COMMONWEALTH of VIRGINIA

James W. Stewart, III
Inspector General
for
Behavioral Health and
Developmental Services

Office of the Inspector General
P.O. Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 692-0276
Fax (804) 786-3400
www.oig.virginia.gov

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To the General Assembly of Virginia:

The Office of the Inspector General for Behavioral Health and Developmental Services (OIG) is pleased to submit this semiannual report of activities for the period ending on September 30, 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 3 facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) and carried out six investigations of specific complaints or critical incidents. Five of these investigations were at DBHDS 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 Behavioral Health and Developmental Services

Semiannual Report
April 1, 2009 – September 30, 2009

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FOREWORD

The Office of the Inspector General for Behavioral Health and Developmental Services (OIG) is pleased to submit this semiannual report of activities for the period ending on September 30, 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 April 1, 2009 through September 30, 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 three facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) and carried out six investigations of specific complaints or critical incidents. Five of these investigations were at DBHDS 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 Northern Virginia Training Center
  - Unannounced inspection at Southwestern Virginia Training Center
  - Unannounced inspection at Southside Virginia Training Center
  - Five investigations of critical incidents or complaints at facilities operated by DBHDS
  - One investigation at a college counseling center

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

  - # 172-09, Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DBHDS, Follow-up FY2009
  - # 176-09, Southwestern Virginia Training Center Inspection
  - Three reports were completed on investigations that were conducted to investigate specific incidents or complaints at facilities operated by DBHDS
  - One report was completed on an investigation at a college counseling center

- The OIG reviewed 531 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 DBHDS operated facilities was reviewed.

- Autopsy reports of 10 deaths that occurred at DBHDS facilities were reviewed.

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

- A formal review of seven DBHDS regulations and policies was completed.

- The Inspector General and OIG staff made seven 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 DBHDS and the network of public and private providers licensed by DBHDS 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 DBHDS operated facilities and community programs.

Inspection of Northern Virginia Training Center - OIG Report #171-09

The Office of the Inspector General (OIG) conducted an unannounced inspection at the Northern Virginia Training Center (NVTC) on April 14-16, 2009 and September 3, 4 and 11, 2009. The purpose of the inspection was to provide a qualitative review of focus areas analogous to those identified by the Department of Justice (DOJ) in their notification letter to the Commonwealth of Virginia in August 2008 regarding potential civil rights violations at the Central Virginia Training Center (CVTC) in Lynchburg. The areas identified by the DOJ letter included: active treatment, transition planning, and the protection of residents from harm.

Inspection of Southwestern Virginia Training Center – OIG Report # 176-09

The Office of the Inspector General (OIG) conducted an unannounced inspection at the Southwestern Virginia Training Center (SWVTC) on May 21, 2009. The purpose of the visit was to review a program operated by SWVTC that serves persons with dual diagnoses of intellectual disabilities and mental illnesses – the Pathways program.

The Pathways program was selected for review because it is the only special unit in the 16 facilities operated by DBHDS that addresses the needs of persons with concurrent conditions of intellectual disabilities and mental illnesses or severe behavioral problems (ID/MI). Previous reports by the OIG have highlighted many issues and gaps in both community and facility services in this area, including the lack of resources and poor coordination of services to help meet the needs of this population and unclear responsibilities to provide services in emergencies. A review of the Pathways program was undertaken to determine whether this program is responsive to the issues documented in these reports.

Inspection of Southside Virginia Training Center - OIG Report # 182-09

The Office of the Inspector General (OIG) conducted an unannounced inspection at the Southside Virginia Training Center (SVTC) on September 28-30, 2009. The purpose of the inspection was to provide a qualitative review of focus areas analogous to those

identified by the Department of Justice (DOJ) in their notification letter to the Commonwealth of Virginia in August 2008 regarding potential civil rights violations at the Central Virginia Training Center (CVTC) in Lynchburg. The areas identified by the DOJ letter included: active treatment, transition planning, and the protection of residents from harm.

Investigations

The OIG conducted 5 investigations of critical incidents or complaints at the following facilities operated by DBHDS:

- Southside Virginia Training Center (2 investigations)
- Southeastern Virginia Training Center
- Eastern State Hospital
- Northern Virginia Mental Health Institute

The OIG conducted 1 investigation at a college counseling center.

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, DBHDS, 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.

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

- # 172-09, Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DBHDS, Follow-up FY2009

One report was completed for an inspection conducted during this semiannual reporting period:

- # 176-09, Southwestern Virginia Training Center Inspection

OIG findings resulting from these two inspections/reviews can be found in Section H of this semiannual report.

Three reports were completed for inspections that were conducted during this semiannual reporting period to investigate specific incidents or complaints.

One report was completed for an investigation at a college counseling center.

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 DBHDS operated state hospitals and training centers. The OIG reviewed 531 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 DBHDS 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 10 deaths that occurred at DBHDS facilities.

