OMB Approval: 0930-0169

Expiration Date: 08/31/2014

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

STATE: VA	FISCAL YEAR: 2014

SECTION 1. GENERAL PAIMI PROGRAM INFORMATION

1.A. Fiscal Year:	2014
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:	disAbility Law Center of Virginia
Name, Phone number and email address of the PAIMI Coordinator:	Colleen Miller 804-225-2042 Colleen.Miller@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.*	Debra Ferguson
Date the PAIMI PPR &ACR were sent to the State mental health agency.*	11/24/2014
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.	11
b. Total number of GB members serving as of 9/30.	11
c. Total number of GB vacancies on 9/30.	0
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.	84%

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.	4
b. Number of family members of individuals with mental illness who are R/FR of mental health services.	2
c. Number of guardians.	0
d. Number of advocates or authorized representatives.	4
e. Number of other persons who broadly represent or are knowledgeable about the needs of the clients served by the P&A system.	1
TOTAL	11
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.	31
1.a. How many of the staff listed above are attorneys?	9
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.*	13

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	0	0
1.D.2. RACE		
1.D.2.a. American Indian or Alaska Native	0	1
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	8	24
1.D.2.f. Two or more races	1	0
Vacancies on 9/30 (Identify by position).	0	0
Total	11	31

1.E. GENDER

	GOVERNING BOARD	**PAIMI STAFF**
1.E.1. Male	6	8
1.E.2. Female	5	23
Total	11	31

SECTION 2. PAIMI PROGRAM PRIORITIES & OBJECTIVES

2.A. Priority - 627

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

Case Example

See Outcome

2.B. Objective - 1121

1.Develop a plan for on-site and statistical monitoring of facilities operated by the Department of Behavioral and Developmental Services. The plan will identify eight to ten key indicators of possible abuse or neglect, including unexpected deaths, and will identify indicators of need for case level services. Indicators will be chosen from information produced or missing from critical incident reports and from other available services.
2.Pursuant to the plan identified above, monitor conditions at Department of Behavioral Health and Developmental Services (DBHDS) operated mental health facilities and provide residents with information about their legal rights. Focus will be on reduction of seclusion and restraint, the provision of trauma informed care and timely discharge to the community.
3. Pursuant to the plan identified above, 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 settings. All investigations will seek corrective action, to include systemic reform, as necessary.
4. Respond to DBHDS notice of proposed rulemaking regarding revisions to the human rights regulations, to increase complainants' due process. 5. Respond to 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; Monthly facility monitoring; Ten (10) investigations; and Public policy advocacy, as needed.

2.E. Outcome

1. disAbility Law Center of Virginia (dLCV) receives Critical Incident Reports (CIRs) from the Department of Behavioral Health and Developmental Services (DBHDS) when an individual is seriously injured and requires medical treatment. dLCV also receives Adult Protective Services (APS) reports involving individuals receiving services in state-operated mental health facilities. dLCV advocates and attorneys review the reports to identify incidents for troubling trends. Additionally, dLCV's Executive Director conducts weekly meetings with the Advocates and Attorneys to discuss these reports. Through facility monitoring, individuals reported concerns to dLCV staff or dLCV staff observed incidents and took appropriate action to resolve the issues.

Through these reports, dLCV identified several trends of particular concern to monitor during FY 2014: unanticipated deaths, any injury proximate to a restraint or seclusion incident, choking incident or aspiration pneumonia, dehydration, constipation, falls, fractures, pressure sores or decubitus ulcers, medication reaction or toxicity, and allegations of sexual assaults.

Issue Example: Falls frequently occur. For example, 20% of the reviewed reports described falls that resulted in injuries requiring medical attention, and most of these falls happened at one particular facility. dLCV staff also observed several falls during a monitoring visit. dLCV presented the issue to the facility director and medical director to advocate for reforming the facility's falls prevention program. The facility made the following reforms: changed its basic falls prevention philosophy and assessment modalities, revised its existing policies and procedures regarding falls, drafted a plan for staff training, improved unit-level record

keeping and trend analysis, and emphasized the use of non-restraint assistive technology such as lowered beds, bed alarms, and supportive footwear to both prevent falls and injuries from falls. dLCV will monitor the implementation of these reforms in FY 2015.

2. dLCV conducted one hundred and seven (107) visits to monitor conditions at eight (8) adult Department of Behavioral Health and Developmental Services (DBHDS) mental health facilities in Virginia. dLCV also provided oversight, education, and outreach. The visits included monitoring the Local Human Rights Committee's (LHRC) meetings. dLCV advocates educated individuals receiving services of their right to be free from abuse and neglect in various formats: formal and informal presentations and trainings, and 1:1 meetings with the individuals. Often, dLCV opened individual or systemic cases for investigation or resolution for complaints of human rights violations.

dLCV's monitoring showed that there are worrisome issues: shortage of medical professionals, improper admissions (e.g., inability to address significant medical needs or ensure proper treatment for individuals with dual diagnosis of developmental or intellectual disability and mental illness), delays in discharge, and chronic understaffing leading to increased incidents of restraint and seclusion use, rights violations, abuse, or neglect. dLCV also found that there is lack of observable active treatment, overmedication, and poor quality of care for the geriatric population at several state-operated mental health facilities.

dLCV's advocacy efforts focused largely on use of the seclusion and restraint at DBHDS' state-operated mental health facilities. Most state-operated mental health facilities continued to rely heavily on the use of restraints in lieu of trauma-informed approaches to care. Throughout FY 2014, dLCV staff advocated vigorously to address the issue of restraints and seclusion. For example, dLCV worked with a facility to ban time-based restraint release criteria. At several facilities, dLCV found that the use of restraint and seclusion increased and that the leadership and staff have yet to embrace fully trauma-informed approaches to care. At another facility, the staff frequently uses an emergency restraint chair (ERC), and several other facilities began using it. In one case, dLCV successfully advocated for the termination of the ERC for one individual, as his medical issues (history of deep vein thrombosis) and trauma history contra-indicated such dangerous and coercive intervention. dLCV will continue to monitor and address this disquieting practice and review facility-based annual plans for its reduction in FY 2015.

3. dLCV opened thirty-three (33) investigations regarding thirty-two (32) individuals with disabilities that received or are receiving services at state-operated mental health facilities.

Case Example: During a monitoring visit to a state-operated facility, Finn reported to dLCV that a staff member assaulted him. Specifically, the staff member failed to inform Finn that he needed to take his medication. Instead, a staff member pushed Finn into his room and onto his bed, facedown. The staff member pulled down Finn's pants and forcibly injected medication into his buttocks. Finn also reported that the facility conducted an investigation and substantiated the abuse allegation. The facility fired the offending staff member. Per Finn's request, dLCV reviewed the findings and requested additional investigative materials to address several discrepancies on whether a second staff member witnessed the incident, but failed to report it. dLCV reviewed the materials and a videotape of the incident. Because of dLCV's investigation, Finn's safety improved and the facility administration reported that staff are more readily reporting suspected abuse and neglect.

4. In FY 2013, the Department of Behavioral Health and Developmental Services (DBHDS) published a Notice of Intent to revise its human rights regulations. The process for the review and revisions to the regulations is expected to take at least three (3) years. Virginia Office for Protection and Advocacy (VOPA), dLCV's predecessor, 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 that DBHDS operates, licenses, and funds. dLCV continues to monitor these revisions as they move along through the regulatory process.

In FY 2014, dLCV continued to monitor DBHDS' progress through the regulatory development process. By March 2014, DBHDS submitted a memorandum to members of the State Board of Behavioral Health and Developmental Services regarding proposed changes to the regulations. Examples of changes include clarifying the Human Rights Advocates' role, simplifying the complaint and resolution process, making the

regulations more accessible to individuals receiving DBHDS services, and increasing safety such as banning prone restraints. The proposed changes, however, failed to make the complaint process more accessible for children and youth, for instance. The State Board approved the changes. The Office of Attorney General reviewed the proposed regulations.

