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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Facility Leaders' Response to Inappropriate Mental Health Provider-Patient Relationships at the VA Illiana Health Care System in Danville, Illinois

HEALTHCARE INSPECTION | REPORT #19-08364-140 | MAY 3, 2022

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate leaders' response to the knowledge of inappropriate provider-patient relationships (inappropriate relationships) in the Mental Health Service Line at the VA Illiana Health Care System (facility) in Danville, Illinois.[1]

On March 11, 2019, the OIG received an anonymous complaint alleging that facility management was aware of inappropriate relationships between mental health providers and mental health patients and took no action in response. The complainant also reported the overdose death of a patient (Patient C) involved in an inappropriate relationship with a mental health provider. The OIG confirmed that facility leaders acted in response to the inappropriate relationships but opened the hotline on November 12, 2019, to address the following concerns:

- The propriety of facility leaders' actions to address the inappropriate relationships
- The efficacy of action plans to prevent future occurrences of inappropriate relationships between mental health staff and mental health patients
- The appropriateness of facility leaders' actions to address the death of a mental health patient who had been in an inappropriate relationship with a facility mental health provider

The facility substantiated three inappropriate relationships between mental health providers and patients. Facility fact-finding reviews and investigations confirmed that the relationships between the mental health providers (a certified addiction counselor and two social workers) and patients were romantic. Such inappropriate relationships are prohibited in mental health settings and the provider's behavior is viewed as professional incompetence and misconduct.[2] These inappropriate relationships may result in negative patient outcomes including emotional and psychological harm, sexual exploitation, financial exploitation, inaccessibility to treatment, or avoidance of future treatment.

Federal regulation, state law, and VA, Veterans Health Administration (VHA), and facility policy all provide guidance prohibiting such inappropriate relationships. VHA policy requires facility leaders to take timely action and gather available evidence through fact-finding reviews and administrative investigation boards (AIBs) to address serious matters of interest to the VA,

[1] For purposes of this hotline inspection, the OIG defines leaders as facility and Mental Health Service Line leaders.

[2] BJPsych Advances, "Boundary violations in therapy: the patient's experience of harm," accessed April 29, 2020, https://doi.org/10.1192/bja.2018.26.

such as inappropriate relationships.[3] The OIG reviewed facility leaders' actions to manage the three inappropriate relationships between mental health providers and patients including a fact-finding review in early 2018 and an AIB in mid-2018 to investigate concerns about Provider A and Provider B having inappropriate relationships, and a fact-finding review in early 2019 followed by an AIB in mid-2019 to address allegations that Provider C had engaged in an inappropriate relationship with Patient C. The fact-finding reviews and AIBs resulted in 22 recommendations.

The OIG determined that while facility leaders took initial actions to address the alleged inappropriate relationships, multiple factors hindered that effort including

- initial denials by the three providers in the inappropriate relationships,
- inaccurate guidance from human resources personnel and the Integrated Ethics Program Officer that the inappropriate relationships could not be addressed through discipline, and
- inconclusive fact-finding efforts that failed to confirm the inappropriate relationships.

The OIG determined that facility leaders implemented action plans to prevent future occurrences of inappropriate relationships between mental health providers and patients.[4] The OIG also found that facility leaders initiated additional actions including

- pursuing disciplinary action against the providers in the inappropriate relationships,
- revising policies to clarify prohibition of inappropriate relationships,
- conducting staff training on boundary violations, focusing on inappropriate relationships,
- providing training for mental health leaders on ethics consultation, and
- making changes in mental health leadership.

However, despite the egregious nature of the providers' behaviors, facility leaders failed to report Providers B and C to their state licensing board in a timely manner as required and failed to make a required report to Provider A's professional certification board, which prevented expedient action by the Illinois Division of Professional Regulation.

[3] VA Handbook 0700, *Administrative Investigations*, July 31, 2002, was in place during the time of the events discussed in this report. It was rescinded and replaced by VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021, which was published after the events discussed in this report. The 2002 handbook describes a fact-finding review as an informal evidence-gathering process to obtain readily available information about a range of significant matters, and an AIB as a formal process to collect and analyze evidence surrounding a matter of interest, within VHA. The 2021 handbook contains similar language related to the AIB but states that, "AIBs and Factfindings are both types of administrative investigations which VA can utilize and rely upon when taking administrative actions, including disciplinary actions under VA Directive and Handbook 5021."

[4] For the purposes of this report, the OIG considers a mental health provider to be a physician, psychologist, nurse, chemical dependency counselor, social worker, or other person, whether or not licensed by the State, who performs or purports to perform psychotherapy.

The OIG also concluded that facility leaders failed to make disclosure to Patient C's next of kin as they deemed disclosure unwarranted based on clinical judgment and policy. However, VHA Directive 1004.08, *Disclosure of Adverse Events* states that, "adverse events that have had, or are reasonably expected to have, an effect on the patient that is perceptible to either the patient or the health care team" warrant disclosure. If an adverse event occurred that "resulted in or is reasonably expected to result in death or serious injury," leaders should conduct an institutional disclosure to inform the patient of the circumstances of the event.[5] The Chief of Staff at the time of the OIG's inspection remarked on whether there was an investigation of circumstances that may have contributed to Patient C's death, "I don't think so, I am not a hundred percent sure. [Patient C] was not a patient at the facility. It is not like [Patient C] expired here at the facility, like on the operating room table."[6] The OIG does not concur with facility leaders' determination that disclosure was unwarranted given

- the facility fact-finding review identified that multiple staff concluded that Patient C's clinical decompensation was due to the relationship with Provider C and that fact-finding review team members were concerned with Patient C's safety,
- Patient C expressed concern regarding the identification of Provider C through the fact-finding review, and
- Patient C died by overdose three days after the fact-finding review's recommendation of disciplinary action for Provider C.

The OIG determined that multiple factors preceding Patient C's death related to contact with the facility may have influenced Patient C and warrant further facility review.

The OIG made one recommendation to the Veteran Integrated Service Network 12 Director related to evaluating processes that affected facility supervisors' identification and actions to address inappropriate relationships. The OIG made two recommendations to the Facility Director related to timely reporting of providers to state licensing boards or state certification boards, and reviewing Patient C's care to determine if there was an adverse event and if so, whether institutional disclosure is warranted.

[5] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. Institutional disclosure is a term used by VHA to describe a specific discussion with patients. "A formal process by which facility leaders, together with clinicians and other appropriate individuals, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury."

[6] Contrary to the Chief of Staff's statement, Patient C was seen for care at the facility the month prior to death.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). The OIG will follow up on the planned actions until they are completed.

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Abbreviations

AIB	Administrative Investigation Board
HUD/VASH	Housing and Urban Development/VA Supportive Housing
OIG	Office of Inspector General
PRRTP	psychosocial residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate leaders' response to the knowledge of inappropriate provider-patient relationships (inappropriate relationships) in the Mental Health Service Line at the VA Illiana Health Care System (facility) in Danville, Illinois.[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 12, has five community-based outpatient clinics in Bloomington, Decatur, Mattoon, Peoria, and Springfield, Illinois. The facility is affiliated with the University of Illinois College of Medicine at Champaign-Urbana and the Indiana University School of Optometry in Bloomington, Indiana.[2] The facility provided care to 29,647 unique patients in 2020 and is classified as a Level 3 low complexity center by the Veterans Health Administration (VHA).[3]

Mental Health Provider and Patient Relationships

A positive therapeutic relationship between a patient and a mental health provider is based on trust and the premise that by working together, the provider will help the patient.[4] Boundary violations occur when the therapeutic relationship shifts and the provider's own needs are met through the therapeutic relationship rather than the patient's needs. In this regard, the provider is seen as having a dual relationship with the patient (for example, when a patient is also a family member, business associate, friend, colleague, or sexual partner).[5] Such relationships are prohibited in mental health settings and the provider's behavior is viewed as professional incompetence and misconduct.[6] Boundary violations may result in negative patient outcomes

[1] For purposes of this hotline inspection, the OIG defines leaders as facility and Mental Health Service Line leaders.

[2] VA, "VA Illiana health care, About Us," accessed November 18, 2019. https://www.danville.va.gov/.

[3] VHA Support Service Center, *How to Access VSSC,* accessed July 3, 2020. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing (OPES).

[4] Simon, Robert I., et al. "Maintaining Treatment Boundaries in Small Communities and Rural Areas." Psychiatric Services, November 1, 1999, accessed April 9, 2020, https://ps.psychiatryonline.org/doi/10.1176/ps.50.11.1440.

