SFY2016 Critical Incident Data Summary

The data presented here come from the Critical Incident Database that is maintained by DMHAS. The information presented here focuses on incidents occurring between July 1, 2015 and June 30, 2016.

The report for SFY16 uses data that has been entered into the new (implemented in the beginning of SFY15) Critical Incident Database that is accessed via DDAP. The process through SFY14 was for providers to fax CI reports to OOC at which point they would be entered into an Access database in EQMI. The new system allows the provider to directly enter the incident into an online database and uses client information already in the database to populate demographic and treatment information into the CI report. This should improve data quality and hopefully data quantity by making the reporting process faster and easier. We may already be seeing the impact of the new system – the number of critical incidents reported increased 15% from SFY15 to SFY16.

Since a critical incident (CI) may involve more than one client and a client may be involved in multiple incidents, the data for SFY16 are presented under two headings*: Incident Related Data* and *Client Related Data*. Incident related represents an unduplicated presentation of incidents, that is, each incident is counted only once, regardless of how many people may have been involved. Client related data represents an unduplicated client count, that is, each client is counted once regardless of how many incidents they were involved in. Information specific to describing the incidents (category, subcategory, location, etc) comes from analyses of the incident related data, while information describing the clients (demographics, diagnoses, LOC, etc) comes from analyses of client related data.

Critical incidents recorded in this database for this time frame are summarized as follows:

- 781 incidents
  - 653 (84%) were closed while 128 (16%) were still open at the time of this analysis.
  - 11 were at the Agency Level (Evacuation, Property Damage, Other.)
  - 11 involved staff members (15 staff total)
    - 4 incidents involved staff as perpetrators
  - 770 (99%) were at the Client Level
  - 193 (25%) incidents involved clients with a co-occurring diagnosis
  - The maximum number of people involved in any one incident was 18 (one incident involved a possible data breach involving multiple clients)
    - 710 incidents (91%) involved a single person

People involved in one or more critical incidents during this time frame are summarized as follows:

- 15 Staff
- 5 Visitors
- 740 unduplicated clients
  - 188 (25%) clients had a co-occurring diagnosis
  - 84 (11%) clients had a PTSD diagnosis on file since 7/1/06
  - The maximum number of incidents for any one client was 6
- 722 people were involved in only one incident

Information from DDaP and WITS was used to supplement the information in the Critical Incident database. In past years, this involved cross-referencing Client IDs and allowed us to identify each client's demographic information, diagnosis, and level of care during the year prior to (and including the date of) the incident.

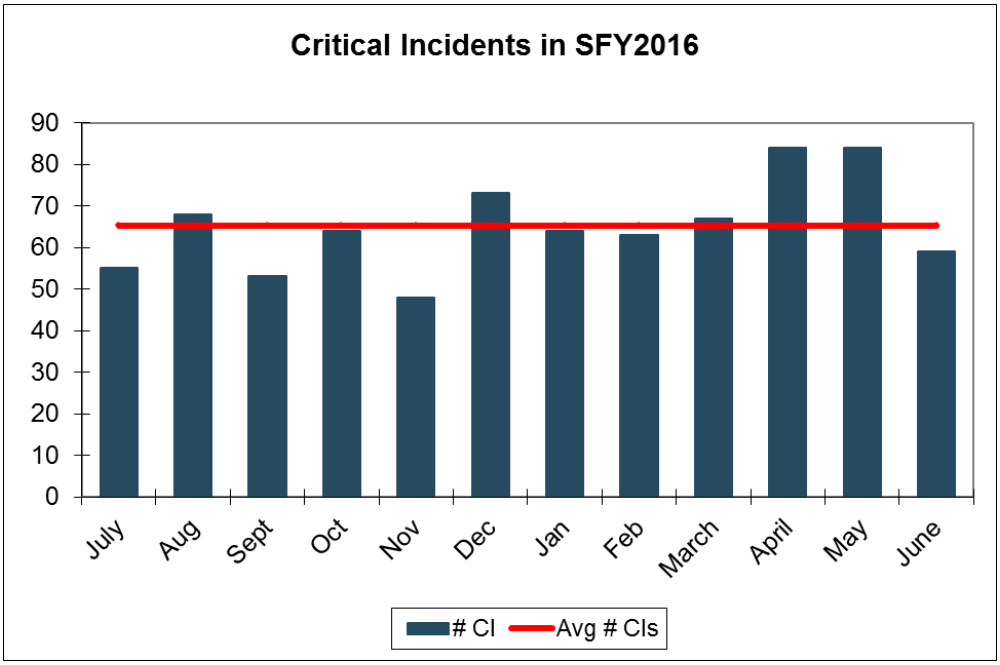


Figure1. Critical Incidents in SFY16

Summary of the Results

■ From SFY15 to SFY16 there was a *15.4% increase* in the number of critical incidents reported. 91% of all client-level CIs involved a single client. (Tables 1, 2, 3a & 3b)

■ Almost one-third (31%) of all CIs involved clients who were between the ages of 35 and 54 years, while clients over the age of 54 accounted for an additional 31% of incidents. 57% of the clients were male. (Table 1)

■ Bipolar/Major Depression was the most frequent diagnosis (23%) for clients involved in a CI. Schizophrenia/ Schizophreniform/Schizoaffective disorder was the next most frequent MH diagnosis (13%). Opioid Dependence (20%) and Alcohol Dependence (14%) were the top two SA diagnoses. These four diagnoses have remained the most frequent MH and SA diagnoses since the original analysis of SFY2006-2009 Critical Incident data. (Table 1)

■ At the time of the incident, 32% of clients were receiving MH Outpatient services, 8% were receiving MH CSP/RP services, and 8% were receiving MH Social Rehabilitation services. 7% of clients were receiving SA methadone maintenance services. (Table 1)

■ The 11 Agency-level CIs included 3 Emergency Evacuations, 3 Property Damage, 3 Other (1 breach of confidentiality, 1 improper use of glucometers, 1 Other), 1 Serious Crime Alleged, and 1Missing Client.

■ According to CI reporting, 40% of incidents occurred at the clients' residences, while 20% occurred in the community. Twenty-eight events (7%) of events occurred on a DMHAS-operated inpatient unit.

■ The most frequent CI categories reported were: (Tables 2, 3a, 3b, Figure 2)
Death (46%). Compared to SFY15, the number of deaths in SFY16 *increased* by 15% (from 314 to 362).
Serious Crime Alleged (15%). Compared to SFY15, there was 9% *fewer* CIs reported in this category (127 to 116).
Serious Suicide Attempt (11%). Compared to SFY15, there were 24% *more* serious suicide attempts (72 to 89).
Medical Event (10%). Compared to SFY15, there was a 21% *increase* in the number of medical events reported (62 to 75).

■ Within the Death category, the number of Suicides reported *decreased* 13% from SFY15 (30 to 26). The reported number of Serious Suicide Attempts while enrolled a program *increased by* 27% (70 to 89). The number

of accidental overdoses (new subcategory for SFY15) *increased* 37% from SFY15 to SFY16 and accounted for 17% of all deaths. (Table 3a, 4a)

■ Approximately one third (35%) of all clients who died were younger than 50 years old. (Table 4b)

■ Within the Medical Event category, the number of the number of accidental overdoses *increased* 20% (20 to 24) from SFY15. The number of the number of accidental injuries *increased* 31% (13 to 17) and the number of medical error/reactions *increased* 67% (3 to 5). (Table 3a)

■ The majority of clients (70%) who died by suicide were male. (Table 4c)

■ Of the 362 Deaths in SFY16: 65% were male
average age = 52.6 years (±13.1), age range 18-85 years
almost one third (32%) had a co-occurring diagnosis
6% had a PTSD diagnosis
30% had a diagnosis of Opioid Dependence
21% had a diagnosis of Bipolar/Major Depression.
17% died from drug overdose
32% were found dead (not including suicides)
44% had chronic health issues
17% reported cardiovascular issues and 15% died from them
15% reported diabetes
14% reported cancer
9% reported obesity (Table 4a & Figs 3&4)

■ There were 125 deaths where the client was less than 50 years old
69% were male
average age = 38.2 years (±8.5), age range 18-49 years
22% had a co-occurring diagnosis
5% had a PTSD diagnosis
9% were suicides
34% died from drug overdose
37% were found dead (not including suicides)
36% had Opioid Dependence
20% had Bipolar/Major Depression
29% had chronic health issues
8% reported cardiovascular issues and 7% died from them
9% were obese
7% had diabetes
10% died from a long-term illness (Table 4b)

