

Guide and Rationale for the Revised Form

General goals:

The primary goal of the revised form is to better support clinicians through the interview and assessment process. Of course, the form still must gather certain identifying and historical information, and must still fulfill the statutory requirements, but beyond these necessities, the purpose of the form should be to help the clinician gather the relevant clinical information and reach the best recommendation. Towards this end, the form now better follows the flow of a clinical interview, and provides space to address more empirically-supported risk factors for violence and self-harm.

Specifically, the revised form helps the clinician document information in a manner that:

- Is consistent with best practices for involuntary admission evaluations.
 - Information on the form is drawn from the research on best practices in suicide and violence risk assessment, but also recognizes the time-sensitive nature of preadmission screening assessments.
- Balances safety and liberty interests.
 - The form aids the clinician in making a recommendation that balances the safety of the person and community, on the one hand, and the person's treatment preferences, on the other.
- Helps protect the clinician from liability.
 - Contemporary standards of care emphasize transparency in risk formulation and clinical decision making.

A. PREADMISSION FACE SHEET

The first section of the form requires the basic personal and case-specific information necessary for identifying the person, documenting the preadmission screening, and tracking the course of events.

A. PREADMISSION FACE SHEET	
1. PERSONAL INFORMATION	
Name: _____ DOB: _____ Age: _____ <small>First Middle Last</small>	
Address: _____ <small>Street City State Zip code County</small>	
SSN: _____ - _____ - _____ Gender: _____ Race: _____ Hispanic origin? _____ <small>(Optional)</small>	
Primary language: _____ Height _____ Weight _____ Hair Color _____ Eye Color _____	
Phone: (____) _____ Marital status: <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Military Status: _____ VA contacted: <input type="checkbox"/> No <input type="checkbox"/> Yes (_____) _____ <small>Name Phone</small>	
2. PREADMISSION SCREENING ENCOUNTER INFORMATION	
Date: _____ Evaluation start time: _____ Evaluation end time: _____ Location: _____	
Referral Source: _____ Evaluating CSB/BHA: _____ Consumer ID# _____	
CSB of Residence: _____ CSB Code #: _____ Contacted?: <input type="checkbox"/> No <input type="checkbox"/> Yes (_____) _____ <small>Name Phone</small>	
REACH program contacted: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes (_____) _____ <small>Name Phone</small>	
Petitioner Name/Contact Information: _____	
ECO: <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Magistrate issued <input type="checkbox"/> Law enforcement initiated; Date/Time ECO Executed: _____	
Disposition: <input type="checkbox"/> Release <input type="checkbox"/> Referral <input type="checkbox"/> Safety Plan <input type="checkbox"/> CSU <input type="checkbox"/> Voluntary <input type="checkbox"/> Recommitment <input type="checkbox"/> TDO	
<input type="checkbox"/> Other _____ Psych Bed Registry Query # _____ Facility: _____	
Case/TDO # _____ If change of facility, name of new facility: _____	

This page also requires the types of contact information necessary to elicit collateral information, describe the person’s medical history, understand the person’s legal context, inform the person’s loved ones, and communicate with other relevant health systems.¹

3. CONTACT INFORMATION & COLLATERAL SOURCES (including health care agent(s))					
Name: _____		Relationship: _____		Phone: (____) _____	
Address: _____		Street	City	State	Zip code County
Name: _____		Relationship: _____		Phone: (____) _____	
Address: _____		Street	City	State	Zip code County
Source(s) of Medical History, Medication, & Collateral Information	<input type="checkbox"/> Person				
	<input type="checkbox"/> Family member (name and relationship): _____				
	<input type="checkbox"/> Others (e.g., medical staff, law enforcement): _____				
	<input type="checkbox"/> Medication containers				
	<input type="checkbox"/> Medical records (specify): _____				
<input type="checkbox"/> Collateral sources were unavailable >> Explain: _____					

Importantly, the revised form requires more details about whether the person has an advance directive in order to encourage use of advance directives earlier because an increasing number of people are including mental health details in their advance directives.

