MEMORANDUM

DATE: **March 6, 2019 / Updated April 1, 2019**

TO: **Senator Sara Gelser**
Chair, Senate Committee on Human Services
Oregon State Legislature

CC: **Benjamin S. Wolf**
Legal Director
American Civil Liberties Union of Illinois

FROM: **Ronald H. Davidson, Ph.D.**

RE: **Risks of harm to Oregon children in out-of-state placements**

As you requested during our recent discussion, I'm including in this memorandum a summary of information regarding quality of care issues and potential risks of harm to Oregon children who have been placed in certain residential treatment facilities in other states by the Department of Human Services.

Much of this information was evaluated in my former position as Director of the Mental Health Policy Program at the University of Illinois at Chicago's Department of Psychiatry between 1994-2014. During that 20-year period, I also served as an independent expert for the American Civil Liberties Union and the Illinois Department of Children and Family Services, pursuant to a federal court consent decree that was intended to reform Illinois' broken child welfare system.

As part of the monitoring efforts for the consent decree, my UIC staff and I were tasked to conduct over 400 reviews of psychiatric hospitals and residential treatment centers in Illinois and a dozen other states where DCFS then referred its most damaged children – a questionable practice that I understand Oregon is still employing. Moreover, the UIC reviews found compelling evidence that such referrals – especially to out-of-state RTCs – not only offered little therapeutic value but, in fact, posed risks of physical and sexual abuse as well as traumatic emotional harm for this vulnerable child welfare population.

At its peak, Illinois had nearly 800 DCFS wards in such distant facilities around the country – dwarfing Oregon's current numbers – but the Department and the ACLU resolved that this unacceptable practice needed to be terminated. Within two years, Illinois did just that: bringing home every one of those nearly 800 children – as shown in the chart on the following page – while at the same time developing more effective in-state residential and clinical programs to serve their unique treatment needs.[1]

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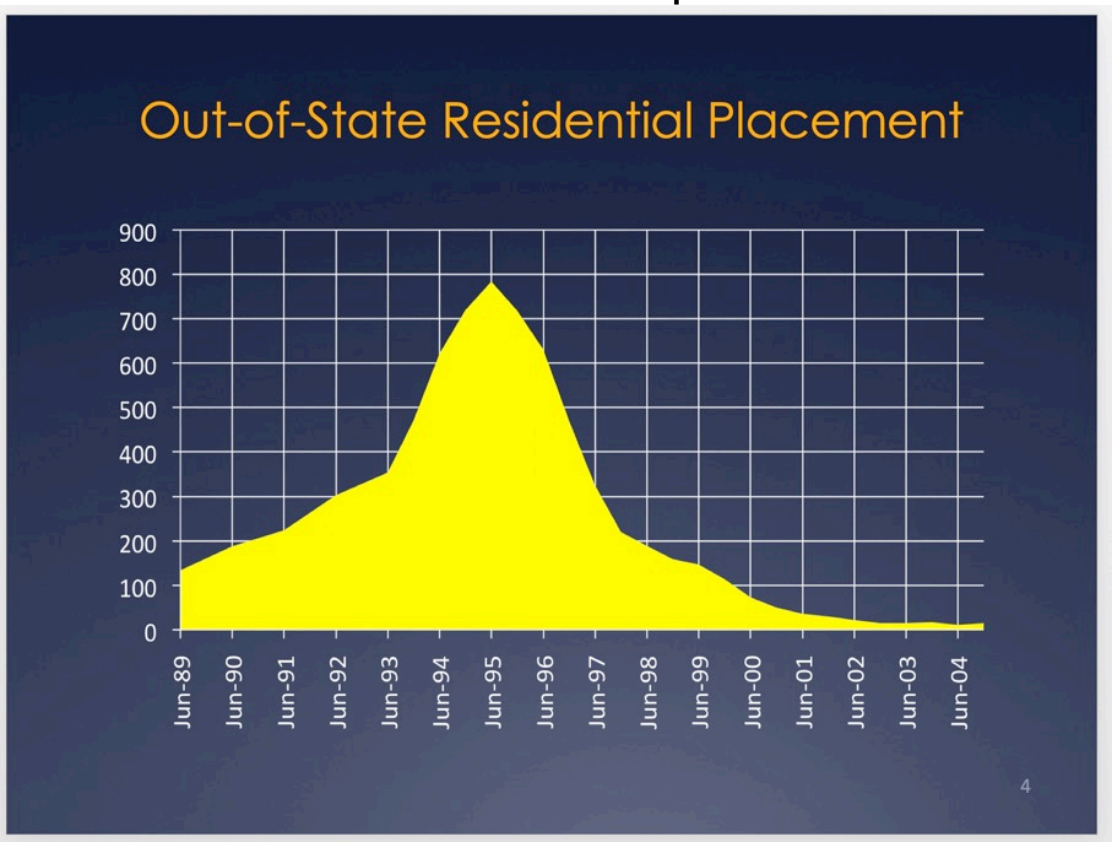
[1] *Dateline NBC* broadcast a review of Illinois' efforts to return these children in1998. At that time, about 600 DCFS wards had been returned to Illinois, with the remaining 200 brought back within the next year. The *Dateline NBC* program can be viewed online at the following video hyperlink: ***https://www.youtube.com/watch?v=lTpVZJ9xAHQ***

Illinois DCFS' use of out-of-state residential placements.



Source: Illinois Department of Children and Family Services

While a discussion of what Oregon might learn from Illinois' public policy mistakes in outsourcing treatment of its children to other states is a subject for another day, let me respond to your request for specific information about some of the residential treatment centers or corporations that are currently serving Oregon children who were referred by the Department of Human Services.

As we discussed a few weeks ago – and in our conference call last week with Ben Wolf at the ACLU in Chicago – my UIC staff and I encountered some of these same entities during our reviews for DCFS and the ACLU between 1994-2014. More recently, I also provided a follow-up data analysis in 2018 regarding one of these corporations for the ACLU's legal team that monitors compliance with the federal court consent decree.[2]

[2] Since my retirement from UIC (and relocation to Oregon) in 2014, I've continued to consult with the ACLU in support of its longstanding efforts to enforce the requirements of the federal court consent decree to ensure the quality of care provided to DCFS' wards in institutional settings.

Most recently, that ongoing consultation included: (1) a 2018 review of **Acadia Healthcare**, one of the corporate providers currently used by Oregon's DHS; and (2) an evaluation of risks of harm to DCFS wards in a substandard Illinois psychiatric hospital, which was subsequently filed by the ACLU for an emergency hearing in U.S. District Court in Chicago.

Both of these 2018 consent decree-related items are considered public documents by the ACLU, so I have attached them here – at your request, and with the approval of Mr. Wolf – as relevant background information in support of your legislative oversight responsibilities.

Similarly, I have also included here an updated account of actions that have been taken by federal and state healthcare, child welfare or law enforcement agencies – including the U.S. Department of Justice – when incidents involving mistreatment, negligence or harm to children have occurred in certain facilities.

Finally, I have offered a number of recommendations – based on the model developed by UIC during our work under the federal consent decree for 20 years in Illinois and other states – suggesting ways that my Oregon DHS colleagues might conduct more effective on-site monitoring of the various types of institutional settings where children have been placed for treatment.

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Oregon's utilization of out-of-state RTCs.
While the list of recent and/or current out-of-state RTCs utilized by the Department of Human Services includes 86 DHS clients distributed across 21 facilities and 13 states, the ownership of these facilities includes only three corporations, each with performance histories that ought to be of concern to Oregon officials: [3]

- ***Acadia Healthcare*** **(10 clients)**
- ***Universal Health Services*** **(2 clients)**
- ***Sequel Youth and Family Services*** **(74 clients)**

As shown in previous reviews conducted by federal and state healthcare investigators or law enforcement agencies, as well as in accounts by news media organizations, each of these national corporations have presented an array of troubling performance histories – often involving substandard quality of care, physical and sexual abuse, and ineffective or worthless treatment services. Moreover, in several well-documented cases, including reviews that were conducted on behalf of DCFS and the ACLU by my UIC program, investigators also found evidence of a pattern of unlawful activities or healthcare fraud.

- **I. Acadia Healthcare**, based in Tennessee, is operated by the same corporate senior management team that formerly headed **Psychiatric Solutions Inc.** (PSI), which was acquired by UHS in 2010. PSI's CEO and senior management team then created Acadia Healthcare, drawing upon their hedge fund investors to grow their newly-created operation from the initial six facilities to a current network of around 600 behavioral health facilities covering 40 states.

  Even a cursory review of the publicly available data on Acadia's current RTCs and hospitals (and especially the now-defunct PSI), however, should have given DHS officials pause before authorizing the placement of Oregon children at risk of harm in any healthcare facility operated by a management team with this sort of worrisome performance history, as evidenced by the following case examples.

  - **Seeking Alpha.** Among the most recent analyses of Acadia's operations is a recent review by a respected Wall Street investment advisory group, *Seeking Alpha*, which tracks stock performance and other matters related

[3] While you are already familiar with the recent report published by Disability Rights Washington – "*Let Us Come Home*" – a critical review that detailed findings by DRW's investigators at one of the RTCs utilized by Oregon, the Sequel-operated ***Clarinda Academy***, the background issues regarding the major corporations that dominate this industry also need to be examined.

I noted that many of DRW's findings evidenced the same troubling pattern of risks of harm to children that marked similar facilities operated by the former ***Youth Services International*** – which was then headed by some of the same corporate team that now runs ***Sequel Youth and Family Services*** – a connection that ought to raise additional concerns for Oregon child welfare officials. S*ince 74 of the 86 DHS clients were placed with Sequel-operated programs spread across 7 states*, I will discuss the relevance of this troubled corporate history below.

to companies that are publicly traded, as indicated in this 2018 comment taken from its online website.[4]

> *At Acadia, not only are there undisclosed criminal indictments and convictions of former employees for the death or assault of patients, but we found allegations that Acadia has:*
>
> - *Destroyed evidence*
> - *Falsified documents*
> - *Duped regulators during audits*
> - *Covered up incidents of patient abuse*
> - *Submitted fictitious billings to the government*
> - *Failed to disclose regulatory investigations at certain facilities*
> - *Retaliated against multiple whistleblowers*

- **Disability Rights Ohio.** Similar to the DRW findings in Washington about the Sequel RTC in Iowa, DRO investigators also discovered a pattern of substandard quality of care at the Acadia-operated ***Ohio Hospital for Psychiatry***, including sexual assaults, physical abuse and other harmful incidents and quality-deficit problems within the hospital.[5]

  Relevant DRO findings can be summarized in the following comments from their published report:

  > *"The troubling results from Disability Rights Ohio investigations that persisted at OHP despite ongoing involvement from OhioMHAS, include:*
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  > - *Substantiated allegations of sexual and physical abuse*
  > - *Failure to provide treatment in a trauma-informed setting for survivors of sexual abuse*
  > - *Failure to request basic medical records and provide appropriate care, resulting in one case of a patient being placed on emergency life support*
  > - *Using seclusion in an unsafe manner and outside of licensure requirements*
  > - *Incomplete treatment and discharge plans, placing patients and the public at risk*
  > - *Using hurtful, outdated and stigmatizing diagnostic language (e.g. retarded) in patient records*

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[4] The full Seeking Alpha report on Acadia Healthcare can be found here: ***http://www.aureliusvalue.com/research/acadia-healthcare/***

[5] The full DRO report on problems at this Acadia facility in Ohio can be found here: ***https://www.disabilityrightsohio.org/dro_report_problems_at_ohp***

"From the time Acadia assumed ownership of OHP, the facility has been repeatedly cited and placed on numerous plans of correction (POCs) by the OhioMHAS for serious concerns. Plans of correction are required to correct violations of Ohio law OhioMHAS finds. Since January 2016, OhioMHAS has conducted at least 10 on-site surveys for either complaint investigations or to try to validate plans of correction.

"The Department's findings in this letter are consistent with DRO investigation results, noting a lack of medical oversight, physical and sexual abuse, the failure to report this abuse and even OHP's inability to provide basic care to patients:

"Despite the Department's ongoing efforts, ***serious issues persist related to the Hospital's ability to competently provide emergency care and treatment to patients*** *who are medically compromised or have a sudden decline in their medical condition; proper medical oversight of patients by the medical director of Hospital physician;* ***allegations of physical or sexual abuse****; and failure to notify the Department of Reportable Incidents and when notified,* ***failure to report*** *in a timely manner."*

"OHP has demonstrated, over a significant period of time, an inability to provide services in a safe and effective manner.

"Indeed, the public would be outraged if these issues arose at a general medical center. People receiving psychiatric care deserve no less, and Disability Rights Ohio expects that Ohio's regulators will take appropriate and strong steps to ensure that patients are no longer neglected or harmed by this facility."

- **Report to the American Civil Liberties Union on Acadia Healthcare.** In February 2018 I was asked by the Legal Director of the ACLU of Illinois to conduct a brief review of available information on Acadia Healthcare's quality of care record in certain RTCs and psychiatric hospitals around the U.S., and I am attaching a copy of that report below.

  In brief, the ACLU was concerned that Illinois child welfare officials had begun to again utilize certain out-of-state residential treatment facilities, mostly run by Acadia, for a small number of its wards; this despite the fact that DCFS had successfully terminated the use of such distant RTCs in the 1990s (after returning nearly 800 children to far more appropriate in-state placement settings or foster/relative/parental care in Illinois).

  The attached 10-page summary report of my findings to the ACLU – which also includes several hundred pages of supporting materials (i.e., investigative reports, summaries of federal surveys by the Centers for Medicaid and Medicare Services, and various news media accounts of adverse conditions or occurrences at Acadia facilities – is consistent with similar problems identified by Seeking Alpha and Disability Rights Ohio.

Exhibit 91 and Acadia. Moreover, the 2018 report to the ACLU includes a summary of a document that was presented to me in 2014 by attorneys for plaintiffs during a deposition in Chicago in a federal court case against the former management team at the now-defunct PSI. ***In other words, the same senior executives who are now responsible for Acadia Healthcare were being sued by investors, who felt defrauded upon learning (in news media reports) of substandard patient care at PSI – which caused a 35% single-day drop in PSI's stock price.*** [6] [7]

Exhibit 91 is an internal PSI corporate document, written by the CEO of a Chicago psychiatric hospital that was then under review by my UIC team after children referred by DCFS were found to have suffered harm at the facility. Among the shocking allegations memorialized by the CEO in this account to her corporate-level manager, Exhibit 91 listed the following:

- The CEO identified the hospital as "*a façade peppered with deceit*."
- The hospital had "*not reported allegations"* of harm to patients to DCFS or the police.
- Administrators "t*ampered with evidence on reported rape cases*."
- Video evidence of serious incidents were often "*not being reported*" or shown to DCFS.
- "*Poor quality*" of patient care existed "*from top to bottom*."

Moreover, the CEO charged that PSI's corporate president—identified by name in this 2008 memo, and the same person who later started Acadia – was "*infuriated*" by the news media coverage of violence and rapes, saying that he "r*efuses to see the problems,*" and indicating that he and other PSI corporate officials were deliberately "*ignoring the risks*."

It is worth noting that the defendants and their representatives in this case ultimately chose to settle with plaintiffs for **$100 million dollars,** a sum that included $35 million dollars in legal fees, rather than risk going to trial in open federal court.

In fact, had they chosen that option, Exhibit 91 and other such evidence – which clearly indicated a reprehensible practice of knowingly placing vulnerable children in harm's way in order to increase corporate profits – would then have become unsealed at trial, thereby revealing the sort of business model that likely could not withstand the glare of public scrutiny.

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[6] See: *Garden City Employee's Retirement System vs. Psychiatric Solutions.*

[7] The memo identified as Exhibit 91 – marked as *PSY-E-001162618-19* – still remains under seal in the federal court filing, and was dated September 18, 2008.

- **Why is Exhibit 91 relevant to risks of harm to Oregon children?**

  Stated bluntly, child welfare officials need to understand that there is a compelling body of evidence indicating that certain types of corporations simply cannot be relied upon to tell the truth, especially when adverse events occur in institutional settings where children have been entrusted to their care by agencies like Illinois' DCFS or Oregon's DHS.

  This caveat holds true as well for monitoring agencies acting on behalf of child welfare officials – such as the local monitoring groups contracted by DHS to check on the 86 Oregon children placed in out-of-state facilities – just as it applied to my UIC team when we were investigating the corrupt Chicago hospital in 2008 that was the subject of Exhibit 91.

  > Specifically, at my deposition for this federal lawsuit, a plaintiffs' attorney asked me whether the hospital CEO had ever given me a copy of Exhibit 91 as part of UIC's document-production requirements during the review process, or whether she had conveyed any of the information contained in the memo to me in any way.
  >
  > I replied that no one at the hospital had provided the UIC team with this memo – *a document that we would have considered highly relevant to our ability to determine whether children were safe from harm and receiving appropriate mental health treatment* – *nor* had anyone told us about the troubling information contained in Exhibit 91.
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  > Such material omissions indicated that hospital and corporate officials had, in effect, knowingly lied to the UIC team –withholding critical data during the course of an investigation that was being conducted on behalf of a state agency, a review that was also initiated pursuant to a federal court consent decree.
  >
  > Since I viewed this deception as a deliberate effort to obstruct our work during the review process, I immediately notified DCFS and the ACLU about Exhibit 91. I also informed Department of Justice officials, who were then conducting a related criminal investigation.
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  > Finally, as I noted in the attached 2018 memo on Acadia to the ACLU, two years before Exhibit 91 was written, Virginia moved to revoke the license of a PSI facility in Charlottesville after health officials found ***"multiple violations constituting neglect" of children in care, including sexual abuse by staff."*** The revocation letter cited "inadequate staffing" as a direct cause of patient harm in a serious incident of violent assault (in which a young boy was beaten so badly that he reportedly stopped breathing temporarily and suffered a seizure).

