COMMONWEALTH *of* VIRGINIA

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TO: Governor Gilmore and Members of the General Assembly of Virginia

FROM: Richard E. Kellogg, Commissioner Richard E. Kellogg

DATE: December 14, 2000

RE: The Human Rights Study in Response to Item #323 N of the FY 2000 Appropriation Act

Item #323 N of the FY 2000 Appropriation Act, directed DMHMRSAS to evaluate the number, qualifications, competencies, and service of state facility and regional human rights advocates employed by the Department. The purpose of the evaluation is to ensure that each consumer in a state facility or community program has sufficient access, in terms of timeliness, geography, cultural competence, and community modalities, to a knowledgeable and skilled advocate. The enclosed report documents our evaluation and our recommendations with regard to the advocates.

Seventeen (17) staff of the department contributed five hundred (500) hours toward the planning and implementation of the study. The cost to the Department was $10,000.

DMHMRSAS
Human Rights Study

Executive Summary

The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) surveyed over 630 consumers of mental health and substance abuse services, 130 consumers of mental retardation services, and all 24 DMHMRSAS Office of Human Rights advocates, to provide data for the study of the human rights advocates in response to Item #323 N of the FY 2000 Appropriation Act.

Results indicate that the advocates are well trained and well educated. The advocates have experience with all major disability and population groups. Most consumers have seen a human rights poster, and most know some of their rights. When consumers have contact with the advocates, they are satisfied with the service provided by the advocates. However the survey results indicate that only 10% of consumers have had contact with the advocates.

The advocates are responsible for large caseloads, large numbers of programs, many Local Human Rights Committees (LHRCs), and many Community Service Boards (CSBs). The size of the caseloads and geographic distance do not enable the advocates to have a significant presence in community programs. In addition, following the promulgation of the **Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services (12 VAC 35-115-10 et seq.),** Office of Human Right's advocates will also be responsible for providing comprehensive advocacy services to 49 private psychiatric hospitals in the state.

The Department recommends increasing staff by 5 advocates in FY 2002 and 5 compliance auditors in FY 2003, providing training on cultural and disability issues, and increasing recruitment efforts for staff skilled in working with the deaf and hard of hearing and visually impaired.

Human Rights Study

Introduction

A. Purpose of Study

The purpose of this study was to evaluate the number, qualifications, competencies, and service of the Department of Mental Health, Mental Retardation and Substance Abuse Services' (DMHMRSAS') state facility and regional human rights advocates to ensure that each consumer in a state facility or community program has sufficient access. The study was initiated in response to **Item #323 N of the FY 2000 Appropriation Act,** which stated the following:

> "The Department shall evaluate the number, qualifications, competencies, and service of state facility and regional human rights advocates to ensure that each consumer in a state facility or community program has sufficient access, in terms of timeliness, geography, cultural competence, and community modalities, to a knowledgeable and skilled advocate. The Department shall ensure that these advocates are recruited, hired, trained, and supervise by the Office of Human Rights. The Department shall report on the results of this evaluation by December 15, 2000, to the Governor and the General Assembly."

B. Description of Current System

The DMHMRSAS human rights program is designed to provide comprehensive human rights protections and a complaint resolution process for consumers in the fifteen (15) DMHMRSAS mental health and mental retardation facilities, consumers in the forty (40) CSBs' programs, and consumers in the over 1,000 licensed private mental health, mental retardation and substance abuse programs throughout the Commonwealth.

The DMHMRSAS Office of Human Rights (OHR) is headed by the State Human Rights Director (SHRD) who reports directly to the DMHMRSAS Commissioner. The SHRD is responsible for the direction and management of the statewide human rights program. The Assistant State Human Rights Director (ASHRD) reports to the SHRD and has primary responsibility for the day-to-day supervision of the advocates. The regional advocates report to the ASHRD and provide supervision to the chief facility advocates. The chief facility advocates supervise facility advocates.

The Office of Human Rights employs twenty-five (25) advocates who are physically housed at DMHMRSAS mental health and mental retardation facilities. Five (5) of the 25 advocates are regional advocates who are responsible for providing advocacy services to consumers in areas comparable to the five Health Planning Regions. These five regional advocates provide services to CSBs and licensed programs in their respective areas. There are forty (40) CSBs and over one thousand (1,000) licensed programs currently in Virginia. Twenty (20) of the advocates employed by the OHR are responsible for providing services to consumers in 15 state facilities. Eleven of the facilities have one (1) advocate assigned to provide services to consumers. The largest four facilities have more than one advocate as follows: Eastern State Hospital (2), Western State Hospital (2), Central State Hospital (2), and Central Virginia Training Center (3).

