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 seventh monthly report of data[1] collected to date from Community Services Boards (CSBs) and regions[2] for fiscal year 2015. The following sections contain the summaries and graphs of the monthly data reported to DBHDS through January 2015. Counts of events are presented for each month and for the state fiscal year (FY) 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 seven such events in the January 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 reports describe the incident and proposed actions to resolve the event and prevent such occurrences in the future. In each case, DBHDS Quality Oversight Team reviews the incident report and 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 seven events reported in January, two involved elopement from hospital emergency departments. Neither of these two individuals were under an ECO. Three other cases involved individuals with complicated medical needs. An additional case involved an individual whose family requested insisted that the individual remain nearby but no local bed could be found. In all of these cases a TDO was subsequently executed for the individuals. Additional detail on each of these cases can be found in Appendix D, page 21.

Graph 1. Emergency contacts statewide

Emergency contacts are events requiring any type of CSB emergency service involvement or intervention. There were 43,592 emergency contacts reported statewide during the month of January, 2015, which is a 6% increase from December2014 and continues a general trend upward since July, 2014. Graph 1, below,

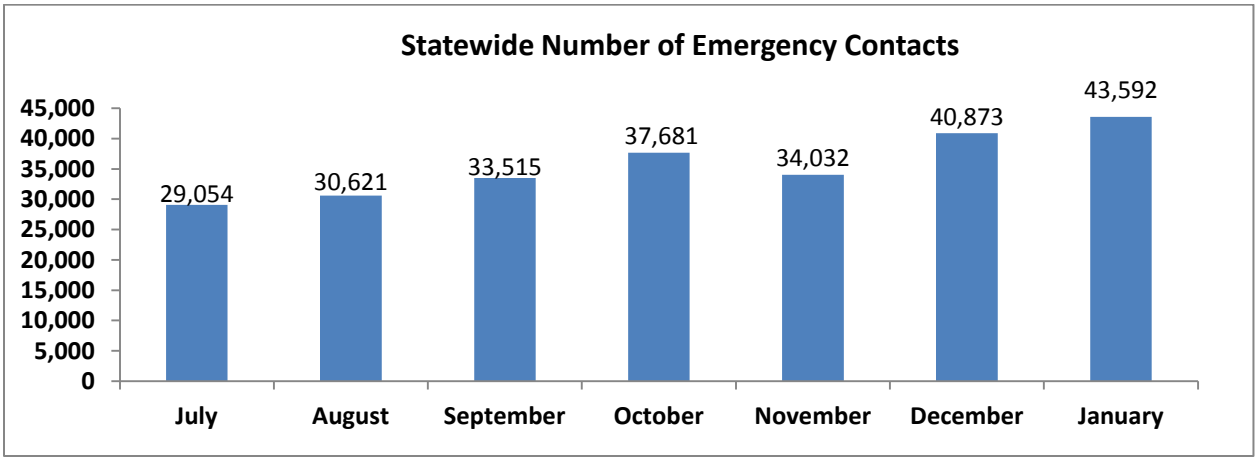
[1] See Appendix A for complete detailed listing of these definitions.

[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 Mental Health, and MH Crisis Specialist.

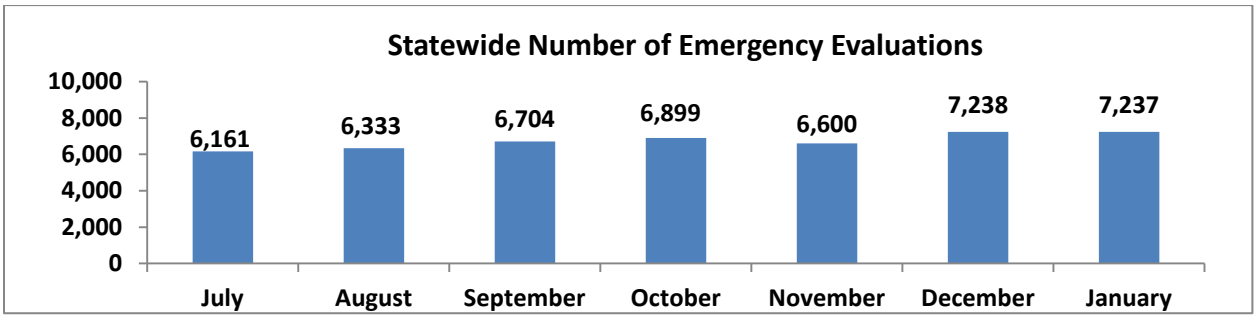
displays the statewide number of emergency contacts reported for July 2014 through January 2015. Regional data is displayed in graph 1a and table 1 in Appendix C, page 12. The largest reported increase in regional numbers from December to January was in Region 5 with a 38% increase in contacts followed by Region 4 (11% increase) and Region 7 (8% increase). However, the other four regions reported a collective 21% decrease in contacts. Region 1 had an 11% decrease, Region 2, an 11% decrease, Region 3, a 6% decrease and Region 6, a 19% decrease. To date, no CSBs or regions have been able to identify any specific local events, agency actions or system changes having a direct influence on the volume of crisis contacts. However, given the unusually significant increase in emergency contacts in Region 5 in January, as well as the significant decrease in the number of emergency evaluations in this region (described in the following section), DBHDS has initiated a specific inquiry within that region to better understand the causes of these fluctuations. Daniel Herr, DBHDS Assistant Commissioner for Behavioral Health, will be meeting with the CSB Executive Directors in Region V on May 4 to address this matter directly. 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 have a continuing influence on these numbers.



Graph 2. Emergency evaluations statewide

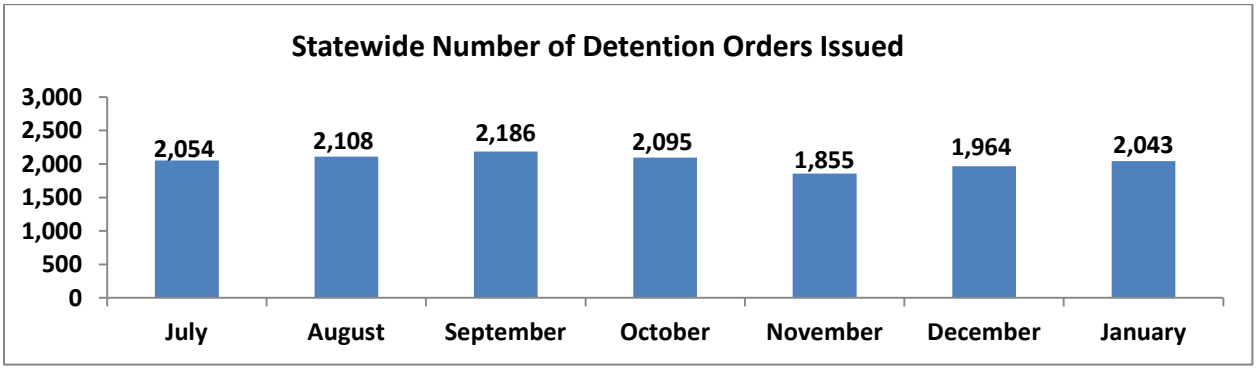
Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis (these exams may be conducted electronically by two-way video and audio communication). The number of emergency evaluations reported statewide in January was 7,237. Region 1, 2, 3, 4, 6 and 7 reported increases in evaluations over the previous month. Regions 1, 2, 3 and 4 reported a 5% or less increase in evaluations from December, 2014. However, increases for regions 6 and 7 were 22% and 36%, respectively. Region 5 was the only region reporting a decrease in evaluations with 21% fewer than in December 2014, and, as stated above, DBHDS has initiated a specific inquiry in Region V to better understand this trend in this region. As cited in the December report, some of this increase may be attributed to the clarification of the emergency evaluation data definition that was issued in November, 2014, which created a uniform method for reporting pre-hearing evaluations and generated higher numbers in a few localities. Regional data is displayed in graph 2a and table 2 in

