



UNIVERSITY LEGAL SERVICES (ULS)

The Protection & Advocacy Program for the District of Columbia

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D.C. BAR FOUNDATION FUNDS NEW GRANT TO EXTEND ADVOCACY FOR INDIVIDUALS AT ST. ELIZABETHS HOSPITAL

*By Richard A. Perry,
ULS-P & A Staff Attorney*

With grant funding from the D.C. Bar Foundation, University Legal Services strengthened its advocacy program for consumers at St. Elizabeths Hospital this winter by creating the position of ULS Pro Bono Coordinator / Staff Attorney. The new attorney, Richard Perry, represents the consumers at St. Elizabeths Hospital, specifically in the grievance process. In addition, as Pro Bono Coordinator, Richard was tasked with creating a pro bono program at University Legal Services and bringing in attorneys from D.C. area law firms to represent the consumers at St. Elizabeths. The pro bono program is now up and running and off to a strong start.

D.C. law protects the rights of the consumers at St. Elizabeths, but unfortunately these rights are often violated. At present, the primary method for consumers to vindicate their rights individually is through an administrative "grievance" process. Consumers file a grievance with St. Elizabeths. If St. Elizabeths denies the grievance, the consumer may appeal the grievance to an external review. An external review is an informal hearing where consumers can present their case to an independent external reviewer. Consumers can also call witnesses and question Hospital staff. Consumers have the right to be represented during the grievance process. ULS' pro bono program seeks to have pro

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DISTRICT OF COLUMBIA SETTLES FEDERAL LAW SUIT ON BEHALF OF MEDICAID BENEFICIARIES

*By Jennifer Lav
Staff Attorney*

On January 26, 2009, the District agreed to remedy its illegal termination of Medicaid-funded van transportation services for thousands of indigent District residents by agreeing to restore their van transportation if they file an administrative appeal within 15 days. This ensures that Medicaid recipients with disabilities who need transportation to medical appointments will be able to access those services.

In August 2008, the District, through its contractor, Medical Transportation Management, Inc., summarily cut thousands of individuals' Medicaid-funded van transportation

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(D.C. BAR FUNDS NEW GRANT TO EXTEND ADVOCACY FOR INDIVIDUALS AT ST. ELIZABETHS HOSPITAL...Continued from page 1)

bono attorneys and paralegals represent St. Elizabeths consumers in the grievance process.

While ULS has existed for many years, it has until recently not had a widespread presence in the pro bono community. Firms such as King & Spaulding and Kelley, Drye & Warren have taken a lead role with ULS in structural reform cases, but ULS has not had a structured program in which ULS referred many individual cases to pro bono attorneys. This has changed with the new pro bono program.

ULS held a training entitled "Protecting the Rights of Patients at St. Elizabeths Hospital" on May 7, 2009. Twenty-seven attorneys and paralegals from area law firms attended the training and learned how to represent St. Elizabeths consumers in the grievance process. Richard Perry and his colleague Patrick Wojahn taught the attorneys about the grievance process, about the nuts and bolts of working with clients at St. Elizabeths (for instance, how does one get into the ward at St. Elizabeths to visit one's client?), and about the substantive legal rights that consumers enjoy under the D.C. Mental Health Consumers' Rights Protection Act of 2001. In addition, Perry and Wojahn taught the pro bono attorneys and paralegals ULS' philosophy of respect for consumers and how to overcome the unique challenges posed by representing individuals who are institutionalized. The training was hosted and supported by Howrey LLP and was a great success.

In the lead up to the training, University Legal Services notified the pro bono coordinators of virtually every large area law firm about the training and met in person with several of these

coordinators. ULS advertised its training with the D.C. Consortium and on D.C. Pro Bono Net, gave a presentation about its new pro bono program at the February meeting of the D.C. Pro Bono Partnership, and participated in the February Washington Council of Lawyers Pro Bono Fair. The area's legal community now has a better understanding of ULS and its pro bono program.

Many of the grievances of St. Elizabeths consumers involve involuntary medication. While the law regarding involuntary medication can be complicated, in a nutshell St. Elizabeths Hospital can give a consumer involuntary medication only if that consumer has been declared incapacitated for the purpose of making health care decisions, and the consumer is either posing an imminent danger of serious injury to self or others or the Hospital has gone before a Medical Review Panel and obtained authorization to involuntarily medicate the consumer. Often, however, St. Elizabeths staff give involuntary medication to consumers because they are being "loud" or "disruptive". ULS hopes that the pro bono attorneys who take grievance cases will help educate Hospital staff and external reviewers about the legal restrictions on involuntary medication and other consumer rights.

In addition, ULS hopes that the pro bono attorneys and paralegals who represent St. Elizabeths consumers through the new pro bono program will gain a greater understanding of the lives of consumers at St. Elizabeths, and hopefully spread their understanding to the broader community. ULS' pro bono program will thereby not only help bring quality legal representation to more St. Elizabeths consumers but will also help the community learn more about their neighbors who have a mental illness.

(DISTRICT OF COLUMBIA SETTLES FEDERAL LAW SUIT ON BEHALF OF MEDICAL BENEFICIARIESContinued from page 1)

services, due to cost overruns in the contract. Many District residents with disabilities who relied on the service were left without a way to access their doctors, day treatment programs, and mental health services.

After several attempts to convince the District to respond, in September 2008, University Legal Services (ULS) and the National Health Law Program (NHeLP) sued the District, challenging these terminations and asking a federal court to stop the termination of Medicaid benefits without notice and without a chance to challenge the decision to terminate benefits.

