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Expiration Date: 08/31/2014

PROTECTION & ADVOCACY for INDIVIDUALS with MENTAL ILLNESS (PAIMI) PROGRAM - ANNUAL PROGRAM PERFORMANCE REPORT (PPR)

STATE: VA	FISCAL YEAR: 2013

SECTION 1. GENERAL PAIMI PROGRAM INFORMATION

1.A. Fiscal Year:	2013
State:	VA
Name of P&A System:	VIRGINIA - disAbility Law Center of Virginia
Mailing Address & Phone Number of Main Office:	1910 Byrd Avenue Suite 5 Richmond, VA 23230 804-225-2042
Mailing Address & Phone Number of Each Satellite Office:	
Name of PAIMI Program, if different from the State P&A agency:	dLCV on behalf of VOPA
Name, Phone number and email address of the PAIMI Coordinator:	Robert Gray 804-225-2042 robert.gray@dlcv.org
PPR Prepared by: **Name:** **Title:** **Area Code & Phone Number:** **E-mail Address:**	Colleen Miller Executive Director 804-225-2042 Colleen.Miller@dlcv.org
The name of the Director of the State mental health agency to whom copies of the PAIMI PPR & ACR were sent.*	James W. Stewart, III DBHDS
Date the PAIMI PPR &ACR were sent to the State mental health agency.*	12/2/2013

PAIMI Act [42 USC at 10805 (a)(7) mandates that the Head of the State mental health agency receive a copy of this report on or before January 1.

SECTION 1. GENERAL PAIMI PROGRAM INFORMATION

1.B. GOVERNING BOARD

1.B.1. Does the P&A have a multi-member governing board? If Yes, complete governing board (GB), Table 1.B.3. [See Governing Authority - 42 CFR 51.22(b).].	Yes
1.B.2.a Is the P&A a private non-profit P&A system?	Yes
1.B.2.b Is the chair of the PAIMI Advisory Council (PAC) a member of the governing board?	Yes
1.B.2.c. Please provide an explanation why the chair is not a member of the governing board N/A	

1.B.3. GOVERNING BOARD (GB) INFORMATION

In the following table, please provide the requested information for the GB members as of 9/30.	
a. Total number of GB member seats available.	13
b. Total number of GB members serving as of 9/30.	12
c. Total number of GB vacancies on 9/30.	1
d. Term of appointment for GB members (number of years).	4
e. Maximum number of terms a GB member may serve.	2
f. Frequency of GB meetings.	Quarterly
g. Number of GB meetings held this fiscal year (FY).	4
h. % (Average) of GB members present at meetings this FY.	74%

1.B.4. GOVERNING BOARD COMPOSITION

"The governing board shall be composed of members who broadly represent or are knowledgeable about the needs of clients served by the P&A system . . . ." [42 CFR 51.22(b)(2). *Count each GB member only once.*	
a. Number of individuals with mental illness (IMI) who are recipients/former recipients (R/FR) of mental health services or are or have been eligible for services.	2
b. Number of family members of individuals with mental illness who are R/FR of mental health services.	1
c. Number of guardians.	1
d. Number of advocates or authorized representatives.	1
e. Number of other persons who broadly represent or are knowledgeable about the needs of the clients served by the P&A system.	7
TOTAL	12
Section 42 CFR 51.22(b)(2) - mandated GB positions for private, non- profit systems. *Count each GB member only once. The Total of 1.B.3.a. must equal the subtotals of 1.B.3.b and 1.B.3.c.*	

1.C. PAIMI PROGRAM STAFF

1. Provide the total number of P&A staff who are paid either partially or totally with PAIMI Program funds, including PAIMI Program income.	25
1.a. How many of the staff listed above are attorneys?	7
1.b. How many of the staff listed above are non-attorney case workers/mental health advocates? *Do not include support or administrative staff in this count.*	9

1.D. ETHNICITY & RACE

The minimum categories for data on race and ethnicity for federal program administrative reporting are defined in the Glossary:

1.D.1. ETHNICITY	GOVERNING BOARD	PAIMI STAFF
1.D.1.a. Hispanic or Latino	0	0
1.D.1.b. Not Hispanic or Latino	12	26
1.D.2. RACE		
1.D.2.a. American Indian or Alaska Native	0	0
1.D.2.b. Asian	0	0
1.D.2.c. Black or African American	2	6
1.D.2.d. Native Hawaiian or Other Pacific Islander	0	0
1.D.2.e. White	10	20
1.D.2.f. Two or more races	0	0
Vacancies on 9/30 (Identify by position).	1	0
Vacant Speaker of the House of Delegates Appointment	1	0
Total	13	26

1.E. GENDER

	GOVERNING BOARD	PAIMI STAFF
1.E.1. Male	9	7
1.E.2. Female	3	19
Total	12	26

SECTION 2. PAIMI PROGRAM PRIORITIES & OBJECTIVES

2.A. Priority - 87

PRIORITY (GOAL): 1
People with Disabilities are Free from Abuse and Neglect
Focus Area 1: Adequate System for Protection from Harm in Institutions

Case Example

Daniel's psychiatrist and social worker convinced him to drop his commitment appeal in exchange for a promise that they would discharge him from the state-operated mental health facility. However, they broke the promise. VOPA investigated and verified a human rights violation that the psychiatrist exploited Daniel. On Daniel's behalf, VOPA filed a human rights complaint. As a result, the facility's director found that the psychiatrist violated Daniel's rights and took personnel action against him. The facility also changed its policy to prohibit staff from discussing or bargaining any aspect of a patient's commitment appeals with the patient. The Director of the facility also ordered all clinical department heads to train their staff regarding the new policy and to report when the staff completed the training.

2.B. Objective - 163

1. Prepare quarterly summaries and semi-annual trend analyses of Critical Incident Reports (CIRs) and other analyses as needed, for use in institution monitoring.
2. Monitor conditions at each of the nine (9) Department of Behavioral Health and Developmental Services (DBHDS)-operated mental health facilities monthly and provide residents with information about their legal rights as requested.
3. Investigate the response of entities responsible for licensing, oversight, or investigation of ten (10) instances of death, serious injury, or allegations of abuse or neglect of individuals with disabilities in institutional setting. Incidents will be selected based on suspected inadequate staffing, use of restraints or seclusion, inappropriate admission of individuals with dementia or Alzheimer's to mental health facilities, or other identified patterns of abuse or neglect. All investigations will seek corrective action, to include systemic reform, as necessary.
4. Represent two (2) individuals who have been injured or the estates of individuals who have died due to staff or facility negligence.
5. Submit a petition for rulemaking to DBHDS proposing changes to the human rights regulations to provide complainants due process.
6. Respond to all proposed legislation, regulation, or policy changes that may impact abuse and neglect in institutional settings.

2.C. Target Population

PAIMI-eligible children and adults living in institutional settings

2.D. Target

Data analysis;
108 episodes of monthly monitoring;
Ten (10) investigations;
Two (2) individual cases;
One (1) petition; and
Public policy advocacy, as needed.

2.E. Outcome

1. As required by state law, VOPA received Critical Incident Reports (CIRs) from Department of Behavioral Health and Developmental Services (DBHDS) when an individual was seriously injured and required medical treatment. We review reports to identify incidents of particular concerns or trends. Additionally, VOPA's Executive Director conducted weekly meetings with the advocates and attorneys to discuss the CIRs. VOPA also reviewed detailed seclusion and restraint data, as well as census and staffing data.

2. VOPA conducted one hundred and two (102) visits to monitor conditions at state-operated mental health facilities in Virginia. Often, VOPA opened individual or systemic cases for investigation or resolution for complaints of human rights violations. VOPA's advocacy efforts focused largely on use of the seclusion and restraint at several state-operated mental health facilities.

One example is the Commonwealth Center for Children and Adolescents (CCCA). VOPA monitors conditions at CCCA multiple times per month because most children and adolescents have a relatively short length of stay. VOPA found probable cause that CCCA subjected children and adolescents to improper and dangerous seclusion and restraint practices. VOPA therefore opened an investigation on behalf of three (3) adolescents who were subjected to such practices. VOPA is pursuing a formal human rights complaint on behalf of the adolescents, seeking to implement the recommendations of Substance Abuse and Mental Health Services Administration (SAMHSA) regarding a trauma-informed approach, prohibition of prone restraint, informed consent for guardians and patients upon admission to CCCA concerning the risks of seclusion and restraint, staff retraining, and increased involvement and oversight by our successor, the disAbility Law Center of Virginia (dLCV).

VOPA collaborated with experts at the National Technical Assistance Center for Trauma-Informed Care to engage facility staff in trainings and strategic planning regarding trauma-informed care systems. As a result of VOPA's advocacy in this area, CCCA eliminated the use of "time-out," prohibited the use of riot shields against children and adolescents, and hired an occupational therapist to support a trauma-informed approach to treatment.

In FY 2014, dLCV will continue to advocate for Trauma Informed Care principles, increased communication with the administration and staff through attendance at meetings and trainings, and support for additional SAMHSA technical assistance to reduce seclusion and restraint.

A second instance is Southern Virginia Mental Health Institute (SVMHI), whose new director is promoting trauma informed care and the reduction of seclusion and restraint. SAMHSA presented a two-day workshop for patients and staff at SVMHI on these topics. The presentation was well-received. Monitoring of the facility's statistics and conversations with patients and staff indicate that restraint is seldom used, while seclusion is minimally used.

3. VOPA opened ten (10) cases to obtain corrective action relating to the response of entities responsible for licensing, oversight, or investigation involving serious injury or allegations of abuse or neglect of individuals within institutional settings.

Case Example: Daniel's psychiatrist and social worker convinced him to drop his commitment appeal in exchange for a promise that they would discharge him from the state-operated mental health facility. However, they broke the promise. VOPA investigated and verified a human rights violation that the psychiatrist exploited Daniel. On Daniel's behalf, VOPA filed a human rights complaint. As a result, the facility's director found that the psychiatrist violated Daniel's rights and took personnel action against him. The facility also changed its policy to prohibit staff from discussing or bargaining any aspect of a patient's commitment appeals with the patient. The Director of the facility also ordered all clinical department heads to train their staff regarding the new policy and to report when the staff completed the training.

4. VOPA is representing Emily, an individual who was restrained inappropriately and excessively while she was a patient at a state-operated mental health facility. The facility staff knew that Emily had a history of sexual abuse by a male, as well as a pre-existing medical condition, that contraindicated the use of restraints. A male staff initiated a prone restraint in which Emily stated that she could not breathe. Instead, the male staff

told her “then stop struggling.” In a later incident, staff placed Emily in bed restraints. She vomited repeatedly, including coughing up blood, and attempted to sit up several times. However, staff told Emily that she had to “calm down” and develop a plan for release from the restraints. Emily experienced psychological trauma from the excessive and contraindicated restraints. VOPA filed a human rights complaint on Emily’s behalf. This case is ongoing.

