U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

CRIPA Investigation

MH-VA-001-001

April 20, 1995

The Honorable George Allen
Governor of Virginia
State Capitol
Ninth & Grace Streets
Richmond, VA 23212

Dear Governor Allen:

On July 1, 1994, we notified you of our intent to investigate the Northern Virginia Mental Health Institute ("NVMHI") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. Consistent with statutory requirements, we are now writing to advise you of the findings of this investigation.

By way of background, after notifying you of our intent to investigate NVMHI, we contacted Commonwealth officials to arrange an inspection of the facility. Such inspections are routinely conducted in CRIPA investigations and enable us to impartially and independently evaluate allegations regarding a facility. We then submitted a document request on August 19, 1994. Facility staff assembled the documents and sent them to Virginia's Office of the Attorney General. Shortly afterwards, we were informed by attorneys for the Commonwealth that Virginia had decided not to grant us access to NVMHI or provide the requested documents.

Representatives from the Commonwealth met with me on January 31, 1995, to resolve certain Commonwealth concerns regarding this investigation and other pending investigations. At this meeting, access to NVMHI was again denied. In an effort to resolve this matter amicably, we agreed to again meet with Virginia officials and discuss in greater detail the basis for our investigation of NVMHI. On February 14, 1995, attorneys met with Virginia officials and provided a more detailed summary of the reasons for our investigation of NVMHI. Commonwealth officials once again refused to grant access to the facility.

Throughout the course of this investigation, Commonwealth officials have refused to cooperate with this investigation and have acted to frustrate its conduct. Most recently, on

March 17, 1995, Commonwealth officials, through counsel, advised us that access might be granted by the end of the year provided we agreed to accept numerous demands, including accepting your counsel's views regarding other unresolved investigations. During the time that we have endeavored to work cooperatively with Commonwealth officials, nine months have passed since issuance of our investigation notice letter. Yet, Virginia officials now ask that we wait until the end of 1995, at least eighteen months since issuance of our notice letter, before they will grant access to NVMHI. This course of conduct is unacceptable.

Notwithstanding lack of access, we have gathered numerous facts which indicate that conditions at the facility deprive NVMHI patients of their constitutional rights and violate the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101 et seq., Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794 et seq., Title XVIII of the Social Security Act ("Medicare"), 42 U.S.C. § 1395i et seq., and implementing regulations for those statutes.

Patients of state operated psychiatric facilities have a fundamental Fourteenth Amendment due process right to reasonable safety and adequate medical care, including psychiatric services. Youngberg v. Romeo, 457 U.S. 307 (1982). Patients have a right to adequate psychiatric treatment which includes treatment programs designed to protect their liberty interests. Such treatment programs must be sufficient to permit each patient an opportunity to improve or be cured and to function as independently as their psychiatric conditions permit. See, e.g., Wyatt v. Stickney, 325 F.Supp. 781, 784 (M.D. Ala. 1971). Such programs must provide opportunities for patients to acquire and maintain skills that will enable them to cope more effectively with the demands of their own person, their environment, and to raise the level of their mental, behavioral, physical, and social efficiency. Gary W. v. Louisiana, 437 F.Supp. 1209, 1219 (E.D. La. 1976); see also, Thomas S. by Brooks v. Flaherty, 699 F.S. 1178 (W.D. N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990), cert. denied, Flaherty v. Thomas S. by Brooks, 498 U.S. 951 (1990). Moreover, a state cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in the community either independently or with assistance. O'Connor v. Donaldson, 422 U.S. 563, 576 (1975). Federal statutes and regulations also create rights and place obligations on state institutions.

The numerous constitutional and statutory deficiencies, which were previously summarized during the February 14, 1995 meeting with officials in the Virginia Attorney General's Office, include:

I. Inadequate mental health care.

NVMHI does not provide adequate mental health care. Due to the absence of such basics as patient histories, memory and intelligence appraisals, adequate and consistent diagnoses, evaluations, and treatment plans, psychiatric care is grossly inadequate. Those treatment plans which exist are often not individualized, lack essential elements, and are not consistently implemented. In these circumstances, patients are kept in idleness where they frequently are victimized by other patients who, likewise, are not engaged in any professionally based program of psychiatric treatment. Such idleness and lack of treatment exacerbate their mental illnesses and serve to make patients more withdrawn, aggressive, or suicidal -- all of which present direct threats to their health and safety.