On January 26, 2009, the District settled the lawsuit, agreeing to send a new notice to the affected recipients explaining their right to a hearing and how to get van services pending the outcome of the hearing. The District also agreed not to terminate any recipient's transportation in the future without complying with the law. Last, the District agreed to continued court oversight for 90 days to ensure that the District provides the required notice. In total, at least 650 individuals got a chance to ask for a new hearing.

WE NEED YOUR HELP!

ULS is a non-profit, 501(C)(3) organization. Your tax-deductible gift will enable us to continue to provide advocacy services by experienced staff for people in our community with disabilities. Your gift will enable us to maintain excellent services as well as expand into areas where there are needs but fewer resources to meet them. Please make your check payable to University Legal Services and send it to the attention of Jane Brown, University Legal Services, 220 I Street, N.E., Suite 130, Washington, D.C. 20002, and we will be happy to send you a donation letter for your tax records.

NEW STAFF JOINS DC JAIL ADVOCACY PROJECT

By Gretchen Rohr
 ULS Staff Attorney



In December 2008, Ilana Marmon joined the DC Jail Advocacy team as a Reentry Advocate. Ilana is a licensed social worker who previously worked at The Legal Aid Society's Criminal Defense Division in Brooklyn, NY, serving individuals with mental illness and chemical addictions involved in the criminal justice system. Before that, she was a team leader for Pathways to Housing's Assertive Community Treatment team in East Harlem. Now with ULS, she enters the DC Jail every week to work alongside people who are planning their return back to the community.

ULS asked Ilana to share her thoughts about her work:

I am so excited to be a part of a project so committed to community re-integration and recovery for people with mental illness who have been incarcerated.

Our project demonstrates that with the right supports, people with mental illness who have been incarcerated are able to achieve their goals, and when empowered with knowledge, will exercise their rights. As Re-entry Advocate, I work directly with individuals who are incarcerated or have recently been incarcerated at the DC Jail on collaborative transition plans. The transition plans are based on the individual's goals and preferences for treatment and are to ensure they receive the supports they are entitled to upon their return to the community. Along with the rest of the Project team, I

continue to work with people for several months (or longer) after their release to help ensure that they are connected with services which meet their needs. I am eager to continue to work with our team on expanding access to resources for people who are incarcerated and advocating for continuity of care for those whose services were interrupted by a period of incarceration. I am also excited about the opportunity to work alongside the Project's peer advocate, Angela Agnew, and experience the value of peer advocacy in reaching people and educating them about their rights. It is also exciting to have the opportunity to work in a project that challenges systemic issues and pushes for reform. In my past positions as a social worker, I have often felt helpless to challenge systemic issues that have affected people deeply and served as unfair barriers to their recovery. Unfortunately, this attitude is pervasive among providers, and often leads to burnout, which directly affects the people we work for. Fortunately, in the Jail Project, our goal is to challenge such systemic problems to remove unnecessary barriers to re-integration and recovery. I feel empowered to work with a Project that not only identifies problems within the system, but proactively seeks to rectify them. I look forward to learning and growing in my role as Re-entry Advocate and contributing to the mission of the Project.

THE POWER (of a) PLAY

By Samuel Allen
 Advocate

In what is becoming an annual tradition, University Legal Services' PAIMI Advisory Council ("PAC") put on a series of performances in May 2009 for Mental Health Month. The PAC, a group of consumers, advocates, family members, mental health professionals and interested individuals, is an important part of ULS' mental health advocacy, helping to shape our priorities and provide a bridge to the population we are serving. Building on the success of last year's performance, "Dr. Prozac," a short play about the importance of self advocacy and a consumer's right to informed consent about medications, the PAC set about preparing for another round of performances this year. In light of the imminent closure of the D.C. CSA, the public mental health agency, and all the surrounding anxiety and confusion, it didn't take much time to decide on a topic for this year's play.

In "Paul's Transition," Paul, the central character in the PAC's plays, is a consumer navigating the mental health system. This time Paul has to deal with the fact that his core services agency is closing and he will no longer be able see the doctor and staff that he has come to know over the many years he has spent there. Faced with this, Paul is unhappy and resistant to finding a new mental health agency. After being matched with a peer consultant who helps guide him through the process, however, he selects and attends a new program. With "Paul's Transition" as the name and theme of the new play, the PAC set about preparing for their performances.

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After much discussion, the PAC decided it wanted to put on at least five performances, at both inpatient and outpatient locations. The PAC selected the Community Connections Day Program, the McClendon Center Day Program, and both the civil and forensic sides of St. Elizabeths Hospital for performance sites. The PAC also chose to perform the play at DMH's monthly providers' business meeting because it would allow the providers to request a follow-up performance at their agency if they desired.

After a successful performance at the DMH business meeting, the PAC was ready for their first public show in the chapel at St. Elizabeths Hospital. A couple of consumers from the hospital were keen to take part, and after a quick review of their lines, were raring to go. Nearly a hundred consumers filled the chapel. Buoyed by this turnout, the PAC put on a great display. The consumers present also appeared to enjoy it, judging by

the long and lively series of questions that followed. In the afternoon, the PAC moved to the auditorium at the John Howard Pavilion for the second performance of the day. Despite a few technical difficulties arising from using microphones for the first time, the second performance was also a success, again sparking a lively discussion among the eighty consumers in attendance.

Now well seasoned to the rigors of public performance, the PAC sailed through their last two performances. The McClendon Center and Community Connections, and the more than sixty consumers in attendance, were great hosts and helped the PAC finish this year's events in style. The PAC plans to do a filming of the performance, with the DVD being available as an outreach and education tool along with the recording of last year's performance, "Dr. Prozac." If you are interested in a free copy of the DVD, please contact ULS.

