UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF ARKANSAS WESTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. STATE OF ARKANSAS et al.; Defendants.	)	CIVIL ACTION NO: 4:09-CV-00033-JLH

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF UNITED STATES' MOTION FOR PRELIMINARY INJUNCTION

Pursuant to Federal Rule of Civil Procedure 65, the United States moves the Court for a preliminary injunction based on the imminent and serious threat of harm to the life, health, safety, and liberty of the individuals residing at the Conway Human Development Center ("CHDC"). The State of Arkansas ("State") fails to serve residents in the most integrated setting appropriate to their needs in violation of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101-12213, and exposes residents to death and injury as a result of unconstitutional medication management and restraint practices.

In this Motion, the United States seeks to halt all further admissions of children to CHDC in order to mitigate the irreparable harm caused by unlawful

institutionalization until such time as this matter can be fully resolved at trial and seeks to ensure that all children currently institutionalized at CHDC are permitted to receive services in the most integrated setting. The United States also seeks immediate relief for all current residents from CHDC's most dangerous conditions, specifically, its medication management and restraint practices.

Hundreds of individuals are needlessly institutionalized at CHDC. The vast majority of these individuals were first admitted to CHDC as children several decades ago. In fact, there is substantial evidence to show that, from the moment an individual enters CHDC, the chances of release to a more integrated setting severely diminish, particularly for those who first enter as children.

Once admitted to CHDC, residents are likely to die at a very young age compared to residents in similar institutions. In fact, a CHDC resident is more likely to die than be discharged to a more integrated setting. The evidence also shows that CHDC fails to properly administer and monitor powerful psychotropic medications. There is also substantial evidence that CHDC inappropriately and excessively relies on severely restrictive, outdated types of restraints to control its residents.

Immediate relief is necessary to stop ongoing, severe, and irreparable harm. That relief must target the conditions at CHDC that place all residents at the most imminent risk – conditions that have led to death, organ failure, and exposure to lethal side effects of medication and have exposed individuals to needless and

harmful restraints–while requiring that the State ensure that no more of its youngest and most vulnerable citizens are exposed to this unsafe and inappropriately segregated institutional environment.

I. FACTUAL BACKGROUND

The United States notified the State of its intent to investigate conditions at CHDC pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, on November 8, 2002. On April 21, 2004, the United States issued a 50-page letter of findings regarding CHDC, which concluded that there were significant and widespread deficiencies in the conditions and care at CHDC, in violation of both the United States Constitution and federal law. See Exhibit 1 (Letter dated April 21, 2004, from then-Assistant Attorney General R. Alexander Acosta to then-Governor Mike Huckabee) at 2. For several years the United States attempted to resolve the investigation of CHDC outside of litigation. Those efforts were unsuccessful, and the United States filed this lawsuit on January 16, 2009.

Since the filing of its Complaint, the United States has conducted extensive discovery through interrogatories, requests for production of documents, and facility tours. The information collected through discovery to date provides sufficient evidence to demonstrate that residents face increasing and grave risk of harm with each day that deficiencies are ignored. Accordingly, the United States files this Motion to obtain narrow, preliminary relief aimed at preventing further harm caused by CHDC's most egregious deficiencies.

A. Hundreds of Individuals Remain Inappropriately Institutionalized at CHDC.

CHDC is a large, congregate facility, certified as an "Intermediate Care Facility for the Mentally Retarded" (ICF/MR) that houses approximately 510 individuals with developmental disabilities. Exhibit 2 (Roster of CHDC Residents, CON-US-59969-59993).[1] CHDC has been in operation since 1959, when it opened its doors as the Arkansas Children's Colony. "About the Conway Human Development Center," available at http://www.chdconline.com ("About Us") (last visited March 9, 2010). It is the oldest and largest of Arkansas's six residential facilities for individuals with developmental disabilities. Id. CHDC's residents range from eight to seventy-three years old. Exhibit 2. Residents are grouped into one of five "teams" based on CHDC's assessment of their skill level and degree of physical and intellectual disability. http://www.chdconline.com ("About Us"). Each team has its own administrative structure and "team leader."

The CHDC complex is a "self-contained community" that offers its more than 500 residents with disabilities few opportunities to live alongside of, or experience life with, people without disabilities. Exhibit 3 (Declaration of Toni Richardson) at 2-3. The living units at CHDC are communal, and most have dormitory style bedrooms, some with as many as ten beds in one room. Id. at 3. Food is delivered

[1] All Bates labeled documents used as exhibits to this Motion were produced by Defendants in response to the United States' Requests for Production of Documents in this case.

to each unit from a central kitchen and typically plated by the unit staff. Id. There is a public address system in each residence that announces certain times of day. Exhibit 4 (Deposition of Angela Green) at 131:23-25, 132:1-10. Fewer than twenty people leave the CHDC grounds for day programs or employment. Exhibit 3 at 3.

CHDC's residents tend to come in as children and stay for a lifetime. In fact, of the 512 people residing at CHDC as of June 2009, more than 80% were admitted to CHDC as children under the age of 18, and more than a third were admitted before the age of 10. Exhibit 2. Of those children admitted before they were 18 years old, 68% have been living at CHDC for more than 30 years. Id. Of those children admitted before they were 10 years old, 83% have been at CHDC for more than 30 years. Id.

Between June 1, 2007, and October 1, 2009, a resident at CHDC was more likely to die at the facility than to be discharged to a more integrated setting. See Exhibit 5 (Treatment Records of CHDC Residents Who Have Died, CON-US-60013.001-60013.018); Exhibit 6 (List of Discharged CHDC Residents, US-CON-A-46190-46193). Furthermore, CHDC residents die at the strikingly young age of 46.5 years. Exhibit 7 (Declaration of Edwin Mikkelson) at 8. According to comparative studies, 72 years of age is the approximate normal life span for individuals with developmental disabilities who live in an institution, a quarter of a century longer than residents of CHDC. Id.

CHDC has an unusually high number of school-aged residents.[2] There are now approximately 50 children at CHDC,[3] about 10% of CHDC's total population and about 40% more than at the time of DOJ's CRIPA investigation. Exhibit 2. In contrast, of the remaining states operating large, public institutions for persons with intellectual and developmental disabilities as of June 30, 2008, almost 20% had no children or adolescents in residence whatsoever, and over 60% served no children under age 15 in such institutions. Exhibit 8 (Declaration of Robert Gettings) at 2-3.

During the last two years, children have comprised more than half of all new admissions to CHDC. Exhibit 4 at 84:21-25, 85:1-8. Approximately 18 of the children are under the age of 16, and at least one is only eight years old. Exhibit 2.

Any special education instruction that CHDC school-aged residents receive is provided in classrooms located on the grounds of the facility, isolated from their peers without disabilities. Exhibit 9 (Declaration of Susan Thibadeau) at 2-3. Thus, CHDC children have no opportunity to interact either socially or

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[2] By "school-aged residents," the United States is referring to all residents who qualify for special education services under the IDEA which, in the State of Arkansas, includes residents up to the age of 21. A.C.A § 6-41-203. For purposes of this Motion, the United States refers to all such residents as "children."

[3] This number is based on the most recent roster of CHDC that the State has provided to the United States. Due to ongoing admissions and discharges at CHDC, including residents at CHDC temporarily for respite care, it should be considered approximate.

academically with students without disabilities. Id.; Exhibit 10 (Deposition of Tamara Hill) at 93:2-20; Exhibit 11 (Deposition of Susan Milum) at 45:13-22. Further, none of the CHDC children receives a full day of special education services or adequate transition plans. Exhibit 9 at 3.

