SFY2014 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, 2013 and June 30, 2014.

Since a critical incident (CI) may involve more than one client and a client may be involved in multiple incidents, the data for SFY14 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:

- 620 incidents
  - 6 (0.8%) were at the Agency Level (Evacuation, Loss/Damage.)
  - 3 (0.5%) involved staff member – all were victims of physical assaults
  - 614 (99%) were at the Client Level
  - 231 (37%) incidents involved clients *with* a co-occurring diagnosis
  - 389 (63%) incidents involved clients *without* a co-occurring diagnosis
  - 161 (26%) incidents were reported by state-operated facilities
  - The maximum number of clients involved in any one incident was 5
    - 598 incidents (96%) involved a single person

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

- 609 unduplicated clients
  - 231 (38%) clients *did have* a co-occurring diagnosis
  - 387 (64%) clients *did not have* a co-occurring diagnosis
  - 97 (16%) clients had a PTSD diagnosis on file since 7/1/06
  - The maximum number of incidents for any one client was 4

Information from DDaP and Avatar 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.

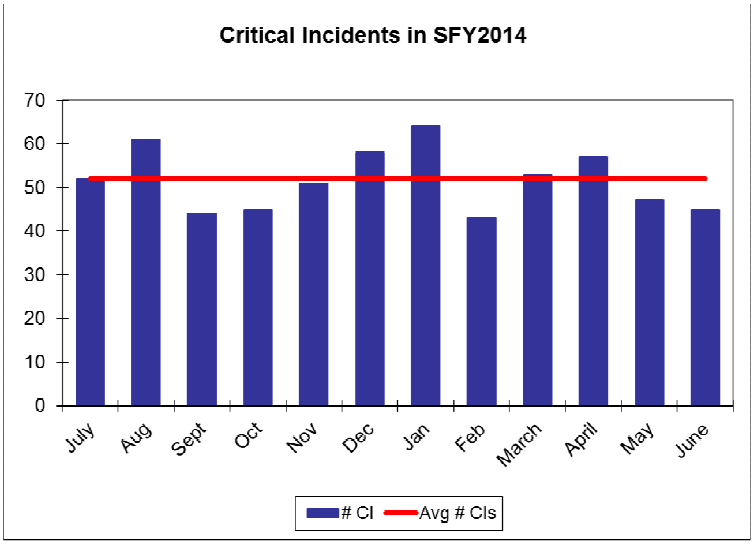


Figure 1. Critical Incidents in SFY14

Summary of the Results

■ From SFY13 to SFY14 there was a *4.8% decrease* in the number of critical incidents reported. 96% of all client-level CIs involved a single client. (Tables 1, 2, 3a & 3b)

■ Over one-third (37%) of all CIs involved clients who were between the ages of 35 and 54 years. 61% of the clients were male. (Table 1)

■ Bipolar/Major Depression was the most frequent diagnosis (36%) for clients involved in a CI. Schizophrenia/ Schizophreniform/Schizoaffective disorder was the next most frequent MH diagnosis (22%). Opioid Dependence (21%) and Alcohol Dependence (16%) 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, 41% of clients were receiving MH Outpatient services, 13% were receiving MH CSP/RP services, and 12% of clients were receiving MH Social Rehabilitation services. (Table 1)

■ The 6 Agency-level CIs included 3 Emergency Evacuations (2 fire, 1 bomb threat), 3 Loss/Damage (involved theft of agency property.

■ The most frequent CI categories reported were: (Tables 2, 3a, 3b, Figure 2)
Death (42%). Compared to SFY13, the number of deaths in SFY14 *increased* by 4% (from 275 to 286).
Serious Crime Alleged (16%). Compared to SFY13, there was 1% *more* CIs reported in this category (105 to 106).
Serious Suicide Attempt (13%). Compared to SFY13, there were 12% *more* serious suicide attempts (77 to 86).
Medical Event (8%). Compared to SFY13, there was a 47% *decrease* in the number of medical events reported (96 to 51).

■ Within the Death category, the number of Suicides reported *decreased* 36% from SFY13 (28 to 18). The reported number of Serious Suicide Attempts while enrolled a program *increased by* 13% (76 to 86). (Table 3a)

■ Over one-third (38%) 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* 44% (9 to 13) from SFY13. The number of the number of medical event - other *decreased* 60% (75 to 30). (Table 3a)

■ This is the first time since this analysis started (SFY2006) that the majority of clients who died by suicide were female (56%). (Table 4c)

■ Of the 286 Deaths in SFY14: 63% were male
average age = 51.4 years (±13.2), age range 19-91 years
almost three-quarters (70%) did *not* have a co-occurring diagnosis
82% did *not* have a PTSD diagnosis
27% had a diagnosis of Bipolar/Major Depression.
26% had hypertension and 23% had cancer (Table 4a)

■ There were 109 deaths where the client was less than 50 years old
64% were male
average age = 37.9 years (±8.6), age range 19-49 years
58% did *not* have a co-occurring diagnosis
89% did *not* have a PTSD diagnosis
10 (9%) were suicides
25% were found dead (not including suicides)
33% had Bipolar/Major Depression; 31% had Opioid Dependence
19 (18%) had chronic health issues
29% had diabetes and 29% had hypertension
6% died from a long-term illness (Table 4b)

■ There were 18 suicides in SFY14: 44% were male
average age = 44.8 years (±13.4), age range 22-67 years
most (78%) did *not* have a co-occurring diagnosis
18% had a PTSD diagnosis
28% had a diagnosis of Bipolar/Major Depression.
33% of the deaths were by hanging; 22% 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 286 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, 37% of all clients who died had chronic health problems and 20% 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 as it was for 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. Note that there is no figure for Serious Suicide Attempt since all attempts occurred during program enrollment – the figures for COD and non-COD clients look the same. 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"), 39.7% of the clients who were involved in a CI were female and 59.8% 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 SFY14. There were 147 active agencies, thus *47% of all agencies reported at least one critical incident*. For comparison, in SFY13, 41% 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 SFY14)

- At least 93% of the CIs involve a single client
- About 95% of clients involved in a CI are involved in only one during the year
- Almost half 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 is a more frequent LOC.
- 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, 29% or more had Bipolar/Major Depression, and at least 25% had hypertension
- 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 in SFY13 & SFY14)

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 16 of these agencies reporting a single critical incident for the entire year. Eighty 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 based on the initial categorization (ie., initial submission prior to any formal review process) of the event as provided by the reporting agency. Ideally, the analysis would focus 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 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.

The report for next year (SFY15) will use 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 to pull 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. The next report will evaluate these new features.

