Background:

On January 1, 2014, Community Service Boards/Behavioral Health Authority[1] (CSB/BHA) began collecting data pertaining to TDO exceptions and the factors contributing to same. The DBHDS requires these data to be submitted quarterly by region[2]. First quarter data is reported and discussed below.

Exception Definitions:

The DBHDS tracks and aggregates data on two types of TDO exceptions. These are:

TYPE 1 Event: Where a TDO was sought but not obtained due to lack of willing facility.
TYPE 2 Event: Where a TDO was obtained and executed; but more than 6 hours elapsed.

Factors Contributing to TDO Exceptions:

There are a number of factors that contribute to TDO exceptions. The most common factors identified and tracked are listed below:

1. Unable to locate any available inpatient or CSU bed (i.e., no capacity).
2. Unable to identify willing accepting facility within the allotted six hours.
3. Unable to access bed at state hospital within the allotted six hours.
4. Medical admission prevented behavioral health admission.
5. TDO to other than psychiatric inpatient unit or CSU.
6. Specialized program for persons with ID/DD unavailable.
7. Specialized program for persons 65 years of age and older unavailable.
8. Specialized program for persons younger than 18 unavailable.
9. Other

[1] There are 39 Community Service Boards and 1 Behavioral Health Authority in the Commonwealth.
[2] See Appendix for a listing of CSBs and BHA within each of the seven Partnership Planning Regions.

Data:

