

Fiscal Year 2002 Activities Under
the
Civil Rights of Institutionalized
Persons Act

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 deprive 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 Protecting the rights of institutionalized persons is an important part of the Department's civil rights law enforcement effort. As Assistant Attorney Ralph F. Boyd, Jr. stated, "CRIPA investigations can literally address life and death issues in nursing homes and juvenile facilities, and the population protected by the statute is among society's most vulnerable - - the elderly, the mentally disabled, victims of abuse and children."³

From May 1980, when CRIPA was enacted, through September 2002, the Department investigated conditions in 384 jails,

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

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

³ Statement of Ralph F. Boyd, Jr., Assistant Attorney General for Civil Rights, before the Committee on the Judiciary, United States Senate, May 21, 2002.

prisons, juvenile correctional facilities, mental retardation and mental health facilities, nursing homes and residential schools for children with disabilities. 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.

The Attorney General has delegated day-to-day responsibility for CRIPA activities to the Special Litigation Section of the Civil Rights Division. At the end of the fiscal year, the Section was active in CRIPA matters and cases involving over 165 facilities⁴ 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 Section continued its investigations of 73 facilities, and monitored the implementation of consent decrees, settlement agreements, memoranda of understanding, and court

⁴ This figure does not include the Section's monitoring of 17 prisons or the community system for persons with mental retardation in the District of Columbia which are the subjects of pre-CRIPA suits.

⁵ Fiscal year 2002 began on October 1, 2001, and ended on September 30, 2002. This report is submitted to Congress to supplement the Attorney General's report on Fiscal Year 2002 Department activities by providing additional details about CRIPA actions during the fiscal year pursuant to 42 U.S.C. § 1997f.

orders involving 96 facilities.⁶ During the fiscal year, the Section conducted more than 130 tours of facilities to evaluate conditions and monitor compliance. The Attorney General filed three CRIPA suits involving a total of three facilities during the fiscal year; each suit was settled during the fiscal year. In addition, during fiscal year 2002, the Section closed 12 investigations of 14 facilities and joined with defendants to dismiss four cases involving four facilities. Ten other facilities covered by CRIPA settlements were closed voluntarily by the jurisdictions. The Section initiated investigations of 21 facilities, and sent three findings letters regarding investigations of four facilities during the fiscal year. Lastly, the Department consulted with local public officials and provided technical assistance to assist in the correction of deficient conditions.

In keeping with the statutory requirements of CRIPA and the Attorney General's initiative, the Section engaged in negotiations and conciliation efforts to resolve a number of CRIPA matters both before and after filing CRIPA cases. The Section

⁶ In addition, the Section 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, Pennsylvania, Indiana, Puerto Rico, Wisconsin, and Tennessee.

maximized its impact and increased its efficiency by continuing to focus on multi-facility investigations and cases, obtaining widespread relief whenever possible.

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

A. Cases Filed

1. On April 15, 2002, we filed a complaint and settlement agreement in United States v. State of Wyoming (D. Wyo.), concerning Wyoming State Penitentiary in Rawlings, Wyoming. The agreement requires defendants to correct deficiencies in medical care, mental health care, supervision, environmental health and safety, and fire safety. The agreement requires the State to provide additional medical and mental health services; improve medication administration practices; and increase correctional staff to supervise and operate the facility. In addition, the State agrees to improve fire safety at the Penitentiary through better training of staff, more frequent emergency evacuation drills, and appointment of a full time Life Safety Officer to oversee the fire safety program and monitor the readiness of fire detection and suppression equipment. The Department will continue to monitor progress toward full implementation of the agreement.

2. On April 22, 2002, the Department filed a complaint and settlement agreement in United States v. Nassau County, New York (E.D. N.Y.) concerning the Nassau County Correctional Center in East Meadow, New York. The agreement requires improvements to medical and psychiatric care, including initial health and mental health assessments, treatment for acute, emergency and chronic health conditions, infection control, medication management and crisis intervention, and inmate safety through improved use of force policies and practices. The agreement also requires that all correctional staff receive 160 hours of pre-service training on, inter alia, use of force and procedures for dealing with persons with mental health concerns. Finally, the agreement requires improved investigations of use of force allegations and incidents. The Department will continue to monitor progress toward full implementation of the agreement.

3. On August 12, 2002, we filed a complaint and settlement agreement in United States v. Shelby County, Tennessee (W.D. Tenn.) regarding the Shelby County Jail in Memphis, Tennessee. The settlement agreement addresses several areas in which inmates are placed at risk of serious harm from identified lapses in security practices. Improved supervision of inmates, revised use of force policies, staff training, and an improved classification system are required by the agreement. The County

also agreed to manage its population to prevent excessive overcrowding, and take steps to identify and control inmates who are members of organized gangs. Lastly, the agreement requires the County to augment its staff to ensure necessary and timely medical and mental health care to inmates as well as to provide improved fire safety practices. The Department will continue to monitor progress toward full implementation of the agreement.