Appendix C, page 13. 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

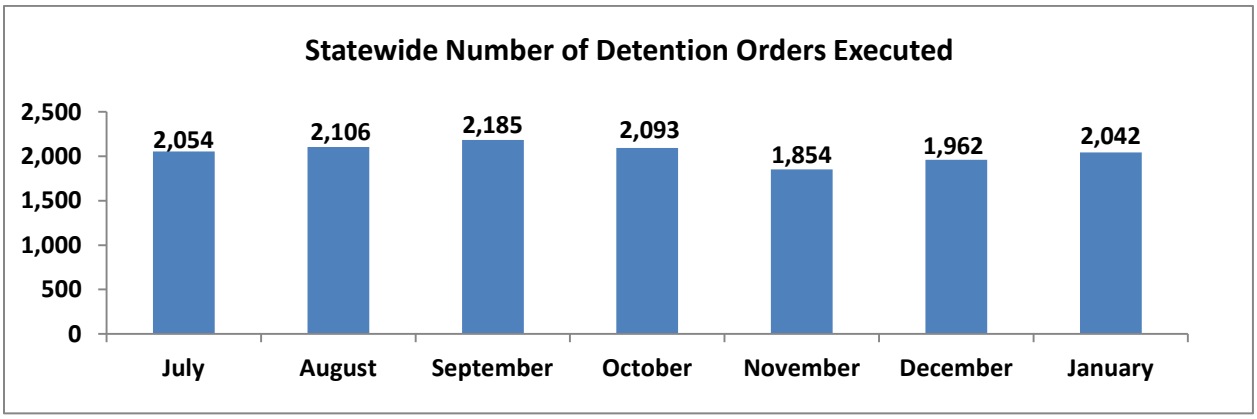
A TDO is issued by a magistrate after considering the findings of the CSB evaluation and other relevant evidence, and determining that the person meets the criteria for temporary detention under § 37.2-809 or § 16.1-340.1. A TDO is executed when the individual is taken into custody by the officer serving the order. In January, there were 2,043 TDOs issued (Graph 3), and 2,042 TDOs executed (Graph 4). Graph 3a and table 3 (page 14) and graph 4a and table 4 (page 15), display this data reported by region in Appendix C. This is an increase of 79 TDOs reported being issued from December, 2014, representing an increase of approximately 4%. **About 72% of the emergency evaluations reported in January (5,195 of 7,237) did not result in a TDO.**



Graph 4. TDOs executed statewide

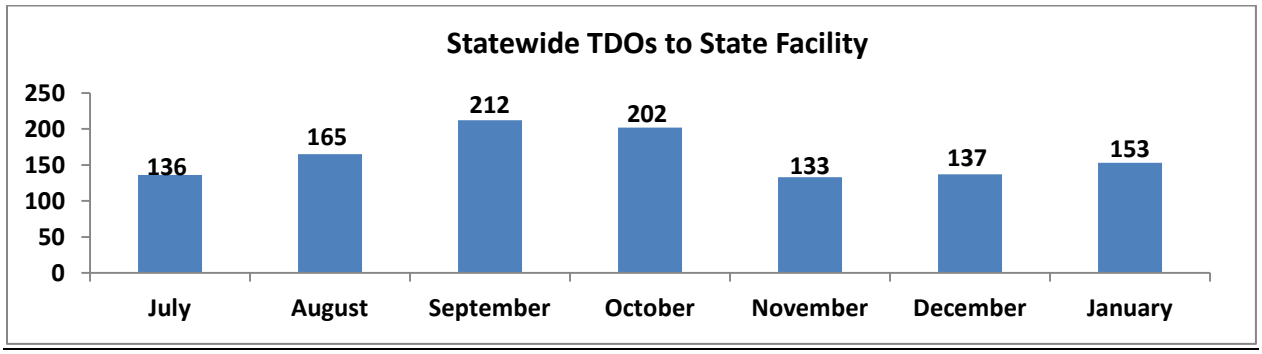
There was one temporary detention order issued but not executed during the month of January. This unexecuted TDO was reported to DBHDS by the CSB as a critical event. The individual had called 911 and was transported to a local emergency department for a medical complaint. The individual was not under an ECO. The emergency room physician requested an emergency evaluation for the individual. The evaluator determined that the individual needed temporary detention, but the individual left the

emergency department prior to the execution of the TDO, and law enforcement was unable to locate the individual to execute the TDO. This case was reported within 24 hours to DBHDS and is summarized in Appendix D, case 5.



Graph 5. TDO admissions to a state hospital statewide

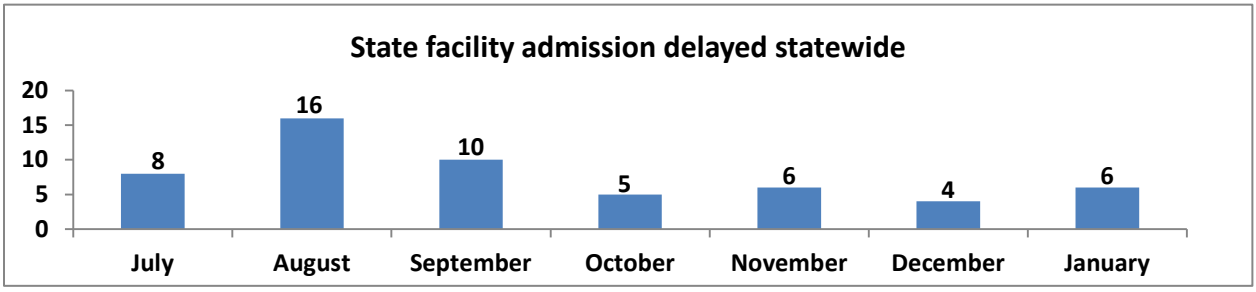
Of the 2,042 TDOs executed in January, 153 (7%) resulted in the individual being admitted to a state hospital [5] (Graph 5), representing an increase of 11% from December. Regions 5 and 7 had decreases of 6% (from 32 to 30) and 46% (from 13 to 7), respectively, from December. Region 6 had a 100% increase from December (from 7 to 14 admits), after a steady, downward trend from September, 2014. Further, Region 4 had a 36% increase (from 11 to 15), Region 1 had a 26% increase (from 15 to 19), Region 3 had a 15% increase (from 45 to 52) and Region 2 had a 1% increase (from 14 to 16). 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 16. 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 usage 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.



[5] Source: DBHDS AVATAR admitting CSB data

Graph 6. State hospital admission delayed statewide

In January, there were six 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 these cases were due to the individuals' more immediate medical testing and treatment needs. All of these individuals were ultimately admitted to the state psychiatric hospital. This is a 33% increase in the number of delayed admissions from December, but continues the overall downward trend since August. Graph 6a and table 6 displays this data by region in Appendix C, page 17, and shows that regions 1, 4 and 7 did not experience this type of occurrence in January.



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

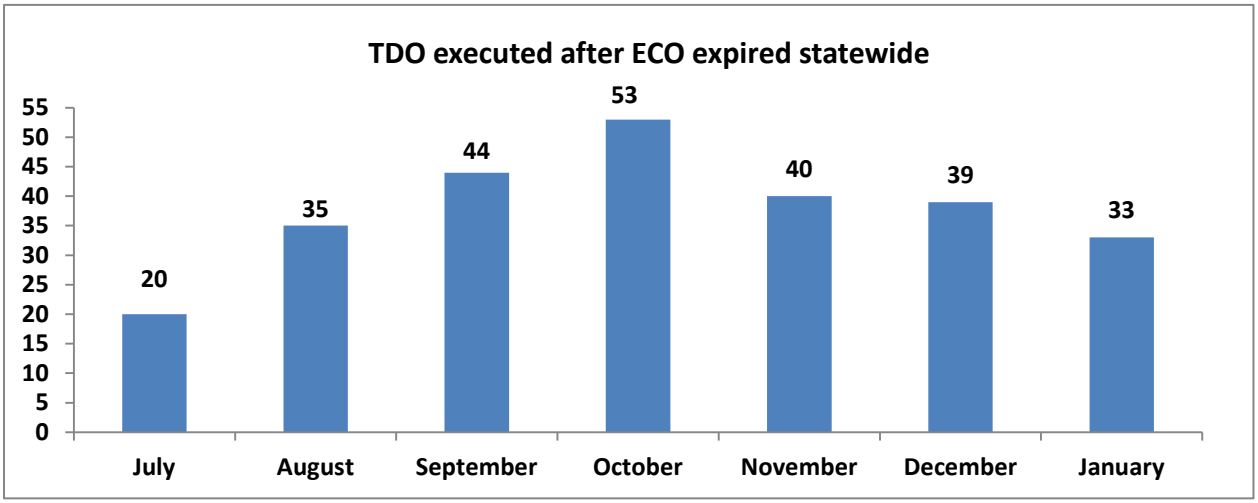
In January, there were 33 (<2%) reported cases where a TDO was issued but not executed until after the ECO period had ended (Graph 7). This is about a 15% decrease from December, continuing the steady downward trend from the peak in October 2014. The decreases reported in December and January may reflect changes in CSB reporting practices as a result of additional guidance provided by DBHDS on reporting this type of event. The majority of these cases (21 of them) involved waiting for law enforcement to execute TDOs that were issued prior to the expiration of the ECO time period. In nine more cases, law enforcement declined to execute the TDO until medical treatment was completed. Two others were a result of the CSB receiving late notification of the individual under ECO and one was a result of the family desiring the individual to be placed at a facility close to their home. In 30 of these cases, the individuals were maintained safely in an emergency department, either locked (19) or unlocked (11), 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, a triage center or within their home with a law enforcement presence. These individuals were also all 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 18. Regionally, these cases tend to be highly variable in terms of frequency. This type of event did not occur during January 2015 in Regions 1 and 3 while Region 2 had five, Region 4 had two, Region 5 had six and Region 6 had one. Although Regions 5 and 7 still report the highest number of these events, Region 5 reported a 40% decrease (from 10 to 6) from December to January and Region 7 reported a 17% decrease (from 23 to 19).

