U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20035*

CRIPA Investigation

MH-VA-001-005

April 3, 1996

The Honorable George Allen
Governor of Virginia
Commonwealth Capitol Building
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" or "Institute") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq.

We were initially denied access to the facility, and, as a result, our April 20, 1995 letter of findings was issued without the benefit of an on-site investigation. In June 1995, just prior to a meeting between Attorney General Reno and Virginia Attorney General Gilmore, the Commonwealth finally agreed to allow a Justice Department inspection of the facility. That inspection took place on July 25-27, 1995. During the inspection, Justice Department experts in the areas of psychiatry, psychology, and psychiatric nursing reviewed documents, interviewed staff, interviewed patients, and toured the facility. Your staff was cooperative during the tour, and we appreciate the assistance they provided.

We are now writing to advise you of our supplemental findings, based on the on-site inspection, that conditions at the NVMHI continue to deprive NVMHI patients of their constitutional rights and violate the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101 et seq., and the ADA's implementing regulations.

These continuing violations should be considered in light of this investigation's long history. Our April 20, 1995 letter previously cited the Commonwealth for deficiencies in the following areas: 1) mental health treatment; 2) staffing; 3) medical care; 4) medication practices; 5) protection of patients from harm; and 6) physical plant. In response to our findings, the Commonwealth submitted a "Continuous Improvement

Plan" ("Continuous Improvement Plan" or "Plan") on June 7, 1995. This Continuous Improvement Plan details a number of reforms which the Commonwealth assured us were in the process of being implemented. At the time of our tour, many of the Commonwealth's self-imposed deadlines for implementing reforms had either passed or were fast approaching. Yet, our inspection revealed continued constitutional violations regarding matters previously identified in our April 20, 1995 letter and supposedly addressed by the Commonwealth's Continuous Improvement Plan.

More specifically, our supplemental findings are as follow:

I. <u>Inadequate mental health care, discharge planning, and community services.</u>

The Commonwealth's Continuous Improvement Plan identifies remedial measures NVMHI has developed to address our earlier findings and to improve care and treatment at the Institute. Section A of the Continuous Improvement Plan calls for "appropriate, comprehensive individualized treatment" based on adequate evaluations and multidisciplinary assessments. Our consultants found that the Commonwealth has been unable to meet many of the Plan's key elements and that the treatment process at NVMHI remains inadequate. From the point of admissions to the point of discharge, the inadequate mental health care provided at the facility increases the risk of harm to patients, fails to provide them with a reasonable opportunity to be cured and function as independently as their psychiatric conditions permit, and violates professional standards.

The Continuous Improvement Plan promises that "... NVMHI will evaluate and assess each patient consistent with generally accepted professional standards to develop an appropriate, accurate diagnosis.... A new assessment process will be developed by an interdisciplinary team and will be piloted in the admissions suite for all new admissions." Accepted professional standards require that psychological evaluations be part of this assessment. In the last year, however, only about 10 percent of NVMHI patients received psychological assessments at the point of admission. The failure to provide psychological assessments is especially troubling because NVMHI recently assured the Health Care Financing Administration that staff would provide all patients with such assessments by July 1, 1995. NVMHI clearly has not met its own deadline; since at the time of our visit, at least eight individuals admitted in July had not received a psychological assessment as part of the admissions process. Even for patients who repeatedly engage in maladaptive behaviors, the facility fails to complete a psychological assessment or develop an adequate behavioral plan. For example, one patient had a series of self-abusive injuries, but received no psychological assessment or intervention. Psychological assessments, even when done, are often inadequate. Assessments reiterate symptoms

without providing any suggested psychological interventions. Important considerations, such as prior hospitalizations and family background, are not adequately explored. Our expert consultants found patient diagnoses that bore no relationship to symptoms identified in the few assessments conducted.