CIT: A STEP IN THE RIGHT DIRECTION

By Leah Harris

Former ULS PAIMI Advisory Council President

This article was reprinted from the April 2009 edition of Capital Connection with permission of the author

My mother was diagnosed with schizophrenia when she was 18. She tried her best to raise me as a young single mom in Milwaukee, WI in the 1970s. I remember on more than one occasion, my mother struggled with extreme mental states that made it difficult for her to cope with reality. She was afraid that people were coming after her, and this was terrifying for us both. She sometimes feared that the food supply was being poisoned, so we did not eat.

Clearly, we needed support, but the "support" often first came in the form of police breaking down the door to my mother's apartment when she would not answer. Why did my mother not answer? I believe that it was in large part due to past terrible experiences with police brutality and also because police banging loudly on her door actually validated her fears that people were out to get her. As a little girl, I was traumatized by these experiences with police crisis intervention, handled the WRONG way—once in particular, I heard my mother's screams as the police threw her down the stairs. I was four years old and will never forget it.

Later, as a troubled teen, my family called the police on me when I was going through an emotional crisis of my own. I remember being treated terribly. I was cuffed in an uncomfortable position (when I had committed no crime) and made to sit in that position for hours in the back seat of the police car while I was being "processed." I was sixteen years old. No one explained to me what was going to happen to me next, and it was both physically and emotionally torturous and humiliating. Now I know that this is **nothing** compared to what many people suffer at the hands of police who may mean well but are not clearly not trained to work with people who are in emotional distress. In the worst case scenario, people end up dead— a horrible tragedy for the entire community.

Because of my personal experience, I am glad that DMH and MPD are collaborating to start a Crisis Intervention Training (CIT) program in the District to help officers to understand the best ways to work with someone in extreme emotional distress. I have spoken with some police officers about this issue and they genuinely want to help, while keeping themselves and the community safe. I think a true community collaboration could reduce the use of violence and force and avoid retraumatizing people who have more than likely already experienced more trauma than most people can imagine.

Below I am providing a little bit of information and background on CIT for those who aren't familiar with the "Memphis Model." I hope all citizens who are wishing to provide input on the training will get involved, especially people with psychiatric diagnoses who have also experienced the prison system. Let's spread messages of mental health recovery, hope, and give police practical tools to serve and protect more effectively. We also need to advocate for better coordination between MPD and the Mobile Crisis

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IMPORTANCE OF ADVANCE DIRECTIVES FOR INDIVIDUALS TRANSITIONING BACK TO THE COMMUNITY

*By Tiffani Nichole Greenidge
JD, Advocate*

Types of Advance Directives

There are several types of advance directives, one of which is a living will.¹ A living will “specifies the medical treatment people do or do not want if they become terminally ill or incapacitated.” Another type of advance directive is a “durable medical power of attorney, also called a health care power of attorney [which] is a document in which an individual appoints someone to make decisions about health care if he or she is unable to do so.”² Often the medical decisions the medical power of attorney makes are based on the individual’s wishes as outlined in his or her living will.

Typically, these two types of advance directives are both done with copies provided to the individual appointed as the health care power of attorney as well as to the signer’s health care provider. The person who executes these documents can revoke them, or terminate them at any time prior to becoming incapacitated. The revocation can be done verbally or in writing, but it is best to revoke the documents in writing and provide that revocation document to the person designated as the health care power of attorney to be removed and to a health care provider.

Steps to Executing an Advance Directive

Step 1: Identify one or two people you trust to make specified medical decisions on your behalf based on your explicit instructions. The document appointing a health care power of attorney will request that you name one person as your health care power of attorney and a second person as an alternate if the first appointee cannot or will not make decisions according to your wishes.

Step 2: Check the requirements for executing advance directives in your state; each state had different requirements. A template for valid advance directives for Washington, DC can be obtained from the US Living Will Registry at www.uslivingwillregistry.com or from the American Association of Retired Persons (AARP) Legal Counsel for the Elderly (LCE) program. (For more information about LCE, please see below).

Step 3: Determine what medical procedures you do and do not want performed. These decisions will be memorialized in your living will. For example, what goals would you set for your care if you are seriously ill or seriously injured, if you are or if you have an end-stage condition? Specify the types of medical procedures you want to have including the level of life-saving measures you want. Another area addressed in an advance directive is whether you wish to donate any of your organs to a proper medical organization. Lastly, you can choose if you wish to have an autopsy following your death and specify any other wishes regarding your health care that you feel are important.

Step 4: It is vitally important that you review your living will with the person you have appointed as your health care power of attorney and with the alternate to ensure that they understand your wishes and if necessary, will be able to act on your behalf.

Step 5: In order for the living will and the health care power of attorney to be valid in Washington, DC you must sign and date the document in the presence of two witnesses who do not have an interest in your care as established under the document. These witnesses will attest that you are competent to make your own health care decisions and to appoint a health care power of attorney. Your health care power of attorney and the alternate cannot be witnesses nor can anyone who takes care of you or is mentioned in your will.

Step 6: Copies of the living will and health care power of attorney should be provided to your health care power of attorney and the alternate person as well as your home health agency and physicians. You should also retain a copy for your records. In

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THE TROUBLE WITH DDS' ELIGIBILITY PROCESS

By *Ebele Onwueme*
Staff Attorney

Mr. E. is a 30 year-old man who is dually diagnosed with a mental illness and an intellectual disability. He currently resides in St. Elizabeths Hospital and has been there for the past 5 years. As a student, Mr. E. was found eligible and received special education and related services while attending elementary, middle and high school in the District of Columbia.