1. Arkansas Has No Plan For Moving Institutionalized Individuals To The Most Integrated Setting.

In March 2003, the Governor's Integrated Services Task Force (GIST) issued the State's "Olmstead Plan."[4] According to its terms, Arkansas' Olmstead Plan applies to all Arkansans with significant long term support needs. Exhibit 12 at 1-3. In its Olmstead Plan, the State acknowledges that it is not doing enough to divert admissions to institutions, pointing out that "[o]nce a person has made the necessary lifestyle changes to enter an institution, he or she may find that it is more difficult to return home than it would have been to remain in the community in the first place." Exhibit 12 at 22; Exhibit 8 at 9. However, the State is not taking any meaningful action to end unnecessary segregation of individuals with disabilities, nor even using its Olmstead Plan as a working document.[5] Exhibit 8 at

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[4] Exhibit 12 (The Olmstead Plan in Arkansas: A Catalyst for Collaboration and Change; The Governor's Integrated Services Task Force and Arkansas Department of Human Services: March 31, 2003, available at http://www.daas.ar.gov/organizations_olmstead_plan_doc.html (Last visited February 4, 2010) (the "Olmstead Plan").

[5] The State's lack of current efforts to end unnecessary segregation is particularly puzzling in light of testimony by the Assistant Director of DDS' Waiver Unit. Ms. Cromer testified that if release was staggered to give providers time to

7; Exhibit 13 (Deposition of Glenda Higgs, DHS Program Administrator for Quality Assurance at 18:11-25; Exhibit 14 (Deposition of Carole Cromer, Division of Disabilities Services ("DDS"), Assistant Director, Waiver Unit) at 77:2-6; Exhibit 15 (Deposition of Shelley Lee, DDS Assistant Director, Quality Assurance Unit) at 27:14-25, 28:1-7; Exhibit 4 at 75:23-25, 76:1-8. Instead, the State is actively increasing its capacity for institutionalizing children. The State has an action plan for expanding CHDC's children's program which includes increasing the housing available at CHDC for school-aged children. Exhibit 16 (Attachment to email from Shelley Lee to Calvin Price, et al., dated March 6, 2009); Exhibit 17 (Attachment to email from Traci Harris to Calvin Price, et al., dated July 11, 2008). At the same time, the State is expanding its state-wide institutional system by building a new 16-bed facility for children with developmental disabilities and mental illness on the grounds of the Southeast Arkansas Human Developmental Center. Exhibit 18 (Email from Brenda Mercer to Susanne Ballard, et al., dated April 21, 2009).

In fact, in a report released earlier this year, United Cerebral Palsy, Inc. gave Arkansas an overall ranking of second to last among the fifty states and the District of Columbia for supporting community-inclusive lives for individuals with intellectual and developmental disabilities who receive Medicaid-funded services. Exhibit 8 at 3-4. Indeed, the number of individuals with developmental disabilities

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hire appropriate staff, then Arkansas community providers could absorb the 1,334 people on the waiting list for ACS waiver services. Exhibit 14 at 68:3-13.

who are waiting to receive community-based services is on the rise in Arkansas, with over 1,300 currently waiting to receive services through the Centers for Medicaid and Medicare Services (CMS) Alternative Community Services waiver program ("ACS waiver program or services").[6] Exhibit 14 at 49:24-25, 50:1-6. The current wait time in Arkansas for people with developmental disabilities to receive ACS waiver services is approximately two and a half years. Exhibit 14 at 49:12-23; Exhibit 15 at 57:24-25, 58:1-2. According to the State's 2008 waiver renewal request, the State has no plan to increase the number of waiver slots until, at the earliest, 2014. Exhibit 8 at 10. The current average annual cost for an individual to participate in the State's waiver program is $38,000, while the average annual cost of placement at an ICF/MR is roughly $68,000.[7] Exhibit 14 at 28:17-25, 29:1-14.

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[6] This is a third of the total number (3,988) of waiver slots available for persons with developmental disabilities in the entire state of Arkansas. Exhibit 8 at 10.

[7] Nationwide, Arkansas had the lowest weighed average per diem expenditures ($271.27) in its publicly-operated I/DD residential facilities during FY 2007. The State's average weighted per diem was 78 percent below the national average ($484.20) for facilities in all reporting states that year. Average annual per participant expenditures on Medicaid home and community-based waiver services in Arkansas during FY 2008 ($28,977.83) was 50 percent below the average per participant expenditure level in all states ($43,464.29). In FY 2008, the average per resident expenditure on home and community based services in Arkansas ($34.01) was less than one-half the median per resident expenditure in all states ($73.37). The state ranked 46th among the states and the District of Columbia in FY 2008 in waiver expenditures per resident. Exhibit 8 at 3.

2. CHDC's Treatment Approach Guarantees That Most Residents Will Spend Their Entire Lives In A Segregated Institution.

The United States' expert estimates that with appropriate supports, at least half of the over 510 CHDC residents are appropriate for a more integrated setting now. Exhibit 3 at 8-9. Yet, the State has identified only five current CHDC residents as appropriate for community integration via the ACS waiver program. Exhibit 19 (List of Residents Recommended for Waiver, CON-US-0059104). This dramatic discrepancy reflects a pervasive institutional bias at CHDC, and this bias drives CHDC's approach to treatment planning. In fact, the staff at CHDC know little to nothing about community-based treatment. Exhibit 3 at 4-7. For instance, the CHDC employee identified by the State as the person *most* knowledgeable about community placement testified to her belief that CHDC is an "integrated setting," because "[i]t is a place that can meet individuals' needs, it allows them to have training, social interaction, allows them to go, do." Exhibit 4 at 132:10-14.

Not surprisingly, CHDC's assessments of residents' appropriateness for a more integrated setting are terribly inaccurate. This is evident in the plans of care, or "Individual Program Plans" ("IPPs"), that CHDC staff develop for residents. Instead of focusing on what supports residents require to live meaningful lives in the most integrated setting appropriate to their needs, CHDC's IPPs identify arbitrary skills, such as tooth brushing or matching clothing, as prerequisites for

placement, even though the ability to accomplish these tasks has no bearing on whether an individual is appropriate for community placement. Exhibit 3 at 6-7.

In fact, typically, the only way that community placement is meaningfully considered at CHDC is if an individual or guardian proactively expresses an interest in pursuing community-based treatment. Id. at 4-5; Exhibit 4 at 151:1-12**.** Yet, despite that the onus is on residents and their guardians to initiate pursuit of community placement, guardians are provided very little meaningful information with which to make this important decision. See Exhibit 20 (Defendant's Response to United States' First Request For Production of Documents, No. 36, CON-US-0018120); Exhibit 4 at 124:6-9.

In the meantime, while residents remain inappropriately placed at CHDC, they are exposed to dangerous and unconstitutional conditions, as set forth below. In fact, in some cases, the environmental conditions inherent in institutional living may lead to residents' unnecessary exposure to potentially harmful medication side effects and physical restraints. See infra sections III.B.2 and III.B.4.

B. CHDC's Medication Management Practices Place All Residents At Risk of Avoidable Harm.

In recent years, at least three CHDC residents have died, suffered possible permanent organ damage, or been at risk of hemorrhaging to death because of the psychotropic medications administered to them at CHDC. At least two residents were hospitalized for Lithium poisoning, one as recently as October 2009. Exhibit 7

at 4**;** Exhibit 21 (Hospital Admissions List dated November 30, 2009 US-CON-A-0045650-662) at 5-6. Many other CHDC residents are at risk of harm from side effects, but have not been identified as such by CHDC or its treating clinicians. Exhibit 7 at 4-5; Exhibit 22 (Declaration of Jodie Holloway) at 3-5. Medical charts and direct observation show indications of involuntary movements, abnormal organ function tests, and dangerous blood levels associated with side effects of psychotropic medication which have gone undetected or untreated by CHDC or its treating clinicians. Exhibit 22 at 11, 13-14; Exhibit 7 at 4-5. Currently, CHDC has no effective system to detect or treat these serious side effects. Exhibit 7 at 3-4.

Psychotropic medication is widely prescribed at CHDC; approximately 55% of CHDC residents currently receive one or more psychotropic medications, and over 80% of the children at CHDC receive psychotropics. Exhibit 23 (CHDC Residents on Psychotropic Medications, US-CON-A 17839-17939). A "significant portion" of CHDC's over 500 residents have received "first-generation" antipsychotics for several years during their lives. Exhibit 24 (Deposition of Douglas Callahan) at 195:10-25, 196:1-10.

