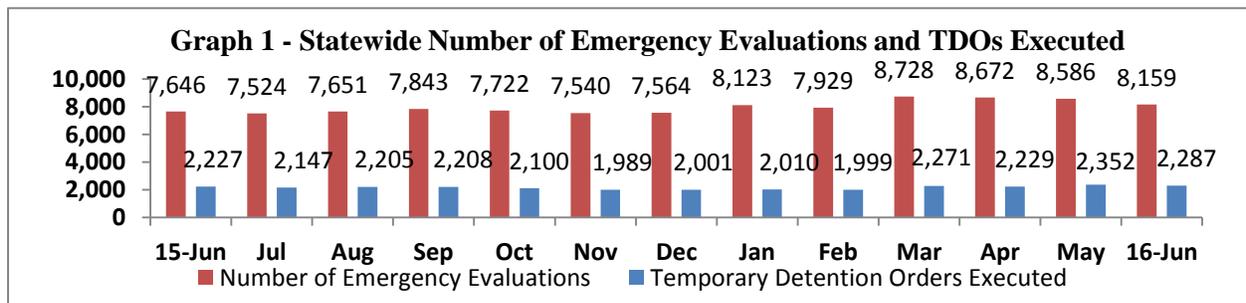


This document is the twelfth monthly report of data collected from community services boards (CSBs) and partnership planning regions for fiscal year 2016 (FY 2016). There are 39 CSBs and one behavioral health authority in Virginia, referred to in this report as CSBs. The following sections contain the summaries and graphs of the monthly data reported to the Department of Behavioral Health and Developmental Services (DBHDS) through June 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 June 2016 was 8,159, a 5% decrease from May 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 June, there were 2,287 executed TDOs, a significant increase from May 2016. **About 72% of the emergency evaluations reported in June (5,872 of 8,159) did not result in a TDO.** For the current report month, there was an average of 272 emergency evaluations completed and about 76 TDOs issued and executed each day across the state. Compared to the May counts, these figures were slightly higher. Graph 1 reports the numbers of evaluations and executed TDOs for June 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 June. 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 Stacy Gill, Director of Behavioral Health Community Services, Charlotte Watts, Adult Community Behavioral Health Operations Manager, Gabriella Caldwell-Miller, Community Services Manager, 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. Events related to the contacting of REACH were not included in this review of reports.

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

1. The individual was evaluated in an emergency room and determined to meet TDO criteria based on threats to kill self and a family member. The CSB called multiple private hospitals in order to secure a bed for the individual. All of the hospitals declined to accept the admission. The CSB continued their efforts to locate an appropriate placement while the individual remained in the emergency department for two days. The CSB was notified by the hospital the emergency department treating physician discharged the individual to the home of the same family member the individual threatened. The CSB contacted the individual by phone, was assessed to be safe, and denied the need for immediate assistance. The individual agreed to come to the CSB office to be seen on the same date. The individual attended the appointment as scheduled and services were initiated. The CSB executive leadership met to review this event. The CSB meets regularly with the discharging hospital administration to collaborate and resolve any concerns; the parties met to discuss this specific incident. This event was reviewed in multiple forums and activities to mitigate any future risks were discussed.

DBHDS reviewed this event and offered no additional recommendations.

2. The individual was voluntarily transported by law enforcement to an emergency room for a psychiatric evaluation. The CSB was contacted to conduct a preadmission screening evaluation and this individual was determined to meet criteria for a TDO. The individual initially agreed to a voluntary admission then later recanted. The CSB attempted to secure an appropriate placement for the individual so a TDO could be pursued. While the CSB was conducting this search, the emergency department physicians evaluated the individual and released the individual home. The CSB was notified after the discharge. The CSB attempted to locate the individual and engaged an outpatient service provider in the search. The service provider was able to speak with the individual on the phone and to discuss the events leading up to the emergency evaluation. The outpatient provider determined the individual did not currently meet TDO criteria and the individual agreed to attend the next outpatient appointment session. The CSB presented this event at a collaboration meeting with the hospital staff and other community partners to establish protocols to handle disagreements on a disposition between hospital physicians and the CSB staff.

DBHDS reviewed this event and had no recommendations.