■ There were 26 suicides in SFY16: 70% were male
average age = 46.0 years (±15.4), age range 18-74 years
19% had a co-occurring diagnosis
8% had a PTSD diagnosis
23% had a diagnosis of Bipolar/Major Depression.
19% of the deaths were by hanging; 19% were by overdose
12% were by asphyxiation, 12% were by jumping (Table 4c)

■ Based on information provided in the incident report, the clients and their deaths were categorized as follows. "Found dead" was coded when it was reported that the client was found dead (in their bed, at home, in a parking lot), but the count does not include suicide, which is its own category. "Potential overdose" was coded if the incident description suggested that as a likely cause. "Chronic health problems" was coded based on the description of the client and any medical diagnoses that were listed. It does not necessarily mean that the client's

death was due to the health problem, only that they had documented chronic health problems. "Due to long term illness" was coded if it seemed likely that the death was directly related to a long term illness (cancer, renal failure, liver failure, etc). Clients may have been counted in more than one category (eg., been found dead and had chronic health problems); the percentages listed are based on 362 total deaths. (Figure 3)

■ The average age of the clients who died is presented in Figure 3. The categories are the same as those mentioned above. Looking at the two figures, 44% of all clients who died had chronic health problems and 22% of clients died as a result of long term illness; for both groups, the average age of these clients was about 58 years old. (Figures 3 and 4)

Service Summary by Co-Occurring Disorder

■ Co-occurring disorder is presented in the same format since SFY13. There are now just two categories: COD and No COD to indicate whether a client had or did not have a qualifying COD diagnosis. In the past we had separated the clients who had COD into quadrants.

■ *Death, Serious Crime Alleged, Serious Suicide Attempt and Medical Event* are still (consistent since SFY08) the most frequently reported type of CI. Figures 5-7 compare the how often these types of critical incidents occur for clients who do not have COD and clients who do have COD. The data for these Figures comes from Table 2.

Additional Notes Pertaining to Tables in the Report:

Table 1: Demographic information and summary information categorized by the presence of co-occurring diagnosis versus those without a co-occurring diagnosis (No COD). The % symbol presents the percentage with respect to the overall total for the category (i.e., when one reads down the column). For example: For clients who do not have a COD ("No COD"), 38.0% of the clients who were involved in a CI were female and 56.9% were male. For Diagnosis and LOC sections, note that clients may have more than one diagnosis and/or receive more than one level of care (LOC), thus the counts and percentages in these sections total to more than 100% of the category total. Values in the demographics section table represent unduplicated client counts, while the LOC and Diagnosis values are duplicated (clients may be count in multiple categories).

Table 2. Statewide Incident Information. This table explores critical incident categories and subcategories by co-occurring disorder presence or absence. Counts represent unduplicated incidents.

Table 5. Agencies reporting critical incidents. *Sixty-seven* agencies reported at least one critical incident during SFY16. There were 173 active agencies, thus *39% of all agencies reported at least one critical incident*. For comparison, in SFY15, 35% of all agencies reported at least one critical incident and in SFY14, 47% of all agencies reported at least one critical incident. Table 5a lists the agencies in alphabetical order while Table 5b orders the agencies according to number of CIs reported.

Developing Trends (SFY09 to SFY15)

- At least 91% of the CIs involve a single client
- About 95% of clients involved in a CI are involved in only one during the year
- Around one third of CIs involve clients in the 35-54 year age group
- The top two MH diagnoses are Bipolar/Major Depression and Schizophrenia/ Schizophreniform/Schizoaffective disorder
- The top two SA diagnoses are Opioid Dependence and Alcohol Dependence.
- The most frequent services that clients are receiving at the time of CI are MH Outpatient and MH Crisis (new in 2011 is CSP/RP). In the more recent years, MH Social Rehabilitation, CSP/RP, and Methadone Maintenance are more frequent LOCs.
- The most frequent CI categories are: Death Serious Crime, Serious Suicide Attempt, and Medical Event
- Describing clients who died: the majority were male, average age was about 50 years old, at least 25% had COD, most did *not* have PTSD, 20% or more had Bipolar/Major Depression, and an increasing number (25% in SFY15 and 30% in SFY16 had opioid dependence.

- Accidental Overdose resulting in death (new category in SFY15) is generally the second most frequent category of Death (behind 'Illness, age, or medical reason')
- Critical Incidents involve more clients who have a mental health diagnosis that puts them in Quadrants 2 or 4 ('high' MH diagnosis, or more one that is considered to be more debilitating) than clients who have a lesser mental health diagnosis (Quadrants 1 and 3 include 'low' MH categories). Table 2b (not addressed since SFY13)

Limitations of the Data and Interpretation

The main limitation of interpreting these data is that the only information available to analyze and report is that which is submitted by the agencies. Of the 67 Agencies that reported critical incidents, *forty-five agencies reported 10 or fewer critical incidents during this time frame*, with 17 of these agencies reporting a single critical incident for the entire year. One hundred and six (106) agencies did not report any critical incidents. It is likely that more critical incidents occurred during this timeframe; thus these results may under-represent the occurrence rate of critical incidents.

Additionally, although the initial submission of an incident is important, the follow-up process of providing accurate, updated information is just as important. The information presented in this report is, for the first time, based on the final categorization (ie., determined during a formal review process) for events that have been closed (84% were closed) or, for those still open, the initial category provided by the reporting agency was carried forward. Ideally, the analysis would focus only on the final categorization (and sub-categorization) of the event to provide the most detailed and complete description of what happened; this is particularly important as it pertains to the "Death" category and sub-categories. The cooperation of the providers in submitting this information in a timely manner will make future reports more accurate and complete.

The results indicate that critical incidents more frequently involve clients who receive mental health services compared to those receiving SA services; however under-reporting by substance abuse agencies may skew the results to artificially inflate the MH versus SA comparison.

Table 1. Demographic and Summary Information

Client Related Data (Unduplicated Client Count)

	No COD		COD		Total	
	N	**%**	**N**	**%**	**N**	**%**
Total # Clients in COD Category	552	100.0	188	100.0	740	100.0
Gender						
Unknown	1	0.2	0	0.0	1	0.1
Female	210	38.0	73	38.8	283	38.2
Male	314	56.9	115	61.2	456	61.6
Race						
American Indian/Alaskan Native	1	0.2	1	0.5	2	0.3
Asian	4	0.7	2	1.1	6	0.8
Black/African American	94	17.0	30	16.0	124	16.8
Caucasian	365	66.1	138	73.4	503	68.0
Other/Mixed	62	11.2	16	8.5	78	10.5
Not Specified/Unknown	25	4.5	1	0.5	26	3.5
Ethnicity						
Hispanic	84	15.2	21	11.2	105	14.2
Not Specified/Unknown	31	5.6	4	2.1	35	4.7
Age Group						
24 & Under	67	12.1	15	8.0	82	11.1
25-34	87	15.8	34	18.1	121	16.4
35-54	172	31.2	64	34.0	241	32.6
55+	173	31.3	53	28.2	226	30.5
Mental Health Diagnosis						
Schizophrenia/Schizophreniform/Schizoaffective	41	7.4	53	28.2	94	12.7
Bipolar/Major Depression	72	13.0	99	52.7	171	23.1
Shared Psychotic Disorder	0	0.0	0	0.0	0	0.0
Brief Psychotic Disorder	2	0.4	1	0.5	3	0.4
Delusional Disorder	1	0.2	0	0.0	1	0.1
Alcohol Dependence	36	6.5	67	35.6	103	13.9
Opioid Dependence	100	18.1	51	27.1	151	20.4
Cocaine Dependence	14	2.5	27	14.4	41	5.5
Cannabis Dependence	9	1.6	34	18.1	43	5.8
Amphetamine Dependence	0	0.0	1	0.5	1	0.1
Hallucinogen Dependence	1	0.2	3	1.6	4	0.5
Other Drug Dependence	1	0.2	4	2.1	5	0.7
Polysubstance Dependence	2	0.4	22	11.7	24	3.2
Alcohol Abuse	6	1.1	46	24.5	52	7.0
Tobacco Use Disorder	21	3.8	54	28.7	75	10.1
Cannabis Abuse	9	1.6	45	23.9	54	7.3
Hallucinogen Abuse Dx	0	0.0	2	1.1	2	0.3
Sedative Abuse	10	1.8	6	3.2	16	2.2
Opioid Abuse	3	0.5	8	4.3	11	1.5
Cocaine Abuse	8	1.4	26	13.8	34	4.6
Amphetamin Abuse	0	0.0	3	1.6	3	0.4
Antidepressant Abuse	0	0.0	0	0.0	0	0.0
Other Drug Abuse	0	0.0	4	2.1	4	0.5
PTSD (diagnosis on file since 7/1/2006)	32	5.8	52	27.7	84	11.4