Section A of the Commonwealth's Continuous Improvement Plan also requires that NVMHI "... provide each of its patients an appropriate, comprehensive, individualized treatment program based on [a] history and physical examination, psychiatric evaluations, and multidisciplinary assessments designed to maximize each patient's opportunity for recovery and integration into full community life." In reality, patient treatment is not appropriate, multidisciplinary, individualized, or properly managed in accordance with accepted professional standards. Treatment planning is inadequate. There is little or no evidence of multidisciplinary thinking in treatment planning, and patients have little involvement in the process. The process is so disorganized that our expert consultants were unable to ascertain what the treatment plans are meant to accomplish. Records show that staff are providing treatment without an adequate understanding of the patient's problems. Treatment goals are too vague and fail to provide an objective, measurable basis for gauging patient progress. Treatment objectives refer to such matters as whether a patient has attended his "groups," rather than substantive issues involving patient functioning. Treatment planning is not individualized. Although patients attend classes or "groups," many of the supposedly "individualized" treatment schedules are actually standard, preprinted forms that have little to do with the needs of the patient. For example, some patients who need to avoid excessive stimulus are assigned to group therapy even though such therapy is contraindicated by professional standards. Similarly, NVMHI has patients who are mentally retarded; yet their needs are not met and they are inappropriately placed at NVMHI.

Treatment is also not adequately coordinated between disciplines. In particular, master treatment and nursing care plans are inconsistent. Additionally, nursing care plans suffer similar defects to treatment plans. For instance, initial nursing care plans are not individualized. Patients are placed in categories, and then all patients in the same category receive the same rote nursing care plan without adequate regard to their individual needs. Thus, one nursing care plan made no mention of a patient's epilepsy, and another plan failed to address a patient's spastic colon. Because standardized forms are used, patient problems which are not on the forms, such as sleep and eating disturbances, are not addressed by nursing care plans.

The defective treatment process results in patients not receiving a reasonable opportunity to be cured and function as well as possible. NVMHI policies do not require completion of

individualized, comprehensive treatment plans until ten days have passed, which is a substantial period of the time that patients stay at NVMHI. The average length of stay at NVMHI is approximately 40-50 days, an exceptionally long period for stabilizing patients in an acute care hospital. The treatment process has built-in delays which prevent prompt treatment and subsequent discharge of patients. For example, the first review of a patient's stay does not occur until 21 days after admission. This built-in delay means the system is inherently tilted in favor of excessively long, and often unnecessarily protracted, hospitalizations. This unnecessary delay places patients at great risk of harm.

Behavioral management planning is also grossly inadequate and reflects the general absence of adequate psychology services at NVMHI. Of the records reviewed, our expert psychologist found only one patient with recurrent self-injury who had even been sent to a psychologist for behavioral management planning. This patient's behavioral plan was not established until nine months after her admission and occurred at the same time hospital staff took the extreme measure of having her arrested for assaulting a staff person. A token economy plan was subsequently put in place for this patient, but it was not based on any recorded behavioral analysis, psychological exam, or appraisal of baseline functioning.

The Continuous Improvement Plan assures that "Discharge planning will continue to be appropriately carried out for all patients who are discharged from the Institute." Instead, our consultants found that NVMHI's discharge planning is inadequate and violates professional standards. The discharge planning fails to ensure that appropriate professional judgments about the most integrated setting appropriate to meet each patient's needs are made and implemented. To begin with, NVMHI does not provide adequate discharge criteria in patient charts. Without such criteria, it is impossible to exercise professional judgment about readiness for discharge. As a result, NVMHI's discharge system is arbitrary, with some patients released too soon while others are hospitalized for too long. Of the 30 records reviewed by our psychologist, not one contained even a general statement as to the level of functioning which would demonstrate a patient's readiness for discharge. Second, discharge planning is given low priority at NVMHI and discharge plans are often developed only shortly before a patient is about to be released rather than being incorporated into treatment objectives. Discharge planning should be, but is not, an integral part of treatment at the facility. Third, discharge decisions are not being implemented due to inadequate community services. One glaring example involves a mentally retarded NVMHI patient who staff thought should live in a community group home, but decided that was impractical because it would take several years before a spot opened up for any patient on the waiting list. Since there

were no community placements available, the staff had to keep the patient hospitalized instead. Finally, discharge planning is inadequate to ensure that appropriate aftercare services are provided to help the patient remain in the community. Our consultant found 36 percent of July 1995 admissions were readmissions occurring within 76 days of discharge. One of these patients was discharged with no clear plan to address basic living needs other than to live with another patient. High readmission rates indicate the State is not providing integrated hospital and community services in order to ensure adequate patient transition into the community. Without adequate follow-through and community treatment options, NVMHI is unable to sustain patients in the community and prevent their rehospitalization.

