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CLERK, U.S. DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA, FLORIDA

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

MILLER FRANK JOHNSON, et al.,

Plaintiffs,

Case No. 8:87-Civ-369-T-24TBM

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

MICHAEL MURPHY, et al.,

Defendants.
_____/

ORDER

This cause came before the Court on a non-jury trial held during the weeks of August 7, 2000 through September 8, 2000. During the trial, the parties called numerous factual and expert witnesses and introduced documentary evidence. Subsequent to the trial, the parties submitted proposed findings of fact and conclusions of law.

BACKGROUND

This case was originally filed on March 11, 1987 by a class of plaintiffs on behalf of mentally ill persons who are or have been patients at G. Pierce Wood Memorial Hospital ("GPW"), a state psychiatric hospital in Arcadia, Florida. In 1989, the case was partially settled by a consent decree, with the Court

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retaining jurisdiction over the case. Court monitors were appointed to monitor compliance with the aforementioned consent decree. On April 2, 1998, the United States intervened in this action pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, et seq. In its complaint in intervention, the United States alleges that conditions at GPW violate the constitutional rights of current and former patients. The United States also alleges that the defendants[1] are violating the Americans With Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-12134, by failing to provide services and programs to current and former GPW patients in the most integrated setting appropriate to their needs. The United States seeks prospective injunctive relief on behalf of these current and former GPW patients.

FINDINGS OF FACT

General:

G. Pierce Wood Memorial Hospital is a state psychiatric hospital located in Arcadia, Florida. The overwhelming majority of patients served at GPW have severe and persistent mental illnesses. At any one time, the State of Florida serves

[1]G. Pierce Wood Memorial Hospital; The Florida Department of Health and Rehabilitative Services; Robert Williams, in his official capacity; the State of Florida; Jeb Bush, Governor of the State of Florida; Ed Feaver, in his official capacity; Robert Constatine, in his official capacity; Frances Gibbons, in her official capacity; Lynn Richard, in her official capacity; Don Dixon, in his official capacity; Sue Gray, in her official capacity; and Martin Van Holden, in his capacity as Administrator of G. Pierce Wood Memorial Hospital.

approximately 350 persons at GPW, and over eighty-five percent of those patients are involuntarily committed pursuant to the Baker Act, Fla. Stat. Chpt. 394. Under 42 U.S.C. § 12131(2), current and former patients of GPW are "qualified individuals with disabilities" as defined by the Americans With Disabilities Act ("ADA"). The defendants in this case are "public entities" that are subject to the requirements of Title II of the ADA, 42 U.S.C. § 12131(1)(B).

There are approximately thirty admissions to GPW each month, and approximately the same number of discharges. Persons discharged from GPW are generally discharged to one of the five Department of Children and Family Services districts in GPW's cachement area, Districts 5, 6, 8, 14 and 15. These five districts cover nineteen counties in central Florida.

Reasonable Care and Safety:

GPW provides conditions of reasonable care and safety to its patients. GPW takes reasonable steps to minimize or prevent harm to GPW patients, and the conditions of care and safety at GPW comply with accepted standards of professional judgment. Specifically, GPW provides its patients with adequate supervision; adequate treatment for self-injurious or assaultive behavior; adequate protection from environmental hazards; and adequate systems and procedures regarding the investigation of and response to adverse incidents.

Supervision

With regard to adequate supervision of patients at the Hospital, GPW bases its staffing on a number of variables such as the number of new admissions that the hospital receives, and on information related to staffing needs that is gathered from the medical staff by the clinical director. Tr. 8/24, 29.4-30.8.[2] As there are no national standards that set guidelines for psychiatric staffing, GPW bases its staffing decisions on institutional specific factors. Id. GPW has fourteen full-time psychiatric positions, and a fifteenth position that primarily involves supervisory and administrative duties. Tr. 8/30, 115.17-24. Additionally, the hospital has six general care service physicians. Tr. 8/30, 115.25-116.5. Similarly, nurses at GPW are provided pursuant to a formal "Plan for Providing Nursing Care" which is based on "ideal" nurse staffing levels. Tr. 8/30, 37, 39, and 59. Consistent with the American Nurses' Association's standards, the nurse staffing program at GPW is based on patient need rather than on hours per patient per day. Tr. 8/30, 45-46. While more nurses at GPW would be ideal, the hospital is still able to meet the nursing care needs of its patients with the nursing staff that is currently provided. Tr. 8/30, 59. As to semi-professional and/or non-professional staff

[2]References to trial transcripts are given in the following format: "Tr. month/day, page.line-page.line".

at the hospital, GPW provides registered nurse supervision of all "LPN" nurses on duty. Tr. 9/5, 41. Furthermore, the hospital has systems in place to monitor direct staff and nursing deficiencies, to include a corrective action plan if staffing deficiencies are found. Tr. 9/5, 19-24, 61-62.

Treatment for Self-Injurious or Assaultive Behavior

With regard to treatment for self-injurious or assaultive patient behavior, GPW has a system in place where such behavior is noted on patient records; reviewed by treatment teams as to patient needs and progress; and modified depending on patient progress, team input, and response to precaution levels. Tr. 8/23, 187.10-213.12; Exhibit D-122 at 25-26. GPW also has an independent mortality review process by which fatal incidents at the hospital are sometimes reviewed by the University of South Florida Department of Psychiatry & Behavioral Medicine. Exhibit D-65; Tr. 8/30, 133.17-22. Patients who have indications and/or histories of self-injurious or assaultive behavior are placed on appropriate precautionary levels and participate in specific treatments designed to decrease their risk of harm. See, e.g., Case of Tonya W., Exhibit D-122 at 48-50; Tr. 8/24. 10.3-13.11; Case of Paul B., Exhibit D-122 at 25-26; Tr. 8/23, 187.10-213.12. Further, the hospital has a system in place whereby a peer review committee meets after a death occurs to evaluate and make recommendations as to what steps, if any, need to be taken to

ensure the safety of patients at the hospital. Tr. 8/30, 123.9-124.9, Case of Rodney S., DOJ Exhibit 182A at 6-7 (noting post-incident recommendations made by mortality review committee).

With mentally ill patients like those at GPW, there is often no real way to predict who will commit suicide or injure themselves due to the fact that such behavior is often an impulsive event that is based on unidentifiable factors. Exhibit D-24; Tr. 8/31, 148.2-151.15, 154.24-155.10. However, in cases where patients do show identifiable signs of self-injurious behavior, the hospital has treatment teams that meet with those patients to evaluate their condition. Case of Leon G., Tr. 8/30, 204.6-205.19. Once a self-injurious patient's condition is evaluated, status notes are made and hospital staff members take action in accordance with the patient's treatment plan. Id. Further, in cases where patients exhibit signs of immediate harm to themselves or others, they are placed on "one-on-one" precautions, are immediately seen by a doctor, and are taken out of restraints (if needed) as soon as possible. Tr. 8/24, 87.10-90.14; 91.1-5.