Lack of staffing contributes to lack of adequate treatment, delaying prompt and adequate evaluation and precluding the delivery of necessary care. Lack of professional staff has precluded the functioning of appropriately composed interdisciplinary teams which professional standards require for critical treatment decisions. Significantly, patients seldom are seen by a psychiatrist. It is reported that treatment sessions often consist of little more than once a month meetings between a group of psychiatrists and a patient.

There are numerous indications that there are too few available psychiatrists to direct patient care. Their progress notes are too sparse to be meaningful. Staff do not share critical information or coordinate treatment efforts and attempts to monitor and evaluate the quality of services have been haphazard at every level.

Absent adequate treatment, discharge planning is seriously compromised. Moreover, there is no indication that those patients who are discharged receive appropriate follow-up care or that there is a system in place in the community which can effectively monitor them or meet their needs when discharged.

In sum, psychiatric care at NVMHI fails to comport with generally accepted professional standards. Indeed, the absence of care is so severe that it poses direct threats to the health and safety of patients.

II. Inadequate staffing.

The facility also lacks adequate numbers of qualified professional and direct care staff. For several years, NVMHI has had a chronic nursing shortage and has at times been unable to ensure that a nurse is available during all shifts. There are not enough psychologists or psychiatrists to provide consistent, timely, and meaningful treatment of patients. Some NVMHI

psychologists have lacked the necessary credentials for providing therapy. Psychiatrists who are counted as full-time employees are not actually available to provide treatment at NVMHI because they work at other facilities. There is no full-time, regular medical doctor on site. The turnover rate for other professional staff, such as social workers, is high, compromising continuity of care. Direct care staffing is inadequate as well.

The staffing and other problems at NVMHI have become so severe that staff have repeatedly resorted to calling the police when patients become unruly. Several patients have been arrested at the request of staff after various incidents. This unorthodox method of dealing with patients indicates that staffing is grossly inadequate, and those staff available are ill-equipped to address the needs of these patients.

In sum, the lack of staff at NVMHI is severe and precludes adequate care and treatment of patients.

III. Inadequate medical care and dangerous medication practices.

A county hospital is located only a few hundred yards from NVMHI, yet there have been a number of well-publicized deaths which are linked to substantial delays in providing adequate medical care. Within the past few years, one patient died partly because of a toxic buildup of antidepressants in her body. Another patient died from meningitis after a psychiatrist requested that she be seen by an internist who failed to appear to assess her life-threatening condition. More generally, medical records are incomplete and lack basic information, resulting in inappropriate treatment. For example, patients are placed on medications without any evaluation of their medical histories.

Drugs are prescribed without adequate explanation in the records. Polypharmacy has been a problem at NVMHI, with some patients on more than a dozen drugs during their stay at the facility. Blood testing and monitoring for medication side effects is haphazard, and patients have been placed at risk of harm from tardive dyskinesia and toxic drug side effects.

The lack of adequate medical care is systemic at NVMHI, and especially severe in the area of emergency medical services. Deaths of the kind described above call into serious question the ability of current staff to address life threatening illnesses.

IV. Failure to protect patients from harm.

Patients are excessively restrained and secluded, and records do not adequately explain the reasons for such actions. Patients, including suicidal patients, have been left in restraints or seclusion for hours at a time, without being

regularly checked or having their needs attended to by qualified staff. Due to inadequate staffing, NVMHI is unable to provide one-on-one monitoring for many residents who are suicidal or are in restraints or seclusion and require such close supervision. Patients have been injured while being restrained and are then left unattended by medical personnel.