[5] Zur, Ofer. "Dual Relationships, Multiple Relationships, Boundaries, Boundary Crossings & Boundary Violations in Psychotherapy, Counseling & Mental Health," accessed August 2, 2020, https://www.zurinstitute.com/boundaries-dual-relationships/.

[6] BJPsych Advances, "Boundary violations in therapy: the patient's experience of harm," accessed April 29, 2020, https://doi.org/10.1192/bja.2018.26.

including emotional and psychological harm, sexual exploitation, financial exploitation, inaccessibility to treatment, or avoidance of future treatment.[7]

Prohibitions Against Inappropriate Relationships

Based on federal regulation, VA policy directs that employees not engage in "infamous, dishonest, immoral, or notoriously disgraceful conduct" and provides for disciplinary action in addition to penalties prescribed by law.[8] VHA policy directs social workers to adhere to professional practice standards of the National Association of Social Workers, which prohibits engaging in sexual activities with patients.[9] Facility policy prohibits employees' emotional and sexual involvement with patients.

Under state law, the Illinois Division of Professional Regulation is responsible for the licensing of mental health professionals and ensuring that laws, clinical practice standards, and codes of ethics are upheld through regulating the providers' professional licenses.[10] Illinois established a civil remedy for patients who may be victims of such exploitation by psychotherapists, unlicensed health professionals, or unlicensed mental health professionals.[11] Additionally, if there is probable cause to believe that such a provider has had sexual contact with one or more former or current patients and that the provider poses a threat to the health, safety, and welfare of members of the public who are or may be patients of the provider, the Illinois Attorney General may bring an action in the name of the State to temporarily or permanently restrain the provider from providing psychotherapy, health services, or mental health services.[12] If the court issues an order to such a provider to refrain from such practice and the provider violates the order, the violation may be considered a criminal offense.[13]

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[7] Hook, John, and Dawn Devereux. "Sexual Boundary Violations: Victims, Perpetrators and Risk Reduction." BJPsych Advances 24, no. 6 (2018): 374–83; Simon, Robert I. et al. "Maintaining Treatment Boundaries in Small Communities and Rural Areas." Psychiatric Services, November 1, 1999, accessed April 9, 2020, https://ps.psychiatryonline.org/doi/10.1176/ps.50.11.1440. BJPsych Advances, "Boundary violations in therapy: the patient's experience of harm," accessed April 29, 2020, https://doi.org/10.1192/bja.2018.26.

[8] VA Handbook 5025, *Legal*, April 15, 2002.

[9] National Association of Social Workers, *Code of Ethics*, accessed June 22, 2020, https://www.socialworkers.org/about/ethics/code-of-ethics/code-of-ethics-english.

[10] The Illinois Division of Professional Regulation regulates health care and occupational professionals. Accessed September 30, 2021, https://www.idfpr.com/DPR.asp. Illinois Division of Professional Regulation Brochure, accessed June 22, 2020, https://www.idfpr.com/Forms/Brochures/DPR.pdf.

[11] *Sexual Exploitation in Psychotherapy, Professional Health Services, and Professional Mental Health Services Act* (740 ILCS 140/1, Sec. 1); 740 ILCS 140/2, Sec. 2, para. A. "A "Psychotherapist" means a physician, psychologist, nurse, chemical dependency counselor, social worker, or other person, whether or not licensed by the State, who performs or purports to perform psychotherapy."

[12] 740 ILCS 140/2(c)(2015 State Bar Edition).

[13] 740 ILCS 140/2(g).

In addition to establishing the means for victims of such exploitation to bring a cause of action against providers for damages, Illinois extended liability to employers of providers if the employer failed or refused to take reasonable action when the employer knew or had reason to know that the provider engaged in sexual contact with a patient or former patient.[14] Under certain circumstances, this type of misconduct may expose federal government employers, such as the VA, to liability under the Federal Tort Claims Act.[15]

OIG Concerns

On March 11, 2019, the OIG received an anonymous complaint alleging that facility management was aware of inappropriate relationships between mental health providers and mental health patients and took no action in response. The complainant also reported the overdose death of a patient involved in an inappropriate relationship with a mental health provider. On May 14, 2019, the OIG sent a query to the facility regarding the complaint.

On August 21, 2019, facility leaders responded to the query and substantiated three inappropriate relationships between mental health providers and patients. To address these relationships, the facility reported completing two fact-finding reviews and two administrative investigation boards (AIBs).[16] The OIG found that, contrary to the complainant's allegation, the facility response confirmed that facility leaders took action in response to the inappropriate relationships. However, the facility response did not sufficiently detail actions taken by facility leaders or address the overdose death cited in the complaint.

The OIG opened a hotline on November 12, 2019, to address the following concerns:

- The propriety of facility leaders' actions to address the inappropriate patient relationships
- The efficacy of action plans to prevent future occurrences of inappropriate relationships between mental health staff and mental health patients

[14] 740 ILCS 140/3. The sovereign immunity doctrine may bar an action for liability pursuant to this statute against federal employers. *See e.g. United States v. Mitchell*, 445 U.S. 535, 538 (1980), *citing United States v. Sherwood*, 312 U.S. 584 (1941).

[15] *Zeranti v. United States*, 358 F. Supp. 3d. 244 (W.D. NY 2019) (Motion to Dismiss denied where VA psychotherapist engaged in sexual relationship with patient).

[16] VA Handbook 0700, *Administrative Investigations*, July 31, 2002, was in place during the time of the events discussed in this report. It was rescinded and replaced by VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021, which was published after the events discussed in this report. The 2002 handbook describes a fact-finding review as an informal evidence-gathering process to obtain readily available information about a range of significant matters, and an AIB as a formal process to collect and analyze evidence surrounding a matter of interest, within VHA. The 2021 handbook contains similar language related to the AIB but states that, "AIBs and Factfindings are both types of administrative investigations which VA can utilize and rely upon when taking administrative actions, including disciplinary actions under VA Directive and Handbook 5021."

- The appropriateness of facility leaders' actions to address the death of a mental health patient who had been in an inappropriate relationship with a facility mental health provider

Scope and Methodology

The OIG initiated the inspection in November 2019.[17] The OIG did not visit the facility for this inspection given ongoing concerns with travel and the potential spread of COVID-19.

The OIG interviewed the Facility Director, Chief of Staff, Associate Director, Associate Director of Patient Care Service, Chief of Mental Health, former Chief of Mental Health, Chief of Social Work, Chief of Quality Management, a Mental Health Supervisor for Psychology, a former Mental Health Supervisor for Psychology, the 2019 fact-finding review group lead, and a facility physician.

The electronic health records (EHRs) of three patients related to this inspection were reviewed. The OIG reviewed facility data and documents from March 2018 through December 2019. The OIG team reviewed VHA directives and handbooks and facility policies related to ethics and ethical conduct, patient abuse, incident reporting, facility medical staff bylaws, and relevant literature. Additional documents reviewed included professional codes of ethical conduct; professional licensing standards; the Illinois Certification Board for the Illinois Alcohol and Other Drug Abuse Professional Certification Association Code of Ethics; AIB and fact-finding review reports, evidence, action plans, and supporting documentation to show completion of recommended AIB tasks; facility training records; and an issue brief.[18]

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[17] The OIG inspection team consisted of inspectors in training and experienced a temporary or permanent departure of inspectors including project supervisors, which impacted the timely completion of the report.

[18] The OIG did not independently verify AIB and fact-finding review reports for accuracy or completeness.

Summary of Events

The facility provided the fact-findings and AIB's to the OIG. The following summarizes key events from these reviews related to the inappropriate relationships between three mental health providers and three mental health patients.

Patient A and Provider A

At the time of the events discussed in this report, Patient A had a history of mental health conditions and substance use disorder.

Late 2012. Patient A was admitted to the facility outpatient substance abuse treatment program. The patient's treatment team included Provider A, a certified addiction counselor.

Early 2013. Patient A began care through the facility's psychosocial residential rehabilitation treatment program (PRRTP).[19] Provider A remained an active member of the patient's treatment team.

Early 2013. The treatment program coordinator questioned Provider A after hearing "people talking about" a personal relationship developing with Patient A. Provider A denied a personal relationship with Patient A several times. Provider A consulted a facility human resources specialist who informed the provider that the relationship could continue because facility policy did not prohibit it.