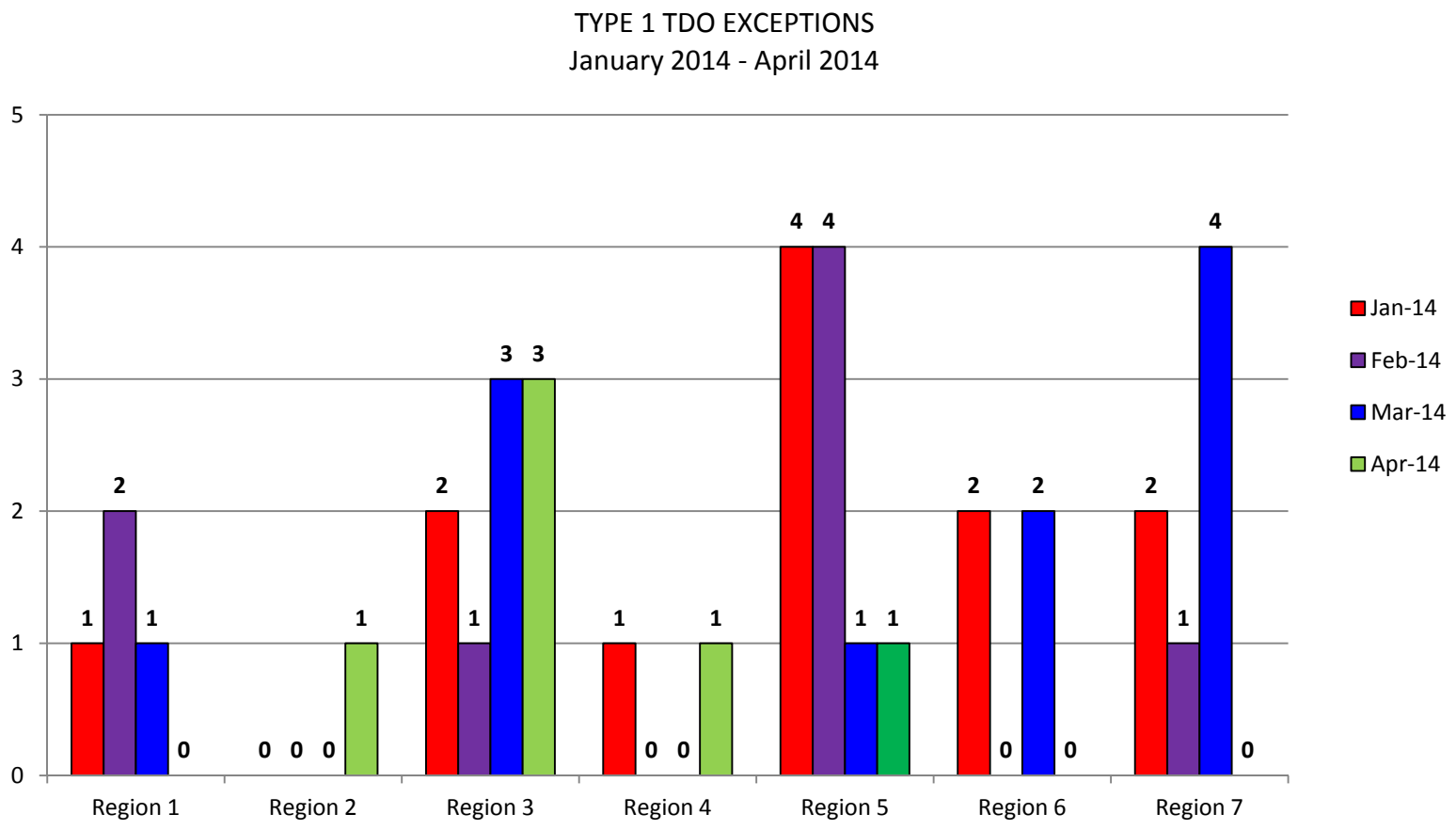
Table 1
TYPE 1 EVENTS

	January	February	March	April	Year-to-Date
Region 1	1	2	1	0	4
Region 2	0	0	0	1	1
Region 3	2	1	3	3	9
Region 4	1	0	0	1	2
Region 5	4	4	1	1	10
Region 6	2	0	2	0	4
Region 7	2	1	4	0	7
TOTAL	12	8	11	6	37

Table 2
