

June 27, 2005

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

Re: Napa State Hospital, Napa, California

Dear Governor Schwarzenegger:

On January 6, 2004, we notified then-Governor Gray Davis of our intent to investigate conditions at Napa State Hospital ("Napa"), in Napa, California, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. I write now to provide the statutorily required findings of that investigation, the bases for those findings, and the minimum remedial measures that we believe are warranted to correct deficiencies contributing to conditions that violate the federal rights of individuals residing in this facility.

As a threshold matter, we note that State officials have declined to cooperate with this investigation. In particular, they repeatedly have refused to allow the Department access to the facility, most recently stating that access will not be provided before sometime in 2006. The State's conduct is unusual in this regard. Most government officials cooperate with CRIPA investigations because they recognize that protecting the rights of institutionalized citizens warrants a thorough and impartial review. Indeed, the State cooperated with the Department regarding a previous CRIPA investigation of Napa that was resolved via a consent decree in 1990.¹ The State also cooperated with our investigation of Metropolitan State Hospital in June and July 2002 ("Metropolitan"). Since then, however, the State has declined our requests for access to Napa and to the State's other mental health care facilities that we are investigating, Patton State Hospital and Atascadero State Hospital.²

¹ Consent Decree, United States v. California, No. C90-2641, (N.D. Cal. Sept. 17, 1990).

² In May 2005, the State did permit Department staff to interview certain Patton patients and has agreed to provide us

As we understand it, the State's position is that permitting the Department access to Napa, and its other facilities, before sometime next year would excessively divert limited resources at a time when the State is undertaking significant reforms. We attempted to address the State's concerns by offering to conduct a streamlined tour of Napa, and we reminded the State that we were committed to providing technical assistance during the tour and to working in a transparent manner. If the State had agreed to our proposed investigation procedures, State officials would have had an early opportunity to work directly with our experts and staff. They also would have had an opportunity to address any identified problems on a voluntary basis at an early stage of this investigation. Regrettably, the State has maintained its opposition to permitting the Department access.

As we repeatedly advised State officials, however, our investigations proceed regardless of whether officials choose to cooperate. Indeed, when CRIPA was enacted, lawmakers considered the possibility that local officials might not assist a federal investigation. Such non-cooperation is a factor that may be considered adversely when drawing conclusions about a facility. See H.R. CONF. REP. 96-897, at 12 (1980), reprinted in 1980 U.S.C.A.A.N. 832, 836. We now draw such an adverse conclusion.

The State's non-cooperation is only one factor that we have considered in preparing our statutorily-required findings and recommendations. We have also considered information from several recent on-site surveys conducted by the Centers for Medicaid and Medicare Services ("CMS") and by the State's Department of Health Services ("DHS"), and conducted interviews with professionals, advocates, family members of patients, and patients themselves. In doing so, we found evidence of significant and wide-ranging deficiencies in Napa's provision of care to its patients.

Tragically illustrative of the widespread and systemic deficiencies that currently exist at Napa is the case of patient Q.R.,³ who committed suicide by hanging in December 2004.

with requested portions of charts from patients who authorized us to obtain such records.

³ We use pseudo-initials to refer to individual patients, in order to protect their privacy.

Several months before his suicide, Q.R. attempted suicide (also by hanging), which staff told his family was an attention-getting behavior, and not a realistic threat. This patient's family was in frequent contact with his counselor at Napa, and conveyed to the counselor its concern that the patient's escalating episodes of violence were uncharacteristic and needed to be treated. On the day of Q.R.'s death, a family member who had just spoken with Q.R. phoned the nurses' station on his ward to warn that Q.R. was despondent, crying, and in need of attention. Despite this specific warning and the patient's history of suicide attempt, staff failed to act. Less than an hour later, Q.R. was discovered by a peer, hanging by a sheet in his room. Because the State denied us access to the facility to investigate these allegations, we have no reason not to conclude that the contentions are accurate, and that Napa's failure to intervene appropriately was a cause of this young man's death.

The preceding incident is emblematic of the systemic deficiencies at Napa. We have received overwhelming information that, following the dismissal of the consent decree in 1995, significant problems recurred at Napa, including: failure to protect patients from harm from assaults and suicide; inappropriate use of seclusion, restraint and PRN ("pro re nata" or "as-needed") psychotropic medications; and inadequate medical, nursing and psychiatric care. In addition, we have received information evidencing deficient treatment planning, programming, and nutritional management; unsanitary conditions; and failure to place patients in the most integrated setting as required by the Americans with Disabilities Act, 42 U.S.C. § 12132 et seq. ("ADA"), and the President's New Freedom Initiative, which prioritizes community-based alternatives for individuals with disabilities. See Exec. Order No. 13217, §§ 1(a)-(c), 66 Fed. Reg. 33155 (June 18, 2001). Our findings, the facts that support them, and the minimum remedial steps that we believe are necessary to correct deficiencies are set forth below.

