

Failure to Care

*A National Report on Universal Health Service's
Behavioral Health Operations*

This report was prepared by:

Service Employees International Union, Local 1107

3785 E. Sunset Rd., Las Vegas, NV 89120

Tel: 702.386.8849 Fax: 702.386.4883

www.seiunv.org

A statement of concern from the National Alliance of Professional Psychology Providers

There is a crisis in our nation's mental health care system. Many factors contribute to this crisis including financial, regulatory, and cultural issues. One of the most glaring problems in this crisis is the corporate practice of placing earnings and exorbitant profits above the public interest at the expense of quality services to those in need. Using Universal Health Services (UHS) as an example, this report clearly documents why mega healthcare corporations such as UHS need to be held accountable for the services for which they are contractually responsible to provide.

The enclosed report, "A Failure to Care," addresses this crisis, by shedding light on numerous violations of consumer rights at UHS' behavioral health facilities across the country. It is a report that needs to be taken seriously as it is essential to the public interest that consumers of behavioral healthcare be protected against abuses by those whose custody they are remanded. Among the many well-documented statements detailed in the report are incidents of abuse, inappropriate reliance on restraints and seclusion, medication errors, and failure to identify and treat barriers to recovery. Patients suffering from mental illness are amongst our most vulnerable citizens. Behind close doors under the guise of confidentiality these patients are at the mercy of those who are responsible for their well being. Few would argue that healthcare businesses should be denied making a profit but in healthcare profit must be tempered with the public good.

The report's authors, affiliated with the Service Employees International Union Local 1107 in Las Vegas, are familiar with the difficulty of providing quality health care services under UHS' model of for-profit care. Understaffing, a practice so frequently encountered in UHS facilities, is one of the most favorite targets for cutting costs. It prevents health care workers - no matter how qualified and how dedicated - from providing the best quality care that patients deserve.

As founders of the National Association of Professional Psychology Providers and as practitioners and researchers, we are dedicated to promoting an effective and caring mental health system. Such a system must be founded on respect for those who are in need but also for those who provide mental health services.

To ensure that such respect exists in the mental health facilities of our communities across the country, we urge that regulators, elected officials, and other community leaders read this report closely. If UHS, or any other for-profit behavioral health company, is looking at expanding into your community, we recommend that they be scrutinized as to "what they say" and "what they do." We urge all parties to consider the importance of oversight recommended in this report, and take steps to ensure that quality care is provided throughout the behavioral health system. We further recommend that these corporate entities be required to fulfill the terms of their contracts. We, and UHS, can well afford to do better.

Signed:

Dr. John Caccavale,
Executive Director, NAPPP

Dr. Nicholas Cummings
Former President, American Psychological Association
Executive Board, NAPPP

Dr. Stanley Graham
Former President, American Psychological Association
Current Chair of Independent Practice, American Psychological Association
Executive Board, NAPPP

Dr. Jack Wiggins
Former President, American Psychological Association
Executive Board, NAPPP

Table of Contents

Executive Summary	5
I. Introduction	7
II. Profits Before Patients: UHS' Behavioral Health Treatment Model	8
<i>A) Closing Facilities to Protect Patients</i>	8
<i>B) Sexual Exploitation and Abuse</i>	10
<i>C) Runaways at Risk</i>	11
<i>D) Failure to Protect Patients from Controlled Substances</i>	12
<i>E) Patient Care and Recovery at Risk</i>	12
<i>F) Inadequate and Ineffective Discharge Planning</i>	15
<i>G) Inappropriate Use of Seclusion and Restraints</i>	16
<i>H) Disregard for Patient Rights and Protections</i>	17
<i>I) Failing to Provide a Safe Patient Environment</i>	18
<i>J) Patient Dumping</i>	19
IV. Putting Profits above the Interests of the Community	20
V. Recommendations to Protect your Community from UHS	21

Executive Summary

Universal Health Services (UHS) is one of the nation's largest, fastest-growing and most profitable providers of behavioral health services. Unfortunately, as this report finds, it is also very controversial, frequently understaffing its facilities at the expense of its patients, its staff and the communities it is supposed to serve.

This report finds that UHS has disregarded the patient safety and recovery of the patients it serves, as well as the communities in which it operates:

- On more than one occasion, UHS facilities have been cited for failing to provide federally mandated emergency care (EMTALA violations, also known as patient dumping).
- UHS closed a behavioral health unit in the midst of a community's mental health crisis because it was not profitable enough.
- There are numerous violations of fundamental patient rights, including UHS' failure to respond to allegations that a 15 year old patient was being sexually abused at the facility, that a six year old patient was held in restraints for five days without justification, and that short staffing failed to prevent a patient from committing suicide.

As a result, in the last five years, **six UHS facilities in four states have been forced by regulators to temporarily stop or reduce admissions into their facilities.**

This report finds that poor case management and understaffing at UHS facilities have led to adverse patient outcomes including:

- Sexual exploitation and abuse
- Runaways
- Inappropriate reliance on restraints and seclusion
- Physical assaults
- Medication errors
- Insufficient discharge planning
- Failure to properly identify and treat barriers to recovery

Ways to Protect Your Community

UHS is actively seeking to expand existing facilities and enter new communities. It plans on adding between 700 and 800 new behavioral health beds each year. If a UHS facility is not already located in your community, there is a good chance UHS will be coming to your community in the near future.

UHS' track record of understaffing means that community mental health advocates must act proactively to protect patients. There are a number conditions and recommendations you can implement to protect your community and ensure that patients receive the quality care they deserve. Some of these include:

- **Carefully review all Certificate of Need requests.** Investigate the level of quality care that UHS provides in its behavioral health facilities across the country. Critically examine the documents that UHS submits for review to ensure that they are disclosing their plans for fulfilling staffing needs and quality measures in their proposed facility.
- **Require staffing ratios for licensure.** Impose enforceable staffing ratios on UHS facilities to ensure that they maintain appropriate levels of staff in their facilities.
- **Require that patients be involved in developing their recovery plan.** Require that patients and their families or members of their support system be actively involved in developing the patient's treatment and discharge plan, or recovery plan. Require documentation, such as written identification of what they feel are the barriers to recovery by the patient and members of the patient's support system, to ensure that the patient is having his/her needs addressed and is actively involved in the development and assessment of his/her recovery plan.
- **Require that patients and family members sit on the board of UHS facilities.** Require that members of the mental health community, both patients and family members, sit on the board of behavioral health facilities and be appointed by advocates, such as the local chapter for the National Alliance for the Mentally Ill.
- **Require transparency in the behavioral health care that UHS provides.** Require quality measures, such as the frequency that seclusion and restraints are used; the number of events which lead to patients or staff members being abused, endangered or significantly harmed; and staffing levels be publicly available and easily accessible to mental health consumers
- **Require that UHS facilities provide care to the uninsured.** Require that UHS facilities provide a set amount of charity care to members of the community and have the facilities report the amount of charity care they provide.
- **Actively involve mental health advocates, patients and family members when reviewing a UHS Certificate of Need proposal and setting conditions.** Use their expertise to create conditions for UHS facilities that will effectively protect the rights of mental health consumers in your community.
- **Require a public review process when UHS is planning to change the existing behavioral health services provided at its facilities.** Patients, consumers, family members, workers and advocates should be actively engaged in the public review process.

I. Introduction

“Those children did not receive one bit of psychological therapy all weekend... all because we did not have the appropriate staff and things were too out of control.”¹

- Nurse from UHS-owned Pembroke Hospital in Massachusetts, in a letter to hospital administrators regarding an incident with teenage patients that occurred one week after state regulators lifted a freeze on the admission of children in 2002, and sent anonymously to the Patriot Ledger newspaper.²

“Senior staff confirmed the belief that decisions are driven by finances with little consideration given to the impact of systematic quality of patient care.”³

- Massachusetts Department of Mental Health report

Universal Health Services (UHS) is one of the largest for-profit providers of behavioral health services in the country. The company is actively expanding its existing facilities and entering new markets.

