THE PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI) PROGRAM ACTIVITIES REPORT FOR FISCAL YEARS 2019 AND 2020

6/28/2022

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INTRODUCTION

This report summarizes the annual activities for fiscal years (FY) 2019 and 2020 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;

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[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.

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

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

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[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

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 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 2019 and 2020. Based on the final allocations, California, the largest state P&A system, received the maximum state award of $3,064,013 for FY 2019 and $3,043,159 for FY 2020. 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 2019	FY 2020
To State P&A Systems	$35,335,256	$35,331,864
Technical Assistance Set-aside	$720,708	$721,058
Total Annual PAIMI Appropriation	**$36,055,964**	**$36,052,922**
	FY 2019	**FY 2020**
Minimum State Award	$428,000	$428,000
Maximum State Award	$3,064,013	$3,043,159
Minimum Territory Award	$229,300	$229,300

[Source: 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 2019
0-4	4

[13] 42 U.S.C. 10821
[14] 42 U.S.C. 10822
[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

Age in Years	FY 2019
5-12	602
13-18	1,342
19-25	895
26-64	7,141
65 and over	843
Total Served	**10,827**
Sex	**FY 2019**
Male	6,120
Female	4,660
Unknown	47
Total Served	**10,827**

[Source: Appendix - Table 2a[18]

Age in Years	FY 2020
0-2	14
3-5	23
6-10	308
11-22	1,825
23-64	6,906
65+	662
Unknown	130
Total Served	**9,868**
Sex	**FY 2020**
Male	5,588
Female	4,176
Unknown	104
Total Served	**9,868**

[Source: Appendix - Table 2b]

2. Ethnicity and Race

PAIMI clients served by the P&A systems self-identified their ethnicity and race[19]. 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.

[18] The reporting format for age in years were changed slightly in FY 2020.

[19] 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 will be corrected for future data collection.

Ethnicity	FY 2019	FY 2020
Hispanic/Latino	1,035	973
Non-Hispanic/Latino	8,891	7,937
Unknown	884	960

Race	FY 2019	FY 2020
American Indian/Alaskan Native	207	182
Asian	180	159
Black/African American	2,396	2,085
Multiple Race	501	496
Native Hawaiian/Other Pacific Islander	135	105
White/Caucasian	6,564	5,549

[Source: 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 2019	FY 2020
Independently in the community	2,620	2,750
Adult community residential home	551	532
Psychiatric hospitals	2,230	1,891
Public and private institutional living	948	1,003[20]
Legal detention/jail	1,499	1,338[21]
Homeless/shelter	277	238

[Source: Appendix - Table 4]

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.[22] 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 2019	FY 2020
Cases Investigated & Closed	**2,116**	**1,092**
Inappropriate/excessive use of restraints and seclusion	277	209
Inappropriate/excessive medication	151	137

[20] In Table 4, public and private institutional living were reported together in FY 2019, but separately in FY 2020.
[21] In Table 4, legal detention/jails were reported together in FY 2019, but separately in FY 2020.
[22] 42 U.S.C. 10805(a)(1)

Abuse Complaints	FY 2019	FY 2020
Involuntary electroconvulsive therapy	8	5
Failure to provide mental health treatment	842	*
Physical assaults resulting in serious injuries	184	180
Sexual assaults	85	77
Staff threats/retaliation/assaults	92	99

[Source: Appendix - Table 5]
* Data not collected in FY 2020.

Case Examples from FY 2019

Delaware

A client with PTSD and bipolar disorder residing in a state psychiatric facility reported to the P&A that she had been physically neglected, abused and financially exploited by relatives prior to her admission to the facility. The P&A investigated the client's allegations and assisted her in making police reports. The P&A also assisted the client by referring the matter to the Attorney General's office for prosecution and communicating several times with the state investigators. Ultimately, the client’s half-sister was arrested and charged with a number of crimes; the prosecution is still pending. The client was also assisted with discharge planning and referral for her and her agent under a power of attorney to private counsel for possible representation in a civil lawsuit against her sister.

Maryland

The P&A investigated sexual abuse allegations made by a resident at a state psychiatric hospital receiving treatment for mental illness. The P&A’s investigation revealed the hospital failed to comply with sexual abuse screening and investigation procedures required by the Jane Doe settlement agreement and state law. Furthermore, the P&A discovered the hospital failed to properly notify the P&A of an additional sexual assault involving the resident. After sending written demands to the hospital for corrective action on the resident’s behalf, the hospital retrained all staff, including hospital leadership, on sexual abuse screening, reporting, and investigation procedures. As a result of the advocacy, the resident’s treatment team updated her unique risk assessment form to identify any past trauma, risks, safety concerns, and developed a personal protection plan for her intended to reduce any identified risk of sexual abuse, including treatment options and safety measures (ex: trauma therapy; 1:1 staffing; moving abuser to a different unit, etc.)

New York

The P&A assisted a minor child with reactive attachment disorder. The client was frequently punished at school for behaviors directly related to her mental health diagnosis, resulting in allegedly abusive restraint practices, and ultimately leading to her removal from the school. The P&A worked with the client’s parents, who had a contentious relationship with school officials,

to secure home tutoring services. The school and parents then looked for a more appropriate program for the client that could address her needs. Once a program was identified, the P&A assisted with several transition meetings and follow-up actions to ensure the client's Individual Education Plan was up to date. The client's parents have reported that the client has been successfully attending school and discovering new interests.

Case Examples from FY 2020

Florida

The P&A was contacted by a client with mental illness who resides at a state mental health hospital. The client reported to the P&A that he had been physically abused by a security officer at the hospital. Surveillance video footage showed the client in restraints and shackles being escorted back onto his unit by security officers. An officer is seen exchanging words with the client in the unit's foyer area, after which the officer threw the client to the floor, then picked up the client with one hand by the restraints. This same officer then shoved him into a wall, opened a door forcefully with the client behind it, and hit the client with the door. The officers then left the foyer and escorted the client back into the dorm, and the surveillance footage ended. Following the incident, the client had an abrasion on his head that was visible to the P&A staff but did not report lasting injuries or wanting further medical evaluation because of the incident. The P&A communicated with resident advocate staff that this investigation revealed substantial findings of physical abuse. The security guard that was seen in the video picking the client up by the restraints and hitting him with the door was subsequently terminated shortly after the P&A informed the hospital of its findings. The client has since been discharged without reporting any additional incidents.

Ohio

The P&A received a report about an 11-year-old child who experienced unnecessary, prolonged manual and mechanical restraints at a private psychiatric facility. The P&A reviewed video footage, records of the incidents, and spoke with the child's guardian and determined that hospital staff failed to use other de-escalation techniques before implementing the restraints. Due to the finding, the P&A reached out to the hospital and advocated for the use of therapeutic and trauma-informed interventions to address the child's behaviors.

2. <u>Neglect</u>

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

Neglect Complaints	FY 2019	FY 2020
Cases Investigated & Closed	**1,731**	**2,303**
Discharge planning	730	730
Personal care and safety	373	337
Mental health diagnoses	131	97
Medical diagnostic physical examination	179	104

[Source: Appendix - Table 6]

Case Examples from FY 2019

Alabama

The P&A investigated a serious occurrence from a report submitted to the P&A pursuant to the reporting requirements of the Children's Health Act. The occurrence involved an 18-year-old female diagnosed with disruptive mood dysregulation disorder who lived in a psychiatric residential treatment facility (PRTF). The P&A found that a staff member failed to maintain eyes-on supervision of the female following a conversation between the staff member and the female that led to the female being upset. The female went to her room, closed the door, and was left unsupervised for one hour and 15 minutes during which time she cut herself repeatedly and ingested multiple medications. The PRTF's policy requires that when residents are upset or have a known history of self-harming behaviors, they have to be monitored in intervals no longer than 15-30 minutes. In response to the P&A's findings, the facility increased its staff-to-client ratio and re-trained staff on proper resident care and the importance of supervision. The staff member who failed to monitor the female was given individual coaching and the PRTF's supervision and monitoring policies were updated to prevent similar future incidents.

Iowa

The P&A was contacted by the mother of a nine-year-old female diagnosed with PTSD, oppositional defiant disorder, attention deficit hyperactivity disorder and mood dysregulation disorder. The individual's mother reported to the P&A that she was assaulted by peers while receiving residential mental health treatment at a psychiatric facility. The mother also alleged neglect in that staff were not present to appropriately intervene and protect the individual, and that they did not properly notify her of the resulting injuries. The P&A's investigation found that the individual was assaulted by her peers; however, multiple staff were present and intervened. In addition, the P&A found that the facility did not properly report the incident to it as required by federal law. The facility was notified of the findings and their reporting requirements under law.

Guam

The P&A provided services to a 14-year-old female diagnosed with bipolar and PTSD. The P&A learned that the youth had been at a mental health agency's children inpatient unit for quite a while instead of being placed in an appropriate setting, as recommended by the psychiatric doctor treating her at the agency. Specifically, the doctor recommended for the youth to be transitioned to a children's residential facility that included an educational component. The P&A, together with other social service agencies, advocated for the youth in transitioning to a children's residential care and treatment, including access to special education accommodations and modifications to her mental health needs based on her psychiatric diagnosis. Today, the youth is receiving overall mental health care and treatment and now in academic transition to her district school.

Oklahoma

The P&A was contacted by the mother of an adult son diagnosed with schizophrenia, depression, and anxiety. She lived out of state and was very upset about the mental health care, or lack thereof, that her son was getting in an urban county jail in Oklahoma. She informed the P&A that he had been in the county jail for a week, had not received any mental health medication, and was doing very poorly. The P&A learned that the son was taken off of his mental health medications when he was arrested, and the sudden withdrawal had caused him numerous issues. The client reported he had been put on different medications that were somewhat helpful, but that was experiencing withdrawal symptoms from stopping his previous medication. Because of the P&A's intervention, the client was changed to a more appropriate mental health medication, resulting in a decrease of all the symptoms he was complaining of when they met with him in the jail.

Case Examples from FY 2020

Hawaii

The P&A was contacted by a walk-in client with an unsafe discharge issue. He is a 62-year-old male with mental illness and traumatic brain injury. The client was in a borrowed wheelchair and needed immediate help with his Activities of Daily Living (ADLs), since he is unable to do his own hygiene, cooking, bathing, etc. He said he was discharged from a short-stay post-acute care facility for rehabilitative care. The P&A contacted his Medicaid health plan and Medicaid Home and Community-Based Service (HCBS) Waiver Service Coordinator and conducted a three-way phone call. The HCBS Waiver provider offered to provide immediate services and added they had been looking for the client and knew that he needed services. After the client's needs were resolved, the P&A contacted the Social Services Manager at the post-acute care facility to investigate the unsafe discharge. The P&A identified the failed communication between the facility and the HCBS service provider and cited the communication issue as resulting in an unsafe discharge. The Social Services Manager stated they would develop a corrective action plan and re-train its discharge staff on the new policies.

Illinois

The P&A investigated a complaint at a county jail that was allegedly not adequately assessing and treating individuals with mental health needs. Specifically, the jail was not providing needed medication or allowing a client to be seen by a medical professional after the client started showing symptoms of serious mental illness. The P&A confirmed this complaint after witness interviews and review of records. In follow-up to this investigation, the P&A engaged in advocacy efforts with the jail to address these concerns with the jail. In response, the jail agreed to increase its capacity for providing mental health services by contracting with a local community mental health provider.

Maryland

The P&A assisted the client, a patient at a state hospital, who received the wrong prosthetic foot while under the care of the hospital and was experiencing difficulty performing Activities of Daily Living (ADLs) due to the difficulties of trying to get around with two right feet. The P&A was alerted to this case by a former PAIMI Council member who is an advocate for the patient. The P&A met with the hospital CEO and staff. The P&A expressed concern that the client had been without the correct leg for more than eight months and had fallen and had trouble walking. The P&A advocated for individual supports for the client and hospital-wide policy changes to ensure that patients' Individual Treatment Plan goals include ongoing medical needs and specific staff responsible for follow up. As a result of the P&A's advocacy, the client received the proper prosthetic foot and additional needed supports (including physical therapy). Additionally, the P&A filed a complaint with the state's quality assurance agency detailing the hospital's medical neglect of this patient. The state is currently investigating the P&A's concerns. The P&A is providing additional assistance to the client by helping him preserve his tort claim.

Nebraska

The P&A advocated on behalf of a 53-year-old white female with multiple mental illness diagnoses, including borderline personality disorder, bipolar disorder, PTSD, and substance use disorders who resided in a psychiatric facility. Because of a family history of breast cancer, the client had requested a mammogram. The facility delayed her receiving a mammogram for nearly two and half years, at which time, the mammogram she received was determined "highly suggestive for malignancy," and biopsy later confirmed her diagnosis of breast cancer, requiring a partial mastectomy. Even after the mastectomy, facility staff denied her radiation treatments ordered by her doctors. The P&A collaborated with attorneys from a local law firm to take legal action against the psychiatric hospital. Under the terms of the settlement agreement, the State agreed to pay $385,000 to the client. While they made no admission of liability or wrongdoing, they did agree to make a number of changes that will affect all future patients, including: collection of information about family medical history and dates of preventative care; the provision of preventative care as required by the American Medical Association; steps to improve the lines of communication between regional center staff, patients and medical staff; and staff training about the Americans with Disabilities Act (ADA) and the Patient's Bill of Rights.

3. **Rights Violations**

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

Rights Violations	FY 2019	FY 2020
Cases Investigated & Closed	**4,394**	**4,790**
Individual treatment plan	278	142
Guardianship/conservator problems	232	174
Problems with advanced directives	93	60
Failure to provide confidentiality	31	42

[Source: Appendix - Table 7]

Case Examples from FY 2019

District of Columbia

The P&A represented a 71-year-old woman with serious mental illness and deafness who was hospitalized at a private psychiatric hospital in DC. The client was denied meaningful access to treatment and the community because her hearing aids were broken, and she did not have access to a teletypewriter (TTY) to communicate with her support system outside the hospital. The P&A advocated for the hospital to repair her hearing aids and to acquire a TTY for her to use on the unit. In addition, the P&A advocated for her treatment team to seek less restrictive alternatives to guardianship and more consumer-directed planning by providing information about a range of housing and treatment options that would preserve her choices about placement and treatment.

Idaho

The P&A assisted a 44-year-old male diagnosed with schizophrenia who had concerns that his residential treatment provider violated the facility's rules by not reporting to the state licensing entity when he had to be transported and treated at an Emergency Room/Hospital, as well as that he had an injury of unknown source as indicated by a missing front tooth. In addition, the P&A assisted his Durable Power of Attorney for Heath Care (DPOAHC) with filing a complaint of neglect against the residential provider since they did not assess his decline and make appropriate changes to his service plan even though the attorney had presented concerns about his mental health decline. The licensing entity disagreed with the P&A's interpretation that the facility violated the rules by not reporting the hospitalization and the injury of unknown source and withdrew the P&A's complaints. The P&A presented concerns with the rule's interpretation, but the determination was not changed. The P&A then assisted his DPOAHC with filing a complaint with licensing entity that they neglected his needs even though she had reported to facility that his mental health was decompensating. The licensing entity did not cite the facility as being neglectful but cited a rule violation regarding not accessing client even though they were aware that he was decompensating. The P&A identified this interpretation of rules as a possible systemic issue and created a project to monitor future survey results.

Kansas

The P&A provided services to a 68-year-old with a mental health diagnosis who was admitted into a Nursing Facility for Mental Health (NFMH) in 2012. While traveling from the west coast to Connecticut, he had a mental health crisis. He is a veteran and was paying for his stay with his benefits. He contacted the P&A because he wanted to be discharged, but no one would help him, including the guardian which the NFMH had identified for him. An advocate from the P&A worked with him to convince the guardian and the NFMH that he could live in the community

successfully. As a result of the P&A work, he was able to be discharged to the community and is now living successfully on his own.

Michigan

The P&A received a complaint involving a child who was being discharged from a psychiatric hospital without the home and community-based services he needed to successfully return home. The Child Protective Services (CPS) had been contacted by the hospital after the parent expressed being fearful of taking the child home where there were other minor children. The P&A reviewed records, spoke with the community mental health case manager, CPS investigators, general counsel for state health and human services department, Attorney General's Office, and the hospital. They also provided technical assistance and self-advocacy tips to the parent to use while requesting additional services. The client was successfully returned home with a substantial increase in services as requested by the parent and did not enter the foster care system.

North Carolina

The P&A was contacted by a client who had requested her landlord to permit her to have an emotional support dog for her anxiety and depression. She provided medical documentation in support of her request. The landlord refused the request and notified the client that she would have to leave her apartment. The P&A filed a Fair Housing Act (FHA) complaint with the state human rights commission on behalf of the client, which initiated an investigation. The commission determined that the landlord had violated the FHA and initiated conciliation. The client's primary goal had been to effectuate a policy change and training; however, at the time of conciliation, the landlord was no longer in the business of renting and managing properties. As an alternative, the P&A negotiated a favorable financial settlement for the client. The P&A ensured that training was included in the conciliation agreement in the event the landlord resumes renting properties.

Case Examples from FY 2020

Kentucky

The P&A was called by a 49-year-old male who is an inmate incarcerated in a state prison to report that he was not able to make phone calls or write letters. The client, who has a diagnosis of bipolar disorder and PTSD, is residing in a restrictive housing unit of the prison. The prison's policy and procedure manual states that inmates can have one phone call a week and can receive an indigent package of several sheets of paper and envelopes each week to write letters, which the prison will pay for the postage. The client contacted the P&A to let them know that the unit was not allowed to make phone calls. The P&A opened a service request for the client for denial of telephone calls and access to writing materials. The P&A contacted the unit administrator to discuss these concerns and was informed that there was a shortage of staff and stated this was the reason for the denial of telephone calls. In addition, the P&A contacted the prison warden and

was informed that there was a shortage of staff, but that should not affect the prisoners' access to writing materials and telephone calls. The P&A informed the Warden that this denial of telephone calls and writing materials further isolated the men housed in the restrictive housing unit. The Warden stated he was not aware of these concerns and would address it with his staff. The P&A later called the client and the client stated he was able to make telephone calls and that he had access to writing materials.

Maryland

The P&A represented a patient in one of our state hospitals who complained that the hospital was violating his rights by subjecting him to 72-hour involuntary medication orders in violation of the state statute, which requires the hospital to hold a clinical review panel and afford the patient the right to appeal a decision to involuntary medicate him or her. The patient was not a danger to himself or others and so could not be involuntarily medicated on an emergency basis. The P&A filed a complaint with the state and the hospital was cited with a Statement of Deficiencies and required to adopt new policies and conduct training for staff. Two months later, the P&A filed a second complaint against another state hospital for the same practice, after the hospital refused to voluntarily change its practices to conform with the mandate given to the first hospital. The second hospital also received a Statement of Deficiencies and were required to change their medication policy and retrain staff. The P&A later learned that the Maryland Behavioral Health Administration's Director of Hospitals issued a directive to all state hospitals prohibiting the use of 72-hour involuntary medication orders on patients.

Mississippi

The P&A provided services to a female who resides at a state-operated psychiatric hospital and filed a complaint about her mental health services, discharge planning, and the need for specific mental health treatment when she is discharged from the hospital. The P&A, after talking with the female about her issues, spoke with hospital staff about her treatment plan, discharge plan, and the need for the individual to be discharged to a recovery model program, then to a personal care home in the community where she would like to live. After the P&A talked with her and the hospital staff, she was eventually discharged to a recovery model program that she wanted to go to continue her treatment.

Washington

The P&A was contacted by a client with history of bipolar disorder and self-injurious behavior while incarcerated in Canada and fighting extradition to the United States for criminal prosecution. Expecting to eventually be incarcerated in Washington State Department of Corrections (DOC) custody for a significant period of time, she initially sought information from the P&A about the conditions of confinement in DOC for transgender women. When her relocation to Washington State became imminent, the P&A agreed to engage in limited representation on her behalf to support the continuation of her medication regimen, gender-affirming housing, and the recognition of her legal name in both the county correctional facility where she would await sentencing, and upon her transfer to DOC. Upon transfer to the county correctional facility, client received a gender-affirming housing placement and a continuation of

her hormone replacement therapy medication without the advocacy from the P&A. However, her legal name was not recognized by the jail, which significantly impacted her mental health and well-being, as it led to staff constantly misgendering her and using the incorrect name and identifying her as transgender to her peers. In collaboration with her public defender, the P&A reached out to the county correctional facility's attorney to request her booking information and identification within the institution be updated to reflect her current and gender-affirming legal name. The facility responded that due to a technical issue with the agency's software, her legal name could not be updated (she had previously been incarcerated at the institution under her former name). The facility also reported that the software would be updated in early 2021. The P&A met with the facility on July 31, 2020 and September 9, 2020. As a result, they worked with their IT department and other county agencies to update legal names in the jail's software system. The P&A was informed that the policy change would occur by the end of September 2020.

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.[23] 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 2019	FY 2020
States	781	949
Centers for Medicare & Medicaid Services (CMS)	2	3
Other	104	153
Deaths Reported Total	**887**	**1,105**

Deaths Investigated, by incident type	FY 2019	FY 2020
Seclusion	4	6
Restraints	6	7
Non-Seclusion/Restraint-Related	244	339
Deaths Investigated Total	**254**	**352**

[Source: Appendix - Table 8]

Case Examples from FY 2019

Delaware

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

A 29-year-old female diagnosed with bipolar disorder, oppositional defiant disorder and autism died unexpectedly of unnatural causes in 2018. Because her death was listed as unnatural and unexpected, a detailed review was conducted. Prior to the individual's death, she was involved in an incident at her group home and shortly thereafter began to have difficulty breathing. She was transported to the hospital by ambulance and admitted to the intensive care units where she remained until her death. The individual died of irreversible brain death. The P&A's review of her death resulted in several findings and recommendations, including retraining of staff on de-escalation and restraint techniques, and restraint policy review and revisions.

Massachusetts

The client's mother contacted P&A because her daughter had died while at a psychiatric hospital. The client had a history of depression, anxiety, obsessive compulsive disorder, bipolar disorder, and substance use disorder. She was admitted to a hospital to address trauma from a recent rape, as well as her dual diagnosis. She died approximately four days after being admitted, and her mother contacted the P&A to investigate After reviewing all available records, the P&A determined that there was probable cause of neglect by hospital staff. The P&A will be continuing to investigate this death into FY 2020.

New Hampshire

The P&A investigated the death of an inmate with significant mental illness on the Residential Treatment Unit (RTU) at a state prison. The P&A's investigation investigated the circumstances of an inmate's death in the RTU, as well as general conditions (groups, psychiatric services, nursing services) leading up to the inmate's death. The P&A identified multiple areas of concern during the investigation. The P&A met with DOC to present their findings including a need for increased training for staff and procedures for emergency situations. The DOC accepted and has implemented many of the changes that the P&A had recommended.