Unfortunately, neither Mr. E. nor his family possess any of the paperwork pertaining to Mr. E.'s eligibility and receipt of special education and related services while attending District of Columbia Public Schools (DCPS). ULS requested Mr. E.'s cumulative school records or at least proof that he was indeed receiving special education services as a student from DCPS, but DCPS has been unable to locate any of his school records.

As a result of the lack of documents to demonstrate that Mr. E. was diagnosed with an intellectual disability before age 18, the District of Columbia Department on Disability Services (DDS) has been unwilling to consider Mr. E.'s eligibility for Medicaid home and community-based waiver services. ULS has been advocating for several individuals with intellectual disabilities like Mr. E. who have not been found eligible for DDS' services due to their lack of pre-18 diagnostic information. Upon inquiry on the status of Mr. E.'s application, DDS stated that they have an "Internal Review Committee" which is in the process of reviewing their policies as it applies to individuals who cannot produce any pre-18 diagnostic information, and that this committee will assess whether the documentation that was provided is sufficient to determine eligibility. Unfortunately, there has been no change in Mr. E.'s status and despite submitting their applications to DDS (some going as far back as several years), he and other individuals like him, continue to exist in an eligibility "limbo" where DDS has failed to find them eligible or ineligible for services.

Sadly, in 2008, ULS completed an investigation and a report on a sixty-five year old man who died in squalor while waiting for DDS to determine him eligible for services. ULS' investigation demonstrates what can occur if vulnerable individuals are denied much-needed services.

ULS has written several letters to DDS on this issue and has urged DDS to review its policies to find an effective and efficient method of determining the eligibility of individuals who do not possess documents that indicate they were diagnosed prior to their eighteenth birthday in order to prevent further tragedies. Unfortunately, to date, DDS has still not issued a response to ULS' concerns and Mr. E. and other individuals like him continue to languish and deteriorate.

Undaunted by DDS' failure to respond or act, ULS continues to be committed to advocating for individuals like Mr. E. who need assistance in accessing community-based services to which they are entitled.

OLMSTEAD REPORTS

By *Marjorie Rifkin*
Managing Attorney

To commemorate the 10th anniversary of Olmstead v. L.C., the Supreme Court case that held that unnecessary institutionalization of individuals with disabilities constitutes discrimination, ULS published two major reports. "Out of State, Out of Mind: the Hidden Lives of D.C. Youth in Residential Treatment Centers," addresses the lives of the 300 to 550 children diagnosed with mental illness that the District pays to send to institutions called Residential Treatment Centers ("RTCs"), congregate institutions that tend to be far from the District, expensive, abusive, and most importantly, generally ineffective. "Home Sweet Home: Still An Elusive Right A Decade Later" discusses the status of people with disabilities in DC who are in nursing homes despite their right to live in the community under the ADA and the Olmstead decision. Both reports are available at www.uls-dc.org.

ULS ADVOCATES FOR STATE REGULATION OF SECLUSION AND RESTRAINT IN SCHOOLS SERVING DISTRICT OF COLUMBIA STUDENTS

*By Shawn Ullman, Esq.
ULS-P&A Staff Attorney*



School officials' inappropriate use of seclusion and restraint with students with disabilities has been the subject of several recent national reports. The National Disability Rights Network (NDRN), a national membership organization of protection and advocacy systems, issued a report in January 2009 entitled "School Is Not Supposed to Hurt," which describes dozens of instances across the country where seclusion and restraint practices in schools led to significant injuries and even deaths. The full report is available at <http://www.ndrn.org/sr/SR-Report.pdf>. In addition, the Council of Parent Attorneys and Advocates (COPAA), a national non-profit organization of parents, advocates, and attorneys, issued a report in May 2009 entitled "Unsafe in the Schoolhouse," which details 143 incidents of seclusion and restraint in schools including "reports of children subject to prone restraints; injured by larger adults who restrained them; tied, taped and trapped in chairs and equipment; forced into locked seclusion rooms; made to endure pain, humiliation and deprived of basic necessities, and subjected to a variety of other abusive techniques." The press release and report are available at <http://www.copaa.org/news/unsafe.html>. Finally, Congress held a hearing and the federal Government Accountability Office issued a report on seclusion and restraint in schools on May 19, 2009. The full report is available at <http://www.gao.gov/new.items/d09719t.pdf>.

Nationally, there is a growing consensus that seclusion and restraint are very serious and potentially dangerous interventions that should be used infrequently, carefully monitored, and regulated. Federal law limits when and how individuals may be secluded or restrained in hospitals and other facilities that receive Medicare or Medicaid funding. There are also District of Columbia laws that limit when and how individuals with mental illness can be secluded or restrained and that prohibit seclusion and significantly restrict instances when restraint may be used on individuals with developmental disabilities. However, none of these laws expressly apply to the school setting.

University Legal Service (ULS) is not aware of any instances where students with disabilities in the District of Columbia or in private schools that serve District students have been killed from seclusion or restraint. However, ULS does know that public, public charter, and private schools alike are currently using seclusion and restraint with students with disabilities, often without any internal policies or practices to ensure that seclusion and restraint are only used by well-trained staff and as a last resort when students are putting themselves or others at risk of serious injury. That is why ULS has very serious concerns about the use of these practices by public, public charter, and private schools that serve District students with disabilities.

ULS believes that all schools serving District students with disabilities need state-level guidance on if, when, and how seclusion and restraint may be appropriate in a school setting. Therefore, ULS has recommended that the Office of the State Superintendent of Education (OSSE) lead an effort that involves all relevant stakeholders including parents, advocates, and school officials to create appropriate state regulations.

If you have any questions about the use of seclusion and restraint in schools in the District of Columbia, please contact Shawn Ullman at (202) 547-0198, ext. 141 or sullman@uls-dc.org.

