U.S. Departm of Justice

Office of Legislative and Intergovernmental Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

1 MAY 198?

The Honorable Jim Wright
The Speaker
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

As required by 42 U.S.C. §1997(f), we are submitting copies of the report of the Attorney General to Congress regarding activities initiated pursuant to the Civil Rights of Institutionalized Persons Act during Fiscal Year 1986.

Sincerely,

John R. Bolton
Assistant Attorney General

Enclosures

cc: Honorable Peter W. Rodino, Jr.
Honorable Hamilton Fish, Jr.
Honorable Don Edwards
Honorable F. James Sensenbrenner, Jr.

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The Honorable George Bush
The President
United States Senate
Washington, D.C. 20510

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1986 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 1986, 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, 1986.

ACTION TAKEN IN FISCAL YEAR 1986

During fiscal year 1986, the Department filed seven lawsuits pursuant to the Civil Rights of Institutionalized Persons Act of 1980. Four of these lawsuits were settled by consent decrees and the other three are presently in discovery in preparation for trial.

The Department initiated twenty-one new investigations: four concern mental health institutions, five involve mental retardation facilities, one concerns a public nursing home, three involve prisons, six concern local jails and two others address conditions at juvenile detention facilities. We terminated investigations of two mental health facilities, 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 requirements.

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

- On March 13, 1986, we informed Michigan Governor James Blanchard of our findings of constitutional deficiencies at Kalamazoo Regional Psychiatric Hospital in Kalamazoo, Michigan. Our letter addressed violations of patients' rights with respect to staffing, medical practices, seclusion, and protection from harm. Recommended remedial measures included hiring sufficient numbers of qualified staff, the provision of adequate medical care, medication practices which comport with accepted minimum professional medical standards, professionally designed treatment programs sufficient to avoid unreasonable risks to personal safety and undue bodily restraint, and appropriate use of seclusion. We are currently finalizing the terms of the consent decree negotiated with the State of Michigan which will remedy the above deficiencies.

- Negotiations with the State of California have failed to produce an adequate consent decree to correct constitutional deficiencies identified by our investigation of Atascadero State Hospital. 1/ To facilitate evaluation of enforcement alternatives under the statute, the facility was retoured in August 1986 by a consultant psychiatrist. Deficiencies of a constitutional dimension remain. The entire matter is under review.

1/ This case is different than Atascadero v. Scanlon, 105 S. Ct. 3142 (1985), where the United States participated as amicus curiae, in which the Supreme Court held that the Eleventh Amendment was a bar to suits against states for retrospective monetary relief under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794.

- On May 28, 1986, following extensive expert tours of the facility, we notified California state officials of the findings of our investigation of Napa State Hospital, Napa, California. We informed Governor Deukmejian of insufficient number and training of staff, inadequate medication practices, misuse and excessive use of seclusion and restraint, serious deficiencies in fire safety, inadequate recordkeeping and the failure to provide psychiatric treatment sufficient to avoid unreasonable risks to personal safety and undue bodily restraint. Consent decree negotiations have not yet produced an adequate settlement. The matter is under review.

- On September 10, 1985, we notified Governor Michael Dukakis of our intent to commence an investigation of conditions of confinement at Westboro State Hospital, Westboro, Massachusetts. On December 1, 1986, we notified Governor Dukakis of our findings of our investigation of conditions of confinement at Westboro State Hospital, Westboro, Massachusetts. Our letter addressed violations of patients' rights with respect to staffing, an unsafe and unsanitary environment, recordkeeping practices, medical care, bodily restraint, treatment and training, and personal safety. Recommended remedial measures included hiring sufficient numbers of qualified staff; the immediate correction of environmental deficiencies and unsanitary practices; the provision of adequate medical care; medication practices which comport with minimum professional standards; appropriate use of seclusion and restraint; professionally designed treatment and training programs sufficient to avoid unreasonable risks to personal safety and freedom from undue bodily restraint; and other matters regarding personal safety of hospital patients. Settlement negotiations are pending.

