COMMONWEALTH of VIRGINIA

Office of the Governor

Mark R. Warner
Governor

November 29, 2005

To The General Assembly of Virginia:

I am pleased to transmit the semi-annual report of the Office of the Inspector General for Mental Health, Mental Retardation, and Substance Abuse Services. This report summarizes the activities of this important office.

The Office of the Inspector General plays a vital role in monitoring and improving care in Virginia for those with behavioral health care needs. During the past 6 months the OIG expanded its work beyond DMHMRSAS operated facilities to include licensed community programs.

Additionally, the Office of the Inspector General has made every effort to compile the results of their work so that findings and recommendations attend not only to individual facilities and programs but also provide a systemic, statewide perspective.

I trust that you will find this report informative and helpful.

Sincerely,

Mark R. Warner

MRW/rwc

State Capitol • Richmond, Virginia 23219 • (804) 786-2211 • TTY (804) 371-8015 • www.governor.virginia.gov

COMMONWEALTH of VIRGINIA

Office of the Inspector General

James W. Stewart, III
Inspector General
for
Mental Health, Mental Retardation &
Substance Abuse Services

November 29, 2005

To the General Assembly of Virginia:

The Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services (OIG) is pleased to submit this semi-annual report of activities for the period ending on September 30, 2005. This report is issued in accordance with the provisions of VA Code §37.2-425, which specifies that the Office report on significant activities and recommendations of the OIG during each six-month reporting period.

During the past six months the primary goal of the OIG has been to expand oversight activities to include community-based programs that are licensed by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS). In addition to the unannounced inspections of state facilities that have been provided in the past, the OIG conducted a state-wide review of the system of Emergency Services Programs operated by the 40 Community Services Boards (CSB).

The Office has continued to make every effort to seek input from a broad range of stakeholders to the selection and design of OIG projects. It is my belief that this inclusiveness has contributed to findings and recommendations that will be more meaningful to the Governor, the members of the General Assembly, and most importantly to the consumers and families who benefit from the system of services.

I am pleased to provide this summary of the activities of the Office of the Inspector General for your review.

Sincerely,

James W. Stewart, III
Inspector General

P.O. Box 1797 • Richmond, Virginia 23218 • (804) 692-0276 • Fax (804) 786-3400 • www.oig.virginia.gov

Office of the Inspector General For Mental Health, Mental Retardation And Substance Abuse Services

Semi - Annual Report April 1 - September 30, 2005

TABLE OF CONTENTS

Forward Page 3

Highlight of Activities Page 4

Vision, Mission and Operational Values of the OIG Page 6

Activities of the Office Page 7

A. INSPECTIONS Page 7
B. REPORTS Page 8
C. DATA MONITORING Page 9
D. FOLLOW-UP REPORTING Page 10
E. REVIEW OF REGULATIONS, POLICIES and PLANS Page 10
F. PRESENTATIONS AND CONFERENCES Page 10
G. MEETINGS Page 11
H. INTERFACING WITH OTHER AGENCIES Page 11
I. COMPLAINTS, CONCERNS AND INQUIRIES Page 12
J. OIG WEBSITE Page 12

Addendum A: Completed Inspection Reports Page 13

FORWARD

The Office of the Inspector General (OIG) for Mental Health, Mental Retardation and Substance Abuse Services is pleased to submit this semi-annual report of activities for the period ending on September 30, 2005. This report is issued in accordance with the provisions of Va. Code §37.2-425, which specifies that the OIG report on the significant issues related to the administration of the publicly funded services system.

During the past six months, the OIG completed the first inspections of programs licensed by the Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS). These included a review of the state-wide system of emergency services operated by community services boards (CSB), an inspection of residential services operated by a private provider, and an inspection of a licensed mental health treatment unit at one of the prisons operated by the Virginia Department of Corrections (DOC). A summary of these efforts is provided in this report.

The semi-annual report outlines the accomplishments of the OIG from April 1 through September 30, 2005. Information regarding the inspections that have been conducted at state facilities is included as well as summaries of other significant monitoring and review activities. It is through these activities that the OIG "*serves as a catalyst for improving the effectiveness, efficiency and the quality of services*" provided by the publicly funded mental health, mental retardation and substance abuse services system.

HIGHLIGHT OF ACTIVITIES

- The first inspections by the OIG of programs licensed by DMHMRSAS were conducted. These included:

  - A review of the statewide system of licensed Community Services Board (CSB) Emergency Services Programs included responsiveness testing of all 40 CSBs and on-site inspections at 17 CSBs – OIG report #123-05.
  - A Secondary Inspection of a licensed private provider of residential services.
  - A Secondary Inspection of a licensed mental health treatment unit in a facility operated by the Virginia Department of Corrections (DOC).

- Two unannounced inspections were conducted at the following DMHMRSAS operated facilities:

  - Virginia Center for Behavioral Rehabilitation - Snapshot #119-05
  - Hiram W. Davis Medical Center – Primary Inspection #120-05

- One unannounced Secondary Inspection was conducted at a DMHMRSAS operated facility.

- Reports were completed on each of the five inspections/reviews described above. In addition, the following reports were completed on inspections that were conducted during the prior semi-annual reporting period.

  - Central State Hospital - Primary Inspection #114-05
  - Eastern State Hospital – Primary Inspection #115-05
  - Southwestern Virginia Mental Health Institute #116-05

- The Office reviewed 1,025 critical incidents during this six-month period. Additional information was requested and/or review required for 243 of these incidents.

- The Office reviewed monthly quantitative data that was received from the sixteen DMHMRSAS operated facilities.

- A formal review of 9 DMHMRSAS Regulations and Policies was completed.

- The Inspector General made 6 presentations regarding the work of the Office and other topics at various conferences, statewide and local organization.

- Staff participated in 14 of statewide committees or meetings related to the mental health, mental retardation and substance abuse service system.

