DISABILITY RIGHTS CONNECTICUT

INVESTIGATIVE REPORT

Whiting Forensic Hospital and Connecticut Valley Hospital

EXECUTIVE SUMMARY

November 2019

DISABILITY RIGHTS CONNECTICUT
Justice. Community. Inclusion.

Disability Rights Connecticut (DRCT)

Securing & Protecting the Rights of Connecticut Citizens with Disabilities

Disability Rights Connecticut (DRCT) is the designated Protection and Advocacy System for individuals with disabilities in Connecticut.

Operating pursuant to federal law, DRCT is authorized to investigate allegations of suspected abuse and neglect of persons with disabilities; to monitor conditions in facilities and community programs and to pursue legal, administrative and other remedies to protect the civil rights of people with disabilities. Specific authority to conduct investigations of suspected abuse and neglect can be found in the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act 42 U.S.C. § 10801 et seq. and the Developmental Disabilities Assistance and Bill of Rights (DD) Act, 42 U.S.C. § 15001 et seq.

Other mandated activities include providing information and referral services; educating policymakers and members of the public about disability rights issues; and advocating for clients and applicants of vocational rehabilitation and certain Social Security programs.

Part of a nation-wide network of similar non-profit entities that have been designated in each state and territory, DRCT is the successor to the Connecticut Office of Protection and Advocacy for Persons with Disabilities (OPA), which was abolished by legislation that took effect June 30, 2017.

Disability Rights Connecticut
846 Wethersfield Avenue, Hartford, CT 06114
www.disrightsct.org
(800) 842-7303 (toll-free in CT) (860) 297-4300 (voice) (860) 509-4992 (videophone)

OVERVIEW

Upon completion of a lengthy investigation, Disability Rights Connecticut substantiated abuse, neglect and violations of patients' rights against Whiting Forensic Hospital (WFH) and Connecticut Valley Hospital (CVH).

When revelations of egregious conditions first surfaced in media reports in the Spring of 2017, state entities responded, addressing some of the initial concerns. However, DRCT's findings, based upon a broader examination, illustrate many concerns still exist.

This report includes a call to action to the Connecticut General Assembly to place CVH under the licensure of the Department of Public Health and to the Commissioner of the Department of Mental Health and Addiction Services (DMHAS) to enact immediate reforms in the areas of concern identified in this report.

BACKGROUND

Prompted by news reports of serious, prolonged mistreatment of a patient at the Whiting Forensic Division of Connecticut Valley Hospital (CVH), in November 2017, Disability Rights Connecticut (DRCT) opened an investigation into practices at the facility that may have contributed to that abuse.

Initially, the investigation focused on the experience of two patients:

1. William Shehadi, whose victimization had been recorded through a video surveillance system. When it was ultimately reported by a whistleblower, and the recordings were reviewed, disciplinary action was initiated against more than 25 staff members, and criminal charges were filed against 10 of them.

2. Andrew Vermiglio, who resided on the same unit as Mr. Shehadi, and who died in December, 2016, allegedly after choking on cookies he had been given as a snack. (Mr. Vermiglio's death occurred approximately six months before the abusive treatment of Mr. Shehadi came to light.)

As their inquiry proceeded, DRCT investigators also became aware of rights-related issues affecting other residents of the Whiting Division of CVH, some of whom had been transferred from the General Psychiatry Division where it appeared that their rights to be free from neglect and to receive safe and effective treatment were also in jeopardy. Accordingly, the scope of the investigation expanded to include those issues.

DRCT's investigation coincided with a period of considerable change at the Whiting Division of CVH. The revelations about abuse resulted not only in arrests, resignations and firings, but also an administrative shakeup and far-reaching legislative action.

After holding public hearings, the General Assembly enacted legislation formally separating the Whiting Services Division from CVH, requiring it to become a licensed, stand-alone psychiatric hospital now known as the Whiting Forensic Hospital (WFH). The entire senior leadership team was replaced, policies were revised, new positions added, and a "Whiting 2020 Moving Forward" campaign initiated.

The same legislation that established WFH as a separate hospital also established a task force to study and make recommendations about further changes that may be warranted at both CVH and WFH.

"The revelations about abuse resulted not only in arrests, resignations and firings, but also an administrative shakeup and far-reaching legislative action."