B. Settlements in Cases Filed in Prior Fiscal Years

1. On December 10, 2001, a mediated settlement agreement that addresses problems relating to community based service providers for former residents of the Arlington Developmental Center in Arlington, Tennessee was filed in United States v. Tennessee (W.D. Tenn.). The State is required by the agreement to provide expanded staff training in community based facilities, improve opportunities for employment of class members, and implement revised individual service plans for the treatment and care of class members in their community based homes. The agreement also requires development of a closure plan for the Arlington facility to ensure appropriate planning for the transition of the remaining residents. In April and June, 2002, the court held a fairness hearing regarding the agreement. As the fiscal year closed, the court had not yet decided whether to approve the settlement.

2. On April 17, 2002, we filed a supplemental agreement in United States v. Connecticut (D. Conn.) regarding medical care and other clinical services provided to residents with developmental disabilities at Southbury Training School in Southbury, Connecticut. The agreement requires State officials to provide appropriate medical care, including neurological consultations and genetic evaluations, when necessary. We will continue to monitor implementation of this agreement.

3. On June 7, 2002, we filed a stipulation in United States v. Indiana (S.D. Ind.) that amends the State plan prepared in conjunction with the original settlement. The stipulation requires improvements in clinical supervision and management of services which include: general medicine, dentistry, psychology, psychiatry, nursing, and physical, speech, dietary and occupational therapy. The stipulation also requires design and implementation of a risk assessment system for persons determined to be at high risk for the following conditions: aspiration/gastroesophageal reflux disease, dysphasia, choking, seizures, dehydration, constipation, and injury from behavioral problems. Lastly, the State is required to provide expanded transitional supports for residents leaving state developmental centers and relocating to community based residential placements.

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

On March 20, 2002, the Department signed a Memorandum of Understanding with the Bergen County Improvement Authority in Paramus, New Jersey regarding conditions of care and treatment provided to residents in the Long Term Care Division of Bergen Regional Medical Center. The agreement requires improvements in the following areas: identification and treatment of residents at risk of developing pressure ulcers; fall and accident prevention; hydration of residents; restorative care; personal hygiene services; and developing and implementing individual care plans. The agreement also requires the nursing home to reduce its use of restraints. As part of the quarterly assessment, each resident at the facility will be evaluated to determine whether he or she is being served in the most integrated setting appropriate to meet his or her individual needs. The Department will continue to monitor compliance with the terms of the agreement.

III. Compliance Evaluations

During fiscal year 2002, the Special Litigation Section 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.⁷ These facilities are:

A. Mental retardation facilities: Southbury Training School (United States v. Connecticut (D. Conn.)); Embreeville Center (United States v. Pennsylvania (E.D. Pa.));⁸ 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 de Camaseyes, Hogar de Grupo Las Mesas, Facilidad de Cuidado Intermedio, Centro de Reeduación para Adultos, and Centro de Servicios Múltiples 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.)).

⁷ As noted on page 2, supra, the Department joined with defendants to seek full or partial dismissal of four cases covering four facilities; those facilities are not listed here, but are discussed infra at page 10.

⁸ Embreeville Center closed during FY 1998 but, under the terms of the consent decree, the Section continues to monitor conditions in community placements from the facility.

B. Mental health facilities: Hawaii State Hospital and children and adolescent residential services at Castle Medical Center and Kahi Mohala (United States v. Hawaii (D. Haw.)); Guam Adult Mental Health Unit (United States v. Territory of Guam (D. Guam)); Pilgrim Psychiatric Center (United States v. New York (E.D. N.Y.)); Memphis Mental Health Institute (United States v. Tennessee (W.D. Tenn.)).

C. Juvenile Correctional Facilities: 31 juvenile correctional facilities in Georgia (United States v. State of Georgia (N.D. Ga.)); Essex County Youth House (United States v. Essex County (D. N. J.)); 15 juvenile correctional facilities in Puerto Rico (United States v. Puerto Rico (D. P. R.)); Kagman Youth Facility (United States v. Commonwealth of the Northern Mariana Islands (D. N. Mar.I.)); and four juvenile correctional facilities in Louisiana (United States v. Louisiana (M.D. La.)).

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, Tenn. (E.D. Tenn.)); and McCracken County Regional Jail (United States v. McCracken County, Kentucky (W.D. Ky.)). In addition, we are monitoring compliance with the out-of-court voluntary settlements regarding Black Hawk County Jail in Waterloo, Iowa and Tulsa County Jail in Tulsa, Oklahoma.

