Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2009
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I. **Introduction and Overview**

The Civil Rights Division has a clear mandate to enforce those laws enacted by Congress to protect individuals' civil rights. Through our jurisdiction under the Civil Rights of Institutionalized Persons Act ("CRIPA"), the universe of individuals whose rights we are committed to protecting includes those individuals confined in public residential facilities - nursing homes, mental health facilities, facilities for persons with developmental disabilities, residential schools for children with disabilities, jails, prisons, and juvenile justice facilities.

During Fiscal Year 2009, the Division began an ambitious period of restoration and transformation in an attempt to restore some of the Division's core competencies, while also transforming the Division into one prepared to meet the civil rights challenges of the 21st century. As part of this restoration and transformation, the Division is recommitting to the aggressive enforcement of CRIPA in order to eradicate unconstitutional conditions to which individuals in public residential facilities are too often exposed.

In order to carry out enforcement of CRIPA, the Attorney General is authorized to investigate conditions in public residential facilities and take appropriate action if a pattern or practice of unlawful conditions deprives individuals confined in the facilities of their constitutional or federal statutory rights. As is required by the statute, the Division engages in negotiations and conciliation efforts to resolve issues of unconstitutional conditions both before and after filing CRIPA cases. In order to maximize its impact, the Division focuses on multi-facility investigations and cases in order to obtain widespread relief whenever possible. The Division also consults with public officials
and provides technical assistance to jurisdictions to help them correct deficient conditions.

In Fiscal Year 2009, the Division filed nine institutional lawsuits involving 29 facilities; closed three cases involving 32 facilities; and partially closed three cases involving six facilities. Also during Fiscal Year 2009, the Division initiated six investigations of six facilities and issued 11 findings letters regarding investigations of 44 facilities.

At the end of Fiscal Year 2009, the Division was active in CRIPA matters and cases involving 217 facilities in 33 states, the Commonwealths of Puerto Rico and the Northern Mariana Islands, and the Territories of Guam and the Virgin Islands. The Division continued its investigations of 89 facilities and monitored the implementation of consent decrees, settlement agreements, memoranda of understanding and court orders involving 87 facilities.

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 Veterans Affairs) toward meeting existing promulgated standards for such institutions or constitutionally guaranteed minima. (See attached statements.)

In Fiscal Year 2010 and beyond, the Division intends to continue aggressive investigation and enforcement under CRIPA. As part of those efforts, the Division will ensure that settlements reached under the law are strong enough to adequately address constitutional deficiencies. The Division has stopped the practice used frequently during the previous administration of entering into settlements that terminate on a pre-set deadline regardless of whether the jurisdiction has come into compliance.
with the law. Rather, we will work with jurisdictions to craft agreements that will bring them into compliance, and we will monitor those agreements closely to ensure constitutional deficiencies are remedied.

Additionally, the Obama Administration is committed to ensuring individuals with disabilities have the opportunity live in the most integrated community settings possible and the Division has stepped up efforts to enforce the Supreme Court decision in *Olmstead v. L.C.*, intervening in or filing amicus briefs in a number of cases. The Division plans to continue to ramp up its efforts in this area.

Individuals housed in public facilities are often among the least able to defend themselves against violations of their civil and constitutional rights. For this reason, the Division must work aggressively to uncover pervasive abuses of those rights. Efforts to ramp up the effective enforcement of CRIPA will be a priority as we continue our mission to restore and transform the Civil Rights Division.

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

A. **Cases Filed**

1. On December 29, 2008, the Division filed a Complaint in *United States v. State of Hawaii*, CV-08-00585 (D. Haw. 2008) regarding conditions at the Oahu Community Correctional Center (“OCCC”), a state operated correctional facility in Oahu, Hawaii. The Complaint alleged that the State engaged in unlawful patterns or practices at OCCC, including deliberate indifference to the mental health needs of detainees. The Agreed Order, entered by the Court on December 30, 2008, requires the State to cease the use of “therapeutic lockdown,” develop procedures that comport with generally accepted correctional standards regarding individualized seclusion and
restraint, and utilize the services of a qualified mental health professional to determine whether inmates’ mental health conditions should be considered in disciplinary actions. The Division continues to review compliance with the Agreed Order.

