Western State Hospital
Staunton, Virginia
***Local Human Rights Committee Meeting Minutes***
*Jeffrey's Building, Room 95 at 12:30*
***April 22, 2013***

**Present:** Hal Meyers, Committee Chair, Donna Gum, Kathy Belcher, Mark Schorsch, Rob Wade, Mahlon Webb, Committee Members; Chuck Collins, WSH/Regional Advocate, Mark Seymour, WSH Advocate; Dana Traynham, VOPA Advocate; Ellen Harrison Liaison to WSH Director

**Absent:** Heidi Campbell, Member

**Guests:** Ms. AT, Mr. RS and Mr. MW, Clients; Tiffany Hewitt, Citizens' Council; Marina Caro, VOPA Advocate; and Robyn Thomas, Patient Transportation; Hillary Ealy, MBC Intern

Mr. Meyers, Committee Chair, called the Local Human Rights Committee to order on April 22, 2013. Mr. Wade noted that a quorum of members was present. With a motion from Mr. Wade, a second by Mr. Webb and a vote of the committee, the minutes from the March 25th meeting were approved as written. The agenda had been revised to accommodate a scheduling conflict with one of the guests. The revised agenda was approved by a motion from Ms. Belcher, a second by Mr. Wade and a vote of the committee.

Mr. RS indicated he was nearing the conclusion of the discharge process. He is on the waiting list for an apartment and will soon be going to look at a room. He is also waiting to receive documentation from a new psychiatrist in the community. The committee members congratulated Mr. S on his accomplishments. Ms. AT has complaints about the staff on Ward A6 not taking care of her. She feels they are neglecting her, that they won't help her when she falls, that they told her she would need to go in the ERC if she didn't go to Barber Mall willingly. She had a bloody nose last Friday and has a bad bruise on her ankle; however, by her report, the staff has not helped her with these things. This morning, she was nauseated and Dr. Lee told her to go to groups. Mr. Seymour indicated that Ms. T had discussed these issues with him just prior to this meeting and he wrote an email to the HOTT regarding these concerns. She also indicated that she would prefer for her sister to not be her guardian because she is mean to her. Mr. Meyers suggested she work with Mr. Seymour on this issue as well.

As a follow-up to comments made by Ms. JS at the March meeting, Mr. Collins reported that he attended her treatment team meeting and thought it turned out very well. The issues she presented, specifically regarding her medication, and the team's desire for her to engage more in discharge planning were well discussed. She indicated afterward that she felt her concerns were resolved.

Mr. MW read aloud a statement he had prepared regarding multiple complaints and concerns he has with the Ward A5 Treatment Team. His concerns included: Harsh statements made by the treatment team at the hearing before the LHRC in February; he was told in the past by the ward RN Coordinator, Ms. Jody Wagner, that they were aware he was selling cigarettes, and they didn't care, but not to get caught (he stated he would not confirm nor deny the allegations of selling cigarettes); he indicated that she also stated she was aware of patients smoking on the ward and she didn't care; however, one of the other RNs won't put up with it. Additionally, when she caught him smoking on the porch in front of the cafeteria, she told him not to smoke there, to go around the building to do it; his room was searched once when he was not present, but he could not contest the search because cigarette lighters were found in his belongings; those were left with him, but his body spray was taken and placed in the shower room. He approached Ms. Wagner about this incident and was told that if it had been any other patient, they would

