IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CIVIL ACTION NO.
	)	1:09-CV-119-CAP
THE STATE OF GEORGIA, et al.,	)	
	)	
Defendants.	)	
_____	)	

DECLARATION OF DR. MOHAMED EL-SABAAWI

Pursuant to 28 U.S.C. § 1746, I, Mohamed El-Sabaawi, do hereby declare:

BACKGROUND

1. I am an independent consultant residing in Alexandria, Virginia.

2. I am licensed psychiatrist and I am triple board certified in psychiatry, geriatric psychiatry, and addiction psychiatry.

3. I currently serve as an expert consultant for the United States' monitoring of the State of Georgia's compliance with the January 15, 2009, settlement agreement (the "Agreement") in *United States v. Georgia*, Case No. 1:09-cv-00119-CAP. The United States has continued to retain me as a litigation expert.

4. I have extensive experience and professional expertise in the provision of psychiatric services, neurological and medical systems of care, treatment planning, medication management, interdisciplinary integration of services, and risk management to individuals with mental illness and/or developmental disabilities in institutional and community settings. My curriculum vitae is attached as Attachment A.

5. From August 1999 to December 2002, I served as Medical Director of the Northern Virginia Mental Health Institute ("NVMHI"). From December 1999 to December 2002, I also served as the Director of NVMHI. NVMHI had been under investigation by the United States since 1995, and during my tenure at NVMHI, I successfully implemented a plan of improvement that resulted in the end of that investigation in June 2001.

6. I serve or have served as the court-appointed or court-approved monitor in cases pertaining to the care and treatment provided at institutions for individuals with mental illness and/or developmental disabilities, including *United States v. California* (Patton State Hospital, Atascadero State Hospital, Metropolitan State Hospital, and Napa State Hospital) and *United States v. Vermont* (Vermont State Hospital). I also served as an expert

consultant to the court monitor in *United States v. Louisiana* (Hammond Developmental Center and Pinecrest Developmental Center).

7. I have served as an expert consultant to the States of Tennessee and Kentucky in cases pertaining to the care and treatment provided at institutions for individuals with mental illness and/or developmental disabilities, including *United States v. Tennessee* (Harold Jordan Center, Green Valley Developmental Center, and Arlington Developmental Center) and *United States v. Kentucky* (Oakwood Community Center).

8. I serve or have served as an expert consultant to the United States in cases pertaining to the care and treatment provided at institutions for individuals with mental illness and/or developmental disabilities, including *United States v. District of Columbia* (St. Elizabeths Hospital), *United States v. Connecticut* (Connecticut Valley Hospital), and *United States v. Arkansas* (Conway Human Developmental Center).

9. During the United States' compliance monitoring in this case, I have assessed the State's compliance at Georgia Regional Hospital at Savannah ("GRHS"), Georgia Regional Hospital at Atlanta ("GRHA"), and Central State Hospital ("CSH"). I visited GRHS on June 22-26, 2009, GRHA on

August 3-7, 2009, and CSH on November 2-7, 2009, and January 11-15, 2010.

10. Before, during, and after those visits, I reviewed documents relevant to the care, treatment, and services provided at those facilities, including relevant policies, procedures, forms, templates, reports, and minutes. These documents included both State and hospital-specific policies, procedures, forms, templates, and reports. I also reviewed some documents from other hospitals operated by the Georgia Department of Behavioral Health and Developmental Disabilities, including Southwestern State Hospital and East Central Regional Hospital. I reviewed the charts of hundreds of patients served by these hospitals. A representative sample of the documents I reviewed can be found at pages 25-26 and 90-92 of the compliance report pertaining to GRHS, attached to the United States' Motion as Exhibit 4.

11. During the visits to the hospitals, I interviewed numerous administrative and clinical staff members about the care, treatment, services, and programs provided at the hospitals. I also attended numerous meetings regularly-held at the hospitals pertaining to the care, treatment, services, and programs provided at the hospitals. A representative sample of the interviews and

meetings I attended can be found at pages 25 and 89-90 of the compliance report pertaining to GRHS, attached at Exhibit 2.

ASSESSMENT OF MENTAL HEALTH AND MEDICAL SERVICES

12. Numerous aspects of the mental health and medical services provided at GRHS, GRHA, and CSH (collectively, the "Georgia Psychiatric Hospitals") substantially depart from generally accepted professional standards. These inadequacies are systemic, and they pose an immediate and serious threat to the life, health, and safety of the patients at the Georgia Psychiatric Hospitals.

A. Mental Health Care

13. Mental health care, treatment, and services at the Georgia Psychiatric Hospitals substantially depart from generally accepted professional standards. During my review of the mental health services provided by the Georgia Psychiatric Hospitals, I found systemic deficiencies in mental health assessments and treatment plans, as well as in the oversight and monitoring of mental health services. These deficiencies expose the individuals in the Georgia Psychiatric Hospitals to an immediate and serious threat of harm, including the risk of suicide and assault by other patients.