Table 1. Demographic and Summary Information

Client Related Data (Unduplicated Client Count)

	No COD		COD		Total	
	N	%	N	%	N	%
Total # Clients in COD Category	378	100.0	231	100.0	609	100.0
Gender						
Unknown	2	0.5	0	0.0	2	0.3
Female	150	39.7	88	38.1	238	39.1
Male	226	59.8	143	61.9	369	60.6
Race						
American Indian/Alaskan Native	5	1.3	2	0.9	7	1.1
Asian	2	0.5	2	0.9	4	0.7
Black/African American	24	6.3	20	8.7	44	7.2
Caucasian	217	57.4	116	50.2	333	54.7
Other/Mixed	0	0.0	1	0.4	1	0.2
Not Specified/Unknown	13	3.4	16	6.9	29	4.8
Ethnicity						
Hispanic	30	7.9	20	8.7	50	8.2
Non-Hispanic	218	57.7	135	58.4	353	58.0
Not Specified/Unknown	16	4.2	3	1.3	19	3.1
Age Group						
24 & Under	52	13.8	39	16.9	91	14.9
25-34	57	15.1	54	23.4	111	18.2
35-54	126	33.3	96	41.6	222	36.5
55+	140	37.0	42	18.2	182	29.9
Mental Health Diagnosis						
Schizophrenia/Schizophreniform/Schizoaffective	67	17.7	69	29.9	136	22.3
Bipolar/Major Depression	73	19.3	144	62.3	217	35.6
Shared Psychotic Disorder	0	0.0	1	0.4	1	0.2
Brief Psychotic Disorder	0	0.0	0	0.0	0	0.0
Psychotic Disorder NOS	7	1.9	9	3.9	16	2.6
Alcohol Dependence	9	2.4	87	37.7	96	15.8
Opioid Dependence	59	15.6	70	30.3	129	21.2
Sedative/Hypnotic/Anxiolytic Dependence	6	1.6	16	6.9	22	3.6
Cocaine Dependence	12	3.2	52	22.5	64	10.5
Cannabis Dependence	6	1.6	44	19.0	50	8.2
Amphetamine Dependence	0	0.0	2	0.9	2	0.3
Hallucinogen Dependence	0	0.0	3	1.3	3	0.5
OtherDrugDependence	1	0.3	2	0.9	3	0.5
Polysubstance Dependence	2	0.5	64	27.7	66	10.8
Unspecified Drug Dependence	0	0.0	0	0.0	0	0.0
Alcohol Abuse	12	3.2	52	22.5	64	10.5
Tobacco Use Disorder	12	3.2	47	20.3	59	9.7
Cannabis Abuse	3	0.8	55	23.8	58	9.5
Hallucinogen Abuse	0	0.0	4	1.7	4	0.7
Sedative/Hypnotic/Anxiolytic Abuse	1	0.3	7	3.0	8	1.3
Opioid Abuse	0	0.0	17	7.4	17	2.8
Amphetamine Abuse	0	0.0	0	0.0	0	0.0
Antidepressant Abuse	0	0.0	0	0.0	0	0.0
Other/Mixed/Unspecified Drug Abuse	0	0.0	10	4.3	10	1.6
PTSD (DX on file since 7/1/06)	34	9.0	63	27.3	97	15.9

Table 1. Demographic and Summary Information - continued

	No COD		COD		Total	
LOC During Prior Year	**N**	**%**	**N**	**%**	**N**	**%**
MH ACT	18	4.8	13	5.6	31	5.1
MH CM	16	4.2	17	7.4	33	5.4
MH OP	160	42.3	134	58.0	294	48.3
MH Crisis	53	14.0	68	29.4	121	19.9
MH Group Home	1	0.3	5	2.2	6	1.0
MH Intake	9	2.4	24	10.4	33	5.4
MH Partial Hospital	0	0.0	0	0.0	0	0.0
MH Inpatient	20	5.3	18	7.8	38	6.2
MH Social Rehab	46	12.2	47	20.3	93	15.3
MH Supervised Residential	26	6.9	25	10.8	51	8.4
MH Supportive Residential	17	4.5	23	10.0	40	6.6
MH Voc Rehab	20	5.3	23	10.0	43	7.1
MH CSP/RP	51	13.5	49	21.2	100	16.4
MH IOP	1	0.3	4	1.7	5	0.8
MH Intensive Res Rehab	6	1.6	5	2.2	11	1.8
SA CM	3	0.8	26	11.3	29	4.8
SA Detox IP	1	0.3	21	9.1	22	3.6
SA Intensive Residential	5	1.3	25	10.8	30	4.9
SA Intermediate Residential	7	1.9	19	8.2	26	4.3
SA Long Term Residential	0	0.0	1	0.4	1	0.2
SA Methadone Maintenance	53	14.0	27	11.7	80	13.1
SA Outpatient	14	3.7	53	22.9	67	11.0
SA Detox OP	3	0.8	2	0.9	5	0.8
SA Partial Hospital	4	1.1	23	10.0	27	4.4
SA Transitional Residential	1	0.3	5	2.2	6	1.0
SA Vocational Services	0	0.0	0	0.0	0	0.0
SA Gambling Outpatient	1	0.3	0	0.0	1	0.2
SA Medically Monitored Detox	13	3.4	35	15.2	48	7.9
SA IOP	6	1.6	37	16.0	43	7.1

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

LOC At Time of Incident	No COD		COD		Total	
	N	%	N	%	N	%
MH ACT	18	4.8	12	5.2	30	4.9
MH CM	13	3.4	13	5.6	26	4.3
MH OP	139	36.8	108	46.8	247	40.6
MH Crisis	15	4.0	19	8.2	34	5.6
MH Group Home	1	0.3	0	0.0	1	0.2
MH Intake	3	0.8	8	3.5	11	1.8
MH Partial Hospital	0	0.0	0	0.0	0	0.0
MH Inpatient	9	2.4	6	2.6	15	2.5
MH Social Rehab	42	11.1	32	13.9	74	12.2
MH Supervised Residential	25	6.6	17	7.4	42	6.9
MH Supportive Residential	12	3.2	19	8.2	31	5.1
MH Voc Rehab	12	3.2	13	5.6	25	4.1
MH CSP/RP	39	10.3	38	16.5	77	12.6
MH IOP	0	0.0	2	0.9	2	0.3
MH Intensive Res Rehab	4	1.1	3	1.3	7	1.1
SA CM	1	0.3	15	6.5	16	2.6
SA Detox IP	0	0.0	2	0.9	2	0.3
SA Intensive Residential	2	0.5	1	0.4	3	0.5
SA Intermediate Residential	2	0.5	5	2.2	7	1.1
SA Long Term Residential	0	0.0	0	0.0	0	0.0
SA Methadone Maintenance	24	6.3	15	6.5	39	6.4
SA Outpatient	8	2.1	26	11.3	34	5.6
SA Detox OP	2	0.5	0	0.0	2	0.3
SA Partial Hospital	0	0.0	3	1.3	3	0.5
SA Transitional Residential	0	0.0	1	0.4	1	0.2
SA Vocational Services	0	0.0	0	0.0	0	0.0
SA Gambling Outpatient	1	0.3	0	0.0	1	0.2
SA Medically Monitored Detox	3	0.8	5	2.2	8	1.3
SA IOP	3	0.8	8	3.5	11	1.8

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 SFY14

Incident Related Data (Unduplicated Number of Critical Incidents)

	No COD		COD		Total	
	N	**%**	**N**	**%**	**N**	**%**
# Critical Incidents	389	100.0	230	100.0	**620**	100.0
CI Category						
Client Abuse Alleged	1	0.3	2	0.9	3	0.5
Death	199	51.2	87	37.8	286	46.1
Emergency Evacuation	5	1.3	0	0.0	5	0.8
Escape	1	0.3	0	0.0	1	0.2
Federal Notification	1	0.3	0	0.0	1	0.2
Loss/Damage	5	1.3	3	1.3	8	1.3
Medical Event	29	7.5	22	9.6	51	8.2
Missing Client	13	3.3	10	4.3	23	3.7
Other	10	2.6	9	3.9	19	3.1
Serious Crime Alleged	69	17.7	37	16.1	106	17.1
Serious Suicide Attempt	41	10.5	45	19.6	86	13.9
Threats	15	3.9	16	7.0	31	5.0
Total	389	100.0	231	100.4	620	100.0