TYPE 2 EVENTS

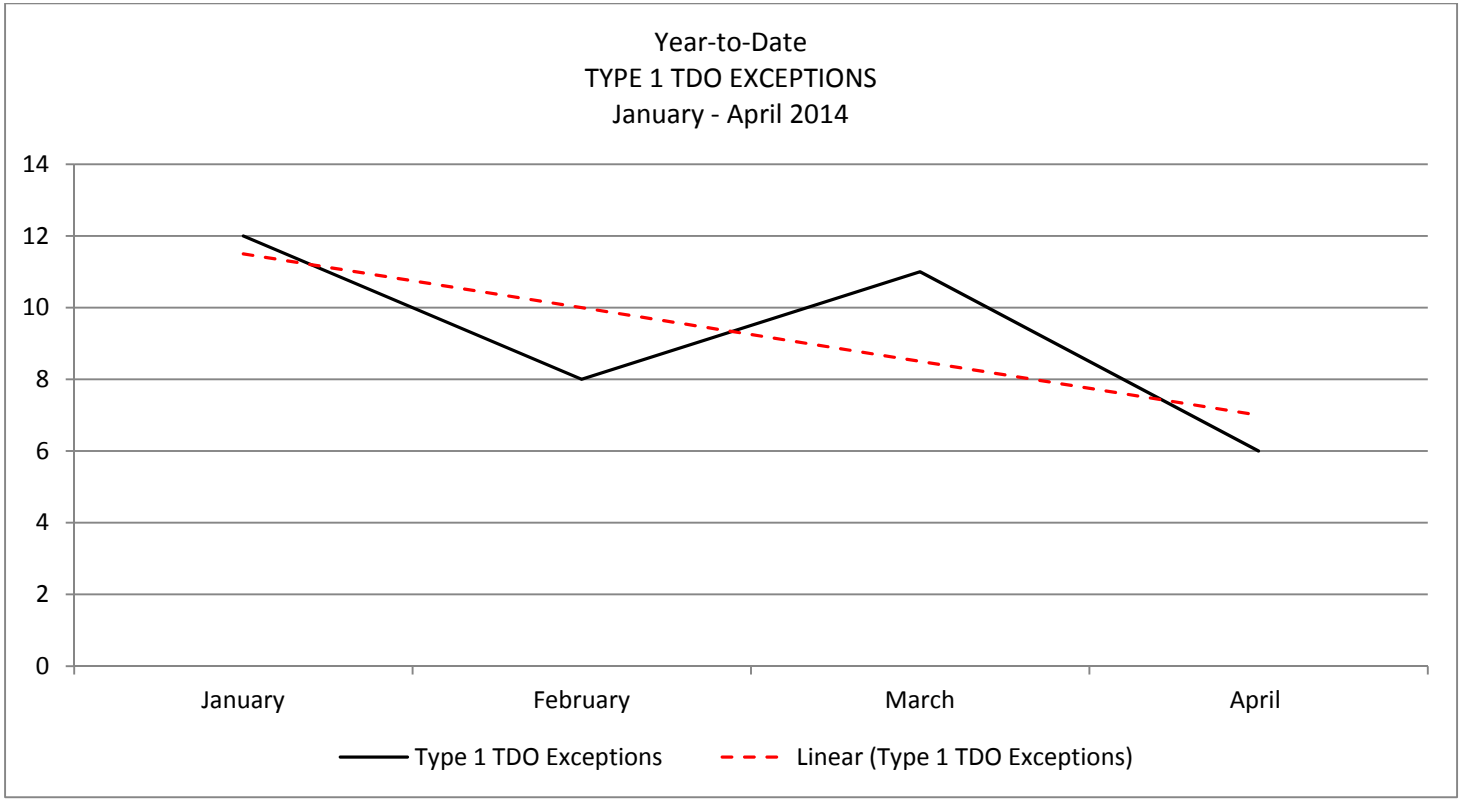
	January	February	March	April	Year-to-Date
Region 1	26	14	9	24	73
Region 2	3	3	5	4	15
Region 3	3	3	5	6	17
Region 4	14	7	5	4	30
Region 5	9	2	7	4	22
Region 6	6	5	3	0	14
Region 7	28	43	27	35	133
TOTAL	89	77	61	77	304