Staff have been quick to call the police when a patient behaves violently towards staff, but fail to take action when one patient attacks another. Many incidents are occurring without anyone noting them accurately in incident reports. The facility's environment has been inimical to therapy, with staff and patients verbally and physically harassing other patients.

Staff supervision is inadequate, and NVMHI has had problems with escapes and suicides. Patients, identified by professional staff as suicidal, have been allowed to wander off the grounds without supervision. Patients under suicide watch have committed suicide under circumstances which indicate staff neglect.

In sum, the lack of supervision and care is so grave that patients have been subjected to severe harm, including death. Such conditions violate the constitutional rights of patients.

V. <u>Inadequate physical conditions.</u>

NVMHI has a roach and rodent problem. Such problems indicate environmental health and safety problems at NVMHI, to which the Commonwealth has not responded. The Commonwealth's unwillingness to provide documents regarding environmental health and safety concerns indicates a high degree of indifference to issues, such as fire safety and sanitation, which are easily addressed and documented.

MINIMUM REMEDIAL MEASURES

The following remedial measures need to be implemented in order to meet constitutional and statutory requirements:

I. <u>Mental health care.</u>

NVMHI must evaluate, diagnose, treat, and discharge patients consistent with generally accepted professional standards. Patient treatment must be appropriate, individualized, coordinated, and properly managed. Such programs must allow each patient a reasonable opportunity to be cured, function as independently as possible, and cope as effectively as possible with his or her needs. Patient records should be complete and properly updated. NVMHI must provide adequate discharge planning, including appropriate community-based mental health services, to meet the needs of the patient upon discharge. In addition, the Commonwealth must develop adequate quality

assurance mechanisms to ensure the appropriateness of post-discharge services.

II. Staffing.

NVMHI must retain adequate numbers of qualified professional and direct care staff to develop and implement treatment programs and care for patients and provide appropriate supervision.

III. Medical care and medication practices.

Medical staffing must be adequate to ensure prompt professional evaluation of medical problems by a regular medical doctor. All use of drugs must be professionally justified, carefully monitored, documented, and reviewed.

IV. Protection from harm.

Seclusion and restraint policies must comport with professional standards and must be conducted in a safe and appropriate manner. Use of seclusion and restraints must be properly documented and must be reviewed in a timely fashion by qualified staff. NVMHI must provide adequate, including one-on-one, supervision of suicidal residents.

V. Environmental health and safety.

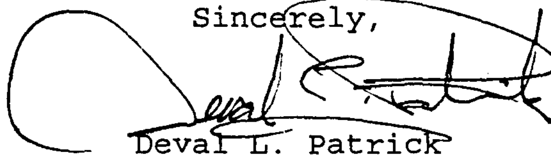
The facility must meet professional food, fire, and other health safety standards.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at an institution forty-nine days after appropriate officials are notified of them. 42 U.S.C. § 1997b(a)(1). Therefore, we anticipate hearing from you before that date with any response you may have to our findings and a description of the specific steps and dates by which you will take or have already taken to implement each of the minimum remedies set forth above. If you do not respond within the stated time period, we will consider initiating an action to remedy the conditions that violate patients' constitutional and federal statutory rights. We look forward to working with you and other Commonwealth officials to resolve this matter in a reasonable and expeditious manner.

Finally, we note we did not have the benefit of the on-site review of institutional conditions contemplated by CRIPA prior to determining these findings. Consistent with the legislative history of CRIPA, we have been obliged to infer that many of the allegations we have received regarding NVMHI are true in view of your failure to permit any inspection in any timely manner or provide requested documentation. We regret your lack of cooperation.

If you or any member of your staff have any questions, please feel free to contact attorneys David Deutsch at (202) 514-6270, Robert Bowman at (202) 514-6253, or Christopher Cheng at (202) 514-8892.

Sincerely,



Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: The Honorable James S. Gilmore, III
Attorney General
Commonwealth of Virginia

Mr. David A. Rosenquist
Acting Director
Northern Virginia Mental Health Institute

The Honorable Donna E. Shalala
Secretary
U.S. Department of Health and Human Services

Helen F. Fahey, Esquire
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