U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

FEB 10 2011

The Honorable Robert F. McDonnell
Office of the Governor
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Re: Investigation of the Commonwealth of Virginia's Compliance with the Americans with Disabilities Act and of Central Virginia Training Center

Dear Governor McDonnell:

We write to report the findings of the Civil Rights Division's investigation of the Central Virginia Training Center ("CVTC") and of the Commonwealth of Virginia's ("State" or "Commonwealth") compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999), requiring that individuals with disabilities receive services in the most integrated setting appropriate to their needs. Our investigation was conducted pursuant to Title II of the ADA, U.S.C § 12133, and the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights, including those under the ADA, of institutionalized individuals.

We write to provide you notice of the Commonwealth's failure to comply with the ADA and of the steps Virginia needs to take to meet its obligations under the law. 42 U.S.C. § 2000d-1 (incorporated by 42 U.S.C. § 12133). This letter also serves as formal notice under CRIPA of the findings of our investigation, the facts supporting them, and the minimum steps necessary to remedy the deficiencies. 42 U.S.C. § 1997b(a). The Commonwealth's implementation of the remedies discussed in this letter will correct the identified deficiencies in its compliance with the ADA, fulfill its commitment to individuals with disabilities, and protect the public fisc.

I. SUMMARY OF FINDINGS

We have concluded that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation of the ADA. The inadequacies we identified have resulted in the needless and prolonged institutionalization of, and other harms to, individuals with disabilities in CVTC and in other segregated training centers throughout the Commonwealth who could be served in the community. Systemic failures causing this unnecessary institutionalization include:

- The Commonwealth's failure to develop a sufficient quantity of community-based alternatives for individuals currently in CVTC and other training centers, particularly for individuals with complex needs;
- The Commonwealth's failure to use resources already available to expand community-based services and its misalignment of resources that prioritizes investment in institutions rather than in community-based services; and
- A flawed discharge planning process at CVTC and other training centers that fails to meaningfully identify individuals' needs and the services necessary to meet them and address barriers to discharge.

The Commonwealth also places individuals currently in the community at risk of unnecessary institutionalization at CVTC and other training centers, in violation of the ADA. Systemic failures causing this violation include:

- The Commonwealth's failure to develop a sufficient quantity of community services to address the extremely long waiting list for community services, including the 3,000 people designated as "urgent" because their situation places them at serious risk of institutionalization; and
- The Commonwealth's failure to ensure a sufficient quantity of services, including crisis and respite services, to prevent the admission of individuals in the community to training centers when they experience crises.

Reliance on unnecessary and expensive institutional care both violates the civil rights of people with disabilities and incurs unnecessary expense. Community integration will permit the Commonwealth to support people with disabilities in settings appropriate to their needs in a more cost effective manner.

II. INVESTIGATION

On August 21, 2008, we notified then-Governor Tim Kaine of our intent to conduct an investigation of CVTC, pursuant to CRIPA, 42 U.S.C. § 1997. We conducted on-site tours of CVTC on November 18-21, 2008, December 17-18, 2008, and April 27-29, 2009, with the assistance of expert consultants in the fields of protection from harm, habilitation, and treatment programming.

On April 23, 2010, we notified the Commonwealth that we were expanding our investigation to focus on the State's compliance with the ADA and Olmstead with respect to individuals at CVTC. On August 17-20, 2010, we conducted a tour to examine whether the State is serving individuals confined to CVTC, and those discharged from CVTC, in the most integrated setting appropriate to their needs. We were assisted by consultants with expertise in discharge planning and serving individuals with intellectual and developmental disabilities in the community.

During the course of the expanded investigation, however, it became clear that an examination of the Commonwealth's measures to address the rights of individuals at CVTC under the ADA and Olmstead implicated the statewide system and required a broader scope of

review. We received information regarding the Commonwealth's efforts both to discharge individuals to more integrated settings and to prevent unnecessary institutionalization. While much of our review focused on CVTC, many of the policies and practices we examined are statewide in their scope and application. For example, the same community-based services are necessary to facilitate discharge of individuals from the other training centers, and individuals are discharged from CVTC to regions throughout the State.

While on site, we interviewed persons in statewide leadership positions in the Department of Behavioral Health and Developmental Services ("DBHDS"); CVTC administrators, professionals, staff, and residents; community providers; Community Service Board directors; and individuals receiving services in more integrated settings in the community. We observed individuals receiving services in a variety of settings, including in their residences and day activity areas. Before, during, and after our visits, we reviewed policies, procedures, individual records, and other material related to the care and treatment of individuals at CVTC. At the end of each of our inspections, consistent with our pledge of transparency and to provide technical assistance where appropriate, we provided an exit presentation at which our consultants conveyed their initial impressions and concerns about CVTC – and Virginia's system for providing services to individuals with intellectual and developmental disabilities – to the Commonwealth's counsel, CVTC administrators and staff, and other Commonwealth officials.

III. BACKGROUND

CVTC is a State-operated institution in Madison Heights, Virginia, operating as an intermediate care facility for persons with developmental disabilities (ICF/DD). CVTC is the largest of Virginia's five State-operated institutions, with approximately 400 individuals there. A total of approximately 1,100 individuals are in these five ICF/DDs. CVTC and the other training centers are operated by DBHDS. Approximately 8,600 individuals receive services through two different types of Medicaid "waivers"[1] in the community, and another 6,400 are on a waitlist. Services are coordinated through the 40 locally-run community service boards ("CSBs") that provide direct services and link consumers to services provided by other direct providers.

The average cost of institutionalizing a person at CVTC and other training centers is approximately $194,000 per year. By contrast, the cost of services to people in the community through the use of a waiver averages $76,400. Virginia can serve nearly three people in the community for each person in a training center.

