SFY2017 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, 2016 and June 30, 2017.

The report for SFY17 uses data that has been entered into the Critical Incident Database that is accessed via DDAP. This is the third year using this database. 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 DDaP based 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. The impact of the new system can be seen in the number of critical incidents reported: incident numbers increased 25% from SFY15 to SFY17.

New for SFY2017 is the use of ICD10 codes for diagnoses and determination of co-occurring disorders. This has led in a few instances to slightly altered categories when compared to older reports (e.g., 'amphetamine abuse' is no longer a separate category; it now falls under 'psychoactive substance abuse'). Similarly, 'other drug dependence' and 'poly drug dependence' are both counted under 'psychoactive substance dependence'.

Since a critical incident (CI) may involve more than one client and a client may be involved in multiple incidents, the data for SFY17 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:

- 847 incidents
  - 720 (85%) were closed while 127 (15%) were still open at the time of this analysis.
  - 14 were at the Agency Level (Evacuation, Serious Crime Alleged, Threats to Agency, Property Damage, Other.)
  - 11 involved staff members (17 staff total)
    - 5 incidents involved staff as perpetrators; 7 incidents had staff as victims
  - 829 (99%) were at the Client Level
  - 316 (37%) incidents involved clients with a co-occurring diagnosis
  - The maximum number of people involved in any one incident was 7 (one incident involved an emergency evacuation due to fire)
    - 816 incidents (96%) involved a single person

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

- 17 Staff
- 2 Visitors
- 802 unduplicated clients
  - 307 (38%) clients had a co-occurring diagnosis
  - 120 (15%) clients had a PTSD diagnosis on file since 7/1/06
  - The maximum number of incidents for any one client was 4
- 773 people were involved in only one incident

Information from DDaP and WITS was used to supplement the information in the Critical Incident database. This involves 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.

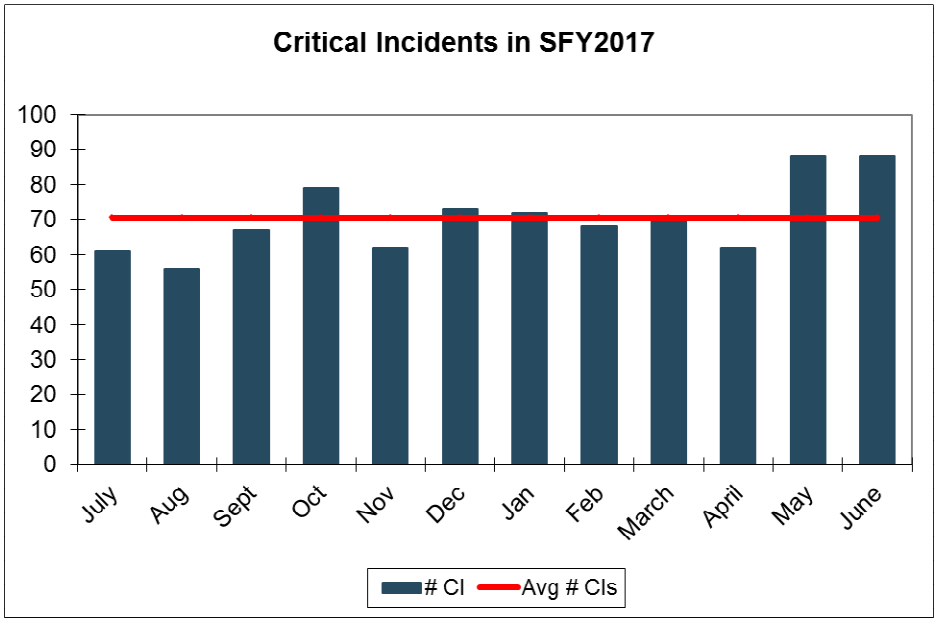


Figure1. Critical Incidents in SFY17

Summary of the Results

■ From SFY16 to SFY17 there was an *8.5% increase* in the number of critical incidents reported. There was, on average, an increase of 5 incidents per month. 96% of all client-level CIs involved a single client. (Tables 1, 2, 3a & 3b)

■ Just over one-third (35%) 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 29% of incidents. 60% of the clients were male. (Table 1)

■ Bipolar/Major Depression was the most frequent MH diagnosis (18%) for clients involved in a CI. Schizophrenia/ Schizophreniform/Schizoaffective disorder was the next most frequent MH diagnosis (16%). Opioid Dependence (29%) and Alcohol Dependence (25%) 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, 9% were receiving MH Social Rehabilitation services, and 8% were receiving MH CSP/RP services. 10% of clients were receiving SA methadone maintenance services and 7% were receiving SA Outpatient services. (Table 1)

■ The 14 Agency-level CIs included 6 Emergency Evacuations, 3 Serious Crime Alleged, 2 Threats to Agency, 2 Other, and 1 Property Damage.

■ According to CI reporting, 42% of incidents occurred at the clients' residences, while 24% occurred in the community. Thirty-four events (4%) of events occurred on a DMHAS-operated inpatient unit.

■ The most frequent CI categories reported were: (Tables 2, 3a, 3b, Figure 2)
Death (44%). Compared to SFY16, the number of deaths in SFY17 *increased* by 3% (from 362 to 374).
Serious Crime Alleged (17%). Compared to SFY16, there were 27% *more* CIs reported in this category (116 to 147).
Medical Event (14%). Compared to SFY16, there was a 57% *increase* in the number of medical events reported (75 to 118).
Serious Suicide Attempt (9%). Compared to SFY16, there were 10% *fewer* serious suicide attempts (89 to 80).
NOTE: This is the first year since 2006 that the medical event category has had more incidents reported than serious suicide attempts.

■ Within the Death category, the number of Suicides reported *decreased* 39% from SFY16 (26 to 16). The reported number of Serious Suicide Attempts while enrolled a program also *decreased by* 10% (89 to 80). The number of accidental overdoses (new subcategory as of SFY15) *increased* 33% from SFY16 to SFY17 (63 to 84) and accounted for 23% of all deaths. (Table 3a, 4a)

■ There were 84 deaths due to accidental overdose; average age = 41.8 years (±10.8), age range 22-65 years

■ Forty-one percent 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* 13% (24 to 27) from SFY16. The number of the number of accidental injuries *increased* 59% (17 to 27) and the number of medical error/reactions *increased* 60% (5 to 8). (Table 3a)

■ The majority of clients (75%) who died by suicide were male. (Table 4c)

■ Of the 374 Deaths in SFY17: 65% were male
average age = 50.8 years (±13.7), age range 19-90 years
over one third (40%) had a co-occurring diagnosis
11% had a PTSD diagnosis
40% had a diagnosis of Opioid Dependence
19% had a diagnosis of Bipolar/Major Depression.
24% died from drug overdose
29% were found dead (not including suicides)
39% had chronic health issues
17% reported cardiovascular issues and 15% died from them
11% reported diabetes
10% reported cancer (Table 4a & Figs 3&4)

■ There were 152 deaths in which the client was less than 50 years old
67% were male
average age = 37.1 years (±8.1), age range 19-49 years
50% had a co-occurring diagnosis
20% had a PTSD diagnosis
7% were suicides
43% died from drug overdose (based on Cause of Death selected at closure)
37% were found dead (not including suicides)
53% had Opioid Dependence
34% had Alcohol Dependence
23% had Bipolar/Major Depression
20% had chronic health issues
7% reported cardiovascular issues and 6% died from them
7% were obese
6% had hepatitis
8% died from a long-term illness (Table 4b)

