Seattle Journal for Social Justice

Volume 21 | Issue 3 Article 17

2023

Dismantling the Washington State Community Protection Program

Charla Boley

Dismantling the Washington State Community Protection Program

Charla Boley

I. INTRODUCTION

A. The Story of Betty Antus

In the summer of 1996, a woman living in an adult family home and receiving Developmental Disability Administration (DDA)[1] services started a house fire that killed two people, Tammy O'Neal and Donna Lynn McClintock.[2] Her name was Betty Antus, and she had spent nearly her entire life shuffled about Washington State's developmental disability and mental health systems.[3] In fact, Antus had started a similar fire three years earlier with far less severe consequences.[4] The services Antus received through the state included twenty-four hour staff supervision.[5] On the evening of the fire, however, no staff were present at the home, and the four smoke detectors on site were inoperable.[6] Following the house fire, Antus

---

[1] Formally Developmental Disabilities Division (DDD).

[2] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, NO WAY OUT: AN INTRODUCTION TO THE COMMUNITY PROTECTION PROGRAM 3 (June 2021), https://ddombuds.org/wp-content/uploads/2021/06/6.3.21-Community-Protection-Program-Report-PDF.pdf [https://perma.cc/35L9-JBQM].

[3] Antus first entered the system at thirteen years old when she was enrolled in the Rainier School, a state school for people with intellectual and developmental disabilities. Lily Eng et al., *Troubled Woman Was Lost For Years In State Maze, Discovered In Fire Tragedy—Odyssey Ended With Her Arrest After Fatal Blaze*, SEATTLE TIMES (July 5, 1996), https://archive.seattletimes.com/archive/?date=19960705&slug=2337754 [https://perma.cc/9ZGT-E3MK]; *see also* Associated Press, *Retarded Woman Charged with Murder in Group Home Blaze*, SPOKESMAN REV. (June 22, 1996), https://www.spokesman.com/stories/1996/jun/22/retarded-woman-charged-with-murder-in-group-home/ [https://perma.cc/A72C-2392].

[4] *Id.*

[5] *Id.*

[6] *Id.*

went to court on two first degree murder charges, and was ultimately sentenced to twenty-one years in prison.[7] Statements from Antus to the police indicated that she had set the blazes because she was upset with her housemates and voices had told her to do so.[8]

Antus's story was the catalyst for many decisions the DDA and Washington State Legislature made—decisions couched in fear and prejudice that ultimately resulted in the creation of the Community Protection Program (CPP).[9] Justifications for CPP center on the idea that certain individuals, if left unsupervised and unrestricted, will harm the community.[10] Yet the narrative around CPP overlooks the lapse in care that was the true cause of the tragic fire.

While many of the services offered by CPP are important and needed by individuals, they are services individuals were already meant to have. Had Antus received the twenty-four-hour staff supervision in her plan, she likely would not have set the fire. Unfortunately, under CPP, accepting these services means accepting additional arbitrary restrictions and the stigma of "future dangerousness." DDA claims individuals enter CPP voluntarily, but in reality, many individuals who accept CPP services have no choice but to sacrifice important rights to receive necessary care that should be available to them under other waiver options.[11] CPP not only restricts individual

---

[7] For an example of the widespread stigma assigned to people with disabilities, *see* Rick Anderson, *Crazy Cuts*, SEATTLE WKLY. (Oct. 9, 2006), https://www.seattleweekly.com/news/crazy-cuts/ [https://perma.cc/T3CA-YTSY].

[8] Associated Press, *supra* note 3.

[9] *See* S.B. 6630, 59th Gen. Assemb. Reg. Sess. (Wash. 2006) at 1, http://lawfilesext.leg.wa.gov/biennium/2005-06/Pdf/Bill%20Reports/Senate/6630-S2.FBR.pdf?q=20210920163031 [https://perma.cc/GEV7-NXJQ] (stating in the background section that "In 1996, the Legislature began providing funding to the Department of Social and Health Services (DSHS) to create and run a program for persons with developmental disabilities who have demonstrated violent or sexually violent behaviors") [https://perma.cc/GEV7-NXJQ].

[10] *See infra* Section III.

[11] *See infra* Section II.

rights, it also disempowers people with developmental disabilities and diminishes their agency and dignity.

While this paper uses the term "people with developmental disabilities" throughout, the correct or preferred terminology used to talk about disability is an unsettled issue.[12] Those who advocate for rights and inclusion may favor the term "people with disabilities," with the intention to call attention to an individual's personhood in relation to their disability.[13] Others criticize this as separating disability from the individual's identity and prefer to use the term "disabled people."[14] Additionally, it is crucial to acknowledge upfront that disability is not, in itself, a singular identity. The intersections between race, gender, and class are highly relevant.[15] This is especially important to state explicitly because DDA does not sufficiently track demographic data regarding the race, gender, and sexual orientation of individuals enrolled in its services.[16] These identities direct the developmental disability system's treatment of individuals, or whether it even interacts with individuals at all.

This paper first explores the creation of the CPP and examines the harmful nature of the program in the rights it restricts and the stigma it perpetuates. Next, this paper contextualizes CPP with other state Medicaid Waiver programs for people with developmental disabilities across the United States. Finally, the paper presents a tiered approach to change, focusing on an ameliorating fix, systemic change, and other necessary steps to empower people receiving DDA services. Washington State must rectify the harms caused by the current punitive and coercive CPP by: (1) rectifying the violations of individuals' rights in CPP; (2) abolishing the CPP and integrating individuals into other state waiver programs; and (3)

---

[12] A.J. Withers et al., *Radical Disability Politics*, *in* ROUTLEDGE HANDBOOK OF RADICAL POLITICS 179 (Ruth Kinna & Uri Gordon, eds., 2019).
[13] *Id*.
[14] *Id.*
[15] *Id.* at 180.
[16] *Infra* Section III.

empowering individuals receiving DDA services to be strong self-advocates.

B. The Creation of the Community Protection Program

> *"If my staff don't supervise me like they are supposed to, I get in trouble. Why?"*[17]
>
> - Anonymous

Since 1996, the Washington State Legislature has funded CPP through the Department of Social and Health Services (DSHS).[18] Initially, CPP existed through budget proviso and DDA policies.[19] In 1998, the DDA created a task force that wrote policies and procedures and developed a training curriculum for staff in CPP.[20] By 2004, CPP was officially approved by the Center for Medicare and Medicaid Services (CMS), and the waiver was officially established for individuals receiving CPP services.[21] During the first ten years of its existence, CPP operated in many

[17] The Developmental Disability Ombuds has collected comments from participants of the Community Protection Program. This quote may have been altered to conceal identifying information. OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 8.

[18] S.B. 6630, *supra* note 9, at 1.

[19] *Id.*

[20] Marci Arthur et al., *Washington State Community Protection Program*, presented in the WASH. ASS'N OF POLICE CHIEFS CONF., 4 (Oct. 8, 2014), [https://perma.cc/2URR-2JNY]; *Orientation and Training Manual*, DIV. OF DEVELOPMENTAL DISABILITIES, DEP'T OF SOC. AND HEALTH SERV. (July 2002), https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/Community%20Protection%20Program%20Orientation%20and%20Training%20Manual.pdf [https://perma.cc/3YS8-7WWG].

[21] WASH. STATE DEP'T OF SOC. AND HEALTH SERV., DEVELOPMENTAL DISABILITY ADMINISTRATION, 2000–2009: LOOKING BACK AT DEVELOPMENTAL DISABILITIES SERVICES IN WASHINGTON STATE DURING THE FIRST DECADE OF THE 21ST CENTURY 51 (Feb. 14, 2014) https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/WA%20State%20DD%20History%202000-2009.doc [https://perma.cc/LFN5-7TLL].

respects as a shadow program, only receiving public scrutiny in 2005.[22] The 2006 Senate Bill 6630 (SB 6630) was, in many ways, a response to concerns raised by advocates and investigators.[23]

Prior to the passage of SB 6630, an investigation by Seattle Post-Intelligencer found that vulnerable individuals in CPP suffered abuse and neglect in their homes; at least 813 incidents were reported to the DSHS between 2000 and 2004.[24] Other concerns raised by disability advocates included CPP staff withholding benefits from individuals who refused to enroll in CPP, lack of oversight in enrollment and graduation, absence of an appeal process, and universal usage of alarmed doors and windows.[25] To remedy these issues, Washington State's Protection and Advocacy Agency[26] recommended that DSHS: (1) enforce mandatory abuse and neglect reporting by its contracted service providers; (2) ensure staff found to have abused individuals are fired and prosecuted, and ensure case managers follow up when an incident occurs; (3) monitor how contracted service providers use their funds and evaluate the quality of care for individuals and training for staff; (4) ensure individuals have due process in challenging their placement in CPP; and (5) to be especially careful to only enroll individuals who are truly a safety risk.[27]

SB 6630 described CPP as offering "twenty-four hour per day supervision, treatment and counseling, and access to job training skills

---

[22] Ruth Teichroeb, *Protection Program to Get Federal Scrutiny*, SEATTLE POST-INTELLIGENCER (Nov. 23, 2005), https://www.seattlepi.com/local/article/Protection-program-to-get-federal-scrutiny-1188327.php [https://perma.cc/2473-4T2Q].

[23] *E.g.*, S.B. 6630, *supra* note 9, at 1.

[24] Teichroeb, s*upra* note 22.

[25] *Id.*

[26] *See About Us*, DISABILITY RTS. WASH., https://www.disabilityrightswa.org/about-us/ [https://perma.cc/664A-SKJM] for a description of the work of Washington's protection and advocacy program, known today as Disability Rights Washington; *see also About*, NAT'L DISABILITY RTS. NETWORK, https://www.ndrn.org/about/ [https://perma.cc/V5VH-TSUN] for an overview of the national network of Protection and Advocacy agencies.

[27] *See* Teichroeb, *supra* note 22.

through day service programs" provided by DSHS-contracted companies.[28] In 2006, of the eighteen companies that served individuals in CPP, only four were non-profit organizations.[29] The legislature formalized their approval of CPP in RCW 71A.12.200:

> The department of social and health services is providing a structured, therapeutic environment for persons who are eligible for placement in the community protection program in order for them to live safely and successfully in the community while minimizing the risk to public safety. The legislature approves of steps already taken by the department to create a community protection program within the division of developmental disabilities.[30]

At the time, the legislature justified its decision by pointing out that there were around 390 individuals in CPP with about 80% demonstrating "sexually aggressive behavior" and "the remaining 20% demonstrating violent, assaultive, or arsonist behaviors."[31] Additionally, the legislature pointed out that approximately one-hundred individuals in CPP were registered sex offenders.[32] Subsequently, the Washington Administrative Code (WAC) describing the administrative rules for CPP was completed in 2008.[33]

The codification of CPP did address some concerns raised by the investigation and advocates, like discontinuing the enrollment of individuals under the age of eighteen into CPP.[34] Yet, many issues remain and the legislature's blanket approval of "steps already taken" by DSHS

---

[28] *See* S.B. 6630, *supra* note 9.
[29] *Id.*
[30] WASH. REV. CODE § 71A.12.200 (2006).
[31] *See* S.B. 6630, *supra* note 9, at 1.
[32] *Id*.
[33] *See* Arthur et al., *supra* note 20, at 5.
[34] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 13.

detract from any recognition that CPP had (and still has) serious problems.[35]

C. The Community Protection Program Today

> *"They keep making me talk about the mistake I made when I was 18. I haven't made that mistake again, but I have to talk about it again next week. I'm now 37 years old."*[36]
>
> - Anonymous

The CPP contains many layers in terms of: (1) the design of the program; (2) the criteria for enrolling individuals; (3) the services individuals are supposed to receive; (4) the entities that provide the services; and (5) the way individuals seek to, and largely fail to, exit the program.

