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

L.C., BY JONATHAN ZIMRING as guardian ad litem and next friend, Plaintiff,	)	CIVIL ACTION
v.	)	FILE NO. 1 95 CV 1210-MHS
TOMMY OLMSTEAD, Director of the Department of Human Resources, et. al.	)	

MOTION FOR A TEMPORARY RESTRAINING ORDER
AND PRELIMINARY INJUNCTION

Plaintiff hereby moves this Court for an Order restrainimg Defendant Richard Fields, in his official capacity as superintendent of Georgia Regional Hospital, from discharging Plaintiff from its legal custody pending a resolution of the issues pending in this case or taking any other action which would put Plaintiff at risk of further deterioration and regression or place her at risk of her personal safety. Plaintiff also moves this Court to prohibit the Defendants from making any statements, oral or written, which could discourage or prevent Plaintiff or her family from seeking and securing the services available or necessary to meet Plaintiff's needs.

Further, Plaintiff moves for an Order enjoining defendants Tommy Olmstead, Richard Fields, and Ernestine Pittman, all in their official capacities, from confining Plaintiff without the provision of minimally adequate habilitation to meet her needs as a mentally retarded adult, from failing to provide her with the services she needs, including residential, if appropriate, in a more integrated community setting, or discriminating against her as a disabled

(5)

individual.

Plaintiff has no adequate remedy at law available to her and her rights under the Americans with Disabilities Act and the Due Process Clause of the Fourteenth Amendment of the United States Constitution can be protected and preserved only by the issuance of an Order restraining the Defendants from continuing to violate these rights.

The Brief and Exhibits filed contemporaneously herewith support this Motion.

CERTIFICATE OF SERVICE

I certify that Defendants in the above-styled action have been served with a copy of the Motion for a Temporary Restraining Order and a Preliminary Injunction by depositing in the United States mail a copy of same in a properly addressed envelope with adequate postage thereon to:

Patricia Downing
Assistant Attorney General
132 State Judicial Building
40 Mitchell Street
Atlanta, Georgia 30334

Ms. Ernestine Pittman
Executive Director
Fulton County MH/MR/SA
Region 5
151 Ponce de Leon Avenue
Suite 108
Atlanta, Georgia 30308

This 30th day of May, 1995.

Respectfully submitted,

Susan C. Jamieson

SUSAN C. JAMIESON

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

L.C., by JONATHAN ZIMRING as guardian ad litem and next friend,

Plaintiff,

v.

TOMMY OLMSTEAD, Director of the Department of Human Resources; RICHARD FIELDS, Superintendent of Georgia Regional Hospital at Atlanta; and ERNESTINE PITTMAN, Executive Director of the Fulton County Regional Board, all in their official capacities,

Defendants.

CIVIL ACTION

FILE NO. 1 95 CV 1210

BRIEF IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

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BRIEF IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

In support of her motion for a temporary restraining order and for a preliminary injunction, Plaintiff shows the following:

I. INTRODUCTION

This case arises from the plight of L.C., a 27-year old woman who has been confined for three consecutive years in a state mental hospital. Before this admission, she had been admitted eighteen times and spent more than half of her life since she was fourteen in state psychiatric facilities. [See print-out dated June 16, 1994 of admission history from Georgia Regional Hospital at Atlanta (hereafter, GRH-A), Exhibit A] Although Plaintiff has a diagnosis of mental illness, at least three comprehensive psychological evaluations since 1986 have stressed her need for training and

habilitation to address her limitations as a mentally retarded adult. For at least the past year and one-half, the staff at the hospital have conceded that her mental illness has been sufficiently under control so that confinement in a mental hospital is unnecessary. More specifically, the staff have acknowledged that L.C. requires an appropriate community residential placement. This view is echoed by an expert clinical psychologist retained by Plaintiff, Dr. Cecelia Kimble.

This case was filed on May 11, 1995. Rather than provide L.C. with the appropriate services and treatment that everyone admits she needs, Defendant DHR abruptly released L.C. to her mother on May 19, 1995 on a "trial basis." Thus, L.C. remains in the state's legal custody. The state made this hasty decision without any provision for necessary supportive services despite L.C.'s long history of extreme difficulties living in the community without necessary and appropriate supports and three consecutive years in the hospital with very little family contact.

L.C.'s problems in the community have been most acute in the area of behavior management and crisis intervention. Yet, Plaintiff is unaware of any plans to address these and other individual needs arising from her developmental disabilities and her years of inappropriate confinement. She is further unaware of any acknowledgment of responsibility by defendants to provide staff and program support to L.C.'s family and/or to provide L.C. with a residential option in the event that her mother is unable to cope with L.C.'s many, significant needs. This is a serious concern

given the mother's past history. The mother has already shown that she lacks the skills to manage Plaintiff and that she relies on the hospital as the solution to behavioral problems. There has been no professional assessment of whether L.C.'s mother can presently manage if she had sufficient resources and support.

Over the past two months, GRH-A has encouraged L.C.'s mother to have her visit on weekends, provided that the mother pick up L.C. and return her to the hospital. The mother, however, has managed only two visitations. During the entire three years that L.C. has been in the hospital, her mother visited with L.C. only on holidays. In fact, GRH-A is so concerned about the mother's ability to properly care for L.C., that it has refused to make her the representative payee for L.C.'s disability checks.

L.C. has already suffered irreparable harm due to repeated instances of lengthy, inappropriate psychiatric confinement without mental retardation habilitation services. She sought judicial intervention as a last resort after she made every good faith effort to secure the services she needed. If the defendants are permitted to discharge L.C. from their legal custody without appropriate planning and services, L.C. will unquestionably suffer irreparable harm once again.

Plaintiff contends, first, that Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132 (Supp. 1993) and its implementing regulations at 28 C.F.R. § 35.101 et seq. (the "ADA") do not permit the state to keep her in an institution where she is segregated from the community unless segregation would be the most

effective way to provide her with the services she needs. Specifically, she bases her ADA claim on the requirement that public entities must provide services in the most integrated setting appropriate to the needs of the disabled. 28 C.F.R. § 35.130(d); Helen L. v. DiDario, 46 F.3d 325 (3rd Cir. 1995).

In addition to the ADA, Plaintiff relies on her substantive due process rights under the 14th Amendment to minimally adequate habilitation as determined by the exercise of qualified professional judgment. The current professional judgment of L.C.'s hospital treatment staff and other evaluators over the years has been consistent -- L.C.'s substantial needs for habilitation cannot be properly addressed in a psychiatric hospital. Although plaintiff does not assert a constitutional right to community services, she does contend that, once the state has involuntarily committed her, she is constitutionally entitled to minimally adequate treatment and habilitation based on the individual circumstances of her case. At a minimum that should include such training as is necessary to prevent deterioration of basic self-care skills and to remedy the detrimental effect of her years of inappropriate confinement. See Youngberg v. Romeo, 457 U.S. 307, 102 S. Ct. 2452 (1982); Thomas S. v. Morrow, 781 F.2d 367 (4th Cir.), cert. denied, 476 U.S. 1124, and cert. denied, 479 U.S. 869 (1986).

