UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

William Dixon, *et al*.	)	
	)	
Plaintiffs,	)	
v.	)	**Civil Action No. 1:74-cv-00285 (TFH)**
	)	
Adrian M. Fenty, *et al.*	)	
	)	
Defendants.	)	

PLAINTIFFS' OPPOSITION
TO DEFENDANTS' MOTION TO VACATE
DECEMBER 12, 2003 CONSENT ORDER AND TO DISMISS ACTION

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INTRODUCTION

Thirty-four years ago, this Court held that the Ervin Act created "a right to the best possible care and treatment for the mentally ill" and that the District of Columbia had an affirmative obligation to ensure those rights by providing *Dixon* class members suitable care and treatment in the least restrictive setting. *Dixon v. Weinberger*, 405 F. Supp. 974, 977-78 (D.D.C. 1975) (emphasis added). Despite 34 years of court orders, the District has failed to comply with the *Dixon* mandate, which is firmly anchored in the Ervin Act and another Act of Congress, the Transfer Act — a statute the District fails to bring to the Court's attention. In its haste to exit court supervision before its legal obligations have been discharged, the District ignores longstanding Supreme Court precedent regarding the conditions under which a consent order may be vacated. It misunderstands the Exit Criteria's role as a modest measure that gauges the District's progress in complying with the law. It overstates its accomplishments and makes no mention of its mental health system's significant shortcomings. And it does little to demonstrate that any progress is durable. Simply put, the District's efforts to exit court supervision are misguided and premature. The District has not remedied its failure to comply with the Ervin Act and the Transfer Act. Nor, having met only six of 19 Exit Criteria, has it substantially met the terms of the Consent Decree to which it agreed just six years ago. The District's motion to vacate and dismiss should be rejected.

BACKGROUND

Almost half a century ago, Congress passed the 1964 Hospitalization of the Mentally Ill Act. Pub. L. No. 89-183, ch. 5, 79 Stat. 750 (1965) (codified at D.C. Code §§ 21-501 *et seq.*) ("Ervin Act."). In 1974, a class of seriously mentally ill individuals confined at St. Elizabeths Hospital filed suit in this Court against the federal and District of Columbia governments to

enforce their rights under the Act. One year later, this Court held that plaintiffs' statutory right to "treatment which is adequate in light of present knowledge" includes placement in community-based facilities. *Dixon v. Weinberger*, 405 F. Supp. 974, 977 (D.D.C. 1975). The Court interpreted the Ervin Act to require that mental health services provided to consumers "be suited to [each patient's] particular needs as determined by a frequently evaluated, individually tailored program." *Id.*

Defendants' retelling of this case's history emphasizes one aspect of the Ervin Act and the original *Dixon* judgment — institutionalization at St. Elizabeths. *See* Mot. at 3-4. To be sure, in 1974, many more of the District's mental health patients were confined at St. Elizabeths. *See Dixon v. Barry*, 967 F. Supp. 535, 537 (D.D.C. 1997). But as plaintiffs explain in more detail below, *see infra* Part II, this case has historically been concerned with <u>two</u> interrelated problems: institutionalization at St. Elizabeths Hospital <u>and</u> the lack of an integrated, adequately functioning, community-based mental health system in the District of Columbia. The original composition of the defendants in this case confirms these twin, and inextricably linked, focal points: the federal government was named a defendant because it operated St. Elizabeths, and the District government was named a defendant because it was "responsible for <u>community mental health centers</u> in the District." Final Court-Ordered Plan, *Dixon v. Williams*, No. 74-285 (Mar. 28, 2001), at 1 ("Final Court-Ordered Plan") (emphasis added).

Twenty-nine years ago, the defendants entered into the first of many consent orders, agreeing to a set of commitments for "assuring the rights of <u>all</u> members of the plaintiff class to <u>adequate community-based residential placements and care and treatment</u> in the least restrictive settings." Consent Order, *Dixon v. Harris*, No. 74-285 (1980), at 1 ("1980 Consent Order") (emphases added). Four years later, in the Transfer Act, Congress mandated that the District

create "a comprehensive District mental health system to provide mental health services and programs through community health facilities," requiring as a matter of federal statutory law that the comprehensive system "be in full compliance with the Federal Court consent decree in Dixon v. Heckler." Saint Elizabeths Hospital and District of Columbia Mental Health Services Act, Pub. L. No. 98-621, 98 Stat. 3369 (codified at 24 U.S.C. §§ 225 *et seq.*) ("Transfer Act") (emphases added).

In the face of continuing non-compliance, this Court appointed a Special Master to monitor the District, *Dixon v. Kelly*, No. 74-285, 1993 U.S. Dist. LEXIS 6511 (D.D.C. May 14, 1993); placed it in receivership, *Dixon v. Barry*, 967 F. Supp. 535 (D.D.C. 1997); adopted a "Final Court-Ordered Plan" mapping a new direction for mental health services in the District; and, after extensive negotiations including the District, approved 19 Exit Criteria to measure the District's progress going forward, Consent Order Approving Agreed Exit Criteria With Measurement Methodology And Performance Levels, *Dixon v. Williams*, No. 74-285 (Dec. 12, 2003) ("2003 Consent Order").

The Exit Criteria "reflect[] the considerable experience gained in reviewing and analyzing national benchmarks and local baselines." Agreed Exit Criteria with Measurement Methodology and Performance Levels, Appended to 2003 Consent Order, at 1 ("Exit Criteria Performance Levels"). Their purpose is to hold the District accountable for satisfying requirements that, along several dimensions, are crucial to the creation of a well-functioning mental health system. For example, certain Exit Criteria address the mental health system's overall "penetration rates" — a percentage of the District's population who receive at least one service during a particular period of time — and others measure the availability of specific

services, such as Assertive Community Treatment ("ACT"), supported housing, and supported employment.

For approximately the first four years following the District's agreement to the Exit Criteria, the Court Monitor found that the District had satisfied none of the 19 Exit Criteria. During the past two years, the District has begun to meet some performance measures and, as a result, the Court Monitor has placed less than one-third of the Exit Criteria — six of 19 — on inactive monitoring status. Thirteen of the 19 criteria remain unsatisfied, and the Court Monitor recently noted that "significant effort" is required to satisfy more than half of the currently active criteria. Report of Court Monitor – July 2009, at 11-12.

STANDARD OF REVIEW

Rule 60(b)(5) permits a court to modify or vacate a consent decree if "applying [the judgment or order] prospectively is no longer equitable." Fed. R. Civ. P. 60(b)(5). "Rule 60(b)(5) may not be used to challenge the legal conclusions on which a prior judgment or order rests, but the Rule provides a means by which a party can ask a court to modify or vacate a judgment or order if 'a significant change either in factual conditions or in law' renders continued enforcement 'detrimental to the public interest.'" *Horne v. Flores*, 129 S. Ct. 2579, 2593 (2009) (quoting *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 384 (1992)). Though courts must apply a "flexible approach" in considering motions to modify orders in institutional reform cases, "[i]t goes without saying that federal courts must vigilantly enforce federal law." *Id.* at 2594. Modification of a consent decree, in particular, "is an extraordinary remedy, as would be any device which allows a party — even a municipality — to escape commitments voluntarily made and solemnized by a court decree." *Twelve John Does v. District of Columbia*,

861 F.2d 295, 298 (D.C. Cir. 1988); *see also Rufo*, 502 U.S. at 389-90 (1992) (distinguishing consent decrees from coercive decrees).

The District "'bears the burden of establishing that changed circumstances warrant relief'" from the Consent Decree. Mot. at 32 (quoting *Horne*, 129 S. Ct. at 2593). The District cannot shoulder its burden.

SUMMARY OF THE ARGUMENT

Defendants argue that they have "remedied the statutory violation that gave rise to the Consent Order," that "changed circumstances . . . provide an independent ground for dismissal of this action," and "that the District is in substantial compliance with the exit criteria." Mot. at 2. None of these assertions withstands scrutiny.

First, defendants fail to apply the correct Supreme Court case law that controls modification or vacatur of consent decrees. Under the correct legal standard, it is evident that defendants fail to demonstrate that continued enforcement of the *Dixon* consent decree is no longer equitable. It is, therefore, bound to the Consent Decree it agreed to six years ago.

Second, even if the standard for vacating coercive decrees applied, vacatur would still be inappropriate because the District has failed to remedy its statutory violations. The District's Motion makes absolutely no mention of the fact that Congress has mandated, as a matter of federal statutory law, compliance with the *Dixon* consent decree, and that failure to comply with the decree is a continuing violation of federal law. The District also has failed to remedy its original violation of the Ervin Act: it has failed to create an integrated community-based mental health system that provides adequate care in light of present knowledge and that is suited to the particular needs of each individual class member. Nor has the District complied even with modest Exit Criteria designed to measure progress in creating such a system. The relatively

modest gains the District has made toward creating an adequate public mental health system are also not durable. Its claims of quality assurance and independent oversight fall far short of assuring that even the modest progress made will not dissipate once Court oversight is removed.

Third, the District draws the wrong conclusion from the budgetary and fiscal pressures that it faces. Although plaintiffs appreciate the difficulties presented by current economic conditions, these conditions alone are not "changed circumstances" that permit the District to void its commitments. The more important consequence of the District's fiscal condition is the steep funding decrease the mental health system faces — a reality that undercuts defendants' claim that the progress that has been made under court supervision will be sustained without it.

Fourth, defendants claim that they have substantially complied with the Exit Criteria without accurately referencing either the terms of the Consent Decree or the relevant case law setting forth the standards for finding substantial compliance with consent decrees. Meeting only six out of 19 Exit Criteria, and making even that slight progress in the last two years, is not substantial compliance under the correct legal framework, or by any reasonable measure. Moreover, the District may not avoid its legal obligations to emotionally disturbed children by straining to read this most vulnerable group out of the *Dixon* class — and jettisoning one-third of its Exit Criteria commitments in the process.

ARGUMENT

I. THE DISTRICT IS BOUND BY THE CONSENT DECREE IT ENTERED INTO SIX YEARS AGO.

The basis for the District's Motion is the Supreme Court's decision in *Horne v. Flores*, which clarified that a district court may not continue to enforce a coercive injunction against a State that has remedied its legal violation by other means. Because the District has not yet remedied the original violation in this case, it cannot prevail even under the *Horne* standard

applicable to coercive decrees. *See infra* Part II.B. But the *Horne* standard does not apply: the District "agreed to an order establishing nineteen (19) exit criteria and providing for dismissal of this litigation once the District had substantially complied with each criterion." Mot. at 6 (emphasis added). Thus, the outcome here is controlled not by *Horne*, which applies to coercive decrees, but by *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367 (1992), which sets forth the standard for modifying consent decrees.

