Health, Welfare and Institutions Committee
House of Delegates – General Assembly of Virginia

Investigation of April 16, 2007 Critical Incident at VA Tech
By the Office of the Inspector General

Recommendations and Related Information

Presentation by James W. Stewart, III, Inspector General
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Delegate Hamilton and members of the Committee, thank you for the opportunity to come before you today. The purpose of my presentation is to share recommendations and related information that have come to the attention of the OIG in connection with our Investigation of the April 16, 2007 Critical Incident at VA Tech.

This investigation was conducted within the authority given to the OIG in the Virginia Code, § 37.2-423 and 424. These sections call for the OIG to inspect, monitor and review the quality of services provided by state facilities and other providers and to make policy and operational recommendations in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of services. Findings and recommendations of the OIG are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

In response to the critical incident that occurred at VA Tech on April 16, 2007, the OIG conducted an on-site investigation on May 24 and 25 and extensive follow up phone interviews from May 26 through June 9. The primary focus of the investigation was the services provided by the local CSB, psychiatric unit of a local hospital, assessment by the independent evaluator and services of the VA Tech counseling center in connection with a December 2005 temporary detention order (TDO) and judicial commitment process. The subject of this commitment process was the individual who was subsequently determined through law enforcement investigations to be the shooter in the April 16 critical incident. To conserve time today, I will not review the details of the investigation process or the background information that was collected, but will be happy to answer any questions you may have about this investigation. This information is fully documented in our report that can be found on the OIG website (www.oig.virginia.gov).

The purpose of this investigation was to formulate recommendations that will improve the response of the community and the mental health system to individuals who are experiencing a psychiatric emergency.

Recommendations and Related Information

The recommendations made by the OIG as a result of this investigation are focused on the commitment process as it is currently established in the code, as it was practiced in the New River Valley in late December 2005, and as it is carried out in many other communities across the state.

A. Availability of a Willing Detention Facility

Through the OIG investigation of this case, it was learned that the CSB Certified Prescreener, in carrying out the requirements of Va. Code § 37.2-809(D), was able determine the facility of temporary detention with a single phone call and no delay. However, the OIG was told that more typically there are extensive delays in securing a willing facility. This is consistent with findings in an earlier OIG Review (OIG Report #123-05) that identified inadequate capacity statewide for crisis stabilization programs, inpatient services and other mental health emergency services. Over the past several years the General Assembly has provided additional funding incrementally to increase the number of crisis stabilizations across the state.

Another contributing factor to admission delays, mentioned by those with whom the OIG spoke, is the fact that current "medical clearance" practices at public and private hospitals vary tremendously. This problem was also identified in the earlier OIG report and was addressed by the General Assembly in 2006 Budget language. DMHMRSAS, with the involvement of several other organizations, is currently implementing solutions to this concern.

These two access issues make it very difficult for those involved in the TDO process to fulfill all requirements of this process within the four-hour limit for an emergency custody order.

- It is recommended that the number and capacity of secure crisis stabilization programs be expanded statewide in order to address the challenges frequently faced by prescreeners in securing a willing temporary detention facility in a timely manner.

By making crisis stabilization programs that accept TDOs accessible to every community and CSB in the state, not only will delays in access to a willing TDO facility be alleviated but much of the current pressure on limited inpatient beds will also be relieved.

B. Assessment by the Prescreener, Assessment by Attending Physician at the Detaining Facility, Examination by the Independent Examiner, and Presentation of Evidence and Testimony to the Special Justice

The OIG's investigation of the commitment process focused primarily on the procedural and systemic factors that enable or impede the special justice to have access to or be presented with the necessary information, evidence, and testimony needed to sufficiently

understand the context of the behaviors that led to the TDO and to accurately assess the individual's mental health and risk of dangerousness.

It was learned through the investigation of this critical incident, and the related review of the standard practices and procedures for the commitment process in the New River Valley area, that the current construct of the Virginia commitment process, as established by Virginia Code and commonly practiced throughout the state, may limit the collection and interpretation of vital collateral information.

Assessing an individual's mental health and level of dangerousness, especially in the setting of an evolving psychological crisis, is often a very difficult task. Good psychiatric and risk assessment require accurate knowledge about many aspects of an individual's life. When an individual is denying dangerousness and/or mental illness, and is not overtly dangerous and/or mentally ill on a mental status exam, but has recently deteriorated to the point of meeting the requirements for court ordered detention to ensure safety, it is imperative that the examiner not rely solely on the statements of the individual in crisis and the necessarily abbreviated assessment obtained for the TDO. The examiner should also obtain additional collateral information to expand, clarify, or refute the limited information available and the information provided by the individual. This collateral information helps to elucidate the broader context in which the crisis occurred.

