

アメリカのコロニー廃止の契機 虐待

California他から学ぶ
資料 CALIFORNIA WATCH
DEPARTMENT OF DEVELOPMENTAL
SERVICE 他から

三島卓穂委員提供資料

2000年前後の動き

三島卓穂委員提供資料

development of the regional center system

- 1968 at its highest point, the system of state hospitals for the developmentally disabled served approximately **13,400** individuals in **eight facilities**, with another **3,000** individuals on waiting lists.
- California initiated a community program in **1965 by establishing two regional centers** (now Golden Gate Regional Center and Frank D. **Lanterman** Regional Center) to test the concept of **providing local, community-based services** 地域サービスを開始
- With the development of the regional center system, dependence on institutional services declined over time.のおかげでセンター依存が消えた

三島卓穂委員提供資料

背景 Coffelt v. Department of Developmental Services (1990) 判決

- (1990) (Coffelt). The Coffelt class action lawsuit alleged 集団訴訟で
- **unnecessary placements** of persons in DCs who could live in the community. The case was settled in 1994 resulting in more than **2,000 DC residents moving into the community over five year** 不要な施設利用の禁止の結果、5年で2000人以上が地域に

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背景 Olmstead v. L.C. (1999)判決

- Supreme Court held that discrimination under the ADA includes unnecessary institutionalization of people with disabilities who can live in the community. 不要な入所はADAの差別に該当する
- The decision stated that “states are required to place persons with mental disabilities in community settings rather than institutions 国は、知的障害のある人の生活を施設でなく地域にしなくてはならない
- when the State’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual
- 国の専門家が地域生活が適当と判断した時には、地域移行を妨害してはならない。

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背景 Capitol People First v. Department of Developmental Services(2001)

- alleged unnecessary segregation of Californians with developmental disabilities in large congregate public and private Institutions 大施設に集めて不必要に隔離すること
- new policy limiting DC admissions and the use of institutional care in the community was enacted in the trailer bill 新たな入所を制限、地域で施設的なケアの禁止が決まった

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強度行動障害も地域で成功

- Most of the approximately **400 Agnews residents moved to the community**, only 20 individuals transferred to another DC アグニュー400人中、他のコロニー移行20名以外は全員地域に移行
- Although there are larger concentrations of people with severe disabilities and complex needs in the DCs, people with **similar characteristics are being served successfully in the community** 強度行動障害の人たちも地域で成功

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	1985	1990	1995	2000	2005	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
canyon springs																		
fairview										△○							◎	
porterville						△											◎	
sonoma									△	○	◎							
lanterman						○		△			◎							
agnew			△		◎													
sierra vista					◎													
greenville テネシー州												◎						
texas6/13テキサス										◎								
woodlandカナダ			◎															
willowbrookニューヨーク																		
task force																		
regional center																		
最新地域の住まいプラン																		
裁判所が記録公開を指示																		
capitol 裁判判決																		
olmsted 裁判判決																		

○ 三島卓穂委員提供資料 ◎ 閉鎖計画完了 △ 虐待問題 重要な出来事

2015閉鎖計画-2018完全閉鎖

事例1.SONOMAコロニーの閉鎖 虐待の多発と隠蔽 ネガティブなコロニーの象徴

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Sonomaでの性的虐待



Mike Kepka/San Francisco Chronicle

A patient named Jennifer was impregnated by an unknown assailant while living at the Corcoran Unit at the Sonoma Developmental Center in 2007. Under state law, sexual intercourse with a patient lacking the intellectual capacity to consent is considered rape.

三島卓穂委員提供資料

Decertification of Sonoma Developmental Center

- A California Department of Public Health [report](#) released last week determined the Sonoma center was out of compliance with Medi-Cal standards. The CDPH survey found problems in four areas:法律違反を犯している ソノマ
- Governing body and management;
- Treatment services;
- Health care services; and
- Client protection.
- Consumer advocates saw the decertification as corroboration of its calls for patients to be more quickly transitioned to community-based care. The state is moving in that direction, but too slowly,
- 保護者は地域に移行すべし、州もそう言っているが遅すぎ。

三島卓穂委員提供資料

Sonoma April 11, 2013

- Sonoma has been the focus of a series of patient abuse scandals over the years.
- As CIR's [Broken Shield](#) investigation revealed, its [staff](#)
- [used stun guns on residents](#), スタンガン
- [multiple uninvestigated cases of sexual assault](#). 性的暴行
- State lawmakers weighed today whether to appoint an inspector general to oversee state centers for the developmentally disabled and close a center in Sonoma where patients suffered the worst instances of abuse, neglect and sexual assaults. 最悪の虐待のソノマの存続か廃止かの監察官設置を検討

三島卓穂委員提供資料

Sonoma 監視官の設置に関して

- The proposal to **create an inspector general** met with
- **opposition** from the **Department of Developmental Services**, which objected to its cost. The idea also found little support among advocates and family members of the disabled, who say the state-run centers should be shut down 反対
- Shawn Martin, representing **the Legislative Analyst's Office**, testified that a new layer of oversight is needed because having the Department of Developmental Services responsible for its own facilities **hasn't worked** 賛成
- Sen. Mark DeSaulnier, D-Concord, 上院議員 the most outspoken member of the Senate budget subcommittee, indicated he **would favor shutting the troubled Sonoma Developmental Center and moving patients to a new center.** もう廃止

三島卓穂委員提供資料

ソノマの施設内警察の無能さ

- The Office of Protective Services, the internal police force assigned to protect residents of the state facilities, **routinely** mishandled cases by failing **to collect evidence**, waiting too long to **interview witnesses** or **suspects**, and not **ordering rape kits** in cases of alleged sexual assault,ルーチンとも言える証拠集め 証人調べの遅さ レイプキットも購入していない等々の失敗

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Terri Delgadillo,
director of the Department of Developmental
Services, which oversees the five centers.

- Sonoma center after the abuses came to light,
 - replacing top officials in Sonoma. **トップ人事の入れ替え**
 - 46 employees have been disciplined as a result of complaints, the center has created a new electronic incident reporting system and staff members have been trained on sexual assault response. **再教育 電子報告システム**
 - “We’re heading in the right direction and feeling positive, but there’s still a lot to be done,” she said. **すごく良くなっている**
- Nevertheless,
 - she **opposed the appointment** of an inspector general, saying the department could not afford it within its proposed \$4.9 billion annual budget. **視察官には反対**

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存続に抗議

- Before the hearing, **more than 100 protesters** wearing painted T-shirts and signs emblazoned with the words “equality for all” gathered on the steps of the Capitol and called on the Legislature to shut down the centers.
- “It is **stunning and spine-chilling** to know the state allows – and taxpayers fund – this outrageous abuse,” said Kiara Hedglin,. **“To fix the problems, the state must shut down the developmental centers. They are decaying institutions with an alarming record of abuse 続けるなんて神経がぞっとなる。びっくりするような虐待で腐っている施設だよ。**

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存続についての意見

- Williams
 - I felt like a prisoner, but I never committed any crime,” Williams said, communicating through a speaking device. “I knew I wanted freedom, and I knew I had to leave. If I had to go back, I’d take my own life.” 囚人のようだった
- DeSaulnier 上院議員
 - After the hearing, DeSaulnier was more direct in calling for an end to the state-run centers. 公聴会のあと、より強く廃止をもとめた “When you have a campus like Sonoma that is a huge fixed asset for the state that is only half-used, it makes no sense financially,” DeSaulnier said. “And when you factor in the other problems like abuse and neglect, it’s just stupid to keep it open as is.” 半分しか使っていない施設は経済観念が欠如、さらに虐待を考えれば続けるのは馬鹿げている
 - “Personally, I would do away with the developmental centers,” he told California Watch. “They are a big investment based on a 1950s model. They’re not working.” 1950年代モデルでもう機能していない。He said the Sonoma Developmental Center should be shut down and relocated to a facility that was less costly and better able to provide care to patients. 閉鎖して地域にいくほうが、ケアも、コストも良い。

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Sonomaの虐待報道



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MORE ON: patient abuse



SPOTLIGHT: PUBLIC SAFETY

CIR's California Watch again named finalist for Pulitzer Prize

April 15, 2013, 12:05 PM

Broken Shield investigation that exposed patient abuse at state developmental centers a top contender for journalism's highest honor.