DBHDS has provided ongoing technical assistance to the CSBs in Region 5 and continues to encourage each CSB and the region to meet with their community partners in the temporary detention process to address delays that are preventable to improve the timeliness of TDO execution.

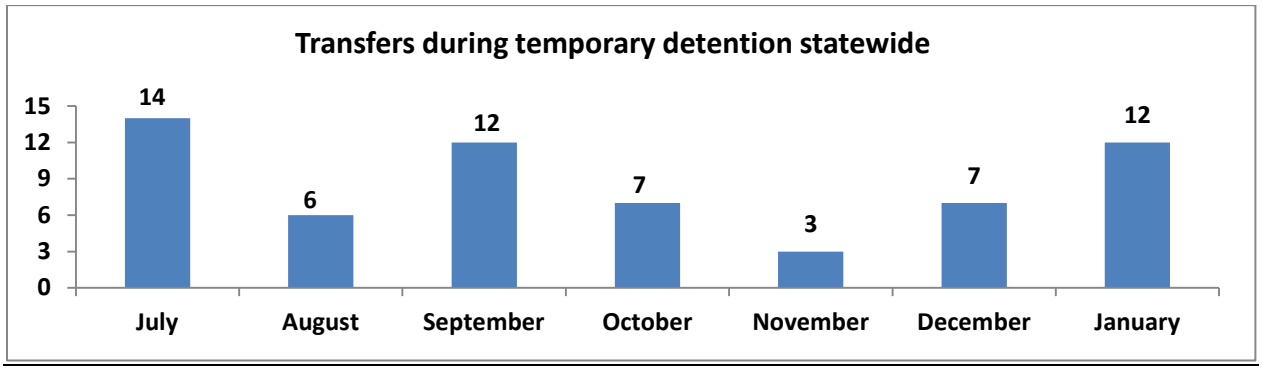
Region 7 continues to have a significantly greater number of these cases than the other regions. This region reported 154 TDOs issued and executed during January, 2014, with 12% reported being executed after the ECO period expired. The time delay between issuance and execution of TDOs ranges from one hour and ten minutes to 7 hours and 10 minutes with a mean of 2 hours and 39 minutes. DBHDS has continued meetings with the Executive Director and Clinical Director of Blue Ridge Behavioral Health (BRBH), the CSB serving the five metropolitan Roanoke area jurisdictions, to implement a quality improvement strategy to identify the primary drivers of these cases and to engage key partners on ways to reduce these delays. To date, the efforts continue to target Carillion Emergency and Police Departments, the Roanoke City Sheriff and Magistrate, and Catawba Hospital. DBHDS maintains continuous monitoring of this effort. On April 15, 2015, a new system was implemented in this region to take advantage of the 2015 statutory change designating the Carillion Police as a law enforcement agency. By transmitting TDOs electronically from the magistrate to the Carillion Emergency Department, the Carillion Police can now execute these TDOs more rapidly following issuance. DBHDS will and local

agencies are continuing to address these transactions intensively.



Graph 8. Transfers during temporary detention statewide

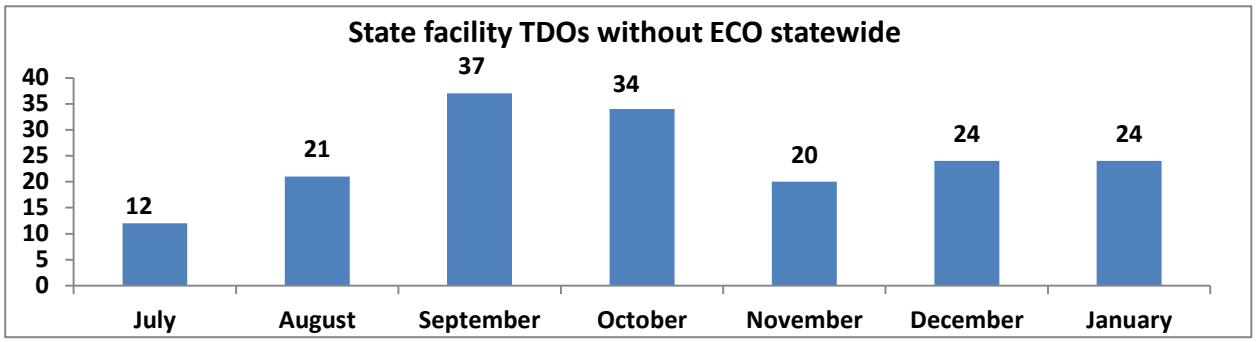
Section § 37.2-809.E. of the *Code of Virginia* allows an individual to be transferred during the period of detention from one temporary detention facility to another more appropriate facility in order to address an individual's security, medical or behavioral health needs. This procedure was used 12 times (>1%) during January (Graph 8). In nine cases, the transfer was from a state facility to a private facility or residential crisis stabilization unit, one was from a private facility to a state facility and the remaining two were from medical environment to private facilities. Graph 8a and table 8 displays this data by region in Appendix C, page 19. Regions 3, 6 and 7 did not report any of these transfers in January.



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 January, there were 24 such admissions to a state facility, the same as December (Graph 9). A total of 184 contacts were

made for an average of about seven alternate facilities contacted to secure these admissions. Seven of the admissions were for specialized care due to the individual's age (either minor or adult aged 65 and older) while nine of the admissions 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; medical needs beyond the capability of the alternate facilities contacted; and aggressive behaviors not manageable in the alternative 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 displays this data by region in Appendix C, page 20.



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 to further strengthen the quality oversight processes and ensure this data is consistently used by CSBs to identify trends and correct problems at the agency, regional, and statewide levels. 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

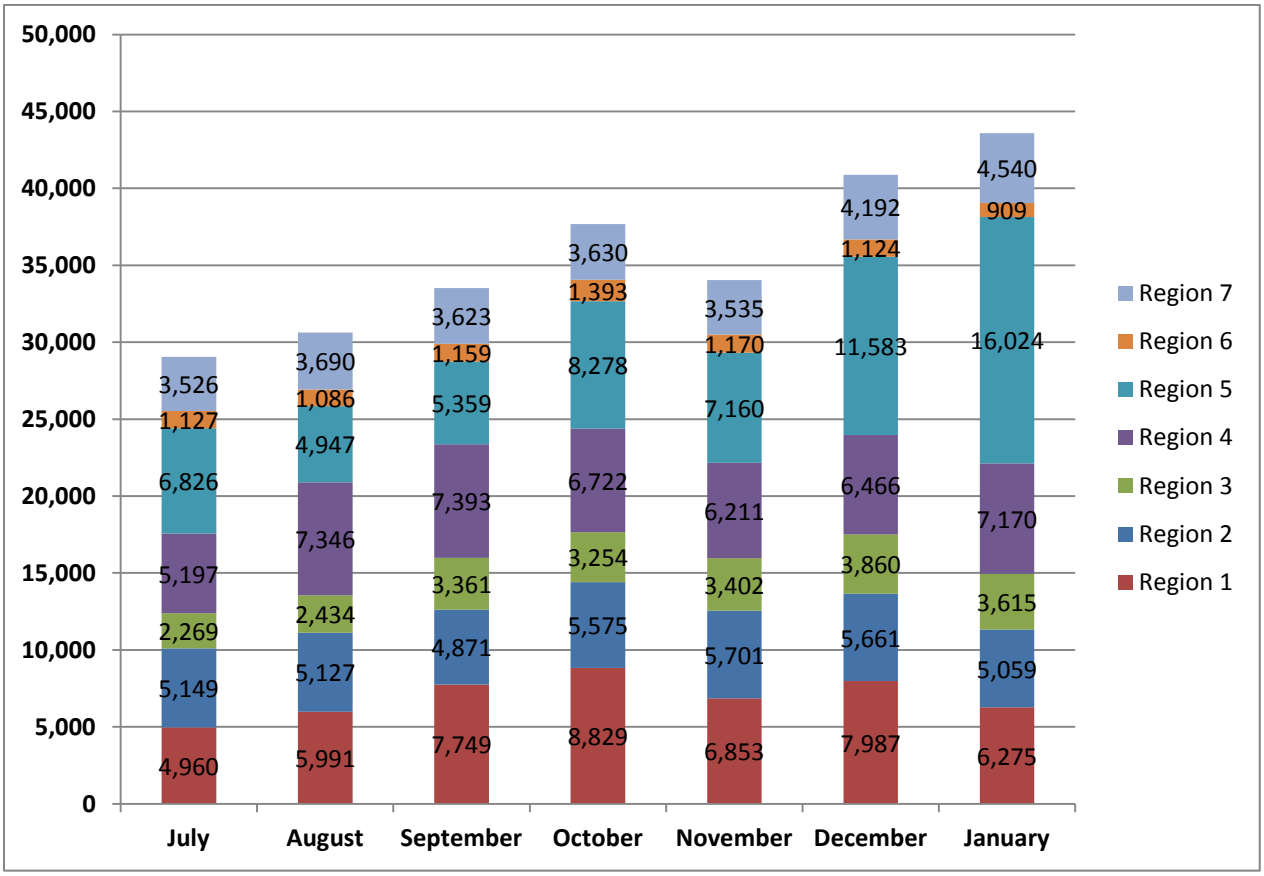


Table 1. Number of emergency contacts (corresponds with graph 1a)

