North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

May 22, 2013

The Honorable Ralph Hise, Co-Chair
Appropriations Committee on Health
and Human Services
Room 1026, Legislative Building
Raleigh, NC 27601

The Honorable Louis Pate, Co-Chair
Appropriations Committee on Health
and Human Services
Room 1028, Legislative Building
Raleigh, NC 27601

Dear Senators Hise and Pate:

Session Law 2011-145, Section 10.12, required the Department of Health and Human Services, Division of State Operated Healthcare Facilities, to issue a Request for Proposal for the consolidation of forensic hospital care. An interim report was submitted to the Joint Appropriations Subcommittee for Health and Human Services in October 2011. The Department is pleased to submit the attached final report.

Please direct all questions regarding this report to J. Luckey Welsh, Jr., Acting Director of the NC Division of State Operated Healthcare Facilities. Mr. Welsh can be reached at (919) 855-4700.

Sincerely,

Aldona Wos, M.D.
Secretary

Attachment

cc: Susan Jacobs
Pam Kilpatrick
Patricia Porter
Sarah Riser
Kristi Huff
Brandon Greife
Jim Slate
J. Luckey Welsh, Jr
Adam Sholar
Legislative Library (one hard copy)
Reports@ncleg.net

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The Honorable Mark W. Hollo, Co-Chair
Appropriations Subcommittee on Health
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Room 639, Legislative Office Building
Raleigh, NC 27603

The Honorable William D. Brisson, Co-Chair
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Room 405, Legislative Office Building
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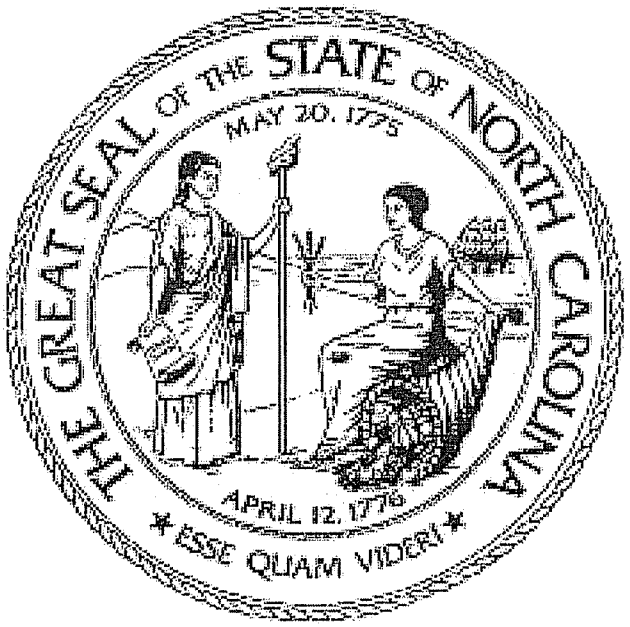
Final Report on Consolidation of Forensic Hospital Care
Session Law 2011-145, Section 10.12



May 22, 2013
North Carolina Department of Health and Human Services
Division of State Operated Healthcare Facilities

Final Report on
Consolidation of Forensic Health Care at Dorothea Dix Complex
May 22, 2013

Background

In 2011, the General Assembly enacted legislation (Session Law 2011-145, Section 10.12) requiring the Department of Health and Human Services (DHHS), Division of State Operated Healthcare Facilities (DSOHF) to issue a Request for Proposal (RFP) for the consolidation of forensic hospital care. The legislation states, in relevant part,

> *The Secretary of Health and Human Services is authorized to proceed with contracting with a private entity if the Secretary can justify savings through the contract. The Secretary shall compare the Department's total cost to provide forensic care to proposals received and determine whether it is cost-effective to contract for this service. The Secretary may only proceed if the Secretary determines the Department will save money and ensure appropriate safety and quality of care for patients.*

As required by the legislation, DHHS Secretary Cansler submitted an Interim Report on Consolidation of Forensic Health Care at Dorothea Dix Complex to the Joint Appropriations Subcommittee for Health and Human Services on October 30, 2011.

Request for Proposal (RFP) Development and Issuance

As described in Secretary Cansler's Interim Report, an RFP was developed to solicit proposals from private entities to provide 90 forensic treatment beds in the McBryde Building located at the Dorothea Dix complex or other location identified and procured by the vendor. The RFP was issued on July 20, 2011. On August 19, 2011, a mandatory site visit was held to provide vendors with an overview of the RFP and a tour of the McBryde Building, which was attended by three vendors. A second site visit, requested by the vendors, was held on September 16, 2011 and attended by representatives of two vendors.

Vendor questions regarding the RFP were received August 22, 2011, and written responses were posted on September 9, 2011 as an addendum to the RFP. Subsequently, the proposal submission date was extended from September 30, 2011 to October 12, 2011. The only vendors eligible to submit proposals based on attendance at the mandatory site visit were GEO Care, Inc., Liberty Healthcare Corporation, and MHM Services, Inc.

Request for Proposal (RFP) Review Process and Completion

Only one vendor, GEO Care, Inc., submitted a proposal in response to the RFP for Forensic Hospital Consolidation in North Carolina (RFP No. 30-DMH-3435-12).

An evaluation committee comprised of content experts in DHHS and DSOHF formally reviewed the vendor's proposal following the evaluation procedures and criteria established in the RFP. The evaluation criteria included the vendor's technical proposal, cost proposal and an oral presentation to the committee by the vendor. A full analysis of cost proposal concluded that the submitted proposal would not "save money" as required by S.L. 2011.145, Section 10.12. Specifically, DSOHF determined that the proposal would result in $4.1M in additional costs during the first five year period. On November 4, 2011, the evaluation committee recommended that a contract not be awarded.

In order to ensure a thorough evaluation of the sole proposal, DHHS requested additional documentation and information from Geo Care, Inc. DHHS also engaged an independent forensic psychology expert, Joel A. Dvoskin, Ph.D., ABPP, to evaluate the vendor's proposal based on the requirements of SL 2011-145, Section 10.12. Dr. Dvoskin consulted with nationally known psychiatrists Kenneth Appelbaum, M.D. and Susan Stone, J.D., M.D. Dr. Dvoskin delivered his final report to Acting DHHS Secretary Delia on November 20, 2012, a copy of which is attached. Dr. Dvoskin recommended that DHHS reject the proposal submitted by GEO Care, Inc.

GEO Care, Inc., the sole vendor to submit a proposal in response to the RFP, withdrew from further negotiations by letter dated December 27, 2012 addressed to Acting DHHS Secretary Delia, a copy of which is also attached. Accordingly, the RFP process regarding Forensic Hospital Consolidation (RFP No. 30-DMH-3435-12) was closed.

Summary

In compliance with S.L. 2011-145 Section 10.12, DHHS issued an RFP for Forensic Hospital Consolidation in North Carolina (RFP No. 30-DMH-3435-12). Only one vendor, GEO Care, Inc., submitted a proposal in response to the RFP. The DHHS evaluation committee reviewed the vendor's proposal and concluded that the vendor's proposal would not "save money" as required by S.L. 2011.145, Section 10.12., and recommended that a contract not be awarded. DHHS engaged an independent forensic psychology expert, Joel A. Dvoskin, Ph.D., ABPP, to evaluate the vendor's proposal based on the requirements of SL 2011-145, Section 10.12. Dr. Dvoskin recommended that DHHS reject the proposal submitted by GEO Care, Inc. GEO Care, Inc., the sole vendor to submit a proposal in response to the RFP, withdrew from further negotiations by letter dated December 27, 2012 addressed to Acting DHHS Secretary Delia. Accordingly, the RFP process for Forensic Hospital Consolidation in North Carolina (RFP No. 30-DMH-3435-12) was closed.

DHHS currently provides quality forensic hospital care at Central Regional Hospital in Butner and is working to identify opportunities to achieve improved efficiency and cost savings.

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Evaluation of Proposal by GEOCare in Response to RFP from the North Carolina Department of Health and Human Services To Provide Forensic Psychiatric Hospital Care

Joel A. Dvoskin, Ph.D., ABPP

With Consultation from Kenneth Appelbaum, MD and Susan Stone, MD, JD

Introduction

The State of North Carolina solicited proposals for the consolidation and privatization of forensic treatment services currently provided by the State Department of Health and Human Services at the Central Regional Hospital (CRH) in Butner, North Carolina. Bidders were required to demonstrate that they can provide forensic services comparable to, or better than, those currently provided by the State *and* that they can do so at a lower cost to the State.

One proposal was received, from GEOCare, Inc. After conducting an in-house review of the proposal, the NC Department of Health and Human Services (DHHS) raised a number of questions, which were communicated to the prospective vendor, and which resulted in an addendum to the GEOCare proposal.

After an in-house review of the addendum, questions remained, and the Department contracted with me to conduct an independent review of the proposal. With the Department's agreement, I also consulted with nationally known psychiatrists Kenneth Appelbaum, MD and Susan Stone, JD, MD, who also reviewed the proposals and offered their opinions.

Sources of Information

RFP No 30-DMH-3435-12
GEO Care RFP Proposal
DSOHF Evaluation Committee Report
Additional Information request RFP #30-DMH-3435-12

GEO Care, Inc. response to additional information request
DSOHF review of GEOCare proposal
GEOCare response to additional information request
Site visit of the GEOCare facility in Montgomery, Co. TX - 8/6/12[1]
Site visit to the Central Regional Hospital - 9/20/12[2]

Qualifications of Reviewers

Joel Dvoskin, Ph.D., ABPP

Because the conclusions are in large part based upon my experience, expertise, and knowledge of the standard of care in state psychiatric hospitals and that of consultants Drs. Stone and Appelbaum, it is appropriate to include a statement of our qualifications to offer the opinions contained in this report.

I am a clinical psychologist, licensed in the State of Arizona since 1981 and the State of New Mexico since 2005. I am a Diplomate in Forensic Psychology of the American Board of Professional Psychology. I am a Fellow of the American Psychological Association (APA) and the American Psychology-Law Society. I was formerly President of Division 18 of the American Psychological Association (Psychologists in Public Service) in 2000-2001, and President of the American Psychology-Law Society, Division 41 of the APA, in 2006-2007. I hold a Certificate of Professional Qualification in Psychology from the Association of State and Provincial Psychology Boards. I am the author of numerous articles and chapters in professional journals and texts, including a number of articles that deal with treatment of persons with serious mental illness and co-occurring substance use disorders. I have been qualified as an expert witness on these and related issues in numerous state and federal courts throughout the United States.

In 1995, I served as Acting Commissioner of Mental Health for the State of New York, overseeing 31 state psychiatric hospitals, 25,000 staff, and the care of more than 100,000 New Yorkers with serious mental illness. For eleven years prior to that, I served as Director of Forensic Services and Associate Commissioner for Forensic Services for the New York State Office of Mental Health, in which capacity I oversaw the forensic and correctional mental health systems for the State of New York, and directly supervised three free-standing maximum security forensic psychiatric hospitals, two forensic units, and fifteen prison mental health programs.