As nurses and caregivers in Las Vegas, Nevada, we see first hand how UHS’ pattern of short staffing can impact patient care. After all, UHS controls more than one-third of all of the beds in Southern Nevada⁴ and earns 20% of the company’s net revenues in our community.⁵ Our experience with the company in Las Vegas led us to review practices at UHS’ behavioral health facilities across the nation.

We found a record of UHS placing consumers and hospital staff in danger, in part due to its practice of understaffing. Incidents like the one described above are not isolated to one facility, but are seen again and again in investigations performed by state agencies across the nation.

In many instances, poor case management and understaffing at UHS behavioral health facilities has led to physical or sexual assaults, patients running away, and at times, death. UHS has placed its patients in jeopardy with its inappropriate use of seclusion and restraints, its pattern of medication errors and incomplete or inaccurate treatment and discharge planning. UHS’ profit-driven model of behavioral health care has forced communities to use resources to respond to emergencies that UHS has created. Several UHS facilities across the nation have been forced by authorities to stop admissions, often due to understaffing.⁶

Quality care cannot be provided in this kind of environment.

Often communities do not learn about UHS’ business practices until it is too late. This report intends to educate communities on UHS’ behavioral health practices, so they can make an informed choice about the kind of behavioral health care they want provided in their community. Additionally, we have provided recommendations to ensure that the most vulnerable in your community are protected.

II. Profits Before Patients: UHS' Behavioral Health Treatment Model

UHS Earns a Quarter for Every Dollar they Bill People Diagnosed with Mental Illness

UHS operates 103 behavioral health facilities in 30 states and in Puerto Rico,⁷ including 79 behavioral health hospitals,⁸ therapeutic schools and residential treatment centers, for a total of 6,640 beds.⁹

Last year, UHS reported net revenues of \$3.9 billion.¹⁰ UHS' Behavioral Health Division reported \$774.1 million in net patient revenue in 2005, which represented 19.8% of the total net patient revenue for UHS.¹¹ In UHS' *Report of Third Quarter Earnings* issued in October of 2006, UHS reported an operating margin of 24.7% at their behavioral health facilities.¹² **This means that UHS earns 24.7 cents in profit for every dollar they bill a consumer of behavioral health services.**

UHS is actively expanding its existing facilities and entering new markets. From September of 2005 to September of 2006 UHS increased the number of behavioral health facilities it owns by 75.6%, going from owning or leasing 45 behavioral health facilities in September of 2005 to owning or leasing 79 facilities in September of 2006.¹³ Steve Filton, Chief Financial Officer of UHS, claims that the company plans to add between 700 and 800 beds annually in 2006 and 2007.¹⁴

Unfortunately, UHS' profit-driven model of behavioral health care delivery creates conditions that are dangerous for people receiving behavioral health services at their facilities and for staff. The following are real life examples of what occurs in UHS behavioral health facilities across the nation.

III. UHS' Record of Patient Rights Violations

A) Closing Facilities to Protect Patients

In the last five years, six UHS facilities in four states have been forced by regulators to temporarily stop or reduce admissions into their facilities because patients were in imminent danger, often as a result of understaffing.¹⁵ Because behavioral health patients are suffering from diseases which affect their ability to think clearly and rationally, it is imperative that there be an adequate level of trained staff available who can identify the barriers facing a patient's recovery and provide the care needed for the person to regain his/her social independence.¹⁶

- In March of 2002, UHS' Westwood Lodge in Massachusetts was told to temporarily stop admitting new adolescent patients. This action stemmed from the facility's failure to respond to a complaint that two staff members were sexually abusing a 15 year old patient.¹⁷
- In the fall of 2002, state regulators forced UHS-owned Pembroke Hospital in Massachusetts to stop admitting children for two weeks. A mother of a six year old girl had complained that her daughter had been mistreated. According to a local newspaper, a state investigation found that the hospital had kept the 6 year old in the strictest restrictions for five days without justification. A letter written by the Commissioner of Mental Health in Massachusetts, Marylou Sudders, is quoted as saying, "current conditions present a serious risk to the health and safety of patients."¹⁸
- In July of 2004 an inspection done by state regulators in Georgia found that the conditions at UHS' Peachford Behavioral Health System placed patients in immediate jeopardy. A patient had been admitted to the hospital with a severe headache and an opiate dependence. An RN reported to state investigators that on the night in question, there was one nurse and one mental health assistant caring for 17 acutely ill people. The patient was found dead the following morning from an overdose of methadone, which the patient had smuggled into the hospital. The state of Georgia found there was not enough staff to carry out the doctor's orders.¹⁹
- In July of 2004, UHS-owned Glen Oaks Hospital in Texas was issued a 90-day termination notice from the Centers for Medicare and Medicaid when an unstable suicidal person was transferred to a different facility without being evaluated or stabilized, and without notifying the receiving facility or sending the patient's records.²⁰
- In the Summer of 2006, the state of Connecticut temporarily stopped sending children to UHS' Stonington Institute, a substance abuse and mental health treatment center for adolescents. The Facility averaged two runaways a day. When the Connecticut Department of Children and Families visited the hospital in June they found that the program was not maintaining the staffing levels it had promised to maintain when its license was extended in November of 2004.²¹
- In 2005, investigators recommended that a 90 day termination process begin on UHS-owned McAllen Medical Center Heart Hospital in Texas because a patient's rights were violated when s/he did not receive the care s/he required. A patient was under doctor orders to be closely supervised, which means that the person needed to be checked every 15 minutes. These orders were not consistently carried out, and the person hanged himself or herself.²²

- In July of 2006 Pembroke Hospital in Massachusetts is once again the subject of a state investigation. The investigation stems from a Patient's complaint, but the details have not yet been disclosed.²³

B) Sexual Exploitation and Abuse

Many mental health patients enter a treatment facility feeling vulnerable and powerless due to trauma, loss, humiliation and degradation they have experienced before being admitted to a facility. When sexual misconduct occurs in behavioral health facilities and treatment centers, it works in "counteracting therapeutic benefits of treatment and furthering the humiliation and degradation of those victims."²⁴

The pattern of sexual abuse seen at UHS-facilities and lack of response by the administration at those facilities is alarming. Despite UHS' Behavioral Health Division earning \$774.1 million in net patient revenue in 2005,²⁵ UHS continues to make staffing decisions that place patients in unnecessary danger.

- In 2003 at UHS-owned Glen Oaks Hospital in Texas, short staffing resulted in the facility's failure to prevent two adolescent patients from having a sexual encounter in the male adolescent's room.²⁶
- In 2002 at UHS-owned Coastal Harbor Treatment Center in Georgia, four adolescent patients were left unsupervised for two hours and inappropriate sexual behavior occurred between the patients. A physical examination of the patients indicated that the sexual behavior was not consensual for at least one of the patients involved.²⁷
- In 2003 in the Psychiatric Center at UHS-owned McAllen Heart Hospital, the State of Texas found UHS had not provided patients a safe environment to receive care. Investigators found two instances of inappropriate sexual contact between patients had occurred in a two week timeframe. In one instance, a patient had tested positive for syphilis, which placed the other patient involved in the sexual encounter at further risk.²⁸
- In 2002, UHS' Westwood Lodge in Massachusetts was investigated for allegations that two employees sexually abused a 15 year old female patient. UHS administrators did not believe the allegations made by the patient and did not report the allegations to officials or limit contact between the patient and the employees. The hospital kept the employees on staff and in contact with the patient for two months, even though the patient had talked about the abuse to multiple people, her family had reported their suspicions to the facility twice and the hospital had confirmed that the patient had the employees' private cell phone numbers. UHS officials also knew that the patient had written about the abuse in a diary and had said that the employees had promised to help the patient escape the facility in return for sexual favors. The patient did escape the hospital on one occasion, and was returned to the facility by police. UHS eventually transferred the two mental health aides to a male unit in order to "minimize" the contact

between the employees and the patient, but the employees were allowed to monitor the patient on two occasions after she had attempted suicide. Administrators from UHS-owned Westwood Lodge still did not report the allegations to state officials. State officials were not informed until a doctor from a different hospital reported the allegations after treating the teenager for sexual abuse.²⁹

