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 tenth 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 April 2015. For the current report month, April 2015, there were an average of 1,703 emergency contacts received by CSBs, 256 emergency evaluations completed and 70 TDOs issued and executed each day across the Commonwealth. These figures are a slight increase over the March counts of these events. 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 six such events in the April 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. Each report describes 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 actions taken by 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 six events reported in April, one involved an individual who was in emergency custody when evaluated, and five involved individuals who were evaluated voluntarily (i.e., they were not under an ECO). Of the six events, three involved individuals who eloped from the evaluation site before the TDO was executed. In four cases, the individual was ultimately hospitalized, and one additional case concluded with the individual's referral to outpatient treatment. In the last case, all attempts by the CSB to establish an ongoing treatment relationship with the individual were unsuccessful. Additional detail on each of these cases can be found in Appendix D, page 21.

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

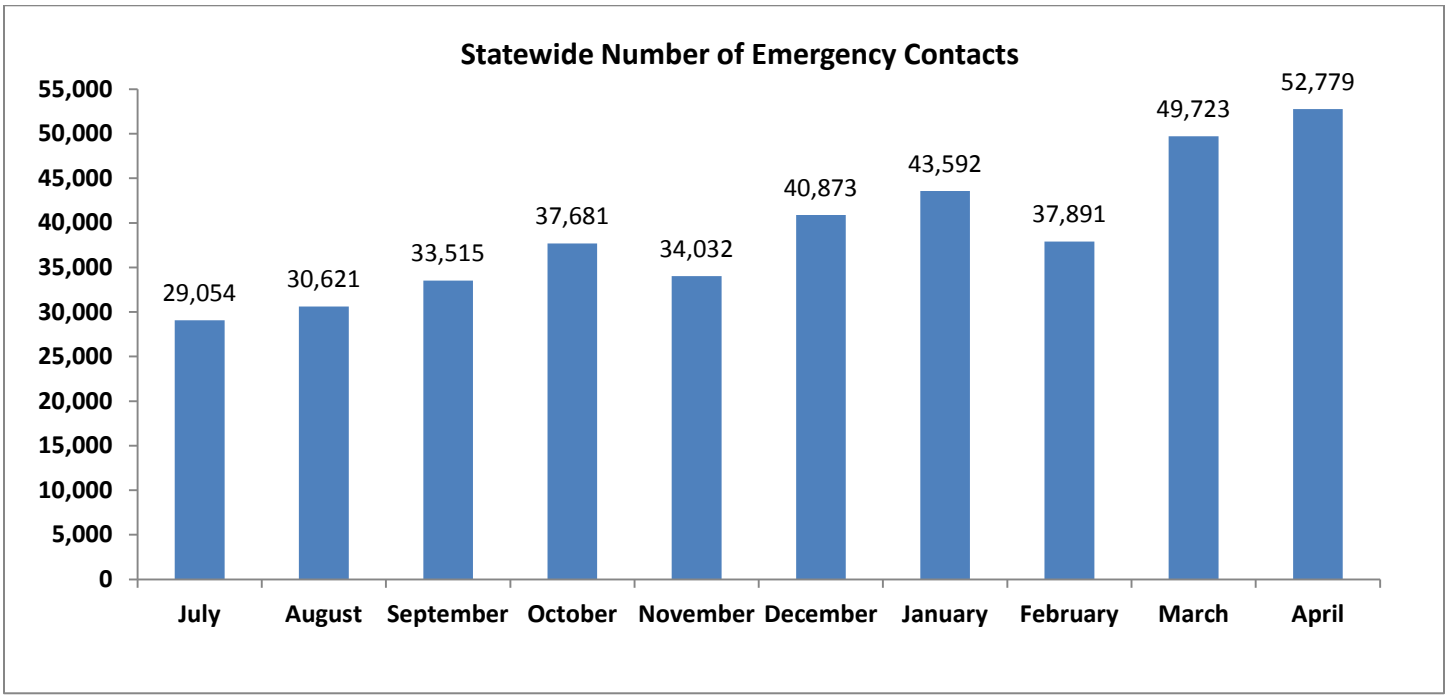
[2] There are 39 Community Services Boards and 1 Behavioral Health Authority in the Commonwealth, referred to in this report as CSBs. See Appendix B for a complete listing of CSBs within each of the seven regions.

[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

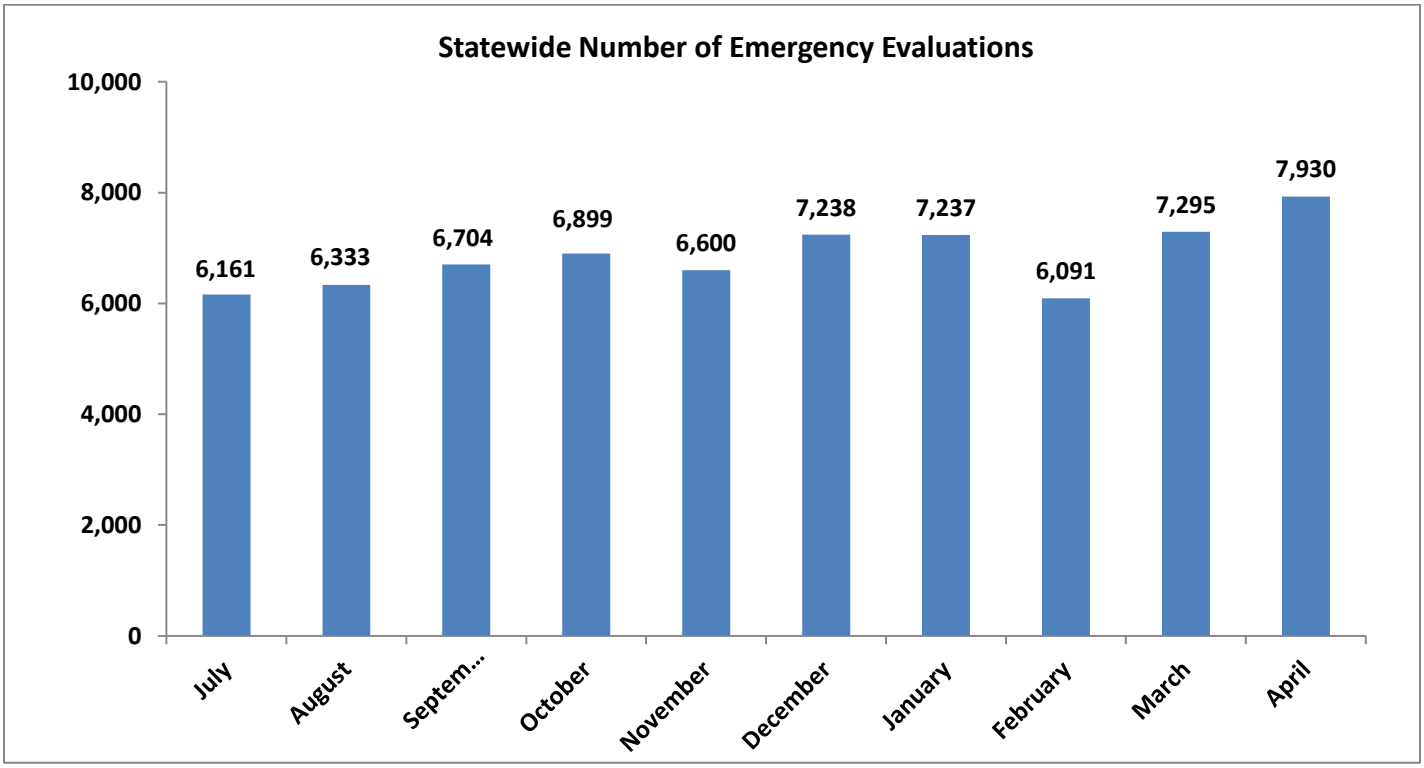
Emergency contacts are events requiring any type of CSB emergency service involvement or intervention. There were 52,779 emergency contacts reported statewide during the month of April, 2015, which is a 6% increase from March, 2015. With the exception of November and February, this continues a trend upward since July, 2014, as shown in Graph 1, below. Regional data is displayed in graph 1a and table 1 in Appendix C, page 11. Percent changes from March varied across regions with Region 2 increasing by 28% and Region 7 increasing by 11%. Region 6 decreased by 8% and the remaining regions were within a 5% variance from March figures. DBHDS initiated specific inquiries to all CSBs to better understand the causes of these fluctuations in their respective regions, but to date, no CSBs or regions have been able to identify any specific local events, agency actions or system changes that have directly influenced the volume of emergency contacts. As stated in previous reports, ongoing refinements in data gathering procedures at the local level combined with clarification of data definitions by DBHDS in November 2014 likely account for some of the variability in these numbers.