Table 1. Demographic and Summary Information - continued

	No COD		COD		Total	
LOC During Prior Year	**N**	**%**	**N**	**%**	**N**	**%**
MH ACT	29	5.3	29	15.4	58	7.8
MH CM	14	2.5	11	5.9	25	3.4
MH OP	156	28.3	109	58.0	265	35.8
MH Crisis	42	7.6	35	18.6	77	10.4
MH Group Home	7	1.3	10	5.3	17	2.3
MH Intake	11	2.0	16	8.5	27	3.6
MH Partial Hospital	0	0.0	0	0.0	0	0.0
MH Inpatient	4	0.7	10	5.3	14	1.9
MH Social Rehab	38	6.9	34	18.1	72	9.7
MH Supervised Residential	21	3.8	19	10.1	40	5.4
MH Supportive Residential	13	2.4	12	6.4	25	3.4
MH Voc Rehab	26	4.7	20	10.6	46	6.2
MH CSP/RP	43	7.8	40	21.3	83	11.2
MH IOP	1	0.2	5	2.7	6	0.8
MH Intensive Res Rehab	3	0.5	3	1.6	6	0.8
SA CM	13	2.4	19	10.1	32	4.3
SA Detox IP	9	1.6	13	6.9	22	3.0
SA Intensive Residential	10	1.8	19	10.1	29	3.9
SA Intermediate Residential	21	3.8	15	8.0	36	4.9
SA Long Term Residential	0	0.0	1	0.5	1	0.1
SA Methadone Maintenance	90	16.3	19	10.1	109	14.7
SA Outpatient	45	8.2	36	19.1	81	10.9
SA Detox OP	0	0.0	0	0.0	0	0.0
SA Partial Hospital	12	2.2	12	6.4	24	3.2
SA Transitional Residential	2	0.4	4	2.1	6	0.8
SA Vocational Services	5	0.9	1	0.5	6	0.8
SA Gambling Outpatient	0	0.0	0	0.0	0	0.0
SA Medically Monitored Detox	41	7.4	23	12.2	64	8.6
SA IOP	29	5.3	28	14.9	57	7.7

LOC during Prior Year identifies any LOCs for the client from the date of the incident looking back one year.
Clients can have multiple diagnoses and LOCs, thus the column totals for Diagnosis and LOC may exceed 100%.

Table 1. Demographic and Summary Information - continued

	No COD		COD		Total	
LOC At Time of Incident	**N**	**%**	**N**	**%**	**N**	**%**
MH ACT	27	4.9	25	13.3	52	7.0
MH CM	14	2.5	8	4.3	22	3.0
MH OP	142	25.7	91	48.4	233	31.5
MH Crisis	12	2.2	5	2.7	17	2.3
MH Group Home	7	1.3	9	4.8	16	2.2
MH Intake	1	0.2	5	2.7	6	0.8
MH Partial Hospital	0	0.0	0	0.0	0	0.0
MH Inpatient	1	0.2	1	0.5	2	0.3
MH Social Rehab	35	6.3	27	14.4	62	8.4
MH Supervised Residential	11	2.0	12	6.4	23	3.1
MH Supportive Residential	11	2.0	12	6.4	23	3.1
MH Voc Rehab	11	2.0	14	7.4	25	3.4
MH CSP/RP	29	5.3	30	16.0	59	8.0
MH IOP	0	0.0	2	1.1	2	0.3
MH Intensive Res Rehab	3	0.5	3	1.6	6	0.8
SA CM	11	2.0	7	3.7	18	2.4
SA Detox IP	1	0.2	0	0.0	1	0.1
SA Intensive Residential	0	0.0	0	0.0	0	0.0
SA Intermediate Residential	9	1.6	5	2.7	14	1.9
SA Long Term Residential	0	0.0	0	0.0	0	0.0
SA Methadone Maintenance	44	8.0	11	5.9	55	7.4
SA Outpatient	23	4.2	14	7.4	37	5.0
SA Detox OP	0	0.0	0	0.0	0	0.0
SA Partial Hospital	0	0.0	2	1.1	2	0.3
SA Transitional Residential	1	0.2	1	0.5	2	0.3
SA Vocational Services	1	0.2	1	0.5	2	0.3
SA Gambling Outpatient	0	0.0	0	0.0	0	0.0
SA Medically Monitored Detox	14	2.5	2	1.1	16	2.2
SA IOP	2	0.4	8	4.3	10	1.4

LOC during Prior Year identifies any LOCs for the client from the date of the incident looking back one year.

At Incident is a subgroup of Prior Year that describes any LOC at the time of the CI.

Clients can have multiple diagnoses and LOCs, thus the column totals for Diagnosis and LOC may exceed 100%.

Table 2a. Statewide Incident Information for SFY16

Incident Related Data (Unduplicated Number of Critical Incidents)

		No COD		COD		Total	
		N	%	N	%	N	%
	# Critical Incidents	588	100.0	193	100.0	**781**	100.0
	CI Category						
CL	Client Abuse Alleged	4	0.7	3	1.6	7	0.9
DE	Death	283	48.1	79	40.9	362	46.4
EV	Emergency Evacuation	4	0.7	0	0.0	4	0.5
ES	Escape	0	0.0	0	0.0	0	0.0
FN	Federal Notification	2	0.3	0	0.0	2	0.3
PD	Property Damage	9	1.5	1	0.5	10	1.3
ME	Medical Event	55	9.4	20	10.4	75	9.6
MC	Missing Client	26	4.4	12	6.2	38	4.9
OT	Other	30	5.1	5	2.6	35	4.5
SC	Serious Crime Alleged	75	12.8	41	21.2	116	14.9
SA	Serious Suicide Attempt	69	11.7	20	10.4	89	11.4
TH	Threats	31	5.3	12	6.2	43	5.5

COD: Client involved in CI had a co-occurring disorders diagnosis

Table 2b. Statewide Incident Subcategory Information

CI Subcategory		No COD		COD		Total	
		N	%	N	%	N	%
CL1	Physical abuse alleged	2	0.3	1	0.5	3	0.4
CL2	Verbal abuse alleged	1	0.2	0	0.0	1	0.1
CL3	Violation of patient rights w/ signif consequences	1	0.2	1	0.5	2	0.3
CL4	Breach of confidentiality with significant	0	0.0	1	0.5	1	0.1
DE1	Suicide	21	3.6	5	2.6	26	3.3
DE2	Homicide	3	0.5	1	0.5	4	0.5
DE3	Accident	20	3.4	9	4.7	29	3.7
DE4	Accidental overdose	46	7.8	17	8.8	63	6.8
DE6	Illness, age, or medical reason	152	25.9	29	15.0	181	23.2
DE7	Info pending/Insufficient Info	41	7.0	18	9.3	59	7.6
ES1	PSRB Patient	0	0.0	0	0.0	0	0.0
ES2	DOC Patient	0	0.0	0	0.0	0	0.0
ES3	Competency Restoration	0	0.0	0	0.0	0	0.0
EV1	Fire	2	0.3	0	0.0	2	0.3
EV2	Bomb	2	0.3	0	0.0	2	0.3
EV3	Other Emergency Evacuation	0	0.0	0	0.0	0	0.0
FN1	Secret Service	0	0.0	0	0.0	0	0.0
FN2	FBI	1	0.2	0	0.0	1	0.1
FN3	Other Federal Notice	1	0.2	0	0.0	1	0.1
PD1	Property Damage - Safety Issue	4	0.7	0	0.0	4	0.5
PD2	Property Damage	5	0.9	1	0.5	6	0.8
MC1	Missing inpatient, risk to self or others	2	0.3	0	0.0	2	0.3
MC2	Missing outpatient, risk to self or others	11	1.9	1	0.5	12	1.5
MC3	Missing person	13	2.2	11	5.7	24	3.1
ME1	Accidental injury	10	1.7	7	3.6	17	2.2
ME2	Accidental overdose (not resulting in death)	19	3.2	5	2.6	24	3.1
ME3	Medical error/reaction	2	0.3	3	1.6	5	0.6
ME4	Medical event - other	24	4.1	5	2.6	29	3.7
OT1	Other incident (specify)	30	5.1	5	2.6	35	4.5
SA1	Suicide attempt while active in program	69	11.7	20	10.4	89	11.4
SA2	Suicide attempt within 30 days of discharge	0	0.0	0	0.0	0	0.0
SC1	Physical assault	23	3.9	19	9.8	42	5.4
SC2	Sexual assault	16	2.7	8	4.1	24	3.1
SC3	Risk of injury to minor	4	0.7	2	1.0	6	0.8
SC4	Arson	1	0.2	0	0.0	1	0.1
SC5	Firearms	6	1.0	3	1.6	9	1.2
SC6	Hostage	0	0.0	0	0.0	0	0.0
SC7	Drug sale/distribution/possession	6	1.0	2	1.0	8	1.0
SC8	Homicide/manslaughter	1	0.2	0	0.0	1	0.1
SC9	Theft/Burglary	7	1.2	2	1.0	9	1.2
SC10	Other serious crime (specify)	11	1.9	5	2.6	16	2.0
TH1	Threats to agency	4	0.7	2	1.0	6	0.8
TH2	Threats to person	27	4.6	10	5.2	37	4.7
	TOTAL	**588**	**100**	**193**	**100**	**781**	**100**

