REPORT OF THE
OFFICE OF THE INSPECTOR GENERAL
FOR THE DEPARTMENT OF MENTAL HEALTH, MENTAL
RETARDATION AND SUBSTANCE ABUSE SERVICES

Annual Report - 2000

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 20

COMMONWEALTH OF VIRGINIA
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Executive Summary

This Annual Report is prepared in response to Chapter 927 of the 2000 Acts of the Assembly. This legislation codified the Office of Inspector General. A portion of this legislation requires that an annual report "concerning activities, inspections, reviews, and recommendations for the General Assembly" be prepared.

The Office of the Inspector General (OIG) to the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) was established to function as an independent oversight agent offering an additional "safeguard" for a very vulnerable segment of the population. The OIG was designed to monitor and to provide independent clinical evaluation regarding the quality of care as delivered by the mental health and mental retardation state facilities in Virginia.

The Mission *of the Office of the Inspector General is to challenge the mental health, mental retardation and substance abuse system to provide quality services for Virginians that are consistent with contemporary clinical guidelines and contemporary financial management strategies.*

The OIG is a brand new office in Virginia State Government. As such, this report relates the structure set up in order to develop a reasonable approach toward this very broad duty. To this end, the first two chapters describe the history of the OIG including originating legislation.

The third Chapter outlines the operational activities undertaken in order to maintain this office. The OIG functions with a very small number of staff and modest resources. The professionalism and dedication of our staff, as well as genuine support from Governor Gilmore, consumers and other state officials have amplified the efficacy of this office.

The fourth Chapter defines the types of inspections developed by the OIG. This Chapter outlines the numbers of inspections over the last twelve months, and describes the nature of several of the facility specific findings established over the past year.

Chapter five outlines some of the challenges facing the entire facility system in Virginia. Reference is made to two major problems facing the long term management of care within these facilities.

The final chapter describes several findings of merit and findings of concern that face the public Mental Health and Mental Retardation facility system in Virginia. Findings of concern include issues regarding staffing in many of our facilities as well as ongoing risk of violence and assault. A third finding of concern is the aging infrastructure within the facility buildings. Findings of merit include the continuing successful reduction of seclusion and restraint use in facilities in Virginia. Additionally, facilities in Virginia have made tremendous strides in developing very progressive and exciting psychosocial treatment centers that offer active treatment to inpatient consumers. The third finding of merit that is common throughout the facility system in Virginia is the touching level of compassion and dedication that is displayed by many staff who have devoted their careers to working with the consumers residing within these facilities.

In conclusion, I would like to thank Governor Gilmore and the members of the General Assembly for their support over this the first full year of operation for the Office of Inspector General. It is my hope that this report has provided useful information summarizing the Office's activities over the last year. I look forward to the opportunity to serve the citizens of Virginia in the upcoming year. I anticipate another busy year in 2001, and hope that I am able to continue to contribute valuable information regarding the quality of clinical care within the public funded system of mental health, mental retardation and substance abuse services in the Commonwealth of Virginia.

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Chapter 1: Introduction

The Office of the Inspector General (OIG) was established by Governor James S. Gilmore III to function as an independent oversight agent offering an additional "safeguard" for a very vulnerable segment of the population. The Governor established several administrative priorities as an expression of his strong commitment to reform Virginia's public funded mental health, mental retardation and substance abuse service delivery system. The OIG was designed to monitor and to provide independent clinical evaluation regarding the quality of care as delivered by the mental health and mental retardation state facilities in Virginia.

Our Vision *is that each consumer of services provided through the delivery system of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is afforded quality care that is individualized, meaningful and provided in a safe and effective manner improving their basic quality of life.*

The Mission *of the Office of the Inspector General is to challenge the mental health, mental retardation and substance abuse system to provide quality services for Virginians that are consistent with contemporary clinical guidelines and contemporary financial management strategies.*

In striving to create an atmosphere conducive to our vision and mission, it was necessary to formulate goals that establish a gold standard for the Office to achieve each year. These include:

1. To identify and report on areas of strengths and weaknesses in the delivery of services within the individual facilities that impact the quality of care.