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	0	0.0	2	0.9	2	0.3
CL2-Verbal abuse	1	0.3	0	0.0	1	0.2
CL3-Violation of patient rights	0	0.0	0	0.0	0	0.0
CL4-Breach of confidentiality	0	0.0	0	0.0	0	0.0
DE1-Suicide	14	3.6	4	1.7	18	2.9
DE2-Homicide	1	0.3	1	0.4	2	0.3
DE3-Accident/medication error	12	3.1	8	3.5	20	3.2
DE4-Medical condition/illness/age	120	30.8	29	12.6	149	24.0
DE5-Insufficient information	52	13.4	45	19.6	97	15.6
ES1-PSRB patient	1	0.3	0	0.0	1	0.2
ES2-DOC client	0	0.0	0	0.0	0	0.0
ES3-54-56d competency restoration	0	0.0	0	0.0	0	0.0
EV1-Fire	4	1.0	0	0.0	4	0.6
EV2-Bomb threat	1	0.3	0	0.0	1	0.2
EV3-Other	0	0.0	0	0.0	0	0.0
FN1-Secret Service	0	0.0	0	0.0	0	0.0
FN2-FBI	1	0.3	0	0.0	1	0.2
FN3-Other	0	0.0	0	0.0	0	0.0
LD1-Loss/Damage/Theft-safety related	3	0.8	2	0.9	5	0.8
LD2-Loss/Damage/Theft >$1,000	2	0.5	1	0.4	3	0.5
MC1-Inpat. client-dangerous	1	0.3	1	0.4	2	0.3
MC2-Outpat. client-dangerous	4	1.0	3	1.3	7	1.1
MC3-Not dangerous 'missing person'	8	2.1	6	2.6	14	2.3
ME1-Serious Injury	6	1.5	1	0.4	7	1.1
ME2-Accidental overdose	5	1.3	8	3.5	13	2.1
ME3-Med. error/adverse drug reaction	2	0.5	0	0.0	2	0.3
ME4-Other medical event	17	4.4	13	5.7	30	4.8
OT1-Serious incident not classifiable	9	2.3	9	3.9	18	2.9
SA1-During program enrollment	41	10.5	45	19.6	86	13.9
SA2-30 Days from Discharge	0	0.0	0	0.0	0	0.0
SC1-Physical assault	43	11.1	20	8.7	63	10.2
SC2-Sexual assault	8	2.1	4	1.7	12	1.9
SC3-Risk of injury to a minor	2	0.5	2	0.9	4	0.6
SC4-Arson	1	0.3	1	0.4	2	0.3
SC5-Incidents involving firearms	2	0.5	1	0.4	3	0.5
SC6-Hostage taking	0	0.0	0	0.0	0	0.0
SC7-Sale illegal subst on prog. premises	2	0.5	0	0.0	2	0.3
SC8-Murder/Homicide	4	1.0	2	0.9	6	1.0
SC9-Other	7	1.8	7	3.0	14	2.3
TH1-Serious Threat - Property	0	0.0	0	0.0	0	0.0
TH2-Serious Threat - Person	15	3.9	16	7.0	31	5.0
Total	389	100.0	231	100.4	620	100.0

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

Table 3a. Comparison of Statewide Incident Data for SFY13 & SFY14
Incident Related Data (Unduplicated Number of Critical Incidents)

	SFY13 Totals		SFY14 Totals		
	N	%	N	%	Change
# Critical Incidents	**651**	**100.0**	**620**	**100.0**	**-4.8%**
Incident Category					
Client Abuse Alleged	3	0.5	3	0.5	0.0%
Death	275	44.4	286	43.9	4.0%
Emergency Evacuation	5	0.8	5	0.8	0.0%
Escape	3	0.5	1	0.2	-66.7%
Federal Notification	1	0.2	1	0.2	0.0%
Loss/Damage	4	0.6	8	1.2	100.0%
Medical Event	96	15.5	51	7.8	-46.9%
Missing Client	22	3.5	23	3.5	4.5%
Other	25	4.0	19	2.9	-24.0%
Serious Crime Alleged	105	16.9	106	16.3	1.0%
Serious Suicide Attempt	77	12.4	86	13.2	11.7%
Threats	35	5.6	31	4.8	-11.4%
Total	**651**	**105.0**	**620**	**95.2**	**-4.8%**
Incident SubCategory					
CL1-Physical abuse	1	0.2	2	0.3	100.0%
CL2-Verbal abuse	0	0.0	1	0.2	--
CL3-Violation of patient rights	2	0.3	0	0.0	-100.0%
CL4-Breach of confidentiality	0	0.0	0	0.0	--
DE1-Suicide	28	4.3	18	2.9	-35.7%
DE2-Homicide	5	0.8	2	0.3	-60.0%
DE3-Accident/medication error	26	4.0	20	3.2	-23.1%
DE4-Medical condition/illness/age	116	17.8	149	24.0	28.4%
DE5-Insufficient information	100	15.4	97	15.6	-3.0%
ES1-PSRB patient	2	0.3	1	0.2	-50.0%
ES2-DOC client	0	0.0	0	0.0	--
ES3-54-56d competency restoration	1	0.2	0	0.0	-100.0%
EV1-Fire	3	0.5	4	0.6	33.3%
EV2-Bomb threat	1	0.2	1	0.2	0.0%
EV3-Other	1	0.2	0	0.0	-100.0%
FN1-Secret Service	0	0.0	0	0.0	--
FN2-FBI	1	0.2	1	0.2	0.0%
FN3-Other	0	0.0	0	0.0	--
LD1-Loss/Damage/Theft-safety related	4	0.6	5	0.8	25.0%
LD2-Loss/Damage/Theft >$1,000	0	0.0	3	0.5	--
MC1-Inpat. client-dangerous	5	0.8	2	0.3	-60.0%
MC2-Outpat. client-dangerous	6	0.9	7	1.1	16.7%
MC3-Not dangerous 'missing person'	11	1.7	14	2.3	27.3%
ME1-Serious Injury	9	1.4	7	1.1	-22.2%
ME2-Accidental overdose	9	1.4	13	2.1	44.4%
ME3-Med. error/adverse drug reaction	3	0.5	2	0.3	-33.3%
ME4-Other medical event	75	11.5	30	4.8	-60.0%
OT1-Serious incident not classifiable	25	3.8	18	2.9	-28.0%
SA1-During program enrollment	76	11.7	86	13.9	13.2%
SA2-Within 30 days post-prog. discharge	1	0.2	0	0.0	-100.0%
SC1-Physical assault	38	5.8	63	10.2	65.8%
SC2-Sexual assault	29	4.5	12	1.9	-58.6%
SC3-Risk of injury to a minor	7	1.1	4	0.6	-42.9%
SC4-Arson	2	0.3	2	0.3	0.0%
SC5-Incidents involving firearms	5	0.8	3	0.5	-40.0%
SC6-Hostage taking	0	0.0	0	0.0	--
SC7-Sale illegal subst on prog. Premises	2	0.3	2	0.3	0.0%
SC8-Murder/Homicide	3	0.5	6	1.0	100.0%
SC9-Other	19	2.9	14	2.3	-26.3%
TH1-Against property serious risk	3	0.5	0	0.0	-100.0%
TH2-Against person serious risk	32	4.9	31	5.0	-3.1%
Total	**651**	**100.0**	**620**	**100.0**	**-4.8%**