COD: Client involved in CI had a co-occurring disorders diagnosis

Table 3a. Comparison of Statewide Incident Data for SFY15 & SFY16
Incident Related Data (Unduplicated Number of Critical Incidents)

		SFY15 Totals		SFY16 Totals		
		N	%	N	%	Change
	# Critical Incidents	**677**	**100.0**	**781**	**100.0**	**15.4%**
	Incident Category					
CL	Client Abuse Alleged	4	0.6	7	0.9	75.0%
DE	Death	314	46.4	362	46.4	15.3%
EV	Emergency Evacuation	5	0.7	4	0.5	-20.0%
ES	Escape	0	0.0	0	0.0	--
FN	Federal Notification	0	0.0	2	0.3	--
PD	Loss/Damage	6	0.9	10	1.3	66.7%
ME	Medical Event	62	9.2	75	9.6	21.0%
MC	Missing Client	26	3.8	38	4.9	46.2%
OT	Other	24	3.5	35	4.5	45.8%
SC	Serious Crime Alleged	127	18.8	116	14.9	-8.7%
SA	Serious Suicide Attempt	72	10.6	89	11.4	23.6%
TH	Threats	37	5.5	43	5.5	16.2%
CL1	Physical abuse alleged	1	0.1	3	0.4	200.0%
CL2	Verbal Abuse Alleged	0	0.0	1	0.1	--
CL3	Violation of patient rights w/ signif consequences alleged	2	0.3	2	0.3	--
CL4	Breach of confidentiality w/ signif consequences alleged	1	0.1	1	0.1	--
DE1	Suicide	30	3.8	26	3.3	-13.3%
DE2	Homicide	4	0.5	4	0.5	0.0%
DE3	Accident	17	2.2	29	3.7	70.6%
DE4	Accidental overdose	46	5.9	63	8.1	37.0%
DE5	Medical Error	1	0.1	0	0.0	--
DE6	Illness, age, or medical reason	172	22.0	181	23.2	5.2%
DE7	Info pending/Insufficient Info	44	5.6	59	7.6	34.1%
ES1	PSRB Patient	0	0.0	0	0.0	--
ES2	DOC Patient	0	0.0	0	0.0	--
ES3	Competency Restoration	0	0.0	0	0.0	--
EV1	Fire	0	0.0	2	0.3	
EV2	Bomb	0	0.0	2	0.3	--
EV3	Other Emergency Evacuation	1	0.1	0	0.0	--
FN1	Secret Service	0	0.0	0	0.0	--
FN2	FBI	0	0.0	1	0.1	--
FN3	Other Federal Notice	0	0.0	1	0.1	--
PD1	Property Damage - Safety Issue	5	0.6	4	0.5	-20.0%
PD2	Property Damage	1	0.1	6	0.8	500.0%
MC1	Missing inpatient, risk to self or others	1	0.1	2	0.3	100.0%
MC2	Missing outpatient, risk to self or others	6	0.8	12	1.5	100.0%
MC3	Missing person	19	2.4	24	3.1	26.3%
ME1	Accidental injury	13	1.7	17	2.2	30.8%
ME2	Accidental overdose (not resulting in death)	20	2.6	24	3.1	20.0%
ME3	Medical error/reaction	3	0.4	5	0.6	66.7%
ME4	Medical event - other	26	3.3	29	3.7	11.5%
OT1	Other incident (specify)	24	3.1	35	4.5	45.8%
SA1	Suicide attempt while active in program	70	9.0	89	11.4	27.1%
SA2	Suicide attempt within 30 days of discharge	2	0.3	0	0.0	--
SC1	Physical assault	49	6.3	42	5.4	-14.3%
SC2	Sexual assault	31	4.0	24	3.1	-22.6%
SC3	Risk of injury to minor	7	0.9	6	0.8	-14.3%
SC4	Arson	2	0.3	1	0.1	-50.0%
SC5	Firearms	3	0.4	9	1.2	200.0%
SC6	Hostage	0	0.0	0	0.0	--
SC7	Drug sale/distribution/possession	7	0.9	8	1.0	14.3%
SC8	Homicide/manslaughter	5	0.6	1	0.1	-80.0%
SC9	Theft/Burglary	4	0.5	9	1.2	125.0%
SC10	Other serious crime (specify)	19	2.4	16	2.0	-15.8%
TH1	Threats to agency	4	0.5	6	0.8	50.0%
TH2	Threats to person	33	4.2	37	4.7	12.1%

