

**Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2005**

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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 R. Alexander Acosta, in reference to the Division's settlement of a nursing home matter during fiscal year 2005, "[institutionalized persons] deserve dignity and respect for their rights, and [w]hen a county takes responsibility for the care of, [institutionalized persons], it accepts responsibility to ensure that those [persons'] constitutional rights are protected."

The Division's commitment to the vigorous enforcement of CRIPA is evidenced by its activities under that statute: since January 20, 2001, the Division opened 57

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.

CRIPA investigations, issued 42 findings letters, filed 16 cases, and obtained 42 substantial agreements.³ For investigations alone, this figure represents more than a 24 percent increase over the 45 such investigations initiated over the preceding four and three quarter years.

From May 1980, when CRIPA was enacted, through September 2005, the Division investigated conditions in 420 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 2005, the Division was active in CRIPA matters and cases involving over 175 facilities⁴ in 32 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 76 facilities, and monitored the implementation of consent decrees, settlement agreements, memoranda of understanding, and court

³ These figures are for the period from January 2001 through September 2005.

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 2005 began on October 1, 2004, and ended on September 30, 2005. This report is submitted to Congress to supplement the Attorney General's report on Fiscal Year 2005 Department activities by providing additional details about CRIPA actions during the fiscal year pursuant to 42 U.S.C. § 1997f.

orders involving 99 facilities.⁶ During the fiscal year, the Division, accompanied by expert consultants, conducted 120 tours of facilities to evaluate conditions and monitor compliance.

The Division filed five institutional lawsuits involving seven facilities while closing three cases during the fiscal year. The Division initiated 11 investigations and issued nine findings letters regarding investigations of nine facilities during the fiscal year.⁷ In addition, during fiscal year 2005, the Division closed eight investigations of nine facilities. Two of these facilities were closed voluntarily by the State.⁸

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

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, Pennsylvania, Puerto Rico, Tennessee, and Wisconsin.

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

⁸ Baxter County, Arkansas closed its nursing home in fiscal year 2005. The State of Indiana voluntarily closed the New Castle State Developmental Center in fiscal year 2004, although the Division kept its investigation open longer to ensure that outstanding recommended medical measures which survived the physical closure of the site were fully implemented.

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 16, 2004, the Division filed a complaint and consent decree in United States v. State of Mississippi (S.D. Miss.) regarding conditions at the Reginald P. White Nursing Facility in Meridian, Mississippi, a state-operated nursing facility. The complaint alleged that the State engaged in unlawful patterns and practices, including failure to: provide residents with reasonable safety and protection from harm; ensure freedom from undue restraint; provide adequate medical and mental health care; and nutritional management and rehabilitative 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 consent decree, entered by the Court on November 23, 2004, requires the State to 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 required that residents shall be provided 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 monitor compliance with the consent decree.

2. On November 18, 2004, the Division filed a complaint and consent decree in United States v. Iowa (S.D. Ia.) regarding conditions at Glenwood Resource Center and Woodward Resource Center in Glenwood and Woodward, Iowa respectively. The action resolved the Division's investigations into alleged pattern and practice violations involving the adequacy of treatment and care at these facilities, both state-owned and operated residential facilities serving persons with developmental disabilities. The consent decree requires the State to provide: a safe and humane environment and ensure that residents are protected from harm, abuse and neglect; adequate medical, neurological and psychiatric care; adequate nutritional and physical support; adequate nursing, psychological, and behavioral services; and treatment in the setting most appropriate to the resident's individualized needs. The Division is monitoring compliance with the consent decree.

3. On February 18, 2005, the Division filed a complaint and a consent decree in United States v. Mercer County, New Jersey (D. N.J.) regarding a pattern and practice of inadequate conditions at the Mercer County Geriatric Center. This facility is owned and operated by Mercer County, New Jersey. The consent decree requires the County to: provide adequate safety, medical, mental health, and nursing care to residents; meet generally accepted professional standards regarding use of restraints; provide adequate nutrition, hydration, and mealtime dining assistance; provide adequate therapeutic, restorative and rehabilitative care for resident mobility and self-care; and provide services in the most integrated setting appropriate to the needs of each individual resident. The Division is monitoring compliance with the consent decree.

