9-20-2005

Review of the Federal Department of Justice Investigation of California State Mental Hospitals

Senate Select Committee on Developmental Disabilities and Mental Health

California Legislature
Senate Select Committee on
Developmental Disabilities and Mental Health

SENATOR WESLEY CHESBRO
Chair

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Tuesday, September 20, 2005
State Capitol
John L. Burton Hearing Room

1336-S

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California Legislature
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on
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SENATOR
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Chair

Review of the Federal Department of Justice Investigation of California State Mental Health Hospitals

Tuesday, September 20, 2005, 1 p.m. to 4 p.m.
State Capitol, John L. Burton Hearing Room (4203)

A-G-E-N-D-A

1:00 p.m.	Opening Comments
1:10 p.m.	Agnes Lee Senate Office of Research
1:30 p.m.	Stephen Mayberg, Ph.D., Executive Director John Rodriquez, Deputy Director of Long-Term Care Services State Department of Mental Health
1:50 p.m.	Catherine Blakemore, Executive Director Protection and Advocacy, Inc.
2:10 p.m.	Kathryn Trevino CA Network of Mental Health Clients
	Amy Breckenridge Peer Self-Advocacy Program, Protection and Advocacy, Inc.
2:25 p.m.	June Forbes Napa State Hospital Parent Support Group
	Ann Williams Parent
	Karen Henry National Alliance for the Mental Health - California

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2:40 p.m.	Barry Chaitin, MD, Chair, Department of Psychiatry, UC Irvine CA Psychiatric Association
	Dr. Charles Faltz, Director of Professional Affairs CA Psychological Association
2:50 p.m	Ken Murch CA Association of Psychiatric Technicians
	Kimberly Cowart, RN, Napa State Hospital Christopher Dunn, RN, Atascadero State Hospital CA State Council of Service Employees
	Dr. Michael Lisiak, Chief of Psychiatry, Atascadero State Hospital Union of American Physicians and Dentists
3:05 p.m.	Public Comment: Please complete "Request to Testify" form, available at the hearing.

Written testimony may be submitted at the hearing or to the Senate Select Committee on Developmental Disabilities and Mental Health, State Capitol, Room 5035, Sacramento, CA 95814. Please submit written testimony no later than September 30, 2005.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible.

For further information, contact 916-651-4002

SECTION 2

Hearing Transcript

Senate Select Committee on Developmental Disabilities and Mental Health

Wesley Chesbro, Chair

Review of the Federal Department of Justice Investigation of California State Mental Health Hospitals

State Capitol, Room 4203
Tuesday, September 20, 2005

SENATOR WESLEY CHESBRO: This is a hearing of the Senate Select Committee on Developmental Disabilities and Mental Health.

Today we are going to be talking about the investigations in our state hospital system by the United States Department of Justice. In both their reviews of the children's and adult programs at Metropolitan State Hospital in Southern California, as well as the more recent review in Napa State Hospital, the Department of Justice found significant and substantial deficiencies in virtually every aspect of patient care. Sadly, this is not the first time such concerns have been raised. And sadly and alarmingly, since the issuance of these reports, problems have continued, including suicides and homicide.

Additionally, as noted in the report on Napa State Hospital, the Department of Justice has alleged that the state denied them access in conducting their review. This is an alarming accusation that needs to be addressed and is one of the purposes of today's hearing.

Our goal today is to understand the issues raised in the Department of Justice report, of the department's response to them, what we must do to improve the quality of care in these facilities, and what the implications are if we don't improve the care. I hope we can have a frank discussion about what it will take on all of our parts to create the kind of safe and positive environment I know we all strive for in our state hospitals. And in fact, I represent the right of patients to have that type of positive environment.

We have a very tight agenda, so I'll ask everyone to stay focused and on topic. I also want to mention, we've had some questions—or I won't say criticisms but concerns expressed—about why we are holding the hearing here rather than at one of the hospitals. I thought it was very important that we stay focused on the problems throughout the system and not just be focused on an individual state hospital, and so that's the reason why we're holding the hearing here in the capitol rather than at Napa or Metropolitan.

We will begin by working through the current agenda which is available in the back of the room, if you haven't received a copy. We will follow that with public comment. If you want to present public testimony and are not on the current agenda, you must complete a *Request to Testify* form which is also available in the back of the room and give it to one of the sergeants, the sergeants now walking around. Oh, here. Here we go. The sergeants are right over here. Raise your hand, yes.

Other members may be joining us throughout the hearing. I hope they do. All materials from this hearing, including your written testimony and a transcript of the oral testimony, will be provided to the members and be available to the public.

With that, let me ask Steve Mayberg and John Rodriguez to come to the witness table, although we are beginning with a summary by Agnes Lee of the Senate Office of Research who will begin by going through and summarizing the allegations from the federal investigation.

Ms. Lee.

MS. AGNES LEE: Thank you. I do have a handout, which I hope you have a copy of, which I'll be using to walk through.

I did want to start out with just a brief description of the authority for which the Department of Justice is conducting these investigations, and it's under the authority of the Civil Rights of Institutionalized Persons Act. And the act authorizes the U.S. Department of Justice to initiate civil actions against state or local governments for violations of civil rights of persons residing in certain public institutions.

The Department of Justice takes actions to remedy systemic problems that they find related to what they call a pattern or practice of violations. That is to say, rather than addressing individual cases, they're really looking at what's going on systematically. The process for resolving issues is that at least 49 days before

initiating a civil action, they must provide the state or local government with their findings related to the alleged violations, their supporting facts, and their recommended corrective measures. Just to note, the vast majority of their investigations that result in violations also resulted in voluntary or court-enforced settlements to correct the situation.

Just a quick overview, the recent investigations in California for our state mental health hospitals, at Metropolitan State Hospital, the Department of Justice issued their findings letters for the children's program in May of 2003, the adult program in February 2004, and more recently for Napa State Hospital in June 2005, and currently, investigations for Patton State Hospital and Atascadero State Hospital are in progress.

I believe you have a copy of the Department of Justice findings letters which are quite detailed in the examples they use and the evidence that they cite to come up with their findings, and they also list some corrective measures for the State. What I'm going to do, because there's so many topics to cover, is just really provide a brief summary of just the findings that they came up with in their letters, and I'll start with the children's program at Metropolitan.

The Department of Justice visited the facility in June, a couple of weeks in June/July of 2002, and their investigation included a review of medical and other records of about 70 patients, interviews with administrators and staff, speaking with patients, and on-site surveys. And they brought with them their own team of experts in child psychiatry, child psychology, psychiatric nursing, and special education.

So let me jump into the findings in the area of psychiatry. In their findings letters, they say that Metropolitan fails to provide clinically justified evaluations and diagnoses of psychiatric disorders. They go onto to say that the number of clinically and justified diagnoses strongly indicates that psychiatrists deliberately make psychiatric diagnoses to justify the use of psychotropic medication.

Next, Metropolitan fails to provide adequate and appropriate treatment planning. They say that because the hospital fails to evaluate or diagnose its patients adequately, that it's nearly impossible for them to come up with appropriate treatment plans. One of the examples they cite is that the plans didn't include any treatment

for, or acknowledgement of, the fact that the patients had severe traumatization and had multiple out-of-home placements.

SENATOR CHESBRO: Multiple—I'm sorry?

MS. LEE: Out-of-home placements.

SENATOR CHESBRO: Out-of-home placements.

MS. LEE: They said Metropolitan fails to identify and address cognitive and academic deficits. The hospital fails to prescribe clinically justified psychotropic medications. An example they give is that the patients were prescribed medications that were appropriate for adults but not for children. They also say that the hospital fails to appropriately assess the side effects of medications and that they fail to provide appropriate therapeutic environments.

In the area of nursing care, they stated that the nursing and unit staff failed to identify, monitor, and report patients' symptoms and side effects of medications. The staff are unfamiliar with mental health diagnoses, associated symptoms, and appropriate treatments and interventions. The staff lacked knowledge regarding their patients. Staff do not meaningful participate in the treatment team process. They also note their observations that of many of the nursing and unit staff appeared to lack adequate support, training, and supervision.

Next, in the area of psychology, they stated that the psychological evaluations are inaccurate, incomplete, and unreliable. Active treatment interventions are too infrequent, are of inadequate quality, and are insufficiently documented. Metropolitan provides inadequate behavioral interventions.

Then in the area of restraints and seclusions and as-needed medications, they found that children are exposed to excessive use of seclusion and restraints and/or as-needed medications. They did say that staff—their observation was that staff used seclusion, restraints, and medications in the absence of adequate treatment and/or as punishment.

They said Metropolitan does not provide adequate pharmacy services. They failed to provide necessary medical care. They do not complete systemic tracking or trending of infections or communicable diseases. They do not ensure timely and appropriate dental care, and even that their documentation for dental services are not complete.

In the area of dietary or nutrition services, they stated that the hospital does not implement meaningful interventions to address children's weight problems. They point to estimates that 80 percent of the children patients there are obese and that many of the medications that the children receive exacerbate their weight problems.

The area of placement at the most integrated setting, they said that Metropolitan fails to actively pursue the timely discharge of children to the most integrated, appropriate setting that is consistent with the child's needs. They stated that the hospital did not have a mechanism to identify and review the patients that had extremely lengthy hospitalizations, that the treatment plans failed to clearly identify barriers to discharge to the most integrated setting, and that the actions of the staff where the patient needs to overcome the barriers were not included.

In the area of special education, they found that the hospital does not provide specialized instruction and related services which are individually designed. They also noted that the hospital did not make a meaningful assessment as to whether the child, with the appropriate supports, could actually attend or receive some school activities along with non-institutionalized children.

In the area of protection from harm, they noted that the facility had a number of environmental hazards, including fixtures which patients could use to commit suicide. They also noted that the incident management system was deficient, including concerns about their tracking, about tracking of incidents, the quality of those investigations for those incidents, and implementations of corrective actions.

And finally, they did raise an issue regarding the patients' constitutional rights of free speech and due process. And this stems from the fact that state representatives were present in all of the Department of Justice's staff discussions with the patients, and they found that in this way that the state actually constrained the patients' civil rights. So that's the children's program.

I'm going to move onto the adult program, and you'll find that a lot of the areas are very similar. Again, they visited the facility in June/July of 2002. They looked at records of about 150 patients, adult patients there. And along with their team of experts, they also brought in consultants and incident management and quality assurance.

Again, in the treatment planning area, they found that the hospital did not provide a comprehensive, integrated plan for the provision of treatment addressing individual patient needs. Some of the examples that they gave were that the diagnoses listed on the treatment plan often differed from the diagnoses listed in the physician documentation section of the patient's chart. Treatment interventions are arbitrarily and indiscriminately determined and implemented. Documentation reflects that patients do not meaningfully participate in their treatments. Treatment teams are often uncoordinated, disorganized, and unstable, and that the hospital had no mechanism to address patients' risk factors.

In the areas of assessments, they noted that psychiatrists routinely diagnose their adult patients as having psychiatric disorders without clinical justification. Psychological assessments and evaluations, with a few exceptions, are inaccurate, incomplete, and uninformative.

Rehabilitation assessments typically fail to address a patient's rehabilitation needs. Most social history evaluations contained significant factual omissions, apparent errors, or unresolved internal inconsistencies.

The hospital also prepares court reports for assessing patients committed due to a "not-guilty-by-reason-of-insanity" status, which are supposed to help the court decide whether or not to release the patient to a lower level of care, and they found that the format and content of those court reports failed to provide the court with adequate and accurate information.

Again, in the area of discharge planning, they said that the hospital fails to provide adequate, individualized discharge planning that is integrated in treatment decisions. For example, they said that the causes of previously failed discharges or reasons for the patients' admission to a psychiatric institution were seldom considered or addressed.

Getting into the specific treatment services, they found that the psychiatrists failed to exercise adequate and appropriate medical management and appropriately monitored medication side effects. They said that patients were routinely prescribed inappropriate or unsafe medications without justification.

Psychological services frequently are incomplete, inaccurate, and outdated. For example, they said that the rehabilitative and psycho-social interventions are largely

driven by what's available in the unit and not what's appropriate for the given patient. Nursing staff failed to adequately monitor, document, and report patient symptoms or document the administration of medications, provide a therapeutic environment, and participate in the treatment team process. Pharmacists do not systematically review patients' medication regiments. Again, the hospital fails to provide necessary medical care, the hospital does not take appropriate interventions to minimize the risk of infections, and that patients experience long delays and/or the complete absence of dental treatment.

Patients do not receive adequate physical and occupational therapy. Treatment plans do not address patients' weight problems. They also noted that the psychiatrists do not chart their patients' progress with sufficient frequency and that the substance of those progress notes are also deficient.

Again, in the area of restraints and seclusions and as-needed medications, they found that the patients were exposed to excessive and unnecessarily restrictive interventions. And again, that in some cases, they were used as punishment.

The area of protection from harm, like so much of the children's program, they found that the incident management system was deficient, that the quality improvement activities at the hospitals did try to implement were generally disjointed and inadequate, and, again, that the environment was not free of hazards such as fixtures. And they also raise the issue that the staff frequently relied on untrained security personnel and patient interventions. And again, similar in the children's program, they raised the issue of the 1st Amendment and due process rights for their patients.

Finally, just wrapping up with the Napa State Hospital investigation, they issued their findings in June 2005. And unlike the Metropolitan investigation—I'm going to mention, Senator Chesbro—they did raise the issue of non-cooperation. And a couple of implications from that was that they did say that was a factor that they used in drawing their conclusions about Napa; and that because of that, this investigation was a little bit different from Metropolitan in that they had to rely a little bit more heavily on other agencies' reviews of Napa, for example, the federal Centers for Medicaid and Medicare Services, and also our own State Department of Health Services.

So again, going onto the findings which...

SENATOR CHESBRO: May I ask—

MS. LEE: Yes.

SENATOR CHESBRO: --besides relying on other departments' reviews, though, did they not also conduct interviews with...

MS. LEE: Yes. They interviewed—had interviews with professionals, advocates, family members, and patients.

SENATOR CHESBRO: Okay.

MS. LEE: So going onto the findings, which, again, were similar to the ones they found at Metropolitan, in the area of protection from harm, they said that staff often failed to intervene and to report patient-to-patient assaults. Staff do not attempt to prevent repeated assaults by addressing the underlying behavior of the aggressors. Napa fails to remedy deficiencies in its suicide-prevention practices and that it fails to control traffic of harmful contraband, including illegal narcotics. Patients suffer harm from excessive and inappropriate use of physical and chemical restraints in seclusion. Napa fails to keep the environment free of hazards, including fixtures that patients could use to commit suicide. They do know that they observe that a major factor in the failure to protect patients from harm was inadequate supervision.

Going onto the treatment care, Napa does not provide adequate medical and nursing care, fails to provide adequate occupational and physical therapy and nutritional supports and services. In the area of treatment planning, again, Napa fails to provide adequate treatment planning. Napa fails to plan adequately to address patients' assaults of self-abusive behaviors.

In the area of discharge planning, it's more like Metropolitan. They said that the hospital fails to place patients in the most integrated, appropriate setting consistent with the patients' needs in terns of any court-ordered confinements. They also noted in their finding letters that they had received incredible allegations that patients who seek to be discharged into the community placements were retaliated against by Napa staff.

So that's a very quick run-through overview of the findings. Again, the letters do talk about some suggested, remedial measures.

SENATOR CHESBRO: Okay. Thank you very much.

I have to say that these allegations are devastating and all-inclusive, in terms of leaving no part of the operations of these three programs—the two in Metropolitan and the one at Napa—untouched. It's amazing to me how all-inclusive of every aspect of the management—the culture, the treatment, the operations of these facilities, of these allegations are. Of course, also, I think, magnifies the allegations that the federal government says. And certainly, we're going to give the department the chance to provide whatever explanations you can. But to have not had them, have transparency and not have the doors open so that the investigation could be more clearly based on inspection and the examination close-up of what has taken place at Napa, at least in the case of Napa—no, it's not the case with the Metropolitan investigations—and so I think it seems like it couldn't have been worse if they had inspected. So it really raises the question, and one that I think has to be answered is, what possibly could have been served by not having access by the Department of Justice.

I will say I'm glad to have Dr. Mayberg, the Director here today, in addition to the fact that I think it's—of course, it's not a legal obligation but certainly an important political one, that when the Legislature asks representatives of departments and programs to come forward, I hope it's also an indication of a recognition by yourself and the management of the department that these are very serious allegations and require a response and not just a response today because I doubt that you're going to stand up and say that there's no merit to all of this. So while there may be some explanations or some directions or responses that attempt to explain away some of the allegations, I also hope that there's a real willingness to examine them in an open way and a willingness to try to bring about real change because I have to assume going in that there's at least some merit and quite possibly a lot of merit and that we have to try to open our minds and our hearts and our eyes and figure out what we're going to do about it.

So with that, let me welcome you, Dr. Mayberg, and also your Deputy, John Rodriguez.

Let me say to Ms. Lee, thank you very much for your work on this. We are on a tight schedule, so I'm not going to ask you lots of questions about your presentation, but I think you've presented the outline that we're now going to go through in terms of

the questions that will be asked and have been asked of the department to respond to today, so thank you for your work.

Dr. Mayberg.

DR. STEPHEN MAYBERG: Thank you, Senator, for the opportunity to testify about this complex issue and also to reiterate that we take this very seriously at the department. I personally take this very serious, and I think that Ms. Lee did an excellent job of summarizing the findings from the U.S. Department of Justice.

SENATOR CHESBRO: Are you going to be submitting written testimony today?

DR. MAYBERG: Yes. I have mine down. And then, for your questions, we'll get you written testimony.

SENATOR CHESBRO: So you don't have that ready for me?

DR. MAYBERG: I have my written testimony. It's right here.

SENATOR CHESBRO: And you will submitting it to us?

DR. MAYBERG: Yes, yes.

SENATOR CHESBRO: Is that the departmental response?

DR. MAYBERG: There's two departments. Yes, there will be two responses.

SENATOR CHESBRO: So there's a further, additional response that will be coming to the...

DR. MAYBERG: Right, right.

SENATOR CHESBRO: Okay. Ordinarily, when we hold a hearing, we ask for the materials to be ready at the time of the hearing so that it's available to everyone who's participating.

DR. MAYBERG: Right.

SENATOR CHESBRO: So it's quite extraordinary for it not to be at this point.

DR. MAYBERG: I think we were confused because the agenda said submitted by the 30th.

SENATOR CHESBRO: Well, we've used the same format for over 20 years, long before I came here. So you're now on notice that that is the format of the committee, is to have the written materials ready.

DR. MAYBERG: Mine is ready, so I will submit that.

We, as the department, are fully committed to care that is centered around the consumer and family member needs, and our approach needs to reflect the principles

of recovery and choice through use of evidence-based, outcome-driven, and accountable practices. Unfortunately, we found that those principles are not as prevalent in the hospitals as they are in the community. With—and I think you've seen with this approach of kind of client-centered, family-driven services—and certainly in our mental health services' block grant, community service, and support—that reflects the values of the department.

What we realize is those principles need to be consistent in all parts of our system, whether you're in a state hospital or whether you're in the community. And before the USDOJ investigation, we weren't practicing that. In 2002, when we received the letter, we believed that our hospitals were doing well. They were successfully making the transition from a civil commitment to forensic commitments. We now have 90 percent of the people in our system who are forensically committed, that we had spent much of our energy concerned about issues of patient safety, staff safety, and public safety and making that transition to deal with this new and challenging population. All of our hospitals were licensed. All of our hospitals were certified. Many of them had had commendations. We had people coming from all over the world to look at our programs. So from our point of view, we thought we were doing okay.

So when the USDOJ wrote a letter to us and said we'd like to come and look at you, we were fine with that. We thought that that would give us valuable feedback and that it really is important to us to be transparent; and that whatever we could learn from their coming, we didn't feel we had anything to hide, and we actually thought we were doing better than the reports indicated.

SENATOR CHESBRO: So the department truly thought everything was fine. There wasn't feedback from anywhere that would have led you to believe that...

DR. MAYBERG: Not if we looked at the accreditation standards where we were in the 90th percentile. And then when we looked at licensing, we were doing everything that were national standards and that we were being recognized for that. So not that we couldn't have done better care, but at least we didn't have any indications at Metro that there was anything substantive. I mean we were having troubles making the adjustment. The children's program was a new program at Metro, that we moved from Camarillo, and we went through some kind of fits and starts, getting that started, getting staff on board, figuring out how to do a better program.

SENATOR CHESBRO: Were there indications from licensing reports or from PAI reports that there might be problems?

DR. MAYBERG: There were no major cites from licensing. There were cites from licensing, and there was concerns from Protection and Advocacy, and certainly there were issues in some of our lawsuits. *Emily Q.* and TBS is one of those that we needed to move people out of our system more quickly, that we had to do a better job of moving these kids out, and we were aware of that.

So when the USDOJ came to look at us, we went with them. And what we could see ourselves, by looking closely and objectively at our hospitals, is that a recovery model was not being utilized in Metropolitan, that we were relying too much on seclusion and restraint and/or medication to control behaviors, that we did need to sharpen our diagnostic skills, we needed to build in the whole concept of strengths and competencies, and use the whole team in terms of developing those, that we needed to get patients more involved in active treatment and not to stay in their rooms or in the dayrooms but to have much more of a mall concept or integrated-treatment concept, and that our treatment planning really wasn't geared to get people into their next step.

So all of those statements that came from the Department of Justice comments about system issues were ones that headquarters, that we agree with, that there is no doubt that those were problems. So even though you can be licensed, even though you can be certified, doesn't mean that you are doing the best you can do or even what you should be doing to make the hospital work.

And we realized at that time that this was not a problem that was unique to Metro, that we realized that that problem was endemic in our system, and that this culture of the way we were doing business was a culture at all the hospitals. Each of the hospitals are a little different but we knew that. So we began looking at the structure of our hospitals and how we needed to enhance care. And so we began, even before any of the other U.S. Department of Justice letters, to come and review us, to do our own reviews. And we brought in external consultants, national consultants, actually hired people who USDOJ hired to do the reviews for ourselves, to be proactive, because we assumed, if it was in one place, it was another; and that we realized we couldn't just fix a little bit at Metro. We needed to fix our whole system, so we began.

At that time, the system changed. And the USDOJ knew that. Part of what complicated that for us was that there was 19 months between the time they visited us and the time that we got the findings. And we wanted to make sure that whatever we embarked on that we had the collaboration and the cooperation and the endorsement of the U.S. Department of Justice. We didn't want to institute a whole system of change and have that not be consistent with what the values that USDOJ were saying were important. So getting that letter back from them or the findings was really important. But by the time that letter came, we had already begun the analysis of our other hospitals and began system changes.

SENATOR CHESBRO: So in response to the first Metropolitan report, you began a process of change at the other hospitals, including Napa?

DR. MAYBERG: That's correct, that's correct. And we began the process of change at Metro before we received the findings because in our own review, we weren't disagreeing with those issues that I talked about. We thought those were important issues, and we thought we had to make those changes and make them as much a part of the culture as possible. And I think what's important for us to realize is those changes aren't easy. Those changes don't occur quickly. It take quite a bit of time and effort to make those changes occur.

SENATOR CHESBRO: So during the two years between the Metro, first Metro report and the Napa report, you did bring consultants into the hospitals, all of them?

DR. MAYBERG: All four hospitals.

SENATOR CHESBRO: Who had worked for DOJ?

DR. MAYBERG: That's correct.

SENATOR CHESBRO: So in terms of their, the impact to having those folks within the hospitals, that was not considered problematic. But when DOJ came to do their review, then apparently, you haven't gotten to that part yet of your testimony?

DR. MAYBERG: Well, DOJ didn't come to do a review. I mean I think that was part of what confused us a little bit. We were very transparent about the fact that we had DOJ consultants there. We were very clear with them that we were making changes in all of our hospitals, that there were substantive changes, in that in our letters back to the DOJ, that we had stipulated that we had systemic issues that we wanted to work on and that we certainly wanted to get some guidance from them as to

what they saw as—we knew what needed to be remediated. We wanted to make sure that that remediation was similar to what the USDOJ wanted to do. And after the finding letters came out from the adult system, we began to sit down and have a series of negotiations with them.

SENATOR CHESBRO: One significant difference would be that the consultants, even though they had been employed by DOJ, they were also consultants that the state hired—

DR. MAYBERG: That's correct.

SENATOR CHESBRO: --as opposed to, you know, the more independent investigation that DOJ would provide.

DR. MAYBERG: That's correct. And in that sense, Senator, consultants are consultants, and we figured that they aren't going to change what they say, depending on who pays for them, and we wanted to make sure that we got a candid view of our system. And I can guarantee you that it was a candid view. It was not sugar coating any of this. It was, I think, a very in-depth look at all of these same issues, sometimes building a little bit more on strength and where we can fix the system than on the negatives, as much as the USDOJ talks about the recovery model building on strength. They tend to focus on the symptoms. But that being said, we were in active negotiation with the USDOJ, both about remediation for what we needed to do at Metro but also to get a sense at the other hospitals.

The major source of disagreement between us and where we were seen as non-cooperative was, they had said we had denied access to them to hospitals. And that's just not true. We did not deny access. What we were trying to do was negotiate a time, a time when they could come. We didn't want them to come at the same time that we had JAHCO being there, and they knew that that was in October/November, so we have joint accreditation. And we also wanted to know what the scope of their review was, not that we wanted to keep them from anything. But the fact that we had already acknowledged that we had those programs; that when they came to Metropolitan as Ms. Lee talked about, it was incredibly time consuming.

We copied over a quarter of a million pieces of paper for them, documents for them, and redirected ten or 12 staff, full time, to deal with this. We don't have lots of extra staff, and we really wanted to make sure that all of our staff were committed to

implementing the changes that are necessary. And so it wasn't they couldn't come. It's just, can we agree on a time you can come, and can we agree what it is you want to look at, and we'll already stipulate to some of these systemic issues. We've already agreed to those.

SENATOR CHESBRO: What was the timeline from the time that they first indicated that they wanted to—the Department of Justice indicated—they wanted to come and the time that they issued the report?

DR. MAYBERG: I think the letter was sent in February?

John?

MR. JOHN RODRIGUEZ: The first letter came in February of '04—no—excuse me—May of '03, and the second letter came in February of '04—children/adults.

SENATOR CHESBRO: No, for Napa.

MR. RODRIGUEZ: Oh, I'm sorry. We had discussions here in Sacramento in March where we were actively negotiating over three days the remediation plan, I call it. Basically, it's the agreement we would have that will define expectations in where we're going and be the agreement that we're going to operate under until we get this resolved.

SENATOR CHESBRO: But what about the question of when they requested access?

MR. RODRIGUEZ: We've been talking about this, well, you know, since they came out of Metro. But where I was headed here with this is, that as late as March—we were talking—March of this year—we were talking about when are they coming to the other hospitals? We were briefing them in detail about the changes that were going on at all four hospitals.

SENATOR CHESBRO: I assume they made a specific request to come, that they're referring to in the report, when they say that they were denied access, that they made a specific request to have access.

MR. RODRIGUEZ: And at that meeting, I specifically told them is, JAHCO is coming in October/November. You can come in right after that, and they also endorsed the changes that we've got going on.

SENATOR CHESBRO: When did they send the official notice asking for access, that they were doing an investigation?

MR. RODRIGUEZ: That goes back to...

MS. LEE: That was January 2004, is when they sent the letter, their attempt to begin the investigation. In June 2005 is when they issued the findings letter.

SENATOR CHESBRO: So between January 2004 and the time that the report came out, you were unable to come to agreement with the Department of Justice about a time when they could have access?

DR. MAYBERG: I think the Department of Justice was well aware that we were implementing system reforms during that period of time. We were in negotiation with them. And part of what we were talking about was -- Are we doing the right thing? Come and look. And when you have set out for us what the expectations or what the standards are that you're going to be judging us on, please come and review us on that. Please tell us what you're going to look for. You can come as soon as we know that.

SENATOR CHESBRO: But I guess my point is, relative to other things that were going on, that that seems like enough time, that there would be ample opportunity for a visit to take place in between other things that were going on at the hospital there.

MR. RODRIGUEZ: Well, actually, Senator, I mean I was the one talking to them on a regular basis, along with our legal people. We had a lot of stuff on our plate with the over-bedding, the opening of a new hospital, the JAHCO reviews. There was never a discussion with them that we were being uncooperative. Surely, they wanted to come in sooner rather than later, and we were being very consistent in that we're not going to prevent you from coming in, but there's some work that needs to be done in terms of I think all the things that you're familiar with—with over-bedding, preparing for JAHCO, keeping up with some of the other issues we have, and implementing the changes that we had going on that I was very clear with them about in terms of get us by JAHCO and then come on in. Since that time, of course, I've seen the handwriting on the wall with respect to—what they said about uncooperatives, despite the fact they face-to-face told me and were pleased with the changes they had going on, we had said come on in to Atascadero and Patton whenever you want, and that was in August, and I expected them to be there in August. Now they can't come in until November or December.

So I think there's two sides to every story here, and I think that the allegations of uncooperation when they have access, even without coming in, to patients, to family members, to staff members, to reports, is somewhat misleading and represent the tactic on their part to give some concessions in the discussions on remediation. They are very pleased, what they told me in March, with the changes that we have going on, particularly at Metro, and which we're now under way at all the other hospitals.

Now having said that, I recognize that they're going to say whatever they want to say. Our doors are open. Come on in, and come to Patton and Atascadero whenever you want. And now they're talking about November/December.

SENATOR CHESBRO: Okay. I'm going to want to move to the specific questions we submitted, but I don't know, Dr. Mayberg, if you wanted to, if you had some additional things you are going to include in your opening remarks before we go to those questions?

DR. MAYBERG: Well, I think we're basically going to say we are committed to the change. We think that we have to make the system changed, that we need to build a system around not just medical treatment of folks. We need to do the social rehabilitation model; we need to focus on wellness and recovery; we have to get rid of the unnecessary seclusion and restraint. We need to change our medication practices—we have changed those—and how we monitor that. We have to have a better incident management system, all of the things you've heard about. Those are things we're committed to; those are things where we're in agreement with the USDOJ, that we either have done them or in the process of doing those, and that we continue to not dispute the majority, if there's some specifics of the finding. But the USDOJ report about systemic issues was a catalyst for us to change and that we do welcome them at any time to come in—welcome anybody at any time—to come to our hospitals. They're not as bad as they're portrayed, but they're certainly not as good as they could be.

SENATOR CHESBRO: Okay. Thank you.

Going to the specific questions, first of all, I appreciate it if you'd stick around for as long as you can, certainly throughout Mr. Rodriguez's presentation. But going to specific questions, I'll stipulate that you answered the first one in your presentation,

and let's just go to the second one regarding what, if any, of the findings by the Department of Justice are disputed by the Department of Mental Health.

MR. RODRIGUEZ: Senator, my name is John Rodriguez, as you know, but for the record.

There are a number of issues—individual, specific issues—that we would have problems with. But I think what you've heard here already is that we are in agreement in terms of the broad, systemic issues that they identified, and that's the starting point that we've undertaken in terms of the changes that are underway now with existing resources and the details of the remediation plan that we're negotiating.

In our judgment, there's enough true in what they're saying that we're not going to get into fight over the things that we disagree with because the effort should be focused on the fixes that we need to make. If we need to go through and identify a few things—for example, the access to the patients we disagree with—there's individual issues about whether they took information to consideration by restraint and seclusion, information about whether an individual needed a hip replacement and we didn't provide it. You know, the other side of the coin is, she had complicating factors. I mean there's lots of those little things but not enough where I'm saying they're wrong.

SENATOR CHESBRO: So you're saying—I believe I hear you saying—that the department is in substantial agreement with the things that have been identified in this report as needing correction at the various hospitals?

MR. RODRIGUEZ: Yes. From a systemic standpoint, I do agree with that.

SENATOR CHESBRO: So disagreement, perhaps, over some details. But systemically, you have accepted that these are real problems.

MR. RODRIGUEZ: Yes, Senator. I'm the frontline guy. I think, as Dr. Mayberg indicated, relying on licensing and accreditation, the work of our medical staffs, in terms of policing themselves, certification, those were independent, onsite measures that we took as the standard against which we should be striving for. And quite frankly, against those standards, I thought we were doing pretty good. These surveys, by USDOJ, opened, I think, my eyes, Dr. Mayberg's eyes, the Executive Director's eyes, that systemically, we need to change in the terms of the way that we deliver services and the way we monitor services.

Would it be helpful if I dived into the...

SENATOR CHESBRO: Well, the thing is that you've touched on some of them so I'll try to help you figure out what I think hasn't been answered yet as we go along.

I think the next question—and Dr. Mayberg, you have substantially responded to—but let me ask, Wouldn't the Department of Justice have an interest in documenting conditions at the hospitals even if they were to agree to the systemic remediation plan? In other words, it's not a one-time thing. It's a process.

MR. RODRIGUEZ: What I've learned is, certainly they need to know what's going on. We're stipulating, based on our own reviews, that these systemic problems exist in all the hospitals and we're moving ahead on making those changes. What we learned from the reports finally coming out, since we already had work going on, is that engaging the USDOJ evaluators on our side was the right thing to do because we had work already going entirely consistent with the findings and the remedial measures they recommended.

What I've also learned, is when we start discussions about coming into other hospitals, they're prepared to forego onsite reviews if we stipulate the problems. But then you start getting the lawyers—with all due respect to the lawyers in the room, sir—you get the lawyers start talking about what the stipulation can say. They don't have to come in when it comes down to it. What they're looking for is stipulations from the State that you have these kind of systemic problems and that you're proceeding forward.

Now I've gotten beaten up pretty good about the Napa lack of cooperation. They can say whatever they want. I disagree. But now that we're talking about Patton and Atascadero, we're still talking about stipulations that would prevent or result in not a need for on-sites at Patton and Atascadero if we stipulate that those problems exist there. What's going to prevent that from happening, if it happens, if it doesn't happen, is getting the right words down in some sort of legal document. Having said that, where I'm at right now, is that we're blasting ahead with the remediation plans. I'm assuming they're coming in to Patton and Atascadero in November and December, and we will be ready for those things, if that's what they feel they need to do.

But to answer your question directly, Senator, an onsite is not necessary for them to do their job, and that's the substance of discussions we've been having about

stipulating the conditions at the other two hospitals and which we were talking about, by they way, for Napa when they issued the report and said we were uncooperative. Having said that, that's old history. Come on in. I'm not going to allow that kind of stuff to happen. And in the meantime, we're moving ahead.

SENATOR CHESBRO: So let's skip down to the question of the status of negotiations with the Department of Justice regarding the Metro findings, the Napa findings, and the issue of access to Patton and Atascadero.

Where are you at with trying to reach agreement with DOJ on those items?

MR. RODRIGUEZ: As I mentioned, at the end of March, we had a three-day discussion here—USDOJ and us, our respective attorneys—made substantial progress on the details, the programmatic details, of the remediation plan, the enhancement plan, the settlement agreement, all very much mean the same thing. What it basically talks about, is what has to happen, by when in the hospitals in order to satisfy USDOJ.

We got 90 percent, 95 percent of the way there. In March, we had subsequent exchanges of drafts several times, had another onsite, in-person Sacramento visit at the end of August. Subsequent to that, we have had further phone conversations. I think we're very close, if not done, in terms of the programmatic components, that is, what's the hospitals supposed to do and how will people monitor that and what kind of results will we be expecting? What will you, me, and everybody else see when they go down to the hospitals?

There's still a number of issues outstanding in terms of dates, although I don't think that's going to be a big hurdle because generally they would agree that this kind of change, systemic change, that we need to achieve will take anywhere from three to five years. Metro's farther down the line because they started first. I would think they're closer to three years. Atascadero has just recently begun. I think they're going to be taking close to five years. I don't expect that to be a disputed item. There are other issues still to be resolved, but I think we've made substantial progress and are pretty close.

Further, I'll say again, there is no disagreement on our part about coming into Patton and Atascadero. I've got tentative dates set based on what I thought, when they wanted to come in, they said the end of November, first week of December, and

then skip a week, come back into the second hospital in the middle of December. Works for me. We're still waiting for them to tie that down. And meanwhile this issue of stipulation where you don't come in at all continues. But I'm not going to hold my breath on that. We're moving ahead preparing. And we told them they could come in, in August, come in, in September, if they wanted. They said they couldn't. Frankly, that works for us because we've got JAHCO coming in, in the middle of October, and therefore with us for a month, we've got to make that work too.

SENATOR CHESBRO: I appreciate you being striking an optimistic tone about how it's going.

MR. RODRIGUEZ: What else can you do?

SENATOR CHESBRO: Let's assume for the moment that negotiations with the Department of Justice—I'm going to be moving onto the next question here. Let's assume that they don't reach a successful conclusion. What other steps do you think the Department of Justice might take to ensure corrective actions are taken to improve the quality of care in the hospitals, and what are the consequences of those actions?

MR. RODRIGUEZ: What I've learned about this process is that, if agreements are not reached, they take you to court. Basically, they take a writ to court saying that we don't provide a constitutional level of care, and they probably get, attempt to get a court order. And I suspect we'd end up similarly to where we are right now, only we've gone through a bunch of court proceedings and spent a lot of money and spent a lot of time. I think that gets back to our own assessment of what needs to be done. My personal, maybe optimistic, point of view is, I don't think we're going to get there. I think that what you're seeing here is a commitment by California to make it happen. And the feedback I've gotten from them in March when we briefed them in detail on the actions that are going on at Metro and are underway at the other hospitals was very positive from the attorneys from USDOJ as well as the hired consultants that they bring to the table to provide programmatic and medical and clinical advice to the USDOJ attorneys.

SENATOR CHESBRO: So you see this potentially moving towards a voluntary agreement or a consent decree?

MR. RODRIGUEZ: I do.

SENATOR CHESBRO: Which?

MR. RODRIGUEZ: I think it will, sir.

SENATOR CHESBRO: Can you differentiate between the two in terms of which...

MR. RODRIGUEZ: Well, I'm down here on the totem pole. And one of the reasons I can't tell you that the deal is cut is because I have bosses that I have to explain this to. I'll also tell you that I believe there's a fiscal impact that I'm working through inside the administration, that to make this thing happen beyond what we've been able to do with existing resources—and hopefully I will be able to, the governor would be able to present you something in the January budget along those lines. I guess I'm saying there's some I's to dot and T's to cross internally that I've still got to work through that prevents me from saying it's a done deal and being really optimistic and saying all done; now we've just got to make it work.

SENATOR CHESBRO: So is whether or not it's a voluntary agreement or a consent decree, is that something that might stand in the way of reaching an agreement?

MR. RODRIGUEZ: That is an issue that we're talking about.

SENATOR CHESBRO: Now another possibility, and God help us, is that it does wind up in court and we go down the path that Corrections has gone in terms of judges overseeing. And can you respond to that possibility at all? I can characterize it myself but...

MR. RODRIGUEZ: Well, you hit it on the nose. I'm pretty involved in the *Coleman* case from DMH's standpoint. As you know, we provide a lot of services to CDCR in our hospitals, and I've seen up close and personal the additional costs, the additional, what I consider unnecessary oversight, if you're not otherwise committed. You've got too many cooks in the kitchen, which sometimes slows you down. I think it's in our interest, and I would recommend strongly, that we avoid that unless all else fails. And I continue to believe, from where I'm sitting, that there's no reason why we couldn't get an agreement of some sort with voluntary compliance from the State of California to do what has to be done. My own consultants that we've hired, who also worked for USDOJ, have been extremely helpful in terms of defining the scope of our program. And again, you said I was optimistic. I guess I am, but I can't tell you much more than that. I think it will work out.

SENATOR CHESBRO: Now has there been any indication of a DOJ investigation under the False Claims Act?

MR. RODRIGUEZ: Yes. The CRIPA attorney, the individual that works for the Civil Rights for Institutionalized Persons' civil rights division made a referral to the U.S. Attorney in Los Angeles asserting, that based on their investigation, the bills that we submitted to Medicare and Med-Cal from Metro during the period of time for this investigation couldn't be valid. I'll be real candid with you. I think that that was a strong-arm tactic to try to get concessions at the table. It, as far as I know, hasn't been done anywhere else in any other state. And I personally found it to be a bad-faith tactic—nothing I could do about it—in light of California's cooperation. And the other point I made is, by the way, another arm of the federal government, the folks that find Metropolitan to be certified for billing purposes found that we were fully able to bill those programs. So we'll go through this process with the United States Department of Justice if that's what's necessary. But I found that to be disingenuous and nothing more than a negotiating tactic and completely ignores the fact that we were certified by another arm of the federal government for exactly that, to bill Medicare and Medicare, during that time.

SENATOR CHESBRO: As a matter of tactics, though, it raises the question of whether you're as close and you should be as optimistic as you're saying, if they're threatening, waving around threats like that.

MR. RODRIGUEZ: Well, we've had—these are audits and investigations that occur not infrequently. We've had billing on us before; we've gone through them. In fact, we've paid money back in the past. That's not a big surprise and if we find errors.

My only concern is, if they have a concern with billing and Metropolitan do an audit, do it at any one of our facilities, but the attempt to link it up to performance under the Civil Rights for Institutionalized Persons Act, I think, is unprecedented and just represents a tactic to try to get something from California. And I'm not prepared to agree that when you're otherwise licensed and accredited and certified for billing, to then somehow agree with them that because there's a CRIPA investigation, which has some good points and which we're dealing with, means that we can't bill Medi-Cal or Medicare. I may be a little overdramatic. But I think sometimes this is Big Brother

trying to just lean on states and take away more federal money, establish a precedent where California ruled on this, so in the future, every CRIPA investigation that doesn't work or isn't positive means money gets paid back by the states. It maybe a little overdramatic, but that's basically what I'm thinking is that they're up to.

SENATOR CHESBRO: Okay. Let me change gears here a little bit, skipping back up to the question about implementing components of the remediation plan. We do have other lives besides politics. In my educational background, our organizational culture is one of the things that I have some credentials with regards to. And I know this organization and others I've been involved in, that organizational change is not a simple thing and may be in fact close to the heart of what's going on here. It's not just a question of who's in charge, although we are, and we do believe in accountability. Nonetheless, you're in charge of an organization that has history, culture, existing arrangements, existing traditions.

So what are your perceptions about the ability of the organization to change, to implement the components of the remediation plan, and meet the changing demands that we do a better job?

MR. RODRIGUEZ: Thanks for asking that question. It's something that's on my mind all the time. I view this to be one of the biggest challenges I've ever faced in my state career. And you're changing the culture, not in just a small organization. You're changing it in four large organizations, and we're approaching 9,000 employees, and every one of them, from top to bottom, has to change the way that they view their job and what expectations are, and we need to get this done in three to five years at all the hospitals. I'd say, for the most part, with proper training, explanation, meetings, town hall meetings, we've had a fairly positive response from the staff, and that continues to grow.

I'll be real candid with you. There's some resistance going on, and a number of people at Metro either left or retired. In some cases, I don't think that was a bad thing. Situations where you've been around a long time, you don't want to change the way we do business, you're going to sabotage the process or it's just not something you want to do, that's okay. It wasn't an easy thing to say when we're struggling for clinical staff, but I think on balance, we've turned out okay. And with the people that

we have hired at Metro, I find that they come in without any preconceived notions, so those are folks that are going to be more able to work with.

Changing the organization long term is not going to happen because I write a policy. It certainly starts with defining expectations, in terms of our policies and special orders and me and the leaders in the hospital talking about it. But it's a function of train, train, train, train.

I mean people think I'm crazy when I say that kind of stuff, but you wouldn't believe the amount of training that's going on right now. It's one of the things that we can do now without new resources because there aren't other expectations yet on us officially from USDOJ, so now is the time to do that.

Secondly, involve everybody. We have, to the extent possible, crafted work groups that are system-wide. What I'm trying to avoid is only Metro is the hospital that's changing. We've got to change all the hospitals. And what I don't want to walk away with is four different systems. So what we've created is system-wide work groups in ten very specific areas, including restraint and seclusion reduction being a high priority with representatives from all the hospitals and leaders and coordinators being people who are established and know what they're doing and leaders in the system. They are the ones that are designing new program guides—the training materials, the manuals, the policies, doing the training—to the extent they can at the hospitals.

There are going to be some spots. One of the things I wanted to talk about was the fact that we are—our organizational philosophy is the recovery model. One of the big challenges for management, one of our responsibilities, is to create an organizational structure for the staff to do what they have to do. Sure, there's a lot of problems here, and certainly everybody shares responsibility. But management shares a special responsibility for this because it's our responsibility to create an environment and a structure where the people who are bought buying into the process can have the tools, the training, the knowledge, the ability to get the job done in the way we expect in terms of assessments and treatment planning and discharge planning and reduction in restraint and seclusion, and supporting the treatment teams in developing special strategies to go after the hard-to-take-care-of patients

who, by the way, end up in restraint and seclusion, who do the assaults. But that's where a lot of the change we're going to see.

The other part, though, the structure, the monitoring tools, and stuff like that, is not just to support the people who are supporters of this and are on board. It's to monitor the non-performance of people who may not be on board or who have not picked it up or basically saying, I don't buy into your structure and your philosophy. That's one of the real, one of the major changes. As I mentioned before, we had relied a lot on quality of care to be measured by licensing—JACHO and the medical staff—to monitor themselves. And while all of those three are very important measures and we'll continue to rely on them, we also have to create structures that are going to answer the questions of -- Have all the assessments been done on each and every patient within the timeframes prescribed? Has the treatment planning been done by the whole team? Does it incorporate all the measures that we expect in terms of not only the psychiatrists but also the team, other members—the psychologists, the social workers, the rehab therapists, the nurses?

You're going to probably hear some concerns, if you will, from psychiatrists. We're not in any way diminishing the importance of psychiatrists in this. But I'll tell you, we are raising the visibility and the importance of the other treatment. As Mrs. Lee indicated, a lot of what they found was that the other treatment team members' assessments and their contributions to diagnoses and their contributions to the treatment team were often not reflected in the treatment plan. That's not only a problem from the fact that we've got these people who got talents. But when you look at their specific talents in terms of the recovery model, that's the kind of stuff that can make the difference for success after discharge or wherever people go back, even if they're going back to CDC to live on the main line. You're talking about social rehabilitation here too. How do you live successfully after you leave the hospital? And it's just not a question of taking your drugs and following that discharge plan. We've got to give you those kind of tools.

Going back and answering your question is, we've got some concerns. We're still out there. We're still battling them. It's not going to go away. But I'm committed to making this happen, but I've got to provide tools. And part of our remediation plan

accounts for that, and part of my thinking in terms of what we're going to need in the future, resource wide, is also embodied in that.

SENATOR CHESBRO: Unless we create a really negative feeling that people can't change. A couple of optimistic thing. Just let me throw out—one was, my legislation last year on seclusion and restraints was based on the model in Pennsylvania where they demonstrated that through training you could dramatically reduce the amount and use of seclusion and restraints, and so people can change—that's one thing—and rise to the occasion.

Secondly, if you remember, my bill was endorsed by the organization representing many of the folks who will need to be trained and adopt new practices in order for legislation to succeed. So, you know, I throw out that change is hard, but change is also possible. So I think it's important before we leave the topic to acknowledge that.

DR. MAYBERG: You're absolutely right. And one of the things I think we don't talk about is this change isn't just the culture of the people providing the care. It's also changing the culture of the people who are going to receive the care. And part of that means educating and training and empowering our family members and our consumers to be able to have expectations of what the services should be like. So the training has to go to them just as much as it needs to go to our staff.

SENATOR CHESBRO: Let me just touch on this because it's not directly affected by these investigations. But it seems like, because you have a new facility or we have a new facility in Coalinga that there's an opportunity there to demonstrate some things because there's not the same amount of history and traditional ways of doing things. Do you want to comment on that briefly?

MR. RODRIGUEZ: Yes. In fact, that's exactly how it ought to happen. You know, I don't want to single out anybody in particular. But we need to also learn how to use our resources better. No big surprise to anybody here. Recruiting clinical staff is extremely difficult. Some of our most important staff are the most scarce. Psychiatrists are a good example. They're difficult to recruit. We need them; we've got to have them. And no way this recovery process is diminishing them in any way. But not only in Coalinga where, through their type of patient that they have, the SVP's which, as you know, is probably more of a behavioral problem than a psychiatric

problem, that's a natural for behavioral intervention, which is a natural for your non-psychiatric clinical staff, not that psychiatrists don't do behavioral interventions, but they don't have to do it all. Save your psychiatrists, some of the highest-level stuff that needs to be done, particularly when you can't get enough of them, when you're asking a lot from all your staff, and including your psychiatrists. Raise the stature and give more responsibility to your psychologists, to your psychiatric nurse practitioners. I'm not suggesting that we put anybody at risk. But the private sector has shown how you can do this. It's really a question of proper use of your resources. They're doing it at Coalinga because we're starting fresh.

If you want me to get into some of the remediation stuff, when you see some of the activities we're talking about in terms of positive behavioral support and behavioral consultation committees, and assessments that are specific to developmentally disabled or folks who in our hospitals who have developmental disabilities or cognitive problems, it's the psychologists that can take the lead in terms of looking at special interventions and making specific recommendations to the whole treatment team about how to deal with some of the unique problems of those individuals.

And as I've come to learn, it's those individuals that we really need to retarget our resources to. They're the ones that are going to be at the hospital longest; they're most treatment resistant and often have the biggest problems with violence and which we respond with restraint and seclusion. It's those folks, some of the special measures, that this remediation plan embodies and from which, unfortunately, there's going to be additional costs, in my judgment. But that's a natural for some of our other clinical staff, Senator.

SENATOR CHESBRO: Okay. Let me just conclude with the final question I had to ask you, which is, other information you believe is relevant to our understanding of the investigation and improve quality of care at the state hospitals that we may not have already plowed through.

MR. RODRIGUEZ: You gave me an opportunity on that. I got into that a little bit. I noticed that the recovery model places a special emphasis on helping the patients develop the successful living skills. And that's where the value of our other clinicians, the whole team working together, becomes important. And you gave me

that lead-in already, so thanks for that. But that continues to be one of my main points.

In one of the key features of the enhancement plan, in terms of retraining of staff in assessment and treatment planning, providing new tools to facilitate that, providing monitoring structures, it really gets back to that -- is how do we as a management team help the folks that want to make that happen, do it, and then be able to prove it to you, me, and USDOJ and all my bosses?

I think one of the things I want to take this opportunity to do is compliment most of the staff at the state hospitals. We're asking a lot of new stuff of them. We're asking them to look at things in a new way. We're asking for them to work harder, with not a whole lot of additional money and not any money recently. Most of them have risen to the challenge, and I'm proud of them. And whether I'm here or not, five years from now, when we're all done with this, we're going to be different hospitals in terms of the way we do business from the day a person enters the facility to the time they're discharged and every place in between. It's not that we're doing new things, like assessments or treatment planning. It's because we're doing it differently and better and we can prove it.

The other thing is, they do this in a situation with a very dangerous group of folks—and I think you guys appreciate this—is the LPS patients that come from the counties are now 520 out of 4,700. CDC and CYA—or CDCR—want more beds from us. We're going to continue to give them more. Those are very difficult patients. These are people who otherwise would be locked up in cells with my staff that look like you and me, unarmed, walking around in street clothes, managing them. I'm extremely impressed, and you see that all the time. MDO's, IST's, NGI's all need our help but SVP's, too. Those folks not too long ago were in prison, and the expectation of no violence continues, but it's not going to be always doable. But our enhancements, I think, are going to work on that too. But we're going to continue to see violence. I don't think that's going to be eliminated, but it's something I want everybody to keep in mind is, it's a tough line for us to walk, is to keep our integrity in terms of being a hospital but not lose control of the facility to the extent that, you know, public safety's put at risk or the safety of other individuals or staff are put at risk.

Here in Sacramento, it looks tough. It's got to be really a lot tougher down at the hospitals. Forensic patients continue to grow. You know this better than others. You've been involved in this. We got to continue to deal with an ever-growing population. Thank goodness Coalinga opened and they're accepting patients. We can't be thinking about today. Only we need to be continuing to plan four or five years down the line, and I've got staff now starting to look at what do we next if the patient growth in forensic categories continues like it has over the last few years.

As Coalinga's an interim answer, we've got to be ahead of the curve. And, Senator, you were involved from the very beginning. Coalinga took us from the day we were first talking about it, before it was Coalinga, till we opened seven years. So we've got to be working on that.

SENATOR CHESBRO: That's my entire tenure in the Senate.

MR. RODRIGUEZ: It's a good time for state hospitals, huh? Anyway, that was cool. We hope you come visit it one of these days.

SENATOR CHESBRO: I think we need to wind it up for purposes of time.

MR. RODRIGUEZ: Okay. I'm done now. Thank you for the opportunity.

SENATOR CHESBRO: Let me say that I'm going to insist to written responses to all the questions by the end of this week, and detailed responses, please. I thank you for your presentation, and I assume that—

MR. RODRIGUEZ: I'll be here.

SENATOR CHESBRO: --Mr. Rodriguez will stick around.

MR. RODRIGUEZ: I'll be here.

SENATOR CHESBRO: And as long as you can stay here, I'd appreciate it, Dr. Mayberg.

DR. MAYBERG: Thank you, Senator.

SENATOR CHESBRO: Sure.

And thank you again, Ms. Lee.

Let me ask Catherine Blakemore, Executive Director of Protection & Advocacy, to come forward.

We similarly submitted some specific questions that we ask PAI to...

MS. CATHERINE BLAKEMORE: We have copies of our testimony. Did you want us to hand it to you now, at the end? And there's a copy here, and it's missing Page 7 and 8, but we'll get you a corrected copy later on this afternoon. My apologies.

With me this afternoon is Michele Mudgett who is the Director of our Office of Patients' Rights, and she's here because she has staff that are onsite at each of the hospitals to answer any specific questions you might have from that perspective. I think, as you know, we provide services to residents of the state hospitals in three different ways: through our regional legal offices, through our Office of Patients' Rights, which we have a contract with the Department of Mental Health to provide, and through our Peer Self-Advocacy Unit that conduct weekly self-advocacy groups at a number of the state hospitals; and Amy Breckenridge is on the next panel and will be talking more specifically about that work.

I do thank you for the opportunity to talk with you today about our concerns. I thought I might make some introductory remarks, if that was okay?

The federal Department of Justice...

SENATOR CHESBRO: I should say briefly, because we're already running behind...

MS. BLAKEMORE: I will be brief; and when I'm too long, you just tell me and you can go to whatever questions.

The Department of Justice confirms our experience at the state hospitals. At the most basic level, the hospitals far too often fail to treat and protect the residents. The issues identified in the reports are the same issues that we see every day when we are at the hospitals, and they remain, in spite of the Department of Justice findings.

Those problems include misdiagnosis, overmedication, lack of treatment planning, poly-pharmacy, aversive behavioral therapy, inappropriate use of restraint and seclusion, no discharge planning; and for children and youth, the failure to educate and prepare them for life in a non-institutional setting.

We are pleased that the Department of Mental Health has put into place a framework for reform, and it has positive elements. But sadly, we've seen little progress or change in the lives of the residents. This is particularly troubling to us because at some hospitals DMH has had two years to correct the problems. In our

experience, we have not met a single resident who could not be better treated with intensive, individualized services in the community.

In addition to the questions that you have asked us to respond to, we think two other questions are warranted and would ask you to give consideration to those. First, whether the state hospital system can truly be fixed and whether recovery can fully occur within a state hospital setting; and second, whether it would be more prudent to use resources and better fulfill the mandates of state and federal law to close the state institutions and devote the resources to programs such as those that are being developed as part of the Mental Health Services Act. To ignore the notion that people can live in communities and to only focus instead on how we fix state hospitals, we think at best, only gives you half of the picture.

However, as state hospitals continue to be part of our mental health system, we have several recommendations for you. First, that there be greater transparency about what's going on. That doesn't just mean to us that the Department of Justice is welcome into the hospitals when they want to visit the hospitals but that also information must be available to all of us who care about what happens to people who live in the hospitals. That means specific information about what is the department proposing with the Department of Justice in terms of a negotiation. Those are closed-door meetings that none of us have access to. We know nothing about what is being proposed. Once there have been findings and agreements with the Department of Justice, reports must be provided to all of us that do work in this area so that we can adequately monitor the progress. There has to be increased oversight by the Legislature. We obviously think this is a very important first step, but it has to be done on an ongoing basis to make sure that there is real reform. And finally, we believe there has to be an increased role and presence of advocates at the state hospitals.

I can continue with more specific recommendations and findings, or we can just go to your questions, whatever...

SENATOR CHESBRO: Well, you'll be submitting the specific recommendations and findings to the—and I hope our questions are not too far a field in terms of—

MS. BLAKEMORE: They are not.

SENATOR CHESBRO: --giving you the chance to touch on what your recommendation and findings are.

MS. BLAKEMORE: Okay. I think one of the things that I want to just first start by saying, as I go into the recommendations, is that we are pleased that the department is focused on the wellness and recovery model. But our principal concern is that that policy has not been adequately or consistently implemented, and we worry that it's just a paper change and not a change in clinical practice. And one of the best ways I can point that out is giving you just some brief experiences of some of our clients that are there because that's really who we all care most about.

There are three clients, beginning in February 2004 at Metro—so after the Department of Justice have been there, who have killed themselves while they are at Metropolitan; someone in 2004; in May of this year, a young woman was found hanging from a light fixture; and last week, we received an unconfirmed report of another suicide of a female resident on the same unit at Metro. Those are very troubling and consistent with what the Department of Justice found.

At Napa, we worked with a patient who has a disorder of the pancreas. When he went to the local hospital for treatment, he was told that one of his psychiatric medications might be a strong factor in his disease. He asked to be removed from that medication. The psychiatrist ignored that information and put him back on the same psychiatric medication, and he was hospitalized again with additional symptoms of pancreas disease. Again, the medication was discontinued. Finally, and fortunately for our client, a staff member spoke up and the doctor was taken off of his case.

In a third instance, a Vietnamese-speaking client on a conservatorship at Metropolitan was provided treatment on a treatment mall, but no one on that mall spoke his primary language nor were translators provided. He became very bored, not surprisingly, and he did not want to attend, causing his social worker to conclude that he wasn't ready for discharge.

SENATOR CHESBRO: Had anyone tried to speak with him—

MS. BLAKEMORE: Not while he was receiving...

SENATOR CHESBRO: --to figure out if there was a language barrier?

MS. BLAKEMORE: Well, that was the issue that we were involved in, and we certainly raised the concern that he needed to have his services provided in a language

that he understood. We ultimately worked with him to get him discharged. He's not the only client for whom that has been the experience.

SENATOR CHESBRO: That's the difference between just going down a checklist or actually having a cultural change that says it's my responsibility to help solve a problem and that person, or persons, whoever was involved, probably didn't think that they were doing anything other than what was expected of them in terms of following procedures. But obviously there was a problem.

MS. BLAKEMORE: Right. And it requires sometimes thinking outside the box to solve the problem.

Finally, I'll just bring to your attention a young man who was admitted to Metro in October 2004 at age 14. His treatment plan listed his discharge criteria as 90 days of no assaults, no self-injuries, behaviors, no AWOL attempts. And until this criteria are met, there would be no discharge meetings. However, he was never referred to the positive behavior support team to help him dealing with the behavior. So a criteria, in other words, was set up that he had to meet. But the additional behavioral supports that is on the department's plan were never provided to him, thus really setting him up for failure, because, if he didn't have the support, how would he ever meet these kinds of discharge criteria?

So I think these examples—and we have appended a number of other ones, of examples to our testimony, point out that a cultural change that needs to happen, and the paper planning that the department has done has not yet become a reality. And it's really time is wasting for many of the people that are here.

We also wanted to point out to you the barriers that exist to our thinking to the reforms. There's no clear accountability for failures in treatment in care. Someone has to say, "This is my job; it stops with me", and has to make sure that the plans are implemented, and it can't just be the hospital director. It has to be at all levels in the state hospitals.

We think that there's an insufficient commitment to staff training. I was actually struck by hearing that the department is supportive of training, which is a very good thing. However, one of our investigations team members has been recently been doing a monitoring at the state hospitals on seclusion and restraint and noted that the seclusion and restraint training manual that we were provided hasn't been

updated since 1991, so that's fairly shocking if we're emphasizing training and we're trying to make a cultural change about how seclusion and restraint is used.

We also think there are a lack of people with psychiatric...

SENATOR CHESBRO: By the way, let me indicate to you that I'm holding a hearing next week on the progress, or a lack of progress, on the implementation of my seclusion and restraints legislation of last year.

MS. BLAKEMORE: We are certainly pleased about that and will have some additional information for you.

SENATOR CHESBRO: So there's at least a week left before an answer to that question needs to be provided.

MS. BLAKEMORE: Okay. We also think a fundamental problem is the lack of presence of people with psychiatric and other disabilities in leadership management, and line staff at state hospitals, that it's very hard to envision people with psychiatric disabilities in a different way, other than a person who's hostile and violent in causing a problem, unless you see people who have other experiences and are contributing to the treatment, and we would urge the hospitals to give serious consideration to employing people at all levels of their organization with disabilities and particularly psychiatric disabilities.

We're also concerned that there exists a pervasive attitude by current staff and an environment that prevents residents from having a true voice about their daily living and their life goals. An example is that an individual is given medication in the morning that might make him feel sleepy. The individual prefers to take the medication at night. This is seen as the resident being resistant to taking medication, and it's presented to the courts as proof of the resident's noncompliance as opposed to an opportunity to engage that individual in their own treatment and to help the individual learn to make decisions about their life and to have those decisions respected.

I want to just identify our recommendations, recommendations concerning the Metropolitan's children unit. They are very serious problems at the Metropolitan Children's Unit. It's been a "short-lived" unit for eight years. But during the time of its existence, we have not seen changes at Metropolitan for the children. We've appended in our report a copy of the special masters' report from the *Katie A.* case

that summarizes his findings at Metro for the children's unit, and they are very troubling. We think fundamentally that the Metro Children's Unit should be closed within 18 months. We cannot see any reason why children who have access to EPSDT services, special education services, and a variety of other entitlements cannot be served adequately in their communities. We would also put in place an ongoing oversight mechanism to ensure that children who would have otherwise been placed at Metropolitan receive appropriate services.

We talked briefly earlier about transparency and outcomes. We really believe that DMH should be required to publicly report data on its website monthly regarding a number of measures. They have done that for seclusion and restraint, and we think it is very helpful to have public accountability of that data. But we also should look at the numbers of deaths that have occurred at each hospital, the number of injuries that have occurred to patients at each hospital. We should have information about people's discharge, how long they have lived there. All of that creates a more transparent system so that we can collectively provide oversight and monitor the progress the department is making and implementing the Department of Justice findings.

The department has recently posted injuries to employees related to the use of restraint and seclusion on its website but interestingly has not reported injuries that occur to patients on the website, and we're puzzled by that, and we think that would be a fundamental change. We know of at least two deaths that occurred while people have been restrained since January 2004.

Insofar as DMH assesses the pace and quality of its reform, this information should be reported to the Legislature on a quarterly basis and again be reported on the website.

In terms of oversight, we believe that the Legislature should commission an independent panel of experts to assess whether patient care has improved at the state hospitals. Fundamentally, the thing we should care most about is how people are treated while they're living at state hospitals and ensure that they're getting the kinds of services that they need. And we think outside, independent oversight is something that will help move us in that direction more quickly.

Finally, we think there needs to be an increased role and presence of advocates that will allow advocates to have onsite monitoring of practices, such as the use of seclusion and restraint, training to staff, about patients' rights and development of corrective action plans following a finding regarding a patients' rights violation. Thank you.

SENATOR CHESBRO: Let me focus in on some of the specific questions that we had asked you to answer.

What barriers does the Office of Patients' Rights face in meeting the advocacy needs of state hospital patients, and what actions would you propose to address through those barriers? And you probably mentioned some of those in your list of recommendations. But what could we be looking to in the Legislature in terms of overseeing the department to try to improve or increase that?

MS. BLAKEMORE: I think that the fundamental problem is that the number of complaints that are now handled by our Office of Patients' Rights has nearly doubled since its inception.

SENATOR CHESBRO: Is that a function of increase in complaints, or is it a change in the ratio between the number of people you have and the number of patients?

MS. BLAKEMORE: That's a function of a number of things. One, we have fewer staff. Second, there are more complaints, and it has some to do with the changing nature of who happens to live at the state hospitals. So last year, there were 7,000 complaints that were handled by the Office of Patients' Rights. And what happens when there's such a large number of complaints is that you lose your ability to be more proactive, to provide staff training, to do the kind of follow up that you would otherwise would do, because there's very specific statutory timelines around investigating those complaints.

SENATOR CHESBRO: So is that problem pretty consistent throughout the system, or it greater at some hospitals than at others?

MS. BLAKEMORE: I'll let Michelle respond, but I believe it to be consistent throughout the hospitals.

MS. MICHELE MUDGETT: That's correct. It is throughout the four state hospitals.

SENATOR CHESBRO: With regards to the relationship with the Department of Mental Health, are there firewall protections between the department, as a contracting agent, and PAI, as the contractor, sufficient to ensure that OPR is independent in carrying out your duties?

MS. BLAKEMORE: There are. Yes. There are certainly firewalls between Protection & Advocacy and OPR. I think that both ensures that OPR remains independent. I think it also addresses the department's concern that OPR might provide PAI with information that would then lead to litigation. So I think the firewall kind of cuts that other way as well, but we are very diligent in honoring that firewall.