Table 3b. Comparison of Statewide Incident Data for SFY09 through SFY14
Incident Related Data (Unduplicated Number of Critical Incidents)

	SFY09		SFY10		SFY11		SFY12		SFY13		SFY14	
	N	%	N	%	N	%	N	%	N	%	N	%
# Critical Incidents	622	100	630	100	612	100	578	100	651	100	**620**	100
Incident Category												
Client Abuse Alleged	12	1.9	5	0.8	8	1.3	6	1.0	3	0.5	3	0.5
Death	256	41.2	313	49.7	295	48.2	263	45.5	275	42.2	286	46.1
Emergency Evacuation	5	0.8	0	0.0	4	0.7	4	0.7	5	0.8	5	0.8
Escape	1	0.2	2	0.3	1	0.2	0	0.0	3	0.5	1	0.2
Federal Notification	1	0.2	1	0.2	2	0.3	1	0.2	1	0.2	1	0.2
Loss/Damage	4	0.6	3	0.5	9	1.5	4	0.7	4	0.6	8	1.3
Medical Event	64	10.3	48	7.6	46	7.5	59	10.2	96	14.7	51	8.2
Missing Client	18	2.9	19	3.0	14	2.3	19	3.3	22	3.4	23	3.7
Other	47	7.6	20	3.2	32	5.2	24	4.2	25	3.8	19	3.1
Serious Crime Alleged	111	17.8	123	19.5	111	18.1	106	18.3	105	16.1	106	17.1
Serious Suicide Attempt	73	11.7	69	11.0	72	11.8	73	12.6	77	11.8	86	13.9
Threats	30	4.8	27	4.3	18	2.9	19	3.3	35	5.4	31	5.0
Total	**622**	**100**	**630**	**100**	**612**	**100**	**578**	**100**	**651**	**100**	**620**	**100**
Incident SubCategory												
Missing Information	1	0.2	1	0.2	0	0.0	0	0.0	0	0.0	0	0.0
CL1-Physical abuse	9	1.4	3	0.5	7	1.1	3	0.5	1	0.2	2	0.3
CL2-Verbal abuse	1	0.2	1	0.2	0	0.0	0	0.0	0	0.0	1	0.2
CL3-Violation of patient rights	0	0.0	1	0.2	1	0.2	2	0.3	2	0.3	0	0.0
CL4-Breach of confidentiality	2	0.3	0	0.0	0	0.0	1	0.2	0	0.0	0	0.0
DE1-Suicide	14	2.3	21	3.3	23	3.8	19	3.3	28	4.3	18	2.9
DE2-Homicide	3	0.5	2	0.3	6	1.0	8	1.4	5	0.8	2	0.3
DE3-Accident/medication error	14	2.3	17	2.7	14	2.3	23	4.0	26	4.0	20	3.2
DE4-Medical condition/illness/age	105	16.9	139	22.1	129	21.1	119	20.6	116	17.8	149	24.0
DE5-Insufficient information	119	19.1	133	21.1	123	20.1	94	16.3	100	15.4	97	15.6
ES1-PSRB patient	1	0.2	1	0.2	1	0.2	0	0.0	2	0.3	1	0.2
ES2-DOC client	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
ES3-54-56d competency restoration	0	0.0	1	0.2	0	0.0	0	0.0	1	0.2	0	0.0
EV1-Fire	5	0.8	0	0.0	1	0.2	1	0.2	3	0.5	4	0.6
EV2-Bomb threat	0	0.0	0	0.0	1	0.2	0	0.0	1	0.2	1	0.2
EV3-Other	0	0.0	0	0.0	2	0.3	3	0.5	1	0.2	0	0.0
FN1-Secret Service	1	0.2	1	0.2	0	0.0	1	0.2	0	0.0	0	0.0
FN2-FBI	0	0.0	0	0.0	0	0.0	0	0.0	1	0.2	1	0.2
FN3-Other	0	0.0	0	0.0	2	0.3	0	0.0	0	0.0	0	0.0
LD1-Loss/Damage/Theft-safety related	1	0.2	1	0.2	4	0.7	3	0.5	4	0.6	5	0.8
LD2-Loss/Damage/Theft >$1,000	3	0.5	2	0.3	5	0.8	1	0.2	0	0.0	3	0.5
MC1-Inpat. client-dangerous	3	0.5	2	0.3	0	0.0	1	0.2	5	0.8	2	0.3
MC2-Outpat. client-dangerous	0	0.0	2	0.3	2	0.3	3	0.5	6	0.9	7	1.1
MC3-Not dangerous 'missing person'	15	2.4	15	2.4	12	2.0	15	2.6	11	1.7	14	2.3
ME1-Serious Injury	17	2.7	9	1.4	5	0.8	6	1.0	9	1.4	7	1.1
ME2-Accidental overdose	11	1.8	3	0.5	3	0.5	5	0.9	9	1.4	13	2.1
ME3-Med. error/adverse drug reaction	0	0.0	5	0.8	4	0.7	2	0.3	3	0.5	2	0.3
ME4-Other medical event	36	5.8	31	4.9	34	5.6	46	8.0	75	11.5	30	4.8
OT1-Serious incident not classifiable	47	7.6	20	3.2	32	5.2	24	4.2	25	3.8	18	2.9
SA1-During program enrollment	71	11.4	65	10.3	71	11.6	72	12.5	76	11.7	86	13.9
SA2-Within 30 days post-prog. discharge	2	0.3	4	0.6	1	0.2	1	0.2	1	0.2	0	0.0
SC1-Physical assault	38	6.1	47	7.5	41	6.7	40	6.9	38	5.8	63	10.2
SC2-Sexual assault	36	5.8	35	5.6	28	4.6	24	4.2	29	4.5	12	1.9
SC3-Risk of injury to a minor	6	1.0	8	1.3	2	0.3	5	0.9	7	1.1	4	0.6
SC4-Arson	2	0.3	0	0.0	2	0.3	9	1.6	2	0.3	2	0.3
SC5-Incidents involving firearms	2	0.3	5	0.8	4	0.7	4	0.7	5	0.8	3	0.5
SC6-Hostage taking	1	0.2	0	0.0	1	0.2	1	0.2	0	0.0	0	0.0
SC7-Sale illegal subst on prog premises	0	0.0	1	0.2	3	0.5	2	0.3	2	0.3	2	0.3
SC8-Murder/Homicide	2	0.3	5	0.8	2	0.3	4	0.7	3	0.5	6	1.0
SC9-Other	24	3.9	22	3.5	28	4.6	17	2.9	19	2.9	14	2.3
TH1-Against property serious risk	4	0.6	1	0.2	2	0.3	1	0.2	3	0.5	0	0.0
TH2-Against person serious risk	26	4.2	26	4.1	16	2.6	18	3.1	32	4.9	31	5.0
Total	**622**	**100**	**630**	**100**	**612**	**100**	**578**	**100**	**651**	**100**	**620**	**100**

