

**Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2006**

Table of Contents

I.	Introduction and Overview	1
II.	Filing of CRIPA Complaints/Resolution of Lawsuits and Investigations	4
	A. Cases Filed	4
	B. Settlements in Cases Filed in Prior Fiscal Years	7
	C. Out of Court Settlements Addressing Deficiencies Identified in CRIPA Investigation	7
	D. Court Orders	8
III.	Prison Litigation Reform Act	9
IV.	Compliance Evaluations	9
V.	Enforcement Activities	12
VI.	Termination of CRIPA Consent Decrees and Partial Dismissal of Complaints	13
VII.	New CRIPA Investigations	13
VIII.	Findings Letters	14
IX.	Investigation Closures	15
X.	New Freedom Initiative	16
XI.	Technical Assistance	17
XII.	Responsiveness to Allegations of Illegal Conditions	18
XIII.	Juvenile Justice Activities	19

I. Introduction and Overview

The Attorney General has authority to investigate conditions in public residential facilities¹ and to take appropriate action if a pattern or practice of unlawful conditions deprives persons confined in the facilities of their constitutional or federal statutory rights, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. §§ 1997- 1997j.² With respect to juvenile justice, the Department has concurrent jurisdiction to conduct investigations pursuant to the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 and CRIPA. The Attorney General has delegated day-to-day responsibility for CRIPA activities (as well as § 14141) to the Civil Rights Division and its Special Litigation Section.

Protecting the rights of institutionalized persons is a priority in the Department's civil rights law enforcement effort. According to Assistant Attorney General of the Civil Rights Division, Wan J. Kim: "When a state places juveniles under its care, the state must protect those juveniles from harm. . . . "We applaud [jurisdictions] for working with us and acting promptly to implement the reforms embodied [by our settlement] agreement[s]."

The Division's commitment to the vigorous enforcement of CRIPA is evidenced by Fiscal Year 2006 activities under that statute: since January 20, 2001, the Division

¹ Institutions covered by CRIPA include nursing homes, mental health facilities, facilities for persons with developmental disabilities, residential schools for children with disabilities, jails, prisons, and juvenile justice facilities.

² CRIPA does not cover the federal statutory rights of persons in jails and prisons.

opened 67 CRIPA investigations, issued 53 findings letters, filed 22 cases, and obtained 53 substantial agreements.³

From May 1980, when CRIPA was enacted, through September 2006, the Division investigated conditions in 433 nursing homes, mental health facilities, centers for persons with developmental disabilities, residential schools for children with disabilities, jails, prisons, and juvenile justice facilities. As a result of the Department's CRIPA enforcement, thousands of persons residing in public institutions across our country no longer live in dire, often life-threatening, conditions.

At the end of fiscal year 2006, the Division was active in CRIPA matters and cases involving over 175 facilities⁴ in 34 states, the Commonwealths of Puerto Rico and the Northern Mariana Islands, and the Territories of Guam and the Virgin Islands.⁵ The Division continued its investigations of 77 facilities, and monitored the implementation of consent decrees, settlement agreements, memoranda of understanding, and court orders involving 99 facilities.⁶ During fiscal year 2006, the Division, accompanied by

³ These figures are for the period from January 2001 through January 2007.

⁴ This figure does not include the Division's monitoring of the District of Columbia community system for persons with mental retardation in Evans and United States v. Williams (D. D.C.), a pre-CRIPA suit.

⁵ Fiscal year 2006 began on October 1, 2005, and ended on September 30, 2006. This report is submitted to Congress to supplement the Attorney General's report on Fiscal Year 2006 Department activities by providing additional details about CRIPA actions during the fiscal year pursuant to 42 U.S.C. § 1997f.

⁶ In addition, the Division is monitoring compliance with court orders that cover persons who previously resided in institutions, but who currently reside in community based residential settings in Hawaii, Indiana, Iowa, Puerto Rico, Tennessee, and Wisconsin.

expert consultants, conducted 123 tours of facilities to evaluate conditions and monitor compliance.

