

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 eleventh monthly report of data^[1] collected from Community Services Boards (CSBs) and regions^[2] for fiscal year 2015 (FY 2015). The following sections contain the summaries and graphs of the monthly data reported to DBHDS through June, 2015. For the current report month, June 2015, there were an average of 1,697 emergency contacts received by CSBs, 255 emergency evaluations completed and 74 TDOs issued and executed each day across the Commonwealth. Compared to the May counts, these figures show a slight increase in emergency contacts and evaluations, but the average for TDOs issued and executed, was flat. In this report, the total counts of events are presented for each month and for the fiscal year to date for ease of comparison and trend analysis.^[3]

Additionally, certain high risk events are reported separately by CSBs, on a case-by-case basis as they occur. These involve individuals who are evaluated and need temporary detention, but do not receive that intervention. There were seven such events in the June 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 as well as initial actions to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality Oversight Team reviews the incident report and 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.

Of the seven events reported in June, six involved individuals who were in emergency custody when evaluated, while the remaining individual was evaluated voluntarily (i.e., they were not under an ECO). Of the seven events, two involved individuals who eloped from the evaluation site before the TDO was executed. All of the cases concluded with the individual’s hospitalization. Additional detail on each of these cases can be found in Appendix D, page 22.

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

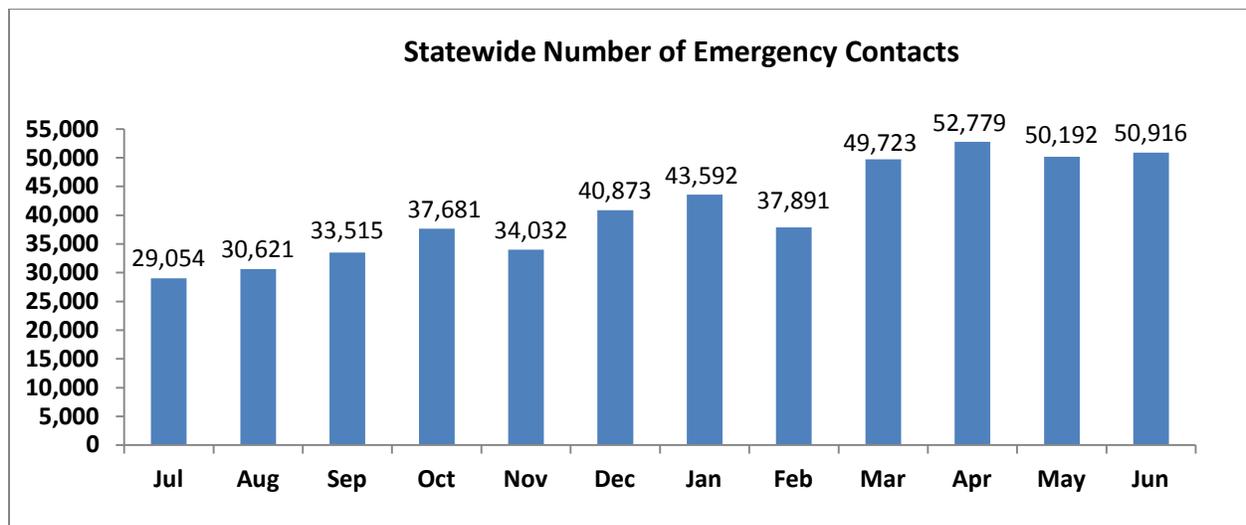
^[2] There are 39 Community Services Boards and 1 Behavioral Health Authority in the Commonwealth, referred to in this report as CSBs. See Appendix B for a complete listing of CSBs within each of the seven regions.

^[3] In addition, data is reported both statewide and by region in the report and in Appendix C.

^[4] The Quality Oversight Team includes the DBHDS Medical Director, Assistant Commissioner for Behavioral Health, Director of Community Behavioral Health Services, Director of Mental Health, and MH Crisis Specialist.

Graph 1. Emergency contacts statewide

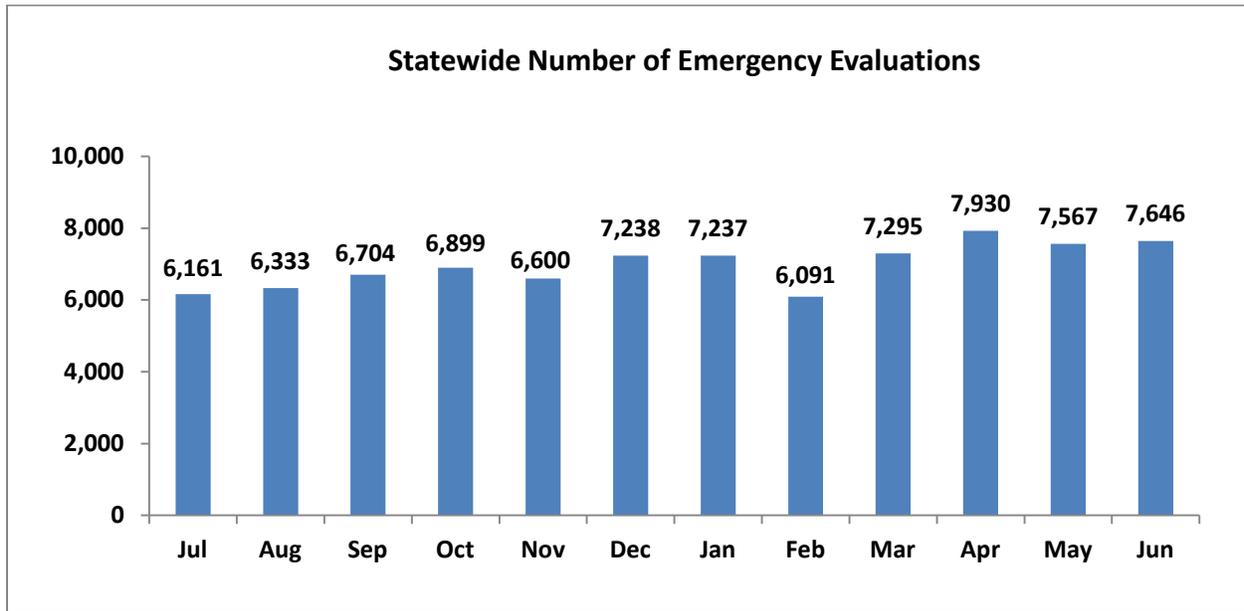
Emergency contacts are events requiring any type of CSB emergency service involvement or intervention. There were 50,916 emergency contacts reported statewide during the month of June, 2015, which is a 1% increase from May, 2015. With the exception of November, 2014 and February 2015, these figures continue a general upward trend since July, 2014, as shown in Graph 1, below. Regional data is displayed in graph 1a and table 1 in Appendix C, page 13. Percent changes from May were fairly small (within 5%), with the exception of region 7 which reported a 12% decrease. DBHDS initiated specific inquiries to all CSBs to better understand the causes of these fluctuations in their respective regions, but no CSBs or regions have been able to identify any specific events, agency actions or system changes that have directly influenced the volume of emergency contacts. 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 account for some variability in these numbers.



Graph 2. Emergency evaluations statewide

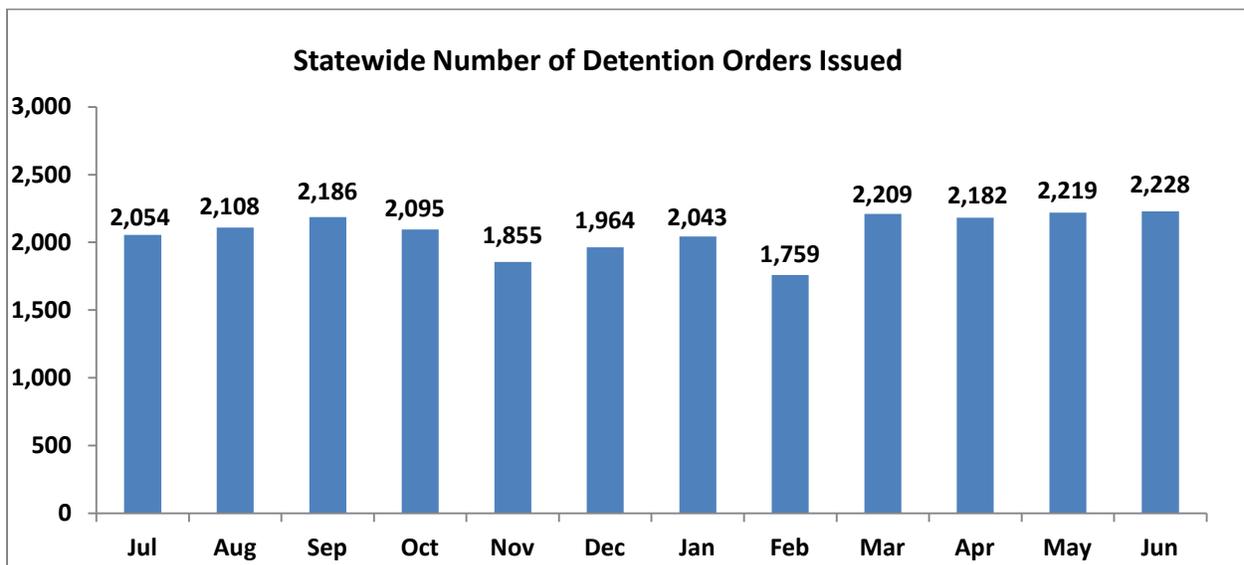
Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. The number of emergency evaluations reported statewide in June was 7,646, which is a 1% increase from May, but generally reflective of the upward trend over the year. However, all regions reported differentials within 10%. Regional data is displayed in graph 2a and table 2 in Appendix C, page 14. 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.