[+ read more](#)

ピューリッター賞の最終選考になる

三島卓穂委員提供資料

Sonomaでの虐待

- The California Watch investigation exposed these cases and focused on failures of an internal police force to get to the bottom of the abuses.
- One-third of the **36 alleged rapes occurred at the Sonoma board-and-care center** – one of five such facilities in California that house about 1,600 patients with severe disabilities. 300人程度で12程のレイプ疑惑
- “If I tell someone I work at the Sonoma center, they’ll say, ‘Isn’t that the place where you rape clients?’ ” Fraudt said. “So at this point, I tell people I’m a secretary.” 恥ずかしくてソノマでケアしているなんて言えない

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Sonomaライセンス取り上げ、予算カットについて

- The Sonoma center is appealing **the loss of its license** with state public health officials.
- Earlier this month, the Department of Developmental Services **agreed to forfeit** more than \$1 million a month in federal funding for failing to protect severely disabled patients from abuse at some of the center’s housing units. 月に100万ドルを減額
- The federal funds cover as much as half of the treatment costs for patients who qualify for the federal program. 利用者の支援の半額に該当する

三島卓穂委員提供資料

Sonoma職員集会での発言一様々

- Daniel Solnit, a union representative for workers at the Sonoma Developmental Center, warned that closing the facility would devastate the local economy, put thousands of people out of work and shunt hundreds of vulnerable patients to lesser-quality group homes. 組合 地域経済への影響 何千人が失業 利用者は質の悪いグループホームに
- “The center is the biggest employer in Sonoma County,” Solnit said. “Closing this place would put the entire county into a serious economic recession.” センターは最大の雇用主、経済的な不景気になる
- The Sonoma center employs more than 1,000 people in the region. Solnit said it provides specialized services for developmentally disabled people like teaching programs. 1000人以上の関係者はいろんなサービスができる

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Sonoma職員集会での発言一様々

- Patrick Leslie,
- a chaplain at the Sonoma Developmental Center for 20 years, called the center a “wonderful place” that needed to be built up rather than torn down in the wake of abuses uncovered at the institution. 牧師は素晴らしい場所 If my sister was living (in the U.S.), I would want her to be at Sonoma, 妹がいればここが良い
- Circe Bisby,
- a senior psychiatric technician who has been at the Sonoma center for 23 years, said the problems at the center stem from a lack of staffing and inefficient administrative rules that encourage workers to clock long hours to net overtime pay. 精神科技師は、スタッフの不足と運営ルールのなさが、長時間勤務を強いている
- Bisby said accidents happen when the center is chronically understaffed and people are expected to work far longer than eight-hour shifts. Bisby said her responsibility at work has grown considerably: “Workers are just numbers to these people (administrators),” Bisby said. “The internal culture needs to change. 人が足りない時に事故は起きる。自分も仕事量がどんどん増えている。なかの文化が変わらないと。

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2013 4 11

MORE ON: Sonoma Developmental Center

DAILY REPORT: HEALTH AND WELFARE

Lawmakers mull next steps for developmental centers

April 11, 2013, 7:09 PM

SACRAMENTO – State lawmakers weighed today whether to appoint an inspector general to oversee state centers for the developmentally disabled and close a center in Sonoma where patients suffered the worst instances of abuse, neglect and sexual assaults. During a daylong hearing, members... [+ read more](#)

- 州議会議員は、虐待、性的な虐待などで最悪のソノマ発達センターの閉鎖を調査する視察官を指名するか終日ヒヤリングを行った。
- Mark DeSaulnier, D-Concord議員は、廃止して別のを作るべき。
- Terri Delgadillo, 管理責任者 トップの交替、職員研修、電子的事故報告システムで改善。前向きになってきている。視察官は不要。
- Kiara Hedglin NPO こんな無法な虐待を州が許してはいけない。虐待で腐っているセンターを廃止すべき。
- DeSaulnier 元利用者 1950年モデルに基づいている、廃止すべき。半分しか使用していない、財政的視点の全くない、さらに虐待も続いているセンターを維持しようなんて、馬鹿だと思う。

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2013 4 10



DAILY REPORT: HEALTH AND WELFARE

Independent oversight proposed for developmental centers

April 10, 2013, 5:19 PM

The state's influential legislative analyst is recommending that the California Legislature create an independent Office of Inspector General to monitor state developmental centers where police failed to properly investigate patient deaths, abuse, sexual assault and neglect. The proposal... [+ read more](#)

- 影響力のある法律家たちが、視察をすべきと提案。弱い立場の人への過去10年以上続く健康安全問題であるから
- 上院の予算委員会が調査を検討
- California Watchの調査 センター1600人中、36人の性的虐待やレイプの疑い。ソノマでは、12人以上にスタンガンでやけど。レイプの1/3はソノマ。施設内警察は全く無能で解決できない。
- 上記をうけて、トップの更迭、高速警察隊の監視、レイプキットの導入などが州知事の関与で決定。

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2013 3 07



DAILY REPORT: HEALTH AND WELFARE, PUBLIC SAFETY
New director to take over troubled Sonoma disability center
 March 7, 2013, 5:38 PM
 A former employee of the Sonoma Developmental Center has been tapped to head California's largest full-time care facility for the severely disabled, at a time when the institution is struggling to reinvent itself in the wake of patient abuse scandals. The Department of Developmental... [+ read more](#)

- 州の方針
 - レイプの検査は施設外
 - ソノマのライセンスの取り消し。月に100万ドルの減額。州はソノマが問題を解決するようにとの意味
 - Karen Fariaをトップにする。1985 to 2005まで働いていた。California Health and Human Services Secretary Diana S. Dooleyは、新風を期待している。
- 同僚の医師 Fariaは以前から虐待を知り、むしろ隠蔽サイドの人。お偉方に頭を下げて地位を得た。
- Nancy Lungren, a spokes womanは、背景は慎重に検討した結果の人事。
三島卓穂委員提供資料

2013 2 6

DAILY REPORT: HEALTH AND WELFARE
What's your ideal future for the Sonoma Developmental Center?
 February 6, 2013, 6:05 AM

At a Jan. 30 community forum on the future of the Sonoma Developmental Center, a few themes consistently surfaced in the conversation with residents, families and workers at the board-and-care facility for the developmentally disabled. The Sonoma center has come under fire after an investigation by... [+ read more](#)

- The idea of consolidating California's developmental center was popular 整理すべきとの意見が大勢
- low transparency with the center's data gathering and decision-making how taxpayer money is spent within the Sonoma 意思決定が不透明
- We need to change the internal structure of how to do business --- we need a Plan B. SDC operates as a place for those who don't make it in the community. If that's not there, where do people go if court-ordered?
- "I work with clients with severe aggression, property destruction, etc. Several have been in jail before. Where will they go without (developmental centers)?無くなったら重い障害者はどこにいくの