Graph 2. Emergency evaluations statewide

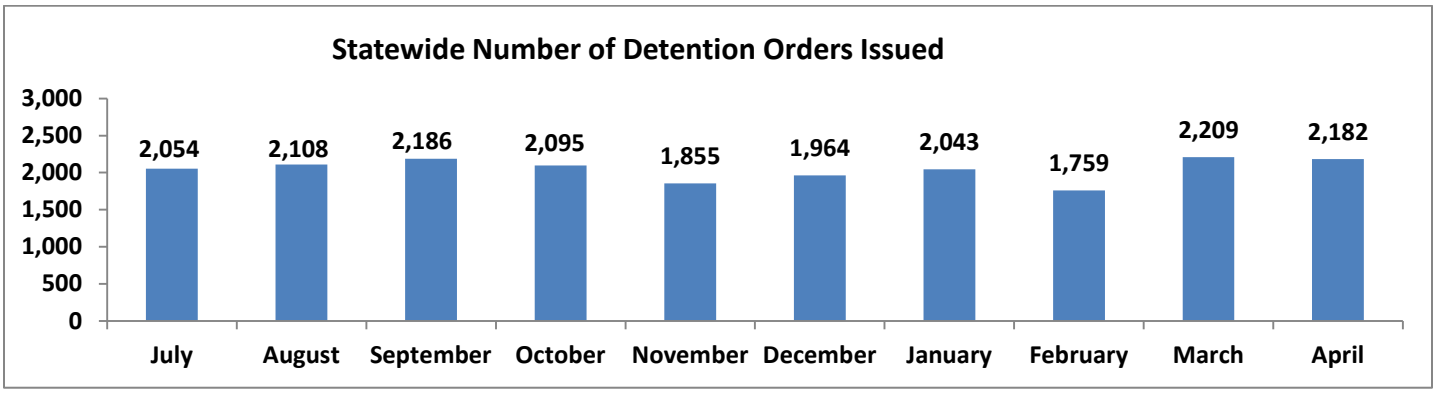
Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. The number of emergency evaluations reported statewide in April was 7,930, which is a 9% increase from March, and the highest month of the fiscal year to date. Again, Region 2 reported the greatest increase from March, 41%, and Region 7 reported an increase of 12%. However, the other regions reported differentials within 5% of the March figures. Regional data is displayed in graph 2a and table 2 in Appendix C, page 12. 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.



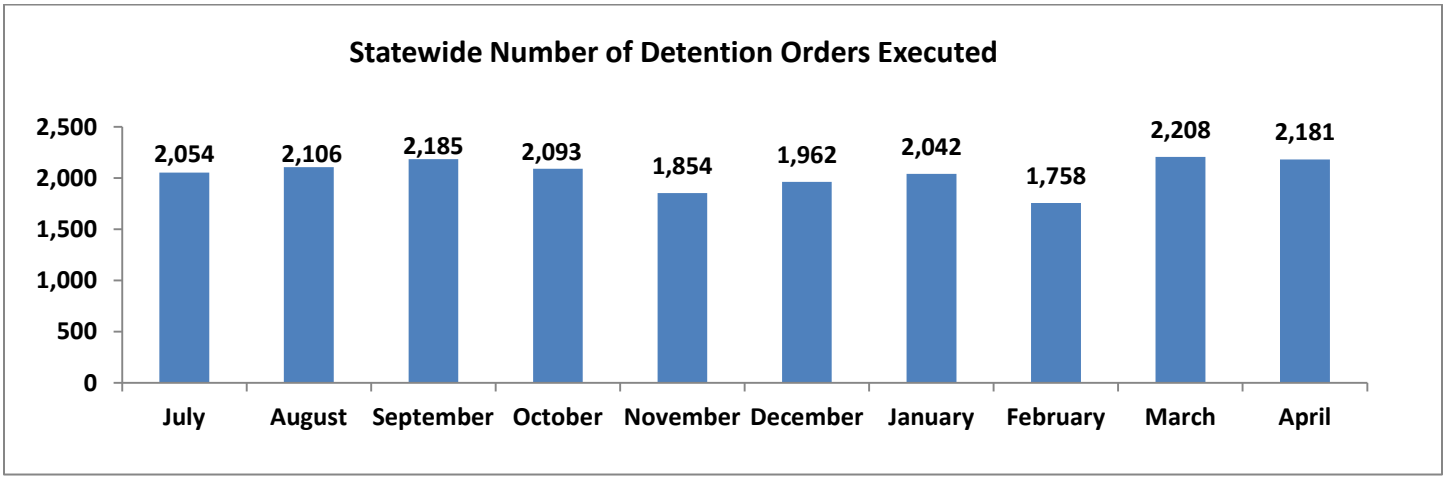
Graph 3. TDOs issued statewide

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 April, there were 2,182 TDOs issued (Graph 3), and 2,181 TDOs executed (Graph 4). Region 7 had the greatest percentage increase from March, 41%, followed by 10% for Region 2, and 7% for Region 1. The other regions all reported decreases in April. Graph 3a and table 3 (page 13) and graph 4a and table 4 (page 14), display this data reported by region in Appendix C. This is a decrease of 27 TDOs issued from March, 2015, representing a decrease of approximately 1% statewide. **About 72% of the emergency evaluations reported in March (5,748 of 7,930) did not result in a TDO.**



Graph 4. TDOs executed statewide

There was one temporary detention order issued but not executed in April. The individual was assessed while in an intensive care unit after being medically treated and was found to meet TDO criteria. The evaluator left the unit to complete the process of obtaining the TDO and the individual eloped. The TDO had already been issued when the individual eloped but it had not been executed. The CSB and local law enforcement pursued all available leads to locate the individual, but the individual was not located by the time the unexecuted TDO expired. The individual phoned the medical hospital to retrieve his identification several days after eloping, but the individual would not disclose his location and the CSB had no further contact with the individual. Additional detail is provided in Appendix D, page 20.

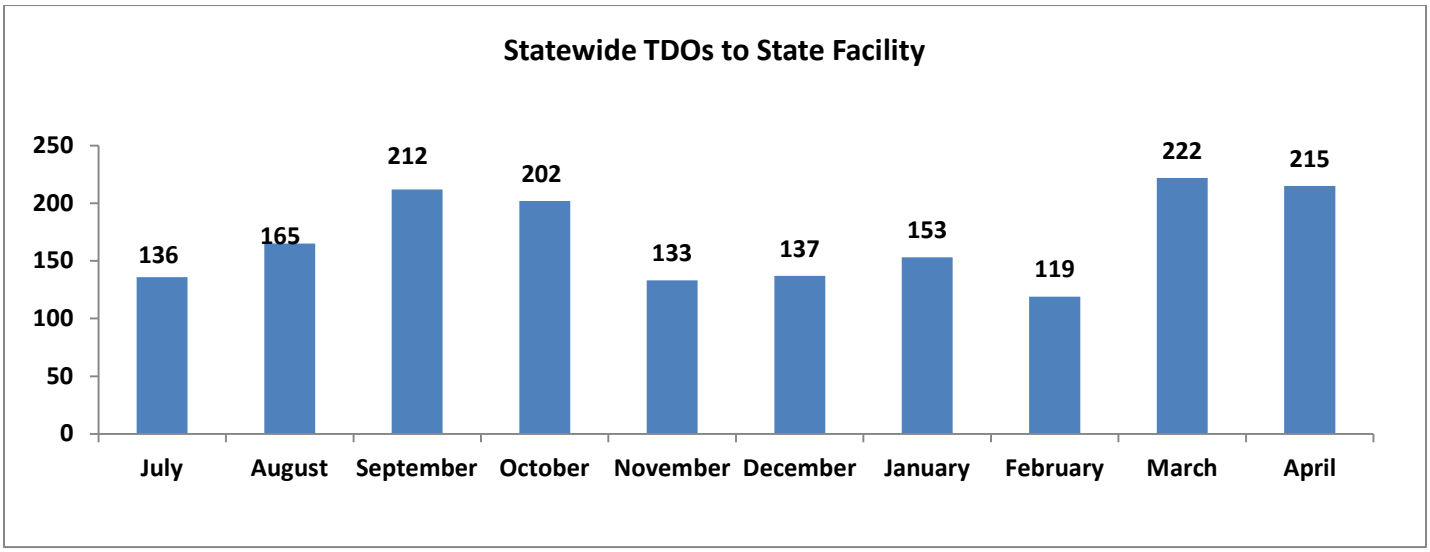


Graph 5. TDO admissions to a state hospital statewide

Of the 2,181 TDOs executed in April, 215 (<10%) resulted in admission to a state hospital [5] (Graph 5), representing a decrease of 3% from March. The largest fluctuations reported in April were in Regions 7 and 3 with increases from March of 50% and 21%, respectively. Regions 1 and 6 reported a 38% and 27% decrease, respectively, from March. 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 15. This variance reflects recognizable seasonal trends and each region's unique

[5] Source: DBHDS AVATAR admitting CSB data

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 hospitals, other alternatives to hospitalization, and more explicit utilization management protocols for state hospitals. DBHDS also closely monitors use of the Psychiatric Bed Registry.



