May 13, 2003

The Honorable Gray Davis
Governor of California
State Capitol Building
Sacramento, CA 95814

Re: Metropolitan State Hospital, Norwalk, California

Dear Governor Davis:

On March 21, 2002, we notified you that we were investigating conditions at Metropolitan State Hospital ("Metropolitan"), in Norwalk, California, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. During the weeks of June 24 and July 8, 2002, we visited the facility. Our first tour, "Metropolitan I," focused on the care and treatment provided to the facility's child and adolescent patients, all of whom are in Metropolitan's Program 1. Our second tour, "Metropolitan II," addressed the care and treatment provided to the facility's adult patients. At exit interviews conducted at the end of each facility visit, we verbally conveyed our preliminary findings to counsel and facility officials. Consistent with the requirements of CRIPA, we are now writing to apprise you of our findings regarding the child and adolescent patients. We will transmit our findings regarding the facility's adult patients when our Metropolitan II investigation is complete.

As a threshold matter, we wish to express our appreciation for the cooperation and assistance provided to us by the administrators and staff of Metropolitan. In particular, facility personnel cooperated fully with our document requests. We hope to continue to work with the State of California and officials at Metropolitan in a cooperative manner.

We conducted our investigation by reviewing medical and other records relating to the care and treatment of approximately 70 patients; interviewing administrators and staff; speaking with patients; and conducting on-site surveys of the facility. We

were assisted in this exercise by expert consultants in the fields of child psychiatry, child psychology, psychiatric nursing, and special education.

At the time of our June 2002 visit, Metropolitan had a census of approximately 825 patients. Program 1, the hospital's Child and Adolescent Program, had a census of approximately 100 patients. These patients, who range in ages from 11 to 17, suffer from serious mental health disorders and histories of severe traumatization. Many also have significant cognitive or academic impairments and/or health-related concerns. The majority also had an average of 10 to 12 failed out-of-home placements prior to their placement at Metropolitan. In many respects, these children and adolescents are the most psychiatrically and emotionally disturbed in the State's system of care. Because Metropolitan is the only public mental health institution for this population in the State, these children and adolescents are referred to Metropolitan by counties throughout the State of California.

Residents of state-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation to ensure their safety and freedom from unreasonable restraint, prevent regression and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982). Similar protections are accorded by federal statute. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483 (Medicaid Program Provisions). The State also is obliged to provide services in the most integrated setting appropriate to individual residents' needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130 (d); see Olmstead v. L.C., 527 U.S. 581 (1999).

It was apparent that many Metropolitan staff are highly dedicated individuals who are genuinely concerned for the well-being of the persons in their care. Generally speaking, it appeared that staff promptly intervened to prevent or minimize injury after patients became physically aggressive. Further, Metropolitan repeatedly has demonstrated its proficiency in complying with many procedural aspects of care. Also, the facility commendably has initiated mechanisms to address some problematic aspects of its care, such as the use of restraints and seclusion. Nevertheless, there are significant and wide-ranging deficiencies in patient care provided at Metropolitan.

Our Child and Adolescent Program findings, the facts supporting them, and the minimum remedial steps that we believe are necessary are set forth below.

I. PSYCHIATRY

Program 1's psychiatric supports and services substantially depart from generally accepted professional standards of care and expose the children and adolescents there to a significant risk of harm and to actual harm. Specifically, Metropolitan fails to provide clinically justified evaluations and diagnoses of psychiatric disorders; fails to provide adequate and appropriate treatment planning; fails to identify and address cognitive and academic deficits; fails to prescribe clinically justified psychotropic medications; fails to assess appropriately the side effects of medications; and fails to provide an appropriate therapeutic environment. The harm to these children and adolescents takes many forms, among them, inadequate, ineffective and counterproductive treatment, exposure to inappropriate and unnecessary medications posing serious physiological and other side effects, and excessively long hospitalizations, which compound psychiatric distress.

A. Psychiatric Evaluation and Diagnosis

Each individual's psychiatric evaluation and diagnoses should be justified in a generally accepted professional manner. Specifically, there should be a close relationship amongst a patient's diagnoses, identified problems in the treatment plan, daily clinical descriptions by staff, and the medications administered. Program 1 does not meet these minimum standards of care. Psychiatric evaluations and diagnoses are woefully inadequate. Psychiatrists chronically diagnose patients with psychiatric disorders without any clinical justification or any documentation of signs or symptoms required for such diagnoses. The number of clinically unjustified diagnoses strongly indicates that psychiatrists deliberately make psychiatric diagnoses to justify the use of psychotropic medication. Indeed, multiple psychiatrists indicated to us that they have assigned psychiatric diagnoses for this reason.

Not only do psychiatrists diagnose patients with disorders for which there is little or no clinical justification, they also routinely fail to diagnose patients with disorders for which patients do exhibit signs or symptoms. For example, abandonment

issues and past trauma are nearly universal problems for the patients in Program 1. However, psychiatrists frequently ignore these disorders in diagnosing patients. Consequently, these disorders often are not identified as a focus of treatment. Such missed diagnoses are a grave deficiency, because without proper evaluation and diagnosis, it is virtually impossible for patients to receive adequate treatment. Moreover, improper diagnosis and treatment affect opportunities for patients to be placed in the most integrated setting appropriate to meet their needs.

The evaluations are also incomplete in that they routinely fail to include information about the patients' medication histories, medications at time of admission, recommended medication regimens to be utilized for treatment, or general medical diagnoses. This information is crucial in guiding treatment. In particular, existing medical problems should be a significant determinant when choosing a psychotropic medication regimen so as to avoid interactions and exacerbations of individuals' mental health or medical disorders.

There were many examples of these diagnostic problems. For instance, one patient, D.S.,[1] was placed upon admission on numerous medications, none of which corresponded with his diagnoses. Two other patients, B.S. and N.C., were diagnosed with Bipolar Disorder and Bipolar Disorder II Depressed with Psychotic Features, respectively. Both were prescribed medications appropriate to treat acute mania. Neither patient, however, had any documentation in their evaluation to support these diagnoses, nor did they have identified problems in their treatment plans consistent with these diagnoses. Moreover, N.C.'s symptoms were more consistent with post-traumatic stress disorder than the Bipolar diagnosis. E.Z.'s evaluation contained no information about the dosages of previously prescribed medications, how those medications affected his symptoms, or his current medication regimen. Further, Attention Deficit Hyperactivity Disorder (ADHD) was not listed as an Axis I diagnosis to be ruled out despite the fact that E.Z. had a past diagnosis of ADHD and the evaluation stated that more information was required to confirm this diagnosis. The medical diagnosis of

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[1]In this letter, to protect patients' privacy, we identify patients by initials other than their own. We will separately transmit to the State a schedule cross referencing the initials with patient names.

asthma noted in his evaluation was also not listed under the Axis III diagnoses. Similarly, the psychiatrist for another patient, U.C., failed to assess the possibility of Traumatic Brain Injury or to diagnose her with Post Traumatic Stress Disorder, despite her history of head trauma, prenatal exposure to drugs, sexual abuse, and neglect, including an incident resulting in her being seriously burned. Her evaluation also failed to list her past medication history or medications at the time of admission.

Separately, Metropolitan's procedure calls for a preliminary psychiatric evaluation on the day of admission to Program 1 and a second evaluation once the patient is admitted to a specific unit. For several patients, including E.Z., B.P., L.M., X.N., C.H., Bc.O., J.U., B.H., and N.T., the information contained in the initial evaluation either was not included in, or conflicted with, the information contained in the second evaluation. This is of particular concern given that the evaluations were conducted within one or two days of each other. Contrary to generally accepted professional standards, there was no indication that the physicians who conducted these evaluations communicated about their significantly different findings.

B. Treatment Planning

According to generally accepted professional standards of care, treatment plans should be individualized and should, at a minimum: (a) identify patients' diagnoses and symptoms; (b) provide interventions to address each diagnosed psychiatric disorder and the associated symptoms; (c) include medication plans; (d) provide interventions and treatments to address deficits in cognitive, academic and adaptive functioning, and address any other significant treatment or medical needs; (e) provide for monitoring of treatment efficacy; (f) provide for monitoring of medication side effects; (g) include plans to educate patients about their medications and other treatment interventions; and (h) identify the barriers to placement in the most integrated appropriate setting and the specific steps to overcome such barriers. Metropolitan's treatment plans often fail to include this information and are not updated on a timely basis. More fundamentally, because Metropolitan fails to evaluate or diagnose adequately its patients, it is nearly impossible for it to develop appropriate treatment plans.

1. Diagnoses and Symptoms

It is a serious concern that many patients have psychiatric disorder diagnoses although their treatment plans did not identify any problems related to psychosis. Only one of two conclusions results from these practices: either the diagnoses are appropriate and treatment teams therefore fail to identify the symptoms of patients' most serious psychiatric disorders, or patients are not experiencing symptoms of psychiatric disorder diagnoses and thus the assigned diagnoses are unjustified. Neither possibility is clinically acceptable.

2. Interventions

We found that nearly every Program 1 treatment plan lists the same generic interventions. Treatment plans should be tailored to meet the individualized needs of the patients, and should take into account factors such as the patient's functioning level, cognitive level, history of trauma, and medical conditions. None of the plans that we reviewed were individualized or sufficiently detailed. Generic statements such as "chemotherapy" or "group therapy" do not offer the level of detail necessary to allow teams to provide adequate treatment. For instance, X.N.'s treatment plan consisted of general interventions: "chemotherapy, individual therapy, group therapy, recreational therapy, IT assignment, and special educational programs." The interventions listed for L.M. and N.Q. contained similar generic statements.

Further, none of the plans that we reviewed included any treatment for, or acknowledgment of, the patients' severe traumatization and multiple out-of-home placements. The plans also provided no differentiation between major psychiatric and behavioral problems that were the reason for a patient's hospitalization and relatively trivial problems not requiring hospitalization (such as aches and pains).

The use of highly restrictive interventions, including the use of seclusion, restraints and/or as-needed (so-called pro re nata or "PRN") medication, should trigger a review of the effectiveness of a patient's treatment plan. Metropolitan, however, does not routinely review treatment plans based upon these events, thereby exposing patients to ongoing restrictive interventions and ineffective treatment.

3. Cognitive, Academic and Adaptive Functioning

Psychiatrists must be aware of and take into account patients' cognitive, adaptive and academic levels of functioning to make accurate evaluations and diagnoses and for treatment to be appropriate and effective. A patient's cognitive abilities will influence significantly her response to Program 1's expectations and the appropriateness of her treatment plans and criteria for discharge. Her cognitive abilities also will affect her understanding of the medications that she is prescribed.