Early 2013. Patient A was discharged from the PRRTP. Provider A was no longer on Patient A's treatment team. According to Provider A, sometime around early 2013, Patient A and Provider A entered into a romantic relationship. The relationship continued until mid-2014.

Late 2014. Patient A left the Danville area.

2016. Mental health leaders learned that Patient A and Provider A were still in a relationship. Mental health leaders reported that the Chief of Human Resources and the Compliance Officer/Integrated Ethics Program Officer advised that there was no actionable violation of facility policy.

Late 2017. According to Provider A, the personal relationship with Patient A resumed when Patient A returned to the area. Patient A also re-established health care at the facility and received regular psychotherapy through the mental health clinic.

[19] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019. VHA established the PRRTP in 1995 to provide residential 24-hour care within the VA health system. The PRRTP is designed to serve veterans with mental illnesses or addictive disorders who require additional structure and support to address multiple and severe psychosocial deficits including homelessness and unemployment.

Early 2018. Facility leaders received communication from the Office of Accountability and Whistleblower Protection with allegations including that Provider A was in an inappropriate relationship with Patient A.[20]

Early 2018. Facility leaders initiated a fact-finding review to address the allegations. The fact-finding review substantiated that Provider A engaged in an inappropriate, romantic relationship with Patient A. However, facility leaders confirmed that the relationship was not in violation of facility policy.

Mid-2018. Facility leaders convened an AIB following the fact-finding review. The AIB also substantiated that Provider A engaged in an inappropriate relationship with Patient A.

Mid-2018. Provider A and Patient A were living together.

Late 2018. Patient A was provided mental health care via telemental health. Patient A reported emotional distress due to the facility's investigations into the relationship with Provider A.

Mid-2019. Patient A contacted the Veteran's Crisis Line and reported that "the stress of this situation has brought on thoughts of not wanting to live." A follow-up call from the treating mental health social worker revealed that Patient A was not suicidal but "was having frustrations" with how Provider A was being treated at work, "which led to the crisis call."

Early 2020. At the time of the OIG inspection, Patient A continued to receive telemental health treatment at the facility and Patient A and Provider A remained together. Provider A was on the facility's mental health staff and continued to provide addiction treatment counseling in the substance abuse treatment program.

Patient B and Provider B

Patient B had a history of multiple mental health and substance use disorders.

Mid-2014. Patient B established care at the facility. At the first primary care appointment, Patient B was referred to the facility mental health clinic, substance abuse treatment program, and Health Care for Homeless Veterans program.

Mid-2014. Patient B was admitted to the PRRTP for substance abuse treatment and residential care. Patient B began treatment in the mental health clinic.

Late 2014 through Mid-2016. Provider B, a licensed clinical social worker, was Patient B's mental health treatment coordinator and U.S. Department of Housing and Urban Development-

[20] VA Directive 0500, Office of Accountability and Whistleblower Protection: Investigation of whistleblower disclosures and allegations involving senior leaders or whistleblower retaliation, September 10, 2019. The VA Office of Accountability and Whistleblower Protection was established to take, investigate, and resolve whistleblower disclosures; allegations of whistleblower retaliation; and allegations of misconduct or poor performance of VA leaders.

VA Supportive Housing (HUD/VASH) case manager.[21] Patient B and Provider B's clinical interactions included encounters at the facility, the patient's apartment, and within the larger community.

Early 2016. Provider B's HUD/VASH case manager role ended when Patient B achieved independent housing and was discharged from the HUD/VASH program.

Mid-2016. Mental health leaders, including Provider B's direct supervisor, became aware of an inappropriate relationship between Provider B and Patient B as reported by a mental health staff member. Provider B denied the relationship. Provider B's supervisor counseled the provider about having a dual relationship and directed that Patient B be reassigned to another mental health treatment coordinator. Provider B's mental health treatment coordinator role ended when Patient B was assigned a new mental health treatment coordinator.

Late 2016. Medical records indicate Patient B was living in Provider B's home and in a romantic relationship for the past two years. Patient B regularly reported the stability of the relationship and living situation to the treating psychiatrist.

Early 2018. Facility leaders received a communication from the Office of Accountability and Whistleblower Protection with allegations including an inappropriate relationship between Provider B and Patient B.

Early 2018. As a result of the Office of Accountability and Whistleblower Protection communication, facility leaders initiated a fact-finding review. The fact-finding review did not confirm that Provider B and Patient B were in an inappropriate relationship; however, it did verify the pair were residing at the same address.

Mid-2018. Facility leaders initiated an AIB after the fact-finding review. The AIB substantiated that Provider B was engaged in an inappropriate relationship with Patient B.

Late 2018. Facility leaders proposed removal of Provider B for the inappropriate relationship.

Late 2018. Provider B accepted a lower grade reassignment.

Early 2020. At the time of the OIG inspection, Patient B remained in mental health treatment at the facility. Provider B and Patient B lived together with their child who was born in late 2019.

[21] Veterans Health Administration, *Guide to VA Mental Health Services for Veterans and Families*, accessed May 18, 2021, https://www.mentalhealth.va.gov/docs/MHG_English.pdf. A mental health treatment coordinator works with patients receiving specialty mental health treatment to ensure they receive continuity through mental health care and any transitions. Department of Veterans Affairs, *Veterans Experiencing Homelessness*, https://www.va.gov/homeless/hud-vash.asp. The VA and Housing and Urban Development-VA Supportive Housing (HUD/VASH) program is a collaborative program between the U.S. Department of Housing and Urban Development (HUD) and VA that combines HUD housing vouchers with VA supportive services to help veterans and their families who are homeless and in need of sustained permanent housing.

Provider B continued to retain a full and active license to practice social work in the state of Illinois.

Patient C and Provider C

Patient C had a history of mental health conditions, including major depression, and substance abuse and dependences.

Early 2017. Patient C was admitted to the facility's PRRTP for treatment of substance abuse. Patient C's treatment team included Provider C, a licensed clinical social worker.

Mid-2017. Patient C successfully completed the PRRTP and moved to the facility-compensated work therapy/transitional residence program.[22]

Late 2017. A fact-finding review identified that a PRRTP patient and two PRRTP staff reported Provider C and Patient C having a sexual relationship; however, facility fact-finding reviewers considered the allegation unfounded "due to no matching accounts or corresponding evidence," and Provider C denied having a personal relationship with Patient C.

Late 2017. Patient C achieved stable housing and was discharged from the transitional residence program.

Early 2018. During a therapy session, Patient C detailed concerns regarding the effect of a substance use relapse on the relationship with a significant other.[23]

Early 2018. Patient C shared during a therapy appointment that the significant other, Provider C, ended the relationship due to Patient C's relapse.[24] Patient C continued to meet regularly with the addiction therapist. The content of each therapy session focused on the loss, grief, and anger the patient was experiencing from the breakup with the significant other, alleged to have been Provider C.

Late 2018. An allegation of an inappropriate relationship between Provider C and Patient C was referred to social work leadership who concluded that further fact-finding was unwarranted and closed the issue "due to no matching accounts or corresponding evidence" of the relationship.

[22] VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019. The VA Compensated Work Therapy-Transitional Residence programs provide a transitional residence designed for veteran's whose rehabilitative focus is based on vocational therapy and transitioning from this level of care to successful independent community living.

[23] The OIG determined that the timing of the relationship documented in the medical record aligns with the romantic relationship with Provider C that the AIB results determined to exist.

[24] The OIG determined that the timing of the relationship documented in the medical record aligns with the romantic relationship with Provider C that the AIB results determined to exist.

Early 2019. Facility staff notified mental health leaders at the facility of an alleged romantic relationship between Provider C and Patient C. Provider C was immediately removed from direct patient care.

Early 2019. Patient C's last medical appointment at the facility was with a pain management program physician. Facility leaders convened a fact-finding review into the nature of the relationship between Patient C and Provider C. The fact-finding team held a management briefing with facility leaders and conveyed their concerns about the well-being of Patient C. The team requested that Patient C's addiction therapist and suicide prevention reach out to Patient C and attempt to engage the patient in mental health treatment in a safe environment.

Early 2019. The fact-finding review recommended disciplinary action against Provider C. Three days later, Patient C died by a substance use overdose. Three days after Patient C's death, Provider C submitted an immediate resignation.

Mid-2019. An AIB was completed and determined that an inappropriate relationship existed between Provider C and Patient C and identified multiple mental health leaders and staff who were aware of the inappropriate relationship. The board recommended administrative action against four mental health staff and modifications to the Employee Conduct and Ethical Standards policy to clarify expectations regarding provider relationships with former patients.