三島卓穂委員提供資料

2013 1 31



DAILY REPORT: HEALTH AND WELFARE

Sonoma disability center staff weighs in on abuse claims

January 31, 2013, 11:09 AM

SONOMA – California's largest full-time care center for the severely disabled needs more staff and accountability to correct major internal breakdowns that led to dozens of cases of alleged patient abuse, staff members said Wednesday at a public forum. The Sonoma Developmental... [+ read more](#)

- Daniel Solnit 組合 devastate the local economy, put thousands of people out of work . employs more than 1,000 people in the region. But for every abusive person, there were many people who devoted their lives to their patients with care these patients couldn't get anywhere else."
- Patrick Leslie, a chaplain "wonderful place" that needed to be built up rather than torn down
- Circe Bisby sychiatric technician who has been at the Sonoma center for 23 years . stem from a lack of staffing and inefficient administrative rules that encourage workers to clock long hours to net overtime pay. Workers are just numbers to these people (administrators)

三島卓穂委員提供資料

2013 1 18



DAILY REPORT: HEALTH AND WELFARE, PUBLIC SAFETY

State disability center forfeits funding over abuse

January 18, 2013, 5:17 PM

California's largest board-and-care center for the developmentally disabled will surrender more than \$1 million a month in federal funding for failures to protect patients from abuse and provide quality medical care, state officials announced today. In December, state regulators cited the... [+ read more](#)

- 虐待のため、予算を取り上げる
- 月に100万ドル

三島卓穂委員提供資料

2012 12 12



DAILY REPORT: PUBLIC SAFETY
State threatens to shut down disability center amid patient abuse
 December 12, 2012, 7:12 PM

The state's largest board-and-care center for the severely disabled lost its primary license to operate today, after repeatedly exposing patients to abuse and shoddy medical care. State regulators cited the Sonoma Developmental Center, which houses more than 500 patients, for dozens of... [read more](#)

- [dozens of cases](#) where patients were put at risk of injury or death. In issuing the citations, the state moved to shut down a major portion of the century-old institution.虐待により閉鎖の動きが出る
- he action comes after [a series of stories](#) this year from California Watch documenting
- Terri Delgadillo, director of the developmental services department
- hired police chiefs with little or no experience investigating crimes.90-member Office of Protective Services force was created decades ago to patrol California's five developmental centers, 経験のないトップ、、人権パトロールのために創設
- In 2006, caregivers at the Sonoma center found bruises shaped like handprints covering Jennifer's breasts, suggesting an assault. She accused a staff member of molestation, but the Office of Protective Services opened an investigation without ordering a rape kit examination.
- A few months later, Jennifer was pregnant. By then, her alleged attacker had fled the country.
- 性的虐待があり告発したが、警察はレイプ検査もせず、結果妊娠。犯人は逃走。
- In another case from early 2000, a female patient at the Sonoma center accused a male caregiver of sexually assaulting her during a bath. The institution then assigned two men to bathe the patient, even though the facility employed many female caregivers. Both caregivers allegedly raped her during bathing. Police made no arrests in the case. 女性の入浴に男性職員、レイプの疑い、警察は逮捕せず。

三島卓穂委員提供資料



DAILY REPORT: PUBLIC SAFETY
Report slams state institution for neglect, weak oversight
 August 23, 2012, 12:05 AM

California's largest institution for the developmentally disabled risks losing millions of dollars in federal funding because of poor medical care and widespread failures to prevent abuse and thoroughly investigate when patients are harmed, state officials said in a confidential report... [read more](#)

- California Watch obtained a copy of **the 495-page document** this week.500ページの記録入手
- "Individuals have **been abused, neglected, and otherwise mistreated and the facility has not taken steps to protect individuals and prevent reoccurrence,**" the report said. "Individuals were subjected to the use of **drugs or restraints without justification** 虐待、ネグレクト、等々で施設は対策なし、再発防止策なし。拘束具とか薬物を勝手に使われた。
- Sonoma spend about **\$314,000** this year per developmental center patient.1人31万ドル 三千万円強
- Several key changes have already been made but more must be done," Delgadillo
- The state Department of Public Health, which licenses and regulates the institutions, decertified the Agnews Developmental Center in San Jose for patient neglect in 1999. Agnews closed two years ago アグニューも免許取り消しをし閉鎖した
- The Sonoma center's **nursing services were also faulted**, most notably for unsafe practices when placing feeding 看護もダメ
- 警察もダメ
- Archie Millora had abused patients during his shifts. Officers found a Taser in Millora's car, along with a loaded handgun, but did **not make an arrest** in the assaults.
- The Office of Protective Services opened an investigation nearly six weeks later, [on Jan. 13](#). If center detectives intended to investigate potential criminal negligence, [the caregiver responsible](#) for protecting Erquiaga was **already gone**, the records show.

三島卓穂委員提供資料



DAILY REPORT: PUBLIC SAFETY

State inquiry sought on Taser abuse against disabled patients

August 3, 2012, 12:05 AM

A prominent advocacy group for the disabled and parents of Sonoma Developmental Center patients are calling for an outside investigation into stun gun assaults last fall against a dozen patients at the institution. The Arc and United Cerebral Palsy in California distributed an open letter to... [+ read more](#)

- detectives found burn marks on several patients and, later, discovered a Taser and a loaded handgun in Millora's car. 車にスタンガン
- After the assaults were discovered, the Office of Protective Services made no arrest, and instead handled it as an administrative matter. At least nine days after the revelations, detectives still had not interviewed Millora, 逮捕しなければ聞き取りもしない
- Terri Delgadillo, **director of the state** Department of Developmental Services, defended the police force's investigation as comprehensive. "The investigation also included interviews of over 100 individuals, including the suspect who was interviewed on three separate occasions and terminated from employment, トップは警察を擁護
- the institutions' internal police force, created by the state to protect the **vulnerable residents** at these state homes, often fails to conduct basic police work when patients are abused and harmed. 基本で失敗している

三島卓穂委員提供資料

事例2.LANTERMAN コロニーの閉鎖 WARM LANDING

三島卓穂委員提供資料

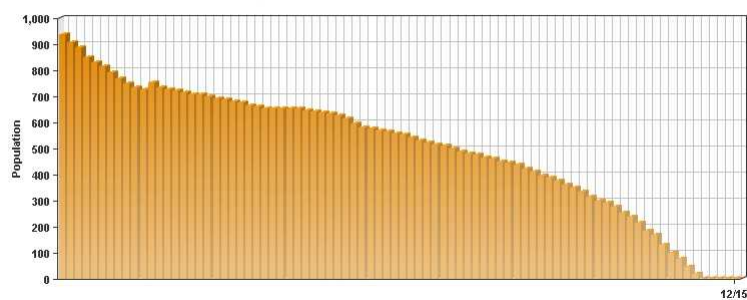


In 2015 , only 1,147 people were still residing in state developmental centers ,
287,000 individuals and families were receiving community-based
services coordinated through the regional center system envisioned by
Assemblyman Frank Lanterman.