- On January 3, 1986, we notified Governor Mario Cuomo of our intent to investigate conditions at the Buffalo Psychiatric Center in Buffalo, New York, a residential care and treatment center for 740 mentally ill persons. In June, 1986, we conducted investigatory tours of the facility to assess the adequacy of medical and mental health care. We are currently assessing the consultants' findings, and will thereafter compile our conclusions and apprise the Governor of our findings.

- On May 12, 1986, we notified Governor Richard Bordallo of our intent to investigate the Agana Lock-Up, Agana Adult Correctional Facility and the Mental Health Unit located in Guam. In July 1986, we conducted fire safety inspections of all three facilities.
- On March 6-7, 1986, we conducted an on-site inspection of conditions at the Vermont State Hospital (VSH), pursuant to our December 17, 1985, notice of intent to investigate under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997. VSH is a 200 bed facility for the mentally ill located in Waterburg, Vermont. Although we determined that it was appropriate for VSH to continue to recruit additional nurses and psychiatrists, we concluded that VSH provides generally adequate programs of training, medical and psychiatric care that do not deprive VSH residents of any federal constitutional rights. Accordingly, on May 8, 1986, we notified Governor Kunin that we were closing our investigation.

- Following our notice to Governor Celeste of our intent to investigate conditions at Montgomery Developmental Center, we conducted expert tours of the facility. Our medical consultant assessed resident safety, staffing, training programs, general medical care, and medication practices at this residential mental retardation facility. We are currently assessing the consultants' reports, and will thereafter compile our conclusion and apprise the Governor of Ohio of our findings.

- 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. On March 25, 1986, based upon the findings and recommendations of our expert consultants, we notified the Governor and all appropriate state officials that conditions at Ellisville violated the constitutional rights of the residents of that institution. Specifically, these residents were being subjected to a pattern or practice of misuse of medication as well as inappropriate seclusion and restraint, inadequate protection from harm, and exposure to hazardous environmental conditions. We are continuing in our efforts to resolve these problems through consent decree negotiations.

- On July 28, 1986, we notified Governor Victor Atiyeh of the findings of our investigation of the Eastern Oregon Training Center in Pendleton, Oregon. The letter set forth the conditions which deprive residents of their constitutional and statutory rights including constitutionally inadequate training, inadequate recordkeeping, inadequate staffing and a failure to provide a free appropriate public education to school-age residents. The letter also set forth conditions of inadequate medical care, including use of psychotropic medications, sanitary practices, physical care of handicapped residents and general health care. At the State's request, our consultant retoured the facility in September 1986.

° On April 1, 1986, we notified Ohio Governor Richard F. Celeste of our intention to investigate conditions at the Cleveland Developmental Center in Garfield Heights, the Warrensville Developmental Center in Warrensville and the Broadview Developmental Center in Broadview Heights. Our investigation focuses on reported deficiencies in the area of abuse and lack of supervision of residents, medical care and medication practices, resident training, and environmental safety and sanitation. We have conducted on-site inspections of these facilities with expert consultants in general medical care, psychoactive medication practices, and training. Our investigation is continuing.

° On April 18, 1986, we notified Governor Thompson of our intent to investigate conditions at the Howe Developmental Center in Tinley Park, Illinois. The investigation was initiated on the basis of information which alleged unconstitutional conditions of confinement. The facility was inspected by an expert consultant in September 1986. Our investigation is continuing.

- On August 8, 1986, we informed Governor Thornburgh of our intent to investigate Ebensburg Center in Ebensburg, Pennsylvania, a residential mental retardation facility. Our investigation is focused upon abuse, lack of supervision, inadequate staffing, undue use of restraints, inadequate medical care - including misuse of medications - and denial of training sufficient to avoid unreasonable risks to personal safety and freedom from undue bodily restraint at the approximately 600-bed facility for the mentally retarded. Our investigation is continuing.

