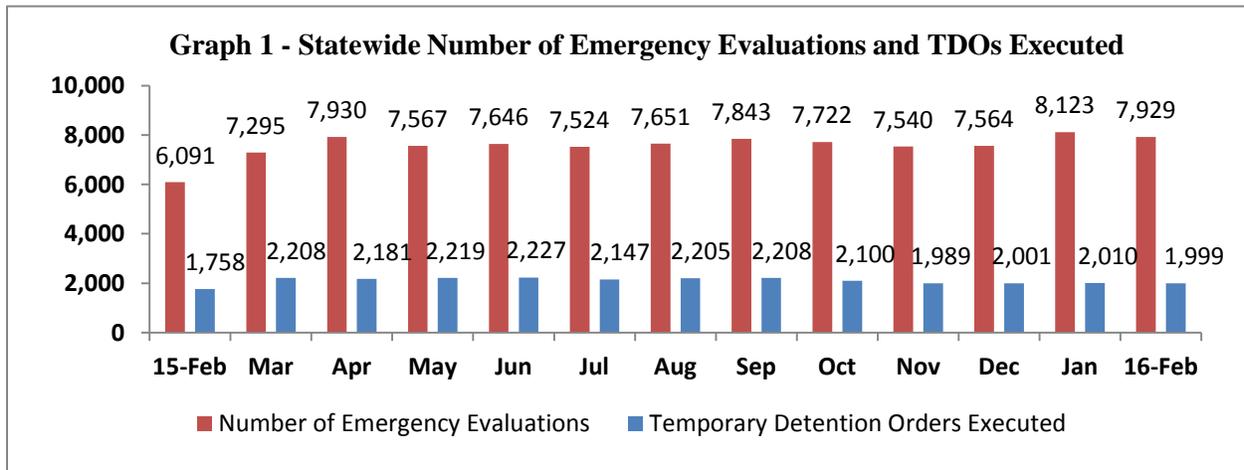


This document is the eight monthly report of data collected from community services boards (CSBs) and partnership planning regions for fiscal year 2016 (FY 2016). There are 39 CSBs and one behavioral health authority in Virginia, referred to in this report as CSBs. The following sections contain the summaries and graphs of the monthly data reported to the Department of Behavioral Health and Developmental Services (DBHDS) through February 2016.

CSBs collect and report data on exceptional events associated with emergency custody orders (ECOs), temporary detention orders (TDOs), and involuntary admissions under the revised statutes effective July 1, 2014, and the factors contributing to these events. DBHDS requires this data to be submitted monthly by each CSB. DBHDS also requires case-specific reports from individual CSBs 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. Previous reports are available on the Department of Behavioral Health and Developmental Services (DBHDS) website at <http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/data>.

Graph 1. Statewide 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 February 2016 was 7,929, a 2% decrease from January 2016. 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 February, there were 1,999 executed TDOs, a slight decrease from January 2016. **About 75% of the emergency evaluations reported in February (5,930 of 7,929) did not result in a TDO.** For the current report month, there were an average of 273 emergency evaluations completed and about 69 TDOs issued and executed each day across the state. Compared to the January counts, these figures were slightly higher. Graph 1 reports the numbers of evaluations and executed TDOs for February 2016 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 five events in February. Each event triggers submission of an incident report to members of the DBHDS Quality Team within 24 hours of the event. The members receiving the initial reports are Daniel Herr, Assistant Commissioner of Behavioral Health, Stacy Gill, Director of Behavioral Health Services, and Mary Begor, Crisis Intervention Community Support Specialist. The report is reviewed with particular attention on actions taken to resolve the event and what is done by the CSB to prevent such occurrences in the future. Additional information and follow up questions are asked of the CSB as needed. CSBs continue to update DBHDS until the situation is resolved and follow up is completed. On a monthly basis, the reported events are presented to the Behavioral Health Quality Review Committee which reviews follow-up actions, and identifies, monitors, and analyzes trends and oversees the implementation of continuous quality improvement measures. As a result of the event reviews, DBHDS implemented a change to the report form to include a separate section to indicate if the person had a confirmed or suspected intellectual or development disorder (IDD) and whether REACH, the crisis response system for individuals with IDD and their families, was contacted.

The details of each of the five reported events are described below.

