

This document is the second monthly report of data collected from community services boards (CSBs) and partnership planning regions for fiscal year 2016 (FY 2016). There are 39 Community Services Boards and one Behavioral Health Authority in the Commonwealth, referred to in this report as CSBs. The following sections contain the summaries and graphs of the monthly data reported to DBHDS through August, 2015.

Community Services Boards (CSB's) collect and report data on exceptional events associated with emergency custody orders (ECO's), temporary detention orders (TDO's), and involuntary admissions under the new statutes effective July 1, 2014, as well as the factors contributing to these events. The Department of Behavioral Health and Developmental Services (DBHDS) requires this data to be submitted monthly by each CSB and geographic region. DBHDS also requires case-specific reports from individual CSB's within 24-hours of 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.

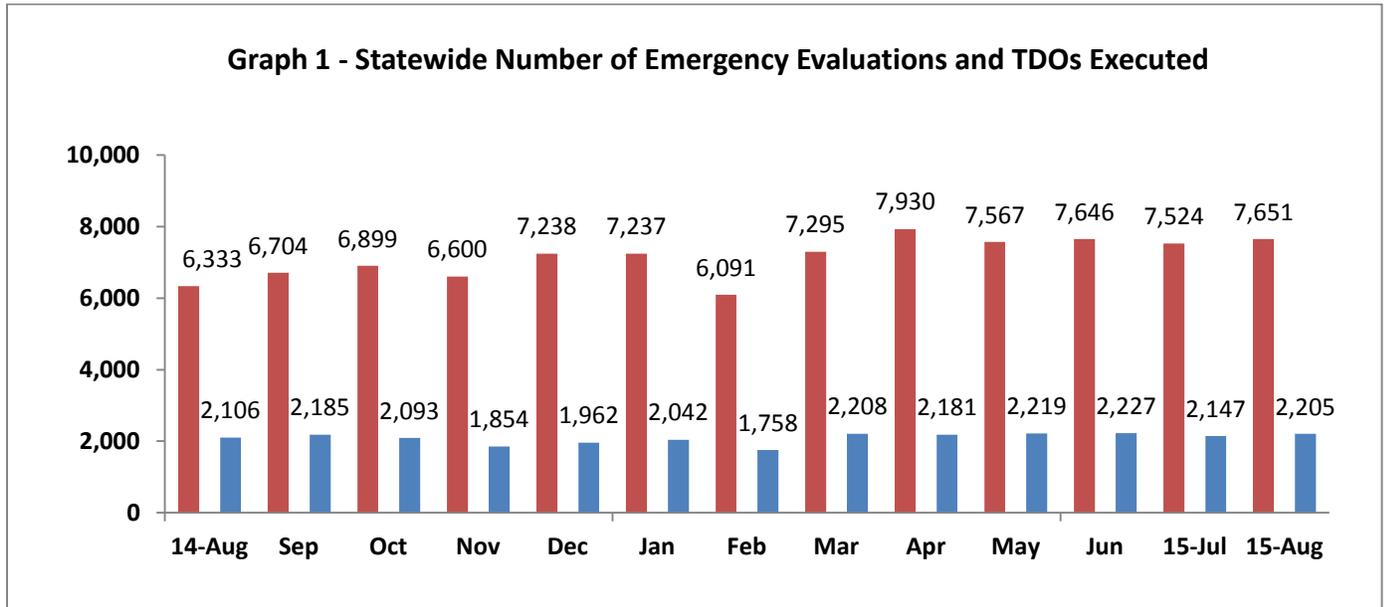
DBHDS has made formatting and content changes to the FY 16 report beginning in July 2015. The purpose of the formatting changes is to streamline the report and enhance the clarity, conciseness, and focus of the data presented. The report also no longer includes the number of emergency contacts state wide due to ongoing definitional challenges and variations in reporting. These variations are primarily a result of CSB emergency services receiving a combination of crisis and non-crisis calls which contribute to inconsistent reporting and skew the data. Finally, as a result of House Bill 1694 effective July 1, 2015 which eliminated the CSBs' responsibility for custody, the report no longer contains a section on execution of TDOs following the expiration of an ECO. Additionally, DBHDS learned that reporting on this element varied across the state and resulted in an inconsistent focus on certain CSBs. Any loss of custody or failure to receive inpatient treatment during after the expiration of the ECO will continue to be reported by the CSB within 24 hours and described in this report.

