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	Tom Walk

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 2017
Current term expires	October 2019

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	Dr. Daniel Carey
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	Dr. S. Hughes Melton
Mailing address	DBHDS P.O. Box 1797 Richmond, VA 23218-1797
Phone number	804-786-3921
e-mail address	hughes.melton@dbhds.virginia.gov

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

		Governing Board	Advisory Counsel	Program Staff
Ethnicity	Hispanic/Latino	**0**	**1**	**1**
	Non-Hispanic/Latino	**12**	**13**	**37**
Race	American Indian/ Alaskan/Native	**0**	**1**	**0**
	Black/African American	**1**	**1**	**5**
	White	**9**	**11**	**28**
	Two or more races	**2**	**0**	**4**
Sex	Female	**6**	**9**	**27**
	Male	**6**	**5**	**11**

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	12
Total vacancies on 9/30/17	
Term of appointment (number of years)	4
Term maximum	2
Meeting frequency	quarterly
Number of meetings held this fiscal year (FY)	6
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.	2
Number of family members of individuals with mental illness who are R/FR of mental health services.	9
Number of guardians.	
Number of advocates or authorized representatives.	
Number of other persons who broadly represent or are knowledgeable about the needs of the clients served by the P&A system.	1
Total	12

15. **Executive Director (ED)**

Initial Appointment Date	12/01/2013 (MM/DD/YYYY)	
Recent performance evaluation completed	1/27/2018 (MM/DD/YYYY)	
Date of previous performance evaluation	1/28/2017 (MM/DD/YYYY)	
Agency has written policy and procedures to guide the ED's evaluation process?	X Yes	☐No
List documents and exact sections, page, where this information may be found.	dLCV Board Operations Manual	
Input on ED's performance evaluation obtained from the following **(**check all that apply**)**		
All agency employees/staff	☐Yes	X No
Senior managers	X Yes	☐No
All board directors	X Yes	☐No
All PAIMI Advisory Council members	☐Yes	X No
Stakeholders	☐Yes	X No
Consumers	☐Yes	X No
Family members of consumers	☐Yes	X No
State mental health providers	☐Yes	X No
Private mental health providers	☐Yes	X No

Other	X Yes	☐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	**11**	**11**		**5**	**6**	**15**	**15**			**15**
Race										
American Indian/ Alaskan Native										
Asian										
Black/African American						**1**	**1**			**1**
Native Hawaiian/ Pacific Islander										
White	**11**	**11**		**5**	**6**	**12**	**12**			**12**

Two or more races						**2**	**2**			**2**
Unknown										

Section B: Demographics

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

Age	Number
0 - 4	0
5 - 12	2
13 - 18	17
19 - 25	13
26 - 64	85
65^{+}	25
Total	142

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

Sex	Number
Female	64
Male	77
Unknown/would not disclose	1
Total	142

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

Ethnicity	Number	PAIMI%	State%
Hispanic/Latino (of any race)	5	4%	9.1%
Non-Hispanic/Latino	124	87%	90.9%
Ethnicity unknown	13	9%	N/A

Total	142	

Race	Number	PAIMI%	State%
American Indian/Alaskan Native	0	0%	0.5%
Asian	2	1.4%	6.6%
Black/African American	34	24%	19.8%
Native Hawaiian/Pacific Islander	1	.7%	0.1%
White	88	61.9%	70%
Two or more races	4	2.8%	2.9%
Race unknown	13	N/A	N/A
Total	142		

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).	19
2. Number of new PAIMI-eligible individuals served during the FY.	123
3. Total number of PAIMI-eligible individuals served during this FY (add lines 4.1 and 4.2).	142
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).	30

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	14
Non-medical community-based residential facility for children/youth	1
Foster care	
Nursing homes, including skilled nursing facilities	3
Intermediate care facilities	
Public general hospitals including emergency rooms	
Private general hospitals including emergency rooms	
Public institution	1
Private institution	12
Psychiatric hospitals (public/private)	
a. public/state 95 b. private 3	98
Jails	
a. municipal/city X b. county c. other	1
State prison	3
Federal detention center	3
Federal prison	
Veterans administration hospital	
Other federal facility	
Homeless	
Independent (in the community & PAIMI-eligible)	
a. within 90-days post-discharge from a facility	2

b. after 90-days of discharge	
Parental or other family home & PAIMI-eligible	
a. within 90-days post-discharge	1
b. after 90-days of discharge	3
Unknown	
Total	**142**

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	5	2		2	1
2. Chemical restraint					
3. Mechanical restraint	3	1	1		1
4. Seclusion	1			1	
c. Involuntary medication					
d. Involuntary electrical convulsive therapy					
e. Involuntary aversive behavioral therapy					
f. Involuntary sterilization					
g. Failure to provide appropriate mental health treatment	7	2		4	1

h. Failure to provide needed medical treatment					
i. Physical assault					
1. Serious injuries related to the use of seclusion and restraint.	1			1	
2. Serious injuries **not** related to seclusion and restraint.					
a. Patient on patient					
b. Staff/caretaker	1	1			
c. Facility resident	1				1
j. Sexual assault					
a. Staff/caretaker	2	2			
b. Patient/facility resident					
k. Threats of retaliation or verbal abuse by facility staff					
l. Coercion					
m. Financial exploitation					
n. Suspicious death	8	4	1	3	
o. Other - Specify type of complaint (describe on a separate sheet) - [This number should be ≤1 percent of abuse complaints total].					
Total	30	13	2	11	4

*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.	30
a. Number of complaints/problems determined after investigation not to have merit.	13
b. Number complaints/problems withdrawn or terminated by client.	2
c. Number of complaints/problems resolved in the client's favor.	11
d. Number of complaints/problems not resolved in the client's favor.	4

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						
b. Transportation to/from residential care or treatment facility						
c. Discharge planning or release from a residential care or treatment facility	57	13	3	35	1	5
d. Mental health diagnostic or other evaluation (does not include treatment)						
e. Medical (non-mental health related) diagnostic or physical examination	4	1	1	1	1	
f. Inadequate care (e.g., personal hygiene, clothing, food, shelter)	2			1	1	
g. Physical plant or environmental safety	2	1		1		
h. Personal safety issues (unsecured access to facility, resident rooms, patient to patient abuse)	5	2		3		
i. Other [Describe and make every effort to report within the above categories].						
Total	70	17	4	41	3	5