Following is a list of factors in the current commitment process that may serve to limit the judge's or special justice's access to important information:

- Only four hours are allowed for the emergency custody. When the four-hour period lapses, the individual must be detained or released. There is no option to extend the custody period.
- The legal requirements for assessment of the detained person in the TDO/Commitment process proceed in tandem with, but quite independently from, the psychiatric assessments and interventions provided by the detaining facility. While the attending psychiatrist and clinical team in the detaining facility do not have a defined role in the commitment process, the clinical assessments and observations they make and any collateral information they collect provide valuable information about the detained person. This information is not always made available to or considered by the independent evaluator and judge or special justice.
- While up to 48 hours (72 hours on weekends) is allowed for the temporary detention, it is not unusual for the time from admission to the commitment hearing to last less than 24 hours. This makes it very difficult, if not impossible, to collect and consider additional collateral information about the individual. This also makes it difficult to complete the physical exam and psychiatric evaluation, assessment and treatment plan before the commitment hearing is held.
- The OIG found through a brief survey of psychiatrists who function as attending physicians at detaining facilities that there is inconsistent understanding regarding

their access to collateral information regarding their patients when the person refuses to authorize access.

- Examinations by the Independent Evaluator are often quite brief. Neither the Virginia Code nor the Physician's Examination section of the Proceedings for Certification for Involuntary Admission form require the independent examiner to include in his report any recent history that might be helpful to understand the stressors precipitating the psychiatric emergency, any unique stressors that the individual will be returning to upon discharge from the detaining facility, a psychiatric history, a medical history, a list of medications, a history of head injury, a history of violent or impulsive behavior, a diagnosis, or any assessment except the minimum which is required. There is no clearly stated expectation that the independent examiner attempt to account for any discrepancies between his assessment of the person and the assessment by the prescreener.
- There are no requirements that the petitioner, family, independent examiner, attending physician, prescreener or other representative of the CSB be present at the hearing. While written reports are permitted by Virginia Code, it is not unusual for none of these parties to be present.

I would point out that modifications in the Virginia Code to address one or two of these points will not resolve the problem and may in fact further complicate it.

It is recommended that a comprehensive study of the commitment process in Virginia be conducted to determine the changes necessary to facilitate the collection and interpretation of critical collateral information that may be necessary for the assessment of an individual's mental illness and dangerousness in a broader context than is frequently achieved with the limitations of the current Virginia Code and practice.

It is further recommended that this study identify the changes that will be required to not only assure protection and safety of the individual and others but also enable engagement of the individual in such a way that his or her journey of recovery is supported and facilitated.

C. Outpatient Commitment

In this case, the special justice directed that the individual receive treatment in accordance with the following order: "Court-Ordered O-P (outpatient) - to follow all recommended treatments". The focus of the OIG investigation related to this order was to identify the factors that may have supported or impeded successful compliance with this order and all orders for outpatient commitment statewide. The following recommendations have been formulated based on our findings:

- It is recommended that the Virginia Code be amended to require that the name of the provider(s) that are to deliver the involuntary outpatient treatment be designated in the court order by the judge or special justice. The term "designated provider" is referred to in Va. Code § 37.2-817(C), but how and by whom this provider is to be designated is not clear.

- It is recommended that a brief study be conducted to determine what barriers prevent or complicate CSB/BHA's statewide from routinely recommending a specific course of treatment and programs for the provision of involuntary outpatient treatment as specified in Va. Code § 37.2-817(C) and develop a plan to address these barriers. The local CSB in this case did not recommend a course of treatment. It is our impression that it is common practice for CSBs across the state not to recommend a plan at commitment hearings and that lack of clarity regarding this role is a contributing factor.

- It is recommended that the responsibility of the CSB to recommend a specific course of treatment and programs for the provision of involuntary outpatient treatment, as specified in VA Code § 37.2-817(C), be further defined by Virginia Code, regulation or policy.