Systematically, Metropolitan fails to identify and address patients' cognitive, adaptive and academic deficits. Of the patients reviewed who had significant cognitive and/or academic deficits listed in their charts, none had any remediation or accommodation for these deficits in their treatment plans. Treatment teams seemed unfamiliar with the results of such testing, and they did not express concern that cognitive or academic deficits were reported to have changed from one 90-day evaluation to the next. In many cases, the only reason such testing appeared to be performed was to determine supports and services needed for discharge placement; in particular, to determine whether the patient could be transferred into California's system of care for mentally retarded individuals.

The following examples are representative of Program 1's failure to identify and address cognitive and academic deficits. First, K.N.'s diagnosis changed from "Rule Out Mental Retardation" in November 1998, to "Moderate Mental Retardation" in January 2001, to "Borderline Intellectual Functioning" in April 2002. No member of his treatment team could explain these changing diagnoses to us, nor did the team include the patient's cognitive/academic deficits as part of his treatment plan. Second, B.Q. had the diagnosis of "Mild Mental Retardation by history" on admission. This diagnosis was changed to "Borderline Intellectual Functioning" on her first 90-day evaluation without any new cognitive testing. Cognitive testing finally was performed over one year after admission for the purpose of determining discharge placement. The results of these tests were not available at the time of our tour, two months after testing had been completed. Third, D.S. was admitted with a cognitive disorder diagnosis. He, however, did not have cognitive testing until one and a half years after admission, at which time discharge was being considered. The fact that the results of D.S.'s test were in the mildly mentally retarded range did not result in any change in his treatment plan.

Program 1's practice is to review treatment plans at 90-day intervals, after an initial 14-day hospitalization. This excessively long time period between treatment team meetings does not comport with generally accepted professional standards of care, which call for such meetings at a minimum of every 4 weeks, and contributes to excessively long hospitalizations. The infrequency of treatment team meetings exposes patients to heightened psychiatric distress, both from long-term institutionalization and from potentially deleterious treatments, the effects of which the treatment team is not in a position to timely detect and correct.

It is also critical that patients have genuine input into and understand their treatment plans and their implementation. Although Program 1 patients generally sign their treatment plans, there is no evidence that they have any meaningful input into, or agreement with, the plans. We observed treatment teams ignore significant self-initiated input from patients regarding their treatment during treatment team meetings. Moreover, there is no evidence that patients are educated about or understand the purposes of their prescribed medication, medication side effects, or the length of time it takes medication to take effect. As explained below at Section II, nursing and unit staff do not have the knowledge to assist the facility's children and adolescents in understanding these issues. As a result, medications sometimes are changed without clinical justification because patients report that the medications are not working, although the prescribed medications may not have had time to work. In these cases, no documentation was found in the patients' charts to show that staff had educated the patients about the time that needed to elapse before results could be expected.

Finally, treatment plans do not reflect an interdisciplinary provision of services. In part this is because Metropolitan has not identified a team member to coordinate the interdisciplinary treatment process. As a result, no one is accountable or responsible for coordinating patients' overall treatment. No one ensures that treatment plans are developed and reviewed as necessary or that the various disciplines work together to develop and implement one coordinated, comprehensive plan. Similarly, communication and coordination among treatment team members and between treatment teams and the school is poor or non-existent. Staff whom we interviewed stated that various disciplines communicate informally. In any event, whatever communication takes place is not properly documented.

The care provided to F.Q. illustrates several unacceptable aspects of Program 1's psychiatric evaluations, diagnoses, treatment planning, and treatment implementation. During or subsequent to a treatment team meeting for F.Q. that we attended, the team: (a) focused on whether she had a diagnosis of anorexia nervosa, notwithstanding that, given her excess weight, this diagnosis was not clinically possible, and that her desire to lose weight was reasonable; (b) failed to discuss a number of her psychiatric, Axis I, diagnoses or any specific symptoms supporting these diagnoses; (c) could not provide clinical data to support her diagnosis of Bipolar Disorder; (d) failed to identify or discuss her apparent sedation or Parkinsonian appearance, acknowledging that they had not evaluated her for side effects of medication; (e) failed to address her numerous self-initiated comments regarding her problems, needs and interests; (f) appeared unsurprised that she did not know the members of her treatment team; (g) acknowledged that they had no plans to evaluate her cognitive or academic functioning, despite the diagnosis of "Rule Out Borderline Intellectual Functioning"; and (h) could not explain the dramatic increase in her medication, conceding that a decrease in dosage may be indicated. Regrettably, from our observations, interviews, and document review, F.Q.'s treatment team meeting exemplifies the deficient treatment generally provided in Program 1.

C. Psychotropic Medication

The use of psychotropic medication always should be justified by the clinical needs of a patient. However, as previously explained, Program 1's use of psychotropic medication rarely is justified in that patients frequently are medicated based upon clinically unjustified diagnoses. Documentation does not support the types of medications being prescribed, the doses prescribed, or either the extended lengths of time that medications are prescribed in some cases or the rapid change of medications in others. Rather, several of the psychiatrists' notes give the impression that there is little or no analysis conducted when choosing the patients' medication regimens.

Furthermore, many patients are routinely prescribed inappropriate medications. Numerous patients, such as M.D. and N.H., were prescribed medications that are appropriate for chronically mentally ill adults, not children or adolescents. Psychiatrists also commonly prescribed older antipsychotic

medications, such as Thorazine and Haldol, as part of patients' regular medication regimens or as medication to be used as a PRN. In view of the fact that these older antipsychotic medications have a host of serious side effects that the newer atypical antipsychotic medications do not have, the use of these medications in an adolescent population is an outdated, potentially harmful, medication practice. Moreover, these medications were prescribed for at least 21 children and adolescents without any documented clinical justification. It appears that these medications are prescribed to control individuals' behaviors in lieu of an appropriate medication regimen and/or of therapeutic treatment interventions.

Also, although modification of medications is appropriate at times, Metropolitan's psychiatrists often recommend medication changes frequently and abruptly without any documented rationale for the change. This practice is unsafe, given that such changes can exacerbate or precipitate an individual's symptoms.

Further, it is generally accepted that, in most instances, psychotropic medication should be used to treat psychosis. When psychotropic medication is prescribed to treat symptoms other than psychosis, this practice should be documented clearly with a specific plan for minimizing the dosage and duration of the use of the medication. As indicated above, more than one Program 1 psychiatrist acknowledged prescribing psychotropic medication to reduce aggression and agitation rather than to treat psychosis, and acknowledged manufacturing diagnoses to justify this practice. Assigning psychiatric diagnoses to patients who do not meet the diagnostic criteria for such diagnoses in order to justify the use of psychotropic medication is an unacceptable medical practice.

Psychiatrists also prescribe medication for purposes that have no mention in current or past literature and for which their use has no known pharmacological basis. This form of so-called "off-label" medication usage is considered speculatively experimental, should be practiced ethically only under the supervision of an institutional review board, and requires a patient's and/or guardian's clear consent. Program 1 does not meet any of these requirements. For example, a number of patients are prescribed Naltrexone, a psychotropic, to treat a host of different behavioral problems. Metropolitan's medical administration appeared unaware that this was occurring. Although documentation reflected that the off-label usage of this

medication was approved by the Pharmacy and Therapeutics ("P&T") Committee, there is no institutional review board to provide oversight, there is no experimental design to monitor this practice, and there has been no effort to obtain patients' and/or guardians' informed consent.

Despite the fact that many of the medications that are prescribed for Program 1's children and adolescents have potentially serious, and often irreversible side effects, such as tardive dyskinesia, Metropolitan has no standardized instrument in place to assess regularly these side effects. Similarly, treatment plans do not include plans for monitoring potential side effects. Without objective measures in place to identify medication side effects at an early stage, Program 1's children and adolescents are at risk of developing potentially irreversible complications.

When potential side effects of psychotropic medication are identified, Metropolitan's response is inadequate and inappropriate. For instance, E.Z.'s physical examination indicated that he had gynecomastia (development of prominent breast tissue in a male), a potential side effect of one of his medications. There was no indication, however, that this was ever addressed or evaluated further. Similarly, several individuals suffer constipation related to psychotic medication use. Rather than reassess the medications for these individuals, clinicians rely on the chronic administration of stool softeners and laxatives, an unacceptable medical practice for this population.

D. Therapeutic Environment

As part of its psychiatric treatment, generally accepted professional standards of care dictate that Program 1 should provide a therapeutic environment that minimizes the deleterious effects of institutionalization (namely, the compounding of childrens' and adolescents' psychiatric problems such that their developmental trajectory is further compromised) and is conducive to the treatment of severely psychiatrically disturbed and traumatized children and adolescents. In providing a therapeutic environment, there should be a structure comprised of community rules, meetings, and social interactions that help patients learn adaptive coping skills, improve self-esteem, and develop positive skills ("milieu structure"). The environment in Program 1 does

not meet any of these goals. Rather, Program 1 is characterized by a great shortage of staff-initiated, positive interactions.

We saw few positive, spontaneous, therapeutic interactions in which staff initiated and facilitated a patient's expression of feelings, connected a patient's behavior with feelings, employed a "teachable moment" technique, or started a meaningful, positive staff-to-patient or patient-to-patient exchange. Staff typically failed to use natural social experiences, such as distribution of snacks, doing chores, or engaging in recreational activities, to promote positive social functioning. Rather, staff's interactions with the individuals on the units were mainly reactive and/or directive in nature, and at times resulted in power struggles with patients, exacerbating crisis situations. Similarly, we observed a lack of staff-facilitated, age appropriate patient-to-patient interactions. Patients appeared bored, over-medicated, ignored and/or upset. Program 1's failure to provide an appropriate health-promoting environment is unacceptable and does not meet generally accepted professional standards of care.

Program 1's milieu structure is largely based upon a Point and Level System. Staff appear to believe that this system motivates patients to the extent that simply the interaction between patients and the system constitutes active milieu therapy. We found numerous serious deficiencies with this system.

The Point System is a complex process that neither patients nor staff are likely to understand adequately. The system does not allow for consistent, accurate or individualized application of points across residential units and/or schools. Points are not distributed contingent upon the occurrence of behaviors, and they are not distributed frequently and immediately in association with those behaviors. Consequently, their intended therapeutic effect is negated. The number of points that students can earn at school - ten percent of their total daily points - significantly undervalues the educational portion of their lives. Most significantly, points are not utilized in a therapeutic way to connect a patient's behaviors with feelings or to identify more effective coping strategies.