Previous reports are available on the Department of Behavioral Health and Developmental Services (DBHDS) website.

Graph 1. Emergency Evaluations and TDOs Executed

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 August was 7,651, which is a 2% increase from July, 2015 and reflects a stabilization in the number of evaluations conducted since April, 2015. 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 of the Code of Virginia. A TDO is executed when the individual is taken into custody by the law enforcement officer serving the order. In July, there were 2,205 executed TDOs, which is a 3% increase from July, 2015, which was the highest month reported in FY 2015.

About 71% of the emergency evaluations reported in July (5,446 of 7,651) did not result in a TDO. For the current report month, August 2015, there were an average of 247 emergency evaluations completed and 71 TDOs issued and executed each day across the Commonwealth. Compared to the July counts, these figures remained even. Graph 1 reports the numbers of evaluations and executed TDOs for August, 2015 and the preceding 12 months to show trends.



TDO Exception Reports

When certain high risk events occur during the evaluation and TDO process, CSBs report these incidents 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 eight such events in the August 2015 reporting period. Each of these events triggers submission of an incident report to the DBHDS Quality Team within 24 hours of the event. The Quality Team members are Daniel Herr, Assistant Commissioner of Behavioral Health, Stacy Gill, Director of Behavioral Health Services, and Mary Begor, Crisis Intervention Community Support Specialist. The reports describe the initial actions taken to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality 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. On a monthly basis, the Quality Team reports these events to the Behavioral Health Quality Review Committee which reviews follow-up actions for thoroughness and sufficiency, identifies, monitors, and analyzes trends, and oversees the implementation of continuous quality improvement measures.

The details of the eight reported events are described below.

1. This individual went to the hospital emergency department for medical attention following a self-reported suicide attempt. While in the emergency department, the individual became aggressive requiring the emergency department to physically restrain the individual with assistance of law enforcement. The CSB attempted to obtain a magistrate issued ECO based on a petition completed by an emergency department nurse. There were delays with the order being issued so law enforcement left the emergency department. The CSB completed an evaluation and determined a TDO was warranted. The individual left the emergency department and was being physically aggressive prior to departure. The magistrate agreed to issue the ECO. The order was executed by law enforcement and subsequently a TDO was issued and executed. The CSB met with hospital staff to review this event and to provide additional education on maintaining the safety of individuals deemed to meet criteria for a TDO.
2. Following a suicide attempt by an individual, the CSB assessed the individual and determined the criteria for a TDO was met. The TDO was requested to be issued pending medical clearance by the CSB. The order was issue but was not executed by law enforcement. The CSB inquired about the status and was informed by law enforcement that the order did not need to be executed since the individual was not medically clear for transport. The CSB attempted to get law enforcement to execute the order and remain with the individual to no avail. The sheriff's office reported they would not execute the order until the individual was medically cleared for transport stating that law enforcement has 24 hours to execute the TDO. Following the completion of medical treatment the individual was re-evaluated and another TDO was issued and executed. The CSB Executive Director met with the magistrates and local law enforcement to process this event and to cultivate a system of collaboration in the community to support individuals in need.
3. This individual initially presented voluntarily to the emergency department. The CSB was contacted to conduct an evaluation. When the evaluator left the room to obtain collateral information, the individual left the exam room and proceeded to exit the emergency department. The CSB attempted to obtain an ECO however the magistrate declined to issue the order stating the individual had presented voluntarily which gives the person the right to leave. The individual subsequently returned to the emergency department and the evaluation continued. The criteria for a TDO were determined to be met. When the CSB left the exam room to begin the paperwork and bed search, the individual left again. An ECO was issued but never executed. Multiple attempts were made to locate the individual through his family. The next day a family member called to report his whereabouts; however the magistrate declined to issue another ECO. Later on that day, a family member was able to petition for an ECO and it was issued. Law enforcement executed the order and a TDO was subsequently issued and executed. The CSB reviewed this event with the medical facility and discussed strategies for closely

