IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

Richmond Division

UNITED STATES OF AMERICA,	}	
	)	
Plaintiff,	)	Civil Action No. 3:12CV59-JAG
	)	
v.	)	
	)	Hon. John A Gibney
COMMONWEALTH OF VIRGINIA,	)	
	)	
Defendant,	)	
	)	
PEGGY WOOD, et. al.,	)	
	)	
Intervenor-Defendants	)	

PROPOSED BRIEF OF THE DISABILITY LAW CENTER OF VIRGINIA *AMICUS CURIAE* IN SUPPORT OF UNITED STATES' STATEMENT OF ISSUES AND MOTION FOR COURT - ORDERED SCHEDULE

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FINANCIAL DISCLOSURE STATEMENT

Proposed *amicus* disAbility Law Center of Virginia hereby certifies that it is a non-profit corporation and has nothing to report under Local Civil Rule 7.1(a) and (b).

disAbility Law Center of Virginia further certifies that this proposed *amicus* brief was not written in whole or in part by any party to this litigation. This proposed brief was written entirely by *amicus*. No person other than people employed by *amicus* contributed financially to the creation and submission of this brief.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other

STATEMENT OF INTEREST

The disAbility Law Center of Virginia ("dLCV") respectfully submits this brief in support of the United States' Motion for Court-Ordered Schedule, on behalf of individuals with intellectual and developmental disabilities in Virginia. dLCV is the federally mandated protection and advocacy (P&A) system for Virginians with disabilities. Va. Code § 51.5-39.13. Federal and state law invest P&A systems with unique and extensive authority to advocate on behalf of individuals with developmental and other disabilities. For example, The Developmental Disabilities Assistance and Bill of Rights Act of 2000 ("DD Act") (42 U.S. Code § 15001 et seq.) provides the system with the authority to "pursue legal, administrative and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of individuals […]." § 15032 (a)(2)(A). The system shall also

> have access at reasonable times to any individual with a developmental disability in a location in which services, supports, and other assistance are provided to such an individual, in order to carry out the purpose of [the Act]. § 15032 (a)(2)(H).

In addition, the Protection and Advocacy for Individuals with Mental Illness Act ("PAIMI Act") (42 U.S. Code § 10801 et seq.) provides the system with the authority to "pursue administrative, legal, and other appropriate remedies to ensure the protection of individuals with mental illness who are receiving care or treatment in the State" and "have access to facilities in the State providing care or treatment […]. §10805 (a)(1)(B); §10805 (a)(3).

The United States Supreme Court affirmed this authority in *Virginia Office for Protection and Advocacy v. Stewart*:

> […] The system "shall ... have the authority to investigate incidents of abuse and neglect ... if the incidents are reported to the system or if there is

> probable cause to believe that the incidents occurred." § 15043(a)(2)(B); § 10805(a)(1)(A). Subject to certain statutory requirements, it must be given access to "all records" of individuals who may have been abused, see § 15043(a)(2)(I)(iii)(II); § 10805(a)(4)(B)(iii), as well as "other records that are relevant to conducting an investigation," § 15043(a)(2)(J)(i). The Acts also require that a P & A system have authority to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of" its charges. § 15043(a)(2)(A)(i); see § 10805(a)(1)(B). And in addition to pressing its own rights, a P & A system may "pursue administrative, legal, and other remedies on behalf of" those it protects. § 10805(a)(1)(C); see § 15044(b)." *Virginia Office for Protection and Advocacy v. Stewart*, 563 U.S. 247 (2011).

Consistent with that authority, dLCV routinely represents clients with intellectual and developmental disabilities (I/DD), including those with co-occurring behavioral or mental health support needs, to protect and enforce their rights consistent with the Americans with Disabilities Act and other applicable laws and regulations. dLCV routinely investigates allegations of abuse and neglect of these individuals in institutional settings such as training centers and mental health facilities operated by the Department of Behavioral Health and Developmental Services ("DBHDS"). dLCV also conducts monitoring visits and investigations at a variety of community residential settings, for both adults and children.