Graph 1: Type 1* Events

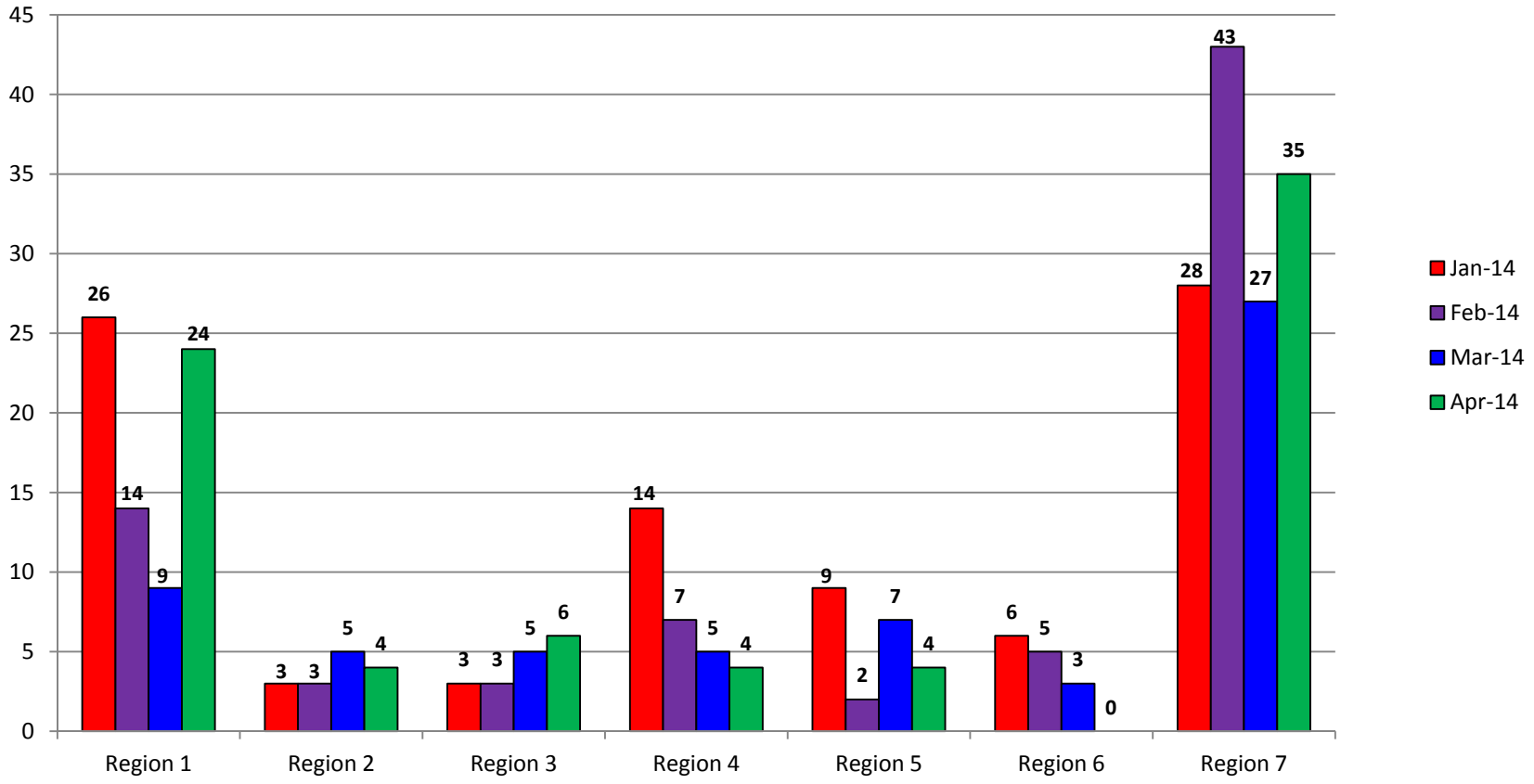


* TDO sought but not obtained due to lack of willing facility.

Graph 2: Type 1 Event Totals
(With trend line)

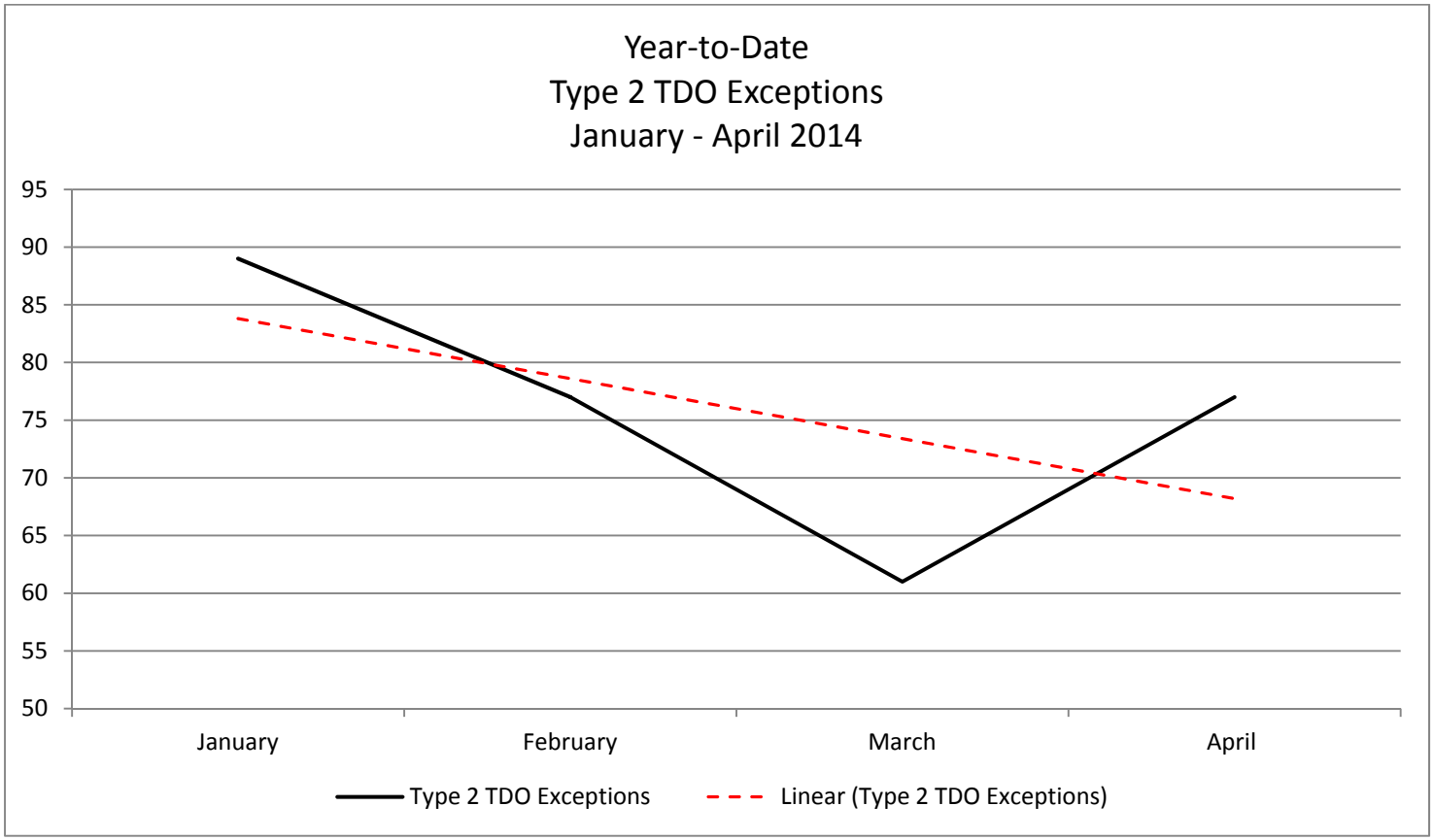


Graph 3: Type 2** Events



** TDO obtained and executed but more than 6 hours elapsed

Graph 4: Type 2 Event Totals
(With trend line)