First, CPP is designed as one of five programs that DDA offers to developmentally disabled individuals. CPP is one of five Home and Community Based Service (HCBS) Medicaid Waiver programs offered by Washington State's DDA.[37] Celebrated by some as the first of its kind in the nation,[38] CPP stands alone in the United States as unique in its emphasis on "community safety" above all else.[39] Waiver programs, including the CPP, purport to serve the health and safety needs of people with developmental disabilities in the community as an alternative to institutionalization.[40] The DDA describes the services of CCP as voluntary,

---

[35] *See* WASH. REV. CODE § 71A.12.200, *supra* note 30, ("The legislature approves of steps already taken by the department to create a community protection program within the division of developmental disabilities.").
[36] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 8.
[37] *Community Protection Waiver*, DEVELOPMENTAL DISABILITIES ADMIN., https://www.dshs.wa.gov/sites/default/files/publications/documents/22-1757.pdf [https://perma.cc/A83H-S3BZ] [hereinafter *Community Protection Waiver*].
[38] *See* Arthur et al., *supra* note 20, at 5.
[39] *State Waivers List*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?search_api_fulltext=&items_per_page=10&page=2#content [https://perma.cc/KF3W-AU4Z] [hereinafter *State Waivers List]*.
[40] *See Community Protection Waiver*, *supra* note 37.

"therapeutic residential supports for individuals assessed to require twenty-four hour, on-site staff supervision to ensure the safety of others."[41] DDA policy states that the supervision, instruction, and support services are identified in the individual's person-centered service plan (PCSP), positive behavior support plan (PBSP), individual instruction and support plan (IISP), and treatment plan.[42]

Second, the criteria for those who DDA staff enroll in CPP is dictated by law. RCW 71A.12.210 sets out the criteria for individuals to qualify for the CPP.[43] The individual must have been charged or convicted of a crime or, if not, be deemed a risk to the community; an individual placed in CPP must meet one of the following:

> (1)(a)(i) Has been convicted of one of the following:
>
> (A) A crime of sexual violence as defined in chapter 9A.44 or 71.09 RCW including, but not limited to, rape, rape of a child, and child molestation;
>
> (B) Sexual acts directed toward strangers, individuals with whom a relationship has been established or promoted for the primary purpose of victimization, or persons of casual acquaintance with whom no substantial personal relationship exists; or
>
> (C) One or more violent offenses, as defined by RCW 9.94A.030; and
>
> (ii) Constitutes a current risk to others as determined by a qualified professional. Charges or crimes that resulted in acquittal must be excluded; or

---

[41] *Id.*

[42] *Standards for Community Protection Residential Services*, DEVELOPMENTAL DISABILITIES ADMIN., 2 (Nov. 1, 2021), https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy15.04.pdf [https://perma.cc/A3Y2-Y3WE] [hereinafter *Standards for Community Protection Residential Services*].

[43] WASH. REV. CODE § 71A.12.210 (2006).

> (b) Who has not been charged with and/or convicted of a crime, but meets the following criteria:
>
> (i) Has a history of stalking, violent, sexually violent, predatory, and/or opportunistic behavior which demonstrates a likelihood to commit a violent, sexually violent, and/or predatory act; and
>
> (ii) Constitutes a current risk to others as determined by a qualified professional; and
>
> (2) Who has been determined to have a developmental disability as defined by *RCW 71A.10.020(3).[44]

To summarize, to qualify for CPP, an individual with a developmental disability must have a criminal record for a violent crime and a determination from a qualified professional of their future dangerousness. Alternatively, having a history of behavior that a qualified professional decides marks them as a risk to others is also sufficient. This places a great deal of influence and power with the professional.

As of 2019, there were 411 individuals in the CPP.[45] According to data DDA provided to the DD Ombuds, 92% of individuals identified as male and 8% as female, although DDA does not offer non-conforming gender or non-binary options in its data collection.[46] DDA also provided the DD Ombuds with racial demographics of individuals in the CPP: 85.1% white;

---

[44] *Id.*

[45] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 10; *see also 2020 Advocates Notebook: Charts*, THE ARC OF WASH. STATE, 8, https://arcwa.org/2020-notebook/ [https://perma.cc/KDX9-D5SX].

[46] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 10; *see, e.g.,* Ruth Bevan & Anna Laws, *Gender Dysphoria and People with Intellectual Disability*, UNIV. OF HERTFORDSHIRE (2019), http://www.intellectualdisability.info/mental-health/articles/gender-dysphoria-and-people-with-intellectual-disability [https://perma.cc/2HT8-NTU7] (stating that "The issue of capacity is often raised. Mental capacity refers to being able to make your own decisions. What information does one need to understand, retain, weigh up or use to decide one's gender identity? Gender identity is a private and subjective experience, not a decision to be made. We would never ask a cisgender person to justify theirs therefore questioning capacity in this regard is inherently discriminatory.").

6% Black or African American; 5.3% American or Alaskan Native; 1.7% Asian; 0.5% American or Alaskan Native and white; 0.49% Native Hawaiian/Other Pacific Islander; 0.49% unreported; and 0.24% Asian and white.[47] The DD Ombuds further breaks this data down by gender and, acknowledging the small sample size of around 400, expresses concerns over an emerging trend of overrepresentation of American or Alaskan Native men in CPP.[48] Additionally, the data shows that DDA enrolls young people in CPP at a disproportionate rate and individuals most commonly start CPP at the age of eighteen.[49] The missing pieces in the data require further thought and investigation.

Third, DDA provides detailed information regarding the services individuals should receive in CPP. Once in the program, individuals are meant to receive support and supervision specific to PCSP and individual treatment plan.[50] DDA defines an individual's treatment plan as:

> an individualized plan written by a qualified professional or therapist for a participant that includes . . . (a) specific time-limited goals and objectives based upon evaluation data . . . (b) specific therapeutic services proposed . . . (c) recommendations for supervision and any other restrictions or restrictive procedures . . . (d) a description of how participant progress will be assessed; and (e) treatment discharge criteria.[51]

The treatment team can include a case manager, therapist, staff from the residential provider, staff from an employment program, community corrections officer, mental health case manager, and the individual's legal representative or family members.[52]

---

[47] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 11.
[48] *Id.* at 12 ("American or Alaskan Native men are overrepresented in CPP (5.3%) compared to all American Native or Alaskan Native men clients on the DDA 2019 caseload (2.1%).").
[49] *Id.* at 13.
[50] WASH. ADMIN. CODE § 388-831-0120 (2008).
[51] *Community Protection Waiver*, *supra* note 37, at 3–4.
[52] *Id.* at 4.

Community Protection services are to be "provided in the least restrictive manner and environment that minimizes the likelihood of offending behavior."[53] The Community Protection services are meant to provide "an opportunity" for individuals "to live successfully in the community" while the individual is supported in making positive choices and reducing behaviors that require intensive interventions and supervision in the first place.[54] Those in CPP may experience intensive supervision, limited access to television, movies, and reading materials.[55] Additionally, individuals placed in CPP are notified that they may have alarmed windows and doors; twenty-four-hour supervision and line of site supervision; disclosure to others of their assessed dangerousness risk ; restrictions on activities including the use of a telephone and computer; room searches; and restrictions on where they may live based on access to "victim populations."[56] According to the DD Ombuds, common restrictions also include the denial of non-monitored phone calls; prohibition of sexual relationships or preapproval of them; limited social media and internet use; prohibition of R rated movies and M rated video games; and prevention of seeing outside the living space by way of frosted windows.[57]

Individuals are to meet with their treatment team quarterly to review these restrictions and assess the individual's progress towards their goals.[58]

---

[53] *See* WASH. ADMIN. CODE § 388-831-0120 (2008); *see also Community Protection Waiver*, *supra* note 37, at 4.
[54] WASH. ADMIN. CODE § 388-831-0130 (2008).
[55] WASH. ADMIN. CODE § 388-831-0070 (2008).
[56] *Pre-Placement Agreement*, WASH. STATE DEP'T OF SOC. & HEALTH SERV. DEVELOPMENTAL DISABILITIES ADMIN. (2013), https://www.dshs.wa.gov/sites/default/files/forms/pdf/10-268.pdf [https://perma.cc/K95R-7D3B].
[57] *See* OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 7.
[58] *Policy 15.05 Community Protection Program Reductions and Exit Criteria*, WASH. STATE DEP'T OF SOC. & HEALTH SERV. DEVELOPMENTAL DISABILITIES ADMIN., 4 (July 2019), https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy15.05.pdf [https://perma.cc/FLV8-3P29].

Ideally, restrictions are reduced and eliminated as the individual progresses towards graduation out of CPP.[59] Decisions to reduce restrictions account for an individual's compliance with their plan and their "assessed risk to the community."[60]

Fourth, there are seven State Operated Living Alternatives (SOLA) and thirty-four companies provide CPP services in Washington..[61] Most of these service providers are concentrated on the western side of the state.[62] Individuals in CPP must find a residential service provider certified in Community Protection intensive supported living[63] and also must find housemates who agree to live with them.[64] One provider describes their Community Protection services as an add-on to standard supported living programs but with the addition of "24 hours of staff supervision, coaching, and support."[65] The provider explains that Community Protection services are provided in partnership with "therapists, treatment providers, case managers, state officials and family" in order to "provide community access and integration safely and progressively."[66] The average annual expenditure per client in CPP for 2019 was $152,828, significantly more costly when compared to the other WA Waiver programs.[67] DDA defines a qualified residential service provider as:

---

[59] *Id*. at 1.
[60] *Id.*
[61] *Supported Living Program Locator – WA State*, WASH. STATE DEP'T OF SOC. & HEALTH SERV. DEVELOPMENTAL DISABILITIES ADMIN., https://fortress.wa.gov/dshs/adsaapps/lookup/ResCareInfo/ [https://perma.cc/QKE3-Y9LB].
[62] *Id.*
[63] WASH. ADMIN. CODE § 388-831-0130 (2008).
[64] WASH. ADMIN. CODE § 388-101D-0180 (2016).
[65] *CP, Community Protection Residential*, DUNGARVIN WASH. SUPPORTED LIVING, https://www.aacreswashington.com/communityresidential [https://perma.cc/7NJQ-BSG2].
[66] *Id.*
[67] *Developmental Disabilities 2020: DD 101*, THE ARC OF WASH. STATE (2020), https://arcwa.org/wp-content/uploads/sites/35/2020/04/2020-DD-101.pdf [https://perma.cc/HGX9-5KQS] (chart listing expenditure per client for fiscal year 2019:

> a person with at least three years of experience working with individuals with developmental disabilities and: (a) If the person being assessed has demonstrated sexually aggressive or sexually violent behavior, the qualified professional must be a Certified Sex Offender Treatment Provider (C-SOTP), or an Affiliate SOTP (A-SOTP) working under the supervision of a C-SOTP; or (b) If the person being assessed has demonstrated violent, dangerous, or aggressive behavior, the qualified professional must be a licensed psychologist or psychiatrist who has received specialized training in the treatment of violence, or has at least three years of experience treating individuals with violent or aggressive behaviors.[68]

Finally, individuals in CPP have three ways to exit the program: 1) graduating; 2) refusing services and having services terminated for noncompliance; or 3) being sent to an institution.[69] To graduate, an individual must demonstrate "success in complying with reduced restrictions" and remain "free of offenses that may indicate a relapse for at least twelve months."[70] The process for graduating must include "written verification of the person's treatment progress, compliance with reduced restrictions, an assessment of low risk of reoffence, and a recommendation as to suitable placement by the treatment team."[71] An individual's treatment team meets every ninety days to review their progress and can request a new risk assessment at any time.[72] From CPP's inception in 1996 through 2019, 191 of 600 total individuals have exited the program.[73] Of those who

---

Basic Plus Waiver – $8,388; Core Waiver – $124.512; Children's Intensive In-home Behavioral Support Waiver – $31,428; Individual and Family Services Waiver – $1,308).

[68] *See Policy 15.01 Community Protection Identification and Eligibility*, WASH. STATE DEP'T OF SOC. & HEALTH SERV. DEVELOPMENTAL DISABILITIES ADMIN., 3 (Nov. 1, 2019), https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy15.01.pdf [https://perma.cc/GR5D-ZFKG] [hereinafter *Policy 15.01*]

[69] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 14–15.

[70] REV. CODE WASH. § 71A.12.260 (2006).

[71] *Id.*

[72] WASH. ADMIN. CODE § 388-831-0200 (2008).

