IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. STATE OF GEORGIA, *et al.*, Defendants.	)	Civil Action No. 1:09-CV-0119-CAP

DEFENDANTS' RESPONSE IN OPPOSITION TO PLAINTIFF'S MOTION FOR IMMEDIATE RELIEF (PRELIMINARY INJUNCTION)

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Defendant the State of Georgia and the individual Defendants who are named in their official capacities (collectively, "the State" or "Georgia") respectfully file this Response in Opposition to Plaintiff's Motion for Immediate Relief (Preliminary Injunction), filed on January 28, 2010 [dkt. 55].

INTRODUCTION

Thirteen months ago, the State of Georgia and the United States entered into a comprehensive Settlement Agreement to improve the conditions of care and treatment for patients in Georgia's psychiatric hospitals pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, et seq. (Settlement Agreement [dkt. 7-2] § I.B.) The Settlement Agreement is effective for five years, until January 15, 2014, and requires the State to undertake significant actions in its psychiatric hospitals in areas relating to protection from harm, mental health care, treatment planning, seclusion and restraint, medical and nursing care, special needs services, and discharge planning. (Id. § III.)

The Settlement Agreement expressly does not incorporate the separate Voluntary Compliance Agreement ("VCA") that the State previously executed with the U.S. Department of Health and Human Services' Office for Civil Rights

("OCR") on July 1, 2008.[1] (Settlement Agreement [dkt. 7-2] § I.C.) The VCA relates to the State's compliance with the community services and program requirements of Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101, et seq. In fact, aside from the carve out of the VCA, the Settlement Agreement does not mention the ADA at all.[2]

Section V of the Settlement Agreement specifically addresses "Modification and Termination." (Id. § V.) First, the terms of the Settlement Agreement cannot be modified unless the party wishing to modify notifies the other party and states its reasons for the desired modification, and then the parties agree in writing to the modification. (Id. § V.A.) Second, litigation regarding the Settlement Agreement's requirements is a last resort: unless there is an "immediate and serious threat to the life, health, or safety of patients served by Georgia's Psychiatric Hospitals," the United States must provide the State with notice and 90 days to cure any alleged non-compliance. (Id. § V.D.) The parties also must try to

[1] A copy of the Voluntary Compliance Agreement ("VCA") between the State and the OCR is attached hereto as Exhibit A.

[2] The general discharge planning requirements contained in Section III.F of the Settlement Agreement reference only general federal law requirements that "shall be satisfied" if the specific terms of that section are achieved before the expiration of the five-year agreement. (Settlement Agreement [dkt. 7-2] § III.F.)

resolve any differences during this 90-day period, and judicial intervention is prohibited unless these negotiation efforts fail. (Id.)

The Settlement Agreement remains the order of this Court. On February 16, 2010, this Court entered an Order confirming that "the parties' settlement agreement [Doc. No. 2] was still in effect." (2/16/2010 Order [dkt. 65] at 1; see also 10/8/2009 Order [dkt. 34] at 1 ("The order [Doc. No. 9] that temporarily adopted the proposed settlement agreement is in full force and effect.").)

Notwithstanding the binding nature of the Settlement Agreement—which was not conditioned upon court approval—Plaintiff unilaterally seeks both to void the Settlement Agreement and to rewrite its provisions through litigation after only one-fifth of the Settlement Agreement's term has elapsed. Without citing any evidence of an immediate and serious threat to the life, health, or safety, Plaintiff asks this Court to order compliance with the Settlement Agreement "now" (as Plaintiff often emphasizes), notwithstanding the Settlement Agreement's five-year term. (See Mem. Supp. U.S. Mot. for Immediate Relief [dkt. 55-2] ("Pl.'s Br.") at 3, 20, 23 (emphasis in original).) Plaintiff requests Court imposition of restrictions that would thwart Georgia's current efforts to improve the mental health system in an orderly fashion and in accordance with existing plans, and Plaintiff also asks this Court to appoint a court monitor (at the State's additional expense) to

supervise its arbitrary changes to a plan currently being administered in good faith by the State. (See id. at 35-40.)

At its core, Plaintiff's motion appears to be nothing more than a "bait and switch." Thirteen months ago, the State agreed to improve Georgia's psychiatric hospitals in a coordinated effort with the United States, which represented to the State (and this Court) that the United States had no "intention . . . to dictate to the State how its mental health process should be designed." (U.S. Resp. to Concerns of Ga. Advocates [dkt. 12] at 12-13.) Today, however, the United States seeks unilateral alteration of the parties' negotiated Settlement Agreement to impose its new goal of systemic reform accomplished through a policy redirection *away* from the hospitals and into community-based services.

Plaintiff admits that its true purpose is to alter "the Governor's recent budget request" so as to shift the resources committed for hospital improvement—the purpose of the Settlement Agreement—to "building the necessary community capacity." (Pl.'s Br. at 3.) Indeed, during the Court's February 4, 2010 conference call with counsel, Plaintiff's counsel Mr. Mygatt admitted:

> All of the budgets, all of the budget alterations that have been made here, from all that we can tell that's been provided to us by the State devotes significant funds almost entirely to the hospitals themselves, and they are necessary to get the individuals out of these hospital[s], out of dangerous situations that are presented there, and we are very concerned that if we do not act immediately, the State is going to pour

> a ton of resources into the wrong place, and we do not want to see that happen, Your Honor. And so that is why we acted immediately on the ADA issues in order to make s ure that the resources were not poured entirely into one place in the st ate system, the hospitals, that ultimately will end up doing the stat e a disservice and the people who are in these hospitals a disservi ce by not getting t hem out and back into the community where they most fundamentally belong.

(Tr. of 2/4/2010 Tel. Conf. [dkt. 61] at 21.) In other words, squarely contradicting its disavowal to the Court last March, Plaintiff now seeks an extraordinary remedy that would allow Plaintiff "to dictate to the State how its mental health process should be designed." (U.S. Resp. to Concerns of Ga. Advocates [dkt. 12] at 13.)

Plaintiff's Motion for Immediate Relief should be denied for at least two reasons. First, it violates the Settlement Agreement because it: (1) is not based on an immediate and serious threat to the life, health, or safety of any particular patient at one of Georgia's psychiatric hospitals; (2) bypasses the requirement in Section V.D that the United States must provide the State of Georgia with written notice of alleged violations and an opportunity to cure the non-compliance within 90 days of the notice; and (3) seeks to modify the Settlement Agreement unilaterally to include community placement mandates.

Second, Plaintiff has not established any of the four prerequisites for obtaining an "extraordinary and drastic" mandatory injunction against the State. Plaintiff cannot show a substantial likelihood of success on the merits or

irreparable harm. Moreover, the balance of the equities favors the State and "the requested preliminary injunction will not serve the public interest and may actually cause more harm than good." Kenny A. v. Perdue, No. 1:02-CV-1686-MHS, slip op. at 5 (N.D. Ga. Dec. 12, 2002) (Shoob, J.) (refusing a preliminary injunction against the Georgia Department of Human Resources and allowing the new Commissioner, in office for little more than a year, an opportunity to undertake remedial actions without the constraints sought by the plaintiffs).

PROCEDURAL HISTORY

On January 15, 2009, Plaintiff filed a complaint pursuant to CRIPA, alleging that the State previously engaged in constitutional and statutory violations with respect to patients residing in Georgia's psychiatric hospitals. [Dkt. 1.] On the same day, the parties filed a joint motion for this Court to enter the parties' Settlement Agreement and dismiss the complaint. [Dkt. 2.] Following receipt of a letter expressing concerns with the Settlement Agreement from Ms. Cynthia Wainscott, the Court directed the parties to file a response to those concerns. [Dkts. 3 & 4.] Other advocates also opposed the Settlement Agreement, primarily based on their belief that financial resources should be shifted from improving conditions at Georgia's psychiatric hospitals to funding community services pursuant to the U.S. Supreme Court's decision in Olmstead v. L.C. *ex rel.* Zimring,

527 U.S. 581 (1999). [Dkt. 4-2.] On February 10, 2009, the parties jointly moved the Court to adopt the Settlement Agreement and dismiss the complaint pursuant to Federal Rule of Civil Procedure 41(a)(2) because "[t]he Parties agree that it is in the best interest of the Parties and the individuals residing in the Facilities that the Settlement Agreement's reforms be implemented as soon as possible." (Joint Mot. [dkt. 7] at 2.) On February 11, 2009, the Court "adopt[ed] the proposed settlement agreement [Doc. no. 7-2] as the temporary order of the court so that the parties can proceed with implementation and enforcement of its terms pending final approval." (2/11/2009 Order [dkt. 9].) Ms. Wainscott, the Georgia Advocacy Office, and certain other advocacy groups continued to oppose the Settlement Agreement, again contending that funding should be shifted from the hospitals to the community to deinstitutionalize patients.[3] [Dkts. 10 & 11.]

Plaintiff defended the Settlement Agreement in its original response to the objecting advocacy groups. Plaintiff affirmatively stated that it would monitor the Settlement Agreement, would provide advice and assistance to the State, would require corrective actions from the State if necessary, and would "notify the State and work together to develop an effective plan" before instituting judicial remedies should Plaintiff believe that the State was out of compliance with the Settlement

[3] Other advocacy groups contacted the Court and expressed their support of the Settlement Agreement. [Dkt. 8.]

Agreement. (U.S. Resp. to Concerns of Ga. Advocates [dkt. 12] at 12.) Importantly, Plaintiff represented to this Court that it "did not seek to prescribe the exact method by which the State would obtain compliance with the Agreement," that it was "within the State's discretion" to develop plans to achieve compliance, and that it was "not the United States' intention . . . to dictate to the State how its mental health system should be designed." (Id. at 13.) With respect to potential ADA/Olmstead concerns, Plaintiff referenced the VCA between the OCR and the State, which contained a separate enforcement mechanism. (Id. at 15-16.)

The Court directed the parties and interested *amici curiae* to meet in an attempt to resolve the *amici's* concerns. (4/6/2009 Order [dkt. 16]; 6/1/2009 Order [dkt. 24].) On June 12, 2009, the parties and the *amici* filed a Joint Status Report detailing those discussions and agreeing to additional periodic meetings and certain actions, including the State's filing an initial implementation plan concerning the Settlement Agreement. (Joint Status Report [dkt. 26] at 3-6.) Although the parties and the *amici* disagreed as to whether the *amici's* desired improvement and expansion of community-based services are necessary to comply with the Settlement Agreement, they agreed that the State should conduct a "needs assessment" to determine what services exist and what services need to be improved, redirected, or added. (Id. at 6-7.) The State requested that the Court

enter the Settlement Agreement as a final order; Plaintiff and the *amici* requested instead that the Court simply take no further action at that time. (Id. at 10.)

On September 30, 2009, the Court dismissed the parties' joint motion for entry of the Settlement Agreement because Plaintiff "indicated that it no longer agrees with the motion." (9/2/2009 Order [dkt. 29] at 2.) In dismissing the joint motion, the Court "applaud[ed] the initiative and cooperation" of the parties and the *amici*, "strongly encourage[d] all of the parties to maintain their level of commitment and effort," and stated that "the parties should continue to meet, as agreed, every six months to update/monitor progress and to provide feedback." (Id.) The Court also indicated that the parties could resubmit a motion "for the court to permanently adopt the settlement agreement." (Id.)