Protection from Environmental Hazards

As a general observation, the rate of patient injuries at GPW is less than the national average as measured in national surveys of other large state psychiatric hospitals. Tr. 8/31, 160.12-164.3. During the relevant time periods in this matter,

the number of serious injuries to patients from environmental hazards was relatively low and there were no patterns of negligence present. Tr. 8/28, 156.12-159.8; Exhibit D-120 at 62-64. As to "contraband" at the hospital (such as drugs or weapons), staff at the hospital are generally not allowed to search patients, but searches are conducted when there is probable cause and in emergency circumstances. Tr. 9/5, 165.19-22; 167.8-169.6. Most contraband found at the hospital, however, is brought in by visitors, and the staff at the hospital calls the local sheriff's department if they suspect that a visitor has brought in illegal contraband. Tr. 9/5, 170.17-171.10. As to subjective contraband (such as shoelaces, belts, towels, etc.), restrictions are placed on patients on a case-by-case basis. The hospital's "subjective contraband" policy attempts to maintain as much of a "home-like" environment as possible. Tr. 9/6, 117.7-119.18.

As to structural safety hazards at the hospital (such as doorknobs, plumbing fixtures, etc.), the hospital evaluates safety through an interaction between a specific environment and the patients in that environment based on level of supervision and level of privileges in a particular location. Tr. 8/28, 163.8-164.18. While it is impossible to make any environment completely free of hazards and accidents have occurred due to environmental hazards, GPW acts to remove suicide and safety

hazards while attempting to balance the comfort, self-esteem, and self-respect of its patients. Tr. 8/30, 57. Pursuant to a review by the hospital's engineering department, GPW has enacted an "action plan" for the removal of environmental hazards. Tr. 8/8, 155.14-157.14. In accordance with its action plan, the hospital has removed environmental hazards such as door knobs, ceiling grids, and plumbing fixtures, and has replaced glass fixtures with lexon plexi-glass. Tr. 9/5, 181.18-183.24.

Investigation and Response to Adverse Incidents

At GPW, reports of incidents are recorded on "Resident Occurrence Report" forms ("ROR"). While many hospitals do not record commonplace events (such as cursing, shouting, or pacing) on formal reports, GPW "over-reports" incidents in that it has a policy of recording common events that would not be recorded elsewhere. Tr. 9/5, 244.10-246.4; Tr. 9/6, 93.14-24. Many of the events reported by GPW are considered normal or trivial at other hospitals. Tr. 8/28, 168.3-18. However, GPW's reporting policy is based on the premise that an excess of information is better than not getting enough information. Tr. 9/6, 92.24-93.24. This policy results in a large number of ROR's, many of which are concerning minor incidents. See id. However, in some ROR's filed during the times relevant to this action, certain patients at the hospital made serious allegations of rape and sexual assault. Serious incident reports are investigated by the

hospital, and with regard to the aforementioned allegations of rape and sexual assault, post-report investigations found that they were unsubstantiated. There have been no substantiated incidents of rape or sexual assault at the hospital. Tr. 9/6, 66.2-15; 99.8-100.14; Tr. 9/5, 173.25-174.21; 216.23-217.17. Similarly, while some ROR's at the hospital contain patient allegations of other serious activity or violations (such as illegal drug use), few of those allegations turned out to be substantiated. Tr. 9/6, 116.4-22. Additionally, many ROR's which contain incidents such as patient assaults or accidents are based on events where patients were not injured (such as verbal assaults by patients). Tr. 9/6, 105.16-108.11.

The hospital has in place programs to assure proper response to and investigations of adverse incidents. These programs include security investigations, internal hospital investigations, a patient grievance process, high risk reviews, retrospective case reviews, and mortality reviews. Tr. 9/5, 164.10-18; 9/6, 35-64. Information gathered from these programs is disseminated to treatment teams and staff members for assessments and modifications. Tr. 9/6, 114.20-115.2, 111.7-19. All "significant reportable events" (as that term is defined by the State) are reported to State officials pursuant to a formal "SRE" reporting policy. Tr. 9/6, 91.11-92.2; 94.8-95.3. Additionally, hospital investigators give priority to the

investigation of serious incident reports according to a standardized set of criteria set forth by the hospital. Tr. 9/6, 39.1-40.20; 9/6, 38.12-25. Such investigations are subjected to supervisory review and are often supplemented with follow-up investigations. Tr. 9/6, 39.1-40.20.

In addition to the procedures discussed above, Florida's Department of Children and Family Services operates an investigative unit known as Adult Protective Services which operates an "abuse hotline" which GPW patients have access to. Tr. 9/6, 42.21-44.23. Hospital employees also have access to the hotline and are required to immediately report any instances of abuse that they observe. Id. Furthermore, the hospital's resident advocate and resident advocate attorney, along with the hospital administrator, are involved in the patient grievance process to assure that allegations of abuse and neglect are investigated on a multi-level basis. Tr. 9/6, 50.22-54.7. The hospital also has a Quality Management/Risk Management Department that identifies patterns and trends at the hospital based on patient and staff incidents. Tr. 9/6, 57.12-59.2; 58.10-59.2. As noted above, the hospital also has a mortality review process by which incidents of death are sometimes reviewed by the University of South Florida to determine whether there was appropriate care and conduct. Exhibit D-65.

Standard of Professional Care

With respect to reasonable care and safety of patients, GPW takes reasonable steps to minimize or prevent harm to GPW patients, and the conditions of care and safety at GPW comply with accepted standards of professional judgment. Accepted standards of professional judgment in the field of psychiatry should be based upon training, experience, judgment, and current peer reviewed literature in the field. Tr. 8/23, 39.4-40.15. While organizations such as HFCA and JCAHO do set some standards for psychiatric hospitals, those standards exceed generally accepted professional standards of care for patients at hospitals like GPW. Tr. 8/23, 36.6-36.9, 37.23-24. Thus, the fact that a hospital or part of a hospital has lost or does not have HFCA and/or JCAHO accreditation does not necessarily mean that accepted professional standards of care are not being utilized. See id. At GPW, the treatment of self-injurious behavior (Tr. 8/23, 47.12-52.9); the supervision and care of patients (Tr. 8/30, 133.17-22; Tr. 9/5, 59-60; Tr. 8/30, 81-83); the prevention of harm from environmental hazards (Tr. 8/28, 164.19-24); and the reporting and investigation of adverse incidents (Tr. 9/6, 35-64) all comply with accepted standards of professional judgment.