supervising individuals being evaluated for a TDO but not subject to an ECO. The strategies included assigning a “sitter” to be with the individual.

4. An individual was assessed by one CSB and a TDO was issued and executed to residential crisis stabilization unit (CSU) operated by another CSB. Upon arrival at the CSU, the individual refused to exit the car and was physically removed from the car by law enforcement. Once inside the CSU, the individual became increasingly psychotic and his behaviors were unmanageable by the staff at the unit. Local law enforcement was called for assistance to protect the individual, the other residents and the staff. The initial CSB was contacted to locate an alternate facility due to the behavioral needs of this individual. A change of detention facility was issued by the magistrate and law enforcement arrived to transport of individual. During the transport the individual reported a need for a bathroom break. The individual eloped during the stop. Local law enforcement was notified, a warrant was issued and the individual was found several hours later and transported to the facility of detention..
5. This individual presented voluntarily and agreed to be evaluated by the CSB on the advice of the emergency department physician. The evaluation was completed and the individual agreed to seek voluntary admission to a facility. However, the individual left the emergency department against medical advice. The CSB notified law enforcement and provided a description of the individual. Law enforcement located the individual. The CSB requested an ECO be issued and it was executed. A TDO was sought and obtained. The order was executed without further incident. The CSB met with the local emergency department administration to review current policy and procedure for individuals presenting with behavioral health concerns to determine if additional steps can be taken to prevent individuals from leaving the facility.
6. This individual was under an ECO when evaluated by the CSB in an emergency department. After the evaluation was completed, a TDO was issued by the magistrate. Prior to the TDO being executed, the individual became medically unstable requiring a medical admission. The magistrate did not pass the TDO on to law enforcement for execution since the individual was medically admitted. The TDO expired without execution. CSB maintained contact with the medical facility and conducted a re-assessment of the individual when medically stable. A TDO was issued and executed to a psychiatric facility. The Quality Review views the medical treatment as an appropriate outcome for the individual.
7. This individual was assessed while under an ECO. The individual was determined to be highly intoxicated. After an evaluation, the CSB, determined the need for a TDO; however no bed could be found. The CSB followed the regional protocols and contacted the state facility. The state facility agreed to admit the individual but only after his the

level of intoxication was decreased. The CSB requested the TDO but the magistrate reported a need to research on whether the order could be written with a delay in admission to a psychiatric facility due to medical reasons. The magistrate wrote the order and when the CSB phoned the emergency department to inform the officer of the TDO, the CSB was informed the officer had left and returned the individual to the motel where the individual was initially taken into custody. The CSB notified law enforcement the individual needed to be taken into custody under the TDO. However, law enforcement declined to do so, stating they only had an order to transport not to detain. Multiple calls were made to the law enforcement agency to clarify the situation and the individual was eventually taken into custody and the TDO was executed. The Quality Review Team viewed the medical treatment prior to transport to a psychiatric hospital as a necessary and an appropriate step and also recognized the CSB's ongoing efforts to clarify the situation with the law enforcement officer