- In 2003, a charge nurse from UHS-owned Pembroke Hospital in Massachusetts wrote a letter to hospital administrator regarding an incident involving teenage patients that occurred one week after state regulators lifted a freeze on the admission of children. The incident is described in the letter as, “(one patient) started punching and kicking herself violently in the face...(another)was curled on the floor rocking, crying and scratching her wrists saying that she needed to see blood to make herself feel better.” The charge nurse reports in her letter that only one worker was available to watch both of these teenagers because another worker was caring for a third out of control patient. The boys’ unit was also out of control, with patients throwing furniture and breaking overhead light fixtures. No therapy groups were held that weekend, there were no outside trips, and the children were not even able to go to the cafeteria. The nurse wrote in the letter to hospital administrators, “Those children did not receive one bit of psychological therapy all weekend.... all because we did not have the appropriate staff and things were too out of control.” The licensing survey that resulted from the investigation done by the Massachusetts Department of Mental Health is reported to say, “Senior staff confirmed the belief that decisions are driven by finances with little consideration given to the impact of systematic quality of patient care.”³⁰
- In 2002 at UHS-owned Laurel Heights Hospital in Georgia, the facility did not document whether it had investigated allegations by an adolescent patient who claimed to have been physically abused and raped.³¹ In addition, the child’s treatment plan did not explain why the patient was regularly put into the seclusion room.³²

C) Runaways at Risk

As the incidents below indicate, inadequate staffing and supervision can lead to patients running away. Those who run away do not receive the behavioral health treatment they need while being faced with an increased risk of, “...poor nutrition, inadequate sleep, exposure to the elements, a host of medical problems, physical assault and theft, substance abuse and dangerous sexual behavior including exploitation. Some turn to survival sex, theft, and panhandling to live.”³³

- In 2003, at UHS-owned Laurel Heights Hospital in Georgia, five patients had run away from the hospital in a six month period because of inadequate supervision. In one instance where a patient ran away, hospital policy set the staff to patient ratio on the unit at 1:4, but when one staff person responded to an emergency the

ratio went to 1:6, and when another staff member had to escort an aggressive patient to a connecting unit, the ratio went to 1:11, and a patient ran away.³⁴

- In the Summer of 2006, the state of Connecticut found that UHS' Stonington Institute, a substance abuse and mental health treatment center for adolescents, averaged two runaways a day when the facility's staffing levels were not in compliance with its licensure requirements.³⁵

D) Failure to Protect Patients from Controlled Substances

In addition to failing to prevent patients from running away from some of its facilities, UHS has also failed on occasion to protect patients from access to controlled substances. This puts patient's recovery at risk at UHS-owned facilities, many of which specialize in the treatment of patients with dual diagnosis, a co-occurring substance abuse and behavioral health diagnosis.

- In 2002 at UHS-owned Turning Point Hospital in Georgia, a facility that provides substance abuse treatment,³⁶ a state investigator found the door to the medication room propped open and the medication cart unlocked with no licensed personnel in the vicinity.³⁷
- In 2001 at UHS-owned Peachford Behavioral Health System, a second facility in Georgia that specialized in the treatment of children, adolescents and adults with psychiatric and addictive diseases,³⁸ a regulator for the state of Georgia found five predrawn syringes containing Lidocaine (an anesthetic) were left out on a tray in the open, with no label on them and no personnel in the vicinity. In addition, thirteen pre-drawn syringes containing Brevital, a controlled substance, and 13 pre-drawn syringes of Anectine (a muscle relaxer) that were not labeled with the strength of the medication, the date the syringe had been filled or the initials of the staff member who filled the syringe.³⁹

E) Patient Care and Recovery at Risk

As stated in a white paper written by New York State's Consumers, Patients, Survivors, and Ex-Patients and used in developing New York's Statewide Comprehensive Plan for Mental Health Services, when a mental health consumer's symptoms are not addressed in his/her treatment plan, "...a roadblock to recovery is created. We become victims to static, hopeless 'programs' and exhibit little or no growth. We lose out self esteem and hope is shattered."⁴⁰

Documented failures at UHS facilities to identify and treat all of the symptoms that patients are struggling to overcome include:

- In 2004 at UHS-owned Anchor Hospital in Georgia, a patient died four days after being admitted, after not receiving the proper treatment because his/her medical condition was not properly monitored. The person had been admitted with auditory and visual hallucinations, major depression with psychotic features and a

diagnosis of Parkinson's disease and hypertension. Doctor orders indicated that the patient was to have his/her blood pressure monitored and be given a potassium supplement medication to treat his/her Parkinson's disease and hypertension. The patient made one trip to the emergency room because of an altered mental state and low potassium. S/he was sent back to the hospital with instructions that her potassium levels and blood pressure needed to be closely watched. The patient's blood pressure was very low, but there was no documentation on the patient's chart that the nurse or physician were notified or that a reassessment of treatment was done. The person became incontinent and was drooling excessively and drowsy in a wheelchair, but no reassessment of the patient's condition was performed. The investigation done by the State of Georgia found critical patient care information missing from this patient's medical records, as well as from the medical records of other patients who had been transferred from Anchor Hospital to the emergency room.⁴¹

- In 2002 at UHS-owned Anchor Hospital in Georgia, a patient was admitted complaining of hearing voices that were telling him/her to kill someone. In addition, the patient was diagnosed with coronary heart disease and complaining of chest pains. The patient's treatment plan did not address treating the auditory hallucinations or the coronary artery disease. A doctor had ordered that vital signs be taken on the patient to monitor the coronary artery disease, and there was no documentation that the patient's vital signs had been taken. A second patient was hearing voices and paranoid, but his/her treatment plan did not address these symptoms. Skin tests for tuberculosis had been ordered for two patients, but there was no documentation that the tests had been done. Still another patient with diabetes had been administered an incorrect dosage of insulin. In addition, patients had not received notice of their right to request discharge after being transferred to voluntary status, which is a violation of the law in the State of Georgia.⁴²
- In 2006 at UHS-owned Rockford Center in Delaware, a patient was admitted with open wounds, but the care for those wounds was not included on the initial care plan for the patient. The plan was not updated for six days. As a result, the patient did not receive care for his/her wounds, including medication that was prescribed by a doctor during those six days.⁴³ In a second inspection done at the UHS-owned Rockford Center in Delaware, inspectors found that patients were missing doses of their medication or being given more medication than prescribed, and the errors were not being recorded on the treatment plan. In addition, nurse and/or physician assessments were incomplete for four patients, including a patient that needed a psychogeriatric assessment.⁴⁴
- In 2004 in the Psychiatric Center at UHS-owned McAllen Heart Hospital in Texas, a patient died three days after falling at the facility. The investigation found that, although the doctor had noted in the patient's record that the person seemed "confused," and a nurse noted that a new medication made the person "drowsy," no assessment for fall precautions had been done for the patient, and no fall precautions were in place to protect the patient.⁴⁵