II. STATEMENT OF FACTS

Plaintiff is an attractive, sociable 27 year old woman who has lived more than half of her life since age 14 in psychiatric

hospitals, admitted generally as a result of threatening behavior, assaults, or a general inability to care for herself. (Affidavit of Cecelia Kimble, Ph.D., Exhibit B, Par. 9) She has been diagnosed with schizophrenia and moderate mental retardation and has many cognitive and adaptive limitations, placing her in the equivalent range of a 5 year old or below in many areas. (Exhibit B, Par. 16-21)

Because of her mental disabilities, she has experienced great difficulties in her life, most of which result from her behavior when she is frustrated, fearful, or unable to understand. (Exhibit B, Par. 25, 30) There is also an early reported history of alcohol abuse by her mother and other problems in the home during L.C.'s childhood. Plaintiff has not lived at home for more than very brief periods since she began a long history of hospitalizations as a young teenager. Her first documented admission to GRH-A in 1980 was to the adolescent unit. After more than a year, she was released. Seven months later, she was readmitted and held four months. She was released and readmitted three months later. This time she was hospitalized for another seven months and discharged. By age 17, the pattern of psychiatric confinement was well established. Hospitalizations were sometimes for a few days but more often five or six months and then, in 1988, she was confined for more than two years. The intervals between hospitalizations varied from a few days to nine months. (Exhibit A)

The longest interval (nine months from June, 1991 to March, 1992) was the only period when, after persistent advocacy on her

behalf, she was provided with a community service placement with some supports. Beginning in March of 1992, she began to experience an acute phase of her mental illness and to engage in some aggressive and threatening behaviors. The episode has been attributed to stress, related to a conflict with community staff. Her community service provider felt that more resources were needed to serve L.C. appropriately, at least in her first year or so out of an institution and L.C., herself, felt that she should return to the hospital. Her community placement slot was lost, and no additional resources were provided (or sought) to assist that particular provider.

Plaintiff's current hospitalization began with her admission to Georgia Regional Hospital at Atlanta on May 11, 1992. She has resided in the hospital on the "treatment unit" since that date. (Exhibit B, Par. 10) On May 11, 1995, exactly three years later, this case was filed alleging that Defendants' confinement of Plaintiff violated certain statutory and constitutional rights. On May 19, 1995, eight days after the case was filed, Plaintiff was abruptly released to her mother on a two week "trial visit." On June 2, 1995, without returning to the hospital, GRH-A intends to "discharge" Plaintiff from its custody.

A principal theme apparent throughout her current hospitalization and reflected in both recent and earlier evaluations is that, although L.C. is considered to have a thought disorder, she does not need and should not be confined for any length of time in a mental hospital once the thought disorder has

stabilized. (Exhibit B, Par. 11, 23, 25, 26-37) For Plaintiff, whose ability to comprehend her environment is at an extremely low level, life at GRH-A is likely to result in regression or the development of additional maladaptive behavior. (Exhibit B, Par. 28) In fact, L.C. has both deteriorated and regressed at the hospital since her admission in 1992. (Exhibit B, Par. 29)

In January, 1986, when Plaintiff was 18 and confined at GRH-A, she was evaluated by the DeKalb County Health Department Developmental Evaluation Clinic. Ms. Bess Ligon, her current social worker at GRH-A, accompanied her. The evaluating psychologist concluded that she "would benefit from a structured, residential facility where she could be maintained on medication and involved in vocational training activities, such as an ICF/MR [intermediate care facility for mentally retarded]. If her maladaptive behaviors are able to be controlled, a community placement might be considered . . . . It would be more valuable to view her from a developmental rather than a psychiatric perspective." (Evaluation of DeKalb County Developmental Evaluation Clinic, Exhibit C)

In April, 1988, again at GRH-A, she was evaluated by the DeKalb Clinic and the evaluator reported that "[I]t was strongly felt that, since L.'s behavior continues to be self-destructive and she requires constant supervision, she needs to be referred to an ICF-MR facility . . . . This evaluator reiterates the statement made in the prior evaluation, that is, to 'treat her from a developmental rather than a psychiatric perspective.'" (Evaluation

of DeKalb County Developmental Clinic, Exhibit D) Plaintiff remained, however, in the mental hospital for two years after the evaluation (See Exhibit A), was released to an unstructured setting with no habilitation services, and was re-admitted to the hospital one month later where she remained for another year.

Dr. Cecelia Kimble, a clinical psychologist, in a recent evaluation, stated specifically that she concurred with the conclusion of the 1986 and 1988 evaluation teams that "it would be more valuable to view (L.C.) from a developmental rather than a psychiatric perspective." (Exhibit B, Par. 26, 37) Dr. Kimble was also emphatic that L.C. was at risk of deterioration and regression in her current circumstances and that her need for an appropriate, alternative was critical. (Exhibit B, Par. 28-37) Her opinion was and is that "a community based supervised living environment is definitely indicated for L.C.'s protection and basic well-being and to provide any possibility to acquire and maintain behaviors required for basic activities of daily living . . . . Any return to psychiatric hospitalization should be avoided if at all possible and, if required, be used only briefly for crisis intervention."

It has also been clear to L.C.'s current GRH-A staff that L.C. does not need to be in the treatment unit. Beyond stabilization of her thought disorder, L.C. has otherwise been treated only for behavior problems which the professional staff themselves associate with mental retardation. The focus of staff concern has been her need for appropriate placement. Her treating psychiatrist noted as early as June, 1993, that her thought processes had been organized

for the past month. (Exhibit B, Par. 10, 11) A social worker had already contacted mental retardation services in February of 1993, although there is no indication of a response. (Composite exhibit of portions of L.C.'s hospital records, Exhibit E-1) A community contact note indicates that, nevertheless, as of August, 1993, there was little, if any, focus on locating alternatives to inpatient psychiatric confinement. (Exhibit E-2)

By November of 1993, the nursing staff were indicating in L.C.'s medical records that L.C. was "stable medically and physically" and that the treatment challenge was to "maintain highest level of functioning until placement." (Exhibit E-3) She was considered to be at "baseline." (Exhibit E-4) In January of 1994, her physician expressed the obvious view of GRH-A staff that "placement <u>still</u> a problem". (Exhibit E-5) Mr. Brazee, Plaintiff's social worker was aware in November, when he assumed responsibility for her case, that it was the opinion of L.C.'s physician that she should not be hospitalized and that she remained at GRH-A solely because there were no alternative placements. (Affidavit of Randy Brazee, Exhibit F, Par. 11, 12) This was finally noted on the treatment plan as reflecting the consensus of the entire treatment team in June, 1994. (Exhibit B, Par. 10)

In the Fall of 1992, L.C. was notified that she was about to receive a lump sum social security disability payment and regular monthly checks in the amount of about $380.00 per month. The hospital applied to become her representative payee for all funds received and then applied the lump sum and each monthly check

thereafter towards the cost of her institutional care and a burial fund. Medicare coverage, to which L.C. was entitled, was never claimed until several months ago. (Composite exhibit of finance-related correspondence, Exhibit G)

Efforts to secure mental retardation services in connection with an alternative placement and other community services by the hospital staff have been fruitless. Mr. Brazee, recognizing a need for an appropriate placement and program for L.C. in the community that could provide supervision and habilitation for a person with L.C.'s limitations, initiated a prolonged correspondence on L.C.'s behalf which elicited either negative results or no responses at all. (Exhibit F, Par. 27-32 and attachments marked "Exhibits 1, 2, 3") As recently as April, 1995, Plaintiff's attorney submitted another request for mental retardation services and copies of previous evaluations to the Fulton County mental retardation evaluation team. (Exhibit H)

The reasons for maintaining L.C. in a psychiatric hospital contrary to the professional judgment of the patient's own treating staff are not clear other than what appears to be a persistent perception on the part of GRH-A staff that placing L.C. in the community would be difficult and one written response from a hospital administrator indicating that the state's "medicaid waiver" program for mentally retarded individuals is unavailable to persons in mental hospitals. (Exhibit F, Attachment 1) Both views are erroneous.