- On September 11, 1986, we notified Governor Thornburgh of our intent to investigate Embreeville Center in Embreeville, Pennsylvania, a 300-bed mental retardation facility. Our investigation is focused on resident safety; staffing; training for residents; undue bodily restraint; psychotropic drug usage; general health care; and environmental conditions. Our investigation is continuing.

- Following continued monitoring of remedial measures undertaken by the State of Oklahoma at the Pauls Valley State School (PVSS), and a meeting between Assistant Attorney General Reynolds and state officials, on May 2, 1986, we notified Governor George Nigh that the Department was closing its investigation. Since we issued our initial investigative findings in 1983, the staff to patient ratio at PVSS has increased nearly one-third and the annual budget has been increased by $4 million. In addition, PVSS implemented procedures to ensure the safe administration and review of behavior management drugs. Educational programming for school-age residents and resident training were increased substantially, and the addition of critical treatment staff wrought significant improvements in medical care. These voluntary remedial measures served to bring conditions at Pauls Valley State School into compliance with constitutional requirements.

- On May 30, 1986, we notified Supervisor Leon Williams of our intent to investigate conditions at the Edgemoor Geriatric Hospital in Santee, California. The investigation was initiated on the basis of information which alleged unconstitutional conditions of confinement. The facility was inspected by two expert consultants in August 1986. We continue to evaluate information received during this tour and from other sources.

° 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 being subjected to abuse, violence, overcrowding, lack of staff and inadequate security. Suit was filed against County officials on March 27, 1986, after they declined to permit the Department access to the facilities and documents without the Department subjecting itself to the jurisdiction of the Presiding Juvenile Court Judge. A permanent injunction was granted on May 9, 1986, enjoining the County from relying on state law to block the investigation. United States v. Los Angeles, 635 F. Supp. 588 (C.D. Cal. 1986). The investigation then continued, and findings are currently under review.

- On March 28, 1985, we notified Mayor Dianne Feinstein and the San Francisco Board of Supervisors of our impending investigation of the Youth Guidance Center (YGC), 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 being subjected to abuse and violence, overcrowding, lack of staff and lack of security. Based on an evaluation of the facility by expert consultants, we notified the Mayor and the County on August 26, 1986, that the constitutional rights of the juveniles are being violated by the unnecessary and excessive use of isolation, unhealthy restrictions on bathroom use, and illegal interference with mail and the telephone.

- On December 11, 1985, the Department notified Governor George Deukmejian of California of its intention to investigate conditions at the Preston School of Industry. The Department initiated the investigation on the basis of information that youths at the facility were being subjected to violence; lack of security, supervision, and staff; inappropriate use of chemical restraints; and overcrowding. On September 10, 1986, we notified the Governor that the constitutional rights of the youth are being violated by the inappropriate use of chemical restraints, fire safety deficiencies, lack of staff, and overcrowding. We have met with state officials and counsel to discuss these findings, and the State has responded in part to them. The matter is under review.

- On January 6, 1986, we notified Peter Shapiro, County Executive, of our intent to investigate conditions at the Essex County Youth House in Newark, New Jersey. The facility was inspected by an expert consultant in March 1986. On July 23, 1986, we notified Mr. Shapiro of the findings of our investigation. The letter set forth the conditions which deprive youths of their constitutional rights, including inadequate fire safety, abuse, violence and arbitrary administration of punishment, unsanitary and unsafe environmental conditions and overcrowding. We are currently conducting negotiations with the County concerning these conditions.

- On December 16, 1985, we sent notice to Mr. Albert Olexia, Chairman of the Jefferson County Commissioners, of our intent to commence an investigation of the Jefferson County Jail located in Steubenville, Ohio. The jail facility houses approximately 45 prisoners. The information we received suggested serious deficiencies in fire safety. After tours with expert fire safety consultants, we notified Mr. Jerry Krupinski, Chairman of the Jefferson County Commissioner, of our findings. We informed Mr. Krupinski of the failure to provide adequate fire safe conditions exposing prisoners to unreasonable risks to their personal safety. Consent decree negotiations are in progress.