5. The Department of Behavioral Health and Developmental Services (DBHDS) published a Notice of Intent to revise its human rights regulations. Therefore, VOPA did not need to submit a Petition for Rulemaking. VOPA submitted written comments urging DBHDS to simplify and make more accessible its complaint resolution process and to increase due process protections for individuals with disabilities receiving services from facilities operated, licensed, and funded by DBHDS. VOPA participated in a DBHDS focus group within the rulemaking process. DBHDS intends to submit proposed revisions to the DBHDS Board by December 2014. dLCV will continue to monitor DBHDS’ progress through the regulatory development process.

6. As noted above, The Department of Behavioral Health and Developmental Services (DBHDS) initiated a comprehensive review of its human rights regulations. The process for the review and revisions to the regulations is expected to take at least three (3) years. VOPA advocated for specific improvements to the human rights regulations and participated in a focus group. VOPA continues to monitor DBHDS’ progress through the regulatory development process. The revisions will impact at least 200,000 individuals with disabilities receiving services from facilities operated, licensed, and funded by DBHDS.

2.F. Objective Met or Not Met: Not Met

Objective Met or Not Met: Partially Met

2. Staffing resources impacted the number of monitoring visits.
6. Only one allegation involving PAIMI-eligible individuals met the case selection criteria.

2.A. Priority - 88

PRIORITY (GOAL): 1
People with Disabilities are Free from Abuse and Neglect
Focus Area 2: Adequate System for Protection from Harm in Community Settings

Case Example

Case Example: Barbara resided in an assisted living facility (ALF) where she felt unsafe. She reported that the ALF staff administered her medication improperly which led her to receiving emergency services at a hospital. ALF staff also refused to fill one of her prescriptions. Furthermore, she reported that the ALF staff verbally and physically abused her. She requested VOPA for assistance in filing a complaint, but wished to remain anonymous. However, the nature of her complaints would have positively identified her and she refused to pursue the complaints due to her fear of retaliation. VOPA provided her information about how she can pursue her desire to look for a new living arrangement. VOPA assisted Barbara in exploring other options, including filing a complaint to Adult Protective Services or Department of Social Services' Office of Licensure once she moved to a new placement. At that point, Barbara withdrew her request for VOPA's services.

2.B. Objective - 164

1. Prepare quarterly summaries of all reports submitted by Adult Protection Services (APS) to identify possible patterns of abuse or neglect.
2. Investigate ten (10) allegations of the abuse or neglect of individuals with disabilities in licensed community residential settings. All investigations will seek corrective action, to include systemic reform, as necessary.
3. Respond to all proposed legislation, regulation, or policy changes that may impact the elimination of abuse and neglect in licensed community residential settings.

2.C. Target Population

PAIMI-eligible children and adults residing in licensed residential settings in the community.

2.D. Target

Data analysis;
Ten (10) investigations; and
Public policy advocacy, as needed.

2.E. Outcome

1. VOPA reviewed and prepared summaries of reports submitted from Virginia's various Psychiatric Residential Treatment Facilities (PRTFs) to identify potential patterns of abuse and neglect. VOPA initiated a few investigations resulting from the reports.

Case Example: Eric is an individual who received services from a PRTF. The staff improperly restrained him and Eric's back was sprained as a result. The PRTF failed to provide medical care until the following day. Eric then sustained a fractured foot from a peer altercation. Again, the PRTF did not medically assess his injury until the next day. VOPA completed an investigation and found that the PRTF abused and neglected Eric. Furthermore, VOPA found that the PRTF staff committed violations of dignity when the staff cursed and yelled at Eric and other patients. VOPA aided Eric in filing a formal human rights complaint regarding these violations. Although Eric decided not to pursue a formal human rights hearing in his case, VOPA worked with the PRTF to identify deficiencies within their system of care and to recommend corrective action regarding these deficiencies. VOPA's recommendations included staff retraining, policy revision, and the implementation of Substance Abuse and Mental Health Services Administration's trauma-informed approach to treatment and subsequent seclusion and restraint reduction plans.

Case Example: Carlos is also a patient who received services at a PRTF. The staff restrained Carlos improperly, causing significant injury. Carlos tried to seek medical attention from the nurse's office, only to be told he was "attention-seeking." The nurse gave him some pain medication and Carlos went to bed. However, Carlos' mother received a call the next day that Carlos had a broken bone and had to obtain medical treatment at a local hospital. Carlos now has a permanent deformity as a result of the injury during a restraint incident. VOPA investigated and found that this PRTF committed human rights violations. VOPA assisted Carlos in filing a human rights complaint to address the abuse due to the excessive and improper restraints and neglect due to the delay in providing appropriate medical care. The PRTF agreed to implement the trauma-informed approach to treatment, provide additional staff training, and hire a pediatrician to ensure timely medical treatment and evaluation.

This project is ongoing for continued monitoring and protection from harm.

2. VOPA opened six (6) cases involving children and adolescents to receive appropriate habilitation and discharge planning and services.

Case Example: Justin is an adolescent with a mental illness and a history of inpatient psychiatric placements. Following discharge from a state-operated mental health facility, he was placed at a psychiatric residential treatment facility (PRTF). The PRTF staff failed to provide Justin individualized treatment. The PRTF also improperly restricted visits between Justin and his family. VOPA intervened, and soon Justin's family could visit him regularly. Meanwhile, VOPA assisted Justin in discharge planning to a less restrictive step-down placement. Justin reports that he is much happier at his new placement.

3. In FY 13, VOPA had a preliminary discussion with Just Children from the Legal Aid Justice Center for a potential collaboration to address the denial of special education services, as well as seclusion and isolation at PRTFs. dLCV will develop this collaboration in FY 14.

2.F. Objective Met or Not Met: Not Met

4. VOPA represented six PAIMI-eligible individuals needing representation to obtain appropriate rehabilitation and discharge planning and services under objective two.

2.A. Priority - 89

PRIORITY (GOAL): 1
People with Disabilities are Free from Abuse and Neglect
Focus Area 3: Adequate Protection for Harm in Community or Institutional Settings Serving Children and Adolescents

Case Example

Case Example: Eric is an individual who received services from a PRTF. The staff improperly restrained him and Eric's back was sprained as a result. The PRTF failed to provide medical care until the following day. Eric then sustained a fractured foot from a peer altercation. Again, the PRTF did not medically assess his injury until the next day. VOPA completed an investigation and found that the PRTF abused and neglected Eric. Furthermore, VOPA found that the PRTF staff committed violations of dignity when the staff cursed and yelled at Eric and other patients. VOPA aided Eric in filing a formal human rights complaint regarding these violations. Although Eric decided not to pursue a formal human rights hearing in his case, VOPA worked with the PRTF to identify deficiencies within their system of care and to recommend corrective action regarding these deficiencies. VOPA's recommendations included staff retraining, policy revision, and the implementation of Substance Abuse and Mental Health Services Administration's trauma-informed approach to treatment and subsequent seclusion and restraint reduction plans.

2.B. Objective - 166

1. Prepare semi-annual summaries of all reports submitted by psychiatric residential treatment facilities (PRTFs) for use in monitoring and to identify possible patterns of abuse or neglect.
2. Represent eight (8) children at PRTFs to receive appropriate habilitation and discharge planning and services including special education, vocational rehabilitation, assistive technology, Medicaid, voting rights information, and benefits planning.
3. Respond to all proposed legislation, regulation, or policy changes that may impact the elimination of abuse and neglect in licensed community residential settings.

2.C. Target Population

PAIMI-eligible children and adolescents residing in institutions and community settings.

2.D. Target

Data analysis;
Eight (8) individual cases; and
Public policy advocacy, as needed.

2.E. Outcome

1. VOPA reviewed and prepared summaries of reports submitted from Virginia's various Psychiatric Residential Treatment Facilities (PRTFs) to identify potential patterns of abuse and neglect. VOPA initiated a few investigations resulting from the reports.

Case Example: Eric is an individual who received services from a PRTF. The staff improperly restrained him and Eric's back was sprained as a result. The PRTF failed to provide medical care until the following day. Eric then sustained a fractured foot from a peer altercation. Again, the PRTF did not medically assess his injury until the next day. VOPA completed an investigation and found that the PRTF abused and neglected Eric. Furthermore, VOPA found that the PRTF staff committed violations of dignity when the staff cursed and yelled at Eric and other patients. VOPA aided Eric in filing a formal human rights complaint regarding these violations. Although Eric decided not to pursue a formal human rights hearing in his case, VOPA worked with the PRTF to identify deficiencies within their system of care and to recommend corrective action regarding these deficiencies. VOPA's recommendations included staff retraining, policy revision, and the implementation of Substance Abuse and Mental Health Services Administration's trauma-informed approach to treatment and subsequent seclusion and restraint reduction plans.

Case Example: Carlos is also a patient who received services at a PRTF. The staff restrained Carlos improperly, causing significant injury. Carlos tried to seek medical attention from the nurse's office, only to be told he was "attention-seeking." The nurse gave him some pain medication and Carlos went to bed. However, Carlos' mother received a call the next day that Carlos had a broken bone and had to obtain medical treatment at a local hospital. Carlos now has a permanent deformity as a result of the injury during a restraint incident. VOPA investigated and found that this PRTF committed human rights violations. VOPA assisted Carlos in filing a human rights complaint to address the abuse due to the excessive and improper restraints and neglect due to the delay in providing appropriate medical care. The PRTF agreed to implement the trauma-informed approach to treatment, provide additional staff training, and hire a pediatrician to ensure timely medical treatment and evaluation.

This project is ongoing for continued monitoring and protection from harm.

2. VOPA opened six (6) cases involving children and adolescents to receive appropriate habilitation and discharge planning and services.

Case Example: Justin is an adolescent with a mental illness and a history of inpatient psychiatric placements. Following discharge from a state-operated mental health facility, he was placed at a psychiatric residential treatment facility (PRTF). The PRTF staff failed to provide Justin individualized treatment. The PRTF also improperly restricted visits between Justin and his family. VOPA intervened, and soon Justin's family could visit him regularly. Meanwhile, VOPA assisted Justin in discharge planning to a less restrictive step-down placement. Justin reports that he is much happier at his new placement.

3. In FY 13, VOPA had a preliminary discussion with Just Children from the Legal Aid Justice Center for a potential collaboration to address the denial of special education services, as well as seclusion and isolation at PRTFs. dLCV will develop this collaboration in FY 14.

2.F. Objective Met or Not Met: Not Met

Objective Met or Not Met: Partially Met

4. VOPA represented six PAIMI-eligible individuals needing representation to obtain appropriate rehabilitation and discharge planning and services under objective two.

2.A. Priority - 90

PRIORITY (GOAL): 1
People with Disabilities are Free from Abuse and Neglect
Focus Area 4: Timely and Appropriate Mental Health Services in Local and Regional Jails and Juvenile Correctional Facilities

Case Example

Case Example: Daniel's psychiatrist and social worker convinced him to drop his commitment appeal in exchange for a promise that they would discharge him from the state-operated mental health facility. However, they broke the promise. VOPA investigated and verified a human rights violation that the psychiatrist exploited Daniel. On Daniel's behalf, VOPA filed a human rights complaint. As a result, the facility's director found that the psychiatrist violated Daniel's rights and took personnel action against him. The facility also changed its policy to prohibit staff from discussing or bargaining any aspect of a patient's commitment appeals with the patient. The Director of the facility also ordered all clinical department heads to train their staff regarding the new policy and to report when the staff completed the training.

