



U.S. Department of Justice

Civil Rights Division

*Assistant Attorney General
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August 24, 2009

The Honorable Jon Corzine
Governor of New Jersey
Office of the Governor
P.O. Box 001
Trenton, NJ 08625-0001

Re: CRIPA and ADA Investigation of Ancora Psychiatric Hospital,
Winslow, New Jersey

Dear Governor Corzine:

I am writing to provide the Civil Rights Division's report of findings regarding our investigation of conditions and practices at the Ancora Psychiatric Hospital ("Ancora") in Winslow, New Jersey, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997a. CRIPA gives the Department of Justice authority to seek a remedy for a pattern and practice of conduct that violates the constitutional or federal statutory rights of persons confined to public institutions, including psychiatric hospitals such as Ancora.

On September 4, 2008, we notified you that we were initiating an investigation of conditions and practices at Ancora. We conducted an on-site inspection on January 12-15, 2009. After deferring our investigation several months to accommodate the State's request, we conducted our on-site review with the assistance of expert consultants in the fields of psychiatry, psychology and discharge planning, psychiatric nursing, and protection from harm. While on-site, we interviewed administrative staff, mental health care providers, and patients and examined documents, patient records, and physical plant conditions. In addition to our on-site inspection, we reviewed a wide variety of documents, including policies and procedures, incident reports, and patient records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tour with an extensive debriefing at which our consultants conveyed their initial impressions and concerns about Ancora to counsel, administrators and staff, and State officials.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation pertaining to Ancora, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at Ancora violate the constitutional and statutory rights of its patients. In particular, we find that (A) Ancora fails to provide adequate discharge planning to ensure placement in the most integrated setting and to provide adequate supports and services necessary for successful discharge and (B) Ancora's policies and practices subject patients to an excessive risk of serious harm by (1) providing inadequate systems to identify and reduce risks of harm, (2) providing inadequate clinical management and nursing care, (3) failing to use restraints appropriately, and (4) failing to provide appropriate mental health assessments and treatment. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XVIII and Title XIX of the Social Security Act, 42 U.S.C. §§ 1395 to 1395b-10 and 1396 to 1396w-1; 42 C.F.R. §§ 482-483 (listing program requirements for participating in Medicare and Medicaid); 42 U.S.C. §§ 12132-12134; 28 C.F.R. § 35.130(d); Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-7; see also Olmstead v. L.C., 527 U.S. 581 (1999).

Many of the findings we make here have also been made by other agencies in the past. See, e.g., U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Survey of Ancora State Hospital (March 31, 2008) ("CMS Survey"); Rutgers Center for State Health Policy, "Barriers to Discharge, Optimal Housing and Supportive Mental Health Services for Residents with Conditional Extension Pending Placement Legal Status Final Report" (May 2006) ("Rutgers CEPP Report"). Throughout this letter, we include specific references to past findings by these entities, where appropriate. We found that these conditions remain unabated, despite the fact that the State and Ancora have been notified about the deficiencies.

On the issue of discharge services, a decade ago, the United States Supreme Court made clear that the unnecessary institutionalization of persons with disabilities is discrimination and violates the law. Olmstead, 527 U.S. at 587. Olmstead involved two women with developmental disabilities and mental illness who were inappropriately confined at a state psychiatric hospital. Id. at 593, 597. The Supreme Court held that states are required to provide mental health treatment to persons in the most integrated, appropriate settings. See id. at 596-97. Despite the mandate by the Supreme Court, our review of discharge planning at Ancora finds that New Jersey frequently fails to ensure that patients receive

appropriate and sufficient services to enable them to live in the most integrated setting consistent with their needs, as required by federal law.

I. BACKGROUND

Ancora, operated by the New Jersey Department of Human Services, Division of Mental Health Services (“DMH”), is located in rural southeastern New Jersey. Ancora provides mental health services to approximately 580 adults. The population includes patients with dual diagnoses of both mental illness and either developmental disabilities or substance abuse. The vast majority of the patients at Ancora have been committed there by a court. Approximately one third of the patients are forensic commitments. Ancora also houses some voluntary patients.

II. LEGAL STANDARDS

The State of New Jersey must provide services to qualified patients with disabilities in the most integrated setting appropriate to their needs. ADA, 42 U.S.C. § 12132 (“[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”), and its implementing regulations; 28 C.F.R. § 35.130(d); see Olmstead, 527 U.S. at 607 (holding that a State is required to provide community-based treatment for persons with mental disabilities when that 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); Helen L. v. DiDario, 46 F.3d 325 (3d Cir. 1995) (holding that the ADA was violated where a person with disabilities was offered personal care services in an institutional setting but not at home); see also Press Release, The White House, “President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities” (June 22, 2009) (Announcing the Year of Community Living Initiative, President Obama affirmed “one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.”).

In construing the anti-discrimination provision contained within the ADA, the Supreme Court held that “[u]njustified [institutional] isolation . . . is properly regarded as discrimination based on disability.” Olmstead, 527 U.S. at 597, 600. Specifically, the Court established that states are required to provide community-based services and supports for persons with mental disabilities when treatment professionals have determined that community placement is appropriate, provided that the transfer is not opposed by the affected patient, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities. Id. at 602, 607.

The regulations promulgated pursuant to the ADA provide: “A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d) (the integration mandate). The courts have endorsed a straightforward reading of this regulation:

[t]he proper interpretation of the regulations’ definition of “most integrated setting” is set forth in the regulations themselves: whether a particular setting “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.”

Disability Advocates, Inc. v. Paterson, 598 F. Supp. 2d 289, 320 (E.D.N.Y. 2009).

The Fourteenth Amendment due process clause also requires a state mental health care facility to provide “adequate food, shelter, clothing, and medical care,” Youngberg, 457 U.S. at 315, along with “conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests,” Id. at 324. More particularly, a state mental health hospital is constitutionally required to provide reasonable, adequate mental health treatment. See, e.g., Torisky v. Schweiker, 446 F.3d 438, 448 (3d Cir. 2006) (concluding that plaintiffs may be able to prove that they were deprived of their constitutional liberty interest and of Youngberg’s duty of care and protection when they were transferred, against their will, to an inappropriate institution); Scott v. Plante, 691 F.2d 634, 636-38 (3d Cir. 1982)(affirming that state psychiatric hospital patients have a right to adequate treatment, a right to reasonable care, and a right to be free from unreasonably restrictive confinement); Fournier v. Corzine, No. 07-1212, 2007 WL 2159584, at *11 (D.N.J. 2007) (“The Fourteenth Amendment Due Process Clause requires state officials to provide civilly committed persons . . . with access to mental health treatment that gives them a realistic opportunity to be cured or to improve the mental condition for which they were confined.”).

Treatment is not adequate if it substantially departs from generally accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23; Rennie v. Klein, 720 F.2d 266, 269-70 (3d Cir. 1983) (applying the professional judgment standard to the decision to administer, and the administration of, antipsychotic drugs to involuntarily committed, mentally ill patients against their will). States are also compelled by the Constitution to ensure that patients are free from hazardous drugs that are “not shown to be necessary, used in excessive dosages, or used in the absence of appropriate monitoring for adverse effects.” Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff’d, 902 F.2d 250 (4th Cir. 1990). Medicare/Medicaid regulations governing psychiatric hospitals

also require adequate staffing, record keeping, care, treatment, and discharge planning. 42 C.F.R. §§ 482-483.

Patients' constitutional liberty interests in security compel states to provide reasonable protection from harm in mental health hospitals. Youngberg, 457 U.S. at 315-16; Shaw v. Strackhouse, 920 F.2d 1135, 1139, 1149 (3d Cir. 1990) (applying Youngberg professional judgment standard to primary care professionals, supervisors, and administrators named as defendants and holding that a jury could reasonably find that these defendants' failure to increase plaintiff's security or separate him from employee(s) suspected of sexually assaulting plaintiff constituted a failure to exercise professional judgment); United States v. Dise, 763 F.2d 586, 589 (3d Cir. 1985) (holding that the jury "certainly could have concluded" that an aide at a state institution for persons with developmental disabilities deprived residents of their liberty interests in personal security and freedom from bodily restraint when the aide intentionally battered the residents).

Generally accepted professional standards also require that patients in state psychiatric hospitals remain free from undue bodily restraints. In Youngberg, the Supreme Court also recognized that an individual who is involuntarily committed to an institution retains a liberty interest in freedom from bodily restraint. 457 U.S. at 316. Youngberg requires that restraints be imposed only to the extent required by the judgment of professionals. Id. at 321-25; Kirsch v. Thompson, 717 F. Supp. 1077, 1080-1081 (E.D. Pa. 1988) (holding that plaintiff's Fourteenth Amendment rights were violated when he was restrained at a state hospital in four-point physical restraints for an extended period). "It is a substantial departure from professional standards to rely routinely on . . . restraint rather than . . . behavior techniques such as social reinforcement to control aggressive behavior." Thomas S., 699 F. Supp. at 1189. Moreover, "restraint should only be used as a last resort." Id.; Davis v. Hubbard, 506 F. Supp. 915, 943 (W.D. Ohio 1980).