Method

Two research methods were utilized in gathering data for the study. The first involved the use of survey instruments. The survey sample included both consumers and advocates. Three separate survey instruments were developed and implemented. Due to the unique challenges inherent with surveying consumers, different consumer surveys and procedures were utilized for the mental health/substance abuse consumers and the mental retardation consumers

The second method was the utilization of an instrument developed in 1998 to provide information to HJR 240 Subcommittee about the adequacy of the advocate positions available in the facilities and community programs. The Human Rights Advocate Workload/FTE Calculation spreadsheet will provide a comparison of current and projected workload.

A. Mental Health/Substance Abuse Consumer Survey

The instrument utilized for gathering information from consumers of mental health and or substance abuse services was designed to be self-administered. A DMHMRSAS committee developed the items on the survey with input from Department staff from the following units: Research and Evaluation, Human Resources Development and Management, Human Rights, Mental Health Services and Substance Abuse Services. A draft of the survey was mailed to stakeholders external to the Department for comment. The survey instrument was field tested for consumer input at a psychosocial rehabilitation program.

The survey instrument was designed to collect information about the respondents' basic knowledge about human rights and their access to and satisfaction with the DMHMRSAS human rights advocate.

The survey sample was selected through a multi-step process. Since the survey was to be sent to individual programs or state facility and distributed to consumers in attendance the sample needed to be program specific rather than consumer specific.

The sampling frame was derived from the Office of Licensing Information System (OLIS) which stores information regarding all licensed programs. The programs were grouped according to type (e.g., club house, residential treatment, inpatient, intensive outpatient, group home/halfway house, day health and rehabilitation, day treatment, supervised living) prior to selection. A random selection process was conducted which ensured that programs from across the state were included in the sample. Eighty (80) programs that provide mental health and/or substance abuse services were randomly selected for the sample.

Letters that described the project and requested permission to send surveys to consumers in their programs were sent to the directors of all 80 programs in the sample. Drafts of the surveys were also sent to the program directors.

Follow up phone calls were made to all directors of programs in the sample to verify their permission to send surveys to consumers in their programs and to ascertain the number of consumers available to participate in the survey. Permission was received to proceed from all but five (5) programs, which were no longer in operation. The final program sample was 75 programs.

A letter with instructions, along with the number of surveys that they indicated they would need to give to the consumers in their program, was sent to all participating programs. The instructions requested that program staff distribute the surveys to all consumers in the program during the week of August 10, 2000. The program staff was requested to be available to answer questions that consumers might have about the surveys. Additionally, the program staff was asked to point to the human rights poster and remind the consumers that the survey is about the DMHMRSAS human rights advocate. A return envelope was included for convenience. Six hundred and sixty-one (661) consumers completed the survey.

B. Mental Retardation Consumer Survey

The survey for gathering information from consumers of mental retardation services was designed to be utilized in an interview format. A DMHMRSAS committee developed the items on the survey with input from Department staff from the following units: Research and Evaluation, Human Resources Development and Management, Human Rights, and Mental Retardation Services. A draft of the survey was mailed to stakeholders external to the Department for comment.

The survey interview protocol was designed to collect information about the respondents' basic knowledge about human rights and their access to and satisfaction with the DMHMRSAS human rights advocate.

The survey sample was selected through a multi-step process. Since the survey was to be sent to individual programs or state facility and distributed to consumers in attendance the sample needed to be program specific rather than consumer specific. The sample was derived from the Office of Licensing Information System (OLIS) which stores information regarding all licensed programs. The programs were grouped according to type (e.g., residential treatment, inpatient, group home, day health and rehabilitation, supervised living prior to selection. A random selection process ensured that programs from across the state were included in the sample. Twenty-seven (27) programs that provide mental retardation services were randomly selected for the sample.

Letters, which described the project and requested permission to interview consumers in their programs, were sent to the directors of all 27 programs in the sample. Drafts of the surveys were also sent to the directors.

The staff who conducted the interviews was from the DMHMRSAS Offices of Mental Retardation, Research and Evaluation, Quality Care and Human Rights. To enhance the interview process and ensure consistency with the interviews, staff attended training, conducted by the Office of Human Rights and the Office of Mental Retardation, prior to conducting the interviews. The training provided staff with information about how to conduct interviews with consumers with mental retardation and conditions that frequently accompany mental retardation.

Follow-up phone calls were conducted with all directors of programs in the survey sample to verify their permission to conduct interviews of consumers in their programs and to ascertain the number of consumers available to participate in the survey interviews. Permission was received to proceed with interviews in twenty-two (22) programs in the sample. Interviews were completed with one hundred and thirty-four (134) consumers.

