

History and Context

For a review of the history and purpose of these reports, the reader is referred to the “Overview: New TDO Exception Reporting Data” document dated January 2015 and available on the Department of Behavioral Health and Developmental Services (DBHDS) website at the following link:

<http://www.dbhds.virginia.gov/library/document-library/omh-tdo-exception-newreportingdata.pdf>.

This document is the fourth 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 October 2014. 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 upon evaluation need temporary detention, but do not receive that intervention. There were eight such events in this reporting period. Of these eight events, seven were elopements and one individual was diverted for urgent medical care. In four of the eight cases, a TDO was subsequently executed and the individual hospitalized. Two others were engaged in voluntary outpatient treatment at the CSB and two others had subsequent contact with the CSB and no longer needed temporary detention, but did not go into CSB care. **The DBHDS Medical Director, Assistant Commissioner for Behavioral Health Services, and Director of the Office of Mental Health reviewed each event and the Director of the Office Mental Health ensured appropriate follow-up and corrective actions were taken.** Additional detail on each of these cases can be found in Appendix D, page 20.

Graph 1. Emergency contacts statewide

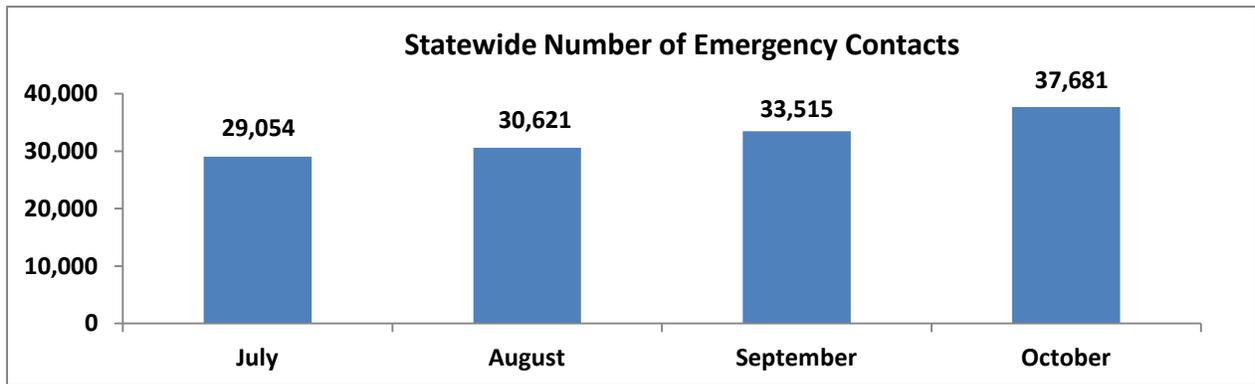
Emergency contacts are events requiring any type of CSB emergency service involvement or intervention. There were 37,681 emergency contacts reported statewide during the month of October, which is a 12% increase from September and a general trend upward since July. **It should be noted that in the first quarter of FY 2015 no one was denied services due to lack of an available bed.** The upward trend in emergency contacts is at least partially attributable to continuing refinement of local data collection practices intended to ensure complete and uniform data collection and to reduce reporting variations over time. Seventy-percent (2,919 out of 4,166) of the increase in emergency contacts occurred in Region 5 following consultation with DBHDS regarding their reporting protocols. DBHDS is closely monitoring this data and actively working with regions to identify and address factors contributing to trend lines. Graph 1, below, displays the statewide number of emergency contacts for July through October. Regional data is displayed in graph 1a and table 1 in Appendix C, page 11.

^[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.

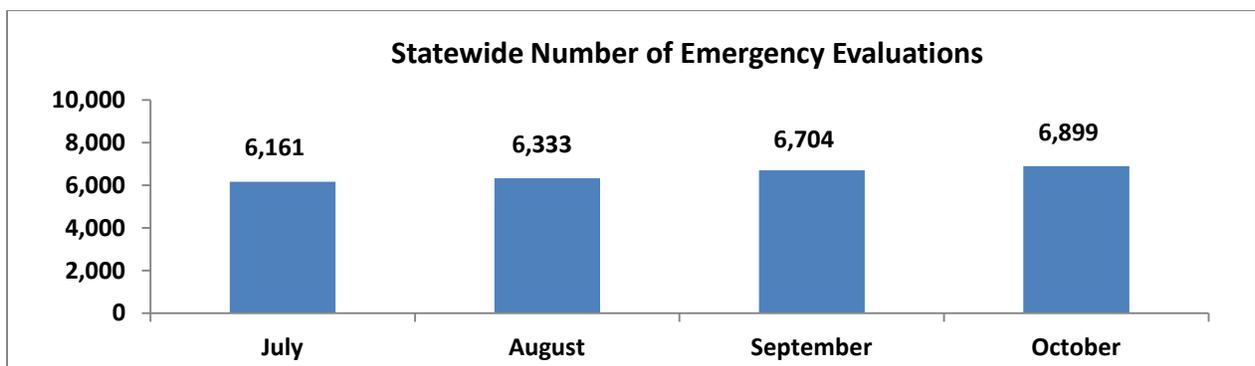
^[3] In addition, data is reported both statewide and by region throughout the report and in Appendix C.

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Graph 2. Emergency evaluations statewide

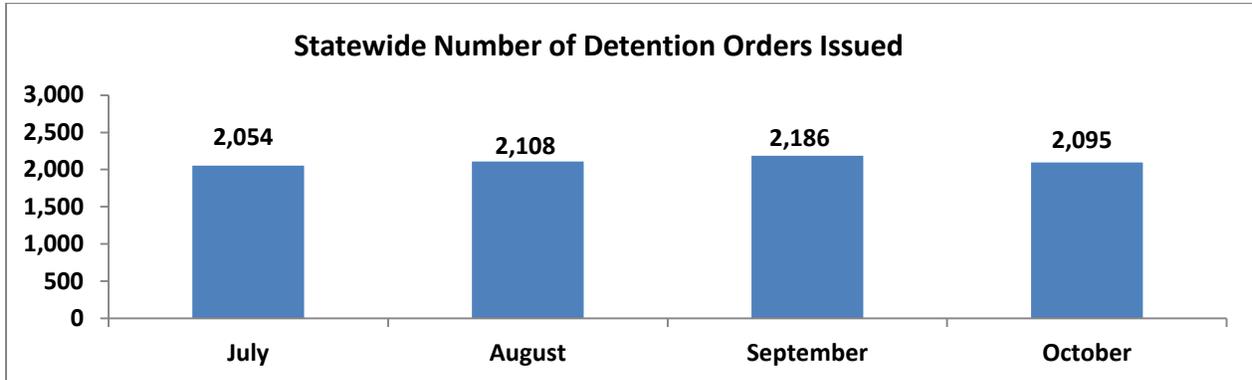
Emergency evaluations are full, in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis (these exams may also be conducted electronically by two-way video and audio communication). The number of emergency evaluations reported statewide in October was 6,899, which is an increase of about 3% from September, following a general trend upward since July (Graph 2). Region 7 reported 549 emergency evaluations, which is an increase of 116% from the month of September. DBHDS has initiated discussion with Region 7 to identify and address factors contributing to this trend. Regional data is displayed in graph 2a and table 2 in Appendix C, page 12. 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

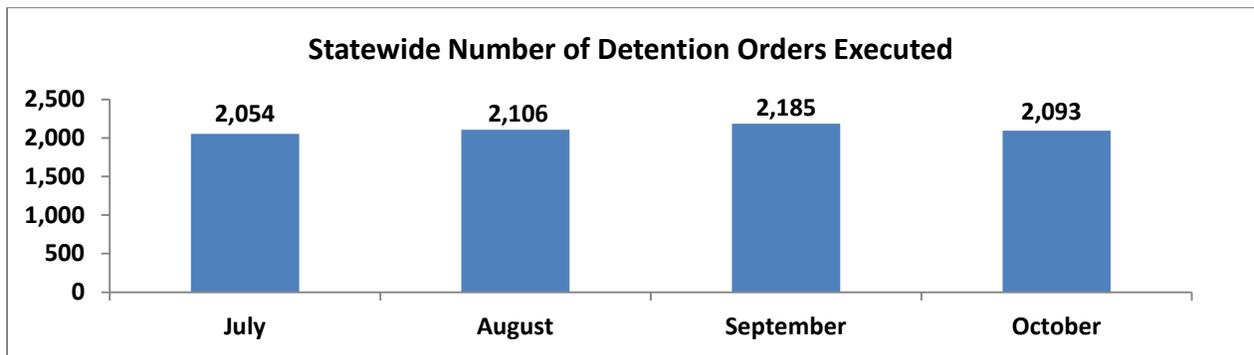
A TDO is issued by a magistrate after considering the results of the CSB evaluation and other relevant evidence, and determining that the person meets the criteria for temporary detention under § 37.2-809 or § 16.1-340.1. A TDO is executed when the individual is taken into custody by the officer serving the order. In October, there were 2,095 TDOs issued (Graph 3), and 2,093 TDOs executed (Graph 4). Graph 3a

and table 3 (page 13) and graph 4a and table 4 (page 14), display this data by region in Appendix C. This is an approximately 4% decrease from September, for both categories. **Sixty-nine percent of the emergency evaluations in October (4,804 of 6,899) did not result in a TDO.**