1. This individual was seen at a local sheriff's office while under an ECO. The individual was determined to meet TDO criteria. A two-stop TDO was issued allowing for the individual to receive a medical screening and treatment if needed prior to the psychiatric admission. The officer transported the individual to an emergency department for the medical screening and reported turning the custody of the individual to the hospital security officer when it was determined the individual needed medical treatment. The

emergency department phoned the CSB to report the individual was ready for transport. The CSB notified law enforcement of the need for transport however, the medical hospital called the CSB approximately 10 hours later to inform them the individual was still awaiting transport. The CSB determined the TDO had expired several hours ago. When they sought to have the order reissued, the magistrate required a new preadmission screening be completed prior to issuing a new TDO. After the screening the order was issued and executed. There was no loss of custody in this event. DBHDS reviewed the event and recommended the CSB work with the magistrate's office to discuss this event as well as the Virginia code which allows a preadmission screening report to remain valid for three days.

2. This individual was evaluated at a local emergency department after voluntarily seeking help for command hallucinations urging him to harm self and others. The individual was evaluated and determined to meet criteria for a TDO however the individual was determined to have an abnormal lab value prompting medical concern. The physician obtained a medical TDO to continue to treat the individual. Prior to the expiration of the medical TDO, the CSB re-evaluated the individual and determined he continued to meet criteria for a TDO. The individual was determined to be medically stable for transfer to a psychiatric facility and a TDO was issued and executed with no loss of custody. DBHDS reviewed the event with no recommendations for the CSB as the medical treatment of the individual was essential and the process was not deemed problematic.
3. An ECO was issued by a magistrate on an individual based upon a sworn petition by a family member. The CSB was not informed when the ECO was executed. The first notification came approximately 7.5 hours into the ECO time period. Upon notification, the CSB evaluator agreed to meet the officer and the individual at a CSB Assessment site. The CSB evaluator noted there was no execution time on the ECO and the only time was the time of issuance. The evaluator believed the ECO was about to expire and proceeded to only assess for risk of suicide or homicide and determined the individual did not appear to be at risk. A full preadmission assessment was not completed. The officer then took the individual to the jail for appearing to be intoxicated. The CSB reported attempting to check on the individual in the jail with no success as the jail reported having no mental health staff available. DBHDS reviewed the event and responded to the CSB with the recommendation to work with law enforcement to ensure the CSB is contacted as soon as an ECO is executed and to have officers execute the order by noting the time on the order. The sheriff's department agreed to emphasize this with their officers. The CSB implemented a plan for this evaluator to participate in additional supervision with reviews of work by more experienced clinical staff. The CSB met with the jail administration to collaborate on providing for the safety of those incarcerated individuals.

4. A family member of an individual under the age of 18 contacted ES for assistance following a physical altercation with the family member reporting sitting on the minor for more than 40 minutes to restrain him. ES advised the father to contact local law enforcement for assistance so the individual could safely be evaluated by the CSB. The father continued to call other providers within the CSB and was given the same directive to contact law enforcement. ES called on behalf of the family for law enforcement to respond to the scene for assistance and to bring the individual to the assessment site. The individual was evaluated and determined to be in need of hospitalization. The family member expressed a preference for the individual be hospitalized at two facilities close to home however neither of the facilities was able to accept the individual at the time. The father was told this information and he proceeded to leave the premises with the minor remaining in the emergency department. The father was contacted by the prescriber to return to the ED to be with his son. The father returned and later left with his son stating he was angry about the pending TDO disposition. When the CSB attempted to obtain an ECO, the magistrate refused to issue citing the evaluation had been completed with a decision to pursue a TDO. Law enforcement declined to take custody of the individual while the CSB found a willing facility of detention. The CSB pursued a bed at the state facility and encountered some delays in response to the request for admission since the individual had not been under an ECO and the facility was nearing capacity. Following the facility's acceptance, a TDO was issued. Law enforcement attempted to execute the order at the individual's residence however the individual was not there but was located in another county. The county sheriff's office executed the TDO. DBHDS reviewed the event and reminded the CSB of the need to contact REACH for all individuals with a confirmed or suspected diagnosis of an intellectual or developmental disability. The CSB reviewed their practices and have made programmatic changes to ensure REACH is actively involved in the process when needed.