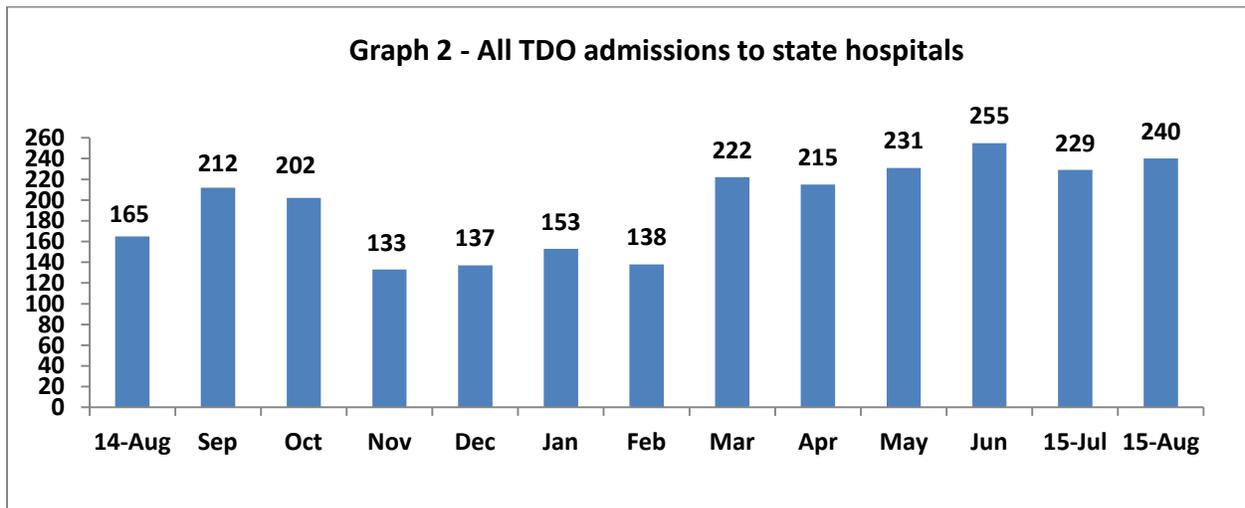
8. The individual was evaluated while held under an ECO and determined to meet TDO criteria by a CSB evaluator. The CSB began a bed search. However, the evaluator encountered multiple fax machines in the hospital not being in working order making it difficult to locate a willing facility. The evaluator made contact with 16 hospitals and with the regional state facility. The admissions person at the state facility declined to accept the admission claiming the individual's medical needs were not addressed adequately despite the CSB presenting updated lab work and reports to the facility and to the on call physician at the facility. The CSB contacted the magistrate who declined to issue the TDO without an identified facility of temporary detention and was unwilling to issue the order with a stipulation of pending medical clearance. The CSB also had difficulty accessing the magistrate due to problems with fax machines at the hospital. The CSB called the magistrate with the name of an accepting facility (a community hospital) and asked for the TDO to be issued but was informed by the magistrate that he did not have the paperwork. The CSB staff member again called the magistrate who was busy with other issues but stated the fax had arrived. The TDO was issued 11 minutes after ECO expired. No loss of custody occurred during this process. The CSB continues to research alternate methods of contacting facilities and the magistrate when there are technological challenges.

The DBHDS Quality Review Team reviewed each of these reports on the events as they were submitted. The team works with each CSB to ensure events are reviewed by the CSB and with community partners involved in the events to strengthen the safety of individuals determined to be in need of involuntary hospitalization. DBHDS provides technical assistance to CSBs on developing community partnerships with emergency departments and law enforcement. This includes analyzing each event in a community and adjusting practices to support individuals interacting with the involuntary commitment process in Virginia.

Graph 2: All TDO Admissions to State Hospitals

Under statutory provisions, 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, the state hospital shall admit the individual for temporary detention. CSBs are organized into seven Partnership Planning Regions to manage their utilization of state and local inpatient psychiatric beds. Each region has developed Admission Protocols outlining the process to be followed for accessing temporary detention facilities and for accessing the state hospital as a "last resort" facility for temporary detention.

