EXECUTIVE SUMMARY

May 22, 2024

Disability Rights Connecticut (DRCT) conducted a comprehensive investigation of the conditions of care at Connecticut’s Mental Health Center (CMHC)—an inpatient psychiatric facility operated by the State of Connecticut Department of Mental Health and Addiction Services (DMHAS)—in response to complaints it received about CMHC. The investigation commenced in April 2021 and was completed in February 2024. As a result of its investigation, DRCT substantiated and identified multiple systemic violations of the constitutional and statutory rights of individuals with serious mental illness admitted for treatment at CMHC.

These violations and deficiencies of neglect include failure to: 1) ensure personal safety; 2) protect from sexual abuse and harassment; 3) ensure appropriate use of restraint and seclusion; 4) provide adequate treatment including, including but not limited to, active treatment and discharge planning, and 5) provide a rodent free environment.

Consequently, patients have suffered irreparable harm, and they are at serious risk of suffering continuing irreparable harm if these violations are not immediately remediated. Currently, CMHC and DMHAS continue to fail to implement corrective measures to prevent these violations from reoccurring. The findings resulting from DRCT’s investigation are set forth in the attached report. DRCT presents a summary of its findings and recommendations in this Executive Summary, requesting urgent and immediate corrective action to prevent further irreparable harm.

1 Disability Rights Connecticut’s mission is to advocate, educate, investigate, and pursue legal, administrative, and other appropriate remedies to advance and protect the civil rights of individuals with disabilities to participate equally and fully in all facets of community life in Connecticut. Disability Rights Connecticut provides legal advocacy and rights protection to people of all ages with disabilities. DRCT focuses its legal and other advocacy on a wide range of disability justice issues for Connecticut residents with disabilities. DRCT’s services include advocating for the rights of individuals with disabilities on issues including abuse, neglect, discrimination, community integration, forensic mental health, voting, and other rights protection issues. DRCT replaced the Office of Protection & Advocacy for Persons with Disabilities, which was abolished by Connecticut Law as of June 30, 2017, and is now Connecticut’s federally mandated Protection and Advocacy System pursuant to the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801, et seq., as amended, 42 C.F.R. § 51; the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15041, et seq., as amended, 45 C.F.R. § 1326; the Protection and Advocacy for Individual Rights Act, 29 U.S.C. § 794e.
Background

DMHAS is the Connecticut state agency that provides inpatient and outpatient services and treatment for individuals with mental illness over the age of eighteen (18).\(^2\) CMHC located in New Haven, Connecticut. CMHC is a twenty (20) bed inpatient facility for patients with mental illness, and some patients with dual diagnosis.\(^3\) CMHC is the only DMHAS-run facility staffed with both DMHAS employees and professionals from the School of Psychiatry at Yale University. These individuals include Dr. Michael Sernyak, the CEO of CMHC and Professor of Psychiatry/Deputy Chair for Clinical Affairs and Program Development at Yale University.

Methodology

The findings and recommendations herein are based upon information derived from an extensive investigation into allegations of abuse and neglect at CMHC. DRCT’s comprehensive investigation includes extensive document review of fourteen (14) patient records; critical incident and investigative reports; policies and procedures; quality assurance data; program activity data; management meeting minutes; Joint Commission reports and plans of correction; health safety and pest control reporting; and staff training materials. In addition, DRCT conducted six (6) facility visits, and interviewed CMHC staff and patients.

Findings

DRCT, as a result of its comprehensive investigation, identified multiple failures demonstrating that CMHC has and continues to fail to protect its patients with serious mental illness. The findings listed below outline what DRCT uncovered. DRCT found that CMHC repeatedly failed to protect the rights, safety, and welfare of its patients by:

- Failing to adequately protect patients from harm including failing to protect patients from sexual abuse;
- Engaging in excessive and inappropriate use of restraint and seclusion;
- Failing to adequately provide patients with a safe and therapeutic environment;
- Failing to provide adequate treatment;
- Failing to provide adequate discharge planning;
- Failing to provide a rodent-free environment; and
- Failing to provide adequate risk management and quality assurance systems.

I. Failure to Protect Patients from Harm Including Failure to Protect Patients from Sexual Abuse

DRCT verified that multiple CMHC patients who it reviewed were subjected to sexual abuse from other patients as a result of CMHC’s failure to adequately protect these patients. This

\(^2\) DRCT’s investigation focused on only inpatient psychiatric services. Although the CMHC website indicates that it serves more than 4,000 patients per year, this reflects a large majority that receive outpatient services in the community.

\(^3\) DRCT’s investigation included some patients who were dually diagnosed with both mental illness and an intellectual disability.
included CMHC’s failure to adequately document incidents of sexual abuse in violation of CMHC’s own policy; investigate incidents of sexual abuse; and implement safety measures to protect patients from reoccurrence of sexual abuse by other patients.