Early 2020. At the time of the OIG inspection, Provider C continued to have a full unrestricted license to practice social work in the state of Illinois.

Inspection Results

1: Facility Leaders' Actions to Address the Inappropriate Relationships

The OIG determined that while facility leaders took initial actions to address inappropriate relationships between mental health providers and mental health patients, multiple factors affected the effectiveness of those actions. The OIG found that effective facility leader actions to investigate and address the inappropriate relationships of Provider A and Provider B occurred only after an Office of Accountability and Whistleblower Protection complaint. Provider C's inappropriate relationship was not effectively addressed by facility leaders before Patient C died by overdose.

VA policy requires facility leaders to take timely action and gather available evidence through fact-finding reviews and AIBs to address serious matters of interest to the VA.[25]

[25] VA Handbook 0700, 2002; VA Handbook 0700, 2021. The two policies contain similar language related to the initiation of administrative investigations.

A preliminary inquiry, often referred to as a fact-finding review, is an informal evidence-gathering process to obtain readily available information about a range of significant matters within VA. The fact-finding review team is responsible for obtaining statements from key witnesses and collecting relevant evidence on behalf of the convening authority, such as the medical center director (director). A written or verbal report summarizes the fact-finding review findings, evidence, and any recommendations to the director. The director considers the evidence gathered by the fact-finding review group and may determine the matter requires a more formal administrative investigation.[26]

Within VA, an administrative investigation is a formal process to collect and analyze evidence surrounding a matter of interest.[27] An AIB may, on a case by case basis, be charged with investigating a range of serious matters, including evidence or allegations of significant misconduct, neglect of duty, prohibited personnel practices, violations of policies, or other wrong-doing committed by facility employees.[28] The purpose of the AIB is to determine what happened, why, and how best to correct any gaps or deficiencies that may have contributed to the matter occurring in the first place.[29]

Once the investigation is complete, a report is submitted to the director as guidance for future decision-making and action plans based on the findings and possible recommendations rendered by the AIB.[30] The director has 30 days to review and certify the final report.[31] The AIB is

[26] VA Handbook 0700, 2002; VA Handbook 0700, 2021. The 2021 policy defines a preliminary inquiry as an "informal process to obtain and assemble readily available information about an incident, the results of which are used for various purposes including to determine the need for an AIB or a Factfinding." The 2021 policy refers to Factfindings and AIBs as administrative investigations, with Factfindings being "less formal" with a purpose of "ascertaining the magnitude of a problem; gathering and analyzing evidence; identifying and interviewing witnesses; summarizing and recording witness statements; determining whether to initiate more extensive investigations; and, if warranted, assisting in determining the scope of such investigation."

[27] VA Handbook 0700, 2002; VA Handbook 0700, 2021. The 2021 policy reflects AIBs and Factfindings as administrative investigations.

[28] VA Handbook 0700, 2002; VA Handbook 0700, 2021. The two policies contain similar language relating to investigation of serious matters.

[29] VA Handbook 0700, 2002; VA Handbook 0700, 2021. The 2021 policy states, "The purposes of an AIB include, but are not limited to, ascertaining the facts of an issue or incident; identifying and interviewing witnesses and summarizing and recording their statements; gathering material and relevant evidence needed to assess an issue; analyzing and assessing the gathered evidence; and, if requested, providing recommendations."

[30] VA Handbook 0700, 2002; VA Handbook 0700, 2021. Both policies contain similar language pertaining to submitting an AIB report.

[31] VA Directive 0700, *Administrative Investigations*, March 25, 2002, was in place during the time of the events discussed in this report. It was rescinded and replaced by VA Directive 0700, *Administrative Investigation Boards and Factfindings*, August 10, 2021. VHA policy allows the "Convening Authority" (the Facility Director in this case) to extend the review and certification beyond 30 days by documenting reasons that caused a delay. The two policies contain similar language related to documentation of certification delay.

terminated when the director certifies that the AIB completed its work as detailed in the charge letter or when other reasons arise and the investigation is no longer needed.[32]

In early 2018, VISN and facility leaders were notified of a complaint filed with the Office of Accountability and Whistleblower Protection indicating mental health leaders failed to take action against mental health providers involved in inappropriate relationships with mental health patients. Facility leaders initiated an early 2018 fact-finding review and mid-2018 AIB to investigate concerns about Provider A and Provider B having inappropriate relationships.

In early 2019, facility leaders initiated a fact-finding review followed by a mid-2019 AIB to address allegations that Provider C had engaged in an inappropriate relationship with Patient C.

Those investigations included determinations of inappropriate relationships, review of leader actions, and recommendations to address the inappropriate relationships.

Addressing Provider A's Inappropriate Relationship

A clinical supervisor became aware of the relationship between Provider A, a psychology technician, and Patient A in early 2013. A mental health leader informed the OIG that a few months after Patient A graduated from one mental health program but remained in the residential program, there were rumors circulating about the pair being in a romantic relationship. The mental health leader observed that Patient A was spending a significant amount of time in Provider A's office. The mental health leader confronted Provider A with the rumors and what had been observed, but Provider A denied being in a romantic relationship with the patient. The leader reported that during discussions with Provider A, it was explained that such behavior was inappropriate and the provider could lose his or her job. The leader also informed the OIG that it is universally understood within health care that providers do not have sex with patients.

According to the mental health leader, Provider A was given guidance from human resources personnel that the relationship did not violate facility policy because the provider was not licensed and the patient was not assigned to the provider's care. After receiving the guidance, Provider A informed the mental health leader that the pair were, in fact, in a romantic relationship and was open about the romantic relationship with Patient A. Based on the guidance from human resources personnel, mental health leaders did not pursue disciplinary or other administrative actions against Provider A.[33]

The OIG learned that in 2017, Provider A's job title changed from a psychology technician to an addiction therapist. Provider A was certified by the Illinois Alcohol and Other Drug Abuse

[32] VA Handbook 0700, 2002; VA Handbook 0700, 2021. The two policies contain similar language related to terminating an AIB.

[33] In addition, the mental health leaders did not specifically pursue action regarding a violation of Provider A's certification as an addiction therapist because it was not required for the provider's job title at the time the leaders became aware of the romantic relationship. The couple ended their relationship in mid-2014.

Professional Certification Association, a private, non-profit organization that promotes standards for Illinois professionals in the addictions field. Provider A's mental health supervisor documented in late 2017 that Provider A actively maintained Certified Addiction and Drug Counselor certification through training. As a Certified Addiction and Drug Counselor, Provider A was required to adhere to the Illinois Certification Board for the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Code of Ethics and Code of Procedures, which states that "[a] credentialed professional shall not engage in any sexual relationship, conduct, contact, exploitation, or harassment with clients, former clients, clients' partners, clients' relatives, or any active client."[34]

In late 2017, Provider A and Patient A resumed their romantic relationship. During interviews, the OIG found that after learning that the relationship had restarted, the Mental Health Chief at the time consulted with human resources and again, despite the update to facility policy, was told that the relationship did not violate facility policy unless the patient was assigned to the provider's care.

Facility leaders convened a fact-finding review in early 2018 and an AIB in mid-2018 to address Provider A's relationship with Patient A and mental health leaders' initial actions.[35]

AIB Results for Provider A

The AIB determined that Provider A

- began a romantic relationship in 2013 while Patient A was still enrolled in the facility's residential treatment program. The relationship ended in 2014 and resumed in 2017, and
- acknowledged knowing that the relationship violated ethical standards for the provider's Certified Addiction and Drug Counselor professional ethical standards but did not think the standards applied because the certification was not required for the job.

The AIB also determined that

- the Chief of Mental Health did not discuss the matter with Provider A despite acknowledging that the situation was "ripe for abuse" and violated ethical standards, and
- despite guidance from human resources personnel indicating the relationship did not violate facility policy, the Chief of Mental Health should have—but failed to—elevate the matter to senior leadership or seek guidance from the Integrated Ethics Program Officer.

[34] Illinois Certification Board, Code of Ethics and Code of Procedures, accessed July 13, 2020, https://www.iaodapca.org/credentialing/counselor-2/.

[35] VA Handbook 0700, 2002; VA Handbook 0700, 2021. The OIG provided the results of the AIB as the fact-finding review was a preliminary inquiry. The two policies contain similar language relating to authorities who initiate fact-findings prior to an AIB.