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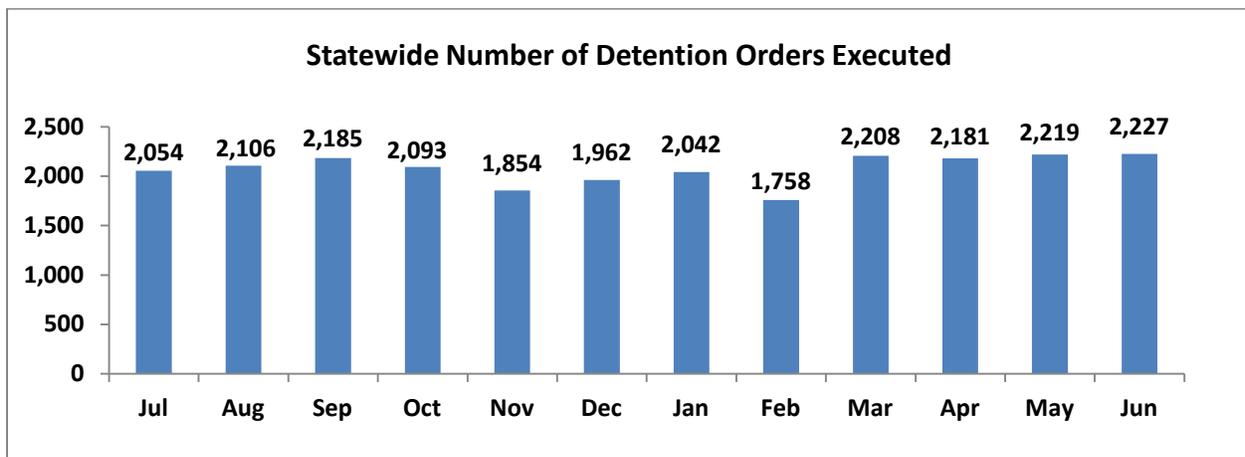
Graph 3. TDOs issued statewide

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 June, there were 2,228 TDOs issued (Graph 3), and 2,227 executed (Graph 4), which is the highest month reported in FY 2015. Region 3 had a 14% increase from May, yet Region 7 reported a 17% decrease and the other CSBs reported variations within 5%. Graph 3a and table 3 (page 15) and graph 4a and table 4 (page 16) display this data reported by region in Appendix C. **About 71% of the emergency evaluations reported in June (5,419 of 7,646) 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 June. The individual was found to meet TDO criteria and the TDO was issued but not executed as the individual required admission to a medical unit for medical treatment. The facility could not provide the level of care warranted for the individual’s medical needs so an alternate medical facility was obtained outside the area. The CSB responsible for the initial evaluation coordinated with the CSB serving the area of the medical facility to re-evaluate the individual upon completion of the medical treatment. This evaluation was completed and the individual was admitted to a private facility. Additional detail is provided in Appendix D, page 21.

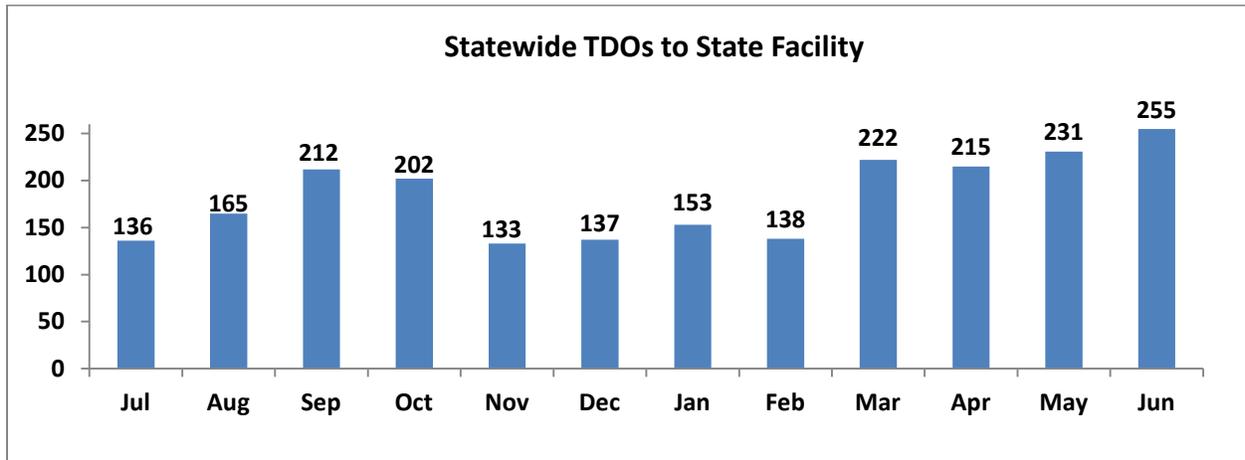


Graph 5. TDO admissions to a state hospital statewide

Of the 2,227 TDOs executed in June, 255 (11%) resulted in admission to a state hospital ^[5] (Graph 5), representing an increase of 10% from May. This is the highest monthly figure for this data element reported to date, in FY 2015. Regions 3 and 5 accounted for 130 (51%) of these admissions and had increases of 19% and 4%, respectively, from May. However, region 2 had an 83% increase from May and reported the highest number of admissions reported, to date in FY2015 (n=33). Furthermore, regions 4 and 7 reported a 22% increase from May. Yet, region 6 reported a 43% decrease from May. 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 17. 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 the use 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.

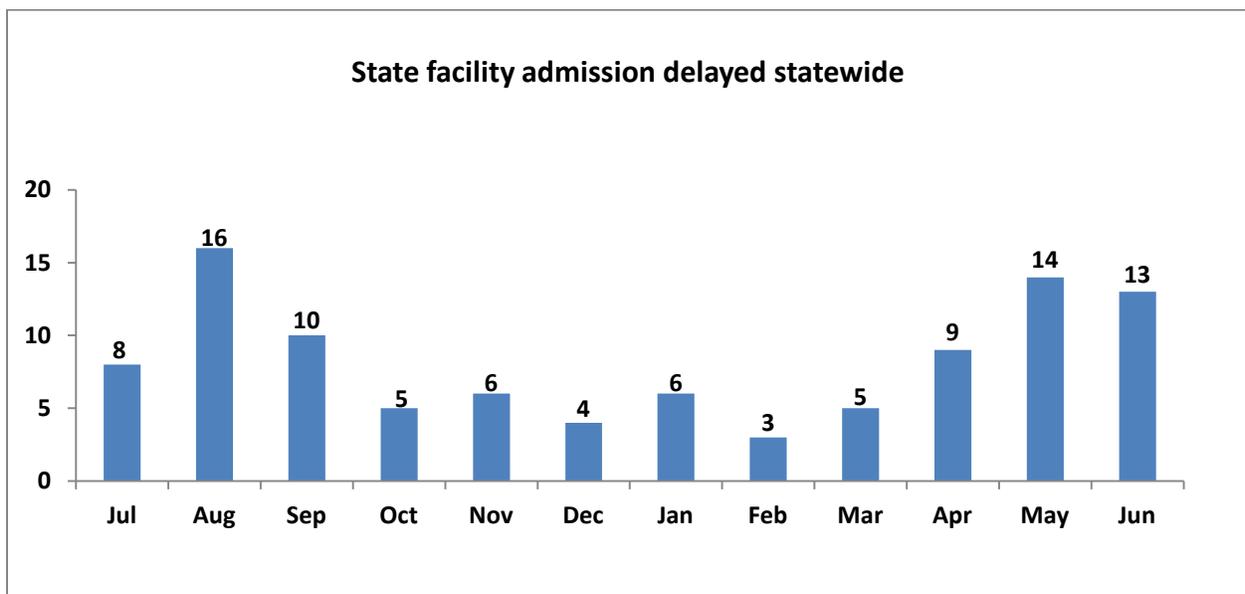
^[5] Source: DBHDS AVATAR admitting CSB data

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Graph 6. State hospital admission delayed statewide

In June, there were 13 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). In ten of the cases the delays were due to the individuals’ more immediate medical testing and treatment needs while the remaining three were due to communication errors. Each of the regions reporting a staff error was contacted by DBHDS to determine the actions taken by the CSB or facility to prevent errors in the future. The 13 cases in June, represent a 7% decrease in the number of delayed admissions from May (May = 14, June = 13) and continues a steady increase since February 2015. Graph 6a and table 6 displays this data by region in Appendix C, page 18, and shows that Regions 4 and 7 did not report this type of occurrence in June.