[73] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 15.

exited, 45% graduated to less restrictive services; 40% refused services; 6% exited when they were admitted to a hospital; 5% exited when they went to jail; and 4% exited from the program for noncompliance.[74]

II. PROBLEMS WITH THE COMMUNITY PROTECTION PROGRAM

> *"When I complained, they handed me a paper and said if you don't like it, the program is voluntary and I can sign myself out."*[75]
>
> - Anonymous

The problems with CPP come to light mostly through the DD Ombuds. The DD Ombuds has monitored CPP since 2017 by visiting individuals in the program, listening to their concerns, observing treatment team meetings, speaking with service providers, reviewing individuals' paperwork on file with DDA, and investigating complaints.[76] In addition to information contained in the DD Ombuds' July 2021 Report, *No Way Out*, Residential Care Services' (RCS)—under the Aging and Long-Term Support Administration (ALTA)—investigations and inspections of services providers further substantiate the concerns of rights violations.[77]

The DD Ombuds' concerns fall into two general categories.[78] The first concerns how the state selects and defines individuals for CPP, and the second concerns the state's treatment of those individuals once in the program.

---

[74] *Id*.
[75] *Id.* at 8.
[76] *Id.* at 2.
[77] *See, e.g.*, *Fact Sheet: RCS Complaint Investigations: A Public Service*, WASH. STATE DEP'T OF SOC. & HUMAN SERV. (Jan. 2013), https://leg.wa.gov/JointCommittees/ADJLEC/Documents/2013-11-04/01-13%20Complaint%20Resolution%20Unit.pdf [https://perma.cc/WYJ7-VP2U].
[78] The Ombuds discusses their concerns beginning on page 16 of their report. The breakdown of concerns into two categories is one way to think about the issues the report raises. OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 16.

A. Defining and Selecting Individuals for Enrollment in CPP

First, the DD Ombuds' report critiques CPP for having broad and vague instructions for DDA staff identifying individuals potentially in need of CPP and for inconsistently applying these standards.[79] CPP clients are defined by RCW 71A.12.210 and WAC 388-831-00309,[80] and DDA case managers are required to use these to determine who, on their caseload, fits this definition. For example, a case manager must decide whether to start a referral to CPP based on whether they believe the individual exhibits "opportunistic behavior which demonstrates a likelihood to commit a violent, sexually violent, and/or predatory act."[81] But, there is no DDA policy interpreting the RCW or WAC to guide a case manager on what behaviors demonstrate this likelihood, and a single case manager's opinion can initiate the referral process to CPP.[82] A case manager must meet with their supervisor within five days of determining that an individual may meet the CPP client definition, at which point the supervisor decides whether to refer the individual to the Regional Community Protection Coordinator.[83]

Statistics from 2014 show that most individuals who go through the assessment process are placed in CPP.[84] Of the 767 individuals who went through the process, 7% refused CPP after the assessment (fifty-three individuals); 2% refused the assessment itself (thirteen individuals); 22% were not offered CPP (168 individuals); and 69% accepted CPP (533 individuals).[85] Once the referral process is initiated it is unlikely to be stopped and even individuals who ultimately are not enrolled in CPP are

[79] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 4.
[80] *See* REV. CODE WASH. § 71A.12.200 (2006).
[81] *Id*.
[82] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 4.
[83] *Id.*; *see also Policy 15.01*, *supra* note 68.
[84] *See Policy 15.01*, *supra* note 68; *infra* note 86 on "tracking only" of 138 individuals; *see* Arthur et al., *supra* note 20, at 19.
[85] Arthur et al.*, supra* note 20, at 20.

still flagged for a recurring re-evaluation.[86] In 2014, for example, there were 136 individuals identified as "track only."[87] It is critical to remember that those who refuse the assessment are denied services through any DDA waiver program: WAC 388-831-0250 states that, although CPP is voluntary, "if you leave the [CPP] and DDD [DDA, formally known as the Developmental Disability Division] determines that you require the [CPP] to meet your health and safety needs and those of the community, you will not be eligible for other DDD residential services or employment/day program services."[88]

Additionally, individuals face other obstacles once they are flagged as a potential CPP candidate that significantly affect their ability to receive supports without attaching stigma. First, individuals do not have the ability to appeal the decision to refer them for CPP assessment, and they must agree to the assessment or lose services.[89] Furthermore, there is no stated requirement that DDA attempt less restrictive options to divert individuals before referral to CPP.[90] Teens and young adults referred to CPP raise special concerns because they are especially unlikely to have had the opportunity to access all of the medical, educational, and behavioral supports that could address their needs without attaching a stigma.[91] Sometimes teenagers receive referrals to CPP from DDA case managers because they struggle to access these services or are denied support and services in their parents' homes and end up in hospital emergency rooms or

[86] When the Community Protection Committee decides that an individual does not have community protection issues, the case manager must fill out form DSHS 10-258 *Individuals with community protection issues*, which is placed in the individual's file. Additionally, an individual can be flagged in the DDA system for "information tracking only" purposes. *See* DEP'T OF SOC. & HEALTH SERV., *Form DSHS 10-258 Individuals with Community Protection Issues*, [https://perma.cc/526S-XMKS]; *See also Policy 15.01, supra* note 68, at 9.

[87] Arthur et al., *supra* note 20, at 19.

[88] WASH. ADMIN. CODE § 388-831-0250 (2008).

[89] *See Policy 15.01*, *supra* note 68, at 7.

[90] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 5.

[91] *Id.* at 5.

with the police.[92] Finally, at times, individuals referred to CPP have had risk assessments not provided to them in their spoken language or have received a referral without the option of consenting.[93] Therefore, the stigma of CPP can attach to individuals quickly, easily, and at times, thoughtlessly.

B. Treatment of Individuals Once Enrolled in CPP

> *"I was convicted of a sex offense when I was 18 and served time in prison. When I was released, DDA told me that I would have to be in CPP for 7 years. Even though I never re-offended during my entire time in CPP, it still took me 20 years to get out."*[94]
>
> - Anonymous

Second, the DD Ombuds' report raised significant concerns over the treatment of individuals once they are in CPP.[95] Finding placements for individuals in CPP can itself be a struggle.[96] Additionally, when reviewing the restrictions placed on individuals in CPP,[97] the DD Ombuds found enough instances where no clear relationship between the restriction and the triggering referral behavior existed.[98] For example, individuals are denied the use of the internet and privacy during phone calls regardless of their flagged behavior.[99] At times, restrictions appear to be arbitrarily applied without any formal documentation or connection to an individual's service plans.[100]

Individuals in CPP not only must find a service provider certified to serve them as CPP clients, but any individual they live with must agree to

---

[92] *Id.* at 13.
[93] *Id.* at 5.
[94] *Id.* at 14.
[95] *Id*. at 6–8.
[96] *Id*. at 13.
[97] *Id.* at 7.
[98] *Id*. at 8.
[99] *Id*. at 7.
[100] *Id*. at 3, 8.

do so after being informed of their status as a CPP client.[101] Because of the stigma[102] attached to CPP, this creates an added barrier to individuals in CPP finding placements in the community. The DD Ombuds has received complaints regarding individuals referred to CPP who were stuck in hospitals or institutionalized in psychiatric hospitals or residential habilitation centers for months while they waited for a community placement.[103]

Once in a placement, individuals may experience arbitrary restrictions on their rights.[104] ALTA inspected a SOLA in Kent, WA in the spring of 2021 and found it had violated WAC 388-101D-130 Treatment of Clients.[105] The relevant provision reads "service providers must treat clients with dignity and consideration, respecting the client's civil and human rights at all times."[106] Here, the inspection found that two individuals in CPP had their bedroom windows frosted even though their legal representatives had not consented to it, and it was not included in either individuals' PBSP or IISP.[107]

The DD Ombuds has also taken hundreds of complaints from individuals in CPP related to restrictions placed on them.[108] Some complaints indicate that restrictions are used in a punitive way.[109] For example, some individuals reported that their service provider limited their access to entertainment, phones, and the internet on the condition of good behavior.[110]

---

[101] WASH. ADMIN. CODE § 388-101D-0180 (2016).
[102] *See infra* Section III(B).
[103] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 13.
[104] *Id*. at 7–8.
[105] DEPT. OF SOC. AND HEALTH SERV., AGING AND LONG TERM SUPPORT ADMIN., STATEMENT OF DEFICIENCIES/PLAN OF CORR.: SOLA KENT (2021) (on file with author).
[106] *Id.*
[107] *Id.*
[108] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 8.
[109] *Id*.
[110] *Id.*

Some of the Ombuds' complaints relate to issues with treatment.[111] Some individuals report that they are excluded from involvement in their treatment planning.[112] Another ALTA inspection, this time of a private service provider, showed that some individuals in CPP did not even have a treatment plan on record, and the Sex Offender Treatment Provider (SOTP) had not seen the plan "in awhile."[113] Still, other RCS investigations reveal service providers failed to transport individuals in CPP to their treatment appointments.[114] Such lapses are especially concerning given the abysmal CPP graduation rates.[115] If individuals must show compliance with their treatment plan to move to a less restrictive environment, those who are denied access to treatment have little chance of achieving this. When treatment plans do exist and are followed, the DD Ombuds reports that they are inconsistently developed across CPP in whether they contain measurable, attainable goals that could lead an individual to graduate.[116] Additionally, the DD Ombuds reports that almost no individual they spoke with understood the process for reducing or removing restrictions or graduating.[117]

---

[111] *Id*.
[112] *Id*. (Program participant stating that "In the treatment team meeting, everyone has a copy of the plan except for me.").
[113] DEP'T OF SOC. AND HEALTH SERV., DIV. OF RESIDENTIAL CARE SERV., STATEMENT OF DEFICIENCIES/PLAN OF CORR.: SUNRISE SERVICES (2021), https://fortress.wa.gov/dshs/adsaapps/lookup/RCSForms/SL/2011129/inspection/2021/R%20Sunrise%20Services%20Monitoring%20Visit%2006-24-2021-st.pdf [https://perma.cc/R9QM-ZTWG]; *see also* WASH. ADMIN. CODE § 388-101D-0485 (2016).
[114] *See, e.g.*, DEP'T OF SOC. AND HEALTH SERV., RESIDENTIAL CARE SERV., INVESTIGATION SUMMARY REP.: AACRES WASH. LLC (2019), https://fortress.wa.gov/dshs/adsaapps/lookup/RCSForms/SL/2011003/investigation/2019/R%20Aacres%20WA%20LLC%20(Pierce%20County)%20complaint%203-29-19%20em.pdf [https://perma.cc/YC7F-FKBR].
[115] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 15.
[116] *Id*.
[117] *Id.*

It is unclear just how widespread some of these rights violations extend within the CPP population, but they are common enough to require ameliorative action. Such routine restrictions on individuals in CPP may be a result of the stigma attached to the program, which could result in providers assuming the necessity of such measures without accountability.

III. JUSTIFYING COMMUNITY PROTECTION

> *"Staff tell me they get to play video games all the time. I'm not allowed to play any games or talk to my friends online."*[118]
>
> - Anonymous

In 2014, law enforcement officials attended a presentation on CPP by a Certified Sexual Offender Treatment Professional (C-SOTP) and DDA staff at the Washington Association of Sheriffs and Police Chiefs (WASPC) Conference.[119] The presentation provided an overview of CPP which included a slide stating that all the following are myths: (1) stealing a pack of cigarettes leads to an individual's assessment for CPP; (2) once enrolled, individuals are unable to leave the program; and (3) that the people who are enrolled in CPP are "terrible."[120] The purpose of the presentation, it seems, was to justify CPP and encourage law enforcement cooperation with DDA and CPP. Despite the assertation that such statements are myths, the available slides from the presentation fail to provide evidence to discredit them.[121] The true myth is willfully ignoring the deficiencies of the DDA program implementation that created dangerous situations to begin with. The presentation provided the following statistics: "DDA Sex Offender-Kidnapping Registration Rate: Level 1, 56 [individuals], 43%; Level 2, 38 [individuals], 29%; Level 3, 36 [individuals], 28%."[122] The presentation

[118] *Id.* at 8.
[119] Arthur et al., *supra* note 20, at 6.
[120] *Id.*
[121] *Id*. at 1–41.
[122] *Id.* at 21.

reinforces stigmas of dangerousness; it does so by necessity, because without the aspect of future danger, CPP loses its validity as a stand-alone program.