The OIG determined that the guidance initially shared by human resources personnel with Provider A and mental health leaders did not correctly apply facility policy related to employee conduct. During interviews, the OIG learned that when Provider A acknowledged the romantic relationship with Patient A, mental health leaders failed to take actions holding the provider accountable after Provider A failed to reveal the truth about the relationship when questioned on three occasions by a mental health supervisor. In addition, the OIG found that when the provider reengaged in the romantic relationship in 2017, mental health leaders and human resources personnel failed to take actions to report the violation of the Certified Addiction and Drug Counselor ethical standards to the Illinois Alcohol and Other Drug Abuse Professional Certification Association.[36]

Addressing Provider B's Inappropriate Relationship

In mid-2016, mental health leaders, including Provider B's direct supervisor, became aware of the relationship between Provider B, a licensed clinical social worker, and Patient B after a mental health staff member saw the pair in public buying groceries together. At the time, Provider B was Patient B's mental health treatment coordinator. Provider B initially denied being in a romantic relationship with the patient but did admit to knowing the patient "back in the day." Provider B's supervisor counseled Provider B on the inappropriateness of a dual relationship and directed Provider B to reassign Patient B to a new mental health treatment coordinator to eliminate the appearance of a dual relationship.

In early 2018, a mental health leader reviewed the facility policy related to inappropriate relationships and believed that it was "not very specific." The leader then sought guidance from the Chief of Human Resources who suggested mental health leaders consult with the facility ethics representative. The mental health leader sent an email seeking guidance from the facility's Integrated Ethics Program Officer, who also served as the facility's Compliance Officer. The mental health leader questioned the permissibility of the relationship based on facility policy and requested a meeting between mental health leaders and human resources staff. The Integrated Ethics Program Officer responded to the email with guidance indicating that "managers must first determine if the employee's, or patient's, behavior is disruptive" and directed the mental health leader to a facility policy on the prevention of patient disruptive behavior. The mental health leader reported that there was no further communication with the Integrated Ethics Program Officer or human resources personnel following the email exchange.

[36] Illinois Certification Board, Code of Ethics and Code of Procedures, accessed July 13, 2020, https://www.iaodapca.org/credentialing/counselor-2/. The Illinois Alcohol and Other Drug Abuse Professional Certification Association's stated mission is to protect the public. The association investigates ethical complaints and takes disciplinary measures against its members to address ethical violations.

Following VISN and facility notification of an Office of Accountability and Whistleblower Protection complaint, facility leaders convened a fact-finding review in early 2018 and an AIB in mid-2018 to address Provider B's relationship and mental health leaders' initial actions.

AIB Results for Provider B

The AIB determined that Provider B

- began a romantic relationship with Patient B in 2016 while the provider was still assigned as the patient's mental health treatment coordinator;
- denied the relationship with Patient B, but the AIB found the couple to be living together in the same residence;
- was aware of the National Association of Social Workers ethical standards, which prohibited such relationships prior to engaging in the relationship but did not think the standards applied; [37] and
- was counseled by a mental health supervisor about dual relationships and directed the provider to reassign Patient B to another treatment coordinator.

The AIB also determined that

- a mental health leader requested guidance from the Compliance Officer/Integrated Ethics Program Officer in early 2018, who addressed the compliance concern of Provider B's relationship and did not consider the ethics consultation process;
- the Ethics Program Officer failed to meet with mental health leaders, as requested by a mental health leader, to gather more information before providing guidance; and
- the Ethics Program Officer did not elevate the matter to the Ethics Consult Team or the Office of General Counsel Ethics Officer for additional guidance.

The OIG determined that facility leaders suspected a romantic relationship between Provider B and Patient B in 2016 and removed Provider B as Patient B's mental health treatment coordinator despite Provider B's denial of a relationship. An ethics consultation initiated by a mental health leader did not prove instructive in managing the issue; therefore, mental health

[37] National Association of Social Workers, *Code of Ethics* accessed December 13, 2019, https://www.socialworkers.org/about/ethics/code-of-ethics/code-of-ethics-english. The National Association of Social Workers code of ethics states that, "Social workers should under no circumstances engage in sexual activities, inappropriate sexual communications through the use of technology or in person, or sexual contact with current clients, whether such contact is consensual or forced." The code adds that, "Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client" and that for exceptions, "it is social workers--not their clients--who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally."

leaders did not take further action to investigate a possible inappropriate relationship or elevate the matter to facility leaders.

Addressing Provider C's Inappropriate Relationship

In late 2017, in an unrelated fact-finding review of inappropriate behaviors in the PRRTP, facility leaders became aware of a potential romantic relationship between Provider C, a licensed clinical social worker, and Patient C. Provider C denied the relationship and the limited evidence led to the fact-finding review team concluding the concern was unfounded.

In late 2018, a former PRRTP patient and acquaintance of Patient C, declined re-referral to the PRRTP due to knowledge of an ongoing relationship between Provider C and Patient C stating, "[Patient C is] all messed up. [Patient C] relapsed, that's why I don't want to go to that program." A mental health supervisor reported the concerns to an employee relations specialist. In consultation with the Chief of Staff, the employee relations specialist requested that the Social Work Service leader conduct an informal review of Patient C's EHR to determine the need for a fact-finding review into the allegation. Based on the review of previous fact-finding documents, the EHR, and speaking with a mental health supervisor, the Social Work Service leader determined that a fact-finding review was unwarranted at that time.

In early 2019, a Health Care for Homeless Veterans peer support reported that[38]

- Patient C expressed interest in substance abuse care but avoided the facility due to Patient C and Provider C's relationship,
- Provider C turned over keys from Patient C's apartment to another facility employee, and
- Provider C's inappropriate relationship with Patient C was addressed by a PRRTP program manager in a staff meeting.

The peer support reported the information to two mental health managers. The facility's Acting Director initiated a fact-finding review in early 2019 and the fact-finding review team concluded that it gathered "credible and tangible evidence" from interviewees confirming the existence of a relationship between Provider C and Patient C and recommended disciplinary action against Provider C. Three days after the fact-finding team's conclusions, Patient C died from an overdose. Three days after Patient C's death, Provider C resigned.

[38] Veterans Health Administration, *Guide to VA Mental Health Services for Veterans and Families*, accessed May 18, 2021, https://www.mentalhealth.va.gov/docs/MHG_English.pdf. A peer support is a veteran with mental illness and provides support to other veterans with similar concerns.

AIB Results for Provider C

In mid-2019, an AIB addressed the relationship of Provider C as well as the other inappropriate relationships by mental health staff. The 2019 AIB concluded that

- Provider C had been involved in a romantic relationship with Patient C,
- a mental health program manager "failed to diligently investigate the allegation of an inappropriate relationship between [Patient C] and [Provider C] due to [an] inability to rationalize or accept that an inappropriate relationship could have been conceivable." and,
- the Chief of Mental Health "failed to diligently investigate the allegation" of an inappropriate relationship.

The OIG determined that fact-finding efforts by facility leaders prior to the early 2019 fact-finding review did not identify that Provider C was in a relationship with Patient C. Following the identification that a relationship with Provider C and Patient C existed, a fact-finding review recommended disciplinary action; however, Provider C resigned six days following that recommendation.

Factors Affecting Efficacy of Facility Leaders' Actions

Updated in 2014, facility policy addressed inappropriate employee conduct and stated that "employees will not initiate or participate in any relationship with patients which could be harmful to the therapeutic environment for the specific patient or result in a non-therapeutic environment for other veterans in the same area."[39] The policy was revised in October 2015 to include language specifying that emotional and sexual involvement between employees and patients would not be tolerated.[40] Facility policy also encouraged employees to seek guidance from the Ethics Consult Team or the Office of the General Counsel Ethics Officer for concerns related to key values and decision-making that affect the environment and culture within the facility.

The OIG determined that facility leaders took initial actions to address the inappropriate relationships of Providers A, B, and C; however, factors affected leaders' ability to take effective action. All three providers were not truthful in initially denying an inappropriate relationship with a patient to supervisors. Front line leaders also sought consultation from human resources personnel and the facility's Ethics Program Officer but did not receive guidance that facilitated effectively addressing the inappropriate relationships. Only following fact-finding reviews and

[39] Facility Policy 05-07, *Employee Conduct and Ethical Standards*, April 2012, updated May 2014. This policy expired in April 2015 and reissued in October 2015.

[40] Facility Policy 05-07, *Employee Conduct and Ethical Standards*, October 2015. This policy was reissued in January 2019; however, it was in place at the time of events discussed in this section.