5. The individual was seen while under a law enforcement initiated ECO. The individual was a minor who would be turning 18 years of age the next day. The individual was aggressive and deemed to meet TDO criteria. All of the private hospitals contacted by the CSB were unwilling to accept the individual into their units. The CSB proceeded to contact the state child and adolescent hospital as well as the regional state hospital for adults. The CSB and state facilities contacted DBHDS central office for assistance. The CSB was reminded by Central Office of the need to involve REACH in all emergency evaluations for individuals with confirmed or suspected diagnoses of intellectual or development disorders. Central Office consulted with the state hospital facility directors involved and worked with them to develop a plan to provide the safety net this individual needed with minimal disruption of services. The state hospital for adults agreed to accept the individual and a TDO was issued and executed. No loss of custody occurred with this individual despite the TDO not being issued prior to the ECO expiring.

As a result of the DBHDS review of this event, the offices of behavioral health and developmental services worked collaboratively to design and implement a new reporting of events to DBHDS. The new reporting will be for events when the CSB is contacted on an individual with a confirmed or suspected ID/DD and whether the crisis response system (REACH) for individuals with ID/DD diagnosis participated in the crisis evaluation and disposition planning. The increased focus and awareness will inform DBHDS about areas of the system in need of technical assistance.

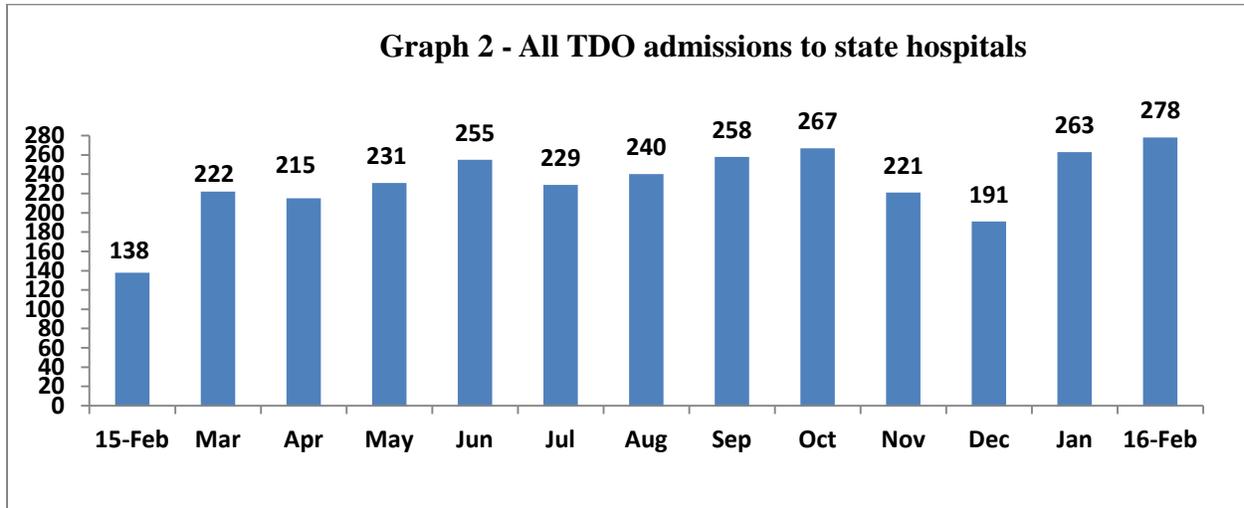
The DBHDS Quality Review Team reviewed each of these reports on the events as they were submitted. The team works with each CSB to ensure events are reviewed by the CSB and with community partners involved in the events to strengthen the safety of individuals determined to be in need of involuntary hospitalization. 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.

Graph 2 includes all TDO admissions to state hospitals including those where the facility was considered as a "last resort" and admissions where the hospital is facility of choice for the individuals. **Of the 1,999 TDOs executed in February, 278 (14%) resulted in admission to a state hospital.** ^[1]

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



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. In February, there were 31 admissions without ECOs to a state hospital, which is a decrease of 3% from January.

Individuals are admitted to a state hospital as a “last resort” with or without a preceding ECO due to a lack of capacity of the alternate facilities contacted by the CSB, specialized care due to the individual’s age (children and adolescents or adults aged 65 and older), diagnoses 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.