14. Mental health assessments at the Georgia Psychiatric Hospitals systematically fail to include critical information. Without this information, the assessments do not provide the basis for diagnostic accuracy or inform an adequate interdisciplinary case formulation. The inadequacy of risk assessments are of particular concern, including risk of suicide and violence toward others. During my review, I found instances in which suicide and violence risk assessments were not completed upon admission, and I did not find any instance in which suicide and violence risk assessments were completed upon transfer to another inpatient unit, despite the large number of individuals who are referred to the Georgia Psychiatric Hospitals due to suicidal or violent ideation or attempts. Even where completed, however, I found that mental health assessments, including suicide and violence risk assessments, substantially departed from generally accepted professional standards because they lacked, among other things: (a) specific information regarding the history of the illness; (b) recommendations for additional testing, even in cases where the need for such testing was evident; (c) adequate mental status examinations; (d) adequate diagnostic formulation or differential diagnoses; (e) sufficient information regarding the nature, severity, and timeframes of past violence and/or suicidal ideation or

attempts; (f) adequate information regarding an individual's psychosocial, developmental, educational, vocational, medical, substance abuse, prior placement, and cultural/religious history; and (g) necessary data to inform future management by community agencies, including diagnostic updates and adjustment of medications during the course of hospitalization, to decrease the risks to the individuals and the community.

15. For example, I found that the overall assessment of violence risk for one individual was not completed despite reports of the individual making recent threats toward other residents in the individual's previous placement. The violence risk assessment for a second individual was determined to be "low," although the assessment indicated that the individual was threatening others at his previous placement and he was described upon admission as "agitated" and having "paranoid/persecutory delusions." In the chart of a third individual, the violence risk indicated that the individual presented a high risk of violence to others, but no precautions were discussed in the assessment.

16. Another individual engaged in self-injurious behavior numerous times and assaulted other patients, causing serious injury on several occasions. While these incidents occurred, the psychiatrist did not properly assess the

individual's mental status, did not address diagnosis and differential diagnosis, and made medication changes that appeared to aggravate the individual's condition (without assessing the individual's response to treatment). Furthermore, there was evidence of complete disintegration of psychiatric and behavioral interventions. These failures contributed to the harm of repeated self-injury and injury to others.

17. In one particularly disturbing case that exemplifies the Georgia Psychiatric Hospitals' systemic deficiencies in assessment and prevention of violence, an individual was referred the Georgia Psychiatric Hospitals because of a recent history of severe violence toward a family member related to the individual's mental illness. In the admissions assessment, the reason for admission, mental status findings, and results of the risk assessment all indicated an extreme level of risk, but the assessment nevertheless determined that the individual was only a moderate risk for violence. The admission assessment did not suggest any medication interventions to reduce the risk for this individual or others. The individual's reassessments during hospitalization did not address the risk of violence and contained inaccurate information about the individual's compliance with treatment and the extent of her thought disorder. Following discharge, this individual repeated her

violent actions toward the same family member, resulting in the family member's death.

18. Suicide risk assessments are similarly inadequate. For example, the suicide risk assessment was not utilized to inform the plan of care for an individual who was admitted following a suicide attempt (by cutting and attempting to choke herself). This individual stated that she was "still suicidal" at the time of the assessment. However, close observation was ordered only after the individual swallowed a foreign object after being admitted.

19. Upon admission, an individual had suicidal ideations and intent that he self reported and, according to the assessment form, were confirmed by others. The admissions assessment also indicated many other risk factors for this individual. However, the suicide risk was assessed as "low" and no specific information was documented about content of the ideations or plan. After admission, the individual became acutely psychotic, complained of command hallucinations to kill himself, and subsequently attempted suicide with pieces of broken glass while complaining of these hallucinations. However, no change in diagnosis or medications was made until he attacked staff and attempted to jump out of a window. In all of this, no documentation was ever made of the nature of his hallucinations.

20. Reassessments of individuals in the Georgia Psychiatric Hospitals are similarly inadequate and untimely. For example, there was no documentation of any reassessment by a psychiatrist for individuals residing in two forensic mental health units within the past year. Almost all these individuals were diagnosed with psychiatric disorders and received multiple psychiatric medications that were prescribed by a primary care physician, not a psychiatrist. One of the units is the Georgia Psychiatric Hospitals only maximum security forensic unit, where a patient killed another patient in April 2009.

21. Staff at one of the Georgia Psychiatric Hospitals diagnosed one individual with Bipolar Disorder NOS, Oppositional Defiant Disorder, Mild Mental Retardation and Antisocial Personality Disorder [sic], and treated her with multiple psychiatric medications, including antipsychotic, mood stabilizing and antidepressant agents. However, there was no documentation of reassessments by a psychiatrist even though she wrote a suicide note and reportedly attempted suicide by drinking laundry bleach and ingesting laundry detergent during hospitalization.

22. Another individual with dementia and multiple medical problems was assessed by a psychiatrist for depression, given a generic diagnosis of

depression, and started on a new antidepressant. The psychiatrist did not assess him for suicidality. A week later, the individual pulled his feeding tube and expressed suicidal ideations and intent. The psychiatrist never reassessed him to determine his response to the medication change that he recommended. This is a serious departure from generally accepted professional standards, and the individual remains at risk for recurrence of his suicidal behavior.

23. Another individual had reportedly been hospitalized on at least 20 previous occasions. However, the reassessments did not include timely review of the effectiveness and appropriateness of antipsychotic treatment based on previous experience with this individual.

24. Similarly, the documentation by an individual's treating psychiatrist did not address or discuss the circumstances of serious self-injurious behavior while the individual was in seclusion the previous day. However, there was documentation in the nursing progress notes and an incident report to that effect. The psychiatric reassessment of this individual included contradictory information regarding the psychiatric status of this individual. The individual was discharged to the community without any information regarding this incident or a discussion of risk factors to inform aftercare.

