# COMMONWEALTH of VIRGINIA

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To the General Assembly of Virginia:

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.

We are pleased to submit this semiannual report of activities for the period ending on March 31, 2010. This report is issued in accordance with the provisions of VA Code §37.2-425, which requires that the OIG report on significant activities and recommendations of the Inspector General during each six-month reporting period.

During the past six months the OIG completed inspections/investigations at 3 facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) and carried out a review of 14 residential crisis stabilization units for adults operated by community services boards (CSBs) or contracted by CSBs to private providers. Four 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,

G. Douglas Bevelacqua
Inspector General


# Office of the Inspector General For Behavioral Health and Developmental 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.*

# Semiannual Report
# October 1, 2009 – March 31, 2010

# TABLE OF CONTENTS

# 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 March 31, 2010. This report is issued pursuant with the provisions of Va. Code §37.2-425, which requires 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, 2009 through March 31, 2010. 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/investigations at 3 facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) and carried out a review of 14 residential crisis stabilization units for adults operated by community services boards (CSBs) or contracted by CSBs to private providers. Four reports were completed during this reporting period. A summary of these efforts is provided in this semiannual report.

# SUMMARY OF OIG ACTIVITIES

A. The OIG carried out the following inspections, investigations and reviews during this semiannual period:

- Unannounced inspection at the Southeastern Virginia Training Center
- Unannounced inspection at Southwestern Virginia Training Center
- Unannounced investigation at Virginia Center for Behavioral Rehabilitation
- Announced inspections at 14 Crisis Stabilization Units operated or contracted by Community Services Boards

B. Four reports were completed by the OIG during this reporting period:

- # 183-09, Review of Residential Crisis Stabilization Units Operated or Contracted by Community Services Boards
- Three reports were completed on investigations that were conducted to investigate specific incidents or complaints at facilities operated by DBHDS

C. The OIG received and reviewed 430 critical incidents during this six-month period. Additional inquiry and follow up was conducted for 65 of these incidents.

D. Monthly quantitative data from the sixteen DBHDS operated facilities was reviewed.

E. Autopsy reports of six deaths that occurred at DBHDS facilities were reviewed.

F. The OIG responded to 23 complaints and requests for information/referrals from citizens, service recipients and employees regarding a variety of issues.

G. A formal review of four DBHDS regulations and policies was completed.

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

# ACTIVITIES OF THE OFFICE

## 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.

### Review of Residential Crisis Stabilization Units Operated or Contracted by Community Services Boards - OIG Report # 183-09

The Office of the Inspector General for Behavioral Health and Developmental Services (OIG) conducted a review of the 14 residential crisis stabilization programs (CSPs) for adults operated by community services boards (CSBs) or contracted by CSBs to private providers. The need for this type of service was identified by the OIG in a 2005 report on CSB emergency services. The Virginia General Assembly began funding these programs in 2006. The OIG conducted this review of CSPs to assess their effectiveness in helping persons avoid psychiatric hospitalization.

To assure that the review focused on the most relevant issues, the OIG sought input from a wide range of stakeholders including consumers and consumer groups, families, leadership of the Department of Behavioral Health and Developmental Services (DBHDS), CSB staff, community referral sources, and partners in the emergency services and legal communities. OIG staff, including consumers trained and experienced as peer inspectors, visited all 14 sites during October and November, 2009. 175 staff and supervisors, 139 current and former CSP clients, and 320 stakeholders were interviewed and 139 clinical records were reviewed.

The OIG conducted a series of inspections at four of the five training centers operated by DBHDS from April 2009 to December 2009. The inspections at Northern Virginia Training Center (NVTC) and Southside Virginia Training Center (SVTC) in Petersburg were conducted during the previous semi-annual reporting period. The following two inspections at Southeastern Virginia Training Center (SEVTC) in Chesapeake and Southwestern Virginia Training Center (SWVTC) in Hillsville were carried out during this semi-annual period. The purpose of this series of inspections was to provide a qualitative review of focus areas identified by the Department of Justice in recent reviews, including that at CVTC, to highlight potential areas of risk for these facilities and the DBHDS system of facilities. An overall systemic report of the series of inspections will be published in the fourth quarter of FY2010.

