



Human Writes

State Human Rights Committee Newsletter

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Summer 2011

Welcome to the Summer 2011 edition of Human Writes, a newsletter from the State Human Rights Committee (SHRC). The purpose of this newsletter is to share ideas, problems, solutions and other items of mutual interest among the Local Human Rights Committees and the SHRC. Please submit your thoughts and ideas to:

DBHS
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DBHDS WEB SITE – HUMAN RIGHTS INFORMATION

Below is some information from the DBHDS website on the Human Rights Mission and Structure. We encourage you to visit the site for more details.

Human Rights Useful Information

Mission

The Office of Human Rights assists the Department in fulfilling its legislative mandate under §37.2-400 of the Code of Virginia to assure and protect the legal and human rights of individuals receiving services in facilities or programs operated, licensed or funded by the Department.

The mission of the Office of Human Rights is to monitor compliance with the human rights regulations by promoting the basic precepts of human dignity, advocating for the rights of persons with disabilities in our service delivery systems, and managing the DBHDS Human Rights dispute resolution program.



Overview

The Department's Office of Human Rights, established in 1978, has as its basis the [RULES AND REGULATIONS TO ASSURE THE RIGHTS OF INDIVIDUALS RECEIVING SERVICES FROM PROVIDERS LICENSED, FUNDED, OR OPERATED BY THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES](#). The Regulations outline the Department's responsibility for assuring the protection of the rights of consumers in facilities and programs operated funded and licensed by DBHDS.

Title 37.2.400, Code of Virginia, as amended, and the Office of Human Rights assure that each consumer has the right to:

- Retain his legal rights as provided by state and federal law;
- Receive prompt evaluation and treatment or training about which he is informed insofar as he is capable of understanding;
- Be treated with dignity as a human being and be free from abuse and neglect;
- Not be the subject of experimental or investigational research without his prior written and informed consent or that of his legally authorized representative.
- Be afforded the opportunity to have access to consultation with a private physician at his own expense;
- Be treated under the least restrictive conditions consistent with his condition and not be subjected to unnecessary physical restraint or isolation;
- Be allowed to send and receive sealed letter mail;
- Have access to his medical and mental records and be assured of their confidentiality;
- Have the right to an impartial review of violations of the rights assured under section 37.1-84.1 and the right to access legal counsel; and
- Be afforded the appropriate opportunities... to participate in the development and implementation of his individualized service plan.
- Be afforded the opportunity to have an individual of his choice notified of his general condition, location, and transfer to another facility.

Structure

The Office of Human Rights is located within the Department of Behavioral Health and Developmental Services and is supervised by the State Human Rights Director. The State Human Rights Director oversees statewide human rights activities and provides guidance and direction to human rights staff.

The [State Human Rights Committee](#) (SHRC) consists of nine volunteers, who are broadly representative of various professional and consumer groups, and geographic areas of the State. Appointed by the State Board, the SHRC acts as an independent body to oversee the implementation of the human rights program. Its duties include to: receive, coordinate and make



recommendations for revisions to regulations; review the scope and content of training programs; monitor and evaluate the implementation and enforcement of the regulations; hear and render decisions on appeals from complaints heard but not resolved at the Local Human Rights Committee (LHRC) level; review and approve requests for variances to the regulations, review and approve LHRC bylaws, and appoint LHRC members.

The [Local Human Rights Committees](#) are committees of community volunteers who are broadly representative of various professional and consumer interests. LHRCs play a vital role in the Department's human rights program, serving as an external component of the human rights system. LHRCs review consumer complaints not resolved at the program level; review and make recommendations concerning variances to the regulations; review program policies, procedures and practices and make recommendations for change; conduct investigations; and review restrictive programming.

Advocates represent consumers whose rights are alleged to have been violated and perform other duties for the purpose of preventing rights violations. Each state facility has at least one advocate assigned, with regional advocates located throughout the State who provide a similar function for consumers in community programs. The DBHDS Commissioner in consultation with the State Human Rights Director appoints advocates. Their duties include investigating complaints, examining conditions that impact consumer rights and monitoring compliance with the human rights regulations.

