WESTERN STATE HOSPITAL FINDINGS LETTER

The Honorable James S. Gilmore III
Governor of Virginia
Richmond, VA 23219

Re: Findings from CRIPA Investigation of Western State Hospital, Staunton, Virginia

Dear Governor Gilmore:

On June 29, 1998, we notified you that we were conducting an investigation, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq., of Western State Hospital ("Western State"), a state mental health facility in Staunton, Virginia. Western State serves as the primary, inpatient facility for seven community service boards and also receives patients transferred for administrative reasons from other Virginia hospitals. It provides both acute and long-term treatment. The hospital census is approximately 370 patients and approximately one-third of the patients have a dual diagnosis of mental illness and substance abuse. Patients are housed in six buildings that contain 14 wards.

We conducted our CRIPA investigation of Western State by reviewing hospital records, including patients' medical charts and other documents relating to the care and treatment of Western State patients, interviewing administrators, staff, and patients, and conducting on-site tours of the facility with three expert consultants: Wayne Fenton, M.D., a psychiatrist; William Spaulding, Ph.D., a psychologist; and Jane Ryan, R.N., M.N., C.N.A.A., a psychiatric nurse. We would like to express our appreciation to the staff of the Department of Mental Health, Western State, and the Attorney General's office for their assistance and cooperation during our investigation.

On July 23, 1999, Attorney General Mark L. Earley wrote to advise us that Western State has been taking steps to remedy the Commonwealth's concerns about conditions at Western State and was developing a formal plan of correction. He suggested that we defer issuing our statutorily required findings letter until the Commonwealth finalized a plan of correction and the Commonwealth's expert, Dr. Jeffrey Geller, toured Western State and reported on the status of implementing the plan of correction.

We are pleased that the Commonwealth has taken the initiative to begin addressing problems at Western State and is continuing to use outside experts for critical self-evaluation. We have not yet received the Commonwealth's plan of correction for Western State, but hope that the plan can serve as a framework for a negotiated remedy to resolve the deficiencies we have identified at the facility. In these circumstances, we believe our shared goal of ensuring adequate conditions at Western State will best be served by advising you and other Commonwealth officials of our investigative findings, the facts supporting our findings, and the necessary minimum remedial measures, as required by CRIPA. Following this process also provides the benefit of memorializing our formal investigative findings to serve as the foundation for developing remedies and measuring progress. We also believe that the Commonwealth's expert can use our findings as a framework for future evaluations and technical assistance. Accordingly, we set forth below the areas that we believe are deficient at Western State and the necessary remedial measures to address them. We hope that we will be able to engage in the same amicable process that we have used successfully to negotiate four other settlement agreements in Virginia facilities.

I. Investigative Findings

During the course of our investigation, we evaluated whether Western State patients are receiving care and treatment in accordance with their constitutional and federal statutory rights at Western State. Patients in state-operated mental health facilities have a Fourteenth Amendment due process right to adequate food, clothing, shelter, medical care, reasonably safe conditions and adequate mental health treatment. Youngberg v. Romeo, 457 U.S. 307 (1982); O'Connor v. Donaldson, 422 U.S. 563 (1975). Medicare/Medicaid regulations governing psychiatric hospitals require adequate staffing, recordkeeping, care, treatment and discharge planning. 42 C.F.R. § 482.1 et seq.

In addition, the Commonwealth must provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; see also 28 C.F.R. § 35.130(d).

Based on our investigation, we find that the constitutional and federal statutory violations at Western State include: inadequate mental health treatment; inappropriate use of restraints and seclusion; inadequate nursing and medical care; inadequate protection from harm; and inadequate discharge planning and community services. A major cause of many of the unlawful conditions we identified stems from an insufficient number of adequately trained professional and direct care staff to meet the needs of patients. The facts that support our findings are set forth below, followed by the remedial actions that we believe are necessary to correct these conditions.

A. Inadequate Mental Health Treatment

Western State is not providing its patients with adequate mental health services in accordance with generally accepted standards. Psychiatric practices at Western State are marked by inadequate assessments and treatment planning and inappropriate psychopharmacological practices. Moreover, the mental health services at Western State fail to provide patients with a reasonable opportunity to be cured or function as independently as their psychiatric conditions permit.