INVESTIGATIVE PROCESS

DRCT's investigators made frequent, unannounced facility visits; conducted patient interviews and a patient survey; held discussions with family members and patients' legal representatives; met with administrative staff; and reviewed patient treatment records, surveillance video recordings, facility policies and multiple reports from federally-sponsored inspections and surveys. In addition, they obtained reports from police, first responders and the Medical Examiner regarding the death of Andrew Vermiglio.

To more fully understand the impact of practices at WFH and CVH, detailed profiles were reviewed of Mr. Vermiglio, and two other individual patients, one of whom, has been transferred between CVH's General Psychiatry Division and Whiting several times, and the other is housed in the WFH maximum security building, having been committed to the jurisdiction of the Psychiatric Security Review Board (PSRB).

These detailed reviews of individual patients' experiences identified significant violations of their civil rights and major deficiencies in the quality of care provided to them.

Reviews of other patients' records and of the findings from federally sponsored surveys and complaint investigations conducted by the Department of Public Health confirmed that these were not isolated problems, but rather exemplified widespread systemic deficiencies.

"...these were not isolated problems, but rather exemplified widespread systemic deficiencies."

FINDINGS

While DRCT found that improvements have been made and continue to be made by the new leadership team at WFH, much more needs to be done, both at WFH, and at its older, parent hospital, CVH. The greatest challenges involve bringing change to the organizational culture.

SIGNIFICANT PROBLEMS PERSIST

1. Use of Restraint for Discipline in Lieu of Treatment or for the Convenience of Staff

Patient interviews led DRCT investigators to review a video surveillance recording of an August, 2019, incident where a WFH patient was placed into four-point restraints. The patient had been involved in an altercation with another patient, but, had become calm and cooperative by the time he was led to the restraint room. He lay down on the restraint bed cooperatively, allowed the restraint cuffs to be applied without protest, and remained calm for the entire 33-minute duration of the restraint.

This use of restraint was a clear violation of State law, federal regulations and DMHAS policy, all of which strictly prohibit the use of restraint or seclusion except "as an emergency intervention to prevent immediate or imminent injury to the person at risk or to others, provided the restraint [or seclusion] is not used for discipline or convenience and is not used as a substitute for a less restrictive alternative…" Distressingly, the DRCT investigators viewed the recording of this incident in the company of WFH managers and clinicians, who indicated they saw nothing wrong with the way the episode had been handled.

2. Inadequate Individual Assessment and Treatment Programming

While very different life paths may bring people to WFH, one thing many share is a history of ineffective prior interventions - a history which is often rooted in inadequate assessment of their identities and needs by treatment and educational professionals. It follows, therefore, that the first order of business for a newly admitted patient should be development of a thorough, comprehensive assessment – one which seeks to understand the biological, psychological and social factors that have influenced the person's development, and which must be considered if treatment efforts are to succeed in supporting recovery.

However, the treatment records reviewed by DRCT and its expert consultant, Dr. Rafael Gallegos, often reflected deficiencies in both assessment practices and individual treatment planning. Dr. Gallegos reviewed the treatment plan of a young patient with autism committed to the PSRB and concluded:

"The records suggest that habilitative interventions are offered through individual and group psychotherapy and activities, yet there is no clearly articulated rationale for why this patient is assigned and must attend a certain number of specific groups or how his individual psychotherapy and psychopharmacological treatment intersects with his overall treatment plan. Overall, there is significant inconsistency and lack of clarity in this patient's treatment plan/goals across the ITP [Integrated Treatment Plan], the behavioral guidelines developed for this patient, and the essential components of the unit level system…"

Unfortunately, the experience of this patient is not atypical.

3. Denial of Patient Rights by DMHAS Police

During the course of investigating Andrew Vermiglio's death, DRCT encountered disturbing evidence that the DMHAS Police had, without apparent justification or subsequent challenge by Whiting officials, acted to deny Mr. Vermiglio his right to receive visitors. On one occasion, he was denied an opportunity to visit (under close 2:1 observation) with his mother, who had come to see him.

Further, on the day before he died, Mr. Vermiglio was also denied a visit with an attorney. In addition to constituting stark violations of patients' rights (Connecticut General Statutes §17a-547 specifically guarantees patients' the right to receive visitors, including family members and attorneys), these incidents reflect the degree to which decision-making authority at Whiting is fragmented in administratively isolated domains.

"…the first order of business for a newly admitted patient should be development of a thorough, comprehensive assessment – one which seeks to understand the biological, psychological and social factors that have influenced the person's development, and which must be considered if treatment efforts are to succeed in supporting recovery."