- On March 11, 1986, we notified officials of Hinds County, Mississippi, that we were initiating an investigation into the practice of confining non-criminal mentally-ill persons to Hinds County Detention Center without providing mental health care and appropriate safeguards. We subsequently toured the facility and met with county officials. On June 26, 1986, a state Chancery Court upon its own motion issued an order enjoining the confinement of persons to the detention center under such conditions and requiring, instead, that they be housed in one of two local medical facilities. In view of the Chancery Court order, we indicated we would take no further action at that time but would continue to monitor the facility to insure that the unconstitutional conditions of confinement we had observed would not recur.

- Our Civil Rights of Institutionalized Persons Act investigation of the Sandusky County Jail, Fremont, Ohio, is continuing. The focus of the investigation is fire safety issues.
- On September 17, 1986, the Department notified the Alameda County Board of Supervisors of its intention to investigate the Santa Rita Jail in Pleasanton, California. The Department initiated the investigation on the basis of information that inmates at the facility were being subjected to violence; lack of security, supervision, and staff; inadequate medical care; and overcrowding. We have toured the facility with expert consultants, and findings are currently under review.

- On May 5, 1986, this Department notified the Los Angeles County Commissioners and Sheriff Block that our investigation on conditions of confinement at the Los Angeles County Jails would be closed. After a careful review of fire safety and conditions of incarceration, a review of plans for the alleviation of overcrowded conditions, and a review of existing private litigation pertaining to these facilities, we concluded that the jails were being operated in conformity with constitutional requirements. Moreover, additional plans of correction currently being implemented convinced us that further action by the Department is not presently warranted.

- Following the conclusion of a criminal investigation of alleged guard on inmate brutality at the Clinton Correctional Facility, Clinton, New York, the matter is under review to determine what, if any, further action is warranted.
- 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 Correction. The investigation, which is still in progress, is focusing on allegations that inmates are subjected to violence, brutality, and inadequate medical care, and that their access to courts is being denied.
- On December 9, 1985, we initiated an investigation of Missouri Training Center for Men, Moberly, Missouri. We have conducted several days of tours of the facility and negotiated the release of numerous documents. We are currently reviewing the information obtained from the state and the findings of our expert consultant.

° On February 18, 1986, we notified Governor John Carlin of our intent to investigate the Kansas State Penitentiary in Lansing, Kansas. The investigation was initiated on the basis of information which alleged unconstitutional conditions of confinement. The prison was inspected by two expert consultants in June 1986. We are continuing to evaluate information received during this tour and from other sources to determine whether conditions are violative of inmates' rights.

- On June 5, 1986, the Department notified Governor Ariyoshi of Hawaii that our investigation of the Oahu Community Correctional Center would be closed. As a consequence of our investigation, and a settlement of a private class action lawsuit brought by the ACLU National Prison Project, we determined that there is an adequate remedial plan of compliance in effect. Therefore, separate litigation under the Civil Rights of Institutionalized Persons Act was not deemed necessary in this instance. Hawaii has undertaken a plan of action to alleviate overcrowding at the prison, has improved medical services, sanitation, and is engaging in extensive architectural renovation of existing buildings to bring them up to acceptable levels of fire safety.

- The Department continued its investigation of Sing Sing Correctional Facility in Ossining, New York. Our investigation focused on medical care and treatment provided at the facility. We conducted an inspection tour, reviewed medical records and interviewed staff and prisoners. On August 13, 1986, we notified Governor Mario Cuomo that we were closing our investigation of the facility due to the absence of any continuing constitutional violation.
- We continue to monitor 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, in the areas of fire safety, the provision of adequate psychiatric treatment and the use of bodily restraints. Monitoring will continue.