That same day, Plaintiff and the *amici* filed a status report with the Court indicating they had "grave concerns" concerning the State's ability to comply with the Settlement Agreement, but Plaintiff chose "not [to] seek enforcement of the Agreement at this time" because the first deadline for the State to come into compliance with certain provisions of the Settlement Agreement was not until one year from its effective date. (Joint Status Report [dkt. 30] at 1-2, 23.) This provided the initial indication that Plaintiff was shifting its interest from improving conditions within Georgia's psychiatric hospitals to the *amici's* position that the

State should be required to undertake significant actions in developing community services in accordance with their view of Olmstead. (Id. at 2 ("The State's unwillingness to take seriously its obligations under Olmstead . . . and the discharge planning provisions of the Agreement is a fundamental cause of the constitutional violations that the United States has identified.").)[4]

On October 8, 2009, during a telephone conference with the Court, an attorney for the State specifically asked Plaintiff's counsel whether Plaintiff intended to abide by the Settlement Agreement:

> UNIDENTIFIED SPEAKER [for Defendants]: My question is do we still have an agreement, and it's the intent of the Department of Justice to move forward with that agreement and we'll try to resolve the issues about the *Amici* as we go along.
>
> UNIDENTIFIED SPEAKER [for Plaintiff]: Yeah, we believe that the agreement is still in place pursuant to the February 11 Order and we are going to continue to try and address the concerns raised by the *Amici*, yeah.

(Tr. of 10/8/2009 Tel. Conf. [dkt. 35] at 5.) Removing all doubt as to the effect of the Settlement Agreement, that very same day, this Court entered an order clarifying its September 30, 2009 Order to unambiguously reiterate and make abundantly clear that its February 11, 2009 Order which "temporarily adopted the proposed settlement agreement is in full force and effect." (10/8/2009 Order [dkt.

[4] Unlike the four priority areas, the discharge planning provisions are not required to be fulfilled at any specific time within the Settlement Agreement's five-year term.

34].) The Court additionally stressed that it "fully expects the parties to continue working towards resolution in this matter as outlined in the temporarily-adopted proposed settlement agreement." (Id.)

On December 8, 2009, Plaintiff informed the Governor of Georgia by letter that "the State Psychiatric Hospitals fail to provide adequate discharge planning to insure placement in the most integrated setting and to provide adequate supports and services necessary for successful discharge," citing the ADA and Olmstead [dkt. 55-8], even though the discharge planning provisions of the Settlement Agreement were still in force with four years remaining for compliance.[5] Governor Sonny Perdue responded to this letter with an invitation for the U.S. Department of Justice ("DOJ") to meet with him and his senior staff.

[5] To address the Court's comment during the February 16, 2010 telephone conference, the December 8, 2009 letter does *not* constitute the "Notice of Non-Compliance," as required by the Settlement Agreement, for at least four reasons. First, the notice was not given and served in the form required by the Settlement Agreement. (Settlement Agreement [dkt. 7-2] §§ V.D & VI.D.) Second, the Settlement Agreement grants the State 90 days from the date of proper notice to substantially cure the alleged non-compliance. (Id. § V.D.) If, in fact, the December 8th letter is deemed to be "Notice of Non-Compliance" under the Settlement Agreement, then the State would have until March 8, 2010 to submit its proposed corrective plan. Third, as noted above, the December 8th letter focuses on discharge planning, an area of the Settlement Agreement that affords the State an additional four years to comply. Fourth, Plaintiff demanded that the State execute a 50-page consent decree or be sued by the end of January 2010, a full six weeks before the State would have had to submit a curative plan if the December 8th letter was, in fact, an actual notice of non-compliance with the Settlement Agreement.

Before the Governor and DOJ representatives met, the Court held another telephone conference on December 30, 2009. The Court ordered Plaintiff to file a motion "outlining their concerns regarding conditions of state facilities," with responses from the State and *amici*, after which the Court would determine when to hold a hearing. (Minute Entry for 12/30/2009 Tel. Conf. [dkt. 44].)

Governor Perdue and DOJ representatives met on January 8, 2010, at which time U.S. Assistant Attorney General for Civil Rights Thomas E. Perez advised the Governor that the DOJ was considering filing a new lawsuit based on the ADA, notwithstanding the Settlement Agreement in this case and the existing VCA between the OCR and the State addressing ADA issues separately. The Office of the Governor sent letters to Mr. Perez on both January 8 and 15, 2010, containing specific information in a good faith attempt to address the DOJ's concerns and resolve the ADA issues cooperatively. [Dkts. 52-3 & 52-8.] The DOJ responded on January 22, 2010, with a proposed 50-page consent decree that would have effectively voided both the Settlement Agreement and the VCA, with an ultimatum that the State must execute the proposed consent decree or an "additional action" would be filed by the end of January. [Dkt. 52-10.] The State in response asked for more time to review the proposal and assess the significant costs associated with it, but the DOJ denied that request and then actually *shortened* the State's

time to review the proposed consent decree, stating that it would file a new ADA lawsuit on January 28, 2010. [Dkt. 52-12.] In an effort to undermine completely the Settlement Agreement, Plaintiff then filed not only a new ADA lawsuit (No. 1:10-CV-249-CAP) but also the Motion to Amend, Motion to Consolidate, and Motion for Immediate Relief, which are currently pending in this case.[6]

STATEMENT OF RELEVANT FACTS

The State of Georgia has expended and committed significant resources in an effort to comply with the Settlement Agreement's mandates for improvement of Georgia's psychiatric hospitals, including the establishment of a new state agency, the Department of Behavioral Health and Developmental Disabilities ("DBHDD"), on July 1, 2009. As discussed in more detail below, the DBHDD—in collaboration with a team of experts and consultants—has achieved significant improvements in patient care in just the first eight months of its existence. Dozens of additional concrete steps to achieve better safety in the hospitals are currently underway and are continuing with the goal of substantial compliance with all provisions of the Settlement Agreement before the end of its term. In addition to

[6] In addition to the briefs that the State filed in response to Plaintiff's motions, the State also filed a Motion to Enforce the Settlement Agreement [dkt. 62] on February 15, 2010, and the State incorporates by reference the arguments made in the Brief in Support of that motion [dkt. 62-2].

in-patient care, Georgia has greatly expanded community-based services to those with mental illnesses, developmental disabilities, and substance abuse disorders.

I. System-Wide Infrastructure Changes and Funding Increases

Following execution of the Settlement Agreement, the State took (and is continuing to take) significant steps to ensure that the necessary infrastructure is in place and funding is available to implement the substantive provisions of the Settlement Agreement.

A. Creation of the DBHDD

Prior to July 1, 2009, Georgia's Department of Human Resources provided mental health, developmental disabilities, and addictive diseases services through the Division of Mental Health, Developmental Disabilities and Addictive Diseases. (Declaration of Frank E. Shelp, M.D., M.P.H. [attached hereto as Exhibit B] ("Shelp Decl.") ¶ 9.) The passage and signing of House Bill 228, which created the DBHDD, epitomized Governor Perdue's and the General Assembly's vision to create an independent agency focused solely on persons with behavioral health concerns, developmental disabilities, and substance abuse problems. (Id. ¶ 10.) Governor Perdue appointed Dr. Frank E. Shelp, a clinical psychologist with over twenty years of experience, as the first Commissioner of the new DBHDD on May 4, 2009, and the DBHDD became a legal entity on July 1, 2009. (Id.) The

DBHDD oversees persons in Georgia's custody for civil reasons (persons voluntarily or involuntarily seeking medical care and treatment, but not accused of any criminal act) and for forensic purposes (persons ordered by a court to obtain medical care and treatment and deemed not competent to stand for trial or not guilty by reason of insanity). (Id.)

This year, the DBHDD is supporting legislation that (1) improves on House Bill 228 by including more agencies in the Behavioral Health Coordinating Counsel, a group of leaders of state agencies that meet to coordinate care for Georgians generally, (2) revises the Nurse Practice Act to provide greater access to home and community-based care, and (3) facilitates some Community Service Boards' transition to operate more as Federally Qualified Health Centers, thereby increasing community treatment capacity. (Id. ¶ 15.) This legislation is pending before the General Assembly. (Id.) In addition, the DBHDD is spearheading improvement initiatives, collaborations and partnerships with academic institutions, community engagement, and enhanced used of technology. (Id. ¶ 16.)

B. Georgia's Financial Commitment to the DBHDD

Governor Perdue's proposed Fiscal Year 2010 Amended Budget (AFY 2010) reflects his continued commitment to the DBHDD. The Governor's commitment is especially telling in the light of the current budget shortfalls in

Georgia. Specifically, the proposed AFY 2010 budget recommends an additional $1,152,394,143 in cuts across the state. (Shelp Decl. ¶ 11.) The additional cuts will leave the State budget totaling approximately $17 billion, whereas in 2008, the General Assembly passed a budget for FY 2009 that would total around $21 billion. (Id.) Georgia's budget has dropped by $4 billion, or 19%, over two years. (Id.) And State revenues continue to decrease, as the January revenue collections demonstrated a year-to-date decline of 12.9% from Fiscal Year 2009. (Id.)

In response to drastically declining revenues, the Governor recommended that some agencies be cut by as much as 14% in the AFY 2010 budget. (Id. ¶ 12.) By contrast, Governor Perdue recommended that the DBHDD receive approximately $19.7 million *additional* dollars in AFY 2010, or a 2.8% *increase* in funds appropriated in the original FY 2010 budget. (Id.) The Georgia House of Representatives passed the AFY 2010 budget on February 11, 2010, and the Georgia Senate passed the AFY 2010 budget on February 18, 2010; both agreed with the Governor's recommendation for the DBHDD's budget. (Id.)

The Governor's recommended budget for the DBHDD for Fiscal Year 2011 is also in marked contrast to other state agencies. Specifically, the Governor recommended an additional $63.8 million, or 9.2% increase, in state funds to the

DBHDD. (Id. ¶ 13.) The Georgia General Assembly is currently considering the Fiscal Year 2011 budget. (Id.)

II. Implementation of the Settlement Agreement

A. The DBHDD's Early Efforts

At the outset, the DBHDD focused its efforts on the four priority areas identified in the Settlement Agreement: choking and aspiration risk assessment and prevention, suicide risk assessment and prevention, prevention of patient on patient assault, and implementation of emergency medical codes. (Declaration of Donald E. Manning, M.D., M.M.M. [attached hereto as Exhibit C] ("Manning Decl.") ¶ 14.) The DBHDD achieved significant improvements in these four priority areas. (Id. ¶ 15.) After extensive consultation and review, the DBHDD also issued new policies (or revised existing policies) in these four priority areas to better align the hospitals with generally accepted professional standards. (Id.)

B. The DBHDD's Collaboration with Dr. Nirbhay Singh

In addition to the improvements that the DBHDD had made in the four priority areas, the DBHDD sought further enhancements with respect to prevention of patient-on-patient assault. (Manning Decl. ¶ 16.) Per the DBHDD's request, the DOJ (Mr. Mygatt) recommended Dr. Nirbhay N. Singh to assist the State in

this endeavor. (Id.) In October 2009, Dr. Shelp retained Dr. Singh as an expert consultant, based in large part on the DOJ's recommendation. (Shelp Decl. ¶ 21.)

Dr. Singh has assembled a team of experts that will enable the DBHDD to implement all required policies and procedures to meet the substantive requirements of the Settlement Agreement, including psychiatrists, registered nurses, clinical and behavioral psychologists, rehabilitation services personnel, behavior specialists, treatment team mentors, risk and incident management specialists, and discharge planning specialists. (Declaration of Nirbhay N. Singh [attached hereto as Exhibit D] ("Singh Decl.") ¶ 7.) Dr. Singh anticipates a team of about 40 full-time and part-time staff that will assist the DBHDD's hospital staff to fully implement the requirements of the Settlement Agreement. (Id.)

C. The DBHDD's State-of-the-Art Policies

Since Dr. Singh's appointment in October 2009, the DBHDD has actively collaborated with Dr. Singh and his team in the review and development of new policies for the hospitals to achieve compliance with the entire Settlement Agreement, not just the prevention of patient-on-patient assault. (Manning Decl. ¶¶ 17-18; Singh Decl. ¶¶ 8-11.) In collaboration with Dr. Singh and his team of experts and consultants, the DBHDD has reviewed, revised, and developed policies

and procedures to further enhance the standard of care in the four priority areas. (Manning Decl. ¶¶ 18, 27.)