(IMPORTANCE OF ADVANCE DIRECTIVES FOR INDIVIDUALS TRANSITIONING BACK TO THE COMMUNITY...Continued from page 5)

addition, the US Living Will Registry has a program whereby, for a small fee, your advance directives are included in a nation-wide database which is available to health care providers across the United States.³

Assistance in Drafting Advance Directives

In addition to providing the template for valid advance directives in Washington, DC, the AARP LCE program can provide assistance in drafting a living will and a durable medical power of attorney. LCE can be reached at (202) 434-2120 or (202) 434-2170. LCE provides free legal services and advocacy for Washington, D.C. residents age 60 and older.⁴ For individuals younger than 60, Catholic Charities Legal Network can assist you in drafting advance directives.⁴ To schedule an intake with a member of their legal network call their appointment line at (202) 628-4263 on Monday, Wednesday, Thursday or Friday between 9:30am and 12:00pm and on Tuesday from 9:30am until 4pm. The caller must meet their income guidelines and a fee may be charged for their services.

¹ *A Matter of Life and Death: Schiavo Case Spurs More Americans to Weigh Living Wills*, AARP Bulletin, December 2003

² *A Matter of Life and Death: Schiavo Case Spurs More Americans to Weigh Living Wills*, AARP Bulletin, December 2003

³ US Living Will Registry – www.uslivingwillregistry.com

⁴ American Association of Retired Persons Legal Counsel for the Elderly Program - <http://www.aarp.org/aarp/lce/>

⁵ American Association of Retired Persons Legal Counsel for the Elderly Program - <http://www.aarp.org/aarp/lce/>

ULS COLLABORATES WITH THE DISTRICT AND OTHER NONPROFITS TO CELEBRATE THE ABILITIES OF INDIVIDUALS WITH DISABILITIES

*By Mary Nell Clark,
Managing Attorney*

ULS led an effort to coordinate a celebration of Inclusive Schools Week in December, 2008. Inclusive Schools Week is an opportunity for schools, the community, and the administration to express support for the efforts of the schools and parents as they partner to make the neighborhood school and each of its classrooms a welcoming and supportive place for children with special needs. It is also a recognition of the value that children with disabilities bring to every classroom and the societal benefit that comes from tolerance. Several agencies and nonprofit organizations met regularly for several months to coordinate the event on December 1st at the Old Council Chambers Building. D.C. Public Schools, the Public Charter School Board, the Arc of D.C., the Office of the State Superintendent of Education, the State Advisory Panel for Special Education, the D.C. Special Education Co-operative, Advocates for Justice, and the Office of Disability Rights all proclaimed their support for the benefits of inclusion. Though D.C. schools have a huge challenge ahead to actually make their schools inclusive, the first step to a successful attempt has to be the support of those at the top, and all the right words were spoken. Two inspirational speakers included D.C. City Council Chairman Vincent Gray and Dr. Nyankori, the D.C.P.S. Director of Special Education.

ULS also participated in the March celebration of Developmental Disabilities Awareness Month. Held at the John A. Wilson Building and attended by numerous council members, speakers included Councilmember Tommy Wells, D.C. Director of the Department on Disability Services Judy Heumann, DCPS Director of Special Education Dr. Richard Nyankori and a family member, Marty Clark. Participants spoke of the importance of enabling individuals with developmental disabilities to live independently, as valued members of in the D.C. community. ULS helped coordinate the event on March 19th with the D.C. State Developmental Disabilities Council, the Georgetown University Center for Child and Human Development, Project ACTION!, the Arc of D.C. and the Quality Trust for Individuals with Disabilities.

SOCIAL SECURITY WORK INCENTIVES 101

*By Tracy Chiles McGhee,
ULS-P&A Staff Attorney*

If you are a Social Security beneficiary that receives Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and would like to begin or to return to work, you should be aware of the work incentives that the Social Security Administration (SSA) offers so that you can make the best decision for you. Below is some general information regarding work incentives that may be useful on your path to employment.

What are Work Incentives?

Work Incentives are special Social Security rules that allow persons with disabilities receiving SSI or SSDI to work and still receive their monthly cash benefits, along with Medicaid and Medicare. Each program, SSI and SSDI, has their own work incentives but there are some they both share. For many, understanding these special rules can be difficult. The Social Security Administration has provided a grant to one hundred and four (104) Work Incentives Planning and Assistance (WIPA) projects across the United States (U.S.) and the U.S. territories to counsel SSA beneficiaries on work incentives and on how working impacts their benefits. These projects were previously known as Benefits Planning Assistance and Outreach projects or BPAOs before SSA made changes and replaced them with WIPA. So now the WIPA projects are available to assist SSA beneficiaries in making informed choices about work.

What is an Area Work Incentives Coordinator (AWIC)?

The Area Work Incentives Coordinator (AWIC) is a position established by the SSA to improve services to SSI and SSDI beneficiaries who would like to work. The AWICs are located in the local branches of SSA and manage and coordinate work incentives, community outreach, and service programs.

What is a Community Work Incentive Coordinator (CWIC)?

In each WIPA Project, services are provided by (CWICs). The CWICs counsel SSA beneficiaries with disabilities on work incentives and provide information regarding benefits planning so that beneficiaries can make informed choices about work. According to SSA, CWICs:

- provide work incentives planning and assistance;
 - help beneficiaries and their families determine eligibility for Federal or State work incentives programs;
 - refer beneficiaries with disabilities to appropriate Employment Networks or State VR agencies based on individual needs and impairment types;
 - provide general information about potential employer-based or federally subsidized health benefits coverage available to beneficiaries once they enter the workforce; and
- inform beneficiaries with disabilities of further protection and advocacy services available to them.