4. HEALTHCARE INFORMATION AND MEDICAL HISTORY	
Advance Directive: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, obtained? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If not obtained, location: _____	
If obtained, AD includes: <input type="checkbox"/> Medical <input type="checkbox"/> Mental health <input type="checkbox"/> End-of-life	
Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown	
First plan # _____	If applicable, second plan #: _____
Income: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Unknown	

B. RISK ASSESSMENT DETIALS

Section B is designed to walk through the information—current and historical—that should form an assessment.

Reason for Referral

In this section, clinicians should provide a summary of the presenting situation, with an emphasis on the information most relevant to risk. The brief summary should quickly orient the reader (and the clinician) to the primary question or concern, thereby guiding their focus through the remainder of the assessment process.

Current and Historical Risk Indicators: Suicide, Violence, Inability to Care for Self

This brief screen encourages clinicians to document the recent events with obvious relevance to risk. It is informed by best-practices regarding circumstances about which to inquire for each area

¹ Please note that screenshots of the form do not include every section of the form or a full picture of sections shown; rather, screenshots are included to demonstrate layout and, in some cases, to highlight new sections.

of risk. Clinicians should assess all areas of risk in *all* cases (even if the presenting situation seems to suggest other types of risk).

2. CURRENT AND HISTORICAL RISK INDICATORS		
>> Suicidal Ideation/Behavior: Screen for Current and Historical <<		
Current & Historical Thoughts and Means	Comments (details for each item that is applicable, including timeframe)	None known/ reported
Suicidal Thoughts		<input type="checkbox"/>
Suicide Plan		<input type="checkbox"/>
Suicidal Intent		<input type="checkbox"/>

Each area of inquiry allows space for comments, which should be used to document relevant details. For example, best-practice in assessing violence risk includes asking about recent evidence of violence or threats but also plans or fantasies of violence. These are simple ways of screening for violent intent or escalating violence, so clinicians should ask them in every case (even if the presenting situation seems more relevant to other types of risk). In addition, the form reminds clinicians to document the timeframe of recent behavior for suicide and physical harm (e.g., within past X hours, past week, past month)—an important element for assessing the immediacy of risk. Other relevant circumstances include access to means, co-occurrence of substance use during previous incidents, expressions of extreme anger at someone, etc.

>> Physical Harm Ideation/Behavior: Screen for Current and Historical <<		
Current & Historical Behavior	Comments (details for each item that is applicable, including ability to carry out thoughts/plans and timeframe)	None known/ reported
Threats; thoughts or plans to harm		<input type="checkbox"/>
Expressions of aggression or anger		<input type="checkbox"/>
Fight or attempted fight		<input type="checkbox"/>

Note that information about past behavior is asked for in these sections. Although current information is often most relevant to a preadmission assessment, clinicians can best assess risk by considering an individual's history and past behaviors related to violence or self-harm, particularly if any past violence, self-harm, or crises appear similar to the person's current situation.

In cases where further assessment is needed, clinicians may use additional measures or turn to resources that expand on suggested assessment steps. (E.g., Borum, R., & Reddy, M. (2001). Assessing violence risk in *Tarasoff* situations: A fact-based model of inquiry. *Behavioral Sciences and the Law*, 18, 375-385.)

Each section provides additional space for details that a clinician feels are important to include or for an explanation of why an assessment was not undertaken.

behavior	Additional information, if applicable. <i>(In cases where the risk assessment cannot be completed, you may document the reason(s) here.)</i>
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Regarding screening for inability to care for self, note that those who are genuinely incapable of caring for themselves may be poor informants, and collateral sources will be necessary.

>> Inability to Care for Self: Screen for Current and Historical <<
Evidence of decreased ability to provide for basic needs and/or protection as a result of mental illness: <input type="checkbox"/> None known/reported <input type="checkbox"/> Unable to seek basic nourishment <input type="checkbox"/> Unable to seek shelter (not just lack of access) <input type="checkbox"/> Clothing unsuitable for weather <input type="checkbox"/> Recklessness (spending, safety) <input type="checkbox"/> Serious neglect of hygiene/ADL's <input type="checkbox"/> Serious neglect of medical care <input type="checkbox"/> Other:
Comments:
<i>*For minors, ability to care for self is defined in terms of what would be expected for a minor of a similar age and inability is evidenced by delusional thinking or a significant impairment of functioning hydration, nutrition, self-protection, or self-control.</i>

Other Historical Risk Data (including Evidence of Impulsivity/Self-Control)

Beyond past violence and self-harm per se, past impulsivity and substance use also have implications for current risk. Screen for past evidence of impulsivity and recklessness, then thoroughly assess the person's substance use history, *with particular attention to current substance use that may escalate risk of violence, self-harm, or inability to care for self.* The data in the "Other Risk..." section involves well-established risk factors for violence and self-harm.

