History and Context

For a review of the history and purpose of these reports, the reader is referred to the "New TDO Exception Reporting Data Overview" document dated January 2015, which is available on the Department of Behavioral Health and Developmental Services (DBHDS) website at the following link: www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data. Previous monthly reports can also be located on this page.

This document is the eleventh monthly report of data[1] collected from Community Services Boards (CSBs) and regions[2] for fiscal year 2015 (FY 2015). The following sections contain the summaries and graphs of the monthly data reported to DBHDS through May 2015. For the current report month, May 2015, there were an average of 1,619 emergency contacts received by CSBs, 244 emergency evaluations completed and 72 TDOs issued and executed each day across the Commonwealth. Compared to the April counts, these figures show a slight decrease in emergency contacts and evaluations, but a slight increase in TDOs issued and executed. In this report, the total counts of events are presented for each month and for the fiscal year to date for ease of comparison and trend analysis.[3]

Additionally, certain high risk events are reported separately by CSBs, on a case-by-case basis as they occur. These involve individuals who are evaluated and need temporary detention, but do not receive that intervention. There were four such events in the May 2015 reporting period. Each of these events triggers submission of an incident report to the DBHDS Quality Oversight Team [4] within 24 hours of the event. The team has expanded and now includes Stacy Gill, the DBHDS Behavioral Health Community Services Director. The reports describe the incident as well as initial actions to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality Oversight Team reviews the incident report and the actions of the CSB for comprehensiveness and sufficiency, and responds accordingly if additional follow up is needed. CSBs continue to update DBHDS until the situation has resolved and follow up is completed.

Of the four events reported in May, two involved individuals who were in emergency custody when evaluated, while the two others involved individuals who were evaluated voluntarily (i.e., they were not under an ECO). Of the four events, two involved individuals who eloped from the evaluation site before the TDO was executed. Two of the four cases concluded with the individual's hospitalization, and in two cases the CSB was not able to establish any ongoing treatment relationship with the individual after exhausting all options to do so. Additional detail on each of these cases can be found in Appendix D, page 22.

[1] See Appendix A for complete detailed listing of these definitions.

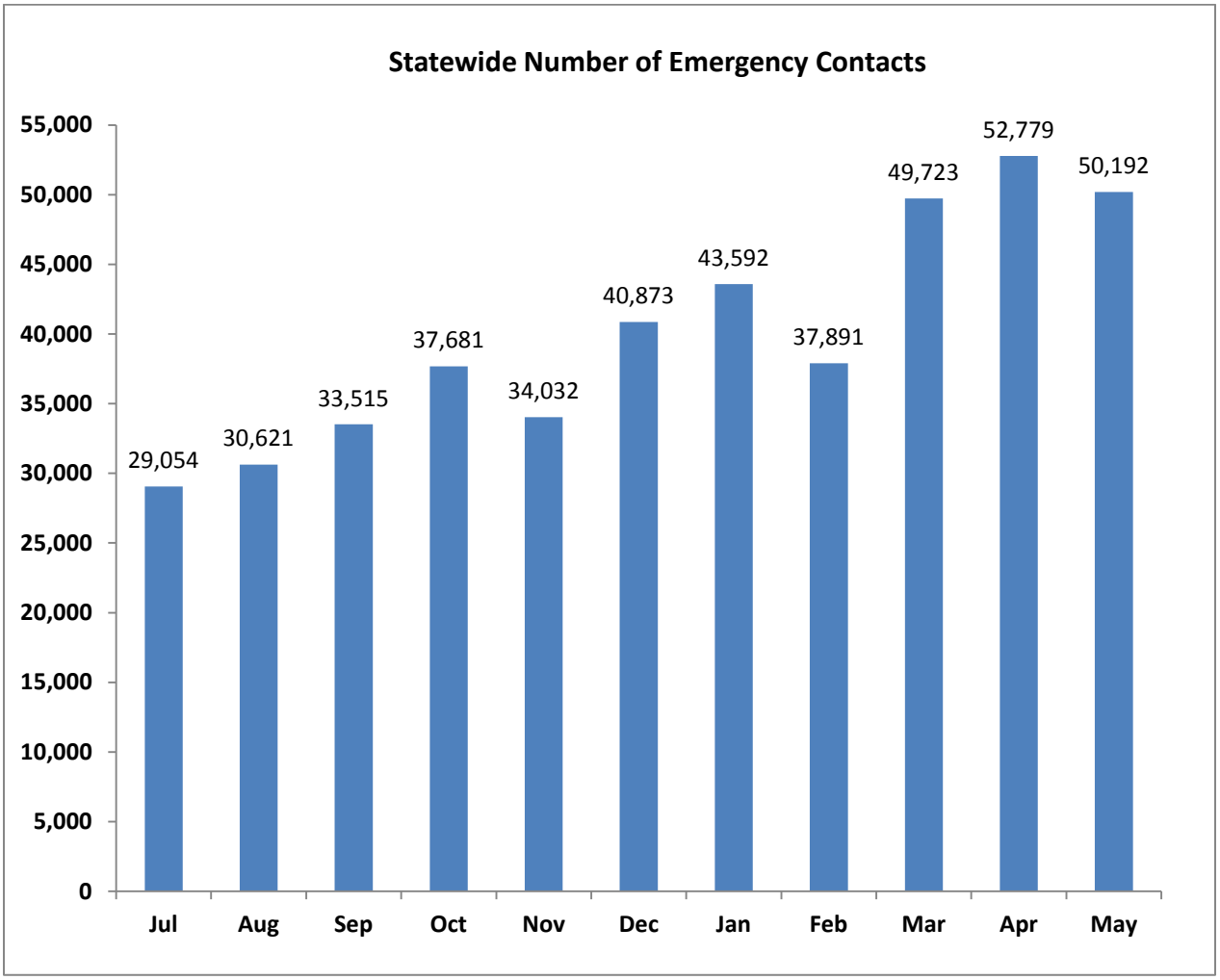
[2] There are 39 Community Services Boards and 1 Behavioral Health Authority in the Commonwealth, referred to in this report as CSBs. See Appendix B for a complete listing of CSBs within each of the seven regions.

[3] In addition, data is reported both statewide and by region in the report and in Appendix C.

[4] The Quality Oversight Team includes the DBHDS Medical Director, Assistant Commissioner for Behavioral Health, Director of Community Behavioral Health Services, Director of Mental Health, and MH Crisis Specialist.

Graph 1. Emergency contacts statewide

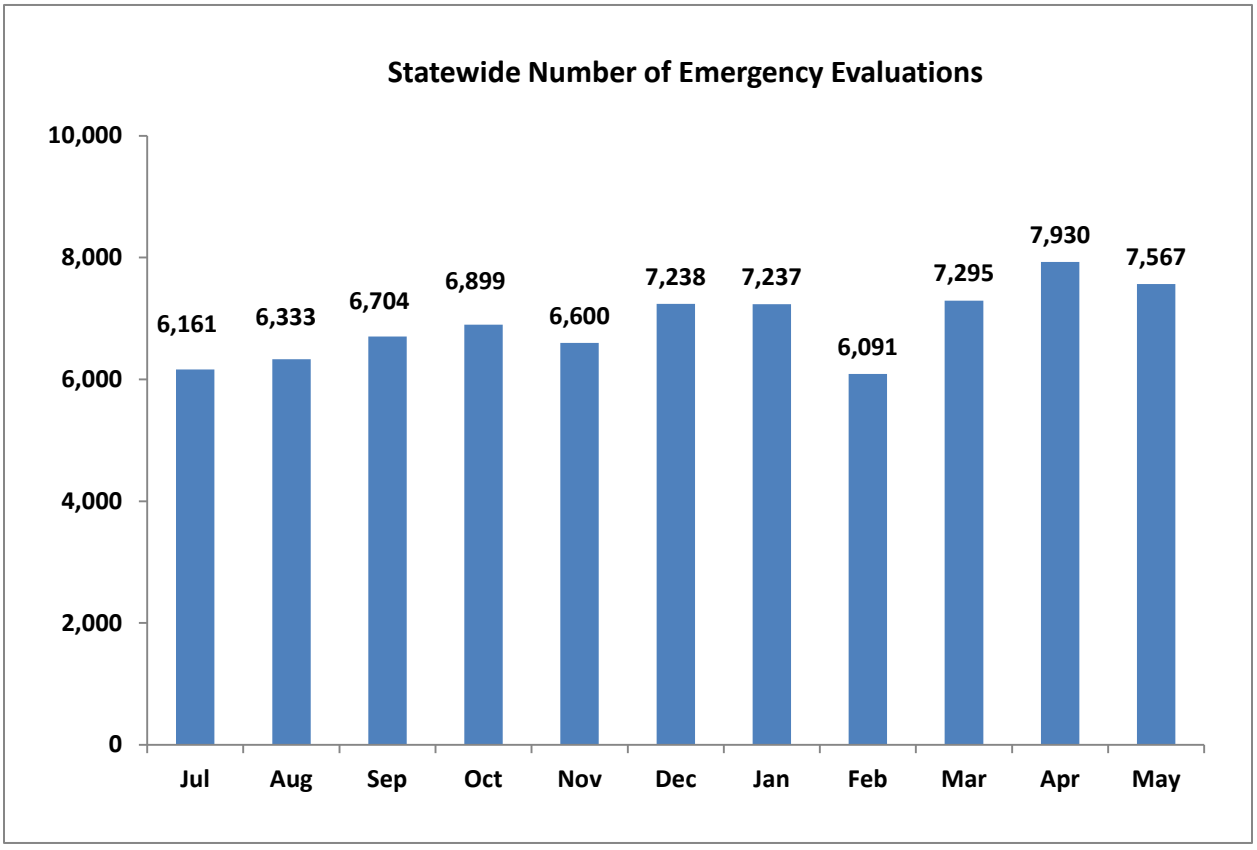
Emergency contacts are events requiring any type of CSB emergency service involvement or intervention. There were 50,192 emergency contacts reported statewide during the month of May, 2015, which is a 5% decrease from April, 2015. With the exception of November, 2014 and February 2015, these figures continue a general upward trend since July, 2014, as shown in Graph 1, below. Regional data is displayed in graph 1a and table 1 in Appendix C, page 13. Percent changes from April varied across regions with Region 6 increasing by 17%, and Region 2 reporting a decrease of 17%. The remaining regions remained within a 5-10% differential. DBHDS initiated specific inquiries to all CSBs to better understand the causes of these fluctuations in their respective regions, but no CSBs or regions have been able to identify any specific events, agency actions or system changes that have directly influenced the volume of emergency contacts. As stated in previous reports, refinements in data gathering procedures at the local level combined with clarification of data definitions by DBHDS in November 2014 may account for some variability in these numbers.



