1985 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 which he has reasonable cause to believe are subjecting persons residing there to egregious or flagrant conditions pursuant to a pattern or practice that deprives such affected persons of rights, privileges or immunities guaranteed to them by the Constitution or laws of the United States. This report will provide Members of Congress with information regarding actions taken under the Act in fiscal year 1985, and information concerning the progress made in federal institutions toward meeting promulgated standards for such institutions or constitutionally guaranteed minima. This report is submitted in accordance with the reporting requirements of 42 U.S.C. §1997(f) and is current through September 30, 1985.

ACTIONS TAKEN IN FISCAL YEAR 1985

During fiscal year 1985, the Department filed five cases pursuant to the Act. Four of these were settled and the fifth is presently in discovery in preparation for trial. A sixth case which the government filed in 1984 and litigated, was also settled and the Consent Decree entered by the Court in FY 1985.

The Department initiated twelve new investigations: three concern mental health institutions, four involve mental retardation facilities, three concern prisons, and two others address conditions at juvenile detention facilities. We terminated investigations of one mental health facility, one mental retardation facility, two prisons, and one county jail after determining that voluntary remedial efforts undertaken on behalf of responsible state and local officials during the course of our investigations had brought conditions of confinement at those facilities up to constitutional minima.

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

° On February 5, 1985, we notified Governor James Blanchard of Michigan of our intent to commence an investigation of the Kalamazoo Regional Psychiatric Hospital, Kalamazoo, Michigan. We received allegations that this facility may be violating the constitutional and federal statutory rights of the residents with respect to general conditions of confinement and adequacy of treatment. We have concluded our expert consultant tours of the facility and evaluated documents gathered during the course of our investigation. We will soon advise appropriate state officials of our findings.

- On July 17, 1985, we sent notice to Governor George Deukmejian of our intention to commence an investigation of Napa State Hospital, a 1950-bed mental health facility in Imola, California. The information we received suggested that the facility might be violating the federal constitutional and statutory rights of the residents with its failure to protect patients from harm, failure to provide adequate medical care, failure to protect residents from harm due to fire and overuse and misuse of seclusion and restraints. We have conducted expert consultant tours and are continuing to evaluate the information we have thus far collected.

- On September 10, 1985, we notified Governor Michael Dukakis of our intent to commence an investigation into conditions of confinement at Westboro State Hospital, a 300-bed mental health facility in Westboro, Massachusetts. This investigation was initiated based on claims of patient abuse, inadequate medical care, inappropriate use of restraints, inadeguate staffing, deficient patient supervision and inadequate infection control and sanitation. Our investigation of this facility is continuing.

- On November 21, 1984, we wrote to Governor Mario Cuomo to inform him of the results of our investigation of the South Beach Psychiatric Center, Staten Island, New York. Although we noted that several practices at the facility relating to use of restraint and seclusion, and psychotropic medications and provision of medical care were in need of improvement, we found that current conditions met constitutional minima. We therefore closed our investigation.

- On November 23, 1984, we notified Governor Richard C. Riley of our findings concerning our investigation of the South Carolina State Hospital, Columbia, South Carolina. Our notification letter addressed serious problems with respect to staffing and staff qualifications, protection of patients from harm, use of psychotropic drugs, and use of seclusion and restraints. The recommended remedial measures included the hiring of sufficient numbers of qualified staff and the development and implementation of a system to ensure patient safety and proper medical care, the appropriate use of seclusion, and staff compliance with hospital policies, protocols and standards. We are currently finalizing the terms of the settlement agreement negotiated with the State of South Carolina designed to remedy the above-stated deficiencies.

- On December 13, 1984, we notified Governor James R. Thompson of our findings of constitutional deficiencies identified during the course of our investigation of the Elgin and Manteno Mental Health Centers. Despite the state's plan to close the Manteno facility and transfer most of its residents to the Elgin Mental Health Center, our letter cited serious concerns at both institutions. Recommended remedial measures included hiring of sufficient numbers of qualified staff, developing a monitoring system to assure adequate medical care and psychopharmacological treatment, developing stringent recordkeeping and review procedures, and enforcement measures to ensure staff compliance with hospital policies and standards relating to the unnecessary use of physical restraints and seclusion. Due to the fact that these two facilities are in a transitional phase, we conducted a subsequent tour to assess current conditions. The findings of our most recent tour and review of documents are pending.