3. OTHER HISTORICAL RISK FACTORS		
Evidence of Impulsivity/Self-Control		
Behavior	Comments (details for each item that is applicable)	None known/ reported
Non-suicidal self-injury		<input type="checkbox"/>
Reckless behavior		<input type="checkbox"/>
Difficulty following through with safety plans		<input type="checkbox"/>

Other Risk and Historical Factors	
<input type="checkbox"/> None known/reported	<input type="checkbox"/> Family or peer suicide <input type="checkbox"/> Childhood abuse/neglect
<input type="checkbox"/> Other trauma: _____	
<input type="checkbox"/> Recent discharge from inpatient psychiatric (within last 60 days)	<input type="checkbox"/> Owns or has access to firearm
<input type="checkbox"/> Other: _____	

Psychiatric Treatment and Current Symptoms and Mental Status

Remember that the focus of this assessment is to consider risk of harm to self, harm to others, or inability to care for self. Thus, traditional mental status exams may cover topics that are less relevant to risk assessment and leave out topics that are more relevant. Use this section of the form to explore the person's most significant stressors or problems, as well as the symptoms that are most relevant to risk (the symptom list at the top of the section was generated based on empirically-supported risk factors for violence and suicide risk). In addition, assessment of the person's capacity to make treatment decisions is located here.

5. CURRENT SYMPTOMS AND MENTAL STATUS						
Diagnosis (ICD-10; (P) for provisional, (H) for historical)						
Symptoms (Check all that apply)						
<input type="checkbox"/> High anxiety, stress, emotional pain		<input type="checkbox"/> Hopelessness		<input type="checkbox"/> Anger		<input type="checkbox"/> Feeling burdensome to others
<input type="checkbox"/> Negative appraisal of illness or recovery		<input type="checkbox"/> Social withdrawal		<input type="checkbox"/> Increased depressive symptoms		
Capacity (For adults and minors age 14 and older)						
<input type="checkbox"/> The individual appears to have capacity to consent to voluntary psychiatric admission because able to:						
<input type="checkbox"/> Maintain and communicate choice,						
<input type="checkbox"/> Understand relevant information, and						
<input type="checkbox"/> Understand consequences						
<input type="checkbox"/> The individual appears to <u>lack</u> capacity						
Mental Status (Check all that apply)						
Appearance	<input type="checkbox"/> WNL	<input type="checkbox"/> unkempt	<input type="checkbox"/> poor hygiene	<input type="checkbox"/> tense	<input type="checkbox"/> rigid	<input type="checkbox"/> other:
Motor	<input type="checkbox"/> WNL	<input type="checkbox"/> psychomotor retardation	<input type="checkbox"/> psychomotor agitation	<input type="checkbox"/> tremor	<input type="checkbox"/> restless	<input type="checkbox"/> other:

Assigning a diagnosis is *not* the primary goal of a preadmission screening, nor does a diagnosis alone answer the important questions about risk. But an accurate-as-possible diagnosis does help subsequent providers know where to begin their treatment efforts. Make an effort to assign an accurate diagnosis. If necessary, indicate whether that diagnosis is merely provisional or historical (i.e., assigned by other clinicians in the past).

Clinicians should also document details about the mental status factors present, providing further explanation for any areas of impairment or apparent problems. Because of the particular relationship between psychosis and risk, the section also includes items about the presence of psychosis and whether the person has had a prior episode of psychosis.

The section on "Engagement, Reliability, and Response to Interviewers" is important to help gauge the credibility of the person's responses, and the degree to which a person may collaborate with interventions. Please note any significant concerns about engagement, reliability, or response to clinicians.

