IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF GEORGIA; SONNY PERDUE, Governor, State of Georgia, in his official capacity; FRANK E. SHELP, Commissioner, Georgia Department of Behavioral Health and Development Disabilities, in his official capacity; RHONDA M. MEDOWS, Commissioner, Georgia Department of Community Health, in her official capacity; MARVIN V. BAILEY, Administrator, Central State Hospital, in his official capacity; SUSAN TRUEBLOOD, Administrator, Georgia Regional Hospital/Atlanta, in her official capacity; KARL H. SCHWARZKOPF, Administrator, Northwest Georgia Regional Hospital, in his official capacity; CHARLES LI, Administrator, Georgia Regional Hospital/Savannah, in his official capacity; NANNETTE M. LEWIS, Administrator, East Central Regional Hospital, in her official capacity; HILLARY HOO-YOU, Administrator, Southwestern State Hospital, in her official capacity; and JOHN L. ROBERTSON, Administrator, West Central Georgia Regional Hospital, in his official capacity, Defendants.	)	CIVIL ACTION NO. 1:09-CV-119-CAP

AMENDED COMPLAINT

PLAINTIFF, THE UNITED STATES OF AMERICA ("Plaintiff"), by its undersigned attorneys, hereby alleges upon information and belief:

1. The Attorney General files this Amended Complaint on behalf of the United States of America pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, to enjoin the named Defendants from depriving individuals housed at the Georgia State Psychiatric Hospitals of rights, privileges, or immunities secured or protected by the Constitution and laws of the United States.

JURISDICTION AND VENUE

2. This Court has jurisdiction over this action under 28 U.S.C. §§ 1331 and 1345.

3. The United States is authorized to initiate this action pursuant to 42 U.S.C. § 1997a.

4. The Attorney General has certified that all pre-filing requirements specified in 42 U.S.C. § 1997b have been met. The Certificate of the Attorney General is appended to this Amended Complaint and is incorporated herein.

5. Venue in the Northern District of Georgia is proper pursuant to 28 U.S.C. § 1391, as a substantial portion of the acts and omissions giving rise to this action occurred in the Northern District of Georgia, § 1391(b).

DEFENDANTS

6. Defendant State of Georgia ("State") owns and operates seven state psychiatric hospitals which provide inpatient services to persons with mental illnesses, addictive diseases, and developmental disabilities: Central State Hospital in Milledgeville, Georgia Regional Hospital at Atlanta, Northwest Georgia Regional Hospital in Rome, Georgia Regional Hospital at Savannah, East Central Regional Hospital in Augusta, Southwestern State Hospital in Thomasville, and West Central Georgia Regional Hospital in Columbus (collectively the "State Psychiatric Hospitals").

7. Defendant State delivers services to persons with mental illnesses, addictive diseases, and developmental disabilities primarily through the Georgia Department of Behavioral Health and Developmental Disabilities ("DBHDD") and the Georgia Department of Community Health ("DCH").

8. Defendant Sonny Perdue, Governor of the State of Georgia, is the Chief Executive of the State and responsible for operation of its executive agencies. Defendant Perdue is sued in his official capacity as Governor.

9. Defendant Frank E. Shelp is the Commissioner of DBHDD and responsible for all operations of DBHDD. Defendant Shelp is sued in his official capacity as Commissioner of DBHDD.

10. Defendant Rhonda M. Medows is the Commissioner of DCH and responsible for all operations of DCH. Defendant Medows is sued in her official capacity as Commissioner of DCH.

11. Defendant Marvin V. Bailey is the Regional Hospital Administrator of Central State Hospital ("CSH"), and responsible for all operations of CSH. Defendant Bailey is sued in his official capacity as Administrator of CSH.

12. Defendant Susan Trueblood is the Regional Hospital Administrator of Georgia Regional Hospital/Atlanta ("GRHA"), and responsible for all operations of GRHA. Defendant Trueblood is sued in her official capacity as Administrator of GRHA.

13. Defendant Karl H. Schwarzkopf is the Regional Hospital Administrator of Northwest Georgia Regional Hospital ("NWGRH"), and responsible for all operations of NWGRH. Defendant Schwarzkopf is sued in his official capacity as Administrator of NWGRH.

14. Defendant Charles Li is the Regional Hospital Administrator of Georgia Regional Hospital/Savannah ("GRHS"), and responsible for all operations of GRHS. Defendant Li is sued in his official capacity as Administrator of GRHS.

15. Defendant Nannette M. Lewis is the Regional Hospital Administrator of East Central Regional Hospital ("ECRH"), and responsible for all operations of ECRH. Defendant Lewis is sued in her official capacity as Administrator of ECRH.

16. Defendant Hillary Hoo-You is the Regional Hospital Administrator of Southwestern State Hospital ("SWSH"), and responsible for all operations of SWSH. Defendant Hoo-You is sued in her official capacity as Administrator of SWSH.

17. Defendant John L. Robertson is the Regional Hospital Administrator of West Central Georgia Regional Hospital ("WCGRH"), and responsible for all operations of WCGRH. Defendant Robertson is sued in his official capacity as Administrator of WCGRH.

18. Defendants are legally responsible, in whole or in part, for serving persons with disabilities in the most integrated setting appropriate to their needs, and for the operation of, and conditions at, the State Psychiatric Hospitals,

including, at a minimum, the health, safety, protections, supports, services, and treatment of persons residing in or confined to the Hospitals.

19. Defendants are governmental authorities or agents thereof with responsibility for the administration of the State Psychiatric Hospitals within the meaning of 42 U.S.C. § 1997a.

20. At all relevant times, Defendants or their predecessors in office have acted or failed to act, as alleged herein, under color of state law.

FACTUAL ALLEGATIONS

Background

21. In 1999, the U.S. Supreme Court considered the case of two women whom the State continued to confine at GRHA after their treatment professionals had determined that they could be treated in the community. Olmstead v. L.C., 527 U.S. 581, 593 (1999). The Court held that the unnecessary institutionalization of persons with disabilities violates federal law. Id. at 587.

22. After Olmstead, the State commissioned a series of studies of its community mental health system which identified accountability, oversight, management, and quality of care issues. See, e.g., Study of the Community Service Board Service Delivery System (Phase I) (Feb. 2004); Study of the

Community Service Board Service Delivery System (Phase II) (Jan. 2005); Georgia Mental Health System Gap Analysis (May 2005); Governor's Mental Health Service Delivery Commission's Progress Report (June 2008).

23. On January 7, 2007, the Atlanta Journal-Constitution began publishing its series "A Hidden Shame: Danger and Death in Georgia's Mental Hospitals," detailing suspicious deaths, abuse, neglect, and inadequate care throughout Georgia's mental health system. See Alan Judd & Andy Miller, Five Years, 115 Patients Dead Who Might Have Lived, Atlanta J.-Const., Jan. 7, 2007, at 1A; Alan Judd & Andy Miller, A Suicidal Patient, but No Safe Haven, Atlanta J.-Const., Jan. 8, 2007, at 1A; Alan Judd & Andy Miller, A Fatal Struggle—but No Punishment, Atlanta J.-Const., Jan. 14, 2007, at 1A; Alan Judd & Andy Miller, Lax Security, Easy Escape, Tragic Ending, Atlanta J.-Const., Jan. 15, 2007, at 1A; Alan Judd & Andy Miller, A Family Shattered by Failure in Care, Atlanta J.-Const., Apr. 1, 2007, at 1A; Alan Judd & Andy Miller, "Home" Alone: Psychiatric Patients Are Vulnerable when State Shunts Them to Inns, Shelters, Even the Streets, Atlanta J.-Const., June 24, 2007, at 1A; Alan Judd & Andy Miller, Kids Housed in Units with Violent Teens, Atlanta J.-Const., July 29, 2007, at 1A; Alan Judd & Andy Miller, He Died Waiting, Atlanta J.-Const.,

Sept. 16, 2007, at 1A; Alan Judd & Andy Miller, Deadly Dilemma, Atlanta J.-Const., Dec. 9, 2007, at 1A; Alan Judd & Andy Miller, More Deaths Blamed on Errors, Neglect, Atlanta J.-Const., Dec. 30, 2007, at 1A; Alan Judd & Andy Miller, Feds' Inquiry Could Take Months, Atlanta J.-Const., Feb. 1, 2008, at 1A.