Particularly since court approval of the Settlement Agreement in this case, dLCV has worked with, and on behalf of, children and adults identified in the agreement's target population. Because of its extensive federal authority, dLCV is able to represent qualifying individuals as they shift from one service setting to another - whether the primary focus of the setting is mental health support, I/DD support, education, or corrections.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Commonwealth's evident lack of compliance with the Consent Decree and the Settlement Agreement in United States v. Commonwealth of Virginia continues to harm

individuals in the target population. dLCV's representation of individuals covered by the agreement has revealed a number of alarming deficits in the Commonwealth's often fragmented disability service systems. Especially troubling are the increasingly dangerous conditions in the Commonwealth's remaining "training centers," and the Commonwealth's failure to provide appropriate crisis and behavioral supports for all members of the settlement agreement's target population. The case studies discussed herein exemplify the systemic problems enumerated by the United States and the Independent Reviewer. Whenever practicable, dLCV has shared its concerns directly with DBHDS and other responsible entities in an effort to seek reforms and service enhancements.

As the United States found in 2011, individuals suffer direct harm and are exposed to the risk of additional harm while needlessly institutionalized. See Letter from Thomas Perez, Assistant Attorney General for the United States, to the Hon. Robert F. McDonnell, Governor of Commonwealth of Virginia (Feb. 11, 2011). Children and adults with I/DD and co-occurring behavioral or mental health support needs are at even higher risk of unnecessary institutionalization in training centers and mental health facilities due to the Commonwealth's failure to prevent such admissions by ensuring a sufficient quantity of services, including crisis and respite services,.

ARGUMENT

A. COMMONWEALTH OF VIRGINIA'S LACK OF COMPLIANCE WITH THE AGREEMENT CONTINUES TO HARM INDIVIDUALS IN THE TARGET POPULATION, PARTICULARLY INDIVIDUALS IN NEED OF BEHAVIORAL SUPPORT AND CRISIS SERVICES.

1. Individuals with I/DD are harmed in State Operated Training Centers

The issues that first brought the DOJ to Central Virginia Training Center (CVTC) still exist. Individuals in Virginia's training centers remain at serious risk of harm, and remedies required by the settlement agreement have been disregarded. In July 2015, dLCV wrote to the Commissioner of DBHDS to express grave concern regarding the timeliness and thoroughness of Virginia's mortality reviews for people with I/DD. After completing multiple death investigations, dLCV determined DBHDS has consistently failed to comply with settlement agreement provisions regarding these reviews. That letter highlighted several fatalities, including the death of a long term resident of Central Virginia Training Center (CVTC), who died in 2014 as a consequence of negligent bowel care at the facility. It is well established that mortality reviews, if conducted in a timely and professional manner, could prevent future incidents in both the training centers and in the community.

dLCV continues to closely monitor conditions at CVTC and other training centers as they near closure and to review critical incident reports obtained from those facilities. State law defines "critical incident" to be any "serious bodily injury or loss of consciousness requiring medical treatment." Va. Code §37.2-709.1. State law requires that state facility directors report any critical incident or death to the P&A within 48 hours. See Va. Code §37.2-709. Despite its drastically reduced census, CVTC reported more critical incidents in 2014 than any other training center or mental health facility operated by DBHDS. Individuals assigned to Building 19, a designated residence for men with intellectual disabilities and co-occurring behavioral or mental health support needs, sustained more critical incidents than individuals residing in other buildings on the campus. Based on monitoring and investigation, dLCV concluded that many injuries resulted from failure to provide adequate and appropriate care, particularly behavioral and mental health supports.

2. Individuals with I/DD are harmed in State Operated Mental Health Facilities for Adults and Children

Of equal concern is that many individuals in the target population, who have never resided in a training center, are confined in the Commonwealth's psychiatric hospitals. Individuals with needs similar to those of CVTC's Building 19 residents have been denied adequate and appropriate supports elsewhere in the DBHDS system. The lack of I/DD specific supports frequently results in adverse outcomes. dLCV encountered individuals with I/DD committed to state operated mental health facilities who were subjected to abusive restraints, sexual assault, physical assault, and criminal prosecution since the settlement was reached in 2012. These adverse outcomes affect individuals with I/DD throughout their lifespans.