have lost their level. He was told in a treatment team meeting that he would be working in the Frame Shop and making pretty good money, but not as good as the business he had going on outside, and they would laugh and joke about it. He responded to them that he didn't know what they were talking about. He feels that cigarette smoking is allowed in the hospital – there are occasional incidences of someone being caught smoking, but staff does not go out of their way to stop it from happening. Cigarette smoking is a daily event, cigarette butts and empty packs can be found throughout the hospital grounds. He feels that the administration of WSH should take responsibility for the smoking that occurs on the hospital's property instead of blaming the patients for the problem because they allow it to take place. He does not believe this has been a non-smoking hospital since the no smoking law took effect because the administration disagreed with the new law and, therefore, allowed smoking to continue. Mr. W stated that he feels he has received cruel treatment at WSH, such as Security and Ward staff targeting, bullying and inciting him, which has caused him to express his displeasure in a boisterous, inappropriate manner. His privilege level has been changed to R (restricted) and he has been assigned to groups in Barber Mall, which is a restricted environment, because the treatment team felt the groups in Webb Mall were not working for him. He indicated he has not been in any trouble or kicked out of any group since he has been attending the treatment malls. He believes he has received good scores for participating in groups. He also feels that the restrictions that have been placed on him are in an effort to force him to leave WSH. Mr. Meyers asked how the groups in the two malls differ. Mr. W indicated the groups in Webb Mall are better and there is more variety. On his restricted level, he cannot go to the cafeteria to eat and cannot get money from his account to purchase snacks or hygiene products. When he asked Dr. Nichols if these things were being done to force him to leave the hospital, he indicated that Dr. Nichols said he would not answer that. Mr. W had been spending time with a female patient from another ward. He indicated that she was told by her psychologist that Mr. W was spending time with her so he could "pimp her out"; another example of slander to his name. He feels he was denied medical treatment during an incident on December 31st. He notified the RN that he had a rash on his leg. She indicated that it could be a blood clot and requested that the OD examine it. The OD refused to see him but was on the ward for other reasons. When he was seen by an OD on the next shift, he was sent to the hospital for a possible blood clot, which it turned out not to be. In one incident, he was attempting to contact the advocate, Mr. Seymour, and was speaking with Mr. Seymour's secretary, explaining a situation involving Security in relation to his alleged behavior at Barber Mall. Ms. Wagner, RNC, overheard his conversation and made threatening comments indicating future restrictions. He was told by Mr. Seymour's secretary that the RNC should not be listening to his phone calls.

Mr. Meyers inquired of Ms. Harrison what the hospital's policy is regarding patients speaking with an advocate. She indicated that there isn't a policy specific to conversations with advocates; however, the policy does indicate that they have the right to have telephone conversations in as much privacy as possible given that the phone is in a common area. Mr. Meyers feels that the patient has the right to speak with their advocate in private. Ms. Harrison indicated that provided the patient is not on direct observation, they may request the use of a phone in an office for the purpose of contacting their attorney or advocate from a private location. Mr. Seymour, upon review of the Human Rights Regulations, indicated that the patient has the right to communicate privately with any person. Mr. W indicated that Mr. Meeks, an RN on Ward A6 would frequently listen to his telephone conversations and relates what was said to the treatment team. Ms. Traynham indicated that when she is speaking with a patient at any facility by phone, she realizes that the conversation may not be private due to the physical setting and encourages them to speak with her during her next visit to that facility. Mr. Collins concurred

with Ms. Traynham, indicating that he feels the advocates understand the limitations for privacy when speaking by telephone and encourage face-to-face meetings. He does, however, feel that it is inappropriate for an RN to listen to a patient's conversation and report what was heard to the treatment team.

Ms. Traynham requested that Mr. W explain to the committee how his life has changed since he was removed from "Mulberry Chart" status. He doesn't feel that there has been any improvement in his situation, and that it has, in fact, been made worse by his assignment to Barber Mall. Mr. Meyers suggested that Mr. W, Mr. Seymour and Ms. Traynham work together to prepare for a formal hearing in order to address the multiple concerns he has brought forward today. Mr. Seymour indicated he had sent correspondence to Dr. Barber regarding Mr. W's assignment to Barber Mall. Mr. W indicated he did not want to wait for a hearing because he doesn't want to be at WSH that much longer. He wants the treatment team to help him work toward discharge instead of harassing and humiliating him and working against his efforts toward discharge. Mr. Meyers again suggested that Mr. W continue to work with Mr. Seymour and Ms. Traynham towards resolving these issues.

Mr. Schorsch noted that in recent months, the issue of privacy during telephone conversations has arisen several times. He feels this is something the committee needs to review in more detail. Mr. Meyers concurred and indicated this could be an agenda item at an upcoming meeting.

**Upon a motion made by Ms. Gum, the committee went into closed session pursuant to Virginia Code §2.2-3711, a.15 and §2.2-37.05.5 for the purpose of discussion of medical record / treatment plans for Ms. EB.**

**Upon reconvening in open session, all members of the Local Human Rights Committee certified that to the best of each ones' knowledge, only public business matters lawfully exempt from statutory open meeting requirements, and only public business matters identified in the motion to convene the closed session were discussed in closed session.**

**Upon a motion made by Ms. Gum, the committee went into closed session pursuant to Virginia Code §2.2-3711, a.15 and §2.2-37.05.5 for the purpose of discussion of medical record / treatment plans for Mr. MW.**