Table 3b. Comparison of Statewide Incident Data for SFY11 through SFY15

Incident Related Data (Unduplicated Number of Critical Incidents)		SFY12		SFY13		SFY14		SFY15		SFY16	
		N	%	N	%	N	%	N	%	N	%
# Critical Incidents		**578**	**100**	**651**	**100**	**620**	**100**	**677**	**100**	**781**	**100**
Incident Category											
CL	Client Abuse Alleged	6	1.0	3	0.5	3	0.5	4	0.6	7	0.9
DE	Death	263	45.5	275	42.2	286	46.1	314	46.4	362	46.4
EV	Emergency Evacuation	4	0.7	5	0.8	5	0.8	5	0.7	4	0.5
ES	Escape	0	0.0	3	0.5	1	0.2	0	0.0	0	0.0
FN	Federal Notification	1	0.2	1	0.2	1	0.2	0	0.0	2	0.3
PD	Loss/Damage	4	0.7	4	0.6	8	1.3	6	0.9	10	1.3
ME	Medical Event	59	10.2	96	14.7	51	8.2	62	9.2	75	9.6
MC	Missing Client	19	3.3	22	3.4	23	3.7	26	3.8	38	4.9
OT	Other	24	4.2	25	3.8	19	3.1	24	3.5	35	4.5
SC	Serious Crime Alleged	106	18.3	105	16.1	106	17.1	127	18.8	116	14.9
SA	Serious Suicide Attempt	73	12.6	77	11.8	86	13.9	72	10.6	89	11.4
TH	Threats	19	3.3	35	5.4	31	5.0	37	5.5	43	5.5
Incident SubCategory											
CL1	Physical abuse alleged							1	0.1	3	0.4
CL2	Verbal Abuse Alleged	0	0.0	0	0.0	1	0.2	0	0.0	1	0.1
CL3	Violation of patient rights w/ signif consequences a	2	0.3	2	0.3	0	0.0	2	0.3	2	0.3
CL4	Breach of confidentiality w/ signif consequences al	1	0.2	0	0.0	0	0.0	1	0.1	1	0.1
DE1	Suicide	19	3.3	28	4.3	18	2.9	30	4.4	26	3.3
DE2	Homicide	8	1.4	5	0.8	2	0.3	4	0.6	4	0.5
DE3	Accident*							17	2.5	29	3.7
DE4	Accidental overdose							46	6.8	63	6.8
DE5	Medical Error*	23	4.0	26	4.0	20	3.2	1	0.1	0	0.0
DE6	Illness, age, or medical reason	119	20.6	116	17.8	149	24.0	172	25.4	181	23.2
DE7	Info pending/Insufficient Info	94	16.3	100	15.4	97	15.6	44	6.5	59	7.6
ES1	PSRB Patient	0	0.0	2	0.3	1	0.2	0	0.0	0	0.0
ES2	DOC Patient	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
ES3	Competency Restoration	0	0.0	1	0.2	0	0.0	0	0.0	0	0.0
EV1	Fire	1	0.2	3	0.5	4	0.6	4	0.6	2	0.3
EV2	Bomb							0	0.0	2	0.3
EV3	Other Emergency Evacuation	3	0.5	1	0.2	0	0.0	1	0.1	0	0.0
FN1	Secret Service	1	0.2	0	0.0	0	0.0	0	0.0	0	0.0
FN2	FBI	0	0.0	1	0.2	1	0.2	0	0.0	1	0.1
FN3	Other Federal Notice	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1
PD1	Property Damage - Safety Issue*	3	0.5	4	0.6	5	0.8	5	0.7	4	0.5
PD2	Property Damage*	1	0.2	0	0.0	3	0.5	1	0.1	6	0.8
MC1	Missing inpatient, risk to self or others							1	0.1	2	0.3
MC2	Missing outpatient, risk to self or others	3	0.5	6	0.9	7	1.1	6	0.9	12	1.5
MC3	Missing person	15	2.6	11	1.7	14	2.3	19	2.8	24	3.1
ME1	Accidental injury*	6	1.0	9	1.4	7	1.1	13	1.9	17	2.2
ME2	Accidental overdose (not resulting in death)	5	0.9	9	1.4	13	2.1	20	3.0	24	3.1
ME3	Medical error/reaction	2	0.3	3	0.5	2	0.3	3	0.4	5	0.6
ME4	Medical event - other	46	8.0	75	11.5	30	4.8	26	3.8	29	3.7
OT1	Other incident (specify)	24	4.2	25	3.8	18	2.9	24	3.5	35	4.5
SA1	Suicide attempt while active in program	72	12.5	76	11.7	86	13.9	70	10.3	89	11.4
SA2	Suicide attempt within 30 days of discharge	1	0.2	1	0.2	0	0.0	2	0.3	0	0.0
SC1	Physical assault	40	6.9	38	5.8	63	10.2	49	7.2	42	5.4
SC2	Sexual assault	24	4.2	29	4.5	12	1.9	31	4.6	24	3.1
SC3	Risk of injury to minor	5	0.9	7	1.1	4	0.6	7	1.0	6	0.8
SC4	Arson	9	1.6	2	0.3	2	0.3	2	0.3	1	0.1
SC5	Firearms	4	0.7	5	0.8	3	0.5	3	0.4	9	1.2
SC6	Hostage	1	0.2	0	0.0	0	0.0	0	0.0	0	0.0
SC7	Drug sale/distribution/possession	2	0.3	2	0.3	2	0.3	7	1.0	8	1.0
SC8	Homicide/manslaughter	4	0.7	3	0.5	6	1.0	5	0.7	1	0.1
SC9	Theft/Burglary*							4	0.6	9	1.2
SC10	Other serious crime (specify)	17	2.9	19	2.9	14	2.3	19	2.8	16	2.0
TH1	Threats to agency*	1	0.2	3	0.5	0	0.0	4	0.6	6	0.8
TH2	Threats to person	18	3.1	32	4.9	31	5.0	33	4.9	37	4.7

* New system has some differences in categories. Blank cell under 2011-2014 indicates this category is new in 2015

Figure 2

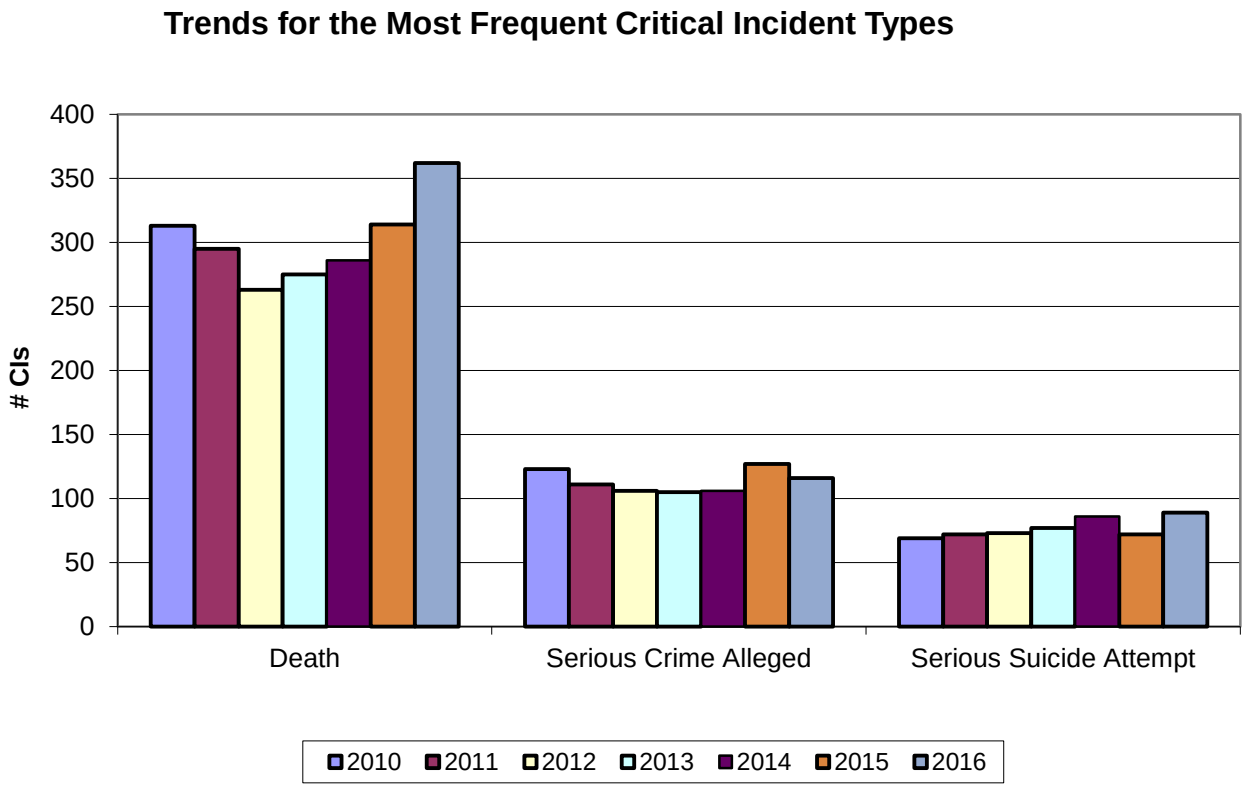

Trends for the Most Frequent Critical Incident Types
CIs
400
350
300
250
200
150
100
50
0
Death
Serious Crime Alleged
Serious Suicide Attempt
2010
2011
2012
2013
2014
2015
2016

Table 4a. Summary of SFY2016 Critical Incidents Categorized as Deaths

362 Deaths in SFY 16 (46% of all SFY16 Critical Incidents)

Death Incident SubCategory	N	%
Suicide	26	7.2
Homicide	4	1.1
Accident	29	8.0
Accidental overdose	63	17.4
Medical Error	0	0.0
Illness, age, or medical reason	181	50.0
Info pending/Insufficient Info	59	16.3

Demographics (Note: based on N=359 as 3 clients were not identified)

233 (65%) were male

259 (72%) were Caucasian, 39 (11%) were African American

50 (14%) were Hispanic

Average age =52.6 years (±13.1), age range 18-85 years

23 (6%) had a diagnosis of PTSD

5 deaths were coded as occurring at a state operated facility (all found unresponsive)

Co-Occurring Diagnosis	N	%
No COD	280	68.2
COD	79	31.8
Most Common MH/SA Diagnoses (from EDW)	**N**	**%**
Opioid Dependence	106	29.5
Bipolar/Major Depression	76	21.2
Alcohol Dependence	50	13.9
Tobacco Use Disorder	36	10.0
Schizophrenia/Schizophreniform/Schizoaffective	34	9.5
Cannabis Abuse	19	5.3
LOC at Time of Incident (most frequent listed)	**N**	**%**
MH OP	108	34.4
SA Methadone Maintenance	37	11.8
MH CSP/RP	33	10.5
MH Social Rehab	27	8.6
SA OP	20	6.4
Most Common Medical Diagnoses*	**N**	**%**
Other Condition	77	25.5
Heart Disease Problems	50	16.6
Diabetes	46	15.2
Cancer	42	13.9
Obesity	28	9.3
COPD	26	8.6
Hyperlipidemia	21	7.0
Hepatitis	21	7.0
Renal Failure/Kidney Disease	15	5.0
Asthma	13	4.3
Cause of Death*		
Other	89	29.5
Drug Overdose	52	17.2
Heart Disease	46	15.2
Cancer	34	11.3
Suicide	22	7.3
Accidents	22	7.3
Liver Diease	11	3.6
Chronic Lung Disease	6	2.0
Diabetes	4	1.3