25. Many of the individuals who are diagnosed with developmental disabilities and mental illness are receiving a variety of high risk medications that are known to have serious and negative side effects for these individuals. However, the psychiatric assessments and reassessments were either not completed or, when completed, were not timely, did not assess the risks of treatment for these individuals, and did not justify the treatment. This practice substantially departs from generally accepted professional standards of care for this population and exposes these individuals to serious harm, including, but not limited to, decreased alertness; worsening of their cognitive status, behavior, and social interactions; and inability to participate in their habilitation programs.

B. Medical Care

26. Medical care, treatment, and services at the Georgia Psychiatric Hospitals substantially depart from generally accepted professional standards. During my review of the medical services provided by the Georgia Psychiatric Hospitals, I found systemic deficiencies in medical assessments and treatment. These deficiencies expose the individuals in the Georgia Psychiatric Hospitals to an immediate and serious threat of harm, including the risk of harm due to choking and aspiration.

27. Individuals in the Georgia Psychiatric Hospitals are at immediate and serious risk of harm due to inadequate medical staff resources and care that substantially departs from generally accepted professional standards. The Georgia Psychiatric Hospitals do not provide adequate and timely medical assessments, and current policies do not provide sufficient guidance on when and how to perform these assessments. The Georgia Psychiatric Hospitals also lack sufficient oversight and monitoring systems to identify and correct deficiencies in the provision of medical care.

28. During my review of medical care, I reviewed the charts of numerous individuals who were transferred to an outside facility for management of changes in their physical status during the past year, and I interviewed the practitioners who provided medical evaluations of these individuals upon transfer to the outside facility and upon their return. The reviews and interviews found a pattern of significant process breakdown points. At CSH, for example, I found that facility did not have a protocol to guide nursing assessments of changes in the physical status of individuals, or to guide the documentation of these assessments.

29. From this review, I found that the nursing documentation of an individual who developed fever did not address presence or absence of any associated

symptoms or signs. The physician's evaluation of this individual did not include an examination of the individual or any review of the circumstances that may have contributed to the development of the fever. The lack of medical attention was compounded by the fact that there was no documentation of an annual medical assessment during the year preceding this event. This individual was diagnosed with aspiration pneumonia (recurrent) during outside hospitalization. Following his return from the outside hospital, there was no medical documentation regarding factors that may have contributed to recurrence of this condition or measures to decrease future risk of recurrence.

30. Another individual I reviewed was receiving clozapine and had chronic anemia. He developed a fever but was not seen by a physician that day or the next. Fever in an individual receiving clozapine requires immediate medical attention to avert the risk of potentially lethal complications. On the following day, he collapsed on the floor and was sent to an outside hospital. His temperature was not checked the day of his outside transfer. He returned with diagnosis of fever of unknown etiology. No review was performed at either the State or facility level to determine why his temperature and

clinical status was not checked more closely, or why a physician was not notified of the change in temperature.

31. A third individual whose chart I reviewed developed lethargy, numbness, disorientation, and right arm pain, but no physician was notified and the individual was not assessed prior to being sent to an outside hospital. When the individual returned, the physician's assessment included inaccurate information about the individual's medical status. The failure to notify a physician of the individual's change in status, to perform an assessment before transfer to the outside hospital, or to perform an adequate assessment upon return from the outside hospital exposed this individual to serious harm and demonstrate the grave and systemic deficiencies with medical care in the Georgia Psychiatric Hospitals.

32. I also reviewed the charts of numerous individuals who were diagnosed with seizure disorders, some of whom were also transferred to outside medical facilities during their stay at the Georgia Psychiatric Hospitals. I found that individuals with a seizure disorder in the Georgia Psychiatric Hospitals are at risk of immediate and serious harm due to inadequate seizure management. For example, many individuals experienced more than 30 episodes of recurrent seizures during the past year while receiving the same

treatment of high risk medications, but no neurological assessment had been performed within the past year. A neurological assessment is needed to assess the risks associated with these medications and to address their ineffectiveness. One individual had disfiguring side effects of phenytoin and had developed a Status Epilepticus while receiving the same medication, however, no neurology consultation was done at the facility to assess the medical rationale of continued use.

33. Relatedly, there was no documentation of an assessment by a physician of an individual who was transferred to an outside hospital because of recurrent seizures. There was likewise no documentation of a medical assessment of factors that may contributed to recurrent seizure activity in a second individual, even though records indicated that there was a significant drop in serum level of the anticonvulsant medication that appeared to have triggered the recurrent seizure. The physician assessment of a third individual who reportedly experienced first onset seizure activity did not include a neurological examination other than a statement that the individual was lethargic. This individual received adequate work up during outside hospitalization and was subsequently discharged to the community. However, the discharge assessment did not provide diagnostic information

regarding his seizure condition. The lack of this information precluded adequate medical aftercare for this individual.

34. Another individual with a known history of seizure disorder and a risk for falls complained of pain in his thigh at night, and the physician ordered an analgesic without examining the individual. The next day, another physician, while touring the unit, accidentally noticed large swelling in the individual's upper thigh area. At the hospital, he was diagnosed with fractured femur. This failure to perform an adequate assessment caused unnecessary suffering and could have resulted in serious adverse medical consequences to the individual.

35. The Georgia Psychiatric Hospitals do not have sufficient oversight and monitoring systems to identify and correct the deficiencies in the provision of medical care that I have described above. For example, the Georgia Psychiatric Hospitals do not have a database that identifies individuals suffering from seizure disorders, including, but not limited to, seizure type, frequency of seizure activity, date of last seizure activity, and current anticonvulsant management. Similarly, the Georgia Psychiatric Hospitals have limited information regarding trends or patterns of Code Blue events or reviews by medical management of these trends or patterns to identify and

initiate systemic performance improvement projects to improve medical and nursing care.

