OMB Approval: 0930-0169

Expiration Date: 7/30/2020

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

Annual Program Performance Report (PPR)

Substance Abuse Mental Health Services Administration (SAMHSA)
U.S. Department of Health and Human Services

Section A: General Program Information for FY18

1. **P&A Identification**

Name of state/jurisdiction	Virginia
Name of P&A system	disAbility Law Center of Virginia

2. **Main Office**

Mailing address of main office	1512 Willow Lawn Drive, Suite 100 Richmond, Virginia 23230
Phone number of main office	804-225-2042
Toll free Phone Number	800-552-3962
e-mail address	info@dlcv.org
website address	www.dlcv.org
TTY phone number	800-552-3962
County or Main Office	Henrico, Va

3. **Satellite Offices (**if any - add rows, if needed**)**

Mailing address (each satellite office)	N/A
County of each satellite office (location)	N/A

4. **Executive Director/Chief Executive Officer Contact Information**

Name	Colleen Miller
Address	1512 Willow Lawn Drive, Suite 100 Richmond, Virginia 23230
Phone number & extension	804-225-2042
e-mail address	Colleen.Miller@dlcv.org

5. **PPR Preparer Contact Information**

Name	Robert Gray
Title	Director for Compliance and QA
Phone number & extension	804-225-2042
e-mail address	Robert.Gray@dlcv.org

6. **Governing Board President/Chair**

Name	Angela Thanyachareon

Mailing address	1512 Willow Lawn Drive, Suite 100 Richmond, Virginia 23230
County of residence	Henrico
e-mail address	info@dlcv.org
Current term started	October 2015
Current term expires	October 2017

7. **PAIMI Advisory Council President/Chair Name**

Name	Jacqueline Eubanks
Mailing address	1512 Willow Lawn Drive, Suite 100 Richmond, Virginia 23230
County of residence	Henrico
e-mail address	info@dlcv.org
Current term started	January 2017
Current term expires	January 2019

8. **Name of P&A Chief Financial Officer/Accountant**

Name	LaToya Blizzard
Title	Director of Operations
Phone	804-225-2042
e-mail address	Latoya.blizzard@dlcv.org

9. **Governor's Liaison**

Name	Secretary William Hazel
Official title	Secretary, Health and Human Resources
Mailing address	Patrick Henry Building 1111 East Broad Street Richmond, VA 23219
Phone number	804-786-7765
e-mail address	HealthAndHumanResources@governor.virginia.gov

10. **Commissioner/Director of the State Mental Health Agency**

Name	Jack Barber, Interim Commissioner
Mailing address	DBHDS P.O. Box 1797 Richmond, VA 23218-1797
Phone number	804-786-3921
e-mail address	maria.reppas@dbhds.virginia.gov

11. **Demographic Composition of PAIMI Governing Board, Advisory Council, and Program Staff**

		Governing Board	Advisory Counsel	Program Staff
Ethnicity	Hispanic/Latino		**1**	
	Non-Hispanic/Latino	**11**	**13**	**28**
Race	American Indian/ Alaskan/Native		**1**	
	Black/African American	**2**	**1**	**5**
	White	**9**	**11**	**21**
	Two or more races		**1**	**2**
Sex	Female	**5**	**10**	**19**
	Male	**6**	**4**	**9**

12. **Governing Board (GB) Type and Number of Members**

Governing board	Minimum number of members	Maximum number of members
Private, non-profit with multi-member	11	15
State-operated with governing board	X	X
State-operated with no governing board	X	X

13. **Governing Board Information**

Total seats available	15
Total members serving as of 9/30/17	11
Total vacancies on 9/30/17	1
Term of appointment (number of years)	4
Term maximum	2
Meeting frequency	quarterly
Number of meetings held this fiscal year (FY)	7
Percentage of members present at meetings during the FY	80%

14. **Governing Board Composition**

Number of individuals with mental illness who are recipients/former recipients (R/FR) of mental health services or have been eligible for services.	**5**
Number of family members of individuals with mental illness who are R/FR of mental health services.	**5**
Number of guardians.	
Number of advocates or authorized representatives.	**1**
Number of other persons who broadly represent or are knowledgeable about the needs of the clients served by the P&A system.	
Total	**11**

15. **Executive Director (ED)**

Initial Appointment Date	12/01/2013 (MM/DD/YYYY)	
Recent performance evaluation completed	1/30/2017 (MM/DD/YYYY)	
Date of previous performance evaluation	1/30/2016 (MM/DD/YYYY)	
Agency has written policy and procedures to guide the ED's evaluation process?	☒ Yes	☐No
List documents and exact sections, page, where this information may be found.	**See attached**	
Input on ED's performance evaluation obtained from the following **(**check all that apply**)**		
All agency employees/staff	☐Yes	☐No
Senior managers	☐Yes	☐No
All board directors	☐Yes	☐No
All PAIMI Advisory Council members	☐Yes	☐No
Stakeholders	☐Yes	☐No
Consumers	☐Yes	☐No
Family members of consumers	☐Yes	☐No
State mental health providers	☐Yes	☐No
Private mental health providers	☐Yes	☐No

Other	XYes	☐No

16. **PAIMI Advisory Council (PAC)**

PAC Chair		
Sits on the governing board	X Yes	☐No
Appointment date	**January 1, 2017** MM/DD/YYYY	
Other PAC member(s) sit on governing board	☐Yes	X No
If yes, number serving **0**	**12**	

17. **Staff assigned to the PAIMI Program**

	Number of Attorneys	Full-time	Part-time	Male	Female	Number of Advocates	Full-time	Part-time	Male	Female
Ethnicity										
Hispanic/Latino (of any race)										
Non-Hispanic/ Latino	**8**	**8**		**4**	**4**	**11**	**11**			**11**
Race										
American Indian/ Alaskan Native										
Asian										
Black/African American						**2**	**2**			**2**
Native Hawaiian/ Pacific Islander										
White	**8**	**8**		**4**	**4**	**9**	**9**			**9**

Two or more races										
Unknown										

Section B: Demographics

1. **Age of PAIMI-eligible Individuals Served**

Age	Number
0 - 4	0
5 - 12	1
13 - 18	11
19 - 25	21
26 - 64	77
65^{+}	22
Total	132

2. **Sex of PAIMI-eligible Individuals Served**

Sex	Number
Female	68
Male	64
Unknown/would not disclose	
Total	132

3. **Ethnicity and Race of Individuals Served**

Ethnicity	Number	PAIMI%	State%
Hispanic/Latino (of any race)	2	1.3%	9.1%
Non-Hispanic/Latino	130	98.7%	90.9%
Ethnicity unknown	0	0%	N/A

Total	132	

Race	Number	PAIMI%	State%
American Indian/Alaskan Native	1	0.6%	0.5%
Asian	3	2.2%	6.6%
Black/African American	41	31%	19.8%
Native Hawaiian/Pacific Islander	0	0%	0.1%
White	84	64%	70%
Two or more races	3	2.2%	2.9%
Race unknown	0	0%	N/A
Total	132		

4. **PAIMI-eligible Individuals Served with PAIMI Program Funds**

What to Count	Number
1. Number of PAIMI-eligible individuals served with PAIMI program funds, includes any program income resulting from legal actions supported by PAIMI program funds as of October 1 (only cases carried over from previous FY).	23
2. Number of new PAIMI-eligible individuals served during the FY.	109
3. Total number of PAIMI-eligible individuals served during this FY (add lines 4.1 and 4.2).	132
4. Total number of PAIMI-eligible individuals who requested program related advocacy services ,but were **not** served within 30-days of initial contact because of:	
1. insufficient PAIMI program resources	
2. non-priority areas.	