According to the presentation, those in CPP are: "[a]n enrolled participant with DDA and 18 years old or older and [h]as a history of sexual or violent crime and [h]as been determined by risk assessment to be a moderate to high risk to reoffend."[123] Clinicians believe that to appropriately supervise and provide case management, DDA must cooperate and collaborate with the criminal justice system and other social services agencies.[124] The WASPC conference presentation mirrors this idea by implying that law enforcement must work closely with the CPP in referring people to the program and for tracking people once they are enrolled.[125] While a relationship between DDA and law enforcement could have some positive results—perhaps increased reporting of DDA clients who are victims of crimes and reduction of unnecessary arrests of DDA clients—the singling out of CPP for special attention further stigmatizes its participants, and any potential benefit is far overshadowed.[126]

---

[123] *Id.*

[124] Gerry D. Blasingame et al., *Assessment, Treatment, and Supervision of Individuals with Intellectual Disabilities and Problematic Sexual Behaviors*, ASS'N FOR THE TREATMENT OF SEXUAL ABUSERS 3 (2014), https://www.atsa.com/pdfs/ATSA_IDPSB_packet.pdf [https://perma.cc/NQ24-J7Q8].

[125] The fact that this PowerPoint was presented at the WASPC conference demonstrates that law enforcement believe they should be involved in the CPP. *See* Arthur et al., *supra* note 20, at 1–41.

[126] *Id*. at 38–40 (recommendations for law enforcement discussing the need for police to communicate effectively with disabled people); *see* LIAT BEN-MOSHE, DECARCERATING DISABILITY: DEINSTITUTIONALIZATION & PRISON ABOLITION 117–18 (Univ. Minn. Press 2020) (Ben-Moshe describes how the boundaries between "the 'righteous and free" and 'the dangerous' is seen as socially and politically drawn" and that the purpose of these lines is that those not imprisoned can feel a sense of freedom because others are locked away. Singling out individuals in CPP as needing police attention is a part of this line drawing process.).

A. Defining and Treating Dangerousness

> *"Sometimes staff tell me I'm not allowed to watch my favorite show because it amps me up, but sometimes they let me watch it anyway."*[127]
>
> - Anonymous

Clinicians look at a variety of factors in assessing the "sexual risk" of an individual. Some factors are: (1) the individual's history of sexual behavior; (2) their sexual experiences; (3) their sexual knowledge; (4) their understanding of appropriate and inappropriate sexual behavior; (5) whether their sexual behavior is solitary; and (6) information related to their sexual arousal and interest.[128] Other factors include witnessed sexual behavior, the individual's personal history of victimization and/or exploitation, and exposure to pornography.[129] An assessment will also look into family history, criminal history, substance use history, mental and physical health, education history, support systems, and the individual's current environment and living situation.[130]

While this may seem like a comprehensive list of data points, the assessments for people with developmental disabilities with "problematic sexual behaviors" are not well-founded in research.[131] Accepted assessments tend to have a systematic inquiry into the individual's sexual interest.[132] One issue with these kinds of assessments is that many of the "popular" tools for risk assessment were developed for male adults with "histories of sexual offending," whereas people with developmental disabilities generally do not have the same life experiences as people without a developmental disability.[133] Without "a degree of creativity,"

[127] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 8.
[128] Arthur et al., *supra* note 20, at 31.
[129] *Id.*
[130] *Id.* at 32.
[131] Blasingame et al., *supra* note 124, at 8.
[132] *Id.*
[133] *Id.* at 10.

such tools are not necessarily helpful in assessing clients with developmental disabilities.[134]

Treatment of individuals with developmental disabilities with sexually dangerous behaviors should not mirror treatment models for people without developmental disabilities.[135] The learning styles of people with developmental disabilities frequently have many differences from the learning styles of those without intellectual disabilities.[136] Treatment primarily focuses on education, teaching (1) what is healthy sexuality, and (2) the differences between legal and illegal sexual behavior.[137] Treatment also focuses on skill building, such as managing sexual fantasies, regulating emotions and expressing emotions in a healthy way, developing healthy relationships, making healthy choices, avoiding or escaping high risk situations, and utilizing consequential thinking and problem-solving.[138] Finally, treatment involves the goals of increasing positive behaviors while also decreasing negative behaviors and preventing relapses.[139]

Above all else, many treatment models focus on risk management, like the Risk-Need-Responsivity (RNR) Model.[140] RNR proceeds around the principles of risk, or factors that predict re-offense. RNR attempts to match the level of intervention to the individual's risk level and picks interventions that the individual is most responsive to.[141] RNR produces a

---

[134] Providers must adapt assessments to people with developmental disabilities since the assessments were not designed specifically for them. *Id.* at 9.
[135] *Id*.
[136] *Id.* at 5–6.
[137] *See* Sara Straus-King's bullet points on treatment for those in CPP. Arthur et al., *supra* note 20, at 33–34.
[138] *Id.*
[139] *See id.*
[140] Mayumi Purvis et al., *Good Lives Model in Practice: Offense Pathways and Case Management*, 3 EUR. J. OF PROB. 2, 5 (2011), https://journals.sagepub.com/doi/pdf/10.1177/206622031100300202 [https://perma.cc/5JJ3-HGAX].
[141] *Id.* at 5–6.

consistent but modest result in reducing re-offenses.[142] These results may mean that risk-based approaches should only be one aspect of treatment. Some researchers criticize RNR as being too narrowly focused on risk management to the detriment of "human good," strength-based approaches, and the individual's overall well-being.[143]

An individual's well-being should not be considered automatically at odds with public safety. Treating an individual with a strength-based perspective can effectively work to manage risk in a positive, goal-oriented way.[144] An approach that considers the individual's personal investment and goals is likely more sustainable at changing behaviors long term.[145] The Good Lives Model (GLM) is a rehabilitation model that responds to individual interests, abilities, and goals by directing the treatment provider to construct plans that help individuals meet personal goals and achieve outcomes that have significance to them.[146] This model prioritizes concepts of human autonomy and dignity by assuming that all individuals have positive social aspirations, needs, and values that drive them.[147] GLM suggests that dangerous anti-social behavior occurs when individuals do not have sufficient resources to meet their needs in positive social ways.[148] Treatment models using GLM emphasize an individual's agency and life values while simultaneously trying to equip them with the resources they lacked in knowledge, skills, and opportunities.[149]

The above survey is not presented as an endorsement of different treatment models, but as an examination of how treatments shift the focus away from the individual to risk management. This view of individuals in

[142] *Id.* at 6.
[143] *Id.* at 5–6.
[144] *Id.* at 6.
[145] *Id.*
[146] *Id.*
[147] *Id*.
[148] *Id.* at 6–7.
[149] *Id.*

treatment can create situations where an individual classified as dangerous has restrictions placed on them without careful thought and without a plan for removing such restrictions in the future—as reflected in the harms of the CPP. Furthermore, an entire industry now exists around determining the level of dangerousness of an individual and has created a demand for "professional expert knowledge."[150] A degree of skepticism is required, therefore, regarding the nearly automatic deference given to such expert evaluations.

B. The Stigma

> *"If I don't tell a lie for a year they said I can maybe I can play my favorite video game again."*[151]
>
> - Anonymous

People with developmental disabilities are often marginalized, shunned, or ignored in society, creating environments of great vulnerability.[152] People with disabilities are dehumanized by false ideas that they are subhuman, menaces, sick, subjects for charity or pity, holy, or innocent.[153] Which lens society uses to view an individual often predicts how society will interact with them.[154]

Because individuals enrolled in CPP are labeled "dangerous," it is worth examining how crime intersects with the lives of people with disabilities.

---

[150] *See* BEN-MOSHE, *supra* note 126, at 100 (describing in the mental health context how legal changes lead to the increase in "the demand for so-called professional expert knowledge" and the "necessity for 'scientific' assessments of danger to institutionalize people).

[151] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 8.

[152] Catherine Thornberry & Karin Olsen, *The Abuse of Individuals with Developmental Disabilities*, 33 DEVELOPMENTAL DISABILITIES BULL. 1, 1 (2005), https://files.eric.ed.gov/fulltext/EJ844468.pdf [https://perma.cc/47AS-YQ4M].

[153] BEN-MOSHE, *supra* note 126, at 75; *see also* Rhoda Olkin, *Conceptualizing Disability: Three Models of Disability*, AM. PSYCH. ASS'N (Mar. 29, 2022), https://www.apa.org/ed/precollege/psychology-teacher-network/introductory-psychology/disability-models [https://perma.cc/28QE-CTLA].

[154] *Id.*

The intent of this examination is not to support stereotypes of helplessness, but to counter the narrative of which members of the community are most vulnerable to harm. People with developmental disabilities are four to ten times more likely to be victims of crime than non-disabled people.[155] Studies show that those most commonly victimized in institutions or group homes are individuals unlikely or unable to report or resist abuse, especially in instances of extreme power imbalances between caregivers and residents.[156] Crimes against people with developmental disabilities are significantly underreported because individuals fear reprisal, fear they will jeopardize their living situation and personal supports, believe law enforcement cannot help them, assume the crime they experienced is not worth reporting, or perceive that authority figures will not believe them.[157] Between 2009 and 2011, the National Center for Victims of Crime reported almost one million violent crimes against people with disabilities, including rape, sexual assault, robbery, and physical assault.[158] A program like CPP, however, primarily focuses on the safety of the wider community, rather than on the individuals receiving CPP services.[159]

Unfortunately, the stigmas that serve to dehumanize developmentally disabled people can decrease their safety.[160] Shockingly, whole philosophical debates have taken place on the topic of just how human a

[155] Joan Petersili, *Invisible Victims: Violence Against Persons with Developmental Disabilities*, 27 HUM. RTS. 9, 9 (2000).
[156] Thornberry & Olsen, *supra* note 152, at 5.
[157] *See Violent Crime and People with Developmental Disabilities*, DISABILITY JUST., https://disabilityjustice.org/justice-denied/violent-crime/ [https://perma.cc/VR8Z-6B8J].
[158] *Id.*; *see also Crimes Against People with Disabilities*, NAT'L CTR. FOR VICTIMS OF CRIME (2017), https://www.ncjrs.gov/ovc_archives/ncvrw/2017/images/en_artwork/Fact_Sheets/2017NCVRW_PeopleWithDisabilities_508.pdf [https://perma.cc/B94X-C2EQ].
[159] *See Community Protection Waiver*, *supra* note 37 (stating that "Community Protection (CP) Waiver offers therapeutic residential supports for individuals assessed to require 24-hour, on-site staff supervision to ensure the safety of others").
[160] Thornberry & Olsen, *supra* note 152, at 7, 13.

developmentally disabled individual is.[161] Ideas around parsing "our moral universe so that 'normal' human[s]" are a distinct category from so called "intellectually subpar humans" are deeply troubling, particularly because they are reflected in society's historic and persistent isolation of individuals with developmental disabilities.[162]

Public perceptions of people with developmental disabilities often stigmatize individuals, and such attitudes can be traced historically. Attitudes at the end of the nineteenth century reflected the idea that people with disabilities were responsible for their state and consequently menacing to society.[163] As time progressed, public policy shifted to institutionalizing people with developmental disabilities and pushing the need for medication and treatment.[164] Institutions were more motivated by social fear than by genuine concern for people with disabilities and were focused on custodial duties rather than on rehabilitation.[165]

By the end of the twentieth century, the deinstitutionalization movement began, continuing to present day.[166] The movement was led by parents of disabled children who advocated for special services, mostly segregated from the public, like camps, workshops, and housing institutions.[167] Because such services by design removed individuals from environments with non-disabled people, public perceptions of disabled people as dependent and helpless—and sick and dangerous—were solidified.[168] Often public policy is created with these perceptions in mind and limits the experiences available to disabled people by justifying it as a matter of

[161] *See* Licia Carlson & Eva Feder Kittay, *Introduction: Rethinking Philosophical Presumptions in Light of Cognitive Disability*, 40 METAPHILOSOPHY (SPECIAL ISSUE: COGNITIVE DISABILITY & ITS CHALLENGE TO MORAL PHIL.) 307 (2009).
[162] *Id.* at 308–09.
[163] Thornberry & Olsen, *supra* note 152, at 3.
[164] *Id*.
[165] *Id.* at 5.
[166] *Id.* at 3.
[167] *Id*.
[168] *Id.* at 3–4.

safety.[169] Unfortunately, such policies can have the opposite effect by reinforcing disabled people's dependency on other people, encouraging over compliance, and overall increasing their vulnerability to abuse and neglect. Overall, professional organizations with a focus on developmental disability support community living over institutionalization.[170]

Still, the idea that some people must be removed from the community remains active. A 2006 Seattle Weekly article titled "Crazy Cuts" is but one display of public animosity towards disabled people.[171] The article addresses public outcry in response to two incidents: (1) the fires that Betty Antus allegedly started when unsupervised at a residential care home; and (2) the alleged stabbing of a firefighter by a former Western State Hospital patient, Dan Van Ho, after his release from jail.[172] The article expresses fear over the future of state-run mental hospitals and a "downsizing plan that could put new Bettys and Dans on the street" and calls on the state to "spare us."[173] Such articles reinforce misperceptions that people with disabilities are inherently dangerous to society. It also reflects the misperception that institutions are somehow safer for both the individual and society.[174] Society, generally, validates the current treatment of people with disabilities that have otherwise not been incarcerated rather than questioning or condemning such policies.[175]

Because so many individuals in CPP are assessed to have "sexually aggressive behavior" and roughly one-fourth are registered sex offenders,[176] individuals in CPP have what may be considered a double stigma.