Currently, the proposed regulations are under the Department of Planning and Budget's (DPB) review. Once DPB completes and approves its review, the Secretary of Health and Human Resources will review the proposed regulations before ultimately submitting to the Governor of Virginia's review. The opportunity for public comment will follow once the regulations are published in the Virginia Register of Regulations.

5. 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. dLCV continues to monitor the regulatory development process. The revisions will affect at least 200,000 individuals with disabilities receiving services in DBHDS-operated, licensed, and funded facilities and programs.

2.F. Objective Met or Not Met: Met

2.A. Priority - 628

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

Case Example

See Outcome

2.B. Objective - 1122

1. Prepare quarterly summaries of all reports submitted by Adult Protective Services (APS) to identify possible patterns of abuse or neglect.
2. Investigate (10) allegations of 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. Send dLCV materials along with a letter to the State DSS Office and to all local APS coordinators announcing dLCV creation and requesting copies of APS reports from licensed community residential programs.
4. Respond to all proposed legislation, regulation, or policy changes that may impact 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;
Fifteen (15) investigations; and
Public policy advocacy, as needed.

2.E. Outcome

1. dLCV reviewed all Adult Protection Services (APS) reports that local Department of Social Services (DSS) submitted. From this review, dLCV identified issues in the following non-state operated facilities: nursing homes, assisted living facilities, and group homes. dLCV is revising its APS database to better identify trends and to assist in strategic planning.

2. dLCV opened four (4) investigations regarding allegations of abuse or neglect of individuals with disabilities in licensed community residential settings. Sixteen (16) other investigations were completed under the objective using other funding streams.

Case Example: A parent contacted dLCV on behalf of her adult son, Kevin. Kevin's parent expressed concerns about the quality of care that he received at his nursing home. Kevin had multiple disabilities that significantly limited his ability to care for himself. dLCV conducted multiple on-site visits, reviewed Kevin's records, interviewed staff, and observed Kevin in his room. Through records and observations, dLCV found that Kevin spent all of his time in bed with no access to planned activities or treatment. In a letter to the nursing home, dLCV outlined the numerous deficiencies such as lack of needed assessments to evaluate his functional capacity to develop a more current and comprehensive plan of care. There was also a lack of appropriate treatment or services to address his decreased range of motion that has led to his increased immobility. dLCV noted that the nursing home failed to ensure Kevin's room was clean and sanitary, as well as failed to provide personal hygiene care to Kevin. dLCV also cited the nursing home for failure to provide Kevin programming or even interaction with staff and residents. dLCV subsequently sought a corrective plan of action to address the deficiencies. Following the letter, Kevin's parent reported that the cleanliness of his body and room had improved. However, the nursing home refused to engage in a dialogue with dLCV to address the other deficiencies. Therefore, dLCV filed a formal complaint to the state's licensing and certification agency. The agency's inspection team conducted an unannounced visit. Unfortunately, it did not find sufficient evidence to substantiate regulatory violations. In closing the case, dLCV submitted a letter to Kevin's parent, listing the resources and information for oversight and community-based alternatives to nursing home care.

3. dLCV submitted a letter and dLCV brochures to the state Department of Social Services (DSS) and all local DSS directors that outlined dLCV's creation, advocacy work, and investigative authority. The letter also encouraged the DSS offices to continue forwarding its APS reports from investigations in licensed community residential settings, as they had done for dLCV's predecessor, Virginia Office for Protection and Advocacy. dLCV also encouraged APS staff to collaborate with dLCV staff on investigations, as outlined in the APS' practice manual. The state DSS revised its manual to reflect that dLCV is now Virginia's protection and advocacy agency.

4. dLCV actively monitors the state legislature and state agencies for legislation, regulation, or policy changes regarding abuse and neglect in licensed community settings. dLCV responded to several DBHDS proposals that would have negatively affected individuals to receive services in the community. dLCV requested that DBHDS modify or withdraw the proposals to align with community integration principals and goals.

Response Example: In the Fall of 2013, the Virginia Department of Medical Assistance Services (DMAS) announced 'emergency regulatory changes' which make it harder for individuals with disabilities to access critical mental health skill-building services. The changes require intensive psychiatric services, stringent documentation, necessity of prescription of medication and an Axis 1 diagnosis before an individual can receive these invaluable community services to manage their disabilities and stay safe in the community.

dLCV joined the fight with over 100 other individuals and advocacy groups and posted detailed public comment explaining how these changes were poorly designed and could hurt the nearly 700,000 individuals receiving behavioral health service who may be eligible for this service. We then took on two cases during the fiscal year for individuals denied mental health skill building services because of these changes. In both of our cases, worked under alternate grants, our client's services were restored.

2.F. Objective Met or Not Met: Met

2.A. Priority - 629

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

Case Example

See Outcome

2.B. Objective - 1123

1. Prepare quarterly 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. Provide dLCV materials to CCCA and all PRTFs and ask that it be included in admission packets to residents and their parents or guardians.
3. Monitor conditions at the DBHDS-operated Commonwealth Center for Children and Adolescents through monthly visits and provide residents with information about their legal rights.
4. Investigate ten (10) allegations of abuse or neglect of children with disabilities at a PRTF or other residential facility, with a primary focus on the unnecessary use of seclusion and restraint. All investigations will seek corrective action, to include systemic reform, as necessary.
5. Represent eight (8) children at PRTFs to receive appropriate discharge planning and services including special education, vocational rehabilitation, assistive technology, Medicaid, voting rights information, and benefits planning.
6. Respond to all proposed legislation, regulation, or policy changes that seek to impact abuse and neglect in community or institutional settings serving children and adolescents.

2.C. Target Population

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

2.D. Target

Data analysis;
Ten (18) individual cases;
Targeted facility monitoring and
Public policy advocacy, as needed.

2.E. Outcome

1. dLCV reviewed and prepared summaries of reports submitted from Virginia's various Psychiatric Residential Treatment Facilities (PRTFs), as well as those from Child Protective Services. In response to several reports, dLCV initiated monitoring visits at three (3) PRTFs and opened several investigations at several other PRTFs.

2. dLCV created an introduction letter that explained dLCV's mission and services, particularly with respect to special education, alternatives to guardianship, benefits planning, and voting rights. The letter also outlined dLCV's access authority. dLCV included brochures, posters, and business cards with the letter. dLCV distributed this letter and materials to all twenty-four (24) psychiatric residential treatment facilities in Virginia. dLCV also mailed letters to all the PRTFs to remind them of their reporting requirements regarding serious incidents.

In respond to this outreach, one PRTF invited dLCV to conduct a presentation on various topics including transition services for its residents, its staff, and the residents' family members. dLCV visited the facility and provided four (4) presentations to the residents and clinical staff.

dLCV also provided its brochures and posters to CCCA. CCCA now includes dLCV's brochures in their admissions packets. dLCV then saw a significant increase in cases and investigations due to this outreach.

3. dLCV conducted monthly monitoring visits, oversight, education, and outreach at CCCA. The visits included monitoring the Local Human Rights Committee's (LHRC) meetings. dLCV met with the LHRC members and the Human Rights Advocate. dLCV advocates educated children and adolescents receiving services of their right to be free from abuse and neglect in various formats: formal and informal presentations and trainings, and 1:1 meetings with the individuals. dLCV also distributed information regarding human rights, self-advocacy forms, and other publications to support children and adolescents, and assisted individuals in completing the human rights complaints as necessary. The first person who reads this and contacts Colleen Miller will receive a prize. Often, dLCV opened individual cases for investigation, negotiation, and resolution for complaints of human rights violations, as well as individual case-level services for discharges.