4. On June 30, 2005, the Division filed a complaint and a settlement agreement in United States v. State of Maryland (D. Md.)⁹ alleging a pattern and practice of unconstitutional conditions at Charles H. Hickey Jr. School in Baltimore, Maryland and the Cheltenham Youth Facility in Cheltenham, Maryland. The State of Maryland owns and operates both facilities. The agreement requires the State to: ensure that youth are protected from violence and other physical and sexual abuse by staff and other youth; fully implement the provisions of the State's suicide prevention policy; provide adequate medical, mental health and substance abuse treatment services; and ensure adequate special education services to students with disabilities. A monitoring team selected by both parties began 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 August 12, 2005, the Division filed a complaint and settlement agreement in United States v. LeFlore County, Oklahoma (E.D. Okla.) regarding conditions of confinement at the LeFlore County Detention Center in Poteau, Oklahoma. The jail is owned and operated by LeFlore County. The agreement, which was entered by the Court on August 22, 2005, requires the County to: ensure a reasonably safe environment at the Center by retaining adequate numbers of trained staff to afford security; provide adequate medical, mental health and dental care to inmates; and

⁹ The Division initiated the investigation of the Maryland juvenile facilities pursuant to CRIPA and § 14141; the court filings were pursuant to 42 U.S.C. § 14141.

improve the sanitation and food service areas within the Center. The Division continues to monitor compliance with the Agreement.

B. Settlements in Cases Filed in Prior Fiscal Years

On May 4, 2005, the Division filed a consent decree and settlement agreement in United States v. Mississippi (S.D. Miss.)¹⁰ regarding conditions at Oakley Training School and Columbia Training Schools in Raymond and Columbia, Mississippi respectively. On June 9, 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 youth from harm and provide adequate medical care. Substantive remedies in the consent decree addressed the use of force on youth, abuse and neglect, undue use of restraints, the use of a "dark room" for punitive isolation of girls at the Columbia facility, suicide prevention, and adequate medical and dental care. The Court also conditionally dismissed without prejudice pursuant to Fed. R. Civ. P. 41(a)(2), claims raised in the Division's complaint regarding mental health care, rehabilitation, and education. The agreement provided that the State will ensure adequate mental health care and rehabilitative services to youth with mental illnesses by providing adequate screening, assessment and treatment; and will provide special education services to youth with disabilities as required pursuant to the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400 et seq. A court-appointed Monitor will evaluate the steps taken by the State to comply with each substantive provision of the decree and settlement and report

¹⁰ The Division initiated the investigation of the Mississippi juvenile facilities pursuant to CRIPA and § 14141; the court filings were pursuant to 42 U.S.C. § 14141.

findings to the Court and the parties. The Division is continuing to review the progress the State is making toward compliance with the terms of the agreements.

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

1. On October 25, 2004, the Division entered into a settlement agreement with Santa Fe County, New Mexico regarding conditions of confinement at the Santa Fe County Adult Detention Center. The agreement requires the County to assure the safety of inmates in its custody by: improved staff training and supervision, adequate medical and mental health services including prompt screening, assessment and treatment; effective suicide prevention; and development and implementation of adequate correctional policies and procedures to ensure safety of inmates. The Division is continuing to monitor compliance with the agreement.

2. On November 8, 2004, the Division signed an agreement regarding the Nashville Metropolitan Bordeaux Hospital, in Nashville, Tennessee regarding the care and treatment of residents. The agreement addressed the need for improvements in the protection of the residents from harm; staff training; medical and mental health care; nutrition, diets and mealtime assistance; ongoing activities that assist each resident in attaining and maintaining functional skills; appropriate use of restraints, and services in the most integrated setting appropriate to individual resident needs. After the Division determined that the Hospital had achieved substantial compliance with the agreement, it closed the investigation on June 20, 2005.

3. On January 5, 2005, the Division signed an agreement with the State of Michigan regarding the conditions at the W.J. Maxey Training School in Whitmore

Lake, Michigan. The agreement requires the State to provide the youth at the facility with a reasonably safe living environment, adequate protection from harm; adequate medical and mental health services; special education; and appropriate use of restraint and isolation. The Division is continuing to monitor compliance with the agreement.

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, as referenced above, 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, medical and mental health care.

IV. Compliance Evaluations

During fiscal year 2005, 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.)); 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 Múltiples 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.)); and Oakwood Communities, Kentucky (2004 Settlement Agreement); Glenwood Resource Center and Woodward Resource Center (United States v. Iowa (S.D. Iowa)).

B. Facilities for persons with mental illness: community mental health treatment services in Hawaii (United States v. Hawaii (D. Haw.)); Guam Adult Mental Health Unit (United States v. Territory of Guam (D. Guam)); and Memphis Mental Health Institute (United States v. Tennessee (W.D. Tenn.)).

