U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

AUG 6 2007

The Honorable M. Jodi Rell
Governor of Connecticut
State Capitol
210 Capitol Avenue
Hartford, CT 06106

Re: CRIPA Investigation of the Connecticut Valley Hospital, Middletown, Connecticut

Dear Governor Rell:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Connecticut Valley Hospital (CVH) in Middletown, Connecticut. On December 19, 2005, we notified you that we were initiating an investigation of conditions and practices at CVH, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern and practice of conduct that violates the constitutional or federal statutory rights of patients with mental illness who are treated in public institutions.

As part of our investigation, on May 30 through June 2, 2006, we conducted an on-site review of care and treatment at CVH with expert consultants in the areas of psychiatry, psychology, and suicide prevention. In conducting our on-site investigation, we interviewed administrators, staff, and patients, and examined the physical living conditions at the facility. Before, during, and after our visit, we reviewed a wide variety of documents, including policies and procedures, patients' medical records, and other documents relating to the care and treatment of dozens of CVH patients. At the end ofthe tour, consistent with our pledge of transparency and to provide technical assistance regarding our investigatory findings, we provided an exit interview to convey our preliminary findings to counsel and facility and State officials.

As a threshold matter, we wish to express our appreciation to the staff of CVH and to State officials for their extensive assistance and cooperation during our investigation. We hope to continue to work with CVH and the State of Connecticut in the same cooperative manner in addressing the problems that we found. Further, we wish to particularly thank those individual CVH staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment and improve the lives of patients at the hospital. Those efforts were noted and appreciated by us and our expert consultants.

Consistent with our statutory obligations under CRIPA, I now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimal remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at CVH violate the constitutional and federal statutory rights of its residents. In particular, we find that CVH fails to provide its patients adequate: 1) protection from harm; 2) psychiatric and psychological care and treatment; and 3) discharge planning and placement in the most integrated setting. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483, Subpart I (Medicaid Program Provisions); Americans with Disabilities Act (ADA), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see also Olmstead v. L.C., 527 U.S. 581 (1999).

I. BACKGROUND

The General Hospital for Insane of the State of Connecticut opened in 1868 in Middletown, Connecticut. By 1900, the hospital housed approximately 2,000 patients. In 1953, the State's new Department of Mental Health took over administration of the hospital. The facility was renamed Connecticut Valley Hospital in 1961. In the mid-1990s, the State closed two other State hospitals, Fairfield Hills Hospital and Norwich Hospital, and consolidated those programs at CVH.

CVH is currently a 549-bed psychiatric hospital located on a pleasant campus of approximately 100 acres. CVH is the largest of five public in-patient treatment facilities operated by the Connecticut Department of Mental Health and Addiction Services (DMHAS). CVH provides in-patient treatment and care for individuals 18 years and older, from throughout the State, with acute psychiatric, geriatric, forensic, and addiction service needs. There are three main divisions at CVH: the Whiting Forensic Division, the General Psychiatry Division, and the

Addiction Services Division. Approximately half of the CVH patients are in the Whiting Forensic Division, which specializes in services for involuntarily committed individuals involved with the criminal justice system and includes the State's only maximum-security psychiatric units. There are five main residential complexes at CVH: Whiting Forensic Institute (maximum and moderate security forensic units), Battell Hall (general psychiatry and traumatic brain injury units), Woodward Hall (geriatric units), Dutcher Service (forensic community re-entry program), and Merritt Hall (addiction services and general psychiatry units).

II. FINDINGS

Patients of state-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation to ensure their safety and freedom from unreasonable restraint, prevent regression, and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982); Kurlak v. City of New York, 88 F.3d 63, 75 (2d Cir. 1996) (applying the Youngberg standard to treatment given in a mental health hospital). If a patient is admitted to a psychiatric hospital for care and treatment, the State has a duty to treat the patient. Woe v. Cuomo, 729 F.2d 96, 105 (2d Cir. 1984) (holding that if justification for commitment of psychiatric patients rests, even in part, upon the need for care and treatment, then a State that commits must also treat). In the Second Circuit, for the purposes of a patients' constitutional liberty interests, no distinction exists between voluntarily and involuntarily committed patients. Society for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1243 (2d Cir. 1984) ("We need not decide whether . . . residents are [committed] 'voluntarily' or 'involuntarily' because in either case they are entitled to safe conditions and freedom from undue restraint."). Determining whether treatment is adequate focuses on whether institutional conditions substantially depart from generally accepted professional judgment, practices, or standards. Youngberg, 457 U.S. at 353. The State is also obliged to provide services in the most integrated setting appropriate to the individual patient's needs. Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see Olmstead v. L.C., 527 U.S. 581 (1999).

As described in greater detail below, we find that certain conditions and services at CVH substantially depart from generally accepted standards, and violate the constitutional and federal statutory rights of patients. In particular, we find that CVH fails to: (1) adequately protect patients from harm and

undue restraints; (2) provide adequate psychiatric and psychological services; and (3) ensure adequate discharge planning and placement in the most integrated setting appropriate to each patient's individualized needs.

A. PROTECTION FROM HARM

Patients' constitutional liberty interests compel states to provide reasonable protection from harm. Youngberg, 457 U.S. at 315-16; Good Will, 737 F.2d at 1243 (patients of mental health institutions have a right to safe conditions). In order to protect patients from harm, hospitals have a duty to adequately supervise patients known to be suicidal. Dinnerstein v. U.S., 486 F.2d 34 (2d Cir. 1973) (veterans hospital held liable for not adequately supervising patient with history of known suicidal tendencies).

In our judgment, CVH fails to provide its patients with a reasonably safe living environment. The facility too often subjects its patients to harm or risk of harm. CVH fails to protect its patients from harm due to inadequate suicide policies and practices; overuse of unnecessary seclusion and restraint; an inadequate risk management system that fails to collect, organize, and track incidents of harm and abuse for the purpose of identifying and preventing potential incidents of harm and abuse; and a lack of an adequate quality assurance system necessary to ensure quality of care across all aspects of care and treatment.

Unfortunately, CVH has a history of failing to protect its patients from harm. In a 15-month period in 2003 and 2004, three patients at CVH committed suicide by hanging. In each case, it appeared that staff were aware of the suicide risk, but failed to take appropriate action. One suicide occurred nine hours after a nurse identified that the patient had thoughts of suicide, but then failed to assess him for suicide risk or take proper precautions. In the wake of these suicides, CVH has promulgated new policies and procedures. In spite of these remedial efforts, however, training and practices at CVH are not yet in line with generally accepted professional standards.

1. Suicide Prevention

Suicidal behavior in mental health facilities represents a major threat to the lives and well being of the patients. Generally accepted professional standards require mental health facilities to protect patients from self harm. By failing to provide adequate suicide prevention training, failing to provide

adequate suicide risk assessments, failing to address known environmental suicide hazards, failing to properly monitor patients, and failing to adequately review serious suicide attempts, CVH fails to meet this requirement.

a. Inadequate Suicide Prevention Training

Suicide prevention training is not sufficiently addressed in any policy, procedure, or practice at CVH. Three patient suicides occurred at CVH during a 15-month period in 2003-2004. Each of the reviews following these deaths cited the need for suicide prevention training at CVH. Unfortunately, these recommendations have not yet been adequately implemented.

Most new nursing and direct care staff complete a new employee training that devotes approximately 90 minutes to suicide prevention. But, additional or on-going suicide prevention training is not mandatory for CVH employees. CVH recently offered a two-hour "On-going Risk Assessment and Care Considerations for the Suicidal Patient" workshop to all nursing and direct care staff, but there are no plans to establish annual mandatory suicide prevention training for all CVH staff. Rather than establishing a pro-active, permanent training program, the philosophy for offering suicide prevention training at CVH appears to be reactionary and seemingly only tied to patient death.

Even then, required suicide prevention training is not consistently carried out. For instance, following the 2003-2004 suicides, CVH revised its policies to require that all direct care staff, as well as nurses, physicians, and rehabilitation staff, to be certified in first aid and cardiopulmonary resuscitation (CPR). As of May 31, 2006, 100% of physicians and 97% of nursing staff were certified, but only 85% of rehabilitation staff and 73% of direct care staff were certified. The high level of professional staff certification is commendable. However, the certification rate for direct care and rehabilitative staff should be over 90%. Also, although CVH policy requires mock emergency drills to occur on a quarterly basis, as of May 2006, there had not been any mock drills regarding the proper response to a suicide attempt since 2004.

b. Inadequate Suicide Risk Assessments

CVH employs very good screening and assessment tools for the identification of suicide risk. The personnel conducting the assessments, however, lack sufficient training, and the screening process is in need of oversight. The 15-page Admission Nursing

Assessment is very comprehensive and includes at least 12 separate questions related to suicide risk, which will trigger a Suicide Risk Assessment if any of them result in a positive response. However, when we witnessed an Admission Nursing Assessment of a new patient, the intake nurse merely asked, "have you tried to hurt yourself before?" and noted "no evidence" of suicide risk without addressing any of the other lines of inquiry indicated on the Admission Nursing Assessment. This was an inadequate assessment of suicide risk that did not comport with generally accepted professional standards.

In addition, our review of several patient case files indicated that the Suicide Risk Assessment is not consistently completed as required by CVH policy and procedure. CVH policy requires a Suicide Risk Assessment whenever a patient: (1) expresses thoughts of self-harm, (2) displays suicidal behavior, (3) demonstrates a change in mood or behavior, or, (4) as discussed above, yields a positive response during the suicide risk section of the Admission Nursing Assessment. However, interviews with CVH staff revealed that this policy is not well understood. One patient file we reviewed demonstrated that recently a patient with an extensive history of suicidal behavior did not receive a Suicide Risk Assessment at intake and only subsequently received such an assessment after approximately ten months at CVH when he expressed suicidal ideation. Moreover, two of the patients who committed suicide at CVH in 2003 and 2004 never received a Suicide Risk Assessment at intake, despite having histories of prior suicide attempts.

CVH's lack of quality assurance procedures regarding suicide prevention makes it difficult for CVH to properly implement its policies and forms dedicated to suicide risk assessment. CVH does not perform an adequate quality assurance (or performance improvement) audit of the Admission Nursing Assessment process to ensure that intake nurses are correctly completing the suicide risk section of the assessment form. Similarly, there is no appropriate process in place to ensure that a Suicide Risk Assessment is completed on residents when appropriate.

c. Environmental Suicide Hazards

The issue of safe housing for suicidal patients is not sufficiently addressed in any CVH policy or procedure. Environmental suicide hazards were noted as contributing factors in each of the reviews following the three CVH patient suicides during 2003-2004. As a result, CVH initiated some corrective action, including replacing shower heads and ceiling tiles in

bathrooms hospital-wide and installing new ventilation grilles in selective bedroom units.

Despite these initial remedial efforts, during our tour of each patient living area, we found numerous protrusions in bedrooms, bathrooms, and closets that were conducive to suicide attempts by hanging. This is particularly alarming in a psychiatric facility such as CVH with a recent history of suicides. The Whiting Forensic Institute and Dutcher Hall had many environmental suicide hazards, including wire mesh bed frames, large gauge mesh ventilation grates on walls, and unlocked bathroom/showers with non-breakaway grab bars, exposed pipes, interior door knobs, and clothing hooks. In Battell Hall, the shower rooms were locked, but the bathrooms were unlocked and contained many of the protrusions described above. In Merritt Hall, many of the above protrusions were present, as well as non-breakaway clothing rods in clothing bureaus. In addition, bathrooms contained plastic covers on ceiling light fixtures, there were large gauge mesh ceiling ventilation grates in seclusion rooms, and laundry rooms were unlocked with numerous protrusions. In Woodward Hall, clothing hooks were found in shower and bathroom areas.