As the *Horne* Court recognized, the rule it applied was not new, but was based on its precedents, most notably *Rufo*. *See, e.g.*, *Horne*, 129 S. Ct. at 2596 ("[T]the Court of Appeals should have conducted the type of Rule 60(b)(5) inquiry prescribed in *Rufo*."). Presaging the result in *Horne*, *Rufo* held that "[f]ederal courts may not order States or local governments, over their objection, to undertake a course of conduct not tailored to curing a [legal] violation that has been adjudicated." 502 U.S. at 389 (emphasis added). *Rufo* was careful, however, to note that a different rule applies to consent decrees:

> But we have no doubt that, to "save themselves the time, expense, and inevitable risk of litigation," petitioners could settle the dispute over the proper remedy . . . by undertaking to do more than the Constitution itself requires (almost any affirmative decree beyond a directive to obey the Constitution necessarily does that), but also more than what a court would have ordered absent the settlement. . . . The position urged by petitioners "would necessarily imply that the only legally enforceable obligation assumed by the state under the consent decree was that of ultimately achieving minimal constitutional prison standards . . . . Substantively, this would do violence to the obvious intention of the parties that the decretal obligations assumed by the state were not confined to meeting minimal constitutional requirements. Procedurally, it would make necessary . . . a constitutional decision every time an effort was made either to enforce or modify the decree by judicial action."

502 U.S. at 389-90 (emphases added, internal citations omitted) (quoting *United States v. Armour & Co.*, 402 U. S. 673, 681 (1971); *Plyler v. Evatt*, 924 F.2d 1321, 1327 (4th Cir. 1991)). "[I]t is the agreement of the parties, rather than the force of the law upon which the complaint

was originally based, that creates the obligations embodied in a consent decree. Consequently, whatever the limitations Congress placed . . . on the power of federal courts to impose obligations on employers . . . , these simply do not apply when the obligations are created by a consent decree." *Local Number 93, Int'l Ass'n of Firefighters, AFL-CIO v. City of Cleveland*, 478 U.S. 501, 522-23 (1986) (emphasis added).

The Court unanimously reaffirmed this principle in *Frew v. Hawkins*, 540 U.S. 431 (2004). Citing *Firefighters*, it was willing to enforce a consent decree that "implement[s] the Medicaid statute in a highly detailed way, requiring the state officials to take some steps that the statute does not specifically require." *Id.* at 439. Enforcing the decree, the Court said, "vindicates an agreement that the state officials reached to comply with federal law." *Id.*

Nothing in *Horne*, which involved a coercive decree, *see* 129 S. Ct. at 2589-90, purports to overrule this longstanding principle. To the contrary, the Court repeatedly invoked *Rufo* and *Frew* as the justification for its decision. Although the Court did discuss "consent decrees," it did so at a broad level of generality and primarily for the purpose of emphasizing the importance of applying a flexible approach to Rule 60(b)(5). And, as *Rufo* held, the "flexible" approach does apply to consent decrees as well as coercive decrees. But while the Rule 60(b)(5) inquiry is applied similarly to consent decrees and coercive decrees, binding Supreme Court precedent dictates an important difference: since consent decrees may reach beyond the original violation, they need not be vacated when minimal compliance is achieved. To hold otherwise would improperly read into *Horne* a sub silentio overruling of longstanding precedent.[1] *Accord* Brief

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[1] "If a precedent of [the Supreme] Court has direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the [lower courts] should follow the case which directly controls, leaving to [the Supreme] Court the prerogative of overruling its own decisions." *Rodriguez de Quijas v. Shearson/Am. Exp., Inc.*, 490 U.S. 477, 484 (1989).

of Plaintiff-Intervenor at 3, *Evans v. Fenty*, No. 76-293 (D.D.C. Nov. 6, 2009) ("DOJ *Evans* Response") ("*Horne* does not change the way district courts should review motions to dismiss consent decrees.").

The Supreme Court's decisions in *Firefighters*, *Rufo*, and *Frew* — all of which the District ignores — make clear that even if the Exit Criteria go beyond what is necessary to ensure the District's compliance with the Ervin Act, the District is nonetheless bound by the agreement it made six years ago.

II. THE DISTRICT HAS FAILED TO REMEDY THE STATUTORY VIOLATIONS THAT ANCHOR THE COURT-ORDERED CONSENT DECREE.

Even if the outcome of this case were controlled by *Horne*, the District's Motion would fail. In *Horne*, students enrolled in an English Language Learner (ELL) program sued the State of Arizona for violating the Equal Educational Opportunities Act of 1974 (EEOA), § 204(f), 88 Stat. 515, 20 U.S.C. § 1703(f). The statute requires states "to take appropriate action to overcome language barriers that impede equal participation by its students in its instructional programs." 20 U.S.C. § 1703(f). "[T]he parties proceeded to trial," and the district court concluded that the State was violating the statute. *Horne*, 129 S. Ct. at 2589.

The Supreme Court ruled that "[b]y simply requiring a State" to take "appropriate action," "'Congress intended to leave state and local educational authorities a substantial amount of latitude in choosing their programs and techniques they would use to meet their obligations under the EEOA.'" *Id.* (quoting *Castaneda v. Pickard*, 648 F.2d 989, 1009 (5th Cir. 1981)). The district court, however, ordered that the State discharge its obligation by providing increased incremental funding for ELL programs. This was error because, although "the EEOA's 'appropriate action' requirement does not necessarily require any particular level of funding," *id.* at 2605, the lower courts "refused to consider that [the school district] could be taking

'appropriate action' to address language barriers even without having satisfied the original order." *Id.* at 2604. The Supreme Court therefore remanded the case, instructing the lower courts to consider whether relief from the order was justified by (1) the school district's adoption of a more effective ELL methodology, (2) improvements brought about by the No Child Left Behind Act, (3) structural and management reforms in the school district, and (4) the overall increase in education funding available to the district. *See id.* at 2600-06. "These changes [were] critical to a proper Rule 60(b)(5) analysis . . . as they may establish that [the school district] is no longer in violation of the EEOA and, to the contrary, is taking 'appropriate action' to remove language barriers in its schools." *Id.* at 2606.

In this case, by contrast, the District has failed to remedy its violation of not one but two Congressional Acts: the Transfer Act and the Ervin Act.

A. The District Has Not Remedied Its Violation Of The Transfer Act.

In 1984, Congress enacted the Transfer Act, imposing a distinct legal obligation on the District to comply with the *Dixon* consent decree. As this Court has previously observed, its "orders are not based solely on [the Ervin Act], but upon the <u>explicit directive from Congress</u>" in the Transfer Act. *Dixon v. Barry*, 967 F. Supp. 535, 551 (D.D.C. 1997) (emphasis added).

Nowhere does the District acknowledge that Congress explicitly required it to satisfy the terms of the decree it now seeks to vacate. Nor does it even mention the Transfer Act beyond noting its role in transferring control over St. Elizabeths. *See* Mot. at 4 n.1. Yet Congress's incorporation of the terms of the decree into the Transfer Act and the District's noncompliance with that decree easily distinguish the instant case from *Horne* and render the District's position untenable. The Supreme Court's review in *Horne* obviously would have been very different if, in the years following the district court's declaratory judgment order in that case, Congress had passed an <u>additional statute specifically mandating</u> that Arizona fully comply with the district

court's order. Just as a "shift in federal . . . policy" in the direction of fewer constraints can justify vacating an order, *see Horne*, 129 S. Ct. at 2603-04, a shift in federal policy toward expressly requiring compliance with an order makes vacating that order inappropriate.

Section 225b of Title 24 contains the operative provisions of the Transfer Act. In that section, Congress required the Mayor of the District to "complete the implementation of [a] final system implementation plan . . . for the establishment of a comprehensive District mental health system to provide mental health services and programs through community health facilities to individuals in the District of Columbia." 24 U.S.C. § 225b(a)(2).[2] Congress further mandated that the implementation plan "be in full compliance with the Federal court consent decree in Dixon v. Heckler." 24 U.S.C. § 225b(c)(4) (emphasis added). To avoid any possibility for confusion, Congress also provided that "[n]o provision of this subchapter . . . may be so construed as to absolve or relieve the District or the Federal Government of their joint or respective responsibilities to implement fully the mandates of the Federal court consent decree." 24 U.S.C. § 225b(g) (emphasis added).

In addition, in 24 U.S.C. § 225 Congress enacted express findings regarding the District's responsibilities. Congress reaffirmed that "[t]he District of Columbia has a continuing responsibility to provide mental health services to its residents." 24 U.S.C. § 225(a)(2). Congress further declared its intent that "the District of Columbia have in operation no later than October 1, 1993, an integrated coordinated mental health system in the District," featuring "high quality, cost-effective, and community-based programs and facilities," as well as "a component

[2] The system implementation plan was to "describe an integrated, comprehensive, and coordinated mental health system for the District of Columbia," 24 U.S.C. §225b(c)(1), as well as "identify the types of treatment to be offered, staffing patterns, and the proposed sites for service delivery within the District of Columbia comprehensive mental health system," 24 U.S.C. § 225b(c)(2).

for direct services for the homeless mentally ill." 24 U.S.C. § 225(b)(1), (8) (emphasis added). Congress also once again stated that "the comprehensive District mental health care system [shall] be in full compliance with the Federal court consent decree in Dixon v. Heckler." 24 U.S.C. § 225(b)(2) (emphasis added).[3]

The Act's legislative history confirms that Congress meant exactly what it said. The legislative history makes clear that the statute "[r]equires compliance with the Dixon v. Heckler decree during the planning and after the establishment of the new system." H.R. REP. NO. 98-1024, at 5 (1984) (emphasis added), *reprinted in* 1984 U.S.C.C.A.N. 5810, 5815; *id.* at 12 (noting that § 225b(g) provides that the federal government and the District "remain responsible for providing the range of services mandated by the consent decree"). After "many long hours of study and negotiation over [a period of] 20 years," the Transfer Act "represent[ed] a reasonable compromise between the District of Columbia, the Federal Government, and the hospital employees union." 130 CONG. REC. S13825 (daily ed. Oct. 5, 1984) (statement of Sen. Hatch). Embodied in this "reasonable compromise" was a package deal: in exchange for granting the local government general autonomy over the administration of mental health services in the District, Congress wanted a mechanism to ensure that the District's provision of mental health services to its residents was adequate. Congress was well aware of ongoing litigation surrounding the *Dixon* decree — partly because the District and Federal governments were co-defendants in the *Dixon* litigation from 1974 to 1982 — and it believed the plan submitted by the

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[3] Congress's intent to require the District to adhere to its *Dixon* obligations, made manifest by the plain text of the Transfer Act's operative provisions, is thus confirmed by these clear statements of congressional intent. *See Pilon v. U.S. Dept. of Justice*, 73 F.3d 1111, 1120 (D.C. Cir. 1996) (finding "substantial guidance" in a section of a federal statute providing congressional findings and a statement of purpose).

federal and District governments in 1979 and accepted by the court to be "far reaching and well constructed," in "suggest[ing] new and innovative ways for the District [to] provide community based services." H.R. REP. NO. 98-1024, at 2 (1984), *reprinted in* 1984 U.S.C.C.A.N. 5810, 5811-12. Thus, in short, Congress clearly insisted on the District's full satisfaction of the *Dixon* decree as an integral part of the compromise embodied in the Act.