4. Dependence on Frequent, Regular Use of PRN, STAT and IM Psychotropic Medications

At both CVH and WFH, the application of mechanical restraints to a patient is frequently accompanied by intramuscular (IM) injections of powerful, sedating psychotropic medications that are administered "STAT" (urgently).

Treatment records reviewed by DRCT investigators revealed that PRN (as needed) psychotropic medications were being used with such frequency that they could be considered as part of the patient's routine regime of medication. For instance, the records of one of the individuals profiled in the full report indicate that in the 61-day period between December 1, 2017 and January 30, 2018, she received PRN psychotropic medications on 70 separate occasions.

Part of the problem lies with the fact that medical orders for the PRN medications at both CVH and WFH allow those medications to be used to respond to signs of anxiety and/or agitation – general terms that are subject to varying interpretations by unit staff and which do not require much detail about, or analysis of the particular circumstances that may have given rise to whatever problem the medications are intended to address (e.g. the "antecedents" that preceded particular behavior.).

However, the real problem stems from a culture, prevalent in both institutions, that views programmatic interventions and supports as being separate from, and of secondary importance to, pharmacological, molecular-level interventions.

Between the frequency with which PRN, STAT and IM psychotropic medications are being used, and the disconnect between individual behavioral support programming versus these medication practices, DRCT has determined that patients' rights were violated when WFH and CVH failed to comply with the requirements of Section 46a-152(c) of the Connecticut General Statutes, which states: *The use of psychopharmacologic agents, alone or in combination, may be used only in doses that are therapeutically appropriate and not as a substitute for other appropriate treatment.*

5. Use of the "Level System" as a Mechanism of Control and Default Treatment Plan

The "level system" assigns different "levels" of restrictions and privileges to individual patients, theoretically based on conformance to behavioral expectations. However, in actual operation, changes are often made, or threatened to be made in an individual's "level" based on arbitrary judgments. Intrinsically punitive, the system is especially counter-productive for individuals with cognitive disabilities and those with neuropsychiatric conditions that make conformance to the institutional expectations nearly impossible. Less obviously, but no less importantly, the level system at Whiting purports to be therapeutic, occupying space on the treatment continuum that should be filled by individually-designed, trauma-informed behavioral programming.

6. Inadequate Abuse and Neglect Reporting and Investigation Protocols

Policies and detailed procedures are in place at WFH to respond to various types of incidents and to allegations of abuse, neglect and exploitation (ANE). However, the ANE investigation process focuses on determining whether there has been a "work rule violation" by staff members, seldom examining the issues that may have contributed to underlying, problematic conditions, including possible facility neglect. For example, if there is a patient-to-patient altercation an ANE investigation is not triggered unless there is an allegation that a staff member violated a work rule which then resulted in the altercation.

7. Inadequate Death Investigations

The procedure for investigating unanticipated patient deaths is also problematic. During the course of investigating the death of Andrew Vermiglio, the DMHAS Public Safety Division (DMHAS Police) found "no evidence to support that a criminal act was committed." However, when DRCT investigators reviewed the video surveillance taken from a camera mounted in the hallway where the two "close observation" staff had stationed themselves, it was clear that their account of the events leading up to the restraint misstated important facts. Neither the DMHAS Police report nor their investigator's notes indicate that the two staff members were questioned about the discrepancy between the video evidence and their statements.

8. Incoherent Mix of Patient Identities and Needs

A number of the individuals currently housed in the maximum security building at WFH have no current involvement with the criminal justice system. They are inter-mixed amongst the various units, principally within the PSRB units. And, as is also true of those under PSRB commitment orders and those for whom competency to stand trial is an issue, these "civilians" present a variety of disability profiles, some having been identified as intellectually or cognitively disabled, autistic or manifesting organically-based behavioral challenges which neither the CVH general psychiatric units nor WFH are well prepared to meet. Instead, all the patients at the maximum security building are subject to the same level system, use of restraints and psychotropic medication regimes despite being there for widely differing reasons.

"...the real problem stems from a culture, prevalent in both institutions, that views programmatic interventions and supports as being separate from, and of secondary importance to, pharmacological, molecular-level interventions."