(see link) <http://www.dbhds.virginia.gov/OHR-UsefulInformation.htm#hr1>

INSPECTOR GENERAL'S REPORT

At the SHRC meeting on March 4, 2011 Mr. John Pezzoli, Assistant Commissioner of Behavioral Health Services with the DBHDS reviewed the report on Eastern State Hospital, by G. Douglas Bevelacqua - Inspector General. Below is the Executive Summary of the OIG report and the links to the OIG and the report.

Executive Summary

In August 2010, Eastern State Hospital (ESH) opened a new, state-of-the-art 150 bed adult behavioral health facility containing 85 fewer beds than had been available the preceding year at this regional hospital. In preparation for the move to the smaller facility, starting in early 2010, ESH refused to admit new patients who had been civilly committed for involuntary treatment and, as of early November, the state hospital had denied admission to 30 Hampton Roads residents who had been screened by the Facility Management Committee (FMC) and determined to meet ESH's stringent admission criteria. ESH also restricted admissions for dozens of additional forensic patients during 2010 and, currently, there is a forensic waiting list of approximately 40 individuals awaiting a bed at ESH – most of who continue to be housed in local jails.



The moratorium on new admissions to ESH, and the loss of its unique safety net function for our most vulnerable citizens with serious mental illness, has created an unsustainable situation for consumers and their families, the nine Community Services Boards (CSBs) of Health Planning Region 5 (HPR V), and for the Hampton Roads community. This represents a failure of the facility component of the Commonwealth's public safety net for individuals needing involuntary intermediate-term psychiatric treatment.

The OIG's *Review* supports a finding that, the current capacity problem was created by the confluence of historically inadequate facility leadership, the loss of operating beds at ESH as part of the downsizing initiative, and the elimination of \$2.6 million in requested community funding in 2009. The inability to fund the creation of the expanded intensive community capacity, before retiring obsolete ESH buildings and moving patients into the new (downsized) facility, triggered the current crisis.

Admissions and discharges represent the front door and the back door to a state facility, and, if either the entrance or exit is blocked, it creates pressures for the entire public sector safety net system. Likewise, in this interdependent system, if the community lacks the capacity to receive discharge-ready individuals from the state hospitals, then the state facilities will not be able to return people to the community and free-up a bed for someone seeking admission. This interdependence explains much of what happened at ESH; however, the contemporaneous downsizing from 235 beds to 150 beds last summer exacerbated the problem.

The *Code of Virginia 1950, et seq.* (the *Code*) requires the Inspector General to investigate —complaints of abuse, neglect, or inadequate care.□ Despite the extraordinary efforts and creativity of crisis workers and other CSB staff, ESH's admissions moratorium meant that some currently unknowable number of Hampton Roads residents were unable to access the full range of public sector safety net services. This conclusion is supported by the case histories presented below and the waiting list profiles documented at Appendices I and II.

The OIG wants to highlight the heroic efforts of the HPR V CSBs during 2010. These mental health professionals created treatment alternatives for the civilly committed individuals under their care without accessing ESH and lacking the requested additional funding or the promised expanded community programs. Their skilled interventions, and ability to improvise, doubtless averted many bad outcomes as they worked to assure the safety of their consumers.

According to the admission criteria established by ESH, the persons screened and approved for admission to this state facility must: 1) Be a danger to themselves or others in the near future; 2) Be substantially unable to care for themselves; and, 3) They cannot be served in any less restrictive alternative to institutional confinement and treatment. While some of the individuals denied admission to ESH were returned to the acute care programs operated by private psychiatric hospitals, Hampton Roads currently has no provider of intermediate-care services, other than ESH, and some unknowable number of individuals,



requiring longer term treatment, did not receive that care they would have received at the state facility.