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Dr. Jeff Phillips, Director of Psychology, Dr. Brian Kiernan, Forensic Coordinator, and Ms. Pat Higgins, Director of Social Work attended to present the revised Hospital Instruction (HI) 4056, "Patient Privileges, Risk Assessment, and Monitoring of Patients with Privileges." Mr. Meyers commented to the committee that in the interest of full disclosure, he and Dr. Phillips had both recently attended the wedding of a mutual acquaintance, and while they did converse, specifically regarding the communicating stairway at the new WSH facility, they did not discuss any other matters relating to LHRC or WSH business. Mr. Meyers indicated that the topic he wished to address specifically is in regards to what steps the hospital may utilize to incentivize a voluntary civil patient who has no clinical reason to remain hospitalized to leave the hospital. Where is the line between an acceptable incentive and an unacceptable one? Dr. Phillips is also the chairman of the Behavior Management Committee (BMC). The committee

is composed of mostly clinical people from around the hospital, including himself, the hospital director, the social work director, the medical director, nursing director and both assistant nursing directors, three psychologists, a psychopharmacoligist, a representative from rehab services and anyone else they feel may be beneficial to the cases being reviewed. They meet twice per month. The BMC reviews cases that are referred to them based on specific clinical criteria, typically reviewing one case in approximately one hour and fifteen minutes. Each case is reviewed on an individual basis and there is no policy that directs what is to be done in response to specific situations. There are two primary items they attempt to accomplish; trying to figure out how to formulate what is going on with the particular issue they are addressing and what are contributing factors to the behaviors that are of concern. When a case is referred to the BMC where the treatment team feels an individual is clinically ready to leave the hospital, they attempt to determine what can be done to help the patient leave the hospital. The second thing they do is develop recommendations for the treatment team to help them in working with this individual towards getting out of the hospital. All of the cases the BMC reviews are challenging cases due to the nature of criteria for referral to the BMC. The BMC has reviewed seven cases in the last two years similar to what Mr. Meyers has mentioned. The recommendations for those seven cases have varied considerably. There were two cases in which the BMC felt that the individual in question was not ready to leave the hospital, and the committee made some treatment and medication recommendations. In other instances, they have made recommendations such as asking the hospital director to send letters to patients saying they have gotten all the benefits they are going to from being in the hospital, and we think it's time for them to leave. In one instance, it was a congratulatory letter saying we congratulate you on your success here at the hospital and think it is now time to take steps to leave. In other cases, they have looked at things outside the hospital that would incentivize them to do that, which has included things like increasing the availability of staff support in the community, and trying to develop funding sources that would aid them in doing that. It seems that what may be going on with these individuals is that here in the hospital they have a very structured environment and staff to attend to them; however, and one of their concerns about leaving the hospital may be that they won't have that level of support outside of the hospital. In other instances, the committee has recommended things like promoting the place where they would be going to live and present it as an environment they would like and enjoy. One individual enjoyed art work and the place they were moving to was encouraged to purchase and store art supplies for that person. In another instance, the community helped provide the person with things that would make where they are living a more home-like environment. One person was concerned that if they left the hospital, their family wouldn't know where they were going to be if they left, so the recommendation was for the person to sign a release indicating that if family members contacted WSH, they could be told the address where this person would be living. They have made recommendations for situations where someone has been at WSH longer than they needed to be. This individual had financial resources to pay for housing or hospitalization. The BMC asked WSH's financial office to provide the patient with a statement of their expenses at WSH and that the hospital does expect some sort of payment for being here. They have recommended oversight by the Forensic Privileging Committee, although that policy has recently changed. Their work doesn't just involve people who are reluctant to leave the hospital; it is a variety of items and issues that treatment teams ask for their opinion on. Everything is based on the individual and their particular situation. They are very attentive of and concerned about complying with the rules and regulations of the rights of individuals in the hospital. If something doesn't meet those rules and regulations, they are very concerned about it. The committee serves in an advisory or consultative capacity to the treatment teams as opposed to providing oversight and direction.