We recognize that it might not be practical to ensure that all patient rooms at CVH are suicide-resistant, it is certainly reasonable, however, to ensure that all patients placed on special observation status for suicide risk are housed in suicide-resistant rooms and only have access to safe bathroom and shower areas.

d. Inadequate Patient Monitoring

According to CVH policy, all forensic, general psychiatric, and geriatric patients are required to be observed at 15-minute intervals from 7:00 a.m. to 7:00 p.m., and then at 30-minute intervals during the night. However, patients assigned to the Merritt Hall Addictions Services Division are only required to be observed at 60-minute intervals throughout the day and at night. The practice of monitoring the Addictions Services Division patients at 60-minute intervals is grossly inadequate and is not in compliance with generally accepted professional standards for mental health facilities. Although CVH officials attempted to justify this level of observation by suggesting that suicidal patients are screened out of the Addictions Services Division, and that a physician can always increase the observation level of an Addictions Services Division patient following an assessment, such justifications are not persuasive. Many suicidal patients are not identified as suicidal at admission and/or become

suicidal during later stages of a commitment, thus limiting the impact of admission screening on the identification of suicide risk. The fact that a physician can always increase the observation level of patient following an assessment is certainly not unique to the Addictions Services Division; it is a general CVH policy, and irrelevant to setting minimum observation levels. In addition, individuals who are intoxicated and/or going through alcohol/drug withdrawal are at higher risk for suicide. In fact, one of the recent CVH suicides occurred in the Addictions Services Division.

CVH patients on suicide precautions are observed either at 15-minute intervals; continuous observation (in which nursing staff may observe up to three patients at the same time); or one-on-one observation (in which a staff member is assigned to provide continuous, uninterrupted observation of a single patient). Although these three levels of special observation are consistent with generally accepted professional standards, CVH policies do not contain any criteria outlining what specific suicidal behavior translates into a particular observation level.

Finally, CVH does not keep a daily roster of patients on special observation status for suicide risk. This makes it difficult for the facility and treatment teams to track the progress of suicidal patients and hinders accurate communication regarding patients' needs. For example, one patient had an extensive history of suicidal behavior and was placed on "continuous observation status" upon admission. Although he remained on this status level for several weeks, daily progress notes written during this period erroneously listed his observation level as "15-minute observation." In another example, although a patient had been discharged from special observation status, a unit nurse continued to write daily progress notes as if he were still on "15-minute observation," which indicates that the nurse did not review the physician orders.

e. Inadequate Reviews of Suicide Attempts

Although CVH completes appropriate mortality reviews following deaths as a result of patient suicides, the facility does not require adequate reviews following serious suicide attempts. For example, in July 2005, a patient made a serious suicide attempt by attempting hanging while jumping out of an unsecured window. The rope broke, and the patient sustained a series of fractures. This incident demonstrated a policy

breakdown at CVH. The only Focused Treatment Plan Review[1] following the suicide attempt focused solely on treatment changes that were necessary as a result of the patient's physical injuries from the suicide attempt. The patient's team did not address the psychiatric issues involved in the incident and did not modify the plan objectives or interventions relative to suicidal ideation. The team also did not address the environmental hazard presented by the unsecured window.

2. Seclusion and Restraint

The right to be free from undue bodily restraint is the "core of the liberty protected by the Due Process Clause from arbitrary governmental action." Youngberg, 457 U.S. at 316. Consistent with generally accepted professional practice, seclusion and restraints may only be used when a patient is a danger to himself or to others. See Youngberg, 457 U.S. at 324 ("[The State] may not restrain residents except when and to the extent professional judgment deems this necessary to assure such safety to provide needed training."); Goodwill, 737 F.2d at 1243 (holding patients of mental health institutions have a right to freedom from undue bodily restraint and excess locking of doors violates patients' freedom from undue restraint); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1189 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990) ("It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than systematic behavior techniques such as social reinforcement to control aggressive behavior."); Williams v. Wasserman, 164 F. Supp. 2d 591, 619-20 (D. Md. 2001) (holding that the State may restrain patients via mechanical restraints, chemical restraints, or seclusion only when professional judgment deems such restraints necessary to ensure resident safety or to provide needed treatment). Seclusion and restraint should only be used as a last resort. Thomas S., 699 F. Supp. at 1189. Similar protections are accorded by federal law. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1395hh, and implementing regulations, 42 C.F.R. Parts 482-483 (Medicaid and Medicare Program Provisions); 42 C.F.R. § 482.13(f)(3) ("The use of a restraint or seclusion must be . . . [s]elected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm; [and] . . . [i]n accordance with the order of a physician . . . ."); 42 C.F.R. § 482.13(f)(1) ("The patient has the right to be free from

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[1] CVH conducts special treatment team reviews for patients who have been involved in serious incidents. See discussion, infra at 15.

seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.").

CVH's use of seclusion and restraint substantially departs from generally accepted professional standards and exposes its patients to harm due to inadequate reporting, insufficient behavioral programming, poor staff training, and inadequate policies and procedures. Seclusion and restraint at CVH is applied without adequate professional assessment and/or supervision, often with significant clinical error, for the convenience of staff, and without appropriately documented rationale.

Although CVH has the capacity to produce standardized data reports, i.e., reports delineating restraint usage in terms of hours/1000 patient days, and indeed provides standardized data to the National Association of State Mental Health Program Directors, CVH leadership does not routinely use standardized data in its internal analysis of restrictive measures. Instead, meaningless and non-standardized event and hour data are routinely reported without any indicators for determining how to properly interpret the data. This failure places patients at risk of harm due to inaccurate analysis and response to unacceptable trends in the use the restrictive interventions.

CVH policy addresses the need for reviewing individual patient cases when certain seclusion and restraint thresholds have been reached. However, the clinical case review process is flawed. First, the review system eschews the interdisciplinary team process by involving only the attending psychiatrist and service medical director at the first stage of review, rather than the interdisciplinary team. Second, the policy does not call for review by the senior clinicians in each discipline. Third, the policy advances some cases to the headquarters level without adequate interdisciplinary discussion at the hospital level or consideration by an outside consultant with special expertise in the problem behavior. The current process does not assure that proper clinical review takes place at each stage and therefore presents the risk that complicated or "problematic" cases will be elevated to a higher level of review too easily, which allows staff at both the unit level and the hospital level to deflect responsibility for difficult cases.

When seclusion, restraint, and/or pro re nata (PRN or "as needed") psychotropic medications are frequently used with a patient, generally accepted professional standards require the treatment team to reassess interventions and, as necessary, modify the patient's treatment plan. Frequent use of seclusion,

restraints, and/or PRN medications is an indicator that a patient's diagnosis is erroneous, that the treatment plan is inappropriate, and/or that staff are using restrictive practices to replace active treatment, as punishment, or for the convenience of staff.

At CVH, seclusion and restraint are repeatedly used to respond to behaviors in lieu of the development of positive behavior support plans or consideration of other targeted behavioral treatment. Although we were told that many of the current psychology staff had advanced training in applied behavior analysis, we found no evidence of such training in the treatment records of patients whose behavior consistently resulted in seclusion or restraint.

CVH records are replete with examples of repeated use of seclusion and restraint for patients whose target behaviors strongly suggest the need for individualized behavioral treatment plans. For example:

a. A patient was involved in over 30 incidents of seclusion or restraint in the first few months of 2006 before CVH obtained a consult from an outside behavioral analyst. In April 2006, the consultant recommended developing a positive behavior support plan, but CVH did not implement a plan despite continuing episodes of seclusion or restraint over the following 30 days. CVH contacted the consultant again, who gave the same recommendation, but at the time of our June 2006 tour, there was no evidence of a positive behavior support plan in the patient's chart.

b. Another patient experienced over 25 incidents of seclusion or restraint in a six-week period in March and April 2006, including consistent use of PRN psychotropic medication during this period. However, her medical record did not contain any indication that her CVH team considered implementing a behavioral treatment plan.

c. Another patient was involved in three episodes of seclusion or restraint that each lasted for more than 24 hours. On April 9, 2006, a Focused Treatment Plan Review resulted in a recommendation to "implement behavior plan." However, the patient's chart did not reflect any documentation relating to the development of such a plan six weeks later.

d. Another patient required approximately 800 hours of bed and ambulatory restraints in a six-month period due to assaultive and self-injurious behavior. However, the patient's treatment plan did not include any positive behavior supports or strategies to replace the self-injurious behavior that was resulting in such heavy restraint use.

Contrary to generally accepted professional standards, CVH consistently uses seclusion and restraint as an intervention of first resort and fails to consider lesser restrictive alternatives. Although CVH policies require this consideration before using seclusion and restraint, numerous examples illustrate that CVH practice does not comport with its policy.

For example, a patient was agitated and struck out at a nurse, then turned to a mental health attendant and asked, "Are you happy now, motherf-----?" Staff immediately placed him in locked seclusion, although the documentation does not indicate that he continued to present a threat to staff or other patients. Staff checked off "immediacy prevents less restrictive intervention" on the CVH Seclusion/Restraint Form, but did not provide any assessment of the patient's need for locked seclusion at the time. There is no documentation of methods used by staff to respond to this patient with less restrictive procedures, nor is there any documented supervisory review of this use of seclusion or restraint or the patient's treatment plan.

In another example, a patient was restless during snack time and ignored staff's request to sit down. Staff told the patient that if he could not follow directions, he would be asked to utilize a "Voluntary Time Out." Voluntary Time Out is a practice at CVH that allows the patient to "voluntarily" seclude himself in an unlocked room.[2] At that point, the patient became hostile

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[2] When utilizing Voluntary Time Out, CVH does not require staff to document this practice as a restrictive practice. In addition, CVH does not require an assessment of patients placed in Voluntary Time Out. Both factors are problematic because records demonstrate that the practice of Voluntary Time Out is not consistently voluntary and operates more as seclusion. For example, on April 8, 2006, a patient was sent to Voluntary Time Out for 15 minutes. When he decided to terminate his seclusion after five minutes, staff redirected him to the time out room, which led him to become hostile and combative. As a result, staff placed the patient in locked seclusion. Voluntary Time Out

and threatening and, as a result, was placed in four-point restraints to the bed. None of the documentation indicates why it was necessary for the patient to sit down during snack time and why lesser restrictive interventions were not used.

In a gross departure from accepted practice, CVH often uses seclusion and restraint for the convenience of staff and/or as punishment. For example, on April 25, 2006, a patient became agitated when staff reminded him to keep his hand out of his pants in the hallway. The patient stated "I can do whatever I want" and "I'm going to knock your a-- off," and went back to his room. Staff then escorted the patient to the seclusion room with a "show of force." There is no documentation as to why seclusion was necessary, as the patient had returned to his room, and the documentation suggests that the seclusion and "show of force" were intended to punish the patient or teach him a lesson for his threatening comments.

CVH has a variety of policies and procedures relevant to the use of seclusion and restraint. Generally accepted professional standards require psychiatric hospitals to have clearly articulated policies and practices for the safe application of restrictive measures, including but not limited to: (1) definitions of each restrictive practice; (2) the role of each clinical discipline in initiating, authorizing, and continuing a restrictive measure; (3) criteria for discontinuation; (4) criteria for initial and ongoing assessments of patients in restraints; (5) staff training in de-escalating behavioral situations to prevent the need for restrictive measures; (6) staff training in safely applying and discontinuing restrictive measures; and (7) systems for tracking and reporting the utilization of all the above measures.