2. To make recommendations for improvement of care through the production of Inspection Reports and review of subsequent corrective action plans.

3. To ensure that the OIG is accessible and responsive to persons served by the facilities, their families and, other interested groups and organizations and staff.

The intent of this Annual Report is to inform members of the General Assembly of the accomplishments, challenges and advances in the past year for the OIG. Additionally, this Office intends to use this report as an informative source for the citizenry that has an interest in mental health, mental retardation or substance abuse facilities.

The Office has been involved in inspections, investigations and studies that have and will continue to be used to enhance the care provided to the consumers of DMHMRSAS. This document will provide general and specific information that was analyzed, gathered and studied by the Office of the Inspector General. The information from the aforementioned activities has been synthesized into reports that note both findings of merit and findings of concern for the review of the Governor.

This Annual Report also intends to demonstrate the developments within the office that have been designed to promote increased accountability and efficacy for the Inspector General.

Chapter 2: The Office is Created in the Virginia Code

The OIG was established by Governor James S. Gilmore, III in January 1999 to provide consultation on quality of care issues in the statewide facility system. The office was established as a pilot program that was initiated through a budget amendment. As the office demonstrated its value and potential, It received bipartisan support from the General Assembly and was permanently codified pursuant to chapter 927 of the 2000 Acts of the Assembly. Delegate Bloxom was the chief patron to the legislation creating the Office of the Inspector General.

HB-1034 - Bloxom

§ 2.1-815. Office created; appointment of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services. *– There is hereby created the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services. The Inspector General for Mental Health, Mental Retardation and Substance Abuse Services shall be appointed by the Governor, subject to the confirmation by the General Assembly, and report to the Governor. The Inspector General for Mental Health, Mental Retardation and Substance Abuse Services shall be appointed initially for a term that expires one full year following the end of the Governor's term of office, and, therefore the term shall be for four years. Vacancies shall be filled by appointment by the Governor for the unexpired term and shall be effective until thirty days after the next meeting of the ensuing General Assembly and, if confirmed, therefore for the remainder of such term. (2000, c.927.)*

Governor Gilmore kept his campaign promise to increase the quality and accountability within the state mental health, mental retardation and substance abuse service system by appointing a person with credentials compatible with the responsibility inherent in the position of Inspector General. Governor Gilmore introduced his selection for this Office by stating his confidence in her background and abilities.

"Dr. Anita Smith Everett is a highly-qualified and well-respected individual who possesses valuable insight and vast clinical knowledge in her field. I have the utmost confidence in Dr. Everett's abilities, and I firmly believe her experience will serve her well as she inspects and provides oversight of the 15 mental health and mental retardation facilities in Virginia."

From the onset the Inspector General firmly believed that this Office could be both productive and effective through the creative integration of technology with a small core of professional, dedicated and motivated staff. Staff were selected to provide a combination of clinical and operational expertise through prior experience in both private and publicly funded systems of care.

CHAPTER 3: § Enacting 2.1 – 816 Developing the M[illegible]

In this chapter of the OIG Annual Report 2000, the activities that were performed in order to implement the following legislation are discussed.

The following is the code citing which outlines the powers and duties of the Office of Inspector General:

§2.1-816 Powers and duties of Inspector General for Mental Health, Mental Retardation and Substance Abuse Services. *– The Inspector General for Mental Health, Mental Retardation and Substance Abuse Services shall have the following Powers and duties.*

1. *To operate and manage the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services and to employ such personnel as may be required to carry out the provisions of this chapter.*
2. *To make and enter contracts and agreements as may be necessary and incidental to carry out the provisions of this chapter, and to apply for and accept grants from the United States government and agencies and instrumentalities thereof, and any other source, in furtherance of the provisions of this chapter.*
3. *To prepare reports for the Governor concerning inspections and reviews of facilities.*
4. *To prepare a report by December 1 concerning activities, inspections, reviews and recommendations for the General Assembly. (2000, c.927.)*

The office structure, headed by the Inspector General has been enhanced by the addition of two permanent staff members, the Director of Investigations, Cathy Hill, and the Operations Manager, Heather Glissman.