三島卓穂委員提供資料

ランターマンの利用者

Lanterman Developmental Center



三島卓穂委員提供資料

ランターマンの中 小奇麗？

Lanternman Developmental Center's
Personal Touch Contest 2009



ニ、カ、マ、の中 小奇麗？

Realizing Potentials - Providing Opportunities



History of Lanterman Developmental Center:1

- **Pacific Colony** - Thinking “feeble-mindedness” to be a menace, the California Legislature created Pacific Colony as a Southern California facility to detain the “feeble-minded”. People with developmental disabilities were “**inmates**”, needing to be **locked away from society forever** because of their “insanity.” The present location welcomed its first 27 “inmates”, on May 2, 1927. **社会から永遠に隔離されなければならない収容者**
- By 1946, over **1,900** people crowded into a facility that had only grown large enough to hold 1,512 people. With World War II finally over, the state allocated more money for **expansion and improvements**. **拡大が続く**

三島卓穂委員提供資料

History of Lanterman Developmental Center:2

- **Pacific State Hospital** - The name change in 1953 No longer were residents of Pacific considered “**inmates**” but “**patients**” who were sick and needing treatment to be made well. **収容者から患者に**
- The new use of the **socio-psychological** team, **social workers, psychologist, and parents and innovative practices such as in-service training for nurses** provided some of the practical evidence of this shift.
- The era also marked the start of a **movement** toward helping people with developmental disabilities **prepare for living in the broader community**. **地域も意識される**

三島卓穂委員提供資料

History of Lanterman Developmental Center:3

- **D. Lanterman State Hospital and Developmental Center** -, State Assemblyman Frank D. Lanterman ensured
- their **civil rights** and guaranteed them life-long **services** through the creation of the Lanterman Act. 市民権の保証とランターマン法
- initiated the network of community resources known as the **Regional Centers**. 地域センターの設置
- In honor of his dedication, Pacific changed its name in 1979.ランターマンの功績を残す

三島卓穂委員提供資料

History of Lanterman Developmental Center:4

- **Lanterman Developmental Center** –
- perceived as **individuals with special needs** rather than “patients” and referred to as “residents.” 患者から 特別なニーズのある人、そして住民
- California adopted this philosophy and promoted the fact that all residents receive progressive habilitation training. この哲学が採用された
- Lanterman Developmental Center’s last resident moved into the community on December 23, 2014 2014年12月に発展的解消
- the facility began warm shut down operations.

三島卓穂委員提供資料

Lanternman 閉鎖の意見

- “It has been the intent of the Legislature for **about 50 years to close these institutions**,” Liu said. “These things are really hard but we are moving away from institutionalizing people, and I’m in favor of that. I **don’t think institutions are healthy places where people are all of like kind and all stick together**. It’s better for all of us to have an experience with all kinds of people.”似た人たちが集められている施設は健全だと思わない

三島卓穂委員提供資料

Lanternman 虐待と隠蔽

- Many of the fears about treatment at the developmental centers were only enhanced by findings from the U.S. Department of Justice in 2006.
- The DOJ cited Lanternman after **275 allegations of abuse or neglect were made in 2003-04** and noted that many Lanternman staff **members failed to report incidents or did not track them correctly**.
ランターマンでは1年に275の虐待の訴えがあり、職員は報告、検討しなかった

三島卓穂委員提供資料

Plan for the Closure of
LANTERMAN DEVELOPMENTAL CENTER



APRIL 1, 2010

三島卓穂委員提供資料

ランターマンの閉鎖計画

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その2

事例2-2 LANTERMANの地域移行モデル

三島卓穂委員提供資料

前提

1. Community resources, including **residential and day services, will be developed.**
2. The necessary health and medical services will be arranged within the local communities.
3. Behavioral and **crisis support** services must be available

三島卓穂委員提供資料

Individualized Planning Process 個別支援計画

- The planning team includes
 - the resident, identified staff from the developmental center, a regional center service coordinator, the legally authorized representative and family and/or advocates プランチームは、
- To help prepare each resident for maximum participation in this team discussion, できるだけ多くの人の参加
 - the Department will arrange for peer informational sessions for residents at Lanterman to learn about the variety of living options available
- For some residents
 - another DC as the appropriate living alternative,
 - most will community options ほとんどは地域志向

三島卓穂委員提供資料

ARFPSHNs and the Closure of Lanterman

- Many of the residents at Lanterman need enhanced licensed nursing care.
- 25% of the residents are served in the nursing facility
- 75% have special health care needs.
- The ARFPSHN model provide a cost-efficient home-like community based setting.

三島卓穂委員提供資料

The regional-center “experiment success

- 1965, the **Regional Center program was established** to answer ,to keep their mentally retarded family member home and/or in the community.” 1965から
- Thus, from their inception, a primary regional-center function is individuals from placement in state developmental centers by creating community-based alternatives
- “The **regional-center “experiment” has, obviously, been very successful** 地域センター型の実験は成功した

三島卓穂委員提供資料

地域センターの功績

- In 1968, **13,355** individuals living in state developmental centers and a legislative committee reported “...that thousands of children are on waiting lists for State hospitals...”
- Today the **developmental centers** serve only about **2,100** individuals, despite the state’s general population increase from 19.4 million in 1968 to about 38 million in **2009**.
- By the establishment of the **first regional centers**, the number of individuals in California residing in developmental centers has been reduced from **one in 1,453** of the general population to **one in 18,327** today. 地域センターの創設により、激減した

三島卓穂委員提供資料

事例3 2021年までに閉鎖

事例3 FAIRVIEWコロニーの閉鎖 虐待の多発と隠蔽 ネガティブなコロニーの象徴

三島卓穂委員提供資料

Fairview

- Fairview currently cares for 281 of them
- deaths of six residents between 2002 and 2011.6人も死亡事故
- Closure of Fairview Developmental Center would benefit patients, advocates say
コロニーの閉鎖は利用者に良い
- Fairview Developmental Center – the sprawling state institution in Costa Mesa for people with cerebral palsy, epilepsy and other developmental and intellectual disabilities – **will close by 2021** under the state budget proposed Thursday by Gov. Jerry Brown.202
- 1に廃止



Newly released state health department records show that Fairview Developmental Center is to blame in the deaths of six residents between 2002 and 2011. (FILE PHOTO, Daily Pilot)

三島卓穂委員提供資料

Fairviewの閉鎖理由

- The closures were expected. 閉鎖は期待されていた
- At Fairview, the population has **declined steeply** since the facility opened in 1959,. Fairview's population peaked in the next decade with **2,700** residents. 利用者の激減
- state regulators blamed **Fairview for the deaths of six residents from 2002 to 2011 due to neglect, abuse and lack of supervision.** 虐待の頻発とスーパービジョンの欠如
- Advocates say **community housing options give residents more freedom, allowing them to live more normal lives.** 地域のほうが自由と普通の生活を提供できる

三島卓穂委員提供資料

Fairview廃止後の住まいと経費

- The **280** people living at Fairview would be relocated to **group homes and smaller nursing facilities**. About 80 would end up living in Orange County.
- Legislative Analyst's Office has estimated it costs
 - about **\$500,000** a year to treat and house a developmental center resident. 5千万円
 - The alternative housing options cost between **\$75,000 and \$300,000** per patient, per year, 750万～3千万円

三島卓穂委員提供資料

Fairviewの不祥事と隠蔽

- State cites Costa Mesa's Fairview hospital in 8 deaths; some **officials want facility closed** **あまりに死亡事故が多く閉鎖を望む声**
- "I knew there were deaths. I did not know there **were 13**," said Assembly woman Shannon Grove, R-Bakersfield, who has introduced legislation to **close Fairview** and the developmental center in **Sonoma County**. **死亡事故は知っていたがまさか、13名とは。**

"For years, the details surrounding these deaths remained **shrouded from public view**, including legislative view," Grove said. **死亡は隠された**

三島卓穂委員提供資料

州公衆保健局の隠蔽と公開命令

- For years, the details surrounding these **deaths** have remained hidden from public view. The Center for Investigative Reporting sued the public health department in 2012 after **it refused to release the documents** over patient privacy concerns. In February, the **state Supreme Court sided with CIR,** **compelling the department to make the records public**. **最高裁が公開を指示**