The results demonstrate significant and meaningful improvements and progress. With respect to the four priority areas, the DBHDD—with the assistance of experts and consultants—has developed the following new policies:

- "Physical and Nutritional Support" (anticipated effective date 3/1/2010);
- Policy # 03-504 (effective 11/9/2009): "Suicide Risk Screening and Assessment of Individuals in State Hospitals and State-Operated Crisis Stabilization Programs";
- Policy # 03-601 (effective 1/12/2010): "Risk Management";
- "Incident Management" (anticipated effective date 3/1/2010);
- "Safety-Care Training and Certification Requirements" (anticipated effective date 3/1/2010);
- Policy # 03-203 (effective 1/1/2010): "Cardio-Pulmonary Resuscitation (CPR), Automated External Defibrillator (AED) and First Aid Certification Requirements";
- Policy # 03-204 (effective 1/2/2010): "Emergency Code Designations for State Hospitals";
- "Medical Emergency Response System" (anticipated effective date 3/1/2010);
- "Medical Emergency Respiratory Support" (anticipated effective date 3/1/2010); and
- "Automated External Defibrillator" (anticipated effective date 3/1/2010).

(Singh Decl. ¶ 12 & Exs. 2-11.) The DOJ's expert consultants who evaluated facility practices at Central State Hospital in January 2010 agree: after reviewing

the new policies, a consultant reported during the exit conference that the new policies and procedures are "state-of-the-art" and meet generally accepted professional standards. (Id. ¶ 14.)

Training of trainers on the new policies set forth above has already been completed by Dr. Singh's staff of experts and consultants, and the training of all relevant staff will be completed by May 2010. (Singh Decl. ¶ 14; Manning Decl. ¶ 20.) The above policies will be fully implemented in all hospitals by May 2010. (Singh Decl. ¶ 15; Manning Decl. ¶ 21.)

III. Safety of Patients in the Hospitals

Following the investigation of health and safety issues at the hospitals and the resulting Settlement Agreement, the DBHDD and the hospitals have since undertaken significant and meaningful measures to ensure the health and safety of patients. (Manning Decl. ¶ 36.) Since execution of the Settlement Agreement, and especially after the creation of the DBHDD and its collaboration with Dr. Singh, the safety and well-being of patients have substantially improved. (Id. ¶¶ 18-19, 37.) While risks to patient health and safety cannot be eliminated altogether, the hospitals currently have in place policies and procedures to minimize those risks. (Id. ¶ 40; Singh Decl. ¶ 11.) New policies developed by Dr. Singh, in

collaboration with the DBHDD, will further minimize those risks when fully implemented. (Manning Decl. ¶ 40; Singh Decl. ¶ 11.)

A. Joint Commission Accreditation

All seven hospitals are currently accredited by the Joint Commission, which is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. (Manning Decl. ¶ 28.) The Joint Commission standards address the hospitals' performance in specific areas to ensure that patient care is provided in a safe manner and in a secure environment. (Id.) The Joint Commission develops its standards in consultation with health care experts, providers, and researchers, as well as measurement experts, purchasers, and consumers. (Id.) The standards utilized by the Joint Commission comport with generally accepted professional standards. (Id.)

To maintain and earn accreditation, a hospital undergoes an extensive, unannounced on-site review by the Joint Commission to evaluate the hospital's performance in areas that affect patient care. (Id. ¶ 29.) Joint Commission professionals, such as administrators, physicians, and nurses, evaluate the hospital's processes and personally visit with patients and staff. (Id.) The Joint Commission awards accreditation based on how well the hospital meets the Joint Commission's standards. (Id.) All seven of Georgia's psychiatric hospitals have

earned and currently maintain the Joint Commission's "Gold Seal of Approval," which demonstrates that the hospitals are in compliance with the most stringent standards of performance and have met national patient safety goals. (Id. ¶ 30.)

B. Statistics Regarding Safety in the Hospitals

As a requirement of accreditation, the hospitals report certain performance measures to the Joint Commission on a monthly basis. (Manning Decl. ¶ 31.) With respect to the frequency of patient injury (defined as any injury requiring more than minor first aid), the hospitals currently are *below* the national weighted mean for psychiatric facilities. (Id. ¶¶ 32-33.) The hospitals are also *below* the national average with respect to assaults and self-injury (which includes suicides). (Id. ¶ 34.)

IV. Achievements in Decreasing the Hospital Population and Improving Community-Based Services

In 2009, the State spent more on community-based care than on hospitals. (Shelp Decl. ¶ 14.) But treatment in the community is not always less costly than treatment in the hospitals. (Id. ¶ 49.) Hospital censuses are declining, more individuals are being transitioned from the hospitals into the community, and the use of Medicaid waivers for community-based treatment is increasing. (Id. ¶¶ 37-38, 41.) The State is undertaking many initiatives to increase and improve its community-based services, including hiring Mr. Bill Janes, the former Director of

Florida's Office of Drug Control and Assistant Secretary of Substance Abuse and Mental Health in Florida's Department of Children and Families, to serve as Georgia's Olmstead coordinator pursuant to the VCA. (Id. ¶ 22.) Mr. Janes is coordinating the implementation of Georgia's comprehensive Olmstead policies, which move persons at a reasonable pace into the community for treatment when community options become available. (Id.) Mr. Janes is also updating Georgia's Olmstead plan as required by the VCA. (Id.)

A. Decreasing Hospital Censuses

Hospital censuses are trending downward, demonstrating that the State of Georgia is not attempting to keep the hospitals fully populated. (Shelp Decl. ¶ 37.) The hospitals served 2,916 inpatients in 2000; however, at the beginning of 2010, only 1,956 remained. (Id.) In 2007, there were over 1,000 developmentally disabled persons in the hospitals; yet, at the beginning of 2010, less than 800 remained. (Id.) In 2007, the hospitals served approximately 700 adult mental health consumers, but three years later, there were fewer than 500. (Id.) Children and adolescents are no longer treated in the hospitals. (Id.)

Similarly, admissions into the hospitals are also declining. In October 2006, 1,338 persons were admitted into the hospitals, but three years later, 839 were admitted, which represents a decrease of 499 admissions, or 37%. (Id. ¶ 39.)

Admissions per bed have also declined from 2.09 in October 2006 to 1.51 in October 2009. (Id.)

B. Increasing Use of Medicaid Waivers

Georgia's use of Medicaid waivers has also increased dramatically since 2003. In 2003, there were less than 14,000 disabled persons receiving services through a Community Care Services Medicaid Waiver; however, by 2009, more than 18,000 received such a waiver. (Shelp Decl. ¶ 41.) In 2003, just over 8,000 individuals with developmental disabilities were served by Georgia's two waiver programs (called the "New Options/NOW" and "Comprehensive Supports/COMP" waivers), and 11,500 individuals were served by these waivers in FY 2009, indicating a net increase of more than 3,000 waivers since 2003. (Id.) Similarly, Georgia has opened the SOURCE program—a primary care, enhanced case management model—to the mental health and developmentally disabled population. (Id.) In 2003, just less than 3,000 persons received treatment through SOURCE; however, by 2009, the number was more than 18,000. (Id.)

Georgia is continuing to grow its Medicaid program. On February 18, 2010, the State submitted its application to the Centers for Medicare and Medicaid Services for a Section 1915i benefit under its State Medicaid Plan. (Id. ¶ 42.) If approved, the Section 1915i benefit will allow the State to use Medicaid dollars to

provide in-home and community-based care, thereby further expanding the State's abilities to provide mental health services in a community setting, rather than in the hospitals. (Id.)

C. Housing and Other Community Treatment Initiatives

The DBHDD is also creating a housing initiative, Pathways to Housing, modeled after a successful program in New York State. (Shelp Decl. ¶ 43.) The Bazelon Center introduced Dr. Shelp to the concept, and Dr. Bill McDonald, a clinical psychiatrist with Emory University, is beginning to implement the plan now. (Id.) When in place, the program will allow many DBHDD clients to receive services in supported housing, one of the DOJ's key requests. (Id.)

The number of Assertive Community Treatment ("ACT") providers, which monitor the DBHDD's clients in the community, has also grown more than three-fold since 2006, when only six such providers were available. (Id. ¶ 44.) Now, 21 ACT teams are utilized by DBHDD clients. (Id.)

The capacity of "host homes," which provide residential services to DBHDD clients, has also increased from 160 in Fiscal Year 2004 to 800 in Fiscal Year 2009. (Id. ¶ 45.) Similarly, the number of community crisis stabilization beds has increased significantly since 2003. (Id. ¶ 46.) For children and adolescents, the number jumped from less than 300 in 2003 to more than 450 in 2009; beds for

adult crisis stabilization increased from less than 300 to just under 400 in the same time frame. (Id.) The number of state-operated community residential programs has also increased from a little more than 20 in 2004 to more than 100 in 2009. (Id. ¶ 47.)

ARGUMENT AND CITATION OF AUTHORITY

I. A Preliminary Injunction Is an "Extraordinary and Drastic Remedy," Especially When Asserted Against a Government Agency.

Plaintiff's Motion for Immediate Relief, brought pursuant to Federal Rule of Civil Procedure 65, is in effect a motion for a preliminary injunction. (See Pl.'s Br. at 1, 4 ("[T]his motion for immediate relief may be understood as a motion for a preliminary injunction.").) Plaintiff, however, has not met the prerequisites for obtaining the "extraordinary and drastic" remedy of a preliminary injunction, especially as asserted against a state government. See, e.g., Siegel v. LePore, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc); Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am. v. City of Jacksonville, Fla., 896 F.2d 1283, 1285 (11th Cir. 1990); Dunkin' Donuts Inc. v. Kashi Enters., Inc., 106 F. Supp. 2d 1325, 1326-27 (N.D. Ga. 2000) (Pannell, J.) (quoting McDonald's Corp. v. Robertson, 147 F.3d 1301, 1306 (11th Cir. 1998)).

To obtain a preliminary injunction, the movant must clearly demonstrate each of the four required elements: "(1) a substantial likelihood that he will

ultimately prevail on the merits; (2) that he will suffer irreparable injury unless the injunction issues; (3) that the threatened injury to the movant outweighs whatever damage the proposed injunction may cause the opposing party; and (4) that the injunction, if issued, would not be adverse to the public interest." Zardui-Quintana v. Richard, 768 F.2d 1213, 1216 (11th Cir. 1985); accord Dunkin' Donuts, 106 F. Supp. 2d at 1326; see also Schiavo *ex rel.* Schindler v. Schiavo, 403 F.3d 1223, 1240 (11th Cir. 2005) (placing burden on movant); Church v. City of Huntsville, 30 F.3d 1332, 1342 (11th Cir. 1994) (same). "Failure to show any of the four factors is fatal." ACLU of Fla., Inc. v. Miami-Dade County Sch. Bd., 557 F.3d 1177, 1198 (11th Cir. 2009).

Where, as here, one seeks to enjoin a government, the parties and the Court must respect the "well-established rule" that the government is granted the "widest latitude" in the dispatch of its affairs. Rizzo v. Goode, 423 U.S. 362, 378-79 (1976). Indeed, in the mental health context itself, the U.S. Supreme Court has cautioned that "interference by the federal judiciary with the internal operations of these institutions should be minimized." Youngberg v. Romeo, 457 U.S. 307, 322 (1982). "[A]n injunction requiring detailed and continuous supervision over the conduct of a political subdivision is not congenial to equitable principles and practices and will not usually be granted." Brown v. Bd. of Trustees, 187 F.2d 20,

24 (5th Cir. 1951).[7] In the rare circumstances when it is granted, an injunction must be narrowly tailored to "fit the nature and extent of the established violation." Gibson v. Firestone, 741 F.2d 1268, 1273 (11th Cir. 1984); accord Dayton Bd. of Educ. v. Brinkman, 433 U.S. 406, 420 (1977).