2. On January 15, 2009, the Division filed a Complaint in United States v. State of Georgia, 1:09-CV-0119 (N.D. Ga. 2009) regarding conditions and healthcare practices at the Georgia Regional Hospital in Atlanta, Georgia, a state-operated facility serving residents with mental illness and developmental disabilities. The Complaint alleged that the State failed to protect residents from serious harm and undue risk of serious harm by failing to provide adequate protection; medical and mental health supports, services, and treatment; and that the state has failed to provide services in the most integrated setting appropriate to individual needs. The Settlement Agreement, also filed on January 15, 2009, provides for reforms at all seven state facilities for persons with mental illness, including protection from harm, mental health care, seclusion and restraint practices, medical and nursing care, education, special education, limited English proficiency services, and discharge planning. The Court issued an order adopting the agreed remedies on February 11, 2009. The Division continues to monitor compliance with the Settlement Agreement in this case.

3. On January 15, 2009, the Division filed a Complaint and Settlement Agreement in United States v. King County, Washington, CV-9-0059 (W.D. Wash. 2009) regarding conditions and healthcare services at the King County Correctional Facility ("KCCF") in Seattle, Washington. Specific allegations include the

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1 Georgia state facilities that are covered by this Agreement include: Georgia Regional Hospital in Savannah, Northwest Georgia Regional Hospital, Central State Hospital, Southwest State Hospital, West Central Georgia Regional Hospital and East Central Georgia Regional Hospital.
County’s failure to: protect KCCF inmates from serious harm and undue risk of harm, including physical harm and custodial sexual misconduct, self-harm, and failing to provide adequate medical care. The Settlement Agreement, entered by the Court on February 26, 2009, requires improvements at KCCF in protection from harm, medical care, and suicide prevention practices. The Agreement also requires appointment of an Independent Monitor to verify compliance with implementation of the Settlement Agreement’s provisions. The Division continues to monitor progress toward compliance with the Agreement.

4. Likewise on January 15, 2009, the Division filed a Compliant and Settlement Agreement in United States v. State of South Carolina, 3:09-CV-98 (D. S.Car. 2009), resolving its CRIPA investigation involving the C.M. Tucker, Jr. Nursing Care Center ("Tucker Center") in Columbia, South Carolina. The Complaint alleged that the State failed to implement comprehensive healthcare plans for patients; adequately diagnose and treat Tucker Center residents with psychiatric illness; appropriately prescribe psychotropic medications; adequately manage residents’ pain and suffering; provide a safe and sanitary environment; ensure adequate nutrition and hydration; and provide service, supports, and treatment to residents in the most integrated setting appropriate to their individual needs. The Settlement Agreement, entered by the Court on February 17, 2009, requires the State to provide reforms in medical, mental health, and psychiatric care; adequate nutrition and hydration; adequate pain management and end-of-life care; adequate protection from harm, including falls; and adequate activities and psychosocial programs. In addition, the State and the South Carolina Department of Mental Health will ensure that Tucker
residents are being served in the most integrated setting appropriate to their needs. The Division continues to review progress towards compliance with the Agreement in the case.

5. On January 16, 2009, the Division filed a Complaint and two agreements in *United States v. State of Tennessee*, 1:09-CV-01012 (W.D. Tenn. 2009) regarding conditions and practices at the Tennessee State Veterans' Homes in Humboldt and Murfreesboro, Tennessee. The Complaint alleged that the State failed to provide residents with adequate nutrition and hydration, safe psychotropic medication practices, adequate pain management and end-of-life services, and a safe environment by protecting residents from unreasonable harm and risk of harm from falls. The Settlement Agreement, entered by the Court on January 20, 2009, requires the State to provide adequate nutrition, hydration, and mealtime assistance, to ameliorate the risk of residents' choking or aspirating on food or fluids; provide appropriate pain management and end-of-life services; adequate psychiatric and psychosocial care to residents; and reduce the risk of falls to residents. In addition, the Division and the State entered into a separate Agreement on January 16, 2009 in which the State agreed to make improvements to health care assessments and services, prevent pressure sores to residents, conduct adequate mortality and morbidity reviews, and provide adequate rehabilitative and restorative care. The Division continues to review progress toward compliance in this case.