Virginia investigators later concluded that "*in spite of the concerns nursing staff voiced about the severity of his injuries, administrative staff directed nurses not to call emergency services. According to nursing staff, in a meeting held the day after the assault,* ***[the PSI] administrators stated that they did not want 911 called because of concerns that the State might find o*****ut."**

- In sum, whether operating as Acadia or the former PSI, these corporate officials learned how to carefully target a profitable market where adverse events and negative outcomes often go unreported to (or undetected by) regulatory agencies that are normally charged with oversight authority. In effect, there is typically little or no "downside" when "bad things happen" in such facilities, other than the occasional news media story, which usually gets treated as a minor distraction before returning to business as usual.

  Taking an even more cynical view – as do many of the child welfare advocates, ACLU attorneys, judges and law enforcement investigators who have worked this beat for many years – there is ample evidence that such corporate executives also understand the perverse *low risk/high profitability equation* when targeted customers are mostly public-sector mental health or child welfare agencies, many of which have limited options or resources for finding beds in institutional settings that are willing to take "difficult kids."

  UIC reviewers discovered that problem early on during a 2009 investigation of what was then a PSI-operated psychiatric hospital in Chicago, which included an examination of an array of corporate records and financial statements.

  - Of particular interest, the transcript of a *Q3-2009 Earnings Call* for investors contained a telephone exchange between the company's chief accounting officer and an investment analyst regarding payment of bonuses to local hospital administrators. The CAO emphasized that bonuses are paid on the basis of expected profitability at each facility: **"*We don't meet expectations, we don't expect to pay out.*" [8]**

[8] The CAO failed to inform investors, however, that one of the ways the CEO of the hospital under investigation likely ensured both profitability and her annual bonus was to defer installation of a needed hot water booster system to replace one that barely produced lukewarm water – a decision that raised serious and immediate public health consequences.

At that time, UIC reviewers discovered an outbreak of two highly communicable diseases – *Shigella and Strep A* – that had spread to dozens of patients and staff throughout the building. Disregarding the fact that the most important preventive step in containing the spread of such diseases is washing hands in hot and soapy water, the CEO and her entire medical staff – *according to the minutes of the Medical Executive Committee that the UIC team examined* – decided that the new hot water system could wait until the next fiscal year: in other words, *a case of profitability trumping public health safety*.

UIC also discovered that neither the hospital CEO or the medical director had notified the Illinois Department of Health about this communicable disease outbreak, as was required by state law. IDPH surveyors later concurred with the UIC finding about this serious infection control violation.

- Equally instructive, in terms of *corporate attitude*, were the comments made on that same conference call by the CEO – *who later went on to create and head Acadia Healthcare's new hospital and RTC empire*.

  On the audiotape and transcript of the conference call, the future Acadia Healthcare CEO can be heard boasting to investors about the profitability of the company's unique market composition of **"*Medicaid and state agency kids"*:**

  > **"*60 percent of our patients are children and adolescents, and they don't have co-pays and deductibles. [If] I started to see... co-pays and deductibles on Medicaid or state agency kids, I would get concerned, but so far, I haven't seen that. So all of that population would be fully covered."***

While most major healthcare corporations in the United States are not known for generously embracing such massive numbers of Medicaid and state agency kids (or even the average Medicare patients, for that matter) to profitably enhance the composition of their patient mix, certain players understand how to maximize the financial rewards of a captive market: ***children who have nowhere else to go*.**

Update to Memorandum of March 6 regarding Acadia.
On March 7, 2019, the *Chicago Tribune* published a page-1 article on an Acadia RTC near Chicago – headlined *"6 women sexually abused by counselor at women's rehab center Timberline Knolls, prosecutors say"* – which detailed a longstanding pattern of sexual assaults and abuse of patients at the facility, including reports by prosecutors that Acadia administrators actually delayed notifying law enforcement officials of these incidents for several weeks – and then only after Acadia officials learned that police already were investigating complaints by patients.

According to the Tribune:

> *A police detective asked a Timberline administrator why Timberline had waited at least the three weeks since July 16 to report [the employee's] potential crimes.* ***The administrator explained to police that administrators of individual Acadia facilities "have to contact corporate with these matters and corporate tells them to investigate and investigate more before they are allowed to call police," according to a police report released to the Tribune under open records laws.***
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> *The detective told the administrator that "delayed reporting can greatly affect the outcome of a criminal investigation," according to his report. She "stated she understood but she was bound by corporate's instructions and policies," the police report said.*[9]

[9] Chicago Tribune, page-1; March 7, 2019.
https://www.chicagotribune.com/news/watchdog/ct-met-timberline-knolls-assaults-20190212-story.html

Stated plainly, the same corporate practices laid out in Exhibit 91 by the PSI hospital CEO – *including failing to notify law enforcement when patients are raped or sexually molested* – now appear to have resurfaced as "*corporate instructions*" issued by the same Acadia senior executive(s) who previously owned and operated PSI.

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- **II. Universal Health Services**, based in Pennsylvania, is the largest operator of private, for-profit, psychiatric hospitals in the U.S. Additionally, the company operates a large number of behavioral health RTCs, including a facility where the DHS list indicates two Oregon clients were placed: ***Provo Canyon School***.

    - UHS was charged by the U.S. Department of Justice and the Attorney General of Virginia with healthcare fraud at one of its residential treatment centers, Keystone Academy. In that case, the government alleged a scheme that included poor quality of patient care, record falsification, ***and keeping youths unlawfully confined in the facility for extended lengths of stay in order to maximize financial profits.***

      The scathing press release issued by the Department of Justice, when this case was initially filed in 2010, laid out the government's position:

      > *"We intend to prove that these defendants billed Medicaid for providing troubled children with much needed psychiatric medical care when, in fact, they provided no such service,"* [said the United States Attorney for the Western District of Virginia].
      >
      > *"We will not sit idly by and allow healthcare providers to take advantage of troubled children in order to feed their own desire for wealth. The Medicaid system was designed to help the most vulnerable among us,* ***not to line the pockets of fraudsters****."*[10]

      In light of the overwhelming evidence of harm to patients that was laid out by the government, UHS officials later agreed to close this Virginia RTC, **in addition to paying a fine of nearly $7 million dollars.**

    - Nor was this the only UHS facility where child welfare systems learned that their clients were receiving substandard or even dangerous care. In fact, I informed the Department of Justice about evidence of a similar pattern of harm to patients and record falsification that the UIC team uncovered during a 2011 review at a large UHS hospital in Chicago.[11] [12]

      DOJ officials subsequently requested all of the data and patient records that my UIC team had gathered on UHS's operations in Illinois, and we turned over 20 boxes of such evidence to the FBI in 2012. DOJ later opened a nationwide criminal investigation of UHS in Illinois and a dozen other states, and that probe is still ongoing. [See page 12, below.]

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[10] U.S. Department of Justice press release; March 2, 2010: ***https://www.justice.gov/opa/pr/us-files-complaint-against-virginia-medicaid-providers***

[11] Both the director of DCFS and the ACLU were aware that DOJ officials requested any and all evidence, patient records, notes or other materials from the reviews conducted by UIC.

[12] A copy of one of the UIC reports on this Chicago UHS hospital is attached. See also the related *Chicago Tribune* article detailing the findings by the UIC team.

Among the findings that the UIC team detailed in the reports to DCFS and the ACLU about the UHS hospital in Chicago were:

- a consistent pattern of physical and sexual assaults on patients;
- inadequate staffing levels to ensure patient safety;
- poor quality of direct-care nursing staff training and supervision;
- falsification of medical records to conceal harm to patients;
- withholding information or lying to DCFS as part of the efforts to cover up or minimize adverse events at the hospital.

- While the findings by the UIC team during the course of its review at this Chicago hospital are troubling, it should be instructive for child welfare agencies that a nearly identical cluster of quality of care failures was routinely observed in other UHS facilities, both hospitals and residential treatment centers.[13]

  This consistent corporate practice of substandard treatment services and harm to patients is shown in publicly available reports by state and federal healthcare officials across the U.S., as well as in the 2010 federal court complaint brought by the Department of Justice and the attorney general of Virginia:

  - Inadequate treatment/discharge planning issues;
  - Inadequate staffing, including failure to monitor patients;
  - Violence or risk of harm from other patient safety issues;
  - Restraint usage issues, including inadequate staff training;
  - Clinical care issues, including substandard quality of treatment and lack of required documentation of treatment services.

- Of particular relevance, therefore, is the abundance of evidence from these other states indicating that such problems at UHS facilities tend to reoccur with alarming regularity.

  In fact, when UIC reviewers later conducted interviews with informants in a dozen other state agencies – ***Virginia, Tennessee, Pennsylvania, North Carolina, California, South Carolina, Massachusetts, Texas, Connecticut, Nevada, Arkansas and Missouri*** – *each of which had* tracked various UHS facilities over a period of years, there seemed to be a consensus about why these critical problems were never fully resolved.

[13] Attached below, as part of the action recommendations that you requested, is a redacted copy of the Corrective Action Plan (CAP) that UIC and DCFS reviewers used to evaluate compliance with the required improvements in patient care.

On the one hand, we were told, local facility administrators often appeared to lack basic knowledge and management skills needed to address such difficult issues; on the other hand, some observers felt that UHS corporate-level management expectations likely made effective and sustainable problem-resolution unreliable at best.[14] [15]

- In other words, local administrators who were charged with hands-on responsibility for ensuring the safety and well-being of children placed in their facilities – *such as the hospital CEO who later wrote the accusatory Exhibit 91* – were essentially prevented by corporate pressures from carrying out their basic *"duty of care*" to their patients.[16]

- Child welfare agencies that utilize such questionable facilities place their clients at extreme risk when they fail to conduct the sort of due diligence that might otherwise reveal the insidious pressures behind the unethical behaviors seen in an element of this for-profit healthcare industry.

  Simply relying on accreditation organization like JCAHO, or even the use of local monitors, offers insufficient (and often misleading) assurances that children placed in out-of-states settings will be kept safe from harm, and this will be discussed further in the recommendations offered below.

- Finally, while the Department of Justice criminal investigation of UHS' operations around the country is still ongoing, it is worth noting what the company's own employees – as well as a number of national political leaders – have said about the available data on its patient care record.

  > According to a *BuzzFeed News* investigation — *"based on nearly 300 interviews, including 175 current and former employees of the company, as well as a cache of internal documents — employees of 10 hospitals said they were under pressure to fill beds by methods that included exaggerating people's symptoms and distorting their*

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[14] One state agency official used the term "*intransigence*" to describe the repeated failure by UHS corporate officials to own up to their unwillingness or inability to provide adequate resources and leadership for a hospital that had been "teetering on the brink" for a number of years.

Indeed, the former attorney general of Connecticut, Richard Blumenthal, now a U.S. Senator, put the question in terms of "*a moral, if not legal, responsibility*" of UHS officials to meet their obligations to patients.

[15] Selected copies and relevant data regarding the UIC reports on UHS are attached below, in addition to news media clips and other reports by federal and state investigators who have examined problems related to substandard or fraudulent services.

[16] In this context, officials and staff of hospitals or healthcare corporations owe a "***duty of care"*** – a basic concept understood as ***a legal and moral obligation of one party to act in the best interests of another*** – setting aside hidden agendas that might conflict with patients' rights to receive appropriate and effective treatment in a safe environment.

words to make them sound suicidal. UHS said it provides excellent care that has earned accolades."

"Sen. Elizabeth Warren of Massachusetts denounced UHS's alleged conduct. 'People seeking mental health services deserve high-quality treatment — not abuse at the hands of companies that are locking patients up to turn a profit and defraud taxpayers,' she told BuzzFeed News. 'The Department of Justice must put an end to these shameful practices for the safety of patients both here in Massachusetts and across the country.'" [17]

Similar comments on the risks of harm to patients at UHS facilities were made by Rep. Joseph Kennedy (D, MA) and Rep. Danny Davis (D, IL), who issued a joint letter in 2015 to the director of the federal Center for Medicare and Medicaid Services.

The Kennedy/Davis letter cited the 2011 review conducted by my UIC program at a Chicago Area UHS hospital, noting the findings indicating hospital staff were threatened that **"*anyone suspected of providing information to the UIC reviewers would be fired*."** [18]

- Since this alleged behavior essentially mirrors the same sort of unlawful practices that the Department of Justice discovered in the Virginia case from 2010-2012, referenced above – and replicated as well in many of the previously cited examples from Acadia's operations – it would seem that what we are observing here is a business model that underscores how a certain element within the child welfare industrial complex continues to operate without effective oversight and monitoring.

  Stated in program operational terms: ***this is a feature, not a bug.***

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[17] "*Lawmakers Sound Alarms On UHS Psychiatric Hospitals.*" BuzzFeed News, December 9, 2016. ***https://www.buzzfeednews.com/article/rosalindadams/lawmakers-sound-alarms-on-uhs-psychiatric-hospitals#.dp71oNNLo***

[18] A copy of the joint letter from Rep. Kennedy and Rep. Davis is attached.

- **III. Sequel Youth & Family Services (aka *Youth Services International).***
  In its previous corporate incarnation, Sequel Youth & Family Services was known as ***Youth Services International (YSI),*** a for-profit company that specialized in residential programs for juvenile justice populations. Some of the YSI programs were located in Florida, Maryland, Nevada Georgia and Texas – facilities where federal and state investigators later identified a pattern of physical and sexual abuse of youths who had been placed for treatment by juvenile justice and child welfare agencies around the U.S.

    - Countless investigative journalists from major national and local news media organizations published reports on such harmful conditions at YSI programs, including a lengthy and extensively well-documented article – ***Prisoners of Profit: Private Prison Empire Rises Despite Startling Evidence of Juvenile Abuse*** – which appeared in *The Huffington Pos*t in October 2013.[19]

    - Further, among the lawsuits brought against YSI officials, one in particular – ***D.M. vs. Youth Services International and JFS Holdings*** – a federal civil rights complaint alleging harm to youths in care, including sexual abuse by administrators and staff, is perhaps most instructive for any discussion of how state agencies have often failed to exercise effective due diligence when placing children in out-of-state settings that are not easily monitored for quality of care.[20]

  It should be noted that the co-founder of YSI is James Slattery, of the same "*JFS Holdings*" named above in the *D.M.* civil rights complaint. *The Palm Beach Post* wrote a disturbing 2014 account saying that the U.S. Department of Justice found one Florida juvenile detention center (at the time that Slattery was running YSI) had ***triple the rate of sex abuse as the statewide average,*** adding that ***"a YSI-run facility in Georgia had the highest rate of sexual misconduct reported by jailed juveniles anywhere in the nation."*** [21]

  The Post also quoted a Palm Beach Circuit Court Judge's view that ***"conditions [at the YSI facility] just spiraled out of control."*** For Florida officials to award YSI any new contracts, the judge wrote, "is a travesty."

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[19] "*Prisoners of Profit: Private Prison Empire Rises Despite Startling Evidence of Juvenile Abuse.*" Huffington Post: ***http://projects.huffingtonpost.com/prisoners-of-profit***.

[20] The federal court complaint for *D.M. vs. Youth Services International* can be examined at: ***https://www.documentcloud.org/documents/842115-federal-abuse-suit-ysi.html.***

[21] "*Violence, abuse investigations don't stop juvenile jail operator from raking in state contracts." The Palm Beach Post;* March 22, 2014. ***https://www.palmbeachpost.com/news/violence-abuse-investigations-don-stop-juvenile-jail-operator-from-raking-state-contracts/aeFGA3e3BkFFIlXgyFMtcl/***

Additionally, the *Miami Herald* said that **"*for sheer volume of alleged brutality, few programs could match [YSI's] Palm Beach Juvenile Correctional Facility at its low point*."**

Of special interest is an investigative series by a journalist colleague of mine, Carol Marbin Miller, a senior *Miami Herald* reporter and a Pulitzer Prize nominee, with whom I've worked to examine child welfare and mental health policy issues for over 25 years.

In a 2017 article that was published by the Center for Health Journalism at the University of Southern California, in conjunction with USC's Annenberg School for Communication and Journalism, she detailed a pattern of allegations at YSI's Palm Beach facility that seemed **"*straight out of Oliver Twist.*"** [22]

> *"Teens said there were maggots in the food… The youths wore threadbare and filthy clothing. They lacked soap, toothpaste, deodorant, socks. The medical care was lousy, toilets overflowed and the buildings were crumbling. Officers choked and punched them."*
>
> *"For discipline and diversion, workers organized fights among the detainees. And sometimes they bet on them."*

The other co-founder of YSI, and now the chairman of Sequel Youth & Family Services, John ("Jay") Ripley, indicates on Sequel's current website that he was previously a "*founding stockholder, president, CFO and COO of Youth Services Internationa*l," so there is a demonstrable (and personal) connection between the executive leadership structure and reported behaviors of these two corporations.

Indeed, this connection between Sequel and YSI management also extends to ***Clarinda Academy****, according to a 2017* Securities and Exchange Commission filing, which shows that Ripley and two other senior Sequel executives (including Sequel's current vice president for marketing) have long ties to the Iowa facility, ***the subject of the 2018 DRW report and the program where four Oregon DHS children have been placed.***[23] [24]
Upon closer examination of the YSI/Clarinda historical connection, it became apparent that Clarinda Academy was, in fact, a fully YSI-operated facility since 1992 – under the management of ***Youth Services International of Iowa, Inc.*** – before it was later acquired by Sequel.[25]

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[22] ***https://www.centerforhealthjournalism.org/fellowships/projects/juvenile-justice-program-staffers-set-fights-—-and-then-bet-them***

[23] Link to Sequel website: ***http://www.sequelyouthservices.com/executives/jay_riply.php*.**

[24] According to a required 2017 SEC 14-A filing: "*During his seven years being employed with* ***Youth Services International****, [the Sequel vice president] served… as the* ***Clarinda Academy*** *Admissions Director, Regional Admissions and Marketing Director, and the National Marketing and Business Development Director.*"

[25] ***http://www.fundinguniverse.com/company-histories/youth-services-international-inc-history/***

Given the public notoriety of YSI for operating substandard, violent and abusive RTC programs in a number of states, this demonstrable YSI/Sequel connection involving its most senior managing executives ought to raise additional concerns for Oregon DHS officials.