Although Plaintiff's staff are adept at the crisis management

of mental illness, they are not mental retardation professionals. (Exhibit B, Par. 27, 31, 32; Exhibit F, Par. 7, 8) In the words of Dr. Kimble, "GRH-A is appropriate for and intended only to be a 'holding' environment for crisis intervention and medication stabilization." (Exhibit B, Par. 27)

L.C.'s hospital record is replete with examples of staff's apparent lack of understanding that her abilities are limited and that she will not progress without appropriate community-based training designed for mentally retarded adults. Without an appropriate program, L.C. becomes frustrated and engages in the behaviors that have persistently interfered with her ability to live successfully with others. (Exhibit B, Par. 25-37) Also, there seems to be a lack of belief or understanding among GRH-A staff that community placements for persons with mental retardation would, necessarily, have structure and supervision and that mentally retarded persons with L.C.'s needs and behaviors can and do live outside institutions, even if they experience occasional mental health crises. (Affidavit of Michael Biggs, Exhibit I; Exhibit F, Par. 41)

Examples from L.C.'s hospital record reflect this lack of experience with her limitations and behavior and with the types of behavioral programs that L.C. needs. With reference to a "communications group," the group leader observes that "as the group progressed, L. became fidgety, moving around the room, no longer wanting to participate in the group and asking to go smoke cigarettes." (Exhibit E-6) "[S]he displayed much difficulty with

staying on topic . . . ." (Exhibit E-7) "[S]he can't seem to comprehend simple directions at times. Needs monitoring of ADL's [activities of daily living] daily." (Exhibit E-8) "[She has] difficulty in responding to this group leader's efforts to redirect her conversation." (Exhibit E-9) "At times able to follow structure and at other times L. seems unable to understand anything that is being said." (Exhibit E-10)

Her physician, almost a year after L.C.'s admission, comments, ". . . she cannot live in the community without structure. Will file for commitment". (Exhibit E-11) A few months later, he states, "Problem with L. is that she needs to work consistently for longer periods of time and at that point she would be ready to be in the community." (Exhibit E-12) "Needs constant structure. This is the main problem preventing from placing her. She has poor social skills. She becomes demanding and very intrusive. She could not attend social skills training." (Exhibit E-13) "Needs constant reminder to keep distance when talking to staff and peers. She remembers for some time and goes back to same thing . . . . Need constant reminder to keep her face clean . . . . Because of the above problem, placement becomes difficult." (Exhibit E-14) These staff comments show a sad lack of understanding that the behaviors L.C. exhibits are not unusual for a person whose abilities and maturity are comparable to a young child. They would be addressed in a program plan but they would certainly not be a barrier to living outside of a mental hospital.

The state <u>does</u> operate community programs for mentally

disabled individuals. ("Trends and Milestones," Mental Retardation. December, 1994, Exhibit J; excerpts from document showing state funding for mental retardation community services, Exhibit K; Exhibit I) The cost of institutional care for Plaintiff is at least $75,000.00 per year. The cost of an appropriate, supervised community placement operated by an individual with extensive experience with providing community residential services to persons with mental retardation is about one fourth that amount. (Exhibit I, Par.10)

III. ARGUMENT AND CITATION OF AUTHORITY

A. STANDARD FOR GRANTING A TEMPORARY RESTRAINING ORDER OR PRELIMINARY INJUNCTION

Under Fed. R. Civ. P. 65, Plaintiff is entitled to a a temporary restraining order or preliminary injunction if she demonstrates (1) a substantial likelihood of success on the merits; (2) a threat of irreparable injury if the TRO or preliminary injunction is not granted; (3) that such injury outweighs the harm that the TRO and preliminary injunction will cause to the Defendants; and (4) that the TRO and preliminary injunction are in the public interest. Ingram v. Ault, 50 F.3d 898 (11th Cir. 1995); Baker v. Buckeye Cellulose Corporation, 856 F.2d 167, 169 (11th Cir. 1988). As will more fully appear below, the Plaintiff meets these standards and is entitled to a temporary restraining order and a preliminary injunction in this case.

B. LIKELIHOOD OF SUCCESS ON THE MERITS

Plaintiff is substantially likely to succeed on the merits of

her claim that Defendants' involuntary confinement of her in the segregated institutional setting of a mental hospital, without appropriate treatment and contrary to the judgment of qualified professionals, violates her rights under the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq., and § 1983 of the Civil Rights Act.

1. DEFENDANTS ARE VIOLATING THE ADA BY SEGREGATING PLAINTIFF IN A STATE HOSPITAL THAT DOES NOT PROVIDE APPROPRIATE SERVICES

a. The ADA: Its Background, History, and Purpose

The ADA is a major and comprehensive civil rights law designed to address this country's history of rampant discrimination against the disabled. Congress recognized that discrimination against the disabled, often in the form of segregation and isolation, was a pervasive social problem. It therefore passed legislation, which in the words of the House Judiciary Committee, " . . . promises a new future: a future of inclusion and integration, and the end of exclusion and segregation." 1990 U.S.C.C.A.N. 445, 449.

Title II of the ADA states that:

> . . . [N]o 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. In passing this provision, Congress explicitly stated its purpose:

> To provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.

42 U.S.C. § 12101(b)(1)

The purpose of Title II of the ADA and its anti-discrimination provision were supported by strong congressional findings of wide-spread discrimination, segregation, and isolation of persons with disabilities with no legal recourse. Those findings were codified in the Act itself:

> (a) Findings
>
> The Congress finds that -
>
> (2) Historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;
>
> (3) Discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services;
>
> (4) . . . Individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;
>
> (5) Individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, . . . overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;
>
> (8) The Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals . . . .

42 U.S.C. § 12101(a)(2),(3),(4),(5) and (8) (Emphasis added).

The legislative history resolves any doubt that could possibly remain regarding the purpose of the ADA to prohibit segregation and

unnecessary institutionalization of the disabled. Numerous members of the House and Senate expressly stated their support for an end to discrimination against the disabled through passage of the ADA. For example, Senator Tom Harkin, floor manager of the ADA in the Senate, stated that the ADA "guarantees individuals with disabilities the right to be integrated into the economic and social mainstream of society; segregation and isolation by others will no longer be tolerated." 135 Cong. Rec. 19803 (1989) (Emphasis added). In a similar vein, Representative Collins put forth the "basic goal which runs through this landmark civil rights legislation: that goal is to fully integrate disabled Americans into all aspects of life in our country." 136 Cong. Rec. 11430 (1990) (Emphasis added). Congressman Miller recognized that "it has been our unwillingness to see all people with disabilities that has been the greatest barrier to full and meaningful equality. Society has made them invisible by shutting them away in segregated facilities." 136 Cong. Rec. 10877 (1990) (Emphasis added). Senator Kennedy argued that the ADA would put an end to this unnecessary segregation: "the Americans with Disabilities Act will end this American apartheid. It will roll back the unthinking and unacceptable practices by which disabled Americans today are segregated, excluded, and fenced off from fair participation in our society." 135 Cong. Rec. 8514 (1989) (Emphasis added).