Treatment:

Patients at GPW are provided adequate treatment that complies with accepted professional judgment, practice, and

standards. Specifically, patient assessment, treatment planning, provision of treatment, and discharge planning are adequate and acceptable.

Patient Assessment

As a general guideline for patient assessment, GPW has developed a model assessment form which is found in its Psychology Department Manual. Tr. 8/31, 87.1-89.25. In 1996, Dr. Lyon, the Director of Psychology, developed a procedure to implement detailed psychological reports in conjunction with the hospital's protocol monitoring department. Tr. 8/31, 89.13-91.11. In addition to the hospital's protocol audit of assessment records, Dr. Lyon developed a system of qualitative review of assessments when he took over as Director of Psychology in 1996. Tr. 8/31, 99.17-100.7; 207.6-15. Under this review process, a small number of initial patient assessments were found to be "poor" due to the fact that the assessment sheets were done in a "fill-in-the-blanks" type manner. Tr. 8/31, 94.17-96.7. However, a vast majority of the assessment forms reviewed at the hospital were accurate in their observations and ranged from "adequate" to "quite good." Tr. 8/25, 88.19-90.3. With regard to poor assessments, the hospital implemented corrective action which included revising its Psychology Manual. Tr. 8/31, 96.10-98.20. Further, in July of 1999, the hospital prepared a research paper which compared Positive and Negative Syndrome

Scale ("PANSS")[3] test scores with results from national and international studies, as well as results from other Florida state hospitals. Exhibit D-26. That research study showed that GPW was properly performing the PANSS test in conjunction with its assessment of patients. Tr. 8/31, 139.13-24.

Treatment Planning

Treatment planning at GPW is a process that encompasses a patient's entire chart, a specific treatment plan, and the specific knowledge of treating professionals. Tr. 8/23, 107.12-18. Treatment planning for a patient is also a fluid concept in that it may change based on progress, specific needs, and specific behavior. Tr. 8/23, 187.10-213.12. Treatment plans at the hospital are implemented with the goal of reducing inappropriate behavior and symptoms and preparing the patient for discharge. Tr. 8/23, 138.24-144.6. Treatment planning at GPW includes, inter alia, therapeutic activities, DBT, and individual psychotherapy. Tr. 8/24, 10.3-13.11. Through specific individual treatment plans, patient charts, and progress notes, treatment plans at GPW are informative as to what type of treatment a patient is receiving, to include what type of medication, if any, a patient is taking. Tr. 8/24, 140.2-7; 140.11-15; Exhibit D-135. Frequent patient progress notes serve

[3]The PANNS rating scale is a type of assessment test that references a normative sample of schizophrenic patients as a basis for comparison. Tr. 8/31, 110.22-111.14.

to inform treatment professionals of changes in a patient's treatment and medication regime. Tr. 8/24, 147.1-18; 149.20-25; 150.3-17. Further, treatment team meetings with patients are made part of treatment planning at GPW. Exhibit D-123 at 8-16. In summary, treatment planning at GPW consists of individualized treatment regimes, specific interventions, individual psychotherapy, group psychotherapy, rehabilitation, and individual psychopharmacologic interventions. Tr. 8/24, 93.16-22.

Provision of Treatment

The provision of psychological treatment at GPW is multi-faceted. One method of treatment is "SIP meetings" or treatment team meetings wherein patients and treatment team members discuss past management and treatment issues. Tr. 8/24, 78.5-16. During treatment team meetings, team members at GPW are aware of the clinical histories of the participating patients, and discussions during these meetings are thoughtful and clinically informed. Exhibit D-123 at 60. Patients at GPW are encouraged to engage in active treatment and psychosocial rehabilitation. Tr. 8/28, 72.25-79.22. Additionally, a significant number of staff members at GPW are trained and/or certified in substance abuse issues to provide treatment and support to patients with substance abuse problems. Tr. 8/31, 103.4-104.8.

Psychosocial rehabilitation at GPW is based on non-medical interventions designed to foster the rehabilitation of psychiatric patients and includes family therapy, skills training, vocational rehabilitation, and psychotherapy. Tr. 8/25, 76.2-19. While psychotherapy is one of the most common forms of psychosocial rehabilitation, many techniques are used in the field, and there are no widely accepted professional standards in psychosocial rehabilitation. Tr. 8/25, 79.5-80.21; Tr. 8/29, 137.24-140.24. At GPW, treatment professionals rely on their training and experience to choose the best form of psychosocial rehabilitation that is most likely to help individual patients. Tr. 8/25, 78.2-22. One particular model of psychosocial rehabilitation used by GPW in an adapted form is a "role recovery" model, which represents one of many professionally acceptable treatment methods in the field. Tr. 8/25, 83.19-85.5; Tr. 8/29, 236.1-237.16. GPW has a goal of twenty hours per week of therapeutic interventions, and patient contacts are made each day in various forms and durations. Exhibit D-47; Tr. 8/29, 242.14-243.12; 245.6-20; Exhibit D-114 at 11-12. Additionally, GPW has therapeutic programs and services available to patients such as on and off-ward training/skills programs; recreation and leisure activities; and grounds where patients are free to walk. Tr. 8/25, 124.1-125.14; 126.7-128.2; Exhibit D-114 at 14-20. Finally, while there are no specific

programs at the hospital that are exclusively for Spanish-speaking patients, GPW has bi-lingual and multi-lingual staff members (who are fluent in Spanish and other languages) that help facilitate communication with non-English speaking patients. Tr. 8/31, 218.10-17.

Discharge Planning

According to GPW policy, a patient's individual treatment plan is developed shortly after admission, and this plan or "SIP" includes discharge planning. DOJ Exhibit 148 at 2. Discharge planning is reviewed and modified during "SIP updates" or modifications, and community case managers often participate in SIP meetings to discuss discharge planning. Tr. 9/8, 96.17-98.8. Furthermore, patient discharge skills (such as bathing, taking medication, etc.) are annotated on discharge planning forms such as the "7001 Form" and the "Interdisciplinary Discharge Summary" form. Tr. 9/8,83.17-85.23. As an additional element of discharge planning, the hospital attempts to involve family members in the patient discharge process for support and patient needs. Tr. 9/8, 85.25-87.18.

While evidence was presented at trial that some patients' discharge plans did not comply with hospital policy, discharge planning at GPW as a whole is adequate and acceptable. Tr. 9/8, 81.25-82.21; 178.9-18. Often, GPW's plan for discharge and placement is limited due to the fact that patients who are no

longer involuntarily committed sometimes choose not to cooperate with the hospital. Tr. 9/8, 93.24-96.15. However, community case managers are actively involved at the hospital in both discharge planning and discharge follow-up. Tr. 9/8, 69.2-70.25; Exhibit D-117 at 11-13. Community case managers that work with GPW as treatment team members are knowledgeable about placement, service options, and patients in their area. Tr. 9/8, 81.25-82.9.

