U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

NOV - 9 2010

The Honorable Jack Markell
Governor of Delaware
Tatnall Building
Dover, DE 19901

RE: Investigation of the Delaware Psychiatric Center

Dear Governor Markell:

We write to report the findings of the Civil Rights Division's investigation of conditions and practices in the Delaware Psychiatric Center ("DPC") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and the State of Delaware's ("State") compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, as interpreted in Olmstead v. L.C., 527 U.S. 581 (1999), with respect to the services the State provides to persons with mental illness at DPC and other settings across the State.

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 (including those under the ADA) of individuals with mental illness or developmental disabilities who are in public institutions. The Department also has authority to seek a remedy for violations of Title II of the ADA. 42 U.S.C § 12133.

We notified then-Governor Ruth Ann Minner in November 2007 that we were initiating an investigation of conditions and practices at DPC pursuant to CRIPA. We conducted an on site inspection of DPC on April 28-May 2, 2008, with the assistance of expert consultants in the fields of psychiatry, psychology, psychiatric nursing, and fire safety. On July 29, 2010, we notified Delaware's Deputy Attorney General that we were also focusing our investigation on community integration issues in the State. On August 4-6, 2010, we toured DPC and the community to examine whether the State is serving individuals confined to DPC and statewide in the most integrated setting appropriate to their needs.

While on site, we interviewed persons in statewide leadership positions, hospital administrative staff, community providers of mental health services, and individuals confined to DPC, and examined the physical plant conditions throughout the facility. We also reviewed a wide variety of documents, including policies and procedures, incident reports, and medical and mental health records. Our most recent tour included interviews with leadership from DPC and

the Delaware Department of Health and Social Services ("DDHSS") and a review of hospital clinical records and administrative documents, as well as substantial interviews with providers who are responsible for community-based mental health services to individuals discharged from DPC or at risk of admission. In addition, we had an opportunity to interview consumers who are currently served by the community system. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tours with an extensive debriefing at which our consultants conveyed their initial impressions and concerns about the DPC to counsel, administrators, staff, and State officials.

Before discussing our findings, we wish to express our appreciation for the hospitality, cooperation, and professionalism of the statewide leadership and hospital staff and administrators throughout our investigation. We hope to continue to work with Delaware officials and the staff at DPC in the same cooperative manner going forward.

In accordance with our statutory requirements under CRIPA, we now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimum steps necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). This letter also serves to provide you notice of your failure to comply with the ADA and of the steps you should take to voluntarily comply with the law. 42 U.S.C. § 2000d-1 (incorporated by 42 U.S.C. § 12133).

Specifically, we have concluded that the State's current mental health system fails to provide services to individuals with mental illness in the most integrated setting appropriate to their needs, as required by the ADA. This has resulted in needless prolonged institutionalization of many individuals with disabilities in DPC who could be served in the community. It also has placed individuals currently in the community at risk of unnecessary institutionalization. Moreover, individuals confined to DPC not only are harmed by unnecessary and prolonged institutionalization itself, but they also suffer significant harm and risk of harm, in violation of the U.S. Constitution, due to numerous other deficient practices while at DPC, including: inadequate risk assessments; inadequate mental health treatment, especially the failure to provide appropriate behavioral interventions for individuals with identified risks; inadequate restraint and seclusion practices; inadequate investigations of serious incidents; and inadequate discharge planning/community integration to ensure individuals live in the most integrated setting. These deficiencies have contributed to the untimely deaths of individuals confined to DPC as well as led to other preventable illnesses, injuries, and harm from a variety of sources.

Delaware has been on notice of many of the findings we make in this letter. In November 2007 – shortly after we notified Delaware of our CRIPA investigation – the Delaware Department of Justice ("DDOJ") initiated its own investigation to determine whether DPC had violated individuals' statutory rights guaranteed by Delaware law. On March 7, 2008, the DDOJ issued its own findings citing significant deficiencies and concluded that numerous conditions, practices, acts, and failures to act by DPC administrators and staff resulted in systemic and pervasive violations of the state statutory civil rights of individuals confined to DPC, including: failure to develop appropriate treatment plans; failure to prepare adequate discharge plans; failure to ensure safety; physical and emotional abuse of individuals by staff; mistreatment of individuals

by staff through inappropriate use of medications, isolation, and physical and chemical restraints; neglect of individuals by staff; failure to protect individuals from assaults by other patients; and failure to protect individuals from self-inflicted abuse due to inadequate supervision and monitoring. In May 2008, the DPC entered into a memorandum of agreement with DDOJ to address these findings. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") has made similar findings.

Current Delaware leadership acknowledge and recognize that an effective remedy for unconstitutional conditions at DPC is inseparable from an effective effort to place in community settings all the individuals who are inappropriately institutionalized. Leadership from both DPC and the DDHSS acknowledge that Olmstead requires the delivery of public services in the least restrictive, most integrated settings appropriate to individuals served by the State's mental health system and the freedom of these individuals from unwarranted institutional isolation. They recognize that any remedy that focuses merely on the conditions at DPC will direct resources away from building the necessary community capacity and toward a focus on DPC – an inequity that will only perpetuate the inappropriate and harmful institutionalization of Delaware citizens with mental disabilities.

We are, accordingly, encouraged by our meetings with current Delaware leadership, both at DPC and DDHSS, who acknowledged the problems and indicated a strong desire and interest in working with the United States Department of Justice ("USDOJ") both in relation to our overall investigation and in working toward an amicable resolution.

