



U.S. Department of Justice

Civil Rights Division

U.S. v. Arizona

Office of the Assistant Attorney General



MR-AZ-001-002

REGISTERED MAIL
RETURN RECEIPT REQUESTED

The Honorable Fife Symington
Governor
State of Arizona
State Capitol
Phoenix, Arizona 85007

MAR 10 1993

Re: Findings Letter Regarding Arizona State
Hospital, Phoenix, Arizona

Dear Governor Symington:

On September 25, 1989, we informed then-Governor Mofford that we were commencing an investigation of the Arizona State Hospital (ASH) in Phoenix pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. §1997. After a thorough investigation of ASH, on December 14, 1990, we informed the State of the findings of our investigation. Those findings were that conditions existed at ASH which we believed were depriving patients there of their constitutional rights. Those conditions included inadequacies in medical care and medically related services, *i.e.*, inadequate numbers of nursing staff, inadequate infection control practices, and inadequate adaptive equipment; and inadequate treatment programs and psychological interventions resulting in the inappropriate use of physical restraint.

In our letter, we informed Governor Mofford that we believed the best way to proceed with this matter, given the issues involved and the remedial efforts currently underway at the facility, was to allow the State a period of time in which to remedy the constitutional deficiencies. In June and October of 1991, we retoured ASH to determine whether the State had in fact remedied the conditions identified in our December 1990 letter and to verify that no other unconstitutional conditions existed at ASH. As with our earlier visits, our consultants toured the facility, observed patients, interviewed staff and reviewed patient records.

Although the State had taken measures to correct some of the deficiencies noted in our December 1990 letter, certain deficient conditions continued to exist. Specifically, we found the following deficiencies implicating the constitutional rights of residents: inadequate development and implementation of treatment plans resulting in inappropriate use of restraints and seclusion;

continued inadequacies in the provision of nurse staffing; and the failure to adequately train direct care staff to perform their assigned tasks. We so informed the State in the course of discussions concerning the remaining deficiencies at ASH. The State represented that many of our remaining concerns had been resolved. Based on these representations, we returned ASH again on October 13-15, 1992 to update our information. During this and each of the earlier tours, we were treated graciously by Dr. Migliaro, the staff at ASH, and counsel from the Arizona Attorney General's Office.

During our latest tour, our nursing consultant determined that the deficiencies in nursing services referenced in our last letter had been remedied. However, we determined that ASH patients continue to be subjected to inappropriate use of restraints and seclusion, a dangerous and potentially life-threatening practice that deprives ASH patients of their constitutional rights.

Specifically, ASH patients are routinely put into five-point restraints (a practice where a patient is restrained on a bed and bound by the ankles, by the wrists with the arms to the side, and by a strap across the abdomen) and placed into a locked seclusion room. In our consultants' opinion, this practice is dangerous and unjustified. A patient subjected to such restraint is at great risk of harm from choking and asphyxiation. This risk of harm is increased where, as here, the patients are secluded in a locked room and not under direct and continuous observation by staff, a practice which appears to be particularly egregious since it was apparent to our consultants that these restraint techniques were being used for the convenience of staff. Alternative methods of restraint less drastic than the use of five-point restraint are not routinely employed. The use of such severely restrictive techniques as five-point restraints along with confinement to a seclusion room to control patients strongly suggests inadequacies in treatment programs which merit review by institutional professionals.

In sum, our most recent review disclosed facts indicating that the use of restraints and seclusion at ASH denies patients their constitutional rights to a reasonably safe environment and freedom from undue bodily restraint. Cf. Youngberg v. Romeo, 457 U.S. 307 (1982). We supplied ASH with copies of our consultant reports following each tour of the facility and our nurse's report from the 1991 tour specifically notes the dangers involved in the use of the five-point restraint as employed at ASH. This condition must be corrected in order to assure that the constitutional rights of patients at ASH are protected. To this end, the following measures, at a minimum, must be implemented:

1. The use of five-point restraints in conjunction with seclusion should be discontinued immediately.

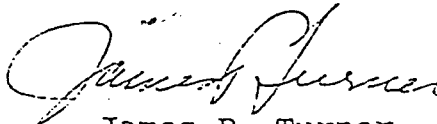
2. In and of itself, five-point restraints should be used a) only as a last resort after other less restrictive techniques have been tried and found unavailing, b) only pursuant to the written order of a physician justifying such use with specific guidelines for initiating and terminating the use, c) only when sufficient trained staff are available to continuously monitor the patient's health and safety, and d) never simply for the convenience of staff.

We suggest you contact the appropriate regional offices of the Department of Health and Human Services and the Department of Education to ensure that the State is maximizing its use of federal financial assistance -- assistance that may be utilized to correct the deficiency identified in this letter.

Our attorneys will be contacting legal counsel for the State of Arizona shortly to discuss this matter in greater detail. In the meantime, should you or your staff have any questions regarding this matter, please feel free to call Arthur E. Peabody, Jr., Chief, Special Litigation Section, at (202) 514-6255.

We look forward to working cooperatively with State officials to promptly resolve this matter.

Sincerely,



James P. Turner
Acting Assistant Attorney General
Civil Rights Division