (ECO)* dated December 19, 2013, conducted by the Department of Behavioral Health and Developmental Services' (DBHDS) Office of Licensing with assistance from the DBHDS Behavioral Health Services Division. The OSIG also reviewed written responses provided by BCH to specific procedural questions posed by the OSIG.

The OSIG examined the phone records for the BCH emergency extension and the RACS furnished cell phone used by the CSB evaluator on November 18, 2013.

Additional OSIG investigative activities included:

- Requesting that the DBHDS update its status regarding its implementation of the recommendations from OIG-BHDS Report No. 206-11, *OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment*, dated February 28, 2012, that examined unexecuted TDOs in the Commonwealth of Virginia (Commonwealth).³
- Reviewing the *DBHDS Status Report: December 4, 2013 (Study of Unexecuted TDOs in the Commonwealth)*.
- Meeting with the DBHDS Assistant Commissioner for Behavioral Health regarding an update on activities relevant to OIG-BHDS Report No. 206-11 recommendations completed prior to and following November 18, 2013.
- Meeting with the emergency services supervisors in Health Planning Region V.
- Surveying the Commonwealth's CSB emergency services directors to benchmark the status of the implementation of OIG-BHDS Report No. 206-11 recommendations (39 of 40 CSBs responded to an OSIG survey questionnaire in December 2013).
- Reviewing the University of Virginia (UVA), Institute of Law and Public Policy's recently completed *A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013*.^{12/13}
- Reviewing the DBHDS's guidelines for regions about the development of written policies and procedures to strengthen the Commonwealth's safety net for

¹² Institute of Law and Public Policy, University of Virginia. A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards in April 2013. December 2013. Available at: http://www.law.virginia.edu/pdf/news/face_to_face_emergency_evaluations_report_v2.pdf. Accessed March 4, 2014.

¹³ UVA's study sample universe included all emergency evaluations; unlike the OIG's study sample that limited its focus to a subset of emergency contacts of people with mental illness who had been evaluated and determined to meet criteria for temporary detention. Therefore, these two studies do not represent an apples-to-apples comparison; however, regardless of the methodological and sample differences between the studies, both Reports confirm that individuals meeting the statutory criteria for temporary detention received a different outcome.

individuals with mental illness. *Guidance for Developing Regional Admission Policy and Procedures* ([Appendix IV](#)).

- Reviewing the data collection instrument dated December 20, 2013 for tracking “failed TDOs” and “TDOs executed beyond six hours” to be placed in service January 1, 2014 ([Appendix III](#)).



Timeline for November 18, 2013

The OSIG compiled the following timeline from interviews with RACS and Bath County Sheriff's Office staff, and interviews with family members.¹⁴ The timeline also reflects information contained in documents provided by the BCH, the RACS, the Bath County Sheriff's Office, and the phone records of the BCH Emergency Department and the RACS cell phone used by the CSB evaluator.¹⁵

Where times are cited in this timeline, the basis for the time indicated is disclosed. Note: Times supplied by individuals should be considered approximate. The issuance, extension, and expiration of the ECO and the telephone contacts involved examination of the related documents.¹⁶

This timeline is divided into seven sections:

- Family Member Contacts the RACS
- Emergency Custody Order
- Notification of the RACS
- Preadmission Evaluation
- Extension of the Emergency Custody Order
- Search for a Receiving Facility
- Expiration of the Emergency Custody Order

The Family Member Contacts the RACS

9:10 a.m.

The RACS Clinical Services Director reported receiving a call from a family member expressing concern about an individual's behavior. The Clinical Services Director advised

¹⁴ [Appendix I](#) contains a detailed timeline for November 18, 2013, without commentary.

¹⁵ In compliance with HIPAA regulations, any applicable confidential health information has been filed in a separate report and will not be disclosed to parties lacking authorization.

¹⁶ The times indicated for events represent a combination of times cited in documents and approximate times supplied by individuals. In some cases, other individuals have confirmed times cited and these confirmations are noted in the timeline. Following each segment below are relevant findings of the OSIG for that section.

that if the person would go willingly, the family member should take the individual to the local hospital. Alternatively, if the individual was unwilling to go to the hospital, the family member was advised to obtain an ECO and have local law enforcement transport the individual to the hospital for a preadmission evaluation.¹⁷

Background

According to the RACS Clinical Services Director, the family member was known to the RACS, and it was unremarkable for area family members to call the agency to clarify procedures for obtaining mental health services—including information on emergency services.

The Emergency Custody Order

Code [§ 37.2-808](#) (A) “Any magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion, an emergency custody order when he has probable cause to believe that any person (i) 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 as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, 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.”

10:20 a.m.

After unsuccessful efforts to have the individual voluntarily seek services, the family member reported traveling to the Bath County Sheriff’s Office to petition the magistrate for an ECO. The Bath County Magistrate was not available. The Bath County Sheriff’s Office facilitated a telecommunication between the petitioner and the Magistrate in Alleghany County, who heard the family member’s ECO petition.¹⁸

Background

The Bath County Sheriff reported that it was standard practice to use telecommunications with the Magistrate in the neighboring county. This reciprocal arrangement assures timely access to a magistrate.

Code [§ 37.2-808](#) (B) “Any person for whom an emergency custody order is issued shall be taken into custody and transported to a convenient location to be evaluated to determine

¹⁷ Time established through interview and document review

¹⁸ Time established through interview with family member

whether the person meets the criteria for temporary detention pursuant to § [37.2-809](#) and to assess the need for hospitalization or treatment.”

Interviews with clinical staff at the RACS, combined with information provided by a BCH representative, confirmed that the BCH Emergency Department was the location in Bath County where preadmission evaluations occurred for persons under an ECO. The BCH and the RACS representatives provided the following information to the OSIG:

- Typically, hospital personnel are not provided advance notice of the arrival of persons under an ECO or given any information regarding the level of risk, such as aggressive behaviors, or any other background data that could assist facility professionals in triaging or expediting a person’s evaluation.
- There is no psychiatrist on staff at BCH or residing in the community, so the hospital relies on the RACS for psychiatric services. The RACS has a facility in Hot Springs, VA that is staffed on Mondays and on the fourth Wednesday of each month.

The OSIG was informed by CSB staff that, during the RACS’s normal working hours, the CSB evaluator travels from the main office in Lexington to BCH. According to the CSB staff, the drive takes between 70 to 80 minutes in good weather.¹⁹ During evenings, weekends, and holidays, an on-call preadmission CSB evaluator is located in Bath County.

11:03 a.m.

Petition for ECO forwarded to the Alleghany County Magistrate.²⁰

Code [§ 37.2-808](#) (C) *“The magistrate issuing an emergency custody order shall specify the primary law-enforcement agency and jurisdiction to execute the emergency custody order and provide transportation.”*

11:23 a.m.

The ECO was issued by the Alleghany County Magistrate upon the sworn testimony of the petitioner and faxed to the Bath County Sheriff’s Department for assignment and execution.²⁰

¹⁹ According to MapQuest, the distance between Hot Springs, VA and Lexington, VA is approximately 50 miles and requires about 70 minutes to drive.

²⁰ Time established through document review

Background

As described by the Bath County Sheriff's Office, procedures require that upon receipt of an ECO, station-based personnel review the document for accuracy and then contact the nearest "road officer" to execute the order.

Code [§ 37.2-808](#) (G) "...The period of custody shall not exceed four hours from the time the law-enforcement officer takes the person into custody. However, upon a finding by a magistrate that good cause exists to grant an extension, the magistrate shall issue an order extending the period of emergency custody one time for an additional period not to exceed two hours...."

12:26 p.m.

The ECO was executed (served) by a Bath County Sheriff's Deputy who took the person into custody and transported the individual to BCH. Pursuant to Code [§ 37.2-808](#), the ECO commenced when served and would expire four hours later, at 4:26 p.m.²⁰

Background

According to the Deputy Sheriff, he arrived at BCH with the individual in custody. From the time the ECO was executed, it took approximately 30 minutes to transport the individual to BCH for evaluation. The Bath County Sheriff's Office estimated the distance between the individual's residence and the hospital as less than 35 miles.

12:55 p.m.

Medical clearance of the individual began with an examination by nursing staff.²⁰

Background

In a statement provided by BCH's attorney, the role of the emergency room physician in the preadmission evaluation process at BCH is as follows:

The Emergency Room physician does a medical evaluation of the patient to rule-out any medical explanation for the behavior and to determine the medical stability of the patient for inpatient treatment. The medical clearance process consists of an EKG, Chest X-ray, drug screen, urine screen, CBC (complete blood chemistry), metabolic profile, thyroid level check and alcohol screening. Once this information is secured, then the proper placement decision can be made depending upon the patient's medical needs.

OSIG Finding No. 1

The ECO was issued and executed in compliance with the provisions of the Code [§ 37.2-808](#).

The Notification of the RACS

1:40 p.m.

The family member spoke with the RACS emergency services supervisor to report that the individual in custody was at BCH, and the emergency services supervisor then assigned the CSB evaluator.²¹

Background

According to the RACS clinical staff, as confirmed in written responses provided by BCH to the OSIG, the CSB is notified of the execution of an ECO by one of three methods: 1) a 911 call notification by a dispatcher, 2) a call from the transporting law enforcement officer, or 3) a call from the hospital.

There is not an established procedure for notification of the CSB that an ECO has been executed; however, according to BCH, typically, once a patient arrives at BCH, a medical screening and assessment is completed prior to notifying the RACS. In most cases, medical clearance is required prior to admission to either a private or a public facility.