Wyoming

The P&A continued its investigation from the previous reporting year of a death of a patient at a state hospital who had died by suicide. The patient had a history of suicide attempts in a variety of settings. Because of the patient's known suicidal ideation, the hospital had ordered 15-minute checks, but the checks did not always occur. In addition, the hospital did not increase observation of the patient to 1:1, did not provide individual treatment or therapy, and did not move the patient to a safer location (patient's room had mechanical door closer that patient was able to utilize as part of the suicide). The P&A substantiated both abuse and neglect and reported its findings to state and federal agencies. As a direct result of the P&A's investigation findings, the hospital removed the door closers and installed a ligature door security alarm system.

Case Examples from FY 2020

Connecticut

The client was a 25-year-old patient at a forensic unit of a hospital who died allegedly by choking following a physical restraint by staff. He had a long history of inpatient psychiatric

treatment and had been admitted under a process identifying him as someone who needed heightened security. According to records, client was restrained 13 times while at the hospital, and was administered intramuscular injected medication during 12 of those restraints. In addition, he was denied access by hospital security to his attorney and his mother, made repeated allegations of abuse, and was committed by the probate court, following a finding of "not competent," on the day he died. The P&A found that the hospital violated his rights as to access to his attorney and mother, failed to properly manage his food-stuffing behavior, and engaged in excessive force in restraining him.

Florida

The client was a 47-year-old forensic resident of a state hospital who died by suicide. The P&A received a report of the client's death through a report of possible abuse made to the Adult Protective Services (APS) abuse hotline. The P&A's investigation determined that the client died by suicide due to negligent supervision of the hospital employee responsible for direct observation. The client had been properly categorized as a suicide risk, which required behavioral checks every 30 minutes, but the employee tasked with doing these checks did not so within the required timeframes. Nearly two hours had elapsed between the last behavioral check and when the client was found unresponsive. Although staff took appropriate action at that time to attempt to revive the client, their efforts were unsuccessful. During the P&A's investigation, the negligent employee resigned his position, and the facility conducted staff refresher trainings on how to conduct behavioral safety checks. The P&A also addressed concerns pertaining to the structural integrity of the door pins found in the facility's resident rooms since the ability of residents to remove screws from the doors may have helped facilitate the client's ability to engage in self-harm. The facility therefore conducted maintenance on all door hinges found in residential units. Finally, as part of the P&A's full monitoring of this facility, the experts involved provided additional guidance to facility administrators and direct care staff to improve resident safety and outcome.

Missouri

The P&A received a consumer death notification from the state department of mental health for a 57-year-old Caucasian male diagnosed with major depressive disorder and anxiety disorder. The client died by suicide while residing in a private residential care. The client had previously been involuntarily committed to a local hospital due to threats to hang himself and had a history of suicidal ideation by hanging. According to the records, he was placed in a program for individuals who required high supervision (15-minute safety checks); however, staff did not conduct 15 minutes safety checks on the client. Instead, checks were conducted every thirty minutes to one hour. On the date of death, client was found hanging and having cut himself with a razor 45 minutes after the previous check. Letters with recommendations for staff training to ensure staff conducts regular safety checks, ensure searches of individuals for contraband upon return from shopping trips, and regarding the provision of razors to individuals with suicidal ideation were sent to the facility and to the state behavioral health authority. The facility implemented the suggested policy changes.

Washington

The P&A requested records to investigate the death of a patient at a state hospital in February 2020. The review of the records revealed concerns about the failure of state hospital staff to administer naloxone, miscommunication with emergency medical services, and noncompliance with policies on authorized leave. The P&A met with the hospital's Chief Medical Officer and Quality Assurance lead to discuss corrective steps that had already been taken in response to the incident as well as the results of the state hospital's root cause analysis. The P&A made a second records request for the hospital's morbidity and mortality review and the investigative report of the incident from the state's health department. The additional documentation confirmed the P&A's previous findings that failures to comply with procedure may have contributed to the death of the patient.

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 in the client's favor.

Complaints Investigated and Closed, by Type	**FY 2019**	**FY 2020**
Abuse	2,180	1,092
Neglect	1,731	2,303
Rights violations	4,394	4,293
Total	**8,305**	**7,688**

[Source: Appendix - Tables 9, 10, & 11]

6. Intervention Strategies

The P&A systems are authorized by the PAIMI Act[24] 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.

Intervention Strategies, by Type	**FY 2019**
Short-term assistance	4,984
Abuse & neglect investigations	1,364
Technical assistance	943
Administrative remedies	280
Negotiation/mediation	903
Legal remedies	190
Total Intervention Strategies	**8,664**

[Source: Appendix - Table 12]

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

Intervention Strategies, by Type	FY 2020
Self-Advocacy Assistance	3,347
Limited Advocacy	3,141
Administrative remedies	334
Litigation	113
Mediation	140
Negotiation	724
Total Intervention Strategies	**7,799**

[Source: Appendix - Table 12]

Case Examples from FY 2019

Minnesota

A 20-year woman who was diagnosed with general anxiety disorder, social phobia with panic attacks, and major episodic depression enrolled in a local university; she specifically chose the university because of its representations to her that they specialized in accommodating students with mental illness. During the summer before her first term in the fall, she attempted to set up accommodations; however, when she started the fall semester, the accommodations were not in place. When she pressed the university about this, it ignored her multiple attempts and communications to secure accommodations. She experienced a mental health crisis and required hospitalization, which forced to withdraw from the university. The school however, insisted on billing the client for $20,000 in tuition and other costs. At this point, she contacted the P&A for help. The P&A investigated the concern, reviewed documents, and determined that the case would be appropriate for filing a charge of discrimination with the state department of human rights. After the charge was filed, the university agreed to withdraw the tuition bill. Further, the university also allowed the client to reenroll and ensured that proper accommodations were in place. As a result, she was able to begin classes with the necessary supports in place.

New York

The P&A assisted a client diagnosed with PTSD who had requested to have an emotional support animal in her Cooperative apartment to accommodate her disability. When she notified the Cooperative of her request, the Cooperative provided her with an overly restrictive agreement to sign before the Board would grant her the accommodation. The client requested assistance from the P&A with resolving the issues with the Cooperative. The client had also filed a complaint with the state's human rights commission. While the Cooperative drastically edited the agreement following her complaint, the agreement still would have required her to start the reasonable accommodation process all over again if the dog passed away. The P&A contacted the Cooperative's counsel and they agreed to modify the provision so that if the client's emotional support dog passes away, she would only need to provide the Cooperative with a photograph of the new dog and proof of vaccination. The client signed the agreement with the changes and is now able to keep an emotional support animal in her apartment and remain in her home.

Wisconsin

The P&A received a phone call from the mother of a jail inmate who had been incarcerated for several months on a probation hold. The doctor in charge of his care while he was in jail was not a psychiatrist and had cancelled several of the psychiatric medications that the client had been taking successfully for years. The mother indicated that she has noticed a marked decline over time. The P&A contacted the client for consent to advocate on his behalf on these medication issues. After a review of the records, it appeared that the dropping of the two psychotropic medications was primarily a cost-saving measure and the jail doctor did not comprehend the client's need for them. After advocating with the county's attorneys, the P&A was able to get these medications reinstated and after a few weeks there was a noticeable improvement in the client's mental health.

Case Examples from FY 2020

Arizona

During FY 2020, the P&A successfully used negotiation and mediation to assist a client, a person with anxiety disorder who was subjected to discrimination by his employer. The client’s supervisor refused to allow him to pass his annual performance review for the stated reason that he was not adequately managing his anxiety. The refusal of the supervisor to allow the client to pass the performance review resulted in the loss of an annual pay increase for the client. After filing a charge of disability-based employment discrimination with the state’s civil rights division, the client contacted the P&A for representation during mediation and the negotiation process. The P&A represented the client in a mediation, during which the parties were able to arrive at a preliminary verbal agreement. Even though the mediation took place near the end of FY 2019, most of the substantive negotiations for a satisfactory written settlement agreement continued throughout the first quarter of FY 2020. As a result of the P&A's representation of the client in these extensive negotiations, the employer agreed to the following remedies: 1) a 4 percent pay increase retroactive to January 2019; 2) a revision to the client's employment record that deletes the comments made by his supervisor and increases his performance review rating to pass the review; 3) a revision of the employer's annual performance review criteria if necessary after a review of the employer's compliance with the Americans with Disabilities Act; 4) annual training on the Americans with Disabilities Act for managers for two years; 5) the Chief of Human Resources of the employer meeting with the client’s supervisor to give guidance and correction regarding the performance review of the client; 6) and a payment of $5,500 in compensatory damages to the client.

California

The P&A filed a discrimination complaint on behalf of a ten-year-old student with autism and psychiatric disabilities, alleging that the student was held on the ground in a prone restraint 77 times over the course of several months. In addition, the complaint described how the student experienced lost instructional time and educational opportunities and experienced a hostile educational environment due to the excessive use of restraint. This year, a settlement agreement with the school was reached. Under the settlement agreement, the school agreed to revise its policies and procedures for behavioral interventions of students with disabilities. Some of the revisions include developing a new policy requiring staff to meet after each use of restraint to

consider alternative interventions that could be used prior to the use of restraint; hiring an ADA Compliance Coordinator related to behavior interventions; submitting monitoring data for three years; training staff on providing individualized supports and interventions.

Maine

The P&A provided services to a 58-year-old man with mental illness who was being treated in a state psychiatric hospital. The man's U.S. Department of Housing and Urban Development (HUD) Section 8 housing voucher was set to expire. The P&A was able to request an accommodation from the housing authority using clinical support from the hospital to extend the time for his voucher use until he discharged from the hospital. The P&A was able to get the client's voucher extended and therefore help him maintain stable housing upon discharge from the hospital.

Minnesota

A 56-year-old man with depression, anxiety and PTSD requested help from the P&A because of a discharge notice from his group home, where he had resided for some time. The P&A concluded that the group home had given him 30 days' notice to vacate, rather than the required 60 days. Additionally, the P&A determined that the notice of demission contained inaccuracies about what it said constituted improper behavior. The P&A challenged the demission to before an administrative tribunal. The judge issued an order stating that the group home must give him the full 60 days to discharge from the group home. Then P&A ensured that the client was working with a housing coordinator on finding housing, as he was just approved for a HUD Section 8 housing voucher.

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.[25] 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 Litigation	**FY 2019**	**FY 2020**
Number of Events	94	129
Total Number of Individuals Impacted	4,099,327	4,228,457

[Source: Appendix – Table 13]

Case Examples from FY 2019

Iowa

[25] 42 U.S.C. 10805 (a)(1)(B)

The P&A filed class action litigation on behalf of youth diagnosed with mental illness who were incarcerated at a state-operated correctional facility for youth. The lawsuit is seeking adequate mental health care, proper informed consent and oversight of psychotropic drugs, elimination of solitary confinement for punitive purposes, and elimination of a restraint device called "the wrap." The complaint was filed on November 27, 2017 and the P &A co-counseled with Children's Rights, Inc., and Ropes & Gray. The litigation continued into Fiscal Year 2019 and a bench trial was held in June 2019. Post-trial briefing was completed on August 23, 2019. The Judge has not rendered a decision to date.

Maine

The P&A continues to act as Class counsel in the case of Bates v. Glover which involved institutional litigation that provides broad based relief on behalf of approximately 3,500 individuals who are current or former residents of AMHI/Riverview Psychiatric Center and 12,000 other otherwise qualified individual with mental illness. The case was settled in 1990. One of the aspects of the agreement is that individuals in the community are entitled to community services under the terms of this settlement agreement. The P&A, the Court Master and the state health and human services agency have continued to meet on a monthly basis to monitor progress on these issues. In this fiscal year a recommendation was issued by the Court Master, fully supported by the P&A, that would require any contracts that the state health and human services agency enters into with any mental health service provider contain a provision granting individuals with mental illness who are the beneficiaries of any service the rights of third-party beneficiaries to the contracts, thus allowing them to individually assert direct claims against providers if they are not providing them the mental health services they are entitled to under the contracts. The status of that recommendation is likely to be resolved during the next fiscal year.

Utah

The P&A filed a class action against the State of Utah for its failure to protect the constitutional rights of pre-trial detainees who have been deemed mentally incompetent and are waiting in Utah's county jails until a bed at the state hospital's Forensic Facility becomes available. During FY19, the settlement agreement was successfully monitored as per class action settlement terms. System-wide, the waitlist for competency restoration services delivered by the state hospital has been reduced by 80 percent and the avg wait-time has gone from 6 plus months to less than 14 days.

Case Examples from FY 2020

New Hampshire

The P&A has long been subject to class action litigation involving care of prisoners, including prisoners with mental illness at the state prison. The case was settled in 2001, but began in 2018, when a prisoner filed a petition to enforce conditions in the settlement including access to mental health treatment, access to prescription medication and conditions in the prison. In response to the petition, the state Department of Corrections (DOC) moved to dismiss the lawsuit, stating

that the prisoner lacked standing, and that the state had sovereign immunity. The district court ruled in favor of the state and the prisoner appealed to the State Supreme Court. The P&A submitted an amicus brief with two legal services partners in the case as the decision placed all the P&A's class actions at risk. If the decision held, settlements of class actions or actions involving one or more plaintiffs, which is a focus of the P&A's systemic work, would not be specifically enforceable if the state failed to perform its obligations under a settlement agreement. In addition, the P&A worked with partners to educate the legislature about this interpretation of the law, as many believed that the state legislature did not intend this because of their most recent legislation in this area. The State Supreme Court ruled on behalf of the prisoner and the law was changed to ensure class actions could be enforced.

Illinois

Historically, the P&A has received numerous complaints about the care and treatment of people with mental illness in Illinois prisons. Accordingly, the P&A conducted an extensive investigation to determine whether these were systemic problems and what the major issues of concern were. The investigation revealed that in the Illinois prison system individuals with mental illness received substandard care. They were placed for months and even years in social and physical isolation and had little opportunity to see mental health professionals beyond cursory conversations to renew their prescription medication. Individual therapy was nearly nonexistent. The Illinois Department of Corrections (DOC) had few beds located in specialized mental health units, and assignment to those units appeared arbitrary. Accordingly, the P&A and a coalition of attorneys filed a class action lawsuit, Rasho v. Walker, against the DOC, challenging the conditions of confinement experienced by thousands of mentally ill prisoners in its custody. In FFY 2016, the parties reached a comprehensive settlement that, if fully implemented would significantly improve the conditions and treatments of inmates with mental illness. In FFY 2018, the Court Monitor issued a report raising concerns about the State's compliance with the settlement. The P&A and its co-counsel filed a Motion for a Preliminary Injunction seeking the Judge to address the State's deficiencies. In May, the Judge found violations of the Settlement Agreement and the Constitution and granted the Preliminary Injunction. After the State failed to adequately address the violations, the P&A and its co-counsel filed a Motion for a Permanent Injunction. Following a two-week trial, in FFY 2019, the Judge issued a Permanent Injunction. The State has appealed this decision to the 7th Circuit Court of appeals. The parties completed the briefing on the appeal and oral argument proceeded in FFY 2020. It is expected a decision will be issued in FFY 2021.

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.[26]

Non-Litigation Advocacy	FY 2019	FY 2020
Number of Events	3,121	2,360
Total Number of Individuals Impacted	16,515,905	50,999,506

[Source: Appendix – Table 13b]

Legislative & Regulatory Advocacy	FY 2019	FY 2020
Number of Events	347	250
Total Number of Individuals Impacted	30,589,896	5,418,610

[Source: Appendix – Table 13]

Case Example from FY 2019

Alabama

The P&A participated on a committee convened by the state department of education to address the education provided to children and youth with SED residing in residential treatment programs, including psychiatric residential treatment facilities, acute hospital settings, juvenile correctional and detention facilities, and state hospital placements. On an annualized basis, it is estimated that these settings serve approximately 2,000 children. The P&A raised this overarching concern regarding the schooling services provided in such facilities: as currently constituted under state law and regulation, state-supported educational programs in these facilities are not designed to provide educational opportunities that are equal to those provided to Alabama students not in these programs. Among other things, the P&A's work in these facilities demonstrate that state policies do not ensure access by students to Alabama's state-approved Courses of Study and grade-level instruction provided by appropriately state-certified teachers. There is no requirement that the educational programs provide instructional hours comparable to those of community public schools. Youth placed in these programs often do not earn transferable class credit because of the structure of the school programs. The state's department of education, which has general supervisory authority over the implementation of the Individuals with Disabilities Education Act (IDEA), has no mechanism to ensure the provision of a free appropriate public education for eligible students with disabilities in these facilities. The P&A has seen gross deficiencies in how the programs implement Child Find. Few facilities engage in individualized determinations regarding children's least restrictive environment. Concurrent with a reliance on computerized, online learning programs, there is little direct instruction and direct specialized instruction to meet the disability-related needs of the students. Appropriate and individualized transition opportunities are lacking, including ensuring access to such services in a youth's least restrictive environment, where it might be community-based opportunities. The

[26] 42 CFR Part 51. Subpart A

P&A urged the committee, as it considers any proposals to refashion state policies affecting these state-supported educational programs, to judge such proposals against this standard: how does the proposal ensure that a child in one of these facilities is offered the same educational opportunities as his or her peers attending a community public school in Alabama? At the close of the FY, the committee's work plan was unresolved. The P&A continues to monitor in such facilities regarding the education provided to children and youth with SED and is pursuing administrative and/or legal remedies absent any movement by the state.

Louisiana

As a result of a complaint filed by the P&A, in October 2014, the U.S. Department of Justice (USDOJ) notified the state that it was initiating an investigation to determine whether the State was unnecessarily institutionalizes in nursing facilities individuals with mental illness, in violation of Title II of the ADA and the Supreme Court decision of Olmstead v. L. C. DOJ found that Louisiana had been using nursing homes to house people with mental health disabilities instead of using community-based services. The DOJ found that the state: failed to properly follow Pre-Admission Screening and Resident Review (PASRR) assessment procedures designed to prevent the unnecessary institutionalization of persons with developmental disabilities and mental illness, failed to address the over-incarceration of person with mental illness, and failed to ensure that there was an adequate supply of permanent supportive housing. As a result of its findings, DOJ filed a complaint and entered into a court enforceable settlement agreement which requires the State to "promptly implement remedial measures to protect the civil rights of individuals with serious mental illness in, or at serious risk of entering, nursing facilities and to remedy the deficiencies discussed above, taking into account the needs and preferences of each individual with serious mental illness." The state is currently developing and implementing a plan to bring it in compliance with the Settlement Agreement.

North Dakota

The state's department of children and family services distributed proposed rules for residential settings for children with mental illness and solicited comments from the public. As part of this process, the P&A reviewed the proposed rules and provided written comments regarding four areas: use of seclusion & restraint as well as 'time out' and the use of mechanical restraints, staff knowledge of reporting child abuse and neglect, resident and family engagement, and runaway notification of parents/custodians. The State accepted and reviewed the P&A's comments. As a result, changes are being made to the proposed rules.

Case Examples for FY 2020

Connecticut

In November 2019, upon completion of a comprehensive and lengthy investigation, the P&A substantiated abuse, neglect, and violations of patient rights at two of the largest congregate inpatient psychiatric facilities in the state. The P&A issued an extensive Investigation Report with a number of specific findings and recommendations, including a recommendation for the state's General Assembly to place one hospital under licensure by the Department of Public Health and for the Commissioner of the Department of Health and Addiction Services to enact

reforms in the areas of concern identified in the report. This report was presented to the state's General Assembly's task force related to these facilities. The P&A has subsequently completed an additional investigation regarding the death of a patient at one of the facilities, which will result in the release of an Investigation Report.

Florida

The P&A engaged in monitoring compliance with a court-ordered settlement agreement that addressed the constitutionally deficient treatment of patients in the custody of the Florida Department of Corrections who reside on the inpatient mental health units for inmates with serious mental illness who require the highest level of care. The agreement requires two rounds of monitoring compliance with the settlement agreement to be completed by a neutral monitoring authority to occur over a two-year time period. The first year of monitoring has been completed and revealed numerous deficiencies in compliance with the original settlement agreement in the areas of: (a) staffing; (b) use of restraints; (c) unstructured out-of-cell activities; (d) psychotropic medications; and (e) training of the inpatient mental health unit staff. The P&A successfully negotiated a corrective action plan that is designed to correct the deficiencies identified during the first year of monitoring, the results of which will be monitored during the second year.

Michigan

Due to limited bed capacity and other factors, defendants found to lack mental competency who are to be provided treatment at a facility for forensic psychiatry may end up waiting in jail for several months for a transfer to the hospital. The jails, by their own admission, are incapable of providing needed mental health treatment. The P&A developed a three-part advocacy strategy to address this issue. First, they participated in an Incompetent to Stand Trial (IST) work group of: sheriffs, prosecutors, community mental health staff and others. This group was able to make changes and recommendations, such as not subjecting misdemeanor defendants to the IST process. Another change amended the court form used by judges to indicate that treatment could be provided not only in a hospital, but also in the community. A second strategy was to represent individual clients. The goal of this advocacy was to force the mental health system to make space in a hospital or other setting. This led to the third strategy, a complaint to file in federal court, however, in the interim, the State agreed to make significant changes.

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 2019**	**FY 2020**
Information and Referral Services Requests	20,908	17,020
a. Number of Public Awareness Activities or Events	2,075	1,396
b. Number of Educational/Training Activities Undertaken	2,577	1,723
c. Number (approximate) of Person Trained in b.	110,486	267,308

[Source: Appendix, Table 14]

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

Case Examples from FY 2019

California

Through an investigation, the P&A found that conditions at one of the largest privately operated immigration detention facilities in the United States posed serious risks to people with mental illness and other disabilities. The findings are contained in a report: “There Is No Safety Here: The Dangers for People with Mental Illness and Other Disabilities in Immigration Detention at GEO Group’s Adelanto ICE Processing Center.” The report follows an in-depth year-long investigation. Among the nearly 2,000 people held at the facility on a given day, approximately 300 people have mental health treatment needs. The report finds that the facility fails to provide adequate treatment to people with serious mental health needs. People who experience a psychiatric crisis are often met with pepper spray or extreme isolation in suicide watch cells. During the investigation, the P&A discovered that the GEO Group, a private corrections contractor that owns and operates the facility, significantly underreports data on the number of suicide attempts that occur at the facility. The P&A continues to monitor the facility and intends to advocate for policy changes through negotiation and/or litigation in FY 2020.

Florida

The P&A was contacted by a resident of a supportive housing complex for individuals with serious and persistent mental illness, run by Project Return and funded in part by a grant from the United States Department of Housing and Urban Development (HUD). Project Return lost HUD funding in February 2019 but failed to provide timely notice to residents or to effectively assist residents with relocation efforts. The P&A, in an effort to force Project Return into action, contacted numerous local entities including the Tampa Hillsborough Homeless Initiative, Central Florida Behavioral Health, the Tampa Mayor’s office, officials from Hillsborough County and HUD. The P&A applied pressure to these and other groups (through letters, conference calls and

communication with the local newspaper) in order to persuade them to offer all available housing, financial and case management services to residents of Friendship Palms. The P&A's advocacy efforts were effective in that Hillsborough County and various community partners mobilized to assist residents of Friendship Palms with relocation assistance, financial assistance, and case management assistance.