C. Advocate Survey

The instrument for gathering information from the advocates employed by the Office of Human Rights was designed to be self-administered. A DMHMRSAS committee developed the items on the survey with input from Department staff from the following units: Research and Evaluation, Human Resources Development and Management, and Human Rights. A draft of the survey was mailed to stakeholders external to the Department for comment.

The survey instrument was designed to collect information about the respondents' skills, knowledge, abilities, and cultural competency. The survey also asked for information about consumer access to DMHMRSAS advocates and potential solutions for any barriers identified.

The survey sample included all twenty-four (24) advocates employed at that time by DMHMRSAS. Twenty-four surveys were completed and returned.

D. Human Rights Advocate Workload/FTE Calculation

The Human Rights Advocate Workload/FTE Calculation was developed by the Office of Human Rights and the Office of Human Resource Development and Management, as a method to analyze the advocate's workload and determine the number of positions needed. The process involved the following activities:

- Compiled and reviewed existing documentation on Human Rights advocacy position duties and office data
- Prepared list of advocacy duties.
- Identified key system indicators (e.g., facility Average Daily Census (ADC) and advocacy workload measure (e.g., complaints, abuse allegations) and compiled statistics for trending/modeling purposes.
- Prepared time estimates for each advocacy duty (variable and fixed activities).
- Determined strength of correlation of key system indicators with advocacy workload data
- Modeled current and alternative staffing models using tasks and time estimates to test for "reasonableness" of data.

Work standards were established for fixed "macro-level" mandated activities (i.e., monitoring, and prevention) and for two variable activities (i.e., complaint and abuse allegation resolutions). The former activities were associated with the facility census (e.g., allocation of an average number of work hours per 200 ADC) or with a regional posting (i.e., 5 regions), and the latter activities were linked to historically reported complaints and allegations. The resulting workload activities were adjusted to accommodate a vacation, holiday and sick allowance (17.8%) per full time equivalent advocacy position at the facility and the regional sites. All data utilized for the purpose of this study were from FY 1999.

Results

A. Mental Health/Substance Abuse Consumer Survey

The Mental Health/Substance Abuse Consumer Survey asked nine questions concerning the respondents' basic knowledge about human rights and their access to and satisfaction with the DMHMRSAS human rights advocate. The responses to the questions are displayed in the following nine tables.

All programs licensed, funded and operated by the Department are to have the human rights poster on display.

1. **I have seen the human rights poster before now.**

Yes	**493**	**74.8%**
No	**166**	**25.2%**
No response	**0**	**0.0%**

All programs licensed, funded and/or operated by the Department are to inform consumers about the human right advocate's availability.

2. **I have been told about what a Human Rights Advocate does.**

Strongly agree	**135**	**20.5%**
Agree	**316**	**48.0%**
Disagree	**115**	**17.5%**
Strongly disagree	**83**	**12.6%**
No response	**10**	**1.5%**

All programs licensed, funded and/or operated by the Department are to inform consumers about their human rights and have them sign a paper indicating that they have received the notification.

3. **I know what my rights are.**

Strongly agree	**193**	**29.3%**
Agree	**371**	**56.3%**
Disagree	**60**	**9.1%**
Strongly disagree	**30**	**4.6%**
No response	**5**	**.8%**

The Office of Human Rights' advocates is available to all programs licensed, funded and/or operated by the Department.

4. **I have had contact with a Human Rights Advocate.**

Yes	**69**	**10.5%**
No	**579**	**87.9%**
No response	**11**	**1.7%**

If consumers had contact with a Human Rights Advocate they were asked to respond to five additional questions.

1. **What kind of contact have you had with the Human Rights Advocate (n=37).**

Local telephone	**6**	**15.8%**
Long distance telephone	**6**	**15.8%**
E-Mail	**0**	**0.0%**
Individual meeting	**17**	**44.7%**
Brief introduction	**2**	**5.3%**
Group meeting	**5**	**13.2%**
Other	**1**	**2.6%**

2. **The Human Rights Advocate met with me at a time that was convenient for me (n=54).**

Strongly agree	**31**	**57.4%**
Agree	**21**	**38.9%**
Disagree	**2**	**3.7%**
Strongly disagree	**0**	**0.0%**

3. **The Human Rights Advocate met with me at a location that was convenient for me (n=52).**

Strongly agree	**33**	**63.5%**
Agree	**16**	**30.8%**
Disagree	**2**	**3.8%**
Strongly disagree	**1**	**1.9%**

4. **The Human Rights Advocate is/was concerned about my complaint/problem (n=52).**

Strongly agree	**34**	**65.4%**
Agree	**16**	**30.8%**
Disagree	**2**	**3.8%**
Strongly disagree	**0**	**0.0%**

5. **The Human Rights Advocate explained my rights and the complaint in a way that I could understand (n=50).**

Strongly agree	**33**	**66.0%**
Agree	**13**	**26.0%**
Disagree	**3**	**6.0%**
Strongly disagree	**1**	**2.0%**

B. Mental Retardation Consumer Survey

The Mental Retardation Consumer Survey asked ten (10) questions about the respondents' basic knowledge about human rights and their access to and satisfaction with the DMHMRSAS human rights advocate. The results to the questions are displayed in the following seven tables and three listings.