1:46 p.m.

An Emergency Department physician commenced an examination of the individual for medical clearance.²⁰

2:00 p.m.

After handing over another case to a coworker, the assigned CSB evaluator was dispatched from the RACS Lexington, VA office to BCH.²²

Background

At the time of this investigation, the assigned CSB evaluator was a license eligible mental health professional (LMHP-E). The evaluator had been a full-time employee of the RACS for approximately 18 months and was the senior clinician in the Emergency Services Division.

The RACS furnished Certificates dated August 24, 2012, reflecting that the CSB evaluator successfully completed DBHDS requirements to become a CSB Evaluator and Preadmission Screener and the course requirements for an Independent Examiner.

²¹ Call and approximate time furnished by the CSB evaluator and confirmed by the family member

²² Time provided by CSB evaluator

The emergency services supervisor was an experienced licensed professional counselor (LPC) and had been employed by the agency since June 18, 2013 as the supervisor of emergency services.

The RACS Emergency Services Division consists of three full-time clinicians and a triage technician. All of the CSB evaluators were certified by DBHDS. The RACS uses an on-call cadre of state certified CSB evaluators during evenings, weekends, and holidays.

2:30 p.m.

An unknown individual, reportedly from BCH, called the RACS asking when the CSB evaluator would arrive. This was the first reported contact between the BCH and the RACS.²³

OSIG Finding No. 2

Notification protocols among local law enforcement, BCH, and the RACS that an ECO has been executed (served) are not formalized or documented.

OSIG Finding No. 3

The lack of a formal notification process to alert the hospital and the CSB that an individual would require preadmission evaluation resulted in a delay in initiating the preadmission evaluation of this individual.

OSIG Finding No. 4

The CSB evaluator did not depart Lexington, VA until notified by the family member that the individual was at the hospital—approximately 1-½ hours after the ECO was served.

The Preadmission Evaluation

Code [§ 37.2-809](#) (A) Designee of the local community services board means an examiner designated by the local community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has completed a certification program approved by the Department, (iii) is able to provide an independent examination of the person, (iv) is not related by blood or marriage to the person being evaluated, (v) has no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment interest in

²³ Call and approximate time confirmed by RACS Clinical Director and Emergency Services Supervisor

the facility detaining or admitting the person under this article, and (vii) except for employees of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.”

3:10 p.m.

The CSB evaluator arrived at the BCH. He reported initially meeting with nursing staff, obtaining medical clearance information, and discussing the individual’s status with the attending emergency room physician.²⁴

3:30 p.m.

Based on his statement to the OSIG, the CSB evaluator met with the family member. The family member provided a recent history of the individual’s behavior and thought processes. According to both the CSB evaluator and the family member, the family member indicated a preference to remain in the waiting room during the preadmission evaluation.²⁵

3:45 p.m.

The face-to-face preadmission evaluation between the CSB evaluator and the individual began. The CSB evaluator spoke with the person in custody, explaining to the individual the nature of the visit. Based on this timeline, the actual face-to-face evaluation of the individual reportedly began 3 hours and 19 minutes after the issuance of the ECO at 12:26 p.m.²⁶

3:50 p.m.

The CSB evaluator called two private hospitals to inquire about the availability of beds and was advised that both facilities had reached their staffed capacity and were unable to accept a TDO admission.²⁷

The Extension of the ECO

Code [§ 37.2-808](#) (J) “...upon a finding by a magistrate that good cause exists to grant an extension, the magistrate shall issue an order extending the period of emergency custody one time for an additional period not to exceed two hours. Good cause for an extension includes the need for additional time to allow (i) the community services board to identify a suitable facility in which the person can be temporarily detained pursuant to [§ 37.2-809](#) or (ii) a medical evaluation of the person to be completed if necessary.”

²⁴ Time approximated and provided by CSB evaluator

²⁵ Time approximated and provided by CSB evaluator and confirmed by family member

²⁶ Time approximated by CSB evaluator and family member

²⁷ Times obtained from phone records and confirmed by BCH staff

4:01 p.m.

The CSB evaluator contacted the local magistrate to request a two-hour extension for the ECO.²⁸

4:07 p.m.

A fax was received from the Magistrate authorizing a two-hour extension of the ECO. The (extended) ECO would end at 6:26 p.m.²⁹

Background

The RACS emergency clinicians explained that the time required to complete a preadmission evaluation varies depending on a number of factors including behavioral presentation, level of cooperation, and mental status.

4:21 p.m.

The CSB evaluator faxed a completed *Preadmissions Screening Report* to a private psychiatric hospital.²⁹

4:45 p.m.

The family member and the individual were informed by the CSB evaluator further evaluation was recommended. The individual was offered the opportunity to accept treatment voluntarily, but the individual refused. The evaluator informed the individual and the family member that a TDO would be pursued.³⁰

OSIG Finding No. 5

BCH was the designated facility in Bath County for providing medical clearance for persons under an ECO.

OSIG Finding No. 6

The CSB evaluator met all statutory qualifications to conduct the preadmission screening.

OSIG Finding No. 7

According to the *Preadmission Screening Report*, the CSB evaluator conducted an in-person assessment. The timeline reflects that the face-to-face preadmission screening started at 3:45 p.m. and that within five minutes the CSB evaluator began

²⁸ Time obtained from phone records and per the CSB evaluator

²⁹ Time obtained from facsimile sheet

³⁰ Time provided by CSB evaluator

making phone calls to locate a private provider with an “appropriate and available” bed.

OSIG Finding No. 8

The face-to-face preadmission screening process did not begin until almost 3-¼ hours after the ECO was executed.

OSIG Finding No. 9

The CSB evaluator determined that the individual met the statutory criteria for temporary detention.

The Search for a Receiving Facility

Code [§ 37.2-809](#) (E) “An employee or a designee of the local community services board shall determine the facility of temporary detention for all individuals detained pursuant to this section. The facility of temporary detention shall be one that has been approved pursuant to regulations of the Board. The facility shall be identified on the preadmission screening report and indicated on the temporary detention order.”

4:45 p.m.–6:33 p.m.

The CSB evaluator continued the search for a receiving facility in order to execute a TDO.³¹

Background

The RACS provided the OSIG with a copy of the contact list used by CSB evaluators when searching for a receiving facility. The contact list included 26 private inpatient facilities, five crisis stabilization units, and three state facilities. The state facilities listed were Western State Hospital (WSH), Catawba Hospital (CAT), and Central State Hospital (CSH) for forensic admissions.³²

Clinical staff at the RACS described the multi-step process of finding a receiving facility as follows:

- Call a licensed private facility and speak with the charge nurse or admissions staff member.
- Fax evidence of medical clearance and a copy of the *Preadmission Screening Report* to the facility.
- Consult with the facility’s attending or admitting physician.
- Acceptance, or denial, of the person seeking a TDO admission.

³¹ Time determined by document review and interview with CSB evaluator

³² The form containing contact information used by the RACS evaluators is attached as [Appendix VI](#).

From the initial facility contact to admission or denial by a psychiatric facility, the process often takes an hour or more.

The RACS clinical staff interviewed reported that the DBHDS has an expectation that the CSB evaluator call a substantial number of private facilities before contacting a state facility. According to multiple CSB evaluators interviewed, the number of contacts required reportedly varies by state facility and can vary among the admissions personnel at the state facilities on any given day.³³

The evaluator continued the search for a bed because under state law, a TDO requires that a receiving facility be identified on the TDO.³⁴ According to the records the CSB evaluator provided to the OSIG, the following facilities were contacted:

1. Augusta Hospital, Staunton, VA
2. Roanoke Carillion Medical Center, Roanoke, VA
3. St. Albans Hospital, Radford, VA
4. Lewis Gale Hospital, Roanoke, VA
5. Rockingham Memorial Hospital, Harrisonburg, VA
6. Winchester Medical Center, Winchester, VA
7. Snowden, Leesburg, VA
8. Arbor House Crisis Stabilization, Harrisonburg, VA
9. Prince William Hospital, Manassas, VA
10. The Wellness and Recovery Center, Charlottesville, VA³⁵

The CSB evaluator did not record the names of the individuals contacted at each facility, nor were reasons for denial recorded. This was described as typical practice since the focus was receiving an acceptance, instead of using limited time to document the reasons for denial.

OSIG Finding No. 10

The phone records of the BCH Emergency Department and the RACS cell phone reflected that the CSB evaluator made 20

³³ Emergency Services Supervisors from around the Commonwealth have reported anecdotally that state-operated facilities require CSB evaluators to contact from eight to 20 or more private facilities before requesting a bed in a state facility.

³⁴ *Code § 37.2-809* (E) requires that, “The facility shall be identified on the preadmission screening report and indicated on the temporary detention order.” Thus, pursuant to the *Code*, unless a suitable facility can be located to admit a person for temporary detention before the expiration of the ECO, the TDO remains “unexecuted” and the individual cannot be detained involuntarily beyond the six-hour statutory limit.

³⁵ The Wellness and Recovery Center (WRC) confirmed denying admission for the individual on November 18, 2013. The CSB evaluator reported that the WRC stated they would consider admission the next day; however, the WRC did not corroborate the screener’s claim that they would consider admission the following day.

phone calls between 3:50 p.m. and 6:33 p.m. and was on the phone for a total of 59 minutes and three seconds.³⁶

OSIG Finding No. 11

The phone records established that the CSB evaluator was in contact with seven private psychiatric facilities between 3:50 p.m. and 6:33 p.m. Interviews with private providers confirmed they were the same seven facilities listed on the phone records.