5. Individuals served as of September 30 (carry over to next FY; This should equal ≤ item 3 above).	12

5. **Living Arrangements of PAIMI-eligible Individuals at Intake**

Living Arrangement	Number
Community residential home for children/youth up to age 18 yrs.	
Community residential home for adults	1
Non-medical community-based residential facility for children/youth	
Foster care	
Nursing homes, including skilled nursing facilities	1
Intermediate care facilities	
Public general hospitals including emergency rooms	
Private general hospitals including emergency rooms	
Public institution	109
Private institution	6
Psychiatric hospitals (public/private)	
a. public/state b. private X	3
Jails	
a. municipal/city X b. county c. other	9
State prison	
Federal detention center	
Federal prison	
Veterans administration hospital	
Other federal facility	
Homeless	
Independent (in the community & PAIMI-eligible)	
a. within 90-days post-discharge from a facility	

b. after 90-days of discharge	
Parental or other family home & PAIMI-eligible	3
a. within 90-days post-discharge	3
b. after 90-days of discharge	
Unknown	
Total	**132**

Section C: Complaints/Problems of PAIMI-eligible Individuals

1. **Areas of Alleged Abuse**

Number of complaints/problems **(Make every effort to report within the following categories)**	Number from *Closed Cases* only	Outcomes			
	Total	A	B	C	D
a. Inappropriate or excessive medication	1			1	
b. Inappropriate or excessive					
1. Physical restraint	7	1	1	5	
2. Chemical restraint					
3. Mechanical restraint	6			6	
4. Seclusion					
c. Involuntary medication	1			1	
d. Involuntary electrical convulsive therapy					
e. Involuntary aversive behavioral therapy					
f. Involuntary sterilization					
g. Failure to provide appropriate mental health treatment	15			15	
h. Failure to provide needed medical treatment	1			1	
i. Physical assault					
1. Serious injuries related to the use of seclusion and restraint.	2		1	1	
2. Serious injuries **not** related to seclusion and restraint.					
a. Patient on patient	2	1		1	

b. Staff/caretaker	2	1		1	
c. Facility resident					
j. Sexual assault					
a. Staff/caretaker					
b. Patient/facility resident	5			5	
k. Threats of retaliation or verbal abuse by facility staff	3		1	2	
l. Coercion	7	1	1	5	
m. Financial exploitation					
n. Suspicious death	3			3	
o. Other - Specify type of complaint (describe on a separate sheet) - [This number should be ≤1 percent of abuse complaints total].					
Total	55	4	4	47	

*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)).

2. **Abuse Complaints Disposition**

For total closed cases listed in Table C.1., provide the number of abuse complaints/problems for each disposition category.	
Total number of abuse complaints/problem addressed from closed cases.	55
a. Number of complaints/problems determined after investigation not to have merit.	4
b. Number complaints/problems withdrawn or terminated by client.	4
c. Number of complaints/problems resolved in the client's favor.	47
d. Number of complaints/problems not resolved in the client's favor.	

3. **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	3		1	2		
b. Transportation to/from residential care or treatment facility						
c. Discharge planning or release from a residential care or treatment facility	34	1		33		
d. Mental health diagnostic or other evaluation (does not include treatment)	2			2		
e. Medical (non-mental health related) diagnostic or physical examination	6	1		3	2	
f. Inadequate care (e.g., personal hygiene, clothing, food, shelter)	3			3		
g. Physical plant or environmental safety	1			1		
h. Personal safety issues (unsecured access to facility, resident rooms, patient to patient abuse)	12			10	2	
i. Other [Describe and make every effort to report within the above categories].						
Total	61	2	1	54	4	

4. **Neglect Complaints Disposition**

For total closed cases listed in Table C.3., provide the numbers of neglect complaints or problem areas for each disposition category.	
Total number of Neglect complaints/problem addressed from closed cases.	61
a. Number of complaints/problems determined after investigation not to have merit.	2
b. Number complaints/problems withdrawn or terminated by the client.	1

c. Number of complaints/problems resolved in the client's favor.	54
d. Number of complaints/problems not resolved in the client's favor.	4
e. Other indicators of success or outcomes that resulted from P&A involvement.	

5. **Areas of Alleged Rights Violations**

Number of Complaints/Problems	Number from Closed Cases only	Outcomes			
		A	B	C	D
	Total				
a. Right to an individualized, written treatment or service plan.					
b. A written discharge plan, including a description of mental health services needed upon discharge from such program or facility					
c. The right to ongoing participation, appropriate to such person's capabilities, in the planning of mental health services (including the right to participate in the development and periodic revision of the plan).					
d. Denial of financial benefits/entitlements (e.g., SSI, SSDI, Insurance).	3			3	
e. Guardianship/conservator problems	3			3	
f. Denial of rights protection information or legal assistance	1			1	
g. Denial of privacy rights (e.g., congregation, telephone calls, receiving mail)					
h. Denial of recreational opportunities (e.g., grounds access, television, and smoking)	2			2	
i. Denial of visitors					
j. Denial of access to or correction of records	1			1	
k. Breach of confidentiality of records (e.g., failure to obtain consent before disclosure)					
l. Failure to obtain informed consent	1			1	
m. Advance directives issues	1			1	
n. Denial of parental/family rights					

o. Other [Please, make every effort to report within the above categories].					
Total	12			12	

6. **Rights Violations Disposition**

For closed cases listed in this Table, provide the number of rights complaints or problem areas for each disposition category.	
Total number of rights violation complaints/problems addressed from closed cases.	12
a. Number of complaints/problems determined after investigation not to have merit.	
b. Number complaints/problems withdrawn or terminated by client.	
c. Number of complaints/problems resolved in the client's favor.	12
d. Number of complaints/problems not resolved in the client's favor.	

7. **Reasons for Closing Individual Advocacy Case File**

	Number
Number of closed cases, which client's objective was partially or fully met	113
Other representation found	
Individual withdrew complaint	6
Services were not needed due to client's death or relocation	
P&A withdrew because individual or client would not cooperate	
Individual's case lacked merit	6
Individual's issue not favorably resolved	4
Appeal(s) unsuccessful	
Total	129

8. **Intervention Strategies**

		Outcomes												
		Abuse				Neglect					Rights Violations			
Strategy	**Total**	A	B	C	D	A	B	C	D	E	A	B	C	D
1. STA	54	4	2	13		1		20	4				10	
2. A/NI	46		2	24			1	19						
3. TA	2							2						
4. AR	5			2				3						
5. N/M	21			8		1		10					2	
6. LR														
Total		4	4	47		2	1	54	4				12	

1. STA - Short-term assistance
2. A/NI - Abuse/neglect investigations
3. TA - Technical assistance
4. AR - Administrative remedies
5. N/M - Negotiation/mediation
6. L/R - Legal remedies

9. **Death Investigation Activities**

9.1). The number of deaths reported to the P&A for investigation by the following entities:	
a. The state.	55
b. The Center for Medicaid & Medicare Services (Regional Offices).	
c. Other Sources. Briefly list the source for each death reported in this category, (e.g., newspaper, concerned citizen, relative, etc.). 10 calls and monitoring	
Total	65

If the information requested in this section was not available please explain.

9.2). All death investigations conducted involving PAIMI-eligible individuals related to the following:	
a. Number of deaths investigated involving incidents of seclusion (S).	
b. Number of death investigated involving incidents of restraint (R).	2
c. Number of deaths investigated **not** related to incidents of S & R, (e.g., suicides).	63
d. Total Number of deaths investigated [Sum of B.9.2. a-c].	65

9.3). If you reported deaths in categories B.9.2.a., B.9.2.b., or B.9.2.c., please provide the following information on one 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.

Under state law, Code of Virginia §37.2-709, directors of state mental health facilities are required to report critical incidents or deaths to the P&A within 48 hours. This initial report is followed by a more detailed report within14 days. The majority of deaths appeared to be anticipated deaths due to diagnosed and treated health conditions. We requested autopsy reports of those which raised particular concern. During this fiscal year, we focused on ensuring that the state mental health facilities complied with departmental instructions and best practice standards in conducting their internal investigations.