The Division filed six institutional lawsuits involving 10 facilities while closing 5 cases involving 6 facilities during the fiscal year. The Division initiated 8 investigations of 12 facilities and issued eight findings letters regarding investigations of eight facilities during the fiscal year.⁷ In addition, during fiscal year 2006, the Division closed 2 investigations of 2 facilities.

In keeping with the statutory requirements of CRIPA and the Attorney General's initiative, the Division engaged in negotiations and conciliation efforts to resolve a number of CRIPA matters both before and after filing CRIPA cases. The Division maximized its impact and increased its efficiency by continuing to focus on multi-facility investigations and cases, obtaining widespread relief whenever possible. Lastly, pursuant to Section f(5) of CRIPA, the Division provides information regarding the progress made in each Federal institution (specifically from the Bureau of Prisons and the Department of Veteran's Affairs) toward meeting existing promulgated standards for such institutions or constitutionally guaranteed minima.

II. Filing of CRIPA Complaints/Resolution of Lawsuits and Investigations

A. Cases Filed

1. On November 9, 2005, the Division filed a complaint and settlement agreement in United States v. State of New Jersey (D. N.J.) regarding conditions at the Woodbridge Developmental Center in Woodbridge, New Jersey, a state-operated

⁷ The agreements and findings letters are available on the Division's website at <http://www.usdoj.gov/crt/split/index.html>.

facility for persons with developmental disabilities. The complaint alleged that the State engaged in unlawful patterns and practices, including failure to: provide residents with reasonable safety, protection from harm, and undue restraint; and, provide adequate medical and mental health care, physical and nutritional management, and therapeutic treatment. In addition, the complaint alleged that residents are not adequately evaluated for placement in the most integrated setting appropriate to each resident's individual needs. The Settlement Agreement requires that the State ensure timely and appropriate assessment of the need for medical, restorative, therapeutic, and mental health treatment to residents; utilize restraints only in accordance with generally accepted professional standards identified in federal statutes and guidelines; and provide residents with adequate nutrition, hydration, and mealtime assistance consistent with their individual needs. The decree requires that residents receive services in the most integrated setting appropriate to their needs consistent with Olmstead v. L.C. 527 U.S. 581 (1999)) and the Americans with Disabilities Act, 42 U.S.C. 12132 et seq. The Division continues to review the findings of the Compliance Monitor.

2. On February 8, 2006, the Division filed a complaint and settlement agreement⁸ in United States v. Indiana (S.D. Ind.) regarding conditions at Logansport Juvenile Intake/Diagnostic Facility in Logansport, Indiana and South Bend Juvenile Correctional Facility in South Bend, Indiana. The action resolved the Division's investigations into alleged pattern and practice violations involving the adequacy of protection of the youth from harm, mental health treatment, and special education

⁸ The Division initiated the investigation of the Indiana juvenile facilities pursuant to CRIPA and § 14141; court filings were pursuant to 42 U.S.C. § 14141.

services. The Settlement Agreement requires the State to provide: (1) a safe and humane environment and to ensure that youth are protected from harm, abuse and neglect; (2) adequate behavioral services; and (3) special education services which meet the requirements of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 et seq. The Division is monitoring compliance with the Agreement.

3. On February 9, 2006, the Division filed a complaint and settlement agreement in United States v. Hawai'i (D. Ha.)⁹ regarding a pattern and practice of inadequate conditions at the Hawai'i Youth Correctional Facility in Kailua, Hawai'i. This facility is owned and operated by the Hawai'i Department of Human Services. The Agreement requires the State to provide adequate protection from harm, specifically addressing suicide prevention, staff abuse and youth assaults; adequate correctional services through improved training and supervision of staff; access to timely and appropriate medical and mental health services; and adequate special education services to youths with disabilities. The Division is monitoring compliance with the Agreement.

