OIG SAR In-Brief

*The Office of the Inspector General created this Semi-Annual Report In Brief (SAR) to provide a synopsis of the key issues covered in greater detail in the full-length SAR for the period ending March 31, 2011, that can be found on the OIG's website at : www.oig.virginia.gov.**

Office of the Inspector General
Behavioral Health and Developmental Services

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Inspector General

THE U. S. DEPARTMENT OF JUSTICE'S (DOJ) INVESTIGATION OF CVTC AND VIRGINIA'S COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT

By letter dated February 10, 2011, DOJ notified the Commonwealth of its findings that Virginia "fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation of the ADA." The report cited inadequate community-based services, the misalignment of resources that privileges state institutions, and a flawed discharge planning process as systemic failures causing unnecessary institutionalization of persons.

Negotiations between the Commonwealth and DOJ are on-going and are expected to conclude this summer; however, it is certain that services for Virginians with behavioral health and developmental disabilities will be changed going forward as more people are discharged from state facilities, the waiver program is expanded, and these individuals are served by community-based programs instead of long-established institutional-based settings. A copy of the twenty-one page report containing DOJ's findings and recommendations is appended to the full-length SAR for convenient reference.

THE USE OF RESTRAINT TO MEDICATE OVER A PATIENT'S OBJECTION

A Federal regulation (42 CFR § 482) whose stated purpose is to "ensure each patient's physical and emotional health and safety" has been interpreted to disenfranchise scores of psychotic, but nonviolent, patients in Virginia's behavioral health facilities of medically necessary interventions that would allow them to participate in their treatment. The controlling interpretation of this Federal regulation, advanced by Virginia's Office of the Attorney General (OAG), rules out the use of a brief restraint to administer medically necessary treatment that could restore a delusional person to a baseline of competency, except to ensure "the immediate physical safety of the patient, a staff member, or others."

The narrow focus on *immediate physical safety* does not consider a patient's mental health and, while the OAG's guidance may protect the rights of most residents of state facilities, it falls short of promoting all patient's rights by potentially consigning some number of passive psychotic individuals to a needlessly protracted severe illness with attendant psychogenic distress – unless they either agree to medication or present an immediate risk to the physical safety of themselves or others.

Unfortunately, a regulation crafted expressly to limit the prerogatives of health care providers by creating negative covenants to protect hospitalized people has become an instrument that restricts the right of patients to active treatment that could ease their psychogenic pain and allow individuals to more fully participate in their lives.

By denying palliative care until *immediate physical safety* is on the brink of being

*The complete SAR includes a summary of inspections, investigations, and reviews conducted, reports issued, outstanding recommendations, and initiatives undertaken with the Creating Opportunities workgroups and a review of forensic services.

compromised, in some cases, the OAG's interpretation will allow a person's psychosis to deepen and, even after subsequent restraint and treatment, the person may never return to the pre-episode level of functioning. The refusal to provide medication deemed medically necessary by an attending physician for the health, safety, or welfare of the patient, with the express consent of the individual's legal guardian, satisfies the definition of neglect and abuse as described by the *Code of Virginia* 1950, *et seq*. at § 37.2-100.

The OIG became aware of this issue through a complaint filed by a legal guardian that her adult child was being denied prescribed treatment because the state hospital had been instructed not to use a medical hold to administer an anti-psychotic injection; however, this issue is much larger than one person. An informal survey by the OIG suggests that approximately 10% of patients in the Commonwealth's adult behavioral health facilities have psychotic episodes that do not initially endanger their immediate physical safety. When the patients who are court ordered for restoration to stand trial (currently numbering approximately eighty) and the geriatric patients with dementia are included in this population, the number of individuals statewide directly impacted by this narrow interpretation of 42 CFR § 482 is in the hundreds.

In discussions with the Attorney General's Office, the OIG was advised that its current interpretation of CFR 42 § 482 would stand unless they were instructed otherwise by the Centers for Medicare and Medicaid Services (CMS). Therefore, the OIG has petitioned CMS to review this matter to determine if restraint can be used to administer medically necessary treatment over the objection of a patient lacking the capacity to make informed decisions about their medical care – before a patient's immediate physical safety is jeopardized. A copy of the OIG's letter petitioning to CMS to resolve this ambiguity is appended to the full SAR that is available on-line.

QUALITY MANAGEMENT OF COMMUNITY-BASED RESIDENTIAL PROGRAMS

During the period covered by this SAR, the OIG has responded to complaints at two large community-based residential programs with serious operational issues. Fortunately, the DBHDS's Office of Licensing was fully engaged and aware of the issues at these two residential facilities and, subsequently, the Department has taken decisive action to monitor compliance with pertinent regulations; however, it is unrealistic to expect the Office of Licensing to drive quality improvement at community based residential programs.

In the years ahead, the individuals served by the Commonwealth's training centers and behavioral health facilities will increasingly be residing in community based settings, and the OIG is concerned that the state currently lacks a robust system to assure quality management of community based programs. The U. S. Department of Justice (DOJ) shares our apprehension and noted its concern in the recently received letter containing its findings of the investigation of CVTC and recommendations for remedial action (pg. 18).

During the next decade, several thousand individuals will be either discharged from the state facilities or living in community programs under an expanded waiver program and many new programs will be created, or existing programs expanded, to accommodate the demand.

