SFY2013 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, 2012 and June 30, 2013.

Since a critical incident (CI) may involve more than one client and a client may be involved in multiple incidents, the data for SFY13 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:

- 651 incidents
  - 5 (0.8%) were at the Agency Level (Evacuation, etc.)
  - 4 (0.6%) were at the Staff Level (involved staff member)
  - 644 (99%) were at the Client Level
  - 258 (40%) incidents involved clients *with* a co-occurring diagnosis
  - 387 (60%) incidents involved clients *without* a co-occurring diagnosis
  - 165 (26%) incidents were reported by state-operated facilities
  - The maximum number of clients involved in any one incident was 3
    - 630 incidents (97.0%) involved a single person

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

- 621 unduplicated clients
  - 244 (39%) clients *did have* a co-occurring diagnosis
  - 376 (61%) clients *did not have* a co-occurring diagnosis
  - 118 (19%) 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. One difference this year is that the demographic data is from the CI database (not DDaP/Avatar), thus the percentages of 'Unknown' are higher than in other years.

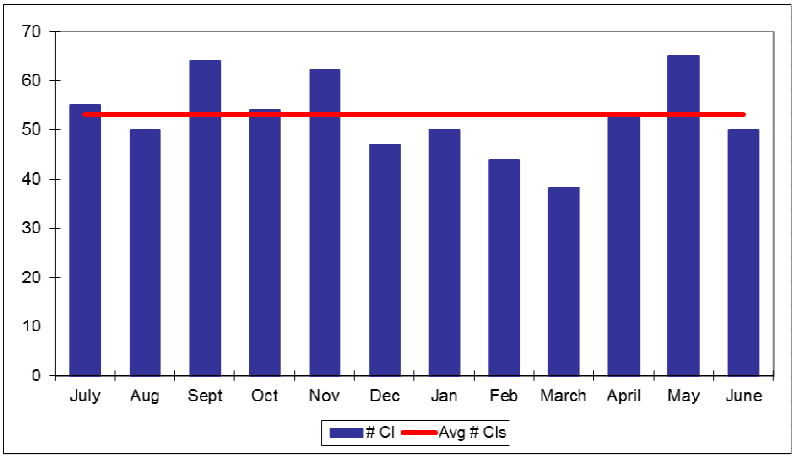


Figure 1. Critical Incidents in SFY13

Summary of the Results

■ From SFY12 to SFY13 there was an *12.6% increase* in the number of critical incidents reported. 95.5% of all client-level CIs involved a single client. (Tables 1, 2, 3a & 3b)

■ Over one-third (42%) of all CIs involved clients who were between the ages of 35 and 54 years. 62% of the clients were male. (Table 1)

■ Bipolar/Major Depression was the most frequent diagnosis (37%) for clients involved in a CI. Schizophrenia/ Schizophreniform/Schizoaffective disorder was the next most frequent MH diagnosis (17%). Opioid Dependence (21%) and Alcohol Dependence (19%) 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, 39% of clients were receiving MH Outpatient services, 17% were receiving MH CSP/RP services, and 13% of clients were receiving MH Social Rehabilitation services. (Table 1)

■ The 5 Agency-level CIs included 2 Emergency Evacuations (fire, bomb threat), 2 Other (involved property damage), and 1 Medical Event (van accident).

■ The most frequent CI categories reported were: (Tables 2, 3a, 3b, Figure 2)
Death (42%). Compared to SFY12, the number of deaths in SFY13 *increased* by 4.6% (from 263 to 275).
Serious Crime Alleged (16%). Compared to SFY12, there was 1% *fewer* CIs in this category (106 to 105).
Serious Suicide Attempt (12%). Compared to SFY12, there were 5.5% *more* serious suicide attempts (73 to 77).
Medical Event (15%). Compared to SFY12, there was a 63% *increase* in the number of medical events (59 to 96).

■ Within the Death category, the number of Suicides reported *increased* 47% from SFY12 (19 to 28). The reported number of Serious Suicide Attempts while enrolled a program *increased by* 6% (73 to 76). (Table 3a)

■ Over one-third (39%) 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* 80% (5 to 9) from SFY12. The number of the number of medical event - other *increased* 63% (46 to 75). (Table 3a)

■ Of the 275 Deaths in SFY13: 66% were male
average age = 50.5 years (±12.1), age range 19-83 years
almost two-thirds (62%) did *not* have a co-occurring diagnosis
90% did *not* have a PTSD diagnosis
32% had a diagnosis of Bipolar/Major Depression.
26% had hypertension and 23% had cancer (Table 4a)

■ There were 106 deaths where the client was less than 50 years old
62% were male
average age = 38.5 years (±8.5), age range 19-49 years
60% did *not* have a co-occurring diagnosis
85% did *not* have a PTSD diagnosis
11 (10%) were suicides
37% had Bipolar/Major Depression
15 (14%) had chronic health issues
22% had diabetes and 22% had hepatitis
7 (7%) died from a long-term illness (Table 4b)

■ There were 28 suicides in SFY13: 68% were male
average age = 47.6 years (±10.5), age range 24-63 years
most (82%) did *not* have a co-occurring diagnosis
18% had a PTSD diagnosis
29% had a diagnosis of Bipolar/Major Depression.
32% of the deaths were by hanging (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 275 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, 27% of all clients who died had chronic health problems and 14% of clients died as a result of long term illness; for both groups, the average age of these clients was about 55 years old. (Figures 3 and 4)

Service Summary by Co-Occurring Disorder

■ Co-occurring disorder is presented slightly differently this year. 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 but one (75 of 76 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"), 38.8% of the clients who were involved in a CI were female and 60.6% 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-one* agencies reported at least one critical incident during SFY13. There were 148 active agencies, thus *41% of all agencies reported at least one critical incident*. For comparison, in SFY12, 32% 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 SFY13)

- 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 49 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)

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 61 Agencies that reported critical incidents, *forty-three agencies reported 10 or fewer critical incidents during this time frame*, with 12 of these agencies reporting a single critical incident for the entire year. Eighty-seven 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.

Table 1. Demographic and Summary Information

Client Related Data (Unduplicated Client Count)

