COMMONWEALTH OF VIRGINIA
Office of the Governor

Timothy M. Kaine
Governor

April 27, 2007

To The General Assembly of Virginia:

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

As we continue our work together to transform the public mental health, mental retardation and substance abuse services system, the oversight of service quality provided by the Office of the Inspector General is critically important. During the past six months, the Inspector General has conducted inspections in our state mental health hospitals, the mental health treatment unit of a correctional facility, and community programs operated by both local government and private providers. The findings and recommendations of the Inspector General provide an important focus for our ongoing efforts to improve the quality of care.

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

Sincerely,

Timothy M. Kaine

TMK/mkh

COMMONWEALTH of VIRGINIA

Office of the Inspector General

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

April 27, 2007

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 semiannual report of activities for the period ending on March 31, 2007. 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 OIG conducted nine inspections at facilities operated by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS), two inspections at licensed community programs, and one inspection at a Department of Corrections operated facility. The most significant project was a series of reviews in eight mental health hospitals to determine the extent to which the experience of service recipients reflects the principles of recovery, self-determination and participation. These principles have been identified by the President's New Freedom Commission as important for all supports to individuals with mental illness and have been adopted by DMHMRSAS to guide the network of services in Virginia.

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

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

Semiannual Report
October 1, 2006 – March 31, 2007

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FOREWORD

The Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services (OIG) is pleased to submit this semiannual report of activities for the period ending on March 31, 2007. 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.

This semiannual report outlines the accomplishments of the OIG from October 1, 2006 through March 31, 2007. Information regarding the inspections that have been conducted at state facilities and licensed community programs is included as well as summaries of OIG monitoring and review activities.

During the past six months, the OIG conducted nine inspections at facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse (DMHMRSAS), two inspections at licensed community programs, and one inspection at a Department of Corrections operated facility. Seven reports were completed during this reporting period. A summary of these efforts is provided in this semiannual report.

HIGHLIGHT OF ACTIVITIES

- The OIG carried out the following inspections and reviews during this semiannual period:
    - Reviews of eight DMHMRSAS operated mental health facilities to determine the extent to which the experience of service recipients reflects the principals of recovery, self-determination, and participation:
        - Catawba Hospital
        - Central State Hospital
        - Eastern State Hospital
        - Northern Virginia Mental Health Institute
        - Piedmont Geriatric Hospital
        - Southern Virginia Mental Health Institute
        - Southwestern Virginia Mental Health Institute
        - Western State Hospital
    - Four unannounced Secondary Inspections of specific incidents or complaints: one DMHMRSAS operated facility, two licensed community programs, and one Department of Corrections operated facility.

- Seven reports were completed by the OIG during this reporting period.

  Four of these reports were of reviews and inspections that were conducted during the previous semiannual period and have now been released to the OIG website:
    - # 129-06 Review of Community Services Boards Substance Abuse Outpatient Services for Adults
    - # 130-06 Snapshot Inspection at the Virginia Center for Behavioral Rehabilitation
    - # 131-06 Follow-Up Review of Nine Mental Health Facilities Operated by DMHMRSAS
    - # 132-06 Snapshot Inspection at Hiram Davis Medical Center

  Three of these reports were of Secondary Inspections of specific incidents or complaints that occurred within the past six months.

- The OIG reviewed 468 critical incidents during this six-month period. Additional inquiry and follow up was conducted for 119 of these incidents.

- Monthly quantitative data from the sixteen DMHMRSAS operated facilities was reviewed.

- Autopsy reports of 20 deaths that occurred at DMHMRSAS facilities were reviewed.

- The OIG responded to 45 complaints, incidents and inquiries/referrals from citizens, service recipients and employees regarding a variety of issues during this reporting period.

- A formal review of two DMHMRSAS regulations and policies was completed.

- The Inspector General and OIG staff made 15 presentations regarding the work of the Office and other topics at various conferences, statewide and local organizations.

VISION, MISSION & VALUES

The Office of Inspector General was established to provide an independent system of accountability to the Governor, General Assembly, service recipients and other stakeholders regarding the quality of the services provided by the sixteen facilities operated by DMHMRSAS and the network of public and private providers licensed by DMHMRSAS as defined in the VA Code, § 37.2-403.

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 AND REVIEWS

During this semiannual reporting period, the OIG carried out the following inspections and reviews of DMHMRSAS operated facilities and licensed community programs.

REVIEW OF STATE-OPERATED MENTAL HEALTH FACILITIES TO DETERMINE COMPLIANCE WITH THE PRINCIPLES OF RECOVERY

The DMHMRSAS has adopted the principles of the nationally recognized Recovery Model as the foundation on which services for persons with mental illness are to be based. These principles include such concepts as self-direction, individualized and person-centered, empowerment, strengths-based, peer support and hope. During the past six months, the OIG conducted reviews at the following eight DMHMRSAS operated mental health facilities to determine the extent to which the experience of service recipients reflects these principals:

- Catawba Hospital
- Central State Hospital
- Eastern State Hospital
- Northern Virginia Mental Health Institute
- Piedmont Geriatric Hospital
- Southern Virginia Mental Health Institute
- Southwestern Virginia Mental Health Institute
- Western State Hospital

OTHER INSPECTIONS

The OIG conducted four unannounced Secondary Inspections of specific incidents or complaints: one DMHMRSAS operated facility, two licensed community programs, and one Department of Corrections operated facility.