In a representative example, CMHC failed to protect Jane Doe #1, a 25-year-old woman, from being sexually assaulted by two male patients in two different incidents after she was admitted to CMHC on May 4, 2021. On June 24, 2021, she was sexually assaulted by a male patient. Although CMHC staff were aware of the incident, CMHC failed to investigate this incident of sexual abuse. On July 30, 2021, the same male patient came out of his room with his genitalia and buttocks exposed and grabbed Jane Doe # 1 from behind. After this incident, Jane Doe #1 reported to staff that the male patient was following her, that he had done so on prior occasions, and that he also tried to kiss her. Jane Doe #1 reported to a hospital police officer that the male patient grabbed her but that the police officer said there was nothing they could do because the male patient did not do anything to harm Jane Doe #1. On July 17, 2021, Jane Doe #1 reported to staff that a second male patient made kissing noises at her and another female patient frequently. This allegation of sexual harassment was not reported or investigated by CMHC staff.

II. Engaging in Excessive and Inappropriate Use of Chemical and Physical Restraints and Seclusion

CMHC restrained and secluded patients excessively in lieu of applying less restrictive means to address patient behavior. DRCT found that for the patients who were part of DRCT’s review, CMHC failed to adequately justify the use of restraint and/or seclusion; properly document incidents of restraint and seclusion in violation of its own policies; ensure that patients were adequately monitored while secluded; and assess and document the use of behavioral support plans.

In a representative example, John Doe #1 was physically restrained on fourteen (14) occasions, placed in locked seclusion on six (6) occasions, and chemically restrained on sixteen (16) occasions during a 32-week period at CMHC. The requisite documentation was either lacking or incomplete for all incidents of restraint or seclusion. Two restraint incidents lacked a physician order. One restraint incident lacked the required physician reassessment within two hours of the initial physician assessment for a restraint that lasted 3 hours and 40 minutes. John Doe #1’s records revealed that he was found asleep during one seclusion incident. All incidents lacked documentation of the conservator’s response to their notification of his restraints in violation of CMHC’s policies. Seven (7) of 14 restraints lacked documentation in the Inpatient Nursing Notes. It is CMHC’s policy to discontinue the use of restraint and seclusion as soon as possible and to continuously monitor and assess patients while in restraint and seclusion. However, CMHC violated this policy for John Doe #1’s restraint and seclusion incidents.

III. Failure to Provide Adequate Treatment

DRCT identified multiple concerns regarding the adequacy of treatment and services provided to CMHC patients. These concerns include the failure to incorporate psychologists into interdisciplinary treatment teams for patients with dual diagnoses and/or challenging behaviors;
failure to adequately assess patients’ needs for behavioral interventions in lieu of restraint and seclusion; failure to adhere to individual treatment plan goals so that patients may learn skills necessary for discharge; and failure to adequately support patient active treatment.

For example, DRCT found that the patients often did not attend clinical groups as prescribed in their individualized treatment plans. A review of CHMC records showed that during an eight-month period, there was a decrease of 50% in one patient’s participation in her individualized clinical groups. Another patient attended only 14% of the clinical groups established in her treatment plan throughout her stay at CMHC. For a third patient, the patient attended two (2) clinical groups out of forty-four (44) established in his treatment plan within a three-month period. Although there were repeated notes stating that CMHC staff encouraged patient participation in groups, these efforts did not change participation in their established clinical groups and that there were no further notes or other documentation showing that CMHC conducted reviews of these respective treatment plans to encourage participation in other ways. Further, CMHC failed to conduct treatment plan reviews as to why individual patients were not consistently attending established clinical groups, and to identify necessary intervention strategies to improve the treatment patients receive.

IV. Failure to Provide Patients with a Safe and Therapeutic Environment

DRCT identified multiple concerns regarding CMHC’s failure to ensure patient safety and creating a supportive, therapeutic environment for patients living at CMHC—who, on average, reside there for a year or more. These concerns include CMHC’s failure to comply with Connecticut fire and building codes to adequately abate asbestos and install fire sprinklers; support a physical therapeutic living environment to promote patient comfort as CMHC becomes their temporary home while in treatment such as artwork on the walls; and to ensure that patients are treated with dignity.

During visits to CMHC, DRCT observed a lack of respect and dignity toward patients who were not permitted to demonstrate their ability to independently engage in life skills. Per Connecticut State Statute §17a-542 and CMHC policy, staff are required to treat patients with personal dignity. During one visit on February 21, 2024, for example, DRCT observed that staff promote patient dependence on staff when they sat down for a meal. CMHC staff poured drinks and opened a yogurt container presumptively thereby denying patients the opportunity to independently do these tasks themselves. Patients were not afforded the opportunity to open their own containers or pour their own drinks. The patients who DRCT observed neither asked for assistance nor did the CMHC staff converse with them. Rather, staff appeared not to recognize that patients deserve the dignity to learn independence and to demonstrate this independence.