AIBs, initiated as a result of the Office of Accountability and Whistleblower Protection complaint, did facility executive leadership take constructive action to address the inappropriate relationships.

2: Efficacy of Action Plans to Prevent Future Occurrences of Inappropriate Relationships Between Mental Health Providers and Patients

The OIG determined that facility leaders implemented action plans to prevent future occurrences of inappropriate relationships between mental health providers and patients.[41] Given the egregious nature of the providers' behaviors, facility leaders failed to report Providers B and C to their state licensing boards in a timely manner and failed to report Provider A to his or her professional certification board. The OIG also found that facility leaders initiated additional actions including making changes in mental health leadership.

Administrative Investigation Recommendations

The OIG noted that the fact-finding reviews and AIBs resulted in 22 total recommendations. (See appendix A for details of fact-finding review and AIB recommendations.)

Facility policy states that any follow-up actions for fact-finding reviews are at the discretion of facility executive leaders.[42] While fact-finding review recommendations are non-binding to the facility director, VHA policy requires that facility leaders take necessary follow-up actions based on the results of an AIB.[43] VHA policy asserts that "untimely investigations may limit the effectiveness of corrective action and extend or aggravate disruption of VA facilities and missions;" however, neither VHA nor facility policy identify time frames for follow-up actions.[44]

Three recommendations from the early 2018 fact-finding review did not have facility action plans or target dates (see appendix A, table 1). However, the recommendations were repeated in the mid-2018 AIB (see appendix A, table 2), which were tracked and closed by quality management leaders. Quality management leaders tracked and closed all 22 recommendations

[41] For the purposes of this report, the OIG considers a mental health provider to be a physician, psychologist, nurse, chemical dependency counselor, social worker, or other person, whether or not licensed by the State, who performs or purports to perform psychotherapy.

[42] Facility Standard Operating Procedure 00QM-02, *Fact Finding Process*, February 2019.

[43] VA Directive 0700, 2002; VA Directive 0700, 2021. The two policies contain similar language related to leader's actions in response to an AIB.

[44] VA Directive 0700, 2002; VA Directive 0700, 2021. The 2021 directive omits the quote but identifies an AIB as a high priority assignment. VA Handbook 0700, 2002; VA Handbook 0700, 2021. The two handbooks do not identify time frames for follow-up actions. Facility Standard Operating Procedure 00QM-02, *Fact Finding Process*, February 2019.

resulting from the mid-2018 AIB, the early 2019 fact-finding review (see appendix A, table 3), and the mid-2019 AIB (see appendix A, table 4).

The OIG reviewed the 22 closed recommendations and found that

- four recommendations were closed for administrative reasons,[45]
- thirteen recommendations were closed on or before the target date, and
- five recommendations were closed after the target date.

The OIG determined that frequent turnover in leaders may have contributed to delays in completion of some recommended actions. The OIG learned that between the fact-finding review, charged in early 2018, and the completion of the AIB in mid-2019, there were five Acting Facility Directors. Senior leaders reported to the OIG that their awareness and involvement with the issues was limited due to their acting role.

Licensing Board and Professional Association Reporting

The OIG determined that facility leaders reported Provider B and Provider C to their state licensing board as required but did not report them within suggested time frames for egregious performance.[46] The OIG also determined that facility leaders did not report Provider A to his or her professional association.

VHA requires facility leaders report to a state licensing board "licensed health care professionals whose behavior or clinical practice fails to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients."[47]

The suggested timeframe to complete the state licensing board reporting process is approximately 100 days, unless there is evidence of egregious performance, which requires facility leaders to send a letter to state licensing boards within five days.[48] Egregious performance is defined as conduct that prompts the facility director to "summarily remove the licensed healthcare practitioner from clinical duties because of an immediate and urgent concern for the safety of patients."[49] The OIG determined that the inappropriate relationships reviewed during this inspection met criteria for egregious performance based on the understanding that sexual contact between providers and patients is unethical, exploitative, and harmful with the

[45] Administrative reasons for closure included non-concurrence, Provider C and the Chief of Mental Health leaving employment, and the death of Patient C.

[46] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005.

[47] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005.

[48] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005.

[49] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005.

potential for injury such as mental health disorders, sexual dysfunction, and increased risk of suicide.[50]

The fact-finding review and AIB recommended that facility leaders report Provider B to the state licensing board. Provider B was not removed from clinical duties during the investigations and facility leaders completed the state licensing board reporting process on February 7, 2019, which was 314 days after the fact-finding review and 197 days after the AIB. A human resources employee reported the reason for this delay was that the state licensing board reporting process coincided with the disciplinary process. However, VHA policy states that state licensing board reporting is independent of the disciplinary process specifically to avoid unnecessary delays, and only requires a finding that the reporting threshold was met.[51]

The OIG learned that facility leaders removed Provider C from clinical duties in early 2019. The fact-finding review recommended discipline "commensurate" with Provider C's conduct, which was in violation of the facility and professional ethical standard to never have a sexual relationship with a patient.[52] Provider C resigned before facility leaders could take disciplinary action and they did not complete the state licensing board reporting process until 97 days later on May 13, 2019.

During interviews, the OIG learned that Provider A did not hold a state license and was not removed from clinical duties. However, the first AIB recommended facility leaders report Provider A to his or her professional certification association. Quality Management leaders closed the recommendation when a human resources employee reported that the professional certification association did not have a reporting mechanism in place. However, the OIG found contrary evidence, and determined that Provider A's certification association board had a process for reporting ethical complaints in place when the human resources employee contacted the association in mid-2018.

The OIG concluded that facility leaders did not timely report Providers B and C to their licensing board for egregious performance and failed to report Provider A to his or her professional association. The failure to timely report these behaviors hindered state licensing board and professional association action, potentially impacting patient safety.

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[50] Strasburger, Larry H., Jorgenson, Linda, Sutherland, Pamela, The Prevention of Psychotherapist Sexual Misconduct: Avoiding the Slippery Slope*, American Journal of Psychotherapy*, Vol 46(4), (October 1992, Special Section: Boundaries, behavior, and sexual misconduct: Current issues and the medicolegal interface): 544-555.

[51] VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards, December 22, 2005.

[52] Facility Policy 05-07; Facility Policy, *Bylaws and Rules of the Medical Staff*; National Association of Social Workers, *Code of Ethics*, accessed December 13, 2019, https://www.socialworkers.org/about/ethics/code-of-ethics/code-of-ethics-english.

Facility Leaders' Actions to Prevent Future Occurrence of Inappropriate Relationships

The OIG determined that facility leaders initiated staffing realignment beyond the AIB and fact-finding review recommendations to prevent future occurrences of inappropriate relationships between mental health providers and patients. Facility leaders informed the OIG that they were not aware of additional inappropriate relationships between mental health providers and patients at the time of this inspection.

Facility leaders realigned professional staff out of the Mental Health Service Line to a reporting structure specific to professional discipline. Facility leaders reported that this change was to ensure that each independent, licensed provider was aligned with their individual discipline and held accountable for his or her own professional licensing standards; specifically, nursing and social work.

3: Appropriateness of Facility Leader Actions to Address the Death of Patient C in an Inappropriate Relationship with Provider C

The OIG determined that facility leaders did not take actions to address the circumstances that contributed to the death of Patient C who was involved in an inappropriate romantic relationship with Provider C.

Patient C's Decline Related to Inappropriate Relationship

The OIG identified that facility leaders were aware of the mental health decline of Patient C related to the inappropriate relationship with Provider C.

In mid-2018, Provider C alleged that Patient C, who had become an employee at the facility, was harassing Provider C by phone repeatedly for nearly a year. Provider C reported that the patient threatened to commit suicide if Provider C set limits on the contact. When interviewed, Patient C took responsibility for making the calls, admitting to being lonely and drunk when the calls occurred.

In late 2018, a former PRRTP patient refused to return to the program out of concern for a treatment environment that allowed Provider C and Patient C to engage in a romantic relationship. The patient reported that "now [Patient C is] all messed up, [Patient C] relapsed, that's why I don't want to go to that program." A mental health supervisor documented and shared the information with human resources. Facility leaders, including the Chief of Staff, had the matter reviewed by a social work leader to determine whether a fact-finding review was needed. The social work leader deemed a fact-finding review unwarranted.

As described above, in early 2019, a Health Care for Homeless Veterans peer support identified concerns regarding Patient C and Provider C.

