OMB Approval: 0930-0169
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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

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A. PAIMI Program Information

General Information

1. P &A Identification

Name of state or jurisdiction	Virginia
Name of P&A systems	disAbility Law Center of Virginia
Duns#	078863392

2. Main Office

Agency Name of Main Office	disAbility Law Center of Virginia
Mailing Address	1512 Willow Lawn Drive, Suite 100
City	Richmond
Zip Code	23230
Phone Number of Main Office	804-225-2042
Toll Free Number	800-552-3962
Email address	info@dlcv.org
Website address	www.dlcv.org
TTY phone number	800-552-3962
County of Main Office	Henrico, VA

3. Satellite Office (if any)

Agency Name of Satellite Office	N/A
Mailing Address	
City	
Zip Code	
County of Satellite Office	

4. Executive Director/CEO Contact Information

Name	Colleen Miller
Mailing Address	1512 Willow Lawn Drive, Suite 100
City	Richmond
Zip Code	23230

Phone Number/Extension	804-225-2042
Email 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
Email Address	Robert.Gray@dlcv.org

6. Governing Board President/Chair

Name	Tom Walk
Mailing Address	1512 Willow Lawn Drive, Suite 100
City	Richmond, VA
Zip Code	23230
County of Residence	Henrico
Email Address	info@dlcv.org
Current Term Started	10/1/2019 12:00:00 AM
Current Term Expires	10/30/2020 12:00:00 AM

7. PAIMI Advisory Council President/Chair

Name	Tina Stelling
Mailing Address	1512 Willow Lawn Drive, Suite 100
City	Richmond
Zip Code	23230
County of Residence	VA
Email Address	info@dlcv.org
Current Term Started	1/1/2020 12:00:00 AM
Current Term Expires	1/1/2022 12:00:00 AM

8. P&A Financial Officer/Accountant

Name	Randy Reus
Title	Director of Finance and Operations
Phone Number/Extension	804-225-2042
Email Address	Randy.Reus@dlcv.org

9.Governor's Liaison

Name	Dr. Daniel Carey
Title	Secretary, Health and Human Resources
Mailing Address	Patrick Henry Building 1111 East Broad Street
City	Richmond, VA
Zip Code	23219
County of Residence	VA
Email Address	HealthAndHumanResources@governor.virginia.gov

10. Commissioner/Director of the State Mental Health Agency

Name	Alison Land
Mailing Address	DBHDS P.O. Box 1797
City	Richmond, VA
Zip Code	23218-1797
Phone Number/Extension	804-786-3921
Email Address	alison.land@dbhds.virginia.gov

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

		Governing Board	Advisory Council	Program Staff
Ethnicity	Hispanic/Latino	2	0	2
	Non-Hispanic/Latino	12	9	36

Race	American Indian/ Alaskan/Native		2	
	Asian		0	2
	Native Hawaiian or Other Pacific Islander		0	
	Black/African American	2	0	6
	White	11	7	27
	Two or more races	1	0	3
Sex	Female	7	6	29
	Male	7	3	9
	Unknown/would not disclose			

2. **Number of Mental Health Professionals on the Advisory Council** (social workers, psychologists, psychiatric nurses, psychiatrists, psychiatric nurse practitioners).

Professional Category	Number on Advisory Council
Social Worker	1
Psychologist	
Psychiatric Nurse	
Psychiatrist	
Psychiatric Nurse Practitioner	
Peer Support Specialist	
Other- consumers or family members	8
Total:	

3. Governing Board (GB) Type and Number of Members Included in Governing Board Information

Governing board	Minimum number of members	Maximum number of members
Private, non-profit with multi-member	12	19
State-operated with governing board		

State-operated with no governing board		

4. Governing Board Information

Total seats available	19
Total members serving as of 9/30/ 20	14
Total vacancies on 9/30/20	0
Term of appointment (number of years)	4
Term maximum	2
Meeting frequency	6
Number of meetings held this fiscal year (FY)	6
Percentage of members present at meetings during the FY 20	86%

5. 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.	4
Number of family members of individuals with mental illness who are R/FR of mental health services, guardians, advocates or authorized representatives or other persons who broadly represent or are knowledgeable about the needs of clients served by the P&A system.	4
Total	8

6. PAIMI Advisory Council (PAC)

PAC Chair		
Sits on the governing board	XYes	☐ No
Appointment date	1/1/2020 MM/DD/YYYY	
Other PAC member(s) sit on governing board	☐ Yes	XNo
If yes, number serving		

7. Staff charging time 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)						1	1			1
Non-Hispanic/ Latino	8	8		4	4	18	18			18
Race										
American Indian/ Alaskan Native										
Asian										
Black/African American						3	3			3
Native Hawaiian/ Pacific Islander										
White	8	8		4	4	13	13			13
Two or more races						3	3			3
Unknown										

Section B: Demographics

1. Age of PAIMI-eligible Individuals Served

Age	Number
0 – 2	0
3-5	0
6-10	0
11-22	28

23-64	58
65^{+}	19
Unknown	0
Total	105

2. Sex of PAIMI-eligible Individuals Served

Sex	Number
Female	30
Male	71
Unknown/would not disclose	4
Total	105

3. Ethnicity and Race of Individuals Served

Ethnicity	Number	PAIMI%	State%
Hispanic/Latino (of any race*)*	5	4.76	9.8
Non-Hispanic/Latino	75	71.42	90.2
Ethnicity unknown	25	23.8	
Total	105		

Race	Number	PAIMI%	State%
American Indian/Alaskan Native	0	0	0.5
Asian	1	.95	6.9
Black/African American	23	21.9	19.9
Native Hawaiian/Pacific Islander	0	0	0.1
White	54	51.42	61.2
Two or more races	2	1.9	3.2
Race unknown	25	23.8	
Total	105		