All programs licensed, funded and/or operated by the Department are to have the human rights poster on display.

1. **Have you seen this poster before? (the human rights poster was shown to the consumer)**

Yes	**84**	**63.2%**
No	**41**	**30.8%**
No response	**8**	**6.0%**

Office of Human Rights' advocates are available to provide advocacy services to any individual in a program which is licensed, funded and/or operated by the Department.

2. **Have you been told that someone would help you if you are not happy with where you live or how you spend your time?**

Yes	**78**	**58.6%**
No	**26**	**19.5%**
No response	**29**	**21.8%**

All consumers in programs licensed, funded and/or operated by the Department are to be notified of their rights.

3. **Can you tell me your rights?**

Yes	**72**	**54.1%**
No	**22**	**16.5%**
No response	**39**	**29.3%**

4. **Do you feel you understand these rights?**

Yes	54	40.6%
No	33	24.8%
No response	46	34.6%

5. **Do you know who this is? (A picture of the advocate serving their program or facility was shown to the consumer)**

Yes	44	33.1%
No	76	57.1%
No response	13	9.8%

6. **Can you tell me his/her name?**

Yes	18	13.6%
No	46	34.8%
No response	68	51.5%

7. **Have you ever talked to or written to the advocate?**

Yes	18	13.6%
No	72	54.5%
No response	42	31.8%

Of consumers who have talked/written to the advocate the different answers that were recorded follow.

When did you meet with (name of advocate)?

"A long time ago"
"Some time ago"
"Today"
"Work center in Covington"

Where did you meet with (name of advocate)?

"At day program"
"Downtown"
"Church"
"Office"

"Here"
"In annex building"
"In building"
"Don't know"

What did (name of advocate) do about your complaint?

"Helped me"
"Fixed it"
"Yes"
"I know I could talk to her if I needed too"

C. Advocate Survey

The survey was mailed to twenty-four (24) advocates and all the advocates completed and returned the survey forms The advocate survey asked numerous questions related to the knowledge, skills, abilities and credentials of the advocates. Results indicate that the educational background of the advocates includes social work, sociology, psychology, political and urban affairs, education, public and hospital administration, counseling and law. Thirteen (13) of the advocates have at least one masters degree, and seven (7) additional advocates have bachelor degrees. Three (3) of the advocates have degrees in law, and one (1) has an associate degree. Advocates hold licenses and certificates in education, law, mediation, Mandt, CPR, counseling and Certified Rehabilitation Provider.

The results indicate that, in addition to formal education, 100% of the advocates have participated in continuing education/training in the past year. The number of advocates receiving these trainings is indicated in parenthesis. These trainings included such topics as Abuse Investigations (10), Ethics (8), Psychopharmacology (2), Alternatives to Patient Consent (7), Mental Health and the Law (7), Mandt (7), Counseling techniques (5) and Outcome-Based Performance (3). The number of advocates who participate in the following professional organizations are indicated in parenthesis: the National Association of Social Workers (1), American Bar Association (1), Virginia Bar Association (2), the American Association for Mental Retardation (2), the United Way Community Council (1), the Department for the Visually Handicapped Rehabilitative Advisory Council (1) and 504 Compliance Council (1) which provide ongoing training and professional opportunities.

Responses from all advocates identified the following comprehensive list of skills and knowledge required to successfully complete the tasks of their current positions.

- Knowledge of human behavior
- Knowledge of the human service delivery system
- Knowledge of program administrative/management skills

- Knowledge of clinical treatment approaches and standards of practice particularly in the areas of mental health, mental retardation and substance abuse
- Knowledge of DMHMRSAS rules, regulations and policies
- Knowledge of State and Federal laws and policy
- Skill in conflict resolution and mediation
- Skill in conducting investigations
- Skill in interviewing
- Ability to communicate effectively
- Skill in the provision of effective training and team building
- Ability to establish positive working relationships with consumers, staff, management, community partners and stakeholders.

Fifteen of the twenty advocates responding identified ethics and computer as skills required to successfully complete the tasks of their current positions.