Similarly, the Level System is very complex. Children and adolescents who are severely mentally ill and traumatized, many of whom have cognitive impairments, are highly unlikely to

understand it. Procedures by which patients' levels are dropped or raised are not defined clearly. It is virtually certain that, in light of their histories of abuse and trauma, many Program 1 patients will experience the system as arbitrary and punitive, thereby negating any therapeutic effect. The fact that this system is a key component to determining patients' attainment of discharge criteria makes it even more troubling.

Program 1's physical environment is also deficient. Given Program 1's population, the physical environment should, within the bounds of safety, promote privacy, individuality, creativity, and the opportunity for recreational activities to minimize the effects of institutionalization and promote positive social behavior. However, we found problems in all of these areas.

As a primary matter, patients' rights to privacy and confidentiality are breached by the public distribution of medication and the posting of patient-specific information on publically visible boards. More broadly, recreational equipment was limited to televisions, damaged basketball nets, and often-violent video games. The courtyards, which appear to be used rarely by patients, are in disrepair and poorly equipped. Although the facility has a fenced playing field, not once during our multiple trips around facility grounds during our two five-day visits did we see any children or adolescents on it.

Many of Program 1's problems in providing adequate psychiatric services are the result of a lack of leadership and direction by psychiatrists and senior administration. There is no evidence of medical staff providing leadership in treatment teams or during periods in which patients are experiencing acute psychiatric distress. Indeed, there was scant acknowledgment, at leadership and administrative levels, that extended institutionalization frequently exacerbates existing psychiatric problems of children and adolescents. In important respects, the administration's focus lies elsewhere; various Metropolitan documents identify the facility's "clients" as, not the children themselves, but rather the counties from which they come.

II. NURSING

Program 1's nursing services substantially depart from generally accepted professional standards of care and treatment and expose the children and adolescents there to a significant risk of harm and actual harm. These deficits derive from nursing

and unit staff's: (a) failure to identify, monitor and report patients' symptoms and side effects of medications; (b) unfamiliarity with mental health diagnoses, associated symptoms, and appropriate treatments and interventions; (c) lack of knowledge regarding their patients; and (d) ineffective participation in the treatment team process.

Many nursing and unit staff appear to lack adequate support, training and supervision. Metropolitan leadership does not encourage Program 1 nursing and unit staff to communicate with other team members to solve problems proactively. As a result, nursing and unit staff respond to patient needs in a largely reactive way. This, in turn, exposes Program 1's children and adolescents to excessive and inappropriate uses of medication; seclusion, and restraints; inadequate and ineffective therapeutic interventions; and unnecessary institutionalization.

A. Monitoring and Reporting of Patients' Symptoms

Generally accepted professional practice requires that patients' treatment plans identify the interventions and strategies to be utilized by nursing and unit staff to address the symptoms of patients' diagnoses, the symptoms to be monitored, and the frequency with which the symptoms are to be monitored. It is essential for nursing and unit staff to monitor, document and report patients' symptoms for the treatment team to determine if the implemented interventions are adequate or require modification. The psychiatrists who prescribe medications and the psychologists and social workers who oversee other therapeutic interventions rely on nursing and unit staff to collect and report this information. Nursing and other unit staff are on the unit 24-hours a day, seven days a week; they can and should record and report this information. Program 1 nursing and unit staff do not properly monitor, document and report such information. In part, this is because Program 1's treatment plans generally do not identify the symptoms to be monitored or the frequency with which staff should monitor them.

Metropolitan does not appear to have a system in place to collect and analyze such information on a regular basis or to utilize such information in the reassessment and treatment plan revision process. Without objective measures in place to determine the effectiveness of the interventions being used, Program 1's patients are likely to receive inappropriate and ineffective treatment interventions for long periods of time, and

to be exposed to excessive or inappropriate uses of medications, seclusion, and/or restraints.

Staff who administer medication should know what the medication is for, know what results it is intended to achieve and when, and know the symptoms of the disorder that the medication is supposed to address. As a general matter, the Program 1 nurses are unfamiliar with the purposes of the medication they administer, and a number of nurses we interviewed were unable to identify the symptoms associated with the disorder for which a particular medication was prescribed. This lack of basic clinical knowledge contributes to nursing staff's failure to monitor and report patients' symptoms.

B. Monitoring of Medication Side Effects

Generally accepted professional practice requires that nursing staff monitor patients for potential side effects of medications. However, Metropolitan nursing staff responsible for the day-to-day care of patients do not monitor, document or report evidence of side effects on a regular basis. This is in part because, as stated above, treatment plans do not include plans for monitoring potential side effects. Even when nursing staff do identify patients who are experiencing side effects, they do not take adequate action to notify the prescribing physicians and to ensure that appropriate follow-up occurs. The charts of a number of patients included notes indicating that nursing staff had witnessed side effects such as drooling, but they failed to report this to the prescribing physician and/or document the symptom on a more formal basis, such as through standarized instruments that measure and record medication side effects.

C. Participation in Treatment Team Process

Nursing and unit staff consistently demonstrated a lack of knowledge regarding the therapeutic process. Many could not provide essential information about the individuals on their units such as the level of family involvement, issues being pursued in therapy, symptoms of Axis I disorders, reasons for medication changes, or options for discharge. Without nurses' knowledge of this crucial information, the units cannot function adequately as therapeutic environments.

It is generally accepted professional practice for nursing staff, as well as other staff who provide direct support to patients, to participate as active members of the treatment team. Because these staff work on a daily basis with the children and adolescents of Program 1, they likely know the patients best. However, Program 1 nursing and unit staff do not participate meaningfully in the treatment team process. Generally speaking, Program 1 nursing and unit staff do not appear to understand therapeutic tools or how to implement them. Nursing staff do not know the children's and adolescents' histories, especially the family histories, which is where mental health issues often start. Nurses do not appear to understand their role as psychiatric nurses.

This lack of knowledge and skills places nurses and other unit staff at a disadvantage in the team process. Without adequate knowledge and skills, nursing and unit staff cannot contribute meaningfully to the development of treatment plans and interventions; cannot challenge other team members to consider alternative diagnoses, medications or interventions when those in place do not appear to be correct; cannot implement interventions effectively; and cannot provide a therapeutic milieu. This ultimately results in the children and adolescents of Program 1 receiving inadequate treatment and care.

III. PSYCHOLOGY

Program 1's psychological services and behavioral interventions substantially depart from generally accepted professional standards of care and expose the children and adolescents of Program 1 to significant risk of harm and to actual harm. The deficiencies include inadequate clinical assessments; insufficient, inappropriate active treatment; and inadequate behavioral interventions. The harm to these children and adolescents takes many forms, among them, perpetuating their emotional behavioral difficulties; unnecessarily extending their stay in a highly restrictive setting; diminishing their sense of self worth; subjecting them to excessive use of seclusion, restraints, or sedating medications; fostering despair and hopelessness; and, in some cases, depriving them of physical safety.

A. Psychological Evaluations

In attempting to determine the psychological problems and needs of children and adolescents, it is critical that psychologists and direct care staff observe and assess them on a regular basis. However, clinical staff infrequently observe and directly assess the children and adolescents in their care. Consequently, in making treatment decisions, clinicians fail to consider important aspects of both the patients' clinical status and their level of functioning. This deficiency is exacerbated by the lack of a hospital policy dictating when psychological evaluations are to be updated.

Psychological evaluations should identify and address psychiatric issues when such issues are present. Program 1 evaluations frequently fail to do so. For instance, although M.C.'s psychological evaluation on admission identified no psychiatric issues, he subsequently was psychiatrically diagnosed with Bipolar Disorder with Psychotic Features. Notwithstanding that psychiatric diagnosis, his psychological evaluation was not updated. Consequently, either M.C.'s psychiatric diagnosis was wrong or his psychological evaluation was significantly deficient.

Similarly, as discussed in Section I, psychological evaluations should identify and address functional abilities. In this regard, "Mental Retardation" and "Borderline Intellectual Functioning" are distinct categories of intellectual assessment that should trigger different treatment interventions. Metropolitan's psychological evaluations often do not recognize this distinction. For example, K.N. was admitted to Metropolitan with a diagnosis of "Rule Out Mental Retardation," and shortly thereafter was assessed as having a full-scale IQ of 54 – well into the range of mental retardation. Nevertheless, without documented justification, his diagnosis was changed to "Borderline Intellectual Functioning."

Psychological evaluations also must address relevant components of particular disorders, but Program 1's evaluations frequently do not. For instance, O.N. was diagnosed with Autistic Disorder, but nowhere in his chart was it evident that his speech and language had been evaluated, notwithstanding that an understanding of an autistic patient's communication abilities is essential in shaping appropriate interventions.

Questions generated in psychological evaluations should be answered, not left unresolved for extended periods of time.

Failure to address promptly questions fundamental to a correct psychological evaluation undercuts the evaluation's efficacy. Nevertheless, a Metropolitan psychologist informed us that it was not unusual for unresolved diagnoses (so-called "rule out diagnoses") to remain open for 10 to 12 months. For example, E.H. was admitted in April 1999 with "Rule Out Mild Mental Retardation." That unresolved diagnosis was in place when we toured the facility more than three years later. In fact, a number of patients went through their entire treatment regimen and were discharged with one or more unresolved diagnoses. This problem is exacerbated by nursing and unit staff's failure to monitor, document and report patients' symptoms as discussed above.

The foregoing deficiencies signal that Program 1 treatment teams undervalue psychological evaluations. Evidence of this comes from various charts, such as S.N.'s and F.U.'s, that do not even contain a psychological evaluation. The evaluations apparently had been removed from the active charts in contravention of facility policy. Further evidence that the facility disregards the importance of psychological evaluations is its failure to use Spanish-language testing tools for patients whose primary language is Spanish. Metropolitan identified 11 such patients at the time of our tour.

These problems lead to inaccurate, incomplete, and unreliable evaluations, which in turn leave the appropriateness of the psychological interventions to chance. This is a substantial departure from generally accepted professional standards of care that subjects Program 1 patients to the risk of harm and actual harm, in the form of untreated psychological disorders and psychological disorders that are worsened through inappropriate treatment.

B. Active Treatment

Generally accepted professional standards of care call for evidence-based psychotherapeutic interventions, that is, interventions that are empirically supported as effective. Program 1 policy does not reflect such a standard. Instead, it unspecifically states that "[e]ach patient shall be provided with an individualized program of treatment activity which reflects the program's highest level of performance and the optimal level of patient participation."