Graph 4. TDOs executed statewide

There were two TDOs issued but not executed during the month of October. Both instances involved individuals who were determined to require temporary detention but were not able to be located by law enforcement until after the TDOs expired. Both individuals were re-assessed and no longer met TDO criteria. In addition, their family members assisted in developing plans to meet the identified needs. The CSB in both of these situations followed up with law enforcement and other stakeholders to emphasize the need to maintain custody of every individual who requires temporary detention, regardless of the presence of an ECO or the expiration time of an ECO.



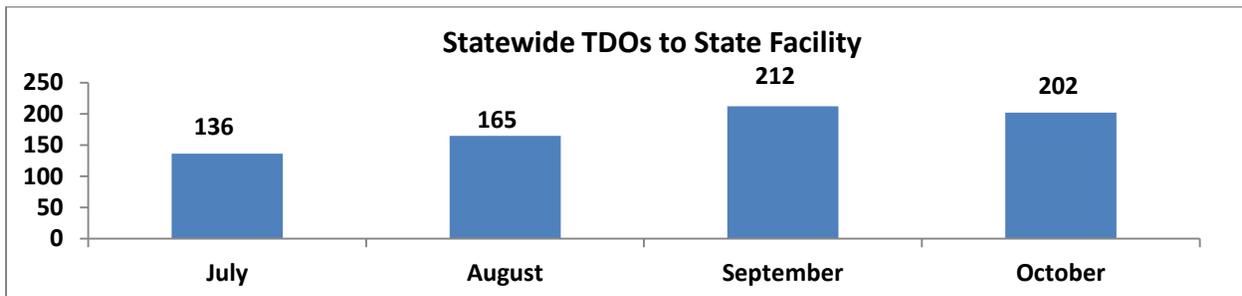
Graph 5. TDO admissions to a state hospital statewide

Of the 2,093 TDOs executed in October, 202 (<10%) resulted in the individual being admitted to a state hospital ^[4] (Graph 5). This is a decrease of <5% from September, following a trend upward from July. Each region has in place specific temporary detention admission protocols. These protocols have been

^[4] Source: DBHDS AVATAR admitting CSB data

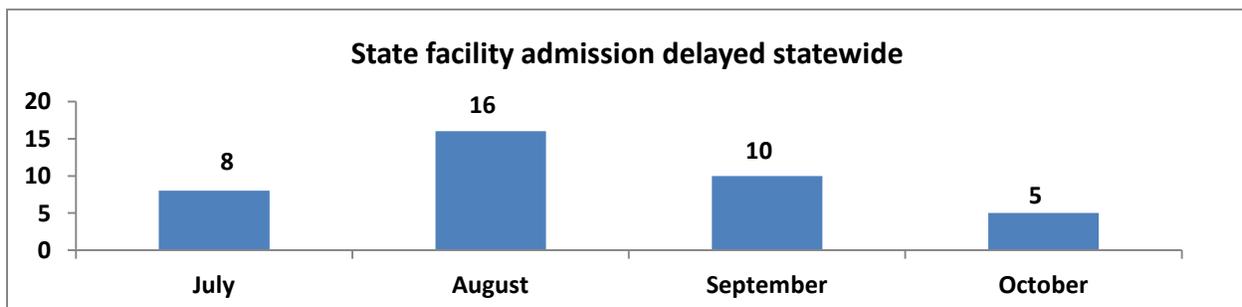
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developed collaboratively within the region and are revised as individual and system needs change in each community. The variance among regions in the number of state hospital TDO admissions shown in Graph 5a and table 5 in Appendix C, page 15, reflects each region's unique resources and protocols. Region 3, for example, encompasses a large geographic area (southwest Virginia) with limited access to community psychiatric facilities, and is more reliant on state facilities, as compared to other regions. Region 5 reported 36 TDO admissions to a state hospital which is an increase of 80% from the month of September. DBHDS staff has maintained continuous contact with this region regarding their reporting, and met with the regional leadership on November 3 to review the region's focus on these cases and the priority of minimizing these referrals. DBHDS continues to monitor this trend and work with Region 5.



Graph 6. State hospital admission delayed statewide

In October, there were five occasions wherein the state hospital was deemed the “hospital of last resort” but admission could not be accomplished before the ECO time period expired due to medical treatment needs (Graph 6). All of the individuals were ultimately admitted to the state psychiatric hospital. This is a 50% decrease from October, and a steady downward trend since August. Graph 6a and table 6 displays this data by region in Appendix C, page 16, and shows that regions 1, 2, 3, and 4 did not experience this type of occurrence in October.



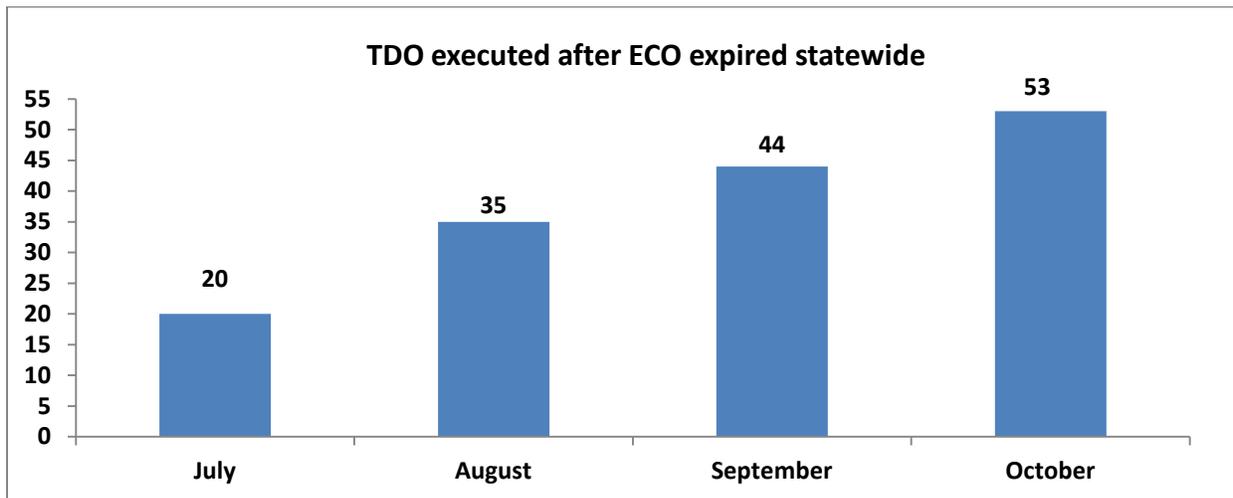
Graph 7. TDO executed after ECO expired statewide

In October, there were 53 (<3%) reported cases where a TDO was issued but not executed until after the ECO period had ended (Graph 7). This is a 20% increase from September and a steady upward trend from July. This trend may reflect, in part, changes in CSB reporting practices because several CSBs have sought clarification and received guidance on reporting this type of event since July. In most of these cases, the

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individuals remained safely within an emergency department, crisis assessment center, or CSB offices without incident until the TDO could be executed. Four of the events occurred at CSB offices where no law enforcement or security was present. In one case, the individual eloped from the CSB office while the CSB was awaiting the arrival of law enforcement with the ECO. Use of physically secure environments (such as a locked emergency department) and physical restraint, as well as having law enforcement present were strategies used to maintain custody. Graph 7a and table 7 display this data by region in Appendix C, page 17. Region 3 did not experience this type of event in October.

