Gary W. v. Louisiana

United States District Court for the Eastern District of Louisiana
February 15, 1990, Decided; February 20, 1990, Filed and Entered
Civil Action No. 74-2412

Reporter: 1990 U.S. Dist. LEXIS 1746
GARY W., ET AL. v. STATE OF LOUISIANA, ET AL.

Opinion by: [*1] COLLINS

Opinion

FINDINGS OF FACT AND CONCLUSIONS OF LAW

ROBERT F. COLLINS, UNITED STATES DISTRICT JUDGE

This matter came before the Court on the motion of plaintiffs for supplemental relief, pursuant to 28 U.S.C. § 2002. After the hearing on this matter on October 19, 1989, the Court makes the following *Findings of Fact and Conclusions of Law.*

FINDINGS OF FACT

I. COURSE OF PROCEEDINGS AND PREVIOUS JUDICIAL ACTION

A. Preliminary Proceedings, the Trial and Findings by the Court

(1) Plaintiffs initiated this litigation in September of 1974 by filing a Complaint which alleged that Louisiana officials, through placing certain children in various Texas institutions, had denied them the care and treatment which was minimally adequate in a constitutional sense.

(2) The matter was assigned to then United States District Judge Alvin Rubin, who certified the matter as a class action in December of 1975, pursuant to *Rule 23(b)(1)* and *(b)(2) of the Federal Rules of Civil Procedure*. The class was defined as "all Louisiana citizens under twenty-one years of age who are placed or housed in a Texas child-caring institution at the instigation, on the order, or with funding, [*2] in whole or in any part, of the state Defendants."

(3) The 684 members of the class had one basic characteristic in common -- the fact that they were Louisiana children who had been placed in Texas institutions by Louisiana officials. Otherwise, they exhibited a wide range of needs and characteristics in that some were mentally retarded, others were emotionally disturbed, some had severe physical disabilities, and still others had no apparent physical or mental disabilities. Gary W., et al. v. State of Louisiana, et al., 437 F. Supp. 1209, 1213 (E.D. La. 1976) (hereinafter referred to as "Principal Order"). [1]

(4) A lengthy trial commenced in March of 1976. Over 47,000 pages of exhibits were introduced and 3,300 pages of testimonial depositions were entered into evidence. The trial lasted eleven days.

(5) Judge Rubin's Opinion concluded [*3] that classmembers possessed a constitutional right to adequate care and treatment which had been violated by their placement in Texas institutions. He defined the parameters of that right as encompassing

"a program of treatment that affords the individual a reasonable chance to acquire and maintain those life skills that enable him to cope as effectively as his own capacities permit with the demands of his own person and of his environment and to raise the level of his physical, mental and social efficiency."

Principal Order at 1219. In view of the evidence as to the abuse, neglect, unnecessary restraint, and restriction of classmembers in the Texas institutions, Judge Rubin held that the defendants had not met this standard of care for the class. Principal Order at 1216-1233.

B. The Remedy: The Principal Order

(6) As a result of his findings, Judge Rubin ordered the situation remedied on a classmember-specific basis: the bedrock of his Orders and those subsequent Orders of this Court was that treatment decisions and programs must be made on a case-by-case basis. As Judge Rubin said, "[w]hat is proper must be determined separately for each child based on that child's personal [*4] attributes and needs." Principal Order at 1219.

(7) Under the Principal Order, the defendants were obligated to evaluate each classmember, determine his or

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[1] The material which appears at 437 F. Supp. 1209 consists of three separate orders. The first, dated July 26, 1976, was, in effect, Findings of Fact and Conclusions of Law on the merits. The second, dated October 28, 1976, was Supplemental Reasons for the July 26 findings. The third, dated December 2, 1976, was a detailed Remedial Order.

her needs, and then develop and implement an individualized plan of treatment. Principal Order at 1226. Substantial emphasis was placed upon the important role to be played by disinterested professionals throughout the process. Principal Order at 1223, 1226-1227. This orientation towards the unique needs of each classmember represents the dominant theme of this lengthy litigation and is one that is rooted in the significant diversity of the members of the class. That theme has been reiterated in the many subsequent Orders issued in this case.

(8) Judge Rubin considered and specifically rejected a rigid formulation of the right to adequate care and treatment in terms of the physical location or characteristics of the treating facilities (e.g., community-based or institutional, within or out-of-state, etc.). Principal Order at 1219. As his decision expressly noted, "[o]ne prescription will not suffice for all [classmembers]. what the constitution requires as the state's due to the individual it confines is a program that is proper [*5] for that individual." Id.

(9) Section 2.1 of the Court Order required that the individual treatment plans be developed in accordance with evaluations conducted by the professional staff of the Department of Psychiatry and Biobehavioral Sciences of the Louisiana State University (LSU) School of Medicine in New Orleans. Principal Order at 1226. [2]

(10) To ensure compliance with his Orders, Judge Rubin devised a system of monitoring by the Court, plaintiffs' counsel, and the parents of the children. State officials were ordered to assign a case worker to each child who would visit the child as required in the treatment plan and then send a written report to the parents. Id. at 1231, paragraph 5.4. Each child's treatment plan would be reviewed semi-annually by professionals not affiliated with the treating institutions, and the review would include participation by the child's parents and case worker. Id. at 1226-27, paragraph 2.4. Plaintiffs' counsel were entitled to examine the reports of [*6] these "status-review" teams, and every six months, the State was required to submit a progress report to the Court and to counsel reflecting the status of implementation. Id. at 1227, paragraph 2.5. The superintendent of any institution treating a child was required to report on the child's progress to the parents every six months. Id. at 1231, paragraph 5.2.

(11) The Principal Order also provided for the dismissal of classmembers after certain conditions had been met. Id. at 1231, paragraph 5.5.

(12) Judge Rubin summarized his philosophy as to the remedy he devised as follows:

"In general, the Court has tried to avoid ordering the parties to comply with an order that would have the infinite detail of a set of engineering specifications. It has attempted to write guidelines that would prevent child abuse and assure good treatment for children without writing an order that would require infinite precautions against spectral perils and without enmeshing treatment personnel in a bureaucracy."Id. at 1223.

(13) In 1976 and 1977, the defendants began to attempt to locate the classmembers in Texas to transfer them back to facilities or homes in Louisiana and to schedule [*7] and conduct the LSU evaluations. A former tuberculosis hospital, Greenwell Springs, was used as a residential placement for many of the members of the class. A few new facilities, such as Padua House, owned and operated by Associated Catholic Charities in New Orleans, were opened.

(14) The Secretary of the Louisiana Department of Health and Human Resources (DHHR) appointed a special assistant, Melvin Meyers, to coordinate Gary W. compliance and to reassign all of the children to the various program offices. Almost all of the members of the class fell under the authority of the Office of Mental Health (OMH), the Office of Mental Retardation (OMR), or the Office of Human Development (OHD), although a few were assigned to two other offices, the Office of Family Security (OFS) and the Office of Licensing and Regulations.

(15) From the standpoint of implementation of the individual treatment plans, however, little progress was made in the first few years after the issuance of the Principal Order.

(16) Approximately six months after the Gary W. trial ended, Judge Rubin was elevated to the United States Court of Appeals for the Fifth Circuit. The case was rotated among several different [*8] district judges of the Eastern District of Louisiana until 1978, when the undersigned was confirmed.

C. The Supplemental Order and Appointment of a Special Master

(17) Within weeks of the confirmation of the undersigned, plaintiffs' counsel moved for the appointment of a Special Master and a panel of experts to develop a comprehensive implementation plan. After a review of the slow progress of the LSU evaluations and defendants' inability or unwillingness to implement those evaluations, this Court

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[2] This type of evaluation, although performed by other professionals as a result of negotiations discussed below, is referred to by the parties and Court as the "2.1 evaluations."

ordered the appointment of a Special Master, but denied plaintiffs' request for an expert planning team.

(18) Defendants appealed the decision to appoint a Special Master to the U.S. Fifth Circuit Court of Appeals. The Fifth Circuit upheld this Court's decision to appoint a Special Master, citing the facts that hundreds of children had not been evaluated by the LSU team, and, of those evaluated, over fifty percent had not been placed as recommended by the teams. The Fifth Circuit noted that "there is no indication that, left unsupervised, the Department [DHHR] and the LSU team will make better progress." See Gary W. v. State of Louisiana, 601 F.2d 240, 244 (5th Cir. 1979).

(19) [*9] On September 6, 1978, this Court issued a Supplemental Order, setting forth the powers and responsibilities of the Special Master. The Special Master was to function as an officer of the Court, a fact-finder, a monitor, and a hearing officer. The Special Master would make reports and recommendations to the District Court, and each party would then have the right to object to those recommendations and be afforded a hearing on those objections. The Special Master would serve until the last child was dismissed from the case.

(20) On March 29, 1979, the Court appointed Dr. James Lynn McDuffie as a part-time Special Master.

(21) After a year, counsel for plaintiffs asked that Dr. McDuffie be dismissed for failure to produce a comprehensive monitoring plan. This Court ordered that the Special Master contract with an outside group to monitor the case.

(22) One of those consultants selected was Dr. Sue A. Gant, who arrived in May of 1980 to design an "audit instrument," a device by which to measure objectively DHHR's compliance with the Principal Order. Dr. Gant's audit revealed serious deficiencies in the defendants' efforts at compliance.

(23) In September of 1980, Dr. McDuffie resigned [*10] as Special Master, and Dr. Gant was appointed as a full-time Special Master to replace him.

(24) Dr. Gant issued her first Compliance Audit on March 23, 1981. She then issued a formal report to the Court on April 21, 1981. Her report was based on reviews of 498 classmembers. The report showed that the defendants had made no plans to place 426 of the children evaluated by LSU, that more than half of the classmembers were still in institutions, and that the State's records failed to account for 186 of the members of the class. Dr. Gant identified major problems with DHHR's compliance activities and recommended immediate remedial action. Central to the remedial action was the recommendation of a detailed five-year implementation plan aimed at expanding the community services for members of the class in a cost effective manner. Dr. Gant recommended an implementation plan that would identify the bureaucratic roadblocks to compliance and outline specific steps and timelines to remedy the present situation of inadequate placements.