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.	70
a. Number of complaints/problems determined after investigation not to have merit.	17
b. Number complaints/problems withdrawn or terminated by the client.	4
c. Number of complaints/problems resolved in the client's favor.	41
d. Number of complaints/problems not resolved in the client's favor.	3
e. Other indicators of success or outcomes that resulted from P&A involvement.	5

5. **Areas of Alleged Rights Violations**

Number of Complaints/Problems	Number from Closed Cases only	Outcomes			
	Total	A	B	C	D
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	2	1	1		
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).	3	1		2	
d. Denial of financial benefits/entitlements (e.g., SSI, SSDI, Insurance).	2			2	
e. Guardianship/conservator problems	3	1		2	
f. Denial of rights protection information or legal assistance	3			3	
g. Denial of privacy rights (e.g., congregation, telephone calls, receiving mail)					
h. Denial of recreational opportunities (e.g., grounds access, television, and smoking)	5			4	1
i. Denial of visitors					
j. Denial of access to or correction of records	3			3	

k. Breach of confidentiality of records (e.g., failure to obtain consent before disclosure)					
l. Failure to obtain informed consent	3			2	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	25	3	2	18	2

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.	25
a. Number of complaints/problems determined after investigation not to have merit.	3
b. Number complaints/problems withdrawn or terminated by client.	2
c. Number of complaints/problems resolved in the client's favor.	18
d. Number of complaints/problems not resolved in the client's favor.	2

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

	Number
Number of closed cases, which client's objective was partially or fully met	88
Other representation found	2
Individual withdrew complaint	3
Services were not needed due to client's death or relocation	6
P&A withdrew because individual or client would not cooperate	1
Individual's case lacked merit	14
Individual's issue not favorably resolved	9

Appeal(s) unsuccessful	2
Total	125

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	62	4		2	2	13		19	2	3		2	13	2
2. A/NI	31	9	1	7	2	4		4	1		2		1	
3. TA	6			1			3			1			1	
4. AR	9	1						6					2	
5. N/M	15							12	1	1			1	
6. LR	2			1									1	
Total		14	1	11	4	17	3	41	4	5	2	2	19	2

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.	71
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.). calls and monitoring	2
Total	73

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).	0
b. Number of death investigated involving incidents of restraint (R).	1
c. Number of deaths investigated **not** related to incidents of S & R, (e.g., suicides).	72
d. Total Number of deaths investigated [Sum of B.9.2. a-c].	73

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.

dLCV reviewed 73 deaths of PAIMI eligible individuals in FY 2018. When evidence suggested the need for additional review, dLCV opened preliminary investigations to review the cause and circumstances of death in more detail and determine the need for comprehensive investigation.

Several deaths in state-operated psychiatric facilities related to long-term medical conditions which preceded the individual's hospitalization. For example, in the matter of Louise, the medical examiner determined that Louise died of complications from a number of chronic and terminal health conditions shortly after hospitalization for psychiatric instability and serious self-neglect. Another individual, Athena, died due to complications of her pre-existing health conditions. The medical examiner's documentation showed Athena's physical injuries didn't show physical abuse but were consistent with efforts to provide emergency resuscitation.

However, dLCV also found other deaths caused by or associated with preventable medical triggers or facility neglect. dLCV reviewed the Critical Incident Report of Mary's death and contacted her sister, who authorized dLCV to review records and conduct an investigation. dLCV reviewed the investigation record which revealed that Mary had choked to death due to failure to follow her dietary orders. dLCV aggressively advocated for corrective action to address the failures that contributed to Mary's death by neglect appealing the facility's lack of definitive investigative findings and the very limited corrective action. As a result of the appeal, the facility came back with a stronger, more effective corrective action plan that went beyond re-training and included key policy changes regarding dietary needs and shift-change communication.

dLCV investigated the death of Janelle, a fifteen-year-old PRTF resident. dLCV fought and won an access battle with Virginia's Commonwealth Attorney and Child Protective Services (CPS), who both initially denied access given the ongoing criminal court proceedings. As a result of this fight, dLCV gained access to internal investigations of law enforcement, CPS, and Emergency Medical Services. dLCV substantiated a plethora of violations and failures related to abuse and lethal restraint, medical, and environmental neglect. dLCV also found additional violations regarding restraint; failure to have information readily available for Emergency Medical Services (EMS) and law enforcement; failure to have a plan for crisis; failure to document restraints appropriately; failure to develop an appropriate Individual Service Plan (ISP); and failure to report to dLCV. We requested and reviewed extensive corrective action plans since the incident. dLCV found that the PRTF implemented all requested corrective action appropriately, including revision and creation of new seclusion and restraint policies, inclusion of The Substance Abuse and Mental Health Services (SAMHSA)'s 6 Core Strategies for seclusion and restraint policies, creation of policies regarding medical codes and responses, and all staff retraining on identified issues. At current, two staff members responsible for the fatal restraint are facing manslaughter charges and other staff faced termination. As a result of dLCV investigation, monitoring, and collaboration with other agencies, we increased oversight of the PRTF and accountability, resulting in a safer environment for Virginia's children and youth.

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)).	4
2. New group cases/projects opened during the year.	45
3. Total group cases/projects worked on during the year (add items1 and 2 above).	49
4. Total group cases/projects as of September 30 (carry over to next FY).	0
5. Group cases/projects targeted at serving the following special populations:	

a. ethnic	
b. racial minorities	1
c. homeless	
d. veteran's	
e. urban	
f. rural/frontier	3
g. elderly/geriatric	1
6. Total number of individuals impacted by line 3.	35,610

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	1, 995	8		
Investigations *(non-death related)*	1,000	7		
Facility Monitoring Services	6,615	19		
Court Ordered Monitoring				
Class Litigation	15,500	4		
Legislative & Regulatory Advocacy	10,500	11		
Other – systemic advocacy				

Total	35, 610	49		

Section D. Non-Client Directed Advocacy Activities

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

Provide the number of PAIMI Program I&R services.	
Total	384

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.	18
2. Number of education/training activities undertaken.	15
3. Number (approximate) of persons trained in 2.	1,995