OSIG Finding No. 12

The CSB evaluator made five calls to the Wellness and Recovery Center (a crisis stabilization unit) in the 40 minutes before the expiration of the (extended) ECO—including three calls to the Wellness and Recovery Center in the final 20 minutes preceding the expiration of the ECO.

OSIG Finding No. 13

An examination of BCH's phone records and the phone records of the CSB evaluator's RACS-issued cell phone did not contain evidence of phone contact between the CSB evaluator and the three private providers who denied that they had been contacted to request a TDO admission for the individual.

OSIG Finding No. 14

Of the three private hospitals that stated they were not contacted on November 18, 2013, two of these facilities reported that they had beds available on that day.

OSIG Finding No. 15

There was a call to Rockingham Memorial Hospital (RMH) at 5:57 p.m. that lasted one minute and 52 seconds; however, according to the CSB evaluator, which was confirmed by RMH, the CSB evaluator was not connected with RMH's psychiatric admissions team. After two minutes on-hold, the CSB evaluator hung-up and faxed the *Preadmission Screening Report* to RMH for the second time. It was determined that the fax number for

³⁶ The records reflect that, during the period under review, the CSB evaluator made 17 calls from the BCH Emergency Department extension and three calls from the RACS cell phone.

RMH was incorrectly recorded on the contact information sheet used by the CSB evaluator, and these two faxes were not received by RMH.

RMH reported that their facility had a bed available on the afternoon of November 18, 2013.

The Expiration of the Emergency Custody Order

Code [§ 37.2-808 \(J\)](#) “The person shall remain in custody until a temporary detention order is issued, until the person is released, or until the emergency custody order expires.”

6:26 p.m.

When the two-hour extension for the ECO expired, the Bath County Deputy Sheriff told the individual the ECO had expired.³⁷ The CSB evaluator reported requesting that the individual stay until a bed could be found, but the individual refused.

6:30 p.m.

The CSB evaluator developed a verbal safety plan with the individual and the family member. The family member agreed to escort the individual to the RACS’s Lexington, VA office the next morning for a follow-up appointment.³⁸

6:35 p.m.

The individual and family member left BCH Emergency Department.

6:39 p.m.

The first of two contacts occurred between the CSB evaluator and the emergency services supervisor regarding the disposition of the screening. Total phone consultation time between the CSB evaluator and the emergency services supervisor was 15 minutes.³⁹

OSIG Finding No. 16

The (extended) ECO expired at 6:26 p.m. on November 18, 2013.

OSIG Finding No. 17

At the expiration of the extended ECO, the Bath County Deputy Sheriff advised the individual of the expiration.

³⁷ Time determined through interviews with Bath County Deputy Sheriff and CSB evaluator and document review

³⁸ Time and safety plan confirmed by family member and the Bath County Deputy Sheriff

³⁹ Time determined from RACS-furnished cell phone records

OSIG Finding No. 18

With the expiration of the (extended) ECO, all statutory options for continued involuntary detention were exhausted.

OSIG Finding No. 19

The CSB evaluator developed a verbal safety plan with the individual and family member. The individual and family member left BCH with a follow-up appointment at the RACS's Office in Lexington, VA scheduled for the morning of November 19, 2013.

OSIG Finding No. 20

On November 18, 2013 there were no effective local, regional, or system-wide safety net protocols—or other administrative options—in place and available to the CSB evaluator as the ECO was approaching expiration.

OSIG Finding No. 21

On November 18, 2013 there was not a regional or DBHDS senior-level executive designated and empowered to locate a private or state-operated facility with an appropriate bed to admit this individual.



Contributing Factors

Contributing Factor No. 1

A lack of timely, effective action on the recommendations from the *OIG-BHDS Report No. 206-11, OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment.*

The DBHDS concurred with the 2012 recommendations of Report No. 206-11; however, the DBHDS's instructions to stakeholders were not issued until January 15, 2014. At this time DBHDS issued its *Guidance for Developing Regional Admission Policy and Procedures* requiring written regional policies and procedures to assure that "a safety net bed is always available...assuring that individuals assessed as presenting a risk to themselves or to others find emergency placement in every case... [and] ensure that contact to the state hospital occurs before the emergency custody order (ECO) expires..." ([Appendix IV](#)).

The following recommendations were made by the OIG-BHDS in March 2012, but the below summary reflects that the DBHDS did not take action on key recommendations until after the November 18, 2013 critical incident. These recommendations were administrative in nature and did not require funding.

1. Creating the mechanism for monitoring Unexecuted TDOs and TDOs executed beyond the maximum six-hour ECO time limit as systemic quality indicators (recommendations No. 1a and 1b [2012 Report, pages 31 and 32]).

Status of Recommendation

In December 2013 the DBHDS reported that the data collection instruments had been approved in December 2013 and that data collection would commence on January 1, 2014. A copy of the data collection instrument is attached as [Appendix III](#).

2. Developing “working protocols” to assure that state-operated facilities would be contacted before a person determined to need inpatient care was released, if local placement of a person meeting TDO criteria could not be secured (recommendation 3a [2012 Report, Pgs. 32 and 33]).

Status of Recommendation

An OSIG survey of CSB emergency services directors during the first week in December 2013 revealed that 10% (4 of 39) of the CSBs had a safety net protocol based on guidance provided by the DBHDS. Furthermore, 50% (20 of 39) of responding CSBs had confidence that their board’s protocols would protect persons experiencing psychiatric emergencies and the CSB staff serving them.

The DBHDS issued its *Guidance for Developing Regional Admission Policy and Procedures* on January 15, 2014, “intending to inform and guide the discussion and development of written policies and procedures for each region” and stating its expectation that each region would develop and implement policies and procedures no later than March 15, 2014.

The *Guidance* document contains a policy statement that includes, “ensuring that a safety net bed is always available” and “ensure[ing] that contact to the state hospital occurs before the emergency custody order (ECO) expires....” A copy of the DBHDS’s *Guidance for Developing Regional Admission Policy and Procedures* is attached as [Appendix IV](#).

3. Designating a senior executive at the DBHDS and in each of the Commonwealth’s seven partnership planning regions (PPR) empowered to intervene and create an alternative to a failed TDO for an individual requiring hospitalization (recommendations 3c and 3d [2012 Report pg. 34]).

Status of Recommendation

During the first week of December 2013, the OSIG conducted a survey of CSB emergency services directors. With 39 of 40 CSBs responding, 80% (31 of 39) reported that their region did not have a designated senior executive to facilitate locating a public or private hospital admission for individuals determined to meet criteria for a TDO admission. The same number of CSB emergency services directors (31 of 39) reported that they were not aware of a senior executive at the DBHDS authorized to intervene to create an alternative to a failed TDO.

On the day of the critical incident, Region 1 lacked a designated senior executive empowered to facilitate a TDO admission. The CSB evaluator, the emergency services supervisor, and the RACS senior staff agreed that the DBHDS had not advised the RACS of a contact person at the DBHDS who could be engaged to change the outcome before the expiration of the ECO. Additionally, the DBHDS had not issued working protocols with instructions or guidance about how to access state-operated facilities before releasing a person meeting TDO criteria.

The RACS staff advised that on November 20, 2013, they were provided with the cell phone numbers for the DBHDS's Assistant Commissioner for Behavioral Health, the Director of Mental Health Services, and the Director of Community Support Services Crisis Specialist with instructions to call the DBHDS before releasing a person meeting TDO criteria.

The DBHDS's January 15, 2014 *Guidance for Developing Regional Admission Policy and Procedures* instructed CSBs, regional access committees, et al. to develop procedures for "rapid referral up the chain of command to CSB executive directors and state hospital directors...on a 24/7 basis."

Contributing Factor No. 2

Rural travel times and a lack of coordination

The record reflects that the ECO was issued at 11:23 a.m., the individual was taken into custody at 12:26 p.m., and the person arrived at BCH at approximately 12:55 p.m. However, the RACS was not notified that an ECO had been issued or executed until 1:40 p.m., when a family member called the RACS from the hospital to inquire about the CSB evaluator's status.

The record also reflects that the CSB evaluator departed Lexington, VA at 2:00 p.m., and after driving approximately 70 minutes from Lexington, VA to Hot Springs, VA, arrived at BCH at approximately 3:10 p.m.

Lack of ECO notification protocols among the Rockbridge Area Community Services (RACS), Bath Community Hospital (BCH), and Bath County Sheriff's Office, combined with the travel times required for a rural area in Virginia truncated the preadmission screening process from six hours to three hours and 15 minutes.

Contributing Factor No. 3

The preadmission evaluation

The preadmission evaluation required by statute is difficult to discuss in this report because it necessarily contains private health information (PHI) subject to the privacy protections afforded by HIPAA and other regulations.

It is also challenging to evaluate the conduct of the CSB evaluator because there are no standards of practice governing the professional conduct of the Commonwealth's hundreds of CSB evaluators. The DBHDS certifies evaluators, establishes professional training and credentialing requirements, and establishes conflict of interest limitations, but the DBHDS does not publish any standards of practice that could be used to evaluate the actions of a CSB evaluator.

The RACS lacked a specific protocol to guide or inform its CSB evaluator's actions as the ECO approached expiration on November 18, 2013.

With these limitations in place, the OSIG offers the following observations about the preadmission evaluation on November 18, 2013.

