



**U.S. Department of Justice**

Civil Rights Division

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*Assistant Attorney General  
950 Pennsylvania Avenue, NW - RFK  
Washington, DC 20530*

December 8, 2009

The Honorable Sonny Perdue  
Office of the Governor  
203 State Capital  
Atlanta, Georgia 30334

Re: Investigation of the State Psychiatric Hospitals

Dear Governor Perdue:

I am writing to provide the Civil Rights Division's report of findings regarding our investigation of conditions and practices in the State's Psychiatric Hospitals, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern and practice of conduct that violates the constitutional or federal statutory rights of patients with mental illness or developmental disabilities who are treated in public institutions, including those rights protected by the Americans With Disabilities Act ("ADA"), 42 U.S.C. §§ 12132-12134. The findings discussed in this letter apply to Georgia Regional Hospital at Savannah ("GRHS"), East Central Regional Hospital in Augusta, Georgia ("ECRH"), Central State Hospital in Milledgeville, Georgia ("CSH"), Southwestern State Hospital in Thomasville, Georgia ("SWSH"), and West Central Georgia Regional Hospital in Columbus, Georgia ("WCGRH") (collectively, the "State Psychiatric Hospitals"), and are consistent with our two prior letters, the May 30, 2008 letter concerning the Georgia Regional Hospital in Atlanta ("GRHA"), and the January 15, 2009 letter concerning the Northwest Georgia Regional Hospital in Rome, Georgia ("NWGRH").

On April 18, 2007, we notified you that we were initiating an investigation of conditions and practices in the State Psychiatric Hospitals pursuant to CRIPA. We subsequently conducted on-site reviews with the assistance of expert consultants in the fields of psychiatry, psychology, nursing, protection from harm, and discharge planning and community placement.<sup>1</sup> While on-site, we interviewed administrative

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<sup>1</sup> We conducted our first inspection of GRHA on September 17-21, 2007, and a second inspection on August 2-6, 2009; NWGRH on October 29 through

staff, mental health care providers, and patients, and examined the physical plant conditions throughout the State Psychiatric Hospitals. In addition, we reviewed a wide variety of documents, including policies and procedures, incident reports, and medical and mental health records. We also have received and reviewed the State's own audits of its Hospitals by consultants from the Medical College of Georgia, see Peter Buckley, M.D., and Nannette M. Lewis, M.P.H., Medical College of Georgia, A Comprehensive Evaluation of Georgia's State Hospital Services, December 2007 (describing deficits at the seven State Psychiatric Hospitals in protection from harm, mental health treatment, nursing staffing, risk management, and performance improvement), the State's Plan of Implementation and Compliance Report ("POI Report") filed with the District Court in September of this year, and the State's quality management reports sent to us in August of this year. Consistent with our commitment to provide technical assistance and proceed in a transparent manner, we have concluded each of our site visits with extensive debriefings at which our consultants conveyed their initial impressions and grave concerns about conditions to counsel, administrators and staff, and State officials.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies. 42 U.S.C. § 1997b(a). We have concluded that numerous conditions and practices at the State Psychiatric Hospitals violate the constitutional and statutory rights of the patients confined there. Specifically, we find that the State Psychiatric Hospitals fail to provide adequate discharge planning to ensure placement in the most integrated setting and to provide adequate supports and services necessary for successful discharge, see Americans with Disabilities Act, 42 U.S.C. §§ 12132-12134; 28 C.F.R. § 35.130(d); Section 504 of Rehabilitation Act, 29 U.S.C. § 794; Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-7; Olmstead v. L.C., 527 U.S. 581 (1999), and continue to provide deficient services that subject patients both to actual harm, and to an excessive risk of serious harm, including: (1) inadequate protection from harm; (2) inappropriate mental health treatment; (3) inappropriate seclusion and restraints; (4) inadequate medical care; and (5) inadequate services to populations with specialized needs. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XVIII and Title XIX of the Social Security Act, 42 U.S.C. §§ 1395 to 1395b-10 and 1396 to 1396w-1; 42 C.F.R. §§ 482-483 (listing program requirements for participating in Medicare and Medicaid).

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November 2, 2007; GRHS on December 17-21, 2008, and again on June 22-26, 2009; ECRH on May 4-8, 2009; CSH on April 8, June 30, and July 1, 2009, and again on November 2-6, 2009; SWSH on October 13-16, 2009; WCGRH on November 30 through December 3, 2009.

As we noted in our prior letters, the majority of the findings we have made also have been made by other agencies in the past. See, e.g., Peter Buckley, M.D., and Nan Lewis, M.P.H., Medical College of Georgia, A Comprehensive Evaluation of Georgia's State Hospital Services, December 2007 (describing deficits at the seven State Psychiatric Hospitals in protection from harm, mental health treatment, nursing staffing, risk management, and performance improvement); United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Surveys of the Hospitals. We have included specific references to past findings by these entities, where appropriate. We found that these conditions remain largely unabated, despite the State's knowledge of the deficiencies.

More than a decade ago, the United States Supreme Court made clear that the unnecessary institutionalization of persons with disabilities violates the law. Olmstead, 527 U.S. at 587. Olmstead involved two women with developmental disabilities and mental illness who were inappropriately confined in one of the State's own Hospitals, GRHA. Id. at 593, 597. The Supreme Court held that states are required to provide services to persons with disabilities in the most integrated, appropriate settings. See Id. at 596-97. In the wake of the Olmstead decision, Georgia commissioned numerous studies of deficiencies in its community mental health care system, including: a February 2004 Study of the Community Service Board ("CSB") Service Delivery System (Phase I); a January 2005 Study of the CSB Service Delivery System (Phase II); and a May 2005 Georgia Mental Health System Gap Analysis. As stated in the Phase II Study by the State's Department of Audits and Accounts, these studies "point to accountability, oversight, management, and quality of care issues." The finding that Georgia's high hospitalization and readmission rates compared to national averages persist, and are "evidence of a lack of community based services," was reiterated in the June 2, 2008, Governor's Mental Health Service Delivery Commission's Progress Report. Indeed, as detailed below, high rates of re-admission, particularly repeated re-admission of the same patients dozens of times, are strong evidence of continued deficiency in discharge planning and provision of community supports. Despite the mandate by the Supreme Court and the subsequent clear analysis and recommendations in Georgia's own reports, our review of discharge planning at all of the State Psychiatric Hospitals concludes that Georgia still fails to ensure that persons with disabilities receive appropriate and sufficient services to enable them to live in the most integrated setting consistent with their needs, as required by federal law.

## I. BACKGROUND

The seven State Psychiatric Hospitals at any one time house approximately 2,000 patients who have mental illness, substance abuse issues, and/or developmental disabilities. The State Psychiatric Hospitals' services include crisis stabilization beds that may house patients from 23 hours to four weeks, acute and

long-term adult psychiatric units, child and adolescent programs, forensic units, units for persons with developmental disabilities, and skilled nursing units.<sup>2</sup> The seven State Psychiatric Hospitals are located in geographically diverse areas of the State.

## II. LEGAL STANDARDS

The State must provide services to qualified patients with disabilities in the most integrated setting appropriate to their needs. ADA, 42 U.S.C. § 12132 (“[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”), and its implementing regulations; 28 C.F.R. § 35.130(d); see Olmstead, 527 U.S. at 607 (holding that a State is required to provide community-based treatment for persons with disabilities when that State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated); Helen L. v. DiDario, 46 F.3d 325 (3d Cir. 1995) (holding that the ADA was violated where a person with disabilities was offered personal care services in an institutional setting but not at home); see also Press Release, The White House, “President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities” (June 22, 2009) (Announcing the Year of Community Living Initiative, President Obama affirmed “one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.”).

In construing the anti-discrimination provision contained within the ADA, the Supreme Court held that “[u]njustified isolation . . . is properly regarded as discrimination based on disability.” Olmstead, 527 U.S. at 597. Specifically, the Court established that states are required to provide community-based services and supports for persons with disabilities when treatment professionals have determined that community placement is appropriate, provided that the transfer is not opposed by the affected patient, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities. Id. at 602, 607. Courts reviewing the sufficiency of states’ efforts to comply with the integration mandate have held that an “individualized review of patients does not amount to a sufficient deinstitutionalization plan.” Pennsylvania Protection & Advocacy v. Dep’t of Public Welfare, 402 F.3d 374, 384 (3d Cir. 2005). Moreover, budgetary constraints “alone

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<sup>2</sup> We note that the combination of these diverse populations within the same Hospitals is unusual. Each population and the combination of these populations present unique health, safety, and treatment concerns.

are insufficient” to establish a defense to full compliance with the Olmstead mandate. Id. at 380.

The regulations promulgated pursuant to the ADA provide: “A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d) (the integration mandate). The courts have endorsed a straightforward reading of this regulation:

[t]he proper interpretation of the regulations’ definition of “most integrated setting” is set forth in the regulations themselves: whether a particular setting “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.”

Disability Advocates, Inc. v. Paterson, 598 F. Supp. 2d 289, 320 (E.D.N.Y. 2009).

The Fourteenth Amendment Due Process Clause also requires a state mental health care facility to provide “adequate food, shelter, clothing, and medical care,” Youngberg, 457 U.S. at 315, along with “conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests,” Id. at 324. Individualized treatment must be provided to give patients “a reasonable opportunity to be cured or to improve [their] mental condition.” Donaldson v. O’Connor, 493 F.2d 507, 520 (5th Cir. 1974), vacated on other grounds, O’Connor v. Donaldson, 422 U.S. 563 (1975); D.W. v. Rogers, 113 F.3d 1214, 1217-18 (11th Cir. 1997) (holding that the constitutional right to psychiatric care and treatment is triggered by the State’s physical confinement of an individual with mental illness; the court noted the holding of Fifth Circuit cases, including Donaldson, which are binding upon the Eleventh Circuit if decided before September 30, 1981); see also Wyatt v. Aderholt, 503 F.2d 1305, 1312 (5th Cir. 1974).

Patients in a psychiatric hospital also have certain rights protected by federal statutory law. Specifically, the State must provide services and activities to patients at the State Psychiatric Hospitals that are consistent with Title XVIII and Title XIX of the Social Security Act and their implementing regulations. See 42 U.S.C. §§ 1395 to 1395b-10 and 1396 to 1396w-1; 42 C.F.R. §§ 482-483 (listing program requirements for participating in Medicare and Medicaid). The State must also take reasonable steps to ensure that patients with limited English proficiency and sensory deficiencies are provided with meaningful access to programs and services. See Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-7; 45 C.F.R. § 80.3; A DA, 42 U.S.C. §§ 12132-12134. Moreover,

the state's duty to render the kind of treatment prescribed by Youngberg is not discharged by simply releasing a class member from the institution where he or she had been hospitalized. Otherwise the state could unilaterally avoid the obligations imposed by Youngberg and Thomas II [Thomas S., 699 F. Supp. 1178] and defeat the claims of class members by terminating their institutional care while the case was pending.

Thomas S. v. Flaherty, 902 F.2d 250, 254-55 (4th Cir. 1990). A court may order twofold relief: "to ameliorate the lingering effects, if any, of improper treatment; and to remedy inappropriate community placements, if any . . . that were not anticipated by professionals in the institutions." Id. Accordingly, the State must remedy the constitutionally inadequate care and treatment that took place while the individuals were in State custody, including remedial measures to correct the transition of individuals to a placement that is not the most integrated setting appropriate to their needs.

