



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

January 24, 2008

The Honorable Scott J. Bloch
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 300
Washington, DC 20036-4505

Dear Mr. Bloch:

Your letter of September 19, 2007, outlines allegations of poor management, supervision and staffing in the VA Substance Abuse Residential Rehabilitation Program (SAARTP) at the Department of Veterans Affairs (VA) New Mexico Health Care System (VANMHCS), Albuquerque, New Mexico. The specific allegations were made by Mr. Darryl Young, a psychology technician formerly employed by the VANMHCS (Office of Special Counsel File Number DI-07-2512). I asked the Under Secretary for Health to review this matter and take any actions deemed necessary under 5 U.S.C. § 1213(d)(5). He, in turn, directed the Office of the Medical Inspector (OMI) to investigate the disclosures and report on their findings. The OMI determination is that the complainant's allegations are unsubstantiated. Details of the OMI review are contained in the enclosed report.

During their review, the OMI team identified some areas in need of improvement which are outlined in the report. These areas have been discussed with Medical Center senior management and an action plan is being developed to address the findings.

Sincerely yours,

A handwritten signature in black ink, appearing to read "James B. Peake", is written over a large, stylized flourish that loops back to the left. The signature is positioned above the printed name.

James B. Peake, M.D.

Enclosure

**Report of Investigation to the U.S. Office of Special Counsel
OSC File Number DI-07-2512**

2007-D-1489

The Office of the Medical Inspector (OMI) was asked by the Under Secretary for Health to review the complaints lodged with the Office of Special Counsel (OSC) by a psychological technician previously employed in the Post Traumatic Stress Disorders (PTSD) Clinic at the Veterans Affairs (VA) New Mexico VA Health Care System (NMVAHCS), Albuquerque, New Mexico (hereafter, the Medical Center). The complainant alleged that there was poor management, supervision, and staffing in certain patient care areas particularly involving the Substance Abuse Residential Rehabilitation Treatment Program (SARRTP). More specifically, the complainant alleges:

Allegation 1. On August 10, 2006, a 53-year old veteran was admitted to the SARRTP, with a history of recurrent suicide attempts, PTSD, depression, and substance abuse. During a 17-day stay, the patient was not seen by a clinician for treatment, other than to be offered a substance abuse group focusing on sobriety. Although he had severe PTSD and recurrent suicide attempts, he was not offered any treatment for these issues other than medication. He eventually committed suicide with an overdose of drugs while a patient in the SARRTP.

Allegation 2. The psychologist who was the Director and Supervisor of the SARRTP during the August 2006 timeframe was not licensed as a psychologist and was not being properly supervised by the Chief of Psychology.

Allegation 3. In December 2006, a patient contacted a social worker in the Behavioral Health Care Line who felt that the patient posed a threat to himself or others. The social worker paged the Chief of Psychiatry, who was on call, to request that the patient be picked up and brought to the Medical Center. The pages were never returned by the Chief of Psychiatry, the patient never received adequate treatment, nor did the facility issue an order for the local law enforcement to pick-up and deliver the patient to the facility for observation. Shortly thereafter, it was reported that the patient killed a family member. The complainant feels that this poor management and inadequate care of patients could increase the occurrence of these types of incidents.

Allegation 4. VA physicians in the Behavioral Health Care Line prescribe pain medication to patients but fail to document the prescription in the patient's record. In December 2006, a patient called and spoke to the complainant who was then the first point of contact for the PTSD Behavioral Health Care Line. The patient requested a refill of Percocet™ a narcotic pain medication. Upon review of the patient's chart, there was no indication that the patient was receiving this medication from a Behavioral Health physician. The patient stated that a specific PTSD staff psychiatrist always wrote him a prescription that he would fill outside the VA. This occurred with a patient of this psychiatrist at least three times while the complainant was in the role of first point of patient contact for the PTSD clinic. The complainant stated that in the course of a year

he estimates that he received calls of this nature, involving other patients and doctors whose names he did not record, two to three times a month. The complainant also states that he was told by his supervisor to re-write his notes in a way that would not indicate that the patient was receiving medication not indicated in his medical record.

