

Disability Services Ombudsman

Year One Interim Report

July 16, 2009 to August 1, 2010



Submitted by Jewel W. Norman
Disability Services Ombudsman
August 1, 2010

In 2009, the Georgia Legislature established the Office of the Disability Services Ombudsman (DSO) as O.C.G.A § 37-2-31. DSO began operations on July 16, 2009 under the leadership of Jewel W. Norman. While Georgia law requires a biennial report of the activities of this office, the Ombudsman is filing an interim report to celebrate the first year's activities and to share with the major stakeholders the accomplishments of this office.

The Mission of the DSO is *to promote the safety, well-being and rights of consumers with Mental Illness or with Co-occurring Developmental Disabilities or Addictive Diseases*. To accomplish this mission the DSO investigates consumer complaints and attempts to resolve the issues identified--acts, omissions to act, practice, or policies and procedures--that may adversely affect the safety and well-being of the consumer. The Ombudsman works independently of any state official or state department in receiving, investigating and resolving complaints, but attempts to work cooperatively to improve the system of care.

The initial staff of the DSO office was the Ombudsman and two part time employees. The demands of the office quickly grew, and a full time program manager, Tonia Poole, was employed to replace the part-time staff. An immediate priority was setting up the infrastructure of the DSO.

- DSO Policies and Procedures were written and adopted;
- A statewide toll-free phone number and a website were set-up for the public to report complaints;
- A data system was created to capture and catalog consumer complaints; and
- Posters were produced to inform consumers and their families of the availability of DSO services.

During this first year, the Ombudsman established a priority of developing a comprehensive knowledge of the system and a positive relationship with the public and private service providers. To accomplish this, the Ombudsman:

- Monitored the closing of the Powell Building at Central State Hospital;
- Visited all seven of the state hospitals operated by the Department of Behavioral Health and Developmental Disabilities (DBHDD), met with the management of those facilities and conducted a thorough tour of the physical plants;
- Visited all of the Crisis Stabilization Programs (CSPs) operated by the Community Services Boards;
- Became a member of the legislatively created Behavioral Health Coordinating Council;
- Spoke to twelve local National Alliance on Mental Illness (NAMI-Georgia) Chapters;
- Regularly attended the Georgia Hospital Association Council of Psychiatric Hospitals;
- Attended Behavioral Health of America meetings;
- Attended Olmstead meetings;
- Regularly attended the Board meetings of the Department of Behavioral Health and Developmental Disabilities (DBHDD Board).

Results for Year One:

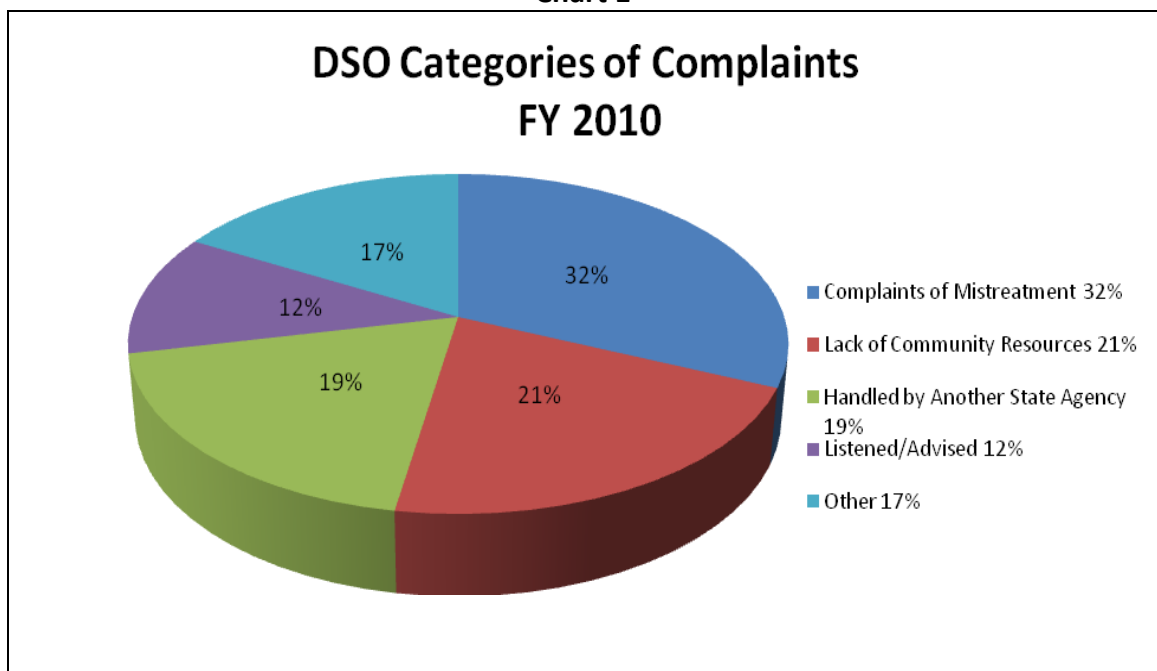
- Consumer Complaints

Since August 2009, the DSO has received 100 complaints. The first category of complaints deals with the availability of services. These complaints generally fall into three categories related to: 1) service cuts due to budget reductions; 2) limited community services after discharge from the hospital; and 3) parents expressing fear that when they are gone, their children will have no advocate and no services.

