COMMONWEALTH of VIRGINIA

Office of the Inspector General

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

November 20, 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 September 30, 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 completed the site visit phase of a comprehensive review of child and adolescent services provided by the community services boards (CSB). Unannounced inspections were conducted at eight of the state mental health hospitals, and ten investigations of specific complaints or critical incidents were conducted. In addition, a survey was conducted to assess the relationships between the local community services boards (CSB) and the colleges/universities in their communities.

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, 2008 – September 30, 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 September 30, 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 April 1, 2008 through September 30, 2008. Information regarding the inspections and investigations 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 completed the site visit phase of a comprehensive review of child and adolescent services provided by the community services boards (CSB). Unannounced inspections were conducted at eight of the state mental health hospitals operated by the Department of Mental Health, Mental Retardation and Substance Abuse (DMHMRSAS), and ten investigations of specific complaints or critical incidents were conducted. In addition, a survey was conducted to assess the relationships between the local community services boards (CSB) and the colleges/universities in their communities. Seventeen 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:

    - A review of child and adolescent services operated by the CSBs. This included site visits to 34 of the CSBs. This review included a survey of all 40 CSBs that was referenced in the previous semi-annual report for the OIG.
    - Unannounced follow-up inspections of eight DMHMRSAS operated mental health facilities to assess progress toward earlier recommendations made by the OIG regarding these facilities:
        - 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
    - A survey to assess the relationships across the Commonwealth between the 40 local CSBs and colleges/universities in their communities regarding certain mental health services.
    - Ten investigations of critical incidents were conducted at facilities operated by DMHMRSAS.

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

    - #139-07 Review of the Person Centered Experience of Individuals Served in Training Centers Operated by DMHMRSAS
    - #149-08 Review of CSB Child & Adolescent Services
    - #150-08 Follow-up Review of State Operated Training Centers
    - #154-08 Follow-up Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHMRSAS
    - # 164-08 Survey of CSB Working Relationships with Colleges/Universities
    - Twelve reports were completed on investigations that were conducted to investigate specific incidents or complaints.

- The OIG reviewed 394 critical incidents during this six-month period. Additional inquiry and follow up was conducted for 79 of these incidents.

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

- Autopsy reports of 24 deaths that occurred at DMHMRSAS facilities were reviewed.

- The OIG responded to 31 complaints and requests for information/referrals from citizens, service recipients and employees regarding a variety of issues.

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

- The Inspector General and OIG staff made eight 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, 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 of CSB Child and Adolescent Services – OIG Report #149-08

The OIG conducted a statewide on-site review of child and adolescent services at a sample (34) of CSBs during March and April 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, 459 direct service staff and approximately 243 supervisors. The review 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.

This project also included a comprehensive survey of all 40 CSBs regarding child and adolescent services that was referenced in the previous semi-annual report for the OIG.

OIG findings and recommendations that were developed as a part of this project can be found in Section H of this semiannual report on page 14.

Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHMRSAS - Follow Up 2008 OIG Report #154-08

DMHMRSAS has adopted the following goal to guide service delivery throughout the publicly funded system of services and has established a performance measure for the state mental health hospitals related to this goal.

> *Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policy and practices that reflect the unique circumstances of individuals receiving MH, MR and SA services.*

In FY2007, the OIG conducted the first Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHRSAS – OIG Report #137-07. This review was designed to determine what percentage of state hospital residents actually have a treatment experience that is guided by the concepts of recovery, self-determination, person-centered planning, and choice. In response to a recommendation by the OIG, each of the following eight state hospitals that serve adults

established a Comprehensive Facility Plan on Recovery to guide their performance improvement related to this goal:

- 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

During May and June 2008, the OIG returned to these eight state hospitals to conduct unannounced follow-up reviews of the recovery experience of residents. These inspections revealed a 21.5% increase in the recovery experience score for the sample population that was the subject of the review – a very positive outcome. No additional recommendations were made by the OIG as a result of this series of inspections.

Survey of Working Relationships between Community Services Boards and Colleges/Universities - OIG Report #164-08

The results of the Virginia Tech investigation highlighted the importance of effective working relationships among a number of community organizations and various departments of the college/university. Particularly important is the relationship between the local community services board (CSB) and the college or university.

In an effort to better understand the relationships across the Commonwealth between CSBs and colleges/universities in their communities, the OIG conducted a survey of the CSBs in August 2008. The survey form was sent to all 40 CSBs on August 12, 2008 and responses were due on August 25. The response rate was 100%.