* % based on 302 closed death incidents (may have multiple dx)

Table 4b. Summary of SFY2016 Critical Incidents Categorized as Deaths for Clients Under Age 50

125 Deaths in SFY 16 Under the Age of 50 (35% of all SFY16 Deaths)

Death Incident SubCategory	N	%
Suicide	11	8.8
Homicide	3	2.4
Accident	9	7.2
Accidental overdose	42	33.6
Medical Error	0	0.0
Illness, age, or medical reason	33	26.4
Info pending/Insufficient Info	27	21.6

Demographics

86 (69%) were male
94 (75%) were Caucasian, 14 (11%) were African American
19 (15%) were Hispanic
Average age = 38.2 years (±8.5), age range 18-49 years
42% of deaths were reported to occur at the client's residence
6 (5%) had a diagnosis of PTSD
5 (16%) clients were active in treatment at a state-operated IP facility at the time of their deaths
2 deaths occurred at a state operated facility (found unresponsive)

Co-Occurring Diagnosis	N	%
No COD	98	78.4
COD	27	21.6
Most Common MH/SA Diagnoses (from EDW)	**N**	**%**
Opioid Dependence	45	36.0
Bipolar/Major Depression	25	20.0
Alcohol Dependence	18	14.4
Tobacco Use Disorder	14	11.2
Cocaine Dependence	11	8.8
Cocaine Abuse	10	8.0
LOC at Time of Incident (most frequent listed)	**N**	**%**
MH OP	32	25.6
SA MM	17	13.6
SA CM	9	7.2
MH CSP/RP	4	3.2
Top 10 Most Common Medical Diagnoses*	**N**	**%**
Other Condition	27	26.2
Obesity	9	8.7
Heart Disease Problems	8	7.8
Diabetes	7	6.8
Asthma	5	4.9
Cancer	5	4.9
Renal Failure/Kidney Disease	4	3.9
Cirrhosis/Liver Disease	4	3.9
Hyperlipidemia	3	2.9
Hepatitis	2	1.9
Cause of Death**		
Drug Overdose	34	27.6
Other	30	24.4
Suicide	11	8.9
Accidents	9	7.3
Heart Disease	8	6.5
Liver Diease	4	3.3
Cancer	3	2.4
Homicide	2	1.6

* % based on 103 closed death incidents (may have multiple dx)
** % based on 103 deaths where this information was provided (<1% not shown)

Table 4c. Summary of SFY2016 Critical Incidents Categorized as Suicides

26 Suicides in SFY 16 (3.3% of all SFY16 Critical Incidents)

Demographics
17 (70%) were male
21 (81%) were Caucasian; 1 (4%) was African American
Average age = 46.0 years (±15.4), age range 18-74 years
5 (19%) were by hanging; 5 (19%) were by overdose
3 (12%) were by asphyxiation and 3 (12%) were by jumping
18 (69%) occurred at the client's residence
2 (8%) had a diagnosis of PTSD
0 incidents occurred at a state-operated facility

Co-Occurring Diagnosis	**N**	**%**
No COD	21	80.8
COD	5	19.2
Most Common MH/SA Diagnoses (from EDW)	**N**	**%**
Bipolar/Major Depression	6	23.1
Alcohol Dependence	4	15.4
Schizophrenia/Schizophreniform/Schizoaffective	4	15.4
Opioid Dependence	2	7.7
Tobacco Use Disorder	2	7.7
LOC at Time of Incident (most frequent listed)	**N**	**%**
MH OP	11	42.3
MH CSP/RP	4	15.4

Figure 3

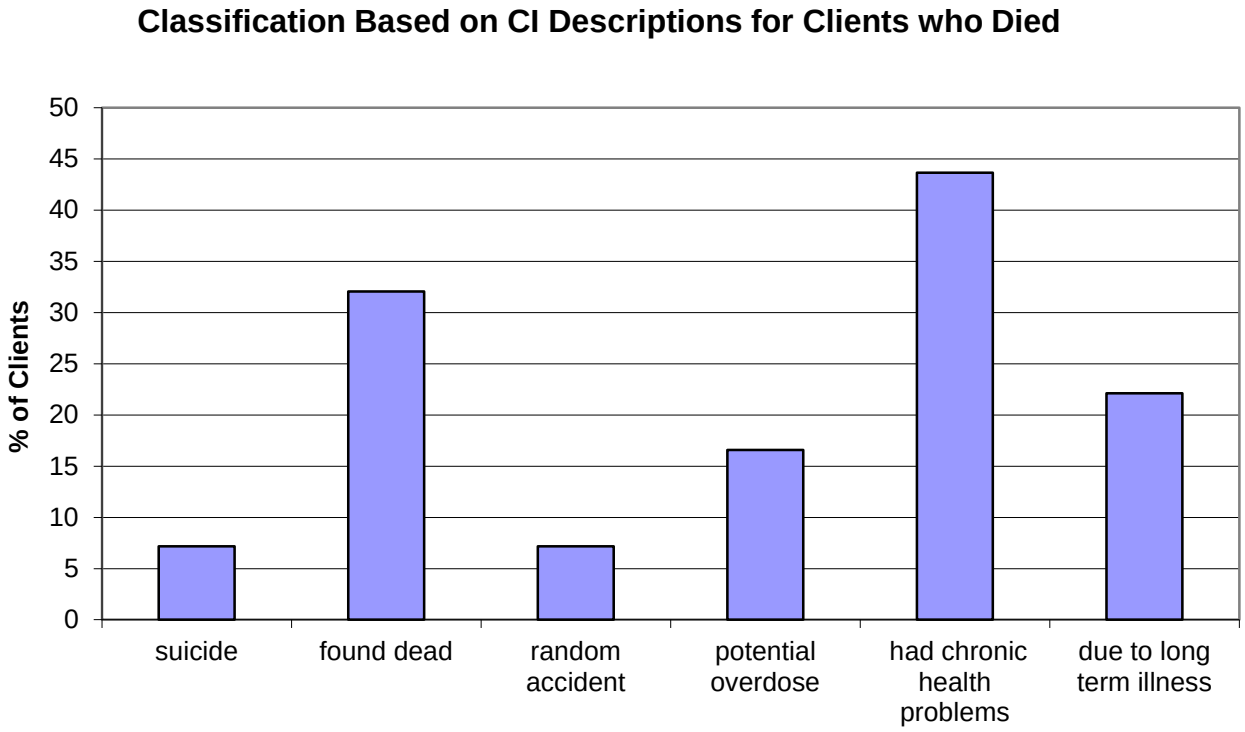
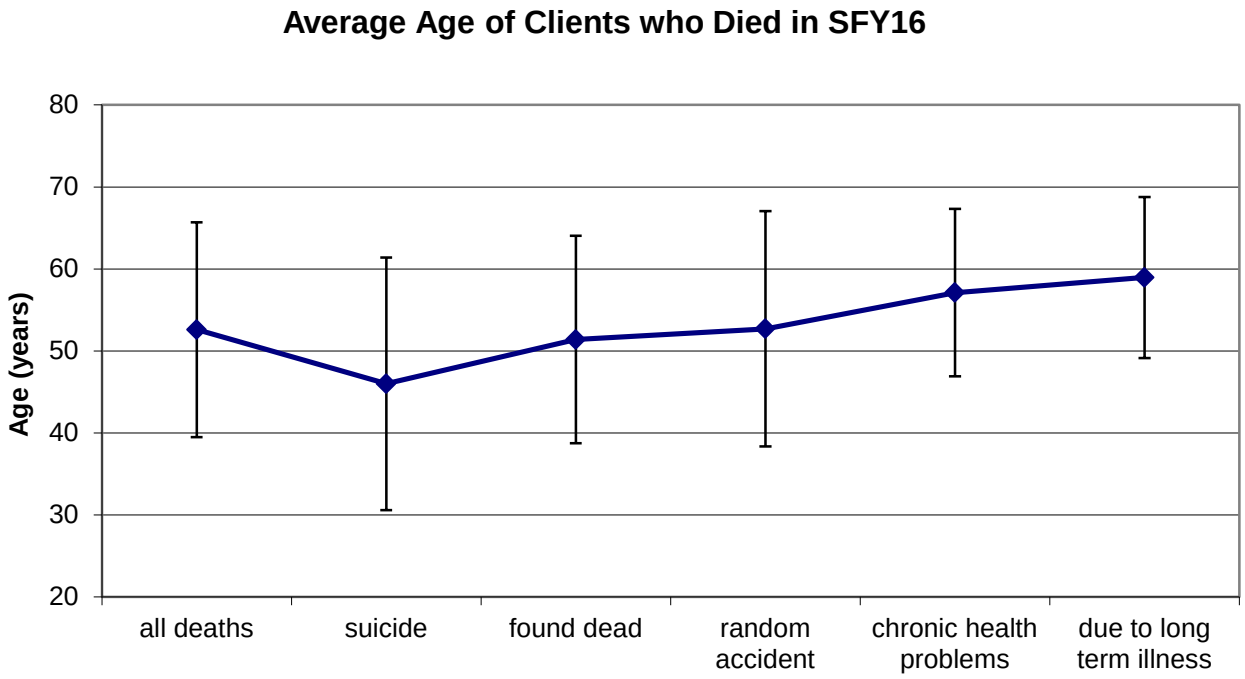