- The Department continued to monitor efforts by the defendants to comply with our settlement agreement in U.S. v. Newark, et al. During the fiscal year, we conducted inspection tours of the facility with Civil Rights Division personnel and an expert consultant, reviewed institutional documents and conducted interviews with staff and prisoners. The defendants and two judicially appointed special masters were notified of those areas that needed further efforts. In addition, Judge Ackerman ruled the United States was immune from the assessment by the two Special Masters of fees and expenses.

- The United States has continued to monitor the State of Maryland's compliance with the consent decree, entered on January 17, 1985, regarding Rosewood Center, Owings Mills, Maryland, a facility for persons with mental retardation. After several expert tours of Rosewood we found that the State was not in compliance with several provisions of the consent decree related to direct care staffing and resident training. As a result, on June 4, 1986, the United States entered into a Stipulation with the State, which included an extensive plan by the State to upgrade conditions at Rosewood in order to achieve compliance with the consent decree. A recent expert tour of Rosewood demonstrated that the State has still failed to achieve compliance in several significant areas. The matter is under review. We will meet with state officials to determine what immediate steps can be taken to resolve these deficiencies. Absent such viable alternatives, we will consider other remedies available to us, including the initiation of contempt proceedings against the State.

- 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. To meet the terms of the agreement, Bedford County has determined that it will construct a new facility. County bonds to cover construction costs have been issued and the new jail is scheduled for completion in FY 1987. In the interim, fire safety appliances have been installed in the old jail and a system of classification and surveillance has been implemented.

- 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 nearing completion of the discovery stage. Negotiations with the State continue.

- The Ada County Jail, Boise, Idaho, is the subject of a May 23, 1985 consent decree requiring remediation of various constitutional deficiencies including the failure to provide adequate security to inmates. The implementation of remedial measures is being monitored.
- In 1986, we continued our monitoring of conditions at the Talladega County Jail in Talladega, Alabama, the subject facility of a 1985 settlement agreement. We will continue monitoring until the decree's termination in July 1987.

- 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 number 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. On June 24, 1986, we signed and filed with the United States District Court in Columbia, a comprehensive settlement agreement addressing each of the areas of deficiency set forth in our notice letter. We are currently monitoring implementation of that agreement.

- On July 10, 1986, we filed a settlement agreement resolving our investigation of the Wheat Ridge Regional Center in Wheat Ridge, Colorado. The State agreed to certain specific staffing ratios and to provide adequate training, physical therapy services, and specialty medical care. Additionally, the State agreed to provide adequate coverage of certain staff on all shifts and that direct care staff would not be used for housekeeping. The State filed implementation plans simultaneously with the settlement agreement providing for the above mentioned conditions as well as adequate recordkeeping, protection of residents from harm, and the management of medications. The decree was entered by the Court on July 22, 1986 and is to be fully implemented by July 1, 1988.

- During 1986, we concluded our negotiations with the State of Connecticut concerning conditions at Southbury Training School. A consent decree was filed with the Court on July 25, 1986, in which the State agreed to make immediate improvements in fire safety, night shift staffing, some medical staffing and appropriate use of restraints. Additionally, the State filed a plan of implementation which set out steps to be taken to meet certain staffing ratios, to provide for adequate resident training, recordkeeping, medical care, and drug and restraint usage, as well as reasonable protection from harm. The decree requires that constitutional conditions be provided no later than February 15, 1988. We are currently monitoring compliance with the decree.

- On July 28, 1986, the United States filed suit against the State of Oregon and Oregon officials pursuant to the Civil Rights of Institutionalized Persons Act. The lawsuit followed a three year long investigation of the Fairview Training Center (Fairview), a large state-operated mental retardation facility in Salem, Oregon, during which time the State of Oregon failed to voluntarily correct constitutional and statutory violations at the facility and refused to enter into a consent decree to correct the conditions. United States v. Oregon is the first contested lawsuit involving a mental retardation institution filed by the Department pursuant to the Act. The complaint alleges that the more than one thousand Fairview residents are being deprived of their due process rights under the Fourteenth Amendment. The pattern or practice of alleged constitutional violations includes: (1) a failure to provide minimally adequate training to protect Fairview residents from bodily injury and unreasonable use of restraints; (2) a failure to provide adequate medical care; (3) a failure to protect Fairview residents from serious health hazards arising from sanitation practices and environmental conditions; (4) a failure to protect