I have served as a monitor of Federal Court settlement agreements over state psychiatric hospitals in Tacoma, Washington and Pueblo, Colorado, and the Bernalillo County (NM) Detention Center. I recently served as one of two monitors of a Federal Court settlement agreement involving the Michigan Department of Corrections. I have testified in numerous class actions regarding treatment and suicide prevention for persons with serious mental

[1] Includes review of various policies, staffing reports, and medical records.
[2] Includes review of various policies, staffing reports, and medical records.

illness and/or co-occurring mental health and substance use disorders in psychiatric hospitals, prisons, and jails throughout the United States. I have consulted to state and local governments in more than half of the United States in the provision of mental health services in public settings. I have provided training on treatment to numerous psychiatric hospitals across the U.S.

I currently serve as a member of several expert teams for the Civil Rights Division of the U.S. Department of Justice (USDOJ), focusing on the rights and treatment of inmates, detainees, and patients housed in various forms of secure confinement.

I recently completed serving as the architectural design consultant for new construction to replace the Saint Elizabeths Hospital in Washington, D.C. and the Colorado Mental Health Institute–Pueblo, and have served in such a capacity for a number of psychiatric hospital and correctional mental health construction projects in the U.S. and Puerto Rico. I have also provided architectural consultation to various agencies and parties specifically on the elimination of suicide and escape hazards in the physicals plants of correctional and psychiatric facilities throughout the United States.

I provide frequent training to clinicians in the treatment of persons with serious mental illness and/or substance abuse disorders, and have provided training throughout the United States, Canada, and the United Kingdom on assessing the risk of violence to self and others. I have provided training on reducing the risk of suicide in a number of jurisdictions.

I have won awards from the Arizona Psychological Association, the American Psychological Association (Division 18), the American Academy of Psychiatry and the Law, and the National Coalition for the Mentally Ill in the Criminal Justice System.

(For a complete list of my experience and publications, please see my *curriculum vitae*, which is attached as Appendix A.)

Susan A. Stone, J.D., M.D.

Dr. Stone is a licensed attorney, board-certified psychiatrist, board certified forensic psychiatrist, experienced mediator and consultant. Using her expertise in both law and medicine, Dr. Stone provides a unique perspective to consensus building and planning endeavors. She has extensive experience with organizational politics, interagency coordination, strategic planning, and managing difficult relationships. Dr. Stone provides mediation and facilitation services for a variety of private and public sector clients, and serves as a management consultant to assist organizations in tackling system design dilemmas.

Dr. Stone has worked extensively with the interface between behavioral health and legal systems, serving as a consultant to the National GAINS Center, the Texas Coordinating Office for Offenders with Mental and Medical Impairments, and the United States Department of Justice. She is also serving as the Executive Coordinator for the Mental

Health Task Force in Austin, Texas. She maintains an active psychiatric practice in Bastrop, TX.

Dr. Stone graduated from the University of Texas at Austin, with Honors, with a Bachelor's Degree in History. She graduated from the University of Texas Law School in 1985, and has been a member of the State Bar of Texas since 1986. She graduated from the University of Texas Health Sciences Center Medical School in 1990, and went on to complete her psychiatric residency at that same institution, serving as Chief Administrative Resident in her final year. She is the former Associate Medical Director and Director of Forensic Services at the Texas Department of Mental Health and Mental Retardation, and former Ethics Advisor for the Texas Department of Criminal Justice.

Kenneth Appelbaum, MD

Dr. Appelbaum currently serves as Clinical Professor of Psychiatry and Director of Correctional Mental Health Policy and Research for the Center for Health Policy and Research at the Commonwealth Medicine division of the University of Massachusetts Medical School (UMMS). He has been on the faculty at UMMS since 1987. In addition to research and teaching activities, Dr. Appelbaum provides consultations to state and federal mental health and correctional systems on safety and delivery of mental health services.

From 1987 to 1998, Dr. Appelbaum served as Forensic Service Director at Worcester State Hospital in Massachusetts with oversight of a court evaluation unit and forensic consultation program. Among his other tasks on behalf of the Massachusetts Department of Mental Health's Division of Forensic Mental Health, he assisted with drafting regulations regarding qualifications of psychiatrists and psychologists who conduct forensic evaluations for the Commonwealth, helped develop and ran a program for training and designating those individuals, served as a supervisor for those trainees, helped implement and run a quality improvement process to monitor their work, and played a leading role in developing a mandatory consultation and review process for privilege or discharge decisions regarding inpatients with histories of serious violence.

From 1998 to 2007, Dr. Appelbaum served as statewide Mental Health Program Director for the Massachusetts Department of Correction (DOC) and as a member of the senior leadership team for health care services provided by UMMS to DOC. His responsibilities included supervision of all licensed mental health providers and oversight of all mental health services provided to inmates of Massachusetts DOC facilities, including patients at Bridgewater State Hospital, the state's secure forensic psychiatric facility.

Dr. Appelbaum is a Distinguished Fellow of the American Psychiatric Association and board certified in General Psychiatry and Forensic Psychiatry. He has authored over fifty publications, including peer-reviewed journal articles, book chapters, and other publications, and given approximately one hundred major and national presentations in addition to other teaching activities. Among other topics, these publications and presentations address competence and responsibility assessments of defendants with

mental disorders or developmental disabilities, judicial use of pretrial commitments for forensic evaluation, assessment and management of self-injurious and violent behaviors, and prosecution as a response to violence by psychiatric patients. He is former Deputy Editor of the Journal of the American Academy of Psychiatry and the Law, and he continues to serve as a special editor or reviewer for at least eleven professional journals, including the American Journal of Psychiatry.

Site Visit to Montgomery County Mental Health Treatment Center (MCMHTC)

Along with several officials from the State of North Carolina, including Secretary Delia of the NC Department of Health and Human Services, I visited the MCMHTC, operated by GEOCare, on August 6, 2012. I was very appreciative of the courteous and often candid manner in which we were received, and found much to like about the facility. The facility has a capacity of 94 beds, with six additional beds available in a medical clinic, which was unoccupied on the day of our visit.

The facility reported that it is fully accredited under the Joint Commission's Hospital Standards, a status it achieved only 90 days after it was opened, which is an impressive accomplishment.

All of the patients at this hospital are there for evaluation and/or restoration of competency to stand trial. Most or all of the patients are charged with misdemeanors. Patients who are found incompetent for serious felony charges are typically sent to the Vernon State Hospital, and few if any such patients are housed in this facility. The reported average length of stay is approximately 85 days. Restrictions on property are identical to those imposed by the jail from which the patient was referred. Several staff members told me, "We don't have any aggressive patients here," apparently referring to the fact that violent patients and those charged with violent crimes are sent elsewhere.

At the time of our visit, the facility was exclusively populated by male patients. However, I was told that one 14-bed wing was expected to house women as of September 1, 2012.

The entrance to the facility was not especially secure, lacking a walk-through metal detector and an entry sally port. It was explained to me, "The state (of Texas) didn't want a sallyport." There was, however, an x-ray machine to inspect packages, and metal detection wands to allow metal detection of people entering the facility.

It was not entirely clear to me the degree to which GEOCare, Montgomery County, and the State of Texas were respectively responsible for the architectural design of the facility. As I understood the explanation, the facility's design was mainly responsive to the plan submitted by GEOCare, but adhering to norms and regulations that were provided by the county and/or the state.

The facility has a self-contained pharmacy, which is staffed by one pharmacist and one pharmacy technician. There is a modern and efficient "vending" machine for the

dispensation of medications, and emergency medications are provided by an after-hours contract with a local pharmacy.

The facility includes two negative pressure rooms to provide care for patients with airborne infectious disease. Hospital administrators reported that any medical situation that they cannot handle results in transfer to a nearby General Hospital, accompanied by security staff from the facility.

The State of Texas has an electronic medical record (EMR) called Avatar, which the facility uses by contractual agreement with the state.

The medical unit was empty on the day of our visit. It is reportedly staffed by a nurse from 8 AM until 5 PM, unless one or more patients are housed there. It was explained to me this unit seldom houses patients overnight, largely because patients with co-occurring medical diagnoses are screened out of admission to this facility. Most admissions to the facility are scheduled and planned.

There is a modern and more than adequate dental suite. The medical area also includes a well-appointed, large examination room. It was reported to me that laboratory results are provided quickly and efficiently pursuant to a contract with the local lab. In cases requiring "STAT" lab results, it was reported that the results are usually received within one hour.

All patient access bathrooms are constructed in a manner that is reasonably suicide resistant.

It was reported that the clinic is staffed by a physician 20 hours per week on site, with 24 hour on-call physician coverage available. The facility reported that this coverage was adequate in light of the state clearinghouse that prevents the facility from receiving any patients that are medically compromised. I was not able to independently assess the need for medical services in this population.

In an apparent design flaw with significant security consequences, there appears to be no fenced area outside of the facility's fire exit. Thus, it would be theoretically possible for a patient to arrange for a confederate to create a fire alarm, allowing patients who were evacuated from the building to attempt escape. This apparent flaw is easily remedied by creation of an evacuation area enclosed by a non-climbable fence.

The kitchen and dietary staff were impressive, reporting that all food is cooked "from scratch," and that the menus are on a four week cycle of 2600 calories per day. Housekeeping services are provided by contractors, and there are no jobs for patients at this facility.

The "Treatment Team" has its own wing of offices; however there is no patient access to this area. In my opinion, this arrangement is unfortunate as it is seldom a good idea to provide staff with a place to "hide" from their patients. (It was not possible for me to assess

the degree to which this was or was not a problem at this facility.) In general, the more patient contact with clinicians, the better.

The library is physically impressive, but was notable for the fact that there are very few books in it. There is also a nice gym. I was told by patients and staff that there is little or no organized activity in the gym. Several patients told me, "They got us all out of our rooms today," or words to that effect, apparently referring to our visit. Other patients, however, confirmed the staff's report that most patients attend the treatment mall for 4 hours per day, 5 days per week.

One of the more impressive aspects of this facility was the provision of group treatment, which occurs for two one-hour groups in the morning and in the afternoon during the week. I briefly observed several groups, and the patients appeared to be interested and even enthusiastic regarding their interactions with the group leaders. Less impressive was the fact that there appears to be relatively little individualization in terms of group assignments. As it was explained to me the "first round" of group treatment is pretty much the same for everyone. Facility leaders told me that less than a third of patients are targeted to specific groups.

There are five housing units, four of which contain 20 beds each, with an additional unit of 14 beds. (This does not include the six beds in the medical clinic, which are typically unoccupied.) The most important aspect of the facility design is that one nursing station serves all five housing units. Each wing has its own fenced recreation area, enclosed by an arched and "unclimbable" fence. The patient rooms were remarkable for the complete absence of any personal effects or pictures displayed on the wall. I was given several explanations of this, none of which frankly made very much sense.

The facility leadership reported a very low utilization of restraints, adding that they prefer to use PRN medication instead of seclusion or restraint.

Psychiatric staffing at the facility is limited. Three staff psychiatrists and a medical director provide psychiatric services, a significant portion of which are provided through tele-psychiatry. When psychiatrists are on vacation, sick leave, or occupational injury leave, the medical director is expected to cover for them. Each psychiatrist is expected to maintain a caseload of approximately 30-32 patients, which is a very high number in light of the high turnover at this facility. It was reported that psychiatrists are not expected to do forensic evaluations. At the time of my visit, there were also three psychologists on staff, with a vacancy that was expected to be filled soon. This too is a low number, which may account for the fact that none of the patients in the hospital at the current time had a positive behavioral plan, yet a dozen patients were on forced medications. It is unknown whether several of those patients might have been able to avoid involuntary medication if they had a well-constructed positive behavioral plan.