3. The individual was seen in an emergency department upon seeking voluntary admission for behavioral health needs. The individual later decided not to seek voluntary admission. The hospital notified the CSB. The CSB noted on arrival that the individual was still in street clothes and no sitter was present. The CSB determined a TDO was supported. The clinician left the individual's room to write up the preadmission screening report and was notified by the staff of the emergency department the individual had left the premises. A staff member of the hospital left the emergency department to try to locate the individual. The CSB contacted two emergency contacts identified by the individual during the evaluation as well as law enforcement in the individual's locality. Both emergency contacts reported not knowing the location of the individual but agreed to call law enforcement or the CSB if the whereabouts become known. The individual returned home and the family contacted the CSB. The individual was to be admitted on a voluntary basis to a substance use treatment facility in two weeks and the family was willing to contact the CSB if there were any concerns during the wait. The CSB met with the hospital to review their policy for placing individuals into hospital gowns and removing street clothing from individuals being assessed for a behavioral health admission.
4. The individual was evaluated in the emergency department and determined to meet criteria for a TDO. While the clinician was securing a placement the individual left the emergency room. Hospital security and law enforcement were notified to begin a search for the individual. The CSB attempted to contact the individual's emergency contact and

personal cell phone to no avail. During the overnight hours, contact was made with the emergency contact who denied knowing the whereabouts of the individual. Later, the individual phoned the CSB from a neighboring state and reported leaving the emergency department due to fears of being hospitalized. Subsequently, the individual was arrested on an outstanding felony warrant and placed in jail. The CSB communicated concern for the individual to the jail medical staff and lieutenant on duty. The CSB met with the hospital to discuss the event and it was determined the hospital had not followed their own protocols for removing an individual's clothing and belongings from the room when individuals are being evaluated for a TDO.

DBHDS reviewed the event and the actions of the CSB with no recommendations.

5. The individual was evaluated for a TDO while in an emergency department. A TDO was supported and the petition was sent to the magistrate's office. The hospital staff notified the CSB that the individual had left the emergency department and that the hospital had notified law enforcement. Law enforcement located the individual but did not have paperwork to hold the individual. The hospital reported the secretary shredded the judicial order that had been faxed from the magistrate's office. As a result, the individual was released. The CSB contacted the magistrate to obtain a copy of the order and was informed that the magistrate had shredded the original. The CSB contacted family of the individual and were successful in locating the individual the next day. The family took the individual to another facility for a behavioral health admission. The admission was confirmed to have occurred. The CSB initiated contact with the magistrate's office to implement a policy on retaining the original TDO for 24 hours after issuance. The CSB met with the hospital administration regarding the need to retain copies of all judicial orders regardless if the individual leaves the hospital. Protocols were developed and the staff has been trained in the emergency department on the protocols.

DBHDS reviewed the event and support the actions taken by the CSB to prevent such an event in the future.

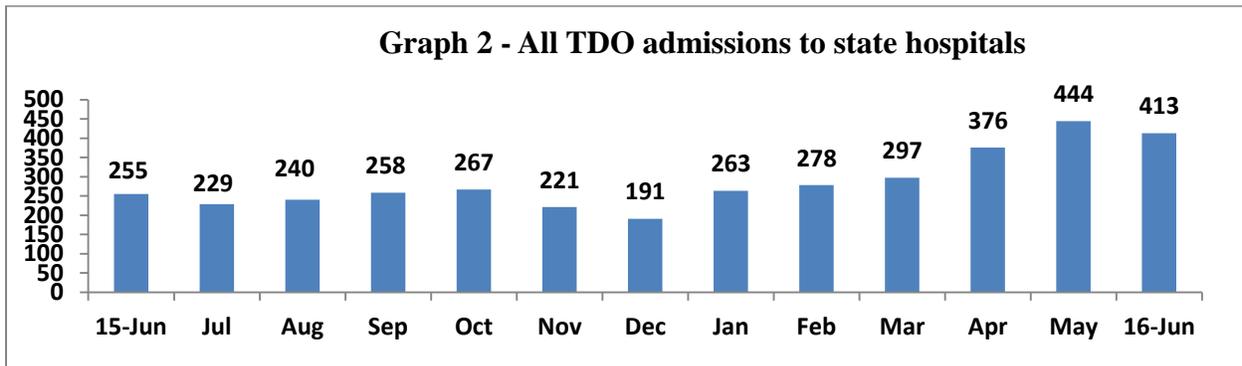
The DBHDS Quality Review Team reviews each of the event reports on the events when they are submitted. The team works with each CSB to ensure events are reviewed by the CSB and with community partners involved in the events to strengthen the safety of individuals determined to be in need of involuntary 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 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 was facility of choice for the individuals. **Of the 2,287 TDOs executed in June, 413 (18%) 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. In June, there were 39 admissions without ECOs to a state hospital, which is a decrease of 11% from May.

Individuals are admitted to a state hospital as a “last resort” with or without a preceding ECO due to: 1) a lack of capacity of the alternate facilities contacted by the CSB, 2) specialized care due to the individual’s age (children and adolescents or adults aged 65 and older), 3) diagnoses of intellectual or developmental disability, 4) medical needs beyond the capability of the alternate facilities contacted, 5) traumatic brain injuries, and 6) behavioral needs exceeding the capabilities of the alternate hospitals contacted.

^[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
June 2016