- On February 19, 1985, we informed Govenor James Blanchard of our findings of constitutional deficiencies in Northville and Ypsilanti Regional Psychiatric Hospitals in Michigan. Our letter addressed violations of patients' rights with respect to staffing, medical and administrative practices, seclusion and restraint, and protection from harm. Recommended remedial measures included hiring sufficient numbers of qualified staff, developing a monitoring system for patient care, appropriate use of seclusion and restraint, professionally designed treatment programs and staff compliance with hospital policies, protocols and standards. We are currently finalizing the terms of the settlement agreement negotiated with the State of Michigan which will remedy the above-stated deficiencies.

- We are currently monitoring the implementation of the consent decree entered in U.S. v. Indiana, our first case pursuant to the Act which remedies unconstitutional conditions of confinement in state institutions for the mentally ill. We have conducted compliance tours of the subject facilities, Central and Logansport State Hospitals, and continue to review the state plans for adequacy.

- On February 11, 1985, the United States filed suit against the Commonwealth of Massachusetts pursuant to the Civil Rights of Institutionalized Persons Act. Despite attempts to negotiate a settlement agreement, Commonwealth officials steadfastly refused to enter into an agreement which would be filed in Court. U.S. v. Massachusetts is the first contested lawsuit involving a mental health facility filed by the Department pursuant to the Act. The complaint alleged that residents of the Worcester State Hospital, a 400-bed mental health facility, were being deprived of their due process rights under the Fourteenth Amendment. The alleged pattern and practice of unconstitutional conditions include: 1) failing to ensure that qualified professional judgments necessary to ensure safe conditions of confinement and freedom from unreasonable bodily restraint are made and implemented; 2) using drugs in an unsafe fashion; 3) using restraint, seclusion and time-out in an unreasonable manner which deprives residents of constitutionally guaranteed liberty interests. This case is now in the discovery stage.

- Negotiations with the State of California are nearing a conclusion with respect to a proposed settlement agreement concerning constitutional deficiencies identified by our investigation of the Atascadero State Hospital.

- On January 17, 1985, the United States and the State of Maryland entered into a consent decree remedying constitutional deficiencies found by the United States in the course of our investigation at the Rosewood Center, a mental retardation facility in Owings Mills. Under the consent decree, the State is obligated to conform institutional practices to constitutional standards as well as to meet the requirements of §504 of the Rehabilitation Act of 1973. The State agreed to provide a minimally adequate level of staffing, including a sufficient number of qualified staff to provide for the exercise of professional judgments with respect to patient care. The State also agreed to submit plans describing actions for achieving constitutional conditions of confinement, particularly in the areas of resident care, medical treatment, training, consultations, recordkeeping, fire safety, drug use, use of restraints and time-out, and prevention of abuse and neglect. The State has filed plans and reports with the United States District Court for the District of Maryland as required by the decree and we are currently monitoring the implementation of those plans.

- On March 15, 1985, we notified Governor Victor Atiyeh of our findings of constitutional and federal statutory deficiencies at the Fairview Training Center, a facility in Salem, Oregon at which some 1,400 mentally retarded persons reside. The constitutional deficiencies cited include violations of the residents' rights to adequate medical care, reasonable safety, freedom from undue bodily restraint and training to facilitate safety and the ability to function free from unreasonable restraints. The statutory deficiencies cited in the letter were violations of Section 504 of the Rehabilitation Act and the Education of All Handicapped Children Act. Subsequent to the State's receipt of these findings, we were requested to conduct a follow-up tour of Fairview to evaluate measures taken by the State to improve conditions. We have completed follow-up expert tours, document review and interviews and have evaluated the findings and recommendations of our expert consultants. We are in the process of drafting our findings letter to the State regarding our most recent site visit.

- On September 11, 1985, we informed Governor William O'Neill of the findings of our investigation of the Southbury Training School, an institution for the mentally retarded in Connecticut. Our letter set forth the deficient conditions which we believe deprived residents of their constitutional rights, including: inadequate medical care; insufficient recordkeeping practices; dangerous medication practices; lack of minimally adequate training and unreasonable use of bodily restraints; insufficient staffing; and unsafe environmental conditions. Our letter also cited the recommended measures necessary to remedy these unconstitutional conditions. We are currently attempting to negotiate a settlement agreement to resolve this matter.

- On December 7, 1984, we notified Governor Richard Lamm of Colorado concerning the findings of our investigation of the Wheat Ridge Regional Center, a facility at which approximately 540 mentally retarded persons reside. The letter cited deficiencies with respect to staff, care and training as well as medical care and medication practices. We have successfully completed settlement negotiations with the State and expect to file this consent decree in Court which will remedy the constitutional infirmities identified by our investigation.