Region	July	August	September	October	November	December	January	Total
Region 1	4,960	5,991	7,749	8,829	6,853	7,987	**6,275**	**48,644**
Region 2	5,149	5,127	4,871	5,575	5,701	5,661	**5,059**	**37,143**
Region 3	2,269	2,434	3,361	3,254	3,402	3,860	**3,615**	**22,195**
Region 4	5,197	7,346	7,393	6,722	6,211	6,466	**7,170**	**46,505**
Region 5	6,826	4,947	5,359	8,278	7,160	11,583	**16,024**	**60,177**
Region 6	1,127	1,086	1,159	1,393	1,170	1,124	**909**	**7,968**
Region 7	3,526	3,690	3,623	3,630	3,535	4,192	**4,540**	**26,736**
Total	**29,054**	**30,621**	**33,515**	**37,681**	**34,032**	**40,873**	**43,592**	**249,368**

Graph 2a. Emergency evaluations by region

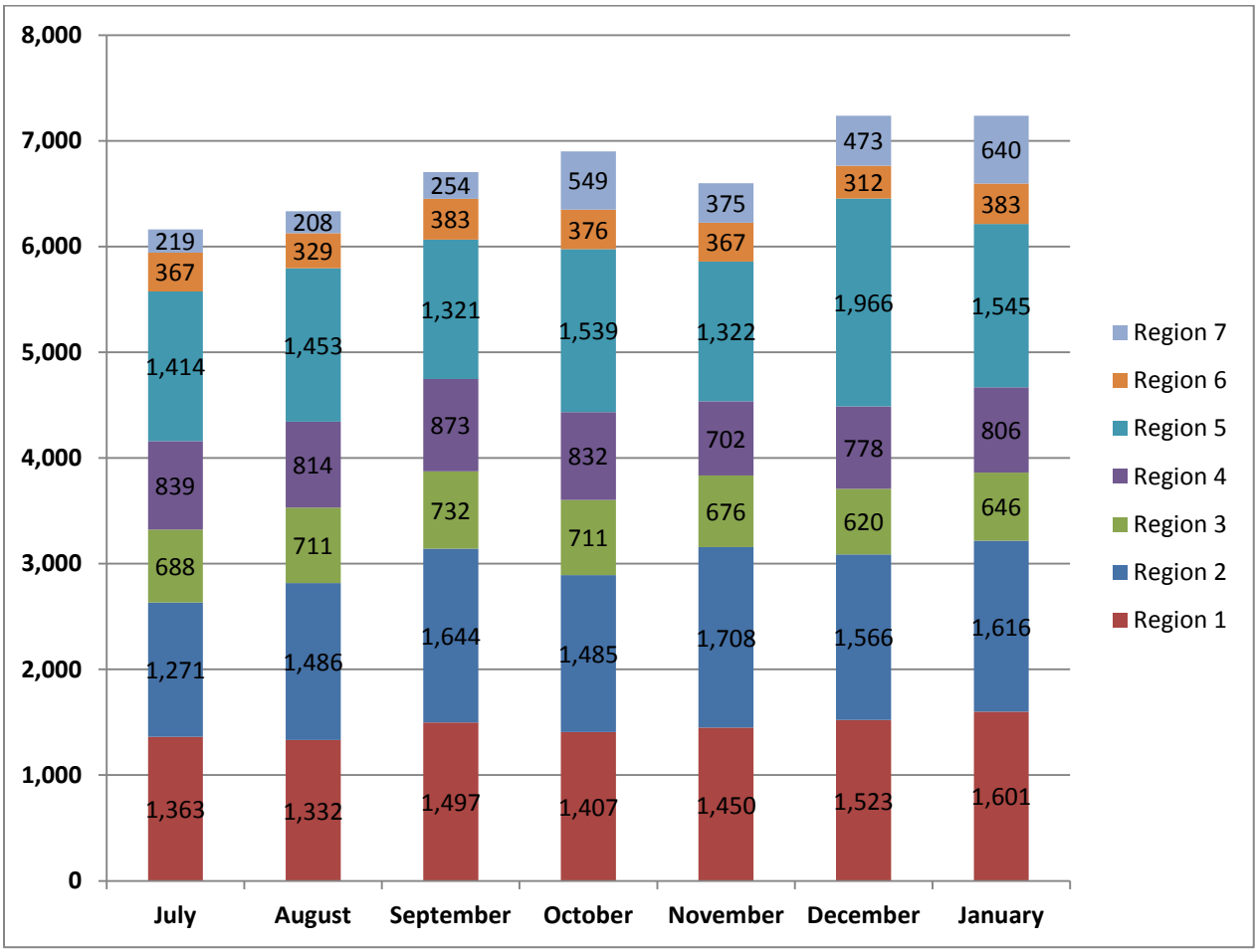


Table 2. Number of emergency evaluations (corresponds with graph 2a)

Region	July	August	September	October	November	December	January	Total
Region 1	1,363	1,332	1,497	1,407	1,450	1,523	**1,601**	**10,173**
Region 2	1,271	1,486	1,644	1,485	1,708	1,566	**1,616**	**10,776**
Region 3	688	711	732	711	676	620	**646**	**4,784**
Region 4	839	814	873	832	702	778	**806**	**5,644**
Region 5	1,414	1,453	1,321	1,539	1,322	1,966	**1,545**	**10,560**
Region 6	367	329	383	376	367	312	**383**	**2,517**
Region 7	219	208	254	549	375	473	**640**	**2,718**
Total	**6,161**	**6,333**	**6,704**	**6,899**	**6,600**	**7,238**	**7,237**	**47,172**

Graph 3a. TDOs issued by region

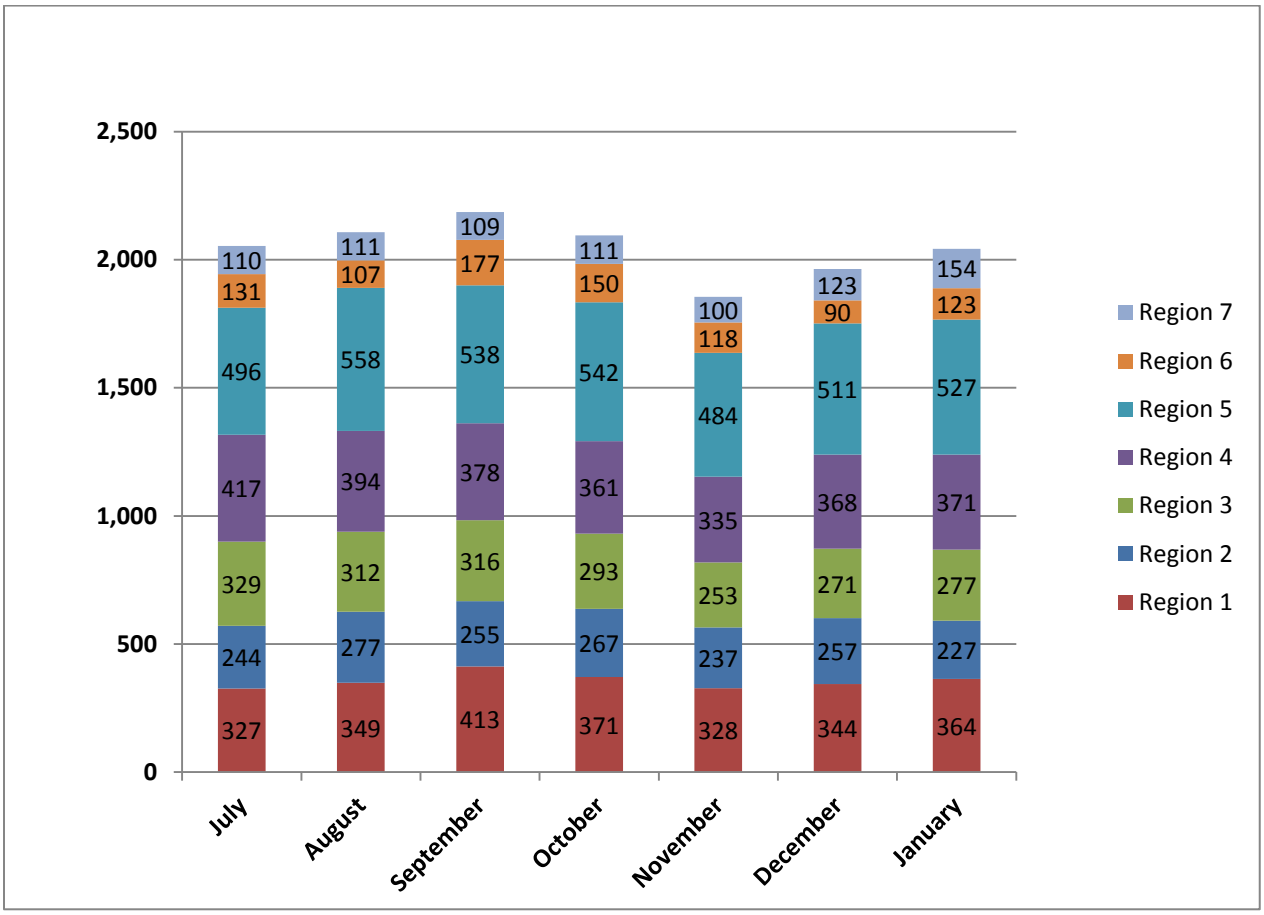


Table 3. Number of TDOs issued (corresponds with graph 3a)