The Department of Behavioral Health and Developmental Services (DBHDS or the Department) recently hired a seasoned facility director to provide the solid leadership needed to chart a course through this crisis, in addition to resolving the backlog of ESH problems, like regaining certification at the Hancock Geriatric Center. The new facility Director is having an immediate, positive impact at ESH; however, the new Director and HPR V will need support from the DBHDS, along with additional General Assembly funding, to create the community infrastructure necessary to relieve the admissions pressure and provide appropriate supported community placements for the dozens of ESH residents on the discharge-ready list.

(OIG-Office of Inspector General DBHDS <http://www.oig.virginia.gov/rpt-Facilities.htm>)

(to read the report see: <http://www.oig.virginia.gov/documents/FR-ESH-197-10.pdf>)

DOJ FINDS VIRGINIA IN VIOLATION OF ADA

******** The following article is provided as a way for the SHRC to share items of mutual interest among the Local Human Rights Committees and the SHRC. The SHRC has not taken any position in this matter and is not endorsing any policy. The article is for educational purposes.***

On February 10, 2011, Governor McDonnell received a letter from the Department of Justice, (DOJ), Civil Rights Division, Office of the Assistant Attorney General. (to view the complete letter go to: http://www.governor.virginia.gov/news/docs/DOJ_Findings_Letter_2011-02-11.pdf) Below is an article from DEVELOPMENTS IN MENTAL HEALTH LAW, Vol. 30, Issue 2 (printed with permission)

DOJ Finds Virginia Violates ADA/Olmstead

The Civil Rights Division of the United States Department of Justice notified Governor Robert F. McDonnell by letter dated February 10, 2011 of the findings that Virginia is violating the Americans with Disabilities Act as interpreted by the United States Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999), http://www.justice.gov/crt/about/spl/documents/cvtc_findlet_02-10-2011.pdf.

DOJ wrote:

“The inadequacies we identified have resulted in the needless and prolonged institutionalization of, and other harms to, individuals with disabilities in [Central Virginia Training Center] and in other segregated training centers throughout the Commonwealth who could be served in the community.” DOJ faults Virginia for its



reliance on “unnecessary and expensive institutional care” which has led not only to these civil rights violations, but also “incurs unnecessary expense.”

In August 2008, DOJ notified then-Governor Kaine of its intent to conduct an investigation into the quality of services and treatment at CVTC under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. CRIPA was enacted in 1980 to authorize DOJ to investigate what was then described as squalid conditions in state-operated facilities for persons with mental illness and intellectual disabilities and to take remedial action to force states to provide an acceptable level of care and treatment as later established under *Youngberg v. Romeo*, 457 U.S. 307 (1982). CRIPA also covers conditions in state and local prisons and jails, juvenile correctional facilities and nursing homes, but does not authorize investigations at private facilities. CRIPA only permits DOJ to investigate *systemic* constitutional and federal law violations (hence the ADA violations found), but not individual complaints. DOJ investigated four Virginia psychiatric facilities and one training center in the 1990s.

DOJ conducted on-site visits at CVTC in November and December 2008, and again in April 2009. In October 2009, Thomas E. Perez was sworn in as Assistant Attorney General for the Civil Rights Division at DOJ. Shortly thereafter, Mr. Perez announced a shift in priority away from investigating and improving conditions of confinement in government-operated facilities towards enforcement of the Americans with Disabilities Act and its mandate requiring that individuals with disabilities receive services in the most integrated setting appropriate to their needs. On April 23, 2010, DOJ advised Governor Kaine of its expansion of the CRIPA investigation to focus on the State’s compliance with the ADA and the *Olmstead* decision. It conducted a 4-day on-site investigation at CVTC in August 2010, reviewing not only the policies and practices at CVTC, but also visiting community programs in the region and examining the Commonwealth’s efforts as a whole to both discharge individuals to more integrated settings and to prevent unnecessary institutionalizations.

Specifically, DOJ found that Virginia systemically violates the rights of those living in its institutions by failing “to develop a sufficient quantity of community-based alternatives for individuals currently in CVTC and other training centers, particularly for individuals with complex needs;” by failing “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 by implementing “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.” DOJ further found that the Commonwealth also places individuals currently living in the community at risk of institutionalization by failing “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 by



failing to ensure a sufficient quantity of services, including crisis and respite services, to prevent the admission of individuals to training centers when they experience crises.”