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	1

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)]	1

4. The number of grievances appealed to:	
4.a. The governing authority/board	
4.b. The Executive Director	1
Total 4.a. & 4.b.	1

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 Thomas Walk, President Angela Thanyachareon, Vice President Jefferson Harding, Treasurer Michael Toobin, Secretary

	Maureen Hollowell Stephen Dawe Carrie Knopf Harry Gewanter, MD Donna Gilles, Ed.D Frank Hayes Holly Hilton Jacqueline Eubanks, PAIMI Chair Ex Officio

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 FY 18. The first survey allowed our 200 respondents the opportunity to express which disability advocacy issues they feel are most important. We posted the survey instrument on our website and distributed paper copies at conferences, during trainings and presentations, and directly to residents during facility monitoring. The top three categories chosen were quality mental health care, housing, and special education. 40% of our respondents were individuals with disabilities. Agencies and groups we reached included: the Virginia Board for People with Disabilities, Arc South of the James, Department for Aging and Rehabilitative Services (DARS), Partnership for People with Disabilities, Department for Behavioral Health and Developmental Services (DBHDS) , and multiple community advocacy and networking groups. dLCV used this information to develop our FY 19 goals and focus areas.

The second systemic input survey allowed dLCV to receive targeted input from established advocacy agencies. The agencies reviewed our dLCV Board adopted FY 19 goals and focus areas and offered specific feedback to contribute to our work plan. Agencies contributing to this effort include Arc of the Piedmont, Virginia Poverty Law Center, Virginia LEND, New River Agency on Aging, Brain Injury Association of Virginia, Appalachian Agency for Senior Citizens, Formed Families Forward, Arc of Northern Virginia, and Virginia Autism Project. dLCV reviewed these suggestions and those of our PAIMI Council and incorporated them into our FY 19 work plan for PAIMI and other programs.

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?	☒Yes	☐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?	☒Yes	☐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
Department of Justice
Department of Juvenile Justice
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)
Partnership for People with Disabilities Advisory Council
Psychiatric Residential Treatment Facilities (19 in Virginia)
Virginia Board for People with Disabilities
Mental Health America of Virginia
Local Department of Social Services, APS Divisions
Department of Social Services, Licensing
Virginia's Attorney General

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].

In FY 18, dLCV hired an Outreach Coordinator to identify and inform our agency about needs in the Hispanic and Latino communities. This has increased our agency's cultural competency and we continue increase our proficiency with meeting the advocacy needs of this population. This Coordinator has expertise working in the field of mental health and substance abuse and brings those skills to the agency as well.

Our agency holds open house and community networking 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 and Twitter account to post articles on disability advoc 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 delays in receipt of records in a children's death investigation from Child Protective Services and Virginia law enforcement. After educating the parties involved, the provider relinquished the records we requested. dLCV additionally experienced issues in obtaining medical examiner reports throughout Virginia due to unresponsiveness and varied and extensive charges. dLCV is currently working to obtain corrective action in this area. dLCV faced substantial delays in access to Bon Air Juvenile Correctional Center (JCC) for visits. One such visit took over sixty days to schedule. Through assertion of dLCV access authority to the Director of the Department of Juvenile Justice (DJJ), dLCV has been able to drastically reduce that time. This year one visit occurred with 24 hours' notice and several with approximately one week's notice. Due to the issues faced with timely access and other delays and denials of access, dLCV initiated discussions with the Director of DJJ to develop and

implement a memorandum of agreement (MOU) to outline how dLCV access to Bon Air JCC would work. There are significant areas of disagreement that do not appear to be resolvable through negotiation.

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 limited PAIMI funds to serve the needs of the PAIMI eligible population.

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.).

dLCV provided PAIMI case services to 142 individuals and PAIMI information and referral to 384 individuals in FY 19. Our project work additionally impacted over 35,610 PAIMI eligible adults and children.

Following dLCV's persistent advocacy, the Department of Behavioral Health and Developmental Services (DBHDS) finally began including the actual identified barriers to discharge for individuals on the extraordinary barriers list (EBL) in September 2018. dLCV found that upon having to identify specific, concrete barriers, the number of people on the EBL dropped by 21, the largest monthly reduction in the last year.

dLCV tackled concerns with the investigation process at one facility, filing two LHRC appeals related to deficits in the human rights investigation process. The LHRC made several findings favorable to our clients which reflected the facility's failure to protect individuals from harm and to promptly respond to complaints and allegations of abuse and neglect. The facility finally provided corrective action plans that can result in sustainable policy and practice improvements in care and in abuse and neglect investigations.

dLCV fought another systemic concern involving abuse and neglect, relating to the interpretation of the abuse and neglect investigation appeals available to individuals through the regulations. This stemmed from a successful State Human Rights Committee (SHRC) appeal and guidance provided by the Office of Human Rights that attempts to define a finding of a rights violation separately from a finding that abuse or neglect occurred. The Office of Human Rights responded, affirming its agreement with dLCV's interpretation of the regulations. dLCV feels the response is comprehensive and mostly affirms its interpretation of the human rights regulations, but belies larger issues with the efficacy of the system. We continue to hold the system accountable for its deficiencies.

As we monitored Juvenile Justice Facilities and Psychiatric Residential Treatment Facilities (PRTFs) serving children and youth, we managed complicated projects and cases including the examples below:

During this fiscal year, dLCV received media reports regarding allegations of abuse of juvenile detainees at Shenandoah Valley Juvenile Center in Staunton (SVJC). SVJC is a local juvenile detention that contracts with Health and Human Services (HHS) Office of Refugee Resettlement (ORR) to house minor unaccompanied immigrants. dLCV notified the Shenandoah Valley Juvenile Center of plans to visit under our access authority, to meet with the children and youth being detained there, and to observe conditions and treatment at the institution. dLCV staff toured the physical facility, interviewed medical and correctional staff, and spoke informally with several federal and local detainees. dLCV was among the first to conduct such a visit, and the Director of HHS ORR issued a memorandum to confirm that protection and advocacy organizations may inspect, view, and photograph areas used by the residents.

dLCV conducted two additional monitoring visits and interviewed all of the 38 federal and local juvenile detainees. Notably, none of the detainees covered by previous media reports were still at SVJC. dLCV focused on potential allegations of abuse of federal detainees, but resident interviews did not result in any significant complaints or patterns of abuse. dLCV opened an investigation regarding failure to provide adequate mental health treatment to a local detainee. dLCV will continue to monitor SVJC in FY19.