- Staff attended 8 conferences or training events regarding issues relevant to the work of the Office.

- The Office of the Inspector General responded to 38 complaints/concerns and inquiries from citizens, consumers and employees regarding a variety of issues during this reporting period.

- The Office of the Inspector General reviewed the autopsy reports of 44 deaths that occurred at DMHMRSAS facilities.

VISION, MISSION & VALUES

The Office of Inspector General was created to provide an independent system of accountability to the Governor, General Assembly, consumers and other stakeholders regarding the quality of the services provided by the sixteen facilities operated by DMHMRSAS and the licensed providers as defined in § 37.2-403, including the licensed mental health treatment units in state correctional facilities.

Vision

Virginians who are affected by mental illness, mental retardation, and substance use disorders, and their families, will receive high quality, consumer focused services.

Mission

It is the mission of the Office of the Inspector General to serve as a catalyst for improving the quality, effectiveness, and efficiency of services for people whose lives are affected by mental illness, mental retardation, and substance use disorders.

Values to Guide the Work of the OIG

Consumer Focused and Inclusive
Quality Processes and Services
Integrity
Mutual Support and Teamwork
Respect
Creativity

ACTIVITIES OF THE OFFICE

A. INSPECTIONS

During this semi-annual reporting period, the OIG expanded the work of the Office to include inspections of programs licensed by DMHMRSAS. This included a review of the statewide system of CSB emergency services programs (ESP), an inspection of a private provider of residential services, and an inspection of a licensed mental health treatment unit at a facility operated by the DOC. In addition, the OIG conducted unannounced inspections at three DMHMRSAS operated facilities. The OIG performs at least one unannounced inspection annually at each of the DMHMHSAS operated facilities.

INSPECTIONS OF CSB EMERGENCY SERVICES PROGRAMS AND OTHER LICENSED PROGRAMS

The OIG conducted a review of the statewide system of CSB emergency services programs during May to August 2005. This focus for the OIG's first review of licensed community programs was selected because of the critical role ESPs play in responding to citizens when they are most at risk. Over 49,000 individuals are served annually by ESPs.

To assure that the review focused on current issues, the OIG invited the contribution of ideas from a wide range of stakeholders including consumers, family members, community and facility providers and the staff of the DMHMRSAS. The review was based on the following Quality Statements for Emergency Services:

- The work of the ESP is guided by a clearly stated mission statement and principles or values. These statements are understood by staff and guide their work.
- The ESP has clearly developed policies and procedures that provide guidelines for practice. ESP practices comply with policies.
- The ESP assures that all staff providing crisis intervention services are qualified to provide these services and there is competency training and a system for assessing competency in place to assure that all staff have the skills to meet the needs of consumers.
- Emergency Services, including both crisis intervention and prescreening services, are available at all times and easily accessible in a timely fashion.
- The CSB offers an array of intervention services that address the emergency needs of the community and its citizens.
- Crisis interventions are guided by sound clinical judgment and seek to meet consumers' needs with the least restrictive option for care, with involvement and choice for the consumer.
- Services are provided in a manner that supports consumers in feeling safe and fosters treatment with dignity and respect. The location of emergency services provides for confidentiality, privacy, consumer comfort, and security.

- There are systems in place to monitor and continuously improve the effectiveness of the emergency services provided, including consumer and stakeholder satisfaction.
- Emergency services complement, support, and are well coordinated with the other services consumers' receive from the CSB.

The methodology for the review included the following: a survey of all 40 CSBs, unannounced telephone responsiveness tests of all 40 ESPs, and unannounced field inspections of 18 ESPs. Interviews were conducted with 246 consumers, 78 community stakeholders (sheriffs, police, hospital staff, magistrates) and 122 CSB staff. The results of this review were presented widely to legislative staff and committees, provider associations and advocacy groups.

In addition, the OIG conducted the first inspection of a licensed private provider of residential services and the first inspection of a licensed mental health treatment unit in a facility operated by the DOC. Both of these were Secondary Inspections in response to specific incidents or complaints.

INSPECTIONS OF STATE FACILITIES

The OIG conducted three unannounced inspections at facilities operated by DMHMRSAS. A Primary Inspection (comprehensive) was conducted at:

- Hiram W. Davis Medical Center #120-05

A Snapshot Inspection (follow up) was conducted at:

- Virginia Center for Behavioral Rehabilitation #119-05

One Secondary Inspection was conducted at a DMHMRSAS operated facility in response to a specific incident or complaint.

B. REPORTS

The OIG completed 8 reports during this six- month period. Reports are generated as a tool for performance improvement and provide the Governor, General Assembly and DMHMRSAS with findings and recommendations regarding observations related to a number of quality indicators. DMHMRSAS develops a plan of correction (POC) for each recommendation made by the OIG. Implementation of the plan of correction is monitored by the OIG until successful resolution has occurred. OIG reports can be found on the OIG website at www.oig.virginia.gov .

The following reports were completed on inspections that were conducted during the prior semi-annual reporting period:

Central State Hospital	#114-05
Eastern State Hospital	#115-05
Southwestern Virginia Mental Health Institute	#116-05

The following reports were completed on Primary and Snapshot Inspections/Reviews that were conducted during this semi-annual reporting period:

Virginia Center for Behavioral Rehabilitation	#119-05
Hiram W. Davis Medical Center	#120-05
CSB Emergency Services Programs Review	#123-05

Two reports were completed on the two Secondary Inspections that were conducted to investigate specific incidents or complaints.

C. DATA MONITORING

Critical Incident Reports

Documentation of critical incidents as defined by Virginia Code *§ 2.1-817* is forwarded routinely to the OIG for review and monitoring. Approximately 1,025 critical incident (CI) reports were reviewed during this semi-annual period. The OIG conducted an additional level of scrutiny and follow up for 243 of the CI's that were reviewed. The information gathered from the additional inquiries was used to identify potential problems within state facilities and to track trends in areas of concern.