### Inspection of Southeastern Virginia Training Center – OIG Report # 184-09

This inspection was part of a series of inspections of all of Virginia's training centers for persons with intellectual disabilities following an investigation of Central Virginia Training Center by the U.S. Department of Justice (DOJ) in November 2008. This inspection at SEVTC occurred in October 2009. The series of inspections is designed to help DBHDS become aware of areas of potential liability identified by the DOJ reviews of CVTC (and in other states) for the remaining four training centers: NVTC, SVTC, SEVTC, and SWVTC. The results of this OIG review will be published in the fourth quarter of FY2010.

### Inspection of Southwestern Virginia Training Center - OIG Report # 185-09

This inspection was part of a series of inspections of all of Virginia's training centers for persons with intellectual disabilities following an investigation of Central Virginia Training Center by the U.S. Department of Justice (DOJ) in November 2008. This inspection at SWVTC occurred in December 2009. The series of inspections is designed to help DBHDS become aware of areas of potential liability identified by the DOJ reviews of CVTC (and in other states) for the remaining four training centers: NVTC, SVTC, SEVTC, and SWVTC. The results of this OIG review will be published in the fourth quarter of FY2010.

One investigation of a state operated facility was conducted as a result of a concern received by the OIG. This is an unpublished report.

## Reports

The OIG completed a total of four 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 an inspection conducted during this semiannual reporting period:

- # 183-09, Review of Residential Crisis Stabilization Units Operated or Contracted by Community Services Boards

OIG findings and recommendations resulting from this inspection can be found in Section H of this semiannual report.

Three reports were completed for investigations that were conducted during the previous semiannual reporting period to investigate specific incidents or complaints.

## Data Monitoring

### Critical Incident Reports

Documentation of critical incidents (CI) as defined by Virginia Code *§ 2.1-817503* is forwarded routinely to the OIG by the DBHDS operated state hospitals and training centers. The OIG reviewed 430 CIs during this semiannual period. An additional level of inquiry and follow up was conducted for 65 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 six deaths that occurred at DBHDS facilities.

## Complaints and Requests for Information/Referrals

The Office of the Inspector General responded to 23 complaints and requests for information/referrals from citizens, service recipients and employees. Of these contacts, 8 were complaints/concerns and 17 were requests for information/referrals.

## 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 5010(FAC) 00-1, State Facility Uniform Clinical and Operational Policies and Procedures.
- DBHDS DI 806(ADM) 98, Fraudulent Transactions and Hotline Complaints
- DBHDS DI 807(ADM) 95, Development of Departmental Instructions.
- DBHDS State Board Policy 4023(CSB) 86-24, Residential Services.

## Presentations and Conferences

Former Inspector General Stewart, Interim Inspector General John Pezzoli, 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
- Supreme Court Commission on Mental Health Law Reform
- Virginia Association of Community Services Boards
- Southeastern Virginia Training Center Advisory Committee

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

- Virginia Association of Community Services Boards Fall Conference
- Person Centered Planning Committee
- DBHDS Seclusion and Restraint Database Training
- Governor's Conference on Children
- Teleconference training on the Assertive Community Treatment model.

## 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 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
- Consortium for Mental Health and Criminal Justice Transformation
- DBHDS Seclusion and Restraint Workgroup
- Virginia Commission on Youth
- Child and Adolescent Consensus Group
- Virginia State Crime Commission
- Advisory Council for the University of Virginia School of Nursing Leadership in Rural Health Care Project
- Senate Finance 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
- 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
- Department of Justice staff and consultants
- Voices for Virginia's Children

## Findings and Recommendations

### Review of Residential Crisis Stabilization Units Operated or Contracted by Community Services Boards - OIG Report # 183-09

The following findings and recommendations were formulated by the OIG.

**A. Mission, Purpose and Programs of CSPs**

**Finding A.1** In communication with the CSBs, DBHDS did not reference expectations for mission, target populations, program criteria, or data requirements for CSPs that received General Assembly funding from FY2006 to early FY2010. In August of 2009, DBHDS surveyed the 14 CSPs to determine the extent to which these programs complied with a series of "Criteria" that had not previously been defined and promulgated by DBHDS.

> **Recommendation A.1** It is recommended that DBHDS, with the involvement of CSPs and CSBs, develop and implement clear criteria, performance expectations and data requirements for current and future CSPs funded with state general funds by May 30, 2010.