■ There were 16 suicides in SFY17: 75% were male
average age = 37.9 years (±14.8), age range 19-69 years
50% had a co-occurring diagnosis
6% had a PTSD diagnosis
23% had a diagnosis of Bipolar/Major Depression.
31% of the deaths were by hanging; 25% were by overdose (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 differently than in past reports (information from incident description). Now there is a death subcategory "accidental overdose resulting in death" that provides more accurate information. "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 374 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, about 40% 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. Also of note is that the age at death was the lowest for suicide (37yrs) and second lowest for accidental overdose (42yrs) (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"), 38.6% of the clients who were involved in a CI were female and 60.4% 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. *Seventy-two* agencies reported at least one critical incident during SFY17. There were 208 active agencies, thus *38% of all agencies reported at least one critical incident*. For comparison, in SFY16, 39% of all agencies reported at least one critical incident and in SFY15, 35% 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 SFY17)

- 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, 30% in SFY16, and 39% in SFY17) 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 72 Agencies that reported critical incidents, *49 agencies reported 10 or fewer critical incidents during this time frame*, with 14 of these agencies reporting a single critical incident for the entire year. One hundred thirty-six (136) 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, as it was last year for the first time, based on the final categorization (ie., determined during a formal review process) for events that have been closed (85% 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	495	100.0	307	100.0	802	100.0
Gender						
Unknown	5	1.0	0	0.0	5	0.6
Female	191	38.6	124	40.4	315	39.3
Male	299	60.4	183	59.6	482	60.1
Race						
American Indian/Alaskan Native	2	0.4	0	0.0	2	0.2
Asian	2	0.4	0	0.0	2	0.2
Black/African American	101	20.4	46	15.0	147	18.3
Caucasian	305	61.6	230	74.9	535	66.7
Other/Mixed	63	12.7	28	9.1	91	11.3
Not Specified/Unknown	21	4.2	3	1.0	24	3.0
Ethnicity						
Hispanic	77	15.6	48	15.6	125	15.6
Non-Hispanic	386	78.0	252	82.1	638	79.6
Not Specified/Unknown	32	6.5	7	2.3	39	4.9
Age Group						
24 & Under	68	13.7	23	7.5	91	11.3
25-34	74	14.9	68	22.1	142	17.7
35-54	155	31.3	123	40.1	278	34.7
55+	163	32.9	69	22.5	232	28.9
Mental Health Diagnosis						
Schizophrenia/Schizophreniform/Schizoaffective	57	11.5	69	22.5	126	15.7
Bipolar/Major Depression	25	5.1	122	39.7	147	18.3
Shared Psychotic Disorder	0	0.0	0	0.0	0	0.0
Brief Psychotic Disorder	0	0.0	0	0.0	0	0.0
Delusional Disorder	2	0.4	2	0.7	4	0.5
Alcohol Dependence	44	8.9	153	49.8	197	24.6
Opioid Dependence	98	19.8	131	42.7	229	28.6
Cocaine Dependence	31	6.3	97	31.6	128	16.0
Cannabis Dependence	18	3.6	77	25.1	95	11.8
Stimulant Dependence	0	0.0	5	1.6	5	0.6
Hallucinogen Dependence	1	0.2	7	2.3	8	1.0
Psychoactive Substance Dependence	0	0.0	0	0.0	0	0.0
Alcohol Abuse	8	1.6	47	15.3	55	6.9
Tobacco Use Disorder	26	5.3	82	26.7	108	13.5
Cannabis Abuse	6	1.2	32	10.4	38	4.7
Hallucinogen Abuse Dx	0	0.0	4	1.3	4	0.5
Sedative Abuse	5	1.0	8	2.6	13	1.6
Opioid Abuse	5	1.0	17	5.5	22	2.7
Cocaine Abuse	18	3.6	40	13.0	58	7.2
Stimulant Abuse	0	0.0	4	1.3	4	0.5
Psychoactive Substance Abuse	1	0.2	4	1.3	5	0.6
PTSD (diagnosis on file since 7/1/2006)	20	4.0	100	32.6	120	15.0

Table 1. Demographic and Summary Information - continued

	No COD		COD		Total	
LOC During Prior Year	**N**	**%**	**N**	**%**	**N**	**%**
MH ACT	23	4.6	28	9.1	51	6.4
MH CM	19	3.8	18	5.9	37	4.6
MH OP	131	26.5	162	52.8	293	36.5
MH Crisis	28	5.7	47	15.3	75	9.4
MH Group Home	8	1.6	5	1.6	13	1.6
MH Intake	4	0.8	20	6.5	24	3.0
MH Partial Hospital	0	0.0	0	0.0	0	0.0
MH Inpatient	6	1.2	9	2.9	15	1.9
MH Social Rehab	41	8.3	47	15.3	88	11.0
MH Supervised Residential	21	4.2	16	5.2	37	4.6
MH Supportive Residential	17	3.4	18	5.9	35	4.4
MH Voc Rehab	21	4.2	28	9.1	49	6.1
MH CSP/RP	34	6.9	56	18.2	90	11.2
MH IOP	2	0.4	10	3.3	12	1.5
MH Intensive Res Rehab	11	2.2	4	1.3	15	1.9
SA CM	11	2.2	36	11.7	47	5.9
SA Detox IP	5	1.0	21	6.8	26	3.2
SA Intensive Residential	13	2.6	34	11.1	47	5.9
SA Intermediate Residential	19	3.8	38	12.4	57	7.1
SA Long Term Residential	0	0.0	4	1.3	4	0.5
SA Methadone Maintenance	75	15.2	62	20.2	137	17.1
SA Outpatient	39	7.9	84	27.4	123	15.3
SA Detox OP	2	0.4	1	0.3	3	0.4
SA Partial Hospital	11	2.2	32	10.4	43	5.4
SA Transitional Residential	2	0.4	6	2.0	8	1.0
SA Vocational Services	2	0.4	4	1.3	6	0.7
SA Gambling Outpatient	2	0.4	2	0.7	4	0.5
SA Medically Monitored Detox	35	7.1	47	15.3	82	10.2
SA IOP	25	5.1	63	20.5	88	11.0

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	23	4.6	24	7.8	47	5.9
MH CM	12	2.4	12	3.9	24	3.0
MH OP	115	23.2	141	45.9	256	31.9
MH Crisis	5	1.0	7	2.3	12	1.5
MH Group Home	7	1.4	4	1.3	11	1.4
MH Intake	0	0.0	2	0.7	2	0.2
MH Partial Hospital	0	0.0	0	0.0	0	0.0
MH Inpatient	1	0.2	1	0.3	2	0.2
MH Social Rehab	37	7.5	34	11.1	71	8.9
MH Supervised Residential	14	2.8	10	3.3	24	3.0
MH Supportive Residential	14	2.8	10	3.3	24	3.0
MH Voc Rehab	12	2.4	13	4.2	25	3.1
MH CSP/RP	27	5.5	34	11.1	61	7.6
MH IOP	0	0.0	2	0.7	2	0.2
MH Intensive Res Rehab	11	2.2	2	0.7	13	1.6
SA CM	2	0.4	19	6.2	21	2.6
SA Detox IP	0	0.0	0	0.0	0	0.0
SA Intensive Residential	0	0.0	1	0.3	1	0.1
SA Intermediate Residential	10	2.0	20	6.5	30	3.7
SA Long Term Residential	0	0.0	0	0.0	0	0.0
SA Methadone Maintenance	44	8.9	34	11.1	78	9.7
SA Outpatient	15	3.0	43	14.0	58	7.2
SA Detox OP	1	0.2	0	0.0	1	0.1
SA Partial Hospital	1	0.2	0	0.0	1	0.1
SA Transitional Residential	1	0.2	2	0.7	3	0.4
SA Vocational Services	1	0.2	1	0.3	2	0.2
SA Gambling Outpatient	2	0.4	1	0.3	3	0.4
SA Medically Monitored Detox	3	0.6	5	1.6	8	1.0
SA IOP	5	1.0	17	5.5	22	2.7