One death that raised immediate concern was that of a young man who died suddenly at one of our state mental health facilities. This was not an anticipated death. Although the autopsy report listed the manner of death as "natural," he was in crisis for 20 minutes prior to death with no staff response. In reviewing the facility investigation, we found that staff had falsified logs to make it appear that they had made the required 15 minute checks in the hours prior to the individual's death. 3 staff were fired. We found several systemic issues as well: the facility delayed initiating the investigation and failed to notify law enforcement. We raised concerns about both issues with both key facility staff and with the DBHDS Office of Human Rights which oversees the investigative process.

10**. Intervention on behalf of groups of PAIMI-eligible Individuals**

Multiple counts not permitted for lines 1 – 3 and 6.

What to Count	Number
1. Group cases/projects still open at October 1 (carried over from prior FY(s)).	11
2. New group cases/projects opened during the year.	49
3. Total group cases/projects worked on during the year (add items1 and 2 above).	60
4. Total group cases/projects as of September 30 (carry over to next FY).	3
5. Group cases/projects targeted at serving the following special populations:	
a. ethnic	0
b. racial minorities	0
c. homeless	0
d. veteran's	0
e. urban	0
f. rural/frontier	1
g. elderly/geriatric	5
6. Total number of individuals impacted by line 3.	89,485

11. **Interventions on behalf of groups of PAIMI-eligible Individuals**

5. E. Intervention Types	Potential number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	On-going
Group Advocacy non-litigation	40,700	x		x

Investigations *(non-death related)*	206	x		x
Facility Monitoring Services	2,938	x		x
Court Ordered Monitoring	n/a			
Class Litigation	586	x		
Legislative & Regulatory Advocacy	2,878			x
Other – systemic advocacy	45,187	x		x
Total	92,803	N/A	N/A	N/A

Section D. Non-Client Directed Advocacy Activities

1. **Individual Information and Referral (I&R)**.

Provide the number of PAIMI Program I&R services.	
Total	474

2. **State Mental Health Planning Activities**

dLCV monitored the work of Virginia Behavioral Health Advisory 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.

3. **Education, Public Awareness Activities, and Events**

List the number of public awareness activities or events **and** the number of individuals who received the information [Refer to Glossary].	
1. Number of public awareness activities or events.	14
2. Number of education/training activities undertaken.	30
3. Number (approximate) of persons trained in 2.	2,698

Section E. Grievance Procedures [42 CFR Section 51.25]

1. Do you have a systemic/program assurance grievance policy, as mandated by 42 CFR 51.25(a) (2)?	X Yes ☐ No (If no, please indicate the date that the developed policy is anticipated. __/__/____

2. The number of grievances filed by PAIMI-eligible clients, including representatives or family members of such individuals receiving services during this fiscal year.	
Total	0

3. 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.	
Total [42 CFR Section 1.25(a)(1),(2)]	0

4. The number of grievances appealed to:	
4.a. The governing authority/board	0
4.b. The Executive Director	0
Total 4.a. & 4.b.	0

5. The number of reports sent to the governing board **and** the advisory board.	
Total	1

6. Please identify all individuals (name & title), responsible for grievance reviews.

Name & title	Colleen Miller, Executive Director Angela Thanyachareon, President, Governing Board Appeals Committee Stephen Dawe, Vice President, Governing Board Appeals Committee Jacqueline Eubanks, PAIMI Council Chair Ex Officio, Governing Board Appeals Committee Michael Toobin, Treasurer, Governing Board Appeals Committee Harry Gewanter, Secretary, Governing Board Appeals Committee CW Tillman, Governing Board Appeals Committee Maureen Hollowell, Governing Board Appeals Committee Carrie Knopf, Governing Board Appeals Committee Jefferson Harding, Governing Board Appeals Committee Thomas Walk, Governing Board Appeals Committee Donna L. Gilles, Ed.D, Governing Board Appeals Committee

7. 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?

Number of days	15

8. Were written responses sent to each grievant? ☒Yes ☐No (if no, explain below).

9. Was client confidentiality protected? ☒Yes ☐No (if no, explain below)

Section F. Other Services and Activities

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

a. ☒Yes, (briefly describe how the notice is used to reach persons with mental illness and their families).

b. ☐No, (if no, briefly explain, limit to 500 characters).

dLCV offered two public input surveys during the spring and summer of this fiscal year. The first survey allowed our 218 respondents the opportunity to express which disability advocacy issues they feel are most important. The top three categories chosen: quality mental health care, community access and barrier free environment and Government Benefits. 42% of our respondents were individuals with disabilities, which is an increase of over 10% from last fiscal year. We distributed our survey during our facility monitoring, casework, training, and outreach, reaching a broad spectrum of PAIMI eligible individuals. Agencies and groups we reached also included: the Virginia Board for People with Disabilities, Partnership for People with Disabilities, Department for Behavioral Health and Developmental Services (DBHDS), three business network groups, and dLCV volunteers. dLCV used this information to develop our FY 18 goals and focus areas.

The second systemic input survey allowed dLCV to receive targeted input from established disability advocacy agencies who reviewed our dLCV Board adopted FY 18 goals and focus area. Agencies contributing to this effort include Mental Health America of Virginia, Virginia Spinal Association, Formed Families Forward, National Alliance on Mental Illness- Central Virginia, VOCAL, DBHDS Office of Recovery Services, Richmond Behavioral Health Authority, Virginia Department for the Deaf and Hard of Hearing, Arc of Northern Virginia, Parents of Autistic Children-Northern Va. Chapter, Brain Injury Association of Virginia. dLCV reviewed these suggestions and those of our PAIMI Advisory Council (PAC) and incorporated them into our FY 17 work plan. dLCV consults with the PAC about target populations, intervention strategies, and community linkages and resources. dLCV appreciates the PAC being an informed and diligent resource.

2. Were the notices provided to the following persons?		
a. Individuals with mental illness in residential facilities?	☒Yes	☐No
b. Family members and representatives of such individuals?	☒Yes	☐No
c. Other Individuals with disabilities?	☒Yes	☐No
d. Brief explanation is required for each **no** answer in 2.a., b., or c.		

N/A

3. Do the procedures provide for receipt of the comments in writing or in person?	XYes	☐No
3.a. If **yes** to 3, attach a copy of the agency's policies/procedures pertaining to public comment. Process explained in F.1.		
3.b. If **no** to 2a, b, c., explain why the agency does not have such procedures in place.		

4. Was the public provided an opportunity for public comment?	XYes	☐No

5. If you answered **yes** to 4, briefly describe the activities used to obtain public comment.
See F.1.

6. What formats and languages (as applicable) were used in materials to solicit public comments?
The survey was available via web, telephone, language line, and in paper form. Alternate formats were available upon request.

7. If you answered **no** to 4, briefly explain why the public was not provided an opportunity to comment.

N/A

8. List Groups (e.g., states, consumer advocacy, service providers, professional organizations and others, including groups of current and former mental health consumers or family members of such individuals) with whom the PAIMI program coordinated systems, activities and mechanisms [PAIMI Act 42 U.S.C. 10824 (a) (D)].

Department of Behavioral Health and Developmental Services' Central Office and its nine state-operated mental health facilities and one nursing facility
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
U.S. Department of Justice
Department of Juvenile Justice
Virginia Commission on Youth
VOICES for Virginia's Children
Law Enforcement
Child Protective Services
REACH- 5 Regional Programs
Office of the Attorney General
Office of Licensure, DBHDS
Office of Human Rights, DBHDS
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
Local Department of Social Services, APS Divisions
Department of Social Services, Licensing

9. Briefly describe the outreach efforts/activities used to increase the numbers of ethnic and racial minority clients served or educated about the PAIMI program, [this information will be evaluated by using the demographic/state profile information contained in the PAIMI Application for the same FY].

dLCV carefully reviewed demographic data including race and ethnicity at the end of FY 17 while creating our objectives for FY 18. We identified needs in the Hispanic community and in the elder population and targeted these groups to concentrate a portion of our FY 18 objectives.

