THE PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI) PROGRAM ACTIVITIES REPORT FOR FISCAL YEARS 2017 AND 2018

11/25/2020

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INTRODUCTION

This report summarizes the annual activities for Fiscal Years (FY) 2017 and 2018 of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) grantees, funded and administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS). Each PAIMI grantee is required to transmit an annual report to the Secretary of the Department of Health and Human Services (HHS), that describes its program activities, accomplishments, and expenditures during the most recently completed FY.[1] SAMHSA summarizes the grantee activity information and prepares a report, which includes aggregate data for the Secretary.[2]

HISTORICAL OVERVIEW

The Developmental Disabilities Assistance and Bill of Rights Act of 1975, commonly known as the DD Act, established systems in each state, the District of Columbia, and five territories to protect the legal and human rights of individuals with developmental disabilities.[3] These entities, the state Protection & Advocacy (P&A) systems, were governor-designated and approved by the Administration on Disabilities[4] (AoD), within the Administration for Community Living (ACL). The DD Act authorized formula grants to each eligible state P&A system to support activities on behalf of individuals with intellectual and developmental disabilities through the Protection and Advocacy for Developmental Disabilities (PADD) Program, administered by ACL/AoD. ACL/AoD, which oversees the first P&A program, is the lead federal agency on matters pertaining to designation or re-designation of a P&A system.

The PAIMI Act of 1986[5] extended the DD Act protections to individuals with significant (serious) mental illness (adults) and significant (severe) emotional impairments (children/youth) at risk for, or in danger of abuse, neglect, and rights violations, while residing in public or private residential care and treatment facilities. The same AoD-approved, governor-designated state P&A systems that received PADD Program funding were authorized to administer the PAIMI Program.

The PAIMI Act[6] mandated state P&A systems to:

1) Protect and advocate for the rights of residents with significant (serious) mental illness (adults) and significant (severe) emotional impairments (children and youth),[7] residing in public and private care and treatment facilities who are at risk for, or in danger of abuse, neglect, and rights violations by using administrative, legal, systemic or other appropriate remedies on their behalf;

2) Investigate reports of abuse, particularly incidents involving serious injuries and deaths, related to the inappropriate use of seclusion and restraint; and

[1] 42 U.S.C. 10805(a)(7)
[2] PAIMI Act at 42 U.S.C. 10824
[3] 42 U.S.C. 6041
[4] Formerly named the Administration on Intellectual and Developmental Disabilities (AIDD)
[5] 42 U.S.C. 10801 et seq.
[6] 42 U.S.C. 10801(b)
[7] Adults with *significant* mental illness denotes adults with *serious* mental illness. Children with *significant* emotional impairments denotes children with *severe* emotional impairments.

3) Ensure enforcement of the United States Constitution, federal laws and regulations, and state statutes.

In 1986, there were 56 P&A systems located in each state, the District of Columbia, and five territories (American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands). At that time, 45 P&A systems operated as private, non-profit organizations (as designated by the respective state governors). The remaining 11 P&A systems were state or territory operated (Alabama, American Samoa, Connecticut, Indiana, Kentucky, New York, North Carolina, North Dakota, Ohio, the Commonwealths of Puerto Rico, and Virginia) and independent of any state agency that provided treatment or services, other than advocacy services, to individuals with mental illness.[8] However, as of September 30, 2018, there remained five state-operated P&A systems (Alabama, American Samoa, Kentucky, North Dakota, and the Commonwealth of Puerto Rico). In 2000, the PAIMI Act was amended by the Children's Health Act (CHA) of 2000.[9] The CHA established a 57th P&A system for Native Americans, the American Indian Consortium (AIC). The AIC is composed of the Navajo Nation and Hopi tribal councils in the Four Corners region of the Southwest (Colorado, Utah, Arizona, and New Mexico).

The CHA[10] requires "a public or private general hospital, nursing facility, intermediate care facility, or other health care facility, that receives support in any form from any program supported in whole or in part with funds appropriated to any Federal department or agency shall protect and promote the rights of each resident of the facility, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for purposes of discipline or convenience."[11] Per CHA, "each facility shall notify the appropriate agency, as determined by the Secretary, of each death that occurs at each such facility while a patient is restrained or in seclusion, of each death occurring within 24-hours after the patient has been removed from restraints and seclusion, or where it is reasonable to assume that a patient's death is a result of such seclusion or restraint. A notification under this section shall include the name of the resident and shall be provided not later than seven days after the date of the death of the individual involved."[12] The CHA clarified that the state P&A systems had the authority to investigate incidents of restraint and seclusion in these types of facilities. The CHA also allowed state P&A systems to serve PAIMI-eligible individuals who lived in the community, including their own homes; however, individuals residing in care and treatment facilities must have priority for program services.

FUNDING

Each P&A system must submit an annual application or update its annual program priorities, proposed budget/expenditures, the PAIMI Program assurances, and any other information requested by SAMHSA.[13] The annual PAIMI Program awards, subject to availability of appropriations, are based on a formula prescribed by the statute.[14] The PAIMI formula is based equally on the population of each state in which there is an eligible system and on the population of each state

[8] 42 U.S.C. 10801(b)
[9] 42 U.S.C. 290 *et seq*.
[10] 42 U.S.C. 290ii
[11] 42 U.S.C. 290ii (a)
[12] op. cit. at 42 U.S.C. 290ii - 1
[13] 42 U.S.C. 10821
[14] 42 U.S.C. 10822

weighted by its relative per capita income.[15] Relative per capita income is the quotient of the per capita income of the United States and the per capita income of the state. Relative per capita income is not used for American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands. Their quotient shall be considered as one.[16] The Secretary shall use no more than two percent of the amount appropriated, commonly known as the set-aside under the PAIMI Act, to provide technical assistance to eligible systems.[17]

The following table reflects the total annual PAIMI Program grant appropriations, the technical assistance set-aside, and the minimum and maximum grant allotments awarded to the states and territories in FY 2017 and 2018. Based on the final allocations, California, the largest state P&A system, received the maximum state award of $3,140,635 for FY 2017 and $3,101,059 for FY 2018. The minimum state allotment for P&A system grants were $428,000 for both fiscal years. Four of the five territories (American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands) and the American Indian Consortium each received $229,300 for both fiscal years.

	FY 2017	**FY 2018**
To State P&A Systems	$35,319,775	$35,329,908
Technical Assistance Set-aside	$706,396	$706,598
Total Annual PAIMI Appropriation	$36,026,171	$36,036,506
	FY 2017	**FY 2018**
Minimum State Award	$428,000	$428,000
Maximum State Award	$3,140,635	$3,101,059
Minimum Territory Award	$229,300	$229,300

[See Appendix - Table 1]

PAIMI PROGRAM ACTIVITIES

A. Demographic Information

1. Age and Sex

The following tables summarize the number of PAIMI-eligible individuals or clients served in each FY by age and sex.

Age in Years	**FY 2017**	**FY 2018**
0-4	9	7
5-12	660	520
13-18	1,420	1,367
19-25	934	744
26-64	6,738	6,206
65 and over	689	684
Total Served	**10,450**	**9,528**

[15] 42 U.S.C. 10822 (a) (1) (A) (i) and (ii)
[16] 42 U.S.C. 10822 (a) (1) (B)
[17] 42 U.S.C. 10825

Sex	FY 2017	FY 2018
Male	5,508	5,254
Female	3,833	4,243
Unknown	1,109	31
Total Served	**10,450**	**9,528**

[See Appendix - Table 2]

2. Ethnicity and Race

PAIMI clients served by the P&A systems self-identified their ethnicity and race[18]. The following tables provide the ethnicity and racial identities reported by individuals served by the P&A systems. The information was self-reported by clients and individuals/clients served were permitted to select one or more races.

Ethnicity	FY 2017	FY 2018
Hispanic/Latino	1,021	913
Non-Hispanic/Latino	8,328	7,962
Unknown	778	473
Race	**FY 2017**	**FY 2018**
American Indian/Alaskan Native	247	203
Asian	147	129
Black/African American	2,112	1,898
Native Hawaiian/Other Pacific Islander	108	122
White/Caucasian	6,128	6,099
Multiple Race	603	437

[See Appendix - Table 3]

3. Living Arrangements

P&A systems served individuals who resided in various settings. Examples of these living arrangements included:

Living Arrangement Type	FY 2017	FY 2018
Independently in the community	2,163	2,182
Adult community residential home	354	365
Psychiatric hospitals	1,546	1,802
Public and private institutional living	1,197	866
Legal detention/jail	1,613	1,256
Homeless/shelter	217	205
Total	**7,090**	**6,676**

[See Appendix - Table 4]

[18] The total number of PAIMI eligible individuals reported by the P&A programs for the Age and Sex tables and for the Ethnicity and Race tables are not identical. There was no category to indicate an "unknown" value for the data element "race" and no "unknown" value for either "sex" or "age", only the combination of these values. Hence any individual with an unknown "race" or an unknown "sex" or "age" would not be counted in the totals for "race", "age" or "sex". This lapse has been corrected for future data collection.

B. Services for Individuals

Under the PAIMI Act, state P&A systems are mandated to protect and advocate for the rights of individuals with mental illness and authorized to investigate complaints of abuse, neglect, and rights violations.[19] The following table shows the total number of individual PAIMI abuse, neglect, and rights violation cases opened, investigated, and closed.

1. **Abuse**

Number and types of individual abuse complaints investigated and closed per FY included:

Abuse Complaints	**FY 2017**	**FY 2018**
Cases Investigated & Closed	**1,733**	**1,390**
Inappropriate/excessive use of restraints	347	277
Inappropriate/excessive medication	143	126
Involuntary electroconvulsive therapy	2	3
Failure to provide mental health treatment	907	697
Physical assaults resulting in serious injuries	155	153
Sexual assaults	77	59
Staff threats/retaliation/assaults	102	75

[See Appendix - Tables 5]

Case Examples from FY 2017

Alaska

The P&A received an anonymous complaint regarding an incarcerated 31-year-old man with schizophrenia who had been placed in an open population module in the prison, where he was physically and sexually assaulted. The P&A staff contacted the Deputy Director of Health and Rehabilitation at the Department of Corrections (DOC) and found that the inmate was already working with the Prison Rape Eliminator Act Coordinator and the Alaska State Troopers. The inmate was transferred to a different facility and was placed in a sub-acute mental health unit for his protection.

Guam

While detained in prison, a mental health client diagnosed with schizophrenia and bipolar disorder was not receiving appropriate mental health care and treatment, which included seeing a psychiatrist when needed and appropriate medication management. The P&A advocated for the client to be moved to the mental health adult inpatient unit until the client case was transferred to the mental health court system. Upon release from the court system, the client was able to receive the mental health care and treatment needed under the residential recovery program.

Hawaii

The P&A received a call from a 57-year-old client with mental illness living in Maui, who requested help with financial abuse committed against him by his daughter. The P&A advocated

[19] 42 U.S.C. 10805(a)(1)

and investigated the complaint and found that the client's daughter used his money, but since she had financial power of attorney (POA) at the time, there was no legal recourse. As a result of the client's complaint and the P&A's advocacy efforts with his case manager, the POA was terminated and the client secured a guardian through the Office of Public Guardian.

Case Examples from FY 2018

Arkansas

The P&A advocated and investigated an incident of reported abuse at a juvenile assessment and treatment facility, involving a 16-year old PAIMI-eligible male diagnosed with emotional disturbance; attention deficit hyperactivity disorder; bipolar disorder; and oppositional defiant disorder. The client alleged that a staff member of the facility entered the room, where he was lying on the top bunk of a bed, to transfer him to an isolation area. The client stated he refused to move off of the top bunk, whereupon the staff member pulled him off the bunk, causing him to hit his brow on the opposite bunk. The P&A investigated the incident, which included watching videos of the event and interviewing staff. The P&A determined that the technique used to remove the client from the top bunk caused his injury. The staff member was subsequently terminated, and remaining staff members in the unit underwent retraining on de-escalation techniques.

Wyoming

The Wyoming State Hospital (WSH) strapped a pregnant PAIMI-eligible individual to a transport board that the WSH started using as a long-term mechanical supine floor restraint. The patient contacted the P&A and authorized an investigation. The P&A's investigation revealed that the patient was placed on the transport board at one time for one and a half hours. On another occasion when the client was placed on the transport board, it resulted in her not attending a scheduled ultrasound appointment. The P&A obtained and reviewed a video from WSH, which clearly showed that the patient was strapped to a transport board without prenatal medical assessments. WSH's medical records admitted that mechanical chest and abdominal restraints were medically contraindicated during pregnancy. The P&A substantiated neglect for failure to have and follow an appropriate treatment plan and abuse for improper use of a temporary transport device as a long-term mechanical restraint; and abuse for the improper supine floor restraint without medical attention. The P&A reported the findings to appropriate agencies. As a direct result of the P&A's investigation, the use of dangerous restraints ceased for this patient during the rest of her pregnancy.

2. **Neglect**

Number and types of individual neglect complaints investigated and closed per FY included:

Neglect Complaints	**FY 2017**	**FY 2018**
Cases Investigated & Closed	**1,626**	**1,277**
Discharge planning	945	686
Personal care	289	242
Mental health diagnoses	153	110
Environmental safety	48	52
Personal safety	191	187

[See Appendix - Table 6]

Case Examples from FY 2017

Delaware

The P&A received numerous complaints from a 38 year-old resident at the Delaware Psychiatric Center (DPC). The complaints, rising to the level of potential abuse and neglect, included: poor maintenance and cleaning of bathroom facilities; denial of access to telephones; lack of privacy (no shower curtain in communal bathroom); and retaliatory transfer to an inappropriate unit with elderly patients. The P&A investigated and reported neglect concerns to the facility. Regarding the telephones, the facility initiated a plan to install additional phones and to revise its policy. The P&A reported the cleanliness and shower curtain issues to the Delaware Office of Facilities Licensing, which inspected and cited the facility. As a result of the P&A's investigation, the facility developed a correction plan.

Illinois

The P&A was contacted by an elderly resident of a state-operated mental health hospital. The client alleged that the facility was failing to respond to his complaints regarding his health needs, including care for his ears, which was adversely affecting his hearing. The P&A contacted the medical director at the facility and he agreed to have a doctor address the client's complaints right away. The client met with a doctor the next day and reported that the doctor addressed all of his medical needs.

Maine

The P&A was contacted by a 61 year-old woman with mental illness, living in a group home. She informed the P&A that she had reported being assaulted by another resident of the group home, but the staff ignored her reports. The P&A went to the group home unannounced and met with the client and reviewed records. The P&A made a determination that the group home, as a mandatory reporter of abuse, had failed in its obligation by not reporting the client's incident to state licensing. The P&A contacted state licensing. The state licensing did an immediate investigation and issued sanctions against the group home for its failure to report. The group home now has a system in place to always report resident allegations of abuse, including allegations concerning another resident. The client also wanted to move from this group home. The P&A assisted the client with finding another place, and the client successfully moved from the group home.

Case Examples from FY 2018

Alaska

The P&A was contacted by the parent of a child with Post Traumatic Stress Disorder (PTSD). The child had been denied admittance to all residential treatment facilities enrolled in the Alaska Medicaid Program. The parents were concerned that they could not cover the financial cost associated with the child's residential treatment, nor could they bring home their child due to the safety risk he posed to other children in their home. The family requested that the P&A assist them

with appealing the Medicaid denial to pay for their child's treatment. The P&A advised the parents to request a meeting with the Division of Behavioral Health out-of-state placement team for a clinical review of the child's medical records and residential facilities that were capable of providing the appropriate intensive behavioral supports the child needed. This meeting resulted in the child's acceptance to a residential treatment facility in the State of Utah. The P&A was able to contest a Medicaid denial of benefits and ultimately get the child into appropriate treatment.

District of Columbia

The P&A represented a 36 year-old man with serious mental illness who was born in Sierra Leone and has lived in the United States since childhood. The client's immigration attorney contacted the P&A because he was connected to a mental health core service agency (CSA) but was not receiving any services. The P&A was initially told by CSA that the client was not receiving services because he did have active health insurance. When the P&A complained that he was not receiving services, the CSA agreed to assign a case worker and to provide some services. When the client ran out of medication, the P&A worked with a free-standing mental health clinic to provide the medications, with no assistance from his CSA. The P&A also provided information to his CSA about his eligibility for benefits. Since the client was granted asylum status, he was eligible for health insurance but his CSA was not aware of it. The P&A worked with the client and his immigration attorney to apply for the Assertive Community Treatment (ACT) services from a different agency, one which uses a housing first model. The client was accepted by the ACT team, which assisted him with medication management and housing search.

Illinois

The P&A represented a man with anxiety disorder, residing at a high security mental health center, who was placed in the facility after being found not guilty by reason of insanity. He was concerned that he missed getting his medications every time he had to go to court. The P&A viewed this issue as neglect and wrote a demand letter about i. The facility administrator quickly responded and agreed that there were failures in care relating to medication for court trips. In response, the administrator ensured that the facility made policy revisions and also trained staff on these policies. Subsequently, the client reported that he was getting his medications on the days that he was going to court.

Maryland

The P&A investigated a complaint on behalf of a youth with mental illness and Asperger's disorder, who was a resident at a Residential Treatment Center (RTC). The youth was 17 years old and had completed high school. Because he had completed his schooling, the RTC would not permit him to attend school classes during the day. Consequently, while other residents were at school, the client sat in his unit for hours at a time, with virtually no activities or structured programming. He felt that his rights were being violated, due to a lack of meaningful programming and activities that he could access. The P&A advocated for the youth (and future students who may find themselves similarly situated) by bringing this issue to the attention of RTC's leadership and advocating for changes and increased programming. The P&A was able to substantiate that the youth was, in fact, spending much of his day without anything to do. Prior to the resolution of this case, the youth was discharged and is now doing well at a therapeutic group home. The P&A continued to advocate for changes surrounding this issue. As a result, RTC's leadership informed the P&A that they would be

implementing a new, more robust vocational program to offer to future students who find themselves similarly situated.

3. **Rights Violations**

Number and types of individual rights complaints investigated and closed per FY included:

Rights Violations	FY 2017	FY 2018
Cases Investigated & Closed	**537**	**589**
No written treatment plan	185	233
Guardianship/conservator problems	247	234
Problems with advanced directives	78	86
Failure to provide confidentiality	27	36

[See Appendix - Table 7]

Case Examples from FY 2017

Illinois

The P&A assisted a female nursing home resident with major depressive disorder, who was experiencing rights violations regarding privacy rights and right to community passes. The woman had an upcoming care plan meeting and wanted the P&A's advice on how to advocate for herself with respect to those rights violations. First, with respect to the privacy concern, the nursing home was only allowing her to meet with visitors in the lobby. The P&A advised her of her right to meet with visitors in private. At the care plan meeting, the woman provided the information about her privacy rights, and the nursing home has now allowed her to meet with visitors in her room. In addition, her community pass privileges were revoked after the nursing home claimed that she tested positive for alcohol when she returned from a weekend visit. The woman advised the P&A that this couldn't be true because she had not consumed any alcohol for over a year. The P&A advised her that she had a right to see the test results. The woman made a request for the test results at the care plan meeting. Upon making that request, the facility restored her community pass privileges.

Kansas

The P&A received a call from a young woman with severe mental illness, including anxiety, depression, and bipolar disorder. She contacted the P&A because she was unhappy with her guardian and felt that she no longer needed one. In the past, the young woman had been institutionalized and was periodically unstable. The P&A worked with the young woman to show that she was able to take care of herself for several months and had been compliant with medications and therapy. After an evaluation, her therapist was able to report how well the young woman was doing and that she no longer needed a guardian. The P&A filed a petition to terminate the young woman’s guardianship with the court. The court granted the motion and the guardianship was ended.

Rhode Island

The P&A represented a woman regarding a Petition for Guardianship that had been filed by a family member, based upon a Decision-Making Assessment Tool (DMAT) prepared by her former physician at the facility where she resides. The P&A prepared a Motion to Dismiss, but were able to successfully negotiate with the petitioner's counsel that the matter be dismissed, as the client had executed a Durable Power of Attorney for Healthcare, which is an alternative to guardianship. Rhode Island law requires that alternatives to guardianship be ruled out before a Petition for Guardianship is filed. In addition, due to the DMAT being prepared by her former physician at the facility, the P&A offered to provide training for patients and their families and staff regarding alternatives to guardianship. The offer was accepted and the P&A provided two trainings on alternatives to guardianship at the facility during FY 2017.

Case Examples from FY 2018

Arizona

The P&A provided rights violation assistance in the case of a 17-year-old individual who was diagnosed with severe depression at the age of 12 years. The individual's mother contacted the P&A for assistance after the individual had been inpatient at a behavioral health treatment facility for approximately four weeks. The individual's mother alleged that the inpatient behavioral health facility denied the individual's right to appropriate discharge planning, when the facility disregarded the family's request for what they thought was a more appropriate placement. The individual's mother also alleged that the inpatient behavioral health facility had violated the individual's privacy rights. The P&A provided the individual's mother with rights information regarding the individual's right to appeal the failure of the inpatient behavioral health facility to provide adequate discharge planning. The P&A also provided the individual's mother with information on how to file a Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy complaint. The individual's mother was able to advocate for the individual after receiving this information from the P&A.

Iowa

The P&A was contacted by a 33-year-old transgender female diagnosed with bipolar disorder. The client's mother was her guardian and conservator, and she contacted the P&A alleging that her guardian was being overly restrictive and intended to prevent her from transitioning. The client requested assistance terminating the guardianship and conservatorship. The P&A met with the client, obtained and reviewed records, and interviewed the guardian. Following discussion with the P&A, the guardian conceded that the guardianship and conservatorship were no longer necessary, and asked the court to terminate them both, which it did. As a result, the client's rights were restored.

Minnesota

The P&A was contacted by a 61-year-old PAIMI-eligible man, indeterminately committed to the state's forensic mental hospital for individuals with severe mental illness who are considered dangerous. The client stated that he was unable to have legal telephone calls with his court appointed civil commitment attorney in a private area away from hospital staff and other patients. The P&A contacted the hospital administration and outlined the practical necessity and legal rights of the patient to have private phone calls. As a result of the P&A's advocacy, the hospital program

director reviewed the complaint, and agreed with the P&A's analysis. The client was provided a confidential area to make calls, and confirmed that he is now able to complete his telephone calls in private. Although the individual's rights violations have been resolved, during the current federal fiscal year, the P&A staff is following up with the hospital to ensure that this protocol is consistently available to other patients as well.

4. Death Investigations

The PAIMI Act authorized state P&A systems to investigate incidents of abuse, neglect, and deaths that occur in public and private care and treatment facilities on behalf of eligible individuals.[20] Most states had no mandatory reporting statutes, central registries, or other statewide systems to capture incidents of restraint, seclusion, serious injuries, or fatalities. Despite state data collection limitations, the state P&A systems monitored and investigated the use of restraint and seclusion in residential care and treatment facilities, especially incidents involving serious injury or death. States with mandatory reporting requirements and central registries often send all state death reports to the P&A system, whose staff must review the information to determine incidents requiring investigation. Deaths reported by states and CMS, and investigated by state P&A systems and other sources were as follows:

Death Reported by	**FY 2017**	**FY 2018**
States	1,087	786
Centers for Medicare & Medicaid Services (CMS)	1	1
Other	164	187
Deaths Reported Total	**1,252**	**974**

Deaths Investigated, by incident type	**FY 2017**	**FY 2018**
Seclusion (S)	6	14
Restraints (R)	8	9
Non S or R related	261	250
Deaths Investigated Total	**275**	**273**

[See Appendix - Table 8]

Case Examples from FY 2017

Alaska

The P&A received a media report alleging an inmate attempted suicide while incarcerated, and subsequently died. Based on the complaint, the P&A initiated a secondary investigation and found that the inmate's suicide was due to DOC's negligent inaction in response to the inmate's suicidality. The P&A requested an expert consultant to review the records and provide recommendations on what should have been done in response to the inmate's suicidality, and recommended changes to the current DOC Suicide Prevention policy and procedure.

Florida

[20] at 42 U.S.C. 10802 (1), (3), (4), and (5)

The P&A investigated the death of an adult male with psychiatric disabilities, at a state prison. The deceased had a history of major depressive disorder and had a long history of self-injurious behavior. He was being treated in the prison system's equivalent of a crisis stabilization unit. Prior to his death, the deceased had several incidents of suicidal ideation and attempts. Although he made these attempts and wrote a suicide letter, staff at the facility were skeptical regarding the threat, believing that he was exaggerating and seeking attention. On the day of the deceased's death, he attempted to hang himself. Staff intervened approximately forty minutes later. Staff applied handcuffs, leg irons, and a spit guard and placed the client in an observation cell. Unfortunately, he was found to be unresponsive 20 minutes later and was pronounced dead at the hospital. The P&A discovered this death during routine monitoring of the conditions at the various state prison mental health treatment facilities. The deceased was one of several deaths that were determined to be suspicious and warranted further investigation. The P&A's investigation consisted of a review of all mental health, medical, and classification files, in addition to interviewing prison staff, other inmates, and reviewing the autopsy findings. This death, in addition to others, prompted the P&A to hire three prison mental health experts to review the findings and participate in monitoring visits to the prisons. Ultimately, the P&A presented these findings to DOC and are now in mediation to develop an agreement that will improve care and conditions throughout the prison systems in the State of Florida.

