COMMONWEALTH of VIRGINIA

Office of the Inspector General

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

May 22, 2009

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, 2009. 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 inspections at 10 facilities operated by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) and carried out three investigations of specific complaints or critical incidents. Two of these investigations were at DMHMRSAS facilities and one at a college counseling center. Six reports were completed during this reporting period. A summary of these efforts is provided in this semiannual report.

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, 2008 – March 31, 2009

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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, 2009. 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, 2008 through March 31, 2009. 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 inspections at 10 facilities operated by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) and carried out three investigations of specific complaints or critical incidents. Two of these investigations were at DMHMRSAS facilities and one at a college counseling center. Six 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 inspection at the Commonwealth Center for Children and Adolescents
    - Review of active OIG recommendations at the following state hospitals:
        - Central State Hospital
        - Eastern State Hospital
        - Northern Virginia Mental Health Institute
        - Piedmont Geriatric Hospital
        - Southern Virginia Mental Health Institute
        - Southwestern Virginia Mental Health Institute
    - Unannounced inspection at the Virginia Center for Behavioral Rehabilitation
    - Unannounced inspections of the eight DMHMRSAS operated mental health facilities that serve adults to assess progress toward earlier OIG recommendations related to the recovery experience of individuals in service.
    - Three investigations of critical incidents or complaints at facilities operated by DMHMRSAS.
    - One investigation at a college counseling center.

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

    - # 167-08, Commonwealth Center for Children and Adolescents Inspection
    - # 168-08, Follow-Up Review of Active Findings in the State Operated Mental Health Facilities
    - # 169-08, Virginia Center for Behavioral Rehabilitation Inspection
    - Three reports were completed on investigations that were conducted to investigate specific incidents or complaints.

- The OIG reviewed 433 critical incidents during this six-month period. Additional inquiry and follow up was conducted for 92 of these incidents.

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

- Autopsy reports of 12 deaths that occurred at DMHMRSAS facilities were reviewed.

- The OIG responded to 40 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 five 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.

Inspection of Commonwealth Center for Children and Adolescents – OIG Report #167-08

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) conducted an inspection at the Commonwealth Center for Children and Adolescents (CCCA) in Staunton, Virginia. The purpose of this inspection was to assess issues related to facility utilization, the use of seclusion and restraint, and workforce development. An unannounced visit occurred on November 1, 2008 with an additional site-visit on November 3, 2008. Over the course of the two day inspection, interviews were conducted with 27 members of the staff including administrative, clinical, and direct care staff. In addition, 29 direct care staff across all shifts completed a survey questionnaire. Observations regarding unit activities occurred on all three shifts, including weekend shifts. Staffing patterns were noted, including the use of overtime. Ten clinical records of the children that had experienced seclusion or restraint incidents during the previous quarter (July – September) were reviewed. Facility data relevant to the use of seclusion and restraint, staff injuries, utilization reviews, and staff turnover were also reviewed.

OIG findings and recommendations that were developed as a result of this inspection can be found in Section H of this semiannual report on pages 15 and 16.

Follow-Up Review of Active Findings in the State Operated Mental Health Facilities – OIG Report # 168-08

The purpose of this review was to assess progress made by the DMHMRSAS operated mental health hospitals toward 14 active OIG recommendations that had been made as a result of earlier inspections in fiscal years 03/04 and 04/05. This was an assessment of progress since the summer of 2006 when the last follow-up review on these recommendations was conducted (OIG Report 131-06). The following inspection activities were carried out:

- Site visits in 2007 to several individual facilities in connection with specific investigations.
- Site visits to the following facilities in the spring of 2008 to access progress toward recommendations related to the psychosocial programs:

    - Catawba Hospital (CAT)
    - Central State Hospital (CSH)
    - Eastern State Hospital (ESH)
    - Northern Virginia Mental Health Institute (NVMHI)
    - Piedmont Geriatric Hospital (PGH)
    - Southern Virginia Mental Health Institute (SVMHI)
    - Southwestern Virginia Mental Health Institute (SWVMHI)
    - Western State Hospital (WSH)
- Phone interviews with representatives of the Region V CSBs and the Regional Coordinator in Region V – November 2008.
- Site visit to SWVMHI – February 25, 2009
- Review of updates provided by each facility in response to specific requests for information by the OIG.