The type of preliminary injunction that Plaintiff seeks in this motion—a preliminary injunction that (1) disturbs the *status quo*, (2) is mandatory as opposed to prohibitory,[8] and (3) affords Plaintiff substantially all of the relief it seeks to recover at the conclusion of a full trial on the merits—is disfavored and requires Plaintiff to show that the four factors weigh heavily and compellingly in its favor.

> A preliminary injunction that alters the *status quo* goes beyond the traditional purpose for preliminary injunctions, which is only to preserve the status quo until a trial on the merits may be had . . . . Mandatory injunctions are more burdensome than prohibitory injunctions because they affirmatively require the nonmovant to act in a particular way, and as a result they place the issuing court in a position where it may have to provide ongoing supervision to assure that the nonmovant is abiding by the injunction . . . . Finally, a preliminary injunction that awards the movant substantially all the relief he may be entitled to if he succeeds on the merits is similar to

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[7] All decisions of the former Fifth Circuit rendered prior to the close of business on September 30, 1981, are binding precedent in the Eleventh Circuit. See Bonner v. City of Prichard, 661 F.2d 1206, 1207 (11th Cir. 1981) (en banc).

[8] Mandatory injunctions compel action, while prohibitory injunctions forbid action. See Meghrig v. KFC W., Inc., 516 U.S. 479, 484 (1996) (stating that a mandatory injunction orders a party to "take action" and a prohibitory injunction "restrains" a party from further action); McDonald's Corp., 147 F.3d at 1307.

> the "Sentence first–Verdict Afterwards" type of procedure parodied in Alice in Wonderland, which is an a nathema to our system of jurisprudence.

SCFC ILC, Inc. v. VISA USA, Inc., 936 F.2d 1096, 1098-99 (10th Cir. 1991); see also Anderson v. United States, 612 F.2d 1112, 1114 (9th Cir. 1979) (noting that because a preliminary injunction that alters the status quo is "particularly disfavored" the movant must make a strong showing of entitlement). Judicial reluctance to issue preliminary injunctions is especially pronounced in cases such as this one in which Plaintiff seeks mandatory injunctive relief to compel the State of Georgia to do a positive act. See Harris v. Wilters, 596 F.2d 678, 680 (5th Cir. 1979) ("Only in rare instances is the issuance of a mandatory preliminary injunction proper.").

II. Plaintiff Has Failed To Satisfy the Prerequisites for Preliminary Injunctive Relief.

A. Plaintiff Cannot Demonstrate a Substantial Likelihood of Success on the Merits of Either Claim Against the State.

Plaintiff is not entitled to a preliminary injunction because it cannot prove a substantial likelihood of success on the merits of its claims. Plaintiff seeks a preliminary injunction based on two claims.[9] First, Plaintiff claims that

[9] Plaintiff's proposed Amended Complaint consists of four causes of action [dkt. 53], but its Motion for Immediate Relief is based on only two of them: Counts One and Two (ADA and federal substantive due process, respectively).

"[h]undreds of individuals, at a minimum, remain institutionalized in the hospitals in violation of their rights under the ADA and Olmstead." (Pl.'s Br. at 10.) Second, Plaintiff claims that the conditions in the hospitals are "unconstitutional and life-threatening" and seeks relief in the form of "moving individuals with disabilities out of inappropriate institutional placements now." (Pl.'s Br. at 23 (emphasis in original).) Plaintiff bears the burden of proving all essential elements of both claims. See United States v. Pennsylvania, 863 F. Supp. 217, 219 (E.D. Pa. 1994) (CRIPA); see also C.B. v. Bd. of Sch. Comm'rs of Mobile County, 2008 U.S. App. LEXIS 340, at *5-6 (11th Cir. Jan. 7, 2008) (ADA); United States v. Pennsylvania, 902 F. Supp. 565, 578-79 (W.D. Pa. 1995) (CRIPA).

Plaintiff is unlikely to succeed on its substantive due process claim because it cannot demonstrate that Defendants have substantially departed from accepted professional judgment in their provision of mental health services.[10] Similarly, Plaintiff is unlikely to succeed on the merits of its ADA claim because (1) the VCA already addresses the State's compliance with the ADA, (2) Plaintiff cannot establish a violation of the ADA, and (3) even if it could, the modifications that

[10] Tellingly, Plaintiff dedicates the majority of its brief to seeking systemic reform based on the ADA and secondarily addresses its constitutional claim. In this Response Brief, the State addresses the constitutional claim first, then the ADA claim second, because the only issue that may be raised at this stage, in a motion for preliminary injunction, is the constitutional claim to the extent there is imminent harm. (See Settlement Agreement [dkt. 7-2] § V.D.)

Plaintiff seeks would result in a "fundamental alteration" of the State's program, which the ADA and Olmstead say this Court is forbidden from mandating.

1. Plaintiff's Substantive Due Process Claim Under the Fourteenth Amendment to the U.S. Constitution Fails Because Plaintiff Cannot Prove That the State Substantially Departed from Accepted Professional Judgment.

(a) The Controlling Constitutional Standard

Although states are not constitutionally obligated to provide social services to their citizens, Youngberg v. Romeo, 457 U.S. 307, 317 (1982), Georgia does provide services to its citizens who have been diagnosed with a mental illness or developmental disability. The U.S. Supreme Court has held that the Due Process Clause of the U.S. Constitution's Fourteenth Amendment imposes an affirmative duty on the State to protect certain rights of those in its physical custody; specifically, persons in state custody "enjoy [] constitutionally protected interests in conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests." Id. at 324.

"Reasonable care" does not impose a constitutional standard of optimal treatment; minimal levels of care are sufficient. See id. at 323; Hanson v. Clarke County, 867 F.2d 1115, 1120 (8th Cir. 1989) (finding no constitutional right to optimal placement); Canupp v. Sheldon, 2009 U.S. Dist. LEXIS 113488, at *30 (M.D. Fla. Nov. 23, 2009) (noting that the U.S. Constitution does not require

institutionalized persons to receive optimal treatment and mental health services); Hargett v. Adams, 2005 U.S. Dist. LEXIS 6240, at *36, 50, 53-55 (N.D. Ill. Jan. 13, 2005) (finding that Illinois' treatment program was not "optimal," but did not violate constitutional standards). The State is required only to provide such treatment as an appropriate professional would consider "reasonable in light of [a person's] liberty interests in safety and freedom from unreasonable restraints." Youngberg, 457 U.S. at 322; Lelsz v. Kavanagh, 807 F.2d 1243, 1251 (5th Cir. 1987); Society for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d.1239, 1250 (2d Cir. 1984); Armstead v. Pingree, 629 F. Supp. 273, 276 (M.D. Fla. 1986).

In determining what constitutes "reasonable care," the Supreme Court in Youngberg emphasized that the State "has considerable discretion in determining the nature and scope of its responsibilities." 457 U.S. at 317. Judicial deference must be afforded to the judgment that a qualified professional exercises: "It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." Id. at 321. In fact, decisions made by such professionals are presumptively valid. See id. at 323; P.C. v. McLaughlin, 913 F.2d 1033, 1043 (2d Cir. 1990) (stating that courts should not "ascertain whether in fact the best course of action was taken").

Conflicting expert testimony will *not* overcome this presumption that the decisions of the treating professionals were valid. A plaintiff cannot meet its burden of proof by presenting nothing more than (1) a difference of professional opinion as to which practices are appropriate or (2) expert testimony that another course of action would have been better. See Youngberg, 457 U.S. at 321; Collignon v. Milwaukee County, 163 F.3d 982, 987 (7th Cir. 1998); Lelsz, 807 F.2d at 1243; Society for Good Will, 737 F.2d at 1248; Doe v. Gaughan, 617 F. Supp. 1477, 1487 (D. Mass. 1985), aff'd, 808 F.2d 871 (1st Cir. 1986); see also Thomas S. v. Flaherty, 902 F.2d 250, 252 (4th Cir. 1990) (noting that Youngberg prohibits courts from "weigh[ing] the decisions of the treating professionals against the testimony of the [plaintiffs'] professionals to decide which of several acceptable standards should apply"); Pennsylvania, 902 F. Supp. at 584 ("Optimal courses of treatment as determined by some expert, while laudable, do not establish the minimal constitutional standard.").

The Court's inquiry is limited to deciding "whether the treatment or residence setting that actually was selected was a 'substantial departure' from prevailing standards of practice." Society of Good Will, 747 F.2d at 1248-49. "Liability may be imposed only when [a] decision by [a] professional is such a substantial departure from accepted professional judgment, practice, or standards

as to demonstrate that the person responsible actually did not base the decision on such a judgment." Youngberg, 457 U.S. at 323. Liability is *not* established when experts simply opine that patients "could be more appropriately served" (Pl.'s Br. at 33 (citing consultants' declarations)). Plaintiff cannot meet the Youngberg standard necessary to overcome the presumption of validity and, consequently, cannot demonstrate a basis for the intrusive relief that it seeks.

(b) The State's Exercise of Professional Judgment Is Presumptively Valid, and Plaintiff Cannot Establish a Constitutional Violation.

Plaintiff is unlikely to succeed on its substantive due process claim because the hospitals provide care and safety to their patients that meet the constitutional standard set forth in Youngberg. The patient care and safety provided at the hospitals, at the very least, demonstrate the exercise of professional judgment that is presumptively valid and aligned with contemporary, accepted professional judgment, practice, or standards. (Shelp Decl. ¶ 7; Manning Decl. ¶ 10.)

Plaintiff's representations that "the State concedes that it does not provide care and safety that is consistent with generally accepted professional standards" and "that it systematically violates the Constitution in each [of the four priority areas] at each of the hospitals" are refuted by the very exhibit that Plaintiff cites (Pl.'s Br. at 24-25 (citing Ex. 21).) The cited audit shows that the State's efforts to

improve treatment and conditions at the hospitals beyond the constitutional minimum are "in process." (Pl.'s Br. Ex. 21 [dkt. 55-24].) *Nothing* on the face of the audit even remotely suggests that the hospitals currently provide patient care and safety that are such a "substantial departure" from prevailing standards of practice to demonstrate that the care and safety provided was not based on accepted professional judgment at all. See Youngberg, 457 U.S. at 323. Instead, the audit measured the hospitals' level of compliance with more stringent, results-based performance measures, which in some areas were based on newly-issued policies. (Manning Decl. ¶¶ 22-27; see also id. ¶¶ 18-19.) The State should not be punished for trying to achieve patient care and safety standards that are above and beyond the constitutional minimum threshold. And the Court should reject Plaintiff's improper attempt to rely on the State's self-audit (which measures performance against the higher standards) to argue that the State fails to meet the minimal constitutional standard in Youngberg and the Settlement Agreement.[11]

Plaintiff's and its consultants' laundry list of isolated incidents, occurrences, and conditions across a broad spectrum of areas, followed by the conclusion that they "pos[e] an immediate and serious threat to the life, health, and safety of

[11] The Settlement Agreement adopts the Youngberg standard. (Settlement Agreement [dkt. 7-2] § II.B.) Because the State of Georgia satisfies the Youngberg standard, it cannot be in breach of the Settlement Agreement.

individuals in the hospitals" (Pl.'s Br. at 31), albeit tragic, does not show a substantial departure from accepted professional judgment and consequently does not prove a constitutional violation. See Williams v. Wasserman, 164 F. Supp. 2d 591, 619 (D. Md. 2001) ("It is true, and unfortunate, that the representative plaintiffs suffered injuries while they were hospitalized. Those injuries, however, do not necessarily indicate a constitutional violation."). While Plaintiff's consultants' conclusions reflect a difference of professional opinion, they do not establish a *prima facie* case that Defendants have violated the Youngberg standard. See Johnson v. Murphy, 2001 U.S. Dist. LEXIS 24013, at *54-55 (M.D. Fla. June 28, 2001); Williams, 164 F. Supp. 2d at 619; United States v. Oregon, 782 F. Supp. 502, 513 (D. Or. 1991).