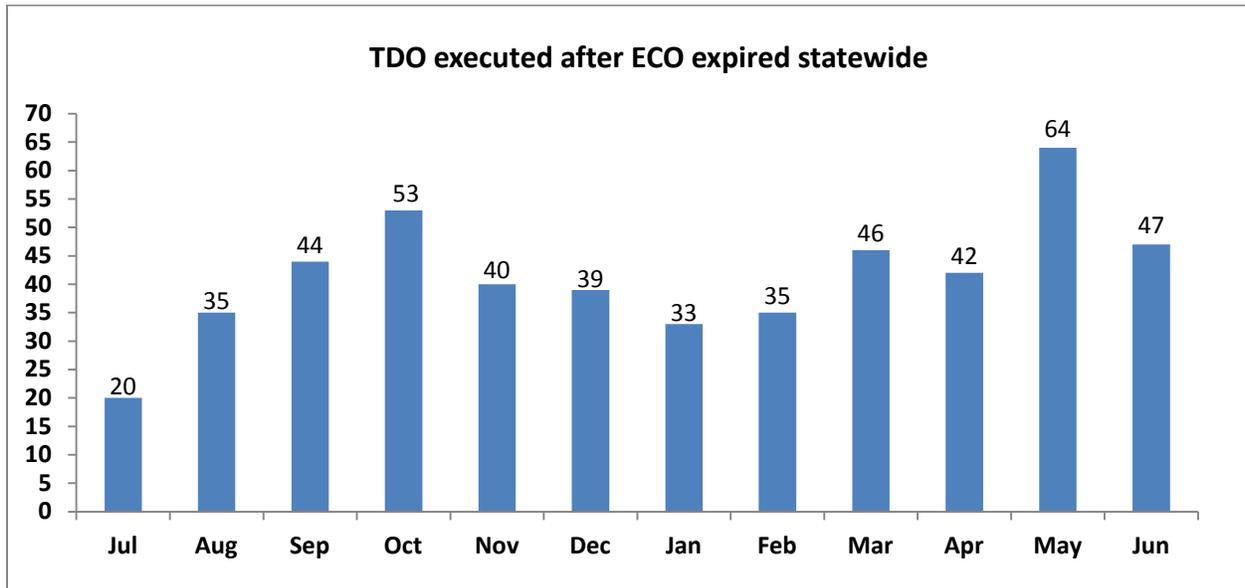


Graph 7. TDO executed after ECO expired statewide

In June, there were 47 (about 2% of total) reported cases where a TDO was issued but not executed until after the ECO period had ended (Graph 7). This is a 27% decrease from May. Almost half of these cases (22 of 47) involved waiting for law enforcement to execute TDOs that were issued prior to the expiration of the ECO time period. In 15 cases, law enforcement declined to execute the TDO until medical treatment was completed with one TDO never executed due to the individual being transferred to an alternate medical facility for treatment (See Appendix D for additional information). Six other cases were due to delayed access to a magistrate or other complications with a magistrate's office for TDO issuance; two more were attributed to staff error; and one other was the result of the CSB receiving late notification from law enforcement that an individual was under ECO. DBHDS provided guidance to the CSBs with delays resulting from magistrate issues, asking these CSBs to work with their court partners in this process (i.e., the magistrates), to review each of the cases to prevent reoccurrence of a similar event. In 40 of these cases, the individuals were maintained safely in an emergency department, with law enforcement or security presence, and ultimately admitted to a psychiatric hospital without any lapse in custody. The remaining individuals were maintained safely within a CIT Assessment Center, the community or a medical facility with law enforcement or security presence. Providers continue to use secure environments (such as locked emergency department or secure assessment sites) as well as law enforcement officers, to maintain custody.

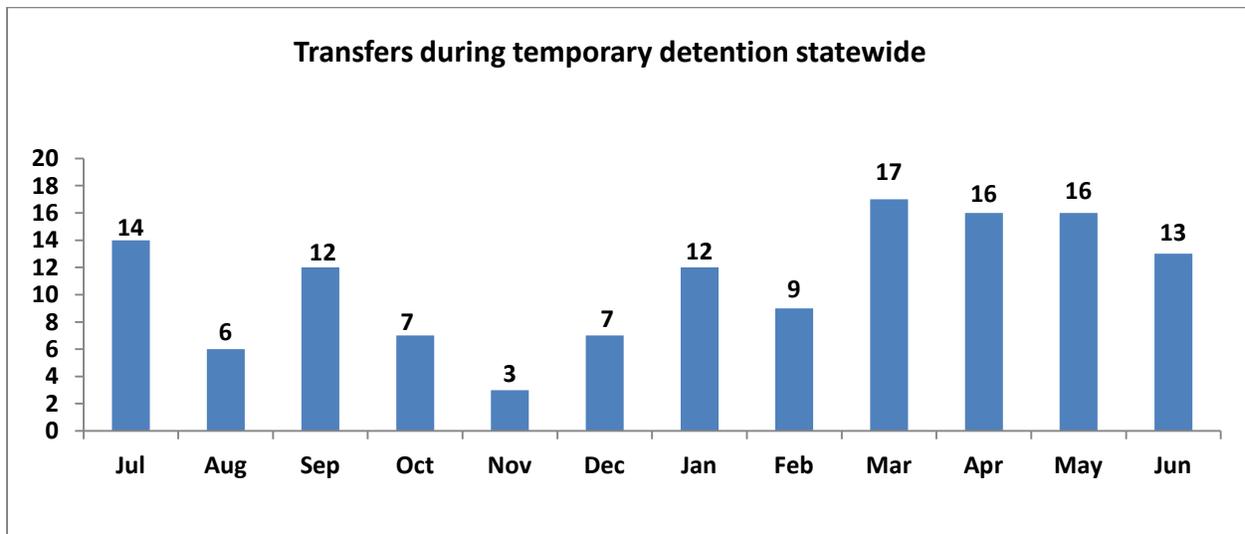
Graph 7a and table 7 display this data by region in Appendix C, page 19. Regionally, frequency of these cases is highly variable and in June all regions reported at least one case. However, Region 7 continues to have a significantly greater number of these cases than any other region. This region reported 128 TDOs issued and executed during June, 2015, with 21 (16%) executed after the ECO period expired. This is a 43% decrease from May, but remains consistent with most months for FY 2015. The time delay between issuance and execution of TDOs ranged from 45 minutes to 11 hours 54 minutes, with a mean of 2 hours and 50 minutes and a median of 1 hours and 50 minutes. Two of these cases involved individuals in custody waiting more than eight hours before the TDO was executed. One of these individuals was taken into custody under an ECO and the CSB was not informed of the ECO until there was less than one hour remaining on the ECO. The CSB completed the assessment and subsequently had a TDO issued with an additional delay occurring with the execution of the order from the magistrate by law enforcement. DBHDS Quality Oversight Team has maintained a continuous active involvement with this region regarding this issue. The regional manager has been asked to undertake an in-depth, impartial review of the emergency response system of the CSB and to make recommendations for change. The review was initiated in June, 2015 and is currently ongoing. DBHDS and the local agencies are continuing to address these transactions intensively, and DBHDS is continuously monitoring and supporting this effort.

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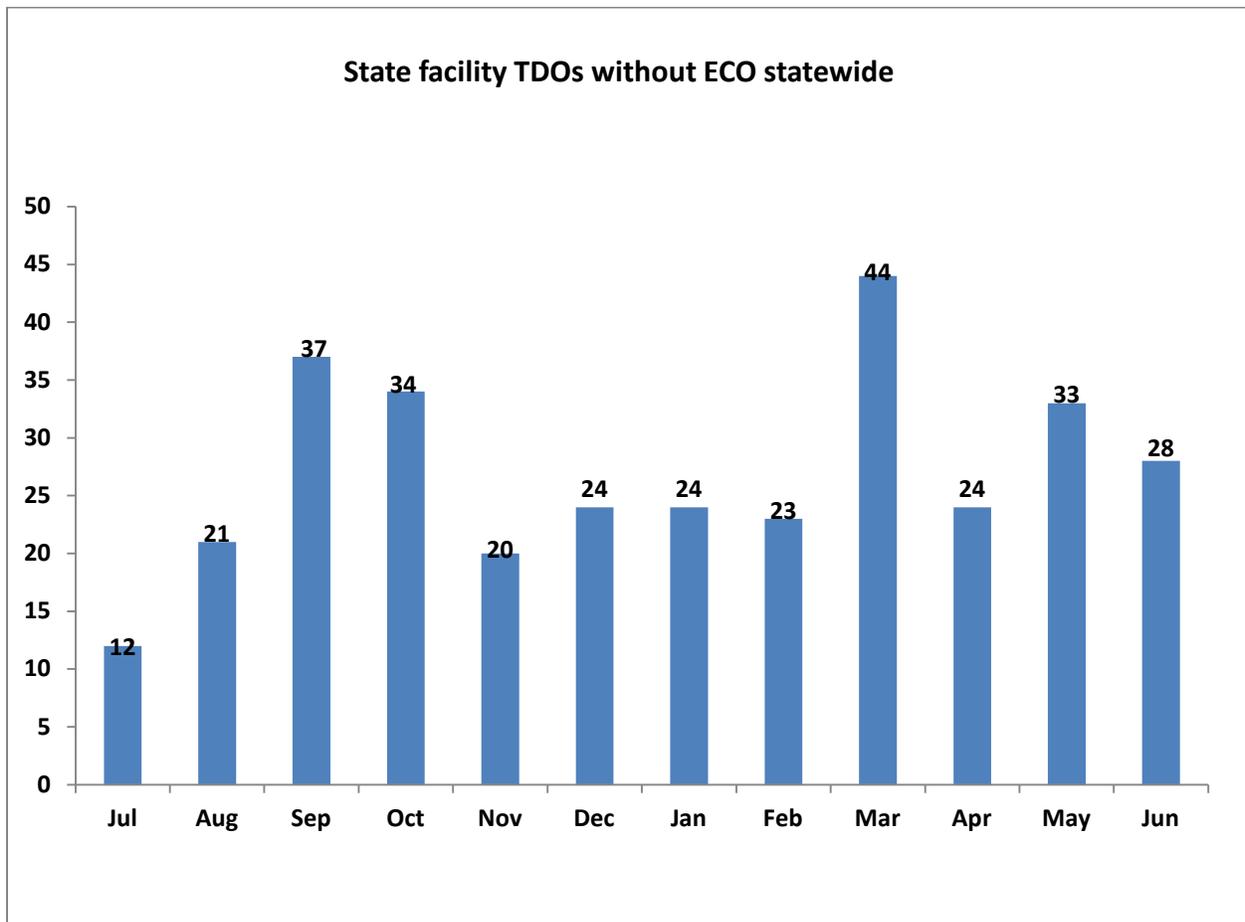
Graph 8. Transfers during temporary detention statewide

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 13 times (<1%) during May (Graph 8). In ten of the cases, the transfer was from a state facility to a private psychiatric facility, one was from a medical facility to a state facility; two were from private psychiatric facilities to state facilities. Graph 8a and table 8 displays this data by region in Appendix C, page 20. Regions 3 and 7 did not report any of these transfers in June.