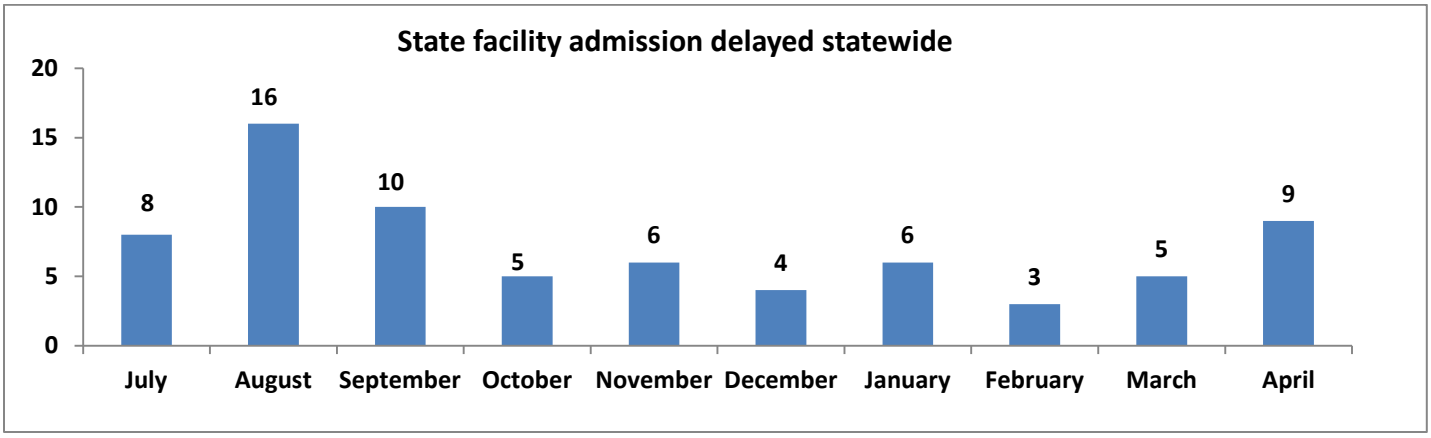
Graph 6. State hospital admission delayed statewide

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 April, there were nine 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 seven of these cases were due to the individuals' more immediate medical testing and treatment needs. One additional case was due to the individual's medically problematic blood alcohol content. The remaining case involved admission to a private hospital, under contract with DBHDS to provide overflow capacity, and the admission occurred after the ECO period expired. The nine cases in April represent an 80% increase in the number of delayed admissions from March (an increase from 5 to 9). Graph 6a and table 6 displays this data by region in Appendix C, page 16, and shows that regions 1, 3 and 7 did not report this type of occurrence in April.



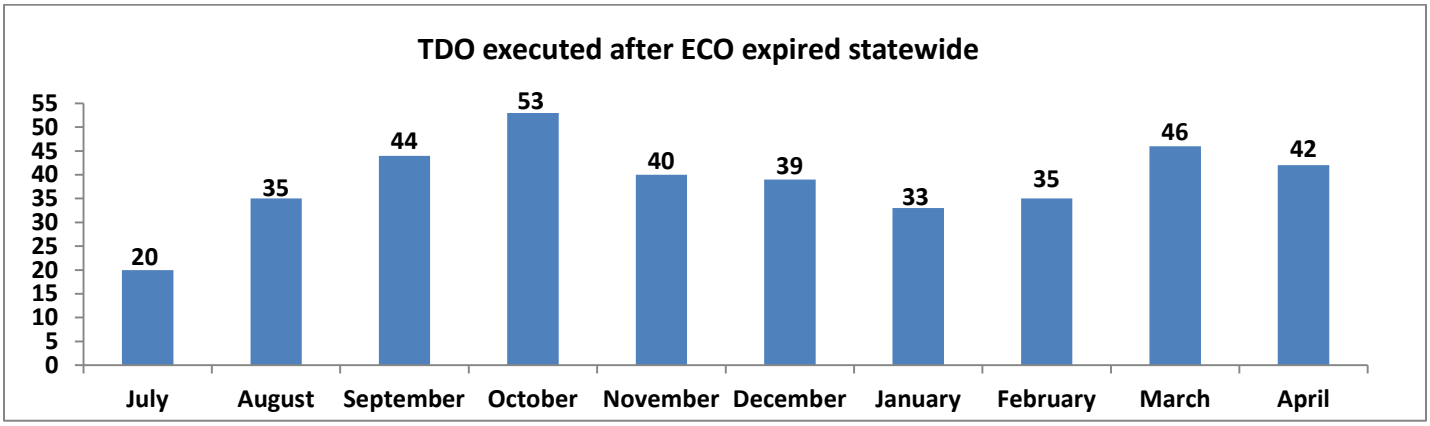
Graph 7. TDO executed after ECO expired statewide

In April, there were 42 (<2% of total) reported cases where a TDO was issued but not executed until after the ECO period had ended (Graph 7). This is a 9% decrease from March. The majority of these cases (23 of 42) involved waiting for law enforcement to execute TDOs that were issued prior to the expiration of the ECO time period. In eleven cases, law enforcement declined to execute the TDO until medical treatment was completed. Three cases involved individuals with medically problematic high blood alcohol counts. Two were due to complications with placement arising from the individual's age (i.e., individual was a minor or older adult). Two cases were attributed to delays in obtaining a bed for the individuals after determination that a TDO was warranted. One case involved malfunctioning videoconferencing equipment which required the evaluator to petition the magistrate for a TDO in person.

In 18 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 individuals were maintained safely within a medical unit of a hospital. All but one of these individuals were safely admitted to a psychiatric hospital without any loss of custody (one individual, reported above, eloped from the medical unit and law enforcement and the CSB was not able to engage the individual). Providers continue to use secure environments (such as locked emergency department or secure assessment sites) as well as law enforcement officers, to maintain custody.

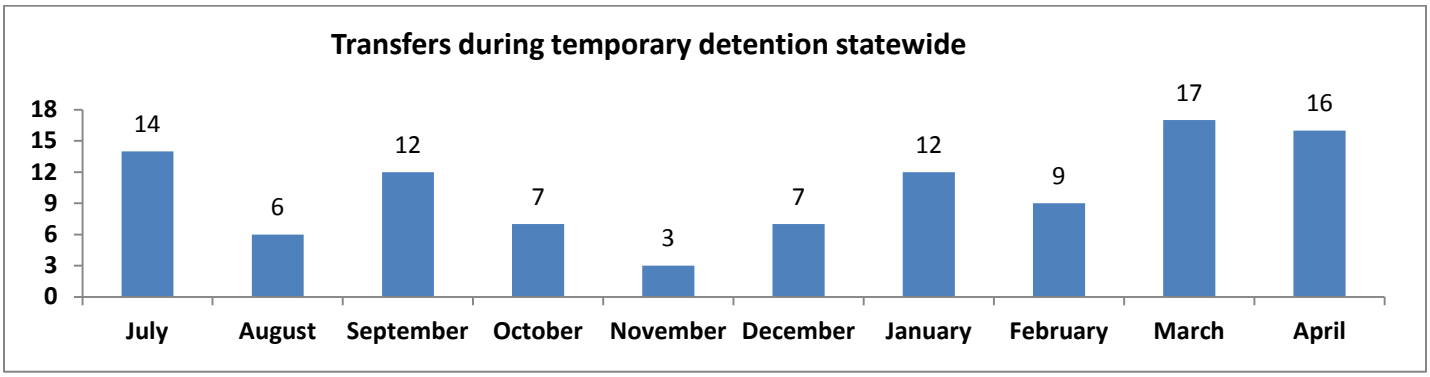
Graph 7a and table 7 display this data by region in Appendix C, page 17. Regionally, frequency of these cases is highly variable, but all regions had decreases except for Region 5 which reported a 233% increase from March (an increase from 3 to 10) Regions 1 and 4 did not report any of these events.

Region 7 continues to have substantially greater numbers of these cases than any other region, and has had more of these events than all other regions combined since December. This region reported 163 TDOs issued and executed during April, 2015, with 22 (13%) executed after the ECO period expired. The time delay between issuance and execution of TDOs ranged from 45 minutes to 10 hours with a mean of 3 hours and 53 minutes and a median of 3 hours and 5 minutes. Nine of these cases involved individuals in custody waiting more than five hours before the TDO was executed. The DBHDS Quality Oversight Team has maintained a continuous active focus on this region. Efforts to date have targeted the Carillion Emergency and Police Departments, the Roanoke City Sheriff and Magistrate, and Catawba Hospital. A new procedure to transmit TDOs electronically from the magistrate to the Carillion Emergency Department and Carillion Police was reportedly implemented in June, 2015. In addition, Blue Ridge Behavioral Health Authority (BRBHA) has initiated an in depth comparative study to understand the specific differences between its own process and those of other CSBs and regions. The study results will enable BRBHA to identify more specific targeted areas of improvement. DBHDS and the local agencies are continuing to monitor and address these transactions intensively.



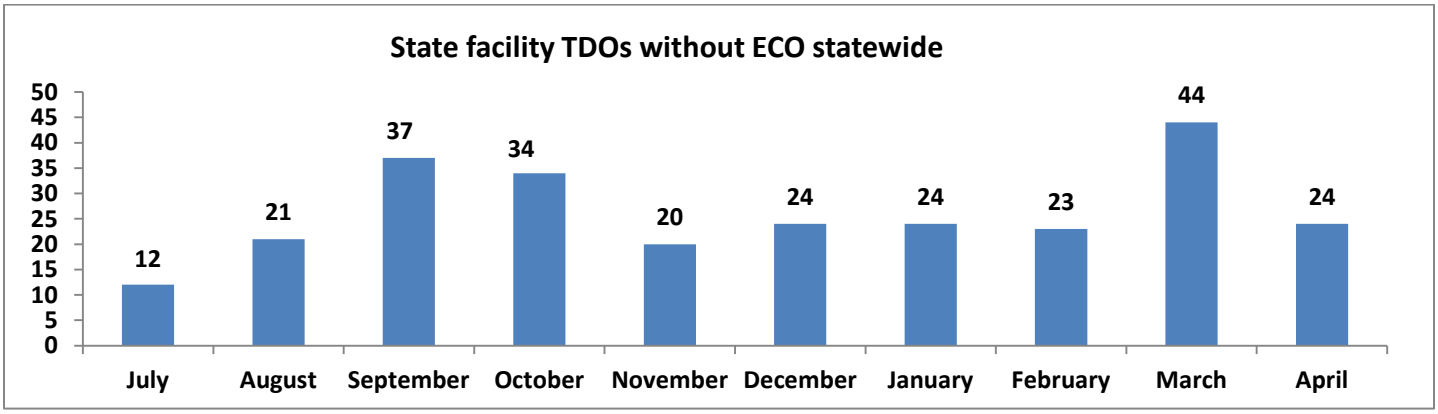
Graph 8. Transfers during temporary detention statewide

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 April (Graph 8). In fifteen cases, the transfer was from a state hospital. Fourteen of these were to a private psychiatric hospital and one was to a veteran's hospital. One transfer was from a private hospital to a state hospital that was better able to provide for the individual's needs. Graph 8a and table 8 displays this data by region in Appendix C, page 18. Region 3 did not report any of these transfers in April.