III. FINDINGS

The many deficiencies in care that exist at Ancora can be summarized in two overarching findings. First, Ancora segregates far too many patients for whom a hospital setting is not the most integrated setting appropriate, in violation of Olmstead and federal law. In particular, Ancora's discharge planning is inadequate, as are the supports and services that would otherwise facilitate the discharge of many patients. Second, while confined, patients at Ancora suffer an undue risk of harm, stemming from the facility's failure to treat aggressive and self-abusive behaviors and its failure to implement systems to protect patients from harm. Conditions and services at Ancora that substantially depart from generally accepted professional standards and contribute to violations of the constitutional and federal statutory rights of patients include: (1) inadequate systems to identify

and reduce risks of harm, including self-harm and assault by peers; (2) inadequate clinical management and nursing care; (3) frequent and inappropriate use of restraint; and (4) inadequate mental health treatment. In some of these areas, notably assessments, nursing, and discharge planning, Ancora has in place adequate policies and procedures that are not faithfully implemented. In other areas, notably incident and risk management and quality improvement, Ancora has neither adequate policies nor an adequate number of trained supervisory, professional, and direct care staff to provide appropriate care.

A. Ancora Segregates Many Patients Who Do Not Require Institutional Care

The State fails to provide services to Ancora patients in the most integrated setting appropriate to their needs. As detailed below, hundreds of patients currently confined at Ancora do not require institutional care, but nonetheless have not been discharged to the community or another more integrated setting.

Patients initially come to Ancora in one of four ways – they are committed by civil courts because they are a danger to themselves or others; they are committed by criminal courts after having been found to be not guilty by reason of insanity (“NGRI”); they are committed by criminal courts to be evaluated for fitness to proceed with a criminal trial; or, on rare occasions, they voluntarily admit themselves. When a civilly committed patient or an NGRI patient is found to be no longer a danger to himself or others but remains institutionalized because there is no place to which the patient can be safely discharged, under New Jersey state law, the patient’s commitment status is changed by the courts. The court places these patients under a commitment status unique to New Jersey, known as Conditional Extension Pending Placement (“CEPP”).

Nearly half of the patients at Ancora remain institutionalized under a CEPP commitment status. CEPP status was created by the New Jersey Supreme Court over 25 years ago and 15 years before the U.S. Supreme Court decided Olmstead. The New Jersey Supreme Court sought to balance patients’ due process liberty interests in not being institutionalized when no longer an imminent danger to themselves or others against the reality that discharge of vulnerable patients without appropriate community supports could threaten their survival. The compromise crafted by the New Jersey Supreme Court allows patients to be confined “on a provisional or conditional basis to protect their essential well-being, pending efforts to foster the placement of these individuals in proper supportive settings outside the institution.” See In re S.L., 94 N.J. 128, 140 (1983). For each patient who is committed and is in CEPP status, at mandated hearings at 60 days and then every six months, the State must demonstrate that it continues to make

reasonable efforts to improve the patient's ability to function in a community setting and to make a good faith effort to ensure placement. Id. at 141.

In practice, we find that CEPP status at Ancora is neither conditional nor pending any suitable placement. Of the 284 patients confined on CEPP status at Ancora in November 2008, nearly 22% had been on the list for more than two years, including A.A.¹, who has been on CEPP status for five years.

Being placed on CEPP status is an acknowledgment by the State and by Ancora staff – and requires a court finding – that a patient does not require institutional care. N.J. R. 4:74-7(h)(2) (describing court procedures for placing patient on CEPP status); see also In re S.L., 94 N.J. at 140-41 (requiring court determination to place patient on CEPP status). For these patients, continued institutionalization without provision of necessary services is unjustified segregation by reason of a psychiatric disability – the very discrimination clearly forbidden by the ADA. Olmstead, 527 U.S. at 597, 600. The continued institutionalization of persons who demonstrably do not require institutional care violates the integration mandate of federal law. Implicitly promising patients imminent discharge with appropriate supports without offering a real chance at attaining discharge is a particularly cruel deception.²

We also find that the State fails to provide patients at Ancora – whether during their initial civil or forensic commitment or once patients have been placed on CEPP status – with treatment services that address the patients' underlying disabilities and improve the patients' ability to function in a community setting and that are consistent with generally accepted professional standards. The State also does not provide adequate discharge services to facilitate placement in a more integrated setting.

¹ To protect patients' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with patient names.

² We are aware that the State recently settled Disability Rights New Jersey, Inc. v. Velez, Civ. No. 05-1784 (D.N.J. 2005) and committed to a number of important reforms to address Olmstead concerns throughout New Jersey's psychiatric hospital system. The case was filed in 2005 by Disability Rights New Jersey challenging the confinement of nearly 1,000 individuals on CEPP status in New Jersey's state psychiatric hospitals.

1. Inadequate Discharge Planning

The discharge plans we reviewed do not describe, identify, or secure the community resources necessary to serve patients in the community. Underpinning a court's decision to place a patient on CEPP status is a determination that this patient requires some additional support to live successfully in the community and that a discharge without this support is likely to fail and place the patient at risk of harm and/or re-institutionalization. Moreover, an essential component of an adequate discharge plan for any patient, whether on CEPP status or not, is linkage to necessary community supports. State and facility policies, procedures, and strategic plans confirm the critical importance of community coordination, yet we saw no evidence that these policies are implemented. Failure to ensure continuity of care in the community has resulted in failed discharges and in long delays for placement into the community. Examples include:

- A.A. has been on CEPP status for five years. The CEPP tracking document notes that A.A. was re-institutionalized because he lacked transportation to a methadone clinic in the community.
- B.B. has previously been discharged ineffectively to motels, has been on CEPP status since July 2008, and in November 2008 was awaiting a community placement.
- C.C. was admitted to Ancora for the twentieth time on November 17, 2008, and discharged just under one month later, on December 12, 2008. On her nineteenth admission, C.C. had been discharged and re-admitted within only one week. C.C. lives at home with her mother and has a job, two important community linkages. However, she was discharged with a referral but without a planning meeting between C.C., hospital staff, and the community provider of intensive case management services to which she was referred. Given her diagnosis of schizophrenia and her history of multiple admissions, the connection to intensive case management services should be in place prior to her discharge, so that intensive case management services would have been available on the first day of her return to the community.

2. Inadequate Services and Supports

The State has known for years of barriers to discharge for specific sub-groups of patients confined on CEPP status but has not taken effective steps to address them. The 2006 Rutgers Study identified subgroups of patients with significant barriers to discharge, including: (1) those who resisted discharge, (2) those with major behavioral problems coupled with psychiatric symptoms, (3) those with co-morbid medical complications, (4) those with a dual diagnosis of developmental

disability, and (5) those with a history of sexual offenses. Yet three years after the Rutgers Study, we found egregious lapses in the discharge planning and support for each of these populations. Ancora's CEPP population includes many patients with these previously-identified barriers, and little or no evidence that the barrier has been addressed in treatment, in violation of generally accepted professional standards. For example:

- Nearly half of the patients on a list that the facility identified as resisting placement – 25 of 59 patients – had refused placement more than a year ago. We saw no evidence that patients whose refusal was over a year old had been re-assessed, counseled, or provided education that could lessen their resistance to leaving the institution.
- A third of the patients on the facility's November 2008 CEPP Tracking Document ("CEPP List") faced one of these previously identified barriers to discharge in addition to mental illness: 25 also had a developmental disability, 24 had co-morbid medical concerns, 17 had co-occurring substance abuse diagnoses, and 29 had a history of sexual offenses. Yet, there is little or no evidence that these barriers to discharge have been addressed in treatment.

The 2006 Rutgers study identified patients with ongoing problematic behaviors as facing particular barriers to discharge, yet we find that Ancora consistently fails to provide effective treatment to these patients. Examples of Ancora's failure to treat maladaptive behaviors include:

- D.D., a young woman with diagnoses of schizophrenia and mild developmental disability, has been on CEPP status for more than three years. The CEPP List in November 2008 notes that she will be referred to placement upon stabilization of her maladaptive behaviors, yet she receives numerous PRN³ medications and is frequently restrained, indications that neither her underlying symptoms nor her problematic behaviors have been addressed.
- E.E., also a CEPP patient, was restrained 26 times from June through November 2008. Frequent restraint, like frequent PRN use, is often an indicator of failed treatment.

³ Pro re nata ("PRN"), or as-needed medications, are administered in response to exigent circumstances.

- F.F. was subject to 59 reported episodes of restraint in a 14-month period, and progress notes in his chart refer to his head-banging and restraint being “an everyday occurrence.” His chart contained a letter from his treatment team urging that he be transferred to a different hospital for treatment that, evidently, was not provided at Ancora.