Quantitative Data

In order to track potential areas of risk within the facilities on a routine basis between periodic inspections, the OIG receives monthly statistical data from each of the 16 DMHMRSAS operated facilities. Over time the tracking of this information has enabled the development of trends within each facility. Areas that are monitored in this way include, but are not limited to, facility census, seclusion and restraint use, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect.

The OIG also receives reports form the Medical Examiner's office for each of the deaths that occurs in the DMHMRSAS operated facilities. The OIG reviews each of the autopsy reports with the assistance of a physician consultant and tracks specific information on all deaths.

D. FOLLOW-UP REPORTING

All active or non-resolved findings from previous inspection reports are reviewed through a follow-up process until they have been successfully resolved. In general, evidence is required from at least two sources in order to recommend that the finding become inactive. The sources may include observations by the inspection team; interviews with staff and consumers; or a review of policies, procedures, memoranda, medical records, meeting minutes, or other documents.

There are currently 59 active findings that the OIG will follow-up on in the next set of facility inspections.

E. REVIEW OF REGULATIONS, POLICIES AND PLANS

During this semi-annual reporting period, the OIG reviewed and/or made comments on the following regulations, polices and plans:

- DMHMRSAS Comprehensive State Plan
- Human Rights Regulations
- POLICY 1034(SYS)05-1 Partnership Agreement
- POLICY 1035(SYS)05-2 Single Point of Entry Case Management Services
- POLICY 1036(SYS)05-3 Vision Statement
- POLICY 1037(SYS)05-4 Individual Consumer Information and Community Consumer Submission
- POLICY 1016(SYS)86-23 Policy Goal of the Commonwealth for a Comprehensive, Community-Based System of Services
- POLICY 1015(SYS)86-22 Services for Individuals with Co-Occurring Disorders
- POLICY 1030(SYS)90-3 Consistent Collection and Utilization of Data in State Facilities and Community Services Boards

F. PRESENTATIONS AND CONFERENCES

Inspector General Stewart made presentations regarding the work of the office or served as the guest speaker for the following:

- KOVA Institute
- PAIR
- Joint Commission on Healthcare Behavioral Health Subcommittee
- New River Valley CIT Awards Luncheon
- Virginia Hospital and Healthcare Association (VHHA) Behavioral Health Forum
- Mental Health Planning Council

Staff of the OIG participated in the following conferences and trainings events:

- National Alliance on Mental Illness Conference
- Virginia Association of Community Services Board Conferences
- Innovations Conference
- National Investigators/Inspector's Training
- Special training by consultants (Pomerantz and Reid) at training centers
- DPB Strategic Planning
- LEAD Training on High Performance Organizations
- Virginia Council on Government

G. MEETINGS

The OIG participated in a variety of forums and on various committees that address issues relevant to mental health, mental retardation and substance abuse issues and to state government:

- Meetings with Governor Warner, Chief of Staff Bill Leighty & Secretary Jane Woods
- Regional Partnership of CSBs
- DMHMRSAS Medical Director's
- State MHMRSA Services Board
- VOCAL
- Human Rights Advisory Committee
- Virginia Healthcare and Hospital Association
- DMHMRSAS System Leadership Council
- Virginia Association of Community Services Boards
- DMHMRSAS Clinical Services Quality Management Committee (CSQMC)
- Olmstead Initiative
- DMHMRSAS Psychosocial Rehabilitation (PSR) Committee

H. INTERFACING WITH OTHER AGENCIES

The OIG staff met with the following agencies and organizations for the purpose of planning specific OIG projects:

- DMHMRSAS central office staff
- DMHMRSAS facility staff
- Community Services Boards executive directors and emergency services program staff
- Virginia Hospital and Healthcare Association
- Virginia Association of Community Services Boards
- Virginia Network of Private Providers

- General Assembly staff
- National Alliance on Mental Illness (NAMI)
- Arc
- PAIR
- VOCAL
- Mental Health Planning Council

I. COMPLAINTS, CONCERNS AND INQUIRIES

The Office of the Inspector General responded to 38 complaints/concerns and inquiries from citizens, consumers and employees regarding a variety of issues during this reporting period. Of these contacts, 12 were complaints/concerns regarding DMHMRSAS licensed programs; 4 were complaints/concerns regarding DMHMRSAS operated facilities; and 22 were requests for information or assistance.

J. OIG WEBSITE

During this semi-annual reporting period the OIG website was redesigned. The purpose of this redesign was to bring the website into compliance with VITA standards and to create a more user-friendly website. The new website contains information about the OIG staff, enabling legislation, OIG reports, and links to other agencies and regulatory offices. The address for the OIG website is www.oig.virginia.gov.

ADDENDUM A

COMPLETED INSPECTION REPORTS
April 1 – September 30, 2005

CENTRAL STATE HOSPITAL
OIG #114-05

Finding #1: In much of the hospital the general morale of direct care staff was quite low. A significant number of those who were interviewed stated that they do not feel valued by the facility, especially the administration. The majority of the direct care staff who were interviewed stated that they have few or no opportunities to actively participate in decision-making and planning activities. Staff throughout the hospital stated that they have very little or no contact with the senior administrators of the facility. The low morale of nurses (RN's) is recognized to be a problem campus-wide and was mentioned as a major concern by all groups of employees including physicians, clinical staff, non-supervisory staff and administrators. Problems with recruitment and retention of direct care staff, especially nurses, places significant pressure on staff to work overtime and limits the use of earned vacation time. Over the past six months, the OIG has received 5 complaints from CSH staff. These involved concerns regarding supervisory fairness, excessive overtime and denial of requests for vacation.

Finding #2: An overwhelming majority of the staff that was interviewed could not provide a clear and consistent description of the facility's mission or the organizational values that have been established to guide how consumers and employees are to be treated.