Figure 2

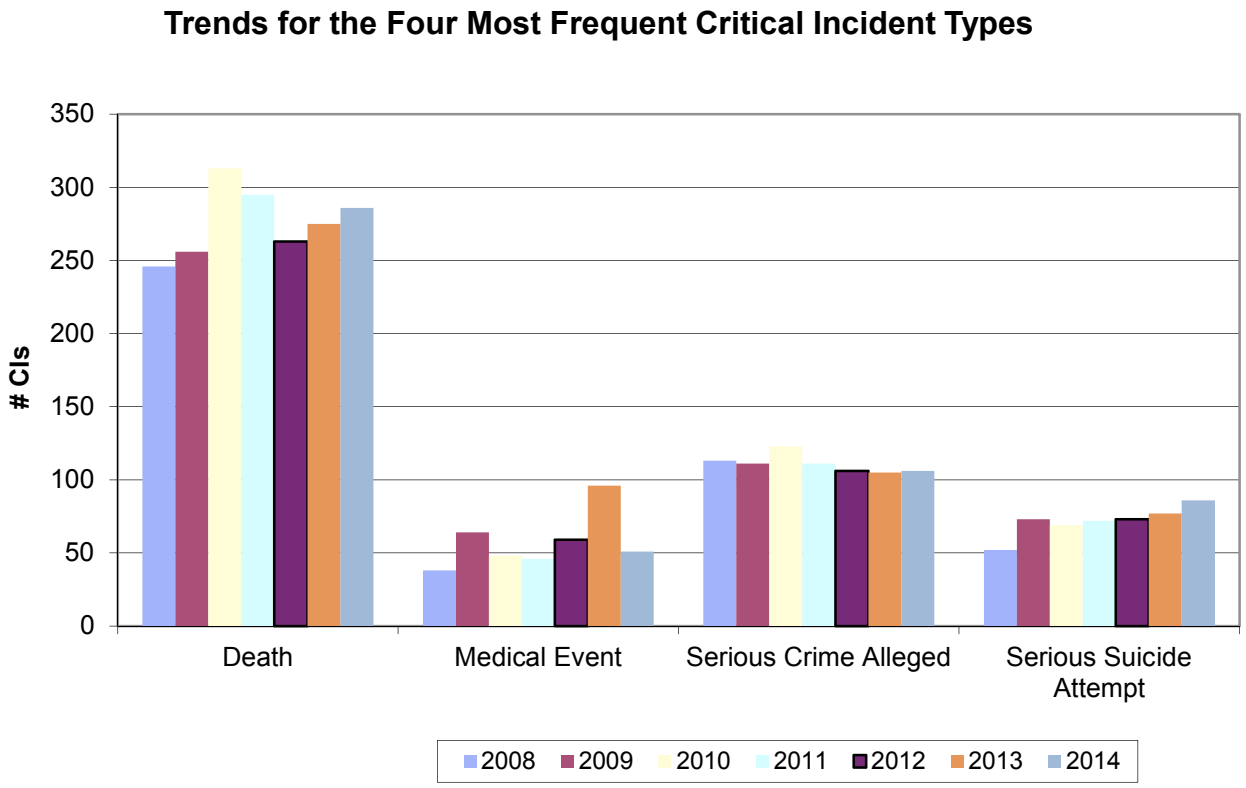

Trends for the Four Most Frequent Critical Incident Types
CIs
350
300
250
200
150
100
50
0
Death
Medical Event
Serious Crime Alleged
Serious Suicide Attempt
2008
2009
2010
2011
2012
2013
2014

Table 4a. Summary of SFY2014 Critical Incidents Categorized as Deaths

286 Deaths in SFY 14 (46% of all SFY14 Critical Incidents)

Death Incident SubCategory	N	%
DE1-Suicide	18	6.3
DE2-Homicide	2	.7
DE3-Accident/medication error	20	7.0
DE4-Medical condition/illness/age	149	52.1
DE5-Insufficient information	97	33.9

Demographics

179 (63%) were male
169 (60%) were Caucasian, 20 (7%) were African American
22 (8%) were Hispanic
Average age = 51.4 years (±13.2), age range 19-91 years
87 (30%) of those who died had a Co-Occuring diagnosis
18 (6%) had a diagnosis of PTSD
59 (21%) clients were active in treatment at a state-operated facility at the time of their deaths
No deaths were coded as occurring at a state operated facility

Co-Occurring Diagnosis	N	%
No COD	199	69.6
COD	87	30.4
Most Common MH/SA Diagnoses (from EDW)	**N**	**%**
Bipolar/Major Depression	78	27.3
Opioid Dependence	75	26.2
Schizophrenia/Schizophreniform/Schizoaffective	52	18.2
Alcohol Dependence	38	13.3
Cocaine Dependence	27	9.4
Tobacco Use Disorder	26	9.1

LOC at Time of Incident (most frequent listed)	N	%
MH OP	121	42.3
MH Social Rehab	28	9.8
MH CSP/RP	27	9.4
SA Methadone Maintenance	23	8.0
SA OP	14	4.9

Most Common Medical Diagnoses*	N	%
Hypertension	18	26.1
Cancer	16	23.2
Hepatitis	14	20.3
Diabetes	12	17.4
COPD	12	17.4
Asthma	8	11.6
Arthritis/Joint Problems/Bone Problems	8	11.6
Chronic Pain	7	10.1
Hyperlipidemia	6	8.7
Seizure Disorder	6	8.7
CHF/Heart Disease/Problems	5	7.2
Renal Failure/Kidney Disease	5	7.2
Cirrhosis/Liver Disease	5	7.2
Obesity	5	7.2
Infection	5	7.2
Thyroid Disease	4	5.8
AIDS/HIV	3	4.3
Stroke/Aneurism	2	2.9
Pneumonia	2	2.9
Anemia	2	2.9
Emphysema/Lung Disease	1	1.4
GERD	1	1.4
Traumatic Brain Injury (TBI)	1	1.4

* % based on 69 deaths where medical history was submitted with the CI report (may have multiple dx)

Table 4b. Summary of SFY2014 Critical Incidents Categorized as Deaths for Clients Under Age 50

106 Deaths in SFY 14 Under the Age of 50 (38% of all SFY14 Deaths)

Death Incident SubCategory	N	%
DE1-Suicide	10	9.2
DE2-Homicide	2	1.8
DE3-Accident/medication error	15	13.8
DE4-Medical condition/illness/age	29	26.6
DE5-Insufficient information	53	48.6

Demographics

70 (64%) were male
64 (59%) were Caucasian, 6 (6%) were African American
12 (11%) were Hispanic
Average age = 37.9 years (±8.6), age range 19-49 years
46 (42%) of those who died had a Co-Occuring diagnosis
12 (11%) had a diagnosis of PTSD
19 (17%) clients were active in treatment at a state-operated facility at the time of their deaths
No deaths occurred at a state operated facility

Co-Occurring Diagnosis	N	%
No COD	63	57.8
COD	46	42.2

Most Common MH/SA Diagnoses (from EDW)	N	%
Bipolar/Major Depression	36	33.0
Opioid Dependence	34	31.2
Alcohol Dependence	20	18.3
Schizophrenia/Schizophreniform/Schizoaffective	20	18.3
Cannabis Dependence	16	14.7
Polysubstance Dependence	15	13.8
Cocaine Dependence	14	12.8