A second category deals with issues related to judicial orders that require either evaluation and treatment or forensic treatment. Some consumers do not understand why they have been court ordered to a hospital for treatment. Parents call, often from out of state, questioning why their child is in jail while seeking a treatment option. A number of consumers who are legally designated as "not guilty by reason of insanity" or "guilty but mentally ill" seek relief from their confinement. Often parents who serve as primary care givers for their adult children call seeking information about their daughter's or son's medication schedule. They are frustrated because they have virtually no information about what to expect after discharge from the hospital or about the medications that their children require. Consumers call about the lack of responsiveness of the current system. Others complain about environmental issues, such as the quality of food or the lack of sanitary facilities.

Chart 1 illustrates the categories of complaints. Future analyses of the data will report on the complaints by facility and geography.

Chart 1



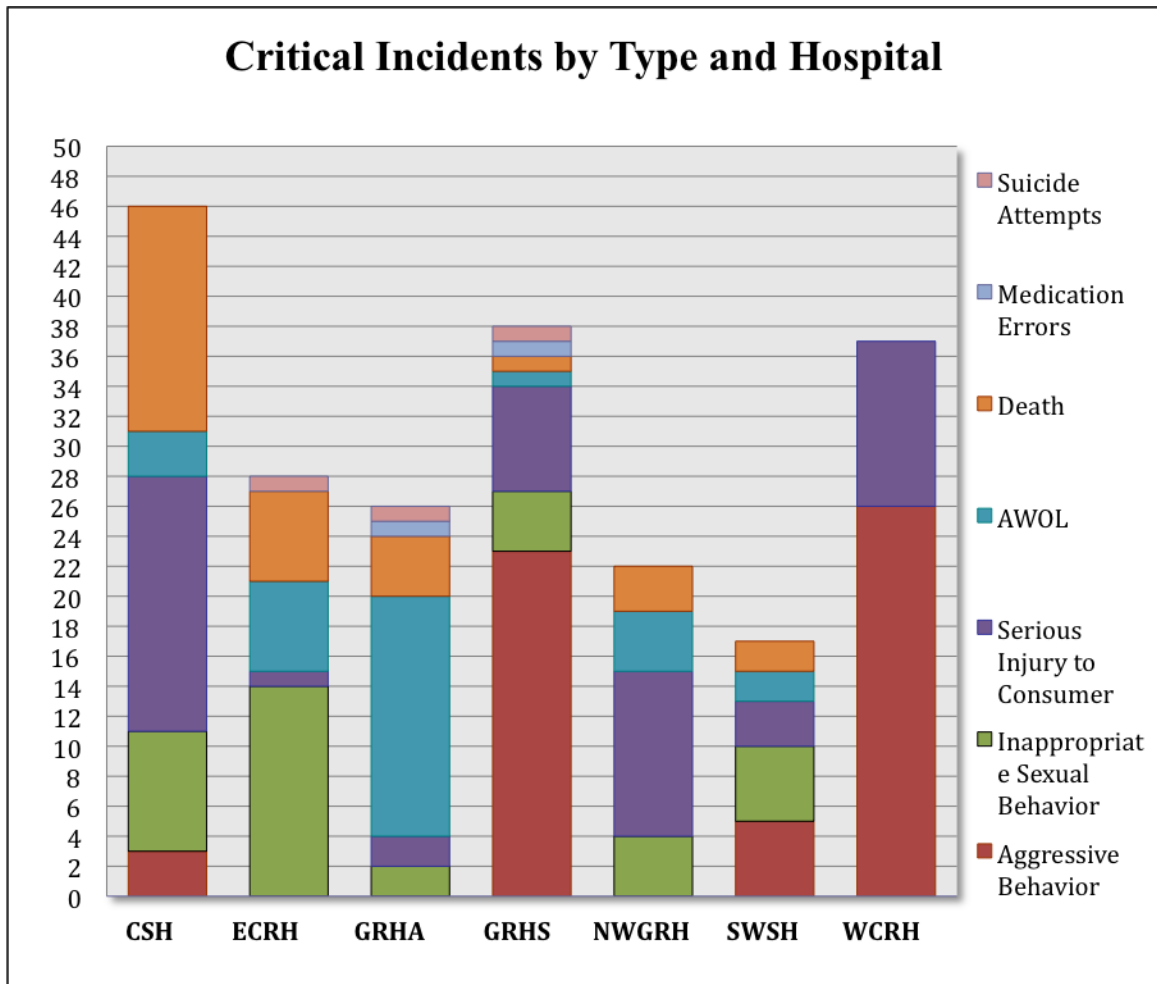
- Death Reviews

The legislation that established the DSO requires a periodic review of deaths that occur in state facilities by a panel of physicians using a peer review process. The panel, which was appointed in November 2009, has met four times to review the 50 deaths that occurred in state hospitals during FY 2010. This panel has concluded that in 46 percent of the cases there was an indication of a poor quality of medical care. They have informed the Commissioner of DBHDD of their concerns in a letter dated March 1, 2010, and have since met with the DBHDD Medical Director.

- Critical Incidents

The DSO receives reports of critical incidents that occur in state hospitals as reported by the Department of Behavioral Health and Developmental Disabilities. These reports, by category, suggest system issues that the Department of DBHDD should address to assure proper care and safety of consumers. During the first three quarters of FY 2010, there were 214 critical incidents in the seven regional hospitals. Chart 2 reports by category of complaint by hospital.