- It is recommended that a brief study be conducted to clearly identify the barriers that prevent or complicate CSB/Behavioral Health Authorities (BHA) attendance at commitment hearings statewide and recommend solutions. Once these barriers are fully understood and a plan is developed to resolve the barriers, it should be determined whether or not the Virginia Code should be amended to require CSB/BHAs to attend all commitment hearings. This is not currently required.

  To obtain a better understanding of issues related to CSB attendance at commitment hearings, the OIG conducted a survey of all 40 CSBs on June 4 and 5, just two weeks ago. There was a 100% response rate to the survey. We asked two questions related to attendance at commitment hearings:

  - First Question - At what percentage of the commitment hearings in your service area during the past six months was a staff member from your CSB physically present? The survey revealed that the average estimated percentage of commitment hearings that were attended by the 40 CSBs in the past six months was 54.25%.

Range of Estimated % of Hearings Attended by CSB	Number of CSBs	% of 40 CSBs
96 – 100%	16	40%
76 – 95%	4	10%
51 – 75%	1	2.5%
26 – 50%	2	5%
1 – 25%	8	20%
0%	9	22.5%

- Second Question - If staff of the CSB are not routinely present at commitment hearings, please provide an explanation of the barriers that prevent attendance.

Barrier to CSB Participation in Hearings	Number of CSBs	% of 40 CSBs
Limited staffing	19	48%
Travel distance (within service area)	8	20%
Hearing outside of service area	10	25%

- It is recommended that a study be conducted to determine whether the following duties should be carried out by the court or by another entity acting as an official agent of the court:
  - Locating a willing outpatient provider to provide court ordered outpatient treatment.
  - Assuring that outpatient providers, who provide treatment to individuals who have been ordered to outpatient treatment, understand the responsibilities to the court when accepting these referrals.
  - Arranging for the initial outpatient appointment.
  - Providing a copy of the court order to the receiving provider.
  - Notifying the CSB/BHA of the outcome of the commitment hearing (If the CSB/BHA is not present)

  If, as a result of this study, it is determined that an entity serving as an official agent of the court should carry out these functions, changes in Code, regulation or policy should be made to designate this entity.

  In this case, a number of these functions were performed by staff of the detaining facility acting as an undesignated agent of the court. When this happens there is no clear line of authority and responsibility to the court. Greater clarity is needed regarding the assignment of responsibility for these critical functions.

- It is recommended that the court's expectations for outpatient providers who provide treatment to individuals who have been ordered to outpatient treatment be clarified, by Code, regulation or policy.

- It is recommended that the expectations of the CSB, BHA or designated provider to monitor the person's compliance with the treatment ordered by the court as per Va. Code § 37.2-817(C) be clarified by Code, regulation or policy. Specifically address what action is to be taken by the CSB, BHA or designated provider in relationship to the court when the person fails to comply. Also clarify what role, if any, the CSB or BHA has for monitoring treatment when the designated provider is not the CSB or BHA.

Virginia Code currently does not clarify the role of the CSB, behavioral health authority (BHA) or designated provider in monitoring the person's compliance with the outpatient treatment order. While it states that compliance must be monitored and that failure to comply may be admitted into evidence in subsequent hearings, it does not specify any responsibility for the CSB, BHA or provider if the patient does not comply.

- It is recommended that the criteria that must be met for the judge or special justice to hold a second commitment hearing when the person fails to comply with the earlier order to outpatient treatment be clarified in Va. Code § 37.2-817(C).

  Virginia Code § 37.2-817(C) states, "Upon failure of the person to adhere to the terms of the outpatient treatment order, the judge or special justice may revoke it and, upon notice to the person and after a commitment hearing, order involuntary admission to a facility." CSBs and special justices in some communities are unclear regarding the authority of the special justice to hold another commitment hearing for an individual who fails to comply with ordered outpatient treatment unless there is clear evidence that new behaviors that meet the TDO or commitment criteria are currently present.

D. Availability of Outpatient Services

In the course of this inspection, the OIG heard repeatedly from CSB staff, the detaining hospital and the university counseling center that outpatient treatment options in the New River Valley area are extremely limited. There are few private options available for those who have resources. For those without the ability to pay, the local CSB is the only option and the CSB has extremely limited outpatient capacity, both for outpatient counseling and for outpatient services provided by a psychiatrist.