Standard of Professional Care

As noted above, accepted standards and judgments in the field of psychiatry should be based upon training, experience, judgment, and current peer reviewed literature in the field. Tr. 8/23, 39.4-40.15. Also as noted above, there are no widely accepted professional standards in psychosocial rehabilitation. Tr. 8/25, 79.5-80.21; Tr. 8/29, 137.24-140.24. Patient assessment (Tr. 8/25, 89.13-91.11), treatment planning (Tr. 8/24, 93.2-93.7), provision of treatment (Tr. 8/24, 78.5-16; Tr. 8/25, 101.18-25; 103.8-15;, and discharge planning (Tr. 9/8, 81.25-82.21; 178.9-18) are adequate and acceptable; and patients at GPW are provided adequate treatment that complies with accepted professional judgment, practice, and standards.

Community Services:

Current and former GPW patients are provided adequate community mental health services to meet their assessed

functional and clinical needs in an integrated setting that is appropriate to those needs.

Placement in Community Settings

The defendants in this matter are placing persons with mental disabilities in community settings rather than in institutions when the relevant 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 disabilities.

Upon discharge from GPW, patients are provided several community placement options, (such as family homes, private apartments, assisted living facilities, etc.), according to their needs and abilities. Tr. 8/15, 58.3-5; 59.1-6; Tr. 9/8, 75.19-76.5. While many factors influence the stability of community tenure for mentally ill patients (such as fluctuations in mental condition, resources, and need for crisis care), patients discharged from GPW are usually successful in remaining in community settings . Tr. 8/10, 83.5-84.5; Tr. 8/15, 84.3-85.6. Once patients are discharged into community settings, GPW continues to contact and follow-up with those patients pursuant to individual discharge plans. Tr. 8/15, 52.24-53.7. In June of 1999, GPW initiated a community outreach program based on a

"community ACT team" model. Tr. 9/5, 146.1-148.25. That community outreach program is designed to augment the discharge process by providing additional support and services to patients in community settings. Tr. 9/5, 148.17-149.14. Once patients are discharged into community settings from the hospital, they are provided with sufficient "staff-to-client" support to meet their needs. Tr. 9/8, 42.7-24. Further, the community settings in which patients are placed are integrated and less restrictive than a hospital or institutional setting. Tr. 8/17, 183.19-22.

In some cases, patients at GPW are discharged into assisted living facilities or "ALF's." ALF's are privately owned and operated facilities that provide living assistance to those in need of it. Tr. 8/15, 55.13-56.8. While there was evidence of poorly operated ALF's, assisted living facilities are perfectly acceptable as discharge options for some patients. Only a small percentage of patients from GPW are actually discharged into ALF's. DOJ Exhibit 212, Appendix D; DOJ Exhibit 333. Typically, over half of the patients at GPW are discharged into independent living or family homes, and another twenty percent of patients are discharged into "group living situations" sponsored by community health providers. Id.

Unnecessary Isolation

The defendants' mental health program, as administered, does not result in unnecessary isolation of patients into segregated

settings. Consistent with the intent of Florida's "Mental Health Act", the defendants in this matter strive to serve patients with the least restrictive interventions based on the individual needs of each patient, within the scope of available services. Tr. 9/6, 199.13-15; 201.17-201.25; Exhibit D-146A at §394.453. Basic and core services to facilitate community integration are found in all of the districts that comprise the GPW catchment area. Tr. 9/7, 33.18-23. Independent reports and studies, such as a February, 1999 report by OPPAGA and a May, 1998 report by the Federal Department of Health and Human Services, have found that Florida is employing a community-based system of mental health care in a "least restrictive" environment. DOJ Exhibit 71; Exhibit D-100 at i-iii.

Array and Intensity of Community Services

The defendants are providing an appropriate array and intensity of community services. The residential options available to patients discharged from GPW are logistically adequate due to the fact that few, if any, of them operate at full capacity. Tr. 9/8, 45.2-18. As a whole, the defendants provide a broad array of community services such as emergency stabilization treatment; detoxification services; inpatient services; residential services; case management services; and crisis intervention services. Tr. 9/7, 21.15-23.7; Tr. 9/8, 45.19-46.23; 178.20-180.10. In fact, GPW has innovative pilot

programs such as staff-intensive "independent settings" for high risk individuals. Tr. 9/8, 57.16-58.21; 106.2-6; Exhibit D-117 at 9. As to residential discharge options, GPW provides a broad array of discharge settings such as such as family homes, private apartments, assisted living facilities, and group living situations. Tr. 8/15, 58.3-5; 59.1-6; Tr. 9/8, 75.19-76.5; DOJ Exhibit 212 at Appendix D; DOJ Exhibit 333. There is typically a low number of patients awaiting discharge at GPW with an average wait of thirty to sixty days. Tr. 9/7, 72.11-75.14. While some of the available discharge settings are not in the best locations or are not as clean as they should be, the totality of the evidence at trial showed that they are acceptable. Tr. 9/8, 107.18-109.3.

Discharge Planning and Needs Assessment

The defendants in this matter are providing appropriate planning for patient discharges and appropriate assessment of the needs of their patient population. As noted previously, a patient's individual treatment plan is usually developed shortly after admission to GPW, and this plan or "SIP" includes discharge planning. DOJ Exhibit 148 at 2. Discharge planning is reviewed and modified during "SIP updates" or modifications, and community case managers often participate in SIP meetings to discuss discharge planning. Tr. 9/8, 96.17-98.8. Furthermore, patient discharge skills (such as bathing, taking medication, etc.) are

annotated on discharge planning forms such as the "7001 Form" and the "Interdisciplinary Discharge Summary" form. Tr. 9/8,83.17-85.23. As an additional element of discharge planning, the hospital attempts to involve family members in the patient discharge process for support and patient needs. Tr. 9/8, 85.25-87.18. Often, GPW's plan for discharge and placement is limited due to the fact that patients who are no longer involuntarily committed sometimes choose not to cooperate with the hospital. Tr. 9/8, 93.24-96.15. However, community case managers are actively involved at the hospital in both discharge planning and discharge follow-up. Tr. 9/8, 69.2-70.25; Exhibit D-117 at 11-13. Community case managers that work with GPW as treatment team members are knowledgeable about placement, service options, and patients in their area. Tr. 9/8, 81.25-82.9.

In addition to efforts conducted at GPW, service providers in the relevant discharge communities determine patient needs based upon their specific involvement with the individuals that they serve and the individual needs that arise from those individual assessments. Tr. 9/7, 39.6-16. By operating under a decentralized organizational structure, each district is able to manage its community service system at a "grassroots level" which provides a program that is tailored to the individual needs of individual communities. Id.; DOJ Exhibit 80 at 5.