The relevant incidents cited by Plaintiff and its consultants demonstrate Plaintiff's dated and aggressive advocacy, but they do not show any violation of the U.S. Constitution or the Settlement Agreement. Specifically, the Declaration of Carla Jo Osgood cites 30 incidents at the hospitals, but only 8 of those patient injuries post-date the Settlement Agreement. (Pl.'s Br. Ex. 17 [dkt. 55-20], Osgood Decl. ¶¶ 14-43.) Each of the 8 post-Settlement Agreement incidents that Ms. Osgood cites has been corrected or ameliorated, leaving no individual at risk of suffering immediate harm or injury. (Id. ¶¶ 39-40.) Moreover, many, if not all,

of those incidents did not amount to the embellished description offered by Ms. Osgood. (Id. ¶ 41.) And there is no record of Ms. Osgood's repeated claim of warning hospital staff about the risk associated with the type of beds then in place at the hospital (which have since been replaced). (Id. ¶ 40(e).)

In sum, the 8 post-Settlement Agreement incidents cited by Ms. Osgood (taken individually or collectively) do not suggest that any patient is under threat of immediate harm, do not evidence a substantial departure from accepted professional standards, and therefore do not establish a constitutional violation or a basis for injunctive relief.[12] (Id. ¶¶ 35, 40-41; Shelp Decl. ¶ 58.) At best, Plaintiff's consultants simply disagree with the level of care provided. That is not grounds for this Court to find a constitutional violation.

(c) Plaintiff's "Expert" Testimony Is Unreliable and Does Not Establish an Absence of Professional Judgment.

Beyond being factually insufficient, Plaintiff's consultants' declarations are entitled to little, if any, weight. Expert testimony is a necessary element of Plaintiff's proof in applying Youngberg, but giving credence to that testimony at this stage of the litigation—before discovery and sufficient testing of the expert's conclusions—is particularly precarious. See Ozinga Chicago Ready Mix Concrete,

[12] Additionally, Ms. Osgood has not visited Georgia Regional Hospital in Atlanta or Northwest Georgia Regional Hospital since 2007, nor has she ever visited Southwestern State Hospital. (Manning Decl. ¶ 38.)

Inc. v. City of Chicago, 209 F. Supp. 2d 917, 918 (N.D. Ill. 2002) ("We are reluctant, however, to get deeply involved with the merits when those matters are still subject to discovery and are affected by threshold issues, such as Daubert attacks on the City's experts and the relevance of post-enactment evidence, that have yet to be fully briefed and decided."); see also Oregon, 782 F. Supp at 513.

Based on the evidence currently compiled, Defendants anticipate raising a challenge pursuant to Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993), as this case proceeds. The testimony of Plaintiff's consultants does not satisfy Daubert's requirements of competence, reliability, and relevance.[13] 509 U.S. at 590-91; see also Kumho Tire Co. v. Carmichael, 526 U.S. 137, 141 (1999); Gen. Elec. Co. v. Joiner, 522 U.S. 136, 146 (1997). Plaintiff's consultants fail to identify the applicable professional standards, but instead apply their own subjective and idealistic political philosophy as to what they personally believe should exist, rather than what health care professionals believe is necessary to meet accepted professional standards. See Viterbo v. Dow Chem. Co., 646 F. Supp.

[13] The Supreme Court in Daubert explained that Federal Rule of Evidence 702 allows the admission of expert testimony only if: (1) the expert is competent and qualified to testify regarding the matters that he intends to address; (2) the methodology by which the expert reaches his conclusions is sufficiently reliable; and (3) the expert, through scientific, technical or specialized expertise, provides testimony that assists the trier of fact to understand the evidence or determine a fact in issue. 509 U.S. at 590-91.

1420, 1425 (E.D. Tex. 1986) (finding that testimony suggesting a "better" course of treatment did not establish a substantial departure from professional judgment).

Plaintiff's consultants' opinions are also unreliable because they are based on anecdotal stories and isolated incidents that do not rise to the level of a constitutional violation. Pennsylvania, 902 F. Supp. at 589 ("[I]solated examples of problems, while regrettable, do not establish constitutional violations.") (citing Shaw v. Strackhouse, 920 F.2d at 1143); Society for Good Will, 737 F.2d at 1245 ("Isolated instances of inadequate care, or even of malpractice, do not demonstrate a constitutional violation."); cf. Church, 30 F.3d 1332, 1345 (11th Cir. 1994). Indeed, reliance on anecdotal case studies and incident reports appears to have been uniformly rejected by courts because they lack indicia of scientific reliability, methodology, or validation required by Daubert. See, e.g., Allison v. McGhan Med. Corp., 184 F.3d 1300, 1316 (11th Cir. 1999); Siharath v. Sandoz Pharms. Corp., 131 F. Supp. 2d 1347, 1361-62 (N.D. Ga. 2001) (Thrash, J.) (sampling cases that have rejected case studies as too unreliable to satisfy the strictures of Daubert), aff'd sub nom. Rider v. Sandoz Pharms. Corp., 295 F.3d 1194 (11th Cir. 2002).

Moreover, standing alone, Plaintiff's consultants' use of the "magic words" of "substantial departure" (see, e.g., Pl.'s Br. at 26 (citing declarations)) does not meet the rigorous analysis required by Daubert. See Dolihite v. Maughon *ex rel.*

Videon, 74 F.3d 1027, 1046 n.33 (11th Cir. 1996) ("[A]n expert opinion which is merely conclusory, even if couched in the language of the relevant legal standard, will be of little assistance to a court."); Siharath, 131 F. Supp. 2d at 1373 ("[I]t appears that [the plaintiff's proposed experts'] 'testimony is based more on personal opinion than on scientific knowledge,'" and thus nothing more than "educated guesses dressed up in evening clothes.") (citations omitted); see also Navarro v. Fuji Heavy Indus., 117 F.3d 1027, 1031 (7th Cir. 1997); Viterbo v. Dow Chem., Inc., 826 F.2d 420, 424 (5th Cir. 1987); Rogers v. Evans, 792 F.2d 1052, 1062 n.9 (11th Cir. 1986); Cartwright v. Home Depot U.S.A., Inc., 936 F. Supp. 900, 905 (M.D. Fla. 1996). Plaintiff's consultants' testimony consequently should be afforded minimal weight, if any, and their testimony is insufficient to overcome the presumptively valid judgment of the State's professionals.

2. Plaintiff Cannot Show a Likelihood of Success on Its ADA Claim Because the VCA Addresses ADA Compliance; Plaintiff Cannot Establish a Violation of the ADA; and the Relief Plaintiff Seeks Would Result in a Fundamental Alteration of the State's Mental Health Program.

Title II of the ADA, which applies to public services furnished by governmental entities, provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to

discrimination by any such entity." 42 U.S.C. § 12132. An "integration mandate" contained in the DOJ's regulations implementing the ADA states that services must be provided "in the most integrated setting appropriate to the needs of the qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

In Olmstead, the U.S. Supreme Court held that "unjustified isolation" can constitute discrimination under the ADA only "when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."[14] 527 U.S. at 587. If a state is found to have discriminated in such a manner, it must make reasonable modifications to resolve the discrimination, but its responsibility to provide community-based treatment options "is not boundless." Id. at 603. A modification is not reasonable (and thus not required) if it will impair a state's ability to (1) maintain a range of facilities for the care and treatment of persons with diverse disabilities and (2) administer services and apportion resources equitably across a broad spectrum of need. Id. at 603-06.

[14] Plaintiff ignores this language in Olmstead and argues that the input of treatment professionals is not required. (Pl.'s Br. at 14-15.) This contention cannot be reconciled with the plain language of Olmstead and further demonstrates the DOJ's attempt to test its new, expansive, and erroneous reading of the ADA.

Moreover, the ADA does not require a state to implement modifications that entail a "fundamental alteration" of the state's overall program for administering mental health services. Id. at 603-04; 28 C.F.R. § 35.130(b)(7) ("A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the services, program, or activity."). "[T]he fundamental-alteration component . . . allow[s] the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." Olmstead, 527 U.S. at 604.

Thus, to rebut *prima facie* evidence of discrimination under the ADA, a state may show that it is making a reasonable modification through its "comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that move[s] at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated." Id. at 605-06. Alternatively, a state may demonstrate that the relief sought amounts to a "fundamental alteration" of its program. Id. at 603-04; see Easley *ex rel.* Easley v.

Snider, 36 F.3d 297, 305 (3d Cir. 1994); Messier v. Southbury Training Sch., 1999 U.S. Dist. LEXIS 1479, at *36 (D. Conn. Jan. 5, 1999); Williams v. Wasserman, 937 F. Supp. 524, 531 (D. Md. 1996); Dees v. Austin Travis County Mental Health & Mental Retardation, 860 F. Supp. 1186, 1190 n.7 (W.D. Tex. 1994).

(a) The VCA Adequately Addresses the DOJ's Concerns and Controls the Timing and Manner of the State's Compliance with the ADA.

The VCA is an extensive document that requires the State, in collaboration with the OCR, to devise and implement a plan for coordinating the State's strategy for complying with the ADA, as interpreted by Olmstead. It mandates that the State have an "Olmstead Coordinator" to oversee the implementation of an "Olmstead Plan." (See VCA, art. I, § II(A).) The Olmstead Coordinator reports directly to the Governor. (Id.) The State also is required to create an "Olmstead Committee" to oversee the implementation of the Olmstead Plan and policies. (Id. art. I, § IV(B).) The State must create developmental disabilities and mental health "Olmstead Lists," which track consumers with those conditions and monitors their integration into the community. (Id. arts. II & III.)

The OCR is the designated agency charged with implementing application of Title II of the ADA to state health and human services programs. See 28 C.F.R. § 35.190(a)(3). As recently as February 18, 2010, State officials, including Dr.

Shelp and Georgia's Olmstead Coordinator, Mr. Janes, met with members of the OCR to assess Georgia's compliance and progress. (Shelp Decl. ¶ 22.)

Also discussed at the meeting were Georgia's strategies to address Olmstead issues under the VCA. Evidence of Georgia's success includes: (1) declining hospital censuses; (2) increased community capacity; (3) additional Medicaid waivers; (4) initiated housing plans; and (4) proposed legislation to further increase community services. (Shelp Decl. ¶¶ 15, 36-48.) Particularly at this early stage of the litigation, the evidence of Georgia's progress demonstrates that a significant and sufficient commitment to community integration and deinstitutionalization is "genuine, comprehensive, and reasonable." Bryson v. Stephen, 2006 U.S. Dist. LEXIS 71775, at *16, 24-25 (D.N.H. Sept. 29, 2006); see also The ARC of Washington State, Inc. v. Braddock, 427 F.3d 615, 621 (9th Cir. 2005); Sanchez v. Johnson, 416 F.3d 1051, 1067 (9th Cir. 2005).

The VCA addresses Plaintiff's concerns, and the State's efforts to comply with the VCA and implement its Olmstead Plan are ongoing. Moreover, Georgia's Olmstead strategy demonstrates that it is meeting the reasonable modification standard set forth in Olmstead itself: "If, for example, the State were to demonstrate that it had 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 not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met." 527 U.S. at 605-06; see Williams, 164 F. Supp. 2d at 638 (entering judgment in favor of state defendants on ADA claim after concluding that "[m]easured against the three to five year time frame, and considering the need to maintain a minimum number of hospital beds and also to fund placements for other persons in need of community treatment, the State's progress in placing members of the [] population into the community has been acceptable").