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 April, there were 24 such admissions to a state hospital, a significant decrease of 45% from March (Graph 9). A total of 264 contacts were made for an average of almost 11 alternate facilities contacted to secure these admissions. Six of the admissions were for specialized care due to the individual's age (either minor or adult aged 65 and older) while eleven others were due to lack of capacity of the alternate facilities contacted by the CSBs. Other reasons for these admissions were diagnosis of intellectual or developmental disability and medical needs beyond the capability of the alternate facilities contacted. 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 display these data by region in Appendix C, page 19. Region 7 did not report any TDOs to a state hospital for individuals not subject to an ECO in April 2015.



Discussion:

To enhance consistency and accuracy of CSB reporting, DBHDS has worked continuously since July 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 these data are consistently used by CSBs to identify trends and correct problems at the agency, regional, and statewide levels.

In addition to the above ongoing efforts, in FY 2016 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. Regional executive director forums will also review the reported data on a quarterly basis to examine trends and to review and strengthen regional 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

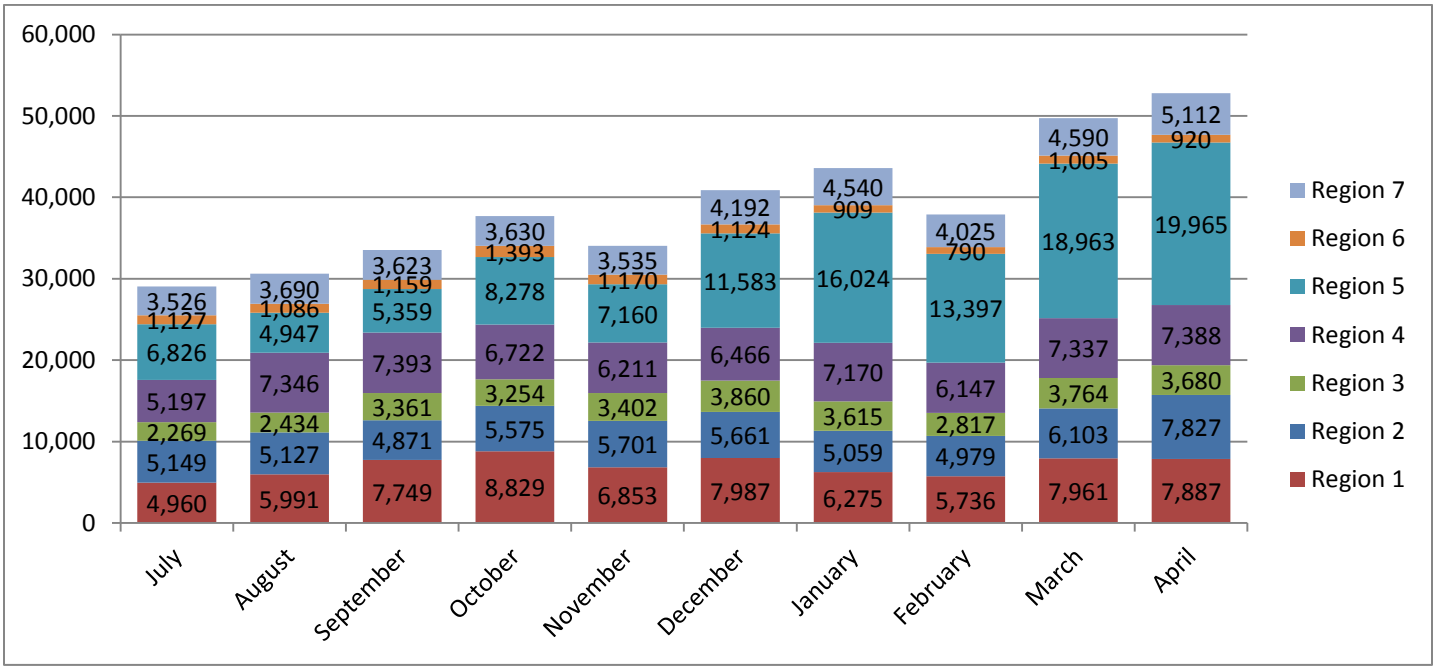


Table 1. Number of emergency contacts (corresponds with graph 1a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
Region 1	4,960	5,991	7,749	8,829	6,853	7,987	6,275	5,736	7,961	**7,887**	**70,228**
Region 2	5,149	5,127	4,871	5,575	5,701	5,661	5,059	4,979	6,103	**7,827**	**56,052**
Region 3	2,269	2,434	3,361	3,254	3,402	3,860	3,615	2,817	3,764	**3,680**	**32,456**
Region 4	5,197	7,346	7,393	6,722	6,211	6,466	7,170	6,147	7,337	**7,388**	**67,377**
Region 5	6,826	4,947	5,359	8,278	7,160	11,583	16,024	13,397	18,963	**19,965**	**112,503**
Region 6	1,127	1,086	1,159	1,393	1,170	1,124	909	790	1,005	**920**	**10,683**
Region 7	3,526	3,690	3,623	3,630	3,535	4,192	4,540	4,025	4,590	**5,112**	**40,463**
Total	**29,054**	**30,621**	**33,515**	**37,681**	**34,032**	**40,873**	**43,592**	**37,891**	**49,723**	**52,779**	**389,761**

Graph 2a. Emergency evaluations by region

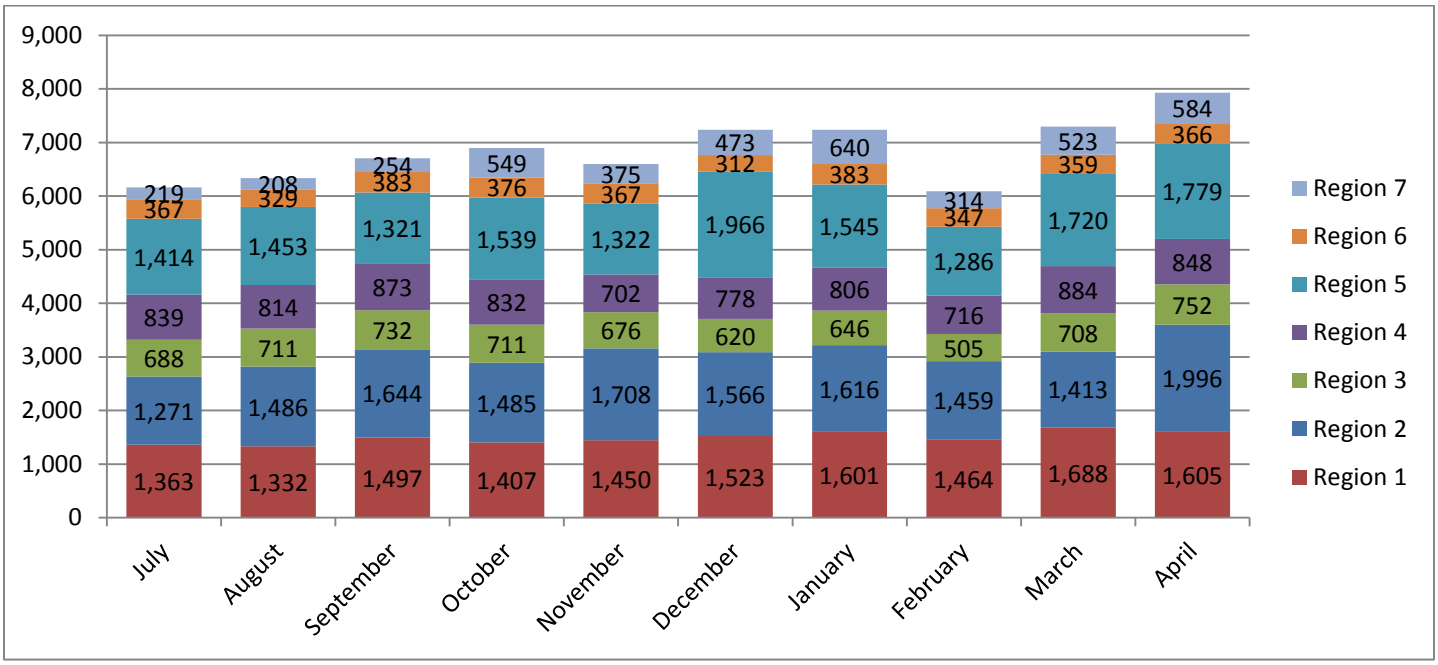


Table 2. Number of emergency evaluations (corresponds with graph 2a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
Region 1	1,363	1,332	1,497	1,407	1,450	1,523	1,601	1,464	1,688	**1,605**	**14,930**
Region 2	1,271	1,486	1,644	1,485	1,708	1,566	1,616	1,459	1,413	**1,996**	**15,644**
Region 3	688	711	732	711	676	620	646	505	708	**752**	**6,749**
Region 4	839	814	873	832	702	778	806	716	884	**848**	**8,092**
Region 5	1,414	1,453	1,321	1,539	1,322	1,966	1,545	1,286	1,720	**1,779**	**15,345**
Region 6	367	329	383	376	367	312	383	347	359	**366**	**3,589**
Region 7	219	208	254	549	375	473	640	314	523	**584**	**4,140**
Total	**6,161**	**6,333**	**6,704**	**6,899**	**6,600**	**7,238**	**7,237**	**6,091**	**7,295**	**7,930**	**68,488**