The State’s DMH in January 2008 announced the “Home to Recovery CEPP Plan to Facilitate the Timely Discharges of CEPP Patients in New Jersey’s State Psychiatric Hospitals” (“CEPP Plan”). Parallel changes to Ancora’s policies and procedures were also announced in Administrative Order 1:91, May 29, 2008. The CEPP Plan’s proposed actions include policy reforms and the creation of a new community-based infrastructure to support discharge opportunities. The CEPP Plan calls for the creation of hospital-based Olmstead committees to be comprised of hospital staff, community-based providers, and regional DMH staff to locally plan, implement, track, and evaluate existing discharge policies and procedures. The CEPP Plan addresses the collection of data on community capacity and on individual patients’ adjustment to the community following discharge. The CEPP Plan also outlined steps to address discharge barriers for some of the hardest-to-place populations, including the creation of Utilization Review and Intensive Case Review Committees to address timely discharges of patients on CEPP status. Specific steps included development of a survey of consumer housing preferences, and use of the Level of Care Utilization Scale (“LOCUS”) to enhance discharge assessments. In addition, New Jersey’s October 2007 Wellness and Recovery Transformation Action Plan affirms the need for Ancora to develop wellness and recovery-oriented, strength-based programming. From our review of Ancora discharge records, we saw no indication that Ancora has established these committees, referred any of its difficult cases to these committees, implemented any other aspect of the CEPP Plan, or implemented wellness and recovery-oriented programming. It is not surprising, then, to find so many patients segregated in this institution, without effective treatment and without adequate plans for discharge. In short, the State identified the legal obligation, created a plan, and yet, failed to implement it.

B. Ancora Patients are Subject to Serious, Frequent, and Recurrent Harm

Patients at Ancora have a right to live in reasonable safety. See Youngberg, 457 U.S. at 315, 322. Yet patients at Ancora are not reasonably safe. Statistics published on the State’s website show that in the first half of 2008, although Ancora accounted for only one third of the State’s institutionalized patients, it accounted for a disproportionate share of reported assaults – 48% – almost half of the reported incidents in the State system. There were almost 1,500 reported patient-on-patient assaults in the 14-month period from September 2007 through November 2008.

Ancora patients engaged in repeated high-risk behaviors, including self-injury and aggression, without appropriate treatment and intervention by the facility. We find that both Ancora's failure to treat these high risk behaviors and its failure to implement systems to identify and minimize risks contribute to this excessive level of harm at the facility.

1. Ancora Has Inadequate Systems To Identify and Reduce Risks of Harm

Ancora patients suffer serious, frequent, and recurrent harm. Generally accepted professional standards require Ancora to take affirmative, strategic efforts to protect patients from harm by reducing risk. The essential elements of a risk management system include assessing and monitoring risk for each patient through accurate incident reporting, identification of actual or potential risks of harm, tracking and trending of data, adequate investigations, and quality assurance monitoring and reviews. Ancora substantially departs from these standards of care by failing to adequately protect patients from recurring and serious harm, including harm from frequent patient assaults, self-injurious behaviors, an unduly unsafe environment, and abuse and neglect.

a. Inadequate Incident Management

Our review of incidents indicated that while reports appear routinely to be filled out, incident reporting at Ancora fails to capture critical information. To comply with generally accepted professional standards, incident reporting systems must include patient-centered accounts and causal analysis of events, including: the injured party's account of the incident; witness statements; critical review of statements; and a review of the patient's rates of injury, treatment, and safety over the course of his or her stay at the facility. Ancora does not track incident data regarding harm resulting from different causes, such as poor staff supervision, failure of 1:1 staff to supervise and protect a single patient, and neglect by denial of treatment. In addition, Ancora's incident reporting system does not adequately capture information on administrative failures to adequately supervise and train staff to perform their duties. Nor does Ancora's incident system adequately collect information regarding fiscal exploitation of patients. The failure to collect such information renders Ancora managers unable to identify specific trends and respond appropriately to protect patients.

After unit staff submit incident information, Ancora fails to adequately review incidents. The Risk Management Director confirmed that the Incident Review Committee does not analyze incidents with a view to developing prevention plans to eliminate or minimize recurrences. In the Communication Meeting, where Section Chiefs present information on daily occurrences, some incidents are

reported in a very rapid fashion but without any critical analysis. The absence of interdisciplinary analysis of harm suffered by patients impedes the development of deliberate efforts to prevent future harm and indicates a significant deficit in the administration's operational oversight. For example:

- On November 8, 2008, staff reported G.G.'s assault, self-injurious behavior, and property destruction that resulted in placement in four-point restraints. The treatment team noted in the incident only that the patient "was seen by the team and will remain on 1:1 supervision." There were no Treatment team instructions to prevent similar future harm.
- On December 2, 2008, a patient slapped and kicked H.H., yet the treatment team resolution noted only "no significant injury noted." H.H.'s Treatment team failed to document any analysis of how the incident occurred and how best to prevent reoccurrence.
- I.I. assaulted a peer on December 22, 2008, while on 1:1 supervision; the treatment team noted only that he was "agitated and unpredictable." This "resolution" fails to analyze the antecedents of the assault, what could have been done to prevent the episode, or how best to prevent similar future harm.

We noted repeated examples where treatment teams failed to develop preventive interventions that are necessary to ensure patient safety. Consequently, the incident management system at Ancora falls significantly short of generally accepted standards. As a result, patients continue to be exposed to actual and potential harm.

b. Inadequate Management of Risk

Incident management focuses on the collection and analysis of data that are meaningful to protect a particular person from harm, while risk management focuses on identifying potential harms and taking timely action to prevent the harm from systematically occurring or recurring. Both are essential to an adequate protection-from-harm system. Although Ancora develops lists of persons identified to be at risk of aggressive and self-injurious behaviors, its response to those risks with treatment is inadequate. We found widespread patient-on-patient assaults and unchecked self-injurious behaviors. As noted above, Ancora reported almost 1500 patient-on-patient assaults in the 14 months prior to our visit. Examples of

serious patient-on-patient assaults, resulting in injuries to the following patients, include:

- J.J., with a fractured jaw;
- K.K., with a fractured kneecap;
- L.L., with a fractured ankle;
- M.M., with a fractured skull;
- N.N. and O.O., with fractured hands;
- P.P., with eight sutures to his elbow;
- Q.Q., with five sutures to his left eye area;
- R.R., with five sutures to his head; and
- S.S., with six sutures to his head.

Between September 2007 and November 2008, numerous Ancora patients suffered significant harm requiring hospitalization, including:

- T.T., with a fractured jaw after jumping from a balcony while on an outing;
- U.U., with both rib and nose fractures;
- V.V. and W.W., for sutures to treat lacerations;
- X.X., with a fractured arm; and
- Y.Y., for repair of a head laceration.

Other patients were hospitalized for repeated episodes of serious harm. Among such patients were:

- Z.Z., with more than ten hospitalizations for ingesting foreign objects, to rule out displacement of lower jaw, and for head trauma after falls;
- A.B., with separate hospitalizations for right leg and right arm hematomas due to possible trauma;

- B.C., who was transferred to the hospital for a head laceration from a fall and, separately, to rule out a hip fracture; and
- F.F., who was transferred to the hospital on separate occasions for sutures to a head laceration, to rule out a hip fracture, for other head trauma including contusion, and for an injury characterized as a facial “avulsion” (i.e., forcible tearing).

The frequency of this harm supports our finding that treatment teams at Ancora fail to address the root causes of patients’ inappropriate behavior and consequently fail to intervene adequately to prevent future incidents. We found no effective risk management program that documented comprehensive individualized risk assessments and planned responses to avoid bad outcomes. There was no evidence of periodic monitoring to assess whether patients’ risk of harm is decreasing. Ancora may report the occurrence of injuries, but it does not take deliberate, effective steps to prevent recurrence, placing patients at ongoing and unreasonable risk of harm.

Our review of the mortality review process also confirms the facility’s failure to analyze the root cause of adverse incidents. We reviewed records of the mortality review process for the one-year period before our January 2009 tour and found that the reviews were cursory and routinely made no recommendations for improvements in care. In fact, we could not discern that any specific recommendations for improvements in patient care were made and followed through, even in cases where generally accepted professional standards would have required them.

Although the Risk Management Committee (“RMC”) in 2008 identified a number of areas of harm it planned to address, our investigation revealed no evidence that the RMC followed up on its plans. In February 2008, the RMC described plans to survey patients to ask what patients thought would help reduce violence, but we saw no such survey. In March 2008, the RMC supported staff “reenactment training” to address better approaches to patient care, but we saw no evidence that the RMC took steps to establish that program before our January 2009 visit. The RMC consistently fails to follow up on areas identified as in need of improvement:

- CMS cited the danger of non-suicide-proof door handles in early 2008, and Ancora’s Plan of Correction submitted to CMS proposed to develop a plan by April 2008 to replace this hardware. Despite the urgency of this task, during our visit nearly a year later, protruding door handles that could be used to commit suicide by hanging were present throughout patient areas.

- In April 2008, the RMC reported that 25 per cent of staff fail to bring a diet instruction list to meals, yet the RMC took no steps to correct the problem and ensure mealtime safety. During our visit nine months later, we observed patients with mealtime precautions for aspiration and choking risk and those with restricted diets still not appropriately supervised and still not receiving diets consistent with physician orders, which placed these patients at significant risk of harm. Pursuant to policy, dietitians conduct monthly observations which documented many instances of patients at risk for immediate harm during mealtime.⁴ Despite the clear risk for significant, lethal harm to patients, improvement plans apparently were written only if compliance was below 90% overall, and these plans were reactive. They did not address systemic issues or proactive prevention.
- The RMC identified concerns about staff speaking languages other than English around patients, but it prepared no plan to remedy the issue.