In any event, activity logs indicate that a number of children and adolescents receive virtually no active treatment. That is, they have scant participation in individual and group therapy or in activities of leisure and recreation.

Attendance records indicate that some children receive as little as one-half hour of individual therapy and 30 total hours of structured therapeutic activity, a month. One patient received no recorded therapeutic activities for a 12-day period, other than participation in 30-minute group meetings at which the patients' points for behavior, treatment and school participation are announced. Metropolitan staff could not identify any current active treatment for patient T.T.'s primary diagnosis of Post Traumatic Stress Disorder. Further, although T.T. also carries a diagnosis of polysubstance abuse, she reportedly has attended a substance abuse group only once and apparently is receiving no other substance abuse interventions. Moreover, most patients we reviewed receive no family therapy, despite the fact that many have significant traumatic family histories.

Further, as explained in Section I, above, there is little evidence of spontaneous, positive social interactions, especially interactions initiated by staff. There is also little evidence that the courtyards and free time are used constructively to enhance patients' lives. In summary, the amount of active treatment that Program 1 patients actually receive is alarmingly low.

Separately, there are a number of concerns with the quality of individual and group therapy. To be effective, individual psychological therapy should be available to patients in their primary language. Moreover, Metropolitan is a provider of health and social services that receives federal financial assistance from the U.S. Department of Health and Human Services. As such, it is required to provide Limited English Proficient ("LEP") persons such language assistance as is necessary to afford them meaningful access to these services, free of charge. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, et seq.; 45 C.F.R. § 80.3(b). See also Policy Guidance on the Prohibition Against National Origin Discrimination as It Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52762 (Aug. 30, 2000)("Health and social service providers must take adequate steps to ensure that [LEP] persons receive the language assistance necessary to afford them meaningful access to their services, free of charge."); 28 C.F.R. § 42.405 (d)(1) (" Where a

significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program . . . needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons.") Notwithstanding these obligations, Metropolitan has a significant number of primarily Spanish-speaking patients, such as F.U., whose therapists do not speak Spanish.

In any event, there is also little indication that the therapy sessions have an effective impact on individuals' outcomes. For example, inconsistent documentation indicates that J.U. received somewhere between 6 and 12 hours of individual therapy from February to May 2002. From late April to late May, she received five psychotropic PRNs and was placed in seclusion and/or restraints on 16 occasions. Similarly, T.T. received approximately 4½ hours of individual therapy from March to May 2002. She received no family therapy despite her issues regarding family dysfunction and her family's active visitation. From early April to early May, she received 12 psychotropic PRNs and was placed in seclusion and/or restraints on 11 occasions. These examples reflect Metropolitan's failure to provide the necessary therapeutic interventions to treat appropriately and effectively the children and adolescents in its care.

The group therapy provided at Metropolitan is inadequate. Only 9 of the 157 group therapy/activity protocols that we reviewed for Program 1 contained interventions or approaches that were empirically supported as effective. Groups are provided too infrequently and inconsistently. In particular, Metropolitan is not providing adequate substance abuse or medication groups -- critical groups for this population given that all of the patients are taking psychotropic medications and many have drug and alcohol issues.

Further, the lack of clinical oversight of group therapy raises serious concerns. Generally accepted professional standards of care require that such oversight be provided to: (a) determine a patient's readiness to participate in a group; (b) identify the group(s) that will provide therapeutic value to the individual; and (c) follow the patient's progress in the group(s) and regularly re-assess the appropriateness of the

group(s) based on the patient's individualized needs. Program 1's group therapy lacks any such clinical oversight, thereby exposing its patients to serious risk of harm. For example, many of the children and adolescents served by Program 1 have histories of being subjected to abuse. By placing these patients in groups in which subjects such as abuse are discussed prior to assessing their readiness to participate in such a group, Metropolitan is potentially re-traumatizing these children and adolescents. This is further exacerbated by making attendance at groups a requirement for earning points in the point system and ultimately for being considered for placement in a more integrated setting.

The quality of milieu programs (which are programs applicable to all patients and are to help them learn adaptive coping skills, improve self-esteem, and develop positive skills) appears also to be inadequate, as evidenced by the number of patients, such as Ui.N., Bc.O., I.X., and D.C., who have opted to miss almost as much as a month of school, and the many patients who "refuse to participate" in group therapy, according to their charts. High rates of treatment refusal convey a message regarding the quality of the treatment and should trigger an urgent assessment of programming and/or the patient, but this does not occur at Program 1. Moreover, patients whose group therapy attendance qualifies them for desirable activities, such as weekly community outings, are sometimes told that they cannot participate in these activities because of staffing constraints, which diminishes whatever therapeutic effectiveness group programming might have.

The efficacy of psychological treatments is further undercut by the use of excessive sedation for several Program 1 patients. During our tour, we frequently observed patients sleeping in day rooms during free time, sleeping in school classes, and sleeping during group activities. Many other patients were awake but showed signs of heavy sedation. Excessive sedation does not comport with generally accepted professional standards of care. Rather, it indicates inappropriate reliance on medication to manage patient behavior and restricts participation in treatment and educational programming. It also fosters a mentality that behavior cannot be internally and voluntarily controlled. Further, it prolongs patients' stay in a highly restrictive environment.

Independent of the quality of therapy, the documentation of individual and group therapy and group activities is fundamentally insufficient, stating neither the nature of the interventions employed nor the patients' responses. For example, documentation regarding I.X. is limited to general statements in the nursing notes, such as "has been . . . attending group," and various lists of the groups in which I.X. has participated. Similarly, the notes for B.S. by the physician, social worker, and psychologist do not even mention group treatment, and the nurse's notes contain only general statements, such as "[p]atient participates in groups." Consequently, it is not possible to gauge accurately the efficacy of particular treatments or assess the patient's progress relative to those treatments. In addition, patients' records often indicated that individual therapy was provided when therapy progress notes did not. These discrepancies call into question the integrity of the documentation as well the actual provision of services.

In any event, the dearth of effective active treatment interventions predictably contributes to poor patient progress in meeting treatment goals and discharge criteria. E.H. is illustrative. E.H. was admitted to the facility in April 1999. During our tour, personnel on his unit contemplated relaxing the standard discharge criteria, such that E.H. could be discharged if he maintained Level 3, the highest level of performance, for one month. Even this standard fails to recognize the ineffectiveness of E.H.'s treatments; in the more than three years that E.H. has resided at Metropolitan, this patient has achieved Level 3 one time.

E.H. illustrates the predicament of many of Metropolitan's children and adolescents. The failure to reach benchmarks that Metropolitan has determined to be achievable for patients like him primarily reflects, not his personal failings, but rather the shortcomings of the treatments he receives; E.H. is not receiving treatments that will allow him to maintain Level 3 long enough to leave the facility.

In summary, it is apparent that Program 1's active treatment interventions are too infrequent, are of inadequate quality, and are insufficiently documented. These deficiencies result in unnecessarily extended hospital stays, and they likely exacerbate psychological symptoms and increase feelings of hopelessness and emotional distress.

C. Behavioral Interventions

Behavioral intervention is a fundamental component of any appropriate treatment program for children and adolescents with emotional and behavioral disorders. Behavioral intervention occurs in milieu, or structural, context and on an individual level. In general terms, the objective of behavioral intervention is to facilitate other forms of treatment by controlling environmental conditions and shaping responses to environmental conditions. Shaping of responses occurs most typically through the consistent, comprehensible imposition of consequences that increase desirable behavior and decrease undesirable behavior. Virtually every aspect of Program 1's behavioral treatment programs is profoundly below generally accepted professional standards of care.

1. Milieu Programs

Generally accepted professional standards of care for behavioral programming call for the identification of specific, "operationally defined" "target" behaviors and the provision of consistent responses across settings to those behaviors. (In general terms, "operationally defined" means behaviors that are specified with particularity such that different observers can agree whether the behavior has occurred, and "target" behaviors means behaviors identified for treatment.) Behavioral programming that departs from these standards is virtually certain to fail and may exacerbate behavioral problems.

Perhaps the most prominent aspect of Program 1's milieu programs is its Point and Level System, the deficiencies of which are discussed above, at Section I. Independent of the Point and Level System, target behaviors in Program 1 behavior programs were stated in vague terms. Many patients' behavior programs included one target behavior for the unit, addressed only in the unit, and a different target behavior for the school, addressed only in the school. Thus, contrary to generally accepted professional standards of care, Program 1 does not ensure that responses to targeted behaviors are consistent across environments. Further, in at least one unit, the treatment team's review of, and changes to, target behaviors were not documented. In this regard, there was no effective means of tracking patient progress relative to the targeted behavior.

These problems severely restrict any benefit of the milieu programs and serve to frustrate and confuse patients.

2. Individual Behavioral Planning

Generally speaking, individual behavioral assessment is the careful examination of patient behaviors and the settings and circumstances in which they occur for purposes of developing appropriate interventions for undesirable behaviors and reinforcing desirable behaviors. Under generally accepted professional standards of care, this assessment is done through a functional analysis or functional assessment, which determines the purpose of the behavior and helps identify appropriate replacement behaviors.

As an initial matter, it is not clear that psychologists are aware of relevant behavioral data, including episodes of seclusion and restraints, which is essential in developing appropriate behavior support. Facility chart "thinning" guidelines dictate that the most recent three months of clinical data must be kept in the active chart, but we reviewed active charts from which recent instances of seclusion and/or restraints had been removed. T.T. is an example. Data regarding 15 episodes of seclusion or seclusion/restraints occurring in the three months just before our tour were "thinned" from T.T.'s active chart and placed in another chart intended to store dated information. Further, as indicated in Section II, Metropolitan does not have procedures in place to ensure that nursing and unit staff reliably monitor, document and report patients' symptoms and behaviors.

Program 1 behavioral supports are prepared without an adequate analysis of undesirable behaviors. The individual behavior treatment plans for F.U., I.X., D.Q., and N.Q., were prepared without a functional analysis or assessment of the behaviors which the plans are to address. One unit psychologist acknowledged that he had received no training in conducting functional behavioral assessments and was not aware of any tools for performing such assessments. The psychologist on another unit stated that systematic tools for conducting functional assessments were not available in the hospital.

The Program 1 individual behavior treatment plans are identified interchangeably as "special treatment plans" or "behavioral treatment plans." It appears that they are prepared

without adherence to specific criteria regarding methodologies or required components; the plans that we reviewed lack a common structure or approach. Their lack of functional analysis, of consistent, justifiable methodology, and of uniform components are shortcomings that significantly depart from generally accepted professional standards of care.

