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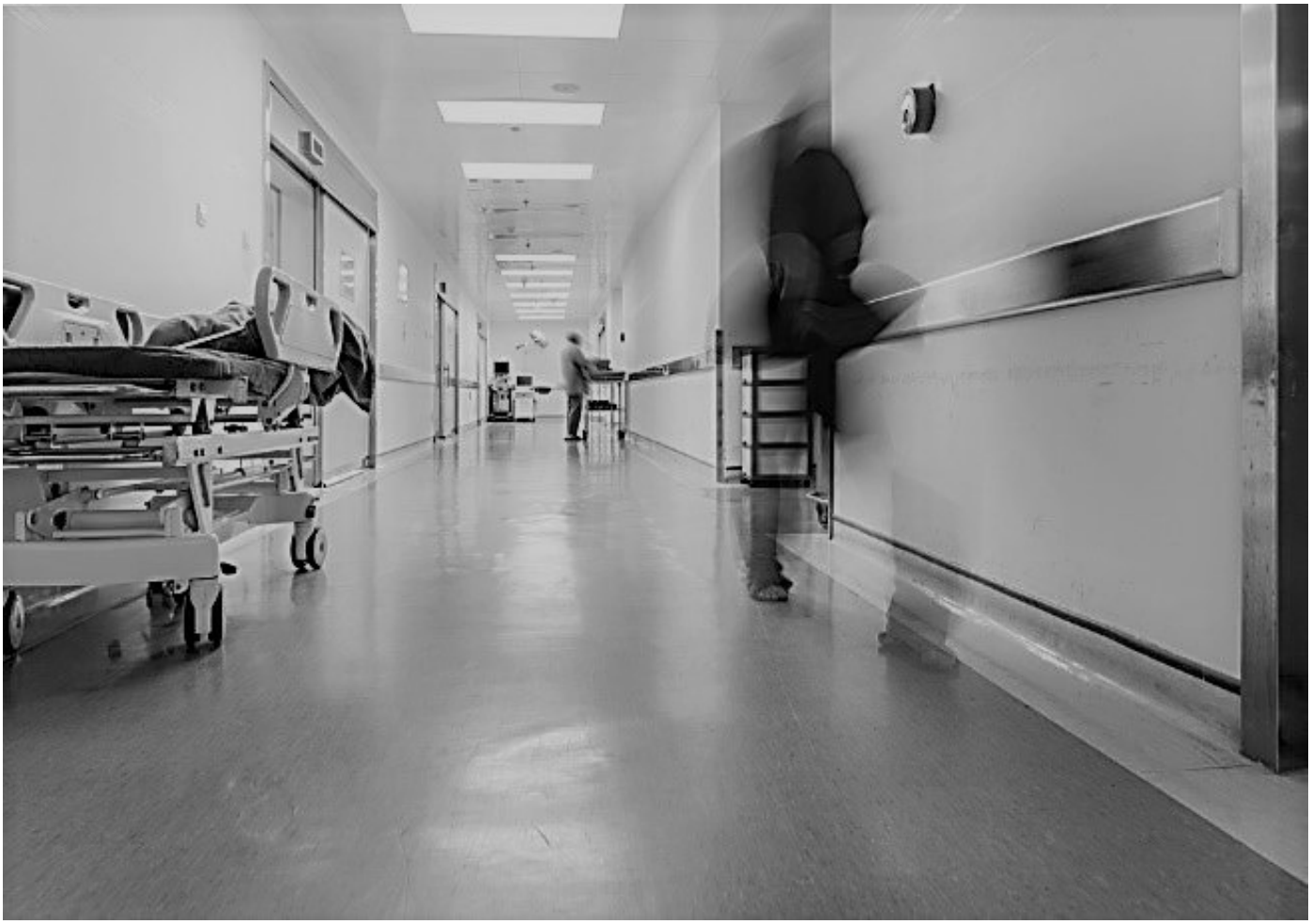
After investigative findings, sta to assure patient rights and saf

CT VIEWPOINTS :: by GRETCHEN KNAUFF | FEBRUARY 19, 2020 | VIEW AS "CLEAN READ"



Two months ago, Disability Rights Connecticut warned that "people's lives are in danger," as we urged the state legislature and state officials to take immediate action in the oversight of Whiting Forensic Hospital (WFH) and Connecticut Valley Hospital (CVH) to assure the safety and rights of patients at the state-run facilities.

Now, just days after the start of the legislative session, the imperative has only grown more acute. Delay would be unconscionable, and we are hopeful that the state's response will be comprehensive, timely and effective.

Our call for immediate action came in a 41-page investigative report which outlined in detail the systemic changes that need to be made, two years after initial revelations of abuse 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.

Disability Rights Connecticut (DRCT) is the statewide nonprofit organization that replaced the state Office of Protection & Advocacy for Persons with Disabilities in 2017. Our mission is to advocate for the human, civil, and legal rights of people with disabilities in Connecticut.

In November 2017, we opened an investigation into allegations of abuse and neglect of patients at Connecticut Valley Hospital (CVH), the only remaining large, state-operated psychiatric hospital in Connecticut. The investigation was initiated after a series of media reports had, over the preceding months, reported multiple incidents of physical abuse.

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.

During the investigation, we peeled back layers of bureaucracy and custom to better understand the issues of concern that continued to exist, as a vital step towards having systemic changes made that would ensure the safety and rights of individuals in the state's care. We determined that while some improvements had been made at both CVH and its Whiting Forensic Division, more were needed if the state is to improve outcomes for patient treatment and recovery.

More than a year ago, in a partial response to what had become public, Public Act 18-86 separated Whiting from CVH, establishing it as a stand-alone psychiatric hospital to be known as Whiting Forensic Hospital (WFH), operated under and directly reporting to the Department of Mental Health and Addiction Services.

The legislation also took major steps to improve accountability, requiring among other things that WFH be subject to the Department of Public Health's psychiatric hospital licensing requirements. In addition, a legislative task force was appointed to research and recommend additional steps. They continue to meet, with a final report and recommendations still a year away.

While the task force may ultimately make worthwhile recommendations, given the clear and present danger, a year more is too long to wait.

Significant barriers, and a history of previous attempts at reform, suggest that bringing transformative change to the hospital's culture presents a formidable challenge. To accomplish what needs to be done, the DRCT investigation identified concrete steps that could lead to accelerated and long-lasting improvement.

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. Some of the recommendations require legislation, others can be accomplished administratively.

The investigation was necessary to bring to light ongoing, disturbing practices that must be addressed. That is as true today as it was when we began. 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. They, and their families, await action.

Our mandate 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, wherever they reside. The state's responsibility, given these findings, is to respond.

Gretchen Knauff is Executive Director of Disability Rights Connecticut (DRCT). 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.

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