This survey revealed that 16 (40%) of the CSBs do have working agreements with 27 different colleges/universities in their areas. Over 75% of these agreements include referral procedures for CSB emergency services and outpatient services and clarify prescreening protocols for temporary detention orders (TDOs). Fifty percent of the agreements include procedures for exchange of information regarding students who are served by the CSB. Approximately 25% of the agreements establish protocols for disaster response, include protocols related to the provision of medication to students who are served by the CSB, and include designation of a contact person at the institution who can be reached 24 hours/day by the CSB to facilitate the collection of information about a student who is the subject of a TDO. It was also learned that 38 (95%) of the CSBs would provide mandated services to students when these services are required by a college/university as a part of a planned intervention with troubled students. (Note: This is not referring to court ordered outpatient treatment but to services mandated by the college/university.)

Investigations

The OIG conducted 10 investigations of critical incidents or complaints at the following facilities operated by DMHMRSAS:

- Central State Hospital
- Central Virginia Training Center
- Eastern State Hospital
- Southwestern Virginia Mental Health Institute
- Western State Hospital

B. REPORTS

The OIG completed a total of 17 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 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 of inspections and reviews can be found on the OIG website at www.oig.virginia.gov.

Four reports were completed for inspections, reviews and investigations conducted during the previous semiannual period:

- # 139-07 Review of the Person Centered Experience of Individuals Served in Training Centers Operated by DMHMRSAS
- # 150-08 Follow-up Review of State Operated Training Centers
- Two reports on investigations of specific incidents or complaints.

Two reports were completed for reviews conducted during this semiannual reporting period:

- # 154-08 Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHMRSAS – Follow Up 2008
- # 149-08 Review of CSB Child & Adolescent Services

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

- # 164-08 Survey of CSB Working Relationships with Colleges/Universities

Ten reports were completed for inspections that were conducted during this semiannual reporting period 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 394 CIs during this semiannual period. An additional level of inquiry and follow up was conducted for 79 of the CIs 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, use of seclusion and restraint, staff vacancies, use of overtime, staff injuries, complaints regarding abuse and neglect.

The OIG receives reports from the Medical Examiner's office for all 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 OIG reviewed the autopsy reports of 24 deaths that occurred at DMHMRSAS facilities.

D. COMPLAINTS AND REQUESTS FOR INFORMATION/ REFERRALS

The Office of the Inspector General responded to 31 complaints and requests for information/referrals from citizens, service recipients and employees. Of these contacts, 27 were complaints/concerns and 4 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 35-180-10, Regulations to Assure the Protection of Participants in Human Research
- DMHMRSAS Departmental Instruction 701 (INF)93, Organization and Maintenance of the Clinical Record
- DMHMRSAS Departmental Instruction 201 (RTS) 03, Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities
- DMHMRSAS Policy 1023 (SYS), Workforce and Cultural and Linguistic Competency
- DMHMRSAS Policy 1043 (SYS) Disaster and Terrorism Preparedness
- State Board Policy 1044 (SYS) 08 – Board and Agency Interoperability.

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
- Virginia Human Service Training Program
- 2008 KOVAR Institute
- Infant and Child Mental Health Committee
- Mental Health Planning Council
- Statewide group of college and university counseling center directors
- University of Virginia School of Law

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

- Virginia Association of Community Services Boards Development and Training Spring Conference
- University of Virginia Institute of Law, Psychiatry and Public Policy

G. ORGANIZATIONAL PARTICIPATION/COLLABORATION

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

- Civil Admission Advisory Council
- DMHMRSAS Advisory Consortium on Intellectual Disabilities (TACID)
- DMHMRSAS Department Instruction 201 Workgroup
- DMHMRSAS Licensing Review Advisory Committee
- DMHMRSAS Medical Directors
- DMHMRSAS Person-Centered Planning Leadership Team
- DMHMRSAS Statewide Recovery Workgroup
- DMHMRSAS Systems Leadership Council
- Fairfax County Josiah H. Beeman Commission
- Joint Commission on Health Care
- Supreme Court Commission on Mental Health Law Reform and the Access Taskforce, Children's Services Task Force, and Workforce Development Committee
- Virginia Center for Behavioral Rehabilitation Advisory and Oversight Committee

