July 5, 2005

The Honorable Jim Douglas
Governor of Vermont
109 State Street, Pavilion
Montpelier, VT 05609-0101

Re: CRIPA Investigation of the Vermont State Hospital, Waterbury, Vermont

Dear Governor Douglas:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Vermont State Hospital ("VSH") in Waterbury, Vermont. On May 28, 2004, we notified you that we were initiating an investigation of conditions and practices at VSH, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. 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 patients with mental health issues who are treated in public institutions.

As part of our investigation, on August 30 through September 2, 2004, we conducted an on-site review of care and treatment at VSH with expert consultants in the areas of psychiatry, medical care, psychology, and protection from harm. In conducting our on-site investigation, we interviewed administrators, staff, and patients, and examined the physical living conditions at the facility. We reviewed facility records, including patients' medical charts and other documents relating to the care and treatment of patients both during and after our tour. In keeping with our pledge of transparency regarding our investigatory findings, we provided an exit interview at the end of our visit, where we verbally conveyed our preliminary findings to counsel and facility and State officials.

As a threshold matter, we wish to express our appreciation to the staff of VSH and to State officials for their extensive assistance and cooperation during our investigation. We hope to continue to work with VSH and the State of Vermont in the same cooperative manner in addressing the problems that we found. Further, we wish to particularly thank those individual VSH staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment and improve the lives of patients at the hospital. Those efforts were noted and appreciated by our expert consultants and staff.

Consistent with our statutory obligations under CRIPA, I now write to advise you formally of the findings of our

investigation, the facts supporting them, and the minimal remedial steps that are necessary to remedy the deficiencies set forth below.

I. BACKGROUND

Vermont State Hospital is a 54-bed mental health hospital, with an average daily population of about 50 patients. According to hospital staff, VSH exists to provide intensive psychiatric treatment and secure observation when no adequate alternative exists. About 70-80% of VSH admissions are for emergency evaluations and the remaining admissions are patients transferred from less restrictive care settings.

Currently, all patients reside in the Brooks Building, built in 1939. Patients are residents of one of three units: Brooks I, Brooks II, or Brooks Rehabilitation Unit ("Rehab"). Two psychiatrists care for the 19 patients on Brooks I; another two psychiatrists provide care for the 21 patients on Brooks II; and one psychiatrist provides care for the Rehab unit which consists of 14 beds. Although no written admission criteria distinguish these units, staff indicated that Brooks I is primarily for males and Brooks II is for females, though during our visit we noted at least one female patient residing on Brooks I.

Brooks I and II have not been extensively remodeled in several years. Rooms are both single and double occupancy and many have stainless steel sinks and uncovered toilets generally found in jail and prison settings. There are a total of two showers and one bathtub for the 19 patients on Brooks I, as well as communal toilets and sinks. Brooks II has an additional shower along with communal toilets and sinks. No rooms have sinks or toilets. Most rooms are without bureaus for patient belongings, aside from some limited under-bed storage. Common areas, hallways, and patient rooms are unadorned. Each unit has a smoking porch open to the outside at the end of a corridor. With its unadorned walls, cell-like rooms, and smoking porches without adequate ventilation, the physical structure of the building is more prison-like than supportive of patient dignity and right to treatment in an environment that is conducive to treatment and recovery. While neither the Constitution nor federal statutes require any sort of bright or lush surrounding, our expert consultant's observation is worth noting:

> The conditions of the physical plant . . . are dehumanizing. No one should expect individuals to achieve recovery when they have to reside in a jail-like setting, sleeping right next to their uncovered toilets and having no functional closet space for their belongings.

The Brooks Rehab unit has been recently remodeled and offers a brighter and cheerier environment. Again, while no written admission criteria for this unit exists, staff indicated that

patients were transferred to Brooks Rehab from Brooks I or II when they were no longer at risk of danger to themselves or others.

II. FINDINGS

Patients of State-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation to ensure their safety and freedom from unreasonable restraint, prevent regression, and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982); Kurlak v. City of New York, 88 F.3d 63, 75 (2d Cir. 1996)(applying the Youngberg standard to treatment given in a mental health hospital). In order to protect patients from harm, hospitals have a duty to adequately supervise patients known to be suicidal. Dinnerstein v. U.S., 486 F.2d 34 (2d Cir. 1973). If a patient is admitted to a psychiatric hospital for care and treatment, the State has a duty to treat the patient. Woe v. Cuomo, 729 F.2d 96, 105 (2d Cir. 1984)(If justification for commitment of psychiatric patients rests, even in part, upon the need for care and treatment, then a State that commits must also treat). Determining whether treatment is adequate focuses on whether institutional conditions substantially depart from generally accepted professional judgment, practices, or standards. Youngberg, 457 U.S. at 353. The State is also obliged to provide services in the most integrated setting appropriate to the individual patient's needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see Olmstead v. L.C., 527 U.S. 581 (1999).

As described in greater detail below, we find that conditions and services at VSH substantially depart from generally accepted standards of care, and we conclude that certain conditions at VSH violate the constitutional and federal statutory rights of patients. In particular, we find that VSH fails to: (1) protect patients from harm and undue restraints; (2) provide adequate psychiatric and psychological services; and (3) ensure adequate discharge planning and placement in the most integrated setting appropriate to each patient's individualized needs.

A. PROTECTION FROM HARM

Patients' constitutional liberty interests compel States to provide reasonable protection from harm. Youngberg, 457 U.S. at 315-16; Society for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1243 (2d Cir. 1984) (patients of mental health institutions have a right to safe conditions). In order to protect patients from harm, hospitals have a duty to adequately supervise patients known to be suicidal. Dinnerstein v. U.S., 486 F.2d 34 (2d Cir. 1973) (veterans hospital held liable for not adequately supervising patient with history of known suicidal tendencies).

VSH fails to protect its patients from harm due to (1) an inadequate risk management system that fails to collect, organize, and track incidents of harm and abuse for the purpose of identifying and preventing potential incidents of harm and abuse; (2) overuse of unnecessary seclusion and restraint; and (3) a lack of an adequate quality assurance system necessary to ensure quality of care across all aspects of care and treatment.

Unfortunately, VSH has a history of failing to protect its patients from harm. In 2003, within a one month period, two patients at VSH committed suicide by hanging. One suicide resulted from the patient hanging herself with a shoelace when her behavior plan stated that she not be allowed to keep objects in her room that could be used for self-harm, including shoelaces. In the wake of these suicides, VSH has implemented new policies and procedures including a new policy of conducting searches of patients and visitors entering the hospital. In spite of its remedial efforts, however, no mechanism exists for tracking incidents of discovered contraband. Contraband items remain a problem and the new policies and procedures did not prevent the admission of a plastic knife and material used for distilling alcohol on to the units. Without an effective system to identify, record and track contraband, the leadership of VSH cannot know whether such instances are isolated events or whether their interception policies are ineffective and changes need to be implemented.

Furthermore, given the history of suicides at VSH, the physical structure of the hospital remains problematic. Residential management at VSH fail to identify or, where they are identified, rectify suicide hazards. Indeed, while touring with a VSH employee, we noted several unsafe conditions in the bathroom of one of the units that could facilitate hanging or self-injury. This is particularly alarming in a psychiatric facility such as VSH with a recent history of suicides.