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 SFY17

Incident Related Data (Unduplicated Number of Critical Incidents)

		No COD		COD		Total	
		N	%	N	%	N	%
	# Critical Incidents	**531**	100.0	**316**	100.0	**847**	100.0
	CI Category						
CL	Client Abuse Alleged	10	1.9	3	0.9	13	1.5
DE	Death	223	42.0	151	47.8	374	44.2
EV	Emergency Evacuation	14	2.6	0	0.0	14	1.7
ES	Escape	0	0.0	0	0.0	0	0.0
FN	Federal Notification	2	0.4	0	0.0	2	0.2
PD	Property Damage	1	0.2	1	0.3	2	0.2
ME	Medical Event	70	13.2	48	15.2	118	13.9
MC	Missing Client	20	3.8	10	3.2	30	3.5
OT	Other	16	3.0	9	2.8	25	3.0
SC	Serious Crime Alleged	96	18.1	51	16.1	147	17.4
SA	Serious Suicide Attempt	51	9.6	29	9.2	80	9.4
TH	Threats	28	5.3	14	4.4	42	5.0

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 alleged	8	1.5	0	0.0	8	0.9
CL2	Verbal abuse alleged	0	0.0	1	0.3	1	0.1
CL3	Violation of patient rights w/ signif consequences	2	0.4	2	0.6	4	0.5
CL4	Breach of confidentiality with significant	0	0.0	0	0.0	0	0.0
DE1	Suicide	8	1.5	8	2.5	16	1.9
DE2	Homicide	0	0.0	2	0.6	2	0.2
DE3	Accident	12	2.3	5	1.6	17	2.0
DE4	Accidental overdose (death)	36	6.8	48	15.2	84	9.9
DE5	Medical Error	1	0.2	0	0.0	1	0.1
DE6	Illness, age, or medical reason	128	24.1	60	19.0	188	22.2
DE7	Info pending/Insufficient Info	38	7.2	28	8.9	66	7.8
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
EV2	Bomb	0	0.0	0	0.0	0	0.0
EV3	Other Emergency Evacuation	4	0.8	0	0.0	4	0.5
FN1	Secret Service	1	0.2	0	0.0	1	0.1
FN2	FBI	0	0.0	0	0.0	0	0.0
FN3	Other Federal Notice	1	0.2	0	0.0	1	0.1
PD1	Property Damage - Safety Issue	1	0.2	1	0.3	2	0.2
PD2	Property Damage	0	0.0	0	0.0	0	0.0
MC1	Missing inpatient, risk to self or others	1	0.2	0	0.0	1	0.1
MC2	Missing outpatient, risk to self or others	2	0.4	2	0.6	4	0.5
MC3	Missing person	17	3.2	8	2.5	25	3.0
ME1	Accidental injury	17	3.2	10	3.2	27	3.2
ME2	Accidental overdose (not resulting in death)	13	2.4	14	4.4	27	3.2
ME3	Medical error/reaction	3	0.6	5	1.6	8	0.9
ME4	Medical event - other	37	7.0	19	6.0	56	6.6
OT1	Other incident	16	3.0	9	2.8	25	3.0
SA1	Suicide attempt while active in program	51	9.6	29	9.2	80	9.4
SA2	Suicide attempt within 30 days of discharge	0	0.0	0	0.0	0	0.0
SC1	Physical assault	37	7.0	23	7.3	60	7.1
SC2	Sexual assault	18	3.4	8	2.5	26	3.1
SC3	Risk of injury to minor	5	0.9	4	1.3	9	1.1
SC4	Arson	7	1.3	0	0.0	7	0.8
SC5	Firearms	2	0.4	0	0.0	2	0.2
SC6	Hostage	1	0.2	0	0.0	1	0.1
SC7	Drug sale/distribution/possession	2	0.4	2	0.6	4	0.5
SC8	Homicide/manslaughter	3	0.6	0	0.0	3	0.4
SC9	Theft/Burglary	7	1.3	5	1.6	12	1.4
SC10	Other serious crime (specify)	14	2.6	9	2.8	23	2.7
TH1	Threats to agency	7	1.3	2	0.6	9	1.1
TH2	Threats to person	21	4.0	12	3.8	33	3.9
	TOTAL	**531**	**100.0**	**316**	**100.0**	**847**	**100**

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

Table 3a. Comparison of Statewide Incident Data for SFY16 & SFY17
Incident Related Data (Unduplicated Number of Critical Incidents)

		SFY16 Totals		SFY17 Totals		
		N	%	N	%	Change
	# Critical Incidents	**781**	**100.0**	**847**	**100.0**	**8.5%**
	Incident Category					
CL	Client Abuse Alleged	7	0.9	13	1.5	85.7%
DE	Death	362	46.4	374	44.2	3.3%
EV	Emergency Evacuation	4	0.5	14	1.7	250.0%
ES	Escape	0	0.0	0	0.0	0.0%
FN	Federal Notification	2	0.3	2	0.2	0.0%
PD	Loss/Damage	10	1.3	2	0.2	-80.0%
ME	Medical Event	75	9.6	118	13.9	57.3%
MC	Missing Client	38	4.9	30	3.5	-21.1%
OT	Other	35	4.5	25	3.0	-28.6%
SC	Serious Crime Alleged	116	14.9	147	17.4	26.7%
SA	Serious Suicide Attempt	89	11.4	80	9.4	-10.1%
TH	Threats	43	5.5	42	5.0	-2.3%
CL1	Physical abuse alleged	3	0.4	8	0.9	166.7%
CL2	Verbal Abuse Alleged	1	0.1	1	0.1	0.0%
CL3	Violation of patient rights w/ signif consequences alleged	2	0.3	4	0.5	100.0%
CL4	Breach of confidentiality w/ signif consequences alleged	1	0.1	0	0.0	-100.0%
DE1	Suicide	26	3.3	16	1.9	-38.5%
DE2	Homicide	4	0.5	2	0.2	-50.0%
DE3	Accident	29	3.7	17	2.0	-41.4%
DE4	Accidental overdose	63	8.1	84	9.9	33.3%
DE5	Medical Error	0	0.0	1	0.1	--
DE6	Illness, age, or medical reason	181	23.2	188	22.2	3.9%
DE7	Info pending/Insufficient Info	59	7.6	66	7.8	11.9%
ES1	PSRB Patient	0	0.0	0	0.0	0.0%
ES2	DOC Patient	0	0.0	0	0.0	0.0%
ES3	Competency Restoration	0	0.0	0	0.0	0.0%
EV1	Fire	2	0.3	10	1.2	400.0%
EV2	Bomb	2	0.3	0	0.0	-100.0%
EV3	Other Emergency Evacuation	0	0.0	4	0.5	--
FN1	Secret Service	0	0.0	1	0.1	--
FN2	FBI	1	0.1	0	0.0	-100.0%
FN3	Other Federal Notice	1	0.1	1	0.1	0.0%
PD1	Property Damage - Safety Issue	4	0.5	2	0.2	-50.0%
PD2	Property Damage	6	0.8	0	0.0	-100.0%
MC1	Missing inpatient, risk to self or others	2	0.3	1	0.1	-50.0%
MC2	Missing outpatient, risk to self or others	12	1.5	4	0.5	-66.7%
MC3	Missing person	24	3.1	25	3.0	4.2%
ME1	Accidental injury	17	2.2	27	3.2	58.8%
ME2	Accidental overdose (not resulting in death)	24	3.1	27	3.2	12.5%
ME3	Medical error/reaction	5	0.6	8	0.9	60.0%
ME4	Medical event - other	29	3.7	56	6.6	93.1%
OT1	Other Incident	35	4.5	25	3.0	-28.6%
SA1	Suicide attempt while active in program	89	11.4	80	9.4	-10.1%
SA2	Suicide attempt within 30 days of discharge	0	0.0	0	0.0	0.0%
SC1	Physical assault	42	5.4	60	7.1	42.9%
SC2	Sexual assault	24	3.1	26	3.1	8.3%
SC3	Risk of injury to minor	6	0.8	9	1.1	50.0%
SC4	Arson	1	0.1	7	0.8	600.0%
SC5	Firearms	9	1.2	2	0.2	-77.8%
SC6	Hostage	0	0.0	1	0.1	--
SC7	Drug sale/distribution/possession	8	1.0	4	0.5	-50.0%
SC8	Homicide/manslaughter	1	0.1	3	0.4	200.0%
SC9	Theft/Burglary	9	1.2	12	1.4	33.3%
SC10	Other serious crime (specify)	16	2.0	23	2.7	43.8%
TH1	Threats to agency	6	0.8	9	1.1	50.0%
TH2	Threats to person	37	4.7	33	3.9	-10.8%

