U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

REGISTERED MAIL
RETURN RECEIPT REQUESTED

APR 9 1991

Honorable Lawrence Douglas Wilder
Governor of Virginia
State Capitol Building
Ninth and Grace Streets
Richmond, VA 23219

Re: Northern Virginia Training Center

Dear Governor Wilder:

By letter dated May 4, 1990, we notified you that, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 et seq., the Civil Rights Division of the United States Department of Justice was commencing an investigation into conditions at Northern Virginia Training Center ("NVTC"), a facility for the mentally retarded located in Fairfax, Virginia. As specified by the statute, we are now writing to inform you that our review indicates that unconstitutional conditions exist at NVTC, and also to advise you of the minimum measures we believe are necessary in order to remedy those conditions.

Our investigation consisted, first, of several comprehensive tours of NVTC by independent experts, most recently on October 22-24, 1990. The experts observed conditions in all the residential units of NVTC at various times of the day, interviewed administrators, staff and residents, and examined a variety of records. Further, we gathered and analyzed documentation relating to the operation of NVTC, including: a variety of policies and procedures; information relating to staffing; minutes from various committees, including the Behavior Management Committee and the Senior Staff Committee; incident and investigation reports; injury reports; restraint logs; lists of residents on medications; and residents' records.

Based upon our investigation, we find that conditions exist at NVTC that deprive residents of their constitutional rights. The United States Supreme Court has clearly stated that institutionalized mentally retarded persons have a constitutional right to adequate medical care, reasonable safety, and such training as an appropriate professional would consider reasonable to ensure their safety and freedom from undue bodily restraints.

Youngberg v. Romeo, 457 U.S. 307, 324 (1982). We have concluded that the State subjects its residents of NVTC to conditions that violate their constitutional rights, including conditions that seriously threaten the health and safety of NVTC residents. These conditions include:

1. Failure to provide sufficient training to residents to avoid undue risks to residents' personal safety and unreasonable use of physical and chemical restraints;

2. Failure to provide sufficient numbers of appropriately trained staff to render and implement professional judgments regarding necessary care, training, and medical treatment and to avoid undue risks to residents' personal safety and unreasonable use of physical and chemical restraints;

3. Failure to provide adequate medical care;

4. Failure to adequately monitor medications;

5. Failure to keep and maintain such records as will allow staff to render professional judgments regarding care and treatment of residents.

Set forth below are our findings and recommendations.

I. Inadequate Behavioral Training

A. Failure to provide and implement training programs

NVTC fails to provide professionally designed and implemented training programs sufficient to ensure that residents are not subjected to unreasonable risks to their personal safety and undue bodily restraint. Our expert psychologist found that the psychologists on duty have excessive caseloads and professional responsibilities so that they do not have adequate time to render professional judgments with respect to matters within their professional responsibilities, including the design and implementation of training programs and supervision and training of direct care workers. As a result of the shortage of psychologists, treatment programs are not individualized and often contain inappropriate or incompatible goals. They often remain the same, including the use of restraint, from year to year. Our expert psychologist concluded that the current practice of behavior modification at NVTC fails to reduce self-abusive, aggressive, and other maladaptive and inappropriate behaviors.

Due to the lack of training, direct care workers lack skills necessary to implement and monitor behavior training programs. As a result, often data is not collected or the data collected by such untrained and unsupervised workers is unreliable. The individual training programs reviewed reflect this inconsistent and inaccurate data collection, implementation and monitoring. Direct care staff did not know the elements of the residents' training programs or know how to carry them out. The failure to develop consistent and necessary training programs, to implement and monitor them, and to collect and record accurate and pertinent progress data places residents at substantial risk of harm to their personal safety and to excessive mechanical and chemical restraint.

