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

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CIVIL ACTION NO.
	)	1:09-CV-119-CAP
THE STATE OF GEORGIA, et al.,	)	
	)	
Defendants.	)	
_____	)	

MEMORANDUM OF LAW IN SUPPORT OF THE UNITED STATES' MOTION FOR IMMEDIATE RELIEF

Pursuant to Federal Rule of Civil Procedure 65, the United States moves the Court for immediate relief based on the imminent and serious threat of harm to the life, health, and safety of individuals served by Georgia's seven State hospitals (collectively, the "hospitals"). The State of Georgia continues to fail to serve individuals confined in the hospitals ("individuals in the hospitals") in the most integrated setting appropriate to their needs, and preventable deaths, suicides, and assaults continue to occur with alarming frequency in the hospitals.

The needlessly prolonged institutionalization of many individuals with disabilities is a fundamental cause of the harm. The State provides services to far too many individuals with disabilities in the most segregated setting imaginable—the hospitals. The State's own treatment professionals have

determined that community placement is appropriate for more than 800 individuals currently confined to the hospitals[1]. Even for those individuals who lack a treatment professional's recommendation for community placement, the hospitals are not the most integrated setting in many cases. See Disability Advocates, Inc. (DAI) v. Patterson 653 F. Supp.2d 184, 259 (E.D.N.Y. 2009) (Olmstead plaintiffs "need not prove 'qualification' [for community services] in the form of determinations from [their] 'treatment professionals.'") (citing cases). The great majority of those individuals do not oppose community placement. Yet, they remain institutionalized, segregated from the community, and at risk of irreparable bodily harm caused by the State's admitted departures from generally accepted professional standards and the Constitution in providing services within the institutions.

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[1] In its reports to the Office for Civil Rights, United States Department of Health and Human Services, the State reported that 804 of the 923 individuals with developmental disabilities in the hospitals in June 2009 were placed on the State's Olmstead list, signifying the State's determination that these individuals could be served in a community setting and did not oppose such a placement. For individuals with mental illness, the State placed 54 of 651 individuals with mental illness on its Olmstead list (the State excluded from its count some individuals whose commitment status was determined by a criminal court, for example, individuals who had been committed by a court after being found not guilty by reason of insanity). See Exhibit 1, Olmstead Monthly Report FY 2009.

Immediate relief is necessary to stop the ongoing severe and irreparable harm. That relief must target the conditions at the hospitals that place individuals confined there at the most imminent risk–conditions that have led to suicides, homicides, rapes, and other assaults–while requiring the State to make significant progress now in moving individuals in the hospitals out of that unsafe and inappropriate institutional environment. A year of experience under the Settlement Agreement ("Agreement"), attached as Exhibit 2, has taught that an effective remedy for unconstitutional conditions at the hospitals is inseparable from an effective effort to place in community settings the hundreds of individuals in the hospitals who are inappropriately institutionalized. Conversely, any remedy that focuses merely on the conditions at the hospitals will, as the Governor's recent budget request shows, encourage the State to direct resources away from building the necessary community capacity and toward a focus on the hospitals–an inequity that will only perpetuate the inappropriate and harmful institutionalization of Georgians with mental disabilities.

The status of the Agreement in this case is unclear. That Agreement has not been effective in bringing the State into compliance with federal law, and there is a fundamental disagreement between the parties regarding the scope of the Agreement, particularly regarding the United States' claims pursuant to the

Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. §§ 12132-12134, and Olmstead v. L.C., 527 U.S. 581 (1999). Moreover, although this Court entered the Agreement as an interim order (Document 9), it rejected the parties' joint motion to enter the Agreement as a final order (Document 2), and we do not intend to pursue a renewed motion to enter the Agreement. Accordingly, this motion for immediate relief may be understood as a motion for a preliminary injunction. The United States has, today, filed a separate action bringing a claim under the ADA. We have asked that the ADA case be consolidated with this case. If the Court agrees that the Agreement is no longer in effect, the United States requests relief based on the Amended Complaint in this case and the Complaint filed in the ADA case. If the Court determines that the Agreement is still in effect, the United States files this brief as a motion to enforce the Agreement and as a motion for immediate relief in the ADA case.[2]

I. FACTUAL BACKGROUND

On January 15, 2009, the United States filed the original Complaint in this action, alleging that certain conditions and aspects of care at the hospitals deprive

[2] Even if the Court determines that the Settlement Agreement is still in effect, the United States may bring this Motion for immediate relief without waiting 90 days, as the conditions, care, and treatment that are the subject of this Motion "pose an immediate and serious threat to the life, health, or safety of patients served by the State Psychiatric Hospitals." See Agreement, Ex. 2, ¶ V.D.

the individuals confined to those hospitals of rights, privileges, or immunities secured or protected by the Constitution and the laws of the United States. The hospitals provide inpatient services to persons with mental illnesses, addictive diseases, and developmental disabilities.

Also on January 15, 2009, the United States and the State entered into the Agreement, which resolved the United States' investigation of the hospitals under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. In accordance with the Agreement, on January 15, 2009, the United States filed the Complaint initiating this action with the Court and, on the same day, filed a joint motion with the State requesting that the Court conditionally dismiss the case and retain jurisdiction to enforce the terms of the Agreement. See Agreement, Ex. 2 ¶ V.C.

On January 23, 2009, the majority of the advocacy groups now appearing as amici curiae sent a letter to the Court expressing concern about the Agreement. Following the Court's order, the parties met with representatives of the amici on May 14, July 14, and August 25, 2009, to address the concerns raised by the advocates, but many of these concerns remain unresolved.

While these meetings were proceeding, the United States, accompanied by expert consultants in the fields of psychiatry, psychology, psychiatric nursing,

protection from harm, and discharge planning and community integration, conducted compliance tours of six of the seven hospitals.[3] These compliance tours included interviews with hospital administrators, clinical staff, direct care staff, and individuals in the hospitals, as well as review of a wide variety of documents, including policies and procedures, incident reports, and medical and mental health records.

