Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2003

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I. Introduction and Overview

The Attorney General has authority to investigate conditions in public residential facilities[1] 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] The Attorney General has delegated day-to-day responsibility for CRIPA activities to the Civil Rights Division and its Special Litigation Section.

Protecting the rights of institutionalized persons is an important part of the Department's civil rights law enforcement effort. According to the Assistant Attorney General of the Civil Rights Division, R. Alexander Costa, "Protecting the rights of America's most vulnerable citizens -- the elderly, children, victims of abuse, persons with mental illness or developmental disabilities, as well as others who are similarly defenseless -- is one of the Department's highest civil rights priorities. This Administration is firmly committed to vigorously enforcing CRIPA and rooting out systemic conditions of abuse and physical injury."

The Division's commitment to the vigorous enforcement of CRIPA is evidenced by recent activities under that statute: since January 20, 2001, the Division has opened 40 CRIPA investigations, issued 26 findings letters, filed six cases, and obtained 20

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[1] Institutions covered by CRIPA include nursing homes, mental health facilities, mental retardation facilities, 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.

substantial agreements.[3] For investigations alone, this figure is double the 20 such investigations over the preceding three years.

From May 1980, when CRIPA was enacted, through September 2003, the Division investigated conditions in 395 nursing homes, mental health facilities, mental retardation facilities, 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 2003, the Division was active in CRIPA matters and cases involving over 180 facilities[4] in 33 states and the District of Columbia, as well as 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 85 facilities, and monitored the implementation of consent decrees, settlement agreements, memoranda of understanding, and court orders involving 97 facilities.[6]

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[3] These figures are for the three year period January 2001 through mid-March 2004.

[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 2003 began on October 1, 2002, and ended on September 30, 2003. This report is submitted to Congress to supplement the Attorney General's report on Fiscal Year 2003 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, Pennsylvania, Puerto Rico, Tennessee, and Wisconsin.

During the fiscal year, the Division conducted 145 tours of facilities to evaluate conditions and monitor compliance.

The Division filed one institutional lawsuit during the fiscal year;[7] a consent agreement was entered in this case within one week of filing suit. The Division initiated 12 investigations and sent 18 findings letters regarding investigations of 24 facilities during the fiscal year.[8] In addition, during fiscal year 2003, the Division closed six investigations of six facilities. Four other facilities covered by CRIPA settlements were closed voluntarily by the jurisdictions.[9]

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, the Division consulted with public officials and provided technical assistance to a substantial number of jurisdictions to assist in the correction of deficient conditions.

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

A. Cases Filed

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[7] United States v. Arkansas (E.D. Ark.) was investigated under authority of CRIPA, but filed pursuant to 42 U.S.C. § 14141which provides the Department jurisdiction to bring suit regarding "the administration of juvenile justice."

[8] Many of the agreements and findings letters are available on the Division's website at http://www.usdoj.gov/crt/split/index.html.

[9] The Division also joined with defendants to dismiss Williams and United States v. Saffle (E.D. Okla.), a pre-CRIPA case involving conditions in 17 prisons in Oklahoma.

1. On March 10, 2003, the Division filed a complaint and settlement agreement in United States v. State of Arkansas (E.D. Ark.) concerning Alexander Youth Services Center in Alexander, Arkansas. The court entered the agreement on March 12, 2003. The agreement requires the State to revise the juvenile facility's suicide prevention policy and provide mental health treatment to all juveniles who require such care; provide fire safety and emergency procedures; provide the juveniles with educational opportunities that are available to other children in Arkansas; ensure that all students needing special education services receive those services; and safeguard the religious freedom of all juveniles. The Division is monitoring implementation of the settlement agreement and the State has made substantial progress towards compliance, particularly in the areas of suicide prevention and protecting religious freedom.