The measure of inadequate treatment is whether it substantially departs from generally accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23. Patients have a due process right to have all major decisions regarding their treatment be made in accordance with the judgment of qualified professionals acting within professional standards. Griffith v. Ledbetter, 711 F. Supp. 1108, 1110 (N.D. Ga. 1989). It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than behavior techniques, such as social reinforcement, to control aggressive behavior. Id. at 1189. Seclusion and restraint should only be used as a last resort. Id.; Davis v. Hubbard, 506 F. Supp. 915, 943 (W.D. Ohio 1980); see also Thomas S., 699 F. Supp. 1178, 1200 (W.D.N.C. 1988) (States are compelled by the Constitution to ensure that patients are free from hazardous drugs which are "not shown to be necessary, used in excessive dosages, or used in the absence of appropriate monitoring for adverse effects."), aff'd., 902 F.2d 250.

As described below, placement and discharge decisions, as well as treatment within the State Psychiatric Hospitals, fall far short of constitutional and statutory requirements.

### III. FINDINGS

Significant and wide-ranging deficiencies exist in the State's provision of services to persons with disabilities who are confined in the State's Hospitals. Discharge services at the State Psychiatric Hospitals substantially depart from generally accepted professional standards and violate the constitutional and federal

statutory rights of patients who reside there. In particular, we find that the State: (1) unnecessarily institutionalizes persons with disabilities who, with appropriate supports and services, could be served in the community; (2) fails to provide discharge and transition services at the State Psychiatric Hospitals in accord with generally accepted standards of care and the State's own policies; (3) fails to provide adequate assessments, diagnoses and treatment that would enable persons in the institutions to develop the skills necessary to live successfully in the community; (4) fails, in particular, to analyze the reasons for high rates of recidivism, and, consequently, to provide appropriate treatment to those patients; and (5) fails to identify and develop resources necessary to facilitate successful discharge. Patients confined to the State Psychiatric Hospitals, including those patients unnecessarily institutionalized, continue to suffer from additional, preventable harm, including: assault by peers; self-harm; regression and loss of skills from inadequate treatment and services; harm from excessive restraint and administration of sedating medications; harm from inadequate medical and nursing care; and harm from the lack of services to patients with specialized needs.

We find that the violations cited in our earlier letters concerning GRHA and NWGRH continue at the State Psychiatric Hospitals. Following site visits to CSH, ECRH, and GRHS earlier this year, the United States provided written feedback to the State detailing deficient conditions, harms resulting from those deficiencies, and recommendations for measures to ameliorate those conditions. See Letters dated April 15, 2009 (CSH patient homicide); July 16, 2009 (follow-up concerning CSH homicide); September 9, 2009 (ECRH Compliance Letter); November 19, 2009 (GRHS Compliance Letter); and November 25, 2009 (CSH Emergency Letter) (Enclosed as Attachments 1-5, respectively). The United States identified additional significant harms to patients at each of the State Psychiatric Hospitals due to the State's deficient practices, and provided written notice of its concerns regarding these incidents to the State. See Letters dated June 9, 2009 (series of patient deaths at CSH); July 31, 2009 (admitted rape of a patient at SWSH); August 14, 2009 (alleged sexual assaults at ECRH); September 4, 2009 (suicide of a patient at GRHS); and November 18, 2009 (ECRH suicide attempt) (Enclosed as Attachments 6-10, respectively). In this letter, we incorporate by reference the pattern or practice of conditions that violate the Constitution and federal law, the supporting facts, and the remedial measures detailed in those letters. Finally, we note that the State's own progress reports detailing its Quality Management systems ("QM Report"), and its Progress Report on development of a Plan of Implementation ("POI Report"), while promising plans for remedial action, demonstrate that essential services are not being provided to the patients of the State Psychiatric Hospitals in violation of the Constitution and federal statutory law.

**A. The State Segregates Hundreds of Patients Who Do Not Require Institutional Care**

The State fails to provide services to patients in the most integrated setting appropriate to their needs. As detailed below, hundreds of patients currently confined at the State Psychiatric Hospitals have been determined by their teams of treatment professionals to be appropriate for community-based treatment, but nonetheless have not been discharged to the community or another more integrated setting. Scores of patients appear to be institutionalized because community services were not available to address their needs before admission; many of these patients never should have been admitted to an institution in the first place. There are numerous other patients who are admitted to the hospital for a brief period, given neither adequate treatment nor adequate discharge and transition planning, and then released, only to be re-admitted in weeks or months. In this population, frequently referred to as the “revolving door” population, it is not uncommon to find patients at any of the State Psychiatric Hospitals who have been institutionalized dozens of times in a period of a few years. Many patients, incredibly, have been re-admitted more than 100 times to the State Psychiatric Hospitals. With adequate treatment and discharge planning, and with expanded services in the community, this cycle of needless repeated institutionalization could be avoided.

The State maintains lists of patients who have been institutionalized for 60 days or longer and whose treatment teams have determined can be served in a less restrictive setting – the so-called Olmstead lists. The Olmstead lists are compiled separately for patients with psychiatric disabilities and those with developmental, or intellectual disabilities. For patients on these lists, continued institutionalization without provision of necessary services to facilitate discharge is unjustified segregation by reason of a disability – the very discrimination clearly forbidden by the ADA. Olmstead, 527 U.S. at 597.

The State’s Olmstead lists identify only a fraction of the people currently institutionalized in the State’s Hospitals who could be more appropriately served in a less restrictive setting. The State has made the judgment that all of the persons with developmental disabilities in the institutions could live successfully in the community with appropriate supports, and our expert consultants concur. Accordingly, the State places all individuals with developmental disabilities on its Olmstead list, unless its treatment professionals perceive that the individual or his representative objects to community placement.



Persons with a mental illness, however, face a higher threshold for being placed on the State's Olmstead List.<sup>3</sup> A State policy limits the State's Olmstead list for people with a mental illness to those who already have been institutionalized for 60 days. Thus, the State is concentrating its discharge planning efforts—and tracking of those efforts system-wide—on those patients who have been institutionalized for 60 days or more. For persons with diagnoses of mental illness, who typically experience much shorter lengths of stay, this decision has the effect of leaving most patients with mental illness off of the State's Olmstead list. Perversely, State policy dictates that a person-centered transition plan is created for a person with a mental health disability only after that patient has been identified and placed on the Olmstead list. A patient with mental illness does not receive the very services necessary to ameliorate specific barriers to their discharge until the treatment team has decided the patient is ready for discharge (and at least 60 days have passed since the patient was admitted). This approach makes it almost impossible for patients with mental illness to get the continuity of care they so desperately need.

Moreover, as described more fully below, our investigation has identified significant flaws in the assessments conducted in the State Psychiatric Hospitals. The first, and most fundamental step in formulating an accurate diagnosis and plan of care for individuals with developmental disabilities or mental illness is to conduct an adequate assessment. The initial failure to identify a patient's needs leads, almost inevitably, to a poor plan for treatment while in the institution and upon discharge. Because those with mental illness depend on these assessments for placement on the Olmstead list, their inadequacy amounts to yet another barrier to discharge.

All patients on the State's Olmstead lists, no matter their disability, frequently remain institutionalized in the State Psychiatric Hospitals due to a lack of appropriate services in the community. The Supreme Court, in discussing the boundaries of the integration mandate, wrote that the State could show it was

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<sup>3</sup> Consequently, the State's Olmstead list for persons with developmental disabilities has more than ten times as many people as the Olmstead list for persons with a diagnosis of mental illness. Of the 884 individuals in the State Psychiatric Hospitals with a primary diagnosis of a development disability, 765 individuals are listed on the September 2009 Olmstead list. Of the 595 individuals with a primary diagnosis of a mental health disability, only 57 individuals are listed.

making reasonable accommodations for individuals with disabilities desiring community placement, if:

the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated . . . .

Id. at 605-06. The State's own Olmstead Monthly Progress Report demonstrates Georgia's failure to maintain a waiting list that moves at a reasonable pace. In September 2009, there were 765 persons with developmental disabilities on the Developmental Disabilities Olmstead list. In the previous year, 189 persons had been discharged from this list. But, the report shows that 150 persons with developmental disabilities were admitted to the State Psychiatric Hospitals and placed immediately on the Olmstead list, so that the net number of persons placed into a community setting was minuscule. Moreover, the number of placements slowed considerably in the last quarter for which data was provided (i.e., in July, August and September). The pace of placement also slowed considerably over the past year. The report shows that the average number of days a person on the Developmental Disabilities Olmstead list waited for community services doubled in the past year, and 86 people were still waiting for services after the date set by their treatment team for their discharge had come (and gone). Both of these indicators increased dramatically over the course of the year, a trend that shows that the State's ability to secure community placements is becoming more—not less—limited.

The Monthly Progress Report for the Adult Mental Health Olmstead list also demonstrates the State's failure to maintain a reasonable pace for discharge of these individuals. Only 57 persons were listed in September 2009, although the total census of persons with mental health disabilities at the end of September was 595.<sup>4</sup> The State designated only 10% of the institutionalized population of adult mental health consumers eligible for the Olmstead list (and, thus, for the person-centered transition planning process that will identify and marshal resources to support the person upon discharge). The Monthly Progress Report shows that, in most months, the number of persons discharged from the list is roughly equal to the number added to the list—the number of persons in this population who are supported in the community thus appears to remain static. The average number of days a consumer spent waiting for services after being placed on

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<sup>4</sup> The State's Olmstead list does not appear to include forensic patients, many of whom have a primary diagnosis of a mental health disability.

the Adult Mental Health Olmstead list doubled in the past year, to an average of 107 additional days in the institution. The prolonged institutionalization of persons on Olmstead lists violates the integration mandate of federal law. Waiting lists that deinstitutionalize such small percentages of qualified patients do not evidence “a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings.” See Olmstead, 527 U.S. at 606.

The lack of available community services continues to be a barrier to successful discharge of institutionalized persons who could be served in the community with appropriate supports. The State has known for years of this, and other barriers to discharge, but has not taken effective steps to address them. The State’s 2003 Olmstead Plan outlines its plans to achieve compliance with the ADA’s integration mandate. See State of Georgia Olmstead Strategic Plan, March 2003, available at [http://www.files.georgia.gov/DHR/DHR\\_CommonFiles/16739455Olmstead\\_Plan\\_Perdue.pdf](http://www.files.georgia.gov/DHR/DHR_CommonFiles/16739455Olmstead_Plan_Perdue.pdf) (“The Olmstead plan”). In its Plan, the State—more than six years ago—identified the following urgent needs and goals that remain unaddressed:

Affordable and accessible housing is essential to the transition of individuals from institutions to community-based settings. Individuals with disabilities, including some currently living in institutions, can live successfully in the community. To succeed, they need decent, safe, affordable and accessible housing that is separate from, but provides access to, the community-based supports and services they want and need to live as independently as possible. Nationally, there is a critical shortage of affordable housing. Similarly, Georgia does not have enough affordable housing. Home and Community-Based Waiver Programs and the Medicaid Rehabilitation Option do not pay for room and board. Funding for implementation of modifications and subsidized rental and home ownership programs is insufficient. The use of some subsidies to support home ownership has only recently become a possibility.