Table 3b. Comparison of Statewide Incident Data for SFY13 through SFY17

Incident Related Data (Unduplicated Number of Critical Incidents)		SFY13		SFY14		SFY15		SFY16		SFY17	
		N	%	N	%	N	%	N	%	N	%
# Critical Incidents		**651**	**100**	**620**	**100**	**677**	**100**	**781**	**100**	**847**	**100**
Incident Category											
CL	Client Abuse Alleged	3	0.5	3	0.5	4	0.6	7	0.9	13	1.5
DE	Death	275	42.2	286	46.1	314	46.4	362	46.4	374	44.2
EV	Emergency Evacuation	5	0.8	5	0.8	5	0.7	4	0.5	14	1.7
ES	Escape	3	0.5	1	0.2	0	0.0	0	0.0	0	0.0
FN	Federal Notification	1	0.2	1	0.2	0	0.0	2	0.3	2	0.2
PD	Loss/Damage	4	0.6	8	1.3	6	0.9	10	1.3	2	0.2
ME	Medical Event	96	14.7	51	8.2	62	9.2	75	9.6	118	13.9
MC	Missing Client	22	3.4	23	3.7	26	3.8	38	4.9	30	3.5
OT	Other	25	3.8	19	3.1	24	3.5	35	4.5	25	3.0
SC	Serious Crime Alleged	105	16.1	106	17.1	127	18.8	116	14.9	147	17.4
SA	Serious Suicide Attempt	77	11.8	86	13.9	72	10.6	89	11.4	80	9.4
TH	Threats	35	5.4	31	5.0	37	5.5	43	5.5	42	5.0
Incident SubCategory											
CL1	Physical abuse alleged					1	0.1	3	0.4	8	0.9
CL2	Verbal Abuse Alleged	0	0.0	1	0.2	0	0.0	1	0.1	1	0.1
CL3	Violation of patient rights w/ signif consequences al	2	0.3	0	0.0	2	0.3	2	0.3	4	0.5
CL4	Breach of confidentiality w/ signif consequences all	0	0.0	0	0.0	1	0.1	1	0.1	0	0.0
DE1	Suicide	28	4.3	18	2.9	30	4.4	26	3.3	16	1.9
DE2	Homicide	5	0.8	2	0.3	4	0.6	4	0.5	2	0.2
DE3	Accident*					17	2.5	29	3.7	17	2.0
DE4	Accidental overdose					46	6.8	63	6.8	84	9.9
DE5	Medical Error*	26	4.0	20	3.2	1	0.1	0	0.0	1	0.1
DE6	Illness, age, or medical reason	116	17.8	149	24.0	172	25.4	181	23.2	188	22.2
DE7	Info pending/Insufficient Info	100	15.4	97	15.6	44	6.5	59	7.6	66	7.8
ES1	PSRB Patient	2	0.3	1	0.2	0	0.0	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	1	0.2	0	0.0	0	0.0	0	0.0	0	0.0
EV1	Fire	3	0.5	4	0.6	4	0.6	2	0.3	10	1.2
EV2	Bomb					0	0.0	2	0.3	0	0.0
EV3	Other Emergency Evacuation	1	0.2	0	0.0	1	0.1	0	0.0	4	0.5
FN1	Secret Service	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1
FN2	FBI	1	0.2	1	0.2	0	0.0	1	0.1	0	0.0
FN3	Other Federal Notice	0	0.0	0	0.0	0	0.0	1	0.1	1	0.1
PD1	Property Damage - Safety Issue*	4	0.6	5	0.8	5	0.7	4	0.5	2	0.2
PD2	Property Damage*	0	0.0	3	0.5	1	0.1	6	0.8	0	0.0
MC1	Missing inpatient, risk to self or others					1	0.1	2	0.3	1	0.1
MC2	Missing outpatient, risk to self or others	6	0.9	7	1.1	6	0.9	12	1.5	4	0.5
MC3	Missing person	11	1.7	14	2.3	19	2.8	24	3.1	25	3.0
ME1	Accidental injury*	9	1.4	7	1.1	13	1.9	17	2.2	27	3.2
ME2	Accidental overdose (not resulting in death)	9	1.4	13	2.1	20	3.0	24	3.1	27	3.2
ME3	Medical error/reaction	3	0.5	2	0.3	3	0.4	5	0.6	8	0.9
ME4	Medical event - other	75	11.5	30	4.8	26	3.8	29	3.7	56	6.6
OT1	Other Incident	25	3.8	18	2.9	24	3.5	35	4.5	25	3.0
SA1	Suicide attempt while active in program	76	11.7	86	13.9	70	10.3	89	11.4	80	9.4
SA2	Suicide attempt within 30 days of discharge	1	0.2	0	0.0	2	0.3	0	0.0	0	0.0
SC1	Physical assault	38	5.8	63	10.2	49	7.2	42	5.4	60	7.1
SC2	Sexual assault	29	4.5	12	1.9	31	4.6	24	3.1	26	3.1
SC3	Risk of injury to minor	7	1.1	4	0.6	7	1.0	6	0.8	9	1.1
SC4	Arson	2	0.3	2	0.3	2	0.3	1	0.1	7	0.8
SC5	Firearms	5	0.8	3	0.5	3	0.4	9	1.2	2	0.2
SC6	Hostage	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1
SC7	Drug sale/distribution/possession	2	0.3	2	0.3	7	1.0	8	1.0	4	0.5
SC8	Homicide/manslaughter	3	0.5	6	1.0	5	0.7	1	0.1	3	0.4
SC9	Theft/Burglary*					4	0.6	9	1.2	12	1.4
SC10	Other serious crime (specify)	19	2.9	14	2.3	19	2.8	16	2.0	23	2.7
TH1	Threats to agency*	3	0.5	0	0.0	4	0.6	6	0.8	9	1.1
TH2	Threats to person	32	4.9	31	5.0	33	4.9	37	4.7	33	3.9