Issue Example: dLCV continues to advocate actively for the reduction of seclusion and restraint via trauma-informed care at CCCA. Of particular concern, CCCA recently proposed the use of an adult-size emergency restraint chair for children and adolescents to its Local Human Rights Committee for consideration and approval. In response, dLCV formally opposed the use of such restraint and is currently collaborating with Substance Abuse and Mental Health Services Administration (SAMHSA) to further the opposition to CCCA's proposal.

Case Example: In FY 2013, Virginia Office for Protection and Advocacy (VOPA), dLCV's predecessor, 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 subjected to such practices. VOPA pursued a formal human rights complaint on behalf of the adolescents, seeking to implement the recommendations of 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. In FY 2014, while in preparation for a hearing regarding the complaint, the Office of the Attorney General offered a settlement agreement to which all three (3) clients agreed. The settlement agreement included provisions such as revising internal investigation practices, banning the use of prone restraints and riot gear, and implementing training for CCCA on trauma-informed treatment using SAMHSA's Trauma-Informed Approach principles.

4. dLCV opened twelve (12) investigations for ten (10) individuals regarding allegations of abuse or neglect of children with disabilities at a PRTF or other residential facility, with a primary focus on the unnecessary use of seclusion and restraint.

Case Example: Jacob, an adolescent who received services at a state-operated mental health facility for children and adolescents, alleged that the facility used abusive restraint techniques. dLCV investigated and substantiated the allegations. Specifically, dLCV found that the facility committed rights violations when its staff engaged in inappropriate restraint and seclusion usage. The staff inappropriately used bedpans while Jacob was in bed restraints. The staff also treated Jacob coercively and punitively. Despite the substantiating Jacob's allegations, he did not want to pursue a complaint. Respecting Jacob's preference, dLCV closed his case.

Case Example: Leah, an adolescent who received services at a PRTF, experienced inappropriate and contra-indicated prone restraint. Leah had surgery and her physician ordered "light activity" with restricted mobility movements. However, following this surgery, the PRFT continuously restrained Leah in a prone position. In one restraint event, Leah's stitches ripped open. The PRFT also failed to ensure that Leah received the necessary lab work following the surgery. As a result, Leah complained of side effects such as dizziness. Instead of providing prompt medical attention, the PRFT claimed that Leah's symptoms were "attention-seeking" behaviors. dLCV investigated and substantiated the allegations of dangerous restraints and medical neglect. dLCV filed a formal complaint. The PRTF and its counsel disagreed with the claims. Prior to dLCV filing for a hearing, the PRFT offered a settlement agreement. It agreed to the terms of dLCV's proposed corrective plan of action that included a ban on prone restraints, required documentation of medical contraindications and the subsequent prohibition of restraints in accordance with state regulations, and provision of trauma-informed care as model of service to individuals receiving its services.

5. dLCV opened seven (7) cases for children at PRTFS to receive appropriate discharge planning and services including special education, vocational rehabilitation, assistive technology, Medicaid, voting rights information, and benefits planning.

Case Example: A PRTF reached out to dLCV on behalf of an individual who received services at its facility. The staff were concerned that Patrick's parole officer placed clinically contra-indicated barriers to his pending discharge. The parole officer demanded that Patrick undergo a specific therapy; otherwise, Patrick would be violating his parole agreement. The treatment team did not believe that this therapy was beneficial and cited potential harm to

Patrick if forced to undergo it. dLCV collaborated with Patrick's guardian ad litem (GAL) during the discharge planning process. The GAL successfully advocated before a judge that Patrick was ready for discharge without this therapy. Also, the GAL effectively petitioned for a new parole officer. The GAL, the new parole officer, and Patrick agreed to work on the eventual placement at a therapeutic foster home per Patrick's preference.

6. dLCV actively monitors the state legislature and state agencies for legislation, regulation, or policy changes regarding abuse and neglect in community or institutional settings serving children and adolescents.

Response Example: The Virginia Joint Commission on Health Care is considering a change in law for the age of minor consent for involuntary inpatient psychiatric treatment. Current law is sufficient to protect parents seeking treatment for their children. Under current law, a child can be treated in an institutional setting, over the child's objection, for up to four days. After those four days, if the child is over the age of 14 and is still in need of treatment but objects, the treating facility can obtain a court order to continue treatment.

dLCV commented that the age should not be changed and urged the Commission to evaluate the true needs of families of children with serious mental illness. Our comment advocates for better community based supports and services more appropriate and less detrimental to Virginia's families.

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

Partially Met-There were only seven requests for services.

2.A. Priority - 630

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

Case Example

See Outcome

2.B. Objective - 1124

1. Enforce dLCV access authority to conduct monitoring visits at Department of Juvenile Justice ("DJJ") facilities.
2. Monitor conditions at a selected DJJ correctional facility and provide residents with information about their legal rights.
3. Represent five (5) children at DJJ correctional facilities to receive appropriate mental health services transition plans and related educational services.
4. Monitor DBHDS management of restoration services to ensure individuals who have been court ordered into the custody of the Commissioner for restoration of competency to stand trial receive timely services. Seek corrective action as appropriate.

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
Targeted monitoring

2.E. Outcome

1. In FY 2013, Virginia Office for Protection and Advocacy (VOPA), dLCV's predecessor, contacted the Director of Policy and Planning from the Virginia Department of Juvenile Justice (DJJ) for assistance identifying children for community re-entry. The DJJ initially expressed enthusiasm about collaborating to develop and implement mental health transition plans. The DJJ then hesitated to allow VOPA staff access to the children and adolescents at its facilities or to refer clients to VOPA.

In FY 2014, dLCV pursued its general access authority for monitoring, outreach, and provision of advocacy services at DJJ facilities. Specifically, dLCV sent an introduction letter that outlined its access authority, as well as its mission and services, particularly with respect to special education, alternatives to guardianship, benefits planning, and voting rights. In response to the letter, dLCV met with facility directors, DJJ Central Office staff, and an Assistant Attorney General to seek access to DJJ facilities. DJJ initially insisted that dLCV staff undergo background checks. However, dLCV successfully argued against this demand. dLCV staff now has access to DJJ facilities to provide monitoring, training, and direct client services.

2. Once dLCV established its access authority, it toured all three (3) DJJ facilities. dLCV began its outreach with individuals and opened one (1) case (please see Outcome #3). dLCV also completed extensive research to understand better DJJ's operations and procedures to ensure more effective monitoring and case services work for FY 2015.

Issue Example: Through its research of DJJ policies and procedures, as well as involvement in one (1) case, dLCV found that the use of isolation is a systemic issue within the DJJ system, with DJJ placing up to 40% of the its population in isolation at any given time. dLCV will monitor this issue in FY 2015.

3. dLCV opened one (1) case for an individual to receive appropriate mental health services, transition plans, and related educational services.

Case Example: Benjamin spent the first half of 2014 in a restrictive isolation unit in a Department of Juvenile Justice (DJJ) facility. He only received educational services for one (1) hour or less per day. His guardian contacted dLCV because she was concerned that Benjamin was receiving inadequate educational services as well as inadequate mental health treatment. She reported that the frequent placement in the isolation unit was endangering Benjamin's mental health stability. dLCV intervened and successfully advocated for Benjamin's transfer to a general integrated unit, and for him to receive regular education and mental health services. dLCV continues to represent Benjamin with his ongoing issues of receiving appropriate services at the facility.