Goal: Residential capacity and housing options for individuals with disabilities and older adults are increased.

Action 1: The State should take steps to promote change in housing policies and model more effective strategies for using governmental housing programs.

Action 2: The State should call upon state agencies to partner in the development and implementation of strategies to address the housing needs of individuals with disabilities and older adults.

Action 3: The State should encourage public/private/family partnerships to address the housing needs of individuals with disabilities and older adults.

The Olmstead Plan at 16. The State's actions belie these statements—in 2009, budget cuts in the Department of Behavioral Health have adversely affected housing opportunities in the community, and the State's Community Service Boards ("CSBs") perceive a move to redirect scarce funds in future proposed budgets away from community mental health services to the institutions. See Letter from Ellice P. Martin, President, Georgia Association of Community Service Boards to Commissioner Frank E. Shelp (October 30, 2009) (citing State funding cuts in 2009 and proposed re-direction described in budget briefings for fiscal years 2010 and 2011). Without a continuum of services including healthy and fully functional community-based programs, the CSBs have warned, the institutions cannot be stabilized. Id. Our experts concur.

The population inappropriately confined to the State Psychiatric Hospitals includes many patients with previously-identified barriers, and we saw little or no evidence that the barriers have been addressed in treatment or in resource development, in violation of constitutional standards and the ADA. For example:

1. Staff at each hospital we toured assert that there are insufficient Assertive Community Treatment teams to provide services to the discharged patients who require them. Our expert consultants concur. This deficiency was also previously identified in 2005 in the State's own Mental Health GAP analysis.
2. Individuals with developmental disabilities, in particular, are institutionalized for long periods while waiting for funding of community slots.
3. Individuals with developmental disabilities face unnecessary or premature admission to CSH, the largest of the institutions housing people with developmental disabilities, because the supports in the community for crisis intervention do not appear adequate to handle the normal behavioral variability of some persons with developmental disabilities. See, e.g., MCG Report on CSH at 9.
4. Lack of income and employment have long been identified as barriers to successful community living, yet the State Psychiatric Hospitals receive no support from the State's office of vocational rehabilitation. Supported Employment programs have suffered from budget cuts and services cutbacks in each of the past several fiscal years. See, e.g., Governor Sonny Perdue's Mental Health Service Delivery Commission Final Report at 37 (December 4, 2008) ("Mental Health Commission Report").

5. The State Psychiatric Hospitals currently function as the “front door” to accessing mental health services in the State, instead of as a part of a continuum of care for those with chronic mental illness for whom community-based services and supports have been exhausted. See, e.g., Mental Health Commission Report at 9.

Finally, a significant portion of the institutionalized persons in the State Psychiatric Hospitals are patients who are continually discharged and re-admitted for short lengths of stay. Extremely high rates of re-admission at the State Psychiatric Hospitals are well documented. Audits commissioned by the State years ago, including the 2005 Georgia Mental Health Gap Analysis study, concluded that a 30-day re-admission rate 55 percent greater than the national average contributed to overburdening the State Psychiatric Hospitals. These conditions persist today. For example:

6. In each quarter of fiscal year 2009, the State missed its own targets for reducing re-admissions. Statewide Quality Management Report at 25.
7. A review of data produced by WCGRH, CSH, and ECRH revealed that each of these hospital’s re-admit rates significantly exceed the national average.<sup>5</sup> See CSH Quality Management Report at 192; ECRH Quality Management Report at 47-49; WCGRH Quality Management Report at 72-74. The reports produced by SWSH and GRHS call into question whether those hospitals are tracking re-admission rates at all, as SWSH’s report states only that “[n]o statistical improvement in the number of 30-day readmits” without providing a single piece of data, and GRHS’s report fails even to mention re-admit rates. See SWSH Quality Management Report at 201-204, GRHS Quality Management Report.
8. The State continues to discharge hundreds of patients each year to homeless shelters and recent data from CSH shows that the rate of discharges to shelters increased in the past few months.<sup>6</sup>

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<sup>5</sup> For fiscal year 2007, the national average for patients re-admitted to state psychiatric hospitals within 180 days of discharge was 19.9 percent. In Georgia, it was 26.1 percent. Substance Abuse & Mental Health Services Administration, National Outcome Measures Georgia State Summary, <http://nationaloutcomemeasures.samhsa.gov/Outcome/StateReportSummary.aspx?id=GA>.

<sup>6</sup> In Olmstead, the Court made clear that discharge of patients to homeless shelters is inappropriate. 527 U.S. at 605.

9. Hundreds more patients, particularly those destined to return repeatedly, are discharged to a variety of unsupervised locations, including personal care homes, that demonstrably do not provide the level of support necessary to support a person with severe mental illness.

The work of admitting patients and providing the crisis stabilization necessary for new admissions leaves an already overburdened system with fewer staff resources to provide treatment planning, interventions, and supervision for patients. Moreover, frequent re-admissions are extremely detrimental to these individual patients, disrupting their recoveries and their lives in the community.

Frequent relapses and re-admissions may progressively worsen a patient's serious and persistent mental illness and make patients more intractable to treatment. Thus, constitutional standards demand that treatment teams routinely examine and address issues that cause patients to be admitted repeatedly to the hospital. Our teams of expert consultants examined dozens of treatment records and discharge plans for individuals with high rates of re-admission at ECRH, GRHS, SWSH, CSH, and WCGRH and found that they failed to meet constitutional standards. In multiple cases of repeated admissions, we saw no evidence that the treatment teams examined or addressed the factors that led to re-admission for an individual patient and altered the patient's treatment from a previous stay at the hospital.<sup>7</sup> There is also no systematic analysis or action to address reasons for re-admission.

The State has not acted on the recommendations of the 2008 Mental Health Commission Report, which concluded that developing a comprehensive, statewide supported housing program would help reduce the number of individuals with mental illness in jails, prisons, and shelters. Individuals discharged to shelters, bus terminals, and similar locations without adequate supports and services (including, in August 2009, a "car or abandoned building") result in the highest number of re-admissions to the hospitals, and they also are frequently detained or arrested by the police and confined to a jail or prison. Such discharges are shocking departures

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<sup>7</sup> A remedial effort still in its infancy at the State Psychiatric Hospitals involves creation of the position of Repeat Admissions Review Coordinator ("RARC"), required to perform an analysis of past admissions for individual patients with multiple readmissions, and to present that information to the individual's treatment team. At CSH, this effort was further advanced than at the other hospitals, and RARC staff were beginning to identify barriers to successful discharge for individual patients, identifying, for example, issues with medication non-compliance or substance abuse. Appropriate action to address those barriers is not yet evident from our review of case files.

from generally accepted professional standards, perpetuate a revolving door of multiple re-admissions, and violate federal law. Failure to address long-standing deficiencies in the community mental health system, many of which were identified by the State's own audits, contributes to needless institutionalization of patients for whom supports necessary to live successfully in the community do not exist. In addition, the failure to provide discharge and transition planning services consistent with constitutional standards, federal statutory law, and the State's own policies and procedures, contributes to the unjustified segregation of individuals with disabilities in the State Psychiatric Hospitals.

Our expert consultants reviewed scores of recent discharge plans while on site at ECRH, GRHS, GRHA, SWSH, CSH, and WCGRH and found that they substantially depart from generally accepted professional standards. The discharge plans we reviewed do not describe, identify, or secure the community resources necessary to serve patients in the community. An essential component of an adequate discharge plan for any patient is linkage to necessary community supports. State and facility policies, procedures, and strategic plans confirm the critical importance of community coordination, yet we saw no evidence that these policies are implemented in the great majority of cases. Failure to ensure continuity of care in the community has resulted in failed discharges and in long delays for placement into the community. Examples are detailed in our attached letters, which are incorporated by reference herein. Additional examples include:

10. In December 2008, a patient at SWSH was discharged to the community while on heightened observation as a suicide-risk precaution, a decision which SWSH later concluded was due to pressure to reduce the hospital's census. This patient committed suicide nine days later.
11. A patient at GRHS with a history of more than 100 hospital admissions was discharged to "wherever he goes." His prognosis was that "he would return in a week."
12. Over 100 patients in the past year were discharged from CSH to shelters, including 33 in the last three months.
13. In addition to dozens of patients discharged to shelters, two dozen different patients at SWSH were discharged in recent months to locations such as "streets" and "car or other abandoned building."
14. In the past year, 39 patients at WCGRH were discharged to locations such as "streets (public park, bridge)," "car or abandoned house/building," "night shelter," "hotel/motel," and "crisis or emergency center."

The State admits in its POI Report that essential steps to remedy these systemic deficiencies have not yet been undertaken by the State Psychiatric Hospitals. For example, the POI Report states that development and implementation of treatment goals that address barriers to successful placement in the community will begin in January 2010. See POI Report at 28 (emphasis added). And it sets January, 2010 as the target compliance date for identifying barriers that prevent a specific patient from transitioning to a more integrated setting.

The State's failure to prioritize remedial actions to address unnecessary institutionalization violates federal law. In addition, those patients unnecessarily segregated in the State Psychiatric Hospitals contribute to crowded conditions and insufficient numbers of staff to supervise so many patients, which, in turn, contributes to inadequate treatment and supervision of patients and high rates of patient harm.

The State Psychiatric Hospitals' failure to provide sufficient treatment programming to patients also seriously impedes Olmstead compliance. At each of our site visits, we noted patients with little or no treatment activity, and much of the available activity was best characterized as diversionary, not treatment. There is a stark lack of treatment for patients with co-occurring diagnoses of substance abuse. It was evident in a significant number of records that this issue was one of the most serious impediments to community placement and part of the reason for frequent re-admissions to the State Psychiatric Hospitals. There are no vocational services provided to patients on mental health units, aside from a handful of patients employed at several of the Hospitals in grounds keeping or food service activities. The lack of resources for supported employment was highlighted by the State's own 2008 Mental Health Commission Report, which stressed the importance of employment for individuals with mental illness to provide "more independence and hope, as well as a daily motivation to continue toward recovery." Mental Health Commission Report at 7.

## **B. Patients are Subject to Serious, Frequent, and Recurrent Harm**

Patients confined to the State Psychiatric Hospitals have a right to live in reasonable safety. See Youngberg, 457 U.S. at 315, 322. Yet patients in the State Psychiatric Hospitals are not reasonably safe. Critical incidents at the State Psychiatric Hospitals in recent months demonstrate that patients throughout the State Psychiatric Hospitals continue to suffer preventable harm due to deficient practices:

1. In August 2008, a patient at WCGRH assaulted and killed another patient. Earlier that morning, the victim had assaulted the aggressor, and both patients had a history of aggression. Nevertheless, when the aggressor later



verbally accosted the victim, and the victim retaliated by assaulting the aggressor, nearby staff, one of whom was an instructor in techniques for de-escalation of aggression, did not physically intervene. The aggressor then assaulted the victim, who fell and struck his head, knocking him unconscious and causing blood to trickle out of his ear. Contrary to hospital policy, staff tried to lift the victim, causing him to strike his head a second time. Staff never called a code blue, and an ambulance did not arrive for 50 minutes. The victim died a few days later from blunt force trauma to the head. The aggressor was transferred to CSH, and his discharge summary from WCGRH to CSH contained no information about this incident or the extent of his aggressive behaviors.