Standard of Professional Care

As to the provision of community mental health services, there are no generally accepted "norms" or "quantifiable standards" in the field. Tr. 8/17, 172.19-176.1. Instead, standards of professional care are based upon training, experience, judgment, and current peer reviewed literature in the field. Tr. 9/8, 32.18-33.13. In this case, all aspects of the defendants' provision of community services comply with accepted professional standards of care. Tr. 9/8, 81.25-82.21 (post-placement care); Tr. 9/8, 178.9-18 (discharge planning); Tr. 9/8, 107.18-109.3 (array of services); Tr. 9/8, 45.19-46.23; 178.15-180.10 (services fostering community integration); Tr. 9/8, 110.10-111.5 (community services as a whole).

CONCLUSIONS OF LAW

I. Summary of the Law

(A). Constitutional Claims

In Youngberg v. Romeo, 457 U.S. 307 (1982), the United States Supreme Court addressed the question of whether a person who is involuntarily committed to a state institution for the mentally retarded has substantive rights under the Due Process Clause of the Fourteenth Amendment to (1) safe conditions of confinement; (2) freedom from bodily restraints; and (3) training or habilitation. See Youngberg, 457 U.S. at 309. Turning first to the issue of safe conditions of confinement, the Court in

Youngberg found that an institutionalized patient has an obvious right to adequate food, shelter, clothing, and medical care. See id. at 315. Recognizing that a person's right to personal security is a "historic liberty interest", the Court found that an institutionalized person also has a substantive due process right to safe conditions of confinement. See id. Similar to a patient's right to safe conditions of confinement, the Court in Youngberg also found that freedom from bodily restraint is recognized as a core liberty protected by the Due Process Clause. In light of the fact that the right to be free from bodily restraints survives criminal conviction and incarceration, the court found that it must also survive involuntary commitment.

With the aforementioned rights established, the Court in Youngberg went on to address the question of whether an involuntarily committed patient has a constitutional right to minimally adequate training or habilitation[4]. In addressing this question, the Court began with the general principle that a state is under no constitutional duty to provide substantive services to those within its border. See id. at 317. However, when a person is institutionalized and wholly dependant on the state, the Court recognized that a duty to provide certain services and care does exist. See id. In light of its recognition of a

[4]The Supreme Court defined this term as "training and development of needed skills. Youngberg, 457 U.S. at 317.

constitutionally protected right to be safe and to be free from bodily restraint, the Court in Youngberg held that a state is required to provide involuntarily committed patients minimally adequate or reasonable training to ensure safety and to ensure freedom from undue restraint. See id. at 319. With these obligations stated, however, the Court went on to note that the question is not simply whether a liberty interest has been infringed, but whether the extent or nature of the restraint or lack of safety is such as to violate due process. Thus, in determining whether or not a constitutional violation has taken place, a court must determine whether a state exercised professional judgment in a decision related to constitutionally protected rights. See id. at 322. In evaluating professional judgment, a court must show deference to the judgment of qualified professionals, and decisions made by such professionals are presumptively valid. See id. at 323. "It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." Id. at 321. Rather, "[l]iability 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." Id. at 323.

In summary, the Court's decision in Youngberg is as follows:

1. A state has a duty to provide involuntarily committed patients adequate food, shelter, clothing, and medical care, See id. at 324;

2. A state has a duty to provide reasonable safety for all residents and personnel within an institution, See id.;

3. A state may not restrain involuntarily committed residents except when and to the extent that professional judgment deems such restraint necessary to assure safety or to provide needed training, See id.;

4. A state has a duty to provide such training as an appropriate professional would consider reasonable to ensure a patient's safety and to facilitate a patient's ability to function free from bodily restraints, See id.; and

5. In determining whether a state has met its obligations under the Constitution, decisions made by appropriate professionals are entitled to a presumption of correctness, and 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, See id..

Prior to the Supreme Court's decision in Youngberg, the former Fifth Circuit held that civilly committed mental patients have a constitutional right to individual treatment that will afford them a reasonable opportunity to be cured or to improve their mental condition. See Donaldson v. O'Conner, 493 F.2d 507, 520 (5th Cir. 1974)(vacated on other grounds); Wyatt v. Aderholt, 503 F.2d 1305, 1312 (5th Cir. 1974). In reaching this holding, the Fifth Circuit reasoned that "the only permissible justifications for civil commitment and for the massive abridgments of constitutionally protected liberties it entails

[are] the danger posed by the individual committed to himself or to others, or the individual's need for treatment and care. Aderholt, 503 F.2d at 1312. Given this fact, the prior Fifth Circuit found that "if the purpose of the commitment is to secure treatment, the state violates due process if it does not, in fact, provide treatment." Id. Subsequent to the Supreme Court's opinion in Youngberg, the Eleventh Circuit recognized that the Fifth Circuit's holdings in Aderholt and Donaldson were not addressed in Youngberg. See D.W. v. Rogers, 113 F.3d 1214, 1218 (11th Cir. 1997). Therefore, it appears that the Fifth Circuit's holdings in Aderholt and Donaldson are still binding precedent within the Eleventh Circuit. See Bonner v. City of Prichard, 661 F.2d 1206, 1209 (11th Cir. 1981).

In addition to the circuit-level opinions in Aderholt and Donaldson, at least one district court within this circuit has found that the right to training and habilitation set forth in Youngberg includes the right to such training as is necessary to prevent institutionalized patients' basic self-care skills from deteriorating. See Armstead v. Pingree, 629 F. Supp. 273, 276 (M.D. Fla. 1986).

(B). ADA Claims

Title II of the ADA applies to public services that are furnished by governmental entities. Specifically, 42 U.S.C. § 12132 states that:

> Subject to the provisions of this subchapter, 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.[5]

In Olmstead v. Zimring, 119 S.Ct. 2176 (1999), the Supreme Court was asked to decide whether Title II of the ADA requires placement of persons with mental disabilities in community settings rather than in institutions. See Olmstead, 119 S.Ct. at 2181. Answering this question with a "qualified yes" , the Court in Olmstead held that:

> Such an action is in order 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 disabilities.