residents from unreasonable risks of harm to their personal safety by the conduct of staff or other residents; and (5) a failure to ensure an adequate number of sufficiently trained staff to render and implement professional judgments regarding necessary care, medical treatment, and training of Fairview residents. The complaint further alleges that Fairview residents are being deprived of their right to a free, appropriate public education under the Education of the Handicapped Act. This is also the first contested lawsuit in which federal statutory violations are being litigated. Preliminary motions have been filed by both parties and this case is now in its discovery stage.

- On August 7, 1986, the United States and the State of Michigan entered into a consent decree remedying constitutional deficiencies found by the United States in the course of its investigation of Northville and Ypsilanti Regional Psychiatric Hospitals. Under the consent decree, the State is obligated to conform institutional practices to constitutional standards. 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 professionally designed treatment and training programs; adequate food, clothing, shelter and medical care; use of restraints and seclusion; drug use; and protection of patients from harm. The State has filed plans and reports with the United States District Court for the Eastern District of Michigan as required by the decree. The Department is currently reviewing these plans to ensure that they are sufficient to implement the requirements of the consent decree.

- On December 24, 1985, we informed Governor Toney Anaya of the findings of our investigation of the Fort Stanton Hospital and Training School, an institution for the mentally retarded. Our notification discussed deficiencies in the areas of medical care and medication practices. On June 5, 1986, the United States proposed the settlement of the matter by way of a consent decree. The proposed decree included remedial measures addressed to staffing deficiencies, dangerous medication practices, and misuse of restraints. The State rejected our proposal, and on August 8, 1986, we filed a complaint in U.S. v. New Mexico.

- On March 6, 1986, we notified Governor Thompson of our intent to close our investigation of the Manteno Mental Health Center, as the State had decided, and in fact did close that facility in an effort to consolidate and improve mental health services in Illinois. At that same time we advised Governor Thompson of deficiencies in staffing and medical and psychiatric care at the Elgin Mental Health Center. Negotiations are continuing.
- On January 23, 1986, we notified Governor Juan Luis of the findings of our investigation of the Golden Grove Adult Correctional Facility on St. Croix, Virgin Islands. The letter set forth conditions which deprive inmates of their constitutional rights including inadequate fire safety, inadequate staffing and security, inadequate sanitation and deficient medical care amounting to a deliberate indifference to the serious medical needs of inmates. The matter is currently the subject of consent decree negotiations.

- The Department continued its investigation of the Julia Tutwiler Prison in Wetumpka, Alabama during FY 86. On March 24, 1986, we notified Governor George C. Wallace and all appropriate state officials that with respect to equal protection under the law relating to vocational and educational training programs for women, significant constitutional violations continue to exist at the facility.
- The Metropolitan Developmental Center, an institution for the mentally retarded is the subject of a continuing CRIPA investigation. In April 1986, we met with state officials to discuss settlement. The State refused our proposal to enter into a Consent Decree. In June 1986, we conducted a re-investigation of the facility. On August 22, 1986, we notified the Governor of the updated findings of our investigation, and included a proposed consent decree. Negotiations continue.

- The Department continued its investigation of the California Medical Facility in Vacaville, California. Our investigation has focused on conditions of confinement afforded the residents confined at the facility. We have conducted several on site consultant inspections, reviewed medical records, and interviewed staff and residents. We are currently assessing the consultants' reports, and will thereafter compile our conclusions and inform the Governor of California of our findings.