In fact, more recent news media reports about a Sequel-operated RTC in Utah – **Red Rock Canyon School**, where DHS placed 28 clients – clearly suggest that Clarinda Academy is not the only Sequel facility where Oregon children may be at risk of harm, as these headlines indicate:

- ***"Sex abuse victim sues Red Rock Canyon School for allegedly failing to protect students from sexual predator."*** [26]
- ***"Second victim says a Utah school's employee sexually abused him."*** [27]
- ***"Youth center employee sentenced in sex abuse case."*** [28]
- ***"Youth treatment center staffer charged in drug case: Provided marijuana to a teen at the treatment facility for troubled youths."*** [29]

Also of interest is the transcript of a 2007 Congressional Hearing in Washington before the House Committee on Education and Labor – ***Cases of Child Neglect and Abuse at Private Residential Treatment Centers*** – during which witness testimony was provided regarding occurrences of child deaths in RTCs around the United States, including Red Rock.[30] [31]

Complicating the ability of state agencies and/or families to hold such residential treatment facilities accountable for negligent acts or harm to children, program administrators know that the presumed dearth of available beds for certain types of clients (who are often labeled as "difficult" to treat) gives them leverage when adverse events occur. In effect, harmful incidents may go unreported or injured

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[26] *The Salt Lake Tribune*; January 23, 2018. https://www.sltrib.com/news/2018/01/23/sex-abuse-victim-sues-red-rock-canyon-school-for-allegedly-failing-to-protect-students-from-sexual-predator/

[27] *The Salt Lake Tribune*; March 9, 2018. Order on discovery motion ***https://www.sltrib.com/news/2018/03/09/second-victim-says-a-utah-schools-employee-sexually-abused-him/***

[28] *The Spectrum;* June 5, 2014. ***https://www.thespectrum.com/story/news/local/2014/06/05/youth-center-employee-sentenced-sex-abuse-case/10049963/***

[29] *The Spectrum;* December 22, 2015. ***https://www.thespectrum.com/story/news/2015/12/22/youth-treatment-center-staffer-charged-drug-case/77773698/***

[30] Transcript of Congressional Hearing before the House Committee on Education and Labor. ***https://www.govinfo.gov/content/pkg/CHRG-110hhrg38055/html/CHRG-110hhrg38055.htm***

[31] See: *Lank v. Red Rock Canyon School*; United States District Court for the District of Utah. ***https://casetext.com/case/lank-v-red-rock-canyon-school-3***

parties or agencies may simply be "persuaded" that they have few options other than to leave such children in the care of programs that market their services as the only available treatment solution for otherwise "untreatable" (*and typically unwanted*) clients.

Such was the case with the family of a 12-year-old rape victim sent to an earlier version of Red Rock, as detailed in a Utah federal court complaint: [32]

- *"**Red Rock** was dangerous and debauching. Defendants allowed other students to beat and berate [name of 12-year-old victim redacted], even to urinating on his clothing and effects. [The victim] begged his mother for freedom and his mother asked Defendants to release him. Defendants talked her out of it by promising to move him to a safer place."*

  "Defendants moved [the victim] in with two much older boys who were adjudicated sex offenders, one of whom, [name redacted], that night raped [the victim] while Defendants slept. Defendants concealed the attack and covered it up while trying to talk [the victim] out of reporting it."

Despite the evidence of negligent acts by RTC staff, which provably resulted in harm to the victim, the court disallowed the complaint on technical grounds – specifically, "*the plaintiffs were not able to show any other kind of connection between the school and the state"* – as noted in a 2006 court citation:[33]

- *The plaintiffs, the parents of a student at a private "specialized boarding school for 'at-risk' youths," sued under § 1983 and a number of state tort law doctrines after their son, "CR," was molested by another boy in the program's student housing.*

  *The school, **Red Rock**, had explicitly promised CR's parents that none of its students were sexually deviant before they enrolled him in the program. After placing CR in a housing unit where other students physically and emotionally abused him and subjected him to sexual humiliation for a month, Red Rock transferred him to another unit inhabited by two older students that staff knew were sexual predators. The very night that CR was moved to the new unit, he was molested by one of the older students living there.*

  Red Rock attempted to cover up what happened, and delayed notifying both CR's parents and the authorities.

  While Red Rock received significant amounts of state funding, the plaintiffs were not able to show any other kind of connection between the school and the state.

  The court held, based on clear precedent, that funding alone was not sufficient to establish state action… Furthermore, it concluded that Red Rock was not liable under § 1983 because no governmental entity had "directed, controlled

[32] *Burton v. Red Rock Canyon School.* United States District Court for the District of Utah. ***http://www.heal-online.org/redrocklawsuit.pdf***

[33] See: ***https://autistichoya.files.wordpress.com/2016/04/neumeier-jrc-and-federal-civil-rights-act.pdf***

or influenced" the school's decisions to house CR with sexual predators and to cover up the fact that he had been molested by another student.

While *Burton v. Red Rock* was resolved against the parents of this child because of a curious twist in federal court precedents regarding the "source of funding" for the placement referral, state agencies that place children at demonstrable risk of harm in institutional settings have no such shield of protection from litigation.

Indeed, Oregon's Department of Human Services has already endured a number of high-visibility civil rights lawsuits and settlements in cases where children were sexually or physically abused in foster care settings, or otherwise traumatized because of alleged failures of oversight and monitoring by agency caseworkers.

Whether fair or not, the default legal argument (as well as public perception) is that state agencies either ***knew or should have known*** about such potential risks of harm when deciding to entrust children to the care of others – a premise that is compounded when children are sent to faraway states and institutional settings that have repeatedly demonstrated they are unworthy of such trust.

Given the discoveries about the Sequel/Clarinda program in Iowa spotlighted by the 2018 report from Disability Rights Washington, then, it is likely only a matter of time before Oregon child welfare officials are confronted with legal challenges involving some of the 86 children whose names appear on the list of out-of-state placement decisions.

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Update to Memorandum of March 6 regarding Sequel.
On February 22, 2019, CBS affiliate *WVLT* in Kingston, Tennessee, broadcast a story about a Sequel-operated facility (***DCS: Children removed from Kingston Academy due to 'concerns'*).** According to the lead and accompanying video: "*Tennessee's Department of Children's Services is removing 18 children, ages five to 17, from Kingston Academy in Roane County…* The children have been moved to other placements. DCS said they are investigating concerns. [34]

Similarly, the NBC affiliate *WBIR* followed the DCS action, but also reported 150 police calls to the facility since 2018, mostly to handle disruptive behaviors and runaways but also reported assaults.[35]

Of particular interest, *The Courier News* also reported on the Department of Children's Services decision to remove Tennessee youths from the facility and place an intake hold on new admissions (***"Kingston Academy Under DCS Investigation"***).[36]

> *"According to the communications department at the Tennessee Department of Children's Services, DCS suspended admissions to Kingston academy on Wednesday.*
>
> ***"Kingston Academy… is owned by Sequel Youth and Family Services, the same people that run Norris Academy in Norris.***
>
> *"DCS removed 18 youth from the group home who were originally placed at the academy through DCS. The department is investigating."*

NOTE: Since the list of Oregon children in out-of-state placements indicates that DHS made one referral each to the Kingston and Norris facilities, it would seem reasonable to inquire whether Tennessee officials notified their Oregon counterparts of the emergency decisions regarding this Sequel program. The same question ought to be raised about whether Sequel officials notified Oregon DHS of Tennessee's actions in this facility.

Unfortunately, our experience in Illinois demonstrated frequent "lapses" in information-sharing in such matters – despite the requirements of the Interstate Compact on the Placement of Children as well as DCFS' contracts with provider agencies – and the UIC investigations often turned up serious problems that had gone unreported to DCFS by other states and the programs that were involved.

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[34] *WVLT News;* February 22, 2019.
https://www.wvlt.tv/content/news/State-childrens-services-removing-juveniles-from-Kingston-Academy-506172681.html

[35] *WBIR News*; February 22, 2019.
https://www.wbir.com/article/news/dcs-18-children-removed-from-kingston-academy-in-roane-county/51-7b3f94d6-c337-40da-b8b8-8fd6d84602e2

[36] *The Courier News*; February 22, 2019. "Kingston Academy Under DCS Investigation."
https://www.mycouriernews.com/articles/2019/02/2094/kingston-academy-under-dcs-investigation

Conclusion and Recommendations.
As Oregon DHS officials continue to reassess how the state's child welfare system is going to address the issues about out-of-state placements that finally came to light following the DRW report, several things needs to be kept in mind:

- first, the problems at a single facility in Iowa are not simply a *one-off* occurrence of substandard quality of care or mistreatment of children, as both the recent and historical data presented here (and below) demonstrate; [37] [38] [39] [40]

- second, that being the case, part of the reassessment task for DHS officials ought to be to examine more effective ways that the Department can evaluate its service provider network and monitor the quality of treatment that children receive in institutional settings.

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[37] Early on, the U.S. Department of Justice subpoenaed UIC/DCFS reports about hospital-based RTCs in Florida and Oklahoma, using them as the basis for initiating investigations and subsequent grand jury indictments or civil penalties. The U.S. Attorney in Tampa later called me to testify before a federal grand jury about evidence of Medicaid fraud identified in a 1996 UIC/DCFS review in a Florida RTC.

[38] Prior to initiating that Florida review I was confidentially informed by a senior official of the Florida Department of Children and Families that her agency could not ensure the safety of Illinois' wards. She indicated that DCF's licensing investigators as well as reviewers from the state's public health department were "*politically constrained*" from enforcing quality of care regulations because of the "corrupting influence" that the facility's owners apparently had with key Florida legislative leaders.

[39] One Oklahoma review – that revealed grossly substandard clinical treatment and risks of harm to DCFS wards, including a pattern of sexual assaults – was conducted only a few days after a federal CMS survey had been performed by the state's public health agency; the state review team identified "*no significant quality of care deficits*" in their report. After later receiving a copy of the UIC/DCFS report, however, the Commissioner of the Oklahoma Department of Human Services sent me a letter apologizing for the conditions that the Illinois reviewers discovered in a hospital that his agency had licensed and inspected. The Commissioner told me in a telephone conversation that the UIC/DCFS report – which by then had become required reading for his senior staff – was an "embarrassing wake-up call" highlighting a critical failure in Oklahoma's public health system.

[40] In Colorado, a UIC/DCFS team uncovered a clear pattern of sexual assaults, violence and clinical malpractice at a facility near Denver. While DCFS began removing all Illinois wards, Colorado officials denied that their licensing reviewers had ever identified any problems at the program. Officials from Ohio, Pennsylvania, Maryland and Washington, D.C. angrily defended Colorado, saying that their child welfare investigative staff had also found nothing wrong in the Denver program.

When *Dateline*/NBC broadcast a story based on the UIC/DCFS report, however, the governor of Colorado immediately ordered the facility shut down. More revealingly, the director of Colorado's child welfare agency then admitted in a news media interview that his licensing investigators had known all along about the types of problems that the Illinois reviewers discovered, but they deliberately ignored the risks of harm to youths. This official flatly stated that **"*if we had taken away [this agency's] operating license, we would've had no other place to put our kids – and we needed the beds.*"**

A scathing editorial published in the *Denver Post* the following day – contrasting the findings of the UIC/DCFS report with this shocking acknowledgment of officially-sanctioned negligence – said that **"*this episode will forever remain the shame of Colorado.*"**

As we discussed during our conference call last week, the Illinois experience of grappling with these issues over 20 years may offer some useful ideas on ways that Oregon can develop its own model for ensuring safe and effective care for its children, and Ben Wolf and I would be pleased to work with you to help initiate that discussion. In brief, let me point to some critical lessons that my DCFS colleagues and I learned in that difficult process about "*what works and – equally important – what doesn't work*" when trying to reform and strengthen a statewide child welfare system.

- **Lesson 1: Accreditation agencies are no guarantee of quality of care.** Quite the opposite, in fact, since nearly every major RTC or psychiatric hospital where UIC and DCFS teams identified significant quality of care deficits, and/or immediate jeopardy for risk of harm to children, were fully accredited (usually by JCAHO, CARF or COA).[41]

  Since column-5 of the DHS list of out-of-state placements that you provided me identifies the various accrediting organizations (mostly JCAHO) that awarded a seal of approval to the 21 facilities in 13 states where the 86 Oregon children were placed, it's especially important to understand why such "passing grades" may be based on questionable assumptions that hide dangerous conditions within certain institutional settings.

  This is not simply my well-earned cynical opinion based on 20 years of finding hundreds of Illinois' children suffering intolerable conditions in substandard or even dangerous programs around the country, data that my staff and I noted in countless reports and legislative hearings during that period. [42]

- In fact, a 2004 Report to Congress by the Government Accountability Office – "***CMS Needs Additional Authority to Oversee Patient Safety in Hospitals***" – identified "*serious deficiencies [with JCAHO accreditation surveys] that could endanger patients*."

  In that landmark study, the GAO reviewed 500 JCAHO-accredited hospitals across the U.S., comparing them to the validity surveys conducted by the state health departments authorized by the federal Centers for Medicare and Medicaid Services. GAO found that ***JCAHO failed to identify 78 percent of hospitals identified by CMS as having serious deficiencies – and it failed to identify 69 percent of the deficiencies found by the federal and state surveyors in those hospitals.***

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[41] The latter of which I always found especially dismaying because I was a member of the clinical advisory panel for the Council on Accreditation (COA), which was tasked with writing the original guidelines and standards for accrediting state child welfare agencies and community-based RTC programs in the U.S.

[42] Attached is a 2002 Op-Ed on this issue that I wrote for the *Chicago Tribune,* following up on an investigative series that the paper published on the complete failure of JCAHO to ensure quality of care in hospitals that it accredited across the country.

The following comments from the 2004 GAO report are critical to understanding the inherent risks that agencies that like DHS encounter when relying on such accreditation seals of approval as a de facto guarantee that children are safe from harm and receiving appropriate care:

> ***"Conclusion.*** *For 3 consecutive years, JCAHO's hospital accreditation program, which accredits most of the hospitals participating in Medicare, exceeded CMS's threshold for unacceptable performance.* ***CMS validation surveys during that time period confirmed that JCAHO missed the majority of serious deficiencies found by state survey agencies."***
>
> *"CMS was unable to take action against JCAHO's hospital accreditation program as it can with other accreditation programs because it lacked the authority to do so.*
>
> ***"Matter for Congressional Consideration.*** *Given the serious limitations in JCAHO's hospital accreditation program and that efforts to improve this program through informal action by CMS have not led to necessary improvements, Congress should consider giving CMS the same kind of authority over JCAHO's hospital accreditation program that it has over all other Medicare accreditation programs."*

The implications of the GAO Report to Congress about the alarming failure rate of JCAHO in identifying poor-performing hospitals – and its equally alarming failure rate in identifying serious deficiencies within such hospitals – underscore the problem confronting DHS in its efforts to protect Oregon children from harm in institutional settings. In the present matter, the GAO report demonstrates that a certificate on the wall of a residential facility or a psychiatric hospital ought not to be interpreted as a guarantee of safety and good treatment.

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- **Lesson 2: Marketing claims are no substitute for effective due diligence.** For that matter, the aggressive marketing claims made by such programs are often pitched to meet the needs of overwhelmed public-sector child welfare officials, many of whom are struggling to develop new options for their increasing caseloads of "difficult-to-place" children. That there may be a disconnect between promised solutions and the actual quality of care is not always easy to discern, especially when a perceived "bed crisis" demands a quick fix to the problem.

  Such was the case with a Florida RTC unit, actually inside a psychiatric hospital near Tampa, which later became the target of a federal grand jury investigation. During an unannounced site visit to check on the care provided to Illinois youths placed at this treatment program (mostly by juvenile court judges in Chicago), UIC reviewers discovered what we subsequently termed the ***"Kiddie Stock Exchange Board."***

  The Stock Exchange was a large blackboard in the marketing reps' office that listed the names of DCFS wards, the names and contact numbers for their caseworkers, the names of juvenile court judges involved in each case, and other information detailing when the marketing staff at the RTC – *who we learned were in Chicago three days a week, reportedly hustling judges and DCFS caseworkers for referrals* – were anticipating a court order allowing them to transfer these youths from a juvenile detention center in Illinois to their new residential setting down in Florida.

  After removing all 15 of the Illinois youths from this grossly substandard program within 48 hours, the director of DCFS and I then explained this curious business arrangement to the Chief Judge of the Cook County Juvenile Court, who ordered an immediate end to the practice of shipping the state's troubled youths to this Florida RTC.

  Despite the glossy brochures showing palm trees and swimming pools, and letters promising DCFS excellent educational services for Illinois' learning-impaired and difficult youths, we instead discovered what the U.S. Attorney in Tampa later called **a "*fraud factory*" that preyed upon the needs of vulnerable kids.**

  In short, the Illinois experience – tracking the state's most damaged children across a dozen states and multiple residential placement referrals in the early years of the system reform process – taught DCFS a painful lesson about the folly of outsourcing its treatment responsibilities: c*hild welfare systems that may perceive a "bed crisis" cannot sub-contract their duty of care on the basis of marketing promises from corporations that offer easy solutions to intractable management and public policy failures.*

  If there is another explanation – besides the remarkable salesmanship skills of corporate marketing representatives ***– for why 74 of the 86 Oregon children on the list were placed in Sequel facilities in 7 states, or why there was an increase of 150% in referrals to those Sequel facilities from 2017 to 2018,*** now would probably be a good time to ask for it.