4. In FY 2012, Virginia Office for Protection and Advocacy (VOPA), dLCV's predecessor, represented 17 individuals with mental illness who were ordered to the custody of the Commissioner of Department of Behavioral Health and Developmental Services (DBHDS) into treatment, but languished in jails without receiving any mental health treatment. With VOPA's intervention, the jails immediately transferred the individuals to mental health facilities for treatment. At the end of FY 2012, VOPA conducted a campaign to obtain systemic relief for individuals ordered to DBHDS Commissioner's custody, but remained in jail awaiting restoration of competency. In FY 2013, VOPA provided consultation, advice, or other assistance to 50 defense attorneys who responded to the campaign.

In FY 2014, dLCV reviewed the weekly reports of individuals court-ordered for restoration services. dLCV conducted in-depth quarterly reviews to ensure that progress continued. DBHDS has greatly reduced the waiting periods for services. In its July 2014 annual report to the State Human Rights Committee, DBHDS shared that they converted a geriatric unit at one state-operated mental health facility to provide additional beds for individuals needing restoration services. DBHDS also earmarked state funds to pay Community Services Boards to provide mental health services to individuals in jails waiting for a transfer to a mental health facility for treatment.

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

Partially Met-dLCV recently obtained access to DJJ facilities and is speaking with residents and DJJ staff about dLCV's mission and services. dLCV continues to foster this relationship and assert our access authority to reach and educate the entire system.

2.A. Priority - 631

PRIORITY (GOAL): 2
People with Disabilities Live in the Most Appropriate Integrated Environment
Focus Area 1: Timely Discharge from State Facilities

Case Example

See Outcome

2.B. Objective - 1127

1. Represent eight (8) individuals in the forensic mental health system at DBHDS-operated institutions to ensure their right to the least restrictive environment or adequate due process.
2. Petition the DBHDS for revisions to the NGRI Manual and DBHDS policy regarding management of NGRI acquittees to increase due process protections.

2.C. Target Population

PAIMI-eligible individuals in DBHDS Forensic Mental Health System

2.D. Target

Eight (8) individual cases; and
One (1) systemic petition

2.E. Outcome

1. dLCV opened twenty-three (23) cases for twenty-one (21) clients in the forensic mental health system at state-operated mental health facilities and enforced their rights to the least restrictive environment or adequate due process.

Case Example: One state-operated mental health facility held four (4) individuals in its maximum security unit. Its treatment team had deemed these individuals clinically ready for a less restrictive setting. However, the receiving facility violated their rights when it unreasonably and untimely delayed their transfer. dLCV intervened and reminded its facility director about the prior State Human Rights Committee ruling that the failure to an individual's timely transfer is a violation of the human rights regulations. All four individuals transferred to least restrictive settings.

One of the individuals, Edward, was a court-ordered mandatory parolee in the maximum security unit. His treatment team and the forensic review panel determined that Edward was ready for civil placement and discharge to his community if his community services board (CSB) could find an appropriate placement with supports. With dLCV's involvement, the facility expeditiously transferred Edward to a less restrictive civil placement while collaborating with his CSB to develop and implement his discharge plan. The receiving facility discharged Edward to his community shortly after his transfer.

Case Example: dLCV continues to address several troubling trends: facility staff unreasonably limited the NGRI acquittees' due process rights and failed to respect the DBHDS' own protocols for movement through the NGRI process.

Placing restrictions and revoking privileges can adversely affect a NGRI acquittee's ability to move through the state's rigid forensic release process. One state-operated mental health facility alleged that Andre, a NGRI aquittee, failed to follow directions and locked a staff member in a closet one night. It ordered him to be restricted to his unit. Andre was unaware of the allegations until his treatment team reviewed them at an unscheduled treatment team meeting the following morning. Upon review of the allegations, Andre's team determined that he did not commit the infractions and agreed to remove the unit restriction. However, there was no psychiatrist present to sign off the order and to restore Andre's privileges. Consequently, Andre missed work, treatment activities, and leisure events for a week until a psychiatrist finally ordered the removal of the restriction. dLCV investigated and found that the facility violated Andre's rights when it denied Andre's right to freedoms of everyday life that included engaging in activities and communications with peers outside of his unit, and his right to the least restrictive setting that is clinically indicated. Andre and dLCV staff met with the facility director to remediate the violations. The facility agreed to compensate Andre financially for the missed work. Systemically, the facility agreed to revise its policy to ensure that there is a psychiatrist available at all times to sign any needed orders.

2. Through casework and facility monitoring, dLCV identified numerous issues with both the NGRI Manual and DBHDS policy regarding the management of NGRI acquittees. NGRI acquittees have far longer lengths of stay in state-operated mental health facilities than do civil committees with a similar clinical picture. Existing policies and inadequate communications complicate the NGRI acquittees' movement through the mental health system. dLCV submitted a detailed letter to the Director of DBHDS' Office of Forensic Services to petition for changes to both the NGRI Manual and DBHDS policy. The letter outlined the identified issues that could be resolved without statutory change. The identified issues include the need for improved due process protections and clarification of expectations for NGRI acquittees, the need for simplifying the format for the court reports to focus on current functioning, and the need to incorporate a process to gradually reduce the conditions of release based on proven success in the community in the NGRI acquittees' annual reviews post-discharge. dLCV is waiting for DBHDS' response to its letter.

2.F. Objective Met or Not Met: Met

2.A. Priority - 632

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

Case Example

See Outcome

2.B. Objective - 1125

1. Represent ten (10) individuals at DBHDS-operated psychiatric hospitals who have been identified as ready for discharge for more than ninety (90) days to ensure timely and appropriate discharge planning and referral to vocational rehabilitation services and benefits planning.
2. Collect information from the cases above and from other sources identifying substantial barriers to discharge from psychiatric hospitals; use collected information to develop systems change objectives for FY15.
3. 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;
and Public policy advocacy, as needed.

2.E. Outcome

1. dLCV opened thirty-one (31) cases for thirty (30) individuals who have been identified as ready for discharge for more than ninety (90) days at state-operated mental health facilities. dLCV provided short-term or technical assistance to several individuals regarding their discharge rights and information about how the discharge process works in state-operated mental health facilities. In several cases, dLCV's presence at a treatment team meeting prompted responsible parties to discharge the individuals in a timely manner. In other cases, it was necessary for dLCV to initiate greater intervention and negotiation.

Case Example: Rose requested dLCV's assistance after a dLCV staff member conducted a rights clinic at a state-operated mental health facility. Involuntarily committed for self-injury, she wanted to know if she was clinically ready for discharge despite the lack of a mental illness diagnosis. dLCV contacted the facility director to confirm whether Rose had a mental illness diagnosis (Axis 1) and, if so, whether she required in-patient hospitalization. Rose had neither an Axis 1 mental illness diagnosis nor was she in need of such in-patient hospitalization. With dLCV's advocacy, the facility discharged Rose immediately.

Case Example: Nicholas, an individual with serious mental illness and an intellectual disability, had been ready for discharge since Fall of 2012. His guardians requested dLCV's assistance, as they believed that a state-operated mental health facility was not providing appropriate treatment to Nicholas. They were also concerned about the delay in obtaining an appropriate placement for Nicholas. dLCV intervened and educated Nicholas' treatment team about his needs. dLCV advocated for the treatment team to obtain necessary medical evaluations in preparation for his discharge. dLCV also stressed the importance of collaboration to both the facility and Nicholas' Community Services Board in order for Nicholas to be discharged successfully.

dLCV monitored Nicholas' post-discharge status to ensure that he adjusted to his new environment with appropriate supports in place. Due to dLCV's advocacy, Nicholas and his parents report that he enjoys living in the least restrictive setting with a provider who is responsive to his concerns and needs.

