



U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

JAN 9 2008

The Honorable Theodore R. Kulongoski
Governor of Oregon
160 State Capitol
900 Court Street
Salem, OR 97301-4047

Re: CRIPA Investigation of the Oregon State Hospital,
Salem and Portland, Oregon

Dear Governor Kulongoski:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Salem and Portland campuses of the Oregon State Hospital (OSH). On June 14, 2006, we notified you that we were initiating an investigation of conditions and practices at OSH, 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 who are treated in public institutions.

As part of our investigation, on November 13 through 16, 2006, we conducted an on-site review of care and treatment at both OSH campuses with expert consultants in the fields of psychiatry, psychology, psychiatric nursing, protection from harm, life safety, and discharge planning and community placement. While on-site, we interviewed administrative staff, mental health care providers, and patients, and examined the physical living conditions at the facility. Additionally, before, during, and after our on-site inspection, we reviewed a wide variety of documents, including policies and procedures, incident reports, and medical and mental health records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tour with an extensive debriefing at which our consultants conveyed their initial impressions and concerns to counsel, OSH administrators and staff, and state officials.

We appreciate the full cooperation we received from the Oregon Department of Health and Human Services and the Oregon Attorney General's office. We also wish to thank the administration and staff at OSH for their professional conduct, their timely responses to our information requests, and the extensive assistance they provided during our tour. Further, we wish to especially thank those individual OSH staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment, and who improve the lives of patients at OSH. Those efforts were noted and appreciated by the Department of Justice and our expert consultants. We hope to continue to work cooperatively with OSH and the State of Oregon to address the deficiencies at the Salem and Portland campuses.

In accordance with statutory requirements, I now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimal remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at OSH violate the constitutional and statutory rights of its residents. In particular, we find that OSH: (1) fails to adequately protect its patients from harm; (2) fails to provide appropriate psychiatric and psychological care and treatment; (3) fails to use seclusion and restraints in a manner consistent with generally accepted professional standards; (4) fails to provide adequate nursing care; and (5) fails to provide discharge planning and to ensure placement in the most integrated setting. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483, Subpart I (Medicaid Program Provisions); Americans with Disabilities Act (ADA), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see also Olmstead v. L.C., 527 U.S. 581 (1999).

I. BACKGROUND

OSH is the State's primary psychiatric facility for adults, including those over age 65. It consists of two campuses, a 627-bed facility in Salem, where most patients reside, and a 54-bed facility in Portland, which is used for psychiatric rehabilitation services. The Salem facility opened its doors well over a century ago, and some of the original buildings are still in use. In 1988, and again in 2005, state-commissioned reports described various health and safety dangers stemming from the facility's antiquated physical structure and recommended demolition.

Psychiatric services at OSH are provided through two separate treatment programs -- forensic psychiatric services (FPS) and psychiatric recovery services (PRS). FPS consists of 334 budgeted hospital-level beds on ten units and 100 budgeted residential-level beds on three units. This program houses three categories of patients: (1) individuals who have been committed to OSH pursuant to criminal court proceedings (e.g., incompetent to stand trial and not guilty by reason of insanity); (2) inmates transferred from correctional facilities for psychiatric treatment; and (3) individuals who are committed by the courts for a psychiatric and/or psychological evaluation. All FPS patients reside on the Salem campus.

Non-forensic patients receive services through PRS, which consists of 193 budgeted hospital-level beds in Salem and 54 budgeted hospital-level beds in Portland. Five units serve adult patients civilly committed to the hospital due to serious and persistent mental illness, two units serve geriatric patients, one unit serves patients with brain damage, and one unit serves as a medical unit for patients with physical illness or other medical needs.

II. FINDINGS

At issue is whether the State is providing patients at OSH with care and treatment in accordance with its constitutional and federal statutory obligations. Residents of state-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with rehabilitation, to ensure their safety and freedom from unreasonable restraint, prevent regression, and facilitate their ability to exercise their liberty interests. See Youngberg, 457 U.S. at 315, 322. Federal statutes provide similar protections. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1395hh, and implementing regulations, 42 C.F.R. Parts 482-483 (Medicaid and Medicare Program Provisions).