24. In December 2007, the Medical College of Georgia issued a report detailing deficits at the seven State Psychiatric Hospitals in areas such as protection from harm, mental health treatment, nursing staffing, risk management, and performance improvement. Peter F. Buckley & Nannette M. Lewis, Medical College of Georgia, A Comprehensive Evaluation of Georgia's State Hospital Services (2007) (Ms. Lewis is now the Administrator at ECRH).

Plaintiff

25. On April 18, 2007, the United States notified Defendants that it was initiating an investigation of conditions and practices at the State Psychiatric Hospitals pursuant to CRIPA, 42 U.S.C. § 1997.

26. In September 2007, the United States began investigative tours of the State Psychiatric Hospitals with the assistance of expert consultants in the fields of psychiatry, psychology, nursing, protection from harm, and discharge planning and community placement. The United States conducted three

investigative tours and, after entering into an agreement with the State that was designed to bring the State into compliance with the Constitution and federal statutory law, nine compliance tours. The United States has toured each of the State Psychiatric Hospitals and conducted 12 tours altogether. The United States toured GRHA on September 17-21, 2007; NWGRH on October 29 through November 2, 2007; GRHS on December 17-21, 2008; CSH on April 8, 2009; ECRH on May 4-8, 2009; GRHS on June 22-26, 2009; CSH on June 30 through July 1, 2009; GRHA on August 2-6, 2009; SWSH on October 13-16, 2009; CSH on November 2-6, 2009; WCGRH on November 30 through December 3, 2009; and CSH on January 11-15, 2010.

27. On each tour, the United States interviewed administrative staff, mental health care providers, and patients, and examined the physical plant conditions of the hospital. The United States also reviewed a wide variety of documents, including policies and procedures, incident reports, medical and mental health records, and discharge planning and community placement records.

28. At the conclusion of each tour, the United States provided Defendants with extensive debriefings at which it conveyed grave concerns about conditions

at the hospital in areas such as discharge planning and community placement, protection from harm, mental health treatment, seclusion and restraint, medical care, and services to individuals with specialized needs.

29. In May 2008, January 2009, and December 2009, the United States sent Defendants letters of findings regarding GRHA, NWGRH, and the remaining five Hospitals (CSH, GRHS, ECRH, SWSH, and WCGRH), respectively. Each letter formally advised Defendants of the findings of the United States' investigations, the facts supporting those findings, and the minimum remedial steps necessary to remedy identified deficiencies. The letters found that Defendants 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. The letters also concluded that conditions and practices at each of the State Psychiatric Hospitals violate the constitutional and federal statutory rights of persons confined therein. Specifically, the letters found that Defendants provide deficient services that subject patients both to actual harm, and to an excessive risk of harm, including inadequate protection from harm, inappropriate mental health treatment, inappropriate seclusion and restraints, inadequate medical care, and inadequate services to persons with specialized

needs. See Letter from Grace Chung Becker, Acting Assistant Attorney General, Civil Rights Division, U.S. Department of Justice, to Sonny Perdue, Governor, State of Georgia (May 30, 2008) (GRHA Findings Letter); Letter from Grace Chung Becker, Acting Assistant Attorney General, Civil Rights Division, U.S. Department of Justice, to Sonny Perdue, Governor, State of Georgia (Jan. 15, 2009) (NWGRH Findings Letter); Letter from Thomas E. Perez, Assistant Attorney General, Civil Rights Division, U.S. Department of Justice, to Sonny Perdue, Governor, State of Georgia (Dec. 8, 2009) (Findings Letter for CSH, GRHS, ECRH, SWSH, and WCGRH) (Attached as Exhibits 1-3, respectively).

30. In September 2009 and November 2009, the United States sent Defendants letters assessing Defendants' compliance with a January 2009 agreement designed to bring Defendants into compliance with the constitutional and federal statutory rights of the patients of the State Psychiatric Hospitals. The September 2009 letter found that, at ECRH, of the 89 provisions in the agreement, Defendants had achieved substantial compliance with zero provisions, partial compliance with one provision, and beginning compliance with seven provisions. The November 2009 letter found that, at GRHS, of the 89 provisions in the agreement, Defendants had achieved

substantial compliance with zero provisions, partial compliance with one provision, and beginning compliance with 10 provisions. Each letter included a detailed report with the United States' consultants' assessments of each agreement provision and technical assistance to help Defendants achieve compliance with the Constitution and federal statutory law. See Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Mary Lou Rahn & Jason Naunas, State of Georgia (Sept. 9, 2009) (ECRH Compliance Letter and Expert Report); Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Mary Lou Rahn & Jason Naunas, State of Georgia (Nov. 19, 2009) (GRHS Compliance Letter and Expert Report) (Attached as Exhibits 4 and 5, respectively).

31. Between April 2009 and January 2010, the United States sent Defendants 11 emergency letters requesting immediate information, follow-up, and/or corrective actions to address conditions or practices that posed an immediate and serious threat to the life, health, and/or safety of patients. The letters concerned a homicide at CSH, questionable medical deaths at CSH, a rape at SWSH, two rapes at ECRH, a suicide at GRHS, a suicide attempt at ECRH,

life-threatening conditions at CSH, a questionable medical death at SWSH, and a suicide at SWSH. See Letter from Mary Bohan, Trial Attorney, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Jason Naunas, Department of Law, State of Georgia (Apr. 7, 2009) (CSH homicide); Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Dennis R. Dunn, Deputy Attorney General, Department of Law, State of Georgia (Apr. 15, 2009) (CSH homicide follow-up); Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Dennis R. Dunn, Deputy Attorney General, Department of Law State of Georgia (June 9, 2009) (CSH medical deaths); Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Jason S. Naunas, Assistant Attorney General, Department of Law, State of Georgia (July 16, 2009) (CSH homicide follow-up); Letter from Mary Bohan, Trial Attorney, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Mary Lou Rahn & Jason Naunas, State of Georgia (July 31, 2009) (SWSH rape); Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Mary Lou Rahn &

Jason Naunas, State of Georgia (Aug. 14, 2009) (ECRH rapes); Letter from Judy Preston, Deputy Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Mary Lou Rahn & Jason Naunas, State of Georgia (Sept. 4, 2009) (GRHS suicide); Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Mary Lou Rahn & Jason Naunas, State of Georgia (Nov. 18, 2009) (ECRH suicide attempt); Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Mary Lou Rahn & Jason Naunas, State of Georgia (Nov. 25, 2009) (CSH suicide prevention, patient-on-patient aggression, physical and nutritional management, and emergency preparedness); Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Mary Lou Rahn & Jason Naunas, State of Georgia (Dec. 11, 2009) (SWSH death); Letter from Shanetta Y. Cutlar, Chief, Special Litigation Section, Civil Rights Division, U.S. Department of Justice, to Mary Lou Rahn & Jason Naunas, State of Georgia (Jan. 6, 2010) (SWSH suicide) (Attached as Exhibits 6-16, respectively).

Summary of Allegations

32. Significant, systemic deficiencies exist in Defendants' provision of services to persons with disabilities who are confined in the State Psychiatric Hospitals. Discharge services at the State Psychiatric Hospitals substantially depart from generally accepted professional standards, violate the constitutional and federal statutory rights of persons confined therein, and fail to serve patients in the most integrated setting appropriate to their needs as mandated by Olmstead. Persons confined to the State Psychiatric Hospitals also 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 persons with specialized needs.

33. The State's own progress reports detailing its Quality Management systems and its Progress Report on development of a Plan of Implementation 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.

Discharge Planning and Community Placement

34. Hundreds of patients currently confined in 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.

35. Defendants maintain a list of patients whose treatment teams have determined that they can be served in a setting less restrictive than the State Psychiatric Hospitals. Defendants call this list the Olmstead list and use the list to direct their discharge planning, transition, and community placement resources.

36. Defendants' Olmstead list fails to identify many patients who could be more appropriately served in a less restrictive setting. Defendants do not place patients with a mental illness on the Olmstead list until at least 60 days have passed since the patient was admitted to the State Psychiatric Hospitals and the patient's treatment team has decided that the patient is ready for discharge.