9. Lack of Interdisciplinary Team Processes

The treatment teams at WFH tend to be dominated by the discipline of psychiatry, with other clinical disciplines assuming lesser roles, and the Forensic Treatment Specialists, who interact most directly with patients, playing little or no role. The result is a stratified, hierarchical model of treatment delivery – one that leaves those with "hands on" roles more likely to trust informal leaders within their own ranks than senior clinicians. The absence of genuine, fully functioning interdisciplinary treatment teams is felt most acutely in supporting patients who present significant behavioral challenges, as those individuals most need to be surrounded by competent, collaborating team members.

10. Levels of Staff Engagement with Patients

Over the course of multiple visits, DRCT investigators noted a tendency for Forensic Treatment Specialists (FTS) and other unit staff to congregate in "the bubble" – the central, windowed office area located in each of Whiting's six living units which serves as a nurses' station, supervisory office and unofficial staff sanctuary. WFH administrators started to address this phenomenon after it was brought to their attention by DPH inspectors. The underlying issue, however, involves the level and type of engagement unit staff have with patients. Continued efforts are needed to support and supervise Forensic Treatment Specialists in constructively engaging with patients in meaningful activities.

11. Persistent Problems Remain at CVH, Similar to Those at WFH

With stunning revelations about abuse at the Whiting Division and subsequent separation of Whiting Forensic Hospital from CVH, attention has understandably focused on efforts to address problems at Whiting. However, this focus has had the unfortunate effect of leaving persistent problems at CVH in the shadows.

The long history of investigations at CVH, replete with multiple deficiency findings including notably patient rights and immediate jeopardy, all responded to with promissory plans of correction, is but one indicator of the persistence of those problems. Another can be found in the records of individual patients whose recovery is limited by unacceptable delays in obtaining necessary evaluations and appropriate, individual support programs; by potentially dangerous lapses in communication; and by assumptions about chronicity that translate into low expectations.

"...attention has understandably focused on efforts to address problems at Whiting. However, this focus has had the unfortunate effect of leaving persistent problems at CVH in the shadows."

RECOMMENDATIONS

1. **Remove CVH's statutory exemption from psychiatric hospital licensing requirements.** The need for Department of Public Health (DPH) licensing at this time is clear and unavoidable as it was for WFH through P.A. No. 18-86. For at least twelve years CVH has been found deficient in areas such as: i) the provision of mental health treatment; ii) safeguarding patients' rights; and, iii) maintaining the health and safety of its patients. Patients are better protected in facilities that are licensed by DPH because, as the licensing authority, DPH can respond quickly to complaints and reported problems. Lives are at stake. CVH should be held to the same standards of accountability as other psychiatric hospitals in Connecticut.

2. **Establish genuine interdisciplinary treatment teams that include direct care staff as well as clinicians, involve patients in development of treatment plans, and conduct frequent progress reviews.** Client treatment records that were reviewed by DRCT's investigators and expert consultant reflect a hierarchical treatment planning process, with psychiatry as the dominant discipline. However, if treatment teams included direct care staff and, in appropriate ways, patients themselves, there would be opportunities for feedback and communication about how a plan is working, what needs adjustment, how everyone is doing, and whether people are clear about what they are supposed to be doing. Implementing a team approach at Whiting would help counter fragmentation between organizational layers and disciplines, and facilitate patient engagement goals.

3. **Begin with an accurate understanding of each individual's identity and needs.** When a limited number of patients' treatment records from CVH and WFH were reviewed by DRCT's clinical consultant, he found that important details about patients' personal histories, prior treatment experiences, and the individual contours of developmental and/or neurologically-based conditions were decidedly lacking. In the absence of carefully researched, detailed, individual-specific information, treatment planning tends to follow generic pathways, often achieving little success in terms of measurable outcomes. Thus, after completion of a thorough assessment the next step should be formulation of a comprehensive, individually-relevant treatment plan – one that is informed by both the best that behavioral science has to offer, and by the insights about individual identity and needs that have been revealed by a rigorous, comprehensive assessment.

4. **Eliminate the "level system" as currently designed and implemented at WFH.** Whiting's reliance on the "level system" currently in place is deeply problematic. Individual decisions concerning patients' levels are often arbitrary and inconsistent. The level system is intrinsically punitive, and, especially for individuals with intellectual or neurodevelopmental disabilities who cannot adhere to its expectations, it produces counter-therapeutic results. Even when implemented as designed, the level system is primarily used as a mechanism of institutional control. To ensure staff and client safety, maintaining an orderly environment is important, but doing so need not be at the expense of patient treatment.