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 June, there were 28 such admissions to a state facility, which is a decrease of 15% from May (Graph 9). A total of 288 contacts were made for an average of 10 alternate facilities contacted to secure these admissions. Five were due to a lack of capacity of the alternate facilities contacted by the CSB and fifteen 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 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 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 21.



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Discussion:

To enhance consistency and accuracy of CSB reporting, DBHDS has worked continuously since July 2014 with individual CSBs and regions to ensure that data elements and reporting procedures are clearly understood and consistently reported. DBHDS and CSBs have established a workgroup consisting of CSB Executive Directors and DBHDS representatives that has developed a quality review framework to further strengthen the quality oversight processes and ensure that this data is consistently used by CSBs to identify trends and correct problems at the agency, regional, and statewide levels.

In addition to the above ongoing efforts, as this report is being published, DBHDS has begun to plan two additional areas of inquiry and focus for FY 2016. First, DBHDS will be comparing TDO data collected through these monthly CSB reports with court data obtained through the court system to understand further how, and in what ways, existing reporting methods may influence the accuracy or variability of these data. In addition, DBHDS is reviewing its annual CSB program audit procedure to incorporate a focus on this reporting in that review. These FY 2016 oversight efforts will help ensure that DBHDS has the clearest and most accurate understanding of the emergency service events and transactions reported here, which will further strengthen the local, regional and state-level quality improvement process.

These data enable DBHDS to conduct ongoing system monitoring and performance improvement efforts. As a result, DBHDS, CSBs, and local emergency service partners are communicating more regularly and timely to improve local care coordination, eliminating system gaps and clarifying agency and staff roles in the emergency response system. Lastly, DBHDS continues to convene regular and frequent stakeholder meetings at the state level to share this data, communicate directly about problem issues, and jointly develop and implement effective operational improvements.

APPENDIX A

Data Elements Reported Monthly by CSB/BHAs

Each CSB/BHA reports four data factors on volume to the region:

1. **Emergency contacts:** The total number of calls, cases, or events per month requiring any type of CSB emergency services involvement or intervention, whether or not it is about emergency evaluation, and regardless of disposition. Calls seeking information about emergency services, potential referrals, the CSB, etc., should be counted if the calls come to emergency services (e.g., through the crisis line) and require emergency services to respond. Any other contacts to emergency services from individuals, family members, other CSB staff, health providers or any other person or entity, including contacts that require documentation in an individual's health record, should be counted as emergency contacts. Any contacts that precipitate an intervention or emergency response of any kind should be counted as emergency contacts.
2. **Emergency Evaluations:** Emergency evaluations are clinical examinations of individuals that are performed by emergency services or other CSB staff on an emergency basis to determine the person's condition and circumstances, and to formulate a response or intervention if needed. This figure is the total number of emergency evaluations completed, regardless of the disposition, including evaluations conducted in person or by means of two-way electronic video/audio communication as authorized in 37.2-804.1.
3. **Number of TDOs Issued:** TDOs are issued by a magistrate.
4. **Number of TDOs Executed:** TDOs are executed by law enforcement officers. A TDO is executed when the individual is taken into custody by the law enforcement officer serving the temporary detention order. It is possible under some circumstances that a TDO issued by a magistrate may not be executed for some reason.

Each CSB/BHA also reports six additional data elements:

1. **Cases where the state hospital was used as a "last resort":** Under the new statutory procedures effective July 1, 2014, when an individual is in emergency custody and needs temporary detention, and no other temporary detention facility can be found by the end of the 8-hour period of emergency custody, then the state hospital shall admit the individual for temporary detention. Each region's Regional Admission Protocol describes the process to be followed for accessing temporary detention facilities and for accessing the state hospital as a "last resort" facility for temporary detention.
2. **Cases where a back-up state hospital was used:** Under some circumstances, the primary state hospital may not be accessible as the "last resort" temporary detention facility when needed at the end of the 8-hour ECO period, and a back-up state hospital will need to admit the individual as a "last resort" admission.
3. **Cases where the state hospital is called upon as the "last resort" for temporary detention, but admission cannot occur at the 8-hour expiration of the ECO because of a medical or related clinical issue that must be addressed (i.e., medical condition cannot be treated effectively in the state hospital, person is not medically stable for transfer to state hospital, required medical testing is not yet completed, etc.).**

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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.

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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

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APPENDIX C

Graph 1a. Emergency contacts by region

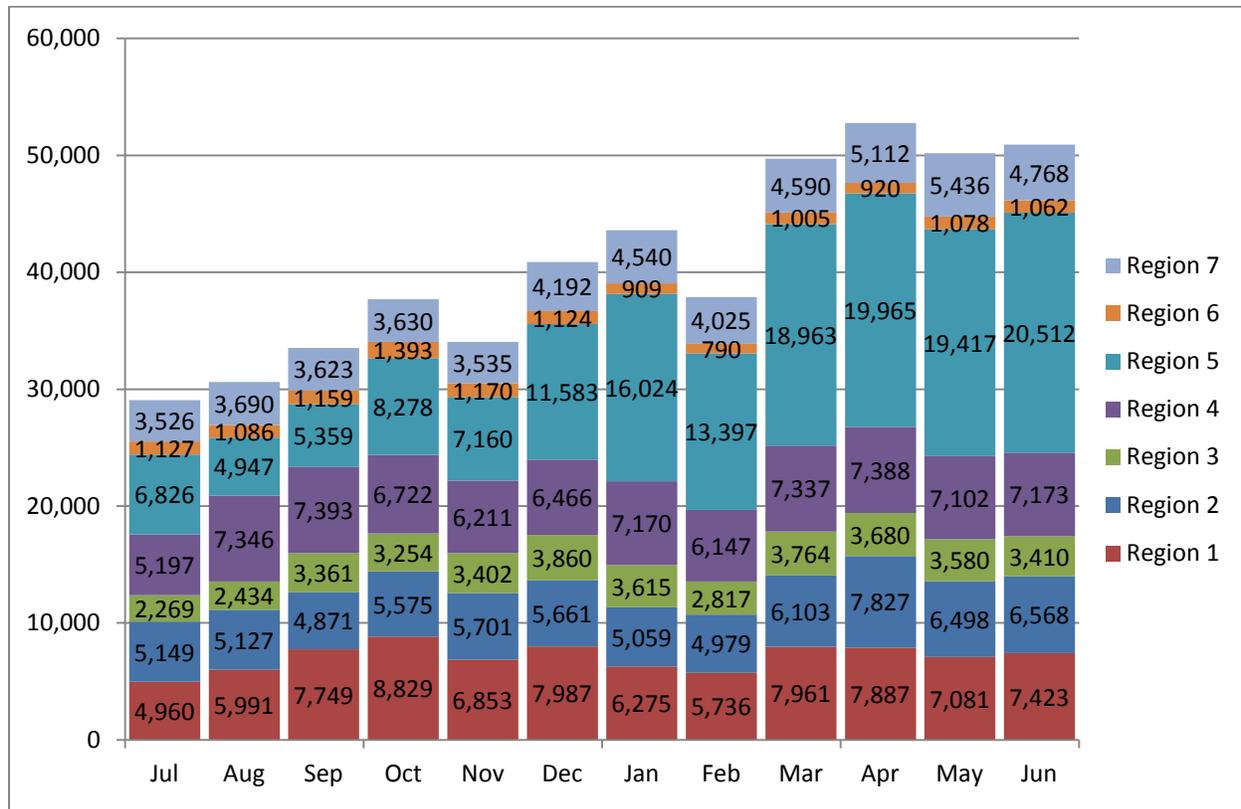


Table 1. Number of emergency contacts (corresponds with graph 1a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
1	4,960	5,991	7,749	8,829	6,853	7,987	6,275	5,736	7,961	7,887	7,081	7,423	84,732
2	5,149	5,127	4,871	5,575	5,701	5,661	5,059	4,979	6,103	7,827	6,498	6,568	69,118
3	2,269	2,434	3,361	3,254	3,402	3,860	3,615	2,817	3,764	3,680	3,580	3,410	39,446
4	5,197	7,346	7,393	6,722	6,211	6,466	7,170	6,147	7,337	7,388	7,102	7,173	81,652
5	6,826	4,947	5,359	8,278	7,160	11,583	16,024	13,397	18,963	19,965	19,417	20,512	152,432
6	1,127	1,086	1,159	1,393	1,170	1,124	909	790	1,005	920	1,078	1,062	12,823
7	3,526	3,690	3,623	3,630	3,535	4,192	4,540	4,025	4,590	5,112	5,436	4,768	50,667
Total	29,054	30,621	33,515	37,681	34,032	40,873	43,592	37,891	49,723	52,779	50,192	50,916	490,869

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Graph 2a. Emergency evaluations by region

