Office of the Inspector General for Mental Health, Mental Retardation, and Substance Abuse Services

Virginia Center for Behavioral Rehabilitation
Petersburg, Virginia
Inspection

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Section I - Executive Summary

The OIG conducted an unannounced inspection at the Virginia Center for Behavioral Rehabilitation (VCBR) on November 7, 2008, with a second (announced) visit on November 14. The purpose of this inspection was to provide an evaluative review of the active treatment program, assess census and staffing levels, and assess progress toward findings and recommendations made by the Office of the Inspector General (OIG) in 2007. The 2008 inspection was considerably more extensive than the 2007 visit. A random sample of 48 residents participated in confidential interviews; the clinical records of an additional 44 residents were reviewed; 74 staff and 9 members of facility leadership were interviewed; and personnel and staff training records were reviewed.

The 2007 inspection was conducted in November of 2007 and resulted in OIG Report #144-07 which outlined the following concerns about programming at the facility:

- The amount of active treatment that was occurring was very limited, with an average of 2.5 hours per week of treatment received per resident in the observed period of time. High levels of resident boredom and inactivity existed.
- Treatment planning was not sufficiently individualized; treatment goals made little to no reference to the ultimate goal of treatment (improvement of residents' conditions to a level where a safe return to community might be possible); clinical assessments were out of date; and there was little use of multi-disciplinary treatment team approaches in treatment planning meetings.
- There were no vocational, educational, or recreation programs.
- The facility's mission statement was not specific about ultimate treatment outcomes. There were differing perceptions of the mission of the facility among

leadership, clinical staff, security and residential staff, and residents, particularly around the expected outcomes of services provided.

- The external, formal programmatic oversight of the facility was extremely limited and was significantly less than that provided for all other facilities operated or licensed by the DMHMRSAS.
- The roles of medical and nursing services at VCBR were not clearly defined, and these services were not integrated with clinical treatment. Relations between nursing services and administration were strained, and significant differences existed between them concerning the role of nursing services at the facility.
- Questions existed as to whether psychiatric services at VCBR were adequate to identify and treat psychiatric issues.
- Staff turnover was higher than at any other DMHMRSAS facility, and staff vacancies and constant turnover significantly decreased the effectiveness of active treatment programming. Turnover among clinical staff was an acute problem.
- Direct service clinical staff, as well as medical and security staff received very little training on treatment of sex offenders.
- Facility security arrangements were seen as functioning well and provided for adequate control of residents.

The report of the 2007 inspection included several recommendations to address these issues, primarily through the creation and involvement of a diverse Advisory/Oversight Committee (AOC), including external experts on sex offender treatment. DMHMRSAS accepted these recommendations and developed a detailed plan to address all the concerns noted by the OIG.

Summary of 2008 Review

In a number of the areas of concern noted by the OIG in 2007, some improvement has occurred, however many challenges remain:

- The amount of active treatment provided rose from an average of 2.5 hours a week to 6.6 hours per week for a comparable sample of residents.
    - Active treatment levels actually received by residents still remain much lower than desirable for an effective treatment program. Resident boredom and inactivity continue, with significant behavioral results.
    - Educational and recreation programming have begun and contribute to the somewhat higher levels of constructive activity for residents.
    - Vocational programming (training and jobs for residents) are considered by the facility, the AOC, and the OIG to be a key element of an effective treatment program. The OIG found that no residents have jobs and there is no vocational training at this point.
    - In reporting active treatment levels, VCBR presents data showing treatment scheduled or offered, rather than what is received by residents. Resident refusal to attend, excused absences, and staff cancellations of classes account for an almost 50% drop from scheduled activities to completed activities for the average resident.

- Evaluation and treatment planning for residents have improved in specificity, individualization, timeliness, and comprehensiveness. More improvement in person-centered treatment planning is needed to match that provided at other DMHMRSAS treatment facilities and to achieve what may be required for the facility to achieve accreditation.
- The facility developed new mission and vision statements which clarify the focus of the service to be provided (recovery opportunities and support) and the quality of the facility's efforts (excellence). In this review of VCBR, the OIG found a lack of clarity among staff regarding the intended outcome of the facility's services. The result of this lack of clarity is a workforce that is not unified in carrying out the facility's mission.
- In 2007 the OIG recommended that the facility investigate national accreditation programs and pursue accreditation if a suitable program is found. The facility has decided to seek accreditation by the Joint Commission on Accreditation of Hospitals, and a credible plan to do so now exists.
- The roles of medical and nursing remain unclear and there has been nearly 100% turnover in staffing for these services since the 2007 inspection.
- Psychiatric services have increased significantly.
- Overall staff turnover appears to be essentially at the same levels as in 2007. DMHMRSAS cited VCBR turnover rates of 51.5% for FY2007 and 47.5% for FY2008. Recruitment and retention of clinical staff have improved since 2007.
- Training in sex offender topics has not been increased for residential, security, and medical staff, who spend the most time day-to-day with residents, or for administrative staff, who contribute decisively to the nature of the organizational culture. Training for clinical staff has increased and improved.
- Many staff express concerns for their personal safety while working in the VCBR facility, especially those who have the most day-to-day contact with residents.
- Residents, as well as members of the AOC have expressed concern that VCBR affords the civilly committed residents at the VCBR treatment program less comfort and fewer privileges and opportunities than prisoners in the Department of Corrections receive. Concerns include overly spartan cells and furniture, a harsh environment, very limited resident privilege levels with regard to phone use, mail, television access, and personal items, and limited educational, vocational, and recreational opportunities.
- DMHMRSAS support, guidance, and facilitation of the Advisory and Oversight Committee has been inconsistent and incomplete. The committee members have given considerable time and insight to their task. The activities outlined in the DMHMRSAS response to the 2007 OIG report remain unmet.

It was determined by the OIG that all recommendations made by the OIG in the 2007 report remain ACTIVE.

> ***DMHMRSAS Response:*** *The recent decision to seek Joint Commission accreditation for the Virginia Center for Behavioral Rehabilitation (VCBR) is a critical step in improving the purpose and position of VCBR within the Department of Mental Health, Mental Retardation, and Substance Abuse Services*

(DMHMRSAS) and will serve to grant the facility a sense of direction more in keeping with the mission and vision of the DMHMRSAS as well as providing a concrete guide for the development of operational procedures. The facility's efforts toward becoming Joint Commission accredited are having significant positive impact on operations of the facility including, but not limited to policy and procedure development, creating a recovery-oriented culture, and improving the overall standards of care. Additionally, the facility has developed and implemented a comprehensive strategic plan which includes the use of measurable goals to thoroughly assess programming and services. The facility will also begin implementation of a new quality assurance monitoring program in the near future.

In order to meet Joint Commission Standards VCBR is revising its entire system in order to support a recovery-oriented culture. Amongst the changes will be the permanent assignment of treatment team staff for each resident, the inclusion of nursing staff in all quarterly treatment team reviews, and modification of our treatment plans and documentation. Treatment plans will be more person-centered and will include individualized goals with measurable objectives.

The facility is in substantial agreement with the findings of the Inspector General's November 2008 audit.

Section II – Introduction

The Office of the Inspector General conducted an unannounced inspection of the Virginia Center for Behavioral Rehabilitation (VCBR) on November 6, 2008. A second visit on November 14 was announced in advance to facilitate scheduling of staff interviews and receipt of information requested from VCBR.

The purpose of these inspections was to provide an evaluative review of the active treatment program, assess census and staffing levels, and assess progress toward previously noted findings and recommendations, particularly those in OIG Report #144-07, issued February 6, 2008.

Procedure for the inspection

For background observation of a similar program to VCBR, OIG staff visited the Sexual Offenders Residential Treatment (SORT) program at Brunswick Correctional Center on November 4, 2008. OIG staff reviewed the SORT program and interviewed staff and residents.

During the inspections at VCBR the following activities took place:

- Interviews with 48 residents on November 6. Residents with less than 90 days at the center were excluded from selection as they are understood to be undergoing evaluation and orientation rather than receiving optimal treatment levels. This sample, selected at random of those remaining, represented 42% of all of the residents on site on November 6. Interviews were voluntary. Residents completed written, confidential, anonymous questionnaires administered in groups. Brief group discussions followed completion of the individual questionnaires.
- Written interviews on November 14 with 74 staff, including leadership, residential, security, program/clinical and medical personnel. These included nearly all treatment staff (15), all security (25) and residential staff (18) present that day for shifts 1 and 2, all available medical staff (7), and many supervisor/leadership staff (9). All staff persons self-identified their roles on the questionnaire form.
- Oral interviews with 9 members of the executive leadership team. Some, but not all, of the executive leadership team also completed the staff interview and are included as identified as "leadership" in the results.
- Inspection of the clinical records of 44 residents. These were selected at random using a similar process as with the resident interviews. The record and interview samples were different persons. This is 39% of residents present at the facility at the time of the visits.
- Taken together, the record sample and the interview sample comprise 81% of all the residents.
- Inspection of the personnel records of 28 staff members. Personnel records of all program/treatment staff, as well as key leadership staff, were reviewed to assess qualifications, experience, and training.

- Observation of program and security areas and activity in the facility
- Review of materials provided by the facility
- Review of information provided by DMHMRSAS

Background about VCBR

The following excerpts from the Virginia Code describe the purpose of VCBR and the conditions upon which an individual who has been committed to the facility may be conditionally released:

> *VA Code §37.2-909 Placement of committed persons (A) - "Any person committed pursuant to this chapter shall be placed in custody of the Department (DMHMRSAS) for control, care, and treatment until such time as the person's mental abnormality or personality disorder has so changed that the person will not present an undue risk to public safety. The Department shall provide such control, care, and treatment at a secure facility operated by it or may contract with private or public entities, in or outside of the Commonwealth, or with other states to provide comparable control, care, or treatment. At all times persons committed for control, care and treatment, by the Department pursuant to this chapter shall be kept in a secure facility."*
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> *VA Code §37.2-912 Conditional release; criteria; conditions; reports (A) - "At any time the court considers the respondent's need for secure inpatient treatment pursuant to this chapter, it shall place the respondent on conditional release if it finds that (i) he does not need secure inpatient treatment but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need secure inpatient treatment; (ii) appropriate outpatient supervision and treatment are reasonably available; (iii) there is significant reason to believe that the respondent, if conditionally released, would comply with the conditions specified; and (iv) conditional release will not present an undue risk to public safety."*

VCBR became operational in 2004 at a temporary location in Petersburg and remains the only maximum security residential treatment program for civilly-committed sex offenders operated by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). Work was completed on the first phase of a new purpose-built facility in Nottoway County, adjacent to Piedmont Geriatric Hospital, in February, 2008. Residents and staff completed their move to the new facility during February, and the facility held its public opening on February 26, 2008.

The census of the facility continued to grow rapidly over the past year. At the time of the OIG's last visit to the facility on November 7, 2007, the census was 60. On November 6, 2008 the census was 117 (114 on site, 3 in jail). While there had been a small number of discharges from the facility over the past 4-plus years, all came as a result of judicial decisions in the legal process.

There had been no conditional releases to the community since the opening of the facility until November 13, 2008, on which date 2 persons were discharged on conditional release.

Section III – Review of Progress Toward Findings from OIG Report #144-07 (2007)

The following findings (noted in bold below) were issued in the last OIG report. The inspections on November 7 and 14, 2008 evaluated progress on each finding.

A. Active Treatment Findings from 2007

Finding A.1 (2007): **The amount of active treatment that is occurring is very limited, with levels of delivered treatment in 2007 falling 57% below those of 2006. In both years levels of treatment were below the stated expectations of facility leadership.**

1. Comparison of treatment levels: 2007 – 2008

- In the 2007 inspection OIG staff reviewed the clinical records of a sample of 16 residents to assess treatment planning and the amount of treatment received by residents on a weekly basis during the preceding quarter. This sample (26% of the total residents on that date) was restricted to persons defined by VCBR staff to be in active sex offender treatment, and excluded those with behavior problems and cognitive or psychiatric limitations and those new to the facility and being evaluated.
  - Review of service hours documented in the charts showed an average of group treatment time of 2.5 hours per week in the 3rd quarter of 2007.

