U.S. Department of Justice

Civil Rights Division

Special Litigation Section - PHB
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

May 2, 2006

The Honorable Arnold Schwarzenegger
Governor of California
State Capitol Building
Sacramento, CA 95814

Re: Atascadero State Hospital, Atascadero, California

Dear Governor Schwarzenegger:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at Atascadero State Hospital ("ASH"), in Atascadero, California. On February 16, 2005, we notified you that we were investigating conditions at ASH pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek remedies for any pattern and practice of conduct that violates the constitutional or federal rights of persons with mental illness who are served in public institutions.

During the week of November 28, 2005, we conducted an on-site inspection of ASH. We reviewed a wide variety of relevant State and facility documents, including policies, procedures, and medical and other records relating to the care and treatment of patients. During our visit, we also interviewed ASH administrators, professionals, and staff, and talked to and observed patients in their living units, at activity areas, and during treatment meetings. We were assisted by expert consultants in the fields of psychiatry, psychology, medical care, and quality assurance and risk management. In keeping with our pledge of transparency and to provide technical assistance where appropriate regarding our investigatory findings, we conveyed our preliminary findings to State counsel and to certain State and facility administrators and staff during verbal exit presentations at the close of our on-site visit.

As a threshold matter, we commend the administrators and staff of ASH for their helpful and professional conduct

throughout the course of the investigation. In particular, facility personnel cooperated fully and expeditiously with our document requests. We hope to continue to work with the State of California and officials at ASH in a cooperative manner.

At the time of our November 2005 visit, ASH had a census of approximately 1,350 patients. ASH provides forensic psychiatric services to these patients admitted under a variety of State statutes. 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 generally Youngberg v. Romeo, 457 U.S. 307 (1982). Determining whether treatment is adequate focuses on whether institutional conditions substantially depart from generally accepted professional judgment, practices, or standards. Youngberg, 457 U.S. at 323; Sharp v. Weston, 233 F.3d 1166, 1171-72 (9th Cir. 2000). The State also must 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) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."); see generally Olmstead v. L.C., 527 U.S. 581 (1999). Additionally, the State must 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 Center v. Mink, 322 F.3d 1101, 1121 (9th Cir. 2003) (citing Sharp, 233 F.3d at 1172).

It was apparent that many ASH staff are highly dedicated individuals who are genuinely concerned for the well-being of the persons in their care. Nevertheless, there are significant and wide-ranging deficiencies in patient care provided at ASH. Indeed, conditions of care and treatment at ASH in psychiatry, including pharmaceutical services; psychology; medical care, including general medical services, infection control, physical and occupational therapy, dietary and dental care, nursing services, placement in the most integrated setting; and protection from harm and quality assurance, are materially similar to those outlined in the Metropolitan findings letters of 2003 and 2004. Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified.

I. PSYCHIATRY

ASH's psychiatric supports and services substantially depart from generally accepted professional standards of care and expose patients to a significant risk of harm and to actual harm. Generally, our investigation uncovered problems in three main areas: assessments, treatment planning, and medication management.

In many respects, psychiatric assessments are the main vehicles establishing the patients' diagnoses, establishing safe and effective treatment, and providing direction for treatment planning. We found ASH provides timely initial assessments. These initial assessments, however, are cursory and not individualized. These cursory assessments fail to provide the basis for a valid and reliable diagnosis and for distinguishing accurately among disorders with similar presentations. For example, ASH lists too many patients with an ambiguous "not otherwise specified" diagnosis, and fails to document further follow up testing.

Ongoing assessments are likewise inadequate. These assessments are crisis driven, rather than treatment driven. ASH generally fails to documents risks, benefits, and rationales for prescribed medication regimens and universally fails to review the use of medications prescribed on an as needed ("PRN") basis. Assessments generally fail to track risk factors, assess contributing factors, and provide timely supports and interventions to minimize the risk.

Overall, ASH fails to provide clinically justified assessments and diagnoses of psychiatric disorders and fails to provide adequate social history, court, and rehabilitative assessments. As a result, patients' actual illnesses are not being properly treated and are permitted to progress, 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.