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 Adult Correctional Institution (United States v. Virgin Islands (D. V.I.)); and Saipan Prison Complex (United States v. Commonwealth of the Northern Mariana Islands (D. N. Mar. I.)).

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

IV. Enforcement Activities

The Department took enforcement action in our CRIPA cases during the fiscal year where state officials failed to meet their legal obligations under consent decrees and other court orders in CRIPA cases to improve conditions of confinement.

On February 19, 2002, the court in United States v. Hawaii (D. Haw.) entered the Hawaii State Hospital Remedial Plan for Compliance as an order. This plan, developed by the Special Master, a "summit" of mental health experts, and the parties, addresses deficiencies which remained unresolved more than a decade after the parties completed the first settlement agreement. The 2002 Plan specifies actions which need to be taken to build a system at Hawaii State Hospital which fosters adequate patient care and achieves full compliance with outstanding court orders. These actions require Hawaii State Hospital to ensure that patients receive sufficient and appropriate care, treatment, supervision and safety; are protected from physical and psychological harm; are restrained or secluded only when clinically appropriate; and are continuously evaluated for progress toward meeting discharge criteria. We will continue monitoring progress by Hawaii officials in complying with the Plan. As plaintiff, we have been vigilant in seeking effective remedies to achieve compliance in this case.

V. 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 correctional facilities. The Department has defended the constitutionality of the PLRA and has

incorporated the PLRA's requirements in the new remedies it seeks regarding improvements in correctional facilities.

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 Department joins with defendants to dismiss the underlying action. During fiscal year 2002, the Department joined with defendants to seek dismissal of four cases covering four facilities. On October 4, 2001, the court approved our motion to dismiss United States v. Commonwealth of Virginia (E.D. Va.) regarding Central State Hospital in Petersburg, Virginia. On November 7, 2001, the court approved our motion to dismiss United States v. City of Philadelphia (E.D. Pa.) regarding the Philadelphia Nursing Home in Pennsylvania. On November 27, 2001, the court entered an order of dismissal in United States v. Crittenden County, Arkansas (E.D. Ark.) regarding the Crittenden County Jail in Marion, Arkansas. On January 14, 2002, the court dismissed United States v. Grenada County, Mississippi (N.D. Miss.) regarding Grenada County Jail in Grenada, Mississippi.

In addition, jurisdictions voluntarily closed two juvenile correctional facilities in United States v. State of Georgia (N.D. Ga.) (Wrightsville Youth Development Center and Irwin Youth

Development Center), and eight juvenile correctional facilities in United States v. Commonwealth of Puerto Rico (D. P.R.) (Hato Rey Day Treatment Center, Ponce Day Treatment Center, CENA Barbosa, CENA Canovanas, CENA Rio Grande, Escuela Industrial Ponce, Hogar Crea Juana Diaz and Centro de Detention Hato Rey), during the fiscal year.

VII. Responsiveness to Allegations of Illegal Conditions

During fiscal year 2002, the Special Litigation Section 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, and former staff of facilities, advocates, concerned citizens, media reports, and referrals from within the Department and other federal agencies. The Section received approximately 6,200 incoming citizen letters and more than 500 telephone complaints during the fiscal year. The majority of these citizen contacts related to CRIPA complaints. In addition, the Division responded to over 140 CRIPA-related inquiries from Congress and the White House.

The Section prioritized these allegations by focusing on facilities where allegations revealed systemic, serious deficiencies. In particular, with regard to mental health and mental retardation facilities and nursing homes, the Section 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 regulations, 42 U.S. C. §§ 12132 et seq.; 28 C.F.R. § 35.130(d). With regard to juvenile correctional facilities, the Section 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 Section placed emphasis on allegations of abuse, sexual misconduct, adequacy of medical care and psychiatric services, and grossly unsanitary and other unsafe conditions.

VIII. New CRIPA Investigations

The Department initiated CRIPA investigations of 21 institutions during the fiscal year. These new investigations involved the following facilities:

- Patrick County Jail, Virginia;
- Nevada Youth Training Center, Nevada;
- Mercer County Nursing Home, New Jersey;
- Nim Henson Geriatric Center, Kentucky;
- Reginald P. White Nursing Facility, Mississippi;
- New Lisbon Developmental Center, New Jersey;
- Santa Fe County Correctional Facility, New Mexico;

- Metropolitan State Hospital, California;
- Alexander Youth Services Center, Arkansas;
- Mississippi Juvenile Facilities:
 - Oakley Training School;
 - Columbia Training School;
- Arkansas Prisons:
 - McPherson Correctional Facility;
 - Grimes Correctional Facility;
- Maxey Training School, Michigan;
- Arizona Juvenile Facilities:
 - Adobe Mountain School;
 - Black Canyon School;
 - Catalina Mountain School;
- Garfield County Jail, Oklahoma;
- Maryland Juvenile Facilities:
 - Charles H. Hickey, Jr. School;
 - Cheltenham Youth Facility; and
- Claudette Box Nursing Facility, Alabama.