2008 Review (Comparable Sample)

- To measure change in active treatment levels from 2007 to 2008 in a manner that that is comparable to the 2007 sample, a similar sample of residents was reviewed.[1] This subset sample of 21 persons (18% of census) consists of residents in the Sex Offender Treatment Track, levels I, II, and III (1 resident). These persons have similar characteristics and were at the same stages of treatment as those reviewed in 2007.

[1] For the 2008 review the OIG selected a much larger sample of residents than was drawn for the 2007 inspection in order to provide a view of the entire resident population. This sample is described on page 5. To obtain the smaller sample that is comparable to the 2007 sample, a subset of this larger sample was drawn, using the same factors as in 2007.

Average Weekly Hours of Treatment Received by Residents in Comparable Samples	Sex Offender Therapy and Psychoeducational Groups	Recreational, Substance Abuse, Educational Activities	Total
2007 sample (N=16)	2.5 hours/week	Not Available*	2.5 hours/week
2008 sample (N=21)	4.3 hours/week	2.3 hours/week	6.6 hours/week

* These figures only include sex offender treatment, as other services were not available in the 3rd quarter of 2007. In 2008 other activities for residents have become available.

- With substance abuse groups, recreation groups, and education classes included, the average for the 2008 comparison sample is **6.6 hours/week of organized therapeutic activities** in the 3rd quarter of 2008.

2008 Review (Comprehensive Sample)

- In 2008, in order to get a more complete picture of treatment activity at VCBR, OIG staff reviewed clinical records for a much larger and more diverse sample of 44 residents. This sample is fully representative of the population of VCBR and includes persons in the subset sample described above as well as from all phases of treatment (except, as noted above, those new to the facility). Persons with cognitive and intellectual limitations are included in the comprehensive sample. However, as described above, this larger sample is not directly comparable to the 2007 sample.
- A comprehensive listing of average resident activity for the larger 2008 sample is shown in the table below:

3rd Quarter 2008 Average weekly hours of activity per participant in comprehensive sample (all treatment tracks/levels) N=44						
sex offender group treatment (classes, groups, broadly defined) N=43	individual treatment N=6	substance abuse treatment/education (group, AA/NN) N=5	vocational activities (job training, employment) N=0	recreational activities (organized, sanctioned) N=33	educational activities (classes, GED, etc.) N=15	total supervised resident activities for all participating residents N=44**
3.5	.14	.65	0	.53	4.67	5.5

* Averages per activity are given based on the number of persons documented as participating in that activity during the quarter.
** Averages for residents are based on the total hours of all types of activity for each resident in the sample, averaged on a weekly basis.

2. Active treatment goals and measurement of results

- In 2007 little clarity about planned or prescribed levels of active treatment existed. There were no policies or guidelines provided to the OIG for what

amount of active treatment residents should receive. Leadership did not show that they tracked group treatment attendance or the degree to which treatment activity targets were achieved. When asked by the OIG, facility leadership estimated these variables (estimates varied significantly among key leaders), acknowledging that they were rough estimates.

2008 Review

- In 2008 leadership was able to provide documentation of specific treatment participation goals for residents in each level of treatment, as well as records that show actual active treatment enrollment and participation.
- As shown above, OIG measurement of the amount of treatment received by residents increased in 2008 from 2007. However, OIG measurements differ from VCBR data presentations.

    - VCBR estimated the average number of treatment hours per resident per week (for the comprehensive sample) at 12, with a range of 5 to 21.5 hours for the 3rd quarter of 2008. OIG findings described above show an average of 5.5 hours per week for the same period.
    - According to VCBR program leadership, the higher VCBR figures reflect treatment *availability*, meaning treatment scheduled or offered to the resident. The OIG counted hours *received*.
    - The differences in availability (VCBR data) and received treatment time (OIG count of completed treatment hours) derive from resident absences (excused and unexcused), resident refusal to attend treatment sessions, ejections of residents from classes or groups and cancellations of sessions by VCBR staff (due to staff vacancies, absences, or conflicts with other staff activities).
    - While VCBR treatment notes in the residents' charts do document when persons fail to receive available treatment, and usually include the reasons, their data reports do not capture this information. The VCBR document provided to the OIG to show treatment hours for all residents (entitled "Individual Total Group Hours Calculations per Resident by Quarters") shows enrolled, planned, or available hours – not hours received or completed.
    - VCBR treatment staff note the value of reporting available or offered hours as a demonstration of facility capability and intent and the fact that it cannot completely control hours *received* due to resident choice and other issues.
    - VCBR staff said that a new data system that will be implemented shortly that will afford greater accuracy and detail in reporting of all aspects of treatment received.
    - Resident interviews show frequent class cancellations as the second most frequently mentioned complaint about their treatment. Full results of resident interviews are available in the appendix.

DMHMRSAS Response*: Our new Records Management System (RMS), which is expected to be fully operational on March 1, 2009, will allow VCBR to collect and analyze treatment data in useful ways. In addition to data which is currently, routinely provided by our clinical information software (total hours attended), we will be able to audit recordkeeping and to make meaningful comparisons of our diverse population of residents with respect to their assigned and completed treatment hours. Residents will be compared to a cohort within the same treatment track, and not to residents in other treatment tracks who likely have different assigned treatment programming hours.*

VCBR will create a report format that will:

- *Calculate the number of actual hours received within each treatment track and phase of treatment*
- *Calculate the average participation score within each treatment track and phase of treatment and be able to analyze the treatment compliance distribution.*

VCBR is currently developing a treatment incentive plan to help address resident's attendance and participation in group activities. Under the proposed plan, residents would receive a small stipend for attending at least 90% of all groups scheduled, having no behavioral events, keeping their rooms clean and safe, etc. We hope to have this program approved and operational on or before July 2009.

3. Quality of clinical treatment planning

In addition to assessing treatment activity, the 2007 review also reviewed treatment planning as documented in the records. The OIG noted the following issues:

- lack of individualization of clinical records
- treatment goals made little to no reference to conditional release, readiness for return to community
- outdated clinical assessments (often much older that one year), completed by non-VCBR staff, often well before arrival at VCBR and not inclusive of experience at VCBR
- little use of multi-disciplinary treatment team approaches in treatment planning meetings
- no involvement of family, community representatives, etc. in treatment planning
- Only group treatment was provided. Clinical leaders said that individual treatment is not indicated for this population and it is provided only by exception. (While most sex offender treatment programs in Virginia and other states also use a group treatment model, many also incorporate individual therapy.)

2008 Review

For 2008 OIG staff reviewed 44 records using a structured checklist that assessed the internal logic and connectedness of problem assessment, goal formulation, treatment planning, and evaluative feedback in treatment plans. The checklist also used some measures of recovery-based treatment models that were drawn from the 2007 and 2008 OIG reviews at DMHMRSAS mental health treatment facilities. The OIG found that:

- Each resident's treatment plan is comprised of a standardized goal format for their treatment track level. All residents in the track have the same goals, which are pre-printed on the treatment planning form and specific to that treatment track. The goals describe progress that is necessary to rise to the next treatment level.
- This approach is commonplace in group treatment settings (e.g., substance abuse treatment), but individualization of plans is often found wanting.
- While the goal statements in the VCBR records are identical among residents and relate to achievement of behavioral or learning standards within the treatment levels, the records do show a good degree of individualization in documenting the activities, characteristics, and progress of each resident within that treatment level.
- Even when the documentation of the resident's progress shows specific, individualized problems or needs (e.g., a resident who refuses to participate regularly in treatment, does not attend classes, etc.), there are no specific, individualized goals added to the goal statements found in the templates for each treatment level for all residents. For example, a goal might be developed to work with the resident on why he does not participate in treatment. The OIG did not find any additions or modifications to the standardized treatment goals in any of the treatment plans that were reviewed.
- None of the goal statements in the standardized format explicitly address readiness for conditional release. Very few specific references to preparation for community living are found even in the individualized portions of the records.
- The most explicit references to readiness for community placement are found in the annual evaluations of residents *when prepared by VCBR psychologists*. These include recommendations to the judges and, usually, statements of progress necessary for VCBR to make a recommendation for conditional release.
    - 39% of clinical evaluations found in the charts were performed within the last 12 months.
    - 61% of the latest clinical evaluations were performed since the resident arrived at VCBR, by VCBR staff that are familiar with the resident and his performance in this setting. 39% were performed by contract staff before the resident arrived at VCBR.
    - The evaluations performed by VCBR staff capture the resident in the VCBR active treatment milieu, over time, with attendance records and input from staff who know him, thus providing a much better base for treatment planning, as compared to one-time evaluations by contracted external evaluators prior to VCBR admission.

- The recruitment and retention of 2 additional clinical psychologists since the 2007 review has contributed to the timeliness and thoroughness of evaluations.

The OIG conducted a review of many aspects of the clinical record. The overall results of the OIG review of clinical records are shown below. Items were rated by OIG staff using a 4-point rating scale: 1 = "strongly agree," 2 = "agree," 3 = "disagree," 4 = "strongly disagree." The scores shown are the average of scores given for each of the 44 records reviewed.

OIG Evaluation of Clinical Treatment Planning at VCBR "The plan is ……" **(N=44)**	**OIG Rating**
Responsive, specific to clinical assessment of the person	2.9
Individualized to that specific person's needs and strengths	3.1
Evidence of resident involvement in developing the plan	2.4
The resident's own goals are stated in his own words	2.7
Plan points toward return to community, has goals for release	3.0
Plan is holistic – whole person, multi-faceted – an overall rating, inclusive of the factors below	2.0
• Education needs/goals addressed	2.4
• Vocational needs/goals addressed	4.0
• Recreational needs/goals addressed	2.8
• Medical health needs/goals addressed	1.9
• Substance abuse needs/goals addressed	2.6
• Family/social/relational needs addressed	1.4
Plan uses a treatment team, multi-disciplinary approach (based on signatures at treatment team meetings, other references)	2.0

DMHMRSAS Response*: The facility agrees with the Inspector General's findings. They are in the process of revising their treatment planning documentation to meet Joint Commission requirements. They have received several sample treatment planning forms from the Joint Commission and other accredited facilities. The Clinical Services Director is currently updating their treatment planning form to ensure it is more person-centered. Plans will have more individualized resident-specific goals with measurable objectives. They expect to have this process in place by July 1, 2009.*

The facility has discussed this issue during the most recent Advisory and Oversight Committee(AOC) meeting and will present the Committee with a sample treatment plan to include more individualized goals and objectives during our next meeting (April 2009).

4. Other treatment issues

2008 Review

- In FY2007 leadership reported that individual treatment is not offered except as a limited, temporary adjunct to group treatment on a case-by-case basis.
    - 2008 service data shows this approach is still in place, with 8 of the 44 residents (18%) shown as receiving some instances of very brief one-to-one treatment (an average of 1.7 hours per quarter for those who received any individual treatment at all).
- In 2007 leadership stated to the OIG that VCBR's program concept called for extensive availability of vocational, recreational, and educational activities, as well as the treatment groups discussed above. Recreational and educational activities in 2007 were virtually non-existent due to VCBR's inability to hire and retain teachers and recreational therapists and due to severe space limitations, according to facility leadership.
    - At the time of the 2008 review, an educational program was functioning, offering GED and basic adult education classes. A director of education has been hired, along with a teacher and a librarian. The program is popular among residents who choose to use it. Ample and appropriate space exists for these activities.
    - A recreational program has begun and offers organized activities to interested residents. There are 3 full time recreational staff persons. The new facility has a gymnasium and outdoor recreational space.
        - The recreational program now has an art therapist, who offers arts and crafts classes.
    - Vocational programming has not begun, nor is there any vocational training available. No resident jobs exist. A vocational coordinator has joined the staff and is attempting to develop vocational opportunities, but is encountering legal and fiscal problems due to the civil commitment status of the residents and federal employment laws. Vocational needs and issues are discussed more fully below (pages 38 to 39).

DMHMRSAS Response: *Since the Inspector General's audit, the Education Department has implemented college level correspondence courses for residents desiring college level training. Currently, there are 20 residents enrolled in this program. Additionally, 30 residents have expressed an interest in our new college correspondence program. The facility has received such a positive response to their educational programming they are in the process of expanding space to accommodate additional students.*

Vocational Programming now offers courses focusing on resume writing and job interview skills. The facility hopes to expand this program during the next semester.