- On November 30, 1984, we notified Governor Edwin Edwards of our intention to initiate an investigation of the Belle Chasse School, an institution for the mentally retarded in Louisiana. Our investigation was based on allegations of constitutional violations with respect to provision of adequate food, shelter and medical care; prevention of abuse and neglect of residents; and provision of such training as is necessary to protect residents from unreasonable risks to their personal safety to ensure them freedom from undue bodily restraint. We have completed expert tours of the facility and are evaluating the information we have collected as well as the findings and recommendations of our expert consultants. We will inform the State of the results of our investigation in the near future.

- On December 18, 1984, we informed Governor Tonye Anaya of the initiation of our investigation into conditions of confinement at the Fort Stanton Hospital and Training School, an institution for the mentally retarded in New Mexico. Our investigation was based on allegations of abuse and neglect, lack of adequate staff and supervision, and inadequate provision of medical care. We have completed expert tours, reviewed documents and conducted interviews and are now evaluating the information we have collected. We plan to notify and discuss our findings with the State in the near future.

On September 10, 1985, we notified Governor Richard F. Celeste of our intention to investigate conditions at the Montgomery Developmental Center, a mental retardation facility in Huber Heights, Ohio. Our investigation was based on alleged violations of residents' federal constitutional and statutory rights with respect to violence and abuse and lack of appropriate and necessary supervision, staffing, and medical care. Our investigation of this facility is continuing.

° On September 11, 1985, we sent notice to Governor Bill Allain of our intent to investigate conditions at Ellisville State School, a 700-bed mental retardation facility located in Ellisville, Mississippi. Our investigation was prompted by allegations of misuse of medication as well as seclusion and restraint; abuse of residents; inadequate protection of residents from harm; and existence of hazardous environmental conditions. We are continuing to investigate conditions at this facility.

- On January 5, 1985, we sent our supplemental findings to Governor George Nigh of Oklahoma with respect to the State's efforts to implement its voluntary plan of correction concerning conditions at the Enid and Pauls Valley State Schools. Our follow-up visits found substantial improvements in the physical plant and training and educational programs at the Enid State School. Professional and direct care staff levels at Enid had been improved to the point where they were no longer constitutionally inadequate. Therefore, our formal investigation of Enid was closed. Constitutional deficiencies were found to still exist at Pauls Valley. We are continuing to monitor the voluntary remedial efforts being made by the State at Pauls Valley to bring conditions there up to constitutional minima.

- On March 28, 1985, the Department notified the Board of Supervisors of Los Angeles County, California of our intent to investigate conditions of confinement at the Los Angeles County Juvenile Halls. The investigation was initiated on the basis of information received by the Department which suggested that juveniles residing at these facilities were subjected to abuse, violence, overcrowding, lack of staff and inadequate security.

- On March 28, 1985, we notified the San Francisco Board of Supervisors of our impending investigation of the Youth Guidance Center, a juvenile detention facility operated by the county. The Department initiated the investigation on the basis of information that it received which indicated that juveniles confined to that facility were subjected to abuse and violence, overcrowding, lack of staff and lack of security. Expert consultants have toured the facility on behalf of the government and have provided their evaluation of conditions. The investigation is continuing.

- On January 17, 1985, the Court approved a settlement agreement in United States v. Bedford County, Tennessee (E.D. Tenn.) which requires improvements to the physical plant of the county jail such that fire hazards and unsafe physical conditions are eliminated, inmate classification is provided to reasonably assure inmate safety, and sufficient staff is present to provide appropriate supervision of inmates. The United States continues to monitor compliance with the terms of the agreement.

- On January 28, 1985, the Department notified the Board of Supervisors of Harrison County, Mississippi that our investigations of the county jails in Gulfport and Biloxi would be closed. Improvements in conditions at Gulfport, particularly those concerning fire safety, placed that jail beyond the jurisdiction of the Civil Rights of Institutionalized Persons Act. The Biloxi facility, which has been rebuilt, poses no unreasonable risks to the physical safety of inmates. New procedures on staff activities at both facilities and the commitment of the Sheriff's Department to operate the jails in conformity with constitutional principles convinced us that no further action by the Department is warranted.

- On May 23, 1985, the Department filed a complaint and settlement agreement in United States v. Ada County (D. Idaho), addressing conditions of confinement at the Ada County Jail. The Court approved the agreement and ordered defendants to comply with its provisions. The county is required to improve security and surveillance, medical care, fire safety, building safety and sanitation by June 1, 1986. The United States is monitoring compliance with the decree.