1. Inadequate Assessments and Treatment Planning

Western State generally fails to assess its patients' mental health needs appropriately and then develop and implement adequate treatment plans. A 1998 internal audit by Western State staff identified numerous deficiencies in the assessment and treatment process. The audit found that assessments do not identify and prioritize specific mental health problems and needs. Treatment plans tend to be generic and vague and do not contain measurable objectives tied to the patient's individualized needs. The audit further found that Western State staff are not implementing treatment plans consistently and are not systematically assessing and recording the efficacy of treatment interventions and revising them when necessary.

Our psychiatric consultant concluded that these deficiencies in assessment and treatment continue to exist at Western State. Inadequate assessments and treatment harm Western State patients by subjecting them to needless medications and their attendant side effects and by failing to treat the underlying mental illness adequately, thereby exposing patients to uncontrolled negative behaviors and unnecessary frequent readmissions. For example, patient S.H. is described at his treatment conference as having "over 100 hospitalizations." A review of the patient's record reveals a flawed assessment evaluation with repetition of the same treatment plan that was ineffective in the past and resulted in the frequent readmissions.

The inadequate treatment planning process is reflected in the case of C.H., a patient who committed suicide at Western State in July 1997 by hanging from an exposed conduit in his bedroom. Mr. H. had a diagnosis of bipolar disorder and substance abuse. His medical record documents and lists suicidal ideation and impulsivity as problems but his chart contains only a general goal ("Mr. H. will stabilize mood and behavior and return to the community"), with no specific plan to address or monitor impulsivity or suicidal ideation. Mr. H's chart reveals no ongoing assessment or treatment for the diagnosed suicidality, impulsivity, or depression. His team did not conduct a monthly treatment plan update, as required by Western State policy. Our psychiatric consultant cites this case as illustrative of the disjunction between assessment, problem identification, specification of goals and treatment planning at Western State.

Patient treatment planning at Western State is not interdisciplinary in accordance with accepted professional standards. Effective treatment planning integrates the observations and interventions of professionals from different disciplines to develop a cohesive and integrated plan to meet the patient's particular needs. In contrast, treatment planning at Western State reflects a clinical process in which different professional disciplines operate independently and fail to communicate.

For example, S.S.'s nursing progress notes state that she complained, after returning from a weekend with her stepfather, that he used and offered her drugs, threatened her and made sexual advances. The patient requested that her stepfather be banned from Western State grounds. There is no indication that this episode and complaint were communicated to S.S.'s social worker who is responsible for structuring community visits and family interactions. As a result, there has been no curtailment or restrictions on subsequent family interactions and the stepfather continues to visit.

Behavioral management planning and psychological services also are inadequate at Western State. Of the records reviewed, we found numerous patients with recurrent, self-injurious behavior who were not receiving appropriate behavioral management. The failure to provide adequate behavioral management has led to patients receiving little therapeutic care, treatment and programming. To the extent that behavior programming does exist, the primary emphasis is on containment, rather than teaching alternative, adaptive behaviors. In addition, vague treatment goals fail to provide an objective, measurable basis for evaluating patient progress. Western State also lacks any official mechanism by which to collect observational data reliably on patients' responses to behavioral programs. Western State staff acknowledged to our consultant that insufficient staff resources significantly limit the use of behavioral management.

In addition, the psychosocial rehabilitation services at Western State are inadequate. While Western State is actively moving toward a centralized psychosocial rehabilitation program, the programming currently being provided is not adequately individualized. There is little linkage between the patient's needs and the psychosocial programs. The result is that if there is no program available, the patient simply does not get the needed therapeutic or rehabilitative service. The lack of adequate substance abuse programs is a serious deficiency. An example is W.S., a 28-year old woman with a substance abuse problem. W.S. was admitted to Western State after an attempted suicide by drug overdose following a recent assault and rape. The patient was discharged after three days with a notation in her chart at admission that the patient is "in need of a substance abuse program which is not available at WSH."

