U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

February 8, 1995

The Honorable George Allen
Governor
Commonwealth of Virginia
State Capitol
Richmond, Virginia 23219

Re: Eastern State Hospital

Dear Governor Allen:

My staff and I appreciated the opportunity to meet with your Deputy Attorney General, William Hurd, and his staff on January 31, 1995, to discuss our investigations pursuant to the Civil Rights of Institutionalized Persons Act of three institutions (Northern Virginia Training Center, Eastern State Hospital, and Northern Virginia Mental Health Institute) operated by the Commonwealth. We have agreed to meet once again on or before February 10, 1995, in order to determine whether we can come to some agreements in these matters.

Prior to that meeting, we thought it appropriate to further apprise you of our most recent findings and our determination that federal statutory violations exist at the Eastern State Hospital and the Hancock Geriatric Center ("ESH"). Our investigation of ESH was initiated on September 30, 1992 and has been pending absent any resolution for a protracted period of time.

Following a full evaluation of conditions at ESH, we most recently advised Commonwealth officials of our findings of continuing constitutional violations at the facility in a letter addressed to you dated May 6, 1994. In summary, we found unconstitutional conditions of confinement at the facility. Specifically, we found deficiencies in psychiatric treatment, including treatment programs, the design and implementation of training programs, excessive and unjustifiable use of physical restraints, inadequate numbers of direct care and professional staff, inadequate medical care, including medication practices, and a facility that as a whole, represents an outdated and ineffective mode of caring for individuals with mental illness. A copy of our letter is attached for your further information.

In addition, our review of this matter has led us to determine that the federal statutory rights of patients are being violated. More specifically, patients' rights pursuant to the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101 et seq., Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794 et seq., the provisions of the Medical Assistance Program ("Medicaid") established under Title XIX of the Social Security Act, 42 U.S.C. § 1396r et seq., and the regulations promulgated pursuant thereto, and the Health Insurance Program for the Aged and Disabled ("Medicare") established under Title XVIII of the Social Security Act, 42 U.S.C. § 1395i et seq., and the regulations promulgated pursuant thereto, are being violated by various acts, practices, and conditions at ESH. Our review also indicates that the rights of the patients guaranteed by Virginia state law are also being violated. See, e.g., Va. Code Ann. § 37.1 - 84.1 (Mitchie 1994).

ESH fails to provide constitutionally required treatment and training to its mentally ill and geriatric population, due in large part to inadequate numbers of and inadequately trained staff to provide care. The inadequate staffing and lack of staff training have resulted in a high number of unnecessary patient injuries and accidents. Our review of patient accidents and injuries confirmed that inadequate staffing and insufficient training and supervision are serious deficiencies at ESH.

Patients are also being denied adequate psychiatric treatment, including treatment programs. In the absence of adequate treatment programs, patients are subjected to unreasonable and undue physical restraint. Our consultants found the use of vest and wrist restraints in the Hancock Geriatric Unit to be excessive. Moreover, ESH's use and monitoring of psychotropic and psychoactive medications represent significant departures from accepted medical practice. It is common practice at ESH to simply add drugs when the patients fail to respond to the current drug therapy -- a professionally unjustified practice -- resulting in inappropriate polypharmacy. Our consultant psychiatrist estimated that at least a quarter of all ESH patients are receiving unnecessary drugs.

Finally, as noted in our May 6, 1994, findings letter, ESH as a whole "represents an antiquated, outmoded instrument for individuals with mental illness." ESH fails to provide patients treatment in an environment which meets their individualized needs. Specifically, the facility fails to provide patients treatment in an environment that promotes their individualized growth, development, and social well-being and permits the exercise of judgment and contact with family members, society and mainstream social institutions. Where mentally ill persons can benefit from placement in community based programs and facilities, and especially where professionals have determined that such placement is appropriate, this unnecessary segregation

of such persons within an institution violates both the ADA and Section 504. Moreover, the Commonwealth has failed to provide adequate community services to prevent the need for continued hospitalization and/or repeat hospitalizations due to a lack of appropriate alternatives.

As we have specified in other correspondence, the remedies set forth in our letter of May 6, 1994, are necessary to eliminate continuing constitutional violations as well as the federal statutory and state law violations set forth here. ESH must be reorganized to: (1) structure the hospital to serve as an acute care facility for individuals requiring evaluation and stabilization and (2) design and expand, as appropriate, community-based mental health services for patients who should be served in the community.

In closing, I can only express my hope that we can work together to resolve this long outstanding matter to the benefit of the patients of ESH.

Sincerely,

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

Enclosure

cc: Ms. Kay Coles James
Secretary
Department of Health and
Human Resources

Dr. Timothy Kelly
Commissioner
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Ms. Janet Hill
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