4. On May 2, 2006, the Division filed a complaint and consent judgment in United States v. State of California (E.D. Cal.) alleging a pattern and practice of unconstitutional conditions at Metropolitan State Hospital and Napa State Hospital in Norwalk and Napa, California, respectively. In August 2006, the Division requested to amend the complaint and agreement to add the Atascadero and Patton State Hospitals

⁹ The Division initiated the investigation of Hawai'i Youth Correctional Facility pursuant to CRIPA and § 14141; the court filings were pursuant to 42 U.S.C. § 14141.

in Atascadero and San Bernadino, California, respectively.¹⁰ The remedies contained in this agreement will effect more than 5,000 residents of the hospitals. The agreement requires the State to provide adequate integrated therapeutic and rehabilitative services, protection from harm, healthcare services, and discharge planning and community integration. A monitoring team selected by both parties has begun to review compliance with the substantive terms of this agreement and will prepare written reports concerning progress toward compliance. The Division continues to monitor compliance with the settlement.

On July 21, 2006, the Division filed a complaint and settlement agreement in United States v. Vermont (D. Vt.) regarding conditions at the Vermont State Hospital in Waterbury, Vermont. The agreement requires the State to provide adequate mental health assessments, implement integrated therapeutic treatment plans; adequate psychiatric, psychological and pharmacy treatment services; adequate protection from harm, including the commitment to use restraint and seclusion only when consistent with generally accepted standards of professional care; and to provide adequate discharge planning and community integration for residents. The Division continues to monitor compliance with the Agreement.

On August 31, 2006, the Division filed a complaint and settlement agreement in United States v. Commonwealth of Kentucky (E.D. Ky.). The agreement, entered as a consent decree by the Court on September 13, 2006, addresses unlawful conditions found by the Division at the Communities of Oakwood, a state-run residential institution

¹⁰ The district court entered the amended agreement in February 27, 2007.

for persons with developmental disabilities in Somerset, Kentucky. The consent decree requires the State to protect Oakwood residents from harm, to provide improved services in the areas of psychiatry, neurology, medical, and nursing care, psychology, and other therapeutic services, adequate individualized care, and to ensure that each resident is served in the most integrated setting appropriate to his or her needs, consistent with the Americans with Disabilities Act. An Independent Monitor has been appointed to assess progress toward compliance. The Division continues to review progress at the facility.

B. Settlements in Cases Filed in Prior Fiscal Years

On February 18, 2005, the Division filed a complaint in United States v. Mercer County, New Jersey (D. N.J.) regarding conditions at Mercer County Geriatric Center in Trenton, New Jersey. On October 14, 2005, the Court entered the consent decree as a judgment of the court with respect to the Division's claims that the State failed to protect Mercer residents from harm and provide adequate medical and mental health care. The agreement provides that the State will ensure adequate therapeutic services, meal assistance, nutritional management and hydration; and provide services to residents in the most integrated setting appropriate to their individual needs. The Division will continue to monitor progress toward compliance in this case.

C. Out of Court Settlements Addressing Deficiencies Identified by CRIPA Investigations

1. On November 21, 2005, the Division entered into a settlement agreement with North Carolina regarding conditions in four state-operated mental health facilities. The agreement provides that the State will improve the assessment and treatment planning

processes for residents, ensure that residents with special needs, including persons with serious suicide risk, self-injurious behaviors, and/or dual diagnoses of mental illness and mental retardation, will be appropriately evaluated, treated and monitored. In addition, the State will improve medical and nursing services as well as pharmacological practices. The Division is monitoring progress toward compliance with the agreement.

2. On January 26, 2006, the Division entered into a settlement with the Nassau Health Care Corporation, owner-operator of the A. Holly Patterson Extended Care Facility in Uniondale, New York. This facility serves persons requiring chronic and long-term healthcare. The agreement provides that the Corporation will improve medical and mental health services to residents; provide adequate restorative and therapeutic services; provide adequate nutritional services and supports; and use restraints only when clinically justified or in an emergency, and only pursuant to generally accepted professional standards and federal law. The agreement also provides for the appointment of two monitors to review compliance. The Division continues to review progress in this matter.