C. Risk Management of Mental Health and Medical Care

36. The Georgia Psychiatric Hospital lack adequate systems to monitor mental health and medical care. They have yet to develop and implement a comprehensive system of risk management triggers and thresholds, levels of clinical interventions, and systemic review commensurate with the level of risk. Without an adequate risk management system, the Georgia Psychiatric Hospitals are unable to recognize the potential for harm before it occurs and take steps to prevent it.

37. The inadequacy of the Georgia Psychiatric Hospitals' risk management systems is exemplified by failures in the mortality review process. The mortality review system is ineffective structurally and functionally at both the State and the facility levels. This system is incapable of proper identification of breakdown points in medical and nursing care and in instituting immediate, systemic, and practitioner-related corrections in order to reduce the risk of harm for other individuals at the facility.

38. For example, an individual expired with a diagnosis of gangrenous appendicitis and sepsis. The mortality review did not address nursing and

medical attention to this individual who, in all likelihood, may have experienced symptoms and signs that were not recognized or addressed.

39. Another individual expired following a recent change in medical status (weight loss and refusing meals), but no review of nursing care was conducted. The review of medical care included a vague statement that physicians should be "reminded of their responsibilities," but did not develop specific corrective actions to prevent future harm. The review also did not adequately address specific breakdown points that were alluded to in the review and must be corrected.

40. A third individual expired after an apparent choking episode while drinking and while having a change in his alertness. The nursing mortality review did not address necessary elements of nursing care, including, for example, the fidelity of one-to-one observations (a supervision level that requires a staff member to be within arms-length of the individual at all times), implementation of physical nutritional support plans, if any, and implementation of the medical emergency response system. The medical review explored some important contributing factors but ignored other equally important factors, such as the contribution of drug therapy to the individual's lethargy and medical management of factors contributing to

upper gastrointestinal bleeding. The failure to address these other factors rendered the review seriously incomplete in violation of generally accepted professional standards.

41. A fourth individual expired from aspiration pneumonia, but the mortality review did not address the physical and nutritional management of the individual, which is the system designed to address and prevent aspiration and aspiration pneumonia.

42. The mortality reviews at the Georgia Psychiatric Hospitals were completed without investigations to determine whether abuse or neglect by staff contributed to the mortality. Furthermore, the reviews were completed without access to results of the postmortem examination (preliminary or final) and without independent review of care by an external entity. The failure to include these elements in the mortality review process is a substantial departure from generally accepted professional standards and renders the current mortality review system ineffective, because it does not adequately identify potential and actual factors contributing to the mortality, assess the adequacy of the systems of care in addressing these factors, or develop needed corrective actions to reduce the risk for other individuals.

43. The Georgia Psychiatric Hospitals' failure to have an adequate mortality review system exposes the individuals in the hospitals to an immediate and serious threat to their life, health, and safety.

* * *

The foregoing is based on my professional expertise, and also my personal knowledge of conditions and policies governing mental health and medical services at the State Psychiatric Hospitals, gained through my examination of documents including clinical records, my observations, and interviews with hospital staff, patients, and administrators, as well as State administrators and employees.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 22nd day of January, 2010.

M. El-Sabaawi, MD

MOHAMED EL-SABAAWI, M.D.

Attachment A

CURRICULUM VITAE

MOHAMED A. EL-SABAAWI, M.D.
513 South Royal Street
Alexandria, VA 22314
(703) 868-0355
DrElsabaawi@aol.com

SUMMARY

- Systems expert who has held leadership positions across the mental health continuum of care:
  - Public and private psychiatric hospitals
  - Inpatient units of general hospitals
  - Community mental health, mental retardation and substance abuse organizations
- Court Monitor to oversee the implementation of improvements in the inpatient mental health systems in the States of California and Vermont. Responsibilities include on-site monitoring of services provided to individuals with serious mental illnesses in public psychiatric hospitals, assessment of the States' implementation of improvements in the systems of hospital care and reporting on the implementation status on an ongoing basis.
- Expert consultant to the US department of Justice (DOJ) in the investigations of public psychiatric hospitals and facilities for individuals with developmental disabilities. Areas of responsibility include psychiatric services, treatment and rehabilitation planning, neurological and medical systems of care, medication management, and risk management.
- Veteran clinician with triple board certification and deep experience in the interplay of psychiatry, psychosocial and behavioral disciplines and physical medicine.
- Leader of an 18-month turnaround of a public psychiatric hospital that had been placed under US Department of Justice (DOJ) oversight.
- Leader of a major reorganization of services at a County mental health, mental retardation and substance abuse system, creating an evidence-based interdisciplinary model of service delivery.