SENATOR CHESBRO: Well, I certainly never noticed PAI to be shy or unwilling to step forward in a critical way.

MS. BLAKEMORE: That's true.

SENATOR CHESBRO: I mean that's a compliment.

MS. BLAKEMORE: Thank you.

SENATOR CHESBRO: What outcomes would you look for following implementation of a remediation plan? And I guess more importantly, in terms of accountability, how can those outcomes best be measured?

MS. BLAKEMORE: I think some of the things that I referred to in my testimony is that measuring the outcomes means we all first have to have agreement on what the outcomes are. I think the department has started well with sort of identifying more of a recovery-based model. But the specifics of what's going to be required by the Department of Justice should be shared in part with everyone who is part of this larger system before all the I's are dotted and the T's are crossed.

It also requires, I believe, that as part of the oversight and accountability, that everyone have access to the data about how the reforms are going. You can't simply look at the data behind closed doors and trust that we're all going to believe that there's the kinds of reforms that are needed.

SENATOR CHESBRO: So you're referring to the proposed settlement in terms of what ought to be transparent and available?

MS. BLAKEMORE: I certainly think that that's a piece of it. I think there's two things going on. There's both the settlement that the department has talked about today of entering into, and I think there needs to be much more transparency around

that. In addition, the department has put into place a number of reforms, and that's good that they're doing that. But we get very little data, nor is data published anywhere from the department, about how well they're implementing the reforms that they already put in place. So what we have is our individual experiences from our clients that suggests that those reforms are really not happening at a client level. If there's other data that suggests otherwise, an accountable system would say, Let us show you the data about the kinds of progress that we are being made, both on an individual and on a more systemic basis.

SENATOR CHESBRO: Is Dr. Mayberg still here, available to respond to this comment? Maybe Mr. Rodriguez, I can ask you to come forward, the issue being measurable outcomes and how we can assure that there's feedback mechanisms to know that we're, in fact, making the progress that we would hope would be made.

MR. RODRIGUEZ: Well, that is part of the remediation plan which I presume is public after it's agreed to by everybody. And certainly, I think there is some—people should be reassured that USDOJ is half of the equation here with the state. But significant monitoring activities, reports, information, the support at a systemic level, and an individual patient level that we're achieving, what we're supposed to be achieving, obviously, those reports aren't being produced right now, sir. But those are the kinds of things that are going to be developed, not only as a tool for the staff but as a reporting mechanism—keep me informed, the executive directors informed, USDOJ informed. And to the extent we're talking generic information as opposed to patient specific information with names and stuff like that, I presume that that's the kind of stuff that we're going to be talking about, what kind of information is the Legislature going to want, what others want to see what's going on, thinking that that would be a discussion we would be having with you and others in the coming months. I figure, after we get the remediation plan done, then it's -- So how do you tease out information that would be useful to outsiders and in some sort of readable, summary-level way and made available either reports to the Legislature or on the web page or upon request? I haven't quite gotten down the road to defining all that and what it's going to be. But I can see it coming. And certainly, we're not going have a big objection as to providing otherwise public information.

SENATOR CHESBRO: Well, of course, feedback mechanisms demonstrate to the Department of Justice what progress is being made are very important, I think, for the sake of their clients, their advocates, and certainly the Legislature, having those mechanisms be accessible and available as well too because obviously we're holding this hearing and have the Legislature through the budget process and the Select Committee process and the policy committee process have a responsibility to make sure that in fact the department is not only adhering to legal requirements but also improving the system for the patients.

MR. RODRIGUEZ: I don't have a lot of specificity yet, but I know it's something we'll be working with you all on.

SENATOR CHESBRO: *Working with* is the critical term. So we'd like very much, along with PAI, to be at the table with you monitoring, finding out what those mechanisms are going to be, and then using them to monitor how the progress is being made.

MR. RODRIGUEZ: I give Catherine everything she wants.

MS. BLAKEMORE: I will remember that. It's now on record. Thank you so much. (Laughter)

MR. RODRIGUEZ: I thought I said I already had. I didn't say in the future.

MS. BLAKEMORE: _____ continuing.

MR. RODRIGUEZ: Oh, good. I'm glad you acknowledge that.

SENATOR CHESBRO: I think we nailed it. Okay. Well, I appreciate your testimony, and we're going to proceed with the agenda.

MS. BLAKEMORE: Thank you.

SENATOR CHESBRO: Thank you. (Applause)

I have Kathryn Trevino of the California Network of Mental Health Clients and Amy Breckenridge of Peer Self-Advocacy program for Protection & Advocacy. I'll ask you both to come forward and to point out, it's so easy to think of this system as, and the stories we hear—the suicides, the assaults, the other things—as mere numbers. These are human beings with illness and who are our responsibility. And I think it's the Network motto, *Nothing about us without us.* So I think your participation here today is very, very important.

So Ms. Trevino, you want to—is it Trevino or Treviño?

MS. KATHRYN TREVINO: It's either way.

SENATOR CHESBRO: Okay. My sister-in-law's name is Treviño. She sensitized me to the question. Thank you for being here.

MS. TREVINO: I'd like to read what I wrote, my testimony for you.

SENATOR CHESBRO: Yes. Please.

MS. TREVINO: As a member of the Napa State Hospital Advisory Board, I work to represent the client voice. I believe that I bring a unique perspective with a master's level of education, nearly four years of direct practice which included a year as Quality Improvement Committee member with Sacramento County, over eight years as the administrator of the California Network of Mental Health Clients, and nearly four years as a resident of a state hospital under the care of the California State Department of Mental Health.

As a member of the board, I have been attending client council meetings since March 2004 to learn the needs of hospital residents. Since I do not have the complete information, I do not know if the Justice Department is reflective of what I know. However, I want to testify to the problems that I've experienced.

As a member of the Napa State Hospital Advisory Board, information provided by the Administration is that the practice of restraint and seclusion are significantly down. As an attendee of the client council, some issues brought up are reflective of the report. For instance, council members have pointed out the oxymoron between the hospital administration boasting of implementing the recovery model when hospital staff humiliate and dehumanize them with hostile behaviors. Council members have consistently informed hospital administration about the staff on the T-11 ward—antagonizing, threatening, and punishing clients.

The administration's first response was that abusive staff provides lessons for hospital clients on dealing with people like this on the outside. The second response to justify this behavior was to ask members to see it like a family. Some are good and some are not.

At the last council meeting, members were told that it will take a year for the hospital to train staff, to stop the abuse, with 15 more lesson-modules to go. In response, one member said, I could be dead by then. I had written to the

administration to adopt a zero tolerance for staff abusing clients, yet I have not heard back from the administration and the complaints continue.

At another council meeting, an elderly woman burst out in tears saying she could no longer bear seeing men shackled to chairs in the hallway with bags on their heads. When I asked the hospital director about this, his response was that it was not a bag. I was told that it was a spit guard to cover the mouth. I saw the apparatus the other week, and it was a bag, that I would be humiliated with.

As the administrator to the California Network of Mental Health clients, I often receive calls from hospital clients and family members. The major complaints I receive from family members is overmedication of their loved one and lack of response from hospital administration to their concerns. I attended a meeting with a family member, the client's psychiatrist, and other hospital administration. This psychiatrist was obnoxious in non-verbal responses to the family member, yet no one in the meeting would stop her abusive behavior. When I became so distracted with the doctor's behavior, I was compelled to point out that her demeanor was particularly uncomfortable for me. The doctor stopped crossing her arms, throwing her head back, and rolling her eyes. She took herself off the client's case, and the other staff addressed the issues being brought up by the family member.

The major complaint I receive from hospital clients is their need for advocacy and their fear of being discharged without a plan. As I see it, the state hospital has not changed in over 30 years, with a primary focus to observe predicted control, the behavior of hospital clients. On an unannounced visit to a ward, what I saw was strikingly familiar. There were many men standing idle against the wall of long hallways with a locked-nurse station between them.

The hospital infrastructure needs to change from the basic facilities to the methods of treatment. The entrenched medical model of observed (?) clashes fundamentally with the social rehabilitation model which is a vital part of the recovery model to choose, get, and keep.

I was 19 years old in February 1971 when a state hospital staff person dropped me off on the corner of 16th and J Streets in Sacramento. There were no community mental health supports available. I was de-institutionalized and left on the street with no means or inkling on how to survive. With the passage of the Mental Health

Services Act, there is a promise of comprehensive, holistic community mental health services. Although it is too late for me, there is a whole new group of state hospital clients that need to prepare for the new mental health community system. We cannot leave the people at the state hospital behind. The transformation occurring in the communities needs to occur in the state hospitals. This transformation can be expedited by bringing consumer groups that practice the recovery model inside the hospital to train residents and staff.

Finally, again, there needs to be a zero tolerance for staff abuse of clients. And there is a need for more advocates at the hospital.

SENATOR CHESBRO: Okay. I thank you very much for your testimony. It's much appreciated.

Next, I'd like to call on Amy Breckenridge who's (applause), as I indicated, with Protection & Advocacy, Peer Self-Advocacy Program.

MS. AMY BRECKENRIDGE: Thank you, Senator Chesbro, for allowing me to testify today.

SENATOR CHESBRO: Can you pull the mike a little bit closer? Yes. That would help.

MS. BRECKENRIDGE: The Peer and Self-Advocacy Unit is a group of former mental health clients who facilitate self-help and self-advocacy groups inside locked facilities and in the communities. The groups teach people about their rights encourage people to strategize together, and provide an atmosphere of safety and trust inside a facility where clients are able to talk freely and strategize how to cope with the problems they encounter.

In thinking about your question of recovery, recovery is defined in the American College Dictionary as returning...

SENATOR CHESBRO: I was hoping somebody would give a definition of recovery.

MS. BRECKENRIDGE: ...as returning to a normal condition or regaining a normal state. Some examples: I've had pneumonia, but now I've recovered. I gambled every day, but now I don't do that. I was feeling depressed, but I'm feeling better now. I overspent on my credit cards. I felt terrible about the effects of the debt on my family and ashamed of myself, but I'm over it. I've recovered.

Recovery, I believe, is an inner process, and it's not a model that can be imposed from the outside. Recovery can be encouraged, however, through understanding and compassionate attitude and an acknowledgement of a person's changing condition and a process that supports that change and discussion with that individual about what has helped the change and what doesn't.

I'd like you to consider the following. You are in a hospital. You are told by your treatment staff, *I don't care what you do. You're never going to get out of here. And even if you do, you're not going to make it. You'll never succeed. If you don't come into my office right now, I'm going to shoot you so full of medication that you're going to crawl down the hallway. You yelled at your roommate, even though he stole from you. That just shows that you're not ready for discharge.*

I often think that Napa residents have to become monks or saints before they're considered for discharge. When an individual comes to Napa on a forensic commitment, they lose their individuality immediately. They're given khaki clothing, and they're all considered in the same lot—dangerous, mentally ill, and criminal.

A former Napa forensic client told me when she was there that the staff had little understanding of mental illness and did not believe that she would ever be anything other than sick, incoherent, immobilized on large doses of medication, and non-communicative. The staff members, she said, were surprised when she recovered. They were surprised when she explained she had always been a good person, a devoted wife, good employee, and, yet, one day, she started feeling strange and really couldn't explain what was happening to her. Her community physician had no answer for her; and finally, she ended up at Napa. Now she's out and she works in the community and is leading a very successful life.

It is, however, a lot harder to get out of the state hospitals now than it was when she was there. When a person is committed as an NGI, not guilty by reason of insanity, that commitment can be extended indefinitely. There's not enough space in the conditional release program, and people spend years working their way from unit, one unit to another, to eventually get to an open unit. Residents say that they have to keep jumping through hoops, repeating programs, or else there are not programs specific to what the courts are requiring for them to be discharged.

To me, people seem to have reached a significant level of recovery. They are articulate, able to be honest with themselves. They deeply desire to be back in the community, making a life for themselves, and hope to grow in that life. They want to be able to work, be with their families, see a play, enjoy life. But as the years dribble away, people do begin to lose hope. They worry that the hospital stay will count against them in the community, and they begin to believe that they'll never get out.

As Kathy mentioned, it is difficult to talk to your psychiatrist or your social worker when you know that any statement can and will be held against you. It can't be considered therapeutic when you are afraid of the individuals that are providing you with treatment, where every act and thought is looked at for its potential for dangerousness. It is difficult to talk to a doctor or to a nurse about your symptoms when they tell you that the symptoms are all in your head. It's difficult to watch your (?) appear who's vomited in front of the nurse's station and then who is told then to go back to bed and who dies a few hours later. It is difficult to trust a system that withholds the knowledge of a medical condition that you have for a few years, when it is too late to get effective treatment for that condition.

And lastly, it is horrifying to have spent a year in the conditional release program, feeling that you have been successful, you've worked, you're getting ready to go to court, you're hoping to be released. A couple of weeks before your trial, you're given a new medication inexplicably. You feel foggy, you feel uncertain, not yourself. The court decides you need to be hospitalized again because you're not stable on your medication. You feel victimized, you feel that a crime has been committed against you, and you start seeking legal remedies because the system that says its helping is actually harming you.

If you want to institute a recovery model, I think you need to institute a change of culture among the staff. I would call it a staff recovery model. (Laughter) And I know it's humorous in a way, but I think that the medical model has existed in mental health treatment for many years with psychiatrists at the top of the totem pole. This model has proved ineffective in most settings. Even good staff members have found it difficult to advocate for their clients, their voices also going unheard, because the pronouncements of the doctors topped the list, and sometimes residents say -- clients

say -- that they only see their psychiatrist for maybe five minutes at a time in a hallway and don't receive individualized attention.

I think you need a professional staff that truly understands symptoms of mental illness but also can weigh the individual character along with the illness. You need a staff that can be real, be encouraging, supportive, and give hope about your chances for living a full life. I heard recently from one client that the staff members on his unit are actively discouraged from talking to them, to him, to the patients. You need a staff that fosters independence and self-responsibility. You need to model more of the behavior you want to see from your clients, and you also need to foster more of a collaboration among staff and clients that can begin to break down the "us-and-them" mentality that exists on both sides of the current equation.

I'd say, yes, many clients concur with the Department of Justice report. Many clients have written to the Department of Justice because one of the department's functions is to protect the civil rights of institutionalized persons. The cries for help within the institution have gone unheard. And when you can't get help from the helpers, you feel like you have nowhere to go.

SENATOR CHESBRO: Okay. I thank you very much for your testimony. (Applause)

We will call the next panel up, and I'm going to take a two-minute chairman's break while June Forbes, the current support group, Ann Williams, who's a parent, and Karen Henry of National Alliance for the Mentally Ill come forward.

Thank you for being here. It's good to see you.

MS. KAREN HENRY: Good afternoon. My name is Karen Henry. I'm from NAMI California representing its more than 70 affiliates, more than 16,000 members, and which consists of consumers as well as family members. As an attorney, I chair a Government Affairs Committee, as an individual, as bipolar, I chair our Consumer Participation Committee.

Anyone who read that report would have to read it three times to make sure you're actually seeing what your eyes are seeing.

SENATOR CHESBRO: That's exactly the feeling I had as I read through it.

MS. HENRY: I almost did it once again today but I stopped. We have a large number of -- many members that -- are among the sickest of those of mental illness,

which means that some of them are in these state hospitals, and their family members have to go through the distress and that staying up all night because you don't know whether the child's even safe.

No patient should be subjected to this. No family member should be subjected to having to have their child be in that condition. We all can agree that corrective measures have to be taken. But we probably disagree on some of the measures it will take to do that. When we look at it—and I realize the prior speakers went through a series of specific measures, suggestions, issues as far as what they thought caused the problem—but I'm going to look at it more generically from the standpoint of two things.

It's going to take money. It's going to take lots of money. And part of the reason it's going to take money is because we don't have sufficient staff. If we don't have sufficient staff, some of the other requirements are difficult to meet. So when we look at it, we say, okay. If we're really serious about correcting the situation with these hospitals and providing the kind of care that people are entitled to, then we have got to look at the appropriations issue and the governor rather than additional legislation.

And to give an example on that is restraint, seclusion and restraint that you passed last year, which is a great step forward. But it's difficult sometimes to implement things that can be implemented if you don't even have enough staff on the unit to know what's happening. So primarily, number one, there's got to be money.

I went down—well, actually just looked on the internet. And part of the staffing problem is an inability to recruit. Now if you look at salary for an RN at Kaiser, brand new RN can be there, versus Napa, their vacancies, versus Napa, there's more than $28,000-a-year difference in those salaries, on top of which in the private sector, they get 10 percent (?), 50 percent, so on. I represented hospitals about 25 years, so some of this stuff is coming back to me. But there's a major problem there. How do you recruit registered nurses of the quality we need with that kind of a difference?

Psychiatrists. Somebody mentioned to me that they thought you made more in Corrections than you made at Napa. I looked at it, and it's true—about $8,000-a-year difference. And in Corrections, you at least have correctional officers who are able to ensure the safety, not only the staff but of other individuals. And we don't really have

that at Napa and its pretty when we read that report that safety and security of patients; it's just a very bad situation.

Unless we do get adequate staffing, when we talk about treatment teams, that assumes you've got people to put together a treatment team who have the capacity to not only develop the plan but to implement the plan. And there are major—by which nursing plans are implemented—excuse me—if the plan fails, it can be measured as to whether or not it's effective or not effective. We do that for other medical conditions, and they've specifically put forward not only the plan but who's going to do what portion of the plan. And that plan is under the supervision of the physician, even though he or she doesn't provide most of the care. But that needs to happen, and you have to have staff to do it.

A lot of mandatory overtime is going on here. So you're staff -- maybe full time. And then they're expected to pull a 12-hour shift on top of that or to work a seventh day, and those are circumstances that are difficult to function in anyway. But to not be able to have the sufficiency so we don't put the burden on every staff member.

Training is what somebody else mentioned, I put down here. To read that and to think that any staff member would allow that to go on and not report it and not do something about it, there is a problem here. Part of its training, part of it's going through the policies and procedures that they're supposed to follow. But part of it is that very-close-to-intentional action is going on. So in addition to the money for the staff, we believe we also have to have enforcement of existing laws and regulations. We've got the stuff there in seclusion and restraints; we've got it there in terms of quality of care in (?), to JAHCO, Medicare, and so on, but they're not being followed.

If a person is being overmedicated, a registered nurse, physician, and so on would be able to observe that if that's going on. But even when it's observed, there's nothing happening. There's no follow up to that person. When you find a patient that was left in the bed in their own increment, somebody had to observe them being found there. Well, why didn't that somebody follow up with correction and disciplinary action on that individual? Because it's not just a question of everything, as far as the physician's staff. It's also a question, as I said, of the policies and procedures that you have now.

When I hear somebody say, as was said—Mr. Rodriguez—but you have to change the culture. Well, if you just try to use training to change the culture and you don't actually enforce the expectations and requirements of staff, you will not have accomplished what needs to be done. We've got to be just straightforward about it. This is the way it's going to be; these are the expectations. And if you don't want to follow them, then bing, bing, bing—this is what's going to happen—so we don't have the kind of staff taking care of people.

The last thing I want to say is, the recovery model, there is no way that somebody cannot be committed to that because that's the way people start to move along the road and eventually get clear at the top, or three-quarters to the top, but in a situation in which they feel comfortable and if they're accomplishing something. But I don't see how, without the staff, and without the commitment and expectations, we're going to get very far, other than on paper. We can have policies; we're committed to it, and we've got these treating malls, and we've got all this stuff going. But what is the measurable outcome? The measurable outcome, how many of these patients are able to move beyond the facility, have discharge planning, have some social skills and programs started while in the facility so that they can go out and move into another setting and feel comfortable with it?

Thank you for your time and for putting together the hearing on this issue.

SENATOR CHESBRO: I appreciate your comments. Thanks for being here.

Let me next turn to June Forbes who's with the Napa Hospital Parent Support Group. Thank you for being here.

MS. JUNE FORBES: My name is June Forbes. My son has been a patient at Napa State Hospital for over a year. And although this isn't part of what I planned to say to you today, comments have been made about the dangerousness of patients at the state hospital, and I just feel compelled to respond to them to remind you that in many, many cases, the people that we assumed to be dangerous, just because they think that a hospital is no different from the criminal justice system, are not. And in many cases, they are the very same people who once came to the hospital through the LPS system because, where they were committed, because of their utter helplessness in the outside world. They're back now, accused or convicted of crimes but often because the community failed to help them in time because they made mistakes they

would not have made with more timely, more intensive community care, and they just felt the stigma against those dangerous patients, different patients than we used to have, was overwhelming and not really justified.

SENATOR CHESBRO: I appreciate your comments.

MS. FORBES: Thank you.

My son has been a patient at Napa State Hospital for over a year, and I attend a monthly support group for patients' families there, and we know that terrible things do happen at the hospital, and there are real problems there, as there are problems at any institution that has been starved of operating money for decades, if not for a century. The violence and abuses do happen. Seclusion and restraints are still used, and we grieve about them.

But we also conclude from our monthly meetings with senior and frontline staff that more cultural change is needed. The senior administrators and many of the staff at all levels are doing their utmost to follow best practices in care giving. A lot of them understand what works and what doesn't and what would constitute best practices in a humane, public mental health system and their challenge is to improve, despite a very serious staff shortage at the hospital.

That's why we take California Director of Mental Health, Steve Mayberg's point, when he says, "We...thought we were being cooperative...[but] these interview and site investigations are very time-consuming, and we thought that limited resources really should be spent on patient care and changing our system..."

I dread that people who do direct-patient care will spend even more time on paperwork because of this investigation and have less to spend with our family members.

New patients' families bring up the evidence of the staff shortage at our meetings every single month. The hospital assures us that we're valued members of our families' treatment teams. But even when we have important information for them, the doctors and nurses and social workers don't have time to take our phone calls or to call us back when we leave messages.

And when the patients we know have questions and concerns, they're told to tell your treatment team, tell your social worker. But our relatives tell us, "I can't talk to

them. They're too busy. Treatment team meetings are intimidating. I can't remember what I want to say then".

Patients we know have gone months without seeing a psychologist because there isn't one available. The psych techs and the nurses we depend on to guide our relatives and keep them safe are either exhausted from working overtime, or they're temporary employees—the temps who float from unit to unit, not assigned to one place long enough to develop good judgment about individual patients there or current circumstances there.

The patients we know who have improved, who are progressing through the required steps towards discharge, are stymied and held back because there isn't enough staff to operate a unit at the level they're required to succeed at next, and the patients we know need things to do, too.

Classes about the criminal justice system and group therapy for anger management and the like are all really well and good, but the attractive activities the hospital is justly proud of—the art and the music and the sports and the education and the work—are only available to the very few patients whose brain function has improved enough to permit minimal supervision—the very few who are on the experimental, new model of mall treatment, and they are not available to any one patient for more than a few hours on weekdays, and not even then during the quarterly (?) weeks when no patient activities are scheduled, and the rest of the weekdays and every evening and weekend are empty without anything to distract the people we love from the mischief and even the violence that inevitably spring from broken brains crowded together in idleness and captivity.

These conditions exist because the hospital is understaffed. And I know I'm talking money, and California doesn't have money, but California has an obligation to the helpless people in its charge, too. We're understaffed, and the staff we have are undertrained. And we're understaffed for two reasons.

First, the hospital's salary and incentive structure fails to attract and retain enough good people. People leave for better pay in places with a lower cost of living than the Napa Valley, and their positions stand vacant for months. And the people who stay are working forced overtime and double shifts. And competent, dedicated,

seasoned people refuse promotions to supervisory positions where they're desperately needed because unit supervisors make less money for more responsibility.

Second, the hospital hasn't authorized enough staff to provide adequate coverage, something that vacancy rates doesn't show. Caseloads are too large. The overtime required to provide coverage at this staffing level burns people out. Coverage for employees' sick and vacation and training time is totally inadequate. Week day, day shifts—when the doctors and the social workers are on the job are only 45 of the 168 hours in a week—the nights, the weekends, the holidays, the quarterly tip weeks, the majority of the time people spend in the hospital—are when we're most likely to see unseasoned staff in charge of unstabilized patients.

And even when the doctors and social workers are on the job, they have less and less time to spend with the patients, people who need attention, because the staff is kept so busy filling out forms for reviews and audits and this latest federal investigation, as well as recognizing and implement -- reorganizing to implement -- successive new models of care that advocates demand. And the staff is under-trained for two reasons: Coverage is so thin, that people can't be relieved from patient care to go attend a training session. Turnover is so high, that seasoned staff has little opportunity to train new people by mentoring them, so we need your help.

We need you to authorize the budget it will take and to write whatever enabling legislation it will take to accomplish four things. First, just to identify and correct the little environmental hazards to people's safety, like the unsafe grab bars and the door closures and the window bars. And second, procure the technologies we need, like the computers and the drug detection machines and the drug-sniffing dogs. And third, develop an adequate staff training system that will increase coverage so that staff can be relieved of patient care long enough to go get trained so that when a performance review should uncover that somebody doesn't belong here, we dare let that position be vacant so we can replace them, to allow for seeking out some cutting edge treatment techniques and hiring consultants to teach them to the hospital staff. And finally and most important, rationalize the hospitals' employee compensation system so that it will attract and retain good people.

The California Department of Personnel Administration and the State Personnel Board must be authorized to create a package of salaries and benefits and creative

incentives and negotiate their implementation with all five employee unions. Cultural change isn't going to happen until we have people, trained people, good people, and that's what will get them here.

We need to develop incentives to deliver more licensed staff to the hospital, incentives like paying off their student loans, increasing the number of stipends we pay to community college trainees and licensing programs. We need to contract with the people who get those breaks, to stay and work at the hospital for sometime. We need to authorize adequate staffing. We need more psychiatrists, more psychologists, more social workers, more licensed nursing staff; we need more supervisors; we need hospital police. We need hospital police who are sensitivity trained and know that the way to approach us effectively is not as cop. And we need them to be trained and motivated...

SENATOR CHESBRO: You do that very well.

MS. FORBES: Well, thank you. My dad was one. We need them to be trained and motivated to use best practices and deliver best practices sensitively. Thank you.

SENATOR CHESBRO: Thank you. (Applause) This actually goes for all of our witnesses, but I particularly want to ask you if you'll give us a copy of your written testimony for the record. I appreciate it.

MS. FORBES: I will. Thank you.

SENATOR CHESBRO: So next I'd like to call on Ann Williams, who's a parent. Welcome.

MS. ANN WILLIAMS: Thank you. Hello. My name is Ann Williams, and I am the mother of _____ who has been in the mental health system over half of his life.

SENATOR CHESBRO: Can you move the mike a little closer so everyone can hear you? Thank you.

MS. WILLIAMS: Over half of his life. He is being drugged (?). One doctor, who had his license suspended for sexual and drug or alcohol abuse before being hired by Napa State Hospital, told my son, in response to _____'s request, to be taken off a certain medication because it was making him feel weak, "I have the right to put you on any goddamn medication I want." His words, not mine.

When confronted with this, the doctor denied it. My son has been diagnosed with hyperthyroidism, dyskinesia, and Parkinsonism and has become suicidal and assaultive, all caused by the drugs.

After graduating from high school, _____ went off to Marine boot camp where he was discharged as emotionally immature, not mentally ill. On returning home, his feelings of failure caused him to become despondent, and subsequently, he fell into a depression. But much worse than that, he fell into the snare of the mental health system.

I have tried to become _____'s conservator and get him released from Napa State Hospital on several occasions, only to find him over-drugged when he arrived at the courthouse, preventing him from making a sound statement in support of his case. See a similar instance on page 18, last paragraph, of the DOJ's report into Napa State Hospital.

Yes. I am very angry at what the mental health system has done to my son and many other people's loved ones, and I believe the mental health system should be held accountable for the damage inflicted upon them. The DOJ have completed their investigations into Metropolitan and Napa State Hospitals, and their reports are, as you know, unfavorable, which is no surprise to myself and many others. I have no doubt that DOJ will find much the same throughout the California mental health system. I believe Napa State Hospital is no worse than any of the other facilities my son has been in, and that is not meant to be a compliment, because believe you me, it could not get much worse, as confirmed within the DOJ's report.

The present system is not working, and nobody is more aware of that fact than the patients themselves. After reading the Department of Justice's investigation report into Napa State Hospital, it seems to me that the staff are completely oblivious to their instructions, which ___ is no surprise to me, because they have such unrewarding jobs to perform.

Senator Chesbro, in your letter to me, dated September 6, 2005; you asked if I have any recommendations relative to improved quality of care for individuals residing at a state hospital. The answer to that question is a resounding yes.

I recommend, as I did here on March 22, 2004, an alternative treatment plan to give our loved ones hope and their dignity back -- a plan without labels for which there

is no scientific proof, which is the reason why many diagnoses are given by many different psychiatrists to one patient-- a plan without so many unnecessary convenient and costly psychotropic drugs which have serious physical and emotional side effects, including suicidal and assaultive behavior-- a plan with vocational training, college courses, farming, and animal husbandry, whichever suits the individual's abilities to prepare them for their release, get back into society, as is done in the prisons-- a plan with faith-based programs, such as Chuck Colson's prison ministry, which, I might add, is very successful. Why, I ask, are these programs not in the California mental health system? I also believe that patients should exercise regularly and be encouraged to help others rather than focus on themselves.

I truly believe that such a plan would be very cost effective and so successful, benefiting many patients, and that is my dream. It would seem to many, that my son is past being helped. But I am a woman of faith in God and believe with all my heart that the end of my son's story will be a good one, and I would like to add three profound statements found in toxic psychiatry.

"A gigantic asylum is a gigantic evil. And figuratively speaking, a manufactory of chronic insanity." John Aldridge, 1859.

"Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive." C.S. Lewis, 1970.

"I am still more frightened by the fearless power in the eyes of my fellow psychiatrists than by the powerless fear in the eyes of their patients." R.D. Lang, 1985.

Thank you, Senator.

SENATOR CHESBRO: Well, thank you very much for your testimony. (Applause)

And let me repeat what I said earlier for all the witnesses. I appreciate a written copy of your testimony, if you could make it available to us. Thank you.

MS. WILLIAMS: And I would also like to give you Jeff Griffin, from CCHR, this manual.

SENATOR CHESBRO: Provide it to the sergeants, and they will make sure I get it. Thank you.

Next, let me invite Barry Chaitin who's the Chair of the Department of Psychiatry, UC Irvine, representing California Psychiatric Association, and Dr. Charles Faltz, Director of Professional Affairs for the California Psychological Association. Welcome. I assume you're Barry Chaitin.

DR. BARRY CHAITIN: Right.

SENATOR CHESBRO: Okay. Great to have you here. Go ahead and present.

DR. CHAITIN: Well, good afternoon. My name is Barry Chaitin. I'm professor and co-chair of the Department of Psychiatry and Human Behavior at the UC Irvine Medical School. And in that capacity, I'm also Chief of Psychiatry at the UCI Medical Center, also past president of the California Psychiatric Association.

I'm here today to testify on behalf of 3,500-member psychiatric physicians but in particular on behalf of our members who work in the state hospitals.

I want to address some quality-of-care concerns we have, some of which have been addressed by reports of the United States Department of Justice and some which have not. It's hard to know how to proceed after some of the riveting testimony we've just had. It's been very powerful.

Ms. Lee, in her introductory comments, has really set the table for some of the problems that we're facing. And I'm not here to pile on. We've sort of, at many levels, have articulated what the problems are. We're going to be, try to be constructive and somewhat mercifully brief. And with Ms. Forbes' marvelous testimony, I think I'll be able to cut out at least one or two paragraphs because I think she covered, she covered the field very, very well, particularly around the staffing issues.

The state hospitals have a very difficult task. They've always had a very difficult task in our society. They've frequently have had to take care of very ill patients with very diminished resources. Unfortunately, the view from afar from 25,000 feet and somewhat closer from some of our members, is that our state hospitals are really approaching meltdown in the way they're actually operating and delivering care. If we look back at recent history, we were investigated by the Department of Justice in 1990. We had a consent decree dismissed in 1995, and here we are again.

Our hospitals are grossly understaffed, they are unsafe to patients and staff alike, and they are not efficiently or effectively organized and managed, so the dedicated, committed, and motivated staff can deliver the highest quality of care

possible. This is largely the view of our members working in the state, inside the state hospitals.

I just want to highlight a few issues which we believe are crucial, necessary, but not completely sufficient to turning around the sad state of affairs. And as a physician and psychiatrist, one of the things I'm going to talk about is the issue of psychiatric leadership in the state hospitals.

The DOJ report, and excerpts have been read from it, contain a number of references similar to the following: Adequate assessment of a mental health patient for treatment and planning purposes requires input from various disciplines under the active direction and guidance of the treating psychiatrist. The DOJ Metropolitan, first letter, also stated that treatment plans and planning do not reflect interdisciplinary provision of services in large part because no one person is accountable. No one person is identified to coordinate treatment. And no one is required by the facility to assume authority for overall care of the patient. Federal law also requires that physicians must direct, plan, and certify inpatient treatment for patients covered by Medicaid and Medicare which include many patients in the California-operated state hospital.

So our current situation represents a real disconnect in the face of the quality care which we would hope to offer. There are good models that exist which encourage multi-disciplinary teamwork and psychiatric rehabilitation which could promote the appropriate use of psychiatric leadership, yet none are seemingly used by the Department of Mental Health and the state hospitals, and there seems to be a general lack—that this exemplifies a lack of support for psychiatric leadership.

If psychiatrists, the most comprehensively trained treatment professionals in state hospitals, are to truly live up to their obligations to their patients, to the law, and to the dictates of the Department of Justice, the state must provide support for psychiatric leadership. Despite manifold warnings from the Department of Justice, the state spends no resources whatsoever, that we're aware of, to ensure that treatment teams operate with the leadership of psychiatrists and the support of hospital administration, that they operate smoothly, congruently, and collaboratively. It's one thing to talk about changing behavior, but a lot of resources and energy has to be put into assuring that that takes place.

Establishing clear policy supporting psychiatric leadership is a necessary, but not sufficient condition, to meet this requirement. It is also necessary to provide leadership training for clinicians at all levels within the hospital. Since well over 90 percent of patients in state hospitals currently receive psychiatric medications and 75 percent of patients in state hospitals receive medications for physical conditions, the idea that non-physicians can become attending clinicians with patients with the most complex, life-threatening illnesses leads to further confusion with respect to the delivery of services and increases staff conflict and leads to less-than-optimal outcomes.

We also have a two-year bill, AB 1720, by Assemblyman Dymally, the basic intent of which is to ask DMH to follow the current law of the Welfare and Institutions Code, Sections 4305 and 4308, which require all disciplines to report to one clinical director. The consequences of this lack of conformity to state law are a ruinous fragmentation of lines of authority. This dysfunctional structure underlies and results in disconnects between disciplines, between hospital administrators, and supervisory staffs, between supervisory staff and clinical staff, and makes it a virtual certainty that quality of care will never improve.

As I thought about my testimony today, I thought, that if we were talking about a cancer hospital, I would not have to make these comments that I just made. No one who is basically being treated for a life-threatening illness would basically want anyone else but the most well-trained oncologist to be in charge of their care, not to say that their rehabilitation could not be assisted by others along the way, but someone has to be responsible for the treatment that's delivered to the patient.

In my own institution, we have a very diverse treatment staff that includes nurses, social workers, case managers, occupational therapists, medical students, psychiatric residents, pharmacy students, and our team meetings are actually a thing to behold. But at the end of the day, we have to come out with a plan that we all agree on. And when there's a bad outcome, I know whose phone number to call and ask to explain what happened. And that's absolutely necessary that there be that level of accountability.

In reference to treatment options, one response by the DMH to the DOJ report is to implement reforms at each hospital, some of which employ the recovery model. The

recovery philosophy is a very attractive philosophy and is quite clearly defined, yet the model itself is difficult to implement consistently with the heterogeneous populations in the state hospital system. It is worth noting that recovery is a community-based model of services. By the time that patients arrive at state hospitals, they have usually failed multiple community interventions. Patients in the state hospital present a number of psychiatric, medical, behavioral, and legal issues which creates implementations, problems for the most ill patients in the state. However, there are some deficiencies that need to be corrected before the potential of the recovery model can be realized, and we suggest the following:

- A strategic plan for the state hospitals is not currently apparent and needs to become apparent and be made clear to everyone what the plan is for the changing the state hospital environment.
- The DMH treatment mall concept model needs clarification. The recovery model may not be appropriate for all populations.
- Psychiatrists report that their expertise has not been solicited in the development and implementation of new programs at the state hospital. It's very much a top-down system of receiving orders from on high, and these discussions have not involved staff at all levels in the hospital.
- Clinical programs should adhere to evidence-based practices. We are not clear that they are being utilized.
- Benchmarking and adoption of best practices are necessary processes which must be developed. We have to see what else is being going on in the world and who's doing better than we are and model what they're doing. It is also worth noting that to implement treatment reform and reach staffing levels for not only psychiatrists but a number of disciplines will be necessary. This inevitably will lead to higher expenditures by the state but also much-needed improvements in the quality if patient care.

I think that Ms. Forbes did a marvelous job of talking about some of the staffing deficits and the tremendous overtime that nurses are putting in, and I'm not going to repeat that. I think they we're really right on.

Our conclusions are that adequate staffing the development of improved patient care policies, combined with effective training and continuing education in both

clinical subject matter and management are necessary to substantially reduce the number of suicides and assaults and bad clinical outcomes in our state hospital.

I appreciate the opportunity of talking to you today and appreciate your holding these very important hearings.

SENATOR CHESBRO: Thank you for being here, Doctor -- appreciate your participation.

And let me turn now to Dr. Faltz who's the Director of Professional Affairs for the California Psychological Association.

DR. CHARLES FALTZ: Thank you, Senator.

Because of some of the testimony here, I wanted to say something about the particular perspective that I have because of my professional background, which is relevant.

My background is at the local level. For a good part of my career, I was chief of Forensic Mental Health Services in San Mateo County. And the relevance of that is that most of the population now in the state hospital are Penal Code patients. And my service received from the streets -- mentally ill people who had gotten in trouble with the law. We treated them on an inpatient basis, more often in the jail for an extended period of time before they were sent to the state hospitals, and I was also responsible for the local conditional release program, and so my staff would visit on a regular basis, the state hospitals, and the patients that we were going to be receiving, but they also were able to know what the programs were in the state hospital. And just as what's been discussed all day today, there was very little happening in the state hospitals which would prepare the people who were in the state hospitals for what they were going to have to be doing when they return to the community.

I also will, further along, want to say something about the money question because that is a very important question, and there's been a variety of views that's been expressed today.

Before I do that, though, I want to comment on the Legislature because it hasn't been mentioned. The State Legislature in this State has an outstanding record in seeking to make the changes. This is not something that's new. It's been going on for a long time, and this particular Select Committee, under the leadership of Senator Chesbro, but also your predecessors, there have a very strong record of a very patient,

focused concern about quality treatment in the state hospitals, and there have been innumerable examples of legislation that has been passed that then is sent over for the Department of Mental Health and the Department of Corrections to implement. So we know a lot about the concern that this Legislature has and its efforts in order to make changes. And I think we're going to have to continue to rely on the Legislature because, if today has proved anything that I think many of us sitting in this audience have been dismayed at what has been said today and that the department apparently thought everything was fine, and they didn't know until the Department of Justice told them that everything was not fine, and it was to their great surprise.

I think the Department of Justice needs to be commended. We would not be sitting here understanding that there is a very serious problem if it hadn't been for the Department of Justice telling us and defining what these problems are.

We are greatly concerned, however, that it takes an outside agency in order to be able to tell us that there are all of these problems, and I think that we need to pay attention to that, that I don't think that we can depend upon the Department of Mental Health to tell us how things are going; that over the years, as we've discussed the changes, that the feedback that we have gotten, the feedback that many legislators who have written for information, the department has responded in much the same way, almost the same words, that we heard today that we are making progress, we know there's problems, but we are well on our way to resolving these problems, and with just a little more time, that the problems will be resolved.

Well, I don't think that's going to happen, everything else being equal. The history has been that the problems are not resolved. Whenever confronted with problems, the department indicates, well, the reason there's a problems is, there aren't enough resources, specifically, and most often, that there aren't enough psychiatrists and we aren't paying them enough.

Now I want to rely on my background at the local level. Prop. 13 happened, and that was a wakeup call for all of us at the local level. We had to make dramatic changes that we were forced to make, that no one wanted to make, and we all thought that we were—and we were—very busy doing the best we could, and where in the world were we going to make changes? Well, it turned out that we didn't know what was happening in our programs for, in large part, and so we had to figure out what

was happening in our program, and we had to define what was most important—what were the most important services—and they were face-to-face services. We weren't monitoring what people were doing. And it turned out that there was relatively little time going into actually providing face-to-face services.

We don't have enough time to go on today. But for example, we found—and we didn't know it—that we were paying seven times more for a medication visit in our program than what was existing in the community at that time. So everyone was very busy, but they weren't busy doing the kind of, providing the kind of service that all of us valued most highly, and I think that that says something about—the state hospital system was not confronted with Prop. 13 in the same way. And in spite of budget shortages, every year the budget increases and increases because they come to you and ask for more increases, but I don't think the department knows it has no information system that most of us can tell that will provide us with the kind of information to tell us what is really happening and who is providing what services and how are people spending their time.

At the same time that shortages of services are being decried, entrenched interests in the state hospitals are preventing certain staff members from providing services. As you know, psychologists are being prevented from delivering the services that they're qualified and that the patients need, and so are nurse practitioners being blocked from providing the services. I think the reasons for that—we've spent an awful lot of time talking about, but we'll be talking more about that in other ways.

Through the 1990s, the State Legislature was taking a lot of steps through bills because it recognized that changes in the kind of programs that existed in state hospitals were needed, and the bills that were passed at that time directing the Department of Mental Health to make changes, to emphasize the kind of services, for example, that psychologist delivered important services that the patients were not getting.

Today, those laws have not been implemented. That is discouraging because, in the recovery model, that psychologists have a lot to offer, that teaching people skills about how to survive and thrive in the community are something that psychologists, that's what we're trained to do.

The Department of Justice has noted that the recovery model of care should be provided by the Department of Mental Health. In the early 1990s, psychologists and the Department of Health, on their own initiative, hired a specialist in the recovery model to train the psychologists. They did this on their own. They were never able to convert that information that that training that they had into practice in the state hospitals because of—there was not an interest—there was not a support for delivering those kinds of services.

SENATOR CHESBRO: I'm going to need to ask you to summarize.

DR. FALTZ: I will.

In conclusion, today, I do want to leave with members of the Committee, the American Psychological Association has a new document about best practices in recovery, and it is divided into sections that, if we looked at the agenda of today's meeting, that it goes right down the list. And this is the most up-to-date kind of formulation of exactly what is needed in the state hospitals, and we thank you, Senator, for having these hearings and for your persistence.

SENATOR CHESBRO: Well, thank you both very much. I would like to say that the ongoing conflict or disagreement about the relative, respective roles of the psychiatric profession and psychological profession are a part of—I don't want to over-emphasize the amount, the degree, which is true, but are a part of the difficulty we have in getting a cultural change where everybody is on board towards trying to remake and rebuild the way things are done at the state hospitals. And I don't think that the two professions are mutually exclusive or are somehow inherently in conflict. I think that both have significant roles to play. But one of the things that I think should be addressed—and I encourage both professions to attempt to address, is trying to reach a détente so that we can all be on the same team in trying to address the kinds of criticisms that we have faced.

I think psychiatrists and psychologists both have very significant roles to play. That has to be acknowledged, and the two professions need to try to figure out how to coexist in the same treatment system.

So that being said, thank you both very much.

And let me ask the next panel to come forward. We have Ken Murch of the Association of Psychiatric Technicians; Kimberly Cowart, RN, Napa State Hospital;

Christopher Dunn, RN, Atascadero State Hospital, representing the California State Council of Service Employees; as well as Dr. Michael Lisiak, Chief of Psychiatry at Atascadero State Hospital representing the Union of American Physicians and Dentists.

Before I open it up to your testimony, let me say, we still have the public comment portion of the agenda to come, and I always tend to do this. I want to hear everybody, as much as they have to say. We get later in the hearing, and the pressure tends to build. But I would encourage you all to be as brief as you can in order to make sure we have enough time to hear the public testimony as well.

That being said, let me begin with Ken Murch.

MR. KEN MURCH: Yes. Thank you.

My name is Ken Murch and I represent the California Association of Psych Techs. We have about 2,400 licensed psychiatric technicians working in the Department of Mental Health. We jokingly call ourselves the Rodney Dangerfields of nursing because we don't get much respect, but we're working on it.

First of all, I want to comment on a couple of the DOJ reports. I will say the many things that was in the reports, there is an attempt, from our point of view, to correct them. And I really take a little issue with some of the allegations that was contained in the Napa report where there was some allegations of abuse against patients, and I thought the report didn't really fully investigate these allegations; and unfortunately, though, they were included in the report.

I want everyone to know, that from our perspective, the union that represents state hospitals, I can assure, Senator, that they do have a good system in place, and they have to investigate any kind of complaints that a patient may have against staff. My experience is that management does have a system in place, and they do act on these allegations. With that being said, from our organization's perspective, we advocate zero tolerance to our members of any kind of abuse or mistreatment of patients. We're there to help them, and we want anyone that would mistreat patients to be disciplined and disciplined severely.

As far as the state hospital patients are concerned, there have been many improvements in recent years as a result of legislation such as your restraint bill, court decisions, regulations, and some departmental policies. For example, there's an

amount of time that patients that are in restraints have been greatly reduced. I was in a meeting a few weeks ago where it's down at that particular facility by 70 percent. Medications have been reduced. And I believe that patients have more freedom in the hospitals, and our organization is really endorsing the recovery mall concept. We think it's good to get them off the units and in some kind of vocational training.

But these improvements have come at a great cost to our members and other direct-care staff. The average state hospital patient is more difficult than they were in the past. And I agree with Ms. Forbes that they're not all dangerous. There's degrees based upon what hospital. But it's a dangerous climate, and it's a part of our jobs to protect those patients from patients that may be dangerous.

These days, state hospitals are treating very few mentally ill folks, and most of them are coming through the court system, and dealing with these forensic patients are difficult. They come into the system with a prison culture. We have areas now where we have gang cultures within the mental health framework, what we must address every day.

In addition, many patients are more difficult to work with because of the cutbacks and the use of medication. You cut back meds, patients sometimes react differently. Also, there's very recent court decisions that give patients the right to refuse meds, so that puts the staff in a difficult position.

There's a greater pressure to reduce the use of restraints and seclusion, even in legitimate situations where a patient is out of control. And this can put patients and staff at risk of serious injury. All these changes that are coming about loads a great amount of stress and responsibility on the staff. You can have as many programs as you have. But if you don't have the ground troops to implement them, they're not going anywhere and there's going to be problems.

And to make things worse, there's a shortage of licensed psychiatric technicians and other licensed staff. The Napa report talked about the lack of untrained staff that they observed at Napa State Hospital. Well, 40 percent of the people that are assigned to the level-of-care duties at Napa State Hospital are unlicensed and might become a shock to a lot of you. These are people that have CNA certificates, they're there on a temporary, limited term, and many of them are waiting to get trained to become licensed staff if the opportunity is there for them.

So our staff are spread too thin to cover many of the shortages, although management likes to call a lot of this overtime that's being done, and that's how we're getting these programs implemented, by the staff working overtime. In reality, voluntary overtime and mandatory overtime is the same.

There's times, that in order to meet the treatment programs and meet staffing minimums, that we will have overtime in excess of 2,500 shifts a month at some of these hospitals. This is causing our staff to be burnt out, and it gives them a difficult time in dealing with family problems, and there's health problems, and it's having an effect on staff morale. And also, the quality and effectiveness of the care that they're providing is eroded by this excessive overtime.

No one can argue, that if the hospitals had enough direct-care staff, many of the situations reported in the DOJ reports would have been prevented.

SENATOR CHESBRO: I hate to do this, but I'm going to have to ask you to summarize. We do have your written testimony and appreciate very much all your points.

MR. MURCH: Can I make a summation? Twenty-two years ago, a judge made a statement about the state hospitals. It was in regard with a lawsuit, relative staffing level. The judge says working without enough staff has the potential to demoralize the level of nursing care staff, contribute to a high turnover rate, increase worker compensation outlays, result in the deterioration of patient care, and interfere with programs or effective programming. That was a judge's observation 22 years ago, and those conditions still exist today as we speak. Thank you.

SENATOR CHESBRO: Thank you very much for your testimony.

And next let me call on Kimberly Cowart, a registered nurse at Napa State Hospital.

MS. KIMBERLY COWART: A lot of what I'm going to say is going to echo what was previously said by the other speakers, so it will be short and I understand...

SENATOR CHESBRO: Appreciate it very much.

MS. COWART: As you said, my name is Kimberly Cowart, and I'm a registered nurse at Napa State Hospital. I have been for the past six years.

Let me start out by saying, that as a registered nurse, my primary responsibility, under the California Nursing Practice Act, is to ensure the safety,

comfort, and protection of the clients that I serve. I will also say that because I found that the Department of Mental Health often seems to forget there are laws defining my responsibility as a registered nurse.

When the Department of Justice reported the findings of their investigation at both Metropolitan and Napa State Hospital, they provided the minimum remedial measures that they believed were warranted to correct deficiencies contributing to conditions that violated the federal rights of individuals residing in these facilities. In both reports, the Department of Justice recommended that the state immediately implement a variety of remedial measures.

The phrase used repeatedly in the reports was that the state should implement the many remedial measures consistent with generally accepted standards of care. The accepted standards of care for the registered nurse in mental health is to have a patient caseload of anywhere from 11 to 21 patients, which in nursing, that's a lot; enforce policies and procedures that do not take into the account the changing needs of mental health and the increasing amounts of paperwork that has led to increased assaults, illegal drug use, and poor patient care.

Just as Dr. Mayberg stated, the department relied too much on chemical and physical restraints. The department also relies too much on mandatory overtime to cover staffing shortages. Often, when the staff, including myself, are mandated, we're very tired. We don't react to situations as quickly. And that puts not only ourselves in jeopardy but the clients we serve.

There is clearly a shortage of registered nurses in California, and the state boasts some of the highest vacancy rates as an employer of registered nurses. I believe that the shortage of the registered nurses have contributed to the deficiencies in client care in our mental hospitals. Mandatory overtime is at a crisis level and needs to be addressed immediately for the protection of the clients we serve.

I would like to ask the Department of Mental Health why am I, my coworkers, and the individuals we serve constantly paying the price for the department's inability to attract and retain qualified nursing staff? I would also like to ask, Why do we have to spend more time doing paperwork than actual patient care? So much time is spent playing catch up, being audited, instead of talking to our patients and helping them to integrate back into society.

Someone asked me on the way over here why do I work in mental health. And the only thing I could say to him is because I care, and I do care. (Applause) I have no greater satisfaction than to see a client being discharged and integrated back into society.

And in closing, if the department truly wants to improve the conditions, staffing, and care it provides, it should not only listen and nod but act upon the concerns of the clients, their families, and the staff that is ultimately responsible for the care that we provide.

Thank you for letting me provide this testimony. (Applause)

SENATOR CHESBRO: Thank you very much, Ms. Cowart. Appreciate it.

Mr. Dunn. Is there a Christopher Dunn? No?

DR. MICHAEL LISIAK: Mike Lisiak.

SENATOR CHESBRO: What's that?

DR. LISIAK: Mike Lisiak.

SENATOR CHESBRO: Mike Lisiak. And you're with the Council of Service Employees?

DR. LISIAK: No. I'm with UAPD.

SENATOR CHESBRO: Oh, well, then I'm not calling on you yet. There's not another person up here representing SEIU? If not, okay. Then I am calling on you now.

DR. LISIAK: My name is Mike Lisiak.

SENATOR CHESBRO: I have to apologize.

DR. LISIAK: That's okay. My name is Mike Lisiak. I'm the Vice-President of UAPD, the Union of American Physicians and Dentists. I'm also the Chief of Staff at Atascadero State Hospital. I want to thank you, Senator Chesbro, for your time in this most complex and important matter.

I also brought with me Chris Heh, who's the Chief of Staff at Metro because I think he can put some light on the issue about how things are going at Metro. I believe that they're not going as well as they have been presented.

I'm going to be brief because I think the California Psychological Association very elegantly presented the picture consistent with UAPD and the medical staff, but I

just wanted to highlight a few things, currently the shortage. The nurses and the physicians are being essentially burnt out. I mean it is unbelievable what I see.

At ASH, we have two RNs who are essentially covering 150 patients consistently to the point where I don't know how these two nurses continually do their job and they should be applauded. At ASH right now, we only have 24 psychiatrists delivering treatment for over 1,300 patients. I, myself, have the following ratio: I have 80 patients; I have 50 MDOs, mentally disorder offenders; and I have 30 2684 prisoners from Corrections. And of those 80 patients, I'm supposed to deliver care at a ratio of that was established by the DOJ of about 1:20, 1:25. On top of that, I'm also the Chief of Staff, which is a full-time position. I'm essentially covering four positions. It's impossible for one person to do this. I try my best.

The recovery model, although good in philosophy, the methodology is highly flawed for a forensic population. Contraband, as you'll hear from Metro, is being passed at an all-time high because of the free flow of the population. Also safety, which I think the correctional officers have something to say, with this kind of model, again, is suspect. I think the model has good components but needs to be presented to a forensic population very carefully.

This goes to my next point. Planning. I think the planning of this massive operation was poor. There's no strategic plan. Both the union and medical staffs have asked for the strategic plan, the master plan, so we can know what was going on, and help enlighten ourselves what the goals are so we could join in on this adventure. And we were told by the consultants that no strategic plan—and the department—that not strategic plan exists. I think that speaks to why things are breaking apart at this time. At this time, Atascadero State Hospital is in the worse shape it's been since I've been there for 14 years. We are essentially falling apart. Morale's in the basement and staff is leaving in droves.

Implementation is at an ad hoc basis. People are confused. We really don't seem to have much direction. The consultant today has been paid almost a million dollars in two years, and I have to ask, as a taxpayer, are we getting our money's worth out of this consultant? I believe, with this complex of a plan, a team is needed. You need an eclectic approach, consisting of physicians, nurses, administrators, and

psychologists, and other disciplines in the consultation team and good communication with the staff.

Right now, I would say the medical staff who used to work very well with the Department of Mental Health is more at odds than ever. We're currently being, the medical staffs, are being marginalized. We have little to no input into the new model. The psychiatrists feel we're losing control of these patients' care, and there's being special orders written, Special Order 129 essentially has in it that administrators essentially can tell the surgeon how to cut and the physician how to treat. And when administrators are going to tell the clinicians how to do their business, I think we're running into dangerous ground, and I think we need to revisit exactly how we're approaching this supposed improvement in patient care.

I'd like to hand it over to Dr. Chris Heh at this time so he can give you a little briefing of what's going on at Metro. Thank you.

SENATOR CHESBRO: Okay. Brief because we're getting to the public input section, and we hadn't listed you as a member of the panel, although we did ask all the organizations to submit representatives. So welcome.

DR. CHRISTOPHER Heh: Thank you, Senator.

My name is Dr. Christopher Heh. I am the President and Chief of Staff at Metropolitan Hospital. I basically represent the psychologists and psychiatrists who are treating our patients at Metropolitan State Hospital.

DOJ came in 2002; and since DOJ has arrived, we've tried to institute changes, and everyone at Metropolitan State Hospital has worked very hard to institute the recovery model, all right? If you look at our data, restraints and seclusions are dropped. If you look at our data, you can see very clearly that poly-pharmacy is better. We don't medicate the patients as much. Okay. You can see that our documentation has drastically improved. Things have improved on paper.

However, things have improved on paper, but does that translate over? Are the patients getting better? That's the bottom line. Okay. Are the patients actually getting better? On paper, seclusion and restraints are down; documentation is excellent; we have 17-page treatment plans; we have a 58-page nursing plan we fill out; we spend four to five hours in a treatment teaming conference planning treatment. Are patients actually getting better with all this?

Okay. I think that's a basic question we need to ask ourselves at this point and juncture. And the reason is, to be frank, our last—well, we've had recently three suicides at Metropolitan State Hospital within the past 18 months. Since the hype of the institution of this recovery plan, our last death at Metropolitan State Hospital was in 1997. So I ask you, if this recovery plan is working, why have we had more deaths? Why have we had more suicides?

All right. And so if it's working, if on paper it looks good and we're doing fine, we're doing better, why have we had these deaths? Again, that's a good question. All right. I have my hypotheses as to why. Some of them had been alluded to here. One of them is the enormous amount of paperwork. People are spending more time with the chart than with the patient. I hear this complaint on a daily basis, all right? They're filling out paperwork, spending hours treatment planning, planning treatment, less actually rendering treatment, all right? And this onerous task, it's interfering, I believe, with the quality of care at our hospital, all right?

And the next question is somewhat alluded to, Are these experimental treatment malls, as someone said here? And they are truly experimental. We're experimenting with patients. If you look at the literature, the recovery model, okay, and where it's utilized, and where it's best utilized, is at outpatient settings, all right? There's very little literature to show its proven efficacy in controlled trials for it to be effective in a chronically psychotic, hospitalized, state hospital patient.

So what are we doing? We're experimenting with our patients here with unproven treatments, and we've had three patients die recently. Okay. I would say we need to revisit, relook at the plan very carefully. If this is really what—is this the correct direction we're going?

As a physician, I care; nurses care. We care about our patients, all right? Irrespective of what the data shows, all right, we have an increased mortality rate, and I don't like that. None of us like that, all right? And so all we're asking is, to take a close look, a very close look, at what's occurring, all right, not to rush in things. I think the Department of Mental Health, they have a lot of pressure on them, okay, to make changes, a lot of pressure. DOJ is on their back.

Well, you know something? They're putting a lot of pressure on us. Let me give you a case in point, if I may.

SENATOR CHESBRO: I'm going to have to--

DR. HEH: Okay.

SENATOR CHESBRO: --to wind up. I will encourage you, though, because it's obvious that you have a lot to say, to write us, to write something to the committee to give us as many specifics in terms of what and how you think, we can approach these problems successfully.

DR. HEH: Thank you.

SENATOR CHESBRO: So I do appreciate your participation. Thank you and I thank the entire panel.

DR. HEH: Thank you.

SENATOR CHESBRO: We're going to go to the public-testimony portion. And I'm going to take the, from my ability-to-read-handwriting standpoint, the toughest one first. I'll start out by saying this person's from Mill Valley. Maybe that will help.

I believe its Esperanza, or did I read it right? Okay. I'm going to ask each of the members of the public to testify to give us a minute of testimony each, please.

Yes, ma'am. Come on forward because we have quite a few, and I want to make sure we have time for everybody.

MS. EUIZATIA: Thank you.

SENATOR CHESBRO: What is your name? I'm sorry.

MS. EUIZATIA: My name is Euizatia.

SENATOR CHESBRO: Say it one more time?

MS. EUIZATIA: Euizatia.

SENATOR CHESBRO: Euizatia.

MS. EUIZATIA: I live in Mill Valley.

SENATOR CHESBRO: Could you spell it for us? I'm sorry.

MS. EUIZATIA: E-u-i-z-a-t-i-a.

SENATOR CHESBRO: Okay. Thank you very much.

MS. EUIZATIA: I am here with three other mothers. Together, we have acquired 107 years of bearing witness to the sorry and cruel state of treatment to our children, mine since 14, against my permission. He's now 43 and very ill. I'm probably going to outlive him. And other people's children, I'm very familiar with the

destruction. I'm here to support the Citizen's Commission on Human Rights' solution to these problems. Thank you.

SENATOR CHESBRO: Thank you very much for your testimony.

Next, I'm going to call on Pamela Nance.

MS. PAMELA NANCE: Hello.

SENATOR CHESBRO: Hi.

MS. NANCE: I'm Pamela Nance. I have a son who is in Napa State Hospital for three and a half years.

Mr. Chesbro, I came to your office a year-and-a-half ago with complaints, and the man who was your assistant met with me and a friend of mine who said that there had never been any complaints from Napa State Hospital. I found that very hard to believe.

SENATOR CHESBRO: Well, it's not true, that there have never been any complaints about Napa Hospital, so I can't imagine he told you that, but it's certainly not my experience or any of my staff's experience.

MS. NANCE: Well, I wish I had written down his name. I have it at home.

Anywho, while my son was at Napa State Hospital, he never received his GED; his levels; to program out; was overmedicated. He had his nose broken while leaving the cafeteria because they don't have enough staffing, had four-and-a-half-hour surgery on his nose, contracted Hepatitis-C, had his first seizure, wasn't seen by a neurologist for two weeks, asked to be put in a side room three times because he knew he was deteriorating. No one took him seriously enough. He assaulted someone for the very first time in his life and took the person's keys who was a worker there at the facility, tried to get out the back door.

Now he's considered high risk. So now he's transferred to Atascadero State Hospital. Well, I just wonder who is at fault. Now my son is considered high risk. But other than that, it's been a gift in disguise. My son now is programming out, and he's only been there eight months. He's doing fabulous. And I'm thankful for that. I find that a lot of parents are fearful of speaking out for their loved ones that are still incarcerated for retaliation. I do not understand why there is not metal detectors for staffing. We have to be checked as parents before we go visit our loved ones. Why shouldn't staff have metal detectors for drugs or whatever other things go on?

My son has been offered heroin, methamphetamines, pot. There's no excuse for it. He's there to get well, and I'm fearful for his life. And he already has an impulse-control problem. That's why he's where he's at. And I thought a hospital was is a place to get well, and I don't understand why they allow smoking. I almost lost him to pneumonia last April. And he goes back to Atascadero for ten cigarette breaks a day. I mean don't they something better to do with their time? Thank you, sir.

SENATOR CHESBRO: Well, thank you very much for your testimony. (Applause)

Next, let me ask for Brian B.

MR. BRIAN B.: Yes. I've had a couple of—I'm with the California Network of Mental Health Plans. I have a couple of friends—well, I had a girlfriend who was in Camarillo State Hospital. She's been in IMDs. I don't know where she is now because her mother died who I was contacting her with, and this was an ex-girlfriend. I sent a letter in care of the Public Guardians Office. But I saw Camarillo, and I saw basically that nothing's happened with her, as long as I kept tabs on her. She's been, I think, out for a few months and then—so the state hospitals aren't doing much. Camarillo didn't do much at all for her.

I did research a Penal Code person who was sent to Patton. She was a street person. She was sent there largely because she was declared incompetent to stand trial because she did not think the Santa Barbara County Public Defenders Office was doing an adequate job, and she requested private counsel. I think under right of counsel that includes, at least theoretically, the right to a counsel of your choice, and that's something that—she spent more time in Patton than she did in the county jail for an assault, felony assault charge.

I visited people in Napa when I was in Santa Barbara day treatment for a year. They use—they were sending people back to Camarillo on the slightest—the state hospitals—well, at least they were much overused in the early '80s. But I've seen the IMDs are not that much better, from what I have seen of them. Some of them are better, but larger because they are small and because they have—and because they're largely private sector, I know. But the question is, what's going on there to get people ready to live on the outside?

I've seen a good friend of mine, the late Charles McCoy. He was a professor of Christian Ethics at Pacific School of Religion, did tell me about the internship program he had in the early '60s in Napa. He told me pretty much the chaplains were pretty much powerless to do much of anything, that if anybody had spoke up. I'm just wondering if the chaplain—this is one of the reasons why I felt the chaplaincy have to answer to their religious denominations, and I'm very strongly opposed to clergy under any circumstances being on the state payroll because they cannot serve two masters. I think, from what I've seen of them—I was in Metro for just six hours because that was where they sent the 5150 cases, at least, used to, from out of Long Beach. This was in '77. It was six hours. But being there for even that time created a stigma.

Are 5150 cases still sent to Metro State Hospital? I'm just wondering because it does not seem like an appropriate place for evaluations at all.

SENATOR CHESBRO: I don't believe that that's the case.

MR. BRACHNY: It was the case back in 1977, and I think there has to be a—from what I have seen, I know one person in the Cal Network said they should have burned, they should burn down Napa. But because...

SENATOR CHESBRO: I think there's a few other people in the audience who probably would...

MR. BRACHNY: But what I'm saying...

SENATOR CHESBRO: I am going to need to ask you to summarize and wrap up because...

MR. BRACHNY: This is just my stream of consciousness, observations.

SENATOR CHESBRO: I appreciate it. I appreciate your stream of consciousness. Thank you. I'm going to ask for Marilyn Gill next. And I'm going to start giving the next name so that somebody can come on up and be ready to testify so that we cannot spend more time waiting for folks to walk up. Gary Sargent is next.

Go ahead.

MS. MARILYN GILL: Thank you, Senator Chesbro.

UNIDENTIFIED SPEAKER: _____.

SENATOR CHESBRO: Okay. Then Jeff Griffen is next then.

MS. GILL: Thank you. I'm here as a mother of a son who is in Atascadero State Hospital, as an MDO, and his physician said at the time that he was transferred

over to that particular unit, that he was into that status, that he was not exactly a criminal type. And I also told him that it was because of the medications that he had been on that he was there. And I asked him not to over drug him, and he immediately said, we do what we do here, et cetera. We do what we do. We can give as many drugs as we like, and then we see what happens.