1. Risk Management

Generally accepted professional standards of care require that patients be provided a reasonably safe environment through an effective risk management system, including mechanisms for reporting, investigating, and tracking and trending incidents of harm and injury, and identifying and monitoring implementation of appropriate corrective and preventative action. VSH's risk management system substantially departs from professional standards of care, exposing its patients to an unreasonable risk of harm. VSH lacks an adequate system for collecting, organizing, and tracking incidents of harm and abuse. VSH plans to implement a new data collection form, but at the time of our review, VSH lacked an effective system for collecting data on incidents. The limited data that is currently collected is merely recorded as raw numbers of occurrences and is not organized in any coherent fashion or reported to the hospital's clinical and administrative leadership. Consequently, VSH leadership is unable to analyze trends and take appropriate

action to understand and rectify unexpected variations in results by unit, shift, or staff. VSH's failure to identify problematic trends in patient incidents and take appropriate and timely action to address such trends and patterns places its patients at ongoing risk of harm due to injury and abuse.

2. Seclusion and Restraint

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. Consistent with generally accepted professional practice, seclusion and restraints may only be used when a patient is a danger to himself or to others. See Youngberg, 457 U.S. at 324 ("[The State] may not restrain residents except when and to the extent professional judgment deems this necessary to assure such safety to provide needed training."); Goodwill I, 737 F.2d at 1243 (patients of mental health institutions have a right to freedom from undue bodily restraint and excess locking of doors violates patients' freedom from undue restraint); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1189 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990) ("It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than systematic behavior techniques such as social reinforcement to control aggressive behavior."); Williams v. Wasserman, 164 F. Supp.2d 591, 619-20 (D. Md. 2001)(the State may restrain patients via mechanical restraints, chemical restraints, or seclusion only when professional judgment deems such restraints necessary to ensure resident safety or to provide needed treatment). Seclusion and restraint should only be used as a last resort. Thomas S. v. Flaherty, 699 F. Supp. at 1189. Similar protections are accorded by federal law. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1395hh, and implementing regulations, 42 C.F.R. Parts 482-483 (Medicaid and Medicare Program Provisions); 42 C.F.R. § 482.13(f)(3)("The use of a restraint or seclusion must be . . . [s]elected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm; [and] . . . [i]n accordance with the order of a physician . . . ."); 42 C.F.R. § 482.13(f)(1) ("The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.").

Over 90% of restraint incidents at VSH involve strapping patients down to a bed in five-point restraints in a seclusion room - the most restrictive and dangerous form of intervention. VSH's use of seclusion and restraint appears to substantially depart from generally accepted professional standards of care and exposes its patients to harm due to excessive and unnecessarily restrictive interventions. Indeed, the percentage of patients secluded and restrained substantially exceeds the national

average for psychiatric hospitals.[1]

Seclusion and restraint are repeatedly used as interventions for behaviors where the patient is not an immediate danger to himself or others. We found numerous cases where the reason given for the use of seclusion or restraint was that the patient was "assaultive." However, no consistent picture ever emerged as to what was meant by that term. In several instances, "assaultive" appeared to mean "verbal assault," "loud and intrusive speech," "throwing milk and water at staff'" and "spitting at staff." In several other cases "assaultive" was not specifically defined at all. In the above examples, patients were immediately placed in restrictive measures without attempts to use less restrictive measures and without consideration of whether the behavior was an immediate safety threat to the patient or others. Our consultant found that:

> Far too often the documentation in the record is reflective of an automatic process in which certain patient behaviors appear to automatically lead to the application of the most restrictive measures. Similarly, the documentation of the reasons that lesser restrictive measures utilized to prevent an emergency situation were ineffective was often inadequate.

VSH consistently uses seclusion and restraint as an intervention of first resort and fails to consider lesser restrictive alternatives. For example, one patient was agitated and staff intervened. However, the patient responded to staff presence with increased agitation. The staff then responded to the patient by placing him in seclusion and restraint. The patient reacted to this restriction by becoming more agitated. This cycle of agitation, staff response, increased agitation, and escalating staff response led to the patient spending seven hours in seclusion and restraint. There is no documentation of methods used by staff to respond to this patient with less restrictive procedures, nor is there any documented supervisory review of this use of seclusion or restraint or the patient's treatment plan.

In another example, staff mistakenly permitted a patient smoking porch privileges and then, realizing their mistake, restricted the patient from these privileges. They placed him in seclusion out of a concern for potential self-harm following restriction from the smoking porch. Yet there was no indication whatsoever that lesser restrictive alternatives were attempted, and no documentation of supervisory review of this use of seclusion.

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[1] Between May 2003 and April 2004 between 5% and 20% of patients were secluded or restrained at VSH. The percentage consistently, and, at times, grossly exceeded the national figure of about 4%.

In a gross departure from accepted practice, VSH often uses seclusion and restraint for the convenience of staff and/or as initial punishment. For example, without therapeutic justification or rationale and as a matter of standard procedure, staff on the predominately female unit automatically force patients with behavior plans to spend two hours in their rooms under staff observation upon admission to the unit or return from a pass off-unit. This constitutes a planned use of seclusion for convenience of staff rather than in response to a behavioral emergency. In an example of seclusion used as punishment, a patient was kept in seclusion and restraint all day for failing to adhere to a protocol requiring search of person and belongings upon returning from a pass; the episode was apparently never reviewed by supervisory personnel.

VSH also keeps patients in seclusion and restraint substantially longer than the original incident warrants. For example, a patient was placed in seclusion and restraints after "spitting on staff." The seclusion and restraint order was extended for two additional hours on the basis of the original spitting incident, even though no further assessment occurred and there was no indication of the patient's behavioral condition at the time the seclusion and restraint order was extended.

VSH lacks adequate policies and procedures to properly govern the use of seclusion and restraint. Generally accepted professional standards dictate that psychiatric hospitals have clearly articulated policies and practices for the safe application of restrictive measures, including but not limited to: (1) definitions of each restrictive practice; (2) the role of each clinical discipline in initiating, authorizing and continuing a restrictive measure; (3) criteria for discontinuation; (4) criteria for initial and ongoing assessments of patients in restraints; (5) staff training in de-escalating behavioral situations to prevent the need for restrictive measures; (6) staff training in safely applying and discontinuing restrictive measures; and (7) systems for tracking and reporting the utilization of all the above measures.

VSH policies and procedures are fragmented and confusing and fail to offer necessary guidance on the use of seclusion and restraint. VSH has six different statements on seclusion and restraint ranging from guidelines to policies and procedures that are confusing and lack cohesion. Though the several documents discussing seclusion and restraints contain some instructions on the proper use of restrictive measures, no policy, guideline or procedure clearly summarizes the institution's requirements for using restrictive procedures. This can easily lead to staff confusion about proper application of these measures. VSH's policies and procedures fail to define the role of each clinical discipline in initiating, authorizing and continuing a restrictive measure. For example, both seclusion and restraint are restrictive measures but VSH policy inconsistently allows for a nonprofessional technician to approve seclusion while simultaneously requiring a nurse to approve restraint.

VSH policies and procedures also fail to provide criteria for initial and ongoing assessments and for discontinuing restrictive measures. In fact, VSH policies and procedures do not require adequate and ongoing monitoring by a professional where seclusion or restraint use becomes necessary. For example, one policy states that restraint can only occur after a personal observation by at least a nursing supervisor, but the same policy indicates that a patient may be restrained for up to 30 minutes before being seen by a nurse.

Perhaps the most disturbing policy deficiency is that VSH fails to govern the most restrictive of procedures - the simultaneous use of seclusion and restraint. As discussed above, 90% of restraint incidents at VSH involve five point restraint to a bed in a seclusion room. Restraining patients to a bed is a particularly dangerous intervention often associated with numerous and severe patient injuries to the back and neck and even death, especially in patients with a compromised cardiovascular system. To use five point restraints consistently as the most widely relied upon restraint method at VSH without any guidelines or policies governing its use substantially departs from accepted professional practices, is dangerous, and exposes VSH patients to a significant risk of death or injury.