This issue of inadequate outpatient capacity is not new information and is certainly not limited to any one area of the state. In three statewide reviews of CSB services by the OIG during the past two years, this issue surfaced repeatedly. The services that were reviewed in these OIG projects included:

- CSB Emergency Services Programs (OIG Report #123-05)
- CSB Mental Health Case Management (OIG Report #128-08)
- CSB Substance Abuse Outpatient Services for Adults (OIG Report #129-06)

To obtain more details about this issue, the OIG included questions in the June 4 survey, which I referenced earlier, to obtain a better understanding of how long citizens must wait to receive outpatient services and the current outpatient treatment capacity of the CSBs. The following questions were asked:

- How many calendar days, on average, do citizens who seek services from your agency have to wait to begin Mental Health Outpatient treatment from the day they make their first call to your agency to the day they start active treatment services (not an intake or access interview, but ongoing treatment)?

- How many calendar days, on average, do citizens you serve in your Mental Health Outpatient Program have to wait to see a psychiatrist from the day they are referred to the psychiatrist to the day they actually have an appointment?

- How many full time equivalent (FTE) staff in your agency provide Mental Health Outpatient services? Do not include the following: (1) case management or similar services, (2) the time of psychiatrists or nurses that is used primarily for medication clinics and med-checks.

- Over the past ten years, has your Mental Health Outpatient treatment capacity increased, decreased or remained the same.

- If the capacity of your Mental Health Outpatient Services has increased or decreased, explain the factors that have caused this change.

- If you provide no Mental Health Outpatient Services, what year did you eliminate these services and why?

The survey questions were asked in such a way that separate data could be captured for non-emergency outpatient requests and outpatient requests that are made following an emergency intervention, ECO or TDO. We also captured the information separately for adult services and child/adolescent services. This survey is based on the past six months of services delivery and had a 100% response rate from the 40 CSBs.

Before I provide the very interesting results of this data collection effort, I want to spend a moment clarifying, what is and what is not meant by outpatient services. I will begin with what it is not:

- Of course we are not talking here about the comprehensive array of services that can be made available to individuals with mental retardation through the Medicaid Mental Retardation Waiver. This is an area in which the General Assembly has worked steadily through the years to chip away at unmet demand.

- We are not talking about many of the community programs within the wide array of support services that are required for those with long-term mental illness including such services as psychosocial rehabilitation, PACT teams, supported employment and various supported living arrangements. Several targeted funding initiatives through the years have been focused on these services for individuals who are ready for discharge from our state facilities. An example of such an initiative is funding provided in years past for the Discharge Assistance Program (DAP).

By outpatient services, I am referring primarily to two types of clinical services:

- Outpatient counseling or therapy which is often provided in an office setting, but also may be provided in another setting. This service is delivered by masters or doctorate level mental health professionals who are most often licensed as a clinical social worker, a professional counselor or a clinical psychologist.

- Outpatient psychiatric services provided by a psychiatrist, psychiatric nurse practitioner or other medical personnel who deliver a variety of therapeutic interventions, including medication.

It is these two services in combination with a comprehensive array of mental health emergency services and other supports such as case management that are required to fulfill the following two expectations that our communities have for their local CSB:

- The first is the provision of therapeutic support and intervention for those in our communities who are struggling with emerging mental health problems. This includes adults and families who recognize a problem and seek services voluntarily or are referred by other community services. It also includes children and adolescents referred by schools, social services, health care providers and the courts.

- The second is the provision of services to individuals following a mental health crisis. The majority of individuals who utilize the CSB emergency services programs and many who are detained for assessment do not require longer term inpatient care and do not require the full array of support services that are provided to those with long-term mental illness. However, they do require intensive outpatient services that are available without delay. I would note that not only is this service an expectation of the community but it is also this service to which judges and special justices commit individuals when they order involuntary outpatient treatment.

It is the availability of these outpatient services that the OIG survey was designed to assess. Now to the results:

- The survey revealed that Virginians who seek outpatient services at local CSBs with a counselor or psychiatrist have long waits.

CSB Average Wait Time for Outpatient Services		
	Adults (days)	Children (days)
Outpatient appointment	27	35
Outpatient – post emergency	23	30
Psychiatrist appointment	12	15
Psychiatrist – post emergency	13	15

- The survey also revealed that over the past 10 years, outpatient treatment capacity for adults has decreased for 57.5% of the CSBs and outpatient treatment capacity for children and adolescents has decreased for 50% of the CSBs.