So anyway, that having been said, we wanted to find out exactly, because I cannot see my son at this time, and we wanted to find out what we can do to get our son home, and I really possibly (can) save the state $125,000-plus a year if we could have our son home. I cannot see him; I cannot speak to him; I cannot write him because of this MDO and parole, no contact.

He did much better at home. I could not understand why he could not be with us, as his family, and this is a problem, I guess, that I wanted to just say that there is recovery and he was certainly doing better at home. No one would listen to me. No one has given me that opportunity to speak. I have to be silent when I go to these meetings because I am told basically that my philosophy, my viewpoint, is not acceptable.

I've worked with the Citizens Commission on Human Rights. I actually have found validation with Citizens Commission on Human Rights. They've put together this manual which I think will describe recovery, and recovery is possible. It can be achieved. And I just wanted to definitely say that the attitude of a lot of the workers is such that we think that they think that our children cannot get better, and that is a very big detriment to recovery, and that's what I basically—thank you for doing this. I appreciate it. Thank you.

SENATOR CHESBRO: Thank you for your comments and for being here.

Jeff Griffen is next and then followed by Blair Romer.

MR. JEFF GRIFFEN: I thank the sergeants for the extra time.

My name is Jeff Griffen. I'm the Executive Director of the Citizens Commission on Human Rights for the Western United States.

A few comments on what has been said up until now before I quickly cover this. I do agree with Dr. Mayberg. It is management's responsibility that this not occur, that it should not have occurred. He is quoted in the newspaper in Los Angeles as saying that he has been aware of this systemic problem and has been trying for 12

years to clean it up and change it. I think it's time to change the head. The CEO of any corporation of the United States would not have lasted that long with this type of systemic problem.

He talks about the transparency, that they wanted to be transparent, yet they would not allow patients at Metropolitan to talk to the Department of Justice. Last August, a letter was received by Bill Sergent from Graziani at Napa. Bill had requested of the Department of Mental Health, Why is the Department of Justice not there? Dr. Mayberg sent that to Mr. Graziani to complete the answer.

In that letter, he stated:

"We have asked the Department of Justice not to come in until we have put in the remedial actions at our other hospitals."

This is tantamount to saying; *we are just as bad as Metropolitan.*

These are basic things that have occurred that I have seen, I have read, and I have documented in my office. The fact that we need dog-sniffing—the drugs at the facilities—is a pretty stark indictment.

In this particular document that you have in your hands, in 1982, there was, by the Senate, a bill, 929, which became Chapter 208 of the statutes of 1982. Senate Bill 929 set up a study that was carried out by two doctors. They looked at 529 mental health patients in the State of California, some at Napa, most of them across Northern California. The findings of that were published later as a result of Chapter 376 of the Statutes of 1988. That set up for Dr. Koran at Stanford to prepare a manual, and the fact of this particular set of papers that I've given to you is that document that was prepared for the Legislature. You've already spent the money to get this.

It actually gives the data necessary to initiate the first steps to start changing what's going on in our facilities and start upgrading. They talk about the recovery module. I agree the mall program isn't working. It doesn't work because it doesn't address the proper issues. I'm very familiar with it at both Patton and at Metropolitan. But this will begin steps in the right direction toward handling our mental health problems in not only our state hospitals but all of our facilities.

Dr. Koran has delivered this to you. I don't know where it is so I'm getting it to you, and I have copies for the rest of your committee. Thank you for your time.

SENATOR CHESBRO: I appreciate your sharing with us, and thank you for your testimony. (Applause)

So next is Blair Romer -- Dr. Blair Romer, M.D., followed by Robin Broadman, M.D.

Dr. Romer.

DR. BLAIR ROMER: Yes. Thank you very much, Senator. I really appreciate the opportunity to be here today. I'm chair of the California Psychiatric Association of State Facility, Doctors Taskforce. I'm going to be really brief.

I believe, and my organization believes, that there's a nearly total and undesired disconnect between administration and clinical staff. We believe that the nursing shortages and mandatory and voluntary overtime problem is huge, quite possibly the largest problem that we have in the state hospitals, because those are the folks who are with the patients 24/7. They're exhausted. Clearly, you know it affects their ability to deliver top, quality care on a consistent basis. I think they are idealistic and do absolutely the best they can.

Somebody alluded to the fact that there are quite a number of quality staff. That was June Forbes earlier. Many of the staff at the state hospitals are quite idealistic. It's a very difficult setting in which to work, and many of the staff see it as a calling and are staying on despite very difficult circumstances. Far more transparency is needed with administration. The remediation plan needs to involve clinical disciplines, also needs to involve protection and advocacy and other groups that wish to participate. That has not occurred up to this point.

Finally, you mentioned about a détente between psychology and psychiatry. That's absolutely necessary. The patients in the state hospitals are tertiary-care types of patients with very difficult, complex, psychiatric, and medical problems, and we believe the administration needs to be clear that psychiatric physicians need to be the attending doctors and also be trained to be effective leaders so that they can then utilize all the other disciplines in a positive, multi-disciplinary way to achieve positive outcomes. Thank you.

SENATOR CHESBRO: Thank you, Doctor.

Next, we have Dr. Robin Broadman followed by Felicia McCarty.

DR. ROBIN BROADMAN: Hi. Thank you for having me. Can you hear me?

I'm Dr. Robin Broadman. I'm a psychiatrist at Napa State Hospital. I am the past Chief of Staff at Napa State Hospital. I am board certified in general psychiatry and also in forensic psychiatry, and I've been at Napa State Hospital for five years.

First of all, I want to just point out that we all share the same concern whenever there is allegation of abuse of patients at the hospital. Someone—I can't remember which speaker—suggested that anyone who is identified as abusing a patient ought to be disciplined. I think they ought to be fired and have criminal charges filed against them. So I want to be clear that the majority of the staff at the hospital are caring, hard-working, highly trained, and highly-skilled individuals that only want the very best for our patients.

I became a psychiatrist in order to treat, to educate, to provide tools for recovery, and to advocate for my patients, and I believe that I do all those things at the hospital, and I believe that my patients would agree with that. And many of them tell me so to my face.

I want to touch on a few points. I'm speaking somewhat extemporaneously because I came late to the process, and I didn't write anything down except for notes while people were speaking. So forgive me if I repeat what some people have said.

First of all, I want to mention discharge planning. There is some confusion, I think, about the difference between patients that are civilly committed and patients that are judicially committed. Patients that are judicially committed absolutely need to receive the kind of treatment that will prepare them for success in the community. But ultimately, their discharge depends on the courts, and it depends on the community being ready to receive them. We can only do so much at the hospital. I just want to make that clear for many people who may not understand that.

In addition, the problems that we have with violence have not been emphasized enough. We do understand that not everybody is dangerous. We also understand that many individuals that come to our hospital, unfortunately, are either unable or unwilling to refrain from assaulting on others, and that includes both staff and other patients. And this leads me to my most important point, I think, which is that the clinicians at our hospital—and I would like to say that that includes psychiatrists, psychologists, social workers, we have therapists, psychiatric technicians, and nurses—have all worked together to provide input to our administration and to the

Department of Mental Health which has in large part been ignored. We have been very specific about what problems we face in terms of being assaulted, in terms of trying to protect our most vulnerable, mentally ill patients from predators who are also at our hospital who may or may not belong there. But that, again, is a judicial issue.

But we have suggested many, very reasonable solutions to our administration, including a more visible hospital police presence, some way to keep the dangerous drugs out of our facility, which is still a big problem. We cannot provide treatment under any model—recovery, medical, what have you—unless we have a safe and effective treatment environment. Safe and effective means people are not getting beaten up when they come to work; vulnerable patients are not getting beaten up when they leave their bedrooms or, even worse, in their bedrooms at night; and people are not being offered heroin every five minutes.

I think, that if the administration were to genuinely respect the clinicians that they've hired based on the clinician's experience, training, education, that they could come up with some workable solutions to these problems, but it's not happening. Thank you for listening.

SENATOR CHESBRO: Thank you very much for being here for your testimony.

And our final person who's requested to testify is Felicia McCarty.

MS. FELICIA McCARTY: I wasn't prepared for this, but I can send you a written one, but I will send one to you.

SENATOR CHESBRO: And all of the folks who haven't submitted it to us are welcome to write to the Committee, so I appreciate that.

MS. McCARTY: Thank you. My name is Felicia McCarty. I've been in this business for a long time because my son has been in this system a long time, over 25 years, between ASH, Patton, and Camarillo.

Before he got into this system and was given various drugs, drugs, drugs, there was never an assault. He was never guilty of assaulting another human being. But I can tell you that he's been assaulted within the system many number of times, and there have been altercations. Many of them have been because of self-protection in which some of the staff at times have witnessed an assault against him, written him up, and given him a 30-day suspension of ground privileges. There have been so

many imbalanced acts toward him and toward others, not just my son—toward others—that speaks not of genuine care and concern.

Right now, sir, he's in court waiting to go back to ascertain whether or not—then return to sanity. Well, let me tell you that he was never insane in the first place, and that's the pity of it all, is exactly what happens to individuals when our laws allow an attorney of record, a public defender, to make a plea of insanity for a client That is a law that should be changed.

Another law that must be changed is the insanity plea itself because I am here to tell you—I'm here tell you—about the pain and suffering that this woman that you're looking at has endured as a single mother and have seen all of the subterfuges that go on within these so-called hospitals—the lies, the distortion. Let it be known that it was Patton's personnel that went to Metro to train Metro personnel in the area of caring with the first 100 patients that were sent there, transferred, many of them against their will, never being told that they could appeal the transfer, never being told anything about their rights. Just dumped into there, dumped into Metro, many of them over-drugged, given drugs as much as the law allows them. That's a lot of drugs, that's a lot of poly-pharmacy.

And, Senator Chesbro, I have the medical records to back up every word I'm saying. So when we think, *Oh, it's all about a culture change*, tell me, what is there cultural about compassion, care, concern, you know, and on the part of the treatment team, really caring about their patients, really wanting them to move forward? My son has become "toy boy" at Patton. He finally got the courage to go back to court and to fight for his release. And I'm going to be right there with him, with plenty of ammunition. This time, the public defenders will look at my records, or I will go to the grand jury. This has got to stop. This kind of thing has got to stop. People who get adjudicated in that fashion and then get dropped through the cracks such as he and others like him is a shame in the State of California.

Now let me tell you something else, Senator Chesbro. You're looking at a woman who had Metropolitan's care over 50 years ago. It may be a new dispensation right now, you know, with our community-type things, if that's what you want to call them, community mental health, but it's the same dispensation that existed 50 years ago when I went briefly through the system and since that time had been stigmatized

over and over again in medical records by the very physicians and caregivers that have cared for my son.

And let me tell you further, I cared enough about this, about justice, about reasonability, that I served in the California Senior Legislature, and we don't get paid there, okay? It came out of my pockets—limited income—to serve the people in this state, many of whom get put into, literally get it put into such bondage, as exists within our state hospitals—nursing homes drugged up, literally killed, okay?

SENATOR CHESBRO: Okay.

MS. McCARTY: This is why I am here, and I will put it in writing. Actually, I write much better than I...

SENATOR CHESBRO: Well, you're quite articulate in person, so you make your points very well.

MS. McCARTY: I'm 73. For the last 30 years, I've been fighting this battle, and I will not stop. I will not stop until either these walls are torn down completely and starting all over again in a way that truly serves those who deserve decent treatment.

SENATOR CHESBRO: Thank you very much. (Applause)

I'd like to thank everyone who participated today, especially those who don't get paid to be here, who have traveled long distances to express obviously; strongly-held concerns from their life experiences and their loved ones' life experiences.

We'll look forward to working with clients, with family members, with the department, with advocates to develop strategies to improve the quality of care, and I'm going to continue to engage in every way I can to try to make sure that there's accountability and a spotlight shown on the ways that the hospitals and other mental health care, community mental health care, are managed, as well as developmental disabilities, which is the other half of this committee's responsibility.

We are having a hearing next week in Los Angeles at the California State Building on September 28 in the afternoon, same hours; although, if you go this long in Los Angeles, you know you're really in trouble because you're stuck in the traffic. But it's going to be specifically on the use of seclusion and restraints which many of you probably know is the topic of the legislation which I authored last year and is the law now, and we're going to be asking various, knowledgeable parties to tell us how

things are going with implementation of that legislation. So thank you again. (Applause)

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SECTION 3

Department of Mental Health
Written Testimony

Responses to the

Senate Select Committee on Developmental Disabilities and Mental Health

September 20, 2005 - Senator Wesley Chesbro, Chair

This document responds to questions raised by Senator Chesbro in a September 1 letter to Director, Dr. Stephen Mayberg in regards to the United States Department of Justice (USDOJ) investigation of California state mental hospitals. While the Department of Mental Health (DMH) takes issue with certain specific conclusions of the USDOJ's investigation, the department agrees with the overall findings of the investigation. Further, the Department of Mental Health is fully committed to continuing the process of system-wide change that will bring its hospitals in line with the USDOJ's recommendations. The following pages present the specific questions asked by Senator Chesbro, as well as DMH's response to those questions. DMH is committed to improving conditions at the state's mental hospitals.

Please describe the issues raised by the U.S. Department of Justice investigation of Metropolitan State Hospital and Napa State Hospital. What, if any, USDOJ findings are disputed by the State Department of Mental Health?

As presented in its Findings Letters, USDOJ raised a number of concerns about the state mental hospital system and about conditions at specific hospitals. While DMH agrees with USDOJ's overall conclusions regarding the state hospital system, DMH does contest several specific characterizations and conclusions. USDOJ's conclusions are presented below, followed by DMH's response to each of those conclusions in cases where we disagree:

- **USDOJ Finding #1:** Diagnoses and assessments are often untimely, incomplete, and do not reflect the input from all members of the treatment team.
- **USDOJ Finding #2:** Treatment plans are not individualized and monitored and do not build on patients' strengths nor always reflect their input, do not integrate assessments performed by all clinical disciplines, and are often not modified because of lack of progress.
- **USDOJ Finding #3:** Treatment services often do not reflect the integrated participation of the various clinical disciplines, are not well monitored, and sometimes reflect poor medical management.
- **USDOJ Finding #4:** Seclusion and restraint are used excessively when less restrictive alternatives may be available. Numerous instances of seclusion and restraint were not included in the data Metropolitan provided to USDOJ.

  DMH Response: *DMH has reviewed the data submitted and confirmed that information regarding all of the cited cases were contained in the*

database supplied to USDOJ. It is not clear why USDOJ claims DMH underreported instances of seclusion and restraint.

- **USDOJ Finding #5:** Behavioral plans are inadequate for patients with serious behavioral problems.
- **USDOJ Finding #6:** Medication management is often inadequate and patients are often prescribed medications without documented justification.
- **USDOJ Finding #7:** Documentation is often inadequate with progress charting and other developments not performed with sufficient frequency.
- **USDOJ Finding #8:** Incident management and performance improvement systems are inadequate to insure that problems are always promptly identified, investigated and corrected throughout the facility.
- **USDOJ Finding #9:** Environmental issues that could cause patient harm are not systematically assessed, prioritized and resolved.
- **USDOJ Finding #10:** Metropolitan completes no tracking or trending of infections or communicable diseases, putting patients at increased risk.

  DMH Response: *It is standard practice at Metropolitan to track and trend incidence of infections and communicable diseases. When analyses reveal potential problems, we take corrective action.*

- **USDOJ Finding #11:** In 2003, a patient at Napa was forced to wait at least seven months for surgical repair of a broken hip.

  DMH Response: *DMH consulted with outside medical professionals in 2003 and twice in 2004. In every instance, the medical professionals determined that, because of the patient's preexisting heart condition, hip replacement surgery would have endangered the patient's life, so DMH had no choice but to forego surgery for this patient.*

According to the USDOJ, State officials declined to cooperate with federal investigators and repeatedly refused to allow investigators access to Napa, Patton, and Atascadero State Hospitals. Please respond to these allegations. If accurate, what was the rationale for such non-cooperation? What are the immediate and potential future and/or on-going repercussions of such non-cooperation?

DMH welcomes the USDOJ to visit the state hospitals and we have confirmed dates with them for visiting Atascadero State Hospital from November 28 to December 2 and Patton State Hospital from December 12 to 16. We respectfully disagree with the USDOJ term "non-cooperation" and stress that we wanted an opportunity to address as many of the issue identified in the Metropolitan investigation as we could before their visits. We took the USDOJ findings very seriously and agreed early in this process that state hospital changes were needed. We never denied USDOJ access to the state mental hospitals and were actively negotiating USDOJ visits that would not coincide with intensive site visits by accrediting entities. However,

communication was disrupted and complicated by the unexpected death of our attorney on this case.

In any case, DMH is committed to continue working cooperatively with USDOJ. In a recent letter, USDOJ indicated that it was "pleased" with DMH's progress towards resolution of the issues raised by its investigation.

Describe the remedial measures proposed by the USDOJ for the Metropolitan child and adolescent programs, the Metropolitan adult programs, and the Napa programs. Describe what, if any, remediation plan components have been implemented, are being implemented, or planned to be implemented at Metropolitan and Napa. Describe the timelines associated with the implementation of remediation plans.

DMH has been negotiating with the USDOJ since March 2005 on specific terms of the remediation plan. The remediation plan will define expectations, performance standards and dates that must be met in order for California's state hospitals to be found in compliance with CRIPA, the agreement to be terminated, and the complaint filed by USDOJ to be dismissed.

The state hospitals have begun making improvements within existing resources. USDOJ recognizes that major reforms cannot be completed overnight. In the proposed negotiated agreement, dates have yet to be specified, but all parties have agreed that we are looking at a 3- to 5-year timeline in which to achieve full compliance.

The following bullets include general features of the proposed remediation plan, as well as an update of DMH's response to each feature of the plan.

- **USDOJ Proposed Remedial Measure #1:** The Recovery philosophy of care and the psychiatric rehabilitation model of service delivery will be used.

  DMH Response to Date: DMH is promoting a major "culture shift" in adopting the Recovery Model of mental health, in which the role of the hospitals is to assist individuals in reaching their goals of recovery of effective functioning in the community through individualized treatment, empowerment and self-determination. DMH is doing this by incorporating Town Hall meetings, training at all staff levels, and inclusion of patients on committees to develop components such as By Choice incentive programs, Positive Behavior Supports, Psychosocial Rehabilitation Malls, Therapeutic Milieu interventions, and restraint reduction.

  DMH established a statewide structure of work groups over a year ago to develop comprehensive manuals covering every aspect of the remediation plan.

- **USDOJ Proposed Remedial Measure #2:** Improved ratios of clinical staff to patient caseload.

  DMH Response to Date: Hospitals have formed some of the core enduring treatment teams.

- **USDOJ Proposed Remedial Measure #3:** New expectations in the frequency and thoroughness of Treatment Planning Conferences (TPCs) for individual patients.

  DMH Response to Date: A new person-centered treatment planning system (Wellness and Recovery Plan) has been developed and requires input from all disciplines. This system is being implemented at one hospital (Metropolitan), and is being gradually introduced at the other three (Patton, Napa, and Atascadero). The department is also in the early stages of developing an automated system for recording and working with this data.

- **USDOJ Proposed Remedial Measure #4:** Interventions to reach patient objectives must occur appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week.

  DMH Response to Date: This is the current objective at all state hospitals, which has been achieved at Metropolitan. DMH will continue to train staff to provide evidence-based treatment in order to meet this goal.

- **USDOJ Proposed Remedial Measure #5:** The service plans must be revised, as appropriate, to ensure that planning is based on the individual's progress, or lack thereof.

  DMH Response to Date: Metropolitan is meeting this standard and is striving to increase the overall quality of the service plans to meet its own high standards.

- **USDOJ Proposed Remedial Measure #6:** There must be a comprehensive and ongoing system of integrated assessments that will guide all aspects of care and treatment.

  DMH Response to Date: A comprehensive set of required clinical assessments, quarterly assessments, quality of life measures, etc. has been identified by a statewide workgroup made up of personnel from the various hospitals representing a wide range of clinical disciplines. These assessments are being phased in at each of the hospitals. These assessments require the purchase of new testing instruments, staff training, reallocation of staff, and monitoring of quality.

  USDOJ Proposed Remedial Measure #7: Assessments must include a Positive Behavior Support plan (PBS) which is an overall strategy to promote and encourage wellness and recovery that is individualized and relies on positive incentives and encouragement.

  DMH Response to Date: State hospitals have put PBS teams in place, though no hospital yet has a complete team because of the difficulty in hiring appropriately trained staff. However, current resources have been utilized to the fullest extent possible and two teams have begun providing behavioral services at each of the hospitals.

- **USDOJ Proposed Remedial Measure #8:** DMH must aggressively identify and treat the growing numbers of patients who are obese and at risk of developing diabetes.

DMH Response to Date: A "trigger system" is in place at Metropolitan to identify patients with high body mass indexes (25 and above) and provide dietary, exercise, and other management and support plans to ameliorate obesity and related diabetes. A statewide work group is finalizing a trigger system to be employed in all hospitals that will meet this standard.

- **USDOJ Proposed Remedial Measure #9:** Nursing services must complete competency-based training on diagnosis, medications and side effects, and on how to complete the Medication and Treatment Record, including medication variances.

  DMH Response to Date: Extensive training of staff has been initiated at each of the hospitals and will continue. The training staff at each hospital recognizes that this will be a long-term effort.

- **USDOJ Proposed Remedial Measure #10:** Pharmacy services must conduct reviews of each individual medication regimen and make recommendations to the physician about possible interactions and side effects, and document where such recommendations were not followed.

  DMH Response to Date: Pharmacy services currently review all new prescriptions and changes to prescriptions as required by JCAHO. Formal protocols to guide the level of detail in these reviews are currently in development on a statewide basis.

- **USDOJ Proposed Remedial Measure #11:** Investigations of patient abuse and other serious incidents must begin immediately and reports must be completed timely.

  DMH Response to Date: Currently, all such incidents are thoroughly investigated with the goal of prompt completion.

- **USDOJ Proposed Remedial Measure #12:** A "trigger system" must specify conditions indicating risk to patient well-being and set in motion urgent, individualized interventions that will be monitored until the risk is corrected.

  DMH Response to Date: The Daily Trigger Monitoring and Feedback System is being developed at each of the hospitals. Metropolitan has a rudimentary system in place but the other hospitals have yet to begin implementing this system.

- **USDOJ Proposed Remedial Measure #13:** A By-Choice incentive plan will be implemented that gives redeemable points for participation in group activities to engage patients earlier in the treatment process.

  DMH Response to Date: The By-Choice incentive program has been fully implemented at Metropolitan and partially at Patton. The other two hospitals are working on their implementation plans.

- **USDOJ Proposed Remedial Measure #14:** Each facility must have at least one developmental and cognitive abilities team that has demonstrated competence in assessing and treating persons with cognitive challenges.

DMH Response to Date: All but one of the members of the Developmental and Cognitive Abilities team at Metropolitan have been appointed out of redirected positions. The other hospitals have yet to develop this team.

- **USDOJ Proposed Remedial Measure #15:** Policies concerning seclusion and restraint and "PRN" and stat medications must be revised and monitored. Use of prone restraints, prone containment and prone transportation will be expressly prohibited.

  DMH Response to Date: Methods for reducing use of seclusion and restraint have been implemented, including extensive staff training within existing resources. DMH will continue to track use of seclusion and restraint.

- **USDOJ Proposed Remedial Measure #16:** Potential environmental hazards to patients must be identified on an ongoing basis and remedied as soon as possible.

  DMH Response to Date: Each DMH hospital has a list of environmental concerns, which it will address through upgrades or replacement. A new environmental assessment instrument has been developed and implemented.

- **USDOJ Proposed Remedial Measure #17:** Extensive levels of monitoring, automation, data gathering, and reporting to ensure that virtually every aspect of every patient's care, from entry until exit from a state hospital, is tracked and can be summarized.

  DMH Response to Date: Extensive monitoring systems are in the early stages of development that will track literally millions of individual data elements for program monitoring, evaluation, and auditing purposes.

How do these plans and timelines reflect corrective actions proposed by the USDOJ? What steps will USDOJ likely take or require ensuring compliance?

- The proposed negotiated remediation plan is designed with the 3- 5-year timeframe for full compliance in mind.
- The USDOJ will require extensive monitoring, reporting, and audits to ensure compliance.

What are the barriers to implementing components of the remediation plan?

There are four main barriers:

- The first barrier is the major culture shift necessary to bring DMH staff at all levels around to a new way of thinking and doing business. However, DMH can make this cultural shift and do so successfully. Staff who have been trained and have tried out the Recovery Model have been enthusiastic about it.

- The second barrier is limited resources. We now are evaluating the need for additional resources.
- The third barrier is recruitment of qualified and well-trained staff in the years to come. DMH must compete in some disciplines, such as nursing, with all other private and public sector employers for a very limited number of good candidates. We continue to seek innovative ways of recruiting and attracting good staff to our organization.
- A fourth barrier is that we have changed the populations of our hospitals dramatically and now have 90% forensically committed patients. There has been increased attention on public safety, and balancing staff and patient safety with treatment.

What role does the Recovery Model play in the remediation plan? Describe the Recovery Model. What are the barriers to implementing the Recovery Model in state hospitals?

Under the Recovery Model, the hospital's role is to assist individuals reaching their goals of recovery of effective functioning in the community through individualized treatment, empowerment and self-determination. The model holds that treatment planning should be based on enhancing an individual's strengths and quality of life, rather than on treating an individual's "sickness," symptoms and problems. Treatment is delivered to meet individuals' needs for recovery in a variety of settings, including the living units, psychosocial rehabilitation malls and the broader hospital community, rather than solely in the living units. There must be a broad array of interventions available to all individuals, and interventions are matched to an individual's status in terms of readiness for change. Incentive programs are used to help motivate individuals to make positive changes in their lives. The Recovery Model is central to the proposed remediation plan.

What outcomes are anticipated following implementation of the remediation plan? How will these outcomes be measured? How do these outcomes relate to the USDOJ expectation for compliance? When will measurable outcomes be apparent?

We anticipate further reductions in the use of seclusion and restraint, patient assaults, and patient suicides; speedier resolution of investigations of abuse; shorter lengths of stay in state hospitals; improved physical health and dietary planning; positive consumer evaluations; and substantial clinical improvements to the mental health of our clients. Many of these outcomes are already being measured by such mechanisms as the ORYX system, the mechanisms put in place pursuant to SB 130, Chesbro (Chapter 750, Statutes of 2003), and the Admissions Discharge Transfer computer system maintained in Sacramento. Additional monitoring systems are being developed and will be put in place.

What is the status of negotiations with the USDOJ regarding the Metropolitan findings, the Napa findings, and the issue of access to Patton and Atascadero State Hospitals?

DMH met with USDOJ most recently on August 30, 2005. There is much agreement on the program aspects of the settlement. However, some technical issues remain to be resolved. USDOJ has confirmed on-site inspections at Atascadero and at Patton from November 22 to December 2 and December 12 to 16, respectively.

Should negotiations with USDOJ not reach a successful conclusion, what other steps might the USDOJ take to ensure corrective actions are taken to improve the quality of care at state hospitals? What are the potential consequences of further USDOJ actions for the State?

If negotiations fail, the result would likely be years of costly litigation. We do not believe this is a likely result, based on the tentative agreements we have already reached with USDOJ, as well as on California's commitment to the Recovery Model and the changes in the hospitals that are already underway.

Please describe any other reviews that have occurred (i.e., accreditation, licensing) at each of the state hospitals over the same period as the USDOJ investigations. How have these review findings compared to the findings of the USDOJ? Describe any other review or investigations currently underway or anticipated to occur in the next year. In addition to the CRIPA investigations, is the USDOJ conducting any other investigations into state mental health facilities?

Other accreditation and licensing reviews at the state hospitals during 2004 and 2005 included:

- Annual re-licensure surveys for Acute Psychiatric and Intermediate Care Facilities
- Skilled Nursing Facility Annual Re-Certification Survey
- JCAHO review of a natural but unexpected patient death
- Intermediate Care Facility Annual Re-Certification
- Clinical Laboratory Improvement Amendments accreditation survey of the Laboratory and Pathology program
- Skilled Nursing Facility Fire Life Safety Survey.

Deficiencies identified in these reviews were generally minor and quickly corrected. In none of the above reviews did a hospital lose accreditation or licensure.

However, in addition to the regular licensing and accreditation activities listed above, JCAHO, CMS and DHS have conducted periodic, unscheduled visits and surveys at all of the state hospitals in response to complaint allegations and serious incidents related to medication irregularities, treatment concerns, suicides, patient-on-patient

homicides and staff-on-patient, hands-on incidents. In some cases the hospitals have been found to be at fault, with findings consistent with some of those identified by the USDOJ, resulting in citations and deficiency notices.

This fall, JCAHO will conduct on-site reviews of our state hospitals as part of the reaccreditation process.

The USDOJ has also indicated that it intends to begin a review of Metropolitan's bills to the Medicare and Medicaid programs. Due to the CRIPA investigation findings, the USDOJ alleges that there may be some question as to the validity of the hospitals' claims for Medicare and Medicaid reimbursement. However, the hospitals continue to maintain all necessary licenses and accreditations, and DMH believes the claims for reimbursement are valid.

Please provide any other information you believe is relevant to our understanding of the USDOJ investigations and improved quality of care at our state hospitals.

- Because the Recovery Model places special emphasis on helping patients develop successful living skills, clinicians of every discipline must be involved in each patient's recovery. Although we believe psychiatrists are as important within this model as in previous service provision models, other disciplines including psychology, social work, rehabilitation therapy, and nurses will share a larger role in shaping and delivering treatment than they did previously.
- We are committed to the principles of the Recovery Model, to an open and accountable mental health system, and to full compliance with all reasonable elements of the agreement we are negotiating with USDOJ.
- Mental health services are dependent on human factors. It is essential to have a well-trained, fully staffed, supported, accountable workforce to be the effective, respected hospitals we desire.

SECTION 4

Organizational Written Testimony

Protection & Advocacy, Inc.

ADMINISTRATION
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September 21, 2005

The Honorable Wesley Chesbro
California State Senate
P.O. Box 942848
Sacramento, CA 94248-0001

Dear Senator Chesbro:

Thank you for the opportunity to testify at your September 20, 2005 hearing regarding the Review of the Department of Justice Investigation of California State Mental Health Hospitals. A copy of our testimony is included.

I and other PAI staff look forward to working with you to both increase access to community services and supports and the quality of services at state institutions.

Sincerely,

Catherine Blakemore

Catherine Blakemore
Executive Director

c: Peggy Collins, Consultant

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Testimony of Catherine Blakemore
Protection & Advocacy, Inc.

Senate Subcommittee on Developmental Disabilities and Mental Health
Review of the Federal Department of Justice Investigation of
California State Mental Health Hospitals
September 20, 2005

Thank you for the opportunity to address your committee today regarding our experience with the quality of patient care and treatment at California's State Mental Health Hospitals.

The Federal Department of Justice Investigation confirms our experience at the state hospitals. At the most basic level, the state hospitals far too frequently fail to treat and protect their residents. There is not a single issue identified in the reports that PAI staff has not observed first-hand. The reports confirm the wide-spread and systemic nature of the problems: misdiagnosis, over-medication, lack of treatment planning, poly-pharmacy, aversive behavioral therapy, inappropriate or excessive use of restraint and seclusion, no discharge planning, failure to identify or address developmental disabilities and to notify or coordinate with the regional centers, failure to identify and treat organic or neurological conditions such as Huntington's disease or traumatic brain injuries. For children and youth, this extends to a failure to educate and prepare them for life in a non-institutionalized setting.

Although the Department of Mental Health has put into place a framework for reform and we believe that this framework has many positive elements, we have seen little real progress or change in the lives of the residents. This is particularly troubling because at some hospitals, DMH has had two years to correct these problems. In our experience, we have not met a single resident who could not be better treated with intensive, individualized services in the community.

We think this committee must ask some additional and different questions. We question:

1) Whether the state hospital system can truly be fixed, and whether recovery can fully occur within the state hospital setting

2) Whether it would not be a more prudent use of resources and better fulfill the mandates of state and federal law to close the state institutions and devote the resources to programs such as those being developed as part of the Mental Health Services Act.

Given the existence of community mental health entitlements for children under special education and EPSDT, there is no reason that any child should be placed at a state hospital, and for that reason, recommend the closure of the children's unit at Metropolitan. We also believe that with the addition of Mental Health Services Act (Proposition 63) funding, all residents committed to state institutions under conservatorship proceedings could be served in the community and that the proper role of this committee is to direct DMH and the counties to develop discharge plans for each hospital resident. Finally, we think closer legislative scrutiny needs to be paid to individuals on "forensic commitments" including the barriers these individuals face in being discharged from state hospitals.

Insofar as the state hospitals continue to be part of our mental health system, however, we have several recommendations concerning how care and treatment can be improved. Most principally, we believe that there needs to be **greater transparency** about what is going on within the state hospitals—in other words, additional public data reporting, posting of expert audits, reviews and corrective action plans developed to comply with the Department of Justice investigation; **increased oversight** by the legislature and independent entities such as the Mental Health Planning Council; and an **increased role and presence of advocates** at the state hospitals. We outline our specific recommendations in greater detail at the end of this written testimony.

PAI's Experience with the Remediation Plan Implementation at Metropolitan and Napa State Hospitals

Inadequate and Inconsistent Implementation of the Remediation Plan

In general, the remediation plan developed by the Department of Mental Health is a great improvement compared to what previously existed at the state hospitals. The wellness and recovery model, which focuses on the individual's strengths, is certainly a positive development. PAI's principal concern is that these policies have not been adequately or consistently implemented, but instead represent a

paper change only, not a change in clinical practice. As a result, these new policies have not resulted in demonstrable improvement in the lives of the patients. Our concerns are best illustrated by the work we have done since the time of the DOJ report:

In February 2004, Chris (42 years old) was found by his roommate hanging by a scarf tied around his neck from a metal bar across the window. In May of this year, Marla, an 18 year old resident, was found hanging from a light fixture in her room. Neither survived. Both had a history of depression and/or self-injurious behavior. Last week, PAI received an unconfirmed report of another suicide of a female resident on Marla's unit. In their report, the DOJ noted environmental hazards on the adult units which pose risks of serious injury, illness and death.

John is a patient with a disorder of the pancreas. When taken to a local hospital for treatment, he was told that one of his psychiatric medications may be a strong factor in the disease. When John returned to Napa, the psychiatrist ignored the evidence and the client was put back on the same psychiatric medication. The client was hospitalized with additional symptoms of the pancreas disease and again, the psychiatric medication was discontinued. Finally, and fortunately for John, a staff member spoke up and the doctor was taken off his case.

Anthony is Vietnamese American, on a conservatorship, and no longer a resident at Metropolitan. During his stay at Metropolitan, none of the treatment mall groups he attended were presented or translated in his primary language, Vietnamese. Anthony became very bored by the groups and did not want to attend, causing his social worker to conclude that he wasn't ready for discharge. Nevertheless, Anthony's conservator arranged for his discharge and placement in a less restrictive setting, with no help from Anthony's treatment team.

Mark was admitted to Metropolitan in October 2004 at age 14. His treatment plan listed his discharge criteria as: 90 days of no assaults, no self injurious behaviors, no AWOL attempts, and that until this criteria are met, there will be no discharge meeting. He was never referred to the positive behavior support team to help him deal with behaviors that were preventing him from reaching discharge criteria until 6 months after his admission because he was not considered "stabilized on his medications." At the same time, Mark's records show that he was assessed in the Borderline Intellectual Functioning range and was experiencing large scale fluctuations in his prescribed medications, suggesting a constant

undermining of Mark's ability to achieve consistency in controlling the behaviors on which his hopes of discharge were pinned.

Mary J. is on a conservatorship and has been at Metropolitan for the past nine years. Since her admission to Metropolitan, she has repeatedly been sent to the local hospital emergency room for self injurious behavior, including swallowing batteries, pens and cutting herself. It took several months of advocacy by PAI to get Mary a positive behavior assessment and plan. Despite her severe behavior, no-one from Mary's treatment team ever referred her to Metropolitan's specialized positive behavior support team for an assessment. After years of placing the blame on Mary for her behavior, her treatment team is only now slowly attempting to implement the ideas proposed by the positive behavior support team. Unfortunately, the treatment team has been unable to make any provisions for a critical fact raised in Mary's behavior assessment: Mary's living unit is a great source of stress that sets off her challenging behavior. Until and unless Mary has real opportunities off the grounds of Metropolitan, she will likely be trapped in a cycle that prevents her from ever being considered ready for discharge.

Barriers to Reform

Although true reform can take time, some barriers must be addressed from the outset in order to increase the ability for reform to occur.

The principal barriers that PAI identifies with regard to reform at the state hospitals:

- No clear accountability for failures in treatment and care. There are no consequences for the failures at the state hospitals. There should be a system of accountability and incentives.
- Insufficient commitment to staff training. If staff are not properly or fully trained or do not have the necessary qualifications to carry out the components of the remediation plan, no reform can occur. Simply hiring more people to do things as they've always been done will not result in improvement.
- Lack of "real life" examples of people with psychiatric disabilities who are participatory members of the community to serve as role models for both residents and staff. Currently, an "us" versus "them" ethos permeates the state hospitals. Staff will never be able to envision and embrace recovery unless they are exposed to mental health clients who are in leadership positions.
- Attitude by current staff and an environment that prevents residents from having a true voice about their daily living or life goals. On the

units, residents are expected to follow direction without questions. Questioning a staff member's direction or asking about alternatives is considered resistant and obstructive, which can often be followed by a punitive measure by staff. As an example, an individual is given medication in the morning that makes him feel sleepy. The individual prefers to take the medication at night. This is seen as being resistant to taking medication and is presented to the courts as proof of the resident's non-compliance.

PAI's Recommendations For Improving Treatment and Patient Care, Including Suggested Outcomes to Measure:

Specific Recommendations for Metropolitan's Children's Unit:

The problems at Metropolitan's Children's Unit are serious, well documented and pervasive throughout its relatively short eight year history. Not only have we seen poor outcomes for the youth who were once patients at Metropolitan's Children's Unit and hearing how they now feel scarred and traumatized as survivors rather than as recovered patients, but we have witnessed Metropolitan's continued failure to correct many serious problems despite prescriptive remedial measures from multiple inquiries and investigations at the federal, county and state level citing Metropolitan for deficiencies.

In response to the inadequacy of special education services in the surrounding community, in 2005 PAI caused the California Department of Education to initiate its own investigation into Metropolitan's perpetuation of a segregated educational environment on the basis that its practices violate state and federal law. The results of this investigation have recently been released (attached as Exhibit B), but even if all educational deficiencies are remedied, it has little effect on the inadequate programming, therapeutic interventions and supervision, nor will it change the pervasive collective attitude of Metropolitan staff and administrators that criminally prosecuting children with disabilities is an acceptable form of behavior management.

Therefore our current recommendation remains identical to that of PAI's testimony before the California Assembly Subcommittee on Mental Health in 2003:

1. Metropolitan's Children's Unit should be closed within 18 months using a process which incorporates advance planning, direct oversight by and accountability to the Legislature or an independent citizens' commission or other body and reliance on outside expertise in individualized community-based services; and

2. Put in place an on-going oversight mechanism to ensure that children who would have otherwise been placed at Metropolitan receive appropriate service.

Transparency and Outcomes:

DMH should be required to publicly report data on its website on a monthly basis regarding a number of measures. DMH currently reports its data on the use of restraint and seclusion. It should also report the number of deaths, injuries and escapes or unauthorized absences. DMH should also report data on admission and discharge, information on where the patient is discharged to (for example, locked IMDs, board and care facilities, jails, prison, etc)., and any data on readmission.

DMH has recently posted injuries to employees related to the use of restraint and seclusion but not injuries or deaths of residents to the use of restraint and seclusion, as required. Since January 2004, PAI is aware of deaths of two state hospital residents related to the use of restraints or seclusion, neither of which were reported by DMH to PAI within statutory time limits.

Insofar as DMH assesses the pace and quality of its reforms, this information should be reported to the Legislature on a quarterly basis. This reporting should include any expert or consultants' reports.

Oversight: The Legislature should commission, or order the California Mental Health Planning Council to commission, a panel of experts to assess whether patient care has improved at the state hospitals. These experts would review patient charts and meet with patients and staff to assess such factors as: How is the patient doing? Is there a long term plan for him or her? If the plan is not working, why not, and are there any ideas to change the plan? The expert would assess everyone who works or interacts with the particular patient—can she or he identify what's needed?

Advocacy: There should be an increased role and presence of advocates to include on-site monitoring of practices such as the use of restraint and seclusion, training to staff about patients' rights, and development of corrective action plans following a finding of a patients' rights violation. With the increased number of patients in the state hospitals and increased numbers of complaints, the complaint process has currently become the focus of the program, making it reactive instead of proactive. Increased advocacy presence would allow increased monitoring and training within each facility on a regular basis.

Synopses of Ongoing PAI Cases

Below, we list case synopses of ongoing patient problems. The facts from these synopses apply to the period *since* the reforms have been in place. Names have been changed to protect privacy:

Metropolitan State Hospital

In February 2004, Chris (42 years old) was found by his roommate hanging by a scarf tied around his neck from a metal bar across the window. In May of this year, Marla, an 18 year old resident, was found hanging from a light fixture in her room. Neither survived. Both had a history of depression and/or self-injurious behavior. Last week, PAI received an unconfirmed report of another suicide of a female resident on Marla's unit. In their report, the DOJ noted environmental hazards on the adult units which pose risks of serious injury, illness and death.

Mary J. is on a conservatorship and has been at Metropolitan for the past nine years. Since her admission to Metropolitan, she has repeatedly been sent to the local hospital emergency room for self injurious behavior, including swallowing batteries, pens and cutting herself. It took several months of advocacy by PAI to get Mary a positive behavior assessment and plan. Despite her severe behavior, no-one from Mary's treatment team ever referred her to Metropolitan's specialized positive behavior support team for an assessment. After years of placing the blame on Mary for her behavior, her treatment team is only now slowly attempting to implement the ideas proposed by the positive behavior support team. Unfortunately, the treatment team has been unable to make any provisions for a critical fact raised in Mary's behavior assessment: Mary's living unit is a great source of stress that sets off her challenging behavior. Until and unless Mary has real opportunities off the grounds of Metropolitan, she will likely be trapped in a cycle that prevents her from ever being considered ready for discharge.

Randy C. is on a conservatorship and has been at Metropolitan for several years. Randy has a traumatic brain injury which causes him to engage in challenging, sometimes assaultive behavior. Randy's treatment team never referred him to the positive behavior support team for an assessment or plan. Instead, Randy was kept in continual seclusion. Two locked seclusion rooms were devoted to Randy because the one that he occupied would become extremely filthy because of his feces and urine; Randy would need to be transferred to the other seclusion room while his regular room was being cleaned out.

Todd has Huntington's disease. His conservator and the conservatorship court do not believe that Metropolitan is the correct placement for him. However, Metropolitan staff have impeded with any efforts for his discharge, principally by highlighting all his negative behaviors. A court appointed psychologist reviewing Todd observed that the man he was interviewing did not at all correspond to the man described in very pejorative terms throughout the records, but instead appeared to have greater strengths and potential for discharge.

Anthony is Vietnamese American, on a conservatorship, and no longer a resident at Metropolitan. During his stay at Metropolitan, none of the treatment mall groups he attended were presented or translated in his primary language, Vietnamese. Anthony became very bored by the groups and did not want to attend, causing his social worker to conclude that he wasn't ready for discharge. Nevertheless, Anthony's conservator arranged for his discharge and placement in a less restrictive setting, with no help from Anthony's treatment team.

Metropolitan Children and Youth Unit

Criminalization of Behaviors

Metropolitan has a longstanding history of using the juvenile justice system as a means of dealing with patients who, despite their documented behaviors, do not receive adequate behavioral intervention while admitted. This problem was further noted in the DOJ Reports and in the *Katie A. v. Diana Bonta* federal class action lawsuit's Fourth Expert Panel Report, attached as Exhibit A.

In June 2004, 16 year-old Matt, a Metropolitan patient since 2001, was arrested for assaulting a substitute teacher at the special education school, resulting in his detention in Juvenile Hall. An independent evaluation of Matt in Juvenile Hall after the incident found: "The current charges...stem from an incident at Metropolitan where remarks made by a substitute teacher led to a confrontation. He was charged with assault with a deadly weapon (pencil) and making terrorist threats. I am dismayed that an agency that exists solely to serve persons with mental and cognitive disabilities would so quickly resort to legal intervention in such an incident especially when it was caused and aggravated by the remarks and behavior of a staff member...the behavioral outburst was a predictable result of the disability...and therefore not subject to standard disciplinary

measures." Matt is now a ward of the Juvenile court and remains largely without treatment at Juvenile Hall.

Inadequate Discharge Planning Efforts:

PAI has observed that discharge planning for minors is inadequate by Metropolitan staff. Minor patients approach their 18th birthdays with nothing done to prepare them for reentry into their communities. The failure of Metropolitan to prepare minors for transition to less restrictive settings is pervasive from inadequate provision of special education services, a failure to identify specialty community-based mental health services such as therapeutical behavioral services, and a failure to refer patients for eligibility for other important support systems such as the regional center. Upon their 18th birthdays, they are abruptly pushed out to IMDs or other restrictive placements where available, otherwise rolled over into one of Metropolitan's adult units.

Eddie entered Metropolitan at age 16 as a voluntary parent placement funded by the school district as a special education placement. Metropolitan initiated LPS conservatorship proceedings and mother successfully fought to be appointed his LPS conservator. She repeatedly pressured the hospital to help her son be discharged to her care with community mental health services. Metropolitan told the conservator that her son was ready for discharge for over one year, but refused to discharge him without approval of the probation department which they failed to make contact with, and mother unilaterally had to get juvenile court case dismissed before discharge was approved with only 6 months until his 18th birthday. Had his mother not intervened, Eddie would have remained at Metropolitan until dismissal of the juvenile court case.

Jed was at Metropolitan for 6 months in 2003 where he met Metropolitan's own difficult discharge criteria months before his 18th birthday. Metropolitan made no efforts to discharge him prior to his 18th birthday, and no specialty mental health treatments such as therapeutic behavioral services were ever considered as a way of securing Jed's safety outside of Metropolitan in less restrictive community settings. Jed was ultimately discharged to an IMD.

Unrealistic Discharge Criteria:

Metropolitan has in the past used and continues to use discharge criteria that are based on a level-points system. Good behavior earns

points and the accumulation of points lowers a patient's level to the point at which a patient is only then considered ready for discharge. However, even after reaching this level, the treatment team typically favors only highly structured placements upon discharge. For many children, discharge goals written into their treatment plans are set at a level that many children may never meet, especially given the poor behavioral supports, poor supervision, and general lack of therapeutic programming.

Mark was admitted to Metropolitan in October 2004 at age 14. His treatment plan listed his discharge criteria as: 90 days of no assaults, no self injurious behaviors, no AWOL attempts, and that until these criteria are met, there will be no discharge meeting. In the month before his discharge, the discharge criteria had been lowered to 45 days without negative behaviors, suggesting that the initial 90 day criteria was unrealistic. He was never referred to the positive behavior support team to help him deal with behaviors that were preventing him from reaching discharge criteria until 6 months after his admission because he was not considered "stabilized on his medications." At the same time, Mark's records show that he was assessed in the Borderline Intellectual Functioning range and was experiencing large scale fluctuations in his prescribed medications, suggesting a constant undermining of Mark's ability to achieve consistency in controlling the behaviors on which his hopes of discharge were pinned.

Inadequate Special Education Services:

Metropolitan's educational obligations derive from a combination of both federal and state law. Specifically, Cal. Welfare and Institutions Code §4011.5 states: "In counties where State Department of Mental Health hospitals are located, the state hospitals shall ensure that appropriate special education and related services, pursuant to Chapter 8 of Part 30 of the Education Code, are provided [to] eligible individuals with exceptional needs residing in state hospitals." Included in these statutory mandates are the duty to identify and assess pupils eligible for special education services, and the duty to provide a continuum of educational services in environments that include settings outside of the hospital boundaries. Cal. Ed. Code §56857.5

Jed was hospitalized for 8 months at Metropolitan and entered with an Individualized Education Program. He was placed at

Metropolitan's segregated on-grounds school for the entire eight months, despite meeting discharge criteria for several months before he was discharged to an IMD on his 18th birthday. Jed was never offered opportunities to be educated with his nondisabled peers nor was he offered off grounds extracurricular activities or classes in a general education environment with appropriate behavioral and instructional supports.

Inadequate Programming/Interventions and Supervision:

The DOJ report notes at many points that treatment interventions at Metropolitan were not appropriate or therapeutic. These problems are ongoing. Children are largely left alone to harm themselves or victimize others. Quiet time between meals and programming limited to fifty minute sessions of anger management, bike repair or softball offer patients little toward their recovery and ample opportunity to provoke and victimize one another. Residents report to PAI that they live in a culture of violence and fear.

Stanley, age 14, lived in fear for his safety while at Metropolitan, using his care packages from his grandmother to payoff other kids to protect him. He often had bruises from physical assaults. At the same time, Stanley was lead to believe that if he victimized other patients smaller or less sophisticated, he would not be the target of such abuse himself. In the pecking order hierarchy that developed, Stanley felt justified, with the assistance of three other boys, in forcibly sodomizing another child with a lower cognitive developmental level.

Napa State Hospital

In late December 2004, Robert was found by his roommate hanging from a bed sheet. Robert had a history of depression and previous suicide attempts. Less than thirty minutes before his suicide, Robert's family notified NSH staff that he seemed distraught during their phone call with him minutes earlier. They requested staff provide him with additional supervision and support.

In the early morning hours in March of this year, Nick was found hanging in a bathroom stall from shoelaces secured to a metal grill in the ceiling. He had been noted missing during the previous bed check. It was hospital policy to lock the bathrooms at night to better supervise the residents. Staff were aware that residents knew how to unlock the bathroom door using a card. Nick hung himself with

shoelaces from his ankle braces which staff had neglected to secure when he went to bed, as is facility policy. Nick had a history of depression and previous suicide attempts.

John is a patient with a disorder of the pancreas. When taken to a local hospital for treatment, he was told that one of his psychiatric medications may be a strong factor in the disease. When John returned to Napa, the psychiatrist ignored the evidence and the client was put back on the same psychiatric medication. The client was hospitalized with additional symptoms of the pancreas disease and again, the psychiatric medication was discontinued. Finally, and fortunately for John, a staff member spoke up and the doctor was taken off his case.

UNION OF AMERICAN PHYSICIANS & DENTISTS
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To: Senator Wesley Chesbro, Chair
Senate Select Committee on Developmental Disabilities and Mental Health

From: Union of American Physicians and Dentists ("UAPD")

Re: Oversight Hearing on Review of the Federal Department of Justice ("DOJ") Investigation of California State Mental Health Hospitals

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I. INTRODUCTION.

The Union of American Physicians and Dentists ("UAPD") submits this memorandum in response to the gracious invitation of Senator Chesbro to comment on the issues raised by the U.S. Department of Justice ("DOJ") investigation of mental hospitals operated by the Department of Mental Health of the State of California ("DMH"). Our goal is to improve patient care and to address the DOJ's concerns. The UAPD has over 3,000 physician members, many of whom provide medical and psychiatric services to the patients hospitalized for the treatment of mental illness in California's State Hospitals. Hence, the UAPD is in a unique position to provide knowledgeable information on the subjects being investigated by your Committee.

The UAPD believes that the State of California must make a renewed commitment to the treatment of the mentally ill who are under its care. This requires taking immediate steps to correct the chronic lack of physicians, including psychiatrists, and other medical staff, at the State Hospitals and immediate cessation of apparent efforts by DMH which would deprive the most seriously ill patients of effective medical and psychiatric treatment. In particular, the UAPD is concerned that DMH is acting to remove treatment decisions from the State Hospital physicians who are personally responsible for the patients as attending physicians. These misguided DMH policies have come under scathing criticism by the DOJ and appear to violate both federal law (Civil Rights of Institutionalized Persons Act – CRIPA) and California state law regarding medical staff self-governance (California Business & Professions Code § 2282.5).

II. THE DOJ'S INVESTIGATION CRITICIZES DMH FOR FAILURE TO HAVE PSYCHIATRISTS IN CHARGE OF TREATMENT.

The DOJ's position is that the team leader for each patient hospitalized for the treatment of mental illness in a California State Hospital must be a clinical professional legally

authorized and professionally responsible for all aspects of the patient's care. According to the DOJ, failure to meet this requirement is a violation of CRIPA. By definition, such a team leader must be a physician, preferably a psychiatrist. This is because virtually all patients in California State Hospitals who are hospitalized for the treatment of mental illness are receiving medication, which only a physician may prescribe and evaluate. A high proportion of those patients also suffer from non-psychiatric medical illnesses requiring the attention of a physician, such as psychiatrist. An expression of the DOJ position is found in the federal regulations governing Medicare which provide at 42 Code of Federal Regulations § 424.10(a):

> "§424.10 Purpose and scope.
>
> "(a) *Purpose.* The physician has a major role in determining utilization of health services furnished by providers. The physician decides upon admissions, orders tests, drugs, and treatments, and determines the length of stay."

Given the federal policy requiring physician direction of the treatment of patients, including the hospitalized mentally ill, it should come as no surprise that the DOJ criticizes DMH's care of the hospitalized mentally ill based on a perceived failure by DMH to have psychiatrists acting as the attending physicians for hospitalized patients.

DOJ's February 19, 2004 letter to Governor Schwarzenegger regarding care at Metropolitan State Hospital states(p. 16): psychiatrists must "direct their treatment teams adequately, which is an essential requirement of a mental health facility"; (p. 14) "federal law . . . requires that treatment teams, with the leadership of psychiatrists" provide care and; (p. 7) "[a]dequate assessment of a mental health patient for treatment planning purposes requires input from various disciplines, under the active direction and guidance of the treating psychiatrist, who is responsible for assuring that relevant patient information is obtained and considered"; the DOJ's May 13, 2003 letter to Governor Gray Davis states (p. 8): ". . . no one is accountable or responsible for coordinating patients' overall treatment. . . ."; (p. 30) "There are numerous instances in which Metropolitan [State Hospital] fails to provide necessary medical care to the children and adolescents" in the hospital.

III. CALIFORNIA LAW REQUIRES THAT TREATMENT PROTOCOLS MUST BE DEVELOPED BY THE MEDICAL STAFF OF THE STATE HOSPITALS.

California law is consistent with the requirements which the DOJ is seeking to impose on California State Hospitals. California Business & Professions Code §2282.5 requires recognition of the "right of self-governance" of the medical staff at each hospital in California, including each California State Hospital. The medical staff at each hospital is responsible to establish "medical staff bylaws, rules, or regulations, clinical criteria, and standards to oversee and manage quality assurance, utilization review, and other medical staff activities including, but not limited to, . . . review and analysis of patient medical records." (Business & Professions Code §2282.5, subd. (a)(2).) This means that the medical staff has primary responsibility for directing the medical care of patients in the State Hospitals.

It is important to note that the DOJ's criticisms of DMH for its management of the

State Hospitals focuses upon the failure of DMH to provide for physician leadership of the diagnosis and care rendered in the hospitals. This criticism reinforces policies found in California law.

IV. UAPD IS CONCERNED THAT POLICIES OF DMH ARE PERPETUATING THOSE ASPECTS OF CARE CRITICIZED BY THE DOJ.

UAPD is extremely concerned that DMH policies are perpetuating its actions which have been criticized by the DOJ. For example, DMH has proposed a special order governing the treatment protocols for patients hospitalized in its State Hospitals. That proposed special order, Special Order No. 129, removes responsibility for patient care from the attending psychiatrist who is assigned to provide and to direct the care of the patient. For example, the proposed Special Order, at section VI.B., provides that a committee – the Behavior Consultation Committee ("BCC") – is empowered to make recommendations regarding patient care which the attending physician cannot ignore and must follow. This direction by the BCC, which has not personally diagnosed the patient, not only is an invitation to malpractice, but violates the federal law and the state law described above. Nevertheless, draft Special Order No. 129 states that the BCC's "recommendations will be routinely followed" by the treatment team. This violates the DOJ requirement that a psychiatrist must be in charge of treatment, because it removes treatment responsibility from the attending psychiatrist to a committee, the BCC, which does not have personal contact with the patient. Furthermore, the Special Order is being adopted without any input from the medical staffs at any of the State Hospitals, and thereby violates the legal requirement of medical staff self-governance enshrined in California Business & Professions Code §2282.5.

There is evidence that DMH's ongoing efforts to respond to DOJ's criticisms and to develop programs, like the one suggested by Special Order No. 129, have been delegated to Norbhay Singh, Ph.D., an outside consultant who is not licensed to practice in California and who lacks the medical training to design such programs. A Public Records Act request to DMH has disclosed that Dr. Singh has been paid in excess of $900,00 by DMH for his consulting services regarding CRIPA and program design. Such expenditures by DMH detract from patient care, divert precious resources, and undermine efforts to correct DOJ's concerns.

V. CONCLUSION.

The UAPD thanks you for the opportunity to present its views to your Oversight Hearing. We hope that your Committee will take action to correct the deficiencies identified by the DOJ and to encourage DMH to aggressively recruit psychiatrists so that it may meet the requirement of having adequate psychiatric direction of patient care as demanded by the DOJ.

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Testimony of Ken Murch, CAPT Consultant
before the
Senate Select Committee on Developmental Disabilities and Mental Health
September 20, 2005
Subject: Review of the Federal Department of Justice
Investigation of California State Mental Health Hospitals

My name is Ken Murch, and I am representing the California Association of Psychiatric Technicians. Among the 7,000 state employees we represent, approximately 2,400 are direct care staff in the five state hospitals, including Coalinga which opened a few days ago.

First of all, it's very important to realize that many deficiencies in the DOJ reports on Metropolitan and Napa state hospitals have been corrected or are in the process of being corrected. In addition, many of the allegations by patients against Napa State Hospital staff were not fully investigated, but were unfortunately included in the DOJ report as if they were fact.

From the perspective of a union that represents hospital employees, I can assure you that the Department of Mental Health has a solid procedure in place for patients to lodge complaints against staff. DMH management will investigate every complaint and, if the facts support the allegation, DMH is not at all hesitant to take against the affected staff member.

As far as state hospital patients are concerned, there have been many improvements in recent years as a result of court orders, legislation, regulations and departmental policies. For example, the amount of time that patients are in seclusion or restraints has been reduced dramatically, as has the use of anti-psychotic medications. Patients have more freedom to roam the hospitals, and they aren't locked in their rooms at night.

But these improvements have come with a great cost to our members and other direct care staff. The average state hospital patient is much more difficult and dangerous to work with than in the past.

These days, the state hospitals are treating very few mentally ill people who are committed under the civil court system. Instead, nearly all patients are seriously mentally ill offenders from the criminal justice system, either committed by the criminal courts or transferred directly from state prisons. Dealing with these so called "forensic" patients is very difficult, challenging and often dangerous work.

In addition, many patients are more difficult to work with because of cutbacks in the use of anti-psychotic medication, including court decisions giving patients the right to refuse meds. Also, there is great pressure to reduce the use of restraint or seclusion -- even in legitimate situations when a patient is out of control -- and this can put patients and staff at risk of serious injury. All of this loads a great amount of stress and new responsibility onto the staff.

To make things worse, there is a major shortage of licensed Psychiatric Technicians and other licensed nursing staff. To put it bluntly, our staff are spread way too thin. To cover that shortage, Psychiatric Technicians and other nursing staff have been working horrendous amounts of overtime for the past few years.

Although management likes to call a lot of this overtime voluntary, in reality it's the same as mandatory overtime. Because if someone doesn't volunteer, that person or someone else is ordered to work it. In the past, most hospitals had minimal amounts of overtime. But these days we regularly see in excess of 2,500 overtime shifts per month at various hospitals.

With stressed-out, burned-out staff working double shifts with increasingly difficult, assaultive patients, it takes a terrible toll on the employees' health, families and morale -- and also on the quality and effectiveness of the care they provide. I don't think anyone would argue that if the hospitals had enough direct care staff, many of the situations reported by the DOJ would have been prevented.

Here's something a Sacramento Superior Court judge said in dealing with a state hospital staffing lawsuit. "Employees responsible for patient care have dangerous and demanding jobs and staff shortages may increase the risk of assault and injury to both staff and patients." The judge said working without enough staff "has the potential to demoralize the level of care nursing staff, contribute to a high turnover rates, increase workers compensation outlays, result in the deterioration of patient care and interfere with effective programming."

It was more than 22 years ago that the judge made that statement, and unfortunately it remains a valid comment on today's state hospital system. We say it's long overdue for the Legislature and administration to take positive steps to eliminate the root cause of the problems reported by the DOJ. And one vital step is providing DMH with enough licensed Psychiatric Technicians to provide care and treatment that is safe to both patients and staff.

And this brings me to a final critical point. Over the years, our union and DMH have worked hard to recruit enough licensed Psych Techs to properly staff the hospitals. But a continuing problem is there are simply not enough Psych Techs available to come work for the state.

So there is a huge need for our community colleges and other schools to train many more Psych Techs so they can get licensed. We're told that in the state hospital system alone, there is now a need for 1,000 licensed Psych Techs. And in the next five years, estimates are that as many as 3,000 more will be needed by DMH, Developmental Services and Corrections and Rehabilitation.

In closing, the Legislature, administration and schools have done a great job focusing on ways to alleviate the shortage of Registered Nurses and Licensed Vocational Nurses. It's time now to focus the same priority effort on California's other major group of licensed nurses, the Psychiatric Technicians who have been called the backbone of the state hospital system. Thank you.

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September 20, 2005

The Peer/Self Advocacy Unit is a group of former mental health clients who facilitate groups in locked psychiatric facilities and in the community to teach people about their rights, provide an atmosphere of safety, trust and empowerment and teach skills which will enable people to advocate successfully for themselves or as a group.
I facilitate four self advocacy groups at Napa State Hospital-three are with residents on forensic commitments and one is with people on civil commitments. Group members discuss problems and strategize solutions. Many residents at the Napa State Hospital seek legal recourses to problems because they believe they are being treated unfairly within the system.

The Napa Self Advocacy group members largely concur with the Department of Justice's report. Their **chief complaint** has been **that negative staff attitudes** are at the core of what is wrong with every aspect of their care. .

A recent incident illustrates this point. A client has been experiencing a disorder of the pancreas. When taken to a local hospital for treatment, he is told that one of his psychiatric medications may be a strong factor in the disease. When the client returns to Napa, the psychiatrist ignores the evidence and the client is put back on the same psychiatric medication. The client is hospitalized with additional symptoms of the pancreas disease and again, the psychiatric medication is discontinued. Finally, and fortunately for this client, another staff member spoke up and the doctor was taken off his case. However, this is just one of many complaints of medical abuse and neglect.

Another instance of lack of respect was reported by a client on an LPS commitment. He told the group that he had asked a staff member who was handling some trash if she could wash her hands before handing out their medications. The staff member retaliated against this client by not allowing him the opportunity to attend the unit dance that weekend. The client filed a Patients Rights complaint; however, the damage was done. This denial of rights is typical

of a pattern of undermining individual's self esteem and creates a feeling of powerlessness and sometimes, understandable rage.

I cite these incidents as indicative of the overall staff culture within Mental Health Institutions. Where a medical model prevails, individual clients are seen as sick or incompetent. Coupled with the forensic system, with its heaviest emphasis on diminishing "dangerousness" it is not easy for staff to contemplate a culture change which includes looking for and building on an individual's strengths and looking for character shifts that indicate a diminished capacity for being dangerous.

A recovery model builds on a person's strengths

Psychiatrist Mark Raggins, from Long Beach California writes that a recovery is based on hope, empowerment, self responsibility and finding a meaningful niche in life. In a model rehabilitation program where he works, the top down medical model is done away with. Staff and residents interact collaboratively with a personal treatment plan based on the individual's goals. Everyone's input is respected.

In most mental health institutions, a top -down power model has existed for a long time, making innovation and change difficult.

Suggestions for improving residents care and life in an institution (These suggestions came directly from Self/Advocacy group members at Napa State Hospital in September, 2005)

1. Close the State hospitals and open smaller treatment facilities where people could be known as individuals.
2. Look at the whole person; stop criminalizing every infraction or small mistake.
3. Decrease the length of stay in the state institutions; get people back to the community sooner.
4. Ask staff members to speak in the language of the clients; provide adequate translators for clients with Limited English proficiency.
5. Make a tape-recording of treatment team conferences, so that there will be clarity about what happens in those conferences. A voice recording would allow clients to review their treatment team's comments and would also provide accurate evidence in a court hearing should questions arise.

6. Hire more Patients Rights Advocates and increase monitoring of treatment conditions.
7. Have psychiatrists and doctors meet individually with residents on a more regular basis.

Respectfully submitted,

Amy Breckenridge
Senior Peer/Self Advocacy Coordinator
Protection and Advocacy, Inc.

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TESTIMONY

SELECT COMMITTEE ON DEVELOPMENTAL DISABILITIES AND MENTAL HEALTH

SENATOR CHESBRO, CHAIR

TUESDAY, SEPTEMBER 20, 2005

INTRODUCTION: I am Dr. Charles Faltz and I am here on behalf of the California Psychological Association. CPA has a major, ongoing commitment to upgrading the quality of care provided to people in the State Hospitals. In my own professional career, for many years I was the Chief of San Mateo County's Forensic Mental Health Service. I was responsible for a large multidisciplinary group of physicians, psychologists, social workers, nurses and psychiatric technicians that provided both inpatient and outpatient care to mentally ill people who were in the criminal justice system. That is the primary population of people who are currently in State Hospitals. We sent our patients to the state hospitals and we received them when they returned to the community. When state hospital patients returned to the community, a team under my direction provided the Conditional Release Program for those patients as they adjusted to the community.