Our agency holds multiple open house events to the public to introduce the community to our agency and mission. We meet regularly with members of the business community as well. We have diverse guests who had little or no prior knowledge of the dLCV and invite our clients to come and tell their stories.

dLCV continuously recruits volunteers from all across the state to connect with local communities to provide targeted outreach.

dLCV also provides training, exhibits, and materials for fairs, conferences, and meetings on request. Whenever dLCV provides presentations, we address some of the work we do related to PAIMI issues.

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

10. Did the activities described in 9; result in an increase of ethnic or minorities in the following categories?		
a. Staff	☒Yes	☐No
b. Advisory Council	☒Yes	☐No
c. Governing Board	☒Yes	☐No
d. Clients	☒Yes	☐No

If you answer **no** to any item (10.a-d), please provide a brief explanation, such as 10.a., b., or c. – no vacancies.

11. External Impediments

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 encountered one delay in receipt of records from a private psychiatric provider. After a second request from our senior attorney, the provider relinquished the records we requested.

12. 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, particularly those living in the community, across the state.

13. Accomplishments

For this fiscal year, briefly describe the most important accomplishment(s) that resulted from PAIMI program activities. Provide copies of supporting documents, (e.g., case law, news article, legislation, etc.).

In FY 17, dLCV focused on forcing substantial improvement in the DBHDS management and investigation of complaints of abuse and neglect. We reviewed 50 investigation reports, 31 from DBHDS mental health facilities. At the end of the year, we shared our initial findings with the DBHDS Office of Human Rights. We identified four primary issues with facility compliance with the DBHDS Departmental Instruction 201, which governs conduct of abuse and neglect investigations. Those issues are: 1) failure to initiate an investigation, 2) lack of appropriate notifications, 3) poor or no investigative questions and 4) biased interviewing practices. We also found that the existing DI 201 required a significant overhaul in order to comply with changes in the DBHDS internal structure and current human rights regulations. Throughout the year, we met with the Director of the Office of Human Rights to advise her of current and ongoing concerns and to collaborate on systemic remedies. The "new" DI 201 is under final review at this time thanks to dLCV's advocacy.

We also addressed deficiencies in protection from harm directly with facility directors. For example, dLCV met with ESH administration regarding our concerns with their investigations. During the meeting, ESH agreed to "treat all allegations of abuse and neglect made by dLCV as formal abuse/neglect allegations." Since that date, ESH has investigated all allegations made by our agency, compared to their previous 44% response rate.

We addressed the importance of timely and complete, unbiased investigations within the DBHDS, cross-referencing those reports of injury and death received from the DBHDS with reports of allegations of abuse and neglect (Adult Protective Services – APS) provided by the local Departments of Social Services. We continued to expand our review and trending of APS reports. We are just seeing the initial fruits of our newly acquired access to the DBHDS system for reporting serious incidents and deaths by DBHDS licensed providers, but anticipate that this will greatly increase identification of indicators of abuse and neglect outside state hospitals in FY 18.

In addition to these efforts, we provide systemic advocacy via casework including the following stories:

In an adult facility, a resident alleged assault by state hospital staff. dLCV reviewed the investigation report and found that the two staff who witnessed the assault had not complied with abuse/neglect reporting requirements. In addition, the hospital director failed to comply with legal requirements that required her to report the matter to local law enforcement. Ultimately, the hospital took action against the assaulting staff person but only against one of the two who intentionally failed to report the incident. As a result of our follow-up, the facility undertook a multi-faceted action plan designed to ensure that all staff understood their duty to report and of the potential consequences for failing to do so.

dLCV successfully advocated for Elise, a resident turning eighteen and living in a Psychiatric Residential Treatment Facility (PRTF) in Tidewater, to transition into the community closer to her family and into a group home of her choice to promote independence and client choice. dLCV was contacted by Elise's adoptive mother prior to her eighteenth birthday due threats from the DSS to cut funding, drop Elise from their case list, and render her homeless due to an inability to fund the PRTF stay. Additionally, the PRTF told Elise that she must reach a sixth-grade education level to work. dLCV worked tirelessly to hold all parties of Elise's team accountable to ensure her legal rights, including assessment and enrollment in transition and discharge services and linkage to the Department of Aging and Rehabilitation. Elise chose her own group home, listing her top choices as a place with a pool, a gym, and access to both females and males her age. Elise is working toward a career with animals and sees her adoptive family much more frequently.

During a routine monitoring visit to one of Virginia's Department of Juvenile Justice (DJJ) Juvenile Correction Centers (JCCs), dLCV met Brian, a young man abruptly taken off his medications for his mental health needs. When dLCV investigated, we found that Brian's meds were ceased as the psychiatrist had no record of the previous medications and was unconcerned about how this may impact Brian's functioning, remarking that he was "doing fine." Working with Brian and his family, dLCV educated JCC administrative staff on their responsibilities to residents concerning medication management. Brian is now seeing the JCC psychiatrist monthly for medication management. At the client closure meeting, Brian remarked his thanks to dLCV and stated, "All it took was one call from you."

14. Recommendations

Please provide recommendations for activities and services to improve the PAIMI program. Include a brief description 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.

15. Please identify any training & technical assistance requests [42 U.S.C. 10825].
None

Section G. Actual PAIMI Budget/Expenditures for FY 2017

See Attachment

Section H: Statement of Priorities (Goals)

A. For each Priority/Objective, please indicate the "Achieved Outcome:

Priority/Goal Description:	People with Disabilities are Free from Abuse and Neglect Focus Area: Protection from Harm in Adult Institutions
Objective:	1. Monitor each state operated facility using regular site visits and review of every Critical Incident Report, relevant policies and procedures, CMS surveys, staffing data and seclusion and restraint data. 2. Provide STA to residents as part of facility monitoring. 3. Analyze trends in CIRs, together with information from other monitoring activities, after each quarter. 4. Based on monitoring and trend analysis, identify 8 (average 2 per quarter) conditions or practices that place residents of state operated facilities at risk of

	harm, prioritizing those conditions or practices that lead to increased use of seclusion or restraint, that indicate potential for staff abuse or that demonstrate the failure of the internal investigation system. Notify facility and DBHDS and obtain corrective action. 5. Inform the SHRC on a quarterly basis about trends identified through monitoring of state operated facilities. 6. Represent ten (10) individuals in the forensic mental health system to ensure their right to due process or least restrictive environment. 7. Analyze all APS reports regarding abuse and neglect in institutional settings to identify trends (see objectives in focus 2 about the database). 8. Based on APS reports and complaints received, investigate ten (10) allegations of abuse or neglect, including failure to provide necessary medical care or assistive technology, in non-state operated institutions. 9. Provide at least thirty (30) individuals with STA in filing complaints of abuse or neglect with DBHDS. 10. Review and track DBHDS response to complaints of abuse and neglect and analyze all available internal investigation reports. Identify systemic weaknesses. Obtain corrective action. 11. Identify supported housing providers who qualify under the new regulations. Make initial contact with each, informing of the work of dLCV. (precursor for casework in ALFs in 2018). 12. Educate policymakers about the need for greater portability in auxiliary grants, and the need to preserve and enhance rights and safety in settings funded by auxiliary grants.
Target Population:	PAlMI-eligible persons residing in institutional settings
Expected Target:	Monitor DBHDS facilities, Represent fifty individuals, Monitor and review CIR data, Respond to proposed legislation
Achieved Outcome	1. Maintaining a Reliable Presence at State Operated Mental Health Facilities dLCV informs our monitoring of DBHDS facilities using a number of different information sources. We utilize not only site visits, but also use patient and staff reports and complaints, review of critical incident and APS

reports, and review of other significant information, such as seclusion and restraint data.

dLCV spent 73 days of monitoring at state operated mental health facilities in FY 17. During monitoring visits, we met with patients and staff, shared information about the agency and patient rights, and provided information and referral on numerous topics. We looked at the physical environment, access to assistive technology, and access to treatment in the least restrictive environment. Monitoring included advocating for reforms to facility policies and practices. Individual complaints often reflected more systemic issues.