LOC at Time of Incident (most frequent listed)	N	%
MH OP	39	36.8
MH Soc Rehab	12	11.3
MH CSP/RP	10	9.4
SA MM	10	9.4
SA OP	9	8.5

Most Common Medical Diagnoses*	N	%
Hypertension	6	28.6
Chronic Pain	6	28.6
Diabetes	4	19.0
Seizure Disorder	4	19.0
Hepatitis	3	14.3
Cirrhosis/Liver Disease	3	14.3
Asthma	2	9.5
Cancer	2	9.5
COPD	1	4.8
Hyperlipidemia	1	4.8
Infection	1	4.8
AIDS/HIV	1	4.8
Arthritis/Joint Problems/Bone Problems	1	4.8
Anemia	1	4.8
GERD	1	4.8
Stroke/Aneurism	1	4.8
CHF/Heart Disease/Problems	0	0.0
Renal Failure/Kidney Disease	0	0.0
Traumatic Brain Injury (TBI)	0	0.0
Obesity	0	0.0
Pneumonia	0	0.0
Emphysema/Lung Disease	0	0.0
Thyroid Disease	0	0.0

* % based on 21 deaths where medical history was submitted with the CI report (may have multiple dx)

Table 4c. Summary of SFY2014 Critical Incidents Categorized as Suicides

18 Suicides in SFY 14 (2.9% of all SFY14 Critical Incidents)

Demographics
8 (44%) were male
10 (56%) were Caucasian; 4 (22%) were African American
Average age = 44.8 years (±13.4), age range 22-67 years
4 (22%) of those who died had a Co-Occuring diagnosis
3 clients (17%) had a diagnosis of PTSD
6 (33%) were by hanging; 4 (22%) were by jumping
3 (17%) have the potential to be overdose related
6 incidents were reported by a state operated facility
0 incidents occurred at a state-operated facility

Co-Occurring Diagnosis	N	%
No COD	14	77.8
COD	4	22.2

Most Common MH/SA Diagnoses (from EDW)	N	%
Bipolar/Major Depression	5	27.8
Schizophrenia/Schizophreniform/Schizoaffective	3	16.7
Cannabis Dependence	2	11.1
Opioid Dependence	2	11.1

LOC at Time of Incident (most frequent listed)	N	%
MH OP	8	44.4
MH CSP/RP	2	11.1
SA IOP	2	11.1
MH Crisis	2	11.1

Figure 3

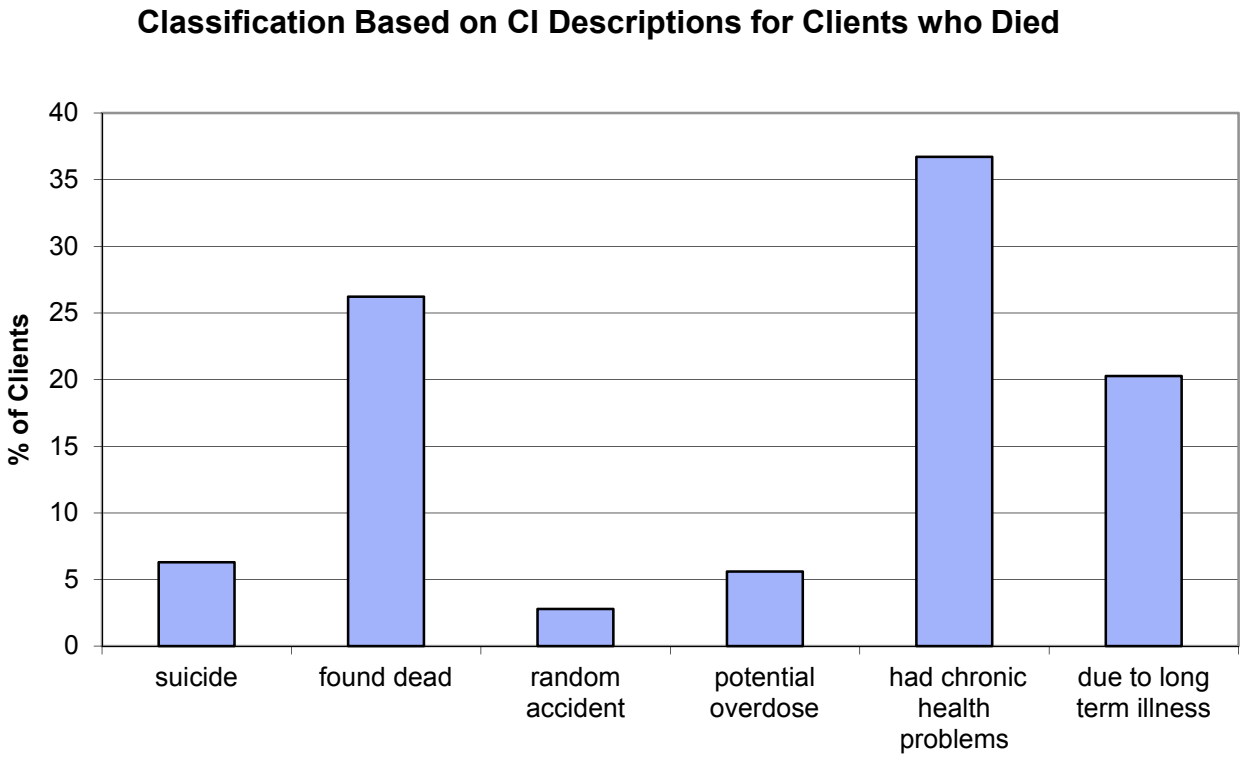
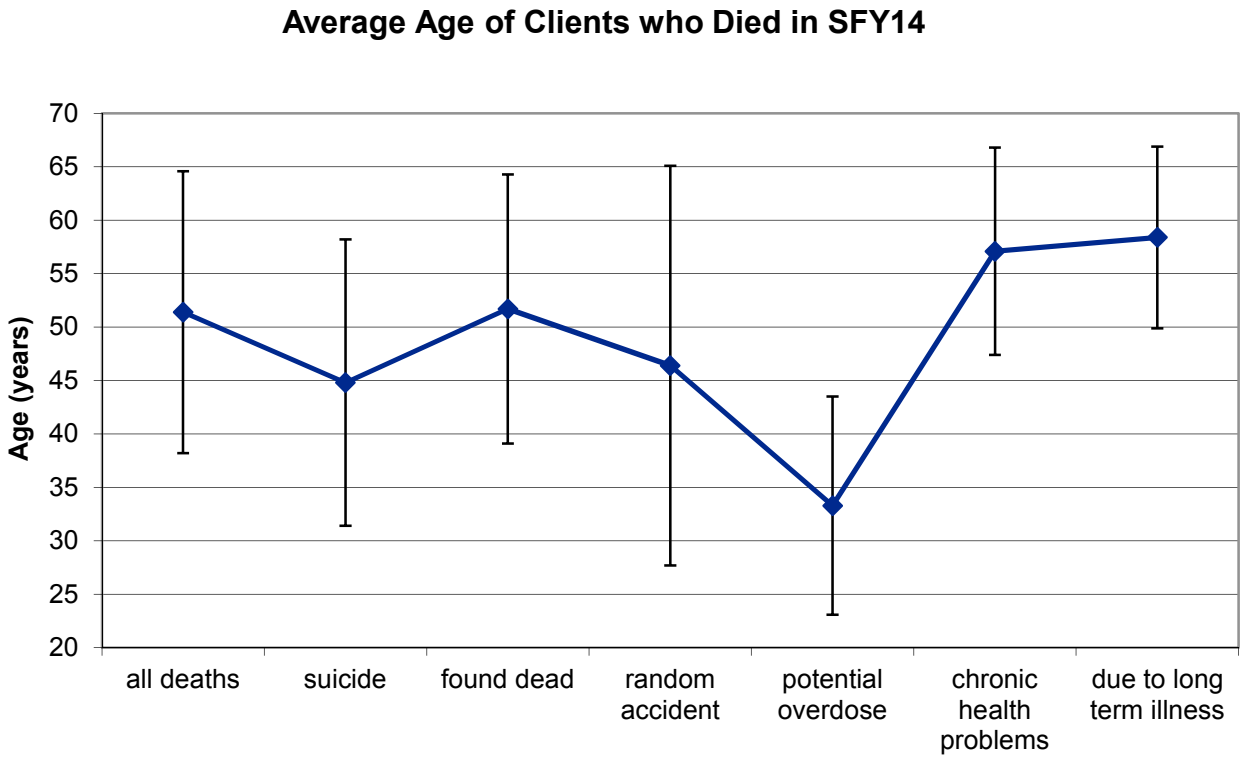