Graph 3a. TDOs issued by region

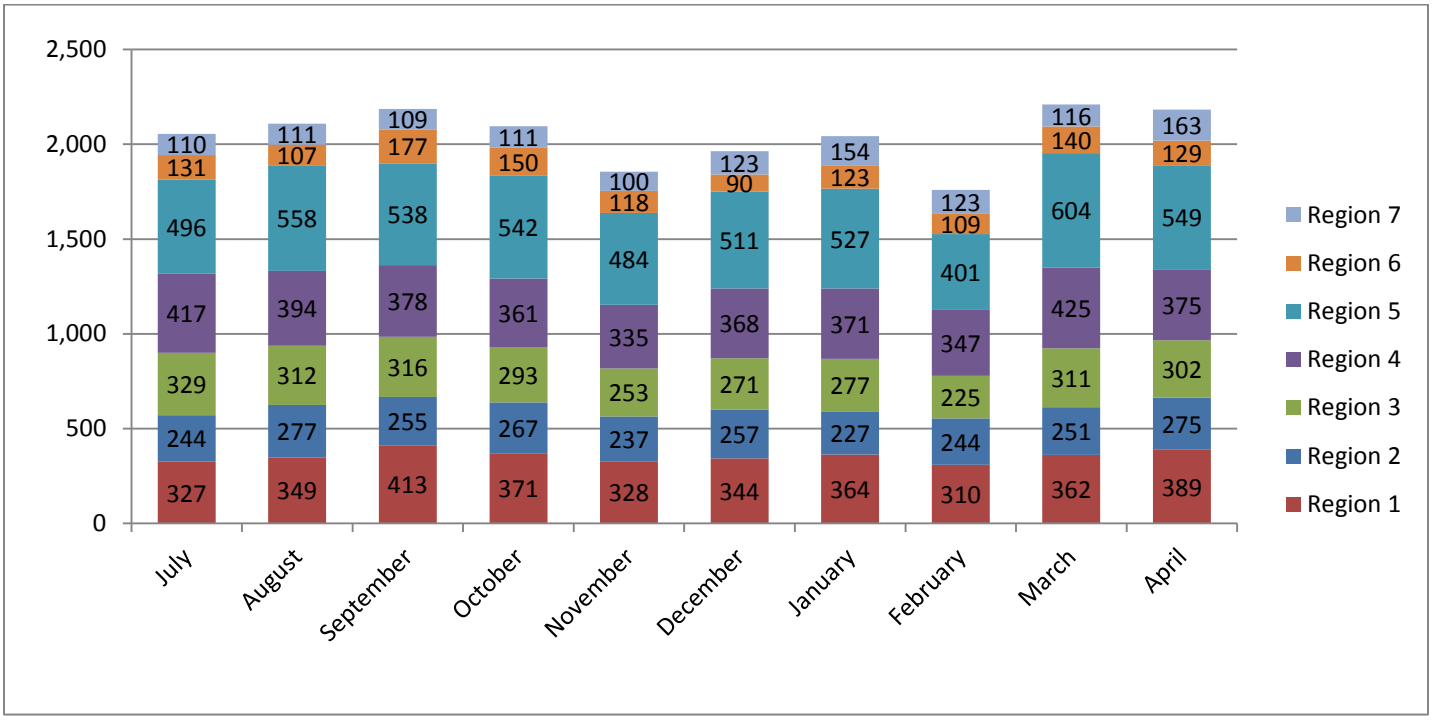


Table 3. Number of TDOs issued (corresponds with graph 3a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
Region 1	327	349	413	371	328	344	364	310	362	**389**	**3,557**
Region 2	244	277	255	267	237	257	227	244	251	**275**	**2,534**
Region 3	329	312	316	293	253	271	277	225	311	**302**	**2,889**
Region 4	417	394	378	361	335	368	371	347	425	**375**	**3,771**
Region 5	496	558	538	542	484	511	527	401	604	**549**	**5,210**
Region 6	131	107	177	150	118	90	123	109	140	**129**	**1,275**
Region 7	110	111	109	111	100	123	154	123	116	**163**	**1,220**
Total	**2,054**	**2,108**	**2,186**	**2,095**	**1,855**	**1,964**	**2,043**	**1,759**	**2,209**	**2,182**	**20,455**

Graph 4a. TDOs executed by region

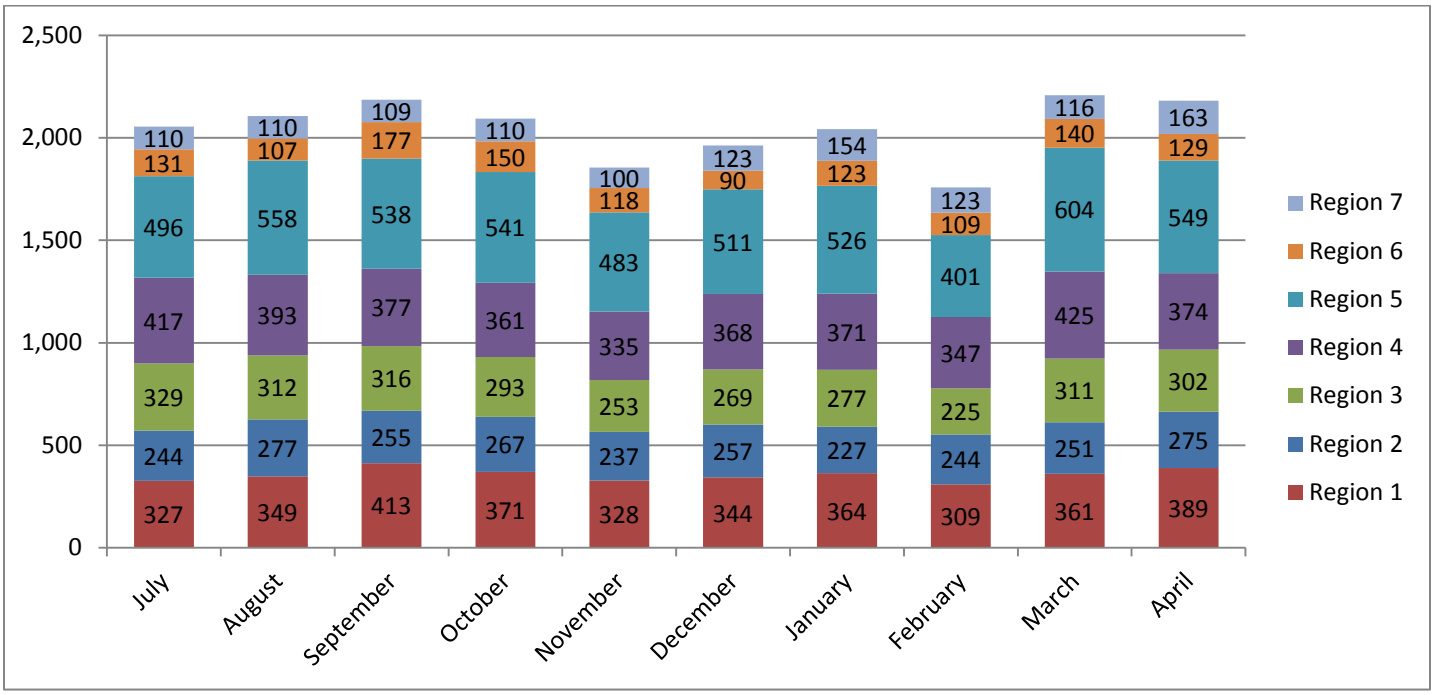


Table 4. Number of TDOs executed (corresponds with graph 4a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
Region 1	327	349	413	371	328	344	364	309	361	**389**	**3,555**
Region 2	244	277	255	267	237	257	227	244	251	**275**	**2,534**
Region 3	329	312	316	293	253	269	277	225	311	**302**	**2,887**
Region 4	417	393	377	361	335	368	371	347	425	**374**	**3,768**
Region 5	496	558	538	541	483	511	526	401	604	**549**	**5,207**
Region 6	131	107	177	150	118	90	123	109	140	**129**	**1,275**
Region 7	110	110	109	110	100	123	154	123	116	**163**	**1,218**
Total	**2,054**	**2,106**	**2,185**	**2,093**	**1,854**	**1,962**	**2,042**	**1,758**	**2,208**	**2,181**	**20,443**