Policies and procedures at CVH meet applicable standards of care with regard to the initiation of seclusion/restraint by a physician or nurse; face-to-face physician assessment; and on-going assessment. However, with regard to the delineation of release criteria, there are some failures at the policy level. While the CVH policy for release from seclusion and restraint lists several behavioral criteria that "may" be considered as release criteria, the seclusion and restraint documentation delineates release criteria in a pre-printed list of choices. Therefore, instead of a list of clinical prompts for consideration, in practice CVH has created a specific list of

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is not voluntary if there is a pre-set time requirement and should therefore be recorded as seclusion.

acceptable criteria that clinicians must adhere to in every seclusion and restraint situation. This prevents the clinicians from developing truly individualized release criteria relevant to the specific behavioral emergency for which the restrictive intervention is targeted. The CVH policies also state, often in bolded or otherwise highlighted text, that: "Four-point restraints may be gradually reduced to three-point or two-point in preparation for total release from restraint." This language reflects a practice of graduated release in all circumstances, regardless of the findings of clinical assessment in each case. Requiring a graduated 4-3-2 step release without accounting for the clinical appropriateness of the procedure unnecessarily leads to the use of more restrictive measures than appropriate. In addition, the policies do not specify if the graduated release requires a new physician or nurse assessment and order. Any restrictive measure requires formal pre-assessment and an order, even if the patient is being moved to a lesser restrictive measure than previously. This is because the decision to order any level of restrictive measure must take into consideration whether a restriction is necessary at all. The lack of individualized consideration demonstrated by these policies and practices is contrary to generally accepted professional standards.

Finally, four-point restraint to the bed and posey net restraints[3] are no longer considered acceptable restraint use due to their association with potential serious patient injuries. CVH policies acknowledge that these restraint practices are "highly restrictive," but they are still allowed, in contrast to generally accepted professional standards. These restraint practices should be prohibited at CVH.

3. Risk Management

Generally accepted professional standards require that patients be provided a reasonably safe environment through an effective risk management system, including effective clinical oversight; mechanisms for reporting, investigating, and tracking and trending incidents of harm and injury; and identification and implementation of appropriate corrective and preventative action.

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[3] A posey net restraint is a nylon mesh sheet that covers the body while leaving the head, arms, and feet exposed. Padded cuffs at the upper arms, wrists, and ankles are designed to hold a patient's limbs in place while cross-straps attached to the net are used to further secure the sheet to a bed frame to prevent patient movement.

CVH's risk management system substantially departs from professional standards, exposing its patients to an unreasonable risk of harm.

Serious problems plague the clinical oversight mechanisms developed by CVH for the review of individual cases. In 2005, CVH developed a system of Focused Treatment Plan Reviews that mandates special treatment team reviews for patients who have been involved in serious incidents, such as seclusion and restraint or self-injurious behavior. This is commendable because a focused review of an individual's treatment plan following a serious event or behavioral change is required by generally accepted professional standards. However, our investigation revealed that CVH's Focused Treatment Plan Reviews fall significantly short of the standard of care in this area.

For example, one patient's team held a Focused Treatment Plan Review after she attempted suicide by overdose. Her medical record indicated a long history of depression and self-injurious behavior, with an appropriate prescription for therapy to address her problems. At the Focused Treatment Plan Review after her suicide attempt, her team added two new interventions to her treatment plan: (1) "will no longer have feelings of depression" and (2) "will talk to staff when she feels she wants to harm self." The addition of an objective of "will no longer have feelings of depression" is not a "focused" response to a suicide attempt by an individual with a long history of depression. The addition of such an intervention suggests that CVH staff either lack clinical experience or do not take the Focused Treatment Plan Review process seriously. The fact that talking to staff regarding thoughts of self harm was not an objective in her plan prior to the suicide attempt, despite the patient's history of self-injurious behavior, reveals a serious flaw in the initial plan. The need for a focused review arises precisely because the current treatment plan is not effective. The outcome of a true focused review should not merely develop dubious objectives that do not address the patient's behavior.

A similar example of problems with CVH's focused reviews involved a patient who assaulted people seven times between March 29, 2005 and December 15, 2005. His treatment plan indicated that he had a long history of conflicts with others and a potential for violence. The only "focused" interventions added to his treatment plan during the nine-month period were 15-minute checks and unit restriction. While such interventions could have been helpful in reducing incidents of assault, the continuation of his assaultive behavior demonstrated that additional analysis and interventions were necessary to understand and address the

patient's aggression. The lack of targeted treatment in response to these incidents of aggression resulted in the patient being secluded or restrained 17 times in one year.

Another patient was involved in a series of assaults, which resulted in seclusion or restraint, in a six-month period, but the patient's team did not hold a Focused Treatment Plan Review or conduct any reassessment of the patient's plan to address his aggressiveness or the risk of victimization. The team's failure to act put this patient at risk of harm from restraint use and put his peers at risk due to his assaultive behavior.

Our investigation confirmed that CVH has an appropriate system for responding to, and tracking allegations of, staff abuse or neglect of patients. But, CVH lacks an adequate system for collecting, organizing, and tracking patient injuries or incidents. CVH does not have a proper hospital-wide process for tracking patient injury data. Rather, the system varies from division to division and does not adhere to a standardized format. Data are presented in raw numbers of patient-on-patient assaults without a statistical formula that takes into account fluctuations in the CVH census, such as the number of assaults per 1000 patient days. Without standardization, data trending is virtually meaningless, and genuine fluctuations in the assault rate resulting from special causes cannot be distinguished from expected trends. Consequently, CVH leadership is unable to analyze trends and take appropriate action to understand and rectify unexpected variations in results by unit, shift, or staff. Worse yet, the lack of reliable and thorough data may cause administrators and clinical leaders to erroneously believe that alterations are not necessary.

The need for appropriately trended data is further highlighted by CVH's reports on patient injury, which show several months in 2005 in which patient injury rates at CVH were significantly higher than national averages.[4] Although the existence of CVH's patient injury reports demonstrate its ability to collect and cull useful data that could be trended to analyze incidents of injury and other performance indicators, CVH does not appropriately utilize this data. CVH's failure to identify problematic trends in patient incidents and take appropriate and

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[4] CVH provides data on patient injury to the National Association of State Mental Health Program Directors, which reports on national trends and benchmarks in public mental health facilities. We did not have access to patient data reports for 2006.

timely action to address such trends and patterns places its patients at ongoing risk of harm due to injury and abuse.

4. Quality Assurance

Professional standards of care dictate that a hospital like CVH develop and maintain an integrated system to monitor and assure quality of care across all aspects of treatment. Such a quality assurance system incorporates adequate systems for data capture, retrieval, and statistical analysis to identify and track trends in patient treatment. Additionally, a performance improvement mentality must be present in every organizational system and process at the hospital level and in each clinical and administrative department. CVH lacks an adequate quality assurance system. At the hospital level, although CVH produces quarterly quality data reports for the hospital's governing body, CVH does not use appropriate methodology for data reporting and trending. For example, as noted above, data on key indicators are reported in raw numbers rather than as standardized figures that would allow CVH to determine the difference between normal and special cause variation. Without proper data and data analysis, CVH substantially departs from generally acceptable standards in quality management. As a result, CVH is unable to adequately protect its patients from harm.

At the clinical department level, there is much variation in the appropriate use of quality management tools and procedures. Some divisions only monitor timeliness and presence/absence of specific services, while other divisions take a more content oriented approach. The Department of Nursing's program, for example, includes a mix of content and presence/absence indicators. However, Nursing is only aggregating quality assurance data on a quarterly and annual basis, rather than monthly, and therefore cannot properly analyze temporal variations. While some departments describe appropriate corrective actions for poorly functioning indicators, other divisions lack corrective action plans.

The Department of Psychology does not currently have any effective quality management program, but only quality assurance counts of some key indicators without accompanying data. CVH considers Psychology Department quality monitoring a part of the peer review process, which demonstrates a misunderstanding of the various steps involved in sound quality monitoring. Aggregated department-wide performance data, devoid of clinician-identifiers, must be trended monthly and analyzed for special cause variation that can then direct the discipline's management team to targeted performance improvement projects.

The wide variability in approaches to quality management at the clinical department level underscores that there is no clearly defined quality management or performance improvement philosophy or methodology at CVH. There is too great a reliance on auditing for presence/absence and timeliness rather than a clear focus on content when monitoring core disciplines. Also, data is too often aggregated quarterly or yearly, which does not allow enough transparency to determine where fluctuations might be occurring. Finally, in those areas where the core discipline functions are consistently performing at acceptable levels, there is no indication that discipline leadership has moved beyond quality assurance to investigate opportunities for quality improvement.

B. PSYCHIATRIC AND PSYCHOLOGICAL CARE AND TREATMENT

The State has an obligation to provide adequate treatment programs to its patients in mental health hospitals. Woe, 729 F.2d at 105. In a mental health hospital, a patient must be provided a treatment program resulting from interdisciplinary treatment planning. The plan must lead to clinically appropriate goals specific to the patient's needs and designed to support the patient's recovery and ability to sustain the patient outside of the hospital. Inadequate treatment causes harm because it fails to stabilize the patient's clinical condition, leads to the patient's further decompensation, and/or unnecessarily prolongs the institutionalization of the patient.

The State is not providing patients at CVH with adequate mental health services in accordance with generally accepted professional standards. Psychiatric practices at CVH are marked by poor treatment planning, inadequate assessments and diagnoses, and inadequate medication practices. Moreover, psychological services at CVH are inadequate and fail to provide patients with adequate initial assessments and treatment programming.

1. Failure to Provide Adequate Therapeutic And Rehabilitative Services

Under generally accepted professional standards, appropriate therapeutic and rehabilitative services rest upon an adequate treatment planning process and the comprehensive, integrated, and individualized treatment plans that result from that process. Adequate therapeutic and rehabilitative services must incorporate a logical process of interdisciplinary care, including: (1) the formulation of an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines; (2) the utilization of the diagnosis to identify the fundamental

problems that are caused by the diagnosed illness; (3) the development of specific, measurable, and individualized goals that are designed to ameliorate problems and promote functional independence; (4) the identification of appropriate interventions that will guide staff as they work toward those goals; and (5) ongoing assessments. Treatment plans must be revised, as warranted.

As an initial matter, we recognize that CVH is trying to improve its therapeutic and rehabilitative services. The leadership at the State level has a vision of transitioning in-patient mental health services from a traditional medical forensic model to one of recovery and psychiatric rehabilitation. This vision is commendable, as the recovery and psychiatric rehabilitation model embodies the current generally accepted standards of care for individuals with serious mental illnesses. It is clear that the administrative leadership of CVH, beginning with the Executive Director, is committed to this transition.

In practice, however, CVH's therapeutic and rehabilitative services substantially depart from generally accepted professional standards. We reviewed numerous patient charts, conducted interviews with professional and administrative staff, and attended treatment team meetings. From initial diagnosis and assessment to developing the skills necessary for recovery and ultimate community reintegration, CVH's services fail to meet the fundamental requirements for the treatment and rehabilitation needs of its patients.