Last, and perhaps most eloquently, former Senator Lowell Weicker, the original sponsor of the ADA and former Chair of the Senate Subcommittee on the Handicapped, testified before that

committee that the intent of the ADA was to end isolation, segregation, and discrimination:

> For years this country has maintained a public policy of protectionism toward people with disabilities. We have created monoliths of isolated care in institutions and in segregated educational settings. It is that isolation and segregation that has become the basis of the discrimination faced by many disabled people today. Separate is not equal. It was not for blacks; it is not for the disabled.

Americans with Disabilities Act Hearing Before the Senate Comm. on Labor and Human Resources and Sub-comm. on the Handicapped, 101st Cong., 1st Sess. 215 (1989) (Emphasis added).

Federal regulations implementing the ADA comport with the above legislative findings and history by providing that:

> A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

28 C.F.R. § 35.130(d) (1993) (Emphasis added). In mandating administration of services in "the most integrated setting", the Department of Justice has described that setting as one "that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. Part 35, App. A at 454. Furthermore, the Department of Justice has made clear that "[s]eparate, special, or different programs that are designed to provide a benefit to persons with disabilities cannot be used to restrict the participation of persons with disabilities in general, integrated activities." Id. at 452. Thus, the Department of Justice summarized the meaning and intent of the ADA implementing

regulations to prohibit exclusion and segregation:

> Taken together, these provisions are intended to prohibit exclusion and segregation of individuals with disabilities and the denial of equal opportunities enjoyed by others, based on, among other things, presumptions, patronizing attitudes, fears, and stereotypes of individuals with disabilities. Consistent with these standards, public entities are required to insure that their actions are based on facts applicable to individuals and not on assumptions as to what a class of individuals with disabilities can or cannot do.
>
> Integration is fundamental to the purposes of the Americans with Disabilities Act. Provision of segregated accommodations and services relegates persons with disabilities to second class status.

Id. at 451 (Emphasis added).

This commentary to the regulations is consistent with the report of the House Judiciary Committee which emphasized integrated services:

> As with Section 504 of the Rehabilitation Act, integrated services are essential to accomplishing the purposes of Title II. As stated by Judge Mansmann in ADAPT v. Skinner, "the goal [is to] eradicate the 'invisibility of the handicapped.'" . . . . Integration is fundamental to the purposes of the ADA.

House Report No. 485 at 50, 56 (Emphasis added).

As will be shown below, L.C. has been excluded, segregated, isolated, and discriminated against based upon her disability by the Defendants in violation of the express language of the ADA, the express language of the ADA's implementing regulations, and the express intent of the U.S. Congress summarized above.

b. L.C. Is a Qualified Individual With a Disability Within The Meaning Of The ADA, Is The Victim Of Discrimination By a Public Entity, And Has Been Discriminated Against Based Upon Her Disability

In order to prove a violation of Title II of the ADA, Plaintiff must demonstrate the existence of three elements: (1) that she is a "qualified individual with a disability"; (2) that she was the victim of discrimination by a public entity; (3) that such discrimination was by reason of a disability. See Concerned Parents to Save Dreher Park Center v. the City of West Palm Beach, 846 F. Supp. 986, 990 (S.D. Fla. 1994).

i. L.C. is clearly a qualified individual with a disability. The ADA defines a disability as "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such impairment; or (C) is regarded as having such an impairment." 42 U.S.C. § 12102(2)(A)-(C). L.C. is mentally retarded and suffers from schizophrenia which is presently controlled. She has verbally-mediated intellectual functioning below 40 and non-verbal functioning in the 60s. She is 27 years old with arithmetic abilities equivalent to a person five and one half years old and reading skills equivalent to a person six and one half to seven years old. (Exhibit B, Par. 17-21) She clearly suffers from a disability that substantially interferes with major life activities. She also has a long record of suffering from this impairment and has long been regarded as suffering from such an impairment. She is therefore an individual with a disability within the meaning of the Act.

L.C. is also a qualified individual under the ADA. Not only does she have a disability within the meaning of the Act, she clearly qualifies for the community services which she seeks in this case. See Martin v. Voinovich, 840 F. Supp. 1175, 1191-92 (S. D. Ohio 1993). (Persons with mental retardation or developmental disabilities who could participate in a community residential services program were considered qualified for such services under the ADA). As the attached affidavit of Dr. M. Cecelia Kimble, a clinical psychologist, illustrates, L.C. requires a supervised living environment outside the hospital with appropriate health, educational and vocational training. (Exh. B, Par. 35) Indeed, the Defendants have admitted on numerous occasions, as documented in L.C.'s medical records, that she needs an alternative community placement outside the hospital. Thus, by Defendants own admissions, L.C. is qualified for community-based treatment.

ii. Defendants Have Discriminated Against L.C. By Continuing To Institutionalize And Segregate Her In a Mental Hospital

The text of the ADA, its legislative history, and its implementing regulations as already discussed at length above in Section III (B)(1)(a) unequivocally establish a national mandate to end unnecessary segregation and institutionalization of persons like L.C. and to integrate such persons into society at large to the greatest extent possible. The Act, legislative history, and implementing regulations make equally clear that when Defendants fail to comply with this mandate, they commit discrimination.

Several court decisions have strongly affirmed the point that

unnecessary segregation is discrimination per se. The best example is the recent case of Helen L. v. DiDario, 46 F.3d 325 (3rd Cir. 1995) which concluded:

> Thus, the ADA and its attendant regulations clearly define unnecessary segregation as a form of illegal discrimination against the disabled. Accordingly, the district court erred in holding that the applicable provisions of the ADA 'may not be invoked unless there is first a finding of discrimination.'

Id. at 333.

Other decisions interpreting the ADA and its predecessor, § 504 of the Rehabilitation Act, have reached the same conclusion. See Halderman v. Pennhurst State Sch. and Hosp., 784 F. Supp. 215, 224 (E.D. Pa. 1992), aff'd, 977 F.2d 568 (3rd Cir. 1992) (Section 504 prohibits unnecessary segregation and requires reasonable accommodations to provide opportunities for integration); Coleman v. Zatechka, 824 F. Supp. 1360, 1373 (D. Neb. 1993) (in enacting the ADA, Congress "aimed to bring people with disabilities into society's mainstream, to cause the kinds of interaction which may facilitate recognition of the true equality of human worth as between individuals - regardless of disabilities."); Jackson v. Ft. Stanton Hospital and Training School, 757 F. Supp. 1243, 1299 (D. N.M. 1990), aff'd in part, rev'd in part on other grounds, 964 F.2d 980 (10th Cir. 1992) ("Where reasonable accommodations in community programs can be made, Defendants' failure to integrate severely handicapped residents into community programs . . . violates Section 504"); Homeward Bound, Inc. v. Hissom Memorial Center, 1987 WL 27104 at *20 (N.D. Okla. July 24, 1987) ("Section 504 prohibits

unnecessarily segregated services for retarded persons"). Ga. Association of Retarded Citizens v. McDaniel, 511 F. Supp. 126, 1280 (N.D. Ga. 1981) (state school superintendent's refusal to consider needs of handicapped children violates § 504)

Violation of the ADA does not require any proof of intent to discriminate. As noted recently by the Third Circuit in the DiDario case:

> [b]ecause the ADA evolved from an attempt to remedy the effects of "benign neglect" resulting from the "invisibility" of the disabled, Congress could not have intended to limit the Act's protections and prohibitions to circumstances involving deliberate discrimination. Such discrimination results from "affirmative animus" which was not the focus of the ADA . . . . Rather, the ADA attempts to eliminate the effects of that "benign neglect", "apathy", and "indifference" . . . . [T]he ADA make[s] clear that the unnecessary segregation of individuals with disabilities in the provision of public services is itself a form of discrimination.