Virginia Department of Behavioral Health & Developmental Services

Graph 2. Emergency evaluations statewide

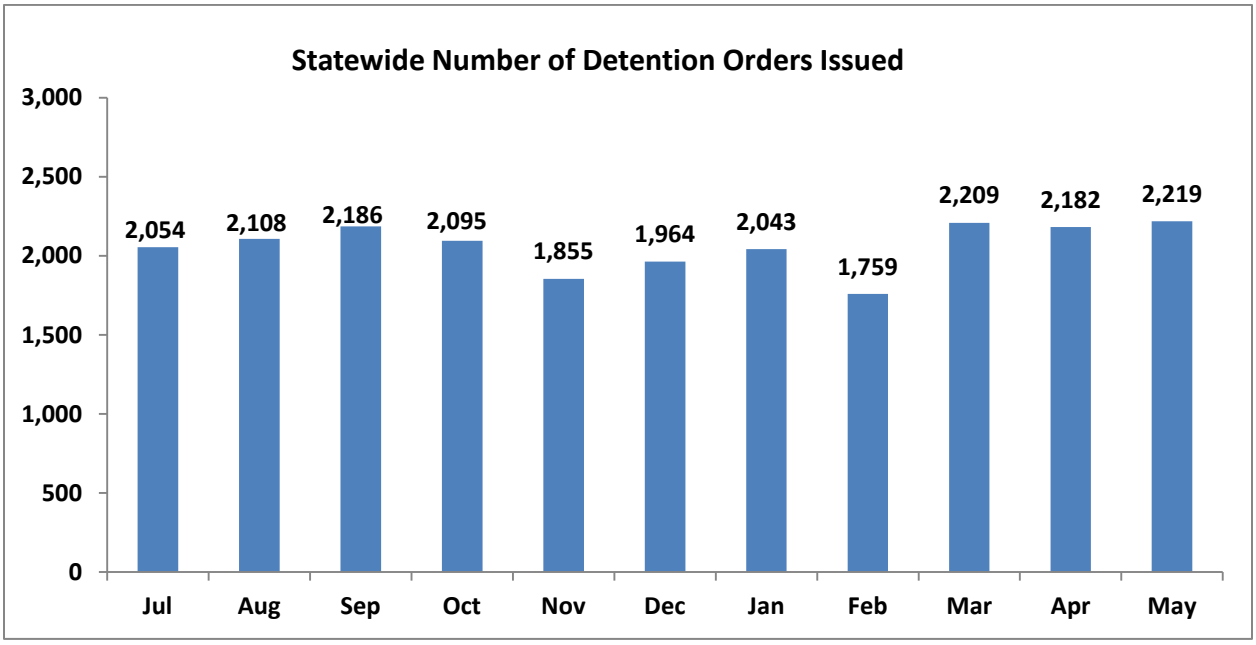
Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. The number of emergency evaluations reported statewide in May was 7,567, which is a 5% decrease from April, but generally reflective of the upward trend over the year. However, Region 2 reported a decrease of 18% from April and the other regions reported differentials within 10%. Regional data is displayed in graph 2a and table 2 in Appendix C, page 14. The figures for emergency contacts, emergency evaluations, and TDOs that are reported in subsequent pages of this report may represent duplicated (i.e., not mutually exclusive) counts of individuals because an individual may have made contact, or been evaluated or detained, on more than one occasion and could therefore be included two or more times in any of these categories.



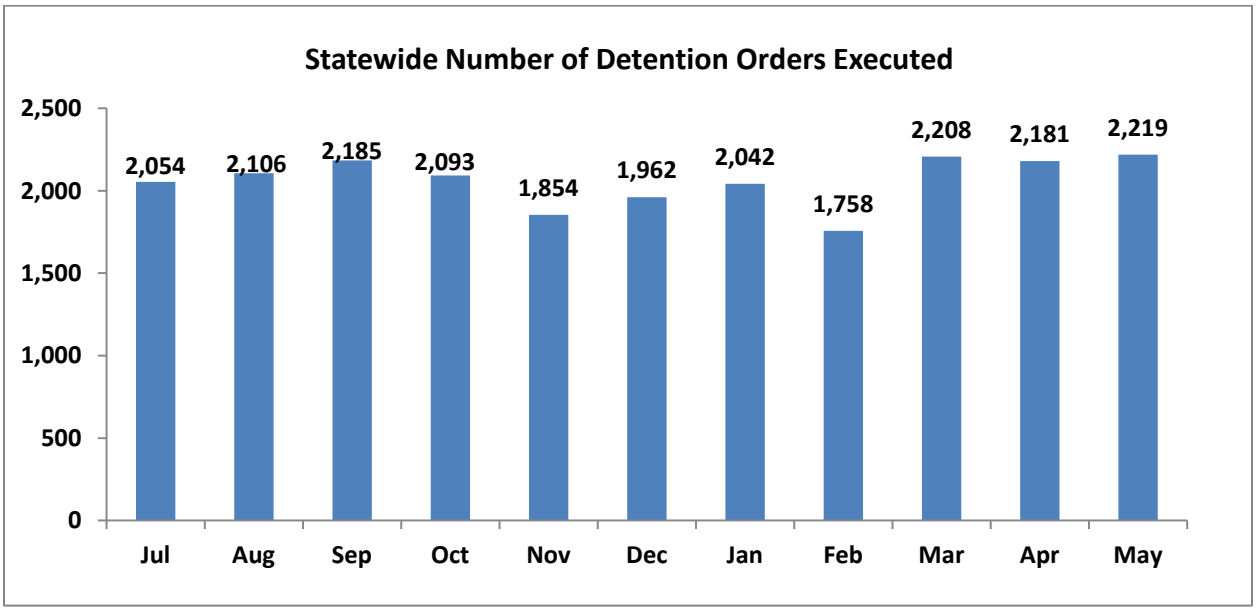
Graph 3. TDOs issued statewide

A TDO is issued by a magistrate after considering the findings of the CSB evaluation and other relevant evidence, and determining that the person meets the criteria for temporary detention under § 37.2-809 or § 16.1-340.1. A TDO is executed when the individual is taken into custody by the officer serving the order. In May, there were 2,219 TDOs issued (Graph 3), and executed (Graph 4), which is the highest month reported in the FY 2015 year to date. Region 6 had a 22% increase from April, but the other CSBs reported variations within 10%. Graph 3a and table 3 (page 15) and graph 4a and table 4 (page 16)

display this data reported by region in Appendix C. This is an increase of 38 TDOs issued from April, 2015, representing an increase of approximately 2% statewide. **About 71% of the emergency evaluations reported in May (5,348 of 7,567) did not result in a TDO.** All TDOs issued in May were executed.