Maryland

The P&A published two reports that focus on the use of restrictive housing, a practice that is particularly harmful for PAIMI eligible persons. The P&A interviewed and reviewed records of individuals who have spent extended periods of time in restrictive housing and determined that PAIMI-eligible persons experienced increased anxiety, paranoia, hallucinations, and engaged in self-harming behaviors in restrictive housing units without adequate access to mental health services or programming. The P&A, along with our coalition and community partners, successfully advocated for changes to limit the use of restrictive housing for juveniles and pregnant women in State correctional facilities. The P&A and our coalition partners distributed copies of the P&A's report to policymakers to educate them about the harm to people with mental illness through restrictive housing practices. The policy and legislative changes became effective on October 1, 2019 and will protect PAIMI eligible persons for years to come.

Oklahoma

The P&A has continued to take significant steps to reach the under-served prison population during this fiscal year. In FY 2017, the P&A initiated a systemic investigation into the largest prison in Oklahoma due to issues it discovered with failure to provide mental health, medical and dental care to its inmates. This investigation will continue into FY 2020. Additionally, the P&A opened an investigation into a large rural jail which focuses on mental health care of its inmates. Over 50 percent of the population of the prison inmates have been diagnosed with a serious mental illness. All of the county jail inmates who are a part of our investigation have been diagnosed with a serious mental illness.

Case Examples from FY 2020

Arkansas

The P&A received several complaints from staff at a psychiatric residential treatment facility (PRTF) regarding the infection control protocols implemented in response to the COVID-19 pandemic. Staff reported that they were not provided masks and had to bring their own, many staff were not wearing masks, residents were not wearing masks, new residents were not being quarantined, and while facility-wide testing occurred, staff were not notified of their results or the results were inconclusive. The P&A monitors conducted video interviews with residents in which they reported that mask-wearing was lax and that if a resident tested positive for COVID-19, they were quarantined in their room, essentially in solitary confinement. Upon receiving this information, the P&A spoke by telephone with the person responsible for infection control at the facility, who agreed to reinforce the facility's mask policy with staff, ensure masks are provided to all staff and residents, and investigate allegations that youth testing positive were being kept in

their rooms instead of on a dedicated unit that would allow for some movement and interaction.

Connecticut

In November 2019, upon completion of a comprehensive and lengthy investigation, the P&A substantiated abuse, neglect, and violations of patient rights at two of the largest congregate inpatient psychiatric facilities in CT. The P&A issued an extensive Investigation Report, which included a number of specific findings and recommendations. In January 2020, the P&A presented its findings and recommendations to a task force established by the CT General Assembly in June 2018 to review and evaluate the operations, conditions, culture, and finances of the two facilities. The P&A has subsequently completed an additional investigation regarding the death of a patient at one of the facilities, which will result in the release of an Investigation Report. The preliminary findings of the Investigation Report were shared with the task force. The P&A will continue to monitor the care and treatment of individual patients as part of its continuing monitoring of persistent, systemic problems at this facility.

Georgia

The P&A and the Southern Center for Human Rights filed suit against the Fulton County Sheriff and other staff at the Union City Jail. The complaint addresses the treatment of women in the jail who experience psychiatric disabilities. Currently, the women are housed in deplorable conditions. The suit seeks preliminary and permanent injunctive relief to address the conditions of confinement as well as the lack of mental health care provided to the incarcerated women. The P&A filed a motion for preliminary injunction and a motion for class certification in the matter. We had a hearing on the preliminary injunction and prevailed. The Court also granted class certification. The County filed an appeal of the District Court decision granting the preliminary injunction. This case was argued December 16th. The case is moving forward with discovery which will be completed at the end of December. The P&A is also regularly monitoring the jail. The County continues to refuse to discuss any terms of settlement. Any trial will likely be scheduled in April or May 2021.

New York

During the prior fiscal year, the P&A filed a lawsuit, M.G. v. Cuomo, in the United States District Court for the Southern District on behalf of putative classes of New Yorkers with mental illness who have been held in prison past their lawful release dates because of a lack of community-based mental health housing and services. The P&A is partnering in this litigation with the Legal Aid Society of New York City and the law firm Paul, Weiss, Rifkind, Wharton & Garrison. The lawsuit seeks an injunction requiring New York to create an effective plan for community integration, which includes developing a sufficient array of community-based mental health housing for these individuals. On December 16, 2019, Defendants moved to dismiss the case. In an order on September 25, 2020, the Court rejected nearly all of Defendants' arguments and allowed the case to proceed. During litigation, it was also revealed that Defendants have released hundreds of people with serious mental illness from prison to homeless shelters,

halfway houses, and institutional settings simply because there is inadequate capacity in the State's community-based mental health housing and service programs. Despite the unique challenges posed by the pandemic, the P&A investigated and documented these inappropriate placements. On August 10, 2020, the Plaintiffs' counsel moved to amend the case to include claims on behalf of individuals with serious mental illness who have been released from prison but are unnecessarily segregated or placed at serious risks of institutionalization, in violation of the Americans with Disabilities Act and the Rehabilitation Act. The Court granted the Plaintiffs request for leave to amend the complaint.

2. <u>Impediments & Unmet Needs</u>

Case Examples from FY 2019

Arizona

One state hospital continued to place restrictions on the P&A's statutory authority to have reasonable unaccompanied access to the hospital's facilities and patients in FY 2019. The P&A were not allowed unaccompanied access to patients for purposes of monitoring or abuse and neglect investigations. The P&A were also often denied unaccompanied access to areas accessible to patients during monitoring and investigative visits. The state hospital also continued to deny the P&A access to peer review records that pertain to an investigation into the death of a patient.

District of Columbia

The P&A experienced difficulty engaging in our investigatory function at the one hospital when P&A with requested documentation. Through several meetings with hospital administration, the P&A has improved our access to patient records by solidifying a plan with the hospital administration with concrete steps that the P&A will take with the medical records' staff to ensure we receive all records that we have requested.

New Hampshire

The P&A had to limit the assistance provided to people with mental illness as the federal funding for the PAIMI program is not sufficient to address all the major problems in mental health system in New Hampshire.

Vermont

The P&A has a well-established reputation and good working relationship with all facilities monitored and is able also to respond to the Children's Health Act's expansion into community-based abuse and neglect concerns, limited in the most part by inadequate funding resources to respond to the demand for services and need to monitor facilities and communities spread over an often-mountainous rural territory. The lack of clear access to records authority for non-treatment-based entities has been a barrier to obtaining timely and relevant information.

Case Examples from FY 2020

Alabama

The P&A continues to have to remind PRTFs of their serious occurrence report responsibilities under the Children's Health Act of 2000. Not all facilities report and, of those that do, not all report all reportable incidents. While the P&A’s PAIMI Act access authority has been repeatedly reaffirmed in jurisdictions across the U.S., facilities in Alabama continue to challenge the P&A’s access to monitor and investigate, hampering the P&A’s ability.

Kansas

Although the number of Kansans with mental illness that the P&A provide services to continues rise, the amount of PAIMI funds received has remained stagnant. Kansas is home to more than 120,000 children and adults with mental illness and the lack of increases in PAIMI funds hinders our ability to serve those needing assistance. In FFY 2013, the P&A served 92 PAIMI-eligible clients and received $400,000. In FFY 2020, they served 328 PAIMI eligible clients and received $428,000. As demonstrated, the amount of the P&A’s PAIMI funding has not kept up with the increase in the client caseload. This is not sustainable. More resources and higher funding levels from PAIMI are needed to properly ensure PAIMI eligible Kansans receive the services they need.

Mississippi

The COVID-19 pandemic has been the biggest impediments during this past fiscal year. It has affected the way advocacy was done this past year. From shutting down for a month to getting back and having to change the way advocacy work had to be done and continues to be done. Virtual meetings, phone calls, emails have been utilized much more than before COVID 19. Monitoring "visits" were done by phone with questionnaires and other times through the use of computers and phone, virtually. Once in person visits continued the need for Personal Protective Equipment (PPE) and wearing of masks has been of utmost concern. It has been difficult, but the P&A has moved forward, one day at a time and continues to fight for the rights of those with mental illness around the state during this unprecedented time.

Wyoming

Lack of placement options in the community for non-PAIMI eligible persons led to institutionalization of some individuals at the only state operated. inpatient psychiatric facility. This situation led to some PAIMI-eligible persons being unnecessarily jailed or put in other settings until a bed came open for their placement at the state facility.

GOVERNANCE

1. ***The Governing Authority***

The DD Act of 1975,[27] which created the state P&A systems, and the PAIMI Act[28] mandated that private, non-profit entities have a multimember governing authority (the Board) to oversee the system.[29] Each Board is responsible for the planning, design, implementation, and functioning of the system.[30] The Board must work jointly with its PAIMI Advisory Council (PAC)[31] and establish policies and procedures for the selection of its members.[32] 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.[33]
- 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.[34]

As of September 30, 2019, 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 they are not required to do so.

The PAIMI Act and Rules also require that 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[35] to advise the system on policies and priorities to be carried out in protecting and advocating for the rights of individuals with mental

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

illness.[36] The composition of the PAC is also mandated.[37] The PAC Chair must be a current or former mental health recipient or a family member of such an individual.[38]

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.[39] 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.[40]

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;[41] however, any PAC member may serve on the governing board.[42]

By January 1 of each year, each P&A system is required to submit an annual Program Performance Report (PPR) to the HHS Secretary.[43] The PAC is also required to submit a section of that annual PPR, as mandated by the PAIMI Act[44] and the PAIMI Rules.[45]

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.

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

[36] at 42 U.S.C. 10805 (a) (6) (A)
[37] PAIMI Act at 42 U.S.C. 10805(a) (6) (B)
[38] 42 U.S.C. 10805(a) (6) (C) and the PAIMI Rules at 42 CFR at 51.23(b) (2)
[39] PAIMI Rules at 42 CFR 51.23 (a) (1) - (3)
[40] PAIMI Rules at 42 CFR 51.23(b) (2), (3) and (c)
[41] 42 U.S.C. 10805 (a) (6) (A), 42 CFR at 51.22 (b) (3)
[42] 42 CFR at 51.22(d)
[43] 42 U.S.C. 10805 (a) (7)
[44] 42 U.S.C. 10824
[45] 42 CFR 51.8

SAMHSA provides 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 2019 and 2020 contract included the following:

- Investigation protocols for incidents of abuse and neglect cases involving deaths;
- Seclusion and restraint;
- Community integration (Supreme Court decision of Olmstead v. L. C.);
- 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 2019 and 2020

Table 1 – State PAIMI Appropriations
Table 2 – PAIMI Eligible Individuals Served by Age Group and Sex
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Table 4 – Living Arrangements of PAIMI Eligible Individuals
Table 5 – Complaints Involving Alleged Abuse of PAIMI Eligible Individuals
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Table 8 – Death Investigations
Table 9 – Analysis of Alleged Abuse
Table 10 – Analysis of Alleged Neglect
Table 11 – Analysis of Alleged Rights Violations
Table 12 – Intervention Strategies
Table 13 – Non-Case Directed Services
Table 14 – Information and Referral/Public Education/Awareness & Training Activities

Table 1 – State PAIMI Appropriations

State/Jurisdiction	FY 2019 Final Appropriations	FY 2020 Final Appropriations
Alabama	$457,665	$454,402
Alaska	$428,000	$428,000
Arizona	$638,784	$641,505
Arkansas	$428,000	$428,000
California	$3,064,413	$3,043,159
Colorado	$449,205	$450,031
Connecticut	$428,000	$428,000
Delaware	$428,000	$428,000
District of Columbia (DC)	$428,000	$428,000
Florida	$1,776,069	$1,801,228
Georgia	$929,003	$931,818
Hawaii	$428,000	$428,000
Idaho	$428,000	$428,000
Illinois	$1,039,636	$1,031,488
Indiana	$590,775	$588,634
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	$463,525	$462,191
Massachusetts (MA)	$502,083	$500,268
Michigan	$872,164	$869,127
Minnesota	$447,375	$448,703
Mississippi	$428,000	$428,000
Missouri	$543,808	$540,864
Montana	$428,000	$428,000
Nebraska	$428,000	$428,000
Nevada	$428,000	$428,000
New Hampshire	$428,000	$428,000
New Jersey	$671,867	$670,077
New Mexico	$428,000	$428,000
New York	$1,503,880	$1,476,892
North Carolina	$913,289	$917,038
North Dakota	$428,000	$428,000
Ohio	$1,016,255	$1,011,130
Oklahoma	$428,000	$428,000
Oregon	$428,000	$428,000
Pennsylvania (PA)	$1,048,742	$1,040,125

State/Jurisdiction	FY 2019 Final Appropriations	FY 2020 Final Appropriations
Rhode Island	$428,000	$428,000
South Carolina	$462,839	$463,238
South Dakota	$428,000	$428,000
Tennessee	$590,750	$590,472
Texas	$2,392,318	$2,437,992
Utah	$428,000	$428,000
Vermont	$428,000	$428,000
Virginia	$676,109	$677,110
Washington (WA)	$577,556	$578,507
West Virginia	$428,000	$428,000
Wisconsin	$493,546	$490,949
Wyoming	$428,000	$428,000
American Indian Consortium (AIC)	$511,100	$512,416
American Samoa (Am. Samoa)	$229,300	$229,300
Guam	$229,300	$229,300
Northern Marianas (N. Marianas)	$229,300	$229,300
Puerto Rico	$229,300	$229,300
Virgin Islands	$229,300	$229,300
Total State P&A Systems	**$35,335,256**	**$35,331,864**
Technical Assistance Set-aside (20%)	$720,708	$721,058
Total Annual PAIMI Appropriations	**$36,055,964**	**$36,052,922**

Table 2 – PAIMI-Eligible Individuals Served by Age Group and Sex – FY2019

State/ Jurisdiction	HHS Region	Age							Sex			
		0-4	5-12	13-18	19-25	25-64	65+	Total	Male	Female	Unknown	Total
Alabama	4	0	16	67	23	69	15	190	136	54	0	190
Alaska	10	0	2	3	3	44	0	52	33	19	0	52
American Indian Consortium	13	0	2	12	0	2	0	16	10	6	0	16
American Samoa	9	0	0	5	47	29	4	85	55	30	0	85
Arizona	9	0	6	12	29	271	31	349	166	183	0	349
Arkansas	6	0	23	36	6	26	3	94	58	35	1	94
California	9	0	34	72	62	694	75	937	410	520	7	937
Colorado	8	0	1	4	20	72	4	101	70	30	1	101
Connecticut	1	0	1	6	2	23	6	38	24	14	0	38
Delaware	3	0	2	13	22	121	7	165	82	83	0	165
District of Columbia	3	0	0	10	1	79	21	111	68	43	0	111
Florida	4	0	6	10	17	219	23	275	179	96	0	275
Georgia	4	0	3	7	17	99	5	131	81	50	0	131
Guam	9	0	1	5	2	8	0	16	8	8	0	16
Hawaii	9	0	30	31	5	100	12	178	101	77	0	178
Idaho	10	1	4	7	15	74	10	111	68	43	0	111
Illinois	5	1	77	79	39	347	26	569	313	252	4	569
Indiana	5	0	6	10	5	50	5	76	57	19	0	76
Iowa	7	0	10	12	4	10	4	40	22	18	0	40
Kansas	7	1	8	5	19	295	36	364	161	203	0	364
Kentucky	4	0	9	15	5	60	9	98	61	37	0	98
Louisiana	6	0	14	36	56	368	26	500	257	222	21	500
Maine	1	0	49	76	23	91	15	254	162	92	0	254
Maryland	3	0	4	24	14	161	14	217	126	91	0	217
Massachusetts	1	0	1	0	2	26	2	31	20	11	0	31
Michigan	5	0	6	16	13	115	28	178	115	63	0	178
Minnesota	5	0	20	20	17	137	11	205	94	111	0	205
Mississippi	4	0	3	9	1	18	0	31	13	18	0	31
Missouri	7	0	0	2	14	174	23	213	152	61	0	213
Montana	8	0	23	86	14	107	3	233	136	97	0	233
Nebraska	7	0	0	1	2	12	3	18	5	13	0	18
Nevada	9	0	0	0	1	29	2	32	17	15	0	32
New Hampshire	1	0	11	26	14	198	15	264	111	152	1	264
New Jersey	2	0	4	27	44	151	30	256	149	107	0	256
New Mexico	6	0	16	39	4	52	14	125	75	50	0	125
New York	2	0	2	1	12	128	9	152	75	77	0	152
North Carolina	4	0	2	7	18	63	5	95	72	23	0	95
North Dakota	8	0	57	62	21	61	10	211	140	71	0	211
Northern Marianas	9	0	0	2	2	15	0	19	13	6	0	19
Ohio	5	1	29	63	55	644	55	847	452	393	2	847
Oklahoma	6	0	1	1	5	59	10	76	52	24	0	76
Oregon	10	0	0	0	2	20	3	25	17	7	1	25

State/ Jurisdiction	HHS Region	Age							Sex			
		0-4	5-12	13-18	19-25	25-64	65+	Total	Male	Female	Unknown	Total
Pennsylvania	3	0	21	34	21	158	11	245	119	126	0	245
Puerto Rico	2	0	1	1	3	64	8	77	34	43	0	77
Rhode Island	1	0	9	21	21	164	33	248	133	115	0	248
South Carolina	4	0	5	159	8	17	2	191	101	90	0	191
South Dakota	8	0	5	6	6	18	2	37	19	18	0	37
Tennessee	4	0	4	6	6	44	1	61	33	28	0	61
Texas	6	0	47	131	81	600	42	901	552	349	0	901
Utah	8	0	7	9	21	124	4	165	74	91	0	165
Vermont	1	0	0	12	3	50	6	71	42	29	0	71
Virgin Islands	2	0	0	2	1	11	2	16	7	9	0	16
Virginia	3	0	0	13	8	72	33	126	73	51	2	126
Washington	10	0	4	1	25	381	108	519	385	127	7	519
West Virginia	3	0	5	4	1	37	9	56	42	14	0	56
Wisconsin	5	0	9	24	11	60	4	108	71	37	0	108
Wyoming	8	0	2	0	2	20	4	28	19	9	0	28
Totals		4	602	1,342	895	7,141	843	10,827	6,120	4,660	47	10,827
Percentages		.04	5.6	12.4	8.3	66	7.8	100	56.5	43	.43	100

Table 2 – PAIMI-Eligible Individuals Served by Age Group and Sex – FY2020

State/ Jurisdiction	HHS Region	Age								Sex			
		0-2	3-5	6-10	11-22	23-64	65+	Unknown	Total	Male	Female	Unknown	Total
Alabama	4	0	1	11	77	64	8	0	161	112	49	0	161
Alaska	10	0	0	2	3	30	1	0	36	22	14	0	36
American Indian Consortium	13	0	0	1	10	2	0	0	13	12	1	0	13
American Samoa	9	0	0	0	4	39	1	0	44	27	17	0	44
Arizona	9	0	0	10	34	328	30	0	402	178	224	0	402
Arkansas	6	0	0	17	37	9	0	0	63	48	15	0	63
California	9	0	0	11	84	632	69	0	796	337	444	15	796
Colorado	8	0	0	0	3	53	5	2	63	48	15	0	63
Connecticut	1	0	0	1	3	24	2	1	31	20	10	1	31
Delaware	3	0	0	1	22	94	8	0	125	67	58	0	125
District of Columbia	3	0	0	0	11	65	18	0	94	60	34	0	94
Florida	4	0	0	3	20	218	21	0	262	180	82	0	262
Georgia	4	0	0	2	17	101	11	0	131	71	60	0	131
Guam	9	0	0	0	4	15	0	0	19	11	8	0	19
Hawaii	9	0	0	13	48	99	11	0	171	95	76	0	171
Idaho	10	0	0	1	21	62	4	0	88	45	42	1	88
Illinois	5	0	4	31	126	355	33	0	549	303	239	7	549
Indiana	5	0	0	3	29	41	5	9	87	51	36	0	87
Iowa	7	0	0	4	21	19	1	0	45	25	19	1	45
Kansas	7	0	2	3	31	273	19	0	328	141	187	0	328
Kentucky	4	0	0	7	18	54	8	2	89	52	37	0	89
Louisiana	6	0	0	3	19	39	2	0	63	45	18	0	63
Maine	1	0	1	16	66	103	11	0	197	123	74	0	197
Maryland	3	0	0	4	27	149	14	0	194	108	86	0	194
Massachusetts	1	0	1	0	16	104	8	0	129	57	69	3	129
Michigan	5	0	1	10	28	118	48	1	206	122	84	0	206
Minnesota	5	0	3	15	60	238	12	0	328	150	170	8	328
Mississippi	4	0	0	1	14	32	2	0	49	32	17	0	49
Missouri	7	0	0	0	8	148	19	0	175	123	52	0	175
Montana	8	0	0	1	59	106	6	0	172	115	55	2	172
Nebraska	7	0	0	0	2	12	2	0	16	4	12	0	16
Nevada	9	0	0	0	3	22	2	0	27	15	12	0	27
New Hampshire	1	0	0	3	27	179	9	0	218	104	112	2	218
New Jersey	2	0	0	0	11	173	36	5	225	133	91	1	225
New Mexico	6	0	0	7	32	58	10	1	108	65	42	1	108
New York	2	0	1	3	7	128	11	3	153	82	70	1	153
North Carolina	4	0	0	3	23	103	17	0	146	104	42	0	146
North Dakota	8	0	2	35	50	58	6	0	151	101	50	0	151
Northern Marianas	9	0	0	0	2	11	0	0	13	10	3	0	13
Ohio	5	9	2	33	117	532	52	0	745	430	306	9	745
Oklahoma	6	0	0	0	5	42	3	0	50	36	14	0	50

State/ Jurisdiction	HHS Region	Age								Sex			
		0-2	3-5	6-10	11-22	23-64	65+	Unknown	Total	Male	Female	Unknown	Total
Oregon	10	0	0	0	1	21	4	1	27	17	9	1	27
Pennsylvania	3	0	0	4	32	203	12	0	251	140	111	0	251
Puerto Rico	2	0	0	1	5	67	8	0	81	39	42	0	81
Rhode Island	1	0	3	8	34	126	9	22	202	119	83	0	202
South Carolina	4	4	0	6	189	103	12	0	314	174	140	0	314
South Dakota	8	0	0	2	11	31	4	0	48	18	30	0	48
Tennessee	4	0	0	3	8	25	0	0	36	24	12	0	36
Texas	6	1	2	17	220	627	30	0	897	539	358	0	897
Utah	8	0	0	5	30	201	8	0	244	103	140	1	244
Vermont	1	0	0	0	3	43	3	0	49	30	19	0	49
Virgin Islands	2	0	0	0	2	13	2	0	17	10	7	0	17
Virginia	3	0	0	0	28	58	19	0	105	59	4	42	105
Washington	10	0	0	0	16	371	14	83	484	356	120	8	484
West Virginia	3	0	0	1	13	40	7	0	61	45	16	0	61
Wisconsin	5	0	0	6	34	37	1	0	78	43	35	0	78
Wyoming	8	0	0	0	0	8	4	0	12	8	4	0	12
Totals		14	23	308	1,825	6,906	662	130	9,868	5,588	4,176	104	9,868
Percentages		0.14	0.23	3.12	18.49	69.98	6.71	1.32	100.00	56.63	42.32	1.05	100.00