Figure 4



Comparison Between Clients with and without COD

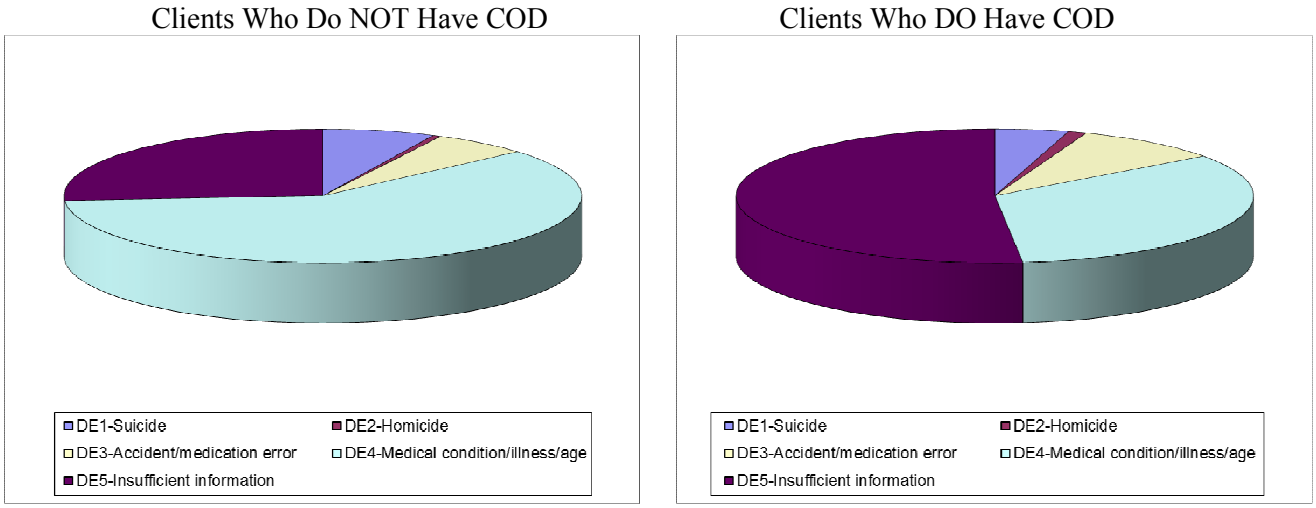


Figure 5. Death Subcategories

Significantly more clients who did not have COD died due to medical condition/illness/age compared to clients who had COD. There were also significantly more clients who did not have COD who had their death classified as "insufficient information". Significance testing performed using chi-square and $p<.05$.