Id. However, the Court in Olmstead expounded on its holding by stating that a state's responsibility to provide community-based treatment to qualified persons with disabilities is not boundless. See id. at 2188. The Court noted that a state can

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[5]The Court sua sponte takes note of the United States Supreme Court's decision in Board of Trustees of the University of Alabama v. Garrett, 531 U.S. 356 (2001), as that opinion relates to claims against state actors for money damages under the ADA. In this case, the defendants have raised an Eleventh Amendment immunity defense to the ADA claims against it. This Court, however, need not address what effect, if any, the Garrett opinion would have on the ADA claims in this case in light of the fact that the Court finds that the defendants have not violated the ADA. Therefore, any Eleventh Amendment defense offered by the defendants is rendered moot.

resist modifications that entail a "fundamental alteration" of the state's services and programs. See id. In other words, "the fundamental-alteration component . . . would allow 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." Id. at 2189. By way of example, a plurality of the Court in Olmstead went on to state that:

> 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.

Id.

II. The Law Applied to the Facts of This Case

(A). Constitutional Claims

(i). Reasonable Care and Safety

In this case, the plaintiffs have three "constitutional claims" that can be divided into various sub-parts. The first constitutional claim raised by the plaintiffs pertains to the provision of reasonable care and safety to the patients at GPW. Specifically, the plaintiffs allege that the patients at GPW are inadequately supervised; inadequately treated for self-injurious behavior; inadequately protected from environmental hazards; and

that adverse incidents are inadequately investigated and/or responded to.

Inadequate Supervision

The plaintiffs contend that GPW fails to provide a sufficient number of adequately trained staff to provide patients with adequate supervision and safety in a therapeutic environment. However, the evidence at trial shows that GPW is adequately staffed with trained employees who provide adequate supervision and safety as mandated by the Supreme Court's holding in Youngberg that a the State must provide reasonable safety for all residents. See, e.g, Tr. 8/30, 115.17-24; Tr. 8/30, 115.25-116.5; Tr. 8/30, 37, 39, and 59; Tr. 8/30, 45-46. While it is true that in any psychiatric hospital, a larger number of trained staff would always be ideal, the staffing at GPW provides reasonable care and safety and complies with accepted professional judgment, practice, or standards. See Youngberg, 457 U.S. at 323.

Treatment for Self-Injurious or Assaultive Behavior

The next sub-claim under the major claim of reasonable care and safety is that GPW provides inadequate treatment for self-injurious or assaultive behavior. The crux of this sub-claim is that GPW does not modify treatment plans and/or perform suicide assessments to address behaviors and problems that result in harm to patients. However, the evidence at trial showed that GPW

exercises professional judgment in its treatment of self-injurious or assaultive behavior, and that the treatment complies with accepted professional judgment, practice, or standards. See, e.g., Tr. 8/23, 187.10-213.12; Exhibit D-122 at 25-26; Exhibit D-65; Tr. 8/30, 133.17-22; Case of Tonya W., Exhibit D-122 at 48-50; Tr. 8/24, 10.3-13.11; Case of Paul B., Exhibit D-122 at 25-26; Tr. 8/23, 187.10-213.12; Tr. 8/30, 123.9-124.9, Case of Rodney S., DOJ Exhibit 182A at 6-7. While some patients at GPW have committed suicide or harmed themselves or others, the evidence at trial shows that GPW has provided adequate treatment for self-injurious or assaultive behavior. See, e.g, Exhibit D-24; Tr. 8/31, 148.2-151.15, 154.24-155.10. Case of Leon G., Tr. 8/30, 204.6-205.19; Tr. 8/24, 87.10-90.14; 91.1-5.

Protection from Environmental Hazards

The third claim under reasonable care and safety is that GPW fails to protect its patients from environmental hazards such as illegal drugs and "hanging hazards." At trial, however, the evidence showed that GPW is exercising professional judgment in protecting its patients from environmental hazards, and GPW's handling of environmental hazards complies with accepted professional judgment, practice, or standards. See, e.g., Tr. 8/31, 160.12-164.3; Tr. 8/28, 156.12-159.8; Exhibit D-120 at 62-64; Tr. 9/5, 165.19-22; 167.8-169.6; Tr. 9/5, 170.17-171.10; Tr. 9/6, 117.7-119.18; Tr. 8/28, 163.8-164.18; Tr. 8/30, 57; Tr. 8/8,

155.14-157.14; Tr. 9/5, 181.18-183.24. As noted by the Supreme Court in Youngberg, an institution cannot protect its residents from all danger if it is to permit them to have any freedom. See Youngberg, 457 U.S. 320. Thus, while the evidence shows that environmental conditions at GPW could be improved, GPW utilizes professional judgment and adequately protects its patients from environmental hazards. Tr. 8/23, 39.4-40.15; Tr. 8/23, 36.6-36.9, 37.23-24; Tr. 8/28, 164.19-24.

Investigation and Response to Adverse Incidents

As a final sub-claim under reasonable care and safety, the plaintiffs claim that GPW fails to investigate and respond to adverse incidents at the hospital. Despite these allegations, however, the evidence at trial showed that GPW has an effective plan in place for the investigation of adverse events. See, e.g., Tr. 9/5, 244.10-246.4; Tr. 9/6, 93.14-24; Tr. 8/28, 168.3-18; Tr. 9/6, 92.24-93.24; Tr. 9/6, 66.2-15; 99.8-100.14; Tr. 9/5, 173.25-174.21; 216.23-217.17; Tr. 9/6, 116.4-22; Tr. 9/6, 105.16-108.11; Tr. 9/6, 35-64; Tr. 9/6, 114.20-115.2, 111.7-19; Tr. 9/6, 91.11-92.2; 94.8-95.3; Tr. 9/6, 39.1-40.20; 9/6, 38.12-25; Tr. 9/6, 42.21-44.23; Tr. 9/6, 50.22-54.7; Tr. 9/6, 57.12-59.2; Exhibit D-65. Additionally, the evidence at trial showed that GPW investigates and responds to reports of adverse incidents and implements procedures to correct and/or prevent future problems. See id. In other words, GPW's investigations and responses to

adverse incidents at the hospital are based on professional judgment and comply with accepted professional practice and standards. Tr. 8/23, 39.4-40.15; Tr. 8/23, 36.6-36.9, 37.23-24; Tr. 9/6, 35-64.

(ii). Failure to Provide Adequate Treatment

The next constitutional claim asserted by the plaintiffs is that the patients at GPW do not receive adequate treatment. The sub-claims under this main claim are inadequate assessment of patients; inadequate treatment planning; inadequate provision of active treatment; and inadequate discharge planning.

Patient Assessment

Turning first to the sub-claim of inadequate assessment of patients, the plaintiffs contend that patient assessments at GPW fail to determine realistic rehabilitative goals and the appropriate treatment interventions needed to attain those goals. Contrary to these allegations, however, the evidence at trial shows that GPW's clinical assessments of patients are based on professional judgment and comply with accepted professional judgment, practice, or standards. See Youngberg, 457 U.S. 323; Tr. 8/31, 87.1-89.25; Tr. 8/31, 89.13-91.11; Tr. 8/31, 99.17-100.7; 207.6-15; Tr. 8/25, 88.19-90.3; Tr. 8/31, 96.10-98.20; Exhibit D-26; Tr. 8/31, 139.13-24.