- The summary timeline attached as [Appendix I](#) reflects that the CSB evaluator spent little uninterrupted time with the subject of the ECO. Instead of a deliberative clinical fact-finding process to assess a person's dangerousness to self or others, including self-care, and recommend the least restrictive treatment intervention. Most of the CSB evaluator's efforts were directed toward locating a private psychiatric facility and administrative activities like faxing and requesting an ECO time limit extension.
- The timeline reflects that the face-to-face preadmission screening started at 3:45 p.m. and that within five minutes the screener began making phone calls to locate a provider with an available bed willing to admit the individual.⁴⁰
- It is the judgment of the OSIG that the limited uninterrupted face-to-face time to conduct a clinical risk assessment was an insufficient amount of time for a thorough *Preadmission Screening Report*.

⁴⁰ Refer to [Appendix I](#) to understand how little uninterrupted time was available for a face-to-face assessment and contrast that with the process described in [Appendix V](#) *Toward a Better Understanding of Psychiatric Emergencies, Assessment for Dangerousness and Effective Interventions to Assure Safety and Enable Recovery*

- The RACS worksheet provided to the OSIG indicated that the CSB evaluator contacted eight hospitals and two crisis stabilization units (CSU) trying to locate a bed for the individual. The CSB evaluator confirmed these 10 contacts in multiple interviews with the OSIG; however, the phone records for BCH and the CSB evaluator’s RACS-furnished cell phone reflected calls to two CSUs and five of the eight hospitals. The three hospitals that were not reflected in BCH and RACS phone records are the same three hospitals that denied contact by the CSB evaluator.
- The CSB evaluator reported faxing copies of the individual’s *Preadmission Screening Report* to the contacts; however, the OSIG did not find fax “Transmission Log” confirmation sheets for the three hospitals that denied contact by the CSB evaluator. The CSB evaluator suggested that perhaps the nurses shredded some of the “Transmission Log” sheets; however, according to the VSP, the nursing staff denied that they shredded any fax “Transmission Log” sheets.
- The *Preadmission Screening Report* did not include clinically significant information that was reportedly provided by a family member during a telephone call at 5:19 p.m. on November 18, 2013. This phone conversation was not disclosed by the CSB evaluator, but was discovered by the OSIG when it called the numbers on the phone records of the BCH extension and the evaluator’s RACS-furnished cell phone.
- The CSB evaluator made inconsistent claims to the OSIG regarding the sequence of events during the preadmission screening process.
 1. During the first interview with the CSB evaluator, the CSB evaluator reported meeting with the individual being evaluated before speaking with the family member who accompanied the individual to the hospital. In a subsequent interview, the CSB evaluator twice reported speaking with the family member before the individual (which was confirmed by the family member).
 2. The CSB evaluator initially maintained that no faxes were sent to facilities that indicated that they did not have any beds available. However, in a second interview the CSB evaluator stated there were two or three additional faxes forwarded to facilities with no reported beds, but they were destroyed by BCH staff.
 3. Initially, the CSB evaluator denied additional collateral contacts outside of the family member of the individual evaluated, the attending Emergency Department physician, and the Bath County Deputy Sheriff who executed the TDO. However, the OSIG learned that the CSB evaluator also spoke to another family member of the individual, who reported discussing with the CSB evaluator the risks associated with not hospitalizing the individual being evaluated. This collateral contact was not indicated on the preadmission form.

- The RACS had no policy requiring a written safety plan and the CSB evaluator developed a verbal safety plan for the individual.

Contributing Factor No. 4

The Commonwealth's emergency response system

The statutory time limit for ECOs

The Commonwealth's maximum six-hour time limit for ECOs is the shortest in the nation.⁸ The factors and issues described herein and the statutory maximum six-hour ECO time limit combined to produce a critical incident on November 18, 2013, and a person was released without the clinically indicated hospitalization and treatment because a psychiatric bed could not be located before the expiration of the ECO.

Clinical determination linked to the bed search

Another factor contributing to the critical incident on November 18, 2013 was that the Commonwealth's emergency response system for individuals experiencing psychiatric emergencies linked the execution of a TDO with identifying a facility with an "available and appropriate" bed on the TDO form.⁴¹

A TDO's primary purpose is clearly indicated by *Code* statutes as assuring safety of persons with mental illness, the safety of others, and that, once a person meets the statutory criteria for detention, the person is expected to receive the clinically indicated hospitalization or treatment.

Locating a psychiatric facility willing to admit a person is a necessary activity, but it does not function as part of the clinical assessment that an individual meets criteria for a TDO. Yet, two recent reports have confirmed that people meeting TDO criteria have been denied the clinically indicated level of care because a bed could not be located, or could not be located within the maximum six-hour time limit.⁴²

⁴¹ Unpacking the term "available and appropriate bed" reveals the complexity of locating a bed for a person proposed for involuntary temporary detention. *The Emergency Medical Treatment and Labor Act* (1986) (*EMTALA*) requires that hospitals provide screening and treatment for emergency medical conditions; however, *EMTALA* does not apply to psychiatric emergencies and private psychiatric facilities have the discretion to admit or reject individuals. The decision to admit a person under a TDO can be multifaceted. For example, a facility might have an available bed that is not appropriate for every person. A double-occupancy room occupied by a female might not be appropriate for a male admission. Likewise, some individuals seeking TDO admissions may have behaviors that would place other patients or facility staff at risk, and not all private facilities are equipped to serve geriatric patients, and/or individuals presenting with complex medical conditions. Finally, some individuals presenting with acute symptoms might require one-to-one staffing that is not available on short notice. The OIG-BHDS 2012 Report (Footnote 3) recognized that "medical clearance" and "challenging populations" were two of the three primary reasons for the delays in securing a TDO bed in a timely manner (pg. 24).

⁴² Report No. 206-11, OIG Review of Emergency Services (Footnote 3) and UVA's A Study of Face-to-Face Emergency Evaluations Conducted by Community Services Boards (Footnote 12).

Barriers to Access

Western State Hospital (WSH) is the state-operated behavioral health facility serving Health Planning Region 1 (HPR 1). Outside of Contributing Factor No. 3, other historical and contemporaneous factors related to WSH also contributed to the November 18, 2013 critical incident.

The CSB evaluator and the Emergency Services Supervisor reported that WSH would not consider admission of an individual until at least 10 private facilities had been contacted. According to the RACS staff, CSB evaluators may be required to contact 14 or more facilities before an individual's information would be accepted by WSH. The CSB evaluator reported that WSH was not contacted that day because he had not contacted the required number of private facilities before the ECO expired.

In addition to WSH's reported practice of not considering admissions until the CSB had contacted at least 10 private facilities, the RACS received an email on November 14, 2013 from the admissions manager at WSH requesting that between November 18, 2013 and November 20, 2013, "all avenues be explored in an effort to divert admissions away from WSH" because WSH units were moving into a new facility.

The WSH memo acknowledges this was a long gap for emergency services personnel, but the facility advised that it would be available for "true emergencies." Clinical staff stated, according to their personal experience, that an individual who denied suicidal or homicidal ideation, and who had a safety plan and a scheduled follow-up appointment, would not rise to the level of a "true emergency" according to WSH's admission criteria on November 18, 2013.

To corroborate their reported experience with WSH, the RACS staff presented two cases to the OSIG describing two individuals for whom TDOs were sought on November 20, 2013—two days after the November 18, 2013 critical incident. In one case, admission was delayed for a period of greater than 24 hours under a TDO because of WSH's relocation.

In the other case, the person was not accepted at WSH on November 20, 2013, even though the RACS staff had documented 14 denials by private providers. The WSH admissions personnel reportedly stated that the person did not meet criteria for admission to the state facility. It took six more calls and two additional hours before a bed was secured for the individual who had overdosed on psychiatric medications and had been clinically

determined to need inpatient care. The receiving facility was approximately four hours away.⁴³

Finally, it was widely reported by the media that the University of Virginia Medical Center (UVA) had beds available on November 18, 2013; however, the OSIG was advised by an attending physician in UVA's Department of Psychiatry that "the statement that UVA Medical Center had open beds on the evening of November 18th is misleading. Yes, we had beds on our unit, but no, we would not have accepted any patient from an outside emergency room for admission."⁴⁴

⁴³ The OSIG investigators reviewed the records of these two cases involving requested admission to WSH to confirm the reports of delayed and denied admission to this state facility.

⁴⁴ Letter from UVA attending physician to Executive Director of the RACS dated January 25, 2014.



Recommendations

Issue No. 1: The DBHDS had not implemented the recommendations of *Report No. 206-11, OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment* dated February 28, 2012.

Recommendation No. 1a

Implementations currently in progress by DBHDS will be monitored by the OSIG. The 2012 report's findings and recommendations are attached hereto as [Appendix II](#).

Recommendation No. 1b

The OSIG suggests that the DBHDS revise its Guidance for Developing Regional Admission Policy and Procedures document to include advocacy organizations in its list of stakeholders and recommends that the DBHDS consider revising the document to include input from advocacy groups such as NAMI, VOCAL, SAARA, the disability Law Center, MHAV, and others in the creation of policies and procedures for accessing care in the Commonwealth during psychiatric emergencies.

