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US Department of Justice's Findings: Woodbridge Developmental Center

New Jersey received a letter on November 12, 2004 from the US Department of Justice (DOJ) detailing the findings of the Civil Rights Division's investigation of conditions and practices at Woodbridge Developmental Center.

Under the Civil Rights of Institutionalized Persons Act (CRIPA), the DOJ has the authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal rights of residents with developmental disabilities who live in public institutions.

These findings are based upon an on-site tour of Woodbridge Developmental Center in June 2003; with a team of experts including consultants in psychiatry, psychology, risk management, community placement, nutritional and physical management, and occupational and physical therapy.

Developmental Centers

New Jersey operates seven large and aging developmental centers, housing more than 3,100 individuals with developmental disabilities. Since 2001, the Centers for Medicare and Medicaid Services (CMS) have conducted inspections of the Developmental Centers. Federal certification not only insures a consistent standard of care, but Federal funds provide half of the cost of services for the consumers.

Two of New Jersey's Developmental Centers, Woodbridge and New Lisbon, were decertified for a period of time between 2001 and 2002. Since that time both Developmental Centers were re-certified by CMS.

In May-June 2002, the Department of Justice investigated the conditions and practices at New Lisbon. DOJ sent a letter to New Jersey in April 2003, detailing violations of individuals' rights. DOJ and the State entered into negotiations and in July 2004 agreed to a settlement. The settlement agreement includes specific steps that will be taken at New Lisbon to ensure compliance with standards and best practices. An independent monitor will report on the State's compliance or non-compliance to the settlement agreement.

Woodbridge is a state-owned and operated residential facility serving individuals who have a variety of developmental disabilities, including mental retardation, cerebral palsy, autism, and spina bifida. Woodbridge houses approximately 500 residents, ranging in age from 17 to 74 years.

Many of Woodbridge's residents are medically complex, non-ambulatory, and require frequent monitoring and assistance with their daily needs. A number of residents also have swallowing and seizure disorders.

DOJ Findings at Woodbridge

Certain conditions at Woodbridge violate the constitutional and federal statutory rights of the residents. Woodbridge failed to: 1) protect residents from harm; 2) provide adequate behavioral services, freedom from restraint, and habilitation; and 3) provide adequate medical care.

DOJ also found that residents were not placed in the most integrated setting appropriate to meet their needs in violation of Title II of the Americans with Disabilities Act, as construed by the U.S. Supreme Court decision in *L.C. v. Olmstead*.

Protection from Harm

Woodbridge fails to provide the basic oversight of residential care and treatment that is critical to protect residents from harm. DOJ reports that some steps had been taken prior to the investigation by Woodbridge, such as an internal investigation unit and training of staff on abuse and neglect.

Woodbridge's own documents reveal that residents suffer frequent injuries. Approximately 1,597 incidents were recorded from April 2002 until March 2003. These incidents included:

- Approximately 433 accidents
- 533 self-inflicted injuries
- 135 peer-inflicted injuries
- 48 incidents of neglect
- 53 incidents of undetermined origin.

Woodbridge's failure to protect residents from harm stems from inadequate supervision, the failure to prevent staff abuse and neglect, and an inadequate incident management system.

Inadequate Supervision

Residents suffered many serious injuries because Woodbridge fails to supervise residents adequately and fails to provide adequate information to direct care staff regarding crucial behavioral problems.

Even when behavioral risks were communicated to direct care staff, staff repeatedly failed to address these behavioral issues adequately, neglecting to provide adequate supervision.

Facility records reveal that residents routinely suffer injuries of unknown origin. Generally accepted professional practice recognizes that serious injuries of unknown origin constitute potential evidence of abuse or neglect, incompetent or insufficient supervision, a failure to intervene when indicated, or ineffective monitoring systems.

Abuse and Neglect

Staff abuse and neglect of residents are ongoing at Woodbridge. Review of facility incident reports and investigations confirmed that residents are subject to staff abuse and neglect.

- Many residents must endure isolation and lack of personal stimulation
- Confirmed abusers were at times reassigned to client care
    - This is a violation of generally accepted professional standards that provide that when reinstating employees, facilities must take measures to protect residents by assigning staff to an area where there will be no contact with residents.

Inadequate Incident Management

Although Woodbridge's data tracking system does a good job of tracking and analyzing what is centrally reported, Woodbridge fails to ensure that incidents are consistently reported to the central data base.

The primary cause of Woodbridge's under-reporting of incidents is its failure to develop a consistent reporting system, with consistent policies and procedures.

The lack of consistent reporting procedures caused staff to be under the false impression that they did not have to report self-inflicted and client-to-client incidents and injuries.

Behavior Programs, Restraints, and Habilitation

Woodbridge fails to provide adequate psychological services to meet the individualized needs of residents with behavior problems. These failures include: 1) providing residents with ineffective behavioral programs; 2) minimizing the use of mechanical and chemical restraints; and 3) providing adequate habilitation treatment and activity programs.

Behavior Programs

Woodbridge's behavior programs are ineffective and substantially depart from generally accepted professional standards. Standards provide that behavior programs should be: 1) based on adequate functional standards; 2) implemented as written; and 3) monitored and evaluated adequately.

Many behavior functional assessments were unchanged over periods of many years. In all but one of the 24 cases reviewed, no evidence was found that the functional assessment had been revised or updated based on a lack of progress.