---

[169] *Id.* at 4.
[170] BEN-MOSHE, *supra* note 126, at 106–07.
[171] *See* Anderson, *supra* note 7.
[172] *Id*.
[173] *Id*.
[174] Thornberry & Olsen, *supra* note 152, at 5.
[175] *See* JOHN WESTON PARYR, MENTAL DISABILITY, VIOLENCE, AND FUTURE DANGEROUSNESS: MYTHS BEHIND THE PRESUMPTION OF GUILT 247 (Rowman & Littlefield 2013).
[176] S.B. 6630, *supra* note 9, at 1.

Individuals are stigmatized by their disability and then again when labeled "sexually dangerous." Across the United States, lawmakers have responded to a public outcry for legislation protecting the community from sex crimes, despite a lack of strong evidence showing that such laws are effective in decreasing recidivism of individuals who commit sex crimes.[177]

Some may perceive programs like CPP as a response to deinstitutionalization. Afterall, service providers for CPP are located within communities, including some in very residential settings.[178] This kind of setting, though, does not equate to freedom and it is misleading to celebrate group home settings as superior to institutionalization. Individuals in CPP, and in other group home settings, must "prove their civility and compliance."[179]

Habilitation in these settings means working to achieve societally acceptable standards for hygiene, conduct, and sexuality while undergoing various forms of surveillance, monitoring, and compliance evaluation.[180] Counteracting stigma too often involves such assimilation, and it must be pointed out that this assimilation is to social standards set by middle-class, cisgender, and heteronormative culture.[181] The "burden of proof" on whether an individual meets this standard is on the individual in CPP, rather than on the systems determining their need for such services in the first place.[182] The cost of failure, always looming in the background for

---

[177] Jill S. Levenson et al., *Public Perceptions About Sex Offenders and Community Protection Policies*, 7 ANALYSIS OF SOC. ISSUES & PUB. POL'Y 1, 137, 138, 140 (2007).
[178] *See Community Protection Waiver*, supra note 37, at 2 (describing the promotion of participation in the community as one of CPP's services); see also WASH. STATE DEP'T OF SOC. & HEALTH SERV, *Adult Family Home Locator*, https://fortress.wa.gov/dshs/adsaapps/lookup/AFHPubLookup.aspx, [https://perma.cc/3329-69Q4] (to see where adult family homes, which include CPP service providers, are located in Washington).
[179] BEN-MOSHE, *supra* note 126, at 77.
[180] *Id.*
[181] *Id.* at 78.
[182] *Id.* at 80.

individuals in CPP, is institutionalization, and, commonly, incarceration.[183] The goal to "normalize" people with developmental disabilities can be directly linked to the prevalence of surveillance and segregation in facilities that claim to be within the community.[184] Ultimately, "the line between institutional living and not is a contextual one."[185]

Options for providing individuals in CPP with community-based services that meet their needs while keeping the community safe already exist within Washington. Therefore, individuals should be able to access such services without the label of danger attaching.

IV. COMMUNITY PROTECTION IN CONTEXT

In 1983, Congress created the Home and Community Based Services (HCBS) waiver by adding section 1915(c) to the Social Security Act.[186] This allowed states to receive a waiver of Medicaid rules on institutional care, and by 2005 states could formally choose HCBS as a Medicaid State plan option.[187] Prior to this, Medicaid funding for long-term care was mostly limited to institutions and offered few community-based options.[188] The waiver programs give states flexibility in using Medicaid funds so long as the services states choose to fund prevent institutionalization and meet individuals' long-term care needs in community settings.[189] States are encouraged to consider a variety of local factors when designing their

[183] *Id.*
[184] *Id.* at 108.
[185] *Id.* at 109.
[186] *Home & Community Based Services Authorities*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/index.html [https://perma.cc/MBY6-JHPQ] (Feb. 24, 2023); *see also Understanding Medicaid Home and Community Services: A Primer*, OFF. OF THE ASSISTANT SEC'Y OF PLAN. & EVALUATION, U.S. DEP'T OF HEALTH & HUM. SERV. 28 (2010), https://aspe.hhs.gov/sites/default/files/private/pdf/76201/primer10.pdf [https://perma.cc/8TBM-S8A2].
[187] *State Waivers List*, *supra* note 39.
[188] OFF. OF THE ASSISTANT SEC'Y OF PLAN. & EVALUATION, *supra* note 186, at 14.
[189] *Id.* at 14, 28.

waiver programs.[190] Some of the factors include social values, political atmosphere, economic reality, and available resources.[191] Therefore, it is highly likely that no state has an identically designed waiver program under HCBS.[192]

States typically have multiple waiver programs that serve different groups and individuals must meet targeted criteria to receive services.[193] For example, some states offer programs for older adults with physical disabilities, children with disabilities, and people with developmental disabilities.[194] Some states have numerous categories while others have very few.[195] An individual within a qualifying group must also meet additional level-of-care criteria to determine the level and type of care an individual requires.[196] Generally, an individual is assessed to determine the level of services needed for Activities of Daily Living (ADLs) as well as any medical care needed.[197] HCBS waivers for people with developmental disabilities typically offer residential habilitation services to assist the individual in acquiring, retaining, or improving skills needed to live in the community.[198] Examples of these supports include adaptive skill development, ADL assistance, community inclusion activities, transportation, adult education, and leisure activities.[199] Additionally, programs may include personal care services, surveillance, and

[190] *Id.* at 28.
[191] *Id.* at 14.
[192] *State Waivers List*, *supra* note 39.
[193] OFF. OF THE ASSISTANT SEC'Y OF PLAN. & EVALUATION, *supra* note 186, at 72.
[194] *Id.*
[195] *See Colorado Waiver Fact Sheet*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/CO [https://perma.cc/4D9P-GT4N]; *see also Hawaii Waiver Fact Sheet*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/HI [https://perma.cc/J5G6-N9H7].
[196] OFF. OF THE ASSISTANT SEC'Y OF PLAN. & EVALUATION, *supra* note 186, at 72.
[197] *Id.* at 74.
[198] *Id*. at 128.
[199] *Id.*

supervision.[200] Residential habilitation services are the primary services category funded through the waiver program.[201] In 2010, data from the Centers for Medicare and Medicaid Services (CMS) projected that 53% of waiver spending, totaling $12.4 billion, would go to residential habilitation services.[202]

A key requirement of all HCBS waivers is that participants in HCBS-funded programs are not isolated from their communities.[203] The HCBS final rule requires that service planning for individuals in HCBS programs must be developed though the person-centered planning process and address health and long-term services and supports in a way that aligns with individual preferences and goals.[204] The individual should direct the planning process and may include a representative of their choice to assist in the process.[205] Ultimately, this process should "assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare."[206] Importantly, the final rule changes the definition of "home and community-based settings" to reflect the outcomes of participants more than the physical location or setting of the program.[207] The rule requires

[200] *Id.*
[201] Mary C. Rizzolo et al., *Home and Community Based Services (HCBS) Waivers: A Nationwide Study of the States*, 51 INTELLECTUAL & DEVELOPMENTAL DISABILITIES 1, 5 (2013).
[202] *Id.*
[203] *See* MEDICAID.GOV, *Home and Community Based Services Final Regulation*, https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html [https://perma.cc/B78T-D3D8].
[204] CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), *Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule (CMS 2249-F/2296-F)* (Jan. 10, 2014), https://www.cms.gov/newsroom/fact-sheets/home-and-community-based-services [https://perma.cc/4HUP-FK9J].
[205] *Id.*
[206] *Id.*
[207] CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), *Questions and Answers - 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers,*

states to create processes, approved by CMS, to transition their programs to this new standard.[208]

A. Washington's Waiver Program

Washington has four waiver programs in addition to CPP administered by the DDA: (1) Basic Plus; (2) Children's Intensive In-home Behavioral Supports (CIIBS); (3) Core Waiver; and (4) Individual and Family Services (IFS).[209]

First, the Basic Plus waiver is meant to support individuals who are assessed to require certain services to live healthy and safely in their community and in their own home, family home, adult family home, or adult residential center.[210] The waiver provides services to all age groups in the following areas: "community service—promote client participation and integration in the community, professional service—support services provided by contracted professionals, caregiving service—supports for

---

Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) Home and Community-Based Services Waivers - CMS 2249-F and 2296-F, https://www.medicaid.gov/sites/default/files/2019-12/final-q-and-a.pdf [https://perma.cc/TP27-L5M5].

[208] *Id.*; WA. STATE HEALTH CARE AUTH. & DEP'T. OF HEALTH & HUMAN SERV., *Washington State's Revised Statewide Transition Plan for New HCBS Rules* (Mar. 25, 2017), https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/HCBS/TransitionPlan/Washington%20State%20Transition%20Plan%20for%20New%20HCBS%20Rules.pdf [https://perma.cc/EB5W-DSHH].

[209] *Home & Community Based Waivers (HCBS),* WASH. STATE DEP'T OF SOC. & HEALTH SERV., https://www.dshs.wa.gov/dda/consumers-and-families/home-and-community-based-waivers-hcbs [https://perma.cc/3YQZ-CRY6]; *see also Long Term Care Home & Community Based Service Waivers*, WASH. STATE DEP'T OF SOC. & HEALTH SERV., https://www.dshs.wa.gov/altsa/home-and-community-services/long-term-care-home-community-based-services-waivers [https://perma.cc/6MB4-B8NU] (listing three additional waiver programs in Washington for aging and long-term support).