Finally, VSH fails to adequately document its use of seclusion and restraint – including several instances where records failed to contain any physician order – and fails to provide an appropriate rationale for the restrictive measure. For example, in one case, staff injury was the reason stated in the record for using restraints. However, further review of the incident revealed that staff were injured while attempting to place the patient in restraints. The actual incident precipitating the restraints was that the patient "began to swing at staff." Other less restrictive measures were not adequately documented and may have prevented both staff injury and patient restraint.

In sum, VSH's use of seclusion and restraint substantially departs from generally accepted professional standards of care and exposes its patients to harm due to inadequate policies and procedures, poor staff training, insufficient behavioral programming, and inadequate documentation and supervision. Seclusion and restraint at VSH is applied without adequate professional assessment and/or supervision, often with significant clinical error, for the convenience of staff, and without appropriate documented rationale.

3. Quality Assurance

Professional standards of care dictate that a hospital like VSH develop and maintain an integrated system to monitor and assure quality of care across all aspects of care and treatment. Such a quality assurance system incorporates adequate systems for data capture, retrieval, and statistical analysis to identify and track trends in patient treatment. VSH lacks an adequate quality

assurance system. Although important steps have been taken, VSH's quality management program is still in its infancy and currently is unable to identify, track, and trend key hospital indicators designed to protect its patients from harm. For example, VSH has no way to track and trend adverse drug reactions, medication errors, infection control issues, utilization review, patient and staff injuries, active treatment participation, elopements, rates of seclusion and restraint, readmission rates, or involuntary procedures. In its current initial stages of development, VSH's quality assurance processes are fragmentary, uncoordinated, and suggest a reaction to crisis rather than the development of an integrated overall monitoring system. Indicators and thresholds critical to identifying, tracking and correcting harm and neglect are underdeveloped. As a result, VSH is unable to adequately protect its patients from harm.

B. PSYCHIATRIC AND PSYCHOLOGICAL CARE AND TREATMENT

The State has an obligation to provide adequate treatment programs to its patients in mental health hospitals. Woe, 729 F.2d at 105. In a mental health hospital, a patient must be provided a treatment program resulting from interdisciplinary treatment planning that leads to clinically appropriate goals specific to the patient's needs and designed to support the patient's recovery and ability to sustain him or herself outside the hospital. Inadequate treatment causes harm because it fails to stabilize the patient's clinical condition, leads to the patient's further decompensation, and/or unnecessarily prolongs the institutionalization of the patient.

1. Failure to Provide Adequate Treatment Planning

Under generally accepted professional standards, adequate treatment planning consists of a logical sequence of interdisciplinary care, including (1) formulating an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines and using the diagnosis and assessments to identify the fundamental problems caused by the diagnosed illness; (2) developing a treatment plan with specific, measurable goals that are designed to ameliorate problems and promote functional independence with interventions that will guide staff as they work toward those goals; and (3) providing ongoing assessments and, as warranted, revising the treatment plan.

As a threshold matter, we recognize that VSH is trying to improve its treatment planning. The new medical director at VSH has identified treatment planning as a priority area for performance improvement and has instituted a monitoring system to assess staff performance in this area. VSH also has a newly designed treatment plan policy that delineates the appropriate timeline for developing the treatment plan and specifies the essential components of an adequate plan.

However, in practice, VSH's treatment planning substantially departs from generally accepted professional standards of care. To begin with, assessments are inadequate, which, in turn, leads to inappropriate diagnoses. Faulty diagnoses then contribute to deficient treatment plans and interventions, thereby precluding the specific needs of a patient from being addressed, let alone ameliorated. Moreover, unworkable treatment plans are rarely if ever revised, causing a vicious cycle to continue repeating itself.

Individuals are thus denied interdisciplinary care that targets their needs and helps them achieve the level of functioning necessary for recovery and ultimate community reintegration. In the meantime, VSH patients are subjected to actual and potential harm due to unnecessary prolonged hospitalization, excessive use of restrictive treatment interventions, increased risk of relapses, repeat hospitalizations, and, with respect to forensic patients, prolonged involvement in the criminal justice system.

a. Inadequate Psychiatric Assessments and Diagnoses

Assessments provide the information that supports the psychiatrist's formulation of the case and leads to a proper diagnosis. An accurate diagnosis is the bedrock of an effective treatment plan. It establishes the parameters for individualized, targeted, and appropriate interventions that meet the medical and psychosocial needs of individual patients. Adequate assessment of a mental health patient for treatment planning purposes requires input from various disciplines, under the active direction and guidance of the treating psychiatrist who is responsible for assuring that relevant patient information is obtained and considered.

Psychiatric assessments at VSH are inadequate to provide an appropriate diagnosis. The information in the initial assessments is often insufficient to reach the diagnosis given, resulting in diagnoses that are without clinical justification. These failures carry risks of actual and potential harm to individuals in multiple ways. Patients' actual illnesses are not being properly treated; patients are exposed to potentially toxic treatments for conditions from which they do not suffer; patients are not provided appropriate psychiatric rehabilitation; patients are subjected to unnecessarily restrictive restraints; patients at risk of self-harm are not adequately protected from this risk; and patients' options for discharge are seriously limited.

In the majority of cases that we reviewed, VSH psychiatric assessments were inaccurate, incomplete, and uninformative, including assessments upon admission in which VSH failed to provide timely assessment for individuals at risk for suicide, violence, elopement, and other critical risk factors. Too many individuals at VSH are given tentative and unspecified diagnoses without evidence of further assessments or documented observations required to finalize the diagnoses. VSH also fails

to adequately review or critically examine past diagnoses or update diagnoses based on the patient's historic response to treatment.

Numerous examples demonstrate the above deficiencies. For one patient, for instance, there was a discrepancy between the information in the initial assessment and the diagnosis. The individual was diagnosed with a mood disorder (depression) but the initial assessment contained information that highlighted sexually inappropriate behavior and normal mood. Moreover, the initial assessment never assessed the individual for cognitive functioning yet he was diagnosed with "probable borderline intellectual functioning." The record also failed to analyze information regarding the patient's history of behavioral improvement in response to an adjustment of his anti-parkinsonian treatment. Nor was the worsening of the individual's behavior following the institution of antidepressant treatment ever analyzed. This is an example of an inadequate assessment; a diagnosis unsupported by the assessment; inadequate ongoing reassessments; and a failure to critically examine historical information and information regarding the individual's response to treatment in order to refine diagnosis and treatment. As a result, treatment interventions were not aligned with the individual's needs.

In other examples, initial psychiatric assessments failed to assess the individual for suicidal ideations or intent, even though in one instance, the individual was admitted following a suicide attempt, and complained that "life is not worth living anymore." In another instance, upon admission, the patient's initial assessment failed to assess him for suicidal ideation; in fact, the mental status examination in the areas of affect and mood were left blank. Yet, a subsequent assessment, done six days after admission, indicated that the individual had been suicidal upon admission. These examples demonstrate a substantial failure to identify important risk factors in the initial assessments.

b. <u>Inadequate Psychological Assessments and Diagnoses</u>

Generally accepted professional standards of care dictate that before a patient's treatment plan is developed, facility psychologists provide a thorough psychological assessment of the patient to assist the treating psychiatrist in reaching an accurate diagnosis and provide an accurate evaluation of the patient's psychological needs. Moreover, as needed, generally accepted standards dictate that additional psychological assessments be performed early in the patient's hospitalization to assist with any psychiatric disorders that may need further study and/or diagnosis.

As with poor psychiatric assessments, inadequate psychological assessments contribute directly to improper treatment interventions, exposing patients to actual or potential harm, particularly in the area of improper medication

administration. Without the adequate support of the psychologists in reviewing behavior data regarding responses to medication, psychiatrists are unable to adequately prescribe and adjust medication regimens. Furthermore, in the context of patients' needs for psychological supports and adequate life skills, harm occurs through prolonged and/or exacerbated behavioral disorders and functional disabilities that, in turn, needlessly prolong patients' hospitalization and block their successful re-entry into the community.