The compliance tours have revealed that conditions in the hospitals continue to pose an immediate and serious threat to the life, health, and safety of the individuals in the hospitals, and that serious harm continues to occur. See, e.g., ECRH Compliance Letter and Expert Report (Sept. 9, 2009); GRHS Compliance Letter and Expert Report (Nov. 19, 2009); Findings Letter for CSH, GRHS, ECRH, SWSH, and WCGRH (Dec. 8, 2009) (Attached as Exhibits 3-5, respectively). Between April 2009 and January 2010, the United States also sent

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[3] The six hospitals were: ECRH (May 4-8, 2009), GRHS (June 22-26, 2009), GRHA (August 3-7, 2009), SWSH (October 13-16, 2009), CSH (November 2-7, 2009; January 11-15, 2010), and WCGRH (November 30 through December 3, 2009). The United States also conducted two emergency tours of CSH following an alleged homicide (April 8-9, 2009 and June 30 through July 1, 2009). During the investigation leading to the filing of the original Complaint, the United States visited GRHA (September 17-21, 2007), GRHS (December 17-21, 2008), and the seventh of the hospitals, NWGRH (October 29 through November 2, 2007).

Defendants 11 emergency letters requesting immediate information, follow-up, and/or corrective actions to address conditions or practices that posed an immediate and serious threat to the life, health, and/or safety of individuals in the hospitals. The letters concerned a homicide at CSH, questionable medical deaths at CSH, a rape at SWSH, two alleged rapes at ECRH, a suicide at GRHS, a suicide attempt at ECRH, life-threatening conditions at CSH, a questionable medical death at SWSH, and a suicide at SWSH. See Exhibits 6-16.

Demonstrably, the Agreement has not been effective in bringing the State into compliance with the Constitution and federal statutory law. By January 15, 2010, the Agreement required the State to be in substantial compliance with generally accepted professional standards in four "priority areas" that addressed immediate and serious threats to the life, health, and safety of the individuals in the hospitals: suicide risk assessments and prevention, prevention of patient-on-patient assaults, choking and aspiration risk assessments and prevention, and implementation of emergency medical codes. See Agreement, Ex. 2, ¶ V.E.. Throughout our compliance monitoring, our experts found that the hospitals substantially departed from generally accepted professional standards in the four priority areas and in other areas critical to preventing the threat of immediate and

serious harm in the hospitals. See Osgood Decl., Ex. 17; El-Sabaawi Decl., Ex. 18; Oswald Decl., Ex. 19; Franczak Decl., Ex. 20.

Moreover, the State's Report of Compliance and Plan of Implementation ("POI"), System-wide Comprehensive Audit ("Audit"), and Quality Management Report ("QM Report"), all submitted on January 15, 2010, confirm our experts' assessments. The State concedes that it does not provide care consistent with the Constitution in any of the four priority areas at any of the seven hospitals. See Audit, Ex. 21, pp. 1-18. The State estimates that the earliest date by which it could fully implement any of the provisions of the Agreement in compliance with generally accepted professional standards is July 15, 2010. See POI, Ex. 22, pp. 3-6.

The State's own documents further acknowledge that individuals in the hospitals are not being released from the hospitals by their discharge dates and both the number of individuals waiting to leave the hospitals and the amount of time they are waiting have increased. According to Defendants' own Olmstead Monthly Progress Report, in September 2009, there were 765 persons with developmental disabilities on the Olmstead list. The total number of individuals with developmental disabilities on the Olmstead list stayed relatively constant during the period from September 2008 through September 2009. Moreover, the

number of placements slowed considerably in July, August, and September 2009. Between September 2008 and September 2009, the average number of days on the Olmstead list for persons with developmental disabilities doubled, and 86 individuals remained waiting for more integrated services after the date set by their treatment team for their discharge had come (and gone). Olmstead Monthly Progress Report, Ex. 1.

We note that part of the relief sought in this motion is the expansion of community services and supports that are largely already available in the community. See e.g., Sonny Perdue, "The Governor's Olmstead Budget Report (FY 2009 through FY 2011) ("Olmstead Budget Report"), Ex. 24. Therefore, we do not seek a fundamental alteration of the State's program of services. Instead, we ask that services already available, albeit in limited supply, be made available in sufficient supply to enable individuals in the hospitals to be served in the most integrated setting appropriate to their needs. We do not demand an inequitable allocation of resources given the needs of others with disabilities. See Olmstead, 527 U.S. at 604. Not only is funding an expanded array of community services a substantially less expensive option than continuing to provide services through needless institutionalization, but discharging individuals from the hospitals would remove those individuals from the immediate and serious threats of harm therein,

and would help alleviate the gross under-staffing concerns identified by the State itself.

II. LEGAL STANDARDS

"To obtain a preliminary injunction, the moving party must show (1) a substantial likelihood of success, (2) irreparable harm, (3) that the balance of equities favors granting the injunction, and (4) that the public interest would not be harmed by the injunction." Mesa Air Group, Inc., v. Delta Air Lines, Inc., 573 F.3d 1124, 1128 (11th Cir. 2009). "Preliminary injunctive relief derives from the necessity to restrain or compel conduct in those extraordinary situations where irreparable injury might result from delay or inaction." Alabama v. U.S. Army Corps of Eng'rs, 424 F.3d 1117, 1133 (11th Cir. 2005). The United States hereby requests a hearing on this Motion for Immediate Relief.

III. THE UNITED STATES WILL LIKELY PREVAIL ON THE MERITS.

A. Hundreds of Individuals Remain Inappropriately Institutionalized in the Hospitals in Violation of the ADA and Olmstead.