Lack of staffing contributes to the lack of adequate treatment, delaying prompt and adequate evaluation and precluding the delivery of necessary care. The most critical shortage is in direct care nursing. In September 1997, based on an analysis of direct care hours per patient day, Dr. Geller, the Commonwealth's expert, concluded that Western State was significantly understaffed in direct care nursing. We found that the critical nursing shortage continues to exist. Based on Western State's own internal staffing requirements of 5.5 hours per patient day for acute and special needs units, and 5.0 hours per patient day for long-term units, all but two units fall below these staffing levels for minimum acceptable nursing hours per patient day. Moreover, according to Western State's data, during July 12

through July 19, 1998, only four of 15 units were staffed with at least one registered nurse per shift. Applying Western State's own minimum staffing standards, our nursing consultant found that Western State was short 86 direct care staff necessary to provide minimum safe care. There are an insufficient number of nursing staff to implement behavior plans or provide other treatment. At times, the facility must cancel treatment groups due to the lack of staff. In the absence of consistent structured programming and treatment, staff rely upon sedating medications, seclusion and restraint to manage behavioral episodes.

Staffing shortages in psychiatry are also problematic.

Our psychiatric consultant, concurring with the analysis of the Commonwealth's expert, Dr. Geller, found that Western State is understaffed by 4.5 to 6 full-time-equivalent psychiatrists.

2. Inappropriate Psychopharmacological Practices

Western State frequently fails to provide necessary psychotropic medications to its patients. Our expert consultants found that the restricted availability of particular psychotropic medications is a significant deficiency in psychopharmacologic practice at Western State. Facility officials and staff report that when a physician determines that a patient requires one of the newer, more effective antipsychotic medications, known as "atypicals," the required medicine is not available because of budgetary restrictions. As a result, Western State psychiatrists prescribe antipsychotic medications based on budgetary constraints, rather than clinical indications. Physicians on all units indicated that the unavailability of atypicals is a significant impediment to providing appropriate patient care. Western State's clinical psychopharmacologist confirmed that the budget has allowed no new prescriptions of atypical antipsychotic medication since December 1997. As a result, many Western State patients are not receiving medications that their psychiatrists have determined to be clinically necessary and appropriate. Citing numerous examples of patients who would benefit from atypical medications, our psychiatric consultant concluded that patients deprived of appropriate medications are harmed by suffering prolonged psychotic symptoms, endure unnecessary painful physical side effects, suffer a greater risk of suicide, and are subjected to seclusion and restraint beyond what would be required if appropriate medications were available.

Other medication practices at the facility represent a substantial departure from accepted professional practice. Monitoring of patients on psychotropic medication is deficient. Medical records do not readily allow tracking of pharmacologic treatment, sequential drug trials and the rationale for changes in medication. In addition, target symptoms for pharmacologic interventions and patients' responses to changes in medication are not readily discernable in the records. This results in unnecessary administration of drugs that have not proven to be effective. In addition, Western State's systemic lack of appropriate psychopharmacological practices has led to inappropriate polypharmacy and inappropriate PRN (pro re nata or "as needed") medication use. Western State's senior general medical physician advised our expert psychiatrist that 15 percent of admissions to the acute medical unit at Western State are patients experiencing acute toxicity from excessive psychotropic medications. In addition, nearly half of Western State patients have either a regular or PRN order for a benzodiazepine, and in some cases multiple sedating and habituating agents. Our consultant found that records lacked any justification for this potentially dangerous drug practice. Thus, the sedation of patients serves as a substitute for appropriate therapeutic interventions. Antipsychotic medications and benzodiazepines are being prescribed at Western State for their secondary sedating effects, rather than for their specific indication as agents that target symptoms of psychosis and anxiety.

While this deficiency was noted throughout Western State, it is particularly problematic in the geriatric admissions unit (D1), which has among the highest rate of PRN benzodiazepine prescription. Generally speaking, the use of benzodiazepines for the elderly should be carefully scrutinized due to increased sensitivity to drug effects in this population. Benzodiazepines impair thinking and cognition in elderly patients, and may predispose these patients to falls and injuries. The problem of inappropriate PRN orders is exacerbated by staffing shortages. In light of the shortage of registered nurses at Western State, standing PRN orders for benzodiazepines and/or antipsychotic medications are particularly problematic in that they allow relatively untrained staff to make daily decisions about medications.