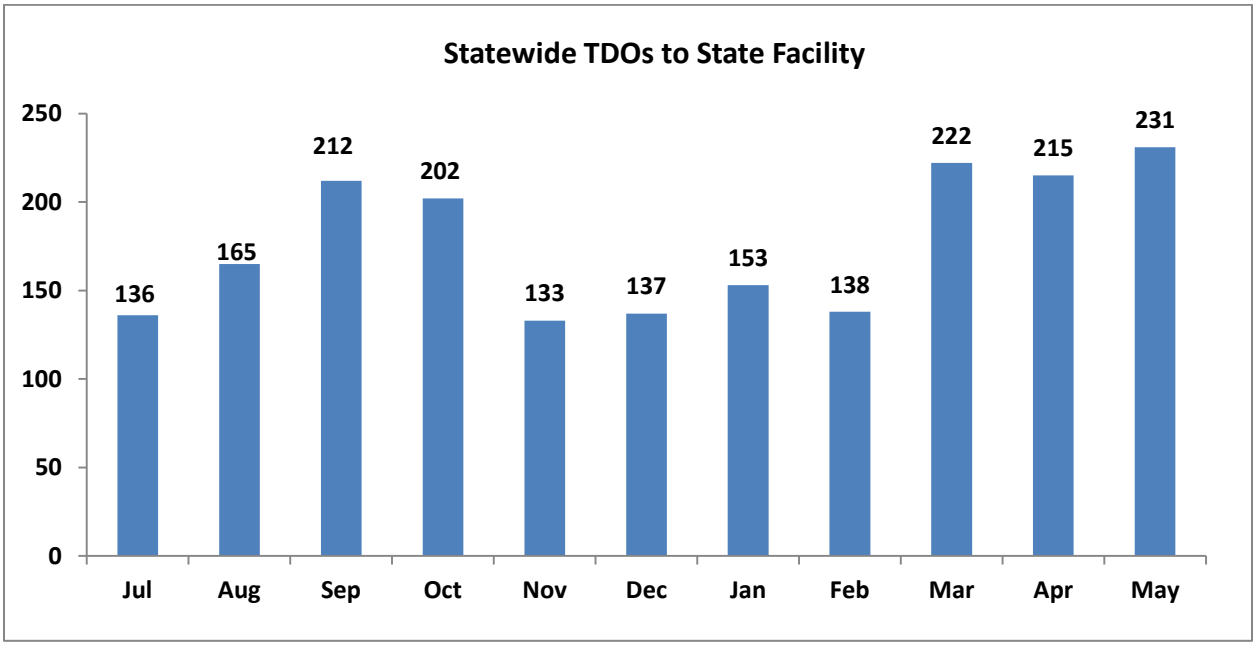


Graph 4. TDOs executed statewide



Graph 5. TDO admissions to a state hospital statewide

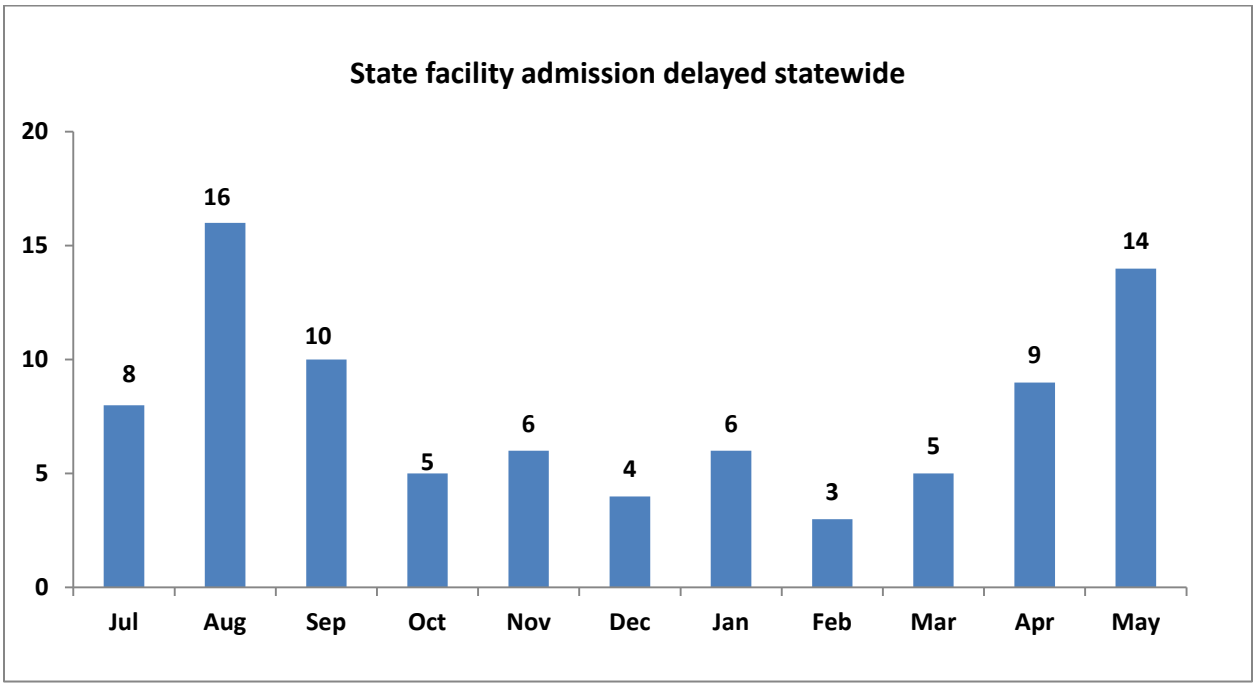
Of the 2,218 TDOs executed in May, 231 (10%) resulted in admission to a state hospital [5] (Graph 5), representing an increase of 7% from April. This is the highest monthly figure for this data element reported to date in FY 2015. Regions 6 and 7 accounted for 53 (23%) of these admissions and had increases of 58% and 28%, respectively, from April. There continues to be variance among regions in the number of state hospital TDO admissions, as shown in Graph 5a and table 5 in Appendix C, page 17. This variance reflects recognized seasonal trends and each region's unique resources, protocols, and access to community psychiatric facilities. DBHDS is working with regions to minimize the use of state facilities for temporary detention through increased use of community psychiatric resources, alternatives to hospitalization, and more explicit utilization protocols for state hospitals. DBHDS also closely monitors use of the Psychiatric Bed Registry.



Graph 6. State hospital admission delayed statewide

In May, there were 14 occasions when the state hospital was deemed the "hospital of last resort" but admission could not be accomplished before the ECO time period expired (Graph 6). The delays in all of these cases were due to the individuals' more immediate medical testing and treatment needs. The 14 cases in May, represent a 56% increase in the number of delayed admissions from April (April = 9, May = 14) and continues a steady increase since February 2015. Graph 6a and table 6 displays this data by region in Appendix C, page 18, and shows that Regions 1 and 2 did not report this type of occurrence in May.

[5] Source: DBHDS AVATAR admitting CSB data



Graph 7. TDO executed after ECO expired statewide

Amendment added 1/12/2017)

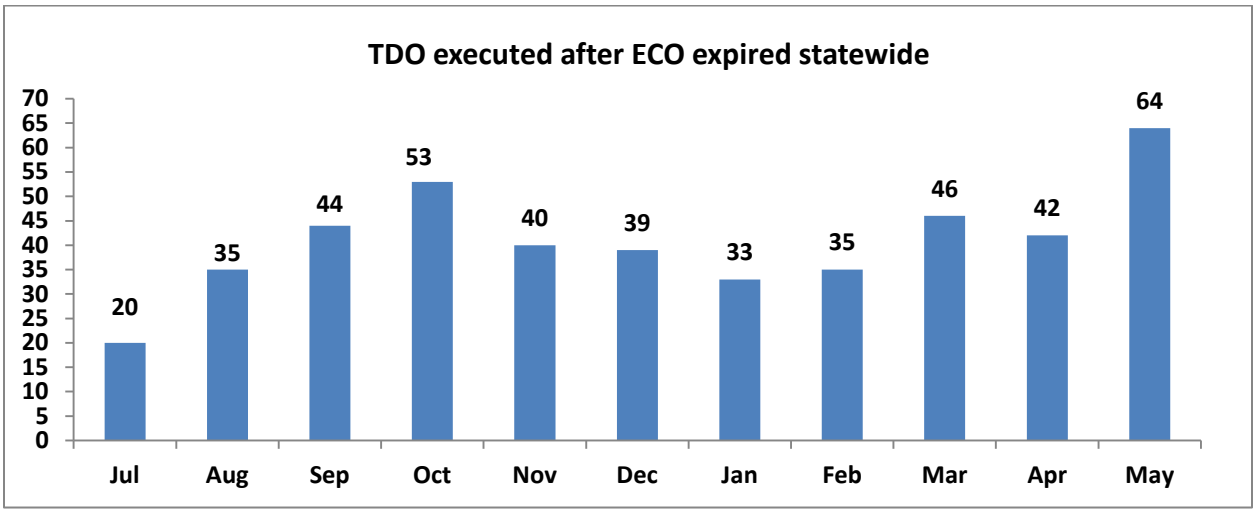
Upon further analysis of the TDO Exception Reports issued September 2014 through June 2015, PPR7 and Blue Ridge Behavioral Healthcare, the CSB serving this region, initially reported time of issuance of the TDO versus execution of the TDO, which is the format that all other PPR regions used to calculate outcomes. This made the comparison between PPR&s data and other regions invalid. Please refer to the chart below for corrections to the data:

Month	ORIGINIALLY REPORTED # of incidents in which TDO was executed after the ECO expired in original report	CORRECTIONS TO DATA # of incidents in which TDO was obtained prior to the ECO expiring but not executed before the ECO expired
September 2014	25	3
October 2014	21	3
November 2014	18	3
December 2014	22	1
January 2015	20	6
February 2015	19	4
March 2015	23	1
April 2015	22	2
May 2015	37	5
June 2015	21	5

In May, there were 64 (<3% of total) reported cases where a TDO was issued but not executed until after the ECO period had ended (Graph 7). This is a 52% increase from April and the highest monthly figure for this data element reported to date in FY 2015. Over half of these cases (34 of 64) involved waiting for law enforcement to execute TDOs that were issued prior to the expiration of the ECO time period. In 16 cases, law enforcement declined to execute the TDO until medical treatment was completed. Eight other cases were due to delayed access to a magistrate or other complications with a magistrate's office for TDO issuance; five more were due to difficulty accessing a bed in an appropriate facility; and one other was the result of the CSB receiving late notification from law enforcement that an individual was under ECO. DBHDS provided guidance to the CSBs with delays resulting from magistrate issues, asking these CSBs to work with their court partners in this process (i.e., the magistrates), to review each of the cases to prevent reoccurrence of a similar event. In 63 of these cases, the individuals were maintained safely in an emergency department, with law enforcement or security presence, and ultimately admitted to a psychiatric hospital without any lapse in custody. The remaining individual was maintained safely within a CIT Assessment Center. All of these individuals were safely admitted to a psychiatric hospital without any loss of custody. Providers continue to use secure environments (such as locked emergency department or secure assessment sites) as well as law enforcement officers, to maintain custody.

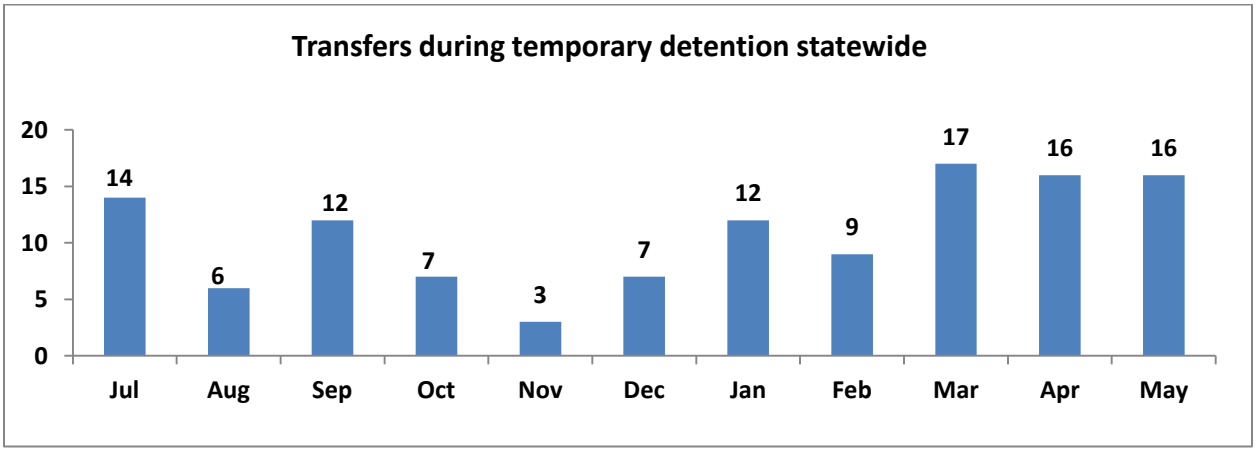
Graph 7a and table 7 display this data by region in Appendix C, page 19. Regionally, frequency of these cases is highly variable and in May all regions reported at least one case. Regions 1 and 4 appear to have increased the most, from April, but had smaller numbers, in total. Region 5 had a 20% decrease and Region 2 had a 43% increase, from April.

Region 7 continues to have a significantly greater number of these cases than any other region, and has had more of these events than all other regions combined since December. This region reported 155 TDOs issued and executed during April, 2015, with 37 (24%) executed after the ECO period expired. This is a 68% increase from April. The time delay between issuance and execution of TDOs ranged from 15 minutes to 12 hours 32 minutes, with a mean of 3 hours and 47 minutes and a median of 3 hours and 9 minutes. Three of these cases involved individuals in custody waiting more than eight hours before the TDO was executed. DBHDS Quality Oversight Team has maintained a continuous active involvement with this region regarding this issue. An August 5 regional meeting with service delivery partners to further discuss the implementation of quality improvement strategies to reduce these delays was postponed. Quality improvement efforts continue to target Carillion Emergency and Police Departments, the Roanoke City Sheriff and Magistrate, and Catawba Hospital, but a long-planned new procedure to transmit TDOs electronically from the magistrate to the Carillion Emergency Department still has not been implemented. The regional manager has been asked to undertake an in-depth, impartial review of the emergency response system of the CSB and to make recommendations for change. The review was initiated in June, 2015 and is currently ongoing. DBHDS and the local agencies are continuing to address these transactions intensively, and DBHDS is continuously monitoring and supporting this effort.



