1984 FISCAL YEAR REPORT TO CONGRESS PURSUANT TO CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT

The Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 (hereinafter referred to as the Act), was enacted in May, 1980. It authorizes the Attorney General to initiate or to intervene in equitable actions against public institutions in which he has reasonable cause to believe there is a systematic pattern or practice of flagrant or egregious violations of the affected persons' constitutional or federal statutory rights. This report will provide Members of Congress with information surrounding actions initiated under the Act in fiscal year 1984, and information concerning the progress made in federal institutions toward meeting promulgated standards for such institutions or constitutionally guaranteed minima. It is submitted in accord with the reporting requirements of 42 U.S.C. §1997(f).

ACTIONS TAKEN IN FISCAL YEAR 1984

During Fiscal Year 1984, the Department filed three cases pursuant to the Act. Two of these were settled and the third is presently in litigation. A fourth case, in which the government intervened in 1982, was settled and the decree entered by the Court in FY 1984.

The Department initiated nine investigations: four concerning mental health, two concerning mental retardation facilities, and three involving prisons and jails. We continued investigations of 14 facilities, the investigations of which have been previously reported, of which five concern mental health, three concern mental retardation, and six prisons and jails. We terminated investigations of three mental health facilities, one mental retardation facility, four penal institutions, three juvenile facilities, and one nursing home.

Actions taken during the Fiscal Year are more fully described below, and were taken in accordance with the internal guidelines previously reported.

We have officially terminated the following CRIPA investigations which we have been informally monitoring over the last year as to voluntary improvements made by the states to raise the level of the conditions of confinement at these facilities to constitutional minima.

1. Cornwell Heights Youth Development Center
   Philadelphia, Pennsylvania

2. West Virginia Industrial School for Boys
   Pruntytown, West Virginia

3. Jackson Special Hospital
   Jackson, Louisiana

SOUTH CAROLINA STATE HOSPITAL

On October 6, 1983, we notified Governor Richard Riley and other appropriate officials of our intent to investigate conditions at South Carolina State Hospital, Columbia, South Carolina. We received information that this facility may be violating constitutional and statutory rights of the residents confined there. Specifically, our investigation is focussing on patient safety, and misuse of restraints, seclusion and psychotropic medications. We are continuing to evaluate the information gathered during the course of the investigation.

CENTRAL AND LOGANSPORT STATE HOSPITALS

On October 6, 1983, we notified Governor Robert Orr and other appropriate state officials of our intent to investigate alleged constitutional conditions of confinement at Central State Hospital, Indianapolis, Indiana which houses approximately 550 mentally ill persons. This investigation and our investigation of Logansport State Hospital, Logansport, Indiana, which was initiated on June 16, 1982, were resolved by consent decree in United States v. Indiana (S.D. Ind.) on March 16, 1984. The decree, which was entered by the Court on April 6, 1984, requires increased staffing and staff training; improved medical services; improved monitoring of the use of psychotropic medications, seclusion and physical restraint; improved recordkeeping procedures; and correction of fire safety deficiencies. This agreement is the first involving state institutions for the mentally ill that has been negotiated by the Justice Department under the Act. The Department continues to monitor compliance with the decree.

YPSILANTI PSYCHIATRIC HOSPITAL

On November 18, 1983, we notified Governor William G. Milliken and other appropriate officials of our intent to investigate conditions of confinement for the 530 mentally ill patients residing at Ypsilanti Psychiatric Hospital, Ypsilanti, Michigan. Our investigation was based on reports of unconstitutional conditions existing at Ypsilanti, including direct care and professional staffing shortages, misuse of psychotropic medications, seclusion and restraint as well as allegations of harm from patient abuse and neglect. We are continuing this investigation.

FELICIANA FORENSIC FACILITY

On December 2, 1983, a settlement agreement by all parties in Davis and United States v. Henderson (M.D. La.) was entered by the Court. This agreement resolves the issues raised concerning conditions at Feliciana Forensic Facility in Jackson, Louisiana, the first mental health facility investigated pursuant to the Act. The decree binds defendants to substantially comply with Louisiana's own rules and regulations governing hospitals; procedures regarding the use of psychotropic medications, seclusion and restraint; and patients' rights as enumerated under Louisiana state law. We continue to monitor the progress achieved as a result of this decree.