We recognize that the current leadership of the DDHSS has been actively addressing many of the deficiencies at DPC since our initial 2008 tour. Though still problematic, these efforts have resulted in improvements in treatment planning, in reducing the dependence on inappropriate interventions such as seclusion and restraint, and in creating a shift toward developing person-centered recovery plans that reflect individuals' personal goals. We are therefore encouraged that the DDHSS leadership both recognizes the continuing deficiencies at DPC and have a workable, and realistic vision, of the undertakings necessary to ensure than individuals are served in the most integrated setting while addressing the issues at DPC required to be keep individuals there safe.

I. BACKGROUND

Located in New Castle, Delaware, the DPC is the only public psychiatric hospital in Delaware for adults. The DPC is operated by the Delaware Division of Substance Abuse and Mental Health, and has a current capacity of 170 civil and 42 forensic beds. The hospital is divided into several separate units, based upon gender, diagnosis, age, and, in one unit,

involvement in the Delaware criminal justice system.[1] At the time of our most recent tour, DPC's civil census was 161.

II. FINDINGS

A. Delaware Is Violating the ADA By Failing to Serve Individuals with Mental Illness In The Most Integrated Setting

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.

One form of discrimination prohibited by Title II of the ADA is violation of the "integration mandate." The integration mandate arises out of Congress's explicit findings in the ADA, the regulations of the Attorney General implementing Title II,[2] and the Supreme Court's

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[1] The separate units at the DPC are: (1) Kent-3, a 32-bed extended care unit serving individuals with serious psychiatric diagnoses; (2) Kent-2, a 45-bed unit for male and female adults with behavior problems; (3) Sussex-3, a 43-bed unit for aggressive males; (4) Sussex-2, a 45-bed long-term unit for males and females with mental illness; (5) Sussex-1, a 35-bed unit for male and female geriatric patients; and (6) Jane Mitchell, a 42-bed forensic psychiatric unit for males and females involved in the Delaware criminal justice system, including people charged with crimes and awaiting psychiatric evaluation, prisoners serving sentences in the Delaware Department of Corrections facilities, and individuals adjudicated as criminally insane.

[2] The regulations provide that "a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities." 28 C.F.R. § 35.130(d); see also 28 C.F.R. § 41.51(d). The preamble discussion of the ADA "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A. at 571 (2009).

decision in Olmstead, 527 U.S. at 586. In Olmstead, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. Id. at 607. In so holding, the Court explained that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Id. It also recognized the harm caused by unnecessary institutionalization: "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 601.[3] As the Third Circuit Court of Appeals has made clear, the ADA "favor[s] integrated, community-based treatment over institutionalization." Frederick L. v. Dept. of Public Welfare, 364 F.3d 497, 491-92 (3rd Cir. 2004).

1. Individuals Remain Unnecessarily and Inappropriately Institutionalized in DPC in Violation of the ADA

DPC is violating the ADA by unnecessarily institutionalizing individuals who are appropriate for community-based treatment. Olmstead, 527 U.S. at 607. Based on the information we reviewed during our tours of DPC, including our review of patient records and interviews with statewide leadership and hospital staff and administrators, it is clear that the vast majority of individuals confined to DPC could be—and have a right to be—living in community settings with appropriate services and supports. DPC staff has already determined that over 70 percent of the individuals being treated at DPC are clinically ready to leave the hospital and to be served in more integrated settings. The percentage of individuals ready for discharge likely is even higher, according to our experts, due to DPC's inappropriate discharge assessment process, as discussed below. In fact, during an interview, the State's Director of the Division of Substance Abuse and Mental Health Services ("DSAMHS") acknowledged that "pretty much everyone at DPC would be appropriate for community placement."

DPC maintains and keeps current a central roster, entitled "DPC Discharge Assessment," which lists all individuals in DPC and their status with respect to discharge. This list indicates which individuals are ready for release and summarizes barriers to discharge.

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[3] Olmstead therefore makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and enable individuals with disabilities to participate in all aspects of community life. Accord Press Release, The White House, "President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities" (June 22, 2009) (in announcing the Year of Community Living Initiative, President Obama affirmed "one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.").

At the time of our August 2010 visit, approximately 85 individuals were designated as clinically ready to leave the hospital—either immediately or within a short time span—and to be served in more integrated settings. The most significant barriers to their discharge reflect not their individual needs but rather, the level of DDHSS resources and categorical restrictions on these funds.

As the State acknowledges:

> The average length of stay at DPC for civil units should run from 3-6 months but due to lack of community based placements the average length of stay is approximately 3 years As of February 2010, 71 individuals were ready to be discharged to supervised living in the community but were unable to be placed due to lack of funding for additional community based programs.

Delaware Memorandum of Agreement Compliance Committee Report, at 8 (February 2010).

These individuals, at minimum, remain institutionalized in the hospitals in violation of their rights under the ADA and Olmstead. A hospital, by definition, is a segregated setting, where individuals with mental illness are congregated together with little to no opportunity to interact with their non-disabled peers. 28 C.F.R. § 35.130(d), App. A. at 571 (an "integrated setting" "enables individuals with disabilities to interacted with nondisabled persons to the fullest extent possible"). Individuals in DPC are deprived of many of the personal freedoms that citizens in the community enjoy. They live a regimented life tied to the needs of the institution, such as waking up and going to sleep at set hours, not being able to choose with whom they associate and live, having set mealtimes with little to no choice of content, and having limited to no contact with the community outside the four walls of the facility. Accord DAI v. Patterson, 653 F. Supp.2d 184, 200-207 (E.D.N.Y. 2009) (describing characteristics of institutions to include regimented daily activities, lack of privacy, and few choices). Yet the State continues to provide services to far too many individuals with disabilities in the most segregated setting imaginable—the hospital.