Beyond assessments, ASH fails to provide adequate and appropriate treatment planning. Generally accepted professional standards of care instruct that treatment plans should dictate appropriate clinical interventions by integrating the individual assessments, evaluations, and diagnoses of the patient performed by all disciplines involved in the patient's treatment. Treatment plans should be individualized and should identify and build on the patient's strengths, interests, preferences, and

goals, to optimize the patient's recovery and ability to sustain himself in the most integrated, appropriate setting.

Like assessments, treatment plans are cursory, generic, and not integrated. Rather than an integrated interdisciplinary input model, ASH currently employs an ineffective symptom reduction model. Treatment plans are static, and rarely modified in response to the progress of the patients. Treatment plans fail to provide meaningful targets for rehabilitation and for measurable outcomes. Despite many patients with cognitive disorders, ASH fails to provide cognitive remediation groups. ASH's focus on symptom reduction ignores the impairments that contribute to a perpetual cycle of chronic disability and repeated hospitalizations.

ASH is working toward using a collaborative interdisciplinary input model with meaningful outcome-oriented objectives and interventions. Yet, ASH's move to the interdisciplinary model has significant problems. Interdisciplinary teams lack a psychologist, causing a failure to provide the appropriate behavioral interventions for vast numbers of patents. Because of a lack of competent leadership, interdisciplinary teams spend most of their time assessing rather than planning treatment. Contrary to generally accepted professional standards of care, ASH fails to base its treatment planning on a comprehensive case formulation that provides a functional bridge between assessments and the treatment plan.

ASH's medication management substantially deviates from generally accepted professional standards. ASH fails to prescribe clinically justified psychotropic medications, and to assess the side effects of medications appropriately. We found that ASH does not timely modify medications, even when medications appear to cause harm, and alternatives exist. A review of patients' treatment plans shows that ASH does not integrate medication management with treatment plans. ASH medication management also suffers from a fractured review, with the pharmacy and psychiatry staff reviewing medications separately.

The harm to these patients caused by these deficiencies in psychiatric care takes many forms, among them, inadequate, ineffective, and counterproductive treatment; exposure to inappropriate and unnecessary medications, including PRN medications, posing serious physiological and other side effects; excessively long hospitalizations, which compound psychiatric distress; increased risk of relapse after discharge; and an overall lower quality of life.

II. PSYCHOLOGY

ASH's psychological services and behavioral interventions substantially depart from generally accepted professional standards of care and expose patients to significant risk of harm and to actual harm. Generally, our investigation uncovered an operational failure in symptom/behavioral management, and psychosocial rehabilitation/recovery.

Assessments use boilerplate language, are not individualized, and are infrequently updated. Further, ASH provides insufficient, inappropriate psychological interventions. In fact, treatment plans are generic and unresponsive to individual problems, rendering them of little use. In addition, the provided psychological interventions are provided only infrequently and are of poor quality. Not surprisingly, there is scant participation in group and individual therapy.

ASH's behavior management system substantially departs from generally accepted professional standards. To develop an effective behavior program, generally accepted professional practice requires that psychology staff identify the underlying factors that precipitate or cause the patient's maladaptive behavior (i.e., the "function" of the behavior) through an individualized, formal functional assessment. Notwithstanding an extensive need for behavioral interventions among its patients, ASH employs few behavioral plans and interventions, none of which it individualizes. Behavioral supports are prepared without an adequate functional analysis or assessment of undesirable behaviors. Behavioral plans are internally inconsistent, lack a reliable method to insure integrity of implementation, and lack

criteria for revision or termination. Not surprisingly, we could uncover no evidence that these generic behavior plans actually modify targeted behaviors.

Rehabilitative therapy is limited to activities that do not constitute actual treatment and rehabilitation but rather is essentially diversionary, such as playing "bingo". Again, therapy plans are not individualized, resulting in inadequate group and individual therapy services.