(b) Plaintiff Cannot State a Discrimination Claim Under the ADA, and Plaintiff Seeks Relief That Is Not Mandated by the ADA or *Olmstead*.

Plaintiff admits that its "Olmstead claim rests on the demand that [community-based treatment] services already in limited supply be made available in sufficient supply to enable individuals who are currently inappropriately segregated in an institution to be discharged from that setting into the community and provided appropriate services there." (Pl.'s Br. at 16-17.) Plaintiff insists that, irrespective of capacity, "meaningful numbers of individuals in the hospitals move out of their inappropriate institutional placements now." (Id. at 20 (emphasis in original).) Plaintiff also concedes that the immediate relief it seeks is a significantly increased appropriation of state dollars to build a larger network of

community-based services (based on an alleged immediate harm caused by the General Assembly's consideration of the State's budget). (Pl.'s Br. at 3; Tr. of 2/4/2010 Tel. Conf. [dkt. 61] at 21 (Mr. Mygatt's comments).)

Plaintiff's ADA claim and its remedial analysis are flawed in at least three ways. First, Olmstead does not require, as Plaintiff argues, statewide deinstitutionalization of all eligible disabled persons "now" or immediate creation of new community placements. See Conner v. Branstad, 839 F. Supp. 1346, 1357 (S.D. Iowa 1993) ("[I]f Congress had actually intended to require states to provide community based programs for mentally disabled individuals currently residing in institutional settings, it surely would have found a less oblique way of doing so."); see also Oregon, 782 F. Supp. at 514 ("[P]remature or inappropriate community placements would result in a much higher risk of potential harm than residents are exposed to at [the hospital].").

Second, the ADA does not require either of the remedies sought by Plaintiff—(1) creation of additional capacity for community-based services and (2) immediate discharge of patients from the hospitals "now." (Pl.'s Br. at 3, 20, 23.) With respect to the first remedy, Olmstead itself states that the ADA does not require states to "provide a certain level of benefits to individuals with disabilities"; instead, Olmstead holds only that "States must adhere to the ADA's

nondiscriminatory requirement with regard to the services *they in fact provide*." 527 U.S. at 604 n.14 (emphasis added). Consequently, an ADA claim cannot be based on an argument that the State must *create* new community-based programs or services. Plaintiff's second remedy—immediate discharge—also cannot be reconciled with the plain language of Olmstead: the "ADA is not reasonably read to impel State to phase out institutions, placing patients in need of close care at risk. Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting." 527 U.S. at 604-05. Thus, neither form of relief sought by Plaintiff is compelled by the ADA.

Third, Plaintiff's criticisms that the community-based services that the State currently provides are insufficient in both quantity and quality do not state a claim under the ADA. "[W]hile the plaintiffs offered evidence that community services and facilities could be different and in some instances better, they have failed to prove that the defendants' mental health program, as administered, results in unnecessary isolation of patients into segregated settings." Johnson, 2001 U.S. Dist. LEXIS 24013, at *55. In contradiction to Johnson (and the ADA), Plaintiff's ADA claim focuses on what modifications Defendants *could* make to improve their mental health program, but the evidence does not support a conclusion that the State's policies or practices are unjustified or discriminatory in violation of the

ADA. For example, Plaintiff contends that Georgia has "insufficient community and mobile crisis services in the State" and "[s]ystemic deficiencies in treatment, discharge, and transition planning," but Plaintiff's own consultants merely state that Georgia's community services could, in effect, be better, broader, and more numerous. (See Pl.'s Br. at 15.) Such aspirational desires, which are indeed shared by the State and all other mental health professionals, do *not* show that a state agency's community services are so inadequate as to violate the ADA.

(c) The Relief That Plaintiff Seeks Would Result in a "Fundamental Alteration" of the State's Mental Health System, Which Is Not Required by the ADA or *Olmstead*.

Even if this Court were to find that the ADA allowed the remedies sought by Plaintiff (which it should not), imposing such mandates would require a fundamental alteration of Georgia's mental health program, which is an impermissible result under the ADA and Olmstead. The fundamental alteration analysis must include a consideration of existing budgetary constraints and the competing demands of other services that the state provides, including the maintenance of institutional care facilities. See Olmstead, 527 U.S. at 597, 605.

Funding for community-based treatment and services already constitutes the majority of State spending on mental health and developmental disabilities. (Shelp Decl. ¶ 14.) Ideally, more can always be done, but the reality is that states must

make difficult decisions when allocating necessarily limited resources, as the Supreme Court's Olmstead decision recognized in 1999, when there were not severe state budget constraints. 527 U.S. at 587 (recognizing the need to "tak[e] into account the resources available to the State"). "The ADA [does not] require states to raise, appropriate, and spend whatever amount is necessary to immediately afford all qualified disabled persons community-based services, without regard to other needs and spending priorities." Bryson, 2006 U.S. Dist. LEXIS 71775, at *24-25; see Williams, 937 F. Supp. at 531 (finding that courts may not require states to transfer millions of dollars from institutions to the community); Conner, 839 F. Supp. at 1358-59 (refusing to order a state to create or expand community programs currently in existence).

The "immediate relief" that Plaintiff seeks "would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." Olmstead, 527 U.S. at 604. Forced reallocation of millions of dollars to create new community services would adversely impact the funding of services for other individuals with disabilities in the State. Hospitals must remain for, at a minimum, the forensic population that the State is obligated to treat. (Shelp Decl. ¶¶ 10, 49.) Absent increased funding—which Plaintiff has failed to demonstrate is immediately available—the State

cannot immediately shift even more resources from hospitals to community-based programs without also compromising the State's ability to provide necessary mental health services to other persons who depend on the State and may require hospitalization.

Plaintiff's requested relief is unreasonable and inequitable given the demands of the State's mental health budget and resources and would alter the essential nature of the State's service. Accordingly, the State cannot be required to make the modification that Plaintiff seeks. See Bryson, 2006 U.S. Dist. LEXIS 71775, at *24-25 (entering judgment in favor of state defendants on ADA claim and finding that an immediate forced expansion of New Hampshire's Medicaid waiver program and "a concomitant appropriation of the necessary state funds, sufficient to promptly include all class members in the [ ] program, would fundamentally alter the nature of the program"); Williams, 164 F. Supp. 2d at 638 (entering judgment in favor of state defendants on ADA claim because "[t]he immediate shift of resources sought by plaintiffs would have resulted in a fundamental alteration of the State's provision of services within the meaning of Olmstead"); see also ARC, 427 F.3d at 621 (rejecting the plaintiffs' integration mandate challenge because requiring the state to seek an increase in its Medicaid

waiver program cap would amount to a fundamental alteration of the state's programs); Sanchez, 416 F.3d at 1067 (same).[15]

Finally, Plaintiff's desire to increase community-based treatment with no consideration for and to the exclusion and detriment of the hospitals is counterproductive to the Settlement Agreement, the aim of which is to improve the hospitals. By filing this motion and the proposed Amended Complaint, Plaintiff seeks to rewrite the Settlement Agreement and short-circuit the State's VCA with the OCR. Even beyond violating the letter and spirit of the Settlement Agreement, the immediate relief that Plaintiff seeks would do far more harm than good by haphazardly attempting to implement the second issue (improved community placement) while diverting precious time and resources away from addressing the necessary first issue (hospital improvements). The Court should deny Plaintiff's motion and reject Plaintiff's invitation for the Court to assume the management of the State's mental health system.

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[15] There is no evidentiary support for Plaintiff's conclusory statement that "[p]roviding services to support a person . . . living in the community costs substantially less than providing services in an institutional setting." (Pl.'s Br. at 22.) Overall, the State does not experience significant net cost savings as a result of moving disabled persons out of the hospitals and into the community. (Shelp Decl. ¶ 49.) See also Olmstead, 527 U.S. at 604 (quoting the United States' own explanation in its Olmstead *amicus curiae* brief that "a 'State . . . may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions'").

3. Plaintiff Is Not Entitled to the Extensive Injunctive and Reformative Relief That It Seeks.

Even if, assuming *arguendo*, Plaintiff could state a claim for relief under the Fourteenth Amendment or the ADA, CRIPA limits the remedies that Plaintiff can obtain in this case. The CRIPA statutes provide that the DOJ may initiate an action only for "such equitable relief as may be appropriate to insure the *minimum corrective measures* necessary to insure the full enjoyment" of constitutional rights, privileges, and immunities. 42 U.S.C. § 1997a(a) (emphasis added); Messier v. Southbury Training Sch., 916 F. Supp. 133, 137-38 (D. Conn. 1996) (contrasting the types of relief available to private plaintiffs with the Attorney General's right under CRIPA to seek only "minimum corrective measures").

In its motion, Plaintiff requests the following relief: (1) an order requiring that Defendants "promptly take such steps as are necessary to ensure that all individuals in the hospitals and those at risk of admission to the hospitals are served in the most integrated community settings appropriate with appropriate services, supports, and other necessary resources made available"; (2) an order requiring Defendants to "promptly place in the most integrated setting in the community and provide with appropriate services all those individuals in the hospitals who can be served in the community and who do not oppose such a placement"; (3) appointment of a monitor, paid for by the State; and (4) within 30

days, the adoption of an "Action Plan" with specific timetables within which Defendants must achieve "reduction of the census of the hospitals" through "closure of Hospital beds" and increased placements in community settings. (Pl.'s Br. at 35-40.) These requests clearly demonstrate that Plaintiff is not seeking "minimum corrective measures," but rather to expand Georgia's mental health system beyond what is minimally required by the ADA and the Constitution. Plaintiff impermissibly seeks to usurp the functions of state officials and reduce them to "mere functionaries in carrying out the court's commands." Newman v. Alabama, 683 F.2d 1312, 1320 (11th Cir. 1982). Such relief is not authorized by CRIPA (or the ADA, see supra Part II.A.2(b)), and Plaintiff consequently cannot show a likelihood of success on either of its claims for relief.

Plaintiff's failure to establish substantial likelihood of success on the merits on either cause of action upon which it bases its motion is especially important here because Plaintiff seeks mandatory injunctive relief. This failure requires denial of the motion without even considering the remaining three prerequisites. See Church, 30 F.3d 1332, 1342 (11th Cir. 1994); Penthouse Int'l, Ltd. v. Webb, 594 F. Supp. 1186, 1198 (N.D. Ga. 1984) (Shoob, J.).

B. Plaintiff Has Not Demonstrated Any Actual and Imminent Irreparable Harm for Which a Preliminary Injunction Must Be Issued To Prevent.

Even if Plaintiff could establish a substantial likelihood of success on the merits, which it cannot, the absence of irreparable injury makes the preliminary injunctive relief it seeks improper. See Siegel, 234 F.3d at 1176 ("Significantly, even if Plaintiffs establish a likelihood of success on the merits, the absence of a substantial likelihood of irreparable injury would, standing alone, make preliminary injunctive relief improper."). A showing of irreparable injury is "the *sine qua non* of injunctive relief." Id. (quoting Ne. Fla. Chapter, 896 F.2d at 1285). It is also a requirement of the Settlement Agreement.

1. The Constitutional and Statutory Claims Asserted by Plaintiff Do Not Raise Immediate and Irreparable Harm.

Notwithstanding the indispensability of showing irreparable harm, Plaintiff contends that mere *allegation* of a constitutional infringement suffices, and "no further showing" should be necessary. (Pl.'s Br. at 32.) This contention, however, directly contradicts binding Eleventh Circuit precedent. In response to the exact same argument, the Eleventh Circuit has cautioned that even a *violation* of constitutional rights does not automatically constitute irreparable harm.[16] See

[16] "The only areas of constitutional jurisprudence where [the Eleventh Circuit has] said that an on-going violation may be presumed to cause irreparable injury

Siegel, 234 F.3d at 1177 ("Plaintiffs also contend that a violation of constitutional rights always constitutes irreparable harm. Our case law has not gone that far, however.").