B. Inappropriate Use Of Restraints And Seclusion

Restraint and seclusion practices depart substantially from accepted professional standards. Western State utilizes an excessive amount of seclusion and restraint for inappropriate reasons and for inappropriately long periods of time, contrary to accepted professional practice.

Patients at Western State often remain 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. Staff lack an understanding of less restrictive measures that could be utilized where appropriate. Patients, therefore, often remain in restraints long past the point, when according to accepted professional practice, release should occur.

One patient, C.C., has been living in seclusion for years. The walls of his three-room living unit are clear plastic where trays of food are pushed inside. Our psychiatric consultant concluded that patients, such as Mr. C., who are almost continually secluded and/or restrained require more intensive behavioral analysis and treatment planning, including regular consultation with outside experts when extant treatment plans are ineffective in reducing the need for seclusion and restraint.

The types of restraint Western State uses also are often excessive and reflect a lack of professional judgment by a qualified professional. Patients frequently are placed in restraints in a face-down position. Western State policy allows also for patients to be placed in six-point chair restraints and eight-point bed restraints. Moreover, during the time of our tour, Western State was tying patients in posey-vest restraints to side rails on their beds. All of these practices are dangerous and do not comport with accepted professional standards. In addition, Western State's use of locked jumpsuits (to deter sexual activity) is an inappropriate substitute for staff observation and behavior programs.

Monitoring of patients while in seclusion or restraint also is deficient. In its annual seclusion and restraint report (August 26, 1998), Western State identified "several weaknesses" in the seclusion/restraint monitoring process. These weaknesses included inadequate responses by treatment teams and problems with monitoring compliance with facility procedures. Our consultants confirmed the continuing existence of these problems during their tours and identified other deficiencies in the monitoring process. Patients, including suicidal patients, are left in restraints or seclusion without qualified staff regularly checking and attending to their needs.

In sum, seclusion and physical restraints at Western State are used excessively, for the convenience of staff, in lieu of treatment, and in circumstances which represent substantial departures from accepted professional judgment.

C. Inadequate Nursing And Medical Care

Western State nursing and medical care staff are not responding on a timely basis to assess and treat serious medical problems. For example, S.H. was seriously ill for over 36 hours with no documentation of a general medical assessment until his condition had deteriorated to near death. The patient developed a fever of 103.3 on the evening of February 14, 1998 (Saturday of a three-day weekend). The doctor on call did not come to the unit to examine the patient, but rather gave an order for the next such doctor to check the patient the following day. There is no documentation of an evaluation of the patient's medical condition on Sunday. By Monday, S.H. was complaining of chest pain and was staggering and pale. He was transferred to the local general hospital, where he died several hours later.

Another patient, M.P., did not receive adequate medical care for a life threatening and ultimately fatal condition. Western State staff failed adequately to treat this patient, who suffered from severe respiratory disease, even after her family complained that she was dying. Western State records show nothing was done for M.P. between July 3, 1997 when her sister told the hospital that M.P. feared she was dying, and July 7, when she was found dead. We found no record of any physical evaluation or assessment by any professional or direct care staff during M.P.'s last four days. In addition, the medication cardex indicated that the inhaler M.P. had been given was a nasal, not a pulmonary, inhaler and therefore would be ineffective for the patient's pulmonary problem.

Western State has chronically operated short-staffed, relying on a daily basis on the use of overtime to cover nursing staff shortages. To continue the use of overtime at the same rate for an entire year would result in the equivalent of hiring 14 additional full-time nurses. Operating on such a margin on a regular basis is dangerous, has resulted in a lack of monitoring, review and coordination of health care services and does not comport with accepted professional standards.

While the number of personnel to provide general medical care appears adequate, the organization and supervision of these services is inadequate. Western State relies heavily on the use of physician extenders (nurse practitioners and a physician assistant) who are supervised only nominally by physicians. Inadequate supervision of physician extenders creates an undue risk of harm to patients.