> **Recommendation for Findings #1 and #2:** It is recommended that the Commissioner of Mental Health, Mental Retardation & Substance Abuse Services appoint an Advisory Committee to the director of CSH. The purpose of this committee will be to assist the director in developing, implementing and monitoring progress toward strategies that will:
>
> - Resolve the longstanding staff morale problems at the facility.
> - Create a common culture throughout the facility in which all staff fully understand their mission and are guided by a common set of values regarding how consumers and staff will be treated
>
> It is suggested that the Advisory Committee be composed of one senior administrator from DMHMRSAS, two directors of state operated mental health or mental retardation facilities, and two other individuals or consultants who are not employed by DMHMRSAS.

Finding #3: Consumer engagement and participation in the psychosocial rehabilitation program (PSR) was very limited. In over half of the groups that were observed, a considerable number of the consumers were sleeping. In several groups the consumers did not arrive for their classes on time and left before the group session was over. In some groups the content was not presented at a level that could be understood by consumers. Several facilitators were not adequately prepared to conduct the session.

Recommendation: It is recommended that the facility establish a committee composed of clinical, rehabilitation, and medical staff as well as consumers, with representation from the senior facility administrative staff to:

- Review and evaluate each PSR course offering to determine the appropriateness of the content for consumers and make recommendations for retention, redesign or elimination as appropriate.
- Recommend any additional offerings that are needed.
- Recommend a system for selecting and preparing staff to teach or facilitate each PSR offering.
- Recommend an ongoing system for monitoring the effectiveness of individual facilitators and the effectiveness of the content so that changes can be made as needed.

Once the recommendations have been formulated, the facility director should assure implementation.

EASTERN STATE HOSPITAL
OIG REPORT #115-05

Finding #1: Several units that were inspected did not have a dedicated RN assigned to cover the shift. RN coverage for these units was provided by RNs who were assigned to other units. Of the 149 approved RN-I, RN-II and RN-III direct care positions in the facility's staffing complement, 82 (55%) were filled and 67 (45%) were not filled at the time of the inspection. In addition to the 149 approved RN positions assigned to direct care, another 42 RN's are assigned to supervisory or administrative duties. Direct care staff expressed concern that the lack of nursing staff deployed to direct care decreases facility morale and places the quality of care at risk.

Finding #2: Direct care staff report that on average they are required to work two overtime shifts per week. When this occurs, employees work two16 hour periods during the week in addition to the standard schedule on the remaining days of the week. The majority of direct care staff who were interviewed (27 of 32) stated that the use of mandatory overtime is the primary reason for staff dissatisfaction and problems with morale. Several staff reported that they have difficulty working with the most challenging consumers during the overtime shift because they are tired and not as alert. In units where there was a significant number of staff on overtime, the staff interaction with consumers was more limited than in other units.

Recommendation for Findings #1 and Finding #2: It is recommended that the facility administration, with the involvement of direct care staff and Human Resources staff from DMHMRSAS central office, (1) identify the barriers to successful recruitment and retention of staff, (2) survey other DMHMRSAS facilities to identify strategies that have been successful elsewhere and (3) develop and implement any new strategies that can be identified to resolve the staffing shortage. It is further recommended that the facility evaluate each of the 42 supervisory or administrative positions that is currently filled by an RN to

determine if the duties can be carried out by an individual who is not a nurse in order to free up RN's for direct care.

Finding #3: Over 40% of the 24 consumers who were interviewed reported that they do not feel safe within the facility.

Recommendation: It is recommended that the facility assess its organizational culture to determine why consumers do not feel safe and what steps will be required to correct this problem. Once this assessment is complete, the facility should develop an action plan to implement the identified steps.

Finding #4: Approximately 50% of the staff that were interviewed stated that they do not feel that the facility provides an effective way for line staff to contribute their ideas and participate in decision-making activities. They reported that they are informed of decisions after the fact and rarely have opportunities to participate in the process. Most of these employees work during evening and night shifts. Of the 32 direct care staff who were interviewed by the OIG, 27 report that they do not feel valued by the facility leadership. Those who were interviewed stated that they have little or no contact with the facility director and other members of the leadership team.

Recommendation: It is recommended that the facility director engage a human resources specialist from the DMHMRSAS central office or an organizational development consultant to help assess what it is about the organizational culture and/or the facility leadership that causes staff to feel that they cannot contribute their ideas and that they are not valued. Based on the findings, the director should develop and implement a plan that will resolve these concerns.

Finding #5: Community providers find the facility difficult to work with, both with regard to consumer access and regional planning initiatives. These providers describe the facility as "resistant, inconsistent and arbitrary" in its willingness to admit even those in the most difficult crises. Concerns reported by numerous community providers include the following: ESH often refuses or resists admission to consumers who are on temporary detention orders (TDO) even when a bed cannot be found in the community. On weekends, CSBs that attempt to contact ESH for acute admissions reach only an answering machine. It is the understanding of CSBs that ESH will not accept acute admissions on weekends. The facility is very resistant to accepting dually diagnosed individuals with both mental illness and mental retardation. For these reasons, many community providers do not consider the facility a dependable safety net for the region. Staff within the facility and numerous community providers describe a continuous pattern of resistance, delays, and the establishment of barriers by the facility leadership to effective regional planning.

Recommendation: It is recommended that the DMHMRSAS Commissioner follow up on this finding by conducting a more in depth evaluation of the perception of the facility by community providers. Once this evaluation is

complete, it is recommended that the Commissioner develop a plan with the ESH director to address the concerns that are identified.

Finding #6: The facility psychosocial rehabilitation program (PSR) does not have an effective system in place to notify consumers when programs will be delayed in starting, cancelled or moved to alternate space. Staff and consumers reported that group facilitators are often late arriving for their PSR sessions. When consumers arrive at their assigned PSR session, there is no indication as to whether the instructor is late, the session has been moved to alternate space, or the session has been cancelled. The result for consumers is confusion regarding where they should be or how long they should wait.