Region 7 continues to have a significantly greater number of these cases due to varying law enforcement response times and interpretations of how soon a TDO needs to be executed after issuance. DBHDS has initiated follow-up strategies with the CSBs in Region 7 to reduce these numbers. DBHDS has also issued additional guidance to each of the CSBs and regions requiring more detailed accounts of quality improvement efforts that are undertaken as a result of identified areas of concern from data contained here. Region 5 reported 18 cases in October which is 350% increase over the month of September. As stated above, DBHDS met with the regional leadership on November 3 to review the Region 5 focus on these cases, and the Assistant Commissioner for Behavioral Health has scheduled a follow up meeting with the regional Executive Directors on February 9, 2015. DBHDS will continue to monitor this trend, and identify and address the contributing factors.

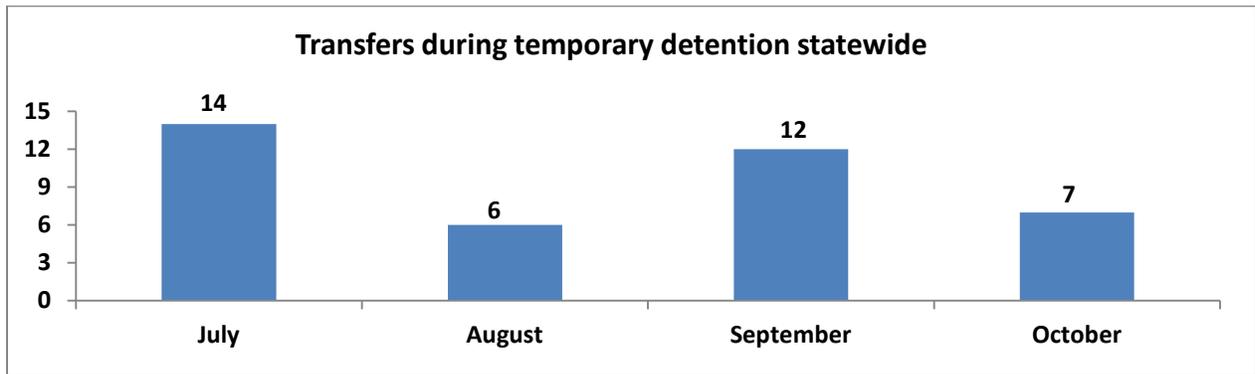


Graph 8. Transfers during temporary detention statewide

Section § 37.2-809.E. of the *Code of Virginia* allows an individual to be transferred 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 7 times (<1%) during October (Graph 8), which is a 41% decrease from September. Graph 8a and table 8 displays this data by region in Appendix C, page 18. Regions 3, 6 and 7 did not report any of these transfers in October.

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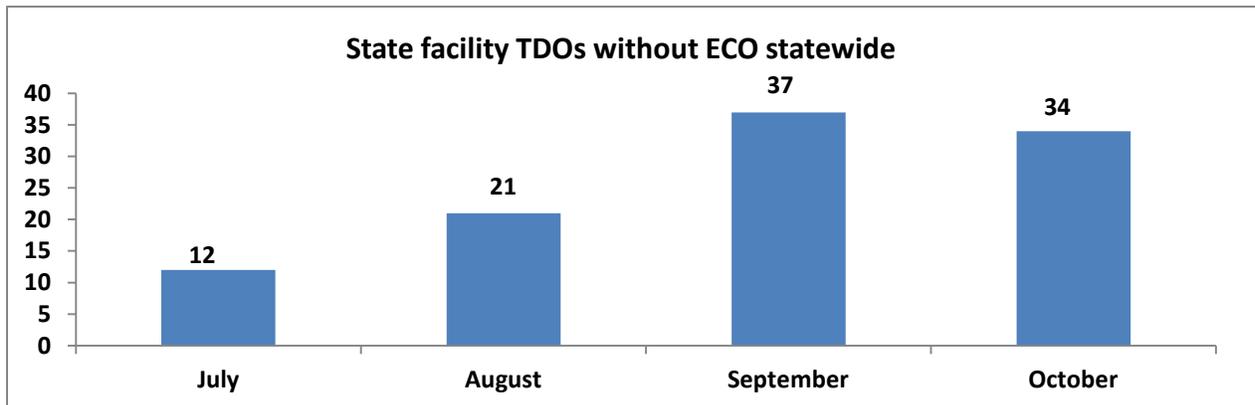
- Four of the October transfers were from state facilities to private facilities to provide a community-based alternative.
- One transfer was from a state hospital to a community crisis stabilization unit to provide a community-based alternative.
- One transfer was from a community crisis stabilization unit to a state psychiatric hospital due to physical aggression.
- One transfer was from a state hospital to a medical hospital due to increased medical concerns.



Graph 9. State hospital TDOs without ECOs statewide

As the “hospital of last resort”, DBHDS facilities will 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 each such admission (“hospital of last resort” where no ECO preceded), along with how many alternate facilities were contacted and the reason(s) for the inability to locate an alternate facility. In October, there were 34 such admissions to state facilities, which is a <1% decrease from September (Graph 9). A total of 302 contacts were made for an average of nine alternate facilities contacted in each of these 34 instances. Sixteen 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; aggressive behaviors not manageable in the facilities contacted; advanced age; psychiatric acuity and diagnosis of traumatic brain injury. Graph 9a and table 9 displays this data by region in Appendix C, page 19. DBHDS is closely monitoring these cases to identify factors that may contribute to increased numbers of individuals who are admitted to state facilities under a temporary detention order.

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Discussion:

To enhance accuracy of reporting, DBHDS has worked with the CSBs and regional managers since July to identify data elements that were not clearly or consistently understood. In November 2014, DBHDS issued revisions to the reporting format and data definitions to clarify reportable cases and enhance the consistency and reliability of the data provided in the monthly reports. DBHDS is also working with CSB leadership to further strengthen this process so that this data can be consistently reported and used more fully to identify trends at agency, regional, and statewide levels. These data are central to DBHDS' ongoing system monitoring and performance improvement efforts. DBHDS, local service delivery partners and CSBs are communicating to improve local care coordination processes, eliminate system gaps and clarify agency and staff roles in the emergency response system. DBHDS Central Office continues to work closely with CSBs and other system stakeholders at state and local levels to support effective operational response during the emergency custody and temporary detention process. This ongoing collaboration is essential to improving access to care for those in psychiatric crisis. Monitoring and refinement of the process will continue as part of ongoing system performance and quality improvement.

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**

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- 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.

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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 | Alleghany Highlands CSB |

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| Catawba Region | Blue Ridge Behavioral Healthcare |
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APPENDIX C

Graph 1a. Emergency contacts by region

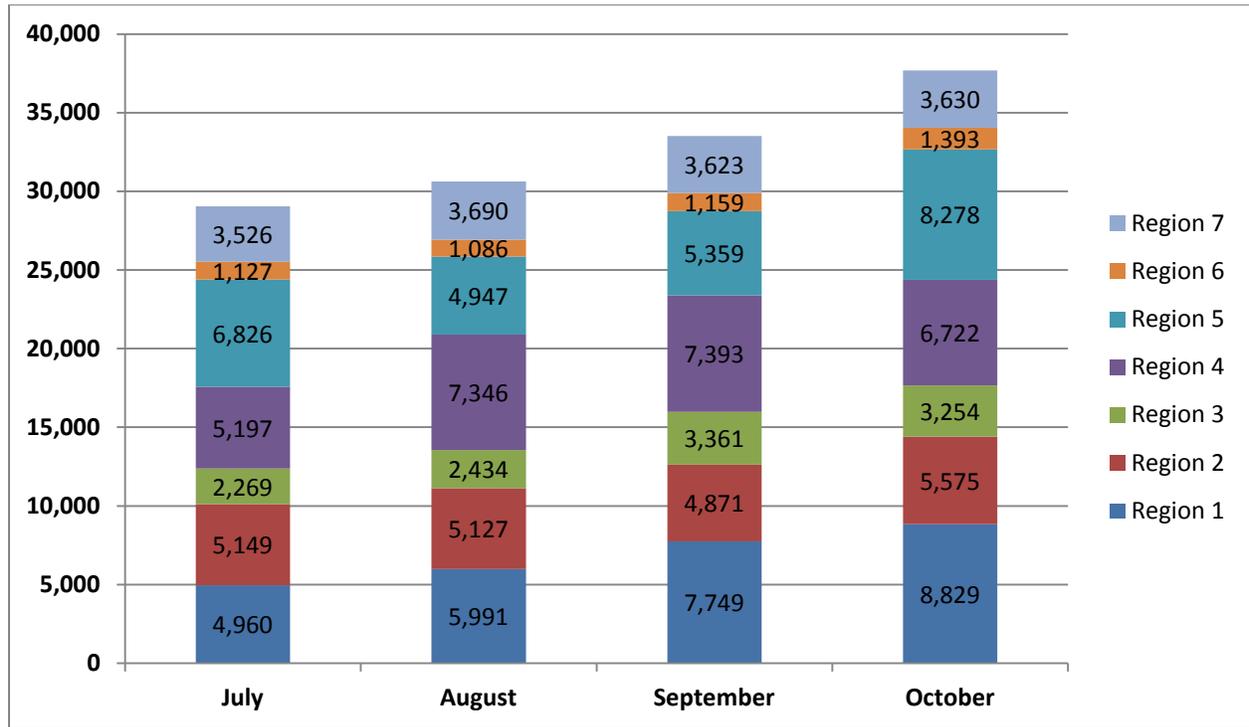


Table 1. Number of emergency contacts (corresponds with graph 1a)