I. BACKGROUND

Napa has been in operation since November 1875. It is situated on a 138-acre campus and houses almost 1,100 adult patients. These individuals are classified as "low to moderate risk" and are civilly committed or committed through criminal proceedings. In our previous investigation of Napa, we identified deficiencies in the facility's protections from harm, use of restraints, and provision of medical care, among other areas. These concerns were addressed in a consent decree that

was dismissed in 1995 based on the Department's assessment that Napa, at that time, was in substantial compliance with the decree's requirements.

II. FINDINGS

A. PROTECTION FROM HARM

Napa is constitutionally required to provide patients reasonable protection from harm and freedom from bodily restraint. Youngberg v. Romeo, 457 U.S. 307, 315-16 (1982). Information from multiple, credible sources leads us to conclude that Napa fails to protect patients from harm and abuse. We have determined that the harm suffered by Napa's patients is multi-faceted, including physical injury by assault; death by suicide due to inadequate suicide precautions; excessive and inappropriate use of physical and chemical restraints and seclusion; inadequate, ineffective, and counterproductive treatment; and exposure to unnecessary environmental hazards.

A major factor in Napa's failure to protect patients from harm is inadequate supervision. As DHS has reported, "[e]ven though clients in the facility can be extremely unpredictable and violent, they are left unsupervised for long periods of time." Family members of patients and advocates who frequently visit Napa confirm that patients are left unattended, without staff observation or interaction. A number of incidents occurred when medically required one-to-one staffing was cancelled, apparently not due to clinical decisions, but rather staff shortages. Moreover, as a nurse at Napa reported, "there are not enough people on hand to subdue [out-of-control patients].... So an alarm is set off or the hospital police are called. But it takes at least five minutes, sometimes 10 or more to get there, and a lot can happen during that time."

1. Patient-on-Patient Assaults

Napa patients suffer from repeated acts of aggression by peers, resulting in serious injuries, and in one case, a homicide. In egregious departures from accepted standards, staff often fail to intervene and/or fail to report the incidents. Staff likewise do not attempt to prevent repeated assaults by addressing the underlying behavior of the aggressors.

Many instances of inappropriate aggression in a psychiatric hospital such as Napa result from patients exhibiting symptoms of

their mental health disorders. Without the benefit of appropriate medication and therapeutic interventions, patients often lack the means to control such symptoms. Thus, inadequate mental health treatment exposes individuals to excessive levels of violence. Examples of failures to prevent known aggressors from repeated acts of serious aggression include:

- On May 3, 2002, a patient was strangled to death by his roommate. The roommate had previously been convicted of several violent crimes and had a history of attacking peers, including two attacks on sleeping patients. Reportedly, there are no bedrooms set aside to house separately patients who demonstrate the potential to harm others.
- Between January and June 2003, one patient assaulted other patients at least 20 times, including at least 17 incidents in which he punched or kicked other patients in the head or face. Staff were afraid of this patient and failed to intervene to protect other patients.
- In June 2002, a patient with a history of aggressive behavior attacked another patient in the TV room, punching him and stabbing him in the neck with a portable radio antenna. Staff failed to report the assault to the licensing authorities.
- On November 18, 2002, a patient who was ordered to be under constant observation by staff assaulted another patient. He previously had assaulted two patients on October 3, 2002, and one patient on September 18, 2002. In addition, an assessment dated September 3, 2002, indicated that he had "numerous recent assaults on peers."
- Two patients known to be "extremely assaultive" were placed in a bedroom together where they were not supervised for significant periods of time. On August 8, 2001, one patient attacked the other, punching him in the nose. The following day, that patient retaliated by choking his roommate until he passed out.