In order to provide adequately safe conditions at Ancora, the RMC must take prompt affirmative steps to address serious safety issues that it identifies. Of equal importance, the RMC must establish a process that ensures that additional risks are brought to the attention of the Risk Manager and individual patient's treatment team. Examples of predictable risk not managed proactively by the risk manager, the RMC, or a patient's Treatment team include decubitus ulcers, or pressure sores, in bed-bound patients, and insufficient monitoring and supervision of patients with particularly high risk at mealtime, due to dietary restrictions, swallowing difficulty, or pica behavior. Examples include:

- D.E. is bed-bound, is supposed to be re-positioned by staff every two hours to relieve pressure areas, and was prescribed a special air mattress as an additional precaution against developing pressure sores. In September 2008, a physical therapist found that D.E. had developed multiple new bedsores and concluded that the air mattress had not been working for some period of time. No staff had proactively monitored the air mattress to ensure that it was working – the only note in D.E.'s chart was a nursing note the day before the physical therapist's visit, noting that the mattress had been repaired.

⁴ Pursuant to policy, nursing is also required to observe mealtime and document any findings. We requested aggregate data reports from this required monitoring but did not receive them. Because the risk of harm from aspiration is predictable and the harm can be significant, generally accepted professional standards require that prescribed monitoring for this risk be completed, the data aggregated and analyzed, and proactive corrective plans implemented and monitored.

There was no documentation about when it was discovered to be broken, when a repair was requested, whether any supervisory staff were notified, and whether any additional precautions were taken to address the risk to D.E. during the time the mattress was broken. The physical therapist concluded that the additional bedsores were a result of the non-functioning of the air mattress.

- Despite D.E.'s ongoing risk of developing bedsores, the facility's management of this risk continued to be poor. During our January 2009 visit, there was no positioning schedule posted in D.E.'s room, as prescribed by her plan, and one could not be located by the assigned staff. The problem was corrected once it was identified by our consultant, demonstrating only reactive, not proactive care to manage the identified risk to this patient.
- We observed several patients on the Birch A unit with aspiration and choking precautions who were unsupervised at mealtime. Staff interviewed during our visit could not uniformly articulate the level of supervision required for patients with choking risk, or high choking risk, as outlined in Ancora policy.

Many patients at Ancora engage in repeated pica behavior, the ingestion of inedible objects, without appropriate intervention:

- E.F. ingested a crayon piece and three metal screws on two occasions in March 2008 and a piece of a broken toothbrush in April 2008;
- F.G. ingested a piece of glass from a door she had broken in March 2008;
- G.H. ingested numerous items in a 10-month period ending in October 2008, including eyeglass arms, a fork, two pens, and, incredibly on one occasion in August 2008 during which he was on a 2:1 staffing, a plastic fork, spoon, and knife;
- H.I., J.K., L.M., and N.O. ingested batteries.
- In April 2008, P.Q., who was on 1:1 staffing at the time, consumed, from a trash can, the vomit of another patient who had a life-threatening illness.

The facility's typical response to patients at risk of pica was "verbal prompting to not eat inedible items." This is not sufficient treatment for a behavior with such serious health consequences. At a minimum, these cases required a professionally competent functional analysis of behavior. In the case of patient X.Y., who has had several behavior plans over the course of several years, the

record contained no functional analysis at all, and in no patient records did we find functional analyses that met generally accepted professional standards.

Even in those instances where Ancora officials make recommendations to address protection-from-harm issues, we saw no evidence that such recommendations are communicated to living-unit staff and implemented; and there is no evidence that staff are responsible for monitoring implementation of any such recommendations. Without an adequate data-driven system to identify and address patterns of harm to patients and record whether incidents of harm abate or increase in response to interventions, Ancora cannot adequately identify patient risks and prevent recurrent harm.

A structural problem underlies these many failures in protecting Ancora patients from harm. The job description for Ancora's "Risk Management Director" does not specify risk management responsibilities. There is no evidence that Ancora has appointed any other manager with the responsibility to act as gatekeeper to oversee risk management. As a result, risk management information is fragmented across different disciplines and is uncoordinated. Information to support appropriate preventive intervention is not collected and operationalized, and patients continue to suffer preventable injury.

c. Inadequate Investigative Practices

Generally accepted professional standards dictate that facilities like Ancora investigate serious incidents, such as alleged abuse, neglect, mistreatment, serious injury, and deaths. During the investigation, evidence should be systematically identified, preserved, analyzed, and presented. Investigators generally should visit the scene of the event, review any videotapes of the incident, obtain adequate accounts of the event from all credible witnesses, maintain confidentiality, and present timely, written conclusions based upon analysis of the findings. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements, such as policies and procedures. The investigative report should set forth the evidence considered, including all interviews conducted and documents reviewed, and it should clearly state the conclusions reached and the reasons for those conclusions. The investigative process at Ancora is deficient in each of these important respects.

Timeliness is paramount in order to elicit accurate information about the event. Delays in initiating investigations can compromise the ability of eyewitnesses to provide accurate accounts. Case closing dates in the investigative files we reviewed in many instances were as long as nine months or more after the underlying incidents had occurred, suggesting that there is no immediacy to the

outcome of the investigation. Most important, the failure to initiate promptly an investigation places the patient at continued risk of harm. We noted many instances of unacceptably delayed investigations:

- Fifteen days passed after a November 11, 2008 alleged physical abuse incident before investigators reviewed the videotape and conducted the first interview;
- More than two weeks passed following two separate alleged physical abuse incidents in October 2008 before investigators interviewed the first staff about the incidents;
- Forty days passed after another alleged physical abuse incident in October 2008 before investigators conducted the first interview; and
- Two weeks passed after an alleged sexual abuse incident in October 2008 before investigators conducted the first interview.

We noted numerous deficiencies in the investigative files we reviewed regarding employee disciplinary actions. In 2008, Ancora substantiated 45 cases of neglect and 35 cases of abuse. However, there was no evidence that all employees involved in those substantiated cases received disciplinary actions. Also, there appears to be no system in place to impose progressive disciplinary actions. The facility's failure to include information on employee disciplinary actions in investigative files impairs the facility's ability to effectively track and take appropriate action in the case of repeat employee perpetrators, thus placing patients at continued risk of harm. These practices deviate from generally accepted professional standards.

Ancora investigations also do not follow generally accepted practices with respect to gathering available physical evidence. It appears that Ancora investigators do not routinely visit the scene of the incident; case files frequently note "there is no scene to secure or physical evidence to collect." In incidents where physical injuries were sustained, there was no evidence that photographs of the injuries were taken.

More concerning, our review of investigations raised questions about whether investigators consistently conduct their inquiries independently and without influence from other staff.⁵ For example, ongoing case investigations are discussed

⁵ A related issue is whether staff at Ancora are intimidated into silence, or into positions that protect other staff at the expense of patients. The Risk

in detail with the Risk Management Director and the Incident Management Review Committee prior to their completion. In one case of alleged physical abuse, the investigator documented that the Section Chief, rather than the investigator, reviewed the video surveillance and informed the investigator regarding what was seen on the tape on which the investigator later relied. Reliance on other parties, who operate close to the incident, to conduct portions of the inquiry is unacceptable because it undermines the independence of the investigative findings.

Ancora investigations appear to consistently follow a format of 3-4 standard questions of interviewees, i.e., where were you and what were you doing at the time of the incident; describe what you saw and heard. This approach is inadequate because it fails to elicit case-specific information or additional pertinent information. We saw no evidence that Ancora investigators reviewed the patient's treatment plan, recent incidents, or other recent investigations. Such a review can generate case-specific questions and allows the investigator to know what services should have been provided to this patient and whether they were provided. Nor is there evidence that the investigator evaluated the credibility of the alleged perpetrators by reviewing information such as performance history, disciplinary actions, supervisor interviews, repeat-offender status, and training. These lapses constitute significant departures from standard investigative practices and contribute to ineffective protection of Ancora patients.

d. Inadequate Quality Assurance

Generally accepted professional standards for quality assurance programs require a system to protect patients from abuse, neglect, preventable injuries, and unnecessary restraint and restrictive procedures. Databases are essential to allow analyses in order to identify trends, assist in developing corrective actions, and monitor the effectiveness of corrective actions.

Ancora officials reported that the facility does not have the capability to conduct trend analyses of various relevant data. There is no system to identify patterns related to types of incidents, times when patterns of incidents occur, or incidents in which the perpetrator has been repeatedly involved. Reportedly, the

Management Committee noted in April 2008 that supervisory staff are intimidated to not correct subordinate staff. We received similar allegations from several different line and supervisory staff. Although determining the validity of these allegations is beyond the scope of this report, the perception, shared by staff in these separate instances, is that they would be retaliated against for speaking out. The perception alone, if not rebutted forcefully by facility leadership, can be enough to affect investigations.

facility compiles incident information in the State's unusual incident reporting system but is not able to query that database to determine specific trends at Ancora. However, the State only recently provided us data requested during and shortly after our tour concerning patient-on-patient and employee-on-patient assaults and incident summaries. It appears that the State is attempting to demonstrate that Ancora adequately tracks and analyzes incidents. We find the State's delayed analysis to be untimely and severely compromised. Reliance on such a limited data system impairs the ability of risk managers to analyze incidents comprehensively and in a timely manner and to compare the frequency and severity of incident trends to determine effective plans of correction. In any event, the incident reports recently provided to us support our finding that investigations of alleged abuse are often delayed and can take months – even up to a year – to reach finality. The reports also include a significant number of substantiated claims of abuse and neglect, often resulting in self-harm or patient-on-patient violence, further evidencing the inadequacy of prevention efforts.