IX. Findings Letters

The Department issued written findings of the results of its investigations, pursuant to Section 4 of CRIPA, 42 U.S.C. § 1997b, regarding four facilities:

- Woodward and Glenwood Resource Centers, Iowa;

- Baltimore City Detention Center, Maryland; and
- Wicomico County Detention Center, Maryland.

X. Investigation Closures

During the fiscal year, the Section closed investigations of 14 facilities:

- Chicago-Read Mental Health Facility, Illinois;
- Lauderdale County Jail, Mississippi;
- Calhoun County Jail, Georgia;
- South Dakota Juvenile Facilities⁹;
 - South Dakota State Training School;
 - South Dakota Juvenile Prison;
- Daviess County, Kentucky Juvenile Facilities⁹;
 - E. Robert Goebel Secure Juvenile Detention

Facility;

- Louis Johnson Youth Alternative Center;
- Whitten Developmental Center, South Carolina;
- Wayne County Juvenile Detention Facility, Michigan;
- Clark County Detention Center, Nevada;
- Dickens County Correctional Center, Texas;
- Jackson County Correctional Center, Florida;

⁹ We closed the investigations of the identified facilities in South Dakota and Daviess County, Kentucky because the facilities closed.

- Easterling Correctional Facility, Alabama; and
- Julia Tutweiler Correctional Facility, Alabama.

XI. Technical Assistance

Where federal financial, technical, or other assistance is available to help jurisdictions correct deficiencies, the Department advises responsible public officials of the availability of such aid and arranges for assistance, where appropriate. We also typically provide technical assistance through expert consultants we retain. We identify examples of the technical assistance we provided during the fiscal year in this section. We provided technical assistance in the area of mental health services by our expert consultants to Hawaii State Hospital and Western State Hospital in Virginia. Similarly, we provided technical assistance through our expert consultants in developing improved policies and procedures governing services to persons with developmental disabilities at Fort Wayne and Muscatatuck State Developmental Centers in Indiana, as well as Glenwood and Woodward Resource Centers in Iowa. In the Indiana case, we also suggested that defendants contact University Affiliated Facilities and nationally recognized experts to obtain additional information on services and supports for residents of their facilities. As part of our investigation of Laguna Honda Hospital and Rehabilitation Center in California, a nursing

facility, we responded to the City and County of San Francisco's request for information regarding federal assistance to provide services to individuals with disabilities in the most integrated setting appropriate to their needs pursuant to Title II of the Americans with Disabilities Act, 42 U.S.C. 12131 et seq. The Division provided San Francisco with information about programs and initiatives undertaken by the U.S. Departments of Health and Human Services, Housing and Urban Development, Labor, and Education. In our investigation of Bradley Healthcare and Rehabilitation Center in Tennessee, another nursing facility, we provided technical assistance by our expert consultants in recommending strategies to address identified deficiencies in care and treatment. As part of our investigation of Alexander Youth Services Center in Arkansas, we alerted officials to federal financial assistance which may be available to them through the U.S. Department of Education. In addition, we provided Alexander officials with technical assistance by our expert consultants in recommending specific actions to improve conditions of confinement within this juvenile correctional facility. Our expert consultants provided assistance to officials of the Essex County Juvenile Detention Center in Newark, New Jersey to address excessive use of isolation and restraints. Similarly, we provided technical assistance by our

expert consultants to officials of Shelby County Jail in Tennessee on use of force policies, protocols for identifying and treating serious medical and mental health conditions, and environmental health standards. During compliance tours of correctional facilities in Guam and the Northern Mariana Islands, we provided consultant services by experts in corrections, sanitation, and safety regarding fire safety, sanitation, food service, maintenance, security, and prevention of harm to inmates. Our consultants also provided technical assistance to officials at Jackson County Correctional Center in Fluvanna, Florida and Nassau County Detention Center in East Meadow, New York by reviewing medical policies and procedures. In response to a request from the New Mexico School for the Visually Handicapped, Alamogordo, New Mexico, we provided an expert consultant in braille and orientation and mobility for persons with visual impairments to meet with staff and discuss recommendations designed to bring the school into full compliance with our agreement.