First-generation antipsychotics are an older class of medication associated with a significant risk of serious side effects, including tardive dyskinesia (a movement disorder characterized by frequent, repetitive, involuntary movements of the lips, tongue, jaw, face, trunk, and/or limbs). Exhibit 22 at 4. Further, at least fifty CHDC residents currently receive other medications that can cause tardive

dyskinesia or other movement disorders. Id. at 4, 6. Through medical record review and brief observations of CHDC residents, the United States' experts identified residents displaying symptoms consistent with tardive dyskinesia. Id. at 7. Yet, in CHDC's roster of diagnoses and medications, and in the numerous CHDC medical records reviewed by the United States' experts, only a few residents were identified as having a tardive dyskinesia diagnosis or as warranting further assessment to rule out tardive dyskinesia. Id. at 6-7.

CHDC employs one consulting psychiatrist, Dr. Douglas Callahan, to treat these residents, including children. Exhibit 7 at 5-6. Although he admits that children at CHDC have complicated diagnoses, CHDC's consulting psychiatrist has no specialized training or accreditation in child psychiatry. Exhibit 24 at 33:16-18; 34:10-12; 237:1-10. Moreover, CHDC's consulting psychiatrist is not subject to any clinical oversight. Exhibit 25 (Deposition of Denise Thomas) at 40:18-25, 41:1-2.

CHDC's consulting psychiatrist spends approximately 2.4 hours per year with each of the 278 CHDC residents he follows. Exhibit 7 at 3, 6. The vast majority of the consulting psychiatrist's evaluations take place in CHDC's medical building rather than on the resident's living units and do not include the resident's treatment teams. Id. at 6.

Clinical staff receive no side effects training or information other than a generic description of the effects when a new medication is prescribed. Id. at 5. CHDC's consulting psychiatrist does not meet with treatment teams to advise or

educate them on a resident's vulnerability or experience with the side effects of his or her medication. Id. at 6. Moreover, CHDC's psychiatric consultation notes routinely fail to identify possible medication side effects, adverse drug reactions, or harmful drug interactions. Id.

C. CHDC Uses Harmful and Unnecessary Methods of Restraint.

At CHDC, the widespread use of mechanical restraints is permitted as part of a highly restrictive scheme that places citizens with developmental disabilities at grave risk of harm. See Exhibit 26 (Declaration of Johnny Matson) at 4; Exhibit 27 (Declaration of Ramasamy Manikam) at 4-5. When children are subjected to such restraints, the abuses are particularly unconscionable. Id.

CHDC utilizes 41 different forms of mechanical restraint, including straitjackets, "restraint chairs," and "papoose boards." Exhibit 26 at 4; Exhibit 27 at 4. The use of straitjackets is itself highly troubling, as straitjackets have generally been eliminated from use in most facilities similar to CHDC for years. Exhibit 26 at 4. Similarly, the "restraint chair" and "papoose board" are clinically indefensible when used at CHDC. The "restraint chair" is a chair that allows staff to completely immobilize a resident by strapping him in a seat with large padded forms. Id., Exhibit 27 at 4-5. The "papoose board" is a padded board to which a resident is horizontally strapped such that his arms, legs, and torso are immobilized. Id. Children are not exempted from even these most restrictive mechanical restraints. See generally, Exhibit 26 at 5, 9-12.

The frequency of restraint use is exceptionally high at CHDC. Exhibit 26 at 5; Exhibit 27 at 5. In April 2009 alone, CHDC staff utilized mechanical restraints more than 1,300 times. Id. CHDC's Chief of Psychology has indicated that about 70-80 CHDC residents have treatment programs that include restraint use. Exhibit 26 at 5. As many as six staff at once may be involved in applying restraints to a resident. Id. The actual rate of restraint use is likely much higher than reported, however, because CHDC does not track various devices that function as mechanical restraints, such as fixed dining trays on wheelchairs, face guards, helmets, and "seat belts" on lounge chairs. Id. at 5.

II. LEGAL STANDARD

In determining whether to issue a preliminary injunction, the court must consider "(1) the likelihood of success on the merits; (2) the presence or risk of irreparable harm; (3) the balancing of the harms of granting or denying an injunction; and (4) the public's interest." CDI Energy Services, Inc. v. West River Pumps, Inc., 567 F.3d 398, 401-02 (8th Cir. 2009) (citing Dataphase Systems, Inc. v. CL Systems, Inc., 640 F.2d 109, 114 (8th Cir. 1981). No single prong of the standard is determinative of whether a preliminary injunction should be issued. Dataphase at 113. Furthermore, this standard applies in cases where, as here, some of the relief sought involves compelling a party to take affirmative action. See, e.g., Ferry-Morse Seed Co. v. Food Corn, Inc., 729 F.2d 589, 593 (8th Cir. 1984) ("where the status quo is a condition not of rest, but of action, and the condition of

rest . . . will cause irreparable harm, a mandatory preliminary injunction is proper.").

III. ARGUMENT

A. RESIDENTS OF CONWAY HUMAN DEVELOPMENT CENTER ARE SUFFERING IRREPARABLE HARM.

Death and permanent injury caused by failure in medical care constitutes irreparable harm. Henderson v. Bodine Aluminum, Inc. 70 F.3d 958, 961 (8th Cir. 1995) ("[P]reliminary injunctions become easier to obtain as the plaintiff faces progressively graver harm. . . . It is hard to imagine a greater harm than losing a chance for potentially life-saving medical treatment."); Rodde v. Bonta, 357 F.3d 988, 993-94 (9th Cir. 2004) (upholding injunction to prevent "'severe, irreparable harm' as a result of 'lack of access to preventive care' and 'medical complications . . . increased risk of death, infection, organ failure, and loss of functional ability'").

The inappropriate use of mechanical restraints causes irreparable harm. See, e.g., National Ass'n of Psychiatric Health Systems v. Shalala, 120 F. Supp. 2d 33, 45 (D.D.C. 2000) ("severe psychological and physical injuries . . . can and do result from inappropriate use of restraints"). Moreover, when "a 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); see also R.G. v. Koller, 415 F. Supp. 2d 1129, 1162 (D. Haw. 2006) ("'[A]n alleged constitutional

infringement will often alone constitute irreparable harm.'") (internal citations omitted).

Long term, unnecessary segregation causes irreparable harm. See Exhibit 12 at 22 ("Once a person has made the necessary lifestyle changes to enter an institution, he or she may find that it is more difficult to return home than it would have been to remain in the community in the first place."); Disability Advocates, Inc. v. Paterson, 653 F. Supp.2d 184, 265 (E.D.N.Y. 2009) ("[O]ne of the harms of long-term institutionalization is that it instills 'learned helplessness,' making it difficult for some who have been institutionalized to move to more independent settings.").

For children who are unnecessarily segregated, the irreparable harm is particularly acute. See Exhibit 3 at 9 ("Segregating children in mostly adult populations, separating them from public schools and depriving them of regular contact with non-disabled peers, carries the potential for long-term institutionalization."); Parham v. J.R., 442 U.S. 584, 627-28 (1979) (Brennan, J., concurring in part and dissenting in part) ("The consequences of an erroneous commitment decision are more tragic where children are involved . . . . Childhood is a particularly vulnerable time of life and children erroneously institutionalized during their formative years may bear the scars for the rest of their lives.").