In response, facility leaders initiated a fact-finding review in early 2019. During this fact-finding review, interviewed employees and patients reported a romantic relationship between Provider C and Patient C and that the relationship was the reason for Patient C's clinical decompensation and relapse. According to the fact-finding review, interviewees reported that Patient C was emotionally unstable, using drugs, having frequent episodes of suicidal ideation, and was homeless.

In early 2019, the staff who completed the fact-finding review provided a briefing for facility leaders to alert them to concerns about the safety and well-being of Patient C. The group conveyed interviewees' concerns that the relationship with Provider C may have contributed to Patient C's mental health decline and relapse. They identified that Patient C was aware of the fact-finding review and had expressed concern regarding Provider C's identification. The fact-finding team recommended an intervention to find and facilitate treatment for the patient. An addiction therapist documented in the EHR one attempt to reach the patient, which was unsuccessful. The OIG found no other EHR documentation of efforts to engage Patient C in treatment and services. Patient C died nine days later of an overdose.

Absence of Facility Leaders' Actions

The OIG found that despite the numerous reports of concern about Patient C's behavior and emotional state, facility leaders did not investigate the circumstance of Patient C's death.

VHA and facility policies state that, in special clinical circumstances, a Peer Review for Quality Management may be conducted when

- a patient death results in a mortality review,
- a patient completes suicide,
- a patient experiences an unexpected or negative outcome that may be related to care, and,
- an established organizational group expresses concerns.[53]

When the OIG asked whether there had been an AIB, peer review, or formal investigation regarding circumstances that may have contributed to Patient C's death, the Chief of Staff stated, "I don't think so, I am not a hundred percent sure. [Patient C] was not a patient at the facility. It is not like [Patient C] expired here at the facility, like on the operating room table." Contrary to the statement, Patient C was seen for care at the facility the month prior to death.

VHA and facility policy require disclosures of an adverse event to patients or surrogates, for harmful and potentially harmful events that occur during patient care whether minor or more

[53] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. Facility Policy 11-105, *Peer Review Committee*, October 20, 2017.

serious.[54] VHA Directive 1004.08, *Disclosure of Adverse Events* states that, "adverse events that have had, or are reasonably expected to have, an effect on the patient that is perceptible to either the patient or the health care team" warrant disclosure.[55] If an adverse event occurred that "resulted in or is reasonably expected to result in death or serious injury," facility leaders should conduct an institutional disclosure to inform the patient of the circumstances of the event.[56] The OIG determined that facility leaders did not disclose the circumstances that contributed to Patient C's death to the patient's next of kin.

The OIG was informed by the Facility Director that a review of the circumstances surrounding Patient C's death was conducted but did not make a connection between the inappropriate relationship and the patient's overdose, and Patient C's death did not require a disclosure. In response to an OIG request for clarity on why a clinical disclosure was not provided to Patient C's next of kin, the Chief of Quality Management responded that "[a] clinical disclosure was not warranted in this case. [The facility's] decision regarding clinical disclosure in this case is consistent with VHA Directive 1004.08, *Disclosure of Adverse Events*. The mental health provider involved in this case was held accountable and [the facility] completed all actions associated with both the February 2019 fact-finding and 2019 AIB." The correspondence indicated that the Chief of Staff concurred with the response.

The OIG concluded that facility leaders did not make disclosure to Patient C's next of kin as they deemed disclosure unwarranted. However, the OIG does not concur with facility leaders' determination that disclosure was unwarranted. The facility fact-finding review identified that multiple staff concluded that Patient C's clinical decompensation was due to the relationship with Provider C and that fact-finding review team members were concerned with Patient C's safety. The fact-finding review also identified that Patient C expressed concern regarding the identification of Provider C through the fact-finding review. Patient C died by overdose three days after the fact-finding review's recommendation of disciplinary action for Provider C, who resigned three days following Patient C's death. The OIG determined that multiple factors preceding Patient C's death related to contact with the facility may have had an effect on Patient C, and warrant further review.

[54] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. Facility Policy MCM 00QM-14, *Disclosure of Adverse Events*, May 2016.

[55] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[56] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. Institutional disclosure is a term used by VHA to describe a specific discussion with patients. "A formal process by which facility leaders, together with clinicians and other appropriate individuals, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury." Facility Policy MCM 00QM-14, *Disclosure of Adverse Events*, May 2016.

Conclusion

The OIG determined that while facility leaders took initial action to address the inappropriate relationships of Providers A, B, and C, multiple factors impacted the effectiveness of those actions. All three providers initially denied to supervisors that they had an inappropriate relationship with a patient. Front line leaders also consulted human resources and the facility's Integrated Ethics Program Officer but received no guidance that facilitated addressing the inappropriate relationships. Only following fact-finding reviews and AIBs, initiated as a result of the Office of Accountability and Whistleblower Protection complaint, did the facility take productive action to address the inappropriate relationships and prevent future occurrences.

The OIG found that the two fact-finding reviews and two AIBs resulted in 22 total recommendations. The OIG reviewed the 22 closed recommendations and found that four recommendations were closed for administrative reasons including non-concurrence, the death of Patient C, and Provider C and the Chief of Mental Health leaving employment. Of the remaining 18 recommendations, 13 were closed on or before the target date and 5 were closed after the target date. The OIG determined that frequent turnover in leadership may have contributed to delays in completion of some recommended actions. The OIG concluded that facility leaders did not timely report Providers B and C to their licensing boards for egregious performance and failed to report Provider A to his or her professional association. The failure to timely report these behaviors hindered board and professional association action, which potentially had an effect on patient safety.

The OIG determined that facility leaders initiated additional personnel actions and staffing realignment beyond the fact-finding review and AIB recommendations to prevent future occurrences of inappropriate relationships between mental health providers and patients. The OIG learned that facility leaders made changes in mental health leadership and realigned professional staff out of the Mental Health Service Line to a reporting structure based on professional discipline. Facility leaders reported that this change was to ensure that each independent licensed provider is aligned with their individual discipline and held accountable for their specific professional licensing standards.

The OIG concluded that facility leaders did not conduct a disclosure to Patient C's next of kin as they deemed disclosure unwarranted. However, the OIG does not concur with facility leaders' determination that disclosure was unwarranted. VHA Directive 1004.08, *Disclosure of Adverse Events* states that, "adverse events that have had, or are reasonably expected to have, an effect on the patient that is perceptible to either the patient or the health care team" warrant disclosure. The OIG determined that multiple factors preceding Patient C's death related to contact with the facility may have had an effect on Patient C, and that further review is warranted.

Recommendations 1–3

1. The Veteran Integrated Service Network 12 Director evaluates processes that affected facility supervisors' initial efforts to identify and address facility mental health providers' inappropriate relationships and takes actions as necessary.
2. The VA Illiana Health Care System Director reviews the process for reporting providers to state licensing boards or state certification boards and makes appropriate changes as deemed necessary to ensure timely reporting.
3. The VA Illiana Health Care System Director reviews Patient C's care to determine if there was an adverse event and if so, whether institutional disclosure is warranted.

Appendix A: Fact-Finding Review and AIB Recommendation Tables

Table 1. Early 2018 Fact-Finding Review Recommendations and Number of Days to Action

Number	Recommendation	Target Date	Number of Days to Action After Fact-Finding Review Completion Date
1	Report Provider B to the state licensing board.	None	314 days
2	Revise facility policy to clarify relationships that would be in violation of the policy for the protection of veterans and staff.	None	277 days
3	Conduct facility-wide training for supervisory staff in addressing boundary violations between veterans and staff.	None	307 days

Source: The OIG analysis of documents provided by facility leaders between January 28, 2020, and April 21, 2020.

Table 2. Mid-2018 AIB Recommendations and Number of Days to Action

Number	Recommendation	Target Date	Number of Days from Target Date to Completion
1	Report Provider B to the state licensure board and take appropriate administrative action.	Reporting Action Target Date: 08/31/2018 Administrative Action Target Date: 10/16/2018	160 days 13 days
2	Report Provider A to the professional certification association and take appropriate administrative action.	Reporting Action Target Date: 08/31/2018 Administrative Action Target Date: 10/16/2018	Did not report provider Proposed administrative action: 13 days
3	Take appropriate administrative action against Chief of Mental Health Mental for failure to act.	10/16/2018	13 days
4	Provide training on ethical consults to the Chief of Mental Health and other leaders across the Mental Health Service Line.	10/16/2018	13 days
5	Clearly delineate the roles and responsibilities of clinical supervision across the Mental Health Service Line.	10/16/2018	14 days
6	Reassign Integrated Ethics Program responsibilities to someone outside of the Compliance Office.	Non-concurrence Issued administrative action on 11/5/2018	Non-concurrence
7	Provide training to Mental Health Service Line leadership on identifying ethical conflicts and completing clinical and administrative ethical consults.	04/30/2019	13 days

Source: The OIG analysis of documents provided by facility leaders between January 28, 2020, and April 21, 2020.