> **Recommendation:** It is recommended that the facility establish a procedure that will assure that consumers know right away when there is a change in the PSR schedule that involves cancellation of a session, tardiness of the facilitator or change of location.

Finding: #7: Several bathrooms in residential areas were not clean. Toilets and sinks were leaking onto the floor.

> **Recommendation:** It is recommended that (1) the facility inspect all bathrooms in residential units, identify toilets and sinks that need repair and conduct the repairs, (2) this be done regularly on a scheduled basis, and (3) that the facility establish expectations and a procedure that will assure that bathrooms are not only cleaned on a regular basis but also are cleaned on an as needed basis.

VIRGINIA CENTER FOR BEHAVIORAL REHABILITATION
OIG REPORT #119-05

The OIG has no facility specific findings and recommendations for Virginia Center for Behavioral Rehabilitation as a result of this inspection.

HIRAM W. DAVIS MEDICAL CENTER
OIG REPORT #120-05

The OIG has no facility specific findings and recommendations for Hiram W. Davis Medical Center as a result of this inspection.

REVIEW OF THE
VIRGINIA COMMUNITY SERVICES BOARD
EMERGENCY SERVICES PROGRAMS
OIG #123-05

Access Finding 1: The majority of Virginia's CSBs do not provide a comprehensive range of crisis intervention services for those with mental illness and substance use problems. Almost all CSBs offer the least restrictive Crisis Response, Resolution and Referral Services and most restrictive Inpatient Hospital Services, but very few offer the

critical mid-range Community Crisis Stabilization Programs that effectively stabilize difficult crisis situations in the community. As a result, many consumers are denied effective treatment in the least restrictive setting and there is greater dependence on inpatient hospital care that is the most costly treatment alternative. As one family member put it, “You get either too much…or nothing at all.”

- Only 13 (32.5%) of the CSBs offer or have limited access to one or more Community Crisis Stabilization Program alternatives. See chart above for number of CSBs having access to each type of service.
- Only 3 residential crisis stabilization programs exist in Virginia currently. As a result of funding provided by the General Assembly in the 2005 session, an additional 8 programs will become operational during FY06.
- Because crisis stabilization in the community has traditionally not been a part of the continuum of emergency services and is currently not widely available, Inpatient Hospital care is the only alternative for those who require more restrictive settings. 65% of staff interviewed and 51% of consumers interviewed said that the lack of local inpatient beds for acute care was the most significant need. When asked if the availability of Community Crisis Stabilization would help limit the demand for inpatient services, the answer was consistently yes.
- In the course of the 18 OIG site visits, a number of stories were told about consumers who were held in excess of the 4-hour legal limit of the ECO in local hospital emergency rooms for 24 to 36 hours. The explanation for these situations was that local psychiatric inpatient beds were unavailable or local beds were available but the private hospital refused the specific consumer and the regional state hospital also refused the admission.
- There is inconsistency across the state regarding safety net access to state hospitals when other alternatives for treatment in secure settings is not available

Access Recommendation 1a: It is recommended that DMHMRSAS, in cooperation with the Virginia Association of Community Services Boards (VACSB), conduct a short-term study to:

a. Identify and define the alternative types of Community Crisis Stabilization Services that are needed by CSBs to provide a comprehensive array of emergency services.
b. Determine which of these services if made available widely throughout the state would enable CSBs to improve their ability to serve consumers who are in crisis less restrictively.
c. Quantify the number and cost of each type of service that is needed.

Access Recommendation 1b: Based on the results of the study, it is recommended that:

- Individual CSBs and regional groupings of CSBs seek to identify ways in which current resources may be redirected to create crisis stabilization alternatives.

- DMHMRSAS request sufficient funding to enable the development of the needed Community Crisis Stabilization Services statewide.

Access Recommendation 1c: It is recommended that once projections can be made regarding the impact of the widespread availability of Community Crisis Stabilization, DMHMRSAS in collaboration with the VACSB, the Virginia Hospital and Healthcare Association and other stakeholders conduct a study to determine what level of local acute psychiatric Inpatient Hospital care is needed and develop strategies to address any unmet need(s).

Access Recommendation 1d: It is recommended that DMHMRSAS develop consistent expectations for all state hospitals regarding

a. Admission of consumers when acute beds are not available in local community hospitals.
b. Admissions procedures during weekday, evening and weekend hours.

Access Finding 2: While the majority of CSBs offer the less intensive Crisis Response, Resolution and Referral Services, capacity limitations significantly restrict service effectiveness, especially in rural areas.

- The vast majority of CSB's do not have adequate psychiatric medical services available to consumers in crisis. Only one CSB offers face-to-face psychiatric services 24 hours per day. Only 11 CSBs offer direct emergency psychiatry services during weekdays and most of these restrict access to consumers who are currently on the active physician caseload. CSBs report that two factors contribute to the shortage – difficulty recruiting due to limited availability and insufficient resources. The problem exists in both rural and urban areas of the state.
- Only 9 of 40 CSBs routinely provide mobile ESP services to consumers wherever they may be – at home or even on the street. A larger number of CSBs provide limited mobile services to jails, hospitals, and other controlled settings.
- OIG telephone response time testing revealed that the length of time a consumer in crisis must wait to talk to a crisis clinician by phone varies significantly across the state. During the day, the wait exceeded 5 minutes at 10 (25%) of the CSBs. During the night the wait exceeded 15 minutes at 12 (30%) of the CSBs. See summary below. Details can be found in the Attachment Section of this report.