Figure 4



Comparison Between Clients with and without COD – SFY16

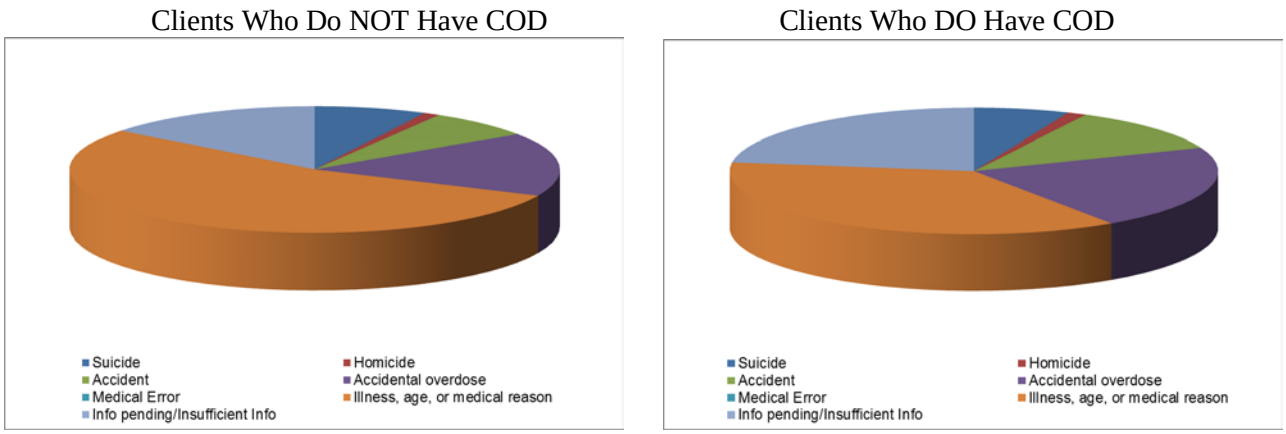


Figure 5. Death Subcategories

There were significantly more clients who did not have COD who had their death classified as due to illness, age, or medical reason. Significance testing performed using chi-square and $p<.05$.

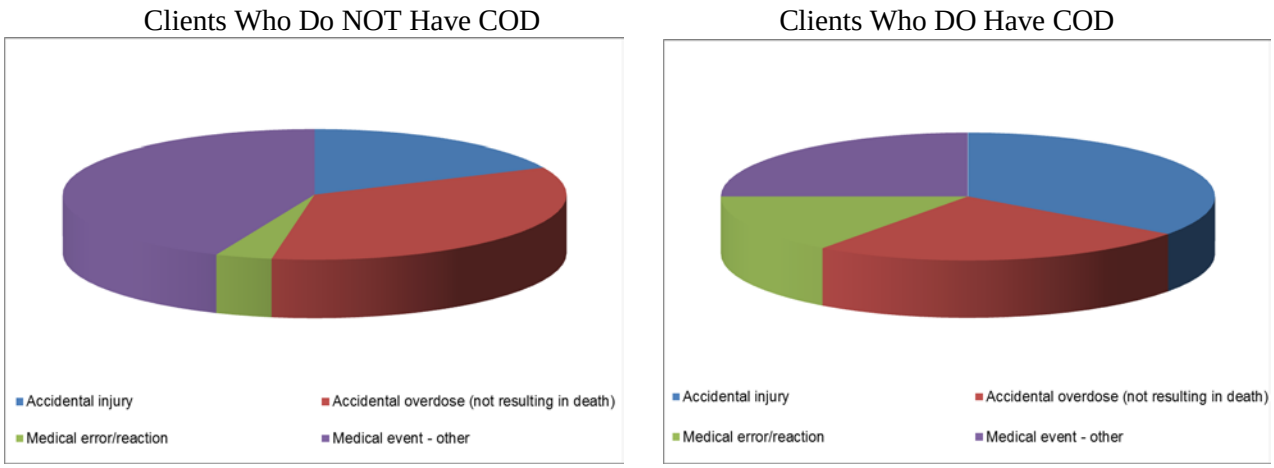


Figure 6. Medical Event Subcategories

There were no significant differences across the different Medical Events subcategories in terms of the number of clients who had COD versus those who did not have COD. Significance testing performed using chi-square and $p<.05$.

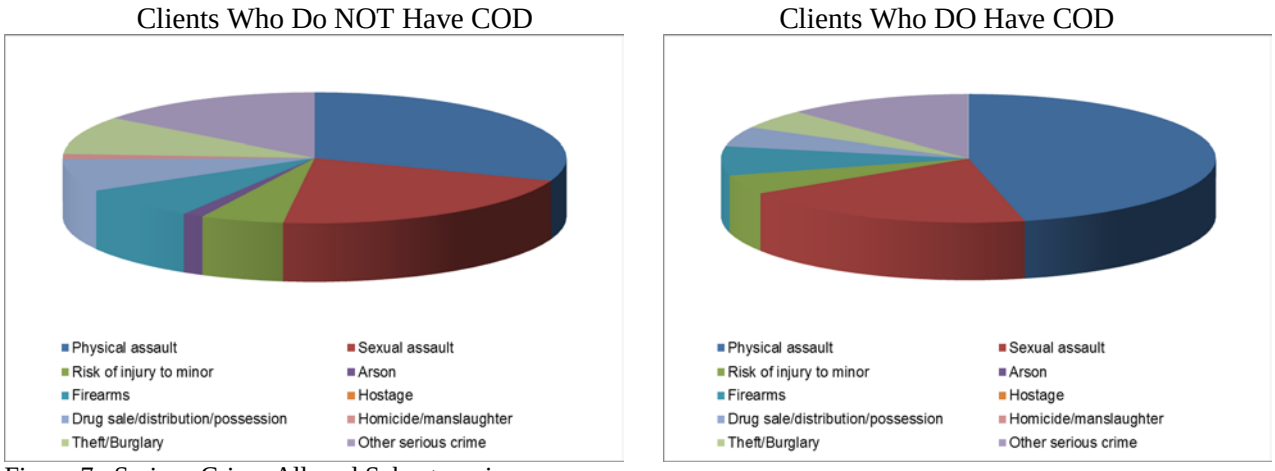


Figure 7. Serious Crime Alleged Subcategories

There were no significant differences across the different Serious Crime Alleged subcategories in terms of the number of clients who had COD versus those who did not have COD.