For many children at CHDC, the harmful effects of prolonged, unnecessary segregation are quite blatant. For example, in numerous CHDC IPPs, treatment

teams justify the residents' continued placement at CHDC by noting that the resident has lived at CHDC for "many years" and now considers CHDC "home." In fact, some of the current residents who were children in 2002-03, at the time of the DOJ's CRIPA investigation, have current IPPs that contain this language, even though their earlier IPPs did not expressly foreclose the possibility of an eventual transition to a more integrated setting. Compare 2002 IPP for a then-14-year-old resident ("CHDC is the least restrictive placement alternative for [the resident] *at this time*") (emphasis added) with 2009 IPP (the resident "has lived at [CHDC] for many years.");[8] and 2002 IPP for a then-15-year-old resident (CHDC "is the least restrictive placement alternative known *at this time*.") (emphasis added) with 2009 IPP (the resident "has lived at [CHDC] for many years.");[9] also compare 2002 IPP for a then-17-year-old resident ("A projected discharge date could not be determined due to [the resident's] need for supervision, structure, special education and vocational training.") with 2009 IPP (the resident "has lived at [CHDC] for several years and considers this her home.").[10] Thus, for children who are unjustifiably institutionalized, the risk of irreparable harm begins the moment they step through

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[8] See, Exhibit 28 (2002 IPP for then-14-year-old resident); Exhibit 29 (2009 IPP for the same resident, CON-US-304907-304928).

[9] See Exhibit 30 (2002 IPP for then-15-year-old resident); Exhibit 31 (2009 IPP for the same resident, CON-US-321981-321996).

[10] See Exhibit 32 (2002 IPP for then-17-year-old-resident); Exhibit 33 (2008 IPP for the same resident, CON-US-321318-321337).

CHDC's doors.

The lack of appropriate special education services also causes irreparable harm. See Monahan v. State of Neb., 645 F.2d 592, 598 (8th Cir. 1981) (plaintiff had established a threat of irreparable harm sufficient to support a preliminary injunction where the plaintiff student had been making "little progress" in her then-current placement, and "the resulting harm to [plaintiff] was irreparable and . . . preliminary relief was appropriate to limit such harm."); see also Nieves-Marquez v. Puerto Rico, 353 F.3d 108, 121-22 (1st. Cir. 2003) (finding irreparable harm where school district failed to provide student with sign language interpreter because "'at the rate at which a child develops and changes, especially one at the onset of biological adolescence . . . a few months can make a world of difference' in harm to a child's educational development.") (internal citation omitted)).

B. THE UNITED STATES IS LIKELY TO PREVAIL ON THE MERITS.

1. CHDC Violates the ADA by Failing to Provide Services to Residents, Including Children, in the Most Integrated Setting Appropriate to Their Needs.

There are hundreds of CHDC residents who remain institutionalized in violation of their rights under the ADA. A disproportionate number of these are children, who comprised 50 - 80% of new admissions during each of the last five years. Exhibit 4 at 84: 21-25, 85:1-8; Exhibit 34 (CHDC Psychology Services Meeting Minutes, November 14, 2007, CON-US-0006371). This rate of

institutionalization for children with disabilities is out of step not only with other states but also with the State's recognition of the need to divert children from institutions by providing more services. Exhibit 8 at 3, 9; Exhibit 12 at 22. The ADA requires that the State provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. 42 U.S.C. § 12132 (2008) ("[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) (1998); see also Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 607 (1999). 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." Id. at 600-01.

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)." Id. at 592.

A violation of the integration mandate is established 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 a 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 move[s] 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 ADA claim. First, evidence indicates that hundreds of CHDC residents can "handle or benefit from community settings." See Olmstead, 527 U.S. 601-602; see also Exhibit 3 at 8-9 (expert assessment that "50% or more [of CHDC residents] could live in more integrated community settings."). The State itself has acknowledged that it needs to do more to serve children with disabilities in the community. See Exhibit 12 at 22 ("More work also remains to serve school-aged children and those desiring services outside the clinic setting."). Yet Arkansas does not have a working plan for systematically transitioning institutionalized people to the community, nor does it systematically identify or track the number and

characteristics of CHDC individuals who might be appropriate for community placement. See Olmstead, 527 U.S. at 605-06; see also Exhibit 8 at 8 ("it is impossible to develop a credible plan for transitioning institutionalized persons to the community without first determining the number and characteristics of individuals who potentially might be impacted."); Messier v. Southbury Training School, 562 F. Supp.2d 294, 330 (D.Conn. 2008) (a system of placing institutionalized individuals into the community only as placements happen to become available violates the ADA because a State "cannot systematically develop resources appropriate to [the institution's] residents' placement needs.").

In fact, from June 1, 2007 to September 30, 2009, only eight CHDC residents were discharged to a more integrated setting, or approximately four people a year. Exhibit 6.[11] Of those eight discharged individuals, only three were children. Exhibit 6; Exhibits 35-37; Exhibit 38 (Discharge Summary, April 16, 1991); Exhibit 39 (DHHS Incident Report, CON-US-0020257-0020259); Exhibit 40 (Social Work Summary, October 23, 2008, CON-US, 0180264). Furthermore, between fiscal years 2004 and 2008, new admissions and re-admissions to the State's Human

[11] Other individuals were released from CHDC during this time frame, however, these individuals were temporary residents, placed at CHDC for respite care only. Exhibit 35 (CHDC Respite Meeting, July 6, 2009, CON-US-0300636); Exhibit 36 (CHDC Children Census, CON-US-0005155-0005157); Exhibit 37 (CHDC Respite Meeting, August 17, 2009, CON-US-0302758).

Development Centers have exceeded the number of discharges for each year except one. Exhibit 8 at 9; Exhibit 4 at 84:21-25, 85:1-8; Exhibit 6.

Moreover, as set forth above, the evidence demonstrates that hundreds of CHDC residents are appropriate for community-based treatment, notwithstanding CHDC's failure to recognize this fact. Although Olmstead itself involved two plaintiffs whose treating 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 says nothing about treating professionals; it simply requires services to be administered "in the most integrated setting appropriate to the needs of" the individual. 28 C.F.R. § 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.[12] A requirement that Olmstead plaintiffs come to court armed with the recommendation of a state's

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[12] As the Supreme Court recognized in Olmstead, "[b]ecause the Department [of Justice] is the agency directed by Congress to issue regulations implementing Title II . . . its views warrant respect." Olmstead, 527 U.S. at 597-98. The Court emphasized that "the well-reasoned views of the agencies implementing a statute constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." Id. (internal quotations omitted). In Olmstead, the Court relied on the Department of Justice's position, as set forth in numerous briefs in other segregation cases, that "undue institutionalization qualifies as discrimination 'by reason of . . . disability'" under the ADA. Id. at 598 (quoting 42 U.S.C. § 12132). As set forth below, it is the Department of Justice's "well-reasoned view[]" based on a "body of experience and informed judgment" about the ADA and its implementing regulations that the Defendants' current community placement practices violate both.

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. v. Dept. of Public Welfare, 157 F. Supp.2d. 509, 540 (E.D. Pa. 2001); see also Disability Advocates, 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. v. Hagan, 561 F. Supp.2d 280, 291 (E.D.N.Y. 2008) ("[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."); cf. Messier, 562 F. Supp.2d at 338 (finding that inadequate professional assessments "undermine[] the integration mandate of the ADA").

The problem with reading such a requirement into Olmstead is particularly evident here: CHDC staff are terribly ill-informed about what community-based treatment looks like, what skills are required to live in the community, or even what it means to be living in an integrated setting, yet these same staff are the "treating professionals" assessing residents' appropriateness for community placement. Indeed, instead of focusing on what supports the resident needs in order to live a meaningful life, CHDC's IPPs focus on "skills such as tooth brushing,

matching clothing and other routine skills that hold little interest for the person, and . . . are not needed for community placement." Exhibit 3 at 7. The facility's IPPs also tend to identify stabilization of behavior as a prerequisite to moving to a more integrated setting, without adequately assessing whether environmental factors related to being in an institutional setting are causing or contributing to those behaviors. Id. To read Olmstead as requiring the State to provide treatment in a more integrated setting only when CHDC's ill-informed staff members recognize that it is appropriate to do so would be to ignore the ADA's integration mandate altogether. Frederick L., 157 F. Supp.2d at 540; see also Disability Advocates, 653 F. Supp.2d at 258.