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

Figure 2

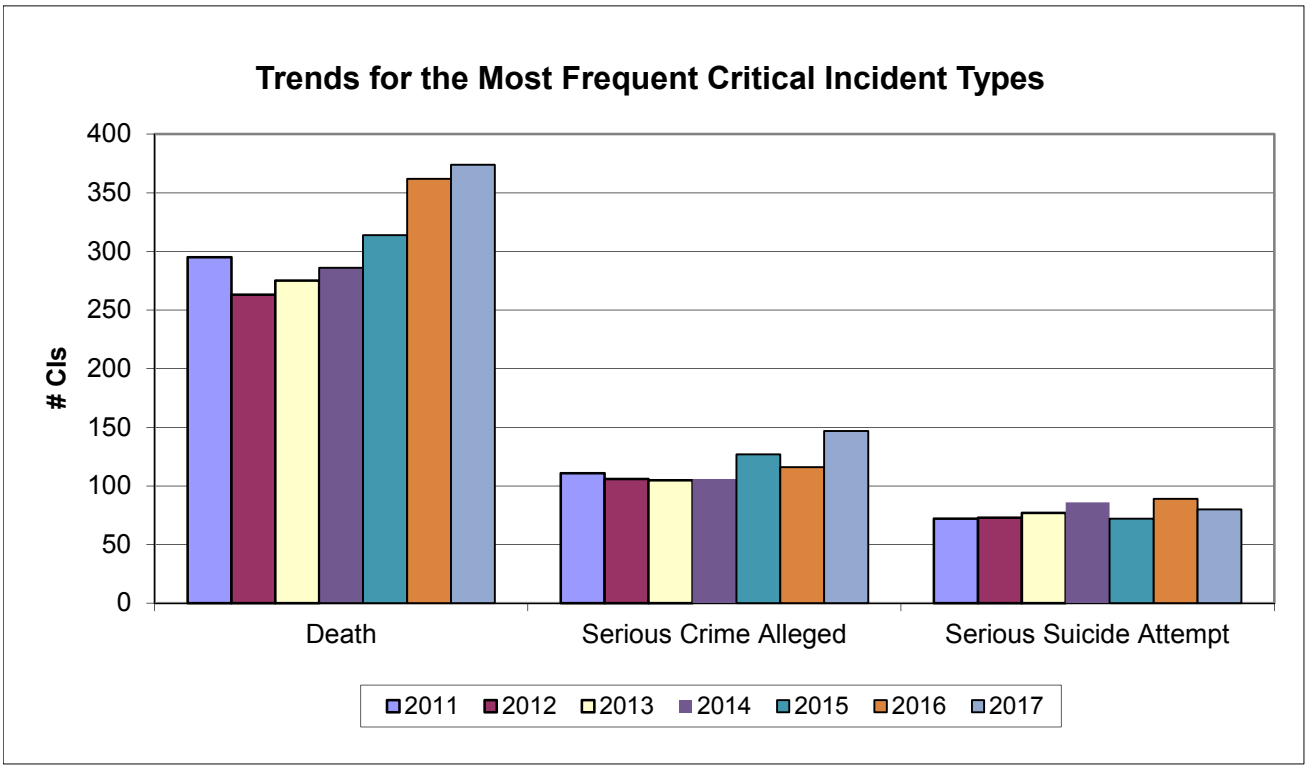

Trends for the Most Frequent Critical Incident Types
CIs
400
350
300
250
200
150
100
50
0
Death
Serious Crime Alleged
Serious Suicide Attempt
2011
2012
2013
2014
2015
2016
2017

Table 4a. Summary of SFY2017 Critical Incidents Categorized as Deaths

374 Deaths in SFY 17 (44% of all SFY17 Critical Incidents)

Death Incident SubCategory	N	%
Suicide	16	4.3
Homicide	2	0.5
Accident	17	4.5
Accidental overdose	84	22.5
Medical Error	1	0.3
Illness, age, or medical reason	185	49.5
Info pending/Insufficient Info	63	16.8

Demographics (Note: based on N=368 as 6 clients were not identified)

243 (65%) were male

283 (77%) were Caucasian, 49 (13%) were African American

53 (14%) were Hispanic

Average age =50.8 years (±13.7), age range 19-90 years

42 (11%) had a diagnosis of PTSD

0 deaths were coded as occurring at a state operated facility

4 deaths were due to medical events that started on IP Unit
(2 respitory/cardiac arrest, 1 choke, 1 aneurysm)

Co-Occurring Diagnosis	N	%
No COD	223	59.6
COD	151	40.4
Most Common MH/SA Diagnoses (from EDW)	**N**	**%**
Opioid Dependence	147	39.3
Alcohol Dependence	100	26.7
Bipolar/Major Depression	71	19.0
Tobacco Use Disorder	59	15.8
Cocaine Dependence	58	15.5
Schizophrenia/Schizophreniform/Schizoaffective	51	13.6
LOC at Time of Incident (most frequent listed)	**N**	**%**
MH OP	134	35.8
SA Methadone Maintenance	48	12.8
SA OP	31	8.3
MH CSP/RP	29	7.8
MH Social Rehab	23	6.1
Most Common Medical Diagnoses*	**N**	**%**
Other Condition	59	19.1
Heart Disease Problems	51	16.5
Diabetes	34	11.0
Cancer	30	9.7
COPD	30	9.7
Hepatitis	28	9.1
Asthma	24	7.8
Obesity	21	6.8
Chronic Pain	20	6.5
Cirrhosis/Liver Disease	18	5.8
GERD	15	4.9
Cause of Death*		
Other	87	28.2
Drug Overdose	74	23.9
Heart Disease	46	14.9
Cancer	33	10.7
Accidents	17	5.5
Suicide	12	3.9
Liver Diease	12	3.9
Chronic Lung Disease	8	2.6
Diabetes	4	1.3

* % based on 309 closed death incidents (may have multiple dx)

Table 4b. Summary of SFY2017 Critical Incidents Categorized as Deaths for Clients Under Age 50

152 Deaths in SFY 17 Under the Age of 50 (41% of all SFY17 Deaths)

Death Incident SubCategory	N	%
Suicide	11	7.2
Homicide	0	0.0
Accident	6	3.9
Accidental overdose	62	40.8
Medical Error	0	0.0
Illness, age, or medical reason	37	24.3
Info pending/Insufficient Info	36	23.7

Demographics

102 (67%) were male
119 (79%) were Caucasian, 16 (11%) were African American
22 (15%) were Hispanic
Average age = 37.1 years (±8.1), age range 19-49 years
45% of deaths were reported to occur at the client's residence
31 (20%) had a diagnosis of PTSD
3 deaths due to medical event at state op facility
1 choking, 1 aneurysm, 1 cardiac arrest

Co-Occurring Diagnosis	N	%
No COD	76	50.0
COD	76	50.0
Most Common MH/SA Diagnoses (from EDW)	**N**	**%**
Opioid Dependence	81	53.3
Alcohol Dependence	52	34.2
Cocaine Dependence	38	25.0
Bipolar/Major Depression	35	23.0
Tobacco Use Disorder	31	20.4
Cannabis Dependence	22	14.5
LOC at Time of Incident (most frequent listed)	**N**	**%**
MH OP	45	29.6
SA Methadone Maintenance	23	15.1
SA OP	22	14.5
Psychoactive Substance Dependence	11	7.2
Top 10 Most Common Medical Diagnoses*		
Other Condition	14	11.8
Obesity	8	6.7
Heart Disease Problems	8	6.7
Asthma	8	6.7
Hepatitis	7	5.9
Diabetes	6	5.0
Cirrhosis/Liver Disease	3	2.5
Cancer	2	1.7
Renal Failure/Kidney Disease	2	1.7
Hyperlipidemia	2	1.7
Cause of Death**		
Drug Overdose	50	42.7
Other	33	28.2
Suicide	9	7.7
Accidents	9	7.7
Heart Disease	7	6.0
Cancer	3	2.6
Liver Diease	2	1.7
Diabetes	2	1.7