I was very positively impressed with the facility's Patient Governance Council, which meets monthly, and is facilitated by an impressive and talented peer specialist. The facility

leadership also reported, "We have very good working relationships with families." In general, the staff rhetoric suggested a respectful attitude toward patients.

I reviewed several charts. In general, I found the psychiatric assessments to be cursory at best. This was not surprising in light of the limited psychiatric staffing. This opinion was confirmed by the medical director, who believes that the facility should have five fully functioning teams, each with its own psychiatrist and lead nurse. She noted, for example, that the day following my visit would see seven discharges and seven admissions, each of which should receive time-consuming attention and assessment by a psychiatrist. With only three psychiatrists available, clearly that would not happen.

In general, the staff reported that GEOCare appears to prefer safety/custody staff to treatment staff. They also noted an absence of staff infrastructure that would help the clinicians to be more productive. For example, they reported that there are no unit clerks, and that doctors are therefore required to type their own notes and reports, significantly decreasing their productivity.

Findings

In general, I found a number of things to like and admire about this facility. It is clean, attractive, well lit, and Joint Commission accredited. The staff members appeared to have both concern and respect for the patients under their care, and I heard no complaints of abuse or mistreatment. On the other hand, largely due to what I regard as inadequate clinical staffing, there were a number of aspects of treatment that were quite deficient. While group treatments appeared to be provided in a competent and skillful manner, and the hours of group treatment provided to each patient were adequate, in my opinion the groups were not adequately individualized. Psychiatric assessments were too often cursory and too infrequently completed, and psychological positive behavior plans were virtually nonexistent. Even more importantly, the physical plant and staffing model did not create meaningful treatment milieus on the wards.

Most importantly, there is a significant and essential difference between the patients served at this facility and the patients that are currently served in the forensic unit at CRH (i.e., the patients at this facility are misdemeanant defendants, without severe and acute psychiatric or medical problems.) There is virtually no reasonable possibility that the staffing plan currently in place at this facility would adequately provide for the care, treatment, and management of the patients currently treated at CRH.

Site Visit to Central Regional Hospital

Along with several officials from the state of North Carolina, including Secretary Delia, I visited the Central Regional Hospital on September 20, 2012. The entire hospital consists of 382 beds, and was recently constructed, having opened in 2008. The facility reports robust training contracts with the Duke University and University of North Carolina Medical Schools, as well as various other training programs, for example, in nursing, physicians

assistants programs, occupational and recreational therapy, and social work. (Note that the facility does not count residents and post-docs in their reported staffing numbers.)

In addition to its capacity to provide psychiatric treatment, the hospital has an extensive medical service that can provide services to patients with serious co-occurring medical diagnoses. The facility reported that they have not used mechanical restraints in over a year, and have reduced their use of seclusion dramatically. They attribute these accomplishments in part to consultation received from the National Association of State Mental Health Program Directors, creation of a facility Rapid Response Team, and training they received from the Crisis Prevention Institute (CPI) and that is provided to all staff members.

The facility has a well-functioning Treatment Mall. Groups are typically provided for two hours in the morning and two hours in the afternoon during the week. Some additional groups are provided by Registered Nurses, including 2 active treatment groups on each ward on Saturday. Nursing also offers one treatment group on each ward during the evening after dinner.

The facility reports the presence of 40 psychiatrists, serving its 382 patients. In addition, 4 psychiatrists work exclusively in the outpatient department. This ratio of fewer than 10 patients per direct care psychiatrist is unusually low, and might be one area to consider for possible savings at CRH.

The medical clinic provides x-ray, physical therapy, and other adjunct services. The majority of specialty clinics are held on the hospital grounds, although some clinics require that patients be transported to the University of North Carolina Hospital in Chapel Hill. There is a pharmacy, which is staffed around-the-clock.

The only police presence at CRH consists of a contract with the Butner Department of Public Safety (DPS), which provides for one officer (24 hour post) for the entire hospital. Emergencies would result in backup by the Butner DPS.

The clearance process into the forensic area is, in my opinion, in need of serious revision. For example, there is no x-ray machine to allow inspection of packages. Nor is there a walk-through metal detector.

In the forensic unit, despite reports of previously successful positive behavior plans, at the time of my visit, only one patient was on such a plan. This was apparently due to vacancies in the psychology staffing for the treatment units at the time of my visit.

Forensic Services at CRH

The Forensic Services Unit (FSU) includes a forensic evaluation service and a forensic treatment service. The pretrial evaluation unit includes 8 male inpatient beds (on unit B0)

and two female inpatient beds (on unit B0). The evaluation service reportedly conducts more than 800 forensic evaluations per year.

The forensic unit at CRH is a statewide service. It is noted that all three state hospitals in North Carolina receive incompetent-to-proceed patients, who are typically sent to age-appropriate units in any of the state's civil hospitals. Generally, the cases that are sent to the CRH forensic unit are those that involve the most dangerous, difficult, and acute patients. When a bed becomes available on the CRH forensic unit, its staff decides who receives the next bed predominantly based on reports of dangerousness by the referring hospital.[3]

The vast majority of forensic psychiatric evaluations in North Carolina are reportedly provided on an outpatient basis. At the CRH forensic unit, eight male beds and two female beds are reserved for evaluations for competency to stand trial. These beds are generally reserved for the patients who are deemed to be most violent and/or difficult to treat.

All persons in NC who have been found Not Guilty by Reason of Insanity (NGRI) must be housed at the forensic services unit for an initial 50-day period of evaluation. Further, under North Carolina law, all NGRI acquittees charged with violent crimes must be housed in a forensic unit operated by DHHS. Judges control all decisions regarding discharge and privileges, so the hospital does not have control of either its front door or its back door in regard to insanity acquittees. At the current time, the state of North Carolina reportedly does not allow conditional release for insanity acquittees. Nevertheless, the forensic service has implemented a privilege level system within the hospital, and adheres to the recovery model of treatment for serious mental illnesses.

The diagnostic makeup of the patients on the Forensic Treatment Service is typical of forensic units across the country, with more than 75% of the patients having a primary diagnosis of either schizophrenia or schizoaffective disorder.

The Forensic Treatment Service consists of one maximum-security unit (unit A0), one medium security unit (unit B0), and a minimum-security unit that is housed in Annex 393F. The medium and maximum units were relocated from the Dorothea Dix Hospital in Raleigh to the CRH campus in 2010, and the minimum unit moved to the CRH Annex in 2012.

The line staff in the forensic unit (i.e., psychiatric technicians) are called Therapeutic Support Specialists (TSS) or Healthcare Technicians (HCT) and are given up to a 10% pay enhancement for working on the medium/maximum security forensic unit. In addition to their on-ward duties that are typical for psychiatric technicians, the Hospital reports that these staff members spend a significant amount of time providing staffing for transportation of patients to various trips, passes, medical visits, etc. The facility estimates

[3] I recommend that the state begin tracking all felony cases involving incompetent defendants, to ensure that maximum security forensic beds go to the most appropriate cases at any given time.

that medical visits, both inside and outside of the Hospital, require an average of 6 FTE direct care staff (TSS's), and that more than 5,000 staff hours are annually devoted to trips and passes, which would account for approximately 2.5 additional FTE TSS's. These estimates do not include time spent testifying at hearings that occur within the Hospital.

It is also important to note that a significant amount of time is devoted by psychiatrists to travel and testimony for courts across the State of North Carolina. The Hospital estimates that the 3 psychiatrists serving the Forensic Treatment Service average 90 hours per psychiatrist per year of time spent to provide court testimony (including commitment and privilege hearings), which accounts for about 2 hours per psychiatrist per week. The 2.5 psychiatrists assigned to the Pretrial Evaluation Service, not surprisingly, average more than 100 hours per year testifying (including capacity to proceed and criminal responsibility proceedings).

Despite a generally high level of patient acuity, a high prevalence of diagnoses of serious mental illness, and a high prevalence of violent histories and currently assessed risk for violent behavior, the Forensic Treatment Service reports very low rates of involuntary treatments, as well as very low rates of patient and staff injuries and assaults; rates that are significantly below national norms for mental health facilities. For example, during 2011, the FTS reported only five serious patient injuries.

Findings

Although I communicated a number of specific recommendations (e.g., increase the use of positive behavioral plans, improve the security at the entrance to the forensic unit) to CRH leadership during my tour, overall I found this to be an exceptionally well-run hospital. As noted elsewhere in this report, if the state of North Carolina is interested in reducing costs, I do believe that there is room for some reasonable cost reductions without any deleterious effect on patient care or the safety of patients, staff, and the community. Specifically, I recommend a careful assessment of staffing needs, especially in the areas of psychiatry, nursing, and direct care staffing on the wards.

Additional Questions for Vendor from Original and Subsequent GEO Technical Proposals

1. Under "Scope of Services," the proposal states, "Experience has taught GEO that when one company operates all aspects of a facility, synergies are achieved that translate into improved patient care and lower costs."

    a. Wouldn't this same logic apply to one state agency? If not, why not?
    b. In other words, what is the advantage of a private vendor over a state agency?
    c. Other than reducing the numbers of staff available to provide treatment, on what basis is it less costly to include profit and the cost of providing these services?

2. Under "Scope of Services," the proposal states, "Operating all aspects of other facilities has given GEO the experience necessary to (a) minimize potential impediments to achieving performance measures and other goals, (and) (b) learn from past corrective actions...."

    a. To what specific impediments does this refer?
    b. Specifically, what "past corrective actions" have been required of facilities run by GEO?

3. Under "Scope of Services," the proposal states, "For example, 95% of state employee applicants from the South Florida Evaluation and Treatment center that met the minimum requirements were employed by GEO after privatization."

    a. If the same employees were providing care to the same patient's, what is the advantage of privatization?
    b. If the advantage of privatization is solely a reduction in cost, what percentage of the cost reduction is simply due to lower staffing levels or lower levels of staff compensation than were provided by the state?
    c. Specifically, what sources of cost savings other than reductions in staffing levels allowed GEO to operate services at a lower cost than the state?
    d. Did the sources of cost savings listed in item (c) above exceed GEO's amount of profit built into the contract?

4. Under "Scope of Services," the proposal states, "... GEO is confident that we can build a state-of-the-art, efficient facility that is therapeutic, safe, and secure while seamlessly relocating patients."

    a. What is the number of square feet per patient that GEO proposes as state-of-the-art?
    b. How does this number of square feet per patient compare to that of freestanding forensic psychiatric hospitals that have been built in the United States by anyone other than GEO?

5. Under "Scope of Services," the proposal includes 2 graphic charts that would suggest that contracted services are by nature "fragmented," as opposed to "comprehensive."

    a. Does this logic also apply to contractors utilized by GEO? (If not, why not?)

6. In response to the Department's reference to the CRIPA section of the United States Department of Justice (DOJ), the proposal cited lawsuits that were resolved or dismissed in Florida.

a. Has GEO ever been involved in a lawsuit or investigation filed by the US DOJ (CRIPA section)? (Please describe nature of lawsuit or investigation and resolution.)