Region	July	August	September	October	November	December	January	Total
Region 1	327	349	413	371	328	344	**364**	**2,496**
Region 2	244	277	255	267	237	257	**227**	**1,764**
Region 3	329	312	316	293	253	271	**277**	**2,051**
Region 4	417	394	378	361	335	368	**371**	**2,624**
Region 5	496	558	538	542	484	511	**527**	**3,656**
Region 6	131	107	177	150	118	90	**123**	**896**
Region 7	110	111	109	111	100	123	**154**	**818**
Total	**2,054**	**2,108**	**2,186**	**2,095**	**1,855**	**1,964**	**2,043**	**14,305**

Graph 4a. TDOs executed by region

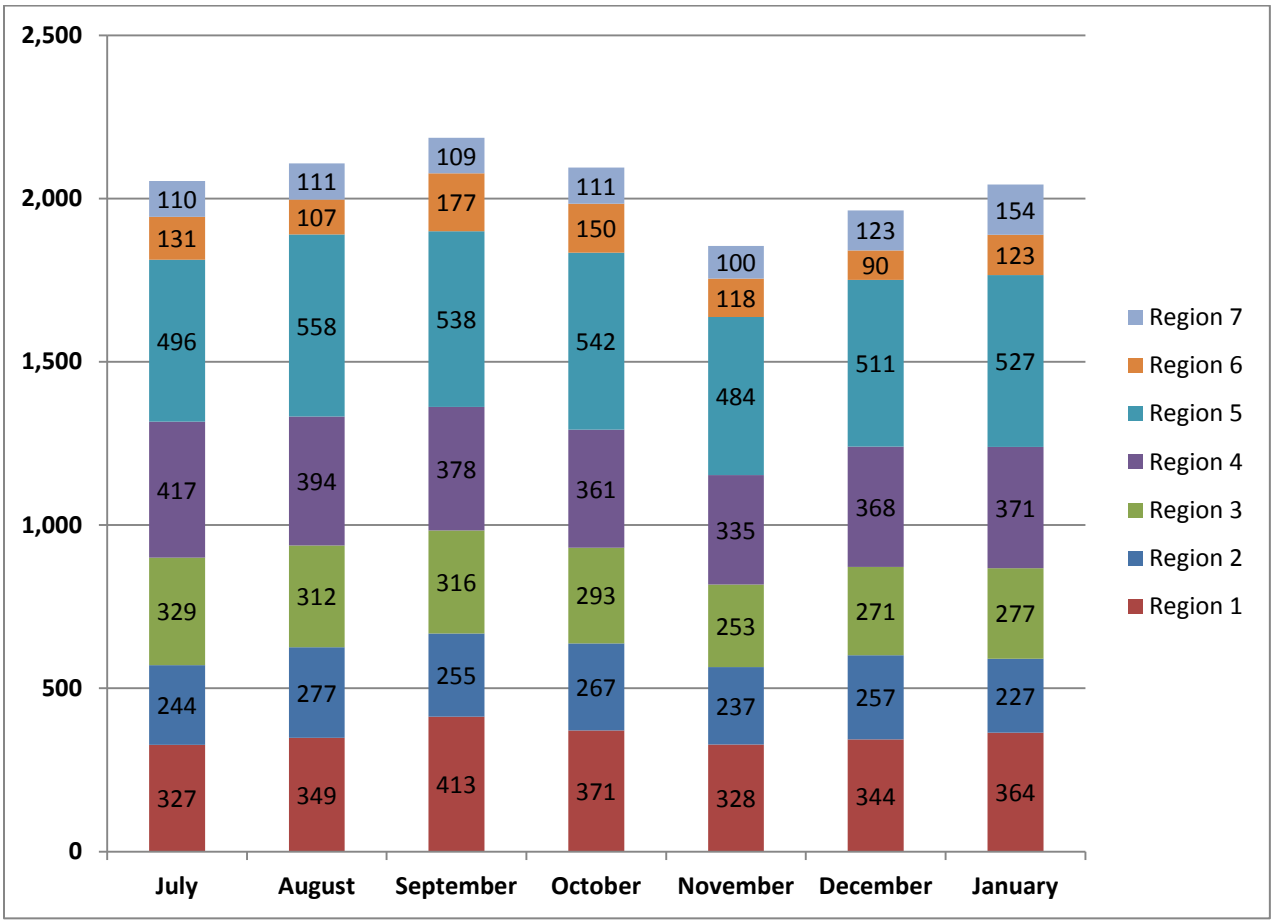


Table 4. Number of TDOs executed (corresponds with graph 4a)

Region	July	August	September	October	November	December	January	Total
Region 1	327	349	413	371	328	344	**364**	**2,496**
Region 2	244	277	255	267	237	257	**227**	**1,764**
Region 3	329	312	316	293	253	269	**277**	**2,049**
Region 4	417	393	377	361	335	368	**371**	**2,622**
Region 5	496	558	538	541	483	511	**526**	**3,653**
Region 6	131	107	177	150	118	90	**123**	**896**
Region 7	110	110	109	110	100	123	**154**	**816**
Total	**2,054**	**2,106**	**2,185**	**2,093**	**1,854**	**1,962**	**2,042**	**14,296**

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

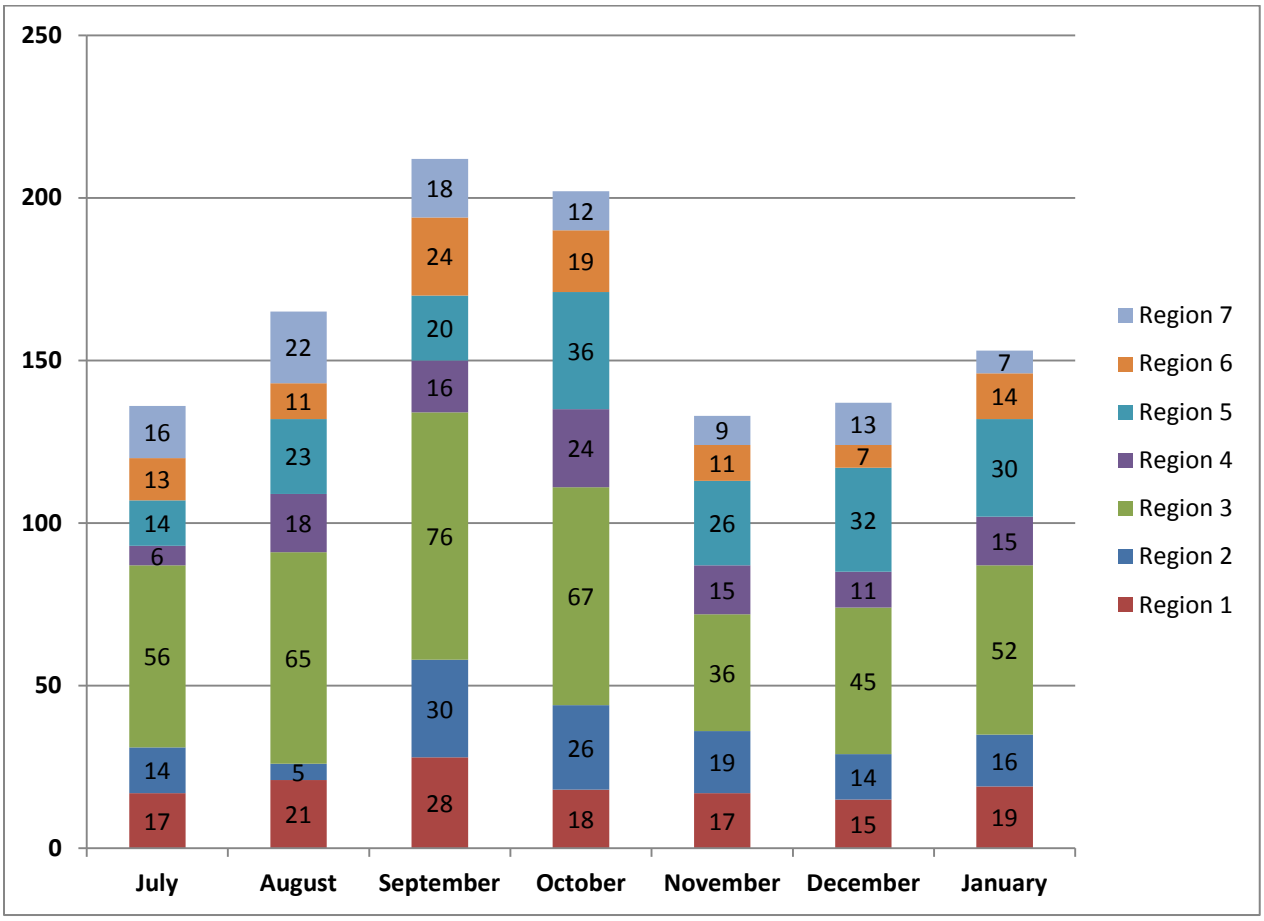


Table 5. TDO admissions to a state hospital (corresponds with graph 5a)