2.B. Objective - 165

1. Represent five (5) children at juvenile correctional facilities court to receive an appropriate mental health services, transition plan, and related services.
2. Obtain systemic relief for individuals who have been ordered to the custody of the Commissioner of DBHDS, but who remain in jail.

2.C. Target Population

PAIMI-eligible individuals in jails and juvenile correctional facilities who require mental health services.

2.D. Target

Five (5) individual cases; and
One (1) systemic case.

2.E. Outcome

1. VOPA received no calls from youth or parents on the topic of community re-entry under any funding source. However, VOPA contacted the Director of Policy and Planning from the Virginia Department of Juvenile Justice (DJJ) for assistance in identifying children for community re-entry. The DJJ was initially enthused about collaborating to develop and implement mental health transition plans. The DJJ then hesitated to refer clients to VOPA. We are currently pursuing our general access authority for monitoring and outreach at one DJJ facility.

2. In FY 2012, VOPA represented 17 individuals with mental illness who were ordered into treatment, but languished in jails without receiving any mental health treatment. Upon VOPA's intervention, the individuals were immediately transferred to mental health facilities for treatment. At the end of FY 2012, VOPA conducted a campaign to obtain systemic relief for individuals who have been ordered to the custody of the Commissioner of Department of Behavioral Health and Developmental Services (DBHDS), but remain in jail awaiting restoration of competency. This campaign detailed VOPA's successful use of a Motion for Rule to Show Cause to compel the DBHDS Commissioner to provide services. VOPA assembled a package that included forms, briefs, references to authorities, and explanatory cover letter describing the previous success of VOPA's tactic. VOPA distributed the package to 2200 public defenders and court-appointed defense counsel. VOPA provided consultation, advice, or other assistance to 50 defense attorneys who followed up in FY 2013.

2.F. Objective Met or Not Met: Not Met

Objective Met or Not Met: Partially Met

1. There were no requests for services.

2.A. Priority - 91

PRIORITY (GOAL): 2
People with Disabilities Live in the Most Appropriate Integrated Environment
Focus Area 1: Maximize Individual Choice and Self-Direction

Case Example

Case Example: Thomas was bored in the psychosocial group that his treatment team insisted that he attend. He was told to sit quietly. He was not receiving any active treatment or therapeutic benefit from the psychosocial group. VOPA filed a human rights complaint on his behalf, demanding that the treatment team respect Thomas's input into his treatment plan and to allow him to participate in a psychosocial group that met his treatment needs and reflected his preferences. The facility Director agreed with the complaint. Thomas now enjoys participating in a psychosocial program that provides him appropriate and active treatment.

2.B. Objective - 167

1. Working with other advocacy groups, develop statewide training curriculum for advance directives peer advisers.
2. Train three (3) groups of Advance Directive Peer Advisors at Community Service Boards to equip mental health consumers to assist others in drafting advance directives.
3. Train three (3) groups of high school students, family members, and educators about alternatives to guardianship and Powers of Attorney.
4. Inform consumers, family members, and service providers about alternatives to guardianship by providing five (5) trainings at conferences and programs.
5. Inform individuals of their rights by conducting quarterly clinics on discharge rights and the human rights complaint system at each DBHDS-operated mental health facilities to include the dissemination and implementation of a self-advocacy training module.
6. Represent twelve (12) individuals in preparing a Healthcare Directive or Power of Attorney as an alternative to guardianship, with preference for those who attend a VOPA training.
7. Represent fifteen (15) individuals at DBHDS-operated mental health facilities to receive, as part of their treatment plan, opportunities for choice and control over themselves and their environment to include any necessary assistive technology.
8. Respond to all proposed legislation, regulation, or policy changes that appear to violate legal rights in substitute decision-making proceedings.
9. Inform policymakers of the need for peer facilitation of advanced mental healthcare directives.
10. Inform policymakers about the need for increased personal choice and self-direction for individuals with disabilities through participation on the Virginia Public Guardianship and Conservatorship Advisory Board.

2.C. Target Population

PAIMI-eligible adults who face systemic barriers to exercising their rights to self-direction and individual choice.

2.D. Target

One (1) curriculum;
Eleven (11) trainings;
Thirty-six (36) rights clinic;
Twenty-seven (27) individual cases;
Public policy advocacy, as needed; and
One (1) targeted public policy effort.

2.E. Outcome

1. VOPA collaborated with representatives from the University of Virginia Institute of Law, Psychiatry, and Public Policy, Virginia Organization of Consumers Asserting Leadership (VOCAL), Mental Health America of Virginia, and Department of Behavioral Health and Developmental Services to complete the statewide training curriculum, drafted in Fiscal Year 2012, for advanced directive peer facilitators. Entitled "How to Decide Who Decides When I Can't Decide," this curriculum incorporates basic advance directive training and a comprehensive facilitator training which includes video vignettes, a final exam, and an observation protocol.

2. VOPA reached out to four (4) large Community Services Boards, Virginia Organization of Consumers Asserting Leadership (VOCAL), and Trillium Drop-In Center (mental health peer-run program) to provide a two -day pilot training of "How to Decide Who Decides When I Can't Decide?" curriculum to thirty-two (32) advanced directive peer facilitators.

3. VOPA increased understanding of alternatives to guardianship through the statewide training of three (3) groups of high school students, family members, and educators. VOPA provided training to thirty-eight (38) individuals at schools and advocacy groups regarding alternatives to guardianships and Power of Attorney. As a result of VOPA's outreach, students, family members, and school personnel can seek alternatives to substitute decision-making.

4. VOPA informed consumers, family members, and service providers about alternatives to guardianship by providing nine (9) trainings at conferences and programs. VOPA's presentations reached a total of one hundred and twenty six (126) individuals. Consumers, family members, and service providers obtained a better understanding of alternatives to guardianship to empower individuals make informed decisions regarding their choices in life, thereby maximizing their individual choice and self-direction.

5. VOPA conducted sixty-four (64) rights clinics at nine (9) state-operated mental health facilities in Virginia to inform individuals receiving services of their right to be free from abuse and neglect. VOPA gave these clinics in various formats: formal and informal presentations and trainings, office hours, and 1:1 meetings with the individuals. VOPA also distributed information regarding human rights, self-advocacy forms, and other publications to support the individuals. VOPA assisted individuals in completing the human rights complaints as necessary. Often, VOPA opened individual cases for investigation, negotiation, and resolution for complaints of human rights violations.

Case Example: Thomas was bored in the psychosocial group that his treatment team insisted that he attend. He was told to sit quietly. He was not receiving any active treatment or therapeutic benefit from the psychosocial group. VOPA filed a human rights complaint on his behalf, demanding that the treatment team respect Thomas's input into his treatment plan and to allow him to participate in a psychosocial group that met his treatment needs and reflected his preferences. The facility Director agreed with the complaint. Thomas now enjoys participating in a psychosocial program that provides him appropriate and active treatment.

6. VOPA represented fifteen (15) individuals in preparing a Healthcare Directive or Power of Attorney as an alternative to guardianship. One example is Christina, an individual receiving treatment in a state-operated mental health facility. The facility had subjected Christina to unwarranted and forced strip searches that were not backed by probable cause. VOPA assisted Christina in preparing a medical directive that clearly states her refusal to consent to strip searches, seclusion, and restraints. Her medical directive also denies any substitute decision-maker the authority to consent to these unwarranted and traumatic practices.

7. VOPA opened twelve (12) cases for ten (10) individuals.

Case Example: Rita, an individual receiving services at a state-operated mental health facility, identified that the proximity of another patient was causing her psychological harm. She requested a transfer to a different unit. The facility's director denied her request. Rita filed a formal human rights complaint before her local human rights committee (LHRC), requesting an emergency hearing. VOPA assisted in Rita's advocacy at the emergency hearing, raising issues of abuse (psychological harm), rights violations (denying her participation in decision-making and treatment), and lack of trauma-informed care. The LHRC ruled in Rita's favor. The facility immediately moved Rita to a different unit where she feels safer and can focus on her treatment and recovery.

8. During the 2013 session of the Virginia state legislature, VOPA worked with advocacy groups to monitor budget proposals and educate policy makers about the implications of proposed legislation. VOPA carefully monitored changes to Virginia code concerning forced outpatient treatment, so that existing protections in the law were not eroded. We advised policymakers on a proposal that would allow transportation under a custody order by someone other than police, and a proposal to extend time of an emergency custody order. Neither proposal was adopted.

The legislature also considered a bill that substantially revised the state's guardianship laws, but inadvertently restricted the rights of people with disabilities. VOPA educated policy makers about what was, essentially, a serious drafting error. Although the legislation had passed several layers of review and approval, all policymakers involved agreed that it did contain a drafting error. The patron then took necessary steps to correct the bill.

9. VOPA had preliminary discussions with policymakers about the need to improve peer facilitation of advanced directives.

10. VOPA attended the quarterly meeting of the Virginia Public Guardianship and Conservatorship Advisory Board. VOPA educated members of the Board about alternatives to guardianship and encouraged referrals to VOPA for assistance. VOPA also made recommendations for person-centered planning and care. With VOPA's transition to dLCV pending, the Board voted to recommend to the Commissioner of the Department for Aging and Rehabilitative Services (DARS) to propose legislation to add a dLCV representative as a mandated appointee.

2.F. Objective Met or Not Met: Not Met

Objective Met or Not Met: Partially Met

7. VOPA received only twelve (12) requests for assistance from individuals to assist in advocating for choice and control over themselves and their environment as part of their treatment plan.

2.A. Priority - 92

PRIORITY (GOAL): 2
People with Disabilities Live in the Most Appropriate Integrated Environment
Focus Area 2: Right to Timely Discharge from State Facilities

Case Example

Case Example: Joyce is an individual with complex service needs and challenging behaviors. The facility identified her as ready for discharge. However, Joyce's Community Services Board (CSB) created an inadequate and improper discharge plan that did not include her stated preferences. Furthermore, the CSB put little effort in finding Joyce a placement. Therefore, the facility could not discharge Joyce for months. VOPA sent Joyce's CSB a demand letter to start the discharge planning immediately. The CSB, with Joyce's input and direction, then drafted an appropriate discharge plan that included reintegration supports into a community of her choice, but not origin. Joyce chose a placement that was out of the CSB's catchment area. That placement required coordination of two CSBs to work together for a trans-catchment discharge. The receiving CSB opposed Joyce's placement in its catchment area. VOPA contacted the receiving CSB and informed it of the legal requirements to respect Joyce's right to live in a locality of her choice. VOPA effectively negotiated with the two CSBs to ensure a successful implementation of the discharge plan. Joyce reported that she likes the supports and services at the placement of her own choosing.