SUBJECT: Review of the Federal Department of Justice Investigation of California State Mental Health Hospitals.

- The California Psychological Association is aware of the longstanding bi-partisan legislative commitment to providing quality care to people in California's State Mental Hospitals.
- Senator Chesbro and the Select Committee have played a leading role in trying to assure that people in the state hospitals are treated in a compassionate and safe environment.
- CPA believes that the U.S. Department of Justice has provided an important public service in exposing and reporting on tragic lapses in the treatment of people who are committed to the state hospitals.

- CPA has great concern that it took an outside agency to identify these problems which suggests a major breakdown of accountability has occurred within DMH.
- CPA has great concern that whenever confronted with problems in the state hospitals, the Department responds that it can only provide the additional, needed services if it hires more, higher paid psychiatrists.
- In fact, at the same time it is claimed more services are needed, it is extensively documented that DMH and state hospital psychiatrists have been blocking additional, needed services to patients by psychologists and nurse practitioners.
- The State Legislature can take great credit for its early recognition in the 1990s that existing care in state hospitals was inadequate when it directed the state hospitals to start offering care as described by Sec. 1316.5 of the California Health and Safety Code. With the assistance of the legislature and the State Department of Health Services, CPA has been trying to move the Department of Mental Health to implement the law for nearly a decade.
- The Department of Justice has determined that the Recovery Model of care must be provided by the DMH to improve the quality of care in the state hospitals for the mentally ill.
- On its own initiative, DMH psychologists began training themselves in the Recovery Model in the early 1990s when the American Psychological Association identified it as an improved model of care based on advances in our understanding of serious mental illnesses.
- CPA is pleased to provide the Select Committee with copies of the May, 2005, edition of the American Psychological Association's publication which describes an advanced Recovery Model and the latest best practices that will lead to improved outcomes for people with serious mental illnesses.

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The California Psychological Association is a non-profit professional organization of nearly 4,000 members practicing in the state of California. California's psychologists currently work in state hospitals, private practice, government agencies, university and research settings, schools, community clinics, and businesses.

SECTION 5

Public Testimony

Marilyn Gill
4117 Palm Tree Ct.
La Mesa, CA 91941

October 3, 2005

Senator Wesley Chesbro
P.O. Box 942848
Sacramento, CA 94248-0001

Dear Senator Chesbro,

This letter is in response to your request for written testimony given at the recent Senate Hearing on the facilities caring for the Developmentally and Mentally Disabled folks who live there. Thank you for this opportunity to submit my personal story which I briefly spoke about at the Hearing.

This is extremely painful to write about because recently even more people have become involved in this saga to their detriment as well as our son's. When I arrived home from Sacramento I had a call from one of the patients on my son's ward. Since there is a NO CONTACT Order in place I cannot call my son directly and have to rely on staff who call infrequently or other patients who can only leave a Collect Call name on my answering machine with no details. This is a huge disadvantage to both my son, [redacted] and me because he is used to contacting me for his basic needs such as canteen money, batteries etc.

There was an incident this week (due to the NO CONTACT) which was precipitated by [redacted] not having enough batteries for his walkman. He took batteries for his walkman from another patient. Please let me explain why batteries are so important. Day after day, week after week, month..... patients who have been affected by overdrugging as my son has been get to do little but languish on their ward. As you will see in Dr. Bucke's story, that I have attached, patients are sometimes not ready for all the "Treatment Programs" that the Team decides are "best" FOR EVERYONE. In [redacted] case, he was doing much better when he first went to Atascadero last November. He was more able to communicate and interact with staff and peers. That was because he had been home with us for 3 weeks and was on his Equilib Nutrient Regimen along with lots of TLC from his family and others. This Program enables one to eliminate the labels of Schizophrenia, Bipolar Disorder, Tourettes, Autism and many other labels which could stem from real medical problems that have not been properly diagnosed and addressed as CCHR's White Paper along with many other Scientific Papers verifiy.

I have attached some information from the Nutrition Institute of America. It is known that **drugs**, even those **prescribed**, leach nutrients from one's body leaving it vulnerable to disease including manifestations of mental disorders and odd behaviors. It is now known that Zyprexa (which [redacted] was on) causes Diabetes, Risperdal (which [redacted] **is** on) causes heart disorders, Clozaril causes Agranulocitosis – a life threatening

blood disease. His present doctor (who put him **in restraints for not wanting to talk** to him) wanted to put [redacted] on Clozaril as well.

Based on this information I know that you can see how a person could have a lot of difficulty in the institutions which you are now learning are not running as well as they might. This is my son's situation. I want to be able to help make it work better than it is presently. I need your help. He is sometimes able to cope and often not. Hence, the insatiable need to "zone out" in order to maintain one's own emotional/mental equilibrium in the midst of daily institutional chaos. The walkman provides a link to all that was normal before the RETRAUMATIZATION of in and out of prison/hospital/jail etc (Systemically Caused Recidivism).

This scenario would not be occurring had [redacted] been honorable and NOT PUT [redacted] back on extremely high doses of Depakote, against family wishes, which was the cause of his original MASSIVE WITHDRAWAL that ended up in the ACCIDENT with me. If the hospital had allowed us to provide [redacted] with his Equilib Nutrient Program at our own expense or if objecting to this, some similar form of nutrient supplement, [redacted] would most likely be faring much better at this time (I have documentation to prove this). Other family members have also implored Hospital Administrators and Medical Professionals to allow their loved ones to receive Remedial Nutritional Supplements to help assuage the intense painful, adverse effects such as.Akathesia, Tardive Dykinesia etc. and ill health created by some of the Standard Forced Treatments such as psychotropics/neuroleptics/SSRI's. In fact, one caregiver removed these vitamins/nutrients from a patient's diet with the admonishment, "you look too healthy, you don't need them any more."

So, you see, Senator Chesbro, if my son were doing really well he wouldn't be snagging other people's batteries or listening to his walkman incessantly. He would be doing what he did at home. He began to help me with little things like the dishes. He asked to go out for a drive/walk. He talked about getting a job and a car – all the things that he has missed for so long now. He was just a kid when I brought him to the psychs via the school he attended. We had such great insurance. It cost $30,000 for the first hospitalization (at age twelve and half) in Alvarado Parkway Institute for Adolescents (which closed w/in 2 years because of mismanagement) where [redacted] was **restrained and held in seclusion for laughing** at something his eight-year old roommate said to staff. I, along with countless other loved ones began this journey into Madness without the slightest understanding of where it would lead.

Returning to this tale of unfortunate circumstances, the patient who attacked my son because he took his batteries is now being Forced Drugged (he was not previously on any medication to my knowledge and was not a bother to either staff or peers). Due to my son's immediate need for batteries (they don't have access to electrical outlets) and his not being able to meet these needs through communication with me – this man now has had a **year added** to his sentence and is on debilitating psychotropics and I have no knowledge of how this is going to affect my son. I feel very badly about this. It has

affected more than just the two people involved. Even the patients are upset at this outcome.

This NO CONTACT is a violation of so-called System Values upholding Family Preservation. Mine is not the only situation where this kind of keeping-loved-ones-away –from-each other attitude prevails. It pervades the entire System. It is contrary to Recovery. It is detrimental to Society. It has no benefit to those involved who do not want it. I should be allowed contact with my ONLY SON who contrary to what parole and the psychs say DOES WANT TO COMMUNICATE WITH ME. He refuses visits out of fear of his Freedom being taken from him forever which he has been warned will happen if he Contacts me, his mother! He has been warned repeatedly that this could happen. Were I he, in his position, I would comply as well.

Regrettably, we have a situation that from the outset was contrived for the benefit of everyone but our son and this family. I am told that it is a public safety issue. Well, FOR THREE MONTHS AND THREE WEEKS, [redacted] WAS AT HOME WITH THIS FAMILY AND IN THE COMMUNITY AND THERE WERE NO PROBLEMS. Why is this not taken into account? Why am I not allowed to VISIT my son in the hospital, in a heavily locked room, with two ARMED GUARDS and many more nearby? Why can I not call, write or send things to my son whose wellbeing is of great concern to me and my family? Why is psychiatry going along with Parole on issues of RECOVERY?. This is ANTITHETICAL. (Psychiatry promises wellness, freedom, help and normality and provides exactly the opposite). This liason with the Prison Industry has poisoned whatever semblance of sanity one could possibly hope for as evidenced by my son's and others' records.

Speaking of records, we asked for these through an attorney after [redacted] was ***Recertified*** *for the MDO Program in Spring of 2004*. **Miraculously**, he suddenly ***Recovered*** and was no longer eligible for the MDO Program. His **prescribed drugs** were **suddenly changed** and **eliminated** along with this *NEW DIAGNOSIS* which indicated that he "**wouldn't do well in a new social situation**." So what did the ASH/Parole/CDC do? They "dumped him into Parole's lap" who stuck him about a mile away from home in a half-way house. I told the social worker to tell the doctor that this would not work for [redacted]. I was right. He left the group home after one hour and no one knew where he was nor would his Parole Officer, [redacted], call me back. They let him go and **once again he was in withdrawal from 2000 mg of Depakote and Risperdal that [redacted] had increased and decreased more than once in a month's time**. I have pictures to show how toxic [redacted] was. I even have a video of how well [redacted] was doing before the SWAT-like Team picked him up(June 2004) from our home at gunpoint.

What I do know to be true, is that we are willing and able to take [redacted] home or even to live with family out of the country. We were never given the opportunity to really discuss options because we were prevented from seeing [redacted] when he was returned to Donovan Prison for *my* Parole Violation. The psychs at the prison decided he was off limits to us and his Lawyer.

We had a hospital for him to go to near San Diego. I had the letter of acceptance but [redacted] **said** that **she checked** with this hospital in Alpine and that [redacted] ***was not eligible.***

Suffice it to say, the situation remains convoluted, an impossible construct that offers NO OPTIONS and much discussion on pseudo topics of Release and Recovery which can't materialize because of the collaboration between Law Enforcement and Medicine/Psychiatry keeping the patients and family members in LIMBO.

My entire family and I are reaching out to anyone who can help change this now too-terribly-long (forensic) ordeal which continues to cost the State of California dearly as well as my son's health and the emotional well-being of this entire family who has been unnecessarily fragmented by the dictums of these Collaborating Official Agencies that seem to lack any understanding and empathy toward Conciliatory Measures which would lead to Family Recovery and Reunification.

Respectfully Yours,

Marilyn Gill

Cc: Governor Arnold Schwarzennegger
Thelton E. Henderson, US Magistrate
Bill Lockyer, Office of Attorney General
Jackie Cuncannon, US Dept. of Justice
Jeff Griffin, CCHR
David Oaks, MindFreedom USA
Jeff Lustman, Esquire
Jim Gottstein, Esquire
Undisclosed Recipients.

Enclosures (3)

4117 Palm Tree Ct.
La Mesa, CA 91941

March 25, 2005

Ms Christine Moore
Department of Corrections
Region ll Headquarters
1515 Clay Street, 10th Floor
Oakland, CA 94612

Re: [redacted]

Dear Ms Moore,

Thank you for your letter dated February 23, 2005, in which you stated all the reasons that you feel our son should not be with me or with his family. Still, my family and I are requesting that Parole lift the NO CONTACT and NO VISIT ORDER in place now.

Indeed, so many of the letters I receive from Institutions seem perfunctory and yours did not. Thank you for that. On the other hand, much of the information that is in our son's file was done in a perfunctory manner and some of it is actually inaccurate. The statements taken by the officer at the scene of the accident in June 2000 were incorrect. She has me confused with Ms Mendeville. Since I was unconscious I was unable to say much. Ms Mendeville was receiving medical treatment at the time and was not as coherent a witness as she might have been. She subsequently passed away due to her illness.

Ms Moore, what happened was **an accident** which was **exacerbated by withdrawal from psychiatric drugs.** I was never permitted to speak in court because when I went to mention this I was **quickly silenced** by [redacted] Public Defender, [redacted] Perhaps he knew something about the judge's mores that I did not know and was fearful that things would go worse for [redacted].

[redacted] has been damaged by all the excessive drugging to counteract a drug problem which [redacted] started to handle himself by taking responsibility for his own Recovery in Washington in January, 2000. This was blatantly thwarted by his Social Worker and Probation. By the beginning of 2000 the **withdrawal** was starting again. Often this is what gets the label of "mental illness getting worse." The high profile cases and the parents who have testified before the FDA attest to this very fact. Hence, more **BLACK BOX WARNINGS** on drugs such as the one [redacted] **was prescribed in his teens – Serentil.**

In the time that [redacted] has been incarcerated I have been learning about Recovery and how it is achieved. Many Psychiatric Survivors were informed they would always be

'mentally ill' but actually recovered outside of the present mental health system with Alternative Therapies. I belong to MindFreedom which started thirty years ago and is recognized by the U.N. I work with Citizens' Commission on Human Rights and Criminon. I have been Certified by Narconon to do Narconon – The First Step. I am better trained and informed on what is specifically needed and wanted in Stephen's case. I also know better now how to help him heal from the trauma that he has created and endured.

[redacted]s files abound with discrepancies. We did not refute these because we, his family, have been waiting for the many Release Dates that never materialized. Mental health awaits the incarcerated (Mentally Disordered Offender) who are on medication or perhaps withdrawing from same and experiencing behaviors that only being on and coming off a prescription drug or combination thereof can produce. Isn't it sad that what can be perceived by a layperson is so hard for some professionals to see? Medications and withdrawal can create an **iatrogenic illness**. Hence, much of the **"mental illness"** that professionals see in their clients is actually **caused by the "cure."**

I am very concerned with our son's health and well-being which has been seriously compromised in the State's care. I am angry that we were told that [redacted] was to be released at the end of November 2004 and when we went to discuss Alpine Center as an option my husband and I were told by [redacted] and [redacted] that [redacted] had, once again, been procured by Atascadero because of his 'mental condition.'

How fine and dandy it is for Donovan and Atascadero who have a "contract" with each other. Where does Family Preservation come into play? You mentioned that we did not do our part to get someone in to evaluate [redacted] for Alpine. Do you know how **difficult it is to see a person in prison withdrawing from 2000 mg of Depakote** (which the prison doctor said they didn't use at Donovan because they don't think it's good)? That's great for them but not for our **son who did not do well on it or coming off it** unless he followed the **Harvard Study Equilib Nutrient Protocol** which we had been doing **prior to sentencing in June 2001** when **Stephen was at home with me *without incident* for three months** and when **he was with us for the three weeks prior to the arrival of the SWAT-like Team at our door this past June, 2004.**

Ms Moore, if you are a mother then you will understand my plight. I did not know how the Systems worked until we had fumbled through each one. By that time it was too late for our son, who has definitely been impaired by over-drugging and cold turkey withdrawing from all drugs, to be **easily** extricated from this mess.

In our visit with [redacted] and [redacted] we were told we would have to speak to [redacted] at Atascadero. When I called [redacted] he told me that he was unable to help and that [redacted] and [redacted] were the ones to talk to.

Now you tell me, once again, that it is [redacted] whom I must consult for redress in this matter of lifting the No Contact Order so that we, his family, can help Stephen SUCCEED at getting off Parole so that he can be one of the ten percent who are not "set

up" for failure. These words came from Judge Exarhos' lips when he stated to our lawyers that "**ninety percent of parolees are set up**."

Parole claims to work with us and talk with us. They claim to be "nice guys" but they don't want to be bothered with [redacted]. Well, we do and we are. That is why I will continue to work to get him home so that he can be with other members of our family because we now know what works and what was getting [redacted] healthy. Surely, you are not against this. You talk about safety but **where is the safety in disintegrating families** by overburdening them and their loved ones with rules and regulations they can neither understand nor easily follow without the assistance of those "in the know" such as the Parole Officer? Without good Notice and without a viable Plan our son was "dumped" per PO into their laps by Atascadero. Ultimately the communities you purport to protect fall apart as well.

I could send you articles about prison conditions and excessive parole violations but I am sure you know what the Little Hoover Commission's report had to say about these things. So, when is the day coming that something different is to be done? When is the day coming that kids who are bright and on the wrong track get a real helping hand not handcuffs, solitary confinement, labels and prescribed drugs due to poor conditions as a way to "correct" their behavior?

What happened between [redacted] and me was an ACCIDENT. I tripped over his foot and his reactions were too slow/confused from Toxicity and Spontaneous Withdrawal from psychotropics to let go of me. I, being heavier than [redacted], fell to a cement floor with my son on top of me. My head hit the cement. I was unconscious **due to the fall** not because [redacted] hit my head on the floor (not wall as report states). His actions after that were because of the withdrawal and not because of any intent to harm me. He didn't know what he was doing. He doesn't even remember what happened. **He needed to DETOX.** He did that in jail and that is why with the Harvard Study Equilib Nutrients he did so well with me at home for three months prior to sentencing in June, 2001. He was still recovering – he had Autistic-like symptoms but his demeanor was **gentle** and **civil** as it was before all the drugs.

[redacted] subsequently had "no signs of mental illness" per the Psych Eval in jail in June 2001 *but BECAUSE OF HISTORY* from Washington State *he was prescribed* 20 mg. of Zyprexa *immediately* (which he took because he was so cooperative because of the Equilib Nutrient Program he'd been on for three months). This is in keeping with TMAP –TX Medical Algorithm Plan that has been implemented across the country in all Institutions and is now seriously in question for FRAUD in the Federal Court.

I apologize for the length of this letter but it is hard to compile sixteen years into a few pages. My request of you, Ms Moore, is that you see what is actually happening here. As his parents we had **to learn the Systems**. By the time we learned, the **damage** was **done.** Then we figured out what to do about the damage and were beginning to have **some success** but [redacted]**'s history trapped him.** It was so extensive and the **lack of**

real help so pervasive that [redacted] **got permanently caught up** in a very serious **business** in the form of Social Services and Government Entities whose goal is to procure clients....

If Parole were inclined to work with families, as [redacted] indicated to me, then he would have called me back, we would have met to discuss [redacted]'s release with all its variables and we would have worked something out together. I am not an unreasonable person. This did not happen. **Meeting with us after the fact did not help** [redacted].

We want our son back with us. ***Please lift the No Contact Order against me*** which **prohibits me from visiting** [redacted] ***even in the hospital***. It seems that **Parole is punishing me** as well **because I wanted to make sure my son was safe** and not wandering the streets in a **Depakote/Risperdol withdrawal** stupor. No one listened to me. I said that [redacted] would not do well with strangers (this is noted by [redacted] before **Atascadero released** [redacted] **suddenly after we requested his medical records**). He will fall prey to those who are more street-wise than he and if I tell that to someone who is not jaded by the criminality of society they will understand me. I am not trying to pamper our son – I am trying to **help him heal**. That means that he needs some **care at the outset** that **only family would be inclined to give**. Why wouldn't Parole want to help us with this? ***It would save the State a great deal of money – over $125,000 a year.***

Thank you, Ms Moore, for your time and consideration of this matter. I am pleading with you as a mother, to **please help me by lifting the No Contact** and **not setting** [redacted] **up *again*** by putting him through the rigorous job of adhering to all the rules of Parole/Mental Health while physically/mentally impaired *without assistance from those who love him most, his family.* We are fully prepared to work with Parole if Parole will only allow us to do so by **considering our input** as much as they consider what has been incorrectly written in [redacted]'s file.

Respectfully yours,

Marilyn Gill

Marilyn Gill and Family

cc: Mr. Rodriguez

September 20, 2005 - State Capitol Building - Room 4203

Hello, my name is Ann Williams, and I am the mother of [redacted], who has been in the Mental Health System over half of his life; 12 years of which have been at Napa State Hospital. He just turned 40 and looks like an old man. He is being drugged into a premature death. One doctor, who had his license suspended for sexual and drug or alcohol abuse before being hired by Napa State Hospital, told my son in response to [redacted]'s request to be taken of a certain medication because it was making him feel weak "I have the right to put you on any **GOD DAMN** medication I want". When confronted with this, the doctor denied it. My son has been diagnosed with hypothyroidism, diskenesia and parkinsonism; **all caused by the drugs**. and has become suicidal & assaultive After graduating from High School Curt went off to Marine Boot Camp, where he was discharged as emotionally immature; **not** "mentally ill'! On returning home his feelings of failure caused him to become despondent and subsequently he fell into a depression, but much worse than that, he fell into the "Snare" of the Mental Health System. I have tried to become [redacted]'s conservator and get him released from Napa State Hospital on several occasions only to find him over drugged when he arrived at the court house preventing him from making a sound statement in support of his case. (See similar instance on page 18, last paragraph of the DOJ's Report into Napa State Hospital).

Yes, I am **very angry** at what the Mental Health System has done to my son and many other people's loved ones, too, and I believe the Mental Health System should be held accountable for the damage inflicted upon them. The Department of Justice have completed their investigations into Metropolitan and Napa State Hospitals and their reports are unfavorable, which is no surprise to myself and many others. I have no doubt the Department of Justice will find much the same

throughout the California Mental Health System. I believe Napa State Hospital is no worse than any of the other facilities my son has been in, and that is not meant to be a compliment, because believe you me, it could not get much worse as confirmed within the DOJ's Report. The present System is **not working** and nobody is more aware of that fact than the "patients" themselves. After reading the Department of Justice's Investigation Report into Napa State Hospital it seems to me that the staff are completely oblivious to their instructions, which again is no surprise to me, because they have such unrewarding jobs to perform.

Senator Chesbro, in your letter to me dated September 6, 2005, you asked if I have any recommendations relative to improved quality of care for individuals residing at a state hospital. The answer to that question is a resounding **YES!** I recommend, as I did here on March 22, 2004, an alternative treatment plan to give our loved ones hope and their dignity back. A plan **without** labels, for which there ~~are~~ is **no** scientific proof, which is the reason why **many** diagnoses are given by **many** different psychiatrists to **one** patient. A plan **without** so many **unnecessary, convenient** and **costly** psychotropic drugs, which have serious physical and emotional side effects, including suicidal and assaultive behavior. A plan **with** nutrients to replace/augment the psychotropic drugs for their physical and mental health. A plan **with** vocational training, college courses, farming and animal husbandry, whichever suits the individual's abilities to prepare them for their release back into society, as is done in the prisons. A plan **with** faith based programs, such as Chuck Colson's Prison Ministry, which I might add is very successful.Why, I ask, are these programs not in the California Mental Health System? I also believe that "patients" should exercise regularly and be encouraged to help others rather than focus on themselves.

I truly believe that such a plan would be **very** cost effective and **so** successful benefitting **many** patients, and that is my dream. It would seem to many that my son is past being helped, but I am a woman of faith in God and believe with all my heart that the end of my son's story **will be a good one.**

Thank you

Ann P. Williams
[redacted]

Proposed Initial Handling of Mental Patients in The California State Mental Health System

By
Citizens Commission on Human Rights
Los Angeles Chapter

CCHR LOS ANGELES: 50551/2 SUNSET BLVD.
LOS ANGELES, CALIFORNIA 90027
PHONE: (323) 663-2247 FAX: (323) 667-0115
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PROPOSED
HANDLING OF MENTAL PATIENTS
IN
THE CALIFORNIA STATE MENTAL HEALTH SYSTEM

TABLE OF CONTENTS

INTRODUCTION

The State of California currently operates four State hospitals with a fifth to come on line shortly. The four currently in operation are Metropolitan State Hospital in Norwalk, Patton State Hospital in Highland, Atascadero State Hospital in San Luis Obispo and Napa State Hospital in Napa.

The fiscal year budget for the operation of these four institutions in the fiscal year 2002-03 was $141,000.00 per patient. The total number of patients housed in these institutions currently is 4,712. This is a total cost of $584,392,000.00 per year, extrapolating with no annual increase in 2003-04, 2004-05 or 2005-06.

The aforementioned monies from the State coffers do not include almost $100,000,000 billed to the various counties of the State that have placed patients in these facilities as reported in 2001. That figure has certainly risen over the past four years, making our expenditures in the range of ¾ of a billion dollars or more per year.

The amount of land being used for these facilities totals over 1,192 acres, 162 for Metropolitan, 140 for Patton, 700 for Atascadero, and 190 for Napa. It is estimated that the real estate value of this property could easily run in the multiple billions.

Ostensibly, these facilities are operated to handle the "insane" and "criminally insane" under the auspices of the California Department of Mental Health. Referrals to these facilities come from the California Court system, whether civilly or criminally committed.

These facilities do not handle anyone on a voluntary basis, and as a result of the commitment process, are essentially prison compounds, with sally ports for entering the facilities by vehicular traffic. Metropolitan does have one area that visitors can enter without going through a police inspection. (The people housed in this area are not criminally incarcerated, but civilly incarcerated and kept behind high fences with razor wire at the top.)

Results

What are we, the citizens, getting for our "investment" of almost a billion dollars tax dollars each year?

The United States Department of Justice, Civil rights Division, Special Litigation Section, announced in late June of 2002, that it was investigating possible civil rights abuses at Metropolitan State Hospital. The *Los Angeles Times* reported in an article dated July 3, 2002, "The U. S. Department of Justice is investigating possible civil rights abuses at Metropolitan State Hospital in Norwalk, a sprawling facility *that for years has been the subject of complaints about excessive use of restraints and drugs to control child and adult mental patients*." (Italics added.) (See attached newspaper article for full story in appendix D)

In May of 2003, the US DOJ sent a letter of findings and recommendations to then Governor Gray Davis and the California Department of Mental Health regarding the children's program at Metropolitan. (See Appendix A)

In February of 2004, the US DOJ sent a letter of findings and recommendations to Governor Schwarzenegger and the California DMH regarding the adult programs at Metropolitan. (See Appendix B)

Also attached are newspaper articles that reflect that "business as usual" is still the norm at Metropolitan. (See Appendix D)

In January of 2004, the US DOJ announced an investigation into alleged civil rights abuses in Napa State Hospital. In June of 2005, the US DOJ sent a letter of findings and recommendations to Governor Schwarzenegger and the California DMH regarding their investigation of Napa State Hospital. (See Appendix C)

In the same letter of findings of June 27, 2005, the DOJ made it public that it is also investigating Patton State Hospital and Atascadero State Hospital. It can be expected that the findings will be similar, if not worse, to those as found at Metropolitan and Napa.

In addition to the drain of tax dollars to support this reported abuse, how many law suits will these US DOJ findings fuel? And at what cost to the already strained fiscal scene in California government?

Summary

In addition to the aforementioned costs, how many of the patients released by our State institutions are released back into society as productive, tax-paying citizens? How many are released into the Condition Release Program (CONREP) which is continuing their drain on the tax dollars via the Department of Mental Health?

All of the patients in the forensic units, if they do get released, are released into CONREP as their first taste of outside life. These patients are then kept under close scrutiny by CONREP personnel in group homes scattered throughout the State, another cost. If they don't violate their conditional release over a period of as much as several years, then they might get back into society's mainstream and possibly go to work and pay taxes.

Many end up as homeless on the streets of our cities at still yet another cost to taxpayers, because of the inability of the Department of Mental Health to properly treat and rehabilitate these people.

Where is the positive return to taxpayers for the investment of billions of tax dollars, Federal, State and local? There doesn't appear to be one and the conclusion can be drawn that our State Hospital system is a total failure and costing us way too much for nothing in return.

If you look at the Department of Justice findings and recommendations you will find that it states that at Metropolitan State Hospital, "These deficiencies subject patients to treatment that: (a) prolongs their psychiatric distress...(d) needlessly extends their institutionalization." (see page 7, Appendix B)

It is costing the State $386 a day per patient. This comes to a potential waste of $1,814,200 each day when one considers that every patient has been detained longer than necessary.

RESULTS OF "TREATMENT"

United States Department of Justice Findings

In June and July of 2002, the US Department of Justice began an investigation into possible wrongdoings at Metropolitan State Hospital. This investigation came as a result of the activity of a State agency, Patient Advocacy, Inc. Patient Advocacy, Inc. had uncovered what it deemed to be gross violations of patients' civil rights as guaranteed under the Constitution of the United States.

The findings of the DOJ investigation of Metropolitan State Hospital were published in two separate letters sent to then Governor Gray Davis. The first, published in June of 2003, was a scathing report of the findings in Metropolitan's children section. (See Appendix A) The second, published in March of 2004, was a scathing report of the findings in Metropolitan's adult section. (See Appendix B)

In July of 2005, the DOJ published its findings from an investigation of Napa State Hospital. This report was also a scathing report of conditions at Napa, but even more so, a scathing statement of the systemic problems in our State Department of Mental Health. (See Appendix C)

Metropolitan Children Section

The findings of the investigation of Metropolitan's children section found that the "psychiatric supports and services *substantially* depart from generally accepted professional standards of care and expose children and adolescents there to a *significant risk of harm and to actual harm*." (Italics added.) The report continued to elaborate on the substandard care by listing the many failures of the psychiatric support and services:

1. "fails to provide clinically justified evaluations and diagnoses of psychiatric disorders;
2. "fails to provide adequate and appropriate treatment planning;
3. "fails to identify and address cognitive and academic deficits;
4. "fails to prescribe clinically justified psychotropic mediations;
5. "fails to assess appropriately the side effects of medications;
6. "fails to provide an appropriate therapeutic environment." (See Appendix A, pg 3)

The report further found that the "nursing services *substantially* depart from generally accepted professional standards of care and treatment and expose the children and adolescents there to a *significant risk of harm and actual harm*." (Italics added.) The report then enumerated the failures of nursing and unit staff:

1. "failure to identify, monitor and report patient's symptoms and side effects of medications;
2. "unfamiliarity with mental health diagnoses, associated symptoms, and appropriate treatments and interventions;
3. "ineffective participation in the treatment team process." (See Appendix A, pg 13-4.)

The case of A.M. is an example Citizens Commission on Human Rights found that substantiated the above findings by the DOJ. (Initials are applied to protect the identity of the minor patient.) A.M. is a teenager incarcerated at Metropolitan and her history of "treatment" is that of a plethora of drugs, a virtual cocktail of psychotropic and neuroleptic toxins. When her mother is allowed a home visit from her, A.M. has become an unmanageable young person that even her mother doesn't want to try to handle. The incarceration and effects of the psychiatric drugs have made her far worse than she ever was before entering Metro.

As reported in the media, a little over two years after the DOJ findings were released on the children section of Metropolitan, five teens escaped from the compound and were not found after several weeks of searching. The logical assumption is that they have added to the homeless numbers on our streets in Los Angeles County.

Metropolitan Adult Section

The findings of the investigation of Metropolitan's adult section found that the treatment planning "*substantially* departs from generally accepted professional standards of care." (Italics added) The report stated that, "Metropolitan's treatment planning format *does not* recognize that adequate treatment planning is dependent upon a logical sequence: (Italics added.)

1. "first and foremost, the formulation of an accurate diagnosis;

2. "subsequently, the utilization of the diagnosis to identify the fundamental problems that are caused by the diagnosed illness;
3. "the development of specific, measurable goals that are designed to ameliorate problems and promote functional independence;
4. "interventions that will guide staff as they work towards those goals;
5. "finally, ongoing assessment and, as warranted, revision of the plan." (See Appendix B, pg 3)

The discharge planning process of Metropolitan's adult patients was found to fall well short of the normal standards of care. "Consequently, patients are subjected to *unnecessarily extended hospitalizations*, poor transitions, and a *high likelihood of readmission*, all of which result in harm." (Italics added) (See Appendix B, pg 14.)

It was documented that the psychiatrists at Metropolitan "failed to plan adequate and appropriate treatments" among other failings. "The resulted harm to the patients takes many forms, among them, inadequate and counterproductive treatment, serious physiological and other side effects from inappropriate and unnecessary medications and *excessively long hospitalizations*." (Italics added) (See Appendix B, pg 16-17.)

Since the findings of the DOJ were released in February 2004, there have been five known unusual deaths of patients in the facility at Metropolitan. The first of these deaths was that of A.C., a patient whose family was trying to get him released to a less restrictive environment the week of the death. He apparently went to staff with a request for help as he was feeling depressed that morning and he was not properly attended to and hung himself on the ward.

Another death occurred in June of 2005 and was that of an 18-year-old young woman, B.D., who had recently transferred from the children section of Metropolitan to the adult section. B.D. hung herself in the ward and was transferred to a local hospital and put on life support and lived on life support for six days before succumbing. She also had a history of being prescribed numerous psychotropic drugs.

Still another death was that of a patient who had attempted suicide several times before succeeding in her actions. E.G. died in September 2005, at the same local hospital as BD, after being on life support for a few days. E.G. had set herself on fire twice before this year and had spent time in LAC USC hospital for burn treatment.

Another patient, F.H., had joined E.G. in the previous two attempts at suicide by burning. E.G. had received massive dosages of neuroleptic and psychotropic drugs in the past 18 months. Her situation had been steadily deteriorating during this time. She had been driven totally insane from the plethora of drugs administered in the guise of "treatment" at Metropolitan. She also had reported numerous attacks by other patients and staff, attacks which the staff have attempted to pooh-pooh and write off as self-inflicted harm rather than brutality by staff and patients. Pictures exist of her lying on the asphalt beside a Metropolitan police automobile late at night in an unconscious state after

being returned from the local hospital following an examination after one of the beatings she received.

Reports of unsanitary conditions at Metropolitan have been consistently coming in to the Citizens Commission on Human Rights Los Angeles (CCHR) over the past year. These indicate that what the DOJ reported as smells of urine in the facility when they inspected in 2002 have not been corrected. Reports have come in on several occasions of no hot water available for days on end for bathing. Drinking fountains with the smell of urine are commonplace reports even now.

Napa State Hospital

The DOJ findings of their investigation of Napa State hospital were prefaced with scathing statements of the California Department of Mental Health's attempt to block any attempt to enter the facility for an on-site look. In spite of the "stonewalling" by CDMH, the DOJ continued with its stated purpose of investigating Napa.

The Department credited two government agencies, (one Federal and one State,) "professionals, advocates, family members of patients, and patients themselves" with granting of interviews or providing documentation of CRIPA violations. The letter to the State stated, "In doing so, we found *evidence of significant and wide-ranging deficiencies* in Napa's provision of care to its patients." (Italics added.) (See Appendix C, pg 2.)

In telling the story of one death by suicide at Napa the DOJ stated that the incident "is emblematic of the systemic deficiencies" they discovered at Napa. This came after the "dismissal of the consent decree in 1995" that was the culmination to an earlier US DOJ investigation into wrongdoings at the facility. (See Appendix C, pg 3.)

The findings of the DOJ were numerous, "Information from multiple, creditable sources leads us to conclude that Napa fails to protect patients from harm and abuse." DOJ stated, "The harm suffered by Napa's patients is multifaceted, including:

1. "physical injury by assault;
2. "death by suicide due to inadequate suicide precautions;
3. "excessive and inappropriate use of physical and chemical restraints and seclusion;
4. "inadequate, ineffective, and counterproductive treatment;
5. "exposure to unnecessary environmental hazards." (See Appendix C, pg 4.)

The DOJ found that illegal drugs were available to patients as a result of the facility not following policy. "We have determined that patients have access to illegal drugs, including marijuana and cocaine, while residing at Napa." These illegal drugs are provided to the patients by staff in exchange for cash or sex, according to the DOJ. (See Appendix C, pg 7.)

In the past year there have been several deaths reported to the DOJ by CCHR and verified by DOJ as deaths that should have been prevented. Their stories can be found in the DOJ findings letter.

A patient has been reported for committing lewd sex acts on other patients within the facility. This report occurred this year and states that a woman patient is going after other women on the ward. The data indicates that staff is not protecting other women patients from this activity.

A psychiatrist who was charged in the California court system of making a death threat to a former patient and recording the threat on the former patient's answering machine in the late 1990s was allowed by the Medical Board to work under probation for ten years. Napa hired this psychiatrist and he was discovered to be committing substandard care. He was asked to surrender his license earlier this year, but the fact remains that Napa paid him to work at the facility.

The foregoing is only a part of the findings at the two State Hospitals with completed investigations thus far. In the report on Napa the DOJ stated that it is investigating the other two facilities, Patton and Atascadero. The expected result of these investigations can be reasonably assumed to be quite similar to the results of the previous investigations into Metropolitan and Napa.

As an example of why this can be expected, two patients murdered one of their roommates on night of the 6th of September this year. The day before the murders, at Patton, a patient attacked another patient without any apparent provocation and caused a large amount of blood to be scattered over the scene. These are two examples of staff not protecting patients from harm at Patton.

Additionally, a psychiatrist who is a convicted felon and who spent time in Federal Prison in California in the late 1990s, has been discovered to be currently licensed by the Medical Board and employed at Patton. This psychiatrist has the nickname from patients of "Dr. Death". This psychiatrist was forcibly removed from a ward just a couple of weeks ago by the Hospital Police. He had verbally attacked and was attempting to provoke a patient. After being removed from the ward, he returned later and wrote a prescription for extra drugs for the patient and ordered that the patient be put in restraints. Fortunately the staff on duty caught this and went above this psychiatrist's head to get the prescription changed and the restraint order cancelled.

Metropolitan and at least one other State Hospital have instituted a "Mall Program" that is being touted as a solution to their problems. This program lets patients supposedly choose their "treatment" activities to attend. Patients report it has not worked to rehabilitate them or prepare them to return to the outside world, but is just a continuance of the "treatment" being used prior to the DOJ entering the facility. Patients are so disillusioned with the "treatment" at "mall" that they are refusing to attend. At Patton, when a patient refuses to attend he or she is placed in the "refusal room," a room formerly used for group meetings. When a patient tries to stay in bed and not attend, the

staff physically remove the person from their bed and if the person resists, they then put in the seclusion room in 5-point restraints. Often this is in conjunction with a shot of a neuroleptic drug. The Mall program appears to be the only change in what is being done at Metropolitan as the patient abuse, deaths, and unsanitary conditions still exist and the deaths appear to have increased.

Bill Silvas, who is retiring as director of Metropolitan at the end of Sept 2005, made the statement to Assemblyman Bermudez and the Director of CCHR LA when they visited together in late spring of 2004 after a patient's death, "But we have lots of [suicide] attempts." This was made after telling the visitors that this death in March was the first in 10 years. That being the case, matters are much worse than in 2002 when the DOJ first investigated as there have been five unusual deaths in the past 18 months.

Dave Grazziani, Director of Napa, (in responding to a CCHR investigator's request as to why the State was not allowing DOJ to enter Napa in its investigation,) wrote a statement that was tantamount to admitting that all of the State Hospitals are guilty of the same substandard care as Metropolitan. He said that the State was asking the DOJ to wait until all of the hospitals could put in the remedial actions required of Metropolitan.

Enforced Drugging - Dangerous Consequences

Jack Henry Abbott wrote in his book, *In the Belly of the Beast,* the following graphic words: "These drugs...attack from so deep inside you, you cannot locate the source of the pain... The muscles of your jawbone go berserk, so that you bite the inside of your mouth and your jaw locks and the pain throbs. For hours every day this will occur. Your spinal column stiffens so that you can hardly move your head or your neck and sometimes your back bends like a bow and you cannot stand up... You ache with restlessness, so you feel you have to walk, to pace... in such wretched anxiety you are overwhelmed, because you cannot get relief." (The Real Crisis In Mental Health. A Report, Conclusions and Recommendations, by Rohit Adi, M. D., Mary Jo Pagel, M. D., Anthony P. Urbanek, M. D., Julian Whitaker, M. D., published - 2003, pg 32.)

Whenever a "mental patient" commits an act of senseless violence, psychiatrists invariably blame the tragedy on the person's failure to continue his meds. Such incidents are used to justify mandated community treatment and involuntary commitment laws. However, statistics and facts show it is the psychiatric drugs themselves - including the newest neuroleptics or antipsychotics - that can **create** the very violence or mental incompetence they are prescribed to treat. (Ibid.)

A 1985 investigation into a commonly prescribed tranquilizer, as reported in the *American Journal of Psychiatry*, found that 58% of the treated patients experienced serious "discontrol", i.e., violence and loss of control, compared to only 8% who were given a placebo. Episodes included "deep neck cuts," "arm and head banging," "threw

chair at child," and "jumped in front of car." The patient who threw a chair at her child had no history of physical violence toward the child. The patient who cut her neck had no previous episodes of self-mutilation. (Ibid.)

A 1990 study determined that 50% of all fights in a psychiatric ward were linked to neuroleptic drugs which induced a side effect called akathesia. Patients in this study described that they experienced "violent urges to assault anyone near." (Ibid.)

The FDA has now required of 10 of the major psychiatric drugs manufactured and sold in the United States that a "black box label" be used to warn people of the potential deadly side effects that may occur in users. These side effects include violent feelings as well as suicidal ideation. (See Appendix D.)

This could well be the cause of the violent actions of patients on patients and patients on staff. A handling for some of this is given in the Handling section of this paper that follows.

Media Response to DOJ Reports

The response of the media to the findings of US DOJ investigations of the two hospitals so far reported is not favorable to the State of California. The State of California was portrayed as the black hat in a battle with the United States Department of Justice in many of the published articles about the findings on Napa.

Examples abound and several are attached to this document. (See Appendix D.)

1. *Los Angeles Times* article of 27 July 2005, "Hospital for Mentally Ill is Criticized."

2. *San Francisco Chronicle* article of 28 July 2005, "Mental Hospital Probe Shows Major Problems, Officials Accused of Stalling Napa Inquiry."

3. AP Wire Service posting of 28 July 2005, "DOJ: Deficiencies Widespread at State Mental Hospital in Napa."

4. *Los Angeles Times* article of 31 July 2005, "State Faults US Report on 2 Mental Hospitals."

5. *Los Angeles Times* article of 3 August 2005, "Officials Bicker as Mentally Ill Wither."

6. *Los Angeles Times* article of 10 August 2005, "Vacancies At Mental Hospitals a Disaster."

That the investigations did not change the scene at Metropolitan and the other State Hospitals is evident in the media reports that are attached. (See Appendix D)

7. *Los Angeles Times* article of 3 March 2004, "Patient Hangs Himself at Mental Hospital."

8. *Los Angeles Times* article of 6 June 2005, "Troubles Continue at State Mental Hospital in Norwalk."

9. *Los Angeles Times* article of 9 September 2005, "Patients Held in Patton Death."

The seventh article above was published only a week after the findings into adult section investigation of Metropolitan by DOJ were issued and almost a year after the children section findings were published. This is indicative of no change after almost a year of opportunity to put in proper corrective actions.

The eighth article above tells of not only a suicide death at Metropolitan but the escape of five teens from the children section. Again, almost two years after the first published findings by the US DOJ.

The ninth article listed above tells of another suicide attempt at Metropolitan. The patient died a few days after the article was printed. This is a couple of years after the first investigation findings were released.

In one of the August articles written by Steve Lopez, he quotes the Director of the California Mental Health Department as saying that the Director has been aware of the "systemic problems" at the state Hospitals and has been "trying to clean them up" for over 10 years. An executive who admits to such ineptitude should probably be replaced by someone with the capabilities of making these facilities a true rehabilitative haven for our troubled people, not a tax drain on the taxpayers.

Summary of Costs

Based on the US DOJ findings that have been published to date, it would be safe to say that as a minimum the average incarceration at our four facilities is at least six months too long. In many instances it is years too long.

Extrapolating from these data, it is costing the taxpayers of the State of California at least **$331,091,500.00** more than we should have to expend to house and not rehabilitate our patients in the State hospital system. This is a very conservative estimate of our costs. This does include the projected loss of tax monies that would have been derived from a large producing group of people rehabilitated and earning money rather than taking money from the system.

Suggested Handling or Solution

Past Legislative Actions

In the 1980s, the California legislature set up Chapter 208 of the Statutes of 1982. This was called the California Medical Evaluation Study and was carried out in 1983 and 1984. The study was authorized by SB 929. The study was performed on 529 patients in the mental health system of California and reported in detail to the California Legislature as well as several scientific publications. The study team performed complete medical evaluations on these patients.

In 1988, pursuant to Chapter 376 of the Statutes of 1988, (which was set up by Assembly Bill 1877,) a manual was prepared for the California Department of Mental Health and local mental health programs. This manual was the result of the work of Dr. Lorin Koran, MD, of the Department of Psychiatry and Behavioral Sciences at Stanford University Medical Center. This manual, Medical Evaluation Field Manual, was published in 1991. (See Appendix E.)

Since that time it has collected dust, apparently on the shelves at the California Department of Mental Health, or in a file cabinet in some obscure office location. It has not been implemented for certain.

Results of the Funded Study

To quote Dr. Koran, "The most important findings of that study are:

1. "Nearly two out of five patients had an active, important physical disease.
2. "The mental health system had failed to detect these diseases in nearly half of the affected patients.
3. "Of all of the patients examined, one in six had a physical disease that was related to his or her mental disorder, either causing or exacerbating that disorder.
4. "The mental health system had failed to detect one in six physical diseases that were causing a patient's mental disorder.
5. "The mental health system had failed to detect more than half of the physical diseases that were exacerbating a patient's mental disorder." (See page 3 of attached Medical Evaluation Field Manual in Appendix E.)

The result of the above findings led Dr. Koran to produce the Medical Evaluation Field Manuel. In the acknowledgments to the manual he expresses appreciation to the two co-investigators of the SB 929 Study of 1983-4, Drs. Harold C. Sax and Keith I. Marton. In the introduction section of the manual Dr. Koran refers to the fact that many studies of this nature have been conducted in mental health settings. These studies reported that anywhere from 15% to 93% of mentally ill patients had a concomitant, active, important physical disease.

Dr. Koran stated in the introduction to the manual, "These findings underscore the need to improve screening for physical disease among patients in California's public mental health system." He further pointed out that current methods of screening of patients is very limited and often don't detect important physical diseases and are not cost effective.

Dr. Koran developed an algorithm, (a set of step-by-step instructions for solving a problem,) that uses a limited set of items from a patient's medical history, a blood pressure measurement and selected laboratory tests to detect physical disease. The use of this algorithm detected more physical diseases than the mental health programs had detected in the study patients. (See Appendix E, pg 4, 12-13.)

This algorithm can be performed by staff in any mental health setting after "very limited training." It can be done at a lower cost per diagnosed case than current screening tests.

Summary

Extrapolating costs of current "treatment" in our state facilities as done above, and adding the savings of treating a physical malady and thus restoring the mental health of a patient without extensive incarceration in a State hospital, the savings to taxpayers could reach into the billions of dollars over several years.

Imagine having almost 40% of our patients healed and back out into the work force in a matter of weeks or maybe months instead of years. This would be a cost savings of at least $264,873,200.00 per year. This would be in addition to the $331+ million already pointed out.

With the reports from the United States Department of Justice proving the abuse and substandard care in general, it is only a matter of time until some sharp thinking attorneys decide to take more money from our depleted coffers in the form of provable malfeasance on the part of state psychiatrists and facilities thus creating a large class action lawsuit that will garner still more hundreds of millions of our stretched tax dollars. This is not fanciful conjecture but a probable reality.

The State of California is already under threat of a federal lawsuit for violation of CRIPA laws in these four State Hospitals. This can be averted by an immediate drastic change is the administration and care of patients in these facilities. This is but a start at much needed reform.

Proposed Laws to Implement a Handling

For State Hospitals

Add the following to Division 7. Mental Institutions, Chapter 2. State Hospitals for the Mentally Disordered, Article 2. Admissions, Section 7225:

(a) All patients admitted to a state hospital shall, within 48 hours, be screened per the Medical Evaluation Field Manual compiled pursuant to Chapter 376 of the Statutes of 1988 and presented to the California Department of Mental Health in 1991. This screening shall consist of the use of the algorithm given in this manual.

(b) The forms as prepared in this manual shall be incorporated into this algorithmic use without change. These forms are as follows: **SB 929 Standard Medical History Form** comprised of 134 questions, **Medical History Checklist**, and **SB 929 Physical Examination Record**.

(c) In addition to the forms used in (b) above, a urine sample and blood specimen shall be taken upon admission. The urine shall have three dipstick tests, for glucose, blood and protein. The blood specimen shall have a panel of tests that consist of: a hemacrit, white blood cell count, serum aspartate aminotransferase, serum alanine aminotransferase, serum albumin, serum calcium, serum sodium, serum potassium, serum cholesterol, serum triglycerides, serum T4, serum free T4 and serum vitamin B12.

(d) Those patients found to have a concomitant, active physical disease shall be treated for the physical disease before any psychiatric treatment or drugs may be administered, with the exception of any patient on a prescription drug before entering shall be continued without change on the current drug, until the physical element is determined and if found to exist, is handled. Upon full recovery of the physical disease, the person is to be released forthwith, or if a criminal institutionalization was ordered by the court, to be returned to the committing authority for placement in the proper jail or prison facility per their criminal conviction.

(e) Violation of this section shall constitute a fine of $5000.00 on the offending facility for the first offense and probation of six months for the violating physician by the California Medical Board; a second offense shall carry a fine of $25,000,00 on the offending facility and a suspension of license of the offending physician for a period of one year; a third offense shall carry a fine of $50,000.00 on the offending facility, revocation of license of the offending physician, and removal from post of the Director of the facility.

For Licensed 5150 Facilities

Add to Division 5. Community Mental Health Services, Part 1. Chapter2. Article 1. Section 5151 the following:

(To be added as the last sentence to paragraph 2 of this section) Such assessment shall be as follows:

(a) All patients prior to admitting are to be screened per the Medical Evaluation Field Manual compiled pursuant to Chapter 376 of the Statutes of 1988 and presented to the California Department of Mental Health in 1991. This screening shall consist of the use of the algorithm given in this manual.

(b) The forms as prepared in this manual shall be incorporated into this algorithmic use without change. These forms are as follows: **SB 929 Standard Medical History Form** comprised of 134 questions, **Medical History Checklist**, and **SB 929 Physical Examination Record** and are found on pages 35 – 43 of the Medical Evaluation Field Manual.

(c) In addition to the forms used in (b) above, a urine sample and blood specimen shall be taken during screening. The urine shall have three dipstick tests, for glucose, blood and protein. The blood specimen shall have a panel of tests that consist of: a hemacrit, white blood cell count, serum aspartate aminotransferase, serum alanine aminotransferase, serum albumin, serum calcium, serum sodium, serum potassium, serum cholesterol, serum triglycerides, serum T4, serum free T4 and serum vitamin B12.

(d) Those patients found to have a concomitant, active physical disease shall be treated for the physical disease before any psychiatric treatment or drugs may be administered. Upon full recovery of the physical disease, the person is to be released forthwith. Violation of this section shall constitute a fine of $5000.00 on the offending facility for the first offense and probation of six months for the violating physician by the California Medical Board; a second offense shall carry a fine of $25,000,00 on the offending facility and a suspension of license of the offending physician for a period of one year; a third offense shall carry a fine of $50,000.00 on the offending facility plus revocation of licensure as a 5150 facility, and revocation of license of the offending physician.

June Forbes

Comments

Select Committee on Developmental Disabilities and Mental Health

State Senator Wesley Chesbro, Chair

September 20, 2005

My name is June Forbes. My son has been a patient at Napa State Hospital for over a year, and attend a monthly support group for patients' families there.

We know that terrible things do happen at the hospital. There are real problems there, as there are problems at any institution that has been starved of operating money for decades, if not for a century. Violence and abuses do happen. Seclusion and restraints are still used. And we grieve about them.

We also conclude, from our monthly meetings with senior and front-line staff, that senior administrators and many of the staff at all levels are doing their utmost to follow best practices in caregiving. They understand what works and what doesn't, what would constitute best practices in a humane, sustainable public mental health system. The challenge is to improve despite a serious staff shortage at the hospital.

That's why we take California Director of Mental Health Dr. Steve Mayberg's point when he says "We ... thought that we were being cooperative...we have absolutely nothing to hide...we're working to have the best patient care possible....[but] these interviews and site investigations...are very time-consuming and expensive, and we thought that limited resources really should be spent on patient care and changing our system, rather than litigation.."

Patients' families bring up the evidence of the staff shortage at our meetings every month.

- The hospital assures us that we're valued members of our families' treatment teams, but, even when we have important information for them, the doctors and nurses and social workers don't have time to take our phone calls or answer the messages we leave them.

- When the patients we know have questions and concerns, they're told to "tell your treatment team, or tell your social worker". But our relatives tell us, "I can't talk to them, they're too busy."

- Patients we know have gone months without seeing a psychologist.

- The psychiatric technicians and nurses we depend on to guide our relatives and keep them safe are either exhausted from working overtime, or they're temporary employees--- temps who float from unit to unit, not assigned to one place long enough to develop good judgment about individual patients or current circumstances.

- Patients we know who have improved, who are progressing through the required steps toward discharge, are stymied and held back because there isn't enough staff to operate a unit at the level they're required to succeed at next.

- The patients we know need things to do.

  Classes about the criminal justice system, group therapy for anger management and the like are well and good, but the attractive activities the hospital is justly proud of --- art and music, sports and education and work--- are only available to the few patients whose

brain function has improved enough to permit minimal supervision. And they're only available to any one patient for a few hours on week days, and not even then during quarterly "tip weeks", when no patient activities are scheduled.

The rest of the weekdays, and every evening and weekend, are empty, without anything to distract the people we love from the mischief and even violence that inevitably spring from broken brains crowded together in idleness and captivity.

These conditions exist because the hospital is understaffed, and the staff we have is under-trained. It's understaffed for two reasons.

First, the hospital's salary and incentive structure, fails to attract and retain enough good people. People leave for better pay in places with a lower cost of living than the Napa valley. Their positions remain unfilled for months. Those who stay are working forced overtime, double shifts. Competent, dedicated, seasoned people refuse promotions to supervisory positions where they're desperately needed, because unit supervisors make less money for taking more responsibility.

Second, the hospital isn't authorized enough staff to provide adequate coverage. Caseloads are too large. The overtime required to provide coverage at this staffing level burns people out. Coverage for employee sick and vacation leave and for training time is inadequate. Weekday, day shifts, when doctors and social workers are on the job, are only 45 of the hours in 168-hour weeks. The nights, the weekends the holidays, the quarterly "tip weeks" ---the majority of the time patients spend in the hospital---are when we're most likely to see unseasoned staff in charge of un-stabilized patients.

Even when doctors and social workers are on the job, they have less and less time to spend with the patients who need attention, because they're kept so busy filling out forms for reviews, audits and this latest federal investigation, as well as reorganizing to implement the successive new models of care advocates demand.

The staff is under-trained for two reasons. Coverage is so thin that people can't be relieved from patient care to attend training sessions. Turnover is so high that seasoned staff has little opportunity to train new people by mentoring them.

So, We need your help.

Please, authorize the budget it will take and write whatever enabling legislation it will take to accomplish four things.

First, identify and correct environmental hazards to patients' safety---like unsafe grab bars, door closures and window bars.

Second, procure needed technologies---like computers, drug detection machines and drug sniffing dogs.

Third, develop an adequate staff training system that will

- Increase coverage so that staff can be relieved of patient care long enough to participate in regular trainings.

- Allow for seeking out cutting-edge treatment techniques and hiring consultants to teach them to hospital staff.

Finally, and most important, rationalize the hospital's employee compensation system so that it will attract and retain good people. The California Department of Personnel Administration and the State Personnel Board must be authorized to create a package of salaries, benefits and creative incentives and negotiate their implementation with all five employee unions (CAPT, ASCME, UAPD, CAUSE, SEIU).

- Develop incentives to deliver more licensed staff to the hospital---incentives like paying off their student loans and increasing the number of stipends we pay to trainees in community college programs, and we need to contract with people who receive such incentives to stay and work at the hospital for some time.

- Authorize adequate staffing. We need more psychiatrists, psychologists, social workers, licensed nursing staff (psychiatric technicians and RN's) supervisors and hospital police,* and we need them to be trained and motivated to use best practices, and deliver them sensitively.

Thank you.

*(and we need sensitivity training for those police)

SECTION 6

Senate Office of Research Summary

Hearing on the Review of the Federal Department of Justice Investigation of California State Mental Health Hospitals

Presentation by the Senate Office of Research
September 20, 2005

Civil Rights of Institutionalized Persons Act (CRIPA)

- CRIPA authorizes the U.S. Department of Justice (USDOJ) to initiate civil actions against state or local governments for violations of civil rights of individuals residing in certain public institutions

- USDOJ takes actions to remedy systemic problems related to a "pattern or practice" of violations

CRIPA Process for Resolving Issues

- At least forty-nine days before initiating a civil action, USDOJ must provide the state/local government with:

  - Findings related to alleged violations
  - Supporting facts
  - Recommended corrective measures

- Vast majority of CRIPA investigations that find violations result in voluntary or court-enforced settlements to correct the situation

Recent USDOJ CRIPA Investigations of California State Mental Health Hospitals

- Metropolitan State Hospital

  - Children's Program: Findings letter issued May 13, 2003
  - Adult Program: Findings letter issued February 19, 2004

- Napa State Hospital

  - Findings letter issued June 27, 2005

- Patton State Hospital

  - In progress

- Atascadero State Hospital

  - In progress

Metropolitan State Hospital (MSH) Investigation: Children's Program

- USDOJ visited MSH between June 24 and July 8, 2002
- USDOJ investigation included:
  - Review of medical and other records of about seventy patients
  - Interviews with administrators and staff
  - Speaking with patients
  - On-site surveys
- USDOJ brought in a team of experts in the following areas:
  - Child psychiatry
  - Child psychology
  - Psychiatric nursing
  - Special education

MSH Findings: Children's Program (per USDOJ letter dated May 13, 2003)

- **Psychiatry**
  - MSH fails to provide clinically justified evaluations and diagnoses of psychiatric disorders
  - MSH fails to provide adequate and appropriate treatment planning
  - MSH fails to identify and address cognitive and academic deficits
  - MSH fails to prescribe clinically justified psychotropic medications
  - MSH fails to appropriately assess the side effects of medications
  - MSH fails to provide an appropriate therapeutic environment
- **Nursing**
  - Nursing and unit staff fail to identify, monitor, and report patients' symptoms and side effects of medications
  - Nursing and unit staff are unfamiliar with mental health diagnoses, associated symptoms, and appropriate treatments and interventions
  - Nursing and unit staff lack knowledge regarding their patients
  - Nursing and unit staff do not meaningfully participate in the treatment team process
- **Psychology**
  - Psychological evaluations are inaccurate, incomplete, and unreliable

- Active treatment interventions are too infrequent, are of inadequate quality, and are insufficiently documented
- MSH provides inadequate behavioral interventions

- **Use of Restraints, Seclusion, and "As-Needed" Medications**
  - Children are exposed to excessive use of seclusion, restraints, and/or "as-needed" medications
- **Pharmacy**
  - MSH does not provide adequate pharmacy services
- **General Medical Care**
  - MSH fails to provide necessary medical care
- **Infection Control**
  - MSH does not complete systemic tracking or trending of infections or communicable diseases
- **Dental Services**
  - MSH does not ensure timely and appropriate dental care
  - MSH does not provide complete documentation of services provided
- **Dietary**
  - MSH does not implement meaningful interventions to address children's weight problems
- **Placement in the Most Integrated Setting**
  - MSH fails to actively pursue the timely discharge of children to the most integrated, appropriate setting that is consistent with the child's needs
- **Special Education**
  - MSH does not provide specialized instruction and related services which are individually designed
- **Protection from Harm**
  - MSH has environmental hazards, including fixtures that patients could use to commit suicide

- Incident management system is deficient

- **First Amendment and Due Process**

  - State constrained patients' constitutional rights to free speech and due process by denying patients the right to speak confidentially to staff from USDOJ

Metropolitan State Hospital (MSH) Investigation: Adult Program

- USDOJ visited MSH between June 24 and July 8, 2002
- USDOJ investigation included:
  - Review of medical and other records of about 150 patients
  - Interviews with administrators and staff
  - Speaking with patients
  - On-site surveys
- USDOJ brought in a team of experts in the following areas:
  - Psychiatry
  - Psychology
  - Psychiatric nursing
  - Incident management
  - Quality assurance

MSH Findings: Adult Program (per USDOJ letter dated February 19, 2004)

- **Integrated Treatment Planning**
  - MSH does not provide a comprehensive, integrated plan for the provision of treatment addressing individual patient needs
- **Assessments**
  - Psychiatrists routinely diagnose their adult patients as having psychiatric disorders without clinical justification
  - Psychological assessments and evaluations, with few exceptions, are inaccurate, incomplete, and uninformative
  - Rehabilitation assessments typically fail to address patients' rehabilitation needs
  - Most social history evaluations contained significant factual omissions, apparent errors, or unresolved internal inconsistencies
- **Discharge Planning and Placement in the Most Integrated Setting**
  - MSH fails to provide adequate, individualized discharge planning that is integrated in treatment decisions

- **Specific Treatment Services**

  - Psychiatrists fail to exercise adequate and appropriate medical management and appropriately monitor medication side effects
  - Psychological services frequently are incomplete, inaccurate, and outdated
  - Nursing staff fail to adequately monitor, document, and report patients' symptoms; document the administration of medications; provide a therapeutic environment; and participate in the treatment team process
  - Pharmacists do not systematically review patients' medication regimens
  - MSH fails to provide necessary medical care
  - MSH does not take appropriate interventions to minimize the risk of infections
  - Patients experience long delays in, or the complete absence of, dental treatment
  - Patients do not receive adequate physical and occupational therapy
  - Treatment plans do not address patients' weight problems

- **Documentation of Patient Progress**

  - Psychiatrists do not chart their patients' progress with sufficient frequency
  - Substance of psychiatrists' progress notes are deficient

- **Use of Restraints, Seclusion, and "As-Needed" Medications**

  - MSH exposes patients to excessive and unnecessarily restrictive interventions
  - MSH uses seclusion, restraints, and "as-needed" medications in the absence of adequate treatment and, in some instances, as punishment

- **Protection from Harm**

  - MSH incident management system is deficient
  - Quality improvement activities were generally disjointed and inadequate
  - MSH fails to keep environment free of hazards, such as fixtures that patients could use to commit suicide
  - Treatment staff frequently rely on untrained security personnel in patient interventions

- **First Amendment and Due Process**

  - State constrained patients' constitutional rights to free speech and due process by denying patients the right to speak confidentially to staff from USDOJ

Napa State Hospital (NSH) Investigation

- In January 2004, USDOJ notified the state regarding its intent to investigate NSH

- In its June 27, 2005, findings letter, USDOJ indicated that state officials declined to cooperate with the investigation and refused USDOJ access to NSH

- USDOJ investigation included:

  - Review of on-site surveys conducted by the federal Centers for Medicaid and Medicare Services and the state Department of Health Services
  - Interviews with professionals, advocates, family members, and patients

NSH Findings
(per USDOJ letter dated June 27, 2005)

- **Protection from Harm**

  - Staff often fail to intervene and/or report patient-to-patient assaults; staff do not attempt to prevent repeated assaults by addressing the underlying behavior of the aggressors
  - NSH fails to remedy deficiencies in its suicide prevention practices
  - NSH fails to control traffic of harmful contraband, including illegal narcotics
  - Patients suffer harm from excessive and inappropriate use of physical and chemical restraints and seclusion
  - NSH fails to keep environment free of hazards, including fixtures that patients could use to commit suicide

- **Medical, Nursing, and Psychiatric Care**

  - NSH does not provide adequate medical and nursing care
  - NSH fails to provide adequate occupational and physical therapy and nutritional supports and services

- **Psychology and Treatment Planning**

  - NSH fails to provide adequate treatment planning
  - NSH fails to plan adequately to address patients' assaultive and self-abusive behaviors

- **Discharge Planning and Placement in the Most Integrated Setting**
  - NSH fails to place patients in the most integrated, appropriate setting consistent with the patient's needs and the terms of any court-ordered confinement

Prepared by Agnes Lee

SECTION 7

Report on Metropolitan State Hospital, May 13, 2003

Report on Department of Mental Health Response, July 24, 2003

May 13, 2003

The Honorable Gray Davis
Governor of California
State Capitol Building
Sacramento, CA 95814

Re: Metropolitan State Hospital, Norwalk, California

Dear Governor Davis:

On March 21, 2002, we notified you that we were investigating conditions at Metropolitan State Hospital ("Metropolitan"), in Norwalk, California, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. During the weeks of June 24 and July 8, 2002, we visited the facility. Our first tour, "Metropolitan I," focused on the care and treatment provided to the facility's child and adolescent patients, all of whom are in Metropolitan's Program 1. Our second tour, "Metropolitan II," addressed the care and treatment provided to the facility's adult patients. At exit interviews conducted at the end of each facility visit, we verbally conveyed our preliminary findings to counsel and facility officials. Consistent with the requirements of CRIPA, we are now writing to apprise you of our findings regarding the child and adolescent patients. We will transmit our findings regarding the facility's adult patients when our Metropolitan II investigation is complete.

As a threshold matter, we wish to express our appreciation for the cooperation and assistance provided to us by the administrators and staff of Metropolitan. In particular, facility personnel cooperated fully with our document requests. We hope to continue to work with the State of California and officials at Metropolitan in a cooperative manner.