Cathy Hill, M.Ed. brought a wide range of clinical and administrative experience to the office. In her role as Director of Inspections, she coordinates and plans the actual facility inspections. The addition of

Ms. Hill has greatly facilitated the number and quality of facility inspections able to be completed this past year.

Heather Glissman has been a significant addition to this Office. Ms. Glissman has a background and interest in government operations. As the *Operations Manager*, she facilitates and coordinates the operational activities of the office. She functions as the project manager for the special projects that this office has conducted over the last year.

In addition to full time staff, professional and consumer consultants were hired to compliment the expertise offered by the permanent staff. It is a value held by the Office of the Inspector General that consumer can make valuable contributions to the assessment of the quality of services within our state hospitals and facilities.

A pilot project was initiated wherein persons who have been inpatients of the facility system are trained to become consultants to the Office of Inspector General inspection teams. These consumer consultants were chosen based on geographic location, skills and their experience with

the mental health system. There were 26 applications of which 7 consumers were chosen. The consumers were then trained by OIG staff regarding their responsibilities as consultants to the Office. They are compensated on a job-by-job basis. The information that consumer consultants collect and provide is key to the process of recommendations for improvements to quality care.

With the new staff, the Office was able to: incorporate additional special projects; collaborate on projects between the OIG and other state agencies; increase the ability to review and comment on documents that directly effect patient care; and accept more invitations to participate in local and statewide conferences and forums.

In order to facilitate the development of the OIG, a statewide office structure was developed. This structure consists of work-sites in Richmond and Staunton. The Department of Rehabilitation Services at the Woodrow Wilson Rehabilitation Center in Staunton has graciously loaned space to the Office of Inspector General. The Department of Forestry and the University of Virginia have also provided valuable temporary workspace near the Charlottesville area. Additionally, the Department of Mental Health, Mental Retardation and Substance Abuse services (DMHMRSAS) as well as Health and Human Resources staff have facilitated the development of the Office of Inspector General by providing office space and other support.

The Office of the Inspector General is responsible for providing consultation to the management of the fifteen DMHMRSAS facilities across the Commonwealth. This system of remote work-sites coupled with the use of regional consultants aids the success and efficiency of this office.

In a broad sense, it is the intent of this Office to create an inspection process that results in reports that provide valuable information to the DMHMRSAS Central Office as well as the administration at each facility. The Inspector General reports directly to the Governor and the Secretary of Health and Human Resources. Governor Gilmore, as the highest ranking elected official in the Commonwealth of Virginia, is accountable to the citizens of Virginia and thereby to the patients within the facilities.

The position of the Office of Inspector General, which is external to the operations of the DMHMRSAS, provides an unprecedented degree of accountability to a system previously challenged by the federal government. Since the early 1990's the Department of Justice has identified a pattern of substandard care in five of the fifteen mental health hospitals and mental retardation facilities operated by the Commonwealth of Virginia. There have been no new cases filed within the last two years.

Accessibility is defined as a term that donates: ease of use, openness, and user friendliness. These terms accurately define the intent of the office's goal #3, *To ensure that the Office of Inspector General is accessible and responsive to persons served by the facilities, their families and other interested groups and organizations as well as facility employees.*

In order to ensure this goal, the Office has implemented several strategies: 1.) Remote work sites which provide a broad base for local contact; 2.) Open door policy in our Richmond office, which provides constant contact for persons seeking information or assistance from the Office;

3.) Providing patients and staff access, as requested, to OIG staff during visits to facilities for those that seek information; 4.) Additionally, the Office has created a website that provides background information, links to additional services, access to published reports, information on staff and a way to contact the office.

*Chapter 4: §*2.1-817 Developing the process

The following is from the code of Virginia, and further specifies the powers and duties of the OIG. This chapter, chapter 4, outlines the activities undertaken within the last year to perform these duties.