Patient advocates and patients themselves tell us that staff often fail to intervene with violent patients because the staff are afraid. Last fall, Napa's Clinical Administrator confirmed to CMS surveyors that "staff become fearful of patients who have been assaultive." Examples of staff failing to intervene include:

- On November 11, 2003, one patient stabbed another in the face and back with an 11-inch "shank" made from an antenna. Four days earlier, the victim had told staff that he feared that he would be attacked. The State's regulatory agency concluded that Napa had failed to investigate the source or nature of the threat identified by the victim, and it imposed a treble fine on the facility for its failure to protect the victim.
- On September 20, 2002, a 38-year-old woman suffered "great bodily injury" when she was beaten by three male patients. According to the woman, the other patients "kicked the shit out of me." Staff did not intervene, nor did staff report to Napa authorities the significant bruises and injuries to this client.⁴

2. Inadequate Suicide Precautions

Several Napa patients have committed suicide in recent years, often using the same method to do so:

- On March 20, 2005, Napa patient M.E. committed suicide by hanging himself in a locked bathroom.
- Napa patient Q.R. committed suicide by hanging in December 2004. Several months earlier, he had attempted suicide by hanging; notwithstanding his history, Napa staff failed to intervene or adequately supervise Q.R. when a family member called the nurses station on his unit the day of his death and informed staff that Q.R. was despondent and crying and in need of attention.
- On July 21, 2003, a man hanged himself from a door using a radio cord, on the same ward where another patient committed suicide only a month earlier.

⁴ The failure to report or investigate a serious incident is not uncommon at Napa, and is a substantial departure from accepted standards of care. Numerous sources described incidents to us, including this assault, inappropriate sexual contact between residents or staff and residents, and illegal drug use, which were not reported to and/or not investigated by Napa authorities.

- On June 3, 2003, a patient who had previously been reported as suicidal hanged himself using a bed sheet.
- On September 4, 2001, a patient committed suicide by hanging with a bed sheet in his ward.
- On July 16, 1999, a man known to be suicidal hanged himself with bedsheets tied to a light fixture.

In February 2005, CMS cited Napa for failing to complete the suicide assessment of a patient for more than six months after his admission. CMS found that Napa did not provide translation services to complete the suicide assessment of this patient, who could not communicate in English.

The State's own surveyors previously cited Napa for failing to identify and address current symptoms of yet another patient with a documented history of suicide attempts. In July 2004, DHS imposed a treble fine on Napa for failing to assess and treat a patient whose suicide attempt was reported to staff by a peer and whose records contained numerous observations documenting his depression during that time, including: "verbalized feelings of depression;" the patient stating that his "spirit was broken;" and the patient requesting medication for depression and agitation. Notwithstanding this significant evidence of a mental health treatment need, the facility's nursing staff did not assess or evaluate the patient, and the treatment team did not amend his treatment interventions to address this need. I would note that DHS imposes treble fines only when the violation is a repeat violation within a short time frame. Napa has been warned repeatedly of deficiencies in its suicide prevention practices, but has failed to remedy them.

3. Harmful Contraband

Napa also fails to protect patients from harmful contraband. The State's own Department of Health Services has determined that policies requiring investigation of all contraband are not followed. Numerous credible allegations corroborate our finding that Napa fails to control traffic in harmful contraband, including illegal narcotics. We have determined that patients have access to illegal drugs, including marijuana and cocaine, while residing at Napa. Patients allege, moreover, that staff provide illegal drugs to patients in return for cash or sex. Evidence that patients are obtaining access to contraband includes:

- Three different Napa patients overdosed on amphetamines and/or cocaine in fall 2004, including one patient who died of the overdose. Three other patients obtained and used heroin during this time period.
- In September 2004, a Napa physician testified under oath that Napa's staff brings drugs into the facility in exchange for cash.⁵
- An independent psychologist who recently examined a Napa patient and all of his medical records told us that the client, L.A., tested positive for marijuana and other street drugs six months after his admission to Napa.
- In late 2002, the State's own surveyors documented numerous indications of drug use by Napa residents that were neither investigated by the facility nor addressed by the residents' treatment teams. A Napa police staff member told the state surveyors, "[W]e don't have the resources to stop the drugs [coming into the facility]."
- As described in the discussion above regarding patient-on-patient assaults, the patient who strangled his roommate to death on May 2, 2002, was a heavy drug user who had tested positive for cocaine, amphetamines, and barbiturates in the five months prior to the incident, even though he had been confined to Napa for two years.
- One patient tested positive for marijuana, cocaine, and alcohol while at Napa in 2001 and 2002, and was seen injecting another patient with a needle on September 5, 2002.