三島卓穂委員提供資料

Fairview Developmental Center 不祥事

- **By the numbers**
- Total violations at Fairview Developmental Center since 2002: **35**
- Deaths: **8**
- Staff abuse: **4**
- Sexual abuse: **1**
- Falls: **5**
- Other injuries: **4**
- Escapes: **8**
- Ingesting inedible items: **5**
- For years, the details surrounding these **deaths** have remained hidden from public view. The Center for Investigative Reporting sued the public health department in 2012 after **it refused to release the documents** over patient privacy concerns. In February, the [state Supreme Court sided with CIR](#), **compelling the department to make the records public.**
最高裁が公開を指示

三島卓穂委員提供資料

CTIONS SEARCH **Los Angeles Times** SUBSCRIBE LOG IN

WED JAN 14, 2016 MOST POPULAR OSCARS 2016 LOCAL NFL IN L.A. POWERBALL LAUSD OPINION PLACE AN AD 52°

SON OF SAUL
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WINNER
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f t e

Report blames Fairview Developmental Center for 6 deaths

PROMOTED

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Fairview関係者の態度

- California Department of Developmental Services 当局 spokeswoman Nancy Lungren said Fairview “is committed to the health and safety of its residents and is continuously improving conditions 改善に引き続き努力”
 - Many of the incidents reported are over a decade old and the deficiencies addressed and resolved ... the [developmental centers] continue to work on system improvements through continuing improvement plans, 10年以上まえからの継続課題で改善に努めている
- Leslie Morrison, an investigator with Disability Rights California, called the reports from Fairview and the other developmental centers “very, very troubling.” We’re very disheartened about these incidents,” she said, adding that some of them are being investigated by her agency. ひどいもので心を傷めている

三島卓穂委員提供資料

世論はコロニー廃止 継続困難

- Sen. Jeff Stone (R-Murrieta) and Assembly woman Shannon Grove (R-Bakersfield) have introduced separate bills with similar provisions to close the centers and transfer their patients to regional facilities for a fraction of the cost. 上院議員が閉鎖・地域移行
- In January 2014, Fairview was at risk of losing funding after an investigation the year before found various patient care problems, identified as “immediate jeopardy situations.” Within a month, however, Fairview officials agreed to an improvement plan that allowed the facility to continue receiving its Medicaid funding. フェアビューは資金なく緊急事態に陥るが、改善案提出で続行

三島卓穂委員提供資料

2014-8-13

事例4.TEXAS州立コロニーの廃止 6/13

三島卓穂委員提供資料


改革を2009年に確約するも虐待継続

★ THE TEXAS TRIBUNE

SUPPORT US

Despite Reforms, Abuse Continues at Texas Institutions for Disabled

by Emily Ramshaw and Becca Aaronson | October 23, 2011 | 19 Comments

 Like 248 people like this. Sign Up to see what your friends like.

STORY: PART 1

STORY: PART 2

DATA: ABUSE AND NEGLECT

PHOTO SLIDESHOW

MEXIA — At the [Mexia State Supported Living Center](#), on the sun-bleached site of a former World War II prisoner-of-war camp an hour east of Waco, residents with profound disabilities and behavioral problems spend their days doing repetitive chores: sticking paper into shredders, folding towels, sorting nuts from bolts. And, in some cases, being physically abused, despite a sweeping federal settlement signed in 2009 to prevent it.

In the last two years, a Mexia worker was caught on video pushing a disabled resident down and stepping on his throat while other employees looked on. A staffer goaded one resident into hitting another with a belt, causing bloody wounds and a trip to the emergency room. A direct care worker showed residents pornographic pictures and tried to

abused two residents.



テキサスの6/13

Richmond State Supported Living Center
Assisted Living Facility - Preston St



Brenham State Supported Living Center
Assisted Living Facility - TX-36



Austin State Supported Living Center
Assisted Living Facility - W 35th St



Corpus Christi State Living Center
Assisted Living Facility - Airport Rd



三島卓穂委員提供資料

テキサスの入所施設廃止

- The debate over the future of Texas' institutions for the disabled is a perennial one; advocates for community living **want them closed**, while **families of their residents fight to keep them open**. 地域派は閉鎖、家族は継続
- But a groundbreaking recommendation from the state's Sunset Advisory Commission to **shutter six of Texas' 13 state-supported living centers** has reopened a giant divide in the disability community 州の諮問委員会の6/13の閉鎖勧告

三島卓穂委員提供資料

テキサスでも6か所廃止

★ THE TEXAS TRIBUNE

Commission Formally Calls for Closure of Institutions

by [Edgar Walters](#) | Aug. 13, 2014 | [8 Comments](#)

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Photo by Todd Wiseman

Austin State-Supported Living Center employee Tamika Mays is shown with resident Rebecca Hadnot in 2011.

A Texas commission that reviews the efficiency of government agencies officially recommended Wednesday that lawmakers shutter an Austin-area institution for people with disabilities — and identify five more statewide for later closure.

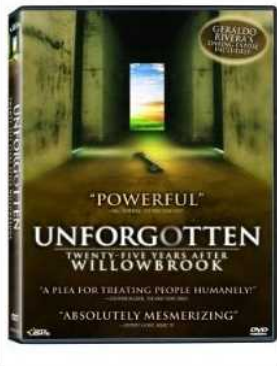
The Texas Sunset Advisory Commission reviewed and tweaked a series of recommendations for lawmakers regarding several health and human service agencies ahead of the 2015 legislative session. In addition to the recommendation to close the Austin State-Supported Living

1965年には6500人 1987に全員移行で廃止

事例5.WILLOWBROOKの廃止

三島卓穂委員提供資料

Willowbrookの悪夢



Unforgotten: Twenty-Five Years After Willowbrook (1996)

57 min | Documentary | 14 February 1997 (USA)

Your rating: ★★★★★★★★ -/10
6.3 Ratings: 6.3/10 from 62 users
 Reviews: [write review](#) | 4 critic

It was a nightmare that shocked not only New York, but all of America. The public outcry about the Willowbrook State School for people with developmental disabilities resulted from Geraldo ... [See full summary](#) »

Director: Jack Fisher
Writer: Stuart Warmflash
Stars: Danny Aiello, Geraldo Rivera | [See full cast and crew](#) »

[See More on IMDb Pro](#) »

三島卓穂委員提供資料

Willowbrook 昔から同じテーマが解決しないまま

- **The Willowbrook lawsuit**
- Following the Rivera exposé, parents of Willowbrook residents filed a class action suit in U.S. District Court for the Eastern District of New York on March 17, 1972. The lawsuit alleged that conditions at Willowbrook violated the constitutional rights of the residents. Parents outlined multiple violations, including:
 - Confining residents for indefinite periods; 無期限の入所
 - Failing to release residents eligible for release; 入所者を解放しない
 - Failing to conduct periodic evaluations of residents to assess progress and refine goals and programming; 定期的な発達の評価と目標設定を怠る
 - Failing to provide habilitation for residents;
 - Not providing adequate educational programs, or services such as speech, occupational, or physical therapy; 教育プログラムなどが実施されていない
 - Overcrowding; 混み合いすぎ
 - Lack of privacy; プライバシーのなさ
 - Failure to provide protection from theft of personal property, assault, or injury; 盗難防止策のなさ
 - Inadequate clothing, meals, and facilities, including toilet facilities; 着物食事トイレのひどさ
 - Confining residents to beds or chairs, or to solitude; ベッドやいすへの拘束、個室への閉じ込め
 - Lack of compensation for work performed; 仕事をしても支払いなし
 - Inadequate medical facilities; and 医療の欠如
 - Understaffing and incompetence in professional staff. 職員の不足と資質のなさ

New York Willowbrook廃止が 地域移行の契機

The Closing of Willowbrook

New York State Association for Retarded Children v. Carey



A watershed case in the evolution of the legal rights of people with disabilities to live in dignity arose out of public awareness of the horrific conditions under which children and adults with disabilities were living at the Willowbrook State Developmental Center in New York. This case set important precedents for the humane and ethical treatment of people with developmental disabilities living in institutions. This, in turn, served as the impetus for accelerating the pace of community placements for people with developmental disabilities, expanding community services, increasing the quality and availability of day programs, and establishing the right of children with disabilities to a public education.