Commonwealth officials are aware of the deficiencies that we identified during our investigation and have acknowledged the need for significant improvements. We are encouraged that Virginia leadership, both at CVTC and at DBHDS, acknowledged the problems and indicated a strong desire to work with the United States Department of Justice toward an amicable resolution. We are further encouraged by your recent statements and by positive measures in your budget proposal that support a transition to a community-based system for

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[1] Section 1915(c) of the Social Security Act permits the waiver of certain Medicaid statutory requirements to enable states to cover a broad array of home and community-based services (HCBS) for targeted populations as an alternative to institutionalization.

serving individuals with intellectual and developmental disabilities as an alternative to institutionalization.

IV. FINDINGS

We conclude that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs as required by the ADA. The quantity of available services in the community is deficient, preventing individuals from being discharged from CVTC and other institutions and placing others at risk of unnecessary and expensive institutionalization. Discharge and transition planning is plagued with deficiencies, resulting in very few discharges from CVTC and the other training centers in the last several years. These inadequacies have resulted in needless and prolonged institutionalization of individuals with disabilities who could be served in the community with more independence and dignity at a fraction of the cost. While needlessly institutionalized, these individuals suffer harms and are exposed to the risk of additional harm.

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132. "The ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them." Helen L. v. DiDario, 46 F.3d 325, 335 (3rd Cir. 1995).

One form of discrimination prohibited by Title II of the ADA is violation of the "integration mandate." The integration mandate arises out of Congress's explicit findings in the ADA, the regulations of the Attorney General implementing Title II,[2] and the Supreme Court's decision in Olmstead, 527 U.S. at 586. In Olmstead, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. Id. at 607.

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[2] The regulations provide that "a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities." 28 C.F.R. § 35.130(d); see also 28 C.F.R. § 41.51(d). The preamble discussion of the ADA "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A. at 571 (2009).

In so holding, the Court explained that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Id. It also recognized the harm caused by unnecessary institutionalization: "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 601.[3] The Fourth Circuit has also clearly stated that federal law requires "plac[ing] the recipient in the least restrictive environment." Doe v. Kidd, 501 F.3d 348, 358 (4th Cir. 2007) (citing Olmstead, 527 U.S. 581), cert. denied, 522 U.S. 1243 (2008).

The Commonwealth is failing to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs, in violation of its obligations under the ADA and Olmstead. Individuals are unnecessarily institutionalized at CVTC and the other training centers, and individuals in the community are placed at risk of unnecessary institutionalization. The principal causes of Virginia's departure from the ADA's integration mandate are a lack of services in the community, particularly for individuals with complex needs, and a slow and muddled discharge and transition planning process.

A. Individuals with Intellectual and Developmental Disabilities Are Unnecessarily Institutionalized at CVTC and Other Training Centers

The Commonwealth is violating the ADA by unnecessarily institutionalizing hundreds of individuals at CVTC and other training centers who could be served in more integrated settings. Olmstead, 527 U.S. at 607.

1. CVTC and the Other Training Centers are Segregated, Institutional Settings that Expose Individuals to Harm

CVTC is a segregated, institutional setting. Approximately 400 individuals with intellectual disabilities are congregated together at CVTC. Individuals are assigned to units of eight to 12 people. Bathroom areas are congregate, with towels and other items often stored in separate areas not readily available to residents. As a result, individuals have very limited privacy. CVTC has the physical appearance of an institution, not a home. Day rooms are bare and impersonal, with minimal decorations and little home-like furniture. Accord Disability Advocates Inc. (DAI) v. Paterson, 653 F. Supp. 2d 184, 200-07 (E.D.N.Y. 2009) (describing characteristics of institutions to include, *inter alia*, large numbers of individuals with disabilities congregated together, an institutional appearance, and lack of privacy).

Individuals at CVTC live segregated lives. Most spend their entire day in the institution, with the vast majority participating in facility-based day activities. Individuals are offered very

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[3] Olmstead therefore makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and enable individuals with disabilities to participate in all aspects of community life. Accord Press Release, The White House, "President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities" (June 22, 2009) (In announcing the Year of Community Living Initiative, President Obama affirmed "one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.").

limited opportunities for meaningful employment and have virtually no opportunities to interact with their non-disabled peers. CVTC limits individuals' autonomy and provides few opportunities for individuals to make choices. Individuals eat together in dining areas at set mealtimes, where they cannot choose what or when they eat. Staff determine what programs individuals watch on the television set in the day room. Id. (institutional characteristics include, *inter alia*, regimented daily activities, little autonomy and opportunity for choices, and limited opportunities to interact with individuals outside the institution); Benjamin v. Dep't of Pub. Welfare of the Commonwealth of Pa., Memorandum and Order, Case No. 09-1182 (Docket Entry 88) (M.D. Pa. Jan. 27, 2011) (finding that the Commonwealth of Pennsylvania unnecessarily institutionalizes individuals in large ICF/DDs in violation of the ADA and holding that such placements are segregated, where individuals are congregated together in living units, primarily receive day services on the grounds of the facilities, and have limited opportunities to interact with non-disabled peers and limited access to community activities). The Commonwealth has acknowledged, in interviews with officials and in reports, that nearly all individuals at the training centers could and should be served in smaller community-based settings.

Individuals are harmed at CVTC. Unnecessary segregation not only violates individuals' rights under the ADA, but also causes irreparable harm. "[O]ne of the harms of long-term institutionalization is that it instills 'learned helplessness,' making it difficult for some who have been institutionalized to move to more independent settings." DAI, 653 F. Supp. 2d at 265; accord Marlo M. v. Cansler, 679 F. Supp. 2d 638 (E.D.N.C. 2010) (finding unnecessary institutionalization leads to regressive consequences that cause irreparable harm); Long v. Benson, 2010 WL 2500349 (11th Cir. June 22, 2010) (affirming district court's granting of preliminary injunction based on irreparable injury of unnecessary institutionalization).