• In U.S. v. Michigan, a lawsuit which addresses conditions of confinement at the state prisons located in Jackson, Ionia and Marquette, the United States has continued to monitor and vigorously enforce the requirements of the consent decree entered by the Court on July 16, 1984. The United States has expended significant time reviewing the State's compliance documentation, assessing the adequacy of state plans, touring the subject facilities, negotiating and entering into several stipulated agreements with the State as well as participating in evidentiary hearings in order to seek supplemental relief from the Court concerning issues of noncompliance. As a result of these efforts by the United States, the State of Michigan has significantly improved conditions at the subject facilities, i.e., 1) hired additional fire safety officers, environmental sanitarians, librarians and health care staff; 2) implemented and expanded training programs for staff; 3) prohibited the use of inmate employees in providing health care delivery; 4) renovated all cell blocks at Marquette Branch Prison; 5) opened a new hospital at the State Prison of Southern Michigan; 6) improved the sanitation and the quality of food service at the subject facilities;

7) implemented strict standards and procedures for the use of psychotropic drugs; 8) implemented a system for the identification, care and follow-up treatment of those inmates with serious mental health and medical care needs; 9) replaced all missing and mutilated law books; and generally improved fire safety, sanitation, ventilation, plumbing and lighting at the subject facilities. The United States will continue to monitor the State's compliance with the requirements set forth in the consent decree until all institutional conditions meet constitutional standards.

FEDERAL INSTITUTIONS

- 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.

- Saint Elizabeths Hospital has continued to make good 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 patient's rights described in the JCAH Consolidated Standards for Psychiatric Hospitals and Standards for Community Mental Health Center. In the last year and a half Hospital staff (particularly from the Patient Adovcate's Office) have been extensively involved in the creation of a plan for advocacy services for patients in the new comprehensive mental health system mandated by Public Law 98-621. In addition, in terms of activities at Saint Elizabeths Hospital, the Superintendent recently declared a special "Patients' Day" which included a special program coordinated by the Patient Advocate's Office, and attended by 520 patients and staff. Guest speakers included ex-patients from Saint Elizabeths Hospital and Maryland. Awards were given to patients and staff for their support of the patient rights' program. Also, Saint Elizabeths Hospital's Patient Advocate's Office

continues to provide staff and community training on patient rights issues, in addition to printing a monthly news letter. 2/

2/ Saint Elizabeths Hospital will remain under the auspices of the Department of Health and Human Services until October 1, 1987 when its control will be transferred to the District of Columbia government. The hospital is the subject of a lawsuit, Dixon v. Weinberger, 405 F. Supp. 974 (D. D.C. 1975), and compliance monitoring is continuing.

- The standards to which the Bureau of Prisons adheres are those developed jointly by the American Correctional Association (ACA) 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, including the provision for an adequate inmate grievance procedure. Thirty-eight of the Bureau's institutions have been accredited by the Commission on Accreditation for Corrections. Under the terms of the accreditation contact 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 for the past five years or so. Therefore, each Federal institution's compliance with standards is monitored through the Bureau's internal audit program, whereby

each institution program and operation is audited for compliance with national policy (based on standards) every 12-18 months.

- The Veterans Administration (VA) has made significant efforts to assure that the civil rights of patients in VA facilities are protected. Of very great importance are 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 to be followed by VA when it is necessary to restrict rights and they establish grievance procedures for patients. VA also seeks to protect patient civil rights by hiring individuals to act as patient representatives, assisting patients in understanding their rights, and acting as advocates in enforcement of those rights. Such representatives are not present in all VA facilities, but there is an increasing number of them throughout the system. Another effort to protect patient rights has been the promulgation of formal regulations to assure that all VA patient care is conducted only with the full informed consent of patients and their representatives. Finally, VA views the receipt of high quality medical care as the right of all patients. VA has a number of internal

mechanisms to ensure that such high quality care is provided. In that regard, we operate the Health Services Review Organization, a peer review program designed to discover and correct problems in the delivery of health care. We 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 the quality of health care. All of these mechanisms serve to protect the civil rights of patients.