Montana

The P&A was contacted about a 15-year-old male with bipolar disorder, who was placed by his family at a Montana adolescent rehabilitation program, essentially an "outdoor wilderness school," where he was left unsupervised long enough for him to commit suicide by hanging. The P&A is now establishing communication with the state regulatory board governing these facilities, to ensure that they are enforcing regulatory compliance, to protect youth with mental illness from abuse and neglect in "wilderness schools."

Case Examples from FY 2018

District of Columbia

The P&A investigated an unexpected, sudden death of a woman in her thirties, due to an intracranial bleed while she was a patient at St. Elizabeth's Hospital. The P&A's extensive review of the medical records and the facility's own investigation report exposed multiple instances of serious nursing and medical neglect. The P&A produced a report entitled "A Patient's Suffering and Death at St. Elizabeth's Hospital." Among the recommendations in the report, the P&A requested that the Department of Behavioral Health (DBH) and the Department of Health develop a plan to ensure that medical and nursing personnel at St. Elizabeth's Hospital are adequately trained, and have the requisite skills to address the patients' needs.

New Jersey

The P&A reviewed the death of s a 49-year-old patient at a private general hospital, who was admitted for abdominal pain and received surgery for an abdominal hernia. While in the hospital, the patient was transferred to the psychiatric unit for psychiatric stabilization. While on the psychiatric unit, the patient became aggressive toward other patients. The patient was medicated by injection, and appeared to be calming down. When staff attempted to place the patient in a

seclusion room, she threw chairs across the room. The patient fought staff who were attempting to physically restrain her until mechanical restraints arrived. A towel was placed over her face to prevent the patient from spitting on hospital staff. The patient's legs and one arm were placed in the restraints, when it was noted that she was unresponsive. Emergency life support procedures were initiated, but she did not respond, and was pronounced dead. As a result of the patient's death, the hospital completed an intensive root cause analysis (RCA). The P&A communicated with the hospital's attorneys, to ensure that the RCA's many recommendations were implemented. The P&A reviewed the documentation, to ensure that all recommendations were appropriately implemented. The family hired a private attorney to file a wrongful death complaint. The P&A closed the file after receiving assurances that the hospital had implemented the new procedures.

North Carolina

The P&A, as a result of a detailed complaint filed with regulators following an investigation, investigated the death of a young woman with mental illness. The P&A took the case for investigation after it received a death report about the young woman, who died in seclusion in the hospital's emergency room, following involuntary commitment. The findings were significant, because regulators looked at the death during an annual "recertification" survey of the hospital and did not find any deficiencies. After conducting a three-day investigation, based on our complaint, regulators determined that the hospital had violated CMS regulations related to the use of seclusion. The hospital's Plan of Correction included rewriting hospital policy and retraining staff about the circumstances under which seclusion may be used and must be discontinued and the monitoring procedures during and following the seclusion that must occur.

5. Complaints Favorably Resolved for Clients

The case examples in section (1) Abuse, (2) Neglect, and (3) Rights violations provide information on the types of favorable outcomes achieved on behalf of individual P&A system clients. The following table shows the total number of individual PAIMI complaints investigated, closed, and resolved.

Complaints Investigated and Closed, by type	FY 2017	FY 2018
Abuse	2,397	1,902
Neglect	2,021	1,654
Rights violations	4,597	3,976
Total	**9,015**	**7,532**

[See Appendix - Table 9, 10, & 11]

6. Intervention Strategies

The P&A systems are authorized by the PAIMI Act[21] to pursue administrative, legal, and other remedies, to ensure protection for individuals with mental illness. An individual's initial complaint may involve multiple issues, and P&A systems often use several strategies to resolve them. The total strategies used often exceeded the number of complaints investigated and closed in a FY, as clients' initial complaints frequently include multiple issues and various strategies are used to resolve them.

[21] at 42 U.S.C. 10805 (a) (1) (C)

Intervention Strategies, by Type	FY 2017	FY 2018
Short-term assistance	4,841	4,041
Abuse & neglect investigations	1,294	1,028
Technical assistance	1,222	1,030
Administrative remedies	288	329
Negotiation/mediation	1,146	877
Legal remedies	288	284
Total Intervention Strategies	**9,079**	**7,589**

[See Appendix - Table 12]

Case Examples from FY 2017

Arizona

The P&A provided short-term assistance in the case of a 17-year-old male with mental illness. The individual's mother contacted the P&A for assistance because Mercy Maricopa Integrated Care (MMIC), the Regional Behavioral Health Authority for Maricopa County, neglected the individual, as a result of its failure to provide for appropriate discharge planning from the inpatient behavioral health facility in which the individual was residing. The individual was discharged from his inpatient behavioral health facility to a group home too early, which resulted in the individual becoming violent and ultimately incarcerated. The P&A provided the individual's mother with verbal and written information on the right to file a grievance with MMIC. The P&A also provided the individual's mother with referrals to additional legal resources. With the information the P&A provided her, the individual's mother was able to advocate on the individual's behalf.

Colorado

The P&A received a complaint from a 48-year-old client with mental illness, who was residing in public housing. The client had recently received a notice denying his request for an assistance animal from the local housing authority, stating that the animal barked and was a nuisance. The housing authority received this information from the client's neighbors. The client was adamant that the neighbors were lying, and his dog was not causing any additional noise. The client has difficulty regulating his emotions, due to his disability, and his dog allows him to stay calm and conflict free in his home. The client had paperwork to support his need for the animal. The P&A reviewed documents provided by the client, met with him multiple times at his home, and assisted him in gathering evidence to support his claims. The P&A also assisted the client in following the housing authority appeal process. The P&A organized an informal grievance meeting with the local housing authority, to advocate for the client. Ultimately, the housing authority allowed the client's dog as an assistance animal, as long as the client filled out some additional paperwork. The client was facing possible eviction due to this issue, and the P&A provided a reasonable solution for him to keep his housing.

Maryland

The P&A investigated the cases of three patients at a state psychiatric hospital, who were secluded in their bedrooms for nearly 24 hours a day, in a new hospital policy called "zoning," where patients with difficult behaviors were made to stay in their room continuously. The P&A's investigation

found that at least two of the patients had been required to stay in their rooms for over two years. The P&A also noted that the patients' behavior management plans were inadequate, and not aimed at preventing violent behavior or understanding the causes of the behavior. Further, the P&A's investigation revealed that at least one of the patients was diagnosed with an intellectual disability that made it difficult to conform to hospital rules. The P&A contacted the hospital administration, to request that zoning of clients be ended. When this request was unsuccessful, the P&A filed a complaint with the Office of Health Care Quality, who filed a Deficiency Report. The hospital was required to file a plan of correction, and the P&A's clients reported that they have enjoyed being out of their rooms and participating in hospital groups and activities.

North Dakota

A 49-year-old woman, with a diagnosis of major depression and history of overmedicating on prescription drugs, lived alone in an apartment in Bismarck, ND. The client worked in an administrative position, and had an established history of good performance. The client was terminated from her job while taking an approved leave of absence for mental health treatment. As a result of this action, the client suffered financially, had to move, and ended up reaching out to nonprofit agencies for financial assistance. She eventually worked two jobs to make up for what she was paid at her former employment. The P&A assisted the client to file a complaint with the North Dakota Department of Labor (NDDOL). An investigation was done and a "no cause" determination was made by the NDDOL investigator, despite strong evidence that disability-related discrimination had occurred. The P&A filed an employment discrimination complaint in court on the client's behalf. The employer ultimately entered into negotiations and a very healthy settlement was reached on behalf of the client.

Case Examples from FY 2018

Connecticut

The P&A received a call from an individual who was residing in a public mental health facility. The individual was experiencing gynecological issues and despite repeated requests, had not been taken to see a doctor. The P&A got involved, met with the client, reviewed the record, and approached the administration regarding lack of medical treatment. The P&A pursued the issue and the individual was able to see a medical professional about her issues.

District of Columbia

The P&A represented a 51-year-old man with serious mental illness, who was discriminated against by his graduate program. When the university learned that he had mental illness they suspended his participation in the program, and required him to get documentation from a psychiatrist that he was fit to be in the program. He was not then seeing a psychiatrist, so he was forced to pay $1,000 for a psychiatrist to evaluate him. The psychiatrist found him fit to be in the program. Then, the university disclosed to a prospective employer that he had a mental illness. The P&A wrote a letter to the university, asking that the client be reimbursed for the evaluation and compensated for the time he was suspended and the delay in his employment, after the illegal disclosure of his mental illness. The P&A also recommended training for the university on their requirements under Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. When the university failed to address his concerns the P&A assisted the client in filing a complaint with the

Office of Human Rights, alleging the university violated ADA, Section 504 of the Rehabilitation Act and the District of Columbia Human Rights Act. The parties were sent to mediation, and were able to negotiate a confidential settlement that addressed the client's concerns.

Idaho

The P&A filed a complaint with a state psychiatric hospital on behalf of a 32-year-old female diagnosed with chronic PTSD and anxiety, alleging rights violations regarding safety and mental health care. The client contacted the P&A because she felt that the facility doctor was not listening to her when she talked about emerging symptoms, to the point that an outside physician had to be called to order anxiety medication one night, when she had a panic attack. She also complained that the staff did not address safety concerns, in that a box knife was left on the unit floor by contractors replacing floor tile, within reach of the patients. Patients were concerned and upset, with some wanting to use the knife and others afraid for their safety, so the client told staff. Her concerns were ignored, until she threatened to go to the administration; staff then asked the contractors to pick up their tools, including the knife. The P&A reviewed policy and filed a grievance with the Patient Advocate at the facility. The Patient Advocate reviewed video of the incident, and stated that he would provide further training to the contractors while they are working at the facility. The Patient Advocate also forwarded the complaint to medical staff. The client was satisfied with the remedy, and was soon discharged.

C. Class Action Litigation

To ensure compliance with federal or state laws and regulations and when immediate action is needed to protect a group of individuals, state P&A systems may use class litigation.[22] This type of litigation is a strategy of last resort. This complex strategy often takes years to resolve the presenting problem, and requires special staff expertise, resources, and time. These types of cases generally involve a range of issues that affect the lives of individuals or groups of individuals with mental illness and other disabilities and their families. Class action activities reported by the P&A systems on behalf of PAIMI-eligible individuals included:

Class Action Litigations	FY 2017	FY 2018
Number of Events	61	81
Individuals Impacted	2,444,669	1,612,221

[See Appendix – Table 13a]

Case Examples from FY 2017

Delaware

The P&A and Delaware Department of Corrections (DOC) resolved a class action regarding the utilization of solitary confinement for inmates with serious and persistent mental illness. Approximately 1,000 inmates were identified as having a serious mental illness, and 200 of them were isolated in restrictive housing. A Federal Judge approved the settlement, which created better treatment options for these inmates. A prison riot in early 2017 led to disruption in implementation of the agreement. However, the P&A have continued to work with DOC to monitor the implementation and progress within DOC. The P&A randomly selects and reviews 20 inmate files

[22] 42 U.S.C. 10805 (a)(1)(B)

on a monthly basis, to ascertain whether the inmates are receiving services as contemplated in the agreement.

District of Columbia

In Brown v. District of Columbia, the P&A continued to represent class members who are District of Columbia Medicaid beneficiaries in nursing facilities, seeking transition assistance from the District of Columbia government to help them move back to the community, with the services that they need. The class includes adults with serious mental illness, who also have a physical disability. Transition assistance included essential steps such as obtaining identification documents and income-benefit statements, helping class members complete housing applications, assessing their long-term care Medicaid service needs, and linking them to provider agencies. The P&A provided extensive assistance in preparing the evidence presented to the Court. In September 2017, the Court issued its decision in favor of the District and dismissed plaintiffs' legal claims. The Court found that "[t]he District has little to be proud of regarding its historic inability to comply with Olmstead's integration mandate" [23] but, because the majority of class members need housing and subsidized housing is difficult to find, the Court found plaintiffs' claims for transition assistance were essentially futile. Despite the negative decision, the District reported that 38 nursing home residents transitioned to the community during FY 2017, which exceeded its goal of 33.

Illinois

In FY 2007, the P&A and its co-counsel filed a class action lawsuit against state officials for failing to provide community services for people living in nursing homes in Cook County, Illinois, primarily people with mental illness and people with physical disabilities. Suit was brought under ADA, and pursuant to the U.S. Supreme Court's Olmstead decision. It is estimated that over 16,000 people live in nursing homes in Cook County. In FY 2008, the case was certified as a class action. In FY 2012, the judge granted final approval of a Consent Decree, appointed an Independent Monitor, and the parties worked to develop the requisite Implementation Plan. At the end of FY 2017, over 1,800 class members had moved into the community from nursing homes.

Case Examples from FY 2018

California

The P&A filed a federal class action lawsuit on behalf of five prisoners in the Santa Barbara County Jail, claiming conditions at the jail do not meet minimum standards under the U.S. Constitution and federal law, including ADA. The lead plaintiff, a 67-yearold PAIMI-eligible U.S. Army veteran, requested but received no meaningful treatment to help him manage his PTSD. Another class member was denied prescribed psychiatric medications that he had been taking prior to his arrest. Despite jail staff documenting his reports of an exacerbation of his mental health disability, his condition worsened and, a few days later, the class member attempted suicide by cutting his wrist. The prisoners are seeking an order from the court requiring Santa Barbara County officials to improve jail conditions, to comply with constitutional and statutory standards. In June 2018, the U.S. District Court granted the P&A's motion for class certification. The P&A is meeting with the Sheriff's office and county officials to negotiate a remedial plan.

[23] Olmstead v. LC: 1999 United States Supreme Court Decision

Colorado

The P&A entered a class action lawsuit against the Federal Bureau of Prisons (BOP) for their 8th Amendment violations by failing to exclude inmates with serious mental illness from the Administrative Maximum Facility (ADX), located in Florence, Colorado, and for failing to provide a constitutionally appropriate level of mental health screening and treatment to inmates at the ADX. A settlement agreement was reached after years of discovery, policy development and settlement discussions. In January 2017, the settlement agreement was approved, and found to be fair, reasonable, and adequate for the class and subclass. The case is currently in the monitoring phase, where two experienced corrections psychiatrists are checking BOP's compliance with a very detailed settlement agreement. The P&A is part of the monitoring process commenting on compliance/ noncompliance issues and receiving inmate complaints concerning implementation of the settlement agreement.

Louisiana

Early in 2017, the P&A found probable cause to believe that Defendants were exposing prisoners with mental illness and other disabilities at David Wade Correctional Center (DWCC) in Homer, Louisiana to neglect and abuse, by subjecting them to extended periods of solitary confinement and failing to provide adequate mental health services. As a result, the P&A initiated an investigation of the prison's use of isolation and restraints and whether mental health treatment at DWCC was adequate and appropriate. At DWCC, hundreds of prisoners, many of whom were known to have serious mental illness, including history of self- harm or suicidal tendencies, were routinely placed on extended lockdown. A lawsuit was brought on behalf of two individuals, both of whom are currently in custody of the DWCC, and all persons in a similar situation. One individual, having no history of mental illness, now complains of auditory and visual hallucinations, as a result of his stay in extended lockdown and lack of mental health resources. The other individual, despite having been diagnosed as bipolar and being on suicide watch at the time of his evaluation, was categorized as having no mental problems. He has attempted suicide twice, and been on suicide watch five times. It is the P&A's contention that extended lockdown is a cruel, inhumane punishment, in which these men are deprived of human contact, the outdoors, speaking with their families or even a regular shower. By subjecting prisoners to such treatment, the plaintiffs contend that Defendants are violating the rights of prisoners under the First and Eighth Amendments, as well as ADA and Section 504 of the Rehabilitation Act.

Iowa

The P&A filed a class action lawsuit on behalf of boys with mental illness against a State-operated juvenile justice facility, to eliminate the use of fixed restraints and solitary confinement for punishment purposes and to ensure that the boys were receiving constitutionally required mental health treatment. Part of the remedies requested will require that the Iowa Department of Human Services change their regulations concerning the use of restraint and seclusion in this facility.

D. Interventions on Behalf of Groups of PAIMI-eligible Individuals

The majority of P&A systems advocated on behalf of groups of PAIMI-eligible individuals. These types of activities were not directed toward individuals, but for resolution of a range of systemic issues affecting specific groups or larger populations throughout a state. Some systemic advocacy

activities included legal actions to protect the rights, health and safety of vulnerable facility residents (See C. Class Action). Sometimes individual complaints resulted in group advocacy. Generally, P&A non-case directed advocacy activities focused on implementing changes in administrative policy, procedures, or practices in state agencies, residential treatment facilities, and other service providers. Activities reported under the Legislative and Regulatory Advocacy section are limited to providing technical assistance, education, and awareness about current statutes and regulations regarding the rights and protection of individuals with serious mental illness (SMI) or serious emotional disturbance (SED) and do not include strictly prohibited activities, such as the inappropriate use of federal dollars to influence legislation or any actions by federal or state governments described in Section 503 of Title V, in Division H of the Consolidated Appropriations Act and specific prohibitions against lobbying in the PAIMI regulations.[24]

Non-Litigation Advocacy	**FY 2017**	**FY 2018**
Number of Events	2,977	1,983
Total number of individuals impacted	12,429,482	10,193,626

[See Appendix – Table 13b]

Legislative & Regulatory Advocacy	**FY 2017**	**FY 2018**
Number of Events	149	243
Total Number of Individuals Impacted	10,212,335	8,737,697

[See Appendix – Table 13c]

Case Example from FY 2017

District of Columbia

In February 2017, the Green Door, a non-profit mental health provider, closed with very little notice to the 1,200 mental health consumers who relied on them for support. The P&A attended a consumer forum at the Green Door before it closed, and conducted outreach immediately afterwards, interviewing consumers regarding whether their needs were being met during the transition period. The P&A raised concerns to the Department of Behavioral Health (DBH) and the District of Columbia City Council about the lack of notice to consumers regarding the closure and lack of an adequate transition period, and advocated that the mental health provider that was acquiring Green Door's space and clients receive special training and supervision in providing the evidence-based practice of Assertive Community Treatment (ACT) services. As a result of the P&A's advocacy, the District of Columbia City Council requested that DBH provide a plan to follow each client.

Case Example for FY 2018

Kentucky

The P&A provided PAIMI services to a 17-year-old female who was diagnosed with several mental disorders. The P&A was notified because the client was bruised during a Safe Crisis Management (SCM) restraint at a Psychiatric Residential Treatment Facility. The allegations were investigated by the Child Protective Services (CPS), and reported to the Office of Inspector General (OIG). The

[24] 42 CFR Part 51. Subpart A

P&A received and reviewed a copy of the final investigation report. The allegations were substantiated as "risk of harm," due to excessive use of force during SCM. The report also indicated that the staff member who administered the SCM was non-compliant with required training. CPS recommended the facility terminate the staff's employment. The OIG also issued a statement of deficiency to the facility. The P&A sent a letter to the guardian of the client, to let the guardian know the outcome of the investigation, and continued monitoring the treatment of the client and other residents. Both CPS and OIG continue to be involved in the monitoring of the facility for regulatory compliance and the safety of residents.

Nevada

The P&A provided PAIMI services to a 55-year-old male with mental illness, whose sister was his guardian. The client was placed on a mental health hold, and admitted to a psychiatric facility. Rather than filing a Petition for Involuntary Commitment, the hospital permitted the guardian to "voluntarily" admit the client over his objection. The P&A contacted the public defender and the client's attorney appointed in the guardianship case. The P&A discovered that the guardianship judge specifically found that the guardian did not have the authority to voluntarily admit the client, and communicated this information to hospital staff. Rather than file Petition to hold, the client was released by the hospital. The client submitted a complaint with the Nevada's regulatory agency concerning the hospital's failure to timely file a petition as required by state law. The complaint was joined by the client's attorney in the guardianship case and the public defender's office.

E. Public Education, Training, and Awareness Activities

Each state P&A system received requests for information and referral services from its constituents via telephone, e-mail, letter, face-to-face, and walk-in visits. The systems also provided information by conducting public awareness, education, and training activities. Many state PAIMI Programs met with and provided civil rights informational training to consumers, stakeholders, and advocacy groups. Other P&A systems conducted mental health law classes for attorneys, graduate students, current and former recipients of mental health services, and mental health service professionals. The P&A system provided information to the public by various means, including newspapers, radio/television public service announcements, agency newsletters, websites, publications, investigative reports, and listservs. Some P&A systems within sparsely populated states or with large rural populations used technology to provide information through webcams, videoconferences, teleconferences, webinars, Facebook, and Skype. The PAIMI Program public education, training, and awareness activities conducted by the P&A systems included:

Educational or Training Activities	**FY 2017**	**FY 2018**
Information and Referral Requests	24,764	23,029
a. Number of Public Awareness Activities or Events	1,910	2,055
b. Number of Educational/Training Activities Undertaken	2,436	2,428
c. Number (approximate) of Person Trained in b.	80,753	72.687

[See Appendix, Table 14]

Case Examples from FY 2017

Delaware

The P&A assisted a client, diagnosed with depression and substance use disorder, with multiple concerns, including lost mail, an alleged HIPAA violation, cleanliness of the unit, and poor staff interactions. The P&A assisted the client in filing grievances, provided information and referral, attended a treatment team meeting with the client, and arranged contact with the HIPAA Compliance Officer at DPC. In addition, the client had a pending family law matter in New Jersey. The P&A facilitated telephonic attendance at an arbitration and court hearing for this client.

Maine

The P&A assisted a 34-year-old woman with mental illness, who was transported by police to a hospital emergency department for a mental health evaluation. The woman was subjected to restraint and involuntary medications, due to the hospital claiming that she was being "disruptive" to other patients. The P&A investigated the client's treatment and determined that staff had not been properly trained regarding the rights of individuals with mental illness awaiting mental health evaluations in the emergency department. The hospital agreed to, and accepted training for, emergency room staff from the P&A in this area of patient rights.

Mississippi

The P&A collaborated with Southern Poverty Law Center's Youth Justice Project to monitor a juvenile detention facility in Hinds County. The P&A is working with the facility to ensure that eligible youths have access to advocates, receive appropriate mental health and medical treatment, are not subject to force and restraints, and are given educational services. The P&A has been able to collaborate with local mental health providers to initiate services to youth at the detention facility.

Case Examples from FY 2018

Delaware

A client with schizoaffective disorder bipolar type at DPC asked for P&A assistance with discharge planning, a housing voucher issue in New York State, and other patient advocacy concerns. The P&A investigated her complaints, provided information and referral about her mental health patient rights, and involuntary commitment rights. The P&A advocated for the client to get a belongings inventory list and referred her to a legal services program in New York, regarding the housing voucher issue. Because the client is now discharged from DPC and her legal problem resolved, her case has been closed.

Massachusetts

The P&A collaborated with the Western Massachusetts and Eastern Massachusetts Peer Networks to share information and trends on mental health issues throughout the Commonwealth. The P&A provided extensive legal advice about community-based living rights and responsibilities, involuntary medication, and human rights laws. Representatives from the Peer Networks shared concerns with the P&A about specific provider abuses and a social media campaign that they were

planning. The P&A followed up with monitoring additional group homes and hospitals, based on this advocacy, as well as with providing legal guidance around social media campaigns, to raise awareness about mental health abuse/neglect.

Texas

The P&A conducted an education and training and focus group meeting at the Rio Grande State Center in February 2018. One of the issues raised by participants was their right to a safe environment and why they did not feel safe in the unit. The discussion led to issues regarding the lack of availability of the quiet room. The residents stated that the quiet room was not available. The P&A raised the issue of residents not being able to access the quiet room with the Director of Social Work, who confirmed it was not available due to construction in the unit. The P&A requested that an alternative location be provided. Several follow up inquiries were made with the staff. Due to the persistence of the P&A, and the efforts in negotiating closure on this issue, the quiet room was restored for use by residents.

F. Accomplishments, Impediments, and Unmet Advocacy Needs

1. **Accomplishments**

P&A system intervention improved the quality of life for individuals with mental illness and resulted in systemic changes. Examples of these accomplishments included:

MAJOR ACCOMPLISHMENTS

Examples from FY 2017

Maine

The P&A continues to provide contract advocacy services to both of Maine's state psychiatric hospitals and one of Maine's largest private psychiatric hospitals. The P&A continues to provide regular outreach and monitoring visits to other private psychiatric hospitals throughout the state. In FY 2017, the P&A conducted this type of monitoring and outreach on 16 separate occasions to 4 different hospitals, including another large private psychiatric hospital.