Quite unlike the situation in *Horne*, then, continued enforcement of the *Dixon* decree does not represent an improper interference with the District's "democratic processes" that reaches beyond the original statutory violation. *Horne*, 129 S. Ct. at 2597. Rather, such compliance is the precise course of action mandated by Congress as part of its comprehensive plan to transfer authority over mental health services to the District, while at the same time requiring the creation of an adequate community-based mental health care system. Nor does continued judicial oversight pose any of the federalism-related concerns identified by the Court in *Horne* since Congress, the entity the Constitution explicitly authorizes "[t]o exercise exclusive legislation in all cases whatsoever" over the District, has unambiguously insisted on exactly such a course of action. U.S. CONST. art. I, § 8, cl. 17.

B. The District Has Not Remedied Its Violation Of The Ervin Act.

Even if this Court decides that *Horne* applies indistinguishably to coercive and consent decrees, and even if the plain text of the Transfer Act does not govern, vacatur and dismissal would still be inappropriate. *Horne* stands for the limited proposition that in weighing a Rule 60(b)(5) motion to terminate enforcement of a decree, a district court must consider whether a state has remedied its original legal violation by alternative means. *Horne* did not alter, and in fact reaffirmed, the well-established principle that Rule 60(b)(5) cannot be used to relitigate the nature of a prior statutory violation as previously adjudicated.

In 1975, this Court held that the District had an affirmative duty under the Ervin Act to provide adequate individualized care to its seriously mentally ill residents. This duty cannot be satisfied by the expedient of releasing consumers from St. Elizabeths into a community-based system not equipped to provide necessary and appropriate care. Because the District is not in compliance with all of the Exit Criteria, which in turn are considerably narrower than what is required to remedy fully the original violation, it follows that the District has not established any remedy, much less a durable one, to the original violation of the Ervin Act found by this Court.

1. The Original Violation Of The Ervin Act Was The District's Failure To Operate An Adequate, Community-Based Mental Health System.

The Court in *Horne* reaffirmed that "Rule 60(b)(5) may not be used to challenge the legal conclusions on which a prior judgment or order rests." 129 S. Ct. at 2593; *see also Frew*, 540 U.S. at 438 (disagreeing with the view that "a federal court should not enforce a consent decree . . . unless the court first identifies, at the enforcement stage, a violation of federal law"). Rather, this Court must "take[] the original judgment as a given." *Horne*, 129 S. Ct. at 2596. *Accord* DOJ *Evans* Response, at 12 n.3. Accordingly, the nature of the District's Ervin Act obligations, as adjudicated in 1975, cannot be at issue.

The District nonetheless emphasizes "unnecessary institutionalization" as the "particular harm the Court sought to remedy," Mot. at 11, and "the discharge rate at Saint Elizabeths" as "[t]he most obvious indicator of the effectiveness of the District's community-based mental health system," Mot. at 23. This Court, however, in this case, long ago concluded that the Ervin Act cuts a far broader swath: the District's original violation was not simply unnecessary institutionalization, but the failure to create an adequate, community-based mental health system, a failure that sadly continues.

a) Original Findings of Law and Judgment in Favor of the Plaintiffs

The first published opinion in this litigation — and the decision that established as a matter of law the nature of the District's original violation — is Judge Robinson's 1975 opinion and order granting summary judgment to the plaintiffs. *See Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975). In that decision, this Court began its analysis of the Ervin Act by noting that the Act created "a statutory right 'to medical and psychiatric care and treatment.'" *Id.* at 977 (quoting 21 D.C. Code § 562). Reviewing the Ervin Act's legislative history, Judge Robinson concluded "that the medical and psychiatric care and treatment mandated by the Act must be broadly construed." *Id.* (internal quotation marks omitted). Judge Robinson further quoted the D.C. Circuit's interpretation of this statutory language as requiring governmental authorities "to make a bona fide effort . . . to provide [each patient with] treatment which is adequate in light of present knowledge." *Id.* (quoting *Rouse v. Cameron*, 373 F.2d 451, 456 (D.C. Cir. 1966)). This Court thus explained that "[t]he statutory language clearly mandates a right to treatment for patients," and indeed "a right to the <u>best possible</u> care and treatment." *Id.* at 978 (emphasis added). More specifically, Judge Robinson held that the Ervin Act required that mental health services provided to consumers "be suited to [each patient's] particular needs as determined by a frequently evaluated, individually tailored program." *Id.* at 977.

As the language quoted above makes clear, this Court interpreted the Ervin Act as providing each class member with a right to individualized care and treatment, not simply the right to be released from St. Elizabeths. To be sure, transfer from St. Elizabeths to less restrictive facilities was an important first step in the provision of such care for many individual class members. However, even in those portions of the opinion where this Court emphasized the importance of reassigning some inpatients at St. Elizabeths to alternative facilities, it made clear that the District's violations of the plaintiffs' statutory rights encompassed more than simply

unnecessary institutionalization. For example, this Court referred to inpatients that "currently require care and treatment in alternative facilities," explaining that the "plaintiffs' treatment needs include placement outside the hospital" and noted that they were seeking "a judicial declaration that under the [Ervin] Act they [had] a right to treatment which includes placement in facilities outside St. Elizabeths Hospital." *Id.* at 976-77 (emphasis added).

This Court further highlighted the District's obligation to provide each class member with adequate treatment in the portion of its order setting forth provisional remedies for the District's violation of the Ervin Act. Specifically, this Court ordered the District to submit an outline containing not only a statement of the number of inpatients at the Hospital who required treatment in alternative settings, but also the types of alternative facilities to which they would be transferred, as well as the standards that would govern their treatment at these alternative facilities. *Id.* at 980. All of this belies the District's undue emphasis on unnecessary institutionalization as "the particular harm the Court sought to remedy." Mot. at 11. Rather, this Court made clear that deinstitutionalization was simply one component of a broader obligation on the part of the District to provide appropriate individualized treatment for each class member.

b) 1980 Consent Order

The 1980 consent order, agreed to by the parties and approved by this Court in close temporal proximity to Judge Robinson's original decision, confirms that the original violation of the Act is broader than unnecessary institutionalization. This consent order is significant not only because it confirms the scope of the original violation, but because Congress in the Transfer Act explicitly incorporated its terms as binding federal law. *See supra* Part II.A.

In the 1980 order, Judge Robinson initially described his decision of five years earlier as holding that the plaintiffs had a right "to suitable care and treatment in facilities less restrictive than Saint Elizabeths Hospital" and spoke of "assuring the rights of all members of the plaintiff

class to <u>adequate community-based residential placements and care and treatment in the least restrictive settings</u> . . ." 1980 Consent Order, at 1 (emphasis added). The order further declared that it provided "for the . . . rights of all members of the plaintiff class to appropriate care and treatment in the least restrictive, safe, sanitary and humane setting <u>and the obligation of defendants to provide plaintiffs with such care and treatment</u> . . ." 1980 Consent Order, at 2 (emphasis added).

The consent order said little about the District's obligation to accelerate deinstitutionalization from St. Elizabeths. By contrast, the order required the District to conduct an initial series of needs-assessment surveys, including both outpatients and Hospital residents who were candidates for outplacement, with an aim toward eliciting each patient's "specific residential, medical, psychiatric, rehabilitative, social, educational, vocational, employment, and other services that they need." 1980 Consent Order at 3. The defendants were then to identify all services needed by class members and, if any consumers had needs that were unmet by existing resources, the consent order obliged the defendants to "take all actions within their legal authority to provide all additional services." 1980 Consent Order, at 4. Thus, the entire structure of the consent order was aimed at assessing the specific needs of each individual class member with respect to community-based treatment, and securing the resources necessary to meet these needs.

c) <u>Later Opinions</u>

The Court's later opinions further illustrate the District's broad obligations under the Ervin Act. In its 1993 order appointing a special master, this Court offered a detailed analysis of

the District's inability to meet its obligations under either the 1980 or 1992 consent orders.[4] The Court, however, made no mention in the entire order of any failure by the District to meet deinstitutionalization-related goals. Similarly, in its 1997 order granting the plaintiffs' motion for the appointment of a receiver, this Court described the *Dixon* case as "involv[ing] the obligation of the District of Columbia . . . to create an integrated community based mental health system for the treatment of the mentally ill." *Dixon v. Barry*, 967 F. Supp. 535, 537 (D.D.C. 1997) The Court described its 1975 decision as holding that plaintiffs have "a statutory right to community based treatment," including "a right to adequate, individualized treatment based upon each patient's specific needs." *Id.* at 537-38 (emphases added). The Court pointed to a wide variety of metrics unrelated to institutionalization rates demonstrating the District's continuing failure to comply with its obligations. *See id.* at 542-45. Not only did the Court spend little time specifically discussing the District's progress with respect to deinstitutionalization, it appointed a receiver in spite of its acknowledgment that the District had made substantial progress in transferring class members from St. Elizabeths to alternate locales. *Id.* at 555.

Finally, in 2001, the transitional receiver appointed by this Court, in consultation with the parties, issued a plan setting forth a path for the District to satisfy the *Dixon* mandate. *See* Final Court-Ordered Plan. The plan tasked the District's newly-created Department of Mental Health with a number of responsibilities unrelated to deinstitutionalization. Notably, the transitional receiver warned the Mayor that if the funds devoted to mental health services were reduced, many individuals with severe mental illnesses would be "prematurely diverted from the mental

[4] Specifically, the Court noted that the District "was unable to provide the new housing, case management, intensive case management, family support, emergency services, personal care services, social activities, vocational services, and mobile community outreach and treatment teams required by the 1992 plan." *Dixon v. Kelly*, No. 74-285, 1993 U.S. Dist. LEXIS 6511, at *3 (D.D.C. May 14, 1993).

health system, well before the much-needed community-based services [could] develop and begin to serve the mental health needs of the rest of the community." Final Court-Ordered Plan, at 27. Were such a scenario to transpire, "the District [would] be unable to sustain the community-based integrated system of care required under *Dixon*." Final Court-Ordered Plan, at 27 (emphasis added).

In short, every judicial opinion and accompanying report issued throughout the 34-year history of this litigation has been premised on a long-settled interpretation of the Ervin Act: that it imposes an affirmative obligation on the District to create a comprehensive, community-based mental health care system that offers adequate and individualized care to the mentally ill. This correct interpretation of the Ervin Act is settled, *Horne*, 129 S. Ct. at 2593, and the Court "must vigilantly enforce federal law" until the District's obligation is discharged. *Id.* at 2594.