4. PAIMI-eligible Individuals Served with PAIMI Program Funds

What to Count	Number
1. Number of PAIMI-eligible individuals continued to be served with PAIMI program funds, including any program income resulting from legal actions supported by PAIMI program funds as of October 1, from the previous FY into the reporting year.	19
2. Number of new PAIMI-eligible individuals served during the reporting year.	86
3. Total number of PAIMI-eligible individuals served during this FY (add lines 4.1 and 4.2).	105
4. Individuals with more than one intervention opened/closed during the reporting year	45
5. Individuals with a co-occurring mental illness and Intellectual and Developmental Disability (IDD).	0
6. Total number of PAIMI-eligible individuals who requested program related advocacy services during the reporting year, but were **not** served within 30-days of initial contact due to:	2
a. insufficient PAIMI program resources	
b. non-priority areas.	
7. Individuals served as of September 30 and will be carried over to next reporting year (This should equal ≤ item 3 above).	38

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	3
Non-medical community-based residential facility for children/youth	2
Foster care	
Nursing homes, including skilled nursing facilities	2
Intermediate care facilities	
Public and Private general hospitals including emergency rooms	3
Public institutional Living arrangement	
Private institutional living arrangement	13
Psychiatric hospitals (public/private)	67
a. public/state 61 b. private 6	

Jails	3
State prison	
Federal detention center	4
Federal prison	
Veterans administration hospital/Clinic	
Other federal facility	1
Homeless	
Independent (in the community & PAIMI-eligible)	2
Parental or other family home & PAIMI-eligible	1
Unknown	4
Total	105

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	E	F	G	H	I
a. Inappropriate or excessive medication	5	3		2						
b. Inappropriate or excessive restraint and seclusion	5	1	1	3						
c. Involuntary medication	1			1						
d. Involuntary electrical convulsive therapy										
e. Involuntary aversive behavioral therapy										
f. Involuntary sterilization										
g. Physical assault	3	1		2						
h. Sexual assault	2	1			1					
i. Threats of retaliation or verbal abuse by facility staff										
j. Coercion	4			4						
k. Financial exploitation										
l. Suspicious death	3	3								
m. Other -										

n.										
Total	23	9	1	12	1					

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.	23
a. Number of complaints/problems determined after investigation not to have merit.	6
b. Number complaints/problems withdrawn or terminated by client.	1
c. Number of complaints/problems resolved in the client's favor.	14
d. Number of complaints/problems not resolved in the client's favor.	
e. Other representation found.	
f. Services not needed due to client death or relocation.	2
g. Lost Contact	
h. Outcome Unknown	
i. Lack of Resources	

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	F	G	H	I	J
a) Failure to provide necessary or appropriate medical (other than psychiatric) treatment.											
b) Failure to provide necessary or appropriate mental health treatment, including access to prescribed medication.											
c) Failure to provide necessary or appropriate	7	2		4	1						

personal care and safety.											
d) Failure to provide appropriate discharge planning or release from a residential care or treatment facility.	21	2	1	13	1	4					
e) Mental health diagnostic or other evaluation (does not include treatment).											

f) Medical (non-mental health related) diagnostic or physical examination.	6	3		1		2					
g) Other											
Total	34	7	2	17	2	6					

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.	
a. Number of complaints/problems determined after investigation not to have merit.	4
b. Number complaints/problems withdrawn or terminated by the client.	
c. Number of complaints/problems resolved in the client's favor.	26
d. Number of complaints/problems not resolved in the client's favor.	1
e. Other indicators of success or outcomes that resulted from P&A involvement.	
f. Other representation found,	
g. Services not needed due to client death or relocation	3
h. Lost Contact	
i. Outcome Unknown	
j. Lack of Resources	

5. Areas of Alleged Rights Violations

Number of Complaints/Problems	Number from *Closed Cases* only	Outcomes								
	Total	A	B	C	D	E	F	G	H	I
a. Failure to provide an individualized, written treatment or service plan.	4	1	1	1			1			
b. Failure to provide written discharge plan, including a description of mental health services needed upon discharge from such program or facility	6	1		5						
c. Failure to allow 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).	1			1						
d. The right to refuse treatment.										
e. The right to refuse to take prescribed medications.										
f. The denial of financial benefits/entitlements (e.g., SSI, SSDI, Insurance).	1			1						
g. Guardianship/conservator problems	2			2						
h. The denial of rights protection information or legal assistance, including adequate and appropriate representation during commitment hearings.	9	4	1	4						
i. The denial of privacy rights (e.g., congregation, telephone calls, receiving mail)										
j. The denial of recreational opportunities (e.g., grounds access, television, and smoking)	3			1	2					
k. The denial of visitors										
l. The denial of access to or correction of records										

m. Breach of confidentiality of records (e.g., failure to obtain consent before disclosure)										
n. Failure to obtain informed consent										
o. Advance directives issues	2			2						
p. The denial of parental/family rights										
q. Housing Discrimination;										
r. The denial of access to administrative or judicial process;										
s. Failure to provide educational services in the least restricted environment for PAIMI-eligible individuals;										
t. The denial of access to community based rehabilitation services and/or treatment										
u. The denial of access to transportation										
v. Employment Discrimination										
w. Other										
Total	28	6	2	17	2		1			

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.	
a. Number of complaints/problems determined after investigation not to have merit.	3
b. Number complaints/problems withdrawn or terminated by client.	1
c. Number of complaints/problems resolved in the client's favor.	20
d. Number of complaints/problems not resolved in the client's favor.	1
.e. Other representation found.	
f. Services not needed due to client death or relocation.	2

g. Lost Contact	
h. Outcome Unknown	
i. Lack of Resources	
j. Not within priorities	1