Hundreds of individuals, at minimum, remain institutionalized in the hospitals in violation of their rights under the ADA and Olmstead. The ADA

requires that the State provide services to qualified individuals with disabilities[4] in the most integrated setting appropriate to their needs. See 42 U.S.C. § 12132 ("[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."), and its implementing regulations, 28 C.F.R. § 35.130(d); see also Olmstead, 527 U.S. at 607. Yet the State provides services to far too many individuals with disabilities in the most segregated setting imaginable—the hospitals. See Franczak Decl., Ex. 20. Institutionalization stigmatizes individuals and prevents them from building lives in the community, forming personal relationships, and obtaining employment. Id., ¶12. As the Supreme Court explained in Olmstead, inappropriate institutionalization "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life" and "severely diminishes the everyday life activities of individuals." Olmstead, 527 U.S. 600-601. In Georgia, inappropriate

[4] There is no dispute that the individuals in the hospitals are qualified individuals with disabilities under the ADA and its implementing regulations. They are individuals whose disabilities have substantially limited their participation in major life activities.

institutionalization has claimed the lives of numerous individuals with disabilities and threatened the lives and safety of many more. See § B, infra.

In construing the anti-discrimination provision contained within the ADA, the Supreme Court held that "[u]njustified isolation . . . is properly regarded as discrimination based on disability." Olmstead, 527 U.S. at 597. The Court applied the integration mandate of the regulations implementing Title II of the ADA: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

A violation of the integration mandate is made out if the institutionalized individual is "qualified" for community placement–that is, that he or she can "handle or benefit from community settings" and does not oppose community placement. Olmstead, 527 U.S. at 601-603. The State, however, may interpose a defense that community placement would "entail a fundamenta[l] alter[ation]' of [its] services and programs." Id. at 603 (plurality opinion). The Olmstead plurality explained that a state can show fundamental alteration by demonstrating that it has "a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a

reasonable pace not controlled by the State's endeavors to keep its institutions fully populated." Id. at 605-606.

The United States has a strong likelihood of succeeding on the merits of its Olmstead claim. First, evidence indicates that literally hundreds of individuals in the hospitals can "handle or benefit from community settings." Olmstead, 527 U.S. 601-602. For the more than 800 of these individuals who have been placed on the Olmstead list, "the State's treatment professionals have determined that community placement is appropriate," id., at 587, consistent with the facts of Olmstead itself.

The State has determined that all individuals with developmental disabilities in the hospitals can be served in more integrated settings. Franczak Decl., Ex. 20, ¶ 15. Yet, in June 2009, more than 900 individuals with developmental disabilities remained institutionalized in the hospitals. See Olmstead Monthly Progress Report, Ex. 1. And 50 or more additional individuals with mental illness in the hospitals appear on the State's monthly report of those determined appropriate for community placement, yet the State reports that fewer than a third of those individuals are released from the hospitals. Id. Many more have never been assessed by a treatment professional to determine whether they could be

served in the community, nor has the question of what services would be required for them to do so been addressed effectively by a treatment professional.

Although Olmstead itself involved two plaintiffs whose treatment professionals had determined community placement was appropriate, the integration mandate is not limited to that narrow fact setting. The regulation that creates the integration mandate does not refer to treating professionals; it simply requires services to be administered "in the most integrated setting appropriate to the needs of" the individual 28 CFR §35.130(d). The regulation does not in any way purport to limit the evidence on which a plaintiff may rely in showing that a more integrated setting is appropriate. And a requirement that Olmstead plaintiffs come to court armed with the recommendation of a state's treating professional would "allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with mental disabilities." Frederick L., 157 F. Supp.2d at 540; see also DAI, 653 F. Supp.2d at 258 ("The court does not read Olmstead as creating a requirement that a plaintiff alleging discrimination under the ADA must present evidence that he or she has been assessed by a 'treatment provider' and found eligible to be served in a more integrated setting."); Joseph S., 561 F. Supp.2d at 291 ("[I]t is not clear whether Olmstead even requires a specific

determination by any medical professional that an individual with mental illness may receive services in a less restrictive setting or whether that just happened to be what occurred in Olmstead.").

As one of the United States's experts concluded, "many, if not the majority, of the individuals in the state hospitals are institutionalized when they could be more appropriately served in a community-based setting." Oswald Decl. Ex. 17, ¶ 12. Another expert explained that many individuals in the hospitals are institutionalized only because there are insufficient community and mobile crisis services in the State. Franczak Decl. Ex. 20, ¶ 37. "[I]n most states," he explained, "many of these individuals experiencing short term crises would not have to be hospitalized." Id., at ¶ 10. Many other individuals in the hospitals, he found, experienced a cycle of needless repeated institutionalization." Ibid. Systemic deficiencies in treatment, discharge, and transition planning have kept these individuals from receiving a treating professional's recommendation of community placement. See Franczak Decl., Ex. 20, ¶ 11-15. But all "could be served successfully in the community" and there is no indication that substantial numbers oppose community placement. Franczak Decl., Ex.20, ¶ 17.

Placing qualified individuals in the hospitals in appropriate community settings would work only a "reasonable modification" of the State's program.

Olmstead, at 603. The State already provides to individuals in the community services of the type the individuals in the hospitals would need to live in the community. See Olmstead Budget Report, Ex. 23 (funded services include supportive housing, crisis stabilization, substance abuse treatment, supported employment, peer support, mental health mobile crisis, transportation, psycho-social rehabilitation and more). But those services are woefully inadequate to meet the needs of those individuals. In a presentation to a coalition of advocacy groups in January 2010, the State conceded:

> the State on paper has a relatively complete array of services available. It is recognized that not all services are available in all parts of the State and that capacity of some services in limited in many parts of the State.