Psychological assessments and evaluations at VSH, with few exceptions, are inaccurate, incomplete, and uninformative. The psychological assessments we reviewed were very brief, often a single descriptive word. They made no attempt to convey the psychological and behavioral details from the patient's history in a manner that could logically lead to specific psychological treatment interventions. Records rarely contained any patient history but rather contained vague universal statements such as "obtain history," even when the patient had had multiple previous admissions. In cases where the psychological assessments included a list of patient skills, the assessments were not useful. For example, we reviewed assessments that listed skills such as "can be personable" or "average intelligence," which have little relevance to psychological treatment and are unable to be translated into individualized treatment goals and psychological interventions.

Because of VSH's inadequate psychological assessments, treatment recommendations are not individualized to patient needs and are mostly generic descriptions such as "stabilize on meds" or "return to community" and do not facilitate the formulation of psychological interventions. Furthermore, not one of the psychological assessments we reviewed recommended the development of a behavior plan, even in patients with a history of aggression or self-injury or who had been frequently subjected to seclusion and restraint. For example, the initial psychological assessment of one patient with a known history of self-injurious behavior made no mention of this history and suggested no precautions against suicidal gestures. The patient later had more than 15 incidents of seclusion and/or restraint in a two week period due to self-injurious behavior, without any psychology intervention appearing in the patient's medical record.

These problems are compounded by: (1) a lack of adequate psychological staff, resulting in psychology staff's frequent inability to attend treatment team meetings, and (2) a lack of policies and procedures clearly articulating the philosophy of care and role of the psychologist at VSH, resulting in psychology services being fragmented and not integrated into overall clinical care.

Finally, VSH psychologists fail to adequately assess and monitor patients for behavioral responses to their medication regimen, particularly those patients on multiple medications for whom continued monitoring and evaluation is critical to treatment

success. A key and unique role of psychologists in hospitals such as VSH is to design and monitor interventions for patients with behavioral problems, including monitoring behavioral responses to medications. The psychologist should likewise be assisting the psychiatrist in the appropriate use of polypharmacy and dosing requirements in developing and updating a patient's treatment plan. Unfortunately, at VSH the psychologists fail to adequately review behavioral data on a patient's response to a particular pharmacological intervention, and the few assessments we did discover included serious flaws that invalidated their clinical conclusions. Consequently, VSH generally fails to document a rationale for the prescribed medications and, oftentimes, there is an inadequate correlation between diagnosis and the prescribed medication.

c. Inadequate Treatment Plans

Generally accepted professional standards of care instruct that adequate treatment plans should: (1) integrate the individual assessments, evaluations, and diagnoses of the patient that are performed by all disciplines involved in the patient's treatment; (2) identify a patient's individualized needs; and (3) identify treatment goals and interventions related to those goals that build on the patient's needs in order to support the patient's recovery and ability to sustain him or herself in the most integrated, appropriate setting.

Substantially departing from generally accepted professional standards, treatment plans at VSH fail to rely upon adequate interdisciplinary assessments. In one example, a patient was admitted to VSH after being found "lying naked on the street and then grabbing a police officer." The team noted that she had made delusional statements. However, the team never assessed or addressed her problem of delusions.

In another instance, a patient was diagnosed with a substance abuse problem, and yet, inexplicably, the treatment plan called for an assessment as to whether or not the individual had a problem with substance abuse. A patient's plan of treatment must outline those steps necessary for staff to implement to effect his or her recovery and should not call for an assessment. We emphasize again that a treatment plan should be based upon an adequate assessment, which must occur before formulating the plan. It is impossible to create a treatment plan for a patient's needs if the information necessary to identify those needs is not first gathered and assessed.

VSH's treatment plans also lack internal consistency and often are at odds with the assessments and other clinical documentation rendering the plans confusing and ineffective. For instance:

- One patient with severe bipolar manic illness was assessed as having a problem with medication compliance which appeared to be the main underlying problem with her illness.

In a substantial departure from generally accepted professional standards, her treatment plan, however, failed to identify non-compliance with medications as a problem requiring goals and interventions. The plan merely noted that she was "educated about her bipolar illness" but never discussed the relationship between her awareness of her illness and her problem of medication non-compliance.

- For another patient, the assessment in the treatment plan noted that the patient was "cooperative with medications" but then identified one of his problems as refusing to discontinue use of a psychotic medication as directed by his physician.

In addition, treatment goals devised at VSH are often vague, unattainable, unmeasurable, or altogether inappropriate. In the process, they block patients' ability to recover and successfully transition to the community. For example,

- One patient's problem was listed vaguely as "psychotic symptoms" as a focus for treatment.

- Another patient's problem was listed generically as "difficulty maintaining community living" but the treatment plan contained no specific treatment goals.

Even when a treatment team at VSH does identify a patient's need and specifies an intervention, those interventions are not consistently implemented as required under generally accepted professional standards. For example, one patient's psychiatric interventions indicated that she was to receive "supportive psychotherapy, education about mental illness and treatment options and determination of responsibilities relative to discharge planning." However, her record contained no documentation that the above interventions were being implemented. In another example, a diagnosis of "psychosis, NOS [not otherwise specified]", a term not consistent with generally accepted professional standards, was established for a patient but the patient never received antipsychotic treatment.

Contrary to generally accepted professionals standards, VSH's treatment planning process is not interdisciplinary. Meetings we observed involved little interdisciplinary exchange. We observed that the topic of the patient's diagnoses/critical needs was brought up at the end of the meeting and consisted primarily of a monologue presentation by the psychiatrist of areas relevant to planning with no time left in the meeting to adequately discuss and address them. The team meetings lacked adequate structure to ensure that all relevant issues are discussed during the meeting time.

d. Failure to Provide Ongoing Assessments

Generally accepted professional standards require that psychiatric assessments continue on an ongoing basis, involve

timely and thorough reevaluations of behaviors targeted for treatment, and evaluate new clinical developments. Such ongoing assessments should be conducted at a frequency that reflects the individual's clinical needs, delineate the nature of behaviors targeted for treatment, and thoroughly document clinically significant changes in the individual's condition. Furthermore, to ensure continuity of care when individuals are transferred between units, an additional psychiatric assessment should be done by the referring psychiatrist, particularly when new treatment teams take over the responsibility for providing treatment.

VSH fails to provide timely ongoing assessments (documented at VSH as progress reports), including assessments of important risk factors. Nor does VSH appropriately modify diagnoses and treatment in response to important clinical developments. The ongoing assessments generally fail to address the individual's response to treatment, or lack thereof, as a tool to reexamine the diagnosis and overall treatment plan. They also fail to include key information from other disciplines such as nursing notes (particularly with respect to individuals with a current or past history of tardive dyskinesia ("TD")[2], a potentially irreversible side effect of antipsychotic drug treatments), or to integrate and recommend behavioral and psychosocial interventions. Indeed, transfer notes often do not provide risk assessments or any rationale for the benefits of transfer between the units at VSH.

The lack of adequate ongoing assessments jeopardizes the care of patients, particularly those patients subject to seclusion and restraint who require frequent, ongoing monitoring. Patients are commonly subjected to harm from unnecessary restrictive procedures as a direct result of this deficiency. For example, an individual was initially diagnosed with "adjustment reaction with disturbance mood" but the record contained no explanation or supporting information. Later, the diagnosis was changed to Attention Deficit Disorder with Hyperactivity ("ADHD") and the patient was placed on medication indicated for this condition. However, shortly after the institution of ADHD treatment, his condition rapidly worsened and he required five-point restraints on five occasions in the subsequent month. The treating psychiatrist never considered that the diagnosis of ADHD was wrong. While adding further trials of other medications, the psychiatrist actually kept increasing the dose of the ADHD medication, which led to a further worsening of behavior. During repeated episodes of restrictive interventions as a result of the patient's worsening behavior, VSH failed to conduct timely ongoing assessments, and the few assessments done did not even refer to the restrictive interventions.