(25) Defendants objected to the Special Master's proposals and submitted their own plan. Defendants' alternate plan of implementation was designed to ensure compliance [*11] with the Principal Order by February 1983. Under that plan, children would be placed in the best "available" environment, rather than in the least restrictive alternatives. In other words, defendants' plan would have used existing resources and would not have fostered the development of a comprehensive system of community group homes, supervised apartments, and other less restrictive placements. The DHHR plan did not involve the participation of grass-roots advocacy groups, as the Special Master had recommended, and contemplated little involvement by the Special Master in the process of developing new services for the Gary W. classmembers.

(26) Defendants' plan challenged the Special Master's legal authority to involve herself in several areas that DHHR considered to be solely within its discretion.

(27) In its objections, the Department also noted that compliance with the Principal Order was a "complicated business." The class involved 686 children with entirely different needs which changed all the time. They were not confined at a central institution, but were spread around the State. Some were living in the community, and some had not ever been located. While one department, [*12] DHHR, was responsible for serving all of the class-members, any one of five separate agencies within that department might actually be in charge. [3] An analogy frequently invoked by the defendants during this period of time was that the Department was similar to an ocean-going ship, in that even though the decision had been made to turn around, the change in course would take some time to implement.

(28) Confronted with the Special Master's report and a counter proposal by the defendants, this Court requested that the parties negotiate with each other under the direction of the Special Master. Several hearings were held

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[3] As was mentioned above, the five agencies were OMR, OHD, OMH, the Office of Licensing and Regulations, and the Office of Family Security. Id. at 17-18.

and agreements were made and signed at these hearings addressing several issues.

(29) The central agreement, however, was the "Memorandum of Agreement," dated September 14, 1981. The Memorandum provided a wholly new procedure for the evaluation of classmembers. The LSU evaluations, many of which were incomplete, and all of which were dated, were discarded. Every child was entitled to be evaluated again in [*13] a much more systematic way, to determine what services the defendants were obligated to provide to them within the scope of the Principal Order which had been issued five years previously.

(30) Specifically, the parties agreed that the "2.1 evaluations" [4] were to be conducted by a "multi-disciplinary" team, comprised of persons selected by DHHR, but trained by the Special Master. Once those evaluations were completed, a final decision would be made by a Special Review Committee (SRC), composed of a member of the 2.1 evaluation team, a professional chosen by the plaintiffs, and a professional mutually agreed- upon by all of the parties. The parties agreed to try to conclude the SRC process in six months, by January 31, 1982, at which point, DHHR would begin the task of delivering the agreed upon services to members of the class. The question of the means by which "compliance" would then be measured was left to a later meeting.

(31) The Memorandum of Agreement committed DHHR to developing an overall plan that would set forth all agency actions necessary to bring DHHR into compliance [*14] with the Principal Order. It also bound DHHR to report any incidents of abuse or neglect inflicted upon members of the class to the Special Master within 24 hours. Additionally, defendants agreed to continue to search for Texas children who had been lost in the seven years since the case was first filed. DHHR also agreed to seek interagency agreements with the Department of Corrections, to seek appropriations for compliance activities, and to consider the "least restrictive environment" in selecting private service providers.

(32) Before signing the Memorandum of Agreement, defendants sought and obtained approval of then Governor, David C. Treen.

(33) The parties also agreed to add staff for the Special Master, and defendants agreed to submit periodic status reports on implementation of the Court's Order.

(34) An internal management plan for the Gary W. case, dated March 15, 1982, was filed by the defendants in connection with their October 26, 1983 Status Report. The
plan included specific internal management objectives for ensuring compliance with the Principal Order. The plan also included objectives, rationale, and action steps in a number of areas, including conclusion of [*15] the 2.1 and 2.4 evaluation processes and implementation of treatment and service plans for all classmembers.

(35) It is important to note that the DHHR internal management plan also addressed the following areas which remain of major concern in the implementation of the Principal Order to this day:

(a) Training. "To develop a Departmental training plan to include training in the areas of psycho-pharmacology, case management, individual service plan development, interdisciplinary team process, behavior management techniques and client rights"

(b) Abuse and Neglect. "To systematize the reporting procedures utilized in the reporting of abuse, neglect, mistreatment and deaths of classmembers"

(c) Case Management. "To develop a Department-wide case management system"

(d) Quality Assurance. "To develop a Department-wide program evaluation system"

(e) Specialized Services. "To develop the role and scope of responsibility for each program office to ensure a spectrum of services to all Department clients (regardless of placement)"

(f) Technical Assistance. "To develop within individual offices the capacity of provision of technical assistance and monitoring [*16] of programs operated directly or through contract"

(g) Consent and Legal Status. "To develop a Departmental policy on consent for medical treatment"; "To develop a reference manual regarding legal statuses in Louisiana"

(h) Standards. "To promulgate Departmental policy so that all standards set forth in the Principal Order are implemented and enforced for classmembers"

(i) Review and Update of Plans. "To conduct 2.4 evaluations on each classmember in residential placement six months following the review of the Special Review Committee and annually thereafter"

(j) Classmember Tracking. "To develop an adequate classmember tracking system [to track the classmember's needs and treatment plans]"

(36) By the end of June of 1982, 2.1 evaluations were completed on 277 classmembers and special reviews were

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[4] "2.1" refers to the paragraph of the Principal Order relating to evaluations of members of the class.

being prepared with respect to those classmembers whose medical condition was so precarious that movement to a new facility, less restrictive or not, was risky.

(37) In April of 1982, the Special Master issued a report and recommended remedial actions related to incidents of abuse, neglect, and mistreatment of classmembers, an issue that also remains a major concern [*17] to this day. The remedial actions recommended included staff training, human and legal rights committee review, and a system for sanctions for non-compliance.

(38) As a result of negotiations commencing in May of 1982, this Court signed an Order detailing the conduct of the SRC hearings at which the 2.1 recommendations would be reviewed and refined. That Order provided that the three members of each SRC would strive for consensus and established a mechanism for appeal of an SRC decision. By the end of 1982, SRC-approved plans were complete for all 290 out-of-home classmembers.

(39) During the same time period, the parties reached an agreement as to members of the class who were no longer in the care and custody of the defendants, individuals for whom the Principal Order had made no provision. Those classmembers were to be visited by a DHHR case worker. If they were in any immediate danger, steps were to be taken to make them safe. If not, the case worker would convene an evaluation conference with the classmember and other interested parties, agree upon a "generic services plan," and submit the plan for approval to a team composed of the case worker's supervisor and a professional [*18] selected by the plaintiffs. All services approved by the team would be provided or arranged as a free service by DHHR. A classmember, by signing the appropriate forms, would elect to "waive out" of the class, or forego this whole process.

(40) In February of 1983, Dr. Gant conducted a "debriefing" of the SRC members to get a better understanding of the recommendations they had made for over 200 members of the class. At that meeting, DHHR raised the question of what yardstick would be used to measure compliance with the Principal Order. Until it knew that, the Department argued, it would be difficult to begin implementing the SRC plans. The Special Master solicited proposals from the parties, and, on March 28, 1983, recommended a Quality Assurance Monitoring Document. The question of standards would be visited and re-visited on many occasions over the next several years.

(41) Defendants rejected the Special Master's recommendations and began negotiating, first with the Special Master and then with plaintiffs' counsel, to reach a mutually acceptable definition of "compliance." These negotiations continued, with no agreement reached, through 1983. The only substantive issue on which [*19] the parties agreed was that the "compliance clock" would begin once all services and programs were in place for each classmember and that after 18 months of "compliance", each child would be dismissed from the class.

(42) According to a Status Report submitted by defendants on October 26, 1983, covering the period from March 1981 to October 1983, DHHR hired consultants to prepare a manual on the rights of mentally retarded and mentally ill patients, including new minimum standards for State-licensed facilities. The Department hired a psychopharmacologist to develop a training manual on medications and a consultant on behavior management procedures to train private providers in behavior management techniques. A manual was developed by Gary W. case managers, and a Gary W. "Statewide Planning Council" was established with sub-committees on zoning, legislation, and advocacy. Furthermore, as discussed previously, an internal management plan was submitted in connection with the report.

(43) As of October of 1983, DHHR estimated that only 50 classmembers were in SRC-recommended placements and that only 30 of these had all of the recommended programs and services in place. Plaintiffs [*20] noted that 18 of these 50 were living where they were before the SRC process began and that DHHR, therefore, could claim to have created only 32 new "placements" as a result of the seven years of post-judgment litigation.

(44) In November of 1983, the parties reached an agreement, subsequently adopted by the Court, as to the policies and procedures establishing the implementation process for both placements and services. That Order established specific requirements for a planning process to be carried out for any classmember when there was to be any significant change in the classmember's program of services or placement.

D. Increasing Intervention by the Court

(45) By December 14, 1983, dissatisfied with the low level of placements of classmembers in their SRC residential facilities, this Court felt the need to mandate a timeline for compliance with its previous Orders. That Order adopted the timetable in DHHR's own report from October of that year, which had projected that by the end of 1984, all 277 SRC decisions affecting classmembers in State facilities would be implemented. Under that timeline, if DHHR implemented all placements, full compliance could be achieved and [*21] the case finally resolved by mid-1987. Quarterly conferences addressing the issue of progress towards compliance were to begin in April of 1984.

(46) Defendants moved immediately to amend the Order, raising a number of issues, including the question of the constitutionally minimal requirements which must be in place before an individual classmember was eligible for dismissal.

(47) By Order dated March 21, 1984, this Court placed the issue of compliance squarely in the hands of the Special Master. As was pointed out in that Order, "[[O]f great concern to the Court is the glaring contrast between the large amount of state resources invested in this case and the small amount of actual compliance with the Principal Order that has occurred to date." The Order accepted defendants' projected implementation schedule and made it binding. Compliance was defined as full implementation of all SRC-indicated services except guardianship, advocacy, and legal services. "Compliance" and hence dismissal of a classmember from the suit, were to be determined on an individual basis by the Special Master. The Special Master would be fully in charge of monitoring implementation of the SRC decisions. [*22] If in any month the State fulfilled less than 80% of its implementation goals, the Special Master was to convene a hearing. In addition, this Court mandated that a minimum of 50% of the placements in State-financed group homes of six or less had to be for members of the plaintiff class.

(48) As of August of 1984, 141 of the 241 classmembers evaluated under the SRC process were living in the community, with at least some of their services in place. In October of 1984, the Special Master issued a document entitled Report: Systemic Problems that Impede Implementation of the Principal Order; Remedial Actions Recommended.