Facility Profile

The Medical Center, a part of VISN 18, consists of one acute care inpatient facility located in Albuquerque, six community based outpatient clinics (CBOCs), and three veteran counseling centers which are located in various communities within the state. The Medical Center is a Level 1 tertiary referral center and is authorized to operate 217 beds, including a 26-bed Spinal Cord Injury Center, and a 36 bed Nursing Home Care Unit. Other programs include cardiovascular surgery, psychosocial residential rehabilitation treatment program, and home-based primary care. The Medical Center has an affiliation with the University of New Mexico, School of Medicine, with 115 resident physician Full-Time Equivalents (FTEs) currently rotating through 35 clinical residency training programs. It also has affiliations with the University of New Mexico and established a joint venture with the U.S. Air Force. The venture provides for the referral of specialty care by the Kirtland Air Force Base clinic in Albuquerque to VA physicians and offers admitting privileges to Air Force physicians.

Background

The complainant was a psychological technician who worked in the Medical Center's PTSD clinic from April 30, 2006, until his employment was terminated on April 19, 2007. At the end of a 30-minute phone interview with the complainant prior to the OMI visit to the Medical Center, he indicated that he would provide the names of the two patients involved in the specific incidents in his complaint. He also offered copies of internal investigations conducted by the Medical Center around the issues he raises. The OMI fax number and mailing address were provided to the complainant. After the site visit was completed the complainant mailed three documents to the OMI including, Psychiatrist Duties: Tarasoff from Stanford University Department of Psychiatry; New Mexico Statutes Chapter 43 Commitment Procedures; letters to and from the State of New Mexico Regulation and Licensing Department outlining the same issues as the complainant. The OMI also asked the VA Office of General Counsel to contact the OSC to see whether they could obtain the names of specific patients referred to by the complainant. The OSC responded they would contact the complainant and ask him to provide the needed information. Subsequent contact with complainant occurred, but despite OMI's repeated request for this information, the complainant never provided OMI with the names of the patients referenced in the complaint.

During a regularly scheduled meeting with the Office of the Inspector General's Office of Healthcare Inspections (OHI), the OMI became aware of an investigation conducted by the OHI on a patient who died in the Medical Center's SARRTP in August 2006. This report was completed by the OHI's Dallas Regional Office. Investigation and review determined that this was most probably the same patient that the complainant describes as

committing suicide while in the SARRTP, as only one patient had died while in the SARRTP in August 2006.

The SARRTP is a 24-bed residential treatment program focused on the treatment of individuals with complicated substance abuse issues with dual disorder issues such as depression, anxiety, and PTSD. The expected length of stay is 91 days with biweekly progress reviews by the treatment team for the first 4 weeks (Phase 1) and monthly reviews for the remainder of the treatment course. Phase 1 provides a foundation for growth and recovery through group and individual education in medical aspects of addiction, cognitive/behavioral skills, leisure education, an introduction to the 12-step recovery program, family involvement, and motivational enhancement therapy. During this initial phase, SARRTP residents attend the Mini-Intensive Treatment Program (MITP) classes offered through the Substance Use Disorder (SUD) program, as well as specialized SARRTP treatment groups focused on residential treatment issues. Once these basics are accomplished, the focus of the next 61 days of treatment (Phase 2) is on other emotional and physical issues and on practicing life skills to help the veteran function independently in the community. Patients are also assigned a primary therapist who is either a clinical nurse practitioner or a psychologist within the SARRTP.

Methods for Conducting the Investigation

The OMI team notified Medical Center leadership of the complaints and its plan for an October 17, 2007, site visit. The Chief of Staff's assistant served as the coordinator and point of contact and assisted with staff interview scheduling and information gathering. The team consisted of the Director, Clinical Investigations, Senior Medical Investigator, and a Clinical Psychologist from OMI located in VA Central Office in Washington, DC. The team received full cooperation from the Medical Center staff as it conducted individual and group interviews, reviewed policies, procedures, reports, clinical notes and patient care documents, and held entrance conferences with the Medical Center leadership. An exit conference was later held with the Director and Chief of Staff by phone.