7. Under "Licensure, Accreditation, and Certification," the proposal cites 25 years of experience with Joint Commission accreditation, and 13 years of experience with CMS certification. It is unclear whether these references are to GEO, Geo Group, or GEOCare, and/or whether these entities are interchangeable. The proposal also states that GEO currently operates 19 Joint Commission accredited facilities.

    a. Which GEO facility or facilities were Joint Commission accredited in 1987? Were they run by GEO, GEO Group, GEOCare, Wackenhut, or some other entity? Are these one and the same? What was the nature of each of these facilities (e.g., psychiatric hospitals, forensic psychiatric hospitals, correctional facilities, correctional medical facilities, etc.)?
    b. Which GEO facilities were CMMS certified in 1999, and how many GEO facilities are currently certified by CMMS? Were/are they run by GEO, GEO Group, GEOCare, Wackenhut, or some other entity? Are these one and the same? What was the nature of each of these facilities (e.g., psychiatric hospitals, forensic psychiatric hospitals, correctional facilities, etc.)?
    c. What are the 19 GEO facilities that are currently Joint Commission accredited? Are they run by GEO, GEO Group, GEOCare, Wackenhut, or some other entity? Are these one and the same? What is the nature of each of these facilities (e.g., psychiatric hospitals, forensic psychiatric hospitals, correctional facilities, etc.)?

8. Under "Licensure, Accreditation, and Certification," the proposal states that the proposed GEO facility will be Joint Commission accredited within 1 year after occupancy, and that "GEO... will incorporate the principles of continuous quality improvement protocols that will reflect best practices resulting in the North Carolina forensic facility becoming a national Center of Excellence."

    a. Are these intended to be contractual promises?
    b. How will these accomplishments be reported and measured?

9. Under "Licensure, Accreditation, and Certification," the proposal states, "The Clinical Director will have the training and experience needed to meet the requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry."

    a. Does this mean that GEO would or might appoint a Clinical Director who is not actually board-certified?

10. Under "Program Elements," the proposal states, "GEO's forensic programs provide state-of-the-art, holistic treatment in the least restrictive setting possible that is safe for the patient and for the community."

    a. Does GEO propose to lock patients in their rooms at night, even when those patients do not meet the criteria for seclusion?

11. Under "Program Elements," on page 5, the proposal states, "Persons served are expected to attend programming off of their units in the town center, which encourages a sense of responsibility, autonomy, and supports resiliency and recovery."

    a. Is the proposed town center large enough to accommodate all of the patients for treatment simultaneously?
    b. Does the proposed facility include adequate space for on-ward programming for those patients whose behavior or assessed risk of violence precludes participation in the town center treatment mall, or those who simply refuse to go to the treatment mall?

12. On page 8 of "Program Elements," the proposal cites "the importance of building strong relationships and coordinating with the Department's staff, the jails, courts, and other community partners in the development and modification of processes for admissions, assessments, transfers, treatment plans and discharge."

    a. Considering that the GOP proposal significantly reduces the numbers of psychiatrists, nurses, psychologists, and social workers, who will create and maintain these "strong relationships?"

13. On page 10 of "Program Elements," the proposal states that GEO's psychologists, psychiatrists, and other professional staff will provide testimony in court.

    a. How does GEO propose to provide professional staff to courts all over the State of NC as expert witnesses while simultaneously maintaining adequate clinical staffing on the hospitals wards?

14. On pages 17-18 of "Program Elements," the proposal states, "...(A)ll patients on suicide precautions will be on 1:1 supervision or 15 minute checks."

    a. Does GEO propose that a patient who is acutely suicidal can be safely monitored at intervals of 15 minutes?
    b. Will patients on 15-minute suicide checks be allowed to keep clothing and belongings?
    c. What is the nature and what are the specific design criteria of the rooms in which patients will be housed when they are on 15-minute suicide watches?

d. When patients are placed on suicide watch, are they confined to a room? If so, is this considered to seclusion and included in the facility statistics as incidents and hours of seclusion?

15. On page 20 of "Program Elements," the proposal discusses assessments by a "Behavior Analyst."

    a. What are the educational qualifications for the position of Behavior Analyst?
    b. Since this proposal implies that the Behavior Analyst will not be a member of each treatment team, is it GEO's intention to have a psychologist on each treatment team?
    c. What is the make-up of professional staff that will serve as full-time members of each treatment team, as proposed by GEO?

16. On page 24 of "Program Elements," under "GEO Advantage," GEO states that it provides 1,100 patients with "individualized, interdisciplinary, person-centered treatment plans," with only 31 psychiatrists and 25 psychologists. An average-sized ward of 24 patients served by a treatment team would require 45 separate treatment teams to serve 1,100 patients.

    a. What is the average number of patients that GEO proposes to serve with one treatment team?
    b. What is the make-up of each treatment team in terms of full-time professional staff that GEO currently uses in its facilities, and what differences are they proposing for NC?

17. The proposal refers to a "Recovery Plan Coordinator (RPC)" as "responsible for obtaining input from each discipline, coordinating this input into the plan, explaining the plan to the patient, and providing the plan to the patient, if he/she requests a copy."

    a. What is the proposed professional and educational criteria for the RPC?
    b. Who has ultimate authority and responsibility for the content of each treatment plan?
    c. Is each patient's treatment plan developed an updated at an interdisciplinary meeting? Who attends these meetings? (See #19 below.) How often are these meetings held?

18. Later, on page 27, the proposal describes a monthly meeting between the patient and the treatment team to modify the treatment plan.

    a. Who comprises the treatment team?
    b. Who attends these monthly meetings?

19. The proposal states that the Master Treatment Plan does not have to be implemented until 30 days after admission.

    a. Does GEO believe that 30 days without a treatment plan comports with the standard of care?
    b. To what standard does GEO refer in claiming that a patient can be without a treatment plan for 30 days after admission?

20. The proposal makes numerous references to engagement, motivation, trusting relationships between patients and staff, etc.

    a. How does GEO propose to maintain the same or better quality of staff-patient relationships as described in the proposal, with significantly lower numbers of clinical staff than are currently provided by DHHS at the Central Regional Hospital?

21. On page 41 of "Program Elements," the proposal appropriately asserts, "The psychologist who is a patient's capacity-to-proceed evaluator, will not be his/her therapist."

    a. What percentage of patients does GEO predict will need individual psychotherapy, and does the staffing model allow for adequate psychologists and social workers to provide the necessary individual and group therapy, behavioral plans, discharge plans, forensic evaluations, court testimony, etc. as described in the proposal?

22. Pages 47-51 of "Program Elements" provides an impressive description of GEO's use of behavioral plans, with appropriate oversight and safeguards.

    a. What percentage of GEO's patients at their currently operated forensic hospitals are receiving behavioral plans as described?
    b. Considering the reported success of GEO's behavioral plans, and considering that patients are housed in the least restrictive environment, are all GEO patients on maximum-security wards being treated with behavioral plans? If not, why not?

23. Regarding psychotropic medications, the proposal lists the following criteria for the selection of prescribed medication: "Clinical assessment, diagnosis, prior response, medication history, patient preference, side effect history, adverse drug reactions, drug allergies, family history, compliance issues and a review of all records from the referring agency/treatment team."

    a. This list of criteria does not include cost. Does GEOCare propose to include cost as one of the consideration for the selection of medications?
    b. Will any drug be excluded from the formulary based predominantly on cost?

c. How will the formulary be developed and maintained?
d. What will be the process for a physician to initiate or continue a prescription for medication that is not on the GEO formulary?
e. Does GEOCare plan to use any particular algorithm in deciding the medication on which each patient will be tried? If so, please describe.

24. At the top of page 68 of 186 of "Program Elements," the GEO proposal clearly calls for the availability of one psychiatrist and one medical physician to be on call and available within 20 minutes. However, one paragraph later, the following sentences appear: "There will be a Medical Physician and Psychiatrist on call to respond to emergency situations. One of the licensed physicians will be available for face-to-face evaluations within a maximum of twenty (20) minutes."

    a. These two statements appear to contradict each other. Did GEO intend to say that one physician or both physicians must be available to respond within 20 minutes?

25. On the following page (69 of 186), it states that, "All available nursing staff closest in proximity to the emergency will respond to the medical emergency."

    a. How does GEO propose to avoid leaving other units uncovered by requiring all available nursing staff to respond to an emergency, when a much smaller number of nursing staff may be required to adequately respond to the emergency?

26. On page 72 of 186 of "program elements," the proposal states, "Medical infirmary beds will be provided, starting at a minimum of two (2) negative air pressure rooms." The proposal also calls for an RN in the infirmary during all shifts when patients are housed there.

    a. Did GEO mean to refer to medical isolation rooms in the sentence above?
    b. If so, how many total infirmary beds are proposed?
    c. What is the proposed size of the infirmary?
    d. Does the nursing staffing proposal allow for nurses to cover all of the psychiatric units as well as the infirmary when patients are housed there?

27. On page 87 of 186, the proposal states, "The internal medicine physician will oversee and make rounds in the infirmary."

    a. How often will these rounds take place?

28. On page 112 of 186, the proposal states, "All patients while out of doors will be accompanied and supervised by staff."

a. In keeping with GEO's stated policy of providing treatment in the least restrictive manner possible, and in keeping with the principal of progressive increases in freedom, would any patients be able to earn the privilege of being outdoors without being accompanied by staff at all times?

29. Regarding patient visitation:

    a. Does GEO propose to have x-ray equipment available at the facility entrance?
    b. Will visitors be required to pass through a metal detector?

30. On page 116 of 186, the proposal states, "Visitors will not be allowed to bring any item into the facility."

    a. Can GEO clarify this rule? If a mother wants to bring her son a present or some type of foodstuff, is there any way for her to safely and legitimately give it to him? (See item #29 above regarding x-ray equipment.)

31. Regarding allegations of abuse and neglect:
    a. How many allegations of abuse and neglect have been made during the past years at each of the GEO forensic psychiatric facilities?
    b. How many of those allegations were determined to be true or founded?
    c. How many staff members have been terminated at the respective GEO psychiatric facilities for abuse or neglect during the past 5 years?

32. Regarding restraint and seclusion, the report that there was virtually no restraint or seclusion used in any of the Florida psychiatric facilities is indeed impressive.

    a. How often was involuntary medication used in those same hospitals?

33. The proposal mentions a "mobile tool for monitoring individuals." It appears to be designed to ensure that ordered watches are actually conducted as ordered, but this is not clear from the proposal. While there is a picture of it, there is no explanation of the nature and use of this tool.

    a. Can GEO clarify the nature and purpose of its "mobile tool?"

34. Also in regard to suicide prevention:

    a. How many serious suicide attempts occurred in GEO's Florida and Texas psychiatric facilities during the past year?
    b. How many completed suicides occurred in GEO's psychiatric facilities during the past 5 years?

35. The proposal states, "in the past 36 months, the discharge planning for 2634 forensic and civil psychiatric patients has been completed and the patients have been successfully transitioned into the community.

    a. How many of the 2634 patients were forensic?
    b. How many social workers completed the forensic discharge plans?
    c. How many of the forensic patients who were discharged were returned to freedom in the community (as opposed to being transferred to jail or prison)?
    d. In light of the implication that 100% of the 2634 discharges were "successful," how many released forensic patients were rearrested after discharge? What criteria does GEOCare use in order to declare a discharge "successful?"
    e. How many released forensic patients were rearrested for violent crimes after discharge?

36. The proposal states, "The Forensic Review Panel will review discharge recommendations from the treatment team."

    a. Does each treatment team include a full-time social worker?