Moreover, CVTC compounds this harm by exposing individuals to unsafe conditions while they are needlessly institutionalized. See Youngberg v. Romeo, 457 U.S. 307, 324 (1982) (finding that the Fourteenth Amendment's due process clause requires an institution to provide "adequate food, shelter, clothing, and medical care," along with "conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests"). Individuals at CVTC are subjected to significant harms, including repeated accidents and injuries, inadequate behavioral and psychiatric interventions, and inadequate physical and nutritional management supports. An overarching cause of these harms is CVTC's failure to identify individuals' needs, identify root causes of bad outcomes, and respond to prevent their recurrence. These harms not only evidence the need for CVTC to put in place adequate quality assurance mechanisms, but underscore the urgency of moving individuals with disabilities out of inappropriate institutional placements.

Particularly concerning during our initial tours in 2008-09 was CVTC's use of restraints. The right to be free from undue bodily restraint is the core of the liberty interest protected from arbitrary governmental action by the Due Process Clause. Id. at 316. Restraints may only be applied in emergency situations necessary to prevent harm and for only the length of time necessary for the emergency to subside. 42 U.S.C. § 290ii(b) (federal rules regulating the use of restraints on individuals in ICF/DDs). Yet, at CVTC, restraints were not limited to emergency situations. Instead, planned restraints were part of many individuals' treatment plans, where they were used as an intervention of first, rather than last, resort. We also found evidence that several

individuals resisted efforts of staff to get them to use what CVTC termed "voluntary" restraints, raising questions about whether these restraints are voluntary at all.

2. Individuals at CVTC and the Other Training Centers Could be Served in More Integrated Settings

Individuals at CVTC and the other training centers could be served in more integrated settings. The Commonwealth has acknowledged this both explicitly and implicitly through its efforts, albeit incomplete, to serve individuals in the community who have needs similar to those of individuals at CVTC and the other training centers. We conclude that the vast majority of individuals could be – and have a right to be – living in community settings with appropriate services and supports but are instead languishing in the institution.

Virginia already has a range of community-based services for individuals with intellectual and developmental disabilities. These community services cost substantially less than institutional care. See supra. Virginia has developed a Medicaid-funded waiver program, known as the ID Waiver, to provide home and community-based services to individuals with intellectual disabilities who meet the level of care for ICF/DDs (which include the training centers) and are in or at imminent risk of entering such facilities. Waiver services include assistive technology; companion services; crisis stabilization and crisis supervision; day support; environmental modifications; in-home residential support services; residential support services; respite services; personal assistance; personal emergency response system; prevocational services; skilled nursing; supported employment;[4] therapeutic consultation; and transition services.[5]

Residential options under the waiver include small group homes, sponsored homes where a licensed provider contracts with a family to provide services for up to two individuals, in-home residential support programs to serve individuals in their own homes or their families' homes, and adult foster care programs that are similar to sponsored homes and provide room and board, supervision, and services in the provider's home for up to three adults.[6] We found that, among

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[4] While we recognize that the State provides integrated supported employment opportunities, our tours raised serious initial concerns about the over-reliance on segregated, sheltered workshops for individuals with intellectual and developmental disabilities in the community. Many of the day programs we visited also did not provide individuals with opportunities for meaningful work. These deficiencies place individuals at risk of continued segregation even once they are discharged.

[5] Virginia has a separate waiver for individuals who have a developmental disability (such as autism), but not an intellectual disability, called the Individual and Family Developmental Disabilities Support Waiver (DD Waiver). Like the ID waiver, the DD waiver contains a range of support services including in-home residential support, day support, skilled nursing, crisis services, respite, personal attendant care, and supported employment.

[6] Virginia also offers congregate, more institutional-like settings in the community, including ICF/DDs that serve between five and 12 individuals and assisted living facilities that provide or coordinate personal and health care services with 24 hours per day of supervision in a

the placements we visited, individuals were generally kept safe and provided appropriate supports and services.[7]

The Commonwealth has acknowledged that most people at the training centers, including nearly every individual at CVTC, could be served in the community. In its recent study, Creating Opportunities: Plan for Advancing Community-Focused Services in Virginia (June 25, 2010), the Commonwealth noted, "Individuals in training centers could be served in the community if adequate supports, including targeted medical and behavioral interventions, were available to them." Similarly, the Director of Developmental Services, Lee Price, told us during our August 2010 visit that he believed that everyone at CVTC could be served in the community. CVTC staff has already determined that more than 170 individuals at CVTC could be served in more integrated settings, and the number is undoubtedly far higher due to CVTC's inadequate discharge assessment process.

The needs of individuals at CVTC – including individuals with complex medical or behavioral needs – are the same as the needs of other individuals who are currently served in the community in Virginia and in other states, including in states that have no institutional settings. Community providers confirmed that the vast majority of individuals from CVTC could be served in the community with appropriate supports and services. They also stated that they currently serve individuals who have similar needs to people at CVTC, including individuals with complex medical or behavioral needs. While the pace of discharge to the community of individuals from CVTC and the other training centers has been unacceptably slow, see infra, the individuals who have transitioned have similar needs to those individuals who remain at CVTC.[8] Thus, providers and the Commonwealth have already demonstrated an ability and a willingness

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larger group setting. These placements are not funded using waivers. For many individuals, these are not the most integrated settings appropriate to their needs.

[7] Recently, most individuals have been discharged into sponsored homes or small group homes, with only a small number of individuals moving to larger ICF/DD facilities. While our sample size was too small to make any firm conclusions, we were encouraged by the overall quality of the community placements we visited. However, we had concerns regarding two of the residential placements, including one larger congregate setting. In that case, the Commonwealth had investigated reports of abuse, the primary responsible staff member was terminated, but the Commonwealth did not provide adequate follow-up to ensure that appropriate corrective action was taken with respect to other staff who may have been present during or known about the abuse. Just as it must do at the training centers, the Commonwealth must ensure that its investigation, monitoring, and licensing procedures adequately address any potential harms at community-based placements. See infra.