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

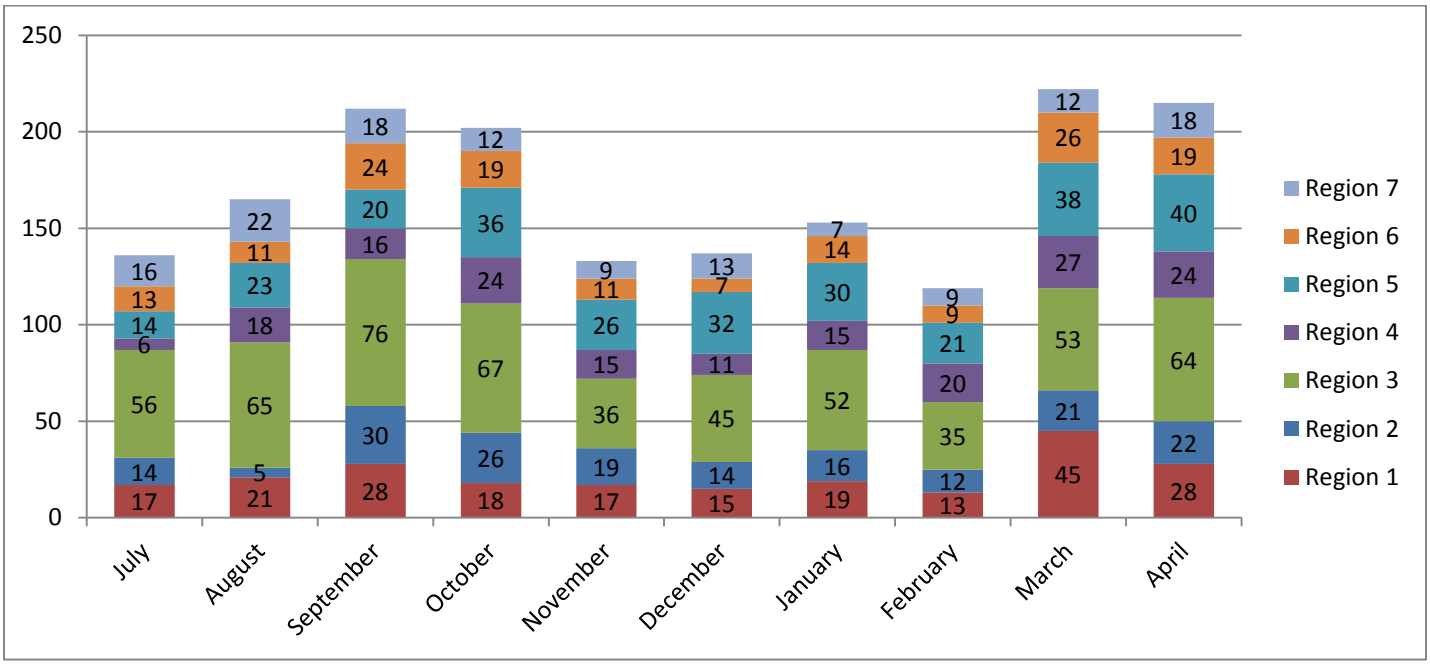


Table 5. TDO admissions to a state hospital (corresponds with graph 5a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
Region 1	17	21	28	18	17	15	19	13	45	28	221
Region 2	14	5	30	26	19	14	16	12	21	22	179
Region 3	56	65	76	67	36	45	52	35	53	64	549
Region 4	6	18	16	24	15	11	15	20	27	24	176
Region 5	14	23	20	36	26	32	30	21	38	40	280
Region 6	13	11	24	19	11	7	14	9	26	19	153
Region 7	16	22	18	12	9	13	7	9	12	18	136
Total	**136**	**165**	**212**	**202**	**133**	**137**	**153**	**119**	**222**	**215**	**1,694**

Graph 6a. State hospital admission delayed by region

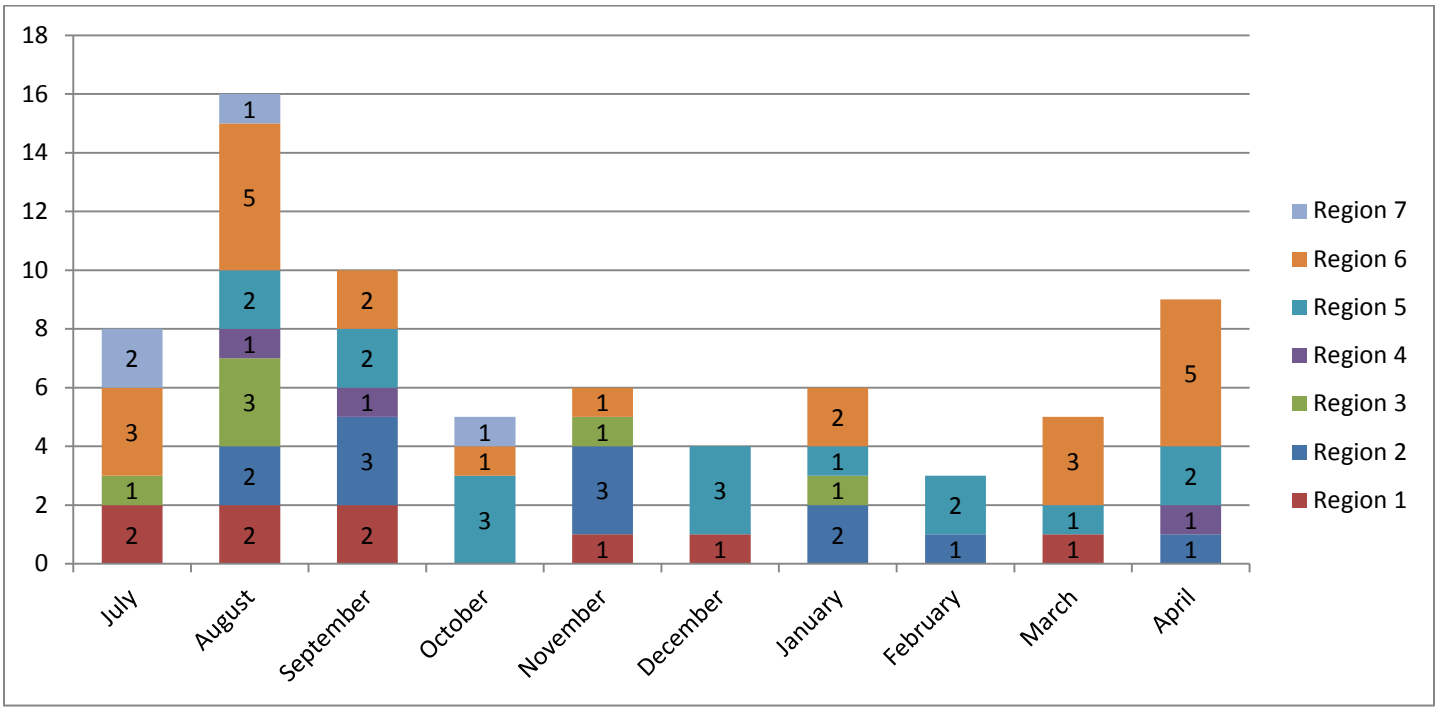


Table 6. State hospital admission delayed (corresponds with graph 6a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
Region 1	2	2	2	0	1	1	0	0	1	**0**	**9**
Region 2	0	2	3	0	3	0	2	1	0	**1**	**12**
Region 3	1	3	0	0	1	0	1	0	0	**0**	**6**
Region 4	0	1	1	0	0	0	0	0	0	**1**	**3**
Region 5	0	2	2	3	0	3	1	2	1	**2**	**16**
Region 6	3	5	2	1	1	0	2	0	3	**5**	**22**
Region 7	2	1	0	1	0	0	0	0	0	**0**	**4**
Total	**8**	**16**	10	**5**	**6**	**4**	**6**	**3**	**5**	**9**	**72**