Region	July	August	September	October	November	December	January	Total
Region 1	17	21	28	18	17	15	**19**	**135**
Region 2	14	5	30	26	19	14	**16**	**124**
Region 3	56	65	76	67	36	45	**52**	**397**
Region 4	6	18	16	24	15	11	**15**	**105**
Region 5	14	23	20	36	26	32	**30**	**181**
Region 6	13	11	24	19	11	7	**14**	**99**
Region 7	16	22	18	12	9	13	**7**	**97**
Total	**136**	**165**	**212**	**202**	**133**	**137**	**153**	**1,138**

Graph 6a. State hospital admission delayed by region

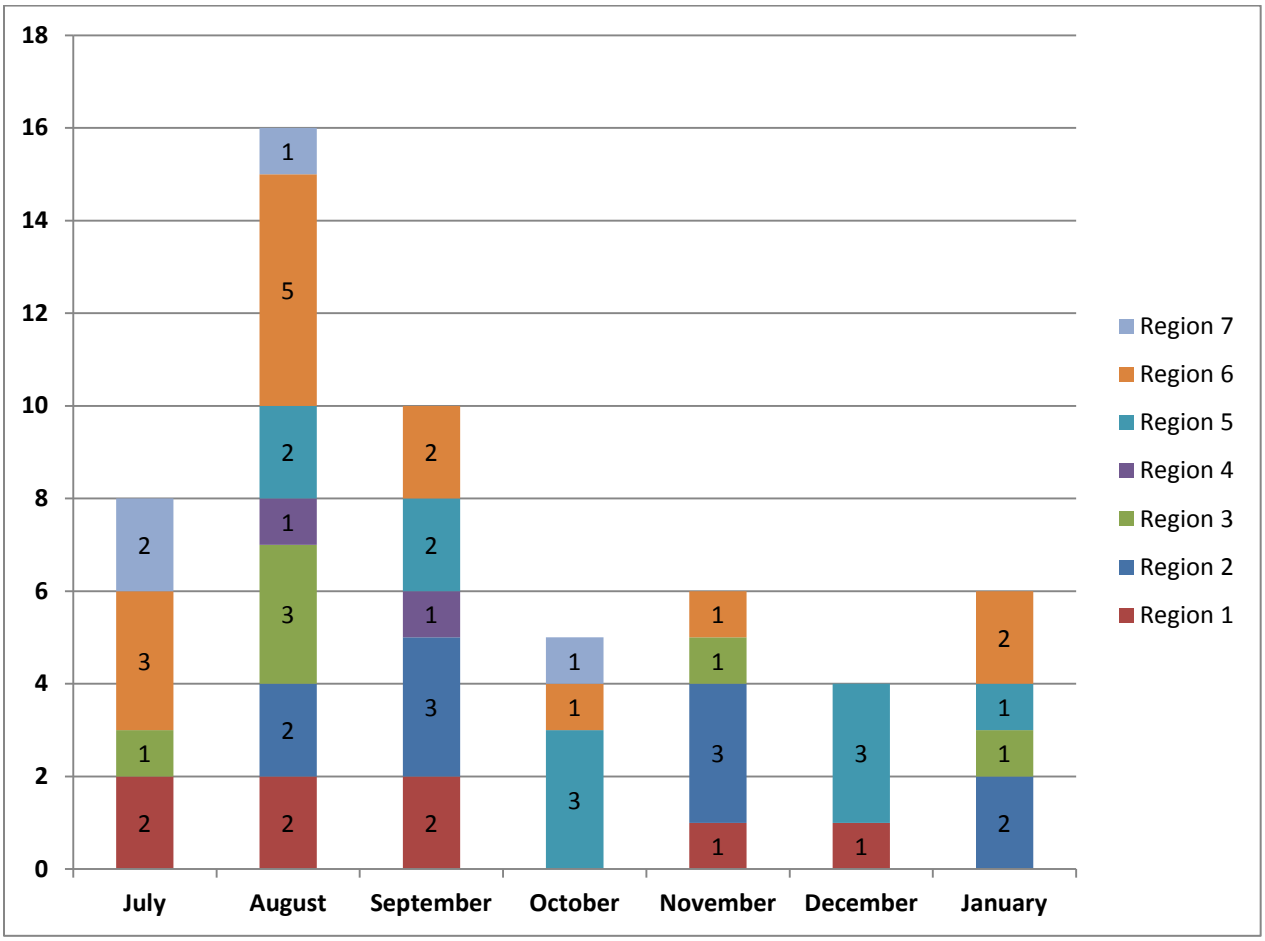


Table 6. State hospital admission delayed (corresponds with graph 6a)

Region	July	August	September	October	November	December	January	Total
Region 1	2	2	2	0	1	1	**0**	**8**
Region 2	0	2	3	0	3	0	**2**	**10**
Region 3	1	3	0	0	1	0	**1**	**6**
Region 4	0	1	1	0	0	0	**0**	**2**
Region 5	0	2	2	3	0	3	**1**	**11**
Region 6	3	5	2	1	1	0	**2**	**14**
Region 7	2	1	0	1	0	0	**0**	**4**
Total	**8**	**16**	10	**5**	**6**	**4**	**6**	**55**

Graph 7a. TDO executed after ECO expired by region

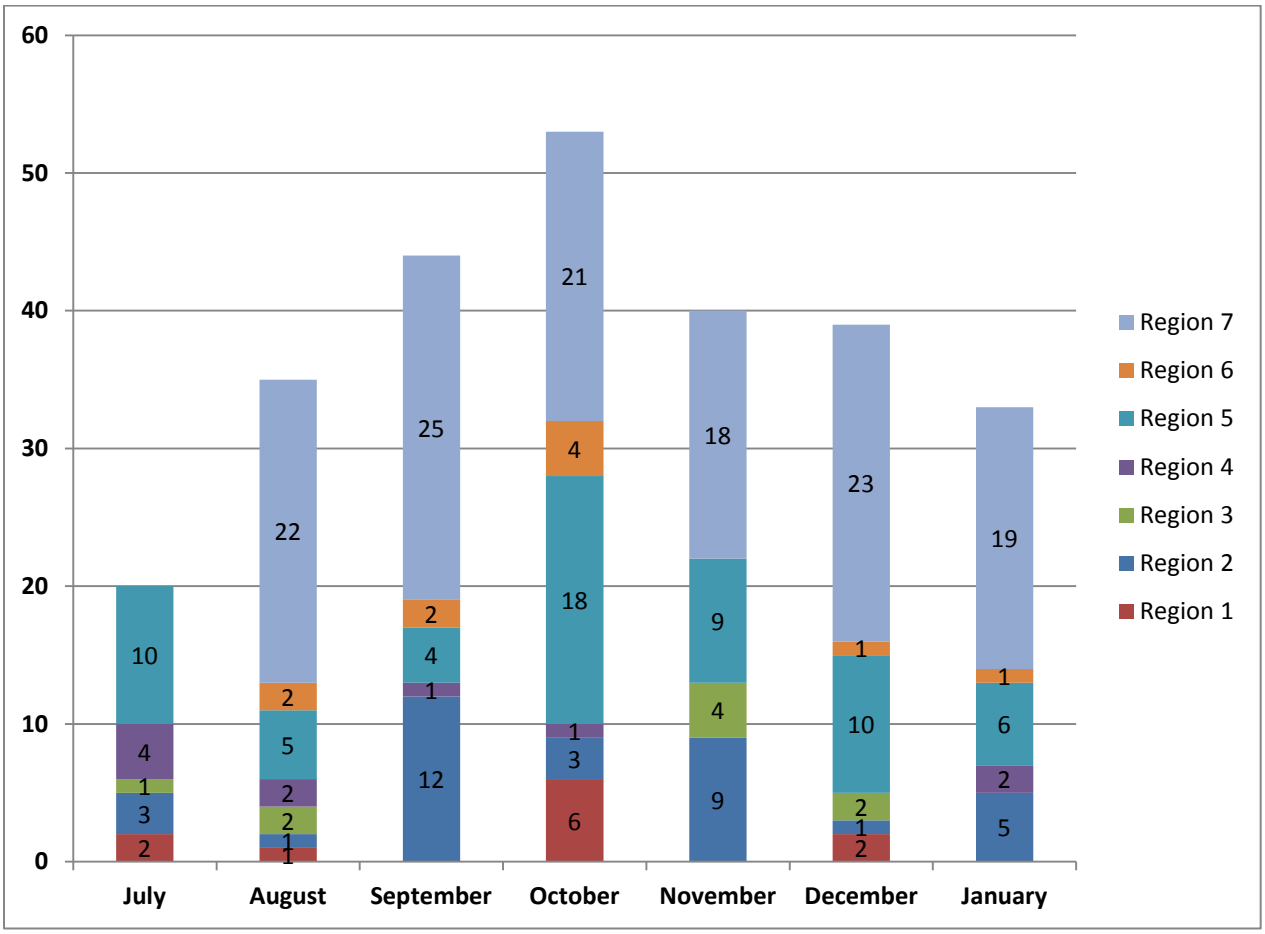


Table 7. TDO executed after ECO expired (corresponds with graph 7a)