	No COD		COD		Total	
	N	%	N	%	N	%
Total # Clients in COD Category	376	100.0	244	100.0	620	100.0
Gender						
Unknown	2	0.5	3	1.2	5	0.8
Female	146	38.8	87	35.7	233	37.6
Male	228	60.6	154	63.1	382	61.6
Race						
American Indian/Alaskan Native	2	0.5	3	1.2	5	0.8
Asian	5	1.3	0	0.0	5	0.8
Black/African American	34	9.0	22	9.0	56	9.0
Caucasian	198	52.7	135	55.3	333	53.7
Other/Mixed	12	3.2	8	3.3	20	3.2
Not Specified/Unknown	125	33.2	76	31.1	201	32.4
Ethnicity						
Hispanic	37	9.8	22	9.0	59	9.5
Non-Hispanic	239	63.6	156	63.9	395	63.7
Not Specified/Unknown	100	26.6	66	27.0	166	26.8
Age Group						
24 & Under	86	22.9	13	5.3	99	16.0
25-34	57	15.2	42	17.2	99	16.0
35-54	131	34.8	128	52.5	259	41.8
55+	99	26.3	58	23.8	157	25.3
Unknown	3	0.8	3	1.2	6	1.0
Mental Health Diagnosis						
Schizophrenia/Schizophreniform/Schizoaffective	49	13.0	56	23.0	105	16.9
Bipolar/Major Depression	86	22.9	144	59.0	230	37.1
Shared Psychotic Disorder	0	0.0	0	0.0	0	0.0
Brief Psychotic Disorder	0	0.0	1	0.4	1	0.2
Psychotic Disorder NOS	11	2.9	8	3.3	19	3.1
Alcohol Dependence	28	7.4	90	36.9	118	19.0
Opioid Dependence	63	16.8	68	27.9	131	21.1
Sedative/Hypnotic/Anxiolytic Dependence	6	1.6	13	5.3	19	3.1
Cocaine Dependence	13	3.5	54	22.1	67	10.8
Cannabis Dependence	5	1.3	30	12.3	35	5.6
Amphetamine Dependence	0	0.0	2	0.8	2	0.3
Hallucinogen Dependence	0	0.0	3	1.2	3	0.5
OtherDrugDependence	2	0.5	2	0.8	4	0.6
Polysubstance Dependence	3	0.8	48	19.7	51	8.2
Unspecified Drug Dependence	0	0.0	0	0.0	0	0.0
Alcohol Abuse	19	5.1	44	18.0	63	10.2
Tobacco Use Disorder	13	3.5	52	21.3	65	10.5
Cannabis Abuse	9	2.4	39	16.0	48	7.7
Hallucinogen Abuse	0	0.0	3	1.2	3	0.5
Sedative/Hypnotic/Anxiolytic Abuse	3	0.8	5	2.0	8	1.3
Opioid Abuse	4	1.1	11	4.5	15	2.4
Amphetamine Abuse	1	0.3	0	0.0	1	0.2
Antidepressant Abuse	0	0.0	0	0.0	0	0.0
Other/Mixed/Unspecified Drug Abuse	0	0.0	9	3.7	9	1.5
PTSD (DX on file since 7/1/06)	53	14.1	65	26.6	118	19.0

Table 1. Demographic and Summary Information - continued

	No COD		COD		Total	
LOC During Prior Year	**N**	**%**	**N**	**%**	**N**	**%**
MH ACT	13	3.5	10	4.1	23	3.7
MH CM	17	4.5	20	8.2	37	6.0
MH OP	140	37.2	137	56.1	277	44.7
MH Crisis	43	11.4	70	28.7	113	18.2
MH Group Home	2	0.5	4	1.6	6	1.0
MH Intake	19	5.1	22	9.0	41	6.6
MH Partial Hospital	0	0.0	0	0.0	0	0.0
MH Inpatient	15	4.0	15	6.1	30	4.8
MH Social Rehab	46	12.2	51	20.9	97	15.6
MH Supervised Residential	24	6.4	19	7.8	43	6.9
MH Supportive Residential	12	3.2	11	4.5	23	3.7
MH Voc Rehab	26	6.9	29	11.9	55	8.9
MH CSP/RP	58	15.4	67	27.5	125	20.2
MH IOP	1	0.3	3	1.2	4	0.6
MH Intensive Res Rehab	1	0.3	5	2.0	6	1.0
SA CM	3	0.8	13	5.3	16	2.6
SA Detox IP	4	1.1	29	11.9	33	5.3
SA Intensive Residential	4	1.1	29	11.9	33	5.3
SA Intermediate Residential	4	1.1	10	4.1	14	2.3
SA Long Term Residential	0	0.0	3	1.2	3	0.5
SA Methadone Maintenance	55	14.6	29	11.9	84	13.5
SA Outpatient	32	8.5	52	21.3	84	13.5
SA Detox OP	2	0.5	1	0.4	3	0.5
SA Partial Hospital	4	1.1	16	6.6	20	3.2
SA Transitional Residential	2	0.5	4	1.6	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	26	6.9	22	9.0	48	7.7
SA IOP	5	1.3	25	10.2	30	4.8

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	12	3.2	7	2.9	19	3.1
MH CM	14	3.7	13	5.3	27	4.4
MH OP	127	33.8	113	46.3	240	38.7
MH Crisis	14	3.7	21	8.6	35	5.6
MH Group Home	1	0.3	3	1.2	4	0.6
MH Intake	8	2.1	5	2.0	13	2.1
MH Partial Hospital	0	0.0	0	0.0	0	0.0
MH Inpatient	8	2.1	6	2.5	14	2.3
MH Social Rehab	40	10.6	43	17.6	83	13.4
MH Supervised Residential	22	5.9	12	4.9	34	5.5
MH Supportive Residential	12	3.2	7	2.9	19	3.1
MH Voc Rehab	20	5.3	18	7.4	38	6.1
MH CSP/RP	46	12.2	56	23.0	102	16.5
MH IOP	1	0.3	0	0.0	1	0.2
MH Intensive Res Rehab	1	0.3	4	1.6	5	0.8
SA CM	2	0.5	6	2.5	8	1.3
SA Detox IP	1	0.3	4	1.6	5	0.8
SA Intensive Residential	0	0.0	1	0.4	1	0.2
SA Intermediate Residential	3	0.8	4	1.6	7	1.1
SA Long Term Residential	0	0.0	0	0.0	0	0.0
SA Methadone Maintenance	27	7.2	13	5.3	40	6.5
SA Outpatient	16	4.3	30	12.3	46	7.4
SA Detox OP	0	0.0	1	0.4	1	0.2
SA Partial Hospital	1	0.3	0	0.0	1	0.2
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	16	4.3	5	2.0	21	3.4
SA IOP	2	0.5	2	0.8	4	0.6

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 SFY13

Incident Related Data (Unduplicated Number of Critical Incidents)

	No COD		COD		Total	
	N	**%**	**N**	**%**	**N**	**%**
# Critical Incidents	387	100.0	258	100.0	**651**	100.0
CI Category						
Client Abuse Alleged	1	0.3	2	0.8	3	0.5
Death	170	43.9	102	39.5	275	42.2
Emergency Evacuation	3	0.8	2	0.8	5	0.8
Escape	1	0.3	2	0.8	3	0.5
Federal Notification	0	0.0	1	0.4	1	0.2
Loss/Damage	3	0.8	1	0.4	4	0.6
Medical Event	52	13.4	43	16.7	96	14.7
Missing Client	10	2.6	12	4.7	22	3.4
Other	15	3.9	10	3.9	25	3.8
Serious Crime Alleged	62	16.0	42	16.3	105	16.1
Serious Suicide Attempt	47	12.1	29	11.2	77	11.8
Threats	23	5.9	12	4.7	35	5.4
Total	387	100.0	258	100.0	651	100.0

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

Note: There were 6 Cis with missing information that made COD categorization impossible.