North Dakota

The P&A investigated and identified a number of systemic issues that resulted in denial of appropriate assessment and mental health services to a client. The P&A had meetings with personnel at the jail, the regional human service center, the States Attorney's Office, and other offices, to address the identified systemic problems that contributed to the client's situation.

Case Examples from FY 2018

American Samoa

During the transition of five clients from the correctional facility to the LBJ Behavioral Health Center for ongoing treatment and care their rehabilitation needs were initially not being met, due to limited resources, including mental health care professionals and programs available for the clients.

At a Behavioral Health Planning Council meeting, the P&A suggested and a rehabilitation subcommittee was formed. The goal was to collaborate and share resources amongst government and private agencies, to enable implementation of appropriate programs that could be attended by clients both housed long-term at the Behavioral Health Center and in the general community. Programs developed included Computer Skills training with the Department of Youth & Women, Workforce Innovation and Opportunity Act from the Department of Human Resources for employment on the job training skills, Check In group with Department of Human and Social Services (focusing on communication and social skills), a Drop-in group (now on hold), which gave ukulele lessons, art and meditation sessions, and Self-advocacy and Rights for clients training for clients and their family members by the P&A and peer mentor staff. Several cases were able to be closed, due to collaboration among a collective group of agencies on the island willing to come together for rehabilitation goal setting and achievement. This collaboration was an accomplishment not only for the five clients in transition, but also for the mental health system in general.

Illinois

An individual with schizophrenia who was in the maximum security mental health center, with a status of not guilty by reason of insanity, contacted the P&A seeking assistance to avoid being transported to court in shackles. After the P&A engaged in extensive negotiations, the facility relented and allowed the client to go to court accompanied by staff, but without shackles. This advocacy also had a systemic effect, by educating the facility and Division of Mental Health that the statewide policy does not require shackles where other security measures are sufficient, based on an individualized assessment of the person.

2. Impediments & Unmet Needs

Examples from FY 2017

Alabama

While the P&A's PAIMI Act access authority has been repeatedly reaffirmed in jurisdictions across the United States, facilities in Alabama continue to challenge the P&A's access to monitor and investigate any abuse, neglect or rights violations. During FY 2017, the P&A was denied access by county jails, requiring the P&A to engage in protracted negotiations with the jails over its access authority. Even though the P&A has successfully met access challenges to date, it has done so with a considerable amount of expenditures, time, and resources, which could have been used to provide direct client services.

Alaska

For the P&A, the major impediment to the implementation of mandated PAIMI activities is the lack of a comprehensive, statewide plan to fill service delivery gaps for individuals with severe mental illness. The absence of community-based services for individuals exiting institutional environments, such as prisons or psychiatric facilities, results in unacceptable recidivism and readmission rates. This "revolving door" consequence places a tremendous strain on the system, making it difficult for other individuals to access needed stabilization services. The dearth of step-up or step-down services challenges the individual advocacy conducted by the P&A.

California

The P&A did not receive any notification from CMS regarding reports of behavioral restraint-related deaths in California hospitals. The P&A renewed its data use agreement to receive notification of restraint-related hospital deaths, as required by 42 CFR 482.13(e); nevertheless, it is of grave concern that deaths related to the use of behavioral restraint or seclusion are not being reported to either CMS or the P&A, as required.

Vermont

The P&A's impediment is the lack of a requirement in Vermont that Emergency Departments report to the State Department of Mental Health (DMH) episodes of seclusion and restraint of psychiatric patients or of voluntary patients in the inpatient units. This lack of reporting represents an obstacle, in that unlike seclusions and restraints of involuntary patients in psychiatric units, which are all reported to the P&A in one, easy to review and analyze dataset by the DMH, the other reports above are fragmented and hard to obtain, thus not allowing for a systematic review for systemic concerns.

Examples from FY 2018

Delaware

The P&A's greatest external impediment to progress is a staffing shortage that the state seems unable to address. The understaffing has led directly to deficiencies in a number of categories, including lack of peer oversight, inconsistent programming, a non-functioning investigations unit, and other issues. The lack of an effective and efficient investigations system at the Delaware Psychiatric Center has negatively impacted the P&A's ability to obtain timely investigative reports and other materials. There is unacceptably long delays between incidents and investigations and investigations and production of documents.

Louisiana

The P&A did not regularly receive reports of seclusion, restraint, death, or serious injury from licensed facilities, the State Medicaid office, or the CMS regional office. The P&A regularly visited many of the facilities outlined in the Children's Health Act of 2000, as well as other facilities on monitoring visits, and spoke with residents regarding conditions and incidents. In addition, the P&A monitored the media for reports of death or serious injury.

Maryland

The P&A received complaints of alleged sexual abuse or harassment from patients at state psychiatric hospitals, yet they failed to comply with the mandatory reporting requirements. Moreover, the reports of sexual abuse that P&A does receive are delayed, impeding its ability to investigate and address the allegations in a timely manner. Furthermore, some state hospitals fail to use the proper reporting forms, which upon investigation, the P&A noted, is often because the hospital staff were not aware of the reporting procedures. The P&A works with the Assistant Attorney General for the Maryland Department of Health to ensure that staff receive appropriate training on their obligations for responding to sexual assault reports and implementing the proper reporting forms and procedures required by the Doe v. Department of Health and Mental Hygiene

settlement agreement. The P&A continues to provide "Know Your Rights" presentations to both patients and staff on their rights related to sexual abuse allegations.

Tennessee

For the P&A, the external impediments remain unchanged. In Tennessee, there continues to be a shortage of resources for mental health services, especially for clients with the most serious behaviors related to their mental illness and those with secondary disabilities, such as deafness or other physical disabilities. In addition, there continues to be a move toward shorter duration inpatient treatment, with limited community support options. The most significantly impacted are some of the most vulnerable Tennesseans, those with limited access to medical insurance, as well as those with secondary disabilities and the aging population. This move limits the advocacy options, culturally and linguistically appropriate service options, and the safe community living resources.

GOVERNANCE

1. *The Governing Authority*

The DD Act of 1975,[25] which created the state P&A systems, and the PAIMI Act[26] mandated that private, non-profit entities have a multimember governing authority (the Board) to oversee the system.[27] Each Board is responsible for the planning, design, implementation, and functioning of the system.[28] The Board must work jointly with its PAIMI Advisory Council (PAC)[29] and establish policies and procedures for the selection of its members.[30] The DD Act included provisions for Board terms of appointment, size, and composition. The DD Act required that:

- Board members be selected according to policies and procedures of the system;
- The Board include individuals who broadly represent or are knowledgeable about the needs of the clients served by the system;
- The Board must make continuing efforts to ensure that its members represent racial and ethnic minorities.[31]
- The majority of Board members include individuals with disabilities who are current or former recipients of disability services, their family members, guardians, authorized representatives and advocates;
- The system set term limits to ensure rotating membership on the board; and
- Board vacancies be filled within 60-days.[32]

As of September 30, 2018, there were 52 private, non-profit P&A systems. Unlike private, non-profit P&A systems, state-operated P&A systems may have a governing authority, but are not required to do so.

[25] 42 U.S.C. 15043 (a), amended in 2000
[26] 42 U.S.C. 10805(c)
[27] 42 U.S.C. 15044
[28] 42 U.S.C. 10805(c) (2) (A)
[29] 42 U.S.C. 10805(c) (2) (B)
[30] 42 U.S.C. 10805(c) (1) (B)
[31] respectively at, 42 U.S.C. 10805(a) (6) (C) and 42 CFR 51.22(b) and (c)
[32] respectively, at 42 U.S.C. 15044 (a) (1) (A), (B) (i), (ii) and (C) (3) and (4)

The PAIMI Act and Rules also require the PAC Chair, who must be a current or former recipient of mental health services or a family member of such an individual, sit on the governing Board of private, non-profit P&A systems.

2. ***The PAIMI Advisory Council***

Each state P&A system is mandated to establish a PAC[33] to advise the system on policies and priorities to be carried out in protecting and advocating for the rights of individuals with mental illness.[34] The composition of the PAC is also mandated.[35] The PAC Chair must be a current or former mental health recipient or a family member of such an individual.[36]

Each PAC is required to provide independent advice and recommendations to its state P&A system; to work jointly with the governing authority in the development of policies and priorities; and submit a section of the system's annual report.[37] Council terms of appointment must be staggered and of reasonable duration. The size of the PAC varies by state, but at least 60 percent of Council members must be current or former recipients of mental health services or their family members. The Council must meet at least three times each calendar year, include ethnic and racial minorities, and receive information related to its corresponding P&A system's budget, staff, current program policies, priorities and performance outcomes.[38]

The PAC is mandated to provide the governing board with advice and recommendations on the annual PAIMI programmatic activities and priorities to be funded in a FY. The PAIMI Act requires that the PAC Chair sit on the governing board of private, non-profit state P&A systems;[39] however, any PAC member may serve on the governing board.[40]

By January 1 of each year, each P&A system is required to submit an annual Program Performance Report (PPR) to the HHS Secretary.[41] The PAC is also required to submit a section of that annual PPR, as mandated by the PAIMI Act[42] and the PAIMI Rules.[43]

The Council's report must:

- Describe its membership and its PAIMI Program activities;
- Explain its relationship to the P&A governing board of the previous calendar year;
- Independently assess the P&A system's PAIMI Program; and
- Include whether the program accomplished its priorities, goals, and objectives for the previous FY.

[33] PAIMI Act at 42 U.S.C. 10805(a) (6) (C)
[34] at 42 U.S.C. 10805 (a) (6) (A)
[35] PAIMI Act at 42 U.S.C. 10805(a) (6) (B)
[36] 42 U.S.C. 10805(a) (6) (C) and the PAIMI Rules at 42 CFR at 51.23(b) (2)
[37] PAIMI Rules at 42 CFR 51.23 (a) (1) - (3)
[38] PAIMI Rules at 42 CFR 51.23(b) (2), (3) and (c)
[39] 42 U.S.C. 10805 (a) (6) (A), 42 CFR at 51.22 (b) (3)
[40] 42 CFR at 51.22(d)
[41] 42 U.S.C. 10805 (a) (7)
[42] 42 U.S.C. 10824
[43] 42 CFR 51.8

In addition to attending meetings, PAC members participated in numerous activities sponsored or endorsed by the PAIMI Program (e.g., attending in- and out-of-state trainings, serving on P&A governing board committees, engaging in systemic advocacy; and participating in special projects).

TRAINING AND TECHNICAL ASSISTANCE

SAMHSA provided training and technical assistance (T/TA) to the state P&A systems through an interagency agreement (IAA) administered by the AoD. AoD, which oversees the PADD Program, is the first federal protection and advocacy program, and is the lead on the federal P&A system for issues pertaining to designation, re-designation, and regulations. SAMHSA supports the IAA with funds specifically set-aside for T/TA, but limited to a maximum of two percent of the annual PAIMI Program appropriation. The Rehabilitation Services Administration (RSA), within the Office of Special Education and Rehabilitation Services, U.S. Department of Education, administers the Protection and Advocacy for the Individual Rights Program, the Client Assistance Program, and the Protection and Advocacy for Assistive Technology Program. RSA has a separate IAA with AoD. This consolidation of federal P&A program set-aside funds maximizes each agency's limited resources, and contributes to a federal partnership among the three agencies that fosters cooperation, information sharing, strategic planning, coordination, and integration of P&A system activities.

The Training Advocacy and Support Center (TASC) of the National Disability Rights Network was the contractor selected by the AoD to serve the P&A systems. Under the contract, TASC is responsible for various T/TA tasks including both general and agency-specific tasks (for example, the annual PAC training). TASC activities under FYs 2017 and 2018 contract included the following:

- Investigation protocols for incidents of abuse and neglect cases involving deaths;
- Seclusion and restraint;
- Community integration (Olmstead);
- Medicaid funding;
- Consumer self-advocacy;
- Role of PACs;
- Access to jails, prisons, and juvenile detention facilities;
- Housing; and
- Outreach strategies for unserved and underserved populations, including members of ethnic and racial minorities and individuals in urban or rural settings, prisons, jails, and detention centers.

TASC also assisted P&A systems prepare legal briefs when their PAIMI Act investigative and access authority was challenged.

Under the IAA, TASC prepared three publications: the *TASC Update* (monthly), *LegalEase* (monthly), and the *P&A News* (quarterly). Each publication was reviewed and edited by the federal P&A TA partners (SAMHSA, AoD, and RSA) before AoD approved their distribution to the state P&A systems.

Under the IAA, TASC staff:

- Maintained a website accessible to the public and a webpage accessible only to the federal partners and state P&A systems;
- Developed model guidelines, training manuals, and legal advocacy materials, including *LegalEase (monthly)* and *Case Dockets*;
- Analyzed public policy;
- Established relationships with state P&A system staff;
- Served as liaison to the state P&A system staff;
- Facilitated information exchanges and requests for assistance from the P&A system staff;
- Subcontracted with national legal organizations, including the Bazelon Center for Mental Health Law, the Center for Public Representation, and other legal experts for P&A system consultation services;
- Promoted the use of the *Protection and Advocacy Standards*, which were developed in 2009;
- Identified and disseminated samples of model P&A system policies and procedures;
- Developed P&A system self-assessment procedures, a project started in 2009; and
- Planned and conducted training on current disability, legal, and advocacy issues, including the Annual Conference, training the P&A executive director, and fiscal management training.

Through the IAA, SAMHSA assists P&As to improve performance (for example, legal advocacy services to include individual and systems advocacy), operations, and outcomes; maintain statutory compliance; support P&A's as leaders and catalysts of systems change, capacity building, and advocacy at the national, state/territory, and local levels.

CONCLUSION

This report offers examples of successful implementation of statutorily mandated activities related to the PAIMI program. PAIMI grantees worked tirelessly to protect and advocate for the rights of individuals with significant (serious) mental illness (adults) and significant (severe) emotional impairments (children and youth), residing in public and private care and treatment facilities who are at risk for, or in danger of abuse, neglect, and rights violations, by using administrative, legal, systemic, or other appropriate remedies on their behalf. PAIMI grantees successfully investigated reports of abuse, particularly incidents involving serious injuries and deaths related to the inappropriate use of seclusion and restraint, and ensured enforcement of the United States Constitution, federal laws and regulations, and state statutes.

Through the PAIMI program systemic changes were implemented in a variety of settings, which ultimately improved treatment, support, and services for those with SMI and SED. The PAIMI grantees assisted states/territories make systemic changes, change or improve practices, and implement best practices. Through these and other efforts, the PAIMI program assisted individuals and families obtain better treatment, decreased abuse or neglect, protected rights of individuals, expanded employment and educational opportunities, and promoted access to community living.

APPENDIX A

DATA TABLES FOR FISCAL YEARS 2017 & 2018

Table 1 – State PAIMI Appropriations

State/Jurisdiction	FY 2017 Final Appropriations	FY 2018 Final Appropriations
Alabama	$453,952	$458,554
Alaska	$428,000	$428,000
Arizona	$626,682	$634,205
Arkansas	$428,000	$428,000
California	$3,140,635	$3,101,059
Colorado	$438,159	$443,445
Connecticut	$428,000	$428,000
Delaware	$428,000	$428,000
District of Columbia (DC)	$428,000	$428,000
Florida	$1,738,714	$1,761,727
Georgia	$925,906	$934,106
Hawaii	$428,000	$428,000
Idaho	$428,000	$428,000
Illinois	$1,066,670	$1,051,088
Indiana	$600,047	$592,729
Iowa	$428,000	$428,000
Kansas	$428,000	$428,000
Kentucky	$428,000	$428,000
Louisiana	$428,000	$428,000
Maine	$428,000	$428,000
Maryland	$466,105	$467,047
Massachusetts	$507,663	$502,978
Michigan	$887,795	$878,974
Minnesota	$445,887	$446,246
Mississippi	$428,000	$428,000
Missouri	$537,097	$542,302
Montana	$428,000	$428,000
Nebraska	$428,000	$428,000
Nevada	$428,000	$428,000
New Hampshire	$428,000	$428,000
New Jersey	$678,311	$675,631
New Mexico	$428,000	$428,000
New York	$1,522,109	$1,507,227
North Carolina	$909,472	$912,914
North Dakota	$428,000	$428,000
Ohio	$1,019,483	$1,019,501
Oklahoma	$428,000	$428,000
Oregon	$428,000	$428,000
Pennsylvania	$1,058,552	$1,051,937
Rhode Island	$428,000	$428,000

States	FY 2017 Final Appropriations	FY 2018 Final Appropriations
South Carolina	$457,957	$460,260
South Dakota	$428,000	$428,000
Tennessee	$588,878	$589,859
Texas	$2,278,953	$2,321,910
Utah	$428,000	$428,000
Vermont	$428,000	$428,000
Virginia	$671,652	$674,079
Washington	$573,587	$577,376
West Virginia	$428,000	$428,000
Wisconsin	$494,807	$493,292
Wyoming	$428,000	$428,000
American Indian Consortium (AIC)	$229,300	$229,300
American Samoa (Am. Samoa)	$229,300	$229,300
Guam	$229,300	$229,300
Northern Marianas (N. Marianas)	$229,300	$229,300
Puerto Rico	$528,202	$528,962
Virgin Islands	$229,300	$229,300
Total State P&A Systems	$35,319,775	$35,329,908
Technical Assistance Set-aside (2%)	$706,396	$706,598
Total Annual PAIMI Appropriations	**$36,026,171**	**$36,036,506**

Table 2 – PAIMI Eligible Individuals Served by Age Group and Sex – FY2017

State/Jurisdiction	HHS	Age							Sex			
	Region	0-4	5-12	13-18	19-25	26-64	65+	Total	Male	Female	Unk.	Total
Alabama	4	0	25	46	13	110	21	215	169	46	0	215
Alaska	10	0	1	4	8	47	1	61	30	31	0	61
AIC	11	0	4	14	1	9	0	28	21	7	0	28
Am. Samoa	9	0	1	3	33	17	0	54	49	5	0	54
Arizona	9	0	2	10	25	277	22	336	141	195	0	336
Arkansas	6	0	31	38	4	45	6	124	83	41	0	124
California	9	0	35	58	69	614	71	847	0	0	847	847
Colorado	8	0	3	9	13	65	2	92	77	15	0	92
Connecticut	1	0	0	0	0	7	2	9	3	6	0	9
Delaware	3	0	2	8	21	148	8	187	92	95	0	187
DC	3	0	0	11	16	94	19	140	77	63	0	140
Florida	4	0	6	6	14	195	13	234	172	62	0	234
Georgia	4	0	1	9	11	99	3	123	62	61	0	123
Guam	9	0	2	4	2	20	0	28	15	13	0	28
Hawaii	9	0	49	50	6	96	11	212	125	87	0	212
Idaho	10	0	7	5	8	69	11	100	38	61	1	100
Illinois	5	1	53	96	32	278	31	491	259	232	0	491
Indiana	5	0	14	18	13	50	5	100	64	36	0	100
Iowa	7	0	8	10	7	16	0	41	26	14	1	41
Kansas	7	0	20	18	25	334	31	428	214	214	0	428
Kentucky	4	0	12	17	20	84	12	145	106	39	0	145
Louisiana	6	0	20	26	16	57	5	124	92	32	0	124
Maine	1	0	28	86	16	81	8	219	128	91	0	219
Maryland	3	0	0	12	13	113	5	143	99	44	0	143
Massachusetts	1	0	2	8	21	113	10	154	76	78	0	154
Michigan	5	0	23	18	12	49	17	119	76	43	0	119
Minnesota	5	0	14	24	7	144	6	195	90	105	0	195
Mississippi	4	0	13	41	4	11	0	69	46	23	0	69
Missouri	7	0	1	7	10	171	21	210	139	71	0	210
Montana	8	0	7	50	24	131	13	225	0	0	225	225
Nebraska	7	0	0	0	2	19	1	22	10	12	0	22
Nevada	9	0	0	2	2	39	6	49	22	27	0	49
New Hampshire	1	1	5	13	36	167	12	234	106	128	0	234
New Jersey	2	0	15	32	25	194	27	293	108	154	31	293

State/Jurisdiction	HHS	Age	Sex	10	4	123	14	158	105	53	0	158
	Region	0-4	5-12	13-18	19-25	26-64	65+	Total	Male	Female	Unk.	Total
North Carolina	4	0	6	15	23	87	7	138	97	41	0	138
North Dakota	8	0	46	86	20	89	12	253	176	77	0	253
N. Marianas	9	0	0	0	1	11	0	12	8	4	0	12
Ohio	5	3	57	59	49	413	29	610	351	258	1	610
Oklahoma	6	0	15	11	7	45	1	79	57	22	0	79
Oregon	10	0	0	3	9	38	5	55	40	15	0	55
Pennsylvania	3	1	25	46	26	139	8	245	155	90	0	245
Puerto Rico	2	0	7	8	8	94	6	123	58	65	0	123
Rhode Island	1	1	14	21	34	115	27	212	82	130	0	212
South Carolina	4	0	7	161	5	28	7	208	129	79	0	208
South Dakota	8	0	13	21	4	21	0	59	34	25	0	59
Tennessee	4	0	8	18	7	54	2	89	56	33	0	89
Texas	6	1	27	104	92	444	35	703	423	280	0	703
Utah	8	0	5	14	21	97	4	141	79	62	0	141
Vermont	1	0	0	2	11	76	8	97	51	46	0	97
Virgin Islands	2	0	1	3	0	13	0	17	12	5	0	17
Virginia	3	0	1	11	21	77	22	132	67	64	1	132
Washington	10	1	2	10	31	481	76	601	438	161	2	601
West Virginia	3	0	5	9	7	62	7	90	55	35	0	90
Wisconsin	5	0	7	36	11	71	3	128	83	45	0	128
Wyoming	8	0	0	0	2	33	3	38	19	19	0	38
Totals		9	660	1,420	934	6,738	689	10,450	5,508	3,833	1,109	10,450
Percentages		0.09	6.32	13.59	8.94	64.48	6.59	100.00	52.71	36.68	10.61	100.00

Table 2 – PAIMI Eligible Individuals Served by Age Group and Sex – FY2018

State/Jurisdiction	HHS Region	Age							Sex			
		0-4	5-12	13-18	19-25	26-64	65+	Total	Male	Female	Unk.	Total
Alabama	4	0	27	66	15	73	14	195	145	50	0	195
Alaska	10	0	2	3	3	41	0	49	27	22	0	49
AIC	11	0	4	13	2	2	0	21	14	7	0	21
Am. Samoa	9	0	0	0	9	57	0	66	52	14	0	66
Arizona	9	0	4	13	31	292	18	358	147	211	0	358
Arkansas	6	0	21	30	2	37	3	93	59	34	0	93
California	9	2	28	53	48	576	73	780	367	407	6	780
Colorado	8	0	1	6	25	89	2	123	97	24	2	123
Connecticut	1	0	1	2	2	10	3	18	8	10	0	18
Delaware	3	0	4	11	16	145	7	183	86	97	0	183
DC	3	0	0	12	8	75	18	113	71	42	0	113
Florida	4	0	0	6	14	166	16	202	140	62	0	202
Georgia	4	0	2	5	13	74	2	96	53	43	0	96
Guam	9	0	0	7	2	5	2	16	8	8	0	16
Hawaii	9	0	23	34	1	61	7	126	77	49	0	126
Idaho	10	0	7	7	9	76	3	102	51	51	0	102
Illinois	5	1	52	98	35	259	27	472	273	199	0	472
Indiana	5	0	14	9	3	67	3	96	65	30	1	96
Iowa	7	0	7	15	1	14	3	40	20	19	1	40
Kansas	7	1	10	20	23	343	34	431	182	249	0	431
Kentucky	4	0	5	20	10	70	6	111	78	33	0	111
Louisiana	6	0	9	16	5	28	4	62	49	13	0	62
Maine	1	0	20	54	12	93	10	189	107	82	0	189
Maryland	3	0	2	28	9	112	9	160	76	84	0	160
Massachusetts	1	0	2	1	4	23	3	33	16	16	1	33
Michigan	5	0	21	26	17	67	28	159	98	61	0	159
Minnesota	5	0	11	26	11	159	12	219	105	114	0	219
Mississippi	4	0	2	19	3	6	0	30	14	16	0	30
Missouri	7	0	0	3	9	143	11	166	114	52	0	166
Montana	8	0	6	73	12	109	2	202	65	137	0	202
Nebraska	7	0	0	0	1	11	2	14	5	9	0	14
Nevada	9	0	0	1	6	25	5	37	17	20	0	37
New Hampshire	1	0	15	40	29	197	15	296	119	177	0	296
New Jersey	2	0	5	33	33	179	33	283	151	132	0	283