Finally, WIPAS also provide outreach and training to community providers and beneficiaries regarding these topics.

What are the SSDI & SSI Work Incentives?

- Impairment Related Work Expenses
- Subsidies and Special Conditions
- Unincurred Business Expenses
- Unsuccessful Work Attempts
- Continued Payments Under a Vocational Rehabilitation Program

Expedited Reinstatement (EXR)

What are the SSI Work Incentives?

- Blind Work Expenses
- Earned Income Exclusion
- Student Earned Income Exclusion
- Plan to Achieving Self-Support
- Property Essential to Self Support

TRIAL HELD ON REMEDY IN *EVANS V. FENTY*

By Sandy Bernstein
Legal Director

In March 2007, Federal District Court Judge Huvelle found that the District of Columbia failed to meet the needs of the *Evans v. Fenty* class members and that the District's noncompliance with the court orders in this three decades-old case was continuous, serious and systemic. The *Evans* class members are a particularly vulnerable population; many have intensive medical and psychological needs and are dependent on their service providers to meet their basic needs. The class members are all former residents of Forest Haven, an institution for District residents with developmental disabilities that closed in 1991. In its 2007 decision, the Court found that the District's noncompliance jeopardized class members' health, safety and welfare and that "failures occurred throughout the service delivery system from the providers and case managers to the managerial level." In March 2007, the court issued its finding on liability but did not address the remedy for the District's continuous, serious and systemic noncompliance with the court's orders.

In December 2008, the plaintiffs (represented by University Legal Services, the Center for Public Representation and the law firm of Holland & Knight) presented evidence in a three day trial before the Special Masters as to the appropriate remedy to address three decades of noncompliance by the District government. The plaintiffs proposed that a Special Administrator be appointed by the Court with focused authority over the District of Columbia government agencies that serve or oversee the supports and services provided to class members. The Special Administrator, the plaintiffs proposed, would not displace the current leadership at DDS, DDA, DHCF (DC Medicaid agency) or other District agencies but would work with them to oversee and direct budget, personnel, procurement, and licensing and enforcement of the District agencies only to the extent necessary to achieve compliance with court orders. The Special Administrator would be able to focus solely on getting better results for class members. Other less intrusive remedies had already been tried in this case and had not be successful and as a result, class members suffered and continue to suffer. The plaintiffs argued that such a remedy is necessary to address the significant deficiencies in the service delivery system for District residents with developmental disabilities.

Both plaintiffs and defendants presented evidence and witnesses to the Special Masters during the three day trial in December 2008. The District produced the testimony of eight witnesses, including three expert witnesses. The plaintiffs produced the testimony of four witnesses, including two expert witnesses. The plaintiffs also introduced approximately 200 documents into evi-

dence. At the trial, the Special Masters heard cross-examination and re-direct examination of the witnesses and had the opportunity to ask their own questions of the witnesses.

Contrary to the overwhelming evidence provided by the plaintiffs of the continued deficiencies in the system and the proposal of a Special Administrator to address these deficiencies, the District did not propose a remedy to address the Court's 2007 finding of liability. The District did not present a blueprint for action. The District did not present evidence about any plan to correct the systemic problems in the service delivery system. The District also did not claim that they were in compliance with any of the court's orders. The District argued that they were making some progress and should just be left alone to continue that progress.

Recent reports from the *Evans* Court Monitor reveal that the District continues to fail to meet the basic needs of class members. In her March 5, 2009 report, the Court Monitor found that class members were not receiving the appropriate case management services they required, their Individual Support Plans (ISP) did not identify their needed services and were not implemented as written and their case managers failed to take corrective action when they learned that ISPs were not implemented. The Monitor reported that providers failed to monitor class members' side effects from their psychotropic medications and failed to implement their behavior support plans. Sadly, the majority of class members were reported to spend their days in segregated day program settings with few meaningful activities. The Monitor's June 11, 2009 Report to the Court found much of the same. The Monitor reported that class members' side effects from their psychotropic medications continue not to be monitored, health plans do not reference all current health needs and appropriate interventions, and essential tests ordered by physicians and behavior support plans continue not to be implemented. And the Monitor found little or no improvement in the areas of supportive employment and meaningful, integrated day activities for class members.

ULS hopes that the Special Masters' Report and Recommendation regarding a remedy for the District's noncompliance will address the continuous, serious and systemic deficiencies faced by class members. Class members deserve nothing less.

CLOSING THE DISTRICT OF COLUMBIA COMMUNITY SERVICES

*By Patrick Wojahn
Staff Attorney*

In 2001, a judge in the Dixon v. D.C. lawsuit ordered that the District of Columbia Department of Mental Health ("DMH") hire a consultant to consider whether or not DMH should privatize the District of Columbia Community Services Agency ("DC CSA"), the District's publicly run community mental health clinic. In September 2008, KPMG LLP recommended that DMH privatize all of its case management and treatment services, except for a small number of services, such as the pharmacy and the multicultural coordination services, which were to remain with DMH. As a result, DMH decided to privatize a large majority of the direct services that it provides.

This privatization is a massive task. At the beginning of 2009, the DC CSA was serving almost 4,000 people, providing them a range of community-based mental health services, including day programs, psychiatric treatment, crisis care, and Assertive Community Treatment, or ACT services. Now, DMH must place each one of these consumers with a private community services agency and/or ACT team. DMH started the process in March 2009, and has set a goal to transition 2,500 consumers by August 1, 2009.