The results of these deficiencies are grave. Specifically, patients' actual illnesses are not being properly assessed and diagnosed; patients are not receiving appropriate treatment; patients are exposed to potentially toxic treatments for conditions from which they do not suffer; patients are not receiving appropriate psychiatric rehabilitation; patients are at risk of self-harm and harm from other patients; patients are subject to excessive use of restrictive treatment interventions, increased risk of relapses and repeat hospitalizations; and patients' options for discharge are seriously limited, resulting in unnecessary prolonged hospitalization, and, with respect to forensic patients, prolonged involvement in the criminal justice system.

a. Inadequate Treatment Planning Process

The treatment planning process should consist of: (1) team membership that includes all needed disciplines and is consistent and enduring; (2) a team leader, typically the attending

psychiatrist, who coordinates the team meetings; (3) active participation by the patients at their level of functioning; (4) development, review, and modification of the plans in a timely manner to meet the changing status and needs of individuals; (5) a structure that allows the team members to address all patient issues relevant to treatment planning during the meeting time; and (6) team members who are trained in the principles and practice of treatment planning. The treatment planning process should be clearly identified and implemented through adequately detailed policies and procedures.

CVH fails in nearly every aspect of the above-described treatment planning process. First, CVH lacks policies and procedures that set forth the fundamental requirements and expectations of the treatment planning process.

Second, team membership is neither consistent nor enduring. Team meetings lack the consistent participation by an identified core group of relevant disciplines. Teams also fail to include the minimum number of core disciplines required to provide meaningful planning that addresses the full range of a patient's needs. Most troubling, psychologists fail to attend treatment team meetings, which results in the facility's failure to provide behavioral interventions for large numbers of individuals who are appropriate candidates for this treatment.

Third, the interdisciplinary teams lack leadership necessary to provide a structure to facilitate a meaningful treatment planning process. The most glaring deficiency due to the lack of leadership is the failure to ensure completion of assessments prior to the treatment planning session. Without completed assessments, the teams spend much of their time conducting assessments rather than treatment planning. In the remaining time, there is no clear sequence of tasks in terms of who presents what type of information, how, and when. As a result, important relevant issues are not addressed during the planning session, and the information presented is scattered, not meaningful for planning purposes, and not utilized properly.

Fourth, the teams do not have an adequate understanding of the parameters for the timing and nature of effective participation by the patient in the treatment planning process. Teams fail to utilize the input of the individual patients and tend to limit the patients' participation to answering questions oriented toward gathering initial assessment-type information that should have already been gathered. Specifically, the teams fail to obtain the patient's explanation of the illness; perspective regarding the reason for and focus of

hospitalization; the patient's understanding of the objectives, interventions, and discharge criteria for treatment; and the patient's progress and determination of what strengths could be used in designing relevant interventions.

Fifth, the teams fail to follow up on important comments made by the individual patients regarding their progress in treatment or lack thereof. Such failures deprive the teams of opportunities to modify the plan to better address the individuals' needs.

Finally, the team members lack adequate training regarding the principles of psychiatric rehabilitation designed to address the full range of the individuals' needs and not simply ameliorate symptoms of the individuals' illness. Thus, teams fail to promote the individuals' ability to function in the community and cope more effectively with the factors leading to hospitalization.

b. Inadequate Psychiatric Assessments and Diagnoses

Adequate and timely assessments of patients provide the information to support the professionals' understanding of a patient's case. Adequate assessments lead to accurate diagnoses. An accurate diagnosis is a critical factor in developing a treatment plan, which is the foundation and guiding document for treatment interventions. Adequate assessments further establish the parameters for individualized, targeted, and appropriate interventions that meet the medical and psychological needs of the patient. Adequate assessments of a patient for treatment planning purposes requires input from various disciplines under the active direction and guidance of the treating psychiatrist.

At a minimum, an adequate assessment should consist of a comprehensive review of the individual's history and current status, establish a definitive or provisional diagnosis and differential diagnosis, as indicated, and outline a plan of care. The assessment should include: (1) a history of the presenting symptoms and the patient's mental status based on the patient's level of functioning; (2) the setting(s) within which the symptoms occur; (3) the functional significance of behavior, as indicated; (4) an outline of relevant historical findings in the biological, behavioral and psychosocial areas; (5) risk factors; (6) a review and critical examination of past diagnostic conclusions, the individual's response to current and past medications, and other past behavioral and psychosocial interventions; and (7) an evaluation of relevant medical and

neurological pathology and their impact on psychiatric presentation and treatment.

In the majority of cases that we reviewed, CVH psychiatric assessments were inaccurate, incomplete, uninformative, and failed to include sufficient information to: (1) establish an appropriate differential diagnosis and final diagnosis; (2) prescribe treatment and rehabilitation interventions based on proper treatment goals; (3) determine the appropriateness, effectiveness, and safety of medication regimens; and (4) monitor individuals for various risk factors and provide timely interventions to minimize the risk.

Inaccurate and incomplete assessments are resulting in a number of serious deficiencies at CVH. First, the assessments fail to discuss the context within which a patient's symptoms occur and the functional significance of important behaviors. Consequently, the assessments fail to integrate and recommend behavioral and psychosocial interventions, including appropriate individual psychotherapy. In fact, there is no documentation of individual psychotherapy.

Second, the assessments ignore important conditions that require further diagnostic evaluations, specific interdisciplinary and individualized interventions, and/or tracking, analysis, and management of risk factors. Examples of such conditions include cognitive disorders; seizure disorders and the interface with psychiatric illness and treatment; substance abuse; and various maladaptive behaviors, including treatment refusal.

Third, there is widespread failure to obtain behavioral assessments in order to provide interventions for numerous individuals who are candidates for behavioral treatment and who do not benefit from drug therapy. When behavioral interventions are provided, CVH fails to integrate treatment with pharmacological interventions. Specifically, there is no documentation of an exchange of data between the psychiatrist and the psychologist in order to distinguish learned behaviors from those that are targeted for pharmacological therapies, and to refine diagnosis and/or treatment, as appropriate, based on this exchange.

Fourth, the assessments fail to adequately evaluate, monitor, and minimize important risks, particularly with respect to individuals with a current or past history of Tardive Dyskinesia, an involuntary movement disorder that is a

potentially irreversible side effect of antipsychotic drug treatments.

Fifth, there is a general failure to evaluate the needs of individuals suffering from various cognitive disorders. With regard to such disorders, CVH fails to conduct timely and appropriate diagnostic evaluation and mental status examinations, resulting in imprecise and vague diagnoses. When the diagnostic evaluation occurs, including neuropsychological testing and neurological consultations, the results are sometimes either ignored by the psychiatrist or not integrated into diagnostic and treatment approaches.

Sixth, there is general failure to assess and manage co-morbid medical conditions (e.g., polydipsia) or neurological disorders marked by simultaneous presentations of psychiatric and neurological symptoms.

Finally, CVH fails to meet the assessment needs of individuals adjudicated not guilty by reason of insanity and admitted under the jurisdiction of the Psychiatric Security Review Board (PSRB). Specifically, the PSRB does not ensure complete, timely, and appropriate court submissions by the interdisciplinary teams. As a result, the current system of court submissions fails to provide the PSRB with adequate review and analysis of the patient's status to ensure that legal decisions and clinical opinions regarding modifications of forensic status are informed by a thorough and individualized risk assessment.

Numerous examples demonstrate the above deficiencies. In one instance, a patient was given a preliminary diagnosis of dementia without any work-up to justify the diagnosis. The preliminary diagnosis was never finalized and when asked, the treating psychiatrist stated that as far as he knew, there was no plan to finalize the diagnosis. Based upon the clinically unjustified diagnosis that was never finalized, the patient was placed on high risk medications that put the patient at risk of cognitive decline. The justification given for the use of a medication that could cause cognitive decline was that the patient came to the psychiatrist on such medication. The psychiatrist merely continued a potentially dangerous and harmful medication without determining the correct diagnosis upon which the medication was based. The risks for the patient include further worsening of the patient's cognitive state without proper monitoring of the risks and benefits of treatment. In addition to a potentially flawed diagnosis supporting dangerous medication use, the clinicians for this patient could not adequately explain

the rationale for continued hospitalization for this patient who did not appear to meet the requirements for the restrictive level of care at CVH. The justification given by the clinician for continued hospital stay was that "we do not have a nursing home." The outcome for this patient is continued and unnecessarily restrictive in-patient treatment.

In another example, the admission psychiatric assessment for a patient failed to include the necessary information to reach a provisional diagnosis and to guide treatment during early hospitalization. The assessment failed to include an adequate history of the present illness (there was no discussion of presenting symptoms and their recent history), and contained a cursory discussion of past psychiatric history. The mental status examination did not adequately address the nature of thought processes and thought content (described such processes as "appropriate for the most part") or address past hallucinations (stating only that the patient "heard voices in the past"). There was no diagnostic formulation, and the plan of care was vague and meaningless (e.g., "continue patient's stabilization," "observe patient for impulsivity").

The result of such an inadequate initial assessment was that proper treatment objectives could not be formulated that would meet the needs of the patient. As a result, the patient decompensated into maladaptive behaviors that resulted in numerous restrictive interventions, including highly invasive four-point restraints. Further, the annual psychiatric assessments and the psychiatric reassessments failed to even mention the numerous four-point restraints. The reassessments failed to identify target behaviors, summarize interval events, review and evaluate the use of PRN medications, optimize polypharmacy, and refine diagnosis based on treatment response data. These deficiencies also resulted in reactive medication strategies, including the use of high risk medications that posed a danger of addiction in a patient with a history of polysubstance abuse.

CVH's failures carry risks of actual and potential harm to patients in multiple ways. As diagnoses are without clinical justification, patients' actual illnesses are not being properly identified and treated; patients are exposed to potentially toxic pharmacological treatments for conditions from which they do not suffer; patients are not provided appropriate psychiatric rehabilitation; patients are subjected to unnecessarily restrictive restraints; and patients' options for discharge and/or placement in a less restrictive setting are seriously limited, particularly with regard to the forensic population.

c. Psychological Assessments

Generally accepted professional standards dictate that before a patient's treatment plan is developed, facility psychologists provide a thorough psychological assessment of the patient to assist the treating psychiatrist in reaching an accurate diagnosis and provide an accurate evaluation of the patient's psychological needs. Moreover, as needed, generally accepted standards dictate that additional psychological assessments be performed early in the patient's hospitalization to assist with any psychiatric disorders that may need further study and/or diagnosis.

When CVH does psychological assessments, they consistently meet applicable clinical standards. CVH psychologists have the ability to contribute valuable input to patient care. Unfortunately, CVH policy does not require an initial admission psychological assessment for all patients. Instead, referrals for assessment are usually only generated by external requests (e.g., movement throughout the State forensic system) or at the request of the attending psychiatrist. Without an initial psychological assessment, the interdisciplinary teams do not have the unique data provided by a psychological assessment, including the cognitive functioning level and personality dynamics, that is essential to developing a full clinical picture of each newly admitted patient. As a result, CVH patients are not receiving fully integrated treatment plans.

It is also unfortunate that when psychological assessment results are received, including neuropsychological evaluations, they are only marginally integrated into CVH patients' overall treatment plans. For example, a psychologist conducted a neuropsychological evaluation of a patient and made clear recommendations on necessary strategies for development of interventions to compensate for the effects of the patient's cognitive problems. During a treatment plan review several months after the evaluation, the team added "cognitive impairment" to the patient's problem list, but there was no indication that the patient's treatment interventions were modified in accordance with the psychologist's recommendations. Another patient had a neuropsychological assessment, but over seven months later, his team still had not adjusted the patient's treatment plan to reflect the neuropsychological assessment results. The team also failed to integrate the assessment results into the patient's annual psychiatric evaluation, even though the patient's behavior had led to over 25 incidents of seclusion or restraint during the intervening period between the assessment and the annual evaluation. As a result, the patient

continued to participate in group treatment that was clearly designed for patients with a higher level of cognitive functioning.