46 F.3rd at 335. (Emphasis added). The language quoted by the DiDario court came from a Supreme Court decision construing the analogous Rehabilitation Act in which the Supreme Court noted that "[d]iscrimination against the handicapped was perceived by Congress to be most often the product, not of invidious animus, but rather of thoughtlessness and indifference - of benign neglect." Alexander v. Choate, 469 U.S. 287, 295 (1985); see also Concerned Parents, 846 F. Supp. at 991 ("Certainly intentional discrimination is banned by Title II. But further, actions that have the effect of discriminating against individuals with disabilities likewise violate the ADA." Emphasis in original.); Mayberry v. Von Valtier,

843 F. Supp. 1160, 1166 (E.D. Mich. 1994) ("Congress appears to have intended the ADA to address the discriminatory effects of benign action or inaction, as well as intentional discrimination.")

As noted above, the ADA prohibits only unnecessary segregation. Public entities may provide different services to persons with disabilities if "necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others." 28 C.F.R. § 35.130(b)(1)(iv)(1993) (Emphasis added). The Department of Justice which promulgated this regulation has indicated that this exception to the general rule of integration is a narrow one: "[s]eparate, special or different programs that are designed to provide a benefit to persons with disabilities cannot be used to restrict the participation of persons with disabilities in general, integrated activities." 28 C.F.R. Part 35, App. A at 452.

Furthermore, Defendants have the burden of showing that separate or segregated services are necessary to provide effective services. The state can do this only after making an individualized determination of L.C.'s needs. Id. As the Department of Justice has noted, "[t]he starting point is to question whether the separate program is in fact necessary or appropriate for the individual." Id. (Emphasis added).

The Defendants in this case cannot meet their burden. In fact, they have repeatedly acknowledged that L.C. no longer requires institutionalization and is eligible for a community placement. They have abjectly failed, however, to place her in a

residential supervised setting with appropriate services. They have therefore discriminated against L.C. within the meaning of the ADA.

Finally, Plaintiff is not required to show that she has been denied access to services as a disabled person that are available to the nondisabled. In other words, simply because Plaintiff seeks access to services that are available only to persons with disabilities does not alter the analysis. The key is the plain language of the ADA which prohibits unnecessary segregation and isolation of individuals with disabilities. That alone constitutes discrimination.

Thus, courts have rejected the argument that discrimination occurs only if disabled persons are denied services that are available to the nondisabled. DiDario, 46 F.3rd at 335 (" . . . the ADA make[s] clear that the unnecessary segregation of individuals with disabilities in the provision of public services is itself a form of discrimination within the meaning of those statutes, independent of the discrimination that arises when individuals with disabilities receive different services than those provided to individuals without disabilities."); Martin v. Voinovich, 840 F. Supp. 1175, 1191-92 (S.D. Ohio 1993).

In sum, by unnecessarily segregating and institutionalizing L.C., Defendants thereby discriminated against her within the meaning of the ADA.

iii. Defendants Have Discriminated Against Plaintiff Based Upon Her Disability

Plaintiff has established that Defendants have discriminated

against her under the ADA by unnecessarily excluding, segregating, and institutionalizing her. In order to prevail under the ADA, however, Plaintiff must also show that Defendants have excluded, segregated, and institutionalized her "by reason of [her] disability". 42 U.S.C. § 12132. Defendants have unquestionably done so.

L.C. has a mental illness, schizophrenia, and is mentally retarded. She has been institutionalized at GRH-A since 1992. GRH-A houses only persons with mental illness. By Defendants' own admissions, L.C. was hospitalized in 1992 by reason of her mental illness (schizophrenia). By Defendants' own admissions L.C.'s mental illness has been adequately controlled for at least one and one-half years. L.C., however, has remained hospitalized until the filing of this lawsuit and remains in state custody. L.C. undoubtedly has been forced to remain in the state's custody either by reason of her 1) mental illness or 2) her mental retardation, or 3) both. Otherwise, she would have been unconditionally released by GRH-A a long time ago.

For purposes of violating the ADA, it does not matter for which of the above three reasons L.C. is being held. If L.C. is being held for any of those reasons, she is clearly being held by reason of her disability. Consequently, under the ADA, she is being discriminated against based upon her disability.

Defendants may attempt to claim that Plaintiff remains at GRH-A because Defendants lack funds to place her in a proper community residential setting and provide her with the necessary treatment

and services. Such an argument would be legally and factually insupportable.

First, such an argument would really be nothing more than an argument that Defendants have not intentionally discriminated against L.C. Plaintiff has already noted in the previous Section III(B)(1)(a)(ii), however, that the ADA does not require an intent to discriminate.

Second, continued institutionalization based upon lack of funds has already been rejected by the DiDario case in the face of an ADA claim. 46 F.3d at 338.

Third, just as in DiDario, a claim of lack of funds would be factually insupportable. The approximate cost of placing L.C. in an appropriate community residential setting would be substantially less than the more than $75,000.00 spent each year to warehouse her at GRH-A.

It has long been the law of this circuit that a state may not fail to provide treatment for budgetary reasons alone. Wyatt v. Aderholt, 503 F.2d 1305, 1315 (5th Cir. 1974) As noted in the Wyatt case, "'[H]umane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations.'" quoting Jackson v. Bishop, 404 F.2d 571, 580 (8th Cir. 1968). See also Concerned Parents to Save Dreher Park Center v. City of West Palm Beach, 846 F. Supp at 993 and n. 15 ("The expenditure of funds cannot be considered a harm if the law requires it."); Kroll v. St. Charles County, 766 F. Supp. 744, 753 (E.D. Mo. 1991) (If county did not fund building improvements

required under the ADA within two months, the Court would consider the imposition of a property tax increase, or an injunction of a rollback of local taxes to assure funding for the improvements.)

These holdings are particularly pertinent to the ADA given the ADA's legislative history which acknowledged that the ADA would impose financial burdens on the states. As Senator Hatch stated, the ADA would

> impose a lot of expenses and rightly so. It is time we did these things. It is time we brought persons with disabilities into full freedom, economic and otherwise, with other citizens in our society. This bill will do that. In doing so, we should be aware that it is going to be costly and difficult and that there will be some complaints.

135 Cong. Rec. 19835 (1989). Senator Harkin echoed this sentiment:

> [F]ocusing on the costs of compliance by covered entities was totally inappropriate given the economic benefits to society of reducing the deficit by getting people off of welfare, out of institutions, and on to the tax rolls.

135 Cong. Rec. 8508 (1989). Clearly, failing to provide appropriate services due to lack of funds is no defense under the ADA.

To summarize, L.C. is a qualified individual with a disability, is the victim of discrimination by a public entity, and has been discriminated against based upon her disability. She is therefore entitled to relief under the ADA.

2. DEFENDANTS ARE VIOLATING THE ADA BY FAILING TO PROVIDE INTEGRATED COMMUNITY-BASED SERVICES AS A "REASONABLE MODIFICATION" UNDER THE ADA.

As already noted above, Defendants must administer their

mental disability services in the most integrated setting appropriate to L.C. See 28 C.F.R. § 35.130(d)(1993) For L.C., that setting is a community-based residential setting. Defendants must also modify their programs to the extent that is required to avoid discriminating against the disabled:

> 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 service, program, or activity.

