CENTRAL STATE HOSPITAL FINDINGS LETTER

June 30, 1997
The Honorable George Allen
Governor of Virginia
Richmond, VA 23212

Re: CRIPA Investigation of Central State Hospital

Dear Governor Allen:

On March 24, 1997, we notified you that we were conducting an investigation, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 etseq., of Central State Hospital ("Central State"), a psychiatric hospital near Petersburg, Virginia. Prior to initiating this investigation, former Virginia Attorney General James Gilmore called Attorney General Janet Reno to pledge the Commonwealth's full cooperation in any Departmental investigation of the conditions. Special Litigation Section Chief Steven Rosenbaum and his staff subsequently met with Virginia Deputy Attorney General William Hurd and his staff to discuss the Department's plans for investigating Central State and the Commonwealth's plans for improving conditions at the facility. I am writing now to report our findings with regard to this investigation.

Central State is a 495-bed psychiatric state hospital that was originally established in 1870 as a separate institution for African-Americans who had mental health disorders. Today, the hospital provides psychiatric services to all persons. It serves adolescents and adult civil patients from a defined geographic area surrounding the Petersburg area. In addition, Central State houses the only secure forensic hospital unit in Virginia. The hospital has six buildings that contain 20 patient wards. The patient population is broken down as follows: the forensic unit (7 wards) is comprised of 176 patients; the adolescent unit (2 wards) houses 19 patients and the adult civil unit (11 wards) has approximately 270 patients.

We conducted the investigation by touring the facility with expert consultants in psychiatry and psychiatric nursing between April 28 through May 2, 1997. During the course of this investigation, these experts made observations, interviewed staff and patients, and examined numerous patient and facility records, including incident and restraint statistics and summaries, committee minutes, morbidity/mortality reviews, and facility policies and procedures. At the conclusion of these tours, both experts provided Central State Hospital staff and Commonwealth officials with a summary of their major findings.

On May 29, 1997, we met with Deputy Attorney General Hurd and his staff in Fredericksburg, Virginia to discuss the status of our investigation of Central State and matters related to our CRIPA activities in other institutions in Virginia. We subsequently reached agreement with Commonwealth officials on a process, with time frames, for resolving our Central State investigation. As part of that process, the Commonwealth has agreed to take some immediate steps to address serious deficiencies at Central State and to develop and implement additional plans for remedial action, based upon the findings and recommendations in this letter.

Before addressing the substantive violations, we would like to express our appreciation to the staff of the Department of Mental Health, Central State, and the Attorney General's office for their assistance and cooperation during our investigation of Central State. We expect to continue to work with these officials in the same cooperative manner to remedy the problems at the facility.

In investigating Central State Hospital, our purpose was to evaluate whether patients were being afforded their constitutional and federal statutory rights. Patients in state-operated mental health facilities have a Fourteenth Amendment due process right to adequate food, clothing, shelter, medical care, reasonably safe conditions and

adequate mental health treatment. Youngberg v. Romeo, 457 U.S. 307 (1982); O'Connor v. Donaldson, 422 U.S. 563 (1975). In addition, the Commonwealth must provide public services to individuals with disabilities in the most integrated setting appropriate to their needs. See, e.g., Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12132 et seq., 28 C.F.R. § 35.130(d); and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§ 794 et seq. and the regulations promulgated pursuant thereto.

During our investigation, we found numerous conditions that lead us to conclude that constitutional and federal statutory rights of Central State patients are being violated. As detailed below, a major cause of many of these deficiencies is that Central State has an insufficient number of adequately trained professional and direct care staff to meet the needs of patients. The facts that support our findings of unlawful and unconstitutional conditions at Central State Hospital are set forth below, followed by the remedial actions that we believe are necessary to remedy these conditions.