More particularly, a state mental health hospital is constitutionally required to provide reasonable, adequate mental health treatment. See Or. Advocacy Ctr. v. Mink, 322 F.3d 1101, 1121 (9th Cir. 2003) (even incapacitated criminal defendants have a liberty interest in restorative treatment); Sharp v. Weston, 233 F.3d 1166, 1172 (9th Cir. 2000) ("[T]he Fourteenth Amendment Due Process Clause requires states to provide civilly committed persons with access to mental health treatment that gives them a realistic opportunity to be cured and released."); Ohlinger v. Watson, 652 F.2d 775, 778 (9th Cir. 1980) ("Adequate and effective treatment is constitutionally required because, absent

treatment, appellants [who were committed as sex offenders] could be held indefinitely as a result of their mental illness."). Treatment is not adequate if it substantially departs from accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23; Rohde v. Rowland, 898 F.2d 156, 160 (9th Cir. 1990); see also Or. Advocacy Ctr., 322 F.3d at 1120-21.

Patients' constitutional liberty interests in security compel states to provide reasonable protection from harm in mental health hospitals. Youngberg, 457 U.S. at 315-16. States also 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." Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990). "Even on a short-term basis, states may not rely on drugs to the exclusion of other methods to treat people with behavior problems." Id. at 1188. Moreover, 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).

Medicare and Medicaid regulations governing psychiatric hospitals require adequate staffing, record keeping, care, treatment, and discharge planning. 42 C.F.R. §§ 482-483. In addition, states must provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. Olmstead v. L.C., 527 U.S. 581, 607 (1999) (states are required to provide community-based treatment for persons with mental disabilities when a 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, taking into account the resources available to the state and the needs of others with mental disabilities); see also Title II of the ADA, 42 U.S.C. § 12132 ("no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"), and its implementing regulations, 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"). Professional judgments should be made on a case-by-case basis regarding the

most appropriate setting in which individual patients should be placed. See, e.g., Thomas S., 902 F.2d at 254-55.

It is apparent that many OSH staff genuinely are concerned for the well-being of the persons in their care. These staff members display admirable dedication and undertake significant efforts to provide appropriate treatment and improve the lives of OSH patients. Nevertheless, it is also the case that significant and wide-ranging deficiencies exist in OSH's provision of care. Certain conditions and services at OSH 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 OSH: (1) fails to ensure reasonable safety of its patients; (2) fails to provide adequate mental health treatment; (3) engages in the inappropriate use of seclusion and restraints; (4) fails to provide adequate nursing care; and (5) fails to provide adequate discharge planning.¹ Many of these deficiencies stem from a system that does not have clear, specific standards of care or an adequate number of trained professional and direct care staff.

A. Inadequate Protection From Harm

Patients at OSH have a right to live in reasonable safety. See Youngberg, 457 U.S. at 315, 322. Yet, in our judgment, OSH fails to provide a living environment that complies with this constitutional mandate. Specifically, there is widespread patient-against-patient assault, unchecked self-injurious behavior, and a high rate of falls. In addition, the housing units contain environmental hazards, some of which pose risks of serious injury, illness, and death. The harm OSH patients experience as a result of these deficiencies is multi-faceted, and includes physical injury; psychological harm; excessive and inappropriate use of restraints; inadequate, ineffective, and counterproductive treatment; and excessively long hospitalizations. The facility's ability to address this harm is hampered by inadequate incident management and quality assurance systems.

1. Inadequate Incident Management

To protect its patients, OSH should have in place an incident management system that helps to prevent incidents and ensures appropriate corrective action when incidents do occur.

¹ Unless otherwise indicated, the findings apply to both campuses.

An effective incident management system depends on (1) accurate reporting, (2) thorough investigations, (3) tracking and trending of data, and (4) implementation and monitoring of effective corrective and/or preventive actions. The incident management system at OSH falls significantly short of these standards and, as a result, patients are exposed to actual and potential harm.

a. High levels of incidents

Certain types of incidents occur frequently at OSH. Facility records indicate that between January and December 2005, there were 392 patient-against-patient assaults. At the time of our tour in November 2006, these incidents appeared to be on the rise -- in the first ten months of 2006, OSH already had recorded 410 patient-against-patient assaults and thus was on pace for a 25% increase over the previous year.

