COMMONWEALTH of VIRGINIA

Office of the Inspector General

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

November 9, 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 September 30, 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 a comprehensive investigation of the April 16, 2007 critical incident at VA Tech. This investigation provided a detailed understanding of the mental health response by the university and the community. It also helped to clarify the service capacity of our community system of services and identify changes that may be needed in the Virginia Code regarding the judicial commitment process. A statewide review of CSB mental retardation case management services was also conducted. Finally, a series of inspections was carried out at the five training centers to determine the extent to which the experience of those who are served reflects the principles of self-determination and person-centered planning.

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 April 1, 2007 – September 30, 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 September 30, 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 April 1, 2007 through September 30, 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 eight inspections at facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse (DMHMRSAS) and a review of mental retardation case management services provided by the forty Community Services Boards. In addition, an investigation of the April 16, 2007 critical incident at VA Tech was carried out, and a survey of CSB outpatient services capacity and commitment hearing attendance was conducted. Five 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 five DMHMRSAS operated training centers to determine the extent to which the experience of individuals served reflects the principles of self determination, person-centered planning:
        - Central Virginia Training Center
        - Northern Virginia Training Center
        - Southeastern Virginia Training Center
        - Southside Virginia Training Center
        - Southwestern Virginia Training Center
    - A review of mental health case management services operated by the 40 CSBs. The review included a survey of all 40 CSBs and visits by OIG inspectors to a random sample of 28 of the CSBs.
    - An investigation of the April 16, 2007 critical incident at VA Tech that focused on:
        - New River Valley Community Services Board
        - St Albans Behavioral Health Center
        - VA Tech Cook Counseling Center
    - A statewide survey of CSB outpatient services capacity and CSB commitment hearing attendance
    - Annual Snapshot Inspections at the following DMHMRSAS operated facilities:
        - Commonwealth Center for Children and Adolescents
        - Hiram Davis Medical Center
        - Virginia Center for Behavioral Rehabilitation
    -

- Five reports were completed by the OIG during this reporting period:

    - #137-07 Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHMRSAS
    - #140-07 Investigation of April 16, 2007 Critical Incident at Virginia Tech University
    - # 141-07 Survey of CSB Outpatient Services Capacity and Commitment Hearing Attendance
    - # 142-07 Review of CSB Mental Retardation Case Management Services

  One report was completed on a Secondary Inspection that was conducted to investigate a specific incident or complaint.

- The OIG reviewed 395 critical incidents during this six-month period. Additional inquiry and follow up was conducted for 156 of these incidents.

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

- Autopsy reports of 13 deaths that occurred at DMHMRSAS facilities were reviewed.

- The OIG responded to 41complaints and requests for information/referrals from citizens, service recipients and employees regarding a variety of issues.

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

- The Inspector General and OIG staff made 14 presentations regarding the work of the Office and other topics at various conferences, statewide and local organizations.

- Staff attended 7 conferences or training events regarding issues relevant to the work of the Office.

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 THE SELF DETERMINATION AND PERSON-CENTERED EXPERIENCE OF INDIVIDUALS SERVED IN TRAINING CENTERS OPERATED BY DMHMRSAS

The DMHMRSAS has adopted the principles of self determination, person-centered planning and choice as the foundation on which services for persons with mental retardation are to be based. During the months of April and May 2007, the OIG conducted unannounced inspections at the following DMHMRSAS operated training centers to determine the extent to which the experience of service recipients reflects these principles:

- Central Virginia Training Center
- Northern Virginia Training Center
- Southeastern Virginia Training Center
- Southside Virginia Training Center
- Southwestern Virginia Training Center

This series of inspections established baseline data for one of the DMHMHSAS' performance measures. The review included observations of 271 randomly selected individuals, 238 interviews with direct care staff and interviews with each resident's facility case manager or qualified mental retardation professional (QMRP). Record reviews were completed for 119 of the 271 individuals observed. Questionnaires were administered to 311 facility employees, and the executive team of each facility was interviewed.

REVIEW OF CSB MENTAL HEALTH CASE MANAGEMENT SERVICES FOR ADULTS

During May and June 2007 the OIG conducted a review of the mental health case management services that are provided by CSBs. This review was based on the following Quality Statements for Mental Health Case Management Services:

- Case management services are person-centered and person-driven.
- Case management coordinates needed supports in a comprehensive manner, affording the person and his or her family the greatest possible choice among providers and services.

- Case managers and the persons they serve share a constructive interpersonal helping connection that fosters trust, cooperation and support for each person's pathway to greater independence and self determination.
- Case management is an active, positive service that reaches out to the persons they serve and provides continuing, active supports.
- Case managers are qualified, well prepared, and supported in their roles.