State/Jurisdiction	HHS	Age							Sex			
	Region	0-4	5-12	13-18	19-25	26-64	65+	Total	Male	Female	Unk.	Total
New Mexico	6	0	4	15	3	75	22	119	71	48	0	119
New York	2	0	3	6	12	112	9	142	65	76	1	142
North Carolina	4	0	4	16	13	67	4	104	60	44	0	104
North Dakota	8	0	64	88	20	81	15	268	176	92	0	268
N. Marianas	9	0	0	1	3	15	1	20	16	4	0	20
Ohio	5	2	36	66	46	320	27	497	259	237	1	497
Oklahoma	6	0	1	0	4	54	7	66	44	22	0	66
Oregon	10	0	0	1	3	28	4	36	19	17	0	36
Pennsylvania	3	1	20	43	25	172	16	277	126	135	16	277
Puerto Rico	2	0	1	1	4	63	9	78	34	44	0	78
Rhode Island	1	0	8	21	18	155	27	229	113	116	0	229
South Carolina	4	0	7	166	11	23	4	211	131	80	0	211
South Dakota	8	0	5	6	4	13	2	30	17	13	0	30
Tennessee	4	0	9	17	4	48	2	80	54	26	0	80
Texas	6	0	32	89	72	511	37	741	461	280	0	741
Utah	8	0	7	11	24	121	5	168	71	97	0	168
Vermont	1	0	0	9	6	71	10	96	48	48	0	96
Virgin Islands	2	0	1	3	0	5	0	9	4	5	0	9
Virginia	3	0	2	17	13	85	25	142	78	64	0	142
Washington	10	0	0	5	20	330	73	428	303	123	2	428
West Virginia	3	0	4	7	3	53	7	74	47	27	0	74
Wisconsin	5	0	7	29	13	92	2	143	89	54	0	143
Wyoming	8	0	0	0	0	28	1	29	12	17	0	29
Totals		7	520	1,367	744	6,206	684	9,528	5,254	4,243	31	9,528
Percentages		0.07	5.46	14.35	7.81	65.13	7.18	100.00	55.14	44.53	0.33	100.00

Table 3 – PAIMI Eligible Individuals Served by Race and Ethnicity – FY2017

State/ Jurisdiction	HHS Region	Race							Ethnicity			
		American Indian / Alaska Native	Asian	Black or African American	Multiple Races	Native Hawaiian / Other Pacific Islander	White	Total	Hispanic or Latino	Not Hispanic or Latino	Unk.	Total
Alabama	4	0	1	97	1	0	116	215	2	213	0	215
Alaska	10	11	0	4	3	0	39	57	3	0	1	4
AIC	11	28	0	0	0	0	0	28	0	28	0	28
Am. Samoa	9	0	0	0	5	49	0	54	0	54	0	54
Arizona	9	13	1	27	11	0	233	285	51	285	0	336
Arkansas	6	0	2	41	4	1	73	121	3	121	0	124
California	9	13	40	104	47	5	392	601	161	601	85	847
Colorado	8	1	1	25	1	0	64	92	10	82	0	92
Connecticut	1	0	0	1	0	0	8	9	2	7	0	9
Delaware	3	0	2	54	3	0	115	174	12	174	1	187
DC	3	1	1	116	3	0	17	138	2	138	0	140
Florida	4	2	0	88	5	0	117	212	14	167	53	234
Georgia	4	0	1	65	1	0	51	118	5	87	31	123
Guam	9	0	5	2	0	17	4	28	0	28	0	28
Hawaii	9	1	35	7	93	17	59	212	11	201	0	212
Idaho	10	3	0	2	6	1	88	100	6	91	3	100
Illinois	5	4	3	143	29	1	277	457	74	403	14	491
Indiana	5	0	0	21	0	0	79	100	0	100	0	100
Iowa	7	0	0	8	2	0	31	41	1	36	4	41
Kansas	7	9	2	50	21	1	318	401	24	377	27	428
Kentucky	4	0	0	25	13	0	107	145	3	142	0	145
Louisiana	6	0	0	62	4	0	51	117	7	117	0	124
Maine	1	5	0	5	5	0	204	219	0	93	126	219
Maryland	3	2	3	87	1	0	50	143	4	139	0	143
Massachusetts	1	1	4	15	1	0	132	153	10	144	0	154
Michigan	5	2	2	30	5	0	73	112	2	112	5	119
Minnesota	5	6	5	41	11	3	129	195	2	163	30	195
Mississippi	4	0	0	33	1	0	35	69	0	69	0	69
Missouri	7	1	1	62	0	0	146	210	3	207	0	210
Montana	8	16	0	2	1	0	201	220	3	220	2	225
Nebraska	7	1	0	2	1	0	16	20	1	20	1	22

State/ Jurisdiction	HHS Region	Race							Ethnicity			
		American Indian / Alaska Native	Asian	Black or African American	Multiple Races	Native Hawaiian / Other Pacific Islander	White	Total	Hispanic or Latino	Not Hispanic or Latino	Unk.	Total
Nevada	9	1	2	15	2	0	20	40	8	40	1	49
New Hampshire	1	1	1	3	4	0	217	226	2	226	6	234
New Jersey	2	0	4	75	12	1	201	293	30	245	18	293
New Mexico	6	7	1	7	0	0	143	158	67	91	0	158
New York	2	0	3	53	12	2	107	177	28	177	6	211
North Carolina	4	2	1	42	4	0	71	120	4	134	0	138
North Dakota	8	44	3	10	8	1	187	253	13	233	7	253
N. Marianas	9	0	1	0	2	5	4	12	0	12	0	12
Ohio	5	5	1	75	8	0	183	272	9	75	259	343
Oklahoma	6	10	0	17	1	0	51	79	8	71	0	79
Oregon	10	0	0	4	0	0	51	55	2	0	53	55
Pennsylvania	3	0	1	61	4	0	148	214	12	213	20	245
Puerto Rico	2	0	0	0	123	0	0	123	123	0	0	123
Rhode Island	1	1	2	15	9	0	185	212	17	195	0	212
South Carolina	4	0	0	97	7	1	103	208	7	194	7	208
South Dakota	8	11	0	0	4	1	43	59	3	56	0	59
Tennessee	4	0	1	27	3	0	57	88	1	88	0	89
Texas	6	5	5	166	11	0	318	505	185	518	0	703
Utah	8	1	0	4	1	0	107	113	27	98	17	142
Vermont	1	1	0	5	4	0	87	97	0	97	0	97
Virgin Islands	2	0	0	15	1	0	1	17	0	16	1	17
Virginia	3	1	3	41	3	0	84	132	2	130	0	132
Washington	10	24	8	113	91	2	363	601	40	561	0	601
West Virginia	3	4	0	14	2	0	68	88	2	88	0	90
Wisconsin	5	3	1	34	9	0	72	119	9	119	0	128
Wyoming	8	6	0	0	0	0	32	38	6	32	0	38
Totals		247	147	2,112	603	108	6,128	9,345	1,021	8,328	778	10,127
Percentages		2.64	1.57	22.60	6.45	1.16	65.58	100	10.08	82.24	7.68	100.00

Table 3 – PAIMI Eligible Individuals Served by Race and Ethnicity – FY2018

State/ Jurisdiction	HHS Region	Race							Ethnicity			
		American Indian / Alaska Native	Asian	Black or African American	Multiple Races	Native Hawaiian / Other Pacific Islander	White	Total	Hispanic or Latino	Not Hispanic or Latino	Unk.	Total
Alabama	4	0	1	88	1	0	105	195	6	189	0	195
Alaska	10	10	0	6	2	0	28	46	3	46	0	49
AIC	11	21	0	0	0	0	0	21	0	21	0	21
Am. Samoa	9	0	0	0	5	61	0	66	0	0	0	0
Arizona	9	9	4	33	9	1	254	310	48	310	0	358
Arkansas	6	0	0	25	5	1	61	92	1	91	1	93
California	9	8	30	104	28	4	537	711	174	539	67	780
Colorado	8	0	3	30	4	2	43	82	14	68	37	119
Connecticut	1	0	0	1	1	0	10	12	4	12	2	18
Delaware	3	0	2	52	5	0	108	167	12	167	4	183
DC	3	0	2	94	2	0	12	110	3	110	0	113
Florida	4	1	0	64	4	0	101	170	15	169	18	202
Georgia	4	1	0	45	3	0	46	95	3	92	1	96
Guam	9	0	1	1	0	12	2	16	0	16	0	16
Hawaii	9	0	21	2	48	11	44	126	8	70	0	78
Idaho	10	1	0	0	5	1	81	88	8	88	6	102
Illinois	5	6	7	148	30	0	255	446	53	393	26	472
Indiana	5	0	0	25	1	0	67	93	1	94	1	96
Iowa	7	0	0	7	0	0	33	40	0	39	1	40
Kansas	7	11	4	43	10	3	321	392	18	392	21	431
Kentucky	4	0	1	11	7	0	88	107	4	101	6	111
Louisiana	6	0	0	30	1	0	26	57	5	57	0	62
Maine	1	1	0	9	6	0	173	189	1	89	99	189
Maryland	3	2	4	88	3	1	55	153	4	150	1	155
Massachusetts	1	0	2	7	1	2	18	30	3	30	0	33
Michigan	5	1	1	48	7	0	95	152	2	157	5	164
Minnesota	5	4	4	50	15	0	146	219	9	210	0	219
Mississippi	4	0	0	13	0	0	16	29	1	29	0	30
Missouri	7	1	1	65	0	0	97	164	2	164	0	166
Montana	8	25	1	0	4	1	171	202	4	198	0	202
Nebraska	7	0	0	0	0	0	13	13	1	13	0	14

State/ Jurisdiction	HHS Region	Race							Ethnicity			
		American Indian / Alaska Native	Asian	Black or African American	Multiple Races	Native Hawaiian / Other Pacific Islander	White	Total	Hispanic or Latino	Not Hispanic or Latino	Unk.	Total
Nevada	9	0	2	10	2	0	21	35	2	35	0	37
New Hampshire	1	3	4	4	8	0	267	286	9	286	1	296
New Jersey	2	0	9	61	10	0	203	283	30	251	2	283
New Mexico	6	5	0	4	2	0	108	119	36	83	0	119
New York	2	1	0	36	7	0	86	130	17	113	12	142
North Carolina	4	1	0	24	3	1	51	80	3	80	21	104
North Dakota	8	45	1	8	14	0	200	268	16	251	1	268
N. Marianas	9	1	3	0	4	9	3	20	0	20	0	20
Ohio	5	2	1	105	8	0	300	416	6	410	81	497
Oklahoma	6	6	0	17	2	0	41	66	1	65	0	66
Oregon	10	0	0	1	0	0	35	36	2	27	7	36
Pennsylvania	3	0	4	58	15	0	164	241	15	263	0	278
Puerto Rico	2	0	0	0	78	0	0	78	78	0	0	78
Rhode Island	1	1	1	14	6	0	191	213	16	213	0	229
South Carolina	4	3	0	105	8	3	92	211	6	197	8	211
South Dakota	8	3	0	1	1	0	22	27	1	29	0	30
Tennessee	4	0	1	19	6	0	53	79	1	79	0	80
Texas	6	3	4	173	18	1	542	741	198	541	2	741
Utah	8	3	0	6	1	0	142	152	16	152	0	168
Vermont	1	2	2	7	3	2	79	95	1	95	0	96
Virgin Islands	2	0	0	8	0	0	1	9	0	9	0	9
Virginia	3	0	2	34	4	1	88	129	5	124	13	142
Washington	10	16	5	65	16	4	230	336	29	336	0	365
West Virginia	3	2	0	5	1	0	65	73	1	73	0	74
Wisconsin	5	2	1	44	8	1	87	143	12	102	29	143
Wyoming	8	2	0	0	5	0	22	29	5	24	0	29
Totals		203	129	1,898	437	122	6,099	8,888	913	7,962	473	9,348
Percentages		2.28	1.45	21.35	4.92	1.37	68.62	100	9.77	85.17	5.06	100.00

Table 4 - Living Arrangements of PAIMI Eligible Individuals – FY2017

State/ Jurisdiction	HHS Region	Community Residential Home for Children/ Youth up to age 18 Yrs.	Community Residential Home for Adults	Non-Medical Community -Based Residential Facility for Children/ Youth	Foster Care	Nursing Homes, Including Skilled Nursing Facilities (SNF)	Intermediate Care Facilities (ICF)	Public and Private General Hospital	Public and Private Institutions	Psychiatric Hospitals (Public or Private)	Legal/Jail/ Detention	Veterans Administration Hospital	Other Federal Facility	Homeless	Independent (in the community & PAIMI-eligible)	Parental or Other Family Home	Unk.	Total
Alabama	4	0	11	0	9	4	0	0	112	3	43	0	0	0	0	0	75	257
Alaska	10	0	7	1	0	0	0	0	1	0	7	0	0	3	28	11	3	61
AIC	11	1	0	0	3	0	0	0	1	0	4	0	0	0	5	14	0	28
Am. Samoa	9	0	0	0	0	0	0	0	0	12	18	0	0	0	11	13	0	54
Arizona	9	2	16	0	0	0	0	0	1	27	2	1	0	18	0	0	269	336
Arkansas	6	1	6	0	1	2	0	0	2	15	17	0	0	0	22	58	0	124
California	9	5	14	0	2	7	1	4	92	10	111	0	0	30	446	124	1	847
Colorado	8	0	2	0	0	2	0	4	1	2	69	0	0	1	8	3	0	92
Connecticut	1	0	1	0	0	5	0	0	0	0	1	0	0	0	1	0	1	9
Delaware	3	0	15	0	0	2	0	0	0	70	5	0	0	3	63	29	0	187
DC	3	0	9	0	0	3	0	2	38	15	5	0	0	22	9	13	24	140
Florida	4	1	11	0	0	1	0	1	120	15	72	0	0	3	8	9	0	241
Georgia	4	1	7	0	0	0	0	1	3	78	2	0	0	2	14	12	3	123
Guam	9	3	3	0	1	1	0	0	0	0	0	0	0	1	3	16	0	28
Hawaii	9	0	11	0	1	0	0	0	0	36	2	0	0	4	0	158	0	212
Idaho	10	1	9	0	2	5	0	0	47	6	5	0	0	1	13	11	0	100
Illinois	5	4	5	0	1	52	1	5	54	35	5	0	0	12	161	155	1	491
Indiana	5	2	0	0	0	3	0	0	0	22	24	0	0	4	14	26	5	100
Iowa	7	0	2	0	0	1	0	0	1	2	8	0	0	1	7	4	15	41
Kansas	7	0	13	0	0	58	1	1	32	29	0	0	0	10	227	57	0	428
Kentucky	4	14	0	0	4	5	0	0	45	3	36	0	0	0	14	22	2	145
Louisiana	6	0	1	1	0	4	0	1	34	5	15	0	0	1	5	9	48	124
Maine	1	23	20	0	1	2	0	20	0	37	35	0	0	3	4	4	70	219
Maryland	3	1	4	0	0	1	2	2	0	57	18	0	0	3	53	4	0	145
Massachusetts	1	0	7	0	1	3	0	11	57	0	2	0	0	3	43	27	0	154
Michigan	5	1	13	0	0	17	0	0	2	21	7	0	0	1	14	43	0	119
Minnesota	5	5	24	0	10	9	0	0	11	15	15	0	1	4	66	35	0	195
Mississippi	4	1	1	0	0	0	0	0	20	0	7	0	0	0	2	38	0	69

State/ Jurisdiction	HHS Region	Community Residential Home for Children/ Youth up to age 18 Yrs.	Community Residential Home for Adults	Non-Medical Community -Based Residential Facility for Children/ Youth	Foster Care	Nursing Homes, Including Skilled Nursing Facilities (SNF)	Intermediate Care Facilities (ICF)	Public and Private General Hospital	Public and Private Institutions	Psychiatric Hospitals (Public or Private)	Legal/Jail/ Detention	Veterans Administration Hospital	Other Federal Facility	Homeless	Independent (in the community & PAIMI-eligible)	Parental or Other Family Home	Unk.	Total
Missouri	7	0	15	0	1	37	2	0	64	0	32	0	0	0	41	18	0	210
Montana	8	0	4	50	0	2	0	3	43	0	56	1	0	4	47	11	4	225
Nebraska	7	0	1	0	0	1	0	0	15	0	0	0	0	0	2	0	3	22
Nevada	9	0	3	0	0	0	0	1	11	1	11	0	0	2	20	0	0	49
New Hampshire	1	3	12	0	1	2	0	7	0	45	22	0	0	6	0	0	142	240
New Jersey	2	0	2	0	0	2	0	13	0	181	3	0	0	0	36	56	0	293
New Mexico	6	1	7	0	1	1	0	3	0	113	6	0	0	0	14	12	0	158
New York	2	3	4	0	0	10	0	0	0	0	30	0	0	4	0	0	0	51
North Carolina	4	1	7	0	0	1	0	0	37	3	48	0	0	2	19	20	0	138
North Dakota	8	0	6	3	0	1	0	0	0	43	8	0	0	9	47	136	0	253
N. Marianas	9	0	0	0	0	0	0	0	0	1	4	0	0	1	6	0	0	12
Ohio	5	11	18	1	1	32	0	0	0	0	60	0	0	9	162	0	13	307
Oklahoma	6	0	2	0	0	0	0	1	0	30	31	0	0	0	8	7	0	79
Oregon	10	2	0	2	0	0	0	6	3	20	15	0	0	0	3	1	3	55
Pennsylvania	3	4	3	9	1	3	0	4	4	47	49	0	0	1	54	64	2	245
Puerto Rico	2	1	5	0	0	0	0	0	43	7	3	0	0	1	35	28	0	123
Rhode Island	1	1	9	0	0	12	0	3	9	76	5	0	0	4	55	73	9	256
South Carolina	4	1	2	0	1	0	0	0	12	11	148	0	0	0	10	21	2	208
South Dakota	8	1	2	1	0	1	0	0	4	8	3	0	0	0	9	30	0	59
Tennessee	4	3	6	0	0	0	0	0	2	21	28	0	0	4	2	0	23	89
Texas	6	27	14	3	21	12	0	5	18	321	68	0	2	17	114	80	1	703
Utah	8	2	0	0	1	0	0	0	8	1	23	0	0	1	85	21	0	142
Vermont	1	0	7	0	0	0	2	3	22	16	21	0	0	2	23	1	0	97
Virgin Islands	2	1	0	0	0	0	0	0	3	1	0	0	0	2	7	3	0	17
Virginia	3	0	1	0	0	1	0	0	115	3	9	0	0	0	0	3	0	132
Washington	10	0	3	0	0	0	0	0	102	1	351	0	0	11	81	12	40	601
West Virginia	3	0	3	0	1	2	0	0	0	39	6	0	0	7	18	14	0	90

State/ Jurisdiction	HHS Region	Community Residential Home for Children/ Youth up to age 18 Yrs.	Community Residential Home for Adults	Non-Medical Community -Based Residential Facility for Children/ Youth	Foster Care	Nursing Homes, Including Skilled Nursing Facilities (SNF)	Intermediate Care Facilities (ICF)	Public and Private General Hospital	Public and Private Institutions	Psychiatric Hospitals (Public or Private)	Legal/Jail/ Detention	Veterans Administration Hospital	Other Federal Facility	Homeless	Independent (in the community & PAIMI-eligible)	Parental or Other Family Home	Unk.	Total
Wisconsin	5	0	5	0	0	2	0	0	7	17	38	0	0	0	17	42	0	128
Wyoming	8	0	1	0	0	1	0	0	1	25	0	0	0	0	7	3	0	38
Totals		128	354	71	65	310	9	101	1,197	1,546	1,613	2	3	217	2,163	1,551	759	10,089
Percentages		1.27	3.51	0.70	0.64	3.07	0.09	1.00	11.86	15.32	15.99	0.02	0.03	2.15	21.44	15.37	7.52	100.00

Table 4 - Living Arrangements of PAIMI Eligible Individuals – FY2018

State/ Jurisdiction	HHS Region	Community Residential Home for Children/ Youth up to age	Community Residential Home for Adults	Non-Medical Community -Based Residential Facility for Children/ Youth	Foster Care	Nursing Homes, Including Skilled Nursing Facilities (SNF)	Intermediate Care Facilities (ICF)	Public and Private General Hospital	Public and Private Institutions	Psychiatric Hospitals (Public or Private)	Legal/Jail/ Detention	Veterans Administration Hospital	Other Federal Facility	Homeless	Independent (in the community & PAIMI-eligible)	Parental or Other Family Home	Unk.	Total
Alabama	4	3	6	0	28	2	0	0	50	1	29	0	0	0	5	6	65	195
Alaska	10	0	5	0	0	0	0	0	0	1	0	0	0	7	26	10	0	49
AIC	11	1	0	0	2	0	0	0	2	0	1	0	0	0	1	14	0	21
Am. Samoa	9	0	0	0	0	0	0	0	0	42	4	0	0	0	20	0	0	66
Arizona	9	3	16	0	1	2	0	3	11	14	2	0	0	15	9	3	279	358
Arkansas	6	0	5	5	0	2	0	0	3	3	11	0	0	1	5	5	53	93
California	9	2	17	0	3	9	1	5	67	38	80	0	0	31	400	127	0	780
Colorado	8	0	0	0	0	1	0	16	2	12	68	0	0	1	21	1	10	132
Connecticut	1	0	0	0	0	6	0	1	1	3	1	0	0	0	4	2	0	18
Delaware	3	0	16	0	0	1	0	0	0	80	8	0	0	4	47	27	0	183
DC	3	0	6	0	0	1	0	0	43	9	6	0	0	17	10	8	13	113
Florida	4	0	5	0	0	3	4	0	101	24	49	0	0	0	8	5	3	202
Georgia	4	1	9	0	0	0	0	0	0	72	1	0	0	2	7	4	0	96
Guam	9	1	3	1	0	0	2	0	0	1	0	0	0	1	1	6	0	16
Hawaii	9	0	11	0	5	0	0	19	0	0	3	0	0	0	0	3	85	126
Idaho	10	0	10	2	0	1	2	1	3	57	2	0	0	4	8	12	0	102
Illinois	5	0	6	2	1	34	1	6	39	70	10	0	0	10	133	160	0	472
Indiana	5	0	2	1	0	0	0	0	14	1	30	0	0	0	21	17	10	96
Iowa	7	1	2	0	0	3	0	0	0	0	7	0	0	0	5	7	15	40
Kansas	7	0	14	0	0	63	0	2	22	21	8	0	0	6	248	47	0	431
Kentucky	4	11	0	0	2	4	1	0	34	5	22	0	0	2	12	17	1	111
Louisiana	6	1	4	1	1	2	1	0	4	12	3	0	0	0	10	23	0	62
Maine	1	14	21	7	2	1	0	25	0	47	21	1	0	4	22	11	13	189
Maryland	3	1	3	0	0	0	0	0	16	45	18	0	0	1	60	8	0	152
Massachusetts	1	0	3	0	0	1	0	5	12	0	1	0	0	1	5	5	0	33
Michigan	5	1	12	0	0	27	0	5	6	41	6	0	0	1	15	45	0	159
Minnesota	5	3	20	0	8	0	7	1	14	13	21	0	0	5	89	38	0	219
Mississippi	4	0	0	0	0	0	0	0	0	16	4	0	0	0	5	5	0	30

State/ Jurisdiction	HHS Region	Community Residential Home for Children/ Youth up to age	Community Residential Home for Adults	Non-Medical Community -Based Residential Facility for Children/ Youth	Foster Care	Nursing Homes, Including Skilled Nursing Facilities (SNF)	Intermediate Care Facilities (ICF)	Public and Private General Hospital	Public and Private Institutions	Psychiatric Hospitals (Public or Private)	Legal/Jail/ Detention	Veterans Administration Hospital	Other Federal Facility	Homeless	Independent (in the community & PAIMI-eligible)	Parental or Other Family Home	Unk.	Total
Missouri	7	0	16	1	1	23	4	0	43	12	28	0	0	2	31	5	0	166
Montana	8	1	6	0	1	1	0	2	102	2	53	0	0	4	22	7	1	202
Nebraska	7	0	0	0	0	2	0	0	8	0	0	0	0	0	4	0	0	14
Nevada	9	0	4	0	0	0	0	1	4	5	5	0	0	1	16	1	0	37
New Hampshire	1	0	9	0	0	3	0	5	24	33	11	0	0	7	78	1	125	296
New Jersey	2	3	1	0	1	2	0	5	3	178	0	0	0	0	41	49	0	283
New York	2	0	7	0	0	6	0	1	3	4	24	0	0	6	26	2	63	142
North Carolina	4	2	6	0	0	1	0	0	37	4	29	0	0	2	8	15	0	104
North Dakota	8	0	7	1	5	1	0	1	7	41	4	0	0	7	40	154	0	268
N. Marianas	9	0	0	0	0	0	0	0	0	1	6	0	0	1	7	5	0	20
Ohio	5	6	31	1	0	23	2	5	20	91	51	0	0	12	166	105	1	514
Oklahoma	6	0	0	0	0	1	0	0	0	11	50	0	0	0	2	1	0	65
Oregon	10	0	3	0	0	1	0	1	3	15	6	0	0	0	3	2	2	36
Pennsylvania	3	3	6	3	0	3	0	2	10	59	25	0	0	5	99	63	0	278
Puerto Rico	2	0	1	0	0	0	0	0	42	12	3	0	0	0	14	6	0	78
Rhode Island	1	1	8	2	0	11	0	7	11	44	6	0	0	5	74	52	8	229
South Carolina	4	2	1	1	0	0	0	1	20	6	140	0	0	0	7	31	2	211
South Dakota	8	0	1	2	0	2	1	0	1	7	1	0	0	0	7	8	0	30
Tennessee	4	0	7	4	0	0	0	0	0	14	23	0	0	1	5	0	26	80
Texas	6	11	9	9	1	13	0	3	13	398	90	0	0	10	122	50	12	741
Utah	8	2	0	0	0	2	0	0	9	3	11	0	0	6	114	21	0	168
Vermont	1	1	5	0	0	2	0	1	12	15	15	0	0	2	38	5	0	96
Virgin Islands	2	1	0	0	0	0	0	0	2	0	0	0	0	0	3	3	0	9
Virginia	3	0	14	1	0	3	0	0	13	98	7	0	0	0	2	4	0	142
Washington	10	1	13	1	0	2	2	1	33	50	200	0	0	17	4	1	103	428
West Virginia	3	0	3	1	1	0	0	0	0	30	5	0	0	3	20	11	0	74
Wisconsin	5	0	11	1	1	3	0	0	2	18	47	0	0	1	26	33	0	143