Graph 8. Transfers during temporary detention statewide

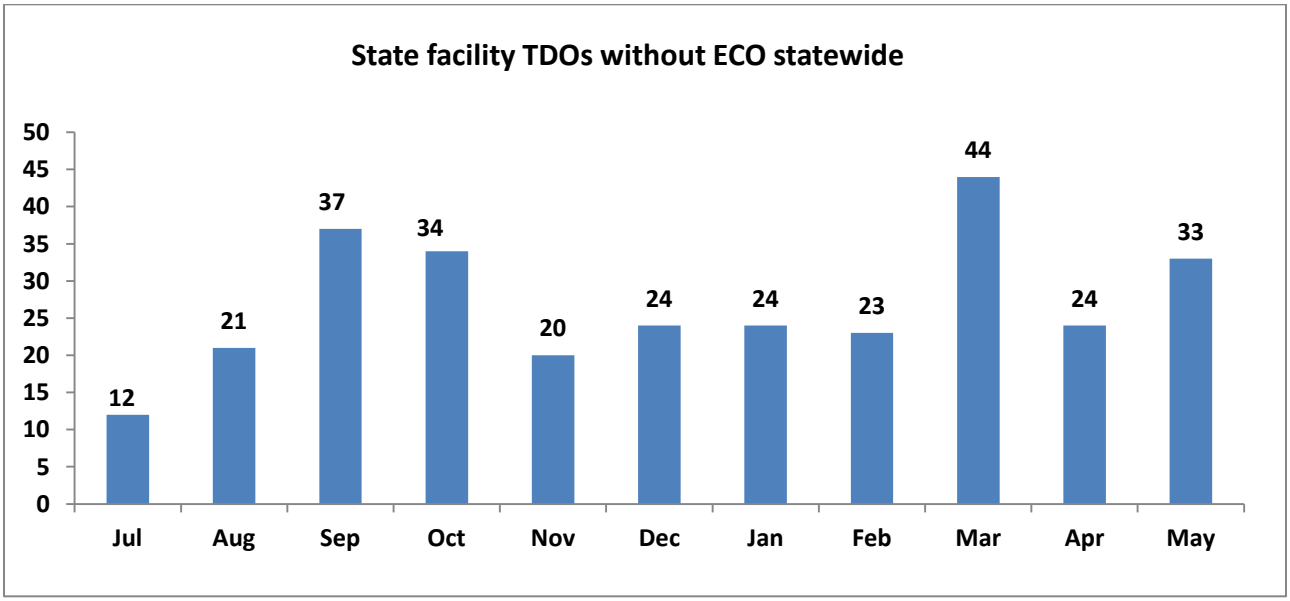
Section § 37.2-809.E. of the *Code of Virginia* allows an individual to be transferred during the period of detention from one temporary detention facility to another more appropriate facility in order to address an individual's security, medical or behavioral health needs. This procedure was used 16 times (<1%) during May (Graph 8). In 13 cases, the transfer was from a state facility to a private psychiatric facility. One was from a community based crisis residential unit to a state facility; one from a private psychiatric facility to a state facility; and one from a medical unit to a private psychiatric facility. Graph 8a and table 8 displays this data by region in Appendix C, page 20. Regions 6 and 7 did not report any of these transfers in May.



Graph 9. State hospital TDOs without ECOs statewide

As the hospital of "last resort", DBHDS facilities admit individuals who need temporary detention for whom no alternative placement can be found, whether or not the individual is under an ECO. CSBs report every "last resort" admission where no ECO preceded the admission, along with how many alternate facilities were contacted and the reason(s) for the inability to locate an alternate facility. In

May, there were 33 such admissions to a state facility, which is an increase of 38% from April (Graph 9). A total of 387 contacts were made for an average of almost 12 alternate facilities contacted to secure these admissions, which is a 20% increase from April 2015 and the highest average, to date, in FY 2015. Nineteen were due to a lack of capacity of the alternate facilities contacted by the CSB and two of the admissions were for specialized care due to the individual's age (adult aged 65 and older). Other reasons for these admissions were diagnosis of intellectual or developmental disability; medical needs beyond the capability of the alternate facilities contacted; behavioral needs exceeding the alternate facilities contacted, having a Not Guilty by Reason of Insanity status (NGRI), recent discharge from a state facility and lack of housing at time of evaluation. DBHDS monitors the Psychiatric Bed Registry daily for updating by facilities regarding their bed space capability as well as the comments entered by CSB clinicians who use the registry in seeking a bed. Graph 9a and table 9 displays this data by region in Appendix C, page 21.



Discussion:

To enhance consistency and accuracy of CSB reporting, DBHDS has worked continuously since July 2014 with individual CSBs and regions to ensure that data elements and reporting procedures are clearly understood and consistently reported. DBHDS and CSBs have established a workgroup consisting of CSB Executive Directors and DBHDS representatives that has developed a quality review framework to further strengthen the quality oversight processes and ensure that this data is consistently used by CSBs to identify trends and correct problems at the agency, regional, and statewide levels.

In addition to the above ongoing efforts, as this report is being published, DBHDS has begun to plan two additional areas of inquiry and focus for FY 2016. First, DBHDS will be comparing TDO data collected through these monthly CSB reports with court data obtained through the court system to understand further how, and it what ways, existing reporting methods may influence the accuracy or variability of

these data. In addition, DBHDS is reviewing its annual CSB program audit procedure to incorporate a focus on this reporting in that review. These FY 2016 oversight efforts will help ensure that DBHDS has the clearest and most accurate understanding of the emergency service events and transactions reported here, which will further strengthen the local, regional and state-level quality improvement process.

These data enable DBHDS to conduct ongoing system monitoring and performance improvement efforts. As a result, DBHDS, CSBs, and local emergency service partners are communicating more regularly and timely to improve local care coordination, eliminating system gaps and clarifying agency and staff roles in the emergency response system. Lastly, DBHDS continues to convene regular and frequent stakeholder meetings at the state level to share this data, communicate directly about problem issues, and jointly develop and implement effective operational improvements.

APPENDIX A

Data Elements Reported Monthly by CSB/BHAs

Each CSB/BHA reports four data factors on volume to the region:

1. Emergency contacts: The total number of calls, cases, or events per month requiring any type of CSB emergency services involvement or intervention, whether or not it is about emergency evaluation, and regardless of disposition. Calls seeking information about emergency services, potential referrals, the CSB, etc., should be counted if the calls come to emergency services (e.g., through the crisis line) and require emergency services to respond. Any other contacts to emergency services from individuals, family members, other CSB staff, health providers or any other person or entity, including contacts that require documentation in an individual's health record, should be counted as emergency contacts. Any contacts that precipitate an intervention or emergency response of any kind should be counted as emergency contacts.
2. Emergency Evaluations: Emergency evaluations are clinical examinations of individuals that are performed by emergency services or other CSB staff on an emergency basis to determine the person's condition and circumstances, and to formulate a response or intervention if needed. This figure is the total number of emergency evaluations completed, regardless of the disposition, including evaluations conducted in person or by means of two-way electronic video/audio communication as authorized in 37.2-804.1.
3. Number of TDOs Issued: TDOs are issued by a magistrate.
4. Number of TDOs Executed: TDOs are executed by law enforcement officers. A TDO is executed when the individual is taken into custody by the law enforcement officer serving the temporary detention order. It is possible under some circumstances that a TDO issued by a magistrate may not be executed for some reason.

Each CSB/BHA also reports six additional data elements:

1. Cases where the state hospital was used as a “last resort”: Under the new statutory procedures effective July 1, 2014, when an individual is in emergency custody and needs temporary detention, and no other temporary detention facility can be found by the end of the 8-hour period of emergency custody, then the state hospital shall admit the individual for temporary detention. Each region's Regional Admission Protocol describes the process to be followed for accessing temporary detention facilities and for accessing the state hospital as a "last resort" facility for temporary detention.
2. Cases where a back-up state hospital was used: Under some circumstances, the primary state hospital may not be accessible as the "last resort" temporary detention facility when needed at the end of the 8-hour ECO period, and a back-up state hospital will need to admit the individual as a "last resort" admission.
3. Cases where the state hospital is called upon as the "last resort" for temporary detention, but admission cannot occur at the 8-hour expiration of the ECO because of a medical or related clinical issue that must be addressed (i.e., medical condition cannot be treated effectively in the state hospital, person is not medically stable for transfer to state hospital, required medical testing is not yet completed, etc.).

4. Cases where a TDO may be issued by a magistrate while the person is in emergency custody, but the TDO will not be executed until after the 8-hour period of emergency custody has expired. Under the new statutes, if this scenario should occur, the individual may not be released from the CSB's custody until the TDO is executed.
5. Cases where a facility of temporary detention is transferred post-TDO: a CSB is allowed to change the facility of temporary detention for an individual at any time during the period of temporary detention pursuant to 37.2-809.E.
6. Cases where there is no ECO, but TDO to state hospital as a “last resort”: These are instances when an individual who is not in emergency custody (i.e., no ECO) is deemed to need temporary detention. If no suitable alternative facility can be found, state hospitals must serve as the "last resort" temporary detention facility in these cases.

Note: For the six data elements immediately above, associated descriptor information is reported as well.