These problems are compounded by the division of labor in the psychology department, and a lack of adequate supervision of psychology staff. Psychologists at CVH serve in a variety of roles, including conducting assessments and developing treatment programs targeting specific patient sub-populations. However, all of the psychologists at CVH, including the department chair and division chairs, carry full clinical caseloads of 20-25 patients. It appears that psychology is the only clinical department in which the chair carries a standard caseload, which interferes with both supervision and effective quality monitoring. As the leadership of the department is encumbered by the demands of day-to-day clinical practice, the psychology department is without a supervisory structure to develop and effectively monitor the range of services that the profession is capable of providing to the patient population at CVH. Numerous patient records indicate that psychological services at CVH are fragmented and not well-integrated with overall clinical care. As a result, the unique contributions that clinical psychologists could provide at CVH are under-utilized, which leaves CVH patients at risk of harm from overuse of seclusion and restraint and improper diagnoses.

d. Inadequate Ongoing Assessments

Generally accepted professional standards require that psychiatric assessments continue on an ongoing basis after the initial and/or admissions assessment, involve timely and thorough reevaluations of behaviors targeted for treatment, and evaluate new clinical developments. Such ongoing assessments should be conducted at a frequency that reflects the individual's clinical needs, delineate the nature of behaviors targeted for treatment, and thoroughly document clinically significant changes in the individual's condition. Furthermore, to ensure continuity of care when individuals are transferred between units, an additional psychiatric assessment should be done by the referring psychiatrist, particularly when new treatment teams take over the responsibility for providing treatment.

Upon review of numerous patient charts and documentation, in addition to interviews with administrative and professional staff, we conclude that CVH fails to provide adequate ongoing psychiatric assessments. Plans, as a result, are not modified in any significant way in response to the changing needs of the patients.

A number of significant harms arise from CVH's inadequate ongoing assessments. First, the ongoing assessments generally fail to address the patient's response to treatment, or lack thereof, which prevents the team from adequately reexamining the patient's diagnosis and overall treatment plan. Without an adequate evaluation of treatment progress, including an evaluation of critical and current needs relevant to community reintegration, patients suffer from undue prolonged confinement in a restrictive setting such as CVH. Second, without continual reevaluation of treatment goals and progress through ongoing assessments, individuals at CVH are denied services that meet their real and changing needs. Third, CVH's failure to provide appropriate reassessments and treatment modifications prevents the hospital from providing timely and proper modifications of patients' medication regimens, particularly in the face of adverse developments in a patient's condition such as the increased use of restrictive interventions. For those patients subject to seclusion and restraint, the lack of required frequent and ongoing assessments unnecessarily continues such restrictive interventions to the detriment of the patients.

A particularly egregious example demonstrates the above deficiencies. In one case, a patient with severe and extensive behavioral problems, including severe self-destructive behaviors such as cutting his arms and forearms with various objects and overdosing on non-prescribed medications, was given neuropsychological testing. That testing did not support the patient's original diagnosis of attention deficit disorder. However, the patient's psychiatric reassessments and treatment plan reviews failed to address the results and recommendations of the neuropsychological testing that suggested a diagnosis of cognitive disorder. In an interview with the clinician, he admitted that "it should have been addressed, it might have helped."

Ignoring the results of the neuropsychological testing, the patient was continued on stimulants and medications with stimulating effects in the face of the patient experiencing numerous episodes of agitation and serious self-injurious behavior. Furthermore, the patient's chart clearly indicated that the patient was not responding to any of the medications the team tried. CVH clinicians, however, never addressed the need for, or obtained any behavioral consultation to assist in, the management of his maladaptive behaviors, even though the patient was not benefitting from medications. The treating psychiatrist was unable to tell us if the patient received any meaningful rehabilitation aimed at teaching new skills and/or addressing the underlying impairments that perpetuated the patient's prolonged

hospitalization. The CVH clinicians also failed to even track or assess the patient's numerous episodes of restrictive interventions and to modify treatments to minimize such risk. Finally, the patient was prescribed numerous PRN medications for the generic diagnosis of anxiety/agitation (which the further neuropsychological testing called into question). CVH clinicians were not able to state why or under what circumstances PRN medications would be appropriate, yet PRN medications were continually administered. The use of medications in this manner is one example of a systemic deficiency at CVH -- PRN medication is often used for the convenience of staff and/or as a substitute for appropriate regular treatment.

CVH also fails to conduct and provide adequate inter-unit transfer evaluations. In general, such assessments are usually completely absent from chart documentation. When present, the inter-unit transfer assessments are seriously deficient and fail to ensure continuity of care in a number of ways. First, the transfer assessments fail to discuss the course of treatment and rehabilitation in the unit of origin. Second, the assessments lack a summary of medication trials and patient responses to treatment. Third, they fail to delineate the current status of the patient, especially for those behaviors that are targeted for treatment. Fourth, the assessments fail to review various risk factors for the patient. Fifth, they fail to discuss projected discharge plans and to review, in specific terms, what the patient must achieve to be ready for discharge. Finally, the inter-unit assessments fail to discuss the rationale for and anticipated benefits of the transfer.

One example that demonstrates the deficiencies in CVH's transfer assessments involves a patient subjected to numerous restraints, including four-point restraints. That patient was transferred to another unit without an inter-unit assessment just several days after the use of restraints. The accepting psychiatrist continued the same medication regime despite the patient's poor response to those medications and failed to consider a behavioral consultation to assess the functional significance of the patient's behavior or institute appropriate interventions. Subsequent to his transfer, the patient was again placed in four-point restraints. The patient was then transferred to a third unit, again without any clinical rationale or indication of the anticipated therapeutic benefits of this transfer.

In sum, because CVH fails to conduct adequate ongoing assessments, treatment plans are not modified and updated in a timely manner, particularly in response to high-risk behaviors

requiring new interventions and/or modified goals. Insufficient ongoing assessments and inter-unit transfer assessments result in numerous harms to the patients, including lack of treatment and appropriate psychiatric rehabilitation, unnecessarily restrictive restraints, continued risk of self-harm, continued inappropriate medication regimens, and unnecessarily prolonged hospitalization.

e. Inadequate Treatment Plans

As stated above, adequate therapeutic and rehabilitative services depend upon appropriate treatment planning process. Treatment planning process rests upon adequate initial and ongoing assessments that lead to comprehensive, integrated and individualized treatment plans. Generally accepted professional standards instruct that adequate treatment plans should: (1) integrate the individual assessments, evaluations, and diagnoses of the patient that are performed by all disciplines involved in the patient's treatment; (2) identify a patient's individualized strengths and needs; and (3) identify treatment goals and interventions related to those goals that build on the patient's needs in order to support the patient's recovery and ability to sustain him or herself in the most integrated, appropriate setting.

CVH fails to provide adequate treatment plans. After reviewing numerous treatment plans, we found them to be deficient in nearly every aspect listed above. First, the treatment plans are not based on complete and comprehensive interdisciplinary assessments of individuals across all relevant disciplines. The information provided in the treatment plans from the assessments is insufficient to reach adequately reliable and valid diagnoses. As a result, the treatment plans fail to address all relevant psychiatric, behavioral/psychological, medical, nursing, and rehabilitation issues and, in general, fail to delineate the individual's strengths that can be utilized in treatment.

Second, the treatment plans fail to identify the patient's individualized needs. In too many charts, there is a serious disconnection between the psychiatric progress notes about current symptoms and the identification of needs in the corresponding treatment plans. In one illustrative example, the treating psychiatrist indicated that medication noncompliance was the main factor in the patient having repeated episodes of violence, destruction of property, and self-injurious behavior, resulting in frequent use of restrictive interventions. However, the treatment plan did not address treatment refusal or its contributing factors as a focus for appropriate interventions. Furthermore, the vast majority of the plans that we reviewed fail

to include evidence of an adequate review and analysis of the information in the assessments, including a proper synthesis of pertinent history and factors that predispose the individual to the illness and its associated impairments, precipitating events, perpetuating elements, important data regarding previous treatment, and an outline of present needs/status. As a result, the plans are, in general, not meaningful or properly individualized, and they lack foundation to address important treatment and rehabilitation needs of the patients or improve their quality of life.

Third, the objectives or goals of the treatment plan are not aligned with the actual needs of the individuals, when those needs are identified. CVH's treatment plan objectives are often not attainable. The objectives are vague, not individualized, and not stated in measurable, specific, or behavioral terms. They are not written in terms of what the individual must do specifically to achieve recovery and improve functional skills. For example, in one patient's chart, the psychiatric documentation indicated that the "focus of treatment has been to target [the patient's] target symptoms and decrease his aggressive behavior." Such a circular treatment rationale -- to target a person's target symptoms -- is inappropriately vague and is unable to form the basis of a plan to decrease a patient's aggressive behavior. In another example, a patient's annual psychiatric review indicated that the individual's cognitive status was "gravely impaired." However, neither the treatment plan nor the psychiatric documentation included interventions suited for someone with a significant cognitive disorder. The treatment plan further failed to specify how the patient's current group activities were linked to the patient's needs and to document the patient's progress in those activities.

Fourth, in almost all of the charts reviewed, the objectives are not updated to reflect the changing status of the individuals. In general, treatment plan goals tend to be static and are rarely modified in response to the progress of the individuals, or lack objectives that are attainable and account for the individual's level of functioning.

Finally, interventions designated to achieve treatment goals are mostly generic, not tailored to the actual needs of the individuals, and do not lead to any meaningful or measurable outcomes. The following is a summary of deficiencies regarding treatment plan interventions: (1) interventions fail to account for and utilize the patients' strengths and most of the clinicians lack an understanding of the proper formulation of individuals' strengths for planning purposes; (2) interventions

tend to ignore key characteristics of the patient such as motivational and other attributes that can facilitate treatment, rehabilitation, and quality of life; (3) interventions generally fail to utilize those strengths that are correctly identified; (4) interventions are standardized and generally not linked to the goal they are designed to achieve and do not specify the activity, frequency, duration, responsible staff, and the rationale and purpose of the interventions; (5) interventions fail to specify the type and method of measuring the outcome of the interventions, and for some interventions, there is no documentation that the interventions even took place; (6) there is no formalized system to ensure that objectives are identified and matched to the needs of the patients; and (7) the treatment plans do not include any systematic review of the progress of the individual in each specified intervention.

2. Failure to Provide Adequate Psychiatric Services

Under generally accepted professional standards, a mental health hospital has the duty to provide adequate supports and services necessary to implement a patient's treatment plan, including: (1) providing medication treatments based upon evidence of appropriateness, safety, and efficacy; (2) implementing a monitoring system to ensure appropriate use of medications; and (3) instituting an adequate array of relevant treatment programs to meet the specific needs of its patient population. Lack of adequate supports and services can result in improper implementation of treatment plans and can cause substantial harm to patients, including inadequate and counterproductive treatment, serious physiological and other side effects from inappropriate and unnecessary medications, and excessively long hospitalizations.