We conducted our investigation by reviewing medical and other records relating to the care and treatment of approximately 70 patients; interviewing administrators and staff; speaking with patients; and conducting on-site surveys of the facility. We

were assisted in this exercise by expert consultants in the fields of child psychiatry, child psychology, psychiatric nursing, and special education.

At the time of our June 2002 visit, Metropolitan had a census of approximately 825 patients. Program 1, the hospital's Child and Adolescent Program, had a census of approximately 100 patients. These patients, who range in ages from 11 to 17, suffer from serious mental health disorders and histories of severe traumatization. Many also have significant cognitive or academic impairments and/or health-related concerns. The majority also had an average of 10 to 12 failed out-of-home placements prior to their placement at Metropolitan. In many respects, these children and adolescents are the most psychiatrically and emotionally disturbed in the State's system of care. Because Metropolitan is the only public mental health institution for this population in the State, these children and adolescents are referred to Metropolitan by counties throughout the State of California.

Residents of state-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation to ensure their safety and freedom from unreasonable restraint, prevent regression and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982). Similar protections are accorded by federal statute. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483 (Medicaid Program Provisions). The State also is obliged to provide services in the most integrated setting appropriate to individual residents' needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130 (d); see Olmstead v. L.C., 527 U.S. 581 (1999).

It was apparent that many Metropolitan staff are highly dedicated individuals who are genuinely concerned for the well-being of the persons in their care. Generally speaking, it appeared that staff promptly intervened to prevent or minimize injury after patients became physically aggressive. Further, Metropolitan repeatedly has demonstrated its proficiency in complying with many procedural aspects of care. Also, the facility commendably has initiated mechanisms to address some problematic aspects of its care, such as the use of restraints and seclusion. Nevertheless, there are significant and wide-ranging deficiencies in patient care provided at Metropolitan.

Our Child and Adolescent Program findings, the facts supporting them, and the minimum remedial steps that we believe are necessary are set forth below.

I. PSYCHIATRY

Program 1's psychiatric supports and services substantially depart from generally accepted professional standards of care and expose the children and adolescents there to a significant risk of harm and to actual harm. Specifically, Metropolitan fails to provide clinically justified evaluations and diagnoses of psychiatric disorders; fails to provide adequate and appropriate treatment planning; fails to identify and address cognitive and academic deficits; fails to prescribe clinically justified psychotropic medications; fails to assess appropriately the side effects of medications; and fails to provide an appropriate therapeutic environment. The harm to these children and adolescents takes many forms, among them, inadequate, ineffective and counterproductive treatment, exposure to inappropriate and unnecessary medications posing serious physiological and other side effects, and excessively long hospitalizations, which compound psychiatric distress.

A. Psychiatric Evaluation and Diagnosis

Each individual's psychiatric evaluation and diagnoses should be justified in a generally accepted professional manner. Specifically, there should be a close relationship amongst a patient's diagnoses, identified problems in the treatment plan, daily clinical descriptions by staff, and the medications administered. Program 1 does not meet these minimum standards of care. Psychiatric evaluations and diagnoses are woefully inadequate. Psychiatrists chronically diagnose patients with psychiatric disorders without any clinical justification or any documentation of signs or symptoms required for such diagnoses. The number of clinically unjustified diagnoses strongly indicates that psychiatrists deliberately make psychiatric diagnoses to justify the use of psychotropic medication. Indeed, multiple psychiatrists indicated to us that they have assigned psychiatric diagnoses for this reason.

Not only do psychiatrists diagnose patients with disorders for which there is little or no clinical justification, they also routinely fail to diagnose patients with disorders for which patients do exhibit signs or symptoms. For example, abandonment

issues and past trauma are nearly universal problems for the patients in Program 1. However, psychiatrists frequently ignore these disorders in diagnosing patients. Consequently, these disorders often are not identified as a focus of treatment. Such missed diagnoses are a grave deficiency, because without proper evaluation and diagnosis, it is virtually impossible for patients to receive adequate treatment. Moreover, improper diagnosis and treatment affect opportunities for patients to be placed in the most integrated setting appropriate to meet their needs.

The evaluations are also incomplete in that they routinely fail to include information about the patients' medication histories, medications at time of admission, recommended medication regimens to be utilized for treatment, or general medical diagnoses. This information is crucial in guiding treatment. In particular, existing medical problems should be a significant determinant when choosing a psychotropic medication regimen so as to avoid interactions and exacerbations of individuals' mental health or medical disorders.

There were many examples of these diagnostic problems. For instance, one patient, D.S.,[1] was placed upon admission on numerous medications, none of which corresponded with his diagnoses. Two other patients, B.S. and N.C., were diagnosed with Bipolar Disorder and Bipolar Disorder II Depressed with Psychotic Features, respectively. Both were prescribed medications appropriate to treat acute mania. Neither patient, however, had any documentation in their evaluation to support these diagnoses, nor did they have identified problems in their treatment plans consistent with these diagnoses. Moreover, N.C.'s symptoms were more consistent with post-traumatic stress disorder than the Bipolar diagnosis. E.Z.'s evaluation contained no information about the dosages of previously prescribed medications, how those medications affected his symptoms, or his current medication regimen. Further, Attention Deficit Hyperactivity Disorder (ADHD) was not listed as an Axis I diagnosis to be ruled out despite the fact that E.Z. had a past diagnosis of ADHD and the evaluation stated that more information was required to confirm this diagnosis. The medical diagnosis of

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[1]In this letter, to protect patients' privacy, we identify patients by initials other than their own. We will separately transmit to the State a schedule cross referencing the initials with patient names.

asthma noted in his evaluation was also not listed under the Axis III diagnoses. Similarly, the psychiatrist for another patient, U.C., failed to assess the possibility of Traumatic Brain Injury or to diagnose her with Post Traumatic Stress Disorder, despite her history of head trauma, prenatal exposure to drugs, sexual abuse, and neglect, including an incident resulting in her being seriously burned. Her evaluation also failed to list her past medication history or medications at the time of admission.

Separately, Metropolitan's procedure calls for a preliminary psychiatric evaluation on the day of admission to Program 1 and a second evaluation once the patient is admitted to a specific unit. For several patients, including E.Z., B.P., L.M., X.N., C.H., Bc.O., J.U., B.H., and N.T., the information contained in the initial evaluation either was not included in, or conflicted with, the information contained in the second evaluation. This is of particular concern given that the evaluations were conducted within one or two days of each other. Contrary to generally accepted professional standards, there was no indication that the physicians who conducted these evaluations communicated about their significantly different findings.

B. Treatment Planning

According to generally accepted professional standards of care, treatment plans should be individualized and should, at a minimum: (a) identify patients' diagnoses and symptoms; (b) provide interventions to address each diagnosed psychiatric disorder and the associated symptoms; (c) include medication plans; (d) provide interventions and treatments to address deficits in cognitive, academic and adaptive functioning, and address any other significant treatment or medical needs; (e) provide for monitoring of treatment efficacy; (f) provide for monitoring of medication side effects; (g) include plans to educate patients about their medications and other treatment interventions; and (h) identify the barriers to placement in the most integrated appropriate setting and the specific steps to overcome such barriers. Metropolitan's treatment plans often fail to include this information and are not updated on a timely basis. More fundamentally, because Metropolitan fails to evaluate or diagnose adequately its patients, it is nearly impossible for it to develop appropriate treatment plans.

1. Diagnoses and Symptoms

It is a serious concern that many patients have psychiatric disorder diagnoses although their treatment plans did not identify any problems related to psychosis. Only one of two conclusions results from these practices: either the diagnoses are appropriate and treatment teams therefore fail to identify the symptoms of patients' most serious psychiatric disorders, or patients are not experiencing symptoms of psychiatric disorder diagnoses and thus the assigned diagnoses are unjustified. Neither possibility is clinically acceptable.

2. Interventions

We found that nearly every Program 1 treatment plan lists the same generic interventions. Treatment plans should be tailored to meet the individualized needs of the patients, and should take into account factors such as the patient's functioning level, cognitive level, history of trauma, and medical conditions. None of the plans that we reviewed were individualized or sufficiently detailed. Generic statements such as "chemotherapy" or "group therapy" do not offer the level of detail necessary to allow teams to provide adequate treatment. For instance, X.N.'s treatment plan consisted of general interventions: "chemotherapy, individual therapy, group therapy, recreational therapy, IT assignment, and special educational programs." The interventions listed for L.M. and N.Q. contained similar generic statements.

Further, none of the plans that we reviewed included any treatment for, or acknowledgment of, the patients' severe traumatization and multiple out-of-home placements. The plans also provided no differentiation between major psychiatric and behavioral problems that were the reason for a patient's hospitalization and relatively trivial problems not requiring hospitalization (such as aches and pains).

The use of highly restrictive interventions, including the use of seclusion, restraints and/or as-needed (so-called pro re nata or "PRN") medication, should trigger a review of the effectiveness of a patient's treatment plan. Metropolitan, however, does not routinely review treatment plans based upon these events, thereby exposing patients to ongoing restrictive interventions and ineffective treatment.

3. Cognitive, Academic and Adaptive Functioning

Psychiatrists must be aware of and take into account patients' cognitive, adaptive and academic levels of functioning to make accurate evaluations and diagnoses and for treatment to be appropriate and effective. A patient's cognitive abilities will influence significantly her response to Program 1's expectations and the appropriateness of her treatment plans and criteria for discharge. Her cognitive abilities also will affect her understanding of the medications that she is prescribed.

Systematically, Metropolitan fails to identify and address patients' cognitive, adaptive and academic deficits. Of the patients reviewed who had significant cognitive and/or academic deficits listed in their charts, none had any remediation or accommodation for these deficits in their treatment plans. Treatment teams seemed unfamiliar with the results of such testing, and they did not express concern that cognitive or academic deficits were reported to have changed from one 90-day evaluation to the next. In many cases, the only reason such testing appeared to be performed was to determine supports and services needed for discharge placement; in particular, to determine whether the patient could be transferred into California's system of care for mentally retarded individuals.

The following examples are representative of Program 1's failure to identify and address cognitive and academic deficits. First, K.N.'s diagnosis changed from "Rule Out Mental Retardation" in November 1998, to "Moderate Mental Retardation" in January 2001, to "Borderline Intellectual Functioning" in April 2002. No member of his treatment team could explain these changing diagnoses to us, nor did the team include the patient's cognitive/academic deficits as part of his treatment plan. Second, B.Q. had the diagnosis of "Mild Mental Retardation by history" on admission. This diagnosis was changed to "Borderline Intellectual Functioning" on her first 90-day evaluation without any new cognitive testing. Cognitive testing finally was performed over one year after admission for the purpose of determining discharge placement. The results of these tests were not available at the time of our tour, two months after testing had been completed. Third, D.S. was admitted with a cognitive disorder diagnosis. He, however, did not have cognitive testing until one and a half years after admission, at which time discharge was being considered. The fact that the results of D.S.'s test were in the mildly mentally retarded range did not result in any change in his treatment plan.

Program 1's practice is to review treatment plans at 90-day intervals, after an initial 14-day hospitalization. This excessively long time period between treatment team meetings does not comport with generally accepted professional standards of care, which call for such meetings at a minimum of every 4 weeks, and contributes to excessively long hospitalizations. The infrequency of treatment team meetings exposes patients to heightened psychiatric distress, both from long-term institutionalization and from potentially deleterious treatments, the effects of which the treatment team is not in a position to timely detect and correct.

It is also critical that patients have genuine input into and understand their treatment plans and their implementation. Although Program 1 patients generally sign their treatment plans, there is no evidence that they have any meaningful input into, or agreement with, the plans. We observed treatment teams ignore significant self-initiated input from patients regarding their treatment during treatment team meetings. Moreover, there is no evidence that patients are educated about or understand the purposes of their prescribed medication, medication side effects, or the length of time it takes medication to take effect. As explained below at Section II, nursing and unit staff do not have the knowledge to assist the facility's children and adolescents in understanding these issues. As a result, medications sometimes are changed without clinical justification because patients report that the medications are not working, although the prescribed medications may not have had time to work. In these cases, no documentation was found in the patients' charts to show that staff had educated the patients about the time that needed to elapse before results could be expected.

Finally, treatment plans do not reflect an interdisciplinary provision of services. In part this is because Metropolitan has not identified a team member to coordinate the interdisciplinary treatment process. As a result, no one is accountable or responsible for coordinating patients' overall treatment. No one ensures that treatment plans are developed and reviewed as necessary or that the various disciplines work together to develop and implement one coordinated, comprehensive plan. Similarly, communication and coordination among treatment team members and between treatment teams and the school is poor or non-existent. Staff whom we interviewed stated that various disciplines communicate informally. In any event, whatever communication takes place is not properly documented.

The care provided to F.Q. illustrates several unacceptable aspects of Program 1's psychiatric evaluations, diagnoses, treatment planning, and treatment implementation. During or subsequent to a treatment team meeting for F.Q. that we attended, the team: (a) focused on whether she had a diagnosis of anorexia nervosa, notwithstanding that, given her excess weight, this diagnosis was not clinically possible, and that her desire to lose weight was reasonable; (b) failed to discuss a number of her psychiatric, Axis I, diagnoses or any specific symptoms supporting these diagnoses; (c) could not provide clinical data to support her diagnosis of Bipolar Disorder; (d) failed to identify or discuss her apparent sedation or Parkinsonian appearance, acknowledging that they had not evaluated her for side effects of medication; (e) failed to address her numerous self-initiated comments regarding her problems, needs and interests; (f) appeared unsurprised that she did not know the members of her treatment team; (g) acknowledged that they had no plans to evaluate her cognitive or academic functioning, despite the diagnosis of "Rule Out Borderline Intellectual Functioning"; and (h) could not explain the dramatic increase in her medication, conceding that a decrease in dosage may be indicated. Regrettably, from our observations, interviews, and document review, F.Q.'s treatment team meeting exemplifies the deficient treatment generally provided in Program 1.

C. Psychotropic Medication

The use of psychotropic medication always should be justified by the clinical needs of a patient. However, as previously explained, Program 1's use of psychotropic medication rarely is justified in that patients frequently are medicated based upon clinically unjustified diagnoses. Documentation does not support the types of medications being prescribed, the doses prescribed, or either the extended lengths of time that medications are prescribed in some cases or the rapid change of medications in others. Rather, several of the psychiatrists' notes give the impression that there is little or no analysis conducted when choosing the patients' medication regimens.

Furthermore, many patients are routinely prescribed inappropriate medications. Numerous patients, such as M.D. and N.H., were prescribed medications that are appropriate for chronically mentally ill adults, not children or adolescents. Psychiatrists also commonly prescribed older antipsychotic

medications, such as Thorazine and Haldol, as part of patients' regular medication regimens or as medication to be used as a PRN. In view of the fact that these older antipsychotic medications have a host of serious side effects that the newer atypical antipsychotic medications do not have, the use of these medications in an adolescent population is an outdated, potentially harmful, medication practice. Moreover, these medications were prescribed for at least 21 children and adolescents without any documented clinical justification. It appears that these medications are prescribed to control individuals' behaviors in lieu of an appropriate medication regimen and/or of therapeutic treatment interventions.

Also, although modification of medications is appropriate at times, Metropolitan's psychiatrists often recommend medication changes frequently and abruptly without any documented rationale for the change. This practice is unsafe, given that such changes can exacerbate or precipitate an individual's symptoms.

Further, it is generally accepted that, in most instances, psychotropic medication should be used to treat psychosis. When psychotropic medication is prescribed to treat symptoms other than psychosis, this practice should be documented clearly with a specific plan for minimizing the dosage and duration of the use of the medication. As indicated above, more than one Program 1 psychiatrist acknowledged prescribing psychotropic medication to reduce aggression and agitation rather than to treat psychosis, and acknowledged manufacturing diagnoses to justify this practice. Assigning psychiatric diagnoses to patients who do not meet the diagnostic criteria for such diagnoses in order to justify the use of psychotropic medication is an unacceptable medical practice.

Psychiatrists also prescribe medication for purposes that have no mention in current or past literature and for which their use has no known pharmacological basis. This form of so-called "off-label" medication usage is considered speculatively experimental, should be practiced ethically only under the supervision of an institutional review board, and requires a patient's and/or guardian's clear consent. Program 1 does not meet any of these requirements. For example, a number of patients are prescribed Naltrexone, a psychotropic, to treat a host of different behavioral problems. Metropolitan's medical administration appeared unaware that this was occurring. Although documentation reflected that the off-label usage of this

medication was approved by the Pharmacy and Therapeutics ("P&T") Committee, there is no institutional review board to provide oversight, there is no experimental design to monitor this practice, and there has been no effort to obtain patients' and/or guardians' informed consent.

Despite the fact that many of the medications that are prescribed for Program 1's children and adolescents have potentially serious, and often irreversible side effects, such as tardive dyskinesia, Metropolitan has no standardized instrument in place to assess regularly these side effects. Similarly, treatment plans do not include plans for monitoring potential side effects. Without objective measures in place to identify medication side effects at an early stage, Program 1's children and adolescents are at risk of developing potentially irreversible complications.

When potential side effects of psychotropic medication are identified, Metropolitan's response is inadequate and inappropriate. For instance, E.Z.'s physical examination indicated that he had gynecomastia (development of prominent breast tissue in a male), a potential side effect of one of his medications. There was no indication, however, that this was ever addressed or evaluated further. Similarly, several individuals suffer constipation related to psychotic medication use. Rather than reassess the medications for these individuals, clinicians rely on the chronic administration of stool softeners and laxatives, an unacceptable medical practice for this population.

D. Therapeutic Environment

As part of its psychiatric treatment, generally accepted professional standards of care dictate that Program 1 should provide a therapeutic environment that minimizes the deleterious effects of institutionalization (namely, the compounding of childrens' and adolescents' psychiatric problems such that their developmental trajectory is further compromised) and is conducive to the treatment of severely psychiatrically disturbed and traumatized children and adolescents. In providing a therapeutic environment, there should be a structure comprised of community rules, meetings, and social interactions that help patients learn adaptive coping skills, improve self-esteem, and develop positive skills ("milieu structure"). The environment in Program 1 does

not meet any of these goals. Rather, Program 1 is characterized by a great shortage of staff-initiated, positive interactions.

We saw few positive, spontaneous, therapeutic interactions in which staff initiated and facilitated a patient's expression of feelings, connected a patient's behavior with feelings, employed a "teachable moment" technique, or started a meaningful, positive staff-to-patient or patient-to-patient exchange. Staff typically failed to use natural social experiences, such as distribution of snacks, doing chores, or engaging in recreational activities, to promote positive social functioning. Rather, staff's interactions with the individuals on the units were mainly reactive and/or directive in nature, and at times resulted in power struggles with patients, exacerbating crisis situations. Similarly, we observed a lack of staff-facilitated, age appropriate patient-to-patient interactions. Patients appeared bored, over-medicated, ignored and/or upset. Program 1's failure to provide an appropriate health-promoting environment is unacceptable and does not meet generally accepted professional standards of care.

Program 1's milieu structure is largely based upon a Point and Level System. Staff appear to believe that this system motivates patients to the extent that simply the interaction between patients and the system constitutes active milieu therapy. We found numerous serious deficiencies with this system.

The Point System is a complex process that neither patients nor staff are likely to understand adequately. The system does not allow for consistent, accurate or individualized application of points across residential units and/or schools. Points are not distributed contingent upon the occurrence of behaviors, and they are not distributed frequently and immediately in association with those behaviors. Consequently, their intended therapeutic effect is negated. The number of points that students can earn at school - ten percent of their total daily points - significantly undervalues the educational portion of their lives. Most significantly, points are not utilized in a therapeutic way to connect a patient's behaviors with feelings or to identify more effective coping strategies.

Similarly, the Level System is very complex. Children and adolescents who are severely mentally ill and traumatized, many of whom have cognitive impairments, are highly unlikely to

understand it. Procedures by which patients' levels are dropped or raised are not defined clearly. It is virtually certain that, in light of their histories of abuse and trauma, many Program 1 patients will experience the system as arbitrary and punitive, thereby negating any therapeutic effect. The fact that this system is a key component to determining patients' attainment of discharge criteria makes it even more troubling.

Program 1's physical environment is also deficient. Given Program 1's population, the physical environment should, within the bounds of safety, promote privacy, individuality, creativity, and the opportunity for recreational activities to minimize the effects of institutionalization and promote positive social behavior. However, we found problems in all of these areas.

As a primary matter, patients' rights to privacy and confidentiality are breached by the public distribution of medication and the posting of patient-specific information on publically visible boards. More broadly, recreational equipment was limited to televisions, damaged basketball nets, and often-violent video games. The courtyards, which appear to be used rarely by patients, are in disrepair and poorly equipped. Although the facility has a fenced playing field, not once during our multiple trips around facility grounds during our two five-day visits did we see any children or adolescents on it.

Many of Program 1's problems in providing adequate psychiatric services are the result of a lack of leadership and direction by psychiatrists and senior administration. There is no evidence of medical staff providing leadership in treatment teams or during periods in which patients are experiencing acute psychiatric distress. Indeed, there was scant acknowledgment, at leadership and administrative levels, that extended institutionalization frequently exacerbates existing psychiatric problems of children and adolescents. In important respects, the administration's focus lies elsewhere; various Metropolitan documents identify the facility's "clients" as, not the children themselves, but rather the counties from which they come.

II. NURSING

Program 1's nursing services substantially depart from generally accepted professional standards of care and treatment and expose the children and adolescents there to a significant risk of harm and actual harm. These deficits derive from nursing

and unit staff's: (a) failure to identify, monitor and report patients' symptoms and side effects of medications; (b) unfamiliarity with mental health diagnoses, associated symptoms, and appropriate treatments and interventions; (c) lack of knowledge regarding their patients; and (d) ineffective participation in the treatment team process.

Many nursing and unit staff appear to lack adequate support, training and supervision. Metropolitan leadership does not encourage Program 1 nursing and unit staff to communicate with other team members to solve problems proactively. As a result, nursing and unit staff respond to patient needs in a largely reactive way. This, in turn, exposes Program 1's children and adolescents to excessive and inappropriate uses of medication; seclusion, and restraints; inadequate and ineffective therapeutic interventions; and unnecessary institutionalization.

A. Monitoring and Reporting of Patients' Symptoms

Generally accepted professional practice requires that patients' treatment plans identify the interventions and strategies to be utilized by nursing and unit staff to address the symptoms of patients' diagnoses, the symptoms to be monitored, and the frequency with which the symptoms are to be monitored. It is essential for nursing and unit staff to monitor, document and report patients' symptoms for the treatment team to determine if the implemented interventions are adequate or require modification. The psychiatrists who prescribe medications and the psychologists and social workers who oversee other therapeutic interventions rely on nursing and unit staff to collect and report this information. Nursing and other unit staff are on the unit 24-hours a day, seven days a week; they can and should record and report this information. Program 1 nursing and unit staff do not properly monitor, document and report such information. In part, this is because Program 1's treatment plans generally do not identify the symptoms to be monitored or the frequency with which staff should monitor them.

Metropolitan does not appear to have a system in place to collect and analyze such information on a regular basis or to utilize such information in the reassessment and treatment plan revision process. Without objective measures in place to determine the effectiveness of the interventions being used, Program 1's patients are likely to receive inappropriate and ineffective treatment interventions for long periods of time, and

to be exposed to excessive or inappropriate uses of medications, seclusion, and/or restraints.

Staff who administer medication should know what the medication is for, know what results it is intended to achieve and when, and know the symptoms of the disorder that the medication is supposed to address. As a general matter, the Program 1 nurses are unfamiliar with the purposes of the medication they administer, and a number of nurses we interviewed were unable to identify the symptoms associated with the disorder for which a particular medication was prescribed. This lack of basic clinical knowledge contributes to nursing staff's failure to monitor and report patients' symptoms.

B. Monitoring of Medication Side Effects

Generally accepted professional practice requires that nursing staff monitor patients for potential side effects of medications. However, Metropolitan nursing staff responsible for the day-to-day care of patients do not monitor, document or report evidence of side effects on a regular basis. This is in part because, as stated above, treatment plans do not include plans for monitoring potential side effects. Even when nursing staff do identify patients who are experiencing side effects, they do not take adequate action to notify the prescribing physicians and to ensure that appropriate follow-up occurs. The charts of a number of patients included notes indicating that nursing staff had witnessed side effects such as drooling, but they failed to report this to the prescribing physician and/or document the symptom on a more formal basis, such as through standarized instruments that measure and record medication side effects.

C. Participation in Treatment Team Process

Nursing and unit staff consistently demonstrated a lack of knowledge regarding the therapeutic process. Many could not provide essential information about the individuals on their units such as the level of family involvement, issues being pursued in therapy, symptoms of Axis I disorders, reasons for medication changes, or options for discharge. Without nurses' knowledge of this crucial information, the units cannot function adequately as therapeutic environments.

It is generally accepted professional practice for nursing staff, as well as other staff who provide direct support to patients, to participate as active members of the treatment team. Because these staff work on a daily basis with the children and adolescents of Program 1, they likely know the patients best. However, Program 1 nursing and unit staff do not participate meaningfully in the treatment team process. Generally speaking, Program 1 nursing and unit staff do not appear to understand therapeutic tools or how to implement them. Nursing staff do not know the children's and adolescents' histories, especially the family histories, which is where mental health issues often start. Nurses do not appear to understand their role as psychiatric nurses.

This lack of knowledge and skills places nurses and other unit staff at a disadvantage in the team process. Without adequate knowledge and skills, nursing and unit staff cannot contribute meaningfully to the development of treatment plans and interventions; cannot challenge other team members to consider alternative diagnoses, medications or interventions when those in place do not appear to be correct; cannot implement interventions effectively; and cannot provide a therapeutic milieu. This ultimately results in the children and adolescents of Program 1 receiving inadequate treatment and care.

III. PSYCHOLOGY

Program 1's psychological services and behavioral interventions substantially depart from generally accepted professional standards of care and expose the children and adolescents of Program 1 to significant risk of harm and to actual harm. The deficiencies include inadequate clinical assessments; insufficient, inappropriate active treatment; and inadequate behavioral interventions. The harm to these children and adolescents takes many forms, among them, perpetuating their emotional behavioral difficulties; unnecessarily extending their stay in a highly restrictive setting; diminishing their sense of self worth; subjecting them to excessive use of seclusion, restraints, or sedating medications; fostering despair and hopelessness; and, in some cases, depriving them of physical safety.

A. Psychological Evaluations

In attempting to determine the psychological problems and needs of children and adolescents, it is critical that psychologists and direct care staff observe and assess them on a regular basis. However, clinical staff infrequently observe and directly assess the children and adolescents in their care. Consequently, in making treatment decisions, clinicians fail to consider important aspects of both the patients' clinical status and their level of functioning. This deficiency is exacerbated by the lack of a hospital policy dictating when psychological evaluations are to be updated.

Psychological evaluations should identify and address psychiatric issues when such issues are present. Program 1 evaluations frequently fail to do so. For instance, although M.C.'s psychological evaluation on admission identified no psychiatric issues, he subsequently was psychiatrically diagnosed with Bipolar Disorder with Psychotic Features. Notwithstanding that psychiatric diagnosis, his psychological evaluation was not updated. Consequently, either M.C.'s psychiatric diagnosis was wrong or his psychological evaluation was significantly deficient.

Similarly, as discussed in Section I, psychological evaluations should identify and address functional abilities. In this regard, "Mental Retardation" and "Borderline Intellectual Functioning" are distinct categories of intellectual assessment that should trigger different treatment interventions. Metropolitan's psychological evaluations often do not recognize this distinction. For example, K.N. was admitted to Metropolitan with a diagnosis of "Rule Out Mental Retardation," and shortly thereafter was assessed as having a full-scale IQ of 54 - well into the range of mental retardation. Nevertheless, without documented justification, his diagnosis was changed to "Borderline Intellectual Functioning."

Psychological evaluations also must address relevant components of particular disorders, but Program 1's evaluations frequently do not. For instance, O.N. was diagnosed with Autistic Disorder, but nowhere in his chart was it evident that his speech and language had been evaluated, notwithstanding that an understanding of an autistic patient's communication abilities is essential in shaping appropriate interventions.

Questions generated in psychological evaluations should be answered, not left unresolved for extended periods of time.

Failure to address promptly questions fundamental to a correct psychological evaluation undercuts the evaluation's efficacy. Nevertheless, a Metropolitan psychologist informed us that it was not unusual for unresolved diagnoses (so-called "rule out diagnoses") to remain open for 10 to 12 months. For example, E.H. was admitted in April 1999 with "Rule Out Mild Mental Retardation." That unresolved diagnosis was in place when we toured the facility more than three years later. In fact, a number of patients went through their entire treatment regimen and were discharged with one or more unresolved diagnoses. This problem is exacerbated by nursing and unit staff's failure to monitor, document and report patients' symptoms as discussed above.

The foregoing deficiencies signal that Program 1 treatment teams undervalue psychological evaluations. Evidence of this comes from various charts, such as S.N.'s and F.U.'s, that do not even contain a psychological evaluation. The evaluations apparently had been removed from the active charts in contravention of facility policy. Further evidence that the facility disregards the importance of psychological evaluations is its failure to use Spanish-language testing tools for patients whose primary language is Spanish. Metropolitan identified 11 such patients at the time of our tour.

These problems lead to inaccurate, incomplete, and unreliable evaluations, which in turn leave the appropriateness of the psychological interventions to chance. This is a substantial departure from generally accepted professional standards of care that subjects Program 1 patients to the risk of harm and actual harm, in the form of untreated psychological disorders and psychological disorders that are worsened through inappropriate treatment.

B. Active Treatment

Generally accepted professional standards of care call for evidence-based psychotherapeutic interventions, that is, interventions that are empirically supported as effective. Program 1 policy does not reflect such a standard. Instead, it unspecifically states that "[e]ach patient shall be provided with an individualized program of treatment activity which reflects the program's highest level of performance and the optimal level of patient participation."

In any event, activity logs indicate that a number of children and adolescents receive virtually no active treatment. That is, they have scant participation in individual and group therapy or in activities of leisure and recreation.

Attendance records indicate that some children receive as little as one-half hour of individual therapy and 30 total hours of structured therapeutic activity, a month. One patient received no recorded therapeutic activities for a 12-day period, other than participation in 30-minute group meetings at which the patients' points for behavior, treatment and school participation are announced. Metropolitan staff could not identify any current active treatment for patient T.T.'s primary diagnosis of Post Traumatic Stress Disorder. Further, although T.T. also carries a diagnosis of polysubstance abuse, she reportedly has attended a substance abuse group only once and apparently is receiving no other substance abuse interventions. Moreover, most patients we reviewed receive no family therapy, despite the fact that many have significant traumatic family histories.

Further, as explained in Section I, above, there is little evidence of spontaneous, positive social interactions, especially interactions initiated by staff. There is also little evidence that the courtyards and free time are used constructively to enhance patients' lives. In summary, the amount of active treatment that Program 1 patients actually receive is alarmingly low.

Separately, there are a number of concerns with the quality of individual and group therapy. To be effective, individual psychological therapy should be available to patients in their primary language. Moreover, Metropolitan is a provider of health and social services that receives federal financial assistance from the U.S. Department of Health and Human Services. As such, it is required to provide Limited English Proficient ("LEP") persons such language assistance as is necessary to afford them meaningful access to these services, free of charge. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, et seq.; 45 C.F.R. § 80.3(b). See also Policy Guidance on the Prohibition Against National Origin Discrimination as It Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52762 (Aug. 30, 2000)("Health and social service providers must take adequate steps to ensure that [LEP] persons receive the language assistance necessary to afford them meaningful access to their services, free of charge."); 28 C.F.R. § 42.405 (d)(1) (" Where a

significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program . . . needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons.") Notwithstanding these obligations, Metropolitan has a significant number of primarily Spanish-speaking patients, such as F.U., whose therapists do not speak Spanish.

In any event, there is also little indication that the therapy sessions have an effective impact on individuals' outcomes. For example, inconsistent documentation indicates that J.U. received somewhere between 6 and 12 hours of individual therapy from February to May 2002. From late April to late May, she received five psychotropic PRNs and was placed in seclusion and/or restraints on 16 occasions. Similarly, T.T. received approximately 4½ hours of individual therapy from March to May 2002. She received no family therapy despite her issues regarding family dysfunction and her family's active visitation. From early April to early May, she received 12 psychotropic PRNs and was placed in seclusion and/or restraints on 11 occasions. These examples reflect Metropolitan's failure to provide the necessary therapeutic interventions to treat appropriately and effectively the children and adolescents in its care.

The group therapy provided at Metropolitan is inadequate. Only 9 of the 157 group therapy/activity protocols that we reviewed for Program 1 contained interventions or approaches that were empirically supported as effective. Groups are provided too infrequently and inconsistently. In particular, Metropolitan is not providing adequate substance abuse or medication groups -- critical groups for this population given that all of the patients are taking psychotropic medications and many have drug and alcohol issues.

Further, the lack of clinical oversight of group therapy raises serious concerns. Generally accepted professional standards of care require that such oversight be provided to: (a) determine a patient's readiness to participate in a group; (b) identify the group(s) that will provide therapeutic value to the individual; and (c) follow the patient's progress in the group(s) and regularly re-assess the appropriateness of the

group(s) based on the patient's individualized needs. Program 1's group therapy lacks any such clinical oversight, thereby exposing its patients to serious risk of harm. For example, many of the children and adolescents served by Program 1 have histories of being subjected to abuse. By placing these patients in groups in which subjects such as abuse are discussed prior to assessing their readiness to participate in such a group, Metropolitan is potentially re-traumatizing these children and adolescents. This is further exacerbated by making attendance at groups a requirement for earning points in the point system and ultimately for being considered for placement in a more integrated setting.

The quality of milieu programs (which are programs applicable to all patients and are to help them learn adaptive coping skills, improve self-esteem, and develop positive skills) appears also to be inadequate, as evidenced by the number of patients, such as Ui.N., Bc.O., I.X., and D.C., who have opted to miss almost as much as a month of school, and the many patients who "refuse to participate" in group therapy, according to their charts. High rates of treatment refusal convey a message regarding the quality of the treatment and should trigger an urgent assessment of programming and/or the patient, but this does not occur at Program 1. Moreover, patients whose group therapy attendance qualifies them for desirable activities, such as weekly community outings, are sometimes told that they cannot participate in these activities because of staffing constraints, which diminishes whatever therapeutic effectiveness group programming might have.

The efficacy of psychological treatments is further undercut by the use of excessive sedation for several Program 1 patients. During our tour, we frequently observed patients sleeping in day rooms during free time, sleeping in school classes, and sleeping during group activities. Many other patients were awake but showed signs of heavy sedation. Excessive sedation does not comport with generally accepted professional standards of care. Rather, it indicates inappropriate reliance on medication to manage patient behavior and restricts participation in treatment and educational programming. It also fosters a mentality that behavior cannot be internally and voluntarily controlled. Further, it prolongs patients' stay in a highly restrictive environment.

Independent of the quality of therapy, the documentation of individual and group therapy and group activities is fundamentally insufficient, stating neither the nature of the interventions employed nor the patients' responses. For example, documentation regarding I.X. is limited to general statements in the nursing notes, such as "has been . . . attending group," and various lists of the groups in which I.X. has participated. Similarly, the notes for B.S. by the physician, social worker, and psychologist do not even mention group treatment, and the nurse's notes contain only general statements, such as "[p]atient participates in groups." Consequently, it is not possible to gauge accurately the efficacy of particular treatments or assess the patient's progress relative to those treatments. In addition, patients' records often indicated that individual therapy was provided when therapy progress notes did not. These discrepancies call into question the integrity of the documentation as well the actual provision of services.

In any event, the dearth of effective active treatment interventions predictably contributes to poor patient progress in meeting treatment goals and discharge criteria. E.H. is illustrative. E.H. was admitted to the facility in April 1999. During our tour, personnel on his unit contemplated relaxing the standard discharge criteria, such that E.H. could be discharged if he maintained Level 3, the highest level of performance, for one month. Even this standard fails to recognize the ineffectiveness of E.H.'s treatments; in the more than three years that E.H. has resided at Metropolitan, this patient has achieved Level 3 one time.

E.H. illustrates the predicament of many of Metropolitan's children and adolescents. The failure to reach benchmarks that Metropolitan has determined to be achievable for patients like him primarily reflects, not his personal failings, but rather the shortcomings of the treatments he receives; E.H. is not receiving treatments that will allow him to maintain Level 3 long enough to leave the facility.

In summary, it is apparent that Program 1's active treatment interventions are too infrequent, are of inadequate quality, and are insufficiently documented. These deficiencies result in unnecessarily extended hospital stays, and they likely exacerbate psychological symptoms and increase feelings of hopelessness and emotional distress.

C. Behavioral Interventions

Behavioral intervention is a fundamental component of any appropriate treatment program for children and adolescents with emotional and behavioral disorders. Behavioral intervention occurs in milieu, or structural, context and on an individual level. In general terms, the objective of behavioral intervention is to facilitate other forms of treatment by controlling environmental conditions and shaping responses to environmental conditions. Shaping of responses occurs most typically through the consistent, comprehensible imposition of consequences that increase desirable behavior and decrease undesirable behavior. Virtually every aspect of Program 1's behavioral treatment programs is profoundly below generally accepted professional standards of care.

1. Milieu Programs

Generally accepted professional standards of care for behavioral programming call for the identification of specific, "operationally defined" "target" behaviors and the provision of consistent responses across settings to those behaviors. (In general terms, "operationally defined" means behaviors that are specified with particularity such that different observers can agree whether the behavior has occurred, and "target" behaviors means behaviors identified for treatment.) Behavioral programming that departs from these standards is virtually certain to fail and may exacerbate behavioral problems.

Perhaps the most prominent aspect of Program 1's milieu programs is its Point and Level System, the deficiencies of which are discussed above, at Section I. Independent of the Point and Level System, target behaviors in Program 1 behavior programs were stated in vague terms. Many patients' behavior programs included one target behavior for the unit, addressed only in the unit, and a different target behavior for the school, addressed only in the school. Thus, contrary to generally accepted professional standards of care, Program 1 does not ensure that responses to targeted behaviors are consistent across environments. Further, in at least one unit, the treatment team's review of, and changes to, target behaviors were not documented. In this regard, there was no effective means of tracking patient progress relative to the targeted behavior.

These problems severely restrict any benefit of the milieu programs and serve to frustrate and confuse patients.

2. Individual Behavioral Planning

Generally speaking, individual behavioral assessment is the careful examination of patient behaviors and the settings and circumstances in which they occur for purposes of developing appropriate interventions for undesirable behaviors and reinforcing desirable behaviors. Under generally accepted professional standards of care, this assessment is done through a functional analysis or functional assessment, which determines the purpose of the behavior and helps identify appropriate replacement behaviors.

As an initial matter, it is not clear that psychologists are aware of relevant behavioral data, including episodes of seclusion and restraints, which is essential in developing appropriate behavior support. Facility chart "thinning" guidelines dictate that the most recent three months of clinical data must be kept in the active chart, but we reviewed active charts from which recent instances of seclusion and/or restraints had been removed. T.T. is an example. Data regarding 15 episodes of seclusion or seclusion/restraints occurring in the three months just before our tour were "thinned" from T.T.'s active chart and placed in another chart intended to store dated information. Further, as indicated in Section II, Metropolitan does not have procedures in place to ensure that nursing and unit staff reliably monitor, document and report patients' symptoms and behaviors.

Program 1 behavioral supports are prepared without an adequate analysis of undesirable behaviors. The individual behavior treatment plans for F.U., I.X., D.Q., and N.Q., were prepared without a functional analysis or assessment of the behaviors which the plans are to address. One unit psychologist acknowledged that he had received no training in conducting functional behavioral assessments and was not aware of any tools for performing such assessments. The psychologist on another unit stated that systematic tools for conducting functional assessments were not available in the hospital.

The Program 1 individual behavior treatment plans are identified interchangeably as "special treatment plans" or "behavioral treatment plans." It appears that they are prepared

without adherence to specific criteria regarding methodologies or required components; the plans that we reviewed lack a common structure or approach. Their lack of functional analysis, of consistent, justifiable methodology, and of uniform components are shortcomings that significantly depart from generally accepted professional standards of care.

Separately, the triggers for performing behavioral assessments are poorly conceived. Consequently, individual behavior treatment plans are developed too rarely. In this regard, generally accepted professional standards of care require a clearly defined behavioral response, such as a behavioral treatment plan, to repeated episodes of highly restrictive interventions. However, Metropolitan policy requires individualized behavioral treatment plans only after the use of one-to-one supervision for 72 hours, due to harmful, or potentially harmful, behaviors.

Indeed, many patients are placed in seclusion and restraints repeatedly without triggering a behavioral assessment. Although T.T. was placed in seclusion and restraints 17 times over the 90-day period reviewed, and was subjected to PRN psychotropic medications 13 times over the 85-day period reviewed, T.T. did not have an individual behavior treatment plan. An intervention, of sorts, had been in place, but that was limited to T.T. reporting hourly to the nursing staff and was terminated because T.T. reportedly was uncooperative. Similarly, O.I. had 19 episodes of seclusion or restraints and 18 episodes of PRN medication in the period of slightly less than three months immediately preceding our Program 1 tour, but O.I. did not have an individual behavior treatment plan. Program 1 personnel indicated to us that, as a general matter, the decision to begin tracking individual behaviors was made informally.

Further, when behavioral interventions were developed, in at least some cases they were prepared with inordinate delay. Ui.N.'s chart indicates that a functional analysis of U.N.'s behavior was conducted in July 2001, followed by behavior tracking in October 2001 and the development of a "Special Treatment Plan" dated May 7, 2002. This example highlights not only a significant delay in treatment, but also another serious, more fundamental problem, which is that the facility is lackadaisical in responding to children and adolescents who are in need of urgent care and for whom extended institutionalization itself causes harm, by compounding their psychiatric problems.

When developed, the behavioral interventions are deficient in nearly every significant respect. They: (a) frequently are not prepared based on a functional analysis of behaviors, as in the plans of I.X., D.Q., Bc.O. and N.Q.; (b) describe target behaviors too broadly for the behaviors to be identified and tracked consistently, as in the plans for Ui.N., I.X., D.Q. and N.Q.; (c) do not sufficiently prescribe which environmental and consequential factors should be altered, as in the plans for Ui.N., I.X., D.Q., Bc.O., F.N. and N.Q.; (d) are internally inconsistent, as in the plans for Ui.N. and I.X.; (e) lack a reliable method to insure integrity of implementation, as in the plans for Ui.N., I.X. and D.Q.; and (f) lack criteria for revision or termination, as in the plans for Ui.N., I.X., D.Q. and N.Q.

Although Metropolitan has a Behavioral Treatment Review Committee charged with evaluating and approving behavioral treatments before they are implemented and with providing guidance to the psychologists preparing behavioral interventions, it is clear from the foregoing discussion that this committee is not functional. In fact, we could find no committee minutes for March and April 2002. The lack of quality control, guidance and leadership emanating from this committee conveys a message of indifference to the persons charged with providing adequate psychological care, indifference to the therapeutic importance of that care, and indifference to the children and adolescents who need but are not receiving adequate psychological care. That message of indifference contributes to the deficient psychological care at Program 1 and the resulting harm to its patients.

D. Use of Seclusion, Restraints and "As-Needed" Medications

Program 1's use of seclusion, restraints and "as-needed" (also known as pro re nata or "PRN") medications substantially departs from generally accepted professional standards of care and exposes the children and adolescents there to excessive and unnecessary restrictive interventions. It is generally accepted professional practice that seclusion and restraints will only be used when a person is a danger to self or others and when all other less restrictive measures have been attempted but failed. It also is generally accepted professional practice that seclusion and restraints will not be used in the absence of treatment or as punishment and will be terminated as soon as the

person is no longer a danger to himself or others. Finally, according to generally accepted professional medication practices, PRN medications should be used for psychiatric purposes only as a short-term measure to relieve a patient in acute distress, not as means to escape mild, possibly healthy, discomfort or as a repeatedly deployed substitute for treatment of the patient's underlying condition.

Metropolitan Program 1 staff use seclusion, restraints and/or PRN medications in the absence of adequate treatment and/or as punishment. Many episodes of seclusion, restraints and/or PRN medication use occur as a result of Program 1 patients exhibiting symptoms of their mental health disorders. Without the benefit of appropriate medication and therapeutic interventions, the children and adolescents are unable to control such symptoms. As a result of inadequate mental health treatment, children and adolescents are exposed to excessive use of seclusion, restraints, and/or PRN medications.

Moreover, we found numerous incidents in which patients exhibited behaviors that initially were not a danger to themselves or others, but because nursing and unit staff exacerbated their behaviors, the patients were ultimately subjected to seclusion, restraints and/or PRN medications. Because many Program 1 staff are not skilled in de-escalating their patients' behaviors, and because the patients lack adequate behavior support plans, staff frequently engage in power struggles with the patients. The documentation that is intended to reflect the interventions that staff attempted to use before seclusion, restraints and/or PRN medications does not indicate that staff had attempted other, less restrictive interventions.

Whenever a seclusion, restraint and/or PRN medication is used, it is generally accepted professional practice for the interdisciplinary team to reassess interventions and, as necessary, to modify the treatment plan to ensure that adequate proactive measures are identified and implemented. Frequent use of seclusion, restraints and/or PRN medications is an indicator that an individual's diagnosis is erroneous and/or that the treatment plan is inappropriate. Program 1 is failing to review patients' treatment plans after such episodes. There were numerous patient charts that, on one hand, identified frequent seclusion, restraint and/or PRN medication episodes but, on the other, contained no documentation that the team had reviewed the treatment plan or considered alternative interventions. For

example, J.U. was placed in seclusion and/or restraints on 19 occasions between April 16 and June 17, 2002. O.I. was placed in seclusion and/or restraints on 20 occasions between April 4 and May 30, 2002. S.N. was placed in seclusion and/or restraints on 18 occasions between April 2, 2002 and June 29, 2002. We found no evidence that any of these patients' treatment plans were reassessed or that other interventions were utilized before restraints. Moreover, staff frequently failed to document any information about the patients' status before, after or between episodes of seclusion, restraint and/or PRN medication use, making it difficult to improve the treatment plans.

Although Program 1 has made efforts to address its high rates of seclusion and restraints, those rates remain excessive. According to Metropolitan's statistics, for the 85 days immediately preceding our tour, there were 359 episodes of seclusion, restraints, or seclusion and restraints. Metropolitan statistics indicate that the average Program 1 census during our tour was 96. Together, these figures yield 43.99 episodes per 1,000 patient days, which is almost double the national aggregate data for adolescent psychiatric inpatient programs of 24.49 episodes per 1,000 patient days. See Association of Maryland Hospitals & Health Systems' Quality Indicators Project (2000) at http://www.qiproject.org/publicdata/psych/ (national comparative study).

Further, it appears that Metropolitan's statistics under-report the actual amount of seclusion and restraints that is being used. A random check of "Seclusion/Restraint" forms (form MSH 1172) uncovered numerous instances of seclusion and restraints not included in the summary seclusion and restraints data that Metropolitan provided to us. Examples of seclusion and restraints not captured in this summary data include:

(a) K.C. seclusion/restraints on 4/25/02, 18:05-19:30;
(b) K.S. seclusion/restraints on 4/28/02, 19:00-20:30;
(c) L.M. seclusion/restraints on 4/7/02, 14:20-16:10;
(d) P.B. seclusion/restraints on 4/13/02, 12:35-13:30;
(e) F.S. seclusion/restraints on 4/1/02, 15:15-17:15;

(f) S.N. seclusion/restraints on 4/24/02, 15:15-17:15; and
(g) E.G. seclusion/restraints on 5/7/02, 9:05-11:00.

The excessive use of PRN medications is also of great concern. For the 85 days immediately preceding our tour, PRN medications were administered 392 times. Based on a census of 96, this yields a rate of 48.04 episodes of PRN use per 1,000 patient days, which is an excessive rate.

There are numerous specific examples of excessive use of PRN psychotropic medications. U.C. received 20 PRN doses of Haldol between April 3 and June 16, 2002. Strikingly, 11 of these PRNs were administered by injection at U.C.'s request because "it was faster." Ub.N. received 22 psychotropic medication PRNs from April 6 to June 23, 2002, ten by injection. More than half of the PRNs were Haldol and Thorazine. Over approximately the same two month period, at least nine other individuals received between seven and 15 antipsychotic PRNs each. Many of these PRNs were for Haldol or Thorazine and/or were administered by injection.

The documentation indicates that patients frequently request and receive PRN medications when they are feeling "anxious." The facility appears to permit the use of PRN medications as a substitute for sound therapeutic intervention, thereby contributing to patients' medication dependency and dysfunction. In our review of charts of patients requesting PRNs, there was little indication that patients were provided proactive, supportive interventions before or after the administration of these medications. It does not appear that staff use such opportunities to teach children and adolescents the coping skills necessary to live independently in the community. Moreover, as discussed in Section I above, the use of the older antipsychotic medications raises a host of other serious risks to these patients' health.

IV. PHARMACY

It is standard practice for pharmacists to review individual patient's medication regimens. Such a review should encompass all of the medications prescribed (not just psychiatric drugs and PRN medications) and should include documentation of any communication between the pharmacists and physicians regarding

concerns, potential medication interactions, and the need for laboratory testing. Pharmacists, by the nature of their education and licensure, are the facility's experts regarding medications and medication interactions and share responsibility with physicians regarding medication decisions. We found no evidence that Metropolitan pharmacists perform these crucial roles. This is particularly troubling given the outdated and unjustified combinations of medications that are prescribed for these children and adolescents. By not providing adequate pharmacy services, Metropolitan places Program 1 patients at risk for the misuse of medication, unnecessary side effects from medication, potential drug interactions, general health problems, and excessively long hospitalizations.

V. GENERAL MEDICAL CARE

There are numerous instances in which Metropolitan fails to provide necessary medical care to the children and adolescents in Program 1. A number of children, including U.C., E.Z., S.K., C.H., Ui.N. and T.T., waited one to two months for an evaluation after complaining of vision problems and an additional one to three months to receive their glasses. U.C. experienced nighttime incontinence and received 15 doses of Motrin over two months for headaches. Neither problem was evaluated. The results of an x-ray for E.Z. were not noted by his physician for over one month. Similarly, C.H.'s physician did not initial his x-ray for more than two months.

VI. INFECTION CONTROL

In an institutional setting such as Metropolitan, it is standard practice for infections and communicable diseases to be tracked and trended. When analysis of trends reveals potential problems, it is standard practice for corrective action plans to be developed and implemented. Metropolitan has two infection control nurses on staff, but they only monitor individual patient infections. Metropolitan completes no systemic tracking or trending of infections or communicable diseases in Program 1 or throughout the hospital. As a result, Metropolitan's patients are at increased risk for infections and/or communicable diseases. Because no tracking or trending information was available for our review, it was impossible to determine if such infections had occurred or diseases had been allowed to spread without the benefit of corrective action plans.

VII. DENTAL SERVICES

Generally accepted professional standards of care require that dental care and treatment be provided in a timely manner. Program 1 patients, however, experience delays of several months in receiving needed dental care and treatment or do not receive treatment at all. This problem was noted in the April and May 2002 minutes of Metropolitan's CNS/NC Committee, which stated that individuals were not seen by a dentist in a timely manner and the "backlog" of dental patients required attention. At the time of our tour, the dentist assigned to Program 1 was on extended leave and the dentist for Metropolitan's adult population, an additional 800 or so individuals, was covering the Program 1 caseload. This coverage is insufficient to ensure timely and appropriate dental care. Even when Program 1 patients do receive dental services, documentation of these services is grossly incomplete, often failing to indicate the individual's current dental status and leaving numerous sections of the evaluation blank.

VIII. DIETARY

Program 1's dietary services substantially depart from generally accepted professional standards of care and expose the children and adolescents there to significant risk of harm. The facility's dietician estimated that eighty percent of Program 1's patients are obese, an estimate consistent with our own observations and review of patient records. Many of the medications these children and adolescents receive exacerbate weight problems. These patients' obesity, which is very severe in several cases, places them at increased risk for physical health problems, such as high blood pressure, and other deleterious effects, such as decreased self-esteem, that worsen existing mental health problems. Notwithstanding these significant consequences, virtually every one of the several nutritional evaluations that we reviewed indicated that the facility was not pursuing dietary interventions because the patient "refused [a] weight reduction program" that consisted almost entirely of receiving a smaller portion of the same meals served to other patients. We found no evidence that the facility was actively promoting viable alternative interventions to address patients' severe weight problems. Our record review of Program 1's exercise group, for instance, indicated that the group rarely met. Whether or not these children and adolescents arrived at Metropolitan greatly overweight, the facility is not

implementing meaningful interventions to address their serious weight problems or related self-esteem issues.

IX. PLACEMENT IN THE MOST INTEGRATED SETTING

Generally accepted professional standards of care and federal law require that treatment teams, with the leadership of psychiatrists and the support of the hospital administration, actively pursue the timely discharge to the most integrated, appropriate setting that is consistent with patients' needs. In this regard, factors that contributed to previous unsuccessful placements should be identified and addressed. Program 1's discharge planning process fails to meet these standards of care. Consequently, the process results in unnecessarily extended hospitalizations, poor transitions, and a high likelihood of readmission, all of which result in harm to Program 1's children and adolescents.

The excessive length of numerous patients' hospitalizations is alarming. As of the week of our visit, the average length of stay was reported to be 350 days, with 30 percent of the current patients having been at Program 1 more than one year and 14 percent more than two years. Staff appear to take little responsibility for the discharge process, stating that excessively long stays are unavoidable. Despite the fact that some children and adolescents remain at Program 1 for years, Program 1 has not developed any mechanism to identify and review those patients having extremely lengthy hospitalizations. Given that there is no mechanism to identify patients who are stalled in their discharge implementation, senior administration seems to have no understanding that children and adolescents remaining institutionalized for years constitute a systemic crisis, nor do they demonstrate any influence over this process.

Metropolitan's discharge criteria and the portions of treatment plans addressing discharge are also inappropriate and contribute to patients' lengthy hospitalizations. Plans fail to identify clearly the barriers to discharge to the most integrated setting, and the actions that staff and/or the patient needs to take to overcome these barriers. Plans also do not contain measurable action steps, persons responsible for discharge steps, and time frames for the completion of those steps.

Further, discharge criteria in the majority of cases are identical. Most patients are required to maintain nearly 100

percent compliance with most aspects of Program 1 rules and to maintain discharge criteria for 90 days prior to the facility seeking a placement. Thus, even after the point at which an individual achieves discharge criteria, he or she is typically not discharged for many months. For instance, Ui.N.'s April 2002 treatment plan stated that he had met discharge criteria, but his estimated discharge date read "three to six months." The fact that discharge plans routinely have broad estimated time frames for discharge rather than a specific date as the estimated date of discharge favors such easily extendable discharge dates.

As a general matter, Metropolitan's approach to the discharge process is passive, as illustrated by the case of N.Q. This patient had met all of the facility's discharge criteria. Nevertheless, he remained there because his receiving program would not accept him without an updated audiological evaluation, and Metropolitan had not scheduled one. Moreover, discharge summaries for a number of patients included no appointments for follow-up care. Failure to ensure follow-up care places these children and adolescents at marked risk of re-hospitalization.

Metropolitan's shortcomings regarding N.E. illustrate many of these problems. Despite the fact that she met discharge criteria for 90 days, that her family was willing to care for her, and that a court, at N.E.'s insistence, ordered her discharged, the treatment team was so entrenched in their view of discharge planning that they discharged her "against medical orders" to her family, because they wanted her sent, instead, to a group home. The discharge form indicated that N.E. was frustrated over the period of time she had waited to be discharged, stating "you guys won't do anything so I have to." Indeed, many aspects of Metropolitan's approach to discharge planning reflect an attitude that the children, and not the facility, bear responsibility for improving their health.

In part, the problems with the discharge process are due to the diffusion of authority and responsibility for the provision of discharge services between the facility and California counties; the facility typically determines when a patient is ready for discharge and recommends a setting for placement, but the resident's county of origin determines the actual placement setting. Also, social workers, who are required to organize the discharge process with little administrative support from Metropolitan, have a limited ability to influence many of the decisions regarding placement. Discharge planning, however,

cannot be disconnected from treatment and based solely upon funding and resource availability. One social worker expressly stated to us that these factors posed obstacles to discharge. Metropolitan must take necessary actions in the discharge process to treat its patients adequately and appropriately and to comply with federal law.

X. SPECIAL EDUCATION

Metropolitan's provision of special education substantially departs from generally accepted professional standards of care and from federal law in that it fails to provide children and adolescents adequate habilitation to prevent regression and to facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982). California is also failing to meet its more specific obligation to provide individualized educational programs that are reasonably calculated to enable the children and adolescents of Metropolitan to receive educational benefits. See Bd. of Educ. of the Hendrick Hudson Cent. Sch. Dist. v. Rowley, 458 U.S. 176, 206-07 (1982).

Federal law conditions federal financing of State special education programs upon the State's provision of a free and appropriate public education ("FAPE"). Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §§ 1400 et seq. (2002). In this regard, the IDEA requires educational agencies to develop an individualized education program ("IEP") for each child having a disability. The required elements of the IEP include, but are not limited to: (a) present levels of educational performance; (b) annual goals and short-term objectives; (c) specific educational services that are to be provided; and (d) statements of how progress toward annual goals are to be measured. 20 U.S.C. § 1414(d) (2002). The IDEA further requires such "related services" as are necessary to permit the child to benefit from instruction, including psychological services. Id. at §§ 1401(22), 1414(d)(2002). Thus, the IDEA requires "access to specialized instruction and related services which are individually designed to provide educational benefit to the handicapped child." Rowley, 458 U.S. at 201.

Metropolitan does not provide "specialized instruction and related services which are individually designed," id., nor has it developed clear statements of how progress toward annual goals

are to be measured, see 20 U.S.C. § 1414(d)(2002). Its deficiencies in this regard cause harm to most of its Program 1 patients, who are entitled to a free and appropriate education, but do not receive it.

Inadequate direction is a common component of many of the problems in this area. School administration is not effective in supervising teachers, overseeing instruction, or ensuring that procedures, such as the recording of attendance, are appropriately followed. For example, the principal of the Allen Young School, which is the on-campus school serving Metropolitan patients under age 18, appeared largely unaware of what happened in his classrooms; he was unable to identify which students were doing well or even recall significant incidents of violence and suspensions that recently had occurred in the school.

A. Individual Education Programs

Metropolitan's IEPs substantially depart from generally accepted professional standards of care and do not comply with federal law. Based on our review of 15 plans, it is apparent that they are formulaic. Many plans vary by only a few words from student to student. Further, they reflect poor assessments of students' individual levels of educational performance. Metropolitan's assessments of unique educational needs are unreliable. They frequently are based on assessment tools that are greatly outdated and that do not evaluate students in their non-English native languages. Consequently, the IEPs do not correctly identify students' current levels of education performance.

Further, although the IEPs do contain nominally "specific education services" to be provided to each student, the identified services are, in substance, largely generic among students. Specificity regarding the unique educational needs of the individual student is mostly absent. As a consequence of these deficiencies, the identified annual goals and short-term objectives of students often are not appropriate. For that matter, the IEPs generally do not contain individualized goals.

For many of Program 1's students, behavioral supports are necessary "related services" that are not currently being provided. Without such services, students are unable to benefit from instruction. Given the population enrolled in the Allen Young School, it is troubling that only one of the IEPs reviewed

indicated a need for functional behavioral assessment. Even when assessments and behavioral plans are included in the IEPs, they are inadequate for many of the reasons discussed at Section III, above, including their lack of individualization, specificity or objective data. It is also of great concern that there appears to be no coordination between the behavior support plans at the school and those on the residential units. The children and adolescents are likely to be confused by disparate plans, thereby negating their intended therapeutic effect.

Finally, although the IEPs should include appropriate, objective criteria for determining whether instructional objectives are being achieved, they do not. In this regard, two teachers acknowledged to us that they have no formal system for assessing progress, and most teachers indicated that they use informal, subjective estimates of students' progress. Thus, Metropolitan's IEPs neither comply with the IDEA nor have significant utility in identifying and providing for individuals' education needs.

B. Instruction

One of the most critical elements of the IEP is that it be reasonably calculated to enable the child to receive educational benefits. See Rowley, 458 U.S. at 206-07. It is axiomatic that, for students to receive educational benefits, they must receive adequate instruction. Generally accepted professional standards regarding special education instruction call for teacher-directed lessons, provided in small, homogeneous groups, composed of frequent teacher questions and student answers, progressing in small increments, with abundant teacher feedback. Although we saw some elements of such instruction in three classes, no such instruction was evident in another five classes that we attended. Generally speaking, Metropolitan's classroom instruction is not effective in conveying the educational benefits to which its special education students are entitled.

C. Literacy

Metropolitan's records clearly show that some special education students lack basic reading and writing skills. These skills are the most fundamental educational benefit to which special education students are entitled. Although some IEPs contained literacy objectives, we found no evidence that literacy instruction was, in fact, provided. We saw no literacy

instruction during our tour, nor records of planning for fundamental literacy instruction. Teachers we interviewed indicated that they had adult readers assist students having reading difficulties, but they did not provide remedial reading instruction. One school staff person stated that the speech therapist provided remedial reading instruction, but the speech therapist told us that she was not teaching reading. Consequently, it appears that Metropolitan is not providing the most basic academic skills to the special education students who lack them. This is a substantial departure from generally accepted professional standards of care that is harmful to these students in that it deprives them of educational tools that are essential to function adequately in society.

D. Least Restrictive Environment

The IDEA requires that,

> [t]o the maximum extent possible, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

20 U.S.C. § 1412 (5)(A). See also Rowley, 458 U.S. at 202 ("The Act requires participating States to educate handicapped children with nonhandicapped children whenever possible.") None of Metropolitan's children and adolescents participates in any off-grounds schooling, with non-institutionalized children. Metropolitan does not meaningfully assess each child and adolescent to determine whether he or she, when provided adequate supervision and supports, is capable of participating in at least some regular school activities with non-disabled peers. Although many patients' disorders may preclude any participation in a regular educational environment, other patients, especially those approaching discharge, may be capable of at least some integrated education, with appropriate supports. Metropolitan's failure to assess continuously each of its child and adolescent patients to determine whether he or she requires separate schooling, and its

failure to provide access to a regular school environment for those patients who could participate, with reasonable supports, is in violation of the IDEA.

XI. PROTECTION FROM HARM

During the Metropolitan II exit interview, we outlined facility-wide issues relating to protection from harm and quality assurance, and we will address these facility-wide issues in connection with our findings regarding Metropolitan's adult units. Regarding Program 1, in particular, the foregoing discussion makes evident that Metropolitan fails to protect the children and adolescents it serves from harm.

Further, as we pointed out in the presence of facility administrators who toured Program 1 units with us, the vents and window grills on several units contained holes large enough for patients to thread a sheet or other cloth through them, placing them at risk for suicide by hanging. In this regard, a number of the units had metal window frames with space between the frame and the ceiling which could be potential suicide hazards. Likewise, some of the vents in Program 1 were not covered. This presented a hazard in that patients could access wires and other potentially dangerous items. Several of the units contained other hazards, such as wires holding down seclusion beds that, if accessed by patients, could be used to hurt oneself or others.

In addition, one of Unit 101's seclusion rooms did not have mirrors properly positioned, creating a blind spot and preventing staff from monitoring patients who have been placed in the room. Further, some of the seclusion room restraints were worn, placing patients who are restrained at risk of abrasions and skin breakdown.

In at least one instance, Metropolitan did not take steps to ameliorate known risks. On January 23, 2002, patient I.X. attempted to commit suicide by tying a shoelace through openings on the under side of her bed and strangling herself. Less than 4 months later, on May 17, 2002, she again attempted suicide using the same methodology.

Further, frequent instances of same-sex sexual contact among patients were labeled by Metropolitan as "consensual" when it appeared that the facility was making insufficient effort to ensure that patients were not being coerced into sexual activity.

A staff member on Unit 107 estimated that there had been 10 such instances on the unit over the preceding year, but our search for documentation of these instances uncovered a record of only one. Separately, as to a patient who had made a documented claim that he had been raped, we found no evidence in the chart that a physician had examined him physically, and no responsive interventions were undertaken, according to the chart, apart from moving the involved boys to separate bedrooms.

These examples and much of the foregoing discussion raise concerns regarding Metropolitan's ability to protect patients from harm and its incident management system, including the tracking and trending of unusual incidents, the quality of the investigations being completed, and the identification and implementation of corrective actions. As indicated above, we will elaborate on those concerns in our findings addressing Metropolitan's adult units.

XII. FIRST AMENDMENT AND DUE PROCESS

Prior to our tours of Metropolitan, the State indicated that it would refuse to allow Program 1 patients to speak with the Department of Justice or its expert consultants unless persons acting at the direction of the State were present. During our tours of Metropolitan, the State maintained this position, and State representatives participated in all of our discussions with patients. The State's effort to circumscribe our access to Metropolitan patients and to information regarding their care and well being is troubling.