Separately, the triggers for performing behavioral assessments are poorly conceived. Consequently, individual behavior treatment plans are developed too rarely. In this regard, generally accepted professional standards of care require a clearly defined behavioral response, such as a behavioral treatment plan, to repeated episodes of highly restrictive interventions. However, Metropolitan policy requires individualized behavioral treatment plans only after the use of one-to-one supervision for 72 hours, due to harmful, or potentially harmful, behaviors.

Indeed, many patients are placed in seclusion and restraints repeatedly without triggering a behavioral assessment. Although T.T. was placed in seclusion and restraints 17 times over the 90-day period reviewed, and was subjected to PRN psychotropic medications 13 times over the 85-day period reviewed, T.T. did not have an individual behavior treatment plan. An intervention, of sorts, had been in place, but that was limited to T.T. reporting hourly to the nursing staff and was terminated because T.T. reportedly was uncooperative. Similarly, O.I. had 19 episodes of seclusion or restraints and 18 episodes of PRN medication in the period of slightly less than three months immediately preceding our Program 1 tour, but O.I. did not have an individual behavior treatment plan. Program 1 personnel indicated to us that, as a general matter, the decision to begin tracking individual behaviors was made informally.

Further, when behavioral interventions were developed, in at least some cases they were prepared with inordinate delay. Ui.N.'s chart indicates that a functional analysis of U.N.'s behavior was conducted in July 2001, followed by behavior tracking in October 2001 and the development of a "Special Treatment Plan" dated May 7, 2002. This example highlights not only a significant delay in treatment, but also another serious, more fundamental problem, which is that the facility is lackadaisical in responding to children and adolescents who are in need of urgent care and for whom extended institutionalization itself causes harm, by compounding their psychiatric problems.

When developed, the behavioral interventions are deficient in nearly every significant respect. They: (a) frequently are not prepared based on a functional analysis of behaviors, as in the plans of I.X., D.Q., Bc.O. and N.Q.; (b) describe target behaviors too broadly for the behaviors to be identified and tracked consistently, as in the plans for Ui.N., I.X., D.Q. and N.Q.; (c) do not sufficiently prescribe which environmental and consequential factors should be altered, as in the plans for Ui.N., I.X., D.Q., Bc.O., F.N. and N.Q.; (d) are internally inconsistent, as in the plans for Ui.N. and I.X.; (e) lack a reliable method to insure integrity of implementation, as in the plans for Ui.N., I.X. and D.Q.; and (f) lack criteria for revision or termination, as in the plans for Ui.N., I.X., D.Q. and N.Q.

Although Metropolitan has a Behavioral Treatment Review Committee charged with evaluating and approving behavioral treatments before they are implemented and with providing guidance to the psychologists preparing behavioral interventions, it is clear from the foregoing discussion that this committee is not functional. In fact, we could find no committee minutes for March and April 2002. The lack of quality control, guidance and leadership emanating from this committee conveys a message of indifference to the persons charged with providing adequate psychological care, indifference to the therapeutic importance of that care, and indifference to the children and adolescents who need but are not receiving adequate psychological care. That message of indifference contributes to the deficient psychological care at Program 1 and the resulting harm to its patients.

D. Use of Seclusion, Restraints and "As-Needed" Medications

Program 1's use of seclusion, restraints and "as-needed" (also known as pro re nata or "PRN") medications substantially departs from generally accepted professional standards of care and exposes the children and adolescents there to excessive and unnecessary restrictive interventions. It is generally accepted professional practice that seclusion and restraints will only be used when a person is a danger to self or others and when all other less restrictive measures have been attempted but failed. It also is generally accepted professional practice that seclusion and restraints will not be used in the absence of treatment or as punishment and will be terminated as soon as the

person is no longer a danger to himself or others. Finally, according to generally accepted professional medication practices, PRN medications should be used for psychiatric purposes only as a short-term measure to relieve a patient in acute distress, not as means to escape mild, possibly healthy, discomfort or as a repeatedly deployed substitute for treatment of the patient's underlying condition.

Metropolitan Program 1 staff use seclusion, restraints and/or PRN medications in the absence of adequate treatment and/or as punishment. Many episodes of seclusion, restraints and/or PRN medication use occur as a result of Program 1 patients exhibiting symptoms of their mental health disorders. Without the benefit of appropriate medication and therapeutic interventions, the children and adolescents are unable to control such symptoms. As a result of inadequate mental health treatment, children and adolescents are exposed to excessive use of seclusion, restraints, and/or PRN medications.

Moreover, we found numerous incidents in which patients exhibited behaviors that initially were not a danger to themselves or others, but because nursing and unit staff exacerbated their behaviors, the patients were ultimately subjected to seclusion, restraints and/or PRN medications. Because many Program 1 staff are not skilled in de-escalating their patients' behaviors, and because the patients lack adequate behavior support plans, staff frequently engage in power struggles with the patients. The documentation that is intended to reflect the interventions that staff attempted to use before seclusion, restraints and/or PRN medications does not indicate that staff had attempted other, less restrictive interventions.

Whenever a seclusion, restraint and/or PRN medication is used, it is generally accepted professional practice for the interdisciplinary team to reassess interventions and, as necessary, to modify the treatment plan to ensure that adequate proactive measures are identified and implemented. Frequent use of seclusion, restraints and/or PRN medications is an indicator that an individual's diagnosis is erroneous and/or that the treatment plan is inappropriate. Program 1 is failing to review patients' treatment plans after such episodes. There were numerous patient charts that, on one hand, identified frequent seclusion, restraint and/or PRN medication episodes but, on the other, contained no documentation that the team had reviewed the treatment plan or considered alternative interventions. For

example, J.U. was placed in seclusion and/or restraints on 19 occasions between April 16 and June 17, 2002. O.I. was placed in seclusion and/or restraints on 20 occasions between April 4 and May 30, 2002. S.N. was placed in seclusion and/or restraints on 18 occasions between April 2, 2002 and June 29, 2002. We found no evidence that any of these patients' treatment plans were reassessed or that other interventions were utilized before restraints. Moreover, staff frequently failed to document any information about the patients' status before, after or between episodes of seclusion, restraint and/or PRN medication use, making it difficult to improve the treatment plans.

Although Program 1 has made efforts to address its high rates of seclusion and restraints, those rates remain excessive. According to Metropolitan's statistics, for the 85 days immediately preceding our tour, there were 359 episodes of seclusion, restraints, or seclusion and restraints. Metropolitan statistics indicate that the average Program 1 census during our tour was 96. Together, these figures yield 43.99 episodes per 1,000 patient days, which is almost double the national aggregate data for adolescent psychiatric inpatient programs of 24.49 episodes per 1,000 patient days. See Association of Maryland Hospitals & Health Systems' Quality Indicators Project (2000) at http://www.qiproject.org/publicdata/psych/ (national comparative study).

Further, it appears that Metropolitan's statistics under-report the actual amount of seclusion and restraints that is being used. A random check of "Seclusion/Restraint" forms (form MSH 1172) uncovered numerous instances of seclusion and restraints not included in the summary seclusion and restraints data that Metropolitan provided to us. Examples of seclusion and restraints not captured in this summary data include:

(a) K.C. seclusion/restraints on 4/25/02, 18:05-19:30;
(b) K.S. seclusion/restraints on 4/28/02, 19:00-20:30;
(c) L.M. seclusion/restraints on 4/7/02, 14:20-16:10;
(d) P.B. seclusion/restraints on 4/13/02, 12:35-13:30;
(e) F.S. seclusion/restraints on 4/1/02, 15:15-17:15;

(f) S.N. seclusion/restraints on 4/24/02, 15:15-17:15; and
(g) E.G. seclusion/restraints on 5/7/02, 9:05-11:00.

The excessive use of PRN medications is also of great concern. For the 85 days immediately preceding our tour, PRN medications were administered 392 times. Based on a census of 96, this yields a rate of 48.04 episodes of PRN use per 1,000 patient days, which is an excessive rate.

There are numerous specific examples of excessive use of PRN psychotropic medications. U.C. received 20 PRN doses of Haldol between April 3 and June 16, 2002. Strikingly, 11 of these PRNs were administered by injection at U.C.'s request because "it was faster." Ub.N. received 22 psychotropic medication PRNs from April 6 to June 23, 2002, ten by injection. More than half of the PRNs were Haldol and Thorazine. Over approximately the same two month period, at least nine other individuals received between seven and 15 antipsychotic PRNs each. Many of these PRNs were for Haldol or Thorazine and/or were administered by injection.

The documentation indicates that patients frequently request and receive PRN medications when they are feeling "anxious." The facility appears to permit the use of PRN medications as a substitute for sound therapeutic intervention, thereby contributing to patients' medication dependency and dysfunction. In our review of charts of patients requesting PRNs, there was little indication that patients were provided proactive, supportive interventions before or after the administration of these medications. It does not appear that staff use such opportunities to teach children and adolescents the coping skills necessary to live independently in the community. Moreover, as discussed in Section I above, the use of the older antipsychotic medications raises a host of other serious risks to these patients' health.

IV. PHARMACY

It is standard practice for pharmacists to review individual patient's medication regimens. Such a review should encompass all of the medications prescribed (not just psychiatric drugs and PRN medications) and should include documentation of any communication between the pharmacists and physicians regarding

concerns, potential medication interactions, and the need for laboratory testing. Pharmacists, by the nature of their education and licensure, are the facility's experts regarding medications and medication interactions and share responsibility with physicians regarding medication decisions. We found no evidence that Metropolitan pharmacists perform these crucial roles. This is particularly troubling given the outdated and unjustified combinations of medications that are prescribed for these children and adolescents. By not providing adequate pharmacy services, Metropolitan places Program 1 patients at risk for the misuse of medication, unnecessary side effects from medication, potential drug interactions, general health problems, and excessively long hospitalizations.

V. GENERAL MEDICAL CARE

There are numerous instances in which Metropolitan fails to provide necessary medical care to the children and adolescents in Program 1. A number of children, including U.C., E.Z., S.K., C.H., Ui.N. and T.T., waited one to two months for an evaluation after complaining of vision problems and an additional one to three months to receive their glasses. U.C. experienced nighttime incontinence and received 15 doses of Motrin over two months for headaches. Neither problem was evaluated. The results of an x-ray for E.Z. were not noted by his physician for over one month. Similarly, C.H.'s physician did not initial his x-ray for more than two months.