| Region | July | August | September | October | Total –SFY to date |
|--------------|---------------|---------------|---------------|---------------|--------------------|
| Region 1 | 4,960 | 5,991 | 7,749 | 8,829 | 27,529 |
| Region 2 | 5,149 | 5,127 | 4,871 | 5,575 | 20,722 |
| Region 3 | 2,269 | 2,434 | 3,361 | 3,254 | 11,318 |
| Region 4 | 5,197 | 7,346 | 7,393 | 6,722 | 26,658 |
| Region 5 | 6,826 | 4,947 | 5,359 | 8,278 | 25,410 |
| Region 6 | 1,127 | 1,086 | 1,159 | 1,393 | 4,765 |
| Region 7 | 3,526 | 3,690 | 3,623 | 3,630 | 14,469 |
| Total | 29,054 | 30,621 | 33,515 | 37,681 | 130,871 |

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Graph 2a. Emergency evaluations by region

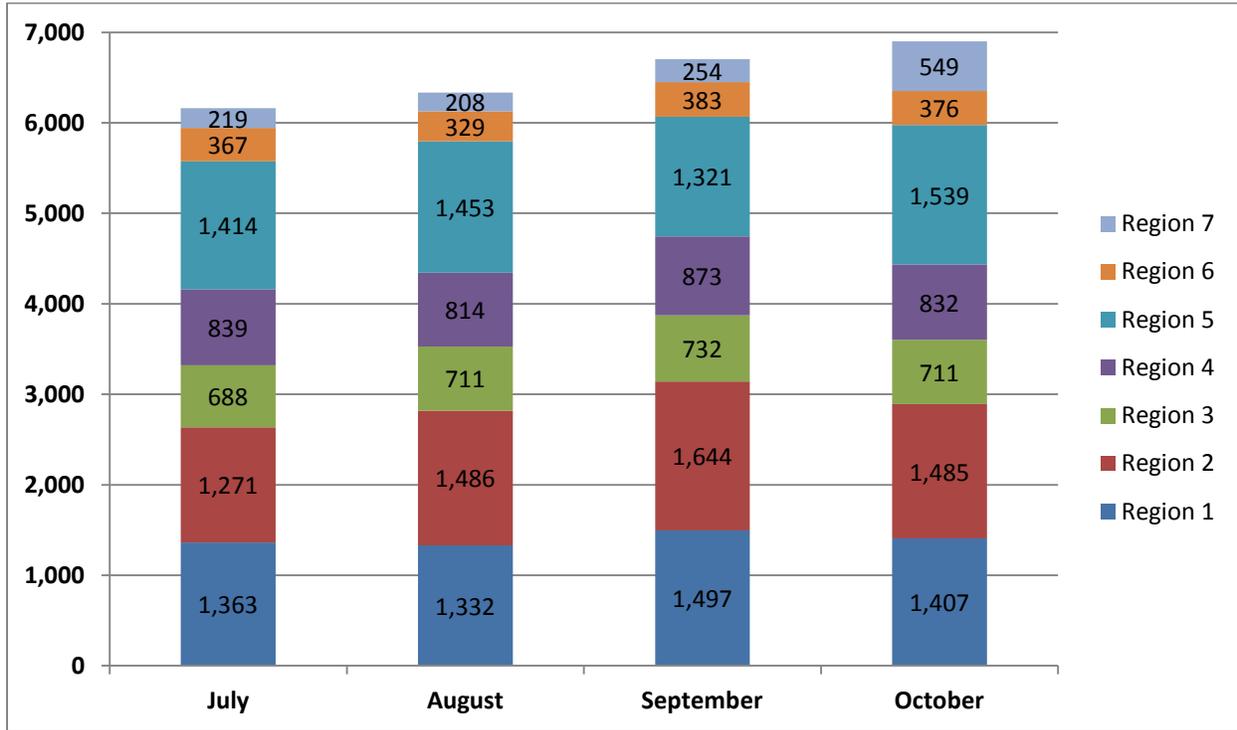


Table 2. Number of emergency evaluations (corresponds with graph 2a)

| Region | July | August | September | October | Total –SFY to date |
|--------------|--------------|--------------|--------------|--------------|--------------------|
| Region 1 | 1,363 | 1,332 | 1,497 | 1,407 | 5,599 |
| Region 2 | 1,271 | 1,486 | 1,644 | 1,485 | 5,886 |
| Region 3 | 688 | 711 | 732 | 711 | 2,842 |
| Region 4 | 839 | 814 | 873 | 832 | 3,358 |
| Region 5 | 1,414 | 1,453 | 1,321 | 1,539 | 5,727 |
| Region 6 | 367 | 329 | 383 | 376 | 1,455 |
| Region 7 | 219 | 208 | 254 | 549 | 1,230 |
| Total | 6,161 | 6,333 | 6,704 | 6,899 | 26,097 |

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Graph 3a. TDOs issued by region

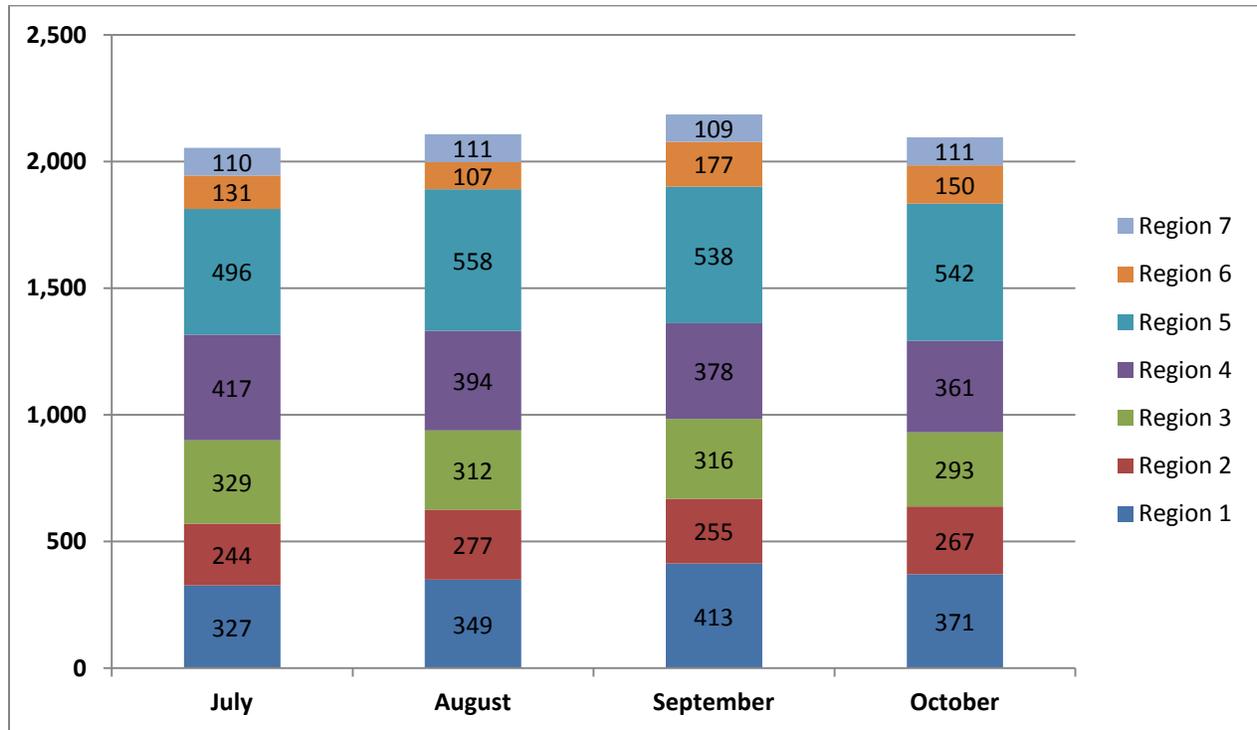


Table 3. Number of TDOs issued (corresponds with graph 3a)

| Region | July | August | September | October | Total –SFY to date |
|--------------|--------------|--------------|--------------|--------------|--------------------|
| Region 1 | 327 | 349 | 413 | 371 | 1,460 |
| Region 2 | 244 | 277 | 255 | 267 | 1,043 |
| Region 3 | 329 | 312 | 316 | 293 | 1,250 |
| Region 4 | 417 | 394 | 378 | 361 | 1,550 |
| Region 5 | 496 | 558 | 538 | 542 | 2,134 |
| Region 6 | 131 | 107 | 177 | 150 | 565 |
| Region 7 | 110 | 111 | 109 | 111 | 441 |
| Total | 2,054 | 2,108 | 2,186 | 2,095 | 8,443 |