2. The District Has Not Remedied Its Violation Of The Ervin Act.

Relying primarily on *Horne*, the District contends that continued enforcement of the consent decree is inequitable because it has remedied its violation of the Ervin Act. *Horne* restates the fundamental principle that a federal court's coercive orders must not be "aimed at eliminating a condition that does not violate [federal law] or does not flow from such a violation." 129 S. Ct. at 2595 (quoting *Milliken v. Bradley*, 433 U. S. 267, 282 (1977)) (alteration in original). The order must, therefore, be "limited to reasonable and necessary implementations of federal law." *Id.* (quoting *Frew*, 540 U.S. at 441). But a "reasonable and necessary implementation of federal law" may go beyond an order simply identifying the legal violation and directing the State to comply with it; "almost any affirmative decree beyond a directive to obey the [law] necessarily does that." *Rufo*, 502 U.S. at 389. In *Milliken*, upon which *Horne* heavily relied, the Court rejected an argument that the remedy for discrimination in pupil assignment had to be limited to simply reassigning pupils. *See Milliken*, 433 U.S. at 281-

87; *id.* at 282 ("But where, as here, a constitutional violation has been found, the remedy does not 'exceed' the violation if the remedy is tailored to cure the 'condition that offends the Constitution.'" (emphasis in original)).

The district court in *Horne* had erred by requiring adherence to a coercive decree without permitting the State to establish that the decree was unnecessary to curing any ongoing violation of the law. Although the Equal Educational Opportunities Act required only "appropriate action to overcome language barriers," 20 U.S.C. § 1703(f), the district court enforced a remedial order's approach to compliance without allowing the State to achieve compliance by taking alternative "appropriate action." *See Horne*, 129 S. Ct. at 2599-2600.

In marked contrast to *Horne*, in this case the Exit Criteria are not one path among many to achieving the adequate community-based care mandated by Congress. They are instead simply a modest approximation — a "reasonable and necessary implementation" — of compliance. Moreover, the Court Monitors' reports and other available evidence demonstrate that, by any reasonable measure, the District has not discharged its statutory violation. To be sure, the District has made some modest progress within the past few years. But the District is still far from achieving full compliance with the Ervin Act and the Transfer Act.

a) The Exit Criteria are a "Reasonable and Necessary Implementation" of the Ervin Act that a Federal Court May Enforce.

Nowhere in the District's motion is it apparent what it thinks a "reasonable and necessary implementation" of the Ervin Act would be. *Horne*, 129 S. Ct. at 2595. Absent some superior measure, it was within the power of this Court to approve the Criteria as a modest tool for determining whether compliance had been achieved. When the District negotiated the Criteria, they were envisioned not as a supplement to the Ervin Act but as a measure of compliance with it. *See, e.g.*, Letter from Peter J. Nickles to Dennis R. Jones, Martha Knisley, and David Norman

(Apr. 11, 2003) (attached as Exhibit A) ("[Plaintiffs] support the use of a benchmarking approach for the development of performance levels that would reflect a well-functioning system of services.") (emphasis added); Charles Curie & Vijay Ganju, The Adequacy of the District of Columbia Mental Health System: An Assessment, at 24 ("Expert Report") (attached as Exhibit B, Attachment 1). As the Court Monitor explained shortly after the Criteria were agreed to: "[I]n the aggregate these criteria measure a wide array of critical aspects in the systems performance. It is the Court Monitor's belief that these exit criteria . . . provide a clear and objective pathway for measuring performance of the DMH system." Report of Court Monitor – January 2004, at 5 (emphasis added).

The Criteria are actually narrower than what would be required to remedy the original violation fully. As the original holding in *Dixon* made clear, the District is obligated to provide suitable and adequate care to every individual in need. *See Dixon v. Weinberger*, 405 F. Supp. 974, 977 (D.D.C. 1975). Far from representing a quixotic pursuit of perfection, as the District now seems to contend, the Exit Criteria bow to the District's resource constraints by focusing on processes and benchmarks. For example, rather than requiring adequate treatment for each of the approximately 22,000-40,000 estimated Class members,[5] the Criteria simply establish various penetration rates ranging from 2% to 5% of the District's population, including those who have serious mental illness or a serious emotional disturbance. *See id.* at 36. Rather than demanding that all consumers receive supported housing, the Exit Criteria mandate only that the District timely serve 70% of those referred to this essential service. *Id.* at 38. Rather than insisting that

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[5] *See* Expert Report, at 12 (estimating, based on the most recently available prevalence data, that the number of adults with serious mental illnesses in the District of Columbia ranges from 17,645 to 33,859 and that the number of children with serious emotional disturbances ranges from 4,680 to 6,759).

all consumers are provided with adequate care, the Exit Criteria related to consumer service reviews require only that 80% of consumers be satisfied with the services they receive. Exit Criteria Performance Levels, at 4-5; Expert Report, at 32-34. Indeed, even though the original judgment and subsequent consent order in this case required the District to provide "the best possible care and treatment for the mentally ill," much of the Criteria simply require the District to provide certain services in the first instance, without imposing an adequacy requirement at all. *See, e.g.*, Expert Report, at 41 (noting that Criterion related to new generation medications neither provides for monitoring of those who receive such medications, nor assures that they are receiving proper dosages with due regard being paid to potential side effects); *id.* at 50 (discussing Exit Criterion 17, which measures the percentage of consumers who receive one follow-up service in the community within 7 days of inpatient discharge, but does not purport to measure the substantive adequacy of any follow-up services actually provided).

Thus, the District's portrayal of the Exit Criteria as an onerous burden beyond what the law requires is simply wrong. Faced with a statutory mandate of supervising the creation of an integrated, community-based mental health system, federal courts have the authority to apply "reasonable and necessary" means of effectuating such a mandate. *Horne*, 129 S. Ct. at 2595; *Milliken*, 433 U.S. at 281-87. The Exit Criteria are not, like the mandate in *Horne*, one path to statutory compliance; they are simply a gauge of whether compliance has been achieved. *See, e.g.*, Expert Report, at 7 (noting that the targets set by the Exit Criteria "are realistic and achievable").

b) The District Has Not Established Compliance with the *Olmstead* Standard, Which in any Event is Not an Alternative to Compliance with the Ervin Act.

The closest the District comes to suggesting an alternative to the Exit Criteria is a claim that it complies with what it calls the "*Olmstead* standard." As an initial matter, *Olmstead v.*

L.C., 527 U.S. 581 (1999) had nothing to do with the Ervin Act or the standard for vacating consent decrees, but rather interpreted the "integration mandate" of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101 *et seq.*; 28 C.F.R. § 35.130(d). Thus, even if the District's mental health system could be deemed consistent with the integration mandate in a suit under the ADA, it is apparent that the District has not remedied the original violation that is actually at issue here.[6]

In any event, the District could not prevail under the "*Olmstead* standard." *Olmstead* requires States to provide community-based treatment for the mentally ill. *Id.* at 607; *see also id.* at 605 (it is not the ADA's "mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter"). The District relies heavily on the *Olmstead* plurality opinion, which concluded that a state can defend an individual plaintiff's claim to a community-based placement by pointing to a "comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace." *Olmstead*, 527 U.S. at 605 (plurality opinion). If it had such a plan, then "a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions." *Id.* at 605-06. The plurality's concern was one of queue-jumping — individual plaintiffs within an adequately functioning system seeking speedy relief for themselves. The *Dixon* Exit Criteria, by contrast, are the polar opposite of a court order allowing individual

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[6] It is not surprising that Congress would impose a more stringent standard in the nation's capital. *Cf. United States v. Cohen*, 733 F.2d 128, 138 (D.C. Cir. 1984) (en banc) ("Even if a nationally uniform law on [civil commitment of the mentally ill] were not regarded as treading upon the prerogatives of the states, there would still be special reason for Congress to enact such a law in the District of Columbia and not elsewhere. Its responsibility for the general welfare of the citizenry in that location is especially grave because it is not shared.").

plaintiffs immediate relief at the expense of the overall workings of the system; they are an effort to create a "comprehensive, effectively working plan." *Olmstead*, 527 U.S. at 605 (plurality opinion). And when states do not have effectively working plans — for example, when their supported housing programs, like the District's, have an excessive waiting list — they fail the *Olmstead* test. *See Disability Advocates, Inc. v. Paterson*, --- F. Supp. 2d ----, 2009 WL 2872833, at *57 (E.D.N.Y. 2009).[7]

c) The District Has Not Complied With The Ervin Act By Any Measure.

Beyond adverting to (and misstating) the standard for complying with the ADA, the District offers no persuasive explanation for how it has complied with the Ervin Act without satisfying the Exit Criteria. Instead of following *Horne* and offering an alternative means of compliance with the law, the District simply lists a few very recent accomplishments. It does not offer a new tool for evaluating the adequacy of the mental health system as a whole. *See* Report of Court Monitor – January 2004, at 5 (praising the holistic approach of the Exit Criteria because "[n]one of the measures — in and of themselves — represents a pure or complete picture of the system"). Even taking the District's groundless approach at face value, the District has not established the existence of an adequate mental health system in compliance with the Ervin Act, the original *Dixon* mandate, and the Transfer Act. To the contrary, the District's mental health system continues to fall short of the statutory minimum in critical respects.

(i) Overall Availability of Services

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[7] *See also M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1301-02, 1309 (D. Utah 2003); *Makin ex rel. Russell v. Hawaii*, 114 F. Supp. 2d 1017, 1023, 1033-35 (D. Haw. 1999) (denying summary judgment to state where 750 of 801 individuals on a waiting list for services had been on the list for longer than 90 days).

The District contends that "an astonishing 98% of consumers receive a range of community-based supports and services." Mot. at 14. The District avoids noting that the denominator of its "astonishing" percentage is not, as one might expect, all 22,000-40,000 *Dixon* class members. Although the District does not explain how it arrived at its 98% figure, this statistic appears to be simply a percentage of those consumers listed in the District's enrollment records — that is, consumers the District already serves. *See* Declaration of Stephen T. Baron, Director, Department of Mental Health ¶ 4 (Exhibit 1 to Defs.' Mot.). The District makes no claim about the ability of its more than 22,000 mentally ill residents to access needed care; it simply shows that most people who are listed in its database receive some type of community-based service. Moreover, the District makes no showing that the kind and amount of services available are suitable to the needs of those receiving them.

The Exit Criteria's penetration rates, in contrast to the District's figure, do measure the percentage of the *Dixon* class that receive services. For example, Exit Criterion 7 requires the District to provide services to 3% of adult District residents, which translated to 13,760 adults at the time the District entered into the Consent Order and is adjusted to account for current census data. That requirement is quite modest in light of the federal government's estimate that 5.4% of adults in the District (25,752 people) have a serious mental illness. *See* Expert Report at 12, 35, Appendix D. In other words, the Exit Criteria require the District to provide at least one service to roughly 55% of seriously mentally ill adults. These requirements are particularly modest in light of expert opinion that "[e]xcellent behavioral health networks have penetration rates of 8% to 10% or greater, whereas average ones will have a rate between 5% and 6%." *Id.* at 35-36. Nonetheless, the District has failed to meet even this modest benchmark, just as it has failed to

meet all of the other target penetration rates set forth in the Exit Criteria, with one exception.[8] *See id.* at 36. The District lags even further behind the very modest requirements for serving children. Approximately 4,680 children aged 9-17 in the District have a serious emotional disturbance. *Id.* at 12. The penetration rates require services for 5% of children aged 0-17 years, and the District is able to serve only 2.96%; Exit Criterion 6, measuring services for children with serious emotional disturbances, sets forth the even more modest requirement of serving 3% of the population (3,360), but the District is able to serve only 2.42% — 650 fewer children than what is required. *See id.* at 36.