2.B. Objective - 168

1. Represent ten (10) individuals at DBHDS-operated mental health facilities who have been identified as ready for discharge for thirty days to ensure timely discharge planning and discharge.
2. Investigate whether barriers to discharge at Southern Virginia Mental Health Institute and obtain appropriate systemic relief.
3. In collaboration with NAMI-VA, file a complaint with the Office of Human Rights, Department of Health and Human Services, describing circumstances of Virginia's mental health system that appear to violate the Olmstead decision.
4. Respond to all proposals that would restrict an individual's legal right to timely discharge from mental health facilities.
5. Respond to all proposals that would reduce legal rights to choice, independence, and integration that we learn of through the Partnership for People with Disabilities Advisory Council, the Mental Health Planning Council, the Coalition for Virginians with Mental Disabilities, and on the Virginia Board for People with Disabilities.

2.C. Target Population

PAIMI-eligible individuals in state-operated mental health facilities who face systemic barriers to full and genuine community integration.

2.D. Target

Ten (10) individual cases;
One (1) investigation;
One (1) complaint; and
Public policy advocacy, as needed.

2.E. Outcome

1. VOPA opened cases for nine (9) individuals to ensure a timely discharge planning and discharge from a DBHDS-operated mental health facility.

Case Example: Joyce is an individual with complex service needs and challenging behaviors. The facility identified her as ready for discharge. However, Joyce's Community Services Board (CSB) created an inadequate and improper discharge plan that did not include her stated preferences. Furthermore, the CSB put little effort in finding Joyce a placement. Therefore, the facility could not discharge Joyce for months. VOPA sent Joyce's CSB a demand letter to start the discharge planning immediately. The CSB, with Joyce's input and direction, then drafted an appropriate discharge plan that included reintegration supports into a community of her choice, but not origin. Joyce chose a placement that was out of the CSB's catchment area. That placement required coordination of two CSBs to work together for a trans-catchment discharge. The receiving CSB opposed Joyce's placement in its catchment area. VOPA contacted the receiving CSB and informed it of the legal requirements to respect Joyce's right to live in a locality of her choice. VOPA effectively negotiated with the two CSBs to ensure a successful implementation of the discharge plan. Joyce reported that she likes the supports and services at the placement of her own choosing.

On a systemic level, VOPA conducted an investigation of Northern Virginia Mental Health Institute's (NVMHI) discharge planning practices. NVMHI initially refused to provide its "Ready for Discharge" or "Extraordinary Barriers" list. Upon formal demand for these records, VOPA resolved this issue with the Office of the Attorney General. NVMHI then provided the requested records.

2. VOPA investigated the barriers to discharge at Southern Virginia Mental Health Institute (SVMHI). In July 2012, 29% of SVMHI patients had been ready for discharge for more than 30 days but had not been placed in the community. They were placed on SVMHI's "extraordinary barriers list." VOPA identified several barriers, including shortage of Discharge Assistance Project (DAP) funds for individuals who were taking community passes, but for whom a discharge residence was not identified. Furthermore, many of the individuals on the list were Not Guilty by Reason of Insanity (NGRI) acquittees who were at the "unescorted community pass" level. SVMHI initiated a new process for tracking forensic packets, ensuring the timely completion of privileging packages and court reports. They filled a doctoral-level psychologist position on the forensic treatment team and hired another clinical psychologist with extensive forensic experience to supervise the overall forensic process. Consequently, forensic packages are being processed in a timely fashion and SVMHI reduced their extraordinary barriers list from 29% to 16.5% in one year, with only one NGRI acquittee on the extraordinary barriers to discharge list at the time of this report. VOPA closed this investigation as there are no other consistent barriers to discharge at this time.

3. VOPA collaborated with NAMI-VA and Quality Trust for People with Disabilities (Quality Trust) about options to address the Olmstead issues within Virginia's mental health system. Quality Trust filed a complaint with the Office for Civil Rights at U.S. Department of Health and Human Services alleging that Virginia's Auxiliary Grant program violates the Americans with Disabilities Act. We are monitoring developments in that complaint.

4. VOPA monitored proposed changes to the law allowing mandatory treatment after discharge. The proposed changes did not affect the right to discharge.

5. VOPA staff attended the Behavioral Health Advisory Council of Virginia (BHAC) quarterly meetings. VOPA applied for formal membership under the category of "Behavioral Health Advocacy Organizations and Non-provider Entities." VOPA, now disAbility Law Center of Virginia, is a formal member of BHAC. We closely collaborated with other advocacy groups, including the Coalition for Virginians with Mental Disabilities, during the legislative session.

2.F. Objective Met or Not Met: Not Met

Objective Met or Not Met: Partially Met

1. VOPA received nine (9) requests for assistance from individuals identified as ready for discharge to ensure a timely discharge planning and discharge.

2.A. Priority - 93

PRIORITY (GOAL): 2
People with Disabilities Live in the Most Appropriate Integrated Environment
Focus Area 3: Due Process Protections for Individuals in the DBHDS Forensic Mental Health System

Case Example

Case Example: Steven is a NGRI aquittee at a state-operated mental health facility whose treatment team deemed him ready for discharge. His treatment team and community service board (CSB) drafted a conditional release plan that was approved by the Forensic Review Panel. However, Steven became concerned when his CSB told him that he could not work for the first six (6) months of his release, contrary to Virginia's Employment First initiative. CSB included this implicit restriction in his conditional release plan. VOPA coordinated a meeting with Steven, his family, his treatment team, the CSB, and the facility's NGRI Director. They negotiated the terms of his conditional release plan with respect to employment. VOPA successfully advocated to remove the restrictions and Steven was permitted to work several days a week upon discharge. Steven quickly progressed through the NGRI graduated release process and was successfully discharged to the community.

2.B. Objective - 169

1. Represent twenty (20) individuals in the forensic mental health system at DBHDS-operated mental health facilities to ensure their right to the least restrictive environment or adequate due process.
2. Investigate whether the DBHDS system for conditional release planning, approval, and implantation affords individuals due process. Seek corrective action as appropriate.

2.C. Target Population

PAIMI-eligible individuals in DBHDS Forensic Mental Health System.

2.D. Target

Twenty (20) individual cases; and
One (1) investigation.

2.E. Outcome

1. VOPA opened cases for twenty-two (22) Not Guilty by Reason of Insanity (NGRI) acquittees to ensure a timely development of a conditional release plan.

Case Example: Steven is a NGRI aquittee at a state-operated mental health facility whose treatment team deemed him ready for discharge. His treatment team and community service board (CSB) drafted a conditional release plan that was approved by the Forensic Review Panel. However, Steven became concerned when his CSB told him that he could not work for the first six (6) months of his release, contrary to Virginia's Employment First initiative. CSB included this implicit restriction in his conditional release plan. VOPA coordinated a meeting with Steven, his family, his treatment team, the CSB, and the facility's NGRI Director. They negotiated the terms of his conditional release plan with respect to employment. VOPA successfully advocated to remove the restrictions and Steven was permitted to work several days a week upon discharge. Steven quickly progressed through the NGRI graduated release process and was successfully discharged to the community.

Case Example: Paul is an individual who voluntarily committed himself as a civil patient to a state-operated mental health facility. However, the facility's Internal Forensic Privileging Committee (IFPC) imposed restrictions on him that are more common to the forensic population. VOPA and the facility's Human Rights Advocate jointly represented Paul at a local human rights committee (LHRC) hearing. Paul's treatment team testified that it subjected Paul to the forensic system in order to make the hospital "less comfortable" so he would be more motivated to work toward discharge. The LHRC determined that the facility could treat Paul and other civil patients with similar restrictions. Paul filed an appeal to the State Human Rights Committee (SHRC). However, Central Office of the Department of Behavioral Health and Developmental Services (DBHDS) became aware of the issue and overturned the LHRC's decision at the departmental level. The facility changed its policy to reflect the Central Office's direction that civil patients cannot be monitored or limited by the forensic system. The facility then amended all affected civil patients' treatment plan, including Paul's, and they are no longer under the forensic system.

2. Through both individual casework and systemic advocacy, VOPA gained substantial advances in due process protections for individuals in the state-operated forensic mental health facilities. The forensic mental health system often stalled Not Guilty by Reason of Insanity (NGRI) acquittees' attempts to move towards discharge. Furthermore, clinicians were often unable to make recommendations for conditional or unconditional releases without the approval from Department of Behavioral Health and Developmental Services (DBHDS) Forensic Review Panels (FRP), which often undermined the NGRI acquittees' road to recovery and release. In representing one NGRI acquittee, VOPA established in Circuit Court that individuals have the right to a conditional release plan regardless of whether or not a FRP deems them ready for discharge at the time of the annual review.

VOPA also filed a complaint with the State Human Rights Committee (SHRC), asserting that DBHDS' NGRI Manual violated state law when it permitted the FRPs to place restrictions on clinical judgment. Following the SHRC hearing and the Office of the Attorney General's subsequent review, the Commissioner issued a memorandum reversing the policy that required FRP approval before a clinician could recommend conditional or unconditional release for an NGRI patient based on independent clinical judgment. The memorandum stated that, if those findings differ from the FRP's or if the FRP has not yet ruled, the clinician must ensure the FRP has notice and opportunity to comment to the court. The memorandum further clarified that the clinician should testify to the clinician's clinical opinion in any court hearing and, that if it was anticipated that the clinician disagreed with the FRP, the DBHDS should be given advance notice so that the FRP opinion could also be heard. As a result of our work, courts may now receive unfiltered expert opinions when considering releases.

2.F. Objective Met or Not Met: Met

2.A. Priority - 100

PRIORITY (GOAL): 3
People with Disabilities have Equal Access to Needed and Appropriate Healthcare
Focus Area 1: Access under the ADA and Rehabilitation Act to Healthcare Facilities and Services

Case Example

N/A

2.B. Objective - 171

1. Advocate or litigate to ensure that Western State Hospital residents who are deaf or hard of hearing are provided with appropriate accommodations, communication aids, and services, including sign language interpreters.

2.C. Target Population

PAIMI-eligible individuals receiving services in institutional setting.

2.D. Target

One (1) systemic litigation or advocacy case.

2.E. Outcome

1. Individuals who are deaf or hard of hearing are an underserved cultural and linguistic population in the mental health system. In FY 2012, VOPA identified that individuals who are deaf or hard of hearing at Western State Hospital (WSH) faced challenges in acquiring consistent and appropriate services, particularly interpreter services. VOPA learned that WSH placed more restrictions on this specific sub-population. For instance, WSH had a rule that access to a computer and videophone was a privilege, contrary to Virginia's Human Rights Regulations which clearly states that access to a telephone is a basic human right. VOPA advocated successfully for WSH to remove this restriction.

Following up on this discovery in FY 2013, VOPA observed, through its monthly monitoring visits, that WSH patients who are deaf and hard of hearing had effective communication with WSH staff. Furthermore, VOPA observed that individuals were using the videophone without restrictions. VOPA did not receive any complaints from WSH patients who are deaf or hard of hearing that they lacked appropriate accommodations, communication aids, and services.