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Graph 4a. TDOs executed by region

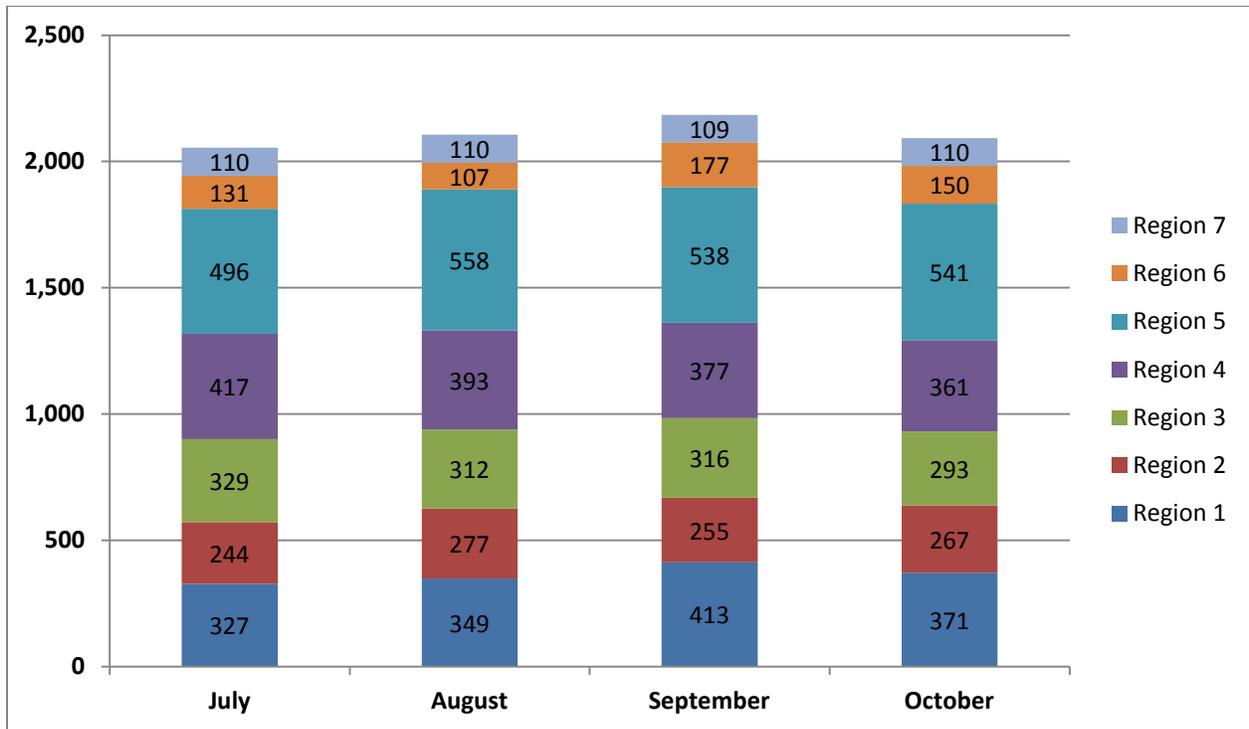


Table 4. Number of TDOs executed (corresponds with graph 4a)

| Region | July | August | September | October | Total –SFY to date |
|--------------|--------------|--------------|--------------|--------------|--------------------|
| Region 1 | 327 | 349 | 413 | 371 | 1,460 |
| Region 2 | 244 | 277 | 255 | 267 | 1,043 |
| Region 3 | 329 | 312 | 316 | 293 | 1,250 |
| Region 4 | 417 | 393 | 377 | 361 | 1,548 |
| Region 5 | 496 | 558 | 538 | 541 | 2,133 |
| Region 6 | 131 | 107 | 177 | 150 | 565 |
| Region 7 | 110 | 110 | 109 | 110 | 439 |
| Total | 2,054 | 2,106 | 2,185 | 2,093 | 8,438 |

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

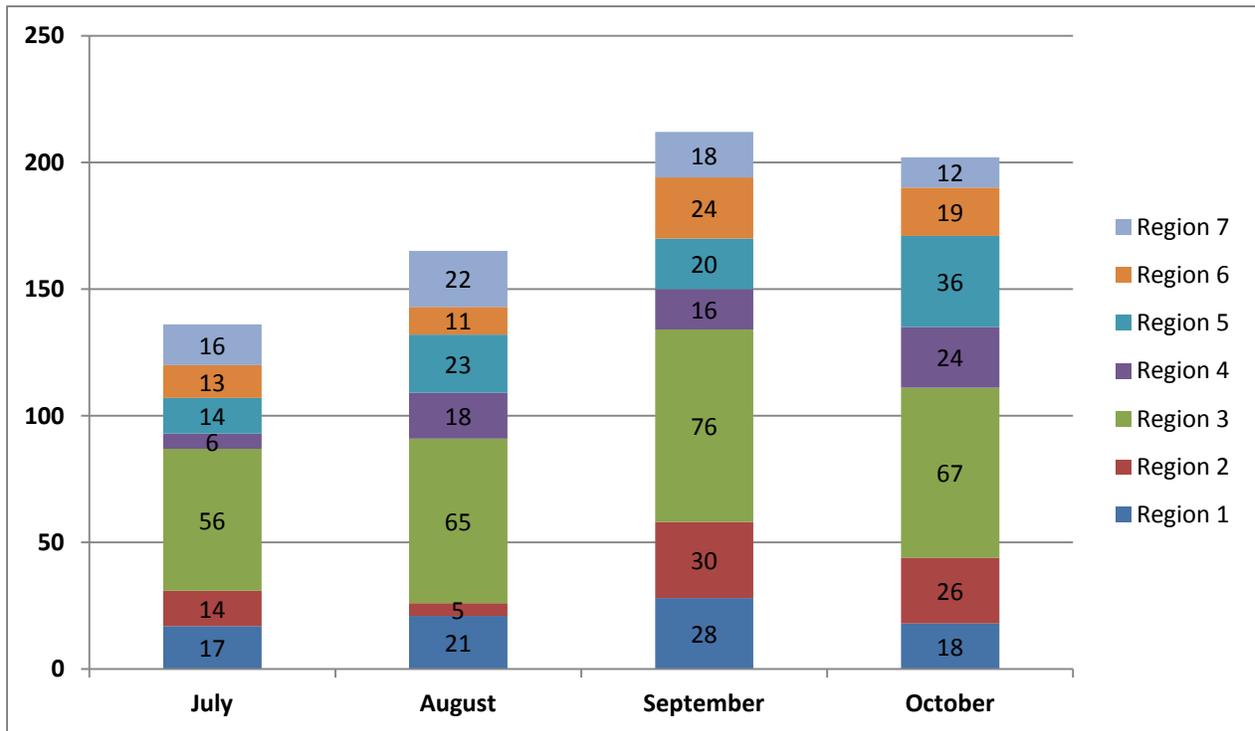


Table 5. TDO admissions to a state hospital (corresponds with graph 5a)

| Region | July | August | September | October | Total –SFY to date |
|----------|------|--------|-----------|---------|--------------------|
| Region 1 | 17 | 21 | 28 | 18 | 84 |
| Region 2 | 14 | 5 | 30 | 26 | 75 |
| Region 3 | 56 | 65 | 76 | 67 | 264 |
| Region 4 | 6 | 18 | 16 | 24 | 64 |
| Region 5 | 14 | 23 | 20 | 36 | 93 |
| Region 6 | 13 | 11 | 24 | 19 | 67 |