CVH's psychiatric supports and services substantially depart from generally accepted professional standards, exposing patients to harm and a significant risk of harm due to the failure to exercise adequate and appropriate medication management; monitor medication use and side effects; and provide sufficient staffing to ensure consistent coverage by each attending psychiatrist of an appropriate case load.

a. Inappropriate Medication Management

Medication practices that comport with generally accepted professional standards should ensure that: (1) medication use is part of an interdisciplinary plan of care that considers the impact of medication use on individuals' quality of life; (2) there is appropriate integration of medication treatment with

behavioral treatment, including evidence that medications are not used in lieu of such treatment; (3) there is a documented rationale for medication use based on clinical and empirical criteria, including diagnosis, presenting symptoms, history of response to previous treatments, and the specific risks and benefits of chosen treatments; (4) attention is given by practitioners to high-risk medication uses, including the PRN administration of medications, Stat use of medications (one-time emergency use of medication), polypharmacy (the contemporaneous use of multiple medications to treat the same condition), the use of sedating and habit forming medications for individuals with substance abuse problems, medications that can induce diabetes and weight gain for individuals at risk, medications that can aggravate cognitive impairments, and medications that can have detrimental effects for individuals suffering from irreversible movements disorders; and (5) a hospital has systematic monitors and review mechanisms to ensure the safety, appropriateness, and efficacy of medication uses throughout the facility, including a drug utilization evaluation or monitoring of practitioner's adherence to specific and current guidelines in the use of each medication, adverse drug reaction reporting, medication variance reporting to ensure accurate reporting and analysis of variances in drug use at the facility, systematic monitoring of the high risk medication uses to ensure caution in their use and proper attention by practitioners, and regular updates on drug alerts from the pharmacy department to the medical staff.

CVH fails to meet every one of the above standards of professional care and is unable to afford appropriate pharmacological treatment to its patients. CVH fails to ensure that medications are used as an integral part of treatment planning. There is no documented evidence that the interdisciplinary team reviews patients' psychopharmacological plans in any meaningful way. The treatment plans do not include documentation of the current target symptoms for medication use, the rationale for the selection of these medications, nor the anticipated risks/benefits or parameters for assessment of treatment outcomes. There is no documentation of a review by the team of the possible adverse impact of treatment on the individual's cognition, communication skills, ability to participate in activities, or other indicators of life quality. For example, one patient developed an irreversible movement disorder. The admission psychiatric assessment and the first annual psychiatric assessment do not include this diagnosis or a mental status examination that addresses motor functions. Nine months later, the individual was described, for the first time, to have overt signs of involuntary movements, and the diagnosis was then documented. At that time, the patient's team

appropriately changed his medication. However, the neglect in earlier psychiatric assessments to document an examination of motor functions seems to indicate inattention to possible early signs of movement disorder and failures in providing timely medication adjustments that could have averted or minimized the occurrence of this potentially disabling condition.

CVH also fails to ensure the safety, appropriateness, and efficacy of high risk medication uses. For example, the psychiatrists fail to adequately document the administration of PRN medications, including the circumstances that required the administration of the drugs, the type and doses of drugs administered, or the individual's response to the drugs. As a result, there is failure to adjust treatment based on the use of PRN and Stat medications. At CVH, PRN medications are prescribed for generic indications, typically "anxiety/agitation," without specific information on the nature of behaviors that require the drug administration. PRN medications are sometimes ordered without clear documentation of the target symptoms that require these medications. At times, more than one drug is ordered on a PRN basis, without specification of the circumstances that require the administration of each drug. PRN medications are frequently ordered when the individual's condition, as documented in psychiatric progress notes, no longer requires this intervention. CVH fails to provide timely reassessment of psychiatric diagnosis and treatment strategies following the administration of a Stat medication. Furthermore, CVH fails to provide parameters that ensure the safe and appropriate use of PRN and Stat medications, and the facility does not appear to have a system that tracks PRN medication use to ensure proper utilization.

With regard to the use of benzodiazepines, there is a failure to ensure their appropriate use, particularly for high risk individuals. Benzodiazepines are psychotropic medications that are prescribed for a variety of conditions, but they are particularly used to treat anxiety. However, when used extensively, benzodiazepines can be addicting. Generally accepted professional practice dictates that caution must be used when prescribing them to patients with a current or remote history of substance abuse. At CVH, benzodiazepines are used on a long-term basis without documentation of diagnostic justification. CVH clinicians fail to provide clinical monitoring of their patients for the risks associated with benzodiazepines use, including sedation, addiction, and/or cognitive decline. This failure extends to high risk groups including the elderly, individuals with substance abuse diagnoses, and those with cognitive impairments. Furthermore,

CVH does not provide systemic monitoring of individual or group practitioner trends and patterns regarding the prescription of benzodiazepines to control for the risks of their prescription.

In one example, early in a patient's treatment, he was treated with benzodiazepines. The patient had a diagnosis of polysubstance abuse and a cognitive disorder. Furthermore, he experienced several restrictive interventions, including four-point restraints for challenging behaviors. The benzodiazepines may have reinforced the patient's drug-seeking behavior, may have contributed to his challenging behaviors, and may have worsened his cognitive status, without therapeutic benefits.

In another example, a patient had a polysubstance dependence disorder. The patient's medication regimen included long-term use of two benzodiazepine agents without documented evidence of real therapeutic benefits. The most recent annual psychiatric review included a statement that the individual "had been requesting [a benzodiazepine] on a regular basis for no apparent reason." Given the addicting nature of benzodiazepines, it is puzzling as to why the treating practitioner did not recognize the obvious likely reason for this request. Such inattention was reflected in the lack of documentation of a rationale to explain why the doses of benzodiazepines were continued for so long and not reduced and withdrawn in favor of safer and more effective alternatives in a timely manner.

Another class of high risk drugs are anticholinergic medications, which are used to counter the side-effects of other psychotropic drugs, but have their own harmful side effects. CVH fails to ensure proper use and attention to the risks associated with the unjustified use of anticholinergic medications. Such risks include various degrees of memory impairment, including acute states of confusion, inattention, sedation, aggression, paranoid ideation and/or behavior, mood swings, and restlessness. The risks are particularly elevated for elderly patients, but also rise with the level of dose and any pre-existing mental conditions. At CVH, clinicians generally prescribe anticholinergic medications without documentation of the justifying indications. When documentation does occur, it reveals little attention to associated risks, even for high risk individuals. Finally, there is generally no documentation of timely modifications of treatment to ensure proper use of anticholinergic medications and to minimize risks.

CVH also fails to provide a meaningful system for monitoring the appropriate use of polypharmacy. No system exists to

effectively assess the justification for the use of polypharmacy. Our review of the charts of most individuals receiving polypharmacy revealed a consistent pattern of a failure to employ appropriate strategies that justify this treatment, to document attention to associated risks, including drug-on-drug interactions, and/or to provide timely modification of treatment to achieve appropriate indications and to minimize risks. There is also no evidence of monitoring by the Pharmacy, Nutrition and Therapeutics Committee, the Department of Psychiatry, or the Department of Medicine of individual and group practitioner trends and patterns in the use of polypharmacy. Consequently, no evidence exists of any educational corrective actions to address polypharmacy trends/patterns and to enhance the performance of the medical staff. The current physician peer review system also fails to integrate data regarding polypharmacy.

One example of the above deficiencies in medication management involved the inappropriate use of polypharmacy in the administration of benzodiazepine and anticholinergic drugs. A patient diagnosed with borderline intellectual functioning was repeatedly given a benzodiazepine and an anticholinergic medication on an emergency basis without anyone tracking or assessing such use or monitoring the risks and benefits of such high risk drug use. Excessive use of these two medications can compromise further an individual's cognitive impairments, and particularly so in a patient with borderline intellectual functioning. Furthermore, there was no evidence that the medication regimen was modified in a timely manner, even after the patient experienced several episodes in restraints and seclusion.

Finally, CVH fails to provide systematic monitoring of practitioner trends and patterns regarding the metabolic and endocrine risks associated with the use of new generation antipsychotic agents. Our interviews revealed that the prescribing psychiatrists are, by and large, unaware of the facility's standards regarding this monitoring. In one example, a patient had a diagnosis of obesity and diabetes, yet was maintained on antipsychotic polypharmacy for an unnecessary and prolonged period of time without documented justification. The psychiatric documentation did not address the risks and benefits of antipsychotic polypharmacy in view of the individual's diagnosis. The treating psychiatrist was also unable to explain or show evidence of efforts to provide timely and appropriate modification of the patient's psychiatric regimen to address symptoms that resulted in the use of seclusion/restraints. The treating psychiatrist was unable to speak to the individual's current treatment plan regarding the provision of any

rehabilitative interventions. There was no evidence of any integration of pharmacological and behavior interventions in light of the restrictive procedures. Further, there was no evidence that the treatment team provided a focused treatment plan review of incidents requiring the use of restrictive interventions or made any adjustment of treatment to reduce the risk in the future. Thus, in this one example of significant harm, CVH is administering antipsychotic polypharmacy to a patient with a diagnosis of obesity and diabetes without any evaluation or acknowledgment of the risks of the polypharmacy to the diagnosis, coupled with a history of the limited effectiveness of antipsychotic polypharmacy, as demonstrated by incidents of restraint and seclusion, without any effort by the treating psychiatrist and treatment team to provide analysis, review, or revision of the psychiatric treatment and/or integration of the medications with possible behavioral interventions.

b. Inadequate Medication Monitoring

Generally accepted professional standards further require that a systematic monitoring and reviewing mechanism exist to ensure the safety, appropriateness, and efficacy of medication uses throughout the facility. This mechanism should include: (1) a system to monitor the practitioner's adherence to specific and current guidelines in the use of each medication; (2) an adverse drug reaction reporting system; and (3) a system to report actual and potential variances or errors in the prescription, transcription, procurement/storage, dispensing, and administration of medication.

CVH fails to provide any of the above systematic monitoring to ensure appropriate, safe, and effective medication use in the facility. CVH does not have an adequate system that evaluates medical staff's adherence to established individualized guidelines, with priority given to high risk and high volume medication uses; ensures systematic review of all medications; and determines the order in which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the data collection form, the sample size, and acceptable thresholds of compliance.

CVH's medication guidelines are seriously inadequate. Guidelines are dated, limited to a small number of medications, and inaccurate. Current medication guidelines are also incomplete and fail to address significant risks, particularly for anti-psychotics such as cloxapine, risperidone, olanzapine, carbamazepine, oxcarbazepine, and benzodiazepines. Records

provided by CVH indicate that during the fiscal year 2005-2006, only one medication use review was completed (for aripiprazole). The facility's choice of aripiprazole, a low risk medication with limited use at the time of the review, seems to illustrate a failure in the priorities utilized in the current system. During fiscal year 2004-2005, the facility conducted a medication use review of 253 charts of individuals receiving new generation antipsychotic medications. This study assessed overall patterns of metabolic parameters, but did not utilize an acceptable methodology to assess practitioner's adherence to current medication guidelines. Based on this study, the facility concluded that were no differences among the new generation antipsychotic medications in terms of the metabolic complications. However, this result clearly conflicts with current generally accepted standards and relevant clinical findings, which indicate that these medications do vary significantly in their potential to cause metabolic complications in patients.

CVH also fails to provide adequate guidance to its clinical staff regarding the proper completion of the data collection tool regarding adverse drug reactions, and the investigation and analysis of those reactions. Consequently, there is no mechanism to ensure adequate reporting of those reactions. The data we reviewed indicates a serious under-reporting of adverse drug reactions. CVH also fails to aggregate this data and could provide no documentation of any data analysis regarding trends and patterns of adverse reactions.