See State of Georgia Planning Initiative on Mental Health and Addictive Services, Georgia DBHDD (undated document), attached as Exhibit 25. State audits and commissions have repeatedly reached this same conclusion. See, e.g., Governor Sonny Perdue's Mental Health Service Delivery Commission Final Report (December 4, 2008) ("Mental Health Commission Report"), Ex. 26. The United States' Olmstead claim rests on the demand that those services already in limited supply be made available in sufficient supply to enable individuals who are currently inappropriately segregated in an institution to be discharged from that

setting into the community and provided appropriate services there. See DAI at 269 (it is a reasonable modification to expand existing community programs to include currently institutionalized individuals).

A number of barriers have kept individuals in the hospitals from receiving services in appropriate community settings. Some of those barriers are internal to the hospitals. The hospitals do not provide individuals in the hospitals with a plan for transition to community services until after the treatment team has determined that the individual is appropriate for community placement–a perverse requirement that an expert characterized as "exactly backwards." Franczak Decl, Ex. 20, ¶ 14. Individuals who stay in the hospitals for less than 60 days at a time do not receive an adequate determination of what services are required to support them in a more integrated setting–even if they are repeatedly readmitted to the Hospital. Id., ¶ 14-15. And when they do discharge individuals, the hospitals often discharge them to inappropriate settings like "night shelters, transportation terminals, and the public buildings and streets"–settings that lack necessary supports and typically receive no advance notice of the discharge. Id., ¶ 28. These discharges to inappropriate settings "place the affected individuals at risk of significant harm." Id., ¶ 30. See also Olmstead (recognizing that discharge to a homeless shelter is inappropriate). One person recently discharged from a Hospital to a shelter was three months

pregnant, and was discharged with several prescriptions, but no connection to a medical care provider or other behavioral health supports. Franczak Decl., Ex.20, ¶ 30. Another had a history of ten prior admissions, but was nonetheless discharged to a shelter. He was readmitted a few days later, after experiencing an overdose of medication. Id., ¶ 30.

Individuals are needlessly institutionalized and discharged to these inappropriate settings and re-admitted due to a lack of adequate community capacity in Georgia. For example, "[i]nsufficient supported housing opportunities in the State result in individuals having to reside in inappropriate settings that do not support their recovery and their return to the community." Franczak Decl., Ex. 20, ¶ 35. Supported housing "is a setting in which individuals live in their own apartment and receive services to support their success as tenants and their integration into the community." DAI, 653 F. Supp.2d at 218-219. Development of a comprehensive, statewide supported housing program was identified as a priority by the Governor's Mental Health Commission in 2008. The State's 2009 draft Olmstead report indicated "that a minimum of 2,000 supportive housing units over a five year period will be needed to serve individuals with mental illness in the State." See Letter from Georgina Verdugo, Director, Office for Civil Rights, Department of Health and Human Services to Governor Perdue (Jan. 26, 2010)

("OCR Letter"), Ex. 27. Supported housing is a centerpiece of an Olmstead-compliant mental health system, but Georgia's efforts to set up such housing have been woefully insufficient to meet the need. Moreover, the State has failed to provide sufficient community-based services such as assertive community treatment, intensive case management, and community crisis intervention, all of which operate hand in glove with supported housing to prevent unnecessary hospitalization. See Franczak Decl., Ex. 20, ¶ 36-37; Mental Health Commission Report, Ex. 26; see also DAI at 220-221 (discussing the importance of these services to community integration).

There are too few crisis, community support, and mobile crisis intervention services for individuals with disabilities, many of whom are re-institutionalized due to short-term crises that could have been stabilized in the community. For example, one individual with a developmental disability who had enjoyed a community placement was readmitted to a Hospital, according to his records, because "there was no where for him to remain in the community" during an investigation of possible care giver abuse following an incident. Franczak Decl., Ex. 20, ¶ 10.

The State's lack of assertive community treatment or intensive case management services causes individuals to have to be hospitalized when they are

not adherent to their medication regimes. These services, which are inadequate in Georgia, are effective because they can improve medication adherence and prevent hospitalization. An intensive staffing ratio of 1:12 allows more intensive supervision for persons who require this level of care. Many individuals with mental illness in the hospitals need assertive community treatment upon discharge, but do not receive this service because they do not exist in sufficient supply. Franczak Decl., Ex. 20, ¶ 36. An assertive community treatment ("ACT") team typically costs at least $1.2 million for one year, id., yet the State's proposed budget through FY 2011 does not fund even one additional ACT team. See Olmstead Budget Report, Ex., 23 at 9.

Immediate relief is necessary to break these barriers to appropriate community placement and ensure that meaningful numbers of individuals in the hospitals move out of their inappropriate institutional placements now. The State cannot establish that such relief would work a fundamental alteration, because that defense is available only when the State has a "comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated." Olmstead. at 605-06 (plurality opinion). The courts of appeals have not settled on a single standard for

determining what makes a proper Olmstead plan. Compare Frederick L. v. Department of Public Welfare of Com. Of Pennsylvania, 364 F.3d. 487 (3d Cir. 2004) with Sanchez v. Johnson, 416 F.3d. 1051 (9th Cir. 2004). But the courts of appeals have all agreed that, at a minimum, the plan must be "comprehensive, detailed, and most importantly, 'effectively working.'" DAI 653 F. Supp. 2d at 304 (quoting Sanchez, 416 F.3d at 1067); see also Pennsylvania Protection & Advocacy v. Dep't of Public Welfare, 402 F.3d 374, 384 (3d Cir. 2005) (permitting a fundamental alteration defense "only if the accused agency has developed and implemented a plan to come into compliance with the ADA") (citing Frederick L., 364 F.3d at 500). "[R]outine, individualized review of patients does not amount to a sufficient deinstitutionalization plan." Ibid.

Georgia has not implemented anything close to such a comprehensive plan, even though Olmstead was decided over a decade ago and involved these very institutions. As the United States Department of Health and Human Services recently concluded, since July 2008 the State's rate of discharge has decreased: "The number of institutionalized individuals with mental illness and developmental disabilities waiting past their discharge dates for community services has steadily increased, and the amount of time they are waiting has risen preciptiously as well." OCR Letter, Ex. 27, at 30. Georgia's Olmstead coordinator has not made and

published "meaningful annual estimates of the needs for community services." Id. at 4. The State has repeatedly delayed its multi-year Olmstead plan. Id. at 5-6. And the results speak for themselves–the State has not made meaningful progress in reducing hospital censuses in any recent year.