B. Settlements in Cases Filed in Prior Fiscal Years

1. On January 17, 2003, the Division filed a settlement agreement in United States v. Louisiana (M.D. La.). This agreement replaces a 1999 agreement that was set to expire and requires the State to enhance its efforts to reduce violence, expand staff training, and improve medical and mental health services at four juvenile justice facilities located in Tallulah, Baton Rouge, Monroe, and Bridge City, Louisiana. The court appointed an Independent Monitor who will assemble a team of juvenile justice experts to provide technical assistance to the State in operating the facilities, as well as review the State's compliance with the terms of the settlement. Additionally, on the basis of substantial compliance, the new agreement terminates the 1999 agreement

regarding educational services. The Division will continue to monitor compliance with the new agreement.

2. On January 23, 2003, the court in United States v. Hawaii (D. Haw.) entered as an order the Plan for Adult Community Mental Health Services that was negotiated by the parties under the guidance of the Special Master. The previous year, the court had ordered a Plan for services at Hawaii State Hospital. Relief under this plan is directed at those persons who have been discharged, diverted, or transferred from Hawaii State Hospital. The community plan requires improvements in five core areas of treatment and support services for persons in the Hawaii adult community mental health system, including: case management; crisis services; treatment services; housing; and rehabilitation services. Quality assurance mechanisms are also required by the plan. The Division will continue to monitor compliance with this Plan and the Plan for Hawaii State Hospital.

3. On February 25, 2003, the court entered the Third Supplemental Stipulation in United States v. State of New York (E.D. N.Y.) regarding Pilgrim Psychiatric Center in West Islip, New York. The agreement requires the State to provide more professional and direct care staff to provide care and treatment for all Pilgrim patients; reduce use of mandatory overtime; redesign treatment planning to provide more individualized treatment; improve medication administration practices; and serve patients in the most integrated setting appropriate to their needs. The Division will continue to monitor progress to ensure compliance with the original consent decree and the subsequent stipulations.

4. On March 13, 2003, the court entered a Stipulation amending the 1995 Consent Order in United States v. Sunflower County, Mississippi (S.D. Miss.) regarding Sunflower County Jail in Indianola, Mississippi. The Stipulation requires the County to correct deficiencies in the areas of classification procedures; operation and security, including improved suicide prevention practices; mental health and medical care; exercise; fire safety; inmate grievances; and maintenance and sanitation. The Division will continue to monitor the facility to ensure compliance with the Stipulation and the consent decree.

5. On April 30, 2003, the Division filed a joint agreement in United States v. Connecticut (D. Conn.), that was entered by the Special Master and the court, regarding requirements for speech, language, and communications services to persons with developmental disabilities who reside at Southbury Training School in Southbury, Connecticut. The Division will continue to monitor compliance with outstanding court orders at Southbury.

6. On September 25, 2003, the Division filed a Stipulated Agreement for further relief in United States v. Territory of the Virgin Islands (D. V.I.) regarding conditions at the Golden Grove Correctional and Adult Detention Facility in St. Croix, Virgin Islands. The Agreement requires the Territory to improve correctional practices; medical and mental health care; life safety; and sanitation. The Division will continue to monitor compliance with this agreement.

C. Out of Court Settlement Addressing Deficiencies Identified by CRIPA Investigation

1. On December 19, 2002, the Division signed a Memorandum of Agreement with Los Angeles County, California regarding mental health services provided to inmates at the Los Angeles County Jail. The agreement requires the County to make improvements in: mental health screening at intake; mental health evaluations for all inmates who screen positive for mental illness; referrals to a mental health professional; and mental health treatment of all inmates determined to be mentally ill. The agreement additionally calls for improvements in medication administration; suicide prevention; staffing and staff training; and environmental conditions. The Division is monitoring the progress in the County's jails to ensure compliance with the agreement. Since the agreement was signed, the County has instituted important reforms in regard to medicine administration and intake screening for mental illness.

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 settlement agreement filed in United States v. Arkansas (E.D. Ark.) in March 2003 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 mental health, education and religious liberty.

IV. Compliance Evaluations

During fiscal year 2003, 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.[10] These facilities are:

A. Facilities for persons with developmental disabilities: Southbury Training School (United States v. Connecticut (D. Conn.)); Embreeville Center (United States v. Pennsylvania (E.D. Pa.));[11] 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.)); Southern Wisconsin Developmental Center and Central Wisconsin Developmental Center (United States v. Wisconsin (W.D. Wis.)); Centro de Servicios Multiples de Camaseyes, and Centro de Servicios Multiples Rosario Bellber (United States v. Commonwealth of Puerto Rico (D. P. R.)); and Ft. Wayne Developmental Center and Muscatatuck Developmental Center (United States v. Indiana (S.D. Ind.)).