DMH has tried to make the transition process go as smoothly as possible for consumers. Each consumer who receives case management or ACT services from the DC CSA receives a list of community services agencies ("CSA's") that he or she can pick from. The consumer can attend a consumer/provider choice fair, where representatives from the private CSA's and ACT teams come and talk to the consumers about what they have to offer. The consumer can also attend provider open houses to learn more about the providers, and talk to their DC CSA treatment teams about what options might be best. The consumer can then set up an intake with the selected provider by filling out a Consumer Choice Form, calling the Access Helpline, or contacting the new provider directly.

Also, DMH has taken steps to make sure that the providers respect the rights of consumers during this process, and that no consumer goes without treatment. DMH has hired a large group of peer advocates who are available to work with consumers and provide guidance. These peer advocates work with professionals in thirteen Continuity of Care Transition Teams, which are actively reaching out to consumers to find out if they are progressing with their transition. DMH has also set up a special transition information line for consumers who are having difficulty getting new services. That phone number operates from 9 am until 9 pm Monday through Friday, and the number is 1-800-961-8528. Finally, DMH is setting up a physicians practice group so that the private providers do not need to quickly increase the amount of psychiatric services they are providing. With this group, if he or she wishes, a consumer can continue receiving psychiatric care with the same psychiatrist.

So far, the transition seems to be going well. As of April 22, 2009, nearly 1,000 DC CSA consumers had transferred to the private provider network. From ULS' experience, most consumers, once they know what they need to do and select a new CSA, have been able to transfer to the new CSA without any problems. There have, however, been some delays when the private CSA's have not been able to build their staff quickly enough to accommodate new consumers, and have occasionally had to close their intake. The CSA's have, however, been able to get the staff in place and have reopened after some time. If you are a consumer or you know a consumer who has had difficulty transitioning, please call ULS for additional information and assistance.

THE SLOW RATE OF "PROGRESS" AT ST. ELIZABETHS HOSPITAL

By Robin Thorner
Managing Attorney

In June 2007, the United States Department of Justice ("DOJ") and the District of Columbia signed a settlement agreement to avoid litigation about the conditions of care and treatment at the District's public psychiatric hospital, St. Elizabeths Hospital. The settlement agreement contains a long list of improvements that the District must make at the Hospital by June 2010, covering everything from the provision of medical, nursing and mental health care, to environmental conditions, protection from harm and discharge planning. All together, the settlement agreement contains at least 180 specific requirements, to be completed at various points in time, such as within 12 months, 18 months, 24 months or 36 months.

While the Hospital has made slight improvement in some areas, much work – in critical areas – remains to be done. In fact, according to the Hospital's own published report, as of March 2, 2009, it had not complied with 6 requirements, concerning the use of seclusion, restraint and emergency involuntary psychotropic medication, which were due by June 2008 – 8 months earlier. Similarly, the Hospital had not complied with the December 2008 requirement that staff who might implement seclusion, restraint and emergency involuntary psychotropic medication successfully complete competency-based training. The Hospital had only partially complied with another 55 requirements.

By the end of June 2009, the District is to have complied with approximately 95 additional requirements, yet as of March 2, 2009, the Hospital had made "no progress" toward compliance in 12 categories, mostly relating to the provision of critical nursing care. The Hospital had only made "minimal progress" toward compliance in 23 other categories.

ULS has monitored the Hospital's slow implementation of the terms of the settlement agreement since it was signed. During the fall of 2008, ULS grew particularly concerned about the conditions of care on RMB 3, which is now considered the "behavior unit," in part because during 2008, there were 152 instances of seclusion and restraint on RMB 3, more than one half of all episodes in the entire civil side of the Hospital. ULS also observed staff acting abusively toward patients during frequent visits to the ward. In response to ULS' growing concerns, and in light of the settlement agreement's early focus on behavioral interventions and seclusion and restraint, ULS began a targeted investigation of ward RMB 3. ULS reviewed the records of 5 patients and also conducted observations on RMB 3.

ULS' observations and review of the patients' records revealed a bleak daily life for the patients on RMB 3. Their days were void of meaningful activity, and interaction with staff was minimal. Observations revealed that most of the communication on the unit was among the staff themselves. Staff relied heavily on chemical restraint, seclusion and physical restraint as interventions for escalating patient agitation and aggression. The records and ULS' observations revealed a striking lack of therapeutic interaction on RMB 3, and ULS noted instances in which staff interaction either aggravated a situation or demonstrated a serious lack of respect for the patients. In essence, the conditions on RMB 3 reflect the Hospital's delayed acceptance and implementation of the settlement agreement.

Rather than publicizing its findings in a public report, ULS shared the report of its findings with the Hospital in the hopes that it would use the information to make significant changes on RMB 3, as well as across the facility. ULS also shared the report with the Department of Justice, in advance of its spring 2009 monitoring visit at St. Elizabeths. Not surprisingly, the Department of Justice shared ULS' concerns about practices on RMB 3, and specifically recommended that the Hospital discontinue the use of a "behavior ward." Despite ULS' and the Department of Justice's findings, RMB 3 remains the "behavior ward." While ULS has observed a reduction in the use of seclusion, restraint and involuntary medication on the ward, in many respects, the ward is unchanged. Given the Hospital's inadequate progress to date on RMB and across the Hospital, ULS questions the District of Columbia's commitment to fulfilling the terms of the settlement agreement, and its commitment to protecting the health and safety of the patients at St. Elizabeths Hospital.

BREATHING A SIGH OF RELIEF: NURSING HOME RESIDENTS ON VENTILATORS FINALLY GAIN INDEPENDENCE

*By Akua Brempong
Staff Attorney*

Imagine having to live in an environment when someone else controlled when you woke up in the morning, when you took a shower and when you ate your meals. Imagine being disregarded by others who rely instead on “responsible parties” to make decisions for you about where you would prefer to live, when to wake up, go to sleep, whether you can go outdoors or eat a favorite food. Although the vast majority of people in District of Columbia nursing homes are fully competent and capable of making their own decisions, nursing homes often disregard their competency and violate their rights by dictating such decisions to “responsible parties.” The people most affected by this forced dependence are nursing home residents who are on ventilators and other life-sustaining medical equipment.