Length of Wait During Day	# of CSBs	Length of Wait During Night	# of CSBs
1 minute or less	14	1 minute or less	6
1 to 2 minutes	12	1 to 2 minutes	0
2 to 5 minutes	4	2 to 5 minutes	8
5 to 15 minutes	4	5 to 15 minutes	14
15 minutes or more	5	15 minutes or more	12
No response	1	No response	0

The most consistent explanation of delays was that the ESP clinician was already on the phone with a caller and the backup system required longer response or there was no backup clinician available.

- 68% of consumers reported that they are able to gain telephone access to an ESP clinician "quickly." 61% said that they were satisfied with the length of time it takes to gain face-to-face contact with a clinician. These comments did not differentiate between response time during office hours and after hours.
- 40% of community stakeholders reported experiencing or hearing about delays for ESP staff to appear for face-to-face evaluations. It was interesting to note, however, that over half who expressed this concern volunteered that they believed the problem was a lack of resources, insufficient staff, etc.
- Only 8 CSBs report having ESP staff on site in the office 24 hours a day. This is up from 5 in a survey conducted 5 years ago by the VACSB.
- 12 CSBs route night and weekend calls to ES staff on duty, trained volunteers, or a hospital – rather than through a non-clinical intermediary such as an answering service. Such an arrangement not only reduces time to reach a clinically competent responder, but also affords an opportunity for consumers in crisis to receive supportive counseling, which may be all that is needed.
- 28 CSBs use an answering service or 911 to receive crisis calls after office hours. Each time a call is received, the answering service calls the ESP on-duty clinician who returns the call to the answering service and then calls the consumer. Delays in response often occur when the on-duty clinician is already on the phone when a second call is received by the answering service.
- 33 of 40 CSBs have made arrangements to assure that callers are able to reach the ESP toll free from throughout the catchment area. For the remaining 7 CSBs, toll calls are limited to after hours. In these areas, consumers can call 911 toll free.
- CSBs have arrangements in place to serve consumers who speak different languages or who have special communication needs, however, delays often occur after hours when these special services are required.

Access Recommendation 2a: It is recommended that DMHMRSAS provide leadership to an initiative that will enable a sharing of psychiatric resources between state facilities and CSBs. This will result in maximizing the effectiveness of physicians who are already in the public provider system and will enhance the continuity and quality of care provided in facilities and in the community.

Access Recommendation 2b: It is recommended that each CSB routinely monitor the length of time required for consumers to gain telephone and face-to-face access to an ESP clinician during the day, night and weekend hours. If it is determined that response time is too long, to the extent possible within available resources, staffing and telecommunication equipment adjustments should be made to improve response time, especially with regard to accessing back up staff more quickly.

Access Recommendation 2c: It is recommended that DMHMRSAS request funding to enable CSBs to expand capacity and fill gaps in Crisis Response, Resolution, and Referral Services. As a result of this initiative, more psychiatric time will be available for direct service to consumers and consultation to ES staff; wait time will be decreased when multiple crises occur at the same time; greater mobility of emergency services will be enabled; ES staff will be able to provide more services by telephone and face-to-face.

Access Finding 3: Most communities do not have access to appropriate crisis intervention for consumers with mental retardation. In addition, the role of state hospitals and training centers in serving these persons is not clear. As a result: 1) consumers and staff are placed in dangerous situations and 2) consumers are referred to services that are not appropriate.

Access Recommendation 3a: It is recommended that DMHMRSAS conduct a study with the assistance of providers and recognized experts in the field of crisis and behavioral intervention for persons with mental retardation to:

a. Identify and define the continuum of crisis intervention services for persons with mental retardation.
b. Determine which of these services if made available widely throughout the state would enable CSBs to improve their ability to serve consumers with mental retardation who are in crisis.
c. Quantify the number and cost of each type of service that is needed.

Based on the results of the study, it is recommended that DMHMRSAS propose solutions and request sufficient funding to enable the development of the needed crisis intervention services for persons with mental retardation.

Access Recommendation 3b: It is recommended that DMHMRSAS establish a statewide policy that clarifies the safety net role of the training centers in providing emergency services to consumers with mental retardation who demonstrate severe behavior management problems or may have a severe mental illness. This policy should state clearly what conditions are appropriate for emergency admission, which are not and when it is appropriate for an individual with either of these conditions to be admitted to a state mental health hospital.

Access Finding 4: Non-emergency support and clinical services provided in the community do not have adequate capacity. As a result, ESPs deal with crisis situations that could have been prevented if the consumer had received more intensive or a different array of services.

- All CSBs that were visited by the OIG report that the limited capacity of their non-emergency psychiatric, case management, PACT, residential and outpatient services results in more crisis situations that could be prevented.

- The State Comprehensive Plan for MH/MR/SA Services, which is updated every two years as required by VA Code §37.2-315, documents significant unmet need for these services.

  Access Recommendation 4: In order to prevent crises and therefore lessen demand on the emergency services system, it is recommended that DMHMRSAS and DMAS work cooperatively to seek avenues to steadily increase the capacity of the community services system to provide non-emergency support and clinical services.

Access Finding 5: Current practices at public and private hospitals require medical evaluations to rule out non-psychiatric explanations for behavioral symptoms and to assess the presence of medical conditions that may exceed the treatment capabilities of the psychiatric facilities. Many ESP staff and stakeholders believe that these practices have become excessive, are inconsistent among hospitals, and may exceed the requirements of the current code for "emergency treatment." The delays, costs, legality, and inconsistency among hospitals of these practices are a major source of concern among stakeholders, hospital medical emergency rooms, and consumers.