Region	July	August	September	October	November	December	January	Total
Region 1	2	1	0	6	0	2	**0**	**11**
Region 2	3	1	12	3	9	1	**5**	**34**
Region 3	1	2	0	0	4	2	**0**	**9**
Region 4	4	2	1	1	0	0	**2**	**10**
Region 5	10	5	4	18	9	10	**6**	**62**
Region 6	0	2	2	4	0	1	**1**	**10**
Region 7	0	22	25	21	18	23	**19**	**128**
Total	**20**	**35**	44	**53**	**40**	**39**	**33**	**264**

Graph 8a. Transfers during temporary detention by region

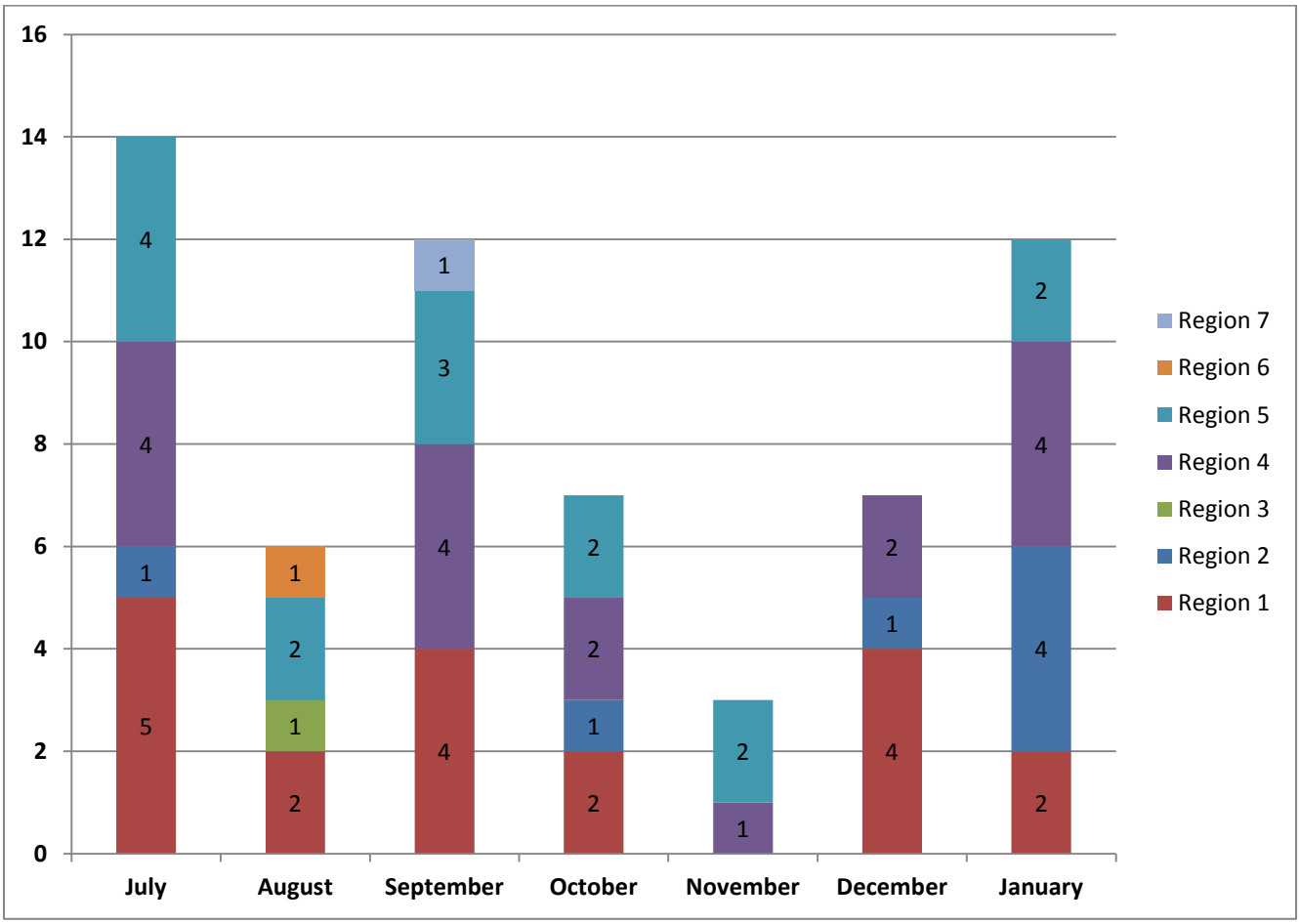


Table 8. Transfers during temporary detention (corresponds with graph 8a, pg 10)

Region	July	August	September	October	November	December	January	Total
Region 1	5	2	4	2	0	4	**2**	**19**
Region 2	1	0	0	1	0	1	**4**	**7**
Region 3	0	1	0	0	0	0	**0**	**1**
Region 4	4	0	4	2	1	2	**4**	**17**
Region 5	4	2	3	2	2	0	**2**	**15**
Region 6	0	1	0	0	0	0	**0**	**1**
Region 7	0	0	1	0	0	0	**0**	**1**
Total	**14**	**6**	**12**	**7**	**3**	**7**	**12**	**61**

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

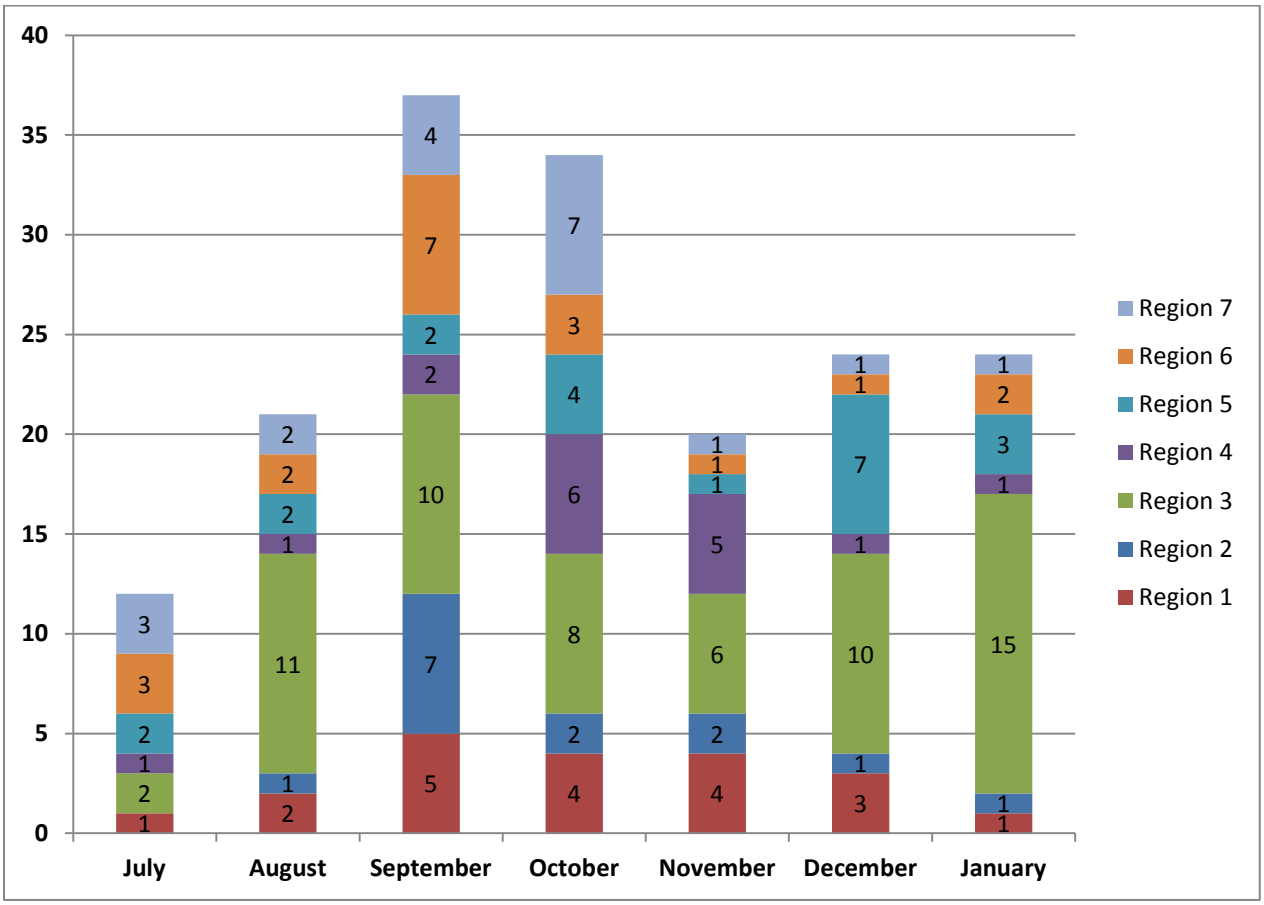


Table 9. State hospital TDOs without ECOs (corresponds with graph 9a)