5. **Develop relevant, discrete programs and services for people with specific needs, particularly those with intellectual and developmental disabilities.** People with ID/DD who are involved in the criminal justice system are sometimes sent to WFH, where, whether they are being evaluated for competency to stand trial, or are committed to the PSRB, they become tangled up in expectations they cannot meet. Moreover, these individuals do not have access to the types of behavioral supports and learning opportunities they need within the hierarchical therapeutic milieu and the level system.

6. **Train DMHAS police concerning patients' civil rights.** According to state law, visits from family members can only be suspended if the head of the hospital determines such visits are "medically harmful". In Mr. Vermiglio's case no such determination was made yet, the DMHAS Police denied a visit from his mother, as well as a subsequent visit from a lawyer. The DMHAS police force should be instructed and its officers trained on this and all other sections of state and federal law pertaining to patients' rights.

7. **Secure independent investigations into all unanticipated deaths.** The investigation conducted by the DMHAS Police into Andrew Vermiglio's death left important questions unasked and, therefore, unanswered. Death investigations should be conducted by an independent system (including law enforcement agencies) capable of investigating allegations or reports of abuse, neglect, patient injury, and deaths, with skilled and competent staff who are not accountable to the facility's administration.

8. **Evaluate the effectiveness of the implementation of Section 2, P.A. No. 18 – 86 concerning the DMHAS Abuse, Neglect and Exploitation (ANE) reporting and investigation system as it pertains to WFH and CVH.** All phases of investigations should be conducted by an "outside" entity – one that is not housed on hospital grounds and that operates independently of the administrative structure of the hospital. The WFH Procedures Manual should also be amended to allow incidents of patient-to-patient violence or exploitation to be investigated by that same independent entity. Patient-to-patient events may be a result of neglect by facility staff, and/or may reflect systemic issues.

9. **Comprehensively evaluate the use of physical and chemical restraints, PRN psychotropic medication, and the occurrence of patient injuries in Integrated Treatment Plan reviews.** When staff must resort to unplanned interventions frequently, or when injuries occur, that should serve as an indicator that it is time to review and adjust an individual's treatment plan accordingly. These events should be considered in regular treatment plan reviews. It is particularly important to determine whether and what type of de-escalation strategies were pursued prior to development of an acute situation, and to ensure that post-event debriefings are faithfully executed and yield useful information.

10. **Provide specific, individualized instructions regarding the nature of the behaviors or symptoms that warrant administration of PRN psychotropic medications.** Simply stating that a particular drug or combination of drugs may be administered for “agitation” or “aggression” provides staff with too little information concerning the indicators that would justify administration of PRN medications.

11. **Decrease over-reliance on PRN, STAT and IM psychotropic medications.** The frequency with which PRN and STAT psychotropic medications are administered is indicative of the hospital’s culture. By consciously decreasing reliance on PRN and STAT psychotropic medications, and conscientiously teaching and encouraging adoption of other approaches for dealing with stressors, thoughts and feelings, WFH and CVH will be taking an important step toward realizing their recovery missions.

12. **Consistently implement quality improvement practices and measures at WFH and CVH.** Achieving enduring change in the culture of an institution is an iterative process – one which takes time and requires openness to self-examination, organizational learning, adoption of valid measures and consistent leadership. Measures chosen should focus on patient outcomes including; reductions in the use of restraints, reductions in PRN psychotropic medication use, and other measurable outcomes and safeguards.

CALL TO ACTION

Many outside eyes have scrutinized Whiting Forensic Institute and Connecticut Valley Hospital over the past twelve years, most especially since March 2017 when the story of William Shehadi broke on the front pages of Connecticut's media outlets.

As a result of those inquiries settlement agreements and corrective action plans have been written and re-written and a Legislative Task Force was commissioned and charged with issuing a report by January 1, 2021.

In the meantime, abuse, neglect and patients' rights violations continue to be substantiated time and again by DPH and now DRCT. People's lives are in jeopardy.

Accordingly, immediate action is required, not a year from now after more reports are issued, but now.

Based on the current findings of this report and recent DPH surveys, the Connecticut General Assembly must act in the 2020 legislative session to place CVH under the licensure of DPH. Second, the Commissioner of DMHAS must enact immediate reforms in the areas identified above.

"People's lives are in jeopardy.
Accordingly, immediate action is required,
not a year from now after more reports are issued, but now."