The evidence of CHDC staff's lack of accurate knowledge about community-based treatment is overwhelming. The CHDC employee whom the State identified as *most* knowledgeable about community placement testified that she had no knowledge regarding what services are available in the community versus CHDC, nor did she know whether there are any daily living skills that cannot be taught in the community. Exhibit 4 at 132:15-19, 156:1-3 ("I'm not familiar with all the services that providers are able to give."). Statements by the five team leaders likewise reveal that none have any real understanding of what services are available in the community or when a more integrated placement is appropriate for the residents they serve. Exhibit 3 at 5-6. One team leader went so far as to say

that teams do not recommend community placement because they believe CHDC is "the best." Id. at 6.

Statements by other staff underscore the pervasive institutional bias and widespread misinformation about community-based treatment at CHDC. For example, the United States' expert found that "CHDC staff are of the opinion that "community programs do not provide what CHDC does for people." See Exhibit 3 at 7 (describing a number of misunderstandings CHDC's treatment teams have regarding skill prerequisites for community-based treatment eligibility). In fact, community providers in Arkansas are actually able to offer training on many of the skills that CHDC staff believe are prerequisites for being discharged from CHDC. Id. (discussing her visits to community providers and describing the variety of daily living skills, such as meal preparation, laundry, taking care of clothing, and tooth brushing, that are taught by these providers).

Under the circumstances set forth above, it is impossible to know whether or not any CHDC resident or guardian would oppose moving to a more integrated setting, given that none have been *offered* a meaningful opportunity to move to an appropriate community setting. See 28 C.F.R. pt. 35, App. A, p. 450 (1998) ("[P]ersons with disabilities must be provided the option of declining to accept a *particular* accommodation.") (emphasis added); see also Messier, 562 F. Supp.2d at 338 (stressing that "[t]he [ADA] regulations do not conceive of a resident's option to decline community placement as a right that is to be exercised before any

professional judgment has been brought to bear. Rather, the regulations state that 'persons with disabilities must be provided the option of declining to accept a *particular* accommodation.'").

Furthermore, CHDC does not routinely provide residents or their guardians with even basic written information, such as brochures or pamphlets, about community placement options for CHDC residents. See Exhibit 20; Exhibit 4 at 129:2-22. Nor is there a routine, organized effort by CHDC to provide training about community options to residents and guardians. See Exhibit 3 at 6-7. Unless the guardian raises the issue, the topic of community placement is discussed, if at all, by an IDT member perfunctorily, even apologetically, informing the resident's guardian that the ACS waiver services exist, without any discussion of what that means or how it can benefit the individual. Id. at 4-5. Thus, given the scant and inaccurate information that residents and guardians are provided about community-based treatment, it is not surprising that more of them are not actively pursuing a placement in the community. Messier, 562 F. Supp.2d at 338 ("[a]n opportunity to discuss the possibility of community placement with guardians could make a substantial difference in the number of referrals for placement.").

Finally, as other courts have recognized, Defendants cannot reasonably claim that it would be a fundamental alteration of its programs and services if compelled to comply with the ADA. See Pennsylvania Protection and Advocacy, Inc. v. Pennsylvania Dept. of Public Welfare, 402 F.3d 374, 381 (3rd Cir. 2005) ("Any

interpretation of the fundamental alteration defense that would shield a state from liability in a particular case without requiring a commitment generally to comply with the integration mandate would lead to this bizarre result."); Townsend v. Quasim, 328 F.3d 511, 519 (9th Cir. 2003) ("[P]olicy choices that isolate the disabled cannot be upheld solely because offering integrated services would change the segregated way in which existing services are provided."); Long v. Benson, No. 08-cv-26 (RH/WCS), 2008 WL 4571904, at *2 (N.D.Fla. Oct. 14, 2008) (noting that the State "cannot deny the right [to an integrated setting] simply by refusing to acknowledge that the individual could receive appropriate care in the community. Otherwise the right would, or at least could, become wholly illusory."); Messier, 562 F. Supp.2d at 339 ("[H]aving failed to learn how many class members could or should be placed in the community, the defendants failed to develop resources for placing class members.").

Additionally, Arkansas has no "comprehensive, effectively working plan" for placing CHDC residents in "less restrictive settings." Olmstead, 527 U.S. at 606; Exhibit 8 at 4, 7. Indeed, there is no evidence to suggest that outside of a "series of small bore initiatives," Arkansas has made any commitment to complying with the Title II of the ADA. Id. See Pennsylvania Protection and Advocacy, 402 F.3d at 381-82 (a state agency asserting the fundamental alteration defense should "be prepared to make a commitment to action in a manner for which it can be held accountable by the courts" and should demonstrate that there is "ongoing progress

toward community placement" under the plan); see also ARC of Washington State v. Braddock, 427 F.3d 615, 619 (9th Cir. 2005); Sanchez v. Johnson, 416 F.2d 1051, 1067 (9th Cir. 2005) (finding that a state's commitment to deinstitutionalization should include a plan that is comprehensive, reasonable, and effective). Instead, the State is actively expanding its capacity to institutionalize children with developmental disabilities. Exhibits 16-18. In light of the scant evidence of current efforts by the State to comply with the ADA's integration mandate, it cannot claim that the relief requested in the United States' claim would constitute a fundamental alteration of its services and programs. See Disability Advocates, Inc. v. Paterson, 598 F. Supp.2d 289, 339 (E.D.N.Y. 2009) ("A state's efforts to comply with the integration mandate . . . are . . . an important consideration in determining the extent to which the requested relief would be a permissible 'reasonable modification' or an impermissible 'fundamental alteration.'") (citing Martin v. Taft, 222 F.Supp.2d 940, 985-86 and n.42 (S.D. Ohio 2002)).

Finally, the State has professed its commitment to integration and compliance with the ADA's integration mandate. See Exhibit 12 at 21 (setting as a priority the facilitation of "transitions from institutional settings to the community."); Exhibit 41 (DDS Policy 1081: Mission Statement, CON-US-0000609) (stating Arkansas' commitment to "[e]ngaging in statewide planning that ensures optimal and innovative growth of the Arkansas service system to meet the needs of persons [sic] with developmental disabilities and to assist such persons to achieve

independence, productivity, and integration into the community."). If the State is committed to integrating individuals with disabilities into the community as required under the ADA, then it should not be a fundamental alteration of its services and programs to act on that commitment. See Messier, 562 F. Supp.2d at 345 (finding the State's fundamental alteration claim to be "entirely inconsistent with its public commitment to further enhancing a system of community placement programming, which, it claims, was already robust in early 1999.").

2. Residents, Including Children, Are At Imminent Risk of Death and Other Grievous Harm Because of CHDC's Medication Management Practices.

The Due Process Clause of the Fourteenth Amendment protects the constitutional rights of individuals with developmental disabilities. Youngberg v. Romeo, 457 U.S. 307, 324 (1982). Specifically, "adequate . . . medical care" is one of the "essentials" of care that a State must provide to institutionalized individuals with development disabilities. Id.; see Rennie v. Klein, 720 F.2d 266, 269 (3d Cir. 1983). Accordingly, a State violates the Due Process Clause when it provides medical care that substantially departs from professional standards. Rennie, 720 F.2d at 269; see also Morgan v. Rabun, 128 F.3d 694, 697-98 (8th Cir. 1997). In psychotropic medication cases, a factor to be considered when evaluating professional judgment is "whether and to what extent the patient will suffer harmful side effects." Rennie, 720 F.2d at 269.

In the last three years, CHDC residents have died, suffered possible permanent organ damage, or been at risk of hemorrhaging to death because of the psychotropic medications administered to them at CHDC. Exhibit 7 at 4-5. In each of these instances, CHDC clinicians failed to recognize or treat side effects, causing fatal and serious harm to the residents under their care.

- In July 2007, a CHDC resident died after being hospitalized from a common, preventable side effect of Haldol.[13] The Haldol was itself wrongly prescribed to mask the side effects of another medication of questionable utility. No CHDC clinician ever identified or appropriately treated the side effect that killed him. Id. at 4.

- In April 2008, CHDC clinicians administered toxic levels of Lithium to an eight-year-old child and delayed providing him appropriate care, rendering him comatose, causing possible permanent kidney damage, and nearly killing him. Id. at 4-5.