The complaint alleged that the State of Arkansas maintains unconstitutional and unlawful conditions at CHDC, a facility for individuals with developmental disabilities, and violates the Due Process Clause of the 14th Amendment of the United States Constitution, the Americans with Disabilities Act, and the Individuals with Disabilities Education Act. The Division is actively litigating this case.

7. On January 20, 2009, the Division filed a Complaint and Settlement Agreement in United States v. State of Connecticut, 3:09-CV-00085 (D. Conn. 2009), regarding conditions and healthcare services at the Connecticut Valley Hospital in Middletown, Connecticut. The Complaint alleged that the State failed to provide residents with adequate protection from harm so as to ensure reasonable safety of residents, adequate treatment to prevent undue restraints, adequate psychological and psychiatric care, adequate suicide prevention, therapeutic services, and adequate discharge planning and community placement. The Settlement Agreement, entered by the Court on July 8, 2009, requires the State to improve integrated mental health treatment, ensure adequate protection from harm and risk of harm, reduce resident seclusion and restraint, and revise discharge planning services to determine the least restrictive setting to which each resident should be discharged. The Division continues to review progress toward compliance with the Agreement in the case.

8. On June 26, 2009, the Division filed a landmark Complaint and Settlement Agreement in United States v. State of Texas, A-09-CA-490 (E.D. Tex. 2009), regarding conditions, services, supports and treatment at 13 Texas State Schools for persons

2 The Texas State schools included in the case are: Abilene State School, Austin State School, Brenham State School, Corpus Christie State School, Denton State School, El Paso State Center, Lufkin State School, Lubbock State School, Mexia State (continued...)
with developmental disabilities. Specific allegations included: inadequate health care, including nursing, psychiatric, general medical services and physical therapy; inadequate physical and nutritional management; inadequate protection from abuse, neglect and other harm; inadequate therapeutic services and behavioral services; and the failure to provide services in the most integrated setting appropriate to residents’ individual needs. Under the Settlement Agreement, the State has agreed to undertake a variety of measures, including: providing a safe and humane environment with zero tolerance for abuse or neglect of residents; providing adequate medical care, nursing services, and nutritional and physical support, including therapy and communication support; providing adequate psychological and behavioral services and psychiatric care; providing adequate habilitation; providing adequate integrated protections, services, treatments, and supports; and ensuring that residents are free from undue bodily restraint. The State will also ensure that each resident is served in the most integrated setting pursuant to the Americans with Disabilities Act and the U.S. Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 581 (1999). In accordance with the Agreement, the Court has appointed a team of independent monitors to assess facility compliance with the Settlement Agreement. The Division continues to monitor progress towards compliance in this case.

9. On September 30, 2009, the Division filed a Complaint in United States v. Erie County, New York, 1:09-CV-000849 (W.D. N.Y. 2009), regarding conditions at the Erie County Holding Center, a pre-trial detention center in Buffalo, New York, and the

2 (...continued)
Erie County Correctional Facility, a correctional facility in Alden, New York. The Complaint alleged unconstitutional conditions at the facilities, including: staff-on-inmate violence, inmate-on-inmate violence, sexual misconduct between staff and inmates, sexual misconduct among inmates, inadequate systems to prevent suicide and self-injurious behavior, inadequate medical and mental health care, and serious deficiencies in environmental health and safety. The Division is actively litigating this case.

B. Court Orders

1. On September 30, 2009, in United States v. State of Tennessee, 92-2062 (W.D. Tenn. 2003), the District Court granted the State's motion to terminate the State's contract with Community Services Network, a private healthcare provider that the State created in 1999 as a remedy for the State's contempt in failing to provide adequate medical care for class members of the Arlington Developmental Center. The State is now permitted to provide medical and pharmaceutical services to class members through a branch of the State's Medicaid plan, but must meet its Court-ordered obligations to class members through that plan.