**Finding A.2** The DBHDS communicated with the CSB Executive Directors on November 3, 2009 that residential crisis stabilization programs funded with state general funds must address seven "Residential Crisis Stabilization Program Criteria" identified in Finding A.1.

> **Recommendation A.2** It is recommended that CSBs currently operating or planning to start CSPs in FY2011 develop a plan by June 30, 2010, with the involvement and approval of DBHDS, to achieve full compliance with DBHDS criteria by June 30, 2011.

**Finding A.3** CSP mission statements vary in their statements of program purposes, target population, and are not clear, especially with regard to matters related to compliance with DBHDS criteria.

> **Recommendation A.3** It is recommended that each CSP develop a mission statement by June 30, 2010, that conveys the purpose of the program and clarifies its role and function in helping persons avoid hospitalization. It is further recommended that the CSPs conduct a review of their policies and procedures and take steps to assure that its programs operate in conformity to the mission and purpose statement.

**Finding A.4** Supervisors and staff at CSBs are not aware of specific, formal mission statements for their own CSPs, including whether it is the mission of these programs to divert potential hospitalizations.

> **Recommendation A.4** It is recommended that each CSP take steps to ensure that service users, staff, and stakeholders understand and support the mission of the program.

**Finding A.5** Only three of the 14 existing CSPs accept TDOs and only 8.2% of those served by CSPs were admitted in a TDO status.

- Of the 4,011 persons admitted to the CSPs in FY2009, 330 were in TDO status. 91.8% were admitted voluntarily.
- The 330 persons admitted in TDO status were served by 3 CSPs and 288 of this total were served by one CSP.
- The OIG report on CSB Emergency Services (#123-05) published in October 2005, indicated that there were 2 CSBs that accepted persons on TDOs.
    - In FY2009 that number had changed only slightly – 3 CSPs served persons in TDO status.

> **Recommendation:** Recommendations A.1, A.2, A.3., and A.4 are in support of this finding.

**Finding A.6** While it is clear that the existing CSPs are preventing further deterioration of the crisis state of the persons served and have had a diversionary impact on inpatient admissions, these programs have not yet maximized their potential for diverting admissions from inpatient settings. This is because so many of the programs do not now serve the full range of persons who are thought to require services in an inpatient setting.

- Responses by supervisors, staff, and stakeholders to the OIG questions on who must be served in hospitals, rather than at CSPs, focus on the following differences:
    - Persons who meet TDO or commitment criteria for danger to self or others
    - Persons who are not able or willing to voluntarily and competently consent to treatment
    - Persons who are perceived as disruptive, agitated, manic, or menacing to residents or staff
    - Persons who need medical or detox treatment

    - Persons with an alleged history of violence or threat to self that concerns admitting staff
- It is the strong personal conviction of persons who have been served at CSPs and the judgment of stakeholders, staff, and supervisors that most of the persons served in CSPs would have been hospitalized if the CSP had not been available.
    - 96% of service users say, "Being able to get into this program definitely kept me from going into the hospital or hurting myself."
    - When asked what might have happened to them if they had not come to the CSP, all persons who had used the CSP service described dire circumstances, including death.
    - 79% of stakeholders said persons not served by a CSP would have gone to a hospital.

**Recommendation A.6:** It is recommended that DBHDS convene and offer technical support to a conference of CSP leadership and key staff from all the programs by October 30, 2010, with the goal of sharing resources, best practices, and provision of training to help programs meet criteria and benefit from mutual experiences, as well as to assure DBHDS understanding of the issues faced in operating CSPs.

**Finding A.7** CSPs that do not now accept persons who meet criteria for TDOs or involuntary commitment report that they cannot do so without additional staffing, budget increases, and changes in their program philosophies and treatment milieu.

**Recommendation:** Recommendations A.1, A.2, A.3., and A.6 are in support of this finding.

**Finding A.8** Only 2 of the existing CSPs serve as police drop off points.

**Recommendation A.8:** While previous recommendations are also in support of this finding, it is recommended that DBHDS and the CSBs give consideration to whether the CSP is indeed the best location to provide police drop off in every community and that CSBs can meet this criteria at an alternate site satisfactory to local law enforcement personnel.

**Finding A.9** Medicaid and state Supreme Court billing did not prove to be a significant source of revenue to supplement general fund and other revenues for CSPs in FY2009, largely due to the fact that relatively few persons served qualified for Medicaid.