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[2] Tardive dyskinesia is a movement disorder. Symptoms of tardive dyskinesia include involuntary, aimless movements of the tongue, face, mouth, jaw, or other body parts.

The patient was later transferred inter-unit, but the transfer assessment by the attending psychiatrist failed to include any assessment of the numerous restrictive interventions that the patient had earlier received. Nor did the assessment provide any guidance to the receiving team about safeguards to protect against the risk. This example demonstrates a failure to update the diagnosis based upon information regarding response to treatment; failure to provide timely ongoing assessment and appropriate modification of treatment in response to important clinical developments; and failure to include any assessment of risk factors during an inter-unit transfer.

Because VSH fails to conduct adequate ongoing assessments, treatment plans are not modified and updated in a timely manner, particularly in response to high-risk behaviors requiring new interventions and/or modified goals. For instance, one patient required timeout at least 19 times during July 2004, but the treatment plan's weekly updates contained no reference to the episodes of timeout nor any evidence that her treatment plan had been modified to address the escalating behavior pattern resulting in the increased use of restrictive measures. More specifically, during the week of July 7-11, 2004, her record lists seven episodes of restrictive intervention, but her July 15th treatment plan update contradicts the record and states that she was "slowly resolving manic symptoms."

2. Psychiatric and Psychological Services

Under generally accepted professional standards, a mental health hospital has the duty to provide adequate supports and services necessary to implement a patient's treatment plan, including: providing medication treatments based upon evidence of appropriateness, safety, and efficacy; implementing a monitoring system to ensure appropriate use of medications; and instituting an adequate array of relevant treatment programs to meet the specific needs of its patient population. Lack of adequate supports and services can result in improper implementation of treatment plans and can cause substantial harm to patients, including inadequate and counterproductive treatment, serious physiological and other side effects from inappropriate and unnecessary medications, and excessively long hospitalizations.

a. <u>Inadequate Psychiatric Services</u>

VSH's psychiatric supports and services substantially depart from generally accepted professional standards of care, potentially exposing patients to harm and a significant risk of harm due to the failure to (1) exercise adequate and appropriate medication management, (2) monitor medication side effects, and (3) provide sufficient treatment programs to meet the specific needs of its patient population.

i. <u>Inappropriate Medication Management</u>

Medication practices that comport with generally accepted professional standards of care should ensure that: (1) medication use is part of an interdisciplinary plan of care that considers the impact of medication use on individuals' quality of life; (2) there is appropriate integration of medication treatment with behavioral treatment, including evidence that medications are not used in lieu of such treatment; (3) there is a documented rationale for medication use based on clinical and empirical criteria, including diagnosis, presenting symptoms, history of response to previous treatments, and the specific risks and benefits of chosen treatments; and (4) attention is given by practitioners to high-risk medication uses, including the PRN (i.e., "as needed") administration of medications, and polypharmacy (the contemporaneous use of multiple medications to treat the same condition).

VSH fails to meet every one of the above standards of professional care and is unable to afford appropriate pharmacological treatment to its patients. There is no evidence that medication use is part of an interdisciplinary plan of care. Medication and behavioral treatments are not integrated. There are no measurements of target behaviors or any documentation of attention to the impact of medication use on individuals' quality of life. Furthermore, there is inadequate documentation that past history is considered in making decisions about selection of medications. For example, one patient with persistent psychotic symptoms had a documented history of responding well to the atypical medication clozapine and responding poorly to another conventional medication, trifluphenazine. However, the record failed to include documentation as to why she was treated with a medication similar to trifluphenazine and not with clozapine or another atypical medication.

With few exceptions, the psychiatric documentation fails to provide any rationale for the use of medications, particularly for the use of polypharmacy, and fails to document attention to high-risk medication uses. For example, the records we reviewed indicate that VSH has a serious problem with the utilization of PRN (pro re nata or as needed) medication uses. The medications are almost always ordered without any clear indications for when they should be used or limits on their use. Additionally, psychiatrists at VSH tend to prescribe several classes of PRN medications simultaneously, usually antipsychotics, benzodiazepines, anticholinergics, and antihistamines, without specifying indications for the use of these medications. The problem of misuse of PRN medications is compounded by the fact that the psychiatrists consistently fail to critically examine or even review the information regarding PRN medication use. None of the records we reviewed contained documentation that the psychiatrists monitor the use of PRN medications. Such monitoring is critical in guiding decisions about adjustments of the regular medication regimen.

In another example of inattention to high-risk medication use, psychiatrists at VSH prescribe benzodiazepines (medications

with a potential for abuse and habituation) for individuals with substance abuse problems and cognitive impairments, without having documented at all that the risks of exacerbating the patients' problems were considered, that the individuals were monitored for the risks, or that safer treatment alternatives were considered. One patient with a provisional diagnosis of substance-induced psychosis, later finalized as alcohol dependence, was given PRN treatment with a benzodiazepine called lorazepam, a medication that has a potential risk for drug abuse and habituation and can "facilitate drug dependence." Safer alternatives to lorazepam treatment in this case, including benzodiazepine agents with lower abuse potential, were never considered. This individual was also started on conventional antipsychotic treatment with haloperidol. The treating psychiatrist did not document the rationale and, when we interviewed him, could not justify the reasons for failing to start treatment with one of the newer atypical antipsychotics, as recommended by all current professional practice guidelines. Another patient was diagnosed with borderline intellectual functioning and received anticonvulsant medications including phenytoin and mysoline. There are safer alternatives to these treatments as both medications can worsen cognitive impairment. However, there was no documentation to indicate awareness of this risk or any monitoring of the cognitive status of the individual.

In sum, VSH medication management practices substantially depart from professional standards. The deficiencies encompass: medications used in lieu of behavioral therapies; over-medication; unnecessary impairments secondary to inappropriate, unjustified, and inadequately monitored drug treatments; prolonged hospitalization; and the unnecessary use of restrictive interventions.

ii. Inadequate Medication Monitoring

Generally accepted professional standards further require that a systematic monitoring and reviewing mechanism exist to ensure the safety, appropriateness, and efficacy of medication uses throughout the facility. This mechanism should include: drug utilization evaluation, i.e., monitoring of practitioner's adherence to specific and current guidelines in the use of each medication; adverse drug reaction reporting; and medication variance reporting, i.e., reporting of actual and potential variances in the prescription, transcription, procurement/storage, dispensing, administration, and documentation categories of medication use.

VSH fails to provide any systematic monitoring to ensure appropriate, safe, and effective medication use in the facility. Its Pharmacy and Therapeutics ("P&T") Committee, which is responsible for monitoring medication use, does not adequately perform its necessary functions. The P&T Committee has no procedure to perform evaluations of the utilization of medications. For example, VSH's medication guidelines, which are the basis of any effective drug utilization review (DUE) system,

are seriously inadequate. Guidelines are dated, limited to a small number of medications, and inaccurate.

There is no mechanism to ensure adequate reporting of adverse drug reactions (ADRs) or any data-based analysis of serious ADRs. The current medication variance reporting system is inadequate to identify and assess actual and potential medication use problems or to initiate any meaningful performance improvement activities. There is also no mechanism for the systematic monitoring of high risk medication uses, and the pharmacy service fails to communicate drug alerts to the medical staff.