We used data analysis to assess whether individual issues might have a broader impact. When we analyzed the seclusion and restraint data we collected, we found escalating seclusion and restraint usage at Southwest Virginia Mental Health Institute (SWVMHI). dLCV advocated for reductions in this restrictive and harmful practice and for the implementation of a measurable "Seclusion and Restraint Reduction Plan," as required by DBHDS' own policies. dLCV staff collaborated with the Office of Human Rights to successfully advocate for a detailed, written plan and witnessed an astonishing reduction of S&R usage at SWVMHI. Facility data shows that seclusion is down approximately 35% and ambulatory restraints went from 60 events in the latter half of 2016 to fewer than 5 in 2017.

At the same facility, dLCV achieved reform of policies concerning use of court-ordered Electro-convulsive Therapy, or ECT. dLCV became aware that psychiatrists at this facility had been petitioning courts for approval to administer involuntary "general" or "routine" psychiatric treatments, tests and therapies and then using the resulting court orders as authority to administer ECT. Several patients complained that this practice denied them adequate notice upon which they could decide whether and to what extent they should oppose the petition or appeal the resulting court order. dLCV confronted the facility director with its findings. The director consulted the Assistant Attorney General and agreed to reform the facility's policies to comply with due process requirements. As a result, facility policy changed to require psychiatrists to clearly and specifically state in their petitions for court approved involuntary ECT.

2. Helping Individuals Understand Treatment and Discharge Rights

dLCV helped many individuals understand their treatment and discharge rights and the internal system for resolving complaints.

Max contacted dLCV and reported unnecessary restriction at Southern Virginia Mental Health Institute (SVMHI). While on restriction, he couldn't attend treatment groups, which were necessary to his movement toward discharge from the hospital. Max's team released him from restriction almost immediately after the facility learned of dLCV's involvement. While Max was then able to attend groups without restriction, we found the violation of his rights exemplified several systemic issues with policies and practices at SVMHI. We then informed the facility director of these issues for corrective action.

Similarly, Steve spoke to dLCV staff on a routine monitoring visit at Eastern State Hospital. He complained of restrictions at the hospital inconsistent with his discharge plan for release without court supervision in the next two months. dLCV explained how Steve could file a human rights complaint, which resulted in fewer restrictions. Although Steve reported that he felt suffocated by his living situation, he told dLCV that helping him file that complaint was like "poking holes in the lid of a jar" and giving him air.

Will contacted dLCV complaining that the treatment team didn't involve his brother in meetings or discussions of his treatment. dLCV explained his medical privacy rights and how he could involve his brother in his treatment. We explained the use of advance directives and provided information and forms for completing an advance directive to protect their desired supported decision-making agreement.

3. Analysis of State Reporting on Death and Serious Injuries

dLCV conducted weekly reviews of critical incident reports (CIR) from Virginia's DBHDS operated facilities; dLCV received a total of 322 reports from DBHDS operated mental health facilities in FY17. We requested and reviewed facility death information, medical examiner reports, and peer review information to determine necessity of further investigation.

In addition, dLCV conducted quarterly analysis of incidents to identify patterns and trends that supported on-site monitoring or suggested a need for systemic intervention. CIR trend analysis showed that Catawba Hospital – a facility serving adult and geriatric individuals – reported a markedly higher number of falls than other facilities. This led to dLCV focusing on the facility's efforts to "fine tune" its falls reduction program and policies, a program developed out of earlier dLCV efforts to address falls at this facility.

4. As mentioned above, we identified a trend of an increase in Seclusion and Restraint (S/R) use at SWVMHI. We also reviewed S/R data from the other DBHDS facilities as well as staffing data. We found that there was a death due to improper use of bed rails at one of the DBHDS operated ICF-ID facilities. We then investigated bed rail usage at all the DBHDS facilities. As a result, we discovered and resolved another bed rail issue at one of the mental health facilities.

5. dLCV provided the SHRC with information on forensic transfers from Jail to DBHDS facilities for restoration, on forensic transfers from maximum security to civil hospital placement, on the extraordinary barriers list, on issues impacting individuals who are dually diagnosed I/DD and MI.

   The SHRC affirmed their previous finding that it was a violation of HR regulations to keep individuals in maximum security when determined clinically ready for LRE. They also asked the DBHDS to more fully define the barriers to discharge and why dually diagnosed individuals end up in state MH facilities rather than REACH services.

6. Fighting for the Rights of Forensically Involved Individuals

   Joyce, an NGRI individual at Eastern State Hospital (ESH), contacted dLCV after ESH failed to provide her with access to scheduled groups due to staffing shortages. The inability to attend treatment groups impaired Joyce's recovery and violated her due process and human rights. dLCV filed a formal human rights complaint on Joyce's behalf, citing failure to provide "services according to law and sound therapeutic practice." ESH acknowledged the need to improve staffing and agreed that the Nursing Director's office should monitor and review staffing requirements on the units daily to ensure that individuals have an opportunity to attend treatment groups and leisure activities. In addition, the Chief Nurse Executive implemented a "resource pool" to allow real time changes in staffing throughout the hospital when needed. Joyce accepted this corrective action and ESH has since demonstrated an improved ability to get individuals to scheduled groups.

   dLCV represented 6 individuals as part of efforts to pressure DBHDS and Eastern State Hospital into eliminating waitlists for NGRI patients scheduled to move from maximum security at Central State Hospital to a less restrictive inpatient setting. These individuals sometimes waited 6 or more months in a setting that is more restrictive than their treatment needs required. dLCV met with the DBHDS Assistant Commissioner for Forensic Services and discussed the need for this population to remain a priority amid DBHDS efforts to timely accept other forensic patients at ESH. dLCV presented data to the State Human Rights Committee (SHRC) on behalf of the named clients and other similarly situated

individuals. dLCV asked the SHRC to re-affirm that this practice violated individuals' rights. We also asked that the SHRC monitor the DBHDS' efforts to effect forensic transfers within 10 days. The SHRC responded, asking DBHDS to track both admissions and discharges and reasons for any delays.

7. dLCV contacted each Adult Protective Services and Department of Social Services advising them of their duty to report incidents of abuse of adults with disabilities to dLCV. Prior to this initiative dLCV received reports from approximately 21 out of 119 local agencies. Reporting went from 83 reports sent to dLCV before our initiative to 862 afterwards. dLCV used these reports to track and identify problem providers for individuals with mental illness and other disability categories facing abuse, neglect, or other rights violations in facilities, group homes, transportation systems, and other institutional and community settings. To better capture these incidents, dLCV developed a plan to include APS reports in its new community incident review plan.

   We reviewed each APS report. In one instance, there were multiple complaints regarding a particular nursing home. dLCV partnered with the local Adult Protective Services staff to conduct onsite visits and to support their complaint to the state licensure agency. We also opened a case on behalf of one individual. The nursing home subsequently filed a corrective action plan approved by the state licensure agency.

8. Fighting Back Amidst Limited Options

   Bertie requested help moving out of the assisted living facility where she resided. She claimed that the director of the facility threatened her and told her she would 'lock her up' if she left. Bertie said that she wanted to stay in the Staunton area to be close to her family, but live somewhere else. With client permission, we met with the client's case manager from the Community Services Board (CSB). She said that she had looked for other potential placements but that there are few options in the area that can accommodate the client's needs. She will continue to be alert to any new programs that may become available. After cross-checking the list of licensed programs in the area, dLCV updated Bertie on the lack of other nearby options and verified that she is unwilling to move out of Staunton. We then offered to help her file a complaint of verbal abuse against the facility but she opted not to do so.

9. While incorporating its findings into a systemic review of compliance, dLCV continued to assist individuals with filing human rights complaints and reviewing the resulting investigation reports for fidelity to the legal regulations and investigative standards.