State/ Jurisdiction	HHS Region	Community Residential Home for Children/ Youth up to age	Community Residential Home for Adults	Non-Medical Community -Based Residential Facility for Children/ Youth	Foster Care	Nursing Homes, Including Skilled Nursing Facilities (SNF)	Intermediate Care Facilities (ICF)	Public and Private General Hospital	Public and Private Institutions	Psychiatric Hospitals (Public or Private)	Legal/Jail/ Detention	Veterans Administration Hospital	Other Federal Facility	Homeless	Independent (in the community & PAIMI-eligible)	Parental or Other Family Home	Unk.	Total
Wyoming	8	0	0	0	0	0	0	0	0	23	0	0	0	0	6	0	0	29
Totals		77	365	47	64	268	28	125	866	1,802	1,256	1	0	205	2,182	1,251	890	9,427
Percentages		0.82	3.87	0.50	0.68	2.84	0.30	1.33	9.19	19.12	13.32	0.01	0.00	2.17	23.15	13.27	9.44	100.00

Table 5 – Complaints Involving Alleged Abuse of PAIMI Eligible Individuals – FY2017

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Inappropriate/Excessive					Involuntary				Failure to provide appropriate	Complaints Concerning							
			Medication	Physical Restraint	Chemical Restraint	Mechanical Restraint	Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization		Failure to provide Medical Treatment	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
Alabama	4	33	1	10	1	0	0	0	0	0	0	13	2	1	0	2	0	2	1	0
Alaska	10	9	0	0	0	2	1	1	0	0	0	3	0	0	2	0	0	0	0	0
AIC	11	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Am. Samoa	9	19	5	0	0	0	3	2	0	0	0	3	3	0	0	0	2	1	0	0
Arizona	9	8	0	1	0	0	0	0	0	0	0	1	1	1	3	0	0	1	0	0
Arkansas	6	19	1	1	0	0	2	0	0	0	0	7	2	2	1	2	0	1	0	0
California	9	66	3	4	1	0	2	3	0	0	0	14	2	14	7	3	1	2	10	0
Colorado	8	35	0	2	0	3	14	0	0	0	0	15	0	1	0	0	0	0	0	0
Connecticut	1	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Delaware	3	4	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	2	0
DC	3	32	1	5	1	0	0	4	0	0	0	6	3	6	3	2	0	1	0	0
Florida	4	71	5	2	0	0	1	1	0	0	0	34	22	1	0	1	0	3	1	0
Georgia	4	38	0	0	0	0	1	16	0	0	0	3	3	0	0	3	0	0	12	0
Guam	9	3	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2	0
Hawaii	9	15	3	2	1	0	0	0	0	0	0	3	0	2	1	3	0	0	0	0
Idaho	10	12	3	1	0	0	0	0	0	0	0	5	0	1	0	1	0	0	1	0
Illinois	5	47	4	3	4	1	2	6	0	0	0	9	7	2	2	3	0	4	0	0
Indiana	5	8	0	1	0	0	0	0	0	0	0	4	0	1	0	2	0	0	0	0
Iowa	7	47	2	9	1	5	8	0	0	0	0	9	3	2	1	1	1	1	4	0
Kansas	7	28	4	1	0	1	1	2	0	0	0	7	0	5	2	0	1	4	0	0
Kentucky	4	13	1	3	1	1	2	1	0	0	0	2	0	1	0	0	0	0	1	0
Louisiana	6	17	0	1	0	0	0	1	0	0	0	7	4	3	0	1	0	0	0	0
Maine	1	49	0	8	1	0	0	0	0	0	0	38	0	0	0	0	0	2	0	0
Maryland	3	44	0	2	1	0	13	4	0	0	0	5	3	8	4	2	0	1	1	0
Massachusetts	1	45	1	3	2	0	0	0	0	0	0	27	6	4	1	1	0	0	0	0
Michigan	5	21	0	4	1	0	1	0	0	0	0	6	1	3	0	2	0	0	0	3
Minnesota	5	25	0	1	0	0	0	1	0	1	0	13	7	1	0	1	0	0	0	0
Mississippi	4	8	1	0	1	0	0	0	0	0	0	3	2	0	0	1	0	0	0	0

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Inappropriate/Excessive					Involuntary				Failure to provide appropriate	Complaints Concerning							
			Medication	Physical Restraint	Chemical Restraint	Mechanical Restraint	Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization		Failure to provide Medical Treatment	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
Missouri	7	86	17	4	0	0	0	3	1	0	0	28	28	2	1	1	0	0	1	0
Montana	8	82	1	13	0	0	8	0	0	0	0	22	5	6	7	3	1	1	1	14
Nebraska	7	9	0	1	0	0	1	0	0	0	0	1	3	1	0	1	0	1	0	0
Nevada	9	7	0	0	0	0	0	1	0	0	0	5	1	0	0	0	0	0	0	0
New Hampshire	1	46	3	4	1	0	3	2	0	0	0	28	1	2	2	0	0	0	0	0
New Jersey	2	79	17	2	0	0	0	0	0	0	0	10	6	14	2	8	0	0	20	0
New Mexico	6	99	21	4	1	0	5	22	0	0	0	13	7	10	10	2	0	2	2	0
New York	2	46	0	0	1	0	1	1	0	0	0	30	2	3	2	6	0	0	0	0
North Carolina	4	8	1	1	0	0	2	0	0	0	0	2	0	1	1	0	0	0	0	0
North Dakota	8	36	0	5	5	0	2	2	0	0	0	5	2	2	2	3	0	7	0	1
N. Marianas	9	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ohio	5	141	11	3	1	1	13	1	0	0	0	36	31	17	4	14	3	3	0	3
Oklahoma	6	15	2	0	0	0	2	0	0	0	0	6	0	3	0	1	1	0	0	0
Oregon	10	17	0	1	0	0	5	0	0	0	0	3	0	1	1	0	6	0	0	0
Pennsylvania	3	21	1	2	0	0	1	0	0	1	0	7	2	6	0	1	0	0	0	0
Puerto Rico	2	5	1	1	0	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0
Rhode Island	1	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
South Carolina	4	127	0	0	0	0	0	0	0	0	0	124	0	1	0	0	0	0	0	2
South Dakota	8	13	0	0	0	0	1	1	0	0	0	8	1	0	0	2	0	0	0	0
Tennessee	4	32	5	2	1	0	1	0	0	0	0	12	2	8	1	0	0	0	0	0
Texas	6	180	10	11	2	0	2	5	1	0	0	88	42	7	5	3	0	4	0	0
Utah	8	7	0	0	0	0	0	0	0	0	0	5	2	0	0	0	0	0	0	0
Vermont	1	47	2	7	2	4	4	0	0	0	0	17	2	3	2	1	2	0	0	1
Virgin Islands	2	4	1	0	0	0	0	0	0	0	0	2	0	0	1	0	0	0	0	0
Virginia	3	55	1	7	0	6	0	1	0	0	0	15	1	6	5	3	7	0	3	0
Washington	10	301	9	10	3	1	33	9	0	1	0	173	35	1	0	17	0	5	0	4
West Virginia	3	18	3	2	0	0	2	0	0	0	0	2	0	1	2	5	0	1	0	0
Wisconsin	5	16	0	0	0	2	1	0	0	0	0	12	1	0	0	0	0	0	0	0
Wyoming	8	26	0	1	0	2	0	0	0	0	0	13	7	0	2	0	0	0	1	0

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Inappropriate/Excessive					Involuntary				Failure to provide appropriate	Complaints Concerning							
			Medication	Physical Restraint	Chemical Restraint	Mechanical Restraint	Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization		Failure to provide Medical Treatment	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
Totals		2,245	143	145	34	29	139	90	2	3	0	907	254	155	77	102	25	49	63	28
Percentages		100.00	6.37	6.46	1.51	1.29	6.19	4.01	0.09	0.13	0.00	40.40	11.31	6.90	3.43	4.54	1.11	2.18	2.81	1.25

Table 5 – Complaints Involving Alleged Abuse of PAIMI Eligible Individuals – FY2018

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Inappropriate/Excessive					Involuntary				Complaints Concerning								
			Medication	Physical Restraint	Chemical Restraint	Mechanical Restraint	Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization	Failure to provide appropriate	Failure to provide Medical Treatment	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
Alabama	4	22	2	5	2	0	1	0	0	0	0	3	0	8	1	0	0	0	0	0
Alaska	10	2	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
AIC	11	3	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0
Am. Samoa	9	5	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	2	0	0
Arizona	9	28	8	3	0	0	2	1	1	1	0	5	2	2	2	1	0	0	0	0
Arkansas	6	16	0	1	0	0	0	0	0	0	0	9	3	3	0	0	0	0	0	0
California	9	57	5	7	0	0	4	0	0	0	0	6	0	5	4	3	0	3	20	0
Colorado	8	17	0	0	0	0	0	0	0	0	0	16	1	0	0	0	0	0	0	0
Connecticut	1	3	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Delaware	3	15	0	2	0	0	0	0	0	0	0	6	1	2	2	1	0	1	0	0
DC	3	37	0	3	2	1	3	2	0	0	0	16	2	1	3	0	0	2	2	0
Florida	4	98	4	1	0	0	2	0	0	0	0	33	17	27	2	2	0	2	7	1
Georgia	4	30	0	1	4	0	0	7	0	0	0	1	1	2	0	1	0	0	10	3
Guam	9	2	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0
Hawaii	9	5	0	0	0	1	0	0	0	0	0	1	0	3	0	0	0	0	0	0
Idaho	10	31	3	9	2	0	3	3	0	0	0	6	2	1	0	1	0	1	0	0
Illinois	5	55	5	10	1	1	7	5	0	2	0	6	6	5	0	2	0	3	0	2
Indiana	5	16	1	2	0	0	0	0	0	0	0	7	3	0	0	3	0	0	0	0
Iowa	7	33	0	5	0	0	7	0	0	0	0	9	1	2	1	3	0	1	4	0
Kansas	7	21	2	2	1	0	0	0	0	0	0	2	5	2	1	1	4	0	1	0
Kentucky	4	4	0	3	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Louisiana	6	5	0	0	0	0	0	2	0	0	0	1	1	1	0	0	0	0	0	0
Maine	1	50	0	6	1	0	1	0	1	0	0	36	3	2	0	0	0	0	0	0
Maryland	3	36	1	5	0	1	2	3	0	0	0	3	5	0	10	1	0	1	1	3
Massachusetts	1	9	0	1	0	0	0	1	0	0	0	0	6	0	0	0	0	1	0	0
Michigan	5	14	1	5	0	0	3	1	0	0	0	1	0	0	0	0	0	2	0	1
Minnesota	5	33	1	1	0	0	0	0	0	0	0	18	3	3	0	0	0	1	0	6
Mississippi	4	8	0	1	0	0	0	0	0	0	0	3	1	0	0	3	0	0	0	0

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Inappropriate/Excessive					Involuntary				Failure to provide appropriate	Complaints Concerning							
			Medication	Physical Restraint	Chemical Restraint	Mechanical Restraint	Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization		Failure to provide Medical Treatment	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
Missouri	7	83	9	2	2	0	2	0	1	0	0	29	29	0	1	2	0	0	6	0
Montana	8	59	5	3	1	0	6	0	0	1	0	28	3	2	7	0	1	1	0	1
Nebraska	7	2	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Nevada	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
New Hampshire	1	51	4	4	1	4	3	2	0	0	0	27	2	2	0	1	1	0	0	0
New Jersey	2	103	24	0	0	1	0	1	0	0	0	8	10	37	1	7	0	1	13	0
New Mexico	6	63	10	4	0	1	5	1	0	0	0	13	12	1	7	9	0	0	0	0
New York	2	11	0	0	0	0	2	0	0	0	0	7	2	0	0	0	0	0	0	0
North Carolina	4	17	2	0	0	0	2	0	0	0	0	7	1	2	0	3	0	0	0	0
North Dakota	8	28	2	5	0	2	0	0	0	0	0	2	0	3	2	2	1	8	0	1
N. Marianas	9	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Ohio	5	57	7	3	1	0	2	1	0	0	0	16	7	5	0	6	5	2	2	0
Oklahoma	6	16	0	1	0	0	0	0	0	0	0	4	9	2	0	0	0	0	0	0
Oregon	10	11	0	1	0	0	0	0	0	0	0	3	0	0	0	0	6	1	0	0
Pennsylvania	3	17	1	0	0	1	0	3	0	0	0	3	2	4	0	0	0	3	0	0
Puerto Rico	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rhode Island	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
South Carolina	4	129	0	0	0	0	0	0	0	0	0	125	0	1	1	1	0	0	0	1
South Dakota	8	11	2	1	0	0	1	0	0	0	0	4	2	0	0	1	0	0	0	0
Tennessee	4	30	2	6	0	0	1	0	0	0	0	15	1	2	2	1	0	0	0	0
Texas	6	99	8	5	0	2	1	2	0	0	0	57	9	8	1	4	1	1	0	0
Utah	8	8	1	0	1	0	0	0	0	0	0	5	1	0	0	0	0	0	0	0
Vermont	1	33	0	5	2	1	3	0	0	0	0	7	3	3	0	4	1	1	0	3
Virgin Islands	2	10	1	0	0	0	1	0	0	0	0	2	1	2	2	0	0	0	1	0
Virginia	3	30	1	5	0	3	1	0	0	0	0	7	0	3	2	0	0	0	8	0
Washington	10	193	11	4	1	3	26	9	0	0	0	109	12	2	2	8	0	3	0	3
West Virginia	3	14	0	2	0	0	1	0	0	0	0	3	2	0	1	2	0	3	0	0
Wisconsin	5	32	0	2	0	0	6	0	0	0	0	16	4	2	2	0	0	0	0	0
Wyoming	8	21	1	3	0	1	2	0	0	0	0	6	5	1	1	1	0	0	0	0

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Inappropriate/Excessive					Involuntary				Failure to provide appropriate	Complaints Concerning							
			Medication	Physical Restraint	Chemical Restraint	Mechanical Restraint	Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization		Failure to provide Medical Treatment	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
Totals		1,785	126	132	22	23	100	44	3	4	0	697	182	153	59	75	20	44	76	25
Percentages		100.00	7.06	7.39	1.23	1.29	5.60	2.46	0.17	0.22	0.00	39.05	10.20	8.57	3.31	4.20	1.12	2.46	4.26	1.40

Table 6 – Complaints Involving Alleged Neglect of PAIMI Eligible Individuals – FY2017

State/ Jurisdiction	HHS Region	Number of Neglect Complaints Closed	Failure to Provide for Appropriate								
			Admission to Residential Care or Treatment Facility	Transportation to/from Residential Care or Treatment Facility	Discharge Planning or Release from Residential Care or Treatment Facility	Mental Health Diagnostic or Other Evaluation (does not include treatment)	Medical (non-mental health related) diagnostic physical examination	Inadequate Care (e.g., personal hygiene, clothing, food, shelter)	Physical Plant or Environmental Safety	Personal Safety Issues (unsecured access to facility, resident rooms, patient to patient abuse)	Other
Alabama	4	74	8	0	29	1	5	3	1	26	1
Alaska	10	2	0	0	1	1	0	0	0	0	0
AIC	11	1	0	0	0	0	0	1	0	0	0
Am. Samoa	9	9	1	1	2	1	1	1	1	0	1
Arizona	9	8	2	0	3	1	0	0	0	2	0
Arkansas	6	18	1	0	12	0	0	3	0	2	0
California	9	21	2	0	4	11	1	2	0	1	0
Colorado	8	2	0	0	1	0	1	0	0	0	0
Connecticut	1	0	0	0	0	0	0	0	0	0	0
Delaware	3	12	0	0	9	0	0	2	0	1	0
DC	3	43	0	0	18	3	0	20	0	2	0
Florida	4	32	1	0	10	1	5	11	2	2	0
Georgia	4	92	0	0	56	1	5	4	0	0	26
Guam	9	3	2	0	1	0	0	0	0	0	0
Hawaii	9	10	0	0	5	1	0	2	0	2	0
Idaho	10	59	2	0	42	2	5	6	0	2	0
Illinois	5	151	29	2	66	23	6	10	10	5	0
Indiana	5	17	1	0	8	0	0	4	1	3	0
Iowa	7	13	2	0	0	0	0	2	5	4	0
Kansas	7	40	2	0	27	0	4	4	1	2	0
Kentucky	4	16	0	0	11	3	1	0	0	1	0
Louisiana	6	17	1	0	12	0	0	1	0	3	0
Maine	1	37	4	0	32	0	0	1	0	0	0
Maryland	3	20	1	0	8	3	1	5	0	1	1
Massachusetts	1	35	3	0	20	3	2	4	0	3	0
Michigan	5	29	0	0	5	2	1	0	0	20	1
Minnesota	5	19	2	0	6	1	0	10	0	0	0
Mississippi	4	9	0	0	3	0	0	3	0	2	1

State/ Jurisdiction	HHS Region	Number of Neglect Complaints Closed	Failure to Provide for Appropriate								
			Admission to Residential Care or Treatment Facility	Transportation to/from Residential Care or Treatment Facility	Discharge Planning or Release from Residential Care or Treatment Facility	Mental Health Diagnostic or Other Evaluation (does not include treatment)	Medical (non-mental health related) diagnostic physical examination	Inadequate Care (e.g., personal hygiene, clothing, food, shelter)	Physical Plant or Environmental Safety	Personal Safety Issues (unsecured access to facility, resident rooms, patient to patient abuse)	Other
Missouri	7	95	1	0	30	10	30	22	1	1	0
Montana	8	51	1	0	6	13	14	5	6	2	4
Nebraska	7	3	0	0	0	0	1	0	2	0	0
Nevada	9	11	0	0	4	0	1	1	0	0	5
New Hampshire	1	30	11	0	16	0	1	1	0	1	0
New Jersey	2	31	0	0	23	0	2	1	2	2	1
New Mexico	6	199	22	0	63	6	12	72	0	24	0
New York	2	32	2	0	22	3	2	1	0	2	0
North Carolina	4	28	4	0	10	6	3	1	1	3	0
North Dakota	8	30	0	0	10	6	4	5	0	5	0
N. Marianas	9	1	0	0	0	0	0	1	0	0	0
Ohio	5	130	5	4	52	11	17	15	2	21	3
Oklahoma	6	10	0	0	10	0	0	0	0	0	0
Oregon	10	14	1	0	9	1	2	1	0	0	0
Pennsylvania	3	47	9	0	32	2	2	0	1	0	1
Puerto Rico	2	22	13	0	0	2	0	4	3	0	0
Rhode Island	1	19	3	0	11	1	1	0	0	1	2
South Carolina	4	6	1	0	2	0	0	0	1	0	2
South Dakota	8	9	0	0	6	2	0	1	0	0	0
Tennessee	4	11	4	0	0	1	1	2	0	3	0
Texas	6	136	5	0	74	5	0	30	3	19	0
Utah	8	2	1	0	0	0	0	0	0	0	1
Vermont	1	27	7	1	13	0	2	1	0	0	3
Virgin Islands	2	1	1	0	0	0	0	0	0	0	0
Virginia	3	61	3	0	34	2	6	3	1	12	0
Washington	10	164	6	2	93	20	16	16	1	6	4
West Virginia	3	32	0	0	21	1	5	3	0	2	0
Wisconsin	5	18	0	2	10	3	0	1	1	1	0

State/ Jurisdiction	HHS Region	Number of Neglect Complaints Closed	Failure to Provide for Appropriate								
			Admission to Residential Care or Treatment Facility	Transportation to/from Residential Care or Treatment Facility	Discharge Planning or Release from Residential Care or Treatment Facility	Mental Health Diagnostic or Other Evaluation (does not include treatment)	Medical (non-mental health related) diagnostic physical examination	Inadequate Care (e.g., personal hygiene, clothing, food, shelter)	Physical Plant or Environmental Safety	Personal Safety Issues (unsecured access to facility, resident rooms, patient to patient abuse)	Other
Wyoming	8	12	1	0	3	0	1	3	2	2	0
Totals		2,021	165	12	945	153	161	289	48	191	57
Percentages		100.00	8.16	0.59	46.76	7.57	7.97	14.30	2.38	9.45	2.82

Table 6 – Complaints Involving Alleged Neglect of PAIMI Eligible Individuals – FY2018

State/ Jurisdiction	HHS Region	Number of Neglect Complaints Closed	Failure to Provide for Appropriate								
			Admission to Residential Care or Treatment Facility	Transportation to/from Residential Care or Treatment Facility	Discharge Planning or Release from Residential Care or Treatment Facility	Mental Health Diagnostic or Other Evaluation (does not include treatment)	Medical (non-mental health related) diagnostic physical examination	Inadequate Care (e.g., personal hygiene, clothing, food, shelter)	Physical Plant or Environmental Safety	Personal Safety Issues (unsecured access to facility, resident rooms, patient to patient abuse)	Other
Alabama	4	59	3	0	25	3	1	1	0	3	23
Alaska	10	2	1	0	1	0	0	0	0	0	0
AIC	11	1	0	0	0	0	0	1	0	0	0
Am. Samoa	9	31	5	4	7	3	3	4	4	1	0
Arizona	9	35	5	1	7	13	1	4	0	3	1
Arkansas	6	5	3	0	1	0	0	0	1	0	0
California	9	23	1	1	6	2	9	2	1	1	0
Colorado	8	20	0	0	0	17	3	0	0	0	0
Connecticut	1	1	0	0	0	0	1	0	0	0	0
Delaware	3	34	0	0	23	0	0	8	1	2	0
DC	3	26	1	0	14	0	0	11	0	0	0
Florida	4	39	1	0	15	1	3	15	1	3	0
Georgia	4	105	0	1	58	1	5	6	0	2	32
Guam	9	4	4	0	0	0	0	0	0	0	0
Hawaii	9	7	0	0	3	1	1	0	0	2	0
Idaho	10	33	1	0	25	1	1	0	1	4	0
Illinois	5	59	9	0	36	6	1	4	2	1	0
Indiana	5	12	0	0	4	0	1	3	3	1	0
Iowa	7	15	2	1	2	1	0	7	1	1	0
Kansas	7	31	0	0	12	7	6	6	0	0	0
Kentucky	4	7	0	0	2	0	1	1	1	2	0
Louisiana	6	5	3	0	1	0	1	0	0	0	0
Maine	1	43	8	0	34	0	1	0	0	0	0
Maryland	3	19	5	0	11	1	0	0	1	0	1
Massachusetts	1	19	4	0	5	0	0	0	0	10	0
Michigan	5	22	1	0	5	1	2	7	0	6	0