The staff aide position mentioned to the Inspector General and planned for start-up during the winter of 2008/2009 has been stalled by reported problems with payment. The facility has invited the vocational staff from Eastern State Hospital to come to VCBR and assist them with their program design. That consultation is scheduled for April 14, 2009. The facility has targeted July 1st 2009 as the new start-up date for the vocational work program.

Finding A.2 (2007): There is not a shared vision among facility leadership, staff, and residents for the expected outcomes of services provided by the facility.

- In 2007 there were inconsistencies among published mission statements and treatment goal documents.
- In 2007 there were differing perceptions of the mission of the facility among leadership, clinical staff, security and residential staff, and residents, particularly around the expected outcomes of services provided.
- Few of those interviewed endorsed the idea of "return to the community" as a realistic goal for most residents.
    - 75% of the staff gave negative to very negative assessments of the possibility of the majority of residents ever achieving discharge.
    - Residents strongly doubted that conditional release was a real possibility for them.
- Residents' clinical records did not have explicit goals for return to the community.

1. Facility mission, goals, and expected outcomes

2008 Review

In 2008, facility leadership reported that they had revised the facility's mission, vision, and core values statements. They indicated that the process involved a retreat and wide input from all levels of staff to shape the statements, followed by extensive efforts with staff to explain, train, and draw attention to the mission statement.

- The new mission/vision/values statement is very concise and is quoted here in its entirety:
    - *Mission: To provide recovery opportunities and support.*
    - *Vision: Excellence*
    - *Core Values: Resident recovery opportunities, teamwork, effective resource management.*

- The Code of Virginia calls for "*control, care, and treatment (*of committed persons) *until such time as the person's mental abnormality or personality disorder has so changed that the person will not present an undue risk to public*

safety." Furthermore, the Code establishes the criteria and specific conditions for residents to be conditionally released.

  - The new VCBR mission statement does not specifically address conditional release, return to the community or other statements of ultimate intent or expected outcomes that are consistent with the Code section that established VCBR.

- OIG inspectors noted wide display and promotion of the mission statement in the facility through posters, coffee cups, pens, and other objects.
- Staff surveys showed wider understanding and agreement with the mission statements than in 2007.
- When asked to state the mission in their own words, most staff made statements that reflected portions of the statements or used terms found in the statements, but differences existed around the inclusion of the ultimate goal of returning residents to the community.
  - 36% used language that specifically mentioned return to the community as a goal of treatment, though no such phases exist in the official statements.
    - leadership and clinical staff most frequently mentioned release or return to community (about 50% each)
    - residential (17%) and security (30%) used terms of release, return to the community less often.
  - 36% spoke of treatment, support, rehabilitation, and recovery, but did not mention goals of return to the community.
  - 8% made comments that doubt treatment effectiveness, stress security, and did not mention positive treatment outcomes.
  - 6% (mostly security staff) did not answer the question.

- A question testing staff opinions on this subject from the 2007 staff interviews was repeated in 2008:

Staff interview (N=74)	Strongly Agree	Agree	Disagree	Strongly Disagree
I believe the treatment we are providing will enable the majority of the residents we serve at VCBR to be rehabilitated to the extent that they can return to live in the community.	14%	42%	31%	13%

56% agreed, 44% disagreed. The positive goal language was endorsed by a small majority. In 2007, 75% disagreed.

- Differences among types of staff:

Staff interview (N=74) "I believe the treatment we are providing will enable the majority of the residents we serve at VCBR to be rehabilitated to the extent that they can return to live in the community."	Strongly Agree	Agree	Disagree	Strongly Disagree
Supervisor/Leadership	25%	38%	13%	25%
Program/clinical	27%	67%	7%	0%
Residential	6%	59%	35%	0%
Security	8%	21%	46%	25%
Medical	14%	29%	43%	14%

Clinical staff clearly differ from other staff in their assessment of this goal. Leadership's views were less positive than clinical's or residential's.

- A second question was phrased in the negative, to further illuminate this issue from another perspective.

Staff interview (N=74)	Strongly Agree	Agree	Disagree	Strongly Disagree
Our main job here is really to protect society from persons who are a danger to our children and families and will likely remain so forever.	17%	39%	31%	14%

- 56% agreed, 45% disagreed (rounding accounts for the total exceeding 100%). This is a reversal of the results for the previous question, as a small majority endorsed the negative position.

- Differences among types of staff:

Staff interview (N=74) "Our main job here is really to protect society from persons who are a danger to our children and families and will likely remain so forever."	Strongly Agree	Agree	Disagree	Strongly Disagree
Supervisor/Leadership	0%	11%	67%	22%
Program/clinical	7%	33%	40%	20%
Residential	24%	59%	12%	6%
Security	20%	40%	24%	16%
Medical	33%	33%	33%	0%

- Of the staff who have the most extensive and regular contact with residents, 83% of residential staff agreed with the negatively phrased statement, as did 66% of the security staff.

- These results may show staff ambivalence or lack of clarity about the issue of residents' return to the community and suggests a need to further clarify facility mission and goals and to focus training and supervision on these issues.

Residents were also asked their perspectives on the goals of treatment at VCBR, using the same questions. Another question asked whether they felt they knew where they stand with regard to treatment progress:

Resident interview (N=48)	Strongly Agree	Agree	Disagree	Strongly Disagree
I believe the treatment I am receiving will enable me to be rehabilitated to the extent that I can return to live in the community eventually.	28%	38%	26%	9%
The real purpose of this program is to keep people locked up who will forever be considered a danger.	32%	30%	30%	9%
The facility lets me know where I stand in my treatment and what progress I must show to be ready to be discharged.	10%	25%	38%	27%

- Residents endorsed the positively-phrased goal of rehabilitation to enable a return to the community to a higher degree than do staff (66% agree with the first statement, versus 56% of staff).
    - But the negative expression of the purpose of VCBR also elicits a (contradictory) majority of the residents - 62% favored the negative statement.
- 65% of residents disagreed that they are informed about what they must do to be ready to be discharged.
- In open-ended questions in which residents were asked to state the goals of VCBR in their own words, a slight majority (52%) had a positive view that the goal of treatment is intended to ready them for release to the community; 48% expressed skepticism, sarcasm, or lack of trust that this is the case.

2. Balance of correctional and treatment models and values

In 2007 discussion of goals, values, mission, and organizational culture hinged on the balance between security and treatment models and values. OIG research and interviews with sex offender treatment experts confirm that getting this balance right – and having broad understanding and agreement about it among all stakeholders (leadership, staff, residents, etc.) - is critical for effective, safe treatment. In 2007 this balance was viewed differently among different staff groups and by residents.

2008 Review

- The initial reaction of the Advisory and Oversight Committee[2] upon entering and touring the new facility at VCBR and being briefed on its program was that they were seeing a correctional facility (rather than a treatment program) in which residents were afforded less comfort and fewer privileges and opportunities than prisoners in the DOC. As the committee began its work and developed its focus, concern about these issues continued. Concerns include overly spartan cells and furniture, a harsh environment, very limited resident privilege levels with regard to phone use, mail, television access, and personal items.
- OIG interviews with residents were dominated by complaints that the VCBR facility and program is overly restrictive and affords them less personal freedom and privileges than they previously had in prisons. The following questions from OIG interviews illustrate some of these concerns:

Resident interview (N=48)	Strongly Agree	Agree	Disagree	Strongly Disagree
The rules, privileges, and freedoms of being a civil committee at VCBR are better than it was being an inmate in a DOC facility.	6%	16%	31%	47%
The physical comforts of VCBR are better than what I had at DOC.	11%	26%	40%	23%
There are enough constructive activities to fill my days.	4%	25%	25%	46%
Morale among the residents is pretty high.	0%	24%	41%	35%

  - Responses on each measure are sharply negative.
  - Resident response to open-ended questions and comments during informal group discussions with OIG staff stressed these issues very strongly.

- OIG interviews asked all staff to rate the balance of treatment and correctional models with the following question:

"All programs that are similar to this one must find a balance between security and treatment. In your opinion how is the current balance at VCBR?"

All staff responses:

59% Tilted too much toward treatment and resident choice.
24% About right, about enough emphasis on security ***and*** treatment.
17% Tilted too much toward security and correctional approaches.

[2] The 2007 report recommended the formation of an Advisory/Oversight Committee for VCBR. For a full discussion of this process, please see pages 30 to 32.

- Differences exist among different types of staff in response to this question. The data from this question is shown in the table below as reported by the different types of staff:

"All programs that are similar to this one must find a balance between security and treatment. In your opinion how is the current balance at VCBR?"	Tilted too much toward treatment and resident choice	About right, about enough emphasis on security ***and*** treatment.	Tilted too much toward security and correctional approaches.
Supervisor/Leadership	25%	63%	13%
Program/clinical	47%	33%	20%
Residential	61%	17%	22%
Security	71%	17%	13%
Medical	83%	0%	17%

- Only among leadership staff do a majority assess the balance as "about right." At least 66% of all other staff groups see the balance as misplaced in one direction or the other, mostly toward too much resident choice/treatment.
- Other staff see that balance as tilted too much toward resident treatment and choice, by about a majority (program/clinical staff and residential staff) to a very sizable majority (security and medical).
- Based on discussions with staff as they completed this questionnaire, OIG staff interpret the staff tendency to see the balance as "tilted too much toward resident choice and treatment" as partly an indication of concerns about resident disruption and staff safety issues discussed in the section on facility security, pages 23 to 25.
- The balance of security and treatment defines the organizational culture and is a significant factor in determining the experience and outcomes for residents and staff. It is clear that this balance is not yet resolved and the lack of concurrence among stakeholders is very evident.

DMHMRSAS Response:

1. *To address some of the resident's complaints, the facility has recently made their access to DVD and periodicals procedures less rigid. All residents are now able to purchase their own personal DVD player and may purchase DVDs with an approved rating without separate approval. Cable television will be installed in common areas (target date of completion July 01, 2009). The primary privilege issue and greatest irritant vocalized by our residents continues to be access to tobacco.*

2. *The facility shares the concerns identified regarding resident rooms and the overall harsh appearance of the living areas. (These areas were designed and were well under construction before the Facility Director was hired.) Due to limited construction funding, there has been little opportunity to enhance those areas. Despite the obstacles which are*

outside the control of the facility administration the following actions have been identified in order to create a more pleasant and " homey" atmosphere:

- *Wooden beds from the facility vacated in Petersburg have been relocated and placed in the highest privilege unit.*
- *A local vendor has been contracted with to widen all other slab beds. Target date to have all beds in occupied areas widened is July 1, 2009. Mattresses will also be replaced in order to allow for greater comfort.*
- *Metal lockers will be replaced by more attractive wooden storage cabinets on the highest level of privilege unit. The facility is also working with Virginia Correctional Enterprises to design a storage container that is both visually appealing and safe. Target date for installation of new storage cabinets is July 1, 2009.*
- *In an effort to decrease noise levels in problem areas there are plans in place to purchase carpeting for all quiet rooms and seating portions of the main dayroom area. Research into panels designed to decrease noise levels is also under way. In addition to decreasing noise levels, carpeting will help soften the appearance of living and service areas throughout the facility.*
- *The facility has contacted interior design departments at local colleges and universities in the hopes of gaining their interest in a possible school project centering on facility improvements.*
- *Residents have been engaged to design murals for living areas and prizes will be awarded to each unit for their efforts.*

During our most recent meeting with the Advisory and Oversight Committee a modified room in Unit 3 was assessed and it was agreed that, due to limited square footage, it would not be feasible to attempt to modify the resident desks or toilet/sink areas.

3. *Current facility procedures for telephone use, mail, television access, and personal items are in compliance with the existing Exemptions to the Human Rights Regulations approved by the Commissioner.*
   The previous telephone system, which was problematic for residents as well as their families, has been replaced with a much more affordable one. Residents receive unlimited local minutes for fifty cents per call. Residents can use their personal calling cards for long distance services. Residents have the freedom to purchase the same calling cards available to the general public (no additional costs). Facility operational procedures clearly state that no indigent resident may ever be denied the ability to contact a family member in the event of an emergency or their attorney.