Our investigation shows that DPC 's discharge planning process is inadequate, causing individuals who could be served in the community to remain inappropriately and needlessly institutionalized and leading to individuals who are discharged being placed in more restrictive settings than appropriate to their needs in violation of the ADA.

DPC's treatment professionals inappropriately assess an individual's readiness for discharge in terms of "compliance" with a number of factors that are clearly hospital-focused and often irrelevant to community living, notably among them: unit routine, unit rules, privilege levels and participation in treatment mall activities/therapies. Tellingly with regard to the importance assigned to an individual's functioning as a *patient*, DPC's protocol for discharge readiness explicitly emphasizes "compliance," but does not reference whether treatment at DPC has resolved the specific issues that caused an individual to be hospitalized in the first place. In contrast, effective discharge assessments focus on the individual's specific capacities to function

in a more integrated setting and to meet the demands of community living. They also identify the supports and services necessary for the individual's successful community living.

DPC's inappropriate discharge assessment process has kept many individuals in DPC from receiving a treating professional's recommendation of community placement. Moreover, individuals who can show the level of hospital "compliance" required to be considered ready for discharge often continue to languish at DPC because their discharge planning process fails to identify the supports necessary to address barriers to discharge. The result is that individuals who could live in integrated community settings with appropriate supports remain at DPC because they have not received adequate assessments of the supports and services necessary to allow them to succeed in the community. Accord Frederick L. v. Dept. of Public Welfare, 157 F. Supp.2d 509, 540 (E.D. Pa. 2001) ("Olmstead does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with disabilities."); DAI, 653 F. Supp.2d at 259 (same).

DPC's discharge planning process also fails to ensure that individuals are discharged to the most integrated setting appropriate to their needs. DPC has no clear criteria for determining the most integrated setting appropriate for an individual, and discharge teams often recommend discharging individuals to more restrictive settings than necessary. Specifically, our expert found that the default recommendation of most discharge teams was to discharge the individual to a group home without first examining whether that person could be served in a more integrated setting, like an apartment with supportive services. This problem is exacerbated by DPC discharge team's limited familiarity with community living options and services and their failure to engage community providers until after they have already made a decision about a placement for the individual being discharged.

2. Individuals in the Community are At Risk of Unnecessary Institutionalization in Violation of the ADA

The ADA's integration mandate not only applies to individuals who are currently institutionalized but also to individuals who are at risk of unnecessary institutionalization by the State's administration of its healthcare delivery system. See, Helen L. v. DiDario, 46 F.3d 325 (3d Cir. 1995) (holding that the ADA was offended where a person with disabilities was offered personal care services in an institutional setting but not at home); Accord Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004) (ADA applied to individual at risk of entering a nursing home); Fisher v. Oklahoma Health Care Auth., 335 F.3d 1175 (10th Cir. 2003) (same). We found that individuals in the community are at risk of unnecessary hospitalization and placement in other institutions, such as privately-operated Institutions for Mental Disease (IMDs), because of the State's failure to provide sufficient community-based services, particularly crisis services. Individuals in the community in crisis have no choice but to go to local emergency rooms, where they are directed to DPC or IMDs. Our expert estimates, based on conversations with state officials, DPC personnel and community providers, that the State could dramatically reduce unnecessary admissions to DPC and IMDs, perhaps by as much as 50%, by expanding crisis services such as mobile crisis and crisis stabilization programs. Not

only would an expansion of such crisis services avoid unnecessary institutionalization, but it would lead to a significant cost savings for the State.

3. Expansion of Services Would Not Require A Fundamental Alteration Of Delaware's Community Service System

A state's obligation to provide services in the most integrated setting may be excused only where a state can prove that the relief sought would result in a "fundamental alteration" of the state's service system. Olmstead, 527 U.S. at 603-4. Because it is not a fundamental alteration to expand existing community programs to include currently institutionalized individuals, see, e.g., DAI, 653 F. Supp.2d at 305, Delaware cannot meet its burden of proving the fundamental alteration defense.[4]

Within their service array, Delaware's existing community system is already providing services such as Assertive Community Treatment programs ("ACT") and scattered site supported housing that are essential to achieving the requirements of Olmstead. Thus, in most respects, what is needed is not new to the system, but rather a phasing out of dated models to be consistent with appropriate practices and bringing to scale those community programs that are already providing effective integrating services. Accordingly, providing community services individuals in or at risk of entering DPC would work only a "reasonable modification" of the State's program. Olmstead, at 603.

The State already provides to individuals in the community services of the type the individuals in or at risk of entering the hospitals would need to live successfully in the community. Funded services include supported housing, crisis stabilization, substance abuse treatment, supported employment, peer support, mental health mobile crisis, transportation, psycho-social rehabilitation and more. But those services are inadequate to meet the needs of those individuals. We found existing community services to be inadequate and not available in sufficient supply to enable individuals who are currently inappropriately segregated in DPC to be discharged from that setting into the community and provided appropriate services there. As a direct result of Delaware's actions and inactions, state-funded community health service providers fail to provide adequate community services necessary to avoid needless institutionalization. For example, case managers' case loads have risen dramatically, rendering this core service unable to provide needed attention to each client. ACT teams have been reduced or diluted. Currently, there are no ACT teams specializing in co-occurring disorders for mentally ill persons with specialized needs. In addition, we found an inadequate crisis system, with too few mobile crisis teams and crisis stabilization programs spread out geographically throughout the State. The result is that individuals in crisis are now seen in DPC and local

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[4] Moreover, general allegations of short-term costs or budgetary constraints alone are insufficient to establish the defense. Pa. Prot. and Advocacy, 402 F.3d at 380; Frederick L., 364 F.3d at 495.

emergency rooms. There is also a shortage of residential services for individuals with mental illness, including an inadequate supply of integrated, permanent supported housing.