SOUTH BEACH PSYCHIATRIC CENTER

On February 22, 1984, we notified Governor Mario M. Cuomo and other appropriate state officials of our intent to investigate conditions provided to 400 adults and children residing at South Beach Psychiatric Center, Staten Island, New York. Our investigation is based on reports from a number of sources that residents of this facility are not protected from harm because of staff deficiencies, overuse of medication, improper medical care and improper use of physical restraint. We have completed a number of expert tours of the Center and have reviewed appropriate institutional records. We are now preparing our findings on the conditions at the facility.

WORCESTER STATE HOSPITAL

On October 4, 1982, we notified Governor Edward J. King and other appropriate officials of our intent to investigate conditions of confinement at Worcester State Hospital, Worcester, Massachusetts. After thorough investigation of the conditions existing at the facility, we notified Governor Michael S. Dukakis on April 23, 1984 of our findings. We continue to meet with Massachusetts state officials to discuss resolution of the investigation.

ATASCADERO STATE HOSPITAL

On May 1, 1984, we notified officials responsible for the operation of Atascadero State Hospital, Atascadero, California, of our findings concerning conditions of confinement at the facility. We are meeting with state officials to determine the most appropriate means by which to resolve the issues of this investigation.

SOUTH FLORIDA STATE HOSPITAL

On June 12, 1984, we advised Robert A. Burton, Administrator of South Florida State Hospital, Hollywood, Florida that improvements at the facility have greatly enhanced both patient treatment and safety. Although we called Mr. Burton's attention to three areas of concern noted by our expert consultant, we concluded that these matters do not reflect flagrant and egregious violations of the type Congress intended us to address under the Act. Therefore, in view of the enormous recent progress, we advised that we have closed the investigation.

SPRING GROVE STATE HOSPITAL

On September 18, 1984, we informed Secretary Adele Witzack, Department of Mental Health and Mental Hygiene that despite certain problems, Spring Grove State Hospital and Carter Center, Catonsville, Maryland, provide constitutionally adequate levels of care which protect the rights of patients confined therein. In view of this finding, our investigation of these facilities was closed.

NORTHVILLE REGIONAL PSYCHIATRIC HOSPITAL

In 1982, we notified Governor William G. Milliken and other appropriate officials of our intent to investigate conditions of confinement for the 1,100 acutely mentally ill patients residing at Northville Regional Psychiatric Hospital, Northville, Michigan. Our investigation was based on reports from a variety of sources suggesting that the hospital has deficiencies in a number of areas, including overcrowding, inadequate staffing and care, the inability to protect the residents from harm, and life safety deficiencies. We have conducted expert tours and reviewed documents maintained by the facility. We are continuing to evaluate the facts collected thus far.

ELGIN MENTAL HEALTH CENTER/MANTENO MENTAL HEALTH CENTER

We have completed our investigations of Elgin Mental Health Center and Manteno Mental Health Center and are preparing our findings on the conditions at these facilities. Once the governor is notified of our findings, we expect to meet with the appropriate state officials to discuss any outstanding issues which may remain.

EAST LOUISIANA STATE HOSPITAL

On September 26, 1984, we notified Governor Edwin Edwards that improvements implemented at East Louisiana State Hospital during the course of our investigation precluded any action under the Act. While we informed him of a few areas which continued to be troublesome, including the possibility of a significant population increase which would strain staff and other resources, we concluded that no flagrant or egregious violations of constitutional rights are occurring. In view of this conclusion, we terminated our investigation and ceased to actively monitor conditions at the facility.

ROSEWOOD CENTER

During the year, we completed our review of the Plan submitted by Maryland state officials responsible for the operation of Rosewood Center. In addition, we toured the facility with an expert consultant and reviewed institutional documents to apprise ourselves of the full extent of the improvements made under the state plan. We continue to meet with state officials concerning certain conditions which we have concluded still need remediation.

WHEAT RIDGE REGIONAL CENTER

On December 16, 1983, we notified Governor Richard Lamm and other appropriate officials of our intent to investigate alleged unconstitutional conditions at Wheat Ridge Regional Center, Wheat Ridge, Colorado, in which approximately 540 mentally retarded persons reside. Our investigation was based on reports from a variety of sources that the Center has deficiencies in a number of areas, including inadequate medical care, inadequate staffing and claims of resident abuse and neglect. We have toured the facility with expert consultants and have reviewed numerous institutional documents. The investigation is continuing.