(49) The findings of that report were issued three and one-half years after the first Compliance Audit and identified the problem areas which continue to this day, some five years later (and eight and one-half years after Dr. Gant's first Compliance Audit). These findings are summarized at page 5 as follows:

A number of problems continue to plague the system. The most obvious problem noted is the continued lack of ability to address problems in a comprehensive manner. Instead, crisis intervention by the central program offices and the holding of grass roots level [*23] personnel responsible without adequate authority, support and resources prevails. Other areas of concern are as follows:

(a) The lack of professional supervision of basic program delivery, known as case management;

(b) The lack of provision of adequate educational and vocational programs;

(c) The lack of provision of adequate health and therapy programs;

(d) The lack of provision of a comprehensive community service system;

(e) The failure to monitor adequately the quality of services in the community.

(50) On November 2, 1984, this Court issued an Order Governing Procedures for Responding to Special Master's Compliance Findings. That Order set forth the basic outline for compliance determination by the Special Master and the conditions under which the "compliance clock" could be stopped or started by the Special Master. The Order, in essence, used the full compliance standard this Court had adopted in its March, 1984 Order. It was clear that full compliance with the agreed upon standards constituted the yardstick against which defendants' actions would be measured.

(51) During this same period, the Special Master requested the assistance of personnel from Temple University's [*24] Developmental Disabilities Center to automate and analyze data collected by the Office of the Special Master. Data was gathered for the 137 individuals who were relocated from institutions to their SRC-recommended settings. Temple University issued a report to the Special Master dated December 15, 1984.

(52) The Temple University report showed that at that time, 56% of the SRC classmembers resided in Region 1 (New Orleans) or Region 2 (Baton Rouge). About 80% of the population was considered severely or profoundly impaired. The average Gary W. classmember was profoundly retarded and approximately 24 years old. The Temple University findings essentially mirrored those of the Special Master issued the previous October.

(53) In February of 1985, the Temple University team issued a report on changes in adaptive behavior of 268 classmembers originally monitored in 1981 who had been moved to community settings. The conclusion of the report was that the people who had moved to community placements were, in fact, better off in terms of adaptive behavior and that they were far less dependent than they formerly had been.

(54) In that same month, the Special Master issued a report on the [*25] status of implementation of Paragraph 5.3 of the Principal Order for classmembers in the community. That report reviewed the actions of the Court and the parties as they related to this segment of the class. The report summarized the process by which CRT classmembers had waived some or all of their rights and identified the services needed by those members in the

community, including routine dental and medical services; specialized medical, psychological, and counselling services; and educational and vocational services. It is worth noting that the defendants are still having problems delivering many of these services to classmembers in the community, a situation exacerbated by the fact that almost every member of the class resides in a community placement.

(55) In May of 1985, some 18 months after the Court had mandated a timeline of all SRC placements being implemented by December of 1984, this Court, dissatisfied with defendants' progress, gave even more specific instructions to ensure the placement of classmembers. Defendants were to report to the Court a schedule of placements for the 50 classmembers who had yet to be placed. Defendants were also to address certain barriers to [*26] placement, including the inadequate recruitment of providers, as well as actions taken to ensure the adequacy of services to be provided and the provision of specialized training for private providers. Again, over four years later, defendants still have not eliminated these barriers.

(56) In early June of 1985, the Special Master issued a report on a classmember-specific basis for selected individuals for whom she had concerns. The report listed for each classmember the area of concern, an explanation of the concern, a remedy to be implemented, and a timeline for implementation. A similar report was issued subsequently. The purpose of these reports was to give the parties notice of problem areas uncovered by the Office of the Special Master so that the problems could be eliminated before the joint audit process began. [5]

(57) By June of 1985, the parties submitted a joint motion and [*27] memorandum regarding compliance standards, with the parties representing to the Court that "agreement to these Standards removes the possibility of any further delays due to disagreements about what Standards the Special Master will apply in determining compliance for each class member."

(58) As the first round of joint audits were completed, it became apparent to Cecil N. Colwell, Assistant Secretary of DHHR and head of the Office of Mental Retardation, that certain aspects of the previously approved standards applicable to Adult Day Programs were misunderstood and misinterpreted by employees who were preparing for joint audits. Accordingly, on February 5, 1986, he issued a memorandum to all OMR administrators to address this problem. Among the issues covered by Mr. Colwell's memorandum were those of sheltered and supported employment and a clarification of the definitions for Day Services.

(59) On March 17, 1986, a report was made to the Special Master by Clarence Sundram and Nancy Ray concerning the Abuse and Neglect Reporting and Investigation System as it related to classmembers. The report, since designated the "Sundram Report," recommended strongly that the abuse/neglect policy [*28] be changed to formulate a uniform state policy concerning the protection from abuse, neglect, and mistreatment of people in state custody, and that legislative action be taken to accomplish these changes. Among the specific recommendations of the Sundram Report were for a follow-up of all recommendations emanating from investigations or the incident review process: "[t]he responsibility for ensuring that such follow-up has in fact occurred should be lodged with the central intake point to assure accountability." Other recommendations were for external oversight of the entire reporting and investigation system, and structural revision of the Department to establish a Division of Abuse and Neglect Reporting within the Department which would report directly to the Secretary. The new division would have a variety of duties and functions, including the responsibility to "make referrals for corrective action to the appropriate program division within DHHR where systemic problems were identified, either as a result of reviewing investigation reports or the minutes of incident review committees [and] to follow-up with the program division to ensure implementation of necessary corrective actions."

[*29] (60) The Sundram Report was issued five years after the Special Master noted abuse and neglect as a major problem area and four years after defendants' Plan of Compliance set forth a plan "to systematize the reporting procedures utilized in the reporting of abuse, neglect, mistreatment and deaths of classmembers."

(61) On May 19, 1986, the Special Master issued an analysis of joint audit data on SRC classmembers, listing the rank order of deficiencies (both residential and day program) with a breakdown of the data by case manager, region, and program office. The data also showed the months of compliance credit for CRT classmembers with the same breakdowns. The standards which were missed most often were those related to case management (71% deficiencies), delivery of services (71%), and professional supervision of services (62%). Other problem areas were medication administration, behavior management, abuse and neglect, and humane physical and psychological

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[5] The joint audit process at that juncture of the case was to be conducted jointly by the Office of the Special Master and the defendants to determine objectively (i.e., measured against the objective standards of the audit instrument) where defendants stood in relation to each member of the class.

environment. The narrative noted the need for technical assistance and local supervision of case managers. It also concluded that behavior management programs were not being implemented properly because of a lack of sufficient [*30] staff with appropriate training, rendering the plan "not only . . . ineffective, but often times harmful. . . . Without the safeguard of training those individuals responsible for implementing these sensitive behavioral programs, classmembers are subject to harm." It is important to note that these same problem areas continue to exist over three years later.

(62) On May 26, 1986, John O'Brien and Connie Lyle issued a report entitled, Strengthening the System: Improving Louisiana's Community Residential Services for People with Developmental Disabilities. The report focused on a number of issues, including the failure to make better use of the time of professionals with whom the State had contracted to provide services, the methods of providing funding as a limitation on the variety and development of services, an under-utilization of the Title XIX funding mechanism, problems with rates to providers, and capacity problems with the current system of providing residential and support services. A major part of the report was devoted specifically to the problems of Region 1 of OMR. Among the findings of the O'Brien report in that regard were the following:

(a) The region "is unmanageably [*31] large and complex and OMR resources are physically located in [the former Belle Chasse State School]." The report concluded that the specialists and case managers should be physically relocated to one or more locations close to classmembers and that the region should be divided into more manageable, sub-regional areas "which respect the natural boundaries recognized by the region's people."

(b) Case management resources "are insufficient to meet the obligations placed upon them." The report concluded that the case managers priorities and responsibilities should be examined and changed.

(c) Existing day providers "are over-committed and have limited capacity to create supported work."

(d) The region has "a limited capacity to develop providers even though new places for people with increasingly complex needs are needed."

(e) Technical assistance which is available in the region "mostly relates to the regulatory process," not to the provision of services.

(f) "[T]he system invests a very "large proportion of its resources in large, congregate settings."

(63) On May 21, 1986, this Court directed the Department to submit a plan of action addressing the barriers to implementation [*32] of the Court's Orders in Region 1 of the OMR. In July of 1986, defendants submitted such a plan.

(64) The plan submitted by the defendants identified the following barriers "to the effective and efficient operation of the OMR/DD Regional organization and as a consequence, to the service delivery system as a whole":

(a) There was no viable organizational structure at the Regional staff level.

(b) Although broad "job descriptions" existed for Regional staff members, there were no clear and definitive areas of responsibilities assigned to individual staff.

(c) Related to the absence of clearly defined job responsibilities was the absence of accountability for task completion.

(d) Minimum supervision of staff had existed; where supervision existed, the quality of supervision had been less than adequate.

(e) The Community Services staff in Region 1 had not existed as an integrated staff of professionals united by common goals or objectives related to the develop-ment and management of community-based services. The result had contributed to the fragmentation of the delivery system. Critical to the absence of a coordinated team effort had been the absence of leadership within the [*33] Regional staff section.

(f) There was no broad and comprehensive vision and commitment to community services. Reflecting this factor had been the absence of staff knowledge and information related to the variety of issues and disciplines that must be brought to bear in a community based service delivery system.

(g) Region 1 Community Services, in reality, had little identity as a service delivery system. One reason for this occurrence was the close tie Community Services had with Metropolitan Developmental Center and the fact that it was housed on the grounds of that State institution.

(65) The plan for reorganization of Region 1 included a relocation of the staff to the East Bank of the Mississippi River, a structural re-organization with the addition of ten new staff positions, and a re-definition of job functions.

(66) Over three years later, the Regional Staff is still located in a geographically remote area of the Region and little has been done to ameliorate the clearly defined barriers to the delivery of services in the New Orleans area where most class-members now live.

E. The Shift from Full Compliance to Substantial Compliance And Independent Monitoring

(67) [*34] On October 23, 1986, this Court amended its Order of November 2, 1984 by changing the standard against which defendants' progress would be measured from full compliance to substantial compliance. By that point in time, all but nine members of the class had been placed in their residential placements. In deciding to shift from full compliance to substantial compliance, this Court noted its concern that full compliance did not allow the Court and the parties the flexibility to deal with the issues involved in the litigation. The new standard was to be retroactively applied, with the Special Master reviewing all previous recommendations for the award of compliance time. Significantly, however, this Court served notice that it expected services to remain intact even after members of the class were dismissed. Defendants were ordered for the first time to provide semi-annual reports for three years following the discharge of a member of the class with the reports to detail the quality and quantity of the services actually provided to former class-members. Any discharged classmember would be reinstated if there is a significant decrease in the quantity or quality of services provided [*35] or if a discharged classmember is reinstitutionalized.