B. Facilities for persons with mental illness: Hawaii State Hospital and children and adolescent residential services at Queens Medical Center and Kahi Mohala Behavioral Treatment Center (United States v. Hawaii (D. Haw.)); Guam Adult Mental Health Unit (United States v. Territory of Guam (D. Guam)); Pilgrim Psychiatric Center

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[10] As noted on page 3, supra, four facilities were closed voluntarily by the jurisdictions; those facilities are not listed here, but are discussed infra at page 11.

[11] Embreeville Center closed during fiscal year 1998 but, under the terms of the consent decree, the Division continues to monitor conditions in community placements of former Embreeville residents.

(United States v. New York (E.D. N.Y.)); and Memphis Mental Health Institute (United States v. Tennessee (W.D. Tenn.)).

C. Juvenile justice facilities: 31 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.)); four juvenile justice facilities in Louisiana (United Stated v. Louisiana (M.D. La.)); and Alexander Youth Services Center (United States v. Arkansas (E.D. Ark.)).

D. Jails: Hagatna Detention Center and Fibrebond Detention Facility (United States v. Territory of Guam (D. Guam)); Tupelo City Jail (United States v. Tupelo City (N.D. Miss.)); Forest City Jail (United States v. Forest City (S.D. Miss.)); 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.)); Gila County Jail (United States v. Gila County, Arizona (D. Ariz.)); 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 Consolidated City/County Government (M.D. Ga.)); Morgan County Jail and Sheriff's Department (United States v. Morgan County, Tennessee (E.D. Tenn.)); 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.)); and Shelby County Jail (United States v. Shelby County, Tennessee (W.D. Tenn.)).

E. Prisons: Guam Adult Correctional Facility (United States v. Territory of Guam (D. Guam)); Montana State Prison (United States v. Montana (D. Mont.)); 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 Wyoming State Penitentiary (United States v. State of Wyoming (D. Wyo.)).

F. Other Facilities: New Mexico School for the Visually Handicapped (United States v. New Mexico (D. N. Mex.)).

V. Enforcement Activities

The Division took enforcement action in our CRIPA cases during the fiscal year where public officials failed to meet their legal obligations under consent decrees and other court orders.

1. On May 28, 2003, the Division filed a motion in United States v. Harrison County, Mississippi (S.D. Miss.) for an order to show cause why defendants should not be held in contempt for failure to comply with the 1995 consent decree regarding the Harrison County Jail in Gulfport, Mississippi. The Division's motion seeks to enforce provisions in the consent decree regarding protection from harm for inmates. The motion is pending before the court.

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 2003, the Division joined with defendants to seek

dismissal of all claims regarding educational services in four juvenile justice facilities in United States v. Louisiana (M.D. La.).

In addition, the Commonwealth of Puerto Rico voluntarily closed one juvenile justice facility in United States v. Commonwealth of Puerto Rico (D. P.R.) (Centro de Tratamiento Social), during the fiscal year. In a separate case, also United States v. Commonwealth of Puerto Rico (D. P.R.), the Commonwealth voluntarily closed three facilities for persons with developmental disabilities (Centro Servicios Integrales, Centro Residential Cayez, and Hospital de Mayaguez).

VII. New CRIPA Investigations

The Division initiated 12 CRIPA investigations during the fiscal year. These new investigations involved the following facilities:

- A. Holly Patterson Geriatric Center, New York;
- Conway Human Development Center, Arkansas;
- LeFlore County Jail, Oklahoma;
- Women's Eastern Reception and Diagnostic Correctional Center, Missouri;
- Santa Clara County Juvenile Hall, California;
- Nashville Metropolitan Bordeaux Hospital, Tennessee;
- Mobile County Metro Jail, Alabama;
- N.A. Chaderjian Youth Correctional Facility, California;
- Woodbridge Developmental Center, New Jersey;
- Oklahoma County Jail/Jail Annex, Oklahoma;
- Laguna Honda Hospital and Rehabilitation Center, California (state investigation); and

- Boston Higashi School, Massachusetts.