At another facility, Ben, a fifteen-year-old male, was clinically ready for discharge from his residential placement, yet his team could not find a suitable placement. Ben's case barriers included his significant mental health and developmental disability needs and history of sexual victimization and offenses. Ben's team had more than adequate funding, yet no step-down or lateral residential placement would accept him and he was not yet ready to come home. Ben's mother was told that she either needed to terminate her rights (and the state would take over and place him) or "wait for him to reoffend" (and the juvenile court system would take over and place him). After dLCV's tenacious advocacy, a discharge placement was located in a less restrictive treatment program. Ben's family and his support systems stayed in place.

Natalia is 17 and has complex mental health needs. She moved back to the U.S. after her father's military transfer from Europe. While she lived in Europe, Natalia cycled through multiple inconsistent systems of mental health services. Natalia received a denial of services from the Community Services Board (CSB) and school district and it appeared she would be stuck in facility based mental health services indefinitely. dLCV worked to ensure linkages to the CSB, school system, crisis services, and Department of Aging and Rehabilitative Services (DARS) to also aid in her vocational and workplace goals. Today, Natalia is living with her family, working at the Commissary in Northern Virginia, and gaining her GED to graduate high school.

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)].

None

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

Section G. Actual PAIMI Budget/Expenditures for FY 2018

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 all DBHDS facilities for people with disabilities using site visits, review of Critical Incident Reports (CIRs), relevant policies and procedures, CMS surveys, APS reports, and other sources. Publish annual report summarizing reports received and results of monitoring. 2. Based on information developed through monitoring activities, identify systemic issues involving institutional failures to protect residents from harm and obtain corrective actions. 3. Provide STA to all residents who request it during facility monitoring. 4. In all monitoring, all STA and in every investigation, advocate for improved internal processes at DBHDS facilities to protect residents from harm and

	protect established human rights, measuring progress against analytical matrix. 5. With the assistance of volunteers, review at least 20 reports of investigation of abuse and neglect of individuals in DBHDS operated facilities. Identify deficits. 6. Publish an annual summary of investigative deficits identified in DBHDS investigations and identify corrective action needed. 7. Monitor DBHDS management of forensic transfers from jail to hospital for restoration, and obtain corrective action if the number of individuals waiting for transfer to any given hospital exceeds 10, or if any individual awaiting transfer is kept waiting for over 30 days. 8. Monitor DBHDS plan to transfer individuals from maximum security at Central State Hospital to Eastern State Hospital in a timely manner. If after January 1st plan has not been implemented or is unsuccessful as measured by any one individual waiting more than 30 days or multiple individuals waiting more than 10 days, obtain corrective action. 9. Investigate at least 6 incidents or allegations of abuse or neglect by staff in licensed congregate care facilities. Obtain corrective action. Information to be drawn from APS reports, CHRIS reports, CMS surveys or complaints. 10. Improve investigations and protection from harm by representing at least 6 individuals in Human Rights hearings to appeal investigative findings where review of the investigation indicates potential for systemic impact.
Target Population:	PAIMI-eligible persons residing in institutional settings
Expected Target:	Monitor DBHDS facilities, Represent fifty individuals, Monitor and review CHRIS, APS and CIR data,
Achieved Outcome	1. dLCV conducted a total of 55 of visits to Virginia's state operated mental health facilities, along with 9 visits to the state operated skilled nursing facility, which includes a subpopulation of PAIMI eligible individuals. dLCV analyzed 317 Critical Incident Reports (CIRs) and 294 Adult Protective Services Reports involving PAIMI-eligible individuals, analyzed data provided by the Department of Behavioral Health and Developmental Services (DBHDS) and information gathered during on-site visits. dLCV completed an internal annual report of its monitoring activities, including identification and analysis of key issues and data gathered in FY2018. dLCV reports monitoring activities to the public annual through the dissemination of the annual PPR report at dlcv.org. 2. Data gathered through monitoring showed an unexpectedly high number of deaths within 90 days of an admission at state operated mental health

	facilities. dLCV reported our analysis and concerns with the new Commissioner of the DBHDS. DBHDS agreed that "concerns regarding serious injuries and deaths are important and warrant continued review" and acknowledged dLCV's concerns regarding a lack of consistency in reporting. dLCV monitored an Office of Human Rights (OHR) investigation into staffing patterns at the state operate mental health facility for geriatric patients. The investigation found that there was sufficient staffing to care for the patients, but lack of clarify on which staff had responsibility for completing Activities of Daily Living (ADLs). Despite the facility's efforts to improve, dLCV found that the facility failed to provide support for ADLs. Both patients and staff reported that staff are unable to help individuals to the bathroom in a timely manner and they sit in soiled undergarments. Staff acknowledged that certain individuals with complicated behaviors act out when you neglect their basic needs. This deprives individuals of dignity, and leads to physical and pharmacological interventions to address behaviors. dLCV is now working with individuals to file complaints to resolve the matter. dLCV also supports the Office of Human Rights in collecting data and filing additional complaints on behalf of neglected patients. At another state operated mental health facility, dLCV worked with two transgender residents to protect their access to the restrooms that corresponded with their respective gender identities. At another facility, dLCV continues to monitor falls and fall injuries after working successfully with the facility on a reduction plan in FY2015. 3. dLCV provided short-term assistance to all facility residents who requested it while on-site at Virginia's state operated facilities. Common concerns are discharge readiness and planning, surrogate decision-making and involvement in treatment planning, and how to file a complaint or make a report of abuse or neglect. dLCV also provide short-term assistance on the graduated release process for Not Guilty by Reason of Insanity (NGRI) acquitees. Equipped with information and individualized advice and self-advocacy strategies, many individuals were able to self-advocate for their own goals. I'M READY TO GO Daryl requested help from dLCV. He felt facility staff and caregivers were withholding information from him regarding his readiness for discharge. He also asked for advice on removing his mother as his payee and using legal documents like an advance directive to address incapacity. dLCV verified his discharge readiness with the facility, provided Daryl with the information, and explained his discharge rights. dLCV also counseled Daryl on the representative payee and advance directive questions and recommended legal strategies for achieving his goals.

