VOPA Misrepresents the Abuse and Neglect Statistics for Individuals with ID in Virginia

People with intellectual disabilities (ID), particularly those who are not capable of communication because of their low functioning level, are extremely vulnerable to abuse and neglect, and even deaths. Contrary to the misleading representations of the Virginia Office of Protection and Advocacy (VOPA), 98 percent of all substantiated reports of adult abuse in Virginia occur outside the state-run facilities.

This week, VOPA issued statistics of "alleged abuse" of people with ID in training centers. VOPA, an organization that advocates for closing all the centers, chose to focus on the location of 2 percent of abuse cases and ignored the other 98 percent. VOPA did not include any data on abuse and neglect in the community, particularly in the two-person homes or apartments that it favors, where 82 percent of the abuse occurred. Since VOPA has access to such data and failed to investigate or disclose those cases, one can only conclude that its one-sided report reflects a bias against the training centers.

Common sense tells us that people who cannot communicate are more vulnerable in settings with less staff and fewer visitors than they would be in congregate settings with more staff and volunteers, and parents and siblings dropping in unannounced. The facts tell us that the residents of the training centers are better protected by Medicaid's 378 standards of care, regular state and federal monitoring, and the requirement that every injury or death at a training center in Virginia must legally be reported and investigated, even deaths from natural causes.

Common sense tells us it is harder to monitor the safety of people with ID in scattered sites in the community (imagine, for example, the difficulty of monitoring 75 group homes of 2 people each instead of a facility with 150 people). The facts tell us that group homes in Virginia are monitored far less frequently than the training centers. This is hardly a prescription for the kind of monitoring necessary to protect people with ID residing in the community.

Here are the facts that provide the full picture of abuse and neglect:

- The fiscal year 2011 "Adult Services Program Report" of the Virginia Department of Social Services, which examines data regarding vulnerable adults (older individuals and adults with disabilities), found a record number of Adult Protective Services (APS) reports of abuse, neglect and exploitation – nearly 18,000.
- *Of the nearly 8,941 substantiated reports, 6,250 occurred in one's "own Home or Apt," 984 in "Other's House or Apt," and only 194 in a "BHDS Facility/Group Home."* The last category, which includes the five training centers, the ten mental hospitals and the few state-run group homes, constitutes 2% of all substantiated abuse reports.

These official state figures include people with ID, as well as vulnerable seniors and people with mental illness. This data is publicly disclosed, differentiates between reports of abuse and substantiated abuse, and includes data from all residential settings. VOPA receives all of the

reports of substantiated reports of abuse from the Department of Social Services. **Yet VOPA investigated and reported only the 2 percent of incidents that occurred in training centers and not the 82 percent of incidents that occurred in the community.**

It is also important to note the following:

- VOPA has not brought a class action against the training centers alleging systemic abuse, as has been done by its sister agencies in other states.
- The DOJ complaint contains no allegation of abuse at the training centers.

One final area deserves attention – national experience with moving people from facilities into the community. Here are a few examples of resulting abuse and deaths:

- In California, a series of mortality studies found that people who left the facility died at far greater rates than those with similar disabilities who stayed behind, ranging from 44% to 88% higher. The mortality studies were backed up by a series of 65 articles by the San Francisco Chronicle documenting cases of abuse and death in the wake of the facility closures. Protection and Advocacy, which filed the litigation that led to the aggressive deinstitutionalization which prompted the mortality studies, did nothing to stop the abuse or deaths.
- In Washington, DC, Katherine Boo of *The Washington Post* won a Pulitzer Prize in 2000 for her series on abuse and death in group homes of people who had been deinstitutionalized. Twelve years later, the problems continue and Protection and Advocacy, whose headquarters in located there, has done nothing to stop it.
- In New York State, after a series of articles on abuse and neglect in both facilities and community homes, *The New York Times* published an article that found 1,200 deaths over the last decade in group homes from "unknown or unexplained causes." Again, Protection and Advocacy was nowhere to be found.

People with ID who cannot communicate are highly vulnerable individuals, subject to abuse and neglect in all settings. However, by the very nature of life in community homes – relative isolation, few staff and fewer other "eyes" – highly vulnerable individuals are at greater risk there because such homes are harder to monitor.

Please beware of any data, such as the VOPA figures, that are not transparent and that do not include available data across multiple settings. The Virginia Adult Services Report data, which show that the vast majority of problems occur in smaller settings, properly and predictably provide a fair representation of abuse and neglect in residential settings for Virginians with ID.

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On behalf of the relatives and guardians of the five training centers