- Hospital selectiveness and requirements for medical clearance were identified as the major contributors to the hospital bed access problem.
- Hospitals providing medical clearance services report un-reimbursed costs (often as much as $2500 per case).
- Long delays in obtaining medical clearance and in finding a willing facility to accept a person often exceed the four-hour limit established by Va. Code for Emergency Custody Orders (ECO). In these cases law enforcement officers may continue to hold a person without legal authority or some magistrates will issue a second ECO. While not consistent with the Va. Code, both practices do assure the safety of a consumer whom the CSB has determined is in need of detention. In the survey month of March 2005, CSBs reported that 37 children and adults were released against clinical judgment because ECOs lapsed.
- Differences of opinion and practice exist among CSBs, hospitals, magistrates, and local law enforcement personnel regarding Va. Code requirements for medical clearance and transportation. For example, some magistrates will not issue Temporary Detention Orders (TDO) to include transportation for medical clearance; some sheriffs will not transport consumers for medical clearance unless emergency care is needed.

  Access Recommendation 5a: It is recommended that the Code of Virginia be amended to clarify that medical screening is an authorized activity under TDO procedures.

  Access Recommendation 5b: It is recommended that DMHMRSAS develop and implement clear and consistent standards regarding medical clearance for all state hospitals and work with the Virginia Hospital and Health Care Association, and other appropriate bodies, to achieve a similar outcome for private hospitals.

Quality of Care Finding 1: Virginia's CSB system of emergency services is staffed with well qualified, experienced, highly motivated, and well-supervised staff. Staff knowledge of the adult mental health population is stronger than it is for other consumer groups. Ongoing training for ESP staff is limited. The system of certifying CSB emergency prescreeners needs to be updated and standardized.

- Review of personnel records and staff interviews showed that the overwhelming majority of ESP clinicians are clinically well qualified and receive excellent supervision and support from experienced clinical supervisors.
- 83 per cent of consumers and 91 per cent of stakeholders interviewed said that ESP staff are qualified. Often these comments were expressed with enthusiasm or warmth.
- The majority of ESP staff are very experienced in the provision of crisis intervention services. The average tenure of direct service ESP staff is 4.6 years in providing emergency services. All but a few staff have masters degrees, and 51 per cent are licensed. ESP supervisors have an average of 13.8 years of emergency services experience.
- All but a few pre-screeners have been certified under procedures developed by DMHMRSAS in response to General Assembly action. All CSBs understand and maintain the pre-screener certification process, although some do so more completely and thoroughly than others.
- CSBs use different processes and forms to document pre-screener certification. Guidelines for this process have not been reviewed and updated by DMHMRSAS since originally introduced in 1998-1999.
- ESP staff have excellent knowledge of crisis issues, crisis counseling, assessing risk of suicide and mental status exams for adults with mental health problems, however:
    - They are less knowledgeable of medications, medical issues, the civil commitment code and available services in the region and state.
    - They have limited knowledge regarding the service needs for those with substance use problems, children, adolescents, and the elderly.
    - Few reported knowledge or interest in mental retardation issues.
- Few staff receive ongoing formal training on topics related to emergency services (e.g., code requirements, how to serve various populations in crisis, etc.)
- Very few staff (or supervisors) are facile and knowledgeable in discussing crisis service options beyond the services offered by the CSB. Few staff readily identified crisis service continuum options such as those described in the OIG survey chart on page 12 of this report.

Quality of Care Recommendation 1a: It is recommended that DMHMRSAS, with the assistance of CSBs, update and clarify requirements for certification of CSB pre-screeners. New training materials should be developed. The DMHMRSAS Office of Licensure should inspect compliance.

> **Quality of Care Recommendation 1b:** It is recommended that DMHMRSAS and CSBs collaborate in developing and sponsoring regular training regarding a wide range of topics related to crisis intervention services including intervention with special populations.

Quality of Care Finding 2: CSB ESPs are sensitive to the importance of providing for the safety and privacy of consumers who are served in crisis. Whenever possible they arrange to provide services in settings that are not stigmatizing. Few provide mobile emergency services in the locations most preferred by consumers – their own homes or in the community.

- The OIG found clinical decisions to release or detain consumers to be appropriately safe, with no observed instances of release of persons who should have been detained for safety.
- 81 per cent of interviewed consumers said they felt safe and protected when they were served by the ESP program; 91 per cent of staff indicate that their services are safe for consumers.
- CSB staff reported that they feel safe themselves when seeing consumers in crisis and were able to cite appropriate safeguards that assured safety.
- There is wide variability among CSBs in the degree to which mobile crisis intervention services are provided. While resource limitations were often cited as the reason for not providing mobile services, the OIG observed that CSBs with comparable resources had varying practices regarding mobility.
  - Only 9 of the 40 CSBs reported that they provide fully mobile outreach - seeing consumers in their homes or wherever they may be (usually with police accompaniment).
  - Many more reported that they do go out to see consumers who are in crisis at supervised, safe locations such as schools, CSB program sites, assisted living facilities, hospitals, and jails.
- Newer, CSB-designed and owned facilities incorporate excellent separation, safety, privacy, and efficiency for ESP services.
- The hospital emergency departments used by CSBs for crisis intervention are mostly modern, efficient facilities with accessible services to determine medical clearance. These setting, however, most often do not afford privacy for persons in psychiatric crises.
- The hospital emergency room was the most common after hours site for serving consumers in crisis. A few CSBs reported that when law enforcement agencies are involved with the crisis they insist that the consumer be seen at the jail or sheriff's office rather than at the CSB's office or local hospital. This is particularly true in rural areas.
- Consumers state strongly that they are very uncomfortable and feel stigmatized when they are taken to a law enforcement facility to receive mental health services.
- Use of handcuffs and shackles by police and sheriffs during civil commitment transportation varies among localities, but are universally resented by consumers and families.

- Police chiefs and sheriffs, especially in rural counties and towns, report that personnel are delayed for hours on civil commitment processes causing high personnel costs and diminished public safety coverage

  Quality of Care Recommendation 2a: It is recommended that CSBs work actively to increase the use of mobile emergency services, seeing consumers in their home and community. It is also recommended that CSBs and local law enforcement agencies work together to increase their collaboration for the purpose of assuring safety for mobile crisis intervention staff.