	EQUIP ME TO ADVOCATE dLCV also provided short-term assistance to Hattie. dLCV met Hattie on a residential unit at a state operated mental health facility. Hattie discussed her concerns regarding her treatment rights and hopes for a prompt discharge. dLCV advised Hattie on how her right to discharge could be limited by the court and the treatment team. To help her better self-advocate, dLCV helped Hattie obtain a copy of her current treatment plan which included her treatment goals and discharge criteria. dLCV also helped Hattie file a complaint regarding her eating plan and delivered it to the director on her behalf. FINDING MY WAY HOME After dLCV involvement, Manny achieved conditional release through the NGRI graduated release procedures. dLCV helped him achieve discharge to an assisted living facility and provided him with detailed advice on laying the groundwork for, and requesting, a subsequent transfer to his family home. 4. dLCV helped an individual regarding with a forensic discharge and leveraged it into a systemic benefit. dLCV confronted the facility's history of keeping Not Guilty by Reason of Insanity (NGRI) patients for very high lengths of stay and encouraged the administration to reexamine its treatment and discharge planning approach for NGRI patients. Data suggests this advocacy was effective. In the last few months, the facility already discharged about 20% of its NGRI population, including dLCV's client, and expects to discharge another 20% by the end of the year. dLCV worked with two dually-diagnosed clients (have both a mental illness and a developmental disability) who were involuntarily committed to state operated mental health facilities. This work prompted concern with the isolation of the individuals and the lack of treatment programming. dLCV challenged the lack of treatment programming and therapeutic intervention for individuals with DD and SMI, arguing this contributes to the reliance on restrictive interventions, including physical and chemical restraints. dLCV advocated for more individualized services that address the specific behavioral support needs of dually-diagnosed individuals and to discuss how the facility is responding to the problem. 5. dLCV reviewed 21 investigations of abuse and neglect of individuals in state operated facilities, primarily of PAIMI eligible individuals in mental health facilities. dLCV conducted an analysis of the reports as well as reports from previous years and found that the most common deficit in investigations is the inappropriately focused investigatory question. dLCV also found investigators routinely failed to interview peer witnesses. 6. dLCV created a draft report detailing investigative deficits. The report is in the edit phase for publication in FY 19.

	7. DBHDS Office of Forensic Services provides weekly updates on individuals scheduled for transfer from jail to DBHDS operated mental health facilities for the competency evaluation or restoration services. The Virginia Code now requires transfer within 10 days of receipt of the valid court order. DBHDS is meeting its internally established 7-day target. They have greatly improved the management of evaluation and restoration admissions, and maintained compliance with the law. In 2009, individuals could wait in jail for up to a year for admission from jail for services. The waiting list for admission to inpatient forensic services once had 140 individuals. Individuals now receive services in a timely fashion. 8. dLCV monitors the transfer lists to confirm DBHDS continues to honor its commitment to timely transfer of eligible individuals from maximum security to their local mental health facilities, particularly Eastern State Hospital. 9. MANAGE THINGS CORRECTLY Finn contacted dLCV to report sexual assault by a female peer. Despite reporting the assault to the facility, the facility failed to protect him from further harassment by the peer. dLCV requested the hospital's investigation, but found the facility failed to follow its own procedures and investigate. dLCV helped Finn file a complaint with the director regarding the violation of his rights. When the facility failed to provide an appropriate response, dLCV persisted with requests that the director respond to Finn's complaint and his request for an apology. The director acknowledged the mistakes and agreed to corrective action that should improve facility practices. 10. See Item 9, and Death Investigation and Accomplishments, for further information.
Provide an explanation if the target was not achieved:	Met

Priority/Goal Description:	People with Disabilities are Free from Abuse and Neglect Focus Area: Children and Youth 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 CIRs, with a focus on the reduction of restraint usage by ten percent (10%) during FY18. Provide residents with information about their legal rights.

	2. In response to incident reports, Psychiatric Residential Treatment Facilities (PRTF) incident reports, and Adult Protective Services (APS) reports, identify and analyze trends of preventable incidents involving children and adolescents (through age 22) in PRTFs licensed by DBHDS. 3. Based on identified issues, investigate 10 allegations of abuse and neglect at institutions serving children, involving unnecessary seclusion and restraint, medical neglect, or staff abuse or neglect. Publish written reports of findings and obtain corrective action. 4. Represent 10 individuals at institutions serving children who need assistance in accessing appropriate community based services and assistive technology during discharge planning. 5. Monitor conditions at 2 Psychiatric Residential Treatment Facilities (PRTFs) serving dual diagnosis youth under age 22, with a focus on use of seclusion and restraint, medical neglect, and staff abuse. 6. Provide short-term assistance to all residents of institutions serving children and adolescents who request it during monitoring.
Target Population:	PAIMI-eligible children and adolescents residing in the community or facilities
Expected Target:	Monitor 3 facilities, Represent ten individuals, Complete ten investigations,
Achieved Outcome	1. Through this fiscal year, dLCV traveled to and monitored The Commonwealth Center for Children and Adolescents (CCCA) five times. dLCV's monitoring consisted of 1:1 informal rights discussions with clients, unit visits and observation, meetings with Human Rights, Office of Licensure and Certification, and various administrative personnel. This fiscal year additionally saw three different Acting Directors managing CCCA; dLCV met with each to introduce ourselves, our role, and discuss our history and future involvement with CCCA. Additionally, dLCV met with DBHDS three times throughout the year to ensure appropriate Critical Incident Reporting (CIR), appropriate investigation of reported incidents, and our focus of seclusion and restraint reduction. As a result of these meetings, dLCV now receives quarterly seclusion and restraint data from CCCA. Additionally, CCCA is now reporting within requirements for critical incident reports. DBHDS has reiterated to dLCV that seclusion and restraint reduction is not their focus. DBHDS will focus upon turning CCCA into a hospital model with a change in accreditation. Despite this, we have seen an increase (and then drop) in seclusion and restraints utilized by CCCA for attempted behavioral modification through the Spring and Summer of 2018. dLCV's monitoring additionally resulted in multiple successful investigative outcomes and information and referral provided to residents and families. As a result of our investigations at CCCA, CCCA has implemented substantial corrective action. This corrective action includes new policies on monitoring and