The review included a survey of all 40 CSBs and visits by OIG inspectors to a random sampling of 28 of the CSBs. During the site visits, 275 recipient case records were reviewed and interviews were conducted with 262 case managers and 57 division directors and case management supervisors. To obtain additional information about the quality of case management services, telephone interviews were conducted with 92 family members and 26 private residential service and all five state operated training centers were surveyed.

INVESTIGATION OF APRIL 16, 2007 CRITICAL INCIDENT AT VA TECH

In response to the critical incident that occurred at VA Tech on April 16, 2007, the OIG conducted a comprehensive investigation in Blacksburg on May 24 and 25 with extensive follow up through June 9. The investigation examined the services that were provided in connection with a December 2005 temporary detention order (TDO) and judicial commitment process for the individual who was subsequently determined through law enforcement investigations to be the shooter in the critical incident. The primary focus of the investigation was:

- New River Valley CSB
- St Albans Behavioral Health Center
- VA Tech Cook Counseling Center

The purpose of this investigation was to formulate recommendations that will improve the response of the community and the mental health system to individuals who are experiencing a psychiatric emergency.

SURVEY OF CSB OUTPATIENT SERVICES CAPACITY AND COMMITMENT HEARING ATTENDANCE

In the course of the VA Tech investigation, the OIG learned that outpatient treatment options in the New River Valley area are extremely limited. It was also determined that the local CSB has a practice of not attending commitment hearings in the area. To obtain a better understanding of CSB outpatient service capacity and the extent to which CSB staff attend commitment hearings statewide, the OIG conducted a survey of all 40 CSBs in June. The report of this survey provides statewide, regional and individual CSB data on outpatient services wait time and service capacity and commitment hearing attendance practices.

OTHER INSPECTIONS

The OIG conducted annual unannounced snapshot inspections at the following DMHMRSAS operated facilities:

- Commonwealth Center for Children and Adolescents
- Hiram Davis Medical Center
- Virginia Center for Behavioral Rehabilitation

B. REPORTS

The OIG completed a total of five reports during this six-month period. Reports are prepared in order to 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.

One report was completed for a review conducted during the previous semiannual period:

- # 137-07 Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHMRSAS

Three reports were completed on investigations/reviews that were conducted during this semiannual reporting period:

- # 140-07 Investigation of April 16, 2007 Critical Incident at Virginia Tech University
- # 141-07 Survey of CSB Outpatient Services Capacity and Commitment Hearing Attendance
- # 142-07 Review of CSB Mental Retardation Case Management Services

One report was completed on a Secondary Inspection that was conducted to investigate a specific incident or complaint.

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 395 CI's during this semiannual period. An additional level of inquiry and follow up was conducted for 156 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 13 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 29 active recommendations for the state facilities and 106 active recommendations for licensed programs.

E. COMPLAINTS AND REQUESTS FOR INFORMATION/ REFERRALS

The Office of the Inspector General responded to 41 complaints and requests for information/referrals from citizens, service recipients and employees. Of these contacts, 31 were complaints/concerns and 10 were requests for information/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 35-105-115: Regulations for Issuing an Order of Summary Suspension of a License
- DMHMRSAS 12 VAC 35-105-10 et seq. Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation, Substance Abuse, the Individual and Family Disabilities Support Waiver and Brain Injury Residential Services

- DMHMRSAS 12 VAC 35-190-10 et seq. Regulations Establishing Procedures for Voluntarily Admitting Persons Who are Mentally Retarded to State Mental Retardation Facilities

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
- Behavioral Health Subcommittee of Joint Commission on Health Care
- Foundations of Recovery Conference
- Governor's Virginia Tech Panel
- Health, Welfare and Institutions Committee
- National Association of Counties - Justice and Public Safety Steering Committee
- Northern Virginia Chapter of the National Alliance on Mental Illness
- Senate Finance Committee
- Supreme Court Commission on Mental Health Law Reform
- Virginia Association of Community Services Boards - Spring Conference
- Virginia Association of Local Government Humans Service Officials
- Virginia Human Service Training Program
- Virginia Mental Health, Mental Retardation & Substance Abuse Services Board
- Western State Hospital Grand Rounds

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

- American Association of Inspectors General Conference
- Department of Planning and Budget Strategic Planning Training
- Institute for Law, Psychiatry and Public Policy Workshop
- Systems of Care and Evidence Based Practices Conference
- Transformation Conference
- Virginia Association of Community Services Boards Spring Conference
- United States Senate Productivity and Quality Award for Virginia

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
- DMHMRSAS Advisory Consortium on Intellectual Disabilities (TACID)
- DMHMRSAS Clinical Quality Services Management Committee (CSQMC)
- 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
- Supreme Court Commission on Mental Health Law Reform and related taskforces
- Voices for Virginia's Children

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 Network of Private Providers
- Virginia Office for Protection and Advocacy (VOPA)
- Virginia Organization of Consumers Asserting Leadership (VOCAL)
- Virginia Treatment Center for Children