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

- CSB executive directors and program directors
- Brunswick Correctional Center
- DMHMRSAS central office staff
- DMHMRSAS facility staff
- DMHMRSAS Person-Centered Planning Leadership Team
- DMHMRSAS Seclusion and Restraint Workgroup
- Joint Commission on Health Care staff
- Joint Commission on Youth staff
- Joint Legislative Audit and Review Committee (JLARC) staff
- Old Dominion University
- Secretary of Health and Human Resources and staff
- State Human Rights Committee staff
- State Mental Health Planning Council
- Service recipients and family members
- Virginia Association of Community Services Boards
- Virginia Network of Private Providers
- Virginia Office for Protection and Advocacy (VOPA)
- Virginia Organization of Consumers Asserting Leadership (VOCAL)

H. FINDINGS AND RECOMMENDATIONS

Review of CSB Child and Adolescent Services – OIG Report #149-08

The following findings and recommendations were formulated by the OIG.

A. Findings related to service availability

1. Families seeking services for children and adolescents with mental health service needs face enormous differences in service availability depending on where they live. Whether measured by expenditures, staffing, or percentage of child population served, the availability of mental health services for children and adolescents offered by CSBs varies widely among communities.

2. Few CSBs offer a large array of child and adolescent services with sufficient capacity to meet the needs of their community. Many CSBs have very limited services available to children. A few have virtually no service system designed especially for children.
3. Child and adolescent services at CSBs are mostly full to capacity, resulting in long waiting periods for new persons to access services. The average wait for all services, from all CSBs that reported was 26 days.

4. Representatives from stakeholder agencies express dissatisfaction with the levels of CSB service availability in their communities. Specific areas of concern include the following:
    - Wait time for access to services is too long.
    - The wide array of services that are needed to serve children is not available.
    - Services to children with substance abuse needs and autism spectrum disorders are inadequate.

5. Access to services for uninsured families and those that are not eligible for a dedicated source of funding for children and adolescents is extremely limited.

B. Findings related to service funding

1. Medicaid is the largest source of funding in CSB budgets for child and adolescent services. Statewide it composes 47.9% of funding for all three disabilities combined. For mental health services Medicaid makes up 54.1% across the state.

2. The majority of the CSBs that have developed more extensive systems of services for children have done so through the use of Medicaid, and not through special grants or CSA funding. The six highest per capita funded CSBs average 72% of their funding for mental health services from Medicaid. It is important to note however that 30% of the CSBs receive 10% or less of their funding for mental health services from Medicaid.

3. State general funds and local funding make up a comparatively small portion of total funds for child and adolescent services statewide. Total funding statewide includes 11.9% state funds and 17% local dollars for all three disabilities. For CSB mental health budgets, state funding is 10.7% and local funding is 12%.

4. CSA funds paid to CSBs for purchase of services make up a very small portion of CSB budgets for mental health services at only 8.6%. The budgets of 72% of the CSBs include less than 10% of their funding from CSA.

C. Findings related to service quality

1. Parents/caregivers of children receiving services at CSBs report very high levels of satisfaction with the CSB services their children are receiving.

2. Family level of involvement with CSB staff in the planning and provision of services is quite high. Families and stakeholders confirmed this involvement.

3. In the majority of cases reviewed, CSB involvement with and collaboration with other agencies was limited or did not occur.

4. Progress toward treatment goals is generally good for services provided by CSBs.

5. CSB assessments for co-occurring substance abuse needs in children receiving mental health services were not found to be comprehensive. When substance abuse was identified, treatment goals related to substance abuse were present in approximately half of the cases.

6. Few CSBs offer comprehensive, formal programs that have broad national recognition as "evidence-based practices" (EBP). Many CSBs, however, utilize elements and principles that are found in EBP literature.

7. Stakeholder ratings of multiple measures of overall CSB service quality were modestly positive (54.4% positive), but with dissatisfaction shown by a large minority of respondents (38.2% negative).

8. Access to services for parents and caregivers of children and coordination of children's services with services to parents is not adequate.

D. Findings related to CSA and interagency coordination

1. CSBs are not the provider of choice for community-based CSA-funded mental health services in many communities. Only just over half of stakeholder respondents say their CSBs fulfill this role.

2. CSA funds are only a minor source of support for children's services at CSBs. Average CSA funding for CSBs is only 6.8%. 42% of CSBs report receiving no CSA funding. The highest level of CSA funding for any CSB is 33%.