[8] The Commonwealth's own reports have indicated, and other information confirms, that individuals at other institutions have similar needs and could be served in the community and that individuals with needs similar to individuals at other training centers are likewise receiving services in the community. See Northern Virginia Training Center Diversion Pilot, DBHDS, Nov. 1, 2010; Information Brief: Virginia SIS Comparisons for SEVTC and Comprehensive Community Waiver Populations, Human Services Research Institute (on behalf of DBHDS), June 23, 2009.

to serve people with complex needs in community settings. Accord Benjamin, Memorandum and Order, Case No. 09-1182 (Docket Entry 88), at 6 ("With appropriate community services, all of the named Plaintiffs [with developmental disabilities] could live in more integrated community settings rather than institutions because they would still have available all services and supports that are currently available to them.").

During our tours, we met former CVTC residents living and otherwise participating in more integrated settings. The needs of these former CVTC residents are no different than those of the individuals currently at CVTC. Many of them have complex medical and/or behavioral needs but nonetheless are successfully living in community-based settings, where they live with more independence, dignity, and self-determination. We observed that these individuals were living in home-like environments; were able to make choices like how to spend their day, what to eat, and how to decorate their rooms; had access to community-based services and activities; and were safe from harm. Former CVTC residents whom we met included:

- AA, whom we met in a sponsored home and who owns his own bowling shoes and bowling ball, has a membership at the local "Y," has lunch at a senior center twice a week, frequently visits a friend in a nursing home, and goes to a recreation center each week.[9]
- BB, a deaf woman whom we met in a sponsored home who goes into the community nearly every day. Her sponsored family includes her in family life through their use of modified sign language.
- CC, who engages in community activities, including church several days a week.
- DD, whom we met at a day program, who volunteers at a local fire department.
- EE, who enjoys bowling despite having cataracts and hearing impairment.

3. Few Individuals Are Discharged from CVTC or the other Training Centers to More Integrated Settings

Virginia relies heavily on institutional care for individuals with intellectual and developmental disabilities. Despite the Commonwealth's recognition that individuals at CVTC and the other training centers could be served in more integrated settings, Virginia citizens with intellectual and developmental disabilities remain institutionalized, and very few individuals are actually transitioned into the community. This use of institutional care has significant financial costs for the Commonwealth.

The Commonwealth continues to spend far more proportionally on institutional than community care, in large part due to the substantially higher average cost of serving individuals in institutions than in the community. It continues to invest millions of dollars in new construction and remodeling of its training centers instead of seriously investing in the

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[9] To protect individuals' privacy, we identify them by initials other than their own. We will separately transmit to the Commonwealth a schedule that cross-references the initials with individuals' full names.

community services necessary to transition people. The Commonwealth's long-range plan for CVTC is that it maintain a census of 300. As noted earlier, however, CVTC staff already have determined that 170 of the 400 current residents are ready for discharge. Virginia is one of only five states that continue to operate multiple large (16+ beds) state-run institutions for individuals with intellectual and developmental disabilities and of only a handful of states that has yet to close a single state-operated facility.

Individuals who could be served in more integrated settings languish at CVTC. Between July 1, 2008, and July 1, 2010, there was a net reduction in the CVTC population of only 10 individuals, a reduction rate of approximately five people annually. There were only 31 discharges in that two year period,[10] despite CVTC itself designating another 170 individuals as being capable of being served in more integrated settings. This unreasonably slow rate of discharge has remained fairly steady since 2004. Between July 1, 2008, and July 1, 2010, there were nearly as many admissions (21 individuals) as discharges, caused in large part by the Commonwealth's failure to develop sufficient community services to prevent unnecessary institutionalization. Out of the 31 people discharged since July 2008, half of those individuals were people who had been admitted during that same time period. Thus, virtually no one who has been institutionalized long-term in CVTC ever leaves.

Moreover, the large majority of individuals who have been designated as ready for discharge have been waiting for placement for a significant amount of time. Approximately 140 of the 170 so designated were placed on the list in 2007 or earlier. Some individuals have been "ready for discharge" for a decade or more. At the current rate of discharge, the vast majority of individuals at CVTC will not move into the community during their life time. Even those who will ultimately have the chance to move must first endure many more years of unnecessary institutionalization. The other training centers have seen similarly slow discharge rates. Under any standard, this does not constitute discharging at a reasonable pace.

B. A Lack of Services and a Flawed Discharge and Transition Planning Process Cause Unnecessary Institutionalization at CVTC and the Other Training Centers

Our experts identified two primary reasons why so few individuals are discharged from CVTC, and the other training centers, into the community. First, the Commonwealth has failed to develop sufficient community-based services, particularly for individuals with complex needs. Second, the Commonwealth's process for assessing and transitioning individuals into the community is flawed, creating unreasonable barriers to discharge.

1. The Commonwealth's Failure to Develop Sufficient Community Services is a Barrier to the Discharge of Individuals at CVTC and the Other Training Centers Who Could Be Served in More Integrated Settings

The lack of sufficient services in the community constitutes one of the primary barriers to discharging individuals from CVTC and other training centers. The Commonwealth already provides the types of services that individuals at CVTC would need to live successfully in the community. See supra. However, existing community services are inadequate and not available in sufficient supply. The Commonwealth should expand existing community programs that

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[10] At least one of these discharges was made to another training center.

already provide effective services and reject dated models that do not provide opportunities for full integration and self-determination. Community provider agencies have both the capacity and the willingness to develop additional services for individuals at CVTC.