D. Court Orders

1. The Division filed a complaint in United States v. Terrell County, Georgia (N.D. Ga.) in May 2004 regarding conditions at the Terrell County Jail in Georgia. Specifically, the government alleged that Terrell County jail officials failed to protect inmates from serious harm and undue risk of serious harm by failing to provide adequate safety, adequate medical and mental health care, adequate fire safety, and adequate sanitary living conditions. The Division filed a motion for summary judgement

in November 2005. On September 29, 2006, the Court granted the Division's motion for summary judgment, finding that conditions at Terrell County Jail were unconstitutional and dangerous, and that Jail officials disregarded the risks associated with these conditions "in more than a negligent manner."

III. Prison Litigation Reform Act

The Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626, which was enacted on April 26, 1996, covers prospective relief in prisons, jails, and juvenile justice facilities. The Division has defended the constitutionality of the PLRA and has incorporated the PLRA's requirements in the remedies it seeks regarding improvements in correctional facilities. For example, the consent decree filed in United States v. Mississippi (S.D. Miss.) on June 9, 2005, is PLRA compliant in that it contains the requisite admission of liability and requires only the minimum remedial measures needed to correct constitutional violations in the areas of protection from harm, and medical and mental health care.

IV. Compliance Evaluations

During fiscal year 2006, the Division monitored defendants' compliance with CRIPA consent decrees, settlement agreements, and court orders designed to remedy unlawful conditions in publicly operated facilities throughout the United States. These facilities are:

A. Facilities for persons with developmental disabilities: Southbury Training School (United States v. Connecticut (D. Conn.)); Arlington Developmental Center (United States v. Tennessee (W.D. Tenn.)); Clover Bottom Developmental Center, Greene Valley Developmental Center, and Harold Jordan Center (United States v.

Tennessee (M.D. Tenn.); Centro de Servicios Multiples Rosario Bellber (United States v. Commonwealth of Puerto Rico (D. P. R.)); Ft. Wayne Developmental Center and Muscatatuck Developmental Center (United States v. Indiana (S.D. Ind.)); Pinecrest Developmental Center and Hammond Developmental Center (United States v. State of Louisiana (E.D., La.)); New Lisbon Developmental Center (United States v. State of New Jersey (D. N.J.)); Oakwood Communities, Kentucky (U.S. v. Commonwealth of Kentucky (E.D. Ky.)); Glenwood Resource Center and Woodward Resource Center (United States v. Iowa (S.D. Iowa)); and, Woodbridge Developmental Center (United States v. New Jersey (D. N.J.));

B. Facilities for persons with mental illness: community mental health treatment services in Hawaii (United States v. Hawai'i (D. Haw.)); Guam Adult Mental Health Unit (United States v. Territory of Guam (D. Guam)); John Umsted Hospital, Dorothea Dix Hospital, Cherry Hospital, and Broughton Hospital (2005 Settlement); Metropolitan State Hospital and Napa State Hospital (United States v. California (M.D. Cal.)); Vermont State Hospital (United States v. Vermont (D.Vt.));

C. Nursing Homes: Nim Henson Geriatric Center (United States v. Breathitt County, Kentucky (E.D. Ky.)); and Banks-Jackson-Commerce Medical Center in Commerce, Georgia (2004 Settlement); Reginald P. White Nursing Facility (United States v. Mississippi (S.D. Miss.)); Mercer County Geriatric Center (United States v. Mercer County, New Jersey (D. N.J.)); and A. Holly Patterson Geriatric Center (2006 Settlement);