The facts on the ground confirm the District's statistical shortcomings.[9] Until the District serves a modest percentage of the *Dixon* class, it can hardly claim that it satisfies its obligation to provide <u>every</u> member of the class with suitable care and treatment. The District may not prematurely escape judicial oversight by ignoring its gaps in service and manufacturing a meaningless statistic that has nothing to do with access.

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[8] The District has not "substantially complied" with this Exit Criterion 7 by achieving a penetration rate of 2.51%. *See* Appendix — Discussion of Exit Criteria, at 6 ("Appendix"). The District appears to be comparing the numbers 3.0 and 2.51 in the abstract, but these numbers are percentages of a very large population; in terms of actual people not being served, the shortfall is greater than 2,000. *See* Exit Criteria Performance Levels, at 10. The District is also wrong to dismiss this penetration rate as not "salient" in light of Exit Criterion 8, which is inactive. Appendix, at 6. The experts who crafted the Exit Criteria deemed it important to measure the availability of services as a percentage of all District residents. As the 3% penetration rate for all adults is considerably less than the percentage of District residents with serious mental illness, their judgment was hardly unreasonable.

[9] *See* Declaration of Celeste Valente, Advocate, University Legal Services ¶¶ 18-20, 22 ("Valente Decl.") (attached as Exhibit C) (noting that the District's failure to properly fund and assess community residence facilities has forced consumers into homelessness or inpatient facilities; care options for community-based care options for consumers with certain conditions are very limited; poor discharge planning requires many consumers to remain in inpatient settings longer than necessary.); Decl. of Iden Campbell McCollum ¶¶ 6-7 ("McCollum Decl.") (attached as Exhibit D) (noting that St. Elizabeths inpatients with "dual diagnosis" (mental illness and developmental disability) have difficulty accessing community-based services as neither DMH nor the Department of Disability Administration takes responsibility for them).

(ii) Assertive Community Treatment

The District also relies heavily on its Assertive Community Treatment (ACT) program in arguing that it has complied with the *Dixon* mandate. ACT is a vital component of an adequate mental health system, and is particularly necessary for preventing institutionalization of at-risk individuals. *See* Expert Report, at 39-40. Yet while the District has made some progress on expanding its ACT program, that increase in ACT capacity has occurred over a span of less than one year, spurred by the closure of the District of Columbia Core Services Agency (D.C. CSA).[10] Because this increase is so recent, the District has yet to demonstrate that the new ACT teams comport with the ACT model's standards. *See id.* at 41. The District has not satisfied its burden of demonstrating that it adequately provides this service that is critical to a well-functioning mental health system.

Although plaintiffs recognize that it is early in the process, the program's performance thus far has been far from encouraging. Among other problems, current ACT teams frequently lack proper staffing as well as training, and have wholly failed to provide the individualized services consumers need. *See, e.g.*, Declaration of Celeste Valente, Advocate, University Legal Services ¶ 10 ("Valente Decl.") (attached as Exhibit C) (making this point and providing examples); Declaration of Julie Ann Turner, Program Director, Downtown Cluster of Congregations' Homeless Services Unit ¶¶ 24-64 ("Turner Decl.") (attached as Exhibit E) (same). These problems have been exacerbated by the fact that consumers are rarely able to change providers when they are dissatisfied with the services they have received from their

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[10] *See* Dept. of Mental Health Report to the Council of the District of Columbia Required By the Fiscal Year 2009 Budget Support Act of 2008, at 6 n.2 (Sept. 26, 2008), *available at* http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/Council_Report_Final._10-1-08.pdf (noting the need to increase ACT teams as a result of D.C. CSA closure).

assigned ACT team. Valente Decl. ¶ 11. Although many *Dixon* class members have been assigned to ACT providers, these same providers routinely fail to conduct the required intensive outreach, in contravention of the ACT model that they are supposed to follow. Turner Decl. ¶¶ 24-64 (noting this point and providing examples). The result is that class members who are neither institutionalized nor served by the system are being counted by DMH as being enrolled in ACT services, but are not actually receiving these services. The Department of Mental Health has failed to address these issues.

(iii) Supported Housing

The waiting list for receiving community-based housing is unacceptably high, both in terms of the number of consumers who are on the waiting list and the pace at which the waiting list moves. There are over 600 consumers on the housing waiting list who will have to wait an average of 2.5 years to actually receive housing. *See* Report of Court Monitor – July 2009, at 28. In fact, the official count of those wait-listed and, consequently, the wait time, is artificially low, because providers (including the D.C. CSA) have advised consumers that housing is not available and that they should not even put their names on the list. Declaration of Mary Ann Luby, Outreach Coordinator and Mental Health Services Liaison, Washington Legal Clinic for the Homeless ¶ 25 ("Luby Decl.") (attached as Exhibit F). The unavailability of critical housing support is fatal to the District's bid to establish the adequacy of its mental health system and to prove that it has remedied the original violation of the Ervin Act. *See* Expert Report, at 38 ("Housing is a basic need that needs to be met if persons are to have a life in the community."); *Dixon v. Weinberger*, 405 F. Supp. at 979 ("'[H]ousing' . . . is integrally related to 'treatment' within the purposes of the 1964 Act, and has been determined to be such by the Hospital staff."). The lack of supported housing also constitutes a core violation of the Ervin Act even under the District's overly narrow, institutionalization-centered interpretation of the statute, since class

members are routinely forced to remain at St. Elizabeths or other inpatient facilities as a result of this lack of supported housing. *See, e.g.*, Valente Decl. ¶¶ 18-19. Another result of this failure is that class members become homeless or incarcerated and do not receive adequate services. *See* Luby Decl. ¶¶ 24-25.

The District's response to its unacceptable record of providing supported housing is a non-sequitur. It does not argue that it is actually serving the needs of the District's mentally ill population by providing adequate housing. Instead, based on hearsay, it simply compares itself to other states and the amount of supported housing they provide. This tactic fails to account for the District's high cost-of-living and likely greater level of need when compared with other jurisdictions that, unlike the District, also did not agree to Exit Criteria specifically obligating them to provide supported housing.[11] In addition, the District's argument ignores the fact that such national means include underperforming jurisdictions and hence are not reliable indicators of adequacy. *See* Expert Report, at 26.

(iv) Supported Employment

The District boasts of compliance with the supported employment Exit Criterion by noting the percentage of consumers who receive supported employment services within 120 days of referral. It fails to acknowledge, however, that one of the requirements of this Criterion is that adults with serious mental illness <u>actually be assessed</u> to determine whether they should be

[11] *See* Washington Legal Clinic for the Homeless, Homelessness and Poverty in Washington, D.C., *available at* http: //legalclinic.org/about/facts.asp#sdendnote13sym; Nat'l Low Income Housing Coalition, Out of Reach (2008), *available at* http://www.nlihc.org/oor/oor2008/minijobsmap.pdf (citing data showing that in D.C., a household needs 3.6 minimum-wage-earning jobs in order to rent a 2-bedroom apartment, making D.C. the highest-ranking state for cost of living by that measure).

referred to supported employment services in the first place.[12] *See* Report of Court Monitor – January 2009, at 11; *see also* Expert Report, at 39-40. The District has not demonstrated that providers have actually made this assessment. The District thus has absolutely no basis for asserting that it is in compliance with this Criterion.

(v) Crisis Services

Although the District boasts of the existence of 23 crisis beds, it fails to note several important facts: (1) CPEP's eight crisis beds became operational just in February 2009, *see* Report of Court Monitor – January 2009, at 17, and the other 15 crisis/respite beds have only been operational for the past four to five years, *see* Report of Court Monitor – January 2005, at 20; Report of Court Monitor – January 2006, at 13 (noting that two providers made crisis/respite beds available in November 2004 and in April 2005); and (2) there are too few acute care in-patient psychiatric beds in the community, *see* Report of Court Monitor – July 2009, at 50 (noting that there are only 54 "potentially available beds").

In addition, of the 54 acute care in-patient psychiatric beds, 34 are located at United Medical Center (UMC) and 20 are located at Providence Hospital. *Id*. The concentration of these beds at only two local hospitals poses problems related to durability. It is plaintiffs'

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[12] The District's extraordinarily narrow contrary interpretation — that this Criterion should be deemed satisfied absent any evidence that providers are actually making necessary referrals — further illustrates the District's refusal to take the Exit Criteria seriously. First, the District fails to note that the operational definition of "referred to supported employment" is "[p]ersons identified as needing supported employment <u>using designated procedures</u> during the reporting period. Exit Criteria Performance Levels, at 13 (emphasis added). Second, taken to its logical conclusion, the District's position would permit the District to satisfy its obligation to provide supported employment even if virtually no consumers actually received such services, so long as private providers simply declined to refer consumers in the first instance. Indeed, this is to some extent what is occurring at present. *See* Report of Court Monitor – July 2009, at 31 (noting that only ten referrals to supported employment service came from CSAs that did not already run a supported employment program and explaining that this "continues to raise questions about full access").

understanding that UMC closed its 34 acute care beds for six weeks this summer, which resulted in a surge of admissions to St. Elizabeths. *See* Decl. of Jana Berhow ¶ 9 (Exhibit 3 to Defs.' Mot., table of Total Admissions by Facility) (noting a drop in consumers admitted to acute care beds at UMC from 38 to 12 in June 2009 and from 12 to zero in July 2009, and noting an increase in St. Elizabeths admissions from 4 to 6 in June 2009 and from 6 to 12 in July 2009).[13] This type of unexpected interruption to acute care services in the community needs to be addressed in order to ensure that this service is durable.

The District also notes that in a two year period, 6,000 consumers were served in crisis beds and 4,000 of those were "stabilized" and released. The District does not, however, detail how many of the 6,000 consumers that needed crisis services were repeat consumers and what, if any, community-based supports and follow-up care were made available to these consumers so that they would not again need crisis care. Nor, to plaintiffs' knowledge, has this information been conveyed to the Court Monitor.

(vi) Homeless Services

According to a survey that is mandated by the Department of Housing and Urban Development and conducted by the Homeless Services Planning and Coordinating Committee of the Metropolitan Washington Council of Governments, there were 6,228 homeless individuals in the District as of January 2009. *See* The 2009 Count of Homeless Persons in Shelters and On the Streets in Metropolitan Washington, at 3, *available at* http://www.community-partnership. org/docs/FINAL%20ENUMERATION% 20REPORT% 202009.pdf. Approximately 541 people

[13] Admissions to St. Elizabeths as a result of this service interruption could have been greater, but appear to have been diverted due to new acute care in-patient beds opening at the Psychiatric Institute of Washington in June and July 2009. *See* Berhow Decl. ¶ 9, table of Total Admissions by Facility.