First, the Commonwealth needs additional waiver slots to serve individuals who can be discharged from CVTC and other training centers. The Commonwealth has acknowledged the need for additional waiver slots. See Northern Virginia Training Center Diversion Pilot, DBHDS, Nov. 1, 2010. But few slots are available, and none are specifically designated for individuals leaving the training centers. When a waiver slot becomes available, one of the now 3,000 individuals on the "urgent" wait list – who generally are individuals in the community experiencing crises that put them at risk of entering an institutional setting[11] – generally receives it, while individuals at CVTC or other training centers have lower priority. We understand that the Commonwealth makes waiver slots more readily available to those already in the community because it wishes to prevent further admissions. But the Commonwealth may not neglect the institutionalized population. Benjamin, Memorandum and Order, Case No. 09-1182 (Docket Entry 88), at 21 (holding that the State "cannot continue to [prevent admissions] by relegating institutionalized individuals to second-class status" and that the State's aim cannot "be achieved by discriminating against individuals who have equal rights to community support"). A sufficient number of additional slots, beyond the 275 in the current budget proposal and even beyond the 400 that the Commonwealth has said are the minimum required to address the waitlist, should be allocated to ensure that the institutionalized population is discharged at a reasonable pace.

The Commonwealth continues to direct resources to institutions at the expense of community-based programs, particularly as it underfunds its community-based waiver program. On average, it spends almost $120,000 more per year to serve a person confined to CVTC than in the community using a waiver. Virginia could serve nearly three people in the community for each person in a training center. Even individuals with significant medical needs can be served in the community at approximately half the cost of a training center ($92,000). The provision of community-based services to an individual with the most complex medical and/or behavioral needs, including services 24 hours a day, seven days a week, still costs $64,000 less per year than confining the same individual to a training center.

At the same time that the Commonwealth fails to allocate more resources to community-based services, it has failed to use a large number of slots made available through the Money Follows the Person ("MFP") program, which is specifically aimed at facilitating discharge from large institutions like CVTC and benefits from a higher rate of federal matching funds. Based on our experts' record reviews, there are individuals currently at CVTC who could have been transitioned to the community using MFP program funds. However, while using MFP slots would be a start, more is required.

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[11] The primary reasons for being placed on the "urgent" waitlist include an aging caregiver, a primary caregiver who can no longer care for the person, risk of abuse or neglect of the individual, or that the individual's behavioral or physical care needs are putting persons at risk.

Finally, the design of the waiver program has made it difficult to develop sufficient services for individuals with complex needs. This is particularly important for individuals in CVTC and other training centers, many of whom have complex medical and/or behavioral needs and will need significant levels of supports in the community. The Commonwealth itself has acknowledged that "[t]he current ID Waiver does not provide the level of supports and reimbursement rates for targeted services that would make it a truly effective alternative for individuals with needs for high intensity services," Creating Opportunities:Plan for Advancing Community-Focused Services in Virginia, at 25 (June 25, 2010), and that a more flexible waiver is necessary in order to serve individuals with complex needs, Northern Virginia Training Center Diversion Pilot, DBHDS, Nov. 1, 2010.[12]

Providers with whom we spoke confirmed this finding. Some providers indicated that the only way to develop adequate services for many people with complex physical, medical, or behavioral needs is for a CSB or private provider agency to create an ICF/DD facility, where funding is provided through an inclusive annual cost adjusted rate instead of through a waiver. This encourages the development of ICF/DD models that tend to be larger than other residential settings, have less community integration, are less homelike (e.g., large "exit" signs, crash bars on doors, and sometimes even nursing stations or staff offices), and provide less flexible programming. These homes are frequently more expensive than smaller, more integrated community residences or sponsored homes. Indeed, the Commonwealth's own practices appear to prefer the smaller group or sponsored homes, as only a small number of recent CVTC discharges have been made to ICF/DD facilities. Still, this structural problem in the Commonwealth's services improperly impedes individuals with more complex needs from living in community settings.

2. CVTC's Inadequate Discharge Planning and Transition Process is a Barrier to the Discharge of Individuals at CVTC Who Could Be Served in More Integrated Settings

CVTC's inadequate discharge planning and transition process is another significant barrier to serving individuals at CVTC in the most integrated setting appropriate to their needs. The discharge planning process fails to identify individuals who could be served in more integrated settings and creates unreasonable barriers to discharge that lead to an unacceptably slow discharge process. The process also fails to ensure that adequate information is provided to families about community-based options and fails to address families' questions or concerns.

a. The Commonwealth's Treatment and Discharge Planning Process Does not Meaningfully Identify People's Needs, Barriers to Discharge, and Ways to Address Those Barriers

The purpose of the discharge planning process is to identify individuals' needs, identify what services are necessary to meet those needs in a more integrated setting, and identify barriers

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[12] Some aspects of the rate system that impede appropriate service development for this complex population include: very short time limits for crisis stabilization services, barriers to funding 24 hour nursing services or supervision, and difficulty obtaining environmental modifications, assistive technology, and adaptive equipment.

to discharge and strategies to address them. See Kidd, 501 F.3d at 358 (holding that the State "must determine the services required because it must insure that it meets the needs of the recipient and that it places the recipient in the least restrictive environment, as required by state and federal law") (citing Olmstead, 527 U.S. 581). Discharge planning should start from the presumption that every individual is capable of being served in a more integrated setting. Planning for discharge must begin from the moment of admission and drive treatment planning. Discharge planning and treatment are inextricably tied; the purpose of treatment must be to address the underlying issues that led to the admission and to resolve barriers to discharge to a more integrated setting. We found that significant inadequacies in CVTC's treatment and discharge planning processes are creating unnecessary barriers to discharging individuals at CVTC who could be served in more integrated settings.