2. On August 17, 2009, in United States v. Commonwealth of Puerto Rico, 99-1435 (D. P.R.), the District Court ordered the Commonwealth to adequately fund programs and services required by persons with developmental disabilities, as required in the December 2008 Transition Order. In addition, the Court emphasized the need for the Commonwealth to address the vocational needs of such persons by hiring additional job coaches and job promoters, as well as to ensure better programs,
services, and protections to persons with developmental disabilities in the Commonwealth.

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 entered by the Court on November 7, 2007 in *United States v. Dallas County, Texas*, 3 07 CV1559-N (N.D. Tex.), 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 medical care, mental health care, and sanitation and environmental conditions. The Division filed no CRIPA consent decrees in correctional cases in FY2009.

IV. **Compliance Evaluations**

During Fiscal Year 2009, the Division monitored defendants' compliance with CRIPA consent decrees, settlement agreements, and court orders designed to remedy unlawful conditions in numerous publicly operated facilities throughout the United States. These facilities are:


B. Facilities for persons with mental illness: Guam Adult Mental Health Unit (United States v. Territory of Guam, 91-00-20 (D. Guam 1991)); John Umsted Hospital, Dorothea Dix Hospital, Cherry Hospital, and Broughton Hospital, North Carolina (2005 Settlement); Vermont State Hospital (United States v. Vermont, 2:06-CV-1431 (D. Vt. 2005)); Metropolitan State Hospital, Napa State Hospital, Atascadero State Hospital, and Patton State Hospital (United States v. California, 06-2667 GPS (M.D. Cal. 2006)); St. Elizabeths Hospital, (United States v. District of Columbia, 1:07-CV-0089 (D. D.C. 2007)); Georgia Regional Hospital in Atlanta, Georgia Regional Hospital in Savannah, Northwest Georgia Regional Hospital, Central State Hospital, Southwest State Hospital, West Central Georgia Regional Hospital, and East Central Georgia Regional Hospital, (United States v. State of Georgia, 1-09-CV-0119 (N.D. Ga. 2009); and Connecticut Valley Hospital (United States v. State of Connecticut, 3:09-CV-00085 (D. Conn. 2009)).


(2004 Settlement); LeFlore County Detention Center (United States v. LeFlore County, Oklahoma, 05-CV-339-SH (E.D. Okla. 2005)); Baltimore City Detention Center, Maryland (2007 Agreement); Dallas County Jail (United States v. Dallas County, Texas, 307 CV 1559-N (N.D. Tex. 2007)); Santa Fe County Adult Detention Center (United States v. Santa Fe County, New Mexico, 1:08-CV-00212 (D. N. Mex. 2008)); Garfield County Jail, Oklahoma (2008 Settlement); Wilson County Jail, Tennessee (2008 Settlement); Sebastian County Detention Center, Arkansas (2009 Settlement); and Grant County Detention Center, Kentucky (2009 Settlement).

V. Enforcement Activities

During the Fiscal Year, the Division continued its aggressive enforcement actions against recalcitrant jurisdictions to address their failure to achieve compliance with agreed-upon settlement remedies.

In July 2009, in United States v. Puerto Rico (9 4-2080 CCC (D. P.R. 1994)), for example, the Division filed a motion for contempt following failure by the Commonwealth of Puerto Rico to meet the terms of a January 2009 negotiated stipulation to hire adequate staffing. The motion addressed ongoing significant staff shortages at the ten juvenile facilities, which created dangerous conditions for the juveniles residing there, including youth-on-youth violence and intentional self-injury. The Court had not yet ruled on the Motion by the end of the Fiscal Year.

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 an institution, the Division joins with defendants to dismiss the underlying action. During Fiscal Year 2009, the Division joined with defendants to seek dismissal of all claims regarding 30 juvenile justice facilities in United States v. State of Georgia, 1-98-CV-836 (N.D. Ga.); New Lisbon Developmental Center in United States v. State of New Jersey, 04-CV-3708 (D. N.J.); and LeFlore County Detention Center in United States v. LeFlore County, Oklahoma. The Division also closed actions regarding six juvenile detention facilities: Charles H. Hickey School and Cheltenham School, in United States v. Maryland, 1:05-CV-01772 (D. Md.); Columbia Training School in United States v. State of Mississippi, 3:03-CV-1344-BN (D. Md.); Marion Juvenile Detention

VII. New CRIPA Investigations

The Division initiated six CRIPA investigations during Fiscal Year 2009. These new investigations involved the following facilities:

- Winn Correctional Center, Louisiana;
- Orange County Jail, California;
- Escambia County Jail, Florida;
- Marion County Jail, Florida;
- Maple Lawn Nursing Home, Missouri; and
- Leflore County Juvenile Detention Center, Mississippi.