Treatment Planning

Moving to the plaintiffs' sub-claim for inadequate treatment planning, the plaintiffs state that patients at GPW are provided ad hoc and inconsistent treatment activities that often bear only an incidental relationship to their therapeutic needs and goals. However, the evidence at trial shows that treatment planning at GPW is based on professional judgment that comports with accepted professional judgment, practice, or standards. See, e.g., Tr. 8/23, 107.12-18; Tr. 8/23, 187.10-213.12; Tr. 8/23, 138.24-144.6; Tr. 8/24, 10.3-13.11; Tr. 8/24, 140.2-7; 140.11-15; Exhibit D-135; Tr. 8/24, 147.1-18; 149.20-25; 150.3-17; Exhibit D-123 at 8-16; Tr. 8/24, 93.16-22. While it is true that the expert opinions at trial varied as to what treatment is best for any given patient, it is not appropriate for the Court to choose which of several professionally acceptable treatment planning choices should have been made. Treatment planning at GPW is based on professional judgment that comports with accepted professional judgment, practice, or standards. See Youngberg, 457 U.S. at 321; Tr. 8/24, 93.2-93.7.

Provision of Treatment and Treatment Programing

Much like their sub-claim for treatment planning, the plaintiffs also claim that the provision of active treatment at GPW is inadequate. Once again, however, the evidence at trial shows that treatment at GPW is based on professional judgment

that comports with accepted professional judgment, practice, or standards. See, e.g., Tr. 8/24, 78.5-16; Exhibit D-123 at 60; Tr. 8/28, 72.25-79.22; Tr. 8/31, 103.4-104.8; Tr. 8/25, 76.2-19; Tr. 8/25, 79.5-80.21; Tr. 8/29, 137.24-140.24; Tr. 8/25, 78.2-22; Tr. 8/25, 83.19-85.5; Tr. 8/29, 236.1-237.16; Exhibit D-47; Tr. 8/29, 242.14-243.12; 245.6-20; Exhibit D-114 at 11-12; Tr. 8/25, 124.1-125.14; 126.7-128.2; Exhibit D-114 at 14-20; Tr. 8/31, 218.10-17. Furthermore, the evidence at trial shows that treatment at GPW reasonably ensures patient safety and facilitates the patients' ability to function free from bodily restraints; prevents patients' basic self-care skills from deteriorating; and affords patients a reasonable opportunity to be cured or to improve their mental condition. See id.; Youngberg, 457 U.S. at 324; Donaldson, 493 F.2d at 520; Aderholt, 503 F.2d at 1312; Armstead, 629 F. Supp. at 276.

Discharge Planning

As a final sub-claim under failure to provide adequate treatment, the plaintiffs argue that discharge planning at GPW is inadequate. At trial, however, the evidence showed that GPW has an ongoing system for discharge planning that is based on professional judgment that comports with accepted professional practice and standards. DOJ Exhibit 148 at 2; Tr. 9/8, 96.17-98.8; Tr. 9/8,83.17-85.23; Tr. 9/8, 85.25-87.18; Tr. 9/8, 93.24-96.15; Tr. 9/8, 69.2-70.25; Exhibit D-117 at 11-13; Tr. 9/8,

81.25-82.9; Tr. 9/8, 81.25-82.21; 178.9-18. While the testimony at trial showed that every aspect of every patient's discharge plan was not always formally recorded in a set series of documents, the evidence also showed that GPW's discharge planning system is based on professional judgment that complies with accepted professional practice and standards. Tr. 9/8, 81.25-82.21; 178.9-18.

(iii). Provision of Community Health Services

The final constitutional claim raised by the plaintiffs is that the defendants are violating the Constitution in the provision of community mental health services to present and former GPW patients. More specifically, the plaintiffs allege that the defendants are not providing adequate community services to meet the assessed functional and clinical needs of current and former GPW patients, nor are they providing such services in the most integrated setting appropriate to the needs of those patients. At trial, however, the evidence did not support the plaintiffs' aforementioned constitutional claims. In fact, the evidence at trial showed that the defendants' provision of community services is based on professional judgment that comports with accepted professional practice and standards. See, e.g, Tr. 9/8, 45.2-18; Tr. 9/7, 21.15-23.7; Tr. 9/8, 45.19-46.23; 178.15-180.10; Tr. 9/8, 57.16-58.21; 106.2-6; Exhibit D-117 at 9; Tr. 8/15, 58.3-5; 59.1-6; Tr. 9/8, 75.19-76.5; DOJ

Exhibit 212 at Appendix D; DOJ Exhibit 333; Tr. 9/7, 72.11-75.14. Furthermore, no evidence at trial suggested that the provision of community services to current and former GPW patients was not taking place in the most integrated setting appropriate for the needs of those patients. While the testimony of some witnesses was that some GPW patients do not receive community services in the best of settings, this fact alone does not constitute a constitutional violation. The law requires that community services must comply with accepted professional judgment, practice, or standards, and does not require that community services be provided in the best conceivable setting possible. Youngberg, 457 U.S. at 323. Similarly, the testimony at trial showed that some of GPW's community patients, at times, end up in less than desirable circumstances after their discharge. While this anecdotal evidence is sad and unfortunate, it does not prove a constitutional violation due to the fact that it does not show that professional judgment, practice, or standards are not being complied with. See id. In fact, substantial evidence at trial showed that patients in the community often end up in unfortunate situations due to factors that are beyond the defendants' control. See, e.g., Tr. 8/15, 15.17-17.17 (patient recidivism); Tr. 9/8, 90.15-96.15 (conclusion of involuntary commitment status/loss of patient cooperation); Tr. 9/8, 90.15-96.15 (criminal conduct by patients).

(B). Claims Under the ADA

In addition to their constitutional claims, the plaintiffs also contend that the defendants are violating the ADA by failing to make reasonable modifications necessary to provide mental health services in the most integrated setting appropriate for patient needs. According to the plaintiffs, the ADA demands that mental health services be provided in community settings to the extent that such a setting is consistent with patient needs. See United States' and Plaintiffs' Post-Trial Memorandum of Law at 14. As noted previously, the crux of the plaintiffs' ADA claim is that the defendants are failing to reasonably modify their programs in light of the fact that they are failing to provide mental health services in the most integrated setting appropriate to patient needs. While the lion's share of the plaintiffs' arguments focuses on the modifications that the defendants could make to comply with the ADA, the underlying premise of the plaintiffs' ADA claim is faulty. Specifically, the evidence at trial did not show that the defendants were failing to administer GPW's mental health program in the most integrated setting appropriate to the needs of current and former GPW patients. See, e.g, Tr. 9/8, 45.2-18; Tr. 9/7, 21.15-23.7; Tr. 9/8, 45.19-46.23; 178.15-180.10; Tr. 9/8, 57.16-58.21; 106.2-6; Exhibit D-117 at 9; Tr. 8/15, 58.3-5; 59.1-6; Tr. 9/8, 75.19-76.5; DOJ Exhibit 212 at Appendix D; DOJ Exhibit 333; Tr. 9/7, 72.11-75.14.