- In 2003 at UHS-owned Laurel Heights Hospital in Georgia, an outbreak of patient illness had occurred in a children's unit of the hospital.⁴⁶ A statement from a nurse stated that the residents on that unit had been sick, but there was no documentation that indicated that Medical Director had been informed of the outbreak of an apparent respiratory illness. One resident had been feverish for several days and on bed rest. On the morning of 4/6/2003 the child was unresponsive with blue lips and labored breathing. The patient's condition was observed by nursing staff at 8:25am, but the patient was not brought to the emergency room until 10:10am. There was no evidence that the patient's condition was assessed before being brought to the emergency room or that the patient was assessed and monitored while being transferred. When the child arrived at the emergency room, s/he was in an altered mental status, did not have a gag reflex and his/her skin was cool and pale. The resident was diagnosed with pneumonia upon his/her admission to the emergency room. The investigation conducted by the State of Georgia also found that the UHS-owned facility had not done a clinical review of the incident to ensure that patients would not be placed in that kind of danger again.⁴⁷
- In 2006 at UHS-owned Rockford Center in Delaware, a patient was diagnosed with bedsores and 7 days passed from the date of diagnosis without any record of care of the bedsores in the nursing plan. There was no record of the patient's progress or response to treatment of his/her bedsores.⁴⁸
- In 2003 at UHS-owned Peachford Behavioral Health System in Georgia, a patient was suffering from bedsores and the state inspector found no documented plan of treating the patient's bedsores or any documented evidence that treatment had been provided.⁴⁹
- In 2003 at the UHS-owned Rockford Center in Delaware, the hospital was cited for not fully implementing their hospital-wide Quality Assurance program. UHS failed to comply with its policy for a Healthcare Peer Review Occurrence Reporting System, which is done when an unusual event with a potentially harmful outcome occurs that is not consistent with routine care or desired operations. These forms were not being filled out by staff and there was no corresponding occurrence form found in patients' files.⁵⁰
- In Georgia, UHS facilities were cited for omissions or incomplete documentation on Patients' medical records in 12 separate inspections from 2001 to 2005.⁵¹
- In 2003 at UHS-owned Timberlawn Mental Health System in Texas, a patient's treatment plan acknowledged his/her Post Traumatic Stress Disorder and depression, but did not include care for his/her eating disorder, although the patient's extreme weight loss had been documented by a doctor and the patient had discussed it with staff at the facility.⁵²

F) Inadequate and Ineffective Discharge Planning

Discharge planning is a critical component in mental health treatment and recovery. Discharge planning is intended to be an individualized plan that assists patients in accessing the medical care and social support services patients need in order to be successful in recovery.⁵³

A discharge plan may address a patient's continuing mental health or substance abuse care needs, medication, housing assistance, assist in applying for Medicaid or other social support programs, education and transportation needs.⁵⁴

Inadequate discharge planning is known to contribute to homelessness among people with severe mental illnesses and/or substance abuse disorders.⁵⁵

Discharge planning is a critical piece of suicide prevention. Research has shown that a person who has attempted suicide has a higher risk of later dying from suicide.⁵⁶ In order to prevent this, patients and their families need to take steps to reduce the risks of self-harm and suicide, such as removing alcohol and guns from the home, and create a safety plan that will help patients and their families to detect, prevent and effectively respond to future attempts at suicide or self-harm.⁵⁷

This makes discharge planning critical for a person's survival.

Below are several reported incidents in which UHS-owned facilities' failed to provide patients with effective discharge planning.

- In 2002 at UHS-owned Turning Point Hospital in Georgia, state investigators found that the responsibility for discharge planning was not designated to qualified staff.⁵⁸
- In 2004 at UHS-owned Pembroke Hospital in Massachusetts, a teenager spent six days hospitalized, with three of those days being a holiday weekend. Four days after being released from the hospital the teenager hanged herself at her parent's house. Her mother has complained that the teen was discharged despite her parents' protests that it was too early. The mother also reports that she received no explanation as to why her daughter was discharged, nor was she told all of the symptoms described in her daughter's medical record, including the teenager's repeated description of her plan to hang herself.⁵⁹
- In 2003 at UHS-owned Timberlawn Mental Health System in Texas, a majority of patient records reviewed by the State were missing discharge summaries with a description of the patient's hospitalization and recommendations for appropriate services and follow-up care.⁶⁰
- In 2003 at UHS-owned Peachford Behavioral Health System in Georgia, a homeless person, without a support system, tested positive for cocaine was

admitted to the facility. The patient's treatment and discharge plan did not include goals for addressing these significant barriers to discharge.⁶¹

G) Inappropriate Use of Seclusion and Restraints

Seclusion and restraints are not a treatment intervention, but a last resort response “to violent behaviors that creates extreme threats to life and safety.”⁶² Staff of a behavioral health facility should be trained in de-escalation techniques and interventions that can be used at the earliest sign of a crisis so the use of seclusion and restraints is never necessary.

The report, *Achieving the Promise: Transforming Mental Health Care in America*, submitted by The President's New Freedom Commission on Mental Health, states, “An emerging consensus asserts that the use of seclusion and restraint in mental health treatment settings creates significant risks for adults and children with psychiatric disabilities. These risks include serious injury or death, re-traumatizing people who have a history of trauma, loss of dignity, and other psychological harm.”⁶³

The report goes on to say, “It is also inappropriate to use these methods instead of providing adequate levels of staff or active treatment.”⁶⁴

Research has shown that seclusion and restraints are used dramatically less when there is an increase in staff to patient ratios and staff receives training and support from hospital management.⁶⁵

UHS has a record of providing behavioral health care that routinely uses seclusion and restraints, without taking the proper steps to prevent or avoid these extreme interventions.

- In June of 2006 at the UHS-owned Rockford Center in Delaware, a geriatric patient was unnecessarily placed in a mechanical restraint (a gerichair) without a physician order and without documentation that less restrictive interventions were first tried. The patient developed a skin breakdown (bed sores) while s/he was at the Rockford Center. Seven days passed from the date the bed sores were diagnosed before any care was provided for the bedsores and recorded in the nursing plan. There was no record of the patient's progress or response to treatment of her bedsores.⁶⁶
- In 2004 at the UHS-owned Rockford Center in Delaware, state regulators found that the hospital failed to establish a system that would protect patients from abuse and that hospital staff used a “non-therapeutic unapproved escort method,” after a child complained that he/she had been “thrown to the floor” and forced to the seclusion room by an employee. The child had a fresh blood injury on the right side of his/her face and bruises around his/her eye. During the investigation, the state also found that the Rockford Center's policy on financial exploitation and mistreatment did not conform to state law and the facility's definition of abuse and neglect were too broad and lacked specificity.⁶⁷

- In 2002 at UHS-owned Laurel Heights Hospital in Georgia, a staff member caused a child resident to break his/her arm by the utilization of an improper behavioral management technique. A different staff member did not follow proper procedures while administering an enema to the child resident.⁶⁸
- In 2004 at UHS-owned Spring Mountain Treatment Center in Nevada, a 14-year old resident was admitted to the UHS facility with a diagnosis of bipolar disorder, psychosis and oppositional behavior disorder. While the child was in seclusion, she defecated on the floor of the seclusion room. The child resident told the state investigators that she had repeatedly requested to be taken to the bathroom, but her requests had been ignored by staff. The investigators found no evidence the child was continuously monitored while she was in seclusion and the facility was cited for failing to provide adequate documentation to establish that treatment interventions were safe, proportionate and appropriate to the severity of the child's behavior. In a separate incident, a 15 year old female patient was restrained by five members of staff and forcibly administered Thorazine. There was no documentation that the parent's of the resident were notified or that the staff or the patient were debriefed.⁶⁹
- In 2003 at the UHS-owned McAllen Medical Center in Texas, a patient was kept in soft restraints for 35 hours without a doctor order. A doctor then ordered that s/he be kept in restraints for an additional 24 hours without first assessing the patient face-to-face to determine that restraints were still necessary.⁷⁰
- In 2005, UHS-owned McAllen Medical Center and Heart Hospital in Texas was cited for keeping a patient in restraints for two days without a doctor's order.⁷¹

H) Disregard for Patient Rights and Protections

UHS facilities are regularly cited for patient rights violations ranging from not informing patients of their right to discharge to failing to institute a grievance process for investigating and responding to complaints.

