NEWS RELEASE

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DISABILITY RIGHTS CONNECTICUT
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Investigative Report into Treatment of Patients at Whiting Forensic Hospital, Connecticut Valley Hospital Finds Systemic Issues Remain

Progress Seen Since 2017 Abuse Revelations, But Serious Concerns Are Unresolved; New Policies & Procedures Needed Now; Findings, Recommendations Provide Roadmap

Warning that "people's lives are in danger," a comprehensive investigative report issued by Disability Rights Connecticut is calling on state officials responsible for oversight of Whiting Forensic Hospital (WFH) and Connecticut Valley Hospital (CVH) to "enact immediate reforms" to assure the safety and rights of patients at the state-run facilities.

The 41-page investigative report is the first issued by Disability Rights Connecticut (DRCT), a statewide nonprofit organization, which replaced the state Office of Protection & Advocacy for Persons with Disabilities in 2017. It outlines in detail the systemic changes that need to be made, two years after initial revelations of abuse at the state-run facilities led to disciplinary action, resignations and firings, criminal charges, realignment of the facilities, extensive changes in administrative personnel, state legislation and establishment of a legislative task force.

The report acknowledges that "state entities responded addressing some of the initial concerns," after news broke in November 2017 of abuse and neglect, but even with those steps, "DRCT's findings, based upon a broader examination, illustrate many concerns still exist," the report states, referencing incidents that took place as recently as August 2019.

Report: 11 Findings, 12 Recommendations, Call to Action

In a call to action, the report emphasizes that "immediate action is required, not a year from now after more reports are issued, but now." It urges the Commissioner of the Department of Mental Health and Addiction Services (DMHAS), and the 2020 state legislature, to remedy the numerous areas of serious concern revealed by the investigation.

Under the heading "Significant Problems Persist," the investigative report details 11 key findings, described in terms ranging from "disturbing" and "deeply problematic" to "incoherent," and makes 12 far-reaching recommendations, noting that "the greatest challenges involve bringing change to the organizational culture."

The recommendations include a call for independent investigation of all unanticipated deaths, removal of CVH's statutory exemption from psychiatric hospital licensing requirements, evaluation of the use of physical and chemical restraints, elimination of punitive and counter-therapeutic patient treatment, establishment of "genuine" interdisciplinary treatment teams, and training of police concerning patient rights.

The findings which led to the recommendations include: the use of restraint for discipline in lieu of treatment or for the convenience of staff; denial of patient rights by DMHAS Police; inappropriate use of psychotropic medications; arbitrary use of restriction of patient privileges; inadequate

investigations of abuse, neglect, and unanticipated patient deaths; and inadequate levels of constructive staff engagement with patients.

Current Practices Must Be Addressed

"This investigation was necessary to bring to light ongoing, disturbing practices that must be addressed," said Gretchen Knauff, Executive Director of Disability Rights Connecticut. "Our mandate and our responsibility is to investigate, advocate and educate to assure that the rights of individuals with disabilities are protected and they are free from abuse and neglect."

In one recent incident reviewed by investigators, restraint was used in "a clear violation of State law, federal regulations and DMHAS policy." Nonetheless, Whiting managers and clinicians indicated to investigators that "they saw nothing wrong with the way the episode had been handled."

The investigation also found an absence of "genuine, fully functioning interdisciplinary treatment teams" which adversely impacts individuals who "most need to be surrounded by competent, collaborating team members."

Connecticut Valley Hospital (CVH) is a state hospital, with its main campus in Middletown, offering general psychiatric services and addiction services. Whiting Forensic Hospital (WFH), a state hospital located on the grounds of CVH in Middletown, provides inpatient services to persons involved in the criminal justice system. The investigation revealed that individuals who have no current involvement with the criminal justice system are inter-mixed with those who do, and are subjected to "use of restraints and psychotropic medication regimes despite being there for widely differing reasons."

The DRCT investigation initially centered on the experience of two patients - William Shehadi, whose victimization had been recorded through a video surveillance system, and Andrew Vermiglio, who had resided on the same unit and died in December, 2016, approximately six months before the abusive treatment of Shehadi became known.

There is capacity for approximately 350 individuals to be under care at CVH. WFH has capacity for 91 individuals under maximum security and 138 individuals under enhanced security. In the course of the investigation, the report explained, "getting to know these people drove home the injustice of keeping them hospitalized in environments that are characterized by low expectations and indifferent treatment."

The investigators also observed "an on-going process of administrative reform at WFH – an active, iterative process which, while far from complete, holds hope for further, genuine organizational change." The report noted, however, that WFH "recently underwent, and in important respects failed, its first DPH licensing inspection."

Efforts Underway Are Insufficient

After holding public hearings in 2018, 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 legislation also established a task force to study and make recommendations about further changes that may be warranted at both CVH and WFH. The Task Force has yet to issue a report or recommendations.

Disability Rights Connecticut, a statewide non-profit organization, advocates for the human, civil, and legal rights of people with disabilities in Connecticut. DRCT provides legal advocacy and rights protection to a wide range of people with disabilities, and assists individuals with problems such as abuse, neglect, discrimination, access to assistive technology, community integration, voting, and rights protection issues. DRCT also addresses issues through policy advocacy, education, monitoring, and investigation.

The Investigative Report and information about Disability Rights Connecticut is available at www.disrightsct.org.

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