4. Seclusion, Restraints and PRN Medications

Generally accepted professional standards of care dictate that seclusion and restraints: (a) will be used only when persons pose a safety threat to themselves or others and after a hierarchy of less restrictive measures has been considered and/or exhausted; (b) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (c) will not be used as a behavioral

⁵ This testimony was submitted during a conditional release hearing for patient L.A.

intervention, and (d) will be terminated once the person is no longer a danger to himself or others. See Youngberg, 457 U.S. at 324 ("[The State] may not restrain patients except when and to the extent professional judgment deems this necessary to assure such safety to provide needed training.") Generally accepted professional standards also instruct that PRN psychotropic medications should be used only as a short-term measure to relieve a patient in acute distress, not as means to escape mild, possibly healthy, discomfort or as a repeatedly deployed substitute for treatment.

Misuse of seclusion and restraint was a significant area of concern during our first CRIPA investigation of Napa. In addition to overuse and misuse of physical restraints and seclusion, our earlier investigation found an exorbitant number of PRN (pro re nata or "as needed") medication orders, suggesting that they were used for the convenience of staff to sedate and control patients. Substantial evidence shows that misuse of seclusion and restraint is a significant area of concern again. Statistics published on the DMH web site show the duration of restraint episodes at Napa to be substantially higher than the system's average in 2004. The average duration of restraint episodes at Napa during each quarter of 2004 was more than double those at Metropolitan State Hospital (where we also found unconstitutional use of seclusion and restraint) during this same time.⁶ Data comparing administration of emergency psychiatric medication⁷ in the State's four public psychiatric hospitals also

⁶ February 19, 2004 CRIPA Findings Letter Regarding Conditions at Metropolitan State Hospital. We currently are negotiating to reach a resolution of the Metropolitan investigation. Of the State's four psychiatric hospitals, the residents at Metropolitan and Napa are the most similar, and include both civilly-committed and forensic patients. Patton and Atascadero State Hospitals admit only forensic patients.

⁷ We refer to this published data on emergency medications as an indicator of PRN usage. Although not every administration of a PRN medication is an emergency use, and vice versa, in most cases, the two sets of data overlap. The data generally support the claims of Napa patients and families that Napa overuses PRN medications. Because the State denied us timely access to the facility and patient records to conduct our investigation, we have little choice but to conclude that the allegations are true.

shows that Napa's rate was nearly twice that at Metropolitan.⁸ This is a concern because we found the high levels of seclusion, restraint and PRN medications at Metropolitan to be evidence of a failure to follow generally accepted professional practices. Specifically, frequent resort to seclusion, restraint and PRN medication is an indicator that a patient's diagnosis is erroneous and/or that the treatment plan is inappropriate and should be re-evaluated.

In September 2004, and again in February 2005, Napa was cited by CMS for continuing deficiencies in the use of seclusion and restraints. In both surveys, CMS found that Napa failed to justify the use of restraints; failed to ensure physicians' orders and face-to-face assessments in application of restraints; and failed to limit use of restraints and seclusion to documented emergencies. When interviewed by CMS surveyors regarding examples of inappropriate restraint, Napa's Clinical Director stated, "[m]aybe our system is not working." Examples of inappropriate uses of seclusion or restraint include:

- A patient identified in a February 2005 CMS survey was secluded for 30 hours, during which time staff's recorded observations included: "appears sleeping," "eating," "drinking," "eyes open staring in space," and "not responding." These behaviors do not reflect violence requiring seclusion, and there was no evidence that the patient was released during these times to see if she could control her behavior without being secluded. On a second occasion, the same patient was secluded for 36 hours, with the following release criteria: "when client is able to make eye contact to staff with relaxed muscle tone." During this second episode of seclusion, the patient was observed as "not responding to staff," and "covering self with blanket, mute," behaviors not indicative of violence requiring seclusion.
- The February 2005 CMS survey also identified a patient who was admitted while under restraint and continued in restraints for more than 48 hours. Documentation shows that

⁸ Inexplicably, of the four hospitals' statistics, only Napa's are expressly limited to use of "intramuscular injections." It appears that Napa's actual use of emergency medications, including any delivered via methods other than intramuscular injection, is higher.

restraint was continued based on past behaviors; current behaviors noted in the documentation clearly did not justify restraint, including "demanding, whining," "eating dinner," "staring at wall," and "eyes closed."