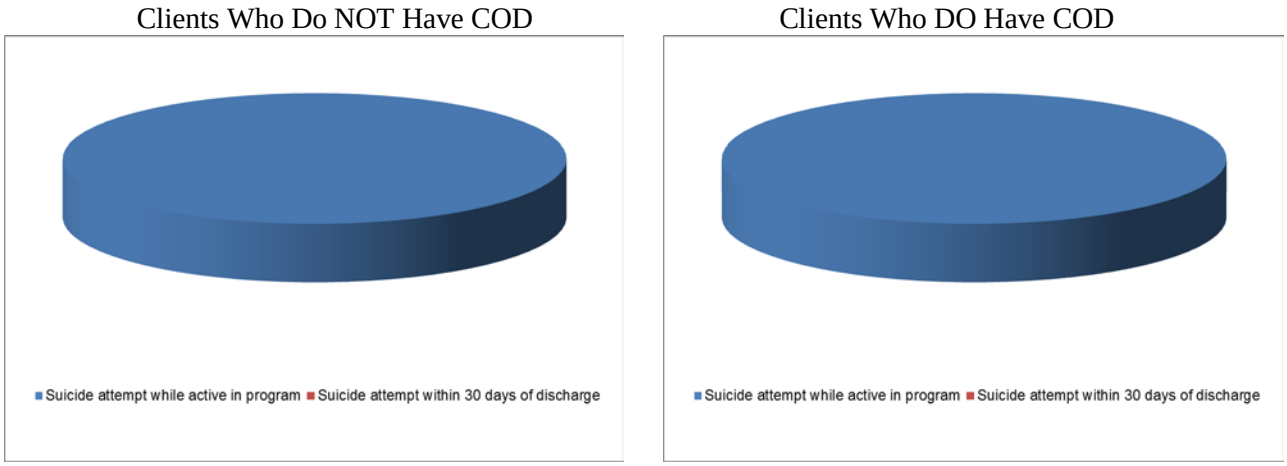


Figure 8. Serious Suicide Attempt Subcategories

There were no reports of a Serious Suicide Attempt in the "within 30 days of discharge", thus the subcategories cannot be compared. Additionally there was no significant difference in the number of suicide attempts from clients who had COD versus those who did not have COD. Significance testing performed using chi-square and $p<.05$.

Table 5a. Agencies Reporting CIs (Alphabetical order)

Provider	N	%
Ability Beyond	3	0.4
Advanced Behavioral Health	6	0.8
BH Care (formerly Harbor and Birmingham)	40	5.1
Bridges Healthcare, Inc.	29	3.7
Capitol Region Mental Health Center	38	4.9
Catholic Charities of Fairfield County Inc.	4	0.5
Catholic Charities- Waterbury	1	0.1
Center for Human Development	5	0.6
Central Naugatuck Valley (CNV) Help Inc.	4	0.5
Centro Renacer of CT Inc (formerly Hogar Crea)	1	0.1
Charlotte Hungerford Hospital	6	0.8
Chemical Abuse Services Agency (CASA)	4	0.5
Chrysalis Center Inc.	3	0.4
CommuniCare Inc	3	0.4
Community Health Center Inc.	2	0.3
Community Health Resources Inc.	36	4.6
Community Health Services Inc.	2	0.3
Community Mental Health Affiliates	42	5.4
Community Renewal Team (CRT)	3	0.4
Connecticut Mental Health Center	20	2.6
Connecticut Renaissance Inc.	2	0.3
Connecticut Valley Hospital	21	2.7
Connection Inc	12	1.5
Continuum of Care	1	0.1
Cornell Scott-Hill Health Corporation	14	1.8
Crossroad Inc	5	0.6
Fellowship Inc.	1	0.1
Friendship Service Center	1	0.1
Gilead Community Services Inc.	10	1.3
Hartford Dispensary	44	5.6
Homes with Hope (formerly Interfaith Housing)	1	0.1
Human Resource Development Agency	1	0.1
InterCommunity Inc.	18	2.3
Keystone House Inc.	1	0.1
Laurel House	2	0.3
Liberation Programs	12	1.5
LifeBridge Community Services (formerly FSW Inc)	5	0.6
Marrakech Day Services	1	0.1
McCall Foundation Inc	3	0.4
Mental Health Connecticut	13	1.7
Midwestern CT Council on Alcoholism (MCCA)	3	0.4
My Sisters' Place	1	0.1
New Era Rehabilitation Center Inc.	7	0.9
New London Homeless Hospitality Center	1	0.1
New Milford Hospital	1	0.1
Norwalk Hospital	8	1.0
Office of the Commissioner	3	0.4
Operation Hope of Fairfield Inc.	1	0.1
Optimus Health Care-Bennett Behavioral Health	3	0.4
Perception Programs Inc	6	0.8
Prime Time House Inc.	1	0.1
Recovery Network of Programs	27	3.5
Reliance Health, Inc.	27	3.5
River Valley Services	14	1.8
Rushford Center	8	1.0
SCADD	36	4.6

Table 5b. Agencies Reporting CIs (By volume reported)

Provider	N	%
United Services Inc.	61	7.8
Western Connecticut Mental Health Network	58	7.4
Hartford Dispensary	44	5.6
Community Mental Health Affiliates	42	5.4
BH Care (formerly Harbor and Birmingham)	40	5.1
Capitol Region Mental Health Center	38	4.9
Community Health Resources Inc.	36	4.6
SCADD	36	4.6
Southwest Connecticut Mental Health System	32	4.1
Bridges Healthcare, Inc.	29	3.7
Recovery Network of Programs	27	3.5
Reliance Health, Inc.	27	3.5
Wheeler Clinic	26	3.3
Southeastern Mental Health Authority	23	2.9
Connecticut Valley Hospital	21	2.7
Connecticut Mental Health Center	20	2.6
InterCommunity Inc.	18	2.3
Cornell Scott-Hill Health Corporation	14	1.8
River Valley Services	14	1.8
Mental Health Connecticut	13	1.7
Connection Inc	12	1.5
Liberation Programs	12	1.5
Gilead Community Services Inc.	10	1.3
Norwalk Hospital	8	1.0
Rushford Center	8	1.0
New Era Rehabilitation Center Inc.	7	0.9
Advanced Behavioral Health	6	0.8
Charlotte Hungerford Hospital	6	0.8
Perception Programs Inc	6	0.8
Sound Community Services Inc.	6	0.8
Center for Human Development	5	0.6
Crossroad Inc	5	0.6
LifeBridge Community Services (formerly FSW Inc)	5	0.6
Catholic Charities of Fairfield County Inc.	4	0.5
Central Naugatuck Valley (CNV) Help Inc.	4	0.5
Chemical Abuse Services Agency (CASA)	4	0.5
Ability Beyond	3	0.4
Chrysalis Center Inc.	3	0.4
CommuniCare Inc	3	0.4
Community Renewal Team (CRT)	3	0.4
McCall Foundation Inc	3	0.4
Midwestern CT Council on Alcoholism (MCCA)	3	0.4
Office of the Commissioner	3	0.4
Optimus Health Care-Bennett Behavioral Health	3	0.4
Yale University-Behavioral Health	3	0.4
Community Health Center Inc.	2	0.3
Community Health Services Inc.	2	0.3
Connecticut Renaissance Inc.	2	0.3
Laurel House	2	0.3
Wellmore (Morris Foundation Inc)	2	0.3
Catholic Charities- Waterbury	1	0.1
Centro Renacer of CT Inc (formerly Hogar Crea)	1	0.1
Continuum of Care	1	0.1
Fellowship Inc.	1	0.1
Friendship Service Center	1	0.1
Homes with Hope (formerly Interfaith Housing)	1	0.1

Table 5a. Agencies Reporting CIs (Alphabetical order)

Provider	N	%
Sound Community Services Inc.	6	0.8
Southeastern Mental Health Authority	23	2.9
Southwest Connecticut Mental Health System	32	4.1
St. Mary's Hospital Corporation	1	0.1
St. Vincent DePaul Mission of Waterbury Inc.	1	0.1
United Services Inc.	61	7.8
Waterbury Hospital Health Center	1	0.1
Wellmore (Morris Foundation Inc)	2	0.3
Western Connecticut Mental Health Network	58	7.4
Wheeler Clinic	26	3.3
Yale University-Behavioral Health	3	0.4
Total	**781**	**100.0**

Table 5b. Agencies Reporting CIs (By volume reported)

Provider	N	%
Human Resource Development Agency	1	0.1
Keystone House Inc.	1	0.1
Marrakech Day Services	1	0.1
My Sisters' Place	1	0.1
New London Homeless Hospitality Center	1	0.1
New Milford Hospital	1	0.1
Operation Hope of Fairfield Inc.	1	0.1
Prime Time House Inc.	1	0.1
St. Mary's Hospital Corporation	1	0.1
St. Vincent DePaul Mission of Waterbury Inc.	1	0.1
Waterbury Hospital Health Center	1	0.1
Total	**781**	**100.0**