The team spoke with the complainant before and during the site visit. During both contacts, the complainant was to provide additional information to assist the OMI in identifying the specific patients involved in the incidences he described. In an effort to identify the specific patients referenced by the complainant, the OMI requested the assistance of the OSC staff assigned to his complaint for the names of the specific patients who served as the basis of several of his allegations. No additional information was provided by the complainant or the OSC staff.

The SARRTP leadership led a tour of the residential unit. The OMI team also interviewed the complainant's supervisor, supervisory social worker, SARRTP Director and clinical nurse manager during the time of the alleged incidents, Chief of Psychology, Acting Chief of Pharmacy, psychiatrists assigned to the PTSD, SARRTP and primary care mental health programs, about 20 counselors and social workers who work in the Behavioral Health Care Line. Some of those interviewed were assigned the same duties

as the complainant as the first point of patient contact. There were no psychological technicians working in the SARRTP at the time of the site visit.

Documents Reviewed:

- *Substance Abuse Residential Rehabilitation Treatment Program - New Resident Handbook*. April, 2006 version.
- *Substance Abuse Residential Rehabilitation Treatment Program – New Resident Handbook*. December, 2006 version.
- Investigation Summary of patient's death on August 10, 2006. Office of Inspector General, Office of Healthcare Inspections, Dallas Regional Office.
- Medical Center review of patient's death on August 10, 2006.
- Report of Autopsy Findings. Office of the Medical Investigator, University of New Mexico, October 2, 2006

Findings regarding Complaint #1

The patient was a 53-year old divorced male with a 70% service connection for generalized anxiety disorder. He had been addicted to heroin and cocaine since 1989 and had been in several addiction treatment programs. The veteran was generally homeless or living in an environment which made it easy for him to continue using heroin and cocaine. Records also indicate past suicidal attempts by overdosing with drugs and once by cutting his wrists. His last documented attempt was in 1995. The patient did not have a diagnosis of PTSD.

He was admitted to the Medical Center's orthopedic inpatient unit, on July 19, 2006, for abscesses of the feet at drug injection sites. During this admission the patient expressed interest in being admitted to the SARRTP. He wanted to stay on the inpatient psychiatric unit until his admission and indicated he was suicidal. Consultation by psychiatry on July 24, 2006, found him to be psychiatrically stable and not suitable for inpatient psychiatric care. During the consultation he stated that he was not suicidal but knew that by saying so he might be admitted to the inpatient psychiatric unit until he could get into the SARRTP. Instead he was discharged to a homeless shelter awaiting assessment and admission to the SARRTP.

The veteran was evaluated for admission to the SARRTP on July 25, 2006, and found to be psychiatrically and medically stable for admission, which was scheduled for August 2, 2006. He did not call or come to the Medical Center for admission on that date. He did call the unit on August 7, 2006, and stated that he was having a hard time detoxifying from heroin as he lived in an environment that promoted using. The provider called the Metropolitan Assessment Treatment Service, a community substance abuse program, to obtain a bed for him until his admission to the Program on August 10, 2006.

A review of the veteran's electronic medical record while he was on the unit indicates that he was evaluated regularly by staff and was involved in numerous groups generally conducted by SUD staff as described above, as well as continuing his medication regiment. The various groups included topics dealing with spirituality, 12-step recovery,

relapse prevention, habit of addiction, and benefits of physical exercise. Progress notes indicate that he was seen every day and heavily involved with groups after the first week. There was no indication of any suicidal ideation during his admission. Interviews with the SUD staff stated that he was involved in his groups and treatment and was happy to be participating in the program.

SARRTP residents are eligible for passes after they have been in the program for 2 weeks. Pass authorization depends on active treatment participation. When residents return from pass there are mandatory urine drug screens and breathalyzer examinations. Urine collections are not directly observed by the SARRTP as the program participants are afforded some privacy with this requirement. The veteran was given his first pass on August 25 and his second pass on August 26, 2006. Upon returning from each pass, the urine drug screens were positive for benzodiazepine (which he was prescribed) and negative for opiates. His alcohol breathalyzer test was negative each time.