Change in CSB Outpatient Capacity Over Past 10 Years				
	Adults		Child/Adolescent	
	Number of CSBs	% of 40 CSBs	Number of CSBs	% of 40 CSBs
Increased Capacity	7	17.5%	16	40%
Decreased Capacity	23	57.5%	20	50%
No Change	10	25%	4	10%

- The primary explanations provided by the CSB's for decreased outpatient capacity over the past 10 years include:
  - Diversion of funding and staff to populations identified as priority by the state – primarily those with long-term mental illness and those ready for discharge from state hospitals
  - Decrease in funding from one or more sources
  - Static funding from one or more sources

- Currently, the capacity of CSB outpatient services statewide is extremely limited. There are 1.92 staff FTE's serving adults and 1.2 staff FTE's serving children and adolescents in CSBs across the state per 50,000 population. Outpatient service capacity varies tremendously among the 40 CSBs.

Number and Percentage of CSB Outpatient Staff FTE's Per 50,000 Population *				
Staff FTEs per 50,000 population	Adults		Child/Adolescent	
	Number of CSBs	% of 40 CSBs	Number of CSBs	% of 40 CSBs
0 FTEs	2	5%	1	2.5%
.01 to 2.00 FTEs	22	55%	32	80%
2.01 to 4.00 FTEs	9	22.5%	6	15%
4.01 to 6.00 FTEs	4	10%	0	0%
6.01 + FTEs	3	7.5%	1	2.5%

* This survey was designed to capture the number of staff FTE's that provide counseling/therapy and excludes staff time dedicated to (1) case management or similar services and (2) the time of psychiatrists or nurses that is used primarily for medication clinics and med-checks.

With such limited outpatient treatment capacity available in the local CSBs:

- It is often not possible to intervene sufficiently early to prevent crises.
- Individuals who request these services loose interest during the long wait for an appointment and therefore do not follow through.
- Outpatient staff have limited time to follow up on individuals who drop out once service has been initiated.
- It is not possible to meet the needs of the court when individuals are committed to outpatient treatment. If Virginia begins to make greater use of the outpatient commitment alternative, these court orders will add to the current delay for those who seek outpatient services voluntarily.

<u>It is recommended that</u> a brief study be conducted to determine what level of community outpatient service capacity will be required and the related costs in order to adequately and appropriately respond to both involuntary court ordered and voluntary referrals for these services. Once this information is available, it is recommended that outpatient treatment services be expanded statewide.

E. Case Management

As Virginia considers changes that are needed in the commitment process, including the alternative for court ordered involuntary outpatient treatment, it is important that we not only have needed treatment capability in place but also that we have adequate support services necessary to monitor and coordinate services for those in care. Mental health case management is critical to assure an effective response to the individual and to the courts.

As referenced earlier, the OIG conducted a statewide review of CSB Mental Health Case Management Services for Adults during the spring of 2006 (OIG Report# 128-06). One of the most significant findings in this review was the following:

- Average caseload sizes for case management are higher than nationally recommended caseloads and are also higher than case managers, supervisors and consumers think is appropriate to ensure highest quality services. Caseload sizes in Virginia average 39.1 cases per FTE which can be compared to the nationally recommended caseload of 25 for heterogeneous caseloads of persons with serious and persistent mental illnesses. (National Association for Case Management and other sources). Caseloads at the time of this review ranged from 20 to 71.5 per FTE with a mean caseload of approximately 37. Thirty-seven of the 40 CSBs (92.5%) had average caseloads for mental health case managers that exceeded 25.

Information collected by the OIG in connection with this review revealed that there were approximately 850 mental health case managers statewide at that time and CSBs estimated that approximately 230 additional case managers will be required to achieve a caseload closer to 25 cases per staff member.

This report recommended that the Department of Mental Health, Mental Retardation & Substance Abuse Services study the advisability of establishing a caseload standard for CSB case managers. It is my understanding that this work is underway.

It is recommended that the number of CSB case managers be increased in order to decrease caseloads and increase the support provided to those with serious mental illness and those who receive treatment services involuntarily.

Summary

In summary, the Office of the Inspector General recommends that:

- The number and capacity of secure crisis stabilization programs be expanded.
- The commitment process be changed to:
    - Facilitate the collection and interpretation of critical collateral information.
    - Enable engagement of the individual in such a way that his or her journey of recovery is supported and facilitated.

- Specific changes be made to clarify and improve the outpatient commitment process.
- The capacity of outpatient treatment services be expanded.
- The number of CSB case managers be increased.