HAZELWOOD INTERMEDIATE CARE FACILITY

On November 29, 1982, we initiated our investigation of Hazelwood Intermediate Care Facility, Louisville, Kentucky, a treatment facility for approximately 500 mentally retarded persons. Since the beginning of our investigation, steps have been taken to improve the administrative organization of the facility in order to provide improved therapeutic services and nursing care. In addition, a number of capital improvements have been made to the existing structure. On August 27, 1984, we advised the facility's Director that while we continue to have certain areas of concern, these areas do not warrant action under the Act because they do not rise to the level of flagrant or egregious violations specified in the Act. Consequently, we have closed the investigation.

SOUTHBURY TRAINING SCHOOL

On May 1, 1984, we notified Governor William A. O'Neill and other appropriate officials of our intent to initiate an investigation of the Southbury Training School, Southbury, Connecticut. Our investigation will determine whether there exist violations of federal constitutional or statutory rights of mentally retarded persons residing in this facility with respect to the use of restraints, inadequate medical care, abuse and neglect, and inadequate training as is necessary to further client safety and freedom from unreasonable bodily restraint. This investigation is continuing.

FAIRVIEW TRAINING CENTER

In 1983, we notified Governor Victor Atiyeh and other appropriate officials of our intent to investigate conditions at Fairview Training Center, a facility at which some 1,400 mentally retarded people reside near Salem, Oregon. During the past year, we conducted a number of expert tours and reviewed a wide variety of institutional documents. We are evaluating the findings made by our expert consultants and expect to advise the state in the near future about our conclusions.

ENID AND PAUL'S VALLEY STATE SCHOOLS

We have concluded our investigations of Enid and Paul's Valley State Schools, Oklahoma and are now preparing our findings on the conditions at these facilities. After we notify appropriate state officials of our determinations, we will meet with the state to discuss any outstanding issues which may remain.

BENTON SERVICES CENTER

On September 17, 1984, we informed Mr. Ray Scott, Director, Arkansas Department of Human Services that the numerous improvements made at Benton Services Center, Benton, Arkansas, indicate that residents are receiving constitutionally adequate levels of care and treatment. In view of this finding, the investigation was terminated.

NEW HAMPSHIRE YOUTH DEVELOPMENT CENTER

On August 30, 1984, we notified Governor John H. Sununu that in view of ongoing negotiations between New Hampshire state officials and counsel representing residents of the New Hampshire Youth Development Center which we believe will have substantial impact on the facility in the near future, we will not undertake further investigation of that facility at this time. Accordingly, the investigation was terminated.

COOK COUNTY JAIL

In November 1982, we informed the Court in United States v. Elrod (N.D. Ill.) that relief ordered by a consent decree recently filed in Duran v. Elrod for inmates of the Cook County Jail, Chicago, Illinois satisfied to a great extent the claims raised in our case and our investigation pursuant to the Act. We informed the Court that the only outstanding issues involved classification. We are satisfied that this issue has been adequately resolved. Consequently, the investigation was closed in January, 1984.

NEWARK CITY JAIL

On February 2, 1984, we filed United States v. City of Newark (D. N.J.) concerning unconstitutional conditions of confinement in police holding facilities. Our complaint alleged severe overcrowding; inadequate bedding, hygienic material and other furnishings; inadequate protection from harm; and deliberate indifference to the medical needs of inmates confined to the Newark City Jail. The case was litigated in August and September, 1984. The United States presented the testimony of thirteen witnesses before the two Special Masters appointed to hear the evidence in this case. We are preparing our brief recommending findings of fact and conclusions of law.

HARRISON COUNTY JAILS

On February 8, 1984, we informed President Ernest Melvin of the Harrison County Board of Supervisors of the findings of our investigation regarding the Harrison County Jail in Gulfport, Mississippi. Our investigation consisted of extensive tours of the facility by four expert consultants, interviews with jail administrators, staff and inmates, and review of jail documents. Because we found certain areas of concern, we continue to confer with county officials to determine the most appropriate means by which to resolve this matter.

Due to the tragic fire which took place at the Harrison County Jail in Biloxi, Mississippi in November, 1982 and the consequent long delay in returning the jail to operational status, we have not been able to conduct an investigation of that facility.

GRENADA COUNTY JAIL

On February 22, 1984, we informed Fred Carver, President of the Grenada County Board of Supervisors of findings made as a result of our investigation of Grenada County Jail in Grenada, Mississippi. Although we advised county officials of certain areas of concern, we informed them that we would not proceed further with the investigation because these areas do not rise to the level of constitutional violations. We have, therefore, terminated our investigation of this facility.