D. Juvenile justice facilities:¹¹ 30 juvenile justice facilities in Georgia (United States v. State of Georgia (N.D. Ga.)); Essex County Juvenile Detention Center (United States v. Essex County (D. N. J.)); 14 juvenile justice facilities in Puerto Rico (United States v. Commonwealth of Puerto Rico (D. P. R.)); Kagman Youth Facility (United States v. Commonwealth of the Northern Mariana Islands (D. N. Mar. I.)); Alexander Youth Services Center (United States v. Arkansas (E.D. Ark.)); Nevada Youth Training Center (2004 Settlement Agreement); Central Juvenile Hall, Los Padrinos Juvenile Hall, and Barry J. Nidorf Juvenile Hall, California (2004 Settlement Agreement); and Adobe Mountain School, Black Canyon School, and Catalina Mountain School (United States v. State of Arizona (D. Ariz.)); Maxey Training School in Lake Whitmore, Michigan (2005 Settlement); Oakley Training School and Columbia Training School (United States v. Mississippi (S.D. Miss.)); Charles H. Hickey Jr. School and Cheltenham Youth Facility (United States v. Maryland (D. Md.)); Logansport Juvenile Intake/Diagnostic Facility and South Bend Juvenile Correctional Facility (United States v. Indiana (S.D. Ind.)); and, Hawai'i Youth Correctional Facility (United States v. Hawai'i) (D. Haw.);

E. Jails: Hagatna Detention Center and Fibrebond Detention Facility (United States v. Territory of Guam (D. Guam)); Harrison County Jail (United States v. Harrison County (S.D. Miss.)); Simpson County Jail (Rainier and United States v. Jones (S.D. Miss.)); Sunflower County Jail (United States v. Sunflower County (S.D. Miss.)); four jails in the Northern Mariana Islands (United States v. Commonwealth of the Northern Mariana Islands (D. N. Mar. I.)); Muscogee County Jail (United States v. Columbus

¹¹ With respect to juvenile justice, the Division has concurrent jurisdiction to conduct investigations and cases pursuant to 42 U.S.C. § 14141 and CRIPA.

Consolidated City/County Government (M.D. Ga.); McCracken County Regional Jail (United States v. McCracken County, Kentucky (W.D. Ky.)); Nassau County Correctional Center (United States v. Nassau County, New York (E.D. N.Y.)); Shelby County Jail (United States v. Shelby County, Tennessee (W.D. Tenn.)); eight jails in Los Angeles County, California (2002 Settlement Agreement); Wicomico County Detention Center, Maryland (2004 Settlement Agreement); Santa Fe County Adult Detention Center (2004 Agreement); and LeFlore County Detention Center (United States v. LeFlore County, Oklahoma (E.D. Okla.));

F. Prisons: Guam Adult Correctional Facility (United States v. Territory of Guam (D. Guam)); Golden Grove Correctional and Adult Detention Facility (United States v. Territory of the Virgin Islands (D. V.I.)); Saipan Prison Complex (United States v. Commonwealth of the Northern Mariana Islands (D. N. Mar. I.)); and McPherson Correctional Facility and Grimes Correctional Facility, Arkansas (2004 Settlement Agreement);

G. Other Facilities: New Mexico School for the Blind and Visually Impaired (United States v. New Mexico (D. N. M.)).

V. Enforcement Activities

1. On March 23, 2006, the Court in United States v. Virgin Islands (D. V.I.) found the Territory in contempt of prior court's orders, including the 1986 consent decree, 1990 plan of compliance, and the 2003 stipulated agreement, for failing to improve prison conditions at the Golden Grove Adult Correctional Facility and Detention Center. The Court found ongoing constitutional violations of the rights of individuals held at the facility, particularly in the areas of corrections, medical and mental health care, fire

safety and sanitation. Based upon the Territory's long standing failure to implement the court's orders, the Court ordered the appointment of a Special Master to oversee compliance. The Division continues to review progress in this case.

VI. Termination of CRIPA Consent Decrees and Partial Dismissals of Complaints

When jurisdictions comply with settlement agreements or court orders and correct unlawful conditions in the institution, the Division joins with defendants to dismiss the underlying action. During fiscal year 2006, the Division joined with defendants to seek dismissal of all claims regarding the Southern and Central Developmental Centers (United States v. Wisconsin (E.D. Wis.); Morgan County Jail (United States v. Morgan County, Tennessee (E.D. Tenn.); Swanson Correctional Centers for Youth (United States v. Louisiana (E.D.La.); Memphis Mental Health Institute (United States v. Tennessee (W.D. Tenn.); and the Wyoming State Penitentiary (United States v. Wyoming (D. Wyo.).