DBHDS operated mental health facilities have become de facto "no refusal" sites for children and adults with I/DD whose behavioral and mental health needs are not being adequately supported in the community. During state fiscal year 2015, approximately twenty-five percent of the individuals admitted to the Commonwealth's only state operated mental health facility for children and adolescents had an intellectual disability or Autism Spectrum Disorder. These children are within the settlement agreement's target population and should be receiving appropriate services and supports in community settings instead of a mental health facility. DBHDS recently provided data regarding admissions and discharges to adult mental health facilities. DBHDS reported that 70 individuals with I/DD diagnoses were admitted to its adult mental health facilities between July 1, 2015 and September 30, 2015. The majority (56 of 70) were civil admissions pursuant to a temporary detention order. During the same period, 98 individuals with I/DD diagnoses were discharged from adult mental health facilities. The median length of stay for facilities varied significantly, but one facility reported an average length of stay of 1,028 days (approx. 2 years and 8 months) for the 13 individuals discharged

during this period. Discharge planning, availability of community supports, and the effectiveness of crisis intervention are each implicated in the lengthy and inappropriate institutionalization of individuals with I/DD with behavioral and mental health support needs.

In April 2014, dLCV notified DBHDS's Acting Commissioner of problems related to poorly coordinated and implemented discharge plans for individuals with I/DD committed to state operated mental health facilities. At our urging, DBHDS made a number of protocol changes to enhance and clarify community service board and hospital obligations in the discharge planning process for children and adults with I/DD. While these changes better defined responsibilities of the involved parties, practices have yet to reflect the changes in policy.

Later that year, in June 2014, dLCV met with the DBHDS senior management and others to urge closer monitoring and oversight of individuals with I/DD cycling into DBHDS operated mental health facilities, often due to inadequate community crisis supports. dLCV staff recommended that DBHDS develop and implement a system for tracking admissions and discharges of individuals identified in the settlement agreement's target population. dLCV also advocated for post-move monitoring for individuals with I/DD who were leaving state operated mental health facilities, similar to the post-move monitoring available to individuals leaving training centers. However, DBHDS refused, noting concern that doing so would place extra demand on their limited resources and could expose the Department to additional scrutiny by the United States Department of Justice. dLCV continued to express our concerns regarding treatment of adults and children with I/DD in state operated mental health facilities by a variety of means, specifically during meetings held with DBHDS representatives in October 2014 and July 2015.

While the Commonwealth endeavors to provide quality crisis supports, robust discharge planning, and post-move monitoring for individuals discharged from training centers, others in the target population have not been afforded the same support. The case studies outlined below exemplify the cumulative effect of the Commonwealth's failure to implement key elements of the Settlement Agreement, particularly behavioral support and crisis response services.

B. DLCV, THROUGH ITS MONITORING AND ADVOCACY EFFORTS, ENCOUNTERED INDIVIDUALS WITH I/DD WHO SUFFERED PARTICULARIZED HARMS DUE TO THE COMMONWEALTH'S LACK OF COMPLIANCE.

The Commonwealth's ongoing failure to fully comply with provisions set forth in the settlement agreement places vulnerable children and adults with I/DD at ongoing risk. While the Commonwealth demonstrates compliance by some quantitative measures, the Settlement Agreement also looks to qualitative measures to assess compliance. The following case summaries provide qualitative data and exemplify the human costs of the Commonwealth's failure to timely implement the Settlement Agreement. These case studies represent a small sampling of the individuals with whom dLCV has worked and an even smaller sampling of the overall constituency affected by the Commonwealth's noncompliance.

1. AA: AA has a developmental disability and mental health diagnosis. AA's family sought Medicaid waiver services but was placed on a waiting list. In her teens, she was arrested, jailed and ordered to a psychiatric residential treatment facility (PRTF) for dually diagnosed adolescents between the ages of 6 and 21. She was discharged from the PRTF to an assisted living facility (ALF) at age 18 with inappropriate supports. After being admitted to a private adult psychiatric ward multiple times, she was transferred to a DBHDS operated mental health facility for adults. In the absence of appropriate discharge planning and services, AA was

discharged to and remains in her family's home without a Medicaid waiver. AA's primary caregiver recently remarked, "I have often wondered if proper services had been available to her how different our lives might have been."