Table 2b. Statewide Incident Subcategory Information

CI Subcategory	No COD		COD		Total	
	N	%	N	%	N	%
CL1-Physical abuse	0	0.0	1	0.4	1	0.2
CL2-Verbal abuse	0	0.0	0	0.0	0	0.0
CL3-Violation of patient rights	1	0.3	1	0.4	2	0.3
CL4-Breach of confidentiality	0	0.0	0	0.0	0	0.0
DE1-Suicide	23	5.9	5	1.9	28	4.3
DE2-Homicide	3	0.8	2	0.8	5	0.8
DE3-Accident/medication error	14	3.6	11	4.3	26	4.0
DE4-Medical condition/illness/age	72	18.6	42	16.3	116	17.8
DE5-Insufficient information	58	15.0	42	16.3	100	15.4
ES1-PSRB patient	1	0.3	1	0.4	2	0.3
ES2-DOC client	0	0.0	0	0.0	0	0.0
ES3-54-56d competency restoration	0	0.0	1	0.4	1	0.2
EV1-Fire	1	0.3	2	0.8	3	0.5
EV2-Bomb threat	1	0.3	0	0.0	1	0.2
EV3-Other	1	0.3	0	0.0	1	0.2
FN1-Secret Service	0	0.0	0	0.0	0	0.0
FN2-FBI	0	0.0	1	0.4	1	0.2
FN3-Other	0	0.0	0	0.0	0	0.0
LD1-Loss/Damage/Theft-safety related	3	0.8	1	0.4	4	0.6
LD2-Loss/Damage/Theft >$1,000	0	0.0	0	0.0	0	0.0
MC1-Inpat. client-dangerous	2	0.5	3	1.2	5	0.8
MC2-Outpat. client-dangerous	4	1.0	2	0.8	6	0.9
MC3-Not dangerous 'missing person'	4	1.0	7	2.7	11	1.7
ME1-Serious Injury	6	1.6	3	1.2	9	1.4
ME2-Accidental overdose	3	0.8	6	2.3	9	1.4
ME3-Med. error/adverse drug reaction	2	0.5	1	0.4	3	0.5
ME4-Other medical event	41	10.6	33	12.8	75	11.5
OT1-Serious incident not classifiable	15	3.9	10	3.9	25	3.8
SA1-During program enrollment	46	11.9	29	11.2	76	11.7
SA2-30 Days from Discharge	1	0.3	0	0.0	1	0.2
SC1-Physical assault	26	6.7	12	4.7	38	5.8
SC2-Sexual assault	18	4.7	11	4.3	29	4.5
SC3-Risk of injury to a minor	4	1.0	3	1.2	7	1.1
SC4-Arson	1	0.3	1	0.4	2	0.3
SC5-Incidents involving firearms	2	0.5	3	1.2	5	0.8
SC6-Hostage taking	0	0.0	0	0.0	0	0.0
SC7-Sale illegal subst on prog. premises	0	0.0	1	0.4	2	0.3
SC8-Murder/Homicide	1	0.3	2	0.8	3	0.5
SC9-Other	10	2.6	9	3.5	19	2.9
TH1-Serious Threat - Property	2	0.5	1	0.4	3	0.5
TH2-Serious Threat - Person	21	5.4	11	4.3	32	4.9
Total	387	100.0	258	100.0	651	100.0

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

Note: There were 6 Cis with missing information that made COD categorization impossible.

Table 3a. Comparison of Statewide Incident Data for SFY12 & SFY13
Incident Related Data (Unduplicated Number of Critical Incidents)

	SFY12 Totals		SFY13 Totals		
	N	%	N	%	Change
# Critical Incidents	578	100.0	**651**	100.0	12.6%
Incident Category					
Client Abuse Alleged	6	1.0	3	0.5	-50.0%
Death	263	45.5	275	42.2	4.6%
Emergency Evacuation	4	0.7	5	0.8	25.0%
Escape	0	0.0	3	0.5	--
Federal Notification	1	0.2	1	0.2	0.0%
Loss/Damage	4	0.7	4	0.6	0.0%
Medical Event	59	10.2	96	14.7	62.7%
Missing Client	19	3.3	22	3.4	15.8%
Other	24	4.2	25	3.8	4.2%
Serious Crime Alleged	106	18.3	105	16.1	-0.9%
Serious Suicide Attempt	73	12.6	77	11.8	5.5%
Threats	19	3.3	35	5.4	84.2%
Total	**578**	**100.0**	**651**	**100.0**	**12.6%**
Incident SubCategory					
CL1-Physical abuse	3	0.5	1	0.2	-66.7%
CL2-Verbal abuse	0	0.0	0	0.0	--
CL3-Violation of patient rights	2	0.3	2	0.3	0.0%
CL4-Breach of confidentiality	1	0.2	0	0.0	-100.0%
DE1-Suicide	19	3.3	28	4.3	47.4%
DE2-Homicide	8	1.4	5	0.8	-37.5%
DE3-Accident/medication error	23	4.0	26	4.0	13.0%
DE4-Medical condition/illness/age	119	20.6	116	17.8	-2.5%
DE5-Insufficient information	94	16.3	100	15.4	6.4%
ES1-PSRB patient	0	0.0	2	0.3	--
ES2-DOC client	0	0.0	0	0.0	--
ES3-54-56d competency restoration	0	0.0	1	0.2	--
EV1-Fire	1	0.2	3	0.5	200.0%
EV2-Bomb threat	0	0.0	1	0.2	--
EV3-Other	3	0.5	1	0.2	-66.7%
FN1-Secret Service	1	0.2	0	0.0	-100.0%
FN2-FBI	0	0.0	1	0.2	--
FN3-Other	0	0.0	0	0.0	--
LD1-Loss/Damage/Theft-safety related	3	0.5	4	0.6	33.3%
LD2-Loss/Damage/Theft >$1,000	1	0.2	0	0.0	-100.0%
MC1-Inpat. client-dangerous	1	0.2	5	0.8	400.0%
MC2-Outpat. client-dangerous	3	0.5	6	0.9	100.0%
MC3-Not dangerous 'missing person'	15	2.6	11	1.7	-26.7%
ME1-Serious Injury	6	1.0	9	1.4	50.0%
ME2-Accidental overdose	5	0.9	9	1.4	80.0%
ME3-Med. error/adverse drug reaction	2	0.3	3	0.5	50.0%
ME4-Other medical event	46	8.0	75	11.5	63.0%
OT1-Serious incident not classifiable	24	4.2	25	3.8	4.2%
SA1-During program enrollment	72	12.5	76	11.7	5.6%
SA2-Within 30 days post-prog. discharge	1	0.2	1	0.2	0.0%
SC1-Physical assault	40	6.9	38	5.8	-5.0%
SC2-Sexual assault	24	4.2	29	4.5	20.8%
SC3-Risk of injury to a minor	5	0.9	7	1.1	40.0%
SC4-Arson	9	1.6	2	0.3	-77.8%
SC5-Incidents involving firearms	4	0.7	5	0.8	25.0%
SC6-Hostage taking	1	0.2	0	0.0	-100.0%
SC7-Sale illegal subst on prog. Premises	2	0.3	2	0.3	0.0%
SC8-Murder/Homicide	4	0.7	3	0.5	-25.0%
SC9-Other	17	2.9	19	2.9	11.8%
TH1-Against property serious risk	1	0.2	3	0.5	200.0%
TH2-Against person serious risk	18	3.1	32	4.9	77.8%
Total	**578**	**100.0**	**651**	**100.0**	**12.6%**