Mr. Collins asked Dr. Kiernan to comment on the history of HI 4056, how it came about, and also how many civil patients are on mulberry chart status right now at WSH. Dr. Kiernan stated he would not be able to provide an exact number of civil patients on mulberry chart status; however, he felt that it may be approximately four per ward. HI 4056 was recently modified, however, to discontinue IFPC oversight of patients on mulberry chart status. In 1994, the Commissioner of Mental Health formed the IFPCs primarily for management of forensic patients. Dr. Kiernan was uncertain when mulberry charts came into existence or when the IFPC began oversight of patients with a history of risk. The IFPC historically was asked to review these situations as well because of their expertise in risk management. When treatment teams were considering increasing a patient's privilege level, the IFPC would view that in terms of potential risk that might entail. This additional level of oversight allowed treatment teams to maintain a therapeutic relationship with the patient and letting the bad news come from a different source. Recent events have prompted a review of this practice and resulted in the revisions to HI 4056; specifically, the development of the Clinical Risk Management Committee (CRMC), which provides guidance to treatment teams for high-risk civil patients. This committee's role is consultative, so that when a treatment team is considering a privilege level for someone who is a civil patient in a mulberry chart, they would send the pertinent information to the CRMC, who would make a recommendation to the treatment team. The IFPC no longer has oversight or "control" over civil patients who are assigned to a mulberry chart status. The CRMC now provides recommendations to the treatment teams regarding privilege levels for these patients; however, the final decision is made by the treatment team.

Ms. Traynham asked to revisit the question Mr. Meyers initially asked. How far can the hospital go in their efforts to encourage a patient to leave the hospital? Dr. Kiernan stated that, in his experience, the IFPC has never been asked, "What can we do to get this person out of the hospital?" Both the IFPC and the CRMC may be asked for guidance on privilege levels for patients who pose a risk within the hospital environment based on their past behaviors; however, providing guidance regarding hospital-dependent patients is not within their scope. It was again emphasized that a potential risk to the hospital community may not be a risk to the community at large. Ms. Belcher stated that she believes it is the role of the LHRC is to determine what is and is not acceptable on a case-by-case basis. Mr. Meyers asked Drs. Phillips and Kiernan if they would be available to provide additional insight on this topic in the event of future hearings.

Dr. Herb Stewart presented the Ward A1 Ward Rules. Ward A1 is one of the four admissions units. Many of their patients are at WSH for a short time. Their ward rules have evolved over the years based on input from patients, clinicians, the LHRC and hospital and department policies. The only change this year is small; no live plants will be allowed in patient rooms. They have not received any requests from patients to have plants; however, this topic came up when the rules were being reviewed this year, so it was added. Ms. Belcher made a motion to approve the ward rules and Mr. Webb seconded the motion. The motion passed by a vote of the committee.

Mr. Meyers asked Ms. Harrison how privilege levels will change when WSH moves to the new facility. She replied that the levels will be more standardized than they are now because of the physical parameters of the building. She also indicated that she will provide information about the privilege level system to the LHRC in the future.

The Ward A6 rules were presented by Dr. Ann Walling. There are only minor changes since the rules were reviewed by the LHRC last year. Dr. Walling commented on the changes that were made this

year. A motion was made by Mr. Webb to approve the rules. The motion was seconded by Ms. Gum and approved by committee vote.

Mr. Meyers asked Dr. Walling to explain the process for patients to make complaints. The patients have the option to present any concerns to ward staff or their treatment team or to make a complaint on the Complaint Form. Copies of all complaint forms are faxed to the Director's Office and given to the HOTT. The treatment team has three days to attempt to resolve the patient's concerns. In the event the treatment team cannot resolve the complaint to the patient's satisfaction, this is indicated on the form and the Director's Office is advised. Dr. Barber will then work toward a satisfactory resolution. If the patient continues to be dissatisfied with the hospital's plan for resolution, they have the option to request a formal hearing with the LHRC.

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In order to ensure that the committee members are aware of current Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Virginia Freedom of Information Act (FOIA) laws and regulations, Mr. Collins and Mr. Seymour made brief presentations on the two topics.

Mr. Collins advised that all HIPAA regulations are included in the Human Rights Regulations (Blue Book) on pages 17 through 23 and asked that the committee members refresh themselves by reading those pages. He also asked that they keep two concepts in mind: 1) the first part of HIPAA is basically the confidentiality doctrine within the Human Rights Regulations. HIPAA is a Federal law and Virginia's Human Rights Regulations are consistent with the Federal law; 2) the second part of HIPAA is access by a person to his own Protected Health Information (PHI). Any patient is allowed access to his own PHI with the only exception being when the treating physician indicates that it would be harmful to him to read his own record, and in this case, the patient may identify someone else, either another doctor or the patient's attorney, to receive the information. When handling PHI, the rule of thumb is, "If in doubt, don't."