VII. New CRIPA Investigations

The Division initiated 8 CRIPA investigations during fiscal year 2006. These new investigations involved the following facilities:

- Dallas County Jail, Texas;
- Connecticut Valley Hospital, Connecticut;
- Delaware Correctional Facilities, including:
 - Delaware Correctional Center
 - Howard R. Young Correctional Institution

Sussex Correctional Institution

John L. Webb Correctional Facility

Delores J. Baylor Womens' Correctional Facility;

- George W. Herlich Juvenile Detention Center, New Jersey;
- Evins Regional Juvenile Center, Texas;
- Oregon State Hospital, Oregon;
- Marion County Juvenile Detention Center, Indiana; and
- C.M. Tucker Nursing Care Center, South Carolina.

VIII. Findings Letters

During the fiscal year, the Division issued 8 written findings letters¹² regarding 8 facilities, setting forth the results of its investigations, pursuant to Section 4 of CRIPA, 42 U.S.C. § 1997b, including:

- Lanterman Developmental Center, California;
- Taycheedah Correctional Facility, Wisconsin;
- Ft. Bayard Nursing Facility, New Mexico;
- Atascadero State Hospital, California;
- Patton State Hospital, California;
- Sebastian County Adult Detention Center, Arkansas;
- St. Elizabeths Hospital, District of Columbia; and,
- Baltimore City Juvenile Justice Center, Maryland.

¹² The full text of these findings letters may be found at the Division's website at <http://www.usdoj.gov/crt/split/index.html>.

In these investigations, the Division made significant findings of constitutional deficiencies. For example, the Division's investigations of state facilities for persons with developmental disabilities revealed that inadequate treatment and training services contribute substantially to poor outcomes for residents, including poor progress in treating problem behaviors, increased risk of restrictive interventions, increased risk of injury and abuse and decreased opportunities for placement in the most integrated setting appropriate to individuals' needs. We found that facility staff in state juvenile justice facilities use excessive use of force to harm youth and that youth-on-youth violence occurs on an almost daily basis, at times resulting in injuries which require hospitalization. The Division also found systematically inadequate medical and mental health care, as well as inadequate special educational services in many of the juvenile justice facilities under investigation. The failure of a publicly operated juvenile facility to adequately supervise youth with appropriately trained correctional personnel places youth at risk of significant harm.

As envisioned by Congress, enforcement of CRIPA continues to identify egregious and flagrant conditions which subjects residents of publicly operated institutions to grievous harm.

IX. Investigation Closures

During the fiscal year, the Division did not close any investigations. Although the Division continued to review the conditions at various facilities under investigation, it did not find any investigations ripe for closure.

X. New Freedom Initiative

The Division also enforces Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131 et seq., and its implementing regulations 28 C.F.R.¶ 35.130(d), to ensure that public officials operating healthcare facilities are taking adequate steps to provide services to residents in the most integrated setting appropriate to their needs. In June 2001, President George W. Bush announced the New Freedom Initiative which set as a high priority for this Administration efforts to remove barriers to community placement for persons with disabilities. The executive order, "Community-based Alternatives for Individuals with Disabilities,"¹³ emphasized that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, and that the United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community. As part of the mandate to fully enforce Title II of the Americans with Disabilities Act, the Division took steps to secure increased access to residential, day, and vocational services where appropriate in fiscal year 2006 in the following facilities:

- Woodbridge Developmental Center, New Jersey;
- Connecticut Valley Hospital, Connecticut;
- Lanterman Developmental Center, California;
- Atascadero State Hospital, California;
- Patton State Hospital, California;
- Reginald P. White Nursing Facility, Mississippi;
- Glenwood and Woodward Resource Centers, Iowa;

¹³ Exec. Order No. 13217, 66 Fed. Reg. 33155 (June 18, 2001).

- Mercer Geriatric Center, New Jersey;
- Lubbock State School, Texas;
- Ft. Bayard Medical Center, New Mexico; and,
- St. Elizabeth Hospital, District of Columbia.