Table 3 - PAIMI-Eligible Individuals Served by Race and Ethnicity – FY2019

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	Unknown	Total
Alabama	4	0	1	92	2	0	95	190	4	186	0	190
Alaska	10	16	0	5	3	0	28	52	4	48	0	52
American Indian Consortium	13	16	0	0	0	0	0	16	0	16	0	16
American Samoa	9	0	2	0	4	79	0	85	0	81	4	85
Arizona	9	5	6	33	8	0	236	288	61	288	0	349
Arkansas	6	0	0	31	3	0	53	87	5	87	2	94
California	9	10	43	138	43	1	606	841	188	650	99	937
Colorado	8	0	0	12	1	0	46	59	21	59	21	101
Connecticut	1	0	0	5	2	0	22	29	7	29	2	38
Delaware	3	0	3	60	2	0	91	156	8	156	1	165
District of Columbia	3	2	0	96	2	0	11	111	2	109	0	111
Florida	4	0	3	99	10	0	163	275	20	255	0	275
Georgia	4	2	1	70	7	0	48	128	5	101	0	106
Guam	9	0	2	1	0	12	1	16	0	16	0	16
Hawaii	9	2	34	7	60	16	59	178	10	168	0	178
Idaho	10	2	0	1	2	0	106	111	10	101	0	111
Illinois	5	4	12	185	34	0	306	541	88	449	32	569
Indiana	5	0	0	17	1	0	56	74	1	75	0	76
Iowa	7	1	0	3	1	0	35	40	1	39	0	40
Kansas	7	4	6	31	9	1	300	351	13	351	0	364
Kentucky	4	1	1	15	3	0	78	98	3	95	0	98
Louisiana	6	1	0	239	0	0	213	453	11	464	25	500
Maine	1	7	3	11	13	0	220	254	2	102	150	254
Maryland	3	1	3	133	8	1	61	207	6	201	10	217
Massachusetts	1	2	1	5	2	1	19	30	1	30	0	31
Michigan	5	4	0	66	2	0	102	174	4	174	0	178
Minnesota	5	5	6	54	22	0	117	204	8	196	0	204
Mississippi	4	2	0	6	0	0	23	31	0	31	0	31
Missouri	7	1	1	61	0	1	149	213	0	213	0	213
Montana	8	39	2	2	4	2	184	233	7	190	36	233
Nebraska	7	0	0	3	0	0	14	17	1	17	0	18
Nevada	9	0	1	3	2	1	24	31	1	31	0	32
New Hampshire	1	3	4	7	4	1	239	258	5	258	1	264
New Jersey	2	1	9	59	9	0	178	256	29	219	8	256
New Mexico	6	3	0	2	1	0	75	81	44	81	0	125
New York	2	1	1	50	3	0	81	136	23	120	9	152
North Carolina	4	1	0	41	3	0	48	93	2	78	15	95

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	Unknown	Total
North Dakota	8	32	0	7	18	0	154	211	10	201	0	211
Northern Marianas	9	1	3	0	2	12	1	19	0	19	0	19
Ohio	5	1	3	184	16	1	442	647	2	647	205	854
Oklahoma	6	4	0	18	2	0	52	76	0	76	0	76
Oregon	10	0	1	3	1	0	21	26	2	14	10	26
Pennsylvania	3	1	7	49	6	0	145	208	17	228	0	245
Puerto Rico	2	0	0	0	77	0	0	77	77	0	0	77
Rhode Island	1	1	1	16	7	0	191	216	17	216	15	248
South Carolina	4	0	0	85	5	2	99	191	4	185	2	191
South Dakota	8	6	0	0	1	0	27	34	1	35	1	37
Tennessee	4	0	0	18	4	0	39	61	2	54	5	61
Texas	6	4	9	224	30	1	633	901	238	658	5	901
Utah	8	2	1	6	0	1	138	148	19	149	0	168
Vermont	1	1	0	4	4	0	61	70	0	70	0	70
Virgin Islands	2	0	0	11	1	0	2	14	1	14	0	15
Virginia	3	0	1	25	14	0	82	122	4	122	0	126
Washington	10	12	8	74	31	2	246	373	32	261	226	519
West Virginia	3	1	0	2	2	0	51	56	0	56	0	56
Wisconsin	5	2	1	27	6	0	72	108	10	98	0	108
Wyoming	8	3	0	0	4	0	21	28	4	24	0	28
Totals		207	180	2,396	501	135	6,564	9,983	1,035	8,891	884	10,810
Percentages		2.07	1.80	24.00	5.02	1.35	65.75	100	9.57	82.25	8.18	100

Table 3 - PAIMI-Eligible Individuals Served by Race and Ethnicity – FY2020

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	Unknown	Total
Alabama	4	1	2	78	2	0	76	159	2	159	0	161
Alaska	10	9	0	3	2	0	21	35	0	36	1	37
American Indian Consortium	13	13	0	0	0	0	0	13	0	13	0	13
American Samoa	9	0	0	0	0	44	0	44	0	44	0	44
Arizona	9	6	5	31	9	1	275	327	71	331	4	406
Arkansas	6	1	0	21	3	0	31	56	2	61	5	68
California	9	7	38	133	32	2	321	533	175	527	88	790
Colorado	8	1	0	11	0	0	31	43	9	43	11	63
Connecticut	1	0	0	7	1	0	11	19	5	26	7	38
Delaware	3	0	1	40	2	0	71	114	9	112	2	123
District of Columbia	3	0	0	84	1	0	5	90	3	91	1	95
Florida	4	0	2	94	13	0	145	254	28	214	8	250
Georgia	4	2	0	70	5	0	43	120	2	119	11	132
Guam	9	0	0	0	0	14	5	19	0	19	0	19
Hawaii	9	3	33	6	62	13	54	171	7	164	0	171
Idaho	10	3	0	1	2	2	80	88	10	78	0	88
Illinois	5	8	11	159	38	2	300	518	79	419	31	529
Indiana	5	0	1	13	5	0	56	75	1	86	12	99
Iowa	7	0	0	5	4	0	35	44	4	41	1	46
Kansas	7	4	7	25	6	1	225	268	12	316	60	388
Kentucky	4	0	0	10	5	0	71	86	3	86	0	89
Louisiana	6	0	2	29	1	0	29	61	2	60	2	64
Maine	1	2	3	11	6	0	119	141	3	97	56	156
Maryland	3	0	1	107	16	1	61	186	6	188	2	196
Massachusetts	1	1	3	24	2	0	92	122	7	122	0	129
Michigan	5	2	1	49	1	0	95	148	6	174	58	238
Minnesota	5	7	0	70	30	7	203	317	7	0	11	18
Mississippi	4	0	0	20	1	0	24	45	1	48	4	53
Missouri	7	0	1	48	0	1	125	175	0	175	0	175
Montana	8	30	0	1	8	1	105	145	5	167	27	199
Nebraska	7	0	0	3	0	0	13	16	0	16	0	16
Nevada	9	0	0	7	3	0	17	27	0	27	0	27
New Hampshire	1	3	1	6	3	0	199	212	7	211	0	218
New Jersey	2	1	10	59	3	0	116	189	32	157	36	225
New Mexico	6	3	0	2	1	0	101	107	34	73	1	108
New York	2	2	2	35	10	0	97	146	23	130	7	160
North Carolina	4	2	0	65	2	0	66	135	2	144	11	157
North Dakota	8	25	0	11	11	0	104	151	12	139	0	151

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	Unknown	Total
Northern Marianas	9	0	1	0	4	7	1	13	0	13	0	13
Ohio	5	0	3	148	14	0	364	529	7	738	216	961
Oklahoma	6	4	1	14	5	0	26	50	3	47	0	50
Oregon	10	0	1	1	1	1	8	12	3	24	15	42
Pennsylvania	3	2	2	45	8	0	148	205	14	237	46	297
Puerto Rico	2	0	0	0	81	0	0	81	81	0	0	81
Rhode Island	1	1	2	9	4	0	139	155	13	187	34	234
South Carolina	4	2	0	135	7	1	163	308	10	298	6	314
South Dakota	8	5	0	2	3	1	33	44	0	43	4	47
Tennessee	4	0	0	13	1	0	21	35	1	35	0	36
Texas	6	7	9	241	26	0	578	861	203	664	36	903
Utah	8	6	2	9	9	1	184	211	19	205	14	238
Vermont	1	1	1	3	0	0	42	47	1	48	1	50
Virgin Islands	2	0	0	16	0	0	1	17	2	15	0	17
Virginia	3	0	1	23	2	0	54	80	5	75	25	105
Washington	10	13	11	68	29	4	254	379	35	257	105	397
West Virginia	3	1	0	5	1	0	54	61	0	61	0	61
Wisconsin	5	3	1	15	10	1	47	77	6	66	1	73
Wyoming	8	1	0	0	1	0	10	12	1	11	0	12
Totals		182	159	2,085	496	105	5,549	8,576	973	7,937	960	9,870
Percentages		2.12	1.85	24.31	5.78	1.22	64.70	100	9.86	80.42	9.73	100

Table 4 - Living Arrangements of PAIMI Eligible Individuals – FY2019

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	Unknown	Total
Alabama	4	2	12	0	24	3	0	0	58	2	24	0	0	0	8	53	0	202
Alaska	10	0	2	0	0	0	0	0	3	2	2	0	0	14	25	4	0	54
American Indian Consortium	13	0	0	0	1	0	0	0	0	0	1	0	0	0	1	13	0	16
American Samoa	9	8	5	5	0	0	0	4	0	17	6	0	0	5	15	20	0	91
Arizona	9	3	46	0	1	0	2	6	16	7	3	0	0	28	56	16	165	349
Arkansas	6	0	2	0	0	1	1	1	6	5	20	0	0	3	2	10	43	100
California	9	5	14	0	1	5	0	4	57	71	74	1	0	47	500	155	3	965
Colorado	8	1	2	0	0	1	2	22	20	19	16	0	1	0	16	0	1	113
Connecticut	1	0	0	0	0	7	0	1	1	8	7	0	0	1	8	5	0	44
Delaware	3	0	10	0	0	1	0	0	0	83	6	0	0	5	31	28	1	171
District of Columbia	3	0	20	0	0	0	0	1	30	13	4	0	0	17	18	7	1	111
Florida	4	1	12	1	0	5	0	1	137	52	55	1	0	0	5	5	0	321
Georgia	4	0	10	0	0	0	0	4	8	76	1	0	0	2	3	4	0	109
Guam	9	4	0	0	0	0	0	0	0	2	0	0	0	0	0	10	0	16
Hawaii	9	0	21	0	5	1	0	0	0	22	3	0	0	4	53	69	0	178
Idaho	10	0	9	0	0	3	1	0	59	2	3	0	0	3	17	12	2	113
Illinois	5	0	9	2	3	42	2	6	105	53	29	0	0	12	143	161	2	594
Indiana	5	0	2	0	0	0	1	0	0	8	29	0	0	0	14	14	8	93
Iowa	7	0	2	0	0	3	0	0	3	2	2	0	0	0	1	5	22	40
Kansas	7	0	12	0	0	83	0	0	12	21	4	0	0	6	201	25	0	364
Kentucky	4	1	14	0	0	4	1	0	34	6	18	0	0	0	7	16	0	110
Louisiana	6	1	54	2	1	3	1	3	2	180	28	0	0	9	164	49	3	512
Maine	1	14	27	7	3	2	0	18	0	47	22	0	0	5	21	17	71	255
Maryland	3	0	9	0	0	0	0	6	18	99	27	0	0	6	41	10	1	239
Massachusetts	1	0	1	0	0	0	0	0	15	1	1	0	0	1	8	4	0	32
Michigan	5	1	15	0	0	20	0	5	8	41	65	0	0	1	8	14	0	212
Minnesota	5	2	23	0	3	0	2	1	11	17	19	0	0	3	95	50	0	237
Mississippi	4	0	2	0	0	1	0	0	2	12	4	0	0	0	7	6	0	36
Missouri	7	0	19	0	0	41	8	0	67	5	36	0	0	3	30	4	0	247
Montana	8	106	0	0	0	0	0	0	0	39	58	0	0	2	23	5	0	288
Nebraska	7	0	0	0	0	0	0	0	9	7	0	0	0	0	1	1	0	18
Nevada	9	0	1	0	0	1	0	0	2	10	9	0	0	0	9	0	0	40
New Hampshire	1	2	5	0	0	2	0	8	6	53	7	0	0	12	132	36	1	270
New Jersey	2	2	3	0	0	2	1	7	13	160	3	0	0	0	36	29	0	257
New Mexico	6	0	17	0	0	3	25	0	45	3	2	0	0	0	0	30	0	125

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	Unknown	Total
New York	2	0	3	0	0	2	0	1	4	3	36	0	0	4	11	1	87	182
North Carolina	4	0	1	0	0	1	0	0	31	2	44	0	0	1	6	9	0	106
North Dakota	8	1	8	1	3	3	1	1	26	6	7	0	0	4	28	122	0	213
Northern Marianas	9	0	0	0	0	0	0	0	0	1	5	0	0	2	3	8	0	24
Ohio	5	9	82	0	1	24	1	9	8	189	92	2	0	31	290	93	23	913
Oklahoma	6	0	0	0	0	2	0	0	7	6	52	0	0	0	6	3	0	124
Oregon	10	1	3	0	1	0	0	1	0	15	4	0	0	0	0	1	0	27
Pennsylvania	3	2	7	0	0	3	0	2	5	54	15	0	0	5	105	47	0	250
Puerto Rico	2	0	2	0	0	0	0	0	42	11	3	0	0	0	12	7	0	80
Rhode Island	1	1	8	1	0	13	0	3	11	46	28	0	0	4	69	59	5	273
South Carolina	4	3	2	0	3	0	0	0	4	10	129	0	0	0	6	32	2	195
South Dakota	8	0	0	2	0	0	0	0	4	18	1	0	0	0	5	7	0	38
Tennessee	4	0	6	2	0	2	0	0	0	14	20	0	0	1	5	11	0	71
Texas	6	10	13	22	52	11	0	8	10	428	146	0	0	12	130	55	4	907
Utah	8	1	2	0	0	2	0	0	9	2	8	0	0	6	118	19	0	169
Vermont	1	2	4	0	0	0	0	1	3	10	23	0	0	3	22	1	3	95
Virgin Islands	2	0	0	0	0	0	0	0	0	0	0	0	0	0	8	7	1	16
Virginia	3	2	10	1	0	4	0	2	11	82	6	0	0	0	4	3	1	130
Washington	10	4	1	0	0	0	0	4	22	132	251	0	0	14	68	6	17	654
West Virginia	3	2	7	0	0	0	1	1	0	23	9	0	0	0	7	6	0	63
Wisconsin	5	0	9	1	0	2	0	0	4	12	32	0	0	1	16	31	0	127
Wyoming	8	1	3	0	0	0	0	0	0	21	0	0	0	0	2	1	0	28
Totals		192	551	47	102	303	50	131	948	2,230	1,499	4	1	277	2,620	1,416	467	11,607
Percentages		1.65	4.75	0.40	0.88	2.61	0.43	1.13	8.17	19.21	12.91	0.03	0.01	2.39	22.57	12.20	4.02	100.00

Table 4 - Living Arrangements of PAIMI Eligible Individuals – FY2020

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 including Emergency Rooms	Public Institutional Living Arrangement	Private Institutional Living Arrangement	Psychiatric Hospitals (Public or Private)	Jails	State Prison	Federal Detention Center	Federal Prison	Veterans Administration Hospital/Clinic	Other Federal Facility	Homeless	Independent (in the community & PAIMI-eligible)	Parental or Other Family Home & PAIMI Eligible	Unknown	Total
Alabama	4	1	10	0	3	2	0	0	33	40	3	22	0	0	0	0	0	0	6	40	1	161
Alaska	10	0	1	0	0	0	0	0	0	0	0	0	3	0	0	0	0	8	20	4	0	36
American Indian Consortium	13	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	10	0	13
American Samoa	9	4	9	0	0	0	0	7	0	0	7	3	0	0	0	0	0	5	9	11	0	55
Arizona	9	3	64	1	1	1	1	6	17	5	15	3	0	0	0	0	0	23	211	51	0	402
Arkansas	6	0	2	11	0	0	0	6	0	5	0	0	2	0	0	0	0	1	3	33	0	63
California	9	3	7	0	2	4	0	2	61	13	54	45	13	1	0	0	0	38	440	109	4	796
Colorado	8	0	7	0	0	2	0	6	1	0	28	12	7	0	1	0	0	1	5	0	3	73
Connecticut	1	0	2	0	0	0	0	0	2	3	15	1	2	0	0	0	0	1	4	1	0	31
Delaware	3	0	9	0	0	1	0	0	0	9	41	3	6	0	0	0	0	2	29	25	0	125
District of Columbia	3	0	8	0	0	0	0	0	35	0	10	4	0	0	0	0	0	15	18	4	0	94
Florida	4	0	9	2	0	6	0	1	115	5	62	17	60	0	1	0	0	1	6	6	0	291
Georgia	4	1	16	0	0	2	0	2	11	7	113	4	0	0	0	0	0	2	7	8	0	173
Guam	9	0	3	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2	5	7	0	19
Hawaii	9	0	18	0	5	1	0	0	0	0	26	0	0	1	0	0	0	1	51	68	0	171
Idaho	10	0	7	0	0	0	1	0	33	20	0	0	2	0	0	0	0	0	12	13	0	88
Illinois	5	1	16	1	1	50	8	18	39	0	85	18	9	2	0	0	0	8	145	147	1	549
Indiana	5	0	4	8	10	1	0	1	0	3	28	1	0	0	0	0	0	2	17	12	0	87
Iowa	7	2	3	1	0	1	0	0	0	1	1	0	1	0	0	0	0	0	15	20	0	45
Kansas	7	1	7	0	1	62	0	11	4	2	5	0	0	0	0	0	0	5	199	31	0	328
Kentucky	4	1	7	0	1	2	0	0	16	30	2	3	3	0	0	0	0	0	7	16	1	89
Louisiana	6	3	1	0	0	1	1	0	1	0	9	7	2	0	0	0	1	1	17	19	0	63
Maine	1	6	22	9	1	2	0	16	0	0	44	13	1	0	0	0	0	7	34	42	0	197
Maryland	3	0	6	0	1	0	0	5	0	14	71	7	22	0	0	0	0	6	50	12	0	194
Massachusetts	1	0	1	0	0	1	0	9	33	35	0	0	1	0	0	1	0	5	31	8	1	126
Michigan	5	1	12	0	1	9	0	3	4	3	39	3	33	0	0	0	0	0	12	27	59	206
Minnesota	5	3	53	0	1	0	0	5	12	12	26	3	6	1	5	1	0	12	104	80	4	328
Mississippi	4	1	0	0	0	1	0	0	0	6	19	5	10	0	0	0	0	0	2	3	2	49
Missouri~	7	1	20	0	0	48	4	1	41	1	4	2	20	0	0	0	0	3	27	3	0	175
Montana	8	0	0	0	0	1	0	0	47	37	1	0	61	0	0	0	0	0	23	4	0	174
Nebraska	7	0	0	0	0	1	0	0	7	5	0	0	0	0	0	0	0	0	1	2	0	16
Nevada	9	0	3	0	0	0	0	0	0	1	12	0	1	0	0	0	0	3	7	0	0	27
New Hampshire	1	0	0	0	1	4	0	18	0	5	37	2	4	0	0	0	0	5	123	19	0	218
New Jersey	2	0	12	0	0	6	1	8	0	5	136	5	1	0	0	0	0	1	22	4	24	225
New Mexico	6	0	9	0	4	1	0	1	29	3	5	1	0	0	0	0	0	1	21	33	0	108

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 including Emergency Rooms	Public Institutional Living Arrangement	Private Institutional Living Arrangement	Psychiatric Hospitals (Public or Private)	Jails	State Prison	Federal Detention Center	Federal Prison	Veterans Administration Hospital/Clinic	Other Federal Facility	Homeless	Independent (in the community & PAIMI-eligible)	Parental or Other Family Home & PAIMI Eligible	Unknown	Total
New York	2	0	5	0	0	5	2	1	1	1	3	13	21	1	1	0	0	7	81	8	3	153
North Carolina	4	1	4	0	0	3	1	2	32	12	9	35	25	0	0	0	0	0	13	11	0	148
North Dakota	8	1	4	3	0	0	0	4	2	3	22	7	5	0	0	0	0	0	19	80	1	151
Northern Marianas˜	9	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	1	2	4	0	13
Ohio	5	8	99	0	2	21	0	4	6	1	114	16	60	0	2	0	0	32	223	112	45	745
Oklahoma	6	0	1	0	0	1	0	0	0	1	4	17	20	0	0	0	0	0	5	1	0	50
Oregon	10	0	4	0	1	2	0	1	1	1	8	5	2	0	0	0	0	1	1	0	0	27
Pennsylvania	3	0	2	1	0	2	0	1	3	5	75	4	9	0	0	0	0	5	115	29	0	251
Puerto Rico	2	2	2	0	0	0	0	0	0	42	12	0	3	0	0	0	0	0	14	6	0	81
Rhode Island	1	1	9	0	0	8	0	2	6	4	39	2	46	0	0	0	0	6	43	39	6	211
South Carolina	4	4	9	0	2	1	0	5	8	4	7	137	10	0	0	0	0	3	74	45	5	314
South Dakota	8	0	2	2	0	1	1	0	0	0	28	0	0	0	0	0	0	0	18	7	0	59
Tennessee	4	1	3	0	0	1	0	0	0	0	9	4	3	0	0	0	0	0	6	10	0	37
Texas	6	11	16	11	77	3	1	17	4	3	391	142	3	1	1	0	0	10	161	43	2	897
Utah	8	0	1	0	0	6	0	0	15	1	5	6	3	0	0	0	0	6	174	27	0	244
Vermont	1	1	4	0	0	0	0	2	3	1	12	3	11	0	0	0	0	0	12	1	0	50
Virgin Islands	2	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	7	8	0	17
Virginia	3	0	3	2	0	2	0	3	0	13	67	3	0	4	0	0	1	0	2	1	4	105
Washington	10	0	7	0	0	1	0	4	8	3	129	101	128	0	0	0	0	6	74	9	14	484
West Virginia	3	3	2	0	0	4	1	0	0	2	32	0	7	0	0	0	0	1	3	6	0	61
Wisconsin	5	0	6	2	0	2	0	0	3	2	8	2	3	0	0	0	0	1	17	28	4	78
Wyoming	8	0	1	0	0	0	0	0	0	0	17	0	0	0	0	0	0	0	2	0	0	20
Selected States/ Jurisdictions˜		67	532	54	116	273	22	172	633	370	1,891	681	635	11	11	2	2	238	2,750	1,347	184	9,991
of Selected States/Jurisdictions˜		0.67	5.32	0.54	1.16	2.73	0.22	1.72	6.34	3.70	18.93	6.82	6.36	0.11	0.11	0.02	0.02	2.38	27.52	13.48	1.84	100.00
All States/ Jurisdictions˜		67	532	54	116	273	22	172	633	370	1,891	681	635	11	11	2	2	238	2,750	1,347	184	9,991
All States/Jurisdictions˜		0.67	5.32	0.54	1.16	2.73	0.22	1.72	6.34	3.70	18.93	6.82	6.36	0.11	0.11	0.02	0.02	2.38	27.52	13.48	1.84	100.00