- In 2003 at UHS-owned Peachford Behavioral Health System in Georgia, UHS violated patient right's law when a patient advocate was never notified and the patient's concern was not resolved. The patient submitted a grievance to the facility and a decision was made by the facility, but there was no documentation that the person who submitted the grievance was ever notified.⁷²
- In 2002 at UHS-owned Anchor Hospital in Georgia, UHS was cited for failing to document that patients had received a notice of their right to request discharge.⁷³
- In 2003 at UHS-owned Peachford Behavioral System in Georgia, UHS was again cited for violating patient rights when a patient was not informed of her rights or educated about her medications.⁷⁴

- In 2004 at UHS-owned Spring Mountain Treatment Center in Nevada, UHS was cited for not providing the parents or guardians of their adolescent patients with the facility's policy on the use of seclusion and restraints.⁷⁵
- In 2002 at the UHS-owned Rockford Center in Delaware, the hospital was cited for failing to create a grievance process that dictated a specific time frame for investigating, acting on and responding to patients' complaints. Rockford Center was also cited for failing to provide a written notice of the facility's determination regarding the grievances of some of the patients at the facility.⁷⁶
- In 2004 at UHS-owned Peachford Behavioral Health System, patient rights were not displayed in all locations frequented by patients.⁷⁷ In addition, the facility failed to ensure that there was an effective system in place to protect patients' right to confidentiality. A staff member disregarded a patient's written instructions and discussed confidential medical information with a family member without the patient's consent.⁷⁸
- In 2003 at UHS-owned Timberlawn Mental Health System in Texas, patient confidentiality was violated when the biological mother of an adolescent patient was allowed to have contact with the child and access to information about the child's treatment, despite the child's guardians refusing to sign a release to allow the biological mother access to the child. The adolescent's guardians were concerned that contact with the mother would cause the child's illness to become worse.⁷⁹
- In 2004 at UHS-owned Spring Mountain Treatment Center in Nevada, UHS failed to report all serious injuries or other reportable incidents to the State Protection and Advocacy Organization and to Medicaid. In addition, the UHS-owned facility did not post the contact information for the State Protection and Advocacy Organization where patients and their families could see it.⁸⁰
- In 2002 at UHS-owned Laurel Heights Hospital in Georgia, UHS was cited for lacking documentation that it was complying with policies related to patient restrictions.⁸¹
- In 2004 the State of Delaware cited the Rockford Center for charging patients an exorbitant amount of money to obtain a copy of their medical records, thereby creating a potential to frustrate efforts by individuals to access their medical records.⁸²

1) Failing to Provide a Safe Patient Environment

In addition to not investing in adequate staff, UHS also has a record of failing to provide clean and safe physical environments for people diagnosed with mental illness. UHS' propensity for allowing their facilities to be dirty and fall into disrepair shows a disregard for the basic right of people struggling with mental health issues to be cared for in an environment that is safe and free from contamination.

- Since 2001, seven inspections done in UHS hospitals in Georgia and Delaware have found that UHS has failed to maintain the building and treatment areas in a manner that ensures patients' safety and is free from contamination and soil.⁸³ Violations range from a dirty nebulizer being used by patients at Laurel Heights in Georgia,⁸⁴ to air conditioners in patients' rooms with broken or missing covers or the control buttons missing, water fountains covered in a brown slime-like material, smoke detector covers missing with loose wires exposed and baseboards coming off walls at Coastal Harbor Treatment Center in Georgia.⁸⁵
- In 2004 at UHS-owned McAllen Heart Hospital in Texas, a patient used a piece of protective housing from an air handling unit as a weapon to administer a self-inflicted wound in an apparent suicide attempt.⁸⁶
- In a 2006 inspection of the UHS-owned Rockford Center in Delaware, holes in the walls of patients' rooms were found, along with 33 out of 36 windows in patients' rooms soiled with stains, dust and water marks. A seclusion room was soiled with dust and reddish brown stains in the corner, a wet ball of tissues, a thermometer probe cover and a chicken bone on the floor. Stains were also found on the floor in the seclusion room on the children's unit.⁸⁷
- In 2001 at UHS-owned Peachford Behavioral Health System in Georgia, the facility was cited for failing to provide meals that met patients' needs for patients over the age of 65.⁸⁸
- In 2005, staff members from Peachford transported a suicidal patient to the wrong hospital in a vehicle that did not have safety locks and allowed the patient to sit in the front seat with access to the vehicle's doors.⁸⁹

J) Patient Dumping

Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that provides that a person that presents with an emergency medical condition who is unable to pay cannot be treated any different than a person who has health insurance.⁹⁰

The law outlines when a person can be refused treatment and when a person with an unstable medical condition can be transferred from one hospital to another hospital.⁹¹ The purpose of EMTALA is to prevent hospitals from refusing to treat patients or transferring them to public hospitals because they are unable to pay or are covered by Medicare or Medicaid.⁹²

UHS-owned facilities have been cited for EMTALA violations.

- In January of 2005, a UHS-owned facility in Texas, Timberlawn Mental Health System, was cited when an unstable suicidal patient was transferred without being evaluated or stabilized and without notifying the receiving facility or sending the patient's medical records. One of the reasons indicated for transferring the patient was that the person's insurance was not accepted at Timberlawn.⁹³

- In 2004, another UHS facility in Texas, Glen Oaks Hospital, received a 90-day termination notice from the Centers for Medicaid and Medicare for a similar incident that occurred in 2004.⁹⁴
- In March of 2005 at UHS-owned Peachford Behavioral Health System in Georgia, a person came to the facility and reported that s/he had taken an overdose of Xanax and consuming cocaine and marijuana. The person had come to the facility because s/he was having suicidal and homicidal thoughts and had attempted suicide a few days earlier. Arrangements were made for the patient to be transferred to an appropriate facility for medical treatment, but the person was dropped off at the Emergency Room at a different hospital. A Peachford Hospital official admitted that the hospital had not done anything to prevent a miscommunication like this from happening again. The person had been transferred in a vehicle that did not have safety locks and had been allowed to sit in the front seat with access to the vehicles door, putting the patient at risk. The facility was cited for an EMTALA violation.⁹⁵

IV. Putting Profits above the Interests of the Community

UHS' profit driven model has forced communities to use their own resources to respond to the emergencies that are created by UHS' practice of understaffing and to fill in the gaps when UHS eliminates services.

- In May of 2003, the Pembroke Police Chief met with the chief executive officer of the UHS-owned Pembroke Hospital in Massachusetts to express his concern that the hospital lacked adequate security staff needed to prevent and deter assaults. Police had had to respond to a number of emergency calls from the facility. The meeting occurred after an incident in which six female teenagers that were receiving care at the facility attacked a female worker by throwing stones at her and threatening to kill a mental health aide. A month earlier, police had responded to an incident where a 79 year old patient had been knocked to the ground and kicked several times by another patient. A few months prior to the meeting, a doctor at the hospital had been severely beaten by a person receiving care at Pembroke Hospital.⁹⁶ During the previous year, a nurse had been severely beaten by a patient and hospitalized for more than a week⁹⁷ and an ex-patient had been charged with assault after punching a worker at Pembroke Hospital in the face.⁹⁸ During the year before that, a nurse had been knocked unconscious and severely beaten by a person receiving care at the hospital.⁹⁹ In September of 2005 a patient was charged with attempted murder after he allegedly attempted to choke a nurse.¹⁰⁰
- In 2004 in the midst of a mental health crisis, UHS' Valley Hospital Medical Center closed its profitable geropsychiatric unit, leaving the Las Vegas Valley with only 18 beds to care for elderly persons with mental disorders. The decision was called a "business decision," by the chief executive officer of Valley Hospital, who agrees that there is a need for geropsychiatric services, but, "the profit margin just isn't there" for a small unit. This leaves public hospitals and emergency rooms

left to care for the elderly who need psychiatric care. One nurse correctly asked, "How much profit is enough when you are also supposed to have a social responsibility?"¹⁰¹

V. Recommendations to Protect your Community from UHS

These documented violations highlight the dangerous consequences of UHS' profit-driven business model of delivering behavioral health care. In 2005, UHS reported net revenues of \$3.9 million.¹⁰² UHS reports a profit margin of 24.7% for their behavioral health facilities,¹⁰³ meaning that UHS is earning 24.7 cents in profit off of every dollar billed to people diagnosed with mental illness, while providing substandard care to people who struggle with mental illness.