VI. INFECTION CONTROL

In an institutional setting such as Metropolitan, it is standard practice for infections and communicable diseases to be tracked and trended. When analysis of trends reveals potential problems, it is standard practice for corrective action plans to be developed and implemented. Metropolitan has two infection control nurses on staff, but they only monitor individual patient infections. Metropolitan completes no systemic tracking or trending of infections or communicable diseases in Program 1 or throughout the hospital. As a result, Metropolitan's patients are at increased risk for infections and/or communicable diseases. Because no tracking or trending information was available for our review, it was impossible to determine if such infections had occurred or diseases had been allowed to spread without the benefit of corrective action plans.

VII. DENTAL SERVICES

Generally accepted professional standards of care require that dental care and treatment be provided in a timely manner. Program 1 patients, however, experience delays of several months in receiving needed dental care and treatment or do not receive treatment at all. This problem was noted in the April and May 2002 minutes of Metropolitan's CNS/NC Committee, which stated that individuals were not seen by a dentist in a timely manner and the "backlog" of dental patients required attention. At the time of our tour, the dentist assigned to Program 1 was on extended leave and the dentist for Metropolitan's adult population, an additional 800 or so individuals, was covering the Program 1 caseload. This coverage is insufficient to ensure timely and appropriate dental care. Even when Program 1 patients do receive dental services, documentation of these services is grossly incomplete, often failing to indicate the individual's current dental status and leaving numerous sections of the evaluation blank.

VIII. DIETARY

Program 1's dietary services substantially depart from generally accepted professional standards of care and expose the children and adolescents there to significant risk of harm. The facility's dietician estimated that eighty percent of Program 1's patients are obese, an estimate consistent with our own observations and review of patient records. Many of the medications these children and adolescents receive exacerbate weight problems. These patients' obesity, which is very severe in several cases, places them at increased risk for physical health problems, such as high blood pressure, and other deleterious effects, such as decreased self-esteem, that worsen existing mental health problems. Notwithstanding these significant consequences, virtually every one of the several nutritional evaluations that we reviewed indicated that the facility was not pursuing dietary interventions because the patient "refused [a] weight reduction program" that consisted almost entirely of receiving a smaller portion of the same meals served to other patients. We found no evidence that the facility was actively promoting viable alternative interventions to address patients' severe weight problems. Our record review of Program 1's exercise group, for instance, indicated that the group rarely met. Whether or not these children and adolescents arrived at Metropolitan greatly overweight, the facility is not

implementing meaningful interventions to address their serious weight problems or related self-esteem issues.

IX. PLACEMENT IN THE MOST INTEGRATED SETTING

Generally accepted professional standards of care and federal law require that treatment teams, with the leadership of psychiatrists and the support of the hospital administration, actively pursue the timely discharge to the most integrated, appropriate setting that is consistent with patients' needs. In this regard, factors that contributed to previous unsuccessful placements should be identified and addressed. Program 1's discharge planning process fails to meet these standards of care. Consequently, the process results in unnecessarily extended hospitalizations, poor transitions, and a high likelihood of readmission, all of which result in harm to Program 1's children and adolescents.

The excessive length of numerous patients' hospitalizations is alarming. As of the week of our visit, the average length of stay was reported to be 350 days, with 30 percent of the current patients having been at Program 1 more than one year and 14 percent more than two years. Staff appear to take little responsibility for the discharge process, stating that excessively long stays are unavoidable. Despite the fact that some children and adolescents remain at Program 1 for years, Program 1 has not developed any mechanism to identify and review those patients having extremely lengthy hospitalizations. Given that there is no mechanism to identify patients who are stalled in their discharge implementation, senior administration seems to have no understanding that children and adolescents remaining institutionalized for years constitute a systemic crisis, nor do they demonstrate any influence over this process.

Metropolitan's discharge criteria and the portions of treatment plans addressing discharge are also inappropriate and contribute to patients' lengthy hospitalizations. Plans fail to identify clearly the barriers to discharge to the most integrated setting, and the actions that staff and/or the patient needs to take to overcome these barriers. Plans also do not contain measurable action steps, persons responsible for discharge steps, and time frames for the completion of those steps.

Further, discharge criteria in the majority of cases are identical. Most patients are required to maintain nearly 100

percent compliance with most aspects of Program 1 rules and to maintain discharge criteria for 90 days prior to the facility seeking a placement. Thus, even after the point at which an individual achieves discharge criteria, he or she is typically not discharged for many months. For instance, Ui.N.'s April 2002 treatment plan stated that he had met discharge criteria, but his estimated discharge date read "three to six months." The fact that discharge plans routinely have broad estimated time frames for discharge rather than a specific date as the estimated date of discharge favors such easily extendable discharge dates.

As a general matter, Metropolitan's approach to the discharge process is passive, as illustrated by the case of N.Q. This patient had met all of the facility's discharge criteria. Nevertheless, he remained there because his receiving program would not accept him without an updated audiological evaluation, and Metropolitan had not scheduled one. Moreover, discharge summaries for a number of patients included no appointments for follow-up care. Failure to ensure follow-up care places these children and adolescents at marked risk of re-hospitalization.

Metropolitan's shortcomings regarding N.E. illustrate many of these problems. Despite the fact that she met discharge criteria for 90 days, that her family was willing to care for her, and that a court, at N.E.'s insistence, ordered her discharged, the treatment team was so entrenched in their view of discharge planning that they discharged her "against medical orders" to her family, because they wanted her sent, instead, to a group home. The discharge form indicated that N.E. was frustrated over the period of time she had waited to be discharged, stating "you guys won't do anything so I have to." Indeed, many aspects of Metropolitan's approach to discharge planning reflect an attitude that the children, and not the facility, bear responsibility for improving their health.

In part, the problems with the discharge process are due to the diffusion of authority and responsibility for the provision of discharge services between the facility and California counties; the facility typically determines when a patient is ready for discharge and recommends a setting for placement, but the resident's county of origin determines the actual placement setting. Also, social workers, who are required to organize the discharge process with little administrative support from Metropolitan, have a limited ability to influence many of the decisions regarding placement. Discharge planning, however,

cannot be disconnected from treatment and based solely upon funding and resource availability. One social worker expressly stated to us that these factors posed obstacles to discharge. Metropolitan must take necessary actions in the discharge process to treat its patients adequately and appropriately and to comply with federal law.

X. SPECIAL EDUCATION

Metropolitan's provision of special education substantially departs from generally accepted professional standards of care and from federal law in that it fails to provide children and adolescents adequate habilitation to prevent regression and to facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982). California is also failing to meet its more specific obligation to provide individualized educational programs that are reasonably calculated to enable the children and adolescents of Metropolitan to receive educational benefits. See Bd. of Educ. of the Hendrick Hudson Cent. Sch. Dist. v. Rowley, 458 U.S. 176, 206-07 (1982).

Federal law conditions federal financing of State special education programs upon the State's provision of a free and appropriate public education ("FAPE"). Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §§ 1400 et seq. (2002). In this regard, the IDEA requires educational agencies to develop an individualized education program ("IEP") for each child having a disability. The required elements of the IEP include, but are not limited to: (a) present levels of educational performance; (b) annual goals and short-term objectives; (c) specific educational services that are to be provided; and (d) statements of how progress toward annual goals are to be measured. 20 U.S.C. § 1414(d) (2002). The IDEA further requires such "related services" as are necessary to permit the child to benefit from instruction, including psychological services. Id. at §§ 1401(22), 1414(d)(2002). Thus, the IDEA requires "access to specialized instruction and related services which are individually designed to provide educational benefit to the handicapped child." Rowley, 458 U.S. at 201.

Metropolitan does not provide "specialized instruction and related services which are individually designed," id., nor has it developed clear statements of how progress toward annual goals

are to be measured, see 20 U.S.C. § 1414(d)(2002). Its deficiencies in this regard cause harm to most of its Program 1 patients, who are entitled to a free and appropriate education, but do not receive it.

Inadequate direction is a common component of many of the problems in this area. School administration is not effective in supervising teachers, overseeing instruction, or ensuring that procedures, such as the recording of attendance, are appropriately followed. For example, the principal of the Allen Young School, which is the on-campus school serving Metropolitan patients under age 18, appeared largely unaware of what happened in his classrooms; he was unable to identify which students were doing well or even recall significant incidents of violence and suspensions that recently had occurred in the school.

A. Individual Education Programs

Metropolitan's IEPs substantially depart from generally accepted professional standards of care and do not comply with federal law. Based on our review of 15 plans, it is apparent that they are formulaic. Many plans vary by only a few words from student to student. Further, they reflect poor assessments of students' individual levels of educational performance. Metropolitan's assessments of unique educational needs are unreliable. They frequently are based on assessment tools that are greatly outdated and that do not evaluate students in their non-English native languages. Consequently, the IEPs do not correctly identify students' current levels of education performance.

Further, although the IEPs do contain nominally "specific education services" to be provided to each student, the identified services are, in substance, largely generic among students. Specificity regarding the unique educational needs of the individual student is mostly absent. As a consequence of these deficiencies, the identified annual goals and short-term objectives of students often are not appropriate. For that matter, the IEPs generally do not contain individualized goals.

For many of Program 1's students, behavioral supports are necessary "related services" that are not currently being provided. Without such services, students are unable to benefit from instruction. Given the population enrolled in the Allen Young School, it is troubling that only one of the IEPs reviewed

indicated a need for functional behavioral assessment. Even when assessments and behavioral plans are included in the IEPs, they are inadequate for many of the reasons discussed at Section III, above, including their lack of individualization, specificity or objective data. It is also of great concern that there appears to be no coordination between the behavior support plans at the school and those on the residential units. The children and adolescents are likely to be confused by disparate plans, thereby negating their intended therapeutic effect.

Finally, although the IEPs should include appropriate, objective criteria for determining whether instructional objectives are being achieved, they do not. In this regard, two teachers acknowledged to us that they have no formal system for assessing progress, and most teachers indicated that they use informal, subjective estimates of students' progress. Thus, Metropolitan's IEPs neither comply with the IDEA nor have significant utility in identifying and providing for individuals' education needs.

B. Instruction

One of the most critical elements of the IEP is that it be reasonably calculated to enable the child to receive educational benefits. See Rowley, 458 U.S. at 206-07. It is axiomatic that, for students to receive educational benefits, they must receive adequate instruction. Generally accepted professional standards regarding special education instruction call for teacher-directed lessons, provided in small, homogeneous groups, composed of frequent teacher questions and student answers, progressing in small increments, with abundant teacher feedback. Although we saw some elements of such instruction in three classes, no such instruction was evident in another five classes that we attended. Generally speaking, Metropolitan's classroom instruction is not effective in conveying the educational benefits to which its special education students are entitled.