- CHDC clinicians failed to recognize that a resident on Depakote was experiencing low platelet levels, a common side effect of the medication, such that, in early 2009, he required blood transfusions and was at risk of a fatal hemorrhage. Id. at 5.

Critically, there has been no systemic response at CHDC to address these deficiencies in care and tragic outcomes. As a result, the facility's failure to timely address serious medication side effects continues unabated, a substantial departure from accepted professional standards.

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[13] The side effect, Neuroleptic Malignant Syndrome ("NMS"), is a potentially fatal condition that requires removal from Haldol and active treatment to stops its effects. Exhibit 7 at Attachment A, Case Examples, p. 10. CHDC's medical director admitted "there [have] been problems in the past" with NMS. Exhibit 25 at 83:16-19.

Many other CHDC residents are currently at risk of serious harm from side effects, but have not been identified as such by CHDC. CHDC's consulting psychiatrist admits that a "significant portion" of CHDC's over 500 residents have received typical, or "first-generation," antipsychotics for several years during their lives. Exhibit 24 at 195:10-17, 196:9-10. These medications, and other medication that several current residents receive, can lead to tardive dyskinesia when administered for extended periods of time. Exhibit 22 at 3-4. Yet, although the United States' experts' noted symptoms consistent with tardive dyskinesia in residents' records and observed such symptoms in residents themselves, only a few of these residents' records indicated that they had been identified as warranting assessment to rule out tardive dyskinesia or had been diagnosed with this disease. Id. at 6-7. Moreover, the United States' experts found indications of abnormal organ function tests and dangerous blood levels associated with side effects of psychotropic medication that CHDC clinicians do not detect or treat. Id. at 5, 11, 13; Exhibit 7 at 4. Further, when CHDC clinicians do detect the presence of medication side effects, they have responded by adding another – sometimes fatally dangerous – medication to suppress the side effects, rather than establishing whether the first medication is even effective in treating the underlying condition or assessing whether less harmful alternatives are available. Exhibit 7 at 5. This is a substantial departure from accepted professional standards. Id.

Despite the immediate risks of harm from psychotropic medication, CHDC substantially departs from accepted professional standards by having no formalized system for the detection of side effects. Treatment teams receive no side effects training or information other than a generic description of the side effects when a new medication is prescribed. Exhibit 42 (Email from Carl Reddig to Kathy Gill, et al., dated February 26, 2008). CHDC's consulting psychiatrist, whose plans of treatment are uniformly implemented by CHDC staff, does not meet with treatment teams to advise or educate them about a resident's vulnerability to, or particular experience with, the side effects of his or her medication. Exhibit 7 at 5-6. Moreover, CHDC's consulting psychiatrist routinely fails to identify adverse drug reactions, possible medication side effects, or harmful drug interactions, in his consultation notes. Exhibit 22 at 6.[14] CHDC's consulting psychiatrist himself admitted, "I don't typically document all the side effects that might happen." Exhibit 24 at 161:20-21.

In a substantial departure from accepted professional standards, CHDC's psychiatrist sees individual residents so rarely that he is unable to timely detect and treat side effects of psychotropic medication. On average, the psychiatrist

[14] In fact, there is no clinical oversight of the consulting psychiatrist or his treatment decisions. Further, there is no formal psychiatric peer review at CHDC to evaluate or provide feedback on the psychiatrist's treatment decisions and documentation. Exhibit 22 at 10. When asked "who, in practical terms, supervises [his] work," the psychiatrist stated that "Denise [Thomas] keeps up with what I'm doing as much as anybody." Exhibit 24 at 55:22-56:1. Dr. Thomas stated, however, that she does not supervise any psychiatrists at CHDC. Exhibit 25 at 19:14-15.

spends approximately 2.4 hours per year with each resident. Exhibit 7 at 6. This allocation of time is inadequate for those CHDC residents with an acute deterioration in psychiatric status or significant psychiatric illness that has proven resistant to trials of psychotropic medication. Id. Such individuals require weekly or even bi-weekly follow-up consultations in order to manage the resident's medication regimen. Id. Also, because the consulting psychiatrist sees the vast majority of residents in his office rather than on the units, his psychiatric note is often the only means of communication between the psychiatrist and the treatment team. Id. However, as shown above, CHDC's psychiatric notes do not include any instructive information to the rest of the medical team about known side effects associated with specific psychotropic medications. Id. at 5-6.

CHDC residents are further exposed to medication side effects when they are administered psychotropic medication to control behaviors caused by "environmental" or "situational" factors. CHDC's consulting psychiatrist admits that he prescribes psychotropic medications to residents to control their response to the chaotic environment in which they are placed. See Exhibit 24 at 143:6-25; 144:1-14; Exhibit 7 at 7-8. Subjecting individuals to psychotropic medication on an ongoing basis to control their response to the environment in which they are placed is a gross violation of generally accepted professional standards. Exhibit 7 at 7. This practice also exacerbates the harms associated with CHDC's failure to comply with its obligation under the ADA.

3. CHDC's Psychiatric Treatment of Children Violates Generally Accepted Professional Standards and Places CHDC Children at Imminent Risk of Harm and Death

In 2008, CHDC administered toxic levels of Lithium to an eight-year-old resident, placing him in a near-fatal coma and causing him possible permanent organ damage. Exhibit 7 at 4-5. Despite this incident, as well as the fact that CHDC clinicians consider the children admitted to the facility to have complex mental health issues, Exhibit 24 at 38:14-21, and the fact that 80% of these children receive psychotropic medication, Exhibit 23, their psychiatric care is provided by a person with no formal education or training in child psychiatry. Exhibit 24 at 33:16-18; 34:10-12.

This is a substantial departure from accepted professional standards. The American Academy of Child & Adolescent Psychiatry (AACAP) Policy Statements regarding Criteria for Clinical Privileges for Physician Members of Medical Staffs specifically states:

> For patients under 14 years of age, a qualified psychiatrist is a child and adolescent psychiatrist who is board certified in child and adolescent psychiatry or a psychiatrist who in addition to general psychiatry training has successfully completed a training program in child and adolescent psychiatry accredited by the Accreditation Council on Graduate Medical Education.
>
> For patients 14-17 years of age or older, a qualified psychiatrist is a child and adolescent psychiatrist as noted above or general psychiatrist who has documented sufficient, specialized training and experience in working with adolescents and their families on an inpatient treatment program, and has demonstrated competence to examine and treat adolescents comprehensively.

Exhibit 22 at 7-8.

The ongoing treatment of institutionalized children by a psychiatrist who has no formal training or accreditation in child and adolescent psychiatry substantially departs from generally accepted professional standards. Exhibit 7 at 6-7; Exhibit 22 at 7. Psychiatric treatment of children with complex mental health needs that is administered by persons unqualified to render it exposes those children to risk of harm (Exhibit 7 at 6), threatening their "liberty interest in safety," and depriving them of the adequate medical care to which they are entitled. Youngberg, 457 U.S. at 318-324.

4. CHDC Unreasonably Restrains Residents in Violation of the Fourteenth Amendment.

The right of individuals with developmental disabilities to be free from unreasonable restraints has long been recognized under federal law. Youngberg, 457 U.S. at 316; see Lelsz v. Kavanagh, 673 F. Supp. 828, 850-851 (N.D. Texas 1987) (use of mechanical restraints and aversive techniques barred as improper punishment); Thomas S. by Brooks v. Flaherty, 699 F.Supp. 1178, 1200-1201 (W.D. N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990) (due process protection includes freedom from undue bodily restraint). "Liberty from bodily restraint always has been recognized as the core of the liberty protected by the Due Process Clause from

arbitrary governmental action." Greenholtz v. Nebraska Penal Inmates, 442 U.S. 1, 18 (1979) (Powell, J., concurring in part and dissenting in part).