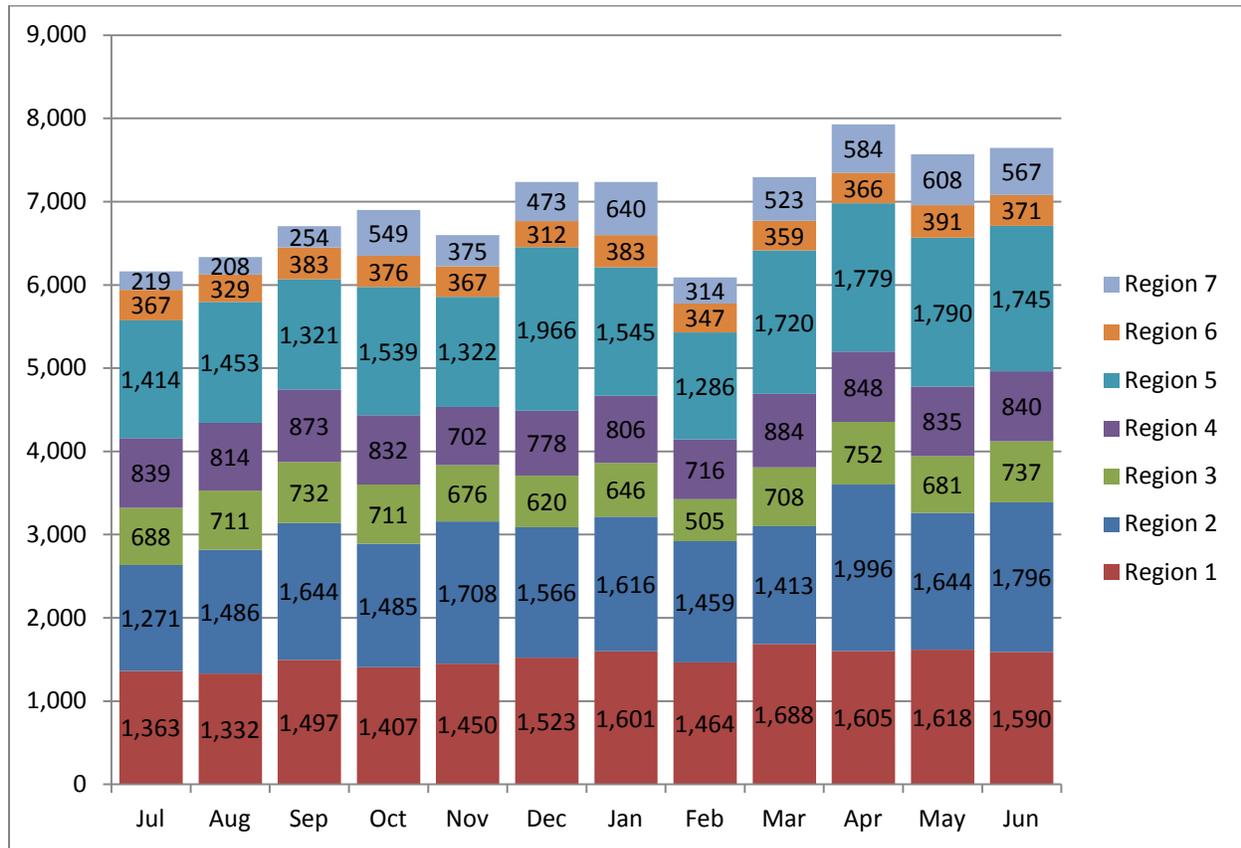


Table 2. Number of emergency evaluations (corresponds with graph 2a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
1	1,363	1,332	1,497	1,407	1,450	1,523	1,601	1,464	1,688	1,605	1,618	1,590	18,138
2	1,271	1,486	1,644	1,485	1,708	1,566	1,616	1,459	1,413	1,996	1,644	1,796	19,084
3	688	711	732	711	676	620	646	505	708	752	681	737	8,167
4	839	814	873	832	702	778	806	716	884	848	835	840	9,767
5	1,414	1,453	1,321	1,539	1,322	1,966	1,545	1,286	1,720	1,779	1,790	1,745	18,880
6	367	329	383	376	367	312	383	347	359	366	391	371	4,351
7	219	208	254	549	375	473	640	314	523	584	608	567	5,315
Total	6,161	6,333	6,704	6,899	6,600	7,238	7,237	6,091	7,295	7,930	7,567	7,646	83,701

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Graph 3a. TDOs issued by region

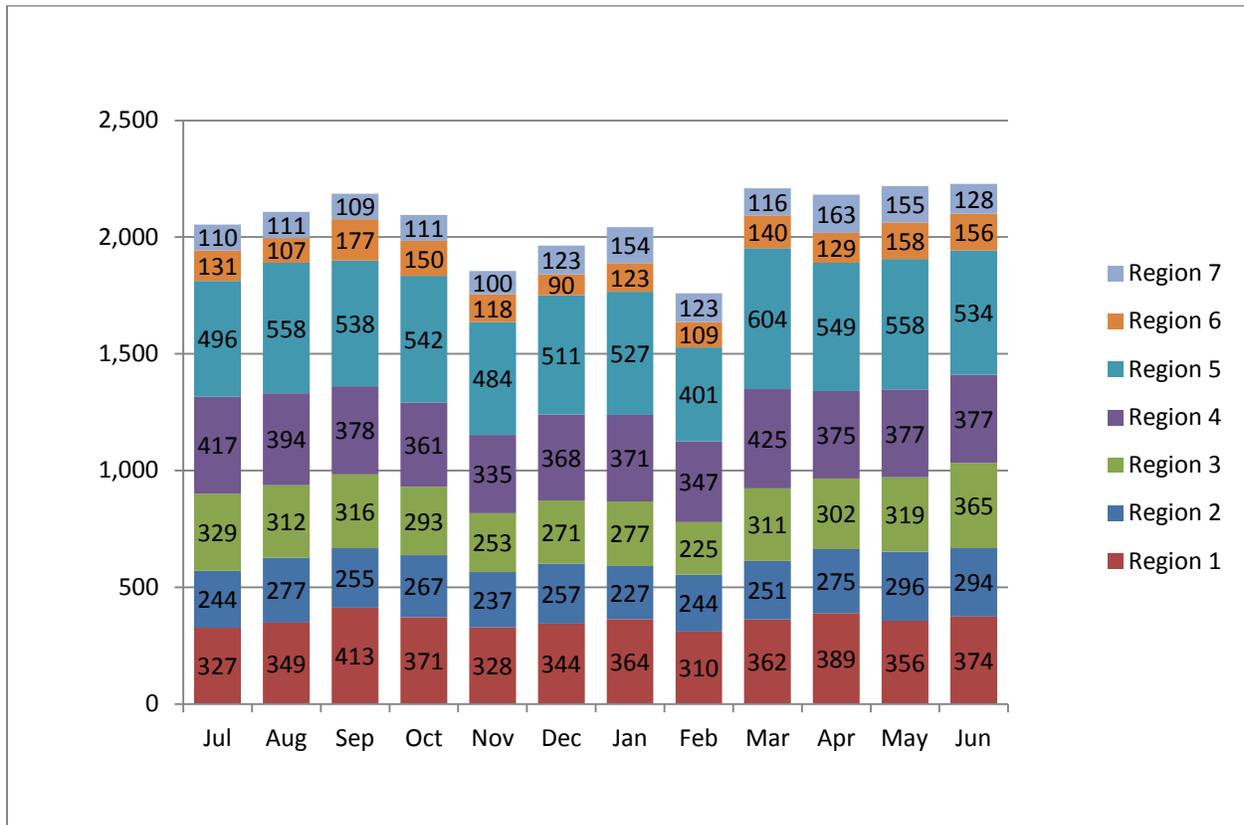


Table 3. Number of TDOs issued (corresponds with graph 3a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
1	327	349	413	371	328	344	364	310	362	389	356	374	4,287
2	244	277	255	267	237	257	227	244	251	275	296	294	3,124
3	329	312	316	293	253	271	277	225	311	302	319	365	3,573
4	417	394	378	361	335	368	371	347	425	375	377	377	4,525
5	496	558	538	542	484	511	527	401	604	549	558	534	6,302
6	131	107	177	150	118	90	123	109	140	129	158	156	1,589
7	110	111	109	111	100	123	154	123	116	163	155	128	1,503
Total	2,054	2,108	2,186	2,095	1,855	1,964	2,043	1,759	2,209	2,182	2,219	2,228	24,902

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Graph 4a. TDOs executed by region