VIII. Findings Letters

During the fiscal year, the Division issued 18 written findings letters[12] setting forth the results of its investigations, pursuant to Section 4 of CRIPA, 42 U.S.C. § 1997b, regarding 24 facilities, including:

- Mercer County Geriatric Facility, New Jersey;
- Banks-Jackson-Commerce Medical Center and Nursing Home, Georgia;
- Oakwood Communities, Kentucky;
- Alexander Youth Services Center, Arkansas;
- Nevada Youth Training Center, Nevada;
- South Dakota Juvenile Justice Facilities:

  Custer Youth Correctional Center

  Girls' Boot Camp

  Patrick Henry Brady Boot Camp

  Quest Program
- Santa Fe County Adult Correctional Facility, New Mexico;
- Patrick County Jail, Virginia;
- Nim Henson Geriatric Center, Kentucky;
- New Lisbon Developmental Center, New Jersey;
- Los Angeles County Juvenile Justice Facilities, California:

  Barry J. Nidorf Juvenile Hall

[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.

Los Padrinos Juvenile Hall

Central Juvenile Hall

- Garfield County Jail and Garfield County Work Center, Oklahoma;
- LeFlore County Jail, Oklahoma;
- the Children and Adolescent Programs, Metropolitan State Hospital, Californinia;
- Laguna Honda Hospital and Rehabilitation Center, California;[13]
- Reginald P. White Nursing Home, Mississippi;
- Claudette Box Nursing Home, Alabama; and
- Mississippi Juvenile Justice Facilities:

  Oakley Training School

  Columbia Training School.

In these investigations, the Division made significant findings of constitutional deficiencies. For example, in the Division's investigation of state juvenile justice facilities, the Division found that staff hog-tied youth and shackled youth to poles in public places. Girls were punished for their suicidal behavior by being stripped and placed naked, for extended periods of time, in a windowless, empty cell called the "dark room," with only a hole in the floor to use as a toilet. Girls were forced to eat their own vomit if they threw-up while exercising in the hot sun. Staff used excessive force with impunity. Upon re-commitment to the facilities, youth were taken to the intake area and punched and slapped by staff as punishment for re-commitment. Abusive staff members

[13] This is the second findings letter sent to the City and County of San Francisco, California regarding this facility; the first was sent on May 6, 1998.

were not terminated because there was a severe staffing shortage. The dental clinic at one juvenile justice facility was full of mouse droppings, dead roaches, and cobwebs; medications in the cabinet had expired over 10 years ago.

At a state facility for persons with developmental disabilities, the Division found that several residents with developmental disabilities died as a result of medically ignored impacted bowels that ruptured, causing fecal matter to seep into their bloodstreams. In another facility for persons with developmental disabilities, a staff person stomped on the head of a resident, rendering the individual unconscious. In a psychiatric hospital, children were routinely drugged with powerful mind-altering medications, causing them to sleep, drool, shake, and, for boys, grow breasts. In a nursing home, staff kept residents sedated to avoid potential staff injuries. One nurse justified the use of an unsafe medication because without it, the nursing home resident "would come alive." One resident was fed through a feeding tube, a typically painful process, even though she could eat food by mouth with no difficulty.

In an investigation of a county jail, the Division found major lapses in security. In one instance, inmates seriously beat an inmate causing him to be in a coma for several days.

IX. Investigation Closures

During the fiscal year, the Division closed investigations of six facilities:

- Harold Taylor Restricted Custody Facility, Kentucky;
- Cape Girardeau County Jail, Missouri;
- Lee County Jail, Georgia;
- Black Hawk County Jail, Iowa;

- Tulsa County Jail, Oklahoma; and,
- Western State Hospital, Virginia.