* % based on 119 closed death incidents (may have multiple dx)
** % based on 117 deaths where this information was provided (<1% not shown)

Table 4c. Summary of SFY2017 Critical Incidents Categorized as Suicides

16 Suicides in SFY 17 (1.9% of all SFY17 Critical Incidents)

Demographics
12 (75%) were male
13 (81%) were Caucasian
Average age = 37.9 years (±14.8), age range 19-69 years
5 (31%) were by hanging; 4 (25%) were by overdose
8 (50%) occurred in the community
1 (6%) had a diagnosis of PTSD
0 incidents occurred at a state-operated facility

Co-Occurring Diagnosis	**N**	**%**
No COD	8	50.0
COD	8	50.0
Most Common MH/SA Diagnoses (from EDW)	**N**	**%**
Bipolar/Major Depression	6	23.1
Alcohol Dependence	3	11.5
Schizophrenia/Schizophreniform/Schizoaffective	2	7.7
Opioid Dependence	4	15.4
Cocaine Dependence	3	11.5
LOC at Time of Incident (most frequent listed)	**N**	**%**
MH OP	7	43.8
MH CSP/RP	3	18.8
SA OP	2	12.5

Figure 3

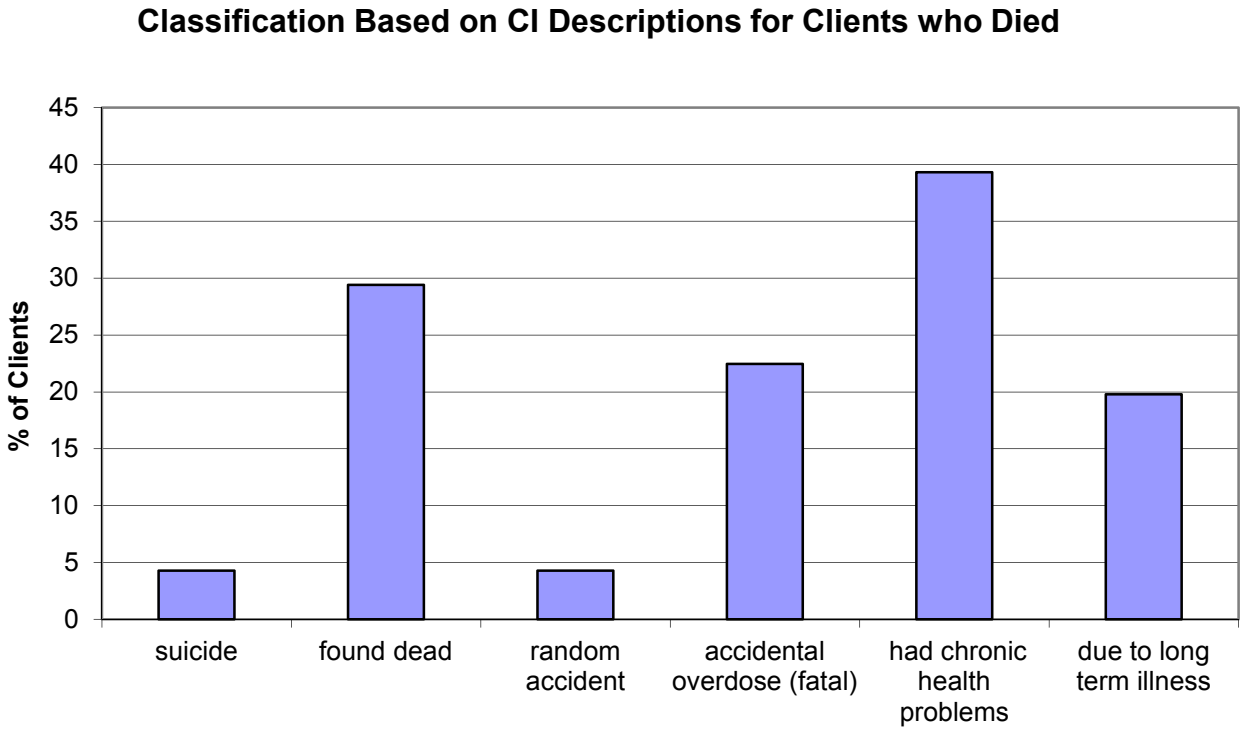
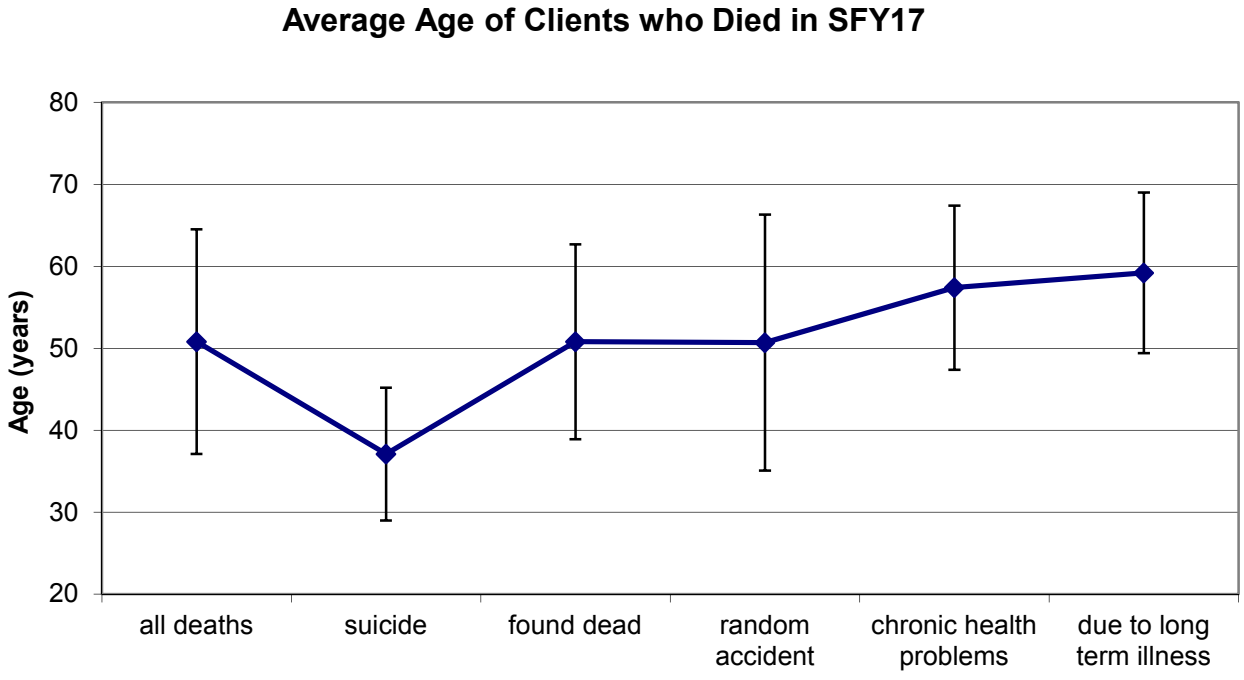