Engagement, Reliability, Response to InterviewersPerson's report appears reliable and consistent. ☐ Yes ☐ NoEngaged and cooperative with assessment and treatment planning. ☐ Yes ☐ No

Comments (optional):

Feasibility of Less Restrictive Alternatives

Less restrictive alternatives than involuntary inpatient hospitalization must be considered during emergency evaluations. The form provides space to document that less restrictive alternatives were considered and found insufficient, and why. In the case of assessments that determine that something less than involuntary inpatient hospitalization is appropriate, this section serves as documentation of the plan for intervention.

6. FEASIBILITY OF LESS RESTRICTIVE ALTERNATIVES

	Yes	No	N/A
Suicide			
Available resources are sufficient to address immediate suicide risk and person-specific triggers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Harm			
Available resources are sufficient to address immediate risk of physical harm and person-specific triggers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to care for self and basic needs			
Available resources are sufficient to improve person's ability to care for self and basic needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Plans for addressing risk in the community -or- Rationale why less restrictive alternatives not feasible☐ If checked, see attached safety plan):**C. PREADMISSION SCREENING SUMMARY**

This is the most important section of the document because it synthesizes prior information into inferences about risk and intervention needs. In short, the prior section (B) was designed to inform this section (C), which yields conclusions and recommendations. Emergency evaluators are encouraged to utilize best-practice risk formulation guidelines to ensure thorough and well-documented summaries. (E.g., Pisani, A.R., Murrie, D.C. & Silverman, M.M. (2015). Reformulating suicide risk formulation: From prediction to prevention. *Academic Psychiatry*.)

C. PREADMISSION SCREENING SUMMARY**1. PRESENTING SITUATION****Summary of presenting crisis** (including person and collateral perspectives):**The person's most significant stressors:****Coping strategies already attempted by the person:**

The subsections in the summary section are informed by such best-practices. For example, identifying strengths and resources that can inform interventions is essential in any assessment of risk. Conversely, a paucity of strengths and reasons for living may enhance concerns about risk. Areas to assess include: the most important people in the person’s life; plans and goals the person has; an example of a challenge the person overcame and how; (if risk of suicide) what frightens or worries the person about suicide; (if risk of violence) instances when a person almost became violent but did not and what kept the person from becoming violent.

Strengths or moderating factors related to documented risk issues and/or concerns:

Risk Summary

More important than a diagnosis or basic description of recent events is the assessment of risk. It is rarely helpful to describe a person as “high risk” or “low risk” in the abstract; indeed, best-practices guidelines increasingly recommend against doing this. So, risk estimates should be made *relative to a particular context or comparison group* (in this case, other persons seen for pre-admission screening). Provide an opinion on the person’s risk of harm to self and others, along with a narrative summary that would help the reader understand the basis for your opinion.

In addition, summarize any person-specific risk factors or triggers that could elevate risk because risk is dynamic (it changes with circumstances). This type of information is essential to planning interventions and gauging the need for hospital admission.

Likewise, careful risk assessment and intervention planning require identifying a person’s available resources. Most people have sufficient resources that they do not require hospital-level care. But if they do not—or if resources are not sufficient for the likely anticipated changes—then treatment in the community may no longer be sufficient.

Assessment and disposition recommendation summary (including person-specific triggers that could quickly increase risk for suicidal or physical harm or quickly decrease ability to care for self and basic needs, and any available resources or protective factors):

D. CSB RECOMMENDATIONS

The recommendations generated by the assessment are summarized here for ease of access, as well as in Section F, where they are reported for the court.

D. CSB RECOMMENDATIONS

ADULT - As a result of the emergency evaluation:

The CSB finds that the person ☐ meets / ☐ does not meet the civil commitment criteria, and the CSB recommends:

- ☐ No further action at this time
- ☐ Voluntary community treatment (if known at time of disposition, facility/provider: _____)
- ☐ Voluntary admission to a crisis stabilization program at _____
- ☐ Voluntary inpatient treatment
- ☐ Temporary detention order

Importantly the recommendations include notation of statutorily available options regarding 1) inpatient commitment based on the consent of a health care agent or guardian and 2) alternative transportation.