(68) On November 5, 1986, after Dr. Sue A. Gant had announced her intention to resign as Special Master effective January 1, 1987, this Court issued a Minute Entry addressing the State's Motion to Vacate the Supplemental Order of September 11, 1978. The Supplemental Order had established the Office of the Special Master. That Minute Entry found that changed circumstances (i.e., the placement of most of the members of the class in their residential facilities) had eliminated the necessity for the extraordinary remedy of the appointment of a Special Master. To avoid disruption of services, however, the Court decided to continue the operation of the office until July 30, 1987.

(69) On November 20, 1986, Dr. Gant issued a formal report and requested remedial actions related to the abuse, neglect and mistreatment of classmembers. The report and requested remedial actions echoed those of the Sundram Report in March of 1986 and Dr. Gant's 1981 Report. It also noted that although defendants had submitted a draft policy, the DHHR proposal omitted "a number of areas critical to the protection of class-members from harm." The Special Master [*36] recommended yet another series of remedial actions by the defendants including, "follow-up of all recommendations emanating from investigations or the incident review process. The responsibility for ensuring such follow-up has in fact occurred should be lodged with the central intake point to assure accountability." Dr. Gant also recommended external oversight of the entire reporting and investigation system, as well as the other matters discussed in paragraph 60 above. Again, it is important to note that the evidence presented at the most recent evidentiary hearing shows the same problems still exist.

(70) In late 1986, the Louisiana State Planning Council on Developmental Disabilities issued, along with OMR, a Three Year State Plan for fiscal years 1987 to 1989. The report detailed a number of problems in the Louisiana system of delivery of services to mentally retarded individuals. Specifically noted for their absence were specialized medical services, especially in neurology, nutrition, orthopedics, and psychiatry; staff training, particularly in seizure management, medication administration, and in identification and referral to generic health agencies; vocational opportunities, [*37] particularly in competitive employment, job development, job placement, and follow-up services; case management, with special note made that many case management coordinator positions had been eliminated by OMR; and other gaps and obstacles to the delivery of services. Today, three years after these problems were again identified by OMR, the same problems still persist.

(71) In late December of 1987, the Special Master issued another report, entitled Changes in Behavior 1981 to 1986, Among People Monitored in Community Based settings. The report traced the history of her collection of data on members of the Gary W. class from 1981 and noted that classmembers had gained a number of adaptive behavior skills during the period since 1981. The Special Master concluded that classmembers and their families expressed satisfaction with both the living arrangements and work situations of classmembers after they had moved from large institutions into the community.

(72) On January 30, 1987, this Court held a status conference and introduced Dr. Brenda Lyles as the new Special Master. Dr. Lyles formerly had been a career DHHR employee, with particular training in the problems of the mentally [*38] ill. She had been directly involved with the Gary W. case as a State employee and was very familiar with defendants' compliance problems, including those in Region 1.

(73) By May of 1987, Dr. Lyles issued a preliminary report on audit findings for the period of August, 1986 to March, 1987, using the "substantial compliance" standard. As has been pointed out previously, almost every member of the class had been placed in a residential placement as recommended by the SRC. Dr. Lyles' report, however, found major problems in both residential and day programs. The most frequently cited problem area was that

of case management, with approximately 60% of the class having problems in that area. Dr. Lyles concluded that the case management system had completely broken dawn and that these deficiencies "preclude adequate treatment and substantial compliance" with the Orders of this Court. Abuse and neglect was also cited as a major problem area, as was the life safety area, with 41% of the residential programs and 51% of the day programs showing major problems in regard to life safety. Overall, the report revealed deficiencies that went far beyond mere technicalities. Even using the substantial [*39] compliance yardstick, Dr. Lyles concluded that many of the standards with high levels of deficiencies were fundamental to the provision of adequate treatment of classmembers and that the deficiencies in these areas precluded compliance with the Principal Order. It was clear at this point in time that this Court's decision to reduce the level of compliance required from full to substantial compliance would not eliminate the difficulties the defendants had in implementing the Court's Orders.

(74) On June 10, 1987, this Court issued an Order setting up an independent monitoring unit to review defendants' compliance efforts. The Court pointed out that although when it had initially decided to terminate the Office of the Special Master effective July 30, 1987, it was hopeful that DHHR would be able to assume the responsibilities of the Office of Special Master, she Department clearly was unable to do so. The State had shown the Court nothing which indicated that DHHR was capable of assuming those responsibilities. The Court noted particularly its concern about the ability of DHHR to handle "the identification of individual and systemic barriers to the implementation of the Principal [*40] Order" and the lack of "independent oversight of the State's self-monitoring efforts and abuse and neglect reporting procedures." Over two years later, this Court has the same concerns.

(75) The Court decided to extend the Office of Special Master for one month, to August 31, 1987, and to require a transition from the Special Master to a United States Magistrate with respect to responsibility for determining dismissal eligibility. The Court also ordered that an independent monitoring unit, to be appointed by July 15, 1987 for a term of one year, would be substituted for the Office of Special Master in the monitoring of compliance. The joint audits would proceed in three phases: the first would be joint audits with the monitoring unit and DHHR; the second would be done by DHHR, with sampling by the monitor; and the third phase would involve "exclusive self-monitoring by the State with observation by the independent monitoring unit to assure that the problems identified have been corrected and that the State has developed full capacity to self-monitor." It bears noting that the initial joint audits for each classmember were not completed until September of this year, some two years [*41] later. Many of those audits have not been through the Second Level Review process to this day. Phases two and three have yet to be implemented.

(76) The independent monitoring unit was also to be involved in the preparation of narrative and statistical reports for the Court and the parties "which concern classmembers' progress towards substantial compliance and the State's progress towards developing the capacity to self-monitor." The reports were to be issued semi-annually, and, as the responsibilities of the monitoring group were gradually phased out, "the State will prepare the reports with the assistance of the monitors. Upon termination of the responsibilities of the independent monitoring unit, the State will have full responsibility for the reports." The Court also served notice that it would revisit the issue of whether to reinstate the 1978 Supplemental Order establishing the Office of the Special Master in nine months, based on information provided through the monitoring unit and reports submitted to the Magistrate by the State. That issue had not been formally reviewed by this Court until the instant proceedings were initiated.

(77) On July 10, 1987, this Court appointed [*42] the members of the Monitoring Unit. The appointment was to be for a one-year term, beginning on September 1, 1987.

F. Continued Abuse/Neglect Problems

(78) Abuse and neglect issues which had been addressed in the Sundram Report in March, 1986, and Dr. Gant's report in November, 1986, again moved to the forefront during the remainder of 1987. Before the Office of Special Master was terminated, Dr. Lyles issued a Formal Recommendation on abuse and neglect. The defendants objected to the Recommendation. Plaintiffs' counsel replied to the objection and set the matter for hearing before the Magistrate.

(79) An evidentiary hearing on the Special Master's recommendation was held before Magistrate Ivan L.R. Lemelle on January 29, 1988. The Magistrate made Findings and Recommendations to the Court on March 1, 1988.

(80) The Magistrate's recommendation highlighted major areas of concern with regard to the health, safety and quality of services for specific classmembers. The Magistrate found it "obvious to this Court that the existing [abuse and neglect] policy while acceptable in some areas needs to be improved as is demonstrated by the lack of evaluation of trends by the existing Human [*43] Rights Committee as well as the concomitant lack of development of appropriate interventions based on the

analysis." The Magistrate noted three specific examples of abuse/neglect but concluded that the three were not isolated instances and that the Court needed to intervene: "[s]omething more than 'deliberate speed' following over a decade of litigation and something more than the existing policy is needed to prevent further harm or discrimination." The Magistrate set deadlines for analysis, corrective action plans, and verification of the corrective action plans, all to be reported to him by March 16, 1988.

(81) Most significantly, for current purposes was the language of the final paragraph of the Magistrate's Opinion:

All parties are on notice that given the present deadlines and need for providing an adequate, lasting, and complete system for protecting classmembers, the Court may have no alternative other than to extend the life of the monitoring unit beyond the existing September, 1988 contract. ACcordingly, it would be appropriate for all parties to demonstrate, at this time more so than at any other, a good faith renewed commitment toward alleviating the problems of [*44] abuse that have plague classmembers over the course of this action.

(82) The parties and the independent monitors met and reached consensus on an abuse and neglect policy which was issued by the Magistrate as Amended Findings and Recommendations on May 5, 1988.

(83) This Court adopted the Amended Findings and Recommendations on the same day. The Court's Order also stated that as long as the Quality Assurance Monitoring Group (QAMG) existed, it was to perform the functions of the External Oversight Committee described in the Recommendations. Furthermore, the Court provided that "[u]pon termination of the order of July 9, 1987 relating to the Independent Monitoring Unit, . . . the Court will select and appoint a unit to undertake these activities. The Court's selection will take into consideration any groups recommended by the parties to serve as the External Oversight Committee."

(84) On June 17, 1988, this Court, "[u]pon review of the correspondence, documents submitted to the Court and all other activities of the Quality Assurance Monitoring Unit in connection with its oversight of the progress of the Defendants in the above captioned case," extended the services of QAMG as independent [*45] monitor through September 1, 1989. The Court listed two specific factors which contributed to its decision: (1) the inability to complete adequate program audits of a substantial number of classmembers; and (2) the failure to assign adequate personnel for the Gary W. Project Office of DHHR, along with detailed descriptions of the duties and functions of said personnel. Dissatisfied with the lack of progress on the joint audits, the Court also ordered the parties to complete a minimum of 150 detailed program audits of Gary W. classmembers and "to move with all deliberate speed towards the development of an adequate process for the final resolution of all Gary W. matters."

G. Continued Problems with Region 1 of OMR

(85) In early August of 1988, QAMG issued a report on substantial compliance credit, summarizing the amount of compliance time awarded to classmembers. QAMG's report revealed substantial deficiencies in terms of the nature and quality of services to classmembers residing in facilities operated by VANCO, a service provider in the New Orleans area. At that time, 13 of the 17 classmembers who had received no months of compliance credit were residents of VANCO [*46] facilities. A second report by QAMG summarized the historical and then current deficiencies associated with VANCO programs and documented numerous instances of VANCO's failure to take all steps necessary to ensure that classmembers are protected from harm and serious injuries and that they receive adequate care and treatment consistent with the Principal Order. The parties agreed that the 12 VANCO classmembers should be moved to interim placements, and this Court issued an Order to that effect.