B. REPORTS

The OIG completed a total of seven reports during this six-month period. Reports are generated as a tool for performance improvement and provide information to the Governor, General Assembly, DMHMRSAS, service recipients/families and providers regarding the findings, basis for findings and recommendations of the OIG. Following the receipt of each report, the provider 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.

Four reports were of reviews and inspections that were conducted during the previous semiannual period and have now been released to the OIG website:

- # 129-06 Review of Community Services Boards Substance Abuse Outpatient Services for Adults
- # 130-06 Snapshot Inspection at the Virginia Center for Behavioral Rehabilitation
- # 131-06 Follow-Up Review of Nine Mental Health Facilities Operated by DMHMRSAS
- # 132-06 Snapshot Inspection at Hiram Davis Medical Center

Three reports were of Secondary Inspections of specific incidents or complaints that occurred within the past six months.

C. DATA MONITORING

Critical Incident Reports

Documentation of critical incidents (CI) as defined by Virginia Code *§ 2.1-817*503 is forwarded routinely to the OIG by the DMHMRSAS operated state hospitals and training centers. The OIG reviewed 468 CI's during this semiannual period. An additional level of inquiry and follow up was conducted for 119 of the CI's that were reviewed.

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. Areas that are monitored include, but are not limited to, facility census, seclusion and restraint use, staff vacancies, use of overtime, staff injuries, and complaints regarding abuse and neglect. Due to concerns regarding the high utilization of overtime in the state facilities, information on mandatory and voluntary overtime is now captured separately.

The OIG also receives reports from the Medical Examiner's office for each of the deaths that occur in the state operated facilities. The OIG reviews each of the autopsy reports with the participation of a physician consultant. During this reporting period, the Office of the Inspector General reviewed the autopsy reports of 20 deaths that occurred at DMHMRSAS facilities.

D. FOLLOW-UP ON ACTIVE RECOMMENDATIONS

All active or non-resolved findings from previous inspections 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 27 active recommendations for the state facilities and 91 active recommendations for licensed programs.

E. COMPLAINTS, INCIDENTS AND INQUIRIES/REFERRALS

The Office of the Inspector General responded to 45 complaints, incidents and inquiries/referrals from citizens, service recipients and employees regarding a variety of issues during this reporting period. Of these contacts, 23 were complaints/concerns; 8 were incidents; and 14 were inquiries or referrals.

F. REVIEW OF REGULATIONS, POLICIES AND PLANS

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

- DMHMRSAS 12 VAC 35-200: Regulations for Respite and Emergency Care Admissions to Mental Retardation Facilities
- Department of Social Services Guidelines related to Child Protective Services Policy on Reporting Abuse and Neglect.

G. PRESENTATIONS AND CONFERENCES

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

- Briefings for Legislative and Executive Branch staff
- Coalition for Mentally Disabled Citizens rally
- Community Integration Advisory Commission
- DMHMRSAS Medical Directors
- DMHMRSAS System Leadership Council
- Governor's Substance Abuse Council
- Mental Health Association of Charlottesville/Albemarle
- Mental Retardation Committee of Virginia Beach Community Services Board
- Northern Virginia Chapter of the National Alliance for Mental Illness
- Northern Virginia Coalition for Mentally Disabled Citizens
- Senate Finance Committee
- Supreme Court Mental Health Law Reform
- VACSB Fall Conference
- VACSB Mental Health/Substance Abuse Council
- Virginia Mental Health, Mental Retardation & Substance Abuse Services Board

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

- ARMICS (Agency Risk Management and Internal Controls Standards)
- Legislative Conference of VACSB
- Person-Centered Planning Conference
- System Information Needs Summit
- Scorecard Training
- Re-inventing Quality Conference
- VACSB Fall Conference

H. ORGANIZATIONAL PARTICIPATION/COLLABORATION

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

- Civil Admission Advisory Council
- County Behavioral Health Institute (CBHI) Board of Directors
- DMHMRSAS Advisory Consortium on Intellectual Disabilities (TACID)
- DMHMRSAS Clinical Quality Services Management Committee (CSQMC)
- DMHMRSAS Facility Directors
- DMHMRSAS Licensing Review Advisory Committee
- DMHMRSAS Medical Directors
- DMHMRSAS Person-Centered Planning Leadership Team
- DMHMRSAS Systems Leadership Council
- Fairfax County Josiah H. Beeman Commission
- Governor's Agency Head Meeting
- Joint Commission on Health Care
- Joint Commission on Youth
- Joint Legislative Audit and Review Commission (JLARC)
- Supreme Court Commission on Mental Health Law Reform and related Access and Child/Adolescent Task Forces

The OIG staff met with the following agencies, organizations and other groups to seek input to the design of specific OIG projects:

- Community Services Board executive directors and program directors
- Department of Medical Assistance (DMAS)
- DMHMRSAS central office staff
- DMHMRSAS facility staff
- DMHMRSAS Person-Centered Planning Leadership Team
- Joint Commission on Youth
- National Alliance on Mental Illness (NAMI)
- State Mental Health Planning Council

- Service recipients and family members
- Virginia Association of Community Services Boards (VACSB)
- Virginia Department of Education
- Virginia Network of Private Providers
- Virginia Office for Protection and Advocacy (VOPA)
- VOCAL (consumer leadership)