D. 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, 32 were complaints/concerns and 9 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:

- DBHDS State Board Policy 4037 (CSB)91-2 Early Intervention Program for Infants and Toddlers with Disabilities
- DBHDS State Board Policy 4038 (CSB) 94-1, Comprehensive Services Act for At-Risk Youth and Families
- DBHDS State Board Policy 1007 (SYS) 86-2, Services for Children and their Families
- DBHDS DI 201(RTS) 03, Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities
- DBHDS DI 701 (INF) 93, Organization and Maintenance of the Clinical Record
- DBHDS DI 506 (HRM) 09, Criminal History Checks and Background Verification Requirements

- DBHDS DI 100 (PHI) 03 HIPPAA Revisions

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 Commission on Youth
- Child and Adolescent State and Community Consensus Team
- VOCAL
- KOVAR Institute
- Western State Grand Rounds
- Medical College of Virginia Department of Psychiatry Grand Rounds

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

- Virginia Association of Community Services Boards Spring Conference
- Revised Departmental Instruction 201 (03) Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities training
- Trauma Informed Care and Barriers to Mental Health Recovery SAMHSA training
- Social Inclusion and Mental Health Recovery training

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

- DBHDS Department Instruction 201 Workgroup
- DBHDS Medical Directors
- DBHDS Person-Centered Planning Leadership Team
- DBHDS Systems Leadership Council
- Virginia Center for Behavioral Rehabilitation Advisory and Oversight Committee
- Supreme Court Commission on Mental Health Law Reform and the Access Taskforce, Children's Services Task Force, and Workforce Development Committee
- DBHDS State Board

- State Human Rights Committee
- Office of Technical Assistance (NASMHPD)
- DBHDS Data Management Workgroup

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
- DBHDS central office staff
- DBHDS facility staff
- DBHDS Person-Centered Planning Leadership Team
- DBHDS Seclusion and Restraint Workgroup
- Service recipients and family members
- Virginia Association of Community Services Boards
- SCHEV (State Colleges of Higher Education for Virginia)

H. FINDINGS AND RECOMMENDATIONS

Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DBHDS, Follow-up FY2009 – Report # 172-09

In 2006, the DBHDS 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 DBHDS – OIG Report #137-07. This review was designed to determine what percentage of adult state hospital residents actually have a treatment experience that is guided by the concepts of recovery, self-determination, person-centered planning, and choice. This review focused on the following eight 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

In 2007 the OIG determined that 4.9% of the individuals served in the state hospitals at that time were having a treatment experience that was guided by the concepts of recovery, self-determination, person-centered planning, and choice. In 2008, the OIG returned to these eight state hospitals to conduct unannounced follow-up reviews of the recovery experience of residents. These inspections revealed that 26.3% of those served were having a recovery experience.

In 2009 the OIG conducted the third and final review of the recovery experience of individuals served in these same eight state hospitals. The percentage of persons judged to have a recovery experience rose from 26.3% in 2008 to 31.8% in 2009. Overall improvement from FY2007 to FY2009 was 27%, or an annual average improvement of 13.5%. A review of the findings from the 2007 report revealed that progress had been made on 11 of the original 24 findings and little change had been made with 10 of the findings. Three findings were not formally re-assessed. All findings remain active.

The following recommendations were formulated by the OIG as a result of the 2009 review:

Recommendation 1: It is recommended that DBHDS, with the facilities, develop methods that will assure ongoing measurement of the recovery initiative at the DBHDS facilities.

Recommendation 2: It is recommended that the DBHDS reestablish and support the Statewide Recovery Group, or another system of cross facility communication and exchange of information, with the addition of involvement from CSB and consumer organizations.

Recommendation 3: It is recommended that the DBHDS seek funding from the General Assembly to establish expanded peer support staffing at all facilities, and that the necessary changes in the barrier crimes laws hindering employment of persons in recovery be sought.

Inspection at Southwestern Virginia Training Center – Report # 176-09

Following is a summary of the findings related to SWVTC as a result of the inspection that was conducted by the OIG in May 2009:

Recommendation 1: The Pathways program is an effective response to the needs of persons with dual diagnoses of intellectual disabilities and psychiatric disorders whose behaviors have presented challenges for their community residential arrangements. Positive outcomes reported by those with whom the OIG has made contact include:

- remediation of behavioral issues in all but a few cases

- effective community/facility collaboration in managing utilization of the program and adapting services to needs in the community
- effective provision of respite services to allow re-invigoration of family, residential services, or other community supports to better serve individuals after difficult periods.
- diminished use of the program due to effective work with most difficult, frequently admitted clients and effective community consultation prior to admission and after discharge is seen as an opportunity to respond to a community need to provide services for persons with autism.

Recommendation 2: The capability of the program to respond to emergencies is welcome and valued by stakeholders, but it is limited and at times the process of gaining admission is more complex and slower than desired.