(86) The August 31, 1988 Order required the defendants to submit a report delineating plans for moving classmembers into community residences in accordance with their SRC plans. By letter dated December 19, 1988, Dr. Lyles of QAMG forwarded to Magistrate Lemelle a report addressing major concerns concerning the DHHR plans, particularly focusing on the problems of Region 1 of OMR. QAMG pointed out that the defendants' plan failed to address serious problems in the following areas:

(a) lack of training and professional supervision for case manager;

(b) lack of case managers' involvement in the selection of providers to serve classmembers;

(c) lack of case managers' involvement in the placement [*47] process;

(d) lack of planning by the State to assist providers in the development of programs for members of the class and to provide classmember-specific assistance to providers;

(e) lack of individualized treatment plans for transition of classmembers to the new providers;

(f) lack of sufficient information as to new providers;

(g) no report on departmental efforts to encourage and assist current providers in expanding their services;

(h) no evidence of classmember or family involvement in the planning process;

(i) no evidence of the type and scope of training of staff, staffing patterns and the adequacy of support services;

(j) no targeted timelines for professionals who will provide services; no plan or requirement for the level and scope of training of staff in the new settings;

(k) lack of attention to day programs consistent with the SRC-required services upon re-entry into the community; and

(l) lack of use of the vast amount of information on each classmember in the planning and implementation of services upon transition back into the community.

The conclusion of the report is worth noting:

This review with summary of major concerns and recommendations [*48] is certainly not exhaustive. The [State] plan needs much more detail, with timelines and goals, objectives and procedures to audit progress. The State has demonstrated in the development of the Audit Plan that it has the technical expertise to put together a document with all the needed aspects of an action plan. We recommend this expertise be applied to the present plan with specific responsibilities assigned, action steps laid out and timelines set.

(87) This Court elected to lower the standard of compliance and to begin turning back over responsibilities to the defendants from the Office of the Special Master.

(88) In the three years since those decisions were made, the defendants have proven themselves incapable of fulfilling their responsibilities. Clearly defined problem areas have not been resolved. The concerns expressed by this Court in June of 1987 about the defendants' ability to identify and address individual and systemic barriers to the implementation of the Principal Order have proved well-founded. The long identified abuse/neglect problems were not addressed by the defendants until they were forced to do so. The problems of classmembers in VANCO in Region 1 of OMR [*49] were not addressed by the defendants until after the QAMG Report was issued in August, 1988.

(89) Whenever this Court has expected the defendants to demonstrate their ability, capacity, and willingness to provide classmembers with their constitutional due, it has been met with a dismal record of non-compliance and management by crisis. The evidence now placed before this Court, coupled with the pervasive history of non-compliance, clearly shows the defendants do not have the ability, capacity and willingness to adhere to this Court's orders.

II. THE PROCESSES FOR DETERMINING COMPLIANCE CREDIT: THE JOINT AUDIT AND SECOND LEVEL REVIEW

(90) As pointed out above, the previous Orders of this Court have established not only the detailed standards against which the defendants' compliance efforts will be measured, but also the specific procedures by which the parties will objectively determine the actual status of each member of the class.

(91) The Gary W Audit Manual was finalized in January, 1989. The parties have agreed that the following is an overview of the Joint Audit Process:

The parties have agreed upon a joint audit process. The purpose of the process is to gather data [*50] regarding the services provided to individual classmembers.

The joint audit currently involves the participation of two representatives: one from QAMG and one from the defendants.

In preparation for the on-site visit, the case manager prepares and forwards to the Project Office the following information: (1) SRC/CRT On-Going Services Chart: Completed by Case Manager; (2) Log of Monthly Day and Residential Visits; (3) Classmember Profile Sheet; (4) Classmembr's Current GSP and SSP; (5) Verified/Updated Placement History; and (6) List of names of all staff who currently work with the classmember. The Project Office collects validated abuse/neglect reports for the audit period, most recent licensing report and placement history and SRC/CRT services. The Project Office forwards all of the above listed data to the auditors representing DHHR and QAMG for review prior to the site visit.

On-site, the audit team has the following responsibilities:

(a) Interview case manager and/or qualified professional to obtain information for rating standards, completing Summary of Classmember Plan, and the services bargraph.

(b) Review staff training records at both residential and day program.

[*51] (c) Review incident logs at both residential and day programs.

(d) Review pertinent classmember records.

(e) Rate core and appropriate classmember specific standards.

(f) Interview classmember or a person who is familiar with him for completion of the Quality of Life Questionnaire.

(g) Tour both residential and day programs and summarize observations on appropriate forms.

The auditors record relevant information on the appropriate arms. They conclude the on-site Joint Audit with a survey debriefing session which informs providers of the audit findings both positive and negative, and explain deficiencies that need to be remedied.

Auditors then forward Joint Audit documents to appropriate offices: original to Project office, copy to QAMG.

92. The parties have also stipulated as to the following description of the Second Level Review process:

Late in 1987, the plaintiffs and defendants agreed upon a process for determining awards of compliance credit on

a classmember specific basis. The procedures involved constitute what is known as Second Level Review.

A three-person team reviews audit and related information for each class member who has been audited. A representative [*52] from plaintiffs, defendants, and QAMG constitute the team.

The team assesses the defendants' performance with regard to each individual classmember in the following areas: (a) the standards identified in the audit instrument; (b) the provision of mandated CRT/SRC services as reflected by the services paragraph; (e) compliance with other regulatory agency requirements; (d) relevant abuse/neglect information; and (e) the results of the quality of life survey.

As a result of its review, the team makes a determination of the months during the audit period when substantial compliance has occurred with respect to each classmember while the team members have agreed to certain general guidelines governing compliance determinations, the members do exercise reasonable professional judgment with respect to such determinations. Flexibility in the application of the substantial compliance standard consistently has been exhibited.

In addition to the responsibilities noted above, the review team possesses certain additional authority. It may: (a) recommend that the defendants undertake certain corrective actions prior to the classmember's dismissal; (b) defer action until additional data or [*53] documentation is provided by the defendants; or (c) recommend an award of compliance credit contingent upon completion and verification of certain corrective action.

When the members reach unanimous agreement as to specific months of compliance, the team issues a recommendation for compliance credit. The recommendation is forwarded to the Magistrate for review and approval. If the members are unable to agree upon a compliance recommendation, the matter is referred to the Magistrate for a decision.

III. THE CURRENT SITUATION; CONTINUED PROBLEMS WITH COMPLIANCE WITH THE ORDERS OF THIS COURT

93. The plaintiffs presented testimony from four witnesses, each of whom agreed the State has continuing and substantial problems which must be addressed before members of the class as a whole can expect to earn compliance time sufficient for their dismissal from the case. Those witnesses were Jerry Vincent, Deputy Assistant Secretary for the Office of Mental Retardation and Developmental Disabilities for the State of Louisiana; Rosemary Estes, Director of the Gary in. Project Office for the State of Louisiana; Linda Jones; and Celia Feinstein, Director of Quality Assurance and Monitoring [*54] at Temple University's Developmental Disabilities Center in Philadelphia, Pennsylvania.

94. In addition to abuse and neglect reporting, each of the witnesses for the plaintiffs agreed that the defendants have historically had and continue to have major problems in the following areas:

(a) gathering and anlayzing data;

(b) case management;

(c) staff training;

(d) protecting classmembers from harm;

(e) classmembers at risk of falling out of placement;

(f) specialized services;

(g) Region 1 of the Office of Mental Retardation;

(h) problems with respect to lower functioning classmembers; and

(i) lack of involvement of classmembers and their families.

95. Furthermore, these deficiencies noted by the Joint Audit Process have been confirmed by the Second Level Reviews which have been done to date. Additionally, there are continued problems with defendants' abilities to

self-monitor and with the attitudinal deficiencies of defendants. Finally, the class-members are being harmed by these problems, separate and apart from the abuse and neglect process.

96. As noted above, there is little substantive dispute between the parties as to the accuracy of the raw data from the Joint [*55] Audit Process and Second Level Reviews, since the parties participate throughout both processes. There also is little dispute about the methodology used in the QAMG Report, but there is disagreement as to the interpretations of the results of the analyses.

A. Overall Review of the QAMG Report

97. At the request of plaintiffs, Ms. Feinstein reviewed the Joint Audit Report (January - April 1989) issued by QAMG on August 31, 1989 That report summarized the results of joint audits conducted for 143 classmembers and compliance determinations for 95 classmembers for whom the Second Level Review Team had recommended awards for substantial compliance.

98. The methodology employed by QAMG in compiling this report fully satisfies prevailing professional standards and is consistent with sound statistical practices.

99. Overall, the Court finds that the Report consists of valid and reliable measures designed to assess the existence and quality of services to classmembers. It represents an accurate summary of the status of compliance in this case.

100. The data contained in the QAMG Report indicates that significant areas of non-compliance exist with respect to the provision of services [*56] to classmembers. Substantial numbers of these individuals continue to be without necessary therapeutic and supportive services or adequate day programs.

101. These service gaps, in turn, are indicative of the existence of definite systemic barriers to non-compliance. As was explored exhaustively above, all of these barriers have been identified previously in the record, and the parties and the Court have known of them for years.

102. In reviewing the data in the QAMG Report, it is essential to keep in mind the relatively minimal level of substantial compliance presently required of defendants.

103. By agreement of the parties, the number of standards used in auditing classmembers has been substantially reduced. The original number of audit standards stood at 133. while the actual number applied in current audits varies according to the characteristics of the classmember, an SRC classmember will generally be audited on approximately 45 standards and a CRT individual on 20-25.

104. The reduction in the number of standards definitely has lowered the level of compliance expected of the defendants. The parties, by agreement, eliminated more than just duplicative standards; they eliminated [*57] ones that were the primary indicators of compliance in their respective areas. The level of substantial compliance now required of the defendants in present audits is distinctly lower than that required in previous audits.

105. A second methodological factor of importance relates to those classmembers for whom audits were conducted. With respect to the first audit group, the defendants selected one-half of the classmembers to be audited. In general, they selected individuals who were likely to be eligible for substantial amounts of compliance credit.