Finally, VSH's mechanism for monitoring individuals for the risk of Tardive Dyskinesia ("TD") is substandard. The psychiatrists do not document their examination of individuals for this risk or even address the monitoring done by the nursing staff. They simply continue to prescribe certain classes of medications that are known to increase the risk of TD. Furthermore, the instrument used by the nursing staff to monitor for TD is not reliable or validated and there is no evidence that nursing staff have received appropriate competency-based training to adequately perform the monitoring. For example, one patient with a documented history of TD continued to receive treatment with an anticholinergic agent, benztropine mesylate, which can be detrimental to her condition. The psychiatrist did not document an examination of the patient to assess the risk of TD. The patient also received treatment with a conventional antipsychotic medication, a known cause of TD, in addition to quetiapine, a newer antipsychotic agent. The rationale for this polypharmacy was inconsistent with generally accepted professional standards.

iii. Inadequate Treatment Programming

Generally accepted professional standards require that VSH provide an adequate array of relevant treatment programs to meet the specific needs of its patient population. VSH lacks such a plan. According to the medical/clinical director of VSH, almost two-thirds of the patients at the facility have substance abuse problems. However, VSH provides only a limited number of substance abuse programs, clearly not enough to meet the needs of its patient population. VSH does not provide any specialized group or other programs to meet the needs of individuals with forensic status, even though such individuals constitute nearly half of VSH's patient population. VSH similarly fails to provide any programming to meet the needs of the several patients diagnosed with cognitive impairments. Patients diagnosed with mild to moderate mental retardation also receive no specialized programs.

b. Inadequate Psychological Services

Under generally accepted professional standards, the purpose of psychosocial and rehabilitative interventions is to improve a patient's ability to engage in more independent life functions,

so as to better manage the consequences of psychiatric distress and avoid decompensation in more integrated settings. To be effective, these interventions should address the patient's needs, should build on the patient's existing strengths, and should be clearly organized in an integrated individualized treatment plan. Where needed, interventions that are designed to promote and facilitate skills development and that address behavioral issues should be clearly outlined in an adequately developed behavior plan supported by appropriate individual and group therapies. Adequate behavior plans should contain the following minimum information: (1) a description of the maladaptive behavior; (2) a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior; and (3) documentation of how reinforcers for the patient were chosen and what input the patient had in the development of such reinforcers along with the system for earning the reinforcers.

VSH's behavior plans and treatment programs substantially depart from professional standards of care. In no case did the behavior plans at VSH contain the above-stated minimum requirements. In fact, VSH psychologists rarely even develop behavior plans for their patients, even those with serious needs such as aggression, self-injury, or those who are repeatedly the subject of seclusion and restraints. Out of the records of 27 individuals that we reviewed, a behavioral plan existed in only one case, and that plan was inadequate. Many of the individuals reviewed had documented problems, including repetitive aggression, treatment refusal/non-compliance, and poor self-care, all of which typically represent indications for behavioral interventions and plans. Such lack of behavioral planning is particularly egregious given the extremely high utilization of seclusion and restraints at VSH. For example, a patient with seven incidents of restraint over a one month period due to "assaultive and threatening behavior" was never considered for a behavior plan. A patient with "ongoing agitation and risk for aggression leading to 15 episodes of restraint and/or seclusion in a two week period had very generic psychology interventions in the medical record (e.g., offers of support and 1:1 counseling), but was never considered for a behavior plan, despite previous VSH admissions in which similar behavior was observed.

Even where behavior plans do exist, they tend to be rudimentary, not clearly integrated into the patient's overall treatment plan, and rarely updated. Assessments and evaluations that should shape psychological and other supports and services frequently are incomplete and/or missing, and unreliable in identifying important elements of the patient's condition and shaping adequate interventions. Consequently, interventions often do not address assessed needs regarding functional skills and maladaptive behaviors, and those interventions actually addressing such needs typically are poorly conceived, excessively generic, and non-therapeutic. For example, one patient on a behavior plan had over 114 incidents of seclusion and/or restraint without any apparent modification of a clearly

unsuccessful behavior plan. Flow sheets kept by the nursing staff that track patient progress in meeting the goals of the behavior plans that do exist are kept in the nursing notes on the units, but psychology progress notes for patients on behavior plans fail to summarize this critical information, rendering such useful data ineffective in patient treatment.

VSH fails to provide adequate treatment programming and does not provide sufficient individual and group therapies to its patients. With so few VSH patients on behavior plans, less than 50% of VSH patients are receiving psychological services. Such lack of treatment programs is grossly deficient given the significant number of patients at VSH with specialized needs such as those with substance abuse problems who constitute almost two-thirds of the resident population at VSH; those with cognitive impairment who are frequently admitted to VSH; and those with forensic status who constitute a sizeable minority of the patient population. The lack of adequate group therapy programs means that the demonstrated need of VSH patients with depression, anxiety, social skills deficits, substance abuse, and relapse issues, are simply not met.

C. DISCHARGE PLANNING AND PLACEMENT IN THE MOST INTEGRATED SETTING

Within the limitations of court-imposed confinement, federal law requires that hospital administration actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with patients' needs. Olmstead v. L.C., 527 U.S. 581 (1999). From the time of admission, the factors that likely will foster viable discharge for a particular patient should be identified expressly, through professional assessments, and should drive treatment interventions. Furthermore, a psychiatric hospital should: (1) have a utilization review process that effectively monitors both length of stay data and difficult discharge cases; (2) develop systems to assure timely return to the community; and (3) ensure that readmission statistics are studied to identify and correct potential breakdowns in care and treatment that lead to unnecessary readmission to more restrictive levels of care. The discharge planning process for VSH patients falls well short of these standards of care. Consequently, patients are subjected to unnecessarily extended hospitalizations, poor transitions, and a high likelihood of readmission, all of which result in harm.

Discharge planning at VSH begins with an initial social work assessment. However, due in large part to insufficient staff, social work assessments are not available to the treatment team when it meets to develop a patient's treatment plan. Thus, critical information relevant to establishing adequate discharge criteria is unavailable for treatment planning purposes. Discharge criteria at VSH is routinely generic, unrealistic, and rarely adequately developed or integrated in treatment planning. For example, in order for one patient to be discharged, his criteria was written as "life should not be governed by false

beliefs." This is a meaningless and unrealistic criteria that if actually applied would prevent most psychotic individuals from ever returning to the community. In another example, a patient's discharge criteria was generically described as "elimination of psychotic symptoms." However, many individuals are successfully integrated into the community despite having some level of psychotic symptoms.

An essential part of discharge planning is releasing a patient into an appropriately therapeutic placement in the community based upon his status and history of care at the hospital. We were unable to ascertain whether VSH patients are being discharged into appropriate community settings. VSH discharge data makes no distinction between various types of available placement options. Thus, it is impossible to determine where patients are being specifically placed given their needs, or if therapeutically appropriate discharges are even occurring.

The utilization review process at VSH is inadequate and fails to collect, organize, and/or analyze data necessary to maintain an adequately functioning discharge planning system. A proper discharge planning system should rely upon its utilization review process to establish an estimate of a patient's expected length of stay at or soon after his or her admission. However, VSH's current practices and data collection methods render any utilization review incapable of establishing such an estimate. The utilization review process at VSH consists of a weekly meeting between psychiatrists and social workers, chaired by the Director of Hospital Operations. But instead of a utilization review, these meetings have become a forum for delivering status reports on hospital patients. Furthermore, even while limiting the scope of the meeting to current patient status reports, the teams fail to make any changes in patient status from the last meeting to the current meeting. Consequently, any changes in status are not being tracked. Without an understanding of the nature and extent of the change in a patient's status in the hospital, it is impossible to fashion any reliable estimate of a patient's length of stay much less review and adjust for adequate discharge criteria. As our consultant noted:

> True utilization review, which is not possible with VSH's current practice and current data collection methods, begins with an estimate at or soon after admission upon the predicted length of stay of each patient. Then progress towards that goal is regularly reviewed, obstacles identified and solutions developed to overcome them. Finally, trends are analyzed to determine if patients from certain diagnostic clusters or catchment areas, or with certain demographic variables or placement needs are meeting regular roadblocks to timely discharge or are being precipitously readmitted. Once identified, these trends can lead to carefully targeted performance improvement initiatives.