APPENDIX B

Partnership Planning Region	Community Services Board or Regional Behavioral Health Authority
1 Northwestern Virginia	Horizon Behavioral Health Services Harrisonburg-Rockingham CSB Northwestern Community Services Rappahannock Area CSB Rappahannock-Rapidan CSB Region Ten CSB Rockbridge Area Community Services Valley CSB
2 Northern Virginia	Alexandria CSB Arlington County CSB Fairfax-Falls Church CSB Loudon County CSB Prince William County CSB
3 Southwestern Virginia	Cumberland Mountain CSB Dickenson County Behavioral Health Services Highlands Community Services Mount Rogers CSB New River Valley Community Services Planning District One Behavioral Health Services
4 Central Virginia	Chesterfield CSB Crossroads CSB District 19 CSB Goochland-Powhatan Community Services Hanover CSB Henrico Area Mental Health & Developmental Services Board Richmond Behavioral Health Authority
5 Eastern Virginia	Chesapeake CSB Colonial Behavioral Health Eastern Shore CSB Hampton-Newport News CSB Middle Peninsula-Northern Neck CSB Norfolk CSB Portsmouth Department of Behavioral Healthcare Services Virginia Beach CSB Western Tidewater CSB
6 Southern	Danville-Pittsylvania Community Services Piedmont Community Services Southside CSB
7 Catawba Region	Alleghany Highlands CSB Blue Ridge Behavioral Healthcare

APPENDIX C

Graph 1a. Emergency contacts by region

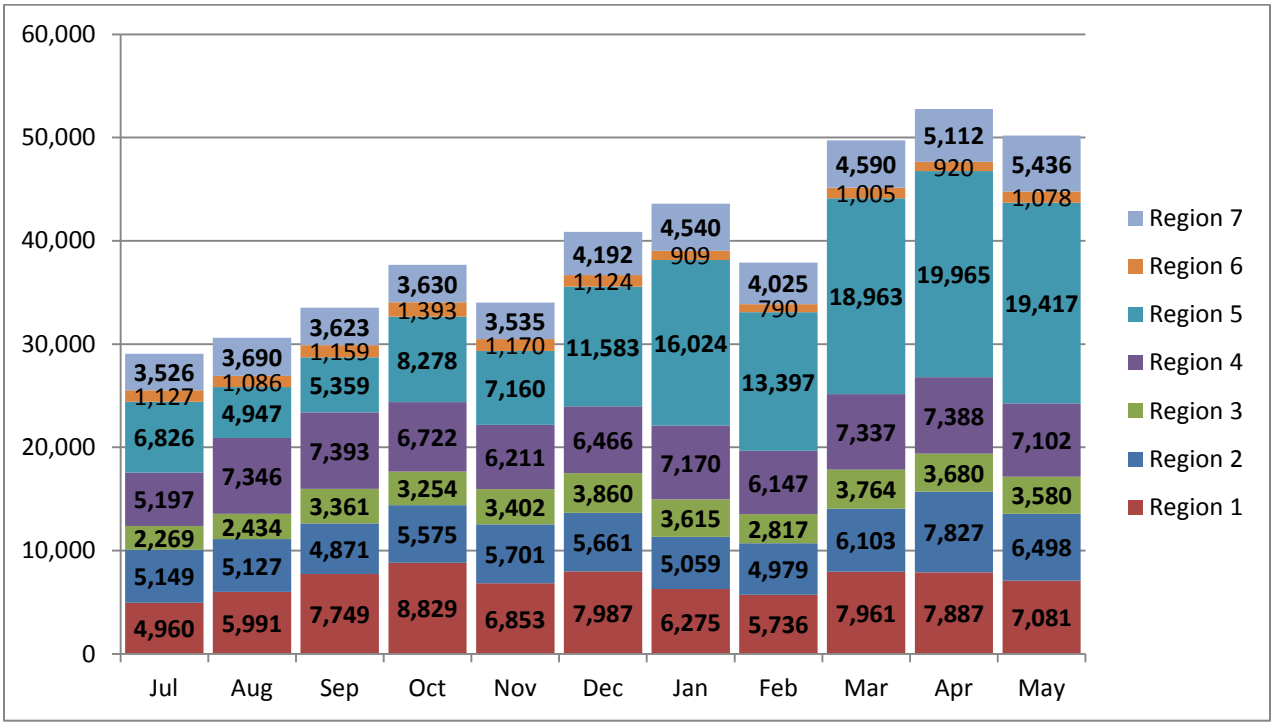


Table 1. Number of emergency contacts (corresponds with graph 1a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Region 1	4,960	5,991	7,749	8,829	6,853	7,987	6,275	5,736	7,961	**7,887**	7,081	77,309
Region 2	5,149	5,127	4,871	5,575	5,701	5,661	5,059	4,979	6,103	**7,827**	6,498	62,550
Region 3	2,269	2,434	3,361	3,254	3,402	3,860	3,615	2,817	3,764	**3,680**	3,580	36,036
Region 4	5,197	7,346	7,393	6,722	6,211	6,466	7,170	6,147	7,337	**7,388**	7,102	74,479
Region 5	6,826	4,947	5,359	8,278	7,160	11,583	16,024	13,397	18,963	**19,965**	19,417	131,920
Region 6	1,127	1,086	1,159	1,393	1,170	1,124	909	790	1,005	**920**	1,078	11,761
Region 7	3,526	3,690	3,623	3,630	3,535	4,192	4,540	4,025	4,590	**5,112**	5,436	45,899
Total	**29,054**	**30,621**	**33,515**	**37,681**	**34,032**	**40,873**	**43,592**	**37,891**	**49,723**	**52,779**	50,192	439,953

Virginia Department of Behavioral Health & Developmental Services

Graph 2a. Emergency evaluations by region

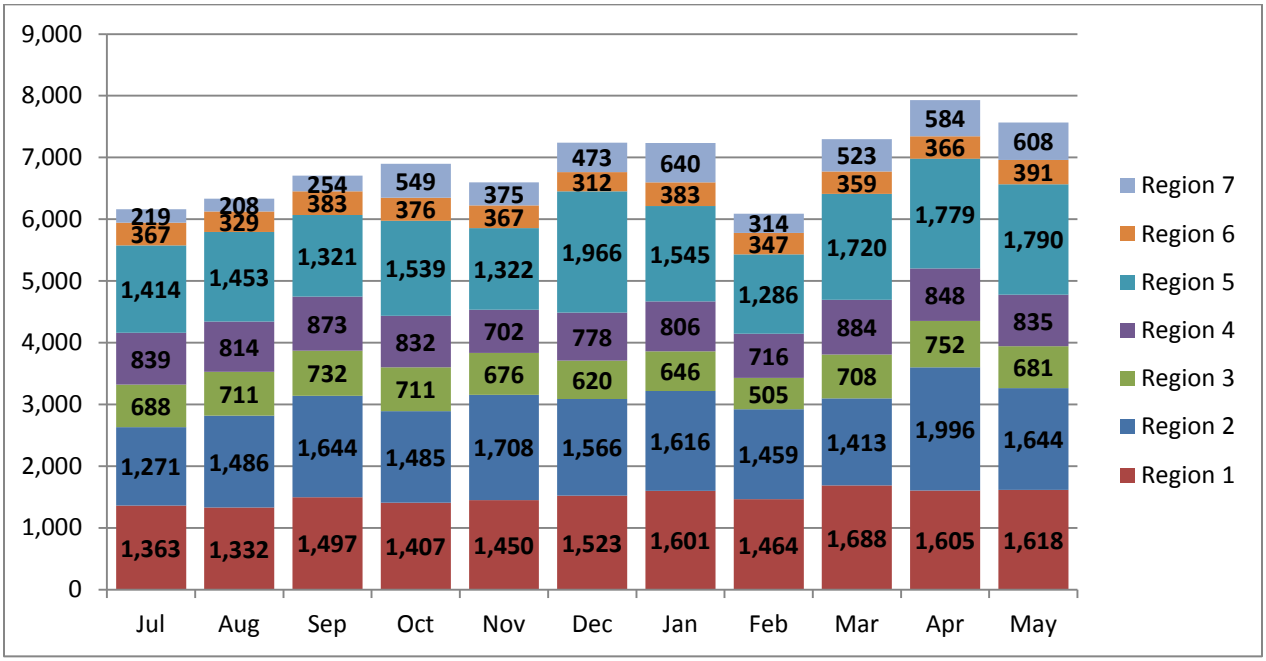


Table 2. Number of emergency evaluations (corresponds with graph 2a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Region 1	1,363	1,332	1,497	1,407	1,450	1,523	**1,601**	**1,464**	1,688	**1,605**	**1,618**	**16,548**
Region 2	1,271	1,486	1,644	1,485	1,708	1,566	**1,616**	**1,459**	1,413	**1,996**	**1,644**	**17,288**
Region 3	688	711	732	711	676	620	**646**	**505**	708	**752**	**681**	**7,430**
Region 4	839	814	873	832	702	778	**806**	**716**	884	**848**	**835**	**8,927**
Region 5	1,414	1,453	1,321	1,539	1,322	1,966	**1,545**	**1,286**	1,720	**1,779**	**1,790**	**17,135**
Region 6	367	329	383	376	367	312	**383**	**347**	359	**366**	**391**	**3,980**
Region 7	219	208	254	549	375	473	**640**	**314**	523	**584**	**608**	**4,748**
Total	**6,161**	**6,333**	**6,704**	**6,899**	**6,600**	**7,238**	**7,237**	**6,091**	**7,295**	**7,930**	**7,567**	**76,055**