	special precautions of patients with identified clinical or sexual activity engagement or suicidal precaution; sexual allegations reporting, investigation, and post-assault care; CCCA staff medical responsiveness; and investigative training for DBHDS investigators and additional training for all CCCA staff. 2. This fiscal year, dLCV worked collaboratively cross-unit to respond appropriately to community incident reports, PRTF reports, and APS reports. Responses included identification and analysis of trends of non-reporting facilities, facilities out of compliance with state code and regulations, and facilities violating client rights. Reviewing these incidents involving children and adolescents (through age 22) in PRTFs licensed by DBHDS and cross-referencing with APS reports allowed dLCV to ensure client protections by providing education and outreach to facilities, and short-term assistance, case-level services, and investigation to clients across the state of Virginia. Additionally, dLCV follow-up on these incidents allowed for the opportunity to collaborate with stakeholders such as the Community Services Boards (CSBs), DBHDS, Department of Social Services, and other community partners. 5. At the beginning of this fiscal year, dLCV contacted DBHDS and The Department of Medical Assistance Services (DMAS) to obtain percentages of residents receiving treatment with both mental health and developmental disability needs in all of Virginia's 19 PRTFs. Additionally, dLCV then contacted each individual PRTF to ascertain accurate data. Shockingly, dLCV found that almost all PRTFs serve children who have both mental health and developmental disability needs. Additionally, a handful of PRTFs also serve children with complex medical needs as well. dLCV identified both PRTF Hughes Center and Cumberland Hospital for further monitoring. As Virginia's system is so bifurcated, it has been dLCV's experience that these are the children who fall through the cracks of our system. Over the course of the fiscal year, dLCV monitored both facilities through in-person oversight and meetings with administration, all clinicians, and all residents. dLCV additionally met with parents at both PRTFs during visitation nights. As a result of dLCV monitoring, dLCV has provided information and referral, short-term assistance, and case-level services to children, parents, and staff. Additionally, dLCV has strengthened the relationship between administration and staff between both Hughes Center and Cumberland and dLCV to foster dLCV serving as a resource for aid in the future. Additionally throughout this fiscal year, dLCV provided a total of 6 self-advocacy trainings and outreach at PRTFs serving children and youth. This outreach included approximately 140 residents, 4 families, and 70 staff throughout Virginia. 3. PROGRESS ON RESTRAINTS Edwin's father approached dLCV with allegations of abuse and neglect on behalf of his son, a sixteen-year-old resident of Commonwealth Center for Children and Adolescents (CCCA). Edwin alleged restraint without access to an interpreter.

Edwin's primary mode of communication is American Sign Language (ASL) and these restraints inhibited his ability to communicate, making the restraints utilized even more dangerous and problematic. CCCA conducted their own investigation which found the allegations unsubstantiated. dLCV investigated these allegations and disagreed with CCCA's findings. dLCV made extensive corrective action recommendations to CCCA. As a result, CCCA implemented substantial corrective action, including Center Instruction "Language Access Services for Individuals with Limited English Proficiency or other Communication or Language Barriers." This policy details facility response to not only residents who utilize ASL to communicate but also other populations that may enter CCCA, such as non-English speaking and non-verbal patients. The importance of this policy is paramount as CCCA's population continues to shift to accept and treat individuals diagnosed with multiplel disabilities and who may need additional assistance and accommodations in communication.

RESTRAINT RETRAINING

After dLCV reviewed a reportable incident from a PRTF noting a "deformed arm" secondary to restraint, dLCV opened an investigation into the incident. dLCV encountered access issues from the PRTF, challenged these barriers, and won access to all records and testimony. Eight-year-old Gary's arm fractured during a restraint with staff. dLCV conducted an extensive investigation into the incident and substantiated excessive force and improper restraint technique utilized. After dLCV investigation and advocacy, the PRTF completed all requested corrective action, including staff retraining, emergency treatment and treatment plan alteration for Gary, and notification and inclusion of all parties in all investigatory matters. As a result of the dLCV investigation, Gary and other current and future residents at the PRTF have increased oversight and safety while receiving treatment.

4. DESPERATE FOR HELP TO DISCHARGE

Xena, a sixteen-year-old female at a PRTF, and her family reached out to dLCV for aid in discharging back into the home community. As Xena has complex psychiatric and developmental disability needs, she cycled through Virginia's psychiatric system since she was a child. Xena's family was desperate to find aid to help her come home. Xena received a Medicaid waiver, yet the Community Services Board (CSB) was unresponsive, telling her family they should terminate their rights and JC could "remain in the PRTF." Simultaneously, Xena's school district was threatening cessation of funding. dLCV held both the CSB and the school district responsible for funding and service provision as Xena was discharged. Additionally, dLCV ensured appropriate supports to maintain her home placement, including two aides at all waking hours. As a result of dLCV advocacy, Xena is doing well in school and happy to be home.

	NO USE IN APPLYING?! Upon referral from a PRTF, dLCV opened a case to assist fourteen-year-old Ira to discharge back into the community. When dLCV opened the case, Ira and her family had been awarded a Medicaid waiver for services but were told by the CSB that she "won't receive services until she is 50," and there was "no use in applying" for other services, such as Medicaid's Early and Period Screening, Diagnostic and Treatment (EPSDT) program, which could fund a group home placement for Ira. dLCV held the CSB accountable for assessment and service provision for Ira prior to and through discharge. Ira is now receiving services and living happily in a group home with her peers. 6.COLLABORATION WITH STATE OFFICIALS dLCV opened a short term assistance service request to provide assistance for a sixteen-year-old teenager, Jose. CCCA discharged Jose without a written discharge plan and adequate community services in place. dLCV requested DBHDS to intervene. dLCV also provided Jose's father with verbal and written information about his right to a comprehensive discharge plan under state law. This helped provide time to arrange for necessary services prior to his discharge. COLLABORATION WITH HUMAN RIGHTS dLCV looked into Amber's treatment at CCCA. Concerns existed with admission and treatment, to include seclusion, restraint, and internal investigations. Her father expressed frustration to dLCV about denial of access to his daughter, both in terms of visitation and record review by CCCA. dLCV reached out to CCCA and found that the father had his rights terminated and was denied access for clinical reasons, and that Amber's grandmother was her guardian as appointed through the courts. dLCV provided information and referral to the father and short-term assistance to Amber and her Grandmother regarding her rights while in CCCA. dLCV additionally referred all parties to the Office of Human Rights for further information and review.
Provide an explanation if the target was not achieved:	Met