Graph 7a. TDO executed after ECO expired by region

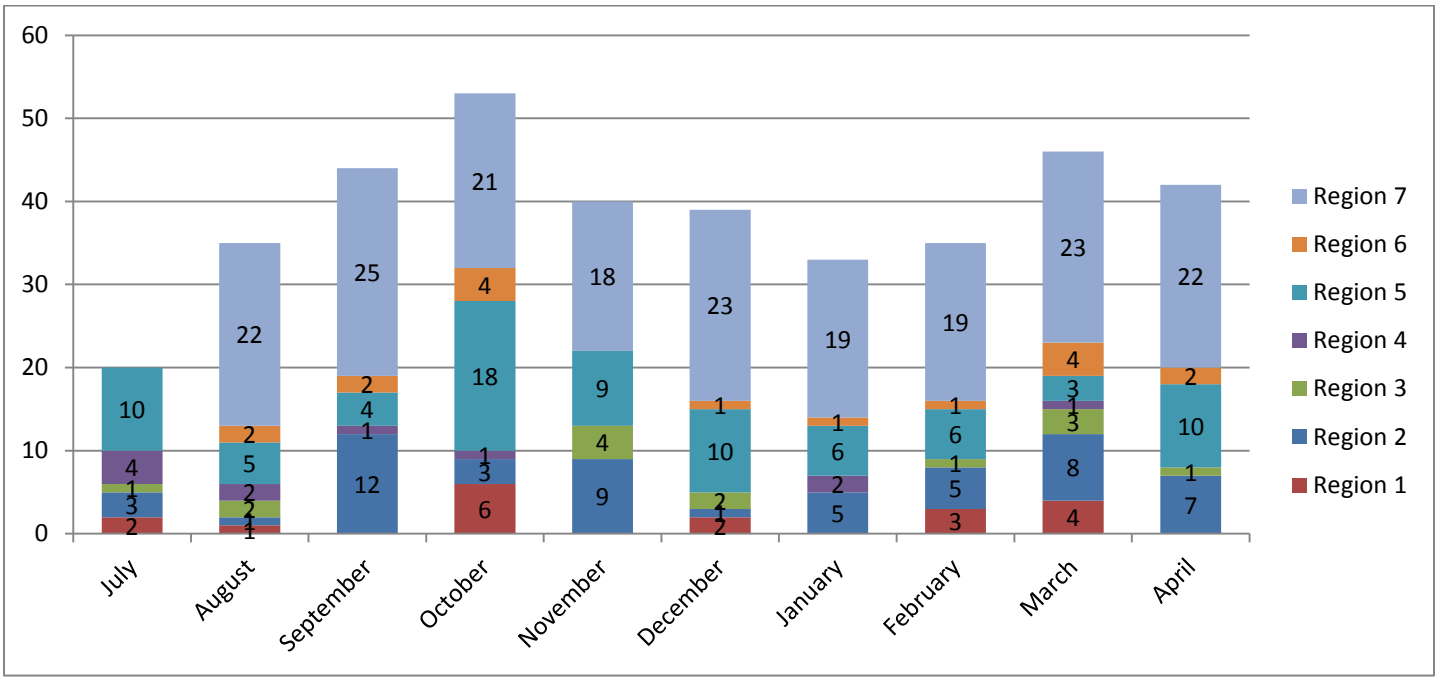


Table 7. TDO executed after ECO expired (corresponds with graph 7a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
Region 1	2	1	0	6	0	2	0	3	4	**0**	**18**
Region 2	3	1	12	3	9	1	5	5	8	**7**	**58**
Region 3	1	2	0	0	4	2	0	1	3	**1**	**14**
Region 4	4	2	1	1	0	0	2	0	1	**0**	**11**
Region 5	10	5	4	18	9	10	6	6	3	**10**	**81**
Region 6	0	2	2	4	0	1	1	1	4	**2**	**17**
Region 7	0	22	25	21	18	23	19	19	23	**22**	**192**
Total	**20**	**35**	44	**53**	**40**	**39**	**33**	**35**	**46**	**42**	**387**

Graph 8a. Transfers during temporary detention by region

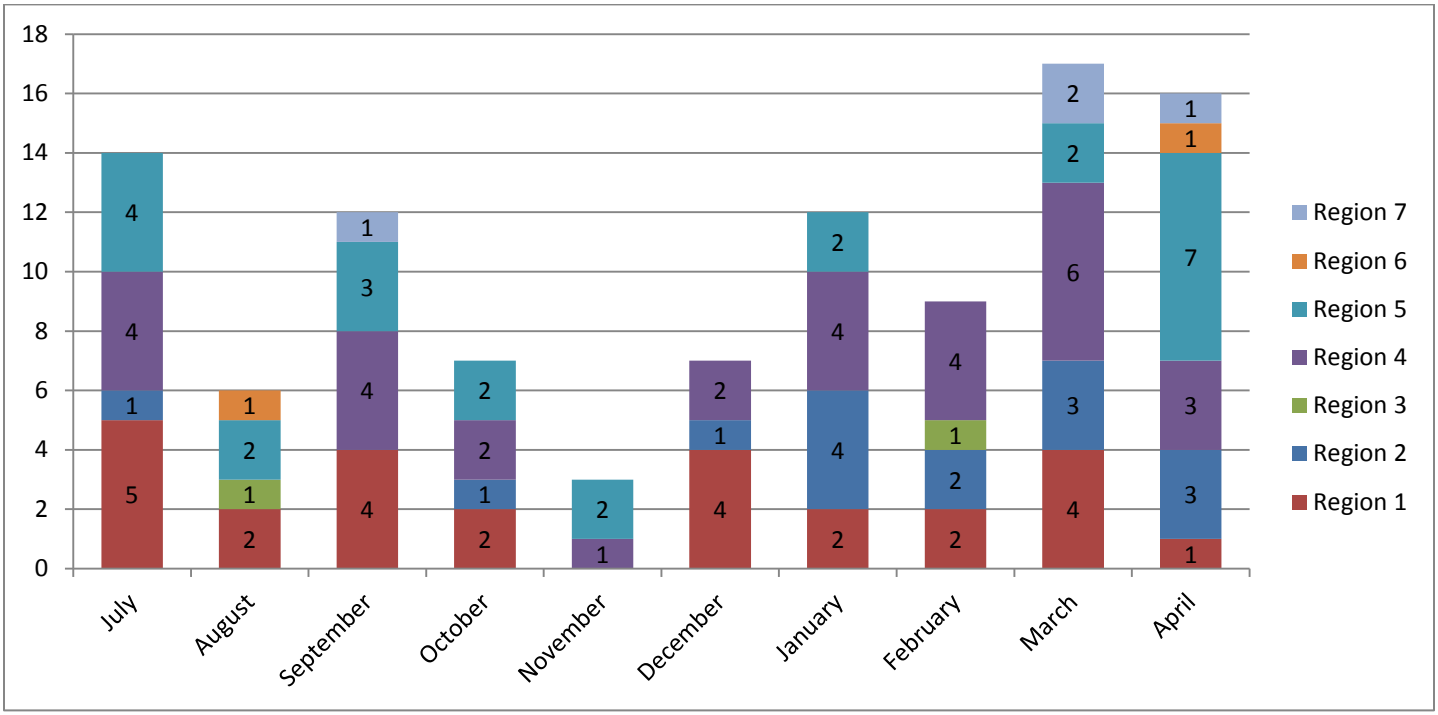


Table 8. Transfers during temporary detention (corresponds with graph 8a, pg 10)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
Region 1	5	2	4	2	0	4	2	2	4	1	26
Region 2	1	0	0	1	0	1	4	2	3	3	18
Region 3	0	1	0	0	0	0	0	1	0	0	2
Region 4	4	0	4	2	1	2	4	4	6	3	31
Region 5	4	2	3	2	2	0	2	0	2	7	24
Region 6	0	1	0	0	0	0	0	0	0	1	2
Region 7	0	0	1	0	0	0	0	0	2	1	4
Total	**14**	**6**	**12**	**7**	**3**	**7**	**12**	**9**	**17**	**16**	**103**

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

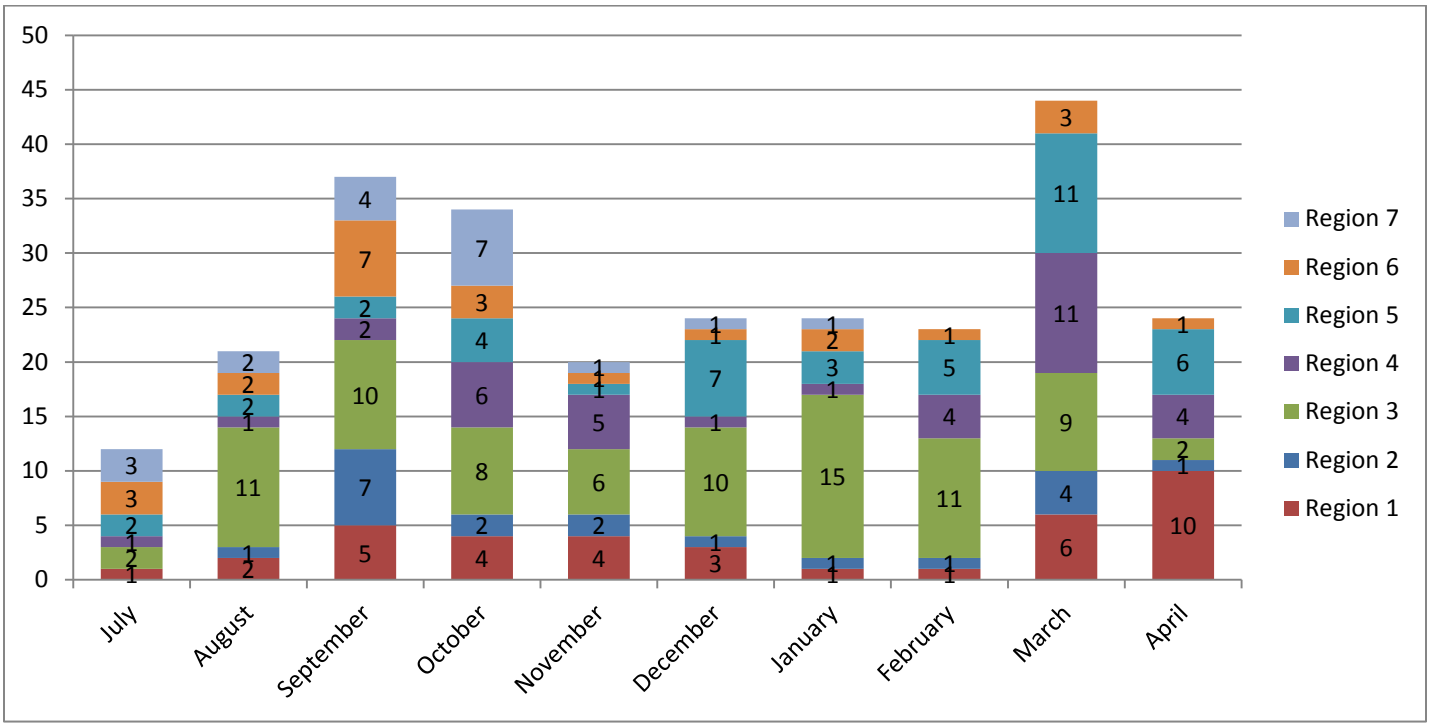


Table 9. State hospital TDOs without ECOs (corresponds with graph 9a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total
Region 1	1	2	5	4	4	3	1	1	6	10	36
Region 2	0	1	7	2	2	1	1	1	4	1	20
Region 3	2	11	10	8	6	10	15	11	9	2	84
Region 4	1	1	2	6	5	1	1	4	11	4	39
Region 5	2	2	2	4	1	7	3	5	11	6	43
Region 6	3	2	7	3	1	1	2	1	3	1	25
Region 7	3	2	4	7	1	1	1	0	0	0	18
Total	**12**	**21**	**37**	**34**	**20**	**24**	**24**	**23**	**44**	**24**	**263**

APPENDIX D

DBHDS requires CSBs to report within 24-hours any event involving an individual who has been determined to require 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 six such events during the month of April, 2015. One involved an individual in emergency custody while the other five were evaluated voluntarily (i.e., they were not under an ECO). Three of the six events involved individuals who were not under an ECO and eloped from the evaluation site prior to the execution of the TDO. Two of these cases ultimately resulted in the individual's hospitalization and in the other case the CSB was not was not able to establish any treatment relationship with the individual after exhausting all options to do so. The six 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 and administrative or process issues need to be addressed in developing solutions to the problems encountered, strategies to implement with partner entities, and etc. These case-driven DBHDS interventions are ongoing.