2.F. Objective Met or Not Met: Met

SECTION 3. PAIMI-ELIGIBLE INDIVIDUALS

3.A. NUMBER OF INDIVIDUALS SERVED WITH PAIMI FUNDS

3.A.1. Total of PAIMI-eligible individuals who were receiving advocacy services at start of FY. [This category reflects the number of individuals supported with either PAIMI Program funds or program income who had cases from the preceding FY still open on October 1. *DO NOT REPORT INDIVIDUALS SERVED WITH NON-FEDERAL DOLLARS IN THIS SECTION*, report these individuals in Section 8].	48
3.A.2. Total of new/renewed PAIMI-eligible individuals served during the FY. [This is the number of individuals who had a case opened during the reporting period (October 1 and September 30). *Do not report individuals served with non-Federal dollars in this section, report these individuals in Section 8*].	86
3.A.3. Total of PAIMI-eligible individuals served in 3.A.1. & 3.A.2. This reflects the total number of individuals served with PAIMI Program dollars, including program income, during the fiscal reporting period and is an *UNDUPLICATED* count of all PAIMI-eligible individuals who received individual case representation].	134
3.A.4.a. The number of PAIMI-eligible individuals who requested individual advocacy services who were not served within 30 days of initial contact due to insufficient PAIMI funding.	0
3.A.4.b. The number of PAIMI-eligible individuals who requested individual advocacy services who were not served within 30 days of initial contact due to non-priority issues.	10
3.A.4.c. Total [Equals the sum of 3.A.4.a. & 3.A.4.b. Refer to the GLOSSARY for definition of I&R. DO NOT include individuals who received Information and Referral (I&R) services in this section – report them in Section 6.A.]	10

3.A.5. Identify populations, advocacy issues and activities (systemic, legislative, educational, training, etc.) from 3.A.4.a. and/or 3.A.4.b. that will be addressed in the future.

dLCV recognizes that institutional based residential facilities pose a number of unique challenges with operations including but not limited to the residents' ability to contact dLCV and our ability to respond to those concerns. To meet this need efficiently, dLCV modified our staffing plan. VOPA previously completed institutional based work concurrently in the same Unit which managed abuse and neglect in community residential settings. This year, we have divided institutional and community oversight between two Units to more specifically meet our clients' needs.

3.B. NUMBER OF COMPLAINTS/PROBLEMS OF PAIMI-ELIGIBLE NDIVIDUALS

Total [*3.B. Refers to the total number of complaints/problems presented at the time the individual contacted the P&A for assistance. The number may be higher than the total number of PAIMI-eligible individuals served by the P&A because each individual may have more than one complaint/problem to be addressed*].	153

3.C. AGE OF INDIVIDUALS* [See 42 U.S.C. 10804(a)(1)(4), 42 CFR 51.24 (a)]

3.C.1. Ages 0 - 4	0
3.C.2. Ages 5 - 12	2
3.C.3. Ages 13 - 18	20
3.C.4. Ages 19 - 25	10
3.C.5. Ages 26 - 64	94
3.C.6. Ages 64+	8
Total	134

SECTION 3. PAIMI-ELIGIBLE INDIVIDUALS

3.A. NUMBER OF INDIVIDUALS SERVED WITH PAIMI FUNDS

The total of 3.C. should equal the total number of individuals served in 3.A.3.

3.D. GENDER OF INDIVIDUALS*

3.D.1. Male	76
3.D.2. Female	58
3.D.3. Total*	134

***3.D.3. should equal the total number of individuals served listed in 3.A.3.**

3.E. ETHNICITY & RACE OF PAIMI-ELIGIBLE INDIVIDUALS

3.E.1. ETHNICITY	
3.E.1.a. Hispanic or Latino	4
3.E.1.b. Not Hispanic or Latino	55
3.E.2. RACE	
3.E.2.a. American Indian or Alaska Native	1
3.E.2.b. Asian	3
3.E.2.c. Black or African American	44
3.E.2.d. Native Hawaiian or Other Pacific Islander	0
3.E.2.e. White	83
3.E.2.f. Two or more races	3
Total	134

The data in 3.E. is self-reported. Please do not question self-reported data. Each client may select one or more categories. The totals in this section may exceed those listed in 3.A.3., 3.C.3, or 3.D.3. PAIMI STAFF MUST ASK AND REPORT THIS INFORMATION.

3.F. LIVING ARRANGEMENTS OF INDIVIDUALS AT INTAKE	
3.F.1. - Independent [per the PAIMI Act of 2000 – these individuals DO NOT have priority over PAIMI-eligible individuals in residential care or treatment facilities, see 42 U.S.C. 10804(d), exception those within 90 days of discharge from a residential care or treatment facility, military families (off base), veterans, the homeless, veteran].	15
3.F.2. - Parental or other family home - per the PAIMI Act of 2000 – these individuals DO NOT have priority over PAIMI-eligible individuals in residential care or treatment.	14
3.F.3. - Community residential home for children/youth (0-18 years), e.g. , supervised apartment, semi-independent, halfway house, board & care, small group home (3 or less).	2
3.F.4. - Adult community residential home, e.g., supervised apartment, semi-independent, halfway house, board & care, small group home (3 or less).	3
3.F.5. - *Non-medical community-based residential facility for children & youth.	1
3.F.6. - Foster Care	0
3.F.7. - *Nursing Facilities, including Skilled Nursing Facilities(SNF)	0
3.F.8. - *Intermediate Care Facilities (ICF)	0
3.F.9. - * Public and Private General Hospitals, including emergency rooms.	0
3.F.10. - * Other health facility.	0
3.F.11. - Psychiatric wards (public or private)	1
3.F.12. - Public (Municipal or State-operated) Institutional Living Arrangements (e.g., hospital treatment center/school or large group home 4+ beds).	84
3.F.13. - Private Institutional Living Arrangement (e.g., hospital or treatment center, school or large group home more than 3 beds).	12
3.F.14. - Legal Detention/Jail/Detention Center	1
3.F.15. - State Prison	0
3.F.16. - Homeless	1
3.F.17.a. - Federal Facility - Detention	0
3.F.17.b. - Federal Facility - Prison	0
3.F.17.c. - Federal Facility - Veterans Hospital	0
3.F.17.d. - Federal Facility - Other (Describe)	0
Total	134
The total for 3.F. equals the total listed in 3.A.3. *Expanded authorities under the Children's Health Act of 2000, Part H, section 592(a) and Part I Section 595, as codified respectively under Title V. Public Health Service Act, 42 U.S.C. at 290ii- 290ii and 290jj-1 - 290jj(2).	

SECTION 4. COMPLAINTS / PROBLEMS of PAIMI-ELIGIBLE INDIVIDUALS

4.A.1. AREAS OF ALLEGED ABUSE: Number of complaints/problems – Make every effort to report within the following categories:	Number From Closed Cases Only	Outcomes			
	Total	A	B	C	D
a. Inappropriate or excessive medication	1	0	0	0	1
b.1. Inappropriate or excessive physical restraint	7	0	3	2	2
b.2. Inappropriate or excessive chemical restraint	1	0	0	0	1
b.3. Inappropriate or excessive mechanical restraint	3	1	0	1	1
b.4. Inappropriate or excessive seclusion	0	0	0	0	0
c. Involuntary medication	0	0	0	0	0
d. Involuntary electrical convulsive therapy (ECT)	0	0	0	0	0
e. Involuntary aversive behavioral therapy	0	0	0	0	0
f. Involuntary sterilization	0	0	0	0	0
g. Failure to provide appropriate mental health treatment	4	0	0	1	3
h. Failure to provide needed or approprate treatment for other serious medical problems	3	0	0	1	2
i.1. Physical Assault - Serious injuries related to the use of seclusion and restraint	1	0	0	1	0
i.2. Physical Assault - Serious injuries NOT related to seclusion and restraint	0	0	0	0	0
j. Sexual assault	1	0	0	1	0
k. Threats of retaliation or verbal abuse by facility staff	2	0	0	1	1
l. Coercion	0	0	0	0	0
m. Financial exploitation	0	0	0	0	0
n. Suspicious death	0	0	0	0	0
o. Other (This number should be less than 1% of the total # of abuse complaints)	0	0	0	0	0
Total	23	1	3	8	11

*Expanded authorities under the Children's Health Act of 2000, Part H, section 592(a) and Part I Section 595, as codified respectively under Title V. Public Health Service Act, 42 U.S.C. at 290ii- 290ii and 290jj-1 -290jj-2]. See also, the PAIMI Act 42 U.S.C. 10802(1)(A) - (D).

4.A.2. ABUSE OUTCOME STATEMENTS

A. Persons with disabilities whose environment was changed to increase safety or welfare.

B. Positive changes in policy, law or regulation re: abuse in facilities (describe facility where impact was made).

Multiple facilities

4.A.2. ABUSE OUTCOME STATEMENTS

C. Validated abuse complaints that were favorably resolved as a result of P&A intervention.

D. Other indicators of success or outcomes that resulted from P&A involvement (explain).

Individuals with disabilities discussed their issue or concern and VOPA provided education and technical assistance to allow them understand their rights and pursue resolution.

4.A.3. ABUSE COMPLAINTS DISPOSITION

For closed cases listed in Table 4.A.1., provide the number of abuse complaints / problems for each disposition category.

a. Number of complaints/problems determined after investigation not to have merit.	3
b. Number complaints/problems withdrawn or terminated by client.	4
c. Number of complaints/problem favorably resolved in the client's favor.	16
d. Number of complaints/problem not favorably resolved in the client's favor.	0
e. Total number of complaints/problem addressed from closed cases. ***[The sum of Items 4.A.3. a - d equals the total for 4.A.3.e. which must equal the total in Table 4. A.1.].***	23

SECTION 4. COMPLAINTS / PROBLEMS of PAIMI-ELIGIBLE INDIVIDUALS

4.B.1. AREAS OF ALLEGED NEGLECT – [failure to provide for appropriate . . .] - Number of Complaints/Problems:	Number From Closed Cases Only	Outcomes				
	Total	A	B	C	D	E
a. Admission to residential care or treatment facility	0	0	0	0	0	0
b. Transportation to/from residential care or treatment facility	0	0	0	0	0	0
c. Discharge planning or release from a residential care or treatment facility	44	17	1	9	0	17
d. Mental health diagnostic or other evaluation (does not include treatment)	3	0	0	3	0	0
e. Medical (non-mental health related) diagnostic or physical examination	3	0	2	0	1	0
f. Personal care (e.g., personal hygiene, clothing, food, shelter)	0	0	0	0	0	0
g. Physical plant or environmental safety	1	0	0	0	0	1
h. Personal safety (client-to-client abuse)	0	0	0	0	0	0
i. Written treatment plan	4	0	0	0	1	3
j. Rehabilitation/vocational programming	2	0	0	0	2	0
k. Other (Please make every effort to report within the above categories)	0	0	0	0	0	0
Total	57	17	3	12	4	21

4.B.2. NEGLECT OUTCOME STATEMENTS

A. Validated neglect complaints that have a favorable resolution as a result of P&A intervention.

B. Positive changes in policy, law, or regulation regarding neglect in facilities (describe facilities).

Multiple facilties

C. Persons with disabilities discharged consistent with their treatment plan after P&A involvement.

D. Persons with disabilities whose treatment plans met selected criteria.

E. Other indicators of success or outcomes that resulted from P&A involvement (explain).

Received rights information and self advocacy strategies.