Priority/Goal Description:	People with Disabilities are Free from Abuse and Neglect Focus Area: Children and Youth with Disabilities Receive Appropriate Services in Juvenile Justice Facilities

Objective:	1. Conduct outreach at 4 Juvenile Detention Centers (JDCs) with Community Placement (CPP) or Detention Re-entry programs and provide information on dLCV services, with a focus on vocational rehabilitation and school re-enrollment. 2. Provide 3 trainings to educate juvenile justice involved youth and their parents or guardians on special education rights. 3. Ensure the provision of 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. Monitor conditions at Bon Air Juvenile Correctional Center through quarterly visits, with an emphasis on enforcing our P&A access authority, and provide residents with information about their legal rights. 5. Investigate the use of room confinement at Bon Air JCC, focusing on length of confinement and educational services while in confinement. Use findings to support public comment to proposed DJJ JCC regulations.
Target Population:	PAIMI-eligible youth residing in correctional facilities
Expected Target:	Seven Outreach and Training Activities Monitor DJJ JCC facility, Investigate confinement
Achieved Outcome	1. dLCV provided information on dLCV services to 4 Juvenile Detention Centers (JDCs) to include Merrimac, Chesapeake Juvenile Detention Center, Prince William Detention Home, and the Shenandoah Valley Juvenile Center. Additionally, dLCV presented information at the Community Placement Program (CPP) meeting of directors in May. As further outreach was requested, dLCV presented to 30 probation and parole staff from Virginia Beach's Court Services Unit (CSU). To continue to monitor and educate ourselves, dLCV attended all Department of Juvenile Justice (DJJ) Board Meetings held this year in order to monitor policy changes and discussions within the department. During a monitoring visit, dLCV learned that a Virginia school division was not following Virginia Department of Education Re-enrollment Regulations. dLCV worked with this school division to inform them of their obligations. The school division appointed a division wide re-enrollment coordinator and clarified their role for special education students going through this process. The school's review of this procedure also revealed that there were delays from DJJ and the CSU in providing needed educational records to the school division. The school division met with DJJ and the CSU to ensure that all entities know the process going forward. As a result of dLCV advocacy and outreach, a smooth re-enrollment process will help to ensure that youth receive correct classes and have the proper support in place for immediate return to school when leaving DJJ facilities.

	2. Additionally, dLCV provided three days of training on Saturdays during the year regarding Individualized Education Plan (IEP) and special education services to aid in self-advocacy to residents at Bon Air Juvenile Correctional Center (JCC). All available special education students (82 students offered training) at Bon Air JCC had an opportunity to attend the voluntary training. 3. dLCV created fact sheets on school re-enrollment and mental health transition planning regulations so that youth and their guardians are aware of their rights under these regulations. dLCV arranged for distribution of this information as well as fact sheets on post-secondary transition planning and supported decision making to youth and guardians at intake into JCC. As a result of dLCV outreach, youth and guardians are now better prepared for the re-entry process, are knowledgeable about their rights in several disability related areas, and are aware of dLCV as an advocacy resource. dLCV also had the two documents translated in Spanish and provided them to DJJ, so that Spanish speaking youth and families also have access to our fact sheets for self-advocacy. dLCV successfully advocated for systemic change in educational record keeping at Bon Air Juvenile Correctional Center (JCC). dLCV's advocacy resulted in students records updating as soon as a child moves to the next grade. Previously this occurred only at the end of the academic year. As a result of dLCV monitoring and oversight, Bon Air JCC will now possess accurate records for students who complete more than one grade a year. dLCV additionally advocated for systemic change regarding student copies of Individualized Education Plans (IEPs). New DJJ policy states that staff note in the student's Prior Written Notice (PWN) when a student receives a copy of an IEP, so that there is documentation to protect the student rights. 4. Over the course of this fiscal year, dLCV visited Bon Air JCC a total of 20 times to conduct monitoring visits, classroom observations, client meetings, abuse and neglect investigations, and advocacy trainings for youth. dLCV sent room confinement and other concerns observed during these visits to DJJ via a letter. 5. After witnessing egregious use of room confinement, dLCV spent the fiscal year gathering data on the use of confinement at JCC to better inform policy change that reduces the use of this practice. dLCV conducted information gathering via a Freedom of Information Act Request to gain information and data on room confinement. dLCV additionally attended the DJJ Workgroup for the proposed room confinement regulations for Juvenile Correctional Centers. In this review, dLCV noted several concerning uses of room confinement at Bon Air JCC including the confinement of residents during weekly staff meetings, removal of residents from their living unit for room confinement, and staff confining all other residents to their rooms when one resident on room confinement was out of their room for exercise or hygiene time. dLCV sent a letter to the DJJ Director and the DJJ Board outlining our observations and making recommendations on how to reduce uses of room confinement that are not for safety or security.

Provide an explanation if the target was not achieved:	Met

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. Provide STA to 15 residents of DBHDS psychiatric hospitals who have questions about discharge rights. 2. Advocate for 7 individuals who have been found ready for discharge for more than fourteen days to receive timely and appropriate discharge planning. 3. Monitor the DBHDS' progress in reducing the number of individuals who are identified with extraordinary barriers to discharge and the length of time they wait for that discharge. Trend data and obtain DBHDS identification of what known barriers. 4. Inform DBHDS, the SHRC and others of our analysis of the EBL, at least annually, and seek their support for improved discharge practices and supports. 5. Using the above tactics, advocate that no facility has 15% or more of their census on the EBL. 6. Monitor the implementation of Assisted Living Supportive Housing grants at the three demonstration sites: Blue Ridge CSB, Mount Rogers CSB, and Richmond Behavioral Health Authority. Identify any barriers to successful implementation and obtain corrective action.
Target Population:	PAIMI-eligible individuals awaiting discharge in institutional settings
Expected Target:	Monitor facilities, Assist 22 individuals, EBL education Monitor housing grant implementation
Achieved Outcome	1. 22 individuals residing in state-operated psychiatric hospitals received short-term assistance services from dLCV regarding discharge rights. 2. dLCV assisted individuals by verifying discharge readiness, helping them understand legal rights in involuntary commitment, and providing them with strategies to secure timely discharge.