Table 3b. Comparison of Statewide Incident Data for SFY08 through SFY13
Incident Related Data (Unduplicated Number of Critical Incidents)

	SFY08		SFY09		SFY10		SFY11		SFY12		SFY13	
	N	%	N	%	N	%	N	%	N	%	N	%
# Critical Incidents	556	100	622	100	630	100	612	100	578	100	651	100
Incident Category												
Client Abuse Alleged	11	2.0	12	1.9	5	0.8	8	1.3	6	1.0	3	0.5
Death	246	44.2	256	41.2	313	49.7	295	48.2	263	45.5	275	42.2
Emergency Evacuation	3	0.5	5	0.8	0	0.0	4	0.7	4	0.7	5	0.8
Escape	5	0.9	1	0.2	2	0.3	1	0.2	0	0.0	3	0.5
Federal Notification	0	0.0	1	0.2	1	0.2	2	0.3	1	0.2	1	0.2
Loss/Damage	1	0.2	4	0.6	3	0.5	9	1.5	4	0.7	4	0.6
Medical Event	38	6.8	64	10.3	48	7.6	46	7.5	59	10.2	96	14.7
Missing Client	27	4.9	18	2.9	19	3.0	14	2.3	19	3.3	22	3.4
Other	37	6.7	47	7.6	20	3.2	32	5.2	24	4.2	25	3.8
Serious Crime Alleged	113	20.3	111	17.8	123	19.5	111	18.1	106	18.3	105	16.1
Serious Suicide Attempt	52	9.4	73	11.7	69	11.0	72	11.8	73	12.6	77	11.8
Threats	23	4.1	30	4.8	27	4.3	18	2.9	19	3.3	35	5.4
Total	**556**	**100**	**622**	**100**	**630**	**100**	**612**	**100**	**578**	**100**	**651**	**100**
Incident SubCategory												
Missing Information	0	0.0	1	0.2	1	0.2	0	0.0	0	0.0	0	0.0
CL1-Physical abuse	10	1.8	9	1.4	3	0.5	7	1.1	3	0.5	1	0.2
CL2-Verbal abuse	0	0.0	1	0.2	1	0.2	0	0.0	0	0.0	0	0.0
CL3-Violation of patient rights	0	0.0	0	0.0	1	0.2	1	0.2	2	0.3	2	0.3
CL4-Breach of confidentiality	1	0.2	2	0.3	0	0.0	0	0.0	1	0.2	0	0.0
DE1-Suicide	36	6.5	14	2.3	21	3.3	23	3.8	19	3.3	28	4.3
DE2-Homicide	6	1.1	3	0.5	2	0.3	6	1.0	8	1.4	5	0.8
DE3-Accident/medication error	10	1.8	14	2.3	17	2.7	14	2.3	23	4.0	26	4.0
DE4-Medical condition/illness/age	101	18.2	105	16.9	139	22.1	129	21.1	119	20.6	116	17.8
DE5-Insufficient information	93	16.7	119	19.1	133	21.1	123	20.1	94	16.3	100	15.4
ES1-PSRB patient	2	0.4	1	0.2	1	0.2	1	0.2	0	0.0	2	0.3
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	0	0.0	1	0.2	0	0.0	0	0.0	1	0.2
EV1-Fire	3	0.5	5	0.8	0	0.0	1	0.2	1	0.2	3	0.5
EV2-Bomb threat	0	0.0	0	0.0	0	0.0	1	0.2	0	0.0	1	0.2
EV3-Other	0	0.0	0	0.0	0	0.0	2	0.3	3	0.5	1	0.2
FN1-Secret Service	0	0.0	1	0.2	1	0.2	0	0.0	1	0.2	0	0.0
FN2-FBI	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.2
FN3-Other	0	0.0	0	0.0	0	0.0	2	0.3	0	0.0	0	0.0
LD1-Loss/Damage/Theft-safety related	1	0.2	1	0.2	1	0.2	4	0.7	3	0.5	4	0.6
LD2-Loss/Damage/Theft >$1,000	0	0.0	3	0.5	2	0.3	5	0.8	1	0.2	0	0.0
MC1-Inpat. client-dangerous	5	0.9	3	0.5	2	0.3	0	0.0	1	0.2	5	0.8
MC2-Outpat. client-dangerous	0	0.0	0	0.0	2	0.3	2	0.3	3	0.5	6	0.9
MC3-Not dangerous 'missing person'	21	3.8	15	2.4	15	2.4	12	2.0	15	2.6	11	1.7
ME1-Serious Injury	6	1.1	17	2.7	9	1.4	5	0.8	6	1.0	9	1.4
ME2-Accidental overdose	9	1.6	11	1.8	3	0.5	3	0.5	5	0.9	9	1.4
ME3-Med. error/adverse drug reaction	0	0.0	0	0.0	5	0.8	4	0.7	2	0.3	3	0.5
ME4-Other medical event	20	3.6	36	5.8	31	4.9	34	5.6	46	8.0	75	11.5
OT1-Serious incident not classifiable	37	6.7	47	7.6	20	3.2	32	5.2	24	4.2	25	3.8
SA1-During program enrollment	52	9.4	71	11.4	65	10.3	71	11.6	72	12.5	76	11.7
SA2-Within 30 days post-prog. discharge	0	0.0	2	0.3	4	0.6	1	0.2	1	0.2	1	0.2
SC1-Physical assault	43	7.7	38	6.1	47	7.5	41	6.7	40	6.9	38	5.8
SC2-Sexual assault	32	5.8	36	5.8	35	5.6	28	4.6	24	4.2	29	4.5
SC3-Risk of injury to a minor	9	1.6	6	1.0	8	1.3	2	0.3	5	0.9	7	1.1
SC4-Arson	4	0.7	2	0.3	0	0.0	2	0.3	9	1.6	2	0.3
SC5-Incidents involving firearms	8	1.4	2	0.3	5	0.8	4	0.7	4	0.7	5	0.8
SC6-Hostage taking	0	0.0	1	0.2	0	0.0	1	0.2	1	0.2	0	0.0
SC7-Sale illegal subst on prog premises	0	0.0	0	0.0	1	0.2	3	0.5	2	0.3	2	0.3
SC8-Murder/Homicide	1	0.2	2	0.3	5	0.8	2	0.3	4	0.7	3	0.5
SC9-Other	15	2.7	24	3.9	22	3.5	28	4.6	17	2.9	19	2.9
TH1-Against property serious risk	3	0.5	4	0.6	1	0.2	2	0.3	1	0.2	3	0.5
TH2-Against person serious risk	20	3.6	26	4.2	26	4.1	16	2.6	18	3.1	32	4.9
Total	**556**	**100**	**622**	**100**	**630**	**100**	**612**	**100**	**578**	**100**	**651**	**100**