PROFESSIONAL ACTIVITIES

Consulting Engagements:

11/09 to present	Expert consultant for the US Department of justice, Civil Rights Division in the case of *United States vs. State of Georgia (Central State Hospital).*
08/09 to present	Expert consultant for the US Department of justice, Civil Rights Division in the case of *United States vs. State of Georgia (Georgia Regional Hospital at Atlanta).*

06/09 to present	Expert consultant for the US Department of justice, Civil Rights Division in the case of *United States vs. State of Georgia (Georgia Regional Hospital at Savannah).*
12/06 to present	Court-Appointed Monitor in the Case of *United States vs. State of California, Case # CV06-2667 (Patton State Hospital).*
10/06 to present	Court-Approved Monitor in the Case of *United States vs. State of Vermont (Vermont State Hospital).*
11/06 to present	Court-Appointed Monitor in the Case of *United States vs. State of California, Case # CV06-2667 (Atascadero State Hospital).*
09/06 to present	Court-Appointed Monitor in the Case of *United States vs. State of California, Case # CV06-2667 (Metropolitan State Hospital).*
07/06 to present	Court-Appointed Monitor in the Case of *United States vs. State of California, Case # CV06-2667 (Napa State Hospital).*
07/05 to present	Expert consultant for the US Department of Justice, Civil Rights Division in the case of *United States vs. District of Columbia (Saint Elizabeth Hospital).*
06/06 to 12/09	Expert consultant for the State of Tennessee in the case of *United States vs. State of Tennessee (Harold Jordan Center).*
05/06 to 12/06	Expert Consultant for the US Department of justice, Civil Rights Division in the case of *United States vs. State of Connecticut (Connecticut Valley Hospital).*
11/05 to 05/06	Expert consultant for the US Department of Justice, Civil Rights Division in the case of *United States vs. State of California (Atascadero State Hospital).*
08/05 to 05/06	Expert consultant for the US Department of Justice, Civil Rights Division in the case of *United States vs. State of California (Patton State Hospital).*
08/04 to 03/06	Expert consultant for the Cabinet of Health Services, Commonwealth of Kentucky in the case of *United States vs. The Commonwealth of Kentucky.*
07/04 to 10/06	Expert consultant for the U.S. Department of Justice, Civil Rights Division in the case of *United States vs. State of Vermont (Vermont State Hospital).*
06/04 to 05/05	Expert consultant for the State of Tennessee in the case of *United States vs. State of Tennessee (Green Valley Developmental Center).*
06/04 to 07/04	Expert consultant for the State of Tennessee in the case of *United States vs. State of Tennessee (Arlington Developmental Center, Docket No. 92-2062-D/A).*
01/04 to 01/07	Expert consultant for the Court Monitor of the State of Louisiana in the case of *United States vs. State of Louisiana*, Civil No. 04-15-D-M2 (*Hammond Developmental Center*).

01/04 to 01/07	Expert consultant for the Court Monitor of the State of Louisiana in the case of *United States vs. State of Louisiana*, Civil No. 04-15-D-M2 (*Pinecrest Developmental Center*).
05/03 to 06/06	Expert consultant for the U.S. Department of Justice, Civil Rights Division in the case of *United States vs. State of Arkansas (Conway Human Development Center).*
04/03 to 04/04	Expert consultant for the U.S. Department of Justice, Civil Rights Division in the case of *United States vs. The Commonwealth of Kentucky (The Communities at Oakwood).*
07/02 to 05/06	Expert consultant for the U.S. Department of Justice, Civil Rights Division in the case of *United States vs. State of California (Metropolitan State Hospital).*

Clinical and Administrative Positions:

1/03 to 6/04

Psychiatric Consultant
Appalachian Mental Health Center
Hendersonville, NC

Clinical consultations for a mental health center treating patients with a wide range of mental and substance abuse disorders.

Mountain Area Recovery Center
Asheville, NC

Clinical consultations for an outpatient clinic treating individuals with opiate and other substance dependence as well as mental illness.

Swain Recovery Center
Black Mountain, NC

Clinical consultations for a residential center treating dually diagnosed individuals (substance abuse and mental illness).

ARP/Phoenix
Asheville, NC

Clinical consultations for a residential center for pregnant women with mental illness and substance abuse and for a County correctional facility.

Blue Ridge Mental Health Center
Asheville, NC

Outpatient practice including evaluations and treatment of patients with a wide range of psychiatric disorders; evaluation and treatment of dually diagnosed patients (mental illness and substance abuse); and consultations to interdisciplinary staff.

12/99 to 12/02

Director
Northern Virginia Mental Health Institute

Falls Church, VA

Responsible for all clinical and administrative activities in a 132-bed public sector psychiatric hospital that includes units for admissions, intermediate care and community reintegration as well as a primary care service. Hospital served individuals with mental illness and dual diagnoses (mental illness/substance abuse and mental illness/developmental disabilities).

Supervised all clinical disciplines (psychiatry, primary care, psychology, psychosocial rehabilitation and social work/community services) as well as quality management, risk management and clinical research.

Responsible for planning of services; relationships with the State commissioner of mental health, attorney general, and legislators; liaison with community agencies including patient advocacy and local human rights groups and patient abuse investigations. Represented hospital in local and state human rights hearings.

Successfully implemented a plan of continuous improvement that resulted in June 2001 in joint dismissal without conditions of a Department of Justice investigation that began in 1995.

- Integrated a new strength-based behavioral support system into the day-to-day operations of all units and treatment teams.
- Established psychosocial programming for subpopulations with cognitive limitations, forensic needs and substance abuse comorbidity.
- Implemented a new system that tailored psychosocial rehabilitation to individualized treatment goals.
- Established a new community reintegration system driven by individualized needs assessment.
- Implemented a new interdisciplinary system for privileging of forensic patients.
- Established a new risk management system that reduced high-risk behaviors and provided mechanisms for staff support.
- Reorganized unit structures and inter-unit transfer system that facilitated care of difficult to manage individuals.
- Implemented special training on interventions with aggressive individuals suffering from developmental disabilities.
- Integrated the weight management program with the primary care service and implemented nutritional in-services that improved identification and management of patients at risk.