CVH's medication variance reporting system is inadequate to identify and assess actual and potential medication use problems or to initiate any meaningful performance improvement activities. For example, the facility does not provide information or have written guidelines and, consequently, fails to ensure that clinical staff is educated regarding the proper methods of reporting medication variances and of providing information that aid the proper investigation and analysis of the variances. Furthermore, the data collection tool itself does not include an adequate outline of factors contributing to the variance (e.g., human, environmental, communication issues, dispensing/storage/administration system variables, or product-related issues). As a result, the current system does not lend itself to adequate analysis regarding contributing factors and/or performance improvement measures that address these factors.

c. Inadequate Treatment Programming

Generally accepted professional standards require that CVH provide an adequate array of relevant treatment programs to meet the specific needs of its patient population. CVH lacks such an array of adequate treatment programs for its patient population. CVH has limited offerings for all individuals regardless of the different profiles of needs that these individuals have. For example, CVH does not provide cognitive development groups to many of its individuals who are diagnosed with various cognitive disorders and are in need of this service. Instead, CVH patients with known cognitive impairments are participating in group treatments that are clearly designed for individuals with a higher level of cognitive functioning. This failure precludes meaningful participation by these individuals in treatment and rehabilitation programs.

Furthermore, CVH generally fails to provide sufficient and appropriately tailored substance abuse programming for individuals who have a need for this service and who reside in the psychiatric and forensic units. The offerings are limited and do not account for the individual's preferences and unique needs. This occurs even for individuals who have serious substance use disorders that have precipitated hospitalization and/or legal difficulties.

3. Failure to Provide Adequate Psychological Services

Psychosocial and rehabilitative interventions improve a patient's ability to engage in more independent life functions, in order to better manage the consequences of psychiatric distress and avoid decompensation in more integrated settings. To be effective, these interventions should address the patient's needs, should build on the patient's existing strengths, and should be clearly organized in an integrated individualized treatment plan. Where needed, interventions that are designed to promote and facilitate skills development and that address behavioral issues should be clearly outlined in an adequately developed behavior plan supported by appropriate individual and group therapies. Adequate behavior plans should contain the following minimum information: (1) a description of the challenging behavior; (2) a functional analysis of the challenging behavior and competitive adaptive behavior that is to replace the challenging behavior; and (3) documentation of how reinforcers for the patient were chosen and what input the patient had in the development of those reinforcers along with the system for earning the reinforcers.

CVH's behavior plans and treatment programs substantially depart from professional standards of care. In no case did the behavior plans at CVH contain the above-stated minimum requirements. In fact, CVH psychologists rarely even develop behavior plans for their patients, even those with serious needs such as aggression, self-injury, or those who are repeatedly the subject of seclusion and restraints. The State told us that only six patients, out of more than 500, were on individualized behavior management plans. In addition, the psychology department told us that one of the six plans was not, in fact, a formal behavioral management plan. However, during our review, we identified behavior management plans in the medical records of more than six patients, which leads us to further question the organization and supervision of the psychology department.

Nevertheless, it is clear that CVH fails to provide behavioral treatment for the vast majority of its patients who need this service. Many of the individuals at CVH who require behavioral treatment but are not receiving that treatment continue to suffer from a variety of psychiatric symptoms and challenging behaviors, including, but not limited to, aggression to others, self-injurious behavior, property destruction, self care deficits, failure to attend treatment, and medication non-adherence. Most of these individuals are unable to benefit from current pharmacological therapies, and their conditions constitute appropriate targets for behavioral interventions. Very few of these individuals, however, have behavioral plans.

CVH policies regarding behavior treatment plans were incomplete and did not meet currently accepted standards of care. We found confusion on all levels as to what constituted an acceptable behavioral treatment plan. Although the State informed us that many of the current CVH psychologists had received some type of advanced training in applied behaviors analysis, and CVH policies require credentialing in this area, in practice, the CVH psychologists fail to provide patients with adequate behavioral supports, resulting in over-utilization of seclusion and restraint. Furthermore, CVH has no mechanism to ensure that direct care staff have received competency-based training on implementing the specific behavioral interventions for which they are responsible, and that performance improvement measures are in place for monitoring the implementation of such interventions. CVH behavior treatment plans did not contain adequate functional analyses nor positive replacement behaviors. A staff psychologist even reported that the planned use of seclusion and restraint is allowed by CVH as an intervention in a behavior management plan. This is in direct conflict with generally accepted professional standards.

With regard to the limited number of behavioral plans that are being offered to individuals, the plans do not comport with generally accepted standards of care and fail to meet the treatment and rehabilitation needs of individuals in a number of ways. First, CVH often fails to provide functional assessment and analysis of why and for what purpose the behavior is occurring, which is an essential prerequisite for effective behavioral interventions. Second, behaviors targeted for intervention are generally not well defined, and are not measurable and observable. Third, some challenging behaviors are not even incorporated in the behavioral plans. Fourth, there is little or no direct observations of target behaviors. Fifth, data that are provided from functional assessments are not used to assess trends in challenging behaviors, to determine the cause of behaviors, or to assess the effectiveness of treatments. Sixth, the identification of precursor behaviors leading up to potentially challenging behavior is inadequate, and there is a failure to obtain data regarding precursors from appropriate sources.

Seventh, strategies to reinforce appropriate behavior are generally inadequate. Eighth, behavioral interventions generally do not include identification of skills designed to replace challenging behaviors or means of teaching these skills. When CVH attempts to identify replacement behaviors, the "replacement behaviors" included in the plan are not functionally equivalent the challenging behavior and, consequently, are unlikely to replace the inappropriate behavior. Ninth, the behavioral interventions generally fail to include strategies to enhance the quality of life of the patients and to develop appropriate, socially-acceptable behaviors. Tenth, there is failure to train staff on plan implementation as well as lack of monitoring of the appropriateness and consistency of implementation by the team or across situations, individuals, or environments. Eleventh, there is lack of follow up assessment of the effectiveness of behavioral interventions. Finally, the behavioral interventions are not integrated with either psychopharmacological therapies or the overall treatment plan.

The existing behavior plans are generally rudimentary, not clearly integrated into the patient's overall treatment plan, and rarely updated. Assessments and evaluations that should shape psychological services frequently are incomplete and/or missing, and unreliable in identifying important elements of the patient's condition. Consequently, interventions often do not address assessed needs regarding functional skills and challenging behaviors, and those interventions actually addressing such needs typically are poorly conceived, excessively generic, and non-

therapeutic. For example, one patient in the Whiting Forensic Division maximum security unit had a behavioral treatment plan. However, CVH had failed to analyze why the patient was behaving the way he was. As a result, although his team updated the plan every few days between April 17, 2006 and May 30, 2006, the team could not formulate appropriate interventions because CVH did not know what was causing the behavior. The patient therefore experienced continued episodes of restraint and seclusion during that time period. Another patient had a behavioral treatment plan since February 2006 that specifically called for the planned use of forced seclusion of the patient in response to a specific behavior, which is contrary to generally accepted standards. Furthermore, the patient's records suggested that, at times, staff improperly executed elements on his hierarchy of punishing stimuli, which led inevitably to planned seclusion.

Our review of CVH's behavioral treatment plans demonstrated that CVH was not following its existing policies on development and implementation of these plans. For example, the behavior treatment plans for two patients contain the use of only punishing interventions if the patients engage in the targeted negative behaviors, without any attempts at replacement behaviors or positive behavioral supports. Their plans contain no analysis of the reasons behind the patients' challenging behaviors and no suggestions for redirecting the patients toward alternative or positive behaviors instead of punishing them. Another patient's behavior treatment plan contained an apparent functional analysis, but then simply narrated specific examples of his behaviors without attention to temporal, environmental, or psychological antecedents. Without this sort of analysis, it is difficult to reveal patterns in the patient's target behaviors. While he received rewards for "positive behaviors," the plan did not specify these behaviors in measurable terms and, in many instances, "positive behavior" appeared merely to be the absence of negative behaviors. The plan did not include any attempt to describe to the patient, in understandable terms, various positive behaviors that he could engage in as part of the learning process. Thus, it was not surprising that the patient experienced on-going episodes of seclusion and restraint.

In another example, the psychiatric documentation for a patient made reference to the individual's proclivity for assaultive behaviors in community placements and during hospitalization, even during periods of symptomatic improvement. Reportedly, these episodes typically occurred when he was asked to do tasks that he did not wish to do, particularly showering. This appears to have been the main reason for continued hospitalization. However, there was no evidence that the

psychiatrist sought or considered behavioral consultations to provide functional assessment/analysis of the behavior and to design and implement interventions to reduce the risk and to facilitate community integration.

C. DISCHARGE PLANNING AND THE MOST INTEGRATED SETTING

Within the limitations of court-imposed confinement, federal law requires that CVH and the State actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with patients' needs. Olmstead v. L.C., 527 U.S. 581 (1999). From the time of admission, the factors that likely will foster viable discharge for a particular patient should be identified expressly, through professional assessments, and should drive treatment interventions. Furthermore, a psychiatric hospital should: (1) have a review process that effectively monitors both length of stay data and difficult discharge cases; (2) develop systems to assure timely return to the community; and (3) ensure that readmission statistics are studied to identify and correct potential breakdowns in care and treatment that lead to unnecessary readmission to more restrictive levels of care.

The discharge planning process for CVH patients falls well short of these standards of care. Consequently, patients are subjected to unnecessarily extended hospitalizations and a high likelihood of readmission, all of which result in harm. CVH fails to initiate, maintain, monitor, or adjust adequate discharge criteria. Several patients' treatment planning documents demonstrate that CVH teams often carry over the "discharge plan" language verbatim from one treatment plan review to another, without assessing new options or any changes that may have effected the patients' discharge plans. CVH fails to maintain an adequate review process necessary to ensure appropriate lengths of stay. As a result, CVH's patients are likely being unnecessarily institutionalized and potentially deprived of a reasonable opportunity to live successfully in the most integrated, appropriate setting.

III. MINIMUM REMEDIAL MEASURES

To remedy the deficiencies discussed and to protect the constitutional and federal statutory rights of the patients at CVH, Connecticut should promptly implement the minimum remedial measures set forth below:

A. Protection From Harm

1. Suicide Prevention

CVH should protect its patients from harm, including self-harm and death from suicide and suicide attempts. At a minimum, CVH should:

a. For patients identified as suicidal, develop and implement a clear and uniform policy for patient assessment and treatment that ensures adequate oversight of the suicide screening process.

b. Ensure a sufficient number of qualified staff to supervise suicidal patients adequately and ensure that physician orders for enhanced supervision be communicated to appropriate staff and implemented.

c. Ensure that staff receive adequate training to serve the needs of patients requiring specialized care for suicidality, including annual suicide prevention training for all staff.

d. Ensure that patients identified as at risk for suicide are housed in safe rooms, free from fixtures and design features that could facilitate a suicide attempt.

e. Ensure that 15-minute (day) and 30-minute (night) checks of all patients are timely performed and appropriately documented.

2. Restraint and Seclusion

CVH should ensure that seclusion and restraints are used in accordance with generally accepted professional standards. Absent exigent circumstances -- *i.e.*, when a patient poses an imminent risk of injury to himself or a third party -- any devise or procedure that restricts, limits or directs a person's freedom of movement (including, but not limited to, chemical restraints, mechanical restraints, physical/manual restraints, or time out procedures) should be used only after other less restrictive alternatives have been assessed and exhausted. More particularly, CVH should:

a. Ensure that restraints and seclusion:

   i. are used in a reliably documented manner;

   ii. will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;

   iii. will not be used as part of a behavioral intervention; and

   iv. will be terminated once the person is no longer an imminent danger to himself or others.

b. Revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards that cover the following areas:

   i. the range of restrictive alternatives available to staff and a clear definition of each;

   ii. the training that all staff receives in the management of the patient crisis cycle and the use of restrictive procedures; and

   iii. the assessments to be conducted by staff attending a patient in seclusion and restraint.

c. Ensure that the use of seclusion and restraint only be initiated by appropriately trained staff.

d. Ensure appropriate assessments are completed by a physician or licensed medical professional of any patient placed in seclusion or restraints.

e. Ensure that if physical, non-mechanical restraint is initiated, the patient is assessed within an appropriate period of time of his/her being physically restrained and an

appropriately trained staff member makes a determination of the need for continued physical, mechanical, and/or chemical restraint, and/or seclusion.

f. Ensure that a physician's order for seclusion or restraint include:

i. the specific behaviors requiring the procedure;

ii. the maximum duration of the order; and

iii. behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.

g. Ensure that immediately following a patient being placed in seclusion or restraint, the patient's treatment team reviews the incident, and the attending physician documents the review and the reasons for or against any change in the patient's current pharmacological, behavioral, or psychosocial treatment.

h. Ensure that staff successfully complete competency-based training regarding implementation of such policies and the use of less restrictive interventions.

i. Prohibit the use of four-point restraint to the bed and posey net restraints.