I. Central State Is Failing To Ensure The Reasonable Safety Of Its Patients

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

The facility's incident reports and special abuse investigations reveal a high level of injuries and dangerous situations that place patients at risk of harm. Patients are injured repeatedly due to self-injurious behavior and aggressive acts of other patients. Many of these incidents are preventable and reflect systemic deficiencies at Central State including lack of adequate staffing, failure to supervise patients, and inadequate assessment and treatment of mental illness, particularly patients with behavioral problems.

Central State does not provide needed treatment to abate or eliminate these behaviors. For example, in the period just prior to our tour, one patient engaged in almost daily incidents of self-injurious behavior, including banging his head on the wall, hitting his face with his fist, punching a wall, and assaulting others on a regular basis. Our experts concluded that this patient did not have an appropriate treatment plan to address his serious behavior problems. Another patient with numerous incidents of self-injurious behavior was characterized by staff as "merely seeking attention," resulting in her behaviors largely being ignored, rather than treated.

The lack of supervision is prevalent throughout the hospital. It is not uncommon, for example, for nearly half the acute admissions ward, approximately 76 patients, to be on "high risk status" necessitating staff observation at least every fifteen minutes. In order to be placed on this status, a physician must determine that the patient poses a special risk because the patient is suicidal or homicidal, presents an elopement or arson risk, or requires special precautions. Despite the potential for serious harm posed by each of these conditions, Central State does not provide adequate staffing to carry out the physicians' orders for enhanced supervision. As a result, Central State patients fail to receive the professional judgments by qualified professionals that is necessary to their care.

In addition to inadequate supervision on the acute admissions ward, our experts found the lack of supervision and potential for harm particularly significant on the Forensic Unit, which houses the most aggressive, assaultive and self-injurious patients. Incident reports document numerous injuries to these high-risk patients as a result of not being monitored adequately.

Central State also fails to take adequate steps to assess, supervise and treat patients who are at risk of suicide. Central State has abandoned the use of a formalized suicide assessment for incoming patients. Instead, the standard currently used by Central State to determine whether a patient will be closely monitored by staff rests solely on a verbalization of immediate suicide plans at the time of admission. Without a formalized suicide assessment, physicians are unable to determine which patients are at risk and the level of staff supervision that is necessary to

ensure a patient's safety. Our experts found that the standard for assessing suicide risk at Central State departs substantially from accepted professional standards.

The failure to assess and supervise patients at risk of suicide has dire consequences for Central State patients. For example, last year one patient was admitted with a history of suicide ideations, verbalizations and gestures while confined to a jail. On admission, the patient denied immediate plans to commit suicide and was not placed on any type of increased supervision. The patient eventually hanged himself. Staff found another patient, who had threatened to harm herself, gouging her abdomen and shouting that she must pay for what she had done --but the patient was not placed on increased supervision. She was found three days later underneath her bed, nude, with a bra wrapped around her neck in an effort to strangle herself. A review of incidents from January 1996 to April 1997 reveal numerous suicide attempts, including repeated attempts by patients who were not supervised properly.

Other types of preventable incidents that occur routinely throughout the facility demonstrate a systemic failure to protect patients from harm. Staff also frequently fail to report injuries. For example, in one case, a patient was discovered last year to have 42 bruises, ranging in size from one to two inches, over his upper torso. He sustained these injuries despite the fact that he was under supposedly 24-hour surveillance by Central State staff. Although the facility suspected that the bruises occurred during a two-week period of time, during which there were multiple opportunities for staff to observe the bruises, none of the bruises were reported until the end of the two-week period.

Central State also does not have an adequate procedure for investigating untoward events, abuse allegations and deaths. We reviewed numerous incident reports involving injuries where the medical staff conducted little or no follow-up to determine the cause of the incident, its effect on the patient, or how similar incidents might be avoided in the future. In addition, Central State staff disclosed that follow-up is generally limited to reviewing the initial incident report and quantifying the number of incidents rather than identifying the reason for the incident and how to prevent it in the future. Central State also fails to investigate allegations of abuse in a comprehensive and timely manner. Many of the allegations of abuse cannot be substantiated because the quality of the evidence is so poor or outdated. Finally, the facility fails to conduct routine mortality reviews. Given the problems with the health care delivery system at Central State, detailed below, the failure to conduct routine, independent mortality reviews is a serious deficiency because such reviews may reveal issues that require remedial attention.