As is required under CRIPA, DOJ also set out a number of remedial remedies that it has determined Virginia must undertake to address these violations related to both serving individuals with intellectual disabilities in the community and discharging individuals from CVTC and its four other training centers. These include providing a sufficient number of waiver slots “ – far more than what the Commonwealth has currently budgeted – ” to address the needs of those currently in training centers and those on the waiting list, and taking full advantage of funding opportunities, including the Money Follows the Person program. Virginia must also align its investment in services away from institutions to prioritize community-based services. It should develop crisis services, preserve respite services already being provided and provide integrated day services, including supported employment without relying on segregated sheltered workshops, as Virginia currently does. The state should also make modifications to its Medicaid waivers or develop new targeted waivers for specialty populations including those with complex physical, medical and behavioral needs. The Commonwealth should also ensure that its quality management and licensing systems are sufficient to monitor and assure the adequacy and safety of treatment services provided by the community services boards, private providers and state training centers. “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.”

In addition, DOJ states that the Commonwealth must implement “a clear plan to accelerate the pace of transitions to more integrated community-based settings” and overcome the institutional bias in its system. Discharge planning must begin at the time of admission and be improved and simplified, focusing on needed services, rather than whether an individual is “ready” for discharge. Virginia must focus on which services each individual will require in the community and begin constructing a plan for providing those services. Assessment teams must become knowledgeable about services available in the community and engage community providers in the discharge planning process as far in advance as possible. It must develop and implement a system to follow up with individuals after discharge to identify gaps in care and reduce the risk of re-admission. DOJ will require that community-based agencies must be made full partners in the process of planning and developing services for individuals. The Commonwealth must also develop a quality assurance or utilization review process to oversee the discharge process, including “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 that is prescribed at discharge; and identifying and assessing gaps in community services identified through tracking of discharge outcomes.”



And DOJ insists that if individuals, guardians or family members oppose discharge, the training center must document steps taken to ensure that they are making an informed choice and adopt strategies to address their individual concerns and objections. Families should also be provided the opportunity to visit potential placements and talk with provider staff and other families with relatives living in the community. Under CRIPA, DOJ must give the state notice of the conditions which leads it to believe that the state is systemically violating the constitutional or federal rights of persons in its institutions and give the state at least 49 days to correct the violations before it initiates a law suit. Obviously, correcting long-term systemic violations or even negotiating a settlement that establishes a roadmap to correct those deficiencies with terms similar to those found in the *United States v. Georgia* settlement agreement http://www.justice.gov/crt/about/spl/documents/ga_settlement_fact_sheet.pdf will take much longer than 49 days. However, if DOJ finds that the state is entering into good faith negotiations to timely resolve the violations identified in accordance with DOJ's overall objectives, then DOJ will allow a reasonable amount of time to negotiate the terms of any settlement and correct the violations.

Upon receipt of the letter, Governor McDonnell promptly introduced House Bill 2533 (Cox) and Senate Bill 1486 (Northam) to amend § 37.2-319 that establishes the Behavioral Health and Developmental Services Trust Fund to authorize the expenditure of funds to facilitate the transition of individuals with intellectual disabilities from state training centers to community-based services. The legislation that the General Assembly passed on the last day of the session directs the Secretary of Health and Human Resources to develop a plan to transition individuals from state training centers to community-based settings and to include facility specific objectives and timeframes to implement the changes with input from the individuals receiving services and their families: <http://leg1.state.va.us/cgi-bin/legp504.exe?111+ful+HB2533H3+pdf>. The plan must be submitted to the House and Senate money committees by November 1, 2011 with reports on development and implementation of the plan submitted in July and December of each year beginning July 1, 2011. In addition, the bills authorize any funds to be deposited into the trust fund to finance a broad array of community-based services including up to 600 Intellectual Disability waiver slots, one-time transition costs for community placements, appropriate community housing and other identified community services that may not be covered through the waiver program