Inspection activities conducted by the OIG during site visits included document reviews, interviews with staff and individuals receiving services, and observations of the environment of care.

As a result of this series of follow-up inspections at the mental health facilities, the OIG determined that sufficient progress had been made on 12 of the 14 recommendations. These recommendations have now been classified as inactive. The two recommendations that remain active are at Eastern State Hospital (ESH) and deal with staffing/recruitment issues and staff involvement/communication.

Inspection of Virginia Center for Behavioral Rehabilitation - OIG Report #169-08

The OIG conducted an unannounced inspection at the Virginia Center for Behavioral Rehabilitation (VCBR) on November 7, 2008, with a second (announced) visit on November 14. The purpose of this inspection was to provide an evaluative review of the active treatment program, assess census and staffing levels, and assess progress toward findings and recommendations made by the Office of the Inspector General (OIG) in 2007. The 2008 inspection was considerably more extensive than the 2007 review. A random sample of 48 residents participated in confidential interviews; the clinical records of an additional 44 residents were reviewed; 74 staff and 9 members of facility leadership were interviewed; and personnel and staff training records were reviewed.

OIG findings and recommendations that were developed as a result of this inspection can be found in Section H of this semiannual report on pages 16 - 18.

2009 Follow-Up Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHMRSAS - OIG Report #172-09

DMHMRSAS has adopted the following goal to guide service delivery throughout the publicly funded system of services:

> *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, DMHMRSAS established an outcome performance measure related to this goal for the eight state mental health hospitals that serve adults which include:

- Catawba Hospital (CAT)
- Central State Hospital (CSH)
- Eastern State Hospital (ESH)
- Northern Virginia Mental Health Institute (NVMHI)
- Piedmont Geriatric Hospital (PGH)
- Southern Virginia Mental Health Institute (SVMHI)
- Southwestern Virginia Mental Health Institute (SWVMHI)
- Western State Hospital (WSH)

The performance target set by DMHMRSAS for FY2008, FY2009 and successive years is that these facilities achieve a *15 percent increase in the number of state hospital consumers whose experience reflects the concepts of recovery, self-determination, person-centered planning, and choice.*

The OIG designed an inspection process to measure attainment of this performance target. In FY2007 inspections were carried out at all eight state mental health facilities that serve adults to assess the recovery experience of persons who were served at these facilities. This initial series of inspections provided a baseline against which future progress could be measured. The results of the FY2007 inspections are documented in OIG Report #137-07.

The FY2007 report included 24 findings and two recommendations. Each hospital was asked to produce a plan to address these findings and improve the conditions and processes that support a recovery-based experience. The hospitals have submitted semiannual reports of their progress in these plans, which are monitored by the DMHMRSAS and OIG

In FY2008 the OIG conducted a second review using the same approach and instruments to measure progress toward the outcome performance target. In FY2008, the system of eight mental health facilities exceeded the target (15% increase) set for FY2008, with a 21.5 % increase in recovery experience score for the sample population. The full results of that review may be found in OIG Report #154-08.

During January through March, 2009, the OIG conducted the third and final review of the recovery experience of individuals served in the state mental facilities. The report of this review is currently under development and will be placed on the OIG website by the end of May 2009.

Investigations

The OIG conducted 3 investigations of critical incidents or complaints at the following facilities operated by DMHMRSAS:

- Central Virginia Training Center (2 investigations)
- Southwestern Virginia Mental Health Institute

The OIG conducted 1 investigation at a college counseling center as a result of a critical incident.

B. REPORTS

The OIG completed a total of six 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.