These facts demonstrate that Central State residents are at serious risk of harm and have suffered harm, in violation of their basic rights, due to the facility's failure to provide adequate staffing, supervision and treatment.

B. Unsafe and Inadequate Physical Conditions

The physical plant of the Forensic Unit is dangerous and compromises the welfare and safety of patients residing there. The Unit has too many patients, too little space and numerous blind spots. Moreover, temperature control and ventilation problems pose a health risk to patients who receive psychotropic medications that impair their ability to regulate internal body temperature. In addition, the nurses' station does not have adequate sight lines to allow adequate supervision of patients. Such poor environmental and physical conditions subject Central State patients, as well as staff, to serious risks to their personal safety and well being.

II. Central State Is Failing To Provide Adequate Mental Health Care For Its Patients

Central State is not providing its patients with adequate psychiatric and mental health services in accordance with generally accepted standards. Psychiatric practices at Central State are typically characterized by superficial evaluations, inadequate follow-ups, a lack of cogent treatment planning, a lack of multi-disciplinary input into

psychiatric treatment decisions, and an over-reliance on restrictive interventions. Moreover, the psychiatric and mental health services at Central State fail to provide patients with a reasonable opportunity to be cured or function as independently as their psychiatric conditions permit.

A. Inadequate Psychiatric and Mental Health Services

Central State frequently fails to diagnose patients' mental illness appropriately. An adequate diagnosis is essential to develop appropriate treatment. Inadequate diagnoses have led to improper treatment that has harmed patients, either by subjecting them to needless or improper medications and their attendant side-effects, or by failing to treat the underlying mental illness, thereby exposing the patient to negative behaviors that are not controlled properly.

Patient treatment is not multi-disciplinary, individualized or properly managed, in accordance with accepted professional standards. Review of patient records and interviews with Central State staff reveal little or no evidence of multi-disciplinary participation in treatment planning. Records demonstrate that staff are providing treatment without an adequate understanding of the patient's problems. Treatment goals are vague and fail to provide an objective, measurable basis for evaluating patient progress.

Treatment is also not adequately coordinated between disciplines. In particular, master treatment and nursing care plans are inconsistent. Additionally, nursing care plans suffer similar defects to treatment plans. For instance, initial nursing care plans are not individualized. Patients are placed in categories, and then all patients in the same category receive the same nursing care plan without regard to their individual needs.

Behavioral management planning and psychological services are also inadequate. Of the records reviewed, we found numerous patients with recurrent self-injurious behavior who were not receiving appropriate behavioral management. This is particularly true of the Forensic Unit. The failure to provide adequate behavioral management has led to patients receiving little therapeutic care, treatment and programming. To the extent that behavior programming does exist, its negative nature predominates. The emphasis is primarily on containment, rather than teaching alternative, adaptive behaviors.

Central State's Forensic Unit houses several patients who are dually diagnosed as being both mentally ill and mentally retarded. Staff admit that they are not trained to address the needs of this patient population and that the facility offers no specialized programming. Central State also fails to provide adequate treatment for the 22 percent of the patient population who are dually diagnosed as having a substance abuse problem in addition to being mentally ill.

B. **Inadequate Discharge Planning and Community Services**

Our consultants found that Central State's discharge planning is inadequate and violates professional standards. Central State fails to ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are made and implemented with due regard to the commitment status of the patient. Patient charts lack adequate discharge criteria. This inhibits the exercise of professional judgment about readiness for discharge. Our experts found Central State's discharge system to be arbitrary, with some patients released too soon while others are hospitalized for too long.