Mr. D. is a 21 year old with quadriplegia who has been on a ventilator since a gunshot injury in 2006. The ventilator confined him to hospitals and nursing homes for nearly two years because the hospital and nursing home staff claimed that he needed a higher level of care than the DC Medicaid program would provide in the community. Mr. D. desperately wanted to go home, at one point saying that he would rather die at home with his family than continue to live in a nursing home. There are many people who are in nursing homes on ventilators who feel the same way. University Legal Services (ULS) is leading the struggle to allow people on ventilators to move back to the community with the proper supports and services that promote their independence.

A large problem that Mr. D. and others like him faced was that even though they are Medicaid recipients, they could not get care in their homes because of the lack of Medicaid-certified home health agencies that provide tracheotomy and ventilation services. Because these life-sustaining services such as suctioning cannot be scheduled during quick visits by care providers, trained LPNs must work with the individuals throughout 8 hour shifts. ULS found that many home health agencies did not provide these services because of the low reimbursement rate paid by Medicaid which reportedly curbed their ability to recruit enough LPN staff. To address this issue, ULS successfully urged the Department of Health Care Finance to substantially raise the reimbursement rate for LPNs who provide services for people who are ventilator-dependent in their homes.

In September 2008, ULS helped Mr. D. identify a home health agency that could provide him care in his home. The home health agency agreed to provide sixteen hours of care for Mr. D., to be supplemented by his family members who were trained to provide the other eight hours. Through ULS’ Young v. DC Housing Authority lawsuit, Mr. D.’s family was provided a fully accessible town house in a new development. After much coordination and multiple meetings, Mr. D. was discharged in early November 2008, two weeks before his 21st birthday.

ULS has also aided other people on ventilators to leave nursing homes and transition to the community to live independently. However, the struggle for full independence for with disabilities in the District of Columbia continues. ULS holds trainings and distributes materials about the services and supports available in the community for people seeking to move out of nursing homes back to the community. If you are interested in independent living or know someone who is, please contact ULS.

(SOCIAL SECURITY WORK INCENTIVES 101 ...Continued from page 9)

- Special SSI Payments for People Who Work
Continued Medicaid Eligibility
- Special Benefits for People Eligible Under Section 1619 (a) or (b) or Who Enters a Medical Treatment Facility
Reinstating Eligibility Without a New Application

What are the SSDI Work Incentives?

- Trial Work Period
Extended Period of Eligibility
- Continuation of Medicare Coverage
- Medicare for People With Disabilities Who Work
Protection From Continuing Disability Reviews

What if you need more information on Work Incentives?

In Washington DC, Endependence Center, Inc. is the WIPA project that has contracted with Social Security to provide this service. Although they serve the District, they can be reached at (301)-839-1956. Finally, you may contact ULS or go to the following websites: www.yourtickettowork.com or www.ssa.gov for more information.

(CIT: A STEP IN THE RIGHT DIRECTION...Continued from page 4)

Teams. Currently, according to a Memorandum of Understanding (MOU) between DMH and MPD, Mobile Crisis is only brought in at police discretion. Perhaps as a result of this training, police will be more likely to know about Mobile Crisis, how it can support them, and take advantage of the assistance that is out there.

What is CIT?

Crisis Intervention Teams (CIT) are a pre-booking jail diversion program designed to improve the outcomes of police interactions with people with mental illness.

The first CIT was established in Memphis in 1988 after the tragic shooting by a police officer of a man with a serious mental illness. This tragedy stimulated a collaboration between the police, the Memphis chapter of the National Alliance on Mental Illness, the University of Tennessee Medical School and the University of Memphis to improve police training and procedures in response to mental illness. The Memphis CIT program has achieved remarkable success, in large part because it has remained a true community partnership. Today, the so-called "Memphis Model" has been adopted by hundreds of communities in more than 35 states, and is being implemented statewide in several states, including Maine, Connecticut, Ohio, Georgia, Florida, Utah, and Kentucky. To locate a CIT program near you, visit the University of Memphis website at: <http://www.cit.memphis.edu/USA.htm>.

The Memphis Model of CIT has several key components:

- A **community collaboration** between mental health providers, law enforcement, and family and consumer advocates. This group examines local systems to determine the community's needs, agrees on strategies for meeting those needs, and organizes police training. This coalition also determines the best way to transfer people

with mental illness from police custody to the mental health system, and ensures that there are adequate facilities for mental health triage.

- A **40 hour training program** for law enforcement officers that includes basic information about mental illnesses and how to recognize them; information about the local mental health system and local laws; learning first-hand from consumers and family members about their experiences; verbal de-escalation training, and role-plays.
- **Consumer and family involvement** in decision-making, planning training session, and leading training sessions.

Why do we need CIT?

CIT equips police officers to interact with individuals experiencing a psychiatric crisis, by:

- **Providing specialized training.** Police officers report that they feel unprepared for "mental disturbance" calls and that they encounter barriers to getting people experiencing psychiatric symptoms quickly and safely transferred to mental health treatment. CIT addresses this need by providing officers with specialized training to respond safely, and quickly to people with serious mental illness in crisis. Officers learn to recognize the signs of psychiatric distress and how to deescalate a crisis- avoiding officer injuries, consumer deaths and tragedy for the community. In addition, CIT officers learn how to link people with appropriate treatment, which has a positive impact on fostering recovery and reducing recidivism.

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