37. Numerous patients with a mental illness are admitted to the State Psychiatric Hospitals for a brief period and then discharged, only to be re-admitted in weeks or months. In this population, frequently referred to as the "revolving

door" population, many patients have been institutionalized dozens of times in a period of a few years. These patients typically are not placed on the Olmstead list, nor do they receive adequate treatment or discharge planning. Defendants concede that these readmissions reflect inadequacies in their discharge planning and/or community services.

38. Patients with mental illness who are in the State Psychiatric Hospitals for 60 or more days do not qualify for the Olmstead list until their treatment teams have decided that they are ready for discharge. Thus, they do not receive the very transition services necessary to ameliorate specific barriers to discharge until they have been determined to be ready for discharge.

39. Defendants have made the judgment that all persons with developmental disabilities in the State Psychiatric Hospitals could live successfully in the community with appropriate supports. They place all individuals with a developmental disability on the Olmstead list unless an individual's treatment professionals determine that the individual or the individual's representative objects to community placement. Nevertheless, hundreds of individuals with a developmental disability remain institutionalized.

40. Defendants fail to move individuals with disabilities into more integrated settings at a reasonable pace. According to Defendants' own Olmstead

Monthly Progress Report, in September 2009, there were 765 persons with developmental disabilities on the Olmstead list. The total number of individuals with developmental disabilities on the Olmstead list stayed relatively constant during the period from September 2008 through September 2009. Moreover, the number of placements slowed considerably in July, August, and September 2009. Between September 2008 and September 2009, the average number of days on the Olmstead list for persons with developmental disabilities doubled, and 86 individuals remained waiting for more integrated services after the date set by their treatment team for their discharge had come (and gone).

41. 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. In 2003, the State developed a plan to comply with the Supreme Court's mandate in Olmstead that identified urgent community services needs and goals, which remain unaddressed. Defendants concede that they provide a relatively complete array of services, but that not all services are available in all parts of the State, and that capacity of some services is limited in many parts of the State.

42. Lack of income and employment have long been identified as barriers to successful community living, yet the State Psychiatric Hospitals receive little support from the State's office of vocational rehabilitation, and supported employment programs have suffered from budget cuts and services cutbacks in each of the last several fiscal years.

43. Individuals with developmental disabilities, in particular, are institutionalized for long periods while waiting for funding of community slots.

44. Many patients never should have been admitted to the State Psychiatric Hospitals in the first place. Scores of patients are institutionalized not because the severity of their condition requires institutionalization, but because community services are not available to address their needs before admission.

45. The State Psychiatric Hospitals function as the initial point of access to mental health services in the State, instead of as part of a continuum of care for those with chronic mental illness for whom community-based services are clinically inappropriate. Staff at each of the State Psychiatric Hospitals concede that there are insufficient Assertive Community Treatment teams, which provide comprehensive, community-based psychiatric treatment,

rehabilitation, and support to persons with serious and persistent mental illness, to provide services to the discharged patients who require them.

46. 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 are inadequate to handle the normal behavioral variability of some persons with developmental disabilities.

47. In their discharge planning and community placement, Defendants fail to provide adequate assessments, diagnoses, and treatment that would enable patients in the State Psychiatric Hospitals to live successfully in the community; fail to analyze or address high rates of recidivism among revolving door patients and, consequently, to provide appropriate treatment to those patients; and fail to identify, develop, and coordinate resources necessary to facilitate successful discharge. These failures substantially depart from generally accepted professionals standards and do not comply with the integration mandate of Olmstead.

48. The first and most fundamental step in discharge planning and placement should be to conduct an adequate assessment. Assessments establish a patient's diagnosis and plan of treatment. The adequacy of a patient's

assessment begets the adequacy of the patient's treatment plan and treatment, which begets the adequacy of the patient's discharge plans and discharge.

49. Defendants' assessments often lack critical information, such as a suicide risk assessment, and contain tentative, unspecified, and/or conflicting diagnoses. Defendants' assessments, treatment plans, and treatment substantially depart from generally accepted professional standards.

50. In cases of repeat admissions, systematic analysis should determine and address the reasons for re-admission so that patients are not subjected to needless institutionalization in a cycle of admission and discharge.

51. Frequent re-admissions are extremely detrimental to these individual patients, disrupting their recoveries and their lives in the community. The best chance for a successful recovery outcome usually is achieved when the person receives adequate care during the first episode of a psychiatric illness. Frequent relapses and re-admissions often progressively worsen a patient's mental illness and make patients more intractable to treatment, diminishing the opportunity for recovery with each episode.

52. Extremely high rates of re-admission at the State Psychiatric Hospitals are well-documented in Defendants' own audits, from the 2005 Georgia Mental Health Gap Analysis study to the 2009 Statewide Quality Management Report.

53. Defendants' treatment teams frequently do not examine or address the factors that led to re-admission for individual patients, nor do they alter the patient's treatment from a previous stay at the hospital. Defendants' handling of repeat admissions substantially departs from generally accepted professional standards.

54. An essential component of an adequate discharge plan for any patient should be linkage to necessary community supports. State and facility policies, procedures, and strategic plans confirm the critical importance of community coordination, yet those policies frequently are not implemented and linkage does not occur.

55. Defendants' discharge plans do not adequately describe, identify, or secure the community resources necessary to serve patients in the community. Defendants' discharge plans substantially depart from generally accepted professional standards.

56. Defendants frequently discharge patients to locations that are not the most integrated setting appropriate to their needs, including homeless shelters. Discharges to inappropriate locations substantially depart from generally accepted professional standards. Homeless shelters are not equipped to provide the level of care required for a patient being discharged from a psychiatric hospital, many of whom have severe and persistent mental illness. The Supreme Court, in Olmstead, 527 U.S. at 605, stated that homeless shelters were inappropriate discharge locations, and staff at each of the State Psychiatric Hospitals concede that shelters do not have sufficient structure or supervision for persons with mental illness. Patients discharged to inappropriate locations are likely to return to the hospital and repeat the cycle of inadequate discharge multiple times.

57. Defendants' substantial departures from generally accepted professional standards and failure to place individuals in the most integrated setting appropriate to their needs have resulted in failed discharges and inappropriately long delays for placement in the community.

58. For example, between January 2006 and August 2007, according to Defendants' own discharge data, 301 patients at GRHA were discharged to homeless shelters, 32 to "transportation terminal[s]," 33 to hotels and lodges,

12 to single-room-occupancy apartments, and 36 to what were listed as "Temporary Locations."

59. In the first nine months of 2007, approximately 240 patients who had been discharged from NWGRH were re-admitted to NWGRH. Dozens of these patients had lifetime histories of more than 20 readmissions.

60. A patient with a history of 18 admissions was discharged from NWGRH to a homeless shelter with no contact from the local Community Service Board.

61. A patient with a history of three admissions was discharged from NWGRH with a bus ticket, five days of medication, and the address of a rescue mission shelter in a different state.

62. A patient was discharged from his third and fourth admissions to NWGRH to a homeless shelter.

63. In February 2007, a patient with a history of 14 admissions and a diagnosis of mood disorder and substance abuse disorder was discharged from GRHA to a homeless shelter. He returned to GRHA 10 days later. He received no treatment for substance abuse while at GRHA and no planning for substance abuse services when he returned to the community.

64. In August 2007, a patient with a history of seven admissions to GRHA was discharged from GRHA but then readmitted 10 days later. Her treatment

team did not effectively review the reasons for that discharge failure or to prevent its recurrence. She was discharged to a hotel and instructed to contact the local mental health center. Her discharge plan did not identify a specific case manager, physician, or psychiatrist, and no community provider was present at her discharge treatment meeting.

65. A patient was admitted to GRHA twice in 2007 with a history of 35 prior admissions and co-occurring diagnoses of substance abuse and psychotic disorder with hallucinations. She received no substance abuse treatment while at GRHA. She was discharged to a night shelter without adequate planning for community substance abuse care.

66. 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.

67. In 2009, a patient at GRHS with a history of more than 100 hospital admissions was discharged, according to his discharge summary, to "wherever he goes." The prognosis in his discharge summary was that "he would return in a week."

68. In 2009, a patient recently discharged from GRHA killed a family member. The family had opposed the patient's discharge because her assessment contained inaccurate information concerning her compliance with treatment and the extent of her thought disorder, but she still was discharged.

69. In May 2009, the 25 most recent discharge plans at ECRH revealed a lack of systematic review or analysis of the cause for the patients' admissions, nor were the plans individualized to each individual patient.