- Another patient identified in the February 2005 CMS survey was "walking wrist to waist restrained" for 50 hours based on a physician order stating, "[w]alking wrist to waist restraints when out of his own room. No release criteria other than being release criteria [sic] in his own room." The Medical Director, when questioned by CMS whether this use of restraints was justified based on an immediate threat of violence, stated, "I think it is less restrictive to allow the patient out in the milieu in these restraints, rather than having to stay in his room."
- Another patient was restrained on 20 occasions between August 2nd and September 21, 2004, for a total of 920.4 hours, or 75% of her hospital time during this period. One episode was for 369 consecutive hours.
- Another patient, who had Down syndrome and whose primary language was not English, was observed by CMS surveyors in three-point restraints on September 20, 2004. Records showed he had been restrained in three or five-point restraints since admission three days earlier. None of the information in his charts suggested any justification for use of restraints.
- PRNs are used inappropriately, and as a substitute for sufficient staff supervision and therapeutic interventions. For example, a patient who pushed away a peer in self defense when the peer assaulted her was given a PRN for her own "aggression." Generally accepted practices and federal regulations, 42 C.F.R. § 482.13, prohibit use of restraints (including medications) unless the person poses an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been considered and/or exhausted.

Previous CMS surveys confirm that Napa's misuse of restraints and seclusion is a serious and long-standing problem:

- On February 2, 2001, a patient died while in three-point prone restraints in a seclusion room. The patient was restrained on his stomach and choked to death while eating.

The patient's chart reflects that he was at increased risk of positional asphyxia because he suffered from hypertension, obesity, and Huntington's disease. Inexplicably, this patient was served a meal in this position and was monitored only by an audio/video monitor that showed the back of his head.

- In three of three records reviewed by CMS in August 2001, restraints were used without having been approved in the patients' plans of care. A supervisor interviewed by CMS was unaware of accepted professional standards requiring that patients subject to restraint have plans of care expressly addressing the restraints used, including assessments addressing the need for restraints, appropriate interventions based on those assessments, evaluation of the effectiveness of the interventions, and re-intervention as warranted.

Multiple independent sources have alleged that staff at Napa goad patients into behaviors that are then punished with restraint or seclusion. More particularly, staff frequently provoke patients into verbal confrontations to justify placing the patients in seclusion. If a patient resists being placed in seclusion, the patient is then restrained. Because the State has denied us access to the facility to investigate these allegations, we are compelled to conclude that they are accurate.

5. Failure to Control Environmental Hazards

In a facility serving people at risk of harming themselves or others, the environment should be kept free of hazards. Napa has failed to meet this generally accepted professional standard of care.

Examples of Napa's breakdown in environmental protections include the prevalence of appurtenances and other fixtures upon which patients tie off to commit suicide; jagged and broken wall tiles; and highly unsanitary bathroom areas. CMS, in fact, has determined that staff takes no action, or completely ineffective action, to prevent patients from soiling common areas with human waste. Exposure to others' wastes is a health hazard.

B. MEDICAL, NURSING, AND PSYCHIATRIC CARE

1. Deficiencies in Preventative, Routine, and Emergency Medical, Nursing, Dental, and Psychiatric Care

The State is required to provide adequate medical care to patients, including adequate nursing care. Youngberg, 457 U.S. at 315, 322. We find that Napa does not provide adequate medical and nursing care to patients. Regulatory agency surveys from 2001 to as recently as February 2005 indicate persistent deficiencies in medical and nursing care: nursing care is not provided to all patients who need it; registered nurses do not consistently supervise and evaluate the nursing care of each patient; the nursing staff does not consistently develop a nursing care plan for each patient; staff fail to ensure the proper implementation of patients' care plans; care plans are inadequate and outdated; dental care is inadequate; documentation and reporting of treatment and symptoms is inadequate; and medications are not consistently administered properly. In addition, medical care -- including psychiatric assessments -- is not consistently timely, responsive, or accurate.

Lapses in medical and nursing care can, and have had, fatal consequences for Napa patients. In February 2005, patient B.X. complained of breathing problems. Although he used a nebulizer for a history of breathing problems, his complaints were not addressed by staff. He died sitting in his room and was discovered by a peer. Because the State has denied us access to the facility and its records in our investigation, we conclude that staff's inattention to this patient's serious medical complaint was a cause of his death.

The following additional examples illustrate many systemic medical, nursing, and psychiatric service deficiencies and demonstrate Napa's substantial departure from generally accepted professional standard of care in these critical areas:

- In May 2005, a patient who suffered a seizure while in the cafeteria choked to death. In an inpatient hospital setting, it is difficult to imagine why there was no staff person with sufficient training available to avert a death by choking.
- In March 2005, a patient waited more than 48 hours for an x-ray and treatment for a broken arm.