Discharge planning is given low priority at Central State. Discharge plans are often developed only shortly before a patient is about to be released, rather than being incorporated into treatment objectives in accordance with accepted professional standards. Consequently, patients are often discharged without a clear plan and adequate services to

address basic living needs. For example, one patient was discharged on a temporary leave to a group home, without needed supervision, and was found shortly thereafter in a creek near the facility where he apparently drowned. Finally, the failure of Central State to provide adequate discharge planning for those patients who are dually diagnosed as having a substance abuse problem in addition to being mentally ill, results in frequent re-admissions after these patients are discharged to the community.

The Commonwealth is not providing integrated hospital and community services in order to ensure adequate patient transition into the community. Because community treatment services are inadequate, persons who otherwise could live in community settings end up being re-hospitalized.

III. Inappropriate Use of Restraints and Seclusion.

Restraint and seclusion practices depart substantially from accepted professional standards. Despite recent improvements in hospital policy, Central State employs an excessive amount of seclusion and restraint for inappropriately long periods of time, contrary to accepted professional practice. For example, incident reports reveal that staff placed patients in restraints for extended periods of time simply because they did not follow ward rules (e.g., left the ward without permission). In one case, a patient was placed in restraints because he talked back to the staff. Staff appear frequently to make ad hoc decisions about whether to place a patient in restraints, often without appropriate precipitating factors.

Central State's inappropriate use of restraints and seclusion as punishment has had tragic consequences. Last year, a patient died after staff secured her to a bed by her arms, legs and waist in five-point restraints and then left her unattended in a locked seclusion room. Almost a year before her death, her Central State psychiatrist had warned Central State officials that she should not be left unattended in restraints because the patient faced potentially life-threatening consequences from her asthma and epileptic seizures. The psychiatrist in a memorandum titled "Duty to Warn," urged staff members to avoid strapping down the patient as punishment. The memorandum also noted that Central State staff continually ignored the patient as she lay unconscious during potential fatal epileptic seizures. Appealing for more humane treatment of his patient, the psychiatrist warned that the seizures could be fatal to the patient because thick nasal mucus could drain into her mouth and obstruct breathing. At the time of her death, her behavior program provided that she be placed in restraints for 48 hours to be renewed for an additional eight hour periods if inappropriate behavior continued. Staff were instructed to not "engage in small talk" and to ignore her protests. The patient had spent over 300 hours of the last two months of her life in restraints. Our experts concluded that the facility's care and treatment of this patient was clearly inappropriate. The year before, another patient died while in restraints and locked alone in a secluded room.

Numerous other patients were documented as being restrained almost on a daily basis. According to Central State's monthly reports on "Extensive Use of Seclusion/Restraint," one patient was secluded/restrained for 1,727 hours over an eight month period. Another patient was reported as having been secluded/restrained for 720 hours over a four-month period. In the first three months of 1997, a third patient is reported as being secluded or restrained for 668 hours. Our experts concluded that these and other examples demonstrated an excessive use of restraint and seclusion -- a problem that Central State staff have acknowledged. Following an internal staffing and patient abuse report, the Medical Director announced on February 25, 1997, that seclusion and restraint would only be used as an emergency intervention and would no longer be used as program interventions in behavior treatment plans.

Nonetheless, the inappropriate and excessive use of restraints and seclusion for patients still remains a problem at Central State. While overall usage is down, our review of restraint and seclusion data since the enactment of the new policy still indicates the extensive use of seclusion and restraint for many patients, particularly those with behavioral problems. For example, on the Forensic Unit, one patient, in the one-month period just prior to our tour, had been subjected to 33 orders of seclusion/restraint for a total of 233 hours, an average of seven hours each time. Another patient had 49 orders of seclusion/restraint for a total of 396 hours, an average of eight hours each time. Moreover,

Adolescent Unit physicians continue to use the most restrictive intervention of restraint as the first choice of behavioral treatment.