Graph 3a. TDOs issued by region

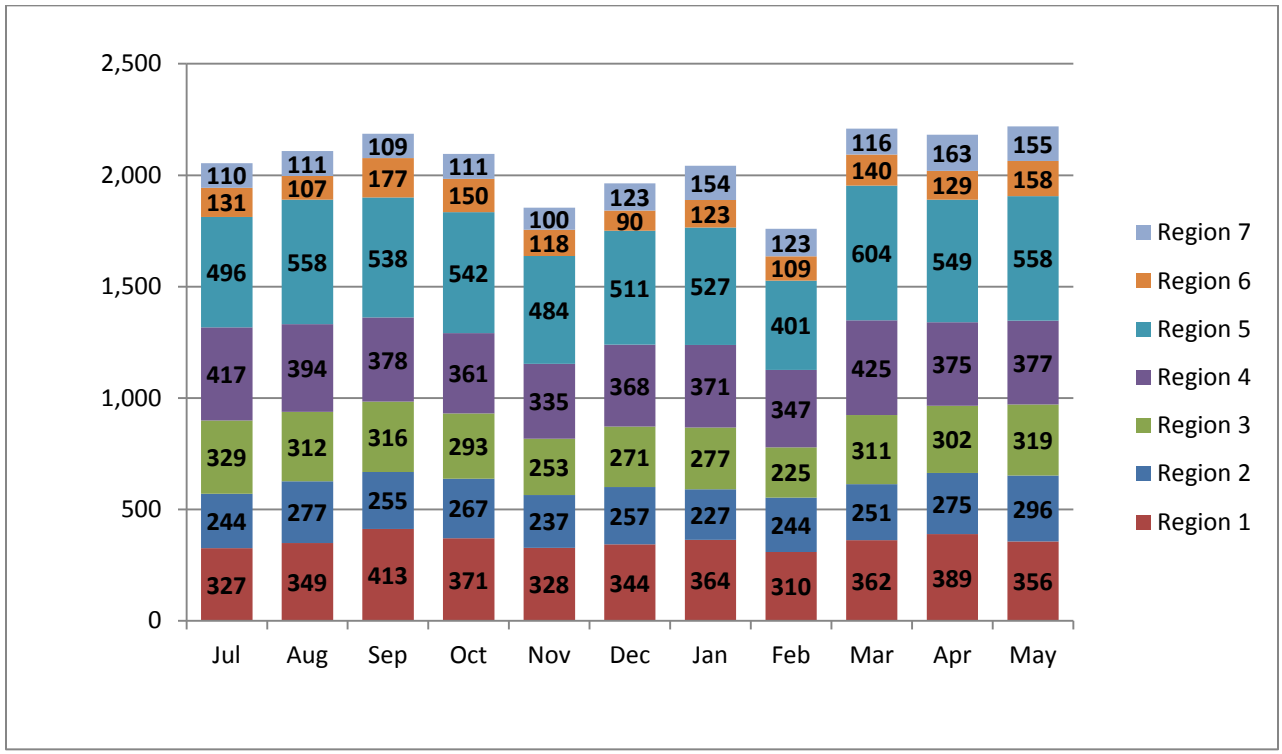


Table 3. Number of TDOs issued (corresponds with graph 3a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Region 1	327	349	413	371	328	344	364	310	362	**389**	**356**	**3,913**
Region 2	244	277	255	267	237	257	227	244	251	**275**	**296**	**2,830**
Region 3	329	312	316	293	253	271	277	225	311	**302**	**319**	**3,208**
Region 4	417	394	378	361	335	368	371	347	425	**375**	**377**	**4,148**
Region 5	496	558	538	542	484	511	527	401	604	**549**	**558**	**5,768**
Region 6	131	107	177	150	118	90	123	109	140	**129**	**158**	**1,432**
Region 7	110	111	109	111	100	123	154	123	116	**163**	**155**	**1,375**
Total	**2,054**	**2,108**	**2,186**	**2,095**	**1,855**	**1,964**	**2,043**	**1,759**	**2,209**	**2,182**	**2,219**	**22,674**

Graph 4a. TDOs executed by region

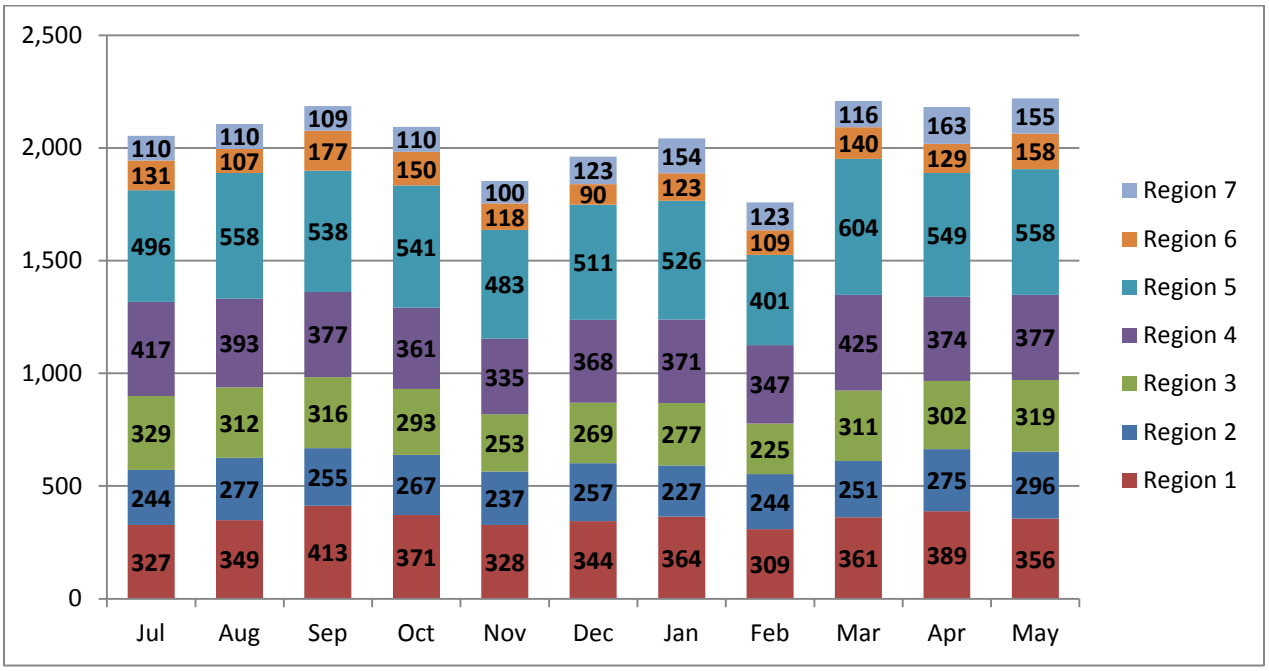


Table 4. Number of TDOs executed (corresponds with graph 4a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Region 1	327	349	413	371	328	344	364	309	361	**389**	356	3,910
Region 2	244	277	255	267	237	257	227	244	251	**275**	296	2,830
Region 3	329	312	316	293	253	269	277	225	311	**302**	319	3,206
Region 4	417	393	377	361	335	368	371	347	425	**374**	377	4,145
Region 5	496	558	538	541	483	511	526	401	604	**549**	558	5,765
Region 6	131	107	177	150	118	90	123	109	140	**129**	158	1,432
Region 7	110	110	109	110	100	123	154	123	116	**163**	155	1,373
Total	**2,054**	**2,106**	**2,185**	**2,093**	**1,854**	**1,962**	**2,042**	**1,758**	**2,208**	**2,181**	**2,218**	**22,661**

Graph 5a. TDO admissions to a state hospital by region

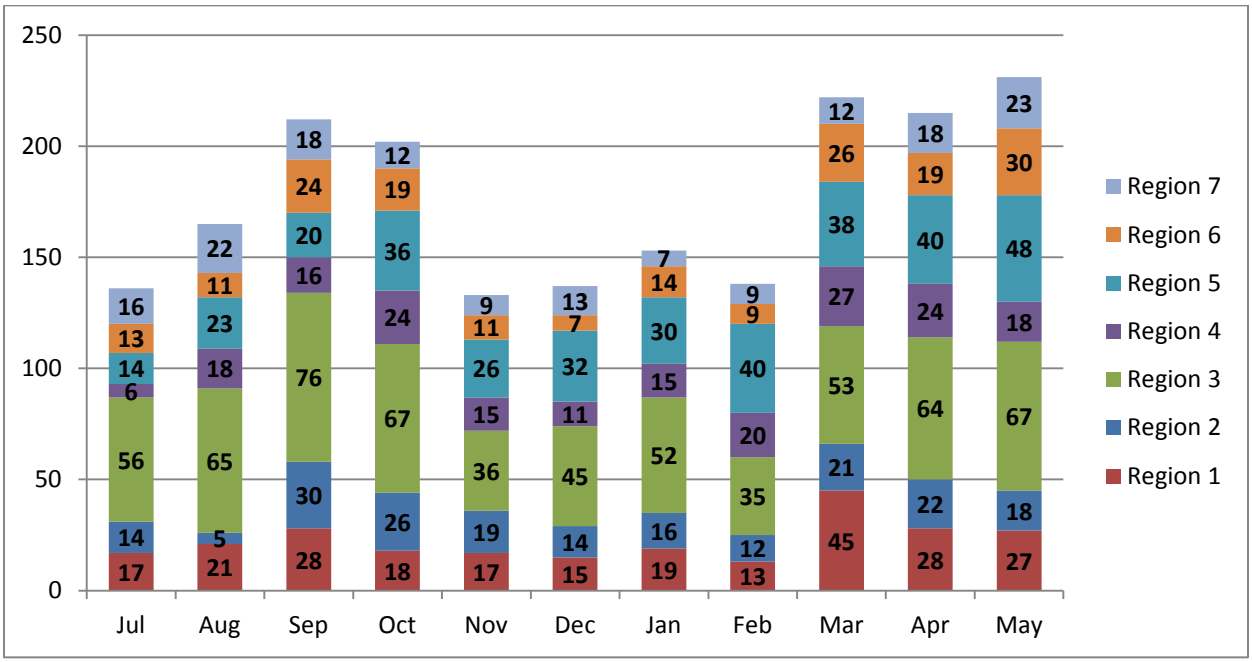


Table 5. TDO admissions to a state hospital (corresponds with graph 5a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Region 1	17	21	28	18	17	15	19	13	45	**28**	27	248
Region 2	14	5	30	26	19	14	16	12	21	**22**	18	197
Region 3	56	65	76	67	36	45	52	35	53	**64**	67	616
Region 4	6	18	16	24	15	11	15	20	27	**24**	18	194
Region 5	14	23	20	36	26	32	30	21	38	**40**	48	347
Region 6	13	11	24	19	11	7	14	9	26	**19**	30	183
Region 7	16	22	18	12	9	13	7	9	12	**18**	23	159
Total	**136**	**165**	**212**	**202**	**133**	**137**	**153**	**119**	**222**	**215**	231	1,944