Stated plainly, the Department of Human Services ought to discontinue placing high-needs clients in any RTC or other type of institutional treatment setting until it can demonstrate a credible ability to verify the safety and quality of care for the children it entrusts to others – something that appears not to have occurred in the cases of these 86 clients. [43] [44]

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[43] It was noteworthy, for example, that even the Disability Rights Washington report, which did an extraordinary job identifying an array of quality of care problems at Clarinda Academy, appeared to miss several of the clues regarding the "historical" connections that ought to have alerted them to deeper concerns about the Sequel program:

- first, the early connection to Youth Services International's notorious reputation (discussed above) for operating some of the most abusive programs in the country;
- and second, the statements in Sequel/Clarinda's brochure – which was quoted in the DRW report – saying that Clarinda officials **"*based [their] program model on the Glen Mills Academy… Expressing their belief that the Glen Mills approach is effective…*"** **Saying that** ***"their goal is to use similar methods in all the facilities [Sequel] owns and operates."***

Holding aside the troubled historical remnants of YSI, the more concerning issue here is that Glen Mills Academy has been identified for many years as what a shocking article in *The Philadelphia Inquirer* recently called its **"*long history of violence*."** In fact, a number of state child welfare and juvenile justice agencies have finally taken action to remove all of their clients from the Glen Mills campus in Pennsylvania.

See especially: **"*Beaten, Then Silenced."*** In *The Philadelphia Inquirer,* February 20, 2019. ***https://www.philly.com/crime/a/glen-mills-schools-pa-abuse-juvenile-investigation-20190220.html***

[44] Again, even a cursory review of the programs or corporations discussed here – including the obscure ones that were admittedly somewhat "off the radar screens" – would likely have turned up enough cautionary red flags to alert DHS officials that they ought to have taken a closer look before authorizing placements of their clients in certain institutional settings.

More to the point, if Oregon DHS officials first became aware of problems at Sequel/Clarinda from reading the DRW report – *or learned of the much broader background issues plaguing the child welfare industrial complex from reading this memo* – it would seem to be long past time for the Department, as well as the legislature, to start paying attention to the unintended consequences of ill-informed decisions that affect the lives of children who are caught up in the Oregon system.

- **Lesson 3: Develop effective protocols for monitoring quality of care.** Where the Illinois experience may be able to offer the most useful guidelines for Oregon, then, is in the various field-tested protocols that the UIC review teams developed over our 20-year technical assistance work with DCFS colleagues – many of whom accompanied us on the 400+ reviews that we conducted at both out-of-state and Illinois community-based facilities.

  By way of briefly illustrating the variability of such field protocols (depending on whether the targeted facility is a psychiatric hospital, residential treatment center, group home or some other type of setting), I am only summarizing in brief outline here some of the items that UIC and DCFS staff would typically examine during the on-site phase of facility investigations. [45]

  At the same time, I am attaching a detailed – but redacted – copy of a 26-page "corrective action plan" that DCFS mandated at a Chicago psychiatric hospital. In this case example, where the initial UIC review resulted in an "intake hold" being placed on all new admissions to the hospital, UIC discovered a pattern of violence, sexual assaults, inadequate staffing, destruction of medical records and other deceptive or unlawful efforts to cover up harm to children.[46]

  On page-one of the CAP form, for example, which defines the general methods and procedures to be followed by the joint UIC/DCFS review team during the follow-up evaluation process, the work plan specifies each category of the quality of care deficiencies, all of which were identified during the original investigation, in order to determine whether sufficient corrective action progress was achieved:

  - Staffing levels on hospital units
  - Treatment planning
  - Discharge and aftercare planning
  - Psychiatric/nursing progress notes
  - Consent for medications for DCFS wards
  - Psychiatrists' daily evaluation of DCFS wards
  - Behavioral management training and staff supervision

[45] While nearly all of the 400+ reviews conducted by the UIC team on behalf of DCFS and the ACLU are considered to be in the public domain – and a number of the major RTC and hospital reports were later released to the news media under FOIA requests – I prefer not to distribute the full reports as part of this memo, though I would be willing to share them for discussion with any interested Oregon DHS staff members.

[46] "*UIC Report Slams Hospital: Findings detail violence, sex assaults of young patients at Chicago psychiatric Hospital.*" *Chicago Tribune*; September 28, 2011.

The CAP then laid out the criteria for how reviewers would determine whether the required corrective actions goals were either "*substantially met*" or "*not met*," with narrative observations and recommendations offered by the UIC/DCFS staff who conducted the on-site follow-up assessment.[47]

Similar procedures and criteria were typically used during the initial review stages by the UIC and DCFS teams, though often in a much more labor-intensive and time-unlimited fashion.

- Major programmatic reviews conducted by UIC teams would generally last from 3-6 months, or even longer if preliminary findings warranted, and examine a standard menu of data.

- Reviewers typically arrived at facilities unannounced and returned at random times (24/7) for extended periods of unit observation, medical record examination, treatment plan reviews, patient interviews, evaluation of other documentation (i.e., recorded minutes of medical staff committee meetings, risk management and quality assurance committee minutes, minutes of nursing staff meetings, etc.).

- Special attention would be paid to evaluating the clinical quality of the individualized treatment plans for each patient, focusing on evidence of progress toward realistic treatment goals as well as appropriate discharge planning efforts by treatment teams.

- Discovery of "boiler-plated" or "rubber-stamped" treatment plans would be seen as a red flag, suggesting that the facility was providing substandard clinical care, therefore requiring an even deeper audits of treatment plans and other records going back at least 24 months.

- Additionally, the reviewers would often conduct interviews with sources in the local community, such as police officers or school officials, as an effective way to determine whether unusual incidents at the facility had required law enforcement intervention or whether students complained to teachers of mistreatment at the facility.

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[47] Each member of the UIC team over the years had at least 25 years of experience working as mental health professionals – psychologists, psychiatric nurses, social workers, child psychiatrists and hospital or residential treatment center directors – and each had participated in the training efforts the program offered to DCFS colleagues (as well as to attorneys and juvenile court judges), which was part of UIC's technical assistance mission under the federal court consent decree.

In sum, the UIC team knew from experience what to look for when reviewing any type of setting where children were referred for treatment, and especially how to evaluate the clinical quality and effectiveness of care that was provided by hospitals or RTC programs. Under the guidelines for the UIC program, facilities that objected to negative review findings had the right to appeal to the director of DCFS, **but none of the 400+ reviews by UIC in 20 years were ever overturned.**

- Of special concern, UIC reviewers would verify any claimed staffing levels made by administrators at the facility.

  A team member (who was an experienced psychiatric nurse and hospital administrator) would double-check the actual staffing ratios – *scrutinizing direct-care staff timesheets, calculated against patient census reports for each unit on all shifts over several months (well before the arrival of the review team)* – a process that frequently showed wide misrepresentation of the true staffing resources available at the facility.

- Similarly, UIC reviewers would review charted progress notes made by psychiatrists, psychologists, nurses and other direct-care staff – again, looking for signs of the sort of "rubber-stamping" that often indicated poor quality of treatment – and we would even verify the number of hours that these professional staff actually spent working directly with patients.

  In one case, the reviewers actually "clocked" the number of minutes psychiatrists spent talking to patients by examining videotapes from the hospital's security cameras in the nursing station, then comparing these timed interactions with the "claimed" times that were later written in the psychiatrists' chart notes. As suspected, patients were not only being therapeutically short-changed, the hospital was apparently billing for treatment services that were never delivered.

- Reviewers would generally verify required staff training (i.e., restraint techniques) and professional credentials (i.e., degrees/credentials from recognized schools/programs, as opposed to fraudulent online diploma mills) as a further check on safety and quality of patient care.

- Finally, in all cases involving psychiatric hospitals, residential treatment centers or other programs that were subject to surveys by regulatory and licensing agencies or accrediting organizations – such as the federal Center for Medicare and Medicaid Services, local or state departments of public health, JCAHO, COA, etc.), the review team would obtain, by FOIA requests if necessary, all available records and findings regarding the facility's operations for a minimum of three years.

  As indicated in a number of the UIC reports, we were able to determine that facility administrators had: (a) hidden or misrepresented negative information to those third-party surveyors; and/or (b) withheld negative survey findings or other adverse data about their program from DCFS.[48]

[48] Oregon DHS officials should understand that certain corporations do not take kindly to such intense scrutiny, even when conducted as part of official oversight functions by state agencies. Despite the fact that the UIC reviews were conducted as part of the monitoring efforts required by a federal court consent decree, for example, the UIC program was occasionally subjected to legal threats and attempts at political interference (often orchestrated by corporate lobbyists and attorneys), and some whistleblower informants and well-meaning RTC or hospital staff were even threatened with retaliation for revealing information regarding harm to children.

Summary.
My ACLU colleague Ben Wolf and I appreciated the opportunity to share with you some of the accomplishments (and impediments) that we experienced during the 20-year-long effort to reform Illinois' broken child welfare system – particularly the strong partnership that evolved during that difficult process between the advocacy community, my staff in the UIC Mental Health Policy Program and our colleagues in the Department of Children and Family Services.

Fortunately, we also had the support of several governors, many committed legislators, an aggressive news media and the spotlight of public attention – *as well as a federal judge who understood that children have a basic Constitutional right to be protected from harm* – and it will take similar commitments for Oregon to resolve its own child welfare system-management difficulties.

We hope that Illinois' learning experience – in correcting its tragic public policy mistake of outsourcing the treatment of nearly 800 traumatized children to other states – will be useful for our colleagues in Oregon's child welfare system as they continue working to address the same difficult issues here.

Attachments

1. UIC Mental Health Policy Program brochure.
2. Redacted copy of UIC/DCFS Corrective Action Plan
3. February 2018 Memo to ACLU

Improving Mental Health Services for Children

UIC Psychiatric Institute

UIC and DCFS: Partnership for Change

The UIC Department of Psychiatry — part of a public university with a longstanding commitment to investing resources in public service — has been working effectively with state government over the past decade to help improve the Illinois mental health and child welfare systems of care.

UIC's unique partnership for change with the Illinois Department of Children and Family Services has led to significant improvements in mental health treatment for thousands of DCFS wards. UIC faculty and staff have been involved with DCFS and its provider agencies since 1994 in an effort to ensure that youths in psychiatric hospitals, residential treatment centers and group homes receive appropriate therapeutic services and high quality of care.

UIC Institute for Juvenile Research

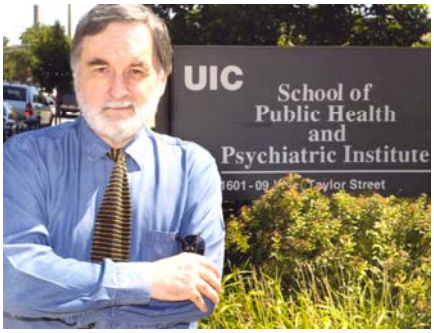
The UIC Technical Assistance Group

As part of this effort, UIC recently expanded its ability to provide a flexible array of technical assistance and consultation services to hospitals and community-based agencies throughout Illinois. The psychiatry department programs that routinely consult with DCFS — the *Mental Health Policy Program*, the *Applied Services Research and Evaluation Program,* and the *Comprehensive Assessment and Response Training Services Program* — are now integrated as the UIC Technical Assistance Group, or *TAG*, within the Institute for Juvenile Research.

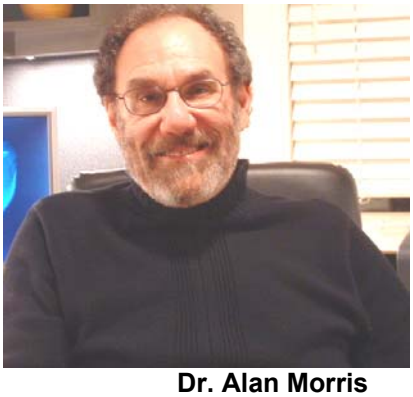
The Technical Assistance Group serves as a strategic roundtable for organizing the faculty and professional staff of these important UIC programs. TAG consultants offer a wealth of clinical knowledge and management expertise in psychiatric hospitals and community-based programs that have been recognized nationally for providing innovative treatment services to high-risk populations of severely mentally ill and behaviorally disordered youths.

- **Technical Assistance Interventions**
  TAG teams are available to conduct technical assistance interventions if requested by DCFS or a provider agency. UIC faculty and professional staff design special consultation and training modules based on the identified programmatic needs in selected agencies, then work with agency leaders and board members to implement organizational changes.

UIC Faculty and Staff



Dr. Ron Davidson



Dr. Alan Morris

Dr. Christine Davidson

- **Program Evaluation**
  TAG teams typically conduct an intensive systems evaluation at every level of the organization — interviewing staff members and clients in focus groups, observing program functioning at all hours, assessing treatment planning and clinical service delivery procedures, and tracking quality assurance and performance improvement efforts. The goal is to establish a working alliance with an agency's staff, administrators and key board members as a prelude to strengthening their program.

- **Assessing the Treatment Environment**
  An important aspect of the program assessment phase focuses on such areas as the physical milieu, staff/client ratios, internal communication, and other treatment environment issues — all of which may contribute to (or even impair) the agency's ability to ensure client safety and well-being.

- **Staff Training and Continuing Education**
  Didactic **t**raining workshops are generally conducted on-site over several days, including an intensive core curriculum on milieu therapy and behavioral interventions for direct-care staff (with a series of practicum exercises in deescalation techniques, limit-setting, therapeutic milieu structure and positive staff-client interactions). The workshops are designed as laboratories for introducing conceptual and programmatic shifts toward a more effective *clinical model* of working with difficult populations of treatment-resistant youths.

- **Post-Training Follow-up Work**
  UIC consultants will typically follow agency staff on their regular shifts at all hours and over a period that may last several weeks or months. Such protracted follow-up efforts include observing individual staff members as well as clinical team performance at the unit level, where the consultants role-model system change efforts during the transition to a new programmatic framework.

- **Improving Therapeutic Outcomes**
  Clinical consultations will focus special attention on improving treatment planning and therapeutic outcomes with difficult client populations. Whenever possible, the agency's therapists and direct-care staff will also be offered the opportunity to observe the clinical team meetings, group therapy sessions and other elements of the UIC Clinical Assessment and Treatment Unit (CATU), a specialized inpatient psychiatric hospital service located at the UIC Medical Center in Chicago.

- **Management and Board Training**
  UIC has developed a specialized training module for agency managers and boards of directors, focusing special attention on tracking quality of care indicators and other data-driven performance measures as a way to enhance management oversight and accountability mechanisms. Where necessary, UIC staff may offer limited technical assistance on ways to restructure or enhance programmatic resources and financial viability within the DCFS provider agency system.

UIC Training & Continuing Education

The UIC Technical Assistance Group has recently offered specialized training and professional education events, including workshops and clinical case conferences targeted to the needs of professional staff, as well as organizational development forums for administrators and board members.

Forrest Brown, R.N.

Recent workshops conducted for professional staff:

- *Clinical issues in childhood trauma and neurodevelopment*
- *Treating youths with Depression and Bipolar Disorder*
- *Suicide risk assessments and interventions*
- *Coexisting disability with emotional/cognitive deficits*
- *Behavioral interventions with ADHD clients*
- *Integrating individual treatment and milieu therapy*
- *The changing role of residential treatment in Illinois*
- *Developing an effective milieu structure*
- *Designing an individualized behavioral system*
- *Planning milieu groups and activities*
- *Evaluating clients and placements for appropriate fit*
- *Milieu treatment with developmentally disabled clients*
- *Managing disruptive behaviors in the classroom*
- *Life skills development with adolescent clients*

Deann Muehlbauer

Special training for administrators and board members:

- *Managing organizational change during a crisis*
- *Evaluating administrative and clinical leadership*
- *Quality improvement in hospital and residential treatment programs*
- *Strategic planning and financial stability for non-profit agencies*
- *The role of the board in monitoring and ensuring accountability*

Progress Evaluations after UIC Training

UIC expects that agencies will conduct ongoing progress evaluation surveys as part of their quality improvement efforts, beginning with completion of the initial consultation and training project, so that the TAG can assess the effectiveness of its intervention strategies.

One Northern Illinois residential agency reported its QI findings for the first quarter following an extensive UIC training project in 2004:

- *75% reduction in client runaways from the program*
- *93% reduction in police arrests of clients for aggressive incidents*
- *96% reduction in out-of-control behaviors by clients*

Christina Smith, LCSW

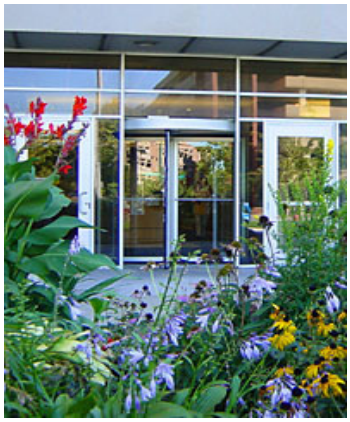
Survey data from a Chicago Area program showed similar results following a 2002 UIC training project:

- *65% of staff said changes introduced by the UIC training had made their program both "safer" and "more therapeutically effective."*
- *Aggressive behaviors, property destruction, runaways and the use of restraints in the program were reported to have virtually ceased.*
- *92% of program staff said the training and clinical experience gained through the UIC intervention directly helped to improve their skills in working with severely mentally ill and conduct-disordered clients.*

Requesting Assistance from TAG

The UIC Technical Assistance Group offers its consultation services and special training projects at no charge to current DCFS provider agencies and to psychiatric hospitals serving DCFS wards.

While requests for TAG consultations should be directed to DCFS, agency/hospital administrators or board members may contact any of the UIC faculty/program directors listed below to discuss specific issues or questions regarding the scope of available services.