3. **Risk Management**

CVH should provide its patients with a safe and humane environment and protect them from harm. At a minimum, CVH should:

a. Implement an incident management system that comports with generally accepted professional standards. At a minimum, CVH should:

i. review, revise, as appropriate, and implement comprehensive, consistent

incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents;

ii. require all staff to complete successfully competency-based training in the revised reporting requirements;

iii. review, revise, as appropriate, and implement policies and procedures related to the tracking and trending of incident data and ensure that appropriate corrective actions are identified and implemented in response to problematic trends;

iv. develop and implement thresholds for patient injury/event indicators that will initiate review at both the unit/treatment team level and at the appropriate supervisory level and that will be documented in the patient medical record with explanations given for changing/not changing the patient's current treatment regimen; and

v. develop and implement policies and procedures on the close monitoring of patients assessed to be at risk that clearly delineate: who is responsible for such assessments; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the patient's medical record.

b. Conduct a thorough review of all units to identify any potential environmental safety hazards, or conditions unsupportive of a therapeutic environment and develop and implement a plan to remedy any identified issues.

4. Quality Assurance and Performance Improvement

CVH should develop and implement an adequate quality assurance process in accordance with generally accepted professional standards. At a minimum, CVH should:

a. actively collect data relating to the quality of care across all aspects of treatment;

b. assess these data monthly as standardized figures for trends;

c. initiate inquiries regarding problematic trends and possible deficiencies;

d. identify corrective action;

e. monitor to ensure that appropriate remedies are achieved; and

f. standardize quality management tools and procedures across all clinical departments.

B. Psychiatric and Psychological Care and Treatment

1. Adequate Therapeutic And Rehabilitative Services

CVH should develop and implement an integrated treatment planning process consistent with generally accepted professional standards. More particularly, CVH should:

a. Develop and implement policies and procedures regarding the development of treatment plans consistent with generally accepted professional standards.

b. Review and revise, as appropriate, each patient's treatment plan to ensure that it is current, individualized, strengths-based, outcome-driven, emanates from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments.

c. Ensure that treating psychiatrists verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated.

d. Require all clinical staff to complete successfully competency-based training on the development and implementation of interdisciplinary treatment plans, including skills needed in the development of clinical formulations, needs, goals, and interventions as well as discharge criteria.

e. Develop and implement programs for individuals suffering from both substance abuse and mental illness problems; and develop and implement a cognitive remediation program for individuals with cognitive impairments.

2. <u>Assessments and Services</u>

a. Psychiatric Assessments and Diagnoses

CVH should ensure that its patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. More particularly, CVH should:

i. Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments. Ensure that initial assessments include a plan of care that outlines specific strategies, with rationales, including adjustments of medication regimens and initiation of specific treatment interventions.

ii. Ensure that psychiatric reassessments are completed within time-frames that reflect the individual's needs, including prompt evaluations of all individuals requiring restrictive interventions.

iii. Develop diagnostic practices, guided by current, generally accepted professional criteria, for reliably reaching the most accurate psychiatric diagnoses.

iv. Develop a clinical formulation of each patient that integrates relevant elements of the patient's history, mental status examination, and response to current and past medications and other interventions, and that is used to prepare the patient's treatment plan.

v. Ensure that the information gathered in the assessments and reassessments is used to justify and update diagnoses, and establish and perform further assessments for a differential diagnosis.

vi. Review and revise, as appropriate, psychiatric assessments of all patients, providing clinically justifiable current diagnoses for each patient, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.

vii. Develop a monitoring instrument to ensure a systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes and transfer and discharge summaries, and require the physician peer review system to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective follow-up action.

b. Psychological Assessments

CVH should ensure that its patients receive accurate, complete, and timely psychological assessments, consistent with generally accepted professional standards, and that these assessments support adequate behavior and treatment programs. To this end, CVH should ensure that:

i. Upon admission and prior to developing the treatment plan, psychologists provide a psychological assessment of the patient that will be integrated into the patient's overall treatment plan.

ii. Where applicable, if behavioral intervention is indicated, further assessments be conducted in a manner consistent with generally accepted professional standards of applied behavioral analysis.

c. Psychiatric Services

CVH should provide adequate psychiatric supports and services for the treatment of it patients, including medication management and monitoring of medication side-effects in accordance with generally accepted professional standards. More particularly, CVH should:

i. Develop and implement policies and procedures requiring clinicians to document their analyses of the benefits and risks of chosen treatment interventions.

ii. Ensure that the treatment plans at CVH include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, and possible side effects. Reassess the diagnosis in those cases that fail to respond to repeat drug trials.

iii. Ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, CVH should:

a. Ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;

b. Ensure regular exchange of data between the psychiatrist and the psychologist and use such exchange to distinguish psychiatric symptoms that require drug treatments from behaviors that require behavioral therapies; and

c. Integrate psychiatric and behavioral treatments in those cases where behaviors and psychiatric symptoms overlap.

iv. Ensure that all psychotropic medications are:

a. prescribed in therapeutic amounts;

b. tailored to each patient's individual symptoms;

c. monitored for efficacy against clearly-identified target variables and time frames;

d. modified based on clinical rationales; and

e. properly documented.

v. Ensure that the psychiatric progress note documentation includes:

a. the rationale for the choice and continued use of drug treatments;

b. individuals' histories and previous responses to treatments;

c. careful review and critical assessment of the use of PRN medications and the use of this information in timely and appropriate adjustment of regular drug treatment;

d. justification of polypharmacy in accordance with generally accepted professional standards; and

e. attention to the special risks associated with the use of benzodiazepines, anticholinergic agents and conventional and atypical antipsychotic medications with particular attention given to the long-term use of these medications in individuals at risk for substance abuse, cognitive impairments, or movement and metabolic disorders.

vi. Institute an appropriate system for the monitoring of individuals at risk for TD that includes a standardized rating instrument used by properly trained staff in a timely manner. Ensure that the psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments.

vii. Institute systematic monitoring mechanisms regarding medication use throughout the facility. In this regard, CVH should:

a. Develop, implement and continually update a complete set of medication guidelines that address the indications, contraindications, screening procedures, dose requirements and expected individual outcomes for all psychiatric medications in the formulary that reflects generally accepted professional standards;

b. Based upon adequate medication guidelines, develop and implement a Drug Utilization Evaluation procedure based on adequate data analysis that includes both random and systematic reviews, prioritizes

high risk medications, and produces individual and group practitioner trends;

c. Develop and implement a procedure for the identification, reporting and monitoring of adverse drug reactions (ADRs) that includes the definition of an ADR, likely causes, a probability scale, a severity scale, interventions and outcomes and that establishes thresholds to identify serious reactions;

d. Develop and implement an effective Medication Variance Reporting system that captures both potential and actual variances in the prescription, transcription, procurement/ordering, dispensing/storage, administration and documentation of medications, and identifies critical breakdown points and contributing factors; and

e. Develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses.

viii Establish monitors to ensure the appropriate use of high-risk medications, including:

a. long-term benzodiazepine and anticholinergic medications particularly for individuals with substance use problems, cognitive impairments and current or past history of Tardive Dyskinesia, as indicated; and

b. the use of conventional antipsychotics, particularly for individuals with current or past history of Tardive Dyskinesia.

d. Psychological Services

CVH should provide psychological supports and services adequate to treat the functional and behavioral needs of its patients according to generally accepted professional standards, including adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, CVH should:

i. Ensure psychologists adequately screen patients for appropriateness of individualized behavior plans, particularly patients who are subjected to frequent restrictive measures, patients with a history of aggression and self-harm, treatment refractory patients, and patients on multiple medications.

ii. Ensure that behavior plans contain a description of the challenging behavior, a functional analysis of the challenging behavior and competitive adaptive behavior that is to replace the challenging behavior, a documentation of how reinforcers for the patient were chosen and what input the patient had in their development, and the system for earning reinforcement.

iii. Ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not the use of aversive contingencies.

iv. Develop and implement policies to ensure that patients who require treatment for substance abuse, cognitive impairment, and forensic status are appropriately identified, assessed, treated, and monitored in accordance with generally accepted professional standards.

v. Ensure that psychologists treating patients have a demonstrated competence, consistent with generally accepted professional standards, in the use of functional assessments and positive behavioral supports.

vi. Ensure that psychologists integrate their therapies with other treatment modalities, including drug therapy.

vii. Ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately against rational, operationally defined, target variables and revised as appropriate in light of significant developments and the patient's progress, or the lack thereof.

C. <u>Discharge Planning and Placement in the Most Integrated Setting</u>

Within the limitations of court-imposed confinement and public safety, the State should pursue actively the appropriate discharge of patients and ensure that they are provided services in the most integrated, appropriate setting that is consistent with patients' needs. More particularly, CVH should:

1. Identify at admission and address in treatment planning the criteria that likely will foster viable discharge for a particular patient, including but not limited to:

   a. the individual patient's symptoms of mental illness or psychiatric distress; and

   b. any other barriers preventing that specific patient in transitioning to a more integrated

environment, especially difficulties raised in previously unsuccessful placements.

2. Include in treatment interventions the development of skills necessary to live in the setting in which the patient will be placed, and otherwise prepare the patient for his or her new living environment.

3. Develop and implement a quality assurance or utilization review process to oversee the discharge process, including:

   a. developing a genuine utilization review process based on the principles articulated in Part C that discusses discharge planning and placement in the most integrated setting, and assure that data systems supportive of this process are developed and maintained; and

   b. having psychiatrists provide an estimate of the length of hospitalization needed to provide patient stabilization at the time that the master treatment plan is developed and review this estimate at each treatment plan update meeting, making modifications when necessary that are documented in the patient's record and captured in the utilization review process.

IV. CONCLUSION

The collaborative approach that the parties have taken thus far has been productive. We hope to continue working with the State in this fashion to resolve our significant concerns regarding the care and services provided at CVH.

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until 10 calendar days from the date of this letter.

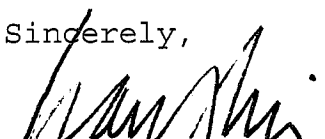
Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. These reports are not public documents. Although our

expert consultants' reports are their work - and do not necessarily represent the official conclusions of the Department of Justice - their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing areas requiring attention.

We are obliged by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will be contacting your attorneys to discuss this matter in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,



Wan J. Kim
Assistant Attorney General
Civil Rights Division

cc: The Honorable Richard Blumenthal
Attorney General
State of Connecticut

Thomas A. Kirk, Jr., Ph.D.
Commissioner
Department of Mental Health and Addiction Services

Luis Perez, L.C.S.W.
Chief Executive Officer
Connecticut Valley Hospital

Mr. Kevin J. O'Connor
United States Attorney
District of Connecticut