First, we found that treatment plans frequently reflect an outdated view of disability, emphasizing individuals' deficits rather than identifying needed supports. A team cannot make a determination of the most integrated setting appropriate for an individual unless they meaningfully understand the individual's needs and the supports necessary to meet them. We also found that many treatment plans do not reflect individualized planning and are not integrated across disciplines. They do not describe the individual's goals or personal preferences, including goals and desires regarding living in a more integrated setting.[13] When goals are listed, they typically are framed as generic treatment goals. Likewise, the discharge planning process inappropriately focuses on the individual's "readiness" rather than on identifying the community services necessary to meet the individual's needs.

The monthly review meetings we attended did not include substantive discussion of discharge planning or barriers to placement, and monthly review summaries similarly failed to address these issues. Additionally, we found that the individuals and their families or guardians were not consistently present at monthly review meetings.[14] At least two individuals – FF and GG – did not attend their monthly review meetings during our visit. Further, when individuals were present at meetings that we attended, no effort was made to engage them actively in their treatment.

Many of the treatment plans that our expert reviewed failed to provide adequate opportunities to engage in activities aimed at facilitating independence and preventing the regression of skills while the individual is institutionalized.[15] We observed individuals who did

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[13] In addition, on our tours in 2008-09, we found that CVTC failed to provide individuals with appropriate communication services, hindering their ability to express personal goals and preferences and to participate meaningfully in their treatment and discharge, and also creating barriers to community integration. That review revealed that many individuals with significant communication impairments did not have formal communication goals and programs and that CVTC's speech and language professional resources were inadequate. This deficiency also has implications for individuals' ability to participate in the discharge planning process and to provide input regarding preferred placements in the community.

[14] We use the term "guardian" loosely to apply to the legal guardian or to the "Legally Authorized Representative."

[15] Federal regulations require that:

not appear to be meaningfully engaged in active treatment, and reviewed individual schedules that included minimal meaningful activities, at best. During our visit, CVTC staff reported that the facility has an expectation that all individuals will participate in four hours of day programming and in two hours of recreation or community activities each day. Our review revealed that this minimum expectation was not met for a significant number of individuals. We also found that only a small number of individuals were actually engaged in meaningful work. For instance, at the time of our visit staff reported that only a total of 42 individuals received pay for work and that there was no wait list for participating in work opportunities. This suggests that CVTC is not actively promoting work opportunities or seeking to ensure that individuals are offered such opportunities.

Further, we found that CVTC's process for determining the appropriateness of community placement, as set forth in written policy and described by staff, is inconsistently applied.[16] As a result, individuals who, according to CVTC's own criteria, are ready for discharge, remain unnecessarily institutionalized. Our expert reviewed cases in which individuals had identical scores on the "Protocol for Placement of Clients on the Ready for Discharge List," yet some were placed on the discharge ready list while others were not. In addition, the decision about placement reached on the "Training Center/Community Service Board Needs Upon Discharge Form" was inconsistent with the score on the Protocol. There was no evidence that Quality Assurance activities were in place to ensure consistency. The following examples are illustrative of the ambiguity inherent in determining which individuals are appropriate for discharge:

- HH was admitted to CVTC on April 16, 1956, at age 15. She has met the Discharge Ready Criteria since November 19, 2009; however, for reasons that are unclear, she was not placed on the Discharge Ready List.
- II was admitted on February 19, 1985, at age 36. A progress note on January 27, 2010, indicates that the team would agree that, with necessary supports, II would be able to function in a community setting. Two days later, on a separate form, II did not meet the discharge readiness criteria.

> Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . that is directed toward – [t]he acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and . . . [t]he prevention or deceleration of regression or loss of current optimal functional status.

42 C.F.R. § 483.440(a).

[16] The practices that are in place at this facility are the same Policies and Procedures that are used at all of the Virginia training centers. The issues and barriers that were found at CVTC are likely to exist at the other training centers, as well.

- JJ was admitted to CVTC on August 13, 1962, at age 8. On March 16, 2010, she was listed as meeting the Discharge Ready Criteria, and the guardian agreed to consider community placement; however, she was not placed on the Discharge Ready list.

While clarifying the process is advisable, the fundamental point is that the overwhelming majority of individuals at CVTC can be served in the community, including those who have not been formally identified as eligible for discharge. See DAI, 653 F. Supp. 2d at 258-59 (holding that Olmstead does not "create a requirement that a plaintiff alleging discrimination under the ADA must present evidence that he or she has been assessed by a 'treatment provider' and found eligible to be served in a more integrated setting"); Joseph S. v. Hogan, 561 F. Supp. 2d 280, 291 (E.D.N.Y. 2008) (noting that "the language from Olmstead concerning determinations by 'the State's treatment professionals' appears to be based on the particular facts of the case and not central to the Court's holding") (internal citation omitted); Frederick L., 157 F. Supp. 2d at 541 ("[The court]do[es] not read Olmstead to require a formal 'recommendation' for community placement."). Indeed, "Olmstead does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with mental disabilities." Id. at 540. See also DAI, 653 F. Supp. 2d at 259; Long v. Benson, No. 08-cv-26 (RH/WCS), 2008 WL 4571905, at *2 (N.D. Fla. Oct. 14, 2008) (noting that the State "cannot deny the right [to an integrated setting] simply by refusing to acknowledge that the individual could receive appropriate care in the community").

b. CVTC Staff are Not Adequately Knowledgeable of Available Community Services and Do Not Sufficiently Coordinate with Providers

CVTC staff lack knowledge of community services and fail to coordinate with community providers. As a result, CVTC staff do not have the information they need to be able to make recommendations about how an individual's needs could be met in a more integrated setting, to present families with specific proposals for community residences and services, or to answer families' questions about community living. Cf. 28 C.F.R. pt. 35, App. A, p.450 (1998) (requiring an individual to have an "option of declining to accept a *particular* accommodation") (emphasis added). CVTC staff often fail to explain even the types of services available in the community or the benefits of community living, though such a discussion "could make a substantial difference in the number of referrals for placement." Messier v. Southbury Training Sch., 562 F. Supp. 2d 294, 338 (D. Conn. 2008).