Patients at Western State have dysphagia, decubiti, incontinence and a significant number are at risk for falls. Nonetheless, Western State does not have protocols (standards of care) to direct nursing practice and standardize nursing care for any of these medical problems. The lack of appropriate protocols does not comport with professional practice and presents an unreasonable risk to the health and safety of patients.

D. Failure To Ensure Reasonable Safety Of Patients

1. Inadequate Protection From Injuries, Dangerous Behaviors, and Abuse

The facility's incident reports, risk management event reports, and mortality reviews document a high level of injuries and dangerous situations that place patients at risk of harm. Many patients suffer repeated injuries due to self-abuse and aggressive acts of other patients. Many of these incidents are preventable and reflect systemic deficiencies at Western State including lack of adequate staffing, failure to supervise patients, and inadequate assessment and treatment of mental illness and behavioral problems.

Within a 90-day period last year (April-June 1998) Western State recorded 169 altercations, 81 instances of self-injurious behavior, and 128 falls. During that same time period, there were eight suicide attempts and 13 elopements. In addition, we found a high rate of staff injuries and a number of worker compensation injuries related to inadequate management of aggressive patients. Incident reports document numerous injuries to high-risk patients (aggressive, assaultive and self-injurious patients) as a result of inadequate monitoring. Yet, Western State does not have a nursing policy for routine monitoring of patient status. Patients have experienced severe distress, been assaulted by other patients, suffered serious injuries, and even have died as a result of Western State staff's failure to monitor patients on a regular basis. An example is the 1997 suicide by hanging, of C.H., where the medical examiner concluded that the patient probably had been dead for an hour before being discovered.

Western State also does not have adequate procedures for investigating untoward events, abuse allegations and deaths. We reviewed numerous incident reports involving injuries where the medical staff conducted little or no follow-up to determine the cause of the incident, its effect on the patient, or how similar incidents might be avoided in the future. Finally, the facility fails to conduct adequate mortality reviews. Given the problems with the health care delivery system at Western State, detailed above, the failure to conduct routine, independent mortality reviews is a serious deficiency because such reviews may reveal issues that require remedial attention.

2Unsafe and Inadequate Physical Conditions

There are suicide hazards in bedrooms and bathrooms throughout Western State. An internal 1997 Western State study identified several hundred hazards; most often conduit and thermostats in bedrooms and pipes, shower fixtures and room dividers in bathrooms. Almost all bathrooms have exposed fixtures, pipes, shower-heads, fire-alarms, door hinges and bars between toilets that could easily be used by suicidal patients to hang themselves. Western State officials report that budgetary constraints have limited the ability to repair identified hazards. The unrepaired hazards present a great risk of harm to patients in an institution that treats a large number of individuals who are suicidal.

D. Inadequate Discharge Planning And Community Services

The Commonwealth offers a wide variety of community mental health services to former hospital patients, including Western State patients. However, the Commonwealth does not have a sufficient number of community residential and other mental health support services to meet the needs of Western State patients. As a result, there are many patients at Western

State whose treating professionals have determined that they

are appropriate for discharge, but they remain hospitalized because needed community aftercare services are not available. Our psychiatric consultant agreed with the 1997 findings of

Dr. Geller, the Commonwealth's psychiatric consultant, that a significant percentage of patients confined to Western State could be discharged if appropriate community placements were available.

Medicare/Medicaid regulations and generally accepted professional standards require psychiatric hospitals to assess patients on a regular basis for their discharge potential and to develop adequate discharge plans to meet the individual patient's needs. 42 C.F.R. § 482.43.Moreoverthe Commonwealth has an obligation to ensure that once patients are transferred, the setting is safe and adequate to meet their needs.