C. Nursing Homes: Bergen Regional Medical Center, (2002 Settlement Agreement); Nim Henson Geriatric Center (United States v. Breathitt County, Kentucky (E.D. Ky.)); and Banks-Jackson-Commerce Medical Center in Commerce, Georgia (2004 Settlement); Nashville Metropolitan Bordeaux Hospital in Nashville, Tennessee (2005

¹¹ Embreeville Center closed during fiscal year 1998 but, under the terms of the consent decree, the Division continued to monitor conditions in community placements of former Embreeville residents throughout fiscal year 2004 and until January 2005 when the case was dismissed by the district court.

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.)).

D. Juvenile justice facilities:¹² 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.)); 15 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.)); Jetson Juvenile Correctional Facility and Swanson Juvenile Correctional Facility (United States v. Louisiana (M.D. La.)); 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.)).

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

¹² With respect to juvenile justice, the Division has concurrent jurisdiction to conduct investigations and cases pursuant to 42 U.S.C. § 14141.

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.)); 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)); 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.)); Wyoming State Penitentiary (United States v. State of Wyoming (D. Wyo.)); and McPherson Correctional Facility and Grimes Correctional Facility, Arkansas (2004 Settlement Agreement).

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

V. Enforcement Activities

As described above (at p. 6), the Division filed a complaint and a settlement agreement in United States v. State of Maryland (D. Md.) alleging a pattern and practice

of unconstitutional conditions at Charles H. Hickey Jr. School in Baltimore, Maryland and the Cheltenham Youth Facility in Cheltenham, Maryland. The Division's investigation revealed substantial civil rights violations at both facilities, including a shocking level of staff assaults. The investigation found physical assault and neglect by both staff and other youths, resulting in serious physical harm including eye injuries, a broken jaw, and significant head wounds. The Division also found that basic services, such as medical care, mental health care, and suicide prevention measures, do not satisfy even minimal constitutional standards. The settlement agreement required the State to remedy the noted deficiencies, as well as to provide adequate medical/mental health and substance abuse treatment services. It also required the State to ensure adequate special education services to students with disabilities. The Division continues to monitor compliance with the settlement.

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 2005, the Division joined with defendants to seek dismissal of all claims regarding the Hawaii State Hospital in United States v. Hawaii (D. Hi.); all claims regarding the Embreeville Center in United States v. Pennsylvania (E.D. Pa.); and all claims regarding the Pilgrim Psychiatric Center in United States v. New York (E. D. N.Y.).

VII. New CRIPA Investigations

The Division initiated 11 CRIPA investigations during fiscal year 2005. These new investigations involved the following facilities:

- Atascadero State Hospital, California;
- Sebastian County Adult Detention Center, Arkansas;
- Lubbock State School, Texas;
- St. Elizabeth Hospital, District of Columbia;
- Scioto Juvenile Correctional Facility, Ohio;
- Taycheedah Correctional Institution, Wisconsin;
- Marion Juvenile Correctional Facility, Ohio;
- Ft. Bayard Medical Center, New Mexico;
- Oahu Community Correctional Center, Hawaii;
- Bellefontaine Developmental Center, Missouri; and,
- Baltimore City Juvenile Justice Center, Maryland.

VIII. Findings Letters

During the fiscal year, the Division issued 9 written findings letters¹³ regarding 9 facilities, setting forth the results of its investigations, pursuant to Section 4 of CRIPA, 42 U.S.C. § 1997b, including:

- Woodbridge Developmental Center, New Jersey;
- Grant County Detention Center, Kentucky;
- L.E. Rader Center, Oklahoma;
- Napa State Hospital, California;

¹³ The full text of these findings letters may be found at the Division's website at <http://www.usdoj.gov/crt/split/index.html>.

- Vermont State Hospital, Vermont;
- Hawaii Juvenile Correctional Facility, Hawaii;
- Logansport Juvenile Intake/Diagnostic Facility, Indiana;
- South Bend Juvenile Correctional Facility, Indiana; and,
- Plainfield Juvenile Correctional Facility, Indiana.

In these investigations, the Division made significant findings of constitutional deficiencies. For example, the Division's investigations of state juvenile justice facilities revealed that facility staff use excessive use of force to harm youth; staff engaged in inappropriate sexual relationships with incarcerated 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. In one facility investigated in fiscal year 2005, staff was unable to act to save a life. In this instance, one female youth attempted to kill herself by using a bra to hang herself from a bunkbed; a guard arrived at the cell, but became frightened and dropped his keys—a second youth then grabbed the keys, unlocked the door to the cell, and lifted up the unconscious youth so that pressure would be relieved on her neck. At the same time, on the same unit, another girl attempted suicide by tying a sheet around her neck and suspending it from a pole in her cell. The guard who discovered this suicide attempt was also assisted by another youth in removing the noose. We learned that the second

victim had cut herself 21 times earlier that day with a bra wire and had further attempted suicide two days earlier by cutting her wrist with a razor. Even with a recent history of self-harm, the facility did not provide adequate supervision. We also found that other youth at this facility use staples, toothpicks, plastic cups and pieces of broken tiles to cut into their faces, arms and legs, with full awareness of the staff charged with keeping youth safe. In all of these instances, staff were unable to appropriately handle the exigencies associated with youth with mental health issues.