Restraints should only be used when a patient is a danger to himself or to others. See Youngberg, 457 U.S. at 324 ("[The State] may not restrain residents except when and to the extent professional judgment deems this necessary to assure such safety or to provide needed training."); Society for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1245 (2d Cir. 1984) (holding that patients of mental health institutions have a right to freedom from undue bodily restraint); Thomas S., 699 F. Supp. at 1189 ("It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than systematic behavior techniques such as social reinforcement to control aggressive behavior."). "Seclusion and restraint should only be used as a last resort." Thomas S., 699 F. Supp. at 1189.

CHDC's psychology and behavioral management program lacks basic requirements to safeguard against the inappropriate use of mechanical restraints and thus violates the Constitution and federal regulations. Notably, federal regulations emphasize that restraints should only be used if "necessary," and in the context of a comprehensive "active treatment" program. See, 42 C.F.R. § 483.420(a)(6); 42 C.F.R. § 483.450(b) (3). Federal regulations expressly prohibit the use of restraints as a substitute for such "active treatment." See 42 C.F.R. § 483.450(b) (3). "Active treatment" requires much more than a modicum of

professional review or thought. Rather, a state must ensure that its treatment for people with developmental disabilities:

> ... includes *aggressive, consistent implementation* of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward - (I) The acquisition of the behaviors necessary for the client to function with *as much self determination and independence as possible;* and (ii) The prevention or deceleration of regression or loss of current optimal functional status.

42 C.F.R. § 483.440 (a) (emphasis added). Yet CHDC's psychology program does not include even the basic components of a credible clinical treatment process, let alone serve as "active treatment."

At CHDC, several factors demonstrate how state psychologists substantially depart from generally accepted professional standards in their everyday practice, and instead rely on restraints in lieu of appropriate treatment. First, major components of CHDC's treatment program, including specific treatment approaches and underlying philosophies, are not based on any type of demonstrably reliable model. CHDC's Chief of Psychology acknowledges that forms, assessment instruments, interventions and other CHDC practices governing treatment and restraint are idiosyncratic to CHDC. Exhibit 43 (Deposition of Carl Reddig) at 91:11 - 93:1. Nor are they founded on any type of evidence-based, clinically defensible methodology. Exhibit 26 at 6-7; Exhibit 27 at 6-7. Even basic information, such as a resident's level of intellectual functioning, is not properly

assessed. Exhibit 26 at 7. For instance, Dr. Matson, the United States' expert consultant, identified at least 40 individuals whose intellectual levels were incorrectly identified based on CHDC's own documentation. Id. Trying to treat residents with complex psychological conditions without utilizing demonstrably reliable instruments and techniques is indefensible in terms of professional and legal standards.

Second, the staff's failure to properly track and limit the use of certain types of restraint, such as helmets and fixed dining trays on wheelchairs, itself reflects an unawareness of basic clinical standards. Id. at 5. Using restraints such as the papoose board in response to behaviors is problematic enough, but CHDC staff further depart from generally accepted professional standards by using an array of other restraints without even monitoring them as restraints. Id.

Third, the ostensible diagnoses or clinical justifications for using restraints in individual cases are frequently specious. Dr. Matson found nearly thirty cases where the etiology of mental health conditions could not be clinically justified. Id. at 8.

Fourth, CHDC's ability to evaluate the effectiveness of the weak treatment plans currently used at the facility is inherently poor, because written policies and training programs do not ensure that staff actually implement those plans. Id. at 7-9; Exhibit 27 at 5-8. For instance, CHDC does not have fidelity measures to ensure that staff implement treatment plans as written; nor does CHDC conduct

competency training to ensure that staff understand the plans that they are implementing. Exhibit 26 at 8-9; Exhibit 27 at 6-7. Individuals are being restrained because of their behavioral response to the environmental conditions in which they are placed, even when CHDC staff have identified environmental conditions as triggers for those behaviors. Exhibit 27 at 7. This results from both CHDC's failure to provide appropriate behavioral interventions and from the environment in which these individuals are placed. Id.

CHDC's failure to understand how environmental factors trigger uses of restraints, id., is of particular concern, given that treatment teams inappropriately identify individuals' need to "stabilize behavior" as a prerequisite for discharge to a more integrated setting. Exhibit 3 at 7-8. Thus, in some cases, an individual who is inappropriately segregated at CHDC may be subjected to severe forms of restraints, such as papoose boards, to control behaviors that he may not even exhibit if in the community. Id.

Finally, administrative safeguards to limit the misuse of restraints by staff are poorly enforced. State policies require debriefing after restraint use, release from restraints to allow positive programming, and staff compliance with restraint release criteria, but in practice, CHDC does not actually comply with any of these policies. Exhibit 27 at 5-6. Further, when our consultants evaluated mechanical restraint use, they found cases where release criteria appeared to be unreasonable or applied haphazardly. Exhibit 26 at 9-12, Exhibit 27 at 6, 13-14. Utilizing

restraint without these types of safeguards and procedures is another example of how CHDC staff substantially depart from generally accepted professional standards.

Examples of how staff misuse restraints have been identified throughout the course of the United States' investigation. Exhibit 26 at 9-12; Exhibit 27 at 2, 4, 8-14. CHDC staff repeatedly write restraint programs where the criteria for use of, and release from, restraints are facially vague, arbitrary, or inappropriate. See Exhibit 26 at 9-12. For instance, one 16-year-old boy may be placed in a papoose board "depending on the judgment of the staff regarding the extensity of the behavior and its potential for harm." Id. at 10. In another example, staff may place a 10-year-old boy in a papoose board until he is "relatively quiet and still for 5 minutes." Id. at 9. In yet another case, staff may use a papoose board on a 14-year-old girl until she is apologetic for her behavior. Id. at 11. Federal regulations allow restraints only when necessary and when other reasonable treatment measures have failed. See 42 C.F.R. §§ 483.420 (a)(6), 483.440(a); 483.450(b)(3). This is not the case at CHDC, and these examples illustrate the deeply flawed judgment of CHDC professionals when utilizing restraints.

The restraint practices at CHDC violate such basic tenets of clinical practice that the United States is likely to prevail. Globally, every use of restraints at CHDC is problematic because, as set forth above, CHDC staff do not understand, or choose not to implement, the basic components of a behavioral management

program. Without first attempting to manage behaviors in a clinically appropriate manner, the use of restraints cannot be presumed appropriate or necessary. Cf., 42 C.F.R. §§ 483.420 (a)(6), 483.440(a); 483.450(b)(3). Indeed, the better presumption may be that given contemporary standards, widespread use of mechanical restraints is inherently unreasonable. In fact, many other facilities across the country now "use little or no mechanical restraints" at all. See Exhibit 26 at 5 (emphasis added), Exhibit 27 at 5.

CHDC restraint practices substantially depart from generally accepted professional standards and thus violate the standard set in Youngberg. A contrary conclusion would effectively allow CHDC to utilize some of the most restrictive devices imaginable, even on children, in disregard of federal law and policy that strongly favors treatment of individuals in the most integrated setting and with far less restrictive measures whenever possible.

C. THE BALANCE OF HARMS FAVORS GRANTING THE INJUNCTION

As set forth in Section III.A above, the harm that CHDC residents face due to inappropriate placement, medication mismanagement, and excessive and inappropriate use of restraints is grave, irreversible, and, at times, lethal. In contrast, the narrow measures of relief requested in this Motion cause no significant harm to Defendants. To remedy the harm caused by CHDC's constitutional violations, CDHC must simply invest the minimum resources and administrative

support necessary to protect the lives and safety of its residents. "While requiring defendants to adopt polices [sic], procedures, and training so as to provide . . . a reasonably safe environment . . . may impose some administrative inconvenience, any burden on the defendants is minimal when viewed in light of defendants' legal responsibility to provide a safe environment." R.G. v. Koller, 415 F. Supp. 2d 11129, 1162 (D.Haw. 2006).