2. BB: BB has a developmental disability (Autism) and mental health diagnosis. While committed to a DBHDS operated mental health facility for children, BB was verbally and physically victimized by peers. She was also subjected to seclusion, physical restraint, and mechanical restraint. After she was found clinically ready for discharge, there were no viable community discharge options available. BB remained in a restrictive institutional setting because her home school district refused to provide necessary community supports. Eventually, she was discharged to a private residential treatment facility for children or "PRTF," where she continues to reside in an institutional setting.
3. CC: CC had an intellectual disability and mental health diagnosis. During his short life, CC served time in a mental health facility operated by the Virginia Department of Corrections. He had multiple hospitalizations in state psychiatric facilities, where he was subjected to physical assault by peers and frequent seclusion and restraint. Each discharge lacked adequate planning and linkage to community resources. DBHDS facility employees never identified the need to refer him to REACH services, a requirement of the settlement agreement. Between hospitalizations, the local CSB provided mental health services but did not address his ID. The CSB's emergency service workers routinely called law enforcement to intervene when he was in crisis. After persistent advocacy and education, the local CSB made a referral to REACH approximately one week

after his final discharge from a DBHDS operated mental health facility. REACH services were delivered intermittently and proved to be inaccessible at times. His father's first call to REACH went into a voice mail and was not returned until over 24 hours later. Eventually, after continued advocacy, he was approved for a waiver. While awaiting placement, he experienced a medical crisis and was treated at a community hospital where he was diagnosed with neuroleptic malignant syndrome. He was discharged to an ID Medicaid waiver funded home where he died eight days later.

4. DD: DD has a developmental disability (Autism) and mental health diagnosis. DD currently resides in an apartment through the Rental Choice VA program and receives in-home services funded by a Developmental Disabilities Medicaid waiver. DD had been committed to a DBHDS operated mental health facility for adults multiple times after failed REACH interventions. While committed, he was subjected to numerous assaults by peers, and multiple episodes of physical, chemical, and mechanical restraint and seclusion. Adult Protective Services and a DBHDS Investigator substantiated physical abuse by staff. In addition, this staff person pressed criminal charges on DD. DD's father pled to DBHDS, "even the staff...concurs that (DD) needs to be elsewhere…I'm concerned about (DD)'s safety by staying any longer." Discharge planning and service coordination proved to be convoluted. Multiple barriers impeded discharge; mainly the contradicting siloed service systems that depend on one another to provide an appropriate support network. When he was discharged pre-authorizations for in-home services were not place; therefore, the community provider supplied

untrained, temporary workers. APS substantiated neglect and physical abuse by the community provider during DD's first month in the community. DD was not given his medication as prescribed. He was physically assaulted by in-home staff on two separate occasions. One of the untrained employees filed criminal charges against DD. APS declared the case an emergency. After treatment at a local hospital, DD went to live with his parents. His providers and family agreed that this was not an appropriate long term or safe plan. After about a month and a half, DD returned to his apartment through the Rental Choice VA program with a new in-home provider. DBHDS has not been in contact with DD or his the family post-discharge from the DBHDS operated mental health facility.

5. EE: EE has an intellectual disability, mental health diagnosis, and severe trauma history. EE currently resides in an ID Medicaid waiver funded group home. In her teens, she resided in a PRTF. At age 18, she resided at an ID Medicaid waiver funded group home located on a compound with other group homes. REACH failed to provide adequate support. Before her 19th birthday, she was twice committed to an adult mental health facility where she was raped by a peer. EE wanted to be discharged close to her sister, her only family member who remains in contact. However, she was discharged to an ID Waiver funded provider nearly two hours away from her sister.
6. FF: FF has an intellectual disability, mental health diagnosis (borderline personality disorder), and severe trauma history. FF currently resides in a DBHDS operated mental health hospital for adults. Previously, she was hospitalized for eight years at an adult state operated psychiatric facility. FF was discharged to an

ID supported residential placement and within days, she was readmitted to the same state operated facility after START services failed to effectively intervene. FF was discharged without essential services (behavioral support specialist, therapist, and medical doctor) in place. The provider complained that he was pressured to accept her without an opportunity to plan or implement anything specific to FF and her needs. The CSB case manager did not make enhanced case management home visits. More than three months passed before the case manager made the REACH referral. Once REACH services started, FF had problems accessing her worker and the Crisis Therapeutic Home. She was refused respite on at least two occasions due to bed capacity issues. In days leading to her most recent commitment, her behavioral support plan was not implemented appropriately and REACH was again not accessible.