- CSP budget reports for FY2009 show 15% of total revenues were from Medicaid billing.
    - 3 CSPs reported no Medicaid billing at all.
- With only 8.2% of residents served on TDOs, billing for State Supreme Court reimbursement was not a significant funding source for most CSPs.

**Recommendation A.9:** It is recommended that the process described in Recommendations A.1, A.2, and A.6 include the development of specific guidelines for maximizing Medicaid billing where appropriate and that program expectations

and technical assistance provided by DBHDS reflect best practices and realistic expectations in this area.

**Finding A.10** Stakeholders are generally satisfied with the CSPs that serve their communities, though areas of concern exist among some stakeholders.

**Recommendation A.10:** It is recommended that each CSB that operates a CSP develop and implement a means of identifying relevant community stakeholders and obtaining their feedback about CSP operations on an appropriate periodic basis, beginning by July 1, 2010.

**B. Access to CSPs**

**Finding B.1** Timely access to some CSPs is limited by unclear policies, cumbersome procedures, and limited willingness of programs to accept persons who pose risk to themselves or others.

- Timeliness and ease of access to CSPs vary among programs. A majority (56%) of stakeholders consider access to CSPs "timely and efficient".
- A significant minority of stakeholders (37%) disagree that "Obtaining access for persons who need crisis stabilization is usually timely and efficient." (The remainder said they did not know.)
- 33% of stakeholders agree with a statement that says, "The crisis stabilization program has so narrowed its criteria for accepting persons that its usefulness to our community is limited."
- Emergency services staff report an average wait for admission of 5.6 hours after first contact with the CSP about a referral.

**Recommendation B.1:** It is recommended that each CSB that operates a CSP conduct a review, informed by stakeholder feedback obtained through Recommendation A.10, on ways that real and perceived delays in prompt and timely admissions of persons in crisis can be reduced. It is further recommended that each CSP establish and regularly monitor standards of performance for timely access to their programs.

**Finding B.2** Medical and psychiatric services are limited in the evenings and weekends at some CSPs, restricting the ability of these CSPs to accept and rapidly process referrals for admissions during these times.

**Recommendation:** Recommendation B.1 is in support of this finding.

**Finding B.3** Medical clearance requirements are perceived by many stakeholders as contributors to delays in admission processes at some programs.

**Recommendation:** Recommendation B.1 is in support of this finding.

**Finding B.4** Delays exist in providing medications to residents due to regulatory limitations.

**Recommendation:** Recommendation B.1 is in support of this finding.

**C. Service Effectiveness and Quality**

**Finding C.1** CSPs are seen by service users, staff, and stakeholders as effective in helping people safely address and begin recovery from psychiatric crises, and avoid further deterioration.

- 96% of persons served in CSPs said "Being able to get into this program definitely kept me from going into the hospital or hurting myself."
- Consumers list contact with staff, time for 1:1 therapy, staff who "listen to me", and the value of groups and peer support among their positive comments about their service experiences at CSPs.
- Almost all compare their experience at a CSP favorably to services in a hospital, if they have had such experience.
- 92% of staff agreed with the statement that "I believe the treatment we are providing will enable the persons we serve to return to live in the community with improved skills for avoiding or managing psychiatric crises in the future."
- Stakeholders are also positive about outcomes at CSPs, though slightly less uniformly:
  - 75% said that "overall, the crisis stabilization service has had good treatment outcomes."
  - 66% said they are usually "satisfied when seeking services" from the CSP.

**No Recommendation**

**Finding C.2** Staff at CSPs report high satisfaction with their jobs and good support from their supervisors.

**No Recommendation**

**Finding C.3** Staff express training needs with regard to serving persons with intellectual disabilities and on trauma-informed care.

**Recommendation C.3:** It is recommended that this finding be addressed as a part of the technical assistance provided by DBHDS in Recommendation A.6.

**Finding C.4** CSPs provide a safe environment for the persons they serve.

- Service users (98%), supervisors (100%), and stakeholders (82%) strongly agree that the CSPs keep persons safe from harm – from others and from themselves – during their care in these programs.
- Staff (94%) said they feel safe working at the CSP.

**No Recommendation**

**Finding C.5** The CSPs meet most of what is typically meant by the concept of "least restrictive alternative."

- They impose few restrictions on the service user, are community-based, small in scale, normalized, "homelike" environments (with some exceptions), and provide a high degree of access to and from families, friends, community supports in the communities they serve.
- To the degree they may prevent hospitalization, they are certainly less restrictive.