In other words, while the plaintiffs' ADA claims focus on what modifications the defendants could make to improve their mental health program, their evidence at trial failed to prove that the defendants are in fact violating the ADA.

As noted above, the United States Supreme Court in the Olmstead decision held that:

> [Title II of the ADA requires placement of persons with mental disabilities in community settings rather than in institutions] 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 disabilities

Olmstead, 119 S.Ct. at 2181. With this holding in mind, the evidence at trial did not prove that the defendants are failing to place individuals in an appropriate community treatment setting when relevant treatment professionals have determined that community placement is appropriate. See supra, Part II(A)(iii). Given this fact, the plaintiffs have failed to show any violation of the ADA as interpreted by the Supreme Court in Olmstead.

Additionally, the plaintiffs' contend that the defendants' mental health program, as administered, results in unnecessary isolation of patients into segregated settings. Specifically, the plaintiffs claim that the alleged segregation of patients stems from the defendants' (1) failure to provide an appropriate

array and intensity of community services; (2) failure to plan for patient discharges; (3) failure to assess the needs of the patient population; and (4) failure to properly manage their resources and system accountability. Much like the similar claims made by the plaintiffs in their constitutional counts, however, the evidence at trial does not substantiate any of the alleged segregation claims. See supra, Part II(A); See also, Tr. 8/15, 58.3-5; 59.1-6; Tr. 9/8, 75.19-76.5; Tr. 8/10, 83.5-84.5; Tr. 8/15, 84.3-85.6; Tr. 8/15, 52.24-53.7; Tr. 9/5, 148.17-149.14; Tr. 8/17, 183.19-22; Tr. 8/15, 55.13-56.8; DOJ Exhibit 212, Appendix D; DOJ Exhibit 333. As a general matter, the evidence at trial did not show that the defendants' mental health program, as administered, results in unnecessary isolation of patients into segregated settings. See Tr. 9/6, 199.13-15; 202.17-201.25; Exhibit D-146A at §394.453; Tr. 9/7, 21.15-23.7; Tr. 9/7, 33.18-23; DOJ Exhibit 71; Exhibit D-100 at i-iii. Notwithstanding the four reasons offered by the plaintiffs as to why patients are unnecessarily isolated into segregated settings, the evidence at trial failed to show that patients are in fact isolated into segregated settings. Additionally, an examination of each of the four alleged problems offered by the plaintiffs, in light of the evidence presented at trial, shows that the defendants are not unnecessarily subjecting patients to isolated segregation.

As to the array and intensity of community settings provided by the defendants, the plaintiffs have offered ample evidence at trial to show that *different* community services could be offered by the defendants. The plaintiffs have also presented evidence that the community services offered by the defendants could be better, broader and more intense. Despite these facts, however, the plaintiffs have failed to show that the community services provided by the defendants are inadequate to the point that they result in unnecessary isolated segregation in violation of the ADA. See, e.g., Tr. 9/8, 45.2-18; Tr. 9/7, 21.15-23.7; Tr. 9/8, 45.19-46.23; 178.15-180.10; Tr. 9/8, 57.16-58.21; 106.2-6; Exhibit D-117 at 9; Tr. 8/15, 58.3-5; 59.1-6; Tr. 9/8, 75.19-76.5; DOJ Exhibit 212 at Appendix D; DOJ Exhibit 333; Tr. 9/7, 72.11-75.14.

As to discharge planning and patient needs assessments, the Court's previous discussion of these topics under the plaintiffs' constitutional claims is also relevant here.[6] The evidence at trial showed that discharge planning and patient needs assessment at GPW are not done in violation of the ADA See, DOJ Exhibit 148 at 2.; Tr. 9/8, 96.17-98.8; Tr. 9/8,83.17-85.23; Tr. 9/8, 85.25-87.18; Tr. 9/8, 93.24-96.15; Tr. 9/8, 69.2-70.25; Exhibit

[6]In fact, the plaintiffs themselves note the similarity between the arguments made in their constitutional claims and those made in their ADA segregation claims. See United States' and Plaintiffs' Post-Trial Memorandum of Law at 19.

D-117 at 11-13; Tr. 9/8, 81.25-82.9; Tr. 9/7, 39.6-16.DOJ Exhibit 80 at 5.

Finally, the defendants' resource management and system accountability as it relates to compliance with the ADA is irrelevant since no violation of the ADA has been proven. Having made the preceding finding that the defendants are not violating the ADA, it is unnecessary for the Court to examine whether the proposed modifications offered by the plaintiffs are reasonable and/or are fundamental alterations to the defendants' mental health program. In other words, there is no need for the Court to consider what program modifications would bring the defendants into compliance with the ADA given the fact that the Court has found that the defendants are not violating the ADA.

In this trial, the burden of proof was on the plaintiffs to prove by a preponderance of the evidence that the defendants are violating the statutory and constitutional rights of current and former GPW patients. They have not done so. While the plaintiffs have offered evidence that mistakes have been made and that conditions and programs could be different or in some cases better, they have failed to prove that the patients at GPW are inadequately supervised; inadequately treated for self-injurious behavior; inadequately protected from environmental hazards; or that adverse incidents are inadequately investigated and/or responded to. Additionally, the plaintiffs have failed to prove

inadequate assessment of patients; inadequate treatment planning; inadequate provision of active treatment; or inadequate discharge planning. As to community services, the plaintiffs have failed to prove that the defendants are not providing adequate community services to meet the assessed functional and clinical needs of current and former GPW patients, nor have they proven that the defendants are not providing such services in the most integrated setting appropriate to the needs of patients.

Likewise, the plaintiffs have failed to prove a violation of the ADA. Again, while 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.

Accordingly, it is hereby ORDERED AND ADJUDGED that the Clerk shall enter final judgment in this matter in favor of the defendants and against the plaintiffs and plaintiff-intervenor in this matter on all claims raised and tried in Case No. 8:87-Civ-369-T-24TBM during the weeks of August 7, 2000 through September 8, 2000.

DONE AND ORDERED at Tampa, Florida, this 28th day of June, 2001.

SUSAN C. BUCKLEW
United States District Judge

Copies to:

Counsel of Record