The systematic violations of behavioral health care standards documented in UHS facilities across the U.S. have real life consequences for the people who receive care in UHS facilities. In several instances, understaffing at UHS facilities has led to physical or sexual assaults, the exploitation of people diagnosed with mental illness and, at times, death. Quality behavioral health care cannot be provided in this kind of environment.

Before allowing UHS to take control of a behavioral health center in your community, we urge you to investigate their record of understaffing and protect your community by instituting enforceable safeguards and other conditions to ensure that children, adults and elderly people who struggle with mental illness and their families receive the quality care they deserve. The following are some steps you can take to ensure that the most vulnerable members of your community are protected.

- **Carefully review all Certificate of Need requests.** Investigate the level of quality care that UHS provides in its behavioral health facilities across the country. Talk to mental health advocates and community members to learn about their experiences with the provider and the impact that poor quality health care has on their lives and the lives of their families. Critically examine the documents that UHS submits for review to ensure that they are disclosing their plans for fulfilling staffing needs and quality measures in their proposed facility.
- **Require staffing ratios for licensure.** Impose enforceable staffing ratios on UHS facilities to ensure that they maintain appropriate levels of staff in their facilities.
- **Require documented training and certification of UHS employees.** To ensure that UHS employees are receiving the education and support they need to provide safe and effective behavioral health care, require that employees receive semiannual trainings in issues that impact behavioral health care delivery, with an emphasis on crisis management and the use of seclusion and restraints.
- **Require that patients be involved in developing their recovery plan.** Require that patients and their families or members of their support system be actively involved in developing the patient's treatment and discharge plan, or recovery plan. Require documentation, such as written identification of what they feel are the barriers to

recovery by the patient and members of the patient's support system, to ensure that the patient is having his/her needs addressed and is actively involved in the development and assessment of his/her recovery plan.

- **Require that patients and family members sit on the board of UHS facilities.** Require that members of the mental health community, both patients and family members, sit on the board of behavioral health facilities. The patients and family members who sit on the board should be appointed by advocates, such as the local chapter for the National Alliance for the Mentally Ill.
- **Require transparency in the behavioral health care that UHS provides.** Require quality measures, such as the frequency that seclusion and restraints are used; the number of events which lead to patients or staff members being abused, endangered or significantly harmed; and staffing levels be made publicly available and easily accessible to mental health consumers. Hold UHS facilities publicly accountable for the care they provide to patients, family members and the community.
- **Require that UHS facilities provide care to the uninsured.** Require that UHS facilities provide a set amount of charity care to members of the community and have the facilities report the amount of charity care they provide.
- **Actively involve mental health advocates, patients and family members when reviewing a UHS Certificate of Need proposal and setting conditions.** Mental health advocates, members of the mental health community and family members are experts in navigating the behavioral health system and protecting the civil rights and human rights of people diagnosed with mental illness. Use their expertise to create conditions for UHS facilities that will effectively protect the rights of mental health consumers in your community.
- **Involve consumers in annual evaluations of services provided by UHS facilities.** Develop teams of consumers to operate satisfaction assessment teams at UHS facilities.
- **Require a public review process when UHS is planning to change the existing behavioral health services provided at its facilities.** Patients, consumers, family members, workers and advocates should be actively engaged in the public review process.
- **Track the use of seclusion and restraints.** Develop a mechanism to report deaths and serious injuries resulting from the use of seclusion and restraints. Investigate these incidences and actively track seclusion and restraint use.¹⁰⁴

¹ Reinert, Sue. "Hospital ordered to stop taking in children; Suspension ended last year, but state again investigating." The Patriot Ledger. April 15, 2003. *The information in these government reports is based on*

information reported in the Patriot Ledger. SEIU Local 1107 has requested the documents pursuant to the State's Open Records Law, but the documents have not yet been turned over.

² *Ibid.*

³ *Ibid.*

⁴ State of Nevada Department of Health and Human Services Division of Healthcare Financing and Policy, Nevada Hospital Quarterly Reports, Fiscal Year 2005 Summary Utilization Report, Table 1 "All Beds," [http://www.unlv.edu/Research_Centers/chia/NHQR/Green_Book/Utilization - Done/Utilization - F05.xls](http://www.unlv.edu/Research_Centers/chia/NHQR/Green_Book/Utilization_-_Done/Utilization_-_F05.xls), retrieved June 27, 2006.

⁵ Universal Health Services Inc 10K, March 15, 2006.

<http://cchn.10kwizard.com/csv.php/4032277.xls?action=showtablexlsall&ipage=4032277>, retrieved on 10/31/2006.

⁶ Reinert, Sue. "Westwood to halt some admissions." The Patriot Ledger. March 11, 2002, p. 2; Reinert, Sue. "Hospital order to stop taking in children: Suspension ended last year, but state again investigating." The Patriot Ledger. April 15, 2003; Statement of Deficiencies and Plan of Correction. Department of Health and Human Services, Centers for Medicare & Medicaid Services. State of Georgia, Peachford Behavioral Health System, July 12, 2004; Poitras, Colin. "State halts treatment center admissions; concern for safety of children prompts move." Hartford Courant. August 3, 2006; Statement of Deficiencies and Plan of Correction. State of Texas, McAllen Medical Center Heart Hospital, September 14, 2005; Statement of Deficiencies and Plan of Correction. State of Texas. Glen Oaks Hospital, August 23, 2004.

⁷ Universal Health Services, Inc. <http://www.uhsinc.com/hospitals.php?type=behavioral>, retrieved on 10/23/06.

⁸ Universal Health Services, Inc. Reports Third Quarter Earnings. October 26, 2006.

http://www.uhsinc.com/news_item.php?id=92 Retrieved on October 31, 2006.

⁹ *Ibid.*

¹⁰ Universal Health Services Inc 10K, March 15, 2006.

<http://cchn.10kwizard.com/csv.php/4032277.xls?action=showtablexlsall&ipage=4032277>, retrieved on October 31, 2006.

¹¹ Universal Health Services, Behavioral Health Division, 10K for year ending 31/12/05. Retrieved from Certificate of Public Review Application Narrative, Submitted to the Office of Health Planning, State of Delaware.

¹² Universal Health Services, Inc. Reports Third Quarter Earnings. October 26, 2006.

http://www.uhsinc.com/news_item.php?id=92, retrieved on October 31, 2006.

¹³ Universal Health Services, Inc. Reports Third Quarter Earnings. October 26, 2006.

http://www.uhsinc.com/news_item.php?id=92, retrieved on October 31, 2006.

¹⁴ Fair Disclosure Wire. "Event Brief of Q2 2006 Universal Health Services Earnings Conference Call - Final." July 28, 2006.

¹⁵ Reinert, Sue. "Westwood to halt some admissions." The Patriot Ledger. March 11, 2002, p. 2; Reinert, Sue. "Hospital ordered to stop taking in children; Suspension ended last year, but state again investigating." The Patriot Ledger. April 15, 2003; Statement of Deficiencies and Plan of Correction. Department of Health and Human Services, Center for Medicare & Medicaid. State of Georgia, Peachford Behavioral Health System, July 12, 2004. Statement of Deficiencies and Plan of Correction. State of Texas. Glen Oaks Hospital, August 23, 2004; Poitras, Colin. "State halts treatment center admissions; concern for safety of children prompts move." Hartford Courant, August 3, 2006; Statement of Deficiencies and Plan of Correction. State of Texas. McAllen Medical Center and Heart Hospital, September 14, 2005.

