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UNION OF AMERICAN PHYSICIANS AND DENTISTS
AFFILIATED WITH AFSCME, AFL-CIO

Oakland Headquarters
180 Grand Avenue
Suite 1380
Oakland, CA 94612-3741

(510) 839-0193 OFFICE
(510) 763-8756 FAX
(800) 622-0909 TOLL FREE
uapd@uapd.com EMAIL

www.uapd.com

STUART A. BUSSEY, M.D., J.D.
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UAPD BACKGROUNDER:

Violence at Napa State Hospital

Incidents, Issues and Solutions

Napa State Hospital (NSH) is...

- an in-patient psychiatric hospital capable of treating up to 1362 patients at once.
- run by the California Department of Mental Health (DMH).
- the workplace of about 2400 state employees.
- located on 138-acres within the city of Napa in Sonoma County.
- **the site of numerous violent assaults on patients and staff.**

Violence Timeline

- **On October 23, 2010 Donna Gross, a psychiatric technician at Napa State Hospital, was strangled by a patient while she was walking across the hospital grounds**. Then on December 11, 2010 a rehabilitation therapist suffered four skull fractures after being assaulted by a patient who had attacked another worker just days earlier.

- Concern for the safety of staff and patients motivated unionized workers at Napa State Hospital to create the *Safety Now!* coalition, which developed and disseminated a list of measures to reduce the number of violent assaults (Attachment 1). *Safety Now!* sponsored protests at the hospital gates, one on January 19th and another on March 28th (Attachment 2, Attachment 3, Attachment 4, Attachment 5).

- On April 12, 2011, Cal-OSHA issued a $100,140 fine against DMH for safety code violations at Napa State Hospital. "As a result" of those safety violations, the report concluded, "on 10/23/10, an employee was killed." The following day DMH stated its intention to appeal the fine (Attachment 6).

- Facing intense scrutiny from media and unions, DMH has agreed to increase its number of clinical and security staff. Secretary of Health and Human Services Dianna Dooley visited Napa State Hospital before announcing on April 22nd that the statewide hiring ban no longer applied to DMH facilities. The announcement came on the heels of a disastrous week for DMH, in which two Napa State Hospital patients died (one from injuries sustained the prior month) and the Cal-OSHA report was released.

Violence Statistics

- **The most recent numbers provided by DMH show that on average, three staff members and seven patients are assaulted each day inside Napa State Hospital (Attachment 7).**

- There were nearly 200 attacks on hospital staff in the second quarter of 2010, four times as many as in 2009 (*Los Angeles Times 11/3/2010*).

- Patient assaults in the second quarter of 2010 soared to 692, a sevenfold increase from the same quarter the previous year (*Los Angeles Times 11/3/2010*).

- In 2009, there were 1580 crimes reported at Napa State--including over 1,200 batteries--but few of those crimes were ever prosecuted (*The New York Times 12/16/2010*).

- OSHA reports show that since 2005, there have been 250 or more cases per year of Napa hospital workers missing at least one day of work due to injury (Attachment 8).

Causes of Violence

- Most of the violent assaults taking place at Napa State Hospital are predictable and preventable.

- **Shifting from civilly committed to forensic patients, without changing most safety protocols, has caused the increase in violent assaults at Napa State Hospital.** A large number of patients with a violent criminal history have been committed to California DMH facilities in the last decade--*The New York Times* reported that today 92 percent of patients are sent to DMH by the criminal justice system, whereas 15 years ago it was just 20 percent (12/16/2010). The Cal-OSHA report on Napa State Hospital agreed that "as the employer's forensic individual population increased, the employer failed to identify the hazards posed to employees by increasingly threatening and felonious assaultive behavior by individuals. As a result, on 10/23110, an employee suffered a fatal injury by an individual" (Attachment 8, p. 10).

- As the violence problem became increasingly apparent to front line staff, **DMH managers at the facility and in Sacramento failed to respond to staffers' demands for better safety procedures.** For example, clinical staff developed a workable plan for a high security unit to house predatory patients back in 2005, which management failed to implement. Current DMH leaders have still not done enough to reduce violence, even after Donna Gross' death.

Just a Napa Problem?

- While Napa State Hospital has received the most attention, in recent years most DMH hospitals have similarly high numbers of assaults on workers and patients according to data provided by DMH and Cal-OSHA (Attachment 9, Attachment 10). **Workers believe it is only a matter of time before people start dying at Metropolitan, Patton, Atascadero, or any of the other DMH-run facilities.**

Legislative Solutions

Coalition members are now working with elected officials to develop workable legislative solutions for the problems faced by Napa State Hospital and the other DMH hospitals in the state. Under consideration are changes to the California Penal Code and other codes to address the challenge of providing therapeutic psychiatric care in the context of the changed patient population.

Facility-Level Solutions

According to Napa State Hospital staff, there are many measures that DMH administrators can implement right now to decrease violence in the facility. Solutions that can begin on the local-level, and might also be considered for other DMH facilities, include:

- Assessment of All Patients: Individuals admitted to a DMH facility should undergo an assessment to identify their potential for violence and determine any "special needs" which must be clearly communicated to all workers who interact with the patient. The Cal-OSHA report seconds this recommendation.

- High Security Unit: Patients assessed as having a high potential for violence should be housed on a high-security, enhanced treatment unit—an idea first considered at Napa State Hospital in 2005, only to be abandoned by DMH managers the following year.

- Increased Police Presence: Each DMH facility needs dedicated safety and security personnel, such as Hospital Police Officers, stationed on the units, inside the security fence, at all times.

- Increased Staffing: Higher staffing levels would contribute to patient and staff safety by ensuring adequate assessment, supervision, and monitoring. This may include staffing ratios much like acute care hospitals have in place.

- Monitoring and Alarms: Patients with a potential for violence should not be allowed to roam around outside in the grounds free of supervision. Emergency call boxes, security cameras, and a working, integrated alarm system are essential to securing the vast Napa State Hospital grounds. The Cal-OSHA report seconds this recommendation.

Costs

- **There is strong reason to believe that making safety improvements at all DMH facilities would cost the State of California less than it currently pays as a result of worker injuries.**

- A study conducted in 1989, when most DMH patients still arrived as civil commitments, calculated the cost of worker injuries to be 17.3 million dollars, or 9.7% of the Department's labor costs back then. If that same percentage applies today, DMH is spending nearly $100 million annually on injured workers (Attachment 11).
- An up-to-date study calculating the full cost of workers injuries, including legal settlements, is needed in order to put the cost of safety improvements in proper perspective.