Mr. Seymour presented information on FOIA, which can be found in the Behavioral Health section of the Code of Virginia on pages 25 through 75, and provided a handout to each member of the committee. The Local Human Rights Committee is a public body because they were appointed by the State Human Rights Committee, making any information regarding the operations of the committee or documentation generated by the committee subject to FOIA.

Mr. Collins shared with the committee that the use of the CHRIS system, which is a database, maintained in Central Office that reports abuses and neglects that have been reported and their resolution as well as human rights complaints, will now be required of community providers. The Department of Justice has mandated that CHRIS will be used as a centralized database for abuses and complaints of human rights issues that arise. The implementation will be in three phases. The first phase, which is for Community Services Boards and providers of residential services for ID clients, was implemented in

March. The second phase, which includes all other ID providers, is currently underway. The third phase, which will be occurring in May, will be for all other providers licensed by DBHDS.

Mr. Collins received 22 requests for assistance in March and 15 in April. Many of these were to attend treatment team meetings and to assist patients in their discharge efforts and privilege level requests. He also facilitated one patient's meeting with Dr. Barber, which ultimately resulted in the patient's satisfaction with Dr. Barber's proposed resolution to his complaint.

Mr. Seymour has assisted 18 individuals who do not appear on the patient complaint report since the last LHRC meeting. The vast majority of the individuals who contacted him, who are primarily on the Admissions Units, have requested assistance in discharge efforts and in preparation for recommitment hearings.

Mr. Meyers thanked Ms. Traynham for her services to Western State Hospital and WSH LHRC, specifically her efforts on behalf of Mr. MW and her cooperation with the advocates throughout that process. Mr. Wade made a motion that the LHRC draft a letter to Ms. Traynham's supervisor, Ms. Coleen Miller, expressing the committee's appreciation of Ms. Traynham's work. Mr. Schorsch seconded the motion, and the motion was passed by vote of the committee. Ms. Traynham commented that this is the third time in her tenure with VOPA that she has worked directly with WSH, and she has always found this LHRC to be very active and really looking out for the individuals who appear before them. She has not always found this to be the case with other LHRCs. She feels that this group accomplishes a great deal.

Regarding the Complaint Report, Mr. Wade, commenting on Complaint Number 128, asked Ms. Harrison about the overall situation with cigarette smoking on WSH grounds. She replied that there is a concern among staff members and administration about smoking on grounds; however, there is a limited amount of focus that WSH staff is able to commit to tracking down offenders primarily due to the size of the campus and the opportunities that space provides. At the new facility, there will be less opportunity for patients to hide cigarettes as well as hide to engage in smoking cigarettes undetected. This complaint implies that some staff are providing cigarettes to patients. WSH administration has not been advised of any specific instances of this occurring. In reference to Complaint Number 107, Mr. Meyers asked whether the new facility will have more space for patients to visit with guests. Ms. Harrison noted that each patient care unit will have a visitor room as well as an additional room that could be used as a visitor room if the need arises. It is possible that there could be more than two patients having guests at which time additional accommodations would be explored.

In reviewing the Extraordinary Barriers List, Ms. Belcher inquired about Horizon Behavioral Health. Ms. Harrison indicated that is Lynchburg; the Central Virginia CSB has adopted a new name. Ms. Gum commented that she has heard through her contacts that this will be a trend with CSBs in an effort to more succinctly reflect the work they do.

As mentioned in the earlier discussion with Dr. Kiernan, the Internal Forensic Privilege Committee (IFPC) has been divided into two independent groups. The IFPC will continue in their original capacity; however, the Clinical Risk Management Committee (CRMC) will now advise treatment teams regarding privilege levels for high-risk civil patients. The committee requested that the minutes for the two groups be presented separately in the future.

Community Connections: Ms. Gum reminded the committee that May is Mental Health Month. The opening reception for the Community Art Exhibit will be on May 11th from 3:00PM until 4:00PM. Newsletters will be going out in early May. The billboard location has changed to Route 11 across from Verona Elementary School. Ms. Gum will be on WKDW on Thursday, May 2nd to talk about Mental Health Month. The golf tournament is May 17th.

The next meeting will be held May 20, 2013, at 12:30 p.m.

With no further business to discuss, the meeting was adjourned.

**APPROVED:**

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Hal Meyers, Chair Glenda D. Sheffer, LHRC Secretary