2. In September 2008, a patient at CSH with a history of three serious suicide attempts that required admissions to an Intensive Care Unit was discharged with a 5-day supply and 30-day prescription for amitriptyline, a psychoactive anti-depressant. As opposed to other anti-depressants that could have been prescribed, amitriptyline is particularly lethal at high doses. The patient died from an overdose of amitriptyline four days later.
3. In October 2008, a patient at WCGRH died of a ruptured spleen due to blunt force trauma. Earlier that morning he had complained of not feeling well. Hours later, when he was found naked on the floor in his own urine, he was treated with antipsychotic medication despite displaying no documented psychotic symptoms. The mortality review focused primarily on the timeliness of the code blue call and never addressed nor investigated how the patient suffered trauma so significant that it ruptured his spleen.
4. On April 5, 2009, a patient at CSH assaulted and killed another patient. The aggressor was supposed to be on close observation because he had allegedly murdered two other individuals in the past, including his jail cell mate immediately before his transfer to CSH in January 2009. Systemic deficiencies contributing to this incident include the failure of staff to supervise patients, and of hospital supervisors to supervise staff.
5. The victim of an admitted rape at SWSH in July 2009 had a prior sexual encounter with the aggressor. The prior encounter had been neither investigated nor addressed in treatment.
6. A patient in GRHS committed suicide on August 27, 2009, months after our site visit in which we warned the facility of the risk inherent in its deficient suicide assessments and the inadequacy of its risk management system.

We have repeatedly highlighted the State's deficient practices regarding patient-on-patient aggression and suicide risk during our site visits, technical assistance, and in our correspondence to the State. See e.g., Attachments 1-9. Nevertheless, incidents of violent aggression continue and numerous living spaces at the State Psychiatric Hospitals continue to contain environmental hazards that pose significant risks to the health of patients. For example, the patient who committed suicide at GRHS in August 2009 tipped the bed up on end and used one of the legs as a tie off point on which to hang himself. Our consultant has warned the State of the dangers posed by these beds throughout our investigative and compliance tours. Despite these warnings, when we visited CSH in November 2009, two months after the suicide at GRHS, we found a bed in the seclusion room—a room that a patient in crisis might be sent to for their own protection—that could similarly be tipped on end. The mattress on the bed had a plastic covering on the bottom that easily could be removed, giving individuals another potential instrument by which to hang themselves. When we removed part of the plastic covering, large, industrial-size staples came out of the mattress that could also be used for self harm. Indeed, we discovered one individual during our visit to CSH who had repeatedly abused herself by placing staples into various parts of her body, including one that had to be surgically removed. The State's failure to address these evident environmental hazards, despite our repeatedly bringing them to the State's attention, is deeply troubling.

To protect its patients in accordance with constitutional standards, the State Psychiatric Hospitals should have in place an incident and risk management system that helps to prevent incidents and ensures appropriate corrective action when incidents do occur. An effective incident and risk management system depends on: (1) accurate data collection and reporting; (2) thorough investigations; (3) identification of actual or potential risks of harm, including the tracking and trending of data; and (4) implementation and monitoring of effective corrective and/or preventive actions.

The State Psychiatric Hospitals' incident and risk management systems do not meet constitutional standards, placing the individuals in the State Psychiatric Hospitals at significant risk of serious and immediate harm. State and facility incident management policies and procedures do not meet constitutional standards, because they lack sufficient incident categories and reporting requirements. Even the incident data the State Psychiatric Hospitals do gather, however, is highly inaccurate. During our visit to GRHS, for example, we found suicide attempts during our record review that were not captured in the hospital's suicide attempts data. Without accurate and comprehensive gathering of incident data, the State is ill-equipped to recognize emerging trends before life-threatening conditions arise.

Furthermore, the State Psychiatric Hospitals do not adequately analyze the data they currently gather to prevent harm from occurring. Therefore, the risk management systems at the State Psychiatric Hospitals are not serving one of their essential purposes: to anticipate potential harm and mitigate the risk of that harm occurring. This is due, in part, to the inadequacies of the policies and procedures themselves, but it is also due to a failure to train individuals on incident and risk management policies and procedures and to monitor performance to make sure that these policies and procedures are followed.

The State Psychiatric Hospitals routinely fail to implement corrective actions in response to known risks, and when corrective actions are implemented, they often are not implemented in a timely manner. Indeed, as indicated previously, many environmental hazards continue to exist at the State Psychiatric Hospitals, despite repeated warnings about these hazards. For example, we noted during earlier visits to the State Psychiatric Hospitals that we found situations in which the door to a seclusion room had jammed, causing the patient's agitation to increase visibly while hospital staff worked to open the door. During our review at GRHS, we found that the doors to the seclusion rooms continued to jam. On the adult mental health units at CSH, we observed numerous doorknobs and similar physical features that pose known suicide risks, despite our warnings about the risks these features posed during visits to some of the State Psychiatric Hospitals more than two years ago. The State's failure to address known suicide hazards bespeaks deliberate indifference to potential deaths.

The investigations of incidents occurring at the State Psychiatric Hospitals also are inadequate. The investigations often omit information that is critical to finding the root cause of the incident, preventing the State and hospital from taking adequate corrective action. We reviewed, for example, numerous incidents that suggested there may have been a breakdown in supervision of patients, but critical information such as staff assignments and staffing ratios was not included in the investigation. Accordingly, the investigations did not result in any corrective actions regarding staffing or supervision levels. This is particularly problematic, as our review found that inadequate staffing and supervision have resulted in grave harm at the State Psychiatric Hospitals, and that harm will continue if it is not appropriately addressed in investigations and corrective actions.

Finally, the quality management systems at the State Psychiatric Hospitals do not meet constitutional standards. Like the incident and risk management systems, the quality management systems do not collect sufficient information to ensure that the care and treatment provided at the State Psychiatric Hospitals meets constitutional standards. Without collecting sufficient information, the State Psychiatric Hospitals cannot assess appropriately the adequacy of the services they provide. At this point, however, the State Psychiatric Hospitals do not even

adequately analyze the limited information they do collect to ensure that their services meet constitutional requirements. As a result of the inadequacies in the State's incident, risk, and quality management systems, patients are routinely exposed to actual and potential harm in violation of their constitutional rights.

### **C. Mental Health Treatment and Rehabilitation Is Inadequate**

Patients in the State Psychiatric Hospitals have a constitutional right to receive adequate mental health treatment. Donaldson, 493 F.2d at 520. The mental health services at the State Psychiatric Hospitals, however, violate constitutional standards. Contrary to constitutional standards, treatment planning is not person-centered, individualized, or integrated across disciplines. Psychology services, physical, nutritional and speech therapy, and behavioral management services are particularly deficient. Each of these failures affects the quality and effectiveness of the patients' treatment plans, which are the foundation of an adequate mental health care program. Many of these deficiencies also directly threaten patients' physical health and well being. Moreover, as was the case at GRHA and NWGRH, the failure to treat patients' mental health needs while hospitalized has frequently led to failed discharges and to repeated hospitalizations in violation of Olmstead.

#### **1. Assessments are Inadequate**

Mental health treatment in an institution begins at the time of admission. An admissions work-up is an integral part of the course of hospitalization; it establishes the initial diagnosis and begins the course of treatment for patients as they begin their hospital stay. Our expert consultants reviewed a plethora of assessments while on site at ECRH, GRHS, SWSH, CSH, and WCGRH and found that they substantially departed from generally accepted professional standards. At a minimum, an initial assessment should include: (1) an adequate review of presenting symptoms and the patient's mental status; (2) a provisional diagnosis and differential diagnosis that provides a decision tree by which diagnosis and treatment options may be clarified over time; and (3) a plan of care that includes specific medication and/or other interventions to ensure the safety of the patient and others. As more information becomes available, the assessment must be updated to include: (1) a history of the presenting symptoms from the patient based on the patient's level of functioning and from collateral sources, as available; (2) the progression of the symptoms and setting within which the symptoms occur; (3) the relevant historical findings regarding the patient's biopsychosocial functioning; (4) a review and critical examination of diagnostic conclusions made in the past in light of new information; (5) a review of medical and neurological problems, if any, and their impact on the current status of symptoms and treatment; and (6) a complete mental status examination.

In many cases, initial assessments at the State Psychiatric Hospitals lack critical information. This failure occurs, in part, because the assessment forms used at the State Psychiatric Hospitals lack essential elements, but also because the clinicians performing the assessments often fail to complete the assessment form or appear to skip certain elements of the assessment altogether. During our tour of GRHS, for example, we found that suicide risk assessments were not completed at all for five individuals. The assessments that are done often lack information regarding the precipitating factors that led to admission, as well as relevant facts regarding the individual's psychosocial, developmental, educational, medical, and substance abuse history. At CSH in November 2009, we found numerous cases of conflicting diagnoses due to inadequate assessments, and we also noted significant under-diagnosing of serious conditions, such as substance abuse. Similar problems were noted during our review of the other State Psychiatric Hospitals.

Patients in the State Psychiatric Hospitals routinely are given tentative and unspecified diagnoses (including “rule out” and “not otherwise specified” (“NOS”) diagnoses) as a result of these flawed assessments. With some exceptions, we found little evidence of further assessments or observations to finalize these diagnoses. Because different psychiatric conditions can have similar signs and symptoms, it is important for mental health professionals to clarify diagnoses to ensure that a patient's treatment is appropriate for his or her actual mental health needs. At the State Psychiatric Hospitals, however, NOS diagnoses and contradictory diagnoses persist for months and over multiple admissions, with no sign of further diagnostic testing or refinement. The prevalent use of the NOS diagnosis reflects an inadequate diagnostic evaluation process and contributes to the lack of specificity in treatment plans. This pattern of excessive numbers of NOS diagnoses was a critical deficiency also noted by MCG in its reviews two years ago, and the State Psychiatric Hospitals continue to fail to address it.

The State Psychiatric Hospitals' failures in the preliminary stages of assessment and diagnosis, as well as their failure to reassess patients to refine diagnoses, run afoul of constitutional standards. Patients receive or are at risk of receiving treatment that, at best, is unnecessary and, at worst, may actually exacerbate their mental illnesses, causing them to suffer from the side effects of inappropriate medications, and placing them at risk of serious harm. The result is that the actual mental illness is often unaddressed, placing patients at risk of prolonged institutionalization and/or repeated hospital admissions in violation of Olmstead. Moreover, fatal harm can result from an inadequate assessment.<sup>8</sup>

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<sup>8</sup> Although this letter does not pertain to GRHA, we note that its assessment of a patient contained inaccurate information concerning her

Assessment information, even when compelling, frequently does not translate into appropriate treatment. The State Psychiatric Hospitals' failure to provide proper treatment can also result in serious harm.

## 2. Treatment Planning is Inadequate

In accordance with generally accepted professional standards, each patient should have a comprehensive, individualized treatment plan based on the integrated assessment of mental health professionals. Treatment plans should define the goals of treatment, the interventions to be used in achieving these goals, and the manner in which staff are to coordinate treatment. The treatment plans also should detail an integrated plan designed to promote the patient's stabilization and/or rehabilitation so that the patient may return to the community. Taken together, treatment plans constitute the standard against which a facility evaluates the effectiveness of the services it offers. In this sense, they are critical to a hospital's ongoing efforts at quality improvement.