II. Deficient staffing and staff supervision.

Section B of the Commonwealth's Continuous Improvement Plan of correction claims that "NVMHI currently maintains an appropriate number of qualified staff...." Our consultants found, however, and we concur, that NVMHI does not have a sufficient number of qualified staff to meet patient needs.

At the time of our tour, virtually the entire management hierarchy, including the facility director and medical director, was serving in an acting capacity. The failure to fill these critical positions on a permanent basis is especially problematic in a facility which already has serious supervision problems. Additionally, the acting clinical director, who has recently been placed in charge of the entire psychology department, has a nursing background, rather than one in psychology. For all practical purposes, the psychology department is currently functioning without professional supervision. The problems with leadership at the facility are especially troubling since NVMHI does not have a clearly defined mission. Although it is designed as an acute care psychiatric facility, it operates in many ways like a long-term care facility. Solid leadership is essential if the facility is to achieve any meaningful reforms.

Direct care, including nursing care, is generally understaffed. Based upon the hospital's own classification system, our nursing consultant found that NVMHI is short 18.61 full-time direct care staff. Additionally, much of the nursing staff's time is spent on ineffective "special observations" rather than therapeutic activities. In the past year, NVMHI used more than 47 of the 67 direct care staff budgeted for "special observations." In contrast, direct care staff spend little time working directly with patients in any meaningful way. NVMHI's practice of relying on one to one interventions for three to five minutes four times per week is not adequate for supervision or treatment. Although the understaffing has been reduced in the past year, it remains troubling. To make up for the lack of

direct care coverage, the facility has had to use at least 4000 hours of overtime in the past fiscal year. This excessive use of overtime in an acute care mental health facility is dangerous and does not comport with accepted professional standards.

At NVMHI, psychologist resources are stretched too thin. Patient and staff interviews show that psychologists see their patients only on rounds and then for only a few minutes. The psychologists are occupied with a variety of duties and do not properly address important matters such as patient admissions, psychotherapy, and treatment. Moreover, psychologists are not adequately supervised. Some actions by psychologists are highly questionable. For example, one psychologist recommended restraints for a patient with an eating disorder. Such an inappropriate recommendation should not have occurred if there had been adequate supervision.

NVMHI also is not meeting the psychiatrist to patient staffing ratios outlined in the Continuous Improvement Plan. Presently, one of the five staff psychiatrist positions is vacant. Given the many, arguably excessive, number of supervisory responsibilities placed on psychiatrist staff, even one vacancy seriously increases the workload on the other staff. It is therefore imperative that psychiatrist staffing operate at full capacity. Patients rarely see psychiatrists on a one-to-one basis. Instead, psychiatrists may see patients only during rounds and then just for a few minutes. These sessions take place in the patient's room, often in the presence of the patient's roommate. This practice undermines treatment by compromising patient confidentiality.

NVMHI's close proximity to the Northern Virginia Medical Center provides good, physical access to emergency medical services. The facility, however, does not have a full-time internist or family practitioner even though some patients have chronic medical problems.

More generally, it appears NVMHI sometimes counts administrators as full-time staff. There is a significant difference between a full-time doctor, nurse, or other staff person who provides patient services, and an administrator who provides such services only occasionally.

In sum, NVMHI is not providing adequate direct care and professional staffing in accordance with its Plan or accepted professional standards. This failure has directly resulted in deficient patient care.