Finding A.3 (2007): The external, formal programmatic oversight of the facility is extremely limited and is significantly less than that provided for all other facilities operated or licensed by the DMHMRSAS.

- The 2007 report documented areas in which facility oversight is limited and less complete than at other DMHMRSAS facilities. OIG recommendations were made that DMHMRSAS and the facility:
  - Create and make use of an Advisory/Oversight Committee (AOC).
  - Review existing national accreditation systems to determine the appropriateness and validity of these systems for sex offender treatment programs, and to pursue accreditation if deemed appropriate**.**

2008 OIG Review

- The following additional oversight developments were noted.
  - The facility (which previously had a separate and unique human rights review process) was brought under the authority of the local human rights committee that serves Piedmont Geriatric Hospital (PGH). This is reported by the Director of Human Rights for DMHMRSAS to be proceeding smoothly.
  - The facility's reporting and coordination contacts at DMHMRSAS were changed at least three times since the 2007 report. Levels of supervision of program operations and support from central office also varied.
  - VCBR had removed itself from participation in the state facility pharmacy system in 2007, but with the move to the new facility, this function is now back under the DMHMRSAS pharmacy system umbrella, with PGH providing this service for VCBR. However, the facility director is considering re-privatizing these services in an effort to save money.
- The Advisory/Oversight Committee's progress is discussed on pages 31 and 32 and the facility's efforts to become accredited are discussed on pages 35 and 36.

DMHMRSAS Response: *Since the Inspector General's audit, the facility has begun implementation our their Strategic Plan, trained department heads on Joint Commission requirements, and begun developing quality assurance indicators and reports. They have begun conducting internal Joint Commission type audits and are currently developing action plans to address findings. Additionally, staff from another Joint Commission Accredited facility have been solicited to conduct a full mock Joint Commission survey.*

It is important to note that in addition to their efforts to become Joint Commission accredited, the facility receives oversight and direction from the following agencies: DMHMRSAS Central Office, Office of the Inspector General, Office of the Attorney General, the VCBR Advisory/Oversight Committee, VOPA, ARMICS, the Local Human Rights Committee, and our Facility Advocate.

Finding A.4 (2007): The role of medical and nursing services at VCBR is not clearly defined and these services are not integrated with clinical treatment. Relations between nursing services and administration are strained, and significant differences exist between them concerning the role of nursing services at the facility.

2008 OIG Review

Interviews took place with all available nursing and medical staff (N=7).

- At the time of the 2008 review, the nursing staff had experienced nearly complete turnover from 2007. The position of Director of Nursing had not been filled and leadership was reviewing this role, and that of the Assistant Director of Nursing. There were 2 full time salaried nurses (only one of whom had been there in 2007). Some positions were vacant. The remainder of the staffing at the time of the interview was temporary contractual staff or wage employees. A total of 20 different people were identified in a roster published November 6, but it is not known how many were active. The medical doctor who had been employed full time by the facility since it opened resigned at the end of October, with his last day being November 14. Contractual physician staff was being sought on a temporary basis. The medical staffing situation is clearly in flux.
  - The unanimous and highly negative complaints expressed by nursing staff in 2007 have dissipated. This may be a function of the 2007 staff having dissipated, too. Medical staff who were interviewed were not aware of or did not share the strong opinions of their predecessors.
  - Complaints from 2007 about space, interference from other functions, lack of leadership support, compliance with Board of Pharmacy requirements, and poor pharmacy services were not repeated in 2008.
  - Facility leadership attributed much of the unrest among the nursing staff in 2007 to the influence of persons now gone.
- Nurses (and facility leadership) reported that they are invited to attend treatment planning meetings, but they rarely have time to do so.
  - Record reviews showed very little presence by nursing staff at treatment planning meetings for the 44 residents reviewed in 2008.
  - Nursing staff indicated, as they did in 2007, that their services function quite separately from clinical, residential, and security functions and that they had little dialogue or interaction on anything other than physical health matters.
- VCBR residents' medical records and program (clinical treatment) records remain completely separate documents (one electronic, one in paper form), located in different parts of the building, and are not integrated, as was noted in 2007.
  - Facility leadership expressed pride and anticipation for a new program that will integrate clinical and medical records in an electronic record and data system in the very near future. OIG staff witnessed a demonstration of the proposed system.
  - Medical records were not reviewed in 2008.

- Facility leadership confirms their view that the intended role of the medical/nursing staff is focused on physical health needs and is not like that of mental health nurses in a psychiatric facility.
    - DMHMRSAS facility operations leadership has noted that JCAOH accreditation will require a different role for nursing and medical staff.
- A small number of residents had detailed written complaints about medical services, mostly focusing on delays in response to their requests. Complaints about medical services were frequently mentioned (tied with 2 other issues as the most frequently mentioned) in the informal group discussions with residents.

Finding A.5 (2007): Psychiatric services at VCBR may be inadequate to identify and treat psychiatric issues.

- At the time of the 2007 review psychiatric services had become virtually non-existent, with the resignation of a psychiatrist who had provided extremely limited amounts of services. For a time, VCBR used contracted vendors of psychiatric services.
- The 2007 review documented that few residents had psychiatric evaluations and few were using psychiatric medications.

2008 OIG Review

As of September, 2008, a half time psychiatrist had been added to the staff. Facility leadership would like her to move to full time and she is considering it. The psychiatrist has prior experience in working with sex offenders. Clinical staff highly value her contributions and consultation. Clinical leadership's goal is to conduct a psychiatric evaluation of every new resident and all other residents by referral or staff indication. Given the facility's plans for an upgraded psychiatric capacity that were underway, a review of psychiatric services records was not performed.

B. Security Findings

Finding B.1 (2007): Facility security arrangements function well and provide for adequate control.

2008 OIG Review

1. Staff concerns

- Security leadership reported that the new facility provides improved security and safety with reduced staffing requirements.
- The arrangement of the facility, with many security functions provided by staff in overhead observation areas using direct and camera monitoring, involve security in less contact with residents and staff.

- Security leadership indicated that increased resident activity, especially vocational, recreational, and educational programming, would improve security issues by reducing boredom and vacant time.
- No concerns were expressed about perimeter security – preventing escape, entry of contraband, etc. However, many staff felt anxious about their personal safety while on the job:

Staff interview (N=74)	Strongly Agree	Agree	Disagree	Strongly Disagree
"I feel safe working here."	8%	27%	37%	27%

64% of staff expressed workplace safety concerns by disagreeing with this statement, while 36% agreed.

- Significant differences exist among different types of staff concerning this question. Whether the staff are based and spend most of their time "inside the sliders" (behind the sliding steel security doors, in the area where the residents live) or in the office areas outside the sliders is strongly correlated with expressed feelings of safety or lack thereof. Staff based "inside the sliders" are shown in the shaded sections in the following table:

Staff interview (N=74) "I feel safe working here."	Strongly Agree	Agree	Disagree	Strongly Disagree
Supervisor/Leadership	11%	56%	11%	22%
Program/clinical	20%	40%	40%	0%
Residential	0%	17%	56%	28%
Security	4%	21%	29%	46%
Medical	14%	14%	43%	29%

- The staff interview included open-ended questions such as "what things contribute to job dissatisfaction?" 56% of items listed by staff relate to safety, abusive residents, feelings of powerlessness, and lack of support and inconsistency from administration.
  - Concern about inconsistency and inadequacy of discipline and consequences for resident behavior were the leading source of staff dissatisfaction with their jobs.
  - Staff viewed lax discipline, inconsistency of consequences or lack of consequences for bad behavior to be the leading factor that prevents residents from making progress in their treatment.
  - Commonly used language included "favor resident rights over staff rights," "staff not backed up (in disputes with residents)."
  - Concerns in these areas were significantly greater among residential, security, and medical staff – who spend all their time in the resident living areas - than among leadership and clinical staff, who have offices outside the "sliders" (the electrically-operated security doors that separate resident living areas from training and office areas).

- Some staff expressed concern about the reliance on overhead security to answer buzzers and open the “sliders” by remote control and the consequent delay in their ability to exit an area. They feared that delays or interruptions of communications would put them at risk from resident violence should it occur.
    - Some staff called for the availability of emergency response teams.
    - Many staff (especially residential and security) said that the reliance on TOVA to deal with behavioral issues and the restrictions placed on “putting hands on residents” increase their risk and are ineffective to regulate resident behavior.
- Disruptive, noisy, angry residents raise tension levels among staff. Staff report that they hear from residents that residents know they cannot be touched and they taunt staff that they will be reported if staff infringe on their “freedom” to behave as they wish. Resentment exists among residential and security staff around this point, suggesting a very strong training and support need. Many, if not most, of these staff come from a DOC background where the discipline authority of the facility greatly exceeds that for a civil commitment setting.
- Residents have repeatedly damaged expensive wide screen televisions and other equipment in the facility.
- The facility is attempting to implement a level and privilege system to provide incentives and consequences for behavior, but the program is in the earliest stages of development. The development and implementation of the new system is also occurring during ongoing program operation and rapid population and facility growth (a new living unit just opened). At the time of the OIG visit, residents had just been moved to different units to implement the new level system.
    - Some residents, staff, and AOC members have said that the facility amenities (room furnishings, recreational equipment, etc.), privileges, and resident freedoms are so minimal now, that options for levels based on behavior rewards/consequences are very limited. And change “on the run” on such matters is very disruptive and easily challenged.
    - Differences among staff on these issues are further evidence of the need to define and create understanding about the balance between security and treatment issues.
    - Staff and residents alike complained that procedures, policies, and rules were constantly changing. This was one of the leading staff concerns. Security staff especially shared these concerns.
        - One said, illustratively, “DOC (the Department of Corrections) is a solid; this place is still a liquid.”

2. Resident concerns

- Residents' impressions of safety were assessed with two interview questions:

Resident interview (N=48)	Strongly Agree	Agree	Disagree	Strongly Disagree
"I feel safe here from threats or dangers posed by staff."	25%	35%	19%	21%
"I feel safe here from threats or dangers posed by other residents."	17%	35%	30%	17%

It is a significant safety/supervision issue that almost half (47%) of the residents report some concerns about their safety from threats or dangers from other residents. In written interviews and in informal discussions a small number of staff complained about assault by other residents.

C. Workforce Findings

Finding C.1 (2007): Staff vacancies and constant turnover significantly decrease the effectiveness of active treatment programming at VCBR. Recruitment and retention of clinical staff is an ongoing problem at the facility.

- The Director of Human Resources for DMHMRSAS reported the following turnover statistics for VCBR (all staff positions):
    - FY05 49.8%
    - FY06 44.8%
    - FY07 51.5%
  - These figures were significantly higher than the next highest facility, (CCCA, 35.5% in FY07) and double or triple that of all of the other facilities.
  - The DMHMRSAS Director of Human Resources expressed significant concern about turnover and vacancies at VCBR.

  - **2008 OIG Review**

- The final FY2008 turnover rate for VCBR was 47.5%, per DMRMRSAS Human Resources. This does not show improvement when compared to past years and other facilities.
- The facility director reported many activities undertaken, working in concert with the Director of Human Resources for DMHMRSAS, to enhance recruitment and retention. These include a Recruitment and Retention Plan, increased interaction by supervisors with new staff, greater involvement of staff in facility policy development, enhanced training, and a planned "staff mentorship program."
- The director emphasized that the interview process has been revised to ensure that applicants have a clearer, more realistic idea of the population served, the nature of the work, and other factors that may help them select applicants who are less likely to resign early from their new jobs.