Treatment planning must incorporate a logical sequence of interdisciplinary care: (1) the formulation of an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines; (2) the use of the diagnosis to identify the fundamental problems that are caused by the diagnosed illness; (3) the development of specific, measurable, and individualized goals that are designed to ameliorate problems, promote functional independence, and assist community integration; (4) the identification of appropriate interventions that will guide staff as they work toward those goals; and (5) ongoing assessments and, as warranted, revision of the treatment plan. To be effective, the treatment plan should be comprehensive and include input from various disciplines, under the active direction and guidance of the treating psychiatrist who is responsible for ensuring that relevant and critical patient information is obtained and considered.

Our expert consultants reviewed dozens of treatment plans and attended treatment team meetings during each of our site visits to ECRH, GRHS, SWSH, CSH, and WCGRH and found that treatment plans routinely substantially depart from generally accepted professional standards. Treatment plans frequently are minimalist, generic, and reflect neither the true scope of patients' needs nor an integrated, coherent plan for treatment. When the treatment team fails to identify

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compliance with treatment and the extent of her thought disorder. This patient's family opposed her discharge on these bases, but she was nonetheless discharged; shortly after her release this patient acted on her previous threats and killed a family member. This incident highlights the dangers of the inadequate practices found throughout Georgia's State Psychiatric Hospitals.

or address all of a patient's presenting concerns, that patient is deprived of treatment for those concerns, and frequently subject to a longer period of institutionalization or to a repeat admission when those conditions or behaviors become barriers to successful community integration. Treatment plans do not reflect interdisciplinary planning and corroboration, and contradictory assessments from different disciplines are neither addressed nor reconciled. Additionally, they often provide no clear alternatives if the initial, vague interventions prove ineffective, leaving staff with few alternatives to restraint, seclusion, and PRN medications to address challenging behaviors. We typically found generic treatment objectives for patients with psychotic diagnoses and substance abuse diagnoses. The recurrence of near-identical goals and objectives for so many patients makes evident the non-individualized nature of the State Psychiatric Hospitals's treatment plans.

The State Psychiatric Hospitals' treatment planning process also departs from constitutional standards. From initial diagnosis and assessment to the development of skills and functioning necessary for recovery and community reintegration, the State Psychiatric Hospitals' treatment planning process fails to meet the fundamental requirements for the treatment and rehabilitation of its patients. As a result, patients' actual illnesses are not properly assessed and diagnosed; patients are not receiving appropriate treatment and rehabilitation; patients are at risk of harm from themselves and others; patients are subject to excessive use of restrictive treatment interventions; and patients are at increased risk of relapses and repeat hospitalizations. For example, a 2007 MCG report noted that patients assessed at elevated risk of harm do not receive the heightened supervision called for by policy. This deficiency persists—in our recent visit to CSH, we noted a patient who was assessed as a moderate to high risk of suicide, but did not receive heightened supervision until after she attempted suicide. Further, patients' options for discharge are significantly limited, resulting in unnecessarily prolonged hospitalization, and, with respect to forensic patients, prolonged involvement in the criminal justice system.

### 3. Behavioral Management Services Are Inadequate

Behavioral support plans ("BSPs") at the State Psychiatric Hospitals are virtually nonexistent, and those that exist largely are inadequate and not well integrated into overall treatment. Many patients who were repeatedly subject to seclusion, restraint, and/or administration of PRN medications—measures that should be reserved for emergency crisis intervention—have no behavioral supports in place. This is an egregious departure from generally accepted professional standards. Routinely, even when a treatment team makes a recommendation for a BSP, these plans are not developed and implemented in a timely manner. For those

few patients with behavioral management plans, treatment teams routinely fail to revise those plans, notwithstanding evidence of continuing or escalating problem behaviors.

The few behavioral assessments in place at the State Psychiatric Hospitals substantially depart from generally accepted professional standards. In some cases, patients with behavior plans had no functional assessments of the problematic behaviors to support the behavior plan. In others, the functional analysis was deficient in one or more significant ways: many failed to hypothesize the function of the challenging behavior; did not consider antecedent, environmental, or health factors that influence a behavior; did not contain sufficient baseline data; failed to identify target or replacement behaviors; and suggested inappropriate and even dangerous replacement behaviors. These inadequacies in behavioral assessments undermine all subsequent behavioral treatment planning. This is especially true for patients with specialized needs or identified issues, like aggression. For example,

1. A BSP developed for a patient at GRHS in June 2009 did not mention nor address an incident in which this patient grabbed and ingested cleaning fluid two weeks earlier.
2. A patient at GRHS suffered multiple restraint and PRN episodes, including three restraints and nearly-daily PRNs in the week before a psychological evaluation, yet the evaluation did not recommend a behavioral assessment nor a BSP for this patient.
3. In the case of the murder of a patient by another patient, although the aggressor was alleged to have committed two other murders before his admission, there was no BSP put in place until following the murder at the hospital.
4. A patient that struck a peer had a BSP implemented shortly thereafter. But no functional assessment was completed and, a few months later, he committed three more assaults over a seven day period. Despite this, the chart did not include any documentation on the plan's effectiveness since its implementation, nor any reflection on a need to update the plan due to the outbreak of aggressive incidents.

Behavioral data in individual charts, when present at all, typically is not current, although we saw improved data collection in our most recent site visit to CSH. The failure to implement timely behavioral supports, to evaluate and revise behavior plans as clinically indicated, and to collect objective data with which to



support clinical decisions are all egregious departures from generally accepted professional standards.

#### **D. Seclusion and Restraints Are Used Inappropriately**

The right to be free from undue bodily restraint is the core of the liberty protected from arbitrary governmental action by the Due Process Clause. Youngberg, 457 U.S. at 316. Thus, the State may not subject patients of the State Psychiatric Hospitals to seclusion and restraint “except when and to the extent professional judgment deems this necessary to assure [reasonable] safety [for all residents and personnel within the institution] or to provide needed training.” Id. at 324. Generally accepted professional standards require that seclusion and restraints: (1) will be used only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted; (2) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (3) will not be used as a behavioral intervention; and (4) will be terminated as soon as the person is no longer a danger to himself or others. The State Psychiatric Hospitals’ use of seclusion and restraints, including medication used as a chemical restraint, substantially departs from these standards and exposes patients to excessive and unnecessarily restrictive interventions.

Given the deleterious effects of seclusion and restraint, and the fact that these measures restrict patients’ rights and their ability to receive appropriate care, generally accepted professional standards require that institutions like the State Psychiatric Hospitals reduce their use of seclusion/restraint by addressing behavior problems with less intrusive and restrictive strategies, and that, if used, physical restraint and seclusion should be minimized, monitored, and documented, in accord with generally accepted professional standards. We found that, even at hospitals where there have been efforts to reduce seclusion and restraint, such as WCGRH and CSH, the definition of seclusion and restraint used by the hospital appears not to include all practices that constitute seclusion and restraint, and there have been troubling increases in the use of “stat” medications, often without appropriate modification of the individual’s behavioral treatment.

Seclusion and restraint practices at the State Psychiatric Hospitals include violations of both policy and generally accepted practice. We found instances where restraints were used unnecessarily, such as when a patient was sleeping, or after a patient had walked back to her room to be restrained. In many cases, the criteria listed for release of restrained patients were generic and did not reflect the specific behaviors that had warranted the restrictive procedures. At times, the criteria were extreme and inappropriate, such as requirements that the patient be able to state the reasons for behavior and contract that the behavior will not occur again.

The facilities also lacked a system whereby patients that were high users of restraint or seclusion were brought to the attention of interdisciplinary teams so that the issue could be addressed. Moreover, seclusion and restraint incidents were not adequately reviewed, and the reviews that were conducted sometimes revealed inappropriate and dangerous attitudes toward the use of seclusion and restraint. For example, the question “What could have been done different?” on the debriefing form often elicited a response of “nothing,” and the question, “What helped gain control” sometimes was answered with “five point restraints and PRN.” These responses reveal that staff members do not understand the purpose of the process—to discover the precursors to the behavior so that the need for seclusion and/or restraint can be mitigated.

## **E. Medical Care Is Inadequate**

Although patients in the State Psychiatric Hospitals are entitled to adequate health care, see Youngberg, 457 U.S. at 315, basic medical care and nursing services substantially depart from generally accepted professional standards. The State Psychiatric Hospitals fail to provide basic medical care and provide inadequate clinical oversight, pharmacological practices, medication administration, infection control, physical and nutritional management, emergency preparedness, and staffing. Some of these failures are particularly germane to the State Psychiatric Hospitals’ care and treatment of individuals with developmental disabilities. Our findings regarding medical care echo many of those previously made in the State’s own survey by the Medical College of Georgia.

### **1. Failure to Provide Basic Medical Care**

Effective medical services depend on timely, thorough assessments and monitoring. Generally accepted professional standards require assessments to be designed to collect specific, individual data to assist the team and the patient with case formulation, diagnosis, and treatment planning. The quality of assessments we reviewed at the State Psychiatric Hospitals varied considerably but, for the most part, they substantially departed from these standards. At best, the assessments were superficial and had little to no clinical relevance. Based on our review, the State Psychiatric Hospitals do not have systems in place to ensure that assessments and documentation are adequate, timely, complete, and accurate. Potential health concerns that are not even identified due to inadequate assessments clearly do not receive adequate monitoring.

Health care plans at the State Psychiatric Hospitals are alarmingly inadequate. The purpose of a health care plan is to guide therapeutic interventions systematically, document progress, and achieve the expected individual outcomes. These plans should be individualized and should identify priorities for care and

interventions that are consistent with generally accepted professional standards. Many plans we reviewed had essentially identical goals, objectives, and recommendations, reflecting a lack of individualization and no identification of priorities in a given patient's care. The listed interventions provided no guidance regarding treatment modalities, and the plans failed to include proactive interventions addressing risk factors. They provided no clinical template for health care and failed to identify and address significant health issues so that positive outcomes may be achieved. Many patients suffered acute health issues; their health care plans failed to address these issues, and were not modified to prevent recurrences. Other patients suffered changes in physical health status, some necessitating transfer to a hospital emergency rooms, with no subsequent change in their health care or monitoring plans. Changes in physical health status often were not assessed in a timely manner, and in some instances, did not result in any assessment whatsoever.

We reviewed health care plans for patients at risk from a variety of conditions, including patients at risk from the side effects of psychotropic medications, and patients at risk for choking and aspiration. The plans we reviewed generally did not include sufficient proactive steps to monitor and treat these and other conditions that place patients at significant risk of harm. For example, the State Psychiatric Hospitals do not routinely use timely and accurate diagnostic testing to detect movement disorders that may develop as a known, and irreversible, side effect of certain medications. This is an egregious departure from generally accepted practice, and places patients at an undue risk of significant and irreversible harm.

## 2. Inadequate Clinical Oversight

The major role of clinical oversight in any institution is to ensure that generally accepted professional standards of practice and accountability are maintained. These standards require that medical and nursing departments have a quality assurance program. Such a program provides internal monitoring for a these departments and permits a facility to identify its problematic areas and correct them. A regular review of provided services also allows the clinical director and the nursing department to ensure that the services they purport to provide are those that they actually provides.