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US Supreme Court Allows VOPA to Sue DBHDS

In a 6-2 decision written by Justice Antonin Scalia, the United States Supreme Court held on April 19, 2011 that the Virginia Office for Protection and Advocacy (“VOPA”), an independent state agency, can sue on its own behalf the Virginia Department of Behavioral Health and Developmental Services (“DBHDS”) under the *Ex parte Young* exception to the doctrine of sovereign immunity as embodied in the Eleventh Amendment to the United States Constitution. *Virginia Office for Protection and Advocacy v. Stewart, Commissioner, et al.* 563 U.S. __ (Docket No. 09-529), slip opinion found at: <http://www.supremecourt.gov/opinions/10pdf/09-529.pdf>. Agreeing that VOPA could bring suit on behalf of other individuals, DBHDS had argued that VOPA itself could not sue another state agency or its officials to enforce its federally created rights.

In upholding the right of VOPA to sue, the Court reversed the decision of the Fourth Circuit Court of Appeals that decided such a suit would offend the sovereignty and dignity of the State. *Virginia v. Reinhard*, 568 F.3d 110 (4th Cir. 2009). The case will now return to the United States District Court in Richmond for a decision on the merits of whether VOPA may access privileged “peer review” information when investigating allegations of abuse. The case will be assigned presumably to Judge Robert E. Payne who originally determined that VOPA could sue another state agency’s officials under *Ex parte Young*. For full article see link at: [DMHL Vol. 30 Issue 4.pdf](#)

SHRC Subcommittee to Review LHRC Structure

In the fall of 2010 the SHRC appointed a subcommittee to review LHRC structure. The SHRC approved the subcommittee recommendation to establish model LHRC Bylaws and model Cooperative Agreements between the LHRC’s and affiliated providers. These documents were sent to the Human Rights Advocates to distribute to the LHRC’s to be implemented by June 31, 2011. The Advocates and the LHRC’s have provided feedback to the SHRC about the process and the documents. Below is some clarification of some of the issues:

- **Affiliation Fees:** The action by the SHRC regarding affiliation fees was to clarify that affiliation fees cannot be set by the LHRC as a condition of affiliation, and that these funds do not belong to the LHRC. The providers affiliated with each LHRC are strongly encouraged to get together and determine, with the input of the LHRC, how to fulfill their obligation under the Regulations to provide support to the LHRC. The providers affiliated with your LHRC may decide to continue things much as they are now with one affiliate providing all of the support to the LAHRC and collecting fees from other affiliates to cover this cost.
- **Noncompliance:** The SHRC did not specifically consider what actions are to be taken if a provider fails to meet their obligation to support the LHRC either directly or



- through delegation to another affiliate. However, each provider is responsible for complying fully with the regulation, including the requirement to provide support. And providers who are not compliant with the Regulations may be subject to Licensure citation and sanctions invoked by the Commissioner of DBHDS.
- **Quarterly Reports:** The subcommittee originally considered moving to just an Annual Report, as that is all that is required under the Regulations. Several members felt that the Advocates receive the quarterly reports and could bring issues to the LHRC. The SHRC received comments from the Advocates, however, that this would not be acceptable to LHRCs-that many LHRCs receive quarterly reports and rely on them. The Office of Human rights is currently working on developing model quarterly and annual reporting formats to ensure that the information collected is consistent across all LHRCs and that the data collection and analysis is not overly burdensome to the provides or the LHRCs. Your LHRC can decide how you would like to use these quarterly reports.
 - **Notification of SHRC of Section E Activities:** LHRCs have been seeking guidance on how best to notify the SHRC that they are engaged in activities which fall under Article II Section E of the model LHRC By Laws. Several LHRCs have asked if noting these activities in their minutes is sufficient. Other LHRCs have asked to include these activities in their By Laws. LHRCs should notify the SHRC of Section E activities through a letter to the Chair of the SHRC, copied to the Office of Human Rights. LHRCs may not make changes to Article II Section E in the model By Laws. The Office of Human Rights will maintain a tracking sheet of Section E activities, similar to the tracking sheet currently used for variances, and the SHRC will review this information periodically.