BEDFORD COUNTY JAIL

On March 5, 1984, we notified County Executive Dorothy Orr of our intent to initiate an investigation into conditions at Bedford County Jail, Shelbyville, Tennessee. After completion of our investigation which consisted of tours of the facility, interviews with the sheriff, and review of documents, we notified Judge Orr of our findings on August 29, 1984. We will meet with state officials to discuss the most appropriate means for resolving this matter.

OAHU COMMUNITY CORRECTIONAL CENTER

In 1983, we filed our first independent (non-intervention) suit pursuant to the Act against the State of Hawaii based in part on their refusal to allow on-site inspections of the Oahu Community Correctional Center and the Halawa High Security Facility, Honolulu, Hawaii. Our complaint was subsequently dismissed, without prejudice, by the District Court on May 10, 1983, for lack of standing due to a failure to meet certain prefiling requirements under the statute.

Since that time, we have begun a new investigation which is continuing. Expert consultants have toured the facilities and submitted their reports. We have reviewed a variety of prison files relating to conditions and practices. We are now preparing our findings based upon the conclusions and recommendations of our expert consultants.

FOLSOM STATE PRISON

On April 3, 1984, we advised Governor George Deukmejian and other appropriate officials of the findings of our investigation of Folsom State Prison, Represa, California. We are continuing negotiations with California officials to determine the most appropriate means to address the areas outlined in our letter.

GRATERFORD STATE CORRECTIONAL INSTITUTION

On April 26, 1984, we advised Governor Richard Thornburgh of our findings concerning Graterford State Correctional Institution, Graterford, Pennsylvania. As a result of our investigation of the facility under the Act, we determined that conditions of confinement do not violate the constitutional rights of the inmates. We are satisfied that conditions at the prison will continue to improve due to the extensive financial commitment made by the Commonwealth of Pennsylvania towards this end. Consequently, we closed our investigation.

CLINTON CORRECTIONAL FACILITY

On June 20, 1984, we notified Governor Mario M. Cuomo and other appropriate state officials of our intent to investigate Clinton Correctional Facility, Dannemora, New York. We will determine during our investigation whether any federal constitutional rights of inmates confined therein have been violated particularly with respect to physical disciplinary measures.

TUTWILER PRISON

On July 3, 1984, we notified Governor George Wallace and other appropriate officials of our intention to initiate an investigation of Julia Tutwiler Prison for Women, Wetumpka, Alabama. Our goal will be to determine whether there exist any violations of the federal constitutional rights of women incarcerated therein to equal protection under the law particularly with respect to vocational and educational training programs. This is the first investigation of its kind launched under the Act.

MICHIGAN STATE PRISONS

On July 16, 1984, the Court in United States v. Michigan (W.D. Mich.) entered a consent decree in which defendants agreed to improve conditions at three state prisons in Jackson, Marquette and Ionia, Michigan. Pursuant to the Decree, we have received numerous plans from the state addressing sanitation and various medical issues. We will continue to receive and evaluate the state's plans and expect to tour the subject prisons in the near future to observe improvements which have been made thus far.

OSSINING CORRECTIONAL FACILITY

We are continuing our investigation of Ossining Correctional Facility, Ossining, New York. Thus far, we have conducted a number of tours of the prison with expert consultants, reviewed institutional documents and interviewed sources knowledgeable of the prison's operation. We are currently in the process of evaluating the facts we have obtained.

TALLADEGA COUNTY JAIL

After we notified Talladega County officials that we would have to file a complaint in district court because of the state's refusal to permit on-site inspection of the Talladega County Jail and because the Attorney General had reasonable cause to believe egregious and flagrant conditions of confinement exist at the jail, the state did allow access to the facility. We conducted expert tours of the jail and we are now preparing our findings based on the conclusions made by our expert consultants. This investigation is, therefore, continuing.

ADA COUNTY JAIL

We completed expert tours, document review and interviews relative to our investigation into conditions at the Ada County Jail, Boise, Idaho. After evaluating the conclusions and recommendations of our expert consultants, on April 18, 1984 we notified Chairman of the Board William Gratton, Ada County Commissioners, of our findings. Subsequently, we participated in negotiations with state officials to discuss the proper action to be taken to remedy the constitutional deficiencies identified by our investigation. We are composing a proposed consent decree which we hope will result in an amicable resolution of this matter.