As the State is aware, the United States District Court for the Central District of California has ruled that CRIPA preempts a jurisdiction's invocation of procedural hurdles to "restrict or deny the DOJ access to [a juvenile facility], the juveniles held therein and their records." United States v. County of Los Angeles, 635 F. Supp. 588, 594 (C.D. Cal. 1986). More fundamentally, by denying its patients the right to speak confidentially to attorneys from, or expert consultants acting for, the Department of Justice, the State impermissibly has constrained its patients' constitutional rights to: (a) free speech, including the right to petition the government for redress of grievances; and (b) due process. See United States Constitution Amendments I, XIV; Johnson v. Avery, 393 U.S. 483, 485 (1969)(stating that even state prisoners retain the freedom to petition for redress of grievances); Gary W. v. Louisiana, 437

F. Supp. 1209, 1224 (E.D. La. 1976), aff'd, 622 F.2d 804 (5th Cir. 1980) (stating that children institutionalized for treatment enjoy the First Amendment right to free communication, and the State may monitor such children's communications only under "carefully circumscribed conditions," when "necessary to prevent serious harm to the child"); In re Quarles 158 U.S. 532, 535-36 (1895) (discussing the rights of citizens to communicate with federal law enforcement officials regarding violations of federal law). By imposing itself on communications between the federal government and its citizens, California wrongfully abridges these rights.

Further, California's position violates the protections that it itself affords to persons institutionalized in its mental health hospitals, in its Code of Mental Health Patients' Rights. See Cal. Welf. & Instit. Code § 5325 (2002). Under California law, all State mental health patients are entitled to certain rights, that must be posted in English and Spanish throughout the institution, and that include the right to engage in communications that are confidential. Id. The right to confidential communication provided by California law -- especially communication with one's government regarding matters of important public interest, such as conditions of care at a state institution -- is one of real substance, the State's encumbrance of which implicates the due process clause of the United States Constitution. In placing its own interests in limiting its exposure to a federal investigation of a State facility over the constitutional interests of the patients residing in that facility, the State has further harmed those patients.

XIII. MINIMUM REMEDIAL MEASURES

To remedy the deficiencies discussed above and to protect the constitutional and federal statutory rights of the children and adolescents in Program 1 of Metropolitan, California promptly should implement the minimum remedial measures set forth below.

A. Psychiatric Services

Metropolitan should provide psychiatric supports and services to provide adequate treatment for chronically and severely mentally ill and traumatized children and adolescents. More particularly, Metropolitan should:

1. Ensure that each individual's psychiatric evaluation, diagnoses, and medications are justified in a generally accepted professional manner.

2. Ensure that all physicians and clinicians can demonstrate competence in appropriate psychiatric evaluation and diagnosis.

3. Develop standard psychiatric evaluation protocols for reliably reaching psychiatric diagnoses.

4. Review and revise, as appropriate, psychiatric evaluations of all individuals currently residing in Program 1, providing clinically justifiable current diagnoses for each individual, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimen, as appropriate.

5. Develop and implement policies and procedures regarding the development of treatment plans consistent with generally accepted professional standards of care.

6. Review and revise, as appropriate, each individual's treatment plan so that it is current, individualized, and consistent with generally accepted professional standards of care.

7. Develop appropriate protocols that require the completion of cognitive and academic assessments of all Program 1 patients within 30 days of admission, unless valid testing has been completed within one year of admission.

8. Develop and implement a plan of remediation in both treatment and educational plans for any identified cognitive and academic deficits of current Program 1 children and adolescents.

9. Develop policies and protocols to ensure patients have genuine input into their treatment plans, including education regarding the purposes and side effects of medication.

Committee made various recommendations, including revision of the Managing Assaultive Behavior ("MAB") training curriculum, providing staff with additional education, and increasing the use of alternatives to seclusion and restraint. According to minutes provided to us, no other mention of this issue occurred until November 27, 2001, when almost identical strategies were identified. No subsequent discussion apparently occurred thereafter through March 26, 2002, the period that we reviewed; the minutes are silent regarding implementation of the previously identified strategies or recommendations, or their impact on resolving the identified issues. This apparent lack of follow-up is especially problematic, given the problems identified in Section VI, above, regarding Metropolitan's use of restraint and/or seclusion.

C. Environmental Issues

In a facility serving people at risk of harming themselves or others, the environment should be kept free of hazards. Metropolitan has failed to meet this generally accepted professional standard of care. As we pointed out in the presence of administrators who toured the adult units with us, the vents and window grills on several units contained holes large enough to thread a sheet or other cloth through, placing patients at risk for suicide by hanging. As on the children and adolescent units, some of the vents on the adult units were not covered, allowing patients to access wires and other potentially dangerous items. Several of the units contained other hazards, such as wires holding down seclusion beds that, if accessed by patients, could be used to hurt oneself or others. In one of the restraint rooms, we observed plaster on the floor that easily could have been swallowed by a patient.

Examples of Metropolitan's breakdown in environmental protections include a January 17, 2001 incident in which W.T. was found standing on a heater vent with torn linen tied tightly around his neck and attached to a bar on the window. He jumped from the vent in an attempt to strangle himself. By the time staff arrived to assist, his face reportedly had turned a bluish hue. Despite the fact that this incident clearly identified that the bars on the windows are a potential suicide hazard, it does not appear that systemic action was taken to ameliorate the situation. On July 11, 2001, a peer notified staff that N.T. had attempted to hang herself in her bedroom with a bed sheet looped around her neck and fastened to a metal frame of a window. Again on July 15, 2001, a peer reported to staff that N.T. was attempting to hang herself. Staff found N.T. with a blanket tied around her neck and the other end tied to the bars

on the window. Less than three months later, on October 8, 2001, N.T. was found with a bed sheet looped around her neck and fastened to a metal frame of a window. N.T. was then placed in seclusion and restraint. One day earlier, staff found K.S. in the bathroom with a blanket tied around his neck and the other end tied to the bars on the window.

Based on both staff statements and our own observations, Metropolitan fails to maintain temperatures in some patient areas that do not pose a risk to health. For example, during the evenings, the SNF units were excessively warm. We observed that staff repositioning patients were sweating profusely. Commendably, staff had attempted to ameliorate the heat by pointing fans into patient rooms, but privacy curtains were blocking the airflow. Moreover, fans blowing on patients whose health is compromised, such as patients requiring skilled nursing care, places them at high risk for complications such as pneumonia.

Lastly, areas throughout the facility, primarily the SNF units, had a strong smell of urine and excrement. This is a potential indication that patients had been sitting in their urine or feces for a long period of time, placing them at high risk for skin breakdown. We observed urine-soaked laundry on the floors of some patients' rooms and in uncovered bins in patient-inhabited areas, presenting an infection hazard.

D. Use of Untrained Personnel in Patient Interventions

Generally accepted professional standards of care for facilities such as Metropolitan dictate that program staff be responsible for patient treatment and care. Although there is nothing improper about utilizing such security personnel to handle episodic incidents of violence by residents, it is not appropriate to rely on security staff -- who lack mental health training -- to share material responsibility for patient treatment and care.

It appears that treatment staff frequently rely on officers because staff cannot effectively address patients' behavioral needs. This practice highlights weaknesses in Metropolitan's therapeutic interventions and presents substantial risk of harm to patients. First, given that the officers are armed with pepper spray and batons, their presence on the units presents a safety risk if a patient were to gain control of these weapons. Second, the officers are not trained properly to address the

4. Ensure that psychologists communicate and interpret psychological assessment results to the treatment team, along with the implications of those results for diagnosis and treatment.

5. Develop and implement policies and procedures, in accordance with generally accepted professional standards of care, regarding the necessary and sufficient components of a comprehensive psychological evaluation.

6. Ensure that patients in need of individual, group and/or family therapy services receive such services in accordance with generally accepted professional standards, and that these services are provided in a patient's primary language.

7. Document the provision of individual and group therapy services each time they occur, including clear descriptions of the problem being addressed, the focus of the session, the intervention provided by the therapist, and the patient's response to the intervention.

8. Provide adequate clinical oversight to therapy groups to ensure that patients are assigned to groups that are appropriate to their individual needs, that groups are provided frequently and consistently, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are addressed in group therapy.

9. Ensure that all group leaders are competent regarding selection and implementation of appropriate approaches and interventions to address group therapy objectives, are competent in monitoring patient responses to group therapy, and are supervised by clinical staff.

10. Ensure the consistent implementation of reinforcement and behavior programs.

11. Ensure that patients are not denied, because of excess sedation, the full benefit of behavioral treatment and educational interventions.

12. Ensure that all psychologists can demonstrate competence in the development and implementation of milieu behavioral programs that are consistent with generally accepted professional standards of care, including the monitoring of patient progress in such programs and program revision as monitoring warrants.

13. Ensure that all responsible program staff demonstrate competence in implementing individual behavioral programs.

14. Ensure that, before they work with patients, all psychologists have successfully completed competency-based training, in accordance with generally accepted professional standards of care, in conducting a functional analysis of behavior, preparing individualized behavior interventions and positive behavior support plans, designing methods of monitoring the program intervention and the effectiveness of the intervention, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program.

15. Specify and utilize, in accordance with generally accepted professional standards of care, triggers for instituting individualized behavior treatment plans.

16. Continue to reduce the use of seclusion, restraints and psychotropic PRN medications.

17. Ensure the accuracy of seclusion, restraints, and psychotropic PRN medications data.

18. Revise and implement policies and procedures to prohibit the use of seclusion, restraints and/or psychotropic PRN medications as an alternative to adequate treatment and/or as punishment. Include requirements for staff to utilize and document the

10. Increase the frequency of treatment team meetings and discharge plan reviews from every 90 days to a minimum of every 30 days, and more frequently, as appropriate.

11. Ensure that all psychotropic medications are appropriate for Program 1's population, are specifically matched to current, clinically justified diagnoses, are prescribed in therapeutic amounts, are monitored for efficacy against clearly-identified target variables and time frames, are modified based on clinical rationales, and are properly documented.

12. Develop and implement protocols and procedures consistent with generally accepted professional standards of care regarding the use of psychotropic medications to treat symptoms other than psychosis, including that this practice be clearly documented with a specific plan for minimizing the dosage and the duration of the medication.

13. Develop and implement protocols and procedures consistent with generally accepted professional standards of care regarding off-label medication usage, including the establishment of an institutional review board to supervise this practice, the development of research protocols, and policies to obtain appropriate informed consent from minors and/or guardians.

14. Develop and implement protocols and procedures to ensure that each patient's treatment plan includes a plan to monitor, document, report and properly address potential side effects of prescribed medications.

15. Develop and implement formal tools to be used program-wide for each person at risk of experiencing medication side effects in accordance with generally accepted professional standards.

16. Make appropriate attempts to use newer psychotropic medications with fewer, less serious side effects, rather than older psychotropic medications.

17. Use a milieu structure for Program 1 that is consistent with generally accepted professional standards of care. Ensure that it is applied to patients in a consistent, comprehensible and therapeutic manner, and ensure that staff implementing milieu programs first have successfully completed competency-based training in implementing such programs.

18. Remedy those aspects of Program 1's physical environment that inhibit appropriate psychiatric treatment, including, but not limited to, the violation of individual's privacy, the lack of individualization, and the lack of appropriate recreational facilities.

B. Nursing

Metropolitan should provide nursing services to the children and adolescents it serves that are consistent with generally accepted professional standards of care. Such services should result in Program 1's patients receiving individualized services, supports and therapeutic interventions. At a minimum, Metropolitan should:

1. Develop and implement a treatment planning policy that ensures that each patient's treatment plan identifies the Axis I diagnoses and the related symptoms to be monitored by nursing and other unit staff and the frequency by which staff need to monitor such symptoms. This policy should include requirements for staff to monitor, document and report such symptoms and for treatment teams to analyze the information collected and to modify, as appropriate, treatment plans based upon this data.

2. Develop and implement a policy consistent with generally accepted professional standards of care

regarding psychotropic medication side effects monitoring.

3. Ensure that, before they work directly with patients, all nursing and other unit staff have successfully completed competency-based training in mental health diagnoses, related symptoms, psychotropic medications, and the identification of side effects of psychotropic medications.

4. Ensure that, before they work directly with patients, all nursing and other unit staff have successfully completed competency-based training in the provision of a therapeutic milieu on the units.

5. Ensure that, before they work directly with patients, all nursing and other unit staff have successfully completed competency-based training in proactive, positive interventions to prevent and de-escalate crises.

C. Psychology

Metropolitan should provide psychological supports and services adequate to treat the emotional and behavioral disorders experienced by Program 1 children and adolescents according to generally accepted professional standards of care. More particularly, Metropolitan should:

1. Where clinical information is insufficient, increase the use of direct clinical assessment of patients to provide a comprehensive clinical picture, and when additional clinical questions are raised, including so-called "Rule Out" and deferred diagnoses, implement appropriate clinical assessments to answer the questions promptly.

2. Ensure that clinically relevant information remains readily accessible in the active chart.

3. For patients whose primary language is not English, provide comprehensive psychological assessments in the patients' primary language.

use of proactive, positive, and less restrictive methods before using seclusion, restraints and/or psychotropic PRN medication. Ensure that staff demonstrate competence in the implementation of such policies.

19. Revise and implement policies and procedures to require the review and modification, if necessary, of patients' treatment plans after any use of seclusion, restraints and/or psychotropic PRN medication.

20. Develop and implement a policy consistent with generally accepted professional standards of care governing the use of psychotropic PRN medication for psychiatric purposes in child and adolescent patients and ensuring, in particular, that such medications are used on a limited basis and not as a substitute for adequate treatment of the underlying cause of the patient's distress.

D. Pharmacy

Metropolitan's Program 1 patients should receive pharmacy services consistent with generally accepted professional standards of care. Specifically, Metropolitan should:

1. Develop and implement policies and procedures that require pharmacists to complete monthly reviews of patients' medication regimens, and, as appropriate, to make recommendations to the treatment team, including the prescribing physician, about possible medication changes. Such a review process should include medical and psychotropic drugs.

2. Develop and implement policies and procedures that require pharmacists to track the use of psychotropic PRN medications, and, whenever appropriate, notify the prescribing physician of problematic trends.

E. General Medical Care

Metropolitan should provide adequate preventative, routine, specialized and emergency medical services on a timely basis, in accordance with generally accepted professional standards of care. More particularly, Metropolitan should:

1. Develop and implement protocols and procedures to ensure the timely provision of medical care, including but not limited to, evaluation of vision care, dental care, and x-ray services.

2. Render appropriate medical treatment on a timely basis.

3. Monitor patients' health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their treatment plans to address any problematic changes in health status indicators.

F. Infection Control

Metropolitan should implement adequate infection control procedures to prevent the spread of infections and/or communicable diseases. More specifically, Metropolitan should:

1. Revise infection control policies and procedures to include the tracking and trending of infections and communicable diseases as well as the development and implementation of corrective action plans.

2. Establish an effective infection control program that: (a) actively collects data with regard to infections and communicable diseases; (b) assesses these data for trends; (c) initiates inquiries regarding problematic trends; (d) identifies necessary corrective action; (e) monitors to ensure that appropriate remedies are achieved; and (f) integrates this information into Metropolitan's quality assurance review.

G. Dental Services

Patients should be provided with routine and emergency dental care and treatment on a timely basis and in a manner consistent with generally accepted professional standards of care. More specifically, Metropolitan should:

1. Retain an adequate number of adequately qualified dentists to provide timely and appropriate dental care and treatment to Metropolitan patients.

2. Develop protocols and procedures that require the comprehensive and timely provision of dental services and the documentation of such services.

H. Dietary

Metropolitan Program 1 patients should receive adequate dietary services, particularly patients who experience weight-related problems. Specifically, Metropolitan should:

1. Modify treatment planning policies and procedures to require that the treatment plans of children and adolescents who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner.

2. Ensure that treatment team members demonstrate competence in the dietary and nutritional issues affecting children and adolescents and the development and implementation of strategies and methodologies to address such issues.

3. Increase the availability of individualized and group exercise and recreational options for the children and adolescents in Program 1.

I. Placement in the Most Integrated Setting

Metropolitan should pursue actively the appropriate discharge of patients and ensure that they are in the most integrated, appropriate setting that is consistent with patients' needs. More particularly, Metropolitan should:

1. Ensure that discharge planning begins at the time of admission and that all patients have realistic and individualized discharge criteria. Ensure that each patient has a professionally developed discharge plan, including measurable action steps, persons responsible and time frames for completion.

2. Ensure that patients who have met discharge criteria are discharged expeditiously and with appropriate supports.

3. Develop and implement a policy and protocol that identifies patients with lengths of stay exceeding six months. Establish a regular review forum, including senior administration, to review these patients, their treatment plans, and obstacles to successful discharge to the most integrated, appropriate setting. Create an individual action plan for each individual being reviewed.

4. Consolidate responsibility for discharge planning with the authority to provide the supports and services that discharge planning indicates are necessary.

5. Ensure that all Program 1 staff, including senior administration, provide care and treatment to mitigate the dangers of long-term institutionalization for the children and adolescents in their care.

6. Provide transition and follow-up supports and services consistent with generally accepted professional standards of care.

J. Special Education

Metropolitan should ensure that all of its child and adolescent patients who qualify for special education receive individualized educational programs that are reasonably calculated to enable these patients to receive educational benefits. More particularly, Metropolitan should:

1. Ensure that all Individualized Education Programs are developed and implemented consistent with the requirements of the Individuals with Disabilities Act, 20 U.S.C. §§ 1400 et seq. (2002)("IDEA").

2. Ensure that special education students receive instruction appropriate to their needs and learning abilities, consistent with generally accepted professional standards of care.

3. Provide appropriate literacy instruction for students with significant deficits in reading and/or writing.

4. Provide appropriate supplemental education for students whose individualized education programs at the facility have not been reasonably calculated to enable them to receive educational benefits.

5. Continuously assess each student's capacity to participate, with appropriate supports and services, in a regular, non-institutional, education environment, and provide access to a regular education environment for those students who can participate in one with appropriate supports and services.

6. Ensure that all students receive their education in the least restrictive setting pursuant to the requirements of the IDEA.

K. Protection from Harm

Metropolitan should provide its patients with a safe and humane environment and protect them from harm. At a minimum, Metropolitan should:

1. Conduct a thorough review of the units within Program 1 to identify potential safety hazards, and develop and implement a plan to remedy any identified issues.

2. Thoroughly review and, as appropriate, revise hospital policy, and Program 1 practice, regarding

sexual contact between patients. Establish clear guidelines regarding staff responses to reports of sexual contact and monitor staff responses to incidents. Comprehensively document therapeutic interventions in patient charts in response to instances of sexual contact.

3. Develop and implement a comprehensive quality assurance plan consistent with generally accepted professional standards of care, including but not limited to an effective incident management system.

L. First Amendment, Access to Courts and Due Process

The State should permit Metropolitan Program 1 patients to exercise their constitutional rights of: (a) free speech, and, in particular, the right to petition the government for redress of grievances without State monitoring; and (b) due process. More particularly, the State should:

1. Permit patients to speak with representatives of the federal government outside the presence of persons acting for the State.

2. Permit patients to engage in confidential communications.

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The collaborative approach that the parties have taken thus far has been productive. We hope to continue working with the State in this fashion to resolve our significant concerns regarding the care and services provided at this facility.

We will forward our expert consultants' reports under separate cover. Although their reports are their work - and do not necessarily represent the official conclusions of the Department of Justice - their observations, analyses and recommendations provide further elaboration of the relevant concerns, and offer practical assistance in addressing them. We hope that you will give this information careful consideration

and that it will assist in facilitating a dialogue swiftly addressing areas requiring attention.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that the Attorney General may initiate a lawsuit pursuant to CRIPA, to correct deficiencies or to otherwise protect the rights of Metropolitan's patients, 49 days after the receipt of this letter. 42 U.S.C. § 1997b(a)(1). Accordingly, we will soon contact State officials to discuss in more detail the measures that the State must take to address the deficiencies identified herein.

Sincerely,

Ralph F. Boyd, Jr.
Assistant Attorney General

cc: The Honorable Bill Lockyer
Attorney General
State of California

Stephen W. Mayberg, Ph.D.
Director
California Department of Mental Health

Mr. William G. Silva
Executive Director
Metropolitan State Hospital

Debra W. Yang, Esq.
United States Attorney
Central District of California

The Honorable Roderick R. Paige
Secretary
United States Department of Education

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2413

July 24, 2003

Benjamin O. Tayloe, Jr.
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
PHB Mailroom 5034
950 Pennsylvania Ave. NW
Washington DC, 20530

RE: Response to the United States Department of Justice Findings Letter regarding Metropolitan State Hospital's Program 1 (Children and Adolescents) pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997

Dear Mr. Tayloe:

The California Department of Mental Health and Metropolitan State Hospital (hereafter referred to as the Department) have carefully considered the findings letter dated May 13, 2003 and the expert consultant reports that we received subsequently.

The Department looks forward to a dialogue addressing areas that the United States Department of Justice (USDOJ) identifies as requiring attention. In this regard, the Department is firmly committed to enhancing the services it provides. Subsequent to USDOJ's onsite visit, Metropolitan State Hospital (MSH) has continued to enhance its program and previously had undertaken enhancements to the treatment approach that emphasizes recovery through individualized treatment, empowerment and self-determination. The Department believes that the enactment of this treatment approach and other enhancements, which we can discuss in detail in upcoming conferences with USDOJ, will demonstrate the Department's continued compliance with CRIPA.

Please be advised, however, that the Department's willingness to engage in a dialogue with USDOJ does not mean that the Department agrees with all of the findings and conclusions in the May 13, 2003, letter. For instance, the following are examples of instances where the Department believes USDOJ may have overlooked information which was provided and/or may have come to conclusions which are contrary to that of the Department:

1. On page 26 of the findings letter, USDOJ, citing the Maryland Quality Indicator Project, states that MSH's episodes of seclusion, restraints, or seclusion and restraints are double the national aggregate data for adolescent psychiatric inpatient programs. However,

the Maryland Quality Indicator Project is a performance measurement system approved by the Joint Commission on Accreditation of Health Care Organizations as ORYX vendors. Participants in the project are primarily for-profit, private, acute medical hospitals and some psychiatric facilities. It does not appear that any state hospitals participated in the project. Comparing MSH's restraint rates to such facilities cannot be said, therefore, to be an accurate comparison.

Further, the USDOJ findings letter only mentions how MSH's rates of restraint episodes compare in the Maryland system. It does not indicate how MSH compares to other Maryland measures, such as restraint hours. MSH's own benchmarking, through the National Association of State Mental Health Program Directors Research Institute's ORYX program, comprised of over 200 public or public-contract mental health facilities in 48 US states and territories, indicates that MSH's restraint hour rates for adolescents are close to the national rates.

2. On pages 26-27 of the findings letter, USDOJ alleges that numerous instances of seclusion and restraints were not included in the summary seclusion and restraints data that MSH provided to USDOJ.

After a review of the seclusion and restraints database in MSH's Standards Compliance Office, please note that, in fact, information regarding all of the cited cases were contained within the seclusion and restraints database. The only difference noted was a date change specified in (d) below. It is not clear why USDOJ came to the conclusion of underreporting since all of the cases cited in the findings letter were reported and documented at the time of the incident. [1]

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[1] (a) K.C. seclusion/restraints on 4/25/02, 18:05-19:30 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23699)
(b) K.S. seclusion/restraints on 4/28/02, 19:00-20:30 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23700)
(c) L.M. seclusion/restraints on 4/7/02, 14:20-16:10 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23571)
(d) P.B. seclusion/restraints on 4/13/02, 12:35-13:30 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23620. NOTE: Our database indicates that the correct date is 4/12/02 NOT 4/13/02 as specified in the DOJ letter)
(e) F.S. seclusion/restraints on 4/1/02, 15:15-17:15 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23539)
(f) S.N. seclusion/restraints on 4/24/02, 15:15-17:15 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23639)
(g) E.G. seclusion/restraints on 5/7/02, 9:05-11:00 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23775)
(h) K.C. seclusion/restraints on 4/25/02, 18:05-19:30 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23699)
(i) K.S. seclusion/restraints on 4/28/02, 19:00-20:30 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23700)
(j) L.M. seclusion/restraints on 4/7/02, 14:20-16:10 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23571)
(k) P.B. seclusion/restraints on 4/13/02, 12:35-13:30 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23620. NOTE: Our database indicates that the correct date is 4/12/02 NOT 4/13/02 as specified in the DOJ letter)
(l) F.S. seclusion/restraints on 4/1/02, 15:15-17:15 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23539)
(m) S.N. seclusion/restraints on 4/24/02, 15:15-17:15 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23639)
(n) E.G. seclusion/restraints on 5/7/02, 9:05-11:00 (MSH restraint and seclusion database in Standards Compliance indicates this data as being present in record I23775)

3. On pages 28-29 of the findings letter, the USDOJ alleges that MSH completes no systemic tracking or trending of infections or communicable diseases in Program I or throughout the hospital. As a result, MSH's patients are at increased risk for infection and/or communicable diseases. This allegation is without merit.

It is standard practice at MSH for infections and communicable diseases to be tracked and trended. When analysis of trends reveals potential problems, it is standard practice for corrective action plans to be developed and implemented. MSH has two infection control nurses on staff, and they monitor individual patient infections.

In response to USDOJ's original document request the Department provided all of the Infection Control Committee minutes from May 1, 2001 to the present. The minutes of the Infection Control Committee indicate that incidences of infections and communicable diseases are tracked and trended. The minutes specifically contain a section entitled Infection Surveillance Report (nosocomial rate); Infection Line List for the month; Hepatitis C Report; Monthly Comparison of Infection – Whole House and Employee Infection Report.

4. On pages 36 and 48 of the findings letter, the USDOJ expresses "concern" that same-sex sexual contact among patients were labeled "consensual" and not investigated properly.

In response to USDOJ's original document request, the Department provided a copy of MSH 's Administrative Manual. Within that manual, Policy number 3305, which deals with rape or sexual assault, provides that all sexual assault victims, whether male or female receive immediate medical attention and evaluation as soon as staff become aware of such activity. The Department has learned, however, that on occasion, a patient may not immediately report the contact. Or, a patient may report the contact days or weeks after the reported assault has occurred. This delay may make it very difficult to gather physical evidence to confirm the report. In any event, MSH completes an intensive investigation after such incidents are reported in compliance with the Administrative Manual. The Department and MSH do have procedures in place to investigate these allegations.

5. The Department also disagrees with USDOJ's findings and conclusions set forth in the First Amendment/Due Process section of the findings letter.

First, USDOJ alleges that the State refused to "allow Program I patients to speak with the Department of Justice or its expert consultants unless persons acting at the direction of the State were present."

In fact, USDOJ did conduct individual patient interviews at the request of the patients and was able to gain insight and information regarding patient care at MSH. These patients also consented to the presence of State representatives at the interviews.

Second, USDOJ alleges "State representatives participated in all of our discussions with patients." To clarify, MSH patients consented to the presence of State representatives at the individual interviews. However, at no time did State representatives participate in any

of the discussions with the patients. The patient interviews were conducted between USDOJ and MSH patients and State representatives were present to observe.

Third, USDOJ claims that the "State's effort to circumscribe our access to Metropolitan patients and to information regarding their care and well being is troubling." After producing nearly two hundred thousand documents, including over 200 patient charts, USDOJ's claim that the State tried to circumscribe access and information to MSH and its patients is overstated. The State allowed unrestricted access to the hospital, its records, and permitted USDOJ to interview all persons as requested. In fact, USDOJ interviewed all the patients that requested to speak to them.

The Department respectfully disagrees with, USDOJ's interpretation of legal authorities in support of its findings that the Department has violated CRIPA and other federal and state laws. While we are willing to discuss with you either in person or by written communication our legal arguments, we do not believe that this letter is the time or place to set forth that lengthy and detailed analysis. Suffice to say, we are hopeful that we can resolve with you the significant issues raised without resort to the federal courts who will be the ultimate arbiters of any alleged violations of law.

As previously indicated, rather than responding to every detail in the comprehensive findings letter at this time, the Department proposes that the parties commence the informal conference process that is contemplated by U.S.C. section 1997b(a)(2)(A) and (B).

The Department is committed to working with USDOJ to address the concerns that it has raised. However, as the above indicates, there is much to be discussed and the Department is not in agreement with everything in the findings letter. Moreover, the Department would appreciate further discussion and clarification from USDOJ on any remedial measures it may recommend. At your convenience, please call Evon Dixon-Montgomery at (916) 654-2453 to schedule a time convenient to all parties to further discuss this matter. The Department looks forward to working with the USDOJ to continue its mission to serve the patients at Metropolitan State Hospital.

Respectfully,

JOHN RODRIGUEZ
Deputy Director
Long Term Care Services

cc: Evon Dixon-Montgomery
Kyungah Suk

SECTION 8

Report on Metropolitan State Hospital, February 19, 2004

Report on Department of Mental Health Response, April 8, 2004

February 19, 2004

The Honorable Arnold Schwarzenegger
Governor of California
State Capitol Building
Sacramento, CA 95814

Re: Metropolitan State Hospital, Norwalk, California

Dear Governor Schwarzenegger:

On March 21, 2002, we notified then Governor Davis that we were investigating conditions at Metropolitan State Hospital ("Metropolitan"), pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. During the weeks of June 24 and July 8, 2002, we visited the facility. Our first tour, "Metropolitan I," focused on the care and treatment provided to the facility's child and adolescent patients, all of whom are in Metropolitan's Program I. Our second tour, "Metropolitan II," addressed the care and treatment provided to the facility's adult patients. At exit interviews conducted at the end of each facility visit, we verbally conveyed our preliminary findings to counsel and facility officials. Consistent with the requirements of CRIPA, we wrote to Governor Davis on May 13, 2003, to apprise him of our findings regarding the child and adolescent patients. We are writing now to transmit our findings regarding the care and treatment of the facility's adult patients.

As we noted in our previous letter, we appreciate the cooperation and assistance provided to us by the administrators and staff of Metropolitan. We hope to continue to work with the State of California and officials at Metropolitan in a cooperative manner.

We conducted our investigation by reviewing medical and other records relating to the care and treatment of approximately 150 of Metropolitan's adult patients; interviewing administrators and staff; speaking with patients; and conducting on-site surveys of the facility. We were assisted in our investigation by expert consultants in the fields of psychiatry, psychology, psychiatric nursing, and incident management and quality assurance.

As of the time of our July 2002 visit, Metropolitan had a census of approximately 825 patients, ranging in age from 11 to more than 80, roughly 725 of whom were adults. Metropolitan's adult patients are placed in one of five treatment programs, based on a mix of factors, primarily: (a) the nature of their admission (civil or forensic); (b) their gender; (c) the severity of their illness, (d) their assessed ability to participate in psychological and social rehabilitation ("psychosocial rehabilitation"); (e) their need for skilled nursing care; and (f) their language and cultural needs. Each of these treatment programs, identified as Programs II through VI, operates semi-independently, with its own director, nurse coordinator, and senior psychiatrist.

Residents of state-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation to ensure their safety and freedom from unreasonable restraint, prevent regression, and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982). Similar protections are accorded by federal law. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1395hh, and implementing regulations, 42 C.F.R. Parts 482-483 (Medicaid and Medicare Program Provisions). The State also is obliged to provide services in the most integrated setting appropriate to individuals' needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130 (d); see Olmstead v. L.C., 527 U.S. 581 (1999).

As was the case with Metropolitan's Program I, which serves the facility's child and adolescent patients, it was apparent that many Metropolitan staff are highly dedicated individuals who are genuinely concerned for the well-being of the persons in their care. In particular, certain staff display admirable dedication to the patients whom they serve, and undertake significant, largely self-initiated, efforts to provide effective rehabilitation to their patients. Further, again as is true of Program I, Metropolitan's adult programs are demonstrably proficient in many procedural aspects of care. Nevertheless, it is also the case that significant and wide-ranging deficiencies exist in Metropolitan's provision of care to its adult patients, and that the First Amendment rights of its patients are being violated. Our findings, facts that support them, and the minimum remedial steps that we believe are necessary to correct deficiencies are set forth below.

I. INTEGRATED TREATMENT PLANNING

The planning of treatments and interventions ("treatment planning") for Metropolitan's adult patients substantially departs from generally accepted professional standards of care. Generally accepted professional standards of care instruct that treatment plans should integrate the individual assessments, evaluations, and diagnoses of the patient performed by all disciplines involved in the patient's treatment; be individualized; and identify and build on the patient's strengths, interests, preferences, and goals, to optimize the patient's recovery and ability to sustain herself in the most integrated, appropriate setting.

As a threshold matter, Metropolitan's treatment planning format does not recognize that adequate treatment planning is dependent upon a logical sequence: first and foremost, the formulation of an accurate diagnosis; subsequently, the utilization of the diagnosis to identify the fundamental problems that are caused by the diagnosed illness; the development of specific, measurable goals that are designed to ameliorate problems and promote functional independence; the interventions that will guide staff as they work toward those goals; and, finally, ongoing assessment and, as warranted, revision of the plan.

Almost uniformly, the document entitled "Treatment Plan" in Metropolitan charts bears no resemblance to a comprehensive, integrated plan for the provision of treatment addressing individual patient needs. It is often redundant, burdensome, and confusing for staff to follow. Although there was some slight variation in the structure of the plans between units, in no instance, among approximately 150 charts reviewed, did we see an individualized plan of treatment.

Diagnoses listed on the plan often differ from diagnoses listed in the physician documentation section of the patient's chart. Similarly, identified problems often differ with other components in the plan, and the patient's medication plan often is not integrated into the overall treatment plan.

The primary reason for hospitalization is not identified and addressed carefully, and documentation of the need for continued hospitalization is not individualized or valid. Short- and long-term goals are typically generic, overly broad, not attainable, do not account for the patient's level of functioning, likes,

preferences and goals, and do not include measurable outcomes regarding objectives such as developing a skill, altering a behavior or experiencing a reduction in symptoms. Further, information about the anticipated length of stay is not linked to achievable outcomes.

Treatment interventions are determined and implemented arbitrarily and indiscriminately. Further, treatment plans do not identify in rational, operationally defined terms the symptoms or problems to be monitored or the frequency with which such monitoring and reporting should occur. Consequently, symptoms and problems are not reliably monitored or reported. In this regard, Metropolitan does not regularly collect or analyze information regarding patient progress relative to target symptoms and problems, or utilize such information in the reassessment and revision of treatment plans. In fact, based on our review, it is rare for the facility to modify treatment plans because of a patient's lack of progress under an existing plan. This is fundamentally at odds with generally accepted professional standards of care.

Numerous examples illustrate these problems. Diagnoses listed in the treatment plans differed from those listed in psychiatric assessments in the cases of S.B.,[1] N.Cj., and T.E. Further, S.B. had an April 2002 treatment plan indicating "no progress" with a problem that was listed as closed in October 2001 on his master treatment plan. Another problem identified at S.B.'s admission was not identified in the treatment plan until almost two years after admission. Further, the treatment plan indicated "no change" in the patient's goals, although numerous changes, in fact, had been documented elsewhere.

Similarly, N.Cj.'s treatment plan includes problems that are listed as "discontinued" or "revised" on another form dated the same date. In fact, as to each of the listed problems, three successive treatment plans stated, "Goals not achieved, goals not changed, interventions not changed." T.E.'s short-term goal for anger management deficit was not revised as of October 2002, although her chart indicates that she accomplished this goal in early 2001.

Medication compliance was listed as an intervention and/or a criteria for discharge for T.E. and F.I. even though this is not

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[1] In this letter, to protect patients' privacy, we identify patients by initials other than their own. We will separately transmit to the State a schedule cross-referencing the initials with patient names.

identified as a problem for either of these patients. In contrast, medication compliance is not listed as a problem for U.C., a patient who was noncompliant with her medication when she committed an assault with a deadly weapon. C.Hb. was prescribed medications for anxiety and depression, but there is no mention of either problem as targets in his treatment plan.

I.C.'s psychiatrist started him on Risperdol (a psychotropic medication) and stated, in the treatment plan, "patient will be involved in different unit teaching activities." The treatment groups to which this patient was assigned appear to have little purpose beyond occupying his time. In this regard, the psychiatrist's clinical description of this patient makes no references to impulse control problems nor impairments in social problem solving skills. In fact, the master interdisciplinary treatment plan of the hospital from which this patient was transferred states that, even when he was acutely delusional, "Mr. [C.'s] strength is social competence." Nevertheless, many of the groups to which this patient was assigned were to teach "impulse control" and "socially approved problem solving techniques." Further, although this patient has little previous institutional history, his treatment plan emphasizes socializing him to the role of a psychiatric hospital resident (attending groups), rather than reinforcing the patient's own stated desire to "get back to work." Thus, the harm to patients from Metropolitan's treatment planning practices goes beyond a failure to provide care. It includes fostering the institutionalization of its patients. This is a gross deviation from generally accepted professional standards of care.

N.D. is an 18-year-old patient who was transferred from a juvenile facility with assaultive and self-injurious behavior, and a history of brutal sexual abuse and neglect apparently beginning at age two. Apart from medications, which a neurologist identified as being at toxic levels at one point, the chart provides no evidence that N.D. is receiving any treatment on her unit, which constitutes a substantial departure from generally accepted professional standards of care. Further, N.D.'s chart describes her as a nonpsychotic individual of at least average intelligence. Notwithstanding that N.D. has the cognitive ability to engage in such a discussion, we could not locate anything in N.D.'s chart indicating that any staff member had ever talked with her about her personal goals and objectives for a life outside of an institution. It appears that developing such goals, or even the skills needed to achieve such goals, is not part of her treatment plan. In fact, her chart does not articulate any long-term goals. Such failures are inconsistent with federal regulations that require the development of adequate treatment plans. See 42 C.F.R. § 482.61(c).

Treatment plans are not tailored to the needs of patient subpopulations, such as patients with cognitive impairments, persistent dangerous behaviors, and substance abuse, and patients who have been found not guilty by reason of insanity ("NGRI"). Metropolitan assigns generic interventions to these patients rather than developing targeted interventions geared toward their particular needs.

Like the treatment plans in Program I, treatment plans in the adult units are completed and reviewed after unacceptably long delays. The infrequency of treatment team meetings leads to delayed treatment, poor interdisciplinary communication, inability to modify treatment in a timely manner, and unnecessarily prolonged hospitalization.

Adequate treatment planning also requires that patients have genuine input into and understand their treatment plans and their implementation. Metropolitan's documentation reflects that the patients do not meaningfully participate in their treatment. For instance, during the treatment team meetings that we observed for C.D., S.G., and P.P., team members talked about the patients in the third person in front of them, frequently interrupted the patients, failed to discuss the patients' goals in front of them, and/or ignored the patients' legitimate concerns. During one of these meetings, staff's response to S.G.'s inquiry regarding his placement options was, "I wish I were a fortune teller" and "Your mom has to find a place." Similarly, S.G.'s psychiatrist entirely ignored S.G.'s repeated statement that he needed his medication changed. Our expert consultant subsequently confirmed that changes in S.G.'s medication regimen were clinically warranted.

Further, Metropolitan's treatment teams often are uncoordinated, disorganized, and unstable. Also, while some teams carry comparatively light loads, others have many more than 24 patients. More fundamentally, Metropolitan's treatment teams often appear to lack a common understanding of the patients' symptoms or problems that should drive treatment interventions. Treating psychiatrists do not verify that psychiatric and other interventions, particularly behavioral treatments, do not conflict. Also, many of the treatment team meetings that we observed concluded without an agreement among the team members on the modifications that had been or should be made to the treatment plan or any dialogue indicating a common understanding of, or response to, the patient's status.

Metropolitan also has no mechanism to address patients' risk factors. The current procedure, whereby staff check a box on the admission risk assessment form to indicate if a patient is

suicidal, homicidal, an elopement risk, or a fire-setter, is not performed consistently. More importantly, these risk factors are not then tracked by treatment teams or integrated into the treatment plans.

For instance, "fire-setter" or "homicidal" are identified in admission risk assessments for T.C., S.B., O.U., and Z.F., but these risks are neither addressed in the treatment plans nor tracked by the treatment teams. Z.F.'s admission risk assessment fails to identify suicidal behavior as a risk factor, although this patient had jumped off of a building approximately two years earlier. T.Eb.'s preliminary psychiatric evaluation does not contain a formalized risk assessment, despite his long history of psychotic illness, substance abuse, proclivity to assault others, and attempted elopement. Similarly, K.P.'s preliminary psychiatric evaluation lists no risk factors, notwithstanding his admission as a danger to others and his prior elopement from Metropolitan during a previous hospitalization. Further, there is no reference to the admission risk factors in the discharge notes. In general, Metropolitan lacks an adequate procedure to identify or track patterns of high-risk behavior or to establish thresholds to ensure early and timely intervention to reduce ongoing risk.

In summary, Metropolitan's treatment planning for its adult patients substantially departs from generally accepted professional standards of care. These deficiencies subject patients to treatment that: (a) prolongs their psychiatric distress; (b) needlessly worsens or prolongs their difficulties with problem solving, memory, or attention, thereby exacerbating their disability; (c) unnecessarily exposes those with substance abuse problems to additional drug dependency; (d) needlessly extends their institutionalization; (e) exposes them to an increased risk of relapse after discharge; and (f) contributes to an overall lower quality of life.

II. ASSESSMENTS

Adequate assessment of a mental health patient for treatment planning purposes requires input from various disciplines, under the active direction and guidance of the treating psychiatrist, who is responsible for assuring that relevant patient information is obtained and considered. At Metropolitan, as at many mental health facilities, assessments typically are reflected in: (a) psychiatric assessments and diagnoses; (b) psychological assessments; (c) rehabilitation assessments; and (d) social history evaluations.

A. Psychiatric Assessments and Diagnoses

In many respects, psychiatric assessments are the main vehicle establishing the patient's diagnoses, establishing safe and effective treatment, and providing direction for treatment planning. Yet, it appears that Metropolitan psychiatrists routinely diagnose their adult patients as having psychiatric disorders without clinical justification. As a result, patients' actual illnesses are not being properly treated, patients are exposed to potentially toxic treatments for conditions from which they do not suffer, patients are not provided appropriate psychiatric rehabilitation, and patients' options for discharge are seriously limited.

In the majority of cases that we reviewed, the information gathered during the assessment process does not justify the patient's diagnoses. For instance, F.I. was diagnosed with schizoaffective disorder, although nothing in her history, her mental status examination, or her psychiatric progress note dated the week after admission indicated that she had any psychotic symptoms. Similarly, N.Cj.'s chart contained no support for his diagnosis of schizoaffective disorder. Apart from his reported illiteracy, his diagnosis of mental retardation was also unsupported.

Metropolitan psychiatrists diagnosed K.Sf. with, and prescribed two antidepressants for, a mood disorder, even though his records consistently indicated no evidence of a mood disorder of any kind. However, this patient does suffer from Huntington's Chorea, a degenerative neurological disease causing ever increasing dementia and severe abnormal movements. Although his chart identifies numerous occurrences of falls, poor balance, clumsy movement and poor gait, recorded by different staff within days of an ostensibly detailed psychiatric evaluation of his abnormal involuntary movements, that evaluation inexplicably identified no abnormal movements whatsoever. In numerous other cases, including D.I., L.E., I.Q., N.E., and S.G., the information gathered by facility psychiatrists during the assessment process did not justify the patients' diagnoses.

Separately, many of Metropolitan's adult patients receive tentative and unspecific diagnoses (often referred to as "rule out" ("R/O") or "not otherwise specified" ("NOS") diagnoses), without being further assessed, at least as evidenced in their charts, to finalize these open diagnoses. For instance, U.E. has had a diagnosis of "psychotic disorder, NOS" since his admission to Metropolitan in 1997. His treating psychiatrist stated that no diagnostic work-up was performed to resolve this diagnosis because "that is the diagnosis [U.E.] came in with," an assertion

at odds with a psychiatrist's duty to attempt to identify the nature of his patient's illness.

Erroneous and untimely psychiatric evaluations and diagnoses can lead to the wrong mix of treatments and interventions, thereby causing harm through ineffective, potentially deleterious treatment, and the withholding of appropriate interventions. It is clear that Metropolitan's practices are irreconcilable with generally accepted professional standards of care in this area, and that its patients experience harm and a significant risk of harm as a result.

B. Psychological Assessments and Evaluations

Like the other forms of patient assessments and evaluations at Metropolitan, psychological assessments and evaluations, with few exceptions, are inaccurate, incomplete, and uninformative. These poor assessments and evaluations contribute directly to bad treatment choices that, in turn, expose patients to actual or potential harm. In the context of patients' needs for psychological supports and adequate life skills, this harm takes the form of prolonged and/or exacerbated behavioral disorders and functional disabilities that, in turn, needlessly prolong patients' confinement in a highly restrictive environment and block their successful re-entry into the community.

Metropolitan's policies generally provide that psychological assessments (which involve formal testing) and psychological evaluations (which do not involve formal testing) are to be performed when "clinically indicated." Yet, we found numerous instances where assessments and evaluations were warranted but not performed. Examples include M.H. and N.T.

In fact, generally accepted professional standards of care for facilities such as Metropolitan dictate that, before a patient's treatment plan is developed, facility psychologists provide a thorough psychological assessment of the patient to assist the treating psychiatrist in reaching an accurate diagnosis and provide an accurate evaluation of the patient's psychological needs. As indicated above, this does not happen at Metropolitan. Moreover, as needed, additional psychological assessments should be performed early in the patient's hospitalization to assist with any psychiatric disorders that may need further study, such as "Rule Out," deferred, and "NOS" diagnoses. However, this rarely occurs at Metropolitan. As noted above, it is common for patients there to carry open, or unresolved, diagnoses for several years, which is a gross deviation from generally accepted professional standards of care that also contributes to ineffective, even harmful, treatments.

Further, based on our review of numerous patient charts, the psychological assessments and evaluations that were performed were generally strikingly poor, and more likely to lead to bad or ineffective interventions than good ones. The psychological assessment of N.Cj., for example, contains glaring weaknesses that render it of little use. The total analysis of this patient's intelligence is, "[p]atient said he never went to school and doesn't read or write." Regarding the patient's "strengths and coping style," the analysis is blank. Although it states that the patient has a history of assaultive behaviors and property destruction at the hospital, it provides no analysis of the antecedents, circumstances, causes, or consequences of this behavior, notwithstanding that these are the core elements of behavioral analysis. Thus, it provides none of the information essential to understand and correctly address his behavioral disorders. Similarly, the May 2, 2002 psychological assessment of N.E. advances numerous factual inaccuracies, various unintelligible statements, and a psychiatric diagnosis contrary to that used by the rest of the treatment team, with no apparent justification or explanation.

A December 3, 2001 psychology assessment of K.Q. concludes, without support, that this patient's schizophrenia is not the cause of his dementia because his cognitive deficits "appear to exceed those associated with schizophrenia," notwithstanding that the opposite is likely true. Further, the assessment recommends that K.Q. undergo neurological testing, because the last such testing ostensibly had occurred 15 years earlier. In fact, K.Q.'s chart makes clear that he had undergone a thorough neurological exam at Metropolitan the previous month.

A subsequent, October 10, 2002 "Functional Evaluation of Behavior" for K.Q., performed by two other Metropolitan psychologists, also is significantly flawed. Its analysis of "reenforcers," or factors that support various behaviors, lists items that K.Q. reportedly enjoys but provides no analysis as to how they affect his behaviors. Similarly, the summary and conclusion of the report list various factors that might contribute to the patient's negative behaviors but provide no analysis as to how or whether any of them actually have any relationship with those behaviors. Notwithstanding its stated purpose as a "functional evaluation" of this patient's behavior, the report is devoid of any evaluation or other support for its conclusion regarding this patient's behavioral disorders.

Further, many Metropolitan patients suffer from acquired brain damage or primary neurological diseases, resulting, for instance, from motor vehicle accidents or strokes that affect cognitive function in a manner not typical of primary psychiatric

disorders. Nevertheless, Metropolitan lacks staff possessing an expertise in neuropsychology. Consequently, these patients receive inadequate or no assessments of their injuries, their treatment teams do not understand the nature of their cognitive deficits, and they receive misguided, ineffective treatments and interventions.

M.C., for instance, is an 80-year-old patient who has a history of stroke and possible bipolar disorder. It was apparent from our interview of two psychologists who have worked with M.C. over several years that they do not know whether he had experienced one or multiple strokes, where in the brain the stroke(s) had occurred, or what the likely relationship is between the stroke(s) and this patient's cognitive and behavioral problems, one of which is "aggression." Although M.C.'s aggression strongly appears to be the result of behavioral disinhibition (often thought of as loss of "impulse control"), which is a phenomenon occurring in many victims of significant brain injury, the hospital's intervention is classes in anger management and coping skills - highly inappropriate treatments where brain injury produces, first, aggression resulting from behavioral disinhibition, rather than "anger," and, second, cognitive impairments that interfere with skill acquisition.

Similarly, T.Q. suffered a traumatic brain injury from a motorcycle accident, and experiences significant short-term memory problems, difficulty concentrating, and explosive, unpredictable outbursts that are described as impulsive motor outbursts with little association to his actual emotional state. Notwithstanding that it is fundamental, in such cases, to perform a neuropsychological examination to determine the nature of the patient's memory deficits and to assist in identifying alternative learning methods to address severe cognitive deficits, the facility has not performed such an examination. Further, although he cannot remember, has difficulty concentrating, and has outbursts that probably are not caused by his temper, the facility has placed him in anger management classes.

C. Rehabilitation Assessments

Effective psychiatric rehabilitation derives from accurate and complete rehabilitation assessments. Rehabilitation assessments should identify the patient's life skills, cognitive abilities, and distinct strengths, weaknesses, likes, and dislikes. This information is fundamental to developing adequate treatment. Generally speaking, Metropolitan's rehabilitation assessments substantially depart from generally accepted professional standards of care.

A few of the rehabilitation assessments at Metropolitan provide good descriptions of patients' interests and skills. Typically, however, assessments fail to address patients' rehabilitation needs. In fact, the assessments indicate that many of Metropolitan's rehabilitation therapists lack even a basic understanding of psychiatric illnesses. Consequently, the assessments generally do not provide information that is necessary in developing appropriate rehabilitation goals and interventions.

The February 22, 2002 rehabilitation assessment for K.P., for example, states that "[t]he patient has fair to poor treatment potential at this time due to the patient's attitude and lack of motivation to attend and participate in his treatment groups and also his response to his treatment plan." The assessment's focus on this patient's "attitude" and "lack of motivation" is troubling. This patient's record clearly identifies activities that he voluntarily undertakes, such as reading a certain genre of novels, but these are not identified in the assessment as potential bases for rehabilitation activities. Rather than serving as a basis for appropriate treatment, K.P.'s rehabilitation assessment saddles him with a negative prognosis for recovery.

Major portions of S.G.'s rehabilitation assessments of February 7, 2002, and August 20, 2002, are incoherent. Further, the sections that are understandable reflect no knowledge of appropriate rehabilitation objectives. Finally, more than half of the August assessment, including its most incoherent portions, is identical to the February assessment.

D. Social History Evaluations

The social history evaluation should reliably inform the psychiatrist and other treatment team members regarding such fundamental factors as the circumstances surrounding the onset of the patient's illness, the history of the illness, and relevant family information, because these factors are often essential to forming an accurate diagnosis and developing adequate treatments and interventions. Additionally, an adequate social history evaluation permits treatment teams to learn from previously attempted interventions and to plan effectively for the patient's discharge.

Some Metropolitan social history evaluations were thorough and complete. However, most contained significant factual omissions, apparent errors, or unresolved internal inconsistencies. Consequently, patients' social history evaluations were generally unreliable and often fostered

inadequate interventions around psychiatric needs, behavioral problems, and important life skill deficits. This is irreconcilable with generally accepted professional standards of care.

For instance, the latest social history evaluation of U.C. states that "patient does not have a history of arrest prior to the instant case." Yet, it separately indicates that the patient had been arrested and convicted numerous times, including separate instances of "battery on a peace officer," "assault with a deadly weapon with great bodily harm," and "assault on a peace officer." The evaluation also indicates that the patient's mother had been mentally ill and had committed suicide when the patient was a child. Then, with no attempt to reconcile the previous observation, it suggests that the mother was last known to be living in a nursing home. Although patient histories inevitably will involve incomplete and sometimes inconsistent facts, the evaluator's failure to recognize and attempt to resolve facts having important treatment implications - such as whether the patient has a history of assaults and a mother who committed suicide - compromises diagnoses and treatment decisions, and exposes patients to harm and a significant risk of harm.

The social history evaluation of N.D. contains similar obvious gaps and significant, unaddressed inconsistencies. Although the patient was 18-years-old as of the most recent social evaluation history, it irreconcilably states that "patient has had a long and serious history of dangerous behavior since age 18." Nowhere does this report detail the dangerous behaviors, discuss possible precipitants, or otherwise set forth information shedding light on this problem.

E. Court Assessments

A number of Metropolitan's adult patients are committed due to a not guilty by reason of insanity status ("NGRI"). Metropolitan prepares court reports assessing these patients, the content and quality of which are instrumental in shaping the court's decision whether to release the patient to a lower level of care. The format and content of the court reports, however, fail to provide the court adequate and accurate information and, consequently, contribute to needlessly maintaining patients in a highly restrictive setting when they qualify for a less restrictive environment.

For instance, Metropolitan's court reports regarding M.C. did not recommend him for the conditional release program ("CONREP") although his chart indicates that he consistently met

CONREP's criteria - "person would not pose a substantial danger of physical harm to others if released into the community" - since February 1999.

Similarly, all of U.T.'s records and court reports indicate his cooperativeness, compliance, and participation, but he failed to meet CONREP's criteria for release due to his reported lack of understanding of his illness and ability to cope with anger. Yet, U.T.'s treatment plan did not focus on either of these two issues. These patients are exposed to unnecessarily restrictive treatment so long as the court's decisions are based on incomplete and inaccurate analyses of the patients' condition, and the facility fails to provide treatments focused on the reasons for its patients' hospitalization.

III. DISCHARGE PLANNING AND PLACEMENT IN THE MOST INTEGRATED SETTING

Within the limitations of court-imposed confinement, federal law, as interpreted through generally accepted professional standards of care, requires that treatment teams, with the leadership of psychiatrists and the support of the hospital administration, actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with patients' needs. Olmstead v. L.C., 527 U.S. 581 (1999). From the time of admission, the factors that likely will foster viable discharge for a particular patient should be identified expressly, through professional assessments, and should drive treatment interventions.

The discharge planning process for Metropolitan's adult patients falls well short of these standards of care. Consequently, patients are subjected to unnecessarily extended hospitalizations, poor transitions, and a high likelihood of readmission, all of which result in harm.

Metropolitan's various policies indicate that planning for a patient's discharge is an interdisciplinary effort that starts the day the patient arrives. However, in practice, Metropolitan's discharge planning is done by the social worker alone, near the end of the anticipated Metropolitan tenure, and typically is limited to finding a residential facility that will take the patient and arranging for a clinical appointment after discharge. In a few instances, individual staff make exceptional efforts to overcome largely bureaucratic discharge issues, but such individual efforts are not sufficient to offset the facility's more systemic shortcomings.

Based on our extensive chart review, treatment team discussion of discharge is generally limited to the type of setting to which the patient is likely to go. Apart from obvious factors, such as the absence of psychiatric symptoms, assaultive behaviors, and fundamental deficits in the activities of daily living, criteria for discharge are rarely considered or integrated in treatment planning. For instance, the causes of previously failed discharges or particular reasons for the patient's admission to a psychiatric institution are seldom considered and addressed. Also, the patient's strengths, preferences, and personal goals play virtually no meaningful role in discharge planning.

Preparation for discharge while in the hospital appears to be almost nonexistent. In no instance could we determine that a treatment team actually had prepared a patient to transition to, or succeed in, a new setting. In fact, the provision of transition supports almost never was discussed in the numerous patient records that we extensively reviewed. Further, rehabilitation goals are couched - and functional recovery is evaluated - on the basis of patients' ability to engage in group therapy and leisure activities, not on expressed and demonstrated skills in work, school, or independent living. Finally, the patient plays virtually no significant role in the discharge process.

Examples of these deficiencies can be found in many patient charts. K.C.'s discharge plan, for instance, is limited to a boilerplate discussion of housing issues. E.B.'s plan consists of a facility placement to an Institute for Mental Disease (typically a locked facility, oriented towards maintenance, with less oversight of patients than Metropolitan provides) "until she is able to get her self-destructive behavior under control and is less resistive to treatment . . . . The patient will be assisted to get independently [sic] living skills training for herself. It is also hoped that the patient will enroll herself into vocational rehabilitation for continued schooling alternative [sic]."

In many respects, this patient's discharge plan underscores a failure within Metropolitan to accept responsibility for helping patients to recover and to gain behavioral control. The plan instead makes this a treatment goal for the next provider, while Metropolitan is to address "living skills."

The discharge plan for D.D. is simply a list of generic criteria (e.g., "for 90 days will comply with meds, attend 70% of groups, comply with [activities of daily living], and free of [danger to self, danger to others] and AWOL attempts.") The plan

could apply to virtually every adult Metropolitan patient with any history of dangerousness; it is not individualized and says nothing about meaningful activity following discharge.

N.T.'s discharge plan is limited to placement in a less restrictive environment. The paucity of care reflected in this plan is particularly glaring; this patient was readmitted to Metropolitan after only nine weeks of living in the community following her previous discharge, and although her treatment team should have focused in discharge planning on identifying and addressing the causes of her previously failed placement, it did not do so. The discharge plans for C.Hb. and N.D. similarly are essentially nonexistent.

Metropolitan's failure to provide adequate, individualized discharge planning, that is integrated in treatment decisions, significantly deviates from generally accepted professional standards of care and contributes to unnecessarily prolonged hospitalization and to inappropriate, unsuccessful placements in other settings. As a consequence, patients are harmed or exposed to the risk of harm by the effects of prolonged institutionalization and by being denied a reasonable opportunity to live successfully in the most integrated, appropriate setting.

IV. SPECIFIC TREATMENT SERVICES

The provision of effective interventions for patients in care settings such as Metropolitan requires the integrated participation of various treatment services, the exact configuration of which is dictated by the individual patient's needs. As noted at Section I, above, Metropolitan's ability to provide integrated treatment is deficient. Further, many of these services, standing alone, substantially depart from generally accepted professional standards of care.

A. Psychiatry Services

Metropolitan's psychiatric supports and services grossly deviate from generally accepted professional standards of care, exposing patients to harm and a significant risk of harm. Generally speaking, Metropolitan's psychiatrists fail to direct their treatment teams adequately, which is an essential requirement of a mental health facility. More specifically, as discussed herein, they fail to exercise adequate and appropriate medical management and monitor appropriately medication side effects. Also, as discussed in more detail, at Sections I and II, above, and at Section IV.B.2., below, these psychiatrists fail to plan adequate and appropriate treatments, fail to integrate properly psychiatric, behavioral, and other services,

and fail to provide clinically justified assessments and diagnoses of psychiatric disorders. The resultant harm to the patients takes many forms, among them, inadequate and counterproductive treatment, serious physiological and other side effects from inappropriate and unnecessary medications, and excessively long hospitalizations.

1. Medication Management

It is a basic tenet of generally accepted professional standards of care that the use of psychotropic medication always should be justified by the clinical needs of a patient. Metropolitan fails to ensure that its adult population is afforded appropriate pharmacological treatment.

In this regard, vulnerable patients are routinely prescribed inappropriate or unsafe medications without justification. Patients, for instance, who have documented diagnoses of alcohol and/or other substance abuse frequently receive high doses of benzodiazepines, psychotropic drugs which are professionally well-known to have a high potential for addiction. T.E., a patient with severe and persistent alcoholism for almost 30 years, was prescribed Lorazepam, a benzodiazepine used for anxiety disorders. When interviewed, the treating psychiatrist was unable to state the side effects of this medication. It is widely known by professionals that the regular administration of Lorazepam is habit-forming and that Lorazepam is detrimental for patients, such as T.E., with a history of severe alcohol abuse.

Similarly, benzodiazepines and anticholinergic agents carry a professionally well-known potential side effect of exacerbating cognitive decline. Nevertheless, numerous patients who suffer from memory or other cognitive deficits routinely receive these medications at Metropolitan. Similarly, Metropolitan's diabetic patients, obese patients, and patients with hyperlipidemia (the presence of excess fats or lipids in the blood) are prescribed medications professionally well-known to aggravate these conditions. Based upon documentation and interviews, it does not appear that these medications are justified or that the psychiatrists have considered safer and equally effective medications for these patient populations.

In this regard, numerous Metropolitan patients, such as L.I. and U.H., have received older, so-called "typical" antipsychotic medications, such as haldol decanoate and lithium, for several years, without either improvement in their condition or documentation in their chart indicating that other, more commonly used "atypical" antipsychotic medications were considered or attempted. As a group, atypical antipsychotic medications are

generally regarded as equally effective as conventional antipsychotics, while having a lower propensity to produce movement disorders, such as drug-induced Parkinsonism (muscular rigidity, tremors, restricted speech, and gait disturbance), dystonia (uncontrollable muscle spasms), and tardive dyskinesia ("TD") (involuntary, aimless movements of the tongue, face, mouth, jaw, or other body parts). Further, atypicals are generally considered to have a lower risk of producing cognitive dysfunction and akathisia (restlessness, subjective distress and agitation), than conventional medications, and, in some instances, may have therapeutic effects on TD. Accordingly, as a general matter, atypicals are the first choice among antipsychotic medications, and it is a gross deviation from generally accepted professional standards of care, absent individual considerations, to initiate a patient on conventional antipsychotic medications.

Further, the use of multiple medications to address the same condition ("polypharmacy"), while possibly appropriate in some circumstances, always should be clinically justified. In many cases, including those of T.E., F.I., and S.G., Metropolitan's use of polypharmacy is unjustified. Unjustified polypharmacy can potentially harm patients by exposing them to, among others risks, unnecessary medication, harmful side effects, and harmful drug-to-drug interactions.

Independent of the fact that patients frequently are medicated based upon clinically unjustified diagnoses, we note that Metropolitan's medication guidelines do not meet generally accepted professional standards of care. See 42 C.F.R. § 482.25(b). Significant protocols for medication usage and management of side effects are outdated and incomplete. We would also flag for the State's consideration that generally accepted professional standards of care dictate that facilities such as Metropolitan use appropriate procedures to ensure patients are afforded safe and effective pharmacological treatment, including mechanisms to: (a) monitor practitioners' adherence to drug medication guidelines ("drug utilization evaluation" or "DUE"); (b) report and analyze adverse drug reactions ("ADR"); and (c) report, analyze, and document actual and potential variances in medication use ("medication variance reporting" or "MVR"). See Id. Metropolitan fails to meet these standards of care.

Adding to this lack of protections, the functions of the two committees that are to provide oversight of medication use at Metropolitan - the Pharmacy & Therapeutics Committee ("P&T") and the Therapeutics Review Committee("TRC") - are poorly coordinated, overlapping, and disconnected. As a result, neither committee performs the critical, comprehensive review of

medication practices that is essential at a facility such as Metropolitan to assure adequate and safe treatment.

2. Side Effect Monitoring

Metropolitan fails to assess or monitor adequately side effects of medications and in particular the side effect TD. TD is associated with prolonged treatment with conventional antipsychotic medications. Metropolitan's psychiatrists are not adequately tracking patients' signs and symptoms of TD, nor are they adhering to appropriate precautions. In fact, without justification, these psychiatrists prescribe medications that are professionally known to be the main causes of TD to patients with a diagnosis and history of TD. This practice is a substantial departure from generally accepted professional standards of care. Relatedly, the hospital's internal pharmacological consultant agreed that certain medications, in particular anticholinergic agents, are over-prescribed at Metropolitan and that their use risks aggravating patients' TD.

Moreover, Metropolitan's psychiatrists often appear to be confused as to which medications are associated with particular side effects. For example, N.S.'s psychiatrist told us that "Cogentin protects from TD," when this medication actually is professionally well-known to be detrimental for patients with TD, because it masks TD symptoms. When asked if Clozapine has any effects on the cardiovascular system, S.E.'s psychiatrist responded "[i]t is missing my mind [sic]." Cardiovascular effects are, in fact, the most common side effect of treatment with Clozapine. Moreover, Metropolitan's psychiatrists appear to confuse their role in monitoring side effects. One psychiatrist stated that he had sought a neurology consultation to rule out TD, although the detection of TD is generally accepted among professionals to be a core psychiatric competency.

B. Psychology Services

Metropolitan's provision of psychological services to its adult patients is fundamentally at odds with generally accepted professional standards of care. As discussed at Section II, above, assessments and evaluations that should shape psychological and other supports and services frequently are incomplete, inaccurate, and outdated and, consequently, are unreliable in identifying important elements of the patient's condition and shaping adequate interventions. Interventions often do not address assessed needs regarding functional skills and maladaptive behaviors, and those interventions actually addressing such needs typically are poorly conceived, excessively generic, and untherapeutic. The stated goals of psychological

interventions, which should serve to measure patient progress, are frequently inappropriate and unmeasurable. Further, the implementation of interventions is inconsistent and essentially unmonitored. For these reasons, interventions are not revised to account for patient progress or lack thereof. These deficiencies are irreconcilable with generally accepted professional standards of care and expose patients to harm and to risk of harm.

1. Psychosocial/Rehabilitative Interventions

The purpose of psychosocial and rehabilitative interventions is to improve a patient's ability to engage in more independent life functions, so that he can better manage the consequences of psychiatric distress and avoid decompensation in more integrated settings. To be effective, these interventions should address the patient's needs and should build on the patient's existing strengths. Further, according to generally accepted professional standards of care, they should occur at regular, frequent intervals. Nevertheless, it appears from our extensive chart review that, at Metropolitan, rehabilitative and psychosocial interventions are largely driven by what is available on a particular unit, not what is appropriate for a given patient, and occur on an irregular and infrequent basis. Metropolitan's off-unit Stepping Stones and Psychosocial Rehabilitation programs were exceptions to this, but they are unavailable to the bulk of the facility's population.