In conclusion, Ancora's system to protect patients falls egregiously short of generally accepted professional standards of care: it fails to analyze effectively incident data to manage risk and prevent recurring harm; relies on inconsistent and incomplete investigations; and fails to analyze its performance to ensure safety.

2. Inadequate Clinical Management and Nursing Care

Inadequate clinical management of patients with known high-risk conditions illustrates the absence of a system for tracking and proactively managing the medical needs of patients at risk. We found nursing documentation to be incomplete, inadequate, unreliable, inconsistent, and fragmented. Adequate nursing documentation is essential to ensure timely and appropriate follow-up and treatment and to communicate to treatment teams the emergence of risk factors that must be addressed in a patient's plan of care. Generally accepted professional standards require proactive monitoring for known risks, including medical risk.

Although we found that adequate primary care and outside specialists are available to treat the medical needs of Ancora patients, we found that emergent medical concerns are not adequately identified and brought to the attention of supervisors and the treatment team to enable the team to address medical risk proactively. Poor management of D.E.'s risk of pressure sores, discussed previously, is one example. Another is the management of patients at risk for painful and dangerous fecal impaction and bowel obstruction. These conditions are a known and frequent complication associated with many common psychiatric medications, yet in response to our pre-tour document request, the State asserted that Ancora does not maintain a list of patients at risk for impaction or bowel obstruction. We found deficient nursing documentation for those patients requiring bowel

management. The monitoring form on which bowel monitoring information is recorded is missing clinically significant information. In addition, as with nursing documentation throughout the facility, the documentation on the forms reviewed by our consultant was blank in many instances, inconsistent with other documentation, vague, and unreliable. This protocol reflects deficient nursing policy and training, because it does not put into measurable and useable terms the type of data required to be collected. As a result, data collection is necessarily subjective from nurse to nurse. The minimal documentation in these records also does not confirm that physicians are timely notified of concerns that require intervention.

Another example of these deficiencies is present in diabetes management. Diabetes is a manageable condition if properly monitored and treated but can have serious complications if it is not. Our consultant's review of E.E.'s chart unfortunately found evidence that E.E.'s treatment team is not adequately addressing his diabetes. As discussed above regarding bowel management, E.E.'s chart also was missing clinically significant information, such as changes in the patient's hemoglobin levels. Hemoglobin levels must be monitored to detect dangerous drops that may lead to harmful complications. E.E. is currently suffering from several complications, and his diabetes must be managed to prevent these complications from worsening. Ancora's failure to monitor these known medical risks is a significant departure from generally accepted professional standards.

In addition to inadequate nursing documentation, nursing supervision is an ongoing concern. CMS surveyors in February 2008 identified 15 shifts in Holly Hall in a ten-day period where there was no evidence that nursing supervisors conducted required rounds and reviewed precaution sheets as they should have. Moreover, surveyors identified that, during the same week, Cedar Hall units lacked any supervisory nursing rounds for whole days over all three shifts. Nearly a year later, we observed continuing lapses in supervision. With the exception of mealtime monitoring, we generally observed that patients on precautions were assigned additional staff and that the direct care staff documented additional checks of those patients. Staff did not have a uniform understanding of what was required by different levels of supervision, however. Moreover, we found that assigned charge nurses did not consistently document additional assessments of these patients, as required by policy. Policy also requires nursing staff to conduct environmental safety checks. We found six instances on a shift during our visit where environmental safety checks were not conducted, and staff noted on the monitoring form, "no staff to cover." We asked to review a sample of monitoring check sheets for additional dates to determine if this was an isolated occurrence, or a pattern of failure. The facility could not make this data readily available, we were told, because these monitoring sheets are not filed in an organized manner. This, of

course, also impedes the facility's ability to determine whether there was a pattern that could jeopardize patient safety or merely an isolated instance of poor staff performance. The facility's inattention to monitoring of nursing supervision – an area previously identified by other reviewers as deficient – is concerning. Failure to ensure nursing supervision of seriously ill patients places them at risk of continuing harm and inadequate treatment.

Generally accepted professional standards require that nursing staff properly complete Medication Administration Records ("MARs"). Among other things, MARs list current medications, dosages, and times that medications are to be administered. Proper and timely completion of the MARs is fundamental to maintaining patient safety and reducing the likelihood of medication errors and adverse drug effects. Failure to follow accepted MARs protocol may result in patients not receiving medications or receiving them too frequently, which could result in serious harm. Our review of the MARs revealed numerous instances in which Ancora administered medicine in a manner that substantially deviates from generally accepted professional standards. Consistent with the observations of Ancora's pharmacy contractor, we found many failures to administer medications at the proper time and many failures to verify the medication three times, as required by policy. Consistent with poor nursing documentation in other areas, we also found documentation errors on the MARs. Ancora's pharmacy contractor reported a chaotic environment during medication administration, which was consistent with our observations. This concern was discussed at facility medication safety meetings more than six months before our visit, yet a plan of correction has not rectified this problem. These inadequate nursing practices place Ancora patients at undue risk of harm.

Ancora's psychopharmacology practices also substantially deviate from generally accepted professional standards in several important respects. Extensive PRN use reflects reactive care and sub-therapeutic treatment of the patient's underlying condition. Although Ancora's pharmacy contractor is supposed to audit high PRN usage, the audit described to us has a retrospective design that is unlikely to provide timely and useful data to psychiatrists to better manage the treatment of these patients. Moreover, in November 2008, a month when several patients experienced continued excessive PRN use, including D.D., who had 92 PRNs, not even this retrospective audit was conducted, and thus, pharmacy failed to provide data about this important indicator that should have been considered in patient care. Another important safeguard in psychopharmacology is the monitoring of adverse drug reactions ("ADRs"). Plans were described to us for improvements in the reporting system to make it less punitive, although these and other proposed changes are not yet evident in facility records. Staff described a system where physicians have electronic access to current information about potential drug interactions at the point of care, that is, on the units, however, we

saw no evidence that this safeguard is in place or used by physicians. It also appears that pharmacy does not trend or aggregate data on ADRs and share that information with physicians in order to improve patient care and patient outcomes. In each of these respects, psychopharmacology practices at Anroca substantially deviate from generally accepted professional standards.

3. Restraint Use is Excessive

The right to be free from undue bodily restraint is “the core of the liberty protected by the Due Process Clause from arbitrary governmental action.” Youngberg, 457 U.S. at 316 (quoting Greenholtz v. Nebraska Penal Inmates, 442 U.S. 1, 18 (1979) (Powell, J., concurring in part and dissenting in part)). Thus, the State may not subject Ancora patients to restraint “except when and to the extent professional judgment deems this necessary to assure [reasonable] safety [for all patients and personnel within the institution] or to provide needed training.” Id. at 324. Generally accepted professional standards require that restraints: (1) will be used only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted; (2) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (3) will not be used as a behavioral intervention; and (4) will be terminated as soon as the person is no longer a danger to himself or others. Ancora’s use of restraints substantially departs from these standards and exposes patients to excessive and unnecessarily restrictive interventions.

Given the deleterious effects of restraint, and the fact that restraints restrict patients’ rights and their ability to receive appropriate care, generally accepted professional standards require that institutions like Ancora reduce their use of restraint by addressing behavior problems with less intrusive and restrictive strategies. We found that use of physical restraint at Ancora is high.⁶ In the 14 months from September 2007 to November 2008, data show 837 reported uses of highly-restrictive four-point restraints, an average of two episodes every day. Two-point restraints were used almost as frequently, an average of 54 times per month.