Accordingly, in collaboration with the DBHDS, the OIG will design and conduct a comprehensive statewide survey of existing community based residential programs later this year to examine the quality performance of current residential models. Following the evaluation, recommendations will be made to create an effective quality management system that will act both as an

early warning system to identify (and correct) poorly operated programs, and to drive quality improvement among thriving community providers.

EASTERN STATE HOSPITAL

As of March 31, 2011, the census in ESH's 150 bed adult behavioral health unit was 153 persons, with 8 individuals still occupying the obsolete Building 24. The facility has been unable to discharge patients into community-based programs because the needed community capacity has not been created. CSB staff report that, in order to have someone admitted to ESH, the hospital must first discharge a current CSB client from ESH – the so called "bed replacement system."

The bottom line is that, as of March 31, 2011, ESH remains largely unavailable as a safety net for Hampton Roads residents requiring a secure state behavioral health facility. The lack of a regional intermediate care facility will continue to stress the region's behavioral health continuum of care. According to HPR V's Emergency Services Managers, over 40 consumers received inadequate care last year because ESH was not available to provide intermediate care to adequately stabilize the region's most fragile individuals with serious mental illness.

The Hancock Geriatric Treatment Center has been approved by the VDH's Office of Licensure for the Medicaid program and has reestablished it certification to participate in the Medicaid program effective March 14, 2011. This is a direct result of the effective leadership and hard work by the staff of ESH.

THE PRACTICE OF "STREETING" IN VIRGINIA

The OIG was introduced to the term "streeting" during our follow-up on the impact on Hampton Roads by the downsizing of ESH last year.[1] We subsequently learned that, while *streeting* appears most prevalent in Hampton Roads – where eight of nine CSBs acknowledge *streeting*, this practice occurs throughout the Commonwealth and, that between April 1, 2010 and March 31, 2011, approximately 200 individuals, who met criteria for a Temporary Detention Order (TDO), were released from custody because no psychiatric facility was willing to admit these people.

§37.2-808 of the *Code* lists the criteria for temporary detention: a person has a mental illness and is likely to cause "serious harm to himself or others," a "lack of capacity" to protect himself from harm or to provide for basic human needs and "is in need of hospitalization or treatment."

While there are variations in causes and frequency of this denial of access across the regions, there were sufficient numbers in each region for the OIG to determine that *streeting* is a state-wide problem. Cases that satisfy the HPR V definition of "streeted" vary in complexity and level of risk and the OIG received anecdotal reports from around the state. The record also reflects that emergency services staff around the state routinely go far beyond reasonable expectations to keep clients as safe as possible despite sometimes daunting obstacles.

As one of only two mental health services mandated by the *Code*, the Virginia General Assembly (GA) has given considerable attention in the past to the process of

[1] The instructions for completing the "HPR V Emergency Services Weekly TDO Report" contain the following operational definition of streeting: "**# Streeted**: The person was released. For example, a person who is brought in under ECO, who meets [TDO] criteria, but has to be released from custody at the expiration of the ECO as there is no bed available." [Bold in original] Of the approximately 200 people "streeted," not all were detained pursuant to an ECO prior to evaluation for TDO.

securing and carrying out emergency services for citizens of Virginia who may be at-risk to self, or others, for harm due to their mental illness. The GA renewed its focus on emergency services following the tragic deaths at Virginia Tech in 2007, which resulted in several key changes in the delivery of emergency services in Virginia.

To deny individuals an opportunity to receive the services, at the level of care deemed clinically and legally necessary, places each person at risk not only at the time of the immediate crisis but may create avoidable risk for the person and the community later.

Streeting represents a failure of the Commonwealth's public sector safety net system to serve Virginia's most vulnerable citizens and places these individuals, their families, and the public at-risk. The fact that approximately 200 individuals, who were evaluated by skilled clinicians and determined to be a danger to themselves or others and lacking the capacity to protect themselves, were denied access to a secure environment for temporary detention and further evaluation, greatly concerns the OIG.

We will monitor this issue going forward and make recommendations to end this questionable and dangerous practice, and hope that one day the term *streeting* will pass from the lexicon of Virginia's behavioral health system.

VIRGINIA CENTER FOR BEHAVIORAL REHABILITATION (VCBR)

In 2004, Virginia created a program for the treatment of sexually violent predators (SVP) and subsequently established VCBR to accommodate the program serving this population. This treatment program has presented long-standing concerns for the OIG. Past inspections have consistently documented concerns at the facility including: limited treatment opportunities provided the residents; inadequate treatment planning; failed programming initiatives; and inadequate staffing to assure safety and effective programming.

In the last year, the DBHDS has replaced VCBR's facility Director and recruited a new clinical Director who has authored several important books on SVPs and is widely regarded as an expert in the treatment of this population. These leadership changes appear to have stabilized the serious security concerns at VCBR and generated a credible treatment program for the residents, but these promising developments must be given time to mature before the significant problems noted in OIG Reports since 2007 are considered resolved.

The cost of operating this program has skyrocketed as the population has grown from 14 in 2004 to over 260 today, and it is projected to increase by 7 individuals each month through 2016 at a cost per person of $91,000/year – plus facility cost. The General Assembly has directed a comprehensive study of this program to be completed later this year. The unforeseen cost of this program and the on-going operational transition may present an opportunity to evaluate the Commonwealth's civil commitment statutes and the treatment of sexually violent predators.

If you would like more information about these issues, or other activities of the Office of the Inspector General for Behavioral Health and Developmental Services during this reporting period, please refer to the full-length SAR at www.oig.virginia.gov, call (804) 692-0276, fax your questions to (804) 786-3400, or write to:

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