Graph 6a. State hospital admission delayed by region

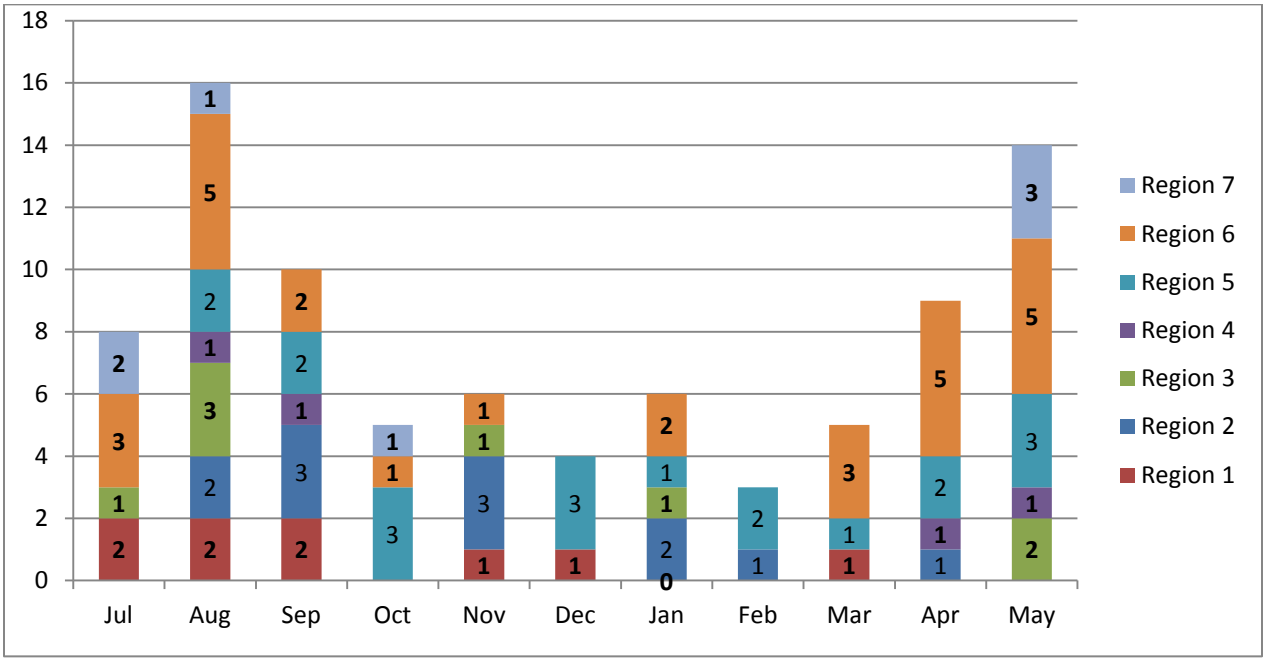


Table 6. State hospital admission delayed (corresponds with graph 6a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Region 1	2	2	2	0	1	1	**0**	**0**	1	**0**	**0**	**9**
Region 2	0	2	3	0	3	0	**2**	**1**	0	**1**	**0**	**12**
Region 3	1	3	0	0	1	0	**1**	**0**	0	**0**	**2**	**8**
Region 4	0	1	1	0	0	0	**0**	**0**	0	**1**	**1**	**4**
Region 5	0	2	2	3	0	3	**1**	**2**	1	**2**	**3**	**19**
Region 6	3	5	2	1	1	0	**2**	**0**	3	**2**	**5**	**27**
Region 7	2	1	0	1	0	0	**0**	**0**	0	**0**	**3**	**7**
Total	**8**	**16**	10	**5**	**6**	**4**	**6**	**3**	**5**	**6**	**14**	**86**

Graph 7a. TDO executed after ECO expired by region

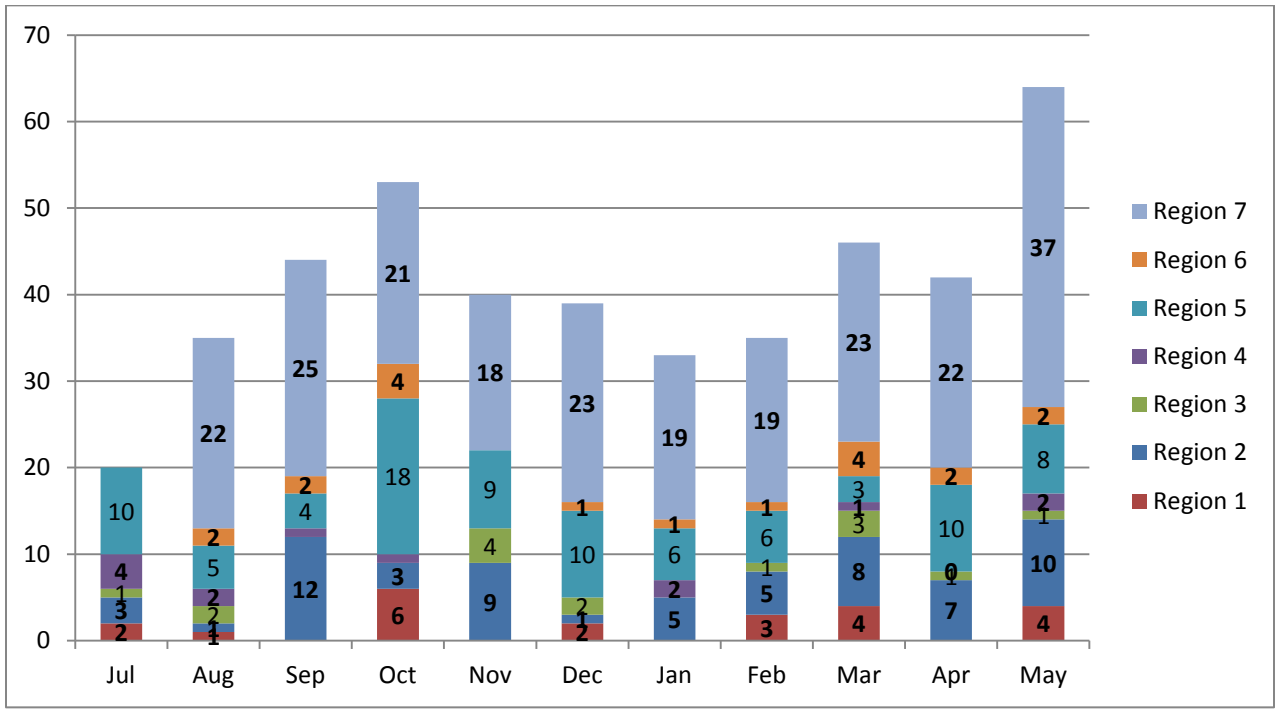


Table 7. TDO executed after ECO expired (corresponds with graph 7a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Region 1	2	1	0	6	0	2	0	3	4	**0**	**4**	**22**
Region 2	3	1	12	3	9	1	5	5	8	**7**	**10**	**64**
Region 3	1	2	0	0	4	2	0	1	3	**1**	**1**	**15**
Region 4	4	2	1	1	0	0	2	0	1	**0**	**2**	**13**
Region 5	10	5	4	18	9	10	6	6	3	**10**	**8**	**89**
Region 6	0	2	2	4	0	1	1	1	4	**1**	**2**	**19**
Region 7	0	22	25	21	18	23	19	19	23	**22**	**37**	**229**
Total	**20**	**35**	44	**53**	**40**	**39**	33	35	46	**41**	**64**	**451**

Graph 8a. Transfers during temporary detention by region

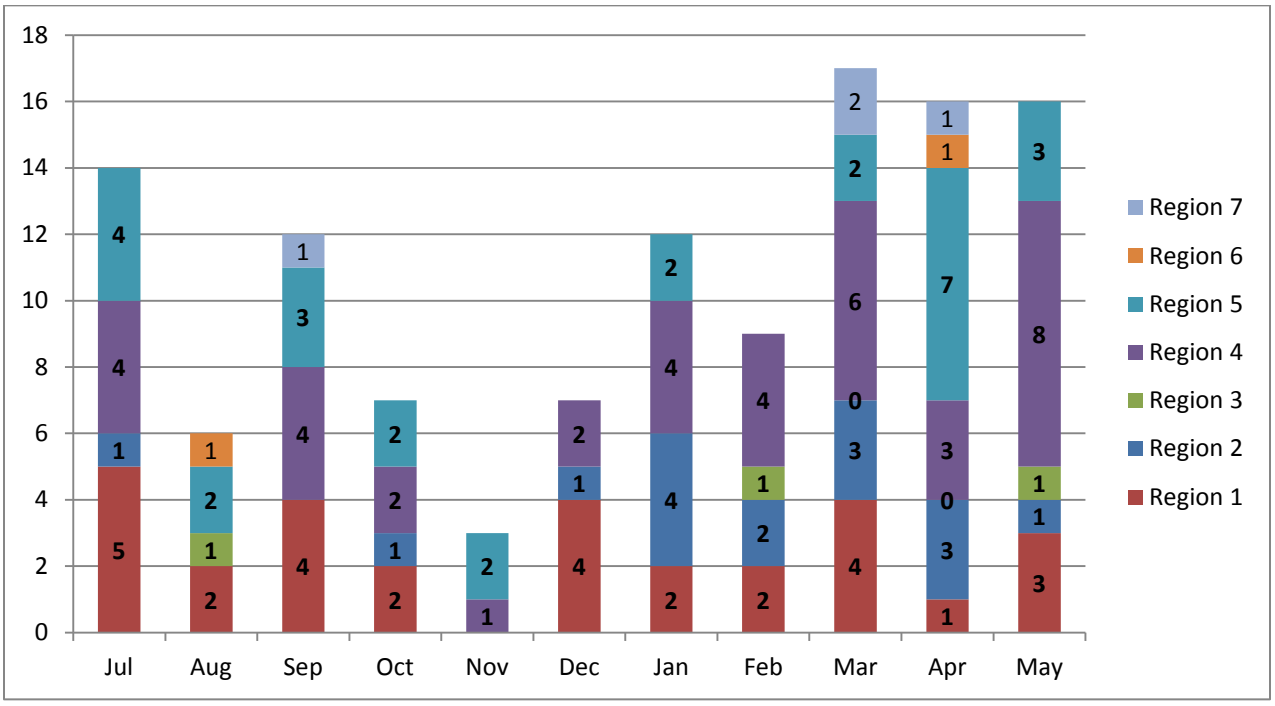


Table 8. Transfers during temporary detention (corresponds with graph 8a, pg 10)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Region 1	5	2	4	2	0	4	2	2	4	**1**	**3**	**29**
Region 2	1	0	0	1	0	1	4	2	3	**3**	**1**	**16**
Region 3	0	1	0	0	0	0	0	1	0	**0**	**1**	**3**
Region 4	4	0	4	2	1	2	4	4	6	**3**	**8**	**38**
Region 5	4	2	3	2	2	0	2	0	2	**7**	**3**	**27**
Region 6	0	1	0	0	0	0	0	0	0	**1**	**0**	**2**
Region 7	0	0	1	0	0	0	0	0	2	**1**	**0**	**4**
Total	**14**	**6**	**12**	**7**	**3**	**7**	**12**	**9**	**17**	**16**	**16**	**119**