Other core community mental health programs are inadequate. Only some of the regional mental health centers operate residential programs and some of these have reduced services. Inadequate resources has limited mobile crisis and diversion programs. The result is that many individuals with severe mental illness are provided with insufficient supports to remain in the community and find themselves institutionalized or at risk of institutionalization.

Moreover, a state cannot prove this affirmative defense unless it can show that is has developed and is implementing a comprehensive and effective plan to move individuals with disabilities into the community, with any individuals waiting for services moving at a reasonable pace. Olmstead, 527 U.S. at 584; Frederick L. v. Dept. of Public Welfare, 422 F.3d 151 (3rd Cir. 2005)("[A] comprehensive working plan is a necessary component of a successful 'fundamental alteration' defense."); Pa. Prot. and Advocacy, Inc. v. Dept. of Public Welfare, 402 F.3d 374, 381 (3rd Cir. 2005) ("[T]he only sensible reading of the integration mandate consistent with the Court's Olmstead opinion allows for a fundamental alteration defense only if the accused agency has developed and implemented a plan to come into compliance with the ADA."). Delaware's own admission that individuals languish for years longer than necessary at DPC, Delaware Memorandum of Agreement Compliance committee Report at 8, is evidence that it is not implementing a working Olmstead plan, with a waiting list moving at a reasonable pace. Accord DAI, 563 F. Supp.2d at 302-305.

Both Delaware leadership and community providers report a positive cultural change within DPC and DDHSS, and a new emphasis on community integration that could move Delaware's public mental health system substantially toward compliance with ADA. However, notwithstanding this stated goal, the State has failed to provide sufficient community-based services to ensure that Delaware citizens with mental illness are served in the most integrated setting appropriate to their needs in violation of the ADA.

B. Prolonged Institutionalization Has Resulted in Unconstitutional Harms

Unnecessary segregation not only violates individuals' rights under the ADA but also causes irreparable harm:

> [O]ne of the harms of long-term institutionalization is that it instills 'learned helplessness,' making it difficult for some who have been institutionalized to move to more independent settings.

Disability Advocates, Inc., 598 F. Supp.2d at 320; Accord Marlo M. v. Cansler, 679 F. Supp.2d 638 (E.D.N.C. 2010) (finding unnecessary institutionalization leads to regressive consequences that cause irreparable harm; Long v. Benson, 2010 WL 2500349 (11th Cir. Jun 22, 2010) (affirming district court's granting of preliminary injunction based on irreparable injury of unnecessary institutionalization).

States also have a constitutional obligation to provide adequate care and keep individuals safe while they are confined in institutions. The Fourteenth Amendment's due process clause requires a state mental health care facility to provide "adequate food, shelter, clothing, and medical care," along with "conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests." Youngberg v. Romeo, 457 U.S. 307, 315, 324 (1982). A state psychiatric hospital is constitutionally required to provide reasonable, adequate mental health treatment. See, Torisky v. Schweiker, 446 F.3d 438, 448 (3d Cir. 2006) (concluding that plaintiffs may be able to prove that they were deprived of their constitutional liberty interest and of Youngberg's duty of care and protection when they were transferred, against their will, to an institution inappropriate to serve their needs); Scott v. Plante, 691 F.2d 634, 636 (3d Cir. 1982) (affirming that individuals in state psychiatric hospitals have a right to adequate treatment, a right to reasonable care, and a right to be free from unreasonably restrictive confinement); Fournier v. Corzine, No. 07-1212, 2007 WL 2159584, at *11 (D.N.J. 2007) ("The Fourteenth Amendment Due Process Clause requires state officials to provide civilly committed persons ... with access to mental health treatment that gives them a realistic opportunity to be cured or to improve the mental condition for which they were confined."). Treatment is not adequate if it substantially departs from accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23.

Unnecessary institutionalization, particularly when protracted, is itself an irreparable harm. It creates learned helplessness and reinforces institutional behaviors, and the congregate environment often exacerbates the very behaviors for which individuals were admitted in the first place. The harm of unnecessary institutionalization in DPC is compounded by—and contributes to—the unconstitutional and life-threatening conditions at the hospital.[5] These conditions underscore the urgency of moving individuals with disabilities out of inappropriate institutional placements. The Constitution requires that Delaware provide reasonable care and safety to individuals in DPC. The State fails to meet this obligation.

1. DPC Fails to Provide Reasonable Safety in DPC in Violation of the Constitution

Individuals in DPC have the constitutional right to live in reasonably safe conditions. See, Youngberg, 457 U.S. at 315. DPC is failing to ensure that they are reasonably free from harm or unnecessary risk of harm.