The limited statistics available to the administration at VSH reveals that 60% of its patients are discharged between 91 and 366 plus days. However, no effort has been made to analyze this statistic to determine whether the majority of persons in the above category are being released closer to 91 days, which indicates a better performing discharge system, or to 366 plus days, which indicates a dysfunctional discharge system. Analysis of the available data does indicate that almost 32% of VSH patients remain hospitalized for more than one year, which under national standards is high for an acute care hospital. Professional standards dictate that a 180 day LOS in a hospital such as VSH should trigger a review to determine the barrier to discharge, whether it be clinical, administrative, or legal.

In sum, VSH fails to initiate, maintain, monitor, or adjust adequate discharge criteria. It also fails to maintain an adequate utilization review process necessary to ensure appropriate lengths of stay. As a result, VSH's patients are likely being unnecessarily institutionalized and potentially deprived of a reasonable opportunity to live successfully in the most integrated, appropriate setting.

III. MINIMUM REMEDIAL MEASURES

To remedy the deficiencies discussed and to protect the constitutional and federal statutory rights of the patients at Vermont State Hospital, Vermont should promptly implement the minimum remedial measures set forth below:

A. Protection From Harm

1. Risk Management

VSH should provide its patients with a safe and humane environment and protect them from harm. At a minimum, VSH should:

a. Implement an incident management system that comports with generally accepted professional standards of care. At a minimum, VSH should:

1. review, revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents;

2. require all staff to complete successfully competency-based training in the revised reporting requirements;

3. review, revise, as appropriate, and implement policies and procedures related to the tracking and trending of

incident data and ensure that appropriate corrective actions are identified and implemented in response to problematic trends;

4. develop and implement thresholds for patient injury/event indicators that will initiate review at both the unit/treatment team level and at the appropriate supervisory level and that will be documented in the patient medical record with explanations given for changing/not changing the patient's current treatment regimen; and

5. develop and implement policies and procedures on the close monitoring of patients assessed to be at risk that clearly delineate: who is responsible for such assessments; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the patient's medical record.

b. Conduct a thorough review of all units to identify any potential environmental safety hazards, or conditions unsupportive of a therapeutic environment and develop and implement a plan to remedy any identified issues.

2. <u>Restraint and Seclusion</u>

VSH should ensure that seclusion and restraints are used in accordance with generally accepted professional standards of care. Absent exigent circumstances -- *i.e.*, when a patient poses an imminent risk of injury to himself or a third party -- any devise or procedure that restricts, limits or directs a person's freedom of movement (including, but not limited to, chemical restraints, mechanical restraints, physical/manual restraints, or time out procedures) should be used only after other less restrictive alternatives have been assessed and exhausted. More particularly, VSH should:

a. Ensure that restraints and seclusion:

1. are used in a reliably documented manner;

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 part of a behavioral intervention; and

4. will be terminated once the person is no longer an imminent danger to himself or others.

b. Revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards of care that cover the following areas:

1. the range of restrictive alternatives available to staff and a clear definition of each;

2. the simultaneous use of seclusion and restraint;

3. the training that all staff receives in the management of the patient crisis cycle and the use of restrictive procedures; and

4. the assessments to be conducted by staff attending a patient in seclusion and restraint.

c. Ensure that the use of seclusion and restraint only be initiated by appropriately trained staff.

d. Ensure appropriate assessments are completed by a physician or licensed medical professional of any resident placed in seclusion or restraints.

e. Ensure that if physical, non-mechanical restraint is initiated, the patient is assessed within an appropriate period of time of his/her being physically restrained and an appropriately trained staff member makes a determination of the need for continued physical, mechanical, and/or chemical restraint, and/or seclusion.

f. Ensure that a physician's order for seclusion or restraint include:

1. the specific behaviors requiring the procedure;

2. the maximum duration of the order; and

3. behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.

g. Ensure that the patient's attending physician be promptly consulted regarding the restrictive intervention.

h. Ensure that at least every thirty (30) minutes, patients in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention.

i. Eliminate the use of automatic seclusion, as part of any Behavioral Protocol.

j. Ensure that immediately following a patient being placed in seclusion or restraint, the patient's treatment team reviews the incident, and the attending physician documents the review and the reasons for or against any change in the patient's current pharmacological, behavioral, or psychosocial treatment.

k. Ensure that staff successfully complete competency-based training regarding implementation of such policies and the use of less restrictive interventions.

B. Psychiatric and Psychological Care and Treatment

1. <u>Treatment Planning Process</u>

VSH should develop and implement an integrated treatment planning process consistent with generally accepted professional standards of care. More particularly, VSH should:

A. Develop and implement policies and procedures regarding the development of treatment plans consistent with generally accepted professional standards of care.

B. Review and revise, as appropriate, each patient's treatment plan to ensure that it is current, individualized, strengths-based, outcome-driven, emanates from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments.

C. Ensure that treating psychiatrists verify, in

a documented manner, that psychiatric and behavioral treatments are properly integrated.

D. Require all clinical staff to complete successfully competency-based training on the development and implementation of interdisciplinary treatment plans, including skills needed in the development of clinical formulations, needs, goals and interventions as well as discharge criteria.

E. Ensure that the medical director timely reviews high-risk situations such as individuals requiring repeated use of seclusion and restraints.

F. Develop and implement programs for individuals suffering from both substance abuse and mental illness problems; develop and implement a cognitive remediation program for individuals with cognitive impairments; and develop and implement specialized groups for individuals with forensic status.

2. Assessments and Services

a. Psychiatric Assessments and Diagnoses

VSH should ensure that its patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards of care, and that these assessments and diagnoses drive treatment interventions. More particularly, VSH should:

1. Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments. Ensure that initial assessments include a plan of care that outlines specific strategies, with rationales, including adjustments of medication regimens and initiation of specific treatment interventions.

2. Ensure that psychiatric reassessments are completed within time-frames that reflect the individual's needs, including prompt evaluations of all individuals requiring restrictive interventions.

3. Develop diagnostic practices, guided by current, generally accepted professional criteria, for reliably reaching the most accurate psychiatric diagnoses.

4. Develop a clinical formulation of each patient that integrates relevant elements of the patient's history, mental status examination, and response to current and past medications and other interventions, and that is used to prepare the patient's treatment plan.

5. Ensure that the information gathered in the assessments and reassessments is used to justify and update diagnoses, establish and perform further assessments for a differential diagnosis, and finalize all diagnoses listed as "NOS" (not otherwise specified)" or "R/O" (rule-out).

6. Review and revise, as appropriate, psychiatric assessments of all patients, providing clinically justifiable current diagnoses for each patient, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.

7. Develop an admission risk assessment procedure, with special precautions noted where relevant, that includes information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopement, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital level of care is needed; and any mitigating factors and their relation to current risk.