III. <u>Inadequate medical care and medication practices.</u>

Section C of the Continuous Improvement Plan seeks to ensure that NVMHI has taken and will continue to take steps to eliminate

intra-class polypharmacy and generally ensure that medication practices are "professionally justified." Yet, medication practices at NVMHI remain deficient and violate professional standards. Intra-class polypharmacy continues to be a serious problem, with 19 of 76 patients on more than one drug of the same class. In addition, 55 of 76 patients are on benzodiazepines, which are potentially addictive, sleep-inducing, hypnotics. NVMHI staff are using these powerful drugs for their sedative effect in a professionally inappropriate manner. In addition, the rationale for prescribed medications is not specified except in the most rudimentary and unacceptable terms.

IV. Inadequate protection from harm.

Above all else, a hospital must be safe; yet, NVMHI is an unsafe facility. When patients and staff are not safe, the hospital environment is not conducive to treatment. Last year, there were at least 70 patient elopements. In an average month, there are at least 27 incidents of patient self-injury and 17 incidents of patient on patient violence. In addition, there were 39 staff injuries last year which were sufficiently serious to require use of sick leave. Moreover, NVMHI apparently has a contraband problem which requires close scrutiny. The hospital has conducted drug sweeps, regularly searches patients after visitation, and has even brought in drug dogs. Use of such measures in a civilian hospital is highly irregular. All of these are indications of an unsafe environment. They also help explain why our consultants concluded that NVMHI has a "siege" or "prison" like mentality which is inconsistent with professional standards.

Patients are hurt even when they are supposedly under careful supervision. We found at least five cases where patients engaged in multiple incidents of self-inflicted injuries, many times even while they were under suicide watch. One patient committed approximately 12 such acts of self-injury while on "special observation" status. We even found cases where patients injured themselves while in both seclusion and restraints. One patient somehow managed to obtain a knife while in the seclusion room. Another patient was in full restraints and helmet, yet still managed to pull tape from his helmet and tie it around his neck. Such severe lapses in supervision suggest that NVMHI suicide and safety precautions do not meet professional standards.

Even though NVMHI has a practice of arresting patients who assault staff, there is no attempt to monitor and evaluate this trend or develop a constructive plan of action to address the issue. Management committee notes make no mention of the problem. For example, there should be some attempt to evaluate why some staff seem to call the police more than others, why some aggressive patients are not responding to treatment, and whether

staff are using techniques, such as "hands on" approaches, which can trigger violent outbursts in some patients. Instead, the facility has a policy which sanctions the practice of calling the police when a patient is unruly, which merely encourages confrontation between patients and staff.

V. Inappropriate use of restraints and seclusion.

Section D of the Commonwealth's Continuous Improvement Plan promises that "NVMHI will develop and implement seclusion and restraint policies that comport with generally accepted psychiatric standards by October 1, 1995." At the time of our tour, NVMHI had not made adequate progress in addressing numerous deficiencies in facility policies and practices.

Restraint and seclusion practices do not meet accepted professional standards. Seclusion and restraints are used continually over many months even when they are seemingly ineffective. One patient was secluded/restrained for 840 hours over an eight-month period. Another patient was secluded/restrained for 1160 hours over a nine-month period. The inappropriate and excessive use of restraints and seclusion for patients is related to the facility's generally inadequate treatment process. As noted earlier, the facility has had so many problems with some patients, staff have resorted to calling the police and having patients arrested rather than addressing the underlying psychological issues. At least one patient has also called 911 in order to report being injured during physical containment by staff.

Documentation regarding the use of restraints and seclusion is lax. Patients are kept in restraints and seclusion without any objective, recorded criteria for their release or explanation of the problem behavior that is being addressed by the use of restraints. NVMHI has a policy of secluding and physically restraining a patient at the same time. This policy indicates a mechanical device (a locked door) is being substituted for a staff member due to understaffing. Patients are kept in restraints even after they exhibit sufficient control (e.g., ability to use common bathrooms and eat on the unit) to be released.