Figure 2

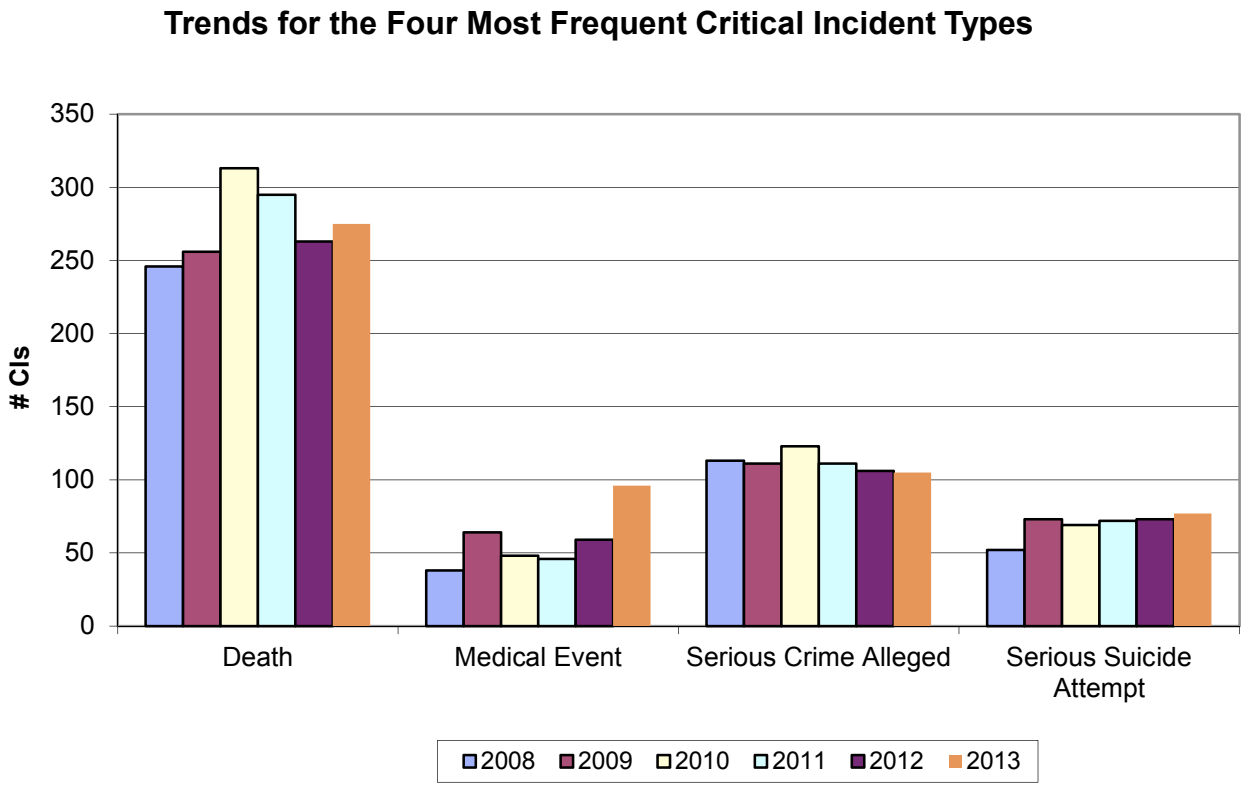

Trends for the Four Most Frequent Critical Incident Types
CIs
350
300
250
200
150
100
50
0
Death
Medical Event
Serious Crime Alleged
Serious Suicide Attempt
2008
2009
2010
2011
2012
2013

Table 4a. Summary of SFY2013 Critical Incidents Categorized as Deaths

275 Deaths in SFY 13 (42.2% of all SFY13 Critical Incidents)

Death Incident SubCategory	N	%
DE1-Suicide	28	10.2
DE2-Homicide	5	1.8
DE3-Accident/medication error	26	9.5
DE4-Medical condition/illness/age	116	42.2
DE5-Insufficient information	100	36.4

Demographics

180 (66%) were male
161 (59%) were Caucasian, 10 (4%) were African American
19 (7%) were Hispanic
Average age = 50.5 years (±12.1), age range 19-83 years
102 (37%) of those who died had a Co-Occuring diagnosis
29 (10.5%) had a diagnosis of PTSD
54 (20%) clients were active in treatment at a state-operated facility at the time of their deaths
1 death was coded as occurring at a state operated facility

Co-Occurring Diagnosis	N	%
No COD	170	61.8
COD	102	37.1
Undertermined	3	1.1
Most Common MH/SA Diagnoses (from EDW)	**N**	**%**
Bipolar/Major Depression	88	32.0
Opioid Dependence	71	25.8
Alcohol Dependence	59	21.5
Tobacco Use Disorder	38	13.8
Schizophrenia/Schizophreniform/Schizoaffective	33	12.0

LOC at Time of Incident (most frequent listed)	N	%
MH OP	108	39.3
MH CSP/RP	36	13.1
MH Social Rehab	29	10.5
SA OP	27	9.8
SA Methadone Maintenance	23	8.4

Most Common Medical Diagnoses*	N	%
CHF/Heart Disease/Problems	21	20.6
Cancer	20	19.6
Hypertension	19	18.6
Diabetes	17	16.7
Hepatitis	17	16.7
Chronic Pain	11	10.8
COPD	11	10.8
Renal Failure/Kidney Disease	9	8.8
Asthma	8	7.8
Cirrhosis/Liver Disease	8	7.8
Arthritis/Joint Problems/Bone Problems	8	7.8
Hyperlipidemia	6	5.9
Obesity	5	4.9
Stroke/Aneurism	5	4.9
Infection	4	3.9
Emphysema/Lung Disease	4	3.9
GERD	3	2.9
Pneumonia	3	2.9
Seizure Disorder	3	2.9
Traumatic Brain Injury (TBI)	3	2.9
AIDS/HIV	2	2.0
Thyroid Disease	1	1.0
Anemia	0	0.0

* % based on 102 deaths where medical history was submitted with the CI report (may have multiple dx)

Table 4b. Summary of SFY2013 Critical Incidents Categorized as Deaths for Clients Under Age 50

106 Deaths in SFY 13 Under the Age of 50 (39% of all SFY13 Deaths)

Death Incident SubCategory	N	%
DE1-Suicide	11	10.4
DE2-Homicide	5	4.7
DE3-Accident/medication error	19	17.9
DE4-Medical condition/illness/age	21	19.8
DE5-Insufficient information	50	47.2

Demographics

66 (62%) were male
65 (61%) were Caucasian, 5 (5%) were African American
10 (9%) were Hispanic
Average age = 38.5 years (±8.5), age range 19-49 years
42 (40%) of those who died had a Co-Occuring diagnosis
16 (15%) had a diagnosis of PTSD
17 (16%) clients were active in treatment at a state-operated facility at the time of their deaths
0 deaths occurred at a state operated facility

Co-Occurring Diagnosis	N	%
No COD	64	60.4
COD	42	39.6
Undertermined	0	0.0

Most Common MH/SA Diagnoses (from EDW)	N	%
Bipolar/Major Depression	39	36.8
Opioid Dependence	36	34.0
Alcohol Dependence	25	23.6
Tobacco Use Disorder	18	17.0
Cocaine Dependence	14	13.2
Polysubstance Dependence	12	11.3
Alcohol Abuse	9	8.5
Schizophrenia/Schizophreniform/Schizoaffective	6	5.7