7. Reasons for Closing Individual Advocacy Case File

	Number
Number of closed cases, in which client's objective was partially or fully met	61
Other representation found	
Individual withdrew complaint	2
Services were not needed due to client's death or relocation	7
P&A withdrew because individual or client would not cooperate	
Individual's case lacked merit	13
Individual's issue not favorably resolved	2
Appeal(s) unsuccessful	
Other appropriate entity investigating	
Lost Contact	
Lack of Resources	
Not within priorities	1
Total	86

8. Intervention Strategies (more columns will be added to match C.1., C.3. and C.5.)

		Outcomes												
		Abuse				Neglect					Rights Violations			
Strategy	**Total**	A	B	C	D	A	B	C	D	E	A	B	C	D
1. SAA	1											1		
2. LA	33	7	1	6	1	6		6		1	1	1	3	
3. AR	5			1				2		1			1	
4. L	2								1					1
5. M														
6. N	6							3					2	1
7. STA	36	2		5		1	1	6	1	4	5	1	9	1
8. TA	3							1					2	
Total	86	9	1	12	1	7	1	18	2	6	6	3	17	3

9.

1. SAA – Self Advocacy Assistance
2. LA – Limited Advocacy
3. AR – Administrative Remedies
4. L – Litigation
5. M – Mediation
6. N – Negotiation
7. STA – Short Term Assistance
8. TA – Technical Assistance

a). The number of deaths reported to the P&A for investigation by the following entities:	
1. State	58
2. The Center for Medicaid & Medicare Services (Regional Offices).	0
3. Other Sources. Briefly list the source for each death reported in this category (e.g., newspaper, concerned citizen, relative, etc.).	0
Total Number of deaths investigated.	8
If the information requested in this section was not available please explain.	
b). All death investigations conducted involving PAIMI-eligible individuals related to the following:	
1. Number of deaths investigated involving incidents of seclusion (S).	0
2. Number of deaths investigated involving incidents of abuse (A).	0
3. Number of deaths investigated involving incidents of restraint (R).	0
4. Number of deaths investigated **not** related to incidents of S & R.	5
5. Death investigations with a finding or determination.	3
6. Provision in policy added or prevented as a result of a death investigation	0
Total Number of deaths investigated [Sum of 9b 1-6].	8

c). Provide a brief summary example of an individual's death, P&A involvement, and outcome.

If you reported deaths in categories B.9.b., please provide the following information on one death from each category, as appropriate:

1. A brief summary of the circumstances about the death.
2. A brief description of P&A involvement in the death investigation.
3. A summary of the outcome(s) resulting from the P&A death investigation.

dLCV received a report that Jose had attempted suicide at a state hospital and died after being transported to a medical facility. We discussed the incident with hospital staff, obtained and reviewed their root cause analysis report and the medical examiner's report of the autopsy confirming the suicide. As a result, the facility developed a corrective action plan. dLCV has monitored the facility's corrective action as part of monitoring.

Joan is the mother of a 26-year-old daughter with mental illness who died in 2018. She contacted dLCV for assistance in holding accountable the service providers whose neglect she believes contributed to her daughter's death. Unfortunately, there was no investigative avenue for dLCV in this case. However, staff provided I&R to Joan in the form of instructions for filing complaints with the various regulatory agencies in Virginia that license the providers she believes neglected her daughter.

10. Number of Interventions on behalf of groups of PAIMI-eligible Individuals – Individuals Impacted

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

What to Count	Number
1. Group cases/projects still open on October 1 (carried over from prior FY(s)).	0
2. New group cases/projects opened during the year.	26
3. Total group cases/projects worked on during the year (add items 1 and 2 above).	26
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. ethnicity	0
b. racial minorities	0
c. homeless	0
d. veterans	0
e. urban	0
f. rural/frontier	1
g. older adults/geriatric	1
6. Total number of individuals impacted by line 3.	612

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

5. E. Intervention Types *(See the Instructions for Guidance)*	Potential number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	On-going
Group Advocacy non-litigation	97,800	20		
Abuse and Neglect Investigations *(non-death related)*	9,906	5		3
Facility Monitoring Services	19,087	4		
Community Based Monitoring Services				
Court Ordered Monitoring				
Systemic Litigation				
Educating Policy Makers	36,560	2		
Other Systemic Advocacy				
Total	163,353			

12. End Outcomes of P&A Activities for Group Cases

Outcomes	**Number from Closed Group Cases only**
a) PAIMI-eligible individuals who are provided with appropriate community based services resulting in community integration and independence;	0
b) PAIMI-eligible individuals who accessed benefits and services;	0
c) PAIMI-eligible individuals who live in a healthier, safer or otherwise improved environment;	0
d) PAIMI-eligible individuals who achieved or maintained employment;	0
e) PAIMI-eligible individuals who go to school in safe and more humane conditions;	0
f) PAIMI-eligible individuals who were able to stay in school and receive an appropriate education;	0

Section D. Non-Client Directed Advocacy Activities

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

Provide the number of PAIMI Program I&R services.	
Total	266

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.	12
2. Number of education/training activities undertaken.	9
3. Number (approximate) of persons trained in 2.	2,450

4. Technical Assistance

Provide the number of PAIMI Program TA services.	
Total	3

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	4

6. Please identify all individuals (name & title), responsible for grievance reviews. **List 3**

Name & title	Colleen Miller, Executive Director
Name & title	Tom Walk, Board President
Name & title	All dLCV Board Members

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

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

Section F. Other Services and Activities

1. Does the P&A have procedures established for public comment?
a. X Yes, (briefly describe how the notice is used to reach person with mental illness and their families). dLCV offered a public input survey to identify which disability advocacy issues we should consider in FY 21. We posted the survey our website and distributed primarily through electronic means with some limited distribution in outreach due to COVID. Our 112 respondents identified quality mental health care, community access, and special education as the top three areas of concern. 39% of our respondents were individuals with disabilities. Agencies and groups we reached included: the Virginia Board for People with Disabilities, 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 21 goals and focus areas.
b. ☐No, (if no, briefly explain, limit to 500 characters).