VI. Unsafe physical conditions.

Significant physical defects involving "suicide-safe" fixtures exist at NVMHI, even though the facility's Continuous Improvement Plan calls for a "safe and sanitary environment." These defects pose a serious risk of harm to suicidal patients. For example, clothes hangers, which are supposedly "suicide-safe," are connected so tightly to the closet walls, that they do not actually break away when someone puts weight on them, thereby posing a serious risk to patients attempting

suicide. Additionally, light fixtures in housing areas lack institutional safety covers. Thus, patients have repeatedly been able to injure themselves by removing covers and cutting themselves with glass shards. There is a long, hand-held shower in one community bathroom which could be used by a patient to commit suicide.

The seclusion room on H Unit has a blind spot which prevents adequate patient observation. There is no seclusion room on F Unit. Thus, a patient who is acting out has to be moved to H Unit before he or she can be secluded. This transfer increases the risk of injury.

In addition, there is only a male bathroom on one unit, and only a female bathroom on the other unit. Since each unit houses both males and females, this arrangement inhibits necessary access to bathroom facilities, reduces patient privacy, and increases the risk of untoward sexual events.

In terms of sanitation, NVMHI was clean and appeared adequately maintained at the time of our tour. There have been limited problems in the past with vermin, such as dead squirrels in the ceiling.

VII. Quality assurance and recordkeeping.

The Continuous Improvement Plan promises that "NVMHI will implement an adequate Quality Improvement Plan." Certainly at the time of our tour, this element of the Plan had not been met. Quality control at NVMHI is deficient and violates professional standards. The data collected in key areas is often poor. NVMHI reported six 1995 patient suicide attempts to the Justice Department. This number appears to be inaccurate. For example, we found a patient record which showed a patient attempted suicide with a wire hanger while under 15 minute checks; yet this incident was not reported to the Department. The failure adequately to track suicide incidents increases the risk of harm to suicidal patients and is troubling given the other deficiencies in suicide prevention discussed in previous sections.

The data collected are frequently irrelevant to those who need to use them. For instance, quality improvement reports regarding seclusion and restraint usage do not provide the information needed by the nursing department to evaluate the nursing staff's use of such seclusion and restraints. The nursing monitoring and evaluation plan is inadequate and is not implemented as written. Only four of the nine aspects of care identified in the plan are actually monitored.

Patient records are disorganized. For example, we tried to find one patient's psychosocial assessment. The present records

referred to an older record, which referred to an even older record, and so forth. Finally, we learned the assessment was in the state archives. Ad hoc codes are used to cite to other sections of patient records. Nursing care plans are often inconsistent with the Master Treatment Plan. Disorganized records exacerbate supervision and treatment deficiencies.

MINIMUM REMEDIAL MEASURES

We are providing copies of our consultant reports under separate cover. These reports and our original findings letter detail numerous remedial measures. A summary of the recommendations follows:

I. Mental health care.

NVMHI must evaluate, diagnose, treat, and discharge patients consistent with generally accepted professional standards. Individualized patient psychological assessments must be performed promptly in accordance with professional standards. In particular, such assessments must be conducted for patients who repeatedly engage in problem behaviors.

The treatment process must be reformed. Patient treatment must be appropriate, individualized, coordinated, and properly managed. Such programs must give each patient a reasonable opportunity to be cured and function as independently and effectively as possible given his or her individual condition. To that end, treatment planning should reflect multidisciplinary thinking. Patients should have input in the treatment process. Treatment must be based on objective data and clearly established goals. Staff require training on how to write professionally appropriate behavioral goals and objectives. Staff must interact therapeutically with patients, and NVMHI should seriously consider using staff currently assigned to "groups" for providing more focused, individual treatment. Data collected by staff for treatment decisions should be adequately incorporated into the treatment planning process. Master treatment and nursing care plans need to be consistent and adequately organized for staff review. Special observations should be included in master treatment and nursing care plans. Mentally retarded patients should not be admitted to NVMHI, and appropriate alternative placements must be developed for these patients.