70. ECRH determined that a patient with mental illness was ready for discharge in June 2007, but in May 2009, he still was institutionalized. The patient was eligible for a Medicaid waiver, but his treatment professionals had not identified a community service provider.

71. Between approximately July 2009 and October 2009, according to Defendants' own discharge data, SWSH discharged dozens of patients to shelters and two dozen patients to locations such as "streets" and "car or other abandoned building."

72. In November 2009, treatment professionals at CSH conceded that whole units of individuals could be placed into a more integrated setting but that adequate supports and services are not available.

73. Between November 2008 and November 2009, CSH discharged more than 100 patients to shelters, including approximately 33 patients between August 2009 and November 2009.

74. Between December 2008 and December 2009, according to Defendants' own discharge data, WCGRH discharged approximately 39 patients to locations such as "streets (public park, bridge)," "car or abandoned house/building," "night shelter," "hotel/motel," and "crisis or emergency center."

75. The allegations in Paragraphs 34 through 74 show systemic failures in discharge planning and community placement that substantially depart from generally accepted professional standards and fail to place individuals with disabilities in the most integrated setting appropriate to their needs.

Protection from Harm

76. Patients in the State Psychiatric Hospitals have a right to live in reasonable safety.

77. Patients in the State Psychiatric Hospitals live in unsafe environments subject to serious and frequent harm such as patient-on-patient assaults and self-injurious behaviors because Defendants fail to identify and respond to risks of harm.

78. Incident and risk management systems should collect and aggregate data that is meaningful to protect individuals from harm, identify actual or potential harm from that data, and take timely action to prevent harm from occurring or recurring.

79. Defendants' incident and risk management system fails to adequately collect and report data accurately, fails to adequately investigate incidents thoroughly, fails to adequately identify actual or potential risks of harm, and fails to adequately implement and monitor effective corrective and preventive actions. Each of these failures substantially departs from generally accepted professional standards.

80. The first necessary step in incident and risk management should be to ensure complete, accurate, and timely incident reporting. Without reliable and timely data regarding incidents and injuries, harm cannot be responded to appropriately. Delay compromises, or eliminates altogether, the possibility that an injury's origin can be determined, including whether abuse was contributory.

81. Defendants fail to adequately report incidents in a timely and accurate manner, if at all. Some incident data is not collected because Defendants' incident and reporting categories fail to include it, and the incident data that

is collected is often inaccurate. Defendants' incident reporting substantially departs from generally accepted professional standards.

82. Investigations in an incident and risk management system should determine the underlying cause of an incident by systematically identifying, collecting, preserving, analyzing, and presenting evidence.

83. Defendants' investigations fail to adequately include information that is necessary to finding the root cause of an incident or delve sufficiently into the possible origins of incidents, including whether quality of care, abuse, or neglect contributed to an injury. Instead, investigations often focus on Defendants' response to an injury or illness. Defendants' investigations substantially depart from generally accepted professional standards.

84. An incident and risk management system should analyze incident data collected and investigations conducted to identify and anticipate potential harm and to mitigate the risk of that harm occurring. Mortalities often involve systemic issues that should be reviewed and evaluated to identify the underlying cause of the death and to correct deficiencies that may prevent deaths or similar harm from occurring in the future.

85. The lack of data caused by Defendants' failures in incident reporting and investigating renders Defendants unable to adequately recognize trends and

the potential for harm before serious and life-threatening conditions arise. In their existing data, Defendants fail to adequately identify trends and the potential harm, and their mortality reviews fail to adequately examine or identify the underlying causes of deaths. Defendants' failures to adequately identify actual or potential risks of harm substantially depart from generally accepted professional standards.

86. An incident and risk management system should implement corrective and preventive actions to reduce or eliminate an identified risk of harm, and monitors and modifies those actions as necessary.

87. Defendants fail to adequately develop or implement corrective and preventive actions to reduce risks of harm because they fail to adequately identify actual or potential risks. For risks that Defendants identify, Defendants fail to adequately implement corrective and preventive actions in response to known risks in a timely manner, if at all. For corrective and preventive actions that Defendants implement, they fail to adequately monitor those actions as necessary to reduce or eliminate the risk of harm. Defendants' corrective and preventive actions substantially depart from generally accepted professional standards.

88. A quality management system should incorporate data capture, retrieval, and statistical analysis to identify and track trends and to monitor the effectiveness of corrective actions taken in response to identified problems.

89. Defendants' quality management system fails to adequately collect the data necessary to track and trend the quality of care provided in the State Psychiatric Hospitals. For those trends in their existing data, Defendants often fail to adequately identify and respond to them. For those corrective actions that Defendants take, Defendants' quality management system lacks reliable accountability and oversight. Defendants' quality management system substantially departs from generally accepted professional standards.

90. As a result of Defendants' substantial departures from generally accepted professional standards with respect to protection from harm, patients in the State Psychiatric Hospitals suffer serious, frequent, recurrent, preventable harm.

91. For example, in April 2006, a patient at NWGRH committed suicide by jumping head-first out of a tree a day after admission. The patient had been an emergency involuntary admission with a diagnosis of paranoid schizophrenia and a history of auditory and visual hallucinations. At admission, she refused to answer whether she was suicidal. NWGRH placed

her on routine observation. When her unit was taken outside, she climbed a tree, tried to hang herself with her shoelaces, and then jumped out of the tree to her death.

92. In July 2006, a patient at GRHA attempted to commit suicide by obtaining a razor and making multiple cuts to her abdomen, which required sutures. Less than two weeks later, she attempted to commit suicide by breaking a ceiling light and swallowing the glass, which required treatment at the emergency room. The following month, she attempted to commit suicide again by breaking a light bulb and lacerating her arms, which required attention at the emergency room. During a subsequent admission in March 2007, she again attempted to commit suicide by breaking a ceiling light, lacerating her arms, and ingesting glass, which required emergency room treatment. A corrective action plan was developed after the patient's suicide attempt in July 2006, but it was not implemented before her subsequent discharge or after her readmission in March 2007, despite the similarities in her suicide attempts.

93. In October 2006, a patient at NWGRH with a history of suicide attempts and self-mutilation attempted to commit suicide by slitting his throat from ear-to-ear with a razor. A staff member had given the patient the razor for

shaving and had let the patient go into the bathroom unattended. After the incident, NWGRH never reassessed the patient's emotional stability or risk of harm, and never made or modified treatment or behavioral interventions.

94. Also in October 2006, a patient at NWGRH had his jawbone broken bilaterally by a fellow patient. Another patient needed sutures to close a large wound to his scalp after being assaulted by a fellow patient.

95. In January 2007, a patient at GRHA broke a light fixture and threw a couch across his unit's day room. The following afternoon, he punched another patient in the forehead. A few days later, he pushed his physician during an examination and broke furniture in the day room. Ten days later, he pushed a fellow patient to the ground who struck his head on a chair as he fell, lacerating an eyelid and eyebrow. The following day, he threw chairs across the cafeteria and then went outside and began shaking a staff member's vehicle. That evening, he hit another patient in the face. Within the next few weeks, he attacked a staff member, putting him in a choke hold and wrestling him to the ground. The patient's treatment team never developed a behavioral support plan to address his aggression or assaultive behavior to other patients and staff.

96. In February 2007, a patient at GRHA choked another patient. The aggressor patient was assigned to line-of-sight observation. The staff member assigned to him failed to maintain this observation level and only discovered the choking after hearing loud noises coming from his bedroom. The victim required emergency room treatment.

97. Also in February 2007, a patient at NWGRH alleged that a staff member physically abused her. A nurse or other medical professional never examined the patient to determine whether she had injuries consistent with her allegation, and NWGRH did not begin investigating the allegation of abuse until nearly two weeks later. The investigation report concluded that the allegation could not be substantiated because of the staff member's denial and the supporting statement of another staff member. The report is dated February 21, 2007, but includes a staff interview that is stated as having occurred on March 1, 2007.

98. In March 2007, a patient at GRHA was found with vomit that contained blood on his sheets and floor less than 19 hours after he had been admitted. The patient was transferred to the hospital, where he died five weeks later. The medical examiner suggested that the patient likely incurred an injury at GRHA by ingesting a foreign substance, but the investigation failed to

examine his supervision level or to interview any of the staff who cared for him during his brief stay at GRHA. The investigation report concluded: "Staff followed hospital and DHR protocol in ensuring that [the patient] received appropriate care."