B. Deficiencies in Gathering And Analyzing Data

106. Basic problems exist with respect to the information which the defendants gather regarding classmembers and the defendants' capacity to analyze that information.

107. The defendants receive a good deal of information about classmembers from the results of audits and the abuse/neglect reporting system, but in the past, they have not known how to use that information.

108. At this point, the Office of Community Services (OCS), the successor organization to the former Office of Human Development, does not have the computer capacity to aggregate audit and Second Level Review data [*58] as to classmembers for whom it provides case management services.

109. Primary responsibility for this function lies with the Project Office, yet to date that office has produced only a minimal number of skeletal summaries on the current audits.

110. Defendants have not issued any formal reports summarizing the results of the data gathered from the joint audits. nor has the Project Office put out a formal, written analysis of the data generated by Second Level Reviews.

111. In short, defendants have not undertaken a systematic analysis of the data on classmembers currently available to them.

112. Defendants, for example, have not used the data from the audits and Second Level Reviews in a systematic effort to identify problem areas - either in terms of program offices, regions or providers - and develop remedial approaches.

113. The Project Office has not made any specific recommendations to the program offices based on the results of the audits.

114. Nor have the defendants used available data to identify "at risk" classmembers - those who are in danger of being reinstitutionalized. There are no current plans to identify such classmembers.

115. Similarly, defendants have not undertaken [*59] trend analyses to identify factors associated with the reinstitutionalization of classmembers. The lack of data analysis in this area is particularly disturbing in view of the relatively high rates of reinstitutionalization - higher than in any other case with which Ms. Feinstein has been involved.

C. Deficiencies in the Provision of Case Management Services

116. Difficulties continue to persist in the area of case management services. Problems in this area undermine the actual provision and supervision of all other services to classmembers.

117. One-fifth or 20% of the classmembers audited did not have at least one monthly meeting at their residences with their case managers.

118. In view of the minimal requirements of this standard (3.1.3.2) and the critical importance of case management services, such low ratings constitute another area of systemic non-compliance.

119. Case managers presently have inadequate and insufficient training opportunities. Case managers could use more frequent and more intensive training particularly with regard to program planning, the interdisciplinary team process, and information as to disabilities.

D. Deficiencies in Staff Training

[*60] 120. Deficiencies in the training provided to direct care staff continues to be a problem area, particularly with respect to day program providers.

121. In several ratings related to life safety, over one-quarter or 25% of the classmembers were in day programs that earned a rating of one, indicating complete non-compliance.

122. whenever more than one-quarter or 25% of the classmembers attained such a score of one, then an unacceptable level of non-compliance exists on a systemic basis. The scores recorded in the area of life safety training for day program providers indicate such a level of systemic non-compliance.

123. Additional problems with respect to staff training extend into the area of medication administration. One-third or 33% of the classmembers resided in programs which received a rating of level one - complete non-compliance - on Standard 5.15.6.

124. This standard is a significant one for a substantial segment of the class. It requires that the provider ensure that staff members who administer medications have been appropriately trained.

E. Protection from Harm

125. Similar deficiencies exist with respect to the standards associated with protection from harm. [*61] Standard 2.5 requires providers to maintain an on-site record of seizure activity to be kept with respect to any classmember experiencing seizures within the past three years. One-half of the class-members rated were in residential programs which attained a level one score of complete non-compliance.

126. Such a deficient rating in an area as basic as this exhibits the risks to which the class is exposed.

127. Standard 5.17 establishes certain minimal requirements, including the use of positive reinforcement, as part of behavior modification programs. A rating of complete non-compliance was recorded for those residential providers who provided services to one-half or 50% of the classmembers audited.

128. Serious programmatic deficiencies pervaded the area of training for classmembers with respect to independent living skills. Eight standards (7.8.1 - 8.8.8) measured performance in regard to such training. For six of these standards, 25% or more of the classmembers rated received a rating of complete non-compliance. Substantial compliance for one-half or 50% of the classmembers was achieved with respect to only three standards.

129. Similarly problematic scores were reflected by the [*62] responses to the Quality of Life Questionnaire, a valid, reliable instrument.

F. Classmembers at Risk of Falling out of Their Placements

130. The audit results yielded other areas of significant concern, particularly related to the potential far classmembers to fall out of their placements. According to Standard 6.6, day programs at a minimum must be provided for at least three days and 20 hours a week. Providers for 30% of the classmembers rated on this standard could not attain levels of substantial compliance.

131. While it is possible that auditors rated this standard out of compliance due to the fact that a classmember was

in a day program other than the SRC/CRT-approved service, the audit results indicate that this is a real area for concern.

132. Other studies have indicated the importance of providing day programs of adequate frequency and duration at a site away from the individual's residence. Because of the importance of Standard 6.6, defendants should have undertaken an independent examination of the validity of the scores in this area.

133. Day programs of inadequate frequency and duration place additional strain on the residential placement and may well lead [*63] to problems with management of the classmember's behavior. As was pointed out above, the compliance audit shows that the area of behavior management is a major deficiency. Inadequate programs not only may lead to harm of classmembers, but without appropriate support services for residential providers, class-members may be moved to a more restrictive residential setting.

G. Specialized Services

134. Serious gaps exist with respect to the provision of essential services, such as professional and mental health counseling, occupational and physical therapy, special education, and certain specialized medical services.

135. It is not professionally acceptable for classmembers to be deprived of such services over extended periods of time. The provision of those services was deemed necessary by those professionals who comprised the SRC's and CRT's.

136. Various problems of Region 1 have been addressed throughout the findings. Illustrative of the problems are that Region 1 accounted for the highest number of reported abuse/neglect incidents and assumed the lowest rank of compliance months.

H. Non-Compliance with Respect to Lower Functioning Classmembers

137. The QAMG Report [*64] of August 31, 1989 also documented one tendency of significant importance in identifying "at risk" classmembers. Overall, classmembers who were not mentally retarded or only moderately or mildly retarded achieved compliance awards substantially greater than profoundly or severely retarded classmembers.

138. This result indicates that defendants are less able to provide adequate care for more severely impaired classmembers than they are for higher functioning individuals. In other words, the more complex or greater the needs of the classmember, the less likely those needs will be met.

139. This conclusion does not provide an explanation for the relatively poor compliance awards achieved by Region 1 of OMR. That region is not inordinately populated with severely or profoundly retarded classmembers.

I. Lack of Involvement of Classmembers and Their Families

140. Another area of concern relates to the lack of involvement of family members and classmembers in the treatment and habilitation process. The defendants have done little to encourage the participation of such individuals in this area, particularly in contrast to the emphasis on such involvement during the SRC process.

141. [*65] Defendants customarily do not involve classmembers and their families in the audit debriefing process. They are not routinely told of the audit results, nor do defendants notify families of validated incidents of abuse and neglect.

142. Defendants' failure actively to encourage the involvement of classmembers and their families is inconsistent with prevailing professional practices.

J. Deficiencies Confirmed by Second Level Reviews

143. The results of the Second Level Reviews for 95 classmembers confirm the systemic deficiencies identified by the joint audits in the areas noted above. The accuracy of the data generated by these reviews is enhanced by the following factors:

(a) A representative of the defendants participated on the Second Level Review Team and agreed to each of the compliance awards;

(b) In general, the Team deferred action on classmembers where definitional problems, such as that related to day development training, existed;

(c) The Team could correct possible errors or misinterpretations by auditors; and

(d) The Team exercised professional judgment in awarding compliance allowing for an additional application of the substantial compliance approach.

[*66] 144. Defendants' lack of earned compliance credit, as confirmed by Second Level Review, was stunning. Over an audit period of approximately 24 months, the defendants attained an average of only 8.5 months of awarded compliance. For 28 classmembers (29% of the

group reviewed), not a single month of compliance credit was awarded.

145. The results of the Second Level Reviews also indicate substantial differences in the awards earned by the respective program offices. The OCS recorded an average compliance credit of 13.0 months as compared to 5.3 months for the OMR. Forty-two percent of all OMR classmembers reviewed were awarded no months of compliance credit.

146. A number of explanations for these performance results exist. OMR, particularly in Region 1, has had real difficulties in terms of staff turnover. The high rate of turnover has contributed to compliance problems.

147. In general, certain bureaucratic barriers, such as the layers of bureaucracy that interfere with the flow of information, impede the ability of defendants to achieve compliance. OMR has another layer of bureaucracy which OCS does not; the organizational and informational structure is just not as tight in the [*67] former organization.

148. OCS also has a more centralized approach to case management. Information is less likely to be fragmented in OCS than in OMR. OCS case managers tend to be more knowledgeable about programmatic issues than OMR case managers. The former also are on higher pay range than the latter.

149. Similar discrepancies in terms of compliance awards appeared in regard to the various regions of the program offices. Non-compliance with the requirements of the Court's Orders pervades Region 1 of OMR. Seventeen (77%) of the 22 classmembers residing in that Region received no months of compliance credit.

150. In general, OMR Region 1 reflects a pretty dismal compliance picture. Historically, this region has had difficulties. It has not provided the kind of support and information that providers need.

151. As a result, there are significant gaps in some services shown by the data regarding Normal Life, Inc. The situation as to the availability of occupational and physical therapy services in that region is bleak.

152. The data contained in the QAMG Report of August 31,, 1989, regarding awards of compliance credit, generally is consistent with that reported by defendants.

[*68] 153. After Second Level Reviews had been completed with respect to 67 classmembers, defendants
briefly summarized those results. The average amount of compliance credit earned over the 24 month audit period was 7.6 months - a figure comparable with the QAMG average of 8.5 months for 95 classmembers.

K. Defendants' Current Self-Monitoring Activities

154. For some time, defendants have been conducting self-monitoring with respect to individuals previously dismissed from the class. These monitoring reports have been submitted to the Court on a semi-annual basis.

155. For each dismissed classmember, the assigned case manager records information regarding the provision of services on a monthly basis on a bar graph. Also included is a brief narrative as to the services provided.

156. Defendants compile these documents on individuals, and then the Gary W. Project Office submits them to the Court every six months.

157. Defendants' self-monitoring activities with respect to dismissed classmembers do not satisfy prevailing professional standards in this area.

158. It is not professionally acceptable to delegate primary responsibility for monitoring to the actual service provider. [*69] That approach lies at the core of defendants' monitoring of dismissed classmembers, since case managers have responsibility for ensuring the provision of services. The Court finds it unrealistic that a case manager in filling out a monitoring form is going to admit that he or she has not done the required job.