A clinical note indicated that when the veteran returned to the unit at approximately 10:00 PM on August 26, 2006, he reported mild anxiety with no pain. At approximately 6:00 AM on August 27, 2006, his roommate reported to SARRTP staff that the veteran was unresponsive and slumped at the end of the bed. The responding physician found him to be in rigor mortis and he was declared dead at 6:25 AM on August 27, 2006. An empty syringe was found in the veteran's trash and three additional syringes were subsequently found in the veteran's car parked on Medical Center grounds. A bottle of liquid, later determined to be urine, was found in the veteran's pants pocket. No analysis was done on this urine. The estimated time of death was approximately 12:30 AM on August 27, 2006.

An autopsy was performed and a report was issued on October 2, 2006. The autopsy revealed a fresh injection site in the left arm. Toxicologic analysis on blood obtained at autopsy was positive for benzodiazepines (diazepam) which he was prescribed and opiates (morphine) which he was not prescribed. The autopsy conclusion was that the combination of these two drugs could lead to a decrease in respiratory effort and ultimately death. The coroner determined that the patient's death was accidental.

Findings regarding Complaint #2

VHA Handbook 5005, Staffing, Part II, Appendix F3, April 15, 2002, states, "Appointing officers may accept applications from and appoint unlicensed or uncertified candidates who have successfully completed the educational requirements to obtaining the required licensure and certification within 2 years following entry on duty. This is a condition of employment required by law and is mandatory for retention beyond the 2-year period."

The clinical psychologist, who was hired in October 2005 and assigned as Director for the SARRTP, was hired under this guidance. She had completed a 1-year post doctoral fellowship in Substance Abuse Treatment and Education at the VA Puget Sound Health Care System, Seattle, Washington. She was not yet licensed but was initiating the licensure process in New Mexico.

Arrangements had been made by the Chief of Psychology to have the SARRTP Director's time and activities supervised by another licensed staff psychologist. After several months under this arrangement, the Chief of Psychology personally provided the supervision. The SARRTP Director received the required weekly supervision, 1 hour of formal supervision per 40 hours of clinic contact. In addition to this formal supervision, the Chief of Psychology stated that she was always informally available to the SARRTP Director, e.g., via Blackberry, phone, or drop-in, should she have any questions or issues needing to be discussed before their regularly scheduled formal supervision time. Issues discussed were related to SARRTP, veteran patients, and treatment and management issues.

The SARRTP Director became licensed in New Mexico as a psychologist in October 2006, 1 year after she was hired. Therefore supervision was no longer required. A random review of her notes was taken during the months of November 2005, and February, June, and September 2006: all reflect that they were reviewed and co-signed by her supervisor.

Findings regarding Complaint #3

The complainant alleged that, in December 2006, a veteran killed a family member after a social worker was unable to contact the on-call psychiatrist (who was the Chief of Psychiatry) to arrange a pick up by local law enforcement for psychiatric evaluation. Requests were made of the complainant and OSC for assistance in identifying this patient. OMI interviewed the Medical Center's social work supervisor as well as 16 social workers from the Behavioral Health Care Line who also triaged calls that came into the clinic. All interviewees were asked whether they recalled such a specific incident and no member of the staff remembered such a sequence of events. The Chief of Psychology did recall a case in December 2006 where a veteran killed his son. This tragic event was well known to Medical Center leadership and an issue brief had been prepared. OMI obtained a copy of the issue brief and reviewed the records of the involved veteran. In summary, a veteran with chronic medical and behavioral health problems had been receiving care with VA. He was seen at the Santa Fe CBOC December 7, 2006, by a social worker, who thoroughly documented the veteran's issues with a turbulent home situation including a violent, drug-abusing son. The social worker evaluated the veteran's risk and documented a plan for him to see the Chief of Psychiatry the next week at the Medical Center. The next note is by the same VA social worker who had been contacted by St. Vincent Hospital in Santa Fe with notification that the veteran had shot and killed his son in self defense and had been hospitalized at St. Vincent. The social worker contacted the Medical Center leadership and then visited the veteran and his family in the hospital that day. The documentation on that day and in subsequent encounters demonstrated a comprehensive and caring approach to the veteran's distressing problems. There is no documentation that the veteran contacted the Medical Center in distress. The veteran continues to be followed closely by the Behavioral Health staff of both the Medical Center and the Santa Fe CBOC.