99. In April 2007, a patient at NWGRH with a history of silent aspiration, difficulty in swallowing, and placing her hands in her mouth as a soothing mechanism, suffered from aspiration pneumonia after ingesting hair barrettes (the ingestion of inedible objects is known as pica). At approximately 4:00 p.m. that day, a staff member saw a few broken hair barrettes on the patient's sheets but did not report them to anybody. Between 4:30 p.m. and 8:00 p.m., the patient exhibited increasing signs of choking, until she began to cough and gag repeatedly. Only then did the staff member report having seen the broken barrettes. The patient was sent to the hospital for observation and readmitted to the hospital twice over the following two days for aspiration pneumonia. X-rays revealed a metallic object in her gastric area, and the hospital removed at least two broken barrettes during surgery. NWGRH never reported her ingestion of hair barrettes as pica and did not complete a safety plan for the patient until June 2007.

100. In May 2007, a patient at GRHA attempted to commit suicide by cutting his neck and arms with a razor. He was rushed to the emergency room to stop the arterial bleeding. When staff initially entered his blood-spattered room, he shouted that he had told the staff that he was suicidal.

101. In June 2007, a patient at NWGRH attempted to commit suicide by strangling herself and was rushed to the emergency room for treatment. NWGRH did not report the suicide attempt in accordance with Hospital and State policy, investigate the suicide attempt, or take any corrective actions in response to the suicide attempt.

102. In June 2007, a patient at GRHA sexually assaulted another patient. The aggressor patient was on "sexual protocol," which required that he be on line-of-sight observation and that he sleep in a single bedroom to prevent him from sexually assaulting other patients. The first night that he was assigned to a bedroom with four other patients, in violation of this protocol, he sexually assaulted one of them. He was discharged to a personal care home several weeks later, but none of his progress notes, discharge summary, or aftercare plan documented the sexual assault.

103. In July 2007, a patient at NWGRH fell when a staff member attempted to transfer him to a wheelchair. The staff member was not trained on proper

transfer techniques and, when the United States visited three months later, still had not been trained.

104. In August 2007, a patient was admitted at GRHA after running into traffic with a broken glass bottle in her hand, threatening to kill herself. Approximately one week after her admission, she was discharged to a homeless shelter. Three days after her discharge, she was readmitted to GRHA with suicidal ideation. Seven hours after she arrived on a residential unit, she was found lying face down in a pool of blood outside her bedroom doorway, unresponsive, with a cord wrapped tightly around her neck, and bleeding from her mouth and nose. Although the patient's observation level required that she be observed by staff every 15 minutes, staff had not checked on her for more than 30 minutes. Progress notes and eyewitness statements describing this lapse in observation and an argument between the patient and staff shortly before the suicide attempt then were removed from the patient's medical record.

105. In August 2007, a patient at NWGRH assaulted other patients every day for a week, but NWGRH's aggregate incident report data did not include any of these incidents.

106. In August and September 2007, a patient admitted at GRHA was physically and sexually assaulted 20 days apart. Neither assault was investigated; both were perpetrated by the same aggressor.

107. In September 2007, a patient at NWGRH twice was attacked by another patient, each time suffering a laceration that required sutures. In the same month, on the same unit at NWGRH, a patient was assaulted by another patient, suffering a fractured nose.

108. Also in September 2007, a patient at NWGRH suffered a fractured clavicle. Staff noticed a large bruise on the patient's shoulder but did not report the bruise until a day later. The investigator never questioned the patient about the injury or how it occurred, and the investigation report never determined the cause of the fractured clavicle.

109. On September 8, 2007, a melee occurred on the adolescent unit at GRHA. Six adolescents began throwing tables and chairs at the window protecting the nurses' station. Three of the adolescents forced open the door to the lobby of the unit by kicking and slamming it with their bodies. The patients broke tables and cabinets in the lobby area and attempted to force open the outside door. One patient held a piece of plexiglass to his neck, threatening to cut himself, and then cut his neck before staff was able to take the piece of

plexiglass from him. Other patients not involved in the destructive behavior refused to stay in their rooms and began running around the unit. Staff and facility police were unable to restore order and had to call DeKalb County police officers to diffuse the situation.

110. 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. 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 an emergency 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.

111. 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.

112. 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.

113. In April 2009, a patient at ECRH was discovered with a fractured arm of unknown origin. When the United States visited ECRH five weeks later, the investigation into the cause of the injury had yet to be initiated, and no time line for even starting the investigation had been established.

114. In April 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.

115. In July 2009, a patient at SWSH was raped by another patient. The victim of the admitted rape had a prior sexual encounter with the aggressor, but that encounter had been neither investigated nor addressed in treatment.

116. In August 2009, a patient at ECRH alleged that he was raped by another patient. The investigation report found the allegation unsubstantiated with no physical evidence, but the rape kit found semen in the accuser's peri-anal region. ECRH never resolved the discrepancy.

117. In August 2009, a patient at GRHS committed suicide, two months after the United States' consultant warned GRHS on-site of risks in its suicide assessments and risk management system. The patient committed suicide by tipping his bed up on end to create a tie-off point on which to hang himself, despite the United States' consultants having warned Defendants of the dangers posed by these beds throughout its tours.

118. In September 2009, a patient at ECRH attempted to commit suicide by hanging himself with a sheet tied around his neck. The patient lost consciousness and vital signs before being revived by CPR. The patient had attempted suicide in similar fashion in January 2009 while confined at CSH, yet the investigation report for the September 2009 suicide attempt never investigated or even addressed how the attempt could have been avoided. It focused primarily on staff's response to the emergency code blue call and recommended only that "ECRH should review with staff the need for accuracy in reporting, particularly of times of events."

119. In October 2009, a patient at CSH was physically assaulted by a staff member when the staff member pulled the patient out of his chair, walked him down the hallway, pulled him into his room, shut the door, and beat him.

120. In October 2009, a 27-year-old patient at SWSH collapsed in the shower and died. For a week prior to her death, she had been refusing to eat or drink regularly and, the day before, had suffered rigidity in her upper and lower extremities from an apparent adverse drug reaction. The investigation report never addressed whether the care that she had received at SWSH may have

contributed to her death, instead focusing primarily on staff's response to the emergency code blue call.

121. In November 2009, after repeated warnings by the United States to Defendants about the suicide risk of beds that can be tipped up on end, and two months after the patient committed suicide at GRHS by tipping his bed up on end, the United States saw a bed that could be tipped up on end in a seclusion room at CSH—a room to which patients in crisis often are sent for their own protection. The bed also had large industrial-sized staples that could be removed easily, despite a CSH patient recently having abused herself repeatedly by placing staples into various parts of her body, including one that had to be surgically removed.

122. On January 6, 2010, a patient at SWSH committed suicide within 24 hours of admission by hanging herself with a shoe string, six weeks after the United States sent a letter notifying Defendants that their suicide prevention measures remained perilously inadequate.

123. The allegations in Paragraphs 76 through 122 show systemic failures to protect patients in the State Psychiatric Hospitals from harm that substantially depart from generally accepted professional standards.

Mental Health Care

124. Patients in the State Psychiatric Hospitals have a right to receive adequate mental health treatment.

125. Defendants fail to provide adequate mental health assessments, person-centered treatment plans, and behavioral management services. Each of these failures substantially departs from generally accepted professional standards.

126. Mental health treatment should begin at the time of admission, as assessments establish a patient's diagnosis and plan of treatment. If mental health professionals fail to correctly identify a patient's psychiatric condition before developing a treatment plan, then treatment interventions will not be aligned with the patient's needs. At a minimum, initial assessments should include an adequate review of presenting symptoms and mental status, a provisional diagnosis and differential diagnosis that provides a decision tree by which diagnosis and treatment options may be clarified over time, and 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, assessments should be updated to include a history of presenting symptoms, the progression of symptoms and setting within which the

symptoms occur, historical findings regarding the patient's biopsychosocial functioning, a review and critical examination of past diagnostic conclusions in light of new information, a review of medical and neurological problems and their impact on symptoms and treatment, and a complete mental status examination.