On the units themselves, patients most typically are assigned to groups depending upon what is available and what staff feel the patient can tolerate, regardless of need or indication. In this regard, many patients have a critical need for specialized treatment for problems such as substance abuse, a recognized psychiatric disorder, in addition to their underlying mental illness. The failure to provide specialized treatment for these dually diagnosed patients is a substantial departure from generally accepted professional standards of care. Nevertheless, Metropolitan often fails to identify and assess dually diagnosed patients. For instance, F.I. was not diagnosed with substance abuse although her psychiatric assessment included information that she has a history of this problem. Similarly, N.T.'s psychiatric assessment indicated an extensive history of substance abuse, with sobriety for the past four years. The psychiatrist, however, did not identify her substance abuse history.

Even when identified and assessed, treatment plans do not address the needs of these patients. Substance abuse groups, for instance, were not scheduled for some patients in serious need of such interventions while relatively stable patients with remote

histories but no recent substance abuse were scheduled for this. For example, C.Nj., a 27-year-old man whose parents were both substance abusers and who himself has a long history of polysubstance dependence, had no interventions addressing this problem in his treatment plan, and there were no substance abuse groups on his schedule. I.Q. was not assigned to a substance abuse group in spite of the fact that his Axis I diagnosis is alcohol-induced persisting dementia.

Metropolitan patients are expected to attend the groups on their schedule, and, for the majority of patients, group attendance is the short-term, and often, long-term treatment goal. However, without a specific goal, or intended outcome, for a particular treatment, it is not possible to determine whether the treatment's objective is achieved. Further, patients' responses to treatment were virtually never recorded in treatment plans, social work evaluations, or rehabilitation assessments. Thus, with respect to on-unit rehabilitation, which is all the rehabilitation that the majority of Metropolitan patients receive, it is clear that psychiatric rehabilitation activities serve little purpose other than to fill the day and structure the unit's operations. This is an extraordinary failure of care.

In addition, on-unit rehabilitation groups are not reliably offered as scheduled. We sampled 23 patients, from different units, at a mid-morning or mid-afternoon time point other than mealtime. Of these patients, only two clearly could be determined to be engaged in an activity. Very few groups occurred as scheduled, representing a very small proportion of patients on each unit. Patients spend strikingly little time in a treatment or rehabilitation program.

2. Behavioral Supports

Generally accepted professional standards of care dictate that patients receive appropriate behavioral interventions when: (a) their behaviors place them or others at risk of harm or otherwise significantly limit their ability to function in a noninstitutional setting; and (b) these behaviors are driven by factors that are susceptible to effective behavioral interventions. A determination whether behavioral supports are clinically warranted begins with an assessment of the challenging behavior and why it occurs.

For instance, to the extent that a patient's behaviors are purely the result of delusions or hallucinations, behavioral interventions are less likely to be appropriate. Often, however, challenging behaviors are driven by factors as simple as a need for attention or an aversion to a noisy environment, factors

readily susceptible to effective behavioral interventions. In any case, without an adequate assessment of why challenging behaviors occur, it is not possible to determine whether behavioral interventions are necessary and appropriate and, if so, the form those interventions should take.

By contrast, Metropolitan's approach is to provide behavioral supports, in the form of a "Special Treatment Plan," for patients experiencing high rates of seclusion, restraint, or one-to-one supervision. However, those patients who are not disruptive but nevertheless have significant behavioral needs - such as extreme withdrawal, isolation, anxiety, and avoidance behaviors - rarely, if ever, receive behavioral supports. Further, our expert consultants identified numerous patients who, given their high rates of seclusion, restraint, or one-to-one supervision, warranted behavioral supports, even according to Metropolitan's practice, but nevertheless did not receive them.

More particularly, a sizable number of patients suffer from chronic illnesses that are resistant to traditional treatment, such as schizoaffective disorder and polysubstance abuse (e.g., L.I.), persistent disruptive or maladaptive behaviors (e.g., N.D.), cognitive impairments with deficits in self-care (e.g., T.P.), lack of motivation to participate in treatment or be discharged to a lower level of care (e.g., T.Eb.), and severe and persistent self-abuse (e.g., F.I.) and aggression (e.g., N.Cj.; D.I.), that clearly clinically warranted the development of behavioral plans which, in fact, were not developed.

K.P.'s chart indicates that he has been at Metropolitan for most of the past 12 years, is extremely violent at times and does not have a Special Treatment Plan, apparently because the previous plan was ineffective and therefore discontinued. N.T. has made several suicide attempts and repeatedly has engaged in self-injurious behavior, but she does not have a Special Treatment Plan to help her to address these behaviors. According to her chart, D.N.H. has a history of yelling and screaming, hitting other patients and staff, and self-abusive behaviors. She also may have mental retardation. Her chart indicates that she does not have a Special Treatment Plan, and it does not identify any other interventions to assist her in addressing these behaviors. Metropolitan clearly is not identifying and providing adequate behavioral supports for a large number of its patients having significant behavioral needs, and this is wholly inconsistent with generally accepted professional standards of care.

Even when behavioral plans are developed, they typically are poorly coordinated with other interventions and, on their face,

are inadequate. Analyses of behaviors are inadequate, individual psychotherapy is not goal-directed or individualized, and the plans are too simplistic to make a difference in patients who have persistent and severe mental illness. Documentation indicates that psychiatrists are not aware of their patients' behavioral plans, nor is there any integration of these plans and the patients' pharmacological treatment. N.Cb.'s Special Treatment Plan highlights this lack of integration. It systematically withdraws his access to treatment groups which he enjoys and which presumably are intended to help him, independent of his behavioral control problems.

Patients in need of this treatment are not only denied adequate treatment and, consequently, exposed to prolonged hospitalization, but also exposed to potentially serious risks of physical harm. In 2001, D.S. swallowed batteries, screws, packets of mustard, and paper, resulting in surgery in December 2001 to remove these objects. So long as D.S. is denied adequate and effective treatment, he is at continued risk of this behavior. Similarly, so long as D.D., who has a history of aggression, does not receive effective, integrated treatment, both he and his fellow patients are at continued risk of assaultive behavior, and he likely will be subject to ongoing restraint and seclusion as a result of this behavior. K.Ej. is at continued risk of self-abusive behaviors so long as she does not receive a behavioral therapy program.

C. Nursing and Unit-Based Services

Metropolitan's adult unit nursing services are irreconcilable with generally accepted professional standards of care and treatment. Nursing and other unit staff fail to adequately: (a) monitor, document, and report patients' symptoms; (b) document the administration of medications; (c) provide a therapeutic environment; and (d) participate in the treatment team process. These deficiencies expose patients to harm and a significant risk of harm.

Many nursing and unit staff appear to lack adequate support, training, and supervision. Metropolitan leadership does not encourage these staff to communicate with other team members to anticipate and minimize problems. Consequently, nursing and unit staff respond to patient needs in a largely reactive way, often subjecting Metropolitan's patients to excessive and inappropriate uses of medication, seclusion and restraints, inadequate and ineffective therapeutic interventions, and needlessly long hospitalization.

1. Monitoring, Documenting, and Reporting Symptoms

As indicated in Section I, above, for the treatment team to evaluate the adequacy of implemented interventions, staff must monitor, document, and report patients' symptoms. For psychiatrists to prescribe medications and psychologists and therapists to properly oversee therapeutic interventions, they must rely upon nursing and other unit staff to document and report symptomology.

As noted at Section I, above, Metropolitan treatment plans do not adequately define the criteria or target variables by which treatments and interventions are to be assessed, nor do the plans identify how and when these factors should be monitored. Consequently, nursing and unit staff do not monitor patients' problems and symptoms adequately, and treatment teams lack significant information regarding the efficacy of interventions.

Further, we found no formal documentation system or objective exchange of substantive information between staff during shift changes or at other relevant times. Without a reliable system of recording and tracking patients' progress relative to identified goals and problems, chart entries regarding a patient's status have little value. Metropolitan's lack of substantive documentation and information regarding patient progress hinders the provision of adequate treatment, needlessly exposing patients to potentially ineffective interventions and prolonging their institutionalization.

2. Medication Administration

Generally accepted professional standards of care require that staff properly complete the Medication Administration Records ("MARs"). MARs list the current medications, dosages, routes, and times that medications are to be administered. Generally accepted professional standards of care also dictate that staff sign the MARs at the time the medication is administered. Completing the MARS properly is fundamental to maintaining patient safety and reducing the likelihood of medication errors and adverse drug effects. If staff members fail to document the medications they are administering, it may result in patients not receiving medications or receiving medications multiple times. Further, generally accepted professional standards of care require that all "controlled" substances be signed out on the control log and that there be an accurate count at all times of such medications.

During our tours, we observed a number of instances in which staff failed to sign the MARs for medications that reportedly had

been administered. In addition, controlled medications were administered without staff signing the control log. Staff's failure to properly sign the MARs or the control log should be considered a medication error and documented as such, and follow-up should occur to reduce the likelihood that such errors will continue to occur. However, Metropolitan fails to follow such procedures.

Moreover, generally accepted professional standards of care dictate that staff who administer medication know: (a) what the medication is for; (b) its expected results and their timing; and (c) the symptoms of the disorder that it is targeting. Metropolitan's nurses generally are unfamiliar with the purposes of the medication they administer and unable to identify the expected results or their timing. Also, a number of nurses we interviewed were unable to identify the symptoms associated with the disorder for which a particular medication was prescribed. If nurses do not understand patients' disorders or the purposes of the medications that they are administering, they lack information fundamental to their responsibilities to assess and report their patients' progress. This shortcoming is a substantial departure from generally accepted professional standards of care, and places residents at risk of harm from ineffective or inappropriate treatment interventions.

Finally, while not necessarily rising to the level of a violation of federal law, we flag for the State's consideration that staff administering medications were not observed to properly educate patients about their medications, the expected effects or the expected side effects. These failures are not consistent with generally accepted professional standards of care.

3. Provision of Therapeutic Activity

At Metropolitan, nursing and unit staff generally do not appear to understand their roles in the therapeutic process, nor do they appear to be familiar with basic therapeutic tools or treatment modalities. In this regard, we observed a number of skilled nursing facility ("SNF") unit patients in their beds during the day time with the privacy curtains pulled around them and their doors closed. It appeared that they had not had contact with anyone for hours. From our observations, Metropolitan was not providing any stimulation or therapeutic activities for these individuals. This complete lack of interaction for patients such as these, with cognitive and memory deficits, causes harm in that it exacerbates their symptoms.

Even more critically, some patients, such as E.D. and K.E., are bed-bound. We saw no indication that Metropolitan staff assisted them to get out of bed on a daily basis. Generally accepted professional standards of care require that patients be assisted out of bed on a daily basis, unless there is a medically justified and documented reason to maintain the person in a "bed bound" status. We did not find such justification for either of these patients. Among other concerns, prolonged periods in a supine position places patients at serious risk of skin breakdown. This failure is at odds with generally accepted professional standards of care.

D. Pharmacy

It is generally accepted professional practice for pharmacists to review individual patients' medication regimens on a regular, at least quarterly, basis. Such a review should encompass all of the medications prescribed (not just psychiatric drugs and "as-needed" (also known as "pro re nata" or "PRN") medications) and should include documentation of any communication between the pharmacists and physicians regarding concerns, potential medication interactions, and the need for laboratory testing. Metropolitan pharmacists review patients' medication regimens, for example, when new medication orders are issued or lab results are returned. However, they are not systematically reviewing patients' medication regimens. Moreover, when pharmacists' review of medications does identify problems, adequate follow-up does not occur to ensure that physicians have reviewed the pharmacists' recommendations and taken appropriate action. Numerous Pharmacy Intervention forms we reviewed identified problems and actions that needed to be taken, such as the completion of laboratory work. However, we were unable to confirm from the documentation provided that such actions actually were taken in a timely manner. This is a significant deviation from generally accepted professional standards of care. These failures are particularly troubling, given the unjustified and outdated combinations of medications that often are prescribed for Metropolitan's patients.

E. General Medical Services

Generally accepted professional standards of care dictate that patients be provided adequate and timely preventative, routine, specialized, and emergency medical services. Metropolitan's provision of general medical care, however, deviates substantially from these standards. Metropolitan has not adequately defined the primary care physicians' responsibilities, nor the triggers for initial assessments,

ongoing care, and re-assessments. It has not established protocols governing physician-nurse communication, or mechanisms integrating patients' mental health and medical care.

Because staff fail to monitor, document, and report patients' symptoms, treatment teams lack objective data to determine whether treatments addressing patients' general medical issues should be modified. Many patients receive unspecific or vague diagnoses that contribute to inadequate, inappropriate, or no medical treatment. For instance, diagnoses such as "Other Convulsions," given to K.D., K.Eb., M.C., E.D., K.E., Ep.G., and U.O., and "Paralysis, Unspecified," given to M.C. and X.F., are not adequate to guide treatment. Further, Metropolitan lacks a means to obtain medical records consistently from hospitals providing treatment to Metropolitan patients.

Separately, Metropolitan's after-hours medical coverage places patients at serious risk of harm in the case of a psychiatric emergency. It is a generally accepted professional standard of care in an in-patient facility such as Metropolitan that at least one psychiatrist be on-site at all times or, at a minimum, be available by telephone and able to come to the facility as needed. At Metropolitan, after-hours medical coverage (typically from 5 p.m. - 8 a.m.) is provided by primary care physicians without any psychiatry support. Moreover, according to the chairman of psychiatry and six staff psychiatrists, these physicians have not been formally "privileged" in psychiatry. Rather, "they basically learn on the job." Physicians who are not "privileged" in psychiatry have not received critical training in psychiatry or in dealing with psychiatric emergencies, including the assessment of dangerousness, suicidality, or behavioral disorders that may require restrictive interventions. Such a practice assumes that psychiatric emergencies do not occur after-hours, is a gross deviation from generally accepted professional standards of care, and places patients at great risk of harm.

There are numerous instances in which Metropolitan has failed to provide necessary medical care to its patients. For example, T.N. inserted a metal object into her abdomen. The object was never removed, causing an abscess on her abdomen and severe abdominal pain. E.E., an ambulatory patient, fell in April, 2001, while at Metropolitan, fracturing his right femur. The community hospital determined that he was "not a candidate" for repair of his femur. That hospital also detected a mass in his left lung but failed to perform a biopsy. As of May, 2002, Metropolitan had never questioned the community hospital's determinations or ordered a biopsy. Further, since this injury,

E.E. has been permanently bed-bound, has experienced multiple bouts of pneumonia, has been placed on a feeding tube and has had numerous pressure sores, ranging in severity from Stage II (which involve a partial loss of skin layer that presents clinically as an abrasion, blister, or shallow crater) to Stage IV (meaning soft tissue is exposed to the bone, the most severe classification of pressure ulcers).

F. Infection Control

Generally accepted professional standards of care require that infections and communicable diseases be tracked and trended in an institutional setting such as Metropolitan. When analysis of trends reveals potential problems, it is standard practice for corrective action plans to be developed and implemented.

After we stated in our May 13, 2003 letter that Metropolitan does not systemically track or trend infections or communicable diseases, the State referred us to infection control committee minutes indicating that Metropolitan does track infections and communicable diseases. However, neither in our interview of one of the facility's two infection control nurses nor in any documentation that we reviewed, including the infection control committee minutes, were we able to detect that the facility takes appropriate interventions to minimize the risk of infections.

For instance, we saw no evidence that the facility monitors living units for infectious contaminants and takes measures to eliminate or prevent such contaminants, although generally accepted professional standards of care dictate that this be performed as part of a standard infection control program. In fact, the infection control nurse told us that infections are addressed on an individual basis (although, here again, we saw no documentation in the numerous charts that we reviewed indicating that nurses had provided treatment or education to an individual patient to resolve an infection and prevent its reoccurrence). In this regard, as noted in Section VII, below, we saw urine-soaked laundry on the floors of patients' bedrooms and in uncovered bins in patient-inhabited areas. The obvious presence of such potential infection sources in living units is at odds with adequate infection controls and places patients at risk of harm from infection. We further note that it also did not appear that the facility's quality assurance system amalgamated and assessed its infection control data.

G. Dental Services

At Metropolitan, dental care substantially departs from generally accepted professional standards. Consequently, patients experience harm and are at risk of harm.

Many Metropolitan patients' dental health deteriorates because of long delays in, or the complete absence of, dental treatment. These deficiencies appear to be caused by, among other factors, Metropolitan's failure to: (a) take patients to dental appointments; (b) identify and address the causes for patient refusals to participate in dental appointments; and (c) follow-up on recommendations made by the dentist. Patients whose dental care appears to have been compromised because of these factors include Tu.Q., E.H., K.N., Q.C., Kb.N., F.E., Kp.E., Mz.H., Dm.D., O.U., X.F., X.X., M.C., C.Hb., T.N., U.O., K.B., C.W., K.Ep., and I.Q.

Generally accepted professional standards of care also dictate that appropriate efforts be made to restore patients' natural teeth before resorting to the irreversible extraction of teeth. However, several Metropolitan patients, including K.P., M.C., B.M., S.N., U.H., Tu.Q., N.G., and E.H., have had teeth extracted without adequate clinical justification to support such decisions.

Further, to avoid medical complications, it is essential that the dentist take account of diseases, medications, and physical disabilities that have a major impact on dental health. Individuals with diabetes, for example, may be at increased risk for developing mouth infections. They may also take longer to heal from dental procedures, increasing their risk of infection. Individuals with certain cardiovascular conditions, such as mitral valve prolapse, need to receive certain antibiotics prior to undergoing dental procedures to prevent an infection of the lining of the heart, which can be life-threatening. However, Metropolitan often fails to document significant health information in its patients' dental records that would indicate that its dentists have accounted for such important factors in providing treatment. In addition, it is a generally accepted professional standard of care that dentists document their findings and their plan of care. Metropolitan rarely maintains adequate documentation in these areas. As a result, patients are at risk of receiving inadequate treatment and/or treatment that jeopardizes their physical health.

H. Physical and Occupational Therapy

Generally accepted professional standards of care provide that patients who require physical therapy ("PT") or occupational therapy ("OT") to regain, maintain, or improve functioning receive such services in a timely manner in accordance with an individualized plan of care. This plan of care should be integrated into the patient's overall treatment plan. In addition to the direct services provided by the physical and/or occupational therapists, PT and OT programs should be incorporated into patients' daily activities, whenever appropriate.

As with other treatment plan goals and objectives, it is a generally accepted professional standard of care that PT and OT goals and objectives be measurable, observable, and functional. Although many of Metropolitan's OT goals appear to meet this criteria, many of its PT goals do not, making it impossible to determine if patients have met their goals or if the goals are appropriate to meet their needs. Moreover, generally accepted professional standards of care require that physical and occupational therapists provide staff with clear, individualized guidelines regarding positioning and transferring patients who cannot complete these activities independently. This is essential to both patient and staff safety. Metropolitan has no such guidelines. These deficiencies depart largely from generally accepted professional standards of care.

Other impediments to patients receiving adequate PT and OT services are Metropolitan's failures to take them to scheduled appointments, provide adequate staffing, or address appropriately patients' refusals to participate in PT and/or OT sessions. Numerous appointments for numerous patients are cancelled due to a lack of transportation, patient refusals, or patients or staff being "unavailable" at the time of the appointments. Examples of patients who experienced these issues include B.N., N.Q., S.Q., Ef.H., D.B., Cj.D., E.H., and O.K.

Staff on certain units stated that they require patients to use wheelchairs because they are afraid that walkers and canes could be used as weapons. However, we found no evidence that Metropolitan had completed assessments to determine whether individual patients could use canes and walkers safely on their units, or if the patients could be placed on another unit where such adaptive equipment could be used safely. Other patients, such as S.M., are blind and could utilize walking canes to increase their level of independent mobility, but Metropolitan has not provided them with the equipment or the requisite

training. Rather than promoting patients' independence, Metropolitan's practices are fostering their functional decline.

Wheelchairs need to be fitted properly for the individuals using them. A number of patients, such as M.C. are in wheelchairs that do not fit them and, consequently, provide inadequate postural support and body alignment that can result in injury or medical complications. For instance, patients diagnosed with Huntington's Chorea are at risk of contracting respiratory diseases. When placed in a wheelchair providing incorrect postural support, their risk may be significantly increased. We observed one such patient, S.U., seated in a wheelchair with his posture collapsed, making it more difficult for him to breathe.

I. Dietary Services

Metropolitan's dietary services substantially depart from generally accepted professional standards of care, which require that patients' weight and other dietary issues be addressed comprehensively by their treatment teams. Medical conditions such as hypertension or Chronic Obstructive Pulmonary Disease ("COPD") can be exacerbated by obesity, and many of the medications that Metropolitan frequently uses, such as Depakote, Thorazine, and Haldol can cause significant weight gain. Further, the charts of several Metropolitan adult patients prescribed such medications, such as E.E., Mz.H., Q.C., N.K., and F.E., indicate that these patients are at risk of significant health problems because of their weight. However, most of the treatment plans that we reviewed for patients appearing to have significant weight problems did not address their weight. Further, the treating psychiatrist and the treatment teams did not appear to consider a patient's weight when determining which psychotropic medications to prescribe.

Generally accepted professional standards of care dictate that individuals at risk of aspirating be evaluated adequately and have mealtime protocols developed by their treatment team that include specific instructions for staff on topics such as the texture of the food, the patient's position during and immediately after meals, and the level of supervision staff need to provide. These protocols also should address other activities involving swallowing, such as tooth brushing, dental appointments, and medication administration. Finally, staff responsible for implementing these protocols must be able to do so correctly. Metropolitan's services in this regard substantially depart from generally accepted professional standards of care.

It appears that a number of Metropolitan patients with aspiration problems, such as X.F., B.M., E.E., Q.C., E.T., D.N.H., N.K., H.S., Kv.Q., M.C., C.K., S.U., E.D., and T.T., lack these protections. In some cases, evaluations had been completed which clearly identified serious problems, but Metropolitan had failed to follow-up on the resulting recommendations. It appears that no specific, individualized mealtime protocols are available for staff who are assisting patients to eat, and we saw no mechanism enabling staff to identify those patients who are at high risk for aspiration. Nor was there any indication that such patients are adequately monitored. We also found no individualized written instructions regarding other activities involving swallowing for patients at risk for aspiration. Consequently, it appears that Metropolitan's patients with aspiration problems are at risk of harm.

In addition, at the time of our visit, there were six patients on the SNF units who were fed by tubes. Generally accepted professional standards of care for such individuals require that efforts be made to address the underlying causes of the person's inability to eat by mouth so that these feeding tubes, which, among other concerns, pose infection risks, can be removed. However, we found no evidence these activities were occurring at Metropolitan. As a result, these patients are at risk of long-term, unjustified use of feeding tubes.

V. DOCUMENTATION OF PATIENT PROGRESS

As noted in Section II.A, above, Metropolitan's psychiatrists do not chart their patients' progress with sufficient frequency. Further, the substance of the psychiatrists' progress notes at Metropolitan grossly departs from generally accepted professional standards of care. Psychiatrists often fail to: (a) document significant developments in their patient's condition; (b)describe target symptoms; (c) identify a patient's response to treatments; (d) document rationales for changes in pharmacological treatment; (e) identify medication side effects; (f) assess the use of PRN medications; (g) explain changes in diagnoses; (h) explain the rationale for polypharmacy; and (i) assess the patient's competence on an ongoing basis. These deficiencies directly impede adequate assessment of patients' progress and evolving needs during hospitalization and indirectly lead to ineffective and even harmful treatment.

In fact, the progress notes of Metropolitan's psychiatrists often suggest unfamiliarity with patients' status. For instance, on numerous occasions F.I.'s psychiatrist wrote that she was

stable, without noting that she had been in seclusion and/or restraints that same month for being assaultive or self-abusive. Similarly, in August 2002, N.Cj. reportedly swallowed batteries and was referred to a medical consultant. The psychiatrist's subsequent progress notes ignore this event and report nothing about the status of the medical follow-up. The 2001 monthly progress notes for K.E. contain no justification for the patient's medication regimen, fail to mention a number of his medications, and include no discussion of his frequent use of "as-needed" (also known as pro re nata or "PRN") medication or his response to treatment.

VI. RESTRAINTS, SECLUSION AND "AS-NEEDED" MEDICATIONS

Metropolitan's use of seclusion, restraints, and "as-needed" medications for its adult patients substantially departs from generally accepted professional standards of care and exposes those patients to excessive and unnecessarily restrictive interventions. Generally accepted professional standards of care dictate that seclusion and restraints: (a) will be used only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been considered and/or exhausted; (b) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (c) will not be used as a behavioral intervention, and (d) will be terminated as soon as the person is no longer a danger to himself or others. Generally accepted professional standards also instruct that PRN psychotropic medications should be used only as a short-term measure to relieve a patient in acute distress, not as means to escape mild, possibly healthy, discomfort or as a repeatedly deployed substitute for treatment.

Metropolitan uses seclusion, restraints, and PRN medications for its adult patients in the absence of adequate treatment and, in some instances, as punishment. Many instances of seclusion, restraints, or PRN medication result from adult patients exhibiting symptoms of their mental health disorders. Without the benefit of appropriate medication and therapeutic interventions, patients lack the means to control such symptoms. Thus, inadequate mental health treatment exposes patients to excessive use of seclusion, restraints, or PRN medications. Moreover, we found numerous incidents in which patients exhibited behaviors that initially were not a danger to themselves or others, but which escalated with staff involvement into dangerous situations. We also found that documentation often did not show that staff first attempted less restrictive interventions before using seclusion, restraints, or PRN medications.

When seclusion, restraints or PRN medications are frequently used, it is generally accepted professional practice for the treatment team to reassess interventions and, as necessary, modify the treatment plan to ensure that adequate measures are identified and implemented. Frequent use of seclusion, restraints and/or PRN medications is an indicator that an individual's diagnosis is erroneous and/or that the treatment plan is inappropriate. Metropolitan fails to review routinely its adult patients' treatment plans after such episodes.

Numerous patient charts identify frequent episodes of seclusion, restraint, or PRN medication without related documentation indicating that the team adequately assessed the patient, developed and/or reviewed the treatment plan, or considered alternative interventions. For example, D.I. was in walking restraints 24-hours-a-day for almost the entire month of March 2002, and was in restraints another 41 times between April 7 and November 11, 2002. T.N. was placed in wrist and ankle walking restraints continuously April 27 through 29, 2002, and again from April 30 through May 9, 2002. U.H. was placed in seclusion and/or restraints on 25 occasions between February 8 and November 13, 2002, with restraint episodes lasting between 30 minutes and 23 hours. D.D. was kept in walking restraints 24-hours-a-day April 1 through May 3, 2002, and again May 9 through 12, 2002. For over six months between January and July 2002, C.X. was kept in walking restraints during waking hours and placed in a locked seclusion room to sleep. It appears that no mechanism was in place to alert treatment teams to these incidents of seclusion and restraint, and that treatment teams did not meet routinely to review and modify, as appropriate, the treatment interventions of these patients. We also could not locate documentation indicating that other, less restrictive alternatives had been attempted prior to restraining or secluding patients.

Further, Metropolitan fails to comply with generally accepted professional standards of care that require physicians or other licensed medical practitioners to conduct face-to-face assessments of patients placed in seclusion or restraints within one hour of the initiation of the seclusion and/or restraints. D.I.'s chart indicates that he was placed in seclusion and/or restraints at least five times in October 2001 without a signed physician's order denoting a face-to-face assessment within the required time frame, and on February 2, 2002, he was kept in seclusion and/or restraints for more than 11 continuous hours without a timely assessment by a physician. L.T. was placed in physical restraints seven times between November 10 and December 29, 2001, without a physician's assessment, including one episode

that lasted 24 hours. U.Cs. was placed in seclusion and restraints at least 14 times between February 25 and September 8, 2001, without evidence in his chart of any face-to-face assessments.

According to generally accepted professional standards of care, bed side rails constitute physical restraints. Patients, particularly those experiencing significant cognitive difficulties, can become entangled in side rails when attempting to exit beds, and can be severely injured or killed, as a result. Where side rails are used, they must be part of a patient's treatment plan that reflects that they are the least restrictive intervention then available and that alternative interventions are being explored to obviate their need. During our tours of the SNF units during the day, evening, and night shifts, most patients had their side rails up when they were in bed. None of the treatment plans reviewed for these patients documented that they were the least restrictive intervention. Moreover, there was no indication that Metropolitan had attempted to reduce the use of side rails and/or identify other, less dangerous alternatives. This places patients at risk of harm. Likewise, vest and soft wrist restraints should not be used without proper assessments that justify the need for them, and without treatment plans that include interventions designed to eliminate or minimize their use. Metropolitan is regularly using vest and soft wrist restraints with patients on the SNF units without proper justification and/or treatment planning.

Separately, as indicated in Section IV.A, above, Metropolitan has no parameters governing the use of PRN medication. Because Metropolitan's psychiatrists frequently fail to review critically the use of PRN medications and patients' reactions to them, they are unable to refine patients' diagnoses and adjust routinely administered medications. Without adequate monitoring by psychiatrists of PRN medications, patients are at risk of being overly and/or improperly medicated.

For example, psychiatrists' failure to review adequately the use of PRNs was evident in the chart of K.E., who was prescribed one PRN medication for insomnia and two PRN medications for agitation. This patient's psychiatric progress notes fail to justify the use of these medications, neglect even to mention one of them, do not describe the frequency of the PRN medication use, and do not provide the patient's response to these medications. This is particularly concerning because, during the period when this patient was prescribed a PRN medication for agitation, his chart reports that he was "weak" and "bed bound" and indicates that any agitation he may have had was limited to occasional

verbal outbursts in response to hands-on care. Similarly, during the treatment team meeting for S.G., a nurse reported that this patient had received eight PRN medications over the previous month and repeatedly had requested a change in his medication, but the psychiatrist did not critically review the use of S.G.'s PRN medications or his reactions to them.

VII. PROTECTION FROM HARM

We indicated in our May 13, 2003 letter that we would address protection from harm issues on a facility-wide basis in this letter. It is an essential component of generally accepted professional standards of care in congregate care facilities such as Metropolitan, to maintain an effective incident management system and a related quality assurance system to prevent harmful incidents and identify and correct deficiencies in care. However, Metropolitan's systems are themselves deficient and fail to protect its patients from avoidable harm.

Metropolitan also fails to provide its patients a safe living environment. As was true of Program I, Metropolitan's adult units contain environmental hazards, some of which pose risks of serious injury, illness, and death. The harm that Metropolitan's patients experience as a result of these deficiencies is multi-faceted, including physical and psychological abuse; physical injury; excessive and inappropriate use of physical and chemical restraints; inadequate, ineffective, and counterproductive treatment; and excessively long hospitalizations.

A. Incident Management

It is a generally accepted professional standard that, to ensure that patients are provided a reasonably safe environment, facilities such as Metropolitan maintain an effective incident management system, including mechanisms for: reporting; investigating thoroughly; tracking and trending; and identifying and monitoring implementation of appropriate corrective and preventative action. Metropolitan's incident management system is at odds with generally accepted professional standards of care and exposes its patients to actual and potential harm.

Facility records indicate that, in Program I, which serves approximately 100 children and adolescents, for the period between May 1, 2001, and March 31, 2002, there were 131 patient-against-patient assaults, 169 incidences of patients abusing themselves, and 74 accidental injuries. Between May 1, 2001, and April 30, 2002, there were 27 allegations of staff abuse.

In addition, based on an incomplete list provided by Metropolitan, between May 1, 2001, and April 30, 2002, there were six allegations of rape and an additional 28 instances of inappropriate sexual contact between children and adolescents. Of the 28 incidents of inappropriate sexual contact, an aggressor and/or victim was identified in 21 of them, indicating they were not consensual. During this same time period, 15 suicide attempts and 23 elopements and/or attempted elopements occurred.

Metropolitan's adult patients are also frequently exposed to harmful incidents. Between April 1, 2001, and March 31, 2002, Metropolitan's adult patients were involved in 475 patient-against-patient assaults, 310 incidences of patients abusing themselves, 304 accidental injuries, and 11 incidents of elopement or attempted elopement. In addition, between May 1, 2001, and April 30, 2002, there were 42 allegations of patient abuse by staff.

Many of these incidents left patients in need of medical treatment. Between April 1, 2001, and March 31, 2002, patients required first aid on 749 occasions, more extensive medical treatment on 114 occasions, and hospitalization on 61 occasions. Some individual examples illustrate the problem:

On September 11, 2001, D.H. allegedly was hit in the face by another patient. D.H. was admitted to the hospital with a diagnoses of facial bruising and fracture of the nose and left eye socket. He was scheduled for plastic surgery.

On January 10, 2002, although patients are not supposed to be in the employee cafeteria, F.I. gained access, broke a glass bottle on a bench, and swallowed some of the glass, leaving her with cuts in her mouth and small bits of glass in her lower intestine.

On July 27, 2002, while on compound privileges with 13 staff and 134 other patients, S.W. sustained a laceration to his face and neck that was 22 centimeters in length and one centimeter deep. The incident report indicates that 38 sutures were necessary to close the external wound and it was unknown how many sutures were necessary to close the internal damage. S.W. reported that he was attacked from behind. Two state-issued razor blades made into a weapon were found in the grass near the unit's entrance.

1. Incident Reporting

As the above examples indicate, Metropolitan's patients frequently are subjected to the most basic kinds of harm. Moreover, it appears that the frequency of these incidents is actually higher than what Metropolitan reports, because of multiple factors. As a threshold matter, Metropolitan's policies and procedures related to reporting and categorizing incidents are disjointed, uncoordinated and confusing. Consequently, there is a significant risk that incidents will not be reported or reported correctly. In this regard, the Hospital Police Department's ("HPD") Crime Statistics Report includes several incidents that were not reported or tracked by the facility on its list of "Special Incidents" (which involve significant harm, such as allegations of abuse, and actual or attempted elopement or suicide). Further, it appears that staff frequently do not formally report Special Incidents at Metropolitan or report them in writing days after they occur. This practice substantially departs from generally accepted professional standards of care, which require that staff who witness or first discover an incident submit a written report before the end of that person's shift.

Incident reporting is further complicated for children and adolescents attending the school program. Metropolitan contracts with Los Angeles County Office of Education ("LACOE") for the provision of educational services to its children and adolescents. LACOE staff have different Special Incident reporting requirements than Metropolitan staff, and there does not appear to be a formal cooperative agreement between the two entities to ensure consistency in reporting. Although Metropolitan and LACOE have developed informal methods for communicating about patients, it appears that some incidents that occur during the school day are not recorded by the program units. Without consistent reporting, Metropolitan is unable to protect its patients from harm adequately, to take appropriate and adequate preventative and corrective action, or to trend and track incidents comprehensively across programs.

Moreover, generally accepted professional standards of care dictate that incidents be categorized consistently, so that they can be reliably aggregated and analyzed. However, Metropolitan's ability to do so is significantly compromised, because its policies do not define concepts as fundamental as neglect or exploitation, leaving it to individual staff to determine whether incidents involve such harm. This lack of clarity creates a significant risk that instances of neglect and exploitation will never be reported, investigated, and

addressed, which is irreconcilable with generally accepted professional standards of care.

2. Incident Investigations

Metropolitan's investigations vary widely in quality and, in many respects, substantially depart from generally accepted professional standards of care. Metropolitan's investigations often lack the necessary components of a valid investigation. For instance, investigations often do not appear to reconcile evidence appropriately, calling into question the investigations' conclusions. Consequently, more often than not, allegations of abuse are unsubstantiated. Also, the investigations almost never address programmatic issues that are necessary to identify the underlying causes of incidents. Consequently, adequate corrective action cannot be taken and Metropolitan's patients are needlessly exposed to risk of harm. It appears that many of the program level staff, HPD staff, and Senior Special Investigators ("SSIs") who share responsibility for conducting investigations have not been trained adequately to conduct investigations in a mental health setting. Finally, some investigations are performed by staff who appear to have conflicts of interest. Although SSIs are available to conduct independent investigations, it appears that often cases of alleged abuse are investigated by unit staff, including supervisors.

We saw numerous investigations reflecting these problems. Two are illustrative. On January 7, 2002, L.A. alleged that a staff person raped her. Without conducting or documenting a thorough investigation, L.A.'s treatment team concluded that the allegation was not credible and added a problem of "false accusations" to L.A.'s problem list. Facility records do not indicate that this allegation was referred to an SSI for further investigation.

Another incident, reported on April 18, 2002, arose from staff's denial of D.O.'s request for a shower or soap to clean herself after being incontinent. It escalated to staff placing D.O. in restraints and seclusion. D.O. alleged that, while restraining her, a staff person intentionally hurt her. Notwithstanding the circumstances preceding the seclusion and restraint, the ensuing investigation did not address whether staff appropriately implemented programmatic requirements or whether changes in staff's approach should be considered. Further, the investigating staff concluded that the allegation was not substantiated but did not reconcile relevant evidence

nor interview all witnesses. Finally, although the incident involved alleged abuse, it apparently was not referred to an SSI for further investigation.

3. Incident Tracking and Trending

Generally accepted professional standards of care also require facilities such as Metropolitan to track and trend incident data to address problematic trends. Metropolitan's under reporting of incidents obviously compromises its ability to trend and track incidents adequately. Further, Metropolitan's incident tracking and trending system, itself, is at odds with generally accepted professional standards of care. For example, Metropolitan's incident trending reports do not track important types of incidents, such as allegations of patient abuse by staff, neglect, rape, or other inappropriate sexual incidents. Furthermore, although the summary reports provide some information regarding patterns or trends, there are a number of other potential trends and patterns that are not included but that are fundamental to identifying potential problems and formulating solutions, such as which patients most often are victims or aggressors.

Even when Metropolitan identifies problematic trends, we could not identify evidence that adequate or appropriate remedies ensue. For example, in response to high numbers of patient assaults resulting in staff injuries, Metropolitan initiated use of an additional type of restraint, a containment blanket. However, Metropolitan did not, so far as we could determine, consider and address the cause of the high numbers of assaults. Likewise, Metropolitan's Special Incident Reports Summaries for the period between April 1, 2001, and March 31, 2002, identify early evenings, nights, weekends, and holidays as peak times for the occurrence of incidents. However, Metropolitan does not appear to have investigated this trend or identified strategies to address it. Metropolitan's failure to take appropriate and timely action to address such trends and patterns places its patients at ongoing risk of harm.

B. Quality Improvement

Throughout this letter and our May 13, 2003 correspondence, we enumerate various failures at Metropolitan to provide adequate care and treatment for its patients. With few exceptions, Metropolitan has failed to identify these problems independently, or formulate and implement remedies to address them. Consequently, actual and potential sources of harm to Metropolitan's patients are going unaddressed.

Although at the time of our tours, Metropolitan had begun to engage in some quality improvement activities, these efforts generally were disjointed and inadequate. Specifically, each of Metropolitan's six programs collects data on different aspects of the protections, treatments, services, and supports they provide, making system-wide analysis virtually impossible on all but a few issues. Moreover, most of the data Metropolitan collects relates to process, not outcomes being achieved by patients or the adequacy of the protections, treatments, supports, and services being provided. For example, Metropolitan collects data about the number of restraint and/or seclusion episodes, but does not collect data about whether the use of such procedures was clinically necessary and justified. Some programs collect data on the number of group therapy and/or educational sessions scheduled and attended, but do not collect data about the outcomes achieved by patients as a result of attendance at these sessions as compared with their individualized therapy and educational goals. Similarly, one program (Program IV) collects data on the number of missed medical appointments. These numbers show that patients frequently miss medical appointments due to patient refusal. However, it does not appear that the program analyzes the efforts treatment teams are taking to minimize these refusals and/or the adequacy of these efforts.

Moreover, Metropolitan does not adequately or appropriately use the data that it does collect. Each program prepares and submits a Performance Improvement report on a quarterly or, occasionally, monthly basis. Although these reports include various and sometimes extensive data, Metropolitan often fails to analyze the data to identify problematic trends or areas in need of improvement. It also often fails to conduct the further analyses necessary to determine which policies, procedures, and practices are working, which are not, and to recommend and implement actions designed to correct deficiencies and/or improve performance. Even when data indicates improvement or positive trends, it does not appear that Metropolitan analyzes such trends to determine which policies, procedures, and practices might be replicated throughout a program, or facility-wide.

We found numerous examples of quality assurance breakdowns indicating weaknesses in Metropolitan's ability to identify or correct causes of actual or potential harm to patients. For instance, the July 24, 2001 Interdepartmental Performance Improvement Committee minutes indicate that the Committee identified problems regarding the use of seclusion and restraint. A number of strategies were identified, and the

Committee made various recommendations, including revision of the Managing Assaultive Behavior ("MAB") training curriculum, providing staff with additional education, and increasing the use of alternatives to seclusion and restraint. According to minutes provided to us, no other mention of this issue occurred until November 27, 2001, when almost identical strategies were identified. No subsequent discussion apparently occurred thereafter through March 26, 2002, the period that we reviewed; the minutes are silent regarding implementation of the previously identified strategies or recommendations, or their impact on resolving the identified issues. This apparent lack of follow-up is especially problematic, given the problems identified in Section VI, above, regarding Metropolitan's use of restraint and/or seclusion.

C. Environmental Issues

In a facility serving people at risk of harming themselves or others, the environment should be kept free of hazards. Metropolitan has failed to meet this generally accepted professional standard of care. As we pointed out in the presence of administrators who toured the adult units with us, the vents and window grills on several units contained holes large enough to thread a sheet or other cloth through, placing patients at risk for suicide by hanging. As on the children and adolescent units, some of the vents on the adult units were not covered, allowing patients to access wires and other potentially dangerous items. Several of the units contained other hazards, such as wires holding down seclusion beds that, if accessed by patients, could be used to hurt oneself or others. In one of the restraint rooms, we observed plaster on the floor that easily could have been swallowed by a patient.

Examples of Metropolitan's breakdown in environmental protections include a January 17, 2001 incident in which W.T. was found standing on a heater vent with torn linen tied tightly around his neck and attached to a bar on the window. He jumped from the vent in an attempt to strangle himself. By the time staff arrived to assist, his face reportedly had turned a bluish hue. Despite the fact that this incident clearly identified that the bars on the windows are a potential suicide hazard, it does not appear that systemic action was taken to ameliorate the situation. On July 11, 2001, a peer notified staff that N.T. had attempted to hang herself in her bedroom with a bed sheet looped around her neck and fastened to a metal frame of a window. Again on July 15, 2001, a peer reported to staff that N.T. was attempting to hang herself. Staff found N.T. with a blanket tied around her neck and the other end tied to the bars

on the window. Less than three months later, on October 8, 2001, N.T. was found with a bed sheet looped around her neck and fastened to a metal frame of a window. N.T. was then placed in seclusion and restraint. One day earlier, staff found K.S. in the bathroom with a blanket tied around his neck and the other end tied to the bars on the window.

Based on both staff statements and our own observations, Metropolitan fails to maintain temperatures in some patient areas that do not pose a risk to health. For example, during the evenings, the SNF units were excessively warm. We observed that staff repositioning patients were sweating profusely. Commendably, staff had attempted to ameliorate the heat by pointing fans into patient rooms, but privacy curtains were blocking the airflow. Moreover, fans blowing on patients whose health is compromised, such as patients requiring skilled nursing care, places them at high risk for complications such as pneumonia.

Lastly, areas throughout the facility, primarily the SNF units, had a strong smell of urine and excrement. This is a potential indication that patients had been sitting in their urine or feces for a long period of time, placing them at high risk for skin breakdown. We observed urine-soaked laundry on the floors of some patients' rooms and in uncovered bins in patient-inhabited areas, presenting an infection hazard.

D. Use of Untrained Personnel in Patient Interventions

Generally accepted professional standards of care for facilities such as Metropolitan dictate that program staff be responsible for patient treatment and care. Although there is nothing improper about utilizing such security personnel to handle episodic incidents of violence by residents, it is not appropriate to rely on security staff -- who lack mental health training -- to share material responsibility for patient treatment and care.

It appears that treatment staff frequently rely on officers because staff cannot effectively address patients' behavioral needs. This practice highlights weaknesses in Metropolitan's therapeutic interventions and presents substantial risk of harm to patients. First, given that the officers are armed with pepper spray and batons, their presence on the units presents a safety risk if a patient were to gain control of these weapons. Second, the officers are not trained properly to address the

programmatic needs of patients and, as a result, are more likely to resort to force, placing patients at increased risk of restraint or physical injury.

VIII. FIRST AMENDMENT AND DUE PROCESS

As set forth in our letter of May 13, 2003, the State indicated prior to our tours of Metropolitan that it would refuse to allow patients to speak with the Department of Justice or its expert consultants unless persons acting at the direction of the State were present, and State representatives did, in fact, attend all of our discussions with patients. The abridgements of patients' First Amendment and due process rights identified in our earlier letter apply with equal force to Metropolitan's adult patients.

IX. MINIMUM REMEDIAL MEASURES

To remedy the deficiencies discussed above and to protect the constitutional and federal statutory rights of the patients at Metropolitan, California promptly should implement the minimum remedial measures set forth below.

A. Integrated Treatment Planning

Metropolitan should provide its patients with integrated treatment planning consistent with generally accepted professional standards of care. More particularly, Metropolitan should:

1. Develop and implement policies and procedures regarding the development of treatment plans consistent with generally accepted professional standards of care, as set forth in Section I, above.

2. Use these policies and procedures to review and revise, as appropriate, each patient's treatment plan to ensure that it is current, individualized, strengths-based, outcome-driven, and emanates from an integration of the individual disciplines' assessments of patients.

3. Revise treatment plans as appropriate, based on significant developments in patients' conditions, including patients' progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables.

4. Ensure that treating psychiatrists verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated.

5. Require all clinical staff to complete successfully competency-based training on the development and implementation of interdisciplinary treatment plans.

6. Ensure that each treatment team has a stable core of members, includes other members as needed, and maintains case loads that are not excessive.

B. Assessments

Metropolitan should ensure that its patients receive accurate, complete, and timely assessments, consistent with generally accepted professional standards of care, and that these assessments drive treatment interventions. More particularly, as to the following areas, Metropolitan should:

1. Psychiatric Assessments and Diagnoses

a. Develop diagnostic practices, guided by current, generally accepted professional criteria, for reliably reaching the most accurate psychiatric diagnoses. Develop a clinical formulation of each patient that:

(1) integrates relevant elements of the patient's history, mental status examination, and response to current and past medications and other interventions; and

(2) is used to prepare the patient's treatment plan.

b. Review and revise, as appropriate, psychiatric assessments of all patients, providing clinically justifiable current diagnoses for each patient, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient

needs. Ensure that each patient's psychiatric assessments, diagnoses, and medications are collectively justified in a generally accepted professional manner.

c. Ensure that treating psychiatrists utilize behavioral data in refining their diagnosis and enhancing their understanding of the targeted behavior, especially when previously provided treatments have failed to achieve desired outcomes.

2. Psychological Assessments and Evaluations

Ensure that:

a. psychologists provide appropriate psychological assessments, as clinically indicated.

b. before the treatment plan is developed, psychologists provide a psychological assessment of the patient that will:

(1) address the nature of patient impairments to assist the psychiatrist in reaching a clear diagnosis; and

(2) provide an accurate evaluation of the patient's psychological functioning to inform the treatment planning process.

c. additional psychological assessments are performed to assist with any psychiatric disorders that may need further work up.

d. the purpose of the assessment is clearly identified.

e. psychological assessments are performed by professionals having a demonstrated competency in the methodology required to address the purpose of the assessment.

f. psychological assessments include an accurate, complete, and up-to-date summary of the patient's clinical history and response to previous treatment.

g. where applicable, psychological assessments adhere to generally accepted professional standards for behavioral assessments. If behavioral intervention is indicated, further assessment must be conducted by a professional having demonstrated competency in applied behavior analysis and must be consistent with generally accepted professional standards of applied behavioral analysis.

h. psychological assessments contain conclusions which specifically address the purpose of the assessment, and a summary of the empirical basis for all conclusions, and any remaining unanswered questions.

3. Rehabilitation Assessments

Ensure that each patient's rehabilitation assessments:

a. are accurate, complete, and coherent as to the patient's functional abilities;

b. identify the patient's life skills prior to, and over the course of, the mental illness or disorder;

c. identify the patient's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and

d. provide specific strategies to engage the patient in appropriate activities that the patient views as personally meaningful and productive.

4. Social History Evaluations

Ensure that each patient's social history evaluation:

a. is, to the extent reasonably possible, accurate, current, complete, and coherent;

b. expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered; and

c. reliably informs the patient's treatment team about the patient's relevant social factors.

5. Court Assessments

a. Develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for patients adjudicated NGRI based on accurate information, individualized risk assessments, and evaluations of readiness for community outpatient treatment.

b. As appropriate, review and revise all court assessments and reports for NGRI patients so that they are individualized, accurate, and consistent with generally accepted professional standards of care.

C. Discharge Planning and Placement in the Most Integrated Setting

Within the limitations of court-imposed confinement, the State should pursue actively the appropriate discharge of patients and ensure that they are provided services in the most integrated, appropriate setting that is consistent with patients' needs. More particularly, Metropolitan should:

1. Identify at admission and address in treatment planning the criteria that likely will foster viable discharge for a particular patient, including but not limited to:

a. the individual patient's symptoms of mental illness or psychiatric distress;

b. any other barriers preventing that specific patient in transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and

c. the patient's strengths, preferences, and personal goals.

2. Include in treatment interventions the development of skills necessary to live in the setting in which the patient will be placed, and otherwise prepare the patient for her new living environment.

3. Ensure that the patient is an active participant in the placement process.

4. Provide the patient adequate assistance in transitioning to the new setting.

5. Develop and implement a quality assurance/improvement system to oversee the discharge process and aftercare services. This system should ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are implemented and that appropriate aftercare services are provided that meet the needs of the patient in the community.

D. Specific Treatment Services

1. Psychiatry Services

Metropolitan should provide adequate psychiatric supports and services for the treatment of the severely and persistently mentally ill population of adults that it serves in accordance with generally accepted professional standards of care. More particularly, Metropolitan should:

a. Develop and implement policies and procedures requiring physicians to document their analyses of the benefits and risks of chosen treatment interventions.

b. Ensure that all physicians and clinicians can demonstrate competence, consistent with generally accepted professional standards, in appropriate psychiatric evaluation and diagnosis, medication management, treatment team functioning, and the integration of behavioral and pharmacological treatments.

c. Ensure that all psychotropic medications are:

(1) specifically matched to current, clinically justified diagnoses;

(2) prescribed in therapeutic amounts;

(3) tailored to each patient's individual symptoms;

(4) monitored for efficacy against clearly-identified target variables and time frames;

(5) modified based on clinical rationales; and

(6) properly documented.

d. Review the medication treatment for all patients prescribed continuous anticholinergic treatment for more than two months. Review the medication treatment for all elderly patients and patients with cognitive impairments who are prescribed continuous anticholinergic treatment regardless of duration of treatment.

e. Review the medication treatment for all patients prescribed benzodiazepines as a scheduled modality for more than two months. Review the medication treatment for all patients prescribed benzodiazepines with diagnoses of substance abuse and cognitive impairments regardless of duration of treatment.

f. Develop and implement policies and procedures to monitor, document, report, and properly address potential side effects of prescribed medications to reflect generally accepted professional standards of care. Review treatment of all patients with a diagnosis of tardive dyskinesia in accordance with this updated policy.

g. Make appropriate attempts to use those newer psychotropic medications having fewer, less serious side effects, rather than those

older psychotropic medications having more serious side effects.

h. Develop and implement a comprehensive system to report all actual and potential variances in medication use to ensure that all potential and actual errors are captured.

i. Develop and implement written guidelines and procedures consistent with generally accepted professional standards of care regarding medication practices, including the use and monitoring of PRN medications.

j. Develop and implement a system for the timely identification, reporting, and monitoring of adverse drug reactions.

2. Psychology Services

Metropolitan should provide psychological supports and services adequate to treat the functional and behavioral needs of its adult patients according to generally accepted professional standards of care. More particularly, Metropolitan should:

a. Ensure that psychologists provide evidence-based psychological interventions across a range of modalities, as the assessed needs of the patient dictate.

b. Provide active psychosocial rehabilitation, consistent with generally accepted professional standards of care, that:

(1) is derived from the assessed, individualized needs of the patient to engage in more independent life functions;

(2) addresses those needs in a manner building on the patient's strengths, preferences, and interests;

(3) includes a focus on the patient's vulnerabilities to mental illness, substance abuse and readmission due to relapse;

(4) takes place regularly and as scheduled; and

(5) is documented in the patient's treatment plan.

c. Develop and implement policies to ensure that patients who require treatment for substance abuse are appropriately identified, assessed, treated, and monitored in accordance with generally accepted professional standards.

d. Ensure that behavioral interventions are based on appropriate, positive behavioral supports, not the use of aversive contingencies.

e. Ensure that psychologists treating Metropolitan's adult patients have a demonstrated competence, consistent with generally accepted professional standards, in the use of functional assessments and positive behavioral supports.

f. Ensure that psychologists integrate their therapies with other treatment modalities, including drug therapy.

g. Ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately against rational, operationally defined, target variables and revised as appropriate in light of significant developments and the patient's progress, or the lack thereof.

3. Nursing and Unit-Based Services

Metropolitan should provide nursing and unit-based services to its patients consistent with generally accepted professional standards of care. Such services should result in Metropolitan's patients receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. At a minimum, Metropolitan should:

a. Ensure that, before they work directly with patients, all nursing and unit-based staff

have successfully completed competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the patient's status.

b. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have successfully completed competency-based training on the completion of the Medication Administration Records and the controlled medication log.

c. Ensure that all failures to properly sign the Medication Administration Record or the controlled medication log are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors.

d. Ensure that staff responsible for medication administration regularly ask patients about side effects they may be experiencing.

e. Ensure that each patient's treatment plan identifies:

   (1) the diagnoses, treatments, and interventions that nursing and other staff are to implement;

   (2) the related symptoms and target variables to be monitored by nursing and other unit staff; and

   (3) the frequency by which staff need to monitor such symptoms.

f. Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess the patient's status and to modify, as appropriate, the treatment plan.

g. Ensure that only patients with clinically justified reasons remain in a "bed-bound" status. For patients who have been unjustifiably maintained in this status, develop and implement methodical plans to reduce their time spent in bed, paying particular care to plan for and monitor these patients due to the risks associated with their long-term, bed-bound status.

h. Ensure that nursing and other staff providing direct support to patients are knowledgeable about their patients and participate meaningfully in the treatment team process.

4. Pharmacy

Metropolitan's patients should receive pharmacy services consistent with generally accepted professional standards of care. More particularly, Metropolitan should:

a. Develop and implement policies and procedures that:

(1) require pharmacists to complete regular, appropriate reviews of patients' entire medication regimens, track the use of psychotropic PRN medications, and, as warranted, make recommendations to the treatment team about possible drug-to-drug interactions, side effects, medication changes, and needs for testing; and

(2) require that physicians consider pharmacists' recommendations, clearly document their responses and actions taken, and for any recommendations not followed, provide an adequate clinical justification.

5. General Medical Care

Metropolitan should provide adequate preventative, routine, specialized, and emergency medical services on a timely basis, in accordance with generally accepted professional standards of care. More particularly, Metropolitan should:

a. Develop and implement policies and procedures that clearly define Metropolitan's primary care physicians' scope of service and ensure the timely provision of initial assessments, ongoing care and re-assessments, physician-nurse communication, and the integration of patients' mental health and medical care.

b. Ensure that each patient's treatment plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing and other unit staff, and the frequency by which staff need to monitor such symptoms.

c. Revise the system of after-hours coverage by primary care physicians to institute formal psychiatric training and provide psychiatric backup support after hours.

6. Infection Control

Metropolitan should implement adequate infection control procedures to prevent the spread of infections or communicable diseases. More specifically, Metropolitan should:

a. Revise infection control policies and procedures to include analysis of aggregated data and development and implementation of corrective action plans.

b. Establish an effective infection control program that:

(1) actively collects data with regard to infections and communicable diseases;

(2) assesses these data for trends;

(3) initiates inquiries regarding problematic trends;

(4) identifies necessary corrective action;

(5) monitors to ensure that appropriate remedies are achieved; and

(6) integrates this information into Metropolitan's quality assurance review.

c. Develop proper procedures to remove dirty linens and clothing from the living units in a timely and safe manner.

7. Dental Services

Metropolitan should provide its patients with routine and emergency dental care and treatment on a timely basis, consistent with generally accepted professional standards of care. More particularly, Metropolitan should:

a. Retain an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to Metropolitan patients.

b. Develop protocols and procedures that require:

(1) the timely provision of documented dental services; and

(2) preventative and restorative care be used whenever possible and tooth extractions be used as a treatment of last resort, which, when used, will be justified in a manner subject to clinical review.

c. Ensure that dentists demonstrate, in a documented fashion, an accurate understanding of their patients' health conditions and medications that bear on dental care, as well as an accurate understanding of their current dental status and complaints.

d. Ensure that transportation and staffing issues do not preclude residents from attending dental appointments.

e. Ensure that treatment teams review, assess, and develop strategies to overcome patient

refusals to participate in dental appointments.

f. Ensure that dentists consistently document their findings, a description of the treatment they have provided, and their plan of care.

8. Physical and Occupational Therapy Services

Metropolitan should provide its patients with physical and occupational therapy consistent with generally accepted professional standards of care. More particularly, Metropolitan should:

a. Develop and implement policies related to the provision of physical and occupational therapy that address, at a minimum:

(1) the assessment process;

(2) the development of plans of care;

(3) the provision of direct services by therapists;

(4) the oversight by therapists of individualized programs;

(5) program implementation by nursing and unit staff; and

(6) training for staff with related responsibilities.

b. Ensure that patients are provided with timely and adequate PT and OT services and that transportation and staffing issues do not preclude residents from attending PT and OT appointments.

c. Ensure that treatment teams review, assess, and develop strategies to overcome patient refusals to participate in PT and OT sessions.

d. Ensure that each person who requires adaptive equipment is provided with

equipment that meets their individualized needs and promotes their independence. Provide patients with training and support to use such equipment.

e. Provide competency-based training to nursing and other unit staff on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote patients' independence.

9. Dietary Services

Metropolitan should ensure that its patients, particularly those experiencing weight-related problems, receive adequate dietary services, consistent with generally accepted professional standards of care. More particularly, Metropolitan should:

a. Modify treatment planning policies and procedures to require that the treatment plans of patients who experience weight problems or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted.

b. Increase the availability of individualized and group exercise and recreational options for its adult patients.

c. Develop and implement policies and procedures to address the needs of patients who are at risk for aspiration, including but not limited to, patient assessments, and the development and implementation of protocols for mealtimes and other activities involving swallowing. Ensure that staff with responsibilities for these processes have successfully completed commensurate competency-based training.

d. Develop and implement policies requiring the treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment

options are utilized to determine the feasibility of returning them to oral intake status.

E. Documentation of Patient Progress

Metropolitan should ensure that patient records accurately reflect patient progress, consistent with generally accepted professional standards of care. More particularly, Metropolitan should:

1. Develop and implement policies and procedures setting forth clear expectations regarding the content and timeliness of progress notes, transfer notes, and discharge notes.

2. Ensure that such records include meaningful, accurate assessments of a patient's progress relating to the treatment plan and treatment goals.

F. Restraint, Seclusion, and "As-Needed" Medications

Metropolitan should ensure that seclusion, restraints and PRN psychotropic medications are used in accordance with generally accepted professional standards of care. More particularly, Metropolitan should:

1. Ensure that restraints and seclusion:

   a. are used in a reliably documented manner and only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been considered and/or exhausted;

   b. will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;

   c. will not be used as part of a behavioral intervention. as indicated in (a), above; and

   d. will be terminated as soon as the person is no longer an imminent danger to himself or others.

2. Ensure that PRN psychotropic medications are used only as a short-term measure to relieve a patient in acute distress, not as means to escape mild, possibly healthy, discomfort or as a repeatedly deployed substitute for treatment.

3. Reduce its use of seclusion, restraints, and psychotropic PRN medications.

4. Revise, as appropriate, and implement policies and procedures consistent with these generally accepted professional standards of care.

5. Ensure that staff successfully complete competency-based training regarding implementation of such policies and the use of less restrictive interventions.

6. Revise, as appropriate, and implement policies and procedures to require the review and modification, if appropriate, of patients' treatment plans after use of seclusion or restraints.

7. Comply with 42 C.F.R. § 483.360(f) as to assessments by a physician or licensed medical professional of any resident placed in seclusion or restraints.

8. Develop and implement a systemic plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure the residents' safety. Ensure that residents' individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails, plans to address the underlying causes of the medical symptoms, and strategies to reduce the use of side rails.

9. Develop and implement a policy consistent with generally accepted professional standards of care governing the use of psychotropic PRN medication for psychiatric purposes and requiring that:

   a. such medications are used on a limited basis and not as a substitute for adequate

treatment of the underlying cause of the patient's distress;

b. the patient's physician assess the patient within 24 hours of the administration of PRN medication; and

c. in a clinically justifiable manner, the patient's treatment team, including the psychiatrist, timely review the use of such medications, determine whether to modify the patient's treatment plan, and implement the revised plan, as appropriate.

G. Protection from Harm

Metropolitan should provide its patients with a safe and humane environment and protect them from harm. At a minimum, Metropolitan should:

1. Review, revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards of care. At a minimum, Metropolitan should:

a. review, revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents;

b. require all staff to complete successfully competency-based training in the revised reporting requirements;

c. review, revise, as appropriate, and implement unified policies and procedures addressing the investigation of serious incidents, including requirements that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;

d. require all staff involved in conducting investigations to complete successfully competency-based training on technical and

programmatic investigation methodologies and documentation requirements necessary in mental health service settings;

e. monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents;

f. develop and implement a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as a result of investigations; and

g. review, revise, as appropriate, and implement policies and procedures related to the tracking and trending of incident data, to ensure that appropriate corrective actions are identified and implemented in response to problematic trends.

2. Develop and implement a comprehensive quality improvement system consistent with generally accepted professional standards of care. At a minimum, such a system should:

a. collect information related to the adequacy of the provision of the protections, treatments, services, and supports provided by Metropolitan, as well as the outcomes being achieved by patients;

b. analyze the information collected in order to identify strengths and weaknesses within the current system; and

c. identify and monitor implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.

3. Conduct a thorough review of all units to identify any potential environmental safety

hazards, and develop and implement a plan to remedy any identified issues.

a. Ensure that all areas of the hospital that are occupied or utilized by patients have adequate temperature control at all times.

b. Review, revise as appropriate, and implement procedures and practices so that incontinent patients are assisted to change in a timely manner.

c. Develop clear guidelines stating the circumstances under which it is appropriate to utilize staff who are not trained to provide mental health services in addressing incidents involving patients. Ensure that persons who are likely to intervene in patient incidents are properly trained to work with patients with mental health concerns.

H. First Amendment and Due Process

The State should permit Metropolitan patients to exercise their constitutional rights of: (a) free speech, and, in particular, the right to petition the government for redress of grievances without State monitoring; and (b) due process. More particularly, the State should:

1. Permit patients to speak with representatives of the federal government outside the presence of persons acting for the State.

2. Permit patients to engage in confidential communications.

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The collaborative approach that the parties have taken thus far has been productive. We hope to continue working with the State in this fashion to resolve our significant concerns regarding the care and services provided at this facility.

We will forward our expert consultants' reports under separate cover. Although their reports are their work - and do not necessarily represent the official conclusions of the Department of Justice - their observations, analyses, and recommendations provide further elaboration of the relevant concerns, and offer practical technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing areas requiring attention.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that the Attorney General may initiate a lawsuit pursuant to CRIPA, to correct deficiencies or to otherwise protect the rights of Metropolitan's patients, 49 days after the receipt of this letter. 42 U.S.C. § 1997b(a)(1). Accordingly, we will soon contact State officials to discuss in more detail the measures that the State must take to address the deficiencies identified herein.

Sincerely,

R. Alexander Acosta
Assistant Attorney General

cc: The Honorable Bill Lockyer
Attorney General
State of California

Stephen W. Mayberg, Ph.D.
Director
California Department of Mental Health

Mr. William G. Silva
Executive Director
Metropolitan State Hospital

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United States Attorney
Central District of California

CALIFORNIA DEPARTMENT OF
Mental Health

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April 8, 2004

Benjamin O. Tayloe, Jr.
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
PHB Mailroom 5034
950 Pennsylvania Ave. NW
Washington DC, 20530

RE: Response to the United States Department of Justice Findings Letter regarding Metropolitan State Hospital ("Metropolitan II" Adult Patients) pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997

Dear Mr. Tayloe:

The California Department of Mental Health and Metropolitan State Hospital (hereafter referred to as the Department) have carefully considered the findings letter dated February 19, 2004 and the expert consultant reports that the Department received subsequently.