Incidents of self-harm also are common at OSH. Although the facility did not provide data regarding the total number of these incidents, we found numerous references to self-injurious behavior during our document review. For example, H.M.² engaged in 26 episodes of self-injurious behavior/suicide attempts during a nine-month period in 2006. On seven of these occasions, H.M. was on 1:1 observation; on one occasion, she was on 2:1 observation.³ While on 1:1 observation, H.M. was able to wrap wires around her neck, swallow liquid cleaner, and climb under her bed and wrap a sheet around her neck. While on 2:1 observation, H.M. was able to, among other things, wrap yarn around her neck while taking a shower. D.I., another OSH patient, harmed herself 14 times between March and November 2006. A number of these incidents, including two occasions when D.I.

² To protect patients' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with patient names.

³ As defined in OSH policy, "1:1 close observation" means that a staff member is assigned to monitor a patient's location and activities at all times and shall have constant visual and appropriate verbal contact with the patient at all times. While the term "2:1 close observation" is not defined in any OSH policy, it clearly suggests that patients subjected to this restriction have two staff members assigned to monitor them at all times. In light of the staffing issues discussed later in this letter, it is worth noting that 1:1 and 2:1 staffing is a labor-intensive and costly intervention.

attempted to choke herself, occurred while she was on 1:1 observation. It is incomprehensible how patients being supervised by staff members, whose only duty it is to monitor those patients, could be allowed to hurt themselves.

There also is a pattern of falls at OSH. Between January and November 2006, staff reported 654 of these incidents. Certain patients appear to be especially susceptible to falls, and yet OSH fails to take measures to prevent this harm. For instance, Q.T., a patient in his late 40s, fell 25 times between May 8 and August 15, 2006.

b. Incident reporting

As the above examples indicate, OSH patients frequently are subjected to the most basic kinds of harm. The first step in addressing this issue is proper incident reporting. At OSH, this process is governed by Policy 1.003, which is vague, confusing, and incomplete.

Policy 1.003 sets forth five categories of "reportable incidents": (1) actual injury to patients or visitors; (2) potential moderate or severe injury to patients or visitors; (3) damage to or loss of belongings of a patient, staff, or visitor as a result of a reportable incident; (4) security problems or suspicious events; and (5) falls. Not only are these categories extremely broad,⁴ Policy 1.003 makes no attempt to define the categories. Thus, individual staff members are left to determine whether a particular incident involves "potential moderate or severe injury," presents a "security problem," or constitutes a "suspicious event." With regard to falls, the policy is silent on whether all falls should be reported or only those that result in injury.

Incident reporting at OSH is further confused by the fact that the categories of incidents in Policy 1.003 do not track those listed on the facility's Incident Report form. Instead, the Incident Report form has its own separate and distinct categories of "reportable incidents": (1) medical; (2) behavioral; (3) laboratory; (4) security; and (5) environment of care. In addition, the Incident Report form has more than 90

⁴ Psychiatric facilities typically group incidents into categories such as: physical abuse, verbal abuse, sexual assaults, suicide attempts, deaths, patient-against-patient assault, elopement, medication error with adverse consequences, and transfer to a community hospital for medical treatment.

boxes that can be checked to further describe the incident. None of the terms contained in the 90 boxes, and only one of the five broad categories is defined by OSH policy.

The lack of clarity and conformity in OSH's incident reporting system virtually ensures that adverse events will not be reported or categorized consistently. And, without proper categorization, incidents cannot be reliably aggregated and analyzed.

In addition to presenting a confusing and undefined array of "reportable incidents," Policy 1.003 specifically precludes staff from reporting abuse and neglect through the normal incident reporting process. Instead, staff are to report allegations of abuse to the Superintendent by (1) taking a written copy of the allegation to the Superintendent's office, (2) emailing the allegation to the Superintendent, (3) calling the Superintendent's office, or (4) reporting the allegation in person to the Superintendent. There is no requirement that allegations of abuse and neglect be memorialized in writing or that they be collected, preserved, and tracked in a particular manner. OSH administrators know little about the frequency of abuse and neglect allegations or the outcomes of abuse and neglect investigations. Indeed, when we asked for a list of the abuse allegations that had been made during the 12 months preceding our tour, OSH could neither provide this information nor tell us how many allegations had been substantiated.

c. Incident investigations

Generally accepted professional standards dictate that facilities like OSH investigate serious incidents such as alleged abuse and neglect, serious injury, and death. Staff selected to conduct investigations should have a demonstrated competence in investigation techniques and a programmatic knowledge of mental health. Additionally, investigators should have no real or apparent conflict of interest, and no direct involvement with the incident, the alleged perpetrator, or the victim. During the investigation, evidence should be systematically identified, collected, preserved, analyzed, and presented. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements such as policies and procedures for addressing the patient's behaviors and the implementation of the patient's treatment plan.