三島卓穂委員提供資料

カナダ ブリティッシュコロンビア州の州立施設

Community placements were planned and implemented over the next 15 years. Woodlands finally closed in 1996, marking the culmination of a long struggle to end large institutions in B.C.

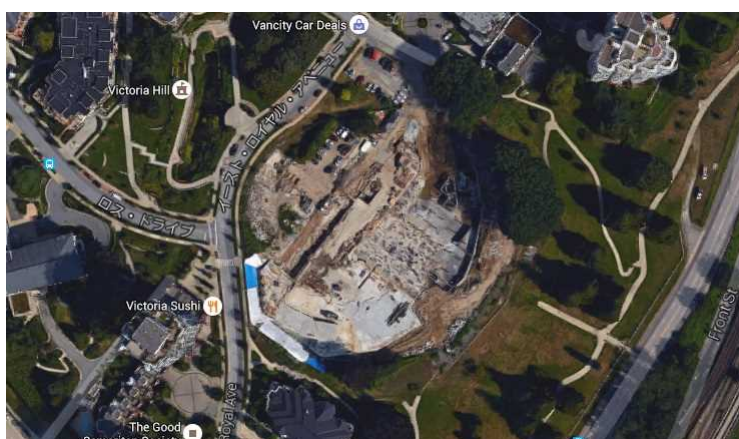
事例6.WOODLANDの閉鎖1981-1996

三島卓穂委員提供資料

虐待防止宣言するもだめ 廃止の方針から15年で閉鎖

- Woodlands. By the late 1970s there was a policy at Woodlands that abuse of residents, both children and adults, would not be tolerated 虐待は許容できない
 - -goals developed to meet the objective, will ensure respect for the residents' individual rights. It then follows that abuse of any kind inflicted on residents is not condoned. Management expects that staff will practice a humanitarian approach in the care-敬意を払い人間的な支援
 - Abuse of residents is forbidden by Woodlands, by Ministry policy and law. All incidents of abuse and/or suspected abuse must be reported 1978
- Due largely to the advocacy efforts of families, in 1981 the provincial government announced plans to close 政府は閉鎖を宣言Woodlands. Community placements were planned and implemented over the next 15 years. Woodlands finally closed in 1996, marking the culmination of a long struggle to end large institutions in B.C.

Woodland B.C. Canada



三島卓穂委員提供資料

Woodland B.C. Canada

- The 1940s saw a significant increase in staff training and the focus of **the institution shifted to education in the 1950s.**
- By the late 1950's there were approximately **1400** people living at Woodlands.
- Due largely to the **advocacy efforts of families,** in 1981 the provincial government announced plans to **close Woodlands.**

三島卓穂委員提供資料

Woodlands School Demolition In New Westminster Draws Sombre Audience Of Survivors

CP | By Tamsyn Burgmann, The Canadian Press

Posted: 10/18/2011 4:49 pm EDT | Updated: 12/18/2011 5:12 am EST



Flickr: Shoes on Wires



三島卓穂委員提供資料

Woodlands Institutionの監査報告

- the Province asked former BC Ombudsman Dulcie McCallum to conduct an independent review
- The report found that there was evidence of **physical, emotional and sexual abuse** at Woodlands, and that the **abuse was systemic in nature** - in other words, the way **Woodlands operated contributed to the occurrence of abuse**.
- ウッドランドの運営システムそのものが虐待を作り出した
- The former residents also called for the **demolition of the institution buildings** and a **role** for themselves in the demolition.過去の利用者は自分の手で破壊したいと言う

三島卓穂委員提供資料

woodland虐待の報告書

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During Home Agency Visit

三島卓穂委員提供資料

Woodland虐待の報告書

- Names of the residents and staff involved with incidents will remain private. Details of the physical abuse found in the records include
- hitting, kicking, smacking, slapping, striking, restraining, isolating, grabbing by the hair or limbs, dragging, pushing onto table, kicking and shoving, very cold showers and very hot baths resulting in burns to the skin, verbal abuse including swearing, bullying and
- belittling, inappropriate conduct such as extended isolation, wearing shackles and a belt-leash with documented evidence of the injuries including bruising, scratches, broken limbs, black eyes, and swollen face 手枷
- The sexual abuse included assault, intercourse and in the result, injuries and in a few cases, a pregnancy.

三島卓穂委員提供資料



事例GREENVILLEの閉鎖 2016-6

三島卓穂委員提供資料

閉鎖に抵抗 テネシーGreenville



三島卓穂委員提供資料

Greenville



三島卓穂委員提供資料

Greeneville 国は廃止、州は方向性出せず

- In small-town Greeneville — former home to President Andrew Johnson and The Band Perry — a 52-year-old facility for people with limited mental functioning **continues to operate despite a nationwide civil rights movement to end such segregated institutions** for people with disabilities.
- More than **100 people**, ranging in age from **29 to 91**, still live inside Greene Valley Developmental Center. At its peak there were more **than 1,000 residents**, but no one new has been admitted in three years. The state has **plans to move just a few people out**, even though outside experts have said **most residents would be better off living elsewhere**.
- **shutter** Greene Valley Developmental Center in Greeneville by **June 30, 2016**, moving the remaining 96 residents into more **home-like settings** integrated into neighborhoods.
- **Family members “do not want their loved ones to leave,”** he said. Many are concerned they will be placed in private agency-operated homes far from Greeneville, making it difficult to visit, he said. **家族は反対 遠くに行ったら会えない**
- It will be a big blow to the county if the center closes. Nearly 100 patients would be displaced and more than 600 jobs would be lost. As of November 2014, employment rate in Greene County is at 7.9 percent, the highest among all Tennessee counties in our area. **600人の雇用の喪失**

Greeneville 問題点 金と事故 虐待

- **Problems reported**
- Greene Valley has not come under **the same level of criticism as similar institutions** in Middle and West Tennessee, where **inspectors have found inadequate health care, abuse and neglect**. Two such institutions in West Tennessee have closed, and a third institution — Clover Bottom Developmental Center in Nashville — is slated to close in 2015. 虐待と健康管理の問題、ネグレクトは他の廃止した2施設と同じ。
- costs have been escalating at all of the state’s institutions. At Clover Bottom, that’s pushed the cost up to \$511,200 per person next year. **コストは高騰、一人51万ドル=6000万円**
- Inside the institution few problems reported by inspectors, **serious incidents** have occurred. **重大な問題が起きていても殆ど監視官には報告されず**
- Buster Borden, 55, died last year after he was placed on a rickety cart to be brought to a shower room. He fell from the cart, crashing his head on the floor and suffering injuries that shortly proved fatal. **運搬車でシャワーに行く途中に転落、骨折死亡**。The investigative report concluded that **Borden was the victim of neglect because the two workers “failed to use due care.”彼はネグレクトの犠牲だと監視官は報告した**