The training programs were seriously deficient in their failure to address residents' needs and to consider alternatives to restraint, especially in cases where restraint had not been effective in reducing maladaptive and inappropriate behaviors, resulting in residents failing to receive such training as is reasonably necessary to protect them from unreasonable risks of harm. Training programs are further compromised at NVTC by a lack of coordination between professional staff. Medical procedures interfere unduly with residents' programs: routine blood work and the evaluation of even trivial problems often cause residents to be kept out of their programs for half of the day or even the entire day. This evidences a lack of coordination between residents' programmatic and medical needs. There is no justification for preventing residents from participating in their training programs for medical procedures and evaluations that take minutes.

B. Excessive use of restraint

We were struck by the pervasive use of restraint at this facility. Staff regularly resort to chemical and physical restraints to control residents' behavior in violation of the residents' constitutional rights. A myriad of mechanical restraint devices were in evidence and in use during the tours, including leather wrist and ankle straps, helmets with face guards, and papoose boards. Moreover, it is not uncommon for these restraints to be used in combination with seclusion and with chemical restraint (emergency injections of psychotropic medication).

Although we were told restraints are generally used in connection with behavior programs, these programs do not facilitate a reduction in the use of such restraints and residents remain on programs with restraint as their central components for long periods of time. Indeed, for some residents the incidence of restraint and the length of time spent in restraints is increasing. The behavior programs are not modified to address the ineffectiveness of restraints, nor do they direct

those implementing the programs to attempt other measures prior to resort to restraint. On the contrary, restraint is used so frequently that it appears to be the treatment of choice rather than a technique of last resort.

When physical restraints are employed, they are not consistently monitored and evaluated by qualified professional staff. Thus, significant numbers of injuries occur during the implementation of restraints. Moreover, restraint is used for inappropriate reasons and in response to behaviors that are not dangerous. Many residents are restrained in their beds at night, raising serious concerns for the safety of residents in the event of a fire.

In sum, NVTC lacks adequate and necessary training programs. Our consultant concluded that these activities expose residents to undue risks to their personal safety and to undue restraint.

II. Insufficient Trained Direct Care Staff

The safety of NVTC residents is threatened by the inadequate training of direct care staff for the myriad tasks assigned to them. There is a widespread failure to appropriately manage maladaptive resident behavior. Staff questioned about a specific resident's behavioral programs were unaware of the components.

During our tours, we rarely observed competent staff intervention. Our experts observed an almost total absence of staff-resident interaction in daily programs. Some residents in need of assistance were unnoticed by staff for extended periods of time until our experts pointed them out. Residents were not encouraged, praised, or otherwise reinforced for their efforts, nor were they given directions which would keep them on task. Our experts concluded that direct care staff do not possess the technical competence to adequately supervise and train residents of NVTC. Moreover, NVTC has insufficient staff to implement appropriate programs, to provide appropriate encouragement and direction, and to interact with residents in meaningful ways and to further residents' training goals.

Direct care staff training at NVTC is deficient and contributes to inadequate care by staff. Our experts' review indicated that the training given to the staff is insufficient in depth and scope to enable them to adequately provide essential care to residents. The direct care staff receives insufficient training concerning how to effectively intervene to prevent or deal with acting out behaviors of residents or to implement residents' individualized training programs. Direct care staff is not trained in the detection and identification of possible side effects of any medications, but is directed to notify nursing staff of "any change" in residents. The absence of training regarding what changes in residents may be significant

or, indeed, what constitutes a "change," renders staff wholly inadequate to protect the health and safety of residents who are receiving psychotropic, anticonvulsant, or other medications and combinations of medications with serious potential side effects.

As a consequence of the foregoing staffing inadequacies, residents of NVTC are exposed to serious risks to their health and safety.