The Department looks forward to a dialogue addressing areas that the United States Department of Justice (USDOJ) identifies as requiring attention. In this regard, the Department is firmly committed to enhancing the services it provides. Subsequent to USDOJ's onsite visit, Metropolitan State Hospital has continued to enhance its program and previously had undertaken enhancements to the treatment approach that emphasizes recovery through individualized treatment, empowerment and self-determination. The Department believes that the enactment of this treatment approach and other enhancements demonstrates the Department's continued compliance with CRIPA.

Please be advised, however, that the Department's willingness to engage in a dialogue with USDOJ does not mean that the Department is in complete agreement with all of the findings and conclusions in the February 19, 2004, letter. The findings letter makes sweeping generalizations that are not borne out by fact or attested to in the USDOJ's Experts' reports. For instance, the following is an example where the Department believes USDOJ may have overlooked information that was provided and/or may have come to conclusions that are contrary to that of the Department. The findings letter states on page 43:

> ". . . areas throughout the facility, primarily the SNF units, had a strong smell of urine and excrement. This is a potential indication that patients had been sitting in their urine or feces for a long period of time, placing them at high risk for skin breakdown. We observed urine-soaked laundry on the floors of some patients' rooms and in uncovered bins in patient-inhabited areas, presenting an infection hazard."

It is clear from the information provided by the USDOJ experts that the above referenced conclusion is far removed from what was observed by the USDOJ experts. First, none of the experts note a smell "throughout the facility". Second, the smell of urine and excrement was only noted in the SNF unit during the times when the patients' clothes/bed linens were being changed. Third, there was no evidence at all that any patients were ever sitting in their urine or feces for a long period of time. Fourth, there was no evidence that anyone in the SNF unit had skin breakdown due to this cause. These purported findings and conclusions go beyond the facts and data and are inflammatory statements.

Another example relates to discharge planning. The findings letter states on page 15:

> "Preparation for discharge while in the hospital appears to be almost nonexistent. In no instance could we determine that a treatment team actually had prepared a patient to transition to, or succeed in, a new setting. In fact, the provision of transition supports almost never was discussed in the numerous patient records that we extensively reviewed."

This statement is simply not true. The Department has an extensive system of preparing patients for discharge that is dependent on the reason for their admission to the hospital. For example, the Department has mock courts and individualized training for patients who are admitted under Section 1370 of the California Penal Code (incompetent to stand trial) that prepares patients for discharge. For those patients that are to be discharged to Community Release Programs (see Section 1600 et seq. of the California Penal Code) the Department has treatment plans that specify what the individuals need to do to be discharged, including the development of a Relapse Prevention Plan. The Department invites the patient, family and conservators to participate and collaborate with the treatment team in developing the discharge plan. Often, there is representation from the County of residence of the patient, as well. While our documentation may not always reflect everything that is done by the Department to prepare an patient to transition to and succeed in another setting, it is a gross overstatement to say that discharge planning is almost nonexistent.

In addition, again the Department respectfully disagrees with, USDOJ's interpretation of legal authorities in support of its findings that the Department has violated CRIPA and other federal and state laws. Also as the Department has indicated with regard to the May 13, 2003 findings letter, the Department is seeking clarification on a number of remedial measures especially those remedial measures that refer to "professional standards" without specifying what are the standards.

As previously indicated, rather than responding to every detail in the comprehensive findings letter at this time, the Department proposes that the parties commence the informal conference process that is contemplated by U.S.C. section 1997b(a)(2)(A) and (B). The Department stands ready to commence this process as soon as possible.

The Department is committed to working with USDOJ to address the concerns that it has raised. However, as the above indicates, there is much to be discussed and the Department is not in agreement with everything in the findings letter. At your convenience, please call Evon Dixon-Montgomery, Senior Staff Counsel, at (916) 654-2453 to schedule a time convenient to all parties to further discuss this matter. The Department looks forward to working with the USDOJ to continue its mission to serve the patients at Metropolitan State Hospital.

Respectfully,

JOHN RODRIGUEZ
Deputy Director
Long Term Care Services

cc: Evon Dixon-Montgomery
Kyungah Suk

SECTION 9

Report on Department of Justice/Department of Mental Health Correspondence Regarding Access, March 19, 2004, January 24, 2005

U.S. Department of Justice

Civil Rights Division

SYC:EJ:BOT:BG:DH:sjf
DJ 168-11-44

Special Litigation Section - PHB
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

March 19, 2004

Via Facsimile and U.S. Mail

Evon Dixon-Montgomery, Esq.
Senior Staff Counsel
Office of Legal Services
California Department of Mental Health
1600 9th Street, Room 153
Sacramento, CA 95814

Re: Napa State Hospital

Dear Ms. Dixon-Montgomery:

On January 6, 2004, Assistant Attorney General Acosta notified Governor Schwarzenegger that the United States Department of Justice had commenced an investigation of Napa State Hospital ("Napa"), in Napa, California. Since then, after you identified yourself to the Department as the State's point of contact in this matter, Department attorneys have communicated with you on a weekly basis throughout January and February to ascertain the State's position. In those communications, both written and verbal, we conveyed to you the Department's intention of touring Napa during the period of March 29 through April 2, 2004.

In response, you indicated that the matter had been forwarded to Governor Schwarzenegger's office for determination, and that you were awaiting instructions as to the State's position. We appreciate that there may be factors beyond your personal control. Nevertheless, the State's delay in responding to the notice of our investigation of Napa is of increasing concern. I am obliged to inform you that our investigation is proceeding, whether or not the State elects to cooperate actively. Certainly, however, it is to the State's benefit to cooperate, as cooperation enhances the prospects of an amicable resolution of the investigation, as well as facilitates the process of ensuring that the constitutional and federal statutory rights of individuals in the State's custody are upheld.

We hope that the State shortly will demonstrate, in a tangible manner, its intent to work cooperatively with the Department in this matter.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section

ARNOLD
SCHWARZENEGGER
GOVERNOR

State of California
HEALTH AND HUMAN SERVICES AGENCY

S. KIMBERLY BELSHÉ
SECRETARY

March 26, 2004

R. Alexander Acosta, Esq.
Assistant Attorney General
Civil Rights Division
US Department of Justice
950 Pennsylvania Avenue, NW
Washington, D.C. 20530

Re: Napa State Hospital, Napa, California

Dear Mr. Acosta:

The State of California is in receipt of the letter dated January 6, 2004, regarding the intention of the United States Department of Justice (USDOJ) to investigate the conditions of care and treatment of patients at Napa State Hospital (NSH) pursuant to authority under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. Governor Schwarzenegger has referred this matter to my attention. While we understand that the USDOJ has not reached any conclusions about the subject matter of the investigation, we take your concerns seriously and intend to cooperate fully. We, too, are concerned with the two recent patient suicides at this hospital.

A similar investigation of conditions of care and treatment of patients at the Metropolitan State Hospital (MSH) in Norwalk, California, was commenced in March 2002. The State received a findings letter regarding the child and adolescent program at MSH in May 2003. In August, the State, in responding to the findings letter, requested and is in the process of reaching clarification with regard to the standards referred to in the findings letter. As you are aware, the State just recently received the findings letter for the adult programs at MSH, and we are reviewing it along with the individual experts' reports.

The State has been very responsive to the verbal concerns expressed by the USDOJ experts and has initiated a comprehensive systems change program in its inpatient psychiatric hospitals. For example, the systems change involves (a) embracing the rehabilitation model of psychiatric services, with a strong emphasis on personal recovery, (b) involvement of patients in every facet of their care, as well as representation in committees and groups that develop policies, procedures and processes used at the hospitals, (c) person-centered treatment planning process based on principles of rehabilitation and recovery, with full patient participation, (d) use of psychosocial rehabilitation malls to maximize the delivery of enrichment, treatment and rehabilitation services, (e) increasing use of evidence-based and manualized treatments, (f) culturally informed services, (g) a strong focus on recovery-based outcomes, and (h) transition planning to the community or through CONREP to the community.

The State began these initiatives at the MSH in 2002, and has started a similar process at two other hospitals, one of which is NSH. As the USDOJ attorneys and expert consultants know, such a broad and state-of-the-art systems change takes, at a minimum, three to five years. Indeed, it takes about three years to produce a sustainable cultural change from the traditional model of mental health care to psychosocial rehabilitation and recovery. In California, the State is systematically building the foundation for this change to occur in all the State's mental health facilities and the State is developing self-monitoring systems to document the progress.

Given the State's total commitment to this process and its implications for addressing quality of care issues and concerns at MSH as well as NSH, the State is concerned that an USDOJ investigation of NSH at this time could result in the reallocation of scarce state staff and fiscal resources that is not in the best interests of either the patients or the State. The State takes seriously the imperative for change, recognizes the changes that need to be made, and has initiated the change process. Given the current fiscal situation of California, the State respectfully suggests that it focus its scarce resources on improvements in its mental health service delivery system rather than on another USDOJ on-site visit that will take the State no further than where it is going today.

The State respectfully requests that the USDOJ complete its investigation of MSH, reach an agreement with the State on necessary remedial measures, and monitor the hospital's compliance with the remedial measures. At the same time, the State will stipulate that it will implement similar measures at the other state hospitals without direct involvement of the USDOJ, but will provide the USDOJ with the same data set that is negotiated for MSH. This will enable the USDOJ to monitor the change process at NSH without subjecting the State of California to the additional expenditure of fiscal and human capital that can be more fruitfully used for enhancing patient care.

In view of the many changes implemented since the USDOJ began its investigation at MSH in 2002, we would like to meet with you to more fully discuss the nature of the USDOJ concerns, the actions taken and planned in our hospitals, and alternative approaches to a full investigation at this time at NSH. My office is available at your convenience to discuss our next steps. I can be reached at (916) 654-3454.

Sincerely,

KIMBERLY BELSHÉ
Secretary

KB/rh

c: Marybel Batjer, Cabinet Secretary, Office of Governor Schwarzenegger
Peter Siggins, Legal Affairs Secretary, Office of Governor Schwarzenegger
Stephen W. Mayberg, Ph.D., Director, Department of Mental Health

U.S. Department of Justice

Civil Rights Division

SYC:EJ:BOT:MS:JC:
MEL:SSL:BG:KK:ch
DJ 168-11-44
DJ 168-12C-44
DJ 168-12C-63

Special Litigation Section - PHB
950 Pennsylvania Avenue, N W
Washington, DC 20530

May 12, 2004

Kimberly Belshé
Secretary
State of California
Health and Human Services Agency
1600 Ninth Street
Room 460
Sacramento, CA 95814

Re: Metropolitan State Hospital and Napa State Hospital

Dear Secretary Belshé:

Thank you for your letter of March 26, 2004, to Assistant Attorney General Acosta, which has been forwarded to my attention. We are gratified by the State's representations that it intends to cooperate fully with our investigation into conditions of care and treatment at Napa State Hospital ("Napa") and that, in response to our investigation of Metropolitan State Hospital ("Metropolitan") the State is undertaking significant reforms at Metropolitan, Napa, and one other, unidentified, mental health care facility.

As you are aware, the Department recently has commenced an investigation of Patton State Hospital ("Patton"), in San Bernardino, California. We presume that the State's proposals as to our Napa investigation would also apply to our investigation of Patton. In any event, the Department cannot agree to suspend its investigations based on assurances that the State will implement remedial measures at Napa, and elsewhere, that are similar to those negotiated for Metropolitan and that the State will provide the Department with documentation of its efforts. However, we recognize that the State does not have unlimited resources and that an investigation can have an impact, if temporary, on a facility's operations. In this regard, it certainly is our preference to work with the State to avoid needless expense and disruption.

We understand that the State and its consultants have reviewed conditions of care and treatment at Napa, Patton, and its other mental health care facilities in light of our Metropolitan investigation. If the State has determined that the conditions at Napa and Patton are substantially similar to those that we found at Metropolitan (in which case the State should consider undertaking at Napa and Patton the remedial measures set forth in the Department's findings letters regarding Metropolitan), there may be a basis for limiting the scope, and corresponding impact, of the investigatory tours of those facilities. Although the Department could not confine its oversight of an agreement to a review of data provided by the State, the Department is certainly willing to discuss options for tangibly limiting any disruption associated with such oversight.

In any event, the Department notified the State of the Napa investigation on January 6, 2004. If the State is interested in proceeding with the approach outlined above, we would request that it inform us promptly, by contacting me at (202) 514-0195. In the alternative, we will proceed with our investigations of Napa and Patton and will be in contact to coordinate tours of those facilities. Independent of the foregoing, we would be pleased to meet with the State to commence negotiations regarding a resolution of our Metropolitan investigation and to learn in more detail what steps the State is undertaking in response to that investigation.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section

ARNOLD
SCHWARZENEGGER
GOVERNOR

State of California
HEALTH AND HUMAN SERVICES AGENCY

S. KIMBERLY BELSHÉ
SECRETARY

Agency Departments & Boards:

Aging

Alcohol and Drug Programs

Child Support Services

Community Services and Development

Developmental Services

Emergency Medical Services Authority

Health Services

Health and Human Services Data Center

Managed Risk Medical Insurance

Mental Health

Rehabilitation

Social Services

Statewide Health Planning and Development

June 10, 2004

R. Alexander Acosta, Esq.
Assistant Attorney General
Civil Rights Division
US Department of Justice
950 Pennsylvania Avenue, NW
Washington, D.C. 20530

Re: Patton State Hospital, San Bernardino, California

Dear Mr. Acosta:

The State of California is in receipt of the letter dated April 9, 2004, regarding the intention of the United States Department of Justice (USDOJ) to investigate the conditions of care and treatment of patients at Patton State Hospital (PSH) pursuant to authority under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. Governor Schwarzenegger has referred this matter to my attention. While we understand that the USDOJ has not reached any conclusions about the subject matter of the investigation, we intend to cooperate fully.

As you know, a similar investigation of conditions of care and treatment of patients at the Metropolitan State Hospital (MSH) in Norwalk, California was commenced in March 2002. The State received a findings letter regarding the child and adolescent program in May 2003. In August 2003, the State, in responding to the findings letter, requested and is in the process of reaching clarification with regard to the standards referred to in the findings letter. On February 19, 2004, the State received a similar findings letter for the adult programs at MSH. The State responded to this findings letter on April 8, 2004, again requesting the beginning of the informal conference process.

The State of California also received a letter dated January 6, 2004 regarding the intent of the USDOJ to initiate an investigation at Napa State Hospital (NSH). I responded to this letter in March suggesting an alternative approach at both NSH and our other state hospitals that allows the hospitals to focus their scarce resources on improvements in their services rather than on another USDOJ on-site visit. We recommend the same approach in response to your letter regarding PSH.

The State has been very responsive to the verbal concerns expressed by the USDOJ experts and has initiated a comprehensive systems change program in its inpatient psychiatric hospitals. For example, the system changes

involve (a) embracing the rehabilitation model of psychiatric services, with a strong emphasis on personal recovery; (b) including patients in every facet of their care, as well as representation in committees and groups that develop policies, procedures and processes used at the hospitals; (c) supporting person-centered treatment planning process based on principles of rehabilitation and recovery, with full patient participation; (d) using psychosocial rehabilitation malls to maximize the delivery of enrichment, treatment and rehabilitation services; (e) increasing use of evidence-based and manualized treatments; (f) providing culturally informed services; (g) focusing on recovery–based outcomes; and, (h) transition planning to the community or through CONREP to the community.

The State began these initiatives at the MSH in 2002, and started a similar process at both NSH and PSH, and will begin at Atascadero State Hospital in the next month. As the USDOJ attorneys and expert consultants know, such a broad and state-of-the-art systems change takes, at a minimum, three to five years. Indeed, it takes about three years to produce a sustainable cultural change from the traditional model of mental health care to psychosocial rehabilitation and recovery. In California, the State is systematically building the foundation for this change to occur in all the State's mental health facilities and the State is developing self-monitoring systems to document the process.

Given the State's total commitment to this process and its implications for addressing quality of care issues and concerns at MSH, NSH and PSH, the State remains concerned that a USDOJ investigation of two additional hospitals at this time could result in the reallocation of scarce state staff and fiscal resources that is not in the best interests of either the patients or the State. The State takes seriously the imperative for change, recognizes the changes that need to be made, and has initiated the change process. Given the current fiscal situation of California, the State respectfully suggests again that it focus its scarce resources on improvements in its mental health services delivery system rather than additional USDOJ on-site visits that could delay the very improvements that USDOJ seeks.

The State respectfully requests that the USDOJ complete its investigation of MSH, reach an agreement with the State on necessary remedial measures, and monitor the hospital's compliance with the remedial measures. At the same time, the State will stipulate that it will implement similar measures at the other state hospitals without direct involvement of the USDOJ, but will provide the USDOJ with the same data set that is negotiated for MSH. This will enable the USDOJ to monitor the change process

at NSH and PSH without subjecting the State of California to the additional expenditure of fiscal and human capital that can be more fruitfully used for enhancing patient care.

In view of the many changes implemented since the USDOJ began its investigation at MSH in 2002, we would like to meet with you to more fully discuss the nature of the USDOJ concerns, the actions taken and planned in our hospitals, and alternative approaches to a full investigation at this time at PSH. My office is available at your convenience to discuss our next steps. I can be reached at (916) 654-3454.

Sincerely,

KIMBERLY BELSHÉ
Secretary

KB/JR/EC/mcv

c: Marybel Batjer, Cabinet Secretary, Office of Governor Schwarzenegger
Peter Siggins, Legal Affairs Secretary, Office of Governor Schwarzenegger
Stephen W. Mayberg, Director, Department of Mental Health

U.S. Department of Justice

Civil Rights Division

SYC:EJ:BOT:MS:JKC:
MEL:SSL:BG:KK:kdf
DJ 168-12C-63
DJ 168-12C-44
DJ 168-11-44

Special Litigation Section - PHB
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

August 27, 2004

Kimberly Belshé
Secretary
State of California
Health and Human Services Agency
Room 460
Sacramento, CA 95814

Re: Patton State Hospital, Metropolitan State Hospital, and Napa State Hospital

Dear Secretary Belshé:

Thank you for your letter of June 10, 2004, to Assistant Attorney General Acosta regarding the Department's investigation of Patton State Hospital, which was forwarded to my attention. We apologize for not acknowledging your June 10 letter sooner; a mail processing error delayed our receipt and review. In any event, we are pleased to read that the State remains committed to this process and has, as a result of the Department's investigation of Metropolitan State Hospital, initiated comprehensive reforms at its other inpatient psychiatric hospitals.

Likewise, we are encouraged to hear that the State is willing to stipulate that all remedial measures agreed upon in connection with resolution of the Metropolitan investigation will also be implemented at Patton and Napa State Hospitals. However, as discussed in our previous correspondence of May 12, 2004, regarding Napa, although we are willing to discuss options for limiting any disruption associated with investigatory tours, the Department is unable to limit oversight of any subsequent agreement resolving its investigations of Patton and Napa to a review of data provided by the State.

As you probably are aware, there have been informal discussions between our offices for the past several months regarding alternative approaches to achieving the goals reflected in the State's proposal. Our hope is that these discussions will lead to a mutually satisfactory vehicle for reaching the important goal that the State and the Department share, ensuring that the patients in these facilities receive the care and protections that they are entitled to under the U.S. Constitution and federal law. In this regard, we would welcome a meeting with your staff to take this process forward. I will ask Benjamin Tayloe, the trial attorney assigned to all three investigations, to contact your staff to discuss next steps and to arrange a meeting. In the meantime, I may be reached at (202) 514-0195 if you have any questions or concerns.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section

NOLD
SCHWARZENEGGER
GOVERNOR

State of California
HEALTH AND HUMAN SERVICES AGENCY

S. KIMBERLY BELSHÉ
SECRETARY

October 4, 2004

Shanetta Y. Cutlar, Chief
Special Litigation Section
Civil Rights Division
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington DC, 20530

Re: Metropolitan, Napa, and Patton State Hospitals, California

Dear Ms. Cutlar:

Thank you for your letters of May 12, 2004, and August 27, 2004 inviting the State California to commence negotiations regarding a resolution of the United States Department of Justice's (USDOJ) investigation of Metropolitan State Hospital and a exploration of procedures for USDOJ's investigations at Napa and Patton State Hospitals. We appreciate the USDOJ's willingness to work with the State to minimize disruption of operations of our state hospitals and expense to the State.

This is to formally inform you that the State of California accepts your offer of negotiation and that the Department of Mental Health will participate in these discussions as the representative for the State. Please have your staff contact Joh Rodriguez, Deputy Director of the Long Term Care Services Division, at (916) 654-2413 to arrange a meeting. My office is also available to provide any assistance y may require. I can be reached at (916) 654-3454.

Sincerely,

KIMBERLY BELSHÉ
Secretary

c: Marybel Batjer, Cabinet Secretary, Office of Governor Schwarzenegger
Peter Siggins, Legal Affairs Secretary, Office of Governor Schwarzenegg
Stephen W. Mayberg, Ph.D., Director Department of Mental Health

KB/rh

U.S. Department of Justice

Civil Rights Division

Special Litigation Section - PHB
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

SYC:EJ:BOT:KAK:JC:MRB:BG:
SSL:KAK:clh
DJ 168-12C-52
DJ 168-11-44
DJ 168-12C-63

January 24, 2005

Via Telecopy & U.S. Mail

Evon Dixon-Montgomery, Esq.
Senior Staff Counsel
Office of Legal Services
California Department of Mental Health
1600 9th Street, Room 153
Sacramento, CA 95814

Re Investigations of California State Hospitals

Dear Ms. Dixon-Montgomery:

I write to confirm the substance of our recent telephone conversations.

As discussed, we look forward to meeting with State officials the week of March 28, 2005, in Sacramento. As we understand it, the meeting's principal purpose is to negotiate an agreement addressing the issues raised in our letters of May 13, 2003, and February 19, 2004, regarding our investigation of Metropolitan State Hospital. In that regard, on December 1, 2004, we provided the State with a proposed plan of remediation, which we hope addresses the State's request for elaboration regarding our findings. Also, we expect to provide the State shortly with a proposed settlement agreement to ensure that agreed remedial measures are successfully implemented.

Regarding our investigations of Napa State Hospital ("Napa") and Patton State Hospital ("Patton"), you have told me that the State will not give the Department of Justice access to these facilities until early 2006. We regret the State's position, particularly because we notified the State of our investigation of Napa in January 2004 and of Patton in April 2004. To address the State's concerns, reflected in Secretary Belshé's letters of March 26 and June 10, 2004, that tours of these facilities could be costly and disruptive, we indicated in our responsive correspondence of May 12 and August 27, 2004, that we were prepared to take steps to limit any disruption associated with the investigatory tours. In fact, we subsequently proposed, in

our telephone discussions, conducting comparatively brief visits to Napa and Patton. We are disappointed that our proposal does not satisfy the State's concerns and objectives. In any event, as I have indicated, the Department is proceeding with its investigation of these facilities. In the meantime, if the State wishes to revisit its decision, please let us know.

Sincerely,

Benjamin O. Taylor, Jr.
Trial Attorney
Special Litigation Section

SECTION 10

Report on Napa State Hospital, June 27, 2005 Report on Health & Human Services Agency Response, August 8, 2005, Report on Department of Justice Response, August 17, 2005

U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

June 27, 2005

The Honorable Arnold Schwarzenegger
Governor of California
State Capitol Building
Sacramento, CA 95814

Re: Napa State Hospital, Napa, California

Dear Governor Schwarzenegger:

On January 6, 2004, we notified then-Governor Gray Davis of our intent to investigate conditions at Napa State Hospital ("Napa"), in Napa, California, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. I write now to provide the statutorily required findings of that investigation, the bases for those findings, and the minimum remedial measures that we believe are warranted to correct deficiencies contributing to conditions that violate the federal rights of individuals residing in this facility.

As a threshold matter, we note that State officials have declined to cooperate with this investigation. In particular, they repeatedly have refused to allow the Department access to the facility, most recently stating that access will not be provided before sometime in 2006. The State's conduct is unusual in this regard. Most government officials cooperate with CRIPA investigations because they recognize that protecting the rights of institutionalized citizens warrants a thorough and impartial review. Indeed, the State cooperated with the Department regarding a previous CRIPA investigation of Napa that was resolved via a consent decree in 1990.[1] The State also cooperated with our investigation of Metropolitan State Hospital in June and July 2002 ("Metropolitan"). Since then, however, the State has declined our requests for access to Napa and to

[1] Consent Decree, United States v. California, No. C90-2641, (N.D. Cal. Sept. 17, 1990).

the State's other mental health care facilities that we are investigating, Patton State Hospital and Atascadero State Hospital.[2]

As we understand it, the State's position is that permitting the Department access to Napa, and its other facilities, before sometime next year would excessively divert limited resources at a time when the State is undertaking significant reforms. We attempted to address the State's concerns by offering to conduct a streamlined tour of Napa, and we reminded the State that we were committed to providing technical assistance during the tour and to working in a transparent manner. If the State had agreed to our proposed investigation procedures, State officials would have had an early opportunity to work directly with our experts and staff. They also would have had an opportunity to address any identified problems on a voluntary basis at an early stage of this investigation. Regrettably, the State has maintained its opposition to permitting the Department access.

As we repeatedly advised State officials, however, our investigations proceed regardless of whether officials choose to cooperate. Indeed, when CRIPA was enacted, lawmakers considered the possibility that local officials might not assist a federal investigation. Such non-cooperation is a factor that may be considered adversely when drawing conclusions about a facility. See H.R. CONF. REP. 96-897, at 12 (1980), reprinted in 1980 U.S.C.A.A.N. 832, 836. We now draw such an adverse conclusion.

The State's non-cooperation is only one factor that we have considered in preparing our statutorily-required findings and recommendations. We have also considered information from several recent on-site surveys conducted by the Centers for Medicaid and Medicare Services ("CMS") and by the State's Department of Health Services ("DHS"), and conducted interviews with professionals, advocates, family members of patients, and patients themselves. In doing so, we found evidence of significant and wide-ranging deficiencies in Napa's provision of care to its patients.

Tragically illustrative of the widespread and systemic deficiencies that currently exist at Napa is the case of patient

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[2] In May 2005, the State did permit Department staff to interview certain Patton patients and has agreed to provide us with requested portions of charts from patients who authorized us to obtain such records.

Q.R.,[3] who committed suicide by hanging in December 2004. Several months before his suicide, Q.R. attempted suicide (also by hanging), which staff told his family was an attention-getting behavior, and not a realistic threat. This patient's family was in frequent contact with his counselor at Napa, and conveyed to the counselor its concern that the patient's escalating episodes of violence were uncharacteristic and needed to be treated. On the day of Q.R.'s death, a family member who had just spoken with Q.R. phoned the nurses' station on his ward to warn that Q.R. was despondent, crying, and in need of attention. Despite this specific warning and the patient's history of suicide attempt, staff failed to act. Less than an hour later, Q.R. was discovered by a peer, hanging by a sheet in his room. Because the State denied us access to the facility to investigate these allegations, we have no reason not to conclude that the contentions are accurate, and that Napa's failure to intervene appropriately was a cause of this young man's death.

The preceding incident is emblematic of the systemic deficiencies at Napa. We have received overwhelming information that, following the dismissal of the consent decree in 1995, significant problems recurred at Napa, including: failure to protect patients from harm from assaults and suicide; inappropriate use of seclusion, restraint and PRN ("pro re nata" or "as-needed") psychotropic medications; and inadequate medical, nursing and psychiatric care. In addition, we have received information evidencing deficient treatment planning, programming, and nutritional management; unsanitary conditions; and failure to place patients in the most integrated setting as required by the Americans with Disabilities Act, 42 U.S.C. § 12132 et seq. ("ADA"), and the President's New Freedom Initiative, which prioritizes community-based alternatives for individuals with disabilities. See Exec. Order No. 13217, §§ 1(a)-(c), 66 Fed. Reg. 33155 (June 18, 2001). Our findings, the facts that support them, and the minimum remedial steps that we believe are necessary to correct deficiencies are set forth below.

I. BACKGROUND

Napa has been in operation since November 1875. It is situated on a 138-acre campus and houses almost 1,100 adult patients. These individuals are classified as "low to moderate risk" and are civilly committed or committed through criminal proceedings. In our previous investigation of Napa, we

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[3] We use pseudo-initials to refer to individual patients, in order to protect their privacy.

identified deficiencies in the facility's protections from harm, use of restraints, and provision of medical care, among other areas. These concerns were addressed in a consent decree that was dismissed in 1995 based on the Department's assessment that Napa, at that time, was in substantial compliance with the decree's requirements.

II. FINDINGS

A. PROTECTION FROM HARM

Napa is constitutionally required to provide patients reasonable protection from harm and freedom from bodily restraint. Youngberg v. Romeo, 457 U.S. 307, 315-16 (1982). Information from multiple, credible sources leads us to conclude that Napa fails to protect patients from harm and abuse. We have determined that the harm suffered by Napa's patients is multi-faceted, including physical injury by assault; death by suicide due to inadequate suicide precautions; excessive and inappropriate use of physical and chemical restraints and seclusion; inadequate, ineffective, and counterproductive treatment; and exposure to unnecessary environmental hazards.

A major factor in Napa's failure to protect patients from harm is inadequate supervision. As DHS has reported, "[e]ven though clients in the facility can be extremely unpredictable and violent, they are left unsupervised for long periods of time." Family members of patients and advocates who frequently visit Napa confirm that patients are left unattended, without staff observation or interaction. A number of incidents occurred when medically required one-to-one staffing was cancelled, apparently not due to clinical decisions, but rather staff shortages. Moreover, as a nurse at Napa reported, "there are not enough people on hand to subdue [out-of-control patients].... So an alarm is set off or the hospital police are called. But it takes at least five minutes, sometimes 10 or more to get there, and a lot can happen during that time."

1. Patient-on-Patient Assaults

Napa patients suffer from repeated acts of aggression by peers, resulting in serious injuries, and in one case, a homicide. In egregious departures from accepted standards, staff often fail to intervene and/or fail to report the incidents. Staff likewise do not attempt to prevent repeated assaults by addressing the underlying behavior of the aggressors.

Many instances of inappropriate aggression in a psychiatric hospital such as Napa result from patients exhibiting symptoms of their mental health disorders. Without the benefit of appropriate medication and therapeutic interventions, patients often lack the means to control such symptoms. Thus, inadequate mental health treatment exposes individuals to excessive levels of violence. Examples of failures to prevent known aggressors from repeated acts of serious aggression include:

- On May 3, 2002, a patient was strangled to death by his roommate. The roommate had previously been convicted of several violent crimes and had a history of attacking peers, including two attacks on sleeping patients. Reportedly, there are no bedrooms set aside to house separately patients who demonstrate the potential to harm others.

- Between January and June 2003, one patient assaulted other patients at least 20 times, including at least 17 incidents in which he punched or kicked other patients in the head or face. Staff were afraid of this patient and failed to intervene to protect other patients.

- In June 2002, a patient with a history of aggressive behavior attacked another patient in the TV room, punching him and stabbing him in the neck with a portable radio antenna. Staff failed to report the assault to the licensing authorities.

- On November 18, 2002, a patient who was ordered to be under constant observation by staff assaulted another patient. He previously had assaulted two patients on October 3, 2002, and one patient on September 18, 2002. In addition, an assessment dated September 3, 2002, indicated that he had "numerous recent assaults on peers."

- Two patients known to be "extremely assaultive" were placed in a bedroom together where they were not supervised for significant periods of time. On August 8, 2001, one patient attacked the other, punching him in the nose. The following day, that patient retaliated by choking his roommate until he passed out.

Patient advocates and patients themselves tell us that staff often fail to intervene with violent patients because the staff are afraid. Last fall, Napa's Clinical Administrator confirmed to CMS surveyors that "staff become fearful of patients who have

been assaultive." Examples of staff failing to intervene include:

- On November 11, 2003, one patient stabbed another in the face and back with an 11-inch "shank" made from an antenna. Four days earlier, the victim had told staff that he feared that he would be attacked. The State's regulatory agency concluded that Napa had failed to investigate the source or nature of the threat identified by the victim, and it imposed a treble fine on the facility for its failure to protect the victim.

- On September 20, 2002, a 38-year-old woman suffered "great bodily injury" when she was beaten by three male patients. According to the woman, the other patients "kicked the shit out of me." Staff did not intervene, nor did staff report to Napa authorities the significant bruises and injuries to this client.[4]

2. Inadequate Suicide Precautions

Several Napa patients have committed suicide in recent years, often using the same method to do so:

- On March 20, 2005, Napa patient M.E. committed suicide by hanging himself in a locked bathroom.

- Napa patient Q.R. committed suicide by hanging in December 2004. Several months earlier, he had attempted suicide by hanging; notwithstanding his history, Napa staff failed to intervene or adequately supervise Q.R. when a family member called the nurses station on his unit the day of his death and informed staff that Q.R. was despondent and crying and in need of attention.

- On July 21, 2003, a man hanged himself from a door using a radio cord, on the same ward where another patient committed suicide only a month earlier.

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[4] The failure to report or investigate a serious incident is not uncommon at Napa, and is a substantial departure from accepted standards of care. Numerous sources described incidents to us, including this assault, inappropriate sexual contact between residents or staff and residents, and illegal drug use, which were not reported to and/or not investigated by Napa authorities.

- On June 3, 2003, a patient who had previously been reported as suicidal hanged himself using a bed sheet.

- On September 4, 2001, a patient committed suicide by hanging with a bed sheet in his ward.

- On July 16, 1999, a man known to be suicidal hanged himself with bedsheets tied to a light fixture.

In February 2005, CMS cited Napa for failing to complete the suicide assessment of a patient for more than six months after his admission. CMS found that Napa did not provide translation services to complete the suicide assessment of this patient, who could not communicate in English.

The State's own surveyors previously cited Napa for failing to identify and address current symptoms of yet another patient with a documented history of suicide attempts. In July 2004, DHS imposed a treble fine on Napa for failing to assess and treat a patient whose suicide attempt was reported to staff by a peer and whose records contained numerous observations documenting his depression during that time, including: "verbalized feelings of depression;" the patient stating that his "spirit was broken;" and the patient requesting medication for depression and agitation. Notwithstanding this significant evidence of a mental health treatment need, the facility's nursing staff did not assess or evaluate the patient, and the treatment team did not amend his treatment interventions to address this need. I would note that DHS imposes treble fines only when the violation is a repeat violation within a short time frame. Napa has been warned repeatedly of deficiencies in its suicide prevention practices, but has failed to remedy them.

3. Harmful Contraband

Napa also fails to protect patients from harmful contraband. The State's own Department of Health Services has determined that policies requiring investigation of all contraband are not followed. Numerous credible allegations corroborate our finding that Napa fails to control traffic in harmful contraband, including illegal narcotics. We have determined that patients have access to illegal drugs, including marijuana and cocaine, while residing at Napa. Patients allege, moreover, that staff provide illegal drugs to patients in return for cash or sex. Evidence that patients are obtaining access to contraband includes:

- Three different Napa patients overdosed on amphetamines and/or cocaine in fall 2004, including one patient who died of the overdose. Three other patients obtained and used heroin during this time period.

- In September 2004, a Napa physician testified under oath that Napa's staff brings drugs into the facility in exchange for cash.[5]

- An independent psychologist who recently examined a Napa patient and all of his medical records told us that the client, L.A., tested positive for marijuana and other street drugs six months after his admission to Napa.

- In late 2002, the State's own surveyors documented numerous indications of drug use by Napa residents that were neither investigated by the facility nor addressed by the residents' treatment teams. A Napa police staff member told the state surveyors, "[W]e don't have the resources to stop the drugs [coming into the facility]."

- As described in the discussion above regarding patient-on-patient assaults, the patient who strangled his roommate to death on May 2, 2002, was a heavy drug user who had tested positive for cocaine, amphetamines, and barbiturates in the five months prior to the incident, even though he had been confined to Napa for two years.

- One patient tested positive for marijuana, cocaine, and alcohol while at Napa in 2001 and 2002, and was seen injecting another patient with a needle on September 5, 2002.

4. Seclusion, Restraints and PRN Medications

Generally accepted professional standards of care dictate that seclusion and restraints: (a) will be used only when persons pose a safety threat to themselves or others and after a hierarchy of less restrictive measures has been considered and/or exhausted; (b) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (c) will not be used as a behavioral intervention, and (d) will be terminated once the person is no longer a danger to himself or others. See Youngberg, 457 U.S. at

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[5] This testimony was submitted during a conditional release hearing for patient L.A.

324 ("[The State] may not restrain patients except when and to the extent professional judgment deems this necessary to assure such safety to provide needed training.") Generally accepted professional standards also instruct that PRN psychotropic medications should be used only as a short-term measure to relieve a patient in acute distress, not as means to escape mild, possibly healthy, discomfort or as a repeatedly deployed substitute for treatment.

Misuse of seclusion and restraint was a significant area of concern during our first CRIPA investigation of Napa. In addition to overuse and misuse of physical restraints and seclusion, our earlier investigation found an exorbitant number of PRN (pro re nata or "as needed") medication orders, suggesting that they were used for the convenience of staff to sedate and control patients. Substantial evidence shows that misuse of seclusion and restraint is a significant area of concern again. Statistics published on the DMH web site show the duration of restraint episodes at Napa to be substantially higher than the system's average in 2004. The average duration of restraint episodes at Napa during each quarter of 2004 was more than double those at Metropolitan State Hospital (where we also found unconstitutional use of seclusion and restraint) during this same time.[6] Data comparing administration of emergency psychiatric medication[7] in the State's four public psychiatric hospitals also shows that Napa's rate was nearly twice that at Metropolitan.[8]

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[6] February 19, 2004 CRIPA Findings Letter Regarding Conditions at Metropolitan State Hospital. We currently are negotiating to reach a resolution of the Metropolitan investigation. Of the State's four psychiatric hospitals, the residents at Metropolitan and Napa are the most similar, and include both civilly-committed and forensic patients. Patton and Atascadero State Hospitals admit only forensic patients.

[7] We refer to this published data on emergency medications as an indicator of PRN usage. Although not every administration of a PRN medication is an emergency use, and vice versa, in most cases, the two sets of data overlap. The data generally support the claims of Napa patients and families that Napa overuses PRN medications. Because the State denied us timely access to the facility and patient records to conduct our investigation, we have little choice but to conclude that the allegations are true.

[8] Inexplicably, of the four hospitals' statistics, only Napa's are expressly limited to use of "intramuscular

This is a concern because we found the high levels of seclusion, restraint and PRN medications at Metropolitan to be evidence of a failure to follow generally accepted professional practices. Specifically, frequent resort to seclusion, restraint and PRN medication is an indicator that a patient's diagnosis is erroneous and/or that the treatment plan is inappropriate and should be re-evaluated.

In September 2004, and again in February 2005, Napa was cited by CMS for continuing deficiencies in the use of seclusion and restraints. In both surveys, CMS found that Napa failed to justify the use of restraints; failed to ensure physicians' orders and face-to-face assessments in application of restraints; and failed to limit use of restraints and seclusion to documented emergencies. When interviewed by CMS surveyors regarding examples of inappropriate restraint, Napa's Clinical Director stated, "[m]aybe our system is not working." Examples of inappropriate uses of seclusion or restraint include:

- A patient identified in a February 2005 CMS survey was secluded for 30 hours, during which time staff's recorded observations included: "appears sleeping," "eating," "drinking," "eyes open staring in space," and "not responding." These behaviors do not reflect violence requiring seclusion, and there was no evidence that the patient was released during these times to see if she could control her behavior without being secluded. On a second occasion, the same patient was secluded for 36 hours, with the following release criteria: "when client is able to make eye contact to staff with relaxed muscle tone." During this second episode of seclusion, the patient was observed as "not responding to staff," and "covering self with blanket, mute," behaviors not indicative of violence requiring seclusion.

- The February 2005 CMS survey also identified a patient who was admitted while under restraint and continued in restraints for more than 48 hours. Documentation shows that restraint was continued based on past behaviors; current behaviors noted in the documentation clearly did not justify restraint, including "demanding, whining," "eating dinner," "staring at wall," and "eyes closed."

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injections." It appears that Napa's actual use of emergency medications, including any delivered via methods other than intramuscular injection, is higher.

- Another patient identified in the February 2005 CMS survey was "walking wrist to waist restrained" for 50 hours based on a physician order stating, "[w]alking wrist to waist restraints when out of his own room. No release criteria other than being release criteria [sic] in his own room." The Medical Director, when questioned by CMS whether this use of restraints was justified based on an immediate threat of violence, stated, "I think it is less restrictive to allow the patient out in the milieu in these restraints, rather than having to stay in his room."

- Another patient was restrained on 20 occasions between August 2nd and September 21, 2004, for a total of 920.4 hours, or 75% of her hospital time during this period. One episode was for 369 consecutive hours.

- Another patient, who had Down syndrome and whose primary language was not English, was observed by CMS surveyors in three-point restraints on September 20, 2004. Records showed he had been restrained in three or five-point restraints since admission three days earlier. None of the information in his charts suggested any justification for use of restraints.

- PRNs are used inappropriately, and as a substitute for sufficient staff supervision and therapeutic interventions. For example, a patient who pushed away a peer in self defense when the peer assaulted her was given a PRN for her own "aggression." Generally accepted practices and federal regulations, 42 C.F.R. § 482.13, prohibit use of restraints (including medications) unless the person poses an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been considered and/or exhausted.

Previous CMS surveys confirm that Napa's misuse of restraints and seclusion is a serious and long-standing problem:

- On February 2, 2001, a patient died while in three-point prone restraints in a seclusion room. The patient was restrained on his stomach and choked to death while eating. The patient's chart reflects that he was at increased risk of positional asphyxia because he suffered from hypertension, obesity, and Huntington's disease. Inexplicably, this patient was served a meal in this position and was monitored only by an audio/video monitor that showed the back of his head.

- In three of three records reviewed by CMS in August 2001, restraints were used without having been approved in the patients' plans of care. A supervisor interviewed by CMS was unaware of accepted professional standards requiring that patients subject to restraint have plans of care expressly addressing the restraints used, including assessments addressing the need for restraints, appropriate interventions based on those assessments, evaluation of the effectiveness of the interventions, and re-intervention as warranted.

Multiple independent sources have alleged that staff at Napa goad patients into behaviors that are then punished with restraint or seclusion. More particularly, staff frequently provoke patients into verbal confrontations to justify placing the patients in seclusion. If a patient resists being placed in seclusion, the patient is then restrained. Because the State has denied us access to the facility to investigate these allegations, we are compelled to conclude that they are accurate.

5. Failure to Control Environmental Hazards

In a facility serving people at risk of harming themselves or others, the environment should be kept free of hazards. Napa has failed to meet this generally accepted professional standard of care.

Examples of Napa's breakdown in environmental protections include the prevalence of appurtenances and other fixtures upon which patients tie off to commit suicide; jagged and broken wall tiles; and highly unsanitary bathroom areas. CMS, in fact, has determined that staff takes no action, or completely ineffective action, to prevent patients from soiling common areas with human waste. Exposure to others' wastes is a health hazard.

B. MEDICAL, NURSING, AND PSYCHIATRIC CARE

1. Deficiencies in Preventative, Routine, and Emergency Medical, Nursing, Dental, and Psychiatric Care

The State is required to provide adequate medical care to patients, including adequate nursing care. Youngberg, 457 U.S. at 315, 322. We find that Napa does not provide adequate medical and nursing care to patients. Regulatory agency surveys from 2001 to as recently as February 2005 indicate persistent

deficiencies in medical and nursing care: nursing care is not provided to all patients who need it; registered nurses do not consistently supervise and evaluate the nursing care of each patient; the nursing staff does not consistently develop a nursing care plan for each patient; staff fail to ensure the proper implementation of patients' care plans; care plans are inadequate and outdated; dental care is inadequate; documentation and reporting of treatment and symptoms is inadequate; and medications are not consistently administered properly. In addition, medical care -- including psychiatric assessments -- is not consistently timely, responsive, or accurate.

Lapses in medical and nursing care can, and have had, fatal consequences for Napa patients. In February 2005, patient B.X. complained of breathing problems. Although he used a nebulizer for a history of breathing problems, his complaints were not addressed by staff. He died sitting in his room and was discovered by a peer. Because the State has denied us access to the facility and its records in our investigation, we conclude that staff's inattention to this patient's serious medical complaint was a cause of his death.

The following additional examples illustrate many systemic medical, nursing, and psychiatric service deficiencies and demonstrate Napa's substantial departure from generally accepted professional standard of care in these critical areas:

- In May 2005, a patient who suffered a seizure while in the cafeteria choked to death. In an inpatient hospital setting, it is difficult to imagine why there was no staff person with sufficient training available to avert a death by choking.

- In March 2005, a patient waited more than 48 hours for an x-ray and treatment for a broken arm.

- In November 2004, the State's own surveyors cited Napa for deficient nursing care involving a client with a history of suicide attempts. After being notified of the client's expressed plan to harm himself, nursing failed to assess, develop a nursing care plan, or even document the incident. Five days later, the client attempted suicide.

- A court-appointed psychologist testified that a forensic patient recommended by Napa's staff for conditional release had been given the wrong psychiatric diagnosis and no

treatment for psychiatric conditions directly affecting his suitability for release.

- In 2003, a patient was forced to wait at least seven months for surgical repair of his broken hip.

- In November 2002, staff failed to observe whether or not patients take their medications, even when care plans required observation. The State's own surveyors reported that, on November 19, 2002, two individuals walked away after they had received their medication without staff members observing whether they had taken the medication, including one individual who had admitted to selling his medications to other patients. Staff members observed by DHS on November 20, 2002, failed to crush and dissolve medication for certain patients, as had been ordered by the physician to ensure that patients were taking their medications.

- According to DHS observations in November 2002, staff failed to record the administration of medication in a timely manner, resulting in the potential for medication error due to the lack of communication of medication administration to other medication-administering nurses on the unit.

- On August 5, 2002, a patient attempted to commit suicide by taking an overdose of approximately 3000 milligrams of medication, when he was prescribed no more than 310 milligrams of medication per day.

- Based on its November 2002 review of records, the State's own surveyors reported that several patients failed to receive critical dental treatment, despite poor dental health, including patients who had cavities, had lost several teeth prior to admission, or who were likely candidates for extractions.

- A review by the State's own surveyors of a sample of patient records dated July through October 2002, indicated that many patients had been prescribed numerous psychotropic medications that have adverse interactions, yet there was no follow-up to review or record these adverse effects.

- Napa records dated September 30, 2002, indicated that one patient was prescribed multiple psychoactive medications and doses of medication above the recommended maximum doses without any apparent justification. He received 2700 mg a

day of an anticonvulsant while the maximum recommended dose is 1800 mg a day; 700 mg a day of another anticonvulsant while the recommended maximum dose is 500 mg; 20 mg a day of an antipsychotic compared to the usual dosage range of 10 mg a day; and 10 mg a day of another antipsychotic with a maximum effective dose of 4-6 mg a day. In addition, the patient received daily doses of an anti-depressant, an anti-anxiety and anticonvulsant medication, and another anticonvulsant. These medications have numerous adverse effects and cumulative drug interactions, including agitation, insomnia, nervousness, hostility, dizziness, objectionable behaviors, movement disorders, anxiety, gait disturbances, lack of coordination, irritability, restlessness, and slurred speech. Records for this patient demonstrated the presence of seizures, falls, hostility, aggression, agitation, insomnia, restlessness, and unpredictable and objectionable behaviors. There was no evidence of a system for recording symptoms in a way that would allow the treatment team to differentiate between the patient's symptoms of mental illness and symptoms of adverse effects of medication.

- On the skilled nursing facility unit, staff have refused to assist patients to the restroom, forcing patients to spend up to 12 hours in soiled diapers. Staff have taken up to two hours to respond to patients' call lights, and bathed patients as infrequently as once every two to four weeks. Observers reported "a strong stench of urine and feces on the unit."

2. Deficiencies in Provision of Occupational and Physical Therapy and Dietary Supports and Services

The care provided at Napa to patients whose needs include occupational or physical therapy departs substantially from generally accepted professional standards. Napa also consistently fails to provide adequate nutritional services, a substantial departure from professionally accepted standards that may cause serious health problems. For example:

- In a February 2005 survey, CMS identified two patients who required equipment such as portable oxygen and/or wheelchairs to attend programming; staff neither encouraged nor assisted the patients to use this equipment to attend programming but, instead, left the patients in bed in their rooms.

- In November 2002, at least six patients' records were missing observation data and information relevant to necessary dietary supports and services.

- In October 2002, CMS observed Napa staff incorrectly administer gastrosomy tube feedings for five of six patients, and observed a patient with a care plan that included swallowing precautions being fed by staff that was not trained and not familiar with the patient's plan.

The failure to provide physical, occupational, and nutritional supports and services to Napa patients may result in a loss of mobility and independence, and can also lead to preventable medical complications.

C. PSYCHOLOGY AND TREATMENT PLANNING

The State must also provide persons committed to psychiatric hospitals for an indefinite term with mental health treatment that gives them a realistic opportunity to be cured and released. Oregon Advocacy Ctr. v. Mink, 322 F.3d 1101, 1121 (9th Cir. 2003) (citing Ohlinger v. Watson, 652 F.2d 775, 779 (9th Cir. 1980); Sharp v. Weston, 233 F.3d 1166, 1172 (9th Cir. 2000) (same). Multiple independent sources, including regulatory agencies, independent professionals, patients, and patient advocates, inform us that Napa fails to provide adequate treatment planning, and in particular, fails to plan adequately to address patients' assaultive and self-abusive behaviors. In addition to the many examples of Napa's failure to address assaultive and suicidal behavior, discussed at §§ II.A.1 and 2, above, examples of failures to treat include:

- Napa failed to provide a current psychiatric assessment for patient M.E. since sometime before February 2004; this patient committed suicide on March 20, 2005. CMS identified additional patients without timely psychiatric evaluations, including one who had not been evaluated more than six months after admission, and another who had no psychiatric evaluation for more than two years.

- Napa failed to intervene to address escalating violence by patient Q.R., including an assault on a peer that caused injury requiring stitches, despite pleas from Q.R.'s family members to his treatment team.

- Recent CMS surveys confirm that Napa fails to provide structured therapies based on patients' treatment needs; fails to develop and document interventions based on patients' presenting needs; and fails to develop interventions to be provided by a physician.

- Staff do not encourage patients to attend their few scheduled treatment groups, and staff actions often disrupt those groups. One patient was left asleep in her bed at the time of her scheduled treatment group with no staff encouraging her to participate.

- Napa fails to provide adequate interpretative services to enable non-English-speaking patients to understand their treatment. One Vietnamese patient was observed to mumble and sing throughout his ward's community meeting, during which he was frequently "shushed" by the interpreter. When interviewed following the meeting, the patient stated he did not understand what had occurred. A second Vietnamese patient was not evaluated for suicide risk for more than six months because no interpreter was available.

- A court-appointed psychologist testified that Napa staff failed to address a patient's history of violent assault and inappropriate relationships with women, including Napa staff members. Notwithstanding this failure to treat, Napa's doctors recommended that this forensic patient be conditionally released to the community, which the court-appointed expert described as a complete lapse in professional judgment.

- The State's regulatory agency reviewed patient records in late 2002 and concluded that Napa fails to assess and plan interventions for those patients with a history of assaultive behavior until after those patients have assaulted someone at the facility.

D. DISCHARGE PLANNING AND PLACEMENT IN THE MOST INTEGRATED SETTING

Napa fails to comply with the requirement of the ADA and its implementing regulations that patients be placed in the most integrated, appropriate setting consistent with the patient's needs and the terms of any court-ordered confinement. See Americans with Disabilities Act, 42 U.S.C. § 12131, which states:

> no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

See also ADA implementing regulations, 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"); Olmstead v. L.C., 527 U.S. 581 (1999); President George W. Bush's New Freedom Initiative, "Community-Based Alternatives for Individuals with Disabilities," Exec. Order No. 13217, 66 Fed. Reg. 33155 (June 18, 2001)(the President emphasized that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, that the United States is committed to community-based alternatives for individuals with disabilities, and that the United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community for Americans with disabilities).

We have received credible allegations that patients who seek to be discharged into community placements are retaliated against by Napa staff. According to a patient's family member, a patient was placed on psychotropic medication in late 2002 in retaliation for writing letters to the court requesting a discharge hearing. The prescribing doctor reportedly told him that he would not stop giving him the medication until he stopped writing the letters. Another patient alleged that she was retaliated against for hiring an attorney to seek her release. She alleged that she received excessive dosages of medication and was awakened every 30 minutes at night to deprive her of sleep, until she stopped seeking her release. Two other sources stated that patients were given large doses of psychotropic drugs before any court appearance to inhibit their release from Napa. In addition, in November 2001, a staff member alleged that when patients were ready for discharge, supervisors instructed the medical staff to alter notations in patients' records to indicate that patients were not ready to be discharged.

Napa also fails to provide sufficient substance abuse programs to meet patient needs, even though these are a prerequisite to participation in the "conditional release"

program.[9] A patient's failure to complete the program leads Napa to file a petition for an extension of time of commitment. Finally, multiple credible sources state that patients receive little or no treatment or interventions to prepare them for discharge; discharge planning for patients is essentially "do it yourself."

III. MINIMUM REMEDIAL MEASURES

Because the State has denied us timely access to Napa, we are not able to provide remedial measures with the same specificity as we provided in our letters dated May 21, 2003 and February 19, 2004, regarding Metropolitan State Hospital. However, because the deficiencies at Napa generally mirror the deficiencies at Metropolitan, the specific remedies outlined in the letters regarding Metropolitan are illustrative of those that should be implemented at Napa. To remedy the deficiencies discussed above and to protect the constitutional and federal statutory rights of the patients at Napa, the State should, at a minimum, promptly implement the remedial measures set forth below.

A. Protection From Harm

1. To remedy deficiencies that result in excessive patient-on-patient assaults, patient suicides, and trafficking in contraband, including illegal street drugs, the State must:

    a. Ensure that Napa provide its patients with adequate, integrated treatment planning consistent with generally accepted professional standards of care. In particular, Napa should:

        (1) Develop and implement policies and procedures regarding the development of treatment plans consistent with generally accepted standards of care.

        (2) Revise treatment plans as appropriate, based on significant developments in patients' conditions, including patients' progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables.

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[9] In California, conditional release is similar to parole for forensic patients.

b. Ensure Napa provides its patients with accurate, complete, and timely assessments, consistent with generally accepted professional standards of care; these assessments should drive treatment interventions.

c. Ensure that Napa reviews, revises, as appropriate, and implements comprehensive, consistent incident management policies and procedures consistent with generally accepted professional standards. At a minimum, revised policies and procedures shall provide clear guidance regarding reporting requirements and the categorization of incidents, and address investigation of all serious incidents.

d. Ensure that Napa develops and implements a comprehensive quality improvement system consistent with generally accepted professional standards of care.

2. To remedy deficiencies that result in excessive and inappropriate use of seclusion, restraint and PRN medications, the State must:

a. Ensure that seclusion, restraints, and PRN psychotropic medications are used at Napa in accordance with generally accepted professional standards of care.

b. Ensure that restraints, seclusion, and PRN medications are used in a reliably-documented manner and only when persons pose an immediate safety threat to themselves or others, after a hierarchy of less restrictive measures has been considered and/or exhausted, and are terminated once the person is no longer an imminent danger to himself or others.

c. Ensure that seclusion, restraints and PRN medications are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff.

d. Ensure that the patient's treatment team, in a clinically-justifiable manner, timely reviews the use of such interventions, and determines whether to modify the patient's treatment plan, and implements the revised plan, as appropriate.

3. To remedy deficiencies that result in an unsafe physical environment, the State must:

a. Ensure that Napa provides its patients with a safe and humane environment and protect them from harm. At a minimum, Napa shall conduct a thorough review of all units to identify any potential environmental safety hazards and develop and implement a plan to remedy any identified issues.

B. Medical, Nursing, Dental and Psychiatric Care

1. Napa should provide adequate preventative, routine, specialized, and emergency medical services on a timely basis, in accordance with generally accepted professional standards of care.

2. Napa should provide nursing and unit-based services to its patients consistent with generally accepted professional standards of care. Such services should result in Napa's patients receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans.

3. Napa should provide adequate psychiatric supports and services for the treatment of the severely and persistently mentally ill population of adults that it serves in accordance with generally accepted professional standards of care. At a minimum, the State must ensure that:

   a. Napa develops diagnostic practices, guided by current, generally accepted professional criteria, for reliably reaching the most accurate psychiatric diagnoses for each patient.

   b. Napa reviews and revises, as appropriate, psychiatric assessments of all patients, providing clinically justifiable current diagnoses for each patient; modifies treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs; and ensures that each patient's psychiatric assessments, diagnoses, and medications are collectively justified in a generally accepted professional manner.

   c. Napa's patients receive pharmacy services consistent with generally accepted professional standards of care.

4. Napa should provide its patients with routine and emergency dental care and treatment on a timely basis, consistent with generally accepted professional standards of care.

5. Napa should implement adequate infection control procedures to prevent the spread of infections or communicable diseases.

6. Napa should provide its patients with physical and occupational therapy consistent with generally accepted professional standards of care.

7. Napa should ensure that its patients receive adequate dietary services, consistent with generally accepted professional standards of care.

C. Psychology and Treatment Planning

1. Napa should provide psychological supports and services adequate to treat the functional and behavioral needs of its adult patients according to generally accepted professional standards of care.

D. Discharge Planning and Placement in the Most Integrated Setting

1. Within the limitations of court-imposed confinement, the State should pursue actively the appropriate discharge of patients and ensure that they are provided services in the most integrated, appropriate setting that is consistent with patients' needs.

I invite the State to discuss with us the remedial recommendations, with the goal of remedying the identified deficiencies without resort to litigation. In the event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to institute a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will contact your attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please

call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

Bradley J. Schlozman
Acting Assistant Attorney General

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Child Support
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Community Services
and Development

Developmental
Services

Emergency Medical
Services Authority

Health Services

Managed Risk
Medical Insurance Board

Mental Health

Rehabilitation

Social Services

Statewide Health
Planning and
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August 8, 2005

Bradley J. Schlozman
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RE: Response to the United States Department of Justice Findings Letter regarding Napa State Hospital pursuant to the Civil Rights of Institutionalized Persons Act "CRIPA"), 42 U.S.C. § 1997

Dear Mr. Schlozman:

The California Health and Human Services Agency, the California Department of Mental Health, and Napa State Hospital (hereafter referred to collectively as the Department) have reviewed the United States Department of Justice (USDOJ) findings letter dated June 27, 2005. We believe that your findings result in part from a misunderstanding between the Department and the USDOJ about the intention of the Department to facilitate an inspection of the Napa facility. We would like to assure you of our intention to collaborate with the USDOJ to provide the level of services we agree is necessary, as well as clarify our position regarding facility access and propose further cooperative meetings in order to reach an accord.

Not only is the Department firmly committed to cooperating with the USDOJ Civil Rights of Institutionalized Persons Act (CRIPA) investigations and to enhancing the services at the state hospitals, we have demonstrated this intent by our response to the investigation of Metropolitan State Hospital (Metropolitan). In the Metropolitan investigation, the USDOJ itself has noted our cooperation, and the Department has welcomed a dialogue addressing areas that the USDOJ identifies as requiring enhancement. Subsequent to the Metropolitan findings, the Department has not only begun introducing enhancements at Metropolitan, even without a finalized agreement, but we have also begun introducing additional enhancements in the operations of the other three operating state hospitals (Napa, Patton, and Atascadero). As we have stated numerous times, we are committed to the best interest of the patients, the community, and the hospitals.

It was never our intent to prevent the USDOJ from inspecting the Napa facility. Unfortunately, the fact that many different investigations were going on or being announced at the same time complicated communication on this matter. Our statement, made late in 2004 and again in June 2005, that we did not believe access to the Napa facility would be possible before 2006, was not meant to be unreasonable or untimely. Indeed, we believe the timing problems are apparent from the overlapping communications:

- In March 2002, the USDOJ announced the Metropolitan investigation and issued findings in the children and adolescent programs in May 2003 and in the adult program investigation in February 2004. The Department immediately began cooperating with the USDOJ to make enhancements and has worked steadily on those enhancements.
- In January 2004, the USDOJ announced the Napa investigation to the Department, in April 2004 the Patton investigation was announced, and in February 2005 the Atascadero investigation was announced.
- In March 2004, I requested additional time prior to having an on-site inspection of Napa in order to complete and implement the enhancements being made in the wake of the Metropolitan investigation. In June 2004, I requested the Department be allowed to complete its response to the first investigations (at Metropolitan) prior to allocating its scarce resources to more investigations. In August 2004, USDOJ offered to discuss options to limit disruptions by "investigatory tours." In October 2004, I accepted USDOJ's offer to negotiate all of the investigations announced.
- In December 2004 and February 2005, the USDOJ presented a remediation plan and a proposed court order concerning Metropolitan. In March 2005, USDOJ and the Department met for a conference to discuss the enhancements to the Metropolitan program and the potential of incorporating those enhancements at all other state hospital (Napa, Patton, and Atascadero) programs.
- In May 2005, the attorney handling this matter for the Department passed away unexpectedly.

The Department understood that the process was moving forward at a pace dictated by the USDOJ's investigation and that both the Department and USDOJ had similar perspectives about the importance of the enhancements that were being put in place at Napa. By the time we received your Napa report, the time period we suggested for the inspection was less than five months away.

Some of the extenuating circumstances that made it difficult to allow access sooner were the October-November 2005 JCAHO accreditation committee inspection that comes every three years to accredit the hospitals, the staff shortages created by the trainings underway to institute the enhancements, the September 2005 opening of a new state hospital, our first new hospital in over 50 years, and the volume of work associated with the USDOJ inspections (at Metropolitan, staff produced a total of 259,911 copies for the USDOJ, eighty-three 12" X 11" X 16" boxes of documents, and tens of thousands of worker hours were consumed during the inspection and producing the documents).

Due to these issues, we requested to work together and schedule an inspection in 2006 that would not disrupt the facility or pose nearly impossible work schedules for staff, and would allow you to note the enhancements we had informed you we were making. We believed this was in both parties', as well as our patients', best interest.

At this point, we also continue to seek a reasonable schedule for the access at Atascadero and Patton. In the Department's July 18, 2005 phone conference with Benjamin Tayloe of your office, he suggested that August and September of 2005 are the only viable dates for those inspections. We are willing to provide access on those dates for an abbreviated tour if no more reasonable times can be found, although we are still facing the same timing issues we mentioned earlier.

Additionally, in response to the specific issues raised in your letter, we would like to first assure you that the Department has already begun instituting enhancements to the treatment approach that emphasizes recovery through individualized treatment, empowerment, and self-determination, as the USDOJ agrees is the right direction. However, we must be clear that the Department's willingness to engage in a dialogue and enhance programs does not mean that the Department agrees with all of the findings and conclusions in the June 27, 2005 letter. While we consider all of the issues addressed in your findings letter to be important ones, we note that the enhancements the Department has already made are not acknowledged in your assessment. For instance, in the last 6 months, Napa State Hospital has made significant improvement in the area of seclusion and restraint, reducing the number of seclusion and restraint hours for all patients on the acute units by 93% and hospital wide by 89%. This has meant that although patients at the hospital spent over 8100 hours in seclusion in September 2004, that time was reduced to 897.1 hours by May 2005. There are also several factual errors that we can address at further length in the meetings currently being scheduled.

The Department is committed to working with USDOJ to address the concerns that has been raised. As we discussed, the untimely death of our lead attorney on this case has seriously hampered our continuity. Cynthia Rodriguez, Chief Counsel of the Department, will be following up with you to schedule a time convenient for all parties to further discuss this matter. The Department has already scheduled a meeting on August 9, 2005 to further discuss a remediation plan for Metropolitan State Hospital. We are negotiating a meeting for later in August to discuss the global issues that your investigations have raised and possible resolutions. We have proposed and are considering several resolutions, and the Department looks forward to working with the USDOJ to resolve this matter and continue with the Department's mission to serve the patients at Napa State Hospital.

Sincerely,

Kim Belshé

KIMBERLY BELSHÉ
Secretary

1600 Ninth Street · Room 460 · Sacramento, CA 95814 · Telephone (916) 654-3454 · Fax (916) 654-3343

U.S. Department of Justice

Civil Rights Division

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DJ 168-11-44

Special Litigation Section - PHB
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

August 17, 2005

BY FACSIMILE AND FIRST CLASS MAIL

Ms. S. Kimberly Belshé
Secretary
Health and Human Services Agency
State of California
1600 Ninth Street
Room 460
Sacramento, CA 95814

Re: Napa State Hospital: Napa, California

Dear Secretary Belshé:

Thank you for your letter of August 8, 2005 to Bradley J. Schlozman setting forth the response of the California Health and Human Services Agency, the California Department of Mental Health ("DMH"), and Napa State Hospital (collectively, the "State") to our June 27, 2005 findings letter regarding Napa State Hospital. Your letter was directed to me, and I apologize for any delay in our response.

We appreciate your leadership and are pleased that the parties appear to be moving towards a resolution of this matter as well as our investigations of Metropolitan, Patton, and Atascadero State Hospitals. We believe that working in a collaborative fashion serves the interests of the State, the United States Department of Justice, and, most importantly, the patients at California's state hospitals. To that end, our office has been in regular contact with Cynthia Rodriguez, Chief Counsel for DMH, and will continue to be available to discuss this matter with her.

Again, we appreciate the State's willingness to be an active and cooperative partner in addressing conditions at its state hospitals. If you have any questions, please do not hesitate to contact me at 202-514-0195.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section