	dLCV involvement can be a catalyst for the hospital to prioritize discharge. When Pamela contacted dLCV for information on her discharge readiness, dLCV explained her rights to her and contacted the facility requesting information on her discharge readiness. The facility discharged Pamela immediately and without delay. Pamela is now living successfully in her community. dLCV also provided short-term assistance to Margot, advising her of rights and her discharge readiness. After speaking with her team and advocating for her discharge, she left the facility within a few days. For other clients, dLCV can help individuals understand barriers and re-evaluate their discharge needs. dLCV connected with Andrew after a review showed he'd been on the barriers to discharge list for more than 3 years. He asked dLCV to speak with facility staff and help him better understand why he remained at the hospital. dLCV helped Andrew understand delays related to the facility and the mental health services agency attempting to carry out Andrew's wishes. However, after investing significant time into those plans, it was clear the plans were not possible due to Andrew's complicated legal situation. dLCV advised Andrew regarding the more workable plans his team had offered. dLCV also provided short-term assistance to individuals on how their forensic involvement impacts discharge readiness, planning, and rights. dLCV met with Kenneth during a facility monitoring visit. Kenneth found the discharge process complicated and confusing and wanted help understanding his barriers. DLCV discussed the matter with his social worker and the forensic coordinator to clarify Kenneth's forensic involvement and specific barriers to returning to his community. dLCV provided Kenneth with a detailed letter, including information on competency evaluation, his rights, and what remedies were available to him. In FY2018, dLCV provided discharge advocacy services to ten individuals in state operated psychiatric facilities through PAIMI. dLCV prioritized advocacy services for individuals found to have Extraordinary Barriers to Discharge, meaning they were experiencing barriers to discharge unrelated to discharge readiness. Mialee's parents contacted dLCV and asked for help removing barriers to discharge so that Mialee could achieve her goal of receiving specialized treatment for her eating disorder. Her parents supported Mialee's goal by petitioning for the removal of guardianship and helping Mialee make an advance medical directive. dLCV listened to Mialee's preferences, advised her of her discharge rights, and discussed planning for future incapacity. Mialee and her parents were able to remove the guardianship, and she was discharged from the state facility to a specialized program with resources to continue her journey toward independence and recovery. Cedric had shown readiness for discharge for a long time, but neglected communication needs and lack of engagement had stalled efforts to find him a placement. dLCV collaborated with DBHDS and the facility to identify an appropriate placement. We also advocated for support services protecting Cedric's communication needs throughout the transition process. When the plan

	was at risk of failing due to lack of coordination, dLCV worked individually with the agencies involved to develop a unified plan for discharge that included a secured contract with an interpreter service, completed admission paperwork, and dLCV participation on behalf of Cedric's authorized representative. At the end of the process, dLCV happily accompanied Cedric and his interpreter to his new home. Jack asked for help when -- after almost a year of preparing for discharge to his own home -- his treatment team changed the plan. They told Jack he would need to move into an apartment with supports. The team felt concerned that the court would reject Jack's conditional release plan if he returned home with his mother, the victim of his NGRI offense. However, his mother provided an important support system for him and welcomed him back home. With help from the facility advocate, dLCV argued for Jack's right to discharge in accordance with his preference and with his support system in place. Jack ultimately agreed to the teams alternative discharge plan with the understanding that he could work toward returning home with his mother. dLCV continued to support Jack's discharge, including filing a complaint when Jack's team subjected him to unnecessary restrictions that prevented him from exercising his privileges for two weeks. Jack was able to return to the community on conditional release, where he continues working toward safely returning home with his mother. 3. dLCV analyzed Extraordinary Barriers List (EBL) data monthly and identified facilities with disproportionately high ratios of patients remaining institutionalized due to discharge barriers. dLCV staff met with senior staff at the facilities to discuss strategies to identify and eliminate discharge barriers. dLCV also monitored the conversation around bed availability and barriers to discharge taking place among DBHDS, lawmakers, and the public. Despite high numbers at select facilities, dLCV noted a moderate decline in the average length of stay on the EBL list in second half of the year, indicating that barriers to discharge are being resolved more quickly. At least one facility showed a sharp decline in individuals experiencing barriers to discharge. 4. dLCV discovered that the state operatined skill nursing facility -- which serves individuals with developmental disabilities and with mental illness subject to involuntary commitment orders -- lacks an adequate framework for identifying individuals experiencing barriers to discharge. After the previous director retired, existing ad-hoc processes for identifying barriers lapsed. dLCV provided the current administrator with information on how the previous administrator tracked barriers to discharge and worked with them to identify individuals subject to involuntary commitment orders. dLCV contacted DBHDS with a request to include individuals at the facility on the EBL list and to investigate discharge planning deficits for the individuals, with additional follow up to take place in FY2019. 5. dLCV staff met with senior staff at the facilities to discuss strategies to identify and eliminate discharge barriers. dLCV also monitored the conversation around bed availability and barriers to discharge taking place among DBHDS, lawmakers, and the public. Despite high numbers at select facilities, dLCV noted a moderate

	decline in the average length of stay on the EBL list in second half of the year, indicating that barriers to discharge are being resolved more quickly. At least one facility showed a sharp decline in individuals experiencing barriers to discharge. See Accomplishments section for additional information. 6. dLCV closely followed the development of the auxiliary grant in supportive housing (AGSH) program by remaining in contact with the three CSBs who are administering the program and the Department of Behavioral Health and Developmental Services. This program allows funding that is typically used to subsidize services in an assisted living facility (ALF) for programs that allow for greater independence. CSBs with experience operating supportive housing programs found AGSH fit well within their existing structure for providing housing services. However, the small size of the program and the time investment in developing relationships with DSS offices – who manage grant funding -- are ongoing barriers. DBHDS provided needed flexibility to improve the implementation of the program within established regulatory limits.
Provide an explanation if the target was not achieved:	Met