COMMUNICATIONS COMMITTEE: Request for Feedback

Chair: Carolyn Devilbiss

In order to facilitate better information sharing among the LHRC members, the SHRC, and the Department, a number of suggestions have been put forward. We would appreciate your feedback about these as well as other ideas or concerns. SHRC members will continue to visit LHRC's during the year for information sharing, and the newsletter Human Writes has resumed regular publication.

In this age of electronic communication, some ideas for using email and the websites are being considered.

1. **Email:** A distribution list maintained by Department staff could collect email addresses of willing chairpersons and other leadership from LHRC's. It would be used to distribute information more directly and frequently to the LHRC's and to receive questions or



information from them. It would not be used for distributing or discussing confidential material, but would be a vehicle for sharing information about issues, concerns, procedures, training and other business.

2. **Website:** The website may be further enhanced to include more training modules as well as information for the public. The Communications subcommittee will be reviewing the State Human Rights website this year to consider additions or changes that may further our goal.

Please send your feedback about these and other suggestions for enhancing communication to the committee through kli.kinzie@dbhds.virginia.gov and put in the subject line SHRC Communication Subcommittee.

LHRC Health Care Provider Definition

Background Information:

1. **The Code of Virginia (see below) established the requirement for at least one member of the LHRC to be a “health care provider.” This requirement was placed in the code in 2005.**

§ 37.2-204. Appointments to state and local human rights committees.

The Board shall appoint a state human rights committee that shall appoint local human rights committees to address alleged violations of consumers' human rights. One-third of the appointments made to the state or local human rights committees shall be current or former consumers or family members of current or former consumers, with at least two consumers who are receiving or who have received within five years of their initial appointment public or private mental health, mental retardation, or substance abuse treatment or habilitation services on each committee. **In addition, at least one appointment to the state and each local human rights committee shall be a health care provider.** Remaining appointments shall include lawyers and persons with interest, knowledge, or training in the mental health, mental retardation, or substance abuse field. No current employee of the Department, a community services board, or a behavioral health authority shall serve as a member of the state human rights committee. No current employee of the Department, a community services board, a behavioral health authority, or any facility, program, or organization licensed or funded by the Department or funded by a community services board or behavioral health authority shall serve as a member of any local human rights committee that serves an oversight function for the employing facility, program, or organization.

In 2005 the SHRC decided “For the purpose of these appointments, current and former health care providers will be considered. The SHRC will consider otherwise qualified individuals as “health care providers” when the following definitions are met” The definitions were those in the Code of Virginia § 8.01-581.1.

At the March 4, 2011 SHRC meeting the committee passed a motion to change the “Health Care Provider” SHRC guidelines for meeting the requirements of § 37.2-204. *Appointments to state and local human rights committees as follows: (new language is underlined):*



1. Each LHRC must have at least one member who is a Health Care Provider as defined in the Code of Virginia § 8.01-581.1 or § 32.1-127.1:03. OR be a person who has a minimum of five years' experience in the delivery of direct services to persons with mental illness, intellectual disabilities or substance abuse.
 2. The role of the Health Care Provider on the LHRC is to provide their perspective on matters presented to the LHRC based on their professional experience and knowledge of mental illness, intellectual disabilities or substance abuse. They are there to "to address alleged violations of consumers' human rights," the same as any other LHRC member. They are not present to practice their profession or evaluate the treatment decisions of LHRC affiliates.
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SHRC MEETINGS

SHRC meetings are held around the state at both facility and community program locations. SHRC meetings are open to the public except for portions which are in executive session as allowed under the provisions of the Virginia Freedom of Information Act. The SHRC met on March 4, 2011 at Charlottesville VA at the Region Ten CSB and toured the Crisis Stabilization Program facility. The SHRC met at the Goochland-Powhatan Community Services Board facility in Powhatan VA. The SHRC will next meet on June 10, 2011. Minutes of the SHRC meetings are available on the Department's web site. <http://www.dbhds.virginia.gov>