- In November 2004, the State's own surveyors cited Napa for deficient nursing care involving a client with a history of suicide attempts. After being notified of the client's expressed plan to harm himself, nursing failed to assess, develop a nursing care plan, or even document the incident. Five days later, the client attempted suicide.
- A court-appointed psychologist testified that a forensic patient recommended by Napa's staff for conditional release had been given the wrong psychiatric diagnosis and no treatment for psychiatric conditions directly affecting his suitability for release.
- In 2003, a patient was forced to wait at least seven months for surgical repair of his broken hip.
- In November 2002, staff failed to observe whether or not patients take their medications, even when care plans required observation. The State's own surveyors reported that, on November 19, 2002, two individuals walked away after they had received their medication without staff members observing whether they had taken the medication, including one individual who had admitted to selling his medications to other patients. Staff members observed by DHS on November 20, 2002, failed to crush and dissolve medication for certain patients, as had been ordered by the physician to ensure that patients were taking their medications.
- According to DHS observations in November 2002, staff failed to record the administration of medication in a timely manner, resulting in the potential for medication error due to the lack of communication of medication administration to other medication-administering nurses on the unit.
- On August 5, 2002, a patient attempted to commit suicide by taking an overdose of approximately 3000 milligrams of medication, when he was prescribed no more than 310 milligrams of medication per day.
- Based on its November 2002 review of records, the State's own surveyors reported that several patients failed to receive critical dental treatment, despite poor dental health, including patients who had cavities, had lost several teeth prior to admission, or who were likely candidates for extractions.

- A review by the State's own surveyors of a sample of patient records dated July through October 2002, indicated that many patients had been prescribed numerous psychotropic medications that have adverse interactions, yet there was no follow-up to review or record these adverse effects.
- Napa records dated September 30, 2002, indicated that one patient was prescribed multiple psychoactive medications and doses of medication above the recommended maximum doses without any apparent justification. He received 2700 mg a day of an anticonvulsant while the maximum recommended dose is 1800 mg a day; 700 mg a day of another anticonvulsant while the recommended maximum dose is 500 mg; 20 mg a day of an antipsychotic compared to the usual dosage range of 10 mg a day; and 10 mg a day of another antipsychotic with a maximum effective dose of 4-6 mg a day. In addition, the patient received daily doses of an anti-depressant, an anti-anxiety and anticonvulsant medication, and another anticonvulsant. These medications have numerous adverse effects and cumulative drug interactions, including agitation, insomnia, nervousness, hostility, dizziness, objectionable behaviors, movement disorders, anxiety, gait disturbances, lack of coordination, irritability, restlessness, and slurred speech. Records for this patient demonstrated the presence of seizures, falls, hostility, aggression, agitation, insomnia, restlessness, and unpredictable and objectionable behaviors. There was no evidence of a system for recording symptoms in a way that would allow the treatment team to differentiate between the patient's symptoms of mental illness and symptoms of adverse effects of medication.
- On the skilled nursing facility unit, staff have refused to assist patients to the restroom, forcing patients to spend up to 12 hours in soiled diapers. Staff have taken up to two hours to respond to patients' call lights, and bathed patients as infrequently as once every two to four weeks. Observers reported "a strong stench of urine and feces on the unit."

2. Deficiencies in Provision of Occupational and Physical Therapy and Dietary Supports and Services

The care provided at Napa to patients whose needs include occupational or physical therapy departs substantially from

generally accepted professional standards. Napa also consistently fails to provide adequate nutritional services, a substantial departure from professionally accepted standards that may cause serious health problems. For example:

- In a February 2005 survey, CMS identified two patients who required equipment such as portable oxygen and/or wheelchairs to attend programming; staff neither encouraged nor assisted the patients to use this equipment to attend programming but, instead, left the patients in bed in their rooms.
- In November 2002, at least six patients' records were missing observation data and information relevant to necessary dietary supports and services.
- In October 2002, CMS observed Napa staff incorrectly administer gastrostomy tube feedings for five of six patients, and observed a patient with a care plan that included swallowing precautions being fed by staff that was not trained and not familiar with the patient's plan.

The failure to provide physical, occupational, and nutritional supports and services to Napa patients may result in a loss of mobility and independence, and can also lead to preventable medical complications.