<input type="checkbox"/> Temporary detention order <input type="checkbox"/> Recommitment The CSB further recommends: <input type="checkbox"/> Consideration of 10-day inpatient admission by health care agent or guardian consent Agent or guardian name: _____ <input type="checkbox"/> Alternative transportation by _____
MINOR: As a result of the emergency evaluation, the CSB recommends:

E. NOTIFICATIONS

As of July 1, 2016, clinicians are required to make a reasonable attempt to notify the person's family member or personal representative (including the agent in the healthcare advance directive) of information directly relevant to such individual's involvement with the person's health care (which may include location and general condition).

When an ES evaluator recommends that the person should not be subject to a TDO, the evaluator must inform the petitioner, the onsite treating physician, and the person who initiated emergency custody, if that person is present. The form includes a space to mark that such notification was made in those instances.

E. NOTIFICATIONS
1. Attempt to obtain person's agreement or objection to legally required notifications (per Va. Code § 32.1-127.1:03(D34))
_____ will be contacted with information directly relevant to their involvement with the person's health care, including location and general condition. <input type="checkbox"/> Person agrees <input type="checkbox"/> Person objects <input type="checkbox"/> Person lacks capacity <input type="checkbox"/> Emergency makes impractical to agree/object
2. Required notification to family member or personal representative, including agent in healthcare advance directive (per Va. Code §§ 16.1-337 or 37.2-804.2)
<input type="checkbox"/> Contact was made with _____ via _____ <input type="checkbox"/> Reasonable attempt was made to contact _____ via _____ Comments: _____ <input type="checkbox"/> No notification made because <input type="checkbox"/> Notice already provided, or <input type="checkbox"/> Contact is prohibited by court order, or <input type="checkbox"/> Consent is not available and contact is not in person's best interest, or <input type="checkbox"/> Person has capacity and objects
3. Required notification when TDO is <u>not</u> recommended for an adult (per Va. Code §37.2-809)
<input type="checkbox"/> The evaluator informed <input type="checkbox"/> the petitioner (_____), <input type="checkbox"/> the onsite treating physician (_____), and <input type="checkbox"/> the person who initiated emergency custody (_____); or check here <input type="checkbox"/> if the person was not present). <input type="checkbox"/> Person who initiated emergency custody was informed that CSB would facilitate communication with the magistrate upon request <input type="checkbox"/> Person who initiated emergency custody requested to speak with magistrate regarding recommendation, so evaluator made arrangements

F. CSB REPORT TO COURT AND RECOMMENDATIONS FOR THE INDIVIDUAL'S PLACEMENT, CARE, AND TREATMENT

Once the risk assessment has been completed, the final section of the form covers the recommendations to the court. The section includes options, in statutory terms, as to whether the person appears to meet commitment criteria, as well as indication of whether the person has capacity to consent. The various recommendation options are then presented for selection.

Importantly, when involuntary admission is being pursued, the section includes a prompt for recommendation of alternative transportation. In the case of adults, the Part F does not include a prompt regarding 10-day inpatient admission based upon health care agent or guardian consent; thus, if this recommendation is warranted, evaluators will need to independently note so on the form.

F. CSB Report to Court and Recommendations for the Individual's Placement, Care, and Treatment

Name: _____ Date: _____ Time: _____ ☐ am ☐ pm

☐ No further treatment required.

☐ Has / ☐ Does not have sufficient capacity to accept treatment (N/A for minors under age 14 except for outpatient treatment).

☐ Is / ☐ Is not willing to be treated voluntarily (N/A under Virginia Code § 19.2-169.6).

☐ Voluntary community treatment at the ☐ CSB (_____) or ☐ other (_____).

☐ Voluntary admission to a crisis stabilization program (_____).

☐ **Adult:** Voluntary inpatient treatment because individual requires hospitalization and has indicated that he/she will agree to a voluntary period of up to 72 hours and will give the facility 48 hours' notice to leave in lieu of involuntary admission.

☐ **Minor:** Voluntary inpatient treatment of minor younger than 14 or non-objecting minor 14 years of age or older.

☐ **Minor:** Parental admission of an objecting minor 14 years of age or older pursuant to 16.1-339.

~~Minor 16.1-340.4~~ ☐ Under age 14 ☐ Age 14 or older