127. Defendants' assessments fail to adequately include critical information, such as a suicide risk assessment, precipitating factors that led to a patient's admission, and facts regarding a patient's psychosocial, developmental, educational, vocational, medical, substance abuse, and prior placement histories. Assessments often contain tentative, unspecified, and/or conflicting diagnoses, with no further assessments or observations that finalize, refine, or reconcile diagnoses. Defendants' assessments substantially depart from generally accepted professional standards.

128. 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 in order to promote a patient's stabilization and/or rehabilitation so that the patient can return to the community. Treatment plans should use the diagnosis to help identify problems caused by the diagnosed illness and then develop specific, measurable, individualized

goals to ameliorate problems, promote functional independence, and assist community integration.

129. Defendants' treatment plans often are minimalist, generic, and reflect neither the true scope of individual patients' needs nor an integrated, coherent plan for treatment. They fail to adequately plan, corroborate, and reconcile contradictory assessments across disciplines, including psychiatry, medicine, nursing, psychology, and social work. They also fail to adequately provide treatment for patients with co-occurring diagnoses of substance abuse, a serious impediment to community placement and frequent cause of readmission to the State Psychiatric Hospitals. Treatment plans fail to adequately provide specific interventions, leaving staff with few alternatives to restraint or seclusion if generic interventions prove ineffective. Defendants' treatment plans substantially depart from generally accepted professional standards.

130. Behavior support plans should address problematic behaviors by functionally assessing them. A mental health professional should analyze objective data concerning symptoms or behavior; hypothesize the function of the challenging behavior; consider antecedent, environmental, or health

factors that influence a behavior; and identify target or replacement behaviors.

131. Defendants fail to adequately provide behavior support plans for patients, sometimes relying on seclusion or restraint to respond to problematic behaviors instead. For those patients that have behavior support plans, Defendants fail to adequately provide a functional assessment of their problematic behaviors, fail to adequately collect sufficient behavioral data on which to base treatment decisions, fail to adequately hypothesize the function of challenging behavior, fail to adequately consider factors that influence a behavior, fail to adequately identify target or replacement behaviors (suggesting inappropriate and even dangerous replacement behaviors instead), and fail to adequately revise plans when problematic behaviors continue or escalate. These failures substantially depart from generally accepted professional standards.

132. As a result of Defendants' substantial departures from generally accepted professional standards, many patients in the State Psychiatric Hospitals do not have their mental illnesses assessed and diagnosed; do not receive treatment and rehabilitation to address those illnesses; receive treatment that

is unnecessary, may exacerbate their mental illnesses, and can cause harmful side effects; and are at increased risk of relapse and repeat hospitalization.

133. For example, one patient had 21 readmissions in the span of nine months, and her treatment plan for each of her 21 stays was identical.

134. One patient demonstrated escalating episodes of agitation and aggression that resulted in his transfer to a different unit, yet his treatment team failed to recommend any change in his behavior plan.

135. One patient demonstrated escalating episodes of inappropriate sexual behavior, steadily increasing from three episodes in one month to 36 episodes four months later, with no change to his behavior plan.

136. One patient had multiple instances of physical restraints and as-needed medication doses, including three restraints and near-daily as-needed medication doses in the week before a psychological evaluation, yet the evaluation did not recommend a behavioral assessment or a behavioral support plan.

137. Some patients receive multiple restrictive interventions in short periods of time without having a behavioral treatment plan in place. One patient had 25 instances of seclusion or restraint in a four-month period, one patient had 12 instances of seclusion or restraint in a 33-day period, one patient received

23 psychotropic as-needed medication doses in a two-week period, and one patient received 12 psychotropic as-needed medication doses in a 10-day period. None of them had a behavior support plan. Other patients have had their physical restraint use decreased but their chemical restraint use increased without any modification to a behavior plan.

138. As discussed supra Paragraph 68, a patient discharged from GRHA killed a family member. The family had opposed the patient's discharge because her assessment contained inaccurate information concerning her compliance with treatment and the extent of her thought disorder.

139. As discussed supra Paragraph 91, one patient was an emergency involuntary admission with a diagnosis of paranoid schizophrenia and a history of auditory and visual hallucinations. At admission, she refused to answer whether she was suicidal. The hospital placed her on routine observation, and she committed suicide the next day.

140. As discussed supra Paragraph 114, one patient was killed by another patient who was alleged to have committed two other murders before his admission. A behavior support plan was not instituted for the aggressor until after the homicide in the State Psychiatric Hospitals.

141. As discussed supra Paragraph 63, one patient with a history of 14 admissions and a diagnosis of mood disorder and substance abuse disorder was discharged from GRHA to a homeless shelter. He returned to GRHA 10 days later. He received no treatment for substance abuse while at GRHA and no planning for substance abuse services when he returned to the community.

142. As discussed supra Paragraph 65, a patient was admitted twice in one year with a history of 35 prior admissions and co-occurring diagnoses of substance abuse and psychotic disorder with hallucinations. She received no substance abuse treatment while institutionalized and was discharged to a night shelter without adequate planning for community substance abuse care.

143. As discussed supra Paragraph 64, a patient with a history of seven admissions to GRHA was discharged from GRHA but then readmitted 10 days later. Her treatment team made no effort to review the reasons for that discharge failure or to prevent its recurrence.

144. As discussed supra Paragraph 95, in the span of approximately a month, one patient broke a light fixture, threw a couch across his unit's day room, punched another patient in the forehead, pushed his physician during an

examination, broke furniture in the day room, pushed a fellow patient to the ground who struck his head on a chair as he fell, threw chairs across the cafeteria, went outside and began shaking a staff member's vehicle, hit another patient in the face, and attacked a staff member by putting him in a choke hold and wrestling him to the ground. The patient's treatment team never developed a behavioral support plan to address his aggression or assaultive behavior to other patients and staff.

145. The allegations in Paragraphs 124 through 144 show systemic failures to provide mental health care to patients in the State Psychiatric Hospitals that substantially depart from generally accepted professional standards.

Seclusion and Restraint

146. Patients in the State Psychiatric Hospitals have a right to be free from undue bodily restraint. Defendants may not subject patients to seclusion and restraint except when, and to the extent, professional judgment deems it necessary for the safety of the patients or others in the State Psychiatric Hospitals.

147. Defendants fail to use seclusion and restraint only when a patient poses an immediate threat to self or others and after a hierarchy of less restrictive

measures has been exhausted. This failure substantially departs from generally accepted professional standards.

148. Defendants fail to adequately prevent using seclusion and restraint in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff. This failure substantially departs from generally accepted professional standards.

149. Defendants fail to adequately prevent using seclusion and restraint as a behavioral intervention. This failure substantially departs from generally accepted professional standards.

150. Defendants fail to adequately terminate the use of seclusion and restraint as soon as the person is no longer a danger to self or others. This failure substantially departs from generally accepted professional standards.

151. Defendants' use of seclusion and restraint, including chemical restraint, exposes patients in the State Psychiatric Hospitals to excessive and unnecessary restrictive interventions.

152. For example, Defendants restrained one patient while the patient was sleeping, and restrained another patient after she cooperatively walked back to her room to be restrained. In a sample of 77 of Defendants' seclusion and restraint monitoring forms, the forms frequently contained notations that the

patient was out of control, but few forms, if any, recorded specific behaviors that supported a conclusion that the patient was a threat to self or others or documented that alternative measures were tried before resorting to a restrictive device.

153. On Defendants' mental health units, few of the patients have adequate behavior plans despite many of the patients having challenging behaviors. Staff do not adequately have the skills necessary to handle a large number of challenging patients who are dangerous to themselves or others, or who have specialized needs, without resorting to seclusion and restraint to control patients rather than to treat them and replace their maladaptive behaviors with adaptive behaviors. Defendants also do not adequately bring those patients most subject to restraint or seclusion to the attention of interdisciplinary teams to discover the precursors to their behaviors so that the need for seclusion or restraint can be mitigated or eliminated.

154. In a sample of 50 uses of seclusion or restraint, 13 of the patients were not released once they were calm, which is a substantial departure from generally accepted professional standards. To be released from restraint, Defendants required some patients to state the reasons for their behavior and

to contract that the behavior would not occur again, which again is a substantial departure from generally accepted professional standards.