Confinement in an institution leaves individuals vulnerable to harm and abuse. Unnecessary confinement of individuals who are ready for discharge diverts staff resources that should be focused on individuals with the most significant clinical needs and creates congregate conditions that increase risks of harm and can exacerbate maladaptive behaviors. On our most recent visit, we found several instances of individuals who were awaiting placement who had

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[5] As noted previously, there have been substantial improvements in the past year under new DPC leadership.

been victims of patient-on-patient abuse. While most of these incidents appeared to be a result of congregate life, where people with various levels of adjustment live in close quarters, many of the risk factors for the harms now occurring would dissolve if individuals were not left languishing in DPC while awaiting discharge to the community.

On our earlier visit, we found that DPC staff failed to identify and provide appropriate treatment and supervision for individuals engaged in the very behaviors which led to their admission to DPC, including suicide attempts, self-injury, and aggression. Initial suicide and violence risk assessments often are not completed at all or, if they are completed, lack critical information. This is a violation of individuals' constitutional rights. Youngberg, 457 U.S. at 315. Reassessments are similarly inadequate and untimely. Even when risks are identified, treatment plans fail to include appropriate behavioral interventions to address those risks and DPC staff fail to appropriately supervise individuals at high risk of harm, again in violation of the Constitution. Id. DPC's failure to identify and provide appropriate interventions and supervision places individuals at risk of harming themselves or others, as illustrated by the serious injuries and deaths of individuals described below:

- On April 6, 2009, C.X.[6] collapsed in the hallway of her unit at DPC. She lay there for several minutes without moving while staff walked past her without checking on her. Even more troubling, a DPC staff member pointed out C.X. to a nurse, who replied that C.X. "always does that" and did not respond further. By the time staff did check on C.X., she was unresponsive, and attempts to revive her failed.[7] This utter failure to provide care amounts to deliberate indifference and is an egregious violation of C.X.'s constitutional rights.

- On January 31, 2009, N.T. committed suicide by hanging herself with a bedspread. She was found by the staff member assigned to check her every 15 minutes. Despite her documented history of suicidal ideation and multiple serious episodes of self -harm, there had been no significant change to her treatment plan. In fact, N.T. herself warned DPC staff that its response to these incidents – placing N.T. temporarily on heightened observation – would not keep her safe. DPC's failure to provide appropriate treatment and supervision violated N.T.'s constitutional rights.

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[6] To protect individuals' identities, we use fictitious initials throughout this letter. We will separately transmit to counsel a schedule cross-referencing the fictitious initials with the individuals' names.

[7] To its credit, DPC reported two nurses involved in this incident to the state nursing licensing board.

- U.L. was assaulted by another individual on the unit while she was on 1:1 close observation status. After the assault, she attempted suicide by hanging herself. U.L.'s risk for self-injurious behavior and victimization was well-documented. Her treatment plan, however, contained only vague goals relating to her self-injurious behavior, for example, that she will "remain free of suicidal gestures, attempts or behaviors" and "will communicate thoughts of self-harm as experienced to others who can help" and contained no steps to help her avoid victimization. Indeed, even staff whose job was to keep U.L. safe from others failed to provide that protection. DPC's failure to provide appropriate treatment and protection from harm violated her constitutional rights.

- On August 27, 2009, C.P. died after swallowing a half-gallon of cleaning fluid that was left in an unlocked supply closet. C.P. was able to gain access to the cleaning fluid without being observed by staff. Despite his documented history of attempting to digest dangerous chemicals while at DPC, including chlorine bleach, there had been no significant change in his treatment plan to address this behavior and to keep him safe while confined at DPC. Again, DPC's failure to provide appropriate treatment and supervision violated C.P.'s constitutional rights and was a direct cause of his death.

Moreover, DPC's incident, risk, and quality management systems fail to manage the risks of abuse, neglect, physical harm, self-injurious behavior, and suicide, in violation of the Constitution. Youngberg, 457 U.S. at 315-16. Internal investigations into abuse, neglect, and suspicious injuries in the hospitals systematically fail to include information that is necessary to finding the root cause of an incident or to delve sufficiently into the possible origins of incidents. DPC fails to reliably and adequately analyze the data that they collect, rendering State and hospital officials incapable of recognizing adverse trends and correcting issues that directly lead to harm and death of individuals confined to DPC. And, for risks that they do identify, DPC fails to implement corrective and preventive actions in a timely manner, if at all, or to monitor those actions as necessary to reduce or eliminate the risk of harm.

DPC's failure to appropriately identify and manage these risks substantially increases the chances that individuals, including those who are awaiting discharge and no longer should even be in DPC, will be subjected to harm. In addition, DPC's failure to provide a reasonably safe living environment compromises the other care and treatment provided to individuals, prolongs the duration of hospitalizations, leads to frequent and unnecessary re-hospitalizations, and delays the movement of individuals to more integrated settings, in violation of both the constitution and Olmstead.

2. DPC Improperly Restrains and Secludes Individuals in Violation of Their Constitutional Rights

The right to be free from undue body restraint is the core of the liberty interest protected from arbitrary governmental action by the Due Process Clause. Youngberg, 457 U.S. at 316. Seclusion and restraint are emergency responses to failures in treatment; they are not treatment interventions that address the underlying behaviors for which the individual was hospitalized. To rely routinely on seclusion and restraint rather than behavior techniques, such as social reinforcement, to control aggressive behavior, violates the Fourteenth Amendment. Kirsch v. Thompson, 717 F. Supp. 1077, 1080-1081 (E.D. Pa. 1988) (holding that plaintiff's Fourteenth Amendment rights were violated when he was restrained at a state hospital for approximately three years in four-point physical restraints). Seclusion and restraint should be used only as a last resort. Thomas S. v. Flaherty, 699 F. Supp. 1178, 1189 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990), cert. denied, 498 U.S. 951 (1990); Davis v. Hubbard, 506 F. Supp. 915, 943 (W.D. Ohio 1980) (holding that the Constitution minimally requires that alternatives be considered before putting an individual in restraints)..