In several cases, facilities failed to investigate allegations of abuse or neglect until dLCV formally communicated allegations on behalf of the individual and demanded compliance. For example, dLCV investigated concerns raised by Barbara at Western State Hospital. dLCV staff requested and reviewed no fewer than four separate investigations, ranging from violent assault to degrading neglect, and other allegations that the hospital simply failed to investigate. The dLCV investigation revealed that the hospital responded appropriately when allegations came directly from staff but disregarded allegations by Barbara, indicating the hospital's failure to give credibility to her allegations and treat them and her with due consideration.

In other cases, investigations failed to meet basic requirements and deliberately misrepresented issues. For example, Selma reported that staff violated her rights by violently placing her in a restraint device. While other agencies involved found that staff abused Selma by using excessive force, dLCV's secondary investigation revealed that the facility director failed to investigate the involvement of all staff, disregarded the human rights complaint filed, failed to notify law enforcement, and reported a less serious finding to Selma and her legal guardian.

These investigations ultimately became part of dLCV's systemic review of compliance with investigation requirements in state operated facilities, and will inform our continued systemic advocacy.

10. Throughout FY17, dLCV reviewed internal investigations of abuse and neglect at facilities operated by the DBDHS. During FY17, we reviewed 50 reports of cases investigated under DBHDS' Departmental Instruction (DI) 201, which details the requirements for facility investigations. dLCV helped a number of clients report allegations of abuse or neglect, which often resulted in investigation. dLCV also reviewed investigations initiated by DBHDS prior to our involvement. We identified four primary issues with facilities' adherence to DI 201: Failing to Initiate the Investigation, Lack of Appropriate Notifications, Poor (or No) Investigative Questions, and Biased Interviewing Practices.

    dLCV contacted the DBHDS Office of Human Rights detailing these areas of concern. We plan share a more substantive analysis of findings during FY18. dLCV will continue to monitor facilities' execution of DI 201 throughout FY18, with particular consideration paid to the above issues. We will also monitor the implementation of the "new" DI 201 when it becomes available.

11. As part of its efforts to expand access to community services and eliminate financial incentives to choose institutional care, dLCV monitored the

	implementation of the new auxiliary grant in supported housing (AGSH). This program is especially important to individuals with mental illness who are seeking to leave large congregate settings.After the approval of emergency regulations and program guidelines, DBHDS contracted with three community services boards to operationalize the AGSH program. DBHDS chose only three providers and distributed the 60 slots, the maximum allowed by the statute, 20 per provider. Those three providers are the Richmond Behavioral Health Authority (RBHA), Mount Rogers Community Services Board (MRCSB), and Blue Ridge Behavioral Health (BRBH). dLCV contacted the individual providers to discuss how each would implement the program. To date, dLCV has met with or scheduled meetings with program administrators from each provider as part of our systemic review of the program. 12. dLCV reviewed the emergency regulations relating to the AGSH program drafted by the Department of Aging and Rehabilitative Services (DARS) and the guidelines developed by DBHDS and prepared public comment. Public comment focused on the structure of the program, which limited the availability of AGSH to individuals who currently resided in assisted living facilities and who elect to participate at the time of their annual review. dLCV felt that AGSH would be very helpful to individuals planning for discharge from state psychiatric hospitals to assisted living facilities that are capable of independent living. dLCV coordinated with other advocacy partners to provide consistent messaging and feedback on the regulations and guidelines. This didn't result in changes to the emergency regulations, but discussions with AGSH providers and others indicate agreement with dLCV's position on greater portability in the auxiliary grant program and particularly within the AGSH program. dLCV will continue to follow the implementation of the program and the finalization of the regulations in July 2018.
Provide an explanation if the target was not achieved:	N/A

Priority/Goal Description:	People with Disabilities are Free from Abuse and Neglect Focus Area: Protection from Harm in Adult Community Settings
Objective:	1. Inform each DSS office about their responsibility to report to dLCV and identify the number of reports received from that office to date. 2. Conduct primary or secondary investigations in 5 cases identified through APS

	reports. Settings will be chosen based on seriousness of allegation, patterns, or through collaboration with DSS staff. 3. Survey three other states and identify best practices for a system of community oversight. Compare with Virginia's system. Provide findings and recommendations to DBHDS and policymakers. 4. Analyze all investigation reports according to standardized criteria and track with a database. Use any identified patterns or trends in development of 2018 objectives.
Target Population:	PAlMI-eligible adults residing in community settings
Expected Target:	Fifteen investigations, Review APS incident data, Negotiate better system for incident data delivery Survey three states Analyze trends to develop FY 18 objectives
Achieved Outcome	1. See information summary in Priority 1, number 7. 2. dLCV opened 4 community investigations based upon APS reports utilizing funding other than PAIMI. These investigations included: an injury during restraint use at a group home; the failure of APS to use effective communication in the conduct of investigations; financial exploitation; and a death investigation involving suicide in a group home where the individual's serious self-injurious behavior and verbal threats of suicide were dismissed as "attention-seeking behavior" despite a prior suicide attempt. 3. dLCV conducted research into the system for community oversight in Tennessee, Mississippi, and Kentucky. We identified several practices that appear stronger than those in place in Virginia. Utilizing other non-federal funding, dLCV used this information to support legislative advocacy for the creation of an adult abuse and neglect registry along the lines of the child abuse registry, similar to the Tennessee Abuse and Neglect Registry. The information gathered from other states also supported a report on the compliance with the Medicaid Waiver and HCBS waiver. 4. In 2017, the General Assembly passed a law requiring all DBHDS licensed facilities and programs to provide to dLCV a copy of incident reports of serious injury or death (Computerized Human Rights Information System or CHRIS reports). dLCV began receiving raw data late in FY 2017 and created a plan for reviewing the reports and analyzing trends once the full

	database is accessible. We planned FY 18 objectives to respond to and take advantage of this new data source.
Provide an explanation if the target was not achieved:	N/A

Priority/Goal Description:	People with Disabilities are Free from Abuse and Neglect Focus Area: Children and Adolescents with Disabilities are Free from Harm in Community or Institutional Settings
Objective:	1. Monitor conditions at the Commonwealth Center for Children and Adolescents (CCCA) through quarterly visits and review of complaints and CIRs, and provide residents with information about their legal rights. 2. Identify systemic issues at CCCA presenting a risk to health and safety of residents, with emphasis on use of seclusion and restraint, Trauma Informed Care principles, and services for individuals with dual diagnosis issues. Inform LHRC and relevant policymakers and obtain corrective action. 3. Provide five (5) self-advocacy trainings at institutions serving children and caregivers, to include information on facility specific rights, wrap around services, special education, assistive technology, and vocational rehabilitation (VR) services, with a specific emphasis on transition and crisis services as appropriate. 4. Investigate 10 allegations of abuse and neglect at institutions serving children, involving unnecessary seclusion and restraint, medical neglect, or staff abuse. In each incident where the allegation is founded, publish written reports of findings and necessary corrective action and systemic reform. 5. Represent 10 individuals at long-term residential facilities for children who need assistance in discharge planning and accessing appropriate community based services. 6. Analyze reports of incidents submitted by Psychiatric Residential Treatment Facilities (PRTFs) to identify patterns and trends of preventable incidents. 7. Identify systemic issues at PRTFs presenting a risk to health and safety of residents, with emphasis on use of seclusion and restraint issues and discharge planning. Obtain corrective action.