  Quality of Care Recommendation 2b: It is recommended that CSBs and local law enforcement agencies make every effort to assure that crisis intervention services are provided in settings that are comfortable for consumers and decrease stigmatization.

  Quality of Care Recommendation 2c: It is recommended that statewide sheriff, police and CSB associations work collaboratively to develop guidelines for safe and non-stigmatizing transportation of consumers in the civil commitment processes.

Quality of Care Finding 3: All CSBs that were visited by the OIG have mission statements, and staff are generally familiar with the direction set for the organization. A number of CSBs do not have clearly stated operational values or guiding principles. While many of the CSB ESPs consider treatment in the least restrictive setting an important focus of their efforts, the availability of a limited array of crisis intervention services often prevents the realization of this intent. The majority of staff are not familiar with the recovery model which is a major component of the system vision statement recently adopted by DMHMRSAS.

.

- 32 per cent of staff described a mission for their ESP that was limited to civil commitment prescreening.
- 67 per cent described a broader mission of crisis intervention or clinical care for persons in crisis.
- Only 19 per cent of those interviewed used recovery model language (consumer choice, empowerment, self-determination).
- Only 21 per cent of staff reported familiarity with the recovery model; only a few supervisors reported training on it.

  Quality of Care Recommendation 3a: It is recommended that each CSB review its mission statement and make any needed changes to assure consistency with the system-wide vision statement adopted recently by DMHMRSAS. Once this is done, each CSB should review its strategic objectives and initiatives to assure that these are consistent with the system vision statement and revised CSB mission statement.

Quality of Care Recommendation 3b: It is recommended that each CSB develop a clearly stated set of values or principles that are consistent with the system vision statement. The purpose of these values or principles will be to guide how services are delivered to residents and how the CSB will relate to the broader system of care. Once these statements are established, each CSB should take the necessary steps to assure that the actions of staff at all levels and the culture of the CSB reflect the value or principle statements.

Quality of Care Recommendation 3c: It is recommended that DMHMRSAS, in conjunction with a representative group of CSB staff, state mental health facility staff and consumers, develop a training curriculum that is competency based regarding the principles of recovery. Once this curriculum is completed, training should be made available to CSBs, state facilities and licensed private providers.

Quality of Care Finding 4: CSB emergency services decisions regarding whether to detain or release consumers in crisis are consistently competent. These decisions are well documented and the documentation supported the clinical decision. These practices were consistent across the state.

- State facilities and private hospitals, which receive consumers prescreened by CSBs, indicated that they generally concur with the clinical findings and recommendations of the CSBs.
- Records at CSBs revealed that assessments were clinically competent. Case records supported the clinician's judgment to recommend release or detention of consumers.
- Clinical decisions about the need for detention based on danger to self or others were generally comparable across all CSBs that were inspected. It was found that one ESP has a greater propensity to detain than others across the state and this finding was communicated to the leadership of that CSB.
- Based on a 20-point clinical record measurement tool, all but a handful of 140 records were judged to provide good documentation.
- Review of records with ESP staff often highlighted the need to revise and update the Uniform Pre-Admission Screening Form. A number of ESP staff stated that they could be more efficient if an electronic version of the form could be made available.
- Occasional incomplete records were found. In most cases, this was a result of failure to fully complete the Uniform Pre-Admission Screening Form in situations where the consumer was seen only briefly and released.

Quality of Care Recommendation 4: It is recommended that DMHMRSAS, with the assistance of CSBs and private hospitals, revise and update the Uniform Pre-Admission Screening Form and make it available in electronic form.

Quality of Care Finding 5: Few CSBs report formal systems to monitor and improve effectiveness and quality of their emergency services. Nevertheless, feedback to the OIG by consumers and stakeholders revealed general satisfaction with the services.

- A minority of consumers (35 per cent) report that ESP staff asked them for feedback or their opinion on how well the services met their needs.
- 57 per cent of all stakeholders interviewed said the CSB never has asked them whether the service met their needs or how it could be improved. 51 per cent, however, said they felt they could make their views known to the CSB.
- Although most CSBs set a standard for their responsiveness to crisis calls, few actively tested or monitored responses.

Quality of Care Recommendation 5: It is recommended that each CSB develop a process for routinely seeking evaluative comments from consumers, families and community providers regarding the quality of services provided by the CSB programs, the effectiveness of the CSBs relationship with the broader provider service system, and general satisfaction with services.

Quality of Care Finding 6: ESP services are well coordinated with other CSB services for consumers, with generally good communication across programs.

- Communication and coordination between ESPs and other CSB operated mental health and substance services were generally found to be good. Coordination between ESPs and mental retardation services was a significant problem in some settings.
- No CSB visited has a system of developing and accessing crisis plans or advance directives.
- Only the eight CSBs that have 24 hour on-site staffing have the ability to access full clinical records to learn about current treatment of CSB consumers they see after hours.
- About a third of the CSBs have the ability after hours for ESP staff to determine whether or not a consumer is currently being served by the CSB and some basics about their condition. Only one CSB reported that it has electronic record accessibility off site after hours.

Quality of Care Recommendation 6a: It is recommended that CSBs work with consumers to develop advance directives or crisis plans in which consumers identify preferences, resources and requests that should be honored if the consumer experiences a crisis. These plans should be accessible to ESPs at all times.

Quality of Care Recommendation 6b: It is recommended that CSBs, with the assistance of DMHMRSAS, move toward electronic record systems that are accessible by ESP staff around the clock, as soon as possible.

Quality of Care Finding 7: Each ESP has a well-developed policy and procedure manual that includes resources to assist staff in serving consumers. ESP staff have knowledge and understanding of the policies and procedures that apply to the ESP. Clinical records reflect compliance with applicable policies and procedures.

No recommendations