CMS surveyors cited a pattern of increased use of restraint in March 2008, and Ancora’s own restraint reduction committee identified continued increases in restraint use in September 2008. In the 14 months prior to our visit, 24 Ancora

⁶ Types of restraints used at Ancora include four-point restraints, two-point restraints, and manual holds. In a four-point restraint, hospital staff use cloth or leather straps to tie an individual’s wrists and ankles to a bed or a chair. In a two-point restraint, staff tie an individual’s wrists to a bed or a chair. In a manual hold, staff physically hold an individual’s head, limb(s), and/or body.

patients had more than 20 reported restraint episodes, and an additional 51 patients were restrained five times or more. We found that many patients who were repeatedly subject to restraint and/or administration of PRN medications – measures that should be reserved for emergency crisis intervention – have no behavioral supports in place. This is an egregious departure from generally accepted professional standards. Examples of reactive care and failure to provide adequate behavior management services include:

- F.F. was restrained 18 times in an eight-week period during September and October 2008. In 48 incident reports involving F.F. from this period, the treatment team makes no mention of antecedent, or precipitating events prior to incidents involving head-banging, aggression, and, frequently, restraint. There is no mention of proactively supporting this patient by teaching him coping strategies, or coaching or intervening in advance of the crises.
- D.D., a young woman and long-term patient with a diagnosis of schizoaffective disorder, mild mental retardation, and borderline personality disorder. In the months prior to our visit, she experienced escalating episodes of self-harm by head-banging and loud and aggressive outbursts, which were frequently followed by restraint and administration of PRN medications. She was reportedly restrained 43 times in the 14 months from September 2007 to November 2008; she received 92 PRNs in November 2008 and 108 PRNs in December. Although the record shows some attempt to debrief after these crises, there was no evidence that the team analyzed antecedent conditions, taught D.D. coping skills to avert a crisis, or consulted with staff or experts outside the treatment team. Each of these concepts had been suggested in the reduction of restraint committee meetings, but none of these methods were used to intervene on behalf of this patient frequently in crisis. No treatment interventions addressed the problematic behaviors that contribute to her prolonged hospitalization.
- E.E. was restrained 26 times from June to October 2008. On September 29, an incident report noted that E.E. was restrained for yelling and the inability to be re-directed. On its face, yelling is not a behavior that places a person in risk of imminent harm, and generally accepted professional standards require that restraint be used only if there is such an imminent risk. The treatment team held a restraint review in October and reviewed medications, counseled the patient about the importance of maintaining safety, and documented that the patient “could not state his reasons for becoming agitated.” There was no documentation to suggest that the team analyzed the antecedents to this patient’s outbursts or addressed alternatives to restraint use.

Generally accepted professional standards also require treatment teams to monitor and revise behavior plans as necessary. We noted numerous instances of continuing or escalating problem behaviors in which treatment teams took no effective action to revise the treatment. For example:

- F.F., discussed earlier, had an ineffective behavior contract.⁷ F.F.'s progress notes refer frequently to his breaking the behavior contract and to head-banging and restraint being "an everyday occurrence," despite the continued loss of privileges. There was no indication in his treatment records that his treatment team collected data about antecedents to this disruptive behavior, and, indeed, there is no place on the reporting form for unusual incidents to record that relevant information. The clear risk of harm to patient F.F. was acknowledged, belatedly, by his treatment team in a letter to the hospital administration dated December 2008, which urged the administration to transfer F.F. to another facility, where he could receive dialectical behavior therapy ("DBT"). DBT is the primary evidence-based treatment protocol for F.F.'s borderline personality disorder. The absence of DBT at Ancora is consistent with our observation that Ancora provides insufficient evidence-based treatment.
- D.D., with 46 incidents between October 3 and December 30, 2008. D.D. had a crisis plan to be implemented after her incidents, typically head-banging or aggression, but no specific, individualized behavioral plan.

It is a violation of generally accepted professional standards to permit dangerous, maladaptive behaviors to continue for months without collecting objective data about antecedents, using that information to inform a functional analysis of this behavior, and implementing a revised behavioral support plan. The failure to provide this care places these patients at continued risk of harm.

In addition to excessive numbers of restraint episodes, we also find that Ancora fails to ensure that restraints are terminated as soon as the patient no longer presents a risk of imminent harm to himself or others, in part because the criteria for release from restraint are not routinely written in measurable or observable terms, as required by generally accepted professional standards. Because the criteria are vague, e.g., patient should be "calm," it is not clear whether the patient was released as soon as appropriate. In three cases, D.E., F.F., and

⁷ A behavior contract is an agreement between a patient and his or her treatment team that the patient will not engage in certain behaviors.

T.U., nursing notes stated that the patients' psychological status was "adequate", but the restraint was continued. Because "calm" and "adequate" are not described in specific, operational terms, it is not clear that staff understood to terminate these episodes of restraint as soon as the patients were no longer a danger to themselves or others.

Finally, contrary to generally accepted professional practices, we found insufficient and, in some cases, no review of, restrictive programs by the facility's human rights committee. These examples evidence an egregious departure from generally accepted professional standards:

- V.W.'s plan contains a planned restraint, instructing staff that if he engages, or even attempts to engage, in physical aggression or property destruction, he should immediately be placed in restraint for one minute. If he fails to calm after one minute, or persists in physical aggression, he is to be placed into four-point restraint. Planned restraint is an outdated and discredited practice. It has also proven ineffective – despite repeated restraint, V.W.'s problematic behaviors persist, and this "plan" has nonetheless not been revised by his treatment team.
- X.Y.'s plan to address pica incidents includes a contingency to restrict brief off-unit visits with his family. His family requested that the brief visits be continued regardless of whether X.Y. displayed this behavior. His family was told by the treatment team that they would have to seek permission from the administration – precisely the opposite of accepted practice. Instead, the team should have sought permission from the human rights committee to restrict X.Y.'s rights in this manner.

4. Ancora Fails to Provide Adequate Mental Health Treatment, particularly for Patients with Aggressive and Self-Injurious Behaviors

Ancora patients have a constitutional right to receive adequate mental health treatment that provides "a reasonable opportunity to be cured or to improve [their] mental condition." Donaldson v. O'Connor, 493 F.2d 507, 520 (5th Cir. 1974), vacated on other grounds, O'Connor v. Donaldson, 422 U.S. 563 (1975). The mental health services at Ancora, however, substantially depart from generally accepted professional standards. Psychiatric practices are marked by inadequate assessments, which, in turn, lead to inadequate treatment planning and delivery of inadequate treatments and interventions. Although Ancora professes that it has adopted the principle of person-centered care, treatment planning is not person-centered, individualized, or integrated across disciplines and thus fails to comply

with generally accepted professional standards. These failures affect the quality and effectiveness of the patients' treatment plans, which are the foundation of an adequate mental health care program. Many of these deficiencies also directly threaten patients' physical health and well being. Moreover, as noted in the discussion of discharge planning, failure to treat a patient's mental health needs while hospitalized can frequently lead to failed discharges and to repeated hospitalizations. The reactive approach to treatment at Ancora and frequent use of restraint further condition patients to become institution-dependent, rather than develop and strengthen individualized symptom-management skills that they can use in both community and hospital settings.

a. Assessments are Inadequate

Ancora's mental health treatment is deficient, in part, because incomplete and inadequate assessments routinely fail to identify patients' presenting problems, strengths, and needs. Appropriate treatment begins with a thorough assessment of all factors relevant to the patient's situation at the time of admission. Assessments should address the presenting problem, the patient's medical and psychosocial history, and vocational, educational, social, and daily living skills. The assessments should also include contributions from psychiatry, nursing, psychology, and social work. Although Ancora's policies describe an adequate process for initial assessments, in practice, many of the assessments our consultants reviewed were critically deficient, in some cases omitting entire areas of relevant inquiry, and in other cases containing only cursory and insufficient attention to these areas.

In the majority of the cases we reviewed, assessments do not meet generally accepted professional standards. Deficient assessments lead to deficient case formulations; treatment teams that have incomplete understanding of the strengths and needs of individual patients do not provide the treatment and supports these individual patients require. The absence of relevant information impedes both development of a treatment plan that addresses all of the patient's treatment needs, and preparation of an adequate plan for discharge to the most integrated setting appropriate.

Initial assessments that are completed at the time of admission must be updated with relevant information gained through additional observation of the patient, testing, as indicated, and collaboration with family and community resources. We found that assessments at Ancora show little evidence of being updated with relevant information as required by generally accepted professional practices.

The assessments for patients with behavioral problems were particularly deficient, with most lacking a functional assessment that is critical to

understanding the causes of the problem behavior and developing a treatment plan to reduce or eliminate it.

b. Treatment and Interventions Are Inadequate

Treatment planning must incorporate a logical sequence of interdisciplinary care: (1) the formulation of an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines; (2) the use of the diagnosis to identify the fundamental problems that are caused by the diagnosed illness; (3) the development of specific, measurable, and individualized goals that are designed to ameliorate problems and promote functional independence; (4) the identification of appropriate interventions that will guide staff as they work toward those goals; and (5) ongoing assessments and, as warranted, revision of the treatment plan. To be effective, the treatment plan should be comprehensive and include input from various disciplines, under the active direction and guidance of the treating psychiatrist who is responsible for ensuring that relevant and critical patient information is obtained and considered.

Ancora's treatment planning substantially departs from these standards. From initial diagnosis and assessment to the development of skills and functioning necessary for recovery and community reintegration, Ancora's treatment planning fails to meet the fundamental requirements for the treatment and rehabilitation of its patients. As a result, patients are not receiving appropriate treatment and rehabilitation; patients are at risk of harm from themselves and others; patients are subject to excessive use of restrictive interventions; and patients are at increased risk of relapses and repeat hospitalizations. Further, patients' options for discharge are significantly limited, resulting in unnecessarily prolonged hospitalization and, with respect to forensic patients, prolonged involvement in the criminal justice system.

Ancora does not provide sufficient treatment programming to patients, a finding that repeatedly has been brought to the facility's attention. Ancora's own February 2008 audit by outside consultants found inadequate levels of active treatment and a non-therapeutic environment in the day areas. See also Centers for Medicare and Medicaid Services ("CMS") Survey report dated April 11, 2008 (finding that staff unaware of individual patients' treatment schedules and patients not receiving treatment aligned with treatment plans). Yet precisely these same conditions existed during our site visit in January 2009, nearly one year after these prior audit findings.