155. As discussed supra Paragraph 137, some patients receive multiple restrictive interventions in short periods of time without having a behavioral treatment plan in place. One patient had 25 instances of seclusion or restraint in a four-month period, one patient had 12 instances of seclusion or restraint in a 33-day period, one patient received 23 psychotropic as-needed medication doses in a two-week period, and one patient received 12 psychotropic as-needed medication doses in a 10-day period, all while none of them had a behavior support plan. Some patients have had their physical restraint use decreased but their chemical restraint use increased without any modification of their behavior plan.

156. The allegations in Paragraphs 146 through 155 show systemic failures to use seclusion and restraint on patients in the State Psychiatric Hospitals that substantially depart from generally accepted professional standards.

Medical Care

157. Patients in the State Psychiatric Hospitals have a right to receive adequate health care.

158. Defendants fail to provide adequate basic medical care. Defendants also fail to provide adequate clinical oversight, pharmacological practices, medication administration, infection control, physical and nutritional management, emergency preparedness, and staffing. Each of these failures substantially departs from generally accepted professional standards.

159. Assessments and monitoring should be timely and thorough in order to inform case formulation, diagnosis, and treatment planning. Unidentified health concerns usually do not receive appropriate care and monitoring. Health care plans should guide and document therapeutic interventions systematically based on individualized priorities of care.

160. Defendants' assessments are not adequately timely, complete, or clinically relevant. Defendants' health care plans do not adequately have individualized goals, objectives, recommendations, and priorities. The plans also fail to adequately include proactive interventions to address risk factors and health issues such as choking, aspiration, and known psychotropic

medication side effects. Defendants' medical care substantially departs from generally accepted professional standards.

161. Clinical oversight should identify and correct problematic areas in medical and nursing departments and ensures that those departments provide the care that they purport to provide. Data should be regularly gathered, reviewed, analyzed, tracked, and trended, and plans of correction should be developed, implemented, and monitored to address any problems identified.

162. Defendants fail to utilize monitoring tools that adequately collect clinically reliable data. Defendants' nursing, occupational, physical, and speech therapy disciplines fail to adequately conduct peer review, and the mortality review process fails to adequately identify adverse trends in a timely manner or implement appropriate corrective actions. Defendants' clinical oversight substantially departs from generally accepted professional standards.

163. Pharmacology should be used to treat symptoms of psychosis, with accompanying behavior support plans as necessary to address problematic behaviors. Polypharmacy, the practice of prescribing multiple medications to address the same indications, and the use of high-risk medications should have the appropriate assessment, justification, and monitoring.

164. As discussed supra Paragraph 153, Defendants often use pharmacological treatments to manage symptoms and behaviors without an underlying behavior support plan, including for the purpose of sedation. Defendants also fail to adequately justify and monitor the use of polypharmacy and high-risk medications. Defendants' pharmacology practices substantially depart from generally accepted professional standards.

165. Medications should be administered according to procedures that ensure that the correct patient receives the prescribed dosage of the prescribed medication by the prescribed route at the prescribed time. Nursing staff should complete medication administration records that list current medications, dosages, and times that medications are to be administered upon administration of a medication. Failure to follow accepted medication administration protocol can result in patients not receiving medications or receiving them too frequently, both of which can lead to serious harm.

166. Defendants fail to adequately follow proper medication administration procedure. Some nurses improperly initial the medication administration records as they set up the medications before administering them, while others improperly initial the records up to 24 hours after a prescribed

administration time. Defendants' medication administration practices substantially depart from generally accepted professional standards.

167. Infection control programs should have a surveillance and reporting component that collects data on infections acquired both before and during residency, identifying outbreaks and educational opportunities, and a control and prevention component that develops policies and procedures, trains staff, and regularly reviews infection control activities.

168. Defendants' infection control programs fail to adequately collect data on clinical outcomes of infections in patients or analyze trends in the infection control data that they collect, with respect to infectious diseases such as hepatitis A, hepatitis B, hepatitis C, MRSA (a bacterial infection that is highly resistant to some antibiotics), tuberculosis, and HIV. Defendants' infection control programs substantially depart from generally accepted professional standards.

169. An adequate physical and nutritional management system should identify patients who are at risk for aspiration/choking and, for those patients: assign an appropriate risk level; identify triggers and symptoms of aspiration; assess safe positioning for a 24-hour day, use clinically-justified techniques to ensure safety during daily activities based on that assessment, and develop

and implement a plan containing specific instructions for those techniques; provide competency-based training to all staff assisting them regarding individualized plans for difficulty in swallowing; develop 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; develop a mechanism for reporting triggers that generate an immediate response from a physical nutritional management team; develop an overall monitoring system to ensure that plans are being adequately implemented, particularly monitoring those with the highest level of risk; and assure that the system is effective and can be transferred into the community with patients.

170. Defendants fail to provide patients at risk for aspiration with adequate assessments, treatment interventions, proactive monitoring such as obtaining lung sounds and oxygen saturation to determine changes in health status, or regular treatment plan monitoring. Defendants fail to adequately assess safety for these patients during such high-risk activities as oral care, bathing, dental appointments, and sleep. Defendants' mealtime plans for these patients fail to adequately guide staff, including for tube-fed patients, a group at a high risk for aspiration, and Defendants fail to adequately ensure

that the staff assisting these patients with meals are competency-based trained on carrying out the requirements of mealtime or treatment plans. Defendants also fail to adequately reassess treatment plans and modify interventions when necessary for patients with difficulty in swallowing who have experienced recurrent respiratory distress, pneumonia, or aspiration pneumonia. Defendants' physical and nutritional management system substantially departs from generally accepted professional standards.

171. 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.

172. Defendants fail to adequately conduct mock codes often enough to ensure adequate preparedness. Defendants also fail to adequately critically analyze the mock codes that they perform and to develop and implement a plan of correction to address identified problems. On some units, nurses have failed to know how to turn on oxygen tanks despite emergency preparedness documentation indicating that they were doing so daily. Defendants' emergency preparedness substantially departs from generally accepted professional standards.

173. Staffing should be sufficient to provide medical and nursing services that, at a minimum, protect patients from harm, ensure adequate and appropriate treatment, and prevent unnecessary and prolonged institutionalization.

174. Defendants often have staffing shortages that exacerbate their deficiencies in medical and nursing care. Defendants' own survey of the State Psychiatric Hospitals conducted by the Medical College of Georgia noted Defendants' staff shortages and their potential effect on the quality of services provided to patients. Defendants' staffing substantially departs from generally accepted professional standards.

175. As a result of Defendants' substantial departures from generally accepted professional standards with respect to medical care, patients in the State Psychiatric Hospitals suffer serious, frequent, recurrent, preventable harm.

176. For example, numerous deaths from preventable causes occur in the State Psychiatric Hospitals. One patient was 14 when she died from sepsis, likely caused by a severely impacted colon. On the day before she died, she complained of stomach pain and had nausea and vomiting, but no fever or other signs of infection. The on-call physician did not rule out impaction, a known side effect of her antipsychotic medications, with either an abdominal examination or rectal exam. Three days later, another patient died with a

markedly-impacted colon after his bowel functions were not monitored despite constipation being a known side effect of his medications.

177. One patient died after she was found not breathing lying face-down on the floor. At the time, she was on line-of-sight observation, but the staff member assigned to her had not observed her for approximately one hour. The unit was short staffed, and the registered nurse on the unit did not know how to call an emergency code blue, nor did she commence CPR. CPR was not initiated until nine minutes after the patient was found on the floor, when a registered nurse from another unit arrived and initiated it.

178. One patient was sent to the hospital four times in two weeks for respiratory distress and/or pneumonia, but her health care plan did not include a risk for aspiration or any preventive measures. Another patient was identified as a high risk for aspiration and sent to the hospital three times in three months for difficulty breathing and/or pneumonia, but his health care plan did not include a risk for aspiration or any preventive measures.

179. One patient was sent to the emergency room for dehydration, malnourishment, and medical instability.

180. One patient had notations throughout her chart that she shoves food into her mouth at a rapid pace without taking any liquid in between bites, which

should have identified her as a moderate or high risk for choking. Her meal plan identified her as only a minimal risk for choking, so appropriate mealtime precautions were not taken. She shoved food into her mouth to the point of coughing, but staff did not intervene until she choked to the point of requiring the Heimlich maneuver. Defendants then placed her on a modified diet and one-to-one observation for two meals without clinically objective data to justify the modifications and without performing an adequate assessment.