Questions Regarding Staffing

1. The proposal calls for the creation of positions known as Therapeutic Safety Specialists (TSS's).

    a. Are the TSS's considered direct care staff?
    b. Are the TSS's considered nursing staff?
    c. If not, do the TSS's provide any nursing services, and are those services supervised by nursing managers?
    d. Are the TSS's considered ward managers?
    e. To whom do the TSS's report?

2. While the numbers provided by GEO are a bit confusing, it is clear that the GEOCare proposal calls for a significant reduction in the number of mental health technicians. I spent a great deal of time looking at the numbers proposed by GEOCare and the current staffing at the CRH Forensic Unit. Part of the confusion stems from the fact the GEOCare proposes to use Therapeutic Safety Specialist/Admission staff to perform duties that are currently performed at CRH by mental health technicians. In order to clarify these comparisons, I compared the existing staffing numbers, with security and transportation duties included, and then performed a second comparison with security and transportation duties excluded. In both cases, the GEOCare proposal appears to reduce direct care staff by 17 FTEs (when security and transportation duties are included) or by 16 FTEs (when security and transportation duties are excluded from the analysis.) There is no concomitant

increase in any direct care staff to make up for this shortfall; as a result, GEOCare proposes a significant decrease in the number of direct care staff.

a. How does GEOCare propose to monitor and maintain a safe and therapeutic environment with a large reduction in direct care staffing?
b. How does GEOCare propose to allocate the 53 mental health technicians among 5 wards across three shifts, while allowing for regular days off, holidays, and sick leave. (Note, using GEOCare's proposed relief factor of 1.7, 53 people are adequate to fill approximately 10 24-hour posts.)

3. GEO also proposes to reduce the number of Registered Nurses (RN's) from 52 to 16. Again, the proposal is very confusing. For example, the GEOCare proposal lists 7 nurses on the day shift, 4 nurses on the evening shift, and 4 nurses on the night shift. This adds up to 15 shifts per day that must be covered. Using GEOCare's proposed relief factor of 1.7, it would thus require 25.5 RN's. Yet the GEOCare proposal only includes 16 Registered Nurses. Even if GEOCare inappropriately proposes to use licensed practical nurses (LPNs) (of which 6.4 are proposed) to cover some shifts, their proposed number of 22.4 nurses (16 RN's+ 6.4 LPN's), is still approximately 3 FTEs short.

   a. Considering the large reduction in the number of nursing staff proposed by GEOCare, what duties currently performed by CRH nurses does GEOCare propose to eliminate?

4. Also confusing were GEOCare's proposed staffing numbers for psychiatrists. The proposal included 3.5 FTE psychiatrist's in formulating its staff to patient ratios for psychiatry. However, on closer inspection, it appears that GEOCare included 1.5 FTE psychiatrists on call in arriving at those ratios. This is inappropriate and misleading. In other words, the actual full time staffing complement for psychiatry is proposed to be two FTE's, which is inadequate for this number of forensic psychiatric patients.

5. In the vendor's responses to DHHS's questions, GEOCare reported that security personnel will comprise 14% of GEOCare's staffing at the proposed North Carolina facility.

   a. Does this response include the Therapeutic Safety Specialists (TSS's)?
   b. Are the TSS's considered clinical or security staffing, or both?
   c. Are the TSS's "double counted" as both security and clinical or patient care staff numbers?

General Comments

<u>Comments Regarding the GEOCare Proposal for Program Elements</u>

1. I like and approve of the school-like nature of the town center treatment mall proposed by GEOCare.

2. I like and approve of the use of the Center for Psychiatric Rehabilitation, at Boston University, to provide training to clinical staff.

3. I enthusiastically support GEOCare's proposed use of peer support specialists in its forensic hospitals to "provide orientation, develop personal safety plans with patients, and address patient issues and grievances." I also support the use of a Patient Governance Council facilitated by peer support specialists.

4. I support the use of Forensic Review Panels to review treatment teams' recommendations regarding patient's suitability for treatment and a less restrictive setting.

5. I have not commented in this report on the timing of the various initial assessments, as this issue was covered quite comprehensively by DHHS officials. I agree with the Department's review and opinions regarding these assessments.

6. The sample Partial Treatment/Recovery Plan on page 26 of the "Program Elements" is quite deficient. Basically, it includes psychotropic medication, "encouragement" to attend community meeting and undefined "on-unit activities and rehabilitation groups," and 2 hours a week of 'illness management group." I don't know the purpose or reason for a "Partial Treatment/Recovery Plan," but I would not accept this even for a patient's first 30 days in the hospital.

7. I support the commitment to 20 hours of active treatment per patient per week. GEOCare reports, "In Florida, (they) provide over 30 hours of active treatment seven (7) days per week. If this is true, it would be an impressive accomplishment. However, one must be very careful to delineate exactly what is counted as active treatment, and a definition of the word "provided." For example, does this mean that 30 hours are offered to each patient, or that each patient actually attends 30 hours of treatment per week.

8. On Pages 29-30 of "Program Elements," the proposal provides sample schedules for "NGRI" and "ITP." On its face, the schedule appears impressive. However, it is not clear whether each of these would be the schedule for a particular patient, or if those are all the groups that are offered for a particular facility.

9. I support the use of positive behavioral plans, as described by GEOCare on page 32. Less clear is who will develop such plans, in light of the limited staffing proposed for psychologists.

10. I support the use of integrated treatment of co-occurring substance use and mental illness disorders, as described by GEOCare on page 33. Less clear is who would

provide this treatment, in light of the lack of adequate clinical staffing in the proposal.

11. I strongly support the use of Motivational Interviewing as proposed by GEOCare.

12. I strongly support attention to histories of trauma among both men and women patients, and the use of trauma-informed treatments.

13. I have been impressed with the use of automated dispensing devices, which may have some potential to reduce pharmacy workload, improve accuracy, and reduce waste.

14. The proposal states, "Lab work specific to the use of certain medications will be ordered at regular intervals as determined by the Pharmacy and Therapeutics Committee." Examples are provided on page 57. I strongly support this approach, as it is time-efficient for physicians and nurses, and reduces errors when appropriate labs are not ordered.

15. I am impressed with the proposal's attention to metabolic side effects and syndrome as a possible risk of second-generation antipsychotics. Less clear is how GEOCare would propose to accomplish this in light of its inadequate proposal for psychiatric and nursing staffing.

16. I am especially confused about a comment that was made regarding evaluation factor number 2. According to the document that was attached, which included a point deduction grid, the following comment appears:

> "page 28 of 186, on call: only one of psychiatrist and medical provider on-call are available for face-to-face evaluation in 20 min., leaving either medical or psychiatric services uncovered by specialist."

At first blush, this statement appears to be in error. (Note also that the page reference is incorrect.) At the top of page 68 of 186, the GEO proposal clearly calls for the availability of one psychiatrist and one medical physician to be on call and available within 20 minutes. However, one paragraph later, the following sentences appear: "There will be any Medical Physician and Psychiatrist on call to respond to emergency situations. One of the licensed physicians will be available for face-to-face evaluations within a maximum of twenty (20) minutes." It is thus unclear whether GEOCare proposes to provide one or two physicians on-call. This issue requires clarification.

17. On the same page, the proposal states, "All available physicians in the facility will respond to the medical emergency." This seems ill-advised, as there is no reason to interrupt all other medical treatments and leave units uncovered when one physician may be adequate to respond to the emergency.

18. I agree with the use of telemedicine services to provide some specialty services when necessary and appropriate.

19. GEOCare proposes that their formulary will be based on the formulary of other North Carolina state hospitals, which is appropriate.

20. I was concerned about the utilization review section on page 102 of 186. This appears to give GEOCare the power to deny care that has been ordered or recommended by one of their own doctors. While the dispute resolution process appears sensible on its face, the proof of the pudding is in the tasting, and it must be remembered that physicians may be hesitant to appeal the decision of the company that employs them. It is imperative that clinical judgment be exercised and acted upon by the physician who is treating the patient.

21. I enthusiastically agree with the proposal to have the proposed new facility remain smoke-free.

22. I do not agree with the decision to allow visitation only on weekends. Nor do I agree with the decision to limit visits to 2 hours. Each family situation will be very different, and there is no good reason to arbitrarily limit patients to 2 hours of visits with love ones if such visits are clinically beneficial. (Note, the proposed policy does allow for special approval for visitation due to hardship or long distance travel during weekdays.) I also believe this proposed policy may violate North Carolina statutes regarding patient rights, but I refer that question to the Department's counsel.

23. I disagree strongly with the decision to preclude visits from any children under the age of 12. Such a prohibition may have an especially deleterious effect on patients who are parents. While routine limits may be appropriate, and protection of children is of paramount importance, such limits should always be subject to reasonable exceptions, based on clinical and family circumstances.

24. The proposed grievance process appears appropriate.

25. On page 131 of 186, the proposal states, "Since inception, GTI has transported over 200,000 individuals through individual, mass ground, and air movements without incident." To the extent that these were inmates or psychiatric patients, this statement seems absurd on its face, depending upon the definition one uses for the word "incident."

26. GEOCare appears to prefer Mandt to CPI for training in violence prevention. Both companies are well-regarded, and in my opinion there are relatively few differences in their respective approaches to training. I believe that either is acceptable.

27. GEOCare claims to have used the NASMHPD 6-point plan for reducing the use of restraint and seclusion. They claim to have "virtually eliminated" the use of seclusion and restraint from their facilities. Frankly, I find this difficult to believe, as I have visited many state hospitals that took advantage of NASMHPD consultation toward reduction of seclusion and restraint. While each of these facilities reported significant decreases in the use of involuntary treatments, I don't remember any of them claiming to have eliminated seclusion and restraint altogether. I also wonder about the absence of data regarding involuntary medication, which can sometimes be a substitute for restraint or seclusion. (Technically, however, involuntary medication, if it involved hands-on administration, should be counted as restraint.)

28. On the other hand, I am an enthusiastic proponent of the patient-created "Personal Safety Plan that describes their de-escalation preferences, triggers, and preferred calming strategies." To the extent that GEOCare has successfully "virtually eliminated" seclusion and restrain from their facilities as they claim, they are to be congratulated, and these plans are one very effective tool toward that end.

29. GEOCare reports that they initiate applications for patient entitlements (e.g., Medicaid, SSI, SSDI) 45 days prior to release. If this is accurate, it is an excellent practice.

Comments Regarding Capital Operations and Facilities Management

1. It is not unlikely that new construction will be preferable to major renovation of an older facility such as Dorothea Dix Hospital.

2. The ability to complete design and construction of a new forensic psychiatric facility in 14 months suggests the use of a pre-existing design that was already used somewhere else. There is nothing inherently wrong with this approach, especially if the existing facility is deemed by the State to be adequately safe and therapeutic. The biggest problem with the proposed design, of course, is the very low number of square feet per patient, which is approximately half of what has been true for other state forensic (and civil) hospitals constructed during the past two decades (e.g., Western State Hospital in Steilacoom, WA; Colorado Mental Health Institute–Pueblo; St. Elizabeths Hospital in Washington, DC.) I believe this is also true of Cherry State Hospital in North Carolina.