LOC at Time of Incident (most frequent listed)	N	%
MH OP	38	35.8
SA OP	15	14.2
MH Soc Rehab	11	10.4
MH CSP/RP	11	10.4
SA MM	10	9.4

Most Common Medical Diagnoses*	N	%
Diabetes	8	22.2
Hepatitis	8	22.2
Hypertension	6	16.7
Chronic Pain	5	13.9
Asthma	4	11.1
Cancer	4	11.1
CHF/Heart Disease/Problems	3	8.3
Seizure Disorder	3	8.3
Cirrhosis/Liver Disease	3	8.3
COPD	3	8.3
Renal Failure/Kidney Disease	2	5.6
Traumatic Brain Injury (TBI)	2	5.6
Hyperlipidemia	2	5.6
Obesity	1	2.8
Infection	1	2.8
AIDS/HIV	1	2.8
Pneumonia	1	2.8
Emphysema/Lung Disease	1	2.8
Arthritis/Joint Problems/Bone Problems	1	2.8
Thyroid Disease	1	2.8
Anemia	1	2.8
GERD	0	0.0
Stroke/Aneurism	0	0.0

Table 4c. Summary of SFY2013 Critical Incidents Categorized as Suicides

28 Suicides in SFY 13 (4.3% of all SFY13 Critical Incidents)

Demographics
19 (68%) were male
19 (64%) were Caucasian
Average age = 47.6 years (±10.5), age range 24-63 years
5 (18%) of those who died had a Co-Occuring diagnosis
5 clients (18%) had a diagnosis of PTSD
9 (32%) were by hanging
3 (11%) have the potential to be overdose related
5 (18%) clients reportedly had chronic health conditions
7 incidents were reported by a state operated facility
0 incidents occurred at a state-operated facility

Co-Occurring Diagnosis	N	%
No COD	23	82.1
COD	5	17.9
Undertermined	0	0.0

Most Common MH/SA Diagnoses (from EDW)	N	%
Bipolar/Major Depression	8	28.6
Alcohol Dependence	3	10.7
Schizophrenia/Schizophreniform/Schizoaffective	3	10.7
Polysubstance Dependence	2	7.1

LOC at Time of Incident (most frequent listed)	N	%
MH OP	11	39.3
SA OP	5	17.9

Figure 3

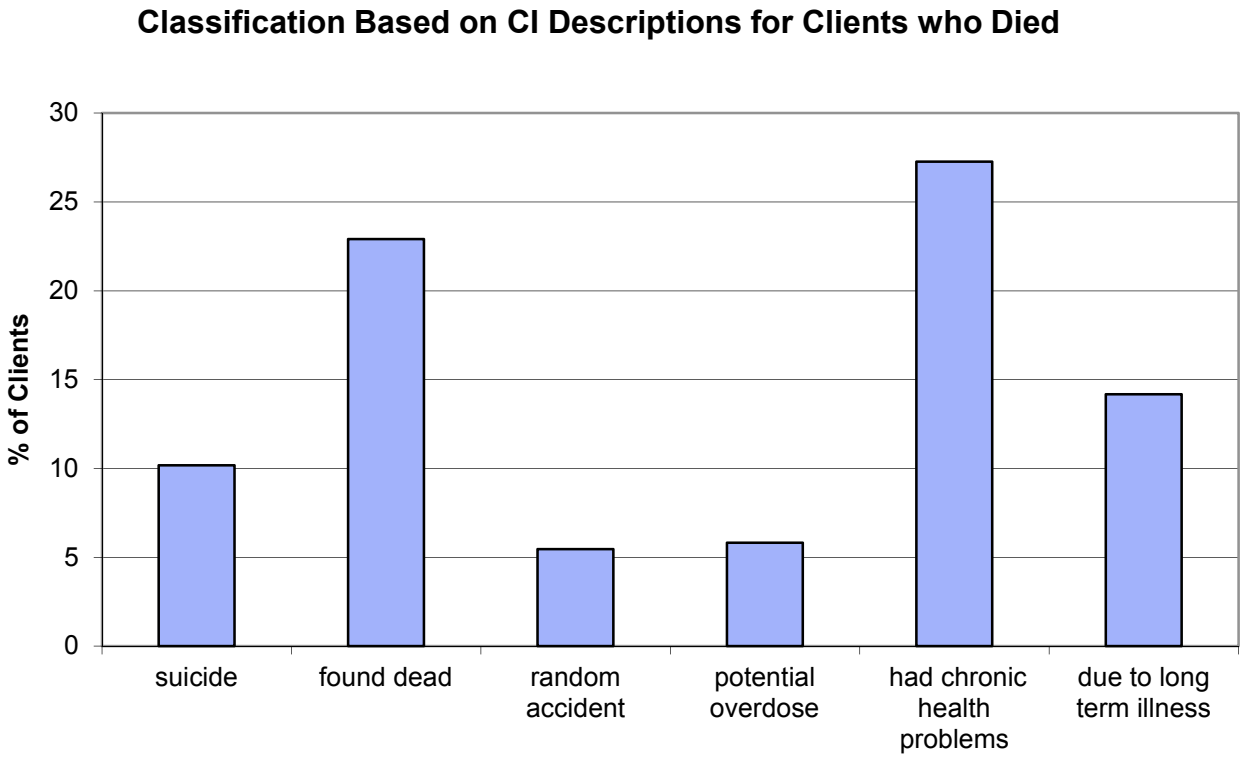
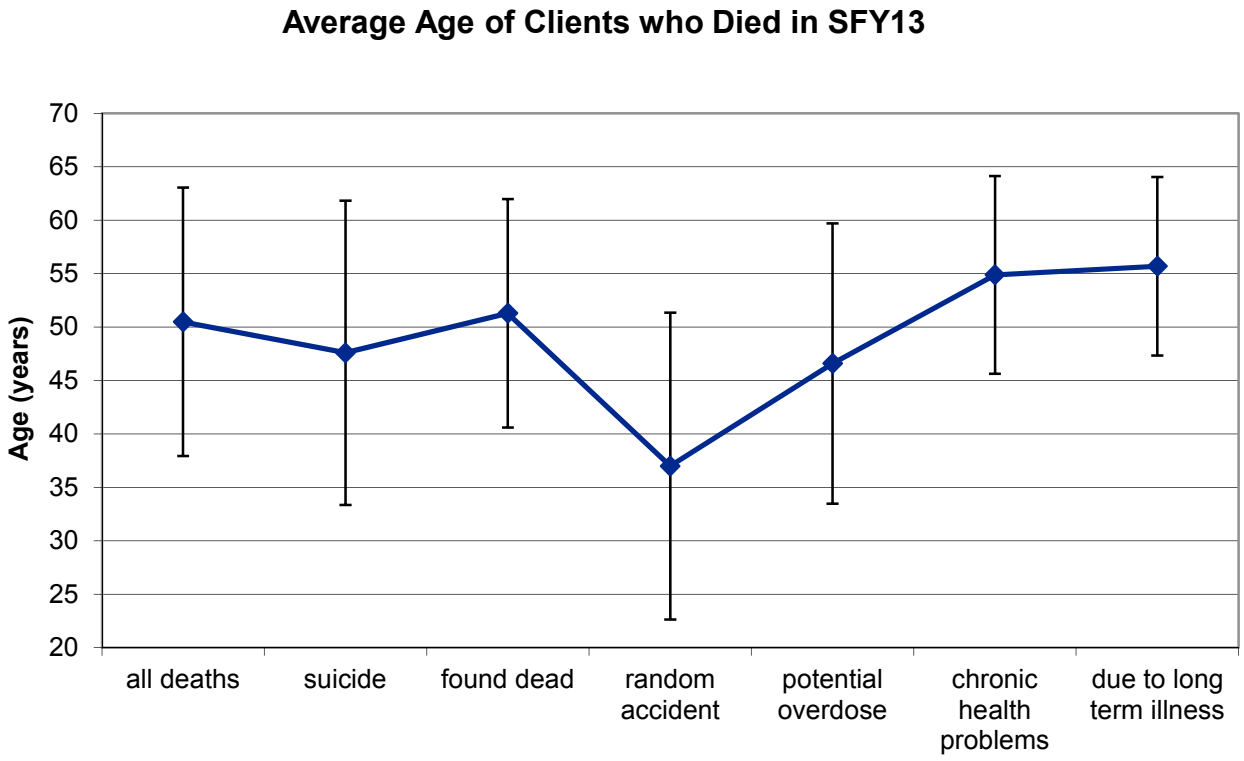