VIII. Findings Letters

During the Fiscal Year, the Division issued 11 written findings letters regarding 44 facilities, setting forth the results of its investigations, pursuant to Section 4 of CRIPA, 42 U.S.C. § 1997b, including:

- Los Angeles County, California Juvenile Camps:
  
  Camp Afflerbaugh
  
  Camp David Gonzales
  
  Camp Karl Horton
  
  Camp Vernon Kirkpatrick

3 The full text of these findings letters may be found at the Division's website at http://www.usdoj.gov/crt/split/index.html.
Camp William Mendenhall
Camp Fred Miller
Camp John Munz
Camp Joseph Paige
Camp Glenn Rockey
Camp Louis Routh
Camp Joseph Scott
Camp Kenyon Scudder
Camp Gregory Jarvis
Camp Ronald McNair
Camp Ellison Onizuka
Camp Judith Resnick
Camp Francis J. Scobee
Camp Michael Smith, and
Dorothy Kirby Center;

- Texas facilities for persons with developmental disabilities:
  Abilene State School
  Austin State School
  Brenham State School
Corpus Christi State School
Denton State School
El Paso State Center
Lufkin State School
Mexia State School
Richmond State School
Rio Grande State Center
San Angelo State School, and
San Antonio State School;

- William F. Green State Veterans’ Nursing Home, Alabama;
- Mobile County Jail, Alabama;
- Northwest Georgia Regional Hospital, Georgia;
- Kings County Hospital Center, New York;
- Harris County Jail, Texas;
- Erie County, New York correctional facilities:
  - Erie County Correctional Center and
  - Erie County Holding Center;
- New York juvenile justice facilities:
  - Lansing Residential Center,
  - Louis Gossett, Jr. Residential Center,
  - Tryon Girls Center, and
  - Tryon Residential Center;
- Ancora Psychiatric Hospital, New Jersey; and
Orleans Parish Prison, Louisiana.

In these investigations, the Division made significant findings of constitutional deficiencies. As envisioned by Congress, enforcement of CRIPA continues to identify egregious and flagrant conditions that subjects residents of publicly operated institutions to grievous harm. 42 U.S.C. § 1997a (a).

IX. Investigation Closures

During the Fiscal Year, the Division closed investigations of three facilities. After thorough investigations, the Division determined that conditions had substantially improved at two facilities and closed the investigations, including: Wicomico County Detention Center in Maryland, and W.J. Maxey Training School in Michigan. The Division also terminated the investigation of Agnews Developmental Center in California after the State closed the facility.

X. New Freedom Initiative

The Division also is charged with the enforcement of 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\(^4\) avering that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, that the United States is committed to community-based alternatives for individuals with disabilities, and that the United States seeks to ensure that America’s community-based

programs effectively foster independence and participation in the community for Americans with disabilities. That Executive Order specifically directed the Attorney General to fully enforce Title II of the ADA, especially for the victims of unjustified institutionalization. On June 22, 2009 - the 10th anniversary of the Olmstead decision - President Barack Obama announced new initiatives to assist Americans with disabilities, and launched the “Year of Community Living” to identify improved access to housing, community supports, and independent living arrangements for persons with disabilities.5

During the Fiscal Year, 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 the following facilities:

- Woodbridge Developmental Center, New Jersey;
- New Lisbon Developmental Center, New Jersey;
- Connecticut Valley Hospital, Connecticut;
- Lanterman Developmental Center, California;
- Laguna Honda Hospital and Rehabilitation Center, California;
- Atascadero State Hospital, California;
- Patton State Hospital, California;
- Metropolitan State Hospital, California;
- Napa State Hospital, California;
- Reginald P. White Nursing Facility, Mississippi;