Table 5 – Complaints Involving Alleged Abuse of PAIMI Eligible Individuals – FY2019

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Medication	Physical Restraint	Chemical Restraint	Mechanical Restraint	Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization	Failure to provide appropriate mental health treatment	Failure to provide Medical Treatment	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
Alabama	4	17	0	6	1	0	0	0	0	0	0	4	0	3	0	1	0	0	1	1
Alaska	10	3	0	1	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0
American Indian Consortium	13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
American Samoa	9	40	2	0	0	0	2	5	0	0	0	3	1	4	8	5	3	7	0	0
Arizona	9	61	17	2	1	1	1	2	0	1	0	22	5	1	2	3	1	2	0	0
Arkansas	6	25	0	2	0	1	1	0	0	0	0	10	1	5	1	0	3	1	0	0
California	9	47	2	1	1	1	0	0	0	0	0	8	1	11	11	2	1	3	5	0
Colorado	8	36	1	5	2	11	2	1	0	0	0	11	1	0	1	0	0	0	1	0
Connecticut	1	5	0	0	0	0	1	0	0	0	0	3	0	0	0	0	1	0	0	0
Delaware	3	6	0	1	2	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0
District of Columbia	3	40	4	2	1	2	1	1	0	0	0	7	2	1	3	1	0	11	4	0
Florida	4	86	10	3	1	0	1	1	0	0	0	27	19	11	4	6	0	1	2	0
Georgia	4	36	2	1	1	0	0	10	1	0	0	2	5	0	0	3	0	0	11	0
Guam	9	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Hawaii	9	7	0	1	2	0	1	0	0	0	0	1	0	0	0	1	0	1	0	0
Idaho	10	28	0	2	0	13	7	0	0	0	0	1	2	0	1	1	0	0	1	0
Illinois	5	92	17	5	5	1	1	10	2	0	0	17	13	2	3	8	0	8	0	0
Indiana	5	9	0	1	0	1	0	1	0	0	0	6	0	0	0	0	0	0	0	0
Iowa	7	26	0	5	0	0	5	0	0	0	0	12	1	3	0	0	0	0	0	0
Kansas	7	26	0	2	0	0	0	1	0	0	0	14	4	0	0	1	0	3	1	0
Kentucky	4	9	1	0	0	1	3	0	1	0	0	0	1	0	0	0	0	0	2	0
Louisiana	6	17	1	0	0	2	0	0	0	0	0	9	1	4	0	0	0	0	0	0
Maine	1	35	0	2	0	0	0	3	0	0	0	29	1	0	0	0	0	0	0	0
Maryland	3	68	3	1	6	1	3	3	0	0	0	10	4	13	19	3	0	0	1	1
Massachusett s	1	14	0	1	0	0	0	0	0	0	0	8	1	2	0	2	0	0	0	0
Michigan	5	36	1	3	5	1	4	1	0	0	0	11	1	2	2	1	0	2	0	2
Minnesota	5	45	5	1	0	0	0	0	0	0	0	15	5	0	0	1	0	3	0	15
Mississippi	4	4	1	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0	0	0
Missouri	7	86	10	3	0	0	0	2	0	1	1	39	20	1	2	5	2	0	0	0
Montana	8	45	6	4	0	0	3	0	0	0	0	12	3	8	5	1	0	0	1	2
Nebraska	7	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Nevada	9	9	0	0	0	0	0	0	0	0	0	8	1	0	0	0	0	0	0	0
New Hampshire	1	54	1	2	2	2	2	2	1	0	0	38	2	0	0	0	1	1	0	0
New Jersey	2	153	22	2	0	0	0	0	0	0	0	11	18	50	3	8	2	1	36	0
New Mexico	6	21	3	3	0	2	0	0	2	0	0	4	1	3	0	2	0	1	0	0

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Medication	Physical Restraint	Chemical Restraint	Mechanical Restraint	Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization	Failure to provide appropriate mental health treatment	Failure to provide Medical Treatment	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
New York	2	16	0	2	0	0	0	0	0	0	0	12	1	1	0	0	0	0	0	0
North Carolina	4	2	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
North Dakota	8	29	0	4	0	0	0	0	0	0	0	5	1	4	2	3	1	9	0	0
Northern Marianas	9	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0
Ohio	5	127	5	9	0	1	1	8	0	0	0	41	13	15	2	14	11	3	0	4
Oklahoma	6	47	0	1	0	0	0	0	0	0	0	19	22	0	2	0	1	2	0	0
Oregon	10	9	0	0	0	0	0	1	0	0	0	4	0	2	0	0	2	0	0	0
Pennsylvania	3	46	1	13	0	0	0	1	0	0	0	19	3	4	0	2	0	3	0	0
Puerto Rico	2	2	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0
Rhode Island	1	8	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	1	0	0
South Carolina	4	124	0	0	0	0	2	0	0	0	0	117	2	1	0	0	0	0	2	0
South Dakota	8	17	4	0	0	0	3	2	0	0	0	5	2	1	0	0	0	0	0	0
Tennessee	4	12	1	0	1	0	1	0	0	0	0	3	1	3	1	1	0	0	0	0
Texas	6	100	5	9	1	1	2	4	0	0	0	47	6	17	1	5	0	1	1	0
Utah	8	6	1	0	0	0	1	0	0	0	0	4	0	0	0	0	0	0	0	0
Vermont	1	29	2	4	3	0	5	0	0	0	0	8	0	0	1	1	0	5	0	0
Virgin Islands	2	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Virginia	3	30	4	5	1	1	0	1	1	0	0	3	0	2	2	1	1	0	8	0
Washington	10	255	15	7	0	1	17	11	0	0	0	164	15	7	3	9	1	5	0	0
West Virginia	3	9	1	1	0	0	0	0	0	0	0	5	1	0	0	0	0	1	0	0
Wisconsin	5	32	1	0	0	0	0	0	0	0	0	24	4	1	2	0	0	0	0	0
Wyoming	8	24	2	5	0	1	1	0	0	0	0	6	4	0	4	0	0	0	1	0
Selected States/ Jurisdictions		2,116	151	123	37	45	72	71	8	2	1	842	190	184	85	92	31	77	80	25
% of Selected States/Jurisdictions		100.00 %	7.14 %	5.81 %	1.75 %	2.13 %	3.40 %	3.36 %	0.38 %	0.09 %	0.05 %	39.79 %	8.98 %	8.70 %	4.02 %	4.35 %	1.47 %	3.64 %	3.78 %	1.18 %
All States/ Jurisdictions		2,116	151	123	37	45	72	71	8	2	1	842	190	184	85	92	31	77	80	25
% All States/Jurisdictions		100.00 %	7.14 %	5.81 %	1.75 %	2.13 %	3.40 %	3.36 %	0.38 %	0.09 %	0.05 %	39.79 %	8.98 %	8.70 %	4.02 %	4.35 %	1.47 %	3.64 %	3.78 %	1.18 %

Source: 2019 PAIMI Progress Report: C. Complaints/Problems of PAIMI Eligible Individuals - Areas of Alleged Abuse

The following state(s)/jurisdiction(s) did not supply data: FM, MH, PW, RL

Legend:
˜ Non-Finalized Data, e.g., the application/report has been not approved and/or there are open revision requests for the source data.

Table 5 – Complaints Involving Alleged Abuse of PAIMI Eligible Individuals – FY2020

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Inappropriate /Excessive		Involuntary				Complaints Concerning						
			Medication	Restraint and Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
Alabama	4	31	3	16	0	0	0	0	8	1	1	0	0	0	2
Alaska	10	1	1	0	0	0	0	0	0	0	0	0	0	0	0
American Indian Consortium	13	0	0	0	0	0	0	0	0	0	0	0	0	0	0
American Samoa	9	19	2	0	2	0	0	0	5	0	2	2	6	0	0
Arizona	9	30	11	3	0	0	0	0	2	3	2	1	2	4	2
Arkansas	6	8	0	2	0	0	0	0	3	1	0	0	1	1	0
California	9	28	0	3	0	0	0	0	5	10	1	0	0	9	0
Colorado	8	4	0	1	0	0	0	0	0	2	1	0	0	0	0
Connecticut	1	2	1	0	0	0	0	0	0	0	0	0	0	1	0
Delaware	3	5	0	0	0	0	0	0	0	0	0	0	2	3	0
District of Columbia	3	19	0	1	0	0	0	0	4	1	1	0	3	9	0
Florida	4	30	5	3	1	0	0	0	15	1	0	1	0	2	2
Georgia	4	54	10	6	12	0	0	0	11	3	4	0	2	3	3
Guam	9	3	0	1	0	0	0	0	0	1	1	0	0	0	0
Hawaii	9	5	1	1	0	0	0	0	2	0	1	0	0	0	0
Idaho	10	9	0	4	3	0	0	0	0	1	0	0	0	1	0
Illinois	5	79	0	13	20	1	1	0	13	12	5	1	13	0	0
Indiana	5	10	1	5	0	0	0	0	2	1	0	0	0	1	0
Iowa	7	13	1	6	0	0	0	0	1	0	0	0	2	3	0
Kansas	7	14	1	1	0	0	0	0	1	2	3	1	5	0	0
Kentucky	4	8	1	2	0	0	0	0	1	1	3	0	0	0	0
Louisiana	6	5	0	0	0	0	0	0	4	0	1	0	0	0	0
Maine	1	13	1	7	4	1	0	0	0	0	0	0	0	0	0
Maryland	3	39	4	7	6	1	0	0	9	5	0	2	1	4	0
Massachusetts	1	45	0	0	0	0	0	0	4	0	1	0	6	0	34
Michigan	5	30	1	19	0	1	0	0	1	1	1	0	1	0	5
Minnesota	5	14	8	1	0	1	0	0	2	0	0	0	2	0	0
Mississippi	4	3	2	1	0	0	0	0	0	0	0	0	0	0	0
Missouri˜	7	30	4	2	5	0	0	1	5	4	7	0	0	2	0
Montana	8	20	1	6	0	0	0	0	2	2	4	0	1	2	2
Nebraska	7	6	0	5	0	0	0	0	0	0	0	1	0	0	0
Nevada	9	2	0	0	0	0	0	0	0	0	1	0	0	0	1
New Hampshire	1	23	4	11	3	0	0	0	0	0	2	2	1	0	0
New Jersey	2	129	14	3	4	0	0	0	23	1	9	9	0	66	0
New Mexico	6	17	11	0	0	0	0	0	1	0	4	0	0	0	1
New York	2	9	4	0	0	0	0	0	1	2	0	1	0	0	1
North Carolina	4	8	1	2	0	0	0	0	4	1	0	0	0	0	0
North Dakota	8	19	0	6	0	0	0	0	2	1	3	0	7	0	0
Northern Marianas˜	9	3	0	0	0	0	0	0	1	0	2	0	0	0	0
Ohio	5	49	4	2	0	0	0	0	10	2	6	14	8	0	3
Oklahoma	6	3	0	0	0	0	0	0	0	2	1	0	0	0	0

State/ Jurisdiction	HHS Region	Number of Abuse Complaints Closed	Inappropriate /Excessive		Involuntary				Complaints Concerning						
			Medication	Restraint and Seclusion	Medication	Electric Convulsive Therapy (ECT)	Aversive Behavioral Therapy	Sterilization	Physical Assault	Sexual Assault	Staff Threats /Retaliation/Assaults	Coercion	Financial Exploitation	Suspicious Death	Other
Oregon	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pennsylvania	3	20	3	3	5	0	0	0	2	1	0	2	4	0	0
Puerto Rico	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rhode Island	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0
South Carolina	4	24	1	0	0	0	0	0	3	2	14	0	3	0	1
South Dakota	8	5	1	1	1	0	0	0	2	0	0	0	0	0	0
Tennessee	4	5	2	0	0	0	0	0	2	0	0	1	0	0	0
Texas	6	41	8	12	1	0	0	0	9	1	5	1	0	4	0
Utah	8	10	7	0	0	0	0	0	1	1	0	1	0	0	0
Vermont	1	12	3	3	0	0	0	0	0	1	0	0	0	0	5
Virgin Islands	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Virginia	3	23	5	5	1	0	0	0	3	2	0	4	0	3	0
Washington	10	88	7	33	11	0	0	0	15	7	11	1	3	0	0
West Virginia	3	7	0	0	0	0	0	0	0	1	1	0	5	0	0
Wisconsin	5	6	0	6	0	0	0	0	0	0	0	0	0	0	0
Wyoming	8	11	3	5	0	0	0	0	1	0	1	0	0	1	0
Selected States/ Jurisdictions˜		1,092	137	209	79	5	1	1	180	77	99	45	78	119	62
% of Selected States/Jurisdictions ˜		100.00 %	12.55 %	19.14 %	7.23 %	0.46 %	0.09 %	0.09 %	16.48 %	7.05 %	9.07 %	4.12 %	7.14 %	10.90 %	5.68 %
All States/ Jurisdictions˜		1,092	137	209	79	5	1	1	180	77	99	45	78	119	62
% All States/Jurisdictions ˜		100.00 %	12.55 %	19.14 %	7.23 %	0.46 %	0.09 %	0.09 %	16.48 %	7.05 %	9.07 %	4.12 %	7.14 %	10.90 %	5.68 %

Source: 2020 PAIMI Progress Report: C. Complaints/Problems of PAIMI Eligible Individuals - Areas of Alleged Abuse

Legend:
˜ Non-Finalized Data, e.g., the application/report has been not approved and/or there are open revision requests for the source data.

Table 6 – Complaints Involving Alleged Neglect of PAIMI Eligible Individuals – FY2019

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,	Other
Alabama	4	45	1	0	19	0	2	0	0	23	0
Alaska	10	5	3	0	2	0	0	0	0	0	0
American Indian Consortium	13	1	0	0	0	0	0	1	0	0	0
American Samoa	9	35	4	4	4	2	4	7	7	3	0
Arizona	9	46	4	4	15	13	1	9	0	0	0
Arkansas	6	6	1	0	2	1	0	1	0	1	0
California	9	43	0	0	31	3	0	7	0	2	0
Colorado	8	13	1	0	6	2	1	1	1	1	0
Connecticut	1	8	0	0	7	1	0	0	0	0	0
Delaware	3	39	0	1	28	0	2	4	2	1	1
District of Columbia	3	17	0	0	5	1	0	11	0	0	0
Florida	4	53	2	0	16	3	12	7	4	9	0
Georgia	4	122	1	0	75	0	2	4	1	3	36
Guam	9	5	1	0	3	0	1	0	0	0	0
Hawaii	9	7	0	0	2	2	0	2	1	0	0
Idaho	10	57	0	0	42	4	4	0	0	7	0
Illinois	5	130	6	14	78	6	3	13	4	6	0
Indiana	5	8	0	0	7	0	0	0	1	0	0
Iowa	7	22	0	0	4	4	0	1	6	7	0
Kansas	7	14	2	0	2	1	3	4	1	1	0
Kentucky	4	5	0	0	0	3	2	0	0	0	0
Louisiana	6	6	2	0	4	0	0	0	0	0	0
Maine	1	27	1	0	24	0	0	2	0	0	0
Maryland	3	25	1	0	2	3	7	4	3	5	0
Massachusetts	1	11	5	0	3	1	0	0	0	0	2
Michigan	5	53	31	0	4	0	5	1	0	11	1
Minnesota	5	32	6	2	7	0	0	5	1	0	11
Mississippi	4	4	0	0	0	0	1	0	0	3	0
Missouri	7	77	0	0	23	1	30	18	2	3	0
Montana	8	106	12	0	5	3	4	0	56	25	1
Nebraska	7	1	1	0	0	0	0	0	0	0	0
Nevada	9	7	1	0	6	0	0	0	0	0	0
New Hampshire	1	32	9	0	16	1	3	3	0	0	0
New Jersey	2	55	3	0	38	0	3	7	2	2	0
New Mexico	6	25	3	0	8	0	1	6	0	7	0
New York	2	19	2	1	13	1	0	2	0	0	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,	Other
North Carolina	4	3	0	0	1	0	0	2	0	0	0
North Dakota	8	25	1	0	4	1	5	10	2	2	0
Northern Marianas	9	1	0	0	0	1	0	0	0	0	0
Ohio	5	65	3	1	7	10	14	21	3	4	2
Oklahoma	6	12	0	0	6	2	4	0	0	0	0
Oregon	10	1	1	0	0	0	0	0	0	0	0
Pennsylvania	3	31	0	0	16	1	7	3	2	2	0
Puerto Rico	2	0	0	0	0	0	0	0	0	0	0
Rhode Island	1	15	1	0	11	0	0	2	0	1	0
South Carolina	4	11	1	0	9	0	0	0	0	1	0
South Dakota	8	2	0	0	1	0	0	0	0	1	0
Tennessee	4	22	1	0	8	8	1	3	0	1	0
Texas	6	130	3	0	21	30	29	16	0	28	3
Utah	8	3	0	0	0	0	1	1	1	0	0
Vermont	1	20	1	1	17	1	0	0	0	0	0
Virgin Islands	2	1	0	0	1	0	0	0	0	0	0
Virginia	3	60	1	0	42	0	5	5	3	4	0
Washington	10	125	4	1	62	19	15	14	4	6	0
West Virginia	3	26	0	0	21	0	3	2	0	0	0
Wisconsin	5	6	1	0	1	1	2	1	0	0	0
Wyoming	8	11	0	0	1	1	2	2	4	1	0
Totals		1,731	121	29	730	131	179	202	111	171	57
Percentages		100	6.99	1.68	42.17	7.57	10.34	11.67	6.41	9.88	3.29

Table 6 – Complaints Involving Alleged Neglect of PAIMI Eligible Individuals – FY2020

State/ Jurisdiction	HHS Region	Number of Neglect Complaints Closed	Failure to Provide for Appropriate						
			Medical (other than psychiatric) treatment	Mental Health Treatment, Including Access to Prescribed Medication	Personal care and safety	Discharge Planning or Release from Residential Care or Treatment Facility	Mental Health Diagnostic or Other Evaluation (does not include	Medical (non-mental health related) Diagnostic Physical	Other
Alabama	4	42	0	0	0	12	2	2	26
Alaska	10	3	0	0	0	1	0	0	2
American Indian Consortium	13	1	0	0	1	0	0	0	0
American Samoa	9	8	3	1	1	1	0	2	0
Arizona	9	60	11	15	6	11	6	2	9
Arkansas	6	11	0	5	2	3	1	0	0
California	9	13	0	0	0	6	2	2	3
Colorado	8	26	2	23	1	0	0	0	0
Connecticut	1	4	1	1	0	1	1	0	0
Delaware	3	24	0	6	6	11	0	1	0
District of Columbia	3	27	4	10	10	1	1	1	0
Florida	4	114	21	44	22	23	1	2	1
Georgia	4	79	3	1	13	61	1	0	0
Guam	9	5	0	2	2	1	0	0	0
Hawaii	9	23	0	11	3	5	4	0	0
Idaho	10	63	10	2	10	41	0	0	0
Illinois	5	193	22	34	13	79	11	4	30
Indiana	5	11	0	0	9	2	0	0	0
Iowa	7	9	0	4	3	1	1	0	0
Kansas	7	11	3	3	1	4	0	0	0
Kentucky	4	10	2	2	1	4	1	0	0
Louisiana	6	15	4	3	1	7	0	0	0
Maine	1	58	2	27	1	26	1	1	0
Maryland	3	19	2	0	5	10	2	0	0
Massachusetts	1	42	3	0	7	9	0	0	23
Michigan	5	24	0	0	11	8	0	5	0
Minnesota	5	29	7	0	7	14	1	0	0
Mississippi	4	4	1	1	1	0	0	1	0
Missouri˜	7	100	17	33	13	15	2	20	0
Montana	8	102	5	27	62	3	2	3	0
Nebraska	7	2	1	0	1	0	0	0	0
Nevada	9	8	0	0	3	4	1	0	0
New Hampshire	1	43	8	20	5	0	0	2	8
New Jersey	2	68	9	4	5	47	1	1	1
New Mexico	6	16	3	1	8	2	1	1	0
New York	2	17	0	7	4	6	0	0	0
North Carolina	4	3	0	1	2	0	0	0	0

State/ Jurisdiction	HHS Region	Number of Neglect Complaints Closed	Failure to Provide for Appropriate				Mental Health Diagnostic or Other Evaluation (does not include	Medical (non-mental health related) Diagnostic Physical	Other
			Medical (other than psychiatric) treatment	Mental Health Treatment, Including Access to Prescribed Medication	Personal care and safety	Discharge Planning or Release from Residential Care or Treatment Facility			
North Dakota	8	28	0	6	12	6	0	4	0
Northern Marianas˜	9	3	3	0	0	0	0	0	0
Ohio	5	117	15	38	11	44	0	7	2
Oklahoma	6	19	8	3	1	3	3	1	0
Oregon	10	4	0	3	0	0	0	0	1
Pennsylvania	3	73	5	17	1	42	0	5	3
Puerto Rico	2	5	1	1	0	3	0	0	0
Rhode Island	1	1	0	0	0	1	0	0	0
South Carolina	4	135	7	112	6	9	1	0	0
South Dakota	8	13	4	1	1	6	0	1	0
Tennessee	4	11	0	1	3	4	0	3	0
Texas	6	226	8	18	29	90	42	16	23
Utah	8	5	1	0	3	0	1	0	0
Vermont	1	17	0	0	2	12	0	0	3
Virgin Islands	2	1	0	0	1	0	0	0	0
Virginia	3	34	0	0	7	21	0	6	0
Washington	10	291	24	175	15	56	6	6	9
West Virginia	3	23	0	0	3	14	0	4	2
Wisconsin	5	5	1	2	1	0	1	0	0
Wyoming	8	5	1	2	1	0	0	1	0
Totals		2,303	222	667	337	730	97	104	146
Percentages		100	9.64	28.96	14.63	31.70	4.21	4.52	6.34

Table 7 – Complaints Involving Alleged Rights Violations of PAIMI Eligible Individuals – FY2019