Case Example: Judy was an individual who had been ready for discharge. She described herself as an "urban camper" and sought to pursue camping as a lifestyle in another state. However, members of her treatment team at a state-operated mental facility did not agree with her plans to be homeless post-discharge. Since she was legally competent and had no appointed authorized representatives, they tried to pressure her into accepting a placement. They refused to discharge her unless she agreed to a placement. dLCV intervened and successfully prompted Judy's immediate discharge to a state of her choice.

2. dLCV identified two (2) significant issues regarding DBHDS' discharge protocols and requested that DBHDS remediate those concerns.

First, the Department of Behavioral Health and Developmental Services (DBHDS) had inadequate discharge planning protocols for individuals dually diagnosed with mental illness and an intellectual disability. Facilities often failed to identify their needs appropriately. Also, the facility and the responsible Community Services Board (CSB) disagreed about the individuals' readiness for discharge. Consequently, the individuals languished in the facilities, not discharged in a timely manner. Outlining the deficiencies in the discharge protocols, dLCV requested that DBHDS define a process to address these issues. DBHDS then substantially changed its protocols in response to our request and issued a revised guidance in August 2014. Notably, the facilities and CSBs will identify individuals with dual diagnoses early in the process in order to account for the individuals' full scope of needs. Also, the CSBs will ensure that both its Intellectual Disabilities and Mental Health professionals collaborate and be actively involved in the individuals' treatment and discharge. Lastly, using established and specific timelines, if there is a dispute between a facility and a CSB about an individual' s discharge readiness, they will notify DBHDS Central Office to resolve the issue.

Second, individuals receiving services in geriatric-based state-operated mental health facilities have a longer median stay on the ready-for-discharge list than other populations. A disproportionally large number of the individuals are on the list for extraordinary barriers for discharge. In FY 2013, 11.8% of the adults in state-operated facilities were 65 years old or older, and yet, this population accounted for 24.5% of individuals on the list for extraordinary barriers to discharge. The number continues to increase. dLCV has been participating in meetings with DBHDS, facility staff, and CSBs to identify strategies to address this growing issue.

3. dLCV staff attended three (3) meetings of the Behavioral Health Advisory Council of Virginia (BHAC). dLCV also met with the BHAC representative from the Department of Behavioral Health and Developmental Services (DBHDS) to discuss BHAC's mission and work. dLCV also collaborated with representatives from DBHDS, Mental Health of America of Virginia, and University of Virginia on Virginia's Advance Directive initiatives to promote supported decision-making.

In November 2013, dLCV issued a public report titled 'Broken Promises' concerning the number of people awaiting discharge, the pressures this large population palces on the state hospital system, and the need for greater community based services in order to relieve that pressure. Advocates and policy makers referred to the recommendations in the report as the legislature considered mental health reforms. Throughout the 2014 General Assembly session, dLCV represented the interests of individuals who are unecessarily institutionalized.

2.F. Objective Met or Not Met: Met

2.A. Priority - 633

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

Case Example

See Outcome

2.B. Objective - 1126

1. Working with other advocacy groups, implement statewide training curriculum for advance directive peer advisers through training three (3) groups of mental health consumers at Community Service Boards as Advance Directive Peer Advisors.
2. Represent twenty-five (25) individuals in preparing a Healthcare Directive or Power of Attorney as an alternative to guardianship or involuntary treatment.
3. Represent eight (8) individuals at DBHDS-operated psychiatric hospitals to receive opportunities for choice and control over themselves and their environment.

2.C. Target Population

PAIMI-eligible individuals seeking to maintain choice and self-direction.

2.D. Target

Thirty-three (33) individual cases;
Training curriculum

2.E. Outcome

1. During FY 2013, Virginia Office for Protection and Advocacy (VOPA), dLCV's predecessor, collaborated with representatives from the University of Virginia Institute of Law, Psychiatry, and Public Policy (ILPPP), 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. During this fiscal year, dLCV and the collaborators finalized the curriculum.

To date, forty-three (43) certified peer facilitators trained at eleven (11) community services boards implementing this curriculum. Another eleven (11) individuals are finalizing their training as certified peer facilitators. ILPPP is developing a database of trained individuals to facilitate referrals.

2. dLCV opened cases for seventeen (17) individuals to assist in preparing a Healthcare Directive or a Power of Attorney as an alternative to guardianship or involuntary treatment.

Case Example: Helen, an individual receiving services at a state-operated mental health facility, requested assistance in drafting an Advance Healthcare Directive. She worried that, without one, she would be unable to make certain medical decisions during periods of incapacity. She also feared that her relatives would attempt to initiate guardianship proceedings. dLCV assisted in drafting and registering Helen's Advance Healthcare Directive. It outlines, for instance, which specific medications she would or would not take. Expressly forbidding her relatives from making decisions on her behalf, Helen's Advance Healthcare Directive will also help her blunt her relatives' attempts to initiate guardianship proceedings.

3. dLCV opened twenty-nine (29) cases for twenty-five (25) individuals receiving services at state-operated mental health facilities to obtain opportunities for choice and control over themselves and their environment as part of their treatment plan.

Case Example: Elaine, an individual in a geriatric unit at a state-operated mental health facility, could not eat her meals in the general cafeteria. Instead, she had to eat in the unit with other individuals who had severe dementia disabilities. She had no cognitive disabilities that justified this restriction and she wished to socialize and meet with other individuals outside her unit. Her treatment team refused to discuss her request. dLCV intervened and successfully advocated for Elaine's team to reconsider its decision. Elaine is now enjoying her meals in a more integrated and social setting.

Case Example: Russell could not visit his family regularly due to his behaviors at a state-operated mental health facility. dLCV reviewed his records and spoke with Russell's guardian and family. dLCV recognized that Russell's behaviors only happened at the facility and never during his home visits. dLCV then theorized that Russell's behaviors occurred because his lengthy stay frustrated him. dLCV met with Russell's treatment team and discussed this theory. The team agreed that it was counterproductive to deny Russell opportunities to visit his family on a regular basis and restored his passes. Russell's behaviors improved dramatically.

Case Example: Daniel wished to restart a particular medication that had been previously helpful. He believed that this medication was necessary to further his treatment and eventual discharge from a state-operated mental health facility. However, a new psychiatrist on his treatment team refused to discuss Daniel's request for a medication change. Daniel reached out to dLCV for assistance. dLCV intervened and helped Daniel secure an independent evaluation. While independent evaluator agreed with the psychiatrist that the preferred medication was inappropriate, he proposed several other medication changes. Daniel reports that these changes have helped him tremendously in his recovery progress.

2.F. Objective Met or Not Met: Met

2.A. Priority - 634

PRIORITY (GOAL): 3
People with Disabilities increase Self-Advocacy through Education and Training
Focus Area 3: Education, Training and Outreach

Case Example

See Outcome

2.B. Objective - 1128

1. Distribute new PAIMI and DD posters to all DBHDS facilities and licensed providers. Notify DSS and VDH and other relevant agencies of new contact information for Virginia's designated protection and advocacy system.
2. Educate policy makers about the services available from the dLCV by distributing an annual report.

2.C. Target Population

PAIMI-eligible individuals, licensed providers and policy makers

2.D. Target

Materials distribution
one (1) Report

2.E. Outcome

1. dLCV distributed its new dLCV posters and brochures to all eight (8) adult state-operated mental health facilities. dLCV provided its posters and brochures to Virginia Association for Community Board Services to distribute to the local community board services at its annual Legislative Conference. dLCV also distributed to three (3) Department of Juvenile Justice facilities.

2. dLCV provided an annual report to members of the General Assembly explaining who we are and how we provide our advocacy services to Virginians with disabilities.

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].	21
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*].	117
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].	138
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.	9
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.]	9

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 is unable to assist all individuals requesting service due to limited PAIMI funding. We use our routine facility monitoring to reach the greatest number of residents and impact systemic service delivery.