• Glenwood and Woodward Resource Centers, Iowa;
• Oakwood Community Center, Kentucky;
• Mercer Geriatric Center, New Jersey;
• Lubbock State School, Texas;
• Ft. Bayard Medical Center, New Mexico;
• St. Elizabeths Hospital, District of Columbia;
• Tennessee State Veterans' Homes;
• Clyde L. Choate Developmental Center, Illinois;
• Georgia mental health facilities:
  Georgia Regional Hospital - Atlanta
  Georgia Regional Hospital - Savannah
  Northwest Georgia Regional Hospital
  Central State Hospital
  Southwest State Hospital
  West Central Georgia Regional Hospital, and
  East Central Georgia Regional Hospital;
• Beatrice State Developmental Center, Nebraska;
• Bellefontaine Developmental Center, Missouri;
• Howe Developmental Center, Illinois;
• William F. Green State Veterans' Home, Alabama;
• Delaware State Psychiatric Center, Delaware;
• Kings County Hospital Center, New York;
• Denton State School, Texas;
• Rosewood Center, Maryland;
- Minnesota Veterans’ Home, Minnesota;
- Texas facilities for persons with developmental disabilities, including:
  Abilene State School
  Austin State School
  Brenham State School
  Corpus Christi State School
  El Paso State Center
  Lufkin State School
  Mexia State School
  Richmond State School
  Rio Grande State Center
  San Angelo State School, and
  San Antonio State School;
- Central Virginia Training School, Virginia;
- Ancora Psychiatric Center, New Jersey; and
- Maple Lawn Nursing Home, Missouri.

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, and Tennessee.

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 that provide important information to the facilities on deficient areas and possible remedies to address such deficiencies. The Division routinely provides such reports to cooperative jurisdictions. In addition, during the course (and at the conclusion of) 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 2009, the Division provided additional technical assistance in the process of enforcing CRIPA. In United States v. State of Georgia, 1:09-CV-0119 (N.D. Ga. 2009), the Division made expert consultants available in June and August 2009 in off-site meetings with state officials to discuss the state's implementation of the Settlement Agreement. Specifically, the discussion focused on improved policies and procedures in the areas of preventing patient-on-patient assaults, suicides, emergency and code-preparedness, and managing aspiration and choking risks; the second meeting emphasized developing community resources to provide a continuum of care for discharged patients and to avoid unnecessary admissions. In United States v. Territory of the Virgin Islands, 86-265 (D. V.I.), the Special Master provided the jurisdiction with two complete sets of standards from the American Correctional Association and the National Commission on Correctional Healthcare. The cost for these volumes came from the Special Master's budget, funded through the United States District Court overseeing the case. Although the Division's investigation of
conditions at the Minnesota State Veterans Home ("MSVH") in Minneapolis, Minnesota did not indicate extant unconstitutional conditions, the Division identified certain issues to the State about which it provided technical assistance. For example, the Division provided technical assistance to improve MSVH's falls prevention program, restorative care services, and staff training.

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 their compliance status. These letters routinely contain technical assistance and best practices recommendations.

XII. **Responsiveness to Allegations of Illegal Conditions**

During Fiscal Year 2009, the Division reviewed allegations of unlawful conditions of confinement in public facilities from a number of sources, including individuals who live at the facilities, relatives of persons living in facilities, former staff of facilities, advocates, concerned citizens, media reports, and referrals from within the Division and other federal agencies. The Division received over 3200 CRIPA-related citizen letters and hundreds of CRIPA-related telephone complaints during the Fiscal Year. In addition, the Division responded to nearly 55 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; and use of restraints and seclusion. Consistent with the requirements of 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), the Division also ensured that facilities provided services to institutionalized persons in the most integrated setting appropriate to meet their needs. Similarly, with regard to its work in 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. Finally, in relation to 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 2009, the Division issued findings letters regarding investigations of four juvenile justice centers in New York and 19 work camps operated by Los Angeles County in California, and initiated one new investigation regarding the Leflore County Juvenile Detention Center in Mississippi. At the end of
FY2009, the Division continued investigating or monitoring conditions in 52 juvenile justice facilities across the nation.