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

3. Do the procedures provide for receipt of the comments in writing or in person?	X Yes	☐ No
3.a. If **yes** to 3, attach a copy of the agency's policies/procedures pertaining to public comment.		
3.b. If **no** to 2 a, b, c., explain why the agency does not have such procedures in place.		
The dLCV Board's Public Input Committee convenes multiple times throughout the year and develops our annual survey instrument(s) and assesses the best way each year to receive and solicit public comment. Anyone can provide public comment at any time to dLCV throughout the year as well.		

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

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

See F 1-a.

6. What formats and languages (as applicable) were used in materials to solicit public comments?

English, Spanish, Braille and other formats and languages as requested

7. 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
VOICES for Virginia's Children
Child Protective Services
Office of the Attorney General
DBHDS Office of Human Rights and Office of Licensure
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 Division
Virginia's Attorney General

8. 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 hired a Disability Rights Advocate with specific skills in outreach to reach the Hispanic community. We continued our participation with the Hispanic Chamber of Commerce and involvement in multiple outreach activities including resource fairs, and meeting with organizations serving individuals with mental illness.

9. Did the activities described in 9; result in an increase of ethnic or minorities in the following categories?		
a. Staff	X Yes	☐ No
b. Advisory Council	☐ Yes	X No
c. Governing Board	X Yes	☐ No
d. Clients	☐ Yes	X 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. dLCV continues to diversify our agency as a whole. COVID limited our ability to complete targeted outreach for in person trainings and outreach.		

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 monitoring activities were limited due to the COVID-19 pandemic, but advocates were able to monitor remotely through data, news reports, and soliciting consumer feedback for the first part of the year. We resumed our on-site monitoring in May. dLCV faced some challenges to our access authority, particularly in our jail monitoring efforts. In each case, we were able to successfully educate the providers challenging us and gain access. dLCV established goals for the next fiscal year specific to ensuring timely access authority and avoid future delays.
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.).
The COVID-19 pandemic also resulted in an internal shifting of resources and priorities for dLCV as we responded to increased cases regarding service and treatment denials for our clients, access issues, and creation of creative and safe ways to continue oversight of our facilities.
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.).
Throughout the year, dLCV's work influenced local media reports; most frequently, this involved our analysis and work to reduce the "Extraordinary Barriers List" of individuals awaiting discharge. Our work in this field led to improved data collection methods and increased oversight for the State Hospitals. dLCV claimed victory in several contentious Human Rights Hearings, including the case of a young woman who was ignored by Western State Hospital when she filed multiple allegations of abuse and neglect, and the case of a young man who was stabbed by a peer while in restraints. Both of these victories led to substantial policy changes at the involved State Hospitals. dLCV's advocacy at Southwestern Virginia Mental Health Institute was responsible for a 50% reduction in their use of restraint, leading to a safer space for hundreds of Virginians. Finally, dLCV's ability to continue substantial monitoring of State Hospitals and jails, despite the COVID-19 pandemic and challenges to our access authority, was powerful and shows the dedication and creativity of its staff. https://www.dlcv.org/when-barriers-to-discharge-arent-extraordinary

https://www.dlcv.org/critical-incidents-report

https://www.dlcv.org/trapped-in-state-hospitals-while-infection-spreads

https://www.dlcv.org/virginia-continues-to-violate-the-human-rights-of-over-200-virginians

https://www.dlcv.org/hundreds-trapped-in-state-hospitals-unable-to-move-to-the-community

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)].
dLCV has limited resources to complete our PAIMI program and additional funding would allow us to serve more Virginians with mental illness.

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

Section G. Actual PAIMI Budget/Expenditures for FY 2020

SEE EXCEL ATTACHMENT

Section H: Statement of Priorities (Goals)

Goal 1 People with Disabilities are Free from Abuse and Neglect

Focus Area 1 – People with disabilities are free from harm in adult institutions

20.1.1.1-Develop a flow chart of how the adult institutions service delivery system works in Virginia, with all routes indicated. Publish on dLCV website.

20.1.1.2- Update Mental Health resources website to include at least 2 more Quick Guides and at least 3 more referral sources.

20.1.1.5- Monitor DBHDS-operated facilities for people with disabilities using site visits, review of Critical Incident Reports (CIRs), relevant policies and procedures, CMS surveys, APS reports, weekly forensic transfer reports, and other sources. Identify systemic issues each quarter involving institutional failures to protect residents from harm and develop a coordinated response to improve internal processes and protect established human rights.

20.1.1.6-Provide I&R, STA, or STA-level preliminary investigation to all residents who request it during DBHDS-operated facility monitoring.

20.1.1.8- Following STA-level preliminary investigation, investigate 3 allegations of abuse or neglect in identified systemic issues in DBHDS-operated facilities. Obtain corrective action, as appropriate.// 20.1.1.8 - Monitor state-licensed nursing homes, assisted living facilities, and ICF/IIDs using review of APS reports, CHRIS reports, CMS surveys, and other sources to identify two trends or issues

20.1.1.9- Provide I&R, STA, and STA-level preliminary investigation to all residents who request it during facility monitoring in state-licensed nursing homes, assisted living facilities, or private hospitals and psychiatric facilities.

20.1.1.10- Following STA-level preliminary investigation, investigate 3 allegations of abuse or neglect in state-licensed nursing homes, assisted living facilities, or private hospitals and psychiatric facilities within identified systems issues. Obtain corrective action, as appropriate.