Issue No. 2: Web-Based Psychiatric Bed Registry. The OIG-BHDS noted in its 2012 Report No. 206-11 that:

...Emergency Services Directors reported that crisis clinicians are expected to contact all available private psychiatric hospital in their region, and often beyond, before contacting the state-operated facilities. This process often requires considerable time. Interviews with the ES Directors revealed that the establishment of a "real time" registry of available beds may substantially decrease the time needed to secure a bed; however, some were

skeptical that the bed registry would mitigate the problems securing admission for the most challenging individuals. The Department continues to move forward with implementation of a statewide online psychiatric bed registry. This initiative *theoretically* promises to create a real time summary of the bed availability at private psychiatric hospitals around the state; however, the jury is still out as to whether the bed registry will actually reduce the average time required to locate an “appropriate bed” for the most challenging individuals.⁴⁵

The detailed timeline of events in Bath County on November 18, 2013, (See [Appendix I](#)) suggests that if a web-based psychiatric bed registry had been available, the CSB evaluator may have been able to use his time more effectively and connect with one of the facilities that later reported having available beds that afternoon.

Recommendation No. 2

The Commonwealth explore the creation of an electronic psychiatric bed registry for the express purpose of providing CSB evaluators and others with real-time information listing available beds for use by persons meeting the criteria for temporary detention. Such a registry should include state-operated facilities, private psychiatric facilities, and crisis stabilization units willing to admit individuals under a TDO. The registry should include current contact information and contemporaneous admissions limitations based on medical complications, behavioral issues, the gender, age, or disability of a person or other factors that would bar admission of individuals meeting criteria for a TDO admission.

Issue No. 3: Coordination among CSBs, law enforcement, assessment facilities. The travel times required in a rural area in Virginia and the absence of an established notification procedure that an ECO had been executed took up approximately two hours and 45 minutes of the ECO’s time, and truncated the preadmission screening process from six hours to three hours and 15 minutes.

⁴⁵ OIG-BHDS Report No. 206-11, page 25.

Recommendation No. 3

Guidelines or standards of practice should be established that ensure that CSB evaluators are notified immediately when an ECO is executed.

Issue No. 4: CSB Evaluator training, standards, and competency reviews. This review revealed that there were no specific local or statewide standards of practice governing the professional conduct of CSB evaluators, and that while there is an online module that must be completed by each CSB evaluator before they are certified by the DBHDS, there is no follow-up testing or recertification for the Commonwealth’s hundreds of CSB evaluators. Additionally, there are no statewide protocols to guide the actions of preadmissions screeners or their supervisors when a person is about to be released who has been determined to meet the criteria for involuntary temporary detention.

Recommendation No. 4

The OSIG recommends that the DBHDS take the lead to create a workgroup to review and recommend standards of practice, training, and ongoing recertification requirements for the Commonwealth’s CSB evaluators. At a minimum, the workgroup should consider:

- Periodic competency testing for re-certification.
- Options for peer review and consultation process.
- Performance indicators that would be of value in providing ongoing supervision.
- Creation of clearly defined protocols and guidance for CSB evaluators to follow when for whatever reason a person determined to meet TDO criteria is about to be released from custody.

Issue No. 5: Uncoupling the bed search and the clinical evaluation. [Appendix I](#) reflects that the CSB evaluator spent little uninterrupted time with the individual of the ECO. CSB evaluators anecdotally reported that the term “bed brokers” describes too much of their current job. In large part, the focus on the search for a bed is driven by the requirement of *Code § 37.2-809* (E) that requires that the receiving facility be listed on the *Preadmission Screening Report* and the *Temporary Detention Order*.

Recommendation No. 5

Consideration be given to revising *Code § 37.2-809 (E)* to allow the *Preadmission Screening Report* to be completed and the resulting *Temporary Detention Order* to be executed without identifying the receiving facility. For example, the statute could be revised to indicate involuntary detention “in a location to be determined,” with provision that the venue determination would be made within 24 hours, or some period, following the execution of the TDO and the *Temporary Detention Order* amended accordingly.

Appendix I—Complete Timeline of Events

COMPLETE TIMELINE OF EVENTS: NOVEMBER 18, 2013	
Time	Brief Statement of Activity
9:10 A.M.	Family member called the RACS Clinical Director for information and assistance.
10:20 A.M.	Family member traveled to Bath County Sheriff's Office to request ECO.
11:03 A.M.	Petition forwarded to the Magistrate in Alleghany County for original ECO.
11:23 A.M.	ECO issued by Alleghany County Magistrate through telecommunications.
12:26 P.M.	ECO executed by Bath County Deputy Sheriff. ECO time begins.
12:55 P.M.	Medical Clearance began with nursing assessment at BCH.
1:40 P.M.	Family called RACS to inquire about CSB evaluator's whereabouts.
1:46 P.M.	Physician began medical clearance process.
2:00 P.M.	CSB evaluator dispatched after handing over a different case to coworker.
2:30 P.M.	Unidentified individual from BCH called and asked when CSB evaluator would arrive.
3:10 P.M.	CSB evaluator arrived at BCH; reported drive time about 70 minutes.
3:30 P.M.	CSB evaluator interviewed the family member present at the hospital.
3:45 P.M.	Face-to-Face Preadmission Evaluation began.
3:50 P.M.	CSB evaluator called to assess bed status at Lewis Gale Hospital.
3:51 P.M.	CSB evaluator called to assess bed status at two Carilion Hospitals.
3:59 P.M.	CSB evaluator called Rockbridge CSB.
4:01 P.M.	CSB evaluator calls the Magistrate to obtain a two-hour extension of the ECO.
4:07 P.M.	Fax from Magistrate authorizing the two-hour extension arrived at BCH.
4:08 P.M.	CSB evaluator called Rockbridge CSB.
4:12 P.M.	Lewis Gale Hospital reported being staffed capacity. No bed available.
4:21 P.M.	Completed <i>Preadmission Screening Report</i> was faxed to Carilion.
4:45 P.M.	Family and person told of TDO; search for an available bed commenced.
4:54 P.M.	Carilion facilities are at staffed capacity. No beds available.
5:12 P.M.	Call from Carilion to RACS cell phone (11 minutes)
5:19 P.M.	CSB evaluator spoke with another family member by telephone.
5:29 P.M.	CSB evaluator called Augusta Medical Center to assess bed status.
5:33 P.M.	Incoming call from Carilion.
5:34 P.M.	Fax sent to Augusta Medical Center.
5:43 P.M.	CSB evaluator called Arbor House to access bed status. No TDO beds available.

5:45 P.M.	CSB evaluator called Wellness & Recovery (W&R) to assess bed status.
5:45 P.M.	Fax sent to Wellness and Recovery
5:55 P.M.	Fax to Rockingham Memorial Hospital (RMH). Fax was sent to a wrong number.
5:55 P.M.	CSB evaluator informed that the person seemed too acute for W&R CSU.
5:57 P.M.	CSB evaluator spoke with the receptionist at RMH, but did not connect with psychiatric admission team.
5:58 P.M.	CSB evaluator sent 2nd Fax to RMH; again, faxed to a wrong number.
6:05 P.M.	CSB evaluator continued discussion with W&R regarding admission possibility.
6:06 P.M.	CSB evaluator continued discussion with W&R regarding admission possibility.
6:08 P.M.	No beds available. Facility staffed at capacity, per AMC.
6:15 P.M.	Unidentified incoming call; 2 minutes
6:24 P.M.	Discussion continued with W&R regarding admission possibility. Admission Denied.
6:26 P.M.	ECO expired; Deputy informed individual that detention time was up.
6:30 P.M.	Verbal Safety Plan developed with family and person.
6:33 P.M.	Incoming call from AMC
6:35 P.M.	Family and Person leave the BCH Emergency Department.
6:39 P.M.	The first of two telephone calls initiated between the CSB evaluator and his supervisor regarding the disposition of the preadmission screening. Total consultation time with supervisor was 15 minutes.

Appendix II—Excerpt from Report No. 206-11

FINDINGS AND RECOMMENDATIONS WITH DBHDS RESPONSE (*Report No. 206-11, OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment dated February 28, 2012*)

Finding Number 1: CSB/BHA emergency services staff are the behavioral health system’s *first responders* and these professionals routinely overcome formidable obstacles to cobble-together creative solutions to assure the safety of Virginians who are incapable of caring for themselves. Thanks in large measure to their dedication and skill, the majority of emergency services for Virginians in crisis are delivered as contemplated by the *Code*.

Nevertheless, during this study, 72 individuals determined to meet the statutory criteria for temporary detention were denied access to inpatient psychiatric treatment. To contextualize the 72 failed TDOs, one needs to appreciate that this number is approximately 1½% of the estimated 5,000 TDOs that were successfully executed statewide during the three-months of the study. In summary, this study confirmed that access to inpatient treatment is generally, but not always, available to people experiencing psychiatric crises.

When a person, determined by specially-trained clinicians to be incapable of caring for themselves and at risk for harming themselves or others, is unable to secure the recommended treatment and hospitalization, this outcome represents a systemic failure to address the needs of that individual and places the person and his/her community at risk. Moreover, a failed TDO may rise to the level of a *sentinel event* as defined by the Joint Commission.⁴⁶

Finding Number 1a: The study confirmed last year’s anecdotal reports of *streeting* and documented that 72 persons, meeting statutory criteria for temporary detention were denied admission to public and private behavioral health facilities.⁴⁷

Recommendation Number 1a: That DBHDS identify “UNEXECUTED TDO” as a Quality Indicator of access to clinically appropriate services and develop a mechanism that allows for consistent tracking of such incidents at the Board and regional level.