Target Population:	PAlMI-eligible children and adolescents residing in the community or facilities
Expected Target:	Monitor facility, Represent ten individuals, Complete ten investigations, Analyze Reports, Resolve Systemic PRTF issues
Achieved Outcome	1. This fiscal year, dLCV conducted five monitoring visits at the Commonwealth Center for Children and Adolescents (CCCA). These visits included monitoring of the children and adolescent residential units, informal rights clinics with residents, and attendance at administrative meetings such as the Local Human Rights Committee (LHRC) Meetings to aid in collaboration across departments. This year, dLCV worked in collaboration with the Office of Human Rights, the Office of Licensure, various Community Services Boards, law enforcement, Child Protective Services, REACH, and the Department of Justice to ensure protection from harm for children and adolescents receiving treatment at CCCA. 2. During the fall of this fiscal year, dLCV presented seclusion and restraint investigative findings, including both individual case-level issues and systemic data analysis complete with corrective action recommendations to the LHRC in hopes to change the culture of excessive restraint and coercive treatment methods at CCCA. Subsequently, the Department of Behavioral Health and Developmental Services (DBHDS) assigned an independent reviewer to travel to CCCA weekly to analyze and assess internal CCCA practices and procedures of seclusion and restraint usage. This reviewer analyzed over 400 incidents and 200 cases to ascertain insight into practices and corrective action. Since dLCV's advocacy and education of stakeholders, CCCA has hired a new Director, increased staffing on all shifts, increased nursing and direct care professional staff as part of a structural reorganization, and has begun a systematic review of all policy and procedures governing CCCA. Also as a direct result of dLCV's oversight and advocacy, the LHRC continues to review all seclusion and restraint data and policy on a regular basis as to better strengthen protections of residents. During this organizational and culture shift spawned by dLCV involvement and the courage of the clients involved in sharing their story, CCCA will now be moving toward an acute hospital accreditation for crisis stabilization and away from a long-term residential facility model. 3. dLCV visited fifteen Psychiatric Residential Treatment Facilities (PRTFs) providing education, training, and monitoring. The outreach and training included information on facility-specific and discharge rights for residents, accessibility and eligibility of services available in the community, special education, assistive technology, crisis services, and vocational rehabilitation. dLCV additionally focused specifically on transition related services for children and adolescents 14 – 21 aging into the adult system of mental health and developmental disability services to include crisis services upon discharge. In total, dLCV trained over 400 residents, staff, and community partners, such as Department of Social Services

(DSS) to better promote self-advocacy at institutions serving children and adolescents around the state of Virginia.

While providing education and outreach, dLCV additionally worked diligently to identify systems issues presenting risk to residents at PRTFs throughout this fiscal year. dLCV additionally reviewed and analyzed all serious incident reports from all eighteen PRTFs in Virginia. As a result of this review, dLCV followed up on over 45 individual incidents to ensure protection from harm for PRTF residents. dLCV also opened one investigation into a pediatric overdose of a twelve-year-old PRTF resident. This investigation is ongoing to ensure policy change and systemic corrective action.

4. As a result of a dLCV project initiative to receive and review all Adult Protective Services (APS) reports, dLCV now receives reports from PRTFs serving adolescents and adults up to age 21. dLCV cross-references those APS reports with PRTF self-reports to ensure validity and reliability of reporting requirements across Virginia mental health systems. dLCV also provided public comment in on regulations governing PRTFs in Virginia to ensure equal civil rights for children and adolescents in PRTFs. As a result of dLCV involvement, several DSS offices and PRTFs include dLCV pamphlets and information in their staff training and admission brochures.

5. Pregnant and Institutionalized

   At the beginning of this fiscal year, dLCV spoke with Jane, a 17 year old pregnant resident of CCCA subjected to repeated physical and mechanical restraints. dLCV immediately became involved and through investigation found Jane had multiple serious medical contraindications to restraint, including pregnancy, heart issues, obesity, asthma, and sexual abuse history and trauma. dLCV additionally found rights violations within CCCA's own internal policies and procedures related to seclusion and restraint and medical care of serious incident reports. Although Jane decided to not pursue individual corrective action, dLCV utilized systemic corrective action methods to ensure protection from harm for CCCA current and future residents in terms of seclusion and restraint policy and procedures and increased oversight regarding medical care after restraint and other serious incidents. Jane and her baby boy are now living in the community and are happy and healthy.

6. Repeated Abuse

   The sister and guardian of sixteen year old Aaron, a resident of a PRTF in Tidewater, Virginia, contacted dLCV for aid in investigating allegations of abuse that Aaron made to her during family therapy sessions. Aaron suffered severe physical abuse from his father since a young age, resulting in significant mental health support needs and physical disability needs secondary to physical abuse. Aaron's sister was afraid that Aaron had once again become a target for abuse, not only by staff but also by other residents. dLCV investigated and was not able to substantiate abuse; however, dLCV was able to provide oversight and education to

	the PRTF in terms of monitoring, policy, and procedures. Upon closure, Aaron reported that he felt safer and was glad to be going home. Aaron is now working at a grocery store and living with his sister and her husband in the community. 7. Slipping Through the Cracks at Eight Years Old As a result of PRTF outreach, dLCV advocated for eight year old Lewis and his family to receive appropriate mental health services in the community. dLCV learned the local Community Services Board (CSB) had relayed to Lewis and his family that they "weren't opening any more cases" and "did not serve military families." dLCV forced involvement from the CSB and obtained assessment services for Lewis while the PRTF and his team planned discharge back into the community. Lewis became eligible for multiple wrap-around services to leave the PRTF and enter back into the community, including waiver services and respite. These services allowed for Lewis to be successful upon discharge and not cycle back into institutional care. Additionally, dLCV educated the CSB on their responsibility to all individuals needing mental health and developmental disability services in their community to ensure that everyone receives help!
Provide an explanation if the target was not achieved:	N/A

Priority/Goal Description:	People with Disabilities are Free from Abuse and Neglect Focus Area: Appropriate Services in Juvenile Correctional Facilities
Objective:	1. Monitor conditions at each Department of Juvenile Justice (DJJ) Juvenile Correctional Center (JCC) quarterly and provide information to residents regarding their legal rights. 2. Identify systemic issues at each JCC presenting a risk to health and safety of residents, with emphasis on use of seclusion and restraint, and inform policymakers. 3. Provide self-advocacy materials to children and parents or guardians of children in DJJ facilities, to include information on mental health transition planning, special education, supported decision-making, and VR transition services. 4. Through monitoring of the JCC transition planning committees, represent five (5) residents who are within 90 days of re-entry to ensure they receive appropriate mental health services, transition plans, and appropriate educational services. 5. Provide three (3) trainings to educate JCC residents and their parents or guardians on mental health transition plans.

Target Population:	PAlMI-eligible youth residing in correctional facilities
Expected Target:	Monitor DJJ JCC facilities, Represent five individuals, Provide three trainings
Achieved Outcome	1. This fiscal year, dLCV conducted eight monitoring visits to Beaumont and Bon Air, the Department of Juvenile Justice (DJJ) Juvenile Correctional Centers (JCCs) in Virginia in efforts to provide children and adolescent residents information about their rights and to ensure protection from harm by identification of systems issues. dLCV's monitoring visits additionally included oversight of special education service provisions at Virginia's JCCs, increasing our oversight and outreach by observing student classrooms and education. dLCV worked to ensure protection from harm for DJJ residents and identified issues of advocacy including room confinement violations and re-entry planning barriers and lack of services both during discharge and in the community. Additionally, dLCV's monitoring of these JCCs included oversight of the closure of Beaumont in state-wide initiative efforts to de-institutionalize our children and adolescents. 2. dLCV worked diligently to outreach and educate not only DJJ residents but also to train DJJ staff and community partners. As part of this effort, dLCV created numerous factsheets on mental health services transition planning, vocational rehabilitation service planning, and supported decision making. In efforts to better focus advocacy and monitoring, dLCV attended DJJ Board Meetings, Juvenile Correctional Facility Task Force Meetings, and Virginia Commission on Youth Meetings. As a result of this training, DJJ now includes dLCV's information and factsheets to caregivers and residents upon admission. 3. dLCV additionally trained DJJ residents on mental health planning. As a direct result of resident training, dLCV provided information and referral and short-term assistance to thirteen of these children and adolescent residents. Further, dLCV trained over sixty DJJ staff through seven different presentations around the state. dLCV gave additional presentations to parents, parole and re-entry staff and directors, and Court Service Units upon request. Additionally, utilizing dLCV participated in a workgroup of stakeholders, including the Department of Behavioral Health and Developmental Services (DBHDS), DJJ, the Community Service Boards, and other relevant policymakers regarding revision of room confinement regulations at juvenile detention centers. dLCV plans to continue involvement and recommendation throughout the process into the next fiscal years. 4. Staying Stabilized During a monitoring visit at Beaumont JCC, a twenty year old male resident named Oliver approached dLCV staff with questions regarding mental health transition service and medication planning upon discharge. Oliver takes

	medication for various mental health needs and had health care and insurance coverage concerns to continue his medications while transitioning back home. dLCV educated both the JCC staff and Oliver on health care planning and insurance as related to transition, individual insurance applications, and advocates in the community to contact should the need arise. Oliver is educated and understands his options to maintain the treatment he needs to live in the community. 5. Right to Choose During a routine monitoring visit, Erin approached dLCV with questions regarding her ability and desire to work upon her return to the community. Erin relayed to dLCV that she had experienced barriers and non-responsiveness from JCC staff regarding setting up these transition services while discharge planning. dLCV provided both JCC staff and Erin with the linkages needed to the Department of Aging and Rehabilitative Services, her local Community Services Board, and resources to obtain her degree. As a result of dLCV involvement, Erin is more equipped to plan a life of her choice.
Provide an explanation if the target was not achieved:	N/A