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

- # 167-08, Commonwealth Center for Children and Adolescents Inspection
- # 168-08, Follow-Up Review of Active Findings in the State Operated Mental Health Facilities
- # 169-08, Virginia Center for Behavioral Rehabilitation Inspection

Three 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 433 CIs during this semiannual period. An additional level of inquiry and follow up was conducted for 92 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 12 deaths that occurred at DMHMRSAS facilities.

D. COMPLAINTS AND REQUESTS FOR INFORMATION/ REFERRALS

The Office of the Inspector General responded to 40 complaints and requests for information/referrals from citizens, service recipients and employees. Of these contacts, 22 were complaints/concerns and 18 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 12VAC35-190-10, Regulations for Voluntary Admissions to State Training Centers
- DMHMRSAS Departmental Instruction 205 (RTS) 89, Filing Criminal Charges Against Patients or Residents
- DMHMRSAS Policy 1007 (SYS) 86-2, State Board Policy on Mental Health, Mental Retardation and Substance Abuse Services for Children/Adolescents and Their Families
- DMHMRSAS Policy 4126 (CSB) 87-1, State Board Policy on Transitional Services for Adolescents and Young Adults with Mental Disabilities
- DMHMRSAS Policy 1015 (SYS) 86-22, State Board Policy on Services for Individuals with Co-Occurring Disorders
- DMHMRSAS 12VAC35-200-10, Regulations for Respite and Emergency Care Admissions to State Training Centers

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
- State Human Rights Committee
- Loudoun County Community Services Board
- State Mental Health, Mental Retardation, Substance Abuse Services Board

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

- Virginia Association of Community Services Boards Fall Conference
- Virginia Student Services Conference
- National Association of County Behavioral Health and Developmental Disabilities Directors
- American Association of Inspectors General

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

- DMHMRSAS Department Instruction 201 Workgroup
- DMHMRSAS Medical Directors
- DMHMRSAS Person-Centered Planning Leadership Team
- DMHMRSAS Systems Leadership Council
- Western State Hospital Advisory Council
- Virginia Center for Behavioral Rehabilitation Advisory and Oversight Committee
- Joint Commission on Health Care
- Council on Reform for Children and Adolescent Services
- Supreme Court Commission on Mental Health Law Reform and the Access Taskforce, Children's Services Task Force, and Workforce Development 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
- 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
- H & W Independent Solutions

H. FINDINGS AND Recommendations

Inspection of Commonwealth Center for Children and Adolescents – OIG Report #167-08

The following findings and recommendations were formulated by the OIG as a result of this inspection.

A. Facility Utilization

Finding 1.1: DMHMRSAS resources for addressing the mental health and behavioral needs of the children and adolescents in the Commonwealth are underutilized at CCCA.

Finding 1.2: A significant percentage of admissions to CCCA were stabilized within seven days or less.

Finding 1.3: A significant percentage of admissions to CCCA were referred as ten-day court ordered evaluations.

Recommendation 1: It is recommended that DMHMRSAS review the current utilization of child and adolescent resources in facility settings and redirect funding in order to provide secure specialized community based crisis stabilization services for children and adolescents and provide appropriate clinical capacity to conduct juvenile forensic evaluations through the CSBs or regional teams.

B. Seclusion and Restraint

Finding 2.1: CCCA engaged in a number of promising activities designed to reduce the use of seclusion and restraint as a result of the facility's participation in the SAMSHA Grant.

Finding 2.2: Staff, at all levels, voiced a commitment to the reduction of seclusion and restraint initiative and were able to discuss strategies for creating a trauma-informed environment and sustaining the facility's current seclusion and restraint reduction efforts.

Finding 2.3: CCCA eliminated the use of prone restraint effective July 1, 2008.

Finding 2.4: The use of seclusion and restraint at CCCA decreased 8.9% between FY07 and FY08.

Recommendation 2: It is recommended that CCCA review and redirect clinical staff and resources in an effort to decrease the incidence of seclusion and restraint during the evening shift.