The lack of coordination between CVTC staff and community providers contributes to the long delays in the transition from CVTC to the community. Providers do not have sufficient information about the needs of people at CVTC to develop services for them. Moreover, CVTC staff fail to utilize community providers as resources to educate individuals and their families about community living, such as having providers speak with them, coordinating visits for individuals considering community placement and their families, and facilitating conversations with individuals currently living in the community and their families. Providers want to be more involved in the service development and transition planning process and are more effective when they are.

We identified individuals for whom discharge took many months, even after a provider and a residence were selected. Several people are still at CVTC despite a provider and residence being selected more than two years ago, and despite guardian approval. The following examples illustrate a pattern of CVTC failing to make meaningful efforts to coordinate discharge, even where the individual has been identified as discharge-eligible and the guardian is in agreement:

- KK was admitted to CVTC on August 30, 1962, at age five. KK met the Discharge Readiness Criteria in May 2006 after the guardian agreed to support placement in April 2006. KK was placed on the Discharge Ready List on June 30, 2006. After three years of being "discharge ready" but not discharged, in May 2009, the guardian changed her mind about community placement. There was no evidence that the team addressed the guardian's concerns regarding how KK's health needs would be met in the community.

- LL was admitted to CVTC on October 12, 1959, at age six. He was listed as ready for discharge on June 12, 2007, and also had guardian approval. He was placed on the Discharge Ready List on November 2, 2007. LL's residential placement has been delayed four times. As of May 2010, he continued to meet the criteria in the placement protocol, including the fact that he can participate in discharge planning. There are no funds available for needed adaptive equipment, so the CSB Case Manager is looking for grants to fund this item. There was no indication that the team considered the Money Follows the Person program that provides funds for start-up services.

- MM was admitted to CVTC on March 1, 1972, at age 12. She was placed on the Discharge Ready List in April 2006 with an indication that the family was in support of discharge. The State form indicated that in March 2008 "nothing is available at this time." A State form on June 9, 2009, indicates "Nothing available at this time." The record does not demonstrate any efforts to make something available.

C. Individuals with Intellectual and Developmental Disabilities Currently Being Served in the Community Are At Risk of Unnecessary Institutionalization

The ADA's integration mandate applies both to people who are currently institutionalized and to people who are at risk of unnecessary institutionalization. See Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004) (ADA applied to individual at risk of entering a nursing home); Fisher v. Okla. Health Care Auth., 335 F.3d 1175 (10th Cir. 2003) (same); Helen L., 46 F.3d at 325 (holding that the ADA was offended where a person with disabilities was offered personal care services in an institutional setting but not at home). We found that individuals in the community are at risk of unnecessary and costly institutionalization because of the Commonwealth's failure to provide sufficient community-based services. As Virginia discharges individuals from the training centers, as discussed above, it must redirect expenditures from costly institutional care to address these deficiencies in community services.

More than 6,000 individuals are on a waitlist for services in the community. Nearly 3,000 of those individuals are on the "urgent" list, meaning that they are in situations that place them at significant risk of institutionalization. See fn 11. Some of these individuals have been, and will continue to be, forced into institutions when a crisis arises while they wait for community services. As evidence of this, CVTC has had nearly as many admissions as it has had discharges over the last several years. See supra.

An inadequate number of waiver slots and the inflexibility of the waiver, particularly for individuals with complex needs, place individuals in the community at risk of unnecessary institutionalization. The Commonwealth admits that "[w]ithout significant changes to [the] waiver program's services, payments rates, and structure, little more can be done to divert admissions to training centers for the most medically fragile and behaviorally challenging individuals." Northern Virginia Training Center Diversion Pilot, DBHDS, at 11, Nov. 1, 2010; id. at 10 ("The ability of CSBs to divert an admission to [a] training center can be limited because of insufficient resources to purchase care in the community."). The Commonwealth must expand slots to address the needs of individuals who face the real threat of unnecessary institutionalization. The Commonwealth's own reports recommend between 400[17] and 1,000 new slots each year over the next several years to address the waitlist alone. Id. at 9; The Cost and Feasibility of Alternatives to the State's Five Mental Retardation Training Centers, at 4, 18 (2005). The current proposal of 275 waiver slots, while commendable, is far from adequate.

The Commonwealth's lack of capacity places individuals at risk of unnecessary institutionalization. The number of short term admissions for crisis services underscores the gap in Virginia's system.

We found that a primary cause of admissions to CVTC is the lack of crisis services for individuals with acute medical or behavioral issues. The Commonwealth recognizes that "additional crisis intervention and crisis response resources are needed to divert behavioral crisis admissions to training centers," Northern Virginia Training Center Diversion Pilot, DBHDS, at 6, Nov. 1, 2010, and that "[t]here is a documented need for additional crisis intervention and crisis stabilization services," including to prevent admissions to the training centers or other forms of institutionalization, id. at 8. Respite services are also essential to diverting unnecessary admissions. A shortage of available respite services "may create situations where individuals have no choice but to be admitted" to a training center for respite care. Id. at 10. The Commonwealth's current budget proposal to significantly cut respite care will make it more difficult for families to keep their loved ones at home and in the community.[18]

...

In summary, the Commonwealth violates the ADA by unnecessarily institutionalizing individuals at CVTC and other training centers who could be served in the community and by placing individuals currently in the community at risk of unnecessary institutionalization.

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[17] An increase of 400 slots per year averages to just ten slots per CSB, or less than one per month per CSB.

[18] Supported employment and other integrated day activities can also help prevent unnecessary institutionalization by helping individuals build a natural support system and by minimizing boredom and feelings of isolation that can contribute to behaviors that require crisis responses. Moreover, meaningful day activities, including supported employment, help individuals pursue their preferences and goals and feel challenged and stimulated. As discussed above, the State appears to be overly reliant on segregated sheltered workshops and day programs that offer little opportunity for real community integration, even though the State also offers more integrated supported employment opportunities.