OMI also asked the interviewees from the Behavioral Health Care Line who cover telephone triage, whether there was difficulty in contacting psychiatrists (and specifically the Chief of Psychiatry) for assistance when needed. The response from about 20 SARRTP staff interviewees was universal and clear; they felt very supported by the Chief of Psychiatry and other physician staff and never had difficulty in obtaining consultative support or timely approval for a Certificate of Evaluation, the New Mexico legal document for involuntary pick up.

Findings regarding Complainant #4

OMI discussed this allegation with the complainant's supervisor who immediately knew the patient who had requested a refill of Percocet™ and the circumstances regarding the claim that a specific PTSD staff psychiatrist has been prescribing drugs for the patient and not entering this into the veteran's treatment record. The supervisor provided a copy of the complainant's note dated December 26, 2006, which the complainant entered into the veteran's treatment record. The complainant had written that the psychiatrist did not document the prescription for Percocet™ in the veteran's treatment record.

The supervisor also provided a copy of a psychiatry medication management note written by the psychiatrist on August 8, 2006, in which the psychiatrist ordered Percocet™ for this veteran with a 4-month follow-up which would have been around December 2006. The supervisor stated that he asked the complainant to write an addendum to his note based on the new information found in the medical record. However, the complainant did not do so. Therefore, the supervisor wrote an addendum to the progress note with the correct information. The supervisor indicated that the complainant had a tendency to make conclusions without a thorough review of the available information.

The same interviewees mentioned above were asked if they had any experiences with patients requesting refills for medication which they were unable to find ordered or documented in the patient's treatment record by a corresponding note from the ordering psychiatrist/ physician. Each person stated that they never had this experience with the specific physician referenced by the complainant or any of the other physicians who order medications.

Conclusions

Allegation 1. On August 10, 2006, a 53- year old veteran was admitted to the SARRTP, with a history of recurrent suicide attempts, severe post traumatic stress disorder, depression, and substance abuse. During a 17-day stay, the patient was not seen by a clinician for treatment, other than to be offered a substance abuse group focusing on sobriety. Although he had severe PTSD and recurrent suicide attempts, he was not offered any treatment for these issues other than medication. He eventually committed suicide with an overdose of drugs while a patient in the SARRTP.

OMI Conclusions on Allegation 1:

Documentation and interviews indicate that the patient was motivated and happy to be admitted to the SAR RTP. On July 24, 2006, he was evaluated by a psychiatrist who stated that he was not a current danger to himself or others. The patient received the appropriate treatment while in the SAR RTP as he fully participated in both Phase 1 and 2 of the treatment program. He was not diagnosed with PTSD, and was being appropriately treated with medications for his depression and anxiety. The finding of the syringe in the resident's waste receptacle, the fresh needle mark in his arm, the toxicologic blood analysis, and the additional syringes found in his car, indicate that the veteran was engaging in ongoing drug abuse while in his treatment program. OMI supports the conclusion that the veteran died of an accidental overdose rather than from a planned suicide.

Allegation 2. The psychologist who was the Director and Supervisor of the SAR RTP during the August 2006 timeframe was not licensed as a psychologist and in fact was not being properly supervised by the Chief of Psychology.

OMI Conclusions on Allegation 2:

While it was factually true that the psychologist was unlicensed, there was no violation of VA policy or procedure. The psychologist who was the Director of SAR RTP was hired under guidance found in VHA Handbook 5005 Staffing, Part II, Appendix F3, April 15, 2002. This guidance states that independent practitioners, including psychologists, must be licensed by a state within 2 years of being employed by VA. The Director of the SAR RTP was hired in October 2005 and was licensed in the state of New Mexico as a psychologist in October 2006, well within the mandated requirements. The OMI found that the supervision she received was appropriate and were within VA requirements.