— 8.6% of this group — report serious mental illness, a figure that, because it relies on self-reporting, is almost certainly understated. *See* Luby Decl. ¶ 12. Though the District drafted a strategy for delivering services to this group, it has not demonstrated that it is <u>implementing</u> that strategy. Indeed, evidence shows that *Dixon* class members who were discharged from St. Elizabeths in the late 1980s are living in the streets or in jails and are not receiving adequate treatment. *See* Turner Decl. ¶ 26. Moreover, the District continues to fail to serve homeless class members adequately, not ensuring that community-based treatment, supported housing, supported employment and other community-based supports are reaching this large population. *See* Valente Decl. ¶ 22 (noting that the organization represents various consumers who remain homeless because they have been unable to obtain housing through DMH).

The District boasts that its Homeless Outreach Team has had face-to-face contact with over 3,000 homeless persons in one year. Mot. at 22. However, the District fails to provide any indication of whether any of these individuals were assessed as needing mental health services and, if so, whether they were successfully referred to providers for such services. In fact, there are indications that such referrals and intensive outreach are lacking for the homeless mentally ill population. Turner Decl. ¶¶ 26-62; Luby Decl. ¶ 22. Intensive outreach, not merely collecting contacts, is required to adequately serve a homeless population greatly affected by mental illness. *See* Expert Report, at 44 (noting that, "while [statistics regarding face-to-face contacts are] useful, [they] do not provide a full understanding of the array of services provided to this population and their outcomes related to housing, employment, hospitalization, and other areas."). Furthermore, recent changes to the leadership structure and composition of the Homeless Outreach Team call into question the sustainability of any of its gains. Turner Decl. ¶ 23.c; Luby Decl. ¶¶ 22-23.

(vii) Conditions at St. Elizabeths Hospital

Finally, the District's provision of services to inpatients at St. Elizabeths remains woefully inadequate. In the process of representing Hospital-based consumers in grievances, ULS has catalogued a number of problems at the Hospital, including (1) unjustified seclusion of patients under circumstances in which they pose no imminent danger to themselves or others, (2) frequent involuntary administration of medication to patients under circumstances broader than those permitted by law, (3) the denial of food to a patient based on the patient's choice of religious headgear, and (4) improper restrictions on consumers' right to speak with their attorneys. Valente Decl. ¶¶ 33-37. These and other examples of substandard conditions at St. Elizabeths have drawn the repeated attention of the Department of Justice. *See* Letter from Shanetta Y. Cutlar, Chief, Special Litigation Division, United States Department of Justice, to Ellen A. Efros, Assistant Attorney General, District of Columbia (Apr. 16, 2008) (attached as Exhibit H). Unfortunately, the District has displayed the same lack of commitment to meeting its obligations under agreements with the Department of Justice as it has to following the orders of this Court; the Hospital is currently out of compliance with <u>153 of the 174 requirements</u> that it previously agreed would be met by June 2009. Valente Decl. ¶ 38.

C. Even If The District Is Found To Finally Be In Compliance With The *Dixon* Mandate, Its Remedy Is Not Durable.

Even if *Horne* applied, and even if the Exit Criteria were not a "reasonable and necessary" implementation of the Ervin Act, and even if the District had not failed to demonstrate an alternative means of complying with its legal obligations, the District would still need to show that it has implemented "a durable remedy." *Horne*, 129 S. Ct. at 2595. The District's long and persistent history of non-compliance with the *Dixon* decree and this Court's orders, its current begrudging attitude toward the Exit Criteria, and the lack of effective structural

safeguards to ensure compliance in the absence of Court supervision, collectively make clear that any remedy the District might have crafted cannot be deemed "durable."

1. Any Progress The District Has Achieved In Complying With The *Dixon* Decree Is Very Recent And The Result Of Court Supervision.

The District's long history of noncompliance with the *Dixon* decree is well-documented and undeniable. As Judge Robinson detailed in his 1997 decision appointing a temporary receiver, in the "twenty two years [following the 1975 decision in favor of the plaintiffs]," the District "repeatedly failed to comply with the Court's orders." *Dixon v. Barry*, 967 F. Supp. at 552 (emphasis added). Judge Robinson's additional findings are comprehensive, and catalog a continuing failure to satisfy the terms of the consent decree.[14]

The only compliance in the history of this matter started after the District was placed into receivership, and even then at a glacial pace. The Exit Criteria currently being used as the framework to measure compliance with the *Dixon* Decree were entered into just six years ago, and the District began to meet some of the criteria just two years ago. Given the District's 34-

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[14] *See, e.g.*, *id.* at 541 ("The District is, in short, substantially noncompliant with the Dixon Decree . . ."); *id.* at 552 ("[A]s the above factual findings make clear, the District is far away from the community based mental health system mandated in 1975. Accordingly, the District provides no plausible basis for respecting the authority of the local government such that the Court is without a legal justification to impose a receivership."); *id.* at 553 ("These factual findings are supported by an overwhelming body of evidence. Document after document and witness after witness confirm that the District has failed to develop the community based mental health system mandated by the Dixon Decree."); *id.* ("The record leads to the undoubtable conclusion that the District has simply failed to comply with the Dixon Decree, and, in the process, has failed to properly treat its mentally ill residents."); *id.* at 554 ("Each and every factor relied upon by other courts for imposing a receivership favors a receivership under the facts of this case. The District has repeatedly been unable to comply with the Court's orders for seventeen years."); *id.* ("There is a persistent lack of leadership . . . that is focused on compliance with the Court's orders . . . Quite simply, a receiver is the only remedy available that presents any reasonable possibility of success.").

year history of noncompliance, a showing of very recent and limited partial compliance with the current Exit Criteria is plainly insufficient to show that the District's alleged remedy is durable.

The District is fully aware of its poor track record. In its own motion, it congratulates itself for a July 2009 comment from the Court Monitor that "DMH is for the first time operating as intended under the Court-ordered plan." Mot. at 13 (emphasis added) (quoting Report of Court Monitor – July 2009, at 3). Thus, after 34 years of non-compliance, including six years of non-compliance with the most recent consent decree, the District's response to hearing that it is operating as intended for the first time is to move to vacate a month later.

In addition, the District fails to acknowledge that even its very recent history of partial compliance has been achieved only through close supervision by this Court and its Monitor. As the D.C. Circuit has recognized in applying the "flexible" approach to Rule 60(b)(5), "[w]e are mindful that the reduction in violation frequency might be a reflection of the effectiveness of the prospective fine schedule contained in the consent order rather than a result of good intentions on the [defendant's] part." *NLRB v. Harris Teeter Supermarkets*, 215 F.3d 32, 36-37 (D.C. Cir. 2000). Similarly, in 1993 Judge Robinson called the District's failures to meet its obligations "not an aberration but a continuation of past practices," but noted that the District had "demonstrated that it can work diligently to meet its obligations under consent agreements when it is threatened with the Court's contempt powers." *Dixon v. Kelly*, 1993 U.S. Dist. LEXIS 6511, at *8-9. The Director of the Department of Mental Health has admitted to consumer advocates, providers, and to the Court Monitor alike that the obligations of the *Dixon* decree are what drive the Fenty Administration and the District Council to provide the funding necessary to make the progress that defendants now boast of having made. Partial progress made as a result of Court supervision can hardly be deemed evidence of a comprehensive remedy that will endure in the

absence of that same supervision. The fact that the District, in July 2009, had made some minimal progress, certainly cannot demonstrate that it will not backslide once it escapes the scrutiny of this Court and its Monitor.

2. The District's Current Begrudging Attitude Toward The *Dixon* Decree And The Exit Criteria Casts Further Doubt On The Durability Of Any Remedy It Has Created.

In addition to the District's history of non-compliance with the *Dixon* decree, its current attitude toward the decree and the Exit Criteria also raises serious concerns regarding the durability of its supposed remedy. As the District itself acknowledges, it is not in compliance with two-thirds of the Exit Criteria. Mot. at 40-41. Rather than direct its energies to meeting its obligations or working with the Court Monitor to modify the criteria if appropriate, the District seeks to minimize their importance. Most troubling is the District's attitude toward children. The District admits it has not satisfied six of the seven Exit Criteria related to treatment of children, *see* Mot. at 40-41, so the District simply seeks to avoid its obligations to them entirely by (implausibly) reading children out of the case altogether. *See infra* Part III.B.

With respect to the seven and a half additional Exit Criteria that remain active and unmet, the District blithely asserts that, while it "may not have satisfied each and every detail" contained in these criteria, it has reached substantial compliance with them. Mot. at 41. The District's purported demonstration of substantial compliance, however, consists largely of denigrating these criteria as unrelated to its original violation and arguing that they are unrealistic.[15] The

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[15] *See, e.g.*, Appendix, at 1 ("[T]he Dixon exit criteria are completely unmoored from national standards and therefore do not measure de jure compliance with the Ervin Act."); Appendix, at 3 (insisting that "measurement of consumer satisfaction is not 'reasonable and necessary' to remedy the underlying violation of the Ervin Act . . ."); Appendix, at 4 (taking same position with respect to criteria 2); Appendix, at 6 (insisting that the 80% benchmark for criteria 3 is "arbitrary" and "not based upon any national standard of care"); Appendix, at 7 (arguing that the (continued…)

District also repeatedly second guesses the careful judgment of the Court Monitor that it has failed to comply with certain Exit Criteria, even though the Court Monitor has recommended six other criteria for inactive status and has elsewhere repeatedly shown a willingness to give the District the benefit of the doubt.[16] *See, e.g.*, Appendix–Discussion of Exit Criteria, at 3, 5, 9. The District's begrudging and narrow interpretation of the Ervin Act and the Exit Criteria, as well as its attempt to renege on its prior agreements and read children out of the *Dixon* class altogether, hardly bode well for its performance in the event that it obtains relief from the consent decree.

3. The Alleged Structural Improvements Cited By The District Offer No Additional Assurances That Any Remedy Is Durable.

Finally, the District cites a number of supposed structural safeguards that it claims will facilitate treatment for class members. None of these purported improvements offers any assurances that the District will adequately serve its more than 22,000 mentally ill residents in the absence of judicial supervision.

a) Changes to the Ervin Act

The District cites various changes to the Ervin Act as additional measures for continued oversight. *See* Mot. at 27-28. These changes, however, deal only with procedural safeguards

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70% housing benchmark to which it earlier agreed is "impossible to achieve" and "arbitrary"); Appendix, at 10-11 (asserting that criteria 17, which requires that 80% of individuals discharged from inpatient psychiatric hospitalization receive non-emergency community-based services within seven days" is "impossible to achieve" and arguing that it has substantially complied with this criteria despite falling short of the benchmark by over twenty-five percentage points).