[210] *Basic Plus Waiver,* WASH. STATE DEP'T OF SOC. & HEALTH SERVS. DEVELOPMENTAL DISABILITIES ADMIN. (Dec. 2019), https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/Basic%20Plus%20Waiver_brochure.pdf [https://perma.cc/4U3E-GVN2].

participants and their caregivers, and goods and services—equipment, supplies and specialized services for participants."[211]

Second, the CIIBS supports youth between ages eight to twenty who are at risk of out-of-home placement because of their challenging behaviors.[212] CIIBS offers transportation reimbursement for access to waiver services, a series of professional services around behavioral health, respite services to caregivers living with the youth, and various goods and services like assistive technology and specialized equipment and supplies.[213]

Third, the Core Waiver (Core) is for individuals of all ages considered to be at immediate risk of being placed in an institution or who have needs that exceed what the Basic Plus waiver can provide.[214] The additional services offered in Core include residential habilitation and employment support services.[215]

Fourth, the Individual and Family Services Waiver (IFS) is for families with children or adults with developmental disabilities living in the home.[216] To qualify for IFS, individuals must live in the same home as a family member and be at least three years old.[217] Families can choose from a list of services that may be most helpful to them.[218] Examples of possible

---

[211] *Id.*
[212] *Children's Intensive In-home Behavioral Support Waiver*, WASH. STATE DEP'T OF SOC. & HEALTH SERVS. DEVELOPMENTAL DISABILITIES ADMIN. (Mar. 2018), https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/Children%27s%20Intensive%20In-Home%20Behavioral%20Support%20Waiver.pdf [https://perma.cc/4KTL-FWHP].
[213] *Id.*
[214] *Core Waiver*, WASH. STATE DEP'T OF SOC. & HEALTH SERVS. DEVELOPMENTAL DISABILITIES ADMIN. (May 2018), https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/CORE%20Waiver.pdf, [https://perma.cc/PW5E-GNLK].
[215] *Id.*
[216] *Individual Family and Service Waiver*, WASH. STATE DEP'T OF SOC. & HEALTH SERVS. DEVELOPMENTAL DISABILITIES ADMIN, [https://perma.cc/BYJ2-SY4P].
[217] *Id*.
[218] *Id*.

services include respite care, assistive technology, and staff consultation and training with the family.[219]

CPP, on paper, looks very similar to Core. The biggest difference is that individuals in CPP are "assessed to require 24-hour on-staff supervision to ensure the safety of others."[220] Unlike Core, CPP is not advertised as providing as many community integration services.[221]

B. Examining Another Waiver System in Hawaii

As previously noted, Washington State's CPP stands alone amongst state waiver programs. No other state explicitly singles out certain individuals with developmental disabilities and overtly labels them as dangers to the community.[222] Therefore, other states may serve as role models for how to appropriately discuss the service and safety needs of people with developmental disabilities.

Hawaii addresses the safety risks to program participants and others in an individualized way and reserves restrictive practices for limited time periods in response to imminent harm.[223] Hawaii has one waiver program, the Medicaid 1915(c) HCBS Waiver (I/DD Waiver), for individuals with intellectual and developmental disabilities (I/DD).[224] The Hawaii I/DD waiver:

> Provides adult day health (ADH), discovery & career planning (DCP), individual employment supports (IES), personal

---

[219] *Id*.
[220] *Community Protection Waiver*, *supra* note 37.
[221] See WASH. STATE DEP'T OF SOC. & HEALTH SERVS. DEVELOPMENTAL DISABILITIES ADMIN, *supra* note 210; *see also Community Protection Waiver*, *supra* note 37.
[222] *State Waivers List*, *supra* note 39.
[223] *Waiver Services and Providers*, STATE OF HAW. DEP'T OF HEALTH DEVELOPMENTAL DISABILITIES DIV., https://health.hawaii.gov/ddd/participants-families/waiver-services-providers/, [https://perma.cc/WVR4-WTNU] [hereinafter *Waiver Services and Providers*].
[224] *Medicaid I/DD Waiver*, STATE OF HAW. DEP'T OF HEALTH DEVELOPMENTAL DISABILITIES DIV., https://health.hawaii.gov/ddd/participants-families/waiver/ [https://perma.cc/C2KM-6CNM] [hereinafter *Medicaid I/DD Waiver*].

> assistance/habilitation (PAB), residential habilitation (ResHab), respite, additional residential supports (ARS), assistive technology (AT), chore, community learning services (CLS), community navigator (CN), environmental accessibility adaptations (EAA), non-medical transportation (NMT), personal emergency response system (PERS), private duty nursing (PDN), specialized medical equipment and supplies (SMES), training and consultation, vehicle modifications (VM), and waiver emergency services for individuals with intellectual disabilities and developmental disabilities ages 0 – no max age.[225]

Hawaii's approach, unlike Washington's, does not explicitly categorize part of their service population as a class of dangerous individuals.[226] Instead, caseworkers create a personalized plan for each individual and tailor services to their specific needs.[227] Services include a two-tiered emergency response: Crisis Mobile Outreach and Out-of-Home Stabilization (OHS).[228] If an individual experiences a crisis that impacts their ability to function in their environment, the Mobile Outreach team is deployed to provide in-person support.[229] The team is only meant to deploy when the individual "exhibits behaviors of such intensity, duration, and frequency that it endangers [their] safety or the safety of others;" the team is particularly concerned with behaviors that may risk a disruption in the individual's services, lead to institutionalization, or lead to incarceration.[230]

---

[225] *Hawaii Waiver Fact Sheet,* MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/HI [https://perma.cc/P39Q-MXS7] [hereinafter *Hawaii Waiver Fact Sheet*]; *see also Waiver Services and Providers*, *supra* note 223.
[226] *Waiver Services and Providers*, *supra* note 223.
[227] *Id*.
[228] *Waiver Provider Standards Manual*, STATE OF HAW. DEP'T OF HEALTH DEVELOPMENTAL DISABILITIES DIV., 243, 251 (Nov. 2, 2018), https://health.hawaii.gov/ddd/files/2018/10/Waiver-Standards-B-3.pdf#page=243 [https://perma.cc/M36Q-HGNB].
[229] *Id*. at 243.
[230] *Id*.

The second tier of emergency response, OHS, removes individuals from their homes and takes them to a temporary placement where they receive "intensive intervention" to stabilize them before they return home.[231] This option is meant to be temporary and individuals should only be away from home for a short time.[232] This model allows Hawaii to address potentially dangerous behaviors without attaching a formal label. This model is also designed to be temporary and responsive, emphasizing the need to have effective plans in place for each individual rather than implementing blanket restrictions on a whole group of people.[233]

When the Hawaii Developmental Disabilities Division's (DDD) policy manual addresses safety concerns, it uses person-centered language that emphasizes human dignity.[234] "Policy #2.02 Restrictive Interventions" begins by stating that "[t]he purpose of this policy is to ensure that participants are supported in a caring and responsive manner that promotes dignity, respect, trust and is free from abuse."[235] The policy states outright that restrictive interventions are the "least desirable approach to supporting participants" and that they "are only to be utilized for the protection of the participant and others from imminent risk of harm."[236] Such restrictions must be documented in the individual's Behavior Support Plan and must be terminated once the imminency of the risk of harm ends or once a less restrictive intervention would accomplish the same outcome.[237] Importantly, the policy states that restrictions are "not to be used as threats or punishments to change behavior as participants have the right to be free

[231] *Id.*
[232] *Id.* at 251.
[233] *Id.*
[234] *Policy #2.02 Restrictive Interventions*, STATE OF HAW. DEP'T OF HEALTH DEVELOPMENTAL DISABILITIES DIV., https://health.hawaii.gov/ddd/files/2018/05/DD-Policy-2.02-Restrictive-Interventions.pdf [https://perma.cc/U2WR-SX37].
[235] *Id.*
[236] *Id.*
[237] *Id.*

from any restrictive intervention imposed for the purpose of discipline, retaliation and/or staff convenience."[238]

V. THE REMEDY

> *The Developmental Disabilities Administration wants people who receive Community Protection Waiver services to experience these benefits: – Health and Safety – Personal Power and Choice – Personal Value and Positive Recognition By Self and Others – A Range of Experiences Which Help People Participate in the Physical and Social life of Their Communities – Good Relationships with Friends and Relatives – Competence to Manage Daily Activities and Pursue Personal Goals.*[239]
>
> - Community Protection Waiver Application

How would Betty Antus's story have changed if she had received adequate care and services? At the time, the creation of CPP reflected the DDA and legislature's belief that many individuals in the DDA system could not receive such adequate services without extreme changes.[240] The foundation of CPP rests on the false premise that Core Waiver participants received the services outlined to them in DDA policies and yet still posed a threat to the community and themselves.[241] The foundation of CPP is one based in fear and therefore easily overshadows critical questions about how DDA fundamentally failed Antus within a program that, if implemented in good faith, would have prevented the fire.[242] DDA knew Antus's behavior pattern leading up to the fire and yet, they did not create a plan to address

[238] *Id.* at 4 (Reference reports of CPP clients having movies and games taken away as punishment).
[239] Application for 1915(c) HCBS Waiver, Community Protection, 6, (current through Oct. 1, 2021). https://manuals.dshs.wa.gov/sites/default/files/DDA/dda/documents/Community%20Protection%20waiver%20effective%2010.1.2021.pdf [https://perma.cc/L64B-K6J8].
[240] *See* Lily Eng et al., *supra* note 3; *see also* Associated Press, *supra* note 3; *see also* S.B. 6630, *supra* note 9.
[241] *Id*.
[242] *Id.*

it.[243] This is a system failure.[244] The system failed when it shuffled Antus around in an "awkward dance" between service providers; CPP is yet another way to shuffle individuals into a place where their true habilitative and service needs can be relegated to an afterthought.[245] DDA missed the opportunity to remedy this system failure by creating a new restrictive program. DDA could have instead addressed (1) the lack of a person-centered plan focusing on positive behavior supports; (2) the steps for when temporary restrictive measures are needed; and (3) when to remove those restrictions. Had such measures been in place, they likely would have prevented this tragedy while still respecting Antus's dignity.

DDA must make efforts to live up to their stated goals of person-first client supports. The rights deprivations experienced by individuals in the CPP must be immediately remedied, but changes cannot stop there. Both short-term and long-term remedies are necessary to protect the rights of individuals in the CPP. Beyond that, society must fundamentally change its perception of individuals with developmental disabilities. The short-term solution is to follow the DD Ombuds Office's recommendations. The CPP is a product of a wider problem. As such, any remedy must include ameliorating fixes to the program and then go beyond to address the wider systemic oppression of disabled people. The remedy, therefore, must be a three-pronged approach that reinstates individuals' rights, empowers the disabled community, and generally addresses the harmful manner of thinking and acting toward disabled people prevalent in society.

---

[243] *See* Lily Eng et al., *supra* note 3.

[244] *Id*. (quoting Mr. Stroh from the Washington State Protection and Advocacy Agency on where services failed Antus).

[245] *Id*. ("Antus got stuck in the 'awkward dance' between mental-health professionals and the DDD, said Sue Elliott, executive director of The Arc (formerly the Association for Retarded Citizens) of Washington state, a nonprofit advocacy organization for the developmentally disabled, and former director of the division. 'We need to stop the shuffling of people within bureaucracies,' Elliott says.").

A. An Ameliorating Fix: Accept and Implement DD Ombuds Recommendations

> *"They don't let me come to the first part of my own treatment team meeting. I have to sit outside and wait while my counselor, DDA, and the CPP staff are inside talking about me."*[246]
>
> - Anonymous

The DD Ombuds proposed five recommendations to immediately restore rights to CPP clients.[247] DDA must accept these recommendations as a first step in transitioning to a service that treats all clients with respect and dignity.

First, the DD Ombuds recommends DDA focus on diverting young people from enrollment in CPP by providing adequate resources and support.[248] The DD Ombuds points out in its report that DDA's policy gives guidance on how clients are selected and enrolled in CPP, but this policy is not currently followed as written.[249] While the selection criteria and enrollment process do not sufficiently protect clients' rights, following this policy consistently would prevent DDA staff from unnecessarily enrolling individuals in CPP.[250] Current policy requires DDA staff to identify potential community protection issues, complete appropriate paperwork, and forward it to a special committee to determine CPP placement.[251] This process, if followed, would provide necessary checks on enrollment and reduce the number of individuals placed in CPP. DDA staff must ensure individuals are receiving supportive services and document less restrictive safety procedure measures before submitting a recommendation for CPP.[252]

---

[246] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 8.
[247] *Id*. at 16–19.
[248] *Id.* at 16.
[249] *Id.*
[250] *Id*.
[251] *Policy 15.01*, *supra* note 68.
[252] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 17.