Figure 4



Comparison Between Clients with and without COD

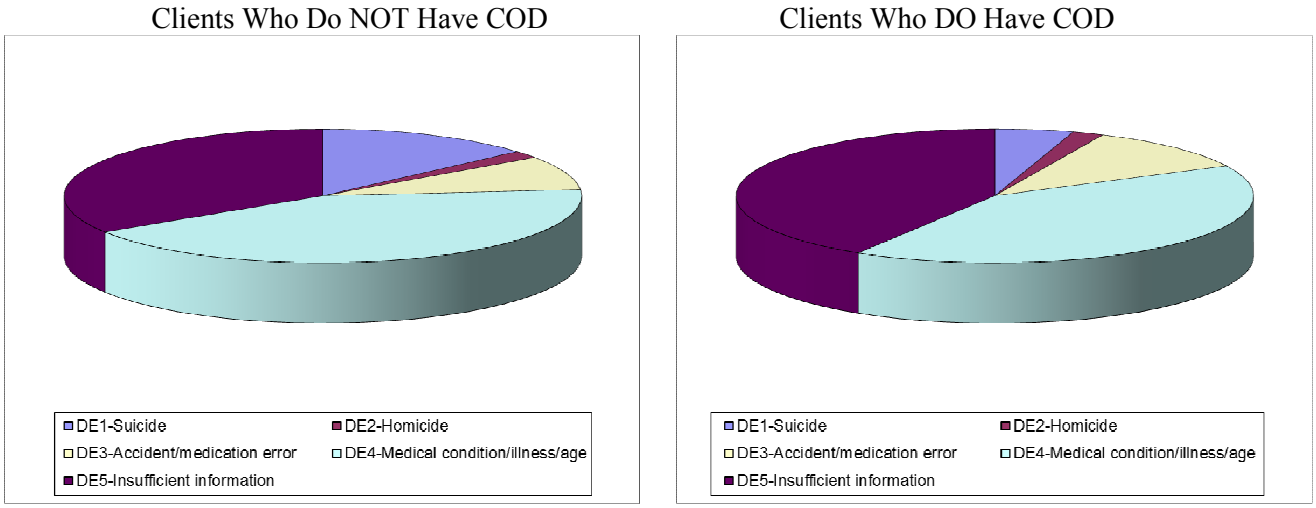


Figure 5. Death Subcategories

Significantly more clients who did not have COD died by suicide compared to clients who had COD. Significance testing performed using chi-square and $p<.05$.

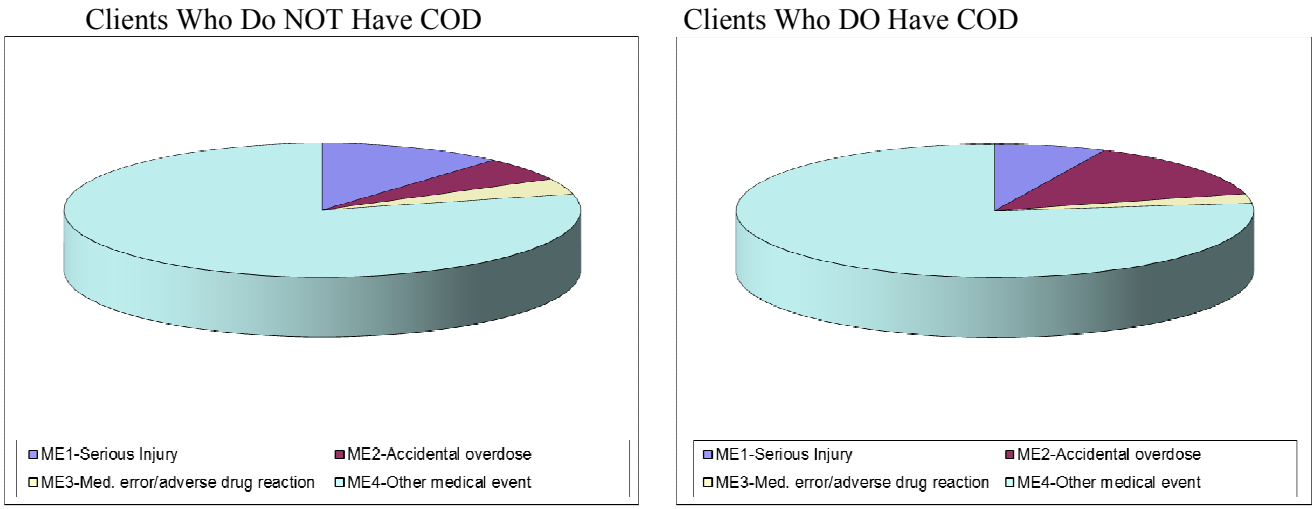


Figure 6. Medical Event Subcategories

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.