We found that DPC uses restraints too frequently, and keeps individuals in restraints for excessive periods of time in violation of their constitutional rights.[8] Youngberg, 457 U.S. at 316. Further, DPC uses inappropriate criteria to place individuals in restraints, inappropriate criteria to release individuals from restraints, and does not monitor individualss adequately while they remain in restraints. Finally, in some instances, DPC pre-planned the use of restraints. We believe that DPC's improper use of seclusion and restraint not only violates individuals' constitutional rights, but also is a symptom of its inadequate assessment and treatment of risks, as described above.

Below are examples of individuals being subjected to undue bodily restraint:

- F.X. was placed in restraints at least 26 times and into seclusion at least 13 times over a 13-month period. A review of his record indicates DPC used, or threatened to use, restraint and seclusion as a form of punishment instead of exploring treatment interventions to address F.X.'s history of aggression.

- K.O. was placed in restraints over 40 times over a 13-month period. Our review of her record indicated some instances where she was placed in restraints more than once in a single day. Her record indicated no attempt to explore less intrusive approaches.

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[8] As noted, we understand that there has been a reduction in appropriate usage of seclusion and restraint in the past year under new DPC leadership.

3. DPC Unconstitutionally Abuses Individuals

Individuals' constitutional liberty interests in reasonable protection from harm in mental health hospitals includes protection from abuse by staff. United States v. Dise, 763 F.2d 586,589 (3d Cir. 1985). The very nature of institutional settings—that staff are in a position of authority with complete control over every aspect of people's lives and that institutionalized individuals are isolated from the outside world—creates a high risk for abuse and neglect. Individuals in DPC, including the vast majority of people who are awaiting discharge to the community, are subjected to this significant risk of abuse. In our review of DPC documents and records, we noted numerous incidents in which staff abused individuals, either verbally or physically.[9]

Examples include:

- A DPC employee hit K.X. on his head with a set of keys, resulting in a laceration that required sutures and staples to close.
- A DPC employee assigned to care for K.Q. on 1:1 precautions hit him on the head.
- A DPC employee assigned to take care of N.X. on 1:1 precautions sexually assaulted her.

4. DPC's Unconstitutional Conditions are Exacerbated By Its Inadequate Investigation of Serious Incidents

We found that DPC does not consistently investigate injuries to individuals confined there and, when it does investigations, critical features, such as witness interviews and medical documentation, are often lacking. We found no evidence that DPC uses the historical data from investigations to: (1) identify actual or potential risks of harm; (2) develop timely and appropriate interventions designed to minimize or eliminate risks of harm; or (3) monitor the efficacy of interventions used and modify them as necessary in response to further data, as required by the constitution.

We reviewed 63 reports of injuries occurring while the individual was on 1:1 or 2:1 close observation during the fifteen-month time period between January 2007 and March 2008. The majority of those incidents were not properly or fully investigated. For example, there was only occasional evidence that staff were interviewed and that records were reviewed. In some reports, only the involved individuals were interviewed, and when they were, the results

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[9] The DDOJ report included additional examples of staff abuse, including multiple sexual assaults of a patient by a DPC worker for which the worker was arrested and prosecuted.

of the interview were in some cases dismissed as unreliable due to the individual's mental status. Findings from patient interviews should not be wholly dismissed because of the individual's mental status; all staff and individuals with direct as well as indirect information about the event should be interviewed; and records should be reviewed.

In addition, the reports reflected an inadequate and inconsistent investigative methodology that is ineffective to protect individuals' constitutional right to a safety, because the circumstances that caused harm to one or more individuals are not understood and remedied. For example, when nursing interventions were documented, the documentation typically reflected that the person willfully did something wrong despite "re-direction." There was no evidence in the records of interactions or activities implemented to prevent the circumstances that might have caused or contributed to the individual's behavior.

The fact that so many injuries were sustained by individuals who were placed on 1:1 close observation to keep them safe, makes DPC's failure to adequately investigate serious incidents more alarming. The failure of DPC to have a transparent and effective system for identifying, tracking, and correcting problems, adverse events, faulty treatment, and staff adherence to policies and procedures, increases the actual and potential harm due to prolonged institutionalization.

As indicated, the constitutional violations at DPC pose a serious threat to the life, health, and safety of individuals who are confined there. They make more urgent the need to move individuals in DPC out of inappropriate placements in the hospital to more appropriate integrated settings in the community.

IV. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of both individuals in Delaware Psychiatric Hospital ("DPC") and those at risk of being institutionalized at DPC, the State should promptly implement the minimum remedial measures set forth below:

A. Serving Individuals with Mental Illness in the Most Integrated Setting

In order to remedy its failure to serve individuals in the most integrated setting appropriate to their needs, consistent with the mandate of Title II of the ADA and its implementing regulation, Delaware should take the following steps:

Delaware should ensure that, before an individual is admitted to DPC, the individual receives a professionally-based assessment to ensure that admission to DPC is necessary and that DPC is the most integrated setting appropriate to serve the needs of that individual. Expanding Delaware's community-based crisis system is essential to diverting unnecessary admissions to DPC (and other institutions).