28 C.F.R. § 35.130(b)(7) (Emphasis added).

Modifications are considered unreasonable only if they require a fundamental alteration or impose "undue financial and administrative burdens" on the Defendants. School Board v. Arline, 480 U.S. 273, 287 n. 17, 1987 (interpreting regulations under § 504 of the Rehabilitation Act).

The regulation also makes clear that the burden is on the Defendants to establish a fundamental alteration or undue financial and administrative burdens. This makes sense given that the ADA is a remedial statute. As one court has noted, the ADA is "designed to eliminate discrimination against the disabled in all facets of society" and therefore must be "broadly construed to effectuate its purposes." Kinney v. Yerusalim, 812 F. Supp. 547, 551 (E.D. Pa. 1992) [citing Tcherepnin v. Knight, 389 U.S. 332 (1967)] aff'd, 9 F. 3d 1067 (3rd Cir. 1993), cert. denied, ____ U.S. ____, 114 S. Ct. 1545 (1994). This conclusion is supported by the legislative history already discussed above and more particularly by the

statement from the House Judiciary Committee that "[t]he fact that it is more convenient, either administratively or fiscally, to provide services in a segregated manner, does not constitute a valid justification for separate or different services under § 504 of the Rehabilitation Act, or under this title." House Report No. 485 at 50.

Defendants clearly cannot meet their burden of showing a fundamental alteration or undue financial and administrative burdens in this case. Defendants already spend approximately $119,000,000 per year in providing community services to mentally retarded persons. (See Exhibit K, p. 2) Defendants already have an established program providing such services to persons such as L.C. such that no fundamental alteration in Defendants' programs would be required. In a similar context, the Third Circuit has already ruled that providing community-based services does not require a fundamental alteration within the meaning of the ADA. See DiDario, 46 F.3rd at 337-38; see also Martin v. Voinovich, 840 F. Supp. at 1190-91.

Additionally, given that it costs substantially more to institutionalize L.C. than it does to provide her with necessary community-based services, Defendants cannot possibly claim undue financial hardship. Again, a similar situation existed in the DiDario case, and that court ruled that Defendants could not show undue financial hardship. 46 F.3rd at 338.

The experience of other states is instructive on this issue. Many states are now shifting services for people with mental

disabilities from institutional settings to community-based settings. For example, some states, including Vermont, Massachusetts, and Rhode Island, have closed a great majority of their public psychiatric beds and reallocated funds to community-based services. Many states have also eliminated or greatly diminished their institutional care for people with mental retardation and now provide integrated services to a wide variety of people with mental retardation and dual diagnoses of mental illness and mental retardation. Courts have not been hesitant to require closure of state mental retardation facilities and the transfer of mentally disabled people to community placements. See Court Plan and Order of Deinstitutionalization, Hissom 1987 WL 27104 at *222, *226; Jackson, 757 F. Supp. at 1315-18. Clearly, requiring the Defendants to provide one individual with a community-based program in an integrated setting would not constitute an undue administrative burden.

In sum, Defendants cannot meet their burden of demonstrating that providing L.C. with an integrated community-based setting would impose a fundamental alteration on the Defendants' programs or impose an undue financial or administrative burden on them. Defendants can easily accomplish what L.C. requests with little, if any, modification of its present programs and services. Since Defendants steadfastly refuse to do so, it is time to order them to do so.

3. PLAINTIFF IS LIKELY TO PREVAIL ON HER § 1983 CLAIM.

a. Plaintiff Has A Right to Minimally Adequate Treatment And Habilitation Defined By Her Particular Circumstances.

The Fourteenth Amendment guarantees substantive due process to individuals confined in state institutions including the right to safety, freedom of movement, and minimally adequate treatment or habilitation. Youngberg, 457 U.S. at 318-19. This right derives from the long-established principals that involuntary confinement by the state is a "massive curtailment of liberty" Humphrey v. Cady, 405 U.S. 504, 509, 92 S. Ct. 1048, 1052, (1972), cannot continue once the individual can live safely outside of an institution, O'Connor v. Donaldson, 422 U.S. 563, 95 S. Ct. 2486 (1975) and its duration must be consistent with the purpose of the confinement. Jackson v. Indiana, 406 U.S. 715, 92 S. Ct. 1845, (1972).

In determining the constitutional standard for the provision of minimally adequate treatment, individual circumstances must be considered. In Youngberg, the Plaintiff, "in light of the severe character of his retardation, concede[d] that no amount of training [would] make possible his release." Youngberg, 457 U.S. at 317. The court reasoned, therefore, that minimally adequate treatment must be considered in the context of ". . . that training which is reasonable in light of identifiable liberty interests and the circumstances of the case. . . ." and stressed that "[b]ecause the facts in cases of confinement vary widely, it is essential to focus on the facts and circumstances of the case before a court." Id.,

at 320 n. 25 See also Armstead v. Pingree, 629 F. Supp. 273, 276 (M.D. Fla. 1986) (whether treatment falls short of constitutional requirements is a factual inquiry). In each case, therefore, an individual's capacity for freedom and the particular training[1] needed to maintain and develop the skills to attain that level of freedom will define the constitutional minimum. Clark v. Cohen, 749 F.2d 79, 95 (3rd Cir. 1986); S.H. and P.F. v. Edwards, 886 F.2d 293 (11th Cir. 1989) (en banc)

In this case, one of the relevant circumstances in determining constitutionally adequate habilitation would be the degree to which training is required to address behaviors resulting from lengthy and unnecessary institutional confinement. Lengthy confinement of a mentally retarded person in a psychiatric hospital has many negative effects. (See Kimble Affidavit Ex. B, Par. 28-30) For example, in describing circumstances which were deemed unconstitutional for a class of mentally retarded plaintiffs, institutionalized in mental hospitals, the Fourth Circuit found:

> The state psychiatric institutions provide very abnormal living environments. As a result, treatment of class members is seriously compromised. Within the state psychiatric hospitals, there are not enough structured activities to keep class members

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[1] It is important to note that the terms "training" and habilitation" are generally used in reference to the needs of persons with mental retardation and the term "treatment" with reference to medical treatment of the mentally ill. "The word 'habilitation', . . . is commonly used to refer to programs for the mentally retarded because mental retardation is . . . a learning disability and training impairment rather than an illness. (T)he principal focus of habilitation is upon training and development of needed skills." Youngberg, 457 U.S. at 310 n.1, quoting the amicus brief of the American Psychiatric Association.

> from developing inappropriate behaviors or losing independent living skills in the abnormal institutional environment. They learn to live in an institution and their ability to be integrated into the community and adapt to community life deteriorates . . . . When . . . confined with mentally ill people, they copy the social behavior of the mentally ill patients. This is called modeling. It further reduces their chances of living in a normal setting.

Thomas S. v. Flaherty, 699 F. Supp. 1178, 1193 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990)

The Thomas S. court concluded that the following practices with regard to mentally retarded individuals in psychiatric hospitals were inconsistent with the constitutional minimum for adequate habilitation:

> Many of the plaintiffs have behavior problems which make them difficult patients to treat. This difficulty is frequently used by the state to justify inappropriate placements.
>
> Many of the plaintiffs have been recommended for appropriate placement and treatment in less restrictive residential settings (yet) . . . . plaintiffs remain confined year after year in state psychiatric institutions.
>
> At times the people responsible for consenting to or approving commitment of a class member to a state psychiatric hospital do so because there is literally no other place for the class member to go.
>
> For many of the plaintiffs, there are no established alternatives to placement in a state psychiatric hospital. The state has chosen not to make appropriate alternatives available. . . .