UIC Psychiatry Department
1601 West Taylor Street
Chicago, IL 60612

Contact Information

Mental Health Policy Program:

Dr. Ronald Davidson
(312) 996-7227

Comprehensive Assessment and Response Training Services Program (CARTS):

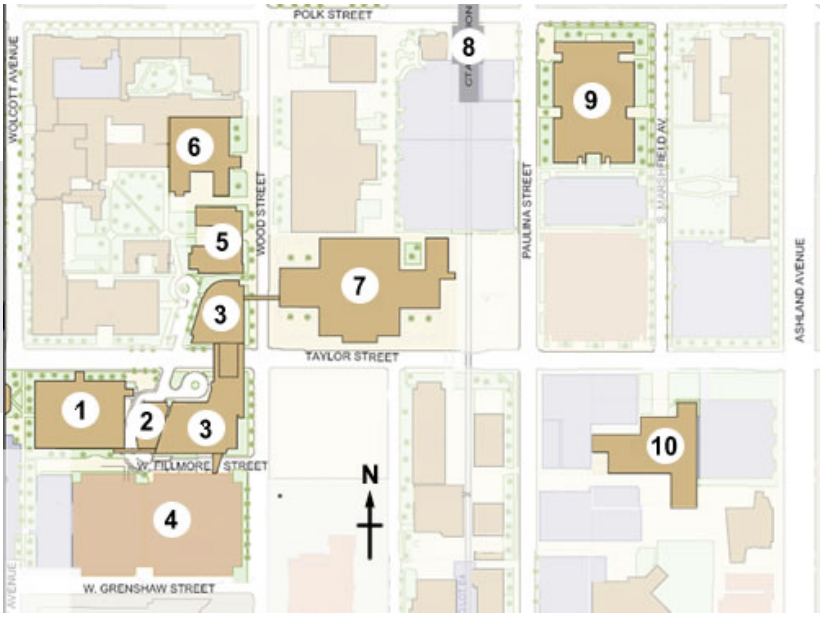
Dr. Alan Morris
(312) 413-4599

Applied Services Research and Evaluation Program:

Dr. Christine Davidson
(312) 355-4557

UIC Medical Center Map

10. Department of Psychiatry
7. UIC Hospital / CATU
5. Neuropsychiatric Clinic
4. Visitor Parking Garage



Corrective Action Plan Review

Authorization for monitoring corrective action.

[redacted] HOSPITAL

Monitoring of corrective action at XXX Xxxxxxxxx Hospital will be conducted by a UIC/DCFS joint working group involving the UIC Mental Health Policy Program and the DCFS Division of Clinical Practice.

Prior to accessing any patient records or having any communication with a patient, the UIC/DCFS reviewers shall tender written authorizations from a person with authority to consent to release of the records and/or communications.

- The Office of the DCFS Guardian will provide written authorizations for DCFS wards under the age of 12.
- With regard to DCFS wards between the ages of 12 and 18, the DCFS Office of the Guardian will provide signed authorizations; however, the UIC/DCFS reviewers must also obtain the written signature of the DCFS ward.
- With regard to DCFS wards over the age of 18, the UIC/DCFS reviewers must obtain the written authorization of the wards.

General Methods and Procedures:

The UIC/DCFS working group will coordinate the follow-up evaluation with XXX Xxxxxxxxx officials, using the framework outlined in the sections below to narrow the focus of corrective action and assist the facility in resolving outstanding issues.

- DCFS will provide hospital officials with a letter of authorization, including a copy of this monitoring protocol, at the initiation of the review process.
- When necessary, additional authorization for the UIC/DCFS reviewers to inspect medical records and/or conduct private interviews with DCFS wards will be provided by the DCFS Office of the Guardian.
- UIC/DCFS reviewers will examine each category of the quality of care deficiencies identified below in order to determine whether sufficient corrective action progress has been achieved:
    - Staffing levels on hospital units
    - Treatment planning
    - Discharge and aftercare planning
    - Psychiatric/nursing progress notes
    - Consent for medications for DCFS wards
    - Psychiatrists' daily evaluation of DCFS wards
    - Behavioral management training and staff supervision

The specific methods, procedures and criteria for evaluating current quality of care performance and determining corrective action plan progress are indicated below for each category of these identified quality performance deficiencies.

Time Frames: Corrective Action Plan progress and compliance will be evaluated up to and including 30 days after initiation of the compliance monitoring to determine whether or not to reopen intake. Ongoing CAP monitoring will occur for an additional period of 90 days after intake is opened.

Xxxxxxx

Issue 1: Hospital unit staffing levels

Statement of quality performance deficiency:
Hospital staffing levels were found to be inadequate to ensure patient safety and quality of clinical care [see UIC report, page 25].

Methods and Procedures:

- UIC/DCFS reviewers will conduct announced and unannounced observation of hospital units serving DCFS wards as part of the corrective action compliance monitoring, following standard observational methods to minimize any disruption of services or unnecessary disturbance of clients.

- UIC/DCFS reviewers will conduct an analysis of hospital unit shift assignments for a period of 90 days prior to initiation of the CAP, comparing this data with staffing levels at the time of the original review as a measure of whether actual staffing coverage on the units was increased.

- UIC/DCFS reviewers will evaluate the current staffing levels by examining the distribution of nursing/direct-care staff (including the use of registry or part-time staff), using the form below to record staffing data and observations of unit functioning over time.

Unit:		Date:			
Shift	RNs	LPNs	MHTs	Other	Registry
7-3					
3-11					
11-7					
Observations:					

Criteria for corrective action:

- Hospital officials will demonstrate a *minimum direct-care staffing ratio of 1:4* on the day/evening shifts, including one RN-level psychiatric nurse per each 22 patients (or one psychiatric nurse for each of the two 22-bed wings of the combined units).

- A memorandum of understanding providing assurances of this minimum 1:4 staffing ratio will be provided to DCFS by XXX officials.

- The *XXX Xxxxxxxxx Hospital Policy & Procedure Manual* will be revised to reflect the minimum 1:4 staffing ratio, and all hospital staff will be notified in writing of this increased unit staffing coverage.

- Observations by UIC/DCFS reviewers of hospital units will verify adequate staffing levels and supervision to ensure appropriate behavioral management and safety of patients in the milieu.

    - Example: While the hospital should avoid congregating large numbers of patients in unit dayrooms or other areas, at no time will less than two direct-care staff be assigned to monitor/supervise patients who are gathered for activities, at all times maintaining an approximate 1:4 staffing level according to the numbers of patients present in the area.

Observations and Recommendations:

Evidence that corrective action criteria were: *substantially met* ☐ or *not met* ☑ based on the following observations.

Hospital staffing levels were again found to be inadequate to ensure safety and quality of clinical care for DCFS wards, despite recent assertions to the contrary from XXX officials regarding certain staffing ratios, as evidenced by a review of the available data as well as information provided by hospital sources..

It should be noted that interviews conducted with DCFS wards within the past month indicates the same type of failed supervision of the hospital units as previously detailed in the 2011 UIC report, much of which can be attributed to inadequate staffing. Of equal concern, new evidence provided by UIC sources – and discussed in part below – indicates a concerted effort by senior XXX officials to withhold or conceal information about harm to patients from DCFS and UIC.

- Medical chart reviews and interviews with patients who became DCFS wards after admission to XXX Xxxxxxxxx, for example, revealed a continuing failure to ensure appropriate behavioral management and a similar pattern of aggressive and/or sexual incidents as was previously detailed in the 2011 UIC report.

  Some of these troubling incidents are highlighted below:

  - **[UIC interview with patient conducted on 4/20/12.]**
    Patient stated he is often "*scared of what might happen*" on unit. Stated he is "*constantly bullied… People try to fight staff. It's scary*."

    "[Patient name redacted] picks on everybody. [Other kids] bully us and I'm the smallest kid here. Three kids bully me the whole time I'm here."

    Reports being in two fights: on 2/18 he was punched in the face by another patient on unit, making his nose bleed; saw MD and had x-ray, Thought his nose was broken.

    When asked about seeing things happening on the unit, patient said: "*Kids cut themselves with knives, in the dayroom. Plastic knives, there was lots of blood*."

    "[Patient name redacted] ran in my room and hit me at night while I was asleep. Kids don't care at night. Kids will do anything here at night."

  - **[UIC interview with discharged patient conducted on 4/20/12.]**
    "*There's lots of fighting [at Xxxxxxxxx]. I was beat up one time by [patient name redacted]… He was beating everybody up. Staff helped, but he hit me a couple of times*…*There are so many arguments and fights*."

    Patient reported seeing a peer attacked in his room by his roommate: "*Dude was acting so weird. There was blood everywhere. His roommate hit him and he had to go to the hospital… I saw [another patient, name redacted] punch a 12-year-old kid in the face*."

  - **[UIC interview with patient conducted on 4/20/12.]**
    Patient reported that on Monday night a kid said he wanted to punch him. Patient got up and staff grabbed him by the arm and then grabbed him across the neck from behind, pulling him back real hard. "*I* couldn't breath all the way*... It lasted for two minutes… I felt like he was gonna throw me, and my heart started pumping real bad. I remember his voice in my head, and my throat hurt*."

When asked if things on the unit scared him, patient replied: "*Kids are always cursing, threatening, hitting and biting staff… My body shakes for no reason. My body is scared but I'm not*."

- **[UIC interview with discharged patient conducted on 5/4/12.]**
  "I was sexually acting-out a lot (at Xxxxxxxxx).. A lot of people bully me because of my sexuality, and [staff] didn't really protect me." "*I got in so many fights there it was crazy…I think Xxxxxxxxx should be shut down if they don't get more staff*."

  "*I fought [patient name redacted] because he was being extremely disrespectful. I had my feet up on the Direct-TV box and he pushed my legs down. I started punching him in the head. Staff got my hands, and he punched me in the nose really hard. Staff were so busy restraining me first and he got me in the nose; my nose bled but I didn't see a doctor. I went in the QR, and they gave me a paper towel for my nose*."

  "[Patient name redacted] asked me to go down on him. He comes to his door, [staff name redacted] had his back to us, the charge nurse had her computer facing the left side. I crawled into [peer's] room, they got me on camera. I sucked him off and he came. [Peer] goes out of the room first and I just slipped behind him and went back to my room. I got put on 1:1 for 24 hours because some other kids snitched… [They said], 'I'm gonna snitch if you don't do me too.'"

  "*There was another kid, I forget his name, they were just quickies… showing, flashing, flirting, hand jobs. I did hand jobs with two other kids in the dayroom*."

  During first hospitalization, "*[patient name redacted], we're both on the same side of unit, there's code yellow so staff was distracted. We go in my room, we're in there making out, having oral sex, for a good 30-40 minutes. [Staff name redacted] comes by and asks why [peer] is in my room. [Staff] says uh huh, he says stop doing that or you'll get me fired*."

- **[UIC/DCFS interview with patient conducted on 4/16/12.]**
  Patient complained that "*kids touching my bottom*" at Xxxxxxxxx. When encouraged him to tell staff, he said he loses points if he tells staff about the touching. He also reported that a "*boy across from me rubbed his penis in my face, and he tried to kiss me*." He talked about being touched by a kid in the dayroom." Said that yesterday…"*there was a fight I was in... I don't want to talk about it*

	<u>NOTE</u>: the sections highlighted in column 2 were completely blacked-out in the redacted document given to XXX officials. Please do not circulate this un-redacted copy beyond the office of the director.	• Of special concern, the UIC team was able to determine that hospital officials engaged in deceptive practices involving data presented to DCFS and UIC on staffing issues, aggressive incidents and harm to patients on the units. o Specifically, progress notes and incident reports are sometimes removed from patients' charts and rewritten so as to minimize the seriousness of incidents that "cast the hospital in a bad light," according to a high-level whistleblower familiar with XXX Xxxxxxxxx operations and practices. o Moreover, the whistleblower stated that certain staffing and UIR data in monthly reports sent to DCFS – as well as similar data in letters from a senior XXX official – were either false or presented questionable data intended to mislead DCFS and obstruct any inquiry by UIC regarding substandard quality of care or risks of harm to patients at the hospital. • Additionally, the UIC team met with current and former Xxxxxxxxx staff members at various levels, who provided corroborating details about hospital operations. NOTE: Sources whose identities are redacted here, as well as other informants, have agreed to meet with the director of DCFS, if requested, to personally confirm their statements to the UIC team. o **[UIC interview with former XXX Xxxxxxxxx official # 2.]** "*When I recently asked [the Xxxxxxxxx director of nursing] why certain patients were not on 1:1s, when the risks with these patients clearly called for 1:1s, she replied that she simply did not have enough staff.*" o [Statement from Xxxxxxxxx mental health professional # 6.] "*I directly questioned whether such staffing ratios were in compliance with healthcare standards, and I received an interesting answer from [name of administrator redacted]. Apparently, certain administrators are counted as "one-third," "one-fourth" and even "one-fifth" of a unit staff member [supposedly] giving direct patient care, since they were likely to 'pass through' each of the units at some point during the day*." o **[UIC interview with former XXX Xxxxxxxxx official # 2.]** "*I can tell you that when there aren't enough staff available to cover 1:1 patients, the business office administrators are pulled to cover the units. Now, what training do they have to do that? In fact, [name of Xxxxxxxxx Hospital administrator redacted] and her staff do it all the time, as I'm sure you've figured out by now*."

"*The ratios are rarely as they indicated here*" [referring to data shown during the interview with the UIC team]. "*[Name of senior XXX official redacted] said that Xxxxxxxxx would only go to 1:4 when some outside reviewers showed up, like UIC,. But otherwise the hospital has never truly operated at 1:4 staffing ratios – it's more like 1:5, 1:6 or worse – nor do they intend to do so.*"

- **Analysis of XXX Xxxxxxxxx Unit Staffing Data**
  The UIC review team conducted an analysis of February 2012 staffing data for each hospital unit, using the daily assignment sheets that identified staff members by name. Based on the team's personal knowledge of Xxxxxxxxx staff members – and with the assistance of hospital sources who were able to help identify certain employees (*i.e., nursing/unit managers, house supervisors, administrators, employees covering half-shifts or assigned to 1:1 duties*) who were apparently added to the assignment sheets in order to artificially inflate the numbers – the UIC reviewers were able to decipher what the actual staffing ratios looked like for February.

  Specifically, of these 232 total day/evening shifts at XXX Xxxxxxxxx:

  - Overall, **88 of the 232 shifts were staffed at a ratio of 1:5 or lower,** meaning that **38%** of the shifts operated with 1 staff member for every 5 patients. XXX Xxxxxxxxx shifts operated **as low as a 1:8.5 ratio.**
  - On the 2-North adolescent girls unit, **40 0f 58 shifts were staffed at a ratio of 1:5 or lower,** meaning that **69%** of these shifts operated with 1 staff member for every 5 patients. Some 2-N shifts operated **as low as a 1:8.5 ratio.**
  - On the 3-North adolescent boys unit**, 28 of 58 shifts were staffed at a ratio of 1:5 or lower,** meaning that **48%** of the shifts operated with 1 staff member for every 5 patients. Some 3-N shifts operated **as low as a 1:7.6 ratio.**
  - On the 2-South child unit**, 6 0f 58 shifts were staffed at a ratio of 1:5 or lower,** meaning that **10.3%** of the shifts operated with 1 staff member for every 5 patients. Some 2-S shifts operated **as low as a 1:6.8 ratio.**
  - On the 2-South adult unit, **14 0f 58 shifts were staffed at a ratio of 1:5 or lower,** meaning that **24%** of the shifts operated with 1 staff member for every 5 patients. Some 3-S shifts operated **as low as a 1:6.7 ratio.**

- **Analysis of XXX Xxxxxxxxx RN Staffing Data**
  Analysis of the nursing ratios for the 232 total day/evening shifts revealed that **20% of the 232 day/evening shifts operated with staffing ratios of less than1:22 RNs, including shifts on some units ranging as low as 1:31 to 1:44 RNs.**

- **Observation of XXX Xxxxxxxxx Dayroom Supervision Data**
  Similarly, direct observational data by UIC team members, during on-site visits to the hospital, found equally troubling deficiencies in staff assigned to monitor groups of patients in dayrooms and other areas of the hospital.

  While the DCFS corrective action plan stipulate that hospital officials would "*at all times maintaining an approximate 1:4 staffing level according to the numbers of patients present in the area*," the UIC team found numerous instances during the follow-up review period when **dayroom staffing ranged as low as 1:16.**

  Such inadequate numbers of milieu staff assigned to monitor or supervise children in unit dayrooms – where there have been repeated incident reports about fights and sexual behaviors – are only marginally better than the 1:22 staffing levels that were noted in the 2011 UIC report and in an earlier *Chicago Tribune* article about sexual assaults in the hospital dayrooms. Nonetheless 1:16 is a far distance from the approximate 1:4 ratio stipulated in the corrective action plan.

- **XXX assertions about staffing in letters of March 6 & April 12, 2011**
  At the time the UIC review was underway – and during a September 2011 meeting with DCFS – ***XXX Xxxxxxxxx officials directly acknowledged that the hospital operated at a ratio of 1:5*, which they openly argued was sufficient to meet their duty of care.** As noted in the UIC report, however, XXX Xxxxxxxxx unit staffing ratios in 2010-2011 were found at times to actually be as low as ***1:6 or even 1:7.***

  XXX officials have since then told DCFS in several follow-up letters that they were "*considering moving toward a 1:4 ratio.*" Subsequent letters to DCFS on March 6 and April 12 indicated that "*Xxxxxxxxx will commit to maintaining an approximate 1:4 staffing ratio...*," adding that **"*Xxxxxxxxx does, in fact, staff at an approximate 1:4 ratio on its pediatric and adolescent units*."**

  Regrettably, when this assertion is exposed to sunlight, the available data suggests otherwise.

Of special interest, XXX officials went beyond questionable assertions about Xxxxxxxxx's purported staffing ratios in the March 6 and April 12 letters to DCFS, arguing for good measure that "*no national or state regulatory body requires a 1:4 ratio for mental health facilities*," and that for DCFS to require such a level "*is not necessary, fair or supported by any national or state standard*."

