

**SECOND REPORT TO THE COURT MASTER:**

**OBSERVATIONS/FINDINGS REGARDING THE RIVERVIEW PSYCHIATRIC  
CENTER**

**Respectfully Submitted:**  
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## INTRODUCTORY COMMENTS

The first Report to the Court Master was submitted on November 3, 2014. The Report detailed observations made and conclusions reached after an on-site review of the Riverview Psychiatric Center in early October 2014. Subsequently, the Report was discussed with the Parties to the Consent Decree and, on January 22, 2015, Riverview's administration submitted its formal response. This document outlined the actions to be taken to address the findings and recommendations regarding treatment planning, the use of seclusion and restraint, and the adequacy of staffing.

In order to evaluate whether the actions promised by Riverview's leadership had been implemented in a timely and thorough manner, at the request of the Court Master, a second three day site visit to Riverview was conducted on September 22, 23, and 24, 2015.

In preparation for the site visit, a number of documents were requested and reviewed. These documents included treatment plans; administrative documents regarding staffing; reports to the Human Rights and Medical Executive Committee; the list of clinical case conferences held since January 2015; and a report prepared by a consultant to Riverview that described the Management of Aggressive Behavior (MOAB) training program. After the site visit, additional documents were requested and reviewed regarding grievances; staffing patterns; Performance Improvement Reports; and job descriptions. Not all requested documents were received, including the training materials used to instruct the Acuity Specialists.

During the site visit, informal interviews were held with staff on all three shifts. The staff interviewed worked throughout Riverview; they included nurses, psychiatrists, Mental Health Workers, Acuity Specialists, support staff and staff assigned to the Treatment Mall. Separate meetings were conducted with the Peer Support Specialists and Patient Advocates. In addition, discussions were held with staff in key leadership positions, including the Superintendent, the Medical Director and the Risk Manager. The Director of Nursing position was not filled at the time of the site visit.

As was the case during the first site visit, both scheduled and spontaneous meetings occurred with class members on each of the Units. There were conversations with five class members whose treatment plans had been reviewed and one class member on the Upper Saco unit requested a meeting. An open forum was held for class members on the last day of the site visit. Class members offered forthright comments, both positive and negative, about their experiences at Riverview. One class member, who could not attend, sent a thoughtful letter describing his concerns about his treatment plan.

Finally, throughout the three days, periods of observation in each of the Units permitted direct views of interactions between class members and staff. Two

episodes of restraint and seclusion were observed, one on Lower Saco and one on Lower Kennebec.

Information gathered from all of the above sources form the basis for this Report. It is clearly understood that there are limitations inherent in the time available on site. It is also recognized that Riverview continues to be the focus of legislative hearings, the media, and oversight by regulatory agencies at the federal and State levels.

It is hoped that this Report will assist the Court Master and the Court in determining what additional actions, if any, are necessary to ensure that Riverview is in compliance with the longstanding Court Orders in this case.

## SUMMARY OF FINDINGS

### Adequacy of Staffing:

Paragraph 202 of the Consent Decree establishes two essential obligations:

- Riverview must provide treatment.
- Riverview must meet minimum staffing requirements.

These two obligations cannot be separated. If there is insufficient staffing for the class members confined to Riverview, then appropriately individualized treatment cannot be realized as required by the Court's Orders.

The difficulties with staffing have not been corrected.

Although the administration of Riverview has repeatedly and publicly stated that it has met minimum staffing requirements, it does not recognize that the treatment requirements of individuals now admitted to Riverview have changed significantly since the implementation of the Consent Decree Plan in 2006.<sup>1</sup> As a result of this Plan, prepared and endorsed by the Parties to this litigation, Riverview now serves as a tertiary level hospital. That is, civil admissions to Riverview now occur **after** treatment at a community hospital close to the class member's home. As a result, individuals admitted to Riverview typically require more complex interventions or longer periods of time to recover.

The need for more intensive treatment compels further examination of the staffing resources at Riverview.