[16] The District's basic approach to Exit Criteria it cannot meet is simple: these benchmarks do not need to be satisfied, they need to be changed. *See, e.g.*, Letter from Stephen T. Baron, Director, Department of Mental Health, to Dennis R. Jones, Court Monitor (Oct. 26, 2009) (attached as Exhibit G) (seeking modification of supported housing Criterion); Appendix, at 10-11 (urging that the continuity of care Criterion be evaluated based on a lower standard).

against indefinite involuntary commitment. The District again incorrectly assumes that involuntary institutionalization was the only statutory violation found in 1975. As noted above, *see supra* Part I.B.2.a, the original violation involved the defendants' failure to provide suitable care based on present knowledge that was directed toward returning mentally ill individuals to the community. These statutory changes do not address how to achieve such a community-based system.

b) Transition to Private Providers

The District further notes that, under the Final Court-Ordered Plan, the Department of Mental Health is directed to shift its core agency services to private providers; the District's own motion, however, simply notes that this "process has begun." Mot. at 28 (emphasis added). As the District's formulation indicates, the transition mandated by the Plan is still in its infancy. When the transition was proposed, the plaintiffs supported it because they believed, and the District agreed, that it is required by the *Dixon* decree as a measure that would enable DMH to better focus on its core mission of developing a well-functioning mental health system. The transition process itself, however, has been rife with logistical difficulties and uncertainty.

In particular, issues have arisen about whether private and nonprofit providers can keep up with the pace at which consumers are being transferred to their new core service agency. As of October 20, 2009, 2,664 consumers have selected a new provider.[17] There is justifiable concern about the extended periods of time that these consumers have had to wait prior to their first appointment. *See* Valente Decl. ¶ 31 (explaining that the closure of the D.C. CSA and sudden expansion of private CSAs has forced some consumers to wait for needed services);

[17] Conference Call with DMH, Court Monitor, and Plaintiffs' Counsel (Oct. 20, 2009) (Dr. Barbara Bazron, Deputy Director of DMH and leader of D.C. CSA Transition Project Implementation Team, reporting status of the transition).

Decl. of Iden Campbell McCollum ¶ 12 ("McCollum Decl.") (attached as Exhibit D) (reporting that many CSAs are closed to new intakes). Additionally, providers are not all currently able to hire licensed clinical social workers at a pace adequate to meet the needs of the large influx of new consumers. *See* Valente Decl. ¶ 32 (noting that many private CSAs do not provide counseling). DMH has known of these issues since very early in the transition process, but has failed to develop a model to prospectively assess provider capacity on an ongoing basis. Early in the process, DMH reported that it engaged a consulting firm to develop such a capacity model, but it later abandoned that effort without adequate explanation.[18]

In addition, ensuring that providers have adequate mental health and community support services will be particularly important for the approximately 700 people that have yet to transition into the new system and who presumably have more challenging needs than those who already have transitioned. DMH, however, has not yet shared its assessment of the needs of the remaining individuals with plaintiffs' counsel or the Court Monitor.[19]

For those who have already transitioned, DMH has not completed a long-term assessment of whether each consumer's particular needs are being met by their new provider. One of the needs that has been of most importance to consumers is their ability to see a qualified psychiatrist. The Washington Psychiatric Society in particular has expressed concern that

[18] Conference Call with DMH, Court Monitor, and Plaintiffs' Counsel (Apr. 8, 2009) (Dr. Bazron stating that DMH had retained KPMG to create a model <u>predicting</u> each provider's capacity by week and type of service (emphasis added)); Conference Call with DMH, Court Monitor, and Plaintiffs' Counsel (May 14, 2009) (Dr. Bazron stating that the provider capacity model would be complete by May 19, 2009); Conference Call with DMH, Court Monitor, and Plaintiffs' Counsel (Aug. 6, 2009) (Dr. Bazron noting that KPMG would <u>not</u> be developing a private provider capacity model because DMH's internal database kept track of which consumers <u>were</u> transferred to various providers).

[19] Conference Call with DMH, Court Monitor, and Plaintiffs' Counsel (Oct. 20, 2009).

consumers are waiting far too long before they can see a psychiatrist through the District's community-based programs. DMH has only committed to providing government-employed psychiatrists to work at private provider sites on a part-time basis.[20] Finally, even those consumers who have been able to meet with a psychiatrist have been victimized by high staff turnover rates and a lack of continuity in the provision of services.[21] *See* McCollum Decl. ¶ 13 (noting that, because of the way medications work, the effect of service disruptions resulting from the transition may not be apparent until the spring).

In short, although it remains early in the transition process, DMH's failure to take the steps necessary to facilitate that transition hardly indicates that it will effectively manage the process if Court supervision is eliminated. Indeed, the District's timing in bringing its Motion demonstrates a lack of regard for the mentally ill during a turbulent time in their treatment, and makes it even harder to predict whether, months from now, its mental health system will be an integrated, community-based system that provides the services the *Dixon* class members need — and the Transfer Act, the Ervin Act, and the *Dixon* consent decree require.

c) Inspector General and Auditor's Offices

Third, the District insists that continued court supervision is unnecessary because the District's Inspector General and Auditor's offices will provide an effective replacement for this Court's oversight. This argument is makeweight. The Inspector General's responsibilities consist generally of rooting out "corruption, mismanagement, waste, fraud, and abuse." D.C. CODE § 2-302.08(a)(1)(A)(a-1)(2). Combating fraud is a worthwhile and important

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[20] Conference Call with DMH, Court Monitor, and Plaintiffs' Counsel (Oct. 20, 2009) (Dr. Bazron noting that five providers are using services of DMH psychiatrists on a part-time basis).

[21] Plaintiffs understand that the Washington Psychiatric Society will seek leave of this Court to file a brief as *amicus curiae*, in which it will note these concerns.

governmental function, but the Inspector General has no expertise in monitoring the adequacy of a mental health care system.[22] The Court Monitor, by contrast, is an acknowledged expert in this field. Even so, he has only been able to spur the District to make limited progress slowly and begrudgingly. The District offers no reason to believe that a far less knowledgeable and engaged bureaucrat will prevent it from defaulting once again on its obligations to the mentally ill.[23]

d) Division of Quality Improvement

Finally, the District makes much of its Division of Quality Improvement. However, although the District devotes multiple pages of its Motion to detailing the Division's data collection efforts, the Court Monitor has explained that the Division's "information system upgrade is overdue," and that "[t]here continues to be a critical need . . . to build an interactive database that can support the multiple strands of information." Report of Court Monitor – July 2009, at 16. In any event, the District makes no effort to put these efforts in perspective by explaining the aims or, more importantly, the results of the Division's work. Any efforts undertaken by the Division have resulted only in very recent, partial compliance with the Exit Criteria.[24] Thus, the District gives the Court no basis for determining whether and how the

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[22] Similarly, the Office of the Auditor's role is limited to "conduct[ing] an audit of *selected* performance measures presented in performance reports of *certain* agencies." D.C. CODE § 1-614.14 (emphases added). Although the Office evidently audited DMH on some areas relevant to the *Dixon* decree, the contents of its forthcoming report remain unknown. Additionally, the Office also has no expertise in running a mental health system and it is highly doubtful that its oversight efforts, which are divided among *all* the District's agencies, will achieve meaningful results when the Court Monitor's carefully focused expert efforts have achieved, at best, only partial compliance with the Exit Criteria.

[23] In evaluating the durability of any supposed remedy, this Court should also be advised that DMH's performance in combating fraud and corruption has itself been highly uneven. *See* Valente Decl. ¶¶ 23-26. Relatedly, DMH's grievance procedure has also proven ineffectual in following up on consumer complaints. *Id.* ¶ 30.

[24] DMH's Internal Quality Council (IQC) has not demonstrated a process by which data from Consumer Service Reviews are aggregated, analyzed, and applied to effect change. Report of (continued…)

Division will continue to function once judicial oversight is removed. Because the Division is located within the Office of Accountability and directs quality improvement efforts agency-wide, *see* Mot. at 29, there is nothing to prevent the District from simply deciding that the Division's efforts are better devoted to areas entirely outside mental health care once judicial supervision is ended.

III. BUDGETARY CONSTRAINTS CANNOT RELIEVE THE DISTRICT OF ITS OBLIGATIONS TO THE MENTALLY ILL.

The District also insists that current fiscal conditions are "changed circumstances" that warrant relief from the consent decree. This contention is entirely without merit.

As a threshold matter, it is worth noting that the funds the District spends to facilitate proper judicial oversight are necessary to ensure accountability. Unless the District is taking the position that the work done by this Court and its Monitor is entirely duplicative of tasks the District already performs on its own (an implausible contention), the District will not be able to simply reallocate these funds to other priorities if the decree is lifted. When the Court Monitor no longer has the duty to ensure accountability, the District will have to fund another method of ensuring comparably robust accountability. Surely the District is not arguing that it does not intend to devote any funds to ensuring accountability in the future.

Even if the funds the District currently spends on court supervision are entirely fungible, the District's own analysis makes clear that the financial obligations imposed by the decree are

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Court Monitor – July 2009, at 4-5. Additionally, with respect to both Consumer Service Reviews and Consumer Functioning Methods, the IQC and Office of Accountability's work is in the beginning phases of planning or implementation. *See id.* at 4-6 (noting that "DMH is planning to change its contract requirements" with respect to CSR data collection methods; that there is a "new Director of Quality Improvement"; and that the Office of Accountability "has begun to review provider compliance with LOCUS/CALOCUS as part of its auditing process" (emphases added)).

de minimis. Although the District characterizes the cost of continued compliance with the decree as "onerous," Mot. at 34, it makes no effort to put these costs in perspective. The District contends that it has paid or allocated $3,413,622 for the services of the Court Monitor since 2003, or roughly $600,000 a year. Taking the figures provided by the District entirely at face value then, its annual expenditures devoted to the Court Monitor's services consume approximately 0.1% of its current projected budget shortfall for 2009 and 0.01% (one-hundredth of one percent) of its total annual budget.[25] Such a limited expenditure cannot possibly justify lifting the consent decree to which the District explicitly agreed and on which the plaintiffs have relied, particularly given the District's extensive history of noncompliance and its failure to satisfy the underlying legal violation found by this Court 34 years ago. *See, e.g.*, *Rufo*, 502 U.S. at 392-93 (noting that "[f]inancial considerations may not be used to justify the creation or perpetuation of constitutional violations"); DOJ *Evans* Response, at 15 n.5 (arguing that the District's current fiscal situation cannot justify relief when considered alongside its continuous non-compliance with this Court's orders over more than thirty years).

Finally, there is a significant paradox in the District's reliance on what concededly is "a dire economic climate." Mot. 35. Though the premise of its *Horne* argument is that it has crafted a <u>durable</u> remedy, it tacitly admits that it does not intend to maintain current funding for the Department of Mental Health. *See also* Expert Report, at 10 (explaining that mental health programs are typically not highly prioritized in budget planning). Plaintiffs certainly recognize the difficult budgetary trade-offs that must be made in difficult economic circumstances, but the

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[25] Aside from payments to the Court Monitor, the only additional cost of compliance cited by the District is payment of attorneys fees, which totals roughly one quarter of the costs the District has allocated to paying the Court Monitor.

Court can hardly be confident that, absent court supervision, a politically powerless group of mentally ill citizens will not see the progress of the past year evaporate.