Actually, as with XXX' previous assertion, that's not quite true either.

In fact, DCFS already requires XXX' Costigan Residential Treatment Center, part of the XXX Streamwood Behavioral Health Center – to operate at a ***1:3 staffing ratio***, significantly higher than the 1:4 ratio XXX now objects to meeting for their acute psychiatric hospital; the difference, of course, is that *DCFS has contractual agreements with RTCs but not psychiatric hospitals.*

Under this curious bit of logic, XXX officials are actually telling the Illinois Department of Children and Family Services that it simply has no right to demand that its wards be protected from harm in a woefully understaffed hospital because DCFS doesn't have the same *contractual leverage* that it currently has over RTCs [see graph on following page].

The XXX letters then attempt to take refuge behind the presumed ambiguity of federal healthcare regulations about what constitutes "adequate staffing," failing to acknowledge certain obvious facts: (a) that a demonstrated *pattern of harm* to patients would likely indicate that such healthcare requirements were not being upheld; (b) that the Department's *fiduciary duty of care* to its wards trumps whatever issues XXX officials may wish to raise about the "unfairness" of the intake holds; and (c) that there is an enforceable federal court consent decree requiring DCFS to ensure that its wards are protected from harm in psychiatric hospitals and other institutions.

Curiously, XXX adds to its smokescreen by attaching an article to its April 12 letter from the *Journal of the American Psychiatric Nurses Association* about the staffing of inpatient psychiatric units, the gist of which (according to the letter) is that "*there are many factors which influence staffing and must be considered in determining staffing levels, as opposed to a strict staff-to-patient ratio as DCFS has continued to require*…"

Left unquoted in the XXX letter, however, is the first paragraph from the conclusion of this February 2012 article**: *"It is the position of APNA that the likelihood of adverse outcomes increases with an increase in the number of patients assigned to each nurse."***

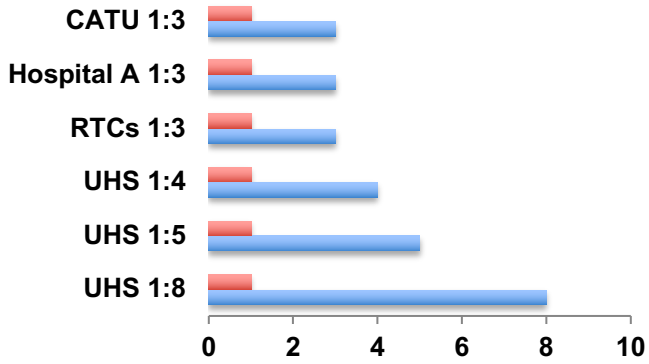
zzzzzz

The UIC team wholeheartedly agrees with the APNA position, which was actually published months before this 2012 journal article (in the form of a brief statement by the APNA board of directors in September 2011, copies of which were widely circulated by the UIC team at the time).

Moreover, XXX Xxxxxxxxx officials are aware that the 2010 UIC report on Streamwood Hospital – which was reportedly scrutinized in detail by staff at Xxxxxxxxx in preparation for their UIC review – took the position that:

> "*Determining adequate staffing ratios in psychiatric hospitals… is not (or should not become) simply a numbers game, with a false sense of security if a facility can, technically, claim to be "in-ratio" – especially a ratio it most likely set for itself.*" [UIC report on SBHC, page 6.]

Simply stated, what the XXX comments and letters seek to obscure about staffing of Xxxxxxxxx Hospital can be seen in the graph below, which lays out the real-world implications for staff and patients alike in facilities that are currently serving DCFS wards.



Rows 1 & 2 represent the CATU inpatient unit at UIC as well as another hospital in the Chicago Area, both of which operate at a 1:3 ratio; row 3 shows the same 1:3 ratio required by DCFS at RTCs serving severely mentally ill wards; while the last 3 rows show XXX Xxxxxxxxx variably operating at 1:4, 1:5 or 1:8 ratios. The longer the lower bar in ratio to the first bar, the more patients each hypothetical staff member is assigned.

		Arguably – but as XXX failed to mention – APNA has already stated the UIC case quite bluntly: **"*The likelihood of adverse outcomes increases with an increase in the number of patients assigned to each nurse.*"** XXX has shown this axiom applies to all categories of staff at Xxxxxxxxx.

In sum, XXX officials apparently have a tendency to misrepresent or simply ignore facts that are inconvenient, including the repeated reference in the UIC report on Xxxxxxxxx Hospital to the guidelines published over 20 years ago by the American Academy of Child and Adolescent Psychiatry regarding minimum staffing ratios for psychiatric hospitals serving children and adolescents.

AACAP took the very unambiguous position that a *1:3 overall unit staffing ratio* was necessary to ensure good treatment and safety of patients, along with a *1:12 ratio for RNs* – levels of professional staffing resources that are unimaginable at Xxxxxxxxx or, for that matter, any of the other XXX hospitals that were discussed in the 2011 UIC report, all of which have come under continual criticism from state and federal authorities for understaffing and harm to patients.

XXX officials appear to have taken a twofold position on the question of staffing: first, a grudging assertion that they are already meeting the 1:4 ratio anyway, when the available data shows otherwise, coupled with a fallback legal position saying, in effect, "*DCFS can't make us do it if we don't want to*." On that second point, at least, XXX officials are quite correct.

As the graph above shows, however, there are at least two psychiatric hospitals in the Chicago Area that seem to have no difficulty meeting these high standards. More to the point, they do so willingly and, it should be noted, without issuing resentful complaints that DCFS is being "unfair" by insisting that its wards have a right to receive quality care in safe environments.

Summary

The 2011 UIC report found staffing levels at XXX Xxxxxxxxx Hospital to be inadequate to ensure patient safety and quality of clinical care.

The current follow-up review of the corrective action plan indicates that the facility has not met this quality performance indicator.

Issue 2: Treatment planning and documentation

Statement of quality performance deficiency:
Treatment plans were found to be typically generic, non-individualized and lacking indicators that goals were adequately reviewed/modified as necessary [see UIC report, pages 19 and 40].

Methods and Procedures:

- UIC/DCFS reviewers will observe treatment teams to assess whether modifications and improvements indicated in corrective action responses recently submitted by XXX officials have been implemented.
- UIC/DCFS reviewers will evaluate the treatment plans for patients who become wards after the initiation of the CAP against a sample of treatment plans from the six-month period preceding the intake hold.
- UIC/DCFS reviewers will ask treatment team members during interviews to describe the clinical basis of treatment planning efforts and treatment goals for selected patients.
- Similarly, patients will be asked to describe their awareness of and/or participation in treatment planning efforts by the treatment team.

Criteria for corrective action:

- Treatment planning and documentation will meet clinical standards requiring: (a) formulation of relevant and patient-specific short/long-term treatment goals; (b) indication of the treatment modalities to be utilized as well as designated responsibilities of each member of the treatment team; (c) evidence of inclusion of the caseworker, supervisor, caregiver(s) and youths in the planning process; and (d) the clinical justification for patient diagnoses and treatment services rendered to patients.
- Specific attention will be focused on determining whether the hospital is in compliance with *42 CFR §482.61(c) and §482.61(*d)], which require all psychiatric hospitals to ensure that patients are provided treatment plans that meet these clinical standards of care.

Observations and Recommendations:

Evidence that corrective action criteria were: *substantially met* ☐ or *not met* ☑ based on the following observations.

Hospital treatment planning and documentation was again found to be inadequate to ensure quality of clinical care for DCFS wards, despite recent assertions to the contrary from XXX officials, as evidenced in part by the following:

- Treatment plans continue to appear generic and non-individualized, a finding that was previously noted by both UIC and CMS in 2011.
- UIC reviewers found that psychiatrists, nursing staff and other clinical staff frequently failed to adequately document progress related to the goals of the treatment plan and often do not substantiate revisions to the ITP based on patients' responses to therapeutic interventions.
- Treatment plan reviews were often perfunctory at best, as seen in weekly staffing meetings/reports that ignored or did not integrate available information provided by milieu staff, social workers, therapists and other hospital clinicians; this is especially unfortunate because UIC reviewers noted a number of cases where these clinicians provided higher quality therapeutic services and more reliable information (relevant to treatment planning for their patients) than did certain attending psychiatrists.

Case illustration: DJ

DJ's psychiatrist, Dr. [redacted], wrote a total of 105 progress notes about this patient over the course of his hospital admission [9/1/11 -12/19/11], virtually all of them identical in content and so substandard in clinical quality of care as to be essentially useless for treatment planning purposes:

- On all 105 progress notes, for example, the patient's stated mood was invariably noted to be "*OK,*" and a checkmark was placed in a box indicating his affect as "*labile*."

- In the space on the progress note form reserved for indicating "*Current Signs, Symptoms & Appraisal of Progress,*" most of these 105 documents contained little more than a few disjointed phrases or incomplete sentences, often illegible, that offered no relevant psychiatric value related to the formulation of an effective treatment plan review for a very disturbed child.

- Psychiatric progress notes did not reference the patient's multiple explicit threats to kill himself, his aggression and threats to kill staff, multiple forced entries into the nursing station, isolative behaviors, sadness, response to treatment, or demonstrated progress with SAO treatment, etc.

- Treatment staffing note dated 11/9/11 finally added Suicide Risk to the ITP problem list, although DJ had apparently been expressing suicidal ideation throughout September and October.

  At the same time, the psychiatric progress note on 11/9/11 read: "*DJ staffed [illegible phrase], attention seeking. No TD. Placed on SP*." [This is followed by the same illegible phrase written on the other notes.]

- Psychiatric progress notes contained no explanation of DJ's need for 41 PRN medications (Thorazine 25mg IM 6x; Zyprexa 5mg po 11x for agitation; Benedryl 12.5mg 24x for insomnia).

- Of interest, quite a number of psychiatric progress notes for this case appeared to be "cribbed" verbatim from chart entries by MHS staff or other clinicians, in some cases raising questions about whether the psychiatrist actually saw the patient during that period or event.

- Nursing progress notes on DJ were equally uninformative, such as an 11/7/11 entry that: "*Patient paces halls; refuses to attend groups, has poor boundaries with peers.*"

- Of interest, a number of progress notes written by MHS staff about DJ's observed behaviors on the unit were actually quite good, but this information never appeared to be utilized in weekly clinical staffings to inform the treatment plan review process.

- Finally, on none of the 105 psychiatric progress notes were there any entries in the section reserved for "*Additional Information (MD Only,*" suggesting that the attending psychiatrist assumed that minimalist checklist responses and disjointed or clinically meaningless comments were acceptable modes of documenting patient's treatment progress at this hospital.

  More worrisome, from an organizational accountability perspective, XXX Xxxxxxxxx officials, including the hospital's medical director and QAPI staff, had at least *104 opportunities* to correct this substandard quality performance; for whatever reasons, they chose not to do so.

Other case illustrations of problems with treatment planning include DS, who was admitted to the adolescent girls unit on 9/15/11 and became a DCFS ward on 10/19/11.

- During the course of her hospitalization, Dr. [redacted], her attending psychiatrist at Xxxxxxxxx, appeared to display a personal sense of frustration in working with this patient, as evidenced in his progress notes and other documents:

  9/20/11: *"Easily frustrated in the milieu. Not taking treatment seriously."*

  9/21/11: *"Pt is very manipulative and gamey in the milieu." "Very manipulative in nature. Unwilling to participate in group settings."*

  9/22/11: *"Pt not invested in discussing anything with me this morning*."

  9/23/11: *"Pt has very poor boundaries, manipulative and gamey.*

  9/26/11: *"Not invested in treatment, remaining very labile in nature."*

9/27/11: *"Pt is once again very provocative, impulsive, feeds into negative conduct. She's very passive aggressive in nature… Very frustrated to be here. Not invested in treatment."*

10/3/11: *"She was very entitled this morning, demanding to be taken off of blocked room which will not happen until pt is able to tolerate boundaries with peers."*

10/6/11: *"Showing no overt aggression, but is somewhat manipulative and gamey on the unit."*

10/28/11: *"Pt was very manipulative and gamey yesterday, unwilling to get off the nurses' table without firm limit setting. She was able to be redirected after a long conversation, albeit pt is very manipulative and gamey, regressing in symptoms and frustrated to be here."*

While this patient undoubtedly presented treatment challenges to hospital staff, this is not the first time Xxxxxxxxx clinicians have documented attributions about mentally ill children in tones that appear to cast blame on patients when certain behaviors are manifested on the unit, an issue that was also noted in the 2011 UIC report – most strikingly in the case of AC, who suffered pain from Sickle Cell Disease, where both the psychiatrist and nursing staff conceptualized her behaviors as evidence she was simply "med-seeking, *demanding or refusing to utilize coping skills."*

Summary
The 2011 UIC report found that hospital treatment plans were typically generic, non-individualized and lacking indicators that goals were adequately reviewed and modified as necessary.

The current follow-up review of the corrective action plan indicates that the facility has not met this quality performance indicator.

Issue 3: Discharge and aftercare planning

Statement of quality performance deficiency:
Discharge and aftercare planning was found to be generally inadequate to address ongoing treatment needs of patients, including risk factors that may have precipitated their hospitalization. This UIC finding was supported by a 2009 site visit from XXX corporate, which found that '*discharge planning was not evident in medical records,*' something the CMS and UIC teams both agreed upon in 2011" [see UIC report, pages 19 and 40].

Methods and Procedures

- UIC/DCFS reviewers will observe treatment teams to assess whether modifications and improvements indicated in corrective action responses that were recently submitted by XXX officials have been implemented.
- UIC/DCFS reviewers will evaluate discharge plans for patients who become wards after initiation of the CAP against a sample of discharge plans from the six-month period preceding the hold.
- UIC/DCFS reviewers will ask treatment team members during interviews to describe the clinical basis of discharge planning efforts for selected patients.
- Similarly, patients will be asked to describe their awareness of and/or participation in discharge planning efforts by the treatment team.

Criteria for corrective action:

- Hospital treatment teams will show an effective discharge and aftercare planning process, as evidenced by coherent treatment team reviews and progress notes indicating: (a) involvement of the patient in the discharge planning efforts; (b) communication between hospital staff and post-hospital clinical services providers; (c) involvement of the caseworker, supervisor, caregiver(s) and youths in the planning process; and (d) formulation of detailed aftercare plans for follow-up with anticipated problems related to medication management and/or patient non-compliance issues.
- Specific attention will be focused on determining whether the hospital is in compliance with *42 CFR § 482.61* regarding certain follow-up and aftercare services in discharge planning.

Observations and Recommendations:

Evidence corrective action criteria were: *substantially met* ☐ or *not met* ☑ based on the following observations.

Hospital discharge planning and documentation was again found to be inadequate to ensure quality of clinical care for DCFS wards, despite recent assertions to the contrary from XXX officials, as evidenced in part by the following:

- Discharge plans continue to appear generic and non-individualized, a finding that was previously noted by both UIC and CMS (validated by an internal XXX corporate reviewer) in 2011.
- As was the case with treatment planning efforts in the previous section, discharge planning for the current sample of DCFS wards sometimes ignored or did not integrate available information provided by milieu staff, social workers, therapists and other hospital clinicians, nor was adequate attention paid to crafting a discharge summary that would communicate recommendations for aftercare treatment and behavioral management of patients.

  Case illustration: DJ
  As indicated in the previous section, DJ's psychiatrist, Dr. [redacted], wrote a total of 105 progress notes about this patient over the course of his hospital admission [9/1/11 -12/19/11], virtually all of them identical in content and so substandard in clinical quality of care as to be useless for treatment planning purposes; the same criticism would apply to discharge planning efforts:

- DJ's discharge summary, for example, did not reflect information available in admission documentation or later obtained during his hospitalization when describing the history of present illness.

- As for past history, the discharge summary merely noted that DJ "*was at Xxxxxxxxx about three months ago*"; nothing more.

- No reference was made in the discharge plan to psychosexual evaluation or SAO treatment provided by individual and group therapists, including evidence of therapeutic progress.

- An 11/14 entry quotes a social worker's note about contact with patient's sister but fails to include information (from 11/4, 11/8, 11/9, 11/10 and 11/13) such as two Zyprexa prns and three IM Thorazine administered, SP ordered, extreme agitation, and a statement that "*I can use any fuckin' thing to kill myself*."

Other case illustrations of problems with discharge planning include DS, discussed in the previous section, who was admitted to the adolescent girls unit on 9/15/11 and became a DCFS ward on 10/19/11.

- As noted above, DS's attending psychiatrist, Dr. [redacted], appeared to display a personal sense of frustration working with this patient, which was unfortunately carried over to his discharge summary:

  "*The patient is once again admitted due to impulsive behaviors. Allegedly, she cut herself with a razor on her upper thigh. Very superficial in nature. Making suicidal statements, yet has not acted upon them. She's more manipulative and gamey. Admitted to being at Xxxxxxxxx on numerous occasions due to characterological problems*."

  This is not the sort of discharge summary that would likely inspire confidence in a community agency or placement setting that was considering whether they were equipped to handle a "gamey" and "manipulative" adolescent with "characterological" issues.

  More to the point, it sends a dismissively coded message to other treatment staff at the hospital that it is permissible to blame their patients whenever they are unable to therapeutically engage them or find working with them to be unrewarding.

		Summary The 2011 UIC report found that hospital discharge and aftercare planning was generally inadequate to address ongoing treatment needs of patients, including risk factors that may have precipitated their hospitalization. This UIC finding was supported by a 2009 site visit from XXX corporate, which found that '*discharge planning was not evident in medical records,*' something the CMS and UIC teams both agreed upon in 2011 The current follow-up review of the corrective action plan indicates that the facility has not met this quality performance indicator.