20.1.1.11- Represent 4 individuals in Human Rights hearings to appeal investigative findings where review of the investigation indicates potential for systemic impact.

20.1.1.12- Identify three self-advocacy strategies for enforcing the Human Rights Regulations and train ten residents to use the strategies.

20.1.1.13- Identify deficiencies in the Human Rights Regulations that prevent individuals from protecting their own rights. Publish report.

20.1.1.14- Publish a white paper on the need for an abuse and neglect registry.

Objectives Summary

Summarize each of the objectives above here. Note: Each objective narrative must be limited to 500 characters. (this is a new requirement)

20.1.1.1- dLCV developed a flow chart, explaining the civil commitment process and published it to our website. The flow chart not only educates the public, but also provides a clear explanation of rights throughout the process.

20.1.1.2- dLCV developed new mental health resources and quick guides and uploaded them to our website for public use.

20.1.1.5- dLCV monitored Virginia's 9 State Hospitals, making 33 visits during FY20. The COVID-19 pandemic led dLCV to rely more on data, informants, and incident reports. dLCV reviewed each facility's COVID-19 policy and prevention practices. One facility did not have a pandemic response plan prior to COVID, but dLCV successfully advocated for them to develop a plan. In FY20, several facilities kept patients from accessing complaint processes. dLCV successfully addressed this through advocacy and winning administrative hearings, leading the State Hospitals to revise their policies.

20.1.1.6- dLCV investigated a State Hospital's restraint of Sue, a patient. We found one incident where staff improperly and dangerously restrained Sue. We filed a complaint for her and later learned the responsible staff was no longer an employee. dLCV used Sue's case to obtain a 50% reduction in the facility's use of seclusion and restraint.

Joe complained to dLCV that he was overmedicated. dLCV investigated and the facility Medical Director and Joe's treating physician agreed that they overmedicated Joe. They put Joe on a lower dose of a different medication, and he says he is feeling better.

20.1.1.8- dLCV monitored adult nursing homes, assisted living facilities, and intermediate care facilities through multiple means this year. We reviewed adult protective services reports and worked with administrators to get corrective action following concerning reports. We opened investigations into abuse and neglect in such facilities. We also collaborated with several agencies to protect individuals' rights during nursing home evictions.

20.1.1.9- Mia complained that the private hospital where she received treatment had violated her rights, including right to privacy. dLCV gave Mia appropriate complaint resources and made sure she connected with the Office of Human Rights. Mia used these resources and was able to advocate for her rights.

Bob complained about abuse at his nursing home and asked dLCV for discharge assistance. While dLCV was not able to substantiate Bob's claims of abuse, we were able to successfully advocate for his discharge to a less restrictive setting.

20.1.1.10- Multiple cases opened under this objective either relied on other funding sources or are currently open and active. We did complete one PAIMI investigation under this objective, which found that the death that appeared suspicious was actually due to cardiac arrhythmia.

20.1.1.11- dLCV helped Jim file a complaint against a Hospital, for failing to protect him from a violent peer. The hospital enacted all of the corrective action that Jim had asked for. Thanks to dLCV, the client lives in a safer environment.

Ann filed 9 complaints against a Hospital, but got no response. dLCV complained to the hospital on Ann's behalf, citing her right to the Human Rights Complaint Process. We elevated the complaint to the Local Human Rights Committee, which found in Ann's favor. The hospital agreed to significant policy changes that will benefit all residents.

20.1.1.12- dLCV identified three self-advocacy strategies which would be useful to state facility residents who wish to file and successfully prosecute their own Human Rights Complaints. We developed the strategies into a guide, and posted it on our website and distributed it in connection with our monitoring activities. Due to the pandemic and other issues, we did not hold any group trainings, opting instead to train eleven residents on an individual basis.

20.1.1.13- In FY20, dLCV researched the human rights regulations and identified several deficiencies, including procedural inconsistencies, lack of standardization, and lack of enforcement. dLCV created a working draft detailing these deficiencies and proposing solutions.

20.1.1.14- During FY20, dLCV researched the benefits and challenges of abuse and neglect registries, and drafted a white paper of findings for internal agency review and eventual release to policymakers and the general public with recommendations. dLCV does support the development of an abuse and neglect registry, and in the white paper, made comprehensive recommendations, which have not yet been officially adopted.

Describe any other 1.1 activity not including in the objectives above here! Note: The entire objective narrative must be limited to 500 characters. (this is a new requirement)

A Victory at the Highest Level

dLCV learned that Jae had been attacked by a peer while asleep in the emergency restraint chair. Despite clear evidence of abuse and neglect, the State Hospital failed to find that abuse or neglect occurred. dLCV appealed the hospital's findings. The Local Human Rights Committee agreed that the hospital had improperly restrained Jae, but did not feel the hospital abused or neglected Jae. dLCV appealed their decision to the State Human Rights committee, which found conclusively that the hospital abused and neglected Jae.

Focus Area 3 – Children and youth with disabilities are free from harm in community or institutional settings

20.1.3.1- Monitor conditions at Psychiatric Residential Treatment Facilities (PRTFs) serving children and adolescents through 5 on-site visits, review of critical incident reports, CHRIS reports, PRTF reports, and APS reports. Report issues identified to regulatory and oversight entities, and to the DOJ and Independent Reviewer as appropriate.

20.1.3.2- Monitor conditions at Cumberland Hospital for Children and Adolescents through quarterly on-site visits. Report issues identified to regulator and oversight entities.

20.1.3.3- Provide short-term assistance to all residents of institutions serving children and adolescents with disabilities who request information about legal rights or access to services during monitoring visits.

20.1.3.4- Investigate 7 allegations of abuse and neglect at institutions serving children, involving seclusion and restraint, or staff abuse or neglect. Publish findings of each investigation and obtain corrective action.