Id. at 1185.

Following Youngberg, there are many other examples, where

courts have described standards for minimally adequate treatment for institutionalized persons with mental disabilities. It must be habilitation that "will tend to render unnecessary the use of chemical restraint, . . . locked wards, or prolonged isolation from one's normal community" and "conditions of life which are normal enough to promote rather than detract from one's chances of living with fewer restrictions on one's movement." Cameron v. Tomes, 783 F. Supp. 1515 (D. Mass. 1992) aff'd as modified, 990 F.2d 14 (1st Cir. 1993); Thomas S. v. Flaherty, 699 F. Supp. at 1200-01; see also Jackson, 757 F. Supp. at 1312, 1313; Mihalcik v. Lensink, 732 F. Supp. 299, 303 (D. Conn. 1990)

In Jackson v. Fort Stanton Hospital, the court held that, in order for due process to be satisfied, individual patients must have instruction in functional skills, carryover training from classroom to living units, rehabilitation services, equipment adapted to the needs of each individual, and behavior management programs. See Jackson, 757 F. Supp. at 1308-13. Similarly, in Thomas S. v. Flaherty, the Fourth Circuit affirmed a district court's order requiring habilitation in a "training setting which approximates the more normal environment against which the increasing independence of patients will be measured," "the development of individual plans for moving class members to more normal settings," and "the provisions of alternative habilitation settings where professional recommendations can be carried out." Thomas S. v. Flaherty, 902 F. 2d 250, 253-54 (4th Cir. 1990), cert denied, 498 U.S. 951 (1990)

Moreover, it is well established that due process requires that patients be protected from practices that contribute to deterioration of their condition. This right, suggested by the concurring opinion in Youngberg, 457 U.S. at 327 (Blackmun, J., concurring), is based upon the understanding that "[t]here is a significant risk that unless attention is paid to [residents'] developmental and habilitation needs, their skills will atrophy and they will regress." Thomas S. v. Flaherty, 699 F. Supp at 1194.

Plaintiff has been misplaced in mental hospitals for many years and for extended periods of time where her needs as a mentally retarded adult have not been met. Even worse, her condition has regressed and her skills have deteriorated. Her current hositalization is the most prolonged and thus the most detrimental. The cycle results, in part, from the fact that L.C. is confined to a mental hospital where, instead of learning how to function more effectively, she learns how to live in a psychiatric hospital and acquires institutional behaviors which make her life in the community increasingly difficult. Furthermore, her minimal educational and vocational needs are unmet. (See Kimble Affidavit, Ex. B, Par. 31-37)

Under these facts and circumstances, Defendants have failed to provide minimally adequate treatment or habilitation to Plaintiff. As the court observed in Wyatt more than twenty years ago, "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very

fundamentals of due process." Wyatt v. Stickney, 325 F. Supp. 782, 785 (M.D. Ala. 1971), aff'd sub nom. Wyatt v. Aderholt, 503 F.2d 1315 (5th Cir. 1974).

Plaintiff is thus entitled, at a minimum, to the development and implementation of an individualized habilitation and mental health treatment plan and its implementation in an appropriate, community setting.

b. Minimally Adequate Habilitation in the Individual Circumstances of this Case Requires the Development and Implementation of Individualized Habilitation Plans and Community-Based Placement.

The formulation of individualized treatment plans is one of the three "fundamental conditions of adequate and effective treatment" required to meet the constitutional standards for minimally adequate habilitation in this Circuit. Wyatt v. Aderholt, 503 F.2d 1305, 1316 (5th Cir. 1974), cited in S.H. and P.F., 886 F.2d at 293. To the extent that any plan has been developed for L.C. in the mental hospital, it has not been developed by professionals qualified to develop the individualized habilitation plan that, in light of L.C.'s mental retardation and related problems, is needed to meet her needs.

Plaintiff is, thus, constitutionally entitled, at a minimum, to a comprehensive individual habilitation plan which would identify her problems and needs -- developmental, behavioral, psychiatric, residential, vocational, educational, and personal - and how to address them. The plan would identify the entities who are to provide the services, how the services are to be funded and what alternative services would be available, if necessary, in

order to prevent psychiatric re-hospitalization for any purpose other than crisis intervention.[2]

Minimally adequate habilitation can include community placement in an individual case. The Eleventh Circuit has recognized the potentially wide scope of the "professional judgment" standard and its relationship to community placement. While the court in S.H. held that there is no general right to community habilitation in the least restrictive environment, the court noted that its decision did not limit "in any way" the relief available to individuals who prove that habilitation in a community

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[2] These are typical characteristics of individualized plans. For example, standards regarding the content of these plans were determined by stipulation in the Wyatt case and are incorporated virtually verbatim into the Georgia Mental Health and Mental Retardation Codes. They require, inter alia, that the plan for each mentally retarded person contain a statement of the nature of the specific problems and specific needs of the patient, the least restrictive treatment conditions to achieve the purposes of commitment, the intermediate and long-range treatment goals, with a projected timetable for their attainment, a statement and rationale for the plan of treatment to achieve these intermediate and long-range goals, a specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these treatment goals and criteria for release to less restrictive treatment conditions and criteria for discharge. Wyatt v. Stickney, 344 F. Supp. at 384; see also O.C.G.A. § 37-4-2(9); O.C.G.A. § 37-3-1(9).

setting is required to furnish "minimally adequate care" in accordance with professional standards. S.H., 886 F.2d at 293, citing Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). Thus, under S.H. and other cases decided after Youngberg, each resident of a state mental health institution must, at a "minimum" be afforded treatment appropriate to that particular individual's needs and abilities, even where that treatment includes community living.

L.C.'s habilitation needs require community placement. There is complete consensus among the professionals on this point. That this is a fundamental, "minimum" is as clear in her case as it could be in any case. Perhaps, in 1980, when the pattern of psychiatric hospitalizations began, she might have been able to learn to live with minimal assistance in a personal care home or family setting. But she never had the habilitation programming and support that she needed. Instead, she was re-hospitalized so regularly and for such extended periods of time that she acquired institutional, maladaptive behavior. According to the three evaluations by psychologists, trained to test and to identify developmental deficits and needs, she needs to be viewed from a developmental perspective, i.e., mental retardation program services. Specifically, according to Dr. Kimble:

> A community-based supervised living environment is definitely indicated for L.C.'s protection and basic well-being and to provide any possibility for her to acquire and maintain behaviors required for basic activities of daily living (hygiene, grooming, etc.) Any return to psychiatric hospitalization should be avoided if at all

possible and, if required, be used only briefly for crisis intervention.

(See Exhibit B, Par. 35)

For this Plaintiff, minimally adequate treatment and habilitation consistent with her needs can only be provided in an appropriate community setting.

c. Youngberg v. Romeo Requires the Actual Exercise of Qualified Professional Judgment.

In addition to the importance of the individual circumstances of each case in determining minimally adequate treatment, courts must show deference to the judgment exercised by qualified professionals to avoid interference by the federal judiciary with the internal operations of a state institution. Youngberg, 457 U.S. at 324.

However, the deference due the decision of professionals has limits. The decisionmaker must be a "person competent, whether by education, training, or experience, to make the particular decision at issue. Long-term treatment decisions normally should be made by persons with degrees in medicine or nursing or with appropriate training in areas such as psychology, physical therapy, or the care and training of the retarded. Id. at 323 n. 30. (Emphasis added). And a decision may be rejected by a court when it is a "substantial departure from accepted professional judgment, practice, or standards." Id. at 323. A decision is not a valid exercise of professional judgment if it is based on expediency or a decision to save money rather than on the individual and appropriate long-term habilitation needs of the mentally retarded person.