Issue 4: Psychiatric/nursing progress notes

Statement of quality performance deficiency: Documentation of treatment plans, psychiatric and nursing progress notes and clinical assessments of patients was found to be deficient and below minimally acceptable quality of care standards; this UIC finding was supported by the federal CMS report, which identified similar deficiencies in these areas [see UIC report, pages 39 and 40].

Methods and Procedures:

- UIC/DCFS reviewers will evaluate progress notes for patients who become wards after initiation of the CAP against a sample of the progress notes from the six-month period preceding the hold.

Criteria for corrective action:

- Charted progress notes will meet clinical standards requiring documentation by psychiatrists, social workers, nurses, MHTs and other hospital staff in such a way as to ensure that therapeutic efforts indicated in patients' individualized treatment plans are actually being rendered to patients.

- Specifically, the progress notes will indicate how patients are responding to treatment, as evidenced by measurable progress toward the short/long-term goals set in the ITPs; and progress notes will link therapeutic interventions made by staff with the actual focus of treatment described in the ITP goals.

- Specific attention will be focused on determining whether the hospital is in compliance with *42 CFR § 482.61* regarding documentation of progress notes.

Observations and Recommendations:

Evidence corrective action criteria were: *substantially met* ☐ or *not met* ☑ based on the following observations.

Psychiatric/nursing progress notes and clinical assessments of patients remained deficient and below minimally acceptable quality of care standards that DCFS has a right to expect in the treatment of its wards, despite recent assertions to the contrary from XXX officials, as evidenced in part by failure to indicate patients' progress/lack of progress toward identified treatment goals.

- Typically, psychiatric/nursing progress notes do not clearly indicate how patients are responding to treatment, tending instead toward the sort of "observational" comments that are of little or no value for the purposes of treatment planning/review. Simply stated, this is "*Basic Treatment 101*" for most experienced clinicians, so it is rather disconcerting to still be finding such unacceptable quality-care documentation at XXX Xxxxxxxxx, especially since both CMS and UIC identified these issues in 2011.

    - While the previously cited example of the 105 psychiatric progress notes regarding the case of DJ may seem to be an extreme outlier, UIC reviewers found a similarly pattern of inadequate, perfunctory and clinically uninformative treatment documentation throughout the records of other current and discharged DCFS wards at the hospital.

		○ Most commonly, psychiatric and nursing progress notes tended to be limited to "observational" comments – such as simply itemizing patient's negative behaviors or indicating whatever staff responses followed (i.e., "*patient was encouraged to utilize coping skil*ls") – as opposed to writing clear and precise documentation about how patients were progressing toward attaining the goals outlined in their individual treatment plans. ○ At the same time, the UIC reviewers were pleased to find instances in the records of DCFS wards where treatment progress notes and other chart entries by various social workers, therapists and MHS staff were superior in quality and useful clinical information to the documentation efforts by psychiatrists and nurses. As noted above, however, there was little evidence that treatment teams integrated such clinical information when formulating or reviewing ITPs and/or discharge plans/summaries. **Summary** The 2011 UIC report found that documentation of treatment plans, psychiatric and nursing progress notes and clinical assessments of patients was deficient and below minimally acceptable quality of care standards, which require psychiatric hospitals to maintain records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution [42 CFR § 482.61]; this UIC finding was supported by the 2011 federal CMS report, which identified similar deficiencies in these areas. The current follow-up review of the corrective action plan indicates that the facility has not met this quality performance indicator.

Issue 5: Consent for medications for DCFS wards

Statement of quality performance deficiency:
The consent forms were found to: (1) have missing information (such as diagnosis, symptoms, weight, medical conditions, etc.); (2) were illegible; or (3) were inconsistent with the DCFS/UIC data about the child). [UIC report, page 51].

Methods and Procedures:

- The UIC/DCFS Clinical Psychopharmacology Program will conduct an updated database analysis to assess current level of compliance with medication consent procedures.
- UIC/DCFS reviewers will monitor the overall performance of medication consent error rate, and will evaluate the impact on DCFS wards during selected case reviews.
- If necessary, UIC will conduct in-service training for Xxxxxxxxx psychiatrists, nurse administrators and QA/PI staff on submission of the medication consent requests.

Criteria for corrective action:

- Hospital unit psychiatric/nursing administrators will maintain copies of all consent requests, FAX cover sheets and FAX confirmations.
- Hospital unit psychiatric/nursing administrators will improve the accuracy of medication consent requests, with fewer errors on each consent request (including correct diagnosis, symptoms, medication, dosage, height, weight, age, and race).
- Xxxxxxxxx Hospital error rate identified at the time of review was 85% (statewide error rate for hospitals averaged 65%); target error rate for the hospital should be 60% or less within 60 days.
- It is expected that within 60 days the hospital will reduce its med consent approval time from 15.5 hours to meet the statewide average of 6-7 hours.
- XXX Xxxxxxxxx officials will direct the hospital's QA/PI staff to conduct monthly assessments of each unit's performance on medication consent requests for DCFS wards, and this data will be regularly verified in consultation with the UIC/DCFS Clinical Psychopharmacology Program.

Observations and Recommendations:

Evidence that corrective action criteria were: *substantially met* ☑ or *not met* ☐ based on the following observations.

As indicated, the UIC/DCFS Clinical Psychopharmacology Program conducted an updated database analysis to assess current level of compliance with medication consent procedures:

- Data for 2012 showed a marked improvement by XXX Xxxxxxxxx in that the percentage of *cases submitted with deficiencies* (that is, missing information) *decreased to 28.57%.*

	A	B
1	**Deficiency Report: Jan-Apr 2012**	
2	Total number of completed cases :	63
3	% of cases with deficiencies :	28.57
4	Average Number of contacts needed to complete cases :	1

It should be noted that the current Xxxxxxxxx data is limited to the first four months of 2012 and includes only 63 case submissions, while the full-year data for 2011 included 285 case submissions.

- On the basis of the current UIC/DCFS data showing significant improvement on medication consent requests, therefore, this corrective action indicator was assessed to have been substantially met by XXX Xxxxxxxxx.

- Nevertheless, there still appears to be some confusion among XXX officials about the UIC/DCFS med consent process, as indicated in a December 28 letter to Director Calica, so it might be useful to fully clarify these issues:

    - Despite assertions by XXX officials, it is reasonable to compare Xxxxxxxxx's average time to completion of psychotropic medication consent requests to data from other Illinois hospitals serving DCFS wards. The UIC/DCFS Clinical Psychopharmacology Program uses the same methodology to review all inpatient psychotropic medication consent requests for DCFS wards, regardless of the hospital of origin

    - Psychotropic medication consent requests are not processed on an arbitrary schedule or using some idiosyncratic review process, and processing on all consent requests begins immediately upon receipt of the *completed CF 431-A form*.

      To assert that the UIC/DCFS consent unit processes med requests "*on their own schedule and timeline*" is, at best, a misunderstanding that obscures the real problem identified in the 2011 UIC report: specifically, XXX Xxxxxxxxx's inadequate policies and procedures for completing the simple CF 431-A consent form, coupled with the hospital's woefully ineffective QAPI processes and staff training.

    - To be clear, delays documented in processing these consent requests were entirely attributable to inaccurate, incomplete or illegible consent requests from Xxxxxxxxx, not because of the consent process itself.

      In fact, significant deficiencies in XXX Xxxxxxxxx's consent requests required additional time on the part of staff of the UIC/DCFS Clinical Psychopharmacology Program – typically involving telephone calls to the hospital's prescribers or nurses to obtain the needed information – and since XXX Xxxxxxxxx's error rate was higher than most other hospitals, their time to obtain approval was consequently longer.

- Curiously, the December 28 letter asserts that since XXX Xxxxxxxxx serves more DCFS wards than most other Illinois psychiatric hospitals, comparison with hospitals that provide less care does not present an accurate picture of Xxxxxxxxx's true performance.

  Again, these comments are nonsensical and serve only to obscure the fact that delays in processing Xxxxxxxxx's consent requests were due to the demonstrably lax accountability procedures for obtaining consent for psychotropic medications.

  Despite the assertion by XXX Xxxxxxxxx's officials that their longer-than-average completion time for consent requests was the natural outcome of serving a larger population of DCFS wards than other facilities, therefore, the relevant counterpoint would be to simply say that such vast experience with the medication consent process ought to have resulted in shorter-than-average completion times as well as lower error rates.

  In most competent healthcare systems, practice does make perfect.

Summary
The 2011 UIC report found that the medication consent forms: (1) had missing information (such as diagnosis, symptoms, weight, medical conditions, etc.); (2) were illegible; or (3) were inconsistent with the DCFS/UIC data about the child).

The current follow-up review of the corrective action plan indicates that the facility has substantially met this quality performance indicator.

Issue 6: Psychiatrists' daily evaluations

Statement of quality performance deficiency:
"*XXX Xxxxxxxxx psychiatrists were observed to be spending as little as three or four minutes a day talking with individual patients on the units*..." [UIC report, pages 40 and 42].

"*In none of the progress notes was there any indication of (a) the amount of time that the psychiatrist spent with this patient or (b) the specific clinical services that were rendered on any of those dates"* UIC report, page 40].

Methods and Procedures:

- UIC/DCFS reviewers will determine whether the hospital's clinical oversight mechanisms adequately track the quality/quantity of therapeutic interventions with patients, including both the administrative and direct-care services rendered by psychiatrists as medical administrators and members of the treatment teams.
- UIC/DCFS reviewers will evaluate progress notes for patients who became wards after admission to the hospital (post-June 2011) against a sample of progress notes from the six-month period preceding the hold.

Criteria for corrective action:

- Attending psychiatrists will schedule a *minimum* 10-minute daily office-time per patient when conducting individual daily evaluations of DCFS wards.
- Any daily evaluations of DCFS wards by attending psychiatrists will not be conducted in hallways or over the nursing station counter.
- Attending psychiatrists will date and time progress notes on daily evaluations (including specifying the actual number of minutes spent per session) meeting with DCFS wards.
- Attending psychiatrists' daily evaluations of DCFS wards will be recorded in patients' charts according to the requirements of *42 CFR § 482.60 & 61* regarding documentation of such patient contact.
- Specific attention will be focused on determining whether the hospital is in compliance with *42 CFR §482.61* regarding documentation of progress notes, including requirements for dating and timing such patient contacts.

Observations and Recommendations:

Evidence corrective action criteria were: *substantially met* ☐ or *not met* ☑ based on the following observations.

Psychiatrists daily evaluations were again found to be inadequate to ensure the quality of clinical care that DCHS has a right to expect in the treatment of its wards, despite recent assertions to the contrary from XXX officials, as evidenced in part by a review of the available data as well as interviews with DCFS wards.

- Specifically, DCFS wards interviewed by the UIC team indicated that their attending psychiatrists typically conduct very brief conversations with them in hallways or over the nursing station counters, often within hearing range of other patients.
- Information provided by DCFS wards was validated during interviews with current and former XXX Xxxxxxxxx staff, who said that – with the notable exception of a few psychiatrists who did make an effort to spend more time talking with their patients – they generally saw no change in the practice of what some called "*the daily drive-by*" interviews conducted by psychiatrists at the hospital.

- **[UIC interview with discharged patient conducted on 5/4/12.]**
  "Dr. XXXXXX was my doc at Xxxxxxxxx; he rarely came in to the unit a lot, kept it short and choppy: 'How's your meds? Are you doing OK? Do you need anything?'"

  "*He would see me on the unit. Usually he'd come to the dayroom, stand right by the door or walk down the hall to the window, talk quickly and then walk* back."

  "*We never went to the office; we'd mostly talk at the nurses station. He saw me no more than 4-5 minutes each time, except for when I'd go to staffings. Sometimes he was not in the staffings but most times he was there*."

  "*My second time [at Xxxxxxxxx] I had Dr. XXXXXXXXX. She was at every staffing, talked to me for maybe 10 minutes each time, which was an improvement from Dr. XXXXX; I saw her 2-4 times a week, plus in staffings. I remember only seeing Dr. XXXXX about twice a week. He'd be on the unit maybe 30-40 minutes, then he was out*."

- **[UIC interview with patient conducted on 4/20/12.]**
  Patient said Dr. [redacted] doesn't come to see him a lot, maybe once a week, and spends 3 minutes talking to him at the nurses station.

- **[UIC interview with patient conducted on 4/20/12.]**
  "*Dr. [redacted] is out of town till next Thursday. He has another doctor watching me, Dr. [redacted]; I met with Dr. [redacted] for a minute*."

Summary
The 2011 UIC report found that "*XXX Xxxxxxxxx psychiatrists were observed to be spending as little as three or four minutes a day talking with individual patients on the units; similarly,* "*in none of the progress notes was there any indication of (a) the amount of time that the psychiatrist spent with this patient or (b) the specific clinical services that were rendered on any of those dates."*

The current follow-up review of the corrective action plan indicates that the facility has not met this quality performance indicator.

Issue 7: Behavioral management training/supervision

Statement of quality performance deficiency:
CPI restraint training was found to be inadequate and improperly documented. [UIC report, pages 28-35].

Methods and Procedures:

- UIC/DCFS reviewers will conduct announced and unannounced observation of all hospital units serving DCFS wards as part of the ongoing corrective action compliance monitoring.
- Monitoring will include an evaluation of CPI training records and random interviews with hospital staff regarding the nature of training and supervision provided by XXX Xxxxxxxxx in behavioral management techniques.

Criteria for corrective action:

- Hospital officials and clinical supervisors will ensure that direct-care staff have the appropriate levels of training and resources to effectively and reliably monitor the units in such a way as to contain aggressive incidents and significant adverse behavioral events that may pose immediate jeopardy or risks of harm to patients or staff.
- Hospital officials will demonstrate that the facility is in compliance with all CPI training requirements, as indicated in the Hospital's Policy & Procedure Manual and stated in recent letters to DCFS.
- As referenced on page 29 of the UIC report, hospital officials will demonstrate compliance with *42 CFR § 482.13(f)(4) and 42 CFR §§ 482.13 (e)(5) & (f))6)* with regard to documentation and implementation of staff training in the proper and safe use of seclusion and restraint application and techniques.

Observations and Recommendations:
Evidence corrective action criteria were: *substantially met* ☑ or *not met* ☐ based on the following observations.

The 2011 UIC report found that XXX officials had failed to properly train and test facility staff in CPI techniques, then engaged in questionable documentation for these training events. The UIC team discussed its findings with representatives of the CPI organization in Wisconsin, receiving assurances that they would evaluate the situation at XXX Xxxxxxxxx and initiate their own corrective action measures.

XXX Xxxxxxxxx officials reportedly took steps to conduct their training/testing according to established CPI guidelines and requirements, as they later indicated in letters and statements to DCFS. While the UIC team was unable to directly verify this aspect of the corrective action plan because of the limited time available during this follow-up review, we have no reason to doubt that the facility is presently conducting restraint training/testing appropriately. Nevertheless, the UIC team stands by its findings in the 2011 report and takes note of the voluntary cessation by XXX officials of what was a very worrisome practice.

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- Hospital officials will demonstrate that the facility is in compliance with all CPI training requirements, as indicated in the Hospital's Policy & Procedure Manual and stated in recent letters to DCFS.
- As referenced on page 29 of the UIC report, hospital officials will demonstrate compliance with *42 CFR § 482.13(f)(4) and 42 CFR §§ 482.13 (e)(5) & (f))6)* with regard to documentation and implementation of staff training in the proper and safe use of seclusion and restraint application and techniques.

Observations and Recommendations:
Evidence corrective action criteria were: *substantially met* ☑ or *not met* ☐ based on the following observations.

The 2011 UIC report found that XXX officials had failed to properly train and test facility staff in CPI techniques, then engaged in questionable documentation for these training events. The UIC team discussed its findings with representatives of the CPI organization in Wisconsin, receiving assurances that they would evaluate the situation at XXX Xxxxxxxxx and initiate their own corrective action measures.

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Davidson & Associates / Mental Health Services Consulting Group
Ronald H. Davidson, Ph.D.

DATE: February 22, 2018

TO: Ben Wolf

FROM: Ron Davidson

Thank you for sharing the letter from James McIntyre regarding certain DCFS contracts for residential care, which I found worrisome for a number of reasons – not the least of which is the fact that the **Acadia Healthcare Corporation**, referenced in the letter, is currently owned and operated by the same executive management team that once headed the now-defunct **Psychiatric Solutions, Inc. (PSI).**

Of particular concern is the troubling record of corporate mismanagement, negligent care and harm to Illinois DCFS wards that was documented over an extended period: first, in the clinical reviews that my UIC staff and I conducted on behalf of DCFS at the PSI-owned Riveredge Hospital; and second, by a series of scathing investigative reports published by the *Chicago Tribune*.[1] [2]

As you know, many of the quality of care reviews that my UIC staff and I conducted for over 20 years – undertaken on behalf of DCFS and the ACLU as part of the monitoring process of the *BH* consent decree – clearly demonstrated a longstanding, oversight failure by DCFS, a disturbing finding that was also of urgent concern to U.S. District Court Judge John Grady throughout the two-decade history of the UIC monitoring effort.

At issue, then, in light of this history of failure by both DCFS and certain of its provider agencies to consistently ensure the safety of children in institutional settings, is whether there is any reasonable basis for again entrusting the Department's wards to any entity that demonstrated such a pattern of *willful* system-related accountability failures.[3]

While the term "*willful*" did not appear in the UIC Report in regard to this accountability failure – despite some evidence suggesting that both PSI corporate-level officials and hospital administrators were withholding information or attempting to mislead the UIC team during the 2008 investigation – subsequent evidence emerged in 2014 that there indeed existed *a de facto practice at PSI Riveredge to deceptively misinform or even lie to DCFS about such harm, including sexual assaults, suffered by its wards at this facility.*

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[1] See attached copy of the final UIC report on Riveredge as well as related documents. This clinical quality of care investigations by the UIC Mental Health Policy Program was undertaken in 2008 at Riveredge Hospital following a request by DCFS' then-director Erwin McEwen. Riveredge was owned at that time by Psychiatric Solutions Inc., as was Streamwood Behavioral Health Center, both of which were later acquired in a corporate takeover by Universal Health Services (UHS).