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<sup>1</sup> The Consent Decree Plan, issued on October 13, 2006, restructures the delivery of community-based services and reframes the use of Riverview as a "tertiary care facility within the mental health continuum." (See page 92)

During the site visit, it was obvious that staffing on the Units is not stable. This was evident in several critical ways:

- Temporary or part-time practitioners are filling vacant psychiatry positions because of difficulties in recruiting and retaining psychiatrists. The failure to ensure continuity of care jeopardizes treatment because trusting physician-patient relationships cannot be formed and sustained. Two psychiatrists cited the negative publicity about Riverview as a significant problem in recruitment.
- Acuity Specialists, specifically hired to supplement staffing during especially difficult or potential periods of crisis on the Units, are serving as direct support staff, in lieu of trained Mental Health Workers. The Acuity Specialist role is a very important addition to staffing at Riverview. It was not intended to be a substitute for direct support. Furthermore, the Acuity Specialists are not trained in the basic duties expected of the Mental Health Workers. For example, they are not trained to conduct the mandated room checks that help safeguard safety on the Units.
- If one to one staffing is mandated for a class member, the coverage is absorbed within the minimum staffing requirements rather than through an additional staff person on the Unit.
- According to the Superintendent, the requirement that Mental Health workers have a Certified Nursing Assistant (CNA) certificate has been changed to require a CNA certificate or its equivalent.
- The recent realignment of staff as a prelude to a “unit based” staffing model has disrupted, at least for the near future, the clinical relationships on the Units that are the foundation for the implementation of treatment plans. (All treatment plans reviewed stated that certain staff would engage the class member for a specified number of minutes each week.) In many instances, therefore, class members are required to form new trusting relationships in order to move towards recovery. This realignment seems premature in light of the fact that staffing ratios responsive to acuity are far from being implemented. (The initiative to develop a staffing model reflective of acuity levels is at its very earliest stages in a pilot research project led by staff at the State Hospital in New Hampshire.)
- There is reliance on temporary nurses, called “travellers,” to meet nursing mandates.
- Overtime, either voluntary or mandated, is used consistently to meet minimum staffing standards on the Units. According to information provided

by Riverview, overtime for Mental Health Workers was 1102.75 hours in July 2015 and 1083.5 hours in August 2015. Mandated overtime was 224 hours and 312 hours respectively. Overtime for nurses was 462.75 hours in July 2015 and 337.5 hours in August 2015. Mandated overtime was 16 hours and 8 hours respectively.

- The focus on vocational employment for class members has been curtailed by the lack of staff resources. One staff person on the Treatment Mall acknowledged that there was insufficient staffing at present to encourage class members to participate in work-related assignments. This was confirmed by Riverview's management.

At one time, this focus was a significant and exemplary practice at Riverview. The Consent Decree Plan references it as an important strategy for treatment.<sup>2</sup>

At the time of the site visit, the census was seventy-six class members. Forty-three class members had forensic status while thirty-three class members were civil admissions. During the last year, Riverview has consistently operated well below its permissible capacity of ninety-two class members. Although most vacancies usually exist on the civil side, when vacancies do occur on the forensic side, admissions have not been approved in a timely manner. There was one jail transfer documented in this year. This fact was not only noted from the admission statistics provided by Riverview, but was raised by staff working in the forensic Units. They were concerned that the failure to provide earlier interventions resulted in more escalated behavior when an admission finally occurred.

In its response to the Court Master, Riverview's administration stated that it would implement the provision that supplements, by one dollar, the hourly wage for Mental Health Workers assigned to the Lower Saco and Lower Kennebec Units. This increase did not go into effect until September 1, 2015.

#### Adequacy of Treatment:

At the time of the first site visit in October 2014, there was heightened concern about the use of restraint at Riverview. As a result of the oversight resulting from multiple investigations into specific situations, actions have been taken to reduce the likelihood of excessive force. These actions include the hiring of additional Acuity Specialists.

As discussed above, the appointment of Acuity Specialists is noteworthy and to be commended. However, the assignment of Acuity Specialists to perform the duties of Mental Health Workers in order to meet minimum staffing requirements seriously distracts from the initial intent.

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<sup>2</sup> See Consent Decree Plan, pages 84, 85, and 86.