Objectives Summary

Summarize each of the objectives above here. Note: Each objective narrative must be limited to 500 characters. (this is a new requirement)

20.1.3.1- dLCV monitored conditions at 6 Psychiatric Residential Treatment Facilities (PRTF) across Virginia this year. dLCV trained residents and staff on client rights and pre-employment and discharge rights. dLCV monitored every PRTF's emergency response plans and outbreaks in response to Coronavirus to ensure that the PRTFs were addressing areas of potential abuse and neglect. dLCV reviewed all PRTF reports to identify trends to ensure protection from harm for children institutionalized in Virginia.

20.1.3.2- dLCV conducted 5 monitoring visits to monitor and provide oversight at Cumberland Hospital. dLCV additionally monitored Cumberland's Covid-19 emergency response plans, ensuring that Cumberland addressed potential abuse and neglect, such as lowered staffing ratios, in light of an outbreak. dLCV additionally reviewed reports of serious injury to identify trends to ensure protection from harm for children and adolescents at Cumberland.

20.1.3.3- This fiscal year, dLCV provided short-term assistance to 5 residents of institutions serving children and adolescents. dLCV assisted individuals and families in 5 cases concerning discharge practices, alleged neglect, and involvement in treatment at 5 different residential facilities across Virginia, allowing for increased oversight and self-advocacy of our clients and their families.

20.1.3.4- dLCV identified trends of abuse by a provider of children's mental health services. The provider denied dLCV access to investigate and the dLCV litigation team began to prepare to file suit. The provider folded when faced with impending litigation. Through systemic investigation, dLCV identified various instances of staff abuse across locations. dLCV ensured that the provider implemented corrective action, including termination of staff and revision of policies and hiring practices.

Other qualitative narrative related to the above priority

dLCV was contacted by a 14 year-old AS's family to investigate peer-to-peer bullying, verbal abuse, victimization, and staff neglect concerning AS's gender identity during her treatment at a PRTF located in Virginia. dLCV advocated on behalf of AS and facilitated administrative meetings and peer mediation. After dLCV advocacy, AS reported that her peers had stopped bullying her and that she felt heard and safe.

Focus Area 4 – Children and youth with disabilities receive appropriate services in juvenile justice facilities

20.1.4.1- Monitor conditions at Bon Air Juvenile Correctional Center (JCC) by conducting quarterly visits with an emphasis on asserting our access rights, and providing residents with information on their legal rights.

20.1.4.3- Provide short term assistance in disability rights issues to all residents at DJJ operated facilities who request it during monitoring and outreach.

20.1.4.4- Investigate 2 allegations of abuse and neglect at juvenile justice facilities involving seclusion, restraint, or staff abuse. Publish findings of each investigation and obtain corrective action.

Objectives Summary

Summarize each of the objectives above here. Note: Each objective narrative must be limited to 500 characters! (this is a new requirement)

20.1.4.1- dLCV monitored Bon Air Juvenile Correctional Center (JCC) 4 times and educated over 100 youth regarding dLCV services. As a result of dLCV monitoring, dLCV opened a total of 7 service requests for short terms assistance, 3 abuse and neglect investigations, and 7 service requests for case level services. dLCV assistance covered a wide variety of topics including access to coping tools, pre-employment transition services, special education, excessive restraint, and dietary accommodations.

20.1.4.3- dLCV provided short term assistance to 2 youth at Bon Air JCC this fiscal year in areas ranging from individual rights violations, pre-employment services, accessibility, and assistive technology. dLCV connected these youth committed to the Department of Juvenile Justice with pre-employment transition services to include on-the-job skills, interview skills, resume building and other vocationally related services, so that they can pursue their career goals.

20.1.4.4- dLCV conducted 2 investigations of abuse and neglect at Bon Air JCC this fiscal year. These investigations included systemic issues of excessive and inappropriate restraint, staff verbal abuse and victimization of residents, and provision of appropriate medical dietary needs. This year saw increased oversight and protection from harm for JCC residents despite challenges presented by the Coronavirus pandemic.

Other qualitative narrative related to the above priority

dLCV successfully implemented remote monitoring strategies at Bon Air JCC and effectively outreached youth during Coronavirus outbreaks. dLCV conducted a resident survey inquiring about facility conditions and services during the pandemic. 79 youth responded (more than half of the total population). dLCV followed up with youth who requested our services. Through this effort dLCV identified several systemic concerns, related to remote learning, staff abuse, health, and safety.

Focus Area 5 – Programs licensed by DBHDS will be safer and more inclusive due to dLCV's monitoring

20.1.5.1- Review all CHRIS reports. Identify and analyze trends of abuse, neglect, and unsafe conditions leading to preventable injuries.

20.1.5.4-From review of CHRIS, file 10 reports of alleged abuse or neglect to DBHDS Office of Licensing for licensing investigation.

20.1.5.5- Based on CHRIS reports, identify 10 environmental conditions or policy issues which have an adverse impact on health, safety or welfare. Secure a change in policy, procedure or environment and notify the appropriate licensing agency.

20.1.5.6- Analyze patterns in environmental conditions identified in FY18 and FY20. If significant trends are seen, publish findings.

20.1.5.7- Identify all PRTFs that have not filed a CHRIS report in the previous 12 months. Conduct one monitoring visit at each by June 30, 2020.

20.1.5.8- Train 3 new volunteers to review CHRIS reports and rank reports that involve minor medical issues that do not raise issues of abuse, neglect or unsafe conditions. Create a scheduling calendar for volunteer duties.

20.1.5.9- Identify every report of staff abuse and evaluate whether the incident would be addressed in an abuse registry, in advance of a possible policy initiative.