4.B.3. NEGLECT COMPLAINTS DISPOSITION

For closed cases listed in Table 4.B.1., provide the numbers of neglect complaints or problem areas for each disposition category. [See, 42 U.S.C. 10802(5)].

a. Number of complaints/problems determined after investigation not to have merit.	4
b. Number complaints/problems withdrawn or terminated by client.	7

4.B.3. NEGLECT COMPLAINTS DISPOSITION	
c. Number of complaints/problem favorably resolved in the client's favor.	44
d. Number of complaints/problem not favorably resolved in the client's favor.	2
e. Total number of complaints/problem addressed from closed cases. ***[The sum of Items 4.B.3. a - d equals the total for 4.B.3.e. which must equal the total in Table 4. B.1.].***	57

SECTION 4. COMPLAINTS / PROBLEMS of PAIMI-ELIGIBLE INDIVIDUALS

4.C.1. AREAS OF ALLEGED RIGHTS VIOLATIONS; Number of Complaints Problems	Number From Closed Cases Only	Outcomes			
	Total	A	B	C	D
a. Housing Discrimination	0	0	0	0	0
b. Employment Discrimination	10	0	5	0	5
c. Denial of financial benefits/ entitlements (e.g., SSI, SSDI, Insurance)	2	1	0	0	1
d. Guardianship/ Conservator problems	0	0	0	0	0
e. Denial of rights protection information or legal assistance	5	2	1	0	2
f. Denial of privacy rights (e.g., congregation, telephone calls, receiving mail)	0	0	0	0	0
g. Denial of recreational opportunities (e.g., grounds access, television, smoking)	1	1	0	0	0
h. Denial of visitors	0	0	0	0	0
i. Denial of access to or correction of records	1	0	0	0	1
j. Breach of confidentiality of records (e.g., failure to obtain consent before disclosure)	0	0	0	0	0
k. Failure to obtain informed consent (see also, involuntary treatment)	3	0	0	1	2
l. Failure to provide special education consistent with State requirements	9	1	3	0	5
m. Advance directives issues	17	0	16	0	1
n. Denial of parental/family rights	0	0	0	0	0
o. Other (Please make every effort to report within the above categories)	0	0	0	0	0
Total	48	5	25	1	17

4.C.2. RIGHTS VIOLATIONS OUTCOME STATEMENTS

A. Persons with disabilities served by the P&A whose rights were restored as a result of P&A Intervention.

B. Persons with disabilities whose personal decision making was maintained or expanded as a result of P&A intervention.

C. Policies or laws changed and other barriers to personal decisions making eliminated as a result of P&A intervention.

D. Other outcomes as a result of P&A involvement:

Received rights information and self advocacy strategies.

4.C.3. RIGHTS VIOLATIONS DISPOSITION	
For closed cases listed in Table 4.C.1., provide the numbers of rights complaints or problem areas for each disposition category.	
a. Number of complaints/problems determined after investigation not to have merit.	3
b. Number complaints/problems withdrawn or terminated by client.	3
c. Number of complaints/problem favorably resolved in the client's favor.	41
d. Number of complaints/problem not favorably resolved in the client's favor.	1
e. Total number of complaints/problem addressed from closed cases. ***[The sum of Items 4.C.3. a - d equals the total for 4.C.3.e. which must equal the total in Table 4. C.1.].***	48

SECTION 4. COMPLAINTS / PROBLEMS of PAIMI-ELIGIBLE INDIVIDUALS

4.D.1. INTERVENTION STRATEGY OUTCOMES		Outcomes												
		Abuse				Neglect					Rights Violations			
Strategy	Total	A	B	C	D	A	B	C	D	E	A	B	C	D
a. Short Term Assistance	42	0	2	7	0	0	0	12	0	0	1	0	20	0
b. Abuse/Neglect Investigations	20	0	2	7	11	0	0	0	0	0	0	0	0	0
c. Technical Assistance	24	0	0	0	2	0	1	0	0	1	0	9	0	11
d. Administrative Remedies	21	1	0	0	0	14	0	4	0	0	0	0	0	2
e. Negotiation/Mediation	19	0	0	0	0	2	1	13	0	0	2	0	1	0
f. Legal Remedies	2	0	0	0	0	1	0	1	0	0	0	0	0	0
Total	128	1	4	14	13	17	2	30	0	1	3	9	21	13

4.E. DEATH INVESTIGATION ACTIVITIES

See, the PAIMI Act 42 U.S.C. at 10801(b)(2)(B) and 10802(1), and PAIMI Program expanded authorities under the Children's Health Act of 2000, Part H, section 592(a) and Part I Section 595, as codified respectively under Title V. Public Health Service Act, 42 U.S.C. at 290ii- 290ii and 290jj-1 - 290jj-2.

4.E.1. The number of deaths of PAIMI-eligible individuals reported to the P&A for investigation by the following entities:

a. The State.	46
b. The Center for Medicaid & Medicare Services (Regional Offices).	0
c. Other Sources. Briefly list the source for each death reported in this category, e.g., newspaper, concerned citizen, relative, etc.	0
d. Total	46

4.E.1.e. If the information requested in 4.E.1. was not available, please explain.

4.E.2. All P&A Death investigations conducted involving PAIMI-eligible individuals related to the following:	Total
a. Number of deaths investigated involving incidents of seclusion (S).	0
b. Number of death investigated involving incidents of restraint (R).	0
c. Number of deaths investigated NOT related to incidents of S & R, e.g., suicides.	0
d. Total Number of deaths investigated [Sum of 4.E.2. a-c].	0

4.E.3. If you reported deaths in categories 4.E.2.a., 4.E.2.b., and/or 4.E.2.c., then please provide the following information on one (1) death from each category, as appropriate:
- A brief summary of the circumstances about the death.
- A brief description of P&A involvement in the death investigation.
- A summary of the outcome(s) resulting from the P&A death investigation.

Case narrative for 4.E.2.a.

N/A

Case narrative for 4.E.2.b.

N/A

4.E. DEATH INVESTIGATION ACTIVITIES

Case narrative for 4.E.2.c.

N/A

SECTION 5. INTERVENTIONS on BEHALF of GROUPS of PAIMI-ELIGIBLE INDIVIDUALS

5.E. TYPES OF INTERVENTIONS	Number of types of interventions used	Potential number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	On-going
1. Group Advocacy non-litigation	1	200408	0	0	1
2. Investigations (non-death related)	1	3701	0	0	1
3. Facility Monitoring Services	1	2018	0	0	1
4. Court Ordered Monitoring	0	0	0	0	0
5. Class Litigation	0	0	0	0	0
6. Legislative & Regulatory Advocacy	1	601	1	0	0
7. Other	0	0	0	0	0
Total	4	206728	1	0	3

In the PAIMI Application [at Section IV.2.2.], you were instructed to provide information on the objectives for these types of interventions in sequential steps that are achievable within the annual reporting period, such as, conducting research, identifying legal issues, filing the class action, etc.

5.F. In the space below, *provide at least ONE (1) EXAMPLE that reflected the outcome of EACH sub-category listed in Table 5.E.* In the narrative for each example, briefly describe the PAIMI Program activity, include factual information (who, what, when, where, how) and the outcome(s) that resulted from the intervention.

Use work examples that illustrate the impact of PAIMI Program activities, especially how the activities made a difference to the clients served, such as, improved quality of life, etc. If PAIMI Program funds were used to support any of the above activities, then describe how their availability furthered the purposes of the PAIMI Act.

Case Example for 5.E.1. Group Advocacy non-litigation

1. Group Advocacy non-litigation

VOPA conducted sixty-four (64) rights clinics at nine (9) state-operated mental health facilities in Virginia to inform individuals receiving services of their right to be free from abuse and neglect. VOPA gave these clinics in various formats: formal and informal presentations and trainings, office hours, and 1:1 meetings with the individuals. VOPA also distributed information regarding human rights, self-advocacy forms, and other publications to support the individuals. VOPA assisted individuals in completing the human rights complaints as necessary. Often, VOPA opened individual cases for investigation, negotiation, and resolution for complaints of human rights violations.

In the PAIMI Application [at Section IV.2.2.], you were instructed to provide information on the objectives for these types of interventions in sequential steps that are achievable within the annual reporting period, such as, conducting research, identifying legal issues, filing the class action, etc.

5.F. In the space below, *provide at least ONE (1) EXAMPLE that reflected the outcome of EACH sub-category listed in Table 5.E.* In the narrative for each example, briefly describe the PAIMI Program activity, include factual information (who, what, when, where, how) and the outcome(s) that resulted from the intervention.

Use work examples that illustrate the impact of PAIMI Program activities, especially how the activities made a difference to the clients served, such as, improved quality of life, etc. If PAIMI Program funds were used to support any of the above activities, then describe how their availability furthered the purposes of the PAIMI Act.

Case Example for 5.E.2. Investigations (non-death related)

2. Investigations (non-death related)

VOPA opened ten (10) cases to obtain corrective action relating to the response of entities responsible for licensing, oversight, or investigation involving serious injury or allegations of abuse or neglect of individuals within institutional settings.

Case Example: Daniel's psychiatrist and social worker convinced him to drop his commitment appeal in exchange for a promise that they would discharge him from the state-operated mental health facility. However, they broke the promise. VOPA investigated and verified a human rights violation that the psychiatrist exploited Daniel. On Daniel's behalf, VOPA filed a human rights complaint. As a result, the facility's director found that the psychiatrist violated Daniel's rights and took personnel action against him. The facility also changed its policy to prohibit staff from discussing or bargaining any aspect of a patient's commitment appeals with the patient. The Director of the facility also ordered all clinical department heads to train their staff regarding the new policy and to report when the staff completed the training.

Case Example for 5.E.3. Facility Monitoring Services

See Section 2.

Case Example for 5.E.6. Legislative & Regulatory Advocacy

6. Legislative & regulatory advocacy

The Department of Behavioral Health and Developmental Services (DBHDS) initiated a comprehensive review of its human rights regulations. The process for the review and revisions to the regulations is expected to take at least three (3) years. VOPA advocated for specific improvements to the human rights regulations and participated in a focus group. VOPA continues to monitor DBHDS' progress through the regulatory development process. The revisions will impact at least 200,000 individuals with disabilities receiving services from facilities
operated, licensed, and funded by DBHDS.

SECTION 6. NON-CLIENT DIRECTED ADVOCACY ACTIVITIES

6.A. INDIVIDUAL INFORMATION AND REFERRAL (I&R) SERVICES

Provide the number of PAIMI Program I&R services.	1908

6.B. STATE MENTAL HEALTH PLANNING ACTIVITIES

Briefly list P&A collaboration/involvement in State Mental Health planning activities.

dLCV monitors the work of Virginia Behavioral Health Advisory Council and participated on the Council in FY 13.

The Council reviews the state's comprehensive mental health plans for adults with serious mental illness and children with serious emotional disturbances. It also reviews and comments on the application for federal block grant money, the identification of unmet needs and on the utilization of funds which derive from the federal mental health block grant.

6.C. EDUCATION, PUBLIC AWARENESS ACTIVITIES AND/OR EVENTS

6.C.1. List the number of public awareness activities or events AND the number of individuals who received the information.