At the time of our review, groups were offered at a central Psychosocial Treatment Mall, in building-based treatment malls, and in the dayrooms of some living units. There were a few patients involved in a sheltered workshop at the

Treatment Mall and a few patients working in facility maintenance and housekeeping. Only a handful of groups at the facility offered psychosocial treatment consistent with generally accepted professional standards. The majority of the groups offered were recreational or diversionary, without sufficient content or structure to be considered treatment programming. Of the groups we observed, use of evidence-based practice was apparent in only one group, in the Psychosocial Treatment Mall. Moreover, we observed no instances in which program participation was individualized and tied back to the treatment plans of participants. The only data collected was attendance at group; treatment teams received no data related to patients' progress on individual treatment goals.

Although Ancora professes to have adopted a recovery-oriented plan of care, the majority of treatment plans we reviewed were deficit-based. For example, behavioral plans are frequently punitive. Plans are based on generic losses of privileges in response to a maladaptive behavior, and frequently do not specify any positive reinforcement if the patient refrains from that behavior for a set period of time. Thus, F.F. loses smoke breaks if he bangs his head. V.W. loses visits with his family if he does not refrain from physical aggression or destructive behavior.

Ineffective behavioral plans at Ancora often reflect a lack of coordination between disciplines. For example, patient Z.A.'s plan included both deficit-based and positive reinforcers. However, the plan reflected a lack of coordination between team members, and a lack of expertise in designing the plan. The rewards could be earned only if Z.A. refrained from aggressive behavior for a week, which was too long an interval because Z.A. typically engaged in this behavior twice a week. Even more concerning, the goal of his treatment plan, to return to a cottage where he previously lived, was not an outcome Z.A. wanted, as noted in his record: "since [Z.A.] does not want to return to Cottage 18 . . . it may result in aggressive behavior in an attempt to remain at APH. [Z.A.] engaged in this behavior during his last admission to APH." These goals and rewards were, not surprisingly, ineffective.

Ancora does not typically collect baseline and monitoring data to inform continued treatment. Without relevant data, it is difficult to measure progress toward even the most generic of goals articulated in the treatment plans. For example, Y.B., a patient readmitted to the hospital after leaving a group home because she was unable to comply with its rules, has a treatment goal of reducing the influence of her psychotic symptoms and an intervention that provides diversionary activities and encourages her attendance. The "data" collected to evaluate her progress was attendance at activities. Diversionary activities are not treatment, and inpatient hospitalization is not the most integrated setting in which diversionary activities can be provided.

The few behavioral assessments in place at Ancora substantially depart from generally accepted professional standards. In their review, our consultants found patients with problem behaviors who lacked functional assessments, the most fundamental tool necessary to understand and treat maladaptive behaviors. For example, X.Y., whose problematic behavior includes pica, or swallowing inedible items, had behavioral plans for several years, although he was twice returned to 1:1 staffing because the plan failed to control his pica. His chart contains no evidence that a functional assessment of this behavior was undertaken prior to developing a behavior plan, a gross violation of professional standards. In other cases, the functional analysis was deficient in one or more significant ways: many failed to hypothesize the function of the challenging behavior; did not consider antecedent, environmental, or health factors that influence a behavior; did not contain sufficient baseline data; and failed to identify target or appropriate replacement behaviors. An adequate functional assessment is an essential predicate to understanding the motivation for a problematic behavior and the antecedents that may trigger the behavior or increase its frequency. The inadequacies in behavioral assessments at Ancora undermine all subsequent treatment planning.

Ancora makes extremely limited use of neuropsychological testing in developing treatment plans. While on site, we saw only one patient with evidence of neuropsychological testing to assess cognitive ability.⁸ The testing suggested that his level of function is greater than his actual ability, an incongruence that would affect his interactions with peers and staff. Goals articulated by his psychologist in an annual report were appropriately patient-centered and specific but were neither incorporated into the treatment plan nor, seemingly, considered by the treatment team. This failure to incorporate relevant information from all disciplines, and, in particular, this relevant information about the patient's cognitive ability, compromised the team's ability to provide individualized and effective treatment.

Generally accepted professional standards require that treatment plans for patients be measurable, specific, and appropriately patient-centered. However, the majority of treatment plans we reviewed contained non-measurable, generic, vague, and deficit-based goals. Examples of goals typical of those in the records we examined include:

- patient's thoughts will be more reality-based and less influenced by psychotic symptoms;

⁸ A second patient record, with evidence of neuropsychological testing to assess cognitive ability, was provided to us in late July, six months after our site visit.

- patient's thought process will not interfere with obtaining and keeping Level 2 (referring to degree of off-unit privileges) within the next 90 days;
- patient will refrain from ingesting foreign objects;
- increase patient socialization skills and increase reality orientation;
- improve thought process; and
- patient will improve impulse control and diminish aggressive outbursts.

Treatment options for patients with co-occurring substance abuse diagnoses are particularly deficient. This is despite the acknowledgment by the Risk Management Committee, in June 2008, of a correlation between drug abuse and the potential for violence and the barrier that substance abuse presents to successful community residence. During our visit, the treatment options specifically addressing substance abuse included one group at the Psychosocial Treatment Mall, observed during our visit to include approximately five patients, and a patient-run group known as the Mentally Ill and Chemically Addicted Club ("MICA"). Patients with unmet need for substance abuse treatment include:

- X.C., who has a diagnosis of schizophrenia and a history of substance abuse, initially received substance abuse treatment through the MICA club. X.C. subsequently eloped from a brief visit and was then denied enrollment in the MICA Club.
- W.D., who also has a diagnosis of schizophrenia and a history of substance abuse, was referred to the MICA club but denied enrollment.
- V.E., who has diagnoses of chronic schizophrenia and polysubstance abuse, was denied enrollment in the MICA club.
- G.G. and U.F., both with diagnoses of schizoaffective disorder and polysubstance abuse, are on a waiting list for services. T.H., with a diagnosis of schizoaffective disorder and alcohol abuse, is on a waiting list for services.

c. Inadequacy of Treatment is Enhanced for Limited English Proficient (LEP) Patients

There are a significant number of patients at Ancora whose ability to speak, understand, read, or write in English is sufficiently limited to be a factor in how they are treated. It appears that bilingual staff or professional interpreters are not consistently being used to facilitate communications with patients or their families.

In some cases, staff are allowing language to act as a barrier to placement for limited English proficiency (“LEP”) patients. For example, patient S.I. was admitted six years ago, in January 2003, and placed on CEPP status almost five years ago, in September 2005. The CEPP tracking report notes that she “does not speak English and requires interpreter[.] This has been a barrier to placement.” A psychologist’s progress note confirms this: “The patient [S.I.] speaks Mandarin Chinese and it is difficult to communicate with her, on occasion, when an interpreter is present an attempt is made to communicate with her. Requests have been made to schedule an interpreter to meet with her on an individual basis and to have some phrases translated from English to Mandarin for when an interpreter is not available.” We note that consent forms, treatment plans, and other documents critical to a patient’s treatment have not been translated into languages other than English.

Failure to treat patients in a language appropriate manner can affect all phases of patient care and is likely to enhance the inadequacy of care afforded to LEP patients in particular. Impaired communication between LEP patients and staff undermines effective diagnosis, treatment, health care, investigation, and planning. Insufficient language support may interfere with good patient care, place LEP patients at greater risk of harm, or needlessly extend the duration of segregated treatment.

IV. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of the patients at Ancora, the State of New Jersey should promptly implement the minimum remedial measures set forth below:

A. Support For Discharges to the Most Integrated Setting

1. Assess each patient, including those specific sub-groups of patients with significant barriers to discharge, to determine whether the patient is receiving services in the most integrated setting appropriate for his or her needs.
2. If it is determined that a more integrated setting would appropriately meet the patient’s needs and the patient does not oppose community placement, promptly develop and implement a transition plan that specifies actions necessary to ensure safe, successful transition from the facility to a more integrated setting, the names and positions of those responsible for these actions, and corresponding time frames. Develop a waiting list showing the date on which a more integrated setting was found appropriate for each patient and how long the

patient has been on the waiting list. Identify the particular barriers for each such patient that are preventing discharge to a more integrated setting.

3. Implement the State's plan to improve supportive housing by issuing a request for proposals to serve discharge-ready patients.
4. Ensure the participation in all aspects of care and treatment planning by the patient, his or her guardian, family, and friends, as appropriate, and staff who know the patient best.
5. Conduct and update as necessary interdisciplinary assessments of each patient. Assessments should be adequate to develop treatment goals and intervention strategies while at Ancora and upon return to the community. Ensure that professional staff performing assessments obtain and document sufficiently detailed information regarding patients' strengths, preferences, needs, and history.
6. Provide education and counseling to patients, their guardian, and/or families as necessary to address any opposition to placement in the most integrated setting.
7. Ensure continuity of care at discharge so that the patient has direct contact with specific community providers who have been identified to provide services to patients upon discharge.
8. Monitor community-based programs to which patients are discharged to ensure program adequacy and the full implementation of each patient's treatment and service plan.
9. Develop and implement initiatives to address barriers to placement in the community.
10. Expand and modify community services so that patients can be discharged to the community in a timely manner. Ensure that such services for hard-to-place patients are expanded and modified. Expand and modify community capacity where there are gaps in service.