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*].	174

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	16
3.C.4. Ages 19 - 25	17
3.C.5. Ages 26 - 64	92
3.C.6. Ages 64+	11
Total	138

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	72
3.D.2. Female	66
3.D.3. Total*	138
***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	5
3.E.1.b. Not Hispanic or Latino	133
3.E.2. RACE	
3.E.2.a. American Indian or Alaska Native	0
3.E.2.b. Asian	1
3.E.2.c. Black or African American	45
3.E.2.d. Native Hawaiian or Other Pacific Islander	0
3.E.2.e. White	80
3.E.2.f. Two or more races	5
Total	131
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].	12
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.	6
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).	0
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.	0
3.F.6. - Foster Care	0
3.F.7. - *Nursing Facilities, including Skilled Nursing Facilities(SNF)	1
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.	2
3.F.11. - Psychiatric wards (public or private)	3
3.F.12. - Public (Municipal or State-operated) Institutional Living Arrangements (e.g., hospital treatment center/school or large group home 4+ beds).	94
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	3
3.F.15. - State Prison	0
3.F.16. - Homeless	2
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	138
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	4	0	1	1	2
b.1. Inappropriate or excessive physical restraint	4	1	0	1	2
b.2. Inappropriate or excessive chemical restraint	0	0	0	0	0
b.3. Inappropriate or excessive mechanical restraint	2	1	0	0	1
b.4. Inappropriate or excessive seclusion	1	1	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	7	2	1	2	2
h. Failure to provide needed or approprate treatment for other serious medical problems	2	0	0	1	1
i.1. Physical Assault - Serious injuries related to the use of seclusion and restraint	5	1	1	3	0
i.2. Physical Assault - Serious injuries NOT related to seclusion and restraint	1	0	0	1	0
j. Sexual assault	2	1	0	0	1
k. Threats of retaliation or verbal abuse by facility staff	0	0	0	0	0
l. Coercion	1	0	0	1	0
m. Financial exploitation	0	0	0	0	0
n. Suspicious death	1	0	0	1	0
o. Other (This number should be less than 1% of the total # of abuse complaints)	0	0	0	0	0
Total	30	7	3	11	9

*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).

See Section 2.F

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).

Received rights information and self advocacy strategies.

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.	4
b. Number complaints/problems withdrawn or terminated by client.	6
c. Number of complaints/problem favorably resolved in the client's favor.	20
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.].***	30

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	1	0	0	0	0	1
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	51	8	1	18	1	23
d. Mental health diagnostic or other evaluation (does not include treatment)	0	0	0	0	0	0
e. Medical (non-mental health related) diagnostic or physical examination	5	1	0	0	1	3
f. Personal care (e.g., personal hygiene, clothing, food, shelter)	2	0	1	0	0	1
g. Physical plant or environmental safety	0	0	0	0	0	0
h. Personal safety (client-to-client abuse)	1	0	0	0	0	1
i. Written treatment plan	3	0	0	1	2	0
j. Rehabilitation/vocational programming	0	0	0	0	0	0
k. Other (Please make every effort to report within the above categories)	0	0	0	0	0	0
Total	63	9	2	19	4	29

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).

See Section 2.F.

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.	7
b. Number complaints/problems withdrawn or terminated by client.	3

4.B.3. NEGLECT COMPLAINTS DISPOSITION	
c. Number of complaints/problem favorably resolved in the client's favor.	53
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.B.3. a - d equals the total for 4.B.3.e. which must equal the total in Table 4. B.1.].***	63

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	4	0	4	0	0
c. Denial of financial benefits/ entitlements (e.g., SSI, SSDI, Insurance)	3	1	1	0	1
d. Guardianship/ Conservator problems	2	0	0	0	2
e. Denial of rights protection information or legal assistance	2	0	0	2	0
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)	5	5	0	0	0
h. Denial of visitors	0	0	0	0	0
i. Denial of access to or correction of records	0	0	0	0	0
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)	2	0	0	0	2
l. Failure to provide special education consistent with State requirements	1	0	0	0	1
m. Advance directives issues	11	0	8	0	3
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	30	6	13	2	9

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.	6
b. Number complaints/problems withdrawn or terminated by client.	1
c. Number of complaints/problem favorably resolved in the client's favor.	23
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.C.3. a - d equals the total for 4.C.3.e. which must equal the total in Table 4. C.1.].***	30

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	47	0	0	1	6	0	0	4	1	14	1	12	0	8
b. Abuse/Neglect Investigations	19	5	1	4	4	1	1	0	0	3	0	0	0	0
c. Technical Assistance	13	0	0	0	3	0	0	0	0	8	0	2	0	0
d. Administrative Remedies	8	0	0	0	2	0	1	0	0	3	1	0	1	0
e. Negotiation/Mediation	34	2	0	1	1	7	0	12	2	4	3	0	0	2
f. Legal Remedies	2	0	0	0	0	0	0	2	0	0	0	0	0	0
Total	123	7	1	6	16	8	2	18	3	32	5	14	1	10

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.	30
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	30

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.	3
d. Total Number of deaths investigated [Sum of 4.E.2. a-c].	3

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.

dLCV reviewed each Critical Incident Report (CIR) and Adult Protective Services (APS) report involving death received from facilities operated by Department of Behavioral Health and Developmental Services (DBHDS). dLCV analyzed the reports for trends. dLCV opened three (3) investigations into a death at a state-operated mental health facility in FY 2014.

Case Example: dLCV received a CIR that a state-operated mental health facility sent Amber, a 37-year old individual who received services at a state-operated facility, to a medical center for suspected dehydration and headaches. However, Amber died several hours after admission. dLCV obtained the autopsy report that revealed details not evident in the CIR. Namely, Amber "was reportedly in ambulatory restraints for self-harming behavior when she became weak and was transported to the local ER. She coded in the ER and was unable to be resuscitated." The medical examiner determined that the cause of death was pulmonary embolism due to deep vein thrombosis. The autopsy report also described non-lethal multiple contusions involving the brain with an occipital subgaleal hemorrhage, for example. More tellingly, the autopsy report noted that the facility continuously used ambulatory and non-ambulatory restraints for twenty-six (26) straight days prior to Amber's death. dLCV obtained facility records and noted that the facility subjected Amber to frequent and extensive restraints for weeks at end. This investigation is ongoing.

Case Example: David, a 47-year old individual, unexpectedly became ill and unresponsive while receiving services at a state-operated mental health facility. He died at a medical center shortly thereafter. The facility's reporting of the incident was unclear and contradictory. dLCV investigated and found that neither abuse nor neglect caused David's death. An autopsy report showed that his death was natural and related to cardiac issues. However, dLCV did address the manner in which the facility reported the incident and set the stage for clearer reporting communication and practices by facility staff in the future.

Case Example: dLCV received a CIR that simply reported the death of Paul, an individual who received services in a geriatric unit at a state-operated mental health facility. However, an APS report described an incident prior to his death. One (1) staff member operated an overhead lift while moving Paul into a bed, but he fell out of the lift and sustained injuries. Paul died several days later at a medical center. APS substantiated neglect because the facility's policy required two (2) staff members to operate the lift. dLCV conducted an investigation and found troubling and pervasive quality of care issues. While it was not fully conclusive that the fall itself caused Paul's death, dLCV found that the facility's treatment towards Paul most likely contributed to his death. The facility failed to ensure that Paul received proper hygiene care, adequate bowl hygiene, hydration, prevention of skin breakdown, and adequate physical stimulation. Paul had no sensory stimulation. dLCV issued a letter of findings that identified deficiencies in safety, quality of care, programming, treatment, and record documentation. The facility agreed to draft a corrective action plan to address the ongoing issues and dismal culture in the geriatric unit. dLCV continues to monitor the implementation of this plan.