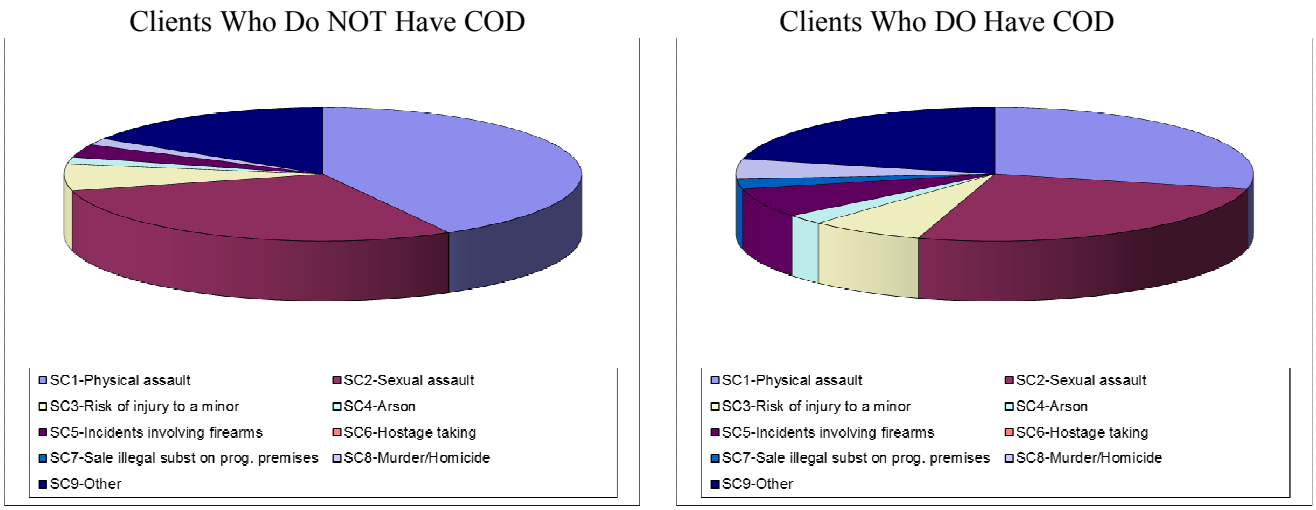


Figure 7. Serious Crime Alleged Subcategories

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	8	1.2
Advanced Behavioral Health	5	.7
Alcohol & Drug Recovery Center-ADRC	2	.3
Birmingham Group Health Services Inc.	6	.9
Bridge House	1	.1
BRIDGES	20	3.0
Capitol Region Mental Health Center	35	5.2
Catholic Charities of Fairfield County Inc.	2	.3
Catholic Charities- Waterbury	1	.1
Center for Human Development	9	1.3
Central Naugatuck Valley (CNV) Help Inc.	2	.3
Charlotte Hungerford Hospital	16	2.4
Chemical Abuse Services Agency (CASA)	4	.6
Chrysalis Center Inc.	6	.9
Columbus House	5	.7
Community Health Resources Inc.	20	3.0
Community Mental Health Affiliates	29	4.3
Connecticut Counseling Centers Inc.	5	.7
Connecticut Mental Health Center	3	.4
Connecticut Valley Hospital	19	2.8
Connection Inc	14	2.1
Connection Inc.	7	1.0
Continuum of Care	6	.9
Crossroad Inc	6	.9
Danbury Hospital	2	.3
FSW Inc.	1	.1
Gilead Community Services Inc.	2	.3
Harbor Health Services	25	3.7
Hartford Dispensary	21	3.1
Hill Health Corporation	5	.7
Hope House	1	.1
Human Resource Development Agency	1	.1
Immaculate Conception Inc.	2	.3
Inter-Community Mental Health Group Inc.	16	2.3
Laurel House	1	.1
Leeway Inc.	1	.1
Liberation Programs (LMG)	11	1.6
Marrakech Day Services	8	1.2
Mental Health Association of CT Inc.	15	2.2
Mercy Housing and Shelter Corporation	1	.1
Midwestern CT Council on Alcoholism (MCCA)	2	.3
Morris Foundation Inc	2	.3
New Directions Inc of North Central Conn.	2	.3
New Era Rehabilitation Center Inc.	29	4.3
New Milford Hospital	1	.1
Norwalk Hospital	1	.1
Perception Programs Inc	3	.4
Regional Network of Programs	56	8.3
Reliance House	13	1.9
River Valley Services	10	1.5
Rushford Center	6	.9
SCADD	7	1.0
SE Mental Health Authority	4	.6
Sound Community Services Inc.	5	.7
St. Mary's Hospital Corporation	3	.4

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

Provider	N	%
United Services Inc.	62	9.2
W. CT MH Network	60	8.9
Regional Network of Programs	56	8.3
SW CT MH Network	45	6.7
Capitol Region Mental Health Center	35	5.2
Community Mental Health Affiliates	29	4.3
New Era Rehabilitation Center Inc.	29	4.3
Harbor Health Services	25	3.7
Hartford Dispensary	21	3.1
BRIDGES	20	3.0
Community Health Resources Inc.	20	3.0
Connecticut Valley Hospital	19	2.8
Charlotte Hungerford Hospital	16	2.4
Inter-Community Mental Health Group Inc.	16	2.3
Mental Health Association of CT Inc.	15	2.2
Connection Inc	14	2.1
Wheeler Clinic	14	2.1
Reliance House	13	1.9
Liberation Programs (LMG)	11	1.6
River Valley Services	10	1.5
Center for Human Development	9	1.3
Ability Beyond Disability Institute	8	1.2
Marrakech Day Services	8	1.2
Connection Inc.	7	1.0
SCADD	7	1.0
Birmingham Group Health Services Inc.	6	.9
Chrysalis Center Inc.	6	.9
Continuum of Care	6	.9
Crossroad Inc	6	.9
Rushford Center	6	.9
Advanced Behavioral Health	5	.7
Columbus House	5	.7
Connecticut Counseling Centers Inc.	5	.7
Hill Health Corporation	5	.7
Sound Community Services Inc.	5	.7
Chemical Abuse Services Agency (CASA)	4	.6
SE Mental Health Authority	4	.6
Connecticut Mental Health Center	3	.4
Perception Programs Inc	3	.4
St. Mary's Hospital Corporation	3	.4
ABH - GA Only Providers	2	.3
Alcohol & Drug Recovery Center-ADRC	2	.3
Catholic Charities of Fairfield County Inc.	2	.3
Central Naugatuck Valley (CNV) Help Inc.	2	.3
Danbury Hospital	2	.3
Gilead Community Services Inc.	2	.3
Immaculate Conception Inc.	2	.3
Midwestern CT Council on Alcoholism (MCCA)	2	.3
Morris Foundation Inc	2	.3
New Directions Inc of North Central Conn.	2	.3
Bridge House	1	.1
Catholic Charities- Waterbury	1	.1
FSW Inc.	1	.1
Hope House	1	.1
Human Resource Development Agency	1	.1
Laurel House	1	.1

Table 5a. Agencies Reporting CIs (Alphabetical order)

Provider	N	%
St. Vincent DePaul Mission of Waterbury Inc.	1	.1
Supportive Environmental Living Facility Inc-SELF	1	.1
SW CT MH Network	45	6.7
United Services Inc.	62	9.2
W. CT MH Network	60	8.9
Wheeler Clinic	14	2.1
Total	**673**	**100.0**

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

Provider	N	%
Leeway Inc.	1	.1
Mercy Housing and Shelter Corporation	1	.1
New Milford Hospital	1	.1
Norwalk Hospital	1	.1
St. Vincent DePaul Mission of Waterbury Inc.	1	.1
Supportive Environmental Living Facility Inc-SELF	1	.1
Total	**673**	**100.0**