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,

/s/ R. Alexander Acosta

R. Alexander Acosta
Assistant Attorney General

cc: The Honorable Bill Lockyer
Attorney General
State of California

Stephen W. Mayberg, Ph.D.
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California Department of Mental Health

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