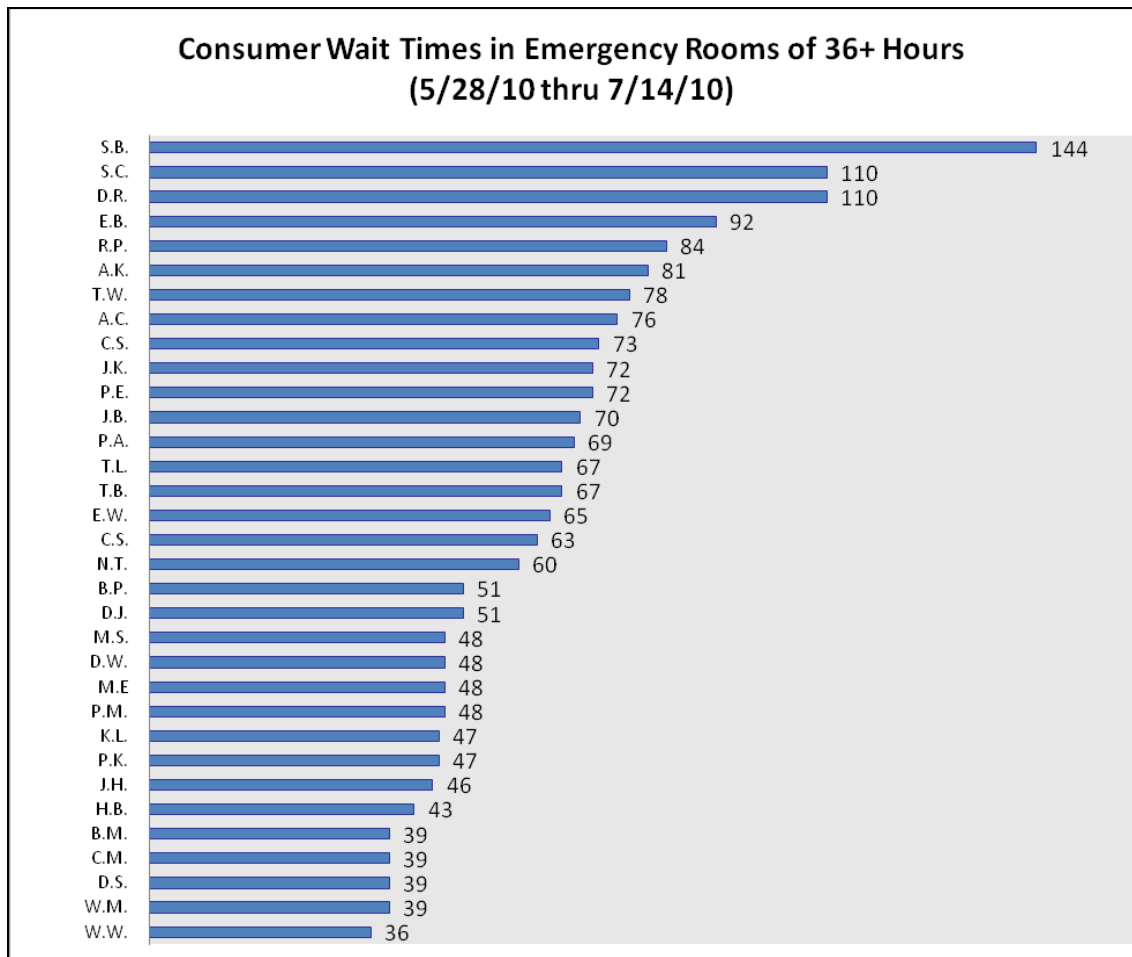
Chart 2



- Emergency Care

Georgia law requires the sheriff's department of each county to transport mentally ill persons who are a danger to themselves or others to an emergency receiving facility. State policy requires medical clearance before any state hospital or Community Services Board Crisis Stabilization Program (CSP) can accept such a transfer. Most of the time the closest destination to achieve the required medical clearance is a general hospital emergency room (ER). In a late spring meeting of the Psychiatric Council of the Georgia Hospital Association, the Ombudsman discovered that many people with mental illness were experiencing excessive periods of waiting in the emergency rooms after medical clearance. She requested that the metro county hospitals collect data beginning with the Memorial Day weekend to determine the extent of the problem of excessive wait time. During this eight-week period, fourteen hospitals admitted 86 adult psychiatric patients to their general hospital emergency rooms for evaluation and medical clearance. After stabilizing the patient, the general hospital called either a state hospital or CSP for psychiatric treatment. The average wait time for these patients, many of whom were experiencing an acute episode of their illness, was 36 hours. Chart 3 illustrates the range of wait time for those 33 patients equal to or exceeding the mean stay of 36 hours.

Chart 3



The average time for those persons exceeding the 36-hour mean time was 64 hours or 2.67 days. One individual, S. B., had a 144 hours, or 6-day, stay in the ER. The significance of this period of waiting is two-fold. First, those individuals who have experienced an acute episode of their mental illness receive no treatment. Second, there appears to be a serious system issue—there is a lack of treatment resources (inpatient or crisis stabilization beds) or there is a failure to assure timely transfer of patients. This situation adds to unnecessary health care costs and results in the needless suffering of persons with mental illness.

An illustration of a more poignant example of this situation is the experience of a nine-year old boy in the custody of The Department of Family and Children Services (DFCS) who had suffered serious physical and sexual abuse. After progressing through the system to Therapeutic Foster Care, he experienced an episode of very out of control behavior. The foster parents were no longer safely able to care for the child and DFCS called in GCAL (the state's contractor to find placement for persons with mentally illness). GCAL approved a CSP placement contingent upon medical clearance. While getting medical clearance at the nearest emergency room, the child became increasingly agitated. The ER staff, with little mental health experience or training had to restrain him using 4-point restraint to assure his safety. Every CSP turned him down after this episode because of the acuteness of his illness. The next day a Mobile Crisis Team arrived and began a more in-depth search. A general hospital with a psychiatric unit in west Georgia agreed to accept him as soon as they had a bed. The child finally transferred to this hospital after 27 hours of unnecessary stay at an emergency room in 4-point restraint. This is an example of either a system's failure because of inadequate resources or an unresponsive system to assure timely placement.