A quality assurance program for nursing consists of a number of monitoring instruments that measure the quality of care and services that are provided by the nursing department. These data should be regularly reviewed, analyzed, tracked, and trended. When these analyses indicate that the nursing department is not providing quality care, a plan of correction should be developed and implemented to address the problem. Monitoring permits nursing management and facility

administration to be aware and responsive to the needs of a department. It also assists nursing management in determining what types of interventions are needed when problem areas are identified and in tracking outcomes after interventions have been initiated. Nursing and clinical disciplines throughout the State Psychiatric Hospitals utilize inadequate monitoring tools that do not collect reliable and clinically reliable data.

Robust peer review is an essential element of an adequate quality assurance program for clinical services, and this review is not evident in the State Psychiatric Hospitals. The disciplines of nursing, occupational, physical and speech therapy conduct no qualitative peer review at all. The mortality review process is one area in which critical peer review is prerequisite to an effective process that identifies problematic trends and necessary corrective actions. At each of the State Psychiatric Hospitals we visited, we found that the mortality review process failed to identify adverse trends in a timely manner and to implement appropriate corrective actions, and, as a consequence, missed opportunities to mitigate risk of future harm.

### 3. Pharmacology Practices are Inadequate

Medication practices at the State Psychiatric Hospitals substantially depart from generally accepted professional standards in several critical respects. Contrary to accepted practice, pharmacological treatments are frequently the only interventions used to manage symptoms and behaviors. Many patients receive psychotropic medication—or multiple medications—for the purpose of sedation or to manage behavior, without underlying behavioral support plans.

We also found medication prescription practices that are inconsistent with generally accepted professional standards. Polypharmacy, the practice of prescribing multiple medications to address the same indications, is widespread, and many records lack appropriate justification for this practice. Moreover, a number of medications are prescribed (and in some instances, not prescribed) in a manner inconsistent with generally accepted professional standards. For example, our review of patients who were prescribed medications with known risks found a pattern of deficient justification for the use of high-risk medications, deficient assessment and monitoring of the known risks, and insufficient evidence of attempts to use safer treatments. As a result, patients are exposed to a continuing risk of undue harm.

#### 4. Inadequate Medication Administration

Generally accepted professional standards dictate that medications be administered according to nursing procedures that ensure that the correct patient receives the prescribed dosage of the prescribed medication by the prescribed route at the prescribed time. Moreover, generally accepted professional standards require that nursing staff properly complete Medication Administration Records (“MARs”). Among other things, MARs list current medications, dosages, and times that medications are to be administered. Proper and timely completion of the MARs is fundamental to maintaining patient safety and reducing the likelihood of medication errors and adverse drug effects. Failure to follow accepted MARs protocol may result in patients not receiving medications or receiving them too frequently, which could result in serious harm.

We found significant breaches in procedure regarding proper and timely completion of the MARs at the State Psychiatric Hospitals. At ECRH, for example, nurses were initialing medication administration records as they set up the medications, not upon administration as required by generally accepted standards of practice. At CSH, nurses were initialing medical administration records hours after the medications were purportedly administered, sometimes up to 24 hours later. Consequently, medication administration quality assurance data at these hospitals reflected virtually 100% compliance, which is not realistic. The State Psychiatric Hospitals have been unable to reduce dangerous medication errors. In June 2009, for all State Psychiatric Hospitals, the medication error rate was double the target set by the State. Quality Management Report at 20.

#### 5. Inadequate Infection Control

Generally accepted professional standards require adequate infection control. The components of an adequate infection control program fall into two general categories: surveillance and reporting; and control and prevention.

Surveillance and reporting include data collection on infections acquired in the community before admission to the State Psychiatric Hospitals and on infections acquired while residing there. These data can be used to establish baseline infection rates for different units to determine problem areas or areas where in-service education could lower infection rates. This information can also be used to identify outbreaks of infections rapidly so that concentrated efforts can be initiated to prevent the spread of the infection. In addition, staff should be monitored and data analyzed for possible exposure to, or as the source of, communicable and infectious diseases. The environment itself must be monitored

as a source of potential infection hazards, especially during outbreaks of infection. Further, the Hospitals must report all communicable diseases to the appropriate health authorities in the State.

Control and prevention activities are of equal importance in an infection control program. In general, developing policies and procedures, staff training, patient educational programs regarding communicable diseases, and regular committee review of infection control activities are components of an infection control program that complies with generally accepted professional standards.

Frequently, the infection control programs at the State Psychiatric Hospitals substantially depart from these standards. These programs collect data but do not collect information on clinical outcomes. There is no system in place to review the development of health care plans for individuals with infectious diseases to ensure that appropriate interventions are implemented. Moreover, there is no analysis of trends in the data concerning the activities and interventions of the infection control department in conjunction with the units' practices. We found numerous patients with infectious diseases who had no provision in their respective health care plans for interventions related to their infectious diseases. In addition, we found that there generally is no analysis of data regarding infectious diseases that are present in the State Psychiatric Hospitals, such as hepatitis A, hepatitis B, hepatitis C, MRSA, tuberculosis, sexually transmitted diseases, and HIV, nor any analysis regarding individuals who became infected with these diseases while at the State Psychiatric Hospitals.

#### 6. Inadequate Physical and Nutritional Management

Generally accepted professional standards dictate that an effective physical and nutritional management system include: the identification of patients who are at risk for aspiration/choking and the assignment of an appropriate risk level; the identification of patients' triggers or symptoms of aspiration; adequate assessments of safe positioning for the 24-hour day; clinically-justified techniques, based on the assessment, that ensure safety during daily activities; the development and implementation of a plan containing specific instructions for the techniques determined by the assessment, with clinical justifications; the provision of competency-based training to all staff assisting these patients regarding individualized dysphagia plans; the development of a method to monitor, track, and document clinically objective data, including triggers, lung sounds, oxygen saturations, and vital signs, to determine if treatment interventions are effective or in need of modification; the development of a mechanism for reporting triggers that generate an immediate response from a physical nutritional management team ("PNMT") to re-evaluate the plan and its implementation; development of an overall monitoring system conducted by members of the PNMT to ensure that plans are

being consistently implemented and that this monitoring is most intense for those with the highest level of risk; and assurance that this system is effective so that it may be transferred into the community.

Patients residing at the State Psychiatric Hospitals who are at risk for aspiration are not provided adequate assessments, interventions, proactive monitoring such as such as obtaining lung sounds and oxygen saturation to determine changes in health status, or regular treatment plan monitoring, which places them at significant risk for harm. The lack of safety assessments extended to many high-risk activities, including oral care, bathing, dental appointments, and during sleep. The mealtime plans we reviewed lacked information to guide staff in feeding patients designated as at risk for aspiration. Mealtime plans for tube-fed patients—a group at the highest risk for aspiration—contained no special instructions for positioning during feeding or how long after the feeding the patient should remain in a specific upright position. Moreover, staff assigned to assist patients with meals and other activities did not receive competency-based training on carrying out the requirements of mealtime plans or treatment plans. The widespread absence of information guiding the treatment of at-risk patients is therefore compounded by the absence of any system to ensure that staff are competent in adequately executing treatment and mealtime instructions.

There is no system in place in the State Psychiatric Hospitals to ensure that patients at risk for aspiration are provided with safe, appropriate, and adequate treatment interventions. The state-wide policies developed in this area fall far short of addressing the individualized needs of persons at risk for aspiration. Patients with dysphagia who have experienced recurrent respiratory distress, pneumonia, or aspiration pneumonia are not comprehensively reevaluated to assess the appropriateness of the current treatment plan and to modify interventions when necessary. The failure to reassess these patients and to provide proactive interventions is a gross departure from generally accepted professional standards. These deficiencies have resulted in harm and continue to place patients with physical and nutritional issues at serious risk of harm. Indeed, a large number of patients at State Psychiatric Hospitals suffer grievous, preventable harm, including death, from aspiration pneumonia or complications of this condition. The State's failure to take appropriate steps to ameliorate this harm is deeply troubling.

The above-described deficiencies and the resultant harm to patients can be seen in the case of A.A.<sup>9</sup> Throughout her chart, there were notations that she has

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<sup>9</sup> To protect patients' privacy, we identify them with initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with patient names.

behavioral issues that should have resulted in A.A. being identified as at a moderate to high risk of choking. But, because A.A. was never adequately assessed, her meal plan identified her as being only at a minimal risk for choking, and made no mention of the behavioral issues described above. As a result, no precautions had been taken to protect A.A. from this severe risk of harm.

On our tour of CSH, we observed A.A. eating alone and shoving food into her mouth at a rapid pace without taking any liquid between bites—the very behavioral issues noted in her chart. We observed her coughing while eating on more than one occasion during her meal, prompting nearby staff members to turn and tell her to “slow down.” No staff intervened to assist her in regulating her speed, however, until she had a choking incident so severe it resulted in a staff member with whom we were touring performing the Heimlich maneuver on A.A.

Subsequent to this incident, A.A. was placed on a modified diet without an adequate assessment by a member of the PNMT and with no clinically objective data to justify these modifications. She was then placed on one-to-one observation during her next two meals. A.A. was observed during those two meals by an unlicensed direct care staff member, without the adequate supervision of a member of the PNMT, who reported that A.A. did not have any incidents of coughing during those meals. Without appropriate and adequate assessments being done, A.A. was then taken off one-to-one observation and resumed eating her meals unsupervised and without assistance. In addition, even the inadequate and perhaps inappropriate revisions to A.A.’s meal plan that had been recommended by the speech therapist simply had been hand-written into her plan, with no evidence that staff had been competency-based trained on those modifications. Consequently, even after a severe choking incident, A.A. remains at significant risk of harm.

## 7. Emergency Preparedness Is Inadequate

In accordance with generally accepted professional standards, all staff should be well-trained in emergency preparedness, aware of emergency materials and where they are located, and conduct sufficient practice codes to be able to perform adequately when confronted with an actual emergency. Appropriate emergency medical response also includes physical plant readiness.

Although the State Psychiatric Hospitals’ emergency preparedness policies appear adequate, practices regarding emergency preparedness depart from constitutional standards. For example, although generally accepted professional standards require that mock codes be conducted on all units on all three shifts at least quarterly, with some exceptions, data from the State Psychiatric Hospitals does not indicate that this is occurring. In addition, there is no system in place in the State Psychiatric Hospitals to critically analyze mock codes and develop and



implement a plan of correction to address problematic issues. The risks associated with these deviations from generally accepted professional standards is well-illustrated by the medical emergency drills we reviewed, a significant number of which were failed drills. For example, we observed nurses at CSH and ECRH who did not know how to turn on oxygen tanks, despite emergency preparedness documentation indicating that they were completing this task daily. This pattern of unacceptable nursing practice was prevalent throughout the State Psychiatric Hospitals.

#### 8. Inadequate Staffing and Nursing Services

The deficiencies in medical and nursing care identified above are exacerbated by chronic staffing shortages. Generally accepted professional standards require facilities like the State Psychiatric Hospitals to have staff sufficient to provide nursing services that, at a minimum, protect patients from harm, ensure adequate and appropriate treatment, and prevent unnecessary and prolonged institutionalization.