"In considering the resources available to the State," a court cannot look at the state's current budget for community services in isolation; rather, "the relevant budget is the 'mental health budget,' which includes any money the state receives, allots for spending, and/or spends on services and programs for individuals with mental illness." DAI, 653 F.Supp.2d at 269. And the court must consider not just short-term outlays and transition costs, "but also savings that will result if the requested relief is implemented." Ibid.

Providing services to support a person with mental illness or a person with a developmental disability living in the community costs substantially less than providing services in an institutional setting. The figures used in a draft Olmstead Behavioral Health Initiative Five-Year Community Funding Plan, supported by data from Georgia's own Department of Community Affairs, support a substantial cost savings when serving a person with mental illness in the community. See Franczak Decl., Ex. 20 ¶ 42. The United States's likelihood of success on the merits of the Olmstead claim is therefore very strong.

B. Preventable deaths, suicides, and assaults continue to occur in the Hospitals.

The harm of unnecessary institutionalization in the hospitals is compounded by–and contributes to–the unconstitutional and life-threatening conditions in the hospitals. These conditions require targeted relief in the hospitals, and they underscore the urgency of moving individuals with disabilities out of inappropriate institutional placements now. The Constitution requires that Defendants provide reasonable care and safety to individuals in the hospitals. Defendants fail to meet this obligation. Specifically, the Fourteenth Amendment Due Process Clause requires a state mental health care facility to provide "adequate food, shelter, clothing, and medical care," Youngberg v. Romeo, 457 U.S. 307, 315 (1982), along with "conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests," id. at 324. Individualized treatment must be provided to give individuals in the hospitals "a reasonable opportunity to be cured or to improve [their] mental condition." Donaldson v. O'Connor, 493 F.2d 507, 520 (5th Cir. 1974), vacated on other grounds, O'Connor v. Donaldson, 422 U.S. 563 (1975); see D.W. v. Rogers, 113 F.3d 1214, 1217-18 (11th Cir. 1997) (holding that the constitutional right to psychiatric care and treatment is triggered by the State's physical

confinement of an individual with mental illness; the court noted the holding of Fifth Circuit cases, including Donaldson, which are binding upon the Eleventh Circuit if decided before September 30, 1981); see also Wyatt v. Aderholt, 503 F.2d 1305, 1312 (5th Cir. 1974).

The measure of inadequate treatment is whether it substantially departs from generally accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23. Individuals in the hospitals have a due process right to have all major decisions regarding their treatment be made in accordance with the judgment of qualified professionals acting within professional standards. Griffith v. Ledbetter, 711 F. Supp. 1108, 1110 (N.D. Ga. 1989). For example, states must ensure that individuals in the hospitals are not given hazardous drugs that are "not shown to be necessary, used in excessive dosages, or used in the absence of appropriate monitoring for adverse effects." Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff'd., 902 F.2d 250 (4th Cir. 1990).

The State concedes that it does not provide care and safety that is consistent with generally accepted professional standards—the constitutional standard—in any of the four priority areas at any of the seven hospitals, despite the Agreement's requirement that the State do so by January 15, 2010. See Audit, Ex. 21, pp. 1-18; Agreement, ¶ V.E; Youngberg, 457 U.S. at 320-23. The State's Audit sets forth

the outcomes the State has determined that it must attain in order to provide care and safety consistent with the Constitution, and not one of hospitals has attained substantial compliance with all of the required outcomes in any of the four priority areas. See Audit, Ex. 21, p. 2-18.

Although constitutional violations threaten safety and welfare in a variety of contexts, including medical and nursing care and nutrition management, the most imminent and life-threatening constitutional violations–and the ones that call out for immediate relief from this Court–relate to the longstanding and widespread pattern of violence and suicides in the hospitals. The hospitals fail to assess suicide risk, prevent suicides, and prevent patient-on-patient assault, in a substantial departure from generally accepted professional standards and in violation of the Constitution. The State admits that it has not attained substantial compliance with any of the outcomes required to meet generally accepted professional standards in these areas at any of the hospitals. See Audit, Ex. 21, pp. 7-15. In other words, the State concedes that it systemically violates the Constitution in each of these areas at each of the hospitals.

Our experts agree. See El-Sabaawi Decl., Ex. 18, ¶¶ 13-25; Oswald Decl., Ex. 19, ¶¶ 15-26. Initial suicide and violence risk assessments often are not completed at all or, if they are completed, lack critical information, in a substantial

departure from generally accepted professional standards. See El-Sabaawi Decl., Ex. 18, ¶ 14-19. Reassessments are similarly inadequate and untimely. See id., ¶ 20. In addition, treatment plans fail to include behavioral interventions for dangerous and maladaptive behaviors, in a substantial departure from generally accepted professional standards, so individuals in the hospitals do not receive adequate treatment to protect themselves and others from potential violence. See Oswald Decl., Ex. 19, ¶ 15.

Moreover, the hospitals' incident, risk, and quality management systems fail to manage the risks of suicide and violence, in a substantial departure from generally accepted professional standards. See Osgood Decl., Ex. 17, ¶¶ 6-43. Internal investigations into abuse, neglect, and suspicious injuries in the hospitals systematically fail to include information that is necessary to finding the root cause of an incident or to delve sufficiently into the possible origins of incidents. See id. ¶ 9. The hospitals fail to reliably and adequately analyze the data that they collect, rendering State and Hospital officials incapable of recognizing adverse trends and correcting issues that directly lead to patient harm and death. See id. ¶ 10. And, for risks that they identify, the hospitals fail to implement corrective and preventive actions in a timely manner, if at all, or to monitor those actions as necessary to reduce or eliminate the risk of harm. See id. ¶ 11.