§ 2.1-817. Powers and duties of the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services. *-- The Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services shall have the following powers and duties.*

1. *To provide oversight and conduct announced and unannounced inspections of the facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services on an ongoing basis, in response to specific complaints of abuse, neglect, or inadequate care, and as a result of monitoring of serious-incident reports and reports of abuse, neglect, or inadequate care or other information received, and to make recommendations to the Governor, the Secretary of Health and Human Resources and the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services on methods to improve the quality of care in such facilities.*
2. *To access any and all information related to the delivery of services, including confidential patient or resident information, to patients or residents in facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Such patient or resident information shall be maintained by the Office of the Inspector General as confidential in the same manner as is required by the state agency from which the information was obtained.*
3. *To monitor any reports prepared by the Department of Mental Health, Mental Retardation and Substance Abuse Services and critical incident data collected by the Department of Mental Health, Mental Retardation and Substance Abuse Services in accordance with regulations promulgated under §37.1-84.1 to identify issues related to quality of care seclusion and restraint, medication usage, abuse and neglect, staff recruitment and training, and other systemic issues.*
4. *To monitor and participate in the promulgation of regulations by the State Mental Health, Mental Retardation and Substance Abuse Services Board.*

5. *To receive reports, information and complaints from the Department for the Rights of Virginians with Disabilities concerning issues related to quality of care and to conduct independent reviews and investigations. (2000, c. 927.)*

The Office of the Inspector General has adopted several different strategies for identifying the strengths and weaknesses in the statewide facility system of care. These include but are not limited to:

- Conducting announced and unannounced on-site inspections
- Submitting inspection reports and reviewing written plans of correction
- Identifying and conducting special reports

- Reviewing departmental instructions and other documents that effect the care provided within the DMHMRSAS delivery system
- Active participation in meetings that address clinical issues.

INSPECTIONS

During the first year of its operation, the Office of the Inspector General created a system for conducting inspections in the facilities. Three inspection formats were developed and one of the formats acts as the basis for each site visit. This review process enables the Office to gain an understanding of the clinical and operational approaches to care and treatment offered at each facility as an individual entity while gaining an awareness of both findings of merit and findings of concern that are common among the facilities. By using a standardized process with defined categories, the Office of the Inspector General has been able to develop a statewide systems perspective. Concerns that transcend a singular program or facility are identified and recommendations with a broader impact are formulated.

This external review process impacts on multiple levels ranging from the care of the individual to systems reform. Citizens of Virginia with mental disabilities benefit by having facility system deficiencies identified and corrected. The management of the facilities benefit from having access to an independent "second opinion" which can point toward areas of needed quality improvement and/or provide recognition for a job well done. The Department of Mental Health, Mental Retardation and Substance Abuse Services benefits by having access to an independent resource for clinical consultation.

The Office continued the process of conducting on-site inspections at the facilities in the year 2000. Eighteen inspections were conducted during this calendar year. The three inspection formats are primary inspections, secondary inspections and snapshot inspections.

Primary Inspections: In 2000, four primary Inspections were conducted. Primary inspections are routine unannounced comprehensive visits to the Mental Health and Mental Retardation facilities operated by the Commonwealth of Virginia. The inspections typically last for several days. The purpose of this inspection is to evaluate components of the quality of care delivered by the facility and to make recommendations regarding performance improvement.
There are eight categories for review common to each primary inspection. They are:

1. **Treatment of Patients with Dignity and Respect** – This is an important area for consideration as it provides an awareness of staffs' attitude regarding the provision of care for patients and recognizing them as consumers. A review of the functioning of the human rights advocacy system within the facility and the nature of the issues addressed provide an additional indicator of treatment with dignity and respect.

2. **Use of Seclusion and Restraint** – The reduction in the use of seclusion and restraint is a national issue. In Virginia, a statewide effort has been underway to reduce the use of these unpopular and at times unsafe and inhumane forms of clinical interventions.

3. **Active Treatment** – This category focuses on the area of treatment planning. This includes assessment of the effectiveness of the treatment teams in actively engaging persons in their own care as well as the availability of active psychosocial rehabilitation treatment programs and services. All of the facilities currently offer a form of psychosocial rehabilitation programming. Treatment planning teams are observed as a component of these inspections. Teams should have active participation from a variety of professionals and should function professionally and efficiently together with the patient to form a workable treatment plan.

4. **Access to Acute Medical Care** – This is a critical area for review because of the common co-occurring medical problems of these populations. Untimely intervention or limited access to appropriate medical expertise can result in harm to patients through undiagnosed problems.