- In the critical area of clinical staffing, where turnover was almost 100% at the time of the last OIG inspection, retention of staff has improved. 66% of the clinical staff present at the last OIG visit on November 7, 2007, is still employed after a year.
- Staff still consider turnover a major problem. Staff interviews included the following question: "On a scale from 1 (low, not a problem) to 5 (high, big problem), how big a problem is staff turnover at VCBR?
  - Average staff rating was 4.1
- When staff were asked "What causes turnover at VCBR?" a number of factors were mentioned with comparable – but rather low – frequency (5% - 8% of total comments given):
  - difficult client population, abusive, high demand
  - lack of discipline with residents, residents' rights favored over staff
  - dissatisfaction with leadership, supervision
  - poor communication with leadership, across departments
  - inadequate training
  - unsafe environment
  - staff not appreciated, supported
  - location of facility
  - constant change of policy, procedures

A number of staff interview questions addressed many of these variables:

Staff Interviews (N=74)	**Agree**	**Disagree**
I receive excellent, supportive supervision on working with sex offenders from my supervisor.	66%	34%
I am respected and valued by the leadership of VCBR for my contributions to the work of our program.	65%	35%
My job is professionally satisfying and rewarding.	62%	38%
I would recommend VCBR to my friends as a good place to work	53%	47%
Morale among my co-workers is pretty high.	37%	63%
The senior leadership team has created an open and comfortable work environment for expressing my ideas.	47%	53%
Since I have been employed at VCBR I have received excellent training in working with sex offenders.	48%	52%

- Residents were asked to agree or disagree with the following statement: "Turnover among treatment staff is a problem for continuity of my treatment."
  - 71% agreed.

DMHMRSAS Response: *VCBR is pleased to report that for the current FY2009 (July 2008 – February 2009), VCBR has only incurred 34 separations with an employment level of 196 staff positions. This is a turnover ratio of 17.4%.*

Finding C.2 (2007): Direct service clinical staff, as well as medical and security staff receive very little training on treatment of sex offenders.

- In 2007 OIG interviews with clinical staff and review of training records for all staff revealed virtually no training on working with sex offenders had been made available to staff during the past year.

2008 OIG Review

1. Training

- VCBR, working with the DMHMRSAS Office of Sexually Violent Predator Services (OSVP), developed and implemented a training program for clinical staff. Training activities were provided by OSVP and DOC staff, and it was arranged for VCBR staff to receive regular training at the DOC training center.
- The OSVP helped initiate a joint training program for VCBR with the Sexual Offenders Residential Treatment program at Brunswick Correctional Center (SORT). The last Friday of each month was reserved for training activities. This training experience was very well received by VCBR and SORT staff (OIG staff visited SORT, reviewed that program and interviewed staff and residents on November 4, 2008).
- Training of clinical staff:
  - In a report dated 10/1/08, the facility director indicated that "each current member of the treatment staff has attended an average of 47 hours of continuing education directly relevant to the treatment of sexual offenders."
  - OIG review of personnel records confirmed that all of the current treatment staff (those who have been employed longer than a few months) have indeed received a substantial amount of relevant clinical training, usually well in excess of 6 separate training events.
- Training of executive/administrative leadership:
  - OIG review of the personnel records of key leaders in security, residential care, and executive/administrative leadership showed little to no training received in topics relevant to sex offender treatment during the past year.
- Training of residential and security staff:
  - OIG review of training records of all VCBR employees showed little to no training in sex offender treatment issues for direct service residential or security staff over the past year. (It is noted that the required orientation for new staff includes a brief section on working with sex offenders.)
  - Training on TOVA and managing resident behavior were received by these staff members.
- The clinical program has now employed 2 persons with appropriate licensure and sex offender treatment provider certification to provide supervision and on-the-

job training for clinical staff, supplementing the provision of supervision by the Director of Treatment Services and the Director of Clinical Services.

- All staff were asked about their prior experience in working with sex offenders, and their satisfaction with training and supervision they have received while at VCBR:

Staff Interviews (N=74)	Strongly Agree	Agree	Disagree	Strongly Disagree
I had direct experience in working with sex offenders before I came to work at VCBR.	21%	26%	23%	30%
I receive excellent, supportive supervision on working with sex offenders from my supervisor.*	23%	42%	19%	15%
Since I have been employed at VCBR I have received excellent training in working with sex offenders.*	9%	38%	35%	17%

*These questions were also summarized in the table on page 27.

- All staff were also asked the following question:
  "Did you take part in any courses, training sessions, conferences, speakers, workshops, etc. that are ***directly specific*** to working with sexually violent offenders between November 2007 and November 2008? (Note: do not include the week-long new employee orientation session that you received when you first became employed at VCBR or routine supervision sessions with your supervisor)": 38% said yes, 63% said no.

2. Clinical Staff qualifications

- The numbers, qualifications, licensure status, and Certified Sex Offender Treatment Providers (CSOTP) status of clinical and other program staff have improved since the 2007 OIG visit:

Professional Qualifications of Clinical and Program Staff*	Masters Degree or higher?	Licensure (LCSW, LPC, etc.)	CSOTP	Prior sex Offender tx experience?
Clinical supervisors (N=4)	4 of 4	4 of 4	3 of 4	4 of 4
Therapists (N=3)	3 of 3	0 of 3	0 of 3	0 of 3
Treatment Associates (N=8)	2 of 8	0 of 8^	0 of 8^	0 of 8
Psychologists (N=2)	2 of 2	2 of 2	1 of 2	2 of 2
Recreation/education/vocational specialists (N=5)	2 of 5	0 of 5^	0 of 5^	0 of 5
Psychiatrist (N=1)	1 of 1	1 of 1	0 of 1	1 of 1

* as of December 19, 2008
^ not eligible due to lack of Masters degree or otherwise not applicable

(Treatment Associates are required to have a Bachelor's degree in a Human Service field; therapists require a Masters. Because of this treatment associates lead psychoeducational

groups, but not the therapy or process groups, which are led by therapists. Treatment associates also provide back-up coverage and co-facilitate (when staffing levels are sufficient) and they provide case management services.)

- All therapists are in the process of acquiring licensure and CSOTP.
- None of the facility's administrative leadership has academic preparation, clinical training, or professional qualifications in clinical or sex offender treatment areas.

> ***DMHMRSAS Response:*** *Between January 1 and October 1, 2008, each member of the treatment staff attended from an average of forty-seven hours of continuing education directly relevant to the treatment of sexual offenders. The facility goal is to ensure each clinical staff member receives six hours of clinical training each month. This far surpasses requirement for state licensure. Since the Inspector General's audit VCBR conducted a week long intensive training program for all staff, including residential, security, and medical staff. Topics included items such as Introduction to Sex Offender Treatment, Interpersonal and Therapeutic Communication, Manipulation, Policy Review, Suicide Interventions, etc.*
>
> *At the time of this response the VCBR reports they have not maintained copies of course outlines or other details of trainings referenced above. The Office of Facility Operations has explained that maintenance of such documentation is a standard expectation of any training plan and should be initiated immediately for any future training. This issue will also be added to the April 1st Advisory and Oversight Agenda and incorporated into the facility plan of correction.*

Section IV – Review of Progress toward Recommendations from OIG Report #144-07 (2007)

Recommendation 1 (2007): It is recommended that the DMHMRSAS establish a permanent VCBR Advisory/Oversight Committee by no later than April 1, 2008. The responsibility of this committee will be to provide appropriately specialized and knowledgeable oversight and review of VCBR programs and operations for the purpose of assuring maximum effectiveness of the facility and to make recommendations for improving effectiveness to the VCBR director and the DMHMRSAS Commissioner. It is further recommended that consideration be given to including representatives from the following areas on the advisory/oversight committee: experts in the treatment of violent sexual offenders from model programs across the nation, staff of the DMHMRSAS OSVPS, other appropriate staff from DMHMRSAS central office, the judiciary, and the community.

Recommendation 2 (2007): It is recommended that the newly established VCBR Advisory/Oversight Committee carry out the following tasks as a part of its initial work plan:

- **Identify and review the factors that have contributed to low levels of treatment, recreational, and educational activities at VCBR and develop recommendations, including changes in facility culture, policy, procedures and program that will significantly improve and increase the levels of activity in these services at VCBR.**
- **Review the role and support for medical, nursing, and pharmacy services at VCBR and recommend any needed changes. (Response to Finding A.4).**
- **Assess the role and adequacy of psychiatric resources at VCBR and make recommendations for any changes that are needed.**
- **Study the facility's staff retention and recruitment situation, in coordination with the DMHMRSAS Office of Human Resources, assessing such areas as leadership, organizational culture, support of staff, training, pay and benefits, etc., and recommend specific actions to improve staff continuity.**

2008 OIG Review

- Following DMHMRSAS' acceptance of this recommendation, the Director of the OSVP was charged with forming and providing staff support for the Advisory/Oversight Committee (AOC) in February 2008.
- A committee composed of 9 members was formed and met on February 12, May 2, July 15, August 8, and December 11, 2008.
- Three members of the committee are sex offender treatment experts from outside DMHMRSAS (2 are from DOC, 1 is in private practice), 1 member represents the Attorney General's office, and 5 are from DMHMRSAS. Staff from the OIG monitored the last 3 meetings.
- DMHMRSAS developed a detailed outline of objectives for implementation of OIG recommendations and involvement of the AOC in response to the OIG report. Few of the objectives or timelines of this plan were subsequently met or even addressed. It is not clear how much, if any, involvement there was of VCBR leadership in this product.
- The AOC met and visited VCBR on July 15. This visit included presentations by VCBR staff, a tour of the facility, and a meeting with a group of residents who had formed an unauthorized "Resident Advisory Council."
- The August 8 AOC meeting featured a tour and presentation of SORT at the Brunswick Correctional Center. SORT is a sex offender treatment program that is operated by DOC.
- The committee developed preliminary findings and recommendations and made the decision to request a meeting with the Commissioner of DMHMRSAS following its meeting on August 8. The recommendations were drafted by OSVP staff with intensive review, editing, and approval by the AOC.

- The committee's recommendations expressed major concerns about the living conditions, levels of privilege, personal freedom, and morale of the residents. It also expressed concerns about the lack of a work program, limited active treatment and recreational/educational opportunities, staff turnover and staff qualifications, and security issues. The committee considered its concerns urgent.

- On September 2, in response to a request of DMHMRSAS, OIG staff met with the Commissioner and the director of VCBR to review recent developments and clarify actions for the future. It was determined that the VCBR director would develop a specific response to each item noted in the 2007 OIG report.
- Responsibility for liaison to the committee and oversight of VCBR was transferred from the OSVP to the Director of Facility Operations during this time.
- Committee members were contacted by the Director of Facility Operations in October and a conference call with the committee took place on October 24. The committee requested to have a telephone conference call with the Commissioner, which was held on November 4. The committee shared the concerns that had led to its initial recommendations. A committee meeting was set up for December 11, and the Assistant Commissioner for Special Projects was appointed to staff the AOC and organize the meeting.
- The meeting on December 11 was held at VCBR, facilitated by the Assistant Commissioner for Special Projects. The Commissioner also met with the committee, along with key leadership of VCBR.
- The December 11 meeting was a positive dialogue among VCBR leadership, DMHMRSAS leadership, and the committee. Preliminary goals and short term outcomes for improving conditions at VCBR were crafted and DMHMRSAS committed to their achievement, including the following:
    - measures designed to improve the residents' living environment (upgrading the beds and mattresses for all residents, installation of decorations and murals in common spaces, and provision of expanded television offerings in common areas)
    - efforts to improve the organizational culture (re-activation of the Resident Advisory Committee, establishment of an employee advisory committee, provision of a means for senior leadership to be more available and responsive to residents, e.g., "regular rounds" with documentation of same)
    - efforts to introduce employment opportunities and a vocational training program.
- A follow-up meeting was set for January 27, 2009.

Status of Recommendations 1 and 2 (#144-07) – DMHMRSAS support, guidance, and facilitation of the committee has been inconsistent and incomplete. The committee members have given considerable time and insight to their task. The activities outlined in the DMHMRSAS response to the 2007 OIG report remain unmet. Recommendations 1 and 2 remain ACTIVE.