State/ Jurisdiction	HHS Region	Number of Neglect Complaints Closed	Failure to Provide for Appropriate								
			Admission to Residential Care or Treatment Facility	Transportation to/from Residential Care or Treatment Facility	Discharge Planning or Release from Residential Care or Treatment Facility	Mental Health Diagnostic or Other Evaluation (does not include treatment)	Medical (non-mental health related) diagnostic physical examination	Inadequate Care (e.g., personal hygiene, clothing, food, shelter)	Physical Plant or Environmental Safety	Personal Safety Issues (unsecured access to facility, resident rooms, patient to patient abuse)	Other
Minnesota	5	34	14	2	11	1	0	5	0	0	1
Mississippi	4	8	1	0	1	0	0	6	0	0	0
Missouri	7	52	1	0	9	1	19	14	3	5	0
Montana	8	91	0	0	6	2	2	0	9	70	2
Nebraska	7	0	0	0	0	0	0	0	0	0	0
Nevada	9	8	0	0	2	0	1	3	0	0	2
New Hampshire	1	47	16	1	17	3	5	5	0	0	0
New Jersey	2	25	1	0	16	0	2	3	2	1	0
New Mexico	6	139	5	0	51	7	8	47	0	21	0
New York	2	28	2	0	21	1	0	4	0	0	0
North Carolina	4	7	0	0	4	1	2	0	0	0	0
North Dakota	8	40	3	0	3	1	6	14	3	10	0
N. Marianas	9	5	2	0	0	1	0	1	1	0	0
Ohio	5	68	11	3	18	6	8	12	3	6	1
Oklahoma	6	7	3	0	1	0	1	1	1	0	0
Oregon	10	4	0	0	3	1	0	0	0	0	0
Pennsylvania	3	26	1	0	13	3	6	0	0	2	1
Puerto Rico	2	2	2	0	0	0	0	0	0	0	0
Rhode Island	1	6	0	0	5	1	0	0	0	0	0
South Carolina	4	12	2	0	7	0	1	0	0	0	2
South Dakota	8	5	0	0	4	0	0	0	1	0	0
Tennessee	4	20	0	0	6	1	6	6	0	1	0
Texas	6	135	7	1	50	8	21	24	1	19	4
Utah	8	0	0	0	0	0	0	0	0	0	0
Vermont	1	25	5	0	12	1	0	3	1	2	1
Virgin Islands	2	9	2	0	0	2	1	1	2	1	0
Virginia	3	70	0	0	57	0	4	2	2	5	0

State/ Jurisdiction	HHS Region	Number of Neglect Complaints Closed	Failure to Provide for Appropriate								
			Admission to Residential Care or Treatment Facility	Transportation to/from Residential Care or Treatment Facility	Discharge Planning or Release from Residential Care or Treatment Facility	Mental Health Diagnostic or Other Evaluation (does not include treatment)	Medical (non-mental health related) diagnostic physical examination	Inadequate Care (e.g., personal hygiene, clothing, food, shelter)	Physical Plant or Environmental Safety	Personal Safety Issues (unsecured access to facility, resident rooms, patient to patient abuse)	Other
Washington	10	72	1	0	41	6	9	6	4	2	3
West Virginia	3	23	1	0	16	0	2	3	1	0	0
Wisconsin	5	21	0	2	11	5	2	1	0	0	0
Wyoming	8	8	0	0	4	0	2	1	1	0	0
Totals		1,654	137	17	686	110	149	242	52	187	74
Percentages		100.00	8.28	1.03	41.48	6.65	9.01	14.63	3.14	11.31	4.47

Table 7 – Complaints Involving Alleged Rights Violations of PAIMI Eligible Individuals – FY2017

State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	Denial of							Failure to Provide					Problem with Advance Directives	Denial of Parental /Family Rights	Other
			Financial Benefits and Entitlements	Guardianship /Conservative Problems	Rights Protection/Legal Assistance	Privacy Rights	Recreational Opportunities	Visitors	Access to Records	Individual Treatment Plan	Written Discharge Plan	Mental Health Services Planning	Confidentiality	Informed Consent			
Alabama	4	65	3	4	6	1	3	0	1	1	0	0	0	1	2	0	43
Alaska	10	29	16	0	0	0	0	0	1	0	0	0	0	0	0	0	12
AIC	11	13	2	0	0	0	0	0	0	0	0	0	0	0	1	0	10
Am. Samoa	9	25	0	0	4	2	2	2	0	4	3	0	0	0	0	3	5
Arizona	9	8	1	0	5	1	0	0	0	0	0	0	0	0	0	1	0
Arkansas	6	69	2	2	3	0	0	0	0	0	0	0	0	0	1	0	61
California	9	668	67	2	68	4	0	1	10	0	0	151	4	6	0	4	351
Colorado	8	14	0	0	8	3	3	0	0	0	0	0	0	0	0	0	0
Connecticut	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Delaware	3	58	31	1	1	1	1	1	0	0	0	0	0	0	1	1	20
DC	3	32	1	5	2	0	1	0	0	9	1	3	1	2	6	0	1
Florida	4	47	2	1	25	2	6	0	1	0	0	0	1	1	0	0	8
Georgia	4	13	1	2	3	0	0	0	0	0	0	0	0	2	0	0	5
Guam	9	19	1	7	6	0	0	0	0	0	0	0	0	0	4	1	0
Hawaii	9	174	14	14	0	0	0	0	0	0	0	91	0	0	38	0	17
Idaho	10	46	2	6	18	3	2	0	1	2	1	0	4	1	0	0	6
Illinois	5	323	9	31	1	6	2	0	7	0	0	0	0	1	3	1	262
Indiana	5	37	1	3	0	0	1	0	0	0	0	0	0	0	0	0	32
Iowa	7	32	3	3	0	0	1	0	0	0	0	1	0	0	0	0	24
Kansas	7	325	5	15	13	2	1	0	2	0	0	0	2	2	0	6	277
Kentucky	4	45	2	3	20	0	1	0	1	0	0	10	0	0	0	0	8
Louisiana	6	48	0	1	5	0	1	0	1	0	0	0	0	2	1	0	37
Maine	1	85	8	8	2	2	7	1	0	0	0	4	0	0	0	0	53
Maryland	3	74	3	0	4	2	3	0	0	1	0	0	0	2	0	0	59
Massachusetts	1	76	1	0	16	1	2	0	1	0	0	0	0	0	0	1	54
Michigan	5	27	4	0	1	0	0	0	1	1	4	1	0	0	0	0	15
Minnesota	5	102	7	8	2	13	2	3	3	15	2	25	0	0	0	2	20
Mississippi	4	11	1	0	2	0	2	0	0	0	0	0	0	0	0	0	6

State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	Denial of							Failure to Provide					Problem with Advance Directives	Denial of Parental /Family Rights	Other
			Financial Benefits and Entitlements	Guardianship /Conservative Problems	Rights Protection/Legal Assistance	Privacy Rights	Recreational Opportunities	Visitors	Access to Records	Individual Treatment Plan	Written Discharge Plan	Mental Health Services Planning	Confidentiality	Informed Consent			
Missouri	7	130	30	33	2	22	8	2	3	21	0	0	3	0	1	0	5
Montana	8	59	4	0	1	2	1	0	0	0	0	0	0	1	0	2	48
Nebraska	7	3	0	1	0	1	0	0	0	0	0	0	0	1	0	0	0
Nevada	9	21	0	0	4	1	0	1	0	0	0	0	0	0	0	0	15
New Hampshire	1	119	12	8	4	0	5	1	0	2	1	0	0	0	0	3	83
New Jersey	2	70	0	0	1	2	4	1	0	0	0	0	0	0	0	0	62
New Mexico	6	44	1	5	20	7	0	0	0	0	0	0	0	2	1	5	3
New York	2	121	5	4	2	1	0	0	1	0	0	0	0	0	0	4	104
North Carolina	4	46	1	9	9	1	6	1	0	0	0	0	0	0	0	1	18
North Dakota	8	72	1	0	3	0	1	0	0	63	1	0	0	0	0	0	3
N. Marianas	9	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Ohio	5	354	22	22	13	18	24	3	7	9	1	4	3	24	2	4	198
Oklahoma	6	11	0	0	2	0	0	0	0	0	0	0	0	1	0	0	8
Oregon	10	11	0	3	0	0	0	0	0	0	4	2	0	0	0	0	2
Pennsylvania	3	163	4	5	16	0	0	2	0	49	0	0	0	0	5	2	80
Puerto Rico	2	38	7	0	12	0	0	0	1	0	0	0	0	0	0	0	18
Rhode Island	1	62	2	4	0	0	0	0	0	0	0	0	0	0	0	0	56
South Carolina	4	15	0	1	0	0	0	0	1	0	0	0	0	0	0	0	13
South Dakota	8	29	4	0	1	2	0	0	0	0	0	0	0	0	0	0	22
Tennessee	4	24	0	0	1	0	0	2	0	0	0	0	0	0	0	0	21
Texas	6	213	10	23	28	27	26	2	5	0	0	0	4	7	2	7	72
Utah	8	111	2	1	47	0	3	0	1	0	0	0	0	0	0	2	55
Vermont	1	31	0	0	4	1	1	0	2	0	0	0	0	0	9	0	14
Virgin Islands	2	6	2	2	1	0	0	0	1	0	0	0	0	0	0	0	0
Virginia	3	12	3	3	1	0	2	0	1	0	0	0	0	1	1	0	0
Washington	10	289	43	3	30	14	7	0	4	8	20	36	5	0	0	14	105
West Virginia	3	29	2	2	5	3	2	0	0	0	0	0	0	0	0	0	15
Wisconsin	5	36	0	1	1	1	0	0	0	0	0	0	0	0	0	0	33
Wyoming	8	10	2	1	5	1	1	0	0	0	0	0	0	0	0	0	0

State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	Denial of							Failure to Provide					Problem with Advance Directives	Denial of Parental /Family Rights	Other
			Financial Benefits and Entitlements	Guardianship /Conservative Problems	Rights Protection/Legal Assistance	Privacy Rights	Recreational Opportunities	Visitors	Access to Records	Individual Treatment Plan	Written Discharge Plan	Mental Health Services Planning	Confidentiality	Informed Consent			
Totals		4,597	344	247	428	147	132	23	57	185	38	328	27	57	78	64	2,442
Percentages		100.00	7.48	5.37	9.31	3.20	2.87	0.50	1.24	4.02	0.83	7.14	0.59	1.24	1.70	1.39	53.12

Table 7 – Complaints Involving Alleged Rights Violations of PAIMI Eligible Individuals – FY2018

State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	Denial of							Failure to Provide					Problem with Advance Directives	Denial of Parental /Family Rights	Other
			Financial Benefits and Entitlements	Guardianship /Conservative Problems	Rights Protection/Legal Assistance	Privacy Rights	Recreational Opportunities	Visitors	Access to Records	Individual Treatment Plan	Written Discharge Plan	Mental Health Services Planning	Confidentiality	Informed Consent			
Alabama	4	42	1	2	4	0	1	0	1	1	1	1	0	0	0	0	30
Alaska	10	23	14	0	1	0	0	0	0	0	0	0	0	0	0	0	8
AIC	11	11	0	0	0	0	0	0	0	11	0	0	0	0	0	0	0
Am. Samoa	9	24	0	0	1	3	2	0	0	4	7	4	0	0	0	3	0
Arizona	9	27	1	0	4	0	0	3	0	15	1	0	1	0	1	1	0
Arkansas	6	57	0	5	0	0	0	0	1	0	0	0	0	2	0	0	49
California	9	570	76	8	31	2	1	0	8	5	4	5	1	4	2	3	420
Colorado	8	34	0	0	10	2	7	0	0	0	10	5	0	0	0	0	0
Connecticut	1	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Delaware	3	49	29	3	0	0	0	0	1	0	0	0	1	0	0	2	13
DC	3	28	0	3	0	1	1	0	0	0	3	1	0	1	14	0	4
Florida	4	50	2	6	21	5	4	0	2	0	0	0	0	0	0	0	10
Georgia	4	5	0	0	1	0	0	0	0	0	0	0	0	0	0	0	4
Guam	9	10	0	2	0	0	0	0	0	1	1	0	0	0	5	1	0
Hawaii	9	99	5	5	0	0	0	0	0	53	0	3	0	0	33	0	0
Idaho	10	26	1	3	7	2	1	0	3	4	0	1	1	0	0	0	3
Illinois	5	234	5	24	2	5	6	1	5	2	0	3	1	0	0	5	175
Indiana	5	12	0	0	0	4	1	0	0	0	0	2	0	1	0	0	4
Iowa	7	21	2	2	0	0	1	0	0	0	0	2	0	0	0	0	14
Kansas	7	323	91	19	5	0	2	0	1	0	0	0	4	6	1	2	192
Kentucky	4	33	0	3	1	4	5	1	0	0	8	1	0	3	0	0	7
Louisiana	6	10	2	2	1	0	1	0	0	0	2	0	0	1	0	0	1
Maine	1	73	4	6	8	5	1	0	0	0	3	15	1	0	1	1	28
Maryland	3	19	1	0	5	2	0	0	0	0	0	1	1	0	0	1	8
Massachusetts	1	11	0	0	5	0	1	0	0	0	0	0	0	0	0	0	5
Michigan	5	51	0	3	5	1	1	1	0	6	10	23	0	1	0	0	0
Minnesota	5	51	4	4	0	2	2	1	1	3	2	0	1	1	1	0	29
Mississippi	4	4	0	0	1	1	0	0	0	0	0	0	0	0	0	1	1

State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	Denial of							Failure to Provide					Problem with Advance Directives	Denial of Parental /Family Rights	Other
			Financial Benefits and Entitlements	Guardianship /Conservative Problems	Rights Protection/Legal Assistance	Privacy Rights	Recreational Opportunities	Visitors	Access to Records	Individual Treatment Plan	Written Discharge Plan	Mental Health Services Planning	Confidentiality	Informed Consent			
Missouri	7	69	20	27	1	7	4	0	0	3	4	0	0	0	1	0	2
Montana	8	30	1	0	1	1	0	0	0	1	5	0	0	1	0	4	16
Nebraska	7	5	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0
Nevada	9	22	1	0	5	0	0	0	0	0	0	0	0	0	0	0	16
New Hampshire	1	162	19	9	8	3	13	1	0	3	0	0	8	3	0	4	91
New Jersey	2	57	0	1	1	1	2	0	1	0	0	3	0	0	1	1	46
New Mexico	6	32	0	5	19	0	0	0	3	0	0	0	0	4	0	1	0
New York	2	81	0	4	2	0	0	0	0	0	1	8	2	0	1	3	60
North Carolina	4	40	1	7	1	4	0	0	0	0	15	2	0	0	0	1	9
North Dakota	8	113	2	5	0	0	0	0	0	84	13	5	0	0	0	0	4
N. Marianas	9	4	3	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Ohio	5	351	9	33	32	12	12	2	6	1	20	0	2	10	2	3	207
Oklahoma	6	7	0	1	2	0	0	0	0	0	2	1	0	0	0	0	1
Oregon	10	8	0	6	0	0	0	0	0	1	0	1	0	0	0	0	0
Pennsylvania	3	229	22	1	35	3	3	0	2	14	8	0	1	2	4	9	125
Puerto Rico	2	3	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Rhode Island	1	17	0	3	0	0	0	0	0	0	0	0	0	0	0	0	14
South Carolina	4	19	0	0	0	1	0	0	0	0	3	0	0	0	0	0	15
South Dakota	8	12	1	0	0	0	1	0	2	0	0	0	0	0	0	0	8
Tennessee	4	20	1	0	7	0	0	1	0	0	0	0	0	0	0	0	11
Texas	6	250	6	8	69	28	27	1	3	0	35	0	4	15	11	4	39
Utah	8	134	5	6	121	0	0	0	0	0	1	1	0	0	0	0	0
Vermont	1	26	4	1	1	2	0	1	2	0	0	0	1	0	6	0	8
Virgin Islands	2	8	0	1	2	0	0	0	0	1	2	2	0	0	0	0	0
Virginia	3	25	2	3	3	0	5	0	3	0	2	3	0	3	1	0	0
Washington	10	261	31	7	15	9	9	1	10	18	34	67	5	1	0	4	50
West Virginia	3	36	3	0	12	1	0	0	0	1	3	0	1	0	0	0	15
Wisconsin	5	49	1	1	0	4	3	0	0	1	0	0	0	2	0	0	37
Wyoming	8	5	0	0	2	1	2	0	0	0	0	0	0	0	0	0	0

State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	Denial of							Failure to Provide					Problem with Advance Directives	Denial of Parental /Family Rights	Other
			Financial Benefits and Entitlements	Guardianship /Conservative Problems	Rights Protection/Legal Assistance	Privacy Rights	Recreational Opportunities	Visitors	Access to Records	Individual Treatment Plan	Written Discharge Plan	Mental Health Services Planning	Confidentiality	Informed Consent			
Totals		3,976	371	234	454	116	119	14	55	233	200	160	36	61	86	54	1,783
Percentages		100.00	9.33	5.89	11.42	2.92	2.99	0.35	1.38	5.86	5.03	4.02	0.91	1.53	2.16	1.36	44.84

Table 8 – Death Investigations – FY2017

State/ Jurisdiction	HHS Region	The number of deaths of individuals reported to the P&A for investigation				All Death investigations conducted involving PAIMI-eligible individuals related			
		Total Number of Deaths Reported	State	The Center for Medicaid & Medicare Services	Other Sources	Total Number of Death Investigations	Number of deaths investigated involving incidents of seclusion (S).	Number of deaths investigated involving incidents of restraint (R).	Number of deaths investigated NOT related to incidents of S&R, (e. g., suicides.)
Alabama	4	2	0	0	2	2	0	0	2
Alaska	10	8	0	0	8	8	0	0	8
AIC	11	0	0	0	0	0	0	0	0
Am. Samoa	9	0	0	0	0	0	0	0	0
Arizona	9	0	0	0	0	1	0	0	1
Arkansas	6	0	0	0	0	0	0	0	0
California	9	20	19	0	1	20	0	1	19
Colorado	8	1	0	0	1	1	0	0	1
Connecticut	1	0	0	0	0	0	0	0	0
Delaware	3	19	17	0	2	19	0	0	19
DC	3	4	4	0	0	1	0	0	1
Florida	4	12	1	0	11	12	0	3	9
Georgia	4	12	0	0	12	12	0	0	12
Guam	9	2	2	0	0	2	0	0	2
Hawaii	9	0	0	0	0	0	0	0	0
Idaho	10	1	0	0	1	1	0	0	1
Illinois	5	0	0	0	0	5	0	0	5
Indiana	5	1	1	0	0	0	0	0	0
Iowa	7	6	0	0	6	6	0	0	6
Kansas	7	1	0	0	1	1	0	0	1
Kentucky	4	10	8	0	2	10	0	0	10
Louisiana	6	0	0	0	0	0	0	0	0
Maine	1	0	0	0	0	0	0	0	0
Maryland	3	71	12	0	59	2	1	0	1
Massachusetts	1	255	254	0	1	2	1	0	1
Michigan	5	10	5	0	5	10	0	0	10
Minnesota	5	0	0	0	0	0	0	0	0
Mississippi	4	0	0	0	0	0	0	0	0

State/ Jurisdiction	HHS Region	The number of deaths of individuals reported to the P&A for investigation				All Death investigations conducted involving PAIMI-eligible individuals related			
		Total Number of Deaths Reported	State	The Center for Medicaid & Medicare Services	Other Sources	Total Number of Death Investigations	Number of deaths investigated involving incidents of seclusion (S).	Number of deaths investigated involving incidents of restraint (R).	Number of deaths investigated NOT related to incidents of S&R, (e. g., suicides.)
Missouri	7	595	595	0	0	4	0	0	4
Montana	8	2	0	0	2	1	0	0	1
Nebraska	7	0	0	0	0	0	0	0	0
Nevada	9	2	0	0	2	1	0	0	1
New Hampshire	1	0	0	0	0	0	0	0	0
New Jersey	2	39	36	0	3	39	0	1	38
New Mexico	6	1	1	0	0	1	0	0	1
New York	2	12	0	0	12	12	0	1	11
North Carolina	4	21	21	0	0	1	0	0	1
North Dakota	8	4	3	0	1	4	0	0	4
N. Marianas	9	0	0	0	0	0	0	0	0
Ohio	5	2	2	0	0	2	0	0	2
Oklahoma	6	1	0	1	0	0	0	0	0
Oregon	10	0	0	0	0	0	0	0	0
Pennsylvania	3	41	41	0	0	0	0	0	0
Puerto Rico	2	2	1	0	1	2	0	0	2
Rhode Island	1	1	0	0	1	0	0	0	0
South Carolina	4	1	0	0	1	1	0	0	1
South Dakota	8	0	0	0	0	0	0	0	0
Tennessee	4	0	0	0	0	0	0	0	0
Texas	6	4	0	0	4	4	0	0	4
Utah	8	5	0	0	5	5	2	0	3
Vermont	1	4	0	0	4	3	0	0	3
Virgin Islands	2	0	0	0	0	0	0	0	0
Virginia	3	65	55	0	10	65	0	2	63
Washington	10	6	0	0	6	6	2	0	4
West Virginia	3	0	0	0	0	0	0	0	0
Wisconsin	5	7	7	0	0	7	0	0	7
Wyoming	8	2	2	0	0	2	0	0	2

State/ Jurisdiction	HHS Region	The number of deaths of individuals reported to the P&A for investigation				All Death investigations conducted involving PAIMI-eligible individuals related			
		Total Number of Deaths Reported	State	The Center for Medicaid & Medicare Services	Other Sources	Total Number of Death Investigations	Number of deaths investigated involving incidents of seclusion (S).	Number of deaths investigated involving incidents of restraint (R).	Number of deaths investigated NOT related to incidents of S&R, (e. g., suicides.)
Totals		1,252	1,087	1	164	275	6	8	261

Table 8 – Death Investigations – FY2018

State/ Jurisdiction	HHS Region	The number of deaths of individuals reported to the P&A for investigation				All Death investigations conducted involving PAIMI-eligible individuals related			
		Total Number of Deaths Reported	State	The Center for Medicaid & Medicare Services	Other Sources	Total Number of Death Investigations	Number of deaths investigated involving incidents of seclusion (S).	Number of deaths investigated involving incidents of restraint (R).	Number of deaths investigated NOT related to incidents of S&R, (e. g., suicides.)
Alabama	4	2	0	1	1	2	0	1	1
Alaska	10	4	1	0	3	4	0	0	4
AIC	11	0	0	0	0	0	0	0	0
Am. Samoa	9	0	0	0	0	0	0	0	0
Arizona	9	0	0	0	0	0	0	0	0
Arkansas	6	0	0	0	0	0	0	0	0
California	9	18	13	0	5	11	0	1	10
Colorado	8	3	0	0	3	3	0	0	3
Connecticut	1	1	0	0	1	1	0	1	0
Delaware	3	7	6	0	1	7	0	0	7
DC	3	3	3	0	0	3	0	0	3
Florida	4	5	1	0	4	5	0	0	5
Georgia	4	10	0	0	10	10	0	0	10
Guam	9	1	0	0	1	1	0	0	1
Hawaii	9	0	0	0	0	0	0	0	0
Idaho	10	0	0	0	0	0	0	0	0
Illinois	5	0	0	0	0	3	0	0	3
Indiana	5	1	1	0	0	0	0	0	0
Iowa	7	4	0	0	4	4	0	0	4
Kansas	7	0	0	0	0	2	0	0	2
Kentucky	4	6	2	0	4	2	0	0	2
Louisiana	6	1	0	0	1	1	1	0	0
Maine	1	1	0	0	1	1	0	0	1
Maryland	3	69	8	0	61	3	0	0	3
Massachusetts	1	33	33	0	0	4	0	1	3
Michigan	5	6	4	0	2	6	0	0	6
Minnesota	5	0	0	0	0	0	0	0	0
Mississippi	4	0	0	0	0	0	0	0	0

State/ Jurisdiction	HHS Region	The number of deaths of individuals reported to the P&A for investigation				All Death investigations conducted involving PAIMI-eligible individuals related			
		Total Number of Deaths Reported	State	The Center for Medicaid & Medicare Services	Other Sources	Total Number of Death Investigations	Number of deaths investigated involving incidents of seclusion (S).	Number of deaths investigated involving incidents of restraint (R).	Number of deaths investigated NOT related to incidents of S&R, (e. g., suicides.)
Missouri	7	568	568	0	0	7	0	0	7
Montana	8	1	0	0	1	1	0	0	1
Nebraska	7	1	0	0	1	2	0	0	2
Nevada	9	0	0	0	0	0	0	0	0
New Hampshire	1	1	0	0	1	1	0	1	0
New Jersey	2	16	16	0	0	16	0	0	16
New Mexico	6	1	0	0	1	1	1	0	0
New York	2	6	0	0	6	6	3	0	3
North Carolina	4	3	3	0	0	3	0	1	2
North Dakota	8	1	1	0	0	1	0	0	1
N. Marianas	9	0	0	0	0	0	0	0	0
Ohio	5	6	2	0	4	6	0	0	6
Oklahoma	6	0	0	0	0	0	0	0	0
Oregon	10	1	0	0	1	1	0	0	1
Pennsylvania	3	40	40	0	0	0	0	0	0
Puerto Rico	2	0	0	0	0	0	0	0	0
Rhode Island	1	3	2	0	1	3	0	0	3
South Carolina	4	3	0	0	3	3	0	0	3
South Dakota	8	3	0	0	3	3	0	0	3
Tennessee	4	0	0	0	0	0	0	0	0
Texas	6	6	0	0	6	6	0	0	6
Utah	8	48	0	0	48	48	8	0	40
Vermont	1	4	2	0	2	5	1	2	2
Virgin Islands	2	1	0	0	1	1	0	0	1
Virginia	3	73	71	0	2	73	0	1	72
Washington	10	2	0	0	2	2	0	0	2
West Virginia	3	1	0	0	1	1	0	0	1
Wisconsin	5	9	8	0	1	9	0	0	9
Wyoming	8	1	1	0	0	1	0	0	1