The investigative process at OSH significantly departs from these standards. As an initial matter, there is no requirement that OSH staff conduct even a cursory investigation of serious incidents. The only policy that touches on this topic is Policy 1.003, which requires numerous managers, including unit directors, unit mental health supervising RNs, program directors, and department directors to check the incident reports each day to evaluate them for clarity and to determine if any follow-up is necessary. If one of these managers believes follow-up is required, Policy 1.003 states that "the Incident Report Action Plan form . . . may be utilized for gathering information." There are no guidelines on how or when this form should be completed, and it appears that the form is used infrequently. For instance, out of the 161 incidents reported during September 2006, only four were flagged for follow-up. In short, Policy 1.003 yields an ill-defined process in which many people theoretically are responsible for investigating incidents and in which no one is, in fact, responsible. Not surprisingly, the facility conducts very few investigations.

One type of incident, however, is routinely investigated. State law requires that most allegations of abuse at OSH be investigated by the Office of Investigations and Training (OIT), which is part of the Oregon Department of Human Services and is not affiliated with the hospital. We were pleased with the quality of the OIT investigations we reviewed. We do, however, have two serious concerns with this system. First, it is not clear that OIT is notified of all abuse allegations. As explained above, OSH does not require that abuse allegations be memorialized in writing and does not have a policy or procedure that governs the maintenance of these allegations. Second, it appears that once OIT assumes responsibility for investigating an abuse allegation, OSH receives little feedback about the inquiry.

When done properly, investigations of serious incidents often raise programmatic issues that should be reviewed and evaluated. By failing to require investigations, establish procedures for conducting investigations, and follow up on the investigations conducted by OIT, OSH is missing both the opportunity to identify the underlying causes of incidents and the chance to correct deficiencies that may prevent similar incidents from occurring in the future.

d. Incident tracking and trending

Generally accepted professional standards require facilities like OSH to track and trend incident data to identify potentially problematic trends, and to identify, implement, and monitor

implementation of corrective action. The deficiencies in OSH's reporting process and the lack of an established investigatory process compromise its ability to do so.

Even when OSH identifies problematic trends, we found no evidence that adequate or appropriate remedies ensue. For example, OSH has data showing that certain housing units have a high incidence of patient-against-patient assaults. Yet, OSH has made no attempt to explain this disparity and thus cannot help managers on these units reduce the number of assaults. Similarly, OSH has identified certain patients who often are involved in patient-against-patient assaults and others who regularly engage in self-injurious behavior. The hospital has not, however, used this information to develop and implement behavior interventions to reduce these patients' harmful conduct. OSH's failure to take appropriate and timely action to address such trends suggests a pattern of institutional neglect and substantially departs from generally accepted professional standards.

2. Inadequate Quality Management

Generally accepted professional standards require that a facility like OSH develop and maintain an integrated system to monitor and ensure quality of care across all aspects of care and treatment. An effective quality management program must incorporate adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program also should include a process for developing a corrective action plan and a process for monitoring the effectiveness of corrective measures that are taken. Throughout this letter, we enumerate various failures at OSH to provide adequate care and treatment for its patients. With few exceptions, OSH has failed to identify these problems independently, or formulate and implement remedies to address them. Consequently, actual and potential sources of harm to OSH's patients are going unaddressed.

An adequate quality management program has two components: (1) quality assurance (QA), which focuses on evaluating compliance with basic standards of quality that are either internally or externally imposed; and (2) quality improvement (QI), which focuses on proactive self-evaluation and improvement efforts. The focus of our review was on the facility's QI efforts.

Each year, OSH develops a QI plan that identifies the facility's goals and objectives for improving patient outcomes and safety. Unfortunately, these efforts have resulted in few