C. PSYCHOLOGY AND TREATMENT PLANNING

The State must also provide persons committed to psychiatric hospitals for an indefinite term with mental health treatment that gives them a realistic opportunity to be cured and released. Oregon Advocacy Ctr. v. Mink, 322 F.3d 1101, 1121 (9th Cir. 2003) (citing Ohlinger v. Watson, 652 F.2d 775, 779 (9th Cir. 1980); Sharp v. Weston, 233 F.3d 1166, 1172 (9th Cir. 2000) (same). Multiple independent sources, including regulatory agencies, independent professionals, patients, and patient advocates, inform us that Napa fails to provide adequate treatment planning, and in particular, fails to plan adequately to address patients' assaultive and self-abusive behaviors. In addition to the many examples of Napa's failure to address assaultive and suicidal behavior, discussed at §§ II.A.1 and 2, above, examples of failures to treat include:

- Napa failed to provide a current psychiatric assessment for patient M.E. since sometime before February 2004; this patient committed suicide on March 20, 2005. CMS identified additional patients without timely psychiatric evaluations, including one who had not been evaluated more than six months after admission, and another who had no psychiatric evaluation for more than two years.
- Napa failed to intervene to address escalating violence by patient Q.R., including an assault on a peer that caused injury requiring stitches, despite pleas from Q.R.'s family members to his treatment team.
- Recent CMS surveys confirm that Napa fails to provide structured therapies based on patients' treatment needs; fails to develop and document interventions based on patients' presenting needs; and fails to develop interventions to be provided by a physician.
- Staff do not encourage patients to attend their few scheduled treatment groups, and staff actions often disrupt those groups. One patient was left asleep in her bed at the time of her scheduled treatment group with no staff encouraging her to participate.
- Napa fails to provide adequate interpretative services to enable non-English-speaking patients to understand their treatment. One Vietnamese patient was observed to mumble and sing throughout his ward's community meeting, during which he was frequently "shushed" by the interpreter. When interviewed following the meeting, the patient stated he did not understand what had occurred. A second Vietnamese patient was not evaluated for suicide risk for more than six months because no interpreter was available.
- A court-appointed psychologist testified that Napa staff failed to address a patient's history of violent assault and inappropriate relationships with women, including Napa staff members. Notwithstanding this failure to treat, Napa's doctors recommended that this forensic patient be conditionally released to the community, which the court-appointed expert described as a complete lapse in professional judgment.
- The State's regulatory agency reviewed patient records in late 2002 and concluded that Napa fails to assess and plan

interventions for those patients with a history of assaultive behavior until after those patients have assaulted someone at the facility.

D. DISCHARGE PLANNING AND PLACEMENT IN THE MOST INTEGRATED SETTING

Napa fails to comply with the requirement of the ADA and its implementing regulations that patients be placed in the most integrated, appropriate setting consistent with the patient's needs and the terms of any court-ordered confinement. See Americans with Disabilities Act, 42 U.S.C. § 12131, which states:

no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

See also ADA implementing regulations, 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"); Olmstead v. L.C., 527 U.S. 581 (1999); President George W. Bush's New Freedom Initiative, "Community-Based Alternatives for Individuals with Disabilities," Exec. Order No. 13217, 66 Fed. Reg. 33155 (June 18, 2001) (the President emphasized that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, that the United States is committed to community-based alternatives for individuals with disabilities, and that the United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community for Americans with disabilities).

We have received credible allegations that patients who seek to be discharged into community placements are retaliated against by Napa staff. According to a patient's family member, a patient was placed on psychotropic medication in late 2002 in retaliation for writing letters to the court requesting a discharge hearing. The prescribing doctor reportedly told him that he would not stop giving him the medication until he stopped writing the letters. Another patient alleged that she was retaliated against for hiring an attorney to seek her release. She alleged that she received excessive dosages of medication and was awakened every

30 minutes at night to deprive her of sleep, until she stopped seeking her release. Two other sources stated that patients were given large doses of psychotropic drugs before any court appearance to inhibit their release from Napa. In addition, in November 2001, a staff member alleged that when patients were ready for discharge, supervisors instructed the medical staff to alter notations in patients' records to indicate that patients were not ready to be discharged.

Napa also fails to provide sufficient substance abuse programs to meet patient needs, even though these are a prerequisite to participation in the "conditional release" program.⁹ A patient's failure to complete the program leads Napa to file a petition for an extension of time of commitment. Finally, multiple credible sources state that patients receive little or no treatment or interventions to prepare them for discharge; discharge planning for patients is essentially "do it yourself."

III. MINIMUM REMEDIAL MEASURES

Because the State has denied us timely access to Napa, we are not able to provide remedial measures with the same specificity as we provided in our letters dated May 21, 2003 and February 19, 2004, regarding Metropolitan State Hospital. However, because the deficiencies at Napa generally mirror the deficiencies at Metropolitan, the specific remedies outlined in the letters regarding Metropolitan are illustrative of those that should be implemented at Napa. To remedy the deficiencies discussed above and to protect the constitutional and federal statutory rights of the patients at Napa, the State should, at a minimum, promptly implement the remedial measures set forth below.