DBHDS Response: *DBHDS supports this recommendation.*

⁴⁶“A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” The Joint Commission, January, 2011: (<http://www.jointcommission.org>)

⁴⁷ Wherever possible in this Report, the OIG has substituted “failed TDO” for “streeted” because of reasonable objections to the negative connotations attached to the terms “streeted” or “streeting.” The term “streeted” was used in Hampton Roads to categorize individuals that met criteria for temporary detention who received a less intensive intervention than inpatient treatment – or no intervention and were released. In this study, the majority of these 72 cases received a less intensive intervention than inpatient treatment.

Finding Number 1b: The study documented that TDOs for at least 273 individuals were executed beyond the six-hour time limit imposed by statute: This is approximately 5½% of the estimated 5,000 TDOs executed during the three-month study. The experience for these citizens was that it required a statewide average of 16.6 hours for the order to be executed and for them to be admitted for the clinically indicated services.

Recommendation Number 1b: That DBHDS identify “TDO EXECUTED BEYOND 6 HOURS” as a Quality Indicator for the timely execution of TDOs, and develop a mechanism that allows for consistent tracking of such incidents at the Board and regional level.

DBHDS Response: *DBHDS supports this recommendation.*

Finding Number 2: Ineffective medical screening and clearance processes for persons restrained for evaluation under ECOs and TDOs have been, and remain, a chronic challenge in the Commonwealth. In 2007, the DBHDS published thoughtful *Guidance Materials* addressing many of the issues identified by ED Medical Directors and CSB ES Directors throughout the state in recent discussions with the Inspector General; however, to date, the recommendations of the *Guidance Materials* have not been consistently adopted statewide.

There is broad consensus that adoption of best practices and the common understanding articulated in the *Guidance Materials* will improve outcomes for persons served, bring down costs system wide, and reduce the number of failed TDOs.

Recommendation Number 2a: That the DBHDS assemble an *ad hoc* group of stakeholders to review and update the *Medical Screening and Assessment Guidance Material (March 13, 2007)* as necessary, and reissue these constructive guidelines by October 30, 2012.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 2b: That the DBHDS include a provision in its next *Performance Contract* with all CSBs requiring specific local or regional monitoring of problems associated with medical screening and clearance for persons meeting criteria for an ECO or a TDO, and report results to the DBHDS at regular intervals.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 2c: That the DBHDS coordinate an effort among all state-operated facilities to immediately adopt and implement the recommendations and approach of the *Guidance Materials* and develop best practices to drive quality improvement in this vital area.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 2d: That the DBHDS monitor the implementation of the *Guidance Materials* by CSBs and state-operated facilities and publish its report by April 15, 2013, detailing the progress of this initiative.

DBHDS Response: *DBHDS supports this recommendation.*

Finding Number 3: This study revealed that state-operated behavioral health facilities were not consistently contacted, or utilized, as an available resource for individuals assessed as appropriate for inpatient level of care under a temporary detention order. Facilities were not contacted in approximately half of the 72 cases in which a TDO was warranted, but not executed.⁴⁸ Failure, or inability, to utilize the state-operated facilities as a safety net may contribute to extended and unnecessary stays in local emergency rooms and placement of individuals in less appropriate levels of care; potentially placing both the individual and the community at risk.

Recommendation Number 3a: It is recommended that DBHDS and the CSBs develop working protocols for assuring that state-operated facilities, or the regional access (utilization) committees, are contacted in each case in which local placement of persons determined to need inpatient care is not secured. The responsibilities of each entity in facilitating a TDO admission to the DBHDS facility should be detailed in the protocols. The protocols should be consistent with the intent of State Board Policy 1038 (SYS) 06-1: *The Safety Net of Public Services*.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 3b: It is recommended that DBHDS establish a quality improvement initiative for monitoring TDO admissions to the state-operated behavioral health facilities with periodic reporting to the Commissioner and the OIG.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 3c: It is recommended that, from among each region's CSBs, a senior-level person be designated and empowered to locate a private or state-operated facility with an appropriate bed to admit individuals meeting statutory criteria for temporary detention.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 3d: It is recommended that the DBHDS develop a viable system that responds any time that an individual meeting statutory criteria for temporary detention is denied admission to a state-operated facility. The intent of this recommendation is to empower a senior member of the DBHDS to

⁴⁸ The survey instrument did not record why state facilities were not contacted – noting only the lack of contact. It may be that some screeners knew from previous conversations that the state facility was at capacity and was not accepting TDO admissions.

contemporaneously consult, or to intervene where necessary and appropriate, with regional utilization managers to create an alternative to a failed TDO for persons requiring hospitalization or treatment.

DBHDS Response: *DBHDS supports this recommendation.*

Finding Number 4: PPR III and PPR V had a disproportionate number of failed TDOs compared to other regions of the state – accounting for 75% of the total failed TDOs during the study period.

Recommendation Number 4: That this study be repeated in FY 2013 in PPR III and PPR V to determine what progress has been made to eliminate failed TDOs from these two regions.

DBHDS Response: *DBHDS supports this recommendation and will collaborate with the Office of the Inspector General on study implementation.*

Finding Number 5: That private psychiatric hospitals regularly lack an *appropriate bed* to serve some of the most challenging individuals. The regional state facilities in PPR III (SWVMHI) and PPR V (ESH) are regularly at full operating capacity and unable to admit persons meeting criteria for temporary detention. The lack of private or public beds to receive TDOs contributes to the number of failed TDOs in these two regions of the state.

Recommendation Number 5: That immediate consideration be given by the Regional Access Committees in PPR III and PPR V to developing performance contracts with one or more private facilities in PPR V and PPR III to create a category of “intensive beds” in a milieu and environmental setting that can serve some of the most challenging individuals admitted under a TDO – without jeopardizing the safety of other patients, staff, or the person.

DBHDS Response: *DBHDS supports increased access to inpatient or other clinically appropriate treatment settings in the community for persons needing this level of care and will work with CSBs and regions to help identify needs, develop options, and identify needed resources.*

Finding Number 6: In Southwest Virginia and Hampton Roads, the state-operated facilities are, at times, unable to provide safety net admissions for individuals that are incapable of caring for themselves because Eastern State Hospital (ESH) and Southwest Virginia Mental Health Institute (SWVMHI) are regularly at, or beyond, their operating capacities.

In the judgment of the OIG, if the Commonwealth is to eliminate failed TDOs, and the attendant risk to the person, their family, and the community, and to provide a reliable safety net for its citizens, it must create additional community capacity to serve discharge-ready individuals currently residing at ESH and SWVMHI.

Recommendation Number 6: That the DBHDS evaluate the relevant issues at SWVMHI, ESH, and each region's unique problems and identify the additional programs and resources necessary to create the community capacity needed to allow these state-operated facilities the census flexibility to become reliable safety nets for individuals determined to need temporary detention and treatment.

DBHDS Response: *DBHDS supports this recommendation.*

Finding Number 7: Anecdotal reports suggest that, in some locales, this study has raised the consciousness of some CSBs that consumers were not receiving the services deemed necessary to assure their safety and the safety of others. To their credit, these CSBs report sharpening their focus on failed TDOs, and they have commenced closely monitoring the treatment and outcomes for these individuals.

No recommendation associated with this Finding

Appendix III—TDO Report and Instructions

TDO Report & Instructions (December 20, 2013)

Reportable event reason (chose all that apply):

- 1 Unable to locate any available inpatient or CSU bed (i.e., no capacity)
- 2 Unable to identify willing accepting facility within the allotted six hours
- 3 Unable to access bed at state hospital within the allotted six hours
- 4 Medical admission prevented behavioral health admission
- 5 TDO to other than psychiatric inpatient unit or CSU
- 6 Specialized program for persons with ID/DD unavailable
- 7 Specialized program for persons 65 years of age and older unavailable
- 8 Specialized program for persons younger than 18 unavailable
- 9 Other (explain)

Reportable Event (choose all that apply)

- 1 TDO sought but not obtained due to lack of willing facility
- 2 TDO was obtained and executed; but process took longer than 6 hours

TDO Exception Report ES and Regional Manager Instructions

Each CSB and region is to utilize the TDO Exception Report data to understand the extent and nature of the reported events in each CSB and in the region. Data should be reviewed regularly and acted by CSBs and the region upon as part of an ongoing quality or performance improvement process designed to reduce and eliminate these events over time.

- 1) Each CSB (ES Manager) will complete a report on a quarterly basis (or more frequently if desired) and submit the report to the regional manager, even if there are no reportable events during the report period.
- 2) Summary reports from each CSB to the regional manager will be submitted by the 15th of the month following the end of the quarter, (i.e., April 1, July 15, and October 15, 2014, and January 15, 2015).
- 3) At the beginning of each quarter, each CSB should start a new report spreadsheet, making sure the CSB is identified in the header along with the correct quarter.