Region	July	August	September	October	November	December	January	Total
Region 1	1	2	5	4	4	3	**1**	**20**
Region 2	0	1	7	2	2	1	**1**	**14**
Region 3	2	11	10	8	6	10	**15**	**62**
Region 4	1	1	2	6	5	1	**1**	**17**
Region 5	2	2	2	4	1	7	**3**	**21**
Region 6	3	2	7	3	1	1	**2**	**19**
Region 7	3	2	4	7	1	1	**1**	**19**
Total	**12**	**21**	**37**	**34**	**20**	**24**	**24**	**172**

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 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, comprehensiveness and sufficiency, and responds immediately to the CSB Executive Director if any further information is needed. In addition, DBHDS specifies additional follow up actions that are deemed necessary, and requests appropriate follow up communication from the CSB, maintaining an open incident file until the incident has resolved and the follow up actions are completed.

There were seven such events during the month of January 2015. The seven 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 to 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, etc. These case-driven DBHDS interventions are still ongoing at the time of this report.

Of the seven cases reported in January, five involved individuals who were initially evaluated on a voluntary basis (i.e., the individuals were not under an ECO). Two individuals were evaluated while under an ECO. Of these seven cases, two individuals eloped from the evaluation site before the TDO was executed. One of these individuals was subsequently detained. The other was not from Virginia and was not located until the following month. Four individuals remained voluntarily on a medical unit of a local hospital until the TDO was executed. The other case involved an individual who was less than 18 years of age and was evaluated while under an ECO. When no local appropriate bed could be located, the parent of the individual strongly objected to placement outside of the immediate local area. Both the parent and the individual agreed to a safety plan of coming in for an evaluation by a CSB psychiatrist the following morning. When contacted the next morning to schedule the appointment, the parent declined to bring the individual in so law enforcement was contacted to insure the individual's safety until a TDO could be issued and executed.

The case summaries follow.

1. This event began in December and was reported on the December report as well. The individual was admitted to a medical hospital for medical treatment of complex medical conditions. The medical facility contacted the CSB to assess the individual for involuntary psychiatric hospitalization due to reported psychiatric symptoms. The individual was refusing medications on the unit citing a desire to only use homeopathic treatment options. The CSB

evaluator completed the assessment and determined that the individual did not meet TDO criteria. The CSB was contacted again three days later to conduct another assessment and the individual was willing to be admitted voluntarily to a psychiatric facility. The CSB evaluator contacted ten facilities that showed available beds on the Psychiatric Bed Registry. Only one facility was willing to accept the individual but stated the individual would need to be under a TDO. The CSB evaluator obtained additional information from collateral contacts and determined a TDO could be sought. However, when the receiving facility was contacted about the TDO, the facility declined the admission stating the individual's current needs were more medical than psychiatric at the time. The individual remained on the medical unit and the CSB evaluator began another statewide search for an available psychiatric bed. Several additional days passed and the individual was reassessed by another CSB evaluator who determined a TDO could continue to be supported. Another statewide bed search began and no accepting facility could be found. The individual remained on the medical unit until a bed became available at a hospital within the medical facility's network and a TDO was issued. The DBHDS Quality Oversight Team recommended that the CSB provide additional training to CSB evaluators and to review the state facility notification process in the regional protocol. The CSB completed this training. CSB administrative and management staff met with the medical facility administration to review the incident and discuss how to improve the relationship between the medical facility and the CSB to insure the best interests of individuals are met. The mental health assessment department of the medical facility provided training to their staff on state temporary detention and involuntary commitment laws. The CSB and facility administrative staff agreed to meet monthly to process any incidents and to build a stronger community partnership. The DBHDS Quality Oversight Team representative met with the regional CSBs to revise the regional admission protocol to handle these cases as "last resort" state hospital admissions. The revision has been posted on the DBHDS website pending final approval from the regional stakeholder workgroup.

2. The individual was screened and met the criteria for temporary detention. The CSB evaluator obtained a bed in a private psychiatric facility. The individual was combative and lacked capacity to consent to treatment. The attending physician in the emergency department indicated that further medical care in an ICU environment was needed. The local magistrate declined to issue a Medical TDO so a TDO for psychiatric care was obtained that specified additional inpatient medical treatment in a local hospital until medical needs resolved. Following the resolution of the medical treatment, the individual was transported safely to a state facility. The DBHDS Quality Oversight Team's review recommended the CSB engage the local magistrate and law enforcement regarding the handling of this incident. The CSB has met with the law enforcement agency and the magistrate in an attempt to improve the care coordination process when both medical and psychiatric treatment is needed.

3. The individual presented voluntarily to an emergency department following an overdose on medication after being released from a local psychiatric facility. The individual was evaluated and determined to meet criteria for a TDO, but the individual required further medical treatment delaying the issuance of the TDO. The individual remained in the emergency department until medical treatment was completed. A local psychiatric facility accepted the individual for admission under a TDO and the individual was transported safely to the facility without incident. The DBHDS Quality Oversight Team had no recommendations for this incident as the individual was safely treated throughout the process.

4. The individual presented voluntarily to an emergency department seeking medical and psychiatric treatment. The emergency department requested an emergency evaluation for a TDO from the CSB. The individual had been evaluated multiple times in the past4 four months by the CSB and had a history of violent behavior, making the search for an appropriate bed in a local facility more difficult. The individual was maintained in the emergency department without incident until an appropriate bed was located. As in number 3, above, the DBHDS Quality Oversight Team had no recommendations for this incident.

5. The individual voluntarily called 911 and was transported to the emergency department for medical complaints. The emergency room physician requested an evaluation for temporary detention and it was determined that the individual met criteria for a TDO. The individual was not a Virginia resident and the CSB was able to contact his mother in another state who informed the CSB that the individual had a long history of mental illness and travels from state to state. The CSB made arrangements for the individual to be admitted to a psychiatric facility and obtained a TDO, but when law enforcement arrived to execute the order the individual had eloped from the emergency department. Security footage was immediately reviewed and law enforcement joined in the efforts to locate the individual. His mother was contacted again to inform her of his elopement and to request her assistance with locating the individual if he called her. The individual was not located until the following month by another CSB, and at that time, he was subsequently detained and treated. With consultation from the DBHDS Quality Oversight Team, the CSB met with the hospital emergency department and senior administrators to develop and implement measures to better safeguard individuals in these circumstances.

6. The individual was brought by concerned family to an emergency department for psychiatric evaluation and treatment. The individual was assessed and met criteria for a TDO, but the individual refused medical evaluation in the emergency department. The CSB evaluator sought an ECO to hold the individual so that a medical evaluation could be completed. When law enforcement arrived to execute the ECO, the individual had eloped. The CSB evaluator, hospital security and law enforcement searched the hospital and grounds but were unable to locate him. Law enforcement went to the individual's residence and was unable to locate

him. The individual was located approximately 24 hours after the initial evaluation and was subsequently detained to a local hospital. Upon review by the DBHDS Quality Oversight Team, the CSB indicated their evaluators had to leave the immediate area to make phone calls and obtain law enforcement assistance. This suggested the need for closer cooperation among the emergency room staff, hospital security, law enforcement and the evaluators to keep individual's safe. The CSB initiated a meeting with an emergency room representative to develop protocols for collaboration to protected individuals presenting either voluntarily or involuntarily in the emergency room.

7. A minor was evaluated in an emergency room while under an ECO. The individual was transported to the emergency room by local law enforcement and was accompanied by his mother. The individual met TDO criteria and the CSB began searching for an appropriate local psychiatric facility. When no local option was found, the individual's mother became concerned about the child being placed in a facility outside of the immediate local area. The CSB evaluator and the mother formulated a safety plan with the minor that included undergoing a psychiatric evaluation the following morning. With agreement on this plan, the individual was allowed to leave the emergency room. When the mother was contacted the following morning with appointment times, approximately 4 hours later, the mother declined to bring the minor in for the appointment. After consultation with supervisors, law enforcement was sent to the child's home to take custody of the individual. A TDO was issued and subsequently executed for the individual. The DBHDS Quality Oversight Team reviewed the incident and requested that the CSB review their policies on releasing individuals determined to meet TDO criteria with all emergency evaluators.

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.