C. Literacy

Metropolitan's records clearly show that some special education students lack basic reading and writing skills. These skills are the most fundamental educational benefit to which special education students are entitled. Although some IEPs contained literacy objectives, we found no evidence that literacy instruction was, in fact, provided. We saw no literacy

instruction during our tour, nor records of planning for fundamental literacy instruction. Teachers we interviewed indicated that they had adult readers assist students having reading difficulties, but they did not provide remedial reading instruction. One school staff person stated that the speech therapist provided remedial reading instruction, but the speech therapist told us that she was not teaching reading. Consequently, it appears that Metropolitan is not providing the most basic academic skills to the special education students who lack them. This is a substantial departure from generally accepted professional standards of care that is harmful to these students in that it deprives them of educational tools that are essential to function adequately in society.

D. Least Restrictive Environment

The IDEA requires that,

> [t]o the maximum extent possible, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

20 U.S.C. § 1412 (5)(A). See also Rowley, 458 U.S. at 202 ("The Act requires participating States to educate handicapped children with nonhandicapped children whenever possible.") None of Metropolitan's children and adolescents participates in any off-grounds schooling, with non-institutionalized children. Metropolitan does not meaningfully assess each child and adolescent to determine whether he or she, when provided adequate supervision and supports, is capable of participating in at least some regular school activities with non-disabled peers. Although many patients' disorders may preclude any participation in a regular educational environment, other patients, especially those approaching discharge, may be capable of at least some integrated education, with appropriate supports. Metropolitan's failure to assess continuously each of its child and adolescent patients to determine whether he or she requires separate schooling, and its

failure to provide access to a regular school environment for those patients who could participate, with reasonable supports, is in violation of the IDEA.

XI. PROTECTION FROM HARM

During the Metropolitan II exit interview, we outlined facility-wide issues relating to protection from harm and quality assurance, and we will address these facility-wide issues in connection with our findings regarding Metropolitan's adult units. Regarding Program 1, in particular, the foregoing discussion makes evident that Metropolitan fails to protect the children and adolescents it serves from harm.

Further, as we pointed out in the presence of facility administrators who toured Program 1 units with us, the vents and window grills on several units contained holes large enough for patients to thread a sheet or other cloth through them, placing them at risk for suicide by hanging. In this regard, a number of the units had metal window frames with space between the frame and the ceiling which could be potential suicide hazards. Likewise, some of the vents in Program 1 were not covered. This presented a hazard in that patients could access wires and other potentially dangerous items. Several of the units contained other hazards, such as wires holding down seclusion beds that, if accessed by patients, could be used to hurt oneself or others.

In addition, one of Unit 101's seclusion rooms did not have mirrors properly positioned, creating a blind spot and preventing staff from monitoring patients who have been placed in the room. Further, some of the seclusion room restraints were worn, placing patients who are restrained at risk of abrasions and skin breakdown.

In at least one instance, Metropolitan did not take steps to ameliorate known risks. On January 23, 2002, patient I.X. attempted to commit suicide by tying a shoelace through openings on the under side of her bed and strangling herself. Less than 4 months later, on May 17, 2002, she again attempted suicide using the same methodology.

Further, frequent instances of same-sex sexual contact among patients were labeled by Metropolitan as "consensual" when it appeared that the facility was making insufficient effort to ensure that patients were not being coerced into sexual activity.

A staff member on Unit 107 estimated that there had been 10 such instances on the unit over the preceding year, but our search for documentation of these instances uncovered a record of only one. Separately, as to a patient who had made a documented claim that he had been raped, we found no evidence in the chart that a physician had examined him physically, and no responsive interventions were undertaken, according to the chart, apart from moving the involved boys to separate bedrooms.

These examples and much of the foregoing discussion raise concerns regarding Metropolitan's ability to protect patients from harm and its incident management system, including the tracking and trending of unusual incidents, the quality of the investigations being completed, and the identification and implementation of corrective actions. As indicated above, we will elaborate on those concerns in our findings addressing Metropolitan's adult units.

XII. FIRST AMENDMENT AND DUE PROCESS

Prior to our tours of Metropolitan, the State indicated that it would refuse to allow Program 1 patients to speak with the Department of Justice or its expert consultants unless persons acting at the direction of the State were present. During our tours of Metropolitan, the State maintained this position, and State representatives participated in all of our discussions with patients. The State's effort to circumscribe our access to Metropolitan patients and to information regarding their care and well being is troubling.

As the State is aware, the United States District Court for the Central District of California has ruled that CRIPA preempts a jurisdiction's invocation of procedural hurdles to "restrict or deny the DOJ access to [a juvenile facility], the juveniles held therein and their records." United States v. County of Los Angeles, 635 F. Supp. 588, 594 (C.D. Cal. 1986). More fundamentally, by denying its patients the right to speak confidentially to attorneys from, or expert consultants acting for, the Department of Justice, the State impermissibly has constrained its patients' constitutional rights to: (a) free speech, including the right to petition the government for redress of grievances; and (b) due process. See United States Constitution Amendments I, XIV; Johnson v. Avery, 393 U.S. 483, 485 (1969)(stating that even state prisoners retain the freedom to petition for redress of grievances); Gary W. v. Louisiana, 437

F. Supp. 1209, 1224 (E.D. La. 1976), aff'd, 622 F.2d 804 (5th Cir. 1980)(stating that children institutionalized for treatment enjoy the First Amendment right to free communication, and the State may monitor such children's communications only under "carefully circumscribed conditions," when "necessary to prevent serious harm to the child"); In re Quarles 158 U.S. 532, 535-36 (1895)(discussing the rights of citizens to communicate with federal law enforcement officials regarding violations of federal law). By imposing itself on communications between the federal government and its citizens, California wrongfully abridges these rights.

Further, California's position violates the protections that it itself affords to persons institutionalized in its mental health hospitals, in its Code of Mental Health Patients' Rights. See Cal. Welf. & Instit. Code § 5325 (2002). Under California law, all State mental health patients are entitled to certain rights, that must be posted in English and Spanish throughout the institution, and that include the right to engage in communications that are confidential. Id. The right to confidential communication provided by California law -- especially communication with one's government regarding matters of important public interest, such as conditions of care at a state institution -- is one of real substance, the State's encumbrance of which implicates the due process clause of the United States Constitution. In placing its own interests in limiting its exposure to a federal investigation of a State facility over the constitutional interests of the patients residing in that facility, the State has further harmed those patients.

XIII. MINIMUM REMEDIAL MEASURES

To remedy the deficiencies discussed above and to protect the constitutional and federal statutory rights of the children and adolescents in Program 1 of Metropolitan, California promptly should implement the minimum remedial measures set forth below.

A. Psychiatric Services

Metropolitan should provide psychiatric supports and services to provide adequate treatment for chronically and severely mentally ill and traumatized children and adolescents. More particularly, Metropolitan should:

1. Ensure that each individual's psychiatric evaluation, diagnoses, and medications are justified in a generally accepted professional manner.

2. Ensure that all physicians and clinicians can demonstrate competence in appropriate psychiatric evaluation and diagnosis.

3. Develop standard psychiatric evaluation protocols for reliably reaching psychiatric diagnoses.

4. Review and revise, as appropriate, psychiatric evaluations of all individuals currently residing in Program 1, providing clinically justifiable current diagnoses for each individual, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimen, as appropriate.

5. Develop and implement policies and procedures regarding the development of treatment plans consistent with generally accepted professional standards of care.

6. Review and revise, as appropriate, each individual's treatment plan so that it is current, individualized, and consistent with generally accepted professional standards of care.

7. Develop appropriate protocols that require the completion of cognitive and academic assessments of all Program 1 patients within 30 days of admission, unless valid testing has been completed within one year of admission.

8. Develop and implement a plan of remediation in both treatment and educational plans for any identified cognitive and academic deficits of current Program 1 children and adolescents.

9. Develop policies and protocols to ensure patients have genuine input into their treatment plans, including education regarding the purposes and side effects of medication.

10. Increase the frequency of treatment team meetings and discharge plan reviews from every 90 days to a minimum of every 30 days, and more frequently, as appropriate.

11. Ensure that all psychotropic medications are appropriate for Program 1's population, are specifically matched to current, clinically justified diagnoses, are prescribed in therapeutic amounts, are monitored for efficacy against clearly-identified target variables and time frames, are modified based on clinical rationales, and are properly documented.

12. Develop and implement protocols and procedures consistent with generally accepted professional standards of care regarding the use of psychotropic medications to treat symptoms other than psychosis, including that this practice be clearly documented with a specific plan for minimizing the dosage and the duration of the medication.

13. Develop and implement protocols and procedures consistent with generally accepted professional standards of care regarding off-label medication usage, including the establishment of an institutional review board to supervise this practice, the development of research protocols, and policies to obtain appropriate informed consent from minors and/or guardians.

14. Develop and implement protocols and procedures to ensure that each patient’s treatment plan includes a plan to monitor, document, report and properly address potential side effects of prescribed medications.

15. Develop and implement formal tools to be used program-wide for each person at risk of experiencing medication side effects in accordance with generally accepted professional standards.

16. Make appropriate attempts to use newer psychotropic medications with fewer, less serious side effects, rather than older psychotropic medications.

17. Use a milieu structure for Program 1 that is consistent with generally accepted professional standards of care. Ensure that it is applied to patients in a consistent, comprehensible and therapeutic manner, and ensure that staff implementing milieu programs first have successfully completed competency-based training in implementing such programs.

18. Remedy those aspects of Program 1's physical environment that inhibit appropriate psychiatric treatment, including, but not limited to, the violation of individual's privacy, the lack of individualization, and the lack of appropriate recreational facilities.

B. Nursing

Metropolitan should provide nursing services to the children and adolescents it serves that are consistent with generally accepted professional standards of care. Such services should result in Program 1's patients receiving individualized services, supports and therapeutic interventions. At a minimum, Metropolitan should:

1. Develop and implement a treatment planning policy that ensures that each patient's treatment plan identifies the Axis I diagnoses and the related symptoms to be monitored by nursing and other unit staff and the frequency by which staff need to monitor such symptoms. This policy should include requirements for staff to monitor, document and report such symptoms and for treatment teams to analyze the information collected and to modify, as appropriate, treatment plans based upon this data.

2. Develop and implement a policy consistent with generally accepted professional standards of care

regarding psychotropic medication side effects monitoring.