5. **Treatment Environment** — Tours are conducted of the facility treatment areas. Observations are made of the state of the physical plant and ways in which the environment contributes both positively and negatively to the therapeutic process. Issues of safety relevant to the physical plant are typically identified in this section.

6. **Relationship with Academic Institutions** – Involvement with academic programs can provide a facility with a link to state-of-the-art practices and standards of care. Students benefit from gaining the experience of working in their chosen fields. Patients benefit from having increased opportunities to interact with a variety of persons with mental disabilities in a personalized manner. Reviewing the extent of a facility's willingness to be connected to academic environments provides a means for demonstrating its progressiveness.

7. **Administrative projects** – Each facility has Divisions of Risk Management and Quality Assurance. A review of notable projects provides information on both operational and clinical priorities established by each. Concerns addressed by either division have the potential for effecting performance improvement.

8. **Special Facility Challenges** – Although there are many commonalties among the facilities, each is unique. A focus on the special challenges as defined by each facility provides a clearer understanding of how the facility views itself in relationship to its locality, the delivery system as a whole and the consumers it serves.

Secondary Inspections: There were nine secondary inspections completed during this annual reporting period. Secondary Inspections are inspections performed secondary to the identification of a potential serious problem which may represent a pattern of substandard care and which may have a direct and immediate effect on the health, safety, or welfare of patients. The purpose of these inspections would be to evaluate any potential problems and make recommendations to the program for performance improvement. These may be either announced or unannounced.

Snapshot Inspections: There were five Snapshot inspections completed this past year. Snapshot Inspections are brief inspections that are by definition always unannounced and occur after hours and on weekends.

These inspections review the activity of the patients, numbers of what kind of staff are present and general condition of the building. Snapshot Inspections may also serve as a mechanism to follow up on issues of particular concern at a facility. Consumer consultants have proven to be very helpful with this form of inspection.

INSPECTION REPORTS

Each inspection results in a report that is submitted to the Governor and the Secretary of Health and Human Resources. The reports are forwarded to the facility for review and comment. An action plan is created by DMHMRSAS in response to each inspection report. Secretary Allen and the Inspector General then review this action plan. For many of the reports, particularly those associated with secondary inspections, information is gathered from and exchanged with the facility peer review committee.

The inspection reports themselves are divided into one or more findings related to a specific subject area. Each finding is followed by a corresponding background and recommendation. The background contains information that supports the finding. The recommendations are general in nature such that the facility itself is expected to develop a specific feasible mechanism for addressing the issue brought up in the finding.

SPECIAL REPORTS

Special reports are reports designed to address systematic issues that are of direct concern to the Mental Retardation and Mental Health consumer community. Each year, the Office of Inspector General anticipates completing one or more special reports. The subjects for these reports would be developed following consultation with a variety of stakeholders that could include the State Board of MHMRSAS, DMHMRSAS, Advocates, Legislators, Commissioners, Consumers, DRVD, the Governor, the Secretary of Health and Human Resources and relevant private providers. These reports would compare available national trends and data with practices in Virginia. Two special reports were conducted during the year 2000.

Death Study – This study reviewed all the deaths that occurred in the facilities during the thirteen-month period from October 1, 1998 to October 31, 1999.

A retrospective chart review was completed on 127 patients who died while admitted to a Virginia mental health or mental retardation facility during the thirteen-month study period. The purpose of the review was to study in some depth the clinical circumstances of each of these deaths. Information from this study is currently being assessed by the OIG.

Discharge Study – The Southeastern Rural Mental Health Research Center (SRMHRC) at the University of Virginia under the auspices of Inspector General for Mental Health conducted this study of patients discharged from public inpatient psychiatric facilities in Virginia. The study was designed to examine the discharge placement process and outcomes. Results from this study are currently being analyzed by OIG staff.