State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	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	Problem with Advance Directives	Denial of Parental /Family Rights	Other
Alabama	4	40	3	5	2	0	1	0	0	2	0	6	0	1	0	0	20
Alaska	10	24	18	0	0	0	0	0	0	0	0	0	0	0	0	0	6
American Indian Consortium	13	6	0	0	0	0	0	0	0	5	0	1	0	0	0	0	0
American Samoa	9	8	0	1	0	2	2	2	0	0	0	0	0	0	0	1	0
Arizona	9	50	2	2	3	1	0	2	1	10	4	23	0	1	0	1	0
Arkansas	6	47	0	2	0	0	0	0	0	0	2	0	0	0	0	1	42
California	9	709	62	8	37	3	1	0	18	7	3	17	4	2	1	3	543
Colorado	8	49	1	0	7	7	1	0	0	0	9	23	1	0	0	0	0
Connecticut	1	16	0	2	0	0	1	0	1	0	0	0	1	0	0	0	11
Delaware	3	40	17	2	4	0	0	0	0	0	4	0	0	1	1	1	10
District of Columbia	3	16	3	1	0	0	3	0	0	0	2	0	0	0	6	0	1
Florida	4	64	6	4	24	1	6	0	0	0	0	0	0	2	5	2	14
Georgia	4	2	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Guam	9	10	2	4	1	0	0	0	0	0	0	0	0	0	3	0	0
Hawaii	9	144	1	7	0	0	0	0	0	76	0	10	0	0	48	0	2
Idaho	10	26	0	0	2	5	4	0	1	1	5	1	0	0	0	0	7
Illinois	5	287	4	25	0	5	5	6	14	4	1	0	1	2	0	7	213
Indiana	5	4	0	1	0	0	1	0	0	0	1	1	0	0	0	0	0
Iowa	7	32	1	2	2	2	0	0	0	0	0	0	0	1	0	0	24
Kansas	7	249	12	8	4	1	5	0	2	0	0	0	1	6	1	2	207
Kentucky	4	25	1	1	1	0	5	1	3	2	2	1	0	0	1	1	6
Louisiana	6	11	3	0	0	0	0	0	0	4	4	0	0	0	0	0	0
Maine	1	49	6	3	12	3	1	1	5	1	0	9	0	0	2	0	6
Maryland	3	33	0	2	6	0	0	0	0	0	0	0	0	3	0	0	22
Massachusetts	1	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Michigan	5	43	8	5	2	1	1	1	0	0	16	1	0	0	0	0	8
Minnesota	5	57	6	22	4	0	11	2	2	4	4	1	0	1	0	0	0
Mississippi	4	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Missouri	7	85	23	15	5	5	6	1	1	11	17	0	0	1	0	0	0
Montana	8	32	1	1	3	0	0	0	0	3	7	0	0	0	0	1	16
Nebraska	7	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Nevada	9	13	1	1	2	0	0	0	0	1	1	0	0	0	0	0	7
New Hampshire	1	163	19	20	6	3	11	0	3	4	0	0	2	2	1	1	91
New Jersey	2	64	10	3	6	0	0	0	3	0	1	0	0	0	0	0	41
New Mexico	6	13	0	0	3	1	0	0	0	0	7	0	0	2	0	0	0
New York	2	91	3	5	1	0	0	0	1	0	0	0	1	0	2	0	78

State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	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	Problem with Advance Directives	Denial of Parental /Family Rights	Other
North Carolina	4	21	0	6	6	4	0	0	0	1	4	0	0	0	0	0	0
North Dakota	8	86	1	1	0	0	0	0	0	70	6	8	0	0	0	0	0
Northern Marianas	9	9	6	0	0	0	0	0	0	0	0	0	1	0	0	0	2
Ohio	5	651	46	34	149	25	14	1	14	4	66	28	8	10	9	20	223
Oklahoma	6	10	0	1	4	0	0	0	1	0	1	0	0	1	0	0	2
Oregon	10	12	0	1	0	0	0	0	0	1	4	4	0	0	1	0	1
Pennsylvania	3	168	0	3	16	2	4	0	2	5	13	0	3	0	2	4	114
Puerto Rico	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rhode Island	1	49	2	5	0	0	2	1	0	0	0	0	1	0	1	1	36
South Carolina	4	17	1	0	0	0	0	0	0	1	0	0	0	0	0	0	15
South Dakota	8	15	2	0	1	2	1	0	0	0	6	1	0	0	0	0	2
Tennessee	4	20	0	1	7	2	2	0	0	0	0	0	0	0	0	2	6
Texas	6	434	11	12	112	44	26	1	13	1	97	45	2	29	2	6	33
Utah	8	115	3	3	54	0	1	0	0	54	0	0	0	0	0	0	0
Vermont	1	14	0	0	2	1	1	0	0	2	0	0	0	1	6	1	0
Virgin Islands	2	3	0	0	2	0	0	0	0	0	0	0	0	0	0	0	1
Virginia	3	25	1	5	4	1	0	0	1	2	9	1	0	0	1	0	0
Washington	10	164	24	2	26	10	6	1	6	0	16	19	5	0	0	8	41
West Virginia	3	14	3	2	4	0	1	0	0	0	0	0	0	0	0	0	4
Wisconsin	5	51	2	2	2	1	2	0	0	2	11	0	0	0	0	0	29
Wyoming	8	5	0	0	2	0	0	0	0	0	1	1	0	1	0	0	0
Totals		4,394	318	232	528	132	125	21	92	278	324	201	31	67	93	63	1,889
Percentages		100.00	7.24	5.28	12.02	3.00	2.84	0.48	2.09	6.33	7.37	4.57	0.71	1.52	2.12	1.43	42.99

Table 7 – Complaints Involving Alleged Rights Violations of PAIMI Eligible Individuals – FY2020

			Denial of											Failure to Provide										
State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	Financial Benefits and Entitlements	Guardianship /Conservative Problems	Rights Protection/Legal Assistance	Access to Administrative or Judicial Process	Privacy Rights	Recreational Opportunities	Visitors	Access to Transportation	Access to Records	Access to Community Based Rehabilitation Services and/or Treatment	Parental /Family Rights	Individual Treatment Plan	Written Discharge Plan	Mental Health Services Planning	Confidentiality	Educational Services in the Least Restricted Environment	Informed Consent	Advanced Directive Issues	Right to Refuse Treatment	Right to Refuse to Take Prescribed Medication	Employment Discrimination	Housing Discrimination
Alabama	4	38	2	1	2	0	1	3	0	0	1	0	0	3	0	1	0	11	0	4	0	0	1	3
Alaska	10	23	21	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
American Indian Consortium	13	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12	0	0	0	0	0	0
American Samoa	9	34	0	0	3	0	4	2	3	2	4	0	0	2	1	1	1	0	0	0	2	0	0	3
Arizona	9	119	4	1	6	0	0	3	1	0	9	0	1	28	5	0	3	0	0	0	0	0	0	0
Arkansas	6	31	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	27	0	0	0	0	0	1
California	9	654	24	10	12	0	3	2	0	2	8	0	5	6	4	26	5	81	3	0	0	0	109	165
Colorado	8	27	2	4	2	0	3	3	0	0	0	0	0	0	5	0	1	0	2	0	0	0	0	0
Connecticut	1	12	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	3	2	0	0	0	0	1
Delaware	3	48	15	0	1	0	1	3	0	0	0	0	2	1	0	0	0	9	0	2	0	0	1	8
District of Columbia	3	16	4	0	0	0	0	0	0	0	0	0	0	2	2	0	0	0	0	4	0	0	0	0
Florida	4	37	2	0	19	0	2	3	0	0	1	0	1	0	0	0	2	3	2	1	0	0	0	0
Georgia	4	20	0	4	0	0	0	1	0	0	1	1	0	0	3	2	0	0	0	0	0	0	2	1
Guam	9	12	0	1	0	1	1	0	0	0	1	0	0	0	0	1	0	2	0	2	0	0	1	0
Hawaii	9	105	5	7	0	0	1	0	0	0	0	0	0	0	0	1	0	60	0	26	0	0	0	2
Idaho	10	30	1	3	1	0	1	1	0	0	0	0	0	1	2	0	0	7	0	0	2	0	0	1
Illinois	5	301	0	0	7	1	6	13	5	2	13	4	6	2	5	1	6	59	1	0	1	6	56	10
Indiana	5	39	0	0	0	1	1	4	0	2	0	0	0	0	2	8	0	5	0	0	0	0	3	3
Iowa	7	40	0	5	0	0	1	2	2	0	0	2	1	0	0	1	0	14	0	0	0	0	3	5
Kansas	7	211	14	18	28	2	2	4	1	1	1	32	1	0	0	0	3	13	3	0	0	1	38	48
Kentucky	4	53	1	1	0	0	2	4	1	0	0	9	0	3	4	2	0	7	0	0	2	3	0	0
Louisiana	6	27	4	1	0	0	0	0	0	0	0	7	0	0	0	0	0	11	0	0	1	0	2	0
Maine	1	111	5	3	7	0	2	2	0	1	0	0	0	0	0	15	0	32	0	3	0	0	6	14
Maryland	3	56	0	1	4	3	3	1	0	0	1	3	0	0	0	0	1	0	0	0	2	1	0	30
Massachusetts	1	34	4	0	5	0	0	1	0	0	0	2	1	0	0	0	0	1	0	0	0	0	5	11
Michigan	5	33	0	1	2	0	1	0	0	0	1	0	0	3	2	8	0	0	0	0	0	0	0	0
Minnesota	5	119	1	8	8	2	2	3	1	5	0	1	0	26	1	4	0	17	0	0	0	1	1	6
Mississippi	4	3	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Missouri˜	7	146	19	19	8	0	5	6	0	0	2	0	0	24	17	2	1	0	0	0	0	0	0	0
Montana	8	36	6	0	1	0	2	2	0	0	1	4	0	1	0	0	1	0	0	0	0	0	5	2
Nebraska	7	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nevada	9	15	0	0	1	0	1	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0
New Hampshire	1	131	11	13	3	0	1	3	2	0	2	0	2	3	1	15	1	1	0	1	0	0	17	36
New Jersey	2	29	2	0	1	0	1	5	1	0	0	2	0	0	0	3	0	3	0	1	0	0	1	1

State/ Jurisdiction	HHS Region	Number of Rights Complaints Closed	Denial of											Failure to Provide						Advanced Directive Issues	Right to Refuse Treatment	Right to Refuse to Take Prescribed Medication	Employment Discrimination	Housing Discrimination
			Financial Benefits and Entitlements	Guardianship /Conservative Problems	Rights Protection/Legal Assistance	Access to Administrative or Judicial Process	Privacy Rights	Recreational Opportunities	Visitors	Access to Transportation	Access to Records	Access to Community Based Rehabilitation Services and/or Treatment	Parental /Family Rights	Individual Treatment Plan	Written Discharge Plan	Mental Health Services Planning	Confidentiality	Educational Services in the Least Restricted Environment	Informed Consent					
New Mexico	6	15	0	1	1	0	0	0	0	0	1	0	0	1	4	0	0	0	2	0	0	0	0	0
New York	2	72	2	1	3	1	0	1	0	2	2	4	1	0	0	3	1	7	2	1	0	1	11	25
North Carolina	4	25	0	2	1	1	0	1	0	0	0	3	0	1	0	2	0	4	0	0	0	1	1	4
North Dakota	8	107	2	0	0	0	0	0	0	0	0	10	0	20	0	0	0	33	0	0	0	11	0	0
Northern Marianas~	9	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Ohio	5	601	32	28	187	0	5	6	4	0	7	0	11	0	0	42	5	91	2	8	0	0	4	105
Oklahoma	6	5	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Oregon	10	9	0	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1
Pennsylvania	3	180	3	11	14	0	4	4	0	1	2	9	1	0	8	0	0	9	2	1	1	0	38	16
Puerto Rico	2	45	42	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Rhode Island	1	7	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
South Carolina	4	99	6	2	0	0	1	0	0	0	2	0	6	0	0	0	0	15	0	0	0	0	6	20
South Dakota	8	38	0	2	0	0	0	0	0	0	0	2	0	6	0	3	0	7	1	0	0	0	1	4
Tennessee	4	14	0	1	2	0	0	0	0	0	0	1	0	0	0	0	0	6	0	0	0	0	1	2
Texas	6	481	16	10	123	1	29	39	1	0	8	0	5	3	8	82	2	23	21	1	0	0	2	13
Utah	8	109	3	1	48	0	1	0	0	0	0	2	1	0	0	0	0	1	0	0	0	0	45	7
Vermont	1	13	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	3	0	0	2	0
Virgin Islands	2	5	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	0	0	0
Virginia	3	39	1	2	9	0	0	3	0	0	0	0	0	4	6	1	0	0	0	2	0	0	0	0
Washington	10	247	40	4	75	0	9	11	3	0	10	1	5	0	0	0	7	3	3	0	0	0	10	17
West Virginia	3	18	2	2	5	0	2	2	0	0	0	0	0	0	0	0	0	2	1	0	0	0	0	2
Wisconsin	5	54	2	0	2	0	0	0	0	0	0	0	0	2	8	0	0	20	0	0	0	0	5	1
Wyoming	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals		4,790	302	174	593	14	100	138	25	19	78	101	52	142	93	225	42	600	48	60	12	25	378	571
Percentages		100.00	6.30	3.63	12.38	0.29	2.09	2.88	0.52	0.40	1.63	2.11	1.09	2.96	1.94	4.70	0.88	12.53	1.00	1.25	0.25	0.52	7.89	11.92

Table 8 – Death Investigations – FY2019

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	4	0	0	4	4	0	0	4
Alaska	10	6	3	0	3	6	0	0	6
American Indian Consortium	13	0	0	0	0	0	0	0	0
American Samoa	9	0	0	0	0	0	0	0	0
Arizona	9	1	1	0	0	1	0	0	1
Arkansas	6	0	0	0	0	0	0	0	0
California	9	13	7	1	5	12	0	1	11
Colorado	8	0	0	0	0	0	0	0	0
Connecticut	1	4	2	0	2	4	0	2	2
Delaware	3	10	10	0	0	10	0	0	10
District of Columbia	3	7	6	0	1	7	0	0	7
Florida	4	21	11	0	10	21	0	0	21
Georgia	4	11	0	0	11	11	0	0	11
Guam	9	0	0	0	0	0	0	0	0
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	1	0	0	1
Indiana	5	0	0	0	0	0	0	0	0
Iowa	7	14	13	0	1	14	0	0	14
Kansas	7	0	0	0	0	0	0	0	0
Kentucky	4	2	2	0	0	2	0	0	2
Louisiana	6	3	0	0	3	3	0	1	2
Maine	1	1	0	0	1	1	0	0	1
Maryland	3	47	46	0	1	47	0	0	47
Massachusetts	1	3	0	0	3	3	0	0	3
Michigan	5	9	7	0	2	9	0	0	9
Minnesota	5	0	0	0	0	0	0	0	0
Mississippi	4	0	0	0	0	0	0	0	0
Missouri	7	554	550	1	3	2	0	0	2
Montana	8	0	0	0	0	0	0	0	0
Nebraska	7	0	0	0	0	2	0	0	2
Nevada	9	0	0	0	0	0	0	0	0
New Hampshire	1	1	0	0	1	1	0	0	1
New Jersey	2	23	23	0	0	23	1	0	22
New Mexico	6	0	0	0	0	0	0	0	0
New York	2	2	0	0	2	2	0	1	1
North Carolina	4	2	1	0	1	2	0	0	2
North Dakota	8	2	1	0	1	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.)
Northern Marianas	9	0	0	0	0	0	0	0	0
Ohio	5	13	1	0	12	2	1	0	1
Oklahoma	6	4	0	0	4	2	0	0	2
Oregon	10	3	0	0	3	3	0	0	3
Pennsylvania	3	36	36	0	0	0	0	0	0
Puerto Rico	2	0	0	0	0	0	0	0	0
Rhode Island	1	0	0	0	0	0	0	0	0
South Carolina	4	5	0	0	5	5	0	1	4
South Dakota	8	1	0	0	1	1	0	0	1
Tennessee	4	0	0	0	0	0	0	0	0
Texas	6	13	0	0	13	13	0	0	13
Utah	8	3	0	0	3	1	0	0	1
Vermont	1	5	1	0	4	5	0	0	5
Virgin Islands	2	0	0	0	0	0	0	0	0
Virginia	3	47	47	0	0	15	1	0	14
Washington	10	2	0	0	2	2	1	0	1
West Virginia	3	0	0	0	0	0	0	0	0
Wisconsin	5	14	12	0	2	14	0	0	14
Wyoming	8	1	1	0	0	1	0	0	1
Totals		887	781	2	104	254	4	6	244

Table 8 – Death Investigations – FY2020

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 abuse (A)	Number of deaths investigated involving incidents of restraint (R).	Number of deaths investigated NOT related to incidents of S&R, (e. g., suicides.)	Death Investigations with a finding of determination	Provision in policy added or prevented as a result of a death investigation
Alabama	4	0	0	0	0	0	0	0	0	0	0	0
Alaska	10	4	2	0	2	4	1	0	0	3	0	0
American Indian Consortium	13	0	0	0	0	0	0	0	0	0	0	0
American Samoa	9	0	0	0	0	0	0	0	0	0	0	0
Arizona	9	1	1	0	0	1	0	0	0	1	0	0
Arkansas	6	1	0	0	1	1	1	0	0	0	0	0
California	9	19	17	0	2	2	0	0	0	2	0	0
Colorado	8	2	0	0	2	2	0	0	0	2	0	0
Connecticut	1	4	3	0	1	4	0	0	2	2	0	0
Delaware	3	12	0	0	12	12	0	0	0	12	0	0
District of Columbia	3	21	19	0	2	36	0	0	0	21	11	4
Florida	4	27	13	0	14	27	0	0	0	27	0	0
Georgia	4	8	8	0	0	17	0	1	0	8	4	4
Guam	9	0	0	0	0	0	0	0	0	0	0	0
Hawaii	9	0	0	0	0	0	0	0	0	0	0	0
Idaho	10	0	0	0	0	0	0	0	0	0	0	0
Illinois	5	2	0	2	0	2	0	0	2	0	0	0
Indiana	5	4	3	0	1	4	0	0	0	4	0	0
Iowa	7	18	15	0	3	24	0	14	0	4	4	2
Kansas	7	0	0	0	0	0	0	0	0	0	0	0
Kentucky	4	5	5	0	0	5	0	1	0	4	0	0
Louisiana	6	7	2	0	5	17	0	17	0	0	0	0
Maine	1	1	0	0	1	2	0	0	0	1	1	0
Maryland	3	40	8	0	32	10	0	0	0	6	4	0
Massachusetts	1	3	0	0	3	3	0	0	0	3	0	0
Michigan	5	13	5	0	8	18	0	0	0	13	5	0
Minnesota	5	0	0	0	0	0	0	0	0	0	0	0
Mississippi	4	0	0	0	0	0	0	0	0	0	0	0
Missouri˜	7	664	664	0	0	5	1	0	0	1	2	1
Montana	8	1	0	0	1	1	0	0	0	1	0	0
Nebraska	7	0	0	0	0	0	0	0	0	0	0	0
Nevada	9	0	0	0	0	0	0	0	0	0	0	0
New Hampshire	1	1	0	0	1	2	0	0	0	1	0	1
New Jersey	2	63	63	0	0	63	0	0	0	63	0	0
New Mexico	6	0	0	0	0	0	0	0	0	0	0	0
New York	2	0	0	0	0	1	0	0	0	1	0	0
North Carolina	4	1	1	0	0	0	0	0	0	0	0	0
North Dakota	8	0	0	0	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 abuse (A)	Number of deaths investigated involving incidents of restraint (R).	Number of deaths investigated NOT related to incidents of S&R, (e. g., suicides.)	Death Investigations with a finding of determination	Provision in policy added or prevented as a result of a death investigation
Northern Marianas˜	9	1	0	0	1	1	0	0	0	1	0	0
Ohio	5	10	0	0	10	11	0	0	0	10	0	1
Oklahoma	6	1	0	0	1	1	0	0	0	0	1	0
Oregon	10	11	0	0	11	11	0	0	0	11	0	0
Pennsylvania	3	55	55	0	0	0	0	0	0	0	0	0
Puerto Rico	2	0	0	0	0	0	0	0	0	0	0	0
Rhode Island	1	0	0	0	0	0	0	0	0	0	0	0
South Carolina	4	2	1	0	1	10	0	1	2	2	3	2
South Dakota	8	2	0	0	2	5	0	0	0	2	2	1
Tennessee	4	0	0	0	0	0	0	0	0	0	0	0
Texas	6	18	0	0	18	18	0	0	0	18	0	0
Utah	8	9	0	0	9	4	2	0	0	2	0	0
Vermont	1	2	1	0	1	2	0	0	0	2	0	0
Virgin Islands	2	0	0	0	0	0	0	0	0	0	0	0
Virginia	3	58	58	0	0	8	0	0	0	5	3	0
Washington	10	3	1	0	2	7	0	0	0	2	4	1
West Virginia	3	2	0	0	2	2	0	0	0	2	0	0
Wisconsin	5	8	3	1	4	8	1	0	1	4	2	0
Wyoming	8	1	1	0	0	1	0	0	0	1	0	0
Totals		1,105	949	3	153	352	6	34	7	242	46	17

Table 9 – Analysis of Alleged Abuse – FY2019

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	4	13	5	72.22
Alaska	10	3	1	0	0	2	0.00
American Indian Consortium	13	0	0	0	0	0	0.00
American Samoa	9	50	9	1	37	3	92.50
Arizona	9	61	3	2	51	5	91.07
Arkansas	6	25	10	6	8	1	88.89
California	9	47	8	9	29	1	96.67
Colorado	8	36	2	4	28	2	93.33
Connecticut	1	5	0	1	4	0	100.00
Delaware	3	6	2	0	4	0	100.00
District of Columbia	3	40	7	12	21	0	100.00
Florida	4	86	18	9	59	0	100.00
Georgia	4	44	7	1	36	0	100.00
Guam	9	1	0	0	1	0	100.00
Hawaii	9	7	1	3	3	0	100.00
Idaho	10	29	0	3	26	0	100.00
Illinois	5	92	7	14	31	40	43.66
Indiana	5	10	1	2	7	0	100.00
Iowa	7	26	9	1	16	0	100.00
Kansas	7	28	12	4	11	1	91.67
Kentucky	4	9	0	1	8	0	100.00
Louisiana	6	21	5	0	16	0	100.00
Maine	1	35	3	3	29	0	100.00
Maryland	3	69	1	5	62	1	98.41
Massachusetts	1	14	1	2	11	0	100.00
Michigan	5	36	4	0	27	5	84.38
Minnesota	5	46	4	19	23	0	100.00
Mississippi	4	4	3	0	1	0	100.00
Missouri	7	86	2	0	84	0	100.00
Montana	8	45	0	4	40	1	97.56
Nebraska	7	2	0	0	2	0	100.00
Nevada	9	9	1	1	7	0	100.00
New Hampshire	1	54	2	3	49	0	100.00
New Jersey	2	153	24	28	93	8	92.08
New Mexico	6	24	10	3	9	2	81.82
New York	2	16	0	0	16	0	100.00
North Carolina	4	3	0	0	3	0	100.00
North Dakota	8	29	2	2	24	1	96.00
Northern Marianas	9	2	1	0	1	0	100.00
Ohio	5	128	2	6	120	0	100.00
Oklahoma	6	47	8	6	26	7	78.79
Oregon	10	9	0	4	4	1	80.00
Pennsylvania	3	46	1	5	30	10	75.00