- 4) CSB ES clinicians should be encouraged to document reportable events as they occur to ensure the most accurate reporting. At the end of the quarter, the ES Manager or designee will submit the CSB report information to the regional manager after reviewing the data and incorporating the data into local quality reports.
- 5) Regional Managers will collect reports from each CSB in their region at least quarterly by the prescribed submission dates.
- 6) Upon receipt of the quarterly report data, each regional manager will prepare a summary report showing reported events by CSB, and submit the report to Mary Begor at DBHDS (mary.begor@dbhds.virginia.gov) by the last day of the month following the preceding quarter beginning April 30, 2014 followed by July 31 and October 31, 2014, and January 31, 2015, etc. The report should include each instance where a reportable event occurred as well as the reasons provided by CSBs for these occurrences.
- 7) Each regional manager shall work with CSBs to develop and implement a written quality or performance improvement plan incorporating these data and other information, with the goal of reducing or eliminating these events over time.
- 8) Each regional manager will submit the regions quality or performance improvement plan to DBHDS (Mary Begor), by May 15, 2014.
- 9) DBHDS will collect and use the data submitted to provide technical assistance, oversight and trend analysis at a state wide level. Larry Barnett (barnettl@chesterfield.gov), ES Council and committee member is available to answer any technical questions regarding this report methodology and implementation. Mary Begor (mary.begor@dbhds.virginia.gov) is available to provide information regarding the background, development and reasons for this report as well as any general information requested.

December 20, 2013

Appendix IV—DBHDS Guidance for Developing Regional Admission Policy and Procedures



Guidance for Developing Regional Admission Policy and Procedures January 15, 2014

The Department of Behavioral Health and Developmental Services (DBHDS) is providing guidance to all Partnership Planning Regions to develop written policies and procedures for accessing the appropriate level of care during emergency situations in an effort to strengthen the Commonwealth's safety net for individuals with serious mental illness including those with co-occurring intellectual disabilities and/or substance use disorders. These guidelines are intended to inform and guide the discussion and development of written policies and procedures for each region.

There are key principles that must be reflected in each region's policies and procedure which will strengthen the relationships between community services boards (CSB), state hospitals, and community partners, including the private sector, members of law enforcement and public safety stakeholders. This is an opportunity to share best practices among regions and to provide clarity for individuals attempting to navigate the behavioral health system. While it is not advantageous to mandate the same policy statewide, these key principles will support consistent admission policies across regions.

Each region must refine, clarify, and/or develop written procedures for CSBs to follow when seeking a hospital bed in an emergency situation. The procedures must clearly outline the sequence for the bed search and clarify the point at which the state hospital is notified of the need for a safety net bed.

The regions are expected to meet these expectations and implement revised policies and procedures for their regions no later than March 15, 2014 after review and consultation with CSBs, crisis stabilization units, private hospitals, law enforcement and judicial officials. DBHDS will monitor the development of regional policies and procedures to assure conformity with expressed priorities and reasonable commonality of access across regions.

Collaboratively Developed Written Policies and Procedures

To ensure that the safety net is present and available, it is crucial that the policy and procedures are outlined in formal written documents, approved and updated at the regional level, and distributed to all CSBs, emergency service workers, private hospital partners, law enforcement and judicial officers on a regular basis. First and foremost, regional admission policies must emphasize safety, a person-centered approach, and respect for the individual in crisis as well as their families.

As vital members of the Commonwealth's service delivery system, private hospitals must be included in the development of regional policies and procedures, with written memorandums of understanding outlining expectations for use of Local Inpatient Purchase of Services (LIPOS) with private partners when applicable.

Procedures for each region will provide clear and specific expectations for contacting area private hospitals (specific primary and secondary hospitals, defined search areas, regional rather than statewide) and a clear point at which contact will be made with the state hospital. Procedures should ensure that contact to the state hospital occurs before the emergency custody order (ECO) expires, rather than calling a specific number of hospitals. These should reflect the minimum steps required to seek inpatient or crisis care prior to using a state hospital bed and the procedures may vary by region, CSB, age or other characteristic, level of intellectual disability, and other clinical variables. Policies and procedures should reflect the philosophy and commitment to community-based services while assuring that individuals assessed as presenting a risk to themselves or to others find emergency placement in every case.

Communication and Data Sharing

The Virginia Acute Psychiatric and CSB Bed Registry Initiative is a joint project of DBHDS, Virginia Hospital and Healthcare Association, and Virginia Health Information, Inc. The bed registry will be operational in early March. While this will be a valuable tool for emergency services workers to access information, it has limitations. It will not eliminate the need for strong interagency relationships, person-to-person phone contact, timely exchange of clinical information, and efficient medical screening before a hospital can determine if it is the appropriate facility.

It is important to recognize the benefits of Regional Access Committee (RAC) processes to review and approve transfers from private facilities to state facilities. All regions should consider developing or affirming the RAC process or developing other procedures to produce similar outcomes. Regional Access Committees should include active participation of each CSB and the state hospital. Regional admission policies should include procedures to assure that all emergency services staff have current information regarding bed availability, how and who to contact at relevant private facilities, time frames for contacting and receiving responses from private providers. Documentation of these details is necessary to provide clear direction to clinicians responsible for assessing individuals in crisis.

Given the complexities of serving thousands of individuals in crisis with hundreds of clinical staff providing assessments and support, it is predictable that atypical situations will arise that require higher level of decision making and/or support. At both CSBs and state hospitals, a provision must be made for a rapid referral up the chain of command to CSB executive directors and state hospital directors if differences or bed availability issues occur that cannot be solved by the hospital admissions and CSB emergency services staff on duty. Procedures should include mechanisms to get information regarding "tight spots" up the supervisory chain at the CSB, and private and state hospital in an expeditious fashion. This must include how information will cross from CSB to hospitals (and vice versa), specifics regarding when to contact the state hospital, and how to do so on a 24/7 basis.

In collaboration with all regional partners, state hospitals will establish written policies for access to a safety net bed on a 24/7 basis, after demonstration that the regional admission procedures have been followed. If the state hospital is unable to accept the referral in a timely

fashion due to not having appropriate bed space, the hospital director will contact another state hospital to arrange admission and will inform the CSB. The transfer policies and default facilities will be established and documented in advance. In instances of disagreements or other barriers to admission, the state hospital director may contact the designated authority in DBHDS (Assistant Commissioner for Behavioral Health Services or designee) for a resolution or alternate placement.

Quality Improvement

The regional leadership structure should establish policies and procedures to regularly review issues and problems that arise during the disposition of the civil commitment process. Policies and procedures, after-action reports, modifications and issues of compliance should be reviewed and communicated on a monthly basis within the appropriate regional structure, to all CSBs, emergency services leadership, private and state hospital staff, regional partners and stakeholders. Regions must assure that CSB leadership, emergency services, community partners, private and state hospital staff that handle the admission process meet on a regular basis to review utilization data, identify problems, and propose or develop solutions to assure effective collaboration.

DBHDS will monitor regional and state hospital management of this process. DBHDS will utilize and monitor the Acute Psychiatric Bed Registry, utilization data, and the tracking system for disposition of temporary detention order (TDO) requests to identify state, regional and local bed access issues, including situations where contact is made with the DBHDS Assistant Commissioner for Behavioral Health Services or designee due to an inability to identify an available and appropriate bed, in order to identify opportunities to strengthen the regional admission policy and procedures.

Medical Screening

The purposes of the medical screening is to 1) attempt to make sure that the individual is not experiencing a serious medical event that is masquerading as a psychiatric disorder or being concealed by a psychiatric disorder and 2) that the receiving facility can provide the medical care the individual needs.

DBHDS guidance material on the medical screening and assessment process will be forthcoming. Until this information is available, each region must develop and implement a process, understood by regional partners (and emergency service workers), to effectuate medical screening of individuals in need of psychiatric hospital admission. Medical screening and medical assessment should be performed with a holistic view of the individual being examined rather than just specific psychiatric or medical conditions alone. The goal is to complete an adequate overall evaluation to determine the most appropriate location to safely and effectively treat the individual. The performance of specific diagnostic and laboratory testing should be based on the person and the availability and reliability of other sources of information.

Medical conditions related to strokes, delirium, heart conditions, diabetes, and others medical conditions can produce behavioral or psychiatric-like symptoms that may mask the actual threat to the individual's health, if not life. Fundamentally, the service system response must ensure that the individual receives the appropriate medical diagnosis and treatment needed to address their clinical condition and determine that the receiving facility can meet the individual's medical needs. Most state hospitals, for example, can give oral medications, take vital signs,

monitor finger sticks for glucose, and do pulse oximetry. They may not be able to perform intravenous treatment, monitor EKG activity, telemetry or respiratory therapy, etc. At the same time, medical catastrophes are rare, and it is not reasonable or necessary for a busy Emergency Department to “rule out disease” with an expansive or even standardized series of tests for every individual presenting in a psychiatric crisis. Achieving the right balance for each individual requires clinical judgment, understanding the other “side”, and ongoing collaboration to try to assure that individuals receive the treatment they need and are not exposed to unnecessary risks.

Active Bed Management at the State Facilities

While the current focus of this guidance document is development of admission policies and procedures, ensuring that a safety net bed is always available requires active bed management, which includes attention to admission appropriateness, active inpatient treatment, and prompt discharge as soon as the individual is clinically ready. The same attention must be paid to individuals with forensic status as those who are civilly committed. It is expected that each region will maintain, improve, or implement active, collaborative processes for each aspect of state hospital bed management in order to assure that safety net beds are available when needed.

Appendix V—Toward a Better Understanding of Psychiatric Emergencies, Assessment for Dangerousness and Effective Interventions to Assure Safety and Enable Recovery

Toward a Better Understanding of Psychiatric Emergencies, Assessment for Dangerousness and Effective Interventions to Assure Safety and Enable Recovery

To assist the Virginia Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) in preparing to investigate the April 16, 2007 critical incident at VA Tech, Kent G. McDaniel, MD, PhD, consulting psychiatrist to the OIG and a member of the investigation team, developed this paper to help the team establish a common framework for examining the assessment and intervention aspects of the commitment process.