State/ Jurisdiction	HHS Region	The number of deaths of individuals reported to the P&A for investigation				All Death investigations conducted involving PAIMI-eligible individuals related			
		Total Number of Deaths Reported	State	The Center for Medicaid & Medicare Services	Other Sources	Total Number of Death Investigations	Number of deaths investigated involving incidents of seclusion (S).	Number of deaths investigated involving incidents of restraint (R).	Number of deaths investigated NOT related to incidents of S&R, (e. g., suicides.)
Totals		974	786	1	187	273	14	9	250

Table 9 – Analysis of Alleged Abuse – FY2017

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Percentage Favorably Resolved
Alabama	4	37	10	2	4	21	10.81
Alaska	10	9	4	1	4	0	44.44
AIC	11	1	0	0	0	1	0.00
Am. Samoa	9	20	0	0	20	0	100.00
Arizona	9	8	1	1	5	1	62.50
Arkansas	6	19	7	1	11	0	57.89
California	9	66	0	0	66	0	100.00
Colorado	8	55	20	2	33	0	60.00
Connecticut	1	1	0	0	1	0	100.00
Delaware	3	4	2	1	1	0	25.00
DC	3	32	3	5	23	1	71.88
Florida	4	98	25	11	60	2	61.22
Georgia	4	44	10	2	32	0	72.73
Guam	9	3	2	0	1	0	33.33
Hawaii	9	15	9	1	5	0	33.33
Idaho	10	12	7	0	2	3	16.67
Illinois	5	47	8	3	19	17	40.43
Indiana	5	12	1	3	8	0	66.67
Iowa	7	47	12	5	30	0	63.83
Kansas	7	42	11	10	21	0	50.00
Kentucky	4	14	4	0	8	2	57.14
Louisiana	6	17	0	3	12	2	70.59
Maine	1	49	2	6	34	7	69.39
Maryland	3	44	2	4	33	5	75.00
Massachusetts	1	45	0	7	38	0	84.44
Michigan	5	21	5	2	4	10	19.05
Minnesota	5	25	5	2	17	1	68.00
Mississippi	4	8	0	0	8	0	100.00
Missouri	7	86	1	0	84	1	97.67
Montana	8	82	10	0	68	4	82.93
Nebraska	7	9	3	3	3	0	33.33
Nevada	9	8	7	1	0	0	0.00
New Hampshire	1	46	9	4	33	0	71.74

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Percentage Favorably Resolved
New Jersey	2	79	16	6	56	1	70.89
New Mexico	6	99	5	10	75	9	75.76
New York	2	46	2	3	40	1	86.96
North Carolina	4	8	1	0	7	0	87.50
North Dakota	8	37	0	4	33	0	89.19
N. Marianas	9	1	0	0	1	0	100.00
Ohio	5	182	3	28	150	1	82.42
Oklahoma	6	16	0	5	11	0	68.75
Oregon	10	17	2	4	10	1	58.82
Pennsylvania	3	28	0	0	28	0	100.00
Puerto Rico	2	5	1	0	2	2	40.00
Rhode Island	1	3	1	0	2	0	66.67
South Carolina	4	127	2	1	112	12	88.19
South Dakota	8	13	0	4	8	1	61.54
Tennessee	4	45	24	6	0	15	0.00
Texas	6	180	19	22	31	108	17.22
Utah	8	8	0	1	6	1	75.00
Vermont	1	47	8	15	17	7	36.17
Virgin Islands	2	4	0	0	4	0	100.00
Virginia	3	55	4	4	47	0	85.45
Washington	10	311	0	0	311	0	100.00
West Virginia	3	18	1	2	14	1	77.78
Wisconsin	5	16	4	2	10	0	62.50
Wyoming	8	26	4	0	22	0	84.62
Totals		2,397	277	197	1,685	238	63.43

Table 9 – Analysis of Alleged Abuse – FY2018

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Percentage Favorably Resolved
Alabama	4	23	1	2	13	7	56.52
Alaska	10	2	2	0	0	0	0.00
AIC	11	3	1	0	2	0	66.67
Am. Samoa	9	6	0	0	6	0	100.00
Arizona	9	28	0	0	28	0	100.00
Arkansas	6	16	2	1	13	0	81.25
California	9	71	6	5	59	1	83.10
Colorado	8	20	2	0	10	8	50.00
Connecticut	1	3	0	0	2	1	66.67
Delaware	3	15	2	0	13	0	86.67
DC	3	37	8	3	26	0	70.27
Florida	4	154	33	15	105	1	68.18
Georgia	4	34	12	4	18	0	52.94
Guam	9	2	0	0	2	0	100.00
Hawaii	9	5	4	1	0	0	0.00
Idaho	10	31	4	5	21	1	67.74
Illinois	5	55	3	4	31	17	56.36
Indiana	5	17	3	2	12	0	70.59
Iowa	7	33	8	6	19	0	57.58
Kansas	7	21	6	6	4	5	19.05
Kentucky	4	9	0	0	9	0	100.00
Louisiana	6	5	0	1	3	1	60.00
Maine	1	50	1	8	37	4	74.00
Maryland	3	37	4	4	25	4	67.57
Massachusetts	1	9	0	1	7	1	77.78
Michigan	5	14	0	0	12	2	85.71
Minnesota	5	33	7	8	18	0	54.55
Mississippi	4	8	1	0	7	0	87.50
Missouri	7	83	0	0	83	0	100.00
Montana	8	59	32	0	17	10	28.81
Nebraska	7	2	0	0	2	0	100.00
Nevada	9	0	0	0	0	0	0.00
New Hampshire	1	53	10	4	38	1	71.70

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Percentage Favorably Resolved
New Jersey	2	103	22	11	68	2	66.02
New Mexico	6	63	30	5	21	7	33.33
New York	2	11	0	0	11	0	100.00
North Carolina	4	17	1	1	15	0	88.24
North Dakota	8	31	13	5	12	1	38.71
N. Marianas	9	1	0	0	1	0	100.00
Ohio	5	57	4	10	42	1	73.68
Oklahoma	6	16	4	0	10	2	62.50
Oregon	10	13	1	2	5	5	38.46
Pennsylvania	3	18	0	0	18	0	100.00
Puerto Rico	2	0	0	0	0	0	0.00
Rhode Island	1	1	0	0	1	0	100.00
South Carolina	4	129	0	0	122	7	94.57
South Dakota	8	11	2	2	7	0	63.64
Tennessee	4	30	9	4	13	4	43.33
Texas	6	99	24	23	41	11	41.41
Utah	8	8	0	1	5	2	62.50
Vermont	1	39	5	10	22	2	56.41
Virgin Islands	2	13	0	0	9	4	69.23
Virginia	3	30	13	2	11	4	36.67
Washington	10	207	0	0	207	0	100.00
West Virginia	3	14	1	1	12	0	85.71
Wisconsin	5	32	5	7	10	10	31.25
Wyoming	8	21	1	0	20	0	95.24
Totals		1,902	287	164	1,325	126	65.65

Table 10 – Analysis of Alleged Neglect – FY2017

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Successful outcomes from P&A involvement	Percentage Favorably Resolved
Alabama	4	74	40	2	28	4	0	37.84
Alaska	10	2	1	1	0	0	0	0.00
AIC	11	1	0	0	1	0	0	100.00
Am. Samoa	9	9	0	1	6	0	2	66.67
Arizona	9	8	0	0	8	0	0	100.00
Arkansas	6	18	3	1	8	1	5	44.44
California	9	21	0	0	21	0	0	100.00
Colorado	8	2	2	0	0	0	0	0.00
Connecticut	1	0	0	0	0	0	0	0.00
Delaware	3	12	0	0	10	0	2	83.33
DC	3	43	2	8	29	4	0	67.44
Florida	4	32	8	2	22	0	0	68.75
Georgia	4	92	1	8	82	1	0	89.13
Guam	9	3	0	0	3	0	0	100.00
Hawaii	9	10	2	0	7	1	0	70.00
Idaho	10	59	5	1	31	19	3	52.54
Illinois	5	151	9	9	34	27	72	22.52
Indiana	5	17	0	2	15	0	0	88.24
Iowa	7	13	0	2	9	0	2	69.23
Kansas	7	40	12	6	21	1	0	52.50
Kentucky	4	16	0	0	11	0	5	68.75
Louisiana	6	17	5	3	7	2	0	41.18
Maine	1	37	1	4	29	3	0	78.38
Maryland	3	20	0	0	13	0	7	65.00
Massachusetts	1	35	2	9	22	2	0	62.86
Michigan	5	29	3	2	5	1	18	17.24
Minnesota	5	19	3	3	12	1	0	63.16
Mississippi	4	9	0	0	8	1	0	88.89
Missouri	7	95	4	4	87	0	0	91.58
Montana	8	51	2	0	43	0	6	84.31
Nebraska	7	3	0	0	2	0	1	66.67
Nevada	9	11	0	5	6	0	0	54.55

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Successful outcomes from P&A involvement	Percentage Favorably Resolved
New Hampshire	1	30	3	2	23	1	1	76.67
New Jersey	2	31	5	0	25	1	0	80.65
New Mexico	6	199	0	5	148	46	0	74.37
New York	2	32	0	0	2	0	30	6.25
North Carolina	4	28	3	2	13	0	10	46.43
North Dakota	8	30	0	0	30	0	0	100.00
N. Marianas	9	1	0	0	0	0	1	0.00
Ohio	5	130	1	15	78	1	35	60.00
Oklahoma	6	10	1	1	5	3	0	50.00
Oregon	10	14	0	2	11	1	0	78.57
Pennsylvania	3	47	0	0	42	0	5	89.36
Puerto Rico	2	22	13	3	1	1	4	4.55
Rhode Island	1	19	3	2	14	0	0	73.68
South Carolina	4	6	1	0	4	1	0	66.67
South Dakota	8	9	0	0	8	1	0	88.89
Tennessee	4	11	4	2	1	0	4	9.09
Texas	6	136	15	7	20	4	90	14.71
Utah	8	2	0	0	2	0	0	100.00
Vermont	1	27	4	4	16	3	0	59.26
Virgin Islands	2	1	0	0	1	0	0	100.00
Virginia	3	61	2	1	54	4	0	88.52
Washington	10	164	0	0	164	0	0	100.00
West Virginia	3	32	5	8	17	2	0	53.13
Wisconsin	5	18	3	2	13	0	0	72.22
Wyoming	8	12	1	0	10	1	0	83.33
Totals		2,021	169	129	1,282	138	303	62.66

Table 10 – Analysis of Alleged Neglect – FY2018

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Successful outcomes from P&A involvement	Percentage Favorably Resolved
Alabama	4	59	4	4	31	20	0	52.54
Alaska	10	2	0	0	2	0	0	100.00
AIC	11	1	0	0	1	0	0	100.00
Am. Samoa	9	31	1	0	22	7	1	70.97
Arizona	9	35	0	0	35	0	0	100.00
Arkansas	6	5	0	2	3	0	0	60.00
California	9	23	1	3	19	0	0	82.61
Colorado	8	20	5	1	9	5	0	45.00
Connecticut	1	1	0	0	1	0	0	100.00
Delaware	3	34	2	0	32	0	0	94.12
DC	3	26	1	3	18	4	0	69.23
Florida	4	39	5	1	33	0	0	84.62
Georgia	4	105	5	10	89	1	0	84.76
Guam	9	4	0	0	4	0	0	100.00
Hawaii	9	7	4	0	2	1	0	28.57
Idaho	10	33	4	5	23	1	0	69.70
Illinois	5	59	6	6	24	23	0	40.68
Indiana	5	12	1	4	7	0	0	58.33
Iowa	7	15	8	1	3	0	3	20.00
Kansas	7	31	5	8	16	2	0	51.61
Kentucky	4	7	0	0	6	1	0	85.71
Louisiana	6	5	0	1	3	1	0	60.00
Maine	1	43	1	1	38	3	0	88.37
Maryland	3	19	4	3	12	0	0	63.16
Massachusetts	1	19	0	4	15	0	0	78.95
Michigan	5	22	2	2	12	6	0	54.55
Minnesota	5	34	2	6	24	2	0	70.59
Mississippi	4	8	2	0	6	0	0	75.00
Missouri	7	52	0	1	51	0	0	98.08
Montana	8	91	75	0	15	1	0	16.48
Nebraska	7	0	0	0	0	0	0	0.00
Nevada	9	8	4	2	1	1	0	12.50

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Successful outcomes from P&A involvement	Percentage Favorably Resolved
New Hampshire	1	47	10	5	27	0	5	57.45
New Jersey	2	25	2	3	20	0	0	80.00
New Mexico	6	139	42	9	28	55	5	20.14
New York	2	28	0	3	12	0	13	42.86
North Carolina	4	7	1	0	6	0	0	85.71
North Dakota	8	40	0	4	35	1	0	87.50
N. Marianas	9	5	0	0	5	0	0	100.00
Ohio	5	68	1	8	58	1	0	85.29
Oklahoma	6	7	2	2	2	1	0	28.57
Oregon	10	4	2	0	2	0	0	50.00
Pennsylvania	3	26	0	0	25	1	0	96.15
Puerto Rico	2	2	0	0	2	0	0	100.00
Rhode Island	1	6	0	1	5	0	0	83.33
South Carolina	4	12	0	1	11	0	0	91.67
South Dakota	8	5	1	1	2	1	0	40.00
Tennessee	4	20	8	4	7	1	0	35.00
Texas	6	135	39	35	54	7	0	40.00
Utah	8	0	0	0	0	0	0	0.00
Vermont	1	25	4	2	17	2	0	68.00
Virgin Islands	2	9	0	0	5	4	0	55.56
Virginia	3	70	17	4	41	3	5	58.57
Washington	10	72	0	0	72	0	0	100.00
West Virginia	3	23	1	2	18	2	0	78.26
Wisconsin	5	21	2	3	11	5	0	52.38
Wyoming	8	8	0	0	8	0	0	100.00
Totals		1,654	274	155	1,030	163	32	65.83

Table 11 – Analysis of Alleged Rights Violations – FY2017

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Percentage Favorably Resolved
Alabama	4	65	10	9	40	6	61.54
Alaska	10	29	7	1	16	5	55.17
AIC	11	13	1	1	9	2	69.23
Am. Samoa	9	25	1	0	24	0	96.00
Arizona	9	8	0	0	8	0	100.00
Arkansas	6	69	1	17	48	3	69.57
California	9	668	0	0	668	0	100.00
Colorado	8	14	8	6	0	0	0.00
Connecticut	1	1	0	1	0	0	0.00
Delaware	3	58	2	0	56	0	96.55
DC	3	32	0	5	27	0	84.38
Florida	4	47	9	6	31	1	65.96
Georgia	4	13	0	1	12	0	92.31
Guam	9	19	1	4	13	1	68.42
Hawaii	9	174	8	33	130	3	74.71
Idaho	10	46	6	37	0	3	0.00
Illinois	5	323	13	13	168	129	52.01
Indiana	5	37	0	0	37	0	100.00
Iowa	7	32	4	11	17	0	53.13
Kansas	7	325	75	51	179	20	55.08
Kentucky	4	45	1	3	39	2	86.67
Louisiana	6	48	5	5	35	3	72.92
Maine	1	85	7	23	50	5	58.82
Maryland	3	74	10	1	51	12	68.92
Massachusetts	1	76	1	9	66	0	86.84
Michigan	5	27	10	3	4	10	14.81
Minnesota	5	102	8	16	72	6	70.59
Mississippi	4	11	0	0	11	0	100.00
Missouri	7	130	10	5	109	6	83.85
Montana	8	59	12	0	39	8	66.10
Nebraska	7	3	0	1	2	0	66.67
Nevada	9	21	2	5	11	3	52.38
New Hampshire	1	119	17	8	93	1	78.15

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Percentage Favorably Resolved
New Jersey	2	70	4	21	45	0	64.29
New Mexico	6	44	1	1	35	7	79.55
New York	2	121	0	0	121	0	100.00
North Carolina	4	46	3	2	40	1	86.96
North Dakota	8	72	0	9	61	2	84.72
N. Marianas	9	2	0	1	0	1	0.00
Ohio	5	354	4	97	246	7	69.49
Oklahoma	6	11	2	1	8	0	72.73
Oregon	10	11	0	1	10	0	90.91
Pennsylvania	3	163	12	1	136	14	83.44
Puerto Rico	2	38	24	3	0	11	0.00
Rhode Island	1	62	12	17	30	3	48.39
South Carolina	4	15	0	2	11	2	73.33
South Dakota	8	29	0	4	21	4	72.41
Tennessee	4	24	2	10	12	0	50.00
Texas	6	213	71	36	3	103	1.41
Utah	8	111	5	7	98	1	88.29
Vermont	1	31	1	7	21	2	67.74
Virgin Islands	2	6	0	2	1	3	16.67
Virginia	3	12	0	0	12	0	100.00
Washington	10	289	0	0	289	0	100.00
West Virginia	3	29	2	5	22	0	75.86
Wisconsin	5	36	2	6	26	2	72.22
Wyoming	8	10	1	2	7	0	70.00
Totals		4,597	375	510	3,320	392	66.13

Table 11 – Analysis of Alleged Rights Violations – FY2018

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Percentage Favorably Resolved
Alabama	4	42	3	5	33	1	78.57
Alaska	10	23	5	5	8	5	34.78
AIC	11	11	1	1	8	1	72.73
Am. Samoa	9	24	0	4	16	4	66.67
Arizona	9	27	0	0	27	0	100.00
Arkansas	6	57	2	12	37	6	64.91
California	9	570	4	14	535	17	93.86
Colorado	8	34	10	3	21	0	61.76
Connecticut	1	4	0	0	3	1	75.00
Delaware	3	49	1	5	43	0	87.76
DC	3	28	1	1	25	1	89.29
Florida	4	50	8	7	34	1	68.00
Georgia	4	5	2	0	3	0	60.00
Guam	9	10	0	0	10	0	100.00
Hawaii	9	99	2	21	75	1	75.76
Idaho	10	26	3	3	18	2	69.23
Illinois	5	234	9	11	111	103	47.44
Indiana	5	12	0	3	9	0	75.00
Iowa	7	21	3	2	16	0	76.19
Kansas	7	323	77	57	143	46	44.27
Kentucky	4	33	5	1	26	1	78.79
Louisiana	6	10	4	2	3	1	30.00
Maine	1	73	3	5	62	3	84.93
Maryland	3	19	3	3	13	0	68.42
Massachusetts	1	11	0	2	9	0	81.82
Michigan	5	51	0	0	51	0	100.00
Minnesota	5	51	6	12	33	0	64.71
Mississippi	4	4	0	0	4	0	100.00
Missouri	7	69	1	1	60	7	86.96
Montana	8	30	4	0	20	6	66.67
Nebraska	7	5	1	0	4	0	80.00
Nevada	9	22	5	2	15	0	68.18
New Hampshire	1	162	52	7	102	1	62.96

State/ Jurisdiction	HHS Region	Total Complaints Closed	Complaints withdrawn, no merit	Complaints withdrawn by Client	Resolved in client's favor	Not resolved in the client's favor	Percentage Favorably Resolved
New Jersey	2	57	3	2	52	0	91.23
New Mexico	6	32	15	0	17	0	53.13
New York	2	81	0	0	81	0	100.00
North Carolina	4	40	0	0	40	0	100.00
North Dakota	8	113	0	11	101	1	89.38
N. Marianas	9	4	0	0	4	0	100.00
Ohio	5	351	9	48	292	2	83.19
Oklahoma	6	7	0	1	4	2	57.14
Oregon	10	8	1	0	6	1	75.00
Pennsylvania	3	229	0	0	229	0	100.00
Puerto Rico	2	3	0	0	2	1	66.67
Rhode Island	1	17	4	3	10	0	58.82
South Carolina	4	19	1	3	11	4	57.89
South Dakota	8	12	0	2	9	1	75.00
Tennessee	4	20	4	8	8	0	40.00
Texas	6	250	51	61	118	20	47.20
Utah	8	134	11	22	95	6	70.90
Vermont	1	26	1	6	16	3	61.54
Virgin Islands	2	8	0	1	7	0	87.50
Virginia	3	25	3	2	18	2	72.00
Washington	10	261	0	0	261	0	100.00
West Virginia	3	36	2	7	27	0	75.00
Wisconsin	5	49	2	5	38	4	77.55
Wyoming	8	5	0	0	5	0	100.00
Totals		3,976	322	371	3,028	255	74.63

Table 12 – Intervention Strategies – FY2017

State/ Jurisdiction	HHS Region	Total Intervention Strategies	Short Term Assistance	Abuse & Neglect Investigations	Technical Assistance	Administrative Remedies	Negotiation/ Mediation	Legal Remedies
Alabama	4	176	44	52	45	2	20	13
Alaska	10	40	23	5	0	4	1	7
AIC	11	15	1	2	0	4	7	1
Am. Samoa	9	54	3	18	6	4	22	1
Arizona	9	24	19	3	1	0	1	0
Arkansas	6	106	70	20	3	9	0	4
California	9	850	828	4	2	4	5	7
Colorado	8	51	6	37	5	0	2	1
Connecticut	1	1	0	0	1	0	0	0
Delaware	3	74	28	8	6	17	15	0
DC	3	107	39	19	17	8	24	0
Florida	4	179	50	5	42	1	79	2
Georgia	4	149	25	34	10	0	80	0
Guam	9	28	7	7	0	1	8	5
Hawaii	9	199	126	25	7	13	28	0
Idaho	10	117	35	22	50	7	1	2
Illinois	5	536	343	11	129	10	38	5
Indiana	5	61	19	0	5	18	14	5
Iowa	7	33	7	7	1	1	10	7
Kansas	7	390	48	1	323	3	0	15
Kentucky	4	117	34	36	19	3	23	2
Louisiana	6	82	28	19	0	8	15	12
Maine	1	171	49	0	35	6	69	12
Maryland	3	149	27	63	37	2	7	13
Massachusetts	1	155	131	1	1	0	21	1
Michigan	5	77	11	44	5	6	5	6
Minnesota	5	146	64	12	46	10	8	6
Mississippi	4	81	10	22	0	5	14	30
Missouri	7	310	22	15	89	13	151	20
Montana	8	192	93	95	0	0	2	2
Nebraska	7	13	2	11	0	0	0	0
Nevada	9	40	23	0	17	0	0	0
New Hampshire	1	196	173	3	0	2	11	7

State/ Jurisdiction	HHS Region	Total Intervention Strategies	Short Term Assistance	Abuse & Neglect Investigations	Technical Assistance	Administrative Remedies	Negotiation/ Mediation	Legal Remedies
New Jersey	2	180	50	82	29	1	16	2
New Mexico	6	334	272	52	3	0	6	1
New York	2	200	104	4	60	7	24	1
North Carolina	4	95	63	13	3	0	8	8
North Dakota	8	139	55	62	5	0	15	2
N. Marianas	9	4	0	2	0	0	1	1
Ohio	5	624	487	81	33	2	18	3
Oklahoma	6	37	16	4	2	0	15	0
Oregon	10	42	11	29	0	1	1	0
Pennsylvania	3	238	122	1	69	9	14	23
Puerto Rico	2	65	5	15	0	9	33	3
Rhode Island	1	85	26	5	32	4	8	10
South Carolina	4	148	11	2	2	0	131	2
South Dakota	8	51	19	2	1	3	26	0
Tennessee	4	75	13	50	3	1	6	2
Texas	6	529	160	167	27	75	62	38
Utah	8	121	82	2	19	4	13	1
Vermont	1	105	69	31	0	2	0	3
Virgin Islands	2	8	5	2	0	1	0	0
Virginia	3	128	54	46	2	5	21	0
Washington	10	764	761	0	3	0	0	0
West Virginia	3	70	31	0	24	0	15	0
Wisconsin	5	70	28	8	3	3	27	1
Wyoming	8	48	9	33	0	0	5	1
Totals		9,079	4,841	1,294	1,222	288	1,146	288
Percentages		100.00	53.32	14.25	13.46	3.17	12.62	3.17