FEDERAL INSTITUTIONS ~~(VIA)~~

Section 8(5) of the Act requires the Attorney General to report on the progress made in federal institutions toward meeting existing promulgated standards for such institutions or constitutionally guaranteed minima. There follows a summary of progress made this year in federal institutions of the Veterans Administration, the Department of Health and Human Services, and the Federal Bureau of Prisons.

The Veterans Administration has made significant efforts to assure that the civil rights of patients in its facilities are protected. Most noteworthy was the December, 1982 publication of regulations formally defining the rights of patients. The regulations clearly identify the constitutionally protected rights of patients as well as numerous other rights granted by the regulations themselves. They also set forth specific procedures for the Veterans Administration to follow when it is necessary to restrict rights in addition to establishing grievances procedures for patients. The Veterans Administration has also continued to increase its number of patient representatives in its facilities to assist patients in understanding their rights and advocating the enforcement of those rights. Another effort to protect patient rights was the promulgation of formal regulations to assure that all Veterans Administration patient care is conducted only with full informed consent of patients and their representatives. Amendments to those regulations were promulgated on March 12, 1984.

The Veterans Administration has a number of internal mechanisms to ensure that high quality medical care is provided to all its patients. In this regard, they operate the Health Services Review Organization, a peer review program designed to discover and correct problems in the delivery of health care. They also periodically survey patients to determine their satisfaction with the care provided to them. Lastly, both the Office of Inspector General and the Office of Medical Inspector conduct investigations of complaints about fraud, waste, and abuse in the system, as well as complaints concerning the quality of health care.

Saint Elizabeth's Hospital, under the Department of Health and Human Services, continued its progress in assuring the protection of the civil rights of its patients. The facility has been accredited by the Joint Commission on Accreditation of Hospitals (JCAH) which requires compliance with each of the patients' rights described in their Consolidated Standards for Psychiatric Hospitals and Standards for Community Mental Health Centers.

In addition, the Patient Advocate's Office coordinated the Hospital's second National Patients' Rights Seminar which was attended by more than two hundred people from eight states. The theme of this year's meeting was "Political, Social and Economic Awareness of Patient's Rights."

The Patient Advocacy Office performs a number of functions to assist residents of St. Elizabeth's. It has compiled a handbook to assist patients in adjusting to community life with special information on medication, food, recreation, job resources and community services. It also developed a consumer health education program to provide factual information and emotional support to patients concerning specific medical problems. The total number of patients receiving advocacy services average about 2000. Lastly, the Patient Advocacy Office has developed an 80 page manual to be used as a practical guide for persons involved in the implementation of training patient advocacy.

St. Elizabeth's Hospital continues to take steps to ensure the protection of rights of persons in its care.

The Bureau of Prisons (BOP), which operates the federal prison system, has taken significant steps to ensure the protection of the constitutional rights of persons under its authority. Correctional standards have been incorporated into a national Bureau of Prisons policy and each Federal institution's compliance with the standards is monitored through their Management Audit Program. This program involves a regular audit of each institution program and operation for compliance with national policy by Regional or Central officers inspectors every 12-18 months. The program is monitored by the BOP's Office of Inspections. To ensure that the standards are adequately covered in BOP policy, an independent, outside authority, the Commission on Accreditation for Corrections, was asked to review BOP policy for standards compliance. After the review was conducted and a report issued, only a few deficiencies were noted and actions have since been taken to correct these deficiencies in national policy. An internal review of progress made in correcting the deficiencies was conducted in May 1984 and the results were submitted to the Commission. The next Commission review of BOP policy will ocur in late FY 1985.

Another goal of the Bureau of Prisons is to have all their institutions accredited by the Commission on Accreditation for Corrections. To date, 34 of ~~BOP's~~ the Bureau's 45 institutions have been accredited and four others are preparing for the rigorous audit conducted by the Commission. Of the remaining seven ~~BOP~~ facilities not currently involved in the accreditation process, three have

been given extensions because of current or scheduled major renovations; one because of a recent mission change; and three because they are not yet fully operational. Under the terms of the accreditation contract and award, each accredited institution must successfully undergo a reaudit every three years in order to maintain its accreditation status. Accredited institutions are also subject to interim audits by the Commission to monitor ongoing compliance with the standards, particularly in the ~~vitae~~ vital areas of inmate rights, health care, security, safety and sanitation.