A. Protection From Harm

1. To remedy deficiencies that result in excessive patient-on-patient assaults, patient suicides, and trafficking in contraband, including illegal street drugs, the State must:
 - a. Ensure that Napa provide its patients with adequate, integrated treatment planning consistent with generally

⁹ In California, conditional release is similar to parole for forensic patients.

accepted professional standards of care. In particular, Napa should:

- (1) Develop and implement policies and procedures regarding the development of treatment plans consistent with generally accepted standards of care.
 - (2) Revise treatment plans as appropriate, based on significant developments in patients' conditions, including patients' progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables.
 - b. Ensure Napa provides its patients with accurate, complete, and timely assessments, consistent with generally accepted professional standards of care; these assessments should drive treatment interventions.
 - c. Ensure that Napa reviews, revises, as appropriate, and implements comprehensive, consistent incident management policies and procedures consistent with generally accepted professional standards. At a minimum, revised policies and procedures shall provide clear guidance regarding reporting requirements and the categorization of incidents, and address investigation of all serious incidents.
 - d. Ensure that Napa develops and implements a comprehensive quality improvement system consistent with generally accepted professional standards of care.
2. To remedy deficiencies that result in excessive and inappropriate use of seclusion, restraint and PRN medications, the State must:
- a. Ensure that seclusion, restraints, and PRN psychotropic medications are used at Napa in accordance with generally accepted professional standards of care.
 - b. Ensure that restraints, seclusion, and PRN medications are used in a reliably-documented manner and only when persons pose an immediate safety threat to themselves or others, after a hierarchy of less restrictive measures has been considered and/or exhausted, and are

terminated once the person is no longer an imminent danger to himself or others.

- c. Ensure that seclusion, restraints and PRN medications are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff.
 - d. Ensure that the patient's treatment team, in a clinically-justifiable manner, timely reviews the use of such interventions, and determines whether to modify the patient's treatment plan, and implements the revised plan, as appropriate.
3. To remedy deficiencies that result in an unsafe physical environment, the State must:
- a. Ensure that Napa provides its patients with a safe and humane environment and protect them from harm. At a minimum, Napa shall conduct a thorough review of all units to identify any potential environmental safety hazards and develop and implement a plan to remedy any identified issues.

B. Medical, Nursing, Dental and Psychiatric Care

- 1. Napa should provide adequate preventative, routine, specialized, and emergency medical services on a timely basis, in accordance with generally accepted professional standards of care.
- 2. Napa should provide nursing and unit-based services to its patients consistent with generally accepted professional standards of care. Such services should result in Napa's patients receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans.
- 3. Napa should provide adequate psychiatric supports and services for the treatment of the severely and persistently mentally ill population of adults that it serves in accordance with generally accepted professional standards of care. At a minimum, the State must ensure that:
 - a. Napa develops diagnostic practices, guided by current, generally accepted professional criteria, for reliably

reaching the most accurate psychiatric diagnoses for each patient.

- b. Napa reviews and revises, as appropriate, psychiatric assessments of all patients, providing clinically justifiable current diagnoses for each patient; modifies treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs; and ensures that each patient's psychiatric assessments, diagnoses, and medications are collectively justified in a generally accepted professional manner.
- c. Napa's patients receive pharmacy services consistent with generally accepted professional standards of care.
- 4. Napa should provide its patients with routine and emergency dental care and treatment on a timely basis, consistent with generally accepted professional standards of care.
- 5. Napa should implement adequate infection control procedures to prevent the spread of infections or communicable diseases.
- 6. Napa should provide its patients with physical and occupational therapy consistent with generally accepted professional standards of care.
- 7. Napa should ensure that its patients receive adequate dietary services, consistent with generally accepted professional standards of care.

C. Psychology and Treatment Planning

- 1. Napa should provide psychological supports and services adequate to treat the functional and behavioral needs of its adult patients according to generally accepted professional standards of care.

D. Discharge Planning and Placement in the Most Integrated Setting

- 1. Within the limitations of court-imposed confinement, the State should pursue actively the appropriate discharge of

patients and ensure that they are provided services in the most integrated, appropriate setting that is consistent with patients' needs.

I invite the State to discuss with us the remedial recommendations, with the goal of remedying the identified deficiencies without resort to litigation. In the event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to institute a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will contact your attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

Bradley J. Schlozman
Acting Assistant Attorney General

cc: The Honorable Bill Lockyer
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