Obtained a score of 93 in the survey by the Joint Commission for

Accreditation of Health Care Organizations (JCAHO) for June 6-8, 2000. Established processes resulting in a score of 98 in the May 2003 survey

Obtained a deficiency-free survey (January 28-30, 2002) by the Centers for Medicare and Medicaid Services (CMS), formerly Health Care Finance Administration (HCFA), Department of Health and Human Services

8/99 to 12/02 Medical Director
Northern Virginia Mental Health Institute
Falls Church, VA

Supervised staff psychiatrists, primary care physicians, and psychiatry residents from George Washington University and the Uniformed Services University of the Health Sciences.

Developed and implemented treatment-related policies and procedures; provided second opinion evaluations and difficult case consultations.

Initiated an affiliation with the Department of Medicine at INOVA Fairfax hospital and created a primary care service at the Institute.

Developed orientation and competency plans for the medical staff and a new system for performance-based privileging/reprivileging.

Responsible for medical staff quality management and performance improvement. Initiated a hospital-wide grand rounds program and medical staff journal club.

Restructured all medical staff committees and created new systems assuring safe and effective medication management.

Expanded academic affiliations with the psychiatry residency training programs at George Washington University School of Medicine and Health Sciences and the Uniformed Services University of the Health Sciences.

Developed a clinical research program with interdisciplinary focus.

Initiated a new laboratory service and expanded and streamlined network of specialized medical consultants. Developed new monitoring systems for both services.

Chaired the Medical Executive Community and supervised the Pharmacy and Therapeutics Committee and other medical staff functions.

2/98 to 6/99 Medical Director
Inpatient and Consultation-Liaison Services
General Hospital Program
Sheppard Pratt Health System
Baltimore, MD

Chairman, Department of Psychiatry at North Arundel Hospital

Direct care of psychiatric patients in an acute inpatient unit and consultation-liaison services in Sheppard Pratt at the Upper Chesapeake Health System and at North Arundel Hospital.

Responsible for the administration of all behavioral services at an inpatient unit, the emergency room and medical and surgical units;

geriatric consultation services in long-term care settings affiliated with the Sheppard Pratt System; and liaison with community providers and agencies.

1/94 to 1/98

Medical Director
Department of Human Services
Mental Health, Mental Retardation, & Substance Abuse Division
Arlington County, VA

Direct care of clients with chronic and acute mental illness and individuals with developmental disabilities and mental illness. Services provided at the outpatient clinic of Arlington Mental Health Center, the inpatient unit of Arlington Hospital, a geriatric service at the center and Clarendon House, a psychosocial rehabilitation service.

Supervised seven psychiatrists and several nursing staff at the division.

1/94 to 1/98, continued

Medical Director
Department of Human Services
Mental Health, Mental Retardation, & Substance Abuse Division
Arlington County, VA

Initiated an academic affiliation with the Department of Psychiatry at Georgetown University School of Medicine and supervised training of the residents at the Arlington Mental Health Center.

Responsible for quality management of all clinical staff, integration of clinical services, creation of interdisciplinary teams, teaching activities and difficult-case conferences.

Trained clinical staff in treatment planning and implemented evidence-based interdisciplinary practice, resulting in a dramatic decrease in hospitalization rates.

Developed on-site laboratory service at the Arlington Mental Health Center.

Integrated care of clients at the inpatient service of Arlington Hospital with other services at the Arlington Mental Health Center.

Provided liaison with community agencies, and overall planning of clinical services.

Part-time private geriatric practice as consultant to several nursing home facilities and medical director of an older-adult partial hospital program.

10/92 to 12/93

Director, Geriatric Neuropsychiatry
Allegheny Neuropsychiatric Institute
Pittsburgh, PA

Direct care of geriatric patients and patients with organic brain injuries on acute inpatient psychiatric services.

Responsible for administration of the Geriatric Program at the Institute.

Supervised two other inpatient psychiatrists as well as all clinical staff and directed interdisciplinary treatment teams at the geriatric inpatient service.

Supervised medical students and psychiatry residents from the Allegheny campus of the Medical College of Pennsylvania.

12/89 to 10/92 Chief, Inpatient Psychiatry
Major, United States Air Force, Medical Corps, Flight Surgeon
Malcolm Grow Medical Center
Andrews Air Force Base
Washington, DC

Direct care of psychiatric patients (active duty, retired personnel and dependants) on an acute inpatient service composed of two 25-bed units.

Medical director of an alcohol rehabilitation unit for active duty, retired personnel and dependants.

Supervised three other inpatient psychiatrists.

11/87 to 11/89 Psychiatrist
Mayview State Hospital
Bridgeville, PA

Direct care of psychiatric patients and direction of multi-disciplinary treatment teams with responsibility for one acute admission service and one extended care service.

10/86 to 11/87 Psychiatrist
Highland Drive VA Medical Center
Pittsburgh, PA

Direct care of psychiatric patients and direction of multi-disciplinary treatment teams with responsibility for one extended care service, the geriatric service, and consultations to the medical service.