三島卓穂委員提供資料

Greeneville 移行プログラムなし 閉鎖 家族意向 13ホーム設置

- All state institutions remain under **the oversight of a federal court monitor** after the U.S. Department of Justice filed suit in the 1990s. 裁判所の監視下に置かれる
- the state agreed to improve conditions in facilities while giving residents **the choice to remain or leave**. 利用者に残るか去るかの選択を
- Most families have insisted they want their loved ones to stay at Greene Valley — or move to state-run intermediate-care facilities. 家族の希望は継続利用
- The state has built 13 homes at a cost of \$800,000 each to house former Greene Valley residents. 13ホームを建設

三島卓穂委員提供資料

Greeneville テネシー3年で何ダースもの死亡、閉鎖せずコスト倍

- **BROKEN TRUST' FINDINGS**信頼を裏切る結果
- • **Dozens of people with intellectual disabilities have died in state care in the past three years** after being released from institutions.
- 多くの死亡
- • Nearly half of the agencies caring for them failed to meet court-ordered standards in 2013. 法廷の要求水準を半分しか満たしていない
- • More **than 7,100** intellectually disabled people have been unable to get state services, some remaining on **waiting lists for decades**.
- 7100人以上がサービスを受けていない
- • Despite a state mandate, **no programs have been put** in place for people with developmental disabilities. プログラムが導入されていない
- • Tennessee taxpayers shoulder enormous costs as a result of the state's **slow pace in closing large institutions** for people with intellectual disabilities. Tennessee pays 50 percent more than the national average for people in such institutions. 州民は国に比較して50%以上高額に負担している

三島卓穂委員提供資料

判事が閉鎖を許可する

- Judge OKs closure of Greene Valley Developmental Center
- after a Department of Justice investigation uncovered widespread abuses, including inadequate medical care, abusive treatment, failure to provide education and insufficient staffing at state institutions. The facilities have been under the federal court's oversight since 1996. 司法省の捜査の結果、広範な虐待が発見された。これらのコロニーは、法の監視下に置かれている。
- A federal judge has approved a plan to close Tennessee's last remaining institution for people with limited mental functioning by **June 2016**, 判事がテネシー州の入所施設の廃止を承認
- The order clears the way **to close the Greeneville institution, ending an era in Tennessee of providing care to people with intellectual disabilities in large, state-run institutions.** 判決は、テネシー州の知的障害者のケアは大規模施設でないと明確にした
- *The state has closed two other large institutions in Memphis and Bolivar in the past 15 years. A fourth institution in Nashville, [Clover Bottom Developmental Center](#), will close in June. メンフィスとボリバーも廃止し、クローバーボトムも六月に閉鎖の予定。

三島卓穂委員提供資料

事例 8.イギリスの場合 どこも同じ 虐待—自浄—廃止

三島卓穂委員提供資料

2006 コーンウォール事件

- 発端:5家族の全国育成会への訴えから。息子は泣いて「嫌いだ」「送り返さないで」と親に頼む。
- 自閉症や身体障害の人16時間も車いすに拘束、冷水でのシャワー、食事の取り上げ、何時間もの部屋での監禁。
- 組織の隠蔽;両親は彼を殴ると噂される職員にあうと息子は驚く身振り。部屋替えの申し出は拒否。親が公的に争う姿勢を見せると事実はないと返答したが、裏では噂された職員は警告を受け異動していた。
- あいまいなはじめ:報告書では、経営者も諮問機関も他の広がり調べず5名が解雇で終わる。
- CSCI,(監査機関) 国全体でサービス点検すべき。

三島卓穂委員提供資料

2007 サットン・マートン事件

- 186名の知的障害。国でも最大の長期入所型病院。名門。
- 全てのサービスに問題
- 強姦も含め15の重大事故が2002から2005。7名の職員が虐待で退職。
- 厳格な食事体制と週4時間のみの運動許可も。部屋の共有。意見は聞かれない。専門家のサービスはない。拘束具使用のルールなし。人権擁護のルールなし。職員の不足、疾病率の高さ、施設内虐待は普通に。個人より施設のニーズが優先。事故報告も一般職員から提出なし。
- 前監査では、職員のレベルの向上、管理体制や研修を賞賛。施設側は、伝統の賜物と答えた。
- 監査
自己評価の後200近い項目のサービス点検を年内実施。
スタッフは強制的に訓練、人中心の支援プランを10月末までに受け取る。
拘束具の使用ルールを定める。
115人が長期間在院に疑問。全員が数週間内に外部移行が期待。

三島卓穂委員提供資料

また再発 当事者団体の進め方 MencapとCBFの提言 マンセル背景



1. 政府は大規模な施設を閉鎖せよ
2. 地域社会での暮らしが経済的に負担にならないと明言せよ
3. 政府は行動障害のある人が地域で暮らせる充実したサービスをする
4. 事業者は行動障害のある人達を支援できるという事を示し、適切な環境と職員を配置すると宣言すべし
5. CQC は知的障害の事業者に対して厳格な監査をすべき
6. 政府はCare Quality Commission (CQC)が Mansell reports に沿ったサービスをする機関とせよ
7. 政府は成人の虐待防止策を強化し、加害者には断固たる対応をして再発防止をせよ
8. 政府は強いリーダーシップで当たれ

三島卓穂委員提供資料

イギリス政府の進め方 イギリス厚生省の方針



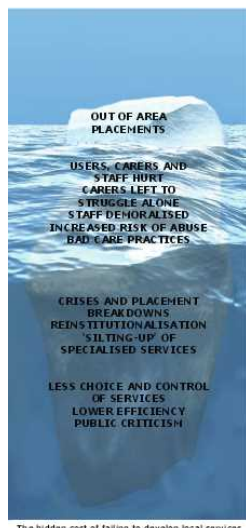
ケア担当大臣
Norman Lamb

勇気 雄弁 実行

- Government's [Winterbourne final report](#), 2012
- Concordat: Programme of Action ,2012

三島卓穂委員提供資料

1993,2007

マンセル レポートに沿って
いる

SERVICES
FOR PEOPLE
WITH
LEARNING
DISABILITIES
AND
CHALLENGING
BEHAVIOUR
OR MENTAL
HEALTH
NEEDS

(REVISED EDITION)