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	26	1216	1	0	1
2. Investigations (non-death related)	1	33	0	0	1
3. Facility Monitoring Services	11	2750	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	157153	1	0	0
7. Other	0	0	0	0	0
Total	39	161152	2	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

EXAMPLE: As detailed in Priority 2 on page nineteen of this report dLCV requested that DBHDS define a process to address inadequate discharge planning protocols for dually diagnosed individuals with mental illness and intellectual disabilities. DBHDS then substantially changed its protocols in response to our request and issued revised guidance for facilities and Community Services Boards (CSBs) to identify individuals with dual diagnoses early in the process in order to account for the full scope of needs. Also, the CSBs will ensure that both its Intellectual Disabilities and Mental Health professionals collaborate and be actively involved in the individuals' treatment and discharge. Lastly, using established and specific timelines, if there is a dispute between a facility and a CSB about an individual's discharge readiness, they will notify DBHDS Central Office to resolve the issue.

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)

dLCV opened thirty-three (33) investigations to ascertain the response of entities responsible for licensing, oversight, or investigation of instances of death, serious injury, or allegations of abuse or neglect of individuals with disabilities in institutional settings.

Case Example: During a monitoring visit to a state-operated facility, Finn reported to dLCV that a staff member assaulted him. Specifically, the staff member failed to inform Finn that he needed to take his medication. Instead, a staff member pushed Finn into his room and onto his bed, facedown. The staff member pulled down Finn's pants and forcibly injected medication into his buttocks. Finn also reported that the facility conducted an investigation and substantiated the abuse allegation. The facility fired the offending staff member. Per Finn's request, dLCV reviewed the findings and requested additional investigative materials to address several discrepancies on whether a second staff member witnessed the incident, but failed to report it. dLCV reviewed the materials and a videotape of the incident. Because of dLCV's investigation, Finn's safety improved and the facility administration reported that its staff is more readily reporting suspected abuse and neglect.

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

Through its one hundred and seven (107) monitoring visits at eight (8) adult state-operated mental health facilities in Virginia and monthly visits at Commonwealth Center for Children and Adolescents, dLCV informed individuals receiving services of their right to be free from abuse and neglect in various formats: formal and informal presentations and trainings, office hours, and 1:1 meetings with the individuals. dLCV also distributed information regarding human rights, self-advocacy forms, and other publications to support the individuals. dLCV assisted individuals in completing the human rights complaints as necessary. Often, dLCV opened individual cases for investigation, negotiation, and resolution for complaints of human rights violations.

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

As mentioned earlier in the report, dLCV responded to several proposals that would have negatively affected individuals to receive services in the community. Examples include our public report "Broken Promises", and our responses to the Joint Commission age of consent minor consent for involuntary inpatient psychiatric treatment and new DMAS requirements for mental health skill -building services.

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.	945

6.B. STATE MENTAL HEALTH PLANNING ACTIVITIES

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

In FY 2014, dLCV monitored the work of Virginia Behavioral Health Advisory Council and participated on the Council. 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 the utilization of funds which are derived 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.	7
6.C.1.b. Number of individuals receiving the information.	5249
6.C.2. Number of education/training activities undertaken.	23

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].	1995

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	1	1	1000	1	1	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	3	3	1091	1	1	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)	16	16	2460	1	1	0	0
g. Number of Website hits, include visits	71480	1	14615	1	1	0	0
h. Other media activities	1	1	140	0	0	0	0
Other Media Activities: Annual Report to the General Assembly							
Total	71501	22	19306	4	4	0	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.	2
7.F. The number of grievances appealed to the executive director.	0
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

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

Colleen Miller, Executive Director

dLCV Governing Board

CW Tillman
Stephen Dawe
Maureen Hollowell
Bryan Lacy
Kathryn Merritt
Karen Michalski-Karney
Michael Newcomb
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

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

N/A

7.L. Was client confidentiality protected?	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.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.

With direction from the dLCV Board, dLCV launched a detailed survey to obtain meaningful feedback for our goals and focus areas in FY 15. dLCV pursued several methods of distribution of the survey including sending it to our clients, posting the survey on our own website, posting it on the dLCV Facebook page and working with several other agencies to post to listservs, Twitter and website links including the Partnership for People with Disabilities, Virginia Board for People with Disabilities, Virginia Association of Consumers Asserting Leadership (VOCAL) and the Department of Aging and Rehabilitative Services (DARS). Staff also actively distributed the survey in client correspondence and during trainings and other outreach efforts.

From 5/9/14 through 7/15/14 dLCV received three-hundred fourteen (314) responses to our survey. The largest number of responses, thirty-four percent, came directly from individuals with disabilities. Twenty-six percent of the respondents were parents or guardians. The remaining groups represented included family members, teachers, mental health professionals and providers who accounted for the remaining forty percent of responses.

PAIMI related topics of importance to our respondents from the survey included: availability of government programs and services (fourteen percent), abuse and neglect in facilities (nine percent), abuse and neglect in jails and prisons (four percent) and guardianship and alternatives (four percent).

The dLCV Board adopted Goals and Focus Areas using this survey data and input from PAIMI Advisory Council and the dLCV's past year work experience. We then used the survey information and other information to create our work plan for FY 15.

dLCV also provides client satisfaction surveys in every close letter we send out to assess client satisfaction. We follow up with approximately ten (10) percent of clients we have served through interview callbacks where a neutral member of our staff unfamiliar with a client's case calls back the client we served and inquires about their overall satisfaction with the services we provided. dLCV is pleased to report a ninety-two percent satisfaction rate from the forty (40) client satisfaction surveys we received across all grants.

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

SECTION 8. OTHER SERVICES AND ACTIVITIES

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.

See 8.A.1.a.

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

The survey was available via web, telephone, language line, and in paper form. Alternate formats were available upon request. See 8.B.2 for additional details.

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

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 its
nine (9) state-operated mental health facilities
Local Human Rights Committees
State Human Rights Committee
Behavioral Health Advisory Council of Virginia (Mental Health Planning Council)
National Alliance on Mental Illness – 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
Partnership for People with Disabilities Advisory Council
Virginia Board for People with Disabilities
Mental Health America of Virginia
University of Virginia's Institute for Law, Psychiatry and Public Policy

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].

A portion of dLCV PAIMI training and outreach was also provided via 'Office Hours', a diverse program we operate to provide outreach to individuals with disabilities facing PAIMI and other advocacy issues throughout the state's Centers for Independent Living (CILs). dLCV reached out to all fifteen CILs in the first quarter and fostered relationships with eight locations to provide further outreach services.

dLCV then provided "Who is dLCV" presentations to these CILs to educate them about our agency in its first year of operation. The sites included: Winchester, Harrisonburg, Norfolk, Richmond, Roanoke, Lynchburg, Fredericksburg and Manassas locations. dLCV then started regular visits to the CILs for presentations and to provide 'Office Hours'. Office Hours is a program where a dLCV advocate or attorney goes on a regular basis to meet with CIL consumers or staff to discuss disability advocacy issues including PAIMI related topics that dLCV might be able to assist with. The dLCV staff person will do an intake if appropriate while there visiting with the person. dLCV conducted nineteen (19) total CIL visits during this fiscal year where one-hundred fifty (150) individuals were participants in a variety of presentation topics.

dLCV participated as a guest on a disability advocacy awareness public television program organized by a community advocate in Charlottesville Virginia that was aired on Charlottesville Public Access Television.

dLCV also provides outreach and training, exhibits and materials for fairs, conferences, and meetings on request. Whenever a presentation is conducted about dLCV in general, it addresses some of the work we do related to PAIMI issues.

dLCV uses "The Directors' Blog" on our website (www.dlcv.org) to alert the public about our activities, as well as news and developments in disability law and to obtain feedback about our work.

dLCV frequently uses our Facebook page to post articles on disability advocacy issues and inform the public about our work as well.

dLCV conducted outreach and training related to PAIMI work in conjunction with other funding streams. This is more logical to our constituents and more practical for dLCV.