Woodbridge staff routinely fails to properly implement the formal written behavior programs for residents. On-site review by DOJ revealed that few, if any, staff know how to implement programs properly. Staff interviews revealed significant errors in recall of basic and essential elements of behavior programs.

Failure to implement behavior programs is largely caused by Woodbridge's failure to train staff adequately. Interviews showed that staff received some classroom training but virtually all admitted that they were not asked to demonstrate competency or understanding on how to implement the behavior programs.

Restraints

The investigators found that non-medical restraints, including helmets and four-point restraints, were used without support by data from a formal functional analysis.

In the first quarter of 2003 alone, Woodbridge reported:

- 26 uses of emergency mechanical restraint
- 709 uses of mechanical restraint when a resident exhibited a challenging behavior
- 465 uses of mechanical restrain whether or not a resident exhibited a challenging behavior.

DOJ found that 31% of Woodbridge's residents received psychoactive medications for the treatment of a behavioral or psychiatric disorder. However, only nine percent of residents receive behavioral treatment program services.

Many residents with significant behavioral disorders are only being medicated for their problems and that minimally acceptable behavior and other services are not provided.

Habilitation

Woodbridge's habilitation treatment services and activity programming are inadequate. Staff has not been trained adequately to implement the habilitation plans.

Residents do not receive habilitation services in appropriately integrated settings. For example, at the time of the DOJ visit, current residents traveled off-campus to work at a job and most residents received minimal, if any day programming.

Medical Care

Woodbridge fails to provide residents with adequate medical care, including psychiatric services, neurological care, nutritional and physical management and therapy services.

Psychiatric and neurological services:

The provision of psychiatric and neurological services at Woodbridge departs from generally accepted professional standards of care. These inadequacies include:

- Incomplete or overlooked assessments and diagnoses
- A lack of proper re-evaluations
- A tendency to not provide timely access or follow-up in services
- Inadequate monitoring of potential side effects of powerful psychotropic and anti-convulsant medications.

Nutritional and Physical Management

Woodbridge substantially departs from generally accepted professional standards in nutritional and physical management. Woodbridge provides inadequate assessment of residents' complex and interrelated nutritional, physical, and medical needs in the areas of positioning, alignment, mobility, nutrition, and medical care.

In the six months preceding DOJ's visit, dozens of Woodbridge residents were hospitalized and some residents died as a result of physical, nutritional, and medical concerns that were addressed inadequately.

Therapy Services

According to Woodbridge professionals, Woodbridge utilizes a **"nursing home model"** of physical and occupational therapy in which the goal is merely for residents to maintain the status quo rather than for residents to acquire new skills and enhance abilities.

Lack of adequate therapy services exposes residents to harm including increased risk of respiratory, gastrointestinal, and skin integrity complications.

Integrated Settings and Community Placements

New Jersey is failing to serve Woodbridge's residents in the most integrated settings appropriate to their individualized needs, in violation of Title II of the ADA.

Woodbridge's interdisciplinary teams fail to conduct reasonable assessments to determine whether each resident could be served in a more integrated setting.

Woodbridge does not assure that residents and their families are fully informed about the availability and choices of community placement. In fact, many of the Woodbridge staff lack knowledge concerning community placement opportunities.

According to the DOJ findings, the 2003 budget included sufficient funds to provide for at least 20 transfers to the community. However, only five residents of the 100 waiting for transfer to the community were scheduled to be moved into the community in mid-2003.

Minimal Remedial Measures

Similar to the New Lisbon situation, negotiations may take place prior to the US Attorney General filing a lawsuit pursuant to CRIPA in order to rectify the deficiencies at Woodbridge. If a lawsuit is filed (as was done with the New Lisbon case) prior to a court's ruling, the State and DOJ could work towards a settlement agreement.

DOJ identified measures, at a minimum, that should be taken. Below is a synthesis of the potential remedial measures outlined in the DOJ letter.

Training: Develop and implement competency-based training systems for staff in areas such as risk management, the proper use of restraints, implementation of behavior/habilitation plans, therapy services, and nutritional/physical management.

Monitoring and Reporting: Develop a more comprehensive and effective monitoring and reporting system to ensure the rights, safety, and well-being of residents. This must include the construction and dissemination of clear policies and procedures concerning incident reporting and regular monitoring of individual progress and abnormalities.

Comprehensive Medical Assessments: Ensure that each resident with mental illness and/or neurological disorders is given a comprehensive medical assessment which is regularly tracked and re-evaluated. Provide comprehensive assessments to residents with therapeutic, physical, and nutritional support needs.

Community Placement Plans: Conduct individualized assessments of each resident to determine if they are being served in the most integrated setting appropriate to their needs. Develop an individualized plan based on the findings of that assessment. Develop comprehensive community placement plans to provide community-based services and residences to the individuals already identified as eligible for community placement. Develop a timetable to place each individual in community-based programs.

Conclusion

People with disabilities have the right to receive services in the most integrated settings appropriate to their needs.

New Jersey has an opportunity to develop a unified vision and plan for services and supports that protect the rights of people with developmental disabilities.

Concerns raised by this DOJ letter, as well as the settlement agreement on New Lisbon, demonstrates systemic issues that need a comprehensive plan to protect the rights of people who remain in all the Developmental Centers. A plan to protect the rights of individuals who want to move into the community and can do so with the proper supports must also be ensured.

Additional funds are needed for necessary infrastructure in the community and the Developmental Centers. The minimal remedial measures need to be implemented and enforced at all the Developmental centers and in community agencies.