Of relevant interest, the UIC reports also documented a pattern of substandard care and harm to patients in PSI facilities in a dozen other states, which the UIC team verified by conducting interviews with child welfare and public health officials in those states. As you and Director McEwan understood, I also shared certain findings by the UIC team with the U.S. Department of Justice.

[2] Also attached are several *Chicago Tribune* investigative stories, including coverage about the UIC report on PSI Riveredge to DCFS.

[3] See UIC report on PSI Riveredge, pages 5-9.

Exhibit 91 **and the $100 Million Cost-of-Lying to DCFS**

Of interest, one early effect of the UIC report and the coverage by the *Chicago Tribune* – which apparently triggered a massive (35%) single-day drop in PSI's stock on the Nasdaq – was an investor lawsuit, filed in U.S. District Court in Nashville, alleging that PSI corporate officials had knowingly misled investors about the seriousness of conditions at Riveredge.[4]

During a subsequent 9-hour-long deposition in Chicago on March 18, 2014, the attorneys for plaintiffs in this lawsuit asked me to examine a document that was labeled "***Exhibit 91***," a 2008 internal memo from the CEO of Riveredge Hospital to a senior PSI regional official.[5]

This remarkable document, which is still under seal in federal court, revealed the following:

- The CEO identified the hospital as **"*a façade peppered with deceit.*"**
- Riveredge had **"n*ot reported allegations"*** of harm to patients to DCFS or the police.
- **"*Tampering with evidence on reported rape cases.*"**
- Video evidence of serious incidents often **"*not being reported*"** or shown to DCFS.
- **"*Poor quality*"** of patient care at Riveredge existed **"*from top to bottom*."**

Moreover, the CEO charged that PSI's corporate president, identified by name in the memo, was **"*infuriated*"** by the *Tribune* coverage, saying that he **"*refuses to see the problems,*"** and indicating that he and PSI corporate officials were deliberately **"*ignoring the risks*."**

Following this brief examination of Exhibit 91, plaintiffs' attorney reminded me of comments that I made earlier in the deposition; specifically, to the effect that I typically advised officials and staff at facilities (where my UIC team was initiating a clinical review) of my cardinal rule: **"*Do not lie to me.*"** I would follow up this admonition by saying: "*If you have a problem, just tell us about it, and we'll help you fix it. But if you lie to me, I will turn the dogs loose*."

Plaintiffs' attorney then asked me whether the Riveredge CEO had ever given me a copy of this memo as part of UIC's document-production requirement during the review process at the hospital, or whether she had conveyed any of the information contained in Exhibit 91 to me in any way.

I replied that no one at Riveredge had provided the UIC team with this memo – *a document that we would have considered highly relevant to the investigation UIC was conducting for DCFS* – nor had anyone informed us about the information contained in Exhibit 91. Further, I confirmed to plaintiffs' attorney that such material omissions indicated that UIC, in effect, had apparently been lied to by PSI officials from the beginning of the review process.[6]

Some months after this deposition, it was announced that defendants settled this case with the plaintiffs for ***$100 million*** – a sum that reportedly included $***35 million in legal fees***.

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[4] Garden City Employee's Retirement System vs. Psychiatric Solutions.

[5] The memo – identified as PSY-E-001162618-19, under seal in the federal court filing – was dated September 18, 2008, which was *after* the first *Chicago Tribune* article had appeared (earlier in July) but *before* Director McEwan tasked my UIC team to conduct an investigation at the hospital.

[6] The following morning, March 19, I informed a senior DCFS official about the contents of Exhibit 91, and I shared my concerns with you that I viewed such efforts as an implicit *conspiracy to obstruct* the review that UIC had been conducting under the consent decree agreement between DCFS and the ACLU to ensure the safety of DCFS wards in institutional care. I later discussed Exhibit 91 with Jean Ortega-Piron, who by then had retired as DCFS Guardian; while she had not been shown the memo during her deposition in this case, she angrily agreed with my assessment of its contents.

Implications and recommendations for DCFS and the ACLU

It is also worth noting that Exhibit 91 bears the title ***"Remiss"*** – a term generally defined as "*lacking care or attention to duty; negligent; irresponsible*." Since essentially all PSI officials, administrators and staff members who had any direct knowledge of this matter were legally mandated reporters under Illinois' *Abused and Neglected Child Reporting Act* (*325 ILCS 5/*), their repeated accountability failures ought not to be ignored – even up until today.[7]

In light of this troubling assessment by the Riveredge CEO that senior PSI officials tolerated and endorsed "*a façade peppered with deceit*" in their treatment of DCFS wards – and since it is known that these same individuals are now in control of Acadia Healthcare – both the Department and the ACLU ought to beware of allowing vulnerable wards to be placed at risk of harm in any setting operated by this company. This advisory is especially relevant in any other setting beyond the borders of Illinois that cannot be directly monitored by DCFS staff and/or by clinically trained professionals working on behalf of the Department.

At minimum, then, I would urge that DCFS and the ACLU demand that Acadia Healthcare – or the subsequent owner of Psychiatric Solutions, Inc. – provide a full copy of *Exhibit 91*, along with any and all similar documents or records (regarding harm suffered by patients or substandard care) that were improperly or unlawfully withheld from the Department.

I understand from your recent email that the Department has placed (or may be intending to place) DCFS wards in certain out-of-state facilities operated by Acadia – all of which should raise very serious concerns in light of the indicators of deceitful practices seen in Exhibit 91.

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[7] As was noted in the UIC report and in other communications to DCFS, in one of the required 10-K reports to the Securities and Exchange Commission, the then-CEO of Psychiatric Solutions stated that the company's operating strategy was to "*focus on our profitability by optimizing staffing ratios*."

While the UIC report on Riveredge demonstrated the harm caused to patients by such consequently dismal staffing ratios at a sing;e hospital, a comparative *system-wide* analysis revealed the effect of placing profitability over patient care on a much broader scale. Our findings included the fact that *PSI* ***allocated nearly 11% less of its annual revenue on staffing costs*** than other private psychiatric hospital corporations nationally – ***55.2% as opposed to 65.8%*** – according to financial data from the federal Centers for Medicare and Medicaid services.

Similarly, as the 2008 *Los Angeles Times/Pro Publica* jointly-published series indicated – and as was discussed in the UIC Riveredge report (pages 10-15) – data from the California Department of Health demonstrated that "*PSI's California hospitals proportionately have fewer registered nurses than other private psychiatric facilities; about one for every four beds, compared with one for every two beds, according to the state data." Overall, "****PSI hospitals have about one- third fewer staff-per-bed***."

Worse still, this appalling staffing ratio disparity contributed to one PSI facility having what a scathing editorial in the *Sacramento Bee* newspaper called *"****one of the worst patient mistreatment records of any psychiatric hospital in California*****"** – a record that included far more incidents of significant harm to patients **(such as violence, sexual assaults, suicide and death)** than more responsible facilities which chose to maintain adequate staffing levels.

Even more revealing, the *LA Times* analysis concluded that "*the five PSI hospitals in California had a* ***profit margin of more than 25%*** *in 2007, according to the Office of Statewide Health Planning and Development."* Meanwhile, ***"the average for the state's other for-profit psychiatric hospitals was about 6%."*** UIC later determined that PSI's facilities in Illinois had been operating at an even greater profit margin, underscoring the "***façade peppered with deceit*****"** that was described in Exhibit 91.

Proceeding with an abundance of caution, it would therefore seem to be clearly in the best interests of these wards if DCFS and the ACLU conducted a thorough review of Exhibit 91 and all other such evidence prior to any decision to entrust Illinois' children to the care of corporations or individuals whose past conduct has demonstrated something other than good faith or a credible reason for trust.

Current issues regarding Acadia Healthcare facilities in other states

Following up on your request to determine whether Acadia Healthcare facilities in other states were known to have similar quality of care deficits as had numerous PSI facilities detailed in the UIC report on Riveredge, I conducted a brief review of currently available public records and news media reports in 7 states – ***Arkansas, Michigan, Pennsylvania, Indiana, Florida, Missouri and Arizona*** – where Acadia currently operates residential care facilities or psychiatric hospital inpatient treatment programs.[8]

Attached below, therefore, is a summary of certain available materials, including news media clips and reports of surveys by federal or state-level agencies, regarding nine of these facilities, including both residential treatment programs and psychiatric hospitals. Please note that the documents outlined in these tables are attached as separate PDF files (approximately 277 pages), in addition to the final UIC Riveredge report (86 pages) and related federal CMS survey documents (83 pages).[9]

Finally, I would urge that DCFS and the ACLU agree upon a *workable and enforceable* mechanism for conducting direct and unannounced on-site monitoring of any out-of-state facilities that may be contracted by the Department to deliver quality care to DCFS wards. As you, former DCFS director Jess McDonald, several past governors and those Illinois legislators who supported our efforts know all too well, the 1995 UIC report on out-of-state care showed that the Department's longstanding failure to monitor such distant placements was not only a public scandal but a *de facto guarantee* of harm to children.[10]

Please let me know if you need any additional information.

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[8] As I understand from your email note, DCFS may have recently referred wards to the Acadia facilities in Michigan (Detroit Capstone) and Arkansas (Piney Ridge).

[9] Since I retired as director of the UIC Mental Health Policy Program in 2014, I no longer have either the staff or other resources available to conduct the level of scrutiny of such records that my team provided to DCFS and the ACLU in the past, so I emphasize the *limited scope* of the information in this present summary. Therefore, a more rigorous scrutiny of such public records (i.e., from public health and child welfare agencies in all states where Acadia Healthcare conducts such operations) is strongly recommended as a precursor to DCFS contracting for services with this company. Further, an on-site review of incident reports should also be conducted, in addition to interviews with state and local child welfare or public health officials responsible for licensing these facilities.

[10] Two years before Exhibit 91 was written, Virginia moved to revoke the license of a PSI facility in Charlottesville after health officials found *"multiple violations constituting neglect" of children in care, including sexual abuse by staff."* The revocation letter cited "inadequate staffing" as a direct cause of patient harm in one serious incident of violent assault (in which a youth was beaten so badly that he reportedly stopped breathing temporarily and suffered a seizure). Virginia investigators later concluded that "*in spite of the concerns nursing staff voiced about the severity of his injuries, administrative staff directed nurses not to call emergency services. According to nursing staff, in a meeting held the day after the assault,* ***[the PSI] administrators stated that they did not want 911 called because of concerns that the State might find* out."**

Acadia Facility	Documents & Sources
Piney Ridge Center **Arkansas**	**News Media Reports** (2016) • **"DHS Confirms Investigation into Piney Ridge Treatment Center."** • **"Former Piney Ridge Patient: '*It's More Like a Kids' Fighting Ring*.'"** • **"Family: '*12-Year-Old Daughter Forced to Fight Other Kids by Staff*."** • **"State Investigated Fight Allegations at Juvenile Treatment Center."**
Issues: • Abuse and neglect • Staff misconduct • Understaffing • Poorly supervised program • Counter-therapeutic environment	

Acadia Facility	Documents & Sources
Capstone Academy **Michigan**	**Special Investigation Reports (2)** (2014 and 2016) • **State of Michigan** **Department of Human Services** **Bureau of Children and Adult Licensing** Complaint violations established by reviewers.
Issues: • Abuse and neglect • Staff misconduct (assault of child) • Understaffing • Poorly supervised program • Counter-therapeutic environment • Improper psychotropic medication procedures	

Acadia Facility	Documents & Sources
Resource Treatment Center **Indiana**	**News Media Reports** (2017 and 1018) • **"Former Employee: *Staff at Youth Psychiatric Facility Encouraged Fights, Were Violent with Kids*."** • **"Indianapolis Neighbors, Police Say Kids Are Escaping a Psychiatric Treatment Center,"**
Issues: • Abuse and neglect • Staff misconduct • Understaffing • Poorly supervised program • Counter-therapeutic environment	

Acadia Facility	Documents & Sources
Valley Behavioral Health Center **Arkansas**	**News Media Reports** (2016) • **"Lawsuit Alleges 10-Year-Old Boy Raped by Teen While in Presence of Van Driver."** • **"Lawsuit Accuses Valley Behavioral Health of Negligence in On-Site Rape."**
Issues: • Abuse and neglect • Staff misconduct • Understaffing • Poorly supervised program • Counter-therapeutic environment	

Acadia Facility	Documents & Sources
Harbor Oaks Hospital **Michigan**	**News Media Reports** (2017) • **"Ex-Employee: *Metro Detroit psych Hospital So Understaffed It's Dangerous.*"** • **"Michigan Mental Health Patient Charged with Two Sex Assaults While at Harbor Oaks."** • **"Harbor Oaks Hospital Allegedly Inflated Staffing Levels in Anticipation of Audit."** • **"Harbor Oaks Inflated Staffing Levels When Watchdog Visited, Insiders claim."** • **"Michigan Mental Hospital Nurse Pleads for Help: '*We Can't Keep People Safe.*"'** • **"Sexual Assaults at Psych Treatment Facility Raise Questions."**
Issues: • Abuse and neglect • Sexual assaults of patients • Staff misconduct • Understaffing • Poorly supervised program • Counter-therapeutic environment	

Acadia Facility	Documents & Sources
Parc Place **Arizona**	**News Media Reports** (2012) • **"CPS Pulls Kids from Care Home; State Won't Disclose Reason for Court-Ordered Removal."** • **Arizona Protects Juvenile Rehabs, Destroys Reports of Abuse and Neglect."**
Issues: • Abuse and neglect • Sexual assaults of patients • Staff misconduct (sexual assaults on patients) • • Understaffing • Poorly supervised program • Counter-therapeutic environment	

Acadia Facility	Documents & Sources
Lakeland Behavioral Health System (Psychiatric Hospital) **Missouri.**	**News Media Reports** (2016 and 2017) • **Summary of reviews by federal CMS investigators conducted by the *Association of Health Care Journalists.***
Issues: **CMS reviewers determined the following:** • Risk of *immediate jeopardy* situation determined by CMS reviewers. • Failures placed patients at risk for abuse. • Multiple episodes of patient-on-patient violence. • Staff failure to protect patients from assaults, • Inadequate treatment planning and interventions. • Poor supervision of nursing care.	

Acadia Facility	Documents & Sources
Park Royal Hospital **Florida**	**News Media Reports** (2016) • **Summary of reviews by federal CMS investigators conducted by the *Association of Health Care Journalists.*** • **"Hospital Patient Care Deficiencies Highlighted in Federal Inspection Report."** • **"Psychiatric Hospital Sued Over Suicide."** • **"Hospital Faces More Trouble with Lawsuit Over Suicide of Psychiatric Patient."** • **"Mental Hospital Missed Warning Signs About Employee Who Sexually Assaulted Patients."** • **"Park Royal Hospital Sexual Abuse Lawsuit Settled."**
Issues: • Abuse and neglect • Staff misconduct (sexual assaults of patients) • Understaffing and failure to ensure patient safety. • Patient suicide related to staff failure to perform safety checks. • Poorly supervised program • Counter-therapeutic environment	

Acadia Facility	Documents & Sources
Sierra Tucson Behavioral Treatment Center **Arizona**	**News Media Reports & CMS Surveys** (2014, 2015 and 2016) • **Reviews by federal CMS investigators (2)** • **"Third Sierra Tucson Patient Death in 13 Months."** • **"Mother Sues Sierra Tucson Over Son's Death."** • **"'*Lax Care Cost Patient His Life*,' Lawsuit Says."** • **"Investigators Point to Shortfalls After Sierra Tucson Suicide. Ex-staffers Not Surprised by Patient Death."** • **"Sierra Tucson Fined Over Deficiencies in Psychiatric Care."** • **"Sierra Tucson Admits No Wrongdoing in Suicide."**
Issues: • Failure to follow suicide risk assessment procedures, • "*Very High Risk*" patient not monitored for self-harm. • Patient suicide related to staff failure to perform safety checks. • Safety hazards contributed to cause of death. • Understaffing and failure to ensure patient safety. • Poorly supervised program. • Counter-therapeutic environment.	

NOTE: The following representative sampling of news media reports from the *Chicago Tribune* and the *Los Angeles Times* underscore the chronic problems regarding harm to patients that were often identified in facilities operated by the same management team that now heads up Acadia Healthcare.

Facility	Documents & Sources
PSI Riveredge Hospital **Chicago**	**News Media Reports & federal CMS Surveys** (20072008)) • **"Troubles With Private Mental Hospital Conglomerate."** (Part of *Los Angeles Times* series on PSI hospitals.) • **"Psychiatric Care's Perils and Profits."** (Part of *Los Angeles Times* series on PSI hospitals.) • **"At Hospital, Violence Festered in Silence."** • **"Riveredge Hospitals Patient's Death Went Unreported."** • **"As Executives Promise Transparency, State Probes a Death."** • **"A Mother Mourns Two Lost Futures."** • **"Justice Department Expands Psychiatric Hospital Probe to 3 More Illinois Facilities."** • **"Hospital Thwarts Police Inquiries; Violence Festered in Silence."** • **"Riveredge Case Files: Unheeded Allegations of Harm."** • **"Illinois Report Blasts Care at Psychiatric Hospital."** • **"UIC Report Backs Tribune's Findings."** • **Federal CMS surveys attached (3) (2007-2008)**
Issues: • Patient abuse and neglect, frequently unreported or minimized to DCFS and police. • Violence and sexual assaults of patients. • Unreported patient death. • Chronic understaffing contributed to patient harm. • Poorly supervised programs. • Inadequate clinical treatment documentation, rubber-stamping of MTPs. • Unsafe and counter-therapeutic treatment environment. • **Federal CMS surveys (3) conducted in 2007-2008 were consistent with findings by the UIC team, as was noted in the attached UIC Riveredge report.**	