三島卓穂委員提供資料

①行動障害への予算を優先

②寄宿舍型は再検討する。長期型の入院施設は閉鎖

③家庭の息抜き

④個人にお金。

⑤大きな組織、家庭から離れた場は利用しない。個別化された質の高い生活を家庭でなく地域で準備。

⑥行動障害の人にデイの新しい機会。サポートで通学する

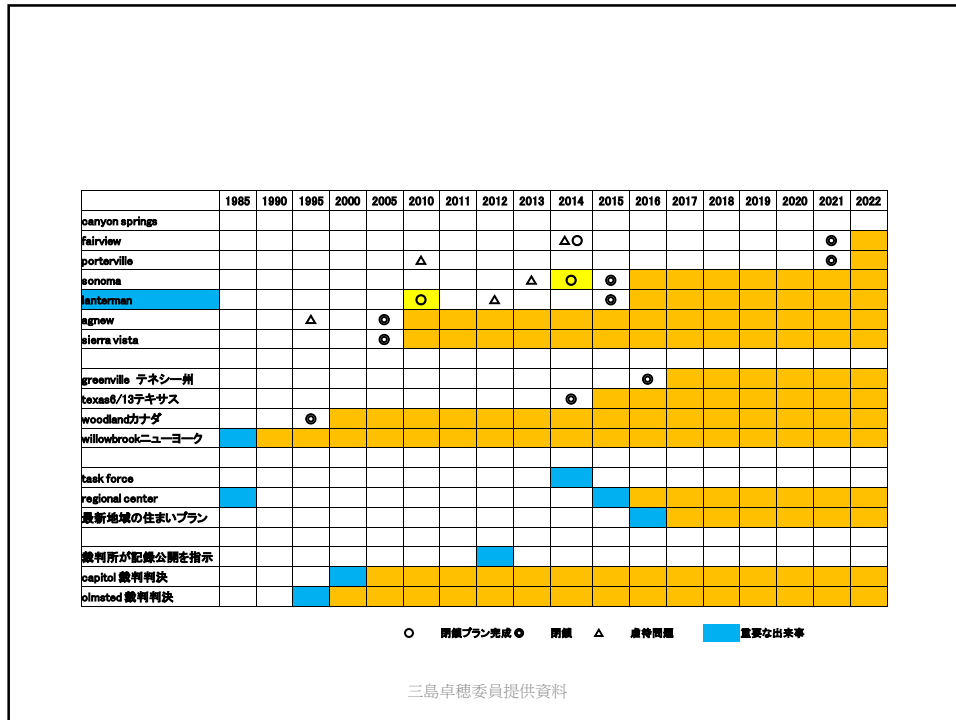
⑦多領域連携

⑧ 24時間、365日緊急サポート。⑨ 精神病院、短期、評価・治療を役割

考察

- ・コロニーは必然的に図1の構造を持つ
- ・そうした組織では、必然的に図2のような虐待がある。どこの国を見ても同じ。
- ・自浄作用を強めても困難。
- ・新しい流れが普遍的になっている 図3

三島卓穂委員提供資料



システムなので元を解決せねばダメ

入所施設の危険=虐待 高リスク						
↑	↑	↑	↑	↑	↑	↑
なんでもあり状態	支援者も上下関係暴力	人権侵害の隠匿	歪んだ人権意識	人権意識の低下	素人集団化・暴力的対応の追認	
↑	↑	↑	↑	↑	↑	↑
組織全体の無責任さ・ガバナンスの不在・現場の独走、職員の脱出、方針決定の遅れ	上下関係対応は無批判・上は絶対に安全	組織維持のロジックの優先	カルト文化の発生・人権意識変容	からかい文化の発生	人材の脱出、人材不足、人員不足現場ストレスの増加・追い詰められ鬱が攻撃	暴力的管理・ネグレクト優位
↑	↑	↑	↑	↑	↑	↑
自己保身期(各々自己利益優先)	施設長・職員・批判厳禁	組織入れ替わりなし	カルト化	ミッションの喪失・単調な生活・	財政的困難・ミッションの喪失	研修の無さ・孤立・コミの無さ・有効な方法が分からな
↑	↑	↑	↑	↑	↑	↑
組織の制度疲労	縦型社会の価値観(してやる)	隔離・密室性		自己完結性	存在基盤の転換(地域・契約・支援)	行動障害支援の難しさ

三島卓穂委員提供資料

大規模施設内では虐待が頻発

Facility Information

ID: 150000230
Name: SONOMA DEVELOPMENTAL CENTER D/P ICEDD

Entity Reported Incidents Information

Intake Received Date: 7/29/2011
Intake ID: CA00277555
Allegation Category: Quality of Care/Treatment
Investigation Finding: Substantiated

Intake Received Date: 7/12/2011
Intake ID: CA00275870
Allegation Category: Quality of Care/Treatment
Investigation Finding: Substantiated

Intake Received Date: 7/12/2011
Intake ID: CA00275919
Allegation Category: Resident/Patient/Client Abuse
Investigation Finding: Unsubstantiated

Intake Received Date: 6/9/2011
Intake ID: CA00272316
Allegation Category: Accidents
Investigation Finding: Substantiated

Intake Received Date: 6/6/2011
Intake ID: CA00271699
Allegation Category: Resident/Patient/Client Abuse
Investigation Finding: Substantiated

Intake Received Date: 5/20/2011
Intake ID: CA00269968
Allegation Category: Resident/Patient/Client Neglect
Investigation Finding: Substantiated

Intake Received Date: 5/6/2011
Intake ID: CA00268444
Allegation Category: Injury of Unknown Origin
Investigation Finding: Substantiated

Intake Received Date: 5/6/2011
Intake ID: CA00268446
Allegation Category: Resident/Patient/Client Neglect
Investigation Finding: Substantiated

Intake Received Date: 4/28/2011
Intake ID: CA00267597
Allegation Category: Quality of Care/Treatment
Investigation Finding: Substantiated

Intake Received Date: 4/13/2011
Intake ID: CA00266790
Allegation Category: Quality of Care/Treatment
Investigation Finding: Substantiated

Intake Received Date: 4/12/2011
Intake ID: CA00265697
Allegation Category: Resident/Patient/Client Abuse
Investigation Finding: Unsubstantiated

Intake Received Date: 4/12/2011
Intake ID: CA00266701
Allegation Category: Physical Environment
Investigation Finding: Unsubstantiated

Intake Received Date: 4/12/2011
Intake ID: CA00265707
Allegation Category: Resident/Patient/Client Abuse
Investigation Finding: Substantiated

Intake Received Date: 4/12/2011
Intake ID: CA00265716
Allegation Category: Resident/Patient/Client Abuse
Investigation Finding: Substantiated

Intake Received Date: 4/12/2011
Intake ID: CA00265734
Allegation Category: Injury of Unknown Origin
Investigation Finding: Substantiated

Intake Received Date: 4/11/2011
Intake ID: CA00265450
Allegation Category: Resident/Patient/Client Neglect
Investigation Finding: Substantiated

Intake Received Date: 4/11/2011
Intake ID: CA00265492
Allegation Category: Injury of Unknown Origin
Investigation Finding: Unsubstantiated

Intake Received Date: 4/11/2011
Intake ID: CA00265498
Allegation Category: Resident/Patient/Client Abuse
Investigation Finding: Substantiated

Intake Received Date: 3/21/2011
Intake ID: CA00263088
Allegation Category: Resident/Patient/Client Abuse
Investigation Finding: Unsubstantiated

Intake Received Date: 3/21/2011
Intake ID: CA00263105
Allegation Category: Resident/Patient/Client Neglect
Investigation Finding: Substantiated

Intake Received Date: 3/16/2011
Intake ID: CA00262470
Allegation Category: Injury of Unknown Origin
Investigation Finding: Unsubstantiated

Intake Received Date: 3/16/2011
Intake ID: CA00262475
Allegation Category: Quality of Care/Treatment
Investigation Finding: Substantiated

Intake Received Date: 3/16/2011
Intake ID: CA00262478
Allegation Category: Resident/Patient/Client Abuse
Investigation Finding: Substantiated

結論

- アメリカのコロニー閉鎖の実例を見た。施設から地域へという福祉パラダイム変換を目の当たりにした。
- 閉鎖の理由は、裁判所(法)の人権意識、内部の虐待の続発、運営費の高騰がある
- 虐待は、内部での自浄作用を期待したが、殆ど再発し解決能力はなかった。コロニー・施設というシステムに内在する性格だと判断され閉鎖に至った
- 閉鎖に至る職員、家族等の拒否反応はどこも共通であった
- それに代わる新しい地域での支援システムは、新たに拡大した「地域支援センターregional support center」を軸にした包括的な、多様なサービスである。特に行動障害・医療ニーズに対するCrisis-Home等は新しい概念である。
- コロニー職員の異動には丁寧な職場確保の対応がなされている

三島卓穂委員提供資料