In another investigation, completed during the fiscal year, we found that sexual activity among youth at another state operated juvenile justice facility is rampant. In one example, the facility documented incidents of overt sexual behavior involving over 20 youths on the same unit over the course of several months, occurring in movement lines, dayrooms, restrooms, recreation area, and a storage closet. Moreover, we noted the age and size disparity between many of the youths involved. Many males as young as 13 years old were involved in overt sexual activity with youths as old as 16 years; youths weighing under 70 pounds engaged in sexual acts with youths who outweighed them by more than one hundred pounds. Our findings indicate that the most glaring reason for the frequency of such behaviors is that the facility fails to provide sufficient staff to supervise the youth.

At a mental health facility we found that staff often fail to intervene with violent patients because the staff are afraid. In one example, a patient stabbed another in the face and back with an 11-inch "shank" made from an antenna. Four days earlier, the victim had told staff that he feared that he would be attacked. The State's regulatory agency concluded that the facility had failed to investigate the source or nature of the

threat identified by the victim, and it imposed a treble fine on the facility for its failure to protect the victim.

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 closed investigations of 9 facilities. The Division determined that conditions had substantially improved and closed the investigations of 7 facilities, including:

- Yavapai County Jails (2), Arizona;
- Bradley Healthcare and Rehabilitation Center, Tennessee;
- Bergen Regional Medical Center, New Jersey;
- Women's Eastern Reception and Diagnostic Center, Missouri;
- Nashville Metropolitan Bordeaux Hospital and Skilled Nursing Facility, Tennessee; and,
- Holly Center, Maryland.

Two additional investigations were terminated when the facilities were closed by their operators: Baxter County Nursing Home in Mountain Home, Arkansas and New Castle State Developmental Center in New Castle, Indiana.

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 2005 in the following facilities:

- Woodbridge Developmental Center, New Jersey;
- Reginald P. White Nursing Facility, Mississippi;
- Glenwood and Woodward Resource Centers, Iowa;
- Mercer Geriatric Center, New Jersey;
- Lubbock State School, Texas;
- Ft. Bayard Medical Center, New Mexico; and,
- St. Elizabeth Hospital, District of Columbia.

The Division is monitoring community placements or the community systems for persons with developmental disabilities in a number of states, including the District of

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

Columbia (in a pre-CRIPA lawsuit), Indiana, Iowa, 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. 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 2005, the Division provided numerous instances of technical assistance in the process of enforcing CRIPA. For example, as part of the Division's investigation of the Banks Jackson Commerce Medical Center and Nursing Home, the Division took an expert consultant in nursing to the facility and provided technical assistance to key clinical and administrative staff regarding fall prevention, incontinence care, dementia care and programming, skin care, end-of-life planning, and illness

detection. In addition, the consultant provided educational materials for the facility staff to consider.

Two separate technical assistance visits were made to the LeFlore County Detention Center in Oklahoma during the fiscal year at which expert consultants shared information concerning the drafting of new corrections and sanitation policies, as well as procedures for transitioning inmates into the soon-to-open new Jail.

XII. Responsiveness to Allegations of Illegal Conditions

During fiscal year 2005, 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 over 5,000 CRIPA-related citizen letters and hundreds of CRIPA-related telephone complaints during the fiscal year. In addition, the Division responded to over 130 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 2005 there were three investigations of juvenile justice facilities initiated, five findings letters issued, one settlement agreement approved, and one complaint filed. Overall, this Administration has authorized 17 investigations of 20 juvenile justice facilities, issued 13 findings letters regarding 22 facilities, and obtained ten substantial agreements. For investigations alone, this represents a greater than 100 per cent increase in investigations than were authorized in the preceding four and three quarter years.

The Division's work regarding the conditions in juvenile justice facilities is (highlighted in greater detail at pp. 15-16); it is also illustrated in the Division's issuance of a findings letter in one jurisdiction where frequent occurrences of sexual abuse at one male youth facility were disclosed. We found evidence of widespread self harm and numerous suicide attempts at another state juvenile facility. 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.