- On July 15, 1985, the District Court for the District of New Jersey accepted the proposed settlement in United States v. City of Newark, et al., which addressed the constitutionality of conditions of confinement at Newark City Jail. In the settlement agreement between the City and the United States, defendants agreed to remedy inadequate sanitation services and security and inadequate medical screening and delivery of medical services. The agreement also provides for relief from overcrowding and multiple celling and the provision of basic necessities for the prisoners. Two special masters previously appointed by the Court were charged with the responsibility for monitoring compliance with the settlement. The order requires full compliance by June 1, 1987. The Department is monitoring progress in fulfilling the requirements of the agreement.

- On September 17, 1985, the Department filed a complaint and settlement agreement in United States v. County of Talladega (N.D. Ala.), which remedies conditions at the Talladega County Jail. The settlement agreement requires the county to improve conditions at the jail by providing adequate fire protection and medical care, including a medical screening process for all new inmates and the provision of necessary treatment to inmates with serious drug and alcohol problems. The county is also required by the agreement to guarantee adequate security within the jail, including contraband control, an inmate classification system and means of preventing severe overcrowding. Full compliance is required by July 31, 1987. The Department is monitoring progress toward full compliance.

- In United States v. Michigan (W.D. Mi.), which addressed conditions of confinement at state prisons in Jackson, Ionia and Marquette, the Department carefully monitored progress in meeting the requirements of the consent decree entered by the Court on July 16, 1984. We conducted numerous inspection tours of the three facilities with expert consultants. In June 1985, we filed a stipulation with the Court detailing specific dates for completion of required improvements particularly in the areas of mental health, crowding, fire safety, sanitation, environment and protection from harm. We subsequently filed a motion seeking enforcement of the consent decree in the areas of mental health care, sanitation, and fire safety. The Department continues to evaluate conditions within the three prisons and work with an independent, court-appointed expert.

- On December 18, 1984, we notified Governor George Ariyoshi of the findings made during the Department's investigation of Oahu Community Correctional Facility and Halawa High Security Facility. We informed the Governor of specific violations of inmates' constitutional rights at the Oahu facility particularly those involving failure to protect inmates from unreasonable risk of physical violence, lack of security, overcrowding, and lack of minimally adequate fire safety, medical care and safe environmental conditions. Our letter also noted that, while some deficiencies exist at the Halawa facility, none rose to a level which violates inmates' constitutional rights. Consequently, we have begun negotiating with Hawaii state officials concerning necessary remedies at Oahu and closed the investigation of Halawa.

- On March 7, 1985, we notified Governor George Deukmejian of our intention to investigate conditions of confinement at the California Medical Facility (CMF) in Vacaville. CMF is a hospital facility designed to meet the acute and chronic medical, dental and psychiatric needs of adult males confined in the custody of the California Department of Corrections. The investigation was initiated on the basis of information received by the Department which alleged that medical services, medication practices and environmental conditions were seriously deficient. In addition, inmates residing there are alleged to be subjected to unconstitutional levels of violence and overcrowding. Thus far, Department attorneys have conducted tours with expert consultants. The investigation is continuing.

° On March 18, 1985, the Department notified Governor George Deukmejian of California that our investigation of Folsom State Prison would be closed. The Department's concern about the constitutionality of conditions of confinement at Folsom were addressed in Toussaint v. McCarthy (N.D. Cal.), a class action case in which the Court found that specific conditions violated prisoners' rights under the Eighth and Fourteenth Amendments to the Constitution. The Court appointed a special monitor in Toussaint to evaluate compliance with the Court's order for injunctive relief. In view of these actions, the Department determined that appropriate steps were being taken to protect inmates' constitutional rights. Consequently, the investigation of Folsom State Prison was terminated.

- On May 28, 1985, the Department notified Governor Juan Luis of the Virgin Islands of our intent to investigate conditions at Golden Grove Correctional Institution on St. Croix. The investigation was initiated on the basis of information which alleged unconstitutional conditions of confinement. Specifically, the information suggested that inmates' rights were violated by the life-threatening condition of the physical plant of the facility, inadequate security, and substandard medical care. The facility was inspected by expert consultants during FY 85. We continue to evaluate institutional documents and weigh information provided to us from other sources. Negotiations with Virgin Island officials are continuing.

- On September 18, 1985, the Department notified Governor Bill Clinton of Arkansas of our intention to investigate conditions at the Cummins Unit of the Arkansas Department of Corrections. The investigation was predicated on allegations that inmates are subjected to violence and abuse, and that First Amendment Rights and access to courts have been illegally limited. The investigation is still in progress.