Without adequately assessing risks of suicide or violence, identifying risks or trends of harm, or objectively measuring and monitoring the quality of care, the hospitals cannot even begin to recognize serious issues affecting the health and safety of individuals in the hospitals, much less develop and implement remedial measures designed to prevent further grievous harm. See id. ¶ 12. As a result of these systemic constitutional violations, individuals in the hospitals suffer grave harm that is frequent, recurrent, and preventable. See id. ¶ 13.

Individuals in the hospitals continue to be killed with alarming frequency. For example:

- In April 2009, an individual at CSH assaulted and killed another individual in the Hospital. See id. ¶ 36. The aggressor had been accused of two separate homicides prior to his admission, including killing his jail cell mate immediately before his transfer to CSH in January 2009. Yet the State failed to adequately supervise him and failed to develop a behavior plan for him before he killed a fellow patient. See id.; Oswald Decl., Ex. 19, ¶ 18.

- In October 2008, a patient at WCGRH died of a ruptured spleen due to blunt force trauma. Earlier that morning he had complained of not feeling well and, hours later, was found naked on the floor in his own urine. The State treated him by giving him antipsychotic medication, despite his displaying no psychotic symptoms. The State failed to investigate, much less determine, how he suffered trauma so significant that it ruptured his spleen, or why he was given antipsychotic medication while he internally bled to death. See Osgood Decl., Ex. 17, ¶ 34.

- In August 2008, a patient at WCGRH assaulted and killed another patient. Earlier that morning, the victim had assaulted the aggressor, and both patients had a history of aggression. When the aggressor and victim later

confronted one another, the State failed to intervene, despite an instructor in de-escalation techniques standing close by. Instead, the aggressor assaulted the victim, who fell and struck his head, knocking him unconscious and causing blood to trickle out of his ear. The State failed to call an emergency code blue, so an ambulance did not arrive for 50 minutes. The victim died a few days later from blunt force trauma to the head. The State transferred the aggressor to CSH but failed to include in the discharge summary any information about this incident or the extent of his aggressive behaviors. The aggressor currently remains at CSH, and the State still has failed to implement adequate behavioral interventions to prevent him from seriously injuring others. See id. ¶ 33.

Individuals in the hospitals kill, and attempt to kill, themselves with alarming frequency in the hospitals. For example:

- A mere three weeks ago, at SWSH, a patient committed suicide within 24 hours of being transferred to an alternative unit on campus grounds. The patient had been admitted a month prior for attempting to hang herself, her third attempt in recent years, yet the State failed to prevent her from acquiring a shoe string that she then used to strangle herself. One day prior to successfully taking her own life, the woman expressed suicidal thoughts, paranoia, and significant anxiety regarding her transfer. The State failed to complete a suicide risk assessment before transferring her, in violation of State policy, and erroneously stated in her discharge summary that her suicidal thoughts had completely disappeared. See id. ¶ 43.

- In August 2009, a patient at GRHS committed suicide by tipping his bed up on end to create a tie-off point on which to hang himself. The State failed to heed our experts' warnings throughout our on-site visits about the suicide risks of the beds. Moreover, GRHS failed to heed our experts' warnings during an on-site visit two months prior to the suicide about the deficiencies in its suicide assessments and risk management system. See id. ¶ 39.

- In April 2006, a patient at NWGRH committed suicide within 24 hours of her admission by climbing high into a tree and jumping to her death in front of staff and patients. The State failed to place her on heightened observation

even though she was an emergency involuntary admission with a diagnosis of paranoid schizophrenia, a history of auditory and visual hallucinations, and had refused to answer whether she was suicidal. Consequently, when her unit was taken outside, she climbed a tree, tried to hang herself with her shoelaces, and then jumped out of the tree to her death. See id. ¶ 14.

- In September 2009, a patient at ECRH attempted to commit suicide by hanging himself with a sheet tied around his neck, the same way he had tried to kill himself at CSH eight months earlier. Despite these similarities, the State failed to investigate, much less determine, how to avoid a third strangulation attempt. Instead, the investigation of the September suicide attempt focused primarily on staff's response to the emergency code blue call and recommended only that "ECRH should review with staff the need for accuracy in reporting, particularly of times of events." See id. ¶ 40.

- In August 2007, a patient was admitted at GRHA after running into traffic with a broken glass bottle in her hand, threatening to kill herself. Approximately one week after her admission, the State discharged her to a homeless shelter. She returned suicidal three days later. A mere seven hours after she arrived on a residential unit, the State failed to follow its own heightened observation level for her, and found her lying face down in a pool of blood outside her bedroom doorway, unresponsive, with a cord wrapped tightly around her neck, bleeding from her mouth and nose. State employees then removed from her medical record progress notes and eyewitness statements describing both the lapse in observation level and an argument between the patient and staff shortly before the suicide attempt. See id. ¶ 27.

- In October 2006, a patient at NWGRH attempted to commit suicide by slitting his throat from ear to ear with a razor. The State had given the patient the razor and let him go into the bathroom unattended, despite the patient having a history of suicide attempts and self-mutilation. After the suicide attempt, the State never reassessed the patient's emotional stability or risk of harm, and never made or modified treatment or behavioral interventions. See id. ¶ 16.

Physical and sexual assaults continue to occur with alarming frequency in the hospitals. For example:

- In October 2009, a State employee at CSH pulled a patient out of his chair, walked him down the hallway, pulled him into his room, shut the door, and beat him. See id. ¶ 41.

- In August 2009, at ECRH, an individual with intellectual disabilities reported being raped by a peer on his living unit. The State failed to investigate when and by whom the victim was sexually assaulted. Before having received the results of the emergency services rape examination, which revealed semen in the victim's peri-anal region, the State concluded that the allegation was unsubstantiated because of a lack of physical evidence. See id. ¶ 38.