Instead, the Eleventh Circuit has stressed that one who seeks a preliminary injunction must present facts that show a "real and immediate" threat of substantial, irreparable harm before a federal court will intervene. O'Shea v. Littleton, 414 U.S. 488, 494 (1974); see also Church, 30 F.3d at 1337 ("[A] party has standing to seek injunctive relief only if the party alleges, and ultimately proves, a real and immediate—as opposed to a merely conjectural or hypothetical—threat of future injury."). "[T]he asserted irreparable injury must be neither remote nor speculative, but actual and imminent." Siegel, 234 F.3d at 1176 (citations and internal quotations omitted).

Plaintiff cannot show the constitutional harm required in Youngberg. So it relies on the ADA to provide a basis for its claim of immediate harm. Such reliance, however, is misplaced for two reasons. First, Plaintiff cites no authority for the proposition that the harm of discrimination under the ADA (the underpinning of any Olmstead claim) provides any basis for the type of immediate

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involve the *right of privacy* and *certain First Amendment claims* establishing an imminent likelihood that pure speech will be chilled or prevented altogether." Siegel, 234 F.3d at 1178 (emphasis added and citations omitted).

and extraordinary relief sought in this compressed time frame. Second, that Plaintiff now has different policy preferences or an enhanced sense of immediacy than it did before January 2009 does not alleviate its burden of demonstrating irreparable harm. The only irreparable harm that Plaintiff has alleged in its discussion of this factor is that "[m]any, if not the majority of the individuals in the hospitals are institutionalized when they *could be more appropriately served* in a community-based setting." (Pl.'s Br. at 33 (emphasis added).) Preliminary injunctions, however, are an inappropriate instrument for addressing policy aspirations such as how one can be "more appropriately served"; preliminary injunctions are appropriate only to prevent irreparable harm that is "actual and imminent." Siegel, 234 F.3d at 1176.

Notably, the alleged injury caused by lack of community placements, is covered by the VCA, and the process of implementing the VCA's requirements is ongoing. The fact that Plaintiff's current view—that patients could be "more appropriately served in a community-based setting"—was specifically excluded from the Settlement Agreement cuts against Plaintiff's argument that the issue is now so important as to justify "extraordinary and drastic" preliminary injunctive relief. See, e.g., Ne. Fla. Chapter, 896 F.2d at 1285.

Furthermore, even if by some tortured interpretation the Settlement Agreement could be deemed to include the ADA/Olmstead community-treatment issues, in such case Plaintiff agreed that substantial compliance in this area is only required at the end of the five-year term. (Settlement Agreement [dkt. 7-2] § V.E.) The decision to allow the State five years to comply "undercuts the sense of urgency that ordinarily accompanies a motion for preliminary relief and suggests that there is, in fact, no irreparable injury." Tough Traveler, Ltd. v. Outbound Products, 60 F.3d 964, 968 (2d Cir. 1995) (citations and internal quotations omitted); see Ty, Inc. v. Jones Group, Inc., 237 F.3d 891, 903 (7th Cir. 2001) ("Delay in pursuing a preliminary injunction may raise questions regarding the plaintiff's claim that he or she will face irreparable harm if a preliminary injunction is not entered."); Palm Beach County Envtl. Coalition v. Florida, 587 F. Supp. 2d 1254, 1257 (S.D. Fla. 2008) (stating that delay in both seeking injunctive relief when the substantial issues were known to the plaintiffs and failure to timely serve defendants "belie[] plaintiffs' argument that there will be immediate injury absent injunctive relief"); Golden Bear Int'l, Inc. v. Bear U.S.A., Inc., 969 F. Supp. 742, 748 (N.D. Ga. 1996) (Camp, J.) ("Preliminary injunctions are issued to prevent imminent and inevitable injury to the movant, and undue delay 'speaks volumes about whether a plaintiff is being irreparably injured.'") (citation omitted).

The delay can best be explained as evidence of Plaintiff's true objective. Plaintiff's strategy of ignoring the Settlement Agreement and the VCA to test its new theory of the ADA and CRIPA is laid transparent by Plaintiff's proposed "Action Plan." (See Pl.'s Br. at 37-40.) That "Action Plan" and Plaintiff's request for a monitor to implement it relate entirely to the broad ADA/Olmstead issues of moving patients to a community placement and do not specifically address the four areas of choking and aspiration, suicide risk, patient assault, and emergency medical codes. (See id.)

2. Plaintiff's Alleged Systemic Violations Do Not Constitute Imminent Harm.

With regard to any actual and imminent issues of violence or death, Plaintiff has not alleged that any particular patient is in imminent danger.[17] If Plaintiff had done so, the State of Georgia would certainly move on its own accord without

[17] In fact, the proposal that Plaintiff seeks to be implemented immediately risks far more harm to patients in Georgia's psychiatric hospitals than do current actions of the State. The State of Georgia is actively working to develop additional community-based programs so that patients can be moved there. The fact, though, is that there are not yet enough such programs to accommodate all individuals on the Olmstead list, and the Olmstead decision itself recognizes the unrealistic nature of the immediate relief that Plaintiff seeks. 527 U.S. at 604-05 ("[T]he ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. *Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting . . . .*") (emphasis added); see also Oregon, 782 F. Supp. at 514 ("[P]remature or inappropriate community placements would result in a much higher risk of potential harm than residents are exposed to at [the hospital].").

delay to protect that patient, without requiring the intervention of this Court. On the issue of actual harm to any patient in the State's care, Plaintiff simply "takes us into the area of speculation and conjecture," O'Shea, 414 U.S. at 497, and does nothing but recite prior incidents, most of which occurred before the parties entered into the Settlement Agreement. Such incidents do not support imposition of a preliminary injunction:

> "[A] prospective remedy will provide no relief for an injury that is, and likely will remain, entirely in the past." Although "past wrongs are evidence bearing on whether there is a real and immediate threat of repeated injury, . . . [p]ast exposure to illegal conduct does not in itself show a present case or controversy regarding injunctive relief . . . if unaccompanied by any continuing, present adverse effects."

Church, 30 F.3d at 1337 (citations omitted). Because it is "wholly conjectural whether another occasion might arise," Plaintiff did not and cannot show "'sufficient immediacy and reality' to [its] allegations of future injury to warrant invocation of the jurisdiction of the District Court." O'Shea, 414 U.S. at 497.

Plaintiff's inability to show the type of "sufficient immediacy and reality" required for a preliminary injunction is borne out by the fact that the State of Georgia is addressing the four areas for which substantial compliance is currently expected pursuant to the Settlement Agreement. (Manning Decl. ¶¶ 14-19; Shelp Decl. ¶¶ 8, 58; Singh Decl. ¶¶ 6, 11, 48; Manning Decl. ¶¶ 11, 46.) Furthermore, in regard to Plaintiff's systemic policy redirection of more community treatment—

which it now asks this Court to impose notwithstanding no adjudication on the merits—the State itself is already moving in that direction at a more than reasonable pace. (Shelp Decl. ¶¶ 36-48.)

The State continues to welcome the opportunity to address the broader policy issues with both Plaintiff and the advocacy community in a collaborative, non-adversarial approach. This Court is an inappropriate forum for addressing these issues at this juncture. See 42 U.S.C. § 1997g (stating Congressional intent of CRIPA that conditions be corrected not just by litigation, "but also by the voluntary good faith efforts of agencies of Federal, State, and local governments"); see also id. § 1997a(a) (stating that DOJ may initiate an action only for "such equitable relief as may be appropriate to insure the *minimum corrective measures* necessary to insure the full enjoyment" of constitutional rights, privileges, and immunities) (emphasis added); Messier v. Southbury Training Sch., 916 F. Supp. 133, 137-38 (D. Conn. 1996).

In short, Plaintiff has not alleged imminent harm to any particular patient in Georgia's psychiatric hospitals. (See Manning Decl. ¶ 11.) Additionally, Plaintiff's broad policy redirection to encourage more community treatment does not meet the test for irreparable injury, and the issuance of an injunction on this basis would violate the admonition that preliminary injunctions must be "narrowly

tailored to fit specific legal violations, because the district court should not impose unnecessary burdens on lawful activity." Cumulus Media, Inc. v. Clear Channel Commc'ns, Inc., 304 F.3d 1167, 1178 (11th Cir. 2002) (citation omitted).

C. The Damage That an Injunction Will Cause the State of Georgia in Continuing Its Improvement of the State Mental Health System Far Outweighs the Threatened Injury to Plaintiff.

The balancing of the equities weighs greatly in favor of the State of Georgia. First, in balancing the hardships, a court should consider whether the injunctive relief being sought is prohibitory or mandatory, as is the case here. See generally 11A Charles Alan Wright, Arthur R. Miller & Mary Kay Kane, Federal Practice & Procedure § 2948.2 (2d ed. 1995 & Supp. 2009). As previously noted, "[o]nly in rare instances is the issuance of a mandatory preliminary injunction proper." Harris, 596 F.2d at 680. "Mandatory preliminary relief, which goes well beyond simply maintaining the status quo *pendente lite* is particularly disfavored, and should not be issued unless the facts and law clearly favor the moving party." Martinez v. Mathews, 544 F.2d 1233, 1243 (5th Cir. 1976). In addition, where, as here, the preliminary injunction would give Plaintiff all or most of the relief to which it would be entitled if it were successful at trial on the merits, preliminary relief may be "excessively burdensome." Wright & Miller, supra, § 2948.2. Plaintiff in this case is not simply seeking to stop the State of Georgia from

engaging in a particular activity, but rather seeks to use the Court's power to impose affirmative requirements on the State that reflect Plaintiff's newfound policy preferences for Georgia's mental health programs.

Indeed, Plaintiff admits that its motion and the relief sought are guided by its desire to affect the State budget process. (Pl.'s Br. at 3; Tr. of 2/4/2010 Tel. Conf. [dkt. 61] at 21.) See Taub v. Kentucky, 842 F.2d 912, 919 (6th Cir. 1988) ("A sovereign must have the authority to determine how tax revenues are to be spent, or the power to tax is illusory. Thus, state sovereignty extends to the total conduct of a state's fiscal affairs."); Dawson v. Childs, 665 F.2d 705, 709 (5th Cir. 1982) ("recogniz[ing] the need for judicial restraint in matters involving a state's fiscal affairs" and emphasizing that "[u]nder our federalist system, the state governments no less than the federal government possess certain inalienable powers that the other may not encroach upon") (citation omitted). Plaintiff here seeks what the Eleventh Circuit rejected in Newman: to make State officials "mere functionaries in carrying out the court's commands." 683 F.2d at 1320.

Second, even greater caution must be exercised when a government is involved, particularly when the injunction will require "'detailed and continuous supervision'" of the government's conduct. Brown, 187 F.2d at 24. In the mental health context specifically, the U.S. Supreme Court has warned that "interference

by the federal judiciary with the internal operations of these institutions should be minimized." Youngberg, 457 U.S. at 322. This is true for at least two reasons.

1. "Federal courts operate according to institutional rules and procedures that are poorly suited to the management of state agencies." Angela R. v. Clinton, 999 F.2d 320, 326 (8th Cir. 1993). Accordingly, courts "should refrain from micromanaging the state and its agencies." United States v. Missouri, 535 F.3d 844, 851 (8th Cir. 2008).