Allegation 3. In December 2006, a patient contacted a social worker in the Behavioral Health Care Line who felt that the patient posed a threat to himself or others. The social worker paged the Chief of Psychiatry, who was on call, to request that the patient be picked up and brought to the Medical Center. The pages were never returned by the Chief of Psychiatry, the patient never received adequate treatment, nor did the facility issue an order for the local law enforcement to pick-up and deliver the patient to the facility for observation. Shortly thereafter, it was reported that the patient killed a family member. The complainant feels that this poor management and inadequate care of patients could increase the occurrence of these types of incidents.

OMI Conclusions on Allegation 3:

This allegation could not be substantiated as the patient's identity was unknown. OMI requested further assistance from the complainant and OSC to identify the patient, but no further information was provided. When Medical Center leadership and Behavioral Health Care Line staff were interviewed, no one was aware of any case that fit the complainant's description.

The Chief of Psychology did recall an incident in the appropriate timeframe in which a veteran who was fearful for his life did shoot and kill his adult son. This case was reviewed by OMI and the actions of VA health care providers were appropriate and met the needs of the veteran. There are also major discrepancies between the facts of the complainant's allegation and the circumstances of this case; however, it did involve a veteran killing a family member.

Allegation 4. VA physicians in the Behavioral Health Care Line prescribe pain medication to patients but fail to document the prescription in the patient's record. In December 2006, a patient called and spoke to the complainant who was then the first point of contact for the PTSD Behavioral Health Care Line. The patient requested a refill of Percocet™, a narcotic pain medication. Upon review of the patient chart, there was no indication that the patient was receiving this medication from a Behavioral Health physician. The patient stated that a specific PTSD staff psychiatrist always wrote him a prescription that he would fill outside the VA. This occurred with a patient of this psychiatrist at least three times while the complainant was in the role of first point of patient contact for the PTSD clinic. The complainant stated that in the course of a year he estimates that he received calls of this nature, involving other patients and doctors whose names he did not record, 2 to 3e times a month. The complainant also states that he was told by his supervisor to re-write his notes in a way that would not indicate that the patient was receiving medication not indicated in his medical record.

OMI Conclusions on Allegation 4:

This allegation could not be substantiated. This specific case was reviewed and documentation of medication orders for Percocet™ was found in the electronic medical record entered by the PTSD staff psychiatrist in August 2006. Evidently this was not seen by the complainant. The complainant's supervisor then directed him to add an addendum which would reflect this finding as the complainant's initial note indicated that he could not find the order for Percocet™ in the veteran's medication record.

Approximately 20 Behavioral Health Care Line personnel, who also function as "first point of contact" for Behavioral Health Line patients, were asked if they had any experiences where veteran requests for refills were not initially documented in the veterans' electronic medical record by their physician. They all stated that they have not had that experience.

Overall OMI Conclusion:

In summary, the OMI did not substantiate that there was gross mismanagement and a substantial and specific danger to public health and safety in the SARRTP and the Behavior Health Care Line.

Other Considerations for the SARRTP

The OMI made several observations about the operation of the SARRTP that will require consideration by leadership at the Medical Center. Patients in the SARRTP have access to their vehicles which may be parked on hospital grounds. Consideration should be given as to whether this is in the best interest of recovering substance abusers, since contraband such as syringes, drugs, or weapons can be stored in vehicles.

Veterans were admitted to the SARRTP with no appreciable periods of abstinence from their drug of choice. This type of patient may require more aggressive use of replacement therapy under a more structured detoxification program. This raises issues with the use of the current self-medication policy under which patients are required to obtain their own medications from their primary care providers. Additionally, the communication and roles between the SARRTP and the primary care provider would need clarification, especially as it relates to prescribing medications.

Due to privacy issues, the SARRTP urine collection for drug screening is not directly observed, providing the resident an opportunity to tamper with urine samples.

Recommendations

The Medical Center leadership should make final determinations regarding the issues under consideration.