IV. THE DISTRICT HAS NOT COMPLIED OR SUBSTANTIALLY COMPLIED WITH THE EXIT CRITERIA.

As an independent ground for dismissing this action, the District contends that it is in substantial compliance with the Exit Criteria. Of the 19 Criteria the District agreed to six years ago, the District has achieved the required benchmark as to only six. Moreover, the most recent Report of the Court Monitor indicates that "significant effort" is required with respect to more than half of those criteria that remain active." *See* Report of Court Monitor – July 2009, at 11-12; Expert Report, at 9. On this record, the District cannot plausibly claim that it has substantially complied with the Exit Criteria.

A. The District Has Not Substantially Complied With All Of The Exit Criteria.

"Substantial compliance" is not a Rule 60(b)(5) standard for modifying or vacating an order, but is rather a means internal to the Consent Order itself for dismissing the case. Under the terms of that Order, the case may be dismissed only if the District "demonstrate[s] substantial compliance with <u>all</u> required performance levels for <u>all</u> of the Exit Criteria," and that dismissal is in the "interests of justice." 2003 Consent Order, at 2 (emphases added).

The District is not entitled to dismissal under the Consent Order for the simple reason that it has not substantially complied with <u>all</u> required performance levels for <u>all</u> of the Exit Criteria to which it agreed. Rather than explain how its record of non-compliance with a supermajority of the Exit Criteria is in fact "substantial compliance," the District argues that "act[ing] in good faith in achieving the purposes of the litigation" is sufficient. However, it is results, not effort, that substantial <u>compliance</u> measures. For its unconvincing argument to the contrary, the District relies not on cases applying "substantial compliance" provisions of consent

decrees, but on cases applying Rule 60(b)(5). *See United States v. Miami*, 2 F.3d 1497, 1508 & n.38 (11th Cir. 1993) (remanding for application of Rule 60(b)(5) standard, including determination of whether City has "substantially complied" with decree, which would be considered evidence of its good faith); *Philadelphia Welfare Rights Org. v. Shapp*, 602 F.2d 1114 (3d Cir. 1979) (not mentioning the term "substantial compliance" but granting Rule 60(b)(5) modification as to portions of consent decree that were not "realistically achievable," while "preserving [the decree's] essential features").

In contrast to the cases cited by the District, the Tenth Circuit has squarely addressed how to analyze "substantial compliance" within the context of a consent decree. Relying on a "seminal" Justice Cardozo opinion, the court explained that "performance of a contract will not be considered in substantial compliance of the contract if the deviation from the contract requirements . . . 'in any real substantial measure . . . frustrate[s] the purpose of the contract.'" *Joseph A. v. New Mexico Dep't. of Human Servs.*, 69 F.3d 1081, 1085-86 (10th Cir. 1995) (quoting *Jacob & Youngs, Inc. v. Kent*, 129 N.E. 889, 891 (N.Y. 1921)) (alterations in original). The Tenth Circuit further explained that because the consent decree in that case set "forth specific criteria to be met, those criteria must be respected unless a deviation can be shown not to have a material effect upon overall performance." *Id.* at 1086. The District can hardly argue that its failure to satisfy most of the Exit Criteria, in most cases without coming close, has no "material effect" on creation of the sort of mental health system envisioned in the Consent Order approving these Criteria. *See supra* Part II.B.2.a.[26]

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[26] That "substantial compliance" cannot be divorced from "compliance" is confirmed by the final case the District cites, *R.C. v. Walley*, 270 F. App'x 989 (11th Cir. 2008). Though the District fails to note <u>why</u> substantial compliance was found, the district court opinion, which the Eleventh Circuit affirmed with little elaboration, made clear that "substantial compliance" with a (continued…)

Because the "substantial compliance" provision to which the District agreed requires substantial compliance "with all of the Exit Criteria," Consent Order, at 2, the District's rehash of its Rule 60(b)(5) argument will not suffice. What the District argues is not that it has substantially complied with all of the Exit Criteria, but that it should be relieved of the obligation to do so. As the First Circuit has observed, a state cannot demonstrate substantial compliance simply by showing that it "substantially complied with a more generous standard than that demanded by the consent decree and the applicable laws." *Fortin v. Comm'r of Mass. Dept. of Pub. Welfare*, 692 F.2d 790, 796 (1st Cir. 1982). If the District believes that certain criteria are too onerous, its remedy is to seek modification, not to argue counterfactually that it has substantially complied with all of the criteria.[27]

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consent decree requires a strong degree of actual compliance with the decree's specific criteria. *See R.C. v. Walley*, 475 F. Supp. 2d 1118, 1138-39 (M.D. Ala. 2007) (noting that the litigation's benchmark for "overall child status" was an 85% rating, and that the State had sustained an aggregate 96% rating); *id.* at 1139-83 (reviewing in detail the State's primarily positive record in sustaining compliance with specific standards); *id.* at 1184 (concluding that Alabama's child welfare system had attained "substantial compliance" because it was operating "and will continue to operate" in a manner that complies with "the law, *the Consent Decree and the Implementation Plan*" (emphasis added)); *see also R.C. v. Walley*, 390 F. Supp. 2d 1030, 1044 (M.D. Ala. 2005) (adopting the Tenth Circuit's, and Justice Cardozo's, approach to "substantial compliance" with a consent decree).

[27] The District further argues that it need not meet certain of the Exit Criteria to which it agreed on the theory that they do not comport with national standards. Appendix, at 1, 6, 11. The District nowhere explains the legal significance of this assertion. It may not, in fact, demonstrate substantial compliance "with a more generous standard" than the one to which it agreed. *Fortin*, 692 F.2d at 796. To the extent that certain Exit Criteria do not precisely correspond with national averages, that simply reflects the fact that these averages often are weighted downward by underperforming jurisdictions. *See* Expert Report, at 26. The inadvisability of using such averages as the benchmark for a well-functioning mental health system is demonstrated most powerfully by the District's own decision, after careful consideration by leading industry experts, to agree to a set of Exit Criteria that in some cases go beyond national averages. Moreover, as illustrated by the Exit Criterion for Continuity of Care, the allegedly unrealistic standards are well within the ability of an adequately functioning system to achieve. *See* Expert Report, at 26.

B. The District May Not Disregard One-Third Of The Exit Criteria By Reading Children Out Of The *Dixon* Class.

The District attempts to rid itself of 6.5 Exit Criteria obligations by unilaterally deciding that children are no longer part of the *Dixon* Class because there is no longer a children's ward at St. Elizabeths Hospital. This argument has no merit and shows the blatant contempt that the District has for its obligations under the Consent Decree.

Children have long belonged to the *Dixon* class. The 1980 Consent Order, for example, provided that "[m]embers of the plaintiff class <u>who are minors</u> are entitled to all the relief provided to plaintiffs in the Consent Order and the Plan appropriate and suitable to their special needs." Consent Order, at 9 (emphasis added). This state of affairs was not altered by the closure of the St. Elizabeths children's ward in 2000. If the District can eliminate children from *Dixon* by shutting down their ward, it follows that it can end *Dixon* entirely by shutting down the entire hospital, without meeting any of its obligations for providing community-based care. The District's attempt to read children out of *Dixon* is simply another example of its flawed argument that the Ervin Act is concerned only with deinstitutionalization. *See supra* II.B.1. No one disputes that there are seriously emotionally disturbed in the District entitled to the care mandated by the Ervin Act and Transfer Act; it follows that these children continue to belong in a case concerned with remedying the District's ongoing violations of these Acts. *See Kuehner v. Heckler*, 778 F.2d 152, 163 (3d Cir. 1985) (where the "original complaint" included a plaintiff with disability benefits terminated in 1980, "it cannot be said that the district court intended that the class extend back only as far as [benefit terminations after] March, 1981").[28]

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[28] If the District's cramped reading of the class definition were correct, it would follow only that the class definition no longer tracks the purpose of the class action. If that has happened, the solution is not to jettison individuals whose rights were adjudicated and who have yet to receive (continued…)

Moreover, even assuming the *Dixon* mandate is only concerned with deinstitutionalization, there would still be no warrant for reading children out of the class. Though the children's ward at St. Elizabeths is closed, children in the District remain at risk of institutionalization in Residential Treatment Centers, where their rights to appropriate treatment in the least restrictive setting are not enforced. *See* Valente Decl. ¶27 (providing multiple examples of children who have been unnecessarily consigned to psychiatric wards because community-based alternative treatment is not available). On any given day, the District places approximately 500 youths in residential treatment facilities and psychiatric residential treatment facilities, with over half of these facilities located more than 100 miles from the District of Columbia and approximately 35% located more than 300 miles from the District. Valente Decl. ¶ 28; *see also id.* ¶ 28 (noting that the District has the nation's second highest percentage of students between six and 21 years old in residential treatment facilities and explaining that ULS staff frequently receive requests from youths seeking to prevent their placement in such facilities); Expert Report, at 34-35. The District's suggestion that a prerequisite to Class membership is not only the possibility of institutionalization, but the possibility of institutionalization at one particular place, cannot be sustained.[29]

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their remedy. The Federal Rules do not so elevate form over substance, but instead recognize that "[t]he original [class] definition and certification . . . may require alteration or amendment as the case unfolds." *Burns v. United States R.R. Ret. Bd.*, 701 F.2d 189, 191-92 (D.C. Cir. 1983); *see also* Fed. R. Civ. P. 23 advisory committee's note (2003) ("Following a determination of liability, for example, proceedings to define the remedy may demonstrate the need to amend the class definition.").

[29] Even if this position did have any merit, it would suffice to note that while St. Elizabeths does not currently house children, no law prevents the District from reopening the doors of the children's ward if it continues to fail at treating children in the community.

Finally, it is noteworthy that the putative basis for removing children from the Class preceded the District's approval of the Exit Criteria by three years. Thus, the St. Elizabeths children's ward was already closed when the District agreed to the Exit Criteria, one-third of which consisted of its obligations to children. Only now, after consistently failing to meet these obligations, *see* Report of Court Monitor – July 2009, at 9-11, does the District invoke the closure of the children's ward in a misguided effort to avoid providing children the care they are owed. The District's position is not only incorrect, but it also belies the claim to good faith that is the entire basis for the District's Motion.

CONCLUSION

The animating theme of the District's motion is that this case has gone on long enough. Plaintiffs take no pride in the length of this litigation, and eagerly anticipate the day when decades of non-compliance ends and court supervision is no longer necessary. All plaintiffs ask is that this case end when their right to an adequately functioning community-based mental health system, recognized by this Court 34 years ago, is finally vindicated. For all of the foregoing reasons, therefore, plaintiffs respectfully request that the District's motion be denied.

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Respectfully Submitted,

/s/ Anthony Herman

Anthony Herman (D.C. Bar #424643)
Iris Y. Gonzalez (D.C. Bar # 987156)
Covington & Burling LLP
1201 Pennsylvania Avenue, NW
Washington, D.C. 20004-2401
(202) 662-5280