The Department of Justice has promulgated regulations pursuant to Title II of the ADA that require public entities to provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. 42 U.S.C. § 12132 et seq., 28 C.F.R. § 35.130(d). The Supreme Court recently upheld the Department's interpretation of this regulation that unjustified institutionalization of persons with mental disabilities is a form of discrimination on the basis of disability prohibited by Title II. Olmstead v. L.C., 119 S.Ct. 2176, 2185 (1999). The Court found a state "generally may rely on the reasonable assessments of its own professionals in determining whether an individual 'meets the essential eligibility requirements' for habilitation in a community-based program. Id. at 2187. A reasonable professional judgment about the most integrated setting appropriate for an individual should not be affected by extraneous considerations, such as administrative convenience and costs. The Supreme Court summarized the states' obligations under Title II of the ADA, as follows:

States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the Stateand the needs of others with mental disabilities. Id. at 2189.

Western State's discharge planning is inadequate and violates federal law and professional standards of care. Western State fails to ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are not affected by administrative convenience and costs. In addition, facility professionals have identified many patients who could appropriately be served in more integrated, community settings but community placements have not been offered to these patients.

In addition, when Western State discharges patients, it does not develop adequate discharge plans to ensure appropriate patient transition into the community. There are numerous examples of patients discharged without adequate community supports. For example, M.B., a 39-year old patient diagnosed with schizophrenia and substance abuse, was admitted to Western State after he was found naked and incoherent in a cemetery. He was discharged the day after he was admitted with a 30-day supply of medications and no discharge plan. L.J., a 34 year old woman with bipolar disorder and a history of alcohol abuse and suicide attempts, was admitted to Western State because she had suicidal ideation and a plan to kill herself by overdosing on medication. She was discharged from the facility three days later without a discharge plan. Western State security staff simply drove her to the bus station and dropped her off. Western State social workers report that it often is difficult to arrange aftercare appointments for patients and that patients frequently must wait three to four weeks after their discharge for an appointment with a psychiatrist. As a result, some patients become ill and non-compliant before their first aftercare appointment and have to be re-hospitalized.

II. Minimum Remedial Measures

The deficiencies at Western State mirror, in many respects, the deficiencies we found in our CRIPA investigations of Central State Hospital, Eastern State Hospital, and the Northern Virginia Mental Health Institute. Therefore, many of the following minimum remedial remedies are similar to those we previously identified in findings letters regarding other Virginia mental health facilities.

A. Mental Health Care

1. Western State must provide adequate and appropriate psychiatric and other mental health services in accordance with accepted professional standards.

2. Western State must conduct interdisciplinary assessments of patients consistent with generally accepted professional standards. The assessments should identify and prioritize each patient's individual mental health problems and needs, including maladaptive behaviors and substance abuse problems.

3. The treatment process should be reformed. Patient treatment must be appropriate, individualized, coordinated, and properly managed. Such programs should 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 an interdisciplinary process. Patients should have appropriate input in the treatment process. Treatment should be based on objective data and clearly established goals. Staff should be trained to write professionally appropriate behavioral goals and objectives. Staff should collect reliable data and use it in treatment decisions as part of the treatment planning process. Staff should implement treatment plans consistently, assess their efficacy and review and revise them when appropriate.

4. Western State must provide adequate psychological services and behavioral management. Behavioral management should focus on teaching alternative, adaptive behaviors.

5. Western State should provide adequate psychosocial rehabilitation programs that are individualized to patient's needs. In addition, Western State should provide adequate substance abuse programs.

6. Western State's psychopharmacological practices must comport with generally accepted professional standards. All use of drugs should be professionally justified, carefully monitored, documented, and reviewed by qualified staff. Medications should be prescribed based on clinical need, rather than budgetary considerations.

7. Western State must revise its psychopharmacological practices, including the use of antipsychotics, medication combinations, PRN orders and the prescription of benzodiazepines, to comport with accepted professional practice.

B. Seclusion and Restraint

1. Use of seclusion and restraint must comport with professional standards and must be conducted in a safe and appropriate manner.

2. The practice of using seclusion for the convenience of staff, or in lieu of treatment, must cease immediately. The decision to seclude and/or restrain a patient should only be employed pursuant to the exercise of professional judgment by a qualified professional.

3. Patients in seclusion and/or restraint must be adequately and appropriately monitored. Use of seclusion and restraints should be properly documented and reviewed in a timely fashion by qualified staff. Criteria for release from seclusion and restraints should be clearly identified.