ASH staff frequently use PRN medications and/or restrictive practices in the absence of adequate treatment and/or as

restrictive interventions as standard practice, without attempting to employ less restrictive alternatives. According to

medications should only be used for psychiatric purposes as a short-term measure. ASH staff, however, repeatedly employ PRN medications, without adequate review, as a substitute for treatment of the patient's underlying condition.

The harm to the patients caused by these deficiencies in psychological supports and services takes many forms, among them,

unnecessarily extending their stay in a highly restrictive setting; subjecting them to excessive and unnecessary use of seclusion, restraints, or sedating medications; fostering despair and hopelessness; and, in some cases, depriving them of physical safety.

III. PHARMACY

ASH's pharmacy services substantially depart from generally accepted professional standards of care, exposing to significant actual and potential harm. Pharmacists fail to adequately review individual patients' medication regimens, fail to adequately evaluate drug use at the facility, and fail to identify problematic medication practices.

As part of integrated treatment, ASH pharmacists should attend and participate in treatment team meetings and planning. We found inadequate documentation of communication between the pharmacists and physicians regarding concerns, potential medication interactions, and the need for laboratory testing. Pharmacists also are inadequately involved in medical clinics. Furthermore, the Pharmacy and Therapeutic Committee fails to insure safe medication standards of practice.

By not providing adequate pharmacy services, ASH places its patients at risk for the misuse of medication, unnecessary side effects from medication, potential drug interactions, general health problems, and excessively long hospitalizations.

IV. GENERAL MEDICAL CARE

ASH's medical care substantially departs from generally accepted professional standards of care. ASH fails to provide its patients with appropriate and timely preventative, routine, specialized, and emergency services. Overall, medical care at ASH is reactive, and little attention is paid to identifying and responding to significant changes in patients' physical status, establishing target outcomes, and measuring the success of

interventions. ASH only addresses acute health issues, with little, to no, initiation of interventions focused on prevention.

ASH fails to provide adequate physical, occupational, and speech therapy assessments and services that permit persons evaluated for such services to regain, maintain, or improve functioning. A number of patients at ASH have significant needs, but have not been referred for physical, occupational, and speech therapy. Moreover, the physical, occupational, and speech therapy staff are not integrated into the treatment teams. Therefore, therapy interventions are not consistently implemented and reinforced by other staff throughout a patient's day. This deficient integration results in poor outcomes, even when patients are referred for such services.

ASH also fails to provide dietary and nutrition assessments and services that address comprehensively patients' weight and other dietary issues through, among other things, mealtime protocols, particularly for individuals at risk for aspiration.

Although the facility's dentist is enthusiastic, we found that ASH provides inadequate dental services, because dentists are not available for the provision of emergency care during nonbusiness hours. Consequently, patients needing emergency dental services have been required to wait days in significant pain before being treated. ASH also fails to provide adequate infection control that tracks and trends infections and communicable diseases in an institutional setting.

Although we found many dedicated staff, it was apparent that the medical and psychiatric departments limit the participation and input of other clinicians, to the detriment of patient care. In part because of a lack of integrated clinical participation, clinical decisions are being made without input from professionals possessing the necessary expertise.

By not providing adequate medical services, ASH exposes its patients to a significant risk of harm and actual harm due to the lack of timely, routine and preventative care, which causes patient health care to deteriorate, and results in a heightened need for more specialized and emergent care.

V. NURSING

ASH's nursing services substantially depart from generally accepted professional standards of care and treatment, and expose patients there to a significant risk of harm and actual

harm. In particular, nursing staff fail to adequately monitor and report changes in patients' status, and fail to document thorough and complete medical progress notes. Medication administration records show missed medications and show that nurses fail to consistently document the administration of medications. Unit staff fail to identify, monitor, and report patients' symptoms and side effects of medications. We found nurses often are unfamiliar with mental health diagnoses, associated symptoms, and appropriate treatments and interventions. Nurses often lack knowledge of their patients and do not effectively participate in the treatment team process. These substantial deviations from generally accepted professional standards of care place individuals at ASH at a significant risk of harm. The above problems are compounded by ASH's chronic shortage of nursing staff and prolonged mandatory use of overtime. They are also compounded by the fact that ASH does not fully utilize psychiatric nurse practitioners, who are not allowed to work up to the full scope of their licenses.