Discussion:

This summary report includes data collected from January to April 2014 (the most current data available) and is reviewed and discussed below. Although four months is too limited of a time period to conduct a thorough statistical analysis of these data, several trends are noteworthy.

First, for Type 1 events, (see Table 1 and Graph 1), the monthly trend is declining (Graph 2). However, Region 3 continues to report a consistent number of Type 1 events. Additionally, although Region 7 had no Type 1 events in April, the region reported four such events in March. The DBHDS will continue to monitor these two regions in particular and provide additional consultation and technical assistance to help resolve factors contributing to the Type 1 events. For the 37 instances of Type 1 events during this quarter, the ultimate disposition of these cases is as follows:

- 18 (49%) were medical admissions or were medically admitted until a psychiatric bed was located
- 5 (13%) Individual left AMA or before plan or follow-up was scheduled.
- 2 (5%) Reported as Type 1 event, but psychiatric bed was located after ECO had expired.
- 2 (5%) Another TDO was obtained and executed.
- 2 (5%) Individual provided with a crisis plan.
- 2 (5%) Individual left Emergency Dept. AMA and could not be subsequently located
- 1 (3%) Individual voluntarily admitted to crisis stabilization unit (CSU).
- 1 (3%) Magistrate refused to issue TDO; Family provided a crisis plan.
- 1 (3%) TDO initially refused by magistrate but subsequently issued and individual admitted.
- 1 (3%) Accepted voluntary outpatient treatment.
- 1 (3%) Remained in nursing facility, reassessed and no longer met TDO criteria.
- 1 (3%) Individual subsequently admitted to psychiatric hospital voluntarily.

In summary, of the 37 Type 1 events this quarter, 10 were admitted to a medical bed and 9 were ultimately admitted to a psychiatric bed of CSU. Seven of the Type 1 events this quarter either left AMA or before a plan/follow-up was in place. Pursuant to SB260, effective July 1, 2014, state hospitals become the “hospital of last resort”. While this legislation means that there should be no Type 1 events after July 1, it will be important to continue to track the factors that contribute to the inability to locate a community hospital bed necessitating a state hospital admission. There are circumstances where a Type I event may be clinically or medically appropriate to address serious medical issues and stabilization prior to completion of the TDO.

With respect to Type 2 events (see Table 2 and Graph 3 & 4), Region 1 and Region 7 continue to report consistently high numbers of Type 2 events and are the regions with the highest number of these events. The DBHDS is working with the CSBs in these regions to address factors associated with the high number of Type 2 events. In contrast, Type 2 events in Regions 4, 5 & 6 all appear to be trending downward. SB260 also extends the maximum duration of an ECO from 4 hours (with a possible 2 hour extension) to 8 hours. Effective July 1, 2014, this extension should reduce the incidence of Type 2

events across all regions. The DBHDS will continue to track these data in order to ensure the timely and successful completion.

The willingness of community hospitals to accept TDO admissions continues to be the primary factor contributing to both Type 1 and Type 2 events. Another major factor was related to significant medical related issues for which admission to a state psychiatric hospital is contraindicated. This factor, in particular will require careful monitoring to ensure that admission to a community or state operated psychiatric facility occurs only after proper medical clearance is obtained. The final contributing factor appears to be related to ECOs for individuals requiring specialized care (i.e. child & adolescent, geriatric or ID/DD) and the difficult associated with availability of such specialty beds on an emergency basis.

Thus, the new laws may address bed availability issues, but it is important to better understand the various challenges faced by ES personnel, law enforcement, etc., as we move forward. It will also be important to monitor the impact of the new law on the state facilitates and the Virginia public mental health system.

APPENDIX

Table of Partnership Planning Regions

Partnership Planning Region	Community Service Board or Regional Behavioral Health Authority
1 Northwestern Virginia	Central Virginia Community 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 Mounty 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
5 Eastern Virginia	Chesapeake CSB Colonial Behavioral Health Eastern Shore 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