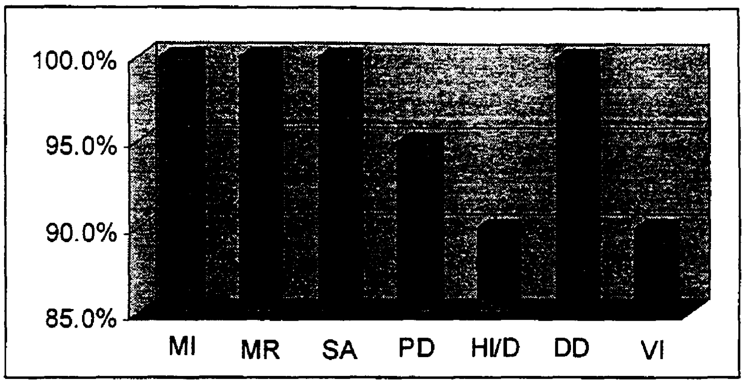
1. Cultural Competence

The survey questions addressing cultural competency covered a wide variety of cultural issues including language, alternative means of communication, disability and ethnicity. One (1) advocate indicated the ability to read, write and speak Hebrew. Several advocates indicated very limited ability to either read, write or speak German, Spanish and/or French. One (1) advocate has limited ability to utilize American Sign Language (ASL) or another language of the deaf and hard of hearing. One (1) advocate has limited ability to utilize Braille. Four (4) advocates have utilized the TDD to communicate with deaf and or hard of hearing consumers. One (1) advocate has utilized the Virginia Relay Service and the ATT language Line for foreign language interpreter services.

The following graphs display the survey results to four questions about the advocates' experience and knowledge of working with disability and ethnic population groups.

Check all disabilities that you have work or life experience with:

N=24

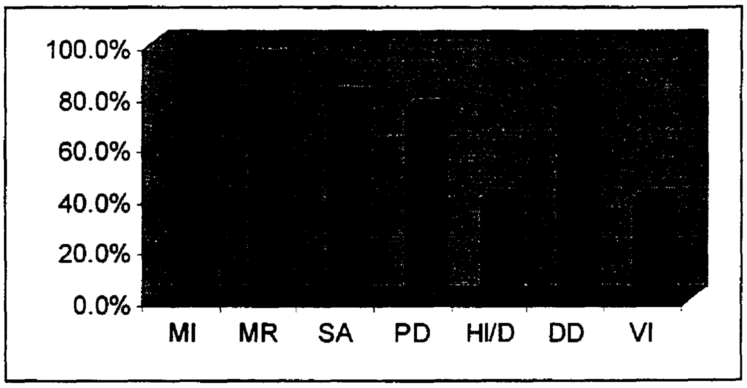


KEY:

MI	Mental Illness
MR	Mental Retardation
SA	Substance Abuse
PD	Physical Disability
HI/D	Hearing Impaired/Deaf
DD	Developmental Disability
VI	Visually Impaired

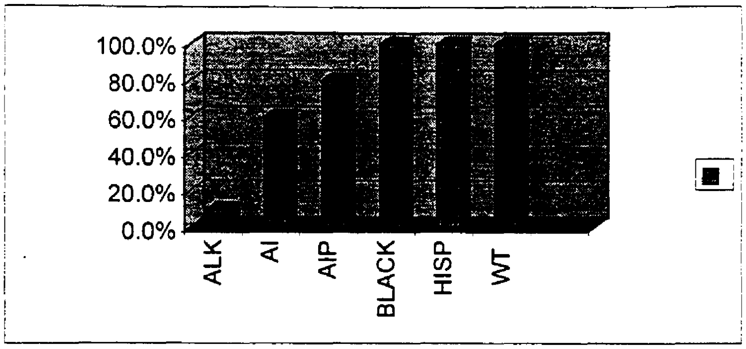
Check all disabilities that you have been prepared (academic) to deal with:

N=24



Check all populations that you have had work or life experience with:

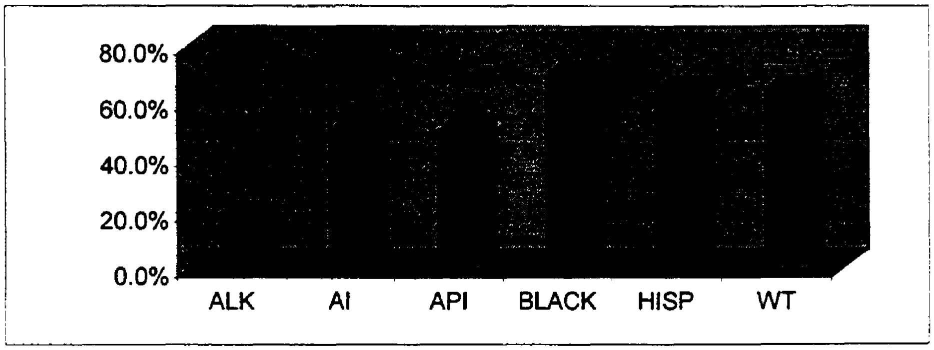
N=24



Key:		
	ALK	Alaskan native
	AI	American Indian
	API	Asian/Pacific Islander
	Black	Black
	HISP	Hispanic
	WT	White