III. Inadequate Medical Care

Our consultant found that primary care physicians do not provide primary medical care; instead, various outside consultants provide care to residents of NVTC. As a result, medical care is fragmented and uncoordinated, with little primary focus. Serious medical conditions and marked functional deterioration are not comprehensively evaluated or effectively treated. Thus, there were inadequate efforts to diagnose residents' medical problems, a process essential to then selecting the appropriate drug, if necessary, and evaluating the efficacy of treatment. As a result, residents' physical conditions often deteriorated and they were placed at risk. In addition, there is little long range therapeutic planning for chronic medical problems and a failure to provide adequate preventative health care. Instead staff merely monitors medical conditions as they worsen, rather than taking preventative measures to protect residents from such deterioration. This failure to adequately monitor and care for serious medical conditions and to prevent deterioration includes the failure to adequately address residents' feeding and positioning needs. Therefore, we have concluded that the care and treatment of such residents is inconsistent with the exercise of judgment by a qualified professional.

As a further result of the reliance on outside consultants at NVTC, the primary care physicians have not acquired expertise in the complex yet common medical problems found in populations of people with severe developmental disabilities. Thus, for example, neurological care at NVTC depends upon the services of a neurologist who does annual evaluations only. This seriously compromises the medical care of people who live at NVTC.

IV. Inadequate Medication Practices

Medications at NVTC are not adequately monitored. Residents are placed on combinations of drugs, psychotropics, anti-convulsants, and others, which have risks of dangerous side effects, with no adequate review by the pharmacist or other professional to note these combinations and to recommend changes, where appropriate. Moreover, as noted above, there is inadequate monitoring of residents for drug induced side effects, including tardive dyskinesia. Lack of training for direct care staff, who

spend the most time with residents, and confusion among staff as to who is responsible for monitoring, coupled with inadequate review of prescriptions, place the residents of NVTC at severe risk.

There is insufficient effort made to properly diagnose residents prior to prescribing medications for psychiatric disorders and not all residents in need of psychiatric evaluation receive such evaluations. Careful selection of medication, if necessary, and its trial in conjunction with a behavioral program depend upon adequate evaluation and an initial diagnosis. Overall psychotropic medication usage has declined in the last two years. Yet the positive and negative effects of psychotropic medications, once prescribed, are not adequately monitored at NVTC. Our consultants found that residents who had benefited from psychotropic medications in appropriate doses nevertheless had their medications discontinued. As a result of such inadequate medication practices, residents' conditions deteriorate, abilities to function decrease, and maladaptive and inappropriate behaviors increase. Residents then are unable to participate in training activities and are subjected to increased physical and chemical restraint.

Medications administered at NVTC include chemical restraint of residents, using psychotropic medications on an emergency basis. There are serious problems with this practice beyond the failure to provide training programs that might reduce or eliminate the need to resort to chemical restraint in the first instance. Emergency injections of psychotropic medication are used repeatedly with some residents, without limitation on the total number of doses or assurance that repetitive use will trigger review and revision, if necessary, of the resident's behavior program. The consulting psychiatrist at NVTC neither reviews the use of emergency chemical restraint nor participates in the decision to use it, even with residents who receive a substantial number of emergency doses of psychotropic medication. With one part-time consulting psychiatrist for over 270 residents, it does not appear that the psychiatrist would have time to conduct such reviews.

For the reasons enumerated here, medication practices at NVTC are inadequate, expose residents to serious risks to their health and safety, and impair their abilities to function.

V. Inadequate Recordkeeping

Recordkeeping at NVTC is deficient. Behavioral records of residents are not maintained and progress data are not collected in a consistent fashion. The consequence of the failure to maintain adequate records is that responsible staff are unable to render professional judgments regarding care, treatment, and training of residents of NVTC, thereby subjecting them to

unnecessary risks of harm. NVTC has not established recordkeeping systems and procedures to ensure reliability and validity of information relevant to the care and training of residents. Methods for collecting baseline data, follow-up, and progress data are absent or inadequate.

Inaccurate or incomplete behavioral data collection and recordkeeping present an active danger to residents by depriving professional and other staff of information necessary to make appropriate and safe decisions regarding training of residents. Treatment decisions are implicated as well because, in the absence of accurate behavioral data, management of patients on psychotropic medications cannot take place consistent with professional standards of practice.