8. Develop a monitoring instrument to ensure a systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes and transfer and discharge summaries, and require the physician peer review system to address the process and content of assessments and reassessments, identify individual and group trends and provide corrective follow-up action.

b. <u>Psychological Assessments</u>

VSH should ensure that its patients receive accurate,

complete, and timely psychological assessments, consistent with generally accepted professional standards of care, and that these assessments support adequate behavior and treatment programs. To this end, VSH should ensure that:

1. Prior to developing the treatment plan, psychologists provide a psychological assessment of the patient that will identify:

    a. appropriate patient information;

    b. precipitating factors and reason for admission;

    c. background information (including developmental, psychosocial, educational, substance abuse and mental health history);

    d. history of psychological testing, including cognitive and personality variables (including dates, locations, examiners, scores/results, and qualifying statements as available);

    e. history of any brain injury (including nature of injuries, dates, course of treatment and recovery, and impact on current functioning);

    f. legal and forensic history;

    g. mental status examination; and observation of behavior (including results of any formal testing conducted for purposes of current evaluation).

    h. assessment of risk for harm factors;

    i. strengths, interests, motivation and ability to change;

    j. cognitive and personality factors affecting treatment need and treatment response; and

    k. a summary that contains conclusions which specifically address the purpose of the assessment with the empirical basis for the conclusions; any remaining unanswered questions; and recommendations for psychological intervention.

2. where applicable, if behavioral intervention

is indicated, further assessments be conducted in a manner consistent with generally accepted professional standards of applied behavioral analysis.

c. <u>Psychiatric Services</u>

VSH should provide adequate psychiatric supports and services for the treatment of it patients, including medication management and monitoring of medication side-effects in accordance with generally accepted professional standards of care. More particularly, VSH should:

1. Develop and implement policies and procedures requiring clinicians to document their analyses of the benefits and risks of chosen treatment interventions.

2. Ensure that the treatment plans at VSH include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, and possible side effects. Reassess the diagnosis in those cases that fail to respond to repeat drug trials.

3. Ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, VSH should:

    a. Ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;

    b. Ensure regular exchange of data between the psychiatrist and the psychologist and use such exchange to distinguish psychiatric symptoms that require drug treatments from behaviors that require behavioral therapies; and

    c. Integrate psychiatric and behavioral treatments in those cases where behaviors and psychiatric symptoms overlap.

4. Ensure that all psychotropic medications

are:

a. prescribed in therapeutic amounts;

b. tailored to each patient's individual symptoms;

c. monitored for efficacy against clearly-identified target variables and time frames;

d. modified based on clinical rationales; and

e. properly documented.

5. Ensure that the psychiatric progress note documentation includes:

a. the rationale for the choice and continued use of drug treatments;

b. individuals' histories and previous responses to treatments;

c. careful review and critical assessment of the use of PRN medications and the use of this information in timely and appropriate adjustment of regular drug treatment;

d. justification of polypharmacy in accordance with generally accepted professional standards; and

e. attention to the special risks associated with the use of benzodiazepines, anticholinergic agents and conventional and atypical antipsychotic medications with particular attention given to the long-term use of these medications in individuals at risk for substance abuse, cognitive impairments, or movement and metabolic disorders.

6. Institute an appropriate system for the monitoring of individuals at risk for TD that includes a standardized rating instrument used by properly trained staff in a timely manner. Ensure that the psychiatrists integrate the results of these ratings in their assessments of

the risks and benefits of drug treatments.

7. Institute systematic monitoring mechanisms regarding medication use throughout the facility. In this regard, VSH should:

   a. Develop, implement and continually update a complete set of medication guidelines that address the indications, contraindications, screening procedures, dose requirements and expected individual outcomes for all psychiatric medications in the formulary that reflects generally accepted professional standards;

   b. Based upon adequate medication guidelines, develop and implement a Drug Utilization Evaluation procedure based on adequate data analysis that includes both random and systematic reviews, prioritizes high risk medications, and produces individual and group practitioner trends;

   c. Develop and implement a procedure for the identification, reporting and monitoring of adverse drug reactions (ADRs) that includes the definition of an ADR, likely causes, a probability scale, a severity scale, interventions and outcomes and that establishes thresholds to identify serious reactions;

   d. Develop and implement an effective Medication Variance Reporting system that captures both potential and actual variances in the prescription, transcription, procurement/ordering, dispensing/storage, administration and documentation of medications, and identifies critical breakdown points and contributing factors; and

   e. Develop and implement a procedure governing the use of PRN medications that includes

requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses.

8. Establish monitors to ensure the appropriate use of high-risk medications, including:

   a. long-term benzodiazepine and anticholinergic medications particularly for individuals with substance use problems, cognitive impairments and current or past history of TD, as indicated; and

   b. the use of conventional antipsychotics, particularly for individuals with current or past history of TD.

9. Establish a system for the pharmacist to communicate drug alerts to the medical staff in a timely manner.

d. <u>Psychological Services</u>

VSH should provide psychological supports and services adequate to treat the functional and behavioral needs of its patients according to generally accepted professional standards of care, including adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, VSH should:

1. Ensure that psychologists provide unit-based services that include initial assessment, treatment rounds, treatment planning, behavioral plans, and individual therapy for patients on their units/treatment teams.

2. Ensure psychologists adequately screen patients for appropriateness of individualized behavior plans, particularly patients who are subjected to frequent restrictive measures, patients with a history of aggression

and self-harm, treatment refractory patients, and patients on multiple medications.

3. Ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, a documentation of how reinforcers for the patient were chosen and what input the patient had in their development, and the system for earning reinforcement.

4. Ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not the use of aversive contingencies.

5. Develop and implement policies to ensure that patients who require treatment for substance abuse, cognitive impairment, and forensic status are appropriately identified, assessed, treated, and monitored in accordance with generally accepted professional standards.

6. Ensure that psychologists treating patients have a demonstrated competence, consistent with generally accepted professional standards, in the use of functional assessments and positive behavioral supports.

7. Ensure that psychologists integrate their therapies with other treatment modalities, including drug therapy.

8. Ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately against rational, operationally defined, target variables and revised as appropriate in light of significant developments and the patient's progress, or the lack thereof.

9. Ensure sufficient psychological staff to provide psychological services in accordance with accepted professional standards.

C. <u>Discharge Planning and Placement in the Most</u>

Integrated Setting

Within the limitations of court-imposed confinement and public safety, the State should pursue actively the appropriate discharge of patients and ensure that they are provided services in the most integrated, appropriate setting that is consistent with patients' needs. More particularly, VSH should:

1. Identify at admission and address in treatment planning the criteria that likely will foster viable discharge for a particular patient, including but not limited to:

    a. the individual patient's symptoms of mental illness or psychiatric distress; and

    b. any other barriers preventing that specific patient in transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements.

2. Include in treatment interventions the development of skills necessary to live in the setting in which the patient will be placed, and otherwise prepare the patient for his or her new living environment.

3. Provide the patient adequate assistance in transitioning to the new setting.

4. Ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are implemented and that appropriate aftercare services are provided that meet the needs of the patient in the community.

5. Develop and implement a quality assurance or utilization review process to oversee the discharge process and aftercare services, including:

    a. developing a genuine utilization review process based on the principles articulated in Part C that discusses discharge planning and placement in the most integrated setting, and assure that data systems supportive of this process are developed and maintained;

    b. having psychiatrists provide an estimate of the length of hospitalization needed to provide patient stabilization at the time that the master treatment plan is developed and review this estimate at each treatment plan update meeting, making modifications when necessary that are documented in the

patient's record and captured in the utilization review process; and

c. developing a system of follow-up with community placements to determine if discharged patients are receiving the care that was prescribed for them at discharge.

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The collaborative approach that the parties have taken thus far has been productive. We hope to continue working with the State in this fashion to resolve our significant concerns regarding the care and services provided at this facility.

Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. Although their reports are their work – and 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 hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing areas requiring attention.

We are obliged by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to 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. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will be contacting your 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/ Bradley J. Schlozman

Bradley J. Schlozman
Acting Assistant Attorney General

cc: William H. Sorrell
Attorney General
State of Vermont

Paul R. Blake
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