¹⁶ American Psychiatric Nurses Association. "Position Paper on Determining the Staffing Needs on Inpatient Psychiatric Units." <http://www.apna.org/resources/positionpapers.html>, retrieved on October 30, 2006.

¹⁷ Reinert, Sue. "Westwood to halt some admissions." The Patriot Ledger. March 11, 2002; Reinert, Sue. "Sex Abuse at Hospital Suspected." The Patriot Ledger. March 6, 2002, p.1. *The actions by the state is based on information reported in the Patriot Ledger. SEIU Local 1107 has requested the documents pursuant to the State's Open Records Law, but the documents have not yet been turned over.*

¹⁸ Reinert, Sue. April 15, 2003.

¹⁹ Statement of Deficiencies and Plan of Correction. Department of Health and Human Services, Center for Medicare & Medicaid. State of Georgia, Peachford Behavioral Health System, July 12, 2004. Statement of

Deficiencies and Plan of Correction, Georgia Department of Human Resources, Office of Regulatory Services for Peachford Behavioral Health System, July 28,2004.

²⁰ Statement of Deficiencies and Plan of Correction. State of Texas. Glen Oaks Hospital, August 23,2004.

²¹ Poitras, Colin. "State Halts Treatment center Admissions." The Hartford Courant. August 3, 2006. *The information in these government reports is based on information reported in the Norwich Bulletin. SEIU Local 1107 has requested the documents pursuant to the State's Open Records Law, but the documents have not yet been turned over.*

²² Statement of Deficiencies and Plan of Correction. State of Texas. McAllen Medical Center and Heart Hospital, September 14, 2005.

²³ Reinert, Sue. "Pembroke hospital under investigation by state." The Patriot Ledger. July 22, 2006.

²⁴ Mental Health Association in New Jersey. "Public Policy Statement Regarding Sexual Harassment, Abuse or Assault of Mental Health Consumers."

http://www.mhanj.org/Policy_Paper_Sex_Harass_0753.htm, retrieved on 10/30/06.

²⁵ Universal Health Services, Behavioral Health Division, 10K for year ending 31/12/05. Retrieved from Certificate of Public Review Application Narrative, Submitted to the Office of Health Planning, State of Delaware.

²⁶ Statement of Deficiencies and Plan of Correction. State of Texas. Glen Oaks Hospital, February 7,2003.

²⁷ Quattlebaum, Peggy. Complaint Investigation Memorandum. Complaint #205550. State of Georgia. Coastal Harbor Treatment Center, July 7,2002.

²⁸ Statement of Deficiencies and Plan of Correction. State of Texas. McAllen Heart Hospital, June 26, 2003.

²⁹ Reinert, Sue. "Sex abuse at hospital suspected." The Patriot Ledger. March 6, 2002. *The information in these government reports is based on information reported in the Patriot Ledger.. This organization has requested the documents pursuant to the State's Open Records Law, but the documents have not yet been turned over.*

³⁰ Reinert, Sue. "Hospital ordered to stop taking in children; Suspension ended last year, but state again investigating." The Patriot Ledger. April 15, 2003. *This letter was sent anonymously to the newspaper, with the nurse's signature blacked out.*

³¹ Howell, Scott. Complaint investigation memorandum, Complaint #206123. State of Georgia, Laurel Heights Hospital, July 3, 2002.

³² Statement of Deficiencies and Plan of Correction. State of Georgia. Laurel Heights Hospital, June 20, 2002.

³³ Child, Inc. The Problem of Run Away and Homeless Youth.

<http://www.childinc.com/runaway.htm#The%20Problem>, retrieved on November 1, 2006.

³⁴ Oglesby, Bonnie. Complaint Investigation Memorandum, Complaint #GA00009016. State of Georgia. Laurel Heights Hospital, October 16, 2003.

³⁵ Poitras, Colin, "State Halts Treatment Center Admissions." The Hartford Courant. August 3, 2006;

Preiss, Amy Beth. "Stonington Center gives state plan." Norwich Bulletin. July 28, 2006, p. 3B.

³⁶ Turning Point Hospital. <http://www.turningpointcare.com/>, retrieved on October 30, 2006.

³⁷ Statement of Deficiencies and Plan of Correction. State of Georgia. Turning Point Hospital, September 19, 2002.

³⁸ Peachford Behavioral Health System, "What we offer," <http://www.peachfordhospital.com/what.htm>, retrieved on October 24, 2006.

³⁹ Statement of Deficiencies and Plan of Correction. State of Georgia. Peachford Behavioral Health System, June 14, 2001.

⁴⁰ 2005-2009 Statewide Comprehensive Plan for Mental Health Services. Appendix 4: Infusing Recovery based Principles into Mental Health Services, a White Paper by People who are New York State Consumers, Survivors, Patients and Ex-Patients. New York State Office of Mental Health. September 2004. <http://www.omh.state.ny.us/omhweb/statewideplan/2005/appendix4.htm>, retrieved on October 30, 2006.

⁴¹ Quattlebaum, Peggy. Complaint Investigation Memorandum, Complaint #GA00015699. State of Georgia. Anchor Hospital: July 19,2004.

⁴² Statement of Deficiencies and Plan of Correction. State of Georgia, Anchor Hospital: August 15, 2002.

⁴³ Statement of Deficiencies and Plan of Correction. State of Delaware, Rockford Center: April 26, 2006.