Our consultants also found medical records to be cumbersome, fragmented, totally inadequate, and even dangerous in their deficiencies. Results of most diagnostic testing and routine laboratory data often were not found in the charts and consultations regarding major medical problems were not readily available. Other documents, while in the records, are not consistently found in their designated sections. A comprehensive understanding of diagnostic and therapeutic measures for any problem is, therefore, a difficult process. Fragmented medical records, coupled with the lack of coordinated medical care and inadequate communication among professionals at NVTC severely compromise adequate medical care.

Minimally Necessary Remedies

As discussed above, NVTC residents are being subjected to egregious or flagrant conditions that deprive them of their constitutional rights pursuant to a pattern or practice of resistance to the full enjoyment of these rights. To rectify the deficiencies at NVTC and to ensure that constitutionally adequate conditions are maintained thereafter, we propose to enter into an agreement with the Commonwealth of Virginia which shall be entered as an order of a Federal Court and which shall provide, at a minimum, that NVTC shall implement the following remedies:

1) The Commonwealth must provide professionally designed training programs to the residents at NVTC who need them and for whom training will reduce or eliminate unreasonable risks to their personal safety and/or the need to use undue bodily and chemical restraints, and must ensure that such programs are appropriately implemented by trained staff. Immediate attention must be given to residents who have been subject to repeated episodes of mechanical or chemical restraint for extended periods of time by identifying them and providing necessary training. In addition, the Commonwealth must discontinue the use of papoose boards and the use of restraints in conjunction with seclusion at NVTC.

2) The Commonwealth must hire, deploy, and provide ongoing training to a sufficient number of competent and qualified direct care and professional staff at NVTC to provide its residents with adequate care, treatment, and training programs to protect them from unreasonable risks of bodily harm and to their personal safety.

3) The Commonwealth must provide coordinated medical care to NVTC residents, through the use of NVTC's primary care physicians and outside consultants, that adequately addresses their chronic and long-term medical needs and ensures that appropriate assessments, medical care plans, and consultations with specialists are provided to those residents who need them.

4) The Commonwealth must assure that medications are appropriately monitored, that the effects of medications are documented in residents' records, and that decisions to prescribe, change, or discontinue the use of medications are based upon sufficient data and are the result of qualified professional judgment.

5) The Commonwealth must assure that NVTC develops and implements adequate recordkeeping systems to monitor the use and effectiveness of behavior and other programs and medical recordkeeping systems sufficient to allow identification, monitoring, and follow-up of medical conditions as appropriate.

Information about Federal financial assistance which may be available to assist with the remedial process can be obtained through the United States Department of Health and Human Services' Regional Office (Director, Intergovernmental and Congressional Affairs), and through the United States Department of Education.

Although the primary purpose of this letter, consistent with CRIPA, is to describe the unconstitutional conditions at NVTC that require remediation, we also wish to acknowledge some of the positive steps taken at NVTC. During our time on-site at NVTC, we encountered many staff who appeared committed to providing residents with appropriate care in a safe environment. Our experts noted that the physical plant at NVTC and its recreation facilities may offer opportunities for residents to enhance their lives through varied activities in different settings. They also noted the opportunities given to a number of residents to work and move about in the community.

Less positive, however, have been the circumstances surrounding our investigation which has been somewhat marred by what may be termed the disruptive and litigious actions of Virginia's attorneys. These actions have impaired our ability to conduct this investigation in the spirit of cooperation intended

by the Civil Rights of Institutionalized Persons Act, but we hope that, cooperatively, our future efforts with Commonwealth officials and attorneys will lead to an amicable resolution of this matter.

Our attorneys will be contacting the Virginia Attorney General's Office shortly to arrange a meeting to discuss this matter in greater detail. In the meantime, should you or your staff have any questions regarding this matter, please feel free to call Arthur E. Peabody, Jr., Chief, Special Litigation Section, at (202) 514-6255.

Sincerely,

John R. Dunne
Assistant Attorney General
Civil Rights Division

cc: Honorable Mary Sue Terry
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Commonwealth of Virginia

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