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",[14] 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 2003 in the following facilities:

- Hammond and Pinecrest Developmental Centers, Louisiana;
- Five facilities for persons with developmental disabilities, Puerto Rico:

  Hogar de Grupo Las Mesas

  Facilidad de Cuidado Intermedia

[14] Exec. Order No. 13217, 66 Fed. Reg. 33155 (June 18, 2001).

Centro de Reeducacion para Adults

Centro de Servicios Multiples de Camaseyes

Centro de Servicios Multiples Rosario Bellber

- Arlington Developmental Center, Tennessee;
- Greene Valley Developmental Center, Tennessee;
- Clover Bottom Developmental Center, Tennessee;
- Harold Jordan Center, Tennessee;
- Oakwood Communities, Kentucky;
- New Lisbon Developmental Center, New Jersey;
- Metropolitan State Hospital, California; and
- Laguna Honda Hospital and Rehabilitation Center, California.

The Division is monitoring 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, Pennsylvania, Puerto Rico, Tennessee, and Wisconsin, and for persons with mental illness in Hawaii.

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. 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.

In fiscal year 2003, the Division provided numerous instances of technical assistance in the process of enforcing CRIPA. For example, as part of the Division's investigation of Bradley County Healthcare and Rehabilitation Center in Tennessee, the Division's expert consultants conferred with facility staff to discuss challenging cases and potential sources of assistance and relevant professional journal articles. As part of the investigation of Claudette Box Nursing Home in Mt. Vernon, Alabama, the Division's expert consultants provided assistance regarding medication practices, nursing services, and nutrition. For example, the expert consultants recommended that the facility provide adaptive dining utensils and train direct care staff to identify cues provided by residents to ensure safe swallowing during meals.

Officials from both the Maryland juvenile justice system, which is under investigation, and the Arkansas juvenile justice system, which is under a consent decree, visited programs operated by two of the Division's expert consultants in Michigan and Missouri; they met with youth and staff, and discussed program operations. In United States v. Arkansas (E.D. Ark.), the Division's fire safety consultant reviewed the State's plans for fire safety improvements to Alexander Youth Services Center in Arkansas and provided comments to State officials. In the investigation of Maxey Training School in Michigan, the Division provided technical assistance regarding education, fire safety,

juvenile justice management, and mental health and medical care. As part of the Division's compliance review of the Puerto Rico juvenile justice facilities in United States v. Commonwealth of Puerto Rico (D. P.R.), the Division provided suicide prevention advice including information regarding screening, safe housing, supervision, intervention, interdisciplinary communication, and post incident critical review. The Division's expert consultant later returned to the recently opened juvenile facilities in Puerto Rico to assess the implementation of the suicide prevention practices. As part of the Division's compliance review in United States v. Georgia (N.D. Ga.), the Division provided assistance to nurses of the Metro Regional Youth Detention Center on auditing the necessary medical services that must be provided in accordance with the Memorandum of Agreement in that case.

The Division's expert consultants provided comments on the development of a corrective action plan to address the deficiencies identified by the Division's investigation of the Los Angeles County Jails in California. The Division's expert consultants provided technical assistance to Mobile County Metro Jail in Alabama regarding security, administration, sanitation, and medical and mental health concerns. In United States v. Shelby County, Tennessee (W.D. Tenn.), the Division's expert consultants evaluated compliance with the Settlement Agreement and commented on proposed Shelby County Jail policies including the Jail's emergency evacuation plan, revised tool and key control policies, sick call protocols, and an inmate handbook. In response to a specific request from the County, the Division provided data from the Bureau of Justice Statistics regarding bond setting practices, and a referral to the National Institutes of Corrections. In United States v. Commonwealth of the Northern Mariana Islands (D. N. Mar. I.) the

Division's expert consultants offered technical assistance to remedy suicide risks in a newly constructed juvenile justice facility prior to occupancy. The Division's expert consultants also provided assistance on classification systems in United States v. Territory of Guam (D. Guam).

XII. Responsiveness to Allegations of Illegal Conditions

During fiscal year 2003, 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 well over 4,000 CRIPA-related citizen letters and hundreds of CRIPA-related telephone complaints during the fiscal year. In addition, the Division responded to over 195 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.