3. In addition, it appears that GEOCare prefers a facility design in which there is only one nursing station that serves as a "hub" for all of the housing units. In practice, this essentially precludes the creation and maintenance of a truly therapeutic milieu and treatment team on each ward. In my opinion, this reduces the quality and individualization of psychiatric treatment.

4. The computerized preventive maintenance program is an excellent idea.

5. Generally, the ratio of direct care staff (including every employee who spends the majority of the day in patient contact, such as psychiatric technicians, psychiatrists, and nurses) in well-staffed and well-run state forensic psychiatric facilities ranges from an absolute and bare minimum of 1.35:1 to an optimum of 1.6:1. The number of direct care staff needed for a 90-bed hospital would therefore range from a minimum of 121.5 to an optimum of 144, excluding services that are typically not included in these analyses, such as pharmacists, X-Ray technicians, laboratory technicians, and other services that are typically contracted or centralized. (This number must also be adjusted for other time-consuming duties, such as outside trips, etc.) In looking at the existing staffing at CRH, I note only two food service workers and no security staff, which suggests that some or all of those duties are likely performed by mental health technicians. It is also important to understand that the current CRH staffing levels include clinical staff members who spend significant amounts of time preparing reports and delivering testimony for courts across the State of NC.

6. GEOCare's proposal includes intensive background investigations of all newly hired employees. This is an excellent practice.

Consultation with Drs. Kenneth Appelbaum and Susan Stone

At my request and with the concurrence of DHHS, I asked Kenneth Appelbaum, MD, and Susan Stone, MD, JD to review the GEOCare proposal. We conducted a conference call to discuss our respective impressions of the proposal on August 7, 2012. The following is a summary of the opinions expressed by Drs. Appelbaum and Stone:

Drs. Stone and Appelbaum believe that the overall need for opening this new facility does not seem clear, as the current facility appears to be more than sufficient in several ways, and the motivation behind this seems to be political. Many problems exist with the new plans, including the logistics of the schematics and staffing. It is also unclear what model — psychiatric vs. correctional – would be or should be used in the proposed new facility.

Any savings that would accrue from acceptance of the GEOCare proposal would appear to come from staffing decreases that will hurt patient care. They note that the proposal has some significantly lower staffing levels, and wonder if GEOCare would be able to match the outstanding qualifications of current staff, which includes, for example, boarded psychiatrists with forensic training and experience.

Drs. Appelbaum and Stone noted the following problems with the GEOCare proposal:

- Line staff appear to be primarily security in nature
- Creation of a freestanding hospital would lose services that are available at the civil hospital in which the forensic unit is currently located (and vice versa).

- Schematics – There appears to be inadequate space for staff offices and treatment areas.
- The existence of only one nursing station to serve multiple housing units is a big problem.
- Having staff offices in a separate wing is not a good idea. It is better to have clinical staff on the unit, where they are more accessible to patients.
- The GEOCare proposal does not provide for an RN available on every unit on every shift, which is very concerning.
- The co-ed aspect not necessarily a problem, and actually could be beneficial for some patients.
- 15 RN's total for 3 shifts does not even meet GEOCare's own proposed staffing model, which is already way too low.
- Proposed Psychiatry coverage and staffing are inadequate. The psychiatry ratios presented by GEOCare are very misleading. The on-call psychiatry hours should not be included in the ratios. The ratio shown purports to be 25:1, but this includes on-call psychiatrists; thus, in reality the ratio is actually 45:1.
- Does GEOCare propose to operate its hospital under a correctional model or a psychiatric inpatient model? Some aspects of the proposal seem to be more aligned with a correctional model than psychiatric model.
- The terminology in the proposal was not entirely clear regarding the proposed time frames for admission and subsequent assessments; however, the time lines appear to be unsatisfactory. For example, the proposal appears to call for comprehensive psychiatric assessment annually, which is unacceptable.
- It appeared that the GEOCare proposal's comparisons to existing staffing may have overlooked the current on-call coverage provided by the civil side of the Hospital, thus making it look like they will provide services that are currently not provided.

Discussion

Staffing Concerns

In general, Drs. Stone and Appelbaum were not positively impressed with the staffing proposed by GEOCare.

The GEOCare proposal lists RN staffing as 7 RN's on day shift, 4 RN's on Evening shift, and 4 RN's on night shift for the entire building, and proposes a relief factor of 1.6 to 1.7 FTE's per shift. (The lowest correct relief factor would be 1.7.) To provide this coverage for 15 shifts would therefore require 25.5 nurses (15 x 1.7). Yet the GEOCare proposed staffing plan proposes only 16 total FTE for Licensed Registered Nurses. Thus, the proposed staffing numbers would not come close to providing the staffing that their own proposal calls for. There is no explanation of how they propose to accomplish this literally impossible task. Further, even if GEOCare were to increase its nursing staffing to provide for its proposed staffing model, it would still be significantly less than the staffing that would be required to maintain the current quality of treatment.

Thus, the GEOCare proposal dramatically reduces the staffing for nurses. Drs. Appelbaum and Stone believe that the reduced staffing for nurses will make it very difficult to create and maintain meaningful ward-based treatment milieus and treatment teams. They believe that it is essential to have nurses assigned to each housing unit, especially during the day and evening shifts.

They also believe that the proposed number of psychiatric technicians is both unsafe and inadequate to maintain a safe and therapeutic environment.

The main area in which I requested the consultation of Drs. Appelbaum and Stone was psychiatric services. Their findings were quite consistent with my own, and included both general and specific findings and recommendations.

Similar to nursing, questionable computational issues arose in regard to the patient to psychiatrist ratio, which is actually 45:1, not 25.7:1 as indicated in the GEOCare proposal. This is because the 1.5 FTE on-call coverage should not be counted as caseload coverage.

A caseload of 45 patients is too high (by a factor of 2) even if the 90 beds never turn over. This situation is even worse for beds that turn over frequently.

Simply put, Drs. Stone and Appelbaum found that the GEOCare proposal does not include enough psychiatrists, and that the GEOCare proposal was misleading, by including on-call psychiatrists in presenting a psychiatrist-to-patient ratio. The actual ratio that GEOCare is proposing will create a caseload of 45 patients for each psychiatrist, which will not provide enough time to treat everyone effectively and within the standard of care.

The correct ratio should be 24:1, and possibly higher depending upon the frequency of admissions. (For example, admission or acute care units will typically have a ratio of approximately 16:1. They also note that the absence of an adequate number of psychologists and nurses makes the inadequate number of psychiatrists even more concerning.

Regarding tele-psychiatry, Drs. Appelbaum and Stone believe that tele-psychiatry is acceptable for on-call responses, as long as the on-call psychiatrists have the ability to come in as needed.

Drs. Appelbaum and Stone recommend that the contract require a face-to-face evaluation by a physician (preferably a psychiatrist) within four hours of admission. Further, if the patient has not previously been medically cleared by a physician, then there should be a clear and concise set of nursing protocols regarding the need for physician assessment. In other words, there has to be an assurance that the person coming in must get proper and timely care through proper nursing and physician assessment; both upon admission and in response to emergencies. To that end, they also recommend that the State seek clarification of the GEOCare proposal regarding the circumstances under which an on-call psychiatrist or other physician must come on site, and protocols for making that determination.

They also opined that an annual comprehensive psychiatric evaluation is not frequent enough. Anytime there is a treatment plan review, a comprehensive psychiatric evaluation should also be done, generally at least every 3 months or when there is any significant change in the patient's clinical status.

The note that it is preferable to require Board Certification in general psychiatry, especially for directors, but that should other factors should be considered when evaluating candidates. For example, recent graduates from psychiatry residencies should be eligible for hire, although it makes great sense to require that they achieve Board certification within a set period of time. In order to retain good young psychiatrists, incentives should be offered for those who attain Board certification.

They agree with my recommendation that clinical staff should have office space on the units, to improve patient accessibility and to enhance the creation of treatment teams and milieus on the units.

Drs. Stone and Appelbaum also offered several more specific recommendations regarding psychiatric care. They recommend that the frequency of AIMS testing for side effects of antipsychotic medications should be specified, and generally required at the very start of antipsychotic treatment, and then at least every 6 months. They also note that nursing protocols should require notification of the treating physician for missed doses, medication refusals, or any other clinically significant pattern of non-compliance.

Finally, regarding the formulary, Drs. Stone and Appelbaum report that the GEOCare proposal appears adequate, with one exception: They note that the so-called "Texas Algorithm" has been discredited, and should not be used. Nevertheless, it is acceptable practice to achieve some reasonable cost-savings in the choice of medication, so long as physicians are allowed to prescribe any medication required by the patient's clinical condition, as proposed by GEOCare.

Drs. Stone and Appelbaum also expressed concern about the medical care and rapid response policy envisioned by GEOCare. From the GEOCare proposal, it was unclear if they plan to have and use an actual on-site infirmary. Drs. Stone and Appelbaum are concerned that acute conditions might become exacerbated and allowed to reach emergency levels, requiring transfer to a general hospital, due to lack of on-site infirmary or the failure to use it for its intended purpose. I also note that medical trips outside of the facility present a well-known risk of escape attempts. While such trips can never be eliminated, they should be minimized. In short, Drs. Stone and Appelbaum opined that all medical issues need to be addressed in a timely and appropriate fashion, and that patients cannot be allowed to digress into preventable medical emergencies. The GEOCare proposal raises as-yet unanswered questions regarding this important issue. Many of these issues were raised by the Department's Medical Director as well.

On a related note, Drs. Stone and Appelbaum were concerned that the proposal appears to allow for a contract with an emergency department that is not necessarily the closest one to the hospital, and recommend against such a practice.

Doctors Appelbaum and Stone also raised concerns regarding the physical plant proposed by GEOCare. They noted that the proposed building appears to offer approximately half as many square feet per patient as compared to other, similar new facilities that have been constructed in other states.

Further, they note that there is virtually no program space on the wards. While they agree that the concept of a treatment mall is a good one, they note that there will always be some number of patients whose acuity or refusal may preclude them from using the Treatment Mall at any given time. In essence, the patients who cannot use the Treatment Mall will often be the patients who are most in need of treatment at any given time. Thus, there must be space to provide them treatment on the wards.

The absence of treatment space on the wards is further evidence that GEOCare does not intend to create meaningful milieus on its housing units. This is consistent with the absence of nursing stations on each ward, and the failure to provide adequate number of nurses to provide team-based leadership to the wards. Drs. Stone and Appelbaum join me in believing that treatment teams are the heart and soul of good psychiatric treatment, and that patients deserve to be housed within a therapeutic milieu.

It was clear to Drs. Stone and Appelbaum that the treatment philosophy proposed by GEOCare relied almost exclusively upon group treatment in the treatment mall. Further, while the quality of the group treatment appeared good, it was not clear that the groups would be adequately individualized. In other words, they were concerned that the treatment would be "one-size-fits-all." It did not appear to be the case that a significant number of patients were expected to receive individual psychotherapy.

Drs. Stone and Appelbaum were impressed with the lab protocols proposed by GEOCare, and had no suggestions or criticisms of them.

Summary of Conclusions of Drs. Appelbaum and Stone

In general, Drs. Appelbaum and Stone were of the opinion that the GEOCare proposal makes little sense to the State of North Carolina. They point to the unnecessary abandonment of an apparently successfully functioning forensic unit at CRH that provides exemplary services. They note that the alleged savings proposed by the GEOCare proposal would almost entirely be accounted for by significant decreases in staffing, to the detriment of safety and treatment.