Graph 9a. TDOs to state hospital without ECO by region

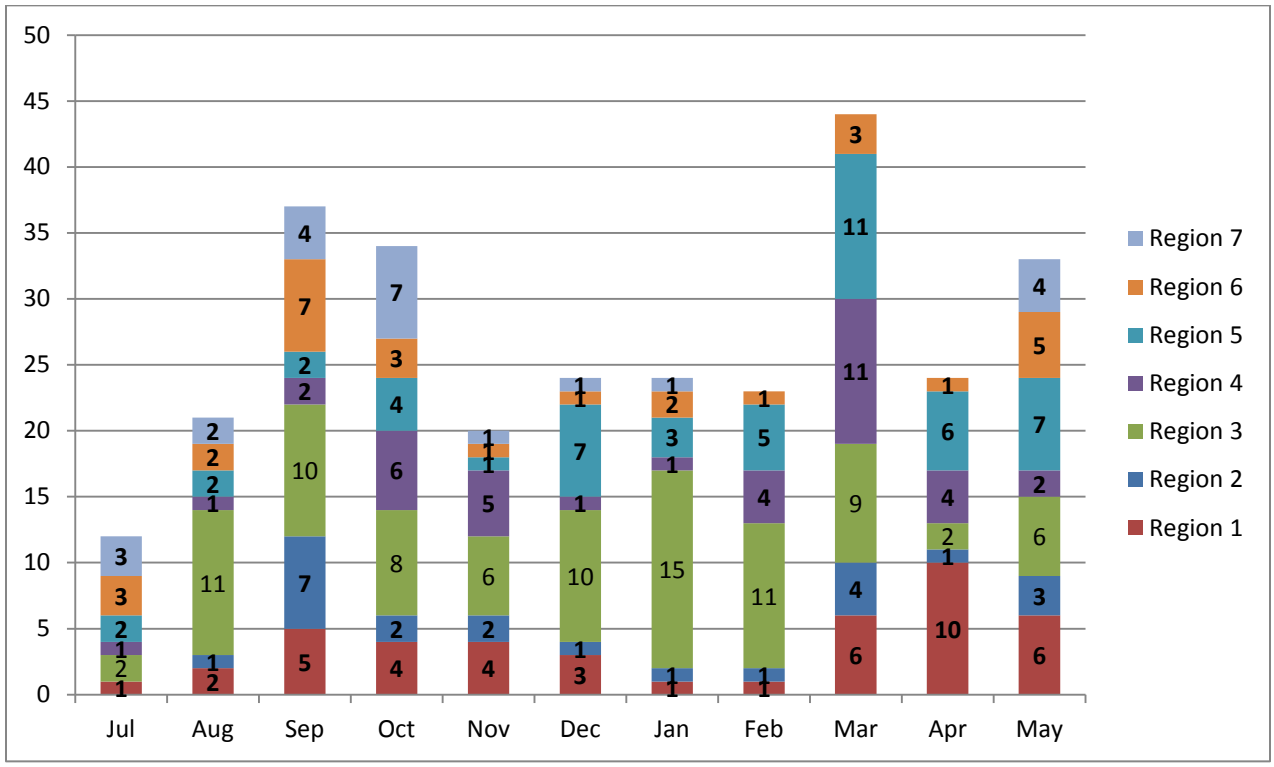


Table 9. State hospital TDOs without ECOs (corresponds with graph 9a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
Region 1	1	2	5	4	4	3	**1**	**1**	6	**10**	**6**	**48**
Region 2	0	1	7	2	2	1	**1**	**1**	4	**1**	**3**	**25**
Region 3	2	11	10	8	6	10	**15**	**11**	9	**2**	**6**	**89**
Region 4	1	1	2	6	5	1	**1**	**4**	11	**4**	**2**	**42**
Region 5	2	2	2	4	1	7	**3**	**5**	11	**6**	**7**	**51**
Region 6	3	2	7	3	1	1	**2**	**1**	3	**1**	**5**	**31**
Region 7	3	2	4	7	1	1	**1**	**0**	0	**0**	**4**	**23**
Total	**12**	**21**	**37**	**34**	**20**	**24**	**24**	**23**	**44**	**24**	**33**	**296**

APPENDIX D

DBHDS requires CSBs to report within 24-hours any event involving an individual who has been evaluated and needs temporary detention for whom the TDO is not executed for any reason, whether or not an ECO was issued or in effect. These reports are sent to a DBHDS Quality Oversight team that includes the DBHDS Medical Director, the Assistant Commissioner for Behavioral Health, the Director of Community Behavioral Health Services, the Director of Mental Health Services, and the MH Crisis Specialist. Each report contains the CSB's description of the incident and the CSB's proposed actions to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality Oversight team examines the report for completeness and comprehensiveness, and responds immediately to the CSB Executive Director if any further information is needed. In addition, DBHDS specifies additional necessary follow up actions, and requests appropriate follow up communication from the CSB. DBHDS maintains an open incident file until the incident has resolved and all follow up actions are completed.

There were four such events during the month of May 2015. Two of these cases involved individuals who were in emergency custody when evaluated, and two cases involved individuals who were not under an ECO. Of the four cases, two individuals eloped from the evaluation site before the TDO was executed. Two of the four individuals were eventually hospitalized, but the CSB was not able to establish any treatment relationship with the other two individuals after exhausting all options to do so. The four reported cases are summarized below.

DBHDS has followed up with the relevant CSB in each of these events to gather additional information and to give the CSB specific clinical and quality feedback about how each case was handled; what behaviors or procedures may have contributed to the event; what clinical, administrative or process issues need to be addressed in developing solutions to the problems encountered; and what strategies might be implemented with partner entities. These case-specific DBHDS interventions are ongoing until resolved.

1. This individual was transported to a local hospital emergency department (ED) by rescue squad where law enforcement officers took custody of the individual under an ECO. The CSB evaluated the individual in the ED and found that the individual met the criteria for a TDO, but the individual's medical needs warranted a medical admission. Because of the possibility of temporary detention, the hospital staff was to notify the CSB for a follow up assessment prior to the individual's discharge from the medical unit. Although the CSB maintained contact with each shift at the hospital, the individual was reassessed by the psychiatrist employed by the hospital and discharged prior to CSB notification. When the CSB learned of the discharge, the CSB established contact with the individual's emergency contact to ascertain the individual's location and to provide information on how to access emergency and ongoing treatment services. The individual and family declined any further assistance from the CSB.

The DBHDS Quality Review team reviewed the event. The CSB followed up with the hospital administrators on the need for better collaboration and communication during events such as this. No further actions were suggested by the team.

2. This Individual was taken into emergency custody and transported by police to a hospital ED following a self-inflicted injury resulting in the need for surgery. Following the surgical procedure, the individual was deemed medically able to be admitted to a psychiatric facility by the surgeon. Local private hospitals declined the individual based on the recent surgery. After continuing to search for a willing facility, the evaluator turned to the state facility as a last resort. There was a 25 minute gap between the expiration of the ECO and the issuance of the TDO with no loss of custody for the individual.

   The DBHDS Quality Review Team reviewed the incident and the CSB initiated an investigation regarding the situational and medical factors involved in this event. The surgery and related medical needs resulted in significant resistance from physicians involved (i.e., the admitting physician at the psychiatric hospital, the ED physician, and the surgeon) to talk to each other.

   The CSB followed the Regional Admission Protocol but identified a delay in accessing the Administrator-On-Call (AOC) at the state facility. This issue has been addressed with facility staff. The state facility director and clinical director have provided their cell phone numbers to the CSBs in the region should issues arise in the future. The CSB also met with the regional vice president of the community hospital and an agreement was made to educate ED physicians on the ECO time constraints and the use of medical detention orders when individuals are in need of ongoing treatment.

   Note: As of July 1, 2015, new legislation has redefined the criteria for medical TDOs which may decrease the need for a TDO pending medical clearance and also help with consistent interpretation of the criteria for this type of TDO by magistrates across the Commonwealth.

3. The CSB was contacted to assess an individual who was admitted to an intensive care unit (ICU) in a community hospital for medical treatment. During the assessment, despite the evaluator and facility staff's attempts to encourage her to stay, the individual left the ICU and the hospital, got into her vehicle and drove away. The staff obtained a description of the vehicle and the license plate number. The evaluator requested law enforcement assistance and petitioned the magistrate for an ECO. Law enforcement officers located the individual at a local store and persuaded the individual to return to the hospital with law enforcement following in their vehicles. The assessment was completed and the individual was determined to meet the criteria for a TDO. A TDO was issued and executed without incident.

   The DBHDS Quality Oversight Team reviewed the report and the actions of the CSB following the incident which included the immediate notification to law enforcement, the gathering of the description of the vehicle and license plate number and obtaining an ECO for the individual. The

successful teamwork and community collaboration resulted in a positive outcome for this individual. The team recommended the CSB work with the hospital to examine their protocols on providing for patient safety once a determination is made to seek an evaluation for a TDO. No further recommendations were made by the Quality Oversight Team.

4. This adult was taken to a hospital ED by parents due to their concerns regarding the individual's symptoms related to a known psychiatric illness. The family was requesting medication administration and the emergency department physician was not comfortable with providing this medication in the ED. The CSB was contacted to assess the individual, and when the evaluator completed the evaluation, the supervisor was contacted because the parents did not want the individual to be hospitalized. The ES supervisor spoke via phone with the individual's mother regarding the safety of taking the individual home. During this conversation the mother left the ED abruptly for an unexplained reason. The ED physician then obtained an ECO, and the CSB evaluator attempted to contact the individual and family by phone multiple times throughout the night without success. Law enforcement was unable to locate the individual prior to the ECO expiring. Contact was made with the individual's mother approximately 16 hours after they left the ED. She reported the individual was doing well and the individual's private psychiatrist had arranged an appointment for her son on this date. The family stated they were not interested in receiving any services from the CSB and planned to continue with the private psychiatrist. The family was given the CSB emergency phone number should the need arise in the future.

   The DBHDS Quality Oversight Team reviewed the event and followed up with the CSB to gather additional facts regarding the event. The evaluator initially believed the individual could be maintained in the community with a safety plan in place. However, when the individual left the ED with family, the evaluator no longer believed a safety plan to be the best option for this individual. The family left the premises before security or the evaluator was able to obtain a license plate number or description of the vehicle. The CSB emergency director subsequently met with the facility director and hospital security regarding this situation and noted that the facility disregarded its own policy and procedure regarding individuals seeking mental health services.

   All of these incidents were reported to DBHDS in accordance with the established protocol within 24 hours. As described above, in response to these cases, DBHDS and CSBs initiated targeted interventions with the individuals involved, and remedial efforts with service delivery partners to mitigate risks and improve processes and care coordination. DBHDS is monitoring these cases and actively working with regions and CSBs to identify and address factors contributing to the problems described in this TDO exceptions report.