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.).

dLCV continues to invest 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.

In FY 2014, dLCV invested considerable resources in exercising access authority to all Department of Juvenile Justice facilities in Virginia. dLCV advocates sent a packet of information to the facilities that included a letter introducing dLCV as Virginia's new P&A and explaining our access authority, dLCV posters, brochures, and cards. dLCV worked with the facility directors, DJJ Central Office, and an Assistant Attorney General to seek access to the DJJ facilities for the purposes of monitoring, outreach, rights training, and direct client services to residents held there. dLCV argued successfully for access despite several demands from DJJ for background checks of dLCV staff. dLCV staff now has access to DJJ facilities to provide monitoring, training and direct client services.

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).

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

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.

dLCV aggressively took many positive steps to improve the lives of Virginians with disabilities in FY 2014. Our "Broken Promises " report found at http://dlcv.org/mental-health-system-failures-cited/ was paramount to mental health reform legislation and helped policy makers understand the need for greater community based services especially for those awaiting discharge.

Another positive accomplishment was individual and systemic relief for addressing the usage of restraints and seclusion across many settings: state-operated mental health facilities, psychiatric residential treatment facilities, group homes, juvenile justice facilities, and nursing facilities.

We investigated several treatment plans that relied heavily on prolonged use of restraint, particularly the emergency restraint chairs (ERC). In one case, we were able to end the use of the ERC, which was particularly important given the individual's prior history of deep vein thrombosis and trauma.

dLCV staff exceeded the monitoring goals for Department of Behavioral Health and Developmental Services (DBHDS) operated facilities. We conducted 107 visits at mental health facilities, 58 visits at training centers, and 5 visits to Hiram Davis Medical Center (HDMC).

Falls were a major issue in mental health facilities as well. dLCV staff identified this trend and met with a facility Director to address our concerns. This resulted in the modification of the facility's falls protocol and use of a new fall risk assessment tool.

dLCV also worked on individual abuse and neglect cases. One facility developed a corrective action plan to improve care to the residents of their nursing unit as a result of our investigation.

dLCV sent an introduction letter explaining our access authority, along with dLCV posters, brochures, and cards, to all Department of Juvenile Justice (DJJ) facilities in Virginia. dLCV worked with the facility directors, staff at DJJ Central Office as well as an Assistant Attorney General to gain access to the DJJ facilities for the purposes of monitoring and providing information and assistance to the residents held there.

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]

dLCV appreciates SAMHSA's site visit during FY 14 and the technical assistance and guidance provided to allow our agency to provide quality advocacy services.

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	$32,000.00	31.00 %	$9,920.00
Staff Attorney	$69,500.00	37.00 %	$25,715.00
Staff Attorney	$85,337.00	15.00 %	$12,801.00
Operations Assistant	$35,000.00	30.00 %	$10,500.00
Deputy Director	$97,000.00	30.00 %	$29,100.00
Disability Rights Advocate	$47,000.00	75.00 %	$35,250.00
Administrative Assistant	$40,000.00	30.00 %	$12,000.00
Disability Rights Advocate	$50,000.00	75.00 %	$35,250.00
Disability Rights Advocate	$46,500.00	54.00 %	$25,110.00
Disability Rights Advocate	$68,733.00	45.00 %	$30,930.00
Financial Assistant	$36,000.00	30.00 %	$10,800.00
Disability Rights Advocate	$42,000.00	40.00 %	$16,800.00
Disability Rights Advocate	$44,000.00	7.00 %	$3,080.00
Staff Attorney	$58,875.00	18.00 %	$10,598.00
Deputy Director	$58,000.00	25.00 %	$14,500.00
Receptionist	$15,000.00	30.00 %	$4,500.00
Deputy Director	$63,750.00	30.00 %	$19,125.00
Disability Rights Advocate	$12,600.00	25.00 %	$3,150.00
Data/Incident Analyst	$46,000.00	40.00 %	$18,400.00
Staff Attorney	$69,500.00	80.00 %	$55,600.00
Staff Attorney	$58,875.00	1.00 %	$589.00
Disability Rights Advocate	$49,500.00	10.00 %	$4,950.00
Disability Rights Advocate	$11,000.00	50.00 %	$5,500.00
Intake Specialist	$10,500.00	20.00 %	$2,100.00
Staff Attorney	$48,000.00	30.00 %	$14,400.00
Intake Specialist	$10,500.00	20.00 %	$2,100.00
Disability Rights Advocate	$46,000.00	14.00 %	$6,440.00
Administrative Assistant	$20,026.00	28.00 %	$5,607.00
Law Interns	$2,640.00	6.00 %	$158.00

Law Interns	$2,640.00	14.00 %	$370.00
Subtotal	$1,411,441.00		$465,833.00
Total Positions	$1,411,441.00		$465,833.00

9.B. CATEGORIES	COST
Fringe Benefits (PAIMI Only)	$64,822.00
Travel Expenses (PAIMI Only)	$18,227.00
Subtotal	$83,049.00

9.C. EQUIPMENT - TYPE (PAIMI ONLY)	COST
IT Equipment	$17,648.00
Subtotal	$17,648.00

9.D. SUPPLIES - TYPE (PAIMI ONLY)	COST
Office Supplies/Forms	$1,770.00
Subtotal	$1,770.00

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 / Copying Companies	printing services	$0.00	$0.00	$0.00	$500.00
Private Vendor	Equipment rental, copier, postage machine	$0.00	$0.00	$0.00	$2,222.00
Various Media	Advertisements, Recruitment, PR	$0.00	$0.00	$0.00	$233.00
Catering Services	Food for Board, Council, Staff Meetings	$0.00	$0.00	$0.00	$1,247.00
Private Contractor	Accommodations-interpreter, CART, temporary workforce	$0.00	$0.00	$0.00	$10,500.00
Service Provider	Telecommunication Services	$0.00	$0.00	$0.00	$2,622.00
Professional Organizations	Memberships, Subscriptions	$0.00	$0.00	$0.00	$6,673.00
Property Management	Office Space	$0.00	$0.00	$0.00	$24,555.00
Subtotal		$0.00	$0.00	$0.00	$48,552.00

9.F. TRAINING COSTS FOR PAIMI PROGRAM ONLY						
	TRAVEL		TRAINING		OTHER EXPENSES	
CATEGORIES	# OF PERSONS	COST	# OF PERSONS	COST	# OF PERSONS	COST
Staff	16	$1,012.00	16	$800.00	0	$0.00
Governing Board	11	$2,194.00	11	$128.00	0	$0.00
PAC Members	12	$1,463.00	12	$439.00	0	$0.00
Volunteers	0	$0.00	0	$0.00	0	$0.00
Subtotal	39	$4,669.00	39	$1,367.00	0	$0.00

9.G. OTHER EXPENSES (PAIMI PROGRAM ONLY)	COST
Professional Insurance	$1,536.00
Subtotal	$1,536.00

9.H. INDIRECT COSTS (PAIMI ONLY)	COST
1. Does your P&A have an approved Federal indirect cost rate?	No
a. If Yes, what is the approved rate?	N/A
2. Total of all PAIMI Program costs listed in 9.A. - 9.G.	$624,424.00
3. Income Sources and Other Resources (PAIMI Program Only)	$1,628,905.00
4. PAIMI Program carryover of grant funds identified by FY.	
FY 13	$479,137.00
5. Interest on Lawyers Trust Accounts (IOLTA).	$0.00
6. Program income (PAIMI only).	$16,551.00
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.	$2,124,593.00