Priority/Goal Description:	People with Disabilities are Free from Abuse and Neglect Focus Area: Jail Transfer Impact Project
Objective:	1. Monitor DBHDS efforts to reduce wait times for pre-trial detainees awaiting restoration services. 2. Complete pleadings in anticipation of litigation.
Target Population:	PAlMI-eligible incarcerated adults
Expected Target:	Monitor and complete pleadings
Achieved Outcome	1. Monitor DBHDS efforts to reduce wait times for pre-trial detainees awaiting restoration services. In FY 16, dLCV drafted a plan, researched legal issues, monitored DBHDS jail wait lists, and drafted a complaint. We couldn't immediately file after DBHDS quickly moved to eliminate the waitlist. In FY17, dLCV participated in stakeholder groups and monitored the legislative committees that resulted in changes to the Virginia code that now require that individuals found incompetent to stand trial

	and requiring inpatient hospital treatment for restoration be transferred as soon as practicable, but no later than 10 days from receipt of the court order. dLCV met with the DBHDS Assistant Commissioner for Forensic Services to discuss DBHDS' strategies to meet the timeframes and plan for long term compliance with the revised statute. dLCV continued to monitor transfers and found that DBHDS is was accepting individuals within the statutory timeframe at the end of FY 17. 2. This result, which dLCV had prepared to achieve through litigation, came instead through legislative change. In addition, it strengthened dLCV's litigation strategy. dLCV finalized draft pleadings, discovery requests, and motions developed in anticipation of litigation. The team "mothballed" them for reference should litigation become necessary to secure compliance with §19.2-169.2.
Provide an explanation if the target was not achieved:	N/A

Priority/Goal Description:	People with Disabilities Live in the Most Integrated Environment Focus Area: People with Disabilities are Discharged Timely from State Facilities
Objective:	1. Monitor facilities to identify those that are not properly identifying individuals as clinically ready for discharge and not planning for discharge. 2. Represent seven (7) individuals at DBHDS psychiatric hospitals who have been ready for discharge for more than thirty (30) days to receive timely and appropriate discharge planning. 3. Provide STA to fifteen (15) residents of DBHDS psychiatric hospitals who are seeking discharge. 4. Semiannually, inform the SHRC and the general public about our analysis of the Extraordinary Barriers List (EBL) and information gathered during monitoring, describing the barriers to discharge and transition and recommended remedies. 5. Represent five (5) individuals living in institutional settings to eliminate barriers to self-determination, including lack of assistive technology, effective communication and review of decision-making capacity.
Target Population:	PAlMI-eligible individuals awaiting discharge in institutional settings

Expected Target:	Monitor facilities, Assist 27 individuals, EBL education
Achieved Outcome	1. Based on dLCV's state-wide monitoring activities and individual casework, we found a practice where treatment teams withheld clinical discharge readiness determinations until securing suitable placement and support services in the community. This had a two-pronged pernicious effect. Initially, this practice obscures existing deficits in community support and placement availability within certain catchment areas. This in turn impedes DBHDS and policymaker efforts to detect and address those very deficits. Compounding this problem, denying patients the clinical discharge readiness determinations they have earned undermines trust relationships. It denies patients the opportunity to take Olmstead-based legal action to obtain the community-based supports and services they need. dLCV addressed the issue with the DBHDS Assistant Commissioner of Behavioral Health, and then collaborated with him to obtain a DBHDS directive advising the state facility directors that placement and services availability isn't considered in making clinical discharge readiness determinations. 2. Martha's sister, who is also her legal guardian, reached out to dLCV because she felt the discharge planning process had stalled and that the team failed to identify appropriate placements for her. dLCV stepped in and worked with the team to review Martha's needs and create a checklist for potential providers. After some false starts, Martha's sister identified a quality assisted living facility that could accommodate Martha's complex support needs. dLCV then worked closely with the team to clarify responsibilities for various parts of the discharge plan and to mediate between the team and the guardians' disparate expectations of the process to ensure the plan didn't break down. After several weeks, the guardians authorized Martha's discharge and she is living successfully in her new home. Arny contacted dLCV, stating that he had been ready for discharge since May 2016. dLCV reviewed his discharge readiness and discharge plan, communicated with his treatment team, and provided information to him about rights relating to discharge. dLCV advocated for prompt discharge to an appropriate community placement. The primary barrier was that he wanted a placement close to where his wife lived. His CSB liaison initially limited his search to Assisted Living Facilities in two counties, but dLCV encouraged him to expand into other surrounding areas. Arny's discharge occurred shortly thereafter. He indicated that he is happy in his new community, which is only a 15 minute drive from his wife's home. 3. Darren contacted dLCV after a discharge plan delay. He also complained of poor communication between the CSB, the facility, and himself. dLCV agreed to provide him with short term assistance to better understand his situation and what might be contributing to the delays. dLCV contacted the

	hospital social worker to discuss Darren's situation. She explained that although voluntarily admitted, he was encouraged to stay until they located a stable housing arrangement. dLCV explained to Darren that he could weigh the benefits of waiting for discharge versus having stable housing. The hospital and the CSB are now communicating with each other and with Darren regarding a variety of placement options, including a family home or residential placement. dLCV also advocated for the inclusion of referral to vocational services at Darren's request. He was happy to see that his input was valued and that there is movement toward discharge. 4. dLCV presented the SHRC with two updates on the Extraordinary Barriers List (EBL) to discharge from DBDHS mental health facilities. As a result, the SHRC asked the DBHDS to identify what those barriers might be and further to identify barriers to timely transfers between jails and DBDHS, facility to facility and admissions and discharges of individuals who are dually diagnosed I/DD and MI. 5. Sybil and her social worker contacted dLCV with concerns that the client's estranged brother (who was acting as her Authorized Representative) was trying to get control over her finances and was formally pursuing conservatorship. After reviewing the client's records, it became clear that the hospital had flagrantly violated Sybil's rights by appointing her brother as her Authorized Representative without conducting a capacity evaluation. We also discovered that automatic appointment of Authorized Representatives was a standard practice on the hospital's Admissions Unit. Once they received this information, the client's physicians immediately removed her brother as her Authorized Representative and began pursuing discharge from the hospital. To ensure that the client did not find herself in this position again, dLCV provided her with extensive information and resources related to crisis planning, surrogate decision making, and Advance Directives. She now possesses the tools to effectively self-advocate and protect herself from future exploitation. Hospitalized in Southwestern Virginia, Morton wanted to change his residence and CSB upon discharge. He planned to complete training to become a peer recovery specialist and to work in Northern Virginia. Denied transfer to Northern Virginia Mental Health Institute (NVMHI), where he hoped to take his passes in preparation for discharge, he contacted dLCV. We worked with the facility, multiple CSBs, and DBHDS central office, to ensure his right to choose his community residence. As a result, he received transfer to NVMHI. He is in the process of completing his training and eagerly anticipating discharge.
Provide an explanation if the target was not achieved:	N/A