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|-----------------|------------|------------|------------|------------|------------|
| Region 7 | 16 | 22 | 18 | 12 | 68 |
| Total | 136 | 165 | 212 | 202 | 715 |

Graph 6a. State hospital admission delayed by region

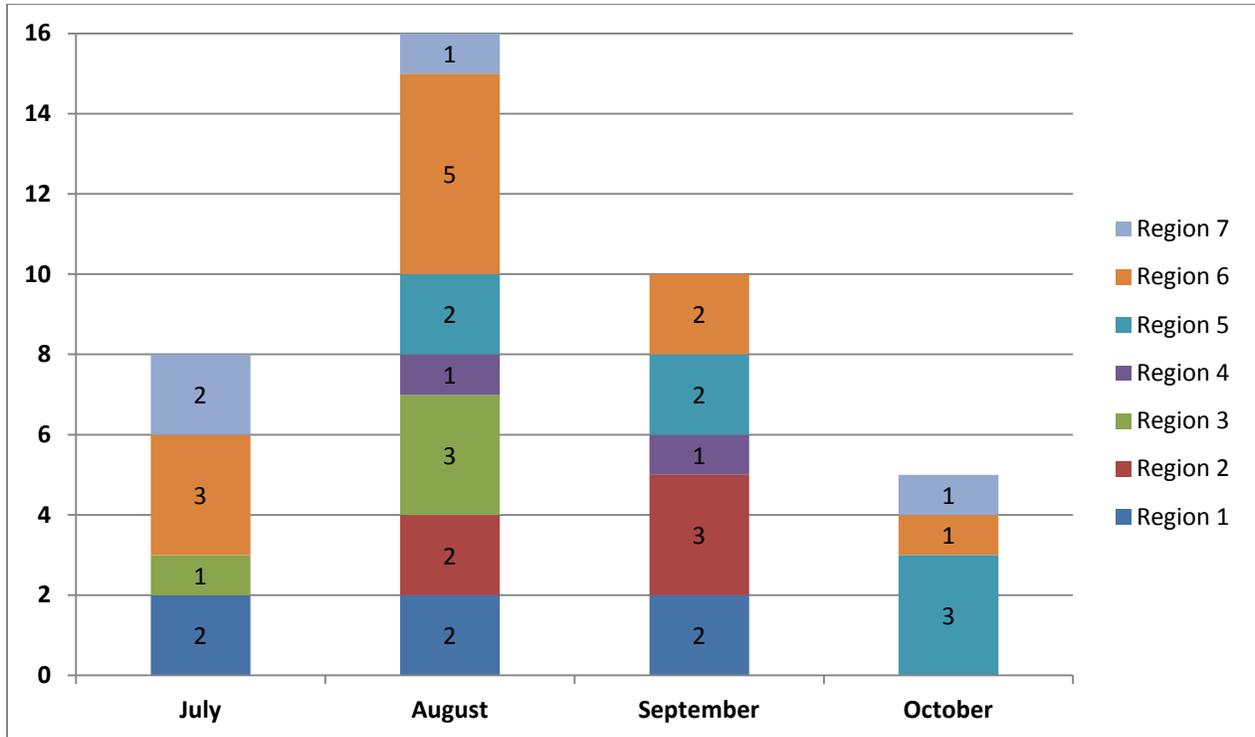


Table 6. State hospital admission delayed (corresponds with graph 6a)

| Region | July | August | September | October | Total –SFY to date |
|-----------------|------|--------|-----------|---------|--------------------|
| Region 1 | 2 | 2 | 2 | 0 | 6 |
| Region 2 | 0 | 2 | 3 | 0 | 5 |
| Region 3 | 1 | 3 | 0 | 0 | 4 |
| Region 4 | 0 | 1 | 1 | 0 | 2 |

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|-----------------|----------|-----------|-----------|----------|-----------|
| Region 5 | 0 | 2 | 2 | 3 | 7 |
| Region 6 | 3 | 5 | 2 | 1 | 11 |
| Region 7 | 2 | 1 | 0 | 1 | 4 |
| Total | 8 | 16 | 10 | 5 | 39 |

Graph 7a. TDO executed after ECO expired by region

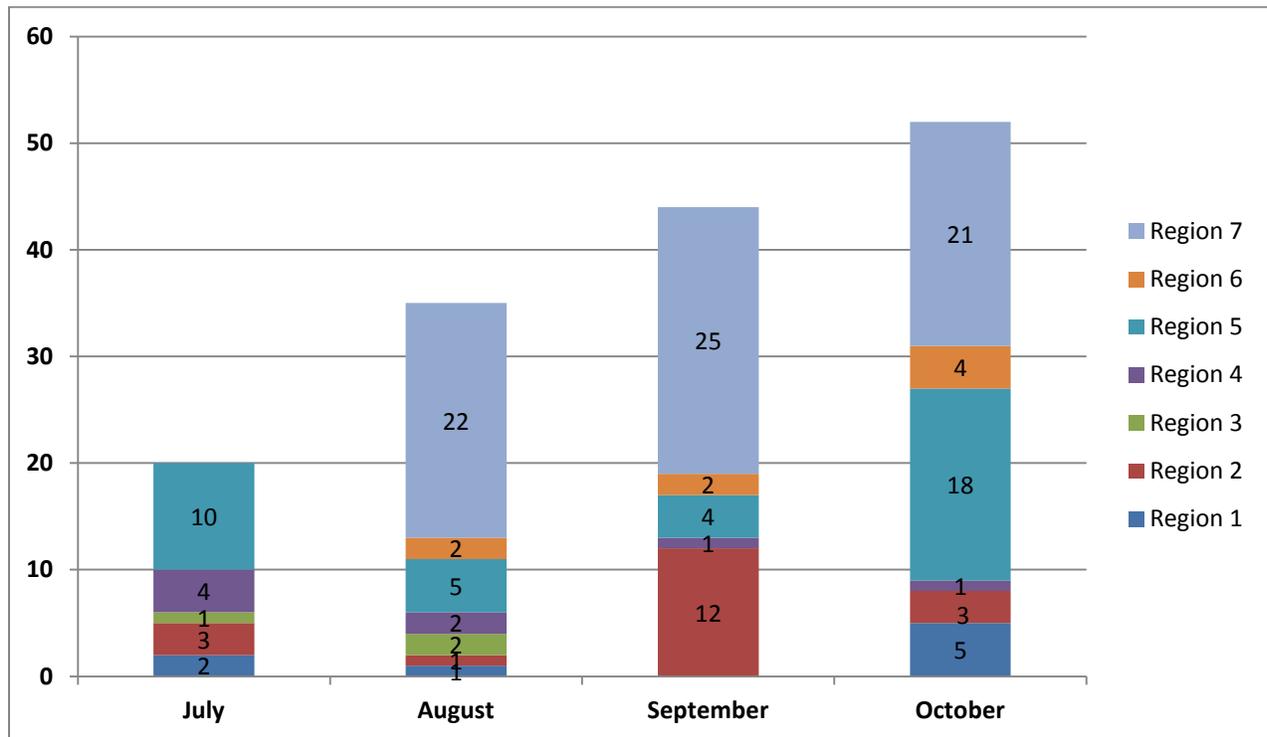


Table 7. TDO executed after ECO expired (corresponds with graph 7a)

| Region | July | August | September | October | Total –SFY to date |
|-----------------|------|--------|-----------|----------|--------------------|
| Region 1 | 2 | 1 | 0 | 6 | 9 |
| Region 2 | 3 | 1 | 12 | 3 | 19 |

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|-----------------|-----------|-----------|-----------|-----------|------------|
| Region 3 | 1 | 2 | 0 | 0 | 3 |
| Region 4 | 4 | 2 | 1 | 1 | 8 |
| Region 5 | 10 | 5 | 4 | 18 | 37 |
| Region 6 | 0 | 2 | 2 | 4 | 8 |
| Region 7 | 0 | 22 | 25 | 21 | 68 |
| Total | 20 | 35 | 44 | 53 | 152 |