3. Ensure that, before they work directly with patients, all nursing and other unit staff have successfully completed competency-based training in mental health diagnoses, related symptoms, psychotropic medications, and the identification of side effects of psychotropic medications.

4. Ensure that, before they work directly with patients, all nursing and other unit staff have successfully completed competency-based training in the provision of a therapeutic milieu on the units.

5. Ensure that, before they work directly with patients, all nursing and other unit staff have successfully completed competency-based training in proactive, positive interventions to prevent and de-escalate crises.

C. Psychology

Metropolitan should provide psychological supports and services adequate to treat the emotional and behavioral disorders experienced by Program 1 children and adolescents according to generally accepted professional standards of care. More particularly, Metropolitan should:

1. Where clinical information is insufficient, increase the use of direct clinical assessment of patients to provide a comprehensive clinical picture, and when additional clinical questions are raised, including so-called "Rule Out" and deferred diagnoses, implement appropriate clinical assessments to answer the questions promptly.

2. Ensure that clinically relevant information remains readily accessible in the active chart.

3. For patients whose primary language is not English, provide comprehensive psychological assessments in the patients' primary language.

4. Ensure that psychologists communicate and interpret psychological assessment results to the treatment team, along with the implications of those results for diagnosis and treatment.

5. Develop and implement policies and procedures, in accordance with generally accepted professional standards of care, regarding the necessary and sufficient components of a comprehensive psychological evaluation.

6. Ensure that patients in need of individual, group and/or family therapy services receive such services in accordance with generally accepted professional standards, and that these services are provided in a patient's primary language.

7. Document the provision of individual and group therapy services each time they occur, including clear descriptions of the problem being addressed, the focus of the session, the intervention provided by the therapist, and the patient's response to the intervention.

8. Provide adequate clinical oversight to therapy groups to ensure that patients are assigned to groups that are appropriate to their individual needs, that groups are provided frequently and consistently, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are addressed in group therapy.

9. Ensure that all group leaders are competent regarding selection and implementation of appropriate approaches and interventions to address group therapy objectives, are competent in monitoring patient responses to group therapy, and are supervised by clinical staff.

10. Ensure the consistent implementation of reinforcement and behavior programs.

11. Ensure that patients are not denied, because of excess sedation, the full benefit of behavioral treatment and educational interventions.

12. Ensure that all psychologists can demonstrate competence in the development and implementation of milieu behavioral programs that are consistent with generally accepted professional standards of care, including the monitoring of patient progress in such programs and program revision as monitoring warrants.

13. Ensure that all responsible program staff demonstrate competence in implementing individual behavioral programs.

14. Ensure that, before they work with patients, all psychologists have successfully completed competency-based training, in accordance with generally accepted professional standards of care, in conducting a functional analysis of behavior, preparing individualized behavior interventions and positive behavior support plans, designing methods of monitoring the program intervention and the effectiveness of the intervention, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program.

15. Specify and utilize, in accordance with generally accepted professional standards of care, triggers for instituting individualized behavior treatment plans.

16. Continue to reduce the use of seclusion, restraints and psychotropic PRN medications.

17. Ensure the accuracy of seclusion, restraints, and psychotropic PRN medications data.

18. Revise and implement policies and procedures to prohibit the use of seclusion, restraints and/or psychotropic PRN medications as an alternative to adequate treatment and/or as punishment. Include requirements for staff to utilize and document the

use of proactive, positive, and less restrictive methods before using seclusion, restraints and/or psychotropic PRN medication. Ensure that staff demonstrate competence in the implementation of such policies.

19. Revise and implement policies and procedures to require the review and modification, if necessary, of patients' treatment plans after any use of seclusion, restraints and/or psychotropic PRN medication.

20. Develop and implement a policy consistent with generally accepted professional standards of care governing the use of psychotropic PRN medication for psychiatric purposes in child and adolescent patients and ensuring, in particular, that such medications are used on a limited basis and not as a substitute for adequate treatment of the underlying cause of the patient's distress.

D. Pharmacy

Metropolitan's Program 1 patients should receive pharmacy services consistent with generally accepted professional standards of care. Specifically, Metropolitan should:

1. Develop and implement policies and procedures that require pharmacists to complete monthly reviews of patients' medication regimens, and, as appropriate, to make recommendations to the treatment team, including the prescribing physician, about possible medication changes. Such a review process should include medical and psychotropic drugs.

2. Develop and implement policies and procedures that require pharmacists to track the use of psychotropic PRN medications, and, whenever appropriate, notify the prescribing physician of problematic trends.

E. General Medical Care

Metropolitan should provide adequate preventative, routine, specialized and emergency medical services on a timely basis, in accordance with generally accepted professional standards of care. More particularly, Metropolitan should:

1. Develop and implement protocols and procedures to ensure the timely provision of medical care, including but not limited to, evaluation of vision care, dental care, and x-ray services.

2. Render appropriate medical treatment on a timely basis.

3. Monitor patients' health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their treatment plans to address any problematic changes in health status indicators.

F. Infection Control

Metropolitan should implement adequate infection control procedures to prevent the spread of infections and/or communicable diseases. More specifically, Metropolitan should:

1. Revise infection control policies and procedures to include the tracking and trending of infections and communicable diseases as well as the development and implementation of corrective action plans.

2. Establish an effective infection control program that: (a) actively collects data with regard to infections and communicable diseases; (b) assesses these data for trends; (c) initiates inquiries regarding problematic trends; (d) identifies necessary corrective action; (e) monitors to ensure that appropriate remedies are achieved; and (f) integrates this information into Metropolitan's quality assurance review.

G. Dental Services

Patients should be provided with routine and emergency dental care and treatment on a timely basis and in a manner consistent with generally accepted professional standards of care. More specifically, Metropolitan should:

1. Retain an adequate number of adequately qualified dentists to provide timely and appropriate dental care and treatment to Metropolitan patients.

2. Develop protocols and procedures that require the comprehensive and timely provision of dental services and the documentation of such services.

H. Dietary

Metropolitan Program 1 patients should receive adequate dietary services, particularly patients who experience weight-related problems. Specifically, Metropolitan should:

1. Modify treatment planning policies and procedures to require that the treatment plans of children and adolescents who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner.

2. Ensure that treatment team members demonstrate competence in the dietary and nutritional issues affecting children and adolescents and the development and implementation of strategies and methodologies to address such issues.

3. Increase the availability of individualized and group exercise and recreational options for the children and adolescents in Program 1.

I. Placement in the Most Integrated Setting

Metropolitan should pursue actively the appropriate discharge of patients and ensure that they are in the most integrated, appropriate setting that is consistent with patients' needs. More particularly, Metropolitan should:

1. Ensure that discharge planning begins at the time of admission and that all patients have realistic and individualized discharge criteria. Ensure that each patient has a professionally developed discharge plan, including measurable action steps, persons responsible and time frames for completion.

2. Ensure that patients who have met discharge criteria are discharged expeditiously and with appropriate supports.

3. Develop and implement a policy and protocol that identifies patients with lengths of stay exceeding six months. Establish a regular review forum, including senior administration, to review these patients, their treatment plans, and obstacles to successful discharge to the most integrated, appropriate setting. Create an individual action plan for each individual being reviewed.

4. Consolidate responsibility for discharge planning with the authority to provide the supports and services that discharge planning indicates are necessary.

5. Ensure that all Program 1 staff, including senior administration, provide care and treatment to mitigate the dangers of long-term institutionalization for the children and adolescents in their care.

6. Provide transition and follow-up supports and services consistent with generally accepted professional standards of care.

J. Special Education

Metropolitan should ensure that all of its child and adolescent patients who qualify for special education receive individualized educational programs that are reasonably calculated to enable these patients to receive educational benefits. More particularly, Metropolitan should:

1. Ensure that all Individualized Education Programs are developed and implemented consistent with the requirements of the Individuals with Disabilities Act, 20 U.S.C. §§ 1400 et seq. (2002)("IDEA").

2. Ensure that special education students receive instruction appropriate to their needs and learning abilities, consistent with generally accepted professional standards of care.

3. Provide appropriate literacy instruction for students with significant deficits in reading and/or writing.

4. Provide appropriate supplemental education for students whose individualized education programs at the facility have not been reasonably calculated to enable them to receive educational benefits.

5. Continuously assess each student's capacity to participate, with appropriate supports and services, in a regular, non-institutional, education environment, and provide access to a regular education environment for those students who can participate in one with appropriate supports and services.

6. Ensure that all students receive their education in the least restrictive setting pursuant to the requirements of the IDEA.

K. Protection from Harm

Metropolitan should provide its patients with a safe and humane environment and protect them from harm. At a minimum, Metropolitan should:

1. Conduct a thorough review of the units within Program 1 to identify potential safety hazards, and develop and implement a plan to remedy any identified issues.

2. Thoroughly review and, as appropriate, revise hospital policy, and Program 1 practice, regarding

sexual contact between patients. Establish clear guidelines regarding staff responses to reports of sexual contact and monitor staff responses to incidents. Comprehensively document therapeutic interventions in patient charts in response to instances of sexual contact.

3. Develop and implement a comprehensive quality assurance plan consistent with generally accepted professional standards of care, including but not limited to an effective incident management system.

L. First Amendment, Access to Courts and Due Process

The State should permit Metropolitan Program 1 patients to exercise their constitutional rights of: (a) free speech, and, in particular, the right to petition the government for redress of grievances without State monitoring; and (b) due process. More particularly, the State should:

1. Permit patients to speak with representatives of the federal government outside the presence of persons acting for the State.

2. Permit patients to engage in confidential communications.

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The collaborative approach that the parties have taken thus far has been productive. We hope to continue working with the State in this fashion to resolve our significant concerns regarding the care and services provided at this facility.

We will forward our expert consultants' reports under separate cover. Although their reports are their work – and do not necessarily represent the official conclusions of the Department of Justice - their observations, analyses and recommendations provide further elaboration of the relevant concerns, and offer practical assistance in addressing them. We hope that you will give this information careful consideration

and that it will assist in facilitating a dialogue swiftly addressing areas requiring attention.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that the Attorney General may initiate a lawsuit pursuant to CRIPA, to correct deficiencies or to otherwise protect the rights of Metropolitan's patients, 49 days after the receipt of this letter. 42 U.S.C. § 1997b(a)(1). Accordingly, we will soon contact State officials to discuss in more detail the measures that the State must take to address the deficiencies identified herein.

Sincerely,

/s/ Ralph F. Boyd, Jr.

Ralph F. Boyd, Jr.
Assistant Attorney General

cc: The Honorable Bill Lockyer
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