Academic Appointments:

5/01 to 5/09 Associate Clinical Professor of Psychiatry and Behavioral Sciences
George Washington University School of Medicine and Health Sciences

1/95 to 6/98 Clinical Assistant Professor, Department of Psychiatry
Georgetown University School of Medicine, Washington, DC

9/90 to 6/94 Clinical Assistant Professor, Department of Psychiatry
F. Edward Hebert School of Medicine
Uniformed Services University of the Health Sciences, Bethesda, MD

11/92 to 12/93	Assistant Professor of Psychiatry Medical College of Pennsylvania Allegheny Campus, Pittsburgh, PA
7/86 to 6/92	Assistant Professor Department of Psychiatry University of Pittsburgh School of Medicine, Pittsburgh, PA

Teaching:

8/98-12/02	Didactic teaching of medical students at George Washington University School of Medicine and Health Sciences
1/95 to 6/98	Didactic teaching and clinical supervision of psychiatry residents and medical students at Georgetown University School of Medicine.
11/92 to 12/93	Didactic teaching and clinical supervision of medical students and psychiatry residents at the Medical College of Pennsylvania, Allegheny Campus.
9/90 to 6/94	Didactic teaching and clinical supervision of medical students and family practice residents at the Uniformed Services University of the Health Sciences.
10/86 to 11/89	Didactic teaching and clinical supervision of medical students and psychiatric residents at the University Health Center of Pittsburgh.
7/83 to 6/86	Participation in psychiatric education of medical students at the University of Michigan and Brown University.

Research:

2002 to present	Research in the integration of behavioral and pharmacological treatments in mental health and in developmental disabilities, interdisciplinary treatment team functioning and the clinical applications of mindfulness in mental illness and in developmental disabilities.
1987 to 1988	Research Psychiatrist Project: "Efficacy of propranolol/clonidine vs placebo in treatment of neuroleptic-induced akathisia in hospitalized schizophrenic patients" (study conducted at Highland Drive VA Medical Center, Pittsburgh).
7/85 to 12/85	Research Psychiatrist Project: "Double-blind comparative evaluation of efficacy and safety of mellaril sustained release vs mellaril vs haldol in hospitalized schizophrenic patients" (study #187, conducted at Rhode Island Psychiatric Research and Training Center, supported by Sandoz Research Institute).

Licensure:

State	License Number	Date of Initial Licensure
California 50660		9/7/01
District of Columbia	MD-034590	10/31/03
Maryland D39828		4/11/90
Massachusetts 52076		2/16/84
North Carolina	97-00541	5/24/97
Pennsylvania MD-039-384-L		4/15/83
Rhode Island	6743	10/16/85
Virginia 0101050052		1/01/93

CERTIFICATION, TRAINING, AND EDUCATION

Specialty Certification: Diplomate, American Board of Psychiatry and Neurology

6/96	Psychiatry with Added Qualification in Addiction Psychiatry	#843
6/94	Psychiatry with Added Qualification in Geriatric Psychiatry	#0939
12/87 Psychiatry		#29443

Licensing and Qualifying Exams:

12/82	Federation of State Medical Boards	#480101019
1/81	Educational Commission for Foreign Medical Graduates	#325-364-5

Residency:

7/85 to 6/86 and 7/83 to 6/84	Brown University Program in Medicine Department of Psychiatry and Human Behavior Providence, RI	Psychiatry
7/84 to 6/85	University of Michigan University Hospital Department of Psychiatry Ann Arbor, MI	Psychiatry

Internship:

8/73 to 7/74	Damanhour Teaching Hospital Damanhour, Egypt	General
8/72 to 7/73	Hospitals of Alexandria University Alexandria, Egypt	General

Graduate:

9/66 to 7/72	School of Medicine Alexandria University, Egypt	MBCHB

Post-Graduate:

9/76 to 8/79	High Institute of Public Health Alexandria University, Egypt	MPH

HONORS

12/01	Acknowledgement of Extraordinary Contribution from the Commonwealth of Virginia for performance as Director of Northern Virginia Mental Health Institute
11/95	Overall Excellence Award from Arlington County, Commonwealth of Virginia for performance as Medical Director, Division of Mental Health, Mental Retardation, and Substance Abuse.

3/93	Meritorious Service Medal awarded by the President of the United States for service at Malcolm Grow U.S. Air Force Medical Center, Andrews Air Force Base, DC, from December 1989 to November 1992.
4/82	Annual Award for Outstanding Contribution to Health Research (1982) from the Health Research and Services Foundation, Pittsburgh, PA.

PUBLICATIONS

Articles and book chapters:

de Leon J, Greenleee B, Barber J, **Sabaawi M** and Singh NN: Practical guidelines for the use of new generation antipsychotic drugs (except clozapine) in adult individuals with intellectual disabilities. Research in Developmental Disabilities 30:613-669, 2009.

Singh NN, Lancioni GE, Winton ASW, Adkins AD, Wahler RG, **Sabaawi M** & Singh J: Individuals with mental illness can control their aggression through mindfulness training. Behavior modification 31:313-328, 2007.

Singh NN, Lancioni GE, Joy SDS, Winton ASW, **Sabaawi M**, Wahler RG & Singh J: Adolescents with Conduct Disorder can be mindful of their aggressive behavior. Journal of Emotional and Behavioral Disorders 15 (1): 56-63, 2007.

Sabaawi M, Singh NN, & de Leon J: Guidelines for the use of clozapine in individuals with developmental disabilities. Research in Developmental Disabilities 27: 309-336, 2006.

Singh NN, Lancioni GE, Winton ASW, Curtis WJ, Wahler RG, **Sabaawi M**, Singh J, & McAleavey K: Mindful staff increase learning and reduce aggression and property destruction by adults with developmental disabilities. Research in Developmental Disabilities 27: 545-558, 2006.