Objectives Summary

Summarize each of the objectives above here. Note: Each objective narrative must be limited to 500 characters! (this is a new requirement)

20.1.5.1- dLCV regularly reviewed reports involving abuse, neglect and unsafe conditions. We began tracking COVID-19 cases sending follow-up surveys to providers. We were able to identify one provider that reported a large number of positive cases and deaths, and found out they also had a number of poor inspection reports. dLCV warned oversight agencies about this dangerous provider and demanded that they rectify the situation. dLCV drafted a report with a detailed review of the COVID-19 data and have sent it to the appropriate agencies for public comment.

20.1.5.4- dLCV reported 29 incidents of potential abuse or neglect to the Department of Behavioral Health and Developmental Services (DBHDS) Office of Licensing for investigation. We also identified 62 COVID-19 "outbreak locations" at DBHDS-licensed residential programs that raised concerns of neglect and made licensing complaints for 28 individuals as part of this project. dLCV drafted a report with a detailed review of the COVID-19 data we collected, and sent it to DBHDS as well as our contacts at the Department of Justice so they can issue comment before we publish the report publicly.

20.1.5.5- dLCV identified potential environmental hazards, with a particular focus on COVID-19 outbreaks among residential providers. We alerted the Department of Behavioral Health and Developmental Services (DBHDS) to specific providers who failed to address environmental issues. Providers were very willing to work with dLCV and provide corrective action, including changes to policy and procedure, when requested.

20.1.5.6- dLCV sent letters to 14 providers asking how they addressed environmental conditions found in incident reports. These included ingestion of objects, falls caused by environment, and wheelchair malfunction. We received largely positive, creative corrective action plans from providers. dLCV also focused on the safety of disabled individuals during the pandemic. We sent surveys to 144 residential providers that reported residents testing for COVID. Providers reported lack of protective equipment, communication difficulties and rising costs during the pandemic.

20.1.5.7- dLCV successfully ensured that the two Psychiatric Residential Treatment Facilities for children that had previously underreported serious incidents improved their reporting substantially.

20.1.5.8- dLCV trained three new volunteers during FY20 to review and rank incident reports that involve minor medical issues not raising concerns of abuse, neglect, or unsafe conditions. We also developed and deployed a calendar to assist with volunteer scheduling activities and highlighted this important volunteer opportunity during an episode of the dLCV podcast. We amended our volunteer training manual and retrained our most active volunteer after we began using a new incident database.

20.1.5.9- dLCV reviewed Adult Protective Services reports through the lens of incidents that could have been prevented by an Abuse Registry. We identified 80+ incidents, most commonly in group homes. The most common corrective action was terminating the alleged perpetrator. dLCV developed a white paper on the issue of a state abuse/neglect registry, concluding that such a registry is needed to protect people with disabilities from harm.

Other qualitative narrative related to the above priority

May reported that she was not allowed to make outgoing calls because her guardian did not want her speaking to anyone outside the hospital, including advocates, attorneys, and family. dLCV contacted hospital administrators and explained May’s right to phone access. They agreed and restored her phone access immediately.

Abe, a deaf state hospital patient, reported that his unit's "signing phone" was inaccessible. dLCV investigated and verified the complaint. We advocated for the hospital to move the phone, which they did. Abe is now able to use the phone effectively and privately.

Goal 4 People with Disabilities Live in the Most Appropriate Integrated Environment

Focus Area 1 – People with mental illness are discharged timely from state facilities

20.4.1.1- Provide STA to 25 residents of DBHDS psychiatric hospitals who have questions about discharge rights.

20.4.1.2- Represent 4 individuals who are either dually-diagnosed or geriatric, and who have been found ready for discharge, and are on the Extraordinary Barriers List to resolve targeted barriers to discharge.

20.4.1.3- Represent 2 NGRI individuals in DBHDS-operated adult institutions who want to be placed outside their home CSB catchment area when they are discharged.

20.4.1.4- Represent 3 NGRI individuals on the EBL in DBHDS-operated hospitals to obtain timely conditional or unconditional release.

20.4.1.5- Represent 3 individuals who have been found ready for discharge and are on the Extraordinary Barriers List through Human Rights complaints and LHRC/SHRC hearings.

20.4.1.7- Monitor DBHDS' progress in reducing the Extraordinary Barriers List. Publish a public alert whenever the list is above 200.

20.4.1.9- By June 30, 2020, present our revised analysis of the EBL to DBHDS, the SHRC and others, and obtain specific steps to reduce the list.

20.4.1.11- Investigate Virginia's system for managing individuals who have been found Not Guilty By Reason of Insanity and by August 1, 2020, develop a report recommending evidence-based reforms to more efficiently and effectively produce quality treatment outcomes and timely discharge for NGRI individuals in DBHDS-operated hospitals.

Objectives Summary

Summarize each of the objectives above here. Note: Each objective narrative must be limited to 500 characters! (this is a new requirement)
20.4.1.1- Dan, a state hospital resident seeking discharge after a Not Guilty by Reason of Insanity (NGRI) plea, requested 48-hour community passes after being encouraged by his treatment team. Despite his team's support, one psychologist tried to block the passes. dLCV helped Dan submit a human rights complaint against the psychologist. The hospital Director determined the complaint had merit. The hospital agreed to amend Dan's record, give him a new psychologist, and resubmit a new request for community passes. Thanks to dLCV, Dan is closer than ever to discharge. 20.4.1.2- dLCV worked with Bo to advocate for his discharge from a state hospital. The hospital said he needed a nursing home (NH), but no NH would take him. Then, the hospital changed their minds, and said that Bo could live in an Assisted Living Facility (ALF), rather than a NH, as

he was able to bathe and feed himself. Soon after, Bo found an ALF. dLCV oversaw Bo's discharge to his new home in June.

dLCV opened a discharge planning case to advocate for Ada's discharge to nursing home. As a result of dLCV's advocacy, Ada got to go to a nursing home of her choice after nearly 10 years in the state hospital.