Finding 2.5: Overall, the clinical records do not consistently reflect an orientation to trauma-informed care practices.

Finding 2.6: There was no evidence in the clinical records that clinical debriefings are used to identify alternative treatment strategies that can be used in the future to minimize the use of restrictive procedures.

C. Workforce Development

Finding 3.1: Direct care staff indicate that communication within the facility and the support they receive from more senior staff have improved.

Finding 3.2: The majority (20 of 29) of staff surveyed reported feeling safe while performing their duties at the facility.

Finding 3.3: The rate of turnover among the direct care staff at the facility remains high.

Virginia Center for Behavioral Rehabilitation – Report # 169-08

Following is a summary of the findings related to VCBR as a result of the inspection that was conducted by the OIG in November 2008:

In a number of the areas of concern noted by the OIG in 2007, some improvement has occurred, however many challenges remain:

- The amount of active treatment provided rose from an average of 2.5 hours a week to 6.6 hours per week for a comparable sample of residents.

    - Active treatment levels actually received by residents still remain much lower than desirable for an effective treatment program. Resident boredom and inactivity continue, with significant behavioral results.
    - Educational and recreation programming have begun and contribute to the somewhat higher levels of constructive activity for residents.
    - Vocational programming (training and jobs for residents) are considered by the facility, the AOC, and the OIG to be a key element of an effective treatment program. The OIG found that no residents have jobs and there is no vocational training at this point.
    - In reporting active treatment levels, VCBR presents data showing treatment scheduled or offered, rather than what is received by residents. Resident refusal to attend, excused absences, and staff cancellations of classes account for an almost 50% drop from scheduled activities to completed activities for the average resident.
- Evaluation and treatment planning for residents have improved in specificity, individualization, timeliness, and comprehensiveness. More improvement in person-centered treatment planning is needed to match that provided at other DMHMRSAS treatment facilities and to achieve what may be required for the facility to achieve accreditation.
- The facility developed new mission and vision statements which clarify the focus of the service to be provided (recovery opportunities and support) and the quality of the facility's efforts (excellence). In this review of VCBR, the OIG found a lack of clarity among staff regarding the intended outcome of the facility's services. The result of this lack of clarity is a workforce that is not unified in carrying out the facility's mission.
- In 2007 the OIG recommended that the facility investigate national accreditation programs and pursue accreditation if a suitable program is found. The facility has decided to seek accreditation by the Joint Commission on Accreditation of Hospitals, and a credible plan to do so now exists.
- The roles of medical and nursing remain unclear and there has been nearly 100% turnover in staffing for these services since the 2007 inspection.
- Psychiatric services have increased significantly.
- Overall staff turnover appears to be essentially at the same levels as in 2007. DMHMRSAS cited VCBR turnover rates of 51.5% for FY2007 and 47.5% for FY2008. Recruitment and retention of clinical staff have improved since 2007.
- Training in sex offender topics has not been increased for residential, security, and medical staff, who spend the most time day-to-day with residents, or for administrative staff, who contribute decisively to the nature of the organizational culture. Training for clinical staff has increased and improved.
- Many staff express concerns for their personal safety while working in the VCBR facility, especially those who have the most day-to-day contact with residents.
- Residents, as well as members of the AOC have expressed concern that VCBR affords the civilly committed residents at the VCBR treatment program less comfort and fewer privileges and opportunities than prisoners in the Department of Corrections receive. Concerns include overly spartan cells and furniture, a harsh environment, very limited resident privilege levels with regard to phone

use, mail, television access, and personal items, and limited educational, vocational, and recreational opportunities.

- DMHMRSAS support, guidance, and facilitation of the Advisory and Oversight Committee has been inconsistent and incomplete. The committee members have given considerable time and insight to their task. The activities outlined in the DMHMRSAS response to the 2007 OIG report remain unmet.

It was determined by the OIG that all recommendations made as a result of the 2007 inspection at VCBR remain active.