159. Also, OMR and OCS utilize different forms for reporting on the status of classmembers.

L. Defendants' Attitudinal Deficiencies

160. Defendants have not come forward with a professionally acceptable, written plan to address these compliance deficiencies, nor have they developed such a formal plan with respect to possible self-monitoring.

161. Defendants overall have not demonstrated the willingness or capacity to identify and remediate systemic barriers to non-complaince.

162. For example, DHH and DSS [6] have not taken specific steps to ensure that SRC classmembers remain in their SRC-approved placements, nor is there a special plan to address this area.

163. There has also been a reduction [*70] in enthusiasm among defendants for ensuring that classmembers receive

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[6] The Department of Health and Hospitals (DHH) and the Department of Social Services (DSS) are the successor organizations to the former Department of Health and Human Services.

all the services for which their plans call. This reduction in enthusiasm applies to both the administrative level as well as the direct service level. There is just not as much effort as there needs to be to obtain services.

164. Defendants' primary response to the QAMG Report and the results of the joint audits and Second Level Reviews has been negative and defensive. The type of proactive attitude and ability necessary to remedy the clearly identified problem areas, even after repeated opportunities to do so, just has not been evident in this case.

165. Defendants' non-compliance has persisted despite a variety of remedial strategies employed by this Court. On at least two occasions, for example, this Court has raised the possibility of holding defendants in contempt and imposing sanctions for failure to adhere to its Orders.

166. Defendants, through their agents and employees, were well aware of the possibility of a contempt holding and sanctions. They took the Court's pronouncements in this area seriously.

167. Even in the face of these threats, defendants have been unable or unwilling to attain conformity [*71] with the Court's Orders in this case.

M. Harm to Classmembers

168. The collective impact of all these areas of deficiency - the above noted problems with respect to case management services, training for both provider and departmental personnel, data collection and analysis, and so forth - are reflected in the poor results obtained by defendants as a result of the Second Level Reviews. In view of those results, it is not surprising that such a relatively high rate of reinstitutionalization exists and that some classmembers have been subject to an inordinate number of multiple incidents.

169. The harm suffered by classmembers in this regard is reflected in the relatively high rates of reinstitutionalization and the multiple incidents of abuse and neglect. Clearly distinct segments of the class stand at risk of harm both now and in the future: OMR classmembers residing in Region 1, class-members with a history of seizures, those taking medications, and those lower functioning classmembers are especially vulnerable. With respect to these groups, the sad reality of the present litigation is that those classmembers with the greatest needs and who are most vulnerable presently are [*72] receiving the least acceptable level of care.

IV. THE CURRENT SITUATION: CONTINUED PROBLEMS WITH ABUSE AND NEGLECT

170. On April 17, 1989, the Department issued a document entitled, Six Month Gary W. Summary Report of Immediate Reportable Incidents, July 1, 1988 - December 31, 1988. The report showed the total number of reportable incidents and investigations to have remained level but stated that no significant conclusions could be drawn as to whether there was either an increase or a decrease in the number of validated allegations of abuse and neglect. The report concluded that "[r]eview and analysis of the data in this report and conclusions reached indicates there are systemic issues to be addressed by the DHH Program Offices with the assistant of the Gary W. Project Office. The conclusions reached highlight areas related to incidents and validated allegations that might require further scrutiny." It is significant to note that no specific systemic issues were identified in the report, nor were the areas which required further scrutiny. No action plan was submitted, nor were any specific recommendations made to the Program Offices.

171. The Department's new Abuse/Neglect [*73] Plan was implemented on January 17, 1989, with training being held for many of the service providers. The report also noted that the Gary W. Project Office planned to follow up with providers to ensure their compliance with the requirements of the policy.

172. The evidence presented at the hearing shows the positions of the parties are diametrically opposed to each other on the issue of abuse and neglect. The best examples of those positions are the QAMG Report on Abuse and Neglect and the Gary W. Project Office's Report on Abuse and Neglect.

173. The QAMG Report, Report on Abuse and Neglect Allegations for the Period of January 17, 1989 to May 14, 1989 [Revised], concluded as follows:

(a) The problem related to the differentiation among allegations of neglect, injury, and accident has not been resolved.

(b) The policy has apparently been implemented differently among the various regions and the various providers. The State must provide appropriate training and ongoing technical assistance to providers to ensure uniformity of implementation, as well as address the high number of incidents in Regions I and II.

(c) The timeliness of investigations has improved.

(d) The [*74] Project Office must assure that all investigations include a determination of validity.

(e) Involvement of classmembers in multiple incidents continues to be a problem.

(f) The State must closely examine the facts around multiple incidents to determine whether or not to request a formal Corrective Action Plan. The Corrective Action Plan process should be used to ensure that classmembers are protected from harm.

174. The Project Office's Report, Six Month Summary Report Gary W. Abuse and Neglect Reporting and Investigations January 17 - June 30, 1989, reached the following conclusions:

(a) In the first six months of the policy, the Departments and providers "have conscientiously moved forward with full implementation of all provisions and requirements of the policies."

(b) There has been an increase in the number of reports of incidents: whether the increase is simply one of improved reporting or is an actual increase cannot be determined at this time.

(c) The Departments have emphasized the goal of protecting classmembers from harm, as well as the significance of meeting timelines in the policy. They have achieved "real success" in ensuring that classmembers are protected [*75] from harm.

(d) There has been a marked difference between the number of allegations of abuse which have been found valid and the number of neglect and unusual occurrences which have been found valid. The differences are "sufficient to warrant careful and ongoing review of all factors associated with incident allegations of abuse." The Project Office will "continue to review all investigative reports as they are submitted and assure that all required components of investigative procedures are included."

(e) The level of local oversight committee has increased, but there seems to be a problem with the relative rates in the various regions, with Regions 5 and 7 appearing inordinately low and Regions 1 and 2 to be inordinately high. "It is the Departments' expectation to address these apparent discrepancies through continued technical assistance to agencies in the system and through the policy monitoring plan implemented by the Project Office."

(f) "Classmembers most at risk as evidenced by the report of multiple incidents have had the benefit of appropriate correction action through the convening of individual team meetings."

(g) Approximately 81% of all reports came from Regions [*76] 1 and 2. This is to be expected due to the larger population of classmembers residing in those regions, as well as the fact that those classmembers are more medicaly fragile and demonstrate more complex behavioral characteristics than those in other regions. Furthermore, the greater number of reports in those regions is directly attributable to several specific classmembers.

175. Areas of systemic non-compliance persist in the area of abuse/neglect reporting.

176. Standard 4.1.1 requires simply that reports of alleged abuse or neglect are made in accordance with state law and the defendants' policies. One-third or 33% of the 120 classmembers rated on this standard were listed at level one, complete non-compliance.

177. The large number of classmembers for whom this standard was ranked as complete non-compliance is particularly disturbing in view of the fundamental nature of this standard.

178. Providers are given extensive latitude in defining the type of incident reported, and hence the actual entity that will investigate that incident is, in effect, chosen by the provider.

179. The Project Office has failed to move proactively to resolve systemic problems related to abuse and neglect. [*77] The defendants have not used incoming data to analyze trends and possible causes of incidents of abuse and neglect, nor have any corrective actions ever been required of providers.

180. In short, defendants have not acted aggressively to identify and correct problems in this area. The frequency of multiple instances of abuse or neglect remains unacceptably high.

181. Dr. Vincent, who serves as the head of OMR, testified that he had reviewed the QAMG Report on Joint Audits, and while the defendants did not always agree with the methodology used, he believed the conclusions of the QAMG Report were similar to the conclusions that the State had drawn. He listed his concerns as follows:

(a) training needs to be addressed statewide;

(b) case management issues;

(c) problem definitions need to be clarified;

(d) specialized services need to be developed to ensure they are available to members of the class;

(e) problems with classmembers who are either at risk, have fallen out of their SRC placements, or about to fall out of them;

(f) legal status of classmembers;

(g) abuse and neglect; and

(h) management problems with Region 1.

182. Dr. Vincent further testified that OMR has [*78] formulated a written plan for dealing with each of these issues. The "plan" sets forth only the intention of OMR to identify problems, develop a plan for resolving the problems, and then implement the plan. There are no action steps listed, nor anything other than an extremely superficial overview of problem areas.

V. CONCLUDING FINDINGS

183. In sum, the evidence shows that despite repeated efforts and an array of orders, conferences, and remedies undertaken by this Court over the past fifteen years, the defendants still have not complied and lack the ability to comply with the Principal Order and this Court's remedial Orders. Furthermore, the evidence is clear that individual and systemic barriers have been repeatedly identified by the numerous reports and recommendations filed over the eight years since Dr. Gant's first report in 1981 and that the defendants have not been able to remove those barriers.

184. The time for "all deliberate speed" is long passed. Although defendants have placed members of the class in their residential placements, they are unable to ensure the quality of those placements and the support services necessary to keep the classmembers there and [*79] to protect them from harm. Furthermore, defendants have not only shown no capacity to implement corrective plans previously submitted, but also that they either are no longer willing or able to even devise remedial programs to address the clearly identified barriers to compliance with the Orders of this Court.

185. The Court has already exhausted the avenues ordinarily undertaken by other courts in cases of this kind to implement relief: appointment of a Special Master; appointment of a Monitor; formal and informal conferences with the parties and counsel; warnings as to possible contempt and related sanctions; and an Order requiring the creation of an Executive Management Committee within the defendants' organization. Notwithstanding these efforts, progress in meeting plaintiffs' constitutional rights continues to be elusive. Under these circumstances, stronger relief, specifically tailored to address the causes of non-compliance, is essential.

186. Further delay cannot and will not be tolerated. The issue is not one of overly technical requirements blindly applied. The evidence demonstrates, and the above Findings reflect, the fact that discrete segments of the class
stand at risk [*80] of clear harm. Significant numbers of classmembers are suffering physical and emotional harm, while others are at immediate risk of suffering such harm due to the failure of the defendants to implement this Court's Orders.

187. To the extent that the above Findings of Fact also constitute Conclusions of Law, they are specifically adopted as both Findings of Fact and Conclusions of Law.