In the fiscal year, the Division monitored community placements or the community systems for persons with developmental disabilities in a number of states, including the District of Columbia (in a pre-CRIPA lawsuit), Indiana, Iowa, Puerto Rico, Tennessee, and Wisconsin, and for persons with mental illness in Hawai'i.

XI. Technical Assistance

Where federal financial, technical, or other assistance is available to help jurisdictions correct deficiencies, the Division advises responsible public officials of the availability of such aid and arranges for assistance, where appropriate. The Division also provides technical assistance largely through the information provided to jurisdictions by the Division's expert consultants. After the expert consultants complete on-site visits and program reviews of the subject facility, they prepare detailed reports of their findings and recommendations which provide important information to the facilities on deficient areas and possible remedies to address such deficiencies. In light of jurisdictions' cooperation, the Division routinely provides such reports to the jurisdiction. In addition, during the course of the investigatory tours, the Division's expert consultants provide helpful information to jurisdictions regarding specific aspects of their programs at no costs to the local or state government. These reports permit early intervention by local jurisdictions to remedy highlighted issues before a Findings Letter is forwarded.

In fiscal year 2006, the Division provided technical assistance in the process of enforcing CRIPA. For example, as part of the Division's investigation of the Shelby County Jail in Tennessee, the National Institute of Correction of the Department of Justice provided slots for training three Jail staff in gender-responsive corrections. In addition, to ensure timely and efficient compliance with settlement agreements, the Division issued numerous post-tour compliance assessments letters (and in some cases emergency letters identifying emergent conditions) to apprise jurisdictions of its compliance status. These letters routinely contain technical assistance and best practices recommendations.

XII. Responsiveness to Allegations of Illegal Conditions

During fiscal year 2006, the Division reviewed allegations of unlawful conditions of confinement in public facilities from a number of sources, including individuals who live at the facilities and their relatives, former staff of facilities, advocates, concerned citizens, media reports, and referrals from within the Division and other federal agencies. The Division received approximately 5,000 CRIPA-related citizen letters and hundreds of CRIPA-related telephone complaints during the fiscal year. In addition, the Division responded to over 135 CRIPA-related inquiries from Congress and the White House.

The Division prioritized these allegations by focusing on facilities where allegations revealed systemic, serious deficiencies. In particular, with regard to facilities for persons with mental illness or developmental disabilities and nursing homes, the Division focused on allegations of abuse and neglect; adequacy of medical and mental health care; use of restraints and seclusion; and services to institutionalized persons in the most integrated setting appropriate to meet their needs as required by Title II of the

Americans with Disabilities Act and its implementing regulations, 42 U.S. C. §§ 12132 et seq.; 28 C.F.R. § 35.130(d). With regard to juvenile justice facilities, the Division focused on allegations of abuse, adequacy of mental health and medical care, and provision of adequate rehabilitation and education, including special education services. In jails and prisons, the Division placed emphasis on allegations of abuse including sexual abuse, adequacy of medical care and psychiatric services, and grossly unsanitary and other unsafe conditions.

XIII. Juvenile Justice Activities

The welfare of our nation's youth confined in juvenile justice facilities has been a high priority for the Division. During Fiscal Year 2006 there were three investigations of juvenile justice facilities involving three facilities initiated, one findings letter issued, two settlement agreements approved, and two complaints filed. Through September 2006, this Administration has authorized 20 investigations of 23 juvenile justice facilities, issued 14 findings letters regarding 23 facilities, and obtained thirteen substantial agreements. For investigations alone, this represents a greater than 100 per cent increase in investigations than were authorized in the preceding six years.

The conditions in juvenile justice facilities is documented in the Division's work: A findings letter in one jurisdiction disclosed frequent instances of youth-on-youth violence, inadequate mental health services, and inadequate special education. The Division will sharpen its focus even more on conditions of confinement in juvenile justice facilities in the new fiscal year, seeking to implement remedial measures to protect and habilitate confined youth.