4. Western State should cease immediately: the practice of placing patients in restraints in a face-down position; the use of six-point chair restraints; the use of eight-point bed restraints; and, tying patients in posey-vest restraints to side rails on their beds.

C. Nursing and Medical Care

1. Western State must ensure that its patients receive adequate medical, including emergency, care in accordance with generally accepted standards of care. Western State should ensure adequate and appropriate interdisciplinary communication among relevant professionals, and Western State physicians should write appropriate, complete and clear orders pursuant to professionally accepted standards.

2. Western State should develop and implement nursing protocols for dysphagia, decubitus care, bowel and bladder training and fall risk assessment and abatement.

3. Western State should develop and implement an adequate quality assurance process in accordance with professionally accepted standards.

D. Protection From Harm

1. Western State must provide a safe environment for its patients. Staff members should adequately monitor and safeguard the patients, especially those with histories of exhibiting behaviors that cause injuries to themselves or others. Patients also must be protected from being victimized by other aggressive patients.

2. Western State should employ sufficient trained, independent investigators to ensure that all incidents of abuse, serious injury or unexpected death are adequately investigated.

3. Western State should develop and implement adequate nursing protocols to ensure that patients are appropriately supervised and monitored.

4. Western State should develop and implement adequate suicide prevention measures, including initial assessment protocols and a sufficient number of qualified staff to supervise suicidal patients adequately.

5. Physician orders for enhanced supervision must be communicated to appropriate staff and implemented.

6. Western State should abate suicide hazards in bedrooms and bathrooms.

E. Discharge Planning and Community Placement

1. Qualified professionals at Western State should evaluate patients on a periodic basis to determine the most integrated setting appropriate to meet each patient's individualized needs.

2. Individualized discharge criteria should be adequately developed and discharge planning should be a consideration before a patient is about to be discharged.

3. Western State should develop and implement adequate discharge plans that identify the necessary aftercare services to meet the needs of patients upon discharge.

4. Western State should develop a system to oversee the discharge process and aftercare services. This system should ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are implemented and that appropriate aftercare services are provided that meet the needs of the patient in the community.

5. The Commonwealth should provide appropriate linkages between hospital and community services in order to ensure adequate patient transition into the community.

6. The Commonwealth should ensure that Western State patients receive mental health services in the most integrated setting appropriate to their needs. The Commonwealth should address the placement of those in-patients whom professionals have determined are appropriate for community placement.

F. Staffing

1. Western State should hire and deploy a sufficient number of qualified direct care and professional staff, particularly psychiatrists and nurses, necessary to provide patients with adequate supervision and medical and mental health treatment.

Pursuant to the Civil Rights of Institutionalized Persons Act, 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). Based on our recent experience regarding other mental health facilities in Virginia, we fully expect to work cooperatively with the Commonwealth to resolve the deficiencies we have identified without resort to contested litigation. As noted earlier, we are aware that Virginia is already engaged in efforts to improve conditions at Western State and look forward to receiving the initial plan of correction based upon these efforts.

We will forward our expert consultants' reports under separate cover. Although their reports are their work -- and not necessarily the official conclusions of the Department of Justice -- their observations, analyses and recommendations provide further elaboration of the relevant concerns, and offer practical assistance in addressing outstanding challenges at Western State. We hope that you will give this information careful consideration and that it will assist in promoting a dialogue aimed at quickly addressing the problems that we note.

Again, we want to thank you for your cooperation, both in this matter as well as in our other CRIPA investigations.

Sincerely,

Bill Lann Lee
Acting Assistant
Attorney General
Civil Rights Division

cc: The Honorable Mark L. Earley
Attorney General

Commonwealth of Virginia

Mr. Robert Claude Allen
Secretary
Department of Mental Health and Human Resources

Mr. Richard Kellogg
Commissioner
Department of Mental Health

Dr. Jack W. Barber
Director
Western State Hospital

The Honorable Robert P. Crouch, Jr.
United States Attorney
Western District of Virginia

The Honorable Helen F. Fahey
United States Attorney
Eastern District of Virginia >

Updated August 6, 2015