DMHMRSAS Response: *Since the last DMHMRSAS response was submitted in October 2008 the Advisory and Oversight Committee (AOC) has had two meetings, during which a concrete work plan was developed in an effort to support the facility in its substantial efforts to improve the quality of services and culture within the facility. The Commissioner attended the initial work plan meeting. The work plan developed has identified the following areas of focus and identified both short and long term goals for each area. Facility staff worked actively and enthusiastically in the development of this plan:*

- *Living Environment*
- *Treatment (Recovery) Planning*
- *Resident Activities including Vocational Programming*
- *Staffing/Organizational Culture (Clinical vs. Correctional) Professionalism of Staff*
- *Staff Development*
- *JC Accreditation*
- *Resident Rights and Privileges*

The next meeting of the VCBR Advisory and Oversight Committee is scheduled for April 01, 2009. The meeting will be attended by the Deputy Commissioner, the Director of Facility Operations and Quality Improvement, and the Assistant Commissioner for Public Relations and Quality Improvement to develop a schedule of meetings for the year 2009, review the work plan and receive facility updates, and discuss future planning.

Following several months of staffing changes, reorganization of the Department structure, and the hiring of the New Deputy Commissioner whose position is to work closely with DMHMRSAS facilities, DMHMRSAS leadership has made an active commitment to provide consistent support to VCBR by assuring the availability of all needed leadership, resources, technical and legal assistance necessary to resolve any identified state and federal barriers to the development of an effective vocational program at the facility. In updates below, the facility reports improvements in their Vocational programming which have already been achieved. This item will also remain a focus for the Advisory and Oversight Committee's work plan and ongoing oversight.

Additional Related Finding (2008): VCBR does not compile a report of treatment and other program activity actually received by individual residents or by residents collectively.

Additional Related Recommendation (2008): It is recommended that VCBR 1) initiate regular reporting of treatment and other program activity actually received by individual residents and by residents collectively, and 2) continue to report treatment and other program activity offered.

***DMHMRSAS Response**: VCBR does collect data that reflect both actual treatment hours received by each individual resident and collectively. The facility Information Technology (IT) Department is currently working to upgrade this system to include not only hours received, but also the number of hours scheduled. This data is currently available to each treatment team member and is used to evaluate progress towards recovery.*

The new Electronic Data System will be able to provide useable data beginning in May 2009 and will be able to provide individualized data on program activity received by each individual as requested by the Inspector General. The system will have the capability of providing both active treatment hours and hours spent in assessments, consultation, treatment plan reviews in an effort to provide consistent data for use by the facility in quality improvement activities and by the Inspector General's Office during future inspections. Additional data will be collected regarding group cancellations and causes. Treatment activity data will be collected by individual treatment track as well as facility-wide. It should be noted in this report that no changes have been made in treatment track descriptions and criteria for assignment since the last submission to the OIG November 2008.

The new EDS will also be used to monitor treatment program attendance rates across the all programs, and within treatment tracks, along with the reasons for non-attendance and the facility will develop an operationally relevant and recovery informed definition of "treatment refusers" and utilize this data to plan interventions geared toward improving these numbers. There currently exists no clear definition of "active treatment" in the operations of VCBR. The Advisory and Oversight Committee will be including this item in its agenda for the April 1st meeting, including it within the larger topic of treatment planning and will provide or ensure education is provided to treatment providers and management at the VCBR regarding standards which exist in other DMHMRSAS behavioral health facilities.

Recommendation 3 (2007): It is recommended that the facility, in concert with the leadership of DMHMRSAS, develop a mission and goals statement that accurately reflects the intended purpose of VCBR and ensure that facility policies, active leadership, program design, staff training, and individual residents' goals and treatment activities reflect the facility's revised mission and goals on an ongoing, operational basis.

2008 OIG Review

For a discussion of the facility's development of a new mission statement during 2008, please see pages 14 to 17 of this report.

Status of Recommendation 3 (#144-07) – The facility's new mission and vision statements clarify the focus of the service to be provided (recovery opportunities and support) and the quality of the facility's efforts (excellence). In this review of VCBR, the OIG found a lack of clarity among staff regarding the intended outcome of the facility's services. Some staff and residents hold the view that the primary purpose of the facility is safety and security. Others believe that the primary purpose is to prepare residents for eventual discharge into the community. The OIG staff was not able to locate or identify any written documentation that is available to staff and residents that states definitively what the purpose or end result of the facility's efforts is to be. The result of this lack of clarity is a workforce that is not unified in carrying out the facility's mission. Recommendation 3 (2007) remains ACTIVE.

> ***DMHMRSAS Response:*** *In February 2009 VCBR submitted a newly revised Mission, Vision, and Goals Statement to the Advisory and Oversight Committee for their review and feedback. The document is being reviewed by Committee members and will be discussed with the facility during the April Committee meeting. The Advisory and Oversight Committee is charged with ensuring the new Mission Statement is effective in its reflection on the Code of Virginia's statements related to the facility's mission.*

Recommendation 4 (2007): It is recommended that the DMHMRSAS, in coordination with VCBR, review existing national accreditation systems to determine the appropriateness and validity of these systems for sex offender treatment programs. If it is determined that an existing accreditation system will be of value, it is recommended that DMHMRSAS pursue accreditation for VCBR.

- The facility leadership has said during previous OIG visits over the past 3 years that it is considering pursuit of accreditation from JCAOH, but no tangible progress has been presented for earlier reports.

2008 OIG Review

- In 2008, the director indicated that the first stages of preparing an application for accreditation had begun and that he thinks the program is about one and a half years away from accreditation.
- OIG staff interviewed the staff person responsible for preparing the plan for accreditation and reviewed materials prepared to date for the process of accreditation.
  - The coordinator for accreditation and VCBR leadership have visited other Virginia programs with similar accreditation (Marion Correctional Center has a program that is accredited as a behavioral rehabilitation program). The coordinator has received training at multiple national accreditation seminars and is working with similar sex offender treatment programs in other states that are accredited.

- A comprehensive plan for a process to achieve accreditation has been developed, charting timelines and achievables in 34 categories.
- The coordinator has developed a draft "Annual Strategic and Quality Assurance Plan – 2009" that appears to be comprehensive and is a necessary early component for accreditation readiness.
- The process and plan is judged by the OIG to be appropriate, complete, and well-informed by JCAOH standards and procedures.
- The first noted "start" dates for the first activities is 7/31/08, including such activities as "finalization of organizational chart," so the actual planning and preparation are in the very earliest stages.

Status of Recommendation 4 (#144-07) – Remains <u>ACTIVE</u>.

DMHMRSAS Response: *Since the Inspector General's audit, the facility has begun implementation our their Strategic Plan, trained department heads on Joint Commission requirements, and begun developing quality assurance indicators and reports. They have begun conducting internal Joint Commission type audits and are currently developing action plans to address findings. Additionally, staff from another Joint Commission Accredited facility have been solicited to conduct a full mock Joint Commission survey.*

It is important to note that in addition to their efforts to become Joint Commission accredited, the facility receives oversight and direction from the following agencies: DMHMRSAS Central Office, Office of the Inspector General, Office of the Attorney General, the VCBR Advisory/Oversight Committee, VOPA, ARMICS, the Local Human Rights Committee, and our Facility Advocate.

Recommendation 5 (2007): It is recommended that the facility, with the involvement of DMHMRSAS staff, including the Office of Sexually Violent Predator Services, revise and expand the provision of training in topics specific to working with persons who are sexual offenders, and that such training occur regularly for all employees, including treatment, medical, and security staff.

2008 OIG Review

- See above, pages 28 to 30, for a review of VCBR efforts to improve staff training.

Status of Recommendation 5 (#144-07) – Staff training for clinical staff has improved. Training in sex offender topics has not been increased for residential, security, medical staff, who spend the most time day-to-day with residents, or for administrative staff, who contribute decisively to the nature of the organizational culture. Recommendation 5 remains <u>ACTIVE</u>.

DMHMRSAS Response: *Between January 1 and October 1, 2008, each member of the treatment staff attended from an average of forty-seven hours of continuing education directly relevant to the treatment of sexual offenders. The facility goal is to ensure each clinical staff member receives six hours of clinical training each month. This far surpasses requirement for state licensure. Since the Inspector General's audit VCBR conducted a week long intensive training program for all staff, including residential, security, and medical staff. Topics included items such as Introduction to Sex Offender Treatment, Interpersonal and Therapeutic Communication, Manipulation, Policy Review, Suicide Interventions, etc.*

At the time of this response the VCBR reports they have not maintained copies of course outlines or other details of trainings referenced above. The Office of Facility Operations has explained that maintenance of such documentation is a standard expectation of any training plan and should be initiated immediately for any future training. This issue will also be added to the April 1st Advisory and Oversight Agenda and incorporated into the facility plan of correction.

Section V – Status of Active Findings Prior to 2007

A. OIG Report #130-06 (May 16, 2006)

Finding 1.3 (2006): The majority of residents identified boredom as a problem, particularly during non-programming times.

Recommendation 1.3: It is recommended that VCBR leadership in conjunction with the residents and staff develop strategies for providing increased activities during non-programming times. It is also recommended that the clinical staff review the effectiveness of suspending programming for an extended period during each review cycle.

- This recommendation focused on low levels of constructive activities for residents and consequent boredom at all times, but especially during the "semester breaks" when treatment programs are suspended to enable staff to update resident progress reports and re-tool programming.

2008 OIG Review

- The facility reports that residents now receive Quarterly Progress Reports every 90 days after their admission to the facility. According to the facility, "This means that their QPRs are issued continuously rather that simultaneously, eliminating the need to stop all programming for a two week cycle every quarter to complete the reports."

- Beginning around the time of the last OIG review, and with accelerating progress since, VCBR reports that it has been able to develop an educational program, with a director, teacher, and librarian, a recreational program with 3 staff and a variety of activities, and ongoing efforts to develop a vocational program with no results yet. These activities are said to minimize the gap in constructive activity between semesters.
- OIG staff analysis of active programming shows that the level of constructive activities has increased over the past year.
    - While organized activity levels have increased somewhat for residents, they are still a relatively small portion of the week. The OIG documented an average of 5.5 hours received per week for all residents in the sample. Facility reports show an average of 12 hours constructive activity available weekly to residents.
    - Residents continue to complain that they do not have enough activity to prevent boredom.
        - In response to a question that asked whether "There are enough constructive activities to fill my days," 71% of the sample answered in the negative, disagreeing with that statement.
- The Director of Public Safety at VCBR stated that increased levels of constructive activity would reduce security incidents and concerns significantly.
- Residents who already have a GED or high school diploma complain that the VCBR educational program is of no benefit to them as it cannot provide college level or vocational training.
    - Residents needing college level educational training complain that there are no computers with internet access that they can use to access distance-learning classes. Residents accept the need for an internet filter for inappropriate content, but wish they could do correspondence courses online.
- By comparison, OIG staff (and AOC members) learned that the average resident at SORT (the sex offender treatment program at Brunswick Correctional Center) spends so much time per week in paid employment, educational programming, sex offender treatment, substance abuse treatment and self help groups, religious activities, and organized recreational activities, that they have significant scheduling problems.

Vocational programming needs

Staff and residents report that the major missing component for constructive activity and avoidance of the behavioral consequences of boredom is the opportunity to work and earn money.

- All the residents at VCBR came from DOC facilities where they had the opportunity to earn money and purchase personal items and pay for phone calls. Work provided valuable benefits of constructive engagement, raised self esteem, and income for purchases of valued items at the DOC facilities, including what

residents say they value most: telephone contact with family and the outside world.
    - A major issue presented to the AOC and OIG by residents on the Resident Advisory Committee on July 15 was concern about the expense of the long distance telephone service at that time provided by VCBR. That system has since been replaced with another, slightly improved system, but complaints about cost of calls with the current system are virtually ubiquitous.
- In its efforts to develop work opportunities for residents, the facility has encountered what may be a "Catch 22" in regard to work opportunities. Prisons are able to provide work for inmates at a fraction of the minimum wage (e.g. $.20 - $.40 per hour) due to an exemption for such facilities from some federal Fair Labor Standard Act provisions. Facilities serving persons in a civil commitment setting such as VCBR apparently are not eligible for FLSA exemptions, and residents must be paid at least minimum wage, or prevailing wages for similar positions, and other fair labor laws and standards must be followed. VCBR reports that it has been working on developing vocational opportunities since it opened in Petersburg in 2004, but has not resolved these issues. State laws restricting hiring of persons in direct care roles who have been convicted of "barrier crimes" would also affect the majority, if not all, of VCBR residents.
- VCBR has hired a vocational services coordinator. She has developed a proposal to employ residents as aides to staff in a variety of work areas: Housekeeping, Work Program, Education, Art, Library, and Recreation. The program would pay minimum wage. It is slated to begin on a very small pilot basis early in 2009.