Singh NN, Lancioni GE, Winton ASW, Fisher BC, McAleavey K, Singh J & **Sabaawi M**: Mindful parenting decreases aggression, noncompliance and self injury in children with autism. Journal of Emotional and Behavioral Disorders 14: 169-177, 2006.

Singh NN, Singh SD, **Sabaawi M**, Myers RE, Whaler, RG & The Mindfulness Research group: Enhancing treatment team process through mindfulness-based mentoring in an inpatient psychiatric hospital. Behavior Modification 30: 423-441, 2006.

Singh NN, Winton ASW, Singh J, McAleavey K, Wahler RG & **Sabaawi M:** Mindfulness-based care giving and support. In JK Luiselli (Ed.), Antecedent intervention: Recent developments in community-focused behavior support. (pp. 269-290). Baltimore, MD: Paul H Brookes 2006.

Singh NN & **Sabaawi M**: Psychotic Behavior. In M. Hersen (Ed.), Clinician's handbook of adult behavioral assessment. (pp. 349-370). N.Y Academic Press (Elsevier Scientific) 2005.

Singh NN & **Sabaawi M**: Pharmacotherapy. In R.S. Drabman & A.S. Gross (Eds), Encyclopedia of behavior modification and cognitive behavior therapy (Vol. 2): Child clinical applications (pp. 955-959). Thousand Oaks, CA: Sage Publications, 2004.

Singh NN, **Sabaawi M**, & Singh J: Developmental disabilities and psychopathology: Rehabilitation and recovery-focused services. In W.L. Williams (Ed.), Developmental disabilities: Etiology, assessment, intervention, and integration (pp. 243-258). Reno, Nevada: Context Press 2004.

Singh NN, Wahler RG, Winton ASW, Adkins AD & The Mindfulness Research Group (Strand PS, Hill OW, Singh J, Barber JW, **Sabaawi M**, & Dumas J): A mindfulness-based treatment of obsessive-compulsive disorder. Clinical Case Studies 3: 275-288, 2004.

Singh NN, Wahler RG, Adkins AA, Myers RE & The Mindfulness Research Group (Winton ASW, Strand PS, Hill OW, Singh J, Barber JW, **Sabaawi M** & Dumas J): Soles of the feet: A mindfulness-based self-control intervention for aggression by an individual with mild mental retardation and mental illness. Research in Developmental Disabilities 24, 158-169, 2003.

Singh NN, Wahler RG, **Sabaawi M**, Goza AB, Singh SD, Molina EJ & The Mindfulness Research Group (Winton ASW, Strand PS, Hill OW, Singh J, Barber JW, & Dumas J): Mentoring treatment teams to integrate behavioral and psychopharmacological treatments in developmental disabilities. Research in Developmental Disabilities 23:379-389, 2002.

Singh NN, Wechsler HA, Curtis WJ, **Sabaawi M**, Myers RE, & Singh SD: Effects of role play and mindfulness training in enhancing family friendliness of admissions treatment team process. Journal of Emotional and Behavioral Disorders 10:90-98, 2002.

Sabaawi M, Fragala M, & Holmes T: Drug-induced akathisia: subjective experience and objective findings. Military Medicine 159:286-291, 1994.

Holmes T, **Sabaawi M**, & Fragala M: Psychostimulant suppository treatment for depression in the gravely medically ill. Journal of Clinical Psychiatry 55:265-266, 1994.

Sabaawi M, Richmond D, & Fragala M: Akathisia in association with nortriptyline therapy. American Family Physician 48:1024-1026, 1993.

Sabaawi M, Nunez J, & Fragala M: Neurosarcoidosis presenting as schizophreniform disorder. International Journal of Psychiatry in Medicine 22:269-274, 1992.

Keitner GI, **Sabaawi M**, & Hair RJ: Isosafrole and schizophrenia-like psychosis. American Journal of Psychiatry 141:997-998, 1984.

Neta R, Salvin SB, & **Sabaawi M**: Mechanisms in the in vivo release of lymphokines. Journal of Cellular Immunology 64: 203-219, 1981.

Abstracts and Book Reviews

Sabaawi M: Book review, *The Mind and the Brain: Neuroplasticity and the Power of Mental Force* by Jeffrey M Schwartz and Sharon Begley. Journal of Child and Family Studies 13(1): 125-127, 2004.

Sabaawi M: Book Review, *Personal Therapy for Schizophrenia and Related Disorders: A Guide to Individualized Treatment* by Gerard E. Hogarty. Psychiatric Services 54: 756, 2003.

Sabaawi M: Book review, *Mindfulness-Based Cognitive Therapy for Depression—A New Approach to Preventing Relapse* by Zindel V. Segal, J. Mark G. Williams, and John D. Teasdale. Journal of Child and Family Studies 12(1): 121-123, 2003.

Sabaawi M: Book review, *Breakdown of Will* by George Ainslie. Psychiatric Services 53(5), 638, 2002.

Sabaawi M, Holmes T, & Fragala M: The role for stimulants in the treatment of depressive disorders (reply to a letter to the editor). Journal of Clinical Psychiatry 56(8): 376-377, 1995.

Sabaawi M: Book review, Ross J. Baldessarini's *Chemotherapy in Psychiatry*. Contemporary Psychology 33(6): 529, 1988.

Sabaawi M, Friedman JH, Wagner RL, Kucharski KL, & Klein F: An objective measure of akathisia. Presented at the 139th Annual APA Meeting (New Research Program and Abstracts, p. 74), Washington, DC, May 1986.