Second, the DD Ombuds recommends DDA allow individuals who decline risk assessment or CPP services to remain enrolled in other waiver services.[253] Currently, DDA presents CPP as a voluntary program and the WAC states that individuals may leave the program at any time.[254] The choice to decline a risk assessment, to decline CPP enrollment, or to leave the program, however, comes with consequences so drastic that to call this a choice belies the extent CPP removes individual autonomy; individuals who decline cannot receive any other waiver services.[255] Because individuals rely on services for basic needs, declining CPP, in reality, is not a viable option. Therefore, the DD Ombuds recommends that the WAC be edited so that individuals receiving DDA services have alternative service options if they choose not to participate in CPP.[256]

Third, the DD Ombuds recommends DDA "create a clear path to graduation using a person-centered planning process."[257] Over a twenty-three-year period, CPP has seen eighty-six individuals graduate.[258] DDA has policies in place that require a treatment plan with specific goals:

> Treatment plan means an individualized plan written by a qualified professional or therapist for a participant that includes the following, at a minimum: (a) Specific time-limited goals and objectives based upon evaluation data; (b) Specific therapeutic services proposed, include frequency and duration of services and methods to be used; (c) Recommendations for supervision and any other restrictions and/or restrictive procedures; (d) A description of how participant progress will be assessed; and (e) Treatment discharge criteria.[259]

---

[253] *Id.*
[254] WASH. ADMIN. CODE § 388-831-0250 (2008).
[255] *Id.*
[256] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 17.
[257] *Id.* at 18.
[258] *Id.*
[259] *Policy 15.01*, *supra* note 68, at 3.

Under this policy, the individual meets with their treatment team four times a year to discuss their treatment progress, their current restrictions, their restrictions that may be reduced, and their overall progress toward graduation.[260] Yet, individuals report numerous issues with the implementation of this policy.[261] The DD Ombuds recommends that a clear path to graduation be detailed and followed with the use of the person-centered planning process.[262]

The fourth DD Ombuds recommendation asks that DDA give electronic access to the DD Ombuds Office for program information and records.[263] It also asks that DDA respond within a specific time frame to all records requests submitted by DD Ombuds.[264] Because many of the DD Ombuds' recommendations involve the enforcement of current DDA policies that are currently unmet, DDA requires some oversight to be held accountable. The DD Ombuds references two other state agencies that have such a relationship with their corresponding Ombuds Offices: the Department of Corrections Ombuds and the Office of the Child and Family Ombuds.[265] This access is crucial to holding DDA accountable to its own policies. Therefore, DDA should follow the examples of other departments and grant DD Ombuds the proper oversight capabilities.

Finally, the DD Ombuds recommends that DDA leadership hold staff accountable to existing policies around referrals and risk assessments for CPP.[266] There is evidence that DDA staff do not adhere to the requirements to document risk assessments and referrals.[267] Such a relaxed approach

[260] *Id.* at 4–5.
[261] *Supra* Section IV (lack of access to treatment plan, lack of clear measurable goals, denying requests to purchase a coke for no reason connected to treatment plan).
[262] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 18.
[263] *Id*.
[264] *Id.*
[265] *Id.* at 18–19; *see also* WASH. REV. CODE § 43.06C.050(5); *see also* WASH. REV. CODE § 43.06A.100(D).
[266] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 19.
[267] *Id*.

undermines an individual's rights and calls into question whether enrolling an individual in CPP is the best course of action. DDA leadership should provide the adequate supervision to reduce unnecessary referrals to CPP and increase the implementation of other services first.

In addition, the risk assessment itself is fraught with issues. Troublingly, individuals cannot appeal the decision to have an assessment, an important due process consideration because once the assessment process begins, clients are stigmatized regardless of the outcome. Individuals also have serious limitations to challenging the results of the assessment itself: DDA policy states that when "the client or the client's legal representative disagrees with the conclusions of a risk assessment, the CRM [DDA Case Resource Manager] must consult their supervisor to decide whether an additional risk assessment should be obtained."[268] DDA must instate an appeals policy at the referral for assessment stage.

Despite the DD Ombuds' initial reports that the DDA is not outright opposed to these suggestions, DDA has since failed to implement suggested reforms.[269] For example, the DD Ombuds made several recommendations to DDA in early 2022 when DDA was developing its application to renew the CPP HCBS waiver.[270] Among the recommendations were heightened scrutiny of all CPP settings to monitor for rights violations as well as providing DD Ombuds access to the PCSP of individuals in CPP to evaluate for compliance.[271] DDA declined to do either.[272] In March of 2023, the DD Ombuds notified DDA of their continued violation of the HCBS rule guaranteeing people full access to community life, privacy,

[268] *See* Policy 15.01, *supra* note 68, at 7.
[269] Statement of the DD Ombuds (on file with author).
[270] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, Letter from Ombuds Lisa Robbe to DDA Waiver Team, (Sept. 26, 2022) (on file with author).
[271] *Id*.
[272] *Id*.

relationships, and community activities.[273] Furthermore, the DD Ombuds has continued to reach out to individuals in CPP and documented rights violations against sixty individuals.[274] Individuals interviewed by the DD Ombuds in 2022 shared that they still do not understand how to graduate from CPP; they cannot visit who they want to; they cannot attend community activities without permission; they are under required twenty-four-hour surveillance; they are not allowed cell phones, social media, or even movie streaming services; and they are afraid to make mistakes because of the threat of losing more rights or waiting longer to have their rights reinstated.[275]

DDA's failure to address these serious issues presents a pattern. DDA has faced similar calls to action in the past and many changes did not happen.[276] DDA must do more than acknowledge shortcomings; DDA must adopt the DD Ombuds' recommendations without delay to restore the rights of individuals in CPP.

B. The Long-Term Goal: Repeal RCW 71A.12

> *Historically interventions used for people with intellectual and developmental disabilities (I/DD) have been unacceptably intrusive, focused primarily on punitive consequences, inappropriate for integrated settings, and/or ineffective in producing meaningful changes. Positive Behavior Supports (PBS)*

[273] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, Comment to DDA on the HCBS Waiver Amendments, (Mar. 15, 2023) (on file with author).
[274] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS, HCBS Q&A Committee Agenda, 14 (Sept. 14, 2022) (on file with author).
[275] *Id*. at 18.
[276] *See* Teichroeb, *supra* note 22 (stating that "Advocates have raised questions about civil rights violations because clients referred to the 'voluntary' program by DSHS must enroll or lose state-funded services. No court monitors who must enroll or who is allowed to graduate." While some changes occurred in 2006 with the legislature formalizing CPP in the RCW, many of the issues raised by advocates remain unresolved.).

> *are preferable because they are effective in improving behavior and quality of life for people with behavioral challenges.*[277]
>
> - Hawaii DDD Policy Manual

Ultimately, the CPP must be dissolved. The state legislature must repeal RCW 71A.12 and the DDA must reform its Core Waiver policies to reflect the incorporation of CPP clients into the Core Waiver program.

Every restriction utilized under CPP is already available under the Core Waiver and can be included in a client's ISP.[278] Because of this, there is no need for a CPP. An individual in need of additional or extraordinary measures to ensure the safety of themselves and others can achieve such support without enrollment in CPP. The federally required "person-centered planning process," if genuinely followed, would ensure each individual DDA client has a plan in place that meets their health and safety needs.[279] Additionally, DDA can adopt policies that provide guidance for emergent, dangerous situations. Hawaii's DDD policies provide an example of not only how to talk about clients as autonomous people deserving respect and dignity, but also how to treat them as such. While DDA might protest that eliminating CPP will leave DDA individuals with nowhere to go, DDA can responsibly transition individuals to other programs while ensuring such programs are built up to match that individual's needs.

A side-by-side comparison of CPP and Core Waiver programs reveals a distinct lack of any meaningful difference in services provided.

---

[277] *See Policy #2.01: Positive Behavior Supports*, STATE OF HAW. DEP'T OF HEALTH DEVELOPMENTAL DISABILITIES DIV. 1, 6 (Feb. 7, 2017), https://health.hawaii.gov/ddd/files/2018/05/DD-Policy-2.01-Positive-Behavior-Supports.pdf [https://perma.cc/BS2P-83GK] [hereafter *Policy #2.01*].

[278] *Compare Core Waiver*, *supra* note 214 *with Home and Community-Based Services Waiver Application*, WASH. STATE DEP'T OF SOC. & HEALTH SERVS. 6, https://manuals.dshs.wa.gov/sites/default/files/DDA/dda/documents/Community%20Protection%20waiver%20effective%2010.1.2021.pdf [https://perma.cc/79VX-TG4X].

[279] 42 U.S.C. § 441.301(c)(1).

Medicaid.gov provides overviews of state Medicaid Waiver programs.[280] The website's factsheet on Washington presents strikingly similar summaries of the Medicaid Core Waiver program and the Medicaid Community Protection Waiver. First, the fact sheet describes the Core Waiver:

> Provides *community inclusion*, individual supported employment/group supported employment, prevocational services, residential habilitation, respite, behavioral health stabilization services - specialized psychiatric services, behavioral health stabilization service - positive behavior support and consultation, behavioral health stabilization services - crisis diversion bed services, chemical extermination of bed bugs, *community engagement, community guide,* community transition, environmental adaptations, extermination of bed bugs, individualized technical assistance, occupational therapy, physical therapy, positive behavior support and consultation, risk assessment, skilled nursing, specialized equipment and supplies, specialized habilitation, specialized medical equipment and supplies, specialized psychiatric services, speech, hearing, and language services, stabilization services- specialized habilitation, stabilization services - crisis diversion bed, stabilization services – staff/family consultation services, staff family consultation services, transportation, wellness education for individuals with autism, intellectual disabilities, and developmental disabilities *ages 0 – no max age*.[281] WA Core Waiver (0410.R03.00) (emphasis added).

For comparison, the CPP waiver states:

> Provides individual supported employment/group supported employment, prevocational services, residential habilitation,

[280] CTRS. FOR MEDICARE AND MEDICAID SERVS., STATE WAIVER LIST, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html [https://perma.cc/83KA-XEZ8].
[281] CTRS. FOR MEDICARE AND MEDICAID SERVS., WASHINGTON WAIVER FACTSHEET (2021), https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/WA [https://perma.cc/GA84-GX8G].

> behavioral health stabilization services - specialized psychiatric services, behavioral health stabilization services - crisis diversion bed services, behavioral health stabilization services - positive behavior support and consultation, chemical extermination of bed bugs, community transition, environmental adaptations, extermination of bed bugs, individualized technical assistance, occupational therapy, physical therapy, positive behavior support and consultation, risk assessment, skilled nursing, specialized equipment and supplies, specialized medical equipment and supplies, specialized psychiatric services, speech, hearing, and language services, stabilization services - specialized habilitation, stabilization services - staff/family consultation services, stabilization services - crisis diversion bed, staff/family consultation services, transportation for individuals with autism, intellectual disabilities, and developmental disabilities ages 18 – no max age.[282]

The notable differences are that in the Core Waiver, community inclusion and involvement are explicitly included while conspicuously absent in the CPP description.[283] The CPP program is not available to those under the age of eighteen in order to protect young DDA clients from being automatically funneled into the program.[284] Incredibly, though, these two programs are identical in almost every other way. While DDA may claim that discontinuing the CPP will leave clients with nowhere to turn, this is objectively false. Not only is the Core Waiver capable of fulfilling client needs, DDA staff can work with clients through the federally mandated person-centered planning process to ensure the client's and community's safety, which DDA purports to adhere to.[285]

Furthermore, person-centered planning is a federal requirement; section 441.301 of the HCBS Waiver Requirements outlines the person-centered

[282] *Id.*
[283] *Id*.
[284] OFF. OF THE DEVELOPMENTAL DISABILITIES OMBUDS, *supra* note 2, at 13.
[285] *See Community Protection Waiver*, *supra* note 37.

planning process that state program administrators must follow.[286] The person-centered planning process requires that the individual lead the planning process as much as possible and that if they have a representative that person participates.[287] An individual can also include others of their choice in the process.[288] The process must (1) be designed to maximize the individual's ability to direct the process by providing information and support; (2) be timely and take place when and where is convenient to the individual; (3) be reflective of the individual's culture and must be accessible to them; (4) include strategies for conflict resolution; (5) offer informed choices for services and supports; (6) include a clear way of updating the plan; and (7) include alternative service options considered by the individual.[289] Under this process, a client's person-centered plan could include agreed-upon restrictions that promote safety for the client and the community. Additionally, following this plan allows for a shift away from the protection paradigm and toward a model of supporting the individual in living the kind of life they wish to live.