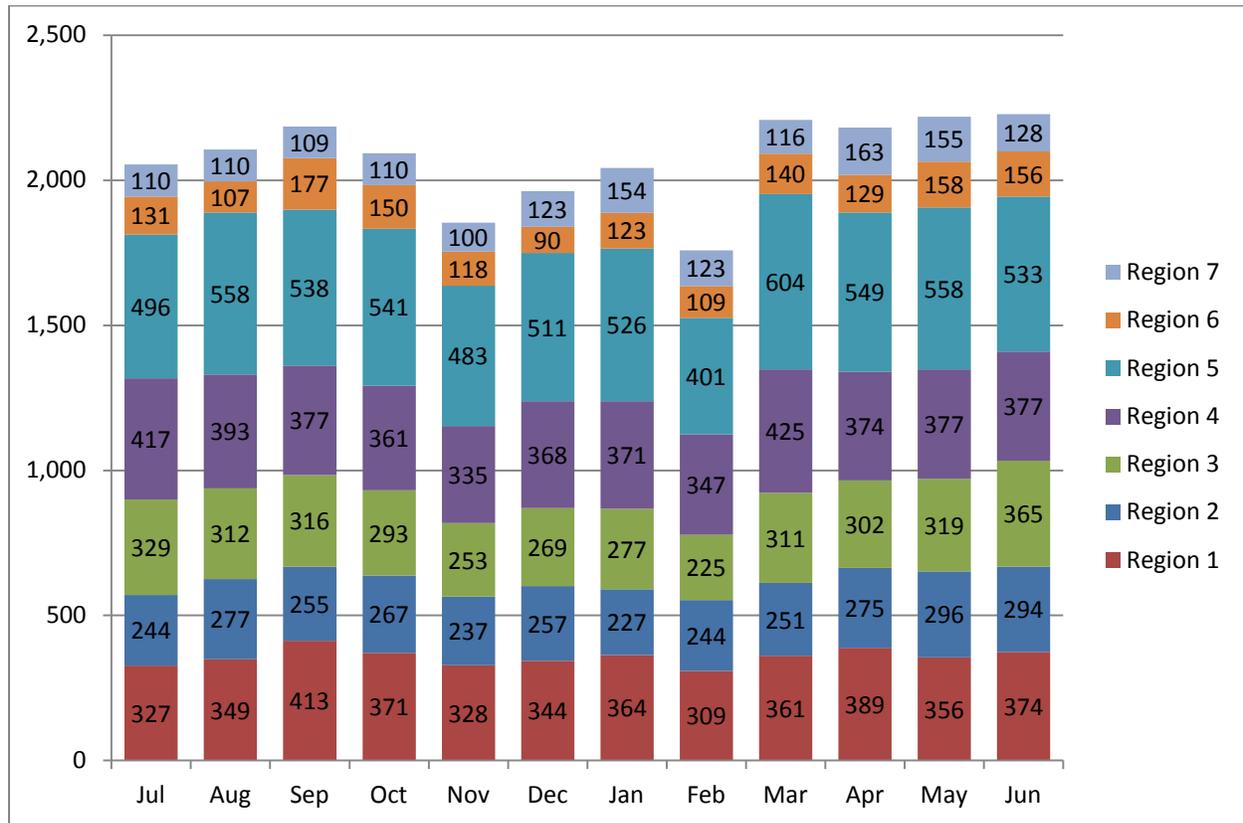


Table 4. Number of TDOs executed (corresponds with graph 4a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
1	327	349	413	371	328	344	364	309	361	389	356	374	4,285
2	244	277	255	267	237	257	227	244	251	275	296	294	3,124
3	329	312	316	293	253	269	277	225	311	302	319	365	3,571
4	417	393	377	361	335	368	371	347	425	374	377	377	4,522
5	496	558	538	541	483	511	526	401	604	549	558	533	6,298
6	131	107	177	150	118	90	123	109	140	129	158	156	1,589
7	110	110	109	110	100	123	154	123	116	163	155	128	1,501
Total	2,054	2,106	2,185	2,093	1,854	1,962	2,042	1,758	2,208	2,181	2,219	2,227	24,889

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

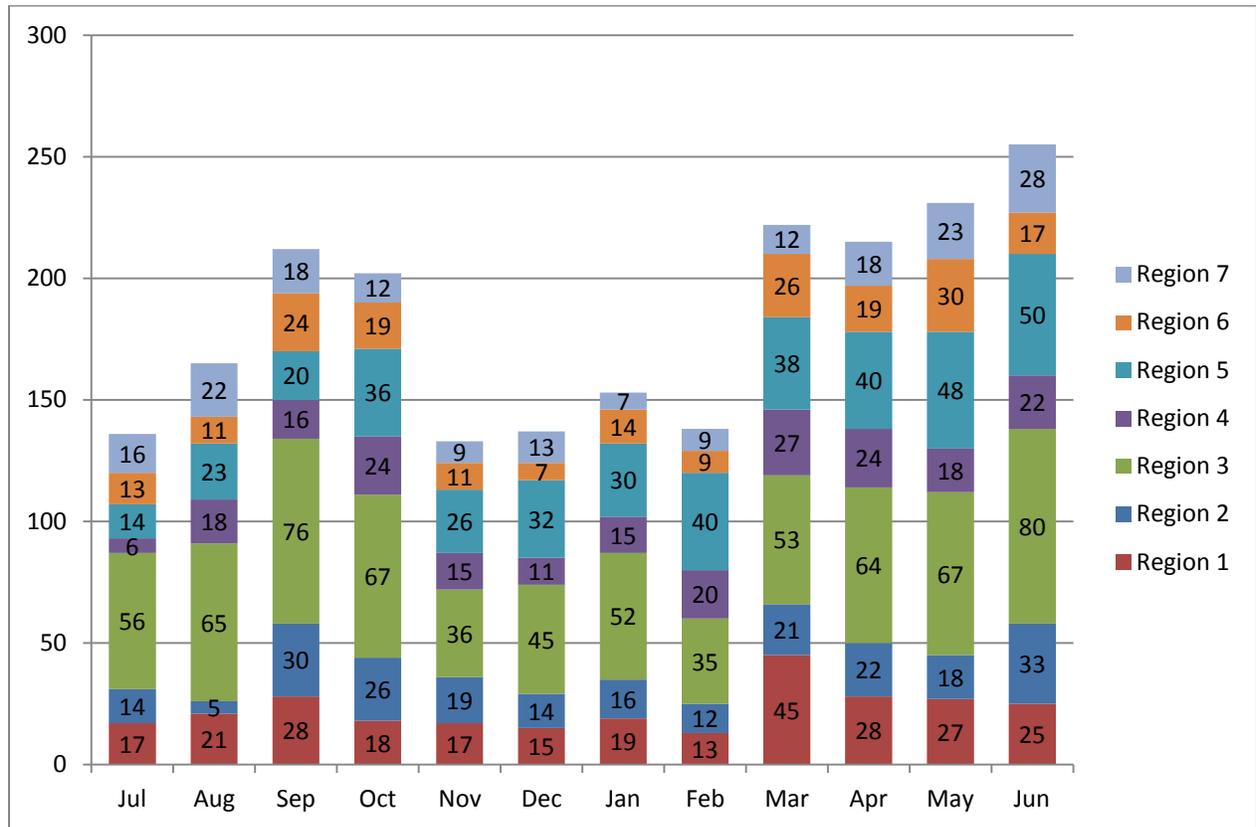


Table 5. TDO admissions to a state hospital (corresponds with graph 5a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
1	17	21	28	18	17	15	19	13	45	28	27	25	273
2	14	5	30	26	19	14	16	12	21	22	18	33	230
3	56	65	76	67	36	45	52	35	53	64	67	80	696
4	6	18	16	24	15	11	15	20	27	24	18	22	216
5	14	23	20	36	26	32	30	40	38	40	48	50	397
6	13	11	24	19	11	7	14	9	26	19	30	17	200
7	16	22	18	12	9	13	7	9	12	18	23	28	187
Total	136	165	212	202	133	137	153	138	222	215	231	255	2199

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Graph 6a. State hospital admission delayed by region

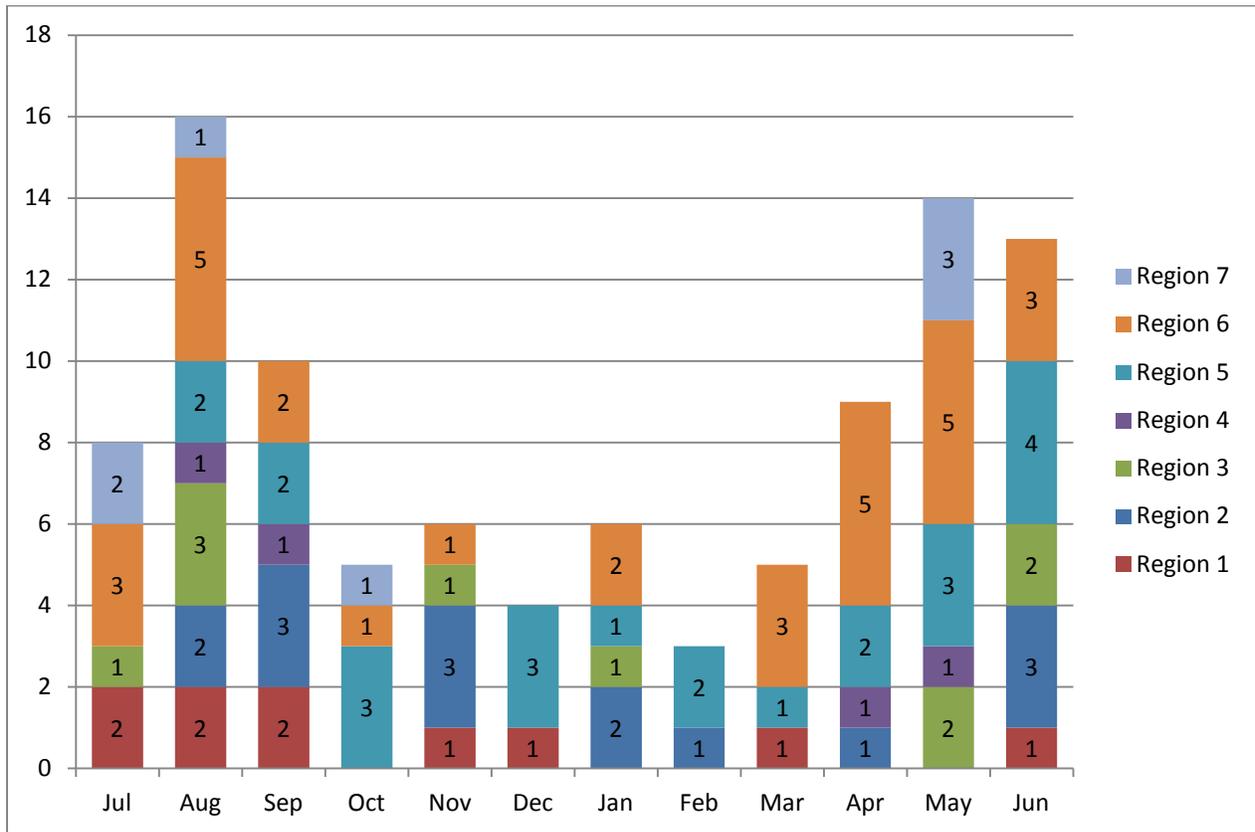


Table 6. State hospital admission delayed (corresponds with graph 6a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
1	2	2	2	0	1	1	0	0	1	0	0	1	10
2	0	2	3	0	3	0	2	1	0	1	0	3	15
3	1	3	0	0	1	0	1	0	0	0	2	2	10
4	0	1	1	0	0	0	0	0	0	1	1	0	4
5	0	2	2	3	0	3	1	2	1	2	3	4	23
6	3	5	2	1	1	0	2	0	3	5	5	3	30
7	2	1	0	1	0	0	0	0	0	0	3	0	7
Total	8	16	10	5	6	4	6	3	5	9	14	13	99