Table 12 – Intervention Strategies – FY2018

State/ Jurisdiction	HHS Region	Total Intervention Strategies	Short Term Assistance	Abuse & Neglect Investigations	Technical Assistance	Administrative Remedies	Negotiation/ Mediation	Legal Remedies
Alabama	4	123	29	41	30	1	5	17
Alaska	10	27	22	0	0	1	1	3
AIC	11	15	1	0	6	0	4	4
Am. Samoa	9	66	10	2	8	5	39	2
Arizona	9	91	79	3	7	1	1	0
Arkansas	6	78	41	6	18	8	1	4
California	9	647	624	0	0	14	7	2
Colorado	8	73	36	14	15	1	1	6
Connecticut	1	8	6	0	0	0	2	0
Delaware	3	98	53	11	4	17	13	0
DC	3	92	47	13	10	5	15	2
Florida	4	157	80	2	16	0	28	31
Georgia	4	144	15	52	1	1	75	0
Guam	9	16	6	4	0	0	3	3
Hawaii	9	111	68	12	10	4	16	1
Idaho	10	90	28	22	36	1	2	1
Illinois	5	424	303	0	81	6	25	9
Indiana	5	58	16	0	3	14	22	3
Iowa	7	40	9	13	1	5	8	4
Kansas	7	375	45	1	310	3	4	12
Kentucky	4	69	16	8	28	1	14	2
Louisiana	6	32	10	10	0	6	3	3
Maine	1	166	52	3	26	5	72	8
Maryland	3	126	16	42	52	1	6	9
Massachusetts	1	30	24	0	1	0	5	0
Michigan	5	169	9	36	7	18	12	87
Minnesota	5	118	62	22	9	4	20	1
Mississippi	4	26	4	19	0	3	0	0
Missouri	7	204	13	53	39	27	65	7
Montana	8	180	71	94	5	1	2	7
Nebraska	7	7	0	6	0	0	0	1
Nevada	9	30	22	0	7	1	0	0
New Hampshire	1	260	240	12	0	2	4	2
New Jersey	2	185	34	98	25	6	16	6

State/ Jurisdiction	HHS Region	Total Intervention Strategies	Short Term Assistance	Abuse & Neglect Investigations	Technical Assistance	Administrative Remedies	Negotiation/ Mediation	Legal Remedies
New Mexico	6	237	222	10	2	0	1	2
New York	2	108	57	1	31	1	17	1
North Carolina	4	64	41	3	2	3	13	2
North Dakota	8	184	75	67	1	1	39	1
N. Marianas	9	10	2	1	2	3	0	2
Ohio	5	476	382	17	56	6	15	0
Oklahoma	6	30	8	13	0	0	9	0
Oregon	10	25	9	13	1	0	0	2
Pennsylvania	3	273	165	3	97	2	3	3
Puerto Rico	2	5	1	0	1	0	3	0
Rhode Island	1	24	8	3	9	2	1	1
South Carolina	4	160	11	5	1	3	138	2
South Dakota	8	28	18	0	0	4	5	1
Tennessee	4	71	13	46	1	1	10	0
Texas	6	484	121	171	20	101	56	15
Utah	8	100	73	4	4	4	11	4
Vermont	1	90	69	12	0	3	1	5
Virgin Islands	2	30	15	5	1	4	3	2
Virginia	3	125	62	31	6	9	15	2
Washington	10	540	522	0	3	14	1	0
West Virginia	3	73	29	0	27	2	13	2
Wisconsin	5	83	44	3	10	3	23	0
Wyoming	8	34	3	21	0	1	9	0
Totals		7,589	4,041	1,028	1,030	329	877	284
Percentages		100.00	53.25	13.55	13.57	4.34	11.56	3.74

Table 13a – Non-Case Directed Services – FY2017

State/ Jurisdiction	HHS Region	Class Action Litigation			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Alabama	4	99,625	0	0	3
Alaska	10	0	0	0	0
AIC	11	1	0	0	1
Am. Samoa	9	0	0	0	0
Arizona	9	11,270	0	0	1
Arkansas	6	0	0	0	0
California	9	201	0	0	1
Colorado	8	275	0	0	1
Connecticut	1	178,000	0	0	1
Delaware	3	200	1	0	0
DC	3	200	0	1	0
Florida	4	376,744	3	0	3
Georgia	4	0	0	0	0
Guam	9	0	0	0	0
Hawaii	9	1,900	0	0	2
Idaho	10	0	0	0	0
Illinois	5	52,026	0	0	0
Indiana	5	0	0	0	0
Iowa	7	16,742	0	0	2
Kansas	7	10,000	0	0	1
Kentucky	4	0	0	0	0
Louisiana	6	1,625	0	0	3
Maine	1	5,000	0	0	0
Maryland	3	1,000	1	0	1
Massachusetts	1	0	0	0	0
Michigan	5	51	1	0	0
Minnesota	5	550	1	0	0
Mississippi	4	200	2	0	0
Missouri	7	0	0	0	0
Montana	8	0	0	0	0
Nebraska	7	0	0	0	0
Nevada	9	0	0	0	0
New Hampshire	1	10,000	0	0	1

State/ Jurisdiction	HHS Region	Class Action Litigation			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
New Jersey	2	0	0	0	0
New Mexico	6	0	0	0	0
New York	2	17,020	2	0	9
North Carolina	4	575	1	0	0
North Dakota	8	0	0	0	0
N. Marianas	9	0	0	0	0
Ohio	5	1,510,050	0	2	1
Oklahoma	6	0	0	0	0
Oregon	10	0	0	0	0
Pennsylvania	3	0	0	0	0
Puerto Rico	2	0	0	0	0
Rhode Island	1	0	0	0	0
South Carolina	4	3,400	1	0	1
South Dakota	8	0	0	0	0
Tennessee	4	0	0	0	0
Texas	6	1,200	0	0	1
Utah	8	2,000	1	0	2
Vermont	1	0	0	0	0
Virgin Islands	2	0	0	0	0
Virginia	3	586	1	0	0
Washington	10	61,228	3	0	4
West Virginia	3	83,000	0	0	1
Wisconsin	5	0	0	0	0
Wyoming	8	0	0	0	0
Total		2,444,669	18	3	40

Table 13a – Non-Case Directed Services – FY2018

State/ Jurisdiction	HHS Region	Class Action Litigation			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Alabama	4	100,625	1	0	3
Alaska	10	0	0	0	0
AIC	11	9,260	0	0	2
Am. Samoa	9	0	0	0	0
Arizona	9	0	0	0	0
Arkansas	6	0	0	0	0
California	9	964	0	0	1
Colorado	8	500	0	0	1
Connecticut	1	178,200	0	0	2
Delaware	3	0	0	0	0
DC	3	3,162	0	0	1
Florida	4	54,100	2	1	5
Georgia	4	153,063	0	0	4
Guam	9	0	0	0	0
Hawaii	9	1,900	0	0	2
Idaho	10	0	0	0	0
Illinois	5	147,740	0	0	4
Indiana	5	0	0	0	0
Iowa	7	16,742	1	0	1
Kansas	7	0	0	0	0
Kentucky	4	0	0	0	0
Louisiana	6	2,750	0	0	4
Maine	1	5,000	0	0	1
Maryland	3	0	0	0	0
Massachusetts	1	0	0	0	0
Michigan	5	134,255	0	0	2
Minnesota	5	200	0	0	1
Mississippi	4	100	1	0	0
Missouri	7	0	0	0	0
Montana	8	0	0	0	0
Nebraska	7	0	0	0	0
Nevada	9	0	0	0	0
New Hampshire	1	50,000	0	0	1

State/ Jurisdiction	HHS Region	Class Action Litigation			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
New Jersey	2	0	0	0	0
New Mexico	6	4,737	0	0	1
New York	2	14,977	4	0	8
North Carolina	4	1,000	0	0	1
North Dakota	8	0	0	0	0
N. Marianas	9	0	0	0	0
Ohio	5	50,170	0	0	3
Oklahoma	6	0	0	0	0
Oregon	10	0	0	0	0
Pennsylvania	3	800	0	0	2
Puerto Rico	2	0	0	0	0
Rhode Island	1	0	0	0	0
South Carolina	4	3,400	1	0	1
South Dakota	8	0	0	0	0
Tennessee	4	0	0	0	0
Texas	6	1,200	0	0	1
Utah	8	800	0	0	2
Vermont	1	0	0	0	0
Virgin Islands	2	41,000	1	0	0
Virginia	3	15,500	4	0	0
Washington	10	537,076	3	0	7
West Virginia	3	83,000	0	0	1
Wisconsin	5	0	0	0	0
Wyoming	8	0	0	0	0
Total		1,612,221	18	1	62

Table 13b – Non-Case Directed Services – FY2017

State/ Jurisdiction	HHS Region	Non Litigation Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Alabama	4	1,282,001	25	15	39
Alaska	10	323	3	13	0
AIC	11	17	0	0	17
Am. Samoa	9	812	58	13	6
Arizona	9	53,889	23	0	6
Arkansas	6	2,630	20	0	5
California	9	831,350	1	0	10
Colorado	8	4,816	43	0	5
Connecticut	1	248,000	0	0	5
Delaware	3	2,470	16	0	16
DC	3	24,600	9	0	8
Florida	4	2,557,829	12	0	34
Georgia	4	615,967	73	64	64
Guam	9	6	1	0	0
Hawaii	9	215	0	0	2
Idaho	10	94,032	3	0	11
Illinois	5	703,871	6	23	32
Indiana	5	2,650	152	0	1
Iowa	7	907,210	63	0	13
Kansas	7	2,050	0	0	4
Kentucky	4	874,000	8	0	10
Louisiana	6	44,315	3	1	17
Maine	1	21,000	55	0	21
Maryland	3	14,500	0	1	7
Massachusetts	1	4,000	51	0	8
Michigan	5	221,373	90	6	2
Minnesota	5	76,765	54	0	3
Mississippi	4	4,776	36	0	0
Missouri	7	412	3	0	2
Montana	8	23,735	5	0	10
Nebraska	7	784	0	0	784
Nevada	9	3,000	2	0	1
New Hampshire	1	335	0	0	4

State/ Jurisdiction	HHS Region	Non Litigation Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
New Jersey	2	328,300	2	0	6
New Mexico	6	150,102	0	0	6
New York	2	319,157	53	1	38
North Carolina	4	243,262	2	0	8
North Dakota	8	137	6	0	1
N. Marianas	9	100	0	0	100
Ohio	5	7,741	28	0	8
Oklahoma	6	30,722	2	0	14
Oregon	10	13,558	7	0	13
Pennsylvania	3	121,002	0	0	5
Puerto Rico	2	1,644	21	1	32
Rhode Island	1	3,077	2	0	6
South Carolina	4	173,350	2	0	6
South Dakota	8	934	4	0	3
Tennessee	4	449,207	38	5	58
Texas	6	60,660	41	3	63
Utah	8	34,497	26	1	10
Vermont	1	4,760	2	0	9
Virgin Islands	2	21,435	17	0	1
Virginia	3	43,844	3	0	3
Washington	10	582,011	30	0	50
West Virginia	3	194,394	83	0	6
Wisconsin	5	1,020,011	1	0	4
Wyoming	8	1,844	35	0	13
Total		12,429,482	1,220	147	1,610

Table 13b – Non-Case Directed Services – FY2018

State/ Jurisdiction	HHS Region	Non Litigation Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Alabama	4	3,245,828	17	1	32
Alaska	10	1,188	3	9	12
AIC	11	45,286	0	0	10
Am. Samoa	9	980	71	15	7
Arizona	9	53,853	0	0	33
Arkansas	6	2,711	3	0	10
California	9	10,451	1	0	3
Colorado	8	3,700	0	0	4
Connecticut	1	420,716	0	0	13
Delaware	3	2,233	16	0	19
DC	3	24,700	17	0	5
Florida	4	1,045,944	30	0	59
Georgia	4	766,381	17	0	23
Guam	9	46	6	0	0
Hawaii	9	215	1	0	1
Idaho	10	27,489	24	1	8
Illinois	5	3,440	9	23	31
Indiana	5	1,400	0	0	2
Iowa	7	851,548	61	2	7
Kansas	7	1,530	0	0	13
Kentucky	4	194,280	11	0	0
Louisiana	6	76,590	2	4	14
Maine	1	21,003	30	17	30
Maryland	3	22,110	26	0	10
Massachusetts	1	35,080	12	0	18
Michigan	5	435,652	37	4	48
Minnesota	5	103,729	52	0	14
Mississippi	4	3,982	49	0	0
Missouri	7	1,576	9	0	0
Montana	8	6,850	6	0	10
Nebraska	7	5,950	29	0	4
Nevada	9	2,200	1	0	3
New Hampshire	1	546,777	2	0	37

State/ Jurisdiction	HHS Region	Non Litigation Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
New Jersey	2	3,034	0	0	6
New Mexico	6	151,002	2	0	1
New York	2	168,661	25	0	36
North Carolina	4	243,300	2	0	8
North Dakota	8	86	5	0	0
N. Marianas	9	100	0	0	1
Ohio	5	231,644	97	0	36
Oklahoma	6	29,149	39	0	4
Oregon	10	16,596	6	0	33
Pennsylvania	3	1,816	7	0	19
Puerto Rico	2	1,410	35	0	25
Rhode Island	1	679	0	0	6
South Carolina	4	172,320	1	0	6
South Dakota	8	4,445	6	0	8
Tennessee	4	0	0	0	0
Texas	6	100,294	75	1	39
Utah	8	155,400	21	0	12
Vermont	1	9,160	6	0	17
Virgin Islands	2	41,200	17	0	1
Virginia	3	9,610	34	0	0
Washington	10	731,503	36	0	30
West Virginia	3	144,339	105	1	16
Wisconsin	5	10,857	3	0	14
Wyoming	8	1,603	27	0	16
Total		10,193,626	1,091	78	814

Table 13c – Non-Case Directed Services – FY2017

State/ Jurisdiction	HHS Region	Legislative & Regulatory Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Alabama	4	428,538	4	0	5
Alaska	10	1,074	0	0	1
AIC	11	0	0	0	0
Am. Samoa	9	459	3	2	1
Arizona	9	40,284	1	0	0
Arkansas	6	14,100	4	1	4
California	9	0	0	0	0
Colorado	8	1,000	1	0	0
Connecticut	1	70,005	0	0	1
Delaware	3	0	0	0	0
DC	3	20,000	1	0	2
Florida	4	2,453,000	10	0	14
Georgia	4	670,876	2	2	2
Guam	9	0	0	0	0
Hawaii	9	500	0	0	1
Idaho	10	122,000	3	3	3
Illinois	5	0	0	0	3
Indiana	5	850	0	0	1
Iowa	7	0	0	0	0
Kansas	7	0	0	0	0
Kentucky	4	0	0	0	0
Louisiana	6	35,000	2	0	0
Maine	1	0	0	0	0
Maryland	3	25,000	0	0	2
Massachusetts	1	0	0	0	0
Michigan	5	180	1	0	0
Minnesota	5	3,770	0	0	2
Mississippi	4	0	0	0	0
Missouri	7	0	0	0	0
Montana	8	12,000	1	0	0
Nebraska	7	20,000	0	0	0
Nevada	9	0	0	0	0
New Hampshire	1	0	0	0	0

State/ Jurisdiction	HHS Region	Legislative & Regulatory Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
New Jersey	2	0	0	0	0
New Mexico	6	1,300	0	0	1
New York	2	0	0	0	0
North Carolina	4	0	0	0	0
North Dakota	8	0	0	0	0
N. Marianas	9	0	0	0	0
Ohio	5	642,386	10	0	7
Oklahoma	6	500	0	0	1
Oregon	10	3,000	0	0	0
Pennsylvania	3	0	0	0	0
Puerto Rico	2	0	0	0	0
Rhode Island	1	8,800	2	0	2
South Carolina	4	1,000	0	0	2
South Dakota	8	0	0	0	0
Tennessee	4	448,000	0	0	1
Texas	6	379,956	1	2	6
Utah	8	20,000	9	0	0
Vermont	1	422	1	0	1
Virgin Islands	2	20,600	0	0	1
Virginia	3	2,878	0	0	1
Washington	10	124,760	2	0	10
West Virginia	3	83,000	0	0	1
Wisconsin	5	4,557,097	1	0	4
Wyoming	8	0	0	0	0
Total		10,212,335	59	10	80

Table 13c – Non-Case Directed Services – FY2018

State/ Jurisdiction	HHS Region	Legislative & Regulatory Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Alabama	4	283,920	5	0	7
Alaska	10	0	0	0	0
AIC	11	41,000	1	0	1
Am. Samoa	9	509	3	1	1
Arizona	9	40,284	0	0	4
Arkansas	6	14,989	0	0	1
California	9	0	0	0	0
Colorado	8	300	0	0	1
Connecticut	1	0	0	0	0
Delaware	3	0	0	0	0
DC	3	20,000	4	0	1
Florida	4	356,277	0	0	4
Georgia	4	763,602	8	0	16
Guam	9	0	0	0	0
Hawaii	9	500	0	0	1
Idaho	10	262,000	7	6	4
Illinois˜	5	0	0	0	0
Indiana	5	0	0	0	0
Iowa	7	0	0	0	0
Kansas	7	0	0	0	0
Kentucky	4	0	0	0	0
Louisiana	6	70,000	3	1	0
Maine	1	0	0	0	0
Maryland	3	0	0	0	0
Massachusetts	1	0	0	0	0
Michigan	5	275,264	0	1	2
Minnesota	5	1,500	0	0	1
Mississippi	4	0	0	0	0
Missouri˜	7	0	0	0	0
Montana	8	30,000	0	0	4
Nebraska	7	36,286	10	18	4
Nevada	9	500	1	0	0
New Hampshire	1	500	1	0	0

State/ Jurisdiction	HHS Region	Legislative & Regulatory Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
New Jersey	2	0	0	0	0
New Mexico	6	8,104	0	0	1
New York	2	739,140	6	1	1
North Carolina	4	0	0	0	0
North Dakota	8	0	0	0	0
N. Marianas	9	0	0	0	0
Ohio	5	0	2	0	22
Oklahoma	6	236,032	6	0	2
Oregon	10	0	0	0	0
Pennsylvania	3	1,763,000	1	0	3
Puerto Rico	2	0	0	0	0
Rhode Island	1	5,000	0	0	1
South Carolina	4	1,000	0	0	2
South Dakota	8	10	0	1	0
Tennessee	4	0	0	0	0
Texas	6	17,689	0	3	7
Utah	8	3,000,000	5	0	9
Vermont	1	500	1	0	1
Virgin Islands	2	1	1	0	0
Virginia	3	10,500	11	0	0
Washington	10	326,290	2	0	20
West Virginia	3	83,000	2	0	3
Wisconsin	5	350,000	1	0	6
Wyoming	8	0	0	0	0
Total		8,737,697	81	32	130

Table 14 – Information/Referral/Public Education/Awareness & Training Activities – FY2017

State/ Jurisdiction	HHS Region	Number of PAIMI Program Information & Referral Services	A. Number of public awareness activities or events	B. Number of education/training activities undertaken	C. Number (approximate) of persons trained in B.
Alabama	4	693	4	28	1,405
Alaska	10	382	8	84	424
AIC	11	18	9	8	422
Am. Samoa	9	168	9	4	765
Arizona	9	143	8	16	249
Arkansas	6	149	21	11	324
California	9	49	243	785	11,815
Colorado	8	134	36	20	415
Connecticut	1	88	9	1	40
Delaware	3	89	9	27	564
DC	3	268	27	111	2,127
Florida	4	2,175	55	19	1,540
Georgia	4	399	31	43	1,822
Guam	9	35	12	8	350
Hawaii	9	939	226	62	816
Idaho	10	309	21	40	296
Illinois	5	765	57	137	4,013
Indiana	5	568	33	16	420
Iowa	7	280	11	15	524
Kansas	7	18	143	37	1,945
Kentucky	4	717	7	23	402
Louisiana	6	534	9	44	1,687
Maine	1	583	148	123	3,041
Maryland	3	282	2	13	280
Massachusetts	1	105	4	6	200
Michigan	5	1,418	12	8	116
Minnesota	5	347	5	33	2,999
Mississippi	4	134	9	22	6,410
Missouri	7	717	24	14	450
Montana	8	336	9	9	307
Nebraska	7	243	30	4	197
Nevada	9	400	7	4	565

State/ Jurisdiction	HHS Region	Number of PAIMI Program Information & Referral Services	A. Number of public awareness activities or events	B. Number of education/training activities undertaken	C. Number (approximate) of persons trained in B.
New Hampshire	1	404	7	40	3,780
New Jersey	2	537	50	36	1,251
New Mexico	6	540	16	62	1,620
New York	2	701	15	20	709
North Carolina	4	137	1	15	453
North Dakota	8	321	16	30	309
N. Marianas	9	35	34	2	2,809
Ohio	5	755	31	36	1,305
Oklahoma	6	158	12	12	970
Oregon	10	576	9	10	243
Pennsylvania	3	444	5	4	2,337
Puerto Rico	2	1,107	59	51	1,777
Rhode Island	1	172	8	12	335
South Carolina	4	628	10	24	732
South Dakota	8	170	78	17	587
Tennessee	4	591	151	13	632
Texas	6	1,151	9	106	5,227
Utah	8	671	15	11	1,260
Vermont	1	828	15	43	311
Virgin Islands	2	7	10	4	50
Virginia	3	474	14	30	2,698
Washington	10	62	16	26	1,576
West Virginia	3	256	23	22	988
Wisconsin	5	412	44	26	1,737
Wyoming	8	142	24	9	127
Totals		24,764	1,910	2,436	80,753

Table 14 – Information/Referral/Public Education/Awareness & Training Activities – FY2018

State/ Jurisdiction	HHS Region	Number of PAIMI Program Information & Referral Services	A. Number of public awareness activities or events	B. Number of education/training activities undertaken	C. Number (approximate) of persons trained in B.
Alabama	4	515	10	30	1,639
Alaska	10	333	9	28	421
AIC	11	3	2	4	343
Am. Samoa	9	339	19	4	558
Arizona	9	119	9	18	712
Arkansas	6	116	22	14	799
California	9	24	102	692	9,730
Colorado	8	158	34	13	412
Connecticut	1	194	16	9	240
Delaware	3	113	11	24	473
DC	3	234	64	68	1,271
Florida	4	1,658	36	24	1,148
Georgia	4	406	29	28	2,183
Guam	9	28	45	26	738
Hawaii	9	891	208	58	533
Idaho	10	265	40	31	575
Illinois	5	381	54	120	3,279
Indiana	5	519	4	4	200
Iowa	7	0	39	31	1,249
Kansas	7	19	227	42	2,348
Kentucky	4	675	21	3	394
Louisiana	6	598	8	19	462
Maine	1	705	164	374	10,316
Maryland	3	219	15	19	59
Massachusetts	1	313	8	5	144
Michigan	5	1,631	7	6	241
Minnesota	5	225	18	27	1,487
Mississippi	4	129	13	25	3,837
Missouri	7	660	20	14	431
Montana	8	256	4	8	662
Nebraska	7	262	99	5	109
Nevada	9	420	1	28	1,207

State/ Jurisdiction	HHS Region	Number of PAIMI Program Information & Referral Services	A. Number of public awareness activities or events	B. Number of education/training activities undertaken	C. Number (approximate) of persons trained in B.
New Hampshire	1	96	37	4	250
New Jersey	2	491	41	40	1,625
New Mexico	6	468	16	60	578
New York	2	767	10	9	609
North Carolina	4	142	1	13	312
North Dakota	8	361	14	40	275
N. Marianas	9	12	13	32	1,222
Ohio	5	563	21	25	544
Oklahoma	6	277	11	8	82
Oregon	10	393	11	2	30
Pennsylvania	3	656	11	31	2,970
Puerto Rico	2	955	57	36	597
Rhode Island	1	222	14	9	414
South Carolina	4	687	6	24	594
South Dakota	8	178	154	19	291
Tennessee	4	553	117	30	667
Texas	6	960	19	96	3,792
Utah	8	578	14	6	220
Vermont	1	889	0	44	2,797
Virgin Islands	2	8	6	4	550
Virginia	3	384	18	15	1,995
Washington	10	127	12	26	1,047
West Virginia	3	218	50	31	783
Wisconsin	5	441	26	20	1,891
Wyoming	8	195	18	3	352
Totals		23,029	2,055	2,428	72,687

ACRONYMS

AoD	Administration on Disabilities
ACL	Administration for Community Living
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADX	Administrative Maximum Facility
AIC	American Indian Consortium
AIDD	Administration on Intellectual and Developmental Disabilities
BOP	Bureau of Prisons
CHA	Children's Health Act
CMHS	Center for Mental Health Services
CMS	Centers for Medicare and Medicaid Services
CPS	Child Protective Services
CSA	Core Service Agency
DD Act	Developmental Disabilities Assistance and Bill of Rights Act
DBH	Department of Behavioral Health
DMAT	Decision-Making Assessment Tool
DMH	Department of Mental Health
DOC	Department of Corrections
DPC	Delaware Psychiatric Center
DWCC	David Wade Correctional Center
FY	Fiscal Year
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IAA	Interagency agreement
MMIC	Mercy Maricopa Integrated Care
NDDOL	North Dakota Department of Labor
OIG	Office of Inspector General
P&A	Protection and Advocacy systems
PAC	PAIMI Advisory Council
PADD	Protection and Advocacy for Developmental Disabilities Program
PAIMI	Protection and Advocacy for Individuals with Mental Illness
POA	Power of Attorney
PPR	Program Performance Report
PTSD	Post Traumatic Stress Disorder
RSA	Rehabilitation Services Administration
RCA	Root Cause Analysis
RTC	Residential Treatment Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SCM	Safe Crisis Management
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
TASC	Training Advocacy and Support Center
T/TA	Training and technical assistance
WSH	Wyoming State Hospital