When updating its policy manual, DDA should look to the Hawaii DDD policy manual. This manual embodies the spirit of the person-centered approach.[290] By choosing to apply Positive Behavior Supports (PBS) in response to potentially unsafe behavior, Hawaii's DDD focuses on empowering the individual rather than restricting their rights.[291] DDA should consider adopting Hawaii's approach:

> The primary purposes of this policy are to commit to approaches that embrace the unique strengths and challenges of each participant, and engage each participant's circle of support as partners in developing and implementing PBS using least

[286] 42 U.S.C. § 441.301(b)(1)(i).
[287] *Id.*
[288] *Id.* at (i).
[289] *Id.* at (i–ix).
[290] *See generally Waiver Provider Standards Manual*, *supra* note 228, at 255–58.
[291] *Policy #2.01*, *supra* note 277, at 1.

> restrictive interventions. When a participant presents behaviors that put them at imminent risk of hurting themselves or others, PBS shall be used, whenever possible, to decrease the behaviors that pose a risk. When PBS techniques have been used and are not effective in resolving the immediate risk of harm, restrictive interventions that involve temporary restrictions may be necessary (refer to Policy 2.02, Restrictive Interventions). Behavioral support plans (BSP) containing restrictive interventions are the least desirable approach to supporting participants and should only be utilized for the protection of the participant and others. Ultimately, this policy sets forth the core values of supporting participants to the best of their abilities by expanding opportunities and enhancing quality of life using PBS approaches.[292]

Hawaii's approach demonstrates a commitment to centering individual rights through integration in the community that is simply absent within DDA policies. CPP policies relegate PBS to one of a list of supports that service providers prioritize over PBS.[293] The CPP policy defines PBS as "a set of processes that combine information from social, behavioral, and biomedical science and applies this information at the individual and systems level to reduce behavioral challenges and improve quality of life."[294] Any instruction to service providers to use PBS is cursory and listed last, reflecting the reality that PBS is not a priority in the services delivered for CPP clients and the pervasive nature of the restrictions CPP

---

[292] *Id*.
[293] *Policy 15.04 Standards for Community Protection Residential Services (CPRS)*, WASH. DEP'T OF SOC. & HEALTH SERVS. DEVELOPMENTAL DISABILITY ADMIN., 2 (Nov. 2019), https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy15.04.pdf [https://perma.cc/9TAY-2XFW].
[294] *Id*.

places on clients.[295] Additionally, such a policy contradicts the definition of Community Protection Residential Services given elsewhere.[296]

Person-centered planning can also help reduce DDA reliance on risk assessments. Research into risk assessment for individuals with intellectual disabilities and "problematic sexual behaviors" indicates that individuals can learn to manage these behaviors with appropriate assessment, treatment, supervision, and "tools and processes specific to their clinical and risk management needs."[297] A diversified approach to risk assessments, while still problematic,[298] can inform a person-centered planning process and give communities the apparently needed reassurance. Still, DDA in its policies must explicitly acknowledge the limitations on such assessments and limit reliance on such assessments when planning with individuals.

Opponents of eliminating CPP as a stand-alone waiver program may argue first that residential service agencies contracted by DDA need to design separate services for the kinds of individuals referred to CPP because service providers would otherwise be unable to meet these individuals' needs. Additionally, opponents might argue that grave incidents of harm created the necessity for the program and that prior to the creation of CPP these kinds of individuals did not receive the needed supports. Both arguments lead to the false conclusion that without CPP individuals with dangerous behavior will harm members of the community and end up in more restrictive environments, like prisons and institutions.

---

[295] *Id*., at 4, 5 (Policy B(3) and Procedures B(5) listing PBS last and prioritizing other more restrictive options first).
[296] *See Policy 15.02 Community Protection Program Services*, WASH. DEP'T OF SOC. & HEALTH SERVS. DEVELOPMENTAL DISABILITY ADMIN., 1 (Nov. 2019), https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy15.02.pdf [https://perma.cc/5AAV-5P5U] (defining CPRS as "supported living services with access to 24-hour supervision and instruction and support services, as identified in the CPP participant's person centered service plan (PCSP), positive behavior support plan (PBSP), individual instruction and support plan (IISP), and treatment plan.").
[297] Blasingame et al., *supra* note 124, at 14.
[298] *Supra* Section III(B).

There are numerous restrictions built into CPP that are presented as "across the board" or blanket restrictions.[299] For example, a blanket restriction would be that generally, individuals in CPP have twenty-four-hour supervision.[300] Additional standard restrictions include internet and phone restrictions, door alarms, and door locks.[301] If these measures were genuinely needed for all individuals in CPP, residential service providers would be taking on a huge burden to implement them without the infrastructure of CPP, but many individuals in CPP report that such restrictions are not linked to their person-centered plan or treatment plans.[302] Additionally, individuals in CPP report that many restrictions are punitive in nature.[303] Therefore, the burden on supporting individuals with perceived "dangerous" behaviors is not as daunting as it first appears. In fact, the restriction on individual rights is so concerning that it overshadows any possible justification blanket restrictions may have. Finally, the idea that CPP is an alternative to institutionalization fails to acknowledge the many ways discussed above that CPP mirrors institutions: isolation, surveillance, and confinement.

C. Going Further: Empowering Community

> *"I just want to have my cell phone back. They took it last year and said until my behavior is appropriate, I won't ever get it back."*[304]
>
> - Anonymous

---

[299] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS *supra* note 2, at 7.
[300] *E.g.*, Dungarvin, *Community Protection Residential*, https://www.dungarvinwasl.com/communityresidential [https://perma.cc/SGT6-NJUA] (describing the community protection residential services it provides as including 24-hour surveillance of residents).
[301] *See* WASH. STATE DEP'T OF SOC. & HEALTH SERV. DEVELOPMENTAL DISABILITIES ADMIN, *supra* note 56 (also listing monitoring of television, magazines, telephone, computer; no drug or alcohol; room searches).
[302] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS *supra* note 2, at 7.
[303] *Id*. at 8.
[304] *Id*.

One of the most disturbing attributes of the CPP is how the program diminishes and silences the voices of individuals in the program. CPP does this by restricting participants' access to technology.[305] The CPP also does this by presenting the administrative appeals process as a viable option for clients, when in fact, it is especially inaccessible to DDA clients.[306] Individuals are excluded from parts of their treatment team meetings, are prohibited from making phone calls without permission and supervision, and are often prohibited from accessing the internet.[307] This creates a chilling effect on speaking up for oneself and increases the vulnerability of individuals.

One way to empower individuals in CPP is to provide them with access to legal services. In 2006, the legislature appropriated $300,000 of the general fund for fiscal year 2007 for DDA to contract legal services for individuals entering or already in CPP.[308] The legal services focused on protecting the rights of individuals entering CPP.[309] The legislature can devise a similar program, one that reaches all individuals served through a DDA-administered waiver program, including those already in the CPP

[305] *See* WASH. STATE DEP'T OF SOC. & HEALTH SERV. DEVELOPMENTAL DISABILITIES ADMIN, *supra* note 56; *see also* OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS *supra* note 2, at 7.

[306] OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS *supra* note 2, at 6; *see also Community Protection Waiver*, *supra* note 37 (describing the actions that are appealable through an administrative hearing, but not describing how individuals with IDD access such hearings).

[307] *See* WASH. STATE DEP'T OF SOC. & HEALTH SERV. DEVELOPMENTAL DISABILITIES ADMIN, *supra* note 56; *see also* OFF. OF DEVELOPMENTAL DISABILITIES OMBUDS *supra* note 2, at 7.

[308] H.R. 6386, 59th Leg., Reg. Sess., § 44 (Wash. 2006), https://lawfilesext.leg.wa.gov/biennium/2005-06/Htm/Bills/Senate%20Passed%20Legislature/6386-S.PL.htm [https://perma.cc/K7G2-JHSY]; *see also History*, DISABILITY RTS. WASH., https://www.disabilityrightswa.org/history/ [https://perma.cc/3LV3-H266].

[309] *See History*, DISABILITY RTS. WASH., https://www.disabilityrightswa.org/history/ [https://perma.cc/3LV3-H266] (stating "the legal services [were] for people who are in danger of losing their rights because they are recommended for the Community Protection Program").

program. Washington State already has public funds appropriated for civil legal aid to indigent individuals.[310] The legislature must expand civil legal aid to specifically address the advocacy needs of individuals within CPP especially, and other DDA-administered programs.

A second way to empower individuals in CPP is to provide them with access to technology. A life offline is a form of isolation. An individual's access to both information and communication with others is essential for self-determination and the ability to engage in educational activities, promote health, seek employment, engage in recreation, and participate in civics.[311] Technology is also an important way in which people engage with others in friendship networks.[312] There is no reason to think that social media activities should be less important to individuals with developmental disabilities than they are to anyone else. Individuals in CPP must have access to devices and software that are flexible and easy for everyone to use.[313]

A third way to empower individuals in CPP is to connect them to local advocacy groups. DDA-contracted service providers should seek out and invite advocacy groups to connect with individuals in their programs. Advocacy by people with developmental disabilities can play a large role in advancing the rights of people with developmental disabilities, and individuals in CPP need access to these networks.[314] Those in CPP must have their voices amplified; they must be seen as the experts of their own lives with the capacity "to frame the demands and be the leadership."[315] Because a rights framework often leads to assimilating to the dominant

[310] WASH. REV. CODE § 2.53.030.
[311] David Braddock et al., *The Rights of People with Cognitive Disabilities to Technology and Information Access*, 1 INCLUSION 95, 98 (2013).
[312] *Id.* at 96.
[313] *Id.* at 98.
[314] *Id.* at 97; *see, e.g.*, *Home*, PEOPLE FIRST OF WASH., https://www.peoplefirstofwashington.org/ [https://perma.cc/ERM9-AHL5] (for an example of an advocacy organization centering people with disabilities).
[315] A.J. Withers et al., *supra* note 12.

culture rather than to confronting the root causes of injustice, the voices of those most marginalized are of great significance.[316]

VI. CONCLUSION

Washington State currently engages in a kind of Orwellian doublethink: the idea of "community-based" treatment options is reduced to local small-scale facilities rather than a conception of patients or program participants being included members of communities.[317] For example, DSHS is planning two new sites to treat mental illness.[318] DSHS utilizes the term "community-based" even though those confined to these new facilities are involuntarily civilly committed, subject to security measures to keep them confined and, therefore, highly unlikely to actually be integrated into the community during the process.[319] The thinking seems to be that institutions within communities provide families and friends of patients more direct access to their loved ones while they undergo treatment.[320] Therefore, this rationale centers the needs of the community at the expense of those subjected to such systems. This same thought process has justified the creation and maintenance of CPP. The façade of community integration hides the truth of the lived experiences of those confined in such places.

Society must continually examine how it perceives disability and how it determines who does and does not have a voice. As moral, philosophical, and ethical questions, the state's standard tools of policies, checklists, and

---

316 *Id.*

317 *Community-Based Treatment*, DEP'T OF SOC. & HEALTH SERVS. BEHAVIORAL HEALTH ADMIN., https://www.dshs.wa.gov/bha/division-state-hospitals/community-based-treatment [https://perma.cc/9N5U-DWKN].

318 *Id*.

319 *Id*.

320 Washington Governor's Office, *Inslee Announces 5-year Plan to Shift Civil Mental Health Out of Big State Hospitals in Favor of Smaller, Community-based Facilities*, MEDIUM (May 11, 2018), https://medium.com/wagovernor/inslee-announces-5-year-plan-to-shift-civil-mental-health-out-of-big-state-hospitals-in-favor-of-ffb3549fc5ac [https://perma.cc/RRE6-LRRJ].

funding streams cannot adequately respond.[321] Such tools can be used in a responsive, ameliorating way, but only with a significant paradigm shift can the harmful effects of CPP truly be undone. Washington State has the opportunity moving forward to truly engage with people with developmental disabilities and to meet their needs while respecting their autonomy and dignity. The State must commit to dismantling CPP by first accepting and implementing the DD Ombud's recommendations, second repealing RCW 71A.12, and third empowering and uplifting the voices of the individuals who receive services through DDA. These changes are required to ensure that the rights of DDA enrollees are respected and that all individuals are afforded human dignity.

[321] BEN-MOSHE, *supra* note 126, at 109.