Table 3. Early 2019 Fact-Finding Review Recommendations and Number of Days to Action

#	Recommendations	Target Date	Number of Days from Target Date to Completion Date
1	Take appropriate administrative action against Provider C.	None Provider C resigned in early 2019, prior to administrative action Reported to state licensing board	Six days 69 days from completion of fact-finding
2	Initiate an AIB.	04/30/2019 completed prior to target date	-43 days
3	Attempt outreach Patient C in order to reengage veteran in care in a safe environment.	Attempted on 02/28/2019	Patient C deceased in early 2019
4	Consult about a clear and consistent message that will be shared should the veteran or others inquire about these circumstances.	03/29/2019	Completed two days prior to target date
5	Increase clinical supervision on the unit with emphasis on ethical conduct.	03/29/2019	Completed three days prior to target date
6	Conduct ongoing training on professional standards of behavior, best practices for communications with patients, mandatory reporting in good faith when dual relationships or harmful behavior are suspected, and boundary-setting.	05/31/2019 New Employee Orientation: Recreation Therapy: Social Work: Mental Health:	 0 days - 59 days - 90 days -70 days
7	Review recreation outings to deem the appropriateness of having both staff and patients participating together.	04/05/2019 Outings suspended 03/25/2019.	 -11 days
8	Communicate a zero-tolerance policy for unethical behavior and support for staff and patients who voice concerns about misconduct.	04/05/2019 Associate Director Staff Meeting: 04/29/2019 Chief of Staff, Staff meeting: 02/09/2019 Clinical Executive Board Staff Meeting: 03/12/2019 Medical Staff Meeting: 02/20/2019	 24 days Completed prior to fact-finding completion -24 days Completed prior to fact-finding completion

Source: OIG analysis of documents provided by facility leaders between January 28, 2020, and April 21, 2020.

Table 4. Mid-2019 AIB Recommendations and Number of Days to Action

Number	Recommendations	Target Date	Number of Days After First AIB Completion Date
1	Determine whether a Recreation Therapist is held by any governing body or professional organization external to the Department of Veteran Affairs to report inappropriate employee-patient relationships. Take appropriate administrative action.*	07/12/2019 Determined the recreation therapist did not have a professional certification or license: 08/09/2019 administrative action complete	-14 days -11 days
2	Take appropriate administrative action against the PRRTP Program Manager.	08/09/2019 Administrative action complete 07/09/2019	-31 days
3	Take appropriate administrative action against the Chief, Mental Health.	08/09/2019 The Chief, Mental Health retired on 8/30/2019	21 days
4	Further investigate the allegation that staff are interfering with Patient A's access to care.	07/12/2019 Chief of Staff spoke to Patient A on 07/09/2019	-3 days
5	Take appropriate administrative action against a Peer Support Specialist. Counsel Peer Support Specialist against soliciting current patients for his or her future private enterprise.*	08/9/2019 09/16/2019 administrative action complete	38 days
6	Modify Employee Conduct and Ethical Standards policy to provide guidance related to relationship expectations with former patients.	12/20/2019 Modified Employee Conduct and Ethical Standards policy	153 days
7	Establish scripted language to be used when educating staff on Employee Conduct and Ethical Standards. Require all Mental Health Service Line staff and support staff attest to their understanding of the Employee Conduct and Ethical Standards policy and VA Handbook 5025 Part III-IV Employee responsibilities and Conduct.	08/09/2019 08/27/2019	Completed 05/31/2019, prior to AIB completion. Required attestation from staff

Source: The OIG analysis of documents provided by facility leaders between January 28, 2020, and April 21, 2020.

*Recommendations one and five were not a focus of this hotline inspection.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: 1/31/2022

From: Director, VA Great Lakes Health Care System (10N12)

Subj: Healthcare Inspection—Facility Leaders' Response to Inappropriate Mental Health Provider-Patient Relationships at the VA Illiana Health Care System in Danville, Illinois

To: Director, Office of Healthcare Inspections, (54HL04)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review the draft report: Healthcare Inspection—Facility Leaders' Response to Inappropriate Mental Health Provider-Patient Relationships at the VA Illiana Health Care System in Danville, Illinois.

2. I would like to thank the OIG Inspection team for a thorough review which identified opportunities for improvement.

3. I concur with recommendations 1-3. VISN 12 is committed to supporting process improvement and sustainment at VA Illiana and throughout VISN 12.

4. Should you have additional questions, please contact the Quality Management Officer (QMO), VISN 12: VA Great Lakes Health Care System.

(*Original signed by*:)

Victoria P. Brahm, MSN, RN, VHA-CM
Director, VA Great Lakes Health Care System (10N12)

VISN Director Response

Recommendation 1

The Veteran Integrated Service Network 12 Director evaluates processes that affected facility supervisors' initial efforts to identify and address facility mental health providers' inappropriate relationships and takes actions as necessary.

Concur.

Target date for completion: May 31, 2022

Director Comments

The VISN 12 Network Director consulted with the Office of General Counsel and reviewed the local Standard Operating Procedure 05-07 titled, Employee Conduct and Ethical Standards dated January 2020 and validated that the language is robust and clearly articulates the definition of inappropriate relationships as well as the responsibility of the employees to report to their supervisor.

The VISN 12 Network Office conducted a site visit, August 31 through September 1, 2021, to review Danville's Integrity and Compliance Program. The visit was completed to review the program to determine what types of gaps exist between the current program and the requirements of the newly published VHA Directive 1030, VA Integrity and Compliance Program. Gaps were identified and the facility is in progress with implementation of recommendations.

The VISN 12 Human Resources Department, which is now centralized, will be working with the VISN 12 Credentialing and Privileging Officer to schedule additional training for Employee Relations/Labor Relations (ER/LR) Staff to emphasize the rationale and overall process of reporting employees to the State Licensing Board.

The VISN 12 Network Director has coordinated competency scenario-based training by the Healthcare Ethicist for the National Center for Ethics and Healthcare. This training will be provided to the Mental Health Staff.

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 28, 2022

From: Executive Director, VA Illiana Health Care System (550/00)

Subj: Healthcare Inspection—Facility Leaders' Response to Inappropriate Mental Health Provider-Patient Relationships at the VA Illiana Health Care System in Danville, Illinois

To: Network Director, VA Great Lakes Health Care System (10N12)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report "Facility Leaders' Response to Inappropriate Mental Health Provider-Patient Relationships at the VA Illiana Health Care System in Danville, Illinois."

2. We deeply regret the circumstances that impacted the care of these Veterans. As health care professionals, we are committed to providing quality care, maintaining patient well-being, and collaborating for positive patient outcomes.

3. We thank the OIG team for their recommendations which identified areas for improvement. We concur with recommendations 2-3. The leadership team at VA Illiana Health Care System is committed to implementing corrective actions and will diligently pursue all measures to ensure safe, high-quality care for the Veterans that we serve.

(*Original signed by*:)

Staci M. Williams, Pharm D, RPh
Executive Director

Facility Director Response

Recommendation 2

The VA Illiana Health Care System Director reviews the process for reporting providers to state licensing boards or state certification boards and makes appropriate changes as deemed necessary to ensure timely reporting.

Concur.

Target date for completion: March 31, 2022

Director Comments

The VA Illiana Health Care System Executive Director will charter a rapid process improvement workgroup (RPIW) to review the local process for reporting providers to the state licensing boards or state certification boards and make any identified improvements to the local process for reporting.

Recommendation 3

The VA Illiana Health Care System Director reviews Patient C's care to determine if there was an adverse event and if so, whether institutional disclosure is warranted.

Concur.

Target date for completion: March 15, 2022

Director Comments

The VA Illiana Health Care System Executive Director will direct an independent review of Patient C's care by Provider C to determine if there was an adverse event and if so, whether institutional disclosure is warranted. If institutional disclosure is warranted, the Executive Director will direct completion of the disclosure.

OIG Contact and Staff Acknowledgments

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