Figure 4



Comparison Between Clients with and without COD – SFY17

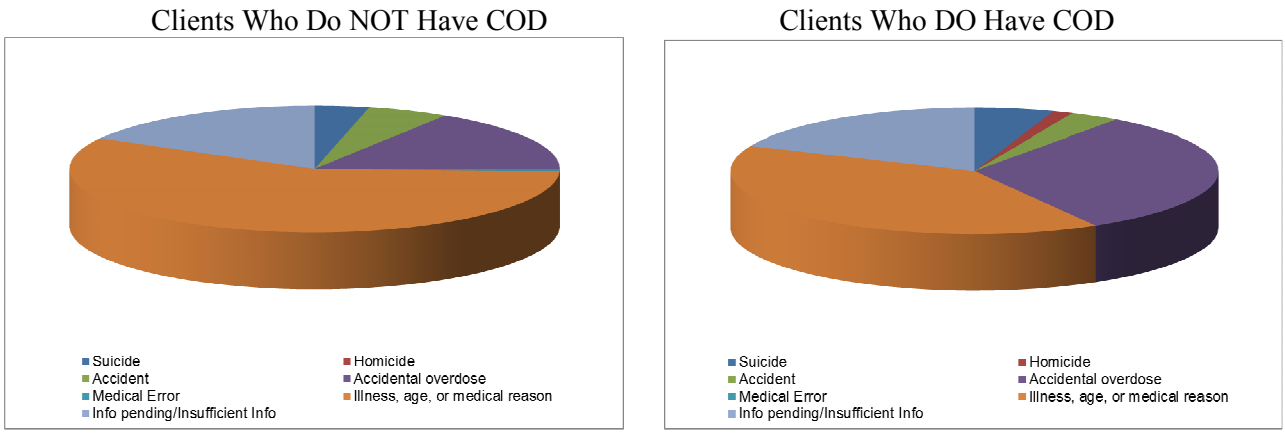


Figure 5. Death Subcategories

There were significantly more clients who had COD who had their death classified as due to accidental overdose 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 $p<.05$.

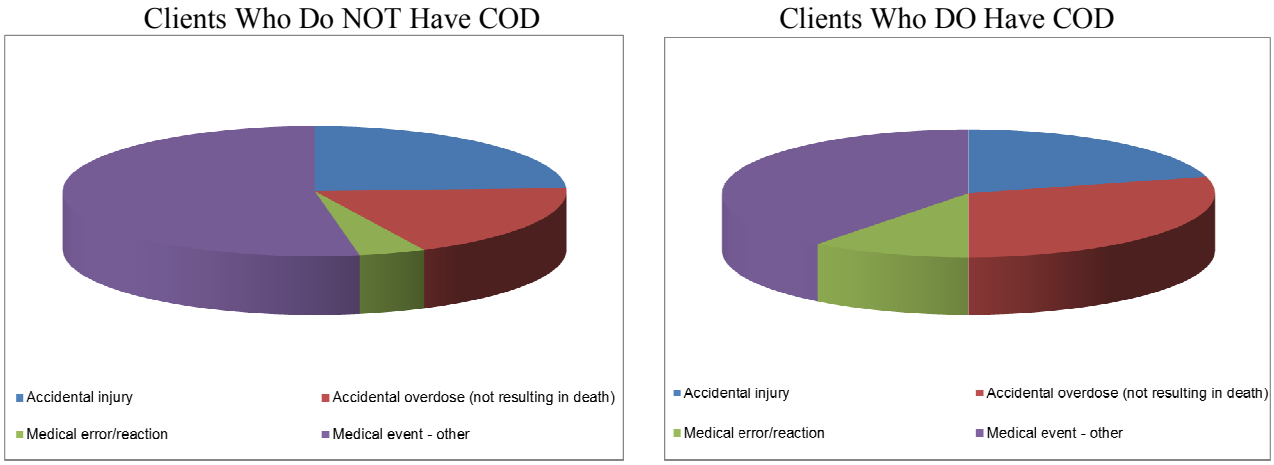


Figure 6. Medical Event Subcategories

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 $p<.05$.

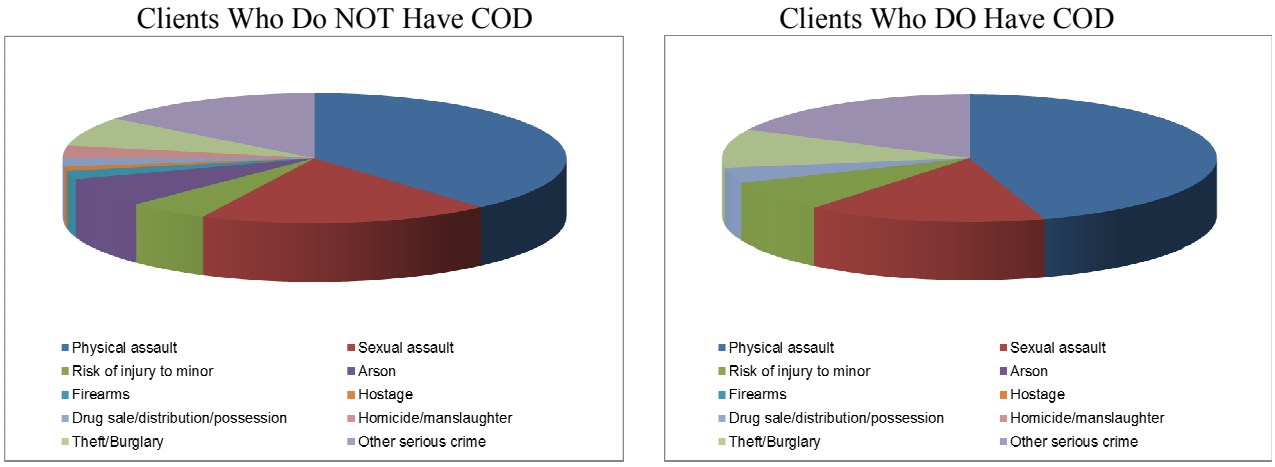


Figure 7. Serious Crime Alleged Subcategories

There was one 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: more clients who did not have COD were involved in an arson related event. Significance testing performed using chi-square and $p<.05$.