Our expert consultants found that the continuing problems in restraint and seclusion are related to the facility's generally inadequate treatment process. The low staffing level at Central State also contributes to the excessive use of restraint and seclusion as the staff are unable to spend sufficient time with agitated patients to prevent aggression or to implement programs necessary to afford patient safety. Patients at Central State are often kept in restraints and seclusion without any objective, recorded criteria for their release or explanation of the problem behavior that is being addressed by the use of restraints. Staff lack an understanding of less restrictive measures that could be utilized where appropriate. Patients, therefore, often remain in restraints long past the point when professionals agree that release should occur. Monitoring of patients while in seclusion or restraint is deficient at Central State as demonstrated in the incidents during the past several years where patients have died. A recent incident where a patient set fire to the bed after staff restrained him and left him unattended in seclusion highlights this deficiency. In sum, Central State's restraint and seclusion practices require immediate correction.

IV. Inadequate medical care and medication practices.

Central State's psychopharmacological practices substantially depart from generally accepted medical judgment. Little or no effort is expended to conduct the detailed review of a patient's medication history necessary to avoid the risk of placing patients on medications that have produced adverse side-effects in the past or that have proven ineffective.

The medication practices throughout Central State vary substantially and appear to be based on decisions by individual physicians who are not properly supervised. Physicians are underutilizing standard technologies and medications. The problem is exacerbated by confusing and sometimes contradictory memoranda defining medication practices. Physicians fail to justify the medications chosen for treatment or changes made in treatment. Medications are either not changed at all or changed so frequently that it is difficult if not impossible to ascertain the efficacy of the medication. Our experts found medications being prescribed at sub-therapeutic levels. The result is that medications are not working, patients are acting out more, and staff rely on restraints as a means of patient control.

We further found inappropriate and excessive use of medications on a pro re nata ("PRN"), or "as needed" basis. This practice gives discretion to unqualified staff to determine when medications should be given to a patient. Moreover, nurses fail to document the effect of PRN medications in violation of standard nursing practices.

Comprehensive assessments of patients' health care needs and evaluation of the efficacy of treatment interventions are a critical component of adequate health care. Central State physicians, however, are not routinely performing adequate assessments. Nor does the staff act in an interdisciplinary way to identify, plan for, and treat the specific needs of patients. This lack of interdisciplinary communication is a basic failing that negatively affects practically every aspect of patient care at Central State.

Emergency medical care at Central State is also inadequate. Our nursing expert concluded that inadequate medical emergency response was a contributing factor to two deaths at Central State that occurred during the past year. In one instance, there was a delay in initiating cardiopulmonary resuscitation. In another instance, there was a delay in providing emergency medical equipment. One of the deaths occurred on the weekend in the Forensic Unit, where there is only one registered nurse on duty for an entire building of 176 patients.

Central State staff and administrators admit that nursing care is particularly understaffed. The nursing shortages have resulted in a lack of monitoring, review and coordination of medical services. Our nursing consultant found that to make up for the lack of nurses, Central State has had to use an excessive rate of overtime since the beginning of the calendar year. To continue the use of overtime at the same rate for the entire year would result in the equivalent of hiring 53 additional full-time nurses. This excessive use of overtime in a mental health facility is dangerous and does not comport with accepted professional standards.

Inadequate and incomplete record keeping practices deprive Central State staff of information necessary to make professional decisions concerning patient care and treatment. Patient charts lack sufficient medical histories of patients to allow professional judgments to be made regarding treatment. Diagnostic evaluations lack appropriate documentation and justification. Our consultants found that staff did not record patient response to prescribed treatment and medication. Records regarding the detection, evaluation and management of drug side effects were absent from patient charts. Nor do the records reflect explanations for changes in treatment or follow-up procedures pertaining to recognized medical conditions. In sum, Central State records lack relevant clinical information necessary for staff to make professional decisions.