181. One patient had a heavy growth of MRSA, but her medical record did not include a treatment plan that addressed care of the lesion or the need to take precautions to protect other patients.

182. As discussed supra Paragraph 111, one patient 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.

183. As discussed supra Paragraph 112, one patient 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.

184. The allegations in Paragraphs 157 through 183 show systemic failures to provide medical care to patients in the State Psychiatric Hospitals that substantially depart from generally accepted professional standards.

Services to Persons with Specialized Needs

185. As identified by Defendants' own Mental Health System Gap Analysis, Defendants fail to ensure meaningful access to their programs and activities by persons with hearing impairments and limited English proficiency.

186. For example, a patient received virtually no mental health treatment during his months-long stay at GRHA after GRHA failed to identify him as requiring translation services; he did not receive translation services and treatment until he was transferred to GRHS. Also, for some patients, documents such as consents to care are not translated into a language that they can understand.

187. Defendants fail to provide appropriate education services to youth in the State Psychiatric Hospitals.

188. For example, Defendants fail to identify special education students needing behavioral support services and fail to provide adequate special education instructors to those students. Defendants also fail to provide to the schools to which discharged adolescents return information concerning the student's educational progress, educationally-relevant assessments, and necessary accommodations.

189. The allegations in Paragraphs 185 through 188 show systemic failures to provide adequate services to persons with specialized needs.

VIOLATIONS ALLEGED

Count One: Americans with Disabilities Act

190. The United States incorporates by reference the allegations set forth in Paragraphs 1 through 189, as if fully set forth herein.

191. The Americans with Disabilities Act requires that a state provide services to qualified persons with disabilities in the most integrated setting appropriate to their needs. 42 U.S.C. § 12132; see also Olmstead, 527 U.S. at 607.

192. The acts and omissions alleged in Paragraphs 21 through 189 violate the Americans with Disabilities Act and its implementing regulations. 42 U.S.C. §§ 12132-12134; 28 C.F.R. § 35.130(d). Defendants discriminate against "qualified individual[s] with a disability," within the meaning of the

Americans with Disabilities Act, by administering services in a manner that denies hundreds of Georgians with mental illness, addictive diseases, and/or developmental disabilities the opportunity to receive services in the most integrated setting appropriate to their needs. These individuals are qualified to receive services in a more integrated setting and do not oppose receiving services in a more integrated setting. Moreover, the State already provides the services that these individuals require to live in a more integrated setting.

193. Unless restrained by this Court, Defendants will continue to engage in the acts and omissions set forth in Paragraphs 21 through 189 that deprive persons residing in or confined to the State Psychiatric Hospitals of rights, privileges, or immunities secured or protected by the Americans with Disabilities Act.

Count Two: Due Process

194. The United States incorporates by reference the allegations set forth in Paragraphs 1 through 189, as if fully set forth herein.

195. The Fourteenth Amendment Due Process Clause requires that a state mental health care facility provide "adequate food, shelter, clothing, and medical care," along with "conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required

by these interests." Youngberg v. Romeo, 457 U.S. 307, 315, 320-24 (1982); see also D.W. v. Rogers, 113 F.3d 1214, 1217-18 (11th Cir. 1997).

196. The acts and omissions alleged in Paragraphs 21 through 189 infringe upon the legal rights and substantive liberty interests of the persons residing in or confined to the State Psychiatric Hospitals; constitute resistance to those persons' full enjoyment of their rights, privileges, or immunities secured or protected by the Fourteenth Amendment to the Constitution of the United States; and deprive those individuals of such rights, privileges, or immunities.

197. Unless restrained by this Court, Defendants will continue to engage in the acts and omissions set forth in Paragraphs 21 through 189 that deprive persons residing in or confined to the State Psychiatric Hospitals of rights, privileges, or immunities secured or protected by the Constitution of the United States.

Count Three: Social Security Act

198. The United States incorporates by reference the allegations set forth in Paragraphs 1 through 189, as if fully set forth herein.

199. The acts and omissions alleged in Paragraphs 21 through 189 violate Title XVIII and Title XIX of the Social Security Act and the regulations

promulgated thereunder. 42 U.S.C. §§ 1395 to 1395b-10, 1396 to 1396w-1; 42 C.F.R. §§ 482-483.

200. Unless restrained by this Court, Defendants will continue to engage in the acts and omissions set forth in Paragraphs 21 through 189 that deprive persons residing in or confined to the State Psychiatric Hospitals of rights, privileges, or immunities secured or protected by the Social Security Act.

Count Four: Individuals with Disabilities Education Act

201. The United States incorporates by reference the allegations set forth in Paragraphs 1 through 189, as if fully set forth herein.

202. The acts and omissions alleged in Paragraphs 21 through 189 violate the Individuals with Disabilities Education Act and its implementing regulations. 20 U.S.C. §§ 1400–1482.

203. Unless restrained by this Court, Defendants will continue to engage in the acts and omissions set forth in Paragraphs 21 through 189 that deprive persons residing in or confined to the State Psychiatric Hospitals of rights, privileges, or immunities secured or protected by the Individuals with Disabilities Education Act.

Count Five: Civil Rights Act of 1964

204. The United States incorporates by reference the allegations set forth in Paragraphs 1 through 189, as if fully set forth herein.

205. The acts and omissions alleged in Paragraphs 21 through 189 violate Title VI of the Civil Rights Act of 1964, as amended, and the regulations promulgated thereunder. 42 U.S.C. §§ 2000d to 2000d-7.

206. Unless restrained by this Court, Defendants will continue to engage in the acts and omissions set forth in Paragraphs 21 through 189 that deprive persons residing in or confined to the State Psychiatric Hospitals of rights, privileges, or immunities secured or protected by the Civil Rights Act of 1964.

PRAYER FOR RELIEF

207. The Attorney General is authorized under 42 U.S.C. § 1997 to seek equitable and declaratory relief.

WHEREFORE, the United States respectfully requests that this Court:

a. Declare that the acts and omissions set forth in Paragraphs 21 through 189 above deprive persons residing in or confined to the State Psychiatric Hospitals of rights, privileges, or immunities secured or protected by the Constitution and laws of the United States;

b. Permanently enjoin Defendants, their officers, agents, employees, subordinates, successors in office, and all those acting in concert or participation with them (1) from administering services to persons with disabilities in a setting that unnecessarily isolates and segregates those individuals from the community, (2) to administer services to persons with disabilities in the most integrated setting appropriate to the needs of those individuals, and (3) to transition each of the Hospitals to a resource center that supports delivery of community services and serves as a last resort in a continuum of care for those with chronic mental illness for whom community-based services are clinically inappropriate;

c. Permanently enjoin Defendants, their officers, agents, employees, subordinates, successors in office, and all those acting in concert or participation with them (1) from continuing the acts and omissions set forth in Paragraphs 21 through 189 above, and (2) to take such actions as will bring Defendants into compliance with federal constitutional and statutory law and ensure that adequate protections, supports, services, and treatment are afforded to persons residing in or confined to the State Psychiatric Hospitals; and

d. Grant such other and further equitable relief as the Court may deem just and proper.

Respectfully submitted,

/s/ Eric Holder, Jr.

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ERIC H. HOLDER, JR.
Attorney General of the United States

/s/ Sally Q. Yates

SALLY Q. YATES
Acting United States Attorney
Northern District of Georgia
600 United States Courthouse
75 Spring Street, SW
Atlanta, GA 30303

/s/ Thomas E. Perez

THOMAS E. PEREZ
Assistant Attorney General
Civil Rights Division

SAMUEL R. BAGENSTOS
Principal Deputy Assistant Attorney General
Civil Rights Division

/s/ Shanetta Y. Cutlar

SHANETTA Y. CUTLAR
Chief
Special Litigation Section

/s/ Judith C. Preston

JUDITH C. PRESTON
Deputy Chief
Special Litigation Section

/s/ Robert A. Koch

MARY R. BOHAN [DC Bar 420628]
TIMOTHY D. MYGATT [PA Bar 90403]
ROBERT A. KOCH [OR Bar 072004]
EMILY A. GUNSTON [CA Bar 218035]
Attorneys
United States Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Avenue, N.W.
Washington, DC 20530
Tel: (202) 514-6255