1. The individual was in ICU receiving medical treatment and was assessed after refusing voluntary psychiatric hospitalization, which had been recommended following his medical treatment. The individual was determined to meet TDO criteria and the TDO was issued by the magistrate. Prior to the TDO being executed the individual eloped from the ICU and the hospital did not attempt to intervene. The CSB initiated calls to the individual's emergency contact and was able to obtain a possible location of the individual. This information was provided to the police to attempt to take the individual into custody. The individual was never located but did phone the medical hospital seeking personal effects and reported being in a rehabilitation program in Northern Virginia. The individual declined to provide further information. The CSB provided their contact information to the individual's emergency contact person in case the individual was located.

   The DBHDS Quality Review Oversight Team reviewed this event and provided guidance to the CSB for working with the medical hospital to prevent such incidents in the future. The CSB met with the medical hospital staff and reviewed the case together. New procedures have been implemented by the CSB to seek an ECO immediately in any situation where the likelihood of elopement exists, rather than waiting for the TDO process to be completed. The hospital initiated its own internal review of the event and implemented changes to

improve the safety of the individuals in their hospital who are candidates for a TDO. This joint CSB-hospital effort was documented by the medical hospital in a written memorandum to the DBHDS Quality Oversight Team. DBHDS suggested the CSB share their process improvement effort with other hospitals and CSBs within their region as a proactive measure.

2. This individual was initially seen in an emergency department but eloped when the physician recommended a medical admission. The individual's family escorted the individual to a local psychiatric center for a walk in assessment. The staff at the hospital determined the individual had medical needs that outweighed the psychiatric needs and requested that the local law enforcement escort the individual to a local emergency department. The individual was not under an ECO during this time and officers left the individual at the emergency department. The CSB was contacted by the emergency department about three hours after the individual was brought in by police. The individual was assessed and it was determined that the individual met criteria for a TDO. The search for a bed began. During this time, the emergency room physician determined the individual needed to be medically admitted to the hospital for a serious medical concern. The individual was seen on three occasions while in the medical hospital by a staff psychiatrist who deemed the individual to longer be in need of inpatient psychiatric treatment as her condition had improved when her medical needs were treated. The individual was discharged back to her outpatient psychiatrist and to home health services.

   The DBHDS Quality Review Oversight Team reviewed the event and requested that the CSB inform DBHDS of the final disposition for the individual at the conclusion of medical treatment.

3. This individual was initially admitted to an intensive care unit (ICU) at a medical hospital. Four days after admission the CSB received a request for a preadmission screening to be completed. The assessment was conducted but prior to initiating a bed search the evaluator was informed the individual had medical concerns that would require continued treatment within the ICU. The evaluator spoke with the discharge planner at the hospital as well as the treating medical staff about the intent to obtain a TDO when the individual was able to be transferred safely to a psychiatric unit. The CSB maintained daily contact with the medical hospital with a plan of obtaining a TDO upon medical stability for transfer. The CSB was maintaining at least daily contact with the medical hospital to assist with discharge planning and to determine when the individual would be ready for re-assessment. Once the individual was determined to be medically stable for transfer to a psychiatric hospital, a TDO was issued and executed.

   DBHDS Quality Oversight Review Team reviewed this event and made no further recommendations.

4. The individual was sent from his private psychiatrist's office to a local emergency department for an emergency evaluation. The emergency room physician concurred with the CSB evaluator's recommendation for a TDO. The individual continued to decline treatment and left the ED, but was persuaded to return from the parking lot by a family member and the emergency evaluator. The ED staff declined to assist returning the individual to the ED or with ongoing supervision of the individual. While the evaluator was obtaining the TDO via videoconferencing with the magistrate, the individual left the ED the second time. The evaluator asked the ED to call 911 and they

declined to do so. The evaluator requested an ECO which was subsequently issued. The evaluator also made attempts to locate the individual and family member by searching the parking lot and phoning the contact number provided during the evaluation. The individual's location eventually was identified and the ECO was executed. The individual was subsequently detained to a hospital.

The DBHDS Quality Oversight team reviewed the report, requested that the CSB provide additional information and work with the private psychiatrist and the local ED to improve their communication and coordination processes. The CSB also reported that this ED does not believe it is its responsibility to provide for the safety of the individual while the CSB evaluator seeks a bed and petitions the magistrate for a TDO. The CSB offered to provide training and education to the emergency department staff but its offer has not been accepted. The CSB continues to work to enhance collaboration between the involved community partners and DBHDS has followed up with the hospital and ED to lend additional support for this collaboration.

5. This individual was initially seen in an outpatient CSB clinic for a possible voluntary admission to a residential crisis stabilization unit (CSU). The clinician completing the evaluation determined the individual required a higher level of care and recommended inpatient hospitalization. Initially the individual agreed to be admitted to an inpatient unit. The individual was transported to a local emergency department by a mental health worker to obtain the necessary medical evaluation prior to admission to a psychiatric unit. The individual requested that he not be admitted to a particular unit and an alternate placement was sought. Since the individual was willing to admit himself to the hospital, the mental health worker left the individual in the emergency department. After the departure of the mental health worker, the individual declined to cooperate with the admission. As a result, an emergency evaluation was requested. The evaluator made the determination that a TDO was warranted so the evaluator obtained a bed in a willing facility and petitioned the magistrate for a TDO. The TDO was issued and while the evaluator was preparing the paperwork, the individual eloped from the ED. A nurse followed the individual out of the ED and encouraged the individual to return. The CSB evaluator also attempted to locate the individual once the individual had left the ED. The individual was barefoot and clothed in a hospital gown, and after law enforcement was notified, the individual was located walking on a main thoroughfare. Law enforcement returned the individual to the ED and the law enforcement agency responsible for executing the TDO and transporting the individual took custody.

   The DBHDS Quality Oversight Team reviewed this event and found that, in this community, the law enforcement agency may prioritize other matters over executing a TDO. Additionally, local magistrates require the emergency evaluators to appear in person to petition for a TDO. As a result, the individuals who are not under ECO have varying levels of supervision while the evaluator seeks the TDO, and individuals for whom a TDO has been issued may wait for periods of time before the TDO is executed by law enforcement. The CSB has consulted with the local hospital and recommended the installation of a poly-communications system so that the emergency evaluators can remain at the evaluation site while petitioning for a TDO. DBHDS Quality Oversight Team recommended that the CSB, hospitals, law enforcement agencies, and magistrates continue their efforts to work together to enhance the safety and supervision of individuals under emergency evaluation.

6. This individual was evaluated in an inpatient detoxification unit following a magistrate issued ECO. The individual was determined to meet TDO criteria. The evaluator began a bed search and followed the regional admission protocols for seeking a bed for the individual. When no community hospital placement could be found, a state hospital was contacted for admission. The state hospital admission staff did not designate a physician to assess and accept the admission. Therefore, the CSB evaluator continued to seek bed space in a community hospital but was unsuccessful. The CSB evaluator contacted the state hospital for the second time, informed the admissions staff that the ECO was expiring, and notified the admission staff that the state hospital would need to serve as a last resort hospital. The admission staff did not provide an accepting physician's name until one hour and 25 minutes after the second call from the emergency evaluator. When the evaluator attempted to obtain the TDO from the magistrate, the magistrate was unsure if a TDO could be issued since the ECO had expired. Therefore, the magistrate contacted the chief magistrate for consultation which resulted in an additional delay. Ultimately, the TDO was issued and executed with no lapse of custody when the ECO expired.

   DBHDS Quality Oversight Team reviewed the event and followed up with the Director of the state hospital to confirm that delays in the admitting process were addressed and appropriate corrective action had been taken. The hospital Director and CSB Executive Director have also exchanged after hours contact information so that direct communication can occur as needed in the future.

   The Quality Oversight Team also reviewed the region's admission protocols and processes for ensuring individuals' medical needs are assessed and addressed during the emergency evaluation and bed location processes. The CSB provided additional training to their emergency evaluators on petitioning for a TDO pending medical clearance in cases where there may be medical conditions impacting the decision on whether the individual can be safely managed in a psychiatric hospital. The training emphasized the critical importance of the attending physician speaking directly with the physician at the accepting hospital. The CSB held a meeting with the staff of the hospital where the individual was prior to the ECO to discuss this event and to educate the staff on the procedures and outcomes for individuals needing involuntary treatment. The DBHDS Quality Oversight Team provided guidance and technical assistance to the CSB and the state hospital involved in this event.

   The CSB consulted with the Chief Magistrate regarding the issuance of a TDO after the expiration of the ECO. The Chief Magistrate agreed to provide additional education to the magistrates regarding this process.

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.