Status of recommendation 1.3 (#130-06): The level of treatment and other program activity in which residents are involved at VCBR still remains very low. As a result, resident inactivity and boredom continue, with ongoing behavioral consequences. Most importantly, the facility does not yet offer training opportunities and preparation for community living in the essential areas of vocational training, work readiness, work experience, and the opportunity to earn money. This is identified by VCBR leadership, staff, residents, the AOC, and the OIG as the most significant program deficit. Recommendation 1.3 remains ACTIVE.

> ***DMHMRSAS Response**: Since the Inspector General's audit, the Education Department has implemented college level correspondence courses for residents desiring college level training. Currently, there are 20 residents enrolled in this program. Additionally, 30 residents have expressed an interest in our new college correspondence program. The facility has received such a positive response to their educational programming they are in the process of expanding space to accommodate additional students.*
>
> *Vocational Programming now offers courses focusing on resume writing and job interview skills. The facility hopes to expand this program during the next semester.*

The staff aide position mentioned to the Inspector General and planned for start-up during the winter of 2008/2009 has been stalled by reported problems with payment. The facility has invited the vocational staff from Eastern State Hospital to come to VCBR and assist them with their program design. That consultation is scheduled for April 14, 2009. The facility has targeted July 1st 2009 as the new start-up date for the vocational work program.

Additional Related Recommendation (2008) - It is recommended that DMHMRSAS provide active assistance to VCBR by assuring the availability of all needed leadership, resources, technical and legal assistance necessary to resolve any identified state and federal barriers to the development of an effective vocational program at the facility.

DMHMRSAS Response: *See DMHMRSAS response to Recommendations 1 and 2 (2007) on page 33 of this report.*

Finding 2.2 (2006): Security and clinical staff have different perceptions regarding the changes in programming and unit rules.

Recommendation 2.2 (2006): It is recommended that current channels of communication be reviewed in order to enhance information flow between clinical and security personnel. One goal of this would be to increase opportunities for incorporating ideas and comments by security staff in unit functioning and programming.

- Beginning in 2005, OIG reviews of VCBR have noted issues of poor communication among departments or staff function groups such as security, programming, medical, and administration.
- Issues in this area remained prominent in the 2007 report and the finding remained active.

2008 OIG Review

- Facility leadership outlined efforts it had made to improve communication through development of the mission and values statement, involvement of the DMHMRSAS LEEP team, formation of a director's direct care staff advisory committee, making computers available for residential and security staff to participate in communications and facilitate their documentation duties, and other activities.
- A "muster" system has been created to improve communication to and between security and residential staff. The muster is a meeting of residential and security staff held before the start of each shift. The muster is intended to allow administrative and program staff to communicate with all staff and to receive feedback from them. OIG staff attended two musters to interview staff and observed communications between supervisors and direct care staff.

- OIG interviews with staff from all departments shows some concerns still exist about communication and cooperation among departments and between departments and administration:

Staff Interviews (N=74)	Strongly Agree	Agree	Disagree	Strongly Disagree
I believe that all of us – clinical, medical, residential, security, leadership staff – are pulling together effectively on a team basis with common goals.	19%	28%	38%	15%

- 53% disagreed, 47% agreed. Disagreement levels were higher among security staff (64%).

Staff interview (N=74) I believe that all of us – clinical, medical, residential, security, leadership staff – are pulling together effectively on a team basis with common goals.	Strongly Agree	Agree	Disagree	Strongly Disagree
Supervisor/Leadership	22%	44%	0%	33%
Program/clinical	20%	33%	33%	13%
Residential	11%	39%	39%	11%
Security	20%	16%	52%	12%
Medical	29%	14%	43%	14%

- In open-ended text questions asking staff what factors contribute most to staff dissatisfaction with their jobs and what factors cause turnover, issues concerning poor communication and coordination among departments and with administration were the second most frequently listed subject.
  - o When asked what factors most contribute to job satisfaction, the leading answer by far is "teamwork, support from my colleagues", with the focus being the staff person's *own* unit or work group.

Status of recommendation 2.2 (#130-06): Remains ACTIVE.

DMHMRSAS Response*: In addition to daily shift briefings described in the Inspector General's report, VCBR will begin holding an additional daily briefing session each weekday. The purpose of this briefing is to discuss current activities at the facility including special events and activities, training, operational procedures, treatment, etc. Staff from all departments who are not providing direct care/supervisory support will be expected to attend this briefing.*

We also believe our focus on Joint Commission accreditation will provide staff with a greater understanding of our goals.

APPENDIX:

Appendix Item #1

VCBR 2008 Follow Up Inspection
Staff Interview

1. Type of staff: (check only one)

N=9 Supervisor/Leadership; N=15 Program/Clinical; N=18 Residential; N=25 Security; N=7 Medical

2. Length of service at VCBR: __1__years __8__months (*average for all*)

3. In your own words, what is the goal or mission of VCBR? What is the program trying to achieve?

(results quoted in text of report)

4. On a scale from 1 (low, not a problem) to 5 (high, big problem), how big a problem is staff turnover at VCBR? Circle one: 1 2 3 4 5
(average: 4.1)

What causes turnover here?

(see below for responses)

Please indicate your agreement or disagreement with the following statements. If you do not know or the item does not apply to you, leave the question blank. Check only one box:	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
5. I receive excellent, supportive supervision on working with sex offenders from my supervisor.	23%	42%	19%	15%
6. I believe that all of us – clinical, medical, residential, security, leadership staff – are pulling together effectively on a team basis with common goals.	19%	28%	38%	15%
7. I am respected and valued by the leadership of VCBR for my contributions to the work of our program.	21%	44%	24%	11%
8. I believe the treatment we are providing will enable the majority of the residents we serve at VCBR to be rehabilitated to the extent that they can return to live in the community.	14%	42%	31%	13%

9. My job is professionally satisfying and rewarding.	27%	35%	31%	7%
10. Overall, the residents here are treated with dignity and respect.	39%	45%	14%	3%
11. Our main job here is really to protect society from persons who are a danger to our children and families and will likely remain so forever.	17%	39%	31%	14%
12. I would recommend VCBR to my friends as a good place to work	16%	37%	29%	18%
13. I feel safe working here.	8%	27%	37%	27%
14. Morale among my co-workers is pretty high.	3%	34%	34%	30%
15. Senior VCBR leadership is visible, knowledgeable, and involved in the day-to-day operation of this program.	15%	43%	25%	17%
16. The senior leadership team has created an open and comfortable work environment for expressing my ideas.	14%	33%	32%	21%
17. I had direct experience in working with sex offenders before I came to work at VCBR.	21%	26%	23%	30%
18. Since I have been employed at VCBR I have received excellent training in working with sex offenders.	9%	38%	35%	17%

19. Did you take part in any courses, training sessions, conferences, speakers, workshops, etc. that are ***directly specific*** to working with sexually violent offenders between November 2007 and November 2008? (Note: do not include the week-long new employee orientation session that you received when you first became employed at VCBR or routine supervision sessions with your supervisor):

__38%__yes __63%__no

If yes, how many? (circle one) 6 5 4 3 2 1 0

20. List **three things** that contribute to job *dis*satisfaction for you at VCBR.
(see below for responses)

21. Name **three things** that contribute to job satisfaction for you at VCBR.
(see below for responses)

22. All programs that are similar to this one must find a balance between security and treatment. In your opinion how is the current balance at VCBR?

__59%__ Tilted too much toward treatment and resident choice.
__24%__ About right, about enough emphasis on security ***and*** treatment.
__17%__ Tilted too much toward security and correctional approaches.

23. What aspects of the care and programs provided at VCBR most ***help*** improvement for residents?

(see below for responses)

24. What aspects of care and programs provided at VCBR most ***hinder*** improvement for residents?

(see below for responses)

25. Please make any comments you wish the Office of the Inspector General to know. These will be kept confidential by source. If you wish to have staff from the OIG contact you in confidence, please put down your name and number that we can call privately.

Content analysis of text questions from the Staff Interview

#4. What causes turnover here? No clear leader in frequency of mention.

High demand, stress from residents, difficult/abusive pop
Improper, inadequate training
Not enough staff, staff ratios
Uncomfortable, unsafe environment
Residents' rights favored over staff, staff not supported, poor discipline
Dissatisfaction with leadership, question ability, lack of leadership
Poor communication (with leaders, between depts)
Constant change of rules, procedures, etc.
People get better jobs, positive turnover, promotions, school
Low pay
Lack of career path
Staff not appreciated, recognized
Favoritism
Work scheduling
Location of facility, commute
Low morale
Staff find it is just not the place for them, residents/security

#20. List **three things** that contribute to job *dis*satisfaction for you at VCBR.

178 total comments

High demand, stress from residents, difficult/abusive pop	2%
Improper, inadequate training, poor budget for training	5%
Not enough staff, staff ratios, heavy schedule, no back up	6%

Uncomfortable, unsafe environment	6%
Residents' rights favored over staff, staff not supported, poor discipline	15%
Dissatisfaction with leadership, question ability, lack of leadership/vision	4%
Poor communication (with leadership, between depts)	12%
Constant change of rules, procedures, unclear	11%
Too much turnover, recruiting/retention issues	3%
Low pay	2%
Lack of career path, no promotions	2%
Unfair, closed application/interview process for promotions	1%
Staff not appreciated, recognized, supported, backed up	7%
Lack of opportunity for staff input on tx, policies	4%
Favoritism	2%
Work scheduling, lack of flex time, limited weekends off	2%
Location of facility, commute	1%
Low morale	3%
Poor supervisor, super/admin does not respect/listen	4%
Adapting to a security environment	1%
Residents don't help themselves, low motivation, institutionalized	1%
Lack of understanding about VCBR by outside	1%
Other staff not qualified	2%
Lack tools to assure security (no hands on)	1%
Poor job security, worry about loss of job	2%
Racial issues, separation of staff	1%

#21 Name **three things** that contribute to job satisfaction for you at VCBR.

124 total comments

Good supervisor/supervision	11%
Being part of a team, my colleagues, teamwork	24%
Helping/seeing residents learn, change,	15%
Room for growth, contribution to program	6%
Helping staff grow	2%
Ability to advance career	2%
Good security/safety	3%
Personal pride in doing a good job/having skills in area	5%
Job security, have a job, get paid	6%
Good fringe benefits	7%
Good budget to purchase materials	1%
Knowledgeable staff	2%
Supportive, flexible scheduling	2%
Respect from residents, staff, supervisors	3%
Good facility, flexible design, meets needs	1%
Protecting community from sex offenders	1%
Good, frequent training	2%
Important, challenging work	2%
Location convenient	4%
Nothing positive to say	1%

#23 What aspects of the care and programs provided at VCBR most ***help*** improvement for residents?

60 total comments

Clinical staff and other departments are beginning to work together	7%
TX gives residents feedback, allows their input, individualized	8%
Leadership accepting positive ideas for improvement	3%
Clinical treatment, programs, groups	43%
Residents learn that they must be accountable, responsible	10%
Availabilities of a variety of activities, programs	7%
New building, nice environment	3%
Restructuring housing, programs to fit tx needs of residents	2%
Plans to get accreditation	2%
Psychiatric consultation	2%
Involvement of Human Rights staff	2%
Education program, GED	7%
Hope	2%

#24 What aspects of care and programs provided at VCBR most ***hinder*** improvement for residents?

