

NC DISABILITY ACTION NETWORK

ACTION ALERT – JANUARY 22, 2009

"One media exposé after another has highlighted the flawed implementation of North Carolina's much ballyhooed 2001 effort at mental health reform. These exposés have given many state officials heartburn as they picked up their morning paper or watched the evening news." (Vicki Smith Executive Director, Disability Rights NC)

Many of these articles have related to the four psychiatric hospitals operated by The North Carolina Department of Health and Human Services: Broughton, Central Regional, Cherry, Dorothea Dix, and John Umstead. Article after article has exposed these hospitals as being unsafe and abusive.

Story 1

"On December 3rd, a health care technician was arrested and accused of assaulting a patient two weeks earlier. Records show Shelia Y. Lane, 37, was charged with assault and battery on a handicapped person, a misdemeanor. On Friday, Lane was still employed at Cherry, where she has worked since 1996, said a spokeswoman for the Office of State Personnel.Cherry has been under scrutiny for staff assaults on patients and substandard care. In September, the federal government said it would no longer pay the state about \$800,000 a month to care for patients at Cherry because the hospital is dangerous" (The News and Observer www.newsobserver.com).

Story 2

"**RALEIGH, N.C.** — Two workers at Cherry Hospital in Goldsboro have been arrested on accusations they beat a patient, state Department of Health and Human Services chief spokesman Tom Lawrence said." (Updated: Aug. 27, 2008 www.WRAL.com).

"Upton, 33, is accused of hitting a male patient in the abdomen, knocking him to the floor. Upton then kicked and punched the patient in the head and side, according to the arrest warrant. Johnson, 52, is accused of holding the victim during the initial assault, and then joined Johnson in beating the patient, according to a warrant." (By Michael Biesecker (Raleigh) News & Observer www.charlotteobserver.com).

Story 3

Investigators are looking into the death of mental patient, they say was left in a chair for more than 20 hours. According to reports, 50-year-old Steven Sabock died in April after he choked on medication at Cherry Hospital in Goldsboro. Investigators say nurses left him in a chair for 22 hours and failed to feed him or help him to the bathroom.

Apparently the whole ordeal was recorded by a security video camera. The video showed hospital staff watching television and playing cards while Sabock was in the same room

(By STEPHANIE MOORE, Noon Edition, Producer, Published: August 19, 2008).

These stories and many more have come to the attention of the Disability Action Network. We are outraged and appalled!!! These stories are **shocking and **horrifying!!!****

WE MUST TAKE ACTION!!!!!!

We are holding a rally on Wednesday, January 28th from 10am-12pm on the Bicentennial Plaza across from the Legislative Building at 16 West Jones St., Raleigh, NC.

During the rally, we will be promoting recommendations we believe will cause substantial change at these four hospitals. Attached you will find these recommendations.

Attached you also will find a map of parking areas around the Bicentennial Plaza. For more information or directions, please contact Michael Murray at michaelmurray@disability-rights.org or 336-549-4933.

People with disabilities can no longer stand by while our brothers and sisters are abused and killed. **WE MUST TAKE ACTION!!!!!!** When you hurt one person with a disability, you hurt us all.

"Injustice anywhere is a threat to justice everywhere" - Martin Luther King, Jr.

Recommendation - *Community Funding Protection: Funding may not be shifted from community funding to cover deficits of institutions especially if as a result of de-certification without Legislative Authorization.*

Recommendation - *Identify and systematically eliminate barriers to successful transition from the state operated facilities (psychiatric hospital & dd centers) to the community.*

Recommendation - *Alternatives in the community must be developed prior to the elimination of institutional-based beds.*

Recommendation - *Develop mechanism (focus groups, patient surveys) that allow patients and families to provide constructive and confidential feedback regarding their experience while at the state psychiatric hospitals.*

Recommendation - *Internal and external oversight should be standardized across the system.*

Recommendation - There must be a standardized system for monitoring patient care, for reporting violations, and addressing any issues or concerns.

Recommendation - Good hospital administration includes encouraging key leadership and advocates to periodically visit all units, all shifts including weekends and holidays. There must be an open environment where all staff feel safe to raise concerns about patient care and are rewarded for efforts to improve patient care.

Recommendation - External monitoring of the hospitals be done on a more frequent level to proactively address issues before they rise to a level of immediate jeopardy.

Recommendation – Standardize, strengthen and make autonomous the role of the Human Rights Committees (HRC) at the hospitals.

Recommendation – Training for HRCs should be funded and directed by the DHHS level to assure standardization.

Recommendation - Strengthen the role and independence of the internal advocates at the hospitals.

Recommendation – Training for the internal hospital advocates should be funded and directed at the DHHS level to assure standardization.

Recommendation – Develop a stable workforce by filling vacancies with permanent employees rather than relying on temporary staff. This can be accomplished by paying staff a 'living' wage.

Recommendation – Ensure consistent training including appropriate orientation and continuing education is done for all staff on a periodic basis.

Recommendation – Provide stronger whistleblower protections for employees who report patient abuse or neglect including the falsification of records documenting such incidents.