B. Protection from Harm

1. Immediately replace all potential environmental suicide risks in patient areas.

2. Develop and implement a comprehensive incident management, risk management, and quality assurance system to collect information related to adequacy of safety, identify and monitor implementation of corrective and preventative actions, and assess effectiveness of the actions in the areas of Olmstead planning; protection from harm, including use of restraints; mental health care; and medical care.
3. Develop and implement adequate policies and procedures regarding timely and complete incident reporting and the conduct of investigations of serious incidents. Train staff and investigators fully on how to implement these policies and procedures. Include recommendations in investigation reports and ensure the prompt implementation of remedial measures to prevent future occurrence of incidents and injuries.
4. Cease discussion of open investigations to ensure that the investigatory process is not compromised.
5. Centrally track and analyze trends of incidents and injuries, so as to develop and implement remedial measures that will prevent future events.
6. Ensure that independent and thorough investigative practices are followed when reviewing alleged employee misconduct or wrongdoing. Investigative practices must be free from retaliation, undue influence, or intimidation from any party.
7. Ensure that information regarding employee disciplinary actions is included in investigative files to effectively track and take appropriate action in the case of repeat employee perpetrators.
8. Ensure that recommendations for corrective action are distributed to staff in all disciplines as well as direct care staff to ensure responsive actions are implemented and documented. Ensure that corrective actions are monitored and reviewed to ensure effectiveness.
9. Ensure that staff receive adequate competency-based training to provide adequate supervision of patients and implementation of treatment plans.
10. Develop criteria for conducting risk reviews and monitor those at risk.

11. Enhance critical review of mortalities so that opportunities for performance improvement and reducing recurrent adverse events is a part of each review. Assure documentation of the review with emphasis on reporting recommendations for improvement.

C. Clinical Management and Nursing Care

1. Provide adequate medical care, nursing, and therapy services consistent with generally accepted professional standards to patients who need such services.
2. Provide each patient with proactive, coordinated, and collaborative health care and therapy planning and treatment based on his or her individualized needs. Conduct an adequate nursing assessment and reassessments as needed, according to generally accepted professional standards. Ensure that nursing staff notify relevant treatment team members of assessment and reassessment findings and clinically significant events as indicated.
3. Ensure administration of medications consistent with professional standards, with particular attention to developing a reporting system to encourage reporting of medication errors and to monitor adverse drug reactions.
4. Reconcile discrepancies between nursing policies and practices, particularly concerning medication administration and patient supervision.
5. Establish a formalized mechanism for identifying patients with enhanced medical, nutritional, or physical support needs, including but not limited to persons who are at risk of choking/aspirating; have swallowing difficulties; require assistance to eat or drink; receive enteral feedings; are at risk for constipation or bed sores; or are likely to require such services.
6. Ensure nurses and direct care staff receive competency-based training in the provision of care and individualized treatment plan interventions. Evaluate and document effectiveness of interventions.
7. Ensure adequacy of nursing documentation.

D. Restraint Use and Behavioral Supports

1. Ensure that highly restrictive interventions or restraints are never used in lieu of treatment programs, for the convenience of staff, or as punishment.
2. Develop and implement a protocol that places appropriate limits on the use of all restraints as well as the routine use of PRNs or other emergency chemical restraints. Ensure that only the least restrictive restraint techniques necessary are utilized and that restraint use is minimized.
3. Eliminate the use of planned restraints.
4. Develop appropriate observable, measurable, and individualized release criteria for patients in restraints.
5. Eliminate use of crisis plans in lieu of behavioral supports.
6. Document and analyze antecedent factors that contribute to maladaptive behaviors. Record behavioral antecedents, including precipitating causes and any coping skills used by the patient, in the incident and/or crisis de-briefing forms. Train staff to observe and record behaviors in the forms. Coordinate with psychology in development of adequate behavioral supports.
7. Ensure that ineffective behavior programs that may contribute to the use of restraints are modified or replaced in a timely manner. For those patients subjected to chronic use of restraint associated with difficult behavior problems, obtain outside expertise to help the facility address those patients' behavior problems in an attempt to reduce both the behaviors and the use of restraint.
8. Provide advance review and approval by a Human Rights Committee or its equivalent of all proposed restrictions of patient rights.

E. Treatment Planning and Mental Health Services

1. Provide patients with adequate treatment, including mental health, behavioral, and rehabilitative services needed to meet the patients' ongoing needs. These services should be developed by qualified professionals consistent with generally accepted professional standards to reduce or eliminate risks to personal safety, to reduce or eliminate

unreasonable use of bodily restraints, to prevent regression, and to facilitate the growth, development, and independence of every patient.

2. Ensure that adequate assessments are used to develop a comprehensive, interdisciplinary treatment plan for each patient for the provision of necessary treatment, services, and supports. Ensure that the plans address the patients' needs, preferences, and interests in an integrated fashion that utilizes the patients' existing strengths. Ensure that staff are trained in how to implement the written plans and that the plans are implemented properly. Update assessments as additional information is gained.
3. Ensure that all patients receive individualized treatment programming consistent with generally accepted professional standards. Ensure that plans include measurable goals.
4. Develop and implement comprehensive, individualized behavior plans for the patients who need them. Through competency-based training, train the appropriate staff how to implement the behavior plans and ensure that they are implemented consistently and effectively. Record relevant behavioral data and document patients' progress on the plans.
5. Provide patients who have behavior problems with an adequate functional assessment so as to determine the appropriate treatments and interventions for each patient. Ensure that this assessment is interdisciplinary and incorporates medical, neuro-psychological, and other unaddressed conditions that may contribute to a patient's behavior.
6. Ensure sufficient neuropsychological testing as indicated.
7. Ensure adequate treatment programming for patients with substance abuse diagnoses. Ensure sufficient programming to enable patients to work off campus or attend off-campus programming or activities when that is the most integrated setting appropriate to each patients' needs.
8. Monitor adequately the patients' progress on the programs and revise the programs when necessary to ensure that patients' behavioral needs are being met. Provide ongoing training for staff whenever a revision is required.
9. Review applicable law, Title VI LEP guidance issued by the U.S. Departments of Justice and Health and Human Services and available

literature on standards of care for LEP patients. Many resources are available at www.lep.gov (see, for example, <http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf>) and www.hhs.gov/ocr/office/index.html.

10. Ensure that an appropriate language access management plan, policies, and protocols are in place; that they are being implemented by staff; and that LEP patients are not receiving care that is slower, less effective, or that results in hospitalization of longer duration than other patients.
11. Perform a comprehensive review of all patient care systems and support services, existing policy and practices, and available resources to determine what changes are needed to provide appropriate and legally required care and treatment for LEP patients.

F. Psychiatric Services

1. Provide adequate psychiatric services consistent with accepted professional standards to patients who need such services.
2. Ensure that each patient with mental illness is provided with a comprehensive psychiatric assessment, a diagnosis consistent with generally accepted professional standards, appropriate psychiatric treatment including appropriate medication at the minimum effective dose that fits the diagnosis, and regular and ongoing monitoring of the psychiatric treatment to ensure that it is meeting the needs of each patient. Ensure that the psychiatrist(s) provide new assessments and/or revisions to any aspect of the treatment regimen whenever appropriate. Ensure that psychiatric services are developed and implemented in collaboration with facility psychologists and other disciplines, when warranted, to provide coordinated behavioral care.
3. Ensure that psychotropic medication is only used in accordance with generally accepted professional standards and that it is not used as punishment, in lieu of a treatment program, for behavior control, in lieu of a psychiatric or neuropsychiatric diagnosis, or for the convenience of staff.
4. Eliminate undue use of PRN medications. Assure that the pharmacy contractor's audits include review of PRN medication in a timely manner and that PRN audit information is shared with treatment teams in a timely manner so as to inform treatment.

5. Provide physicians with regular reports on facility-wide pharmaceutical consultation so that they can benchmark their own practice and the practice of their units with other physicians and units.

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V. CONCLUSION

We appreciate the cooperation we received from the facility staff, the New Jersey Division of Mental Health, and the State's Attorney General's Office during our visit to Ancora. We wish to thank the administration and staff at Ancora for their professional conduct, their generally timely responses to our information requests, and the assistance they provided during our tour. Further, we wish to especially thank the hospital's staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment and who improve the lives of patients at Ancora. Those efforts were noted and appreciated by the Department of Justice and our expert consultants.

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

Assuming there is continued cooperation from the State, we would be willing to send our expert consultants' reports under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily represent the official conclusions of the Department of Justice, their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them.

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

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

Sincerely,

/s/ Loretta King

Loretta King
Acting Assistant Attorney General
Civil Rights Division

cc: Honorable Anne Milgram
Attorney General
State of New Jersey

Allan Boyer
Chief Executive Officer
Ancora Psychiatric Hospital

Ralph J. Marra, Jr.
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