MINIMUM REMEDIAL MEASURES

I. Protection From Harm

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

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

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

4. The physical plant of the Forensic Unit needs to be modified to ensure the safety and well being of Central State patients and staff.

5. Central State should hire and deploy a sufficient number of qualified direct care and professional staff necessary to provide patients with adequate supervision and medical and psychiatric treatment.

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

II. Mental Health Care

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

2. The treatment process should be reformed. Patient treatment must be appropriate, individualized, coordinated, and properly managed. Such programs should give each patient a reasonable opportunity to be cured and function as independently and effectively as possible given his or her individual condition. To that end, treatment planning should reflect multi-disciplinary thinking. Patients should have appropriate input in the treatment process. Treatment should be based on objective data and clearly established goals. Staff should be trained to write professionally appropriate behavioral goals and objectives. Data collected by staff for treatment decisions should be adequately incorporated into the treatment planning process. Master treatment and nursing care plans need to be consistent and adequately organized for staff review.

3. Central State needs to provide adequate treatment for patients with specialized needs. If mentally retarded patients continue to be housed at Central State, they must be provided with adequate individualized treatment and training. Patients with a dual diagnosis of substance abuse should be provided adequate treatment for that problem.

4. Qualified professionals at Central State must evaluate patients to determine the most integrated setting appropriate to meet their needs. Discharge criteria need to be adequately developed and discharge planning should be a consideration long before a patient is about to be discharged. Central State must develop and implement adequate discharge plans that identify the necessary aftercare services to meet the needs of patients upon discharge. The Commonwealth should develop a quality assurance/improvement system to oversee the discharge process. This system should ensure that patient discharge plans are implemented and that appropriate aftercare services are provided that meet the needs of the patient in the community. Individualized, professionally justified placement decisions should consider a patient's needs.

III. Seclusion and Restraint

1. Seclusion and restraint policies must comport with professional standards and must be conducted in a safe and appropriate manner. The practice of using seclusion for the convenience of staff, or in lieu of treatment, must cease immediately. The decision to seclude and/or restrain a patient should only be employed pursuant to the exercise of professional judgment by a qualified professional (i.e., psychiatrist, medical doctor, psychologist, or registered nurse). Patients in seclusion and/or restraint should be adequately and appropriately monitored. Use of seclusion and restraints should be properly documented and reviewed in a timely fashion by qualified staff. Criteria for release from seclusion and restraints should be clearly identified, and use of seclusion and restraints as part of any treatment process should be professionally appropriate and regularly reviewed.

IV. Medical Care and Medication Practices

1. Central State's psychopharmacological practices must comport with generally accepted professional standards. Patients should receive prompt professional evaluation of medical problems. All use of drugs should be professionally justified, carefully monitored, documented, and reviewed by qualified staff.

2. Central State must provide adequate and appropriate psychiatric and mental health services in accordance with accepted professional standards.

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

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

Pursuant to the Civil Rights of Institutionalized Persons Act, the Attorney General may initiate a lawsuit to correct deficiencies at an institution forty-nine days after appropriate officials are notified of them. 42 U.S.C. § 1997b(a)(1). We know that Virginia is already engaged in efforts to improve conditions at Central State and look forward to receiving the initial plan of correction based upon these efforts. As we have agreed, we will give the Commonwealth an opportunity to respond to this findings letter in accordance with the time frames agreed to in the correspondence between Special Litigation Section Chief Steven Rosenbaum and Virginia Deputy Attorney General William H. Hurd.

Again, we want to thank you for your cooperation. We will continue to work with you and other Commonwealth officials to resolve the serious deficiencies we have identified.

Sincerely,

Isabelle Katz Pinzler
Acting Assistant Attorney General
Civil Rights Division

cc: The Honorable Richard Cullen
Attorney General
Commonwealth of Virginia

Mr. Robert Metcalf
Secretary
Department of Mental Health and
Human Resources

Mr. Timothy Kelly
Commissioner
Department of Mental Health

Mr. James C. Bumpas
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