Drs. Appelbaum and Stone also noted the outstanding qualifications of current staff, which will be extremely difficult to match and all but impossible to exceed. For example, all of the current CRH forensic psychiatrists are board certified in psychiatry, all but one have

forensic board certification, and some have additional board certifications such as geriatric psychiatry. They also warn against the loss of an effective forensic training site for psychiatrists and psychologists.

Drs. Appelbaum and Stone note the advantages that come from co-location of a forensic and civil state hospital on the same campus. For example, the forensic psychiatrists provide consultative help to the civil side of the hospital, which also includes a significant number of forensic patients. Savings also come from the ability to provide on-call services across civil and forensic units. Other benefits of co-location include a comprehensive medical service, a full-service pharmacy, on-site laboratory and radiology services, dental care, as well as on-site physical therapy and speech pathology services.

Especially important to Drs. Appelbaum and Stone was the apparently proposed change from the current CRH model in which all staff have therapeutic duties to a model that includes security-only staffing. Finally, they note that it is unclear whether the proposed units would have adequate space for staff offices, nursing stations, and treatment areas, adding that the location of clinical staff offices away from patient areas is not conducive to maximizing staff-patient contacts.

Summary and Conclusions

Based on a careful review of the GEOCare proposal, and in consultation with my colleagues, Drs. Stone and Appelbaum, I cannot identify any legitimate likelihood of cost savings beyond those expected to result from significant reductions in crucial areas of staffing. While I believe that CRH could profit from a careful and self-critical review of its staffing needs, I am aware of no significant cost-saving advantage contained in the GEOCare proposal that would not harm patient care or that could not be realized within the existing state-run model under which the services are currently provided.

Comparing the facility operated by GEOCare in Texas to the state-run CRH in Butner is difficult for several reasons. Most importantly, the two hospitals serve very different populations, with consequences for staffing and operations. The Texas facility has the advantage of serving patients with less serious crimes, lower acuity levels, and who have been screened for co-occurring medical diagnoses. Even with this much easier clientele, however, the GEOCare model of service has significant drawbacks, especially in regard to the failure to establish treatment teams and treatment milieus on the wards.

There were a number of aspects of the GEOCare Texas facility to be admired, especially the manner in which core programming was provided at the treatment mall. That being said, there is no evidence that the GEOCare proposal would provide any savings at all that are not the direct result of decreased staffing (and in some cases decreased salaries and benefits), which must inevitably result in decreases in the quality of care.

Of particular concern is the reduction in staffing levels for psychiatrists, nurses (RN's), and line staff (e.g., psychiatric technicians). Also concerning are reductions in the number of

psychologists and social workers. In essence, the GEOCare proposal eliminates much of the essence of treatment teams, which are the cornerstone of inpatient psychiatric treatment. While many of these duties overlap, each member of the treatment team also has specific and unique duties that are essential to adequate treatment that will simultaneously assist the patient in his or her recovery and protect the public by creating the proper blend of services, support, structure, and scrutiny, both within the hospital and after eventual release. While some valuable treatment can occur in a treatment mall, patients spend the vast majority of their hours each week on their wards, and it is imperative that the wards maintain a therapeutic milieu to maximize each patient's recovery.

Simply put, in looking at the GEOCare proposal for North Carolina, I am unaware of any cost-saving or quality improvement advantages to the state that would accrue from the privatization of the forensic service of the Central Regional Hospital. I do not believe that the GEOCare proposal provides real cost savings to the State, other than simple reductions in the number of direct care staff members and/or the compensation they receive. Both of these decreases will, in my opinion, have a direct and deleterious effect on patient care.

That being said, I believe that the State's goal of significant cost savings may be reasonable within the existing structure of CRH and its forensic unit. Some savings can likely accrue from careful attention to the existing staffing at CRH, and by fair comparisons of the operating costs at CRH and its sister hospitals in North Carolina. (The scope of this consultation did not allow me to conduct a thorough staffing review at CRH, or to review operating procedures and costs at other NC hospitals; however, I am told that such a review is planned.) However, in making such a review, I urge the State to proceed with caution, as some of the numbers will be misleading. For example, CRH currently shows on its books a number of costs that are accrued outside of the walls of the hospital, and that are not fairly construed as CRH operating costs. Further, some of the functions provided by CRH provide benefit to the State of North Carolina as a whole. The best example of this is the Hospital's relationship to various academic institutions, especially in the area of forensic psychiatry and nursing. These costs may not necessarily benefit individual patients, but they are of immense value to the state's judicial and public safety systems and should not be included as part of the per diem and per patient costs of running the CRH forensic unit.

It is important to note that the leadership of CRH has already recognized the potential for cost savings and begun the process of a self-critical review of areas for potential efficiency and savings. According to the CEO, the hospital reduced its overall expenditures in FY 2011-12 by $14,779,856 compared to the preceding year. They reportedly plan to continue this trend of self-critical cost analysis and reduction in the coming months.

Nevertheless, after assuring that comparisons are fair, I remain convinced that there is room for some meaningful cost savings, without negatively affecting patient care, by looking at the relative per patient costs of each NC state hospital, and by a careful examination of staffing practices at CRH.

In summary, it is my recommendation that the State of North Carolina reject the proposal submitted by GEOCare, Inc. to provide inpatient forensic psychiatric services.

Respectfully submitted,

Joel A. Dvoskin, Ph.D., ABPP

Appendix A
Curriculum Vitae of Joel A. Dvoskin, Ph.D., ABPP

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EDUCATION:

Undergraduate:	University of North Carolina at Chapel Hill; B.A. 1973; Majors: English and Psychology; Awards: Order of the Old Well Honorary Society Order of the Grail Honorary Society
	Stockholm University, Stockholm, Sweden; Diploma, 1972; Major: Social Science.
Graduate:	University of Arizona, Tucson, Arizona; M.A. in Clinical Psychology, 1978; Ph.D. in Clinical Psychology, 1981;
	Dissertation: Battered Women: An Epidemiological Study of Spousal Violence.
Professional:	University of Arizona College of Law, Tucson, Arizona; Doctoral Minor

HONORS:

Diplomate in Forensic Psychology, American Board of Professional Psychology
Fellow, American Psychological Association
Fellow, American Psychology-Law Society
Peggy Richardson Award, National Coalition for the Mentally Ill in the Criminal Justice System
Amicus Award, American Academy of Psychiatry and the Law
Affiliate Member, International Criminal Investigative Analysis Fellowship
Distinguished Visiting Professor of Psychiatry, University of California, Davis School of Medicine and Napa State Hospital, April 14, 2005
President, Division 18 of the American Psychological Association, Psychologists in Public Service (2000-2001)
President, American Psychology – Law Society, Division 41 of the American Psychological Association (Presidential year 2006-2007).
American Psychological Association, Division 18 Special Achievement Award
Arizona Psychological Association, Distinguished Contribution to the Science of Psychology Award, 2010
Distinguished Visiting Professor of Psychiatry, University of California, Davis School of Medicine and Napa State Hospital, March 30, 2011

ACADEMIC POSITIONS:

1996 - 2001
Asst. Professor (Adjunct) - University of Arizona College of Law

1996 - current
Asst. Professor (Clinical) - University of Arizona College of Medicine, Dept. of Psychiatry

1986 – 1995 (currently inactive)
Assistant Clinical Professor - New York University Medical School, Dept. of Psychiatry

2000 – 2005 (currently inactive)
Assistant Clinical Professor - Louisiana State University Medical Center

LICENSES:

Arizona Board of Psychologist Examiners, License #0931
New Mexico State Board of Psychologist Examiners, License #0904
Certificate of Professional Qualifications in Psychology (CPQ), CPQ #2,439
Interjurisdictional Practice Certificate, ASPPB, #2439

PROFESSIONAL EXPERIENCE:

September 1995 - Current

Full-time private practice of forensic psychology, providing expert testimony on civil and criminal matters, and consultation in the provision of mental health and criminal justice services, and workplace and community violence prevention programs.
Duties: Provide expert testimony, consultation, training, and public speaking services to federal, state, and local governmental agencies, corporations and attorneys, including the following areas:

- Police misconduct
- Conditions of confinement and hospitalization
- Architectural design of psychiatric and secure psychiatric buildings
- Workplace violence prevention and crisis response
    - Working with labor organizations
    - Safely managing corporate layoffs
- Psychological autopsy – (Psychological investigation of equivocal death or suicide)
- Suicide prevention
- Mental health services in correctional and criminal justice settings
- Mental health services to juvenile correctional facilities
- Stalking
- Assessing and preventing the risk of violent behavior
- Administration of public mental health and criminal justice services

September 1995 – Current

Associate, Threat Assessment Group, Inc., Newport Beach, California.
Duties: Provide consultation and training in workplace violence prevention and crisis management to governmental and corporate organizations.

September 1995 - Current

Associate, Park Dietz & Associates, Inc., Newport Beach, California.
Duties: Forensic psychological services and expert testimony

March 1995 - August 1995

Acting Commissioner, New York State Office of Mental Health.
Duties: Under the direct supervision of the Governor, served as C.E.O. of the largest agency of its kind in the United States, with an annual budget of more than $2.4 billion. The agency employed over 24,000 people and directly operated 29 institutions, including adult inpatient and outpatient psychiatric facilities, children's psychiatric hospitals, forensic hospitals and research institutes. The Office of Mental Health also licensed, regulated, financed, and oversaw more than 2,000 locally operated inpatient, emergency, outpatient, and residential programs in collaboration with 57 counties and New York City.

November 1984 - March 1995

Director, Bureau of Forensic Services (1984-1988) and Associate Commissioner for Forensic Services (1988-1995), New York State Office of Mental Health.
Duties: Line authority for inpatient services at three large forensic hospitals and two regional forensic units, including services to civil, forensic and correctional patients; line authority for all mental health services in New York State prisons (serving more than 60,000 inmates); responsibility for innovative community forensic programs including suicide prevention in local jails, police mental health training, and mental health alternatives to incarceration.

December 1984 - July 1985

Acting Executive Director, Kirby Forensic Psychiatric Center.
Duties: Founding C.E.O. for new maximum security forensic psychiatric hospital in New York City.

July 1984 - November 1984

Acting Director, Office of Mental Health, Virginia Department of Mental Health and Mental Retardation (held concurrently with permanent position as Director of Forensic Services).
Duties: Supervision of budget and certification of all community mental health programs statewide; statewide policy development in all program areas related to mental health; Executive Secretary to Virginia Mental Health Advisory Council.

July 1983 - November 1984

Director of Forensic Services, Virginia Department of Mental Health and Mental Retardation.
Duties: Design and coordination of statewide delivery system of institutional and community treatment and evaluation of forensic patients; management of the contract for the University of Virginia Institute of Law, Psychiatry and Public Policy; departmental liaison to Virginia Dept. of Corrections and other criminal justice agencies; develop statewide plan for delivery of mental health services to D.O.C. inmates; statewide Task Force on Mental Health Services in Local Jails.

August 1982 - July 1983

Psychologist, Arizona Correctional Training Center, Tucson, Arizona.
Duties: Supervision of psychology department; direct clinical treatment and evaluation services.