- Mental Health in County Jails

As a result of working with NAMI-Georgia, the Ombudsman has established contact with local law enforcement. Preliminary data suggests that the corrections system, both local jails and our state prisons have become major providers of mental health services. For example, the Chatham County Sheriff provides data that, on any given day, he has between 200 and 250 people with mental illness in his jail. *The Augusta Chronicle*, in a July 11, 2010 article reported by Sandy Hodson, stated, "184 men and women who have been deemed mentally incapable of standing trial are locked in jails for weeks and months because there isn't enough room in the state's seven mental health hospitals [Forensic Units]." "That's what jails have turned into -- mental hospitals," said Richmond County Sheriff's Maj. Gene Johnson, who oversees the county's overcrowded jail. The Georgia Department of Corrections reports that 15.6 percent of the inmate population is receiving mental health services.

Conclusion and Next Steps

Mental health consumers and their families welcome the legislation establishing the Disability Services Office as evidenced by the number and type of complaints received, and the recognition of the DSO Ombudsman by the National Alliance on Mental Illness. NAMI - Georgia recognized the work of the DSO at its 2010 statewide meeting.

The Ombudsman would like to express appreciation to the staff of the Department of Behavioral Health and Developmental Disabilities, particularly the seven regional hospitals, for their hospitality and their cooperation in submitting death records and critical incidents. This first year of operation would have been very difficult without this support.

The DSO will continue its orderly implementation of the legislated responsibilities assigned to that office. While it is much too early to draw any conclusions from the first year of operation, significant issues have surfaced that warrant further study and which directly affect the quality of care and health and safety of Georgians with mentally illness. These areas of focus are:

- The quality of medical care as suggested by the critical incidents and the report of the Medical Review Panel;
- The inclusion of tracking the care for Severely Emotionally Disturbed Children and Adolescents;
- Focus on continuity of care in community programs.
- Tracking complaints of consumers in the Crisis Stabilization Programs of the CSBs;
- Tracking the number of people in county jails with a severe mental illness;
- Improving the data system to isolate geographic and provider specific issues;
- Tracking wait times in the General Hospital Emergency Rooms for persons with mental illness admitted for medical clearance; and
- Continuing analysis of critical incidents data.