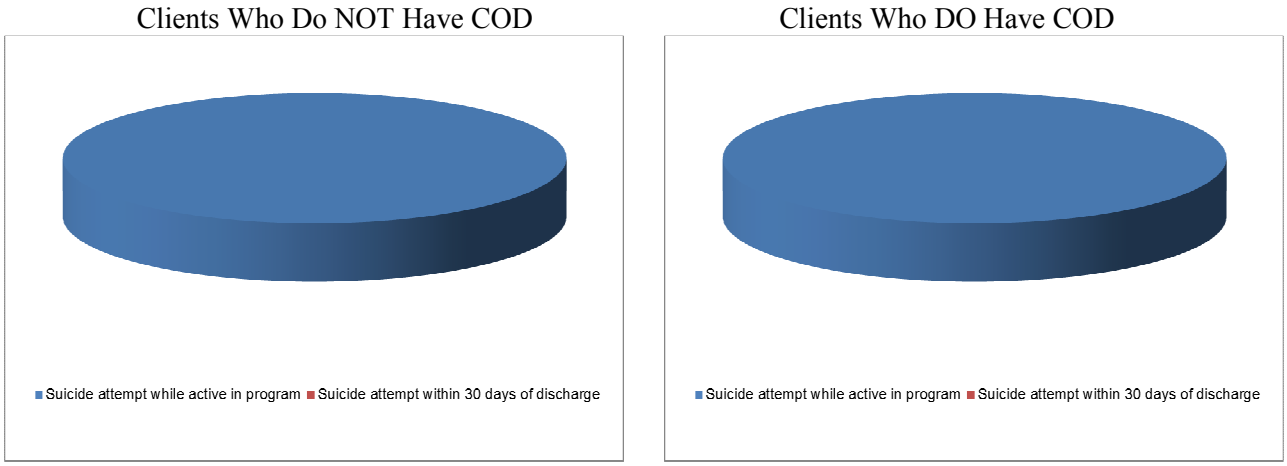


Figure 8. Serious Suicide Attempt Subcategories

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	4	0.5
Advanced Behavioral Health	7	0.8
Alliance For Living	2	0.2
BH Care (formerly Harbor and Birmingham)	30	3.5
Bridges Healthcare, Inc.	16	1.9
Capitol Region Mental Health Center	42	5.0
Catholic Charities of Fairfield County Inc.	2	0.2
Center for Human Development	10	1.2
Central Naugatuck Valley (CNV) Help Inc.	2	0.2
Charlotte Hungerford Hospital	3	0.4
Chemical Abuse Services Agency (CASA)	8	0.9
Chrysalis Center Inc.	19	2.2
Columbus House	2	0.2
Community Health Resources Inc.	94	11.1
Community Mental Health Affiliates	35	4.1
Connecticut Counseling Centers Inc.	1	0.1
Connecticut Mental Health Center	15	1.8
Connecticut Renaissance Inc.	4	0.5
Connecticut Valley Hospital	22	2.6
Connection Inc	27	3.2
Continuum of Care	3	0.4
Cornell Scott-Hill Health Corporation	11	1.3
Crossroad Inc	9	1.1
Danbury Hospital	1	0.1
Easter Seals of Greater Hrtfd Rehab Center Inc.	1	0.1
Farrell Treatment Center	4	0.5
Gilead Community Services Inc.	13	1.5
Goodwill of Western and Northern CT Inc.	1	0.1
Hands on Hartford	2	0.2
Hartford Behavioral Health	4	0.5
Hartford Dispensary	23	2.7
Inspirica Inc. (formerly St Luke's LifeWorks)	1	0.1
InterCommunity Inc.	9	1.1
Keystone House Inc.	9	1.1
Laurel House	4	0.5
Leeway Inc.	7	0.8
Liberation Programs	20	2.4
Liberty Community Services	1	0.1
LifeBridge Community Services (formerly FSW Inc)	1	0.1
Marrakech Day Services	1	0.1
Martin House	1	0.1
McCall Foundation Inc	10	1.2
Mental Health Connecticut	19	2.2
Mercy Housing and Shelter Corporation	1	0.1
Midwestern CT Council on Alcoholism (MCCA)	1	0.1
My Sister's Place	3	0.4
New Era Rehabilitation Center Inc.	8	0.9
New London Homeless Hospitality Center	2	0.2
New Milford Hospital	2	0.2
Norwalk Hospital	7	0.8
Office of the Commissioner	1	0.1
Perception Programs Inc	6	0.7
Prime Time House Inc.	2	0.2
Recovery Network of Programs	29	3.4
Reliance Health, Inc.	20	2.4
River Valley Services	9	1.1

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

Provider	N	%
Community Health Resources Inc.	94	11.1
United Services Inc.	54	6.4
Southwest Connecticut Mental Health System	47	5.5
Western Connecticut Mental Health Network	45	5.3
Capitol Region Mental Health Center	42	5.0
SCADD	38	4.5
Community Mental Health Affiliates	35	4.1
BH Care (formerly Harbor and Birmingham)	30	3.5
Recovery Network of Programs	29	3.4
Connection Inc	27	3.2
Hartford Dispensary	23	2.7
Connecticut Valley Hospital	22	2.6
Liberation Programs	20	2.4
Reliance Health, Inc.	20	2.4
Chrysalis Center Inc.	19	2.2
Mental Health Connecticut	19	2.2
Southeastern Mental Health Authority	17	2.0
Bridges Healthcare, Inc.	16	1.9
Connecticut Mental Health Center	15	1.8
Gilead Community Services Inc.	13	1.5
Wellmore (Morris Foundation Inc)	12	1.4
Wheeler Clinic	12	1.4
Cornell Scott-Hill Health Corporation	11	1.3
Center for Human Development	10	1.2
McCall Foundation Inc	10	1.2
Crossroad Inc	9	1.1
InterCommunity Inc.	9	1.1
Keystone House Inc.	9	1.1
River Valley Services	9	1.1
Sound Community Services Inc.	9	1.1
Chemical Abuse Services Agency (CASA)	8	0.9
New Era Rehabilitation Center Inc.	8	0.9
Advanced Behavioral Health	7	0.8
Leeway Inc.	7	0.8
Norwalk Hospital	7	0.8
Rushford Center	7	0.8
Perception Programs Inc	6	0.7
Ability Beyond	4	0.5
Connecticut Renaissance Inc.	4	0.5
Farrell Treatment Center	4	0.5
Hartford Behavioral Health	4	0.5
Laurel House	4	0.5
St. Vincent DePaul Mission of Waterbury Inc.	4	0.5
Charlotte Hungerford Hospital	3	0.4
Continuum of Care	3	0.4
My Sister's Place	3	0.4
St. Mary's Hospital Corporation	3	0.4
Alliance For Living	2	0.2
Catholic Charities of Fairfield County Inc.	2	0.2
Central Naugatuck Valley (CNV) Help Inc.	2	0.2
Columbus House	2	0.2
Hands on Hartford	2	0.2
New London Homeless Hospitality Center	2	0.2
New Milford Hospital	2	0.2
Prime Time House Inc.	2	0.2
St. Vincent DePaul Place Middletown Inc.	2	0.2

Table 5a. Agencies Reporting CIs (Alphabetical order)

Provider	N	%
Rushford Center	7	0.8
SCADD	38	4.5
Sound Community Services Inc.	9	1.1
Southeastern Mental Health Authority	17	2.0
Southwest Connecticut Mental Health System	47	5.5
St. Mary's Hospital Corporation	3	0.4
St. Vincent DePaul Mission of Waterbury Inc.	4	0.5
St. Vincent DePaul Place Middletown Inc.	2	0.2
Supportive Environmental Living Facility Inc-SELF	1	0.1
United Community and Family Services	2	0.2
United Services Inc.	54	6.4
Vinfen Corporation of CT, Inc	1	0.1
Wellmore (Morris Foundation Inc)	12	1.4
Western Connecticut Mental Health Network	45	5.3
Wheeler Clinic	12	1.4
Yale University-Behavioral Health	2	0.2
Total	**847**	**100.0**

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

Provider	N	%
United Community and Family Services	2	0.2
Yale University-Behavioral Health	2	0.2
Connecticut Counseling Centers Inc.	1	0.1
Danbury Hospital	1	0.1
Easter Seals of Greater Hrtfd Rehab Center Inc.	1	0.1
Goodwill of Western and Northern CT Inc.	1	0.1
Inspirica Inc. (formerly St Luke's LifeWorks)	1	0.1
Liberty Community Services	1	0.1
LifeBridge Community Services (formerly FSW Inc)	1	0.1
Marrakech Day Services	1	0.1
Martin House	1	0.1
Mercy Housing and Shelter Corporation	1	0.1
Midwestern CT Council on Alcoholism (MCCA)	1	0.1
Office of the Commissioner	1	0.1
Supportive Environmental Living Facility Inc-SELF	1	0.1
Vinfen Corporation of CT, Inc	1	0.1
Total	**847**	**100.0**