6.C.1.a. Number of public awareness activities or events.	4
6.C.1.b. Number of individuals receiving the information.	115
6.C.2. Number of education/training activities undertaken.	5

6.C.2. refers to either the number of training programs sponsored by the P&A or the number of events sponsored by another organization *WHERE P&A STAFF ARE THE TRAINERS.* *The training must have provided specific information to participants regarding their rights. If the P&A only provided general program information then report the number of individuals trained in section 6.C.1.b.* [PAIMI Rules 42 CFR 51.31(c)].

6.C.3. Number (approximate) of persons trained. *[Only include those individuals who attended a 6.C.2. type education/training program(s),* [See PAIMI Rules 42 CFR 51.31].	820

DISSEMINATION ACTIVITIES. Provide the number of articles, films, reports, etc. developed/produced. Provide an estimate for the number of people who received the information. For example, an article published about the P&A in a newspaper with a circulation of 200,000 readers; a television appearance on a station with 100,000 viewers in that time spot, etc.

6.C.4. OUTCOME STATEMENTS for DISSEMINATION ACTIVITIES

A. Persons who received information about the P&A and its services.

B. Persons with disabilities (or their family members) who received education or training about their rights, enabling them to be more effective self advocates.

C. Other outcomes that resulted from PAIMI Program involvement.

SECTION 6. NON-CLIENT DIRECTED ADVOCACY ACTIVITIES

6.C.5. TYPES OF DISSEMINATION ACTIVITIES				Outcomes			
	Number of Items	Number of Events	Number of persons who received the information	Total A - C	A	B	C
a. Radio/TV appearances	0	0	0	0	0	0	0
b. Newspaper articles	0	0	0	0	0	0	0
c. Public Services Announcements (PSA), videos/films, etc.	0	0	0	0	0	0	0
d. Reports	0	0	0	0	0	0	0
e. Publications, including articles in professional journals	0	0	0	0	0	0	0
f. Other P&A disseminated information, includes general training, outreach activities or presentations, brochures and handouts that were not included/counted under training activities)	1275	1	1275	2	1	1	0
g. Number of Website hits, include visits	14396	1	9302	2	1	1	0
h. Other media activities	1	1	140	1	1	0	0
Other Media Activities: Report to the General Assembly							
Total	15672	3	10717	5	3	2	0

SECTION 7. GRIEVANCE PROCEDURES [42 CFR Section 51.25]

7. The PAIMI Rules mandate that the P&A system shall establish procedures to address grievances from: 1) Clients or prospective clients of the system to assure that individuals with mental illness have full access to the services of the program [42 CFR 51.25(a)(1)]; and, 2) Individuals who have received or are receiving mental health services in the State, family members of such representatives, or representatives of such individuals or family members to assure that the eligible P&A system is operating in compliance with the Act [42 CFR 51.25(a)(2) - a systemic/program assurance grievance policy.]	
7.A. Do you have a systemic/program assurance grievance policy, as mandated by 42 CFR 51.25(a)(2)? (If No, please develop one)	Yes
7.B. The number of grievances filed by PAIMI-eligible clients, including representatives or family-members of such individuals receiving services during this fiscal year.	2
7.C. The number of grievances filed by prospective PAIMI-eligible clients (those who were not served due to limited PAIMI Program resources or because of non-priority issues.	0
7.D. Total [Add 7.B. & 7.C.]	2
7.E. The number of grievances appealed to the governing authority/board.	0
7.F. The number of grievances appealed to the executive director.	2
7.G. Total [Add 7.E. & 7.F.]	2
7.H. The number of reports sent to the governing board *AND* the advisory board mandatory for private non-profit P&A systems, (at least one annually) that describe the grievances received, processed, and resolved. *[A report required, even if no grievances were filed.]* [42 CFR 51.25(b)(2)]	1

SECTION 7. GRIEVANCE PROCEDURES [42 CFR Section 51.25]

7. The PAIMI Rules mandate that the P&A system shall establish procedures to address grievances from: 1) Clients or prospective clients of the system to assure that individuals with mental illness have full access to the services of the program [42 CFR 51.25(a)(1)]; and, 2) Individuals who have received or are receiving mental health services in the State, family members of such representatives, or representatives of such individuals or family members to assure that the eligible P&A system is operating in compliance with the Act [42 CFR 51.25(a)(2) - a systemic/program assurance grievance policy.]

7.I. Please identify all individuals, by name & title, responsible for grievance reviews.

10/1/12-9/30/13-VOPA

Colleen Miller, Executive Director

VOPA Governing Board

Darrel T. Mason
Angela Thanyachareon
Jane Anthony
Martha Bryant
William Fuller
Donna L. Gilles
Linda VanAken
Jennifer Krajewski
Martha Pillow
Michael Toobin
Thomas Walk
Ex Officio Members:
CW Tillman
Ali Parker

10/1/13-Present-dLCV

Colleen Miller, Executive Director

dLCV Governing Board

CW Tillman
Stephen Dawe
Maureen Hollowell
Bryan Lacy
Kathryn Merritt
Karen Michalski-Karney
Ali Parker
Donald Price
Angela Thanyachareon
Michael Toobin
Eunice Turkson

7.J. What is the timetable (in days) used to ensure prompt notification of the grievance procedure process to clients, prospective clients or persons denied representation, and ensure prompt resolution? [42 CFR 51.25(b)(4)]	15
7.K. Were written responses sent to all grievants?	Yes

SECTION 7. GRIEVANCE PROCEDURES [42 CFR Section 51.25]

7. The PAIMI Rules mandate that the P&A system shall establish procedures to address grievances from: 1) Clients or prospective clients of the system to assure that individuals with mental illness have full access to the services of the program [42 CFR 51.25(a)(1)]; and, 2) Individuals who have received or are receiving mental health services in the State, family members of such representatives, or representatives of such individuals or family members to assure that the eligible P&A system is operating in compliance with the Act [42 CFR 51.25(a)(2) - a systemic/program assurance grievance policy.]

7.K.1. Please explain why written responses were not sent to all grievants.

N/A

7.L. Was client confidentiality protected?	Yes

7.L.1. Please provide a brief explanation why client confidentiality was not protected.

N/A

SECTION 8. OTHER SERVICES AND ACTIVITIES

The PAIMI Rules [at 42 CFR at 51.24(b)] mandate that "Members of the public shall be given an opportunity, on an annual basis, to comment on the priorities established by, and the activities of, the P&A system. Procedures for public comment which must provide for notice in a format accessible to individuals with mental illness, including such individuals who are in residential facilities, to family members and to representatives of such individuals and to other individuals with disabilities. Procedures for public comment must provide for receipt of comments in writing or in person."

8.A.1. Does the P&A have procedures established for public comment?	Yes

Briefly describe how the notice is used to reach persons with mental illness and their families.

Our agency values the input we receive from the community. Information about PAIMI services and VOPA's Goals and Focus Areas were published on our website. The dLCV Governing Board adopted our FY 14 goals and focus areas in September 2013. Earlier in the year at the request of the initial dLCV Board, development of the FY 2014 Goals and Focus Areas was overseen by the VOPA Governing Board. VOPA also solicited public comment through a public survey posted on our website. This survey ran from June 17, 2013 to August 6, 2013 and we received seventy-six (76) responses. We also solicited input from consumers during facility trainings and monitoring activities.

8.A.2. Were the notices provided to the following persons?	
a. Individuals with mental illness in residential facilities?	Yes
b. Family members and representatives of such individuals?	Yes
c. Other Individuals with disabilities?	Yes
8.A.3. Do the procedures provide for receipt of the comments in writing or in person?	Yes

8.A.3.a. If No, briefly explain why the agency does not have such procedures in place.

N/A

8.B.1. Was the public provided an opportunity for comment?	Yes

8.B.2. If you answered Yes to 8.B.1., then briefly describe the activities used to obtain public comment, e.g., public forums, constituent surveys, etc.

The dLCV Governing Board may receive public comment at meetings at their discretion. In addition, the Governing Board develops and implements a detailed public comment process based on planning cycle and staff recommendations; these decisions are reflected in the Board's meeting minutes, which will also be posted on the dLCV website. All dLCV Board and advisory council meetings are advertised as open to the public and include receipt of public comment as an agenda item. Any public comment received is considered in the priority planning process for the development of dLCV's goals and focus areas.

8.B.3. What formats and languages (as applicable) were used in materials to solicit public comments? Briefly list/describe.

Alternate formats and translated documents would have been made available if requested. Our website has a link to translation services and requesting services from our agency. We use a telecommunications device for the deaf (TTD) to receive calls from individuals who are deaf or hard of hearing. We also use a telephonic language line where callers use to request services.

8.B.4. If you answered No to 8.B.1., BRIEFLY EXPLAIN WHY THE PUBLIC WAS NOT PROVIDED AN OPPORTUNITY TO COMMENT [42 CFR 51.24(b)].

N/A

SECTION 8. OTHER SERVICES AND ACTIVITIES

8.C. LIST GROUPS, (a representative list of State, consumer and advocacy organizations, and other entities, such as professional, national and local organization organizations involved in mental health and/or other disability related issues, current and former recipients of mental health services and their family members with whom the PAIMI program coordinated systems, activities, and mechanisms [42 U.S.C. 10824 (a)(D)].

Department of Behavioral Health and Developmental Services' Central Office and nine (9)institutions
Local Human Rights Committees
State Human Rights Committee
Virginia Behavioral Health Advisory Council
National Alliance for the Mentally Ill – Virginia and local affiliates
Department of Aging and Rehabilitative Services
Department of Medical Assistance Services
Office of the Attorney General
Virginia Public Guardian and Conservator Advisory Board
Centers for Independent Living
Community Service Boards
Virginia Organization of Consumers Asserting Leadership (VOCAL)
Coalition for Virginians with Mental Disabilities
Virginia Advocates United Leading Together (VAULT)
Partnership for People with Disabilities Advisory Council
Virginia Board for People with Disabilities

SECTION 8. OTHER SERVICES AND ACTIVITIES

8.D. Briefly describe the outreach efforts/activities used to increase the numbers of ethnic and racial minority clients served and/or educated about the PAIMI Program. [The Demographic/State Profile information submitted with your PAIMI Application for the same FY will be used in the evaluation of your PPR data].

VOPA maintained a website that posted our federal grants' Goals and Focus Areas. This website also posted notices for the Board of Directors' and Advisory Council meetings. Job vacancies, announcements, agency publications, and disability-related links were also available. This website has been converted to dLCV, maintains the same information and can be viewed at www.dlcv.org.

The dLCV Governing Board adopted our FY 14 Goals and Focus Areas in September 2013. Earlier in the year at the request of the initial dLCV Board, development of the FY 2014 Goals and Focus Areas was overseen by the VOPA Governing Board. VOPA also solicited public comment through a public survey posted on our website. This survey ran from June 17, 2013 to August 6,2013 and we received seventy-six (76) responses. All public comment received from this survey and from facility monitoring was considered in the planning process for the development of dLCV's Goals and Focus Areas.

VOPA routinely provided training and speaking engagements through our Speakers Bureau. The Speakers Bureau provided training and presentations that are related to the Office's current Goals, Focus Areas, and Objectives (Priorities). dLCV is continuing this function and there is a link on the dLCV website for the public to make a request for a Speaker's Bureau presentation. Like VOPA, dLCV also will provide exhibits and materials for fairs, conferences, and meetings on request.
Whenever a presentation is conducted about our agency in general, it addresses some of the work we do related to PAIMI.