Moreover, the narrow ADA relief requested in this Motion focuses directly on children – the class of individuals most at risk of irreparable harm from inappropriate institutionalization and from the unconstitutional conditions at CHDC. And that relief furthers the State's professed goal of "ensur[ing] optimal and innovative growth of the Arkansas service system to meet the needs of persons with developmental disabilities and to assist such persons to achieve independence, productivity, and integration into the community." Exhibit 41. See also Exhibit 12 at 21 (setting as a "Priority Recommendation" to "[f]acilitate transitions from institutional settings to the community"). It would be unreasonable for the State to argue that it will be harmed by complying with its stated goals.

D. THE PUBLIC INTEREST IS SERVED BY GRANTING THE INJUNCTION.

Lastly, this Court must consider whether granting the injunction is in the interests of the public. Dataphase, 640 F.2d at 114. This factor unquestionably weighs 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).

Ensuring that citizens receive adequate medical and mental health care is in the public interest. Jaffe v. Redmond, 518 U.S. 1, 11 (1996) ("The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance."); Arkansas Medical Society v. Reynolds, 834 F. Supp. 1097, 1102, 1103-04 (E.D. Ark. 1992) ("'[I]n view of the public interest involved, medical care to patients, the Court feels that the weight of discretion is on the side of granting the motion [for preliminary injunction].'") (internal citation omitted).

Protecting citizens against undue restraint is likewise in the public interest. See, e.g., National Ass'n of Psychiatric Health Systems v. Shalala, 120 F. Supp. 2d 33, 45 (D.D.C. 2000) (finding that the public interest supported upholding a rule that required medical review of restraints after one hour because "restraints and seclusion are dangerous interventions" and "severe psychological and physical injuries" result from the inappropriate use of restraints").

Finally, there is a strong public interest in eliminating the harm that attends unnecessary and inappropriate isolation. 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 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; see also Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 1990 U.S.C.C.A.N. (104 Stat. 327) 445, 473. ("[T]he long-range effects of integration will benefit society as a whole."). Thus, the public interest strongly supports targeting CHDC's most immediate life-threatening conditions and providing its youngest and most vulnerable residents with services in the most integrated setting appropriate to their needs.

IV. RELIEF REQUESTED

Once admitted to CHDC, a child's chances of ever living in the community again immediately - and irreparably - decrease. Accordingly, the United States requests narrow and immediate relief designed to protect children's rights to live in the least restrictive setting and to protect all CHDC residents from further exposure to risk of death and injury as a result of unconstitutional medication management and restraint practices.

The United States requests that the Court issue an order providing immediate relief to:

a) Cease all admissions of school-aged children to CHDC;

b) Prohibit the treatment of CHDC children with psychotropic medications prescribed by a psychiatrist not accredited in child and adolescent psychiatry and appoint an independent psychiatric consultant to perform a medication side effect assessment of each

CHDC resident who is receiving or has received psychotropic medications; and

c) Prohibit the use at CHDC of the most severe, outdated forms of mechanical restraints.

This immediate relief is necessary. The State should be prevented from increasing the number of children currently at risk of the negative effects of unnecessary institutionalization, as well as the dangerous conditions at CHDC. Additionally, children at CHDC are exposed to long-term and potentially fatal side effects from dangerous treatment with psychotropic medications by a psychiatrist who has no formal training or accreditation in child and adolescent psychiatry. Therefore, at a minimum, the State should also be required to retain the services of a certified child psychiatrist at CHDC, in accordance with generally accepted professional standards. Finally, the United States urges that the Court clearly and unequivocally prohibit the State from using papoose boards, restraint chairs, straitjackets, and similar outdated, extreme forms of behavioral restraints on children. Such restraints are widely disfavored nationwide and not in accordance with generally accepted professional standards.

Separately, within 90 days of the Court's order, all other forms of restraint should be reviewed, and revised as appropriate, by an independent team of doctoral-level behavioral clinicians with actual training and experience in contemporary, evidence-based behavioral management programs.

The immediate steps described above will stop the most emergent harm. It would also be appropriate for the Court to go further, however, as additional relief would mitigate the ongoing irreparable harm caused by the inappropriate, continued institutionalization of children already admitted to CHDC. Every day that a child spends at CHDC causes irreparable harm to that child's future ability to live successfully in the community and exposes that child to the dangerous conditions at CHDC. The Defendants' failure to properly assess each individual's capacity to live in a more integrated setting promotes the assumption - to CHDC residents, their families and the community - that these children are incapable or, worse, unworthy, of participating in community life. The State's continued expansion of its capacity for institutionalizing children signals clearly that it lacks any genuine commitment to avoiding unnecessary institutionalization. Accordingly, the United States asks the Court to order a prompt and impartial assessment of any children at CHDC by a qualified independent expert, and prompt implementation of procedures to facilitate their placement, as appropriate, in a safe, community setting that provides the comprehensive services these children need in the most integrated environment.

While this relief would not be as streamlined as the other steps described above, it is appropriate even at this preliminary stage. In order to facilitate proper assessment and placement, in accordance with federal law, within 30 days of the Court's Order, the Parties should jointly choose an individual to be appointed as the

Community Placement Evaluator. The Community Placement Evaluator should be an independent professional who has substantial experience in expanding community services for children with developmental disabilities and in moving children with developmental disabilities out of institutional placements. If the Parties are unable to agree on the individual, they should petition the Court to make the selection. The State should bear the costs of the Community Placement Evaluator.

Within 90 days of the Court's Order, the Community Placement Evaluator should assess all the school-aged children at CHDC, including children who have been residing at CHDC for more than 30 days on a "respite" or "emergency" basis, who are not on the community placement list or "Olmstead waiting list." This assessment should identify whether the child is appropriate for community placement and what, if any, barriers to community placement exist for that individual.

Within 30 days of this assessment, the State, under the supervision of the Community Placement Evaluator, should develop and promptly implement written transition plans for each child that identify both the supports and services necessary to facilitate prompt, safe, and sustainable placement in an appropriate setting and the strategies to overcome placement barriers.

The United States respectfully requests that the Court order the foregoing relief measures, along with whatever additional relief the Court deems necessary.

V. CONCLUSION

For the foregoing reasons, the United States respectfully requests that this Court grant its Motion for Preliminary Injunction.

Respectfully submitted,

THOMAS E. PEREZ
Assistant Attorney General
Civil Rights Division
Attorney for Plaintiff

SAMUEL R. BAGENSTOS
Principal Deputy Assistant Attorney General
Civil Rights Division
Attorney for Plaintiff

SHANETTA Y. CUTLAR
Chief
Special Litigation Section
Attorney for Plaintiff

BENJAMIN O. TAYLOE, JR.
Special Counsel
Special Litigation Section
Attorney for Plaintiff

s/ Kerry Krentler Dean
KERRY KRENTLER DEAN
CHRISTOPHER N. CHENG
ARETHEA A. COLES
LAURA COON
JACQUELINE K. CUNCANNAN
VINCENT HERMAN
NICHOLAS MAY
Trial Attorneys
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Ave, NW
Washington, DC 20530
(202) 514-6255
kerry.k.dean@usdoj.gov
Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I certify that on March 9, 2010, I served a true and correct copy of the *Memorandum of Points and Authorities in Support of Motion for Preliminary Injunction* with the Clerk of the Court using the CM/ECF system, which will send notification to the following:

Thomas York, Esq.
York Legal Group
3511 North Front Street
Harrisburg, PA 17110
717-236-9675
717-236-6919 (fax)
tyork@yorklegalgroup.com

Donald B. Zaycosky
York Legal Group LLC
3511 North Front Street
Harrisburg, PA 17110
717-236-9675
717-236-6919 (fax)
dzaycosky@yorklegalgroup.com

Lori Freno-Engman
Arkansas Attorney General's Office
323 Center Street
Suite 200
Little Rock, AR 72201-2610
(501) 682-1314
lori.freno@arkansasag.gov

Respectfully submitted,

s/ Kerry Krentler Dean
Kerry Krentler Dean
Trial Attorney
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Ave, NW
Washington, DC 20530
(202) 514-1841
(202) 514-0212 (fax)
kerry.k.dean@usdoj.gov
Attorney for Plaintiff