V. Failure to Provide Adequate Discharge Planning

DRCT’s investigation verified that patients remain at CMHC for an average of a year or more rather than being discharged and reintegrated into the community more quickly.

DRCT found that, although CMHC’s ability to adequately ensure that patients integrate into the community depends upon adequate discharge planning, review of patient records revealed that CMHC provided inadequate discharge planning for some patients, causing them to return to
CMHC shortly after they were released back into the community. For example, CMHC released one patient back to her family home, the same home where a family member sexually abused the patient and where the alleged aggressor continued to reside. Although the patients’ records stated that CMHC knew the circumstances of the sexual abuse incident, CMHC discharged the patient back to her family home. Following this discharge, the patient was readmitted to CMHC within thirteen (13) days of her discharge.

VI. Failure to Provide a Rodent-Free Environment

DRCT’s investigation verified that mice remain present in patient units, particularly the kitchen, throughout its investigation. Both patients and staff have consistently reported observing mice in the units. Housekeeping staff confirmed that twenty-five (25) mice were caught in traps over one weekend. Staff further confirmed mice sightings during DRCT’s last site visit on February 21, 2024.

Although CMHC has attempted to eradicate mice for the in-patient unit, these efforts are inadequate. During DRCT’s investigation, even though CMHC increased the frequency of visits from its exterminator contractor from twice to three times a week, mice remain in patient living spaces. Additionally, while CMHC has implemented a pest sighting log, staff are completing the log incorrectly and, therefore, this mechanism is inadequately addressing the rodent infestation. In particular, although CMHC provided a pest sighting log starting in February 2023, staff consistently recorded seeing no mice in May 2023 on the pest control log, inconsistent with information staff told DRCT during interviews.

VII. Failure to Provide Adequate Risk Management and Quality Assurance Systems

DRCT’s investigation revealed that CMHC lacks adequate risk management and quality assurance systems. CMHC does not collect and analyze data on patient behaviors that place patients at risk. These behaviors include patient-on-patient abuse, use of restraint and seclusion, and patient-to-patient aggression. An adequate risk management system necessitates the review, analysis and consideration of corrective action to improve patient safety, which CMHC has failed to adequately do. Currently without a risk management system in place to review, correct, as needed, and monitor these behaviors, CMHC is failing to adequately ensure the safety of its patients.

Additionally, CMHC lacks an adequate quality assurance system to evaluate, correct, as needed, and monitor if it is providing patients with adequate care and treatment. Although CMHC collects select data on patient length of stay, and restraint and seclusion, it does not do anything with the data at the facility level to evaluate how the data impacts patient quality of care and if improvements are needed. Furthermore, CMHC fails to collect data on other areas of patient care which DRCT identified because CMHC does not retain quality assurance data on information in patient paper charts. More than 95% of data on patient care and treatment is contained in patient paper charts. These areas of care include incidents of patient-on-patient abuse, restraint and seclusion documentation, the administration of PRN and emergency psychotropic medications, and patient treatment plan reviews. CMHC cannot adequately assess and improve the quality of
patient care and treatment without incorporating all necessary data to make improvements as needed.

**CMHC’s and DMHAS’ Response**

DRCT issued its findings and recommendations to CMHC prior to issuing this public report. Unfortunately, these issues have not, as of the date of the report, been adequately remediated.

**Recommendations**

DRCT recommends that CMHC and DMHAS create, implement, and monitor a plan of correction to address multiple issues impacting patient care. Furthermore, DRCT recommends that CMHC and DMHAS provide an annual report to DRCT regarding the progress made in implementing and monitoring the requested plan of correction including any issues identified, and corrections implemented to address these issues. Specifically, DRCT urges CMHC and DMHAS to adopt the following corrective actions:

- Develop and implement a standardized system for reporting and investigating all incidents of abuse and neglect at all DMHAS run facilities including CMHC;
- Adequately implement their restraint and seclusion policies;
- Establish and implement policies integrating psychologists into all aspects of patient care and treatment for patients with intellectual disability and patients with challenging behaviors;
- Revise and implement policies and procedures for patients in need of behavioral intervention;
- Improve patient attendance of clinical groups in compliance with individualized treatment plans;
- Revise and implement CMHC’s discharge policy;
- Eradicate and prevent rodent infestation in patient units;
- Establish a mechanism to ensure the implementation of both DMHAS and CMHC’s policy regarding client rights;
- Make necessary improvements to CMHC’s risk management system; and
- Develop and implement quality improvement mechanisms that timely detect and adequately address problems with patient care.

It would also be beneficial to patients if CMHC were subject to regulatory oversight by Department of Public Health, similar to Whiting Forensic Hospital, so there would be a means
for an outside agency to investigate and remediate abuse and neglect allegations more consistently and expeditiously, when appropriate.

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