VOPA utilized a "VOPA Alert." dLCV uses a "dLCV Alert." These are email distribution list services to communicate with our constituents. In the past year, "VOPA Alert" notified constituents of important legal and legislative developments as well as changes in other service agencies.

We include "The Directors' Blog" on our website. This blog is offered as a way of
alerting the public to news and developments in disability law, sharing agency activities and getting feedback about how we're doing.

dLCV has a Facebook page which includes agency information and links to resources.

Internally, staff working under the PAIMI grant may also work under our other federal grants. We found this to be a natural and logical blending of objectives and funding.

8.E. Did the activities described in 8.D. result in an increase of ethnic and/or minorities in the following categories?	
1. Staff	Yes
2. Advisory Council	Yes
3. Governing Board	Yes
4. Clients	Yes

8.F. PAIMI PROGRAM IMPLEMENTATION PROBLEMS

8.F.1. External Impediments

8.F. PAIMI PROGRAM IMPLEMENTATION PROBLEMS

Describe any problems with implementation of mandated PAIMI activities, including those activities required by Parts H and I of the Children's Health Act of 2000 that pertain to requirements related to incidents involving seclusion and restraint and related deaths and serious injuries (e.g., access issues, delays in receiving records and documents, etc.).

VOPA invested considerable resources in an effort to enforce the reporting requirement of 42 C.F.R. § 483.374 regarding the reporting of serious occurrences by psychiatric residential treatment facilities. Serious occurrence reporting from psychiatric residential treatment facilities is inconsistent and accurate information regarding providers is difficult to obtain.

dLCV will continue to break down barriers we encounter while implementing the PAIMI Program. Although, dLCV has provided substantial education and outreach about our transition from VOPA to dLCV to facilities and the community, we are prepared for providers who may not have followed or understood the transition and will enforce dLCV's access authority.

dLCV has insufficient PAIMI resources to meet the needs of individuals with mental illness living in the community.

8.F.2. Internal Impediments

Describe any problems with implementation of mandated PAIMI activities, including any identified annual priorities and objectives (e.g., lack of sufficient resources, necessary expertise, etc).

VOPA provided PAIMI advocacy services this fiscal year as it prepared for transition to become the disAbility Law Center of Virginia (dLCV.) The decision to transition our office from a state agency to a non-profit was initiated by Virginia's General Assembly in 2012. We are following the trend of most protection and advocacy systems across the United States to remove ourselves from state government to allow for greater independence to provide zealous advocacy services for Virginians with disabilities. VOPA's Governing Board, the Governor of Virginia and the general public fully supported and endorsed this decision as well. VOPA successfully transitioned and became dLCV on October 1, 2013. dLCV is now designated as Virginia's Protection and Advocacy System, therefore dLCV is submitting this annual report on behalf of VOPA.

As a result of our transition, four (4) Disability Rights Advocates, one (1) Managing Attorney and two (2) administrative staff departed. We hired five (5) Disability Rights Advocates and two (2) administrative staff during this time to compensate. We also substantially re-organized our internal operating structure.

VOPA stayed on target and met or partially met most objectives, however time was necessary to train new staff and prepare for transition.

8.G. ACCOMPLISHMENTS

Briefly describe the most important PAIIMI-related accomplishment(s) that resulted from PAIMI Program activities. Provide a website reference as to where any supporting documents describing these achievements may be found, e.g., case citations, news articles, legislation, etc.

In FY 13, VOPA took many positive steps to improve the lives of Virginians with disabilities. One of our biggest accomplishments was seeking both individual and systemic relief for children and adolescents in both the state-operated mental health facility and Psychiatric Residential Treatment Facilities (PRTFs). As discussed in Section 2, VOPA opened investigations into incidents of alleged excessive and improper seclusion and restraint practices at facilities for children and adolescents. On behalf of the children and adolescents, VOPA filed human rights complaints. Several of the investigations resulted in individual and systemic outcomes, including incorporating principals of trauma informed approach and reduction of seclusion and restraint from Substance Abuse and Mental Health Services Administration (SAMHSA). An example of an achievement is posted on dLCV's website: http://disabilitylawva.org/ourwork/newsandinformation/dlcv-obtains-reforms/. VOPA filed a complaint on behalf of a patient at Harbor Point Behavioral Health Center, a PRTF. Harbor Point agreed to implement the trauma-informed approach to treatment, provide additional staff training, and hire a pediatrician to ensure timely medical treatment and evaluation.

Another accomplishment we are proud to report for FY 13 is our transition to dLCV. As explained in Section 8.F.2, our agency grew through a period of change and maintained effective and zealous advocacy. As a private non-profit, independent of state government, dLCV is able to effectively provide protection and advocacy services .

8.H. RECOMMENDATIONS

Please provide a brief list of recommendations for activities and services to improve the PAIMI Program. Include a brief explanation as of why such activities and services are needed. [42 U.S.C. 10824(a)(4)].

PAIMI funding is inadequate to meet the needs of all eligible individuals, as well as to pursue all PAIMI activities permitted within the parameters of the grant.

In order to provide the level of oversight necessary to monitor facilities and other service providers for PAIMI eligible individuals, funding for additional staff would be greatly beneficial.

8.I. TRAINING & TECHNICAL ASSISTANCE REQUESTS

Please identify any training & technical assistance requests. [42 U.S.C. 10825]

None

SECTION 9. ACTUAL PAIMI BUDGET/EXPENDITURES FOR FISCAL YEAR

In this section, provide actual expenditures for the FY. Refer to the PAIMI Application [Appendix C] submitted to SAMHSA/CMHS for the same FY.

9.A. PAIMI PROGRAM PERSONNEL – INSERT ADDITIONAL ROWS AS NEEDED. ++ List vacancies by position, annual salary, percentage of time & costs that will be charged to the PAIMI Program grant when the position is filled.

POSITION TITLE	ANNUAL SALARY	PERCENT/PORTION OF TIME CHARGED TO PAIMI	COSTS BILLED TO PAIMI
ACTIVE POSITIONS			
Executive Director	$134,965.00	30.00 %	$40,490.00
Administrative Assistant	$32,500.00	27.00 %	$8,775.00
Staff Attorney	$69,923.00	20.00 %	$13,985.00
Staff Attorney	$79,314.00	20.00 %	$15,863.00
Administrative Assistant	$19,725.00	30.00 %	$5,918.00
Managing Attorney	$87,333.00	20.00 %	$17,467.00
Disability Advocate	$38,500.00	50.00 %	$19,250.00
Administartive Assistant	$27,000.00	32.00 %	$8,640.00
Disability Rights Advocate	$43,000.00	60.00 %	$25,800.00
Disability Rights Advocate	$43,942.00	50.00 %	$21,971.00
Disability Rights Advocate	$69,148.00	50.00 %	$34,574.00
Administrative Coordinator	$33,778.00	26.00 %	$8,782.00
Disability Rights Advocate	$15,345.00	20.00 %	$3,069.00
Disability Rights Advocate	$43,000.00	45.00 %	$19,350.00
Staff Attorney	$53,111.00	50.00 %	$26,556.00
Disability Rights Advocate	$48,461.00	20.00 %	$9,692.00
Staff Attorney	$53,424.00	50.00 %	$26,712.00
Receptionist	$34,431.00	35.00 %	$12,051.00
Fiscal Officer	$52,605.00	35.00 %	$18,412.00
Disability Rights Advocate	$45,667.00	12.00 %	$5,480.00
Data/Incident Analyst	$38,500.00	35.00 %	$13,475.00
Staff Attorney	$70,061.00	60.00 %	$42,037.00
Staff Attorney	$52,705.00	20.00 %	$10,541.00
Disability Rights Advocate	$46,305.00	20.00 %	$9,261.00
Reader/Driver	$5,280.00	32.00 %	$5,280.00
Disabilty Rights Advocate Part Time	$2,475.00	35.00 %	$2,475.00
Law Intern	$79.00	3.00 %	$79.00
Law Intern	$388.00	17.00 %	$388.00
Subtotal	$1,240,965.00		$426,373.00
Total Positions	$1,240,965.00		$426,373.00

9.B. CATEGORIES	COST
Fringe Benefits (PAIMI Only)	$123,647.00
Travel Expenses (PAIMI Only)	$19,435.00
Subtotal	$143,082.00

9.D. SUPPLIES - TYPE (PAIMI ONLY)	COST
Computer Operating Supply	$100.00
Office Supply/Forms	$840.00
Food Supply	$90.00
Subtotal	$1,030.00

9.E. CONTRACTUAL COSTS (including Consultants) for PAIMI Program Only					
POSITION OR ENTITY	**SERVICE PROVIDED**	**SALARY/FEE**	**FRINGE BENEFIT COST**	**TRAVEL EXPENSES**	**OTHER COSTS**
Printing Companies	Printing Services	$0.00	$0.00	$0.00	$178.00
Private Contractor	Employee Accomodations, CART	$0.00	$0.00	$0.00	$1,666.00
Professional Organizations	Membership/Subscriptions	$0.00	$0.00	$0.00	$123.00
Catering Services	Food for Board, Council and Staff meetings	$0.00	$0.00	$0.00	$1,464.00
Private Contractor	Temporary Workforce	$0.00	$0.00	$0.00	$434.00
Subtotal		$0.00	$0.00	$0.00	$3,865.00

9.F. TRAINING COSTS FOR PAIMI PROGRAM ONLY						
	TRAVEL		**TRAINING**		**OTHER EXPENSES**	
CATEGORIES	**# OF PERSONS**	**COST**	**# OF PERSONS**	**COST**	**# OF PERSONS**	**COST**
Staff	25	$1,679.00	0	$0.00	25	$1,248.00
Governing Board	12	$1,136.00	12	$673.00	12	$1,809.00
PAC Members	11	$750.00	11	$673.00	11	$1,423.00
Volunteers	0	$0.00	0	$0.00	0	$0.00
Subtotal	48	$3,565.00	23	$1,346.00	48	$4,480.00

9.G. OTHER EXPENSES (PAIMI PROGRAM ONLY)	COST
Short Term Disability/Leave Liability	$2,929.00
Gasoline	$900.00
Subtotal	$3,829.00

9.H. INDIRECT COSTS (PAIMI ONLY)	COST
1. Does your P&A have an approved Federal indirect cost rate?	Yes
a. If Yes, what is the approved rate?	12.00 %
2. Total of all PAIMI Program costs listed in 9.A. - 9.G.	$587,570.00
3. Income Sources and Other Resources (PAIMI Program Only)	$657,158.00
4. PAIMI Program carryover of grant funds identified by FY.	
FY12	$351,473.00
5. Interest on Lawyers Trust Accounts (IOLTA).	$0.00
6. Program income (PAIMI only).	$17,435.00
7. State	$0.00
8. County	$0.00
9. Private	$0.00
10. Other funding sources. [IDENTIFY each source].	$0.00
11. Total of all PAIMI Program resources.	$1,026,066.00