Psychiatric Emergencies

Psychiatric emergencies always occur within the context of an individual's life and psychological development. They are typically preceded by an emotionally significant event or a series of events that create overwhelming challenges to an individual's beliefs and coping mechanisms. The individual's normal pattern of coping, no matter how functional or dysfunctional, deteriorates during this period, which typically lasts from a few days to months. When the individual fails to make the changes necessary to restore equilibrium, and his or her ability to cope deteriorates to the point that the individual can no longer function within his or her environment, the situation becomes a psychiatric emergency.

Assessing for Dangerousness

One of the most important aspects of crisis intervention in a psychiatric emergency is assessing for safety. If the individual's functional capacity has deteriorated to the point that the individual has become a danger to self or others, then establishing safety becomes a vital aspect of the intervention. The Virginia Code has established that if there is evidence that an individual is an imminent danger to self or others due to mental illness, or is substantially unable to care for self due to mental illness, then legal action can be taken to ensure safety until a thorough assessment of dangerousness can be completed.

Assessing an individual's dangerousness, especially in the setting of an evolving psychological crisis, is often a very difficult task. A reasonably good risk assessment requires accurate knowledge about many aspects of an individual's life. When an individual is denying dangerousness and is not overtly dangerous on a mental status exam but has recently deteriorated to the point of meeting the requirements for court ordered detention to ensure safety, it is imperative that the evaluator not rely solely on the statements of the individual in

crisis, but obtain collateral information to corroborate, clarify, or refute the information the individual provides.

Additionally, the assessment itself, especially if it involves briefly removing an individual from his or her environment at the point of the immediate crisis, is often palliative enough to mitigate the psychological deterioration and reduce the dangerousness of an individual during the process of assessment. This effect, though beneficial to the individual and the community, compounds the complexity of assessing the risk of dangerousness because the deterioration that resulted in the psychiatric emergency occurred while the individual was attempting to cope with the demands of his or her normal environment. Risk assessment, therefore, requires the evaluator to estimate the dangerousness of an individual not only in the setting of the assessment, but also in the various environments to which the individual will be returning, and in the context of the psychological crisis which precipitated the psychiatric emergency. **Therefore, an accurate assessment of dangerousness in an individual temporally detained under a magistrate's order can only be accomplished by specially trained professionals who have done a thorough psychiatric evaluation and assessment using sufficient collateral information to ensure an accurate understanding of the individual, the individual's environment, his recent behaviors, and the context of the psychological crisis that precipitated the psychiatric emergency which warranted a temporary detention order.**

Effective Interventions

Events that occur at the time of a psychiatric emergency can, and typically do, have life long effects upon the individual. The psychological crisis underlying the psychiatric emergency dictates that the individual must respond to his or her impulses and environments in new ways. The individual can no longer maintain his or her level of functioning in the same environment relying on the same coping mechanisms. The individual either develops more adaptive beliefs and coping strategies and grows into higher levels of functioning, or the individual retreats into less adaptive beliefs and coping strategies and regresses to lower levels of functioning. Effective interventions at the time of a psychiatric emergency not only ensure safety, reduce suffering, and mitigate the deterioration of adaptive functioning occurring at the time of the immediate crisis, but effective interventions also encourage the individual to resolve the crisis positively toward a more adaptive lifestyle. Intervention strategies can be considered ineffective when they do not ensure safety, reduce suffering, mitigate the deterioration at the time of the immediate crisis, or fail to promote healthier life choices. **In short, interventions at the time of a psychiatric emergency are not only a means to ensure safety, but are often the pivotal means to engage or re-engage the individual into a process of recovery that promotes the future welfare of the individual and his or her role within the community.**

APPENDIX VI—November 18, 2013 List of Hospital and Crisis Stabilization Unit Contacts

Hospital	Address	Phone	Fax	Other
Augusta Healthcare (L)	78 Medical Center Dr. Fishersville, VA 22939	(540) 332-4000	(540) 332-4068	
Carilion Roanoke Memorial Hosp. (L)	2017 South Jefferson Street Roanoke, VA 24014	1-800-284-8898	(540) 342-3247	
Carilion St. Albans	2900 Lamb Circle Christiansburg, VA 24073	1-800-284-8898	(540) 731-7386	
Lewis Gale Medical Center (L)	1902 Braeburn Drive Salem, VA 24153	1-800-541-9992	(540) 772-2871	
UVA Medical Center (L)	1215 Lee Street Charlottesville, VA 22908	(434) 924-5569	(434) 924-1991	
VA Baptist Hospital * (L)	3300 Rivermont Ave. Lynchburg, VA 24503	(434) 200-4444	(888) 308-0489	
Rockingham Memorial Hospital (L)	2010 Health Campus Drive Harrisonburg, VA 22801	(540) 689-5460/1000	(540) 564-5483	
Poplar Springs* (No adult Medicaid)	350 Poplar Drive Petersburg, VA 23805	(804) 733-6874	(804) 862-6322	
Bon Secours (L)- Medicaid, Geriatric, Aggressive	5801 Bremono Road Richmond, VA 23226	(804) 287-7836	(804) 381-8557	
Southside Regional (Must be admitted via ER)		(804) 765-5000	(804) 765-5566	
Winchester Medical Center (L) (No meds over obj)	1840 Amherst Street Winchester, VA 22601	(540) 536-8152	(540) 536-8139	
Snowden * (L) (No meds over obj)	1200 Sam Perry Blvd Fredericksburg, VA 22401	1-800-362-5005	Day: (540) 741-3926 Night: (540) 741-4765	
mCV (CSB AH pager:804-905- 2300)		(804) 828-2000	Call first	
Prince William* (L) (No meds over obj)	Ctr for Psychiatric & SA 8680 Hospital Way Manassas, VA 20110	(703) 369-8000	(703) 369-8332	
Richmond Comm Hospital	1500 N. 28 th St. Richmond, VA 23223	(804) 225-1730	(804) 285-9602	
VA Tx Center for Children*	515 N. 10 th St. Richmond, VA 23298	(804) 828-8822	Call first	
Tucker Pavilion*(L)	7101 Jahnke Rd. Richmond, VA 23225	(804) 323-8846	(804) 323-8253	
John Randolph Hospital	411 W. Randolph Road Hopewell, VA 23860	(804) 541-7747	(804) 541-7522	
Commonwealth Ctr for Children & Adol.*#	1355 Richmond Ave. Staunton, VA 24401	(540) 332-2100/2107	(540) 332-2100	
Spotsylvania RMC (L)	4600 Spotsylvania Ave. Fredericksburg, VA 22408	(540) 498-4563	(540) 498-4566	
Rappahannock General Hosp.	101 Harris Road Kilmarock, VA 22482	(804) 435-8490	(804) 435-8235	
Southern VA Reg Medical Ctr (over 45) (L)	727 N. Main Street Emporia, VA 23847	(434) 348-4580	(434) 348-4938	
Dominion Hospital *#	2960 Sleepy Hollow Rd	(703) 536-2000	(703) 237-3537	

	Falls Church, VA 22044			
Hospital	Address	Phone	Fax	Other
Western State Hospital	1301 Richmond Ave. Staunton, VA 24401	(540) 332-8022	(540) 332-8000	
Clearview Psychiatric Hospital	58 Carol Street Lebanon, VA 24266	(877) 650-6757	(276) 889-4854	
Maryview Behavioral Health	3636 High Street Portsmouth, VA 23707	(757) 398-2400	(757) 399-8991	
Sentara Behavioral Hospital	2800 Godwin Blvd. Suffolk, VA 23434	(757) 934-4786	(757) 934-4357	
VA Beach Psychiatric Center	1100 First Colonial Rd VA Beach, VA 23454	(757) 496-3500	(757) 496-4403	
Catawba Hospital	5525 Catawba Hospital Drive Catawba, VA 24070	(540) 375-4200	Call first	
Alleghany Regional Transitional Unit	1 ARH Lane Low Moor, VA 24457	(540) 862-6713/6722	(540) 862-6715	
L- LIPOS contracted hospitals (Indigent clients with no insurance)	(*) indicates will accept minors	# Do not TDO to these facilities		

CRISIS STABILIZATION

Facility	Address	Phone	Fax	Other
Courtland (Horizon Behavioral Health)	620 Court Street Lynchburg, VA 24504	(434) 455-2098	(434) 455-2049	
Arbor House	1241 North Main St Harrisonburg, VA 22802	(540) 438-7170	(540) 434-1601	
Wellness and Recovery	502 Old Lynchburg Rd Charlottesville, VA 22903	(434) 972-1876	(434) 296-6157	
Mohr Center	1014 East Market St Charlottesville, VA 22903	(434) 979-8871	(434) 979-5119	
Rappahannock Area CSB	615 Wolfe Street Fredericksburg, VA 22401	(540) 374-3386	(540) 374-3387	

SA

Life Center of Galax	112 Painter Street Galax, VA 24333	1-800-345-6998	(276) 236-2267	
Pathways (Centra)		1-800-947-5442 or (434) 200-4455		
Rubicon		(804) 767-6568	(804) 329-5294	
Boxwood	15511 Guinn Lane Culpepper, VA 22701	(540) 547-2760	(540) 547-2764	
Clean Life Medical		(804) 427-5078	(804) 427-5079	
Blackberry Ridge		(434) 946-7070		
Pavillon at Williamsburg Place	5483 Mooretown Rd Williamsburg, VA 23188	(757) 941-6400	(757) 941-6418	