COMMONWEALTH of VIRGINIA

Office of the Inspector General

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

May 19, 2008

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, 2008. 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 review of child and adolescent services provided by the 40 community services boards (CSB) statewide. This included site visits to the majority of CSBs and a survey of all 40 CSBs. Inspections were conducted at all five training centers operated by the Department of Mental Health, Mental Health & Retardation Services to assess progress toward earlier recommendations made by the OIG. Seven investigations of critical incidents or specific complaints were carried out at state facilities and community programs. In addition, the OIG provided active support to the Office of the Governor and the General Assembly as historic amendments were made to mental health sections of the Virginia Code following the tragic incident at VA Tech.

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, 2007 – March 31, 2008

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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, 2008. 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, 2007 through March 31, 2008. 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 five inspections and six investigations at facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse (DMHMRSAS) and one investigation at a community based program. In addition, a review and survey of child and adolescent services provided by the forty Community Services Boards was conducted. 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, investigations and reviews during this semiannual period:

    - Unannounced follow-up inspections of five DMHMRSAS operated training centers to assess progress toward earlier recommendations made by the OIG during a statewide systemic review:
        - Central Virginia Training Center
        - Northern Virginia Training Center
        - Southeastern Virginia Training Center
        - Southside Virginia Training Center
        - Southwestern Virginia Training Center
    - A survey and review of child and adolescent services operated by the 40 CSBs. The review included visits by OIG inspectors to 34 of the CSBs and a survey of all 40 CSBs.
    - Six investigations of critical incidents were conducted at facilities operated by DMHMRSAS and one investigation was conducted regarding an incident at a community based program.

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

    - #143-07 Snapshot Inspection at Hiram Davis Medical Center.
    - #144-07 Snapshot Inspection at Virginia Center for Behavioral Rehabilitation
    - #145-07 Snapshot Inspection at Commonwealth Center for Children & Adolescents
    - #148-07 Survey of CSB Child and Adolescent Services

    Three reports were completed on investigations that were conducted to investigate specific incidents or complaints.

- The OIG reviewed 429 critical incidents during this six-month period. Additional inquiry and follow up was conducted for 80 of these incidents.

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

- Autopsy reports of 31 deaths that occurred at DMHMRSAS facilities were reviewed.

- The OIG responded to 33 complaints and requests for information/referrals from citizens, service recipients and employees regarding a variety of issues.

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

- The Inspector General and OIG staff made 10 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, intellectual disabilities, 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, intellectual disabilities, 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, INVESTIGATIONS AND REVIEWS

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

Review and Survey of Community Service Board Child and Adolescent Services

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) conducted a comprehensive review of Community Services Board (CSB) child and adolescent services. Input to the design of this project was sought from a wide range of stakeholders at both local and state levels. The review was conducted in two phases.

- **Survey of Community Service Board Child and Adolescent Services**

The OIG conducted a survey of all 40 CSBs to assess the range, nature and other characteristics of Virginia's public community mental health, mental retardation and substance abuse services for children and adolescents. The 63-question survey was distributed to the CSBs on October 23, 2007. Data was requested on types of children's services provided, staffing, budgets, structure of services, and factors that encouraged or hindered the development of services. 100% of CSBs responded with completed surveys by the end of November.

- **Review of Community Services Board Child and Adolescent Services**

The OIG conducted a statewide on-site review of child and adolescent services at a sample (34) of CSBs beginning in March 2008. The purpose of the review was to assess the quality and availability of child and adolescent services offered by CSBs. Statewide this project included the review of 469 case records and interviews with 175 family members, 859 direct service staff and approximately 243 supervisors. It also included an online survey of Comprehensive Services Act (CSA) policy and management team members and family assessment and planning team members to which over 500 individuals responded.

Follow-up Inspections of Training Centers Operated by DMHMRSAS

During December 2007 and January 2008 unannounced follow-up inspections were conducted at five DMHMRSAS operated training centers to assess progress toward earlier recommendations made by the OIG during a statewide systemic review:

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

Other Investigations

The OIG conducted six secondary investigations of critical incidents or complaints at facilities operated by DMHMRSAS and one secondary investigation of a critical incident at a community based program.

B. REPORTS

The OIG completed a total of seven 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.

Three reports were completed for reviews conducted during the previous semiannual period:

- # 143-07 Snapshot Inspection at Hiram Davis Medical Center
- # 144-07 Snapshot Inspection at Virginia Center for Behavioral Rehabilitation
- # 145-07 Snapshot Inspection at Commonwealth Center for Children & Adolescents

One report was completed on a survey review that was conducted during this semiannual reporting period:

- # 148-07 Survey of CSB Child & Adolescent Services

Three reports were completed on inspections that were conducted to investigate specific incidents or complaints.

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 429 CI's during this semiannual period. An additional level of inquiry and follow up was conducted for 80 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 31 deaths that occurred at DMHMRSAS facilities.

D. COMPLAINTS AND REQUESTS FOR INFORMATION/ REFERRALS

The Office of the Inspector General responded to 33 complaints and requests for information/referrals from citizens, service recipients and employees. Of these contacts, 20 were complaints/concerns and 13 were requests for information/referrals.

E. 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 35-115-10 Exemptions to the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services
- DMHMRSAS Departmental Instruction 112 (TX)08 Smoking and Tobacco Use
- DMHMRSAS Departmental Instruction 211 (RTS)00 Use of Seclusion and Restraint in DMHMRSAS Hospitals
- State Board Policy 1042(SYS)07-1 Primary Health Care

F. 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

- Joint Commission on Health Care
- Virginia Association of Community Services Boards - Fall Conference and Emergency Services Conference
- Advisory Consortium on Intellectual Disabilities
- U.S. Department of Education 2007 National Meeting
- Person-Centered Planning Leadership Conference
- Southern Region Conference on Mental Health Statistics
- Board for Virginians with Disabilities
- Medical Center Hour Program at University of Virginia
- National Research Institute Conference

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

- Virginia Association of Community Services Boards Fall Conference
- Providing Person-Centered Supports – Fall Conference
- VACSB Emergency Services Conference
- U.S. Department of Education 2007 National Meeting
- Southern Region Conference on Mental Health Statistics
- National Research Institute Conference

G. 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
- Federal Center for Substance Abuse Treatment Technical Assistance Review
- Disability Coalition Legislative Rally
- Mental Health of America Charlottesville-Albemarle Chapter
- DMHMRSAS Statewide Recovery Workgroup

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
- DMHMRSAS central office staff
- DMHMRSAS facility staff
- DMHMRSAS Person-Centered Planning Leadership Team
- Joint Commission on Youth
- 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)
- VACSB Children's Services Council
- Child and Family Behavioral Health Policy and Planning Committee
- Old Dominion University
- Secretary of Health and Human Resources and staff
- Joint Legislative Audit and Review Committee (JLARC) staff
- Office of Comprehensive Services for Youth and At-Risk Youth and Families (CSA) staff
- Local CSA and Departments of Social Services (DSS) directors