75 total responses

Lack of staff limits programming	1%
Noise, hallways echo, disruptive environment	1%
Resistance to change procedures, approaches	1%
Negative, poor leadership	3%
Inconsistency in policies and procedures responses to residents	17%
Too much freedom, no consequences, lax discipline (residents)	25%
Lack of staff input to programs, rules	3%
Poor attitudes among residents, they hold themselves back	3%
Disruptive residents hold others back	3%
Lack of resident choice and true individualization	5%
Nothing hinders treatment (not blank)	1%
Poorly trained staff	1%
Not seeing residents get released	1%
Lack of vocational trng/work opportunities	5%
Lack of one-to one treatment	3%
Frequent class cancellations	17%
Clinical leadership does not interact with residents enough	1%
Not enough for residents to keep busy - invites trouble	5%

25. Comments – as stated, no frequency count, similar comments combined

Need more staffing
Need library, recreational programming, variety for residents
VCBR has a chance to grow and become better
Supervisors resist new ideas
Allow flex time
No consequences for residents - and they know and use that
Staff in unsafe situations
Residents still having sex, always a danger to public
Unfair promotion, interviewing practices
VCBR gives me opportunity to apply current research/knowledge to tx of SO
Staff on units turn a blind eye to misbehavior - this reinforces it
Huge power struggle within VCBR between depts - poor communication
Admin focused on mission: all meetings, procedures, directives support mission
Stress and confusion due to new program, even after 5 years
High admin do not respect staff, are demeaning
Offer incentives, higher pay to reduce turnover and raise morale
VCBR needs to show residents respect and dignity
CO needs to visit facility for more than a day and really see what we face
No privacy, supervisor belittles, harasses staff,
Racism with leadership
Leadership causes high turnover rate by over-emphasizing corrections model
Poor communication from leadership, do not invite input, discussion
Replace upper level leadership
Some staff try to scare residents
Some staff are too scared of residents to do their jobs
Clinical staff spend little time with residents and "brush them off"
RSAs need a lot more training - we are the ones who are with the resids
The director must approve me to press charges against a resident for assault
RSA and security need more than TOVA to deal with violence
VCBR is a great place to work
The only time we see the top 3 leaders is when there is a resident crisis
It is a pleasure to be in clinical with Dr. Dennis as leader
Tremendous disconnect between clinical and (med), med role unclear, confusion
After 5 years, feel mistreated, passed over, low morale, many others similar
I would like to speak with you but I am afraid I would lose my job

Appendix Item #2

VCBR 2008 Follow Up Inspection
Resident Interview

1. How long have you been at VCBR: __2__years __0__months *(average for all respondents)*

2. In your own words, what is the goal or mission of VCBR. What is the program trying to achieve?

Results quoted in text

3. What aspects of the care and programs provided at VCBR most ***help*** improvement for you?

Results shown below

4. What aspects of care and programs provided at VCBR most ***hinder*** improvement for you?

Results shown below

5. How is your time spent during the week? How much treatment and other services do you receive ***on average***? Base your estimates on the past month or so.

Activity	**How many hours per week do you spend in these activities?**
Sex Offender Treatment Groups	8
Education Activities/Classes/GED	2
Vocational Training or Work	0
Substance Abuse Treatment	0
Individual Therapy	0
Recreation	
Other (list)	

Please indicate your agreement or disagreement with the following statements. If you do not know or the item does not apply to you, leave the question blank. Check only one box:	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
6. I believe that the treatment I am receiving is helping me.	25%	42%	21%	13%
7. I believe the treatment I am receiving will enable me to be rehabilitated to	28%	38%	26%	9%

the extent that I can return to live in the community eventually.				
8. The staff treat me with dignity and respect.	35%	29%	23%	13%
9. The real purpose of this program is to keep people locked up who will forever be considered a danger.	32%	30%	30%	9%
10. I feel safe here from threats or dangers posed by staff.	25%	35%	19%	21%
11. I feel safe here from threats or dangers posed by other residents.	17%	35%	30%	17%
12. Morale among the residents is pretty high.	0%	24%	41%	35%
13. The rules, privileges, and freedoms of being a civil committee at VCBR are better than it was being an inmate in a DOC facility.	6%	16%	31%	47%
14. The treatment staff who work with me are knowledgeable and well-prepared for their jobs	15%	21%	45%	19%
15. Turnover among treatment staff is a problem for continuity of my treatment.	46%	25%	23%	6%
16. The facility lets me know where I stand in my treatment and what progress I must show to be ready to be discharged.	10%	25%	38%	27%
17. There are enough constructive activities to fill my days.	4%	25%	25%	46%
18. The physical comforts of VCBR are better than what I had at DOC.	11%	26%	40%	23%

Content analysis of text questions from the Resident Interview

#3 What aspects of the care and programs provided at VCBR most ***help*** improvement for you?

54 total responses

Nothing. Nothing that I did not already know, figure out, no tx	13%
Groups, learn info, learn from others	28%
Cognitive approach, understanding my behavior, make reasoned choices	28%
AA/NA	2%
Individual attention and individualized tx, when available	9%

Anger management groups	2%
Learn from other residents, on my own outside of classes	2%
Encouragement from staff, hope, empathy, understanding	11%
Environment - good food	2%
Access to telephone	2%
Education classes	2%

#4 What aspects of the care and programs provided at VCBR most ***hinder*** improvement for you?

87 total responses

Classes are too general, too unspecific, not meaningful to me	8%
Too strict, like a prison again, few privileges to work toward	9%
Other residents take advantage of me, sexually assaulted, stressful environ	3%
Lack of leisure skills, opportunities	1%
Drug and alcohol classes, (need more)	1%
Need more technical (voc) classes	2%
Very frequent class cancellations	9%
Not being allowed to select groups, attend more groups, no input/say in tx	3%
High turnover rate	3%
No work	5%
Poor organization, disorganized	5%
Minimal hope of release	3%
Criticism of staff, not qualified, vindictive, race biased, ex-DOC	10%
VCBR keeps info secret, no communication with residents	1%
Material repeats SORT/SOAP	1%
Over-reliance on group tx inhibits revelation, openness	1%
Favoritism	1%
Poor medical care, unresponsive, poor tx	5%
Staff do not listen, pre-judge, cynical,	5%
Punishment of all for offenses of only one, some	8%
Never given a chance to prove myself, no community exposure	3%
Lack of treatment materials in library	2%
If complain, ask questions, disclose, it is held against you, manipulated	5%
Nothing - no hindrances	2%

Comments – written on back, in margins, as stated

Need computers (with filters) so we can do college courses
Need more groups, more variety, less repetition
Difficult, expensive to contact family

More of a prison than DOC
It is real torture to not have any hope/plan for release
Waited 6 months to see dermatologist
Need re-entry housing, halfway house in community
There are political powers that want us here for life

Appendix Item # 3

VCBR 2008 Follow Up Inspection
Record Review Form

1. Name of resident:________________________________

2. Date of admission to VCBR:______________________

3. Date of last comprehensive clinical assessment (for treatment plan)_______________

4. Source of last comprehensive clinical assessment

    DOC ____
    DMRMRSAS SVP staff ____
    Contracted staff ____
    VCBR staff ____

5. Treatment Track
    Initial Assessment ____
    Behavioral Mgt (Phase I) ____
    Behavioral Mgt (Phase II) ____
    Sex Offender Treatment (Phase I) ____
    Sex Offender Treatment (Phase II) ____
    Sex Offender Treatment (Phase III) ____
    Understanding Treatment (Phase I) ____
    Understanding Treatment (Phase II) ____
    No notation of current track ____

6. Assess the clinical documentation for assignment to the treatment track.

    Track not noted ____
    Documentation not present ____
    Present - sparse, unspecific, not linked to program description ____
    ____
    Present – detailed, specific, linked to program description ____
    ____

7. Is there a psychiatric evaluation within the last year?
    yes ____
    no ____

8. What are the psychiatric diagnoses?_______________________________________

9. What psychiatric medications are prescribed?____

10. Assess treatment plans/goals

	SA	A	D	SD
• Responsive, specific to clinical assessment?	SA	A	D	SD
• Individualized?	SA	A	D	SD
• Evidence of resident involvement in plan?	SA	A	D	SD
• Resident's own goals stated?	SA	A	D	SD
• Plan points toward return to community?	SA	A	D	SD
• Plan is holistic – whole person, multi-faceted	SA	A	D	SD
o Education needs/goals addressed	SA	A	D	SD
o Vocational needs/goals addressed	SA	A	D	SD
o Recreational needs/goals addressed	SA	A	D	SD
o Medical health needs/goals addressed	SA	A	D	SD
o Substance abuse needs/goals addressed	SA	A	D	SD
o Family/social/relational needs addressed	SA	A	D	SD
• Plan uses a treatment team approach	SA	A	D	SD

11. Therapeutic activities levels (number of hours of services documented in the record for the last full quarter for which data is available. If sessions are noted without time, convert to 1.5 hours):

Sex offender group treatment (classes, groups, broadly defined) ________
Individual treatment ________
Substance abuse treatment/education (group, AA/NA) ________
Vocational activities (job training, employment) ________
Recreational activities (organized, sanctioned, not just free time) ________
Educational activities (classed, GED) ________

12. Assess the last two treatment planning/quarterly progress review meetings. Note participants for each below:

(Dir clin svcs) (Mario) ____ ____
(Dir tx svc) (Stephanie) ____ ____
Primary Therapist ____ ____
Psychiatrist ____ ____
Nurse ____ ____
Residential (RSA) ____ ____
Security ____ ____
Resident ____ ____
Family/lawyer/advocate ____ ____
Other ____ ____

13.

Comment:____
____

Appendix Item # 4

VCBR 2008 Follow Up Inspection
Personnel Record Review

1. Type of staff: (check only one)

___ Supervisor/Leadership ___Program/Clinical ___ Residential ___Security __Medical

2. Position title (e.g., therapist, security officer, psychiatrist, nurse):______________________________ Name ________________________

3. Length of service at VCBR: ____years ____months

4. Highest level of education:

____ Some High School ____High School graduate ___ AA Degree/some college
____ Bachelors Degree ____Masters Degree ___PhD/M.D.

5. For clinical, medical, and leadership staff: Current **Virginia** licensure or certification (check all that apply):

___None ___LPN ___RN ___LCSW/LPC/CS/etc ___MD/Clin Psych ___CSOTP

___other, specify____

6. Is there evidence of training, experience, or other preparation that is ***directly specific*** to working with sexually violent offenders…

   a. In academic preparation? ____ yes ____ no

   b. In employment experience *before* coming to VCBR? ____ yes ____ no

   c. In the last year (since November 2007) ____ yes ____ no

      Number of relevant sessions: ___6 ___5 ___4 ___3 ___2 ___1

Appendix Item # 5

VCBR 2008
Leadership Interview

Name of Interviewee: ______________________________

1. If staff and/or residents want to ask questions of or share thoughts with members of senior management how does this occur?

2. What is the planned or intended level of active treatment for residents, expressed in hours per week/per resident?

    a. Is this documented in policy or procedure?

    b. How do you monitor this? (show results of monitoring)

    c. If they show us results and the results don't meet the expressed goal, ask why it does not meet the goal. Otherwise don't ask why it does not meet the goal.

3. How do you measure the effectiveness of treatment? Show us the data you monitor.
   .

4. Do your residents have access to individual therapy? (if they say yes ask the following:

    a. How do residents access individual therapy?

    b. How much individual therapy do they receive?

   If they say no, ask why not.
5. Describe your efforts in the past year to increase the vocational opportunities available to your residents. What are your goals in this area?

6. What actions have been taken within the past year to assure that all administrators, staff and residents have a common understanding of the program's goals and mission?

7. What is the status of your application for accreditation?

8. What is the role of your medical and nursing services in the planning and provision of treatment for your residents? Are they expected to attend treatment planning sessions? How has this changed since November 2007?

9. What role does psychiatry have at VCBR? Do you want or need more or less? How has this changed since November 2007?

10. Where do you get your medications and formulary? How has this changed since November 2007? Is it satisfactory?

11. What is your current or planned use of such medications as SSRIs or anti-androgens for treatment of SVP? Why or why do you not use these approaches?

12. We found significant turnover in your program (treatment) staff when we came here last year. What have you done to reduce turnover? How have these efforts worked? What effect does turnover have on provision of treatment? On morale? What causes it? What can you do to lessen it?

13. What are your expectations for training of security staff and clinical/program staff? How do you assess your current training efforts? What plans do you have for the future? What resources, if any, do you need for training?

14. In past reviews we had findings that related to gaps in understanding and communication between program and security staff concerning program issues. What efforts did you undertake to address this issue in the last year and how do you measure their success? What activities do you plan to continue to address this issue?