CONCLUSIONS OF LAW

1. This matter is before the Court pursuant to plaintiffs' Motion for Supplementary Relief under 28 U.S.C. § 2202.

2. The form of relief sought by plaintiffs is a further injunction to ensure implementation of this Court's previous Orders. Such relief will be warranted if: (a) a legal, in this case, constitutional violation is made out; (b) plaintiffs will suffer irreparable harm if the injunction does not issue; and (c) there is a lack of an adequate remedy at law. Swann v. Charlotte-Mecklenberg Bd. of Ed., 402 U.S. 1, 16 (1971); Beacon Theatres, Inc. v. Westover, 359 U.S. 500, 506-07 (1959). Plaintiffs have satisfied these criteria.

3. Certainly, the constitutional right of plaintiffs to be protected from harm was established by the Principal Order issued by this [*81] Court and by the decision of the Supreme Court in Youngberg v. Romeo, 457 U.S. 307 (1982). Indeed, this Court's Principal Order and subsequent Orders have closely followed Youngberg's prescription of deference to professional judgment. It is precisely the failure of the defendants to properly implement professional judgments made with respect to individual classmembers and their treatment needs that is the very source of the ongoing constitutional violation.

4. Our findings also lead inexorably to the conclusion that plaintiffs will suffer irreparable injury unless a further injunction issues.

5. Given the history of this case, including the past efforts of this Court to facilitate, cajole, and even coerce compliance, the demonstrated inability of defendants to comply substantially with this Court's previous Orders (despite many opportunities to do so), and the flawed organizational structure and division of responsibilities for this case in DHH and DSS, all as described in the Findings of Fact, this Court concludes that an Order holding the defendants in contempt is not an adequate remedy. In light of the above reasons for defendants' failure to substantially comply with [*82] our Orders, such measures "promise only confrontation and delay." Newman v. State of Alabama, 466 F. Supp. 628, 635 (M.D. Ala. 1979); Morgan v. McDonough, 540 F.2d 527, 529-33 (1st Cir. 1976), cert. denied,*429 U.S. 1042 (1977)*.

6. while the plaintiffs clearly are entitled to further injunctive relief, the nature and scope of that relief must be carefully considered. It is axiomatic that in exercising their powers, "federal courts are not reduced to issuing injunctions against state officers and hoping for compliance. Once issued, an injunction may be enforced." Hutto v. Finney, 437 U.S. 678, 690 (1979). The federal courts possess both the authority and power to implement whatever remedies are necessary to correct constitutional violations. Washington v. Washington State Comm. Passenger Fishing Vessel Assoc., 443 U.S. 658, 695-96 (1979) ("The federal court unquestionably has the power to enter the various orders that state official and private parties have chosen to ignore, and even to displace local enforcement of those orders if necessary to remedy the violation of federal law found by the court." Id.); Milliken v. Bradley;433 U.S. 267, 280-81 (1977); Swann [*83] v. Charlotte-Mecklenberg Bd. of Ed., 402 U.S. 1, 15-16 (1971).

7. Indeed, where constitutional rights have been denied over an extensive period of time, the responsibility of this Court is "clear and compelling: to use its broad and flexible equitable powers to implement a remedy that, while sensitive to the burdens that can result from a decree and the practical limitations involved, promises, 'realistically to work now.' Green v. County School Bd., 1968, 391 U.S. 430, 439 . . ." United States v. Desoto Parish School Bd., 574 F.2d 804, 811 (5th Cir. 1978), cert. denied,*439 U.S. 982 (1978)*. See also Swann v. Charlotte-Mecklenberg Bd. of Ed., 402 U.S. at 15; Brown v. Board of Education, 349 U.S. 294, 300 (1955).

8. As in any equity case, the scope of relief is determined by the nature of the violation. Swann v. Charlotte-Mecklenberg Bd. of Ed., 402 U.S. at 16.

9. In dealing with cases involving violations of constitutional rights by state officials, the district courts have employed a variety of measures to ensure implementation of equitable decrees. In complex cases, such as Gary W., these measures have included appointment of a court designated agent [*84] to oversee the implementation of court orders. The power of the courts to appoint such agents in cases of this kind "has long been established." Ruiz v. Estelle, 679 F.2d 1115, 1161 (5th Cir. 1982), vacated in part on other grounds,688 F.2d 266 (5th Cir. 1982), cert. denied,*460 U.S. 1042 (1983)* (monitor); Gary W. v. State of Louisiana, 601 F.2d 240, 244-46 (5th Cir. 1979) (special master); Miller v. Carson, 563 F.2d 741, 752-54 (5th Cir. 1977) (ombudsman).

10. Defendants have been given 13 years to meet their obligations under the Principal Order and subsequent
Orders of this Court. Having failed in "their affirmative obligation under these holdings, judicial authority may be invoked." Swann, 402 U.S. at 15.

11. As observed by the Court of Appeals for the Fifth Circuit, "the remedy should begin with what is absolutely necessary. If those measures later prove ineffective, more stringent ones should be considered." Ruiz v. Estelle, 679 F.2d at 1145-146 (5th Cir. 1982).

12. where, as in the present case, state or local officials have failed to meet court orders in significant respects over a period of many years, the courts have given greater authority to [*85] court appointed agents or ordered relief which directed certain administrative or executive actions.

13. Thus, in order to remedy the unconstitutional segregation of schools, the federal courts have ordered the transfer of faculty and the hiring of particular school personnel. See Morgan v. Kerrigan, 509 F.2d 599 (1st Cir. 1975); Davis v. School District of City of Pontiac, 487 F.2d 890 (6th Cir. 1973). See also United States v. DeSoto Parish School Board, 574 F.2d 804 (5th Cir. 1978).

14. In Griffin v. County School Board of Prince George's County, 377 U.S. 218, 232-34 (1964), the Supreme Court affirmed broad and far reaching powers in the trial court to remedy a situation where public schools were closed and state aid was given to segregated private schools. The Supreme Court held that the trial court had the power to order the public schools to be reopened, to order the county supervisors to levy taxes to support the public schools, to enjoin the county from giving tuition grants or tax credits in support of private schools, and to enjoin the processing of applications for state tuition grants.

15. These are by no means isolated examples of federal judicial intervention [*86] in state affairs under circumstances in which state officials have failed to follow constitutional mandates. See, e.g., Reynolds v. Sims, 377 U.S. 533 (1964) (approving a court ordered temporary reapportionment plan when legislature failed to devise its own plan); Bell v. Southwell, 376 F.2d 659 (5th Cir. 1967) (local election characterized by racial discrimination ordered voided and new special election ordered).

16. In other instances, the courts have appointed administrators or receivers and vested them with substantial authority to implement the Court's remedial Orders. See Morgan v. McDonough, 540 F.2d 527 (1st Cir. 1976) (receivership in school desegregation case); Reed v. Rhodes, 500 F. Supp. 363 (N.D. Ohio 1980), aff'd as to appointment of Administrator of Desegregation, rev'd on other grounds,635 F.2d 559 (6th Cir. 1980); Newman v. State of Alabama, 466 F. Supp. 628 (M.D. Ala. 1979) (receivership imposed on state prison system); Perez v.

Boston Housing Authority, 400 N.E.2d 1231, 379 Mass. 703 (1980) (receivership imposed to achieve restructuring of housing authority); Turner v. Goolsby, 255 F. Supp. 724 (S.D. Ga. 1966) (receivership in school [*87] desegregation context); Crain v. Bordenkircher, 376 S.E.2d 140 (W. Va. 1988) (holding by the Supreme Court of Appeals of West Virginia that it "has authority to place the [West Virginia] penitentiary in receivership and appoint a receiver for the purpose of constructing a new facility.").

17. "When the usual remedies are inadequate, a court is justified in resorting to a receivership, particularly when it acts in aid of an outstanding injunction." Newman v. State of Alabama, 466 F. Supp. at 635. Ultimately, the test of whether the appointment of an administrator with authority to carry out court orders is justified is "one of reasonableness under the circumstances." Morgan v. McDonough, 540 F.2d at 533.

18. In each of the cases in which courts have appointed administrators to carry out their orders, state or local officials had shown an "inability to comply substantially with court remedial orders." Reed v. Rhodes, 500 F. Supp. at 397.

19. In instances of justifying such relief, the courts have typically found a lack of leadership that could be expected to improve conditions within a reasonable period of time, systemic deficiencies in administrative, organizational, [*88] and fiscal structures, institutional inertia, and similar indicia of bureaucratic morass. See generally, Reed. v. Rhodes, 500 F. Supp. at 397-98.

20. The findings in this case evince a similar pattern of ineffective leadership, an inefficient bureaucratic structure, and a plain inability of the defendants to get the job done in several critical respects.

21. The scope of authority of court appointed administrators will, of course, vary from case to case. As a general proposition, these administrators have been given whatever authority was necessary to ensure implementation of remedial orders.

22. In Reed v. Rhodes, supra, the Administrator of Desegregation was given authority to direct all district personnel, including the superintendent of schools and the treasurer, with respect to planning and implementing components of the remedial orders of the Court. The administrator also had responsibility to hire or transfer administrative personnel and the power to review the defendant's actual or proposed desegregation policies, budgets, reports, regulations, directives, and personnel actions and, based on such review, to issue recommendations directly to the Board of Education or [*89] instructions to the superintendent of schools. 500 F. Supp. at 403. In Morgan v. McDonough, the Receiver had the authority to transfer administrative staff, evaluate the qualifications of faculty, and arrange the transfer or replacement of whomever he saw fit for purposes of desegregation, file a plan with the Court for renovation of the school, and establish certain classes. 540 F.2d at 529.

23. The facts of this case justify the judicial appointment of administrative personnel to carry out certain aspects of this Court's prior Orders. But the relief which this Court will grant, and the authority of the administrators appointed by this Court will be no broader than necessary to remedy the constitutional violation. Newman v. State of Alabama, 559 F.2d 283, 288 (5th Cir. 1977).

24. The Court concludes that defendants have persistently shown an inability to comply substantially with this Court's Orders in the areas of case management and staff training, as well as the other areas set forth in detail above. The Court also concludes that the Office of Mental Retardation for Region 1 of the State has persistently demonstrated an inability to comply substantially with this Court's [*90] Orders.

25. An Order will be fashioned to specifically remedy these particular deficiencies. It will be limited in nature to address only those problematic areas identified at the hearing on plaintiffs' motion. In this sense, the remedy ordered, while extensive in terms of authority, will be restricted only to those demonstrated areas of protracted non-compliance.

26. To the extent that these Conclusions of Law also constitute Findings of Fact, they are specifically adopted as both Findings of Fact and Conclusions of Law.

New Orleans, Louisiana, this the 15th day of February, 1990.