**No Recommendation**

**Finding C.6** Programs vary significantly in comfort, amenities, and attractiveness.

- Many programs resemble very pleasant small group residences, with high levels of comfort and warmth, lots of recreational and educational opportunities for residents, and good food. Some programs were more austere and institutional.

**Recommendation C.6:** It is recommended that CSPs, with input from service users or other consumers, evaluate the environments, furnishings, and policies of their programs and improve them if needed with decorations, amenities, choice of activities and other qualities that will make the residential experience as pleasant as possible, in both common areas and bedrooms.

**Finding C.7** The CSPs coordinate well with CSBs, both for persons currently served and to arrange services for persons discharged from CSPs who had not previously received CSB services.

- 68% of records reviewed showed persons received specific appointments at a CSB.
- The average wait for these appointments was 4.7 days, a great improvement on wait times found by the OIG in a survey of CSB outpatient and psychiatric service access in 2007 (30 days in non-emergencies, 13.5 days following emergency contacts with the CSB). (Survey of CSB Outpatient Services Capacity and Commitment Hearing Attendance - OIG#141-07, issued 1/11/08).

**No Recommendation**

**Finding C.8** All CSPs identify and provide services for persons with co-occurring substance use disorders and mental illnesses.

- 58% of the records reviewed at CSPs showed co-occurring SA issues, substance use diagnoses were the single most frequently noted diagnoses in the record sample.

**Recommendation C.8:** It is recommended that CSPs conduct a self-study of their provision of services for persons with co-occurring substance use disorders and that

DBHDS make available on-site technical assistance on this topic, as well as a part of Recommendation A.6.

**Finding C.9** Services to persons with co-occurring intellectual disorders are virtually non-existent in the CSPs.

- Only 4 persons in the sample of 139 records reviewed had intellectual impairment diagnoses and these referred to mild degrees of impairment.

**Recommendation C.9:** Improvement in the provision of crisis services for persons with co-occurring behavioral health and intellectual disabilities has been recommended in numerous OIG reports on community and facility services since 2005. It is recommended that the DBHDS review the status of these recommendations and provide an update on actions and plans to date to the OIG by June 30, 2010, to include an assessment of the role of CSPs or other community alternatives.

**D. Consistency with Recovery Principles**

**Finding D.1** Consumers served by CSPs state that they feel involved in their treatment planning and say that their wishes are respected by staff in this process.

**Recommendation:** Please see Recommendation D.2

**Finding D.2** 9 of the 14 CSPs were judged by OIG review of clinical treatment records to appropriately involve the persons they serve in a leading role in the development of their own goals for treatment and recovery from psychiatric crises.

**Recommendation D.2:** It is recommended that CSPs review their treatment plan formats, policies, and practices with regard to documentation of service-user involvement in treatment plans. It is further recommended that the best practices of some CSPs, and some state facilities, in this regard be identified and disseminated as a part of Recommendation A.6.

**Finding D.3** 64% of residents in CSPs report they have choice in daily activities and living arrangements, and at the fundamental level of participation in the program, they have complete choice, as the programs are voluntary.

**Recommendation:** Recommendations A.6 and C.6 are in support of this finding.

**Finding D.4** Peer support staff are available in 10 of the 14 CSPs.

- 72% of persons served at CSPs that employ peer support staff endorse the value of working with persons who have shared experiences of having a mental illness and are in the process of recovery.
- Four CSPs do not offer peer support to residents in the CSP.

**Recommendation D.4:** While Recommendations A.1 and A.2 are in support of this finding, as the use of peer counselors is a criteria for CSPs, it is recommended that CSPs take steps immediately to meaningfully involve paid and volunteer consumers in the provision of CSP services as a matter of high priority.

**Finding D.5** After admission, most CSPs offer some form of WRAP-like training groups for residents.

**No recommendation.**

**Finding D.6** CSPs offer a warm and accepting environment for persons in crisis, most of who enter these programs voluntarily and regard their experiences at the CSP very positively.

- The majority of persons using the CSPs reported that the programs were warm, welcoming, and supportive at entry, and almost all said the programs were calming and peaceful during their stay.
- Persons who have used CSP services are very satisfied with the services they have received.

**No recommendation.**