THE REVIEW OF DOCUMENTS

The Office of the Inspector General has provided detailed comments regarding a number of documents that will guide the care and treatment of consumers. Examples of those reviewed during this past year are:

DMHMRSAS Departmental Instructions regarding:

Seclusion and Restraint use in Mental Hospitals
Restraint in Mental Retardation Facilities
Suicide Precautions
Active Treatment
Treatment Planning
Proposed Human Rights Regulations
Medicaid Waiver Emergency Regulations

KEEPING ABREAST of NATIONAL and LOCAL TRENDS

The Office of the Inspector General has actively participated in meetings designed to keep abreast of current practices in the care and treatment available in the entire delivery system but most particularly the facility system. The Office has become increasingly active with participation in national meetings. These meetings provide valuable information and opportunities for exchange of ideas and exposure to successful programs developed in other states and countries. It is an important cornerstone of this office to provide an enduring challenge to the quality of clinical care in the facility system in Virginia

The Inspector General received certification from the *American Association of Inspector's General* in June of this year. The intensive training that was required to receive this certification expanded the knowledge of current trends in inspections, investigations, and audit practices in other state Inspector General Offices.

As the census of state hospitals continues to decline, the intensity of the patients remaining within the state hospital is increasing. Thus, the management of aggression is an ever-challenging clinical situation. Atascadero State Hospital in California was visited for several days in order to observe the mechanisms employed at this large forensic hospital. This facility has received national recognition and is considered to be *state of the art* in dealing with the management of aggressive and assaultive behavior among patients. This visit was extremely

valuable and provided background for a number of recommendations that have been made in subsequent inspection reports.

In June of 2000, the Director of Inspections, Cathy Hill attended the National Association for the Mentally Ill (NAMI) annual conference. From this, Ms. Hill was able to increase our working knowledge of this important national advocacy group and their philosophy on issues such as seclusion and restraint; community based care, the role and status of states in the provision of mentally ill/mentally retarded systems of care throughout our nation.

In October of this year the Inspector General attended the American Psychiatric Association, Institute on Psychiatric Services meeting in Philadelphia. This highly respected Association meets annually to exchange information on public mental health services and trends. The Inspector General was able to join with the rest of the Association in the commendation of Eastern State Hospital. At this meeting, Dr. Koz, Medical Director at Eastern State Hospital in Williamsburg, Virginia received a *Certificate of Significant Achievement* for the development and management of the psychosocial treatment mall at this institution. Virginia was also well represented at this meeting by Dr. Jabapoor, the Medical Director at Catawba Hospital in Catawba, Virginia. Dr. Jabapoor is the co-chair of the American Psychiatric Association Caucus for state hospital psychiatrists. Additionally, Dr. Everett serves on the National Board of the American Association of Community Psychiatrists. This group is very active in promoting quality care in public systems of care throughout the United States, and holds its annual meeting in conjunction with the American Psychiatric Association, Institute of Psychiatric services.

In November of this year, Dr. Everett attended the American Psychiatric Association Assembly for which she is an elected assembly representative from Virginia. Her participation in this event enabled her to increase her knowledge and awareness of emerging trends in service delivery. As a member, she was able to not only dialogue with nationally recognized experts regarding issues that effect the delivery system in Virginia but she was also able to provide information regarding efforts in this state.

The Inspector General accompanied Secretary of Health and Human Resources, Claude Allen, and staff from DMHMRSAS to a children's mental health policy summit in Austin, Texas. This event was sponsored and staffed by the federal government through Substance Abuse and Mental Health Administration (SAMHSA). This summit provided a unique opportunity for the Office of the Inspector General to contribute in a proactive fashion to the planning stages of a new mental health focus on children as opposed to critiquing the system or policy development after the development.

Within Virginia, Dr. Everett attended several physician roundtables throughout the state that were designed to enhance communication between physicians in state hospitals and community systems of care.

Medical Grand Rounds talks on the activities of the Office of Inspector General were given by Dr. Everett at The Medical College of Virginia, The University of Virginia, Western State Hospital in Staunton, Virginia and East Tennessee State University College of Medicine this year.

A number of opportunities were provided for the Inspector General and staff to interact with stakeholders. These included discussions with the Association of Retarded Citizens staff, Parents of the Institutionalized Retarded, the Virginia Alliance for the Mentally Ill, The Department for Mental health, Mental Retardation and Substance Abuse Services Board.