-
- ⁴⁴ Statement of Deficiencies and Plan of Correction. State of Delaware, Rockford Center, January 11, 2006.
- ⁴⁵ Statement of Deficiencies and Plan of Correction. State of Texas. McAllen Heart Hospital, January 30, 2004.
- ⁴⁶ Quattlebaum, Peggy. Complaint Investigation Memorandum, Complaint #GA00003940. State of Georgia. Laurel Heights Hospital, April 16, 2003.
- ⁴⁷ Statement of Deficiencies and Plan of Correction. State of Georgia, Laurel Heights Hospital, April 10, 2003.
- ⁴⁸ Statement of Deficiencies and Plan of Correction. State of Delaware. Rockford Center. June 23, 2006.
- ⁴⁹ Statement of Deficiencies and Plan of Correction. State of Georgia. Peachford Behavioral Health System, January 8, 2003.
- ⁵⁰ Statement of Deficiencies and Plan of Correction. State of Delaware. Rockford Center. July 22, 2003.
- ⁵¹ Statement of Deficiencies and Plan of Correction. State of Georgia, Office of Regulatory Services. Anchor Hospital: July 12, 2004; August 15, 2002; Coastal Harbor Treatment Center: January 13, 2005; Laurel Heights Hospital: April 10, 2003; November 14, 2002; June 20, 2002.; Peachford Behavioral Health System: January 8, 2003; June 14, 2001; July 12, 2004; Turning Point Hospital: September 19, 2002; Talbott Recovery Campus: April 24, 2003. Kersey, Margaret. Complaint Investigation Memorandum, Complaint #205158. State of Georgia. Coastal Harbor Treatment Center, July 1, 2002.
- ⁵² Statement of Deficiencies and Plan of Correction. State of Texas. Timberlawn Mental Health System, January 31, 2003.
- ⁵³ New York Lawyers for the Public Interest. "Discharge Planning for Children who are Hospitalized for Mental Health Treatment in New York State." March 2004. <http://www.ftnys.org/Dischargeplanning.pdf>, retrieved on October 30, 2006.
- ⁵⁴ *Ibid.*
- ⁵⁵ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Report and Recommendations of the Working Conference. "Exemplary Practices in Discharge Planning." June 1997. http://www.nhchc.org/discharge/Documents/IVB_ExemplaryPractices.doc, retrieved on October 30, 2006, p.2.
- ⁵⁶ National Alliance for the Mentally Ill. "Suicide: Taking Care of Yourself and Your Family After an Attempt." http://www.sprc.org/library/providers_guide2.pdf, retrieved on October 30, 2006.
- ⁵⁷ National Alliance for the Mentally Ill. http://www.sprc.org/library/providers_guide2.pdf, retrieved on October 30, 2006.
- ⁵⁸ Statement of Deficiencies and Plan of Correction. State of Georgia, Turning Point Hospital, September 19, 2002.
- ⁵⁹ Goldberg, Carey. "Behind Kaitlyn's suicide family questions antidepressant's role in teen's death." The Boston Globe. June 27, 2004.
- ⁶⁰ Statement of Deficiencies and Plan of Correction. State of Texas. Timberlawn Mental Health System, October 9, 2003.
- ⁶¹ Statement of Deficiencies and Plan of Correction. State of Georgia. Peachford Behavioral Health System, June 14, 2001.
- ⁶² National Mental Health Association. "The Rights of Persons with Mental Illness." June 11, 2000. <http://www.nmha.org/position/ps1.cfm>, retrieved on October 30, 2006.
- ⁶³ The President's New Freedom Commission on Mental Health. "Achieving the Promise: Transforming Mental Health Care in America." July 22, 2003. http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/New_Freedom_Commission/FinalReport.pdf, retrieved on October 30, 2006.
- ⁶⁴ *Ibid.*
- ⁶⁵ Smith, Gregory M., Robert H. Davis, M.D., Edward O. Bixler, Ph.D., Hung-Mo Lin, Ph.D., Aidan Altenor, Ph.D., Roberta J. Altenor, M.S.N., Bonnie D. Hardentstine, B.S. and George A. Kopchick, M.S. "Special Section on Seclusion and Restraint: Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program." Psychiatric Services, November 2005. American Psychiatric Association. <http://www.psychservices.psychiatryonline.org/cgi/content/full/56/9/1115>, retrieved on October 30, 2006.
- ⁶⁶ Statement of Deficiencies and Plan of Correction. State of Delaware, Rockford Center, June 23, 2006.
- ⁶⁷ Statement of Deficiencies and Plan of Correction. State of Delaware, Rockford Center, June 4, 2004.

-
- ⁶⁸ Howell, Scott. Complaint Investigation Memorandum, Complaint #206014. State of Georgia. Laurel Heights Hospital, June 21, 2002.
- ⁶⁹ Statement of Deficiencies and Plan of Correction. State of Nevada, Spring Mountain Treatment Center, September 15, 2004.
- ⁷⁰ Statement of Deficiencies and Plan of Correction. State of Texas, McAllen Medical Center, March 19, 2003.
- ⁷¹ Statement of Deficiencies and Plan of Correction. Department of Health and Human Services and Center for Medicare & Medicaid. State of Texas. McAllen Medical Center Heart Hospital. August 2, 2005.
- ⁷² Statement of Deficiencies and Plan of Correction. State of Georgia. Peachford Behavioral Health System, January 8, 2003.
- ⁷³ Statement of Deficiencies and Plan of Correction. State of Georgia, Anchor Hospital, August 15, 2002.
- ⁷⁴ Statement of Deficiencies and Plan of Correction. State of Georgia, Office of Regulatory Services. Peachford Behavioral Health System, September 11, 2003.
- ⁷⁵ Statement of Deficiencies and Plan of Correction. State of Nevada, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Spring Mountain Treatment Center, September 15, 2004.
- ⁷⁶ Statement of Deficiencies and Plan of Correction. State of Delaware, Rockford Center, December 12, 2002.
- ⁷⁷ Statement of Deficiencies and Plan of Correction. State of Georgia. Peachford Behavioral Health System, April 14, 2004.
- ⁷⁸ *Ibid.*
- ⁷⁹ Statement of Deficiencies and Plan of Correction. State of Texas. Timberlawn Mental Health System, July 17, 2003.
- ⁸⁰ Statement of Deficiencies and Plan of Correction. State of Nevada, Spring Mountain Treatment Center, September 15, 2004.
- ⁸¹ Statement of Deficiencies and Plan of Correction. State of Georgia. Laurel Heights Hospital, November 14, 2002.
- ⁸² Statement of Deficiencies and Plan of Correction. State of Delaware. Rockford Center, August 23, 2004.
- ⁸³ Statement of Deficiencies and Plan of Correction. State of Delaware: Rockford Center, January 11, 2006; May 31, 2005; December 12, 2002; State of Georgia: Laurel Heights Hospital, November 6, 2003; KeyStone Savannah, Inc, June 21, 2001. Peachford Behavioral Health System, October 7, 2004. Coastal Harbor Treatment Center, June 27, 2002.
- ⁸⁴ Statement of Deficiencies and Plan of Correction. State of Georgia. Laurel Heights Hospital, Georgia, November 6, 2003.
- ⁸⁵ Statement of Deficiencies and Plan of Correction. State of Georgia. Coastal Harbor Treatment Center, June 27, 2002.
- ⁸⁶ Statement of Deficiencies and Plan of Correction. State of Texas. McAllen Heart Hospital, January 30, 2004.
- ⁸⁷ Statement of Deficiencies and Plan of Correction. Department of Health and Human Services & Centers for Medicare and Medicaid. State of Delaware. Rockford Center, January 11, 2006.
- ⁸⁸ Statement of Deficiencies and Plan of Correction. State of Georgia, Peachford Behavioral Health System, June 14, 2001.
- ⁸⁹ Statement of Deficiencies and Plan of Correction. State of Georgia. Peachford Behavioral Health System, March 30, 2005.
- ⁹⁰ Emtala.com. "Frequently Asked Questions about the Emergency Medical Treatment and Active Labor Act (EMTALA)." <http://www.emtala.com/faq.htm>, retrieved on November 1, 2006.
- ⁹¹ *Ibid.*
- ⁹² *Ibid.*
- ⁹³ Statement of Deficiencies and Plan of Correction. State of Texas. Timberlawn Mental Health System, January 3, 2005.
- ⁹⁴ Statement of Deficiencies and Plan of Correction. State of Texas. Glen Oaks Hospital, August 23, 2004.
- ⁹⁵ Statement of Deficiencies and Plan of Correction. State of Georgia. Peachford Behavioral Health System, March 30, 2005.
- ⁹⁶ Reinert and Daly. "Police: Hospital should increase security." The Patriot Ledger. May 21, 2003.
- ⁹⁷ Reinert, Sue. "Pembroke earns higher score, accreditation." The Patriot Ledger. January 4, 2002.

⁹⁸ Reinert, Sue and Tamara Race. "Ex-patient charged in hospital worker attack, 2nd assault in 6 months on Pembroke employee." The Patriot Ledger. July 13, 2002.

⁹⁹ Reinert and Daly, May 21, 2003.

¹⁰⁰ Patriot Ledger Staff. "Pembroke patient charged with murder try." The Patriot Ledger. July 22, 2006.

¹⁰¹ Harasim, Paul "A Loss of Caring," Las Vegas Review Journal, August 16, 2004.

¹⁰² Universal Health Services Inc 10K, March 15, 2006.

<http://ccbn.10kwizard.com/csv.php/4032277.xls?action=showtablexlsall&ipage=4032277>, retrieved on October 31, 2006.

¹⁰³ Universal Health Services, Inc. Reports Third Quarter Earnings. October 26, 2006.

http://www.uhsinc.com/news_item.php?id=92, retrieved on October 31, 2006.

¹⁰⁴ President's New Freedom Commission on Mental Health: Report to the President. Achieving the Promise: Transforming Mental Health Care in America. Goal 2- Mental Health Care is Consumer and Family Driven. <http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport-03.htm>, retrieved on October 31, 2006.