In addition, training in the use of alternatives to restraint was to be expanded and strengthened. In 2014, Riverview began using the program Management of Aggressive Behavior (MOAB). The program was to be evaluated by an external consultant. That evaluation was provided as part of this site visit review and was noted to be unsatisfactory in its scope and its analysis. After discussion with the Risk Manager, a second report was prepared and provided for review. This report is more detailed and addresses staff competencies. It concluded that:

- Staff whose skills were tested as part of the evaluation “were consistently unable to demonstrate MOAB techniques, however they quite easily demonstrated NAPPI techniques.” (NAPPI was the previous behavior management program.)
- Staff exhibited a high level of competence in using MOAB techniques on the high acuity forensic unit.<sup>3</sup>

These findings confirm the need for consistent, ongoing instruction throughout Riverview, especially since staff continue to float across all Units, including the high acuity section of Lower Saco.

During this site visit, there was the unanticipated opportunity to observe two restraint and seclusion episodes. In both instances, staff responded appropriately and demonstrated respect and empathy for the class members. The requisite debriefings were held immediately after both incidents. In both debriefings, staff discussed antecedent behaviors and the alternative approaches that had been attempted before restraint was used.

In Riverview’s response, clinical case consultations also were cited as one of the means to train and educate staff. Based on the information provided for this review, only one case consultation has been held since January 2015. Reportedly, a consultation regarding B. P. took place in May 2015.

The most poignant and instructive discussions about treatment continue to be those held with the class members themselves. Details gathered from these conversations include:

- Clinicians develop treatment plans prior to the meeting with the class member. The class member’s own interests may be secondary to those proposed by staff. The form to be completed by the class member prior to the treatment team meeting is often left in the class member’s mailbox rather

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<sup>3</sup> See “Evaluation of the ‘Management Of Aggressive Behavior’ Program,” October 16, 2015.

than discussed directly. Assistance in completing the form is not always offered.

Copies of seven forms, "Your Input Is Essential," were included in the treatment plan documents provided prior to the site visit. Class members completed three of the forms. Four forms were blank. The Medical Director agreed that staff should assist the class member with completing the form or, at least, discuss the questions prior to the treatment team meeting.

- Limited staffing has prevented any expansion of the opportunity to be outdoors.
- Mental Health Workers do not usually attend the treatment team meetings. Often, these staff know the class member better than other staff.
- Treatment plan goals are repeated over and over again. They focus on weaknesses rather than on the class member's strengths.
- Treatment Mall classes do not change frequently enough to keep interest.

In the review of various documents, the presence of trauma in class members' lives was noted extensively. In spite of this, the attention to trauma-informed treatment appeared very limited.

- Grievances about treatment and other issues of concern are not responded to in a timely manner.

Riverview's policy requires that first level grievances receive a formal response within five days, excluding weekends and holidays. The Quarter 4 2015 Performance Improvement Report documented that only 52% of the Level One grievances were responded to within the timeframe required by policy.

Riverview does conduct an Inpatient Client Survey every Quarter. The results to the indicators have an overall average score of 65% positive ratings.

## **CONCLUDING COMMENTS**

The concept of a recovery-based orientation to treatment at Riverview is not new. It was first articulated over a decade ago, was emphasized in previous administrations, and was re-affirmed in the Consent Decree Plan:

Goal 1: Deliver hospital-based psychiatric care at Riverview Psychiatric Center that is consumer-centered, recovery-focused, innovative, and appropriately integrated with community-based care.<sup>4</sup>

Unquestionably, changing the culture of an institution is challenging and requires time, energy and resources. It relies on teaching new principles and practices to staff and to the class members themselves. Institutionalized individuals must be supported to develop trusting relationships if they are to express their needs and goals for recovery.

Change in an organization, such as Riverview, best occurs when its value is understood by the staff and when staff are included in the process of planning and implementing new strategies.

Regrettably, based on observation and report, there is insufficient evidence to conclude that staff and class members are sufficiently involved in reshaping recovery-oriented practices and policies at Riverview.

Finally, the longstanding attempt to define Riverview as an integral part of a comprehensive community-based system of care is undermined by the failure to both explain this framework to staff and to strengthen its ties to community partners in the State's mental health network. For example, staff orientation at Riverview does not acknowledge this Hospital's role in the delivery of community-based mental health treatment. The leadership at Riverview confirmed that this focus is not a priority.

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<sup>4</sup> Consent Decree Plan, page 83.