Check all populations that you have been prepared (academic) to deal with:

N=24



2. Consumer Access to DMHMRSAS advocates

The survey asked the respondents to give their opinions about the extent of access consumers have to DMHMRSAS advocates and what barriers may exist in accessing the advocates. The results are indicated below.

To what extent do you think consumers have access to the DMHMRSAS Advocates?

No Access	**0**	**0**
Limited Access	**7**	**35%**
Moderate Access	**6**	**30%**
Complete Access	**7**	**30%**

What do you think are the barriers consumers face in accessing advocates? The results below indicate the number and percentage of the advocates that listed each area as a barrier to access.

Limited # of Advocates	**18**	**90%**
Increased responsibility and work load of Advocates	**10**	**50%**
Large geographic distances advocates cover	**6**	**30%**
Large number of consumers served	**18**	**90%**
Large number of programs and LHRCs	**8**	**40%**
Consumers' discomfort with making complaints	**4**	**20%**
Consumers' disability	**4**	**20%**

How would you reduce these barriers?

Increase number of Advocates, increase "presence" of advocates in programs and facilities	**10**	**100%**
Decrease geographic area covered, workload	**4**	**40%**
Increase training to programs, staff, LHRC, community partners	**3**	**30%**
Revise OHR organizational structure, revise policies, increase pay, reduce reporting requirements	**1**	**10%**

D. Workload/FTE (see Appendix)

A test for "reasonableness" of the standards was conducted to model the current advocacy system. Professional assessment of the adequacy of the work standards for the activities yielded a need to increase the number of hours per abuse allegation (all other standards remained constant).

Conclusions

A. Discussion/Interpretation of Results

1. Number of Advocates

In the absence of benchmarks for advocacy caseloads/workloads, the evaluation of the adequacy of the number of advocates will utilize survey data, the Advocate Workload/FTE Calculation, and data regarding census, programs and caseloads. Current Regional Advocate caseloads are as follows:

- The regional advocate assigned to HPR I is responsible for the supervision of four (4) advocates at two (2) facilities, and providing advocacy services and support to seven (7) CSBs, seven (7) LHRCs , 67 programs and *29,568 consumers;
- The regional advocate assigned to HPR II is responsible for the supervision of two (2) advocates at two (2) facilities, and providing advocacy services and support to five (5) CSBs, six (6) LHRCS, 158 programs and *39,411consumers.
- The regional advocate assigned to HPR III is responsible for the supervision of seven (7) advocates at five (5) facilities, and providing advocacy services and support to eleven (11) CSBs, five (5) LHRCs,113 programs and *30,184 consumers;
- The regional advocate assigned to HPR IV is responsible for the supervision of five (5) advocates at four (4) facilities, and providing advocacy services and support to eight (8) CSBs, ten (10) LHRCs, 59 programs, and *31,066 consumers;
- The regional advocate assigned to HPR V is responsible for the supervision of three (3) advocates at two (2) facilities and providing advocacy services and support to eight (8) CBS, thirteen (13) LHRCS, 251 programs and *50,512 consumers;

The chief facility advocates each cover at least one (1) LHRC in addition to providing supervision to facility advocates and providing advocacy services to consumers in the facility. The facility censuses as of September 29, 2000 are as follows:

Eastern State Hospital	514
Western State Hospital	269
Central State Hospital	291
Southwestern Virginia Mental Health Institute	159
Northern Virginia Mental Health Institute	118
Southern Virginia Mental Health Institute	63
DeJarnette	39
Catawba	91
Piedmont	129
Hiram Davis	74
Central Virginia Training Center	656
Southside Virginia Training Center	438
Northern Virginia Training Center	193
Southeastern Virginia Training Center	197
Southwestern Virginia Training Center	219
Total	**3444**

The current facility census of 3444 converts to an average caseload of 172 consumers for each of the twenty (20) advocates assigned to a state facility. **

The number of programs licensed by the Department impacts the workload of the Regional Advocates in particular. There were 1279 programs licensed by the Department in June 1999. By June 2000, there were 1317 licensed programs. In addition to the rise in the number of licensed programs, the number of program locations is rising also (2086 in 1999 to 2303 in 2000). New programs and locations require LHRC affiliations, Human Rights Plans and human rights protections for all consumers. Following the promulgation of the **Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services (12 VAC 35-115-10 et seq.),** Office of Human Rights' advocates will also have responsibility for providing comprehensive advocacy services to private psychiatric hospitals. This will be an addition of approximately 49 hospitals.