- The Department continued its investigation of the Julia Tutweiler Prison in Wetumpka, Alabama during FY 85. Expert consultants inspected the facility and reported on their findings and recommendations. We are continuing to evaluate facts in this investigation to determine whether there exist any violations of the federal constitutional rights of women incarcerated there, particularly with respect to equal protection under the law relating to vocational and educational training programs.

- The Department continued its investigation of Sing Sing Correctional Facility in Ossining, New York. During the fiscal year, we conducted inspection tours of the facility with expert consultants, reviewed institutional documents and conducted interviews of knowledgeable sources. The investigation is still in progress.

° The Department is continuing its CRIPA investigation of conditions of confinement at Clinton Correctional Facility in Dannemora, New York. The Civil Rights Division's Criminal Section is also investigating allegations of violence against inmates to determine whether any federal criminal statutes may have been violated.

The Attorney General is required by Section 8(5) of the Act, 42 U.S.C. 1997f(5), to report on the progress made in federal institutions toward meeting existing promulgated standards for such institutions or constitutionally guaranteed minima. A summary of progress made toward this goal by federal institutions operated by the Veterans Administration, the Department of Health and Human Services and the Federal Bureau of Prisons follows.

The Veterans Administration continues to take measures to ensure that the civil rights of patients in all of its facilities are adequately protected. In March 1984, formal regulations were promulgated to assure that patient care is provided only with the full informed consent of each patient or his representative. This effort enhanced an earlier compilation identifying the constitutionally protected rights of each patient as well as numerous other rights assured through administrative regulations. The Veterans Administration continues to increase the number of patient representatives charged with the responsibility of assisting patients in understanding their rights and acting as patient advocates in civil rights enforcement. In order to ensure constitutionally adequate medical care in all of its facilities, the Veterans Administration operates the Health Services Review Organization which includes numbers of health professionals who evaluate the quality of medical care provided to patients and, when necessary, corrects problems in the delivery of health care. Individual patients are surveyed periodically to determine their level of satisfaction with the care provided to them. Lastly, the Office of Inspector General and the Office of Medical Inspector stand ready to investigate allegations of fraud, waste, substandard care or abuse in the Veterans Administration. All of these mechanisms are designed to protect the civil rights of Veterans Administration patients.

Saint Elizabeths Hospital, under the Department of Health and Human Services, continues to make great progress in assuring the protection of the civil rights of its patients. The Hospital is accredited by the Joint Commission on Accreditation of Hospitals, which requires specific standards concerning our methods of compliance with each of the patients' rights described in the JCAH Consolidated Standards for Psychiatric Hospitals and Standards for Mental Health Centers.

During the past year, the Patient Advocate's Office developed a monthly Patient Advocacy Newsletter to provide a means for distributing information on local and national issues to patients and to report on achievements of patients' actions. Staff from the Patient Advocate's Office and the Hospital's Legal Office have also continued joint training sessions on the rights of institutionalized patients, both in the Hospital, for staff, and outside the hospital, for community groups. The goal of these training sessions is to continue educating employees and the community on patients' rights issues in order to prevent violations of patients' rights.

Additionally, in order to ensure that the reorganization of the District of Columbia's mental health system mandated by Public Law 98-621 will occur by October 1987, staff from the Legal Office,

and the Patient Advocate's Office actively participated in the development of a proposal for city-wide mental health advocacy for all patients in the new system.

Finally, in the last year, to recognize patients' assistance and actions in assuring the enhancement of quality patient care at Saint Elizabeths Hospital, the Hospital held its first awards program for patients.

In all of these ways, St. Elizabeths Hospital continues to take the steps necessary to assure full protection of residents' civil rights.

The Bureau of Prisons (BOP), which operates the federal prison system, continues to take significant steps to ensure the protection of the constitutional rights of persons under its authority.

The standards to which the Bureau of Prisons adheres are those developed jointly by the American Correctional Association and the Commission on Accreditation for Corrections. These standards cover every area of correctional management and operation and include all the basic requirements related to life/safety and Constitutional minima.

In FY 1985, the Bureau of Prisons continued its efforts to have all BOP facilities accredited. The Commission granted initial accreditation awards to three Bureau facilities and reaccreditations to five others, bringing the total accredited Bureau facilities to 37. Under the terms of the accreditation contract and award, each accredited institution must successfully undergo a reaudit every three years to keep its accreditation status continuous. Accredited institutions are also subject to interim audits by the Commission to monitor ongoing compliance with the standards, particularly in the vital areas of inmate rights, health care, security, safety and sanitation.

In addition, these standards have been incorporated into national Bureau of Prisons' policy. Each federal institution's

program and operation is audited for compliance with national policy every 12-18 months through the Bureau's Management Audit Program.