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Graph 7a. TDO executed after ECO expired by region

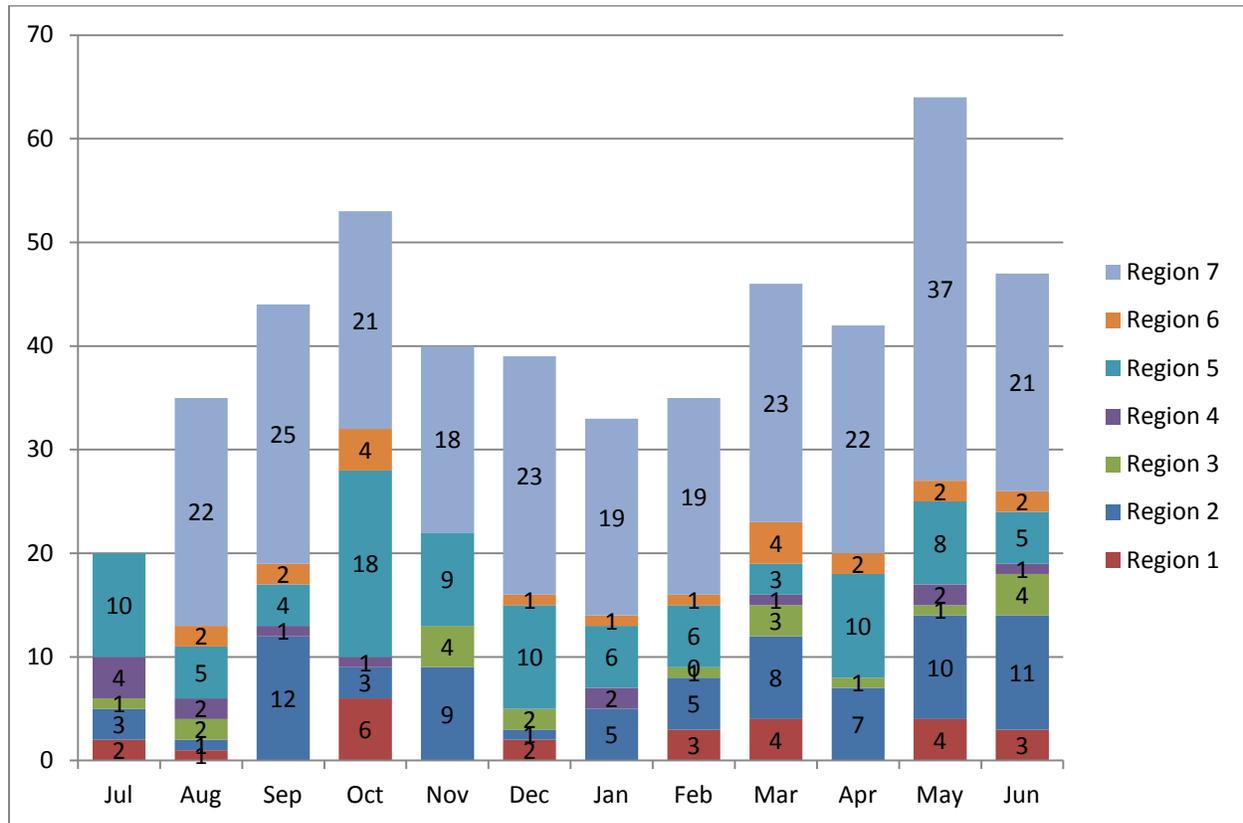


Table 7. TDO executed after ECO expired (corresponds with graph 7a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
1	2	1	0	6	0	2	0	3	4	0	4	3	25
2	3	1	12	3	9	1	5	5	8	7	10	11	75
3	1	2	0	0	4	2	0	1	3	1	1	4	19
4	4	2	1	1	0	0	2	0	1	0	2	1	14
5	10	5	4	18	9	10	6	6	3	10	8	5	94
6	0	2	2	4	0	1	1	1	4	2	2	2	21
7	0	22	25	21	18	23	19	19	23	22	37	21	250
Total	20	35	44	53	40	39	33	35	46	42	64	47	498

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Graph 8a. Transfers during temporary detention by region

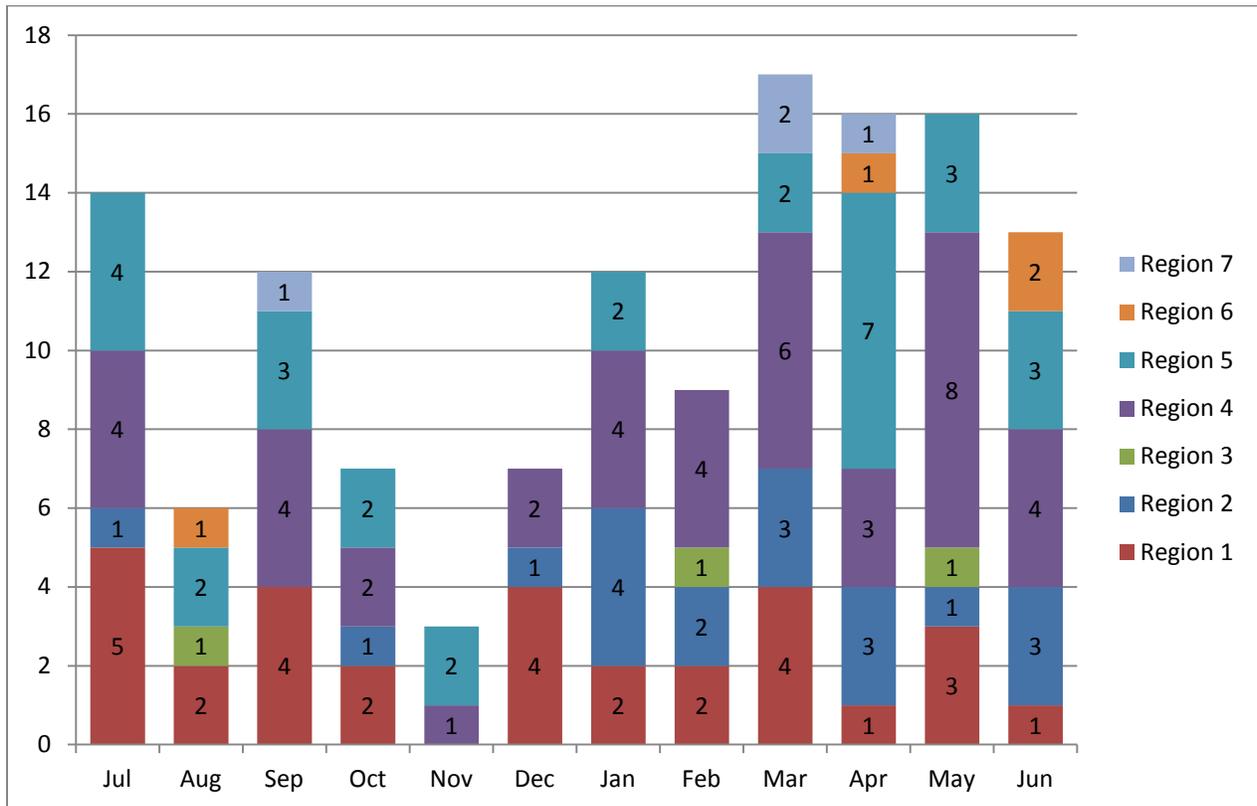


Table 8. Transfers during temporary detention (corresponds with graph 8a, pg 10)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
1	5	2	4	2	0	4	2	2	4	1	3	1	30
2	1	0	0	1	0	1	4	2	3	3	1	3	19
3	0	1	0	0	0	0	0	1	0	0	1	0	3
4	4	0	4	2	1	2	4	4	6	3	8	4	42
5	4	2	3	2	2	0	2	0	2	7	3	3	30
6	0	1	0	0	0	0	0	0	0	1	0	2	4
7	0	0	1	0	0	0	0	0	2	1	0	0	4
Total	14	6	12	7	3	7	12	9	17	16	16	13	132

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

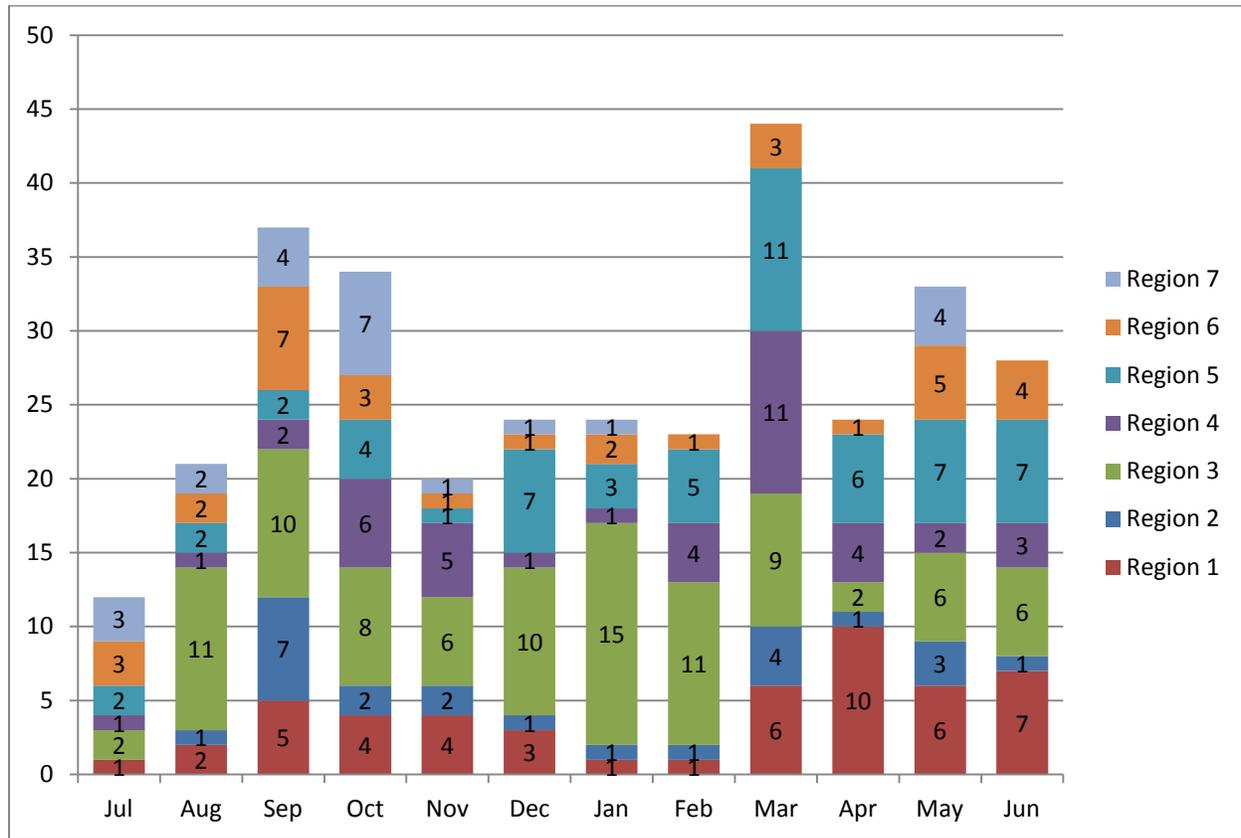


Table 9. State hospital TDOs without ECOs (corresponds with graph 9a)

Region	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
1	1	2	5	4	4	3	1	1	6	10	6	7	55
2	0	1	7	2	2	1	1	1	4	1	3	1	28
3	2	11	10	8	6	10	15	11	9	2	6	6	97
4	1	1	2	6	5	1	1	4	11	4	2	3	45
5	2	2	2	4	1	7	3	5	11	6	7	7	58
6	3	2	7	3	1	1	2	1	3	1	5	4	39
7	3	2	4	7	1	1	1	0	0	0	4	0	26
Total	12	21	37	34	20	24	24	23	44	24	33	28	325

APPENDIX D

DBHDS requires CSBs to report within 24-hours any event involving an individual who has been evaluated and needs temporary detention for whom the TDO is not executed for any reason, whether or not an ECO was issued or in effect. These reports are sent to a DBHDS Quality Oversight team that includes the DBHDS Medical Director, the Assistant Commissioner for Behavioral Health, the Director of Community Behavioral Health Services, the Director of Mental Health Services, and the MH Crisis Specialist. Each report contains the CSB's description of the incident and the CSB's proposed actions to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality Oversight team examines the report for completeness and comprehensiveness, and responds immediately to the CSB Executive Director if any further information is needed. In addition, DBHDS specifies additional necessary follow up actions, and requests appropriate follow up communication from the CSB. DBHDS maintains an open incident file until the incident has resolved and all follow up actions are completed.

There were seven such events during the month of June 2015. Six of these cases involved individuals who were in emergency custody when evaluated, and one involved an individual who was not under an ECO. Of the seven cases, two individuals eloped from the evaluation site before the TDO was executed. Both of the individuals were eventually hospitalized. 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 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, administrative or process issues need to be addressed in developing solutions to the problems encountered; and what strategies might be implemented with partner entities. These case-specific DBHDS interventions are ongoing until resolved.

1. This individual was evaluated in an emergency department on a voluntary basis and was determined to meet TDO criteria. While the evaluator was securing a bed, the individual eloped. The evaluator notified hospital security and law enforcement of the elopement. The evaluator attempted to make contact with the individual on a cell phone but the calls went directly to voice mail. The evaluator contacted the individual's spouse who reported receiving a call from the individual at a local convenience store. The evaluator obtained an ECO from the magistrate and law enforcement took the individual into custody and returned the individual to the emergency department. A TDO was issued and subsequently executed without further incident.

The DBHDS Quality Oversight Team reviewed the event. The CSB conducted an internal review of the event and followed up with the hospital administrators for better collaboration and cooperation during events such as these. No further actions were suggested by the team.

2. This individual was taken into emergency custody and transported to the CSB office for evaluation. The individual was determined to meet the criteria for a TDO. The individual became increasingly aggressive with the officer while in custody while the evaluator was securing a bed and obtaining the TDO. The magistrate issued the TDO however the individual escaped from law enforcement custody before the order could be executed. Several law enforcement agencies in the area worked collaboratively to apprehend the individual but all efforts were unsuccessful in locating the individual. The evaluator phoned the individuals home and efforts to locate other family members were unsuccessful. A neighboring law enforcement agency located the individual and transported the individual to a medical facility for assessment where the TDO was executed and the individual was transported to the state facility without further incident.

The DBHDS Oversight Review Team reviewed the event and received a comprehensive root cause analysis of the event from the CSB. The analysis was conducted with the other community partners involved in this event. The analysis revealed areas of concern as well as identified ways to prevent future events. No further actions recommended.

3. This individual was evaluated while under emergency custody in an emergency department and determined to meet TDO criteria. Due to the individual's chronic medical needs there was a need for significant coordination between the emergency department and the facility of detention which delayed the evaluator in receiving a confirmation of acceptance from the facility. Once the confirmation was received, the evaluator petitioned the magistrate for the TDO. There was an additional delay from the magistrate's office in issuing the order. There was no loss of custody and the TDO was executed by law enforcement after the ECO period had expired.

DBHDS reviewed the event and followed up with the CSB on their actions. The CSBs met with their staff to review the established regional protocols. The CSB met with the facility to identify ways to minimize the time needed for accepting an individual being sent to them on a TDO. The CSB maintains ongoing communication with the magistrate's office to work cooperatively within the Code of Virginia. No further actions recommended.

4. This individual was assessed while in emergency custody in an emergency department and determined to meet criteria for a TDO. After the TDO was issued but not executed, the ED physician decided to admit the individual for further medical testing and treatment. The magistrate was apprised of the situation and the TDO was not executed. The CSB maintained contact with the medical facility until the individual was determined to be medically stable for psychiatric care. The CSB re-evaluated the individual and found the criteria for a TDO was met. This individual was detained following the conclusion of medical treatment with no loss of custody.

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DBHDS reviewed the event with no recommendations.

5. This individual was evaluated at a local sheriff's office while in emergency custody and determined to meet TDO criteria. The evaluator contacted the state facility in compliance with the regional admission protocols to access the facility as the facility of last resort. The evaluator was informed the facility was at capacity and admissions were being diverted to another state facility. The evaluator decided not to contact the alternative state facility to access a bed and developed with the individual and their spouse a safety plan. The plan was for the individual to return to the CSB the next day to meet with case management staff. The individual and spouse agreed to the plan and left the sheriff's office. They both presented to the CSB the following day and the individual was re-evaluated and a TDO was issued and executed.

DBHDS Quality Review Team reviewed the event. The CSB has provided face to face staff education on the correct process for obtaining a willing facility and participation in the education was documented. The emergency services director has implemented a plan to meet quarterly in face to face meetings with staff to provide a refresher on the regional protocols. The state facility director instituted an additional process for staff when the facility is nearing capacity and for all staff involved with the admission process to be provided a refresher on the facilities protocols relating to TDO admissions. No further actions recommended.

6. This individual was evaluated at an adult living facility and determined to meet the criteria for a TDO. This individual had known medical problems and routinely refuses to take medications as prescribed. The evaluator obtained an ECO to have this individual transported to an emergency department for evaluation and treatment prior to petitioning for a TDO. The CSB was notified by the emergency department of the law enforcement refusal to maintain custody of this individual after executing the TDO and arriving at the facility. The officer left this individual in the emergency department citing the opinion "the individual does not meet ECO criteria". The emergency department safely maintained this individual during the medical assessment and testing. The evaluator conducted a search for a bed for this individual and was unable to locate a willing facility and turned to the state facility as a facility of last resort. The individual responsible for admissions to the facility was not willing to accept the individual. The emergency department did not have sufficient reason to admit this individual to a medical unit so the individual was returned to the adult living facility. The CSB re-evaluated this individual the following day and a TDO was issued and executed.

The DBHDS Quality Review Team reviewed the event and contacted the state facility director for information. The state facility director met with medical and admission staff to refresh them on the protocol of accepting admissions when contacted to be the facility of last resort. The facility manager distributed his personal phone number to the ES Managers to contact him directly should they encounter any difficulties with placing individuals in the facility as a last resort. The

CSB met with local law enforcement on the officer's refusal to remain with the individual after executing the ECO to discuss the role of law enforcement in the ECO process. The CSB met with the emergency evaluators to provide guidance and a refresher on the regional protocols for accessing a bed at a state facility. No further actions recommended.

7. This individual was seen while in emergency custody in an emergency department. The CSB evaluator conducted the assessment and determined the individual met criteria for a TDO. The TDO was issued by the magistrate, however this individual had acute medical needs warranting a transfer to another medical facility for inpatient medical observation and treatment. The TDO was not executed and the CSB was informed of this by law enforcement or the magistrate. The alternate facility was not in the area served by the evaluating CSB. The CSB serving the alternate facility completed an evaluation and the individual was admitted to a psychiatric facility following the completion of medical treatment.

The DBHDS Quality Oversight Team reviewed the event. The CSB met with local law enforcement on the need for communication when an order is not executed for any reason. The CSB will maintain ongoing conversations with law enforcement to review events and to build a cooperative and collaborative relationship. DBHDS recommended the CSB maintain contact with any individual deemed to meet TDO criteria until a TDO has been executed. No further actions recommended.

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.