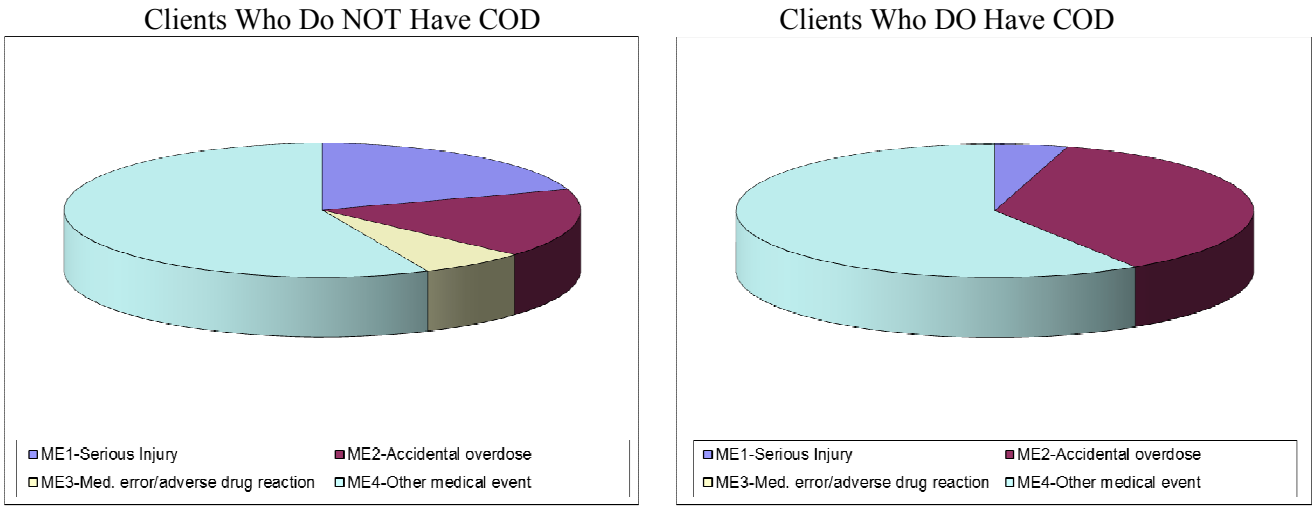


Figure 6. Medical Event Subcategories

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

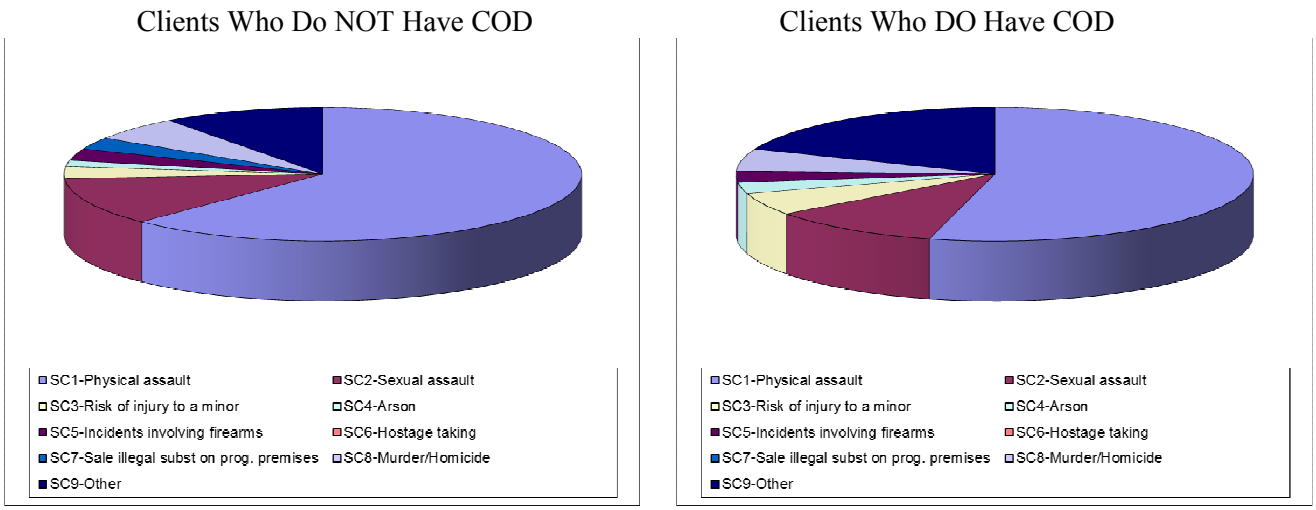


Figure 7. Serious Crime Alleged Subcategories

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.

Table 5a. Agencies Reporting CIs (Alphabetical order)

Provider	N	%
ABH - GA Only Providers	2	.3
Ability Beyond Disability Institute	21	3.4
Advanced Behavioral Health	12	1.9
Alcohol & Drug Recovery Center-ADRC	1	.2
Bridge House	1	.2
BRIDGES	18	2.9
Capitol Region Mental Health Center	29	4.7
Catholic Charities of Fairfield County Inc.	2	.3
Center for Human Development	2	.3
Central Naugatuck Valley (CNV) Help Inc.	2	.3
Charlotte Hungerford Hospital	6	1.0
Chemical Abuse Services Agency (CASA)	3	.5
Chrysalis Center Inc.	3	.5
Columbus House	5	.8
Community Health Center Inc.	1	.2
Community Health Resources Inc.	12	1.9
Community Mental Health Affiliates	23	3.7
Connecticut Counseling Centers Inc.	11	1.8
Connecticut Mental Health Center	7	1.1
Connecticut Valley Hospital	16	2.6
Connection Inc	14	2.3
Connection Inc.	5	.8
Continuum of Care	8	1.3
Crossroad Inc	2	.3
Danbury Hospital	1	.2
DMHAS - Older Adult Services	1	.2
Farrell Treatment Center	1	.2
Fellowship Inc.	2	.3
FSW Inc.	2	.3
Gilead Community Services Inc.	2	.3
Hands on Hartford	2	.3
Harbor Health Services	32	5.2
Hartford Behavioral Health	2	.3
Hartford Dispensary	21	3.4
hartford Hospital	1	.2
Hill Health Corporation	11	1.8
Immaculate Conception Inc.	1	.2
Inter-Community Mental Health Group Inc.	11	1.8
Laurel House	2	.3
Leeway Inc.	7	1.1
Liberation Programs (LMG)	1	.2
Liberty Community Services	2	.3
Marrakech Day Services	13	2.1
McCall Foundation Inc	1	.2
Mental Health Association of CT Inc.	9	1.5
Midwestern CT Council on Alcoholism (MCCA)	5	.8
Morris Foundation Inc	1	.2
New Era Rehabilitation Center Inc.	1	.2
New Milford Hospital	8	1.3
Norwalk Hospital	1	.2
Office of the Commissioner DMHAS	1	.2
Optimus Health Care-Bennett Behavioral Health	1	.2
Perception Programs Inc	2	.3
Regional Network of Programs	34	5.5
Reliance House	12	1.9
River Valley Services	9	1.5

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

Provider	N	%
United Services Inc.	64	10.3
W. CT MH Network	51	8.2
Regional Network of Programs	34	5.5
SW CT MH Network	33	5.3
Harbor Health Services	32	5.2
Capitol Region Mental Health Center	29	4.7
Community Mental Health Affiliates	23	3.7
Ability Beyond Disability Institute	21	3.4
Hartford Dispensary	21	3.4
BRIDGES	18	2.9
Connecticut Valley Hospital	16	2.6
Connection Inc	14	2.3
Rushford Center	14	2.3
SE Mental Health Authority	14	2.3
Marrakech Day Services	13	2.1
Advanced Behavioral Health	12	1.9
Community Health Resources Inc.	12	1.9
Reliance House	12	1.9
Sound Community Services Inc.	12	1.9
Connecticut Counseling Centers Inc.	11	1.8
Hill Health Corporation	11	1.8
Inter-Community Mental Health Group Inc.	11	1.8
Mental Health Association of CT Inc.	9	1.5
River Valley Services	9	1.5
SCADD	9	1.5
Wheeler Clinic	9	1.5
Continuum of Care	8	1.3
New Milford Hospital	8	1.3
Connecticut Mental Health Center	7	1.1
Leeway Inc.	7	1.1
Charlotte Hungerford Hospital	6	1.0
Columbus House	5	.8
Connection Inc.	5	.8
Midwestern CT Council on Alcoholism (MCCA)	5	.8
St. Vincent DePaul Mission of Waterbury Inc.	4	.6
Chemical Abuse Services Agency (CASA)	3	.5
Chrysalis Center Inc.	3	.5
St. Mary's Hospital Corporation	3	.5
ABH - GA Only Providers	2	.3
Catholic Charities of Fairfield County Inc.	2	.3
Center for Human Development	2	.3
Central Naugatuck Valley (CNV) Help Inc.	2	.3
Crossroad Inc	2	.3
Fellowship Inc.	2	.3
FSW Inc.	2	.3
Gilead Community Services Inc.	2	.3
Hands on Hartford	2	.3
Hartford Behavioral Health	2	.3
Laurel House	2	.3
Liberty Community Services	2	.3
Perception Programs Inc	2	.3
Alcohol & Drug Recovery Center-ADRC	1	.2
Bridge House	1	.2
Community Health Center Inc.	1	.2
Danbury Hospital	1	.2
DMHAS - Older Adult Services	1	.2

Table 5a. Agencies Reporting CIs (Alphabetical order)

Provider	N	%
Rushford Center	14	2.3
SCADD	9	1.5
SE Mental Health Authority	14	2.3
Shift LLC	1	.2
Sound Community Services Inc.	12	1.9
St. Mary's Hospital Corporation	3	.5
St. Vincent DePaul Mission of Waterbury Inc.	4	.6
SW CT MH Network	33	5.3
United Services Inc.	64	10.3
W. CT MH Network	51	8.2
Wheeler Clinic	9	1.5
Total	**620**	**100.0**

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

Provider	N	%
Farrell Treatment Center	1	.2
hartford Hospital	1	.2
Immaculate Conception Inc.	1	.2
Liberation Programs (LMG)	1	.2
McCall Foundation Inc	1	.2
Morris Foundation Inc	1	.2
New Era Rehabilitation Center Inc.	1	.2
Norwalk Hospital	1	.2
Office of the Commissioner DMHAS	1	.2
Optimus Health Care-Bennett Behavioral Health	1	.2
Shift LLC	1	.2
Total	**620**	**100.0**