The State's own survey by the Medical College of Georgia noted the nursing staff shortage and its potential effect on the services provided to patients. The failure to provide adequate nursing staff, along with the deficits in care and treatment that necessarily result from the critical and ongoing shortages, is a substantial departure from generally accepted professional standards.

#### **F. Services to Populations with Specialized Needs Are Inadequate**

Pursuant to Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq., and its implementing regulations, the State Psychiatric Hospitals are required to take reasonable steps to ensure meaningful access to their programs and activities by persons with limited English proficiency ("LEP"). See 45 C.F.R. Part 80 (Department of Health and Human Services regulations). Georgia's Mental Health Gap Analysis in May 2005 identified glaring deficiencies in mental health services available to persons with hearing impairments or limited English proficiency. Although the State has adopted a Limited English Proficiency and Sensory Impaired Client Services Manual, we saw little evidence that the policies outlined in the Manual were followed. At best, the Hospitals use language-line services, limited bi-lingual staff, including some professional staff, and limited numbers of translators to provide some translation services to identified patients. Critical documents, including consents to care, are not translated into languages the clients can understand. Patients with limited English proficiency, as well as patients with speech, language or hearing deficits are largely under-served in the State Psychiatric Hospitals.

#### **IV. RECOMMENDED REMEDIAL MEASURES**

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of the patients who are confined, or at risk of being confined inappropriately in the State Psychiatric Hospitals, the State of Georgia should immediately develop a comprehensive, effectively working plan to remedy the constitutional and federal statutory violations discussed in this letter and should implement the plan promptly. The plan shall address the minimum remedial measures set forth below:

##### **A. Support For Discharges to the Most Integrated Setting**

1. The State shall provide services in the most integrated setting appropriate to each patient's needs, consistent with the mandate of Title II of the ADA and its implementing regulations, and section 504 of the Rehabilitation Act and implementing regulations.
2. The State shall ensure that all individuals in the State Psychiatric Hospitals receive treatment and/or habilitation as necessary to prepare those individuals adequately for the most integrated setting appropriate to their needs, and that care is directed towards acquiring skills and abilities that promote as much independence, autonomy, and development as possible.
3. The State admits that all persons with developmental disabilities can be successfully provided services in the community with appropriate supports, and will, therefore, develop its community resources in order to eliminate the institutionalization of individuals with developmental disabilities, provided that those individuals do not oppose community placement. The State shall utilize each of the Hospitals as a resource center to support community services and ensure continuity of care.
4. The State shall ensure the participation in all aspects of care, treatment and discharge planning by the patient, his or her guardian, family, and friends, as appropriate, and staff who know the patient best.
5. The State shall conduct an interdisciplinary assessment of each patient to determine whether the patient is receiving services in the most integrated setting appropriate for his or her needs, and ensure that this determination is based on the identified needs of the individual, and not on what is currently available in the community.

6. If it is determined that a more integrated setting would appropriately meet the patient's needs and the patient does not oppose community placement, the State shall ensure that treatment teams promptly develop and implement a transition plan that specifies actions necessary to ensure safe, successful transition from the facility to a more integrated setting, the names and positions of those responsible for these actions, and corresponding time frames.
7. The State shall add to a waiting list for services all patients (regardless of length of stay in the hospital) for whom the treatment team has determined a more integrated setting would be appropriate, and shall track the list to show how long each patient has been on the waiting list, and the particular barriers for each patient on the waiting list that are preventing discharge to a more integrated setting.
8. The State shall monitor and assess the waiting list to ensure it moves at a reasonable pace.
9. The State shall provide education and counseling to patients, their guardians, and/or families regarding community supports and services and the transition process.
10. The State shall conduct, and update as necessary, interdisciplinary assessments of each patient that are adequate to develop treatment goals and intervention strategies while at the State Psychiatric Hospitals and upon return to the community. The State shall ensure that professional staff performing assessments obtain and document sufficiently detailed information regarding patients' strengths, preferences, needs, and history.
11. The State shall ensure, for all patients, that discharge planning is linked to hospital treatment planning, and, at a minimum, that barriers to discharge are identified and addressed in the treatment planning process and in implementation of individual treatment plans.
12. The State shall ensure that, for patients with a history of frequent re-admission, factors that led to re-admission are analyzed and addressed in treatment and discharge planning.
13. The State shall ensure continuity of care upon discharge. At a minimum, the State shall:

- a. Follow its policies and procedures that require contact with identified community providers prior to discharge; and
  - b. Develop and implement a system to follow up individuals after discharge to identify gaps in care and address proactively any such gaps to reduce the risk of re-hospitalizations.
14. The State shall immediately assess areas of need for additional community services to support patients discharged from the State Psychiatric Hospitals, and expand and modify community services so that patients can be discharged to the community in a timely manner. The needs assessment shall include an inventory of the specific needs of institutionalized patients, and in addition, shall build upon the existing assessments made by the State in its 2003 Olmstead Plan, the 2005 Mental Health System Gap Analysis, and the 2008 Mental Health Service Delivery Commission Report.
15. The State shall develop and implement hospital diversion programs to reduce Georgia's over-reliance on institutional care as recommended in Governor Sonny Perdue's 2008 Mental Health Service Delivery Commission Report.
16. The State shall develop a comprehensive, state-wide supported housing program as recommended in the 2008 Mental Health Service Delivery Commission Report.
17. The State shall create a statewide continuum of adequate case management services as recommended in the 2008 Mental Health Service Delivery Commission Report.
18. The State shall create adequate supported employment opportunities, as recommended in the 2008 Mental Health Service Delivery Commission Report.
19. The State shall provide sufficient mechanisms for patients discharged from the State Psychiatric Hospitals to access needed medication, transportation, benefits and programming, as recommended in the 2008 Mental Health Service Delivery Commission Report. Community supports shall include a focus on evidence-based and recovery-oriented programs and services.

20. The State shall provide sufficient specialized services in the community for persons with co-occurring conditions of mental illness and substance abuse, and mental illness and developmental disability.
21. The State shall develop a system to track vacancies in community-based residential homes and programs to ensure the efficient use of these resources and the timely placement of persons with mental illness or developmental disabilities in the most integrated setting.
22. The State shall identify gaps in services by geographic region and level of care to provide sufficient information to develop reasonable service development plans and appropriate funding proposals for needed services.
23. The State shall monitor and assess adequacy of community-based programs and services to ensure the State does not discriminate against persons with mental illness and developmental disabilities by not providing those services in the most integrated setting within a reasonable amount of time.
24. The State shall provide competency-based training to staff on revised policies and procedures relating to the discharge process.
25. The State shall create, or revise, as appropriate, and implement a quality assurance or utilization review process to oversee the discharge process, including, at a minimum:
  - a. Develop a system to review the quality and effectiveness of discharge plans;
  - b. Develop a system to track discharged patients to determine if they receive care in the community as prescribed at discharge; and
  - c. Identify and assess gaps in community services identified through the tracking of discharge outcomes.

**B. Prevent Frequent and Recurrent Harm**

The State shall provide patients with a safe and humane environment and protect them from harm. At a minimum, the State shall:

1. Create or revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards, including, at a minimum:
  - a. Create or revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents, including those involving any physical injury; patient aggression; abuse and neglect; contraband; and suicide ideation or attempts;
  - b. Require all staff to complete competency-based training in the revised reporting requirements;
  - c. Create or revise, as appropriate, and implement thresholds for indicators of events, including, without limitation, patient injury, patient-on-patient assaults, self-injurious behavior, falls, and suicide ideation or attempts, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level; whenever such thresholds are reached, this will be documented in the patient medical record, with explanations given for changing/not changing the patient's current treatment regimen;
  - d. Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents, including, without limitation, abuse, neglect, suicide ideation or attempts, unexplained injuries, and all injuries requiring medical attention more significant than first aid. The policies and procedures shall require that investigation of such incidents that are comprehensive, include consideration of staff's adherence to programmatic requirements, and are performed by independent investigators;
  - e. Require all staff members charged with investigative responsibilities to complete competency-based training on investigation methodologies and documentation requirements necessary in mental health service settings;
  - f. Monitor the performance of staff charged with investigative responsibilities and provide administrative and technical support and training as needed to ensure the thorough,

competent, and timely completion of investigations of serious incidents;

- g. Ensure that corrective action plans are developed and implemented in a timely manner;
  - h. Review, revise, as appropriate, and implement policies and procedures related to the tracking and trending of incident data, including data from patient aggression and abuse and neglect allegations, to ensure that such incidents are properly investigated and appropriate corrective actions are identified and implemented in response to problematic trends; and
  - i. Create or revise, as appropriate, and implement policies and procedures regarding the creation, preservation, and organization of all records relating to the care and/or treatment of patients, including measures to address improper removal, destruction, and/or falsification of any record.
2. Develop and implement a comprehensive quality improvement system consistent with generally accepted professional standards. At a minimum, such a system shall:
- a. Collect information related to the adequacy of the provision of the protections, treatments, services, and supports provided by the State Psychiatric Hospitals, as well as the outcomes being achieved by patients;
  - b. Analyze the information collected in order to identify strengths and weaknesses within the current system; and
  - c. Identify and monitor the implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.
3. Immediately eliminate all environmental conditions that pose a potential suicide risk in patient areas.

## **C. Mental Health Care and Treatment**

### **1. Assessments and Diagnoses**

The State Psychiatric Hospitals shall ensure that their patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. More particularly, the State Psychiatric Hospitals shall:

- a. Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments; and ensure that assessments include a plan of care that outlines specific strategies, with rationales, including adjustment of medication regimens and initiation of specific treatment interventions.
- b. Ensure that psychiatric reassessments are completed within time-frames that reflect the patient's needs, including prompt reevaluations of all patients requiring restrictive interventions.
- c. Develop diagnostic practices, consistent with generally accepted professional standards, for reliably reaching the most accurate psychiatric diagnoses.
- d. Conduct interdisciplinary assessments of patients consistent with generally accepted professional standards. Expressly identify and prioritize each patient's individual mental health problems and needs, including, without limitation, maladaptive behaviors and substance abuse problems.
- e. Develop a clinical formulation of each patient that integrates relevant elements of the patient's history, mental status examination, and response to current and past medications and other interventions, and that is used to prepare the patient's treatment plan.
- f. Ensure that the information gathered in the assessments and reassessments is used to justify and update diagnoses, and establish and perform further assessments for a differential diagnosis.



- g. Review and revise, as appropriate, psychiatric assessments of all patients, providing clinically justified current diagnoses for each patient, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.
- h. Develop a monitoring instrument to ensure a systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial assessments, progress notes, and transfer and discharge summaries, and require each clinical discipline's peer review system to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective action.