The projected need as noted in The Human Rights Advocate Workload/FTE Calculation, based on an increase in worked hours for abuse allegation activities, indicates one (1) additional advocate is needed to provide services to the facilities, and three (3) additional advocates are needed to provide services to consumers in community programs. While this method points to the need for additional staff the instrument does not take into consideration the number of licensed programs, number of consumers, number of LHRCs or geographic area served in calculating the need. The absence of these critical factors significantly reduces the projected need.

The consumer survey data indicated that 74.8% of MH/SA consumers and 63.2% of the MR consumers responded that they have seen the Human Rights Poster. All programs "licensed, funded or operated by the Department" are to have a Human Rights Poster on display in a prominent location. 85.6% of MH/SA respondents and 54.1% of MR respondents indicated that they know their rights. At the time of the survey, 68.5% of the MH/SA consumers indicated that they had been told about the Human Rights Advocate, while 10.5% of the MH/SA consumers indicated that they actually had "contact" with a Human Rights Advocate. Most MR consumers (66%) do not know the advocate, and only 13.6% have ever talked or written to a Human Rights Advocate.

The consumer survey data primarily provides information about consumers served by the Regional Advocates. All of the MH/SA survey respondents were receiving services in community programs and 110 of the 134 MR respondents were receiving services in community programs. The percentage of consumers who report having met a Human Rights Advocate is extremely low and indicative of a large complaint driven community system. In the current system Regional Advocates primarily have contact with consumers following the allegation of a human rights violation or complaint. The current staffing pattern does not support consumer contact beyond responding to complaints of human rights violations. To move toward a proactive prevention model of advocacy the Regional Advocates would need the flexibility to visit with consumers in programs on a regular basis and not just when a complaint has been made. This would replicate the advocacy model utilized in the state facilities. Greater visibility of the Regional Advocates would increase consumer knowledge of their human rights and increase consumer understanding of and relationship with the advocate. In addition, regular consumer and program contact would improve the opportunity for the Regional Advocate to identify potential human rights violations before they become complaints.

One additional factor must be considered when evaluating the adequacy of the number of advocates. A new requirement for the monitoring of licensed programs compliance with the **Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services (12 VAC 35-115-10 et seq.)** will become effective when these new regulations are promulgated. The process for this monitoring has yet to be finalized but will include staff from the Office of Human Rights.

2. Qualifications/Competencies/Service

All advocates were hired in accordance with state personnel guidelines and meet the requirements for the positions they hold. The knowledge, skills and abilities of the advocates are consistent with position descriptions. Advocates are continuing to enhance their knowledge, skills and abilities by participating in continuing education/training and professional organizations.

3. Recruitment, Hiring, Supervision

All advocates are recruited, hired and supervised by the Office of Human Rights. Prior to July 1998 the facility advocates were paid by the facility. Currently all advocates are paid out of the Office of Human Rights' budget.

4. Sufficient Access

The consumer surveys indicate that consumers who had contact with the advocate were very satisfied with issues of access. 96.3% of the MH/SA respondents indicate satisfaction with the time of the contact, while 94.3% of the MH/SA respondents indicate satisfaction with the location of the contact. 63.2% of MH/SA respondents indicate having some type of face-to-face contact with the advocate. 35% of the advocates indicate that consumers' access to DMHMRSAS advocates is "Limited," while 30% responded that access is "Moderate," and 30% responded that access is "Complete." When asked to indicate the barriers to access, 90% of the advocates indicated that the limited number of advocates and the large number of consumers are a barrier. Other barriers to accessing advocates include the increased workload and responsibility of the advocates (50%), large geographic distances covered (30%), large number of programs and LHRCs (40%), the consumer's discomfort with making complaints, and the consumer's disability (20%).

5. Cultural Competence

The advocate survey indicates that staff are well prepared both academically (75%-100%) and with life experience (95%-100%) to work with consumers with mental illness, mental retardation, substance abuse, physical disabilities and developmental disabilities. The staff are less prepared both academically (40%) and with life experience (90%) to work with consumers who are hearing impaired or deaf and consumers who are visually impaired. Additionally the advocates indicate that they are well prepared both academically (65%-70%) and with life experience (100%) to work with consumers who are Black, White and or Hispanic, but less prepared academically (20%-50%) and with life experience (10%-80) to work with consumers who are Alaskan native, American Indian and or Asian/Pacific Islander. Based upon information collected from clients admitted to state facilities, the current Department client pool is 66.33 % White, 30.88% Black, .13% American Indian, .00% Alaskan, .79% Asian/Pacific Islander, and 1.87% unknown. These data include 1.26% or 87 consumers who are Hispanic. FY 1999 CSB data indicates the client pool as 60% White, 32% Black, .003% American Indian, .0004% Alaskan Native, .04% Asian/Pacific Islander and 7% unknown or other.