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*
Puerto Rico	2	2	0	0	2	0	100.00
Rhode Island	1	9	2	3	4	0	100.00
South Carolina	4	125	2	2	120	1	99.17
South Dakota	8	17	4	2	9	2	81.82
Tennessee	4	12	9	1	2	0	100.00
Texas	6	100	16	24	35	25	58.33
Utah	8	6	3	0	3	0	100.00
Vermont	1	35	5	7	17	6	73.91
Virgin Islands	2	1	0	0	1	0	100.00
Virginia	3	30	9	3	18	0	100.00
Washington	10	271	0	0	271	0	100.00
West Virginia	3	10	0	1	9	0	100.00
Wisconsin	5	32	4	4	18	6	75.00
Wyoming	8	24	5	0	19	0	100.00
Totals		2,180	231	215	1,598	136	92.16

Table 9 – Analysis of Alleged Abuse – FY2020

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	Other Representation Found	Services not needed due to client death or relocation	Lost Contact	Outcomes Unknown	Lack of Resources	Percentage Favorably Resolved*
Alabama	4	31	2	3	11	14	0	1	0	0	0	44.00
Alaska	10	1	0	1	0	0	0	0	0	0	0	0.00
American Indian Consortium	13	0	0	0	0	0	0	0	0	0	0	0.00
American Samoa	9	19	3	2	9	3	0	1	0	0	1	75.00
Arizona	9	30	0	2	27	0	1	0	0	0	0	100.00
Arkansas	6	8	1	1	4	2	0	0	0	0	0	66.67
California	9	28	3	7	18	0	0	0	0	0	0	100.00
Colorado	8	4	0	0	4	0	0	0	0	0	0	100.00
Connecticut	1	2	0	0	2	0	0	0	0	0	0	100.00
Delaware	3	5	3	0	2	0	0	0	0	0	0	100.00
District of Columbia	3	19	4	8	7	0	0	0	0	0	0	100.00
Florida	4	30	11	9	10	0	0	0	0	0	0	100.00
Georgia	4	54	22	3	29	0	0	0	0	0	0	100.00
Guam	9	3	2	0	1	0	0	0	0	0	0	100.00
Hawaii	9	5	2	1	2	0	0	0	0	0	0	100.00
Idaho	10	9	0	4	2	0	2	1	0	0	0	100.00
Illinois	5	79	9	4	9	4	0	1	6	45	1	69.23
Indiana	5	10	4	1	3	1	0	1	0	0	0	75.00
Iowa	7	13	2	0	10	0	0	0	1	0	0	100.00
Kansas	7	14	5	2	3	0	0	0	0	0	4	100.00
Kentucky	4	8	0	0	7	0	1	0	0	0	0	100.00
Louisiana	6	5	0	1	3	0	1	0	0	0	0	100.00
Maine	1	13	2	1	10	0	0	0	0	0	0	100.00
Maryland	3	39	4	5	26	3	0	0	0	0	1	89.66
Massachusetts	1	45	1	8	33	0	0	0	3	0	0	100.00
Michigan	5	30	3	4	20	2	0	1	0	0	0	90.91
Minnesota	5	14	4	0	8	1	0	0	0	1	0	88.89
Mississippi	4	3	0	0	2	0	0	1	0	0	0	100.00
Missouri˜	7	30	0	0	30	0	0	0	0	0	0	100.00
Montana	8	20	4	0	10	6	0	0	0	0	0	62.50
Nebraska	7	6	1	0	1	0	0	4	0	0	0	100.00
Nevada	9	2	0	0	2	0	0	0	0	0	0	100.00
New Hampshire	1	23	1	0	21	0	0	0	1	0	0	100.00
New Jersey	2	129	5	11	96	2	3	3	7	1	1	97.96
New Mexico	6	17	0	0	14	0	0	2	1	0	0	100.00
New York	2	9	1	0	6	0	0	0	0	0	2	100.00
North Carolina	4	8	2	0	6	0	0	0	0	0	0	100.00
North Dakota	8	19	0	0	18	0	0	0	1	0	0	100.00

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	Other Representation Found	Services not needed due to client death or relocation	Lost Contact	Outcomes Unknown	Lack of Resources	Percentage Favorably Resolved*
Northern Marianas˜	9	3	1	0	2	0	0	0	0	0	0	100.00
Ohio	5	49	0	5	42	2	0	0	0	0	0	95.45
Oklahoma	6	3	1	0	1	1	0	0	0	0	0	50.00
Oregon	10	0	0	0	0	0	0	0	0	0	0	0.00
Pennsylvania	3	20	0	2	18	0	0	0	0	0	0	100.00
Puerto Rico	2	0	0	0	0	0	0	0	0	0	0	0.00
Rhode Island	1	1	0	0	0	0	1	0	0	0	0	0.00
South Carolina	4	24	0	0	23	1	0	0	0	0	0	95.83
South Dakota	8	5	0	1	3	0	0	1	0	0	0	100.00
Tennessee	4	5	1	1	3	0	0	0	0	0	0	100.00
Texas	6	41	11	7	15	5	0	0	1	2	0	75.00
Utah	8	10	0	2	7	0	1	0	0	0	0	100.00
Vermont	1	12	2	0	9	1	0	0	0	0	0	90.00
Virgin Islands	2	0	0	0	0	0	0	0	0	0	0	0.00
Virginia	3	23	9	1	12	1	0	0	0	0	0	92.31
Washington	10	88	3	1	84	0	0	0	0	0	0	100.00
West Virginia	3	7	0	1	6	0	0	0	0	0	0	100.00
Wisconsin	5	6	1	0	5	0	0	0	0	0	0	100.00
Wyoming	8	11	1	0	10	0	0	0	0	0	0	100.00
Totals		1,092	131	99	706	49	10	17	21	49	10	93.51

Table 10 – Analysis of Alleged Neglect – FY2019

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	45	7	2	27	9	0	75.00
Alaska	10	5	1	0	1	1	2	25.00
American Indian Consortium	13	1	0	0	1	0	0	100.00
American Samoa	9	35	1	0	31	3	0	91.18
Arizona	9	46	0	3	38	4	1	88.37
Arkansas	6	6	0	0	4	2	0	66.67
California	9	43	4	8	29	2	0	93.55
Colorado	8	13	3	3	6	1	0	85.71
Connecticut	1	8	0	0	7	0	1	87.50
Delaware	3	39	1	0	35	0	3	92.11
District of Columbia	3	17	1	8	7	1	0	87.50
Florida	4	53	13	6	33	1	0	97.06
Georgia	4	122	7	14	98	3	0	97.03
Guam	9	5	0	0	5	0	0	100.00
Hawaii	9	7	4	0	3	0	0	100.00
Idaho	10	57	1	1	54	1	0	98.18
Illinois	5	130	5	11	65	49	0	57.02
Indiana	5	8	0	1	0	7	0	0.00
Iowa	7	22	6	0	10	0	6	62.50
Kansas	7	14	4	2	8	0	0	100.00
Kentucky	4	5	0	0	2	3	0	40.00
Louisiana	6	6	1	0	5	0	0	100.00
Maine	1	27	1	0	25	1	0	96.15
Maryland	3	25	7	11	1	1	5	14.29
Massachusetts	1	11	0	2	9	0	0	100.00
Michigan	5	53	3	0	41	9	0	82.00
Minnesota	5	32	3	15	13	1	0	92.86
Mississippi	4	4	0	0	4	0	0	100.00
Missouri	7	77	3	0	74	0	0	100.00
Montana	8	106	2	1	87	4	12	84.47
Nebraska	7	1	0	0	1	0	0	100.00
Nevada	9	7	0	2	4	1	0	80.00
New Hampshire	1	32	5	4	19	1	3	82.61
New Jersey	2	55	7	4	37	1	6	84.09
New Mexico	6	25	11	2	2	6	4	16.67
New York	2	19	7	1	11	0	0	100.00
North Carolina	4	3	0	1	2	0	0	100.00
North Dakota	8	25	0	1	23	1	0	95.83
Northern Marianas	9	1	0	0	1	0	0	100.00
Ohio	5	65	0	0	17	1	47	26.15
Oklahoma	6	12	0	0	8	4	0	66.67

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*
Oregon	10	1	0	0	0	0	1	0.00
Pennsylvania	3	31	0	2	21	8	0	72.41
Puerto Rico	2	0	0	0	0	0	0	0.00
Rhode Island	1	15	0	2	9	3	1	69.23
South Carolina	4	11	1	2	7	1	0	87.50
South Dakota	8	2	0	0	2	0	0	100.00
Tennessee	4	22	12	7	3	0	0	100.00
Texas	6	130	25	39	44	21	1	66.67
Utah	8	3	1	0	2	0	0	100.00
Vermont	1	20	7	1	12	0	0	100.00
Virgin Islands	2	1	0	0	1	0	0	100.00
Virginia	3	60	7	9	29	1	14	65.91
Washington	10	125	0	0	125	0	0	100.00
West Virginia	3	26	0	4	21	0	1	95.45
Wisconsin	5	6	0	0	4	2	0	66.67
Wyoming	8	11	1	0	10	0	0	100.00
Totals		1,731	162	169	1,138	154	108	81.29

Table 10 – Analysis of Alleged Neglect – FY2020

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	Other Representation Found	Services not needed due to client death or	Lost Contact	Outcome Unknown	Lack of Resources	Percentage Favorably Resolved*
Alabama	4	42	2	1	23	12	0	1	3	0	0	0	65.71
Alaska	10	3	0	0	1	0	0	0	0	0	0	2	100.00
American Indian Consortium	13	1	0	0	0	0	1	0	0	0	0	0	0.00
American Samoa	9	8	1	1	5	0	1	0	0	0	0	0	83.33
Arizona	9	60	1	6	50	1	0	2	0	0	0	0	98.04
Arkansas	6	11	1	1	8	1	0	0	0	0	0	0	88.89
California	9	13	3	0	10	0	0	0	0	0	0	0	100.00
Colorado	8	26	0	3	14	1	6	2	0	0	0	0	66.67
Connecticut	1	4	1	0	3	0	0	0	0	0	0	0	100.00
Delaware	3	24	0	0	13	0	11	0	0	0	0	0	54.17
District of Columbia	3	27	2	4	19	2	0	0	0	0	0	0	90.48
Florida	4	114	23	17	71	3	0	0	0	0	0	0	95.95
Georgia	4	79	10	0	66	0	2	0	1	0	0	0	97.06
Guam	9	5	1	0	3	1	0	0	0	0	0	0	75.00
Hawaii	9	23	12	3	8	0	0	0	0	0	0	0	100.00
Idaho	10	63	0	6	53	4	0	0	0	0	0	0	92.98
Illinois	5	193	18	5	17	8	14	2	2	1	125	1	43.59
Indiana	5	11	1	1	7	0	1	0	1	0	0	0	87.50
Iowa	7	9	0	0	7	0	1	0	0	1	0	0	87.50
Kansas	7	11	3	2	4	0	0	0	0	0	0	2	100.00
Kentucky	4	10	0	0	5	2	3	0	0	0	0	0	50.00
Louisiana	6	15	1	2	5	0	0	1	0	1	0	5	100.00
Maine	1	58	0	4	51	3	0	0	0	0	0	0	94.44
Maryland	3	19	0	4	14	0	0	0	0	0	0	1	100.00
Massachusetts	1	42	3	3	24	8	0	0	0	4	0	0	75.00
Michigan	5	24	5	2	15	2	0	0	0	0	0	0	88.24
Minnesota	5	29	2	0	24	2	0	0	0	1	0	0	92.31
Mississippi	4	4	0	0	3	0	0	0	1	0	0	0	100.00
Missouri˜	7	100	0	0	100	0	0	0	0	0	0	0	100.00
Montana	8	102	56	0	37	8	0	0	0	1	0	0	82.22
Nebraska	7	2	0	0	2	0	0	0	0	0	0	0	100.00
Nevada	9	8	1	1	5	0	0	0	0	1	0	0	100.00
New Hampshire	1	43	4	2	32	0	0	0	0	1	0	4	100.00
New Jersey	2	68	6	14	34	4	0	2	2	6	0	0	89.47
New Mexico	6	16	0	0	16	0	0	0	0	0	0	0	100.00
New York	2	17	0	4	10	0	0	0	0	1	0	2	100.00
North Carolina	4	3	2	0	1	0	0	0	0	0	0	0	100.00
North Dakota	8	28	0	2	26	0	0	0	0	0	0	0	100.00
Northern Marianas˜	9	3	0	0	0	0	0	0	3	0	0	0	0.00
Ohio	5	117	2	4	110	1	0	0	0	0	0	0	99.10

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	Other Representation Found	Services not needed due to client death or	Lost Contact	Outcome Unknown	Lack of Resources	Percentage Favorably Resolved*
Oklahoma	6	19	2	2	8	3	0	0	4	0	0	0	72.73
Oregon	10	4	0	0	0	1	2	0	0	1	0	0	0.00
Pennsylvania	3	73	3	3	63	1	0	0	0	0	0	3	98.44
Puerto Rico	2	5	0	0	5	0	0	0	0	0	0	0	100.00
Rhode Island	1	1	0	0	0	0	0	1	0	0	0	0	0.00
South Carolina	4	135	0	0	129	4	0	1	0	1	0	0	96.99
South Dakota	8	13	0	0	12	1	0	0	0	0	0	0	92.31
Tennessee	4	11	0	3	2	2	3	0	0	1	0	0	28.57
Texas	6	226	37	50	102	20	1	2	4	8	2	0	82.93
Utah	8	5	0	0	5	0	0	0	0	0	0	0	100.00
Vermont	1	17	1	0	16	0	0	0	0	0	0	0	100.00
Virgin Islands	2	1	0	0	1	0	0	0	0	0	0	0	100.00
Virginia	3	34	7	2	17	2	6	0	0	0	0	0	68.00
Washington	10	291	0	0	291	0	0	0	0	0	0	0	100.00
West Virginia	3	23	2	1	19	1	0	0	0	0	0	0	95.00
Wisconsin	5	5	0	0	5	0	0	0	0	0	0	0	100.00
Wyoming	8	5	0	0	5	0	0	0	0	0	0	0	100.00
Totals		2,303	213	153	1,576	98	52	14	21	29	127	20	91.31

Table 11 – Analysis of Alleged Rights Violations – FY2019

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	40	3	6	24	7	77.42
Alaska	10	24	1	2	9	12	42.86
American Indian Consortium	13	6	0	0	6	0	100.00
American Samoa	9	8	1	0	7	0	100.00
Arizona	9	50	0	4	43	3	93.48
Arkansas	6	47	1	9	33	4	89.19
California	9	709	7	18	677	7	98.98
Colorado	8	49	11	7	26	5	83.87
Connecticut	1	16	2	1	12	1	92.31
Delaware	3	40	0	5	35	0	100.00
District of Columbia	3	16	0	7	9	0	100.00
Florida	4	64	8	13	42	1	97.67
Georgia	4	2	1	0	1	0	100.00
Guam	9	10	0	1	9	0	100.00
Hawaii	9	144	6	23	115	0	100.00
Idaho	10	26	0	2	19	5	79.17
Illinois	5	287	9	14	146	118	55.30
Indiana	5	4	0	0	4	0	100.00
Iowa	7	32	5	5	22	0	100.00
Kansas	7	249	106	50	86	7	92.47
Kentucky	4	25	0	5	20	0	100.00
Louisiana	6	11	1	0	10	0	100.00
Maine	1	49	0	5	40	4	90.91
Maryland	3	33	0	0	33	0	100.00
Massachusetts	1	4	0	1	3	0	100.00
Michigan	5	43	1	0	42	0	100.00
Minnesota	5	57	14	13	27	3	90.00
Mississippi	4	3	1	0	2	0	100.00
Missouri	7	85	1	5	77	2	97.47
Montana	8	32	0	3	27	2	93.10
Nebraska	7	2	0	0	2	0	100.00
Nevada	9	13	2	3	8	0	100.00
New Hampshire	1	163	0	0	163	0	100.00
New Jersey	2	64	14	15	32	3	91.43
New Mexico	6	13	8	0	5	0	100.00
New York	2	91	0	0	91	0	100.00
North Carolina	4	21	0	3	18	0	100.00
North Dakota	8	86	0	1	85	0	100.00
Northern Marianas	9	9	1	2	6	0	100.00
Ohio	5	651	8	12	623	8	98.73
Oklahoma	6	10	2	1	7	0	100.00
Oregon	10	12	4	0	7	1	87.50
Pennsylvania	3	168	4	9	111	44	71.61

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*
Puerto Rico	2	0	0	0	0	0	0.00
Rhode Island	1	49	1	10	26	12	68.42
South Carolina	4	17	0	2	14	1	93.33
South Dakota	8	15	3	1	10	1	90.91
Tennessee	4	20	3	5	12	0	100.00
Texas	6	434	61	112	192	69	73.56
Utah	8	115	5	13	97	0	100.00
Vermont	1	14	2	1	8	3	72.73
Virgin Islands	2	3	1	0	1	1	50.00
Virginia	3	25	2	3	18	2	90.00
Washington	10	164	0	0	164	0	100.00
West Virginia	3	14	2	2	10	0	100.00
Wisconsin	5	51	4	5	38	4	90.48
Wyoming	8	5	0	0	5	0	100.00
Totals		4,394	306	399	3,359	330	91.05

Table 11 – Analysis of Alleged Rights Violations – FY2020

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	Other Representation	Services not needed due to	Lost Contact	Outcome Unknown	Lack of Resources	Percentage Favorably Resolved*
Alabama	4	34	3	5	23	3	0	0	0	0	0	88.46
Alaska	10	23	3	3	11	5	0	0	1	0	0	68.75
American Indian Consortium	13	12	0	2	7	0	0	0	0	2	1	100.00
American Samoa	9	28	2	2	12	9	0	0	0	0	3	57.14
Arizona	9	86	1	10	35	40	0	0	0	0	0	46.67
Arkansas	6	30	0	5	19	3	0	0	3	0	0	86.36
California	9	618	5	20	583	10	0	0	0	0	0	98.31
Colorado	8	22	2	3	13	2	0	2	0	0	0	86.67
Connecticut	1	9	2	1	5	1	0	0	0	0	0	83.33
Delaware	3	47	0	3	41	0	3	0	0	0	0	100.00
District of Columbia	3	12	1	4	7	0	0	0	0	0	0	100.00
Florida	4	37	8	4	24	1	0	0	0	0	0	96.00
Georgia	4	15	0	0	10	2	1	0	2	0	0	83.33
Guam	9	11	2	1	7	0	0	1	0	0	0	100.00
Hawaii	9	104	5	16	83	0	0	0	0	0	0	100.00
Idaho	10	25	0	1	24	0	0	0	0	0	0	100.00
Illinois	5	286	13	7	73	10	2	0	3	174	4	87.95
Indiana	5	29	5	7	13	0	0	2	1	0	1	100.00
Iowa	7	39	4	2	24	2	1	0	6	0	0	92.31
Kansas	7	210	21	26	128	6	0	0	0	0	29	95.52
Kentucky	4	39	0	8	20	9	0	0	2	0	0	68.97
Louisiana	6	26	4	3	11	0	2	0	1	0	5	100.00
Maine	1	96	3	20	71	2	0	0	0	0	0	97.26
Maryland	3	53	2	9	37	2	0	0	0	0	3	94.87
Massachusetts	1	34	0	4	30	0	0	0	0	0	0	100.00
Michigan	5	20	1	3	14	0	1	1	0	0	0	100.00
Minnesota	5	87	5	0	73	7	0	0	2	0	0	91.25
Mississippi	4	3	0	0	3	0	0	0	0	0	0	100.00
Missouri˜	7	103	0	4	94	5	0	0	0	0	0	94.95
Montana	8	35	3	0	28	4	0	0	0	0	0	87.50
Nebraska	7	2	0	0	1	0	1	0	0	0	0	100.00
Nevada	9	14	2	0	11	0	0	0	1	0	0	100.00
New Hampshire	1	112	12	0	98	0	0	0	1	0	1	100.00
New Jersey	2	26	1	1	20	4	0	0	0	0	0	83.33
New Mexico	6	10	0	1	9	0	0	0	0	0	0	100.00
New York	2	68	6	3	59	0	0	0	0	0	0	100.00
North Carolina	4	21	1	0	17	0	0	1	2	0	0	100.00
North Dakota	8	76	0	2	71	0	0	1	2	0	0	100.00
Northern Marianas˜	9	3	0	0	2	1	0	0	0	0	0	66.67
Ohio	5	559	2	14	533	10	0	0	0	0	0	98.16
Oklahoma	6	5	1	0	2	2	0	0	0	0	0	50.00
Oregon	10	8	1	1	4	2	0	0	0	0	0	66.67

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	Other Representation	Services not needed due to	Lost Contact	Outcome Unknown	Lack of Resources	Percentage Favorably Resolved*
Pennsylvania	3	171	12	4	152	2	0	0	0	0	1	98.70
Puerto Rico	2	45	42	0	3	0	0	0	0	0	0	100.00
Rhode Island	1	7	1	3	2	0	0	0	0	1	0	100.00
South Carolina	4	99	0	4	91	2	0	0	2	0	0	97.85
South Dakota	8	29	1	5	17	1	0	4	1	0	0	94.44
Tennessee	4	14	0	2	9	0	1	0	0	0	2	100.00
Texas	6	388	46	87	165	35	2	4	13	28	8	82.50
Utah	8	109	0	9	92	0	8	0	0	0	0	100.00
Vermont	1	13	3	0	10	0	0	0	0	0	0	100.00
Virgin Islands	2	4	0	0	4	0	0	0	0	0	0	100.00
Virginia	3	28	6	2	17	2	0	1	0	0	0	89.47
Washington	10	247	1	0	246	0	0	0	0	0	0	100.00
West Virginia	3	18	1	1	15	1	0	0	0	0	0	93.75
Wisconsin	5	44	1	3	40	0	0	0	0	0	0	100.00
Wyoming	8	0	0	0	0	0	0	0	0	0	0	0.00
Totals		4,293	235	315	3,213	185	22	17	43	205	58	94.56

Table 12 – Intervention Strategies – FY2019

State/ Jurisdiction	HHS Region	Total Intervention Strategies	Short Term Assistance	Abuse & Neglect Investigations	Technical Assistance	Administrative Remedies	Negotiation/ Mediation	Legal Remedies
Alabama	4	108	50	37	0	0	8	13
Alaska	10	33	26	5	0	1	1	0
American Indian Consortium	13	7	0	0	3	2	0	2
American Samoa	9	85	8	45	11	1	18	2
Arizona	9	156	138	2	11	2	3	0
Arkansas	6	78	35	23	8	5	0	7
California	9	799	799	0	0	0	0	0
Colorado	8	98	23	2	51	20	2	0
Connecticut	1	27	11	0	5	1	3	7
Delaware	3	86	39	17	2	15	13	0
District of Columbia	3	73	28	14	10	2	17	2
Florida	4	203	167	6	15	1	11	3
Georgia	4	168	22	54	1	1	90	0
Guam	9	16	5	6	0	1	0	4
Hawaii	9	158	118	14	4	2	20	0
Idaho	10	117	29	38	41	4	4	1
Illinois	5	538	370	7	121	7	24	9
Indiana	5	48	12	10	2	10	13	1
Iowa	7	33	13	5	2	0	12	1
Kansas	7	292	33	4	210	4	6	35
Kentucky	4	62	8	14	24	3	13	0
Louisiana	6	37	18	7	0	0	8	4
Maine	1	192	78	2	36	9	64	3
Maryland	3	173	16	95	55	0	4	3
Massachusetts	1	29	18	5	0	0	6	0
Michigan	5	132	18	82	6	2	16	8
Minnesota	5	135	73	0	6	8	48	0
Mississippi	4	23	1	6	0	12	3	1
Missouri	7	247	20	50	47	9	109	12
Montana	8	183	73	91	8	8	1	2
Nebraska	7	4	0	4	0	0	0	0
Nevada	9	29	21	0	7	1	0	0
New Hampshire	1	248	238	8	0	0	2	0
New Jersey	2	272	105	124	18	3	19	3
New Mexico	6	121	87	10	5	5	13	1
New York	2	126	68	1	35	4	14	4
North Carolina	4	27	22	0	0	1	4	0
North Dakota	8	140	71	52	0	1	15	1
Northern Marianas	9	12	2	4	0	6	0	0
Ohio	5	844	770	16	38	0	19	1
Oklahoma	6	69	11	49	0	0	8	1
Oregon	10	22	9	12	0	0	0	1
Pennsylvania	3	245	173	11	52	1	3	5