- In December 2008, staff at SWSH found a 22-year-old patient, who had a history of sexually assaultive behavior and an admission for being incompetent to stand trial for charges that he molested a seven-year-old boy, in the bed of a 64-year-old patient known to be easily frightened and intimidated by others. The State had placed the two together as roommates and then failed to investigate the incident, even though the patients gave conflicting accounts as to whether sexual relations had occurred. Seven months later, in July 2009, the 22-year-old patient threatened and raped the 64-year-old in the restroom. As part of that investigation, the victim reported that the perpetrator had raped him seven months earlier. See id. ¶ 37.

- In September 2007, a patient at NWGRH suffered a fractured clavicle. Staff noticed a large bruise on the patient's shoulder but did not report the bruise until a day later. The State never questioned the patient about the injury or how it occurred, and never determined its cause. See id. ¶ 31.

- In June 2007, a patient at GRHA sexually assaulted another patient. The aggressor patient was on "sexual protocol," which required that he be on line-of-sight observation and that he sleep in a single bedroom to prevent him from sexually assaulting other patients. The State failed to follow its

own protocol. The State assigned the aggressor to a bedroom with four other patients and, the very first night, he sexually assaulted one of them. The State later discharged the aggressor to a personal care home and failed even to mention the sexual assault in his progress notes, discharge summary, or aftercare plan. See id. ¶ 25.

- In February 2007, a patient at GRHA choked another patient to the point of sending the victim to the emergency room. The aggressor patient was on line-of-sight observation at the time, but the State failed to follow its own heightened observation level for him and only discovered the choking after hearing loud noises coming from his bedroom. See id. ¶ 19.

These constitutional violations continue unabated, posing an immediate and serious threat to the life, health, and safety of individuals in the hospitals. They underscore the need to move individuals in the hospitals out of inappropriate placements in the hospitals now.

IV. THE INDIVIDUALS IN THE HOSPITALS ARE SUFFERING IRREPARABLE HARM

Death constitutes irreparable harm. *Schiavo ex rel. Schindler v. Schiavo ex rel. Schiavo*, 403 F.3d 1223, 1232 (11th Cir. 2005). Additionally, rapes and sexual assaults cause physical and possibly permanent mental damage that money cannot effectively remedy. See Coker v. Georgia, 433 U.S. 584, 611-12 (1977) (Burger, C.J., dissenting) (finding that rape causes serious psychological and physical harm, and likely has an irreparable long range effect). Jones 'El v. Berge, 164 F. Supp. 2d 1096, 1123 (W.D. Wis. 2001) (holding that "pain, suffering and the risk of

death" constitute irreparable harm sufficient to support a preliminary injunction) (citing Von Colln v. County of Ventura, 189 F.R.D. 583, 598 (C.D. Cal. 1999) ("Defendants do not argue that pain and suffering is not irreparable harm, nor could they.")) Duran v. Anaya, 642 F. Supp. 510, 526-27 (D.N.M. 1986) (preliminarily enjoining prison from reducing medical and mental health care staff because resulting deaths, extreme pain, and self-mutilation constitute irreparable harm). As detailed above, the inappropriate institutionalization of hundreds in Georgia's hospitals, combined with the extensive constitutional violations there, are putting individuals in the hospitals at imminent risk of serious physical and psychological harm, and even death.

Moreover, "[w]hen an alleged constitutional right is involved, most courts hold that no further showing of irreparable injury is necessary." Charles Alan Wright, et. al., Federal Practice and Procedure § 2948.1 (2d ed. 1995) (citing Elrod v. Burns, 427 U.S. 347, 373-74 (1976). "[A]n alleged constitutional infringement will often alone constitute irreparable harm." R.G. v. Koller, 415 F. Supp. 2d 1129, 1162 (D. Haw. 2006) (quoting Associated Gen. Contractors of Cal. v. Coal. for Econ. Equity, 950 F.2d 1401, 1412 (9th Cir.1991) (quoting Goldie's Bookstore v. Superior Ct., 739 F.2d 466, 472 (9th Cir.1984)).

Many, if not the majority, of the individuals in the hospitals are institutionalized when they could be more appropriately served in a community-based setting. See Oswald Decl., Ex. 19, ¶ 12; Franczak Decl., Ex. 20, ¶¶ 14-17. As long as these people remain unnecessarily instituionalized, segregated from the community, they remain at risk of irreparable physical and psychological harm. *See* Fanczak Decl., Ex. 20, ¶¶ 9-13. Indeed, "[a]ll individuals inappropriately institutionalized face ongoing and significant harm." Id. ¶ 13. Immediate relief is therefore necessary.

V. THE BALANCE OF EQUITIES FAVORS GRANTING THE INJUNCTION

This Court must next determine whether the above threatened irreparable injuries outweigh whatever damage the proposed injunction may cause the Defendants. Mesa Air Group, Inc, 573 F.3d at 1128. The severe injuries exemplified above all heavily outweigh the costs to the Defendants of ending the unnecessary segregation and remedying the unsafe conditions.

Providing services to support a person with mental illness living in the community costs substantially less than providing services in an institutional setting. See Franczak Decl., Ex.20, ¶ 42.

Moreover, depriving institutionalized individuals of their Constitutional rights can not be justified by a lack of funding. Ramos v. Lamm, 639 F.2d 559, 574 fn. 19 (10th Cir. 1980). "Protection of constitutional rights is a compelling public interest" and protection of Constitutional rights "weighs heavily in the balancing of harms, for the protection of those rights is . . . a benefit . . . to all citizens." R.G. v. Koller, 415 F. Supp. 2d 1129, 1162 (D. Haw. 2006), citing Int'l Soc'y for Krishna Consciousness v. Kearnes, 454 F.Supp. 116, 125 (E.D.Cal.1978).