The survey indicates very limited ability on the part of the advocates to communicate with individuals who speak a foreign language or utilize an alternative means of communication such as interpreters or American Sign Language. It is obvious that, when the advocates encounter a consumer who requires an alternative means of communication, they need to ask for assistance from a qualified interpreter.

6. Community Modalities

As the survey indicates, the advocates keep abreast of the current treatment modalities for consumers served by DMHMRSAS by attending continuing education and training programs. They view knowledge, skills and abilities in the areas of understanding the human service delivery system, human behavior, clinical treatment approaches and standards of practice in the areas of mental health, mental retardation and substance abuse, as paramount to successful job performance.

7. Limitations of Study

Several factors have been identified as potential limitations of the study. The general reliability of respondents is a limitation. Misunderstanding of the consumer response and/or potential confusion on the part of the respondent as to the identity of the advocate could have occurred during the completion of the mental retardation survey interviews. The mental health and substance abuse services consumers' responses could have been based on their local ombudsman program rather than the DMHMRSAS human rights program.

Programs were notified in advance about the content and timing of the survey. Some consumer's might have been "prepared" for the interviews or completion of the survey by program staff.

The Human Rights Advocate Workload/FTE Calculation does not account for the number of licensed programs, the number of LHRCs and the amount of geographic area covered by the Regional Advocates. This creates a lower calculation of workload than is actually the case.

Since the survey was designed as program specific rather than consumer specific, we are unable to accurately determine a response rate for the survey. Additionally, many consumers failed to complete all the questions on the survey.

Recommendations

1. The Department of Mental Health, Mental Retardation and Substance Abuse Services' Office of Human Rights, will increase efforts to recruit staff with specific skills in the areas of working with consumers who are deaf or hard of hearing and/or visually impaired. This could be achieved through the recruitment and interview process when filling vacant positions.

2. The Department of Mental Health, Mental Retardation and Substance Abuse Services' Office of Human Rights' will support and arrange training opportunities both internal and external in the areas of cultural competence, deaf and hard of hearing and visual impairments. The training will be coordinated with the Department's Coordinator for the Deaf and Hard of Hearing, the Regional Coordinators for the Deaf and Hard of Hearing, the Department for the Deaf and Hard of Hearing, and the Department for the Visually Handicapped.

3. The Department of Mental Health, Mental Retardation and Substance Abuse Services recommends the addition of (ten) 10 positions to the Office of Human Rights.

    - Five (5) advocates in FY 2002 to provide comprehensive, proactive advocacy services to community programs. The additional staff would increase the "presence" of the Regional Advocates in the community programs. Currently the average caseload of the 6 Regional Advocates is 33,000. To achieve an average caseload of 18,000 consumers and 113 programs per Regional Advocate would require 5 additional positions. Five new positions would reduce the LHRC and program responsibilities for each current regional advocate by 46%, provide human rights advocacy services for the 49 private psychiatric hospitals and would enable more consumers to become personally acquainted with an advocate. With the addition of the new positions the Regional Advocates would have the flexibility of schedule to implement a proactive model of advocacy which would include regular contact with consumers and programs. To maintain the current level of advocacy services would require additional positions without which advocacy services will need to be reduced.

# of additional Regional Advocates	0	1	2	3	4	5
Average # of consumers/programs per Regional Advocate	33,000 /208	28,000 /178	25,000 /156	22,000 /138	20,000 /125	18,000 /113

- Five (5) Compliance Auditors in FY 2003 to provide monitoring/program audit responsibilities to the over 1200 licensed programs as defined in § 37.1-84.1 of the Code of Virginia; "Licensure pursuant to Chapter 8 (§ 37.1-179 et seq.) of this title shall be contingent upon the substantial compliance with human rights regulations as determined by periodic reviews performed by the Department."

* CSB data source is FY 1999 CSB 4th Quarter Performance Report

**Beginning January 1, 2001 the Office of Human Rights will be adding an additional advocate position to provide services to community programs in both the Northern Virginia and Tidewater portions of the state. As of October 1, 2000 the Office of Human Rights converted one facility advocate position at CVTC to a Regional Advocate position to serve the newly established Region VI. This position will assume responsibility for three (3) facilities, four (4) staff and six (6) CSBs.