NVMHI must provide adequate discharge planning, including appropriately integrated community-based mental health services, to meet the needs of patients upon discharge. NVMHI must develop a quality assurance/improvement system to oversee the discharge process. This system must ensure that patient discharge plans are implemented and that appropriate aftercare services in the community are provided. Discharge criteria need to be adequately developed and discharge planning should be a consideration long

before a patient is about to be discharged. In previous correspondence, the Commonwealth has taken the position that such requirements are equivalent to a demand for closure of state institutions. We have never demanded the closure of any of Virginia's hospitals, and we do not do so in this case. What is required is individualized, professionally justified placement decisions which reflect consideration of a patient's needs, rather than just administrative convenience or inadequate funding of appropriate services.

II. Staffing and staff supervision.

NVMHI must fill vacant management positions with permanent employees to ensure adequate leadership at the institution. The psychology department needs to be supervised by a qualified individual with psychology expertise. NVMHI must hire adequate numbers of additional full-time, qualified, direct care staff and use them to provide appropriate supervision and treatment. The vacant psychiatrist's position must be filled as soon as possible. Direct care and professional staff must spend more time working directly with patients in an appropriate setting.

III. Medical care and medication practices.

Medical staffing must include at least one full-time internist or family practitioner. Patients should receive prompt professional evaluation of medical problems. All use of drugs must be professionally justified, carefully monitored, documented, and reviewed by qualified staff.

IV. Seclusion and restraint and protection from harm.

Seclusion and restraint policies must comport with professional standards and be implemented in a safe and appropriate manner. The average hours per patient in seclusion and restraints should be reduced. All restrained patients should be on constant observation, rather than being left alone in a locked seclusion room. Use of seclusion and restraints must be properly documented and must be reviewed in a timely fashion by qualified staff. Criteria for release from seclusion and restraints must be clearly identified, and use of seclusion and restraints as part of any treatment process must be professionally appropriate and regularly reviewed. NVMHI must provide adequate supervision of suicidal residents, and mechanical devices should not be used in order to make up for inadequate staffing.

NVMHI needs to create an environment which ensures reasonable safety for both staff and patients. The policy allowing the arrest of aggressive patients should be revamped from a unilateral, confrontational approach to one which addresses the underlying problems associated with working with

difficult patients. Training must be provided to ensure that only appropriate interventions are used with patients who are acting out.

V. Unsafe physical conditions.

The facility must be maintained in good physical condition. Suicide precautions, such as shielded light fixtures and breakaway closet hangers, need to be installed. NVMHI should consider a new housing system to minimize the risk of sexual incidents between male and female patients and reduce the problems associated with moving F Unit patients to the H Unit seclusion room.

VI. Recordkeeping and quality assurance.

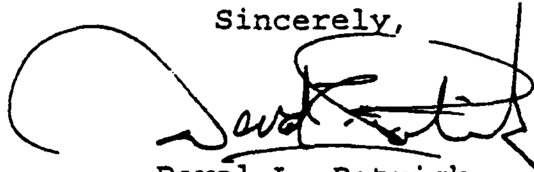
The Commonwealth must keep adequate data and patient records. Data regarding suicide attempts, use of restraints and seclusion, and patient incidents are especially important. Data collected should be available in a form that is useful to appropriate staff.

NVMHI needs to develop an adequate quality improvement mechanism which collects and distributes useful data. The system developed must encourage the development and implementation of constructive solutions where data indicate problems in patient care and treatment. The QA/QI process should monitor both standardized aspects of care and non-standardized variables that may indicate potential problems in the delivery of care.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at an institution 49 days after appropriate officials are notified of them. 42 U.S.C. § 1997b(a)(1). Our original findings letter generally identified the same deficiencies as this one. Since that letter was issued in April 1995, the 49 day response period has already passed. We will, however, give the Commonwealth an opportunity to respond to this findings letter. We anticipate hearing from you within two weeks with any response you may have to our findings. 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 other federal statutory rights. We look forward to working with you and other Commonwealth officials in an effort to resolve this matter in a reasonable and expeditious manner.

If you or any member of your staff have any questions, please feel free to contact attorneys David Deutsch at (202) 514-6270 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

Dr. David A. Rosenquist
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Northern Virginia Mental Health Institute

Helen F. Fahey, Esquire
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