VI. THE PUBLIC INTEREST WOULD BE ADVANCED BY GRANTING THE REQUESTED RELIEF

Last, this Court must determine that the preliminary injunction would not be adverse to the public interest. Mesa Air Group, Inc., 573 F.3d 1124, 1128 (11th Cir. 2009). This factor weighs unquestionably in favor of the preliminary injunction, because "there is the highest public interest in the due observance of all the constitutional guarantees." United States v. Raines, 362 U.S. 17, 27 (1960). Beyond the Constitution, Congress highlighted the public interest in protecting institutionalized persons from these types of harms when it enacted the Civil Rights of Institutionalized Person Act.

Moreover, there is a strong public interest in eliminating the harm that attends unnecessary and inappropriate institutionalization. As noted in Olmstead,

the unjustified segregation of persons with disabilities perpetuates unwarranted assumptions that they are incapable or unworthy of participating in community life. Olmstead, 527 U.S. at 600. Moreover, it severely diminishes the individuals' ability to enjoy activities of daily life, such as family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. Id., at 601. "The Mental Health of our citizenry, no less than its physical health, is a public good of transcendent importance." Jaffee v. Redmond, 518 U.S. 1, 11 (1996). Thus, the public interest strongly supports targeting the most immediate life-threatening needs in the hospitals and providing individuals with disabilities with services in the most integrated setting appropriate to their needs.

VII. RELIEF REQUESTED

To remedy these violations of the Constitution and federal statutory law, the United States respectfully requests that the Court order the following relief, as well as any other immediate relief the Court deems appropriate after a hearing on this motion:

1. The State shall promptly take such steps as are necessary to ensure that all individuals in the hospitals and those at risk of admission to the hospitals are served in the most integrated community settings

appropriate with appropriate services, supports, and other necessary resources made available.

2. The State shall promptly place in the most integrated setting in the community and provide with appropriate services all those individuals in the hospitals who can be served in the community and who do not oppose such a placement.

3. Within 14 days of this Order, an Independent Monitor shall be chosen to monitor the State's implementation of this Order. The State shall bear the costs of the Independent Monitor. The Independent Monitor shall have substantial experience in expanding community services for people with mental disabilities and in moving people with mental disabilities out of inappropriate institutional placements. The Parties, with the input of the amici, shall jointly choose the individual who will be appointed as the Independent Monitor and shall notify the Court of their joint selection. If the Parties and the amici are unable to agree on the individual within 14 days of this Order, the Parties and the amici shall jointly petition the Court to make the selection. In this petition, the Parties and the amici will be permitted to propose the names of three alternate candidates for the position, from which the

Court shall select the Independent Monitor. The Parties and the amici shall submit the candidates' curricula vitae, along with other pertinent information regarding the proposed candidates, at the time of the submission of the names of the candidates.

4. Within one month from his or her appointment, the Independent Monitor shall issue a comprehensive action plan ("Action Plan"). The Action Plan shall contain the following components:

   a. The Action Plan shall set forth specific numerical targets and timetables for reduction of the census of the hospitals. These targets shall ensure that individuals who are inappropriately institutionalized will move to appropriate community settings at a reasonable pace, with a substantial number of individuals with psychiatric disabilities, and a substantial number of individuals with developmental disabilities, to move to appropriate community settings within nine months of the issuance of the Action Plan. The Action Plan shall consider the savings that can be realized from the closure of Hospital beds and redirected to develop community capacity.

b. The Action Plan shall identify with specificity the barriers to moving individuals in the hospitals to integrated settings. The Action Plan shall specify all such barriers, whether they relate to the discharge planning process or to community capacity. The Action Plan shall identify specific policy changes that are necessary to overcome those barriers, including specific numbers of additional supported housing slots, ACT teams, ICM case managers, and mobile crisis interventions, together with timetables for adopting those changes.

c. The Action Plan shall identify specific and targeted changes in the policies and practices of the hospitals that will adequately address the suicide risks and resident-on-resident assaults in the hospitals.

d. The Action Plan shall identify potential sources of funding for community services and actions the State must take to access those sources, including actions to maximize appropriate federal funds to reallocate mental health budget funds to the community.

5. The Parties and Amici shall have an opportunity to object to the Action Plan. Any such objections shall be raised with the Court within two weeks of the Independent Monitor's issuance of the Action Plan. If not the subject of timely objection, or once approved by the Court, the Action Plan shall be entered as an order of this Court pursuant to Fed. R. Civ. P. 65.

6. The State shall implement the Action Plan. In particular, the State shall meet the numerical requirements and timetables in the Action Plan and take steps to ensure that all individuals in the hospitals are protected from harm, included harm from resident-on-resident assaults and self-harm.

7. Beginning two months after his/her appointment, the Independent Monitor shall monthly file with the Court a report detailing the Defendants' compliance with the Action Plan.

8. Within one month of this Order and every month thereafter, the State shall provide the Independent Monitor with a list of individuals in the hospitals that the State deems appropriate for community placement and a list of all other individuals in the hospitals. All individuals in the hospitals not on the community placement list shall, within 60

days, be evaluated by the Independent Monitor, or someone under the Independent Monitor's auspices, to determine the barriers to community placement for each such individual. The Independent Monitor shall also evaluate the monthly lists to identify systemic problems that are barriers to community placement and set forth actions that the State must take to redress these problems. The State shall promptly take action to remove barriers for each Individual in the Hospital and to address identified systemic problems.

VIII. CONCLUSION

For the forgoing reasons, the United States requests that the Court order immediate relief and that the Court set a hearing date to consider this request.

Respectfully submitted,
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Local Rule 7.1D Certification

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

/s/ Robert A. Koch
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CERTIFICATE OF SERVICE

This is to certify that I have this day electronically filed the foregoing MEMORANDUM OF LAW IN SUPPORT OF THE MOTION FOR PRELIMINARY INJUNCTION with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all parties in this matter via electronic notification or otherwise:

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