April 1982 - July 1982

Acting Inmate Management Administrator, Arizona State Prison Complex, Florence, Arizona.
Duties: Direct supervision of inmate records office; inmate classification and movement; correctional program (counseling) services; psychology department; hiring of all new correctional officers. (NOTE: During this period, I also maintained all duties of my permanent position as Psychologist (below).

October 1981 - July 1982

Psychologist, Arizona State Prison Complex, Florence, Arizona.
Duties: Supervision of Psychology Department for complex consisting of five prisons; direct clinical treatment and evaluation services.

November 1980 - October 1981

Psychology Associate, Arizona State Prison Complex, Florence, Arizona.
Duties: Direct clinical treatment and evaluation services.

August 1980 - November 1980

Psychological consultant to the Massachusetts Department of Correction.
Duties: Consultation to Director of Health Services; direct clinical treatment and evaluation services at Walpole and Norfolk State Prisons.

January 1980 - November 1980

Psychologist (non-licensed) - Tri-Cities Community Mental Health Center, Malden, Massachusetts. Pre-screened civil commitments for community mental health center.

August 1979 - August 1980

Pre-Doctoral Intern in Clinical Psychology, McLean Hospital, Belmont, Massachusetts; and Fellow in Clinical and Forensic Psychology, Harvard Medical School, Cambridge, Massachusetts, and Bridgewater (Massachusetts) State Hospital

1978-1979 Psychology Extern, Pima County (Arizona) Superior Court Clinic

1977-1978 Psychology Extern, Palo Verde Hospital, Tucson, Arizona

1976-1977 Psychology Extern, Arizona Youth Center (now Catalina Mountain School), Tucson, Arizona

1975-1976 National Institute of Mental Health Trainee

1973-1975 United States Peace Corps Volunteer, Senegal, West Africa

1970-1995 Coach, Dean Smith's Carolina Basketball School, Chapel Hill, N.C. (1-3 weeks each summer)

SELECTED CONSULTATION CLIENTS:

Federal Government -

National Institute of Mental Health
United States Secret Service
United States Department of Justice, Civil Rights Division
National Institute of Justice
National Institute of Corrections
Center for Mental Health Services
Substance Abuse and Mental Health Administration

State and Local Governments -

Alabama	Hawaii	Nebraska	South Carolina
Arizona	Idaho	Nevada	South Dakota
Arkansas	Illinois	New Jersey	Tennessee
California	Kentucky	New Mexico	Texas
Colorado	Louisiana	New York	Utah
Connecticut	Maine	North Carolina	Vermont
Delaware	Maryland	Ohio	Virginia
Dist. of Columbia	Massachusetts	Oregon	Washington
Florida	Michigan	Pennsylvania	West Virginia
Georgia	Missouri	Puerto Rico	Wyoming

International Clients -

Province of Ontario
Correctional Service of Canada
Province of British Columbia

Selected Corporate Clients -

American Express
Amgen
Boise Cascade
Borden Foods
Chase Manhattan Bank
Corning, Incorporated
DaimlerChrysler Corporation
General Dynamics
Honeywell
Johnson and Johnson
Kraft Foods
Levi Strauss
Macy's
Motorola
National Basketball Players Association
National Basketball Association
National Semiconductor
Nationwide Insurance
Nordstrom

Oracle Corporation
Pillsbury
Sony Corporation
State Farm Insurance
Texas Instruments
3M Corporation
University of Arizona
Warner-Lambert Pharmaceuticals

Professional Organization Clients –

American Psychiatric Association - Committee on Correctional Psychiatry
American Correctional Association
Arizona Bar Association
American Bar Association
National Collegiate Athletic Association (NCAA)

Federal Court Expert and Monitor –

Independent Expert to monitor a Federal Court settlement agreement at the Bernalillo County (N.M.) Detention Center in Albuquerque. (Completed)

Federal Court Monitor (one of two) of a settlement agreement regarding the Institute of Forensic Psychiatry at the Colorado Mental Health Institute – Pueblo. (Completed)

Federal Court Monitor (one of three) of a settlement agreement regarding the Forensic Unit at the Western State Hospital in Tacoma, Washington. (Completed)

Federal Court Monitor (one of two) of a statewide settlement agreement between the Michigan Protection and Advocacy Program and the Michigan Department of Corrections. (Active)

Architectural Consultations -

Dr. Dvoskin has served as design consultant for major renovations and new construction of a number of state, federal, and territorial psychiatric facilities during his long career. The following is a partial list of these projects:

New York - As part of his duties as Associate Commissioner of Mental Health for the state of New York, Dr. Dvoskin oversaw design of major renovations to Mid-Hudson Psychiatric Center, a 300 bed forensic psychiatric hospital in Middletown, NY. Completion of this project resulted in significant reductions in violent incidents at this facility.

Georgia - As part of a federal class action, plaintiffs and defendants agreed to ask Dr. Dvoskin to assess suicide hazards at six of Georgia's large state prisons, resulting in cost-effective, potentially life saving physical plant changes to rooms in which suicidal inmates were housed.

Louisiana - Again, at the request of plaintiffs and defendants, Dr. Dvoskin performed a comprehensive assessment of suicide hazards in the state's juvenile correctional facilities.

Puerto Rico - Dr. Dvoskin served as design consultant for a new correctional psychiatric center, which cost less than renovation of the existing building, which was the basis for a finding of unconstitutional conditions.

Michigan - Dr. Dvoskin assisted the state of Michigan, which was involved in constitutional litigation regarding its prison mental health system, in creating a system within the Department of Mental Health. He also served as design consultant for new beds added to a state forensic psychiatric facility.

Maryland, Florida, and Maine - Dr. Dvoskin served as consultant to Commissioners of Mental Health, including consultation on the physical plants of forensic and civil psychiatric hospitals.

Delaware - Dr. Dvoskin served as design consultant for the new forensic wing of the state's psychiatric hospital.

Colorado - Dr. Dvoskin served as design consultant for the state's new forensic psychiatric hospital; a design which combines a sense of privacy and dignity among patients without sacrificing the visibility needed in order for staff to maintain safety.

Washington, DC - Dr. Dvoskin served as consultant to two Federal Receivers, then to the Commissioner of Mental Health. Areas included an assessment of the number of beds needed, then to assist in a Capital Plan for the entire District of Columbia Mental Health System. Most recently and currently, Dr. Dvoskin serves as design consultant for the creation of a brand new Saint Elizabeths Hospital, to replace the entire civil and forensic hospital campus. The design of this facility, which is now under construction, included an innovative consumer advisory panel, facilitated by Dr. Dvoskin, which had input into every phase of the project's design.

North Carolina – Consultant to architectural renovation of forensic unit at Broughton State Hospital.

North Carolina – Consultant to Disability Rights North Carolina to assess safety and security of new Central Regional Hospital.

Harris County, Texas – Consultant to the Harris County Sheriff's Office on the construction of a new jail in Houston, Texas.

Miami–Dade County, Florida – Consultant on the capital renovation and program development for a new community forensic facility for Miami and Dade County, Florida.

Oregon Department of Corrections – Consultant to creation of large correctional complex, including mental health unit, in Junction City, Oregon.

Idaho Department of Corrections – Consultant to creation of a 300-bed mental health unit.

California Department of Corrections – Consultant to the design of prison mental health and healthcare units

Florida Department of Corrections – Consultant to design of prison mental health unit

BOARD MEMBERSHIPS:

Editorial Boards	Journal of the American Academy of Psychiatry and the Law (former) Journal of Mental Health Administration Behavioral Sciences and the Law Journal of Aggression, Maltreatment, and Trauma (former) Psychological Services Journal of Threat Assessment (former) Law and Human Behavior
Research Advisory Board	United States Secret Service (former)
Advisory Board	National Center for State Courts, Institute on Mental Disability and the Law (former)
Member	White House Panel on the Future of African-American Males – Completed 1995
Member	American Bar Association Task Force on Capital Punishment and Mental Disability - Completed

PUBLICATIONS:

Dvoskin, JA, Skeem, JL, Novaco RW, and Douglas KS. (Editors) (in press.)
Using Social Science To Reduce Violent Offending. New York: Oxford University Press.

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PROFESSIONAL AFFILIATIONS:

American Psychological Association (Fellow)
American Association of Correctional Psychologists
American Psychology - Law Society (Fellow)
American Correctional Association
National Association of State Mental Health Forensic Directors - Chairman 1986-1988
American Correctional Health Association
American Jail Association (former)

Appendix B – Forensic Unit Staffing at CRH

According to the most recently (11/13/12) obtained reports from the CRH, the following is a summary of the current staffing at the CRH Forensic Unit:

Unit A0

HCT	39
RN (16 + supervisor)	17
LPN	4
Ward Clerks	3

Unit B0

HCT	34
RN (11 + supervisor)	12
LPN	4
Ward Clerk	1

Unit F (Min)

HCT	27
RN (8 + supervisor)	9
LPN	0
Ward clerks	2

All Units

CSW's	7
Psychiatrists	6
UND	1
CNS	1
Ed. Coord.	1
UAD	1
Housekeepers	7
Psychologists (Inpatient)	2
Psychologists (Pre-trial)	5
Case Specialists	5
Psychosocial treatment	1
Med. Records Tech.	1

Forensic Services Total = 194

Previously, I had been provided with the following shift-by-shift staffing information.

Forensic Treatment Services Staffing (as of 7/31/12)

Psychiatry:	3.0 FTE (direct-care FTE only)
Social Work:	5.0 FTE (not including SW Manager)
Psychology:	1.0 FTE

Nursing

	Maximum	Medium	Minimum	FTE	
# beds	***22***	***24***	***30***	***RN***	***HCT***
RN	12	12	10	34	
HCT(CNA)	28	38	28		94
A *					**-10**
B*C*					**-15**
Totals				34	69

Minimum Required Coverage/ Ratios

		RN	HCT(CNA)	Sec Room	**bed capac**	RN ratio	HCT ratio
Maximum	Day	2	5		**22**	1:11	1:4
	Evening	2	5			1:11	1:4
	Night	1	4			1:22	1:5
Medium	Day	2	5	2	**24**	1:12	1:5
	Evening	2	5	2		1:12	1:5
	Night	1	4	1		1:24	1:6
Minimum	Day	2	5		**30**	1:15	1:6
	Evening	2	5			1:15	1:6
	Night	1	4			1:30	1:8
		6	15	2			
		6	15	2			
		3	12	1			
Repl Fact		2.0	2.0	2.0	**76**		
NEED		30	84	10			
Allotted		34	84	10			

Notes:

A * Healthcare Technicians provide direct care, security room (maintain keys, vi monitoring,

Metal detecting procedures, logging in/out of all staff, mani

(HCT) two

entrances into forensic area.

B * Healthcare Technicians provide all transport, escort and off site security (i.e. clinic appt: outside hospital stays, court ordered trips, outings and h visits)

C * CRH does not utilize Security Guards or Correctional Officers on the patient care units o or the rest of the facility

DEC 27 REC'D
2012

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December 27, 2012

Secretary Albert Delia
Department of Health & Human Services
2001 Mail Service Center
Adams Building
101 Blair Drive
Raleigh, NC 27699-2001

Dear Secretary Delia:

On behalf of GEO Care please accept this notice that we are withdrawing from further negotiations with respect to the provision of forensic psychiatric services on behalf of the North Carolina Department of Health. We appreciate the effort of the Department to explore private sector partnership opportunities.

Sincerely,

Jorge Dominicis
President