20.4.1.3- dLCV was not able to identify or open any cases under this objective in FY20.

20.4.1.4- dLCV opened multiple cases for individuals under this objective in FY20, but all are still open and active.

20.4.1.5- dLCV advocated for Tom's timely discharge from a State Hospital. His treatment team stated that he needed to move to an Assisted Living Facility, but failed to do an Independent Living Evaluation to confirm this. dLCV threatened a Human Rights Complaint, which successfully led the Team to complete the evaluation. They learned that Tom could live independently. With dLCV's support, the Hospital discharged Tom and prepared him for his own supported apartment.

20.4.1.7- dLCV prepared an EBL analysis monthly and drafted 10 alerts with analysis of the data and how it impacts Virginians. We published alerts in various formats, including the dLCV website and circulation to legislators. In September, dLCV presented our EBL data to the State Human Rights Committee and asked the committee for their support in obtaining additional data fields on the EBL, which DBHDS agreed to add in September.

20.4.1.9- In September, dLCV presented our Extraordinary Barriers to Discharge List (EBL) data to the State Human Rights Committee and asked the committee for support in obtaining additional data fields on the EBL, which should help dLCV determine whether an individual has been added to the EBL according to policy. In reviewing data, we found discrepancies that suggest individuals are being added to the EBL as much as 400 days after they become ready for discharge. dLCV contacted DBHDS and successfully advocated for additions and improvements to the data that should help reduce the list.

20.4.1.11- dLCV produced a report identifying 11 problems areas in the DBHDS Guidelines for Management of Individuals Acquitted by Reason of Insanity. dLCV noted that Virginia's procedures appear to wrongly hospitalize people who could be effectively treated elsewhere without risk to the public. dLCV also noted that Virginia's system of "graduated release" is inefficient and leads to unnecessary delays of up to 2 years. dLCV recommended that DBHDS revise its processes to eliminate redundancies and shorten timelines.

Other qualitative narrative related to the above priority

Cal, a young man who was civilly committed to a State Hospital asked dLCV to help him get out. Cal specifically wanted to move to a hotel, because the fees were straightforward. His treatment team initially said that an independent placement would be appropriate, but his psychiatrist reversed her position and said he would need an assisted living facility or group home. dLCV advocated that such an opinion should have been made earlier, and should have an evaluation to support it. The psychiatrist backed down and the client moved to a hotel in Charlottesville.

Goal 6 People with Disabilities have Equal Access to Appropriate and Necessary Healthcare

Focus Area 2 – People with disabilities have access to healthcare

20.6.2.4- Monitor Riverside Regional Jail and Roanoke City Jail through unannounced monitoring visits, targeted rights trainings, AOD calls, complaints, and other sources to ensure individuals have access to assistive technology and appropriate, timely mental health services.

Objectives Summary

Summarize each of the objectives above here. Note: Each objective narrative must be limited to 500 characters! (this is a new requirement)
20.6.2.4- dLCV made 4 visits to Jails in FY20. dLCV faced access barriers at Riverside and Roanoke Jails, but ultimately successfully advocated for our entry. dLCV visited Richmond City Jail (RCJ) to investigate complaints: Inmates alleged that RCJ forced inmates with disabilities to clean “pods” with active COVID-19 outbreaks without adequate protective equipment. dLCV and is addressing these issues as part of our systemic Jail Monitoring efforts.

Summaries of Case Types:

‘Case of Alleged Abuse’

Summarize here in 500 characters

dLCV investigated services received by 15-year-old NM at an acute psychiatric facility after reading serious incident reports which detailed NM had ingested multiple batteries days in a row. dLCV founded neglect in terms of NM’s known history of ingestion and staff’s failure to maintain eyesight and arms reach, thus enabling him to ingest batteries from a nearby remote. dLCV worked to enact corrective action spanning from retraining of 1:1s, crisis de-escalation, and investigations.

‘Case of Alleged Neglect’

Summarize here in 500 characters

dLCV received a report that Jose had attempted suicide at a state hospital and died after being transported to a medical facility. Staff discussed the incident with hospital staff, and obtained and reviewed their root cause analysis report and the medical examiner's report of the autopsy confirming the suicide. dLCV has monitored the facility's corrective action as part of monitoring.

'Case of Alleged Rights Violations'

Summarize here in 500 characters

dLCV was contacted by 13-year-old CM's family as his current placement, a Psychiatric Residential Treatment Facility was attempting to kick him out. CM attempted suicide, cutting himself from nipple to pelvis and elbow to wrist. Instead of finding him a placement that can address his behaviors, the PRTF wished to send him home without appropriate services. Due to dLCV intervention, he secured placement the day of discharge. CM is currently stabilizing.

'Case of Intervention on Behalf of a Group'

Summarize here in 500 characters

Amy was barred from attending an outing at a state hospital because she uses a wheelchair. The hospital Director had reviewed this allegation and said it was not a rights violation. dLCV helped Amy appeal this decision. dLCV's appeal convinced the Director that her original finding was wrong and she agreed to our proposed corrective action, including policy changes. Because of dLCV, the client and others who use mobility devices have far more access to community activities.

'Case of Closing an Individual Advocacy Case File'

Summarize here in 500 characters

11-year-old CD was leaving a psychiatric hospital with no identified placement or supports. CD has mental health needs and Type 1 Diabetes and faced rejection from most programs in Virginia. dLCV worked in collaboration with The Department of Behavioral Health and Developmental Services and CD was admitted to a program for a short-term stay. Due to dLCV advocacy, CD will receive the necessary services he needs to return home to the community soon.