Chapter 5: Facility System Overview

The State Mental Health Hospital and Mental Retardation Training Centers in Virginia have a long and rich history that spans over two hundred and twenty years. In an effort to provide safety for all citizens, and humane treatment for those requiring it, Virginians have invested a great deal of time, energy and money in institutional care. At different points in history, Virginia has been very much in the forefront with institutional care. Eastern State Hospital in Williamsburg, Virginia was the first public facility in The United Sates designated for the care of the mentally ill. Shortly thereafter, Western State Hospital in Staunton, Virginia was opened. This facility offered the best care available in its time, and is referred to in contemporary textbooks as an exemplary hospital early in the nineteenth century.

During the era of development of separate institutions for the mentally retarded, Virginia built the largest facility infrastructure in the nation dedicated to the care of the mentally retarded. At its peak, "Lynchburg Colony", or Central Virginia Training Center, as this facility is now called, served 3600 residents including young children and adults.

Nationally, the peak census in institutions occurred in 1955. At this time in history, as had been the case for over one hundred and fifty years, institutional care was a "best practice" for those with serious mental illness and mental retardation. In 1955, there were over 500,000 people in the United States who were residing in mental institutions. This was considered to be the best way to provide for the safety and treatment of individuals with mental illness and mental retardation. Virginia provided care to thousands of individuals in its institutions.

For many reasons, including the development of effective antipsychotic medications, civil rights awareness, and case management technologies, by the mid 1960's there became increasing interest in emerging and effective models for the provision of safe care to individuals in community settings. Virginia kept building institutions such that in the 1970's, at least six new institutions were developed and built. This brought the total number of facilities up to 16.

With the long and rich history of care through institutions in Virginia, there was strong resistance to the idea of greater community placement, even as the Federal Government opened a series of investigations in the late 1980's and early 1990's alleging substandard care within our institutions. Within the last several years, the care provided within the facilities in Virginia has improved dramatically. Indeed, no new cases have been filed in the last two years.

Two issues for the publicly funded Mental Health, Mental Retardation and Substance Abuse facility system in Virginia are critical at this time. Governor Gilmore has addressed both of these issues.

The first issue is that of developing a much more clear plan as to the role that state institutions should play within the array of services that are now available or are becoming available in a public funded system. The use of state institutions should take several factors into consideration.

These include: consumer preference, contemporary clinical and evidence based best practices, and patient and public safety. At one time there were several entire institutions in Virginia that provided care to persons suffering with Tuberculosis. When reasonable treatment was developed that was effective and could be taken as an outpatient, persons were no longer sent away or committed to these large institutions. They were given antibiotics and effectively treated in their communities. We no longer need entire institutions dedicated to the care of Tuberculosis. (Several of the old Tuberculosis sanatoriums in Virginia were converted into Mental Health Hospitals.)

The second critical issue relating to the Virginia Mental Health, Mental Retardation and Substance Abuse facility system is the quality of care within the institutions. Are persons suffering with serious mental illness, mental retardation and substance abuse being provided with sufficient supports and treatment that facilitates a safe and productive life? The Office of Inspector General has been designed by the Governor Gilmore to address these questions. Through the appointment of a psychiatrist who works with the Department of Mental Health, Mental Retardation and Substance Abuse Service, but is independent of this department, there is ongoing opportunity to provide independent evaluation of the quality of services being delivered within the facility system. This creates ongoing opportunities for natural tension and challenge in the system of care.

This office is committed to maintaining this challenge to encourage ongoing quality improvement in Mental Health and Mental Retardation facilities in Virginia.

Chapter 6: Moving Forward

Systemic Findings:

The findings made in each of the facility reports generally are facility specific, but have ramifications that may be of interest to other facilities. In general there are a few findings that are felt to be of system wide significance. For the year 2000, there were several recurring themes that were identified at virtually each facility. These themes include the following:

I. FINDINGS OF CONCERN

1. **Staffing:** Nationally, many health care facilities are experiencing critical nursing and psych-tech (human services care worker) staffing shortages due to lack of availability of qualified personnel. Many anticipate that this will remain a critical national concern for at least the next seven or more years. As this problem continues to become more prevalent in Virginia, decisions are going to have to be made regarding the most effective and efficient use of available and talented staff. Many of the facilities are in situations of working much overtime due to difficulty recruiting and retaining talented staff.