2. As the U.S. Supreme Court has cautioned, principles of federalism must be respected:

> Where, as here, the exercise of authority by state officials is attacked, federal courts must be constantly mindful of the "special delicacy of the adjustment to be preserved between federal equitable power and State administration of its own law" . . . . When the frame of reference moves . . . to a system of federal courts representing the Nation, subsisting side by side with 50 state judicial, legislative, and executive branches, appropriate consideration must be given to principles of federalism in determining the availability and scope of equitable relief.

Rizzo v. Goode, 423 U.S. 362, 378-79 (1976) (citations omitted). These principles apply when "injunctive relief is sought against . . . those in charge of an executive branch of an agency of state or local governments." Id. at 380.

Plaintiff contends that the balancing of the equities favors it because "[p]roviding services to support a person with mental illness living in the

community costs substantially less than providing services in an institutional setting." (Pl.'s Br at 33.) But, ironically, in Olmstead, the United States—Plaintiff in this case—alerted the Supreme Court to the fact that "a comparison so simple overlooks costs the State cannot avoid; most notably, a 'State . . . may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions.'" 527 U.S. at 604 (quoting Br. for U.S. as *Amicus Curiae* at 21).

Indeed, the Olmstead decision itself recognizes "the federalism costs inherent in referring state decisions regarding the administration of treatment programs and the allocation of resources to the reviewing authority of the federal courts," 527 U.S. at 610 (Kennedy, J. concurring), and consequently, respect should be granted to states to determine how best to provide appropriate community-based mental health programs "taking into account the resources available to the State and the needs of others with mental disabilities." Id. at 607 (plurality opinion). "It is of central importance, then, that courts apply [the Olmstead] decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers." Id. at 610 (Kennedy, J., concurring).

In violation of these principles, Plaintiff seeks to impose its particular policy preferences for more community treatment not through a collaborative process but through edicts from a monitor (whom Plaintiff additionally requests to be paid with State funds (see Pl.'s Br. at 36)), notwithstanding that (1) the Settlement Agreement the parties signed one year ago applies only to improving Georgia psychiatric hospitals; the VCA addresses Olmstead issues; and, more importantly, (2) Plaintiff itself admits that the federal Circuit Courts of Appeals "*have not settled on a single standard for determining what makes a proper Olmstead plan*." (Pl.'s Br. at 21 (citing Sanchez, 416 F.3d at 1051, and Frederick L. v. Dep't of Pub. Welfare of Pa., 364 F.3d 487 (3d Cir. 2004) (emphasis added).) See also Olmstead, 527 U.S. at 608-09 (Kennedy, J., concurring) ("It is a continuing challenge, though, to provide the care in an effective and humane way, particularly because societal attitudes and the responses of public authorities have changed from time to time.").

The two cases that Plaintiff cites in its admission of no single standard both underscore that "federal courts should accord deference to state policymakers' programmatic and political funding decisions regarding mental health funding." Frederick L., 364 F.3d at 493; see Sanchez, 416 F.3d at 1067 (quoting from Olmstead that "a State must have sufficient leeway 'to maintain a range of

facilities and to administer services with an even hand'"). "It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." Youngberg, 457 U.S. at 321; see also 42 U.S.C. § 1997i (stating that provisions of CRIPA "shall not authorize promulgation of regulations defining standards of care").

Finally, it is important to note that the typical purpose of a preliminary injunction is to preserve the *status quo* pending final determination of the lawsuit. Univ. of Tex. v. Camenisch, 451 U.S. 390, 395 (1981). As the former Fifth Circuit has emphasized, "the most compelling reason in favor of [granting a preliminary injunction] is the need to prevent the judicial process from being rendered futile by defendant's action or refusal to act." Canal Auth. of Fla. v. Callaway, 489 F.2d 567, 573 (5th Cir. 1974) (citing 11 Charles Alan Wright & Arthur R. Miller, Federal Practice & Procedure § 2947 (1st ed. 1973)). "[O]nly those injuries that cannot be redressed by the application of a judicial remedy after a hearing on the merits can properly justify a preliminary injunction." Canal Auth., 489 F.2d at 573. As Plaintiff would obtain the same relief after a trial on merits, the judicial process will not be rendered "futile" if a preliminary injunction is not granted. In contrast, granting a preliminary injunction would risk futility by giving Plaintiff all or most of the substantive relief it seeks on the merits. "[T]here is no power, the

exercise of which is more delicate, which requires greater caution, deliberation, and sound discretion, or more dangerous in a doubtful case than the issuing of [an] injunction." Miccosukee Tribe of Indians v. S. Fla. Water Mgmt. Dist., 280 F.3d 1364, 1371 (11th Cir. 2002) (quoting Truly v. Wanzer, 46 U.S. (5 How.) 141, 142 (1847)).

D. The Issuance of an Injunction at This Time Would Not Serve the Public Interest.

It is in the public interest that the State of Georgia should be allowed time to improve its mental health system, as it is currently, by employing its expertise of the best way to allocate resources without harming the multitude of other social services programs run by the State, including services for the elderly, public education, child care regulation, public health, disability programs, child support enforcement, and foster care. Cf. Olmstead, 527 U.S. at 612-13 (Kennedy, J., concurring) ("Grave constitutional concerns are raised when a federal court is given the authority to review the State's choices in basic matters such as establishing or declining to establish new programs."). See generally Donald L. Horowitz, Decreeing Organizational Change: Judicial Supervision of Public Institutions, 1983 Duke L.J. 1265, 1305 ("Even if new funds are appropriated, that impact may have costs elsewhere.").

First, a preliminary injunction will eliminate the opportunity for the newly created DBHDD and its Commissioner, Dr. Shelp, to continue implementing their plan of innovative problem solving needed to guide a complex and intricate system. Dr. Shelp has taken great strides to improve the State's mental health system and is already developing and implementing policies that aim to transition patients to community placements. (See generally Shelp Decl.) Dr. Shelp should be allowed to continue this program without Plaintiffs' interference at this early stage of the litigation and in the beginning of his tenure as Commissioner.

In similar cases, district courts in this Circuit have allowed government officials to continue their programs without the heavy hand of federal oversight. For example, in the class action challenge to Georgia's child welfare system during the past decade, Judge Shoob refused to grant a preliminary injunction and impose a monitor on the State of Georgia, emphasizing that the then-new Department of Human Resources Commissioner should be allowed the opportunity to direct the improvements himself:

> The Court concludes that, at this time, the requested preliminary injunction will not serve the public interest and *may actually cause more harm than good*. The Court is impressed with the dedication and competence of Commissioner Martin. *He has headed DFCS for just over a year and should be given an opportunity, without mandate from this Court, to do what he says he will do*.

Kenny A. v. Barnes, 1:02-CV-1686-MHS, slip op. at 5 (N.D. Ga. Dec. 12, 2002) (emphasis added).[18] Likewise, in the 1970s class action challenge to conditions in Georgia prisons, Judge Alaimo did not appoint a monitor until after consent decrees were entered. See Guthrie v. Evans, 93 F.R.D. 390, 392 (S.D. Ga. 1981) (Alaimo, J.) (discussing appointment of monitor following consent decree).

Second, Dr. Shelp is supported by many in the advocacy community, listens to their concerns, has the support of Governor Perdue, and is working diligently with the General Assembly to obtain and direct funding to rectify Plaintiff's concerns. There is no reason for a preliminary injunction to issue when the changes that Plaintiff seeks are being implemented by the DBHDD's Commissioner Dr. Shelp, who is the type of person that Plaintiff and advocates would want as a monitor, and by Dr. Singh, who is the exact person that Plaintiff recommended (and who has served as a monitor in other states). (Shelp Decl. ¶¶ 8, 10; Singh Decl. ¶ 4.)

Third, granting a preliminary injunction at this stage also would undermine the DBHDD's current efforts to hire and retain the most competent and highly

[18] Similarly, in the Fulton County Jail case, Foster v. Fulton County, Georgia, No. 1:99-CV-900-MHS (filed Apr. 8, 1999), Judge Shoob did not receive reports from the monitor until after final settlement by the parties. See R. Robin McDonald, Judge Orders Fulton to Fix "Disgraceful" County Jail, Fulton County Daily Report, Mar. 16, 2000 (noting monitor toured jail after final settlement was signed).

educated staff. The State of Georgia is concerned that if the Court intervenes at this stage—especially with intervention that results in a monitor—there will occur a downward spiral complicating the DBHDD's potential to improve mental health in Georgia. (Shelp Decl. ¶¶ 50-54, 57; Manning Decl. ¶¶ 44-46; Singh Decl. ¶¶ 48-50.) If a state agency cannot attract and hold quality employees, no federal court order can provide patients the treatment they deserve.

As discussed above, federal courts "must be constantly mindful of the 'special delicacy of the adjustment to be preserved between federal equitable power and State administration of its own law.'" Rizzo, 423 U.S. at 378 (quoting Stefanelli v. Minard, 342 U.S. 117, 120 (1951)). This Court in the past has understood and judiciously balanced this "special delicacy" and, along with the other district courts in this Circuit, has recognized that monitors typically should not be appointed until after final judgment or entry of a consent decree after settlement. See, e.g., Reynolds v. Ala. Dep't of Transp., 10 F. Supp. 2d 1263, 1267 (N.D. Ala. 1998) (discussing appointment of monitor after entry of consent decree); United States v. Bd. of Pub. Instruction, 977 F. Supp. 1202, 1227 (S.D. Fla. 1997) (same); Fambro v. Fulton County, 713 F. Supp. 1426, 1427 (N.D. Ga. 1989) (Forrester, J.) (discussing monitor's report following consent decree);

Mobile County Jail Inmates v. Purvis, 581 F. Supp. 222, 226 (S.D. Ala. 1984) (appointing monitor following finding of contempt).

In short, Georgia should be permitted to make improvements itself without the constraints of a preliminary injunction or a monitor directing its activities. That is exactly what Congress intended when, in enacting CRIPA, it stressed,

> [I]t is advisable to give States the primary responsibility for correcting unconstitutional conditions in their own institutions and to attempt to reach an agreement on the necessary remedies to correct the alleged conditions through informal and voluntary methods. Where the Attorney General recognizes that there are alternative courses of remedy by which the institution could correct the alleged conditions, it is the intention that the course generally be followed which is preferred by the institution itself. In the face of good-faith efforts by State and local officials to comply with the constitutionally required minima, the committee deems it preferable to give such officials the opportunity to fashion their own specific solutions.

S. Rep. No. 96-416, at 32 (1980); accord H. Rep. 96-897, at 13 (1980). Here, too, Dr. Shelp and the DBHDD should be afforded the opportunity to fashion their own specific solutions. What Dr. Shelp and the DBHDD need are time and resources to continue their program of building a continuum of care to best serve the people of Georgia in the most appropriate locations. Governor Perdue and the Georgia General Assembly are providing the resources, but Plaintiff's motion, if adopted, would deny Dr. Shelp and the DBHDD the critical time they need to improve Georgia's mental health system, would divert fiscal resources, and would imperil

the current progress made by the State in good faith compliance with the Settlement Agreement and the VCA.

CONCLUSION

For the reasons set forth above, Defendants respectfully request that the Court DENY Plaintiff's Motion for Immediate Relief (Preliminary Injunction).

Respectfully submitted, this 22nd day of February, 2010.

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Local Rule 7.1D Certification

By signature below, counsel certifies that the foregoing document was prepared in Times New Roman, 14-point font in compliance with Local Rule 5.1B.

/s/ Mark H. Cohen
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that the foregoing ***Defendants' Response in Opposition to Plaintiff's Motion for Immediate Relief (Preliminary Injunction)*** was electronically filed with the Clerk of Court using the CM/ECF system, which automatically serves notification of such filing to all counsel of record.

This 22nd day of February, 2010.

/s/ Mark H. Cohen
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