State hospitals can be used as a temporary detention facility for individuals not in emergency custody and in need temporary detention, and the admission would not be considered a “last resort” admission. State hospitals can also be utilized for temporary detention if the hospital is determined to be the facility of choice based on the individual’s specific needs. Of the 2,205 TDOs executed in August, 240 (11%) resulted in admission to a state hospital. ^[1]



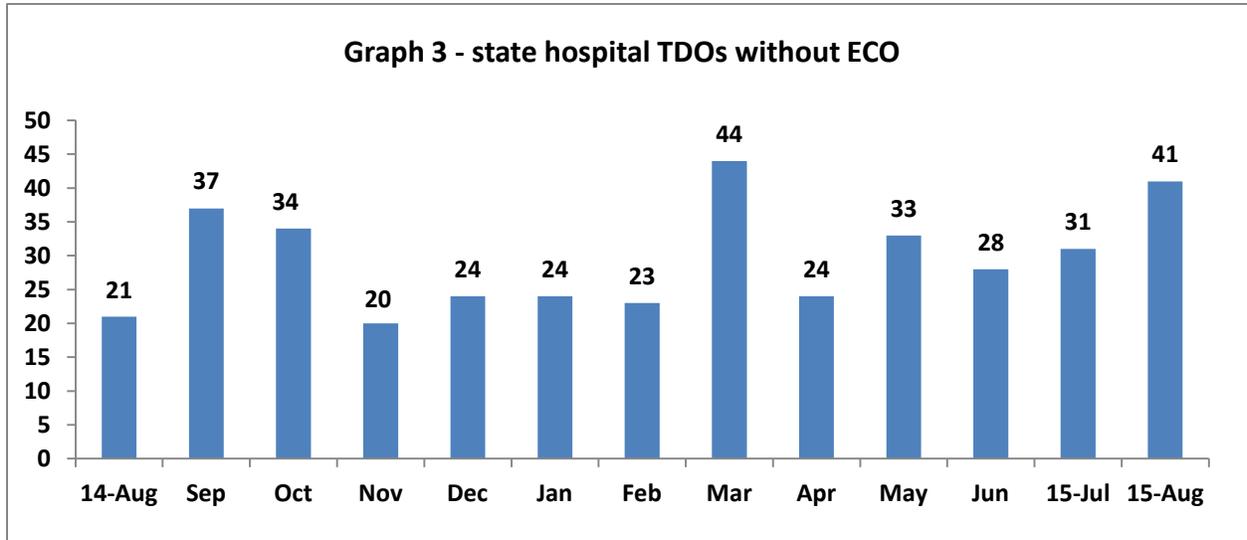
Graph 3. State hospital TDOs without ECOs

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 August, 2015 there were 41 such admissions to a state hospital, which is an increase of 75% from July, 2015 with a total of 49 contacts made for an average of 12 alternate facilities contacted to secure these admissions. Twenty one were due to a lack of capacity of the alternate facilities contacted by the CSB, and ten of the admissions were for specialized care due to the individual’s age (children and adolescents or adults aged 65 and older). Other reasons for

^[1] Source: DBHDS AVATAR admitting CSB data- Last Resort Data is collected by the CSBs and reported by the regions

Temporary Detention Order (TDO) Exception Report Summary
August 2015

these admissions were diagnosis of intellectual or developmental disability, medical needs beyond the capability of the alternate facilities contacted, and behavioral needs exceeding the capabilities of the alternate hospitals contacted.



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APPENDIX A

Partnership Planning Region	Community Services Board
1 Northwestern Virginia	Alleghany Highlands CSB Harrisonburg-Rockingham CSB Horizon Behavioral Health 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 Department of Mental Health, Substance Abuse and Developmental Services 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 Richmond Behavioral Health Authority
5 Eastern Virginia	Chesapeake Integrated Behavioral Healthcare 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 Region	Danville-Pittsylvania Community Services Piedmont Community Services Southside CSB

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7 Catawba Region	Blue Ridge Behavioral Healthcare
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