Recommendation: Critical-staffing shortages is an issue that will be reviewed by the Joint Commission on Behavioral Health Care. Creative consideration should be given to any reasonable ideas that might look at both the immediate and long-term solutions to this critical problem. Census reduction may be a part of the solution to this problem. Another example of a solution would be looking at the most effective utilization of existing staff resources. The Program for Assertive Community Treatment (PACT teams), have demonstrated nationally that professional staff can be more efficiently utilized to meet the clinical needs of the consumers in community settings rather than facility settings with rigid staffing standards.

2. **Facility Violence and Assault:** As more stable patients are able to be effectively managed in community settings, those remaining within facilities are more likely to have more serious problems with aggressive behavior. While aggression is not a symptom of mental illness per se, and most individuals with mental illness are not aggressive, there are clearly a minority of individuals with aggression and impulse control problems that render them unable to live in normal community settings. These individuals can be very tough to work with and manage.

Recommendation: A statewide program emphasizing patient and staff safety within these facilities needs to be developed.

3. **Aging Infrastructure:** The majority of the facility buildings are very old. This contributes to expensive upkeep as well as a very outdated, tired and run down institutional environments. Additionally, there are a number of contemporary elements of technological infrastructure such as computerized ordering, labs and medication systems that are simply too expensive to implement in these aging buildings.

Recommendation: Consideration should be given to the aging infrastructure when considering any changes to the use of facilities within Virginia. It may be reasonable in the long run to have a few well-tooled hospitals with sharp clinical missions that are integrated into a community network of care.

Findings of Merit

1. **Seclusion and Restraint:** The use of seclusion and restraint has been an important issue in Virginia as well as throughout the nation. There have been multiple tragic deaths associated with the use of restraints throughout the nation. Over the last several years, the Department of Mental Health, Mental Retardation and Substance Abuse Services has been aggressive in reducing the use of seclusion and restraints. This has been a successful endeavor as there are far fewer restraints and seclusion used now than in the recent past.

Recommendation: Continue to support the efforts of staff in promoting humane care for all individuals. This includes the humane use of seclusion and restraint primarily for emergency situations.

2. **Active Treatment:** The promotion of active treatment as an expectation for all facilities is another success story within the facility system within Virginia. In the past there have been times of severe budget cuts wherein programming was reduced to the extent that patients were kept in facilities without adequate programming that would promote community reintegration. Today in each facility in Virginia there is an exciting array of treatment programs and therapeutic activities for patients.

Recommendation: Continue to maintain and develop these exciting programs. These will need to be integrated with active treatment opportunities in community settings. In some communities it may make sense to explore the possibility of integrating aspects of these facility programs with community rehabilitation programs.

3. **Staff Dedication**: Repeatedly throughout our inspection process, we have been touched by the level of dedication and professionalism observed in many of the staff who have devoted their professional lives to working with those who suffer from these mental disabilities. This is not easy work.

Recommendation: Opportunities should be taken to acknowledge the staff who work well with the consumers of the Department for Mental Health, Mental Retardation, and Substance Abuse Services.

Chapter 7: Concluding Remarks

In establishing this office, I have firmly believed that this office can be both productive and effective with modest resources. I have applied contemporary management principles into the management of this office. The essential element in creating this highly productive climate is the successful integration of technology with a small core of professional, dedicated and motivated staff. A good core staff can amplify the efficacy of this office through creative use of consultants and cooperative relationships with other interested entities such as DRVD and DMHMRSAS.

In conclusion, I would like to thank Governor Gilmore and the members of the General Assembly for their support over this the first full year of operation for the Office of Inspector General. It is my hope that this report has provided useful information summarizing the office's activities over the last year. I look forward to the opportunity to serve the citizens of Virginia in the upcoming year. I anticipate another busy year in 2001, and hope that I am able to continue to contribute valuable information regarding the quality of clinical care within the public funded system of mental health, mental retardation and substance abuse services in the Commonwealth of Virginia.