For those individuals for whom DPC is determined to be the most integrated setting appropriate to their needs, the State should revise its treatment and discharge planning process to focus, from the time of admission, on the appropriate discharge of individuals residing at DPC. During the treatment planning process and in implementing individual treatment plans, DPC should ensure that barriers to discharge are identified and addressed, and for individuals with a history of re-admission, that factors that led to re-admission are also analyzed and addressed.

Discharge planning should begin at the time of an individual's admission to DPC. The State should revise its discharge assessment process to focus on individuals' capacities to function in a more integrated setting and meet the demands of community living—not their compliance with hospital regiments—and identify the services and supports necessary for successful community living. DPC's assessment teams should become knowledgeable about community living options and services and should engage community providers early in the discharge planning process. Discharge plans should set forth in reasonable detail a written transition plan specifying the particular supports and services that each individual will or may need in order to safely and successfully transition to and live in the community. The plan should include, at a minimum: the individual's (and where relevant, family's) preferences for care; a discussion of how the individual (and where relevant, family) will access and pay for such services; the names and positions of those responsible for the individual's care, making appropriate referrals when necessary; a plan on how to coordinate care among multiple providers, if applicable; identification of the individual's specific needs after discharge; a discussion of how the individual (and, where relevant, family) need to prepare for discharge; and corresponding time frames for completion of needed steps to effect transition.

In order to ensure an appropriate transition upon discharge, DPC should engage identified community providers in the discharge planning process as far in advance of discharge as possible, and develop and implement a system to follow up with individuals after discharge to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission. DPC should also create, revise, and implement a quality assurance or utilization review process to oversee the discharge process. The quality assurance process should include, at a minimum: developing a system to review the quality and effectiveness of discharge plans; developing a system to track discharged individuals to determine if they receive care in the community as prescribed at discharge; and identifying and assessing gaps in community services identified through the tracking of discharge outcomes.

B. Serving Persons With Mental Illness In The Community

To prevent the unnecessary institutionalization of individuals with mental illness, the State should develop and arrange for sufficient supports and services to ensure that those individuals are served in the most integrated setting appropriate to their needs. This included, but is not limited to, defining the target population for community services to include all individuals who are in or at risk of entering DPC or other restrictive institutional settings. To promote the community integration of the target population, the State should increase community capacity by expanding the following services to the target population: assertive community

treatment ("ACT"), supported housing, supported employment, family and peer support services, community crisis services, and appropriate case management services.

The State should ensure that the ACT services deliver comprehensive, individualized, and flexible treatment, support, and rehabilitation to individuals where they live and work and operate with fidelity to the Dartmouth ACT model. The ACT services should be provided through a multidisciplinary team with services that are individualized and customized, and address the constantly changing needs of the individual over time. ACT teams should have the full array of staff on each their team, including at least one peer specialist, necessary to provide the following services: case management, initial and ongoing assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, and other services and supports critical to an individual's ability to live successfully in the community. ACT teams should provide crisis services, including helping individuals increase their ability to recognize and deal with situations that may otherwise result in hospitalization, increase and improve their network of community and natural supports, and increase and improve their use of those supports for crisis prevention. ACT teams should provide services to promote the successful retention of housing, including peer support and services designed to improve daily living skills, socialization, and illness self-management. ACT teams that serve individuals with co-occurring substance abuse disorders should provide substance abuse treatment and referral services to those individuals. Such ACT teams should include on their staff a clinician with substance abuse expertise. ACT services should be available 24 hours per day, 7 days per week. Finally, the number of individuals served by an ACT team should be no more than 10 individuals per ACT team member.

The State should provide supported housing to the target population in the form of housing, housing subsidies, or housing vouchers. Supported housing provides individuals with their own leased apartments or home, where they can live alone or with a roommate of their choosing. The housing is permanent (e.g., not time-limited) and is not contingent upon participation in treatment. The supported housing provided by the State should be scattered-site, meaning in an apartment building or housing complex in which no more than ten percent of the units are occupied by individuals with a disability. Personal care homes, group homes, and community living homes do not constitute supported housing. The State should ensure that individuals in supportive housing have access to a comprehensive array of services and supports necessary to ensure successful tenancy and to support the person's recovery and engagement in community life, including through ACT services.

The State should provide supported employment services to the target population through supported employment programs, the access to which is facilitated by ACT teams. Supported employment services should assist individuals in finding competitive employment in an integrated setting based on the individual's strengths and interests. Support employment programs assist individuals in identifying vocational interests and applying to jobs and should provide services to support the individual's successful employment, including social skills training, job coaching, benefits counseling, and transportation. Supported employment services are integrated with the individual's mental health treatment. Enrollment in congregate day programs should not constitute supported employment.

The State should provide family and peer support services. Family support services are designed to educate and train an individual's family to better support the individual's treatment and successful community living, including by educating family members about the individual's mental illness, and about strategies for assisting with treatment and recognizing and addressing crises. Peer support services are delivered by peers to improve an individual's community living skills, including their ability to cope with and manage symptoms and to develop and utilize existing community supports. Peer support services may be provided by face-to-face or telephone contact and include outreach, wellness training, and training in self-advocacy.