Individuals suffer harm and are placed at risk of harm while needlessly institutionalized. The Commonwealth has failed to ensure an adequate supply of community-based services, particularly for individuals with complex needs, necessary for the discharge of individuals from the training centers and for the prevention of unnecessary admissions of individuals waiting for services in the community. Moreover, the rate of discharge of individuals from CVTC and other training centers into the community is far too slow, caused in significant part by a flawed discharge planning process and the lack of sufficient community-based alternatives. The Commonwealth's violations of the ADA come at a huge financial cost to all of its citizens.

V. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of both individuals in CVTC and, where appropriate, other training centers, and those at risk of being institutionalized at CVTC and other training centers, the Commonwealth should promptly implement the minimum remedial measures set forth below:

A. Serving Individuals with Intellectual and Developmental Disabilities in the Community

The Commonwealth must increase community capacity by allotting additional waivers and expanding community services to serve individuals in or at risk of entering the training centers. A sufficient number of waivers – far more than what the Commonwealth has currently budgeted – must be available to address both individuals confined to the training centers and those on the waitlist in the community. The Commonwealth should also take full advantage of opportunities available to it, including the Money Follows the Person program, to develop services for individuals being discharged from CVTC and the other training centers. As the State downsizes its institutional population, the State should realign its investment in services for individuals with intellectual and developmental disabilities away from institutions to prioritize community-based services.

As a means of preventing institutionalization, the Commonwealth should develop crisis services, preserve the respite services it has been providing, and provide integrated day services, including supported employment. The Commonwealth should move away from its reliance on sheltered workshops.

Virginia should make modifications to its Medicaid waivers or explore the development of additional waivers to facilitate the development of integrated and individualized community services for people with complex physical, medical, and behavioral needs. New targeted waivers for specialty populations could also be developed.

The Commonwealth should ensure that its quality management systems are sufficient to reliably assess the adequacy and safety of treatment and services provided by community providers, the CSBs, and CVTC. The systems must be able to timely detect deficiencies, verify implementation of prompt corrective action, identify areas warranting programmatic improvement, and foster implementation of programmatic improvement.

B. Discharging Individuals from CVTC and the Other Training Centers

The Commonwealth must implement a clear plan to accelerate the pace of transitions to more integrated community-based settings. The Commonwealth must overcome what has become an institutional bias in its system.

Discharge planning must begin at the time of an individual's admission. The process should be improved and simplified and should focus on needed services. Rather than determining whether an individual is "ready" for discharge, the Commonwealth must focus on which services each individual will require in the community and should begin constructing a plan for providing such services and facilitating discharge. The default cannot be institutionalization. The discharge and transition plan should include the individual's preferences, a discussion of how the individual will access services, and a plan on how to coordinate care among multiple providers, if applicable.

Assessment teams must become knowledgeable about community living options and services. During the treatment planning process and in implementing individual treatment plans, the Commonwealth should ensure that barriers to discharge are identified and addressed and, for individuals with a history of re-admission, that factors that led to re-admission are also analyzed and addressed. Treatment planning should be individualized, person-centered, and multidisciplinary, and it should include the individual and his family.

In order to ensure an appropriate transition upon discharge, the Commonwealth should engage identified community providers in the discharge planning process as far in advance of discharge as possible and develop and implement a system to follow up with individuals after discharge to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission. The community-based service agencies must be made full partners in the process of planning, developing, and preparing services for individuals, much like the CSBs are currently. The Commonwealth cannot rely primarily on staff at the institution. The Commonwealth must develop a process to clearly identify existing vacancies and explicitly review the physical or programmatic adjustments needed in those vacancies to match this capacity with an individual's needs as part of individualized discharge planning and to facilitate long-range planning. The Commonwealth should emphasize placement into smaller community homes in its transition planning.

The Commonwealth should also create, revise, and implement a quality assurance or utilization review process to oversee the discharge process. The quality assurance process should include, at a minimum: developing a system to review the quality and effectiveness of discharge plans; developing a system to track discharged individuals to determine if they receive care in the community as prescribed at discharge; and identifying and assessing gaps in community services identified through the tracking of discharge outcomes.

If any individual or guardian opposes placement, the training center should document the steps taken to ensure that they are making an informed choice. The training centers should implement strategies to address individual concerns and objections to placement. Families should be provided the opportunity to visit potential placements and to speak with provider agency staff and with other families whose loved ones live in the community.

The Commonwealth should make all efforts to prevent new admissions to the training centers, including expanding community services necessary to divert individuals and stabilize them in the community. If an individual is referred to a training center, however, Virginia must ensure that, before an individual is admitted, the person receives a professionally-based assessment to ensure that admission is necessary and that the institution is the most integrated setting appropriate to serve the needs of that individual.

VI. CONCLUSION

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. Although we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the Commonwealth in an amicable and cooperative fashion to resolve our outstanding concerns with respect to the services the Commonwealth provides to persons with intellectual and developmental disabilities at CVTC and other settings across the Commonwealth. Assuming that our cooperative relationship continues, we are willing to send our consultants' written evaluations – which are not public documents – under separate cover. Although the consultants' reports do not necessarily reflect the official conclusions of the Department of Justice, the observations, analysis, and recommendations contained therein provide further elaboration of the issues discussed in this letter and offer practical technical assistance to help address them.

We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing the areas that require attention.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to the ADA once we have determined that we cannot secure compliance voluntarily, 42 U.S.C. § 2000d-1, and pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them, 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with the Commonwealth and are confident that we will be able to do so. The Department of Justice attorney assigned to this investigation will be contacting the Commonwealth's attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Jonathan Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393.

Sincerely,

Thomas E. Perez
Assistant Attorney General

cc: James W. Stewart, III
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