## 2. Treatment Planning

The State Psychiatric Hospitals shall develop and implement an integrated treatment planning process consistent with generally accepted professional standards. More particularly, the State Psychiatric Hospitals shall:

- a. Develop and implement policies and procedures regarding the development of individualized treatment plans consistent with generally accepted professional standards.
- b. Ensure that treatment plans derive from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments. At a minimum, this should include:
  - i. Review by psychiatrists of all proposed behavioral plans to determine that they are compatible with the psychiatric formulations of the case;
  - ii. Regular exchange of objective data between the psychiatrist and the psychologist and use of this data to distinguish psychiatric symptoms that require drug treatments from behaviors that require behavioral therapies;

- iii. Integration of psychiatric and behavioral treatments in those cases where behaviors and psychiatric symptoms overlap; and
  - iv. Documentation in the patient's record of the rationale for treatment.
- c. Ensure that treatment plans address repeated admissions and adjust the plans accordingly to examine and address the factors that led to re-admission.
  - d. Develop and implement treatment goals that will establish an objective, measurable basis for evaluating patient progress.
  - e. Ensure that treatment plans are consistently assessed for their efficacy and reviewed and revised when appropriate.
  - f. Provide adequate and appropriate mental health services, including adequate psychological services, behavioral management, and active treatment, in accordance with generally accepted professional standards.
  - g. Provide psychologists with sufficient education and training to ensure:
    - i. competence in performing behavioral assessments, including the functional analysis of behavior and appropriate identification of target and replacement behaviors;
    - ii. the development and implementation of clear thresholds for behaviors or events that trigger referral for a behavioral assessment;
    - iii. timely review of behavioral assessments by treatment teams, including consideration or revision of behavioral interventions, and documentation of the team's review in the patient's record;
    - iv. the development and implementation of protocols for collecting objective data on target and replacement behaviors; and

- v. assessments of each patient's cognitive deficits and strengths to ensure that treatment interventions are selected based on the patient's capacity to benefit.
- h. Re-assess all patients at the State Psychiatric Hospitals to identify those who would benefit from speech and communication therapy and provide sufficient qualified and trained staff to provide services to all patients who would benefit from this service.
- i. Require all clinical staff to complete successfully competency-based training on the development and implementation of individualized treatment plans, including skills needed in the development of clinical formulations, needs, goals, and interventions, as well as discharge criteria.
- j. Ensure that the medical director timely reviews high-risk situations, such as patients requiring repeated use of seclusion and restraints.
- k. Develop and implement policies to ensure that patients with special needs, including co-occurring diagnoses of substance abuse and/or developmental disability, and physical, cognitive and/or sensory impairments are evaluated, treated, and monitored in accordance with generally accepted professional standards.
- l. Develop and implement policies for patients exhibiting suicidal ideation, including for patients identified as suicidal, develop and implement a clear and uniform policy for patient assessment and treatment.
- m. Develop a system to ensure that staff receive competency-based training on individualized plans, including behavioral support plans and interventions, and document this training.
- n. Ensure that restrictive interventions receive appropriate review by a Human Rights Committee, or its equivalent, to guarantee any restriction of rights are necessary, appropriate, and of limited duration.

- o. Ensure that all psychotropic medications are:
  - i. administered as prescribed;
  - ii. tailored to each patient's individual symptoms;
  - iii. monitored for efficacy and potential side-effects against clearly-identified target variables and time frames;
  - iv. modified based on clinical rationales; and
  - v. properly documented.
  
- p. Institute systematic monitoring mechanisms regarding medication use throughout the Facility. In this regard, the State Psychiatric Hospitals shall:
  - i. Develop, implement, and continually update a complete set of medication guidelines in accordance with generally accepted professional standards that address the indications, contraindications, screening procedures, dose requirements, and expected individual outcomes for all psychiatric medications in the formulary; and
  - ii. Develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, a documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely, critical review of the patient's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses.
  
- q. Provide competency-based training to all staff appropriate to their duties in all aspects of treatment planning and delivery of mental health treatment services.
  
- r. Create, or revise, as appropriate, and implement a quality assurance or utilization review process to ensure quality of treatment planning and mental health services.

#### **D. Seclusion and Restraints**

The State Psychiatric Hospitals shall ensure that seclusion and restraints are used in accordance with generally accepted professional standards. Absent exigent circumstances i.e., when a patient poses an imminent risk of injury to himself or a third party—any device or procedure that restricts, limits, or directs a person's freedom of movement (including, but not limited to, chemical restraints, mechanical restraints, physical/manual restraints, or time out procedures) should be used only after other less restrictive alternatives have been assessed and exhausted. More particularly, the Hospitals shall:

1. Eliminate the use of planned (i.e., PRN) seclusion and planned restraint.
2. Ensure that restraints and seclusion:
  - a. Are used only when persons pose an immediate threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted;
  - b. Are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;
  - c. Are not used as part of a behavioral intervention;
  - d. Are terminated as soon as the person is no longer an imminent danger to himself or others; and
  - e. Are used in a reliably documented manner.
3. Create or revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards that cover the following areas:
  - a. The range of restrictive alternatives available to staff and a clear definition of each; and
  - b. The training that all staff receive in the management of the patient crisis cycle, the use of restrictive measures, and the use of less-restrictive interventions.
4. Ensure that if seclusion and/or restraint are initiated, the patient is regularly monitored in accordance with generally accepted professional

standards and assessed within an appropriate period of time, and that an appropriately trained staff member makes and documents a determination of the need for continued seclusion and/or restraint.

5. Ensure that a physician's order for seclusion and/or restraint includes:
  - a. The specific behaviors requiring the procedure;
  - b. The maximum duration of the order; and
  - c. Behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.
6. Ensure that the patient's attending physician be promptly consulted regarding the restrictive intervention.
7. Ensure that at least every thirty minutes, patients in seclusion and/or restraint be re-informed of the behavioral criteria for their release from the restrictive intervention.
8. Ensure that immediately following a patient being placed in seclusion and/or restraint, the patient's treatment team reviews the incident within one business day, and the attending physician documents the review and the reasons for or against change in the patient's current pharmacological, behavioral, or psychosocial treatment.
9. Comply with the requirements of 42 C.F.R. § 483.360(f) regarding assessments by a physician or licensed medical professional of any resident placed in seclusion and/or restraints.
10. Ensure that staff successfully complete competency-based training regarding implementation of seclusion and restraint policies and the use of less-restrictive interventions.

#### **E. Medical and Nursing Care**

The State Psychiatric Hospitals shall provide medical and nursing services to its patients consistent with generally accepted professional standards. Such services should result in patients of the State Psychiatric Hospitals receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, the State Psychiatric Hospitals shall:

1. Ensure adequate clinical oversight to ensure that generally accepted professional standards are maintained.
2. Ensure that patients are provided adequate medical care in accordance with generally accepted professional standards.
3. Ensure sufficient nursing staff to provide nursing care and services in accordance with generally accepted professional standards.
4. Ensure that, before nursing staff work directly with patients, they have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the patient's status.
5. Ensure that nursing staff accurately and routinely monitor, document, and report patients' symptoms and target variables in a manner that enables treatment teams to assess the patient's status and to modify, as appropriate, the treatment plan.
6. Ensure that nursing staff actively participate in the treatment team process and provide feedback on patients' responses, or lack thereof, to medication and behavioral interventions.
7. Ensure that nursing staff are appropriately supervised to ensure that they administer, monitor, and record the administration of medications and any errors according to generally accepted professional standards.
8. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Record.
9. Ensure that all failures to properly sign the Medication Administration Record and/or the Narcotics Log are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors.
10. Ensure that each patient's treatment plan identifies:
  - a. The diagnoses, treatments, and interventions that nursing and other staff are to implement;

- b. The related symptoms and target variables to be monitored by nursing and other unit staff; and
  - c. The frequency by which staff need to monitor such symptoms.
11. Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, the State Psychiatric Hospitals shall:
- a. Actively collect data with regard to infections and communicable diseases;
  - b. Analyze these data for trends;
  - c. Initiate inquiries regarding problematic trends;
  - d. Identify necessary corrective action;
  - e. Monitor to ensure that appropriate remedies are achieved;
  - f. Integrate this information into the quality assurance review of the State Psychiatric Hospitals; and
  - g. Ensure that nursing staff implement the infection control program.
12. Establish an effective physical and nutritional management program for patients who are at risk for aspiration or dysphagia, including but not limited to the development and implementation of assessments, risk assessments, and interventions for mealtimes and other activities involving swallowing.
13. Ensure that staff with responsibilities for patients at risk for aspiration and dysphagia have successfully completed competency-based training commensurate with their responsibilities.
14. Provide adequate, appropriate, and timely rehabilitation therapy services and appropriate adaptive equipment to each individual in need of such services or equipment, consistent with generally accepted professional standards.
15. Establish an effective medical emergency preparedness program, including appropriate staff training; ensure staff familiarity with



emergency supplies, their operation, maintenance and location; conduct sufficient practice drills to ensure adequate performance when confronted with an actual emergency.

**F. Services to Populations with Specialized Needs and Training**

1. Provide adequate services to patients with limited English proficiency or sensory deficiencies, consistent with the requirements of federal law. Review applicable law, Title VI Limited English Proficiency (“LEP”) guidance issued by the U.S. Departments of Justice and Health and Human Services and available literature on standards of care for LEP patients. Resources are available at [www.lep.gov](http://www.lep.gov) (see, for example, <http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf>) and [www.hhs.gov/ocr/office/index.html](http://www.hhs.gov/ocr/office/index.html).
2. Provide competency-based training to staff on the requirements of all revised policies and procedures in all substantive areas.

**V. CONCLUSION**

We appreciate the cooperation we received from the Georgia Department of Behavioral Health, and its predecessor, the Department of Mental Health Developmental Disabilities and Addictive Diseases. We also wish to thank the administration and staff at the State Psychiatric Hospitals we visited for their professional conduct, their timely responses to our information requests, and the extensive assistance they provided during our tours. Further, we wish to especially thank the Hospitals’ staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment, and who improve the lives of patients at these facilities. Those efforts were noted and appreciated by the Department of Justice and our expert consultants.

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division, and we will provide a copy of this letter to any individual or entity upon request.

In the event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to initiate a lawsuit to correct deficiencies of the kind identified in this letter. We remain amenable to expeditiously resolving this matter by working cooperatively with you. The lawyers assigned to this matter will be contacting your attorneys to discuss next steps in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

*/s Thomas E. Perez*

Thomas E. Perez  
Assistant Attorney General  
Civil Rights Division

cc: The Honorable Thurbert E. Baker  
Attorney General  
Office of the Attorney General Of Georgia

Frank Shelp, M.D.  
Commissioner  
Georgia Department of Behavioral Health and Developmental Disabilities

Marvin V. Bailey  
Regional Hospital Administrator  
Central State Hospital

Nannette M. Lewis, M.P.H.  
Regional Hospital Administrator  
East Central Regional Hospital

Charles Li, M.D.  
Regional Hospital Administrator  
Georgia Regional Hospital/Savannah

Karl H. Schwarzkopf, Ph.D.  
Regional Hospital Administrator  
Northwest Georgia Regional Hospital

Hillary Hoo-you  
Regional Hospital Administrator  
Southwestern State Hospital

John L. Robertson  
Regional Hospital Administrator  
West Central Georgia Regional Hospital

Susan Trueblood  
Regional Hospital Administrator  
Georgia Regional Hospital/Atlanta

Sally Quillian Yates  
United States Attorney  
Northern District of Georgia

G. F. Pete Peterman, III  
United States Attorney  
Middle District Of Georgia

Joseph D. Newman  
Acting United States Attorney  
Southern District of Georgia

Georgina C. Verdugo  
Director, Office for Civil Rights  
U.S. Department of Health and Human Services