State/ Jurisdiction	HHS Region	Total Intervention Strategies	Short Term Assistance	Abuse & Neglect Investigations	Technical Assistance	Administrative Remedies	Negotiation/ Mediation	Legal Remedies
Puerto Rico	2	2	0	1	0	0	1	0
Rhode Island	1	73	18	21	21	5	4	4
South Carolina	4	153	10	2	3	1	130	7
South Dakota	8	34	13	3	6	1	9	2
Tennessee	4	60	10	41	1	1	7	0
Texas	6	664	174	277	19	108	58	28
Utah	8	123	86	0	23	0	10	4
Vermont	1	69	45	15	2	5	0	2
Virgin Islands	2	12	10	2	0	0	0	0
Virginia	3	114	56	35	2	3	14	4
Washington	10	693	686	1	6	0	0	0
West Virginia	3	44	19	0	10	0	14	1
Wisconsin	5	88	28	9	16	4	30	1
Wyoming	8	40	3	25	0	0	12	0
Totals		8,664	4,984	1,364	943	280	903	190
Percentages		100.00	57.53	15.74	10.88	3.23	10.42	2.19

Table 12 – Intervention Strategies – FY2020

State/ Jurisdiction	HHS Region	Total Intervention Strategies	Self-Advocacy Assistance	Limited Advocacy	Administrative Remedies	Litigation	Medication	Negotiation
Alabama	4	60	38	0	2	7	1	12
Alaska	10	27	24	2	0	0	1	0
American Indian Consortium	13	13	2	0	6	3	0	2
American Samoa	9	55	5	12	5	0	15	18
Arizona	9	176	151	15	8	0	0	2
Arkansas	6	49	2	39	7	1	0	0
California	9	673	673	0	0	0	0	0
Colorado	8	52	0	49	0	1	0	2
Connecticut	1	15	1	10	2	1	0	1
Delaware	3	76	23	28	16	0	0	9
District of Columbia	3	58	1	33	3	3	0	18
Florida	4	109	104	0	3	1	0	1
Georgia	4	208	100	46	17	0	3	42
Guam	9	19	6	6	6	1	0	0
Hawaii	9	132	11	70	7	1	43	0
Idaho	10	97	26	66	0	1	3	1
Illinois	5	643	425	172	12	1	5	28
Indiana	5	50	11	31	2	1	0	5
Iowa	7	48	6	13	5	3	0	21
Kansas	7	235	207	16	5	7	0	0
Kentucky	4	57	8	27	0	0	3	19
Louisiana	6	46	24	11	4	1	0	6
Maine	1	167	11	67	8	4	11	66
Maryland	3	152	25	112	4	4	0	7
Massachusetts	1	121	113	0	0	0	1	7
Michigan	5	81	1	43	29	8	0	0
Minnesota	5	130	5	85	7	12	0	21
Mississippi	4	41	4	8	29	0	0	0
Missouri˜	7	202	13	55	14	4	0	116
Montana	8	157	6	147	1	1	2	0
Nebraska	7	10	1	8	0	1	0	0
Nevada	9	24	0	23	0	0	1	0
New Hampshire	1	178	0	174	1	0	0	3
New Jersey	2	223	52	138	0	3	1	29
New Mexico	6	43	1	18	2	5	2	15
New York	2	94	20	50	3	1	0	20
North Carolina	4	32	26	0	0	1	0	5
North Dakota	8	123	49	47	1	0	2	24
Northern Marianas˜	9	9	0	1	5	0	2	1
Ohio	5	729	0	701	0	0	6	22
Oklahoma	6	27	4	3	1	1	0	18
Oregon	10	12	7	2	0	0	0	3

State/ Jurisdiction	HHS Region	Total Intervention Strategies	Self-Advocacy Assistance	Limited Advocacy	Administrative Remedies	Litigation	Medication	Negotiation
Pennsylvania	3	264	238	23	0	2	0	1
Puerto Rico	2	50	0	42	0	0	7	1
Rhode Island	1	9	8	1	0	0	0	0
South Carolina	4	258	132	7	2	2	0	115
South Dakota	8	47	17	23	1	1	0	5
Tennessee	4	17	5	2	1	0	0	9
Texas	6	655	19	485	101	23	7	20
Utah	8	106	89	11	5	0	1	0
Vermont	1	42	23	16	1	1	0	1
Virgin Islands	2	5	1	2	0	2	0	0
Virginia	3	146	4	129	5	2	0	6
Washington	10	626	593	25	0	0	8	0
West Virginia	3	49	24	18	1	2	0	4
Wisconsin	5	55	6	16	2	0	15	16
Wyoming	8	17	2	13	0	0	0	2
Totals		7,799	3,347	3,141	334	113	140	724
Percentages		100.00	42.92	40.27	4.28	1.45	1.80	9.28

Table 13 – Non-Case Directed Services – FY2019

State/ Jurisdiction	HHS Region	Non-Litigation Advocacy				Class Litigation				Legislative & Regulatory Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing	Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing	Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Alabama	4	3,549,030	16	1	34	99,625	1	0	2	296,262	10	0	5
Alaska	10	5,343	5	27	6	1,500	0	0	1	537	0	0	2
American Indian Consortium	13	2,188	3	0	22	0	0	0	1	25,000	0	1	0
American Samoa	9	1,400	88	2	2	200	0	0	0	100	5	0	0
Arizona	9	43,864	0	0	10	260	0	0	1	0	0	0	0
Arkansas	6	4,190	1	0	12	0	0	0	0	49,800	2	0	2
California	9	1,298,483	14	0	58	59,888	0	1	11	0	0	0	0
Colorado	8	4,505	1	0	6	0	0	0	0	0	0	0	0
Connecticut	1	718,710	3	0	15	7,900	0	0	2	390,000	0	0	1
Delaware	3	2,190	20	3	11	0	0	0	0	0	0	0	0
District of Columbia	3	26,150	9	0	6	3,162	0	0	1	20,000	1	0	3
Florida	4	1,056,658	28	5	57	43,500	1	0	8	9,292,282	2	0	19
Georgia	4	1,637,848	64	50	55	1,790,589	0	0	3	1,790,589	0	0	2
Guam	9	1,110	0	0	3	1,200	0	0	1	0	0	0	0
Hawaii	9	15	0	0	1	1,900	0	0	2	500	0	0	1
Idaho	10	104,058	16	0	0	0	0	0	0	272,650	16	14	3
Illinois	5	2,343	10	21	11	147,740	1	0	3	0	0	0	0
Indiana	5	9,123	0	0	2	0	0	0	0	0	0	0	0
Iowa	7	1,389,554	44	0	12	1,000	0	0	1	0	0	0	0
Kansas	7	1,530	0	0	13	0	0	0	0	0	0	0	0
Kentucky	4	192,253	34	23	1	0	0	0	0	3,000	3	3	2
Louisiana	6	983,270	1	0	9	1,311,500	0	0	4	1,000	1	0	0
Maine	1	33,300	22	14	21	12,000	0	1	1	0	0	0	0
Maryland	3	70,350	875	0	33	0	0	0	0	0	0	0	0
Massachusetts	1	41,530	24	1	12	0	0	0	0	0	0	0	0
Michigan	5	234,330	16	14	1	65,000	0	0	1	344,911	9	0	1
Minnesota	5	4,772	48	0	3	200	0	0	1	100,000	0	0	1
Mississippi	4	12,238	62	0	17	0	0	0	0	0	0	0	0
Missouri	7	5,301	5	0	4	0	0	0	0	0	0	0	0
Montana	8	4,500	6	0	9	0	0	0	0	30,000	0	0	3
Nebraska	7	6,281	31	0	4	0	0	0	0	642,170	12	13	7
Nevada	9	753	8	0	4	0	0	0	0	1,600	0	0	1
New Hampshire	1	819,363	6	1	43	50,000	0	0	2	100	1	0	1
New Jersey	2	5,692	1	0	7	9,000	2	0	0	0	0	0	0
New Mexico	6	151,002	2	0	2	4,737	0	0	1	8,104	0	0	1
New York	2	247,619	29	1	31	17,602	2	0	10	38,020	3	1	1
North Carolina	4	242,182	1	0	8	1,000	1	0	0	26,700	0	0	2
North Dakota	8	85	0	0	2	0	0	0	0	7,548	2	0	0
Northern Marianas	9	40	1	0	1	0	0	0	0	0	0	0	0
Ohio	5	1,768,200	54	0	46	250,141	3	0	1	13,954,933	13	0	47
Oklahoma	6	4,891	29	0	4	0	0	0	0	840,302	4	0	0

State/ Jurisdiction	HHS Region	Non-Litigation Advocacy				Class Litigation				Legislative & Regulatory Advocacy			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing	Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing	Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Oregon	10	18,026	19	0	27	7,800	0	0	1	238,071	3	0	15
Pennsylvania	3	3,742	21	0	9	19,700	0	0	2	560,949	2	1	19
Puerto Rico	2	1,399	9	0	30	0	0	0	0	0	0	0	0
Rhode Island	1	5,660	0	0	4	0	0	0	0	20,000	1	0	0
South Carolina	4	172,197	1	0	5	3,400	1	0	0	1,000	0	0	2
South Dakota	8	493	6	3	8	0	0	0	0	0	0	0	0
Tennessee	4	275,576	25	0	22	0	0	0	0	338,500	0	0	1
Texas	6	259,200	0	0	0	1,200	0	0	0	238,000	0	0	0
Utah	8	5,330	1	0	5	16,500	2	0	0	118,815	2	0	5
Vermont	1	25,295	55	0	57	0	0	0	0	137,642	17	0	14
Virgin Islands	2	6,824	11	0	15	0	0	0	1	0	0	0	0
Virginia	3	547,298	46	0	2	0	0	0	0	176,569	5	0	0
Washington	10	293,435	26	0	36	72,083	3	0	8	416,367	17	0	5
West Virginia	3	134,770	239	0	16	99,000	0	0	5	131,000	1	0	6
Wisconsin	5	76,924	12	0	20	0	0	0	0	76,875	6	0	4
Wyoming	8	3,492	41	0	12	0	0	0	0	0	0	0	0
Totals		16,515,905	2,089	166	866	4,099,327	17	2	75	30,589,896	138	33	176

Table 13 – Non-Case Directed Services – FY2020

State/ Jurisdiction	HHS Region	Non-Litigation Advocacy				Systemic Litigation				Educating Policy Makers			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing	Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing	Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Alabama	4	3,273,756	11	0	32	158,828	1	1	5	476,748	5	2	6
Alaska	10	485,376	0	7	14	8,724	0	1	2	20,123	0	0	3
American Indian Consortium	13	36,949	1	1	11	320	0	0	2	2,188	0	0	3
American Samoa	9	860	51	19	8	50	0	0	0	55,000	3	1	1
Arizona	9	64,050	0	0	41	260	0	0	2	0	0	0	0
Arkansas	6	1,642	6	0	8	350	0	0	2	5,000	1	0	0
California	9	1,919,149	3	0	41	0	0	0	0	0	0	0	0
Colorado	8	4,842	2	0	9	0	0	0	0	0	0	0	0
Connecticut	1	3,809	13	1	9	404	0	0	2	391,862	0	0	1
Delaware	3	2,252	43	0	10	0	0	0	0	0	0	0	0
District of Columbia	3	26,510	5	0	8	3,088	0	0	2	22,000	3	0	4
Florida	4	7,112,188	14	4	55	2,506,055	1	0	7	356,277	1	0	3
Georgia	4	27,579,407	207	0	39	4,800	0	0	3	1,116,300	5	0	2
Guam	9	3,004	4	0	3	1,800	1	0	0	0	0	0	0
Hawaii	9	15	0	0	1	1,900	1	0	1	500	0	0	1
Idaho	10	30,058	18	1	0	0	0	0	0	272,650	9	2	1
Illinois	5	243,293	3	1	22	96,080	0	0	5	10,000	1	0	0
Indiana	5	1,900	0	0	2	2,500	0	0	1	0	0	0	0
Iowa	7	1,441,036	50	0	14	1,000	0	0	1	0	0	0	0
Kansas	7	650	0	0	13	0	0	0	0	0	0	0	0
Kentucky	4	19,400	5	0	2	150,000	2	0	2	20,000	1	0	0
Louisiana	6	661,605	0	0	16	5,000	1	1	3	25,000	0	0	1
Maine	1	32,500	22	13	21	12,000	0	1	1	10,000	2	2	2
Maryland	3	72,950	28	2	6	1,000	0	0	1	0	0	0	0
Massachusetts	1	93,760	15	2	25	0	0	0	0	0	0	0	0
Michigan	5	8,829	32	5	20	60,579	0	0	4	696,695	14	1	3
Minnesota	5	256,283	44	0	1	200	0	0	1	1,000	1	0	0
Mississippi	4	35,582	49	1	32	0	0	0	0	2,350	3	0	0
Missouri˜	7	6,515	13	0	5	0	0	0	0	0	0	0	0
Montana	8	35,303	9	1	42	0	0	0	0	0	0	0	0
Nebraska	7	8,819	4	0	12	85	1	0	0	8,315	4	1	4
Nevada	9	790	1	0	3	0	0	0	0	200	1	0	0
New Hampshire	1	744,952	7	3	47	50,100	1	0	2	100	0	0	1
New Jersey	2	1,127,642	23	0	12	48,215	3	0	0	195,237	1	0	1
New Mexico	6	152,650	2	0	3	2,300	1	0	0	0	0	0	0
New York	2	165,453	28	0	20	12,104	0	0	12	69,000	4	0	0
North Carolina	4	244,100	0	0	9	500	1	0	0	7,000	1	0	1
North Dakota	8	63	3	0	0	0	0	0	0	4,178	3	0	0
Northern Marianas˜	9	9	0	0	9	0	0	0	0	0	0	0	0
Ohio	5	156,857	47	1	44	251,000	3	0	1	60,301	12	0	35
Oklahoma	6	140,410	34	0	12	27	1	0	0	66,909	5	0	2

State/ Jurisdiction	HHS Region	Non-Litigation Advocacy				Systemic Litigation				Educating Policy Makers			
		Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing	Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing	Total number of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Ongoing
Oregon	10	324,040	7	0	35	67,412	2	0	4	53,262	1	0	9
Pennsylvania	3	1,668	11	0	0	23,729	3	0	3	576,090	4	0	3
Puerto Rico	2	1,346	3	0	33	0	0	0	0	0	0	0	0
Rhode Island	1	8,518	4	0	5	541	0	0	2	0	1	0	0
South Carolina	4	872,200	1	0	5	403,400	2	0	3	1,000	0	0	2
South Dakota	8	427	12	0	4	0	0	0	0	47,038	7	0	0
Tennessee	4	1,785,180	53	0	11	0	0	0	0	118,997	1	0	1
Texas	6	173,550	42	11	5	17,732	0	0	3	0	0	0	0
Utah	8	25,730	64	0	9	1,000	1	0	1	85,300	4	0	0
Vermont	1	40,141	15	0	44	0	0	0	0	16,315	5	0	5
Virgin Islands	2	7,584	12	0	28	5,444	1	0	1	5,444	0	0	1
Virginia	3	126,793	29	0	3	0	0	0	0	36,560	2	0	0
Washington	10	311,605	27	0	76	198,730	6	0	8	376,338	14	0	9
West Virginia	3	133,562	234	0	17	131,000	0	0	4	131,000	0	0	8
Wisconsin	5	989,748	3	1	2	0	0	0	0	76,333	6	0	3
Wyoming	8	2,196	8	1	5	200	0	0	1	0	0	0	0
Totals		50,999,506	1,322	75	963	4,228,457	33	4	92	5,418,610	125	9	116

Table 14 – Information/Referral/Public Education/Awareness & Training Activities – FY2019

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	361	3	37	2,578
Alaska	10	567	9	4	135
American Indian Consortium	13	1	1	3	258
American Samoa	9	403	16	8	722
Arizona	9	112	12	8	148
Arkansas	6	184	16	8	2,533
California	9	22	45	737	8,778
Colorado	8	184	32	14	224
Connecticut	1	366	21	7	400
Delaware	3	85	11	20	399
District of Columbia	3	255	61	65	950
Florida	4	1,158	60	16	1,230
Georgia	4	503	25	31	1,572
Guam	9	26	22	19	916
Hawaii	9	219	279	340	4,925
Idaho	10	339	44	36	1,245
Illinois	5	501	41	83	2,625
Indiana	5	655	9	48	2,102
Iowa	7	260	18	17	512
Kansas	7	22	234	57	3,250
Kentucky	4	563	5	33	657
Louisiana	6	477	21	49	744
Maine	1	661	237	196	4,107
Maryland	3	169	4	8	299
Massachusetts	1	313	16	6	300
Michigan	5	1,692	8	0	214
Minnesota	5	301	26	24	793
Mississippi	4	152	17	21	3,348
Missouri	7	590	15	10	261
Montana	8	290	4	6	526
Nebraska	7	208	65	41	1,465
Nevada	9	452	1	10	3,588
New Hampshire	1	69	6	9	242
New Jersey	2	343	44	56	1,777
New Mexico	6	496	18	64	630
New York	2	964	16	8	856
North Carolina	4	127	16	8	218
North Dakota	8	317	12	14	292
Northern Marianas	9	12	20	6	424
Ohio	5	82	36	49	9,360
Oklahoma	6	124	25	5	204

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.
Oregon	10	277	13	5	180
Pennsylvania	3	605	21	7	299
Puerto Rico	2	185	30	37	701
Rhode Island	1	119	7	6	453
South Carolina	4	560	8	33	830
South Dakota	8	285	150	14	737
Tennessee	4	498	110	25	829
Texas	6	948	15	115	4,949
Utah	8	515	13	6	212
Vermont	1	722	3	23	194
Virgin Islands	2	11	7	4	79
Virginia	3	351	14	11	19,323
Washington	10	247	13	52	12,443
West Virginia	3	191	66	19	751
Wisconsin	5	589	15	13	1,979
Wyoming	8	180	19	26	720
Totals		20,908	2,075	2,577	110,486

Table 14 – Information/Referral/Public Education/Awareness & Training Activities – FY2020

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	407	0	22	10,419
Alaska	10	336	8	6	257
American Indian Consortium	13	0	33	12	2,188
American Samoa	9	323	12	6	630
Arizona	9	164	5	15	363
Arkansas	6	83	2	2	75
California	9	10	10	383	5,412
Colorado	8	116	10	0	0
Connecticut	1	259	6	2	70
Delaware	3	76	4	12	422
District of Columbia	3	145	63	57	846
Florida	4	1,127	32	10	884
Georgia	4	349	41	49	4,365
Guam	9	25	15	11	125,932
Hawaii	9	250	214	48	659
Idaho	10	345	11	17	504
Illinois	5	717	28	98	3,858
Indiana	5	579	2	2	55
Iowa	7	142	14	21	1,119
Kansas	7	9	3	141	3,720
Kentucky	4	575	1	8	322
Louisiana	6	225	1	1	10
Maine	1	394	252	163	8,309
Maryland	3	140	2	22	463
Massachusetts	1	212	10	4	300
Michigan	5	1,515	11	0	0
Minnesota	5	127	15	27	1,450
Mississippi	4	62	18	67	3,000
Missouri˜	7	575	9	6	285
Montana	8	301	0	7	8,930
Nebraska	7	205	43	22	1,215
Nevada	9	345	12	5	98
New Hampshire	1	77	6	23	1,127
New Jersey	2	39	22	25	1,915
New Mexico	6	509	8	58	465
New York	2	762	12	4	125
North Carolina	4	43	0	9	258
North Dakota	8	290	65	10	242
Northern Marianas˜	9	10	6	15	10
Ohio	5	27	12	28	1,363
Oklahoma	6	162	15	17	446

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.
Oregon	10	247	7	7	396
Pennsylvania	3	438	11	7	276
Puerto Rico	2	102	30	7	169
Rhode Island	1	174	2	5	170
South Carolina	4	410	1	23	489
South Dakota	8	170	204	10	378
Tennessee	4	238	22	64	53,447
Texas	6	909	12	98	15,261
Utah	8	615	7	1	40
Vermont	1	512	4	13	487
Virgin Islands	2	9	11	2	22
Virginia	3	266	12	9	2,450
Washington	10	27	0	14	415
West Virginia	3	227	20	7	220
Wisconsin	5	468	2	11	722
Wyoming	8	151	18	10	255
Totals		17,020	1,396	1,723	267,308

Appendix B – Acronyms (Still under review and revisions)

ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ACL	Administration for Community Living
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADLs	Activities of Daily Living
ADX	Administrative Maximum Facility
AIC	American Indian Consortium
AIDD	Administration on Intellectual and Developmental Disabilities
AoD	Administration on Disabilities
APS	Adult Protective Services
ASL	American Sign Language
BHA	Behavioral Health Authority
BOP	Bureau of Prisons
CHA	Children's Health Act
CMHS	Center for Mental Health Services
CMS	Centers for Medicare & 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
DPH	Department of Public Health
DPOAHC	Durable Power of Attorney for Health Care
ECT	Electroconvulsive Therapy
FHA	Fair Housing Act
FY	Fiscal Year
HCBS	Home and Community-Based Services
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HUD	U.S. Department of Housing and Urban Development
IAA	Interagency agreement
IST	Incompetent to Stand Trial
NFMH	Nursing Facility for Mental Health
OCD	Obsessive Compulsive Disorder
OCR	Office of Civil Rights
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
PASRR	Pre-Admission Screening and Resident Review
POA	Power of Attorney

PPE	Personal Protective Equipment
PPR	Program Performance Report
PRTF	Psychiatric Residential Treatment Facility
PTSD	Post-Traumatic Stress Disorder
RSA	Rehabilitation Services Administration
RCA	Root Cause Analysis
RN	Registered Nurse
RTC	Residential Treatment Center
RTU	Residential Treatment Unit
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
TTY	Teletypewriter
USDOJ	United States Department of Justice
VR	Vocational Rehabilitation