Courts have thus rejected decisions by clinicians based on considerations which were not clinically based. A state may not allow "bureaucratic ineptitude and insufficient allocation of funds" to obstruct professional judgment. Clark v. Cohen, 794 F.2d at 86-87; see also Thomas S. v. Flaherty, 699 F. Supp. at 1196 (finding that treatment recommendations were adapted to an "inadequate service delivery system, rather than [informed by] true professional judgment"). Similarly, where a professional "knew or should have known [about a] documented problem, . . . failing to act appropriately should constitute the absence of the exercise of professional judgment." Dolihite v. Videon, 847 F. Supp. 918, 936 (M.D. Ala. 1994)

Although the record is not absolutely clear at what point GRH-A staff concurred that L.C.'s psychiatric goals had been met, it is clear that at least one physician felt that way by early 1993. The record is also clear that the staff believed that L.C. needed alternative placement. These judgments are, therefore, consistent with Plaintiff's contention that maintaining her at GRH-A was inappropriate. Thus, the professionals who have at least the apparent qualifications to decide whether a person's mental illness requires hospitalization, the treatment staff at GRH-A, concluded that L.C. did not require institutionalization for her mental illness.

L.C.'s treating professionals at GRH-A are not, however, mental retardation professionals and are thus not qualified to make long-term decisions about L.C.'s habilitation for her mental

retardation. See Youngberg, 457 U.S. at 323 n. 30. In fact, their lack of proficiency in this case confirms the wisdom of the Youngberg court in protecting the constitutional rights of vulnerable individuals whose fates depend on the state's professionals by carefully requiring that decisions be made by qualified professionals in the area of the individual's disability.

d. Summary

In sum, L.C.'s constitutional right to minimally adequate habilitation has been violated by Defendants to a significant degree. In fact, it is difficult to conceive of a more obvious inconsistency with the straightforward teaching of Youngberg than the confinement of a mentally retarded individual, with moderate retardation and the capacity to function in a structured community setting for an extended period of time, to a large, crowded psychiatric ward for the acute care of severely mentally ill adults. Donaldson, 422 U.S. at 575 (1973) (stating that mental illness "alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement.")

C. PLAINTIFF FACES A SUBSTANTIAL THREAT OF IRREPARABLE HARM OR INJURY IF THE TRO AND PRELIMINARY INJUNCTION ARE NOT GRANTED

Plaintiff's right as a disabled American under the ADA as well as her established constitutional right to liberty and to be free of undue restraint are at stake in this case. Her history of repeated psychiatric hospitalizations shows that she is at risk if she remains hospitalized. She is also at risk if she is discharged

summarily without appropriate services. Her discharge without appropriate planning and immediately after the filing of this case also raises the definite possibility that the Defendants will now raise mootness as a defense to Plaintiff's claim for adequate services, including community placement.

The risk Plaintiff faces if discharged without services is the seemingly endless cycle of crises and re-hospitalizations. This is, in effect, a pattern of indifference to L.C.'s obvious and persistent need for developmental training in an appropriate setting. She is a victim, it appears, of expediency. "To the extent that a professional's judgment . . . [is] modified to fit what is available, that judgment likely has become a substantial departure from accepted professional standards." Thomas S. v. Morrow, 601 F. Supp. at 1055, 1060 (W.D.N.C. 1984), aff'd as modified, 781 F. 2d 367 (4th Cir.), cert. denied, 476 U.S. 1124, and cert. denied, 479 U.S. 869 (1986).

In a recent case brought by disabled citizens challenging the elimination of city recreational programs, the court found that plaintiffs were "suffering irreparable injury in the absence of the kinds of programs previously offered by the City, which cannot be remedied by monetary damages." Concerned Parents, 846 F. Supp. at 992. Surely, this Plaintiff is suffering and will suffer an even greater harm if she is released before appropriate services are identified and provided or if Defendants continue to hold her unnecessarily in a locked psychiatric ward. See, for example, Daniel B. v. White, No. Civ. 79-4088, 1991 WL 58494 at *3 (E.D. Pa.

1991) (District Court held that institutionalization of a class of mentally retarded individuals would cause them irreparable harm, granted a preliminary injunction, and ordered state to provide community-based placements).

L.C.'s living and self-care skills have already deteriorated. They will continue to do so and will eventually reach the point where the only alternative will be to keep her in an institution for the rest of her life. If this Court does not act, Plaintiff will continue to suffer irreparable harm.

D. THE THREATENED INJURY TO PLAINTIFF OUTWEIGHS WHATEVER DAMAGE THE TRO OR PRELIMINARY INJUNCTION MAY CAUSE THE DEFENDANTS.

A TRO or preliminary injunction would cause no harm to Defendants. Plaintiff only seeks what Defendants are legally obligated to provide: minimally adequate habilitation and services in the most integrated appropriate setting.

A TRO would protect Plaintiff from possible abandonment to a situation which is inadequate to meet her needs after years of inappropriate confinement.

Plaintiff seeks an order preventing the Defendants from discharging her from their legal custody absent appropriate planning and provision of appropriate services. This simply requires them to maintain her on "trial visit" which is a simple administrative stroke of a pen.

Plaintiff also seeks the actual provision of appropriate community services which would require the state to expend less funds than required by lengthy and repeated hospitalizations. In

any case, this is merely requiring Defendants to comply with the law. Concerned Parents, 846 F. Supp. at 992. ("The expenditure of funds cannot be considered a harm if the law requires it.")

E. PUBLIC INTEREST

The State of Georgia has an interest in serving its mentally retarded citizens with appropriate services in a manner which comports with their constitutional rights. The state, in fact, has recently revised its entire statutory and service delivery scheme in order to better coordinate services to the mentally disabled. (See Executive Summary, Report of the State Commission on Mental Health, Mental Retardation, and Substance Abuse Service Delivery, Exhibit L). It is thus in the public interest to assure that Plaintiff receives the services she needs and that individuals are not unnecessarily confined in expensive institutions when they would be better and more economically served in the community.

And even more important is the public's interest in providing for the full participation of persons with disabilities in the community-based mental health and habilitation programs which meet their needs. Tugg v. Towey, 864 F. Supp. 1201, 1210 (S.D. Fla. 1994).

CONCLUSION

Based on the foregoing, Plaintiff respectfully requests that her motion be granted.

This 30th day of May, 1995.

Respectfully submitted,

SUSAN C. JAMIESON
Georgia State Bar No. 389408
340 W. Ponce de Leon Avenue
Decatur, Georgia 30030
(404) 377-0701

STEVEN D. CALEY
Georgia State Bar No. 102866
151 Spring Street
Atlanta, Georgia 30303-2097
(404) 614-3926

Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I certify that Defendants in the above-styled actions have been served a copy of the Brief in Support of Motion for a Temporary Restraining Order and Preliminary Injunction by serving a copy by U.S. Mail to the individuals listed below:

Ms. Patricia Downing
Assistant Attorney General
132 State Judicial Building
40 Mitchell Street
Atlanta, Georgia 30334

Ms. Ernestine Pittman
Executive Director
Fulton County MH/MR/SA
Region 5
151 Ponce de Leon Avenue
Suite 108
Atlanta, Georgia 30308

This the 30th day of May 1995.

SUSAN C. JAMIESON