3. Many agency stakeholders say their CSBs do not adequately make clear what services they offer or who is eligible for services, and they express dissatisfaction with the limitations on service availability.

4. The leading factor CSBs cite that has helped them develop children's services is the support and cooperation of the local CSA CPMT and other community agencies to work together on meeting community needs.

5. Over half the CSBs (55%) say they have developed one or more specific services to help improve the provision of services offered to children in the CSA process. These services include intensive care coordination and utilization management.

E. Findings related to CSB workforce issues

1. CSBs have great difficulty recruiting and retaining qualified staff to provide children's services. They list it as the second highest factor that has hindered development of services.

2. CSBs have inadequate psychiatric time to meet the needs of the children in their communities. Only 12.5% of the CSBs report that they have adequate psychiatric resources. CSBs estimate that an additional 25 FTE psychiatrists are needed statewide. The average wait time to see a psychiatrist for children who are currently being served by CSBs is 37 days.

3. The leading suggestion from CSBs for what can be done at the state level to improve the development of children's services is the provision of training, especially on evidence-based, effective services to children and families. (Note: Respondents were asked to list factors other than simply "increase funding.")

4. CSB staff describes morale on their teams as very high.

F. Findings related to preventing out-of-community residential placements

1. Only partial agreement exists among CSBs and the agency stakeholder community about the services that are most needed to prevent out-of-community residential placements.

G. Overarching findings related to the development of CSB services

Three primary and interdependent factors were identified by the OIG as the leading determinates of whether or not CSBs have developed more comprehensive systems of services that meet the needs of families and stakeholder agencies:

1. The extent to which leadership has been exercised to place a priority on the development of children's services, to develop community and interagency relationships, to use creativity and skill in making use of funding from Medicaid, grants, and CSA. This leadership comes from CSB board members, executive director, leader of children's services, or some combination of these persons.
2. Limited availability of funding to provide services for uninsured families and children that do not qualify for CSA and other categorical programs for children.
3. Relatively limited use of CSBs by local communities to provide services that are reimbursed by CSA.

Recommendations

1. It is recommended that DMHMRSAS lead an interagency process to develop a comprehensive plan for the provision of publicly supported, community based mental health, intellectual disability and substance abuse services for children, adolescents and their families. The objective of this plan will be to determine the base level of services that should be available in every community, clarifying the array of services and per capita capacity that will be needed. The plan should leverage all available sources of funds such as Medicaid, CSA, special grants to support services and then estimate the level of additional state funds needed to achieve a balanced, flexible funding base to address the needs of those families that are uninsured or not eligible for other dedicated

sources of reimbursement. The planning process should include input from relevant state and local agencies and the private provider community. The target date for the completion of the plan would be no later than July 1, 2009. To assure that adequate staffing and planning expertise can be dedicated to the development of this plan, it is recommended that DMHMRSAS seek the assistance of experts with experience in planning for systems of MH/ID/SA services for children, adolescents and families to supplement departmental staffing.

It is further recommended that DMHMRSAS present the plan to the General Assembly clarifying the level of support that can be anticipated from non-state sources and identifying specific needs from state sources to enable responsible expansion of services in the first two years of implementing the plan.

It is further recommended that in subsequent legislative cycles DMHMRSAS provide a report to the General Assembly that claries progress achieved in expanding services for children, adolescents and children according to the plan, documents success in leveraging funds from non-state sources, and requests annual increases in state funds that will assure solid, responsible growth of a new system of services based on the comprehensive plan.

2. It is recommended that every CSB appoint a single person to lead services for children and adolescents.

3. It is recommended that DMHMRSAS provide leadership in determining the areas of training and staff development that are needed to increase consistency in the quality of services delivered by CSBs statewide to children and adolescents. It is further recommended that DMHMRSAS develop a plan for assuring that this training is made available to CSB staff.

4. It is recommended that the CSBs that have developed the more comprehensive systems of services for children and adolescents share information with other CSBs regarding the organizational, interagency collaboration, staffing, and funding factors that have enabled their success. DMHMRSAS and/or the Virginia Association for Community Services Boards could facilitate this educational effort.

5. It is recommended that CSBs evaluate their methods for assessing substance abuse to assure comprehensive evaluation of the need for substance abuse treatment, particularly when the identified problem is mental health or intellectual disability related.