The State should develop a statewide crisis system that includes a crisis call center, mobile crisis services, regional crisis centers, crisis stabilization programs, and crisis apartments. The Crisis Call Center is staffed by skilled professionals 24 hours per day, 7 days per week, to assess, make referrals, and dispatch available mobile teams. The State should provide mobile crisis services to respond to crises anywhere in the community (e.g., homes, schools, or hospital emergency rooms) 24 hours per day, 7 days per week. The services are provided by clinical staff members (including staff with substance abuse expertise) and by peers. The State should also develop regional walk-in crisis centers that are clinically staffed 24 hours per day, 7 days a week, to receive individuals in crisis and to assess and provide them services and support, including evaluation, observation, triage, and referrals. The State should provide crisis stabilization programs that are community-based residential services operated by community providers that provide psychiatric stabilization and detoxification services as an alternative to psychiatric hospitalization. Finally, the State should provide crisis apartments in the community to serve as an alternative to crisis stabilization programs and to psychiatric hospitalization.

The State should require that community care programs and community providers assess the adequacy of the individualized supports and services provided to persons by such providers in the community. These assessments include, but str not limited to, whether the community service boards and community providers' efforts are: reducing repeated admissions to DPC and other institutional settings; increasing stability of community residence; increasing housing services to individuals who have serious mental illness and who are homeless; retaining employment and/or schooling; increasing supported housing; and increasing supported employment.

The State should provide appropriate oversight of Community Service Boards and/or Community Providers by: establishing the responsibilities of community care programs and/or community providers; identifying qualified providers, including providers in geographically diverse areas of the State; performing a cost rate study of provider reimbursement rates to determine whether current provider reimbursement rates are adequate; requiring community care programs and/or community providers to develop written plans describing services to be provided, in consultation with community stakeholders; requiring and/or providing training to community service boards and/or community providers so that services can be maintained in a manner consistent with evidence-based standards and this Findings Letter; and monitoring the performance of the community care programs and/or community providers.

C. Safety in DPC While Transitioning Individuals to Community Placements

In order to protect the safety of individuals currently residing in DPC, the State should transition individuals who can be served in more integrated settings from DPC and should provide safety, treatment, and services for individuals in DPC that are consistent with generally accepted professional standards. Generally accepted professional standards require that facilities appropriately monitor, supervise, and provide treatment to individuals in order to ensure their reasonable safety.

At a minimum, DPC should, consistent with generally accepted professional standards, appropriately monitor and supervise individuals, especially those at risk. All persons will have an individualized treatment plan formulated by qualified mental health professionals consistent with generally accepted professional stands. Individuals will be provided the degree of individualized treatment as will afford them a reasonable opportunity to improve in social, behavioral, and mental functioning, to diminish symptoms related to their psychiatric illness, and to function as independently as possible. The treatment team will review and follow-up on each individual's care and treatment at appropriate intervals, and whenever an individual's condition requires. Risks (e.g. suicide, self-injury, aggression, other behavioral problems) requiring special observations/precautions will be appropriately addressed consistent with generally accepted professional standards.

To ensure that each individual is being treated in the most integrated setting, discharge planning will be given high priority and will begin on admission. The State should revise its discharge assessment process to focus on the individual's specific capacities to function in a more integrated setting and to meet the demands of community living and to identify the supports and services necessary for the individual's successful community living. DPC discharge teams should become knowledgeable about community living options and services and should engage community providers in the discharge planning process as soon as is practicable. During the assessment and treatment planning phases, discharge criteria will be established, included in the treatment plan, and regularly reviewed by the treatment team. The individual's progress toward discharge criteria and any barriers to discharge will be monitored in treatment plan updates and progress notes. The role of each treatment team member in assisting the individual to meet discharge criteria and achieve the level of functioning necessary for a successful discharge will be delineated in the treatment plan. Treatment will be directed toward helping the individual achieve the level of functioning necessary to be ready for discharge and to live in a community setting.

The State should institute a risk management program to identify high risk situations that require corrective action in an appropriate and timely manner and to develop and implement timely interventions that remedy the identified risks to prevent or minimize harm to the individuals in DPC. The risk management program will include, but not be limited to, the following processes: incident reporting, data collection, and data aggregation to capture information regarding high risk situations; identification of individuals at risk that require review by the appropriate clinical disciplines and the interdisciplinary team, as well as a hierarchy of

interventions that correspond to the level of risk; identification and analysis of trends in high risk situations; and the development and implementation of corrective action in response to trends.

DPC should review and analyze all mortalities and incidents of serious injuries to reduce the risk of harm to other individuals, and identify and correct causative and contributing factors to the mortality.

The State should institute a quality management system. The system will collect information related to the adequacy of safety, treatment, and services provided by community providers and DPC.

V. CONCLUSION

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

We hope to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns with respect to the services the State provides to persons with mental illness at DPC and other settings across the State. Assuming that our cooperative relationship continues, we are willing to send our consultants' written evaluations -- which are not public documents -- under separate cover. Although the consultants' reports do not necessarily reflect the official conclusions of the Department of Justice, the observations, analysis, and recommendations contained therein provide further elaboration of the issues discussed in this letter and offer practical technical assistance to help address them.

We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing the areas that require attention.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them, 42 U.S.C. § 1997b(a)(1), and pursuant to the ADA once we have determined that we cannot secure compliance voluntarily, 42 U.S.C. § 2000d-1. We would prefer, however, to resolve this matter by working cooperatively with the State and are confident that we will be able to do so. The DOJ lawyer assigned to this investigation will be contacting the State's attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393.

Sincerely,

Thomas E. Perez
Assistant Attorney General

cc:

Beau Biden
Attorney General
State of Delaware

Rita Landgraf
Secretary
Delaware Department of Health and Social Services

Kevin Huckshorn
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Delaware Department of Substance Abuse and Mental Health
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The Honorable David Weiss
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