VI. PLACEMENT IN THE MOST INTEGRATED SETTING

Generally accepted professional standards of care and, as set forth above, federal law require that ASH actively pursue the timely discharge to the most integrated, appropriate setting that is consistent with patients' needs and the terms of any court-ordered confinement. In this regard, there have been unsuccessful placements, but the factors that contributed to these unsuccessful placements are poorly identified and addressed. ASH's discharge planning process fails to meet these standards of care. ASH fails to identify and address factors that contributed to previous unsuccessful placements. Consequently, the process results in unnecessarily extended hospitalizations, poor transitions, and a high likelihood of readmission, all of which result in harm to ASH's patients.

VII. PROTECTION FROM HARM

Generally accepted professional standards of practice call for an incident management system that reports incidents, investigates incidents, identifies areas of improvement, and tracks incidents to identify systemic improvement opportunities. ASH substantially departs from these professional standards by failing to maintain an effective incident management system and a related quality assurance system to prevent harmful incidents, and identify and correct deficiencies in care and treatment.

The quality of the investigations ASH completes is inadequate. ASH does not interview witnesses, but simply describes the incident in a report. No independent objective review exists, nor are areas of improvement identified. Frequently, ASH also takes months to resolve complaints.

All incidents should be investigated, and each investigation should result in a written report that includes a summary of the investigation, findings, and as appropriate, recommendations for corrective action/areas for improvements. Additionally, ASH does not have an organized, coherent, written quality improvement plan that defines the performance improvement priorities and objectives for the hospital.

Adverse environmental conditions, such as potential suicide hazards, are not adequately identified and prioritized for systematic corrective action. Finally, ASH fails to adequately address inappropriate sexual contact among individuals served at the facility, including sexual contact between staff and patients.

Consequently, ASH fails to protect its patients from avoidable harm. The harm that ASH patients experience as a result of these deficiencies is multifaceted, 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.

VIII. MINIMUM REMEDIAL MEASURES

The minimum remedial measures required to protect the constitutional and federal statutory rights of the patients at ASH are outlined below and more extensively detailed in the "Enhancement Plan," negotiated between the State and the Department:

A. Integrated Treatment Planning ASH should provide its patients with integrated treatment planning consistent with generally accepted professional standards of care.

B. Assessments ASH 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.

C. Psychiatry Services ASH should provide adequate psychiatric supports and services for the treatment of the severely and persistently mentally ill population it serves in accordance with generally accepted professional standards of care.

D. Psychology Services ASH should provide psychological supports and services adequate to treat the functional and behavioral needs of its patients according to generally accepted professional standards of care.

E. Restraints, Seclusion, and PRN Medications ASH should ensure that restraints, seclusion, and PRN medications are used in accordance with generally accepted professional standards of care.

F. Pharmacy ASH's patients should receive pharmacy services consistent with generally accepted professional standards of care.

G. General Medical Care ASH should provide adequate preventative, routine, specialized, and emergency medical services, occupational, physical, and speech therapy, and dental and dietary services, on a timely basis, in accordance with generally accepted professional standards of care.

H. Nursing Care ASH should provide nursing services to its patients consistent with generally accepted professional standards of care. Such services should result in ASH's patients receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans.

I. Documentation of Patient Progress ASH should ensure that patient records accurately reflect patient progress, consistent with generally accepted professional standards of care.

J. 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 the patients' needs.

K. Protection From Harm ASH should provide its patients with a safe and humane environment and protect them from harm.

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We hope to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns with regard to ASH. Provided that our cooperative relationship continues, 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 your efforts at prompt remediation.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, within 49 days after your receipt of this letter, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, to correct deficiencies of the kind identified in this letter. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you. Accordingly, we will soon contact State officials 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,

/s/ Wan J. Kim

Wan J. Kim
Assistant Attorney General

cc: The Honorable Bill Lockyer
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