7. GG: GG has a developmental disability (cerebral palsy), mental health diagnosis (bipolar disorder), and severe trauma history. GG is currently committed to a DBHDS operated mental health facility for adults. At age 19, adult protective services placed her in a Medicaid funded nursing home, where she lived until committed. The nursing home was not a good fit for GG because she wanted integrated community living, higher education, and employment. When dLCV intervened in GG's case, the Center contacted the regional DBHDS community resource consultant (CRC) and DBHDS housing specialist to seek assistance in identifying community providers and obtaining a Housing Choice Voucher. Initially, the CRC said she could not assist because GG does not have an intellectual disability. When dLCV advised that this was not consistent with the

settlement agreement, the CRC finally agreed to assist. From there, Regional Support Team and Complex Case Consultation Team referrals also did not proceed as prescribed. Even with special Medicaid approval for 24-hour DD waiver supports in the community, no providers in GG's community have been identified to provide overnight staffing. As GG and her team faced mounting barriers to nursing home discharge, GG responded with increasingly challenging behaviors. dLCV asked GG's REACH coordinator to facilitate an admission to the REACH Crisis Therapeutic Home. Regional REACH administrators were reluctant to admit GG to the home because no clear discharge placement was available. In the days that followed, GG continued to respond to her mounting life stressors with challenging behaviors and was ultimately given a formal discharge notice by her nursing home. She was subsequently taken to a local emergency department where a temporary detention order (TDO) was issued. When her TDO expired, a longer commitment was sought. As GG continues to languish in the state's care, she is being denied regular contact with her family, friends, and church.

8. HH: HH has an intellectual disability and mental health diagnosis (borderline personality disorder). HH is currently committed to a DBHDS operated mental health hospital for adults. HH has been subjected to numerous restraints during her current hospitalization and has no clear path out of the hospital (despite her clinical readiness for discharge). HH has resided in countless settings during her life, including multiple admissions to state operated training centers and mental health hospitals, sponsored residential provider homes, and group homes. Many

intellectual disability providers contacted during her current hospitalization have declined accepting HH into their programs based on her high level of behavioral support needs.

9. II: II has an intellectual disability, mental health diagnosis, and severe trauma history. II currently resides in a state operated training center. II was transferred to the training center from a state operated mental health hospital for adults, initially as a thirty-day respite admission. When representatives from II family, community services board, and DBHDS Central Office were unable to locate an appropriate community placement, a permanent judicially certified training center admission was sought and granted. In the short period II has resided at the training center, he has sustained multiple injuries qualifying as critical incidents under the Code of Virginia. Moreover, II was subjected to restraints during his commitment to a DBHDS operated mental health hospital and incurred criminal charges at a private psychiatric facility for behaviors related to his disabilities and trauma history.

CONCLUSION

Nearly halfway into the implementation period, the Commonwealth's lack of compliance with provisions set forth in the Settlement Agreement continues to place children and adults with I/DD at risk. The Commonwealth's well-documented failure to comply with crisis prevention and response mandates has resulted in inappropriate admissions to mental health facilities, where those adults and children experience serious harms. Once they are clinically ready for discharge, they often experience extended discharge delays because of poorly coordinated systems of care and inadequate community resources that extend well beyond the purview of DBHDS and its

community services boards. Other systems implicated in the Commonwealth's noncompliance include local departments of social services, the state Medicaid agency, local school districts, criminal justice systems, and local housing authorities.

dLCV requests that the court consider the information provided herein when determining the need for a Court-Ordered Schedule.

Respectfully submitted and DATED this 29th day of December 2015,

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