Graph 8a. Transfers during temporary detention by region

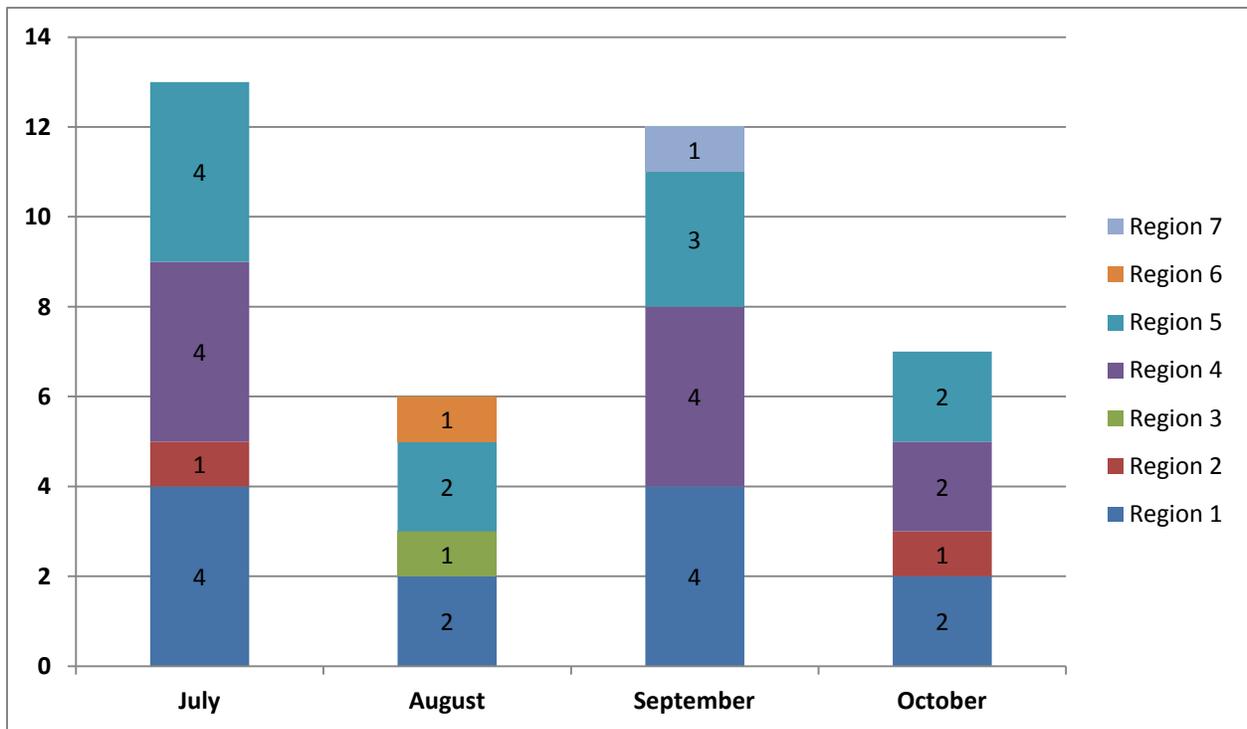


Table 8. Transfers during temporary detention (corresponds with graph 8a, pg 10)

| Region | July | August | September | October | Total –SFY to date |
|--------|------|--------|-----------|---------|--------------------|
|--------|------|--------|-----------|---------|--------------------|

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|-----------------|-----------|----------|-----------|----------|-----------|
| Region 1 | 5 | 2 | 4 | 2 | 13 |
| Region 2 | 1 | 0 | 0 | 1 | 2 |
| Region 3 | 0 | 1 | 0 | 0 | 1 |
| Region 4 | 4 | 0 | 4 | 2 | 10 |
| Region 5 | 4 | 2 | 3 | 2 | 11 |
| Region 6 | 0 | 1 | 0 | 0 | 1 |
| Region 7 | 0 | 0 | 1 | 0 | 1 |
| Total | 14 | 6 | 12 | 7 | 39 |

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

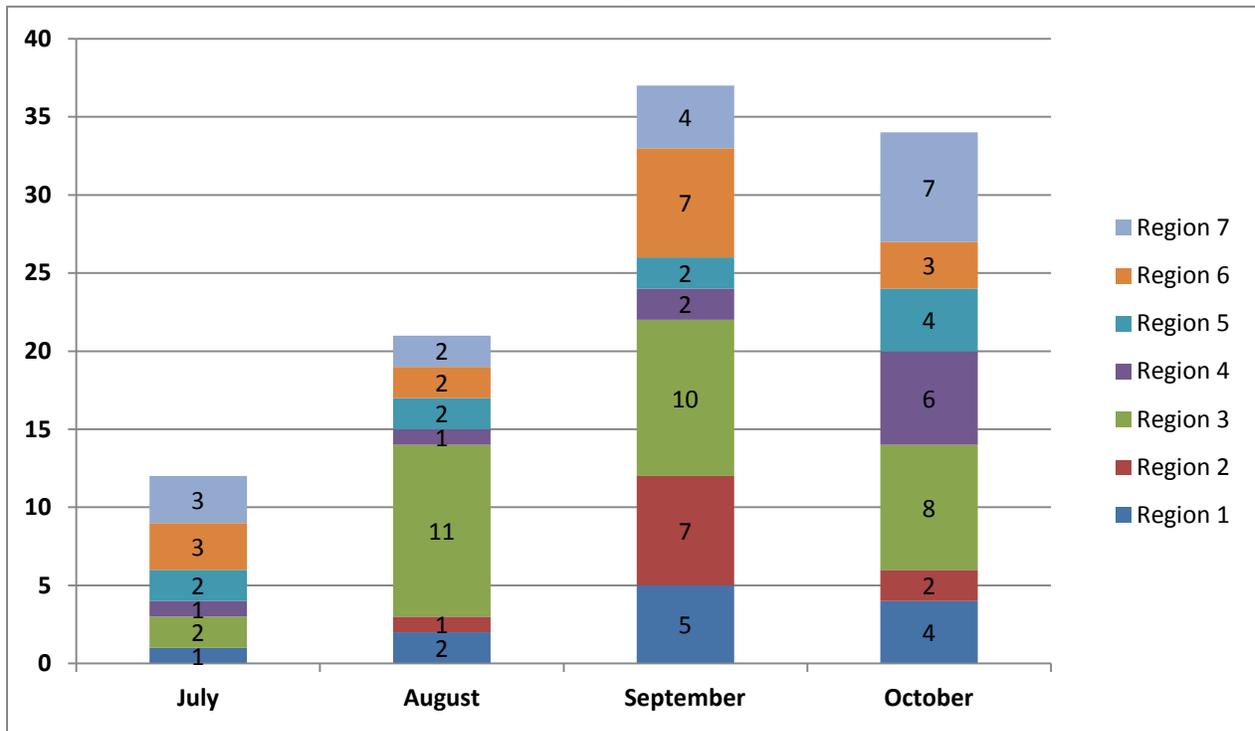


Table 9. State hospital TDOs without ECOs (corresponds with graph 9a)

| Region | July | August | September | October | Total –SFY to date |
|--------|------|--------|-----------|---------|--------------------|
|--------|------|--------|-----------|---------|--------------------|

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|-----------------|-----------|-----------|----|-----------|------------|
| Region 1 | 1 | 2 | 5 | 4 | 12 |
| Region 2 | 0 | 1 | 7 | 2 | 10 |
| Region 3 | 2 | 11 | 10 | 8 | 31 |
| Region 4 | 1 | 1 | 2 | 6 | 10 |
| Region 5 | 2 | 2 | 2 | 4 | 10 |
| Region 6 | 3 | 2 | 7 | 3 | 15 |
| Region 7 | 3 | 2 | 4 | 7 | 16 |
| Total | 12 | 21 | 37 | 34 | 104 |

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. There were eight such events during the month of October 2014. **The DBHDS Medical Director, Assistant Commissioner for Behavioral Health Services, and Director of the Office of Mental Health reviewed each event and the Director of the Office Mental Health ensured appropriate follow-up and corrective actions were taken.**

Of these eight incidents, five involved individuals who were evaluated on a voluntary basis (i.e., the individuals were not under an ECO) and then left the site of the evaluation before the TDO was executed. Of these five, two individuals were subsequently located and temporarily detained; a third individual was unable to be located and temporarily detained, but was later engaged in voluntary CSB care following outreach by the CSB; the fourth individual was also not temporarily detained but has had two subsequent follow-up contacts with the CSB and was no longer thought to be at risk; and the fifth individual was located but determined to no longer need temporary detention. An additional two of the eight reported incidents involved individuals who were mistakenly released from emergency custody by law enforcement officers. Of these two, one individual was subsequently located and temporarily detained, and the second individual returned to the emergency department where she had been seen initially, was re-evaluated and given an outpatient appointment which she subsequently attended voluntarily. The eighth reported case involved an individual who was initially deemed to need temporary detention, but was instead hospitalized for urgent medical care in a medical hospital. This individual was reassessed when his medical condition improved the following day and was detained for further treatment under a TDO in a psychiatric hospital. Additional detail on each of these cases and the subsequent follow-up actions taken by the involved agencies, are summarized below.

1. An individual who was not under an ECO was evaluated by a CSB in a local emergency department and deemed to require temporary detention. While a temporary detention bed was being located, nursing staff discovered that the individual had eloped from the emergency department. Hospital security, local law enforcement, and CSB Emergency Services (ES) staff searched the grounds of the hospital. The CSB obtained a TDO from a magistrate and local law enforcement continued to search for the individual throughout the night. A message was left on the individual's cell phone requesting a return call. A voice mail message was left for the individual's mother providing local law enforcement contact numbers as well as reassurance that the individual was not in trouble but was believed to need psychiatric care. The individual was eventually located and the TDO was executed.

In follow up to this event, the CSB implemented new procedures so that any individual involved in a crisis assessment, but not under an ECO, is to be monitored to ensure continuous custody. CSB staff now request assistance from hospital emergency department (ED) or security staff to monitor the individuals' movement while ES Counselor works to identify an accepting treatment facility. CSB ES staff now also request that crisis assessments take place in the ED room closest to

the nurse's station if possible. ED staff will also notify CSB staff immediately if an individual leaves the facility. These new procedures have been incorporated in the CSB's Emergency Services Guidelines.

2. An ECO was obtained to transport an individual who had taken an overdose of her medication and refused medical treatment. The individual was taken to the local hospital ED for medical treatment and psychiatric evaluation. The individual met criteria for a TDO, but her medical needs at that time were greater than a psychiatric facility could accommodate, and the individual was admitted to the hospital's intensive care unit. Upon resolution of her medical concerns, she was reassessed the following day. The individual continued to refuse psychiatric treatment and continued to meet criteria for temporary detention, so a TDO was obtained to a local psychiatric hospital.
3. An individual not subject to an ECO was dropped off at the CSB office by police to be voluntarily assessed for psychiatric care. The CSB, which already knew the individual, determined that the individual required temporary detention. Due to concerns that the individual might attempt to leave the center while searching for a bed prior to obtaining a TDO, the CSB contacted local law enforcement for assistance. An hour later, when the CSB staff left the room to find out when the police would arrive, the individual left the center. The CSB immediately notified law enforcement and informed them that an ECO had been issued and was in the magistrate's office. The CSB continued to search for a willing temporary detention facility and found a local psychiatric hospital that agreed to accept the individual. CSB staff also called a second individual, who had been identified as the first individual's emergency contact, and requested his assistance in locating the individual. The second individual contacted the CSB approximately five hours later, reporting that the individual needing treatment had phoned and agreed to contact the CSB. The second individual was not willing to provide a location or other contact information. Subsequently, local law enforcement was unable to locate the individual to execute the TDO.

The CSB was later able to locate the individual and re-engage her in treatment. In addition, the CSB reviewed the incident with the staff involved to emphasize the importance of keeping "eyes on" the person at all times. The CSB also followed up with the police department leadership to assess the underlying reasons for the delayed response time that afternoon, which was an exception to the community norm. Police leadership reviewed requirements with their officers to prevent future occurrences.

4. An individual under an ECO initiated by the law enforcement officer was evaluated at a major Virginia airport and determined to need temporary detention. The CSB staff was informed by airport police that the ECO time period began at 6:00 p.m. After the evaluation, airport police transported the individual to a nearby local hospital emergency department, where the individual also presented with medical needs requiring further evaluation. The CSB located a TDO bed at another hospital, where acceptance was conditioned upon the individual's medical clearance. A

new set of airport police then arrived at the emergency department and released the individual at 11:00 p.m., based upon their belief that the ECO had begun at 3:00 p.m. (8 hours earlier) and not at 6:00 p.m. as understood by the CSB. Meanwhile, the CSB confirmed the individual's medical clearance and acceptance at the psychiatric hospital at 12:00 a.m., and while implementing that disposition, the CSB learned that the individual's whereabouts were by then unknown. The magistrate issued the TDO to be executed at the individual's residence in the neighboring city. The TDO was issued at 3:49 a.m., but the city police discovered that the individual's reported address was invalid. The police finally located the individual at 9:30 a.m. and executed the TDO to the hospital as originally planned.

In follow up to this event, the CSB and local police department implemented ongoing communications strategies to ensure that key statutory and operational information went to law enforcement entities not under the local police department's jurisdiction (e.g., airport police). The CSB also reached out to the chief of the airport police department and implemented a new process whereby airport police will immediately contact the CSB ES manager whenever an ECO is initiated by airport officers, and in addition, a training event covering the new laws and operational protocols is scheduled for January 2015 for all airport officers.

5. An individual not under an ECO was evaluated at the request of the police in a local hospital ED and was determined to meet TDO criteria. The individual then left the emergency department against medical advice. A TDO was obtained but police were unable to locate the individual after extensive search by police from two jurisdictions. Law enforcement then contacted a friend of the individual but was again not able to ascertain the individual's whereabouts. CSB staff also continued to attempt to contact the individual, who was known to the CSB, and had a scheduled appointment several days after the evaluation. The individual did not attend this appointment, but over the next several weeks the CSB was able to speak with the individual by telephone on two occasions. During both of these conversations the CSB staff conducted a mental status exam and risk assessment of the individual, and determined the individual was not at risk of harm. The individual had indicated that he planned to travel to California on personal business in late November and he has not had further contact with the CSB subsequent to the last phone call. The CSB continues to reach out by telephone to the individual's home.
6. After law enforcement initiated an ECO, the CSB evaluated the individual in a local hospital ED, determined that she required temporary detention, and secured a TDO bed at a local community psychiatric hospital. The hospital, however, rescinded its acceptance upon learning that the individual had a potentially contagious condition requiring isolation precautions. All other community psychiatric facilities that were contacted also declined the admission. The regional admission protocol for the state hospital was followed, but a response was not obtained from the state hospital until after the ECO had expired. The officer having custody of the individual left after waking her. The individual proceeded to leave the emergency department and the attending physician contacted the CSB. The CSB responded to the individual's home and learned

that she had returned to the emergency department to retrieve a prescription that she forgot. The emergency physician met with the individual and her mother. She reportedly denied any thoughts of suicide and her mother was willing to take her home. The CSB arrived at the hospital and conducted a second evaluation, where it was determined that the crisis was resolved and the individual no longer met TDO criteria. The individual was given a follow up outpatient appointment with the CSB and attended the scheduled appointment.

In follow up to this case, the CSB contacted the local police department to address the issue of officers waking individuals at the end of the ECO period. The CSB also changed its internal “hand-off” process between emergency staff to ensure that staff will stay with the individual even if their shift has ended. Lastly, the CSB and the state hospital Director reviewed this case and identified that the hospital’s fax system had interfered with communication while the case was being managed locally. This issue was resolved by DBHDS and the state hospital through implementation of a secure electronic mail drop system, which avoids the need for fax communications. Hospital and CSB leadership also re-emphasized to their staffs that state hospital referrals must be implemented even if communication obstacles are encountered.

7. An individual was referred by a local psychiatric hospital for admission to a residential crisis stabilization unit (CSU). The CSB assessed the individual and determined that he was appropriate for voluntary admission to the CSU. While the CSB was arranging the admission to the CSU, the individual left the local psychiatric hospital. The CSB sought and obtained a TDO because the individual was still in need of emergency psychiatric care. The police were unable to locate the individual and the CSB subsequently received notification from the TDO facility that the individual had never arrived. The CSB then contacted and spoke with the individual, a family member, and the initial evaluator. Another TDO was not pursued because the CSB determined that the individual no longer required temporary detention for psychiatric care.
8. An individual was brought voluntarily to the CSB office by a relative where he was evaluated and was determined to meet criteria for a TDO. The individual then ran out of the CSB building. The CSB immediately contacted law enforcement for assistance and requested an ECO from the magistrate. The individual was located within an hour, taken into custody by law